



State Fiscal Year 2024 External Quality Review Technical Report for Dental Health Plans

April 2025



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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, timeliness, and accessibility of 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 Behavioral and Physical Health and Aging Services Administration (BPHASA) 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 through 20 years of age. The HKD program's MCEs include two prepaid ambulatory health plans (PAHPs), referred to as dental health plans (DHPs), contracted with MDHHS to administer the dental services. The DHPs contracted with MDHHS during state fiscal year (SFY) 2024 are displayed in Table 1-1.

Table 1-1—DHPs in Michigan

DHP Name	Abbreviation
Blue Cross Blue Shield of Michigan Dental	BCD
Delta Dental of Michigan	DD

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment that were performed by HSAG were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the "CMS EQR Protocols").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 the quality, timeliness, and accessibility of 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 2024 assessment, no DHPs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 that were performed during the preceding

¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Feb 21, 2025.

12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each DHP. Detailed information about each activity’s methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR 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 (CMS EQR Protocol 1)
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by a DHP are accurate based on the measure specifications and reporting requirements.	Protocol 2. Validation of Performance Measures (CMS EQR Protocol 2)
Compliance Review ²	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 (CMS EQR Protocol 3)
Network Adequacy Validation (NAV)	This activity assesses the accuracy of network adequacy indicators reported by a DHP and the extent to which a DHP has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy (CMS EQR Protocol 4)
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by the DHP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)
Child Dental Survey	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 (CMS EQR Protocol 6)

² The compliance review activity was performed by MDHHS. MDHHS provided HSAG with the results of the compliance review activity to include in the annual EQR technical report.

Healthy Kids Dental Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2024 activities 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 HKD program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for MDHHS to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)³ and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the HKD program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. A dash (–) is noted in Table 1-3 if no trends were identified through an EQR activity that substantially impacted a goal; the EQR activity results could not be used to evaluate a goal; or a CQS goal did not include a quality measure for the HKD program's applicable populations.

Table 1-3—HKD Conclusions and Recommendations

Performance Impact on Goals and Objectives ⁴		Performance Domain
Goal #1—Ensure high quality and high levels of access to care		
–	CQS Objective 1.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
–	CQS Objective 1.2: The CQS not does include quality measures for the HKD program under this objective.	
✓	CQS Objective 1.3: While HSAG could not determine the State-specific specifications for the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure based on the CQS, the DHPs' PIPs can be used to assess whether members are accessing dental care. Both DHPs' PIPs, <i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i> and	

³ Michigan Department of Health and Human Services. *Comprehensive Quality Strategy 2023–2026*, August 2024. Available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=3add99dfefdf417fa4e12a2b346f4b3e. Accessed on: Mar 11, 2025.

⁴ All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all CAHPS measures or performance measures and instead focused on the measures with a corresponding quality measure with the CQS.

Performance Impact on Goals and Objectives ⁴		Performance Domain
	<i>Increasing Dental Utilization in Ages One and Two</i> , demonstrated a statistically significant improvement from the baseline rate.	
m	CQS Objective 1.3: While HSAG could not determine the State-specific specifications for the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure based on the CQS, the performance measures included as part of the PMV activity can be used to assess whether members are accessing dental care (i.e., utilization of dental services). However, while the rates for all six of the applicable CMS-416 performance measures (12a–e and 12g) for one DHP increased from the prior year, the rates for the other DHP remained relatively stagnant overall. When considering the utilization rates across both DHPs, the utilization of dental services, and therefore, access to dental care, increased minimally from the prior year.	
–	Each DHP was assessed based upon following its methodologies and interpretations of MDHHS’ expectations for calculating network adequacy standards; however, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across both DHPs. Considering the DHPs did not apply consistent methodology to network adequacy indicator reporting, programwide and comparative results are not available as the results cannot be aggregated or compared across the DHPs. ⁵	
✖	During the process of generating sample cases for the EDV review, HSAG encountered significant challenges with the completeness and accuracy of provider information within MDHHS’ encounter data. Specifically, the data often lacked fully populated National Provider Identifiers (NPIs), which are crucial for accurately identifying providers who meet the criteria for a specific service category. Additionally, the encounter data did not include detailed provider taxonomy codes, which are vital for determining the eligibility of providers for specific services relevant to the review. The lack of detailed taxonomy information hindered HSAG’s ability to categorize and analyze data based on the provider specialty and service type. Complete and accurate encounter data are necessary to monitor and improve the program’s quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. ⁵	
Goal #2—Strengthen person and family-centered approaches		
–	CQS Objective 2.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
–	CQS Objective 2.2: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Access

⁵ While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and objective(s) within the CQS.

Performance Impact on Goals and Objectives ⁴		Performance Domain
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
–	CQS Objective 3.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness
–	CQS Objective 3.2: The EQR activities do not produce data to assess the impact of the <i>Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360</i> quality measure under this objective. ⁶	<input checked="" type="checkbox"/> Access
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes		
–	CQS Objective 4.1: The EQR activities do not produce data to assess the impact of the <i>Diagnostic Dental Visits—CMS 416-12</i> and <i>Preventive Dental Visits—CMS 416-12</i> quality measures under this objective. While these measures are included in the PMV activity, the data reported are not stratified by race and ethnicity.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	CQS Objective 5.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
Recommendations		
<p>Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS’ CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to HKD program members:</p> <ul style="list-style-type: none"> While the DHPs reported according to their methodologies and interpretations of MDHHS’ expectations for the calculation of network adequacy standards, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across both DHPs. HSAG found that the DHPs had categorized pediatric specialists who provided comprehensive care differently and applied different standards to this provider type. Furthermore, although specific guidance was provided on the time frame DHPs should use when completing the provider network table, this guidance was unclear for the GeoAccess summaries, resulting in the use of different time frames by the DHPs. HSAG recommends that MDHHS issue formal guidance on how DHPs should display ratios for general dentists and pediatric specialists providing comprehensive care as well as specific guidance on the time frames DHPs should use when completing the GeoAccess analyses. 		

⁶ While the CQS included several quality measures related to the dental program, only one, *Access to Dental Care—HKD Beneficiaries*, was identified as specifically applying to the HKD program. Additionally, the CQS did not identify whether the *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360* quality measure under Objective 3.2 applied to the HKD program. However, as HSAG could not confirm the applicability of this measure through the CQS, HSAG included this quality measure in Table 1-3. Further, for the two quality measures under Objective 4.1, while the CQS did not specifically identify the HKD program, the DHPs report CMS 416 measures; therefore, HSAG included these quality measures in Table 1-3. The remainder of the dental quality measures were excluded from HSAG’s assessment as they applied to the adult population.

Performance Impact on Goals and Objectives ⁴	Performance Domain
<ul style="list-style-type: none"> • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its DHPs as follows within the required effective dates for each specific requirement: <ul style="list-style-type: none"> – Require the DHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. – Require the DHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each DHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each DHP, and enables the DHPs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining necessary quality checks for quality and appropriateness of care. • To address the challenges identified through the EDV activity and improve the integrity of future data analyses, HSAG recommends that MDHHS: <ul style="list-style-type: none"> – Mandate the inclusion of complete NPIs and provider taxonomy codes in all encounter data submissions. – Introduce robust data verification processes at the point of entry. This step will help in early detection and rectification of incomplete or inaccurate provider data, maintaining the integrity of the database. – Develop a centralized, easily accessible repository for provider data that can be referenced and updated regularly. This will facilitate more efficient data linkage and retrieval, improving the ease and reliability of data analysis. – Implement a regular review and feedback system to monitor the improvements in data quality post-implementation of these changes. This will not only help in measuring the success of the implemented strategies but also in making continuous improvements. • While the CQS included several quality measures related to the dental program, only the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure was identified as applying specifically to the HKD program. While the dental quality measures for the adult population would not apply to the HKD population, HSAG recommends that MDHHS update the CQS to assign the specific program and/or population each dental quality measure applies to, so stakeholders have a clear understanding of which quality measures MDHHS is using to evaluate the different dental programs. 	

2. Overview of the Healthy Kids Dental Program

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Table 2-1 displays the Michigan managed care programs, the MCE(s) responsible for providing services to members, and the populations served.

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	Managed Care Organization (MCO)	1915(b)	July 1997	MHPs provide comprehensive healthcare services to low-income adults and children.
<ul style="list-style-type: none"> MICHild (CHIP) 		1915(b)	January 2016	MICHild is a Medicaid program for low-income uninsured children under the age of 19.
<ul style="list-style-type: none"> Children's Special Health Care Services (CSHCS) 		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
<ul style="list-style-type: none"> Foster Children 		1915(b)	November 2010	Most categories of foster children are mandatorily enrolled in managed care.
<ul style="list-style-type: none"> Pregnant Individuals 		1915(b)	October 2008	Pregnant individuals are mandatorily enrolled in managed care.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
MI Choice Waiver Program PAHPs	PAHP	1915(c) since 1992 1915(b) since 2012	1992	The elderly or disabled adults (aged 18+) who meet the nursing facility level of care.
Dental Health Programs				
HKD (PAHP)	PAHP	1915(b)	October 2016	The HKD program provides dental services to beneficiaries under age 21.
Adult Dental (MHPs)	MCO	1915(b)	April 2023	Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in an MHP, ICO, or Program of All-Inclusive Care for the Elderly (PACE) receive dental benefits through their MHP.
Behavioral Health Managed Care:				
<ul style="list-style-type: none"> Children’s Behavioral Health—Bureau of Children’s Coordinated Health Policy & Supports (BCCHPS) Adult Behavioral Health—Bureau of Specialty Behavioral Health Services (SBHS) 				
Prepaid Inpatient Health Plans (PIHPs)/ Community Mental Health Services Programs (CMHSPs)	PIHP	Behavioral Health 1115 Demonstration Waiver	October 2019	Individuals with intellectual and developmental disabilities (I/DD), serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD)
		1915(i) SPA [State Plan Amendment]	October 2022	
		1115 HMP	April 2014	
		Flint 1115 Waiver or Community Block Grant	May 2016	
		1915(c) Habilitation Supports Waiver (HSW), Children’s Waiver Program (CWP), and Children’s Serious Emotional Disturbance Waiver (SEDW)	October 2019	

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 Dental Health Plans

During the SFY 2024 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—HKD Profiles and Enrollment Data

DHP	Member Enrollment	Covered Services ⁷		Total Enrollment ⁸
BCD	Across the state of Michigan, HKD benefits are available to children who have Medicaid and are under the age of 21	<ul style="list-style-type: none"> Oral exams Teeth cleanings Fluoride treatments X-rays Screenings and assessments 	<ul style="list-style-type: none"> Re-cementing of crowns, bridges, and space maintainers Root canals Extractions 	317,082
DD		<ul style="list-style-type: none"> Fillings Sealants Stainless steel or resin crowns Crown buildup, including pins Space maintainers 	<ul style="list-style-type: none"> Complete, partial, and temporary partial dentures Denture adjustments and repairs Denture rebases and relines 	645,541

⁷ Michigan Department of Health and Human Services. *Healthy Kids Dental Program. What is Covered?* Available at: <https://www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental/what>. Accessed on: Feb 21, 2025.

⁸ Enrollment data provided by MDHHS and effective as of September 26, 2024.

DHP	Member Enrollment	Covered Services ⁷		Total Enrollment ⁸
			<ul style="list-style-type: none"> Emergency treatment to reduce pain Intravenous sedation (when needed) 	

Quality Strategy

The 2023–2026 MDHHS 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 MDHHS Medicaid managed care programs, including CHCP, long-term services and supports (LTSS), dental programs, and behavioral health managed care. 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 2023–2026 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 aligns with the 2022 CMS National Quality Strategy’s (NQS’) eight goals, which aim to promote the highest quality outcomes and the safest care for all individuals and focuses on a person-centric approach as individuals journey across the continuum of care. The 2023–2026 MDHHS CQS also aligns with the MDHHS 2023–2027 Strategic Priorities and supports the MDHHS mission to provide services and administer programs to improve the health, safety, and prosperity of the residents of Michigan. The 2023–2026 MDHHS CQS establishes a new three-year vision to further integrate managed care program priorities to implement quality monitoring and improvement strategies to ensure Medicaid member experience of care is positive, appropriate, and timely. To accomplish the CQS vision, the Medicaid programs collaboratively identified and agreed upon five CQS goals that pursue an integrated framework for population health improvement and a commitment to address health equity and reduce disparate outcomes. These goals and their associated objectives are summarized in Table 2-3, and align with MDHHS’ vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity*.

Table 2-3—2023–2026 MDHHS CQS Goals and Objectives

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
<ul style="list-style-type: none">Goal 1: Embed Quality into the Care JourneyGoal 2: Advance Health EquityGoal 3: Promote Safety	<ul style="list-style-type: none">Public health investmentRacial equityAddress food and nutrition, housing, and other social determinants of health (SDOH)Improve the behavioral health service system for children and familiesImprove maternal-infant health and reduce outcome disparitiesReduce lead exposure for childrenReduce child maltreatment and improve rate of permanency within 12 monthsExpand and simplify safety net accessReduce opioid and drug-related deaths	Objective 1.1: Monitor, track and trend the quality, timeliness and availability of care and services.
		Objective 1.2: Promote prevention, treatment, services, and supports to address acute and chronic conditions in at-risk populations.
		Objective 1.3: Ensure services are delivered to maximize beneficiaries’ health and safety.
Goal #2: Strengthen person and family-centered approaches		
<ul style="list-style-type: none">Goal 1: Embed Quality into the Care JourneyGoal 2: Advance Health EquityGoal 4: Foster Engagement	<ul style="list-style-type: none">Racial equityAddress food and nutrition, housing, and other SDOHImprove the behavioral health service system for children and familiesEnsure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 2.1: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.
		Objective 2.2: Ensure referrals are made to community resources to address SDOH needs.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
<ul style="list-style-type: none">Goal 4: Foster EngagementGoal 5: Strengthen ResiliencyGoal 6: Embrace the Digital Age	<ul style="list-style-type: none">Expand and simplify safety net accessAddress food and nutrition, housing, and other SDOHIntegrate services, including physical and behavioral health, and medical care with LTSSFully implement the Families First Preservation Services Act (FFPSA) state planEnsure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 3.1: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.2: Promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
<ul style="list-style-type: none"> Goal 2: Advance Health Equity Goal 4: Foster Engagement Goal 5: Strengthen Resiliency Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements 	<ul style="list-style-type: none"> Public health investment Racial equity Address food and nutrition, housing, and other SDOH Improve the behavioral health service system for children and families Improve maternal-infant health and reduce outcome disparities Reduce lead exposure for children Reduce child maltreatment and improve rate of permanency Fully implement the FFPSA state plan Expand and simplify safety net access Reduce opioid and drug-related deaths Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	<p>Objective 4.1: Use evidence-informed approaches to address racial and ethnic disparities and health inequity.</p>
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
<ul style="list-style-type: none"> Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements Goal 8: Increasing Alignment 	<ul style="list-style-type: none"> Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	<p>Objective 5.1: Promote value-based models that improve quality of care.</p>

Quality Initiatives and Interventions

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

- 2025 Michigan State Oral Health Plan⁹**—MDHHS and the Michigan Oral Health Coalition (MOHC) have collaborated to develop a focused strategic action plan that outlines the specific steps planned to positively impact oral health in Michigan over the next four years. The overall vision is that all Michiganders have the knowledge, support, and care they need to achieve optimal oral health. The plan identifies measurable goals, strategies, and activities to raise awareness of the

⁹ Michigan Department of Health and Human Services. *2025 Michigan State Oral Health Plan*. Available at: https://www.michigan.gov/documents/mdhhs/Michigan_State_Oral_Health_Plan_2025_747223_7.pdf. Accessed on: Feb 21, 2025.

importance of oral health; improve the oral and overall health of Michiganders; fortify and sustain the oral health infrastructure; promote health equity; and reduce health disparities. The three goals of the 2025 Michigan State Oral Health Plan include:

- Michiganders understand the value of daily oral health care and preventive dental care and have the tools to care for their mouths every day.
- Michigan citizens, dental professionals, and medical providers understand the connection between oral health and overall health.
- Michiganders have access to preventive and restorative oral health care because the state has developed the necessary infrastructure to effectively serve everyone.

The DHPs are contractually required to promote among its network providers the overall goals, objectives, and activities of the 2025 Michigan State Oral Health Plan.

- **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; Healthcare Effectiveness Data and Information Set (HEDIS®)¹⁰ and CMS-416 Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) performance measures; and Dental Quality Alliance (DQA) 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.
- **Performance Bonus**—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.

¹⁰ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

3. Assessment of Dental Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2024 review period to evaluate the performance of the DHPs on providing quality, timely, and accessible dental services to HKD members. Quality, as it pertains to EQR, means the degree to which the DHPs 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. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS’ network adequacy standards) and §438.206 (adherence to MDHHS’ standards for timely access to care and services). Access relates to members’ timely use of services to achieve optimal oral health outcomes, as evidenced by how effective the DHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each DHP.

- **Step 1:** HSAG analyzes the quantitative results obtained from each EQR activity for each DHP to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and accessibility of services furnished by the DHP for the EQR activity.
- **Step 2:** From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about overall quality, timeliness, and accessibility of care and services furnished by the DHP.
- **Step 3:** From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weaknesses in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the DHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity’s objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 3-1 provides HSAG’s timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 8, 2024	October 28, 2024
PMV	May 23, 2024	December 4, 2024

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	October 15, 2023	November 15, 2024
NAV—Analysis	June 3, 2024	October 10, 2024
NAV—Survey	March 29, 2024	September 23, 2024
EDV	February 26, 2024	March 17, 2025
Child Dental Survey	September 20, 2023	August 8, 2024

Validation of Performance Improvement Projects

For the SFY 2024 PIP validation activity, the DHPs continued their MDHHS-mandated PIP topics, reporting Remeasurement 3 data on the performance indicators. HSAG conducted validation on the Design (Steps 1 through 6), Implementation (Steps 7 and 8), and Outcomes (Step 9) stages of the selected PIP topic for each DHP in accordance with the CMS EQR protocol for the validation of PIPs (CMS EQR Protocol 1). Although all steps may not be included in the validation activities for SFY 2024 for both DHPs, the validation rating for each DHP incorporates all steps in the validation process. Table 3-2 outlines the selected PIP topics and performance indicator(s) as defined by each DHP.

Table 3-2—PIP Topic and Performance Indicator(s)

DHP	PIP Topic	Performance Indicator(s)
BCD	<i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i>	The percentage of BCBSM [Blue Cross Blue Shield of Michigan] HKD member visits to a dental provider in the selected federal fiscal year based on data
DD	<i>Increasing Dental Utilization in Ages One and Two</i>	<ol style="list-style-type: none"> Providers Rendering Treatment Increase Ages One and Two Dental Utilization Percentages

Performance Measure Validation

For the SFY 2024 PMV activity, HSAG validated the DHPs’ data collection and reporting processes used to calculate performance measure rates. MDHHS selected a set of performance measures that the DHPs were required to calculate and report. Specifically, the PMV activity included a comprehensive review of the DHPs’ rates for seven EPSDT dental and oral health services performance measures for the SFY 2023 measurement period (October 1, 2022–September 30, 2023) that were reported to CMS using Form CMS-416: Annual EPSDT Participation Report (i.e., CMS-416 Annual EPSDT performance measures). HSAG also validated two DQA dental quality performance measures for the January 1, 2022–December 31, 2023 measurement period. Table 3-3 lists these performance measures.

Table 3-3— CMS-416 Annual EPSDT and DQA Dental Quality Performance Measures for Validation

CMS-416	EPSDT Performance Measures
12a	<i>Total Eligibles Receiving Any Dental Services</i>
12b	<i>Total Eligibles Receiving Preventive Dental Services</i>
12c	<i>Total Eligibles Receiving Dental Treatment Services</i>
12d	<i>Total Eligibles Receiving a Sealant on a Permanent Molar Tooth</i>
12e	<i>Total Eligibles Receiving Diagnostic Dental Services</i>
12f	<i>Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider</i>
12g	<i>Total Eligibles Receiving Any Preventive Dental or Oral Health Services</i>
DQA	Dental Quality Performance Measures
CCN-CH-A	<i>Care Continuity</i>
USS-CH-A	<i>Usual Source of Services</i>

Compliance Review

MDHHS evaluated each DHP’s compliance with federal Medicaid managed care regulations using an annual compliance review process. HSAG examined, compiled, and analyzed the results as presented in the DHP compliance review documentation provided by MDHHS. The SFY 2024 MDHHS compliance review included an evaluation of each DHP’s performance in six program areas, called standards, identified in Table 3-4. These standards are reviewed annually by MDHHS in accordance with an established timeline that spans the state fiscal year. Based on the findings of the compliance review, the DHPs were subject to a corrective action plan (CAP) process as outlined in Appendix A.

Table 3-4—Compliance Review Standards¹

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10	§457.1207
		§438.206	§457.1230(a)
		§438.207	§457.1230(b)
		§438.210	§457.1230(d)
		§438.214	§457.1233(a)
		§438.230	§457.1233(b)

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
3	Members	§438.10 §438.100 §438.114 §438.206 §438.208 §438.210 §438.228 §438.230 Part 438, Subpart F	§457.1207 §457.1220 §457.1228 §457.1230(a) §457.1230(c) §457.1230(d) §457.1260 §457.1233(b)
4	Quality	§438.208 §438.210 §438.236 §438.330	§457.1230(c) §457.1230(d) §457.1233(c) §457.1240(b)
5	MIS [Management Information System]/Financial	§438.56 §438.242	§457.1212 §457.1233(d)
6	OIG [Office of Inspector General]/Program Integrity	§438.230 Part 438, Subpart H	§457.1233(b) §457.1285

¹ HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

Network Adequacy Validation

Network Adequacy Analysis

The NAV activity for SFY 2024 included validation of network adequacy standards and indicators set forth by MDHHS. HSAG assessed the accuracy of MDHHS-defined network adequacy indicators reported by the DHPs and evaluated the DHPs' collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and the systems and processes used in network adequacy calculations, then determined the overall validation rating, which identified the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. Table 3-5 lists the network adequacy standards and indicators HSAG validated. The NAV activity was conducted in accordance with the CMS EQR protocol for the validation of network adequacy (CMS EQR Protocol 4).

Table 3-5—DHP Network Adequacy Indicators Validated

Required Providers	Non-Rural Maximum Time and Distance Standard	Rural Maximum Time and Distance Standard	Provider Maximum Ratios**
General Dentistry*	30 minutes/30 miles	40 minutes/40 miles	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
Endodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Oral Surgeon	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Pediatric Dentist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Periodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Prosthodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies

*DHP may include pediatric specialists who provide comprehensive preventive services in its access calculations of general dentists.

**To be counted in the ratio calculation, a general dentist must be enrolled in Medicaid, and must be at least full-time (minimum of 20 hours per week per practice location). The ratio must reflect the unduplicated number of dentists in each county. If a dentist has multiple office locations and some offices are located in different counties, the contractor may report the dentist in each county where the dentist practices 20 hours or more per week.

Network Validation Survey

During April through June 2024, HSAG completed a network validation survey (NVS) among general and pediatric dental providers contracted with one or both DHPs, during SFY 2024, to ensure members have appropriate access to provider information. The NVS included a provider directory validation (PDV) in which HSAG compared key indicators published in each online directory with the data in the DHP's provider file to confirm whether each DHP's website met the federal requirements in 42 CFR §438.10(h) and state-specific requirements outlined in the HKD program contract. HSAG then validated the accuracy of the online directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also collected information on appointment availability and wait times with the sampled providers for routine dental care visits. The secret shopper approach allows for objective data collection from healthcare providers

without the potential bias introduced by knowing the identity of the caller. Specific survey objectives included the following:

- Determine whether dental service locations accept patients enrolled with the requested DHP for the HKD program and the degree to which DHP and HKD acceptance aligns with the DHP's provider data.
- Determine whether dental service locations accepting HKD for the requested DHP accept new patients and the degree to which new patient acceptance aligns with the DHP's provider data.
- Determine appointment availability with the sampled dental provider service locations for routine dental care visits.

Several limitations and analytic considerations must be noted when reviewing the results of the NVS. These limitations are located in Appendix A—External Quality Review Activity Methodologies.

Encounter Data Validation

In SFY 2024, HSAG conducted and completed an EDV activity for the two DHPs. The EDV activity included:

- Dental Record Review (DRR)—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing MDHHS' electronic encounter data to the information documented in the corresponding members' dental records for dental services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records*, in the CMS EQR Protocol 5.

The goal of the DRR activity was to verify the completeness and accuracy of the dental encounter data by cross-referencing the data with provider-documented information for services rendered. The review encompassed dental records to validate the reported information within the encounter data.

Child Dental Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹¹ 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. HSAG presents top-box scores, which indicate the percentage of parents/caretakers who responded to the survey with the most positive experiences in particular aspects of their child's healthcare. Table 3-6 lists the measures included in the survey.

¹¹ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 3-6—Child Dental Survey Measures

Survey Measures
Global Ratings
<i>Rating of Regular Dentist</i>
<i>Rating of All Dental Care</i>
<i>Rating of Finding a Dentist</i>
<i>Rating of Dental Plan</i>
Composite Measures
<i>Care from Dentists and Staff</i>
<i>Access to Dental Care</i>
<i>Dental Plan Information and Services</i>
Individual Item Measures
<i>Care from Regular Dentist</i>
<i>Would Recommend Regular Dentist</i>
<i>Would Recommend Dental Plan</i>

External Quality Review Activity Results

Blue Cross Blue Shield of Michigan Dental

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation for SFY 2024 evaluated the technical methods of **BCD**’s PIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-7 displays the overall validation rating, the baseline rate, Remeasurement 1, Remeasurement 2, and Remeasurement 3 results for the performance indicators.

Table 3-7—Overall Validation Rating for BCD

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	R3
<i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i>	<i>High Confidence</i>	<i>High Confidence</i>	The percentage of BCBSM [Blue Cross Blue Shield of Michigan] HKD member visits to a dental provider in the selected federal fiscal year based on data.	7.2%	21.3% ↑	24.3% ↑	27.9% ↑

R1 = Remeasurement 1

R2 = Remeasurement 2

R3 = Remeasurement 3

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).

↔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

The goal for the PIP is that **BCD** will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. Table 3-8 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the DHP to support achievement of the PIP goals and address the barriers.

Table 3-8—Remeasurement 3 Barriers and Interventions for BCD

Barriers	Interventions
Low oral health literacy: members do not know when their child should start seeing dentist.	Healthy Beginnings Program: age-specific education, anticipatory guidance and call to action mailer educated parent/guardian of member on importance of dental visit no later than age 1.
Member perception of need: treatment mentality versus prevention mentality.	Live outreach calls to members educating on importance of routine dental visits to prevent dental problems and assistance with scheduling preventive visit.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: BCD conducted accurate statistical testing between measurement periods and provided a narrative interpretation of the Remeasurement 3 results. **BCD** also used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: For the Remeasurement 3 measurement period, **BCD** reported that 27.9 percent of members 0 to 5 years of age had a visit with a dental provider. The reported rate for the performance indicator sustained statistically significant improvement over the baseline measurement performance. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: There were no substantial weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified substantial weaknesses, HSAG recommends **BCD** apply lessons learned and knowledge gained throughout the PIP to future PIPs and other quality improvement activities.

Performance Measure Validation

Performance Results

Table 3-9 demonstrates **BCD**'s final reported rates for the CMS-416 Annual EPSDT performance measures for the SFY 2024 PMV activity measurement period (October 1, 2022–September 30, 2023), and Table 3-10 demonstrates **BCD**'s final reported rates for the DQA dental quality performance measures for the SFY 2024 PMV activity measurement period (January 1, 2022–December 31, 2023). Table 3-11 provides a comparison of the SFY 2022 (October 1, 2021–September 30, 2022) and SFY 2023 (October 1, 2022–September 30, 2023) performance measure data and subsequent rates for the CMS-416 Annual EPSDT measures, and the SFY 2022 (January 1, 2021–December 31, 2022) and SFY 2023 (January 1, 2022–December 31, 2023) rates for the DQA dental quality measures.

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

Age Category (Years)	Denominator	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	12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services
Age < 1	20,637	903	648	68	0	846	0	648
Ages 1–2	66,914	18,576	16,843	1,429	0	18,422	0	16,843
Ages 3–5	106,414	35,432	32,902	9,227	0	34,973	0	32,902
Ages 6–9	60,971	27,435	25,546	11,607	8,847	26,934	0	25,546
Ages 10–14	66,969	23,551	21,630	9,631	7,533	22,835	0	21,630
Ages 15–18	50,207	13,678	11,495	6,657	0	13,068	0	11,495
Ages 19–20	20,759	2,353	1,827	1,293	0	2,281	0	1,827
Total	392,871 ¹	121,928	110,891	39,912	16,380	119,359	0	110,891
	127,940 ²							
Final Rate		31.04%	28.23%	10.16%	12.80%	30.38%	0.00% ³	28.23%

¹ Total denominator count shown is for 12a, 12b, 12c, 12e, 12f, and 12g, as these performance measures are inclusive of all age categories.

² Total denominator count shown is for 12d, as 12d is only inclusive of the 6–9 and 10–14 age categories.

³ The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

**Table 3-10—BCD Final DQA Dental Quality Performance
Measure Rates**

	CCN-CH-A—Total Care Continuity	USS-CH-A—Total Usual Source of Services
Numerator	1,505	1,309
Denominator	3,191	3,191
Final Rate	47.16%	41.02%

Table 3-11—SFY 2022 and SFY 2023 Performance Measure Rate Comparisons

Performance Measures							
CMS-416 Annual EPSDT Performance Measure	Numerator	Denominator	SFY 2022	Numerator	Denominator	SFY 2023	SFY 2022– SFY 2023 Comparison
12a—Total Eligibles Receiving Any Dental Services	105,040	366,402	28.67%	121,928	392,871	31.04%	+2.37%
12b—Total Eligibles Receiving Preventive Dental Services	95,364	366,402	26.10%	110,891	392,871	28.23%	+2.13%
12c—Total Eligibles Receiving Dental Treatment Services	35,344	366,402	9.65%	39,912	392,871	10.16%	+0.51%
12d—Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	11,735	120,028	9.78%	16,380	127,940	12.80%	+3.02%
12e—Total Eligibles Receiving Dental Diagnostic Services	100,528	366,402	27.44%	119,359	392,871	30.38%	+2.94%
12f—Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	0	366,402	0.00%	0	392,871	0.00% ¹	+/-0.00%
12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services	95,634	366,402	26.10%	110,891	392,871	28.23%	+2.13%

Performance Measures							
DQA Dental Quality Measures	Numerator	Denominator	SFY 2022	Numerator	Denominator	SFY 2023	SFY 2022–SFY 2023 Comparison
CCN-CH-A— <i>Care Continuity</i>	304	1,676	18.14%	1,505	3,191	47.16%	+29.02%
USS-CH-A— <i>Usual Source of Services</i>	223	1,676	13.31%	1,309	3,191	41.02%	+27.71%

Indicates a rate increase of 5 percentage points or more.

¹ The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: BCD continued to establish quality improvement interventions to increase performance measure rates and utilization. **BCD** had both performance improvement plans to increase the number of member visits to a dental provider and close health disparities, and member-based interventions designed to support outreach efforts, facilitate scheduling of dental appointments, close gaps in care, and educate members about the importance of dental care. **[Quality, Timeliness, and Access]**

Weaknesses and Recommendations

Weakness #1: For measure 12d, HSAG’s review of **BCD**’s member-level detail file noted that there were 1,313 members who were age 15 as of September 30 of the reporting year. Reporting of measure 12d should only consist of members in the age categories of 6 to 9 and 10 to 14. **[Quality]**

Why the weakness exists: The Form CMS-416 instructions reporting requirements are to report age based on the individual’s age as of September 30 of the reporting year. **BCD** noted that it agreed with the findings and that its review determined that the reporting logic for measure 12d did not exclude members who had turned age 15 as of September 30. Rather measure 12d included the distinct count of members who received a dental service who were ages 6 to 14 on the date of service.

Recommendation: HSAG recommends that **BCD** implement more stringent validation checks and increase the frequency of validation checks prior to submission of data to MDHHS and HSAG. HSAG also recommends that **BCD** review its source code and the Form CMS-416 instructions reporting requirements at least yearly to ensure that the programming logic aligns with the reporting requirements.

Compliance Review

Performance Results

Table 3-12 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-12 also presents BCD's overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, BCD was subject to a corrective action review process outlined in Appendix A.

Table 3-12—Compliance Review Results for BCD

Standard		Number of Scores			Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	BCD ²	Statewide
1	Administrative	5	0	0	100%	100%
2	Providers	12	0	2	86%	89%
3	Members	21	0	0	100%	100%
4	Quality	8	0	0	100%	100%
5	MIS/Financial	38	1	0	97%	99%
6	OIG/Program Integrity	10	0	0	100%	95%
Overall		94	1	2	97%	97%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select criteria under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) criteria and the number of *Not Met* and *Satisfied* (i.e., 0 points) criteria, then dividing the summed score by the total number of criteria for that standard.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following two areas: Operations and Quality. While the results of the focus study were not incorporated into the scoring of the standards within the compliance review activity, BCD met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: BCD achieved full compliance in the Administrative standard, demonstrating that the DHP had an adequate administrative structure, including an organizational chart, key personnel positions, governing body, participation in administrative meetings, and data privacy and information security. [Quality]

Strength #2: BCD achieved full compliance in the Members standard, demonstrating that the DHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; grievance and appeal systems; and member information materials, such as a member handbook, newsletters, and website. [Quality, Timeliness, and Access]

Strength #3: BCD achieved full compliance in the Quality standard, demonstrating that the DHP had an adequate quality program, which included, but was not limited to, clinical practice guidelines (CPGs); utilization management (UM) activities; quality improvement program (QIP) evaluation and work plan; program policies and procedures; PIPs; accreditation; and performance measure rate review. [Quality, Timeliness, and Access]

Strength #4: BCD achieved full compliance in the OIG/Program Integrity standard, demonstrating that the DHP had a sufficient compliance program and processes for submitting accurate data to MDHHS via the quarterly and annual program integrity reports. [Quality]

Weaknesses and Recommendations

Weakness #1: While **BCD** demonstrated moderate performance (i.e., 80 percent or higher but below 90 percent) in the Providers standard, the DHP scored below the statewide average. The DHP received a *Not Met* score for elements *August 2.21–Secret Shopper Calls* and *January 2.9–Provider Appeal Process*. [Quality and Access]

Why the weakness exists: Regarding element *August 2.21* findings, **BCD** did not meet the MDHHS-required 75 percent threshold for the following two indicators: *General Dentists who have the “acceptance of DHP/HKD” on the submitted provider file that matches what shows in the online directory and is confirmed during the call* and *General Dentists who are “accepting new patients” on the submitted provider file that matches what shows in the online directory and is confirmed during the call*. Additionally, regarding element *January 2.9* findings, MDHHS was unable to locate processes for peer-to-peer discussions during the appeal process, the time frames for submitting a provider appeal, and the time frame for a response by the DHP.

Recommendation: **BCD** was required to submit a CAP to address element *January 2.9*, which was approved by MDHHS. MDHHS did not require **BCD** to submit a CAP for element *August 2.21* as MDHHS was analyzing findings for possible enforcement action. As such, HSAG recommends that **BCD** continue to implement action plans and monitoring processes to improve the accuracy of provider data and maintain adequate procedures for provider appeals. Specific to element *August 2.21*, as part of the focus study **BCD** reported that it sends quarterly letters to providers requesting they update information through one of four ways: website, portal, directory validation survey

(DVS), or by notifying their provider partner consultant that the DVS has recently been updated to include a “no changes” option, encouraging providers to respond. As such, HSAG recommends that **BCD** monitor quarterly the number of providers who change their information to determine whether the quarterly letters are successful in triggering providers to update their information or confirm there are no changes.

Weakness #2: While **BCD** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the MIS/Financial standard, the DHP scored below the statewide average. The DHP received a *Satisfied* score for element *February 5.13–Monthly Dental Encounter Timeliness*. [Quality and Timeliness]

Why the weakness exists: **BCD** did not meet the minimum threshold of timeliness for encounters that were paid during the month of November 2023. **BCD** identified an operational error between its vendor and a clearinghouse that caused a delay in processing claims.

Recommendation: MDHHS did not require a CAP to address element *February 5.13* as **BCD** met the minimum threshold for timeliness for encounters paid during the month of December 2023. As such, HSAG recommends that **BCD** continue to implement action plans and monitoring processes to improve the timeliness of dental encounters submissions

Network Adequacy Validation

Performance Results

Based on the results of the Information System Capabilities Assessment (ISCA) combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the DHP’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each DHP according to Table 3-13.

Table 3-13—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **BCD** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **BCD** was aware of a gap, and while corrective steps were underway, the

issue had not been fully resolved at the time of reporting. Adequacy was determined based on the DHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Results are presented by provider type and county in Table 3-14 and Table 3-15, with exceptions highlighted in **orange**.

Table 3-14—BCD Network Adequacy Compliance—Rural

Rural County	General Dentistry Min/Mile	General Dentistry Ratio	Endo-dontist Min/Mile	Oral Surgeon Min/Mile	Pediatric Dentist Min/Mile	Perio-dontist Min/Mile	Prosthodontist Min/Mile
Alcona	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Compliant
Alger	Exception	Compliant	Exception	Exception	Compliant	Exception	Exception
Allegan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Alpena	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Antrim	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Arenac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Baraga	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Barry	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Benzie	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Branch	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Charlevoix	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Cheboygan	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Chippewa	Exception	Compliant	Exception	Exception	Compliant	Exception	Exception
Clare	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Crawford	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Delta	Compliant	Compliant	Exception	Exception	Compliant	Exception	Exception
Dickinson	Exception	Exception	Exception	Compliant	Compliant	Exception	Exception
Emmet	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Gladwin	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Gogebic	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Grand Traverse	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Gratiot	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Hillsdale	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Houghton	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Huron	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ionia	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Iosco	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Iron	Exception	Exception	Exception	Compliant	Compliant	Exception	Exception
Isabella	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant

Rural County	General Dentistry Min/Mile	General Dentistry Ratio	Endo-dontist Min/Mile	Oral Surgeon Min/Mile	Pediatric Dentist Min/Mile	Perio-dontist Min/Mile	Prosthodontist Min/Mile
Kalkaska	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Keweenaw	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Lake	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Leelanau	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Lenawee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Luce	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Mackinac	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Manistee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Marquette	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Mason	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Mecosta	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Menominee	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Missaukee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Montcalm	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Montmorency	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Newaygo	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Oceana	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Ogemaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Ontonagon	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Osceola	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Oscoda	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Compliant
Otsego	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Presque Isle	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Roscommon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Sanilac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Schoolcraft	Compliant	Exception	Exception	Exception	Compliant	Exception	Exception
Shiawassee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
St. Joseph	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Tuscola	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Van Buren	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Wexford	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Table 3-15—BCD Network Adequacy Compliance—Urban

Urban County	General Dentistry Min/Mil	General Dentistry Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prosthodontist Min/Mil
Bay	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Compliant
Berrien	Compliant	Compliant	Exception	Exception	Exception	Exception	Exception
Calhoun	Compliant	Exception	Compliant	Compliant	Compliant	Exception	Compliant
Cass	Compliant	Exception	Exception	Compliant	Compliant	Exception	Compliant
Clinton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Eaton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Genesee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ingham	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Jackson	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Kalamazoo	Compliant	Exception	Compliant	Compliant	Compliant	Exception	Compliant
Kent	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Lapeer	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Livingston	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Macomb	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Midland	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Compliant
Monroe	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Muskegon	Compliant	Compliant	Compliant	Exception	Compliant	Compliant	Compliant
Oakland	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ottawa	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Saginaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
St. Clair	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Washtenaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Wayne	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DentaQuest, BCD’s dental subcontractor, had a thorough three-tier validation system in place to ensure accuracy of its network adequacy indicator reporting, confirming data were accurate, consistent, and reliable. [Access]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for BCD through the NAV activity.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 355 randomly sampled cases by comparing provider data submitted to HSAG by BCD against BCD’s online directory. The sample included 245 general dental providers and 110 pediatric dental providers. Of the total providers found in the directory, 90.4 percent were at the sampled location, while 4.8 percent were not at the sampled location. Additionally, 4.8 percent of the total providers were not found in the online directory.

Table 3-16 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the DHP’s online directory.

Table 3-16—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
General	245	13	5.3%	8	3.3%	224	91.4%
Pediatric	110	4	3.6%	9	8.2%	97	88.2%
BCD Total	355	17	4.8%	17	4.8%	321	90.4%

¹ The denominator includes the number of sampled providers.

Table 3-17 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in BCD’s provider data submission to HSAG and BCD’s online directory. Cases with unmatched results may include incorrect information, or information not listed in the directory (e.g., the DHP’s provider data included a data value for a study indicator, but the online directory did not include a data value for the study indicator).

Table 3-17—Provider Demographic Indicators Matching Online Directory

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider's Name	232	100%	105	99.1%	337	99.7%
Provider Street Address	224	96.6%	98	92.5%	322	95.3%
Provider Suite Number	230	99.1%	105	99.1%	335	99.1%
Provider City	227	97.8%	101	95.3%	328	97.0%
Provider State	232	100%	106	100%	338	100%
Provider ZIP Code	226	97.4%	98	92.5%	324	95.9%
Provider Telephone Number	227	97.8%	99	93.4%	326	96.4%
Provider Type/Specialty	232	100%	106	100%	338	100%
Provider Accepting New Patients	232	100%	106	100%	338	100%
Provider Gender	191	82.3%	82	77.4%	273	80.8%
Provider Primary Language ²	232	100%	105	99.1%	337	99.7%
Non-English Language Speaking Provider (including American Sign Language) ²	225	97.0%	106	100%	331	97.9%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 317 sampled provider locations for **BCD**, with an overall response rate of 92.7 percent. Table 3-18 summarizes the survey response rates (i.e., cases reached) for both DHPs and for **BCD**, by provider category.

Table 3-18—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
General	223	205	91.9%
Pediatric	94	89	94.7%
BCD Total	317	294	92.7%
All DHPs Total	705	657	93.2%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key provider indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-19 summarizes the provider data validation and accuracy results for both DHPs and for **BCD**, by provider category.

Table 3-19—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
General	205	178	86.8%	170	82.9%	167	81.5%	132	64.4%	123	60.0%
Pediatric	89	59	66.3%	57	64.0%	55	61.8%	33	37.1%	33	37.1%
BCD Total	294	237	80.6%	227	77.2%	222	75.5%	165	56.1%	156	53.1%
All DHPs Total	657	584	88.9%	566	86.1%	553	84.2%	412	62.7%	381	58.0%

¹ The denominator includes cases reached.

Table 3-20 displays the number of survey respondents who offered appointments to new patients for routine dental care visits for both DHPs and for **BCD**, by provider category.

Table 3-20—Appointment Availability for Routine Dental Care Visits¹

Provider Category	Number of Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
General	205	107	52.2%
Pediatric	89	18	20.2%
BCD Total	294	125	42.5%
All DHPs Total	657	296	45.1%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing the 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-21 displays the new patient wait time results for routine dental care visits for both DHPs and for **BCD**, by provider category.

Table 3-21—Appointment Wait Time Results for Routine Dental Care Visits

Provider Category	Appointment Wait Time (Calendar Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
General	0	217	27	14	86.0%
Pediatric	0	119	25	19	88.9%

Provider Category	Appointment Wait Time (Calendar Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
BCD Total	0	217	27	14	86.4%
All DHPs Total	0	309	40	18	78.0%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an initial routine dental care appointment that was compliant with the 56-calendar-day standard.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the providers located in the online provider directory, 11 of the 12 indicators had a match rate above 90.0 percent. [Quality]

Strength #2: Overall, 95.2 percent of the sampled providers listed in BCD's provider data were located in BCD's online provider directory. Among the provider categories, 96.4 percent of pediatric providers and 94.7 percent of general providers were located in the online provider directory. [Quality and Access]

Strength #3: BCD's overall response rate for the secret shopper telephone survey was 92.7 percent.

Weaknesses and Recommendations

Weakness #1: Of the total responsive cases, 80.6 percent confirmed the sampled provider was affiliated with the location, 77.2 percent confirmed the correct location, 75.5 percent confirmed the location offered the requested services, 56.1 percent of locations accepted the insurance, and 53.1 percent accepted new patients. [Quality and Access]

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of provider data may have contributed to the low accuracy results.

Recommendation: HSAG recommends that BCD use the case-level analytic data files containing provider deficiencies identified during the survey calls (e.g., incorrect addresses, provider specialty, plan name, program, and new patient acceptance information) to address the provider data deficiencies.

Weakness #2: Among the responsive cases, 42.5 percent were offered an appointment date. General provider locations had an appointment availability rate of 52.2 percent. Pediatric provider locations

had an appointment availability rate of 20.2 percent. Of the cases that offered an appointment, 86.4 percent were compliant with the appointment wait time standard. [**Timeliness and Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information or Medicaid identification (ID). While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **BCD** work with its contracted providers to ensure sufficient appointment availability for its members, especially pediatric providers, whose rate of appointment availability was 20.2 percent. HSAG recommends that **BCD** identify specific appointment availability barriers for pediatric and general dental health providers. HSAG further recommends that **BCD** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **BCD** procured dental records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, such as *Date of Service* and *Dental Procedure Code*, to identify discrepancies and ensure alignment between the dental records and the encounter data submitted to MDHHS.

Table 3-22 outlines the key findings for **BCD** based on the assessment of encounter data completeness and accuracy conducted through a review of members' dental records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-22—Key Findings for BCD

Analysis	Key Findings
Dental Record Procurement Status	
Dental Record Procurement Rate	<ul style="list-style-type: none"> The dental record procurement rate was 61.6 percent, indicating that a significant portion of requested records were not successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured dental records, 48.6 percent included a corresponding second date of service.
Encounter Data Completeness	
Dental Record Omission Rate	<ul style="list-style-type: none"> Both key data elements (i.e., <i>Date of Service</i> and <i>CDT Code</i>) had a relatively high dental record omission rates:

Analysis	Key Findings
	31.8 percent for <i>Date of Service</i> and 33.7 percent for <i>CDT Code</i> . These results highlight that a substantial proportion of encounter data was not adequately supported by the members' dental records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> The encounter data omission rates for both key data elements (i.e., <i>Date of Service</i> and <i>CDT Code</i>) were relatively low: 3.4 percent for <i>Date of Service</i> and 1.5 percent for <i>CDT Code</i>.
Encounter Data Accuracy	
Dental Code Accuracy Rate	<ul style="list-style-type: none"> The <i>CDT Code</i> data element was accurate in 98.8 percent of instances where codes were present in both the dental records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for the key data element (<i>CDT Code</i>) were observed in 89.3 percent of the dates of service present in both data sources (i.e., encounter data and dental records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The *Date of Service* and *CDT Code* data element values identified in the dental records were generally present in the encounter data, as reflected by the low encounter data omission rates of 3.4 percent and 1.5 percent, respectively. [Quality]

Strength #2: When *CDT Code* data element values were present in both the encounter data and the members' dental records and were evaluated independently, the data element values were found to be accurate in 98.8 percent of records. [Quality]

Weaknesses and Recommendations

Weakness #1: BCD was unable to procure all of the requested dental records from its contracted providers primarily due to providers being non-responsive or providers not responding in a timely manner. [Quality]

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were either unaware of the submission requirements or the specified deadlines for providing dental records.

Recommendation: BCD should enhance provider accountability by ensuring contracted providers comply with dental record requests for purposes of auditing, inspection, and oversight. HSAG recommends that BCD strengthen and/or enforce its contract requirements with its providers to ensure timely and complete submission of documentation. This could include clear communication of submission expectations, deadlines, and potential consequences for non-compliance.

Weakness #2: At least 31.8 percent of the *Date of Service* and *CDT Code* data element values identified in the encounter data were not supported by the members’ dental records. [Quality]

Why the weakness exists: Non-submitted dental records are a primary contributor to dental record omissions, as the expected information in the dental records cannot be compared to the encounter data. Additional potential contributing factors include provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, or a lack of detail in the dental records), data submission issues (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, or errors in data transmission).

Recommendation: BCD should conduct a thorough investigation to identify the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. HSAG recommends periodic DRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to develop and provide ongoing education and training for providers. Training topics should include encounter data submissions, dental record documentation requirements, and coding practices. These efforts are essential to reducing future omissions and improving the overall accuracy and completeness of data submissions.

Child Dental Survey

Performance Results

Table 3-23 presents BCD’s SFY 2023 and SFY 2024 top-box scores. The results were assessed to determine if the SFY 2023 score was statistically significantly higher or lower than the SFY 2023 score for each measure. Upward and downward triangles (▲ or ▼) indicate the SFY 2024 scores were statistically significantly higher or lower, respectively, than the SFY 2023 scores.

Table 3-23—Summary of Top-Box Scores for BCD

	SFY 2023	SFY 2024
Global Ratings		
<i>Rating of Regular Dentist</i>	70.37%	76.17%
<i>Rating of All Dental Care</i>	68.99%	71.86%
<i>Rating of Finding a Dentist</i>	59.38% ⁺	50.00% ⁺
<i>Rating of Dental Plan</i>	71.20%	71.43%

	SFY 2023	SFY 2024
Composite Measures		
<i>Care from Dentists and Staff</i>	95.23%	95.16%
<i>Access to Dental Care</i>	72.11%	73.53%
<i>Dental Plan Information and Services</i>	85.13%	89.87%
Individual Items		
<i>Care from Regular Dentists</i>	96.73%	97.66%
<i>Would Recommend Regular Dentist</i>	95.87%	96.21%
<i>Would Recommend Dental Plan</i>	91.94%	95.91%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the SFY 2024 score is statistically significantly higher than the SFY 2023 score.

▼ Indicates the SFY 2024 score is statistically significantly lower than the SFY 2023 score.

No triangle (▲ or ▼) indicates the SFY 2024 score is not statistically significantly higher or lower than the SFY 2023 score.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the child dental survey findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: None of the SFY 2024 top-box scores for **BCD** were statistically significantly higher than the SFY 2023 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: None of the SFY 2024 top-box scores for **BCD** were statistically significantly lower than the SFY 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **BCD** monitor the measures to ensure significant decreases in scores over time do not occur.

Overall Conclusions for Quality, Timeliness, and Accessibility of Healthcare Services

HSAG performed a comprehensive assessment of **BCD**'s aggregated performance, and its overall strengths and weaknesses related to the provision of dental services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **BCD**'s overall performance contributed to the HKD program's progress in achieving the CQS goals and objectives. Table 3-24 displays each MDHHS CQS goal and the EQR activity results that indicate whether the DHP positively (✓), negatively (✗), or minimally (m) impacted the HKD program's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **BCD**'s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective or when a quality measure does not exist for the HKD program.

Table 3-24—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program Quality Measure ¹	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care			
1.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
1.2	The CQS does not include quality measures for the HKD program under this objective.	NA	
1.3	<i>Access to Dental Care—HKD Beneficiaries:</i> While HSAG could not determine the State-specific specifications for this quality measure based on the CQS, the DHP’s PIP activity and performance measures included as part of the PMV activity can be used to assess whether members are accessing dental care. The DHP’s PIP, <i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i> , demonstrated a statistically significant improvement from the baseline rate. Additionally, the DHP’s rate for all six of the applicable CMS-416 performance measures (12a-e and 12g) increased from the prior year, indicating that more members were accessing dental services.	✓	
Goal #2: Strengthen person and family-centered approaches			
2.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
2.2	The CQS does not include quality measures for the HKD program under this objective.	NA	

Objective	Program Quality Measure ¹	Overall Performance Impact	Performance Domain
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)			
3.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
3.2	<i>Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360</i>	NA	<input type="checkbox"/> Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	<i>Diagnostic Dental Visits—CMS 416-12²</i>	NA	<input checked="" type="checkbox"/> Quality
	<i>Preventive Dental Visits—CMS 416-12²</i>	NA	<input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

¹ While the CQS included several quality measures related to the dental program, only one, *Access to Dental Care—HKD Beneficiaries*, was identified as specifically applying to the HKD program. Additionally, the CQS did not identify whether the *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360* quality measure under Objective 3.2 applied to the HKD program. However, as HSAG could not confirm the applicability of this measure through the CQS, HSAG included this quality measure in Table 3-24. Further, for the two quality measures under Objective 4.1, while the CQS did not specifically identify the HKD program, the DHPs report CMS 416 measures; therefore, HSAG included these quality measures in Table 3-24. The remainder of the dental quality measures were excluded from HSAG's assessment as they applied to the adult population.

² The PMV activity does not include stratification of measures by race and ethnicity; therefore, HSAG was unable to assess the DHP's overall performance impact.

Delta Dental of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation for SFY 2024 evaluated the technical methods of **DD**’s PIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-25 displays the overall validation rating, the baseline rate, Remeasurement 1, Remeasurement 2, and Remeasurement 3 results for the performance indicators.

Table 3-25—Overall Validation Rating for DD

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	R3
Increasing Dental Utilization in Ages One and Two	High Confidence	High Confidence	Provider Rendering Treatment	17.4%	13.8% ↔	14.7% ↔	34.8% ↑
			Increase Ages One and Two Dental Utilization Percentages	14.3%	20.5% ↑	17.9% ↑	17.1% ↑

R1 = Remeasurement 1

R2 = Remeasurement 2

R3 = Remeasurement 3

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).

↔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

The goal for the PIP is that **DD** will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. Table 3-26 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the DHP to support achievement of the PIP goals and address the barriers.

Table 3-26—Remeasurement 3 Barriers and Interventions for DD

Barriers	Interventions
Provider availability and office capacity.	Offered members access to a special clinic, outside of normal scheduling, supported by grant funds.
	Offered an incentive to providers to see members 1–2 years of age.
	Offered a year-end bonus to top performing providers who see the most members 1–2 years of age by provider

Barriers	Interventions
	type or clinic type: large group, small group, solo practitioner, and pediatric dentist.
	Collaborative partnership for establishment of a Dental Home with MyCare Health Center in Macomb County, facilitating a family-centered approach and access to care for members aged 1–2 years.
Perceived belief by members that children 1–2 years of age do not need a dental visit.	Text messaging campaign to members educating them on the need for dental services at age 1.
	Developed a free Continuing Education course to educate providers on the needs of this population and how to effectively incorporate into current practice.
	General text messaging campaigns to members educating them on the need for dental services at all ages, how to locate a provider, dental clinics in the area, and oral health education topics.
Prioritization of other needs and member groups by providers.	Increased awareness of project and availability of increased incentive payments through biannual email blasts, mailed flyers, and provider relations representative contact.
	General awareness of HKD population needs for dental services through biannual email blasts, mailed flyers, and provider relations representative contact.
Fear of visiting the dentist during pandemic due to lack of vaccine availability for this age group.	Developed a text messaging campaign to dispel fears of visiting the dentist and contracting COVID-19 (coronavirus disease 2019) by detailing safety measures in place at dental offices.
Provider concerns with supply shortages and increased cost for supplies.	Implemented a \$1,000 credit for providers with Henry Schein to order dental supplies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DD conducted accurate statistical testing between measurement periods and provided a narrative interpretation of the Remeasurement 3 results. **DD** also revisited its causal/barrier analysis process to identify and prioritize barriers to care, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: For the Remeasurement 3 measurement period, **DD** reported that 34.8 percent of its providers rendered treatment to members 1–2 years of age and 17.1 percent of members of the same age group received a dental service during the measurement period. Both of these performance indicators demonstrated statistically significant increases over the baseline performances. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: There were no identified substantial weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified substantial weaknesses, HSAG recommends **DD** apply lessons learned and knowledge gained throughout the PIP to future PIPs and other quality improvement activities.

Performance Measure Validation

Performance Results

Table 3-27 demonstrates **DD**'s final reported rates for the CMS-416 Annual EPSDT performance measures for the SFY 2024 PMV activity measurement period (October 1, 2022–September 30, 2023), and Table 3-28 demonstrates **DD**'s final reported rates for the DQA dental quality performance measures for the SFY 2024 PMV activity measurement period (January 1, 2022–December 31, 2023). Table 3-29 provides a comparison of the SFY 2022 (October 1, 2021–September 30, 2022) and SFY 2023 (October 1, 2022–September 30, 2023) performance measure data and subsequent rates for the CMS-416 Annual EPSDT measures, and the SFY 2022 (January 1, 2021–December 31, 2022) and SFY 2023 (January 1, 2022–December 31, 2023) rates for the DQA dental quality measures.

Table 3-27—DD Final CMS-416 Annual EPSDT Performance Measure Rates

Age Category (Years)	Denominator	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	12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services
Age < 1	20,007	184	100	51	0	145	0	100
Ages 1–2	52,835	9,670	8,436	596	0	9,086	0	8,436
Ages 3–5	86,223	47,025	44,101	14,625	0	45,527	0	44,101

Age Category (Years)	Denominator	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	12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services
Ages 6–9	191,270	124,052	117,196	54,866	30,157	120,125	0	117,196
Ages 10–14	234,435	135,600	128,218	55,050	27,130	130,404	0	128,218
Ages 15–18	182,612	87,609	78,218	41,501	0	82,814	0	78,218
Ages 19–20	67,685	22,488	18,028	11,632	0	20,945	0	18,028
Total	835,067 ¹	426,628	394,297	178,321	57,287	409,046	0	394,297
	425,705 ²							
	Final Rate	51.09%	47.22%	21.35%	13.46%	48.98%	0.00% ³	47.22%

¹ Total denominator count shown is for 12a, 12b, 12c, 12e, 12f, and 12g, as these performance measures are inclusive of all age categories.

² Total denominator count shown is for 12d, as 12d is only inclusive of the 6–9 and 10–14 age categories.

³The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

Table 3-28—DD Final DQA Dental Quality Performance Measure Rates

	CCN-CH-A—Total Care Continuity	USS-CH-A—Total Usual Source of Services
Numerator	301,820	256,352
Denominator	749,801	749,801
Final Rate	40.25%	34.19%

Table 3-29—SFY 2022 and SFY 2023 Performance Measure Rate Comparisons

Performance Measures							
CMS-416 Annual EPSDT Performance Measure	Numerator	Denominator	SFY 2022	Numerator	Denominator	SFY 2023	SFY 2022—SFY 2023 Comparison
12a—Total Eligibles Receiving Any Dental Services	419,840	822,392	51.05%	426,628	835,067	51.09%	+0.04%
12b—Total Eligibles Receiving Preventive Dental Services	389,632	822,392	47.38%	394,297	835,067	47.22%	-0.16%
12c—Total Eligibles Receiving Dental Treatment Services	176,112	822,392	21.41%	178,321	835,067	21.35%	-0.06%
12d—Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	49,895	417,628	11.95%	57,287	425,705	13.46%	+1.51%
12e—Total Eligibles Receiving Dental Diagnostic Services	403,637	822,392	49.08%	409,046	835,067	48.98%	-0.10%
12f—Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	0	822,392	0.00%	0	835,067	0.00% ¹	+/-0.00%
12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services	389,632	822,392	47.38%	394,297	835,067	47.22%	-0.16%
DQA Dental Quality Measures	Numerator	Denominator	SFY 2022	Numerator	Denominator	SFY 2023	SFY 2022—SFY 2023 Comparison
CCN-CH-A—Care Continuity	292,455	737,248	39.67%	301,820	749,801	40.25%	+0.58%
USS-CH-A—Usual Source of Services	253,591	737,248	34.40%	256,352	749,801	34.19%	-0.21%

¹ The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DD established quality improvement interventions to increase performance measure rates. To increase benefit awareness and provide care coordination for its members, **DD** conducted outreach via text messaging campaigns and direct phone calls to members. In addition, performance improvement projects were implemented to increase utilization rates, including provider incentives to see more members, member incentives to receive dental services, and dental screening days to increase access and the availability of appointments. Value-based payment projects were also implemented to increase utilization through provider incentive programs for all participating providers if a specific utilization goal was met. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: For measures 12a, 12b, 12c, and 12e, HSAG's review of the **DD**'s member-level detail file noted that for two reported members the dental service dates listed were earlier than the member dates of birth (DOB). [Quality]

Why the weakness exists: **DD** confirmed that this discrepancy was tied to a dependent record on the commercial plan product side that reflected the incorrect DOBs for the two members. **DD** supplied full enrollment files and demonstrated the appropriate DOBs in its system.

Recommendation: Although the finding had no impact on the performance measure rates, HSAG recommends that **DD** incorporate enhanced validation checks that include checking for any dental service dates that occur prior to member DOBs. This could further ensure data accuracy and timely identification of potential issues.


Compliance Review


Performance Results

Table 3-30 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-30 also presents DD’s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, DD was subject to a corrective action review process outlined in Appendix A.

Table 3-30—Compliance Review Results for DD

Standard		Number of Scores			Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	DD ²	Statewide
1	Administrative	5	0	0	100%	100%
2	Providers	13	0	1	93%	89%
3	Members	21	0	0	100%	100%
4	Quality	8	0	0	100%	100%
5	MIS/Financial	39	0	0	100%	99%
6	OIG/Program Integrity	9	0	1	90%	95%
Overall		95	0	2	98%	97%

 Indicates the standard scored below the statewide rate.

 Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select criteria under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) criteria and the number of *Not Met* and *Satisfied* (i.e., 0 points) criteria, then dividing the summed score by the total number of criteria for that standard.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following two areas: Operations and Quality. While the results of the focus study were not incorporated into the scoring of the standards within the compliance review activity, DD met MDHHS’ expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DD achieved full compliance in the Administrative standard, demonstrating that the DHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: DD achieved full compliance in the Members standard, demonstrating that the DHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; and member information materials, such as a member handbook, newsletters, and website. [Quality, Timeliness, and Access]

Strength #3: DD achieved full compliance in the Quality standard, demonstrating that the DHP had an adequate quality program, which included, but was not limited to, CPGs, UM activities; QIP evaluation and workplan; program policies and procedures; PIPs; accreditation; and performance measure rate review. [Quality, Timeliness, and Access]

Strength #4: DD achieved full compliance in the MIS/Financial standard, demonstrating that the DHP maintained a health information system that collected, analyzed, integrated, and reported data in various program areas and functions, including, but not limited to, financial statements and reports; third-party recovery and subrogation requests; claims and encounter data processes; and provider data. [Quality]

Weaknesses and Recommendations

Weakness #1: While **DD** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the OIG/Program Integrity standard, the DHP scored below the statewide average. The DHP received a *Not Met* score for element *October 6.8–Encounter Adjustment*. [Quality]

Why the weakness exists: **DD** did not meet the minimum match requirements for the October 2023 encounter adjustment submission due to a coding logic issue.

Recommendation: **DD** was required to submit a CAP to address element *October 6.8*, which was approved by MDHHS. As such, HSAG recommends that **DD** continue to implement action plans and monitoring processes to enhance the minimum match rate for encounter adjustments.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the DHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each DHP according to Table 3-31.

Table 3-31—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **DD** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **DD** was aware of a gap, and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the DHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Results are presented by provider type and county in Table 3-32 and Table 3-33, with exceptions highlighted in **orange**.

Table 3-32—DD Network Adequacy Compliance—Rural

Rural County	General Dentistry Min/Mile	General Dentistry Ratio	Endo-dontist Min/Mile	Oral Surgeon Min/Mile	Pediatric Dentist Min/Mile	Perio-dontist Min/Mile	Prosthodontist Min/Mile
Alcona	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Alger	Exception	Exception	Exception	Compliant	Exception	Exception	Exception
Allegan	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Alpena	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Antrim	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Arenac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Baraga	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Barry	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Benzie	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception

Rural County	General Dentistry Min/Mile	General Dentistry Ratio	Endo-dontist Min/Mile	Oral Surgeon Min/Mile	Pediatric Dentist Min/Mile	Perio-dontist Min/Mile	Prosthodontist Min/Mile
Branch	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Charlevoix	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Cheboygan	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Chippewa	Exception	Exception	Exception	Exception	Exception	Exception	Exception
Clare	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Crawford	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Delta	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Dickinson	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Emmet	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Gladwin	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Gogebic	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Grand Traverse	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Gratiot	Exception	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Hillsdale	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Houghton	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Huron	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ionia	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Iosco	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Iron	Exception	Exception	Exception	Compliant	Compliant	Exception	Exception
Isabella	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Kalkaska	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Keweenaw	Exception	Exception	Exception	Compliant	Compliant	Exception	Exception
Lake	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Leelanau	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Lenawee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Luce	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Mackinac	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Manistee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Marquette	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Mason	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Mecosta	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Menominee	Exception	Exception	Exception	Compliant	Compliant	Exception	Exception
Missaukee	Exception	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Montcalm	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Montmorency	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Newaygo	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Rural County	General Dentistry Min/Mile	General Dentistry Ratio	Endo-dontist Min/Mile	Oral Surgeon Min/Mile	Pediatric Dentist Min/Mile	Perio-dontist Min/Mile	Prosthodontist Min/Mile
Oceana	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Ogemaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ontonagon	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Osceola	Exception	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Oscoda	Exception	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Otsego	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Presque Isle	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Roscommon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Sanilac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Schoolcraft	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Shiawassee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
St Joseph	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Tuscola	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Van Buren	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Wexford	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception

Table 3-33—DD Network Adequacy Compliance—Urban

Urban County	General Dentistry Min/Mil	General Dentistry Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prosthodontist Min/Mil
Bay	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Berrien	Compliant	Compliant	Exception	Compliant	Exception	Exception	Compliant
Calhoun	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Cass	Compliant	Compliant	Exception	Compliant	Exception	Exception	Compliant
Clinton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Eaton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Genesee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ingham	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Jackson	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Kalamazoo	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Kent	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Lapeer	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Livingston	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Macomb	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Midland	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant

Urban County	General Dentistry Min/Mil	General Dentistry Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prosthodontist Min/Mil
Monroe	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Muskegon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Oakland	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ottawa	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Saginaw	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
St. Clair	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Washtenaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Wayne	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DD maintained a thoroughly documented deliverable validation process. This documented process helped ensure business continuity in its network adequacy reports and its ability to maintain detailed steps to ensure the accuracy of these submissions. [Access]

Strength #2: DD had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists. [Access]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for DD through the NAV activity.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 409 randomly sampled cases by comparing provider data submitted to HSAG by **DD** against **DD**’s online directory. The sample included 317 general dental providers and 92 pediatric dental providers. Overall, 94.9 percent of the sampled providers were located in the online directory at the sampled location. Additionally, 5.1 percent of the total providers were not found in the online directory.

Table 3-34 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the DHP’s online directories.

Table 3-34—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
General	317	17	5.4%	0	0.0%	300	94.6%
Pediatric	92	4	4.3%	0	0.0%	88	95.7%
DD Total	409	21	5.1%	0	0.0%	388	94.9%

¹ The denominator includes the number of sampled providers.

Table 3-35 displays the total number and the percentages of cases with matched data values for indicators that were reviewed between data values shown in **DD**’s provider data submission to HSAG and **DD**’s online provider directory. Cases with unmatched results may include incorrect information, or information not listed in the directory (e.g., the DHP’s provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-35—Provider Demographic Indicators Matching Online Provider Directory

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	300	100%	88	100%	388	100%
Provider Street Address	300	100%	88	100%	388	100%
Provider Suite Number	300	100%	88	100%	388	100%
Provider City	300	100%	88	100%	388	100%
Provider State	300	100%	88	100%	388	100%

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider ZIP Code	300	100%	88	100%	388	100%
Provider Telephone Number	300	100%	88	100%	388	100%
Provider Type/Specialty	300	100%	88	100%	388	100%
Provider Accepting New Patients	300	100%	88	100%	388	100%
Provider Gender	300	100%	88	100%	388	100%
Provider Primary Language ²	299	99.7%	88	100%	387	99.7%
Non-English Language Speaking Provider (including American Sign Language) ²	299	99.7%	88	100%	387	99.7%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 388 sampled provider locations for **DD**, with an overall response rate of 93.6 percent. Table 3-36 summarizes the survey response rates (i.e., cases reached) for both DHPs and for **DD**, by provider category.

Table 3-36—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
General	300	278	92.7%
Pediatric	88	85	96.6%
DD Total	388	363	93.6%
All DHPs Total	705	657	93.2%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key provider indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-37 summarizes the provider data validation and accuracy results for both DHPs and **DD**, by provider category.

Table 3-37—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
General	278	266	95.7%	259	93.2%	255	91.7%	187	67.3%	170	61.2%
Pediatric	85	81	95.3%	80	94.1%	76	89.4%	60	70.6%	55	64.7%
DD Total	363	347	95.6%	339	93.4%	331	91.2%	247	68.0%	225	62.0%
All DHPs Total	657	584	88.9%	566	86.1%	553	84.2%	412	62.7%	381	58.0%

¹ The denominator includes cases reached.

Table 3-38 displays the number of survey respondents who offered appointments to new patients for routine dental care visits for both DHPs and **DD**, by provider category.

Table 3-38—Appointment Availability for Routine Dental Care Visits¹

Provider Category	Number of Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
General	278	134	48.2%
Pediatric	85	37	43.5%
DD Total	363	171	47.1%
All DHPs Total	657	296	45.1%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-39 displays the new patient wait time results for routine dental care visits for both DHPs and **DD**, by provider category.

Table 3-39—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Calendar Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
General	0	309	46	21	74.6%
Pediatric	1	245	65	38	62.2%

Provider Category	Appointment Wait Time (Calendar Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
DD Total	0	309	50	21	71.9%
All DHPs Total	0	309	40	18	78.0%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an initial routine dental care appointment that was compliant with the 56-calendar-day standard.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS findings for the against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the providers located in the online provider directory, all PDV indicators had a match rate above 99.0 percent. [Quality and Access]

Strength #2: Overall, 93.6 percent of locations were reached, 95.6 percent of locations confirmed affiliation with the sampled provider, 93.4 percent confirmed the address information, and 91.2 percent offered the requested services. [Quality and Access]

Strength #3: Overall, 94.9 percent of the sampled providers listed in DD's provider data were located in DD's online provider directory. Among the provider categories, 95.7 percent of pediatric providers and 94.6 percent of general providers were located in the online provider directory. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Of the responsive cases, 68.0 percent of locations accepted the insurance, and 62.0 percent accepted new patients. [Quality and Access]

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of DD's provider data may have contributed to the low accuracy results.

Recommendation: HSAG recommends that DD use the case-level analytic data files containing provider deficiencies identified during the survey calls (e.g., incorrect plan and new patient acceptance information) to address the provider deficiencies.

Weakness #2: Among the responsive cases, 47.1 percent were offered an appointment date. General provider locations had an appointment availability rate of 48.2 percent and pediatric provider locations had an appointment availability rate of 43.5 percent. Of the cases that offered an

appointment, 71.9 percent were compliant with the appointment wait time standard. [**Timeliness and Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, or a Medicaid ID. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers’ offices to facilitate practice operations.

Recommendation: HSAG recommends that **DD** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **DD** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **DD** procured dental records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, such as *Date of Service* and *Dental Procedure Code*, to identify discrepancies and ensure alignment between the dental records and the encounter data submitted to MDHHS.

Table 3-40 outlines the key findings for **DD** based on the assessment of encounter data completeness and accuracy conducted through a review of members’ dental records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-40—Key Findings for DD

Analysis	Key Findings
Dental Record Procurement Status	
Dental Record Procurement Rate	<ul style="list-style-type: none"> The dental record procurement rate was 97.8 percent, indicating that nearly all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured dental records, 50.0 percent included a corresponding second date of service.
Encounter Data Completeness	
Dental Record Omission Rate	<ul style="list-style-type: none"> Both key data elements (i.e., <i>Date of Service</i> and <i>CDT Code</i>) exhibited relatively low dental record omission rates: 2.3 percent for <i>Date of Service</i> and 6.3 percent for <i>CDT</i>

Analysis	Key Findings
	<i>Code</i> . These results indicate that the encounter data for these elements were well-supported by the members' dental records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> The encounter data omission rates for both key data elements (i.e., <i>Date of Service</i> and <i>CDT Code</i>) were notably low: 1.9 percent for <i>Date of Service</i> and 0.7 percent for <i>CDT Code</i>.
Encounter Data Accuracy	
Dental Code Accuracy Rate	<ul style="list-style-type: none"> The <i>CDT Code</i> data element was accurate in 99.2 percent of instances where codes were present in both the dental records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for key data element (<i>CDT Code</i>) were observed in 85.8 percent of the dates of service present in both data sources (i.e., encounter data and dental records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: A high percentage of *Date of Service* and *CDT Code* data element values in the encounter data were generally supported by the members' dental records, as evidenced by the low dental record omission rates of 2.3 percent and 6.3 percent, respectively. [Quality]

Strength #2: The *Date of Service* and *CDT Code* data element values identified in the dental records were generally present in the encounter data, as reflected by the low encounter data omission rates of 1.9 percent and 0.7 percent, respectively. [Quality]

Strength #3: When *CDT Code* data element values were present in both the encounter data and the members' dental records, they were found to be accurate in 99.2 percent of records. [Quality]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **DD** through the EDV activity

Why the weakness exists: NA

Recommendation: NA

Child Dental Survey

Performance Results

Table 3-41 presents DD’s SFY 2023 and SFY 2024 top-box scores. The results were assessed to determine if the SFY 2024 score was statistically significantly higher or lower than the SFY 2023 score for each measure. Upward and downward triangles (▲ or ▼) indicate SFY 2024 scores were statistically significantly higher or lower than the SFY 2023 scores.

Table 3-41—Summary of Top-Box Scores for DD

	SFY 2023	SFY 2024
Global Ratings		
<i>Rating of Regular Dentist</i>	76.56%	77.18%
<i>Rating of All Dental Care</i>	74.20%	78.63%
<i>Rating of Finding a Dentist</i>	41.67% ⁺	52.94% ⁺
<i>Rating of Dental Plan</i>	70.36%	68.26%
Composite Measures		
<i>Care from Dentists and Staff</i>	95.01%	95.53%
<i>Access to Dental Care</i>	72.29%	75.14%
<i>Dental Plan Information and Services</i>	82.22%	89.56%▲
Individual Items		
<i>Care from Regular Dentists</i>	93.77%	93.24%
<i>Would Recommend Regular Dentist</i>	94.46%	95.17%
<i>Would Recommend Dental Plan</i>	97.47%	95.63%

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the SFY 2024 score is statistically significantly higher than the SFY 2023 score.

▼ Indicates the SFY 2024 score is statistically significantly lower than the SFY 2023 score.

No triangle (▲ or ▼) indicates the SFY 2024 score is not statistically significantly higher or lower than the SFY 2023 score.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the child dental survey findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DD’s SFY 2024 top-box score was statistically significantly higher than the SFY 2023 top-box score for one measure, *Dental Plan Information and Services*. [Quality]

Weaknesses and Recommendations

Weakness #1: None of the SFY 2024 top-box scores for DD were statistically significantly lower than the SFY 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that DD monitor the measures to ensure significant decreases in scores over time do not occur.

Overall Conclusions for Quality, Timeliness, and Accessibility of Healthcare Services

HSAG performed a comprehensive assessment of DD’s aggregated performance, and its overall strengths and weaknesses related to the provision of dental services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how DD’s overall performance contributed to the HKD program’s progress in achieving the CQS goals and objectives. Table 3-42 displays each MDHHS CQS goal and the EQR activity results that indicate whether the DHP positively (✓), negatively (✗), or minimally (m) impacted the HKD program’s progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to DD’s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective or when a quality measure does not exist for the HKD program.

Table 3-42—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program Quality Measure ¹	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care			
1.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
1.2	The CQS does not include quality measures for the HKD program under this objective.	NA	
1.3	<i>Access to Dental Care—HKD Beneficiaries:</i> While HSAG could not determine the State-specific specifications for this quality measure based on the CQS, the DHP’s PIP activity and performance measures included as part of the PMV activity can be used to assess whether members are accessing dental care. The DHP’s PIP, <i>Increasing Dental Utilization in Ages One and Two</i> , demonstrated a statistically significant	m	

Objective	Program Quality Measure ¹	Overall Performance Impact	Performance Domain
	improvement from the baseline rate. However, the six applicable rates for the CMS-416 performance measures (12a-e and 12g) remained relatively stagnant overall when compared to the prior year's rates.		
Goal #2: Strengthen person and family-centered approaches			
2.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
2.2	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Access
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)			
3.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
3.2	<i>Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360</i>	NA	<input type="checkbox"/> Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	<i>Diagnostic Dental Visits—CMS 416-12²</i>	NA	<input checked="" type="checkbox"/> Quality
	<i>Preventive Dental Visits—CMS 416-12²</i>	NA	<input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The CQS does not include quality measures for the HKD program under this objective.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

¹ While the CQS included several quality measures related to the dental program, only one, *Access to Dental Care—HKD Beneficiaries*, was identified as specifically applying to the HKD program. Additionally, the CQS did not identify whether the *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360* quality measure under Objective 3.2 applied to the HKD program. However, as HSAG could not confirm the applicability of this measure through the CQS, HSAG included this quality measure in Table 3-42. Further, for the two quality measures under Objective 4.1, while the CQS did not specifically identify the HKD program, the DHPs report CMS 416measures; therefore, HSAG included these quality measures in Table 3-42. The remainder of the dental quality measures were excluded from HSAG's assessment as they applied to the adult population.

² The PMV activity does not include stratification of measures by race and ethnicity; therefore, HSAG was unable to assess the DHP's overall performance impact.

4. Follow-Up on Prior External Quality Review Recommendations for Dental Health Plans

From the findings of each DHP's performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the HKD program. The recommendations provided to each DHP for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report for Dental Health Plans* are summarized in Table 4-1 and Table 4-2. Each DHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 and Table 4-2.

Blue Cross Blue Shield of Michigan Dental

Table 4-1—Prior Year Recommendations and Responses for BCD

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> There were no identified substantial weaknesses. Although there were no identified substantial weaknesses, HSAG recommends BCD revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. BCD should also continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps. Further, for future PIP validation activities, BCD must provide HSAG with a detailed explanation for any revisions that are made to the initial baseline rate(s) over the time period of the PIP for the identified indicator(s).
<p>MCE's Response: <i>(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)</i></p>
<p>a. Describe initiatives implemented based on recommendations <i>(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)</i>:</p> <ul style="list-style-type: none"> To improve these outcomes, we will continue with the interventions and conduct PDSA cycles using outcomes to determine whether to adapt, adopt or abandon interventions.
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> Blue Cross Blue Shield of Michigan (BCD) maintained improvement from prior measurement period.
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> If at any point new barriers are identified, BCD will modify the barrier analysis accordingly.
<p>HSAG Assessment: HSAG has determined that BCD addressed the prior year's recommendations. BCD revisited its causal/barrier analysis and determined that the barriers remained the same as in the prior year.</p>

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

BCD continued to evaluate the effectiveness of each intervention and used the results to guide the intervention's next steps.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- Upon HSAG's review of **BCD** member-level detail file, it was noted for one member reported in 12a, 12b, 12e, and 12g that the dental service date listed was earlier than the member's date of birth. Although the finding had no impact to the performance measure rates, HSAG recommends **BCD** incorporate more stringent validation checks to confirm the accuracy of member-level data prior to submission to HSAG. The validation steps should include checking for any dental service dates that occur prior to a member's date of birth.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - BCD** instilled a 3-tiered validation check for the Performance Measure rates. This includes a subject matter expert review, leadership review of the data, and a final quality check performed by the Client Engagement team. All stages of quality review require a sign-off from the reviewer.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - The **BCD** Business Intelligence (BI) team has confirmed that there are no logical checks of any kind in the reporting stored procedures to determine if the members Date of Birth is earlier than the Date of Service. The BI team uses the data exactly as entered into the Windward system from the client 834 (or proprietary member eligibility) file.
- Identify any barriers to implementing initiatives:
 - The **BCD** Electronic Enrollment will evaluate the possibility of adding additional validation checks on the inbound files at time of load processing.

HSAG Assessment: HSAG has determined that **BCD** addressed the prior year's recommendation. HSAG did not identify any discrepancies related to dental service dates occurring prior to member DOBs during the current year PMV activity.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review

HSAG recommended the following:

- While **BCD** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Providers standard, the DHP scored below the statewide average. The DHP received a *Not Met* score for element 2.21 *Secret Shopper Calls*. At the time MDHHS provided HSAG with the compliance review findings, MDHHS had not yet determined if a CAP will be required to address element 2.21. As such, HSAG recommends that **BCD** continue to implement action plans and monitoring processes to ensure it meets MDHHS performance thresholds for provider contact/address information accuracy and to ensure all contracted providers are aware of their contract obligations to notify **BCD** when they are no longer accepting new patients. Additionally, HSAG recommends that the DHP continually review the Medicaid

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review

managed care standards and requirements outlined under 42 CFR §438.358 (b)(1)(iii) to ensure that all federally required compliance review requirements are addressed.

- While **BCD** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the DHP scored below the statewide average. The DHP received a *Not Met* score for element 3.6A *Member Appeals*. **BCD** was required to submit a CAP to address element 3.6A, which was approved by MDHHS. As such, HSAG recommends that **BCD** continue to implement action plans and monitoring processes to ensure that all appeals are resolved within the required 30-day time frame.
- While **BCD** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the OIG/Program Integrity standard, the DHP scored below the statewide average. The DHP received *Not Met* scores for element 6.2 *Quarterly Program Integrity Forms—Data Mining for FY 22 Q2* and element 6.8 *Quarterly Program Integrity Forms—Encounter Adjustments for FY21 Q4 and FY22 Q1*. **BCD** was required to submit CAPs to address elements 6.2 and 6.8, which were approved by MDHHS. HSAG recommends that **BCD** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure all data reported for program integrity purposes are accurate (i.e., data mining and encounter adjustments data).

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - BCD updated the Provider Directory Validation Survey to incorporate more stringent language on the necessity of Providers notifying the Plan of any changes.
 - Daily inventory reports were created because of the CAP received for 3.6A. They are monitored daily by Management and staff.
 - A robust checklist was created for all individuals completing the OIG Program Integrity report to ensure alignment on expectations.
 - The OIG Program Integrity report currently involves a manual process. To reduce the potential for human error, BCD is exploring the automation of certain tabs within the report. This initiative is still in the research phase.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - No noted improvement yet as the DVS was updated recently. Not enough data to determine.
 - No CAPs received for 3.6A since this was initiated.
 - No CAPs for OIG report in FY24
- Identify any barriers to implementing initiatives:
 - No barriers at this time.

HSAG Assessment: HSAG has determined that **BCD** partially addressed the prior year's recommendation. The SFY 2024 compliance review activity demonstrated that **BCD** received a *Met* score for elements 3.6A and 6.8, confirming the DHP's action steps were successful in remediating the deficiencies. However, **BCD** received a *Not Met* score for element 2.21. **BCD** continued to not meet the performance indicator thresholds for the secret shopper activity (i.e., *General Dentists who have the "acceptance of DHP/HKD" on the submitted provider file that matches what shows in the online directory and is confirmed during the call and General Dentists who are "accepting new patients" on the submitted provider file that matches what shows in the*

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review

online directory and is confirmed during the call). MDHHS did not require **BCD** to submit a CAP for element 2.21 as MDHHS was analyzing findings for possible enforcement action. As such, HSAG recommends that **BCD** continue to implement action plans and monitoring processes to improve the accuracy of provider data, and it has adequate procedures for provider appeals. Specific to element *August 2.21*, as part of the focus study, **BCD** reported that it sends quarterly letters to providers requesting they update information through one of four ways: website, portal, DVS, or by notifying their provider partner consultant that the DVS has recently been updated to include a “no changes” option, and encouraging providers to respond. As such, HSAG recommends that the **BCD** monitor quarterly the number of providers who change their information to determine whether the quarterly letters are successful in triggering providers to update their information or confirm there are no changes.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Overall, 12.1 percent of the sampled providers listed in **BCD**’s provider data could not be located in **BCD**’s online provider directory. Among the provider categories, 14.8 percent of pediatric providers and 11.9 percent of general providers could not be located in the online provider directory. HSAG recommends that **BCD** use the case-level analytic data files containing provider deficiencies identified during the PDV reviews (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- **BCD**’s overall response rate was 79.6 percent. Of the total responsive cases, 73.8 percent confirmed the sampled provider was affiliated with the location, 68.7 percent confirmed the address, 64.5 percent confirmed the location offered the requested services, 62.6 percent of locations were accepting the insurance, and 57.9 percent accepted new patients. HSAG recommends that **BCD** use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
- Among all surveyed cases, 40.1 percent were offered an appointment date. General provider locations had an appointment availability rate of 40.5 percent. Pediatric provider locations had an appointment availability rate of 35.3 percent. HSAG recommends that **BCD** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **BCD** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

MCE’s Response: *(Note—the narrative within the MCE’s Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Upon review of the 12.1% of providers not displayed in the directory or marked as a data deficiency, we found:
 - Root cause of 28% of the 12.1% of providers not displayed in the directory due to a data problem caused by a conflict in how the data was merged. The issue was rectified and the provider network has been fully merged into the database and providers are accurately reflected in the online directory.
 - 56% were valid removals from directory.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

- Valid removals had termed, were removed from the location, or were updated to exclude from online directory after the file was submitted for the secret shopper audit.
- 16% were incorrect “No Match” designations We found that many of those listed as a “No Match” for address, phone number, city etc., were a match to our system and online directory and were incorrectly listed as a “No Match”.
- Upon review and educational outreach to providers who did not offer an appointment, we found:
 - 30% required further action from BCD.
 - Office did not send timely notification of update to practice/provider/location. BCD updated practice/provider/location based upon outcome of phone validation.
 - Offices provided education on appointment guidelines, office update submission guidelines and assistance, pre-registration guidance.
 - Additional education added to source materials including provider newsletters and website.
 - 63% did not require further action from BCD.
- Verification confirmed:
 - Case disposition: Medical practice does not offer dental. BCD Phone outreach confirmed location is dental office and accepts BCD HKD.
 - Case disposition: Does not accept new patients. BCD Phone outreach confirmed office accepts plan and accepts patients within required timeframes.
 - Case disposition: Reached VM. BCD Phone outreach reached scheduler.
 - Case disposition: Unable to schedule due to limitation. BCD Phone outreach, schedule available no limitation noted during call.
 - Timing issue: Provider/location change after provider file sent.
- We have adopted a new provider directory validation process and procedures to overcome lack of provider compliance.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- With our new remediation process in place (described below), the overall result is to improve efficiency, consistency, and productivity of our processes, ultimately leading to accurate directory data, leading to better results of secret shopper audits and overall member satisfaction.

c. Identify any barriers to implementing initiatives:

- Some of the Network Validation Survey (NVS) data submitted in March 2023 did not match the online provider directory when HSAG performed the Secret Shopper (SS) calls in April and May 2023. When we did our review, it was determined that the data had been updated in Windward and the Online Provider Directory between the time the survey was submitted, and the SS calls took place. This was noted on the feedback from BCD.
- We also observed some data anomalies between what was originally submitted on the NVS, and the Analytic SS data received back for review, i.e. Provider address on the SS file was different from the NVS file originally submitted, causing the data to “not match”.
- Based upon 2023 results, there were 90 cases that did not lead to a new patient appointment outcome. We were able to resolve 51 of those cases through data validation and phone verification (address was valid, location/provider matched, accepted plan and new patients). Of the remaining 39 cases, we found that untimely update notifications from providers/practices were a major barrier.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG Assessment: HSAG has determined that **BCD** partially addressed the prior year's recommendations. **BCD** addressed the data deficiencies noted in the case-level analytic data files, implemented interventions to ensure data directory accuracy, and conducted provider outreach to validate contact information and training. However, 2024 results for **BCD** indicate low appointment availability (42.5 percent). HSAG further recommends that **BCD** work with its contracted providers to ensure sufficient appointment availability for its members and balance procedural efficiencies with providing clear and direct information to members about appointment availability.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **BCD** lacked a robust process to detect duplicated encounters before submitting data to MDHHS. **BCD** should develop a process to detect all potential duplicates before submitting data to MDHHS. Having a reliable mechanism to proactively identify and prevent duplicate encounters is crucial for maintaining data quality and efficiency in the encounter data submission process.
- **BCD** did not provide specific details regarding data quality checks performed by its subcontractor, DentaQuest. **BCD** should establish or refine either its subcontractor's or the DHP's data monitoring reports aimed at assessing the completeness, timeliness, and accuracy of encounter data. By implementing such measures, **BCD** can enhance the overall quality and reliability of the encounter data it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.
- **BCD** indicated it did not store data from its subcontractor, DentaQuest. To support **BCD**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.
- **BCD** relied entirely on its subcontractor for managing its encounter data and acknowledged the absence of oversight regarding how its subcontractor manages these encounters. **BCD** should establish robust oversight mechanisms. This proactive approach will help ensure the completeness and accuracy of the data submitted to MDHHS or processed on its behalf.
- While more than 99.9 percent of unique member IDs identified in the dental encounters were identified in the enrollment data, only 26.0 percent of member IDs identified from the enrollment data were identified in the encounter data. **BCD** should continue to participate in network adequacy validation activities and secret shopper surveys to help determine reasons behind members' underutilization of dental services and take appropriate actions to mitigate any barriers noted through these activities. Additionally, direct engagement with members could help **BCD** ensure enhanced utilization.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Staff turnover attributed to lack of resources. BCD has trained additional staff to work on the Encounter files to increase efficiency of the encounters. The team is more focused on accuracy and quality review than prior years.
 - In addition to the newly trained staff, BCD has implemented a more intuitive review of the encounter data, including internal process documents.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

- Although encounter data remains with the subcontractor, BCD has implemented additional oversight tools and practices including but not limited to additional reporting from the subcontractor, additional validation steps and internal root cause analysis tracking to pinpoint and prevent recurrence of any gaps/potential gaps as it relates to the data that is stored with the subcontractor.
- BCD is continually assessing underutilization and making changes to directly engage with members, encouraging them to go to the Dentist. In FY24, a robust outreach campaign was launched, which included: mailing Postcards, implementing SMS and E-Mail notifications to members, and providing more Mobile Unit events to increase access. We are seeing increasing engagement through QR code scan rates and click through rates of the SMS and E-mail notifications.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- No noted improvement yet from the initiatives implemented.

c. Identify any barriers to implementing initiatives:

- There were no obstacles to the implementation of the initiatives.

HSAG Assessment: HSAG has determined that **BCD** partially addressed the prior year's recommendations. **BCD** has taken steps to address some of the recommendations from HSAG but has yet to achieve full resolution in several areas.

Regarding the recommendation to develop a process to detect potential duplicate encounters before submission, **BCD** has implemented internal process improvements, including training additional staff and focusing on quality reviews. However, no specific mechanism for detecting duplicates before submission was described. Without evidence of a proactive and reliable duplicate detection process, this recommendation was partially addressed. Implementing automated tools or scripts to identify duplicates would enhance data quality and efficiency.

For the recommendation to establish or refine subcontractor data monitoring reports, **BCD** introduced additional oversight tools and practices, including subcontractor reporting, validation steps, and root cause analysis tracking. While these measures demonstrate progress, there is no mention of robust monitoring reports specifically assessing the completeness, timeliness, and accuracy of encounter data. This recommendation was partially addressed. Developing comprehensive monitoring reports with defined metrics would ensure consistent and accurate subcontractor data submissions.

In response to storing subcontractor encounter data within **BCD**'s claims system, **BCD** has not yet transitioned subcontractor encounter data into its claims systems, instead relying on additional reporting and oversight practices. This recommendation was not addressed, as storing data internally would improve accessibility and control over data quality.

Regarding the recommendation to establish robust oversight mechanisms for subcontractor data management, **BCD** noted that it has implemented additional oversight tools and practices to address gaps in subcontractor data management. These steps, including validation and root cause tracking, represent meaningful progress. However, the level of oversight described does not appear to be fully robust or proactive. This recommendation was partially addressed, as more detailed reporting and regular audits would strengthen oversight further.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

Finally, in response to addressing member underutilization of dental services, **BCD** explained that it has launched a robust outreach campaign, utilizing postcards, short message service (SMS), emails, and mobile unit events to engage members. These efforts represent a direct response to the recommendation, demonstrating a clear focus on mitigating barriers to dental service utilization. Although no measurable improvements have been noted yet, this recommendation was fully addressed, assuming these initiatives continue and yield results over time.

In conclusion, **BCD** has made progress in addressing several recommendations, particularly in member engagement efforts to improve dental service utilization. However, critical gaps remain in the areas of duplicate detection, subcontractor monitoring, and internal data storage. To fully address these issues, **BCD** should implement automated duplicate detection tools, establish comprehensive monitoring reports, and transition subcontractor data into its claims systems. Additionally, more robust oversight mechanisms with frequent audits and clear performance metrics would improve subcontractor data management. While no barriers were reported, focused efforts and resource allocation will be essential for addressing these gaps and achieving HSAG's expectations.

6. Prior Year Recommendation From the EQR Technical Report for Child Dental Survey

HSAG recommended the following:

- **BCD's** SFY 2023 top-box score was statistically significantly lower than the SFY 2022 top-box score for one measure, *Would Recommend Dental Plan*. HSAG recommends that **BCD** continue to explore what may be driving the parents/caretakers to not recommend their child's DHP to others, develop initiatives designed to improve quality of care, and focus on improving parents/caretakers of child members' overall experiences with their child's DHP.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):
 - BCD utilizes many tools to increase communication, knowledge, and encouragement that we are here to help the members any way we can. (Robo calls; Welcome Calls; Health Risk Assessment calls for members who may need additional assistance accessing care, experiencing challenges with various social determinants of health, have an acute dental issue or a chronic medical condition that impacts their oral health; Foster Care communications; SMS, Email and Postcard notifications; quarterly newsletter)
 - As part of the Healthy Behaviors program, a \$50 Amazon gift card was provided to members who received a preventive dental visit. This incentive rewards members for engaging in preventive behaviors.
 - BCD will strive to be in the community more for in-person experience.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Additional member outreach via emails, SMS, postcard, etc. are proving successful. We have seen an increase in member utilization in FY24.

6. Prior Year Recommendation From the EQR Technical Report for Child Dental Survey**c. Identify any barriers to implementing initiatives:**

- There were no obstacles to the implementation of the initiatives. We will continue to assess each intervention and other factors that may influence improvements.

HSAG Assessment: HSAG has determined that **BCD** addressed the prior year's recommendations. None of the SFY 2024 top-box scores for **BCD** were statistically significantly lower than the SFY 2023 top-box scores for any measure, including the measure, *Would Recommend Dental Plan*.

Delta Dental of Michigan

Table 4-2—Prior Year Recommendations and Responses for DD

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • DD's first performance indicator, <i>Providers Rendering Treatment</i>, demonstrated a non-significant decline in performance as compared to the baseline. HSAG recommends that DD revisit its causal/barrier analysis process to identify barriers to care for children ages 1 to 2 years in Macomb County and develop specific and targeted interventions to address those barriers.
<p>MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)</p>
<p>a. Describe initiatives implemented based on recommendations (<i>include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation</i>):</p> <ul style="list-style-type: none"> • Delta Dental of Michigan (Delta Dental) made several updates to the causal/barrier analysis to reflect the changes observed in remeasurement period #3. • New additions to the fishbone included the following: instability in enrollment for members due to the redetermination process and providers terminating participation in the Healthy Kids Dental (HKD) program due to Medicaid policies and staffing shortages. • Barriers to care that were removed from the fishbone diagram include: children not vaccinated against COVID-19, Women Infant and Children (WIC) clinics not operating in-person, and health department resources allocated to COVID-19. • All previous barriers, along with the new additions, were considered for interventions; however, Delta Dental shifted from a specific member and provider approach to a more family-centered, whole population approach in remeasurement #3 to ensure long-term success. • Incentive programs and specific dental screening days were discontinued since those are unsustainable in the long-term, and moved to family-centered, general text messaging campaigns on the importance of oral health and to increase benefit awareness for all members of the household, not just 1-2 year olds. • Delta Dental implemented text messaging campaigns introducing local dental clinics in an effort to establish dental homes for these members and increase awareness of nearby providers. • All efforts to increase member and provider awareness were successful in remeasurement period #3. <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • In Fiscal Year (FY) 24, Delta Dental submitted an update for the performance indicator, <i>Providers Rendering Treatment</i>, that demonstrated a statistically significant increase in the number of providers delivering services to this population. • Remeasurement period #3 saw 234 providers rendering treatment to this population, which was a significant increase from 107 providers in remeasurement period #2. • The total percentage of providers delivering services was 34.82%, which was a statistically significant increase from the 14.68% of providers rendering services in remeasurement period #2, and above the mandated goal of 27.4%.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

c. Identify any barriers to implementing initiatives:

- Delta Dental did not identify any barriers to implementing and/or revising the initiatives noted above.

HSAG Assessment: HSAG has determined that **DD** addressed the prior year's recommendation. **DD** revisited its causal/barrier analysis and updated the identified barriers to care and developed or revised interventions.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- Upon HSAG's review of **DD**'s member-level detail file, it was noted for 11 members reported in 12a, 12b, 12c, and 12g that the members turned age 21 years on the last day of the reporting period. In addition, 35 members were identified in 12d that turned age 5 years as of the last day of the reporting period, and two members reported in 12a, 12b, 12c, 12e, and 12g had birth dates after the reporting period. HSAG recommends **DD** incorporate stringent validation checks to confirm the accuracy of reported data counts and member-level data prior to submission. The validation steps should include checking to ensure the appropriate age groups are included in reporting, that member information is accurately reflected in the system, and that member-level data and programming logic is in alignment with the measure specifications.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Delta Dental continues to prioritize accuracy in reporting, including Performance Measure Validation (PMV) reporting with CMS-416 measures and other utilization metrics.
- Following HSAG's review and feedback, Delta Dental updated its source code logic to account for members that turned age 21 and age 5 as of the last day of the reporting period,
- For future submissions, Delta Dental will send the member detail file through a secondary level of review with a separate coder/reviewer not involved in the initial data pull. The two reports will be compared at the member level for differences in age, birth date or other demographic information that could compromise the accuracy of the report. All applicable updates will be made following the secondary review of the file, prior to final submission.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Delta Dental recently completed the PMV virtual review with HSAG for FY23 CMS-416 EPSDT reporting but does not have official feedback on performance to report at this time.

c. Identify any barriers to implementing initiatives:

- Delta Dental did not identify any barriers to implementing and/or revising the initiatives noted above.

HSAG Assessment: HSAG has determined that **DD** addressed the prior year's recommendation. HSAG did not identify any discrepancies related to incorrect age groups included in reporting during the current year PMV activity.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **DD** through the compliance review activity, as the DHP scored 97 percent and above on all compliance review standards. Although no substantial weaknesses

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review

were identified for **DD**, HSAG recommends that the DHP continually review the Medicaid managed care standards and requirements outlined under 42 CFR §438.358 (b)(1)(iii) to ensure that all federally required compliance review requirements are addressed.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Delta Dental continually reviews the Medicaid managed care standards and requirements outlined under 42 CFR §438.358 (b)(1)(iii) to ensure that all federally required compliance review requirements are addressed.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Not Applicable - Delta Dental does not have any performance improvement initiatives to report at this time.
- c. Identify any barriers to implementing initiatives:
 - Delta Dental did not identify any barriers to implementing and/or revising the initiatives noted above.

HSAG Assessment: HSAG has determined that **DD** partially addressed the prior year's recommendation. While **DD** reported that it continually reviews the Medicaid managed care standards and requirements outlined to ensure that all federally required compliance review requirements are addressed, the DHP did not give any details into how it accomplishes this review. Further, the SY 2024 compliance review confirmed **DD** was not compliant with elements 2.21 and 6.8. HSAG recommends that **DD** implement actions to ensure ongoing compliance with the Medicaid managed care and contract requirements

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Overall, 11.9 percent of the sampled providers listed in **DD**'s provider data could not be located in **DD**'s online provider directory. Among the provider categories, 95.0 percent of pediatric providers and 7.7 percent of general providers could not be located in the online provider directory. HSAG recommends that **DD** use the case-level analytic data files containing provider deficiencies identified during the PDV reviews (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Among all surveyed cases, 67.8 percent were offered an appointment date. General provider locations had an appointment availability rate of 67.7 percent. Pediatric provider locations had an appointment availability rate of 100 percent; however, only one pediatric location was located in the directory and accepted new patients. HSAG recommends that **DD** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **DD** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability. Additionally, **DD** should use the case-level analytic data files containing provider deficiencies identified during the PDV reviews (e.g., provider records with incorrect contact information) to address the provider data deficiencies for pediatric providers.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
- The provider directory includes all Delta Dental providers who choose to have their information visible to members in the provider locator tool. Providers may opt-out of the directory based on various factors, including a lack of capacity for new members that might lead to inability to meet appointment timeliness guidelines.
 - Providers may be removed from visibility on the provider locator tool by request or due to the following: no longer seeing patients more than 20 hours per week, or the provider has retired, moved, and/or discontinued practice.
 - Providers not listed on the provider locator tool are available for care coordination purposes and emergencies through internal outreach, which includes pediatric specialists who were noted above as 100% availability for appointments.
 - Delta Dental maintains a strong network in all areas, and although providers may choose to opt-out of the directory, Delta Dental is grateful for their continued service to this population and decision to remain in-network. Delta Dental reviewed the cited procedural barriers to scheduling an appointment in the technical report and notes that these represent common operational processes in certain dental offices, potentially including the surveyed practices. For example, certain dental practice management software packages require the input of patient registration information before the staff member can offer and/or schedule an appointment.
 - Delta Dental regularly reminds dental offices of procedures and requirements regarding appointment timeliness and availability through newsletters, Dental Office Toolkit reminders and email notifications.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Delta Dental does not have applicable and updated appointment availability survey results for FY24 to use for data comparison at this time.
 - Delta Dental reviewed each dental office noted as “not found” in the provider directory in FY23 for accuracy. All providers listed as “not found” fell into one of the categories noted in MCE's Response #4a or was readily located. Delta Dental suspects that this may be due to a typographical error during the search occurred, the dropdown for specialty type not being selected when searching for a Pediatric provider, or potentially the provider name was misspelled leading to a “not found” result.
- c. Identify any barriers to implementing initiatives:
- N/A.

HSAG Assessment: HSAG has determined that **DD** partially addressed the prior year's recommendations. **DD** addressed the data deficiencies noted in the case-level analytic data files, implemented interventions to ensure data directory accuracy, and conducted provider outreach regarding appointment timeliness and availability. However, 2024 results for **DD** indicate low appointment availability (47.1 percent). HSAG further recommends that **DD** work with its contracted providers to ensure sufficient appointment availability for its members and balance procedural efficiencies with providing clear and direct information to members about appointment availability.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **DD** reported conducting quality checks that did not include claim-level completeness and timeliness measures. **DD** should consider enhancing its data quality checks to include measures for completeness and timeliness for data received from its providers. By incorporating these measures, **DD** can enhance the overall quality and reliability of the encounter data it submits, aligning with industry standards and improving data usability for all stakeholders. Regularly reviewing and updating these quality checks will help maintain data integrity over time.
- While more than 99.9 percent of unique member IDs identified in the dental encounters were identified in the enrollment data, nearly 50 percent of member IDs identified from the enrollment data were identified in the encounter data. **DD** should continue to participate in network adequacy validation activities and secret shopper surveys to help determine reasons behind members' underutilization of dental services and take appropriate actions to mitigate any barriers noted through these activities. Additionally, direct engagement with members could help **DD** ensure enhanced utilization.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Delta Dental has implemented a timeliness report to ensure encounters are sent in a timely manner. This is a weekly report that contains a completeness summary which calculates the turnaround time between the date a claim was paid (the paid date) and the date the claim is submitted to the State.
 - Delta Dental continues to outreach members monthly, particularly non-utilizers, to ensure awareness of their HKD benefit and how to contact Delta Dental's Customer Service team for assistance, including finding a dentist.
 - Delta Dental regularly attends health fairs, community events, oral health conferences, oral health coalition meetings and other events where members may be present.
 - Delta Dental has increased communication with members through regular text messaging campaigns, an improved new enrollee survey, and direct phone outreach to connect non-utilizers with a provider in their area.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Delta Dental's timeliness report consistently shows that the maximum turnaround time for claims is six days.
- Identify any barriers to implementing initiatives:
 - N/A.

HSAG Assessment: HSAG has determined that **DD** partially addressed the prior year's recommendations, demonstrating improvements in encounter data timeliness and member engagement. However, further efforts are required to fully address specific recommendations.

For the recommendation to enhance data quality checks to include completeness and timeliness measures, **DD** implemented a weekly timeliness report that tracks the turnaround time between the claim payment date and submission to MDHHS. This initiative addresses the timeliness aspect but does not provide evidence of claim-level completeness measures. The recommendation was partially addressed, as adding completeness metrics and regularly reviewing data quality checks would further enhance data integrity.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

Regarding the recommendation to participate in NAV activities and address barriers to member dental service utilization, **DD** has taken significant steps. These include monthly outreach to nonutilizing members, attendance at community and oral health events, and increased communication through text messaging, surveys, and direct phone outreach. These efforts aim to improve member engagement and utilization of dental services. This recommendation was fully addressed, assuming these initiatives continue and yield measurable results over time.

In conclusion, **DD** has taken significant steps to improve encounter data timeliness and enhance member engagement, effectively addressing aspects of HSAG's recommendations. However, the implementation of claim-level completeness measures in data quality checks remains a gap. To fully address this recommendation, **DD** should incorporate comprehensive completeness checks and ensure these are regularly reviewed. Additionally, while efforts to increase member dental service utilization are commendable, continued monitoring of the effectiveness of these initiatives is essential. No barriers to implementation were identified, indicating that **DD** has the capacity to address the remaining gaps with focused efforts and resource allocation.

6. Prior Year Recommendation From the EQR Technical Report for Child Dental Survey

HSAG recommended the following:

- **DD**'s SFY 2023 top-box score was statistically significantly lower than the SFY 2022 top-box score for one measure, *Rating of Finding a Dentist*. HSAG recommends that **DD** continue to prioritize improvement efforts in those areas that would impact members' access to and timeliness of dental services, including the ease of finding a dentist, since the score for the *Rating of Finding a Dentist* global rating was very low.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
 - Delta Dental continues to prioritize member access to dental services through the online provider locator tool and strategic collaboration with dental providers and community partners, including non-profit dental practices, Federally Qualified Health Centers, PA-161 mobile dental hygiene organizations, as well as private practitioners.
 - In response to the decreased rating for *Rating of Finding a Dentist*, Delta Dental launched a series of internal meetings designed to collect feedback on improvements to the provider locator tool for future implementation.
 - Delta Dental continues to outreach members monthly, particularly non-utilizers, to ensure awareness of their HKD benefit and how to contact Delta Dental's Customer Service team for assistance, including finding a dentist.
 - Delta Dental also has an established care coordination process with Customer Service to fast track members with special circumstances, including those with chronic medical conditions, disabilities, homeless members or those in foster care.
 - Delta Dental regularly attends health fairs, community events, oral health conferences, oral health coalition meetings and other events where members may be present.

6. Prior Year Recommendation From the EQR Technical Report for Child Dental Survey

- Delta Dental has increased communication with members through regular text messaging campaigns, an improved new enrollee survey, and direct phone outreach to connect non-utilizers with a provider in their area.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - In the recently released 2024 Healthy Kids Dental (HKD) Child Dental Survey Report, Delta Dental increased performance from 41.67% in 2023 to 52.94% in 2024, which is an increase of nearly 12%.
 - Delta Dental will continue efforts to improve the provider locator tool, increase awareness of care coordination services for finding a dentist, and outreach within the community highlighting local dental clinics and services.
- a. Identify any barriers to implementing initiatives:
 - Delta Dental did not identify any barriers to implementing and/or revising the initiatives noted above.

HSAG Assessment: HSAG has determined that **DD** has addressed the prior year’s recommendations. None of the SFY 2024 top-box scores for **DD** were statistically significantly lower than the SFY 2023 top-box scores for any measure, including the measure, *Rating of Finding a Dentist*.

5. Dental Health Plan Comparative Information

In addition to performing a comprehensive assessment of each DHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each DHP to assess the HKD program. Specifically, HSAG identifies any patterns and commonalities that exist across the two DHPs and the HKD program, draws conclusions about the overall strengths and weaknesses of the HKD program, and identifies areas in which MDHHS could leverage or modify MDHHS' CQS to promote improvement.

Dental Health Plan External Quality Review 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 2024 validation, the DHPs submitted Remeasurement 3 data for their ongoing PIP topics. Table 5-1 displays each PIP and provides a comparison of the PIP validation rating and outcome scores, by DHP.

Table 5-1—Comparison of PIP Validation Rating and Scores by DHP

DHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores		
				Met	Partially Met	Not Met	Met	Partially Met	Not Met
BCD	<i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i>	<i>High Confidence</i>	<i>High Confidence</i>	100%	0%	0%	100%	0%	0%
DD	<i>Increasing Dental Utilization in Ages One and Two</i>	<i>High Confidence</i>	<i>High Confidence</i>	100%	0%	0%	100%	0%	0%

Performance Measure Validation

As there were no State or national benchmarks established for the CMS-416 Annual EPSDT performance measures during the measurement period (October 1, 2022–September 30, 2023) or for the DQA dental quality measures during the January 1, 2022–December 31, 2023 measurement period, Table 5-2 displays the comparison of performance between the two DHPs for the SFY 2024 performance measure activity. Table 5-2 includes data from the SFY 2023 measurement period (October 1, 2022–September 30, 2023) and the January 1, 2022–December 31, 2023 measurement period for CMS-416 EPSDT quality measures and DQA dental quality measures, respectively.

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

Performance Measures		
CMS-416 Annual EPSDT Performance Measure	BCD	DD
12a—Total Eligibles Receiving Any Dental Services	31.04%	51.09%
12b—Total Eligibles Receiving Preventive Dental Services	28.23%	47.22%
12c—Total Eligibles Receiving Dental Treatment Services	10.16%	21.35%
12d—Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12.80%	13.46%
12e—Total Eligibles Receiving Dental Diagnostic Services	30.38%	48.98%
12f—Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	0.00% ¹	0.00% ¹
12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services	28.23%	47.22%
DQA Dental Performance Measures	BCD	DD
CCN-CH-A—Care Continuity	47.16%	40.25%
USS-CH-A—Usual Source of Services	41.02%	34.19%

¹ The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

DD had higher rates than **BCD** for the CMS-416 EPSDT performance measures for SFY 2023 services. However, **BCD** had higher rates than **DD** for the two DQA dental performance measures. It should be noted that **DD** also had higher overall numerators and denominators than **BCD** for all performance measure rates due to **DD** having a greater number of overall enrolled members during the reporting period. **BCD**'s first year contracting with MDHHS to provide services was during the SFY 2019 reporting period (i.e., **BCD** did not receive members for SFY 2018); therefore, **BCD**'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. This has also impacted the subsequent SFY 2020, SFY 2021, SFY 2022, and SFY 2023 reporting periods. Additionally, MDHHS indicated that **DD** has provided dental services to members for over two decades and, therefore, had more stability in its membership.


Since there were no state targets or national benchmarks established for these performance measures during the applicable measurement periods, the DHP performance measure rate comparisons focus on comparing results between the DHPs. In general, the results indicate that **DD** members are accessing dental services at a greater rate than **BCD** members.

Table 5-3 displays the performance measure rate comparisons for the two DHPs from SFY 2022 to SFY 2023. Negative values in the *SFY 2022–SFY 2023 Comparison* column indicate a rate decrease from SFY 2022 to SFY 2023. Positive values in the *SFY 2022–SFY 2023 Comparison* column indicate a rate increase from SFY 2022 to SFY 2023. Rate increases or decreases of 5 percentage points or more are denoted by shading within the applicable field.

Table 5-3—SFY 2022 and SFY 2023 Performance Measure Rate Comparisons

Performance Measures			
BCD			
CMS-416 Annual EPSDT Performance Measure	SFY 2022	SFY 2023	SFY 2022– SFY 2023 Comparison
12a—Total Eligibles Receiving Any Dental Services	28.67%	31.04%	+2.37%
12b—Total Eligibles Receiving Preventive Dental Services	26.10%	28.23%	+2.13%
12c—Total Eligibles Receiving Dental Treatment Services	9.65%	10.16%	+0.51%
12d—Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	9.78%	12.80%	+3.02%
12e—Total Eligibles Receiving Dental Diagnostic Services	27.44%	30.38%	+2.94%
12f—Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	0.00% ¹	0.00% ¹	+/-0.00%
12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services	26.10%	28.23%	+2.13%
DQA Dental Quality Measures	SFY 2022	SFY 2023	SFY 2022– SFY 2023 Comparison
CCN-CH-A—Care Continuity	18.14%	47.16%	+29.02%
USS-CH-A—Usual Source of Services	13.31%	41.02%	+27.71%
DD			
CMS-416 Annual EPSDT Performance Measure	SFY 2022	SFY 2023	SFY 2022– SFY 2023 Comparison
12a—Total Eligibles Receiving Any Dental Services	51.05%	51.09%	+0.04%
12b—Total Eligibles Receiving Preventive Dental Services	47.38%	47.22%	-0.16%
12c—Total Eligibles Receiving Dental Treatment Services	21.41%	21.35%	-0.06%

Performance Measures			
12d—Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	11.95%	13.46%	+1.51%
12e—Total Eligibles Receiving Dental Diagnostic Services	49.08%	48.98%	-0.10%
12f—Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	0.00%	0.00%	+/-0.00%
12g—Total Eligibles Receiving Any Preventive Dental or Oral Health Services	47.38%	47.22%	-0.16%
DQA Dental Quality Measures	SFY 2022	SFY 2023	SFY 2022– SFY 2023 Comparison
CCN-CH-A—Care Continuity	39.67%	40.25%	+0.58%
USS-CH-A—Usual Source of Services	34.40%	34.19%	-0.21%

 Indicates a rate increase of 5 percentage points or more.


¹ The rate is reported as 0 percent due to the DHP not having any non-dentist providers independently providing oral health services to individuals under the age of 21 years. All DHP services provided are performed by a dentist or under the supervision of a dentist.

Compliance Review

MDHHS calculated the HKD program’s overall performance in each of the six performance areas. Table 5-4 compares the HKD average compliance score in each of the six performance areas with the compliance score achieved by each DHP. The percentages of requirements met for each of the six standards reviewed during the SFY 2024 compliance review are provided.

Table 5-4—Compliance Monitoring Comparative Results

Standard		Compliance Scores		
		BCD	DD	HKD Program
1	Administrative	100%	100%	100%
2	Providers	86%	93%	89%
3	Members	100%	100%	100%
4	Quality	100%	100%	100%
5	MIS/Financial	97%	100%	99%
6	OIG/Program Integrity	100%	90%	95%
Overall		97%	98%	97%

 Indicates statewide performance achieved 100 percent compliance.

Network Adequacy Validation

Network Adequacy Analysis

Each DHP was assessed based upon following its methodologies and interpretations of MDHHS’ expectations; however, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across both DHPs. HSAG found that the DHPs had categorized pediatric specialists who provided comprehensive care differently and applied different standards to this provider type. For example, **BCD** listed primary care dentists as a separate category in their Quest analysis, while **DD** grouped them under the General Dentistry category. Additionally, **BCD** applied the specialist’s time and distance standards for the primary care dentists provider type. Furthermore, although specific guidance was provided on the time frame DHPs should use when completing the provider network table, this guidance was unclear for the GeoAccess summaries, resulting in the use of different time frames by the DHPs. Considering the DHPs did not apply consistent methodology to network adequacy indicator reporting, programwide and comparative results are not available as the results cannot be aggregated or compared across the DHPs.

Network Validation Survey

During April through June 2024, HSAG completed an NVS among general and pediatric dental providers contracted with one or both DHPs to ensure members have appropriate access to provider information. The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the DHP’s provider file. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories.

Table 5-5 and Table 5-6 display the percentage of providers found in the directories, and the percentage of indicators with matches between the DHPs’ provider data files and the online directories, respectively.

Table 5-5—Providers Found in the Directory

DHP	Number of Sampled Providers	General Dental Providers		Pediatric Dental Providers	
		Count	Rate ¹	Count	Rate ¹
BCD	355	232	94.7%	106	96.4%
DD	409	300	94.6%	88	95.7%
DHP Total	764	532	94.7%	194	96.0%

¹ The denominator includes the number of sampled providers.

Table 5-6—PDV Study Indicator Aggregate Match Rates

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	532	100%	193	99.5%	725	99.9%
Provider Street Address	524	98.5%	186	95.9%	710	97.8%
Provider Suite Number	530	99.6%	193	99.5%	723	99.6%
Provider City	527	99.1%	189	97.4%	716	98.6%
Provider State	532	100%	194	100%	726	100%
Provider ZIP Code	526	98.9%	186	95.9%	712	98.1%
Provider Telephone Number	527	99.1%	187	96.4%	714	98.3%
Provider Type/Specialty	532	100%	194	100%	726	100%
Provider Accepting New Patients	532	100%	194	100%	726	100%
Provider Gender	491	92.3%	170	87.6%	661	91.0%
Provider Primary Language ²	531	99.8%	193	99.5%	724	99.7%
Non-English Language Speaking Provider (including American Sign Language) ²	524	98.5%	194	100%	718	98.9%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight key provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey.

Table 5-7 and Table 5-8 display the results of the telephone survey, and appointment availability and wait time results, respectively.

Table 5-7—Telephone Survey Results

DHP	Rate of Cases Reached ¹	Rate of Cases Confirming Provider ²	Rate of Cases Confirming Location ²	Rate of Cases Offering Requested Services ²	Rate of Cases Accepting Insurance ²	Rate of Cases Accepting New Patients ²
BCD	92.7%	80.6%	77.2%	75.5%	56.1%	53.1%
DD	93.6%	95.6%	93.4%	91.2%	68.0%	62.0%

DHP	Rate of Cases Reached ¹	Rate of Cases Confirming Provider ²	Rate of Cases Confirming Location ²	Rate of Cases Offering Requested Services ²	Rate of Cases Accepting Insurance ²	Rate of Cases Accepting New Patients ²
DHP Total	93.2%	88.9%	86.1%	84.2%	62.7%	58.0%

¹ The denominator includes the total number of survey cases (i.e., cases that were found in the online directory and matched on eight key provider indicators: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

² The denominator includes cases reached.

Table 5-8—Appointment Availability and Wait Time Results

DHP	Rate of Cases Offered Appointment ^{1,2}	Rate of Cases Within Standard ³	Average Appointment Wait Time (Calendar Days)
BCD	42.5%	86.4%	27
DD	47.1%	71.9%	50
DHP Total	45.1%	78.0%	40

¹ The denominator includes cases reached.

² Cases offered appointment rates were calculated using cases accepting new patients as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 cases offered appointment rates with the rates in the 2022 and 2023 reports.

³ The denominator includes cases that offered an appointment.

Encounter Data Validation

Representatives from each DHP procured dental records for sampled members from their contracted providers based on the final sample lists provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on two key data elements, *Date of Service* and *Dental Procedure Code (CDT Code)*, to identify discrepancies and ensure alignment between the dental records and the encounter data submitted to MDHHS.

Table 5-9 presents the EDV DRR results for both DHPs stratified by analytic review categories. The analysis categorized findings using three levels of concern: cells with a “✓” indicate no or minor concerns noted, cells with a “–” indicate moderate concerns noted, and cells with an “✗” indicate major concerns noted. For DHP-specific results, refer to Section 3.

Dental Record Procurement Status

The *Dental Record Procurement Status Rate* was assessed based on the following criteria: rates of 95 percent and above were assigned a “✓”, rates 90 percent to less than 95 percent were assigned a “–”, and rates below 90 percent were assigned an “✗”.

Encounter Data Completeness

The completeness of encounter data was assessed based on two key data elements (i.e., *Date of Service* and *CDT Code*). If both data elements had an omission rate of 10 percent or less, a “✓” was assigned. A “–” was assigned if either data element had an omission rate exceeding 10 percent. An “✗” was applied under either of these two conditions: the omission rate for one data element exceeded 25 percent or both data elements had omission rates exceeding 20 percent. These thresholds help identify potential gaps in data submission and provide a consistent standard for completeness evaluation.

Encounter Data Accuracy

For the accuracy rate assessment, the *CDT Code Accuracy Rate* and the *All-Element Accuracy Rate* were used as primary metrics. For CDT code accuracy, if the data element had an accuracy rate of 95 percent or higher a “✓” was assigned. If the data element rate was from 90 percent to less than 95 percent a “–” was assigned, and if the data element rate was below 90 percent an “✗” was assigned.

For the *All-Element Accuracy Rate*, the following classifications were applied: rates of 80 percent or above were assigned a “✓”, rates from 60 percent to below 80 percent were assigned a “–”, and rates below 60 percent were assigned an “✗”.

This classification helps assess the reliability of encounter data across DHPs and highlights areas where accuracy improvements may be necessary. It is important to note that the denominator for the element accuracy rate for each data element was defined differently than the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from individual data element accuracy rates. Using the *CDT Code* data element as an example, each CDT code was assigned to one of the four mutually exclusive categories: dental record omission, encounter data omission, accurate, or inaccurate. When evaluating the element accuracy for each key data element, the denominator is the number of values in the categories of accurate and inaccurate. However, for the all-element accuracy rate, the denominator is the total number of dates of service that matched between the dental records and encounter data, with the numerator representing the total number of dates of service where the corresponding CDT code was accurate. Therefore, for each date of service, if the CDT code was classified under dental record omission, encounter data omission, or inaccurate categories, the date of service was not counted in the numerator for the all-element accuracy rate.

Table 5-9—EDV DHP Comparison

Analysis	BCD	DD
Dental Record Procurement Status		
Dental Record Procurement Rate	x	✓
Second Date of Service Submission Rate	✓	✓
Encounter Data Completeness		
Dental Record Omission Rate	x	✓
Encounter Data Omission Rate	✓	✓
Encounter Data Accuracy		
CDT Code Accuracy Rate	✓	✓
All-Element Accuracy Rate	✓	✓

✓	No or minor concerns noted.
–	Moderate concerns noted.
x	Major concerns noted.

Child Dental Survey

HSAG performed a comparative analysis to identify if one DHP performed statistically significantly higher or lower on each measure compared to the HKD program (i.e., both DHPs combined). HSAG also performed a comparative analysis to identify if the SFY 2024 HKD Program top-box scores were statistically significantly higher or lower than the SFY 2023 HKD Program top-box scores. Table 5-10 presents the SFY 2024 top-box scores for **BCD** and **DD** compared to the SFY 2024 top-box scores of the HKD program as well as presents the SFY 2024 HKD Program top-box scores compared to the SFY 2023 HKD Program top-box scores. SFY 2023 **BCD** and **DD** scores are presented for comparative purposes. Upward and downward arrows (↑ or ↓) indicate DHP SFY 2024 scores were statistically significantly higher or lower, respectively, than the SFY 2024 HKD Program scores. Upward and downward triangles (▲ or ▼) indicate SFY 2024 HKD Program scores were statistically significantly higher or lower, respectively, than the SFY 2023 HKD Program scores.

Table 5-10—DHP and HKD Program Comparisons

	SFY 2023 DHP Results		SFY 2024 DHP Results		HKD Program Results	
	BCD	DD	BCD	DD	SFY 2023	SFY 2024
Global Ratings						
<i>Rating of Regular Dentist</i>	70.37%	76.56%	76.17%	77.18%	73.64%	76.67%
<i>Rating of All Dental Care</i>	68.99%	74.20%	71.86%	78.63%	71.72%	75.27%
<i>Rating of Finding a Dentist</i>	59.38% ⁺	41.67% ⁺	50.00% ⁺	52.94% ⁺	51.79% ⁺	50.98% ⁺
<i>Rating of Dental Plan</i>	71.20%	70.36%	71.43%	68.26%	70.75%	69.82%
Composite Measures						
<i>Care from Dentists and Staff</i>	95.23%	95.01%	95.16%	95.53%	95.11%	95.35%
<i>Access to Dental Care</i>	72.11%	72.29%	73.53%	75.14%	72.23%	74.36%
<i>Dental Plan Information and Services</i>	85.13%	82.22%	89.87%	89.56%	83.86%	89.10%▲
Individual Items						
<i>Care from Regular Dentists</i>	96.73%	93.77%	97.66% ↑	93.24% ↓	95.17%	95.49%
<i>Would Recommend Regular Dentist</i>	95.87%	94.46%	96.21%	95.17%	95.13%	95.69%
<i>Would Recommend Dental Plan</i>	91.94%	97.47%	95.91%	95.63%	94.86%	95.77%

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the SFY 2024 HKD Program score is statistically significantly higher than the SFY 2023 HKD Program score.

▼ Indicates the SFY 2024 HKD Program score is statistically significantly lower than the SFY 2023 HKD Program score.

No triangle (▲ or ▼) indicates the SFY 2024 HKD program score is not statistically significantly higher or lower than the SFY 2023 HKD Program score.

↑ Indicates the DHP SFY 2024 score is statistically significantly higher than the SFY 2024 HKD Program score.

↓ Indicates the DHP SFY 2024 score is statistically significantly lower than the SFY 2024 HKD program score.

No arrow (↑ or ↓) indicates the 2024 score is not statistically significantly higher or lower than the SFY 2024 HKD program score.

6. Programwide 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 dental 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 to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the MDHHS CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members. Table 6-1 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the HKD program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. A dash (–) is noted in Table 6-1 if no trends were identified through an EQR activity that substantially impacted a goal or the EQR activity results could not be used to evaluate a goal.

Table 6-1—Programwide Conclusions and Recommendations

Performance Impact on Goals and Objectives ¹²		Performance Domain
Goal #1—Ensure high quality and high levels of access to care		
–	CQS Objective 1.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
–	CQS Objective 1.2: The CQS not does include quality measures for the HKD program under this objective.	
✓	CQS Objective 1.3: While HSAG could not determine the State-specific specifications for the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure based on the CQS, the DHPs' PIPs can be used to assess whether members are accessing dental care. Both DHPs' PIPs, <i>Increasing the Number of Members Ages 0–5 Accessing Dental Services</i> and <i>Increasing Dental Utilization in Ages One and Two</i> , demonstrated a statistically significant improvement from the baseline rate.	
m	CQS Objective 1.3: While HSAG could not determine the State-specific specifications for the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure based on the CQS, the performance measures included as part of the PMV activity can be used to assess whether members are accessing dental care (i.e., utilization of dental services). However, while the rates for all six of the applicable CMS-416 performance measures (12a–e and 12g) for one DHP increased from the prior year, the rates for the other DHP remained relatively stagnant	

¹² All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all CAHPS measures or performance measures and instead focused on the measures with a corresponding quality measure with the CQS.

Performance Impact on Goals and Objectives ¹²		Performance Domain
	overall. When considering the utilization rates across both DHPs, the utilization of dental services, and therefore, access to dental care, increased minimally from the prior year.	
–	Each DHP was assessed based upon following its methodologies and interpretations of MDHHS’ expectations for calculating network adequacy standards; however, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across both DHPs. Considering the DHPs did not apply consistent methodology to network adequacy indicator reporting, programwide and comparative results are not available as the results cannot be aggregated or compared across the DHPs. ¹³	
✗	During the process of generating sample cases for the EDV review, HSAG encountered significant challenges with the completeness and accuracy of provider information within MDHHS’ encounter data. Specifically, the data often lacked fully populated NPIs, which are crucial for accurately identifying providers who meet the criteria for a specific service category. Additionally, the encounter data did not include detailed provider taxonomy codes, which are vital for determining the eligibility of providers for specific services relevant to the review. The lack of detailed taxonomy information hindered HSAG’s ability to categorize and analyze data based on the provider specialty and service type. Complete and accurate encounter data are necessary to monitor and improve the program’s quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. ¹³	
Goal #2—Strengthen person and family-centered approaches		
–	CQS Objective 2.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
–	CQS Objective 2.2: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Access

¹³ While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and objective(s) within the CQS.

Performance Impact on Goals and Objectives ¹²		Performance Domain
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
–	CQS Objective 3.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness
–	CQS Objective 3.2: The EQR activities do not produce data to assess the impact of the <i>Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360</i> quality measure under this objective. ¹⁴	<input checked="" type="checkbox"/> Access
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes		
–	CQS Objective 4.1: The EQR activities do not produce data to assess the impact of the <i>Diagnostic Dental Visits—CMS 416-12</i> and <i>Preventive Dental Visits—CMS 416-12</i> quality measures under this objective. While these measures are included in the PMV activity, the data reported are not stratified by race and ethnicity.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	CQS Objective 5.1: The CQS not does include quality measures for the HKD program under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
Recommendations		
<p>Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS’ CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to HKD program members:</p> <ul style="list-style-type: none"> While the DHPs reported according to their methodologies and interpretations of MDHHS’ expectations for the calculation of network adequacy standards, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across both DHPs. HSAG found that the DHPs had categorized pediatric specialists who provided comprehensive care differently and applied different standards to this provider type. Furthermore, although specific guidance was provided on the time frame DHPs should use when completing the provider network table, this guidance was unclear for the GeoAccess summaries, resulting in the use of different time frames by the DHPs. HSAG recommends that MDHHS issue formal guidance on how DHPs should display ratios for general dentists and pediatric specialists providing comprehensive care as well as specific guidance on the time frames DHPs should use when completing the GeoAccess analyses. 		

¹⁴ While the CQS included several quality measures related to the dental program, only one, *Access to Dental Care—HKD Beneficiaries*, was identified as specifically applying to the HKD program. Additionally, the CQS did not identify whether the *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360* quality measure under Objective 3.2 applied to the HKD program. However, as HSAG could not confirm the applicability of this measure through the CQS, HSAG included this quality measure in Table 6-1. Further, for the two quality measures under Objective 4.1, while the CQS did not specifically identify the HKD program, the DHPs report CMS 416 measures; therefore, HSAG included these quality measures in Table 6-1. The remainder of the dental quality measures were excluded from HSAG’s assessment as they applied to the adult population.

Performance Impact on Goals and Objectives ¹²	Performance Domain
<ul style="list-style-type: none"> • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its DHPs as follows within the required effective dates for each specific requirement: <ul style="list-style-type: none"> – Require the DHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. – Require the DHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each DHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each DHP, and enables the DHPs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining necessary quality checks for quality and appropriateness of care. • To address the challenges identified through the EDV activity and improve the integrity of future data analyses, HSAG recommends that MDHHS: <ul style="list-style-type: none"> – Mandate the inclusion of complete NPIs and provider taxonomy codes in all encounter data submissions. – Introduce robust data verification processes at the point of entry. This step will help in early detection and rectification of incomplete or inaccurate provider data, maintaining the integrity of the database. – Develop a centralized, easily accessible repository for provider data that can be referenced and updated regularly. This will facilitate more efficient data linkage and retrieval, improving the ease and reliability of data analysis. – Implement a regular review and feedback system to monitor the improvements in data quality post-implementation of these changes. This will not only help in measuring the success of the implemented strategies but also in making continuous improvements. • While the CQS included several quality measures related to the dental program, only the <i>Access to Dental Care—HKD Beneficiaries</i> quality measure was identified as applying specifically to the HKD program. While the dental quality measures for the adult population would not apply to the HKD population, HSAG recommends that MDHHS update the CQS to assign the specific program and/or population each dental quality measure applies to, so stakeholders have a clear understanding of which quality measures MDHHS is using to evaluate the different dental programs. 	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

For SFY 2024, 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:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.
- Evaluating effectiveness of the interventions.
- Planning and initiating 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 the CMS EQR Protocol 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 DHP'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 the DHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the DHP during the PIP.

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 EQR Protocol 1 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 EQR Protocol 1. The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each PIP. For the SFY 2024 submissions, the DHPs reported Remeasurement 2 data and validated for Steps 1 through 9 in the PIP Validation Tool.

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

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

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 (CMS EQR Protocol 1).

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*.

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the DHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable

validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- **High Confidence:** High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- **Moderate Confidence:** Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- **Low Confidence:** Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- **No Confidence:** No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- **High Confidence:** All performance indicators demonstrated *statistically significant* improvement over the baseline.
- **Moderate Confidence:** One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- **Low Confidence:** The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- **No Confidence:** The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

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 2024, the DHPs submitted Remeasurement 3 data for their respective PIP topics. **BCD** used the CMS-416 Annual EPSDT performance measure for the *Increasing the Number of Members Ages 0–5 Accessing Dental Services* performance indicator. **DD** used a modified CMS-416 Annual EPSDT performance 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 Submission Form. These forms provided data and detailed information about each of the PIPs and the activities completed. The DHPs submitted each PIP Submission Form according to the approved timeline. After initial validation, the DHPs received HSAG’s feedback and technical assistance and could resubmit the PIP Submission Forms for final validation. The performance indicator measurement period dates for the PIPs are listed below.

Table A-1—Measurement Period Dates

Data Obtained	Measurement Period	Reporting Year (Measurement Period)
Administrative	Baseline	October 1, 2018–September 30, 2019
Administrative	Remeasurement 1	October 1, 2020–September 30, 2021
Administrative	Remeasurement 2	October 1, 2021–September 30, 2022
Administrative	Remeasurement 3	October 1, 2022–September 30, 2023

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the DHP provided to members, HSAG validated the PIPs to ensure the DHP used a sound methodology in its design and PIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and PIP goal) and qualitative results (e.g., technical design of the PIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the DHP’s Medicaid members.

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 specifications and reporting requirements.

MDHHS identified nine measures to be included in the SFY 2024 PMV activity: seven 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 Annual EPSDT performance measures) and two DQA dental quality performance measures.

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

Each DHP provided HSAG with measure-level detail files, which included the data the DHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the DHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the virtual review, these data were also reviewed live in the DHPs' systems, which provided the DHPs an opportunity to explain processes regarding any unique, case-specific nuances that may not impact final measure reporting. HSAG selected cases across measures to verify that the DHPs have system documentation which supports that the measures appropriately include records for measure reporting.

The DHPs contracted with MDHHS during SFY 2024 and reported data for performance measures selected by MDHHS for the SFY 2023 (October 1, 2022–September 30, 2023) measurement period for the CMS-416 Annual EPSDT measures and January 1, 2022–December 31, 2023 measurement period for the DQA dental quality measures.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each DHP provided to members, HSAG performed a trend analysis of the results where the SFY 2023 performance measure rates were compared to their corresponding SFY 2022 performance measure rates to determine whether there were significant differences. Significant differences between the SFY 2023 performance measure rates and the SFY 2022 performance measure rates are denoted with shading. Performance

measure rates that decreased by more than 5 percentage points are noted with red shading. Performance measure rates that increased by more than 5 percentage points are noted with green shading.

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 state fiscal year and divides the requirements into a 12-month compliance monitoring schedule. The DHPs were provided with the *FY2024 HKD Contract Compliance Review Timeline* that outlined 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 reviews performed during the SFY 2024 contract year. MDHHS conducted a compliance review of six standards as listed in Table A-2. Table A-2 also crosswalks MDHHS' compliance review standards to the associated federal standards and citations.

Table A-2—Compliance Review Standards Crosswalk¹

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10 §438.206 §438.207 §438.210 §438.214 §438.230	§457.1207 §457.1230(a) §457.1230(b) §457.1230(d) §457.1233(a) §457.1233(b)

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
3	Members	§438.10	§457.1207
		§438.100	§457.1220
		§438.114	§457.1228
		§438.206	§457.1230(a)
		§438.208	§457.1230(c)
		§438.210	§457.1230(d)
		§438.228	§457.1260
		§438.230	§457.1233(b)
		Part 438, Subpart F	
4	Quality	§438.208	§457.1230(c)
		§438.210	§457.1230(d)
		§438.236	§457.1233(c)
		§438.330	§457.1240(b)
5	MIS/Financial	§438.56	§457.1212
		§438.242	§457.1233(d)
6	OIG/Program Integrity	§438.230	§457.1233(b)
		Part 438, Subpart H	§457.1285

¹ HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

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.

Attestation—For certain elements, if a DHP met requirements in the last compliance review, the DHP was allowed to attest that the previously submitted documentation was still applicable and had not changed. These attestations are allowed every other year (e.g., if a DHP attested to an item in SFY 2023, it may not attest to the item again in SFY 2024). If the DHP attests two years in a row, it will be considered non-compliant, and the required submission will be considered overdue. No partial attestations were allowable and the DHP must have attested to all portions of the item. Partial attestations were scored as *Not Met* and considered overdue.

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

- *Met*—The DHP's submission met contract and compliance review requirements.
- *Not Met*—The DHP's submission did not meet contract or compliance review requirements.

- *Satisfied*—A compliance item was unable to be scored as *Met* for all portions of an item, but a narrative explanation satisfactorily justified the reason for not meeting the standard (only allowable for elements for items 5.13, 5.15, or 5.16 within the MIS/Financial standard).

For each DHP, MDHHS calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. MDHHS calculated the total score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied*¹⁵ (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard. MDHHS determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements). A summary of DHP-specific and programwide results were provided to HSAG via the *All Plans FY2024 DHP CR Results* report.

Upon receiving a *Not Met* finding, the DHPs were required to submit a CAP,¹⁶ which was reviewed by MDHHS to determine acceptability. If an acceptable CAP was received by the due date, MDHHS provided documentation in the compliance review tools and the *Not Met* score remained. If a CAP was not received by the due date or if the CAP received by MDHHS did not meet requirements, the DHP was subject to financial penalties or paying liquidation damages outlined in the contract. MDHHS' CAP review process included the eight steps (with Step 2 having two separate components) identified in Table A-3.

Table A-3—MDHHS CAP Review Process

Step	Entity Responsible for Completing Step	
	MDHHS	DHP
Step 1: Identify the Issue	✓	
Step 2: DHP Dispute of the CAP (optional)		✓
Step 2a: Response to Dispute	✓	
Step 3: DHP Corrective Action		✓
Step 4: Acceptance of Corrective Action	✓	
Step 5: DHP Revised Corrective Action (if needed)		✓
Step 6: Acceptance of Revised Corrective Action (if needed)	✓	
Step 7: Effectiveness of the CAP		✓
Step 8: Closure	✓	

¹⁵ A *Satisfied* score was considered “neutral” by MDHHS (i.e., was not counted as being a *Met* score, but does not have the same penalty as a *Not Met* score in relation to the auto-assignment algorithm).

¹⁶ Under limited circumstances, MDHHS did not require a CAP for a *Not Met* element. Examples for not requiring a CAP included, but were not limited to: when there is an existing CAP related to the findings; an MDHHS reviewer determined the findings were not egregious due to a lack of clarity of the state-specific requirement; submission was compliant but was not submitted timely.

Focus Studies—MDHHS also conducts annual focus studies with each DHP that consists of staff interviews and select system demonstrations, when applicable. Each year MDHHS determines the scope of the study based on current initiatives and improvement opportunities. Table A-4 displays the topics included in each of the two areas.

Table A-4—Focus Study Areas and Topics

Area	Topics
Operations	<ul style="list-style-type: none"> • CAP Review • Live System Review • Provider Appeals • Foster Care • Network Adequacy: Provider Network
Quality	<ul style="list-style-type: none"> • Discussion of Quality Strategy and Review of Performance: • Outreach and Coordination of Care: <ul style="list-style-type: none"> – Review of Standard of Care – Value-Based Payment (VBP) Strategy Discussion

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 materials produced by the DHPs throughout SFY 2024, including but not limited to the following:

- Policies and procedures
- Program integrity forms and reports
- Provider contract templates
- Subcontractor/delegation agreements
- 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 report
- CPGs
- Organizational charts and key personnel descriptions
- Provider directory
- Consolidated annual report
- Copies of member materials, including new member packets, member handbooks, member newsletters, and provider directories
- Compliance program

- Grievance and appeal processes and logs
- Third party liability recovery documentation
- QIP evaluation and work plan, and UM program and effectiveness review
- Adverse benefit determinations
- Privacy and confidentiality processes
- Enrollment and disenrollment procedures
- Governing body documentation, including member list, meeting dates and minutes, and member appointment policy
- Annual audit findings of data privacy and information security program
- Performance measures

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each DHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated by MDHHS for each standard. HSAG determined each DHP's substantial strengths and weaknesses as follows:

- Strength—Any standard that achieved a 100 percent compliance score.
- Weakness—Any standard that scored below the statewide compliance score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that each DHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each DHP's Medicaid members.

Network Adequacy Validation

Network Adequacy Analysis

Activity Objectives

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, or PAHPs are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the MDHHS-defined network adequacy indicators reported by the DHPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by MDHHS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the DHPs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).¹⁷

HSAG conducted a virtual review with the DHPs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each DHP included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results

¹⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Oct 8, 2024.

- Closing conference
- HSAG conducted interviews with key DHP staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained and Related Time Period

HSAG prepared a document request packet that was submitted to each DHP outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG’s ability to assess each DHP information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the DHP to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the DHP to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions
- Network Adequacy Reporting Template submission to MDHHS using November 2023 enrollment for the provider network table along with the most recent GeoAccess data available

Process for Drawing Conclusions

HSAG calculated each network adequacy indicator’s validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-5.

Table A-5—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

The overall validation rating refers to HSAG’s overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-6 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-6—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations for both DHPs.

By assessing each DHP’s performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the DHPs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table A-7.

Table A-7—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance		✓	✓

Network Validation Survey

Activity Objectives

The primary purpose of the survey was to assess the accuracy of the managed care network information supplied to Michigan Medicaid members enrolled in the HKD program by comparing data obtained from three sources: the DHPs’ provider data files, the DHPs’ online provider directories, and telephone survey calls to sampled provider locations. As a secondary survey objective, HSAG collected appointment availability information for routine dental visits among new patients enrolled with a DHP under the HKD program. Specific survey objectives included the following:

- Determine whether service locations accept patients enrolled with the requested DHP for the HKD program and the degree to which DHP and HKD acceptance aligns with the DHPs’ provider data.
- Determine whether service locations accepting HKD for the requested DHP accept new patients and the degree to which new patient acceptance aligns with the DHPs’ provider data.
- Determine appointment availability with the sampled provider service locations for routine dental visits.

Technical Methods of Data Collection and Analysis

Each DHP submitted provider data to HSAG reflecting general and pediatric dental providers actively contracted with the DHP at the time the data file was created who serve individuals enrolled in the HKD program. Service locations with addresses outside of Michigan, Indiana, Ohio, or Wisconsin were excluded from the sample frame. Out-of-state service locations were included when the provider was located within a reasonable distance (i.e., 30 minutes or 30 miles) of the DHP's applicable regions. Using an MDHHS-approved data request document, each DHP identified general and pediatric dental providers potentially eligible for survey inclusion and submitted the provider data files to HSAG.

The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the DHP's provider file. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. HSAG used an MDHHS-approved methodology and script to conduct the secret shopper telephone surveys. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Using the provider data each DHP supplied to HSAG, secret shopper callers contacted sampled provider locations between April and June 2024 to inquire about appointment availability.

Several limitations and analytic considerations must be noted when reviewing NVS results:

- The provider data submitted by the DHPs in March 2024 may have changed and subsequently been updated in the DHPs' data systems and/or online directories prior to HSAG's PDV reviews and secret shopper survey calls between April and June 2024.
- Reviewers conducted the directory reviews using desktop computers with high-speed Internet connections. Reviewers did not attempt to access or navigate the DHPs' online directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight). The current study cannot speak to whether the results are maintained across the different types of devices that members may use to access provider directories.
- HSAG included cases in the telephone survey only if those cases matched on eight key provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey. It is unknown whether the telephone survey results would have been better, similar, or worse among the PDV cases that did not match on the eight key provider indicators described.
- To maintain the secret nature of the survey and to ensure consistent data collection across cases, callers used a standardized survey script and posed as parents/caretakers of child members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among members who are existing patients or who may accept scenarios outside of the survey script (e.g., leaving voicemails for an office, supplying personally identifying information, or obtaining an appointment through an Internet-based scheduling portal).

- HSAG based wait time survey results on the time to the first available appointment at the sampled location. As such, survey results may underrepresent timely appointments for situations when members are willing to travel to an alternate location.
- Appointment availability rates were calculated using cases accepting new patients as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing the 2024 appointment availability rates with the rates in the 2022 and 2023 reports.
- Survey findings were compiled from self-reported responses supplied to callers by providers' office personnel. As such, survey responses may vary from information obtained at other times or by using other methods of communication (e.g., online portals, speaking to a different representative at the provider's office).
- The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- DHPs are responsible for ensuring that HKD members have access to a provider location within MDHHS' contract standards, rather than requiring that each individual provider or location offer appointments within specified time frames. As such, extended appointment wait times from individual provider locations should be considered in the context of the DHP's processes for assisting HKD members who require timely appointments.

Description of Data Obtained and Related Time Period

HSAG completed PDV reviews and secret shopper calls during April and June 2024. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each DHP provided to members, HSAG analyzed the results of the activity to determine each DHP's substantial strengths and weaknesses by assessing (1) the degree to which the DHP's online provider directory information is accurate, up-to-date, and easy to locate and navigate; (2) which service locations accepted patients enrolled with the requested DHP for the HKD program and the degree to which DHP and HKD acceptance aligned with the DHP's provider data; (3) whether service locations accepting HKD for the requested DHP accepted new patients and the degree to which new patient acceptance aligned with the DHP's provider data; and (4) appointment availability with the sampled service locations for routine dental visits.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2024, MDHHS contracted with HSAG to conduct an EDV activity. HSAG conducted the following core evaluation activity for the two DHPs:

- **DRR**—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing MDHHS's electronic encounter data to the information documented in the corresponding members' dental records for services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records* in the CMS EQR Protocol 5.

The review aimed to verify whether key data elements in the encounter data (i.e., *Date of Service* and *Dental Procedure Code*) were supported by the information found in the dental records. The goal was to answer the following question:

- Are the data elements in the dental encounters complete and accurate when compared to information in the dental records?

Technical Methods of Data Collection and Analysis

The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Eligible Population Identification and Sampling:** HSAG identified eligible members continuously enrolled in the DHP during the review period and generated a sample of members based on this eligibility. Random sampling was used to select 411 members from the eligible population for each DHP. The SURVEYSELECT procedure in SAS[®]¹⁸ was used to randomly select a one dental visit for each sampled member.
- **Dental Record Procurement:** Each DHP procured dental records from its contracted providers and submitted to HSAG through a secure data exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide DHPs in the procurement process.
- **Review Process:** HSAG's trained reviewers verified whether the selected service date from MDHHS' encounter data could be matched with the dental record. For any discrepancies, reviewers

¹⁸ SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

documented omissions or inaccuracies. Reviewers also checked for documentation for a second service date within the study period and validated associated key data elements, if available.

- **Data Collection and Tool:** An HSAG-designed electronic data collection tool was used to ensure consistency in documenting findings. This tool included built-in checks to ensure data accuracy.
- **Data Validation and Quality Control:** HSAG reviewers underwent thorough training and interrater reliability testing, and the collected data were cross-checked to ensure consistency and accuracy throughout the review process.
- **Review Indicators and Analysis:** After the data collection, HSAG analysts conducted data analysis using specific review indicators. Table A-8 displays the review indicators that were used to report the DRR results.

Table A-8—DRR Indicators

Review Indicator	Denominator	Numerator
Dental Record Procurement Rate: Percentage of records submitted. Additionally, the reasons for missing dental records were presented.	Total number of requested sample cases.	Number of requested sample cases with dental records submitted for either the sampled date of service or the second date of service.
Second Date of Service Submission Rate: Percentage of sample cases with a second date of service submitted in the dental records.	Number of sample cases with dental records submitted.	Number of sample cases with a second date of service submitted in the dental records.
Dental Record Omission Rate: Percentage of data elements (e.g., <i>Date of Service</i>) identified in MDHHS' data warehouse that are not found in the members' dental records. HSAG calculated the review indicator for each data element.	Total number of data elements (e.g., <i>Date of Service</i>) identified in MDHHS' data warehouse (i.e., based on the sample dates of service and the second dates of service that are found in MDHHS' data warehouse).	Number of data elements (e.g., <i>Date of Service</i>) in the denominator but not found in the dental records.
Encounter Data Omission Rate: Percentage of data elements (e.g., <i>Date of Service</i>) identified in members' dental records, but not found in MDHHS' data warehouse. HSAG calculated the review indicator for each data element.	Total number of data elements (e.g., <i>Date of Service</i>) identified in members' dental records (i.e., based on the dental records procured for the sample dates of service and second dates of service).	Number of data elements (e.g., <i>Date of Service</i>) in the denominator but not found in MDHHS' data warehouse.

Review Indicator	Denominator	Numerator
Dental Code Accuracy: Percentage of dental procedure codes supported by the dental records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of dental procedure codes that met the following two criteria: <ul style="list-style-type: none"> For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the dental records. Dental procedure codes present for both MDHHS' encounter data and the dental records. 	Number of dental procedure codes supported by the dental records.
All-Element Accuracy Rate: Percentage of dates of service present in both MDHHS' encounter data and the dental records, with the same values for all data elements.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that are in both MDHHS' encounter data and the dental records.	The number of dates of service in the denominator with the same dental procedure codes for a given date of service.

Description of Data Obtained and Related Time Period

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2022, through September 30, 2023.
- Member demographic and enrollment data.
- Provider data.

Data obtained from the DHPs included:

- Dental records for services rendered from October 1, 2022, through September 30, 2023.

Process for Drawing Conclusions

To draw conclusions about the encounter data completeness and accuracy between each DHP's dental records and key data elements from MDHHS' encounter data, HSAG's analysis used key metrics previously described. To identify areas of strengths and weaknesses, HSAG leveraged its extensive experience working with other states in assessing the completeness and accuracy of encounter data, and dental records. This approach provided a comparative framework that enabled a thorough assessment of each DHP's performance. HSAG determined each DHP's substantial strengths and weaknesses as follows:

- Strength—Identified areas where data completeness and accuracy were consistently high, highlighting best practices and successful methodologies implemented by the DHPs.
- Weakness— Highlighted areas with recurring data errors or omissions, assessing the impact on overall data reliability and compliance with MDHHS’ requirements.

Additionally, for each identified weakness, HSAG provided recommendations to support improvements in the quality of encounter data submissions to MDHHS, aiming to enhance data integrity and ensure alignment with state requirements.

Child Dental Survey

Activity Objectives

The child dental survey asks 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.

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 September 30, 2024.

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 DHP. 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 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.”¹⁹ The percentage of top experience ratings and positive responses is referred to as a top-box score. DHP scores with fewer than 100 respondents are denoted in the tables with a cross (+). 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 2023 to April 2024.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each DHP provided to members, HSAG performed a trend analysis of the results where the SFY 2024 scores were compared to their corresponding SFY 2023 scores to determine whether there were statistically significant differences. Statistically significant differences between the SFY 2024 top-box scores and the SFY 2023 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in SFY 2024 than SFY 2023 are noted with green upward (▲) triangles. Scores that were statistically significantly lower in SFY 2024 than SFY 2023 are noted with red downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG compared each DHP’s results to the HKD program (i.e., **BCD** and **DD** combined) to determine if the results were statistically significantly different. Arrows in the table note statistically significant differences. A green upward arrow (↑) indicates a top-box score for one DHP that was statistically significantly higher than the other DHP. Conversely, a red downward arrow (↓) indicates a top-box score for one DHP that was statistically significantly lower than the other DHP.

HSAG also assigned each of the measures to one or more of the domains of quality, timeliness, and accessibility of care and services. This assignment to domains is depicted in Table A-9.

Table A-9—Assignment of Survey Measures to the Quality, Timeliness, and Access Domains

Dental Survey Topic	Quality	Timeliness	Access
<i>Rating of Regular Dentist</i>	✓		
<i>Rating of All Dental Care</i>	✓		
<i>Rating of Finding a Dentist</i>	✓		✓
<i>Rating of Dental Plan</i>	✓		
<i>Care from Dentists and Staff</i>	✓		
<i>Access to Dental Care</i>	✓	✓	✓

¹⁹ 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.

Dental Survey Topic	Quality	Timeliness	Access
<i>Dental Plan Information and Services</i>	✓		
<i>Care from Regular Dentist</i>	✓		
<i>Would Recommend Regular Dentist</i>	✓		
<i>Would Recommend Dental Plan</i>	✓		