STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

NOTICE TO INTERESTED PARTIES, March 28, 2014

The Rhode Island Executive Office of Health and Human Services (RI EOHHS) has prepared a draft proposed *Comprehensive Quality Strategy* for the State's section 1115 Medicaid demonstration and is seeking the input of recipients, the RI EOHHS Medical Care Advisory Committee (MCAC), and other stakeholders. This process has been undertaken to fulfill the requirements of 42 CFR 438.202(b) and the Waiver's associated Special Terms and Conditions (STC). STC # 128 requires the submission of a draft *Comprehensive Quality Strategy* to the Centers for Medicare and Medicaid Services (CMS) within one-hundred and twenty (120) days following CMS' approval of the Rhode Island Comprehensive Demonstration on December 23, 2013.

The State's current CMS-approved Quality Strategy was approved by CMS on April 25, 2013. The proposed draft *Comprehensive Quality Strategy* addresses the quality measures associated with the implementation of Rhody Health Options (RHO) and Connect Care Choice Community Partners (CCCCP), which began on November 1, 2013, and the enrollment of the State's Affordable Care Act (ACA) Adult Expansion population into Medicaid managed care delivery systems, which started on January 1, 2014.

Persons wishing to submit written testimony may do so by April 28, 2014 to Darren J. McDonald, Office of Policy and Innovation, Executive Office of Health and Human Services, Louis Pasteur Building, 57 Howard Avenue, Floor # 1, Cranston, RI 02920. The *Comprehensive Quality Strategy* is attached, as well as accessible on the EOHHS website www.eohhs.ri.gov or available in hard copy upon request (401-462-1965 or RI Relay, dial 711). The referenced appendices in the *Comprehensive Quality Strategy* have been included below via attachment and/or link to the EOHHS website.

2005 CMS Approved Quality Strategy:

http://www.eohhs.ri.gov/ReferenceCenter/ResearchAnalysis/tabid/135/LiveAccId/5920/Default.aspx

2012 CMS Approved Quality Strategy

http://www.eohhs.ri.gov/ReferenceCenter/ReportstoGovernmentPartners.aspx

RHODE ISLAND
1115 WAIVER
COMPREHENSIVE QUALITY STRATEGY

March 2014

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

Revised
February 2014

TABLE OF CONTENTS

INDEX OF TABLES

APPENDICES

Appendix 1: 2005 CMS Approved Quality Strategy

Appendix 2: 2012 CMS Approved Quality Strategy

Appendix 3: Quality Improvement Activity Form Template

Appendix 4: National Committee for Quality Assurance (NCQA) Crosswalk

INTRODUCTION
COMPREHENSIVE QUALITY STRATEGY

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

Subsequently, the State's most recent revision to its *Quality Strategy* was approved by CMS in April 2013. The latter document built upon the core principles that had been previously approved by CMS for RIte Care, with the inclusion of chapters that delineated the components of quality design for Rhody Health Partners, the State's MCO-based Medicaid managed care program for disabled adults, as well as the corresponding design for the State's primary care case management (PCCM) program for disabled adults, Connect Care Choice. The State's current *Quality Strategy* also delineates the quality design for RIte Smiles, the State's dental managed care program for Medicaid-enrolled children born on or after 05/01/2000.

Three (3) major policy initiatives have contributed to the development of Rhode Island's proposed *Comprehensive Quality Strategy*:

- The implementation of Phase One of Rhode Island's program for Medicare and Medicaid Eligible (MME) individuals who are eligible for full Medicaid benefits, as approved by CMS for implementation, which began 11/01/2013. Phase One implementation is the incorporation of home and community based services for Medicaid eligibles and MMEs into a managed care delivery system.
- The enrollment in Medicaid, beginning on 01/01/2014, of adults who are age 19 or older and under 65 who are at or below the Federal Poverty Level based on household income using the application of a modified adjusted grow income (MAGI) who are not pregnant, not entitled to or enrolled in Medicare, and not eligible for mandatory coverage under the State's Medicaid Plan. (This group is referred to as Rhode Island's Affordable Care Act Adult Expansion population.) Additional information on this new population is defined further in Chapter 4.
- CMS' renewal on 12/23/2013 of the State's Comprehensive 1115 Demonstration (Project Number 11-W-00242/1) and the Demonstration's associated Special Terms and Conditions (STCs), which include STC 128 (Comprehensive Quality Strategy).

Rhode Island's two preceding CMS-approved quality strategies have been appended in their entirety to the proposed *Comprehensive Quality Strategy (CQS)* as Appendices One and Two, respectively.

On March 12, 2013, the State submitted a request to renew the State's Comprehensive 1115 Demonstration. The renewal request was approved on December 23, 2013. The Special Terms and Conditions (STCs), waiver and expenditure authorities are effective from the approval date through December 31, 2018. The State operates its entire Medicaid program under the Comprehensive 1115 Demonstration, with an aggregate budget ceiling for Federal reimbursement with the exception of disproportionate share hospital (DSH) payments, administrative expenses, phased Medicare Part D contributions, and payments to local education agencies (LEAs).

The Comprehensive 1115 Demonstration Waiver is built upon three fundamental goals:

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

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

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

The Comprehensive 1115 Waiver helps to assure the financial viability, sustainability, and stability of the State's Medicaid program. In effect, the Comprehensive 1115 Waiver sets forth a strategic approach for reforming the Medicaid program to build a more responsive and a more accountable program that serves Medicaid beneficiaries with the ***right services, in the right setting, and at the right time***.

Serving as the State's Medicaid agency, the Rhode Island Executive Office of Health and Human Services (RI EOHHS) has responsibility for the State's Section 1115 Demonstration Waiver. The EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island, with responsibility for coordinating the organization, financing, and delivery of services and

supports provided through the State's Department of Children, Youth, and Families (DCYF), the Department of Health (HEALTH), the Department of Human Services (DHS) including the divisions of Elderly Affairs and Veterans Affairs, and the Department of Mental Health, Retardation and Hospitals (BHDDH). Because the Rhode Island EOHHS is an integral partner in a broad array of quality initiatives, a new Office of Health Policy and Innovation was established within the agency in 2013.

Rhode Island was one of twenty-six (26) States to be awarded a Medicaid Adult Quality grant from the Center for Medicare and Medicaid Services (CMS)[1] in 2012. Through this grant opportunity EOHHS is able to build State capacity in the reporting and analysis of health care quality. A key focus of this grant will be building the needed capacity and system to produce fifteen (15) clinical quality measures that have been prioritized by the State for analysis across Medicaid's delivery systems, based on the inputs of various stakeholders. (That process was outlined in the State's first Annual Report to CMS for the Adult Quality grant, which was submitted on 01/31/2014.)

The Adult Quality Grant management responsibility referenced above resides in the Office of Policy and Innovation within the RI EOHHS. The Office was designed to centralize oversight of policy and development, health information technology initiatives (including the All Payer Claims Database (APCD) and EHR incentive program), data systems (including MMIS, UHIP – the new enrollment system, and the data warehouse), and quality measurement across Rhode Island's 1115 Waiver.

As a next step, RI EOHHS is working to develop and sustain the infrastructure required to identify and collect meaningful quality measures. A pivotal component of that process is building the system capacity to collect, analyze and share performance based outcomes. Rhode Island is currently seeking to develop a RI Healthcare Quality Measurement, Reporting and Feedback System. This new system would capture data from health care providers to inform quality improvement efforts, payment, and consumer choice. RI Medicaid is working with several partner agencies on this effort. This would represent a tremendous opportunity to truly evaluate the State's healthcare quality performance across systems, payers and providers. A key aspect of this new system will be to ability to publicly report outcomes to enable consumers to make informed decisions about their health care. Another valuable component of such a system will be the ability to harmonize quality measures and reduce duplication of effort, reducing reporting burden and ensuring a streamlined electronic data collection process.

On page 7, Rhode Island has prepared a diagram that has been crafted to depict the qualitative and quantitative analytic components of the proposed *Comprehensive Quality Strategy* for the Section 1115 Demonstration Waiver. The State has endeavored, where possible, to employ the use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF) and which have relevance to Medicaid-enrolled populations, such as the CMS Adult Core Measure Set and the Children's Core

[1] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html

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

Please refer to the diagram shown on page 7, which has been devised to provide a visual depiction of the various qualitative and quantitative measures that will be used to monitor the State's Demonstration Waiver. Measures have been bulleted for each of the following areas of analysis:

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


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

As is customary for Section 1115 waivers, CMS defines "Special Terms and Conditions" (STCs) for the demonstration. In the renewal of Rhode Island's Comprehensive 1115 Demonstration, STC 128 addresses quality assurance and improvement and stipulates:

"The state shall adopt and implement a comprehensive and dynamic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This CQS must include all components of the Medicaid state plan, including but not limited to: the Comprehensive demonstration (RIte Care, Rhody Health, Connect Care Choice, RIte Smiles, and the HCBS programs)."

This update therefore incorporates relevant changes made to RIte Care, Rhody Health Partners, Connect Care Choice, and RIte Smiles as well as separate sections for Rhody Health Options and Connect Care Choice Community Partners.

Enrollment (as of December 31, 2013) in each of these programs has been provided below[2:]

RIte Care – 126,784
Rhody Health Partners – 13,871
Connect Care Choice – 1,757
RIte Smiles – 67,346
Rhody Health Options - 10,986[3]
Connect Care Choice Community Partners - 2,539[4]

[2] These enrollment figures represent a point-in-time snapshot as of 12/31/2013.
[3] This is based on a snapshot of enrollment as of 2/1/2014. The enrollment approach for both Rhody Health Options and Connect Care Choice Community Partners is a phased approach in which the last enrollment wave will occur in April 2014.
[4] This is based on a snapshot of enrollment as of 2/1/2014. The enrollment approach for both Rhody Health Options and Connect Care Choice Community Partners is a phased approach in which the last enrollment wave will occur in April 2014.

CHAPTER 1

OVERVIEW OF FEDERAL QUALITY ASSESMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

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

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

1.1 Medicaid Managed Care Final Regulations

Except for those Federal legal requirements specifically waived in the *approval letter* for 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)[5]. 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."[6]

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

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

    - Monitor and evaluate Health Plan compliance with the standards regularly

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

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

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

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

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

1.2 Medicaid External Quality Review Final Regulations

On January 24, 2003, the Centers for Medicare & Medicaid Services (CMS) published an external quality review (EQR) *Final Rule* in the *Federal Register* to implement Section 4705 of the BBA.[7] The effective date of this *Final Rule* is March 25, 2003 and provides[8]:

> "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."[9]

- **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[10] that "information be obtained through methods consistent with the protocols established under §438.352."

- **EQRO Must Produce A Detailed Technical Report** – The January 24, 2003 *Final Rule* requires[11] that the EQR produce a "detailed technical report" that "describes the manner in which the data from all activities conducted in

---

[7] Essentially Section 1932(c) of the Social Security Act.
[8] *Federal Register*, 68(16), January 24, 2003, 3586.
[9] 42 CFR 438.350(a).
[10] 42 CFR 438.350(e).
[11] 42 CFR 438.364.

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 accordance with 42 CFR 438.360(b)(4), a crosswalk pertaining to NCQA's comparability to the regulatory requirements for compliance is also incorporated. This strategy was approved by CMS in April of 2005[12] and 2013[13].

- **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[14]:

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

Other "mandatory" EQR activities need not be performed by an EQRO, although enhanced FMAP is not available unless an EQRO performs them[15]. Table 1-1 shows these obligations in tabular form.

"Optional" activities[16] include:

- Validation of encounter data
- Administration or validation of consumer or provider surveys of quality of care
- Calculation of additional performance measures[17]
- Conduct of additional quality improvement projects[18]
- Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time

The information provided as a result of the External Quality Review process informs the dialogue between the EQRO and the State, part of which is the determination to continue or recommend alternative quality improvement projects. Rhode Island incorporates the recommendations from the EQRO into the State's oversight and administration of RIte Care, Rhody Health Partners, and Rhody Health Options. Concurrently, each Medicaid-participating Health Plan is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by Rhode Island Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, each Health Plan must make a presentation at the State's

[12] Appendix 1
[13] Appendix 2
[14] 42 CFR 438.358(b).
[15] *Federal Register*. *Op. Cit.*, 3611.
[16] 42 CFR 438.358(c).
[17] Any "additional" performance measures must be validated by an EQRO.
[18] Any "additional" performance improvement projects must be validated by an EQRO.

Oversight and Management meeting, outlining their response to the feedback and recommendations made by the EQRO.

Table 1-1

EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Activity	Mandatory Activity[19]	Must Be Performed by EQRO[20]
Prepare detailed technical report	**Yes**[21]	**Yes**
Validation of performance improvement projects[22]	**Yes**	**No**
Validation of MCO performance measures reported	**Yes**	**No**
Review to determine MCO compliance with standards	**Yes**	**No**
Validation of encounter data	**No**	**No**
Administration or validation of consumer or provider surveys of quality of care	**No**	**No**
Calculation of additional performance measures	**No**	**No**
Conduct of additional quality improvement projects	**No**	**No**
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	**No**	**No**

1.3 Waivers and Special Terms and Conditions

[19] Defined as "mandatory" under the January 24, 2003 *Final Rule*.
[20] According to the provisions of the January 24, 2003 *Final Rule*.
[21] Not listed in the *Final Rule* as a "mandatory" activity in 42 CFR 438.358(b), but "required" by 42 CFR 438.364.
[22] Since 2008, all Quality Improvement Projects are documented using the NCQA's Quality Improvement Activity (QIA) Form. The QIA form can be found in Appendix 3.

The renewal of the Comprehensive 1115 Waiver 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**.** The STCs contained a number of elements germane to measurement of quality of care and access to care improvement, as follows:

- **Comprehensive Quality Strategy** – The State has to address the following quality assurance requirements:

    - Develop a Continuous Quality Strategy that addresses the State's goal for improvement. Goals for improvement should be identified via claims and encounter data, quality metrics and expenditure data.

    - Discuss monitoring and evaluation methods, including components for discovery, remediation, and improvement.

    - 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. Monitoring compliance and contract performance, identifying any problem areas, assisting in the development and implementation of corrective action plans, providing technical assistance to improve cost-effectiveness and ensure that MCOs are addressing any changes in Federal and State rules and regulations.

    - Contract with an external quality review organization (EQRO) for an independent audit each year of the demonstration. Identify standards that are deemed duplicative to what is already addressed under the NCQA MCO accreditation process and ensure the relevant rationale is explicit.

    - 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. Include all Quality Improvement Projects (QIPs), methodology for determining benchmarks, and metrics related to each population covered by Medicaid as a component of the Quality Strategy.

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

    - Delineate Medicaid and contracted providers' responsibilities.

    - Obtain Stakeholder input, including the State's Medical Care Advisory Committee (MCAC) as well as others and ensure the strategy is made available for public comment prior to implementation.

As noted at the beginning of this update, the STCs[23] for the Comprehensive 1115 Demonstration called for the development of a Comprehensive Quality Strategy (CQS):

> "The State shall adopt and implement a comprehensive and dynamic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, requirements across the State's Medicaid program. This CQS must include all components of the Medicaid state plan, including but not limited to: the Comprehensive Demonstration (RIte Care, Rhody Health, Connect Care Choice, RIte Smiles and HCBS)".

When administering the Comprehensive 1115 Demonstration, Rhode Island is responsible for ensuring that the following six (6) assurances, that pertain to 1915(c) waivers, are met for home- and community-based services:

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

Rhode Island Medicaid has constructed a Quality framework and performance indicators for Home and Community Based Services (HCBS) based on the assurances listed above. The use of such performance indicators provides ongoing monitoring of how the Medicaid program is meeting such assurances. As indicated, the renewal of Rhode Island's Comprehensive 1115 Demonstration waiver on December 23, 2013 requires the State to follow the guidance set forth in the STCs. This guidance calls for remaining consistent with the Quality framework that had been utilized under Rhode Island's former 1915(c) waivers. As such, many of the current methods utilized for ongoing monitoring and performance measures continue, and include but are not limited to the following elements:

- Case record review and chart audits
- Provider monitoring, including BCI checks
- Client surveys, including home visits and interviews
- Fiscal and eligibility review, including utilization reviews, and
- Risk assessments

[23] STCs dated December 23, 2013.

In addition to the above discovery and remediation strategies, the HCBS Oversight and Monitoring team meet on a regular basis to review a case from each month in the previous quarter. The purpose of the review is to identify and address quality concerns and develop system change recommendations as indicated. In addition to these quarterly meetings, key evaluation findings and monitoring outcomes and updates are presented to the 1115 Waiver Quality and Evaluation workgroup on a regular basis**.**

- **General Administrative/Reporting Requirements** – The State's Comprehensive 1115 Demonstration Waiver STCs include requirements for quarterly operational reports (STC # 93) and an annual report (STC # 94). On a quarterly basis, the State must present its analysis of the various operational areas under the Demonstration, including but not limited to:
  - Events that affect health care delivery including approval and contracting with new plans; benefits; cost-sharing, enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;
  - Evaluation and Quality Assurance and Monitoring activities and interim findings.

  On an annual basis, the State must submit a draft report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration.

1.4 CHIP Quality Requirements

CHIP, too, has quality requirements. Specifically, 42 CFR 457.495 addresses "access to care and procedures to assure quality and appropriateness of care[24]. The State CHIP Plan must describe how it will assure:

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

- Access to covered services, including emergency services.

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

- That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days

[24] *Federal Register*, 66(8), January 11, 2002, 2666-2688.

after receipt of a request for services, with an extension possible under certain circumstances, and in accordance with State law.[25]

Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub.L. 111-3) required the Secretary of the Department of Health and Human Services to identify an initial core set of child health care quality measures for voluntary use by state programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contract with such programs, and providers of items and services under such programs. CHIPRA also required the Secretary to publish changes to the core set measures beginning in January 2013.

Three (3) measures (Human Papillomavirus (HPV) Vaccine for Female Adolescents, Behavioral Health Risk Assessment for Pregnant Women, and Medication Management for People with Asthma) were added to the Children's Core Set in 2013 and one measure (Otitis Media with Effusion) was retired. Beginning in 2014, CMS retired the following three measures: 1) Appropriate Testing for Children with Pharyngitis (two to 18 years); 2) Annual Pediatric Hemoglobin A1C Testing (five to 17 years); and 3) Annual Percentage of Asthma Patients who are two to 20 years old with one or more Asthma-related emergency visit.

Additionally, Section 401(a)(4) required the development of a standardized reporting format for states that volunteer to report on the core set of measures. CARTS was modified by CMS for standardized reporting on the Children's Core Set measures.

Rhode Island's Executive Office of Health & Human Services was awarded a certificate on 06/15/2012 at the CMS 2nd Annual Medicaid and CHIP Quality Conference. This award acknowledged Rhode Island's achievement in reporting twelve (12) of the measures, which represented one-half of the Initial Core Set of Voluntary Measures for Children during the first year of voluntary reporting. Rhode Island was one of eight (8) States to be recognized for this honor.

[25] *Federal Register*, 66(122), June 25, 2001, 33810-33824.

CHAPTER 2

PROCESS FOR INVOLVING RECIPIENTS AND OTHER STAKEHOLDERS

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

- RI Medicaid posted the "final draft" on the RI EOHHS Website.
- RI Medicaid put a notice in English and Spanish in *The Providence Journal*, the newspaper of widest circulation in the State, making the public aware that the "final draft" was available for review and how to obtain a copy of it. A 30-day comment period was provided.
- RI Medicaid put the "final draft" on the agenda of the Medical Advisory Committee 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 reviews the Quality Strategy periodically with the EOHHS' Consumer Advisory Committee (CAC) and the 1115 Waiver Quality and Evaluation Workgroup to assess the strategy's effectiveness and to update it, as needed.

In addition, Rhode Island will review its Quality Strategy whenever the following temporal events occur: a) new population groups are to be enrolled in managed care delivery systems; and b) Medicaid managed care re-procurement takes place. Such activity was undertaken by the State when it facilitated a series of community stakeholder meetings during the Summer of 2012. These meetings were sponsored by the RI EOHHS to inform the quality design component for the new coverage opportunities afforded through Rhody Health Options (RHO) and Connect Care Choice Community Partners (CCCC-P). Please refer to Chapters 7 and 8 for additional discussion.

CHAPTER 3

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

From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. Table 3-1 shows the various components of RIte Care's CMS-approved quality strategy. In order to track compliance with Federal requirements, the table has been 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 that preceded the Comprehensive 1115 Demonstration Waiver. For additional detail on the Quality Design specific to RIte Care, please see Appendices 1 and 2.

In the proposed Comprehensive Quality Strategy, the State has set forth its quality design for Rhody Health Options and Connect Care Choice Community Partners building upon the core principles that have been previously approved by CMS for RIte Care.

Table 3-1

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

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
1. Assess the quality and appropriateness of care and services to enrollees	• Performance incentive program • Encounter Data System • NCQA information • Member satisfaction survey • Complaint, grievance and appeals reporting • Care management reporting • Compliance dashboard reporting • Pharmacy-related reporting • EQRO studies • Special studies • Contract compliance review • Analysis of the State's priority measures from the CMS Medicaid Adult Core Set and the Core Set of Children's Health Care Quality Measures	

2. Identify the race, ethnicity, and primary language spoken of each enrollee	• MMIS data	
3. Arrange for annual, external independent reviews of the quality and timeliness of, and access to, the services covered under each Health Plan contract	• Performance incentive program • Encounter Data System • NCQA accreditation information • Member satisfaction survey • Audited HEDIS® submissions • Quality Improvement Projects (QIP) EQRO studies • Special studies • Contract compliance review	The State's EQRO is responsible for preparing an annual, plan-specific detailed technical report that assesses the quality, timeliness, and access to the care furnished by each Health Plan.
4. Appropriate use of intermediate sanctions	• Contract compliance review	Provisions for levying intermediate sanctions have always been a part of the RIte Care Health Plan Contract.
5. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement **5.a. Access Standards**		
5.a.1 Availability of services	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA accreditation information • Member satisfaction survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review • Audited HEDIS® submissions • Program management meetings with each RIte Care-participating Health Plan	As outlined in Table 3 – 1 in Appendix 1, the State has had quantitative access standards in effect since 1994.
5.a.2 Assurances of adequate capacity and services	• Provider network reporting • GeoAccess™ reporting	As outlined in Table 3 – 1 in Appendix 1, the State has quantitative capacity standards and has since 1994.

5.a.3 Coordination and continuity of care	• NCQA information • Contract compliance review • Complaint, grievance, and appeals reporting • Care management reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*
5.a.4 Coverage and authorization of services	• Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member satisfaction survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*
5.b. Structure and Operation Standards		
5.b.1 Provider selection	• Provider network data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*
5.b.2 Enrollee information	• Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*
5.b.3 Confidentiality	• NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*
5.b.4 Enrollment and disenrollment	• MMIS data • NCQA information • Complaint, grievance, and appeals reporting • Health Plan change requests • Contract compliance review	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*

5.b.5 Grievance systems 5.b.6 Subcontractual relationships and delegation	• NCQA information • Annual member satisfaction survey • Complaint, grievance, and appeals, reporting • Special studies • Contract compliance review • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review • Program management meetings with each RIte Care-participating Health Plan	State requirements must be met as specified in the *Medicaid Managed Care Services Contract.* State requirements must be met as specified in the *Medicaid Managed Care Services Contract.*

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
5.c. Quality Measurement and Improvement Standards		
5.c.1 Practice guidelines	• NCQA information • Special studies • Contract compliance review	
5.c.2 Quality assessment and performance improvement program	• Performance incentive program • EQRO reports • Quality improvement projects (QIPs) • Encounter Data System • Complaint, grievance, and appeals reporting • NCQA accreditation information • Special studies • Contract compliance review	
5.c.3 Health information systems	• Encounter Data System • Risk-share reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	
6. Encounter Data Requirements	• Encounter Data System • EQRO activities • Special studies • Contract compliance review	The Encounter Data System has been used to produce reports since 1998. It is supplemented by EQRO studies and special studies in areas of access and clinical care interest.
7. Quality Assurance Requirements		
7.a. Methodology to monitor performance	• All mechanisms	Previously, the State had a *Plan for Monitoring RIte Care Health Plans*. That plan was superseded by the CMS-approved Quality Strategy.
7.b. Contract with EQRO	• EQRO activities	The State's EQRO contract was reprocured in 2003, 2006, and 2012.
7.c. Quarterly reports on complaints and grievances	• Complaint, grievance, and appeals reporting • Contract compliance review • Program management meetings with each RIte Care-participating Health Plan	Complaint, grievance, and appeals reporting requirements have been in place since 1994.

7.d. Require that Health Plans meet certain quality assurance requirements	• Contract compliance review • Program management meetings with each RIte Care-participating Health Plan • NCQA information	
8. General Administrative/Reporting Requirements – quarterly and annual reports	• 1115 Comprehensive Demonstration Waiver, Special Terms and Conditions quarterly and annual reports • Annual Children's Health Insurance Program (CHIP) Report	

Table 3-2 shows those areas where the State has established quantitative standards for access.

Table 3-2

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

Area	Quantitative Standard	Mechanism for Measuring It
Availability of services	• Emergency services are available 24 hours a day, 7 days a week • Make services available immediately for an "emergent" medical condition including a mental health or substance abuse condition • Make treatment available within 24 hours for an "urgent" medical problem including a mental health or substance abuse condition • Make services available within 30 days for treatment of a non-emergent, non-urgent medical condition, except for routine physical examinations or for regularly scheduled visits to monitor a chronic medical condition for visits less frequently than once every 30 days • Make services available within five business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition	• Complaint, grievance, and appeals data • Contract compliance review • Member satisfaction surveys • Findings from Health Plans' after-hours access surveys
Adequate capacity and services	• No more than 1,500 RIte Care members for any single PCP in a Health Plan network • No more 1,000 RIte Care members per single PCP within the team or site • Members may self-refer for up to four GYN/family planning (FP) visits annually or for FP services, without obtaining a referral from the PCP	• Provider network reporting • Informal complaints reporting • Encounter Data System
Coverage and authorization of services	• Assignment of a PCP within 20 days of enrollment, if none selected by the enrollee • For children with special health care needs, completion of an Initial Health Screen within 45 days of the effective date of enrollment • For children with special health care needs for whom it is applicable, completion of a Level I Needs Review and Short Term Care Management Plan within 30 days of the effective date of	• On-site review • Member satisfaction survey • Complaint, grievance, and appeals data • Care management reporting

	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	

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

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

Activity	Who Has, Will, or May Perform	Protocol Used/To Be Used
Prepare detailed technical report	• EQRO	EQRO's methods consistent with CMS protocols
Validation of performance improvement projects	• EQRO • Xerox State Healthcare, LLC • EOHHS staff	Methods consistent with CMS protocols
Validation of MCO performance measures reported	• EQRO • NCQA auditors	Methods consistent with CMS protocols and NCQA audit standards and protocols
Review to determine MCO compliance with standards	• EOHHS staff • Xerox State Healthcare, LLC	State-specific protocols consistent with CMS protocols
Validation of encounter data	• Xerox State Healthcare, LLC • May be the EQRO	Validate against claims and/or Against medical records
Administration or validation of consumer or provider surveys of quality of care	• Xerox State Healthcare, LLC • EOHHS staff	State-specific consumer survey consistent with CMS protocols and CAHPS® standards
Calculation of additional performance measures	• EOHHS staff • Xerox State Healthcare, LLC	Methods consistent with CMS protocols
Conduct of additional quality improvement projects	• EOHHS staff • Xerox State Healthcare, LLC	Methods consistent with CMS protocols
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	• EQRO	EQRO's methods consistent with CMS protocols

CHAPTER 4
RHODY HEALTH PARTNERS

Rhody Health Partners members have the same comprehensive benefit package as RIte Care members, with the exception of Home Care Services. However, Rhody Health Partners members do have Home Health Services benefits and as of July 1, 2013 the adult day benefit has been included as part of the comprehensive benefit package. In addition, Rhody Health Partners members have access to out-of-plan benefits covered prior to the State's Comprehensive 1115 Waiver by Section 1915(c) waivers including, for example, homemaker services, environmental modification, home-delivered meals, supportive living arrangements, adult companion services, respite services, and assisted living. As noted previously, the State's former 1915(c) waiver services were integrated into Rhode Island's Comprehensive 1115 Waiver.

As indicated in the Introduction, the renewal of the Comprehensive 1115 Waiver allowed the State to conform to the new coverage opportunities created under the Affordable Care Act (ACA). The new Medicaid Expansion population is enrolled under the Rhody Health Partners comprehensive benefit package, which includes for this new enrollment population additional substance abuse, mental health and HIV covered services and benefits.

During the initial implementation phase, the contracted Managed Care Organizations (MCOs) for the Medicaid Expansion population are submitting start up indicator reports on a weekly and/or monthly basis, which include statistics on Welcome Calls, Initial Health Screens, Utilization Management, Appeals, Informal Complaints, and Call Center Metrics, including provision of Member ID Cards and Handbooks within ten (10) calendar days of enrollment. These start-up indicator reports are in addition to the established quarterly calendar of reports that include but are not limited to finance, quality, compliance and Medicaid program integrity, operational reporting.

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

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

Table 4-1

Rhody Health Partners Quality Design

Date Collection Method	Type of Method	Performed By
Administrative data and hybrid measures, as set forth annually by the NCQA.	The HEDIS® methodology.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Quality Improvement Project (QIP)	NCQA's Quality Improvement Assessment (QIA) methodology that meets CMS protocol requirements.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Annual External Quality Review	Elements as mandated by 42 CFR 438.350(a).	Rhode Island's designated External Quality Review Organization (IPRO, Inc.)
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 4.0 Survey Methodology for Adults in Medicaid.	NCQA-certified CAHPS® vendor
Care Management Report for RHP	Care management reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Compliance Dashboard	Compliance dashboard reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Encounter Data Reporting and Analysis	The managed care encounter dataset is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollment population
Administrative data and hybrid measures as set forth by Measure Stewards for the subset of Medicaid Adult Core Set measures that have been given priority status by the RI EOHHS	Methods include those set forth by the NCQA, The Joint Commission, the AMA-PCPI, and the AHRQ	The RI EOHHS and Medicaid-participating Health Plans serving Rhode Island's RHP enrollees

CHAPTER 5
CONNECT CARE CHOICE

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

Participating primary care sites include:

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

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

Table 5-1
Connect Care Choice Quality Design

Date Collection Method	Type of Method	Performed By
SF-36™	The SF-36™ is a multi-purpose, short-form survey with 36 questions. It yields an 8-scale profile of functional health and well-being scores as well as psychometrically-based physical and mental health summary measures and a preference-based health utility index.	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee
The Index of Independence in Activities of Daily Living (Katz Index of ADL)	The Katz Index assesses basic activities of daily living and ranks adequacy of performance in six functions: bathing, dressing, toileting, transferring, continence, and feeding. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee
The PHQ-9 Patient Health Questionnaire	The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). There are two components of the PHQ-9: Assessing symptoms and functional impairment and deriving a severity score to help monitor treatment.	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee
Selected HEDIS®-like clinical measures which focus on Coronary Artery Disease, Depression, Diabetes, and Smoking & Tobacco Use Cessation	The following HEDIS®-like measures are analyzed by RI Medicaid for the Connect Care Choice Program. Coronary Artery Disease: *Persistence of Beta-blocker Therapy After a Heart Attack*. Depression: *Antidepressant Medication Management (Effective Acute Phase Treatment*). Diabetes: The following components of the	The RI EOHHS

	Comprehensive Diabetes Care measure: Hemoglobin A1c with poor control (<9.0%), LDL control (<100 mg/dL), Eye (retinal) exam performed, Blood Pressure control (<130/80). For all enrollees: *Advising Smokers & Tobacco Users to Quit*.	
Administrative data and hybrid measures as set forth by Measure Stewards for the subset of Medicaid Adult Core Set measures that have been given priority status by the RI EOHHS	Methods include those set forth by the NCQA, The Joint Commission, the AMA-PCPI, and the AHRQ.	The RI EOHHS

CHAPTER 6

RITE SMILES

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

To achieve these goals, Rhode Island transitioned in 2006 from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system, a dental benefit manager (DBM) program with one capitated Plan that serves Medicaid enrolled children born on or after May 1, 2000. Among other responsibilities, the DBM program was charged with:

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

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

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

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

Table 6-1

RIte Smiles Quality Design

Date Collection Method	Type of Method	Performed By
Annual Dental Visit	The HEDIS® methodology.	Medicaid-participating DBM
Quality Improvement Project (QIP)	NCQA's Quality Improvement Assessment (QIA) methodology that meets CMS protocol requirements.	Medicaid-participating DBM

Provider Network Adequacy	Provider network reporting that meets State and Federal Accessibility Standards	Medicaid-participating DBM
Informal Complaints, Grievances, and Appeals	Informal complaints and grievance and appeal reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating DBM
Compliance Dashboard	Compliance dashboard reports are submitted electronically in a spreadsheet template established by RI Medicaid	Medicaid-participating DBM
Encounter Data Reporting and Analysis	The managed care encounter dataset is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	Medicaid-participating DBM
Sealant applications on permanent molars	Paid claims analysis of sealant applications, in conformance with the CMS 416 specifications	The RI EOHHS and the Medicaid-participating DBM

CHAPTER 7
RHODY HEALTH OPTIONS

The goal of the State's Integrated Care Initiative (ICI) is to build on the Rhody Health Partners and Connect Care Choice programs through the integration of acute care services, primary care, and long term services and supports (LTSS). Rhody Health Options (RHO) is the integration of these LTSS services into a managed care delivery system. LTSS includes nursing home care as well as home and community-based supports that allow members to live independently in the community.

The Connect Care Choice Community Partners (CCCC-P) program, the focus of Chapter 8, is the State's Primary Care Case Management (PCCM) model which serves adult populations with complex medical and behavioral, and offers extensive care management services through seventeen (17) comprehensive medical home practice sites throughout the State.

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

- All newly enrolled members have access to out-of-network providers for six months post enrollment,
- The MCO must honor all prior authorizations, including long-term services and supports (LTSS) authorizations, and
- Members residing in an out-of-network nursing facility can remain in that facility if and when the member chooses to change nursing homes.

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

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

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

delivery systems, Medicare services will continue to be administered by the Medicare program.

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

Enrollment began through a staged approach starting on November 1, 2013. The target population for the Integrated Care Initiative will be enrolled over a six-month period which began in November 2013 and will conclude in April of 2014. Each enrollment "wave" assumes that a certain percentage of ICI eligible members will opt out and choose to remain in the fee-for-service delivery system. Enrollment estimates do not include individuals for whom the Executive Office of Health and Human Services (EOHHS) has received returned or undeliverable mail.

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

The following populations are exempt from enrollment in an MCO:

- Medicare beneficiaries who are not eligible for full Medicaid benefits, i.e. Qualified Medicare Beneficiaries (QMBs)
- Specified Low-Income Beneficiaries (SLMBs)
- Qualified Individuals (QIs)
- Individuals who are eligible for partial Medicare benefits (Part A only or Part B/D)
- Individuals residing at Tavares[26], Eleanor Slater[27] Hospital or out-of-State hospitals
- Individuals who are incarcerated (adjudicated and in prison)
- Individuals who are in hospice on the enrollment start date

RHO members have a comprehensive benefit package, which now includes all home and community-based services (e.g., homemaker services, environmental modification,

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

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

home-delivered meals, supportive living arrangements, adult companion services, respite services, and assisted living.)

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

Care Management program elements include:

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

The qualitative oversight of the newly integrated home and community based LTSS services, long-term care services, and nursing home transitions are paramount areas of focus. The State will work with the RHO-participating Health Plan (Neighborhood Health Plan of Rhode Island) to ensure the continued monitoring of the following four (4) quality assurances:

1) Level of Care: Persons enrolled in Nursing Facilities have needs consistent with an institutional level of care
2) Service Plan: Participants have a service plan that is appropriate to their need and that they receive the services and supports specified in the plan
3) Qualified Providers: LTSS providers are qualified to deliver services and supports
4) Health and Welfare: Enrollees' health and welfare are safeguarded and monitored

Table 7-1 shows the quality design for RHO. This quality design was informed by community stakeholders through a series of three (3) public forums which were held

during the Summer of 2012. These forums were held to obtain input and recommendations on the focus of the RHO and Connect Care Choice Community Partners quality design, and specifically quality of care domains. The input obtained through the stakeholder process was then cross-walked against national benchmarks such as the NCQA's HEDIS® and the AHRQ's CAHPS® measures as well as National Quality Forum (NQF)-endorsed measures.

Table 7-1

Rhody Health Options (RHO) Quality Design

Date Collection Method	Type of Method	Performed By
Administrative data and hybrid measures, as set forth annually by the NCQA.	The HEDIS® methodology.	Medicaid-participating Health Plan(s)[28] serving Rhode Island's RHO enrollees
State Specific Quality Measures (See Table 7-2).	On-site audit, reporting, and MDS data.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Quality Improvement Project (QIP)	NCQA's Quality Improvement Assessment (QIA) methodology that meets CMS protocol requirements.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Annual External Quality Review	Elements as mandated by 42 CFR 438.350(a).	Rhode Island's designated External Quality Review Organization (IPRO, Incorporated)
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 5.0 Survey Methodology for Adults in Medicaid.	NCQA-certified CAHPS® vendor (2015 cycle)
Care Management Report for RHO	Care management reports are submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Long Term Services and Supports Operational Report	Long Term Services and Supports Operational Reports are submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Critical Incident Report	The Critical Incident Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Nursing Home Transitions Report	The Nursing Home Transitions Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees

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

Nursing Home Quality Report	The Nursing Home Quality Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
24 hour Emergency Back-Up report	The 24 hour Emergency Back- Up Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Care Transitions Report	The Care Transitions Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Encounter Data Reporting and Analysis	The managed care encounter dataset is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollment population

In 1998, Rhode Island launched its Performance Goal Program. Rhode Island was the 2nd state in the nation to establish a Pay for Performance Program within its Medicaid program. Table 7-2 outlines the State's Performance Goal Program for Rhody Health Options. In addition to national benchmarks such as HEDIS® and CAHPS® measures, the State's Performance Goal Program has established a set of State-specific quality and operational standards in three main focus areas: Member Services, Beneficiary Protection, Care Management and Nursing Home Quality of Care and Transitions to Community.

Table 7-2

Performance Goal Program for RHO

Area	Goal
Member Services	Identification cards are distributed within ten (10) calendar days of Plan receipt of enrollment information
	During standard hours of operation, Member Service calls are answered by a live voice in thirty (30) seconds average speed to answer
	Grievance & appeals are resolved within Federal Balanced Budget Act Time Frames
Care Management	Non-LTSS Members receive an initial telephonic assessment within forty-five (45) days of enrollment
	Non-LTSS Members who are identified for a comprehensive needs assessment will have a face to face visit assessment completed within thirty (30) days of the initial telephonic assessment
	A comprehensive face-to-face visit assessment is completed within fifteen (15) days for recipients of Community Long Term Care Services and Supports (LTSS); within thirty (30) days for nursing home residents
	Care plans clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports, shared decision making, involvement of the Member and/or caregiver in plan development, and assessment of Member goals and preferences

Nursing Home Transitions (NHT)	Members have a risk assessment (as defined per NHT protocol) prior to transition to the community
	Members have a home visit within one (1) calendar day of their transition to the community

Historically the Medicaid Home and Community Based 1915(c) Quality framework has included the following key components:

- The design of a Quality Strategy which includes performance measures, methodology, and sampling strategy
- The monitoring of the implementation of the Quality Strategy and reporting on findings using performance measures
- The correction of non-compliance based on performance measures
- The implementation of corrective action when needed to improve performance

Many of the current methods utilized for monitoring and oversight are based on the CMS Quality framework for home and community-based services (HCBS), which includes the following elements:

- Case record review and chart audits
- Provider monitoring, including BCI checks
- Client surveys, including home visits and interviews
- Fiscal and eligibility review, including utilization reviews, and
- Risk assessments

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

CHAPTER 8
CONNECT CARE CHOICE COMMUNITY PARTNERS

The Connect Care Choice Community Partners (CCCC-P) program is the State's Primary Care Case Management (PCCM) model which serves adults 21 years or older with complex medical and behavioral services, and offers extensive care management services through seventeen (17) comprehensive medical home practice sites throughout the State. The Connect Care Choice Community Partners program addresses the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services through high touch care coordination via a contracted Coordinating Care Entity (CCE). The CCE[29] coordinates the collection of performance data, quality assurance and quality improvement activities. A key feature of the CCE is that it provides a Community Health Team (CHT) that coordinates the social supports and services for both Medicaid-only and MME members.

Participating primary care sites include:

Name	**Locations**
1. Anchor Medical Associates	Providence, Warwick, Lincoln
2. Aquidneck Medical Associates	Newport, Portsmouth
3. Blackstone Valley Community Health Care	Pawtucket, Central Falls
4. Coastal Medical Inc.	Providence
5. Cranston Comprehensive Community Action Program (CCAP)	Cranston
6. East Bay Community Action Program	East Providence, Newport
7. Hillside Family Medicine	Pawtucket, Scituate
8. The Immunology Clinic at Miriam Hospital	Providence
9. Memorial Hospital Center for Primary Care and Prevention	Pawtucket
10. The Miriam Hospital Primary Care Clinic	Providence Providence
11. Providence Community Health Centers:	
• Central Health Center	
• Capitol Hill Health Center	
• Allen Berry Health Center	
• Fox Point Health Center	
• Chafee Health Center	
• Olneyville Health Center	
12. Rhode Island Hospital Ambulatory	Providence

[29] As of 11/01/2013, Rhode Island has contracted with CareLink, Incorporated, for the CCE.

Clinic

13. Thundermist Health Center — Woonsocket, West Warwick, South County
14. Tri-Town Community Action Program (CAP) — Johnston
15. St. Joseph's Ambulatory Clinic — Providence
16. University Medical Group — Providence, Lincoln
17. University Medicine Foundation-Governor St. Primary Care Center — Providence

Table 8-1 shows the quality design for Connect Care Choice Community Partners. This quality design was informed by community stakeholders through a series of three public forums which were held during the Summer of 2012. These forums were held to obtain input and recommendations on the Rhody Health Options and Connect Care Choice Community Partners quality design, and specifically quality of care domains. The input obtained through the stakeholder process was then cross-walked against national benchmarks such as the NCQA's HEDIS® and the AHRQ's CAHPS® measures as well as National Quality Forum (NQF)-endorsed measures.

Table 8-1

Connect Care Choice Community Partners Quality Design

Date Collection Method	Type of Method	Performed By
Administrative data and hybrid measures	Based on HEDIS® methodology.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
State Specific Quality Measures (See Table 8-2).	On-site audit, reporting, and MDS data.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Informal Complaints	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 5.0 Survey Methodology for Adults in Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Care Management Report	Care management reports are submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Long Term Services and Supports Operational Report	Long Term Services and Supports Operational Report are submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Critical Incident Report	Critical Incident Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Nursing Home Transitions Report	Nursing Home Transitions Report is submitted	The CCE serving Rhode Island's Connect Care Choice Community Partners

	electronically in a spreadsheet template established by the RI EOHHS.	enrollees
Nursing Home Quality Report	Nursing Home Quality Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
24 hour Emergency Back-Up report	24 hour Emergency Back- Up Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Care Transitions Report	Care Transitions Report is submitted electronically in a spreadsheet template established by the RI EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Claims and/or Encounter Data Analysis	MMIS is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees

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

Table 8-2

CCCC-P Quality and Operational Standards

Member Services	Member materials are distributed within ten (10) calendar days of Plan receipt of enrollment notification.
	During standard hours of operation, Member Service calls are answered by a live voice in 30 seconds average speed to answer.
	Grievances (Informal Complaints) are resolved within 30 days.
Beneficiary Protection	For members that report a critical incident, the Care Plan must demonstrate the completion of an updated risk assessment and mitigation plan.
	Member and/or caregivers receive education and information, annually at a minimum, about how to identify and report instances of abuse and neglect.
Care Management	Level I and Level II members with LTSS receive an initial telephonic assessment within thirty (3) days of enrollment. Level II Non-LTSS Members receive an initial telephonic assessment within sixty (60) days of initial start-up enrollment and 45 days thereafter.
	Members identified as "At Risk" during the initial telephonic assessment will receive an in-person Health Risk Assessment within sixty (60) days during initial start-up enrollment and fourteen (14) days thereafter.
	Based on a risk profile, members identified as Level I and Level II with LTSS will receive an in-person Health Risk Assessment within sixty (60) days during the initial start-up enrollment and thirty (30) days thereafter.
	Based on a risk profile, member identified as Level II Non LTSS will receive an in-person Health Risk Assessment within one hundred and eighty (180) days during initial start-up enrollment and ninety (90) days thereafter.

	All Health Risk Assessments must be received within two (2) business days of the in-person visit.
	All comprehensive needs assessments conducted by the CCE and/or care manager should include documentation of completed home safety evaluations and appropriate follow up thereafter.
	Members are screened for clinical depression using a standardized tool and follow up is documented.
Nursing Home Quality Measures	Percent of long-stay nursing facility residents (i.e., residing in a nursing facility continuously for one hundred (100) days prior to the second quarter of the calendar year) who were hospitalized within six (6) months of baseline assessment.
	Percent of all long-stay[30] residents in a nursing facility with an annual, quarterly, significant change or correction MDS assessment during the selected quarter who were identified at high risk and who have one more stage 2-4 pressure ulcers.
	Percent of all long-stay residents with a selected target assessment that indicates a urinary tract infection within the last thirty (30) days.
	Percentage of all long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received.
	Percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible pain in the last 5 days.

The Connect Care Choice Community Partner primary care practice network consist of practices that have adopted the "chronic care model" and are certified as a "patient-centered medical home" by the National Committee for Quality Assurance (NCQA). In addition, these practices must meet a high standard of performance, provide evidenced-based chronic disease management, nurse care management, primary and preventive care while encouraging self-management supports and education. The design of this health delivery system is quality focused, holistic in its approach to achieve and maintain wellness as well as to improve access to primary and specialty care. The ability to monitor clinical quality is critical to measuring practice based performance and outcomes. Table 8-3 below provides a list of clinical measures being used to monitor practice based performance on chronic care management and patient self-management.

As noted in Introduction to the proposed Comprehensive Quality Strategy, in 2013 the Rhode Island Executive Office of Health and Human Services was one of twenty-six (26) States to be awarded a Medicaid Adult Quality grant from the Center for Medicare and Medicaid Services (CMS)[31]. Through this grant opportunity EOHHS is able to build State capacity in the reporting and analysis of health care quality. A key focus of this grant will be building the needed capacity and system to produce the clinical quality measures outlined in the table below following the HEDIS® technical specifications for the CCCC-P program.

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

[31] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html

Table 8-3

CCCCP Clinical Quality Measures based on Selected HEDIS®[32] like Clinical Measures		
Measure Name	**Measure Description**	**Measure Steward & Data Source**
Persistence of Beta-Blocker Treatment After a Heart Attack	Percent of Members 18+ during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six (6) months after discharge	NCQA Administrative Claims Chart Review
Adult BMI Assessment	% of members 18-74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	NCQA Administrative Claims & Hybrid
Anti-depressant Medication Management (Effective Acute Phase Treatment)	The % of members 18 + who were diagnosed with a new episode of major depression and treated with anti-depressant medication, and who remained on anti-depressant medication.	NCQA Administrative Claims
Comprehensive Diabetes Care	Hemoglobin A1c with poor control (> 9.0%), LDL control (< 100 mg/dL), Eye (retinal) exam performed, Blood Pressure control (< 140/80).	NCQA Administrative Claims & Hybrid
Advising Smokers & Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smoker or tobacco users and who received cessation advice during measurement year.	NCQA/AHRQ

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

Quality Improvement Activity (QIA) Form Instructions

When to Use the QIA Form

This document is a guide for completing NCQA's Quality Improvement Activity (QIA) form. This form can be used for the QIA required NCQA accreditation and certification programs, as applicable. It must be used to meet the Quality Improvement Projects required for Medicare Advantage Deeming.

You are not required to use the QIA form; however, you must provide the data it requests in order for NCQA to review your QIAs completely and accurately. Submit a QIA for each activity you present by attaching it to the applicable element in the Survey Tool using the **Attach Document** feature in the Survey Tool.

Detailed instructions on attaching documents to the Survey Tool are found in the Survey Tool Instructions under **Help** on the Main Menu bar.

The purpose of the QIA form is to *summarize* the clinical and service quality activities that you are using to demonstrate meaningful improvement in the applicable element.

You should not complete the QIA forms for service or clinical activities that you use to demonstrate compliance with other standards that require data collection and analysis such as member/enrollee satisfaction, availability and access and satisfaction with UM. Document compliance with these standards as you would document any other standard.

All data points must be final when your organization submits the Survey Tool.

NCQA does not recommend using this form to report on activities that have only one data point (e.g., baseline only).

Consult the appropriate Explanation for the meaningful improvement standard for the accreditation or certification program for which you apply.

Remember that you cannot achieve a score of 100% with only one data point. The activity will not be considered.

Achieving Meaningful Improvement

Submit enough data

To receive "credit" for meaningful improvement, you must submit enough data to allow an evaluation of any seasonal variations that could affect the results. On the service side, open-enrollment seasons can affect such activities as ensuring access to primary care and reduction in referral time frames. In most cases you must present:

- annual measurement occurring during the same season (e.g., comparing the first quarter of one year to the first quarter of the following years) for areas that show seasonal differences, such as provision of enrollment cards
- five quarters of data
- fifteen months of data.

Note: *If you do not have adequate data to satisfy the above conditions or if you believe that the results are not biased by seasonal issues, provide an explanation as it relates to QI 12 and QI 13 under* Other Pertinent Methodology Features, *in Section I.*

The improvement must meet the time period covered in the survey

To receive "credit" for meaningful improvement, the improvement must have occurred in the three-year period covered in the survey. For example, if you have annual data on member satisfaction since 1996, but the date of the survey for which this QIA is being prepared is January 2008, only data beginning in 2005 should be shown.

In other words, the improvement must have started at some point during the three years immediately prior to the survey and have been subsequently sustained.

For Renewal Surveys, you may need to present measurements for the year prior to the current survey period if these data were not available for your previous survey.

The QIA Form

The form's five sections

The QIA form is divided into five sections:

- *Section I* Activity Selection and Methodology
- *Section II* Data/Results Table
- *Section III* Analysis Cycle
- *Section IV* Interventions Table
- *Section V* Chart or Graph

Activity name and activity examples

The form first asks you to supply an activity name. The activity name should succinctly encompass the purpose of the activity and begin with an action word that accurately states what the activity is designed to do (e.g., "improving," "increasing," "decreasing," "monitoring"). Examples are listed below.

- decreasing the risk of congestive heart failure
- improving claims turn-around time to practitioners
- increasing the rate of diabetic foot exams
- improving access to behavioral health services
- decreasing practitioner complaints with the referral process.

Section I:
Activity Selection and Methodology

This section asks you to provide the rationale for choosing this QI activity for your organization. Explain why the clinical or service activity affects your members or practitioners.

NCQA requires you to choose service improvements based on their impact on members. NCQA also accepts improvements in practitioner satisfaction that relate to utilization management (UM) processes or effects (e.g., issues identified in UM 11) for *one* service QIA.

Examples are listed below:

- *improvements in turnaround time for prior-authorization requests* decrease the time that members wait to receive care requiring authorization and/or increase productivity for practitioners
- *improvements in UM decision making turn-around-time* ensure more satisfied members and/or practitioners
- *improvements in referral to specialist turnaround time* reduce the number of complaints and appeals regarding referrals.

Rationale

Define the rationale for selecting the activity

This section asks you to define your rationale for selecting this activity for improvement.

- Why was it chosen over others?
- Why is it important to your members or practitioners?
- Why is it worth the resources your organization is spending on it?

Using objective information provide as much information that is specific to your organization as possible.

You do not have to provide generic defenses for most clinical or service issues. For example, do not include explanatory phrases such as “member services departments serve many important functions”, or “neuropathy of the foot is a serious condition that affects thousands of diabetics nationwide.”

Nor is it necessary to provide literature source cites on the importance of a clinical or service issue to members unless it is an unusual topic. Focus on the importance of the activity to your organization.

Importance of activity

Include pertinent organization data or community demographic data that reflect the importance of the activity to your organization’s membership. Describe the magnitude of the issue related to the activity in quantifiable terms.

Activity examples

Examples are listed below.

- Between 2004 and 2005, hospitalization due to diabetic foot neuropathy rose 9 percent. This was the largest increase in any diabetes related hospitalization. Research has shown that periodic foot screening of diabetics and self screening by diabetics can decrease rates of foot neuropathy.
- Practitioner dissatisfaction turnaround time with UM decisions increased from 5 to 15 percent between 2004 and 2005. This was the largest increase in practitioner dissatisfaction the organization has received for four years. In addition, this 15 percent dissatisfaction rate was the highest dissatisfaction rate on the practitioner survey.

Quantifiable Measures

Quantifiable measures clearly and accurately measure the activity

This section asks you to list *all* quantifiable measures you use in this activity, including those added over time. Quantifiable measures should clearly and accurately measure the activity being evaluated. List your baseline benchmarks and goals and if you modify them over time, list the updated benchmark or goal in the table in Section II.

Multiple measures

You may use one or more measures for each activity. For some activities, multiple measures are useful. For example, practitioner complaints and actual turn-around-time for UM decisions would be two measures that are closely linked to the timeliness of UM decisions.

In other cases, multiple measures may not be useful. For example, you may display multiple measures associated with a CHF disease management (DM) program, only one of which shows improvement. Unless the intervention is clearly focused to address that measure, NCQA may not consider the improvement meaningful.

Denominator

Describe here the event being assessed or the members who are eligible for the service or care. Indicate whether all events or eligible members are included, or whether the denominator is a sample. Examples of responses are listed below:

- all physician complaints
- members 35 years of age and older during the measurement year who were hospitalized and discharged alive from January 1–December 24 of the measurement year with a diagnosis of congestive heart failure
- all survey respondents

Numerator

Describe here the criteria being assessed for the service or care:

- all physician complaints concerning UM decision turn-around-time
- members meeting the criteria for inclusion in the denominator who received an ambulatory prescription for ace inhibitors within 90 days of discharge
- survey respondents who do or do not like the event in the denominator

First measurement period

State here the time period covered by the initial assessment.

For clinical issues, this is typically an entire calendar year (e.g., January 1, 2008–December 31, 2008).

For service issues, the measurement period is often monthly or quarterly (e.g., January 2008 or 1Q 2008). Measurement periods may vary by measure. For example, the first measurement period for UM decision timeliness may be the first quarter of 2008, but the measure addressing timeliness may not have started until the third quarter of 2008.

Baseline benchmark

Include here information on how the benchmark was derived as well as the benchmark rate. NCQA defines "benchmark" as the industry measure of best performance against which the organization's performance is compared. It should be directly comparable to your QI measure.

You may describe the benchmark in numerical terms (e.g., the 90th percentile), or in terms of the comparison group (e.g., the best published rate in our state, 85 percent).

The benchmark may be a best practice in an industry based on published data or the best performance within a corporation with multiple organizations. NCQA requires a benchmark *or* a goal, but not both. Many service activities do not have benchmarks. If you are not using a benchmark, insert "NA" in response to this query.

Remember: Benchmarks are not averages; they are the best in class.
The average for a national organization or corporation with multiple organizations is not a benchmark.
The organization's best rate would be considered a benchmark.

Benchmark source

If you give a benchmark, list the organization or publication from which it was obtained and the time period to which it pertains.

Baseline goal

The performance goal is the desired level of achievement for the measure within a reasonable time. It does not have to be based on actual best practices, but it should reflect the level of achievement your organization has targeted.

The goal should be quantitative and stated in numerical terms (e.g., 90 percent, 0.3 appeals per thousand, 3 days).

Most organizations do not set performance goals until after they have collected baseline results. If that is the case, enter NA here.

Words such as "improve," "decrease" or "increase" are not acceptable in stating goals unless they are accompanied by a numerical quantifier (e.g., "improve one standard deviation from baseline" or "decrease by 5 percentage points from the last remeasure").

Remember to use the words "percent" and "percentage" precisely. An increase in practitioner satisfaction with the UM referral system from 35 percent to 40 percent is a 5 percentage point increase, not a 5 percent increase.

State the first goal you set (which, generally, is set after baseline results have been analyzed). NCQA expects that as you achieve your goals, you set new ones. Section II has a space to list updated goals. Examples are listed below.

Goal example

Measure: Pre-service UM decisions.

Numerator: Number of preservice decisions less than 4 days.

Denominator: Number of preservice decisions.

Benchmark: NA

Baseline Goal: 80 percent of preservice decisions are made within 3 days of the request.

Note: *NCQA does not consider achievement of a prespecified goal or benchmark alone as a demonstration of meaningful improvement.*

Baseline Methodology

This section uses tables, check boxes and narrative to enable you to describe your methodology. The more precisely you describe the data you used and how they were obtained; the sampling procedures, if any, that were applied; and any special factors that could have influenced the results, the more easily NCQA can assess the validity and reliability of the findings.

C.1 Data sources

Check all the data sources used. If you used other sources that are not listed, check "Other" and describe the sources completely. Indicate the number of the measure from Section B next to the data source used.

C.2 Data collection methodology

This section is divided into:

- medical/treatment record
- survey
- administrative.

Because you may use different data collection methodologies for different measures, check all that apply. Indicate the number of the measure from Section B next to the data source used. If you collected survey data using more than one of these techniques, check all that apply. If you used different techniques, or if you used other methods to collect administrative data, mark "Other" and describe your data sources completely. You are not limited to the options provided.

Most of these methodologies are self-explanatory. The definitions for the survey data collection methodology are listed below.

Definitions

Personal interview

A face-to-face interview.

Mail

A survey mailed to and returned from the respondent and involving no personal contact.

Phone with CATI script

A telephone interview using a computer-assisted script containing prompts beyond the actual questions that can be used according to a set protocol.

Phone with IVR

A telephone interview involving an interactive voice recognition system rather than a live person.

Internet

A survey conducted using the Internet and involving no personal interaction.

Incentive provided

A survey in which the respondent was given an incentive (e.g., gift certificate, cash) for participating.

Note: *Regardless of the survey methodology, mark this box if the respondent is given any incentive to complete the survey.*

Other

Any other survey methodology different from those listed above.

C.3 Sampling

For each measure that involved sampling, state the sample size, the method used to determine the size and the sampling methodology. If the size is the same for all measures, state "All Measures" and give the information only once. Also provide the size of the full population from which you drew the sample.

Remember that the sampling methodology here relates to your baseline measurement only. Any change to this sampling methodology is reported in Section I.D of this form.

Table elements

Measure. You may use the measure number from the measures listed in Section I.B and abbreviate the name.

Sample size. State the number of the full sample selected, including any oversampling. The denominator listed in Section II provides the number included in the measure.

Determining the sample size. To determine the size, explain the parameters used to determine the sample size, which typically include:

- the assumptions or requirements of the statistical test to be used to verify the significance of observed differences
- the desired degree of confidence in the statistical test (alpha level)
- statistical power (the sensitivity of the statistical test to detect differences; bigger samples yield greater power)
- the margin of error to be allowed when assessing the hypothesis
- the oversample rate
  - the **oversample** is the extra cases included in the sample to replace cases rejected because of contraindications, ineligibility, etc. (In survey measurement, the oversample should be large enough to replace expected nonresponses.) Examples of oversampling are shown below.

Oversampling example

You plan to improve the time required for members to obtain a referral. You conduct telephone surveys of different groups of members who obtained referrals at two points in time, asking them how many days it took for them to get the referral. You have these expectations about the survey:

- the distribution of responses about the "number of days to referral" is normally distributed for both the pre- and post-survey groups
- the t-test is used to test the significance of the pre- and post-differences at alpha = 0.05 and 80 percent power
- a pilot survey showed that the standard deviation of "number of days to referral" responses is 5.25
- the program reduces the average number of days from 8.5 days to 7 days
- the response rate is 85 percent.

Sample size calculations based on the above parameters indicate that you require a sample of 193 completed surveys. You expect that 15 percent of the sampled members will not respond, so you sample 227 members to account for the nonresponse (X *0.85 = 193; X = 193/85; X = 227). This calculation includes 193 members in the original sample plus an oversample of 34 patients to replace those who do not respond.

Sampling method

State the sampling methodology (simple random sample, stratified random sample, convenience sample). State the reasons for exclusions from the sample, if there were any (e.g., "Simple random sampling was used. During the claims pull, three claims were excluded because they were miscoded.").

Remember that if your sampling methodology involves a survey, it is not necessary to complete this table because you have included the Survey Tool and the survey protocol (requested in Section I.C.2).

C.4 Data collection cycle and data analysis cycle

Check the box that applies or describe the frequency of data collection and analysis. Indicate the number of the measure from Section B next to the data source used. For many service activities, the data collection cycle is more frequent than the analysis cycle.

For example, hospitalization data may be collected weekly, but analyzed monthly or quarterly. Survey data may be collected quarterly and analyzed at six-month intervals.

C.5 Other pertinent methodology features

Describe any other methodological decisions or issues that could affect the analysis of the data or influence the results, such as:

- coding definitions
- claims-processing specifications unique to your organization
- claims-processing delays
- unique survey response coding or benefit design (e.g., pharmacy benefits).

If your QIA does not include sufficient data as specified by NCQA policy, or if you believe the results are not biased by seasonal issues because of the definition of the measure, provide your rationale for considering this for QI 12 and QI 13.

Mark this section "NA" if there are no other methodological features that need to be brought to NCQA's attention. You are not required to complete this section past this point.

Changes to Baseline Methodology

This section asks you to describe any methodology changes that were made after the baseline measurement was taken. To compare results accurately, it is best to use the same methodology over time. However, you may need to change methodology in order to strengthen the validity and reliability of the outcome, correct inadequacies in the initial process, or accommodate for lack of resources. Specifying changes that were made is important because those changes influence analysis of the results.

For each affected measure, you must describe:

- the dates during which the changed methodology was used
- how the methodology was changed
- the rationale for the change
- the anticipated impact of the change on the analysis.

If you changed the sampling methodology in the same way for several measures you need to provide the information only once. If the sampling methodology is the same, but the sample size has changed, show only those changes.

Section II:
Data/Results Table

This section consists of a table of the results of the baseline measurement and all of the remeasurements that you are presenting for consideration for the QIA. You may substitute a table of your choice as long as it includes all of the required elements. If there are more than five remeasurement periods, add a row for each additional measure. If you measured a service issue more frequently than quarterly, combine the data by recalculating the numerator and denominator and enter the quarterly result in the table.

Table Description

Quantifiable measure	You may use the measure number from the list of measures completed in Section I and abbreviate the name.
Time period covered	State the time period the measurement covers. It could be quarterly (e.g., 1Q 2008), twice a year (e.g., January–June and July–December 2008), yearly (e.g., 2008), or every other year (e.g., January–December 2006 and January–December 2008).
Numerator/ denominator	List the numerator and denominator for each remeasurement period. If the measure uses survey methodology, state the number of people who met the numerator criteria (numerator) and the number of people who responded to the question (denominator).
Rate or results	Convert the fraction (numerator/denominator) to a percentage.
Comparison benchmark/ comparison goal	List the goal and/or benchmark period in effect during the remeasurement cycle. The comparison goal is blank for the baseline measurement unless you have established a goal prior to pulling the baseline data. A goal based on baseline data that is in effect for the first remeasurement cycle should appear in the comparison box on remeasurement line 1. If you met your goal but there is still opportunity for improvement, NCQA suggests you increase your goal. If you changed your goal for any other reason, explain the basis for doing so in *Section III: Analysis Cycle*. You may also add benchmarks that you did not have at the baseline period.
Statistical test and significance	NCQA *does not* require you to test for statistical significance. Consult the appropriate Standards and Guidelines for the accreditation or certification program for which you are applying for additional information on the requirements for achieving meaningful improvement. If you have performed such tests and choose to report them, however, state the time periods that you compared and the type of statistical test used for each measure. The table has been left open-ended to allow you to compare any time period you choose. Most organizations compare the latest remeasurement to the previous one and the latest remeasurement to the baseline measurement.

Statistical testing is generally not necessary when measures are based on the entire eligible population, and may not be appropriate if the denominator is not based on a random or probability sample or if the measure specifications substantially changed since the last remeasurement period.

For the most common test (comparing two independent rates), the chi-square test of proportions or the z-test of proportions can be used (e.g., a z-test to compare the baseline to remeasure #1, p value = 0.2992; and baseline to remeasure #5, p value = 0.001).

These tests are not appropriate when the same members are being measured at different time periods, in which case the McNemar test for correlated proportions might be appropriate.

If you measure nonrate data, such as average wait times, the t-test or z-test for comparing means would be appropriate, depending on the size of the sample. If you have several independent remeasurements, based on samples, you may want to do an ANOVA test of linear trend to show that the rate is increasing over time.

Section III:
Analysis Cycle

In this section, you are asked to present the results of the quantitative and qualitative analyses you used to interpret the meaning of the results and to identify the opportunities for improvement that you wish to pursue. These analyses involve interpreting the data, which may include collecting additional data; identifying barriers or causes for less-than-desired performance; and designing strategies to overcome the barriers. Implementation of interventions is covered in Section IV.

Time Period and Measures Covered by the Analysis

Focus of the analysis

The analysis may occur after every remeasurement or after grouping several remeasurement periods. Your analysis may focus on one measure, on all measures or on a combination of measures.

For example, an activity designed to improve Preserivce UM decision turn-around time may include three measures:

- time from request to decision
- time from request is notification
- perceived turn-around-time by member

You may collect these data quarterly but analyze the data only twice a year. The first analysis period might include only the first and second measure and the second might include all three measures.

On the clinical side, an example for improving asthma management could include:

- measures of ER visits
- inpatient admissions per thousand
- quality-of-life measures from a member survey.

For example, if you measured ER visits and inpatient admissions monthly and conducted the quality-of-life survey annually, you could analyze the first two measures quarterly and the quality-of-life measure annually.

If you have multiple analysis periods, it is helpful to label them clearly. For example:

- *Analysis I:* Calendar year
- *Analysis II:* Calendar year
- *Analysis III:* January–December 2005.

Identifying and Analyzing Opportunities for Improvement

In this section, you are asked to address the points specified, as appropriate, for the activity *for each analysis cycle.*

B.1 Quantitative analysis

Compare to the goal/benchmark. Have you met your goals and or achieved the benchmark?

Why did the goals change? If you changed your goal, explain why. If you met your goal but there is still opportunity for improvement, NCQA expects you to increase your goal. If you change your goal for any other reason, explain the basis for doing so. Avoid adjusting goals without a sound rationale for doing so.

Has the benchmark changed? If you changed your benchmark, indicate the source of the new benchmark and the date it was adopted.

Compare to previous measurements. Have the results increased or decreased since the previous remeasurement? If so, does this change represent an improvement, or deterioration?

Trends and statistical significance. Describe any trends you identified and their significance. What weight do you place on the presence or absence of statistical significance?

Impact of any methodological changes. Discuss the impact of the methodological changes on the actual results. Could the results be biased, positively or negatively, by the changes in methodology? Explain why or why not.

Overall survey response rate and implications. If any measures in the analysis are based on survey data, give the survey response rate for the entire survey.

Describe the impact that this response rate could have on the reliability of the findings. Variability in response rates in remeasurement periods should also be addressed (e.g., a 20 percent or less response rate is generally considered too low to draw reliable population-based conclusions).

B.2 Qualitative analysis

Techniques and data used. Many techniques exist for determining the barriers or root causes for the results. You may have to collect additional data, stratify the data, or analyze subgroup data in order to drill down sufficiently to understand the reasons for the results. Include both how you performed the barrier analysis and any additional data collected used for barrier analysis.

Brainstorming, multivoting, pareto analysis and fishbone diagramming are common continuous quality improvement techniques used to identify barriers to improvement. In addition to stratifying the data you already have collected to calculate the measure, you may have to analyze the results of other data, such as targeted survey results, complementary data (e.g., complaints in relation to satisfaction survey rates), and results of focus groups.

Expertise of group performing analysis. List the group or committee that was involved in the analysis and state why it was qualified to perform this analysis by describing the composition of the group and its expertise in evaluating this activity. If statistical or survey research analysis is required, describe the qualifications of those involved.

For service issues, such as UM turn-around on decision, the analysis may be performed by departmental managers and staff. Clinical issues may require expertise in the clinical subject matter as well as an understanding of the delivery system, benefit structure and other distinctive aspects of the organization.

NCQA recognizes that many service issues are addressed during the normal course of business and that there may not be a formal a committee structure to address these issues as there is with clinical issues.

Citations from literature. For many clinical and service quality improvement activities, there are sources that contain information about barriers to performance that have already been identified and are generally accepted. You may use these sources to supplement, or substitute for, your own barrier analysis. Give the complete citation (i.e., name of article and journal and date of publication) for each source you have used.

Barriers/opportunities identified. List the barriers to or causes for the less than acceptable performance that you identified, if any. Although NCQA recognizes that inadequate data collection may contribute to low performance, it does not accept improvements in data collection alone as an opportunity to improve.

Barriers and opportunities for improvement must focus on variables (e.g., improving processes, changing benefits, and educating members, practitioners or both) that can result in improved performance.

The following are examples of categories that may create barriers:

- member knowledge
- practitioner knowledge
- benefit coverage
- co-pay restrictions
- organization staffing
- problems with PCP or specialist access
- referral access
- systems issues in the organization.

List opportunities for improvement that you identified from the barriers. For example, you may identify the lack of family involvement in therapy as a barrier to improving depression management for children and adolescents. Next, you may identify as opportunities for improvement the lack of knowledge by the practitioner of the importance of family involvement, the family's unwillingness to participate in therapy, and the child's resistance to parental involvement. You must then choose which of these opportunities to focus on and develop one or more interventions.

Although you list the interventions in relation to the barriers you identified in Section IV, you should justify here the causal link between your interventions and the results you observed. Explain how your interventions influenced the outcome; identify the interventions that were most influential and explain why; and describe any intervening or confounding factors that may have contributed to the changes.

Some barriers do not lead to opportunities because of benefit restrictions, state law or other problems outside the control of the organization.

Remember that opportunities are not the same as barriers or interventions.

Barrier example 1	**Barrier:**	Inadequate coverage of phones during lunch and breaks
	Opportunity:	Improve lunchtime and break coverage
	Intervention:	Revised staff scheduling to provide better coverage using existing staff
Barrier example 2	**Barrier:**	Insufficient psychiatrist availability in a region
	Opportunity:	Increase psychiatrist access by contracting with more psychiatrists
	Intervention:	Recruited six new psychiatrists to meet availability needs

Section IV:
Interventions Table

In this section, you are asked to list the interventions taken to overcome barriers you identified in the previous section.

Note: *You are not required to pursue interventions for all identified barriers.*

Table Description

Date implemented

List the month and year during which the intervention was implemented.

Check if ongoing

Some interventions occur on a regular, ongoing basis. Often the effectiveness of the intervention rests on its repetitive nature.

Check the column if the intervention occurs at some periodic interval, then state its frequency (e.g., monthly, quarterly, annually). Examples are:

- quarterly training for UM staff,
- annual mailings on the importance of colon cancer screening, and
- monthly review of quality reports of timeliness of approving referrals are examples of ongoing interventions.

Intervention

List the interventions chronologically. Generally, you implement interventions after the data are analyzed. If you began interventions prior to analyzing the baseline measure or prior to this survey period and you believe they have an impact on the performance measures during this survey period, list them first. Interventions may be listed under categories, such as member, practitioner, collaborative, and systems, if doing so is useful to you.

Provide a detailed, quantitative definition of the intervention whenever possible. For example, “hired four UM nurses” is more specific than “increased UM staffing.” “Mailed lists of 455 noncompliant members to 54 pediatricians and 31 family practitioners” better describes the magnitude of the intervention than “mailed lists of noncompliant members to practitioners.” You may abbreviate the full name of the intervention after using it for the first time.

Do not include activities that have been planned but not yet implemented (e.g., developing policies, conducting committee meetings or organizing activities).

Remember that you may include interventions taken after the last remeasurement period shown on this form, but they* are not *used by NCQA to determine meaningful improvement.

This list also summarizes your interventions. NCQA surveyors review additional back-up material to document the extent of the intervention and its implementation.

Barriers that interventions address

List all the barriers that each intervention is designed to address, which you should have previously described in Section III. You may abbreviate the name of the barrier. It may be helpful to number the barriers and use the numbers in subsequent references to them.

Do not include barriers related to data collection. An example of a completed Section IV interventions table appears below:

Activity Name: Improving Preserivce UM decision turn-around time

Section IV: Interventions Table

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

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
03/05		Hired 3 UM nurses	Inadequate UM staffing
09/05	X	Instituted weekly lunchtime training sessions conducted by staff of claims, marketing, etc., departments to update UM staff about policies and discuss more efficient decision making processes	UM staff not following timeliness protocols consistently
12/06		Distributed to all practitioners an updated practitioner handbook that included a description of how the UM decision making process and the time frames	Inadequate practitioner knowledge about role of customer service department
4/06	X	Revised session on UM procedures and processes and delivered as part of all new practitioner orientations	Inadequate practitioner knowledge of UM process

Section V:

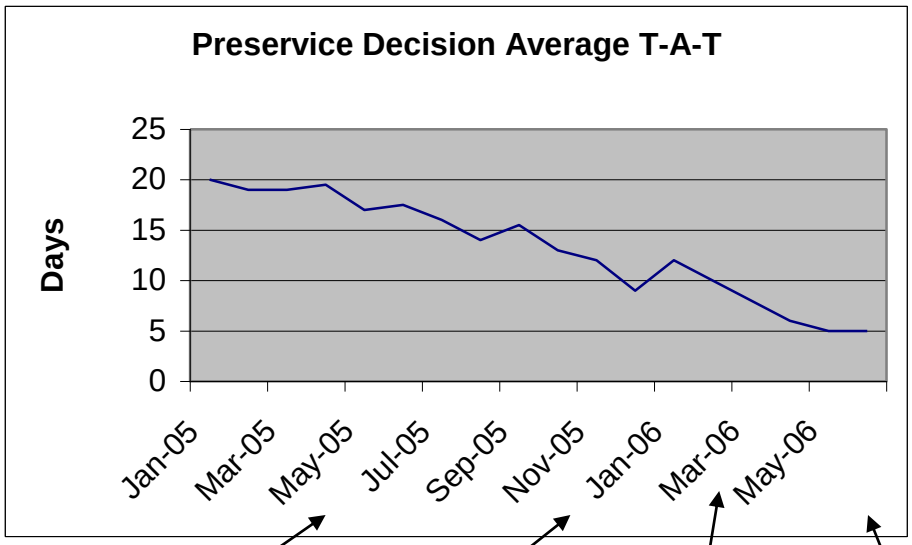
Chart or Graph (Optional)

This section supplements the information you have provided up to now by more fully clarifying the relationship between the results of the remeasurements and the timing of the interventions.

A chart or a graph that plots both the results and the dates you implemented changes designed to improve your results often provides a visual presentation that is helpful in addition to the narrative or tables.

NCQA recommends attaching this "picture" if the activity has more than two measurement periods in order to show the relationship between the timing of the interventions (the cause) and the result of the remeasurements (the effect). Present one chart or graph for each measure unless the measures are closely correlated, which may be displayed in one graphic.

Use whatever type of chart (line, bar, mixed) that clearly presents both your interventions and your performance measures. A simple line graph might be appropriate for service activities with multiple data points, while a bar chart might be more appropriate to show changes in measures with annual measurement points. Interventions are placed on the graph or bar and show the dates of implementation. You may number the interventions and provide a key to the numbering, or you may number the interventions in Section III and use those numbers on the graph or bar. NCQA encourages you to limit the interventions you use to those you have identified as being the strongest.



Jan-05	20
Feb-05	19
Mar-05	19
Apr-05	19.5
May-05	17
Jun-05	17.5
Jul-05	16
Aug-05	14
Sep-05	15.5
Oct-05	13
Nov-05	12
Dec-05	9
Jan-06	12
Feb-06	10
Mar-06	8
Apr-06	6
May-06	5
Jun-06	5

3/05—hired 3 UM nurses

9/05—Instituted weekly lunchtime training sessions conducted by staff of claims, marketing, etc. departments to update UM staff about current health plan policies

12/06—Distributed to all practitioners an updated practitioner handbook that included a description of the UM decision making process and the time frames

4/06—Revised session on UM procedures and processes and delivered as part of all new practitioner orientations

NCQA does not require control charts that display upper and lower confidence limits, but you may include them if you believe they are helpful in demonstrating the stability of the measure over time.

Back-Up Information

NCQA wants to review documentation that supports the information you have summarized on your QIA. In addition to the completed QIA form, NCQA may need additional documentation. Your designated ASC will let you know if this applies.

- Such information often encompasses:
  - all material related to methodology, including data collection tools (e.g., medical record abstraction sheets, codes for administrative data, inter-rater reliability testing, computer algorithms)
  - copies of literature cited, as appropriate
  - excerpts of minutes or other documentation that show how and when analysis was performed
  - tools and supplemental data used in barrier analysis
  - evidence and dates of actions taken:
    - Copies of mailings
    - Newsletters
    - Responses from practitioners or members
    - Revised policies and procedures
    - Excerpts from updated member or practitioner handbooks
    - Revised contracts

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form (an electronic version is available on NCQA's Web site)

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	

Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	

C. Baseline Methodology.

C.1 Data Sources.

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

_____

_____

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

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

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

C.4 Data Collection Cycle.

[ ] Once a year
[ ] Twice a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Once a week
[ ] Once a day
[ ] Continuous
[ ] Other (list and describe):

_____

_____

Data Analysis Cycle.

[ ] Once a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Continuous
[ ] Other (list and describe):

_____

_____

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

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

Include, as appropriate:

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

_____

_____

_____

_____

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						
	Remeasurement 1:						
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						
	Remeasurement 1:						
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						
	Remeasurement 1:						
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

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

Section III: Analysis Cycle
Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis, include the analysis of the following:
- Comparison with the goal/benchmark
- Reasons for changes to goals
- If benchmarks changed since baseline, list source and date of changes
- Comparison with previous measurements
- Trends, increases or decreases in performance or changes in statistical significance (if used)
- Impact of any methodological changes that could impact the results
- For a survey, include the overall response rate and the implications of the survey response rate

B.2 For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:
- Techniques and data (if used) in the analysis
- Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis
- Citations from literature identifying barriers (if any)
- Barriers/opportunities identified through the analysis
- Impact of interventions

Section IV: Interventions Table

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

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

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the

remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

QUALITY/PERFORMANCE IMPROVEMENT AREA	STATE OVERSIGHT & MONITORING MECHANISM	FEDERAL REGULATION	NCQA STANDARD
5. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement			QI 3: Health Services Contracting • Element A: Practitioner Contracts QI 4: Availability of Practitioners • Element A: Cultural Needs and Preferences • Element B: Practitioners Providing Primary Care • Element C:Practitioners Providing Specialty Care
5.a. Access Standards 5.a.1 Availability of services	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review	§438.206	QI 5: Accessibility of Services • Element A: Assessment Against Access Standards MED 1: Medicaid Benefits and Services • Element A: Direct Access to Women's Health Services • Element B: Second Opinions • Element C: Out-of-Network Services • Element D: Out-of-Network Cost to Member • Element E: Hours of Operation Parity RR 3: Subscriber Information
5.a.2 Assurances of adequate capacity and services	• Provider network reporting • NCQA information • Contract compliance review	§438.207	QI 4: Availability of Practitioners • Element B: Practitioners Providing Primary Care • Element C: Ensuring Availability of SCPs
5.a.3 Coordination and continuity of care	• Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	§438.208	QI 4: Availability of Practitioners • Element B: Practitioners Providing Primary Care QI 5: Accessibility of Services • Element A: Assessment Against Access Standards Using valid methodology
5.a.4 Coverage and authorization of services	• Encounter Data System • MMIS data	§438.210	UM 2: Clinical Criteria for UM Decisions • Element C: Consistency in Applying Criteria UM 4: Appropriate Professionals • Element A: Licensed Health Professionals • Element B: Use of Practitioners for UM Decisions • Element F - Affirmative Statement about Incentives

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

5.b.5 Grievance systems	• NCQA information • Annual Member Satisfaction Survey • Complaint, grievance, and appeals, reporting • Special studies • Contract compliance review • Specific to §438.226, analysis by the Rhode Island EOHHS Member Dis-enrollment Request Review Team • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review		• Element A: Adopting Written Policies • Element C: Protection for PHI Sent to Plan Sponsors • Element D: Authorization • Element E: Communication of PHI Use and Disclosure
		§438.226	NCQA Standards are not applicable; please refer to the State Oversight and Monitoring Mechanism
		§438.228	RR 2: Policies for Complaints and Appeals • Element A: Policies and Procedures for Complaints • Element B (and C): Preservice (and Postservice) Appeals UM 2 Element C: Consistency in Applying Clinical Criteria UM 5: Timeliness of UM Decisions • Element B: Notification of Non-BH Decisions UM 8: Policies for Appeals • Element B: Preservice Appeals • Element C: Postservice Appeals • Element E: External Reviews in States With Laws UM 7: Denial Notices • Elements C and F: Reason for Non-Behavioral Health and Behavioral Health Denial • Elements D and G: Non-BH and Behavioral Health Notice of Appeals Rights/Process UM 9 Appropriate Handling of Appeals • Element A: Preservice and Postservice Appeals • Element D - Notification of Appeal Decision/Rights • Element F: Appeals Overturned by the IRO RR 2B: Member notification
5.b.6 Sub contractual relationships and delegation		§438.230	Delegation Standards: CR 12, RR 7, UM 15 and QI 12: Delegation of Credentialing, Rights and Responsibilities, Utilization Management and Quality Improvement • Element A: Written Delegation Agreement • Element D: Predelegation Evaluation • Element F: Reporting • Element G: Opportunities for Improvement

5.c. Quality Measurement and Improvement Standards 5.c.1 Practice guidelines 5.c.2 Quality assessment and performance improvement program 5.c.3 Health information systems	• NCQA information • Special studies • Contract compliance review • Performance incentive program • Encounter Data System • Complaint, grievance, and appeals reporting • NCQA information • Special studies • Contract compliance review • Encounter Data System • Risk-share reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	§438.236	QI 9: Clinical Practice Guidelines • Element A: Adoption and Distribution of Guidelines
		§438.240	QI 1: Program Structure • Element A: Quality Improvement Program Structure HEDIS® Measures: HEDIS® clinical measures account for 32.86 out of 100 points for HP accreditation. CAHPS 4.0H Survey: CAHPS survey results account for 13.00 out of 100 points for HP accreditation
		§438.242	A plan's ability to report HEDIS® indicated that these required systems are in place HEDIS® Compliance Audit A copy of the plan's HEDIS® Data Submission Tool (DST) could be submitted to the state