



Rhode Island Medicaid Managed Care Program Rite Smiles Dental Program UnitedHealthcare Dental 2024 External Quality Review Annual Technical Report April 2026

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

ipro.org

Reference to Medicaid managed care programs and members also includes Children's Health Insurance Program members served under the same managed care programs and contracts.

Per *Title 42 CFR 438.364(a)(7)*, no managed care plan was exempt from the external quality review activities conducted in 2024.

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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 & Medicaid Services. Quality, as it pertains to an external quality review, is defined in *Title 42 Code of Federal Regulations 438.320 Definitions* as “the degree to which a managed care plan, PIHP¹, PAHP², or PCCM³ 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 Title 42 Code of Federal Regulations Section 438.364 External quality review results (a) through (d) and Title 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 2024. This report summarizes the 2024 external quality review results **UnitedHealthcare Dental**, the Rhode Island Medicaid dental managed care plan.

It is important to note that the provision of health care services to each of the applicable Medicaid eligibility groups are evaluated in this report.

2024 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects⁴, validation of performance measures, review of compliance Medicaid and Children’s Health Insurance Program standards, and validation of network adequacy) and one optional activity (validation of quality-of-care survey) that were conducted for measurement year 2024 (January 1, 2024-December 31, 2024). IPRO’s external quality review methodologies for these activities follow the CMS External Quality Review (EQR) Protocols⁵

¹ Prepaid inpatient health plan.

² Prepaid ambulatory health plan.

³ Primary care case management.

⁴ 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.

⁵ The Centers for Medicare & Medicaid Services External Quality Review Protocols website:

published in February 2023. The external quality review activities and corresponding protocols are described in **Table 1**.

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	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 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) data and Core Set results and Core Set dental measure rates to evaluate the effectiveness of UnitedHealthcare Dental’s management of the Rlte Smiles program. The EPSDT data were collected by the Rhode Island Executive Office of Health and Human Services and reported to the Centers for Medicare & Medicaid Services via Form 416 - Annual EPSDT Participation Report. The Core Set rates were calculated by IPRO using data that were submitted by the managed care plan.
Activity 3. Review of Compliance with Medicaid and Children’s Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of the evaluation performed by URAC, as part of the Dental Plan Accreditation, on Medicaid managed care plan compliance with Medicaid standards. Specifically, this review assessed managed care plan compliance with standards under <i>Title 42 Code of Federal Regulations Part 438 – Managed Care</i> .
Activity 4. Validation of Network Adequacy (Required)	Protocol 4	IPRO evaluated the managed care plan data collection methodologies and results to determine managed care plan adherence to the network standards outlined in the <i>Medicaid Managed Care Services Agreement</i> , as well as managed care plan ability to provide an adequate provider network to its Medicaid and Children’s Health Insurance Program populations.
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 Rhode Island Executive Office of Health and Human Services’ requirement to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS [®]) tool. IPRO also reviewed managed care plan provider satisfaction survey reports to verify the validity and reliability of the results and to ensure that the survey was conducted in alignment with the <i>Medicaid Managed Care Services Agreement</i> .

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

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>.

⁶ CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

Rhode Island Medicaid Managed Care Program

The Rhode Island Medicaid Managed Care Program

The State of Rhode Island was granted a Section 1115 Demonstration Waiver⁷ 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 2015⁸. 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 Rhode Island Executive 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, UnitedHealthcare Community Plan of Rhode Island, and Tufts Health Public Plans; and one managed dental health plan: **UnitedHealthcare Dental**. **Table 2** displays a summary of the Medicaid managed care programs and participating managed care plans that were available to Rhode Islanders in 2024.

⁷ 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>.

⁸ 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
Rlte Care Core	A Medicaid managed care plan for children and families.	<ul style="list-style-type: none"> ▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rlte 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.	<ul style="list-style-type: none"> ▪ Neighborhood Health Plan of Rhode Island
Rlte 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.	<ul style="list-style-type: none"> ▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Expansion	A Medicaid managed care plan for low-income adults aged 19-64 years with no dependent children.	<ul style="list-style-type: none"> ▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Partners	A Medicaid managed care plan for eligible adults with disabilities who are 21 years or older.	<ul style="list-style-type: none"> ▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	<ul style="list-style-type: none"> ▪ UnitedHealthcare Dental

The provision of health care services to each of the applicable eligibility groups (Rlte Care Core, Rlte Care for Children in Substitute Care, and Rlte Care for Children with Special Health Care Needs) 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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive 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 Strategy⁹ aligns with the Rhode Island Executive 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 Rhode Island Executive 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.
<ul style="list-style-type: none">▪ 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.
<ul style="list-style-type: none">▪ 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.

⁹ 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

- **2.5** Monitor child immunization rates to maintain high performance.
- **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 Rlte 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 Rhode Island Executive 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, baseline data, remeasurement data, and an assessment of performance between measurement year 2023 and measurement year 2024. Unless indicated otherwise, baseline measurements are from measurement year 2020 (January 1, 2020 through December 31, 2020).

Symbol Key For Table 4	
Symbol	Meaning
▲ (Green Upward Triangle)	Performance Improved
▼ (Red Downward Triangle)	Performance Declined
● (Blue Circle)	No Change
— (Black Dash)	Cannot Compare

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

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
Goal 1: Members receive quality care within all managed care delivery systems.	Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers (<i>Lower rate indicates better performance.</i>) (Medicaid)	8.6%	8.5%	Removed in 2024	—
	Care for Older Adults: Functional Status Assessment (Medicaid)	58.8%	88.8%	92.4%	▲
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%	64.38%	63.99%	▼
	Cervical Cancer Screening (Medicaid)	59.6%	66.09%	63.41%	▼
	Screening for Depression and Follow-Up Plan, Ages 12-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	8.24%	7.60%	▼
	Comprehensive Diabetes Care: Hemoglobin A1c Testing ¹ (Medicaid)	82.2%	Not Available	Not Available	—
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control ¹ (<i>Lower rate indicates better performance.</i>) (Medicaid)	33.2%	27.03%	28.85%	▼
	Controlling High Blood Pressure (Medicaid)	70.7%	73.86%	74.06%	▲
	Asthma Medication Ratio, Ages 5-18 Years (Medicaid and Children’s Health Insurance Program)	65.6%	57.59%	Not Available	—
	Asthma Medication Ratio, Ages 19-64 Years (Medicaid)	53.7%	52.95%	Not Available	—
	Prenatal and Postpartum Care – Timeliness of Prenatal Care, Ages 21 Years and Older (Medicaid)	Not Available	93.4%	85.6%	▼
	Prenatal and Postpartum Care – Timeliness of Prenatal Care, Ages Under 21 Years (Medicaid and Children’s Health Insurance Program)	Not Available	83.6%	83.3%	▼
	Child and Adolescent Well-Care Visits, Ages 3-21 Years	Not Available	61.20%	62.85%	▲

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	(Medicaid and Children’s Health Insurance Program)				
	Childhood Immunization Status – Combination 10 (Medicaid and Children’s Health Insurance Program)	61.0% ²	52.29%	49.82%	▼
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	44.8%	40.70%	39.99%	▼
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	17.9%	14.92%	15.83%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days, Ages 13-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	25.33%	36.00%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days, Ages 13-17 to Years (Medicaid and Children’s Health Insurance Program)	Not Available	49.33%	52.00%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	12.7%	32.61%	32.90%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	23.8%	48.25%	48.86%	▲
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, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	56.8%	59.73%	63.29%	▲
	Follow-Up After Hospitalization for Mental Illness – 30 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	76.6%	77.51%	82.28%	▲
	Follow-Up After Hospitalization for Mental Illness – 7 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	57.2%	59.73%	48.94%	▼

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	Follow-Up After Hospitalization for Mental Illness – 30 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	71.7%	77.51%	69.26%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	57.89%	47.23%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	74.58%	68.34%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	64.6%	57.89%	48.57%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	74.8%	74.58%	64.38%	▼
	Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit (Medicaid)	80.7%	Not Available ³	Not Available ³	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Medications (Medicaid)	67.0%	Not Available ³	Not Available ³	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Strategies (Medicaid)	59.9%	Not Available ³	Not Available ³	—
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Acute Phase, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	58.9%	61.32%	60.40%	▼
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Continuation Phase, Ages 18-64 Years	44.0%	43.66%	44.05%	▲

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	(Medicaid and Children’s Health Insurance Program)				
	Topical Fluoride for Children – Dental Services or Oral Health Services (Medicaid and Children’s Health Insurance Program)	Not Available	8.81%	18.71%	▲
	Topical Fluoride for Children – Dental Services (Medicaid and Children’s Health Insurance Program)	Not Available	17.53%	18.71%	▲
	Topical Fluoride for Children – Oral Health Services (Medicaid and Children’s Health Insurance Program)	Not Available	0.00%	0.00%	●
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	Not Applicable	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.

³ Statewide measurement year 2023 performance for the Medical Assistance with Smoking and Tobacco Use Cessation measures will be calculated by the Centers for Medicare & Medicaid Services using CAHPS data submitted by Rhode Island managed care plans to the Agency for Healthcare Research and Quality’s CAHPS Health Plan Survey Database. At the time of this report, statewide results were not available for inclusion.

Descriptions of the improvement strategies led by the Rhode Island Executive 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 & Medicaid Services and the Rhode Island Executive Office of Health and Human Services.

Accountable entity quality performance is measured and reported by the managed care plans to the Rhode Island Executive Office of Health and Human Services according to the "Medicaid Comprehensive Accountable Entity Common Measure Slate." Measures in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" are used to inform the distribution of shared savings. **Table 5** displays the measures included in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" for 2024, as well as the measure steward and reporting category.

Table 5: Medicaid Comprehensive Accountable Entity Common Measure Slate, Performance Year 2024

Measure	Steward	Category
Breast Cancer Screening	NCQA	P4P
Child and Adolescent Well-Care Visits, Total	NCQA	P4P
Chlamydia Screening	NCQA	Reporting-only
Colorectal Cancer Screening	NCQA	Reporting-only
Controlling High Blood Pressure	NCQA	P4P
Eye Exam for Patients With Diabetes	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 7 Days	NCQA	P4P
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	NCQA	P4P
Immunizations for Adolescents (Combination 2)	NCQA	Reporting-only
Lead Screening in Children	NCQA	P4P
Developmental Screening in the First Three Years of Life	Oregon Health & Science University	Reporting-only
Screening for Depression and Follow-up Plan	Centers for Medicare & Medicaid Services	P4P
Patient Engagement With an Accountable Entity Primary Care Provider	Rhode Island Executive Office of Health and Human Services	Reporting-only
Social Determinants of Health Screening	Rhode Island Executive Office of Health and Human Services	P4P

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

For performance year 2024, the Rhode Island Executive Office of Health and Human Services employed a combination of internal and external sources to set achievement targets. The Rhode Island Executive Office of Health and Human Services set targets for performance year 2024 using accountable entity performance data for 2021, national and New England Medicaid health maintenance organization data from NCQA’s *Quality Compass 2022* (measurement year 2021), and national and Rhode Island data from the Centers for Medicare & Medicaid Services’ *2021 Child and Adult Health Care Quality Measures Report*. **Table 6** displays the performance year 2024 measures and achievement targets.

Table 6: Accountable Entity ‘P4P’ Measure Targets, Performance Year 2024

Measure	Threshold Target	High-Performance Target
Breast Cancer Screening	58%	65%
Child and Adolescent Well-Care Visits, Total	52%	61%
Controlling High Blood Pressure	65%	72%
Eye Exam for Patients With Diabetes	56%	71%
Follow-Up After Hospitalization for Mental Illness – 7 Days	49%	53%
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	52%	60%
Lead Screening in Children	67%	79%
Screening for Depression and Follow-up Plan	50%	61%
Social Determinants of Health Screening	42%	59%

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 a Rhode Island Executive 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.

- July 1, 2022-June 30, 2023 – 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.
- July 1, 2023-June 30, 2024 – 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.

Table 7 displays the Alternative Payment Results for the July 1, 2023 to June 30, 2024 measurement period. Neighborhood Health Plan of Rhode Island and UnitedHealthcare Community Plan of Rhode Island exceeded the 65% goal. Tufts Health Public Plans did not meet the goal.

Table 7: Alternative Payment Results, Measurement Year July 1, 2023-June 30, 2024

Managed Care Plan	July 2023-June 2024 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	87.50%	65%	Met
Tufts Health Public Plans	20.81%		Not Met
UnitedHealthcare Community Plan of Rhode Island	73.08%		Met

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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive 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.

Early Periodic Screening, Diagnosis and Treatment rates for select measures are presented in the **Validation of Performance Measures – Technical Summary** section of this report.

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.
- June 30, 2023 – At least 60% of the managed care plan’s membership is linked to a patient-centered medical home.
- June 30, 2024 – At least 60% of the managed care plan’s membership is linked to a patient-centered medical home.

Table 8 displays the percentage of the managed care plans’ patient-centered medical home assignments as of June 30, 2024 Neighborhood Health Plan of Rhode Island, Tufts Health Public Plans, and UnitedHealthcare Community Plan of Rhode Island exceeded the 60% goal.

Table 8: Patient-Centered Medical Home Assignments, as of June 30, 2024

Managed Care Plan	July 2023-June 2024 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	87.35%	60%	Met
Tufts Health Public Plans	60.17%		Met
UnitedHealthcare Community Plan of Rhode Island	89.71%		Met

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 Rhode Island Executive 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 Rhode Island Executive 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*¹⁰ (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*

¹⁰ Rhode Island Health Information Technology website: <https://eohhs.ri.gov/initiatives/health-information-technology>.

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^{®11}, 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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive Office of Health and Human Services in coordination with Project Governance will determine which data feeds will undergo data aggregator validation, starting with the accountable entity providers in 2025 and expanding year to year.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

Rhode Island's Medicaid Managed Care Quality Strategy provides a comprehensive framework to guide managed care entities in improving the quality of care, timeliness of care, and access to care for Medicaid members. In addition to required external quality review activities, the quality strategy incorporates state- and managed care entity-level initiatives that strengthen monitoring, reporting, and accountability across the Medicaid delivery system.

The Rhode Island Executive Office of Health and Human Services designed the quality strategy to align with the National Quality Strategy established by the Centers for Medicare and Medicaid Services. The strategy emphasizes promoting equity and member engagement, improving quality and health outcomes, facilitating statewide alignment and care coordination, and advancing a health care system that is increasingly electronic and data-driven. Key initiatives reinforce standardized approaches to identifying and addressing social determinants of

¹¹ 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.

health, expanding the use of Child and Adult Core Set quality measures, and leveraging partnerships to advance quality improvement activities.

This assessment evaluates Rhode Island Medicaid’s progress between measurement year 2023 and measurement year 2024 across three of the six quality strategy goals. Overall, performance during this period reflects incremental improvement in several care coordination, behavioral health, and chronic disease management measures, alongside continued challenges in preventive care, pediatric measures, and medication adherence. While some indicators demonstrate positive momentum, declines in key preventive and pediatric metrics highlight ongoing opportunities for targeted intervention.

Goal 1: Members receive quality care within all managed care delivery systems.

The largest improvement was seen in functional status assessments for older adults. Completion rates increased from 58.8% in 2020 to 92.4% in 2024—an increase of 33.6 percentage points. This suggests that care facilities are more consistently evaluating residents’ functional abilities.

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.

Rhode Island Medicaid demonstrated varied performance across Goal 2 measures, with notable improvements in several chronic disease and substance use–related metrics, alongside declines in preventive and pediatric care.

Strengths and Improvements

- Chronic disease management:
 - Controlling high blood pressure increased modestly.
 - Poor blood sugar control among adults with diabetes continued to decline, indicating improved diabetes management.
- Maternal health:
 - Timeliness of prenatal care remained high, indicating effective access to early prenatal services.
- Substance use treatment and follow-up:
 - Follow-up after emergency department visits for alcohol or other drug abuse or dependence improved for adults and adolescents.
 - Improvements were observed for both seven-day and thirty-day follow-up.

Opportunities for Improvement

- Preventive care:
 - Breast cancer screening declined slightly.
 - Cervical cancer screening declined more notably.
- Pediatric care:
 - Childhood immunization rates continued to decline.
 - Screening for depression and follow-up planning among adolescents decreased slightly.
- Asthma medication management:
 - Declines observed across pediatric and adult populations.

Goal 3: Improve care and service coordination and management, with a focus on coordination of services among medical, behavioral, dental, and specialty services providers.

Strengths and Improvements

- Follow-up after hospitalization for mental illness:
 - Improved for children, adolescents, and adults.
 - Thirty-day (30) follow-up rates exceeded 82 percent for pediatric populations and 77 percent for adults.
- Depression treatment:
 - Acute-phase antidepressant treatment adherence improved.

Opportunities for Improvement

- Follow-up after emergency department visits for mental illness:
 - Declines observed, particularly among adolescents, for both seven-day and thirty-day follow-up.
- Long-term antidepressant treatment:
 - Slight decline in continuation-phase adherence.
- Data limitations:
 - Incomplete data for dental services and tobacco cessation limited comprehensive assessment.
- Overall finding:
 - Strong inpatient-to-outpatient coordination, with weaker linkage following emergency department encounters.

Rhode Island Medicaid demonstrated modest progress in selected priority areas, including chronic disease management, follow-up after hospitalization for mental illness, and follow-up after emergency department visits related to substance use. These gains indicate strengthening care coordination and targeted improvement efforts. At the same time, continued declines in preventive care, childhood immunizations, asthma medication management, and follow-up after emergency department visits for mental illness highlight persistent gaps. Overall, performance reflects maintenance of prior gains with incremental improvement in some areas, while underscoring the need for focused interventions, improved care transitions following emergency department use, and sustained attention to preventive and pediatric services to advance the effectiveness of the quality strategy.

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

- Reinforce quality improvement project requirements to the managed care plans.
- Enforce standardized data collection and analysis requirements for managed care plan provider experience surveys to enable performance comparisons across managed care plans.
- Require managed care plans to submit methodologies used to evaluate network adequacy and provider experience to ensure the external quality review organization has sufficient information for validation activities.
- Determine secret shopper timely appointment thresholds to encourage managed care plans to aggressively address barriers to accessing care that is adequate and timely.
- Expand 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.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

Medicaid Managed Care Plan Profile

UnitedHealthcare Dental

The state contracts with **UnitedHealthcare Dental** as a prepaid ambulatory health plan to manage the Rlte Smile dental benefit for children enrolled in Medicaid. Rlte 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 Rlte Care, Rlte Care for Children with Special Health Care Needs, and Rlte Care for Children in Substitute Care.

Table 9 displays **UnitedHealthcare Dental's** enrollment for the Rlte Smiles program for year-end 2019 through year-end 2024, 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. Rlte Smiles enrollment decreased by 8% from 145,080 members in 2023 to 133,039 members in 2024.

Table 9: UnitedHealthcare Dental's Rlte Smiles Enrollment, 2019 to 2024

Year	Number of Members	Percent Change from Previous Year
2019	110,215	-3%
2020	123,280	+12%
2021	93,641	-24%
2022	137,728	+47%
2023	145,080	+5%
2024	133,039	-8%

Note: Enrollment counts for 2019–2023 reflect totals as of December 31, while 2024 enrollment counts are as of October 31.

UnitedHealthcare Dental of Rhode Island's Quality Improvement Program, 2024

The Rhode Island 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 2024 Quality Improvement Program Description met these requirements.

Program Description

UnitedHealthcare Dental administers a comprehensive Quality Improvement Program for the Rhode Island Rlte Smiles Dental Program designed to objectively monitor systematically evaluate and continuously improve the quality and safety of clinical care and quality of services provided to enrolled members including members with special health care needs. The program operates at the dental plan level and does not delegate quality improvement activities.

The Quality Improvement Program functions in coordination with the Utilization Management and Credentialing Programs and is grounded in evidence based nationally recognized clinical practice guidelines. It addresses all aspects of dental care delivery including quality of care quality of service patient safety access and availability member and provider experience health equity and regulatory compliance. Oversight is maintained through an established governance structure that includes the Quality Improvement Utilization Management Committee and the Board of Directors with annual review and approval of the Quality Improvement Program Description Work Plan and Evaluation.

Program Goals

- Promote and integrate quality improvement throughout the dental plans organizational structure and operational processes
- Monitor and evaluate the quality of clinical care and services delivered by network providers using evidence based dental guidelines
- Identify analyze and address opportunities for improvement through targeted interventions and follow up activities
- Coordinate quality improvement risk management patient safety and operational oversight activities
- Maintain compliance with applicable state and federal regulatory requirements and accreditation standards
- Serve culturally and linguistically diverse populations and advance health equity
- Monitor and improve key quality and utilization indicators
- Support members in achieving better oral health outcomes

Program Objectives

- Promote population health management through measurable improvement in preventive dental care and oral health outcomes
- Encourage adoption and use of nationally recognized evidence based clinical practice guidelines by providers
- Improve coordination of care and transitions across providers and care settings
- Enhance the member experience through monitoring of satisfaction grievances appeals and access to care
- Monitor network adequacy and appointment availability and implement corrective actions as needed
- Ensure compliance with accreditation standards and regulatory requirements
- Address cultural linguistic and health equity needs through targeted assessment training and program design

Quality Improvement Program Activities

Clinical Quality Improvement Activities

- Analysis of clinical performance and utilization data to identify gaps in preventive dental services and topical fluoride application
- Implementation and monitoring of Quality Improvement Projects focused on preventive dental services for adolescents and topical fluoride application for children and young adults
- Use of the Plan Do Study Act methodology to test implement and evaluate targeted clinical interventions
- Distribution of Dental Care Opportunity Reports to high volume provider practices to support closure of gaps in care
- Direct provider engagement by Community Based Coordinators to review practice level data discuss barriers and promote evidence based preventive care
- Collaboration with Federally Qualified Health Centers and community partners to deliver preventive services through clinic days and outreach events

Service and Operational Quality Improvement Activities

- Monitoring and evaluation of appointment availability through quarterly secret shopper surveys
- Provider education and follow up related to appointment access standards and directory accuracy
- Ongoing assessment of network adequacy using geo access reporting and targeted provider recruitment activities
- Oversight of credentialing and recredentialing processes to ensure timely and compliant provider participation
- Monitoring of claims processing customer service call performance appeals and grievance timeliness
- New member outreach including welcome calls welcome packets and member education materials

Patient Safety and Coordination of Care Activities

- Oversight of peer review processes to identify and address potential quality of care concerns
- Monitoring of utilization management activities to identify over and under utilization and support appropriate care delivery
- Coordination of care activities to support members requiring medically necessary dental procedures including operating room access and sedation services
- Collaboration with medical plans and care management teams to support dental medical integration and referrals
- Monitoring and analysis of appeals grievances and quality of care complaints to identify trends and improvement opportunities

Health Equity and Language Access Activities

- Assessment of member demographics including age language and geographic location to inform targeted outreach and interventions
- Member education and outreach through mailed materials interactive voice response calls and community based events designed to promote preventive dental care
- Community based education initiatives delivered in schools community organizations and health centers to increase oral health awareness
- Promotion of culturally appropriate care through provider training resources and availability of language services
- Identification and mitigation of barriers related to transportation language access and member engagement through collaboration with community partners

Summary of UnitedHealthcare Dental's Evaluation of the 2024 Quality Assurance and Performance Improvement Program

The 2024 Quality Assessment and Performance Improvement evaluation determined that the Rlte Smiles Dental Quality Improvement Program remained effective and appropriately governed despite ongoing access and workforce challenges. The program demonstrated continued compliance with regulatory requirements and sustained use of data driven quality improvement strategies.

Key Evaluation Findings

- Governance and oversight structures functioned as intended, with routine review and approval of quality improvement activities by the Quality Improvement Utilization Management Committee and the Board of Directors.
- Quality improvement activities addressed clinical care, service quality, access, utilization, member experience, and health equity.

- Preventive dental service rates declined, largely due to provider staffing shortages and reduced appointment availability.
- The topical fluoride Quality Improvement Project exceeded its established performance goal, demonstrating the effectiveness of targeted outreach and provider engagement strategies.
- Credentialing, recredentialing, appeals, grievances, customer service, and claims processing activities consistently met established timeliness and compliance standards.
- Network adequacy monitoring identified ongoing workforce and specialty access challenges, particularly affecting appointment availability.
- Data analytics were consistently used to assess intervention effectiveness and inform program planning.

The evaluation identified workforce constraints and access limitations as the primary challenges impacting performance during 2024. These findings informed priorities for the following year, including expanded focus on high risk age groups, strengthened preventive care interventions, continued monitoring of access standards, and enhanced data driven quality improvement activities.

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, and 7.

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.

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

For the 2024 external quality review, IPRO obtained 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 10 displays the results of **UnitedHealthcare Dental’s** information systems capabilities review conducted as part of the URAC Accreditation survey.

Table 10: 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 Rhode Island Executive Office of Health and Human Services, and consistent with federal requirements.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Rhode Island Executive Office of Health and Human Services for measurement year 2024.

Table 11 displays the titles of the quality improvement projects led by **UnitedHealthcare Dental** for the RIte Smiles population for measurement year 2024.

Table 11: Managed Care Plan Quality Improvement Project Topics, 2024

Managed Care Plan Quality Improvement Project Topics, 2024	
UnitedHealthcare Dental	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

The Rhode Island Executive Office of Health and Human Services requires that quality improvement projects be documented using NCQA's *Quality Improvement Activity Form*. 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 *2024 Quality Improvement Activity Forms* completed by **UnitedHealthcare Dental** 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 12**.

Table 12: 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 indicating that the credibility of the performance improvement project results was at risk.
- 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 2024 external quality review, IPRO reviewed the *2024 Quality Improvement Activity Forms* submitted by **UnitedHealthcare Dental**. 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 two quality improvement projects was at risk.

Table 13 displays a summary of the validation results of **UnitedHealthcare Dental’s** quality improvement projects that were conducted for measurement year 2024. Summaries of each quality improvement project immediately follow.

Table 13: UnitedHealthcare Dental’s Quality Improvement Project Validation Results, Measurement Year 2024

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 14: UnitedHealthcare Dental’s Quality Improvement Project 1 Summary – Preventive Health Services, Measurement Year 2024

UnitedHealthcare Dental’s Quality Improvement Project 1 Summary
<p>Title: Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services Start Year: 2016. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>
<p><u>Aim</u> UnitedHealthcare Dental aims to increase the percentage of children ages 15 to 18 years with preventive health services.</p>
<p><u>Indicator of Performance</u> The percentage of children ages 15 to 18 years continuously enrolled for at least 90 days in Rlte Smiles who received one of the following preventive services: prophylaxis, topical fluoride, or sealant.</p>
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Outreached to members ages 15-18 years with no dental visit within the last 12-months via postcard and interactive voice recordings to educate on the importance of oral hygiene and establishing a dental home.▪ Partnered with federally qualified health centers to two clinic days to members.▪ Participated in the Blackstone Academy career day event for students in the 10th and 11th grades by leading discussions on careers in dentistry, healthy daily oral routines, and the importance attending dental appointments.▪ Delivered oral health education to students attending Rhode Island Nurse Institute Middle College.▪ Delivered oral health education to students who participated in the TIMES2 STEM Academy.▪ Collaborated with the Newport Gulls sports team and providers to incentivize members to complete a preventive health service for tickets to a Newport Gulls game.
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Continued delivering Dental Care Opportunity Reports to high-volume dental offices with the highest number of non-compliant members.

Table 15: UnitedHealthcare Dental’s Quality Improvement Project 1 Indicator Summary – Preventive Services, Measurement Years 2016 to 2024

Members Ages 15-18 Years With Preventive Health Services					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Baseline 2016	Baseline	4,875	9,429	51.70%	Not Applicable
Measurement Year 2017	Remeasurement 4	5,626	11,136	50.52%	56.87%
Measurement Year 2018	Remeasurement 8	10,879	21,323	51.02%	56.87%
Measurement Year 2019	Remeasurement 12	13,262	21,324	62.19%	56.87%
Measurement Year 2020	Remeasurement 16	7,834	23,918	32.75%	56.87%
Measurement Year 2021	Remeasurement 20	9,938	24,891	39.93%	56.87%
Measurement Year 2022	Remeasurement 24	11,291	26,146	43.18%	56.87%
Measurement Year 2023	Remeasurement 28	11,691	27,737	42.15%	56.87%
Measurement Year 2024	Remeasurement 30	11,140	27,654	40.28%	56.87%

Indicator Description: The percentage of children, ages 15-18, who were continuously enrolled for at least 90 days and received a preventive service (prophylaxis, topical fluoride, or sealant) within the measurement period.

Table 16: UnitedHealthcare Dental’s Quality Improvement Project 2 Summary – Topical Fluoride, Measurement Year 2024

UnitedHealthcare Dental’s Quality Improvement Project 2 Summary	
<p>Title: Topical Fluoride for Children Start Year: 2022. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>	
<p><u>Aim</u> UnitedHealthcare Dental aims to increase the percentage of children who receive at least two topical fluoride applications.</p>	
<p><u>Indicator of Performance</u> 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.</p>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Partnered with Blackstone Valley Community Health Center to engage members who with no services in the last 12 to 18 months. Engagement included appointment scheduling assistance and oral health education. ▪ Implemented a classroom-based education program covering the importance of oral heal routines. 	
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Educated Jenks Park Pediatric medical staff on the fluoride application process, as well as leveraging well-child visits to provide the dental service. 	

Table 17: UnitedHealthcare Dental’s Quality Improvement Project 2 Indicator Summary – Topical Fluoride, Measurement Years 2021 to 2024

Members with Topical Fluoride					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2021	Baseline	17,812	116,039	15.35%	Not Applicable
Measurement Year 2022	Remeasurement 4	20,915	116,799	17.91%	18.57%
Measurement Year 2023	Remeasurement 8	21,063	118,127	17.83%	18.57%
Measurement Year 2024	Remeasurement 12	20,296	104,664	19.39%	18.57%

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 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 Rhode Island Executive 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 Rhode Island Executive 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. Further, the Rhode Island Executive Office of Health and Human Services incorporates select HEDIS results into its methodology for the accountable entity shared savings distribution.

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 Rhode Island Executive Office of Health and Human Services for measurement year 2024.

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. Rlte Smiles claims are additionally edited through the dental benefit managers to assure that only approved dental claims are provided by members of the Rlte Smiles provider list to children born on or after May 1, 2000.

Core Set Performance Measures

The Core Set rates for measurement year 2024 were calculated and or validated by IPRO on behalf of the Rhode Island Executive Office of Health and Human Services. **UnitedHealthcare Dental** submitted data for the Core Set measures in **Table 18**.

Table 18: UnitedHealthcare Dental Performance Measures, Measurement Year 2024

Measure	Core Set Abbreviation	Steward	Data Collection Method	Validated by IPRO
Oral Evaluation, Dental Services	OEV-CH	DQA	Administrative	Yes
Sealant Receipt on Permanent First Molars	SFM-CH	DQA	Administrative	Yes
Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes

EPSDT Performance Measures

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 2024 EPSDT measures is January 1, 2024, to December 31, 2024. 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.

Aggregated 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 Fee-For-Service are included in the numerators and denominators.

Description of Data Obtained

Core Set Performance Measures

For the 2024 external quality review, IPRO received a copy of the Rhode Island Core Set Master File for measurement year 2024. The Master File was produced by IPRO for the Executive Office of Health and Human Services and contained data for the measures in **Table 19**. Specifically, the Rhode Island Core Set Master File contained managed care plan and statewide numerators and denominators that were validated by IPRO, as well as measure rates that were calculated by IPRO.

EPSDT Performance Measures

For the 2024 external quality review, IPRO obtained a copy of **UnitedHealthcare Dental's** EPSDT submission for the 2024 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 five 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

Performance Measure Validation

There were no data collection or reporting issues identified for **UnitedHealthcare Dental**.

Table 19: UnitedHealthcare Dental Performance Measure Validation Results, Measurement Year 2024

Performance Measure Category	Validation Statement
Core Set	There were no issues identified.
EPSDT	There were no issues identified.

Performance Measure Rates

Table 20 displays **UnitedHealthcare Dental's** Core Set measure rates for measurement year 2024, as well as Rhode Island's statewide rates for the same period. **Table 21** displays **UnitedHealthcare Dental's** EPSDT measure rates for 2019, 2020, 2021, 2022, 2023, and 2024.

Table 20: UnitedHealthcare Dental's Performance Measures Rates, Measurement Year 2024

Measure	UnitedHealthcare Dental Measurement Year 2024	Rhode Island Measurement Year 2024 ¹
Oral Evaluation, Dental Services		
<i>Under 3 Years</i>	25.40%	25.13%
<i>3-5 Years</i>	51.55%	50.76%
<i>6-14 Years</i>	51.82%	50.69%
<i>15-20 Years</i>	34.93%	33.95%
<i>Total (All Ages)</i>	44.21%	43.24%
Sealant Receipt on Permanent First Molars		
<i>At Least 1 Molar</i>	56.69%	55.15%
<i>All 4 Molars</i>	40.79%	39.67%
Topical Fluoride for Children, Dental or Oral Health Services		
<i>1-2 Years</i>	8.87%	8.82%
<i>3-5 Years</i>	24.88%	24.54%
<i>6-14 Years</i>	23.47%	22.97%
<i>15-20 Years</i>	11.51%	11.18%
<i>Total (All Ages)</i>	19.12%	18.71%

¹ Rhode Island's Measurement Year 2024 rates include Medicaid Managed Care and Fee-For Service populations.

Table 21: UnitedHealthcare Dental’s EPSDT Measure Rates, Measurement Years 2019 to 2024

EPSDT Measure	Measurement Year 2019		Measurement Year 2020		Measurement Year 2021		Measurement Year 2022		Measurement Year 2023		Measurement Year 2024	
	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	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%	63,243	50.20%	58,801	47.41%	64,730	50.15%	61,808	51.58%
Preventive Dental Services	64,448	47.49%	47,847	34.96%	57,899	45.96%	53,601	43.21%	58,240	45.12%	55,779	46.55%
Dental Treatment Services	26,076	19.22%	22,944	16.76%	26,508	21.04%	24,831	20.02%	26,848	20.80%	26,264	21.92%
Sealant on a Permanent Molar	9,259	6.82%	6,217	4.54%	10,634	8.44%	8,355	6.74%	9,764	7.56%	9,441	7.88%
Dental Diagnostic Services	67,907	50.04%	51,733	37.80%	56,241	44.65%	52,807	42.57%	56,721	43.94%	54,803	45.74%
Total Eligible for EPSDT³	135,698		136,863		125,972		124,035		129,083		119,819	

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

² Percentages were calculated using the “Total Individuals Eligible for EPSDT for 90 Consecutive Days” as the denominator, as reported by UnitedHealthcare Dental, for all measures.

³ Total represents members eligible for EPSDT for 90 continuous days.

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 federal Medicaid and Children’s Health Insurance Program standards is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

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

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review to determine managed care compliance with federal Medicaid and Children’s Health Insurance Program standards. Per *Title 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 Rhode Island Executive 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 Rhode Island Executive 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 *Title 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’s was awarded “full” accreditation status by URAC beginning December 1, 2022 to December 1, 2025. **Table 21** 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 *Title 42 Code of Federal Regulations Part 438 Managed Care*.

Table 22: Evaluation of Managed Care Plan Compliance with Federal Medicaid and Children’s Health Insurance Program Standards, 2024

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 Rhode Island Executive 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. The Rhode Island Executive Office of Health and Human Services-established access standards are presented in **Table 22**.

Table 23: 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
▪ 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

Rhode Island Medicaid Managed Care Access Standards

- 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

Title 42 Code of Federal Regulations 438.356 State contract options for external quality review and Title 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 Rhode Island Executive Office of Health and Human Services contracted IPRO to perform the 2024 validation of network adequacy for each managed care plan.

Technical Methods of Data Collection and Analysis

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 *UnitedHealthcare Dental Network Access Report for 2024* and in the quarterly 2024 **UnitedHealthcare Dental’s Network Analysis Report**.

Comparative Results

Network Adequacy Validation Results

UnitedHealthcare Dental evaluated network adequacy using acceptable methodologies. **Table 24** displays the results of IPRO’s validation of network adequacy for **UnitedHealthcare Dental’s** Medicaid and Children’s Health Insurance Program network.

Table 24: UnitedHealthcare Network Adequacy Validation Results, Measurement Year 2024

Managed Care Plan	Network Adequacy Validation Result
UnitedHealthcare Dental	Met

Met means that the managed care plan met or exceeded standards.

Compliance with State Access Requirements

UnitedHealthcare Dental met the access standard for general and pediatric dentists and dental specialists for 100% of members in the all regions.

UnitedHealthcare Dental's quarterly performance against access standards for urban, suburban, and rural geographic areas is displayed **Table 25, Table 26, and Table 27**, respectively.

Table 25: UnitedHealthcare Dental’s Geo Access Analysis – Urban, 2024

Provider Type	Access to Provider Standard	% of Members With Access 2024 Quarter 1	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 2	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 3	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 4	Goal = 100% Met/Not Met
Dental Care									
General and Pediatric Dentists	1 in 20 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 20 Minutes	100%	Met	100%	Met	100%	Met	100%	Met
Specialists (All)	1 in 30 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 30 Minutes	100%	Met	100%	Met	100%	Met	100%	Met

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

Table 26: UnitedHealthcare Dental’s Geo Access Analysis – Suburban, 2024

Provider Type	Access to Provider Standard	% of Members With Access 2024 Quarter 1	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 2	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 3	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 4	Goal = 100% Met/Not Met
Dental Care									
General and Pediatric Dentists	1 in 20 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 20 Minutes	100%	Met	100%	Met	100%	Met	100%	Met
Specialists (All)	1 in 30 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 30 Minutes	100%	Met	100%	Met	100%	Met	100%	Met

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

Table 27: UnitedHealthcare Dental’s Geo Access Analysis – Rural, 2024

Provider Type	Access to Provider Standard	% of Members With Access 2024 Quarter 1	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 2	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 3	Goal = 100% Met/Not Met	% of Members With Access 2024 Quarter 4	Goal = 100% Met/Not Met
Dental Care									
General and Pediatric Dentists	1 in 20 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 20 Minutes	100%	Met	100%	Met	100%	Met	100%	Met
Specialists (All)	1 in 30 Miles	100%	Met	100%	Met	100%	Met	100%	Met
	1 in 30 Minutes	100%	Met	100%	Met	100%	Met	100%	Met

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

Table 26 displays aggregated results of the quarterly secret shopper appointment availability surveys conducted by **UnitedHealthcare Dental** in 2024.

Table 28: UnitedHealthcare Dental’s Appointment Availability Survey Results, 2024

Appointment Type/Provider Specialty	Appointment Wait Time Standard	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made ¹
Dental Care					
Routine	Within 60 days	120	69	57.5%	33.3%
Urgent	Within 48 hours	120	59	49.2%	29.2%

¹The Number of Providers Surveyed is the denominator for Rate of Timely Appointments Made.

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, *Title 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 Rhode Island Executive 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 vendor to administer the CAHPS Dental Plan Survey for measurement year 2024. On behalf of the Rhode Island Executive Office of Health and Human Services, IPRO validated the satisfaction survey sponsored by **UnitedHealthcare Dental** for measurement year 2024.

Technical Methods of Data Collection and Analysis

The standardized survey instrument selected for measurement year 2024 was the CAHPS Dental Plan Survey. The tool was modified to meet objectives of the **UnitedHealthcare Dental** study.

The sample included members who received dental care during the period spanning Quarter 2 of 2024 through Quarter 1 of 2025. Qualified respondents were members who had at least one dental visit within the previous 12 months and were continuously enrolled for that same period.

Table 29 provides a summary of the technical methods of data collection by **UnitedHealthcare Dental**.

Table 29: CAHPS Technical Methods of Data Collection, Measurement Year 2024

Methodology Element	UnitedHealthcare Dental Survey
Survey Tool	CAHPS Dental Plan Survey
Survey Timeframe	May 30, 2025 to June 27, 2025
Method of Collection	Telephone
Sample Size	9,940
Target for Number of Completed Surveys	400
Completed Surveys	401

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 28** displays these categories and the measures which these response categories are used.

Table 30: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
<ul style="list-style-type: none"> ▪ Care from dentists and staff composite ▪ Access to dental care composite ▪ Dental plan services 	Never, Sometimes, Usually, Always <i>(Top-level performance is considered responses of “usually” or “always.”)</i>
Global Rating Measures	
<ul style="list-style-type: none"> ▪ Rating of dental care ▪ Rating of regular dentist ▪ Rating of ease of finding a dentist 	0-10 Scale <i>(Top-level performance is considered scores of “8” or “9” or “10.”)</i>

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

Description of Data Obtained

IPRO received a copy of the final measurement year 2024 study report produced by **UnitedHealthcare Dental’s** certified CAHPS vendor. These report included comprehensive descriptions of the project objectives and methodology, as well as results and analyses.

Comparative Results

Table 74 displays results of **UnitedHealthcare Dental’s** CAHPS Dental Plan Surveys for measurement years 2019, 2020, 2021, 2022, 2023, and 2024. The results in this table reflect top-level responses (8, 9, or 10 and always or usually).

Table 31: UnitedHealthcare Dental’s CAHPS Dental Plan Results, Measurement Years 2019 to 2024

CAHPS Dental Plan Survey Questions/Composites	Measurement Year					
	2019	2020	2021	2022	2023	2024
Would definitely or probably recommend Rlte Smiles by UnitedHealthcare Dental	95.7%	94.2%	95%	96%	96.7%	95.2%
Rating of Dental Care ¹	88.7%	88.1%	88.1%	90.8%	90.0%	87.2%
Rating of Regular Dentist ¹	91.8%	90.9%	89.3%	93.8%▲	92.1%	91.0%
Rating of Ease of Finding a Dentist ¹	69.5%	72.3%	76.6%	73.1%	75.4%	71.8%
Care From Dentists and Staff Composite ²	95.9%	95.5%	94.3%	93.6%	93.6%	94.2%
Dentist explained things in a way that was easy to understand ²	96.2%	95.2%	93.2%	91.2%	93.3%	93.0%
Dentist listened carefully ²	94.9%	96.3%	91.9%▼	91.7%	92.3%	93.6%
Dentist treated you with courtesy and respect ²	97.3%	97.9%	95.6%	95.0%	96.4%	97.9%
Dentist spent enough time with you ²	95.4%	91.5%	92.7%	92.6%	92.3%	91.5%
Dentist/staff did everything to make you feel comfortable during dental work ²	96.7%	97.1%	94.8%	95.0%	92.5%	93.8%
Dentist/dental staff explained what they were doing while treating you ²	95.0%	94.8%	97.5%	96.3%	94.5%	95.7%
Access to Dental Care Composite ²	73.1%	72.3%	73.1%	70.1%	71.7%	70.7%
Regular dental appointments were as soon as you wanted ²	84.7%	85.2%	83.4%	78.6%	80.8%	80.8%
Emergency appointments were as soon as you wanted ³	89.9%	82.4%▼	83.7%	83.5%	83.6%	84.3%
Appointments with dental specialists were as soon as you wanted ²	71.9%	73.3%	73.1%	65.7%	67.8%	67.5%
Spent more than 15 minutes in the waiting room before seeing someone ⁴	81.2%	83.3%	82.2%	86.3%	85.5%	80.7%
If waited more than 15 minutes, were updated on reason and length of delay ²	38.1%	37.3%	43.1%	36.5%	41.0%	40.4%
Dental Plan Services ²	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Found needed information from member service number, written materials, or website ²	75.0%	68.6%	73.0%	76.7%	66.4%	72.2%
Information helped you find a dentist you were happy with ³	90.9%	90.0% ⁵	100%	84.9%▼	90.4%	89.6%
Received needed information from dental plan’s member service ²	68.2%	64.3% ⁵	79.6%	72.1%	65.9%	65.8%
Member service staff treated you with courtesy and respect ²	88.2%	87.0%	89.6%	85.2%	85.9%	87.3%
Satisfaction with the dental plan’s member service ¹	87.4%	81.5%	87.0%	83.9%	85.7%	88.5%

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 Rhode Island Executive 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*, the managed care plans administer the provider satisfaction surveys annually. The objectives of this survey are to evaluate providers' satisfaction with various aspects of working with **UnitedHealthcare Dental** for Rlte Care.

On behalf of the Rhode Island Executive Office of Health and Human Services, IPRO validated the satisfaction survey sponsored by **UnitedHealthcare Dental** for measurement year 2024.

Technical Methods of Data Collection and Analysis

On behalf of **UnitedHealthcare Dental**, UnitedHealthGroup (UHG) administered the measurement year 2024 provider satisfaction survey using the Qualtrics platform. **Table 32** provides a summary of the technical methods of data collection.

Table 32: UnitedHealthcare Dental's Provider Satisfaction Survey Technical Methods of Data Collection, Measurement Year 2024

Methodology Element	Provider Satisfaction Survey
Survey Tool	Non-standard
Survey Timeframe	September 10, 2024 to October 1, 2024
Method of Collection	Email
Program	Rlte Smiles (Medicaid)
Eligible Provider Types	Dental Providers
Sample Size	107
Number of Completed Surveys	12
Response Rate	11%

Responses were classified into response categories. **Table 33** displays these categories and the measures which these response categories are used.

Table 33: Dental Care Provider Satisfaction Survey Questions and Response Options

Question	Response Options
<ul style="list-style-type: none"> Overall, how satisfied are you with the Rlte Smiles Dental Plan? How likely would you be to recommend the Rlte Smiles Dental Plan to a colleague? 	<ul style="list-style-type: none"> Scale 0 (Very Dissatisfied) – 10 (Very Satisfied)
<ul style="list-style-type: none"> How would you rate the amount of knowledge level and accuracy of information of the Rlte Smiles Dental Plan customer service representatives? How would you rate the usefulness of the Rlte Smiles Dental Plan provider portal (UHCdentalproviders.com) and the resources found on the portal (e.g., provider manuals) for you and/or your staff? How would you rate the UnitedHealthcare claim payment process overall? 	<ul style="list-style-type: none"> Scale 0 (Poor) – 10 (Excellent)

Description of Data Obtained

IPRO received a copy of the *2024 Dental Care Provider NPS Study, Rhode Island* report produced by UnitedHealthGroup (UHG) for **UnitedHealthcare Dental** and utilized the results to assess provider satisfaction with the Rlte Smiles program as overseen by **UnitedHealthcare Dental**.

Comparative Results

Table 34 displays the provider survey measures and results for measurement years 2023 and 2024. Results reflect scores of 9 or 10. Due to a low sample size, caution must be used when interpreting the results.

Table 34: UnitedHealthcare Dental’s Provider Satisfaction Survey Results, Measurement Years 2023 and 2024

Question	UnitedHealthcare Dental’s Provider Satisfaction Survey Results	
	Measurement Year 2023	Measurement Year 2024
Overall, how satisfied are you with the Rlte Smiles Dental Plan?	29% (n=14)	17% (n=12)
How likely would you be to recommend the Rlte Smiles Dental Plan to a colleague?	29% (n=14)	17% (n=12)
How would you rate the amount of knowledge level and accuracy of information of the Rlte Smiles Dental Plan customer service representatives?	22% (n=14)	17% (n=12)
How would you rate the usefulness of the Rlte Smiles Dental Plan provider portal and the resources found on the portal for you and/or your staff?	29% (n=14)	25% (n=12)
How would you rate the UnitedHealthcare claim payment process overall?	39% (n=13)	33% (n=12)

Note: Due to a low base size, caution must be used when interpreting the results.
n=Denominator.

Accreditation – Technical Summary

Objectives

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

The Utilization Review Accreditation Commission, or URAC, is an independent, nonprofit accreditation entity dedicated to improving the quality of health care. The Utilization Review Accreditation Commission 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.

The revised dental plan and network standards were streamlined and updated to reflect current foundational focus areas, incorporate a new scoring methodology, and introduce standards aligned with recent industry innovations. These changes are intended to shorten the accreditation and reaccreditation timeline while maintaining alignment with industry best practices informed by extensive client and stakeholder feedback.

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, the Utilization Review Accreditation Commission reviews for regulatory compliance, quality management, information management, staff management, network management, credentialing, and health utilization management.

The Utilization Review Accreditation Commission 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 the Utilization Review Accreditation Commission depending on the application.
- 2) Desktop Review Phase: The lead Utilization Review Accreditation Commission 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: The Utilization Review Accreditation Commission 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 Utilization Review Accreditation Commission 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 35** 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, the Utilization Review Accreditation Commission may randomly choose an organization to monitor its adherence to program standards.)

Table 35: Utilization Review Accreditation Commission (URAC) Accreditation Status Levels and Points

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

Description of Data Obtained

IPRO reviewed a copy of **UnitedHealthcare Dental’s** Utilization Review Accreditation Commission 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 was compliant with the state’s requirement to achieve and maintain accreditation. **UnitedHealthcare Dental** achieved full accreditation status, an overall score of 100%, and no determinations of “not met” for mandatory elements. **UnitedHealthcare Dental’s** “full” accreditation status is effective December 1, 2022 to December 1, 2025.

UnitedHealthcare Dental’s Response to the 2023 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 36** displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2023 external quality review recommendations.

Table 37 display **UnitedHealthcare Dental’s** progress related to the recommendations made in the 2023 *External Quality Review Aggregate Annual Technical Report* as well as IPRO’s assessment of the managed care plan’s response.

Table 36: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed care plan’s quality improvement response resulted in demonstrated improvement.
Remains an Opportunity for Improvement
Managed care plan’s quality improvement response was appropriate; however, more time is needed to observe for performance improvement.
Not Addressed
Managed care plan’s quality improvement response did not address the recommendation; or performance declined.

Table 37: UnitedHealthcare Dental’s Response to the 2023 External Quality Review Recommendations

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Dental’s Response to the 2023 External Quality Review Recommendation	IPRO’s Assessment of UnitedHealthcare Dental’s Response
Quality Improvement Projects	<p>Opportunities for improvement remain for the two quality improvement projects, as UnitedHealthcare Dental did not achieve the established project goals. UnitedHealthcare Dental should consider tailored interventions for subpopulations that have yet to achieve improved outcomes related to the quality improvement topics.</p>	<p><i>Dental Care Opportunity Reports</i> are prepared and delivered to dental offices identified as high volume and had the highest number of non-compliant members seen within that practice within the previous 2 years. In 2024, <i>Dental Care Opportunity Reports</i> were distributed in all 4 quarters. Provider feedback related to the <i>Dental Care Opportunity Report</i> is very positive.</p> <p>Reminder postcards on the importance of preventive dental care and how to establish a dental home were mailed to members who had not been in for care for 12+ months and were within the ages of 2-20 years old. Postcards were mailed in May and September in 2024.</p> <p>Interactive voice recording calls were made in February, April, June, August and October 2024 for members who were 2-20 years old and were noncompliant for 12+ months.</p> <p>Federally Qualified Health Centers scheduled eight clinic days with 621 members receiving preventative dental care.</p> <p>The CBC completed <i>Topical Fluoride Varnish Trainings</i> at four medical offices which included 14 providers. Training sessions included an overview of the fluoride varnish manual, hands-on demonstration, samples of products to begin</p>	<p>Remains an opportunity for improvement.</p>

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Dental's Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of UnitedHealthcare Dental's Response
		<p>application, small child toothbrushes, and a questions and answers session.</p> <p>Collaboration with Newport Gulls baseball team and three provider offices to distribute member tickets to a Newport Gulls game during the season when the member received a preventative dental visit. The offices were offered a free dental voucher to attend a baseball home game of the Newport Gulls team during the season. UnitedHealthcare Dental was a sponsor of the game and had a table where caregivers and members ages 18 and under were educated about the importance of oral health and preventative exams. UnitedHealthcare Dental provided <i>Dental Care Opportunity Reports</i> to dental provider office staff to target members for outreach. Those provider offices report that 250 tickets have been distributed.</p> <p>During 2024, 37 oral health education presentations were given to elementary (kindergarten through grade 5), middle school (grade 6 through grade 8) and high school (grade 9 through grade 12) students. Presentations took place at eight schools and 904 dental kits of age-appropriate dental care products and informational flyers were distributed. The presentations were at multiple cities and towns across the state. Oral health topics included nutritional guidance (how to identify hidden</p>	

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Dental's Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of UnitedHealthcare Dental's Response
		<p>sugars and the difference between natural and added sugars), fluoride benefits (both systemic and topical), how and when to brush, and a hands-on demonstration on effective flossing techniques. Students participated in a hands-on application of fluoride and sealant material on models of dentition.</p> <p>Note, below are the 2024 measurement year quality improvement project rates:</p> <ul style="list-style-type: none"> ▪ Preventative 15-18 QIP final measurement year 2024 rate = 40.28%. ▪ Topical Fluoride 2-20 QIP final measurement year 2024 rate = 19.39%. 	
Performance Measures	None.	Not applicable.	Not applicable.
Compliance with Medicaid and Children's Health Insurance Program Standards	None.	Not applicable.	Not applicable.
Network Adequacy	UnitedHealthcare Dental should address barriers members face when attempting to access care that is timely and appropriate.	Barriers to care are overcome through UnitedHealthcare Dental's Case Management program in collaboration with Network Advancement. The UnitedHealthcare Dental Case Management program follows a member through an individualized treatment plan until the barriers are resolved.	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Dental's Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of UnitedHealthcare Dental's Response
Quality of Care Surveys – Member Satisfaction	UnitedHealthcare Dental should share the results of the member experience survey with network providers, along with recommendations on how providers can positively impact member experience. Additionally, UnitedHealthcare Dental should evaluate its member services' preparedness in providing accurate and appropriate information to members.	UnitedHealthcare Dental shares the member experience survey and provider experience survey data at our Rhode Island Dental Advisory Group annual meeting.	Remains an opportunity for improvement.
Quality of Care Surveys – Provider Satisfaction	UnitedHealthcare Dental should aim to achieve larger sample sizes for future reports. UnitedHealthcare should consider administering surveys using multiple modes for data collection.	UnitedHealthcare Dental moved from a telephone-based survey to an email-based survey in 2023 in an effort to improve outcomes. Network providers are informed of the survey being released in advance of the start date via the UnitedHealthcare Dental Provider Portal. Throughout the open survey period, the survey is discussed during interactions with a provider or office via UnitedHealthcare Dental Provider Services, UnitedHealthcare Dental Network Advocates, or the UnitedHealthcare Dental Community -Based Coordinator. Also, proceeding the survey a notice is included in our provider newsletter.	Remains an opportunity for improvement.
	UnitedHealthcare Dental should address provider concerns captured during the survey.	The annual provider survey offers providers to submit a question or concern through the survey. If provided, a UnitedHealthcare Dental Network Advocate will outreach to a provider to acknowledge and/or support resolution.	Remains an opportunity for improvement.
	UnitedHealthcare Dental should ensure customer service representatives have access to information that is accurate and know procedures	UnitedHealthcare Dental confirms Member Services and Provider Services have accurate and accessible information along with an escalation	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Dental's Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of UnitedHealthcare Dental's Response
	for obtaining information when accurate answers are not immediately known.	process to support member and provider concerns promptly and efficiently.	
	UnitedHealthcare Dental should evaluate possible changes to the current fee/rate structure to increase MCO desirability among providers, and monitor steps in the payment processes to pinpoint where efficiencies can be made.	The UnitedHealthcare Dental fee schedule includes negotiated rates with network providers.	Remains an opportunity for improvement.

UnitedHealthcare Dental’s 2024 Strengths, Opportunities and 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. (*Title 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. (*Title 42 Code of Federal Regulations 438.320 Definitions.*)

The strengths and opportunities for improvement based on the managed care plan’s 2024 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 38** for **UnitedHealthcare Dental’s**. In the table, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by a checkmark ✓). In some cases, IPRO determined that there were no links between these elements (indicated by gray shading).

Table 38: UnitedHealthcare Strengths, Opportunities, and Recommendations, Measurement Year 2024

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
URAC Accreditation				
Strengths	UnitedHealthcare Dental maintained URAC Accreditation status in 2024.	✓	✓	✓
Opportunities	None.	✓	✓	✓
Recommendation	None.	✓	✓	✓
Performance Improvement Projects				
Strengths	Both of UnitedHealthcare Dental’s quality improvement projects met all validation elements reviewed: <i>Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services</i> and <i>Topical Fluoride for Children</i> .			
	<i>Topical Fluoride for Children</i> – UnitedHealthcare Dental demonstrated performance improvement from baseline to measurement year 2024 on the single indicator and exceeded the performance goal.	✓	✓	✓
Opportunities	<i>Increasing the Percent of Children, Ages 15-18, Receiving Preventive Health Services</i> – UnitedHealthcare Dental demonstrated performance decline from baseline to measurement year 2024 on the single indicator and did not meet goal.	✓	✓	✓
Recommendation	UnitedHealthcare Dental should conduct targeted analyses of quality improvement project data to identify subpopulations and geographic areas with persistently low performance and assess whether provider network composition, appointment availability, or workforce constraints are contributing factors. Interventions should be refined to address identified access and delivery barriers and support sustained improvement across both quality improvement project topics.	✓	✓	✓
Performance Measures				
Strengths	UnitedHealthcare Dental’s performance measure data for measurement year 2024 were determined to be reliable.			
	Core Set Rates – UnitedHealthcare Dental reported 12 dental measure rates for measurement year 2024 that exceeded Rhode Island statewide performance, noting that managed care plan-level rates reflect managed care populations while statewide rates include both managed care and fee-for-service populations.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	EPSDT Rates – UnitedHealthcare Dental demonstrated performance improvement between measurement year 2023 and measurement year 2024 on the five EPSDT rates that were reported.	✓	✓	✓
Opportunities	None.			
Recommendation	None.			
Review of Compliance with Medicaid and Children’s Health Insurance Program Standards				
Strengths	UnitedHealthcare Dental is compliant with the standards reviewed under 42 Code of Federal Regulations Part 438 Managed Care.	✓	✓	✓
Opportunities	None.			
Recommendation	None.			
Network Adequacy				
Strengths	UnitedHealthcare Dental’s network analyses for measurement year 2024 were determined to be reliable.			
	UnitedHealthcare Dental met all state-defined time and distance access standards for general and pediatric dentists and dental specialists for 100 percent of its membership across urban, suburban, and rural regions in all four quarters of measurement year 2024.		✓	✓
Opportunities	Appointment availability survey results for measurement year 2024 indicate that, despite meeting geographic access standards, members experienced difficulty securing timely routine and urgent dental appointments, highlighting an access gap related to appointment availability rather than provider location.		✓	✓
Recommendation	In addition to existing case management interventions, UnitedHealthcare Dental should implement plan-wide strategies to improve appointment availability for all members, including those not engaged in case management, given the network-wide impact of appointment access limitations.	✓	✓	✓
Validation of Quality-of-Care Survey, Member Experience Survey				
Strengths	UnitedHealthcare Dental’s score for <i>likelihood to recommend</i> remained high for measurement year 2024.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities	CAHPS results related to ease of finding a dentist and access to dental care, when considered alongside appointment availability survey findings, indicate persistent challenges in timely access to care for members.		✓	✓
Recommendation	UnitedHealthcare Dental should enhance its response to member experience survey findings by implementing targeted, measurable actions to address identified access and communication barriers, rather than limiting follow-up to high-level dissemination of survey results.	✓	✓	✓
Validation of Quality of Care Survey, Provider Satisfaction Survey				
Strengths	None.			
Opportunities	Provider satisfaction survey response rates remained low in measurement year 2024, limiting the reliability of findings. Although results were not statistically significant, declines were observed across all provider satisfaction measures, and reported provider concerns were consistent with issues identified in prior years.	✓	✓	✓
Recommendation	UnitedHealthcare Dental should implement strategies to improve provider survey participation, including consideration of alternative or mixed-mode survey administration approaches to increase response rates.			
	UnitedHealthcare Dental should evaluate whether the current provider satisfaction survey design yields actionable information and, where deficiencies are identified, revise the survey approach and establish a formal process to ensure provider concerns are systematically reviewed, tracked, and resolved.	✓	✓	✓

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 <i>and</i> why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define <i>all</i> 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.	
<input type="checkbox"/> Medical/treatment records <input type="checkbox"/> Administrative data: <input type="checkbox"/> Claims/encounter data <input type="checkbox"/> Complaints <input type="checkbox"/> Appeals <input type="checkbox"/> Telephone service data <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Hybrid (medical/treatment records and administrative) <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Survey data (attach the survey tool and the complete survey protocol) <input type="checkbox"/> 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 Dianer 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: <input type="checkbox"/> Medical/treatment record abstraction If survey, check all that apply: <input type="checkbox"/> Personal interview <input type="checkbox"/> Mail <input type="checkbox"/> Phone with CATI script <input type="checkbox"/> Phone with IVR <input type="checkbox"/> Internet <input type="checkbox"/> Incentive provided <input type="checkbox"/> Other (list and describe):	If administrative, check all that apply: <input type="checkbox"/> Programmed pull from claims/encounter files of all eligible members <input type="checkbox"/> Programmed pull from claims/encounter files of a sample of members <input type="checkbox"/> Complaint/appeal data by reason codes <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Delegated entity data <input type="checkbox"/> Vendor file <input type="checkbox"/> Automated response time file from call center <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Other (list and describe):
C.3 Sampling. If sampling was used, provide the following information.	

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

C.4 Data Collection Cycle.	Data Analysis Cycle.
<input type="checkbox"/> Once a year <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Once a week <input type="checkbox"/> Once a day <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007)	<input type="checkbox"/> Once a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Continuous <input type="checkbox"/> 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*
	<i>Baseline:</i>						

#2 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

#3 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

* 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.