Rhode Island Medicaid Dental Program – RIte Smiles
UnitedHealthcare Dental
2021 External Quality Review
Annual Technical Report
April 2023

Prepared on behalf of:
The State of Rhode Island
Executive Office of Health and Human Services

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About This Report

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted managed care plans. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services.[1] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through *(d)* requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that managed care plans furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the managed care plans with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the Rhode Island Executive Office of Health and Human Services contracted Island Peer Review Organization, Inc. (doing business as IPRO), an external quality review organization, to conduct the external quality review of the managed care plans that were part of Rhode Island's Medicaid managed care program in 2021. This report summarizes the 2021 external quality review results for UnitedHealthcare Dental (UHC-Dental), the Rhode Island Medicaid dental managed care plan.

2021 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects[5], validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional activity (quality-of-care survey) that were conducted for measurement year 2021. IPRO's external quality review methodologies for these activities follow

[1] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.
[2] Prepaid inpatient health plan.
[3] Prepaid ambulatory health plan.
[4] Primary care case management.
[5] Rhode Island refers to performance improvement projects as quality improvement projects, and the term quality improvement project will be used in the remainder of this report.

the *CMS External Quality Review (EQR) Protocols*[6] published in October 2019. The external quality review activities and corresponding protocols are described in **Table 1**.

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed managed care plan quality improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS®[7]) audit results provided by the managed care plans' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance auditors and reported rates to validate that performance measures were calculated according to the Office of Health and Human Services' specifications.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by NCQA, as part of the Accreditation Survey, of Medicaid managed care plan compliance with Medicaid standards. Specifically, this review assessed managed care plan compliance with the standards of *Code of Federal Regulations Part 438 Subpart D* and *Code of Federal Regulations 438.330*.
Activity 4. Validation of Network Adequacy (Required)	Protocol 4 (Published in 2023)	IPRO evaluated managed care plan data to determine adherence managed care plan adhere to the network standards outlined in the *Medicaid Managed Care Services Agreement*, as well as the managed care plans' ability to provide an adequate provider network to its Medicaid population.
Activity 6. Validation of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO reviewed managed care plan member satisfaction survey reports to validate that the methodology aligned with the Office of Health and Human Services' requirement to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[8]) tool. IPRO also reviewed managed care plan provider satisfaction reports to verify the validity and reliability of the results.

The results of IPRO's external quality review are reported under each activity section.

[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.
[7] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[8] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

Rhode Island Medicaid Managed Care Program and Medicaid Quality Strategy

The Rhode Island Medicaid Managed Care Program

The State of Rhode Island was granted a Section 1115 Demonstration Waiver[9] from the Centers for Medicare & Medicaid Services in 1993 to develop and implement a mandatory Medicaid managed care program. Rite Care, Rhode Island's Medicaid managed care program began enrollment in 1994. Since 1994, the Rhode Island Medicaid managed care program has evolved and expanded to meet the health care needs of Rhode Islanders.

In 2015, the *Working Group to Reinvent Medicaid* was established because of an executive order issued by the Governor of Rhode Island and later codified by the Reinventing Medicaid Act of 2015[10]. The Reinventing Medicaid Act required the *Working Group to Reinvent Medicaid* to identify progressive, sustainable savings initiatives to transform Rhode Island's Medicaid program to pay for better outcomes, better coordination, and higher-quality care, instead of more volume. The *Working Group to Reinvent Medicaid* established these four guiding principles the Rhode Island Medicaid managed care program:

1. Pay for value, not volume.
2. Coordinate physical, behavioral, and long-term health care.
3. Rebalance the delivery system away from high-cost settings.
4. Promote efficiency, transparency, and flexibility.

Further, Rhode Island's vision for its Medicaid managed care program as expressed by the *Working Group to Reinvent Medicaid, "*calls for a reinvented Medicaid in which managed care plans contract with integrated provider organizations called accountable entities that will be responsible for the total cost of care and health care quality and outcomes of the attributed population." Accountable entities represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services.

The Office of Health and Human Services currently offers a variety of managed care plans to coordinate the provision, quality, and payment of care for its enrolled members. The Rhode Island Medicaid managed care program covers acute care, primary and specialty care, pharmacy, and behavioral health services through contracts with three managed care plans: Neighborhood Health Plan of Rhode Island, United Healthcare Community Plan of Rhode Island, and Tufts Health Public Plan; and one managed dental health plan: United Healthcare Dental. Table 2 displays a summary of the Medicaid managed care programs and participating managed care plans that were available to Rhode Islanders in 2021.

[9] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. Medicaid.gov About 1115 Demonstrations website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

[10] Title 42 State Affairs and Government Chapter 7.2 Office of Health and Human Services 16.1 Reinventing Medicaid Act of 2015 website: http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-7.2/42-7.2-16.1.htm.

Table 1: Rhode Island Medicaid Managed Care Programs

Program	Program Description	Participating Managed Care Plans
RIte Care Core	Children and families	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
RIte Care Substitute Care	Children in legal custody of the State Department of Children, Youth and Families	▪ Neighborhood Health Plan of Rhode Island
RIte Care for Children with Special Health Care Needs	A Medicaid managed care plan for children with a disability or chronic condition who qualify for supplemental security income, Katie Beckett or adoption subsidy through the Department of Children, Youth, and Families.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Expansion	A Medicaid managed care plan for low-income adults aged 19-64 years with no dependent children.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Partners	A Medicaid managed care plan for eligible adults with disabilities who are 21 years or older.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	▪ United Healthcare Dental

The provision of health care services to each of the applicable eligibility groups (Core RIte Care, RIte Care for Children in Substitute Care, RIte Care for Children with Special Health Care Needs, Rhody Health Expansion, and Rhody Health Partners) are evaluated in this report.

Rhode Island Medicaid Quality Strategy, 2019-2022

The Rhode Island Medicaid quality strategy is a framework for managed care plans on how to improve quality, timeliness, and access to care for Medicaid managed care enrollees; and is utilized by the Office of Health and Human Services as a tool to support the alignment of state and managed care plan Medicaid initiatives, identification of opportunities for improvement, and cost reduction. The Office of Health and Human Services performs periodic reviews of the Medicaid quality strategy to determine the need for revision and to ensure managed care plans are compliant with regulatory standards and have committed adequate resources to perform internal monitoring and ongoing quality improvement. The Office of Health and Human Services updates the Medicaid quality strategy as needed, but no less than once every three years.

Rhode Island's 2019-2022 Medicaid Managed Care Quality Strategy[11] aligns with the Office of Health and Human Services' commitment to facilitating the creation of partnerships using accountable delivery models that integrate medical care, mental health, substance abuse disorders, community health, social services and long-term services, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

Goals for the Rhode Island Medicaid program outlined in the 2019-2022 quality strategy evolved from the guiding principles established by *Working Group to Reinvent Medicaid* and are displayed in Table 3.

Table 2: Rhode Island Medicaid Quality Strategy Goals, 2019-2022

Rhode Island Medicaid Managed Care Quality Strategy Goals
1. Maintain high level managed care performance on priority clinical quality measures.
2. Improve managed care performance on priority measures that still have room for improvement.
3. Improve perinatal outcomes.
4. Increase coordination of services among medical, behavioral, and specialty services and providers
5. Promote effective management of chronic disease, including behavioral health and comorbid conditions.
6. Analyze trends in health disparities and design interventions to promote health equity.
7. Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice.
8. Reduce inappropriate utilization of high-cost settings

To support achievement of the Medicaid managed care quality strategy goals and to ensure Rhode Island Medicaid recipients have access to the highest quality of health care, the Office of Health and Human Services adopts objectives and initiatives to help all parties focus on interventions most likely to result in progress towards the goals of the quality strategy. Table 4 displays these objectives along with the attached goal(s), while descriptions of key initiatives follow.

[11] Rhode Island Medicaid Managed Care Quality Strategy Website: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Reports/QUALITY-STRATEGY.DRAFT.5.3.19.pdf.

Table 3: Rhode Island Medicaid Quality Strategy Objectives and Goals, 2019-2022

Medicaid Quality Strategy Objectives	Linked Medicaid Quality Strategy Goals
Continue to work with managed care entities and the external quality review organization to collect, analyze, compare, and share clinical performance and member experience across plans and programs.	All Goals
Work collaboratively with managed care plans, accountable entities, Office of the Health Insurance Commissioner, and other stakeholders to strategically review and modify measures and specifications for use in Medicaid managed care quality oversight and performance incentives. Establish consequences for declines in managed care entity performance.	Goal 1
Create non-financial incentives such as increasing transparency of managed care entity performance through public reporting of quality metrics and outcomes – both online and in person.	Goals 1 and 2
Review and potentially modify financial incentives (rewards and/or penalties) for managed care plan performance to benchmarks and improvements over time.	Goals 1 through 5
Work with managed care plans and accountable entities to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.	Goals 3, 6, and 8
Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.	Goals 3,4,5,6,8
Monitor and assess managed care plan and accountable entity performance on measures that reflect coordination including follow up after hospitalization for mental health and data from the new care management report related to percentage/number of care plans shared with primary care providers.	Goals 4,5,8
Develop a chronic disease management workgroup and include state partners, managed care entities, and accountable entities, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.	Goals 4,5,8
Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with managed care plans and accountable entities to screen members related to social determinants of health and make referrals based on the screens.	Goals 5,8
Share and aggregate data across all Rhode Island Health and Human Services agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	Goal 6
Continue to require plans to conduct CAHPS 5.0 surveys and annually share managed care plan CAHPS survey results with the MCAC.	Goal 6
Explore future use of a statewide survey to assess member satisfaction related to accountable entities, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from accountable entities.	Goal 7
Explore use of focus groups to solicit additional member input on their experiences and opportunities for improvement.	Goal 7

Accountable Entity Program

Rhode Island contends that a core part of the Medicaid quality strategy is the integration of accountable entities into the Medicaid managed care delivery system. Accountable entities represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. Rhode Island's Accountable Entity Program seeks to achieve the following goals for Medicaid managed care: transition Medicaid from fee-for-service to value-based purchasing at the provider level; focus on total cost of care; create population-based accountability for an attributed population; build interdisciplinary care capacity that extends beyond traditional health care providers; deploy new forms of organization to create shared incentives across a common enterprise; and apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

Rhode Island accountable entity certification standards ensure that qualified accountable entities either have or are developing the capacity and authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital-based services and to long term services and supports and nursing home care. These entities must also demonstrate their capacity and authority to address members' social determinants of health in a way that is acceptable to the Centers for Medicare and Medicaid Services and the Office of Health and Human Services.

Accountable entity quality performance is measured and reported by the managed care plans to the Office of Health and Human Services according to the "Medicaid Comprehensive Accountable Entity Common Measure Slate." Measures in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" are used to inform the distribution of shared savings. **Table 4** displays the measures included in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" for 2021, as well as the measure steward and reporting category.

Table 4: Medicaid Comprehensive Accountable Entity Common Measure Slate, Performance Year 2021

Measure	Steward	Category
Breast Cancer Screening	NCQA	P4P
Child and Adolescent Well-Care Visits, 12 to 17 Years	NCQA	Reporting-only
Child and Adolescent Well-Care Visits, 18 to 21 Years	NCQA	Reporting-only
Child and Adolescent Well-Care Visits, Total	NCQA	Reporting-only
Comprehensive Diabetes Care – Eye Exam	NCQA	P4P
Comprehensive Diabetes Care – HbA1c Control	NCQA	P4P
Controlling High Blood Pressure	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 7 Days	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 30 Days	NCQA	Reporting-only
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	P4P
Developmental Screening in the First Three Years of Life	Oregon Health & Science University	P4P
Screening for Depression and Follow-up Plan	State	P4P
Tobacco Use: Screening and Cessation Intervention	PCPI® Foundation	Reporting-only
Social Determinants of Health Screening	State	P4P

P4P status indicates that an accountable entity's performance on the measure will influence the distribution of any shared savings. **Reporting-only** indicates that measure performance must be reported to Office of Health and Human Services for state monitoring purposes, but that there are no shared savings distribution consequences for reporting of or performance on the measure.

For performance year 2021, the Office of Health and Human Services employed a combination of internal and external sources to set achievement targets. The Office of Health and Human Services set targets for performance year 2021 using accountable entity performance year 2019 data, national and New England Medicaid health maintenance organization data from NCQA's *Quality Compass 2020* (measurement year 2019) and national and Rhode Island state fiscal year 2019 data from the Centers for Medicare & Medicaid Services' *2019 Child and Adult Health Care Quality Measures Report*. Table 6 displays the performance year 2021 measures and achievement targets.

Table 5: Accountable Entity 'P4P' Measure Targets, Performance Year 2021

Measure	Threshold Target	High-Performance Target
Breast Cancer Screening	55.8%	63.2%
Comprehensive Diabetes Care – Eye Exam	51.8%	60.8%
Comprehensive Diabetes Care – HbA1c Control	49.3%	58.7%
Controlling High Blood Pressure	53.8%	64.2%
Follow-Up After Hospitalization for Mental Illness – 7 Days	42.5%	62.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Composite Score	62.9%	67.9%
Developmental Screening in the First Three Years of Life	53.2%	65.0%
Screening for Depression and Follow-up Plan	6.6%	24.8%
Social Determinants of Health Screening	25.0%	50.0%

Accountable entity rates for 'P4P' measures are presented in the Technical Summary – Validation of Performance Measures section of this report.

Alternative Payment Models

Transformation to a value-based health care delivery system is a fundamental policy goal for the State of Rhode Island. A fundamental element of the transition to alternative payment models, is a focus on quality-of-care processes and outcomes. Rhode Island Medicaid managed care plans enter alternative payment model arrangements with certified accountable entities, as required by the *Medicaid Managed Care Services Agreement*, and follow the agreement terms of setting targets for payments to providers. Payments are made utilizing an Office of Health and Human Services-approved Alternative Payment Methodology.

An Alternative Payment Methodology means a payment methodology structured such that it provides economic incentives, rather than focusing on volume of services provided, focus upon such key areas as:

- Improving quality of care;
- Improving population health;
- Impacting cost of care and/or cost of care growth;
- Improving patient experience and engagement; and/or
- Improving access to care.

The Rhode Island Medicaid agreement includes defined targets for managed care plan implementation of contracts with alternative payment arrangements. Targets for alternative payment arrangements are:

- July 1, 2019-June 30, 2020 – At least 50% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 5% higher than the percent required for the previous period.

- July 1, 2020-June 30, 2021 – At least 60% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 5% higher than the percent required for the previous period.
- July 1, 2021-June 3, 2022 – At least 65% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 10% higher than the percent required for the previous period.

Early Periodic Screening, Diagnosis and Treatment

Early periodic screening, diagnosis and treatment is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. As part of its oversight program of managed care plans, the Office of Health and Human Services monitors provision of early periodic screening, diagnosis and treatment to Medicaid managed care members. Medicaid beneficiaries under age 21 are entitled to early periodic screening, diagnosis and treatment services, whether they are enrolled in a Medicaid managed care plan or receive services in a fee-for-service delivery system. The Rhode Island-specific *Annual EPSDT Participation Report,* produced by the Centers for Medicare & Medicaid Services, is used by the Office of Health and Human Services to monitor trends over time, differences across managed care plans, and to compare Rhode Island to other states. The Office of Health and Human Services shares the *Annual EPSDT Participation Report* with the managed care plans to discuss opportunities for improvement and modifications to existing early periodic screening, diagnosis and treatment approaches, as necessary.

Patient Centered Medical Homes

A patient-centered medical home provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. To be recognized as a patient-centered medical home, a practice must meet the three-part definition established by the Office of the Health Insurance Commissioner, which requires demonstration of practice transformation, implementation of cost management initiatives, and clinical improvement.

The *Medicaid Managed Care Services Agreement* includes defined performance targets for managed care plan assignment of members to patient-centered medical homes. Targets for member linkage to a patient-centered medical home are:

- June 30, 2020 – At least 55% of the managed care plan's membership is linked to a patient-centered medical home.
- June 30, 2021 – At least 60% of the managed care plan's membership is linked to a patient-centered medical home.
- June 30, 2022 – At least 60% of the managed care plan's membership is linked to a patient-centered medical home.

NCQA Accreditation

Rhode Island health maintenance organizations are required to obtain and maintain NCQA accreditation and to promptly share accreditation review results and notify the state of any changes in accreditation status. The Office of Health and Human Services reviews and acts on changes in managed care plan accreditation status and has set a performance "floor" to ensure that any denial of accreditation by NCQA is considered cause for termination of the *Medicaid Managed Care Services Agreement*. In addition, managed care plan achievement of no greater than a provisional accreditation status by NCQA requires the managed care plan to submit a corrective action plan within 30 days of the managed care plan's receipt of its final report from the NCQA.

Other licensed organizations, such as dental plans, are not required to maintain NCQA accreditation but are required to maintain accreditation from a recognized, independent accrediting body.

UHC-Dental's accreditation results are presented in the Technical Summary – URAC Accreditation section of this report.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

The Rhode Island Medicaid quality strategy aligns with the Centers for Medicare & Medicaid Services' requirements and provides a framework for managed care plans to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required external quality review activities, the Medicaid quality strategy includes state- and managed care plan-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

Recommendations to the Rhode Island Executive Office of Health and Human Services

In working towards the goals of the 2019-2022 strategy, IPRO recommends that the Office of Health and Human Services consider:

- Establishing appointment availability thresholds for the Medicaid managed care program to hold the managed care plans accountable for increasing the availability of timely appointments.
- Updating the Medicaid quality strategy to explicitly state how performance towards the goals will be evaluated. Each goal should be attached to an outcome measure along with baseline and target rates. Interim reporting of rate performance should be provided to the external quality review organization as part of the annual external quality review assessment.
- Developing a separate quality strategy for the dental Medicaid managed care program or dedicate a section in the overall Medicaid quality strategy to Rite Smiles.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.
- Providing technical assistance to the managed care plans during the conduct of the quality improvement project.
- Consider enforcing minimum sample size requirements for appointment availability and provider satisfaction surveys conducted by the managed care plans.

Medicaid Managed Care Plan Profile

The state contracts with UHC-Dental as a prepaid ambulatory health plan to manage the RIte Smile dental benefit for children enrolled in Medicaid. RIte Smiles serves Medicaid-eligible children under the age of 21, born after May 1, 2000, and residing in the State of Rhode Island. The program covers all Rhode Island Medicaid managed care eligibility groups, including Core RIte Care, RIte Care for Children with Special Health Care Needs (CSHCN), and RIte Care for Children in Substitute Care.

Table 3 displays UHC-Dental's enrollment for the RIte Smiles program for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to the Office of Health and Human Services. The data presented may differ from those in prior reports as enrollment counts will vary based on the time in which the data were abstracted. RIte Smiles enrollment decreased by 24% from 123,280 members in 2020 to 93,641 members in 2021.

Table 6: UHC-Dental's RIte Smiles Enrollment, 2018-2021

	2018	2019	2020	2021
Number of Members	113,461	110,215	123,280	93,641
Percent Change from Previous Year	+6%	-2.9%	+12%	-24%

UHC-Dental's Quality Strategy, 2021-2022

The Executive Office of Health and Human Services requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. UHC-Dental's *2021 Quality Improvement Program Description* met these requirements.

The objective of UHC-Dental's quality improvement program is to ensure that quality of care is being reviewed; that problems are being identified; and that follow-up is planned where indicated. The quality improvement program is directed by all state, federal and client requirements; and addresses various service elements including accessibility, availability, and continuity of care. It also monitors the provisions and utilization of services to ensure they meet professionally recognized standards of care.

Table 7 displays UHC-Dental's quality improvement goals as reported in the *2021 Quality Improvement Program Description*.

Table 7: UHC-Dental's Quality Improvement Goals, 2021

UHC-Dental Quality Improvement Objectives, 2021
▪ Promote and incorporate quality into the dental plan's organizational structure and processes. ▪ Promote effective monitoring and evaluation of patient care and services provided by practitioners and providers for compatibility with evidence-based medicine guidelines. ▪ Identify and analyze opportunities for improvement and implement actions and follow-up. ▪ Coordinate quality improvement, risk management, patient safety, and operational activities. ▪ Maintain compliance with local, state, and federal regulatory requirements and accreditation standards. ▪ Serve culturally and linguistically diverse populations. ▪ Support members living healthier lives.

Technical Summary – Information Systems Capabilities Assessment

Objectives

The *CMS External Quality Review (EQR) Protocols* published in October 2019 by the Centers for Medicare & Medicaid Services state that an Information Systems Capabilities Assessment is a mandatory component of the external quality review as part of Protocols 1, 2, 3, and 4.

Technical Methods of Data Collection and Analysis

As part of the URAC® Dental Plan Accreditation survey, the managed care plan's compliance with information system capabilities standards is evaluated. The standards specify the minimum requirements that information systems should meet and criteria that are used in data collection. Compliance with the URAC information system capabilities standards ensures that the dental plan has effective systems, practices, and control procedures for core business functions and for reporting.

Description of Data Obtained

IPRO reviewed a copy of UHC-Dental's URAC *Application Scoring Summary Report*, dated November 16, 2022. The *Application Scoring Summary Report* presented the accreditation status achieved, the effective term of the accreditation, the overall score achieved, the number of mandatory standard elements not met, and details of each standard reviewed.

Comparative Results

Table 8 displays the results of UHC-Dental's information systems capabilities review conducted as part of the URAC Accreditation survey.

Table 8: URAC Information Systems Capabilities Standards, 2022-2025

URAC Standard Code	Standard Description	UHC-Dental's Audit Results
DP-QM 8.a	Selects, collects, analyzes, and ensures data integrity prior to integrating data that is used to manage key work processes; and	Met
DP-QM 8.b.i	The organization's own performance;	Met
DP-QM 8.b.ii	Customer data; and	Met
DP-QM 8.b.iii	Comparative data.	Met

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid managed care plans to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by a managed care plan. Further, managed care plans are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by section *2.12.03.03 Quality Assurance* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans must conduct at least four quality improvement projects in priority topic areas of its choosing with the mutual agreement of the Office of Health and Human Services, and consistent with federal requirements.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. The Office of Health and Human Services Department conducted this activity for the quality improvement projects that were underway in 2021.

Table 9 displays the titles of the four quality improvement projects led by UHC-Dental for its Medicaid membership in measurement year 2021.

Table 9: UHC-Dental Quality Improvement Project Topics, 2021

UHC-Dental Quality Improvement Project Topics, 2021
1. Increasing the Percent of Children Receiving Preventive Health Services
2. Fissure Sealants on First or Second Molars

Technical Methods of Data Collection and Analysis

All quality improvement projects were documented using NCQA's *Quality Improvement Activity Form*. All data needed to conduct the validation were obtained through these report submissions. A copy of the *Quality Improvement Activity Form* is in Appendix A of this report.

The quality improvement project assessments were conducted using an evaluation approach developed by IPRO and consistent with the Centers for Medicare & Medicaid Services' *Protocol 1 – Validation of Performance Improvement Projects*. IPRO's evaluation involves the following elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan's enrollment.
2. Review of the study question(s) for clarity of statement.

3. Review of the identified study population to ensure it is representative of the managed care plan's enrollment and generalizable to the managed care plan's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the managed care plan achieved sustained improvement.

Following IPRO's evaluation of the 2021 *Quality Improvement Activity Form* completed by the managed care plan for each quality improvement project against the review elements listed above, determinations of "met" and "not met" were used for each element under review. Definitions of these review determinations are presented in Table 10.

Table 10: Review Determination Definitions

Review Determination	Definition
Met	The managed care plan has met or exceeded the standard.
Not Met	The managed care plan has not met the standard.

The review findings were considered to determine whether the quality improvement project outcomes should be accepted as valid and reliable. A determination was made as to the overall credibility of the results of each quality improvement project, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
- The validation findings generally indicate that the credibility for the quality improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at risk are enumerated.

Description of Data Obtained

For the 2021 external quality review, IPRO reviewed managed care plan quality improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of UHC-Dental's methodology found that there were no validation findings that indicated that the credibility of the four quality improvement projects was at risk.

Table 11 displays a summary of the validation results of UHC-Dental's quality improvement projects that were conducted for measurement year 2021. Summaries of each quality improvement projects immediately follow.

Table 11: UHC-Dental's Quality Improvement Project Validation Results, Measurement Year 2021

UHC-Dental's Quality Improvement Project (QIP) Validation Results		
Validation Element	QIP 1	QIP 2
Selected Topic	Met	Met
Study Question	Met	Met
Indicators	Met	Met
Population	Met	Met
Sampling Methods	Met	Met
Data Collection Procedures	Met	Met
Interpretation of Study Results	Met	Met
Improvement Strategies	Met	Met

Table 12: Quality Improvement Project 1 Summary – Preventive Health Services, Measurement Year 2021

UHC-Dental's Quality Improvement Project 1 Summary

Title: Increasing the Percent of Children Receiving Preventive Health Services

Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.

Aim

UHC-Dental aimed to increase the percent of children aged 15 to 18 years with preventive health services.

Indicator of Performance

The percentage of children aged 15 to 18 years continuously enrolled for at least 90 days in RIte Smiles who received one of the following preventive services: prophylaxis, topical fluoride, or sealant.

Member-Focused 2021 Interventions

- Mailed reminder postcards with preventive dental care education to members aged 15 to 18 years who had not been in for care for over 12 months. Directions on how to establish a dental home were included.
- Collaborated with school-based lunch programs to deliver breakfast and lunch to children 18 and under to include dental kits with the meal packages.
- Participated in a 2-day back to school event by distributing oral health kits and healthy habits flyer to students picking up back packs.
- Produced a patient-centered video of the Paw Sox mascot having a dental visit for the Blackstone Valley Community Health Center to play for patients in the waiting room.
- Collaborated with PawSox to distribute dental education via dental kits to Dining on the Diamond attendees.
- Hosted and attended events with the goal of increasing member awareness of the value of preventive dental visits.
- Utilized interactive voice messaging to remind members to complete annual dental visits.
- Partnered with multiple community organizations (including Black Stone Valley Health Center, Paw Sox, Rhode Island Army National Guards) to conduct engagement activities to educate members and caretakers on proper dental care.
- Partnered with four federally qualified health centers/general dentist offices in 2021 to provide member vouchers to local amusement parks to educate and incentivize members to seek dental care.

Provider-Focused 2021 Interventions

UHC-Dental's Quality Improvement Project 1 Summary
Title: Increasing the Percent of Children Receiving Preventive Health Services **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
▪ Continued distribution of gaps in care lists to the top 20 dental providers identified as having the highest volume of plan members and the highest number of plan members with no services within the past two years. ▪ Conducted clinical engagement sessions with high volume dental practices in Providence, Rhode Island.

Table 13: Quality Improvement Project 1 Indicator Summary – Preventive Health Services, Measurement Years 2016 to 2021

Adolescent Members With Preventive Health Services					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Jan 1, 2016 – Dec 31, 2016	Baseline	4,875	9,429	51.70%	Not Applicable
Apr 1, 2016 – Mar 31, 2017	Remeasurement 1	5,566	10,994	50.63%	56.87%
Jul 1, 2016 – Jun 30, 2017	Remeasurement 2	6,265	12,478	50.21%	56.87%
Oct 1, 2016 – Sep 30, 2017	Remeasurement 3	7,019	14,086	49.83%	56.87%
Jan 1, 2017 – Dec 31, 2017	Remeasurement 4	5,626	11,136	50.52%	56.87%
Apr 1, 2017 – Mar 31, 2018	Remeasurement 5	8,481	17,452	48.60%	56.87%
Jul 1, 2017 – Jun 30, 2018	Remeasurement 6	9,124	18,877	48.33%	56.87%
Oct 1, 2018 – Sep 30, 2018	Remeasurement 7	9,999	19,283	51.85%	56.87%
Jan 1, 2018 – Dec 31, 2018	Remeasurement 8	10,879	21,323	51.02%	56.87%
Apr 1, 2018 – Mar 31, 2019	Remeasurement 9	11,351	21,539	52.69%	56.87%
Jul 1, 2018 – Jun 30, 2019	Remeasurement 10	11,643	21,886	53.20%	56.87%
Oct 1, 2018 – Sep 30, 2020	Remeasurement 11	12,255	20,471	59.87%	56.87%
Jan 1, 2019 – Dec 31, 2019	Remeasurement 12	13,262	21,324	62.19%	56.87%
Apr 1, 2019 – Mar 31, 2020	Remeasurement 13	Not Reported	Not Reported	Not Reported	56.87%
Jul 1, 2019 – Jun 30, 2020	Remeasurement 14	11,430	24,112	47.40%	56.87%
Oct 1, 2019 – Sep 30, 2020	Remeasurement 15	8,698	23,846	36.48%	56.87%
Jan 1, 2020 – Dec 31, 2020	Re-measurement 16	7,834	23,918	32.75%	56.87%
Apr 1, 2020– Mar 31, 2021	Re-measurement 17	8,313	24,436	34.02%	56.87%
Jul 1, 2020 – Jun 30, 2021	Re-measurement 18	9,715	24,638	39.43%	56.87%
Oct 1, 2020 – Sep 30, 2021	Re-measurement 19	10,008	24,799	40.36%	56.87%
Jan 1, 2021 – Dec 31, 2021	Re-measurement 20	9,938	24,891	39.93%	56.87%

Table 14: Quality Improvement Project 2 Summary – Fissure Sealants, Measurement Year 2021

UHC-Dental's Quality Improvement Project 2 Summary
Title: Fissure Sealants on First or Second Molars **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHC-Dental aimed to increase the percent of children receiving sealants on their first molars for Medicaid members enrolled for at least 90 days by ten percentage points from 2011-year-end results. Indicator of Performance The percentage of children aged six to nine years, continuously enrolled for 90 days in RIte Smiles, who received a pit and fissure sealant on their first molars. Member-Focused 2021 Interventions ▪ Collaborated with school-based lunch programs to deliver breakfast and lunch to children 18 and under to include dental kits with the meal packages. ▪ Participated in a two-day back to school event by distributing oral health kits and healthy habits flyer to students picking up back packs. ▪ Produced a patient-centered video of the Paw Sox mascot having a dental visit for the Blackstone Valley Community Health Center to play for patients in the waiting room. ▪ Collaborated with PawSox to distribute dental education via dental kits to Dining on the Diamond attendees. ▪ Distributed dental kits at two elementary schools in Providence, Rhode Island. ▪ Hosted and attended events with the goal of increasing member awareness of the value of preventive dental visits. ▪ Collaborated with Ella Risk elementary school to provide dental screenings and sealant placement to students. ▪ Utilized interactive voice messaging to remind members to complete annual dental visits. Provider-Focused 2021 Interventions ▪ Continued distribution of gaps in care lists to the top 20 dental providers identified as having the highest volume of plan members and the highest number of plan members with no services within the past two years.

Table 15: Quality Improvement Project 3 Indicator Summary –Fissure Sealants, Measurement Years 2016 to 2021

Adolescent Members With Preventive Health Services					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Jan 1, 2016 – Dec 31, 2016	Baseline	4,566	25,348	18.01%	Not Applicable
Apr 1, 2016 – Mar 31, 2017	Remeasurement 1	4,571	25,653	17.82%	19.81%
Jul 1, 2016 – Jun 30, 2017	Remeasurement 2	4,697	25,728	18.26%	19.81%
Oct 1, 2016 – Sep 30, 2017	Remeasurement 3	4,656	25,912	17.97%	19.81%
Jan 1, 2017 – Dec 31, 2017	Remeasurement 4	4,632	26,004	17.81%	19.81%
Apr 1, 2017 – Mar 31, 2018	Remeasurement 5	4,532	26,247	17.27%	19.81%
Jul 1, 2017 – Jun 30, 2018	Remeasurement 6	4,419	26,073	16.95%	23.4%
Oct 1, 2018 – Sep 30, 2018	Remeasurement 7	4,555	26,223	17.37%	23.4%
Jan 1, 2018 – Dec 31, 2018	Remeasurement 8	4,823	26,217	18.40%	23.4%
Apr 1, 2018 – Mar 31, 2019	Remeasurement 9	4,755	26,535	17.92%	23.4%
Jul 1, 2018 – Jun 30, 2019	Remeasurement 10	4,739	26,391	17.96%	23.4%
Oct 1, 2018 – Sep 30, 2020	Remeasurement 11	5,130	26,752	19.18%	23.4%
Jan 1, 2019 – Dec 31, 2019	Remeasurement 12	4,789	22,928	20.88%	23.4%
Apr 1, 2019 – Mar 31, 2020	Remeasurement 13	Not Reported	Not Reported	Not Reported	23.4%
Jul 1, 2019 – Jun 30, 2020	Remeasurement 14	4,101	25,874	15.85%	23.4%
Oct 1, 2019 – Sep 30, 2020	Remeasurement 15	3,114	25,602	12.16%	23.4%
Jan 1, 2020 – Dec 31, 2020	Remeasurement 16	2,654	25,333	10.48%	23.4%
Jan 1, 2021 – Dec 31, 2021	Remeasurement 17	4,343	25,928	16.75%	23.4%

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must *Title 42 Code of Federal Regulations 438.330(c) Performance measurement* establishes that the state must identify standard performance measures relating to the performance of managed care plans and that the state requires each managed care plan to annually measure and report to the state on its performance using the standard measures required by the state.

As required by section *2.12.03.03 Quality Assurance* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans must provide performance measure data, specifically HEDIS, to the Office of Health and Human Services within 30 days following the presentation of these results to the managed care plan's quality improvement committee. The Office of Health and Human Services utilizes performance measures to evaluate the quality and accessibility of services furnished to Medicaid beneficiaries and to promote positive health outcomes.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Office of Health and Human Services for measurement year 2021.

Technical Methods of Data Collection and Analysis

All managed care claims are processed through the standard 837 edit process to assure that the state is only paying for Medicaid covered services provided to Medicaid enrolled members by Medicaid registered providers. RIte Smiles claims are additionally edited through the dental benefit managers to assure that only approved dental claims are provided by members of the RIte Smiles provider list to children born on or after May 1, 2000.

Annual rates of dental services reported on the Centers for Medicare & Medicaid Services' *416 EPSDT Report* are compared by health plan and by year to assure data completeness.

The measurement period for the 2021 EPSDT measures is January 1, 2021, to December 31, 2021. The age groups are reported based on each individual's age as of September 30th of the measurement year, not the age the individual was at the time the services were rendered.

For each measure, only individuals who are continuously enrolled for 90 days are included in the totals. Additionally, numerators include the total number of members receiving any service, not the total number of services provided within the measurement year. Therefore, an individual may be counted toward more than one service if the member received different services within the measurement year. As noted previously, the RIte Smiles periodicity schedule calls for each individual to have a clinical dental exam every six months; however, because unique individuals are counted in the measure totals, and not the number of services provided, individuals are counted only once per measure, regardless of whether they received a service more than once within the measurement year.

In addition, the measures do not reflect "sick" visits. Only visits that included an initial or periodic screening are counted. "Dental services" are defined as services provided by, or under the supervision of, a dentist; "oral health services" are defined as services provided by a qualified health care practitioner or dental professional that is neither a dentist nor operating under the supervision of a dentist.

Aggregate rates for the five dental EPSDT measures include all age groups. Measure rates were calculated using the total number of eligibles for EPSDT enrolled for 90 continuous days as the denominator for each measure,

and the total number of eligibles who received each service or treatment as the numerator. Medicaid members enrolled in both managed care and FFS are included in the numerators and denominators.

Description of Data Obtained

For the 2021 external quality review, IPRO obtained a copy of UHC-Dental's submission for the 2020-2021 measurement period from the managed care plan. EPSDT measures were stratified into the following age groups: *<1 Year*, *1-2 Years*, *3-5 Years*, *6-9 Years*, *10-14 Years*, *15-18 Years*, and *19-20 Years*. Data was reported for seven EPSDT measures that assess the total number of children and adolescents receiving dental treatment services: *Any Dental Services*, *Preventive Dental Services*, *Dental Treatment Services*, *Sealant on a Permanent Molar*, and *Dental Diagnostic Services*.

Comparative Results

UHC-Dental demonstrated performance improvement for all five EPSDT measures reported. More members received oral health services by a non-dentist provider in 2020 from 2019. Table 9 displays UHC-Dental's EPSDT measure rates for MY 2019, MY 2020, and MY 2021.

Table 16: UHC-Dental's EPSDT Measure Rates, Measurement Years 2019 to 2021

EPSDT Measure	Measurement Year 2019		Measurement Year 2020		Measurement Year 2021	
	Total Receiving Services[1]	Percent of Total[2]	Total Receiving Services[1]	Percent of Total[2]	Total Receiving Services[1]	Percent of Total[2]
Any Dental Services	69,731	51.39%	54,958	40.16%	58,801	47.41%
Preventive Dental Services	64,448	47.49%	47,847	34.96%	53,601	43.21%
Dental Treatment Services	26,076	19.22%	22,944	16.76%	24,831	20.02%
Sealant on a Permanent Molar	9,259	6.82%	6,217	4.54%	8,355	6.74%
Dental Diagnostic Services	67,907	50.04%	51,733	37.80%	52,807	42.57%
Oral Health Services Provided by a Non-Dentist Provider	226	0.17%	1,454	1.06%	Not Available	Not Applicable
Any Dental or Oral Health Services	69,856	51.48%	54,958	40.16%	Not Available	Not Applicable
Total Eligible for EPSDT[3]	135,698		136,863		124,035	

[1] Medicaid members enrolled in both managed care and fee-for-service programs are included in all totals.

[2] Rates were calculated by IPRO using the "Total Eligible for EPSDT" as the denominator, as reported by UHC-Dental, for all measures.

[3] Only individuals who were eligible for EPSDT for 90 continuous days were included in the numerators and denominator.

Technical Summary – Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan's compliance with the standards of *42 Part 438 Managed Care Subpart D MCO*[12], *PIHP*[13] *and PAHP*[14] *Standards* and the standards of *42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

As required by section *3.02.01 Conformance with State and Federal Regulations* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans are required to meet all regulations specified in *42 Code of Federal Regulations Part 438*.

Per *42 Code of Federal Regulations 438.360 Nonduplication of mandatory activities with Medicare or accreditation review,* in place of a review by the state, its agent or external quality review organization, states can use information obtained from a national accrediting organization review for the external quality review activities. Through this authority, the Office of Health and Human Services uses the results of UHC-Dental's URAC Accreditation Survey to verify dental plan compliance with state and federal standards. *Section 2.2 Licensure/Certifications* require UHC-Dental to seek and maintain accreditation.

On behalf of the Office of Health and Human Services, IPRO reviewed the results of UHC-Dental's most recent URAC Accreditation Survey to verify dental plan compliance with state and federal Medicaid requirements.

Technical Methods of Data Collection and Analysis

IPRO received a copy of UHC-Dental's URAC *Application Scoring Summary Report*, dated November 16, 2022 and used it to verify UHC-Dental's compliance with federal Medicaid standards of *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

Description of Data Obtained

IPRO reviewed a copy of UHC-Dental's URAC *Application Scoring Summary Report*, dated November 16, 2022. The *Application Scoring Summary Report* presented the accreditation status achieved, the effective term of the accreditation, the overall score achieved, the number of mandatory standard elements not met, and details of each standard reviewed.

Comparative Results

UHC-Dental accreditation was granted by URAC on December 1, 2022. Table 17 displays the results of UHC-Dental's most recent URAC Accreditation Survey. It was determined that UHC-Dental was fully compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

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[12] Managed Care Organization.

[13] Prepaid Inpatient Health Plan.

[14] Prepaid Ambulatory Health Plan.

Table 17: Evaluation of Compliance with 42 CFR Part 438 Subpart D and QAPI Standards

Part 438 Subpart D and Subpart E 438.330	UHC-Dental's Results
438.206: Availability of Services	Met
438.207: Assurances of adequate capacity and services	Met
438.208: Coordination and continuity of care	Met
438.210: Coverage and authorization of services	Met
438.214: Provider selection	Met
438.224: Confidentiality	Met
438.228: Grievance and appeal system	Met
438.230: Sub-contractual relationships and delegation	Met
438.236: Practice guidelines	Met
438.242: Health information systems	Met
438.330: Quality assessment and performance improvement program	Met

Technical Summary – Validation of Network Adequacy

Objectives

Title 42 Code of Federal Regulations 438.68 Network adequacy standards requires states that contract with a managed care plan to develop and enforce time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support. The Office of Health and Human Services enforces managed care adoption of the Rhode Island time and distance standards through the *Medicaid Managed Care Services Agreement*.

Section 2*.09 Service Accessibility Standards* of the *Medicaid Managed Care Services Agreement* requires Rhode Island managed care plans to ensure that network providers comply with access and timely appointment availability requirements, and to monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply.

Title 42 Code of Federal Regulations 438.356 State contract options for external quality review and *42 Code of Federal Regulations 438.358 Activities related to external quality review* establish that state agencies must contract with an external quality review organization to perform the annual validation of network adequacy. To meet these federal regulations, the Office of Health and Human Services contracted IPRO to perform the 2021 validation of network adequacy for the Rhode Island Medicaid managed care plans.

Technical Methods of Data Collection and Analysis

The Office of Health and Human Services-established access standards are presented in Table 18.

Table 18: Rhode Island Medicaid Managed Care Network Standards

Rhode Island Medicaid Managed Care Access Standards
Time and Distance Standards
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ Adult Prescribers Within 30 Minutes or 30 Miles
▪ Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours
▪ Routine Care Within 30 Calendar Days

Rhode Island Medicaid Managed Care Access Standards
▪ Physical Exam Within 180 Calendar Days
▪ EPSDT Within 6 Weeks
▪ New Member Within 30 Calendar Days
▪ Non-Emergent or Non-Urgent Mental Health or Substance Use Services Within 10 Calendar Days
Member-to-Primary Care Provider Ratio Standards
▪ No more than 1,500 members to any single primary care provider
▪ No more than 1,000 members per single primary care provider within a primary care provider team
24 Hour Coverage Standard
▪ On a 24 hours a day, 7 days a week basis access to medical and behavioral health services must be available to members either directly through the managed care plan or primary care provider
Other Standards
▪ Each Medicaid network should include Patient Centered Medical Homes that serve as primary care providers

UHC-Dental monitors its provider network for accessibility and network adequacy using the Geo Access software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes.

UHC-Dental monitors its network's ability to provide timely routine and urgent appointments through secret shopper surveys. The data includes the number of providers surveyed, the number of appointments made and not made, the total number of appointments meeting the timeframe standards and appointment rates.

Description of Data Obtained

IPRO's evaluation was performed using network data submitted by UHC-Dental in the quarterly *UnitedHealthcare Dental Network Access Report* for 2021 and in the UHC-Dental's *Network Analysis Report* for the fourth quarter of 2021.

Comparative Results

UHC-Dental met the access standard for general and pediatric dentist for 100% of members in the urban and suburban areas and met this standard for 99.6% of members in the rural area of the state. UHC-Dental met the access standard for 100% of members for all dental specialists in the urban, suburban, and rural regions.

Table 19 shows UHC-Dental performance against the urban, suburban, and rural area geographic access standards by provider type.

Table 19: Geo Access Provider Network Accessibility, December 2021

Provider Type	Access Standard[1]	% of Members Urban	% of Members Suburban	% of Members Rural
General and Pediatric Dentists	1 within 20 minutes	100%	100%	99.6%
All Specialists	1 within 30 minutes	100%	100%	100%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 20 displays the aggregate results of the appointment availability surveys conducted in 2021.

Table 20: Appointment Availability for Network Providers, 2021

Appointment Type	Appointment Standard	# of Providers Surveyed	# of Appointments Made	% of Appointments (N=183)	% of Timely Appointments (N=183)
Routine	Within 60 days	183	103	56.28%	43.72%
Urgent	Within 48 hours	183	75	40.98%	23.50%

N=denominator.

Technical Summary – Validation of Quality-of-Care Surveys, Member Satisfaction

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

Section *2.13.05 Member Satisfaction Report* of the *Medicaid Managed Care Services Agreement* requires the Medicaid managed care plan to sponsor a member satisfaction survey for all Medicaid product lines annually. The goal of the survey is to get feedback from these members about how they view the health care services they receive. The Office of Health and Human Services uses results from the survey to determine variation in member satisfaction among the managed care plans. Further, section *2.13.04 EOHHS Quality Assurance* of the *Medicaid Managed Care Services Agreement* requires that the CAHPS survey tool be administered.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

UHC-Dental independently contracted with a certified CAHPS vendor to administer dental satisfaction survey for measurement year 2021. On behalf of the Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by the managed care plans for measurement year 2021.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for measurement year 2021 was the CAHPS Dental Plan Survey. The tool was modified to meet objectives of the UHC-Dental study.

HEDIS specifications require that the managed care plan provide a list of all eligible members for the sampling frame. Members who have had at least one dental visit in the last 12 months and continuously enrolled for the same period were eligible for the survey.

Table 21 provides a summary of the technical methods of data collection by UHC-Dental.

Table 21: CAHPS Technical Methods of Data Collection, Measurement Year 2021

	UHC-Dental
Member Dental Survey	
Survey Vendor	SPH Analytics
Survey Tool	CAHPS Dental Plan Survey
Survey Timeframe	08/09/2021-08/23/2021
Method of Collection	Telephone
Sample Size	37,527
Response Rate	1.08%

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 22 displays these categories and the measures which these response categories are used.

Table 22: CAHPS Dental Plan Survey Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Care from dentists and staff composite ▪ Access to dental care composite ▪ Dental plan services	Never, Sometimes, Usually, Always *(Top-level performance is considered responses of "usually" or "always.")*
Global Rating Measures	
▪ Rating of dental care ▪ Rating of regular dentist ▪ Rating of ease of finding a dentist	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

All statistical testing was performed at a 95% confidence interval.

To assess UHC-Dental's performance, IPRO compared the managed care plan's scores to national Medicaid performance reported in the *2022 Quality Compass* (measurement year 2021) for all lines of business that reported measurement year 2021 CAHPS data to NCQA.

Description of Data Obtained

IPRO received a copy of the final measurement year 2021 study report produced by SPH Analytics for UHC-Dental. Thes report included descriptions of the project objectives and methodology, as well as managed care plan-level results and analyses.

Comparative Results

Table 23 displays the results of the 2019, 2020, and 2021 CAHPS Dental Plan Survey administered for UHC-Dental.

Table 23: Member Dental CAHPS Results, 2019 and 2020, 2021

Survey Questions/Composites	CAHPS 2019	CAHPS 2020	CAHPS 2021
Would you recommend RIte Smiles by UHC-Dental to someone who wanted to join?	**95.7%**	**94.2%**	**95%**
Rating of Dental Care [1]	**88.7%**	**88.1%**	**88.1%**
Rating of Regular Dentist [1]	**91.8%**	**90.9%**	**89.3%**
Rating of Ease of Finding a Dentist [1]	**69.5%**	**72.3%**	**76.6%**
Care From Dentists and Staff Composite [2]	**95.9%**	**95.5%**	**94.3%**
Dentist explained things in a way that was easy to understand	96.2%	95.2%	93.2%
Dentist listened carefully	94.9%	96.3%	91.9% ▼
Dentist treated you with courtesy and respect	97.3%	97.9%	95.6%
Dentist spent enough time with you	95.4%	91.5%	92.7%
Dentist/dental staff did everything to make you feel comfortable during dental work	96.7%	97.1%	94.8%
Dentist/dental staff explained what they were doing while treating you	95.0%	94.8%	97.5%
Access to Dental Care Composite [2]	**73.1%**	**72.3%**	**73.1%**
Regular dental appointments were as soon as you wanted	84.7%	85.2%	83.4%
Emergency appointments were as soon as you wanted[3]	89.9%	82.4% ▼	83.7%
Appointments with dental specialists were as soon as you wanted	71.9%	73.3%	73.1%
Spent more than 15 minutes in the waiting room before seeing someone[4]	81.2%	83.3%	82.2%
If waited more than 15 minutes, were updated on reason and length of delay	38.1%	37.3%	43.1%
Dental Plan Services [2]	NA	NA	NA
Found needed information from member service number, written materials, or website	75.0%	68.6%	73.0%
Information helped you find a dentist you were happy with[3]	90.9%	90.0%[5]	100%
Received needed information from dental plan's member service	68.2%	64.3%[5]	79.6%
Member service staff treated you with courtesy and respect	88.2%	87.0%	89.6%
Satisfaction with the dental plan's member service[1]	87.4%	81.5%	87.0%

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").
[2] Rates reflect responses of "always" or "usually."
[3] Rates reflect responses of "definitely yes" or "somewhat yes."
[4] Rates reflect responses of "never" or "sometimes."
[5] Sample size is less than 20. Interpret results with caution.
▼ Indicates that the rate is statistically significantly lower than the previous measurement year rate.

Technical Summary – Validation of Quality-of-Care Surveys, Provider Satisfaction

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

Section *2.13.06 Provider Satisfaction Report* of the *Medicaid Managed Care Services Agreement* requires the Medicaid managed care plan to sponsor a satisfaction survey for all Medicaid network providers. The goal of the survey is to get feedback from these providers about how they view the Medicaid program and the managed care plan. The Office of Health and Human Services uses results from the survey to determine variation in provider satisfaction among the managed care plans.

To meet the requirements of the *Medicaid Managed Care Services Agreement*, UHC-Dental administers the Dental Care Provider Satisfaction Survey annually. The objectives of this survey are to evaluate providers' satisfaction with various aspects of working with UHC-Dental for RIte Care.

On behalf of the Office of Health and Human Services, IPRO validated the satisfaction survey sponsored by UHC-Dental for measurement year 2021.

Technical Methods of Data Collection and Analysis

UHC-Dental collaborated with the survey vendor Burke, LLC to conduct the measurement year 2021 provider satisfaction survey. Table 24 provides a summary of the technical methods of data collection.

Table 24: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

Methodology Element	Provider Satisfaction Survey
Survey Administrator	Burke, LLC
Survey Tool	Non-standard
Survey Timeframe	9/24/2021-11/23/2021
Method of Collection	Telephone
Eligible Provider Types	Dental providers
Sample Size	21
Response Rate	27%

Description of Data Obtained

IPRO received a copy of the final study report produced by Burke, Inc. for UHC-Dental and utilized the results to assess provider satisfaction with the RIte Smiles program as overseen by UHC-Dental.

Conclusions and Findings

Table 25 displays the provider survey measures and results for measurement years 2019, 2020, and 2021.

Table 25: Provider Satisfaction Survey Results, Measurement Years 2019, 2020, and 2021

Measures	2019	2020	2021
Call Center Customer Service Performance Ratings			
Accuracy of information provided	50%	51%	53%
Amount of knowledge	38%	34%	47%
Ability of representatives to correctly resolve your issue on the first call	38%	49%	47%
Resolution Process Performance Ratings			
Satisfaction with the resolution process	33%	34%	
Resolving issues in a timely manner	35%	26%	38%
Making it easy to verify eligibility of patients	61%	46%	57%
Network Advocate Performance Ratings			
Being accessible	45%	55%	71%
Being responsive to your needs	50%	64%	65%
Being knowledgeable	52%	59%	59%
Being courteous and professional	65%	59%	65%
Communications Performance Ratings			
The overall communications you receive from RIte Smiles	33%	43%	50%
The provider education materials offered to you by your plan	39%	23%	33%
Claims Process Performance Ratings			
Perceptions of the electronic claim submission process	66%	54%	59%
Revenue and Compensation Performance Ratings			
Adequately compensating you	22%	29%	19%
Communication During the Prior Authorization			
Communications you receive from the RIte Smiles	65%	41%	75%
Timeliness of responses	75%	59%	58%
Clarity of approval criteria	46%	35%	58%
Ease of submission	58%	53%	58%
Providers' Perceptions of RIte Smiles for Scheduling Patient Visits			
Responsiveness of RIte Smiles parents to your treatment recommendations	32%	39%	29%
Frequency of RIte Smiles patients canceling appointments as compared to other dental plans' patients	32%	35%	15%
Satisfaction with the range of services provided by RIte Smiles as compared to other government dental plans	42%	39%	35%
Sealant Agreement Ratings			
The dental staff communicated the importance of using sealants	91%	94%	100%

Technical Summary – URAC Accreditation

Objectives

Section *2.2 Licensure/Certifications* requires that each dental plan seek and maintain accreditation.

The Utilization Review Accreditation Commission (URAC) is an independent, nonprofit accreditation entity dedicated to improving the quality of health care. URAC helps facilitate this by providing health care organizations with renowned accreditation and certification programs that set the highest standards in quality and safety. These standards use evidence-based measures and are developed in collaboration with a wide array of stakeholders, including health plans, providers, and associations.

Technical Methods of Data Collection and Analysis

The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a dental plan are assessed. Additionally, accreditation includes an evaluation of the actual results the dental plan achieved on key dimensions of care, service, and efficacy. Specifically, URAC reviews for regulatory compliance, quality management, information management, staff management, network management, credentialing, and health utilization management.

URAC manages the accreditation process in five phases:

1. Application Submission Phase: The dental plan submits information related to organizational structure, governance, scope of services, and delegation activities. Additional dental plan information is requested by URAC depending on the application.
2. Desktop Review Phase: The lead URAC reviewer scores evidence based on demonstrated compliance with the standards reviewed. The dental plan is evaluated on the factors satisfied in each applicable element and earns a designation of “met,” “partially met,” or “not met” for each element.
3. Validation Review Phase: URAC reviewers validate that the dental plan is following adopted standards through interviews with dental plan leadership, staff members, facility tours, and/or file review.
4. Committee Review Phase: The URAC review team presents an anonymous report to a voluntary accreditation committee to ensure an impartial third-party evaluation. The accreditation committee issues a final determination. Table 26 displays the five possible accreditation determination levels. (Organizations may appeal the final decision if “full” accreditation is not achieved.)
5. Ongoing Monitoring Phase: The accredited dental pan ensures consistent demonstration of quality performance. (During the three-year accreditation cycle, URAC may randomly choose an organization to monitor its adherence to program standards.)

Table 26: URAC Accreditation Status Levels and Points

Accreditation Status	Accreditation Status Explanation
Full Accreditation	Not applicable.
Conditional Accreditation	Deficiencies require action.
Provisional Accreditation	For start ups with less than the required amount of case files.
Corrective Action Needed	Non-accredited status. Deficiencies require correction.
Denial	Not applicable.

Description of Data Obtained

IPRO reviewed a copy of UHC-Dental's URAC *Application Scoring Summary Report*, dated November 16, 2022. The *Application Scoring Summary Report* presented the accreditation status achieved, the effective term of the accreditation, the overall score achieved, the number of mandatory standard elements not met, and details of each standard reviewed.

Comparative Results

As of December 2022, UHC-Dental was compliant with the state's requirement to achieve URAC accreditation. UHC-Dental achieved full accreditation status, an overall score of 100%, and no determinations of "not met" for mandatory elements. URAC's accreditation is effective December 1, 2022 to December 1, 2025.

UHC-Dental's Response to the 2020 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the external quality review organization during the previous year's external quality review." Table 27 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2020 external quality review recommendations. Table 28 displays UHC-Dental's progress related to the recommendations made in the *2020 External Quality Review Aggregate Annual Technical Report* as well as IPRO's assessment of the managed care plan's response.

Table 27: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed care plan's quality improvement response resulted in demonstrated improvement.
Partially Addressed
Managed care plan's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Table 28: UHC-Dental's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	UHC-Dental's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHC-Dental's Response
Quality Improvement Projects	As quality improvement project targets were not met, continue to quality improvement efforts to increase preventive service and sealants on first molars.	The Quality Improvement Project (QIP) reports submitted for the 10/1/2019 to 09/30/2020 monitoring period, UHC Dental did not reach the goal of 56.87% for the Preventive Visits 15-18, year-old members with a rate of 36.48%. In addition, UHC Dental did not meet the goal of 23.40% for the Sealant QIP, the reported rate was 12.16%. Rate decreases are directly related to the COVID 19 pandemic. UnitedHealthcare Dental continues to make strides toward improving the overall delivery of care and service to RIte Smiles members however, progress stalled in 2020 due to the COVID-19 pandemic. The COVID 19 pandemic causes dental office closure, reduce appointment availability, and the new CDC infection control guidelines for office disinfection protocol as well as patient social distancing requirements. As dental offices re-open the dental offices experienced staffing shortage as well as staff requirements to be quarantine after any COVID exposures, this barrier continues to be the number one barrier today. Due to the COVID 19 office closing, schools limiting access and community events being cancelled new initiatives and interventions were unable to be deployed. It is important to note that while the Preventive Visits QIP targets 15-18 years old, UHC Dental's Quality Improvement Program holistically targets and promotes prevention for the entire RIte Smiles membership throughout the year. UHC Dental's Quality Program systematically focuses on the promotion of prevention through a multi-pronged approach that includes provider education and engagement, school and community partnerships and targeted member outreach touchpoints coupled with provider and/or member incentives. The Clinical Quality Department data analytics guide was in place for	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHC-Dental's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHC-Dental's Response
		2020 but many interventions were not able to be completed due to the state COVID mandates for both dental office and schools. The processes established to be able to concurrently monitor performance and tie results back to the interventions were deployed in Q1 2020 and placed on hold the remainder of 2020. Efficacy analysis was conducted on every intervention in Q1 2020. The optimization of our Community Based Coordinator (CBC) has positively contributed to our quality initiatives while improving relations with the members, providers, and community. Operationally, the program maintained its effectiveness in administering the plan benefit efficiently and maintained the quality of care and service rendered to members. UHC Dental will continue to look for alternative ways to reach and educate members as the effects of the COVID 19 pandemic and resulting barriers to dental care continue.	
Performance Measures	UHC-Dental should continue its efforts to educate members on the importance of dental care.	In 2020, EPSDT rate decreases are also directly related to the COVID 19 pandemic. UnitedHealthcare Dental continues to make strides toward improving the overall delivery of care and service to RIte Smiles members however, progress stalled in 2020 due to the COVID-19 pandemic. The COVID-19 pandemic causes dental office closure, reduce appointment availability, and the new CDC infection control guidelines for office disinfection protocol as well as patient social distancing requirements. As dental offices re-open the dental offices experienced staffing shortage as well as staff requirements to be quarantine after any COVID-19 exposures, this barrier continues to be the number one barrier today. Due to the COVID-19 office closing, schools not allowing access and community events cancellations limited UHC's Community Based Coordinated (CBC) ability to hold educational events and interact with students and RIte Smiles members in the community. We were able to educate members with mailing, but not able to meet in person with	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHC-Dental's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHC-Dental's Response
		members for educational opportunities. New initiatives and interventions were unable to be deployed due to the COVID-19 restriction. Member's concern for their safety and possible exposure to COVID-19 during a dental visit were also identified barriers. As we come out of the pandemic, we will steadily increase our presence back in the community and collaborate with community organizations and schools to educate members on the importance of dental care.	
Network Adequacy	Consider the use of mobile services to increase member access to dental care.	February 1, 2022 UHC-Dental launched the RIte Smiles Mobile App. Push notifications supporting oral health wellness sent to all registered.	Addressed.
Network Adequacy	Continue efforts to integrate public health dental hygienists within federally qualified health centers and identify other opportunities to integrate dental care within medical sites.	Medical primary care providers are educated on the application of topical fluoride by UHC-Dental's Community Based Coordinator, CDA, and public health dental hygienist at their annual check-up when appropriate. Primary care providers recommend a follow up visit with a dentist.	Partially addressed.
Network Adequacy	Continue provider reeducation on appointment standards and request providers submit a plan of correction should standards continue to not be met.	UHC-Dental provides consistent education on appointment setting requirements. Secret shopper calls provide education when a provider office is non-compliant upon outreach. Provider contracts, newsletter, manual, PWP, Community Based Coordinator and Network teams support education.	Partially addressed.
Compliance with Medicaid Standards	Despite not undergoing a review, UHC-Dental should evaluate its own compliance with Medicaid standards and proactively address areas of noncompliance. UHC-Dental should document evidence of such activities.	UHC-Dental participates in a process for identifying compliance risks by engaging in an annual UHC Compliance Risk Assessment. The UHC Compliance Risk Assessment offers Compliance Officers, Legal, Regulatory Affairs, and business owners an opportunity to provide insight into risks within their areas of accountability. The risk assessment performs a comprehensive overview of compliance risks inherent to doing business that are prioritized by key stakeholders. This helps to identify where to focus additional time, energy, and resources by identifying the priorities for Compliance teams,	Addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHC-Dental's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHC-Dental's Response
		including monitoring and auditing. The risk assessment process goes through various stages to collect, analyze, and prioritize risk data.	
Quality of Care Surveys	Conduct root cause analysis to identify the reasons driving member perceived barriers to finding general and specialty dentists and accessing dental care.	Members identified being able to locate INN providers within their demographic. However, a shortage of Oral Surgeons (OS) with access to general anesthesia has been a challenge along with dental offices able to timely schedule appointments with providers expressing short staff and high office personnel turnover impacting scheduling patients.	Partially addressed.
Quality of Care Surveys	Consider evaluating member services performance using a secret shopper methodology to assess the validity of increasing member dissatisfaction with obtaining needed information and courteousness and respectfulness of member services representatives.	Recorded calls into Member Service are reviewed for training purposes.	Partially addressed.

Strengths, Opportunities and 2021 Recommendations Related to Quality, Timeliness and Access

UHC-Dental's strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of and **access** to care are presented. These three elements are defined as:

- **Quality** is the degree to which a managed care plan increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 Code of Federal Regulations 438.320 Definitions*.)
- **Timeliness** is the managed care plan's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 Code of Federal Regulations 438.320 Definitions*.)

The strengths and opportunities for improvement based on UHC-Dental's 2021 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 29**. In this table, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Table 29: UHC-Dental's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
URAC Accreditation	UHC-Dental was awarded full accreditation status by URAC.	X	X	X
Quality Improvement Projects – General	Two of two quality improvement projects passed validation.			
Quality Improvement Project – Preventive Health Services	None.			
Quality Improvement Project – Fissure Sealants	None.			
Performance Measures	UHC-Dental demonstrated performance improvement for all five EPSDT measures reported.	X	X	X
Compliance with Medicaid Standards	UHC-Dental is compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.	X	X	X
Network Adequacy			X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	In 2021, UHC-Dental met access standards specialists in all three regions for 100% of its membership, and met access standards for general and pediatrics dentists in the urban and suburban regions for 100% of its membership.			
Quality of Care Surveys – Member Satisfaction	Although not statistically significant, UHC-Dental demonstrated improvement between measurement years 2020 and 2021 on 11 measures of member satisfaction.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHC-Dental demonstrated an improvement between measurement years 2020 and 2021 in scores for 14 of 22 measures of provider satisfaction.	X	X	X
Opportunities for Improvement				
Quality Improvement Project – Preventive Health Services and Preventive Health Services	UHC-Dental's measurement year 2021 rates for the two performance indicators did not meet the goal rate.	X	X	X
Performance Measures	None.			
Compliance with Medicaid Standards	None.			
Network Adequacy	Overall, appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	UHC-Dental demonstrated statistically significant decline in performance between measurement years 2020 and 2021 for one measure of member satisfaction.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHC-Dental demonstrated an improvement between measurement years 2020 and 2021 in scores for eight of 22 measures of provider satisfaction.	X	X	X
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for both quality Improvement projects, as UHC-Dental did not achieve the established project goals. UHC-Dental should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	None.			
Compliance with Medicaid Standards	None.			
Network Adequacy	UHC-Dental should investigate opportunities to improve member access to care.		X	X
Quality of Care Surveys – Member Satisfaction	UHC-Dental should work to improve its performance on measures of member satisfaction that declined in 2021.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHC-Dental should address the key findings of the provider satisfaction survey including compensation rates, network advocate effectiveness, and provider knowledge of the benefit package, including transportation	X	X	X

Appendix A – NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	

C.1 Data Sources.
[ ] Medical/treatment records [ ] Administrative data: [ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data [ ] Hybrid (medical/treatment records and administrative) [ ] Pharmacy data [ ] Survey data (attach the survey tool and the complete survey protocol) [ ] Other (list and describe): _The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCQA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.

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

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

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

Include, as appropriate:

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

Section II: Data/Results Table

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

#1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

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

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

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

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

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

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

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.