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State Fiscal Year 2020 External Quality Review Technical Report for Dental Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by Title 42 of the Code of Federal Regulations (42 CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

The Medical Services Administration (MSA) within MDHHS administers and oversees the Healthy Kids Dental (HKD) program, which provides Medicaid and Children's Health Insurance Program (CHIP) dental benefits to members 0 to 20 years of age. The HKD program's MCEs include two dental health plans (DHPs) contracted with MDHHS to administer the dental services. The DHPs contracted with MDHHS during state fiscal year (SFY) 2020 are displayed in Table 1-1.

Table 1-1—DHPs in Michigan

DHP Name	DHP Short Name
Blue Cross Blue Shield of Michigan	BCBSM
Delta Dental of Michigan	DDMI

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities performed by HSAG and included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1] The purpose of these activities, in general, is to improve the states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2020 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each DHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 31, 2021.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a DHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses the accuracy of performance measures reported by the DHPs and determine the extent to which performance measures reported by the DHPs follow federal specifications and reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a DHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Analysis[1-2]	This activity assesses member experience with a DHP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the DHPs' performance in providing quality, timely, and accessible dental services to MDHHS Medicaid and CHIP members under 21 years of age. For each DHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the DHPs' performance, which can be found in Section 3 of this report. The overall findings and conclusions for both DHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program specific to the HKD program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for MDHHS to further promote its goals and objectives in its quality strategy. Refer to Section 6 for more details.

Table 1-3—Statewide Substantive Findings

Program Strengths
• **Performance Improvement Initiatives**—Through its quality initiatives, including collaboration efforts with the Michigan Oral Health Coalition (MOHC) to develop the Michigan State Oral Health Plan (MSOHP), MDHHS has prioritized the oral health and well-being of Michigan children, which should support future statewide improvement in children's access to high-quality dental care.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Program Strengths
– Through their participation in the state-mandated PIPs, the DHPs focus efforts on quality outcomes related to timely access to preventive dental services. Designing a successful PIP, including the development of effective initiatives to improve performance in this area, has the potential to greatly impact the prevalence of young children seeking dental care and adopting good oral hygiene to support the prevention of future oral health-related problems. – Through the results of the Child Dental Survey, MDHHS and the DHPs can assess parents' and caretakers' experiences with their children's dental care and identify barriers that may be preventing Medicaid and CHIP members from accessing dental services. Through implementation of initiatives to address lower performing areas, and by removing barriers to dental care, the DHPs should see an increase in the utilization of preventive dental services and, consequently, members' oral diseases will be detected in the earlier stages and treatment can be provided at a greatly reduced cost. • **Program Monitoring**—Through its annual compliance monitoring activity, MDHHS has demonstrated an effective system for monitoring the DHPs in critical areas of the managed care program, including administration and management; appeal and grievance systems; member materials; information systems; medical management; program integrity; network adequacy; and quality improvement (QI).
Program Weaknesses
• **Children's Accessibility to Preventive Dental Services**—According to the Centers for Disease Control and Prevention, cavities (also known as tooth decay) are one of the most chronic diseases of childhood in the United States (U.S.). Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Children who have poor oral health often miss more school and receive lower grades than children who do not.[1-3] Although Medicaid and CHIP members under the age of 21 have access to dental benefits through the HKD program, members are not obtaining preventive dental care as confirmed through lower-performing performance measure rates and may be experiencing barriers to accessing care as demonstrated through lower satisfaction scores obtained through the Child Dental Survey. • **Compliance Assessment**—Although MDHHS has demonstrated through its annual compliance activity that it has an effective State monitoring system in accordance with 42 CFR §438.66, the tools and compliance review summaries provided by MDHHS do not appear to include a review of all requirements mandated under 42 CFR §438.358(iii), which requires a comprehensive review of each DHP's compliance with the standards set forth in subpart D of Part 438, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement (QAPI) requirements described in §438.330. Conducting a comprehensive compliance review, in accordance with CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*,[1-4] will provide the DHPs with a sound understanding of their strengths and weaknesses related to quality, timeliness, and access to care. Findings from the comprehensive compliance review activity will also help the DHPs improve their performance with respect to quality, timeliness, and access to care.

[1-3] Centers for Disease Control and Prevention. Children's Oral Health. Available at: https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html. Accessed on: Mar 31, 2021.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 2, 2021.

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
• The 2020 MSOHP is a comprehensive plan of action to improve the oral health of Michigan residents. The plan focuses on education, access, prevention, and policy—understanding that these subject areas overlap in many ways. A focus of the plan includes increasing access to oral health services among individuals who are most adversely affected by disparities, poverty, and other socioeconomic factors.[1-5] HSAG recommends that MDHHS and its DHPs continue to leverage this existing plan and the efforts already underway and work collaboratively with partnering organizations to successfully complete the initiatives listed in the 2020 MSOHP.	**Goal #1:** Ensure high quality and high levels of access to care. **Goal #4:** Reduce racial and ethnic disparities in healthcare and health outcomes.
• To promote DHP accountability, MDHHS should consider setting minimum performance thresholds for all, or a subset of, the existing performance monitoring standards identified in the HKD program contract, such as for the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-6] *Annual Dental Visit* and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental and oral health services performance measures that are reported to CMS using Form CMS-416.	
• MDHHS should focus on improving the accuracy and validity of performance measure rates by conducting PMV in alignment with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*.[1-7] • MDHHS should review its overall compliance monitoring process to ensure adherence to CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*.	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.

[1-5] Michigan Department of Health and Human Services. *Michigan State Oral Health Plan*. Available at: https://www.michigan.gov/documents/mdhhs/2020_MichiganStateOralHealthPlan_FINAL_511929_7.pdf. Accessed on: Mar 31, 2021.

[1-6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 31, 2021.

2. Overview of the Dental Health Plans

Managed Care in Michigan

In Michigan, management of the Medicaid program is spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services are managed by the Managed Care Plan Division in the MSA. Long-term services and supports (LTSS) are implemented by three different MDHHS program areas, including the Long-Term Care Services Division (MI Choice Program); the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly); and the Behavioral Health and Developmental Disabilities Administration (BHDDA) Quality Division. BHDDA also administers Medicaid waivers for people with intellectual/developmental disabilities, mental illness, and serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. Table 2-1 displays the Michigan Medicaid managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program.

Table 2-1—Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	MCEs	MDHHS Division
Comprehensive Health Care Program (CHCP), including: • CHIP—MIChild • Children's Special Health Care Services Program • Healthy Michigan Plan (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)	MSA
Managed LTSS, including: • MI Health Link Demonstration	Integrated Care Organizations (ICOs) Prepaid Inpatient Health Plans (PIHPs)	MSA
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • Healthy Michigan Plan Dental	Prepaid Ambulatory Health Plans (PAHPs)	MSA
Behavioral Health Managed Care	PIHPs	BHDDA

Healthy Kids Dental Program

Beginning in May 2000, MDHHS expanded access to oral health services for Medicaid members, focusing on rural areas, and creating a new Medicaid managed care dental service delivery model called HKD. MDHHS initiated HKD as a pilot program to help improve the dental health of Medicaid-enrolled children. During this pilot, HKD members received services through one contracted dental vendor. After years of continued investment and expansion into additional counties, on October 1, 2016, HKD became available statewide to all children enrolled in Medicaid who are under the age of 21 and to CHIP members under the age of 20. Effective October 1, 2018, MDHHS offered eligible members a choice of two DHPs for the HKD benefit. In addition to giving members a choice of DHPs, the HKD program established new objectives, including better oral health outcomes; physical and oral health coordination; increased utilization of preventive dental services; patient and caretaker oral health education; community partnership collaboration; and incorporation of population makeup, such as socio-economic status, race, education, etc., in consideration of outreach, education, and service delivery.

Overview of DHPs

During the SFY 2020 review period, MDHHS contracted with two DHPs. These DHPs are responsible for the provision of dental services to HKD members. Table 2-2 provides a profile for each DHP.

Table 2-2—DHP Profiles

DHP	Covered Services	Service Area/Regions Served
Blue Cross Blue Shield of Michigan (BCBSM)	• Emergency dental services • Diagnostic services • Preventive services • Sealants • Restorative services • Limited adjunctive services • Endodontic services • Limited crown coverage • Prosthodontic services • Removable prosthodontic • Oral surgery services • Additional medically necessary services, including dental EPSDT services	Statewide
Delta Dental of Michigan (DDMI)		

Quality Strategy

The 2020–2023 MDHHS Comprehensive Quality Strategy (CQS) provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by all MDHHS Medicaid managed care programs, including the HKD program. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services (HHS) National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and were specifically designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Ojectives[2-1]

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes consumers' health and safety.

[2-1] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Mar 31, 2021.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1:** Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

The MDHHS CQS also includes a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule. The common domains include:

- Network Adequacy and Availability
- Access to Care
- Member Satisfaction
- Health Equity

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against the MDHHS CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the MDHHS CQS.

Quality Initiatives and Interventions

To accomplish its objectives, MDHHS, through the HKD program, has implemented several initiatives and interventions that focus on QI. Examples of these initiatives and interventions include:

- **2020 MSOHP**[2-2]—MDHHS and MOHC have collaborated to develop a plan that will work toward achieving optimal oral health among all Michiganders. This oral health plan establishes program goals, implementation steps, and a monitoring plan, and serves as a tool for enlisting collaborators and partners and attracting funding sources. The oral health plan is intended to guide policy makers, providers, community members, and other stakeholders as they work together to improve oral health across the State of Michigan. DHPs must promote among its network providers, the overall goals, objectives, and activities of the 2020 MSOHP; and must use the 2020 MSOHP as part of its guidance in the development of its health promotion and outreach strategies. The 2020 MSOHP is focused on three main areas:
  - Professional Integration: Enhance professional integration between providers across the lifespan.
  - Health Literacy: Increase knowledge and awareness of the importance of oral health to overall health.
  - Increased Access to Oral Healthcare: Increase access to oral healthcare among underserved and/or hard-to-reach populations.
- **Performance Monitoring Standards**—To monitor health plan performance in the areas of quality, access, customer service, and reporting, MDHHS has established performance monitoring standards categorized in the following three areas: Medicaid managed care measures; HEDIS and CMS-416 measures; and Dental Quality Alliance measures. For each performance area, MDHHS established specific measures, goals, minimum performance standards, data sources, and monitoring intervals. Failure to meet the minimum performance standards may result in the implementation of remedial actions and/or improvement plans.

[2-2] Michigan Department of Health and Human Services. *Michigan State Oral Health Plan*. Available at: https://www.michigan.gov/documents/mdhhs/2020_MichiganStateOralHealthPlan_FINAL_511929_7.pdf. Accessed on: Mar 31, 2021.

- **Performance Bonus (value-based payment)**—During each contract year, MDHHS withholds a percentage of the approved capitation payment from each DHP. These funds are used for the DHP performance awards. Criteria for awards include, but are not limited to, assessment of performance in quality of care, access to care, member satisfaction, and administrative functions. Each year, MDHHS establishes and communicates to the DHPs the criteria and standards to be used for the performance bonus awards.

3. Assessment of DHP Performance

DHP Methodology

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2020 review period to comprehensively evaluate the performance of the DHPs on providing quality, timely, and accessible healthcare services to HKD members. Quality, as it pertains to EQR, means the degree to which the DHP increased the likelihood of desired outcomes of its members through its structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the DHPs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

To identify the significant strengths and weaknesses and draw conclusions for each DHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the HKD program. The composite findings for each DHP were analyzed and aggregated to identify overarching conclusions and focus areas for the DHP in alignment with the priorities of MDHHS.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2020 validation, the DHPs initiated their MDHHS-mandated PIP topics reporting the Design stage (Steps I through VI) for the performance indicators to be collected. The purpose of each PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. HSAG's PIP validation ensures that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the QI strategies and activities conducted by the DHP during the project.

Table 3-1 outlines the selected PIP topics and study indicators for the PIP for both DHPs.

Table 3-1—PIP Topics and Study Indicators

DHP	PIP Topic	Study Indicator
BCBSM	*Increasing the Number of Members Ages 0–5 Accessing Dental Services*	The percentage of BCBSM HKD member visits to a dental provider in the selected federal fiscal year based on data.
DDMI	*Increasing Dental Utilization in Ages One and Two*	1. Providers Rendering Treatment 2. Increase Age One and Two Dental Utilization Percentages

Performance Measure Validation

The PMV activity included a comprehensive review of the DHPs' rates for six EPSDT dental and oral health services performance measures that were reported to CMS using Form CMS-416 (i.e., CMS-416 EPSDT performance measures). These six performance measures were calculated and reconciled by the DHPs in collaboration with MDHHS during the measurement period. Table 3-2 lists these performance measures.

Table 3-2—CMS-416 EPSDT Performance Measures for Validation

CMS-416	Performance Measures
12a	*Total Eligibles Receiving Any Dental Services*
12b	*Total Eligibles Receiving Preventive Dental Services*
12c	*Total Eligibles Receiving Dental Treatment Services*
12d	*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*
12e	*Total Eligibles Receiving Dental Diagnostic Services*
12f	*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*

Compliance Review

The DHP compliance review activity is conducted by MDHHS staff members, and consists of an evaluation annually of each DHP's performance in six program areas, called "standards," identified in Table 3-3. MDHHS identified the requirements necessary for review during the SFY and divided the requirements into a 12-month compliance monitoring schedule. For SFY 2020, the DHPs were provided with a *Compliance Review Timeline* outlining the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance. For each criterion reviewed, MDHHS assigned a score of *Pass*, *Incomplete*, or *Fail*. The findings presented in this report were provided to HSAG by MDHHS.

Table 3-3—Compliance Review Standards

Standards	
1	Administrative
2	Provider
3	Member
4	Quality/Utilization
5	MIS [Management Information Systems]/Data Reporting
6	Program Integrity

Dental Survey Analysis

The CAHPS Dental Plan Survey, currently available for the adult population only, was modified by HSAG for administration to a child population to create a Child Dental Survey. The Child Dental Survey asked parents/caretakers to report on and evaluate their experiences with their child's dental care from the DHP, dentists, and staff members. The primary objective of the Child Dental Survey was to evaluate the quality of dental care and services provided to child members enrolled in the HKD program. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with the most positive experiences in particular aspects of their healthcare.

EQR Activity Results

Blue Cross Blue Shield of Michigan

Validation of Performance Improvement Projects

Performance Results

Blue Cross Blue Shield of Michigan reported the Design stage, which includes the PIP methodology and data collection methods. HSAG's review determined whether the PIP design (e.g., aim statement, population, indicator, sampling methods, and data collection methods) were based on sound methodological principles and could reliably measure outcomes. Successful execution of this component of the PIP ensures that reported PIP results are accurate and capable of measuring sustained improvement. Table 3-4 displays the overall validation status for the PIP topic initiated during the SFY 2020 validation.

Table 3-4—Overall Validation Rating for BCBSM

PIP Topic	Validation Rating for Design Stage	Study Indicator	Aim Statement
Increasing the Number of Members Ages 0–5 Accessing Dental Services	*Met*	The percentage of BCBSM HKD member visits to a dental provider in the selected federal fiscal year based on data.	Do targeted interventions increase the percentage of eligible enrollees 0–5 years of age that had at least one dental service during the measurement year?

Once **Blue Cross Blue Shield of Michigan** establishes its PIP design, the process progresses into the Implementation stage. This stage will include data analysis and the development of interventions based on identified barriers to performance. Baseline data will be included in the SFY 2021 annual EQR report, and a description of interventions will be included in the SFY 2022 annual EQR report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Blue Cross Blue Shield of Michigan designed a methodologically sound PIP, which should support members' timely access to high-quality dental providers and improve their oral health.

Weaknesses

Weakness: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends **Blue Cross Blue Shield of Michigan** use the approved methodology and data collection methods as it progresses to reporting baseline measurement results for the next annual submission.

Performance Measure Validation

Performance Results

Table 3-5 demonstrates **Blue Cross Blue Shield of Michigan**'s final reconciled and reported rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 3-5—BCBSM Final CMS-416 EPSDT Performance Measure Rates

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	**25,681**	**23,016**	**9,516**	**3,224**	**25,215**	**0**
Denominator	**145,655**	**145,655**	**145,655**	**47,958**	**145,655**	**145,655**
Final Rate	**17.63%**	**15.80%**	**6.53%**	**6.72%**	**17.31%**	**0.00%**

Strengths, Weaknesses, and Recommendations

Strengths

Strength: No strengths were identified through this activity.

Weaknesses

Weakness: **Blue Cross Blue Shield of Michigan** experienced challenges throughout the reporting process when calculating the pre- and post-reconciled rates for the CMS-416 EPSDT performance measures.

Why the weakness exists: **Blue Cross Blue Shield of Michigan** experienced calculation and validation process difficulties when finalizing and reconciling the CMS-416 EPSDT performance measure rates. These difficulties appeared to be related to various factors, including source code inaccuracies, enrollment data gaps, encounter data inconsistencies, **Blue Cross Blue Shield of Michigan**'s lack of understanding of some of the CMS-416 EPSDT performance measure specifications, and possible data integration gaps. Each of these factors is crucial to ensuring the accuracy of performance measure data through the validation process, which includes steps to provide assurance of data integration, data control, and documentation of performance measure calculations.

Recommendation: HSAG recommends for future performance measure reporting activities that **Blue Cross Blue Shield of Michigan** focus on improving upon the accuracy and validity of performance measure rates by participating in a revised PMV that fully aligns with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*. By participating in a structured PMV that includes an assessment of the integrity of **Blue Cross Blue Shield of Michigan**'s information systems and data extraction process, a review of source code for the performance measures, evaluation of **Blue Cross Blue Shield of Michigan**'s data mapping, performance measure workflow review, a review of data at each stage in the performance measure reporting process, and a member-specific record-level review of both numerator and denominator data, **Blue Cross Blue Shield of Michigan** will provide further assurances of its performance measure rates' reliability and accuracy.

Compliance Review

Performance Results

Table 3-6 presents **Blue Cross Blue Shield of Michigan**'s overall compliance score for each standard, the totals across the six standards reviewed, and the total compliance score across all standards for the SFY 2020 compliance monitoring activity.

Table 3-6—Summary of Compliance Review Results for BCBSM

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	Total Applicable	BCBSM	HKD Program
1	Administrative	5	0	0	5	100%	100%
2	Provider	9	0	0	9	100%	100%
3	Member	7	0	0	7	100%	96%
4	Quality/Utilization	7	0	0	7	100%	100%
5	MIS/Data Reporting	4	0	0	4	100%	94%
6	Program Integrity	27	1	0	28	98%	99%
Overall		**59**	**1**	**0**	**60**	**99%**	**99%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points) or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual DHP scores, then dividing that sum by the total number of applicable criteria reviewed across all DHPs.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Blue Cross Blue Shield of Michigan demonstrated an adequate administrative structure, including an organizational chart, administrative positions, participation in administrative meetings, and a comprehensive third-party audit of its data privacy and information security program, which are necessary to effectively carry out managed care functions.

Strength: Blue Cross Blue Shield of Michigan ensured that services were available and accessible to members in a timely manner through the maintenance of provider contracts and provider directory; monitoring of its contracted providers; providing 24/7 access to member assistance and provider authorizations; maintaining an adequate number of dentists and dental care specialists; and developing processes for community health coordination and communication with providers.

Strength: Blue Cross Blue Shield of Michigan maintained sufficient procedures to ensure members had timely and adequate information via the member identification card, member handbook, member newsletters, and member website; and through **Blue Cross Blue Shield of Michigan**'s grievance and appeal resolution and coordination of processes, which are necessary for members to access and participate in their dental care needs and services.

Strength: Blue Cross Blue Shield of Michigan's quality program demonstrated compliance with all requirements related to clinical practice guidelines (CPGs), the annual quality improvement program (QIP) description work plan and evaluation, the utilization management (UM) program description and effectiveness review, QI and UM policies

and procedures, DHP-initiated PIPs, and performance measures. A comprehensive quality improvement program is necessary to increase and sustain the quality of, and access to, timely healthcare and services received by members.

Strength: **Blue Cross Blue Shield of Michigan** maintained a health information system (HIS) that collected, analyzed, integrated, and reported data in various program areas and functions; for example, member enrollment and disenrollment, provider enrollment, claims payment, grievance and appeal tracking, and quality reporting. An HIS that collects, analyzes, and reports health information is necessary to support healthcare-related decision making and drive improved healthcare outcomes.

Weaknesses

Weakness: While **Blue Cross Blue Shield of Michigan** received one deficiency related to errors in the Tips and Grievances program integrity report, no trends of weakness in any standard were identified.

Why the weakness exists: N/A

Recommendation: Although **Blue Cross Blue Shield of Michigan** submitted a corrective action plan (CAP) to address the noted deficiency, HSAG recommends that **Blue Cross Blue Shield of Michigan** continue to validate all program integrity data submitted to MDHHS to ensure MDHHS has accurate and complete information available to effectively monitor and combat Medicaid fraud, waste, and abuse.

Child Dental Survey Analysis

Performance Results

Table 3-7 presents **Blue Cross Blue Shield of Michigan**'s 2020 top-box scores compared to the top-box scores of the HKD program (i.e., BCBSM and DDMI combined).

Table 3-7—Summary of 2020 Top-Box Scores for BCBSM

	BCBSM	HKD Program
Global Ratings		
Rating of Regular Dentist	70.8%	71.3%
Rating of All Dental Care	71.5%	73.9%
Rating of Finding a Dentist	49.2%*	52.6%*
Rating of Dental Plan	71.8%	70.9%
Composite Measures		
Care from Dentists and Staff	93.4%	94.5%
Access to Dental Care	71.9%	73.5%
Dental Plan Information and Services	86.0%	86.0%

	BCBSM	HKD Program
Individual Item Measures		
Care from Regular Dentist	95.0%	94.4%
Would Recommend Regular Dentist	95.4%	94.4%
Would Recommend Dental Plan	93.9%	95.6%

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the score is statistically significantly higher than the HKD program.
↓ Indicates the score is statistically significantly lower than the HKD program.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: None of the 2020 top-box scores for **Blue Cross Blue Shield of Michigan** were statistically significantly lower than the HKD program.

Weaknesses

Weakness: HSAG did not identify any weaknesses for **Blue Cross Blue Shield of Michigan** for the Child Dental Survey.

Recommendation: Although no weaknesses were identified based on the comparison of **Blue Cross Blue Shield of Michigan**'s member experiences to the overall HKD program's survey results, HSAG recommends **Blue Cross Blue Shield of Michigan** prioritize improvement efforts in those areas that would impact members' access to and timeliness of dental services, including members' ability to get timely appointments and members' perceived negative experiences with their dental providers.

Delta Dental of Michigan

Validation of Performance Improvement Projects

Performance Results

Delta Dental of Michigan reported the Design stage, which includes the PIP methodology and data collection methods. HSAG's review determined whether the PIP design (e.g., aim statement, population, indicator, sampling methods, and data collection methods) were based on sound methodological principles and could reliably measure outcomes. Successful execution of this component of the PIP ensures that reported PIP results are accurate and capable of measuring sustained improvement. Table 3-8 displays the overall validation status for the PIP topic initiated during the SFY 2020 validation.

Table 3-8—Overall Validation Rating for DDMI

PIP Topic	Validation Rating for Design Stage	Study Indicators	Aim Statements
Increasing Dental Utilization in Ages One and Two	*Met*	1. Providers Rendering Treatment 2. Increase Age One and Two Dental Utilization Percentages	1. Will targeted interventions result in a 10 percent increase in the number of providers in an area willing to treat children ages one to two? 2. Will targeted interventions to members in Macomb County, MI, increase the percentage of corresponding members ages one through two years of age receiving any dental service by 5 percent during the PIP 3-year period?

Once **Delta Dental of Michigan** establishes its PIP design, the process progresses into the Implementation stage. This stage will include data analysis and the development of interventions based on identified barriers to performance. Baseline data will be included in the SFY 2021 annual EQR report, and a description of interventions will be included in the SFY 2022 annual EQR report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Michigan designed a methodologically sound PIP, which should support members' timely access to high-quality dental providers and improve their oral health.

Weaknesses

Weakness: There were no identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends **Delta Dental of Michigan** use the approved methodology and data collection methods as it progresses to reporting baseline measurement results for the next annual submission.

Performance Measure Validation

Performance Results

Table 3-9 demonstrates **Delta Dental of Michigan**'s final reconciled and reported rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 3-9—DDMI Final CMS-416 EPSDT Performance Measure Rates

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	**501,420**	**464,033**	**202,631**	**50,039**	**482,627**	**0**
Denominator	**961,831**	**961,831**	**961,831**	**359,691**	**961,831**	**961,831**
Final Rate	**52.13%**	**48.24%**	**21.07%**	**13.91%**	**50.18%**	**0.00%**

Strengths, Weaknesses, and Recommendations

Strengths

Strength: No strengths were identified through this activity.

Weaknesses

Weakness: During the process of reconciling and finalizing the performance measure rates for 12f, HSAG identified inconsistency in reporting, specifically regarding the number of reported members receiving oral health services from non-dentist providers.

Why the weakness exists: **Delta Dental of Michigan** confirmed when originally reporting and calculating the rate for performance measure 12f, **Delta Dental of Michigan** had included Current Dental Terminology (CDT) codes D0190 and D1206, which are to be billed by a dentist or person under the supervision of a dentist. The Form CMS-416 Instructions define a *non-dentist provider* as any qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist. MDHHS and HSAG communicated this definition to **Delta Dental of Michigan**, and, as a result of this clarification, **Delta Dental of Michigan** confirmed its reported rate of 26.77 percent for 12f was inaccurate since **Delta Dental of Michigan** did not reimburse any non-dentist providers for the applicable services in the measurement year. **Delta Dental of Michigan** therefore reported a corrected rate of 0.00 percent.

Recommendation: HSAG recommends in future reporting for **Delta Dental of Michigan** to review any codes that are used to identify the performance measure numerator counts

to ensure they are appropriately applied for each reported performance measure in accordance with required reporting specifications.

Weakness: **Delta Dental of Michigan** experienced challenges throughout the reporting process when calculating the pre- and post-reconciled rates for the CMS-416 EPSDT performance measures.

Why the weakness exists: **Delta Dental of Michigan** experienced calculation and validation process difficulties when finalizing and reconciling the CMS-416 EPSDT performance measure rates. These difficulties appeared to be related to various factors, including source code inaccuracies, enrollment data gaps, encounter data inconsistencies, **Delta Dental of Michigan**'s lack of understanding of some of the CMS-416 EPSDT performance measure specifications, and possible data integration gaps. Each of these factors is crucial to ensuring the accuracy of performance measure data through the validation process, which includes steps to provide assurance of data integration, data control, and documentation of performance measure calculations.

Recommendation: HSAG recommends for future performance measure reporting activities that **Delta Dental of Michigan** focus on improving upon the accuracy and validity of performance measure rates by participating in a revised PMV that fully aligns with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*. By participating in a structured PMV that includes an assessment of the integrity of **Delta Dental of Michigan**'s information systems and data extraction process, a review of source code for the performance measures, evaluation of **Delta Dental of Michigan**'s data mapping, performance measure workflow review, a review of data at each stage in the performance measure reporting process, and a member-specific record-level review of both numerator and denominator data, **Delta Dental of Michigan** will provide further assurances of its performance measure rates' reliability and accuracy.

Compliance Review

Performance Results

Table 3-10 presents **Delta Dental of Michigan**'s overall compliance score for each standard, the totals across the six standards reviewed, and the total compliance score across all standards for the SFY 2020 compliance monitoring activity.

Table 3-10—Summary of Compliance Review Results for DDMI

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	Total Applicable	DDMI	HKD Program
1	Administrative	5	0	0	5	100%	100%
2	Provider	9	0	0	9	100%	100%
3	Member	6	1	0	7	93%	96%

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	Total Applicable	DDMI	HKD Program
4	Quality/Utilization	7	0	0	7	100%	100%
5	MIS/Data Reporting	3	1	0	4	88%	94%
6	Program Integrity	28	0	0	28	100%	99%
Overall		**58**	**2**	**0**	**60**	**98%**	**99%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points) or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual DHP scores, then dividing that sum by the total number of applicable criteria reviewed across all DHPs.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Michigan demonstrated an adequate administrative structure, including an organizational chart, administrative positions, participation in administrative meetings, and a comprehensive third-party audit of its data privacy and information security program, which are necessary to effectively carry out managed care functions.

Strength: Delta Dental of Michigan ensured that services were available and accessible to members in a timely manner through the maintenance of provider contracts and provider directory; monitoring of its contracted providers; providing 24/7 access to member assistance and provider authorizations; maintaining an adequate number of dentists and dental care specialists; and developing processes for community health coordination and communication with providers.

Strength: Delta Dental of Michigan's quality program demonstrated compliance with all requirements related to CPGs, the annual QIP description work plan and evaluation, the UM program description and effectiveness review, QI and UM policies and procedures, DHP-initiated PIPs, and performance measures. A comprehensive quality program is necessary to increase and sustain the quality of, and access to, timely healthcare and services received by members.

Strength: Delta Dental of Michigan demonstrated a sufficient compliance program, including adequacy policies and procedures and employee education on fraud, waste, and abuse; communication between internal and external partners; internal monitoring of utilization and billing practices; and auditing and investigation practices. A comprehensive compliance program promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal and State law, or to federal healthcare program requirements.

Weaknesses

Weakness: While **Delta Dental of Michigan** received two deficiencies in two separate program areas (incorrectly classifying appeals during the implementation of a new tracking system and failure to initially submit all appropriate documentation to support encounter reporting, claims payment and quality reporting processes), no trends of weakness in any standard were identified.

Why the weakness exists: N/A

Recommendation: As **Delta Dental of Michigan** previously submitted a CAP to address these findings, which were accepted by MDHHS, HSAG has no additional recommendations.

Weakness: While **Delta Dental of Michigan** achieved full compliance in the Quality/Utilization standard, MDHHS indicated **Delta Dental of Michigan** does not require prior authorizations for any dental services. **Delta Dental of Michigan**'s coverage and authorization of services processes may lead to overutilization of dental services that are not medically necessary to members' dental conditions.

Recommendation: HSAG recommends that **Delta Dental of Michigan** review its coverage and authorization of services policies and, specifically, determine if appropriate prior authorization requirements are needed given the dental coverage and services covered under the HKD program (for example, prosthodontics and oral surgery services).

Child Dental Survey Analysis

Performance Results

Table 3-11 presents **Delta Dental of Michigan**'s 2020 top-box scores compared to the top-box scores of the HKD program (i.e., BCBSM and DDMI combined).

Table 3-11—Summary of 2020 Top-Box Scores for DDMI

	DDMI	HKD Program
Global Ratings		
Rating of Regular Dentist	71.6%	71.3%
Rating of All Dental Care	75.7%	73.9%
Rating of Finding a Dentist	59.4%*	52.6%*
Rating of Dental Plan	70.2%	70.9%
Composite Measures		
Care from Dentists and Staff	95.2%	94.5%
Access to Dental Care	74.9%	73.5%
Dental Plan Information and Services	86.3%	86.0%

	DDMI	HKD Program
Individual Item Measures		
Care from Regular Dentist	94.0%	94.4%
Would Recommend Regular Dentist	93.7%	94.4%
Would Recommend Dental Plan	96.8%	95.6%

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the score is statistically significantly higher than the HKD program.
↓ Indicates the score is statistically significantly lower than the HKD program.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: None of the 2020 top-box scores for **Delta Dental of Michigan** were statistically significantly lower than the HKD program.

Weaknesses

Weakness: HSAG did not identify any weaknesses for **Delta Dental of Michigan** for the Child Dental Survey.

Recommendation: Although no weaknesses were identified based on the comparison of **Delta Dental of Michigan**'s member experiences to the overall HKD program's survey results, HSAG recommends **Delta Dental of Michigan** prioritize improvement efforts in those areas that would impact members' access to and timeliness of dental services, including members' ability to get timely appointments and members' perceived negative experiences with their dental providers.

4. Follow-Up on Prior EQR Recommendations for DHPs

SFY 2020 is the first year that an annual detailed technical report was completed for the HKD program and the contracted DHPs. Therefore, there were no previous QI recommendations made to MDHHS or to the DHPs by HSAG or another external quality review organization (EQRO) prior to SFY 2020. Future technical reports will include an assessment of the degree to which each DHP addressed the recommendations for QI made by the EQRO during the previous year's EQR.

5. DHP Comparative Information

In addition to performing a comprehensive assessment of the performance of each DHP, HSAG compared the findings and conclusions established for each DHP to assess the HKD program. The overall findings of the DHPs were used to identify the overall strengths and weaknesses of the HKD program and to identify areas in which MDHHS could leverage or modify the MDHHS CQS to promote improvement.

DHP EQR Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the DHPs.

Validation of Performance Improvement Projects

For the SFY 2020 validation, the DHPs provided the PIP design and completed Steps I through VI for their state-mandated PIP topic. Table 5-1 provides a comparison of the validation scores, by DHP.

Table 5-1—Comparison of Validation Scores, by DHP

Overall PIP Validation Status, by DHP		Design Scores		
		Met	Partially Met	Not Met
BCBSM	*Met*	*100%*	*0%*	*0%*
DDMI	*Met*	*100%*	*0%*	*0%*

Performance Measure Validation

Table 5-2 displays the comparison of performance between the two DHPs for the SFY 2020 performance measure activity.

Table 5-2—CMS-416 EPSDT Performance Measure Rate Comparisons

Performance Measures		
CMS-416 Measure	**BCBSM**	**DDMI**
12a—*Total Eligibles Receiving Any Dental Services*	**17.63%**	**52.13%**
12b—*Total Eligibles Receiving Preventive Dental Services*	**15.80%**	**48.24%**
12c—*Total Eligibles Receiving Dental Treatment Services*	**6.53%**	**21.07%**
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	**6.72%**	**13.91%**

Performance Measures		
CMS-416 Measure	**BCBSM**	**DDMI**
12e—*Total Eligibles Receiving Dental Diagnostic Services*	**17.31%**	**50.18%**
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	**0.00%**	**0.00%**

Delta Dental of Michigan had higher rates than **Blue Cross Blue Shield of Michigan** for each reported measure for SFY 2019 services. **Delta Dental of Michigan** also had higher numerators and denominators than **Blue Cross Blue Shield of Michigan** for all performance measure rates due to **Delta Dental of Michigan** having a greater number of enrolled members during the reporting period. **Blue Cross Blue Shield of Michigan**'s first year contracting with MDHHS to provide services was during the SFY 2019 reporting period (i.e., **Blue Cross Blue Shield of Michigan** did not receive members for SFY 2018); therefore, **Blue Cross Blue Shield of Michigan**'s lower membership count resulted in its lower numerator and denominator counts for the CMS-416 EPSDT performance measures for the SFY 2019 reporting period. Additionally, MDHHS indicated that **Delta Dental of Michigan** has provided dental services to members for over two decades and, therefore, had more stability in its membership. Finally, MDHHS further clarified that there were challenges implementing the new **Blue Cross Blue Shield of Michigan** contract, as the MDHHS and **Blue Cross Blue Shield of Michigan** member eligibility data did not consistently match throughout the early portion of SFY 2019. MDHHS indicated this was due to system errors, which were later fixed; however, it may have created confusion during the **Blue Cross Blue Shield of Michigan** member outreach processes, resulting in the potential for delays in reaching enrolled members and, conversely, lower rates. While there are no state or national benchmarks established for these performance measures, the results are indicative that **Delta Dental of Michigan** members are accessing dental services at a greater rate than **Blue Cross Blue Shield of Michigan** members.

MDHHS indicated there are likely key differences in the populations between the DHPs, as **Blue Cross Blue Shield of Michigan** had a higher proportion of membership ages zero to two years old, which could be a contributing factor to **Blue Cross Blue Shield of Michigan**'s lower rates since members under the age of two would be less likely to access the preventive dental services covered under their EPSDT benefits. Research has shown that a lower proportion of Medicaid members under the age of 36 months access preventive dental services and oral health services than Medicaid members over the age of 36 months.[5-1]

[5-1] Arthur T, Rozier RG. *Provision of Preventive Dental Services in Children Enrolled in Medicaid by Nondental Providers*. Pediatrics [serial online]. Feb 2016:137(2). Available at: https://pediatrics.aappublications.org/content/137/2/e20153436. Accessed on: Apr 13, 2021.

Compliance Review

HSAG calculated the HKD program's overall performance in each of the six performance areas. Table 5-3 compares the HKD program average compliance score in each of the six standards with the compliance score achieved by each DHP. The percentages of requirements met for each of the six standards reviewed during the SFY 2020 compliance monitoring activity are provided.

Table 5-3—Summary of SFY 2020 Compliance Review Results

Standard		BCBSM	DDMI	HKD Program
1	Administrative	100%	100%	**100%**
2	Providers	100%	100%	**100%**
3	Members	100%	93%	**96%**
4	Quality/Utilization	100%	100%	**100%**
5	MIS/Data Reporting	100%	88%	**94%**
6	Program Integrity	98%	100%	**99%**
Total Compliance Score		**99%**	**98%**	**99%**

Indicates standards in which the DHPs did not achieve full compliance.

Child Dental Survey Analysis

A comparative analysis was performed to identify if one DHP performed statistically significantly higher or lower on each measure compared to the HKD program (i.e., BCBSM and DDMI combined). Table 5-4 presents the 2020 top-box scores for **Blue Cross Blue Shield of Michigan** and **Delta Dental of Michigan** compared to the top-box scores of the HKD program.

Table 5-4—SFY 2020 DHP Comparisons

	BCBSM	DDMI	HKD Program
Global Ratings			
Rating of Regular Dentist	70.8%	71.6%	71.3%
Rating of All Dental Care	71.5%	75.7%	73.9%
Rating of Finding a Dentist	49.2%*	59.4%*	52.6%*
Rating of Dental Plan	71.8%	70.2%	70.9%
Composite Measures			
Care from Dentists and Staff	93.4%	95.2%	94.5%
Access to Dental Care	71.9%	74.9%	73.5%
Dental Plan Information and Services	86.0%	86.3%	86.0%

	BCBSM	DDMI	HKD Program
Individual Item Measures			
Care from Regular Dentist	95.0%	94.0%	94.4%
Would Recommend Regular Dentist	95.4%	93.7%	94.4%
Would Recommend Dental Plan	93.9%	96.8%	95.6%

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the score is statistically significantly higher than the HKD program.
↓ Indicates the score is statistically significantly lower than the HKD program.

Statewide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each DHP and of the overall strengths and weaknesses of the HKD program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the HKD program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

- **Performance Improvement Initiatives—**Through its quality initiatives, including collaboration efforts with MOHC to develop the MSOHP, MDHHS has prioritized the oral health and well-being of Michigan children, which should support future statewide improvement in children's access to high-quality dental care.
  - Through their participation in the state-mandated PIPs, **Blue Cross Blue Shield of Michigan** and **Delta Dental of Michigan** focus efforts on quality outcomes related to timely access to preventive dental services. Designing a successful PIP, including the development of effective initiatives to improve performance in this area, has the potential to greatly impact the prevalence of young children seeking dental care and adopting good oral hygiene to support the prevention of future oral health-related problems.
  - Through the results of the Child Dental Survey, MDHHS and the DHPs can assess parents' and caretakers' experiences with their children's dental care and identify barriers that may be preventing Medicaid and CHIP members from accessing dental services. Through implementation of initiatives to address lower performing areas, and by removing barriers to dental care, the DHPs should see an increase in the utilization of preventive dental services and, consequently, members' oral diseases will be detected in the earlier stages and treatment can be provided at a greatly reduced cost.
- **Program Monitoring—**Through its annual compliance monitoring activity, MDHHS has demonstrated an effective system for monitoring the DHPs in critical areas of the managed care program, including administration and management; appeal and grievance systems; member materials; information systems; medical management; program integrity; network adequacy; and QI.
  - The HKD program's aggregated score in the six performance areas reviewed as part of the compliance review activity was 99 percent, indicating **Blue Cross Blue Shield of Michigan** and **Delta Dental of Michigan** complied with MDHHS' requests for information and demonstrated strength in conforming to and abiding by the MDHHS-specific monitoring standards, which support quality, timely, and accessible care for Medicaid managed care members enrolled in the HKD program.

- Both DHPs received 100 percent compliance in the Administrative standard, indicating each DHP had an effective governing body with adequate staffing and oversight mechanisms in place to support its obligations under its contract with MDHHS.
- As indicated through an aggregated compliance review score of 100 percent in the Providers standard, the DHPs demonstrated that services were available and accessible to members in a timely manner through the maintenance of provider contracts and provider directories; monitoring their contracted providers; providing 24/7 access to member assistance and provider authorizations; maintaining an adequate number of dentists and dental care specialists; and developing processes for community health coordination and communication efforts with providers.
- **Blue Cross Blue Shield of Michigan** and **Delta Dental of Michigan** scores in the Quality/Utilization standard were 100 percent, suggesting the DHPs had effective QAPI programs in place that included QI and UM policies and procedures to ensure consistency in processes, CPGs to support decisions related to medical necessity, QI evaluations and workplans to evaluate and track QI initiatives and progress, and PIPs to target improvement in clinical and/or nonclinical performance areas.

Weaknesses

HSAG's comprehensive assessment of the DHPs and the HKD program also identified areas of focus that represent significant opportunities for improvement within the program. Based on the SFY 2020 performance measure rates and the Child Dental Survey analyses, members under the age of 21 may be experiencing barriers to care that deter them from accessing preventive dental services. Additionally, HSAG's assessment of MDHHS' compliance monitoring activity indicated an opportunity for MDHHS to enhance its current compliance review process to ensure adherence to 42 CFR §438.258 (b)(iii), and alignment with CMS' expectations under CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*.

- **Children's Accessibility to Preventive Dental Services**—According to the Centers for Disease Control and Prevention, cavities (also known as tooth decay) are one of the most chronic diseases of childhood in the U.S. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Children who have poor oral health often miss more school and receive lower grades than children who do not.[6-1] Although Medicaid and CHIP members under the age of 21 have access to dental benefits through the HKD program, members are not reliably obtaining preventive dental care as confirmed through lower performance measure rates and may be experiencing barriers to accessing care as demonstrated through lower satisfaction scores obtained through the Child Dental Survey.
  - **Delta Dental of Michigan** had higher rates than **Blue Cross Blue Shield of Michigan** for each reported CMS-416 EPSDT performance measure for services in SFY 2019. **Delta Dental of Michigan** also had higher numerators and denominators than **Blue Cross Blue Shield of**

[6-1] Centers for Disease Control and Prevention. Children's Oral Health. Available at: https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html. Accessed on: Mar 31, 2021.

Michigan for all performance measure rates due to **Delta Dental of Michigan** having a greater number of enrolled members during the reporting period. Although **Blue Cross Blue Shield of Michigan** had a lower number of members, the reported rates indicate **Blue Cross Blue Shield of Michigan**'s members may be experiencing more barriers to accessing dental services; however, **Blue Cross Blue Shield of Michigan** had a higher proportion of members aged zero to two years old, which may contribute to the lower rates since members under the age of two are less likely to access preventive services. Additionally, because of the variances in the performance rates between **Blue Cross Blue Shield of Michigan** and **Delta Dental of Michigan**, and lower-performing rates for both plans in several measures overall**,** the performance for the HKD program confirms opportunities for improving child members' access to dental services.

  - The HKD program average for the four global rating measures (*Rating of Regular Dentist*, *Rating of All Dental Care*, *Rating of Finding a Dentist*, and *Rating of Dental Plan*), and the *Access to Dental Care* composite measure captured within the Child Dental Survey received top-box scores of less than 75 percent, indicating more than 25 percent of members who responded to the survey did not have the most positive experiences with their dentist, dental care, dental plan, and their ability to find a dentist, as well as accessing dental services. *Rating of Finding a Dentist* was the lowest overall performing measure (52.6 percent); however, please note, there was also a low number of parents/caretakers who responded to this question in the survey.

- **Compliance Assessment**—Although MDHHS has demonstrated through its annual compliance activity that it has an effective State monitoring system in accordance with 42 CFR §438.66, the tools and compliance review summaries provided by MDHHS do not appear to include a review of all requirements mandated under 42 CFR §438.358(iii), which requires a comprehensive review of each DHP's compliance with the standards set forth in subpart D of Part 438, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the QAPI requirements described in §438.330. Conducting a comprehensive compliance review, in accordance with CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, will provide the DHPs with a sound understanding of their strengths and weaknesses related to quality, timeliness, and access to care. Findings from the comprehensive compliance review activity will also help the DHPs improve their performance with respect to quality, timeliness, and access to care.

Quality Strategy Recommendations for the HKD Program

The MDHHS CQS was designed to improve the health and welfare of the people of the State of Michigan and address the challenges facing the State. Through its CQS, MDHHS is focusing on population health improvement on behalf of all of the Medicaid members it serves, while accomplishing its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs. MDHHS uses three

foundational principles to guide implementation of the CQS to improve the quality of care and services. The principles include:

- A focus on health equity and decreasing racial and ethnic disparities.
- Addressing social determinants of health.
- Using an integrated data-driven approach to identify opportunities and improve outcomes.

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following QI initiatives, which focus on improving children's access to preventive dental services, and target goals #1 and #4 within the MDHHS CQS.

Goal #1: Ensure high quality and high levels of access to care.

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.

- The 2020 MSOHP is a comprehensive plan of action to improve the oral health of Michigan residents. The plan focuses on education, access, prevention, and policy—understanding that these subject areas overlap in many ways. A focus of the plan includes increasing access to oral health services among individuals who are most adversely affected by disparities, poverty, and other socioeconomic factors.[6-2] HSAG recommends that MDHHS and its DHPs continue to leverage this existing plan and the efforts already underway and work collaboratively with partnering organizations to successfully complete the initiatives listed in the 2020 MSOHP.
  - Since ages 1 to 5 years old have the highest prevalence of no preventive dental care visits (51.9 percent),[6-3] MDHHS and its DHPs should continue its focus on providing education to the Medicaid population on the importance of early dental care, and initiate interventions that have the likelihood to increase the use of services for this age group. These interventions should be continually evaluated for effectiveness, and new interventions should be implemented as necessary to further promote good oral health outcomes.
  - In addition to focusing on the younger age group, MDHHS could also require the DHPs to develop and include specific initiatives, such as PIPs, in their quality programs that target disparate racial populations (e.g., the Hispanic population demonstrated the highest rate of no preventive dental care visits).[6-4]
- Because of the identified challenges in the CMS-416 performance measure calculation, reporting, and verification processes, HSAG recommends that MDHHS focus on improving upon the accuracy and validity of performance measure rates by conducting PMV in alignment with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*. By following the CMS EQR *Protocol 2*, MDHHS would be able to reliably assess the accuracy of performance

[6-2] Michigan Department of Health and Human Services. *Michigan State Oral Health Plan*. Available at: https://www.michigan.gov/documents/mdhhs/2020_MichiganStateOralHealthPlan_FINAL_511929_7.pdf. Accessed on: Mar 31, 2021.
[6-3] Ibid.
[6-4] Ibid.

measures reported by the DHPs and determine the extent to which performance measures reported by the DHPs follow federal specifications and reporting requirements.
  - To ensure reliability of PMV, PMV should be conducted for each DHP by following several steps in accordance with the CMS EQR *Protocol 2*, including completing an assessment of the integrity of the DHPs' information systems and data extraction processes; conducting a review of source code for the performance measures; evaluating the DHPs' data mapping; reviewing each DHP's performance measure workflows; conducting a data review at each stage of the performance measure reporting process; and reviewing the member-specific record-level numerator and denominator data. Further, the PMV process could include selecting a sample of records across the performance measures that would allow for the identification of potential issues that the DHPs could then resolve during the data collection process, resulting in final, validated rates based on those improvements.
- To promote DHP accountability, MDHHS should consider setting minimum performance thresholds for all, or a subset of, the existing performance monitoring standards identified in the HKD program contract, such as for the HEDIS *Annual Dental Visit* and CMS-416 measures.

HSAG further recommends MDHHS consider conducting the following compliance initiative, which focuses on improving oversight of the MHPs, and targets Objective 3.1 within the MDHHS CQS.

Objective 3.1—Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.

- Through HSAG's evaluation of the compliance monitoring summary and tools completed by MDHHS and provided to HSAG for the annual assessment, HSAG identified opportunities to improve the overall compliance monitoring process to ensure MDHHS is meeting CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*. Although **Blue Cross Blue Shield of Michigan** scored 99 percent and **Delta Dental of Michigan** scored 98 percent overall in the program areas under review, HSAG was unable to clearly determine that these program areas encompass a review of all requirements mandated under 42 CFR §438.358(iii), which requires a comprehensive review of each DHP's compliance with the standards set forth in subpart D of Part 438, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the QAPI requirements described in §438.330.
  - MDHHS should compare its current monitoring tools to federal Medicaid managed care standards, which are codified at 42 CFR §438 and 42 CFR §457, and include availability of services, §438.206; assurances of adequate capacity and services, §438.207; coordination and continuity of care, §438.208; coverage and authorization of services, §438.210; provider selection, §438.214; confidentiality, §438.224; grievance and appeal systems, §438.228; subcontractual relationships and delegation, §438.230; practice guidelines, §438.236; health information systems, § 438.242; and QAPI program, §438.330; as well as the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, and the emergency and post-stabilization services requirements described in §438.114. MDHHS could consider revising its tools to align with these federal standard names.

- As part of the comprehensive review, MDHHS should verify implementation of DHPs' policies and procedures through a set of targeted file reviews, such as member grievances, member appeals, service authorization denials, credentialing records, care management cases, and delegation contract and oversight documentation. This review allows the auditors to confirm that the DHPs have appropriately and effectively implemented the processes identified through their policy and procedure documents.
- Based on the documented findings within MDHHS' compliance review tools, it was unclear whether MDHHS' compliance review process included interviews of DHP staff members. In accordance with CMS EQR *Protocol 3*, MDHHS' compliance review should include a process to conduct DHP-specific interviews of DHP staff members to collect additional data to supplement and verify the information MDHHS learned through the document review. It is also important for MDHHS to ensure DHP staff members can articulate documented processes and procedures. MDHHS should consider interviewing DHP leadership; information systems staff; quality program staff; provider services staff; member services staff; grievance and appeal staff; UM staff, including medical directors; and care coordinators, as applicable. Additionally, the interviews should be tailored to the DHP being evaluated, and MDHHS should focus its questions on any issues identified through the document review (e.g., gaps in processes, clarification of procedures).
- MDHHS should consider redefining its level of compliance to adhere to CMS-recommended compliance rating scales. HSAG recommends MDHHS consider using a two-point rating scale, which includes *Met* and *Not Met* definitions. The scoring methodology should ensure that compliance is based on MDHHS' evaluation of the DHP's compliance with the regulations under review, and there are details to justify the compliance determination. Prior to making a determination, MDHHS should clarify its understanding of the information collected throughout the compliance review process. MDHHS should then provide the DHP with the opportunity to respond to initial compliance issues to ensure the findings are due to true noncompliance and not due to misunderstanding or misinterpretation of DHP documents. After the site visit activity, MDHHS should also consider collecting and documenting additional information as needed, and the final compliance review scores should reflect the review of this additional information.

Appendix A. External Quality Review Activity Methodologies

Activity Methodologies

Validation of Performance Improvement Projects

Activity Objectives

For SFY 2020, MDHHS required the DHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-1]

1. HSAG evaluates the technical structure of the PIP to ensure that the DHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., aim statement, population, sampling methods, performance indicator[s], and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the DHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the QI strategies and activities conducted by the DHP during the PIP.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 31, 2021.

Technical Methods of Data Collection and Analysis

HSAG, in collaboration with MDHHS, developed the PIP Submission Form, which each DHP completed and submitted to HSAG for review and validation. The PIP Submission Form standardizes the process for submitting information regarding PIPs and ensures alignment with the CMS protocol requirements.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure a uniform validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The CMS protocols identify nine steps that should be validated for each PIP. For the SFY 2020 submissions, the DHPs reported the Design stage and were validated for Steps I through VI in the PIP Validation Tool.

The nine steps included in the PIP Validation Tool are listed below:

Step I.	Appropriate PIP Topic
Step II.	Clearly Defined PIP Aim Statement(s)
Step III.	Correctly Defined PIP Population
Step IV.	Sound Sampling Methods (if sampling was used)
Step V.	Clearly Defined Performance Indicator(s)
Step VI.	Valid and Reliable Data Collection
Step VII.	Sufficient Data Analysis and Interpretation
Step VIII.	Appropriate Improvement Strategies
Step IX.	Real and Sustained Improvement Achieved

HSAG used the following methodology to evaluate PIPs conducted by the DHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The DHP would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a General Comment with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or, one or more critical elements were *Not Met*.

The DHPs had the opportunity to receive initial PIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the PIP for final validation. HSAG forwarded the completed validation tools to MDHHS for distribution to the DHPs.

Description of Data Obtained and Related Time Period

For SFY 2020, the DHPs submitted the PIP design (Steps I through VI) for their respective PIP topics. BCBSM used the CMS-416 EPSDT performance measure for the *Increasing the Number of Members Ages 0–5 Accessing Dental Services* study indicator. DDMI used a modified CMS-416 measure specification for the *Increasing Dental Utilization in Ages One and Two* study indicator and a plan-developed measure specification for the *Providers Rendering Treatment* performance indicator. HSAG obtained the data needed to conduct the PIP validation from each DHP's PIP Summary Form. These forms provided data and detailed information about each of the PIPs and the activities completed. The DHPs submitted each PIP Summary Form according to the approved timeline. After initial validation, the DHPs received HSAG's feedback and technical assistance and resubmitted the PIP Summary Forms for final validation. The performance indicator measurement period dates for the PIPs are listed below.

Table A-1—Measurement Period Dates

Data Obtained	Reporting Year (Measurement Period)
Baseline	October 1, 2018–September 30, 2019
Remeasurement 1	October 1, 2020–September 30, 2021
Remeasurement 2	October 1, 2021–September 30, 2022

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by the DHPs and determine the extent to which performance measures reported by the DHPs follow federal specifications and reporting requirements.

MDHHS identified six EPSDT dental and oral services performance measures that the DHPs were required to calculate and report to CMS using Form CMS-416 (i.e., CMS-416 EPSDT performance measures). MDHHS followed its internal process to reconcile independently calculated rates for these performance measures with data verified by the DHPs and MDHHS, requiring the DHPs to correct discrepant information on an ongoing basis throughout the validation.

Technical Methods of Data Collection and Analysis

The DHPs used the administrative method, which requires that the DHPs identify the eligible population (i.e., the denominator) using administrative data derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative data collected during the measurement period. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Description of Data Obtained and Related Time Period

The DHPs supplied MDHHS with files that were inclusive of the DHPs' claims and encounters as well as member-level detail file data for reconciliation purposes. MDHHS used these files to calculate performance measure data rates. MDHHS then supplied the DHPs with data files that included the performance measure data that was calculated by MDHHS in order for the DHPs to compare the data to encounter data the DHPs had submitted to MDHHS. This allowed for reconciliation and calculation of the final performance measure rates.

The DHPs contracted with MDHHS during SFY 2019 and SFY 2020 and reported data for performance measures selected by MDHHS for the SFY 2019 (October 1, 2018–September 30, 2019) measurement period.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the DHPs' compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in

§438.114, and the QAPI requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance monitoring activities of its two contracted DHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist DHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess DHPs' conformity with State requirements and federal Medicaid managed care regulations. To meet this requirement, MDHHS identifies the requirements necessary for review during the SFY and divides the requirements into a 12-month compliance monitoring schedule. Annually, the DHPs are provided with a *Compliance Review Timeline* outlining the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance.

This technical report presents the results of the compliance monitoring activities performed during the SFY 2020 contract year. MDHHS conducted a compliance review of six standards as listed below:

- Administrative
- Provider
- Member
- Quality/Utilization
- MIS/Data Reporting
- Program Integrity

MDHHS reviewers used the compliance review tool for each DHP to document its findings and to identify, when applicable, specific action(s) required of the DHP to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDHHS assigned one of the following scores:

- *Pass*—The DHP demonstrated meeting the requirements stated in the *FY2020 HKD Compliance Review Timeline* and the contract.
- *Incomplete*—The DHP did not demonstrate meeting the requirements stated in the *FY2020 HKD Compliance Review Timeline* or the contract; and the DHP submitted an acceptable CAP by the due date; or the DHP submitted an attestation in lieu of the required submission.
- *Fail*—The DHP submitted a CAP for an *Incomplete* finding but it was not received by the due date or the CAP received by MDHHS did not meet requirements; or a CAP was required the previous year and the DHP received a CAP again this SFY for the same criteria.

From the *FY 2020 Compliance Review Summary* reports provided by MDHHS for each DHP, HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each DHP across all six standards. The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points) or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual DHP scores, then dividing that sum by the total number of applicable criteria reviewed across all DHPs.

HSAG drew conclusions and made overall assessments about the quality and timeliness of, and access to care provided by the DHPs using MDHHS-documented findings on the compliance review tools from each standard evaluated during the compliance review.

Description of Data Obtained and Related Time Period

To assess the DHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of written documents produced by the DHPs for SFY 2020, including but not limited to the following:

- Policies and procedures
- Program integrity forms and reports
- Provider contract templates
- Subcontractor/delegation monitoring documentation
- Health coordination documentation
- DHP websites, including member and provider information
- Service availability and accessibility documentation, including a network access plan
- Provider appeal log
- Claims monitoring logs
- Clinical practice guidelines
- Organizational charts and key personnel descriptions
- Provider directory
- Consolidated annual report
- Member materials, member handbook, and member newsletters
- Compliance program and program integrity plan
- Grievance and appeal processes and logs
- Community collaboration documentation
- Third party liability recovery documentation
- QIP evaluation and work plan, and UM program and effectiveness review
- MIS operational plan

- Enrollment and disenrollment procedures
- PIPs
- Governing board documentation, including member list, meeting dates and minutes, and member appointment policy
- Annual audit findings of data privacy and information security program
- Performance measures

Dental Survey Analysis

Activity Objectives

The Child Dental Survey asks parents/caretakers to report on and evaluate their experiences with their child's dental care from the dental plan, dentists, and staff members. The primary objective of the Child Dental Survey was to evaluate the quality of dental care and services provided to child members enrolled in the HKD program.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of a Child Dental Survey, which was modified from the CAHPS Dental Plan Survey (currently available for the adult population only) for a child population. A mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) methodology was used for the survey. Child members included as eligible for the survey were 20 years of age or younger as of October 31, 2019.

The survey questions were categorized into various measures of member experience. These measures included four global ratings, three composite measures, and three individual item measures. The global ratings reflected parents'/caretakers' overall experience with their child's regular dentist, dental care, ease of finding a dentist, and the dental plan. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Care from Dentists and Staff* and *Access to Dental Care*). The individual item measures were individual questions that looked at a specific area of care (e.g., *Care from Regular Dentist*).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response score. For each of the three composite and individual item measures, the percentage of respondents who chose a positive response was calculated. Composite and individual item question response choices were: 1. "Never," "Sometimes," "Usually," and "Always," 2. "Definitely Yes," "Somewhat Yes," "Somewhat No," and "Definitely No," or 3. "Definitely Yes," "Probably Yes," "Probably No," and "Definitely No." Positive or top-box responses for the composites and individual items were defined as responses of "Always/Usually," "Somewhat Yes/Definitely Yes," or "Probably

Yes/Definitely Yes."[A-2] The percentage of top-box responses is referred to as a top-box score for the composite and individual item measures.

HSAG compared each DHP's results to the HKD program (i.e., BCBSM and DDMI combined) to determine if the results were statistically significantly different. Arrows in the tables note statistically significant differences. A green upward arrow (↑) indicates a top-box score for one dental plan that was statistically significantly higher than the other dental plan. Conversely, a red downward arrow (↓) indicates a top-box score for one DHP that was statistically significantly lower than the other DHP. DHP scores with fewer than 100 respondents are denoted in the tables with an asterisk (*). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Description of Data Obtained and Related Time Period

HSAG administered the Child Dental Survey to parents/caretakers of child members enrolled in the HKD program from December 2019 to March 2020.

[A-2] The exception to this was Question 18 in the *Access to Dental Care* composite measure, where the response option scale was reversed so responses of "Sometimes/Never" were considered top-box responses.