IPRO
Better healthcare, realized.

RIte Smiles, a Rhode Island Medicaid Dental Program
UnitedHealthcare Dental

2020 External Quality Review
Annual Technical Report

April 2022

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

Table of Contents

List of Tables

I. Executive Summary

Introduction

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care plans (MCPs) 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 MCP. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCPs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCP. The states must further ensure that the EQRO has sufficient information to conduct this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services[1] (CMS). Quality, as it pertains to an EQR, is defined in *42 CFR § 438.320 Definitions* as "the degree to which an MCO[2], PIHP[3], PAHP[4], or PCCM[5] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

The standards of *42 CFR § 438.364 External review results* (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness, and access to health care services that MCPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCPs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with Island Peer Review Organization (IPRO) to assess and report the impact of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provides IPRO's independent evaluation of the services provided by UnitedHealthcare Dental (UHC-Dental) under Rite Smiles, the Rhode Island Medicaid dental program.

Rhode Island RIte Smiles Program

The RIte Smiles program began in 2006 and covers Medicaid-eligible children born on or before May 1, 2000. The EOHHS's Center for Child and Family Health (CCFH) designed RIte Smiles to increase access to dental services beyond the scope of the fee-for-service (FFS) program. Approximately 123,300 members were enrolled in RIte Smiles at the end of 2020.

Scope of External Quality Review Activities

This report focuses on the four federally mandatory EQR activities (validation of performance improvement projects

[1] Centers for Medicare and Medicaid Services Website: https://www.cms.gov/
[2] Managed Care Organization
[3] Prepaid Inpatient Health Plan
[4] Prepaid Ambulatory Health Plan
[5] Primary Care Case Management

[PIPs], validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional EQR activity (validation of quality-of-care surveys) that were conducted. It should be noted that validation of provider network adequacy was instructed at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. As set forth by *42 CFR § 438.358 Activities related to external quality review (b)(1)* EQR activities are:

(i) **Validation[6] of Performance Improvement Projects (Protocol 1) –** This activity validates that MCP performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services. (Note: Rhode Island refers to PIPs as Quality Improvement Projects [QIPs] and the term QIP will be used in the remainder of this report.)

(ii) **Validation of Performance Measures (Protocol 2) –** This activity assesses the accuracy of MCP reported performance measures and determines the extent to which the performance measures follow state specifications and reporting requirements.

(iii) **Compliance Monitoring (Protocol 3) –** This activity determines MCP compliance with its contract and with state and federal regulations.

(iv) **Validation of Network Adequacy (Protocol 4)** – This activity assesses MCP adherence to state standards for time and distance for specific provider types, as well as the MCP's ability to provide timely care. (CMS has not published an official protocol for this activity.)

(v) **Validation of Quality-of-Care Surveys (Protocol 6) –** UHC-Dental conducted 2 quality of care surveys in 2021, one to evaluate member satisfaction with health care and services received and one to evaluate provider satisfaction with UHC-Dental's operations and RIte Smiles benefits. The MCP contracted with a NCQA-certified survey vendor to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the CAHPS Dental Plan Survey.

The results of these EQR activities are reported in the **High-Level Conclusions and Findings** subsection that immediately follows.

High-Level Conclusions and Findings

Validation of Quality Improvement Projects

IPRO's validation of UHC-Dental's 2020 QIPs confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that UHC-Dental was compliant with the standards of *42 CFR § 438.330(d)(2)*. IPRO's assessments of UHC's QIPs found that there were no validation findings that indicated that the credibility of the QIP results was at risk.

Concerning QIP 1, UHC-Dental did not meet its goal to increase the number of RIte Smiles members aged 15 to 18 with preventive dental services. The 2020 remeasurement rate of 36.5% represents UHC-Dental's lowest performance throughout the life of the QIP. However, prior to the COVID-19 pandemic, UHC-Dental demonstrated performance improvement in this area and exceeded the established goal of 56.9%.

[6] CMS defines validation at 42 CFR § 438.320 Definitions as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

Concerning QIP 2, UHC-Dental did not meet its goal to increase the number of RIte Smiles members aged six to nine years with sealants on first molars. The 2020 remeasurement rate of 12.16% represents UHC-Dental's lowest performance throughout the life of the QIP. However, prior to the pandemic, UHC-Dental demonstrated performance improvement in this area but not yet meeting the goal rate of 23.4%.

QIP summaries and detailed validation results are in Section V of this report.

Validation of Performance Measures

IPRO's validation of UHC-Dental's performance measures confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that UHC-Dental was compliant with the standards of *42 CFR § 438.330(c)(2)*. CMS Form 416 was successfully reported by UHC-Dental.

UHC-RI demonstrated performance improvement for one of seven EPSDT measures. More members received oral health services by a non-dentist provider in 2020 from 2019.

All EPSDT performance measure rates are reported in Section V of this report.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

At the time of this report, UHC-Dental had not yet undergone an accreditation process that would have satisfied this requirement. IPRO was unable to conduct the review to determine the state's compliance with conducting a compliance review every three years or to validate UHC-Dental's compliance with federal Medicaid standards.

Validation of Network Adequacy

IPRO's evaluation of UHC-Dental's network evaluation reports confirmed the state's compliance with the requirements of *42 CFR § 438.68 Network adequacy standard (a)* and *(b).* In the absence of a CMS protocol for validation of network adequacy, IPRO assessed UHC-Dental's compliance with the RIte Smiles-established time and distance standards.

UHC-Dental met time and distance standards for 100% of its membership in all regions for all provider types reviewed.

Detailed results of network adequacy assessments are reported in Section V of this report.

Administration of Quality of Care Surveys

Member Satisfaction

Member satisfaction with the RIte Smiles program in 2020 was similar to member satisfaction in 2019 with the exception of a single area of care. Members reported statistically significantly lower satisfaction with getting an emergency appointment within the desired timeframe.

Seven (7) of 21 satisfaction scores demonstrated improvement between 2019 to 2020. However, 12 of the scores were below 90%.

Members reported being satisfied with regularly seen dentists and care received from dentists and staff. Members reported dissatisfaction with ease of finding a dentist and overall access to dental services. Member satisfaction with dental plan services was mixed and declined in 2020 from 2019.

Detailed results of the member satisfaction survey are reported in Section V of this report.

Provider Satisfaction

Provider satisfaction with UHC-Dental in 2020 was similar to provider satisfaction in 2019. There were no statistically significant differences reported. Although more of an indicator of quality of care rather than an indicator of provider satisfaction, 94% of respondents self-reported communicating the importance of using sealants to patients.

Between 2019 and 2020, achievement scores for four of six measures evaluating provider satisfaction with customer service demonstrated improvement, the achievement score for one of three measures evaluating provider satisfaction with UHC-Dental's resolution process demonstrated improvement, the achievement score for one of two measures evaluating provider satisfaction with UHC-Dental's communication demonstrated improvement, achievement scores for four of four measures evaluating provider satisfaction with communications related to prior authorization demonstrated a decline in performance.

Providers were more satisfied with revenue and compensation while more dissatisfied with the electronic claims submission process.

Detailed results of the provider satisfaction survey are reported in Section V of this report.

Recommendations

Per *42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations for improving the quality of care health care services furnished by UHC-dental and recommendations on how EOHHS can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the quality of, timeliness of, and access to health care services furnished to Rhode Island Medicaid managed care enrollees.

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

Recommendations towards achieving the goals of the Medicaid Quality Strategy are in Section III of this report.

EQR Recommendations for United Healthcare Dental

MCP specific recommendations related to the quality of, timeliness of and access to care are in Section VII of this report.

II. Introduction

States that provide Medicaid services through contracts with MCPs are required by federal mandate to conduct EQR activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. EOHHS contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent annual analysis of state and MCP performance related to the quality, timeliness, and accessibility of the care and services it provides. This report is the result of IPRO's evaluation and review of activities in 2020.

III. Rhode Island Medicaid Managed Care

Rhode Island RIte Smiles Program

The RIte Smiles program operates as a component of the State's Medicaid managed care program. RIte Smiles provides dental services to Medicaid-eligible children born on or after May 1, 2000, and who are under age 21[7]. At the end of 2020, there were approximately 123,300 members enrolled in the RIte Smiles program.

The RIte Smiles program was developed by the Rhode Island Executive Office of Health and Human Services, Center for Child, and Family Health (EOHHS-CCFH) to provide increased choice of providers and access beyond the scope of the FFS system. The RIte Smiles dental program began enrollment in September 2006 and is designed to increase access to dental services in both safety net[8] and private practice dental offices for children enrolled in Rhode Island Medicaid.

RIte Smiles, Rhode Island's Medicaid managed care dental program for children, began enrollment in 2006 with the following goals:

- Increase access to primary care dental services for Medicaid-eligible children;
- Increase access to both safety net and private practice dental offices; and
- Promote preventive dental care among Medicaid-eligible children.

RIte Smiles operates as a component of the State's Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which was approved through December 31, 2018[9]. As is typical for Section 1115 waivers, CMS defined "Special Terms and Conditions" (STCs) for the demonstration. The STCs addressing quality assurance and improvement were as follows:

"The State shall keep in place existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 (RIte Care, Rhody Health, Connect Care, RIte Smiles, and PACE.)"

The state contracts with UHC-Dental to manage the RIte Smile dental benefits for children enrolled in Medicaid.

2019 State Medicaid Quality Strategy

For over 25 years, Rhode Island (RI) has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, the contracted Managed Care Entities (MCEs) program have the following responsibilities:

- ensuring a robust network beyond safety-net providers and inclusive of specialty providers;
- increasing appropriate preventive care and services; and

[7] Medicaid-eligible children born before May 1, 2000, remain enrolled in the FFS system.

[8] Safety net providers include public and private non-profit organizations that provide oral health care services for Medicaid-covered individuals. Safety net providers in Rhode Island include Federally-Qualified Health Centers (FQHCs) and hospitals.

[9] In December 2018, the renewal request submitted by EOHHS was approved by CMS, resulting in an extension of the State's Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2023. The Special Terms and Conditions (STCs) of the renewed Waiver include RIte Smiles, in addition to the care delivery systems included in the original Waiver.

- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

Guiding Principles, Goals and Objectives

Rhode Island's Medicaid managed care program is dedicated to improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence, and quality of life. A working group was established to present innovative recommendations to modernize the state's Medicaid program and increase efficiency. The four guiding principles established by the Working Group are:

- pay for value, not volume;
- coordinate physical, behavioral, and long-term health care;
- rebalance the delivery system away from high-cost settings; and
- promote efficiency, transparency, and flexibility.

RI Medicaid also developed the Accountable Entity (AE) program as a core part of its managed care quality strategy which are Rhode Island's version of an accountable care organization. AEs represent interdisciplinary partnership among providers in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. The AE initiative focuses on achieving the following goals:

- Transition Medicaid from fee for service to value-based purchasing at the provider level
- Focus on Total Cost of Care (TCOC)
- 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
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

Evolving from the state's guiding principles, RI Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022. These goals are displayed in **Table 1**.

Table 1: Rhode Island Medicaid Quality Strategy Goals, 2019-2022

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

To support achievement of the Quality Strategy goals, RI Medicaid established specific objectives. The state developed these objectives to focus state, MCE and other activities on interventions likely to result in progress toward the eight managed care goals. These objectives are displayed in **Table 2** along with the attached goal(s).

Table 2: Rhode Island Managed Care Quality Objectives

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

Improvement and Interventions

To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related to the vision and mission, Rhode Island Medicaid engages in multiple interventions. These interventions are based on the results of its MCE assessment activities and focus on the managed care goals and objectives displayed in Table 2. Rhode Island Medicaid's ongoing and expanded interventions for managed care quality and performance improvement include:

- **Ongoing requirements for MCEs to be nationally accredited:** RI Medicaid MCPs are required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status.
- **Tracking participation in APMs related to value-based purchasing (pay for value not volume):** Medicaid MCPs are required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including:
    - Alternate Payment Methodology (APM) Data Report;
    - Value Based Payment Report; and
    - Accountable Entity-specific reports.
- **Pay for Performance Incentives for MCEs and AEs:** RI Medicaid intends to create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics and outcomes – both online and in person.
- **Statewide collaboratives and workgroups that focus on quality of care:** RI Medicaid works with MCEs and the EQRO to collect, analyze, compare, and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement.
- **Soliciting member feedback through a variety of forums and mechanisms:** RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement.

Refer to **Appendix C** of this report for the full 2019-2022 Rhode Island State Medicaid Quality Strategy.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

The EOHHS Medicaid quality strategy aligns with CMS's requirements and provides a framework for MCPs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required EQR activities, EOHHS's quality strategy includes state- and MCP-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

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

In working towards the goals of the 2019-2022 strategy, IPRO recommends that the EOHHS consider:

- Establishing appointment availability thresholds for the Medicaid Managed Care program to hold the MCPs accountable for increasing the availability of timely appointments.
- Updating the Medicaid quality strategy to explicitly state how performance towards the goals will be evaluated. Each goal should be attached to an outcome measure along with baseline and target rates. Interim reporting of rate performance should be provided to the EQRO as part of the annual EQR assessment.
- Developing a separate quality strategy for the dental Medicaid managed care program or dedicate a section in the overall Medicaid quality strategy to RIte Smiles.

IV. United Healthcare Dental

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

Table 3 displays enrollment for the RIte Smiles program for year-end 2018 through year-end 2020, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the time in which the data were abstracted. RIte Smiles enrollment increased by 12% from 110,215 members in 2019 to 123,280 members in 2020.

Table 3: RIte Smiles Enrollment, 2018-2020

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

UHC-Dental's 2020 Quality Improvement Program

The EOHHS 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. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members. UHC-Dental's *2020 Quality Improvement Program Description* meets these requirements.

Objectives and Goals

The UHC-Dental Quality Improvement (QI) Program addresses various elements of care, including accessibility, availability, and continuity of care, and monitors the provision and utilization of services to ensure they meet standards of care. The objectives of UHC-Dental's QI Program are to:

- Objectively and systematically monitor and evaluate aspects of member care.
- Provide a system for the identification of opportunities for improvement and implement strategies to achieve improvement in care and services to members.
- Promote the coordination, documentation, and communication of plan wide quality management and QI activities.
- Monitor the effectiveness of network quality management and peer review activities including the selection and performance of dentists who review issues, the outcomes and effectiveness of those reviews, and their remedial actions.
- Promote inter-departmental collaboration in network-wide QI activities.
- Promote compliance by network Providers with defined credentialing requirements, standards of care, access, availability of services, dental record documentation, and guidelines for the use of preventive dental services and clinical guidelines.
- Provide a mechanism for the credentialing and recredentialing of network and oversight of delegated credentialing that complies with nationally recognized credentialing standards.

- Implement and oversee preventive dental health systems to improve the oral and overall health status of members.

Table 4 displays UHC-Dental's QI goals as reported in the *2020 Quality Improvement Program Description*.

Table 4: UHC-Dental's Quality Improvement Goals for the RIte Smiles Program, 2020

Quality Improvement Goals
1. To measure, monitor, trend, and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks
2. To foster continuous QI in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement
3. To evaluate the effectiveness of implemented changes to the QI Program
4. To reduce or minimize opportunity for adverse impact to Members
5. To improve efficiency, cost effectiveness, value, and productivity in the delivery of oral health services
6. To promote effective communications, awareness, and cooperation between members, participating providers, and the plan
7. To comply with all pertinent legal, professional, and regulatory standards
8. To ensure quality of care, dentists are vetted through a credentialing and recredentialing process
9. To foster the provision of appropriate dental care according to professionally recognized standards
10. To ensure that written policies and procedures are established and maintained by the plan to ensure that quality dental care is provided to the members
11. When indicated, implement improvement plans and document actions taken to improve performance
12. Communicate results of performance measurement to the committees

Quality Improvement Program Activities

The UHC-Dental utilizes a variety of tools to measure and evaluate services provided to RIte Care members. Some of these tools include:

- Appointment availability survey results
- Member complaints and grievances data
- Provider disputes, grievances, and appeals data
- Member and provider satisfactions survey results
- Provider adherence to adopted clinical guidelines
- Findings from quality of care and quality of services oversight and monitoring activities
- Customer service data
- Dental records
- Emergency dental care data

Quality Improvement Program Oversight

UHC-Dental's Quality Improvement Committee oversees the effectiveness of quality management, QI, and preventive oral health education activities. Quarterly status reports disseminated to stakeholders of the QI Program. Documentation regarding the implementation of recommendations for system changes, corrective actions, educational endeavors, and overall effectiveness is maintained.

An annual evaluation of the QI Program is completed to ascertain that the goals are met, and improvement initiatives are effective. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the work plan. Any barriers to the QI process are analyzed and identified to create actions to overcome all barriers to the improvement process.

Development of the annual QI Program considers findings from the program evaluation (i.e., needed improvements, changes in process or structure, follow-up studies) in addition to activities mandated by state and federal programs, and client contractual agreements. UHC-Dental's QI Program Evaluation and Annual Work Plan were reviewed and approved by the Quality Improvement Committee and the BOD.

Table 5 displays key organizational roles of the UHC-Dental QI program.

Table 5: UHC-Dental's Organizational Structure for Quality Improvement

Title	Responsibilities
Board of Directors	Responsible for oversight of the QI Program.
Vice President, Dental Operations	Responsible for the clinical advancement of members. The vice president (VP) is the clinical executive specifically responsible for the execution of the QI, medical management, care delivery transformation, performance measurement, transparency, and dental care affordability programs throughout UnitedHealthcare Dental.
National Chief Dental Director	A licensed dentist responsible for the oversight and evaluation of the clinical quality of dental care services provided to Members and supervises and provides clinical direction to the National QI Program.
Clinical QI Director	Responsible for the oversight of QI activities; direction of the QI Program; and implementation, direction, and evaluation of program objectives.
Dental Plan Dental Director	Responsible for the development, implementation, and review of the internal QI program, which includes oversight of the Utilization Review and Quality Improvement Committees; development of dental practice standards and protocols; investigation of all potential quality of care problems; development and implementation of corrective action plans; development of dental policies; and the referral process for specialty and out-of-plan services. The Chief Dental Director also serves as a liaison between the plan and its providers and communicates regularly with the plan's providers addressing areas of clinical relevance.
Community Based Coordinator	A registered dental hygienist (RDH) who is assigned to practices with large panels that have members who are non-compliant in HEDIS® measures. The community-based coordinator (CBC) also coordinates activities and community events to provide a comprehensive full spectrum of education and support to the provider practices.
Quality Improvement Committee	The decision-making body that is responsible for the implementation, coordination, and integration of all QI activities for the dental plan.

V. EQR Findings and Conclusions Related to Quality, Timeliness and Access

To assess the impact of the RIte Smiles program on **access** to, **timeliness** of, and **quality** of dental care, IPRO reviewed pertinent information from a variety of sources, including state managed care standards, MCP contract requirements, performance measures, and state monitoring reports.

This section of the report discusses the results, or findings, from the required EQR activities (validation of PIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity. For each EQR activity, a summary of the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions and findings are presented.

UHC-Dental's strengths and recommendations related to the **quality** of, **timeliness** of and **access** to care. These three elements are defined as:

- **Quality** is the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP'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 MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

Additionally, **Section VI** of this report includes IPRO's assessment of UHC-Dental's response to the EQR 2019 recommendations per *42 CFR § 438.364 External quality review results (a)(6).*

Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(i) mandates that the state or an EQRO must validate the PIPs that were underway during the preceding twelve (12) months. IPRO performed this activity for the 2020 QIPs. The QIP validation was conducted using an evaluation approach developed by IPRO and consistent with the CMS EQR *Protocol 1-Validation of Performance Improvement Projects*.

MCPs were required to conduct at least two (2) QIPs directed at the needs of the Medicaid-enrolled population, as well as the MCP-established Communities of Care programs[10].

[10] The State's *Medicaid Managed Care Services Contract* (July 2018) requires that all Health Plans establish and maintain a Communities of Care program designed to decrease non-emergent and avoidable emergency department (ED) utilization through service coordination, defined member responsibilities, and associated incentives and rewards.

Technical Methods of Data Collection and Analysis

All QIPs were documented using NCQA's *Quality Improvement Activity* (QIA) *Form*. A copy of the *QIA Form* is in Appendix A of this report.

The QIP assessments were conducted using an evaluation approach developed by IPRO and consistent with CMS EQR *Protocol 1-Validation of Performance Improvement Projects*. IPRO's assessment includes the following ten elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCP'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 MCP's enrollment and generalizable to the MCP's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the QIP.
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 MCP achieved sustained improvement.

Upon IPRO's review of the 2020 QIP QIA Forms completed by the MCPs and provided to IPRO by EOHHS, a determination was made as to the overall credibility of the results of each QIP, with assignment of one of three categories:

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

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and 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.

Conclusions and Findings

UnitedHealthcare Dental conducted the following QIPs in 2020:

- QIP 1 – Increasing the Percent of Children Receiving Preventive Health Services and Increasing the Percent of Children Receiving Preventive Health Services
- QIP 2 – Fissure Sealants on First or Second Molars

IPRO's assessment of UHC-Dental's QIP methodology found that there were no validation findings that indicated that the credibility of the QIP results was at risk. Table 6 displays a summary of the UHC-Dental's QIP assessments. Summaries of each QIP immediately follow.

Table 6: QIP Validation Findings, 2020

Validation Element	QIP 1	QIP 2
Selected Topic	Met	Met
Study Question	Met	Met
Indicators	Met	Met
Population	Met	Met
Sampling Methods	Met	Met
Data collection Procedures	Met	Met
Interpretation of Study Results	Met	Met
Improvement Strategies	Met	Met

QIP 1: Increasing the Percent of Children Receiving Preventive Health Services

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

Indicator/Goal: UHC-Dental evaluated the percentage of children aged 15 to 18 years continuously enrolled for at least 90 days in RIte Smiles who received one of the following preventive services: prophylaxis, topical fluoride, or sealant. UHC-Dental's goal was to increase levels of preventive health services by 10% percent by the end of September 2020 (56.87%).

Member-focused Interventions:

- Collaborated with school-based lunch programs to deliver breakfast and lunch to children 18 and under to include dental kits with the meal packages.
- Participated in a 2-day back to school event by distributing oral health kits and healthy habits flyer to students picking up back packs.
- A patient-centered video of the Paw Sox mascot having a dental visit was made by UHC-Dental and played at Blackstone Valley Community Health Center for patients to watch in the waiting room.
- UHC-Dental and PawSox collaborated to distribute dental education via dental kits to Dining on the Diamond attendees.
- Events were hosted and attended by UHC-Dental with the goal of increasing member awareness of the value of preventive dental visits. In 2020, UHC-Dental engaged with attendees at the Pawtucket Boys & Girls Club to provide education on dental hygiene.
- Interactive voice messaging reminding members to complete annual dental visits were made periodically throughout 2020.
- UHC-Dental and Paw Sox conducted a series of engagement activities to educate members and caretakers on proper dental care.

Provider-focused Interventions:

- Continued distribution of gaps in care lists to the top 20 dental providers identified as having the highest volume of plan members and the highest number of plan members with no services within the past two years.
- Conducted clinical engagement sessions with high volume dental practices in Providence, Rhode Island.

Results: UHC-Dental reported a re-measurement rate of 36.48% for the period of 10/1/19-9/30/20, which is below the performance goal rate of 56.87% by 20.39 percentage points. **Table 7** displays the results of the PIP including measurement periods, numerators, denominators, and overall project goal.

Table 7: QIP 1 Indicator – Adolescent Members with Preventive Health Services, 2016-2020

Time Period Measurement Covers	Measurement	Numerator	Denominator	Results	Goal
Jan 1, 2016 – Dec 31, 2016	Baseline	4,875	9,429	51.70%	Not Applicable
Apr 1, 2016 – Mar 31, 2017	Re-measurement 1	5,566	10,994	50.63%	56.87%
Jul 1, 2016 – Jun 30, 2017	Re-measurement 2	6,265	12,478	50.21%	56.87%
Oct 1, 2016 – Sep 30, 2017	Re-measurement 3	7,019	14,086	49.83%	56.87%
Jan 1, 2017 – Dec 31, 2017	Re-measurement 4	5,626	11,136	50.52%	56.87%
Apr 1, 2017 – Mar 31, 2017	Re-measurement 5	8,481	17,452	48.60%	56.87%
Jul 1, 2017 – Jun 30, 2018	Re-measurement 6	9,124	18,877	48.33%	56.87%
Oct 1, 2017 – Sep 30, 2018	Re-measurement 7	9,999	19,283	51.85%	56.87%
Jan 1, 2018 – Dec 31, 2018	Re-measurement 8	10,879	21,323	51.02%	56.87%
Apr 1, 2018 – Mar 31, 2019	Re-measurement 9	11,351	21,539	52.69%	56.87%
Jul 1, 2018 – Jun 30, 2019	Re-measurement 10	11,643	21,886	53.20%	56.87%
Oct 1, 2018 – Sep 30, 2019	Re-measurement 11	12,255	20,471	59.87%	56.87%
Jan 1, 2019 – Dec 31, 2019	Re-measurement 12	13,262	21,324	62.19%	56.87%
Apr 1, 2019 – Mar 31, 2020	Re-measurement 13	Not Reported	Not Reported	Not Reported	56.87%
Jul 1, 2019 – Jun 30, 2020	Re-measurement 14	11,430	24,112	47.40%	56.87%
Oct 1, 2019 – Sep 30, 2020	Re-measurement 15	8,698	23,846	36.48%	56.87%

QIP 2: Increasing the Percent of Children Receiving Pit and Fissure Sealants on First or Second Molars

Aim: UHC-Dental aimed to increase the percent of children receiving sealants on their first molars for Medicaid members enrolled for at least 90 days by ten percentage points from 2011-year-end results.

Indicator/Goal: The indicator for this QIP is the percentage of children aged six to nine years continuously enrolled for 90 days in RIte Smiles, who received a pit and fissure sealant on their first molars. The goal for this QIP is to increase the percentage of children who received this service to 23.4%.

Member-focused Interventions:

- Collaborated with school-based lunch programs to deliver breakfast and lunch to children 18 and under to include dental kits with the meal packages.
- Participated in a two-day back to school event by distributing oral health kits and healthy habits flyer to students picking up back packs.
- A patient-centered video of the Paw Sox mascot having a dental visit was made by UHC-Dental and played at Blackstone Valley Community Health Center for patients to watch in the waiting room.
- UHC-Dental and Paw Sox collaborated to distribute dental education via dental kits to Dining on the Diamond attendees.
- Distributed dental kits at two elementary schools in Providence, Rhode Island.
- Events were hosted and attended by UHC-Dental with the goal of increasing member awareness of the value of preventive dental visits. In 2020, UHC-Dental engaged with attendees at the Pawtucket Boys & Girls Club to provide education on dental hygiene and collaborated with the Rhode Island Dental Hygienists' Association to provide oral health education to children and caretakers at the Providence Children's Museum.

- Collaborated with Ella Risk elementary school to provide dental screenings and sealant placement to students.
- Interactive voice messaging reminding members to complete annual dental visits were made periodically throughout 2020.

Provider-focused Interventions:

- Continued distribution of gaps in care lists to the top 20 dental providers identified as having the highest volume of plan members and the highest number of plan members with no services within the past two years.

Results: UHC-Dental reported a re-measurement rate of 12.16% for the period of 10/1/19-9/30/20, which was below the QIP goal rate of 23.4% by 10.8 percentage points. **Table 8** displays the results of the PIP including measurement periods, numerators, denominators, and overall project goal.

Table 8: QIP 2 Indicator – Children with Pit and Fissure Sealants, 2016-2020

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

IPRO's assessment of UHC-Dental's strengths and opportunities for improvement related to QIPs, as well as recommendations to improve **quality**, **timeliness** and **access** are presented in **Section VII** of this report.

Validation of Performance Measures

Objectives

The EPSDT measures assess the effectiveness of state EPSDT programs for Medicaid-eligible individuals under the age of 21 years. These measures examine the number of children and adolescents who received health screenings and preventive health services, were referred for corrective treatment, and who received dental treatment. Individuals enrolled in managed care and FFS programs are included in the EPSDT measures. Reporting of EPSDT measure rates is required by CMS for any state that supervises or administers a medical assistance program under Title XIX of the Social Security Act.

States must develop a dental services periodicity schedule, which outlines when members should receive dental treatments and exams. The RIte Smiles periodicity schedule requires that a child receive a clinical dental exam either at the eruption of the first tooth or no later than 12 months old, and then at least every six months following the initial exam or as clinically indicated. The *Rhode Island EPSDT Schedule for Pediatric Oral Health Care* is in Appendix B of this report.

Technical Methods of Data Collection and Analysis

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

Annual rates of dental services reported on the CMS 416 EPSDT Report are compared by health plan and by year to assure data completeness.

The measurement period for the 2020 EPSDT measures is January 1, 2020, to December 31, 2020. The age groups are reported based on each individual's age as of September 30th of the measurement year, not the age the individual was at the time the services were rendered.

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

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

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

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

Description of Data Obtained

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

Conclusions and Findings

UHC-RI demonstrated performance improvement for one of seven EPSDT measures. More members received oral health services by a non-dentist provider in 2020 from 2019. **Table 9** displays UHC-RI's EPSDT measure rates for MY 2018, MY 2019 and MY 2020.

Table 9: UHC-RI's EPSDT Measure Rates, MY 2018-MY 2020

EPSDT Measure	MY 2018		MY 2019		MY 2020	
	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	68,288	49.6%	69,731	51.4%	54,958	40.2%
Preventive Dental Services	62,976	45.8%	64,448	47.5%	47,847	35.0%
Dental Treatment Services	28,319	20.6%	26,076	19.2%	22,944	16.8%
Sealant on a Permanent Molar	8,878	6.5%	9,259	6.8%	6,217	4.5%
Dental Diagnostic Services	66,558	48.4%	67,907	50.0%	51,733	37.8%
Oral Health Services Provided by a Non-Dentist Provider	1,959	1.4%	226	0.2%	1,454	1.1%
Any Dental or Oral Health Services	69,517	50.5%	69,856	51.5%	54,958	40.2%
Total Eligible for EPSDT[3]	137,564		135,698		136,863	

[1] Medicaid members enrolled in both managed care and FFS programs are included in all totals.
[2] Rates were calculated by IPRO using the "Total Eligible for EPSDT" as the denominator, as reported by UHC-Dental, for all measures.
[3] Only individuals who were eligible for EPSDT for 90 continuous days were included in the numerators and denominator

Review of Compliance with Medicaid and CHIP Managed Care Regulations

At the time of this report, UHC-Dental had not yet undergone an accreditation process that would have satisfied this requirement. IPRO was unable to conduct the validation to determine the state's compliance with conducting a compliance review every three years or to validate UHC-Dental's compliance with federal Medicaid standards.

Validation of Network Adequacy

Objectives

In the absence of a CMS protocol for 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv), IPRO assessed MCP compliance with the standards of 42 CFR § 438.358 Network adequacy standards and Section 2.09.02 of the state's Medicaid Managed Care Services Contract.

MCPs must ensure that a sufficient number of primary and specialty care providers are available to members to allow for a reasonable choice among providers. This is required by federal Medicaid requirements, state licensure requirements, NCQA accreditation standards, and the state's Medicaid Managed Care Services Contract.

It is important to note that the Medicaid Managed Care Services Contract has never had "reasonable distance" standards. Regarding the provider network, Section 2.08.01 of the Medicaid Managed Care Services Contract states:

"The Contractor will establish and maintain a robust geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder, and long-term services for the anticipated number of enrollees in the services area; (2) maintain providers in sufficient number, mix, and geographic areas; and (3) make available all services in a timely manner."

For primary care, Section 2.08.03.06 of the Contract states:

"The Contractor agrees to assign no more than fifteen hundred (1,500) members to any single PCP in its network. For PCP teams and PCP sites, the Contractor agrees to assign no more than one thousand (1,000) members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to three thousand (3,000) members."

With respect to access, the Medicaid Managed Care Services Contract has always contained service accessibility standards (e.g., days-to-appointment for non-emergency services), including a "travel time" standard in Section 2.09.02 of the State's Medicaid Managed Care Services Contract, July 2020, which states as follows:

"The Contractor will develop, maintain, and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State-established provider-specific network adequacy standards. The Contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided. Members may, at their discretion, select a participating provider located farther from their home."

Consequently, the standards against which reasonable distances are assessed are developed by each MCP, based on MCP-specific criteria. The Medicaid Managed Care Contract also has a "mainstreaming" provision requiring that,

if a network's provider practice is open to any new patients, then the practice must accept Medicaid managed care enrollees.

Technical Methods of Data Collection and Analysis

RIte Smiles' provider network is monitored for provider accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers' offices and members' homes can be assessed to determine whether members have access to care within a reasonable distance from their homes.

UHC-Dental monitors its networks ability to provide timely routine and urgent dental 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.

IPRO's evaluation included a comparison of United Dental's access data to the State's time and distance standards and a review of appointment availability rates. RIte Smiles' access standard for all general and pediatric dentists was one provider within 20 miles and 20 minutes of a member's home; and one provider within 30 miles and 30 minutes for specialists. RIte Smiles' appointment standards are within 60 days for routine care and within 48 hours for urgent care.

Description of Data Obtained

IPRO's evaluation was performed using network data submitted by UHC-Dental in the *RIteSmiles Dental Network Accessibility Analysis Report* produced in October 2020 and the *RIte Smiles Access Survey Report* for the fourth quarter of 2020.

Conclusions and Findings

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

Table 10 displays RIte Smiles performance against the urban, suburban, and rural area geographic access standards by provider type.

Table 10: GeoAccess Provider Network Accessibility, October 2020

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

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

Table 11 displays the results of the appointment availability survey conducted in the fourth quarter of 2020.

Table 11: Appointment Availability for Network Providers, Fourth Quarter of 2020

Appointment Type	Appointment Standard	# of Providers Surveyed	# of Appointments Made	% of Appointments	% of Timely Appointments
Routine	Within 60 days	133	61	45.9%	45.9%
Urgent	Within 48 hours	140	58	41.4%	30.7%

IPRO's assessment of UHC-Dental's strengths and opportunities for improvement related to network adequacy, as well as recommendations to improve quality, timeliness, and access are presented in Section VII of this report.

Validation of Quality of Care Surveys – Member Experience

Objectives

The EOHHS requires contracted health plans to evaluate and report on member satisfaction annually. UHC-Dental utilizes the CAHPS® Dental Plan Survey to capture such data. The CAHPS® Dental Plan Survey is a standardized questionnaire that asks enrollees to report on their experiences with care and services from a dental plan, the dentists, and their staff.

The CAHPS® Dental Plan Survey is used by those interested in assessing, improving, and reporting on the quality and value offered by dental plans. Objectives include capturing member ratings and assessing member perceptions.

SPH Analytics, a certified CAHPS® vendor, administered the CAHPS® Dental Plan Survey on behalf of UHC-Dental in 2020.

Technical Methods of Data Collection and Analysis

The CAHPS® Dental Plan Survey tool was modified to meet the objectives of the UHC-Dental study.

All data were collected by SPH Analytics using a telephone methodology. Interviews were completed using a computer-assisted telephone interviewing (CATI) approach and were conducted between October 28, 2020, and November 17, 2020.

Members who have had at least one dental visit in the last 12 months and continuously enrolled for the same period were eligible for the survey. UHC-Dental supplied the sample to the vendor, including names and contact information, for 12,487 eligible members. A quota was set at 400 completed interviews, and in total, 211 completed interviews were obtained, resulting in a response rate of 1.7%. SPH Analytics processed all completed surveys and analyzed the results.

Member responses to questionnaire items are summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. In general, somewhat positive responses are included with positive responses as achievements. Specifically, a response of "Usually" or "Always" is considered an achievement, as are responses of "8", "9", or "10" to rating questions.

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

Description of Data Obtained

IPRO received a copy of the final study report produced by SPH Analytics for UHC-Dental and utilized the reported results to assess member satisfaction with the RIte Smiles program as overseen by UHC-Dental.

Findings and Conclusions

Member satisfaction with the RIte Smiles program in 2020 was similar to member satisfaction in 2019 with the exception of a single area of care. Members reported statistically significantly lower satisfaction with getting an emergency appointment within the desired timeframe.

Member loyalty remained high with 94% of surveyed members responding positively to recommending the RIte Smiles program to others. Member satisfaction remained high with regularly seen dentists and demonstrated care from dentists and staff.

Although member satisfaction with ease of finding a dentist demonstrated improvement between 2019 and 2020, dissatisfaction with this area remains high.

Member satisfaction with care received from dentists and staff remained high. Achievement scores for three of five measures demonstrated improvement.

Member satisfaction with access to dental care declined between 2019 and 2020 and remained low despite the demonstrated performance improvement for three of five measures evaluating this area. All achievement scores performed below 90%. As mentioned above, more members dissatisfied with the availability of emergency appointments.

Although achievement scores for five of five measures evaluating member satisfaction with dental plan services demonstrated performance decline, UHC-Dental's performance in this area was mixed. While 90% of members surveyed reported being satisfied with the health plan information used to identify a dentist, only 69% of members reported finding needed information from the health plan's member services department, written materials, or website. Further, only 64% of members surveyed reported receiving needed information from UHC-Dental's member services department.

Table 12 displays the results of the 2019 and 2020 CAHPS Dental Plan Survey administered for UHC-Dental.

Table 12: Member Dental CAHPS Results, 2019 and 2020

Measures	CAHPS 2019	CAHPS 2020
Would you recommend RIte Smiles by UHC-Dental to someone who wanted to join?	95.7%	94.2%
Rating of dental care[1]	88.7%	88.1%
Rating of regular dentist[1]	91.8%	90.9%
Rating of ease of finding a dentist [1]	69.5%	72.3%
Care from dentists and staff composite[2]	95.9%	95.5%
Dentist explained things in a way that was easy to understand	96.2%	95.2%
Dentist listened carefully	94.9%	96.3%
Dentist treated you with courtesy and respect	97.3%	97.9%
Dentist spent enough time with you	95.4%	91.5%
Dentist/dental staff did everything to make you feel comfortable during dental work	96.7%	97.1%
Dentist/dental staff explained what they were doing while treating you	95.0%	94.8%
Access to Dental Care composite[2]	73.1%	72.3%
Regular dental appointments were as soon as you wanted	84.7%	85.2%
Emergency appointments were as soon as you wanted[3]	89.9%	82.4%▼
Appointments with dental specialists were as soon as you wanted	71.9%	73.3%
Spent more than 15 minutes in the waiting room before seeing someone[4]	81.2%	83.3%
If waited more than 15 minutes, were updated on reason and length of delay	38.1%	37.3%

Measures	CAHPS 2019	CAHPS 2020
Dental plan services[2]	NA	NA
Found needed information from member service number, written materials, or website	75.0%	68.6%
Information helped you find a dentist you were happy with[3]	90.9%	90.0%[5]
Received needed information from dental plan's member service	68.2%	64.3%[5]
Member service staff treated you with courtesy and respect	88.2%	87.0%
Satisfaction with the dental plan's member service[1]	87.4%	81.5%

[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 2020 rate is statistically significantly lower than the 2019 rate.

Validation of Quality of Care Surveys – Provider Satisfaction

Objectives

The EOHHS requires contracted health plans to evaluate and report on provider satisfaction annually. UHC-Dental contracted with SPH Analytics, a certified CAHPS® vendor, to administer the 2020 provider satisfaction survey. The objectives of the survey included gauging satisfaction among providers with UHC-Dental, exploring program attributes that are most liked and disliked by providers, identifying attributes that may help improve the relationship between UHC-Dental and providers.

Technical Methods of Data Collection and Analysis

The provider satisfaction survey tool was developed by SPH Analytics to meet the objectives of the UHC-Dental study.

The respondent sample was drawn from the client-provided list of dental care providers in Rhode Island. A total of 36 providers were selected for inclusion in the sample.

All data were collected by SPH Analytics using a telephone methodology. Interviews were completed November 5, 2020, to December 11, 2020. Phone interviews were conducted until five attempts were made to contact all Rhode Island Providers in the client-provided sample.

Provider responses to questionnaire items are summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. Satisfaction achievement scores were calculated using response of "9" or "10" to rating questions.

All statistical significance attained is determined through a test of independent portions

Description of Data Obtained

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

Conclusions and Findings

Provider satisfaction with UHC-Dental in 2020 was similar to provider satisfaction in 2019. There were no statistically significant differences reported. Although more of an indicator of quality of care rather than an indicator of provider satisfaction, 94% of respondents self-reported communicating the importance of using sealants to patients.

Achievement scores for four of six measures evaluating provider satisfaction with customer service demonstrated improvement between 2019 and 2020. Providers were more satisfied with accuracy of information, resolutions achieved on first call, courteousness and friendliness of customer service representative, and thoroughness of responses. Provider dissatisfaction with call center knowledge increased, and provider satisfaction with customer service representatives' willingness to help remained the same.

The achievement score for one of three measures evaluating provider satisfaction with UHC-Dental's resolution process demonstrated improvement between 2019 and 2020. Providers were more satisfied with the overall resolution process. Provider dissatisfaction with resolution timeliness and verification of member eligibility increased.

The achievement score for one of two measures evaluating provider satisfaction with UHC-Dental's communication demonstrated improvement. Providers were more satisfied with overall communications received from UHC-Dental about RIte Smiles. Provider dissatisfaction with provider education materials offered by UHC-Dental increased.

Achievement scores for four of four measures evaluating provider satisfaction with communications related to prior authorization demonstrated a decline in performance. Providers were more dissatisfied with communications received, timeliness of responses, clarity of approval criteria and ease of submission.

Lastly, providers were more satisfied with revenue and compensation while more dissatisfied with the electronic claims submission process.

Table 13 displays the results of the 2019 and 2020 Provider Satisfaction Survey administered for UHC-Dental.

Table 13: Provider Satisfaction Survey Results, 2019 and 2020

Measures	CAHPS 2019	CAHPS 2020
Call Center Customer Service Performance Ratings		
Accuracy of information provided	50%	51%
Amount of knowledge	38%	34%
Ability of representatives to correctly resolve your issue on the first call	38%	49%
Courtesy and friendliness	51%	66%
Willingness to help	49%	49%
Thoroughness of responses	38%	43%
Resolution Process Performance Ratings		
Satisfaction with the resolution process	33%	34%
Resolving issues in a timely manner	35%	26%
Making it easy to verify eligibility of patients	61%	46%
Network Advocate Performance Ratings		
Being accessible	45%	55%
Being responsive to your needs	50%	64%

Measures	CAHPS 2019	CAHPS 2020
Being knowledgeable	52%	59%
Being courteous and professional	65%	59%
Communications Performance Ratings		
The overall communications you receive from RIte Smiles	33%	43%
The provider education materials offered to you by your plan	39%	23%
Claims Process Performance Ratings		
Perceptions of the electronic claim submission process	66%	54%
Revenue and Compensation Performance Ratings		
Adequately compensating you	22%	29%
Communication During the Prior Authorization		
Communications you receive from the RIte Smiles	65%	41%
Timeliness of responses	75%	59%
Clarity of approval criteria	46%	35%
Ease of submission	58%	53%
Providers' Perceptions of RIte Smiles for Scheduling Patient Visits		
Responsiveness of RIte Smiles parents to your treatment recommendations	32%	39%
Frequency of RIte Smiles patients canceling appointments as compared to other dental plans' patients	32%	35%
Satisfaction with the range of services provided by RIte Smiles as compared to other government dental plans	42%	39%
Sealant Agreement Ratings		
The dental staff communicated the importance of using sealants	91%	94%

VI. United Healthcare Dental's Response to the 2019 EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCP. PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 14** displays the assessment categories used by IPRO to describe MCP progress towards addressing the to the 2019 EQR recommendations. **Table 15** displays UHC-Dental's progress related to the *UnitedHealthcare Dental – RIte Smiles Annual External Quality Review Technical Report, Reporting Year 2018*, as well as IPRO's assessment of UHC-Dental's response.

Table 14: MCP Response to Recommendation Assessment Levels

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

Table 15: IPRO's Assessment of UHC-Dental's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCP Response
UHC-Dental should consider the use of mobile dental services to increase member access to services.	Remains an Opportunity for Improvement
UHC-Dental should consider conducting a member satisfaction survey to understand better member perceived issues with quality, timeliness, and access to care.	Partially Addressed
UHC should continue its efforts to integrate public health dental hygienists (PHDHs) within FQHCs and identify other opportunities to integrate dental care within medical sites.	Remains an Opportunity for Improvement
UHC-Dental should continue with its approach to re-educate network providers of appointment standards and request providers submit a plan of correction should standards continue to not be met.	Remains an Opportunity for Improvement

VII. Strengths, Opportunities and 2020 Recommendations Related to Quality, Timeliness and Access

IPRO's external quality review concludes that, in the measurement period 2018-2020, UHC-Dental RIte Smiles program has had a positive impact on the quality and accessibility of services provided to Medicaid recipients, which is supported by the overall increase of members receiving "any dental service" (EPSDT measure). However, overall opportunities to improve dental care remain.

The MCP's strengths and opportunities for improvement identified during IPRO's EQR 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 an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP'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 MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

The strengths and opportunities for improvement based on the MCP's 2020 performance, as well recommendations for improving **quality**, **timeliness,** and **access** to care are presented in **Table 16.** In this table, links between strengths, opportunities, and recommendations to **quality**, **timeliness** and **access** are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Table 16: Strengths, Opportunities and Recommendations for Improvement, 2020

EQR Activity	EQRO Statement	Quality	Timeliness	Access
Strengths				
QIPs	IPRO's assessments of UHC-Dental's QIPs found that there were no validation findings that indicated that the credibility of the QIP results was at risk.			
Performance Measures	UHC-Dental's EPSDT data was successfully reported to CMS.			
Performance Measures	UHC-RI demonstrated performance improvement for one of seven EPSDT measures. More members received oral health services by a non-dentist provider in 2020 from 2019.		X	X
Network Adequacy	UHC-Dental continued to meet time and distance standards, with 100% of its membership having adequate access to all provider types within the urban, suburban, and rural geographic areas.		X	X
Compliance with	Not applicable.			

EQR Activity	EQRO Statement	Quality	Timeliness	Access
Medicaid Standards				
Quality of Care Surveys – Member Satisfaction	Members reported being satisfied with regularly seen dentists and care received from dentists and staff.	X		
Quality of Care Surveys – Provider Satisfaction	Of the providers surveyed, 94% of respondents self-reported communicating the importance of using sealants to patients.	X		
Opportunities for Improvement				
QIPs – Preventive Dental Services	UHC-Dental did not meet its goal to increase the number of RIte Smiles members aged 15 to 18 with preventive dental services. The 2020 remeasurement rate of 36.5% represents UHC-Dental's lowest performance throughout the life of the QIP. However, prior to the COVID-19 pandemic, UHC-Dental demonstrated performance improvement in this area and exceeded the established goal of 56.9%.	X		X
QIPs – Dental Sealants	UHC-Dental did not meet its goal to increase the number of RIte Smiles members aged six to nine years with sealants on first molars. The 2020 remeasurement rate of 12.16% represents UHC-Dental's lowest performance throughout the life of the QIP. However, prior to the pandemic, UHC-Dental demonstrated performance improvement in this area but not yet meeting the goal rate of 23.4%.	X		
Performance Measures	UHC-RI demonstrated performance decline for six of seven EPSDT measures. Fewer members received any dental service in 2020 from 2019.	X	X	X
Network Adequacy	Among surveyed providers, 53% reported timely appointments for routine care and 43% reported timely appointments for urgent care.		X	X
Compliance with Medicaid Standards	Not applicable.			
Quality of Care Surveys	Members reported statistically significantly lower satisfaction with getting an emergency appointment within the desired timeframe. Members reported dissatisfaction with ease of finding a dentist and overall access to dental services. Member satisfaction with dental plan services was mixed but declined overall. Members reported increasing dissatisfaction with the UHC-Dental member services department.	X	X	X
Quality of Care Surveys	Twenty-four (24) of 25 achievement scores for measures evaluating provider satisfaction with the UHC-Dental and the RIte Smiles program performed below 90%. These scores ranged from 23% to 66%.	X	X	X
Recommendations to UHC-Dental to Address Quality, Timeliness and Access				

EQR Activity	EQRO Statement	Quality	Timeliness	Access
QIPs	As QIP targets were not met, continue to QI efforts to increase preventive service and sealants on first molars.	X	X	X
Performance Measures	UHC-Dental should continue its efforts to educate members on the importance of dental care.	X	X	X
Network Adequacy	Consider the use of mobile services to increase member access to dental care.		X	X
Network Adequacy	Continue efforts to integrate PHDHs within FQHCs and identify other opportunities to integrate dental care within medical sites.	X	X	X
Network Adequacy	Continue provider reeducation on appointment standards and request providers submit a plan of correction should standards continue to not be met.		X	X
Compliance with Medicaid Standards	Despite not undergoing a review, UHC-Dental should evaluate its own compliance with Medicaid standards and proactively address areas of noncompliance. UHC-Dental should document evidence of such activities.	X	X	X
Quality of Care Surveys	Conduct root cause analysis to identify the reasons driving member perceived barriers to finding general and specialty dentists and accessing dental care.		X	X
Quality of Care Surveys	Consider evaluating member services performance using a secret shopper methodology to assess the validity of increasing member dissatisfaction with obtaining needed information and courteousness and respectfulness of member services representatives.		X	X

VIII. Appendix A: NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

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

C.1 Data Sources.

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

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

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

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

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

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

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

C.4 Data Collection Cycle.

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

Data Analysis Cycle.

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

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

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.
Include, as appropriate: I. Measure and time period covered II. Type of change III. Rationale for change IV. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method V. Any introduction of bias that could affect the results

Section II: Data/Results Table
Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:

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

#2 Quantifiable Measure:

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

#3 Quantifiable Measure:

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

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

Section III: Analysis Cycle Complete this section for EACH analysis cycle presented.
A. Time Period and Measures That Analysis Covers.
B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.
B.1 For the quantitative analysis: *B.2 For the qualitative analysis:* ▪ Opportunities identified through the analysis Impact of interventions • Next steps

Section IV: Interventions Table			
Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 UM nurses" as opposed to "hired UM nurses"). Do not include intervention planning activities.			
Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Section V: Chart or Graph (Optional)
Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

IX. Appendix B: Rhode Island EPSDT Schedule for Pediatric Oral Health Care

AGE	Infancy							Early Childhood						Middle Childhood						Adolescence									
	Newborn[1]	3-5 days[2]	By 1 Mo	2 Mo	3 Mo	6 Mo	9 Mo	12 Mo	18 Mo	24 Mo	30 Mo	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
Clinical oral examination[1,2]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assess oral growth and development[3]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Caries-risk assessment[4]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Radiographic assessment[5]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Prophylaxis and topical fluoride treatment[4,5]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	o	o	o	o	o	o
Fluoride supplementation[6,7]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Anticipatory guidance/counseling[8]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Oral hygiene counseling[9]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Dietary counseling[10]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Injury prevention counseling[11]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Counseling for nonnutritive habits[12]						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Counseling for speech/language development[13]						◄	►		x	x	x	x	x	x	x														
Alcohol and drug use assessment[13]															x	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Counseling for intraoral/perioral piercing															x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assessment and treatment of developing malocclusion						◄	►		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assessment for pit and fissure sealants[14]								x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assessment and/or removal of third molars																					x	x	x	x	x	x	x	x	x
Transition to adult dental care																					◄								►

Notes:

x To be performed

o Perform when clinically necessary

◄► Perform within indicated timeframe

1 First examination at the eruption of first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

2 Includes assessment of pathology and injuries.

3 By clinical examination.

4 Must be repeated regularly and frequently to maximize effectiveness.

5 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

6 Consider when systemic fluoride exposure is suboptimal.

7 Up to at least 16 years of age.

8 Appropriate discussion and counseling should be an integral part of each visit.

9 Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.

10 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

11 Initially play objects, pacifiers, car seats; then learning to walk, sports, and routine playing.

12 At first discuss the need for additional sucking: digits vs. pacifiers; then the need to wean away from the habit before malocclusion or skeletal dysplasia occurs.

13 For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism. Referral to a Pediatrician, if necessary.

14 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

The Rhode Island Department of Human Services has established *RIte Smiles*, a new program for children designed to improve access to dental care. Children born on or after May 1, 2000 are eligible. For more information on *RIte Smiles,* go to www.dhs.ri.gov, and click on RIte Smiles—Dental Care for Kids.

X. Appendix C: Rhode Island Medicaid Managed Care Quality Strategy, 2019-2022

Page intentionally left blank.

RHODE ISLAND
MEDICAID MANAGED CARE QUALITY STRATEGY

Rhode Island Executive Office of Health and Human Services

Rhode Island Medicaid Virks Building,
3 West Road Cranston, Rhode Island 02920
(401) 462-0140
Fax: (401) 462-6353
http://www.eohhs.ri.gov

July 31, 2019

Section 1: RI Medicaid Managed Care Overview

Section 1.1 Overview

For over 25 years, Rhode Island (RI) has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. Most RI Medicaid members are enrolled in managed care for at least acute care, including behavioral health services, and most children are enrolled in both a managed care organization (MCO) and in the dental Prepaid Ambulatory Health Plan (PAHP). Similar to the state's rationale for managed medical and behavioral health services, the managed dental program (RIte Smiles) was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and better manage Medicaid expenditures for oral health care.

To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, over time Rhode Island has increasingly transitioned from functioning simply as a payer of services to becoming a purchaser of medical, behavioral, and oral health delivery systems. Among other responsibilities, the contracted managed care entities (MCEs) are charged with:

- ensuring a robust network beyond safety-net providers and inclusive of specialty providers,
- increasing appropriate preventive care and services, and
- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with three MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).[1] RI Medicaid operates a Medicaid-Medicare Plan with one of its MCOs to serve dually eligible members in managed care. In addition, RI Medicaid contracts with one dental plan. Rhode Island does not contract with any Prepaid Inpatient Health Plans (PIHP).

RI Medicaid's Managed Care Quality Strategy is required by the Medicaid Managed Care rule, 42 CFR 438 Subpart E.[2] This strategy focuses on RI Medicaid's oversight of MCO and PAHP compliance and quality performance to monitor the quality of care provided to Medicaid and CHIP members.[3] RI Medicaid will work with CMS to ensure that the Quality Strategy meets all content requirements set forth in 42 CFR 438.340 (c)(2).

Throughout this document, the MCOs and the PAHP will be collectively referred to as Managed Care Entities (MCEs), unless otherwise noted. Demonstrating compliance with federal managed care rules, this revised Quality Strategy reflects RI Medicaid's objective to transition to a state-wide collaborative framework for quality improvement activities, including measurement development, data collection, monitoring, and evaluation.

[1] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

[2] This Quality Strategy incorporates CMS guidance from its initial "Quality Considerations for Medicaid and CHIP programs," communicated by CMS in its November 2013 State Health Official Letter and the Quality Strategy Toolkit for States.

[3] Throughout this document, reference to Medicaid managed care programs and members also includes CHIP members served under the same managed care programs and contracts.

Rhode Island contracts with IPRO, a qualified External Quality Review Organization (EQRO) to conduct external quality reviews (EQRs) of its MCEs in accordance with 42 CFR 438.354.

Section 1.2 Rhode Island Medicaid and CHIP

The Executive Office of Health and Human Services (EOHHS) is the single state agency for Rhode Island's Medicaid program and, as such, is responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State's Medicaid program, the EOHHS also serves as the CHIP State Agency under Federal and State laws and regulations.

In 2019, over 317,000 Rhode Island residents are covered by Medicaid under one of the following eligibility categories:

- Adults with incomes up to 138 percent of poverty,
- Pregnant women with household incomes up to 253 percent of poverty,
- Children with household incomes up to 261 percent of poverty, and
- Persons eligible under categories for persons who are aged, blind, or those with a disability.

After the state expanded Medicaid eligibility under the Affordable Care Act, Rhode Island's total Medicaid population increased rapidly, and its uninsured rate dropped to less than four percent. Today, Medicaid is the state's largest health care purchaser covering one out of four Rhode Islanders in a given year. The Medicaid Program constitutes the largest component of the state's annual budget, State General Revenue expenditures are expected to reach $2.9 billion in State Fiscal Year (SFY) 2018.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).[4]

Section 1.3 History of Medicaid Managed Care Programs

The State's initial Medicaid and CHIP managed care program, RIte Care, began in 1994. As shown in Table 1 below, in the 25 years since, there has been a steady increase in the managed care populations and services, including carving in behavioral health services and serving populations with more complex needs.

[4] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

Table 1 Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	RIte Care SCHIP
2000	Children in Substitute Care RIte Share
2003	Children with Special Needs RIte Smiles
2008	Rhody Health Partners
2014	Medicaid Expansion Behavioral Health carved in to managed care
2015	Accountable Entities Pilot
2016	Medicare-Medicaid Plan (MMP)
2018	MCO-Certified Accountable Entities APMs

Today, RI Medicaid and CHIP beneficiaries enrolled in managed care entities include children and families; children in substitute care;[5] children with special health care needs; aged, blind, and disabled adults; low-income adults without children; adults with dual Medicare and Medicaid coverage; and adults who need long-term services and supports (LTSS).

This increase in Medicaid managed care population and services has led RI Medicaid to progressively transition from a fee-for-service claims payer to a more active purchaser of care. Central to this transition has been the state's focus on improved access to and quality of care for Medicaid beneficiaries along with better cost control. Rhode Island Medicaid is committed to managed care as a primary vehicle for the organization and delivery of covered services to eligible Medicaid beneficiaries.

[5] Under the provisions of Rhode Island's 1115 waiver, enrollment in managed care is mandatory for each of these populations except for children in legal custody of the State Department of Children, Youth and Families referenced as Children in Substitute Care.

Section 1.4 Medicaid and CHIP Managed Care in 2019

Approximately 90 percent of Medicaid and CHIP members are enrolled in managed care entities for acute care and/or for dental services. Currently, RI Medicaid contracts with three MCOs and one managed dental health plan. These risk-based managed care contractors are paid per member per month (PMPM) capitation arrangements and include the following MCEs:

- MCOs: Rhode Island's three MCOs include: Neighborhood Health Plan of Rhode Island (Neighborhood); United Healthcare Community Plan of Rhode Island (UHC-RI), and Tufts Health Public Plan (Tufts). Neighborhood and UHC-RI began accepting Medicaid members in Rhode Island's initial managed care program in 1994. Tufts began accepting RI Medicaid members in July 2017. MCOs enroll Medicaid beneficiaries in the following lines of business (LOBs):
    - RIte Care Core (children and families)
    - RIte Care Substitute Care (children in substitute care)
    - RIte Care CSHCN (children with special healthcare needs)
    - Rhody Health Expansion (low-income adults without children)
    - Rhody Health Partners (aged, blind, disabled adults)
- Dental MCE: The state contracts with United Healthcare Dental to manage the RIte Smile dental benefits for children enrolled in Medicaid. Enrollment in United Healthcare Dental began in 2006 for children born on or after May 1, 2000.

For RI Medicaid beneficiaries that are determined eligible, long-term services and supports (LTSS) are offered through a variety of delivery systems. RI Medicaid programs for persons dually eligible for Medicare and/or meeting high level of care determinations, including eligibility for LTSS include:

- Medicare-Medicaid Plan (MMP) Duals: EOHHS, in partnership with CMS and Neighborhood launched an innovative program in 2016 that combined the benefits of Medicare and Medicaid into one managed care plan to improve care for some of the state's most vulnerable residents. Enrollment in MMP duals is voluntary and covered benefits include Medicare Part A, B, and D, and Medicaid Services (including LTSS for those who qualify). (Dental Care and transportation are covered out-of-plan).
- Program for All Inclusive Care for the Elderly (PACE) is a small voluntary program for qualifying eligible individuals over age 55 who require a nursing facility level of care. PACE provides managed care through direct contracts with PACE providers rather than through MCEs.

Table 2 displays MCO and PAHP enrollment in RI Medicaid managed care as of January 2019.

Table 2: Enrollment in Medicaid and CHIP Managed care as of January 2019

Managed Care Program	Members Enrolled in Program	Eligible MCEs
RIte Care Core (children and families)	157,376	Neighborhood Tufts UHC-RI
RIte Care Substitute Care (children in substitute care)	2,631	Neighborhood
RIte Care CSHCN (children with special healthcare needs)	6,967	Neighborhood Tufts UHC-RI
Rhody Health Expansion (low-income adults without children)	71,456	Neighborhood Tufts UHC-RI
Medicare/Medicaid Plan	15,777	Neighborhood
Grand Total MCO Members	264,841	
Dental PAHP Members RIte Smiles	114,101	United Healthcare

Section 2: Guiding Principles, Goals and Objectives

Section 2.1 Medicaid Guiding Principles and Accountable Entities

Rhode Island's Medicaid managed care program is dedicated to improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life.

In 2015, Governor Gina Raimondo established the "Working Group to Reinvent Medicaid," tasked with presenting innovative recommendations to modernize the state's Medicaid program and increase efficiency. The Working Group established four guiding principles:

- pay for value, not volume,
- coordinate physical, behavioral, and long-term health care,
- rebalance the delivery system away from high-cost settings, and
- promote efficiency, transparency and flexibility.

Rhode Island's vision, as expressed in the Reinventing Medicaid report is for "…a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population."

In alignment with its guiding principles, RI Medicaid developed the AE program as a core part of its managed care quality strategy. AEs are Rhode Island's version of an accountable care organization. AEs 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. Medicaid MCOs are required to enter into Alternative Payment Model (APM) arrangements with certified AEs. As of early 2019, RI Medicaid has certified six Comprehensive AEs as part of its Health System Transformation Project (HTSP).

RI Medicaid created the AE Initiative to achieve the following goals in Medicaid managed care:[6]

1. transition Medicaid from fee for service to value-based purchasing at the provider level
2. focus on Total Cost of Care (TCOC)
3. create population-based accountability for an attributed population
4. build interdisciplinary care capacity that extends beyond traditional health care providers
5. deploy new forms of organization to create shared incentives across a common enterprise, and
6. apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

The state's MCO contracts stipulate that only Rhode Island residents who are not eligible for Medicare and are enrolled in Medicaid managed care plans are eligible to participate in the AE Program. In early 2019, qualified

APM contracts were in place between five AEs and two Medicaid MCOs. Combined, close to 150,000 RI Medicaid managed care members are attributed to an AE. These RI Medicaid members include participants in the following programs: RIte Care, Rhody Health Partners, and the Rhody Health Expansion Population. RI Medicaid contracts directly with the MCO, certifies the AEs and works closely with the dyads to improve quality as outlined in the 1115 waiver. More information on AEs is included in *Section 7: Delivery System Reform*.

[6] RI Medicaid Accountable Entity Roadmap http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/AEroadmap041117v6.pdf

Section 2.2 Quality Strategy Goals

Evolving from the state's guiding principles, RI Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022 as depicted in Table 3 below.

Table 3: Managed Care Quality Strategy Goals
1. Maintain high level managed care performance on priority clinical quality measures
2. Improve managed care performance on priority measures that still have room for improvement (i.e., are not 'topped out')
3. Improve perinatal outcomes
4. Increase coordination of services among medical, behavioral, and specialty services and providers
5. Promote effective management of chronic disease, including behavioral health and comorbid conditions
6. Analyze trends in health disparities and design interventions to promote health equity
7. Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice
8. Reduce inappropriate utilization of high-cost settings

This strategic quality framework will be used as a tool for RI Medicaid to better facilitate alignment of agency- wide initiatives that assess managed care progress to date and identify opportunities for improvement to better serve RI Medicaid and CHIP managed care populations in a cost-effective manner. Each of the eight managed care goals is aligned with one or more quality objectives outlined in Section 1.7

In its managed care programs, RI Medicaid employs standard measures that have relevance to Medicaid- enrolled populations. Rhode Island has a lengthy experience with performance measurement via collecting and reporting on HEDIS©[7] measures for each managed care subpopulation it serves. RI Medicaid also requires its managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS)[8] 5.0 surveys. During this quality strategy period, RI Medicaid will focus on strengthening its current MCE measurement and monitoring activities and benchmarks to continually improve performance and achieve the goals of Medicaid managed care. RI Medicaid will also implement and continually improve AE performance measurement specifications, benchmarks and incentives, consistent with the goals of the AE initiative and this Quality Strategy.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[8] CAHPS surveys are developed by the Agency for Healthcare Research and Quality (AHRQ), a government organization and administered by qualified vendors. https://www.ahrq.gov/cahps/index.html

Section 2.3 Quality Strategy Objectives

To support achievement of the Quality Strategy goals, RI Medicaid has established specific objectives as identified in Table 3 below. The state has developed objectives to focus state, MCE and other activities on interventions likely to result in progress toward the eight managed care goals. The right column of the table depicts how each objective aligns with one or more referenced managed care goals as numbered in Section 2.2.

Table 3: Managed Care Quality Objectives	Aligned with Goal #
A. Continue to work with MCEs and the EQRO to collect, analyze, compare and share clinical performance and member experience across plans and programs.	1-8
B. Work collaboratively with MCOs, AEs, OHIC and other stakeholders to strategically review and modify measures and specifications for use in Medicaid managed care quality oversight and performance incentives. Establish consequences for declines in MCE performance.	1
C. Create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.	1,2
D. Review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time.	1-5
E. Work with MCOs and AEs to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.	3, 6, 8
F. Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.	3, 4, 5, 6, 8
G. Increase communication and the provision of coordinated primary care and behavioral health services in the same setting for members attributed to AEs.	4,5,8
H. Monitor and assess MCO and AE performance on measures that reflect coordination including follow up after hospitalization for mental health and data from the new care management report related to percentage/number of care plans shared with PCPs.	4,5,8
I. Develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.	5,8
J. Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens.	6
K. Share and aggregate data across all RI HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	6
L. Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCO CAHPs survey results with the MCAC.	7
M. Explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs.	7
N. Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.	7

Section 3: Development and Review of Quality Strategy

Section 3.1 Quality Management Structure

The EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island, with responsibility for coordinating the organization, financing, and delivery of services and supports provided through the State's Department of children, Youth and Families (DCYF), the Department of Health (DOH), the Department of Human Services (DHS) including the divisions of Elderly Affairs and Veterans Affairs, and the Department of Mental Healthcare, Developmental Disabilities and Hospitals (BHDDH). Serving as the State's Medicaid agency, EOHHS has responsibility for the State's Comprehensive 1115 Demonstration.

RI Medicaid oversees and monitors all contractual obligations of the MCEs to further enhance the goals of improving access to care, promote quality of care and improve health outcomes while containing costs. RI Medicaid also provides technical assistance to MCEs and when necessary, takes corrective action to enhance the provision of high quality, cost- effective care.

Medicaid Quality functions include:

1. measurement selection and/or development,
2. data collection,
3. data analysis and validation,
4. identification of performance benchmarks,
5. presentation of measurement and analysis results, including changes over time, and
6. quality improvement activities.

The above functions are conducted at different levels including: RI Medicaid program level, the MCE level, the AE level, and the provider level, where appropriate and feasible. The cadence of each activity aligns with federal guidelines and best practices. The RI Medicaid managed care quality strategy demonstrates an increase in alignment of priorities and goals across state agencies and Medicaid MCEs. This quality strategy will continue to evolve in the next few years to increase the strategic focus and measurement linked to state objectives for managed care.

RI Medicaid conducts oversight and monitoring meetings with all managed care entities. These monthly meetings are conducted separately with each of the MCEs. Meeting agendas focus on routine and emerging items accordingly. The following content areas are addressed on at least a quarterly basis:

- managed care operations
- quality measurement, benchmarks, and improvement
- managed care financial performance
- Medicaid program integrity

RI Medicaid utilizes a collaborative approach to quality improvement activities at the State level. RI Medicaid coordinates with state partners across health and human services agencies. On a routine basis, representatives from DCYF, BHDDH, DOH join RI Medicaid in routine oversight activities to lend their expertise related to subject matter and populations served. This collaborative approach has proven to be sustainable and efficient.

As part of the 2019-2022 Quality Strategy, the 1115 Quality and Evaluation Workgroup with state partners will be crucial to monitoring various quality improvement efforts occurring within the broad array of Medicaid programming, sharing lessons learned, and discussing quality and evaluation efforts on the horizon.

In addition to managed medical care, there is also state oversight of the managed dental care provided to Medicaid managed care members. The focus of the RI Medicaid dental quality strategy continues to be on ensuring access to preventive dental services for members under age 21 and effective collaboration between state partners. Along with the RI Medicaid dental contract oversight, the DOH regulates the utilization review and quality assurance, or quality management (UR/QA) functions of all licensed Dental Plans, including RIteSmiles. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

Section 3.2 Review and Update of the Quality Strategy

RI Medicaid will conduct an annual review of the Medicaid Managed Care Quality Strategy and complete an update to its quality strategy as needed but note less frequently than every three years. As part of the review, RI Medicaid and its contracted MCEs will meet with interested parties, state partners, and consumer advisors to share annual EQRO results and other data to assess the strategy's effectiveness.

To obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final, the State put the proposed Medicaid Managed Care Quality Strategy on the March 2019 agenda of the Medical Care Advisory Committee (MCAC) for discussion. In April 2019, Rhode Island will post the final draft Medicaid Managed Care Quality Strategy on the RI EOHHS Website for 30 days for public comment. After public comments are received and reviewed, the Quality Strategy will be finalized, and copies will be forwarded to CMS Central and Regional Offices. EOHHS will post the most recent version of the Quality Strategy on its website.

In accordance with 42 CFR 438.204(b)(11), Rhode Island has defined what constitutes a "significant change" that would require revision of the Quality Strategy more frequently than every three years. Rhode Island will update its Quality Strategy whenever any of the following significant changes and/or temporal events occur:

a. a new population group is to be enrolled in Medicaid managed care;
b. a Medicaid managed care procurement takes place
c. substantive changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level, or
d. significant changes in managed care membership demographics or provider network as determined by EOHHS.

Section 3.3 Evaluating the Effectiveness of the Quality Strategy

Rhode Island engages in regular activities to assess the effectiveness of its Medicaid managed care quality strategy including:

- routine monitoring of required MCE reports and data submissions that are due to the state according to a contractually-defined reporting calendar

- collection and analysis of key performance indicators to assess MCE progress toward quality goals and targets at least annually.
- annual review of EQR reports to assess the effectiveness of managed care program in providing quality services in an accessible manner.
- annual strategy review conducted by internal stakeholders for each type ofmanaged care program: acute MCO (including AEs), managed dental, and managed LTSS/Duals.

As MCE, EQR, and other quality reports are reviewed, opportunities may be identified for additional reporting requirements to ensure RI Medicaid is meeting the mission statement assuring access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders.

Internal and external stakeholders provide input to the development of Rhode Island's Medicaid quality programs, and to the Medicaid Managed Care Quality Strategy itself. Through committees, work groups and opportunities for comment, stakeholders identify areas that merit further discussion to ensure the advancement of person-centered, integrated care and quality outcomes for Medicaid managed care members. For example, in 2019, EOHHS convened a series of stakeholder meetings with the AEs and MCOs to discuss the implementation of the AE Total Cost of Care quality measures, pay-for-performance methodology, and the outcome measures and incentive methodology to ensure measures and methodology met the intended program goals. Similarly, RI Medicaid also convened an MCO and AE workgroup to discuss further refinement of the Social Determinants of Health screening measure.

Section 4: Assessment of Managed Care

Section 4.1 State Monitoring of Managed Care Entities

To assess the health care and services furnished by Medicaid MCEs, RI Medicaid has a managed care monitoring system which addresses all aspects of the MCE program consistent with 42 CFR 438.66. For example, the state's oversight and monitoring efforts include assessing performance of each MCE to contract requirements in the following areas:

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services, including the activities of the beneficiary supportsystem.
- finance, including new medical loss ratio (MLR) reporting requirements,
- Information systems, including encounter data reporting,
- marketing,
- medical management, including utilization management and case management.
- program integrity,
- provider network management, including provider directory standards,
- availability and accessibility of services, including network adequacy standards,
- quality improvement, and
- for MMPs, areas related to the delivery of LTSS not otherwise included above and as applicable to the MMP contract.

RI uses data collected from its monitoring activities to improve the performance of its MCE programs. For example, the state MCE oversight includes reviewing:

- enrollment and disenrollment trends in each MCE and other data submitted by the RI Medicaid enrollment broker related to MCE performance
- member grievance and appeal logs,
- provider complaint and appeal logs,
- findings from RI's EQR process,
- results from enrollee and provider satisfaction surveys conducted by the State/EQRO or MCE,
- MCE performance on required quality measures,
- MCE medical management committee reports and minutes,
- the annual quality improvement plan for each MCE.
- audited financial and encounter data submitted by each MCE,
- the MLR summary reports required by 42 CFR 438.8.
- customer service performance data submitted by each MCE, and
- for the MMP contract, other data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

Section 4.2 Specific MCE Oversight Approaches Used by RI Medicaid

Rhode Island Medicaid has detailed procedures and protocols to account for the regular oversight, monitoring, and evaluation of its MCEs in the areas noted above. As part of its managed care program, RI Medicaid employs a variety of mechanisms to assess the quality and appropriateness of care furnished to all MCO and PAHP members including:

1. Contract management - All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions and oversight activities. Contracts include requirements for quality measurement, quality improvement, and reporting. Active Contract Management is a crucial tool in RI Medicaid's oversight. Routine reporting allows RI Medicaid to identify issues, trends and patterns early and efficiently to mitigate any potential concerns. Another key part of its contract management approach are monthly oversight meetings that RI Medicaid directs with each MCE. One topic that may be included in contract oversight meetings, for example, is mental health parity. The state may use this meeting as a forum to address compliance issues or questions related to the updated MCO Contract language related to mental health parity:
    - *The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Qualitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity*

compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.

2. State-level data collection and monitoring – RI Medicaid collects data to compare MCE performance to quality and access standards in the MCE contracts. At least annually, for example, Rhode Island collects HEDIS and other performance measure data from its managed care plans and compares plan performance to national benchmarks, state program performance, and prior plan performance. In addition, the state monitors MCE encounter data to assess trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

RI Medicaid's enhanced Reporting Calendar tool helps MCOs and the state better track, manage, and assess a comprehensive series of standing reports used for oversight and monitoring of the State's managed care programs. MCO reports are submitted monthly, quarterly and annually depending on the reporting cadence on a variety of topics specified by the state, such as:

- Care Management
- Compliance
- Quality Improvement Projects
- Access, secret shopper, provider panel
- Grievances and Appeals
- Financial Reports
- Informal Complaints
- Pharmacy Home

See Appendix C for an abbreviated copy of the MCO Reporting Attestation Form developed by RI Medicaid. The scheduled MCE reports allow RI Medicaid to identify emerging trends, potential barriers or unmet needs, and/or quality of care issues for managed care beneficiaries. The findings from the MCE reports are analyzed by the state and discussed with contracted health plans during monthly MCE Oversight and Monitoring meetings. During this Quality Strategy period, RI Medicaid will expand the enhanced Reporting Calendar tool to apply to the dental PAHP and to the MMP.

In addition, MCEs are required to submit information for financials, operations, and service utilization through the encounter data system. RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions.

3. Performance Incentives - Within the contract for RIte Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). MCOs can earn financial incentives for achieving specified benchmarks for measures in the following domains: utilization, access to care, prevention/screening, women's health, and chronic care management, and behavioral health. The contract for the MMP requires performance measures that are tied to withholds. The plan can earn the withhold payment by meeting benchmarks as outlined in the contract. The PAHP has one required performance measure that is calculated using a HEDIS® methodology.

   To create more meaningful consequences for MCE performance in the future, RI Medicaid will develop and more actively utilize a combination of financial and non-financial incentives for contracted MCEs to meet or exceed performance expectations. To make a stronger business case for MCEs to invest in improved performance on behalf of members, RI Medicaid may amend its MCE policies and contracts to specifically require more transparency on performance and to specify financial penalties on MCEs performing below state-defined minimum benchmarks for certain key measures.

4. Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects (PIPs) annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. RI Medicaid MCOs are contractually obligated to conduct 4 PIPs annually. The dental plan has two contractually required PIP(s). The MMP is also required to perform one additional PIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required quality improvement project.

5. Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the RI Medicaid's goals and objectives. RI Medicaid contracts with an EQRO to perform an independent annual review of each Medicaid MCE. The state's EQRO is involved in reviewing the MCE quality plans as part of its broader role in performing the external quality review of each managed care entity and program.

6. Accreditation Compliance Audit- As part of the annual EQR, the EQRO conducts an annual accreditation compliance audit of contracted MCOs. The compliance review is a mandatory EQR activity and offers valuable feedback to the state and the plans. Based on NCQA rankings, RI's Medicaid health plans continue to rank in the top percentiles of Medicaid plans nationally. The state and the EQR reinforces the State's requirement that participating MCOs maintain accreditation by the NCQA. The state reviews and acts on changes in any MCO's accreditation status and has set a performance "floor" to ensure that any denial of accreditation by NCQA is considered cause for termination of the RI Medicaid MCO Contract. In addition, MCO achievement of no greater than a provisional accreditation status by NCQA requires the MCO to submit a Corrective Action Plan within 30 days of the MCO's receipt of its final report from the NCQA.

RI Medicaid conducts monthly internal staff meetings to discuss MCE attainment of performance goals and standards related to access, quality, health outcomes, member services, network capacity, medical management, program integrity, and financial status. Continuous quality improvement is at the core of RI Medicaid's managed care oversight and monitoring activities. The state conducts ongoing analysis of MCE data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance.

When MCE compliance and/or performance is deemed to be below the established benchmark or contractual requirement, RI Medicaid will impose a corrective action, provide technical assistance and will potentially impose financial penalties as necessary.

In addition to the MCE oversight and monitoring mechanisms detailed in this section, RI Medicaid may make modifications or additions to metric development and specification, performance incentives, and data and reporting requirements as necessary, e.g., as part of a contract amendment, a new procurement, or with the implementation of new managed care programs.

The remainder of Section 4 summarizes components of the RI Medicaid Managed Care Quality Strategy related to oversight of:

- appropriateness of care in managed care (Section 4.3),
- MCE performance levels and targets (Section 4.4) and
- The External Quality Review (Section 4.5).

Section 4.3 Appropriateness of Care in Managed Care

RI Medicaid's oversight of appropriateness of care for Medicaid managed care members includes a variety of state requirements and processes, including early identification and swift treatment, consideration of persons with special health care needs, cultural competency and considerations to measure and address health disparities. This section summarizes key components of the Quality Strategy related to appropriateness of care.

1. EPSDT: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Appropriateness of care begins with early identification and swift treatment. As part of its MCE oversight, RI Medicaid monitors provision of Early Periodic Screening, Diagnosis and Treatment (EPSDT) to managed care members. The *State's CMS 416: Annual EPSDT Participation Report* is produced annually. Medicaid beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or receive services in a fee-for-service delivery system. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Rhode Island uses findings from the CMS 416 Report as part of its Medicaid Quality Strategy to monitor trends over time, differences across managed care contractors, and to compare RI results to data reported by other states. RI Medicaid will share the 416 report results with the MCEs annually, discuss opportunities for improvement and modifications to existing EPSDT approaches as necessary. For example, the CMS 416 report includes but is not limited to the following measures:

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services
- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth
- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

2. Persons with Special Health Care Needs

A critical part of providing appropriate care is identify Medicaid beneficiaries with special health care needs as defined in the MCE contracts. Each MCE must have mechanisms in place to assess enrollees identified as having *special health care needs.* Rhode Island defines children with special health care needs (CSHCN) as: persons up to the age of twenty-one who are blind and/or have a disability and are eligible for Medical Assistance on the basis of SSI; children eligible under Section 1902(e) (3) of the Social Security Administration up to nineteen years of age ("Katie Beckett"); children up to the age of twenty-one receiving subsidized adoption assistance, and children in substitute care or "Foster Care". The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

For each enrollee that the managed care program deems to have special health care needs, the MCE must determine ongoing treatment and monitoring needs. In addition, for members including but not limited to enrollees with special health care needs, who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. Access to Specialists is monitored through a monthly report from the managed care entity.

For populations determined to have special healthcare needs, continuity of care and subsequent planning is crucial. As such, Medicaid MCOs are required to continue the out-of-network coverage for new enrollees for a period of up to six months, and to continue to build their provider network while offering the member a provider with comparable or greater expertise in treating the needs associated with that member's medical condition. See Appendix A for a copy of RI Medicaid's currently proposed Transition of Care (TOC) Policy. This TOC policy is being finalized simultaneously with this Quality Strategy.

3. Cultural Competency

At the time of enrollment, individuals are asked to report their race, ethnicity, and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

4. Health Disparity Analysis

MCOs are required to submit their annual HEDIS® submission stratified by Core RIte Care only and for All Populations, including special needs population such as Rhody Health Partners. As part of Rhode Island's External Quality Review process, analysis is completed to identify differences in rates between the Core RIte Care only group and those including All Populations. (The Health Plans utilize internal quality and analytic tools such as CAHPS®

which is provided in both English and Spanish as well as informal complaints to identify and monitor for potential health disparities.)

In addition, since 2014, (for CY 2013) the Health Plans have provided the following four HEDIS® measures stratified by gender, language, and SSI status:

- *Controlling high blood pressure (CBP)*
- *Cervical cancer screening (CCS)*
- *Comprehensive diabetes care HbA1c Testing (CDC)*
- *Prenatal and Postpartum care: Postpartum care rate (PPC)*

With assistance from the EQRO, the state and MCOs are assessing trends in the disparities shown in these disparity-sensitive national performance measures over time. The state and MCEs are also working to design quality improvement efforts to address social determinants of health and hopefully improve health equity. As part of this Managed Care Quality Strategy, RI Medicaid will support these efforts by:

- working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens, and
- developing a statewide workgroup to resolve barriers to data-sharing and increase the sharing and
- aggregating of data across all state Health and Human Service agencies to better address determinants.

Section 4.4 MCE Performance Measures and Targets

The development of quality measures and performance targets is an essential part of an effective Medicaid program. RI Medicaid identifies performance measures specific to each managed care program or population served across different types of measurement categories. The State works with its MCEs and its EQRO to collect, analyze, and compare MCE and program performance on different types of measures and measure sets that include both clinical performance measures and member experience measures. The MCE measure sets described in this section and the MCO performance measures in Appendix B provide quantifiable performance driven objectives that reflect state priorities and areas of concern for the population covered.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. The RI Medicaid staff work collaboratively with MCOs, AEs, the Office of the Health Insurance Commissioner OHIC and other internal and external stakeholders to strategically review and where needed modify, measures and specifications for use in Medicaid managed care quality oversight and incentive programs.

RI Medicaid has employed use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF). Rhode Island collects and voluntarily reports on most CMS Adult and Child Core Measure Set performance measures.[9] In 2019, Rhode Island reported on 20 measures from the Adult Core Set and 17 measures from the Child Core Set, with measurement reflecting services delivered to Medicaid beneficiaries in CY2017. RI Medicaid also opts to report on some CMS Health Home core measures.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. For example, the Child and Adult Core Measure Sets inform the measures used in RI Medicaid's MCO Performance Goal Program (PGP). In addition, all applicable PGP measures are benchmarked on a national level using the Quality Compass©. Historically, the

[9] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf and

https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf

MCO PGP has provided financial incentives to the health plans for performing in the 90th and 75th national Medicaid percentiles according to Quality Compass rankings.

As RI Medicaid moves forward with new performance measures, specifications and incentive approaches with its AE program, the state also intends to re-visit the MCO performance measures, specifications, and incentives used to support and reward quality improvement and excellence. Similarly, as the state prepares to re-procure its managed dental program, RI Medicaid intends to review the performance measures, expectations, and incentives for future dental plan contractors.

RI Medicaid consults with its EQRO in establishing and assessing CAHPS survey requirements and results for MCEs. All MCEs are required to conduct CAHPS 5.0 member experience surveys and report to RI Medicaid and its EQR on member satisfaction with the plan. RI Medicaid is exploring the use of additional member satisfaction surveys to assess AE performance in the future. For example, Rhode Island will explore the future use of a statewide CAHPS survey to assess consumer satisfaction with members in AEs, such as the potential use of the Clinician Group CG-CAHPS version survey for adults and children receiving primary care services from AEs.

Rhode Island Medicaid has historically relied heavily on HEDIS and NCQA to identify measures and specifications. This has proven to be a crucial component of the success of RI's MCOs as evidenced by their high NCQA rankings. However, recently there have been significant changes in RI's managed care delivery system that may require a more customized approach to at least some managed care performance measures and targets. The catalyst for this shift is inherently connected to the AE program and the future vision of RI Medicaid. With behavioral health benefits carved in and the addition of the AE program, a vast array of managed care services and providers are or will be involved in collecting and reporting on quality data in a new way. RI Medicaid is working to ensure that contracted MCEs, their AE provider partners and behavioral health network providers are equipped to adequately collect and report on quality measures. RI Medicaid has required the MCEs to support provider readiness related to quality. As part of its managed care quality strategy. RI Medicaid will continue to monitor MCE, AE, and provider progress via a variety of oversight and reporting activities.

RI Medicaid has obtained technical assistance from experts in quality to support state efforts and ensure RI Medicaid has a mechanism to track and achieve its goals. RI Medicaid now has some additional capacity to develop measures, collect data, analyze findings and enforce accountability (penalties/incentives). Over the next three years, RI Medicaid will look to include state custom measures into managed care oversight activities. The states modifications to its managed care performance measures and specifications over time will be deigned to ensure that the MCE and AE programs are capturing accurate data to reflect activities related to the state's unique approaches to achieving its quality goals.

Rhode Island Medicaid works to ensure that its performance measures tie back to the agency's goals, objectives, and mission. Measures are chosen that align with the State's commercial partners which lessens provider burden and streamlines expectations. Clinical and non-clinical measures that represent key areas of interest are chosen accordingly. Many MCO performance measures belong to the CMS Adult and Child Core Measure Sets and the measurement domains for AEs are closely aligned with the MCO measures.

To assess MCE performance and establish targets across areas of member experience, clinical performance and monitoring measures, MCE rates are compared to appropriate regional, national, or state benchmarks as available

and applicable. As is currently the practice at RI Medicaid, many of these performance benchmarks will be obtained from the NCQA's Medicaid Quality Compass, from performance comparison across MCEs and, when feasible, from the state's OHIC or its all-payer claims database. Where external benchmarks are not available, EOHHS will use baseline performance and targets established through initial or historical performance (e.g., for new or emerging measures).

Alongside efforts to create new AE performance benchmarks, targets, and quality incentives to support its delivery system reform efforts, during 2019, RI Medicaid will re-examine its MCE performance benchmarks, targets, and consider modifications to financial and non-financial MCO performance incentives. EOHHS shall also consider refinements to the measures used in the Total Cost of Care Program and Medicaid Infrastructure Incentive Program for AEs.

Section 4.5 External Quality Review

As required by 42 CFR 438.350, an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. IPRO is under contract with RI Medicaid to conduct the EQR function for the State. Rhode Island's current Medicaid managed care EQR contract with IPRO runs from January 2019 through January 2020. The contract period for this effort begins on January 1, 2019 through December 31, 2021, with the potential for up to three one-year extensions.

In accordance with 42 CFR Part 438, subpart E, the EQRO performs, at minimum, the mandatory activities of the annual EQR. RI Medicaid may ask the EQRO to perform optional activities for the annual EQR. The EQRO provide technical guidance to MCOs/PAHP on the mandatory and optional activities that provide information for the EQR. These activities will be conducted using protocols or methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352Activities- the EQRO must perform the following activities for each MCO/PAHP:

1. Performance Improvement Projects - Validation of PIPs required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months. Currently, MCOs are required to complete at least four PIPs each year. Additionally, the contract for the MMP requires at least one more PIP. The PAHP is required to complete at least two performance improvement projects each year.
2. Performance Goal Program - Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months.
3. Access -Validation of MCO and PAHP network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 438.14(b)(1) and state standards established in the respective MCE contracts as summarized in Section 5. Validation of network adequacy will include, but not be limited to a secret shopper survey of MCO and dental PAHP provider appointment availability in accordance with contractual requirements established by the state.
4. Accreditation Compliance Review - A review, conducted within the previous three-year period, to determine each MCO's and PAHP's compliance with the standards set forth in 42 CFR Part 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330. Within the contracts for RIte Care, Rhody Health Partners Rhody Health Expansion, Rhody Health Options, and Medicare Medicaid Plan the state requires the MCOs to be accredited by the National Committee for

Quality Assurance as a Medicaid Managed Care organization. The PAHP is accredited by the Utilization Review Accreditation Commission (URAC).

5. Special enhancement activities as needed. In addition, the State reserves the option to direct the EQRO to conduct additional tasks to support the overall scope of this EQR work in order to have flexibility to bring on additional technical assistance and expertise in a timely manner to perform activities which require similar expertise and work functions as those described in 1 to 4 above. One example of this may be the EQRO's future assistance in conducting a CAHPs satisfaction survey for Medicaid members attributed to an AE.
6. The EQRO is responsible for the analysis and evaluation of aggregated information on quality outcomes, timeliness of, and access to the services that a managed care entity or its contractors furnish to Medicaid enrollees. The EQRO produces an annual detailed technical report that summarizes the EQR findings on access and quality of care for MCEs including:
    - A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
    - For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.
    - An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
    - Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
    - An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
    - An evaluation of the effectiveness of the State's quality strategy and recommendations for updates
    - based on the results of the EQR.

Concurrently, each MCE is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by RI Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, each MCO must make a presentation outlining the MCO's response to the feedback and recommendations made by the EQRO to the State formally.

The EQRO presents clear and concrete conclusions and recommendations to assist each MCO, PAHP, and RI Medicaid in formulating and prioritizing interventions to improve performance and to consider when updating the State's managed care quality strategy and other planning documents. A recent EQR can be found here: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/2016AggregateEQRTechnicalReport.pdf

Each MCO and PAHP is required to respond the EQRO's recommendations and to state any improvement strategies that were implemented. The MCO and PAHP responses to previous recommendations are included in the report. Recommendations for improvement that are repeated from the prior year's report are closely monitored by the

EQRO and RI Medicaid. The EQRO produces a technical report for each MCO and PAHP and one aggregate report for RI Medicaid. The aggregate report includes methodologically appropriate comparative information about all MCEs. The EQRO reviews the technical reports with the State and MCEs prior to the State's submission to CMS and posting to the State's website; however, the State or MCEs may not substantively revise the content of the final EQR technical report without evidence of error or omission.

In conjunction with the State's annual continuous quality improvement cycle, findings from the annual EQR reports are presented to RI Medicaid's Quality Improvement Committee for discussion by the State's team which oversees the MCEs. The information provided as a result of the EQR process informs the dialogue between the EQRO and the State. Rhode Island incorporates recommendations from the EQRO into the State's oversight and administration of RIte Care, Rhody Health Partners, RIte Smiles and the Medicare-Medicaid Dual Demonstration program.

Section 5: State Standards

Section 5.1 RI Managed Care Standards

Rhode Island's Medicaid managed care contracts have been reviewed by CMS for compliance with the Medicaid managed care rule and the 2017 version of the *"State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval."*[10] The State is concurrently amending its dental plan contract to clarify the contractor's requirement to specifically comply with all applicable PAHP requirements in 42 CFR 438 per CMS feedback. RI Medicaid is also preparing to make additional changes to its managed dental program when it re- procures its dental contract prior to July 2020. The state seeks to contract with two qualified, statewide Medicaid dental plans by mid-2020.

All RI Medicaid MCEs are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.68 and 42 CFR 438.206-438.210.

For example, in accordance with the standards in 42 CFR 438.206 RI Medicaid ensures that services covered under MCE contracts are accessible and available to enrollees in a timely manner. Each plan must maintain and monitor a network of appropriate providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the MCE contract. The RI Medicaid MCE contracts require plans to monitor access and availability standards of the provider network to determine compliance with state standards and take corrective action if there is a failure to comply by a network provider(s).

Section 5.2 MCO Standards

In the contracts for RIte Care, Rhody Health and Partners Rhody Health Expansion the state has specified time and distance standards for adult and pediatric primary care, obstetrics and gynecology, adult and pediatric behavioral health (mental health and substance use disorder), adult and pediatric specialists, hospitals, and pharmacies.

[10] https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

Table 4 below includes time and distance standards for contracted Medicaid MCOs:

Table 4: MCO Access to Care Standards	
Provider Type	**Time and Distance Standard** **Provider office is located within the lesser of**
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

The RI Medicaid MCO contract, (Section 2.09.04 Appointment Availability) also includes the following state standards. The contracted MCOs agree to make services available to Medicaid members as set forth below:

Table 5: MCO Timeliness of Care Standards	
Appointment	**Access Standard**
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	30 calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 10 calendar days

Among other federal and state requirements, MCE contract provisions related to availability of services require RI Medicaid MCEs to:

- offer an appropriate range of preventive, primary care, and specialty services,
- maintain network sufficient in number, mix, and geographic distribution to meet the needs of enrollees,
- require that network providers offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to Medicaid fee-for-service patients if the provider does not see commercial patients,
- ensure female enrollees have direct access to a women's health specialist,
- provide for a second opinion from a qualified health care professional,
- adequately and timely cover services not available in network,
- provide the state and CMS with assurances of adequate capacity and services as well as assurances and documentation of capacity to serve expected enrollment,
- have evidence-based clinical practice guidelines in accordance with 42 CFR §438.236, and
- comply with requests for data from the EOHHS' EQRO.

Section 5.3 MMP Standards

In the contracts for Rhody Health Options and Medicare Medicaid Plan the state has specified time and distance standards for long-term services and supports.

MMP standards are included in the RI Medicaid MCO contract with Neighborhood and are specific to members who are dually eligible for Medicare and Medicaid and enrolled in this managed care plan. Network requirements, including network adequacy and availability of services under the State's MMP contract are similar to those for managed medical and behavioral health care but also take into account Medicare managed care standards and related federal requirements for plans serving dual-eligibles. Although methods and tools may vary, each long-term service and supports (LTSS) delivery model is expected to ensure that, for example:

- an individual residing in the community who has a level of care of "high" or "highest" will have, at a minimum, a comprehensive annual assessment,

- an individual residing in the community who has a level of care of “high” or “highest” will have, at a minimum, an annual person-centered care/service plan,
- Covered services provided to the individual is based on the assessment and service plan,
- providers maintain required licensure and certification standards,
- training is provided in accordance with state requirements,
- a critical incident management system is instituted to ensure critical incidents are investigated and substantiated and recommendations to protect health and welfare are acted upon, and
- providers will provide monitoring, oversight and face-to-face visitation per program standards.

Section 5.4 Dental PAHP Standards

In the Medicaid managed dental contract, Rhode Island has specified time and distance standards for pediatric dental. RI Medicaid network adequacy and availability of service requirements under the State's managed dental care contract are broadly similar to those for managed medical and care but focused on covered dental services for Medicaid enrollees under age 21. The Dental Plan is contractually required to establish and maintain a geographically accessible statewide network of general and specialty dentists in numbers sufficient to meet specified accessibility standards for its membership. The Dental Plan is also required to contract with all FQHCs providing dental services, as well as with both hospital dental clinics in Rhode Island, and State-approved mobile dental providers.

For example, the Dental PAHP is required to make available dental services for RIte Smiles members within forty-eight (48) hours for urgent dental conditions. The Dental Plan also is required to make available to every member a dental provider, whose office is located within twenty (20) minutes or less driving distance from the member’s home. Members may, at their discretion, select a dental provider located farther from their homes. The Dental plan is required to make services available within forty-eight (48) hours for treatment of an Urgent Dental Conditions and to make services available within sixty (60) days for treatment of a non-emergent, non- urgent dental problem, including preventive dental care. The Dental Plan is also required to make dental services available to new members within sixty (60) days of enrollment.

Section 6: Improvement and Interventions

Section 6.1 Improvement and Interventions

Improvement strategies described throughout this RI Medicaid Quality Strategy document are designed to advance the quality of care delivered by MCEs through ongoing measurement and intervention. To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related the vision and mission, RI Medicaid engages in multiple interventions. These interventions are based on the results of its MCE assessment activities and focus on the managed care goals and objectives described in Section 2.

RI Medicaid’s ongoing and expanded interventions for managed care quality and performance improvement include:

1. Ongoing requirements for MCEs to be nationally accredited

RI Medicaid MCOs will continue to be required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status. As NCQA increases and modifies its Medicaid health plan requirements over time based on best practices nationally, the standards for

RI Medicaid plans are also updated. Loss of NCQA accreditation, or a change to provisional accreditation status will continue to trigger a corrective action plan requirement for RI Medicaid plans and may result in the state terminating an MCO contract. As previously noted, the dental PAHP is accredited by URAC which similarly offers ongoing and updated dental plan utilization review requirements over time. In addition, RI Medicaid uses its EQRO to conduct accreditation reviews of its MCE plans.

During its upcoming re-procurement of the managed dental contract, RI Medicaid will explore modifications to its existing plan accreditation requirements, as well as modifications to contract language related to consequences for loss of sufficient accreditation for its dental plans.

2. Tracking participation in APMs related to value-based purchasing (pay for value not volume)

Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including:

a. Alternate Payment Methodology (APM) Data Report
b. Value Based Payment Report and
c. Accountable Entity-specific reports.

RI Medicaid will review these reports internally and with contracted MCEs and AEs to determine how the progress to date aligns with the goals and objectives identified in this Medicaid managed care Quality Strategy. This APM data and analysis will also inform future state, MCE, AE and work group interventions and quality improvement efforts.

3. Pay for Performance Incentives for MCEs and AEs

As noted in the Managed Care Quality Strategy Objectives in Section 2, RI Medicaid intends create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.

In addition, as part of this Quality Strategy, RI Medicaid will review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time. RI Medicaid will also consider modifications to AE measures and incentives over time based on results of its MCO and AE assessments and its managed care goals and objectives.

Finally, as part of its upcoming managed dental procurement, RI Medicaid intends to both strengthen its model contract requirements related to dental performance, transparency of performance, and consider the use of new or modified financial and/or non-financial performance incentives for its managed dental plans in the future.

4. Statewide collaboratives and workgroups that focus on quality of care

RI Medicaid will continue to work with MCEs and the EQRO to collect, analyze, compare and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement. EOHHS convenes various collaborative workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to the development of improvement projects and program services. Examples of these workgroups include:

- Accountable Entity Advisory Committee
- Behavioral Health Workgroup for Children
- Behavioral Health Workgroup for Adults
- 1115 waiver Demonstration Quality Workgroup
- Integrated Care Initiative Implementation Council
- Governor's Overdose Taskforce
- Long-term Care Coordinated Council

During the period of this Quality Strategy, RI Medicaid will consider how the work of these groups can better align with and support the goals and objectives identified in this Medicaid managed care Quality Strategy. In addition, as noted in **Section 2,** the State will develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.

5. Soliciting member feedback through a variety of forums and mechanisms: empowering members in their care

As previously noted, MCEs and the EQRO are involved in administering and assessing performance and satisfaction surveys sent to Medicaid managed care participants and/or their representatives. RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement. In addition, as part of its managed care objectives, RI Medicaid will explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs. RI Medicaid is also considering the use of managed care focus groups to better identify improvement opportunities and develop measures and strategies to ensure better outcomes that matter to members.

Section 6.2 Intermediate Sanctions

Rhode Island's Medicaid MCO Contracts clearly define intermediate sanctions, as specified in CFR 438.702 and 438.704, which EOHHS will impose if it makes any of the following determinations or findings against an MCO from onsite surveys, enrollee or other complaints, financial status or any other source:

1. EOHHS determines that a Medicaid MCO acts or fails to act as follows:
   a. Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of discrimination.
   b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater.
   c. Acts to discriminate among enrollees on the basis of their health status or need for health care services; the limit is $15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice, subject to an overall limit of $100,000.
   d. Misrepresents or falsifies information that it furnishes to CMS or to EOHHS; EOHHS may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation.

e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation.
f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in CFR 422.208 and 422.210 EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.
g. EOHHS determines whether the Contractor has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by EOHHS or that contain false or materially misleading information. EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.
h. EOHHS determines whether Contractor has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

In addition to any civil monetary penalty levied against a Medicaid MCE as an intermediate sanction, EOHHS may also: a) appoint temporary management to the Contractor; b) grant members the right to disenroll without cause; c) suspend all new enrollment to the Contractor; and/or d) suspend payment for new enrollments to the Contractor. As required in 42 CFR 438.710, EOHHS will give a Medicaid MCE written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeals rights.

Section 6.3 Health Information Technology

Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop and maintain a central repository of membership, medical, behavioral health and pharmacy claims from all commercial insurers, the self-insured, Medicare, and Medicaid. The purpose of APCD is to build a robust database that helps identify areas for improvement, growth, and success across Rhode Island's health care system. The production of actionable data and reports that are complete, accessible, trusted, and relevant allow for meaningful comparison and help inform decisions made by consumers, payers, providers, researchers, and state agencies. As a co-convener of APCD, EOHHS was one of the drivers of the project, and continues to be actively involved in its implementation. EOHHS has access to, and the ability to analyze APCD data including Medicaid and Medicare data in the APCD via a business intelligence tool supported by the APCD analytic Vendor. APCD data will be able to be used to report quality measures derived from claims data across the various Medicaid delivery systems.

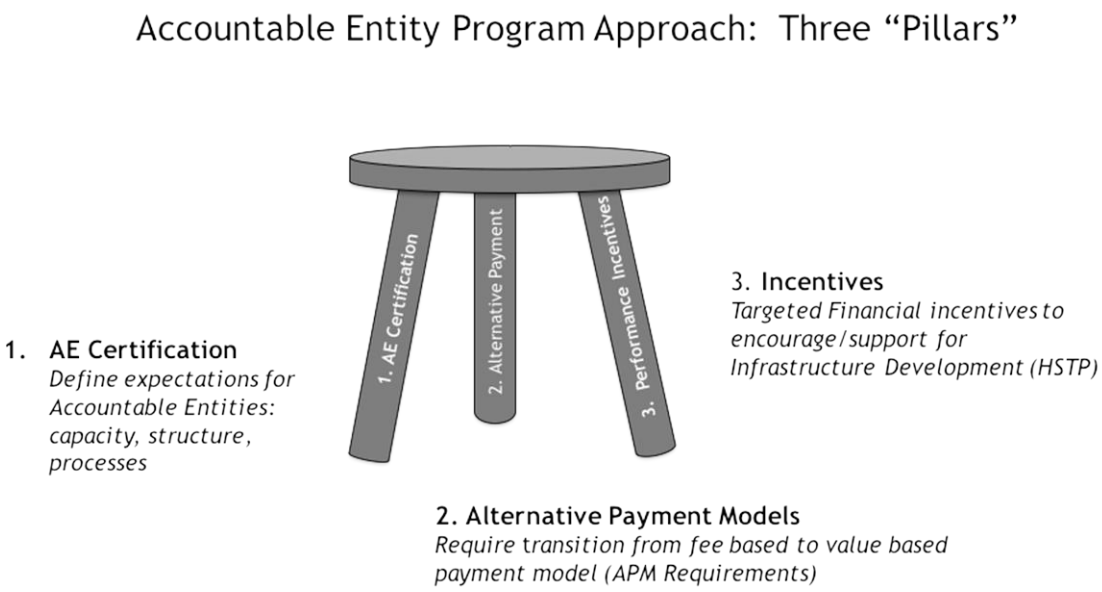
Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health and Human Service agencies have partnered to share information and collaborate towards achieving positive health outcomes and reducing disparities. This has culminated with the development of an eco-system that collects data from each HHS agency that can be shared within each agency. The ecosystem is still in its infancy but is expected to be a promising tool used in quality reporting and active contract management.

The Rhode Island Department of Health (DOH) also provides oversight functions related to the State's HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- KIDSNET Childhood Immunization Registry
- Syndromic Surveillance Registry
- Electronic Lab Reporting
- Prescription Drug Monitoring Program (PDMP)

Section 7: Delivery System Reform

AEs represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model, including but not limited to, behavioral health and social support services. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.



In late 2015, RI Medicaid provisionally certified Pilot AEs and in late 2017, CMS approved the state's AE Roadmap outlining the State's AE Program, Alternative Payment Methodologies (APMs) and the Medicaid Infrastructure Incentive Program (MIIP). The MIIP consists of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program.

EOHHS certifies Accountable Entities which are then eligible to enter into EOHHS-approved alternative payment model contractual arrangements with the Medicaid MCOs. To date, six Comprehensive Accountable Entities have been certified, and qualified APM contracts are in place between five AEs and Medicaid MCOs. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.

To secure full funding, AEs must earn payments by meeting metrics defined by EOHHS and its MCO partners and approved by CMS. Actual incentive payment amounts to AEs will be based on demonstrated AE performance.

Shared priorities are being developed through a joint MCO/AE working group that includes clinical leadership from both the MCOs and the AEs using a data driven approach. RI Medicaid is actively engaged in this process for identifying performance metrics and targets with the MCOs and the AEs.

Below is the initial list of AE performance measures as developed by RI Medicaid. The state identified these AE performance metrics after examining the Medicaid MCO measures, Adult and Child Core Measure Sets, and the OHIC standardized measures for commercial insurers developed as part of Healthy RI. The state's quality strategy

for AEs, as with MCEs, continues to include alignment with other payers in the market and regionally to reduce confusion and administrative burden at the provider level where possible, while continuing to focus efforts on performance improvement.

Initial AE Performance Measures	Steward
Breast Cancer Screening	NCQA
Weight Assessment & Counseling for Physical Activity, Nutrition for Children and Adolescents	NCQA
Developmental Screening in the 1st Three Years of Life	OHSU
Adult BMI Assessment	NCQA
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA
Controlling High Blood Pressure	NCQA
Follow-up after Hospitalization for Mental Illness (7 days & 30 days)	NCQA
Screening for Clinical Depression & Follow-up Plan	CMS
Social Determinants of Health (SDOH) Screen	RI EOHHS

As part of its ongoing quality strategy for MCOs and AEs, RI Medicaid will examine these AE performance metrics annually to determine if and when certain measures will be cycled out, perhaps because performance in some areas have topped out in Rhode Island and there are other opportunities for improvement on which the state wants MCOs and AEs to focus. For example, for AE performance year three, RI Medicaid is removing Adult BMI Assessment from the measure slate and moving the tobacco use measure to "reporting only." For the same time period, RI Medicaid will add two new AE HEDIS measures: Adolescent Well Care Visits and Comprehensive Diabetes Care: Eye Exam.

Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its Medicaid managed care members. Our goals include improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well- being, independence and quality of life.

We are excited by the progress in our AE program and the collaboration between RI Medicaid our contracted MCOs and the state-certified AEs. Today, close to 150,000 RI Medicaid MCO members are attributed to an AE. Consistent with our overall managed care approach, RI Medicaid is developing and refining an AE performance measure set and detailed measure specifications to assess AE performance over time as part of a joint workgroup with the state, the MCOs and their contracted AEs.

While strides have been made in Medicaid managed care accountability and value-based purchasing, Rhode Island continues to work towards a focus on accountability for health outcomes inclusive of population health and social determinants. Rhode Island is on the forefront of a shift from a fee for service model to a value-based payment system; this paradigm shift requires collaboration across delivery systems and stakeholders. There is also limited

capacity within Medicaid managed care to address broader social needs, which often overshadow and exacerbate members' medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence. These issues are particularly problematic when serving the most complex Medicaid populations. In the future, RI Medicaid anticipates taking lessons learned from its AE initiative and its care management initiatives as part of its efforts to improve cost-effective, quality care for the most complex Medicaid populations, including those with long-term care needs.