Rhode Island Medicaid Managed Care Program
RIte Smiles Dental Program
UnitedHealthcare Dental
2022 External Quality Review
Annual Technical Report

April 2024

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 2022. This report summarizes the 2022 external quality review results for UnitedHealthcare Dental, the Rhode Island Medicaid dental managed care plan.

2022 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 two optional activities (validation of encounter data and quality-of-care survey) that were conducted for measurement year 2022. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in February 2023. The external quality review activities and corresponding protocols are described in Table 1.

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[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.

[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website:

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	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 standards under *Code of Federal Regulations Part 438 – Managed Care*.
Activity 4. Validation of Network Adequacy (Required)	Protocol 4 (Published in 2023)	IPRO evaluated the managed care plan data collection methodologies and results to determine managed care plan adherence to the network standards outlined in the *Medicaid Managed Care Services Agreement*, as well as managed care plan ability to provide an adequate provider network to its Medicaid population.
Activity 5. Validation of Encounter Data (Optional)	Protocol 5	IPRO evaluated the accuracy and completeness of encounter data that is considered critical o effective managed care plan operation and oversight.
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.

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https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-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 2022.

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[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 2: Rhode Island Medicaid Managed Care Programs

Program	Program Description	Participating Managed Care Plans
RIte Care Core	A Medicaid managed care plan for children and families.	▪ Neighborhood Health Plan of Rhode Island ▪ UnitedHealthcare Community Plan of Rhode Island ▪ Tufts Public Health Plan
RIte Care for Children in Substitute Care	A Medicaid managed care plan for 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 ▪ UnitedHealthcare Community Plan of Rhode Island ▪ Tufts Public Health Plan
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 ▪ UnitedHealthcare Community Plan of Rhode Island ▪ Tufts Public Health Plan
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 ▪ UnitedHealthcare Community Plan of Rhode Island ▪ Tufts Public Health Plan
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	▪ UnitedHealthcare Dental

The provision of health care services to each of the applicable eligibility groups (RIte Care Core, 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, 2022-2025

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 2022-2025 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 and objectives for the Rhode Island Medicaid program outlined in the 2022-2025 quality strategy evolved from the guiding principles established by *Working Group to Reinvent Medicaid*. 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. Goals and objectives of the 2022-2025 Medicaid quality strategy are in Table 3.

Table 3: Rhode Island Medicaid Quality Strategy Goals and Objectives, 2022-2025

Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives
Goal 1: Members receive quality care within all managed care delivery systems.
▪ 1.1 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. ▪ 1.2 Collaborate with managed care organizations, accountable entities, Office of the Health Insurance Commissioner, and other stakeholders to review and modify measures used in Medicaid managed care quality oversight. ▪ 1.3 Monitor managed care organization performance for dual-eligible Medicare Medicaid population.
Goal 2: Focus on quality performance and improvement in the following key areas: chronic disease management, maternal/infant health, preventive care for children, preventive care for adults, and behavioral health.
▪ 2.1 Continue oversight of managed care organizations and accountable entities to increase timely preventive care, screening, and follow-up for adult and child health. ▪ 2.2 Monitor and assess managed care organization and accountable entity performance improvement on quality measures related to chronic conditions. ▪ 2.3 Increase the use of prenatal and postpartum services. ▪ 2.4 Increase the number and percentage of well-child visits. ▪ 2.5 Monitor child immunization rates to maintain high performance.

[11] Rhode Island Medicaid Managed Care Quality Strategy Website: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-03/RI%20Managed%20Care%20Quality%20Strategy%20CMS%20Initial%20Submission%202022-08-31.pdf.

Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives
▪ 2.6 Increase engagement, treatment, and follow-up care for substance abuse.
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.
▪ 3.1 Increase availability of coordinated primary care and behavioral health services. ▪ 3.2 Improve integration with medical managed care organizations and RIte Smiles (UnitedHealthcare Dental).
Goal 4: Enhance financial and data analytic oversight of managed care organizations.
▪ 4.1 Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. ▪ 4.2 Migrate to value-based payment programs based on quality measures and managed care organization quality improvement projects.
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language data.
▪ 5.1 Implementation of race, ethnicity, and language data collection process to identify gaps in care. ▪ 5.2 Require managed care organizations to provide strategic plans to address social determinants of health, including organizational strategy and stakeholder strategy to improve care delivery model. ▪ 5.3 Assess quality measures that could be stratified by race, ethnicity, and language.
Goal 6: Empower members to make informed choices about their health plans and care.
▪ 6.1 Continue to require managed care organizations to conduct CAHPS surveys and share survey results with stakeholders. ▪ 6.2 Develop person-centered goals for managed care entities. Consider ways to increase development and implementation of individual care plans for members.

The Office of Health and Human Services has further identified measures to track progress towards the six goals listed above. These measures were selected from the Centers for Medicare & Medicaid Services' Child and Adult Core Set Measures and CAHPS. Table 4 presents a summary of the state's Medicaid quality strategy measurement plan, including measure names, populations included in the calculation of the rates, and baseline data. Unless indicated otherwise, baseline measurements are from measurement year 2020 (January 1, 2020 through December 31, 2020).

Table 4: Rhode Island Medicaid Quality Strategy Goals and Measures, 2022-2025

Goal	Measure (Population)	Baseline Measurement Year 2020
Goal 1: Members receive quality care within all managed care delivery systems.	Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers (Medicaid)	8.6%
	Care for Older Adults: Functional Status Assessment (Medicaid)	58.8%
Goal 2: Focus on quality performance and improvement in the following key areas: Chronic Disease Management, Maternal/Infant Health, Preventive Care for Children, Preventive Care for Adults, and Behavioral Health	Breast Cancer Screening (Medicaid)	65.0%
	Cervical Cancer Screening (Medicaid)	59.6%
	Screening for Depression and Follow-Up Plan: 12 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Comprehensive Diabetes Care: Hemoglobin A1c Testing[1] (Medicaid)	82.2%
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control[1] (Medicaid)	33.2%
	Controlling High Blood Pressure (Medicaid)	70.7%
	Asthma Medication Ratio: 5 to 18 Years (Children's Health Insurance Program)	65.6%
	Asthma Medication Ratio: 19 to 64 Years (Medicaid)	53.7%
	Prenatal and Postpartum Care – Timeliness of Prenatal Care (Medicaid, Children's Health Insurance Program)	To Be Determined
	Child and Adolescent Well-Care Visits (Children's Health Insurance Program)	To Be Determined
	Childhood Immunization Status – Combination 10 (Children's Health Insurance Program)	61.0%[2]
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation Total (Medicaid, Children's Health Insurance Program)	44.8%
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement Total (Medicaid, Children's Health Insurance Program)	17.9%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days: 13 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days: 13 17 to Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days (Medicaid)	12.7%

Goal	Measure (Population)	Baseline Measurement Year 2020
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (Medicaid)	23.8%
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.	Follow-Up After Hospitalization for Mental Illness – 7 Days: 6 to 17 Years (Children's Health Insurance Program)	56.8%
	Follow-Up After Hospitalization for Mental Illness – 30 Days: 6 to 17 Years (Children's Health Insurance Program)	76.6%
	Follow-Up After Hospitalization for Mental Illness – 7 Days: 18 Years and Older (Medicaid)	57.2%
	Follow-Up After Hospitalization for Mental Illness – 30 Days: 18 Years and (Medicaid)	71.7%
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days: 6 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days: 6 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days: 18 Years and Older (Medicaid)	64.6%
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days: 18 Years and Older (Medicaid)	74.8%
	Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit (Medicaid)	80.7%
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Medications (Medicaid)	67.0%
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Strategies (Medicaid)	59.9%
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Acute Phase: 18 to 64 (Medicaid)	58.9%
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Continuation Phase: 18 to 64 Years (Medicaid)	44.0%
	Topical Fluoride for Children (Children's Health Insurance Program)	To Be Determined

Goal	Measure (Population)	Baseline Measurement Year 2020
Goal 4: Enhance financial & data analytic oversight of managed care organizations.		
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language data.		
Goal 6: Empower members to make informed choices about their health plans and care.	Adult CAHPS 5.1H (Medicaid)	Not Applicable

[1] NCQA retired components of the HEDIS Comprehensive Diabetes Care measure set and implemented new technical specifications for the continuing components beginning with measurement year 2022.

[2] Rates represents measurement year 2021.

Gray shading indicates that a measure for the goal was not available in the 2022-2025 Medicaid Quality Strategy.

Descriptions of the improvement strategies led by the Office of Health and Human Services to achieve the goals of its 2022-2025 Medicaid Managed Care Quality Strategy are described below.

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.

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 30, 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.

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

Health Information Technology

The Office of Health and Human Services, in cooperation with stakeholders across state agencies and community partners, developed the *Health Information Technology Roadmap and Implementation Plan*[12] (released July 2020) to promote alignment among existing efforts and guide future investments in health information technology. The *Health Information Technology Roadmap and Implementation Plan* reflects needs and opportunities to improve the quality of Rhode Island healthcare services, lower costs, reduce provider burden, and better serve the people of Rhode Island. The goals, objectives, and approved interventions of the *Health Information Technology Roadmap and Implementation Plan* were determined by the Steering Committee with consideration of the following core values:

1. health information technology is an enabler of broader health transformation efforts;
2. a race equity lens must be applied to efforts in order to reduce health disparities; and
3. patients are key and must be considered with all initiatives.

Current initiatives of the *Health Information Technology Roadmap and Implementation Plan* are:

- Developing a new governance and coordination process to ensure statewide alignment.
- Adopting an e-referral system to help address social determinants of health.
- Improving and enhancing CurrentCare®[13], including a new opt-out consent policy to increase use.
- Accessing and increasing data availability and sharing, including key demographic data such as race and ethnicity needed to address health disparities.
- Enhancing behavioral health records-sharing through aligned interpretation of regulations and stakeholder convening.
- Continuing work to improve information sharing during transitions of care, such as between hospitals, primary care practices, and skilled nursing facilities.
- Continuing the development of the Quality Reporting System.

Quality Reporting System

The Office of Health and Human Services implemented the Quality Reporting System, a centralized data system, to encourage the automation of electronic clinical quality measurement and reporting. Data are collected directly from electronic health records or claims systems, aggregated and matched at the patient-level, and used to calculate quality measures and share improvement data among participants. The Office of Health and Human Services successfully connected over 40 Medicaid primary care providers' electronic health system to the Quality Reporting System in September 2021 and achieved Data Aggregator Validation NCQA-certification in February 2022 for the majority of data submitters. The Office of Health and Human Services is considering the feasibility of utilizing the Quality Reporting System as a tool for value-based payment performance metrics beginning in 2023.

[12] Rhode Island Health Information Technology website: https://eohhs.ri.gov/initiatives/health-information-technology.

[13] CurrentCare is a registered trademark of the Rhode Island Quality Institute. CurrentCare is a free service that gives medical professionals and patients access to protected health information, such as prescriptions, lab tests and hospital visits, from multiple sources in one secure place.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

Rhode Island's 2022-2025 quality strategy aligns with the federal regulations in *Title 42 CFR 438.340(b) Managed Care State Quality Strategy*. The quality strategy 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 entity-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

The Rhode Island quality strategy establishes defined goals and objectives that align with the Centers for Medicare & Medicaid Services' National Quality Strategy. The Office of Health and Human Services designed a quality strategy that aims to promote equity and member engagement, improve quality and health outcomes, facilitate statewide alignment and care coordination across programs and systems, and transformation to a health care system that is electronic and data driven.

Additionally, quality improvement initiatives in the 2022-2025 quality strategy reinforce the Office of Health and Human Services' commitment to implementing a standardized process for identifying and addressing social determinants of health needs; increasing the reporting of Core Set Measures and expanding reliance on these measures for performance based incentives and payments; and leveraging partnerships to advance the implementation of the quality strategy.

At this time statewide performance data are not available for the period under review. Remeasurement data for the quality strategy measures (Table 4) are not yet available. An evaluation on the effectiveness of the 2022-2025 quality strategy will include statewide performance in future external quality review technical reports when remeasurement data are available.

Recommendations to the Executive Office of Health and Human Services

In working towards the goals of the 2022-2025 strategy, IPRO recommends that the Office of Health and Human Services consider:

- Establishing target goals for the quality strategy performance measures.
- Establishing a process for managed care plans to request technical assistance from the external quality review organization.
- Requiring managed care plans to submit methodologies used to evaluate network adequacy and provider satisfaction to ensure the external quality review organization has sufficient information for validation activities.
- Enforcing standardized data collection and analysis requirements for managed care plan provider satisfaction surveys to enable performance comparisons across managed care plans.
- Enforcing managed care plan use of the *NCQA Quality Improvement Activity Form* to document quality improvement projects.
- Determining secret shopper timely appointment thresholds to encourage managed care plans to aggressively address barriers to accessing care that is adequate and timely.
- Expanding reporting requirements for managed care plan administered secret shopper surveys to include failure reasons like wrong telephone number, no answer, provider no longer at site, etc.
- Developing a quality strategy template for the managed care plans to use and submit.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

Medicaid Managed Care Plan Profile

The state contracts with UnitedHealthcare 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, and RIte Care for Children in Substitute Care.

Table 5 displays UnitedHealthcare Dental's enrollment for the RIte Smiles program for year-end 2019 through year-end 2022, 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 increased by 47% from 93,641 members in 2021 to 137,728 members in 2022.

Table 5: UnitedHealthcare Dental's RIte Smiles Enrollment, 2019 to 2022

	2019	2020	2021	2022
Number of Members	110,215	123,280	93,641	137,728
Percent Change from Previous Year	-2.9%	+12%	-24%	+47%

UnitedHealthcare Dental's Quality Strategy, 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. UnitedHealthcare Dental's *2022 Quality Improvement Program Description* met these requirements.

The objective of UnitedHealthcare 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 6 displays UnitedHealthcare Dental's quality improvement goals as reported in the *2022 Quality Improvement Program Description*.

Table 6: UnitedHealthcare Dental's Quality Improvement Goals, 2022

UnitedHealthcare Dental's Quality Improvement Objectives, 2022
▪ 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.

Quality Improvement Program Activities

UnitedHealthcare Dental's quality improvement program activities involve a variety of mechanisms to measure and evaluate the total scope of services provided to dental plan members. The framework for program activities may vary and may include but is not limited to, the following functions:

- Fraud and Abuse Program
- Government Programs
- Guidelines for Quality of Care and Quality of Services
- Preventive Care Guidelines and Dental Health Education
- Quality of Care and Quality of Service Oversight and Monitoring

Information Systems Capabilities Assessment – Technical Summary

Objectives

The *CMS External Quality Review (EQR) Protocols* published in February 2023 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, 4, 5 and 7.

Technical Methods of Data Collection and Analysis

The Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of a comprehensive, independent assessment may be substituted for an Information Systems Capabilities Assessment. 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 UnitedHealthcare 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 7 displays the results of UnitedHealthcare Dental's information systems capabilities review conducted as part of the URAC Accreditation survey.

Table 7: UnitedHealthcare Dental's Compliance with URAC Information Systems Capabilities Standards, 2022-2025

URAC Standard Code	Standard Description	UnitedHealthcare 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

External Quality Review Activity 1. Validation of Performance Improvement Projects – Technical Summary

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. The Office of Health and Human Services Department directed UnitedHealthcare Dental to conduct two quality improvement projects in 2022 and to initiate the collection of baseline data in 2022 to inform the development of the remaining required quality improvement projects.

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 2022.

Table 8 displays the titles of the four quality improvement projects led by UnitedHealthcare Dental for the RIte Smiles population in measurement year 2022.

Table 8: UnitedHealthcare Dental Quality Improvement Project Topics, 2022

UnitedHealthcare Dental's Quality Improvement Project Topics, 2022
1. Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services
2. Topical Fluoride for Children

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 2022 *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 9.

Table 9: 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 2022 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 UnitedHealthcare 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 10 displays a summary of the validation results of UnitedHealthcare Dental's quality improvement projects that were conducted for measurement year 2022. Summaries of each quality improvement project immediately follow.

Table 10: UnitedHealthcare Dental's Quality Improvement Project Validation Results, Measurement Year 2022

UnitedHealthcare Dental's Quality Improvement Project Validation Results		
Validation Element	Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services	Topical Fluoride for Children
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 11: UnitedHealthcare Dental's Quality Improvement Project 1 Summary – Preventive Health Services, Measurement Year 2022

UnitedHealthcare Dental's Quality Improvement Project 1 Summary
Title: Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services **Start Year:** 2016. **End Year:** **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UnitedHealthcare Dental aims to increase the percentage 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 2022 Interventions ▪ Continued to mail 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. ▪ Continued interactive voice calls to members with a reminder to complete annual dental visits. ▪ Leveraged the Newport County Wellness Fair to promote oral health by distributing educational materials and giveaways. ▪ Interacted with attendees at the Heart Tree Family Summer Bash to promote preventive dental care and distribute dental kits. ▪ Delivered oral health education to community members who attended the Blackstone Valley Health Center Community Outreach day. ▪ Engaged with community members who attended the Pawtucket YMCA Block Party to discuss oral health tips, how to identify hidden sugars in food and beverages, the importance of preventive dental care, and distribute dental kits. ▪ Engaged with community members who attended the Central Providence HEZ event to discuss oral health tips, how to identify hidden sugars in food and beverages, the importance of preventive dental care, and distribute dental kits. Provider-Focused 2022 Interventions ▪ Continued to distribute gaps in care lists to the top 22 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 onsite visits to high-volume dental practices located in Providence County, Rhode Island to review gaps in care lists and barriers to patient engagement.

Table 12: UnitedHealthcare Dental's Quality Improvement Project 1 Indicator Summary – Preventive Health Services, Measurement Years 2016 to 2022

Members, Ages 15-18, 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	Remeasurement 16	7,834	23,918	32.75%	56.87%
Apr 1, 2020– Mar 31, 2021	Remeasurement 17	8,313	24,436	34.02%	56.87%
Jul 1, 2020 – Jun 30, 2021	Remeasurement 18	9,715	24,638	39.43%	56.87%
Oct 1, 2020 – Sep 30, 2021	Remeasurement 19	10,008	24,799	40.36%	56.87%
Jan 1, 2021 – Dec 31, 2021	Remeasurement 20	9,938	24,891	39.93%	56.87%
Apr 1, 2021– Mar 31, 2022	Remeasurement 21	11,162	25,964	42.99%	56.87%
Jul 1, 2021 – Jun 30, 2022	Remeasurement 22	11,081	26,036	42.56%	56.87%
Oct 1, 2021 – Sep 30, 2022	Remeasurement 23	11,213	26,122	42.93%	56.87%

Table 13: UnitedHealthcare Dental's Quality Improvement Project 2 Summary – Topical Fluoride, Measurement Year 2022

UnitedHealthcare Dental's Quality Improvement Project 2 Summary
Title: Topical Fluoride for Children **Start Year:** 2022. **End Year:** 2024. **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.

Aim

UnitedHealthcare Dental aims to increase the percentage of children who receive at least two topical fluoride applications from 15.35% to 16.89% by the end of 2024.

Indicator of Performance

The percentage of children ages one through 20 years, continuously enrolled in RIte Smiles for twelve months with a gap of no more than 31 days who received at least two topical fluoride applications as a dental or oral health service within the measurement year.

Member-Focused 2022 Interventions

- Continued to mail reminder postcards with education on preventive care, topical fluoride applications, and the importance of establishing a dental home to members aged 1 to 20 years who had not been in for care for over 6 months.
- Continued interactive voice calls to members with a reminder to complete annual dental visits.
- Outreach to members identified as receiving a fluoride varnish from a primary care provider and reminded them to schedule a follow-up visit with a network dentist.
- Continued collaboration with Black Stone Valley Health Center to identify pregnant women needing preventive dental care. These women were provided dental care and education on dental care for infants and toddlers.
- Coordinated dental appointments for members who did not have a dental visit in the last 12 to 18 months during the Blackstone Valley Health Center Healthy Kids Day.
- Participated in a parent and student awareness event at the Nathanial Greene Middle School to provide oral health education, information on topical fluoride applications, and the importances of establishing a dental home.
- Collaborated with Nathanial Greene Middle School to identify school families in need of care and linking them with a dental provider.

Provider-Focused 2022 Interventions

- Continued to distribute gaps in care lists to the top 22 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 onsite visits to high-volume dental practices located in Providence County, Rhode Island to review gaps in care lists and barriers to patient engagement.

Table 14: UnitedHealthcare Dental's Quality Improvement Project 2 Indicator Summary –Topical Fluoride, Measurement Years 2021-2022

Adolescent Members With Preventive Health Services					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Jan. 1, 2021 – Dec 31, 2021	Baseline	116,039	17,812	15.35%	Not Applicable
Apr. 1, 2021 – Mar. 31, 2022	Remeasurement 1	116,269	18,899	16.25%	16.89%
Jul. 1, 2021- Jun 30, 2022	Remeasurement 2	116,114	19,719	16.98%	16.89%
Oct. 1, 2021 – Sept. 30, 2022	Remeasurement 3	116,301	19,807	17.03%	16.89%

External Quality Review Activity 2. Validation of Performance Measures – Technical Summary

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 2022.

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 2022 EPSDT measures is January 1, 2022, to December 31, 2022. 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 period under review, IPRO obtained a copy of UnitedHealthcare Dental's EPSDT submission for the 2022 measurement period. 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 were 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

UnitedHealthcare Dental demonstrated performance improvement for the five EPSDT measures reported. Table 15 displays UnitedHealthcare Dental's EPSDT measure rates for 2019, 2020, 2021, and 2022.

Table 15: UnitedHealthcare Dental's EPSDT Measure Rates, Measurement Years 2019 to 2022

EPSDT Measure	Measurement Year 2019		Measurement Year 2020		Measurement Year 2021		Measurement Year 2022	
	Total Receiving Services[1]	Percent of Total[2]	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%	63,243	50.20%
Preventive Dental Services	64,448	47.49%	47,847	34.96%	53,601	43.21%	57,899	45.96%
Dental Treatment Services	26,076	19.22%	22,944	16.76%	24,831	20.02%	26,508	21.04%
Sealant on a Permanent Molar	9,259	6.82%	6,217	4.54%	8,355	6.74%	10,634	8.44%
Dental Diagnostic Services	67,907	50.04%	51,733	37.80%	52,807	42.57%	56,241	44.65%
Total Eligible for EPSDT[3]	**135,698**		**136,863**		**124,035**		**125,972**	

[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 UnitedHealthcare Dental, for all measures.

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

External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards – Technical Summary

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 set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards*, the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56*, the enrollee rights requirements described in *42 Code of Federal Regulations 438.100*, the emergency and post-stabilization services requirements described in *42 Code of Federal Regulations 438.114*, and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330* is a mandatory external quality review 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 UnitedHealthcare Dental's URAC Accreditation Survey to verify dental plan compliance with state and federal standards. *Section 2.2 Licensure/Certifications* require UnitedHealthcare Dental to seek and maintain accreditation.

On behalf of the Office of Health and Human Services, IPRO reviewed the results of UnitedHealthcare 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 UnitedHealthcare Dental's URAC *Application Scoring Summary Report*, dated November 16, 2022, and used it to verify UnitedHealthcare Dental's compliance with federal Medicaid standards of *42 Code of Federal Regulations Part 438 Managed Care*.

Description of Data Obtained

IPRO reviewed a copy of UnitedHealthcare 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

UnitedHealthcare Dental accreditation was granted by URAC on December 1, 2022. Table 16 displays the results of UnitedHealthcare Dental's most recent URAC Accreditation Survey. It was determined that UnitedHealthcare Dental was fully compliant with the standards of *42 Code of Federal Regulations Part 438 Managed Care*.

Table 16: UnitedHealthcare Dental's Evaluation of Compliance with Federal Medicaid Standards

Federal Medicaid Standard	UnitedHealthcare Dental's Results
438.56 Disenrollment requirements and limitations	Met
438.100 Enrollee rights and requirements	Met
438.114 Emergency and poststabilization services	Met
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

External Quality Review Activity 4. Validation of Network Adequacy – Technical Summary

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 2022 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 17.

Table 17: 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
▪ Outpatient Behavioral/Mental Health Adult Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Outpatient Behavioral/Mental Health Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral Health Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral Health 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

Rhode Island Medicaid Managed Care Access Standards
▪ Routine Care Within 30 Calendar Days
▪ 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

UnitedHealthcare 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.

UnitedHealthcare 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 UnitedHealthcare Dental in the quarterly *UnitedHealthcare Dental Network Access Report* for 2022 and in the UnitedHealthcare Dental's *Network Analysis Report* for the fourth quarter of 2022.

Comparative Results

UnitedHealthcare 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. Similarly, UnitedHealthcare Dental met the access standard for 99.6% of members for all dental specialists in rural regions and 100% of members in urban and suburban regions.

Table 18 shows UnitedHealthcare Dental performance against the urban, suburban, and rural area geographic access standards by provider type.

Table 18: UnitedHealthcare Dental's Geo Access Provider Network Accessibility, December 2022

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%	99.6%

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

Table 19 displays the aggregate results of the appointment availability surveys conducted in 2022.

Table 19: UnitedHealthcare Dental's Appointment Availability for Network Providers, 2022

Appointment Type	Appointment Standard	# of Providers Surveyed	# of Appointments Made	% of Appointments (N=183)	% of Timely Appointments (N=183)
Routine	Within 60 days	127	77	60.6%	48.8%
Urgent	Within 48 hours	127	52	40.9%	33.1%

N=denominator.

External Quality Review Activity 5. Validation of Encounter Data Reported by the Medicaid and Children's Health Insurance Program Managed Care Plan – Technical Summary

Objectives

Title 42 Code of Federal Regulations Section 438.242 Health Information Systems (c) Enrollee encounter data requires that states hold managed care plans contractually responsible for the collection, maintenance, and reporting of encounter data in a manner that meets state and federal standards. These standards are intended to ensure that the encounter data provides a complete and accurate representation of services provided to enrollees.

As required by section *2.13.02 Encounter Data Reporting* of the *Medicaid Managed Care Services Agreement*, and the *Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance* guidance document, Rhode Island managed care plans must submit encounter data, monthly, to the state that is accurate and complete. Managed care plan encounter submissions must include all paid (original, corrected and adjusted/voided, paid at $0 dollars) encounter data and partial payments denied at the line level and paid at the header level. All data reported to the Office of Health and Human Services are housed within the state's Medicaid Management Information System and maintained by fiscal intermediary, Gainwell Technologies, LLC.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (c)(1) encourages states to validate encounter data reported by managed care plans during the preceding 12 months. In 2022, IPRO conducted this activity on behalf of the Office of Health and Human Services. IPRO aimed to verify the completeness and accuracy of encounters with service dates from January 1, 2021 to December 31, 2021 and submitted by UnitedHealthcare Dental to the state between January 1, 2021, and March 31, 2022.

Technical Methods of Data Collection and Analysis

During calendar year 2022, IPRO initiated a review of encounters submitted with service dates from January 1, 2021 to December 31, 2021 and submitted to the state between January 1, 2021, and March 31, 2022. Specifically, a comparison of data housed by UnitedHealthcare Dental to data housed in the state's Medicaid Management Information System was performed. For each data element compared, IPRO aimed to calculate a match rate between the two data sources.

At the request of the Office of Health and Human Services, Gainwell Technologies provided IPRO with the data extracts from the state's Medicaid Management Information System that were needed to carry out this activity. UnitedHealthcare Dental submitted data using the layout developed by IPRO. A file layout was provided for the following encounter type: dental claims.

The validation was conducted using an approach developed by IPRO and consistent with the Centers for Medicare & Medicaid Services' *Protocol 5 – Validation of Encounter Data*. The encounter data validation audit was conducted utilizing the following methodology:

1. UnitedHealthcare Dental submitted specified data elements obtained from their adjudicated source claims that correspond to the selected audit period. To verify the source claims data, IPRO requested that UnitedHealthcare Dental include the internal control number when available. The internal control number is obtained when the encounter is adjudicated in the state's Medicaid Management Information System.
2. IPRO imported UnitedHealthcare Dental's files and generated separate data tables per encounter type. Analyses were conducted using SAS®.

3. To identify discrepancies, IPRO compared the values of each data element from UnitedHealthcare Dental's source data to values of the corresponding data element from the Office of Health and Human Services' source data.
4. The percentage of records with discrepant values were calculated for each data element, and those with less than a 90% match rate were investigated.
5. IPRO reviewed discrepancies and categorized the data element discrepancies for each encounter type, where applicable.
6. Among data elements with less than a 90% match rate, IPRO selected a random sample of 1,000 discrepant records for each encounter type and discrepancy category. IPRO provided counts of all discrepant records by discrepancy category to the Office of Health and Human Services. The sample size was determined based on the number of discrepancies.
7. For UnitedHealthcare Dental, IPRO identified omitted and surplus internal control numbers. The omitted internal control numbers were identified as the encounters in UnitedHealthcare Dental's claims files that were not present in IPRO's data warehouse. The surplus internal control numbers were identified in IPRO's data warehouse that were included in UnitedHealthcare Dental's claims files.

A teleconference was held to discuss preliminary findings and conduct staff interviews. The UnitedHealthcare Dental encounter data validation audit call was conducted on June 6, 2023. UnitedHealthcare Dental's system was reviewed for discrepancies of data elements present in the encounter types between the submitted encounter data validation data file and the data submitted to the Office of Health and Human Services. The attendees of the encounter data validation audit call included the Office of Health and Human Services, UnitedHealthcare Dental, and IPRO. Data elements with less than a 90% match rate were reviewed.

Following the teleconference with UnitedHealthcare Dental, IPRO worked with Gainwell Technologies to identify any inconsistencies between the values and/or information provided by UnitedHealthcare Dental and confirmed the information the Office of Health and Human Services received for each data element by encounter type.

Description of Data Obtained

For this review period, the data source was the IPRO-produced report, "UnitedHealthcare Dental Encounter Data Validation-2021 Claims." The report included comprehensive descriptions of the objectives, methodology, detailed findings, and recommendations for improvement.

Comparative Results

Based upon IPRO's review of UnitedHealthcare Dental's encounter data audit file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from UnitedHealthcare Dental, and discussions with UnitedHealthcare Dental and the Office of Health and Human Services during and following the teleconference, there are areas that require further research by encounter type by UnitedHealthcare Dental, the Office of Health and Human Services, Gainwell, and IPRO.

Surplus and Omitted Internal Control Numbers

The omitted internal control numbers were identified as the encounters in UnitedHealthcare Dental's encounter extract data file that were not present in the Office of Health and Human Services/Gainwell Technologies encounter data file. The surplus internal control numbers were identified in the Office of Health and Human Services/Gainwell Technologies' encounter data for the audit period that were not present or included on UnitedHealthcare Dental's encounter extract data file. Table 20 shows UnitedHealthcare Dental's total number of discrepant surplus and omitted internal control numbers identified by IPRO.

Table 20: UnitedHealthcare Dental's Count of Surplus and Omitted Internal Control Numbers

Encounter Type	Surplus Internal Control Numbers Count[1]	Omitted Internal Control Numbers Count[2]
Dental	154,551	145,657

[1] Surplus internal control numbers are encounters present in the Office of Health and Human Services' Medicaid Management Information System but not submitted in UnitedHealthcare Dental's claim/encounter data validation audit file.
[2] Omitted internal control numbers are encounters in UnitedHealthcare Dental's claim/encounter data validation audit file but not present in the Office of Health and Human Services' Medicaid Management Information System.

Dental Encounters and Claims

Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type. Findings are summarized in Table 21.

Table 21: UnitedHealthcare Dental's Dental Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	Not Validated	
PLAN_CODE	Not Validated	
MEDICAID_MEMBER_ID	30.12	The companion guide indicates that the Rhode Island Medicaid identification number is 10 numerical characters for the Rhode Island Medicaid Recipient Identification Number (MID). UHC Dental is mapping and providing the recipient's state-issued Medicaid identification number that was in place and assigned at the time the claim encounter was adjudicated and reported to EOHHS. The correct value for the Medicaid member identification is the Rhode Island MID, but UHC Dental provided the other/alternate ID on the EDV study file. The discrepancy is associated to an EDV reporting study data extraction issue.
ICN	Not Validated	
MCO_ICN	100	
NUM_ADJ_ICN	98.79	
LINE_NUMBER	Not Validated	
DTE_FIRST_SVC_DTL	99.94	
DTE_LAST_SVC_DTL	99.94	
PLACESVC	99.23	
PTMT_ADJ_DATE	0	The Gainwell file did not contain any values. On the EDV study file, the MCO submitted the MCO payment adjudication date, and there is no distinction between the MCO adjudication date and payment date. During the remote meeting, the MCO confirmed the value provided on the EDV study file was present on the claim system screens and the 837D string. IPRO followed up with Gainwell after the remote meeting. Gainwell advised that the header paid date is only required when the MCO is reporting header only paid claims If reporting detail service line is a paid claim, the MCO should not report header paid date, as reporting both dates will cause a compliance issue. For future

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
		EDV studies, IPRO will modify the scope of work requirement for the payment adjudication date.
AMT_MCO_PAID_HDR	98.90	
AMT_OTH_INS_PD_HDR	0.33	The Gainwell data file appears to be summarizing the MCO paid amount and the other insurance amount. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that the value on the Gainwell data extract includes what is provided by the MCOs and not a calculated/summarized value. IPRO further followed up with Gainwell and provided MCO examples for review.
CDT	90.65	
QTY_UNITS_BILLED	Not Validated	
TOOTHNUMBER	Not Validated	
MODIFIER1	100	
MODIFIER2	100	
MODIFIER3	100	
MODIFIER4	100	
BILLING_PROV_ID	Not Validated	
BILLING_PROV_NPI	99.96	
RENDERING_PROV_ID	Not Validated	
RENDERING_PROV_NPI	100	
REFERRING_PROV_ID	Not Validated	
REFERRING_PROV_NPI	Not Validated	

Yellow shading: < 90% match with MCO reporting study data extraction issue; light green shading: < 90% match and IPRO to follow up with Gainwell; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NPI: National Provider Identifier; UHC: UnitedHealthcare Community Plan of Rhode Island.

External Quality Review Activity 6. Validation of Quality-of-Care Surveys, Member Satisfaction – Technical Summary

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.

UnitedHealthcare Dental independently contracted with a certified CAHPS vendor to administer the Dental Plan Survey for measurement year 2022. On behalf of the Office of Health and Human Services, IPRO validated the satisfaction survey sponsored by UnitedHealthcare Dental for measurement year 2022.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for measurement year 2022 was the CAHPS Dental Plan Survey. The tool was modified to meet objectives of the UnitedHealthcare 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 22 provides a summary of the technical methods of data collection by UnitedHealthcare Dental.

Table 22: UnitedHealthcare Dental's CAHPS Technical Methods of Data Collection, Measurement Year 2022

	UnitedHealthcare Dental
Member Dental Survey	
Survey Vendor	SPH Analytics
Survey Tool	CAHPS Dental Plan Survey
Survey Timeframe	08/09/2022-08/23/2022
Method of Collection	Telephone
Sample Size	37,625
Response Rate	1.07%

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 23 displays these categories and the measures which these response categories are used.

Table 23: 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.

Description of Data Obtained

IPRO received a copy of the *2022 CAHPS Dental Plan Survey* report produced by SPH Analytics for UnitedHealthcare Dental. This report included a high level description of the methodology, executive summary, and managed care plan-level results and analyses.

Comparative Results

Table 24 displays the results of the 2019, 2020, 2021, and 2022 CAHPS Dental Plan Survey administered for UnitedHealthcare Dental.

Table 24: UnitedHealthcare Dental's CAHPS Results, 2019, 2020, 2021, and 2022

Survey Questions/Composites	CAHPS 2019	CAHPS 2020	CAHPS 2021	CAHPS 2022
Would you recommend RIte Smiles by UnitedHealthcare Dental to someone who wanted to join?	95.7%	94.2%	95%	96%
Rating of Dental Care [1]	88.7%	88.1%	88.1%	90.8%
Rating of Regular Dentist [1]	91.8%	90.9%	89.3%	93.8%▲
Rating of Ease of Finding a Dentist [1]	69.5%	72.3%	76.6%	73.1%
Care From Dentists and Staff Composite [2]	95.9%	95.5%	94.3%	93.6%
Dentist explained things in a way that was easy to understand	96.2%	95.2%	93.2%	91.2%
Dentist listened carefully	94.9%	96.3%	91.9%▼	91.7%
Dentist treated you with courtesy and respect	97.3%	97.9%	95.6%	95.0%
Dentist spent enough time with you	95.4%	91.5%	92.7%	92.6%
Dentist/ staff did everything to make you feel comfortable during dental work	96.7%	97.1%	94.8%	95.0%
Dentist/dental staff explained what they were doing while treating you	95.0%	94.8%	97.5%	96.3%
Access to Dental Care Composite [2]	73.1%	72.3%	73.1%	70.1%
Regular dental appointments were as soon as you wanted	84.7%	85.2%	83.4%	78.6%
Emergency appointments were as soon as you wanted[3]	89.9%	82.4%▼	83.7%	83.5%
Appointments with dental specialists were as soon as you wanted	71.9%	73.3%	73.1%	65.7%
Spent more than 15 minutes in the waiting room before seeing someone[4]	81.2%	83.3%	82.2%	86.3%
If waited more than 15 minutes, were updated on reason and length of delay	38.1%	37.3%	43.1%	36.5%
Dental Plan Services [2]	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Found needed information from member service number, written materials, or website	75.0%	68.6%	73.0%	76.7%
Information helped you find a dentist you were happy with[3]	90.9%	90.0%[5]	100%	84.9%▼
Received needed information from dental plan's member service	68.2%	64.3%[5]	79.6%	72.1%
Member service staff treated you with courtesy and respect	88.2%	87.0%	89.6%	85.2%
Satisfaction with the dental plan's member service[1]	87.4%	81.5%	87.0%	83.9%

[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 higher than the previous measurement year rate.

▼ Indicates that the rate is statistically significantly lower than the previous measurement year rate.

External Quality Review Activity 6. Validation of Quality-of-Care Surveys, Provider Satisfaction – Technical Summary

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*, UnitedHealthcare 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 UnitedHealthcare Dental for RIte Care.

On behalf of the Office of Health and Human Services, IPRO validated the satisfaction survey sponsored UnitedHealthcare Dental for measurement year 2022.

Technical Methods of Data Collection and Analysis

UnitedHealthcare Dental contracted with the survey vendor Burke, LLC to conduct the measurement year 2022 provider satisfaction survey. Table 25 provides a summary of the technical methods of data collection.

Table 25: UnitedHealthcare Dental's Provider Satisfaction Survey Technical Methods of Data Collection, Measurement Year 2022

Methodology Element	Provider Satisfaction Survey
Survey Administrator	Burke, LLC
Survey Tool	Non-standard
Survey Timeframe	9/12/2022-11/2/2022
Method of Collection	Telephone
Eligible Provider Types	Dental providers
Sample Size	13
Response Rate	27%

Description of Data Obtained

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

Conclusions and Findings

Table 26 displays the provider survey measures and results for measurement years 2020, 2021 and 2022. Due to a low base size, caution must be used when interpreting the results and year over year comparisons.

Table 26: UnitedHealthcare Dental's Provider Satisfaction Survey Results, Measurement Years 2020, 2021 and 2022

Measures	2020	2021	2022
Call Center Customer Service Performance Ratings			
Accuracy of information provided	51%	53%	23%[1]
Amount of knowledge	34%	47%	15%[1]
Ability of representatives to correctly resolve your issue on the first call	49%	47%	8%[1]
Courtesy and friendliness	66%	58%	38%[1]
Willingness to help	49%	47%	38%[1]
Thoroughness of responses	43%	42%	23%[1]
Resolution Process Performance Ratings			
Satisfaction with the resolution process	34%	33%	15%[1]
Resolving issues in a timely manner	26%	38%	23%[1]
Making it easy to verify eligibility of patients	46%	57%	54%[1]
Network Advocate Performance Ratings			
Being accessible	55%	71%	58%[2]
Being responsive to your needs	64%	65%	67%[2]
Being knowledgeable	59%	59%	58%[2]
Being courteous and professional	59%	65%	75%[2]
Communications Performance Ratings			
The overall communications you receive from RIte Smiles	43%	50%	31%[1]
The provider education materials offered to you by your plan	23%	33%	27%[3]
Claims Process Performance Ratings			
Perceptions of the electronic claim submission process	54%	59%	70%[4]
Claim payment process overall	47%	52%	54%[1]
Revenue and Compensation Performance Ratings			
Adequately compensating you	29%	19%	15%[1]
Communication During the Prior Authorization			
Communications you receive from the RIte Smiles	41%	75%	33%[2]
Timeliness of responses	59%	58%	42%[2]
Clarity of approval criteria	35%	58%	33%[2]
Ease of submission	53%	58%	33%[2]
Providers' Perceptions of RIte Smiles for Scheduling Patient Visits			
Responsiveness of RIte Smiles parents to your treatment recommendations	39%	29%	23%[1]
Frequency of RIte Smiles patients canceling appointments as compared to other dental plans' patients	35%	15%	46%[1]
Satisfaction with the range of services provided by RIte Smiles as compared to other government dental plans	39%	35%	42%[2]
Sealant Agreement Ratings			
The dental staff communicated the importance of using sealants	94%	100%	86%[5]

Note: Due to a low base size, caution must be used when interpreting the results and year over year comparisons.

[1] Denominator = 13 respondents.

[2] Denominator = 12 respondents.

[3] Denominator = 11 respondents.

[4] Denominator = 10 respondents.

[5] Denominator = 7 respondents.

Accreditation – Technical Summary

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 27 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 plan 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 27: URAC Accreditation Status Levels and Points[ii]

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 UnitedHealthcare 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, UnitedHealthcare Dental was compliant with the state's requirement to achieve URAC accreditation. UnitedHealthcare 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.

UnitedHealthcare Dental's Response to the 2021 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 28 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2021 external quality review recommendations. Table 29 displays UnitedHealthcare Dental's progress related to the recommendations made in the *2021 External Quality Review Annual Technical Report* as well as IPRO's assessment of the managed care plan's response.

Table 28: 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, more time is needed to observe for performance improvement.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; or performance declined.

Table 29: UnitedHealthcare Dental's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	UnitedHealthcare Dental's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UnitedHealthcare Dental's Response
Quality Improvement Projects	Opportunities of improvement remain for both quality Improvement projects, as UnitedHealthcare Dental did not achieve the established project goals. UnitedHealthcare Dental should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	UnitedHealthcare Dental applies the Plan Do Study Act (PDSA) Quality Improvement model to identifying the barriers and implementing interventions to create more opportunities and successes. The Sealant QIP was retired as directed by Rhode Island EOHHS as of 2022. A new QIP was implemented with the topic being, "Increasing the percentage of children aged 1 through 20 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, within the reporting year". Interventions for this QIP include A Community Based Outreach Coordinator in the community working with and educating Dental Provider and community organizations, DCOR reporting, IVR calls, reminder mailings and letter to members receiving topical fluoride applications at their PCP office to engage with a dental provider. For the Preventative QIP we continue to monitor the outcomes of current interventions, the effectiveness of the intervention and identify additional program and interventions. In 2022 the effects of the COVID-19 pandemic continued to be a barrier to care. Offices were not closed any longer but staffing issues continued to be a barrier. Dental offices experienced staffing shortages resulting in decreases in available appointments. Our Community Based Coordinator worked with dental offices to have clinic days for RIte Smiles members to complete a dental visit, engaged with HEZ communities for educational opportunities and completed quarterly visits with high volume providers. We continued DCOR reporting, IVR calls, reminder mailings and classroom educational programs as they proved to be successful. The Preventative QIP for period Jan – Dec. 2021 was 39.93%, during 2022 we realized an increase in the Preventative QIP to 43.18%, for the Jan. – Dec. 2022 time period. A new member incentive was implemented for 2023.	Partially addressed.

<table>
<tr><th>External Quality Review Activity</th><th>2020 External Quality Review Recommendation</th><th>UnitedHealthcare Dental's Response to the 2020 External Quality Review Recommendation</th><th>IPRO's Assessment of UnitedHealthcare Dental's Response</th></tr>
<tr><td>Network Adequacy</td><td>UnitedHealthcare Dental should investigate opportunities to improve member access to care.</td><td>Attached Geo Access report supporting network compliance.</td><td>Remains an opportunity for improvement.</td></tr>
<tr><td>Quality of Care Surveys – Member Satisfaction</td><td>UnitedHealthcare Dental should work to improve its performance on measures of member satisfaction that declined in 2021.</td><td>Action plan developed to support member education, increase awareness for provider trainings and increase DBP network.

UHC Dental 2022 Goals:

<table><tr><th>Description</th><th>Focus</th><th>2022 Scope and Timeline</th></tr><tr><td>Provider education / training on Listening skills</td><td>Increase CAHPS survey result by 2% for dentist listening carefully in 2022</td><td>2022 Provider newsletter article education</td></tr><tr><td>Access to Care
Ease of Finding a Dentist</td><td>RIte Smiles Mobile App
Member education on locating a provider</td><td>Implementation of Mobile App Q1 2022</td></tr><tr><td>Access to Specialty Care</td><td>Continue to monitor for opportunities to contract with specialty providers</td><td>Addition of two Oral Surgeons in Q4 2021</td></tr><tr><td>Care from Dentist and Staff</td><td>Diversity and Cultural training</td><td>Online mandatory training accessible on Provider Web Portal (PWP)</td></tr></table></td><td>Remains an opportunity for improvement.</td></tr>
<tr><td>Quality of Care Surveys – Provider Satisfaction</td><td>UnitedHealthcare 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.</td><td>Action plan developed to support member education, increase awareness for provider trainings and increase DBP network.

Q4 Newsletter – Ortho authorization</td><td>Remains an opportunity for improvement.</td></tr>
</table>

External Quality Review Activity	2020 External Quality Review Recommendation	UnitedHealthcare Dental’s Response to the 2020 External Quality Review Recommendation	IPRO’s Assessment of UnitedHealthcare Dental’s Response
		UHC Dental 2022 Goals: Provider (table below)	

UHC Dental 2022 Goals: Provider

Description	Focus	2021 Scope & Timeline
Call Center Knowledge	Cross training service representatives on benefits and processes.	Experienced commercial agents added to the Government Dental lines. Q2 2021 call center adding 105 agents over 7 onboarding periods.
Call Center Curtesy and Professionalism	Support provider concerns through courteous and professional communication from call center representatives	Continued training to emphasis the importance of call center agents having a friendly demeanor through proper training and support.
Prior Auth Communication Process	Increase education to support an understanding of the internal processes for prior auth determinations.	Q2 Provider education on Prior Auth and Peer to Peer processes from Dental Director
Provider Education	Increased communication in all areas to providers.	Q2 Provider email notification process implementation Quarterly Provider National Newsletter Q1 Updates made to Provider Manual and provider Quick Reference Guide (QRG)

Strengths, Opportunities and 2022 Recommendations Related to Quality, Timeliness and Access

UnitedHealthcare 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 UnitedHealthcare Dental's 2022 performance, as well recommendations for improving quality, timeliness, and access to care are presented in Table 30. 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 gray shading).

Table 30: UnitedHealthcare Dental's Strengths, Opportunities, and Recommendations, Measurement Year 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Accreditation	UnitedHealthcare 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 – Topical Fluoride	UnitedHealthcare Dental's performance indicator rate for measurement year 2022 exceeded the goal rate.	X	X	X
Performance Measures	UnitedHealthcare Dental demonstrated performance improvement for all five EPSDT measures that were reported.	X	X	X
Compliance with Medicaid and Children's Health	UnitedHealthcare Dental is compliant with the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care.*	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Insurance Program Standards				
Network Adequacy	In 2022, UnitedHealthcare Dental met access standards for 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.		X	X
Quality of Care Surveys – Member Satisfaction	UnitedHealthcare Dental achieved a CAHPS score for *Rating of Regular Dentist* that was statistically significantly better in measurement year 2022.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UnitedHealthcare Dental demonstrated an improvement between measurement years 2021 and 2022 in six of 26 measures of provider satisfaction.	X	X	X
Opportunities for Improvement				
Quality Improvement Project – Preventive Health Services	UnitedHealthcare Dental's performance indicator rate for measurement year 2022 did not meet the goal rate.	X	X	X
Quality Improvement Project – Topical Fluoride	None.	X	X	X
Performance Measures	None.			
Compliance with Medicaid and Children's Health Insurance Program Standards	None.			
Network Adequacy	Overall, appointment availability among the surveyed providers was low.	X	X	X
Quality of Care Surveys – Member Satisfaction	UnitedHealthcare Dental achieved a CAHPS score related to dental plan services, *Information Helped You Find a Dentist that You Were Happy With*, that was statistically significantly worse in measurement year 2022.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UnitedHealthcare Dental demonstrated a decline in performance between	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	measurement years 2021 and 2022 in 20 of 26 measures of provider satisfaction.			
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for one quality improvement project, as UnitedHealthcare Dental did not achieve the established project goal. UnitedHealthcare Dental should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	X	X	X
Performance Measures	None.			
Compliance with Medicaid and Children's Health Insurance Program Standards	UnitedHealthcare Dental should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for future accreditation surveys.	X	X	X
Network Adequacy	UnitedHealthcare Dental should address barriers members face when attempting to access care that is timely and appropriate.		X	X
Quality of Care Surveys – Member Satisfaction	UnitedHealthcare Dental should ensure its compliance with the contractual requirement to administer a member satisfaction survey annually.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UnitedHealthcare Dental should address key findings of the provider satisfaction survey, especially those that showed substantial declines in satisfaction rates, including the usefulness of RIte Smiles portal and the provider manual, overall satisfaction with the IVR, credentialing and the onboarding process, ability of representatives to correctly resolve issues on the first call, and the resolution process for claim issues.	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.

[ ] 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

Data Analysis Cycle.

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

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

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.
Include, as appropriate: **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.