State Fiscal Year 2025 External Quality Review Technical Report for Dental Health Plans

March 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

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.

Health Services[1] 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) 2025 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").[2] 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

[1] On March 31, 2025, MDHHS announced the reorganization and renaming of the Behavioral and Physical Health and Aging Services Administration (BPHASA), which is now referred to as Health Services. This announcement is available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2025-Bulletins/Final-Bulletin-MMP-25-40-Updates.pdf. Accessed on: Jan 12, 2026.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 12, 2026.

higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2025 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 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	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)

Healthy Kids Dental Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2025 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 (●) 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 does not include quality measures for the HKD program under this objective.	

[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: Jan 12, 2026.

[4] HSAG's analysis did not include all the results of EQR activities without a corresponding CQS quality measure. However, all EQR activities were considered in HSAG's recommendations for program improvement. Additionally, 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. Further, several quality measures applied to the adult population (i.e., *Emergency Dental Care Utilization in Adults, Recommend Dental Plan—Adults*, *Access to Dental Care—Adults*, *SDOH: Total Member Screening Rate for Transportation for Adult Dental Visits*, and *Follow-Up After Emergency Dental Visits in Adults*) and the CQS did not identify a specific population for three quality measures (i.e., *Prenatal and Postpartum Dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic Visits*, *Diabetes Dental Care: Preventive Dental Visit*, and *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360*). Therefore, HSAG could not determine the applicability to the HKD population.

	Performance Impact on Goals and Objectives[4]	Performance Domain
–	**CQS Objective 1.2:** The CQS does not include quality measures for the HKD program under this objective.	☒ Quality ☒ Timeliness ☒ Access
✘	**CQS Objective 1.3:** The aggregated rate for the *Access to Dental Care—HKD Beneficiaries* quality measure did not meet the CQS performance target. Additionally, while not statistically significant, the rate decreased from the prior year.	
Goal #2—Strengthen person and family-centered approaches		
–	**CQS Objective 2.1:** The CQS does not include quality measures for the HKD program under this objective.	☒ Quality ☐ Timeliness ☒ Access
–	**CQS Objective 2.2:** The CQS does not include quality measures for the HKD program under this objective.	
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 does not include quality measures for the HKD program under this objective.	☒ Quality ☒ Timeliness ☒ Access
–	**CQS Objective 3.2:** The CQS does not include quality measures for the HKD program under this objective.	
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 *Diagnostic Dental Visits—CMS 416-12* and *Preventive Dental Visits—CMS 416-12* quality measures under this objective.[5] While these measures are included in the PMV activity, the data reported are not stratified by race and ethnicity. Additionally, while one DHP implemented a PIP focused on eliminating a disparity within its population, the performance indicator is based on a retired HEDIS measure and not specifically a CMS 416-12 measure.	☒ Quality ☒ Timeliness ☒ Access
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	**CQS Objective 5.1:** The EQR activities do not produce data to assess the impact of the *Average Percentage of Plan Payments to Providers Who Are in VBP* [Value Based Payment] *Arrangements ("Big Numerator")* and *Average Percentage of Plan Payments to Providers That Are Tied to Quality (“Small Numerator”)* quality measures under this objective.	☒ Quality ☐ Timeliness ☐ Access

[5] MDHHS reported that it initiated a phased-in approach for the quality measures for which MDHHS initially focused on increasing overall utilization and will focus on disparities for future reporting.

Recommendations

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:

- As HSAG had challenges in determining the applicability of dental program CQS quality measures to the HKD program, 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. MDHHS indicated that it intends to clearly identify the populations to which each measure applies in the next iteration of the CQS.
- Based on the results of the compliance review activity, there is a significant need for MDHHS to enhance its State monitoring activities over the DHPs' service authorization review process. MDHHS has already drafted a new quarterly prior authorization (PA) reporting template to increase its oversight in this area. HSAG recommends that MDHHS continue with its intent to implement the new PA reporting template and use the data to identify potential opportunities for improvement related to timeliness of decisions and trends related to authorization denial rates. In addition to addressing any concerns with individual DHPs, as applicable, MDHHS should consider presenting aggregated data to both DHPs during quality improvement meetings and/or other committee meetings.
- HSAG recommends that MDHHS develop an ABD model notice template that both DHPs are required to use. This will ensure consistency in the information communicated to members regardless of DHP enrollment. A model notice will also help support adherence to language requirements for member materials (e.g., easily understood language and format).
- The compliance review activity identified potential opportunities to clarify MDHHS' care management expectations for the HKD program; specifically related to the required number of attempts to complete the initial health risk screening, completing comprehensive assessments, and developing care plans. HSAG recommends that MDHHS update its contracts with the DHPs to outline care management requirements as determined by MDHHS. Further, 42 CFR §438.208(a)(2) allows states to exempt PAHPs from the requirements of 42 CFR §438.208(c) based on applicability (identification of members who need long-term services and supports [LTSS] or have special health care needs, comprehensive assessments, and care plans [i.e., treatment/service plans]). As such, MDHHS could determine if it will exempt the DHPs from these provisions.
- While the DHPs reported according to their own network adequacy standards' methodologies and interpretations of MDHHS' expectations, there is an opportunity for closer collaboration with MDHHS to establish standardized reporting methods across both DHPs. HSAG identified differences in how pediatric specialists providing comprehensive care were categorized and measured. For example, one DHP listed primary care dentists (PCDs) as a separate category in its analysis, while the other DHP grouped them under the General Dentist category. HSAG recommends that MDHHS issue formal guidance on how DHPs should display ratios for general dentists and pediatric specialists providing comprehensive care and how DHPs should apply the 20-hour service threshold requirement for general dentists and pediatric specialists providing comprehensive care when preparing GeoAccess summaries and other network analyses.
- As the results of the NAV survey suggest that some members may be experiencing limited appointment availability and long wait times for appointments, MDHHS should also consider conducting a phantom network analysis to support additional network oversight monitoring. A "phantom network" refers to provider directories that list providers who are not actually available—either because they are not accepting new patients, have outdated contact information, or do not offer the advertised services. The analysis would identify providers who are incorrectly listed or no longer practicing. By removing phantom providers, the DHPs can assess true network capacity and areas that are inadequately served.

2. Overview of the Healthy Kids Dental Program

Managed Care in Michigan

Health Services 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.
• MIChild (CHIP)		1915(b)	January 2016	MIChild is a Medicaid program for low-income uninsured children under the age of 19.
• 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.
• Foster Children		1915(b)	November 2010	Most categories of foster children are mandatorily enrolled in managed care.
• 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.

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
MI Health Link Demonstration (Integrated Care Organizations [ICOs]) [6]	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.
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: • **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	May 2016	

[6] The MI Health Link Demonstration ended effective January 1, 2026, and was replaced by the MI Coordinated Health (MICH) program administered by the Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs).

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
		Community Block Grant		
		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 2025 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	• Oral exams • Teeth cleanings • Fluoride treatments • X-rays • Screenings and assessments • Fillings • Sealants • Stainless steel or resin crowns • Crown buildup, including pins • Space maintainers	• Re-cementing of crowns, bridges, and space maintainers • Root canals • Extractions • Complete, partial, and temporary partial dentures • Denture adjustments and repairs • Denture rebases and relines • Emergency treatment to reduce pain • Intravenous sedation (when needed)	336,042
DD				621,724

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, 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

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[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: Jan 12, 2026.

[8] Enrollment data provided by MDHHS and effective as of September 2025.

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		
• Goal 1: Embed Quality into the Care Journey • Goal 2: Advance Health Equity • Goal 3: Promote Safety	• Public health investment • Racial equity • Address food and nutrition, housing, and other social determinants of health (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 within 12 months • Expand and simplify safety net access • Reduce 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		
• Goal 1: Embed Quality into the Care Journey • Goal 2: Advance Health Equity • Goal 4: Foster Engagement	• Racial equity • Address food and nutrition, housing, and other SDOH • Improve the behavioral health service system for children and families • Ensure 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.

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
• Goal 4: Foster Engagement • Goal 5: Strengthen Resiliency • Goal 6: Embrace the Digital Age	• Expand and simplify safety net access • Address food and nutrition, housing, and other SDOH • Integrate services, including physical and behavioral health, and medical care with LTSS • Fully implement the Families First Preservation Services Act (FFPSA) state plan • Ensure 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.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
• Goal 2: Advance Health Equity • Goal 4: Foster Engagement • Goal 5: Strengthen Resiliency • Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements	• 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	**Objective 4.1:** Use evidence-informed approaches to address racial and ethnic disparities and health inequity.
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
• Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements • Goal 8: Increasing Alignment	• Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	**Objective 5.1:** Promote value-based models that improve quality of care.

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 Plan**[9]—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 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.

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[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: Jan 21, 2026.

[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 2025 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, evidence-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 2025 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 14, 2025	November 4, 2025
PMV	June 13, 2025	October 21, 2025

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	November 8, 2024	December 24, 2025
NAV—Analysis	January 13, 2025	December 8, 2025
NAV—Survey	March 28, 2025	October 3, 2025
EDV	January 21, 2025	March 10, 2026
Child Dental Survey	September 19, 2024	September 8, 2025

Validation of Performance Improvement Projects

For the SFY 2025 PIP validation activity, the DHPs initiated their MDHHS-mandated clinical and nonclinical PIP topics, reporting the PIP designs. HSAG conducted validation on the Design (Steps 1 through 6) stage of the selected PIP topics 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 2025 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	*Improving Access to Care for Members Ages 15–20*	Percentage of members aged 15–20 who have a dental visit during the measurement period.
	Improving Dental Risk Assessment Response Rate	Percentage of new members who answered at least one question within a dental risk assessment within 90 days of enrollment.
DD	*Black/African American Dental Utilization Disparity*	Black/African American dental utilization percentage.
	New Member Survey	The percentage of Delta Dental of Michigan-eligible HKD members who answered at least one question within a dental risk assessment within 90 days of initial enrollment.

Performance Measure Validation

For the SFY 2025 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 2024 measurement period (October 1, 2023–September 30, 2024) 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, 2023–December 31, 2024, 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	*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 Diagnostic Dental 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*
DQA	**Dental Quality Performance Measures**
CCN-CH-A	*Care Continuity*
USS-CH-A	*Usual Source of Services*

Compliance Review

MDHHS requires its DHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. SFY 2025 was Year One of the three-year cycle of compliance reviews for the HKD program. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan DHPs consist of 14 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2025 through SFY 2027. MDHHS requested that HSAG conduct a review of the first half of the standards in Year One (SFY 2025) and a review of the remaining half of the standards in Year Two (SFY 2026). The SFY 2027 (Year Three) compliance review will consist of a review of the standards and elements that required a corrective action plan (CAP) during the SFY 2025 (Year One) and SFY 2026 (Year Two) compliance review activities. Table 3-4 outlines the standards that will be reviewed over the three-year review cycle. The compliance review activity was conducted in accordance with CMS EQR Protocol 3.

Table 3-4—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (SFY 2025)	Year Two (SFY 2026)	Year Three (SFY 2027)
	Medicaid	CHIP[3]			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each DHP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program [QAPI]	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of the DHP's information systems (IS) capabilities.

[3] CHIP = Children's Health Insurance Program.

Network Adequacy Validation

Network Adequacy Analysis

The NAV activity for SFY 2025 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. HSAG then determined the overall validation rating, which identified

the overall confidence that during the preceding 12 months each DHP used an acceptable methodology 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 results represented a snapshot in time, summarizing cumulative network adequacy data collected over the preceding 12 months. 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

Provider Type	Urbanicity Classification	Acceptable Travel Time	Acceptable Travel Distance	Ratio
General Dentist*	Large Metro	30 Minutes	15 Miles	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
	Metro	30 Minutes	30 Miles	
	Micro	30 Minutes	30 Miles	
	Rural	40 Minutes	40 Miles	
	Extreme Access	120 Minutes	120 Miles	
Endodontics	Large Metro	30 Minutes	15 Miles	No Ratio Applies
	Metro	60 Minutes	60 Miles	
	Micro	60 Minutes	60 Miles	
	Rural	120 Minutes	120 Miles	
	Extreme Access	120 Minutes	120 Miles	
Oral Surgery	Large Metro	30 Minutes	15 Miles	No Ratio Applies
	Metro	60 Minutes	60 Miles	
	Micro	60 Minutes	60 Miles	
	Rural	120 Minutes	120 Miles	
	Extreme Access	120 Minutes	120 Miles	
Periodontics	Large Metro	30 Minutes	15 Miles	No Ratio Applies
	Metro	60 Minutes	60 Miles	
	Micro	60 Minutes	60 Miles	
	Rural	120 Minutes	120 Miles	
	Extreme Access	120 Minutes	120 Miles	
Prosthodontics	Large Metro	30 Minutes	15 Miles	No Ratio Applies
	Metro	60 Minutes	60 Miles	
	Micro	60 Minutes	60 Miles	
	Rural	120 Minutes	120 Miles	
	Extreme Access	120 Minutes	120 Miles	

Provider Type	Urbanicity Classification	Acceptable Travel Time	Acceptable Travel Distance	Ratio
Pediatric Dentist	Large Metro	30 Minutes	15 Miles	No Ratio Applies
	Metro	60 Minutes	60 Miles	
	Micro	60 Minutes	60 Miles	
	Rural	120 Minutes	120 Miles	
	Extreme Access	120 Minutes	120 Miles	

*The contractor 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 2025, HSAG completed a network validation survey (NVS) among general and pediatric dental providers contracted with one or both DHPs, during SFY 2025, 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 meets the federal requirements in 42 of 42 CFR Section (§) §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 2025, HSAG conducted and completed an EDV activity for the two DHPs. The EDV activity included:

- Comparative analysis—analysis of MDHHS' electronic encounter data completeness and accuracy through a comparison between MDHHS' electronic encounter data and the data extracted from the DHPs' data systems. This activity aligns with Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

The goal of the comparative analysis was to evaluate the extent to which encounters submitted to MDHHS by the DHPs were complete and accurate, based on corresponding information maintained in the DHPs' data systems.

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.

Table 3-6—Child Dental Survey Measures

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

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

External Quality Review Activity Results

Blue Cross Blue Shield of Michigan Dental

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2025 evaluated the technical methods of **BCD**'s PIP, including an evaluation of the PIP design (Steps 1–6). 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 outcomes for the Validation Rating 1. Subsequent reports will include the baseline, Remeasurement 1, and Remeasurement 2 results for each PIP topic.

Table 3-7—Overall Validation Rating for BCD

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Improving Access to Care for Members Ages 15–20	*High Confidence*	*Not Assessed*	Percentage of members aged 15–20 who have a dental visit during the measurement period.	—	—	—
Improving Dental Risk Assessment Response Rate	*High Confidence*	*Not Assessed*	Percentage of new members who answered at least one question within a dental risk assessment within 90 days of enrollment.	—	—	—

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
Not Assessed = HSAG did not assess Steps 7–9 for the SFY 2025 annual validation.
Gray shading with a dash (—) = The PIP had not progressed to reporting baseline, R1, or R2 results during SFY 2025.

The goal for the PIP is that **BCD** will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. Once available, Table 3-8 will display 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—Barriers and Interventions for BCD

Improving Access to Care for Members Ages 15–20	
Barriers	**Interventions**
—	—
Improving Dental Risk Assessment Response Rate	
Barriers	**Interventions**
—	—

Gray shading with a dash (—) = The PIP had not progressed to reporting barriers and interventions during SFY 2025.

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 designed a methodologically sound PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified substantial weaknesses, HSAG recommends **BCD** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission. **BCD**'s interventions should also be tailored to address the focus population(s).

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 2025 PMV activity measurement period (October 1, 2023–September 30, 2024), and Table 3-10 demonstrates **BCD**'s final reported rates for the DQA dental quality performance measures for the SFY 2025 PMV activity measurement period (January 1, 2023–December 31, 2024). Table 3-11 provides a comparison of the SFY 2023 (October 1, 2022–September 30, 2023) and SFY 2024 (October 1, 2023–September 30, 2024) performance measure data and subsequent rates for the CMS-416 Annual EPSDT measures, and the SFY 2023 (January 1, 2022–December 31, 2023) and SFY 2024 (January 1, 2023–December 31, 2024) 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	20,200	961	720	53	0	919	0	720
Ages 1–2	57,102	15,518	14,039	1,133	0	15,408	0	14,039
Ages 3–5	114,134	48,302	44,741	13,216	0	47,853	0	44,741
Ages 6–9	61,556	28,429	26,510	11,968	9,658	27,975	0	26,510
Ages 10–14	66,589	24,465	22,671	9,983	7,747	23,878	0	22,671
Ages 15–18	49,733	14,152	12,023	6,667	0	13,606	0	12,023
Ages 19–20	17,743	1,600	1,212	830	0	1,541	0	1,212
Total	387,057[1]	133,427	121,916	43,850	17,405	131,180	0	121,916
	128,145[2]							
	Final Rate	**34.47%**	**31.50%**	**11.33%**	**13.58%**	**33.89%**	**0.00%[3]**	**31.50%**

[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	42,103	32,411
Denominator	151,823	151,823
Final Rate	**27.73%**	**21.35%**

Table 3-11—SFY 2023 Measurement Year and SFY 2024 Measurement Year Performance Measure Rate Comparisons

Performance Measures							
CMS-416 Annual EPSDT Performance Measure	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
12a—*Total Eligibles Receiving Any Dental Services*	121,928	392,871	31.04%	133,427	387,057	34.47%	+3.43%
12b—*Total Eligibles Receiving Preventive Dental Services*	110,891	392,871	28.23%	121,916	387,057	31.50%	+3.27%
12c—*Total Eligibles Receiving Dental Treatment Services*	39,912	392,871	10.16%	43,850	387,057	11.33%	+1.17%
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	16,380	127,940	12.80%	17,405	128,145	13.58%	+0.78%
12e—*Total Eligibles Receiving Dental Diagnostic Services*	119,359	392,871	30.38%	131,180	387,057	33.89%	+3.51%
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	0	392,871	0.00%[1]	0	387,057	0.00%[1]	+/-0.00%
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	110,891	392,871	28.23%	121,916	387,057	31.50%	+3.27%

Performance Measures							
DQA Dental Quality Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
CCN-CH-A—*Care Continuity*	1,505	3,191	47.16%	42,103	151,823	27.73%	**-19.43% ▼**
USS-CH-A—*Usual Source of Services*	1,309	3,191	41.02%	32,411	151,823	21.35%	**-19.67% ▼**

Blue Shading + ▲	Indicates a rate increase of 5 percentage points or more.
Orange Shading - ▼	Indicates a rate decrease 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: DentaQuest, the dental administrator for **BCD**, had well-established processes for the capture of enrollment, claims, and provider data necessary to produce performance measure reporting. This included robust processes related to the extract, transform, and load move of data from source systems to the enterprise data warehouse. **[Quality]**

Strength #2: BCD used several initiatives to improve performance measure results, including targeted member outreach and educations campaigns. The audit found improved rates across all performance measures in measurement year 2024 when compared to measurement year 2023 rates. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: While DentaQuest was able to report valid performance measure rates, the audit review found that the originally submitted member-level detail file did not fully support the rate summary data counts. The auditor could not reproduce the data counts using the data detail. **[Quality]**

Why the weakness exists: DentaQuest identified an issue in the numerator detail, specifically with instances of the claim paid date being reported instead of the date of birth for members and a procedure code that was incorrectly captured for members reported in the numerator, which resulted in variances and missing data.

Recommendation: HSAG recommends that DentaQuest consider including a final validation check in its process to validate the data from the member-level detail tab to ensure that the overall summary counts are supported by the data detail.

Weakness #2: A review of performance measure rates for measurement year 2024 in comparison with measurement year 2023 identified significant changes in numerators, denominators, and rates for the CCH-CH-A and USS-CH-A measures that were not explainable from the data. [**Quality**]

Why the weakness exists: DentaQuest updated its process for provider taxonomy codes, which resulted in missed provider categories with the measurement year 2023 performance measure rate production.

Recommendation: HSAG recommends that DentaQuest continue to review its logic for performance measure reporting each year and to perform prior year rate comparisons to determine the cause of any significant variance. DentaQuest could benefit from performing a reasonability assessment of enrolled members compared to the respective performance measure's denominators and primary source verification for members included and excluded in the denominator to validate the measure logic is functioning as intended.

Compliance Review

Performance Results

Table 3-12 presents an overview of the results of the standards reviewed during the SFY 2025 compliance review for **BCD**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **BCD** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-12—Compliance Review Results for BCD

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	8	8	4	4	0	**50%**
Standard II—Member Rights and Member Information	21	21	16	5	0	**76%**
Standard III—Emergency and Poststabilization Services	13	13	11	2	0	**85%**
Standard IV—Availability of Services	11	11	11	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	7	7	6	1	0	**86%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VI—Coordination and Continuity of Care	8	8	7	1	0	**88%**
Standard VII—Coverage and Authorization of Services	21	21	10	11	0	**48%**
Total	**89**	**89**	**65**	**24**	**0**	**73%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

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 Availability of Services program area, demonstrating that the DHP maintained and monitored an adequate provider network to furnish services to members in adherence to timely access standards and cultural and accessibility considerations. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: BCD received a score of 50 percent in the Disenrollment: Requirements and Limitations program area, indicating that the DHP had challenges adhering to federal and State requirements related to disenrollments for members. [**Timeliness** and **Access**]

Why the weakness exists: BCD received a *Not Met* score for four elements, indicating gaps in the DHP's processes related to the disenrollment of a member who acts in a violent or threatening manner; timely administrative disenrollments; documenting disenrollment requirements in its internal policies and procedures; and adherence to requirements for member requests for disenrollment from the DHP.

Recommendation: As **BCD** submitted a CAP to address the deficiencies identified within the Disenrollment: Requirements and Limitations program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency. HSAG also recommends that the DHP review and implement the additional

recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #2: **BCD** received a score of 76 percent in the Member Rights and Member Information program area, indicating that the DHP had challenges in ensuring critical member materials are provided timely and are easily understood and accessible. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **BCD** received a *Not Met* score for five elements, indicating gaps in the DHP's processes related to the minimum 12-point type requirement for member materials; the timely notification to members of provider terminations; the content of the member handbook; the timeliness of notifying members of significant changes to the member handbook prior to implementation; and the content of the provider directory.

Recommendation: As **BCD** submitted a CAP to address the deficiencies identified within the Member Rights and Member Information program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency. HSAG also recommends that the DHP review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #3: **BCD** received a score of 48 percent in the Coverage and Authorization of Services program area, indicating that the DHP had challenges implementing service authorization requirements and/or there were opportunities to enhance monitoring of these functions. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **BCD** received a *Not Met* score for 11 elements, indicating gaps in the DHP's oversight of delegated utilization management functions; collecting all needed clinical information prior to rendering a denial decision; the content of adverse benefit determinations (ABD) notices; the timely completion of standard and expedited service authorization decisions; the extension provisions; exceptions to the advance notice requirements; ABD notices for claim payment denials; and untimely service authorization decisions.

Recommendation: As **BCD** submitted a CAP to address the deficiencies identified within the Coverage and Authorization of Services program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency. The DHP should also complete a thorough review of its internal service authorization review process and the review process of each delegate, as applicable. HSAG further recommends that the DHP review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #4: No substantial weaknesses were identified for the Emergency and Poststabilization Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care program areas.

Why the weakness exists: NA

Recommendation: While **BCD**'s performance in the Emergency and Poststabilization Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care program areas was not identified as being a substantial weakness, HSAG recommends that the DHP ensure

full implementation of its action plan to address each deficiency and review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements in these areas.

Network Adequacy Validation

Performance Results

Based on the results of the Information Systems 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 the CMS EQR Protocol 4 and as defined in Table 3-5. Table 3-13 presents a summary of the NAV validation ratings for **BCD** by network adequacy standard type.

Table 3-13—BCD Indicator-Level Validation Rating Categories

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider-to-Enrollee Ratio	100%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 34 indicators for **BCD**. Of these indicators, 100 percent received *High Confidence* ratings.

HSAG determined that **BCD** was compliant with 100 percent of the time and distance standards and the ratio standard requirements, at the county level, within the scope of the NAV review or had an approved exception from MDHHS for any requirements that were not met. **BCD** submitted a total of 172 exceptions across the seven provider specialties under the scope of the review. These exceptions demonstrated that **BCD** was aware of existing gaps and had initiated corrective actions; however, the issues were not fully resolved at the time of reporting. Adequacy was assessed based on the DHP's compliance with MDHHS' time and distance (i.e., minutes/miles [min/mil]) and ratio standards, with evaluations conducted for each provider type at the county level. Results are presented by provider type and county in Table 3-14 through Table 3-18, with exceptions shaded in **orange**.

Table 3-14—BCD Network Adequacy Compliance—Large Metro

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Macomb	Compliant	Compliant	Exception	Exception	Exception	Exception	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Oakland	Compliant	Compliant	Exception	Exception	Exception	Exception	Exception
Wayne	Compliant	Compliant	Exception	Exception	Compliant	Exception	Exception

Table 3-15—BCD Network Adequacy Compliance—Metro

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Allegan	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Barry	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Bay	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Berrien	Exception	Exception	Exception	Compliant	Exception	Exception	Exception
Calhoun	Compliant	Exception	Compliant	Compliant	Compliant	Exception	Exception
Cass	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Clinton	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Compliant
Eaton	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Genesee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Grand Traverse	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Ingham	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Compliant
Ionia	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Isabella	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Jackson	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Kalamazoo	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Kent	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Lapeer	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Lenawee	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Livingston	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Midland	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Monroe	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Muskegon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Ottawa	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Saginaw	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Shiawassee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
St. Clair	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
St. Joseph	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Van Buren	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Washtenaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Table 3-16—BCD Network Adequacy Compliance—Micro

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alpena	Compliant	Compliant	Exception	Exception	Compliant	Compliant	Exception
Antrim	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Benzie	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Branch	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Charlevoix	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Clare	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Emmet	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Gladwin	Compliant	Exception	Exception	Compliant	Compliant	Compliant	Exception
Gratiot	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Hillsdale	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Leelanau	Compliant	Compliant	Exception	Exception	Compliant	Compliant	Exception
Marquette	Exception	Compliant	Exception	Compliant	Exception	Exception	Exception
Mason	Compliant	Exception	Compliant	Compliant	Compliant	Exception	Exception
Mecosta	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Montcalm	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Newaygo	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Oceana	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Tuscola	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Wexford	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

Table 3-17—BCD Network Adequacy Compliance—Rural

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alcona	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Arenac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Cheboygan	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Chippewa	Exception	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Crawford	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Delta	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Dickinson	Exception	Exception	Exception	Compliant	Exception	Exception	Exception
Gogebic	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Houghton	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Huron	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Iosco	Compliant	Exception	Exception	Compliant	Compliant	Compliant	Exception
Kalkaska	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Lake	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Mackinac	Compliant	Exception	Exception	Compliant	Compliant	Compliant	Exception
Manistee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Menominee	Compliant	Exception	Exception	Compliant	Exception	Exception	Exception
Missaukee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Montmorency	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Ogemaw	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Osceola	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Oscoda	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Otsego	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Presque Isle	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Roscommon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Sanilac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Table 3-18—BCD Network Adequacy Compliance—Counties with Extreme Access Considerations

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alger	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Baraga	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Iron	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Keweenaw	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Luce	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Ontonagon	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Schoolcraft	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

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, on behalf of **BCD** as its delegate, had a robust process in place to ensure provider data remained accurate and up-to-date through monthly monitoring and quarterly attestations. These efforts helped maintain data integrity and supported compliance with State and contractual requirements. **[Quality]**

Weaknesses and Recommendations

Weakness #1: DentaQuest created a unique category that combined general dentists and pediatric dentists who provided comprehensive preventive care within the network for its GeoAccess summaries. In alignment with MDHHS requirements, this category reflected the unduplicated number of dentists delivering at least 20 hours of service per week. This category was not detailed within the MDHHS contract. **[Quality]**

Why the weakness exists: DentaQuest, on behalf of **BCD,** reported using its interpretation of the requirements and its understanding of how best to represent its network.

Recommendation: HSAG recommends that **BCD** engage with MDHHS to confirm the intent of the reporting requirements, including the specific provider types and services to which they apply.

Doing so will help ensure that **BCD**'s monitoring practices align with MDHHS expectations and improve the accuracy and consistency of its network adequacy evaluations.

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 283 general dental providers and 72 pediatric dental providers. Of the total providers found in the directory, 83.1 percent were at the sampled location, while 8.7 percent were not at the sampled location. Additionally, 8.2 percent of the total providers were not found in the online directory.

Table 3-19 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 3-19—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	283	20	7.1%	24	8.5%	239	84.5%
Pediatric	72	9	12.5%	7	9.7%	56	77.8%
BCD Total	**355**	**29**	**8.2%**	**31**	**8.7%**	**295**	**83.1%**

[1] The denominator includes the number of sampled providers.

Table 3-20 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 3-20—Provider Demographic Indicators Matching Online Directory

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate[1]	Count	Rate[1]	Count	Rate[1]
Provider Street Address	239	90.9%	56	88.9%	**295**	**90.5%**
Provider Suite Number	249	94.7%	62	98.4%	**311**	**95.4%**
Provider City	241	91.6%	58	92.1%	**299**	**91.7%**

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate[1]	Count	Rate[1]	Count	Rate[1]
Provider State	262	99.6%	63	100%	**325**	**99.7%**
Provider ZIP Code	239	90.9%	59	93.7%	**298**	**91.4%**
Provider Telephone Number	237	90.1%	57	90.5%	**294**	**90.2%**
Provider Type/Specialty	263	100%	63	100%	**326**	**100%**
Provider Accepting New Patients	263	100%	63	100%	**326**	**100%**

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

For the secret shopper telephone survey, HSAG attempted to contact 287 sampled provider locations for **BCD**, with an overall response rate of 77.7 percent. Table 3-21 summarizes the survey response rates (i.e., cases reached) for both DHPs and for **BCD**, by provider category.

Table 3-21—Response Rates

Provider Category	Total Number of Cases[1]	Cases Reached	Response Rate
General	232	183	78.9%
Pediatric	55	40	72.7%
BCD Total	**287**	**223**	**77.7%**
Both DHPs Total	**684**	**579**	**84.6%**

[1] Total number of cases includes cases that were found in the directory and matched on all PDV indicators, except suite number.

Table 3-22 summarizes the provider data validation and accuracy results for both DHPs and for **BCD**, by provider category.

Table 3-22—Provider Data Validation and Accuracy Results

Provider Category	Denom[1]	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Requiring Member ID to Confirm Insurance	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
General	183	130	71.0%	122	66.7%	121	66.1%	105	57.4%	6	3.3%
Pediatric	40	23	57.5%	22	55.0%	20	50.0%	19	47.5%	1	2.5%
BCD Total	**223**	**153**	**68.6%**	**144**	**64.6%**	**141**	**63.2%**	**124**	**55.6%**	**7**	**3.1%**

Provider Category	Denom[1]	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Requiring Member ID to Confirm Insurance	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Both DHPs Total	**579**	**490**	**84.6%**	**480**	**82.9%**	**472**	**81.5%**	**432**	**74.6%**	**12**	**2.1%**

[1] The denominator includes cases reached.

Table 3-23 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 3-23—Appointment Availability for Routine Dental Care Visits[1]

Provider Category	Number of Cases Reached	Accepting New Patients		Cases Offered an Appointment	
		Count	Rate[1]	Count	Rate[1]
General	183	107	58.5%	96	52.5%
Pediatric	40	20	50.0%	16	40.0%
BCD Total	**223**	**127**	**57.0%**	**112**	**50.2%**
Both DHPs Total	**579**	**416**	**71.8%**	**359**	**62.0%**

[1] The denominator includes cases reached.

Table 3-24 displays the new patient wait time results for routine dental care visits for both DHPs and for **BCD**, by provider category.

Table 3-24—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	403	26	7	86.5%
Pediatric	0	93	22	10	87.5%
BCD Total	**0**	**403**	**25**	**7**	**86.6%**
Both DHPs Total	**0**	**403**	**27**	**6**	**84.4%**

[1] The denominator includes cases offered an appointment.
[2] Percent of Cases Within Standard represents the percentage of appointments that were within MDHHS' appointment wait time standards (i.e., within eight weeks or 56-calendar-days 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, all PDV indicators had a match rate above 90.0 percent. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Reviewers located only 83.1 percent of the sampled providers in **BCD**'s online provider directory. Among the provider categories, 77.8 percent of pediatric providers and 84.5 percent of general providers were located in the online provider directory. [**Quality** and **Access**]
Why the weakness exists: While **BCD** submitted provider data to HSAG, the providers listed in the data were not confirmed within the **BCD** online provider directory. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory.
Recommendation: HSAG recommends that **BCD** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., inaccurate and/or missing provider information) to address the provider data deficiencies.

Weakness #2: **BCD**'s overall response rate for the secret shopper telephone survey was 77.7 percent. [**Quality** and **Access**]
Why the weakness exists: In addition to limitations related to the secret shopper approach, **BCD**'s provider data included some invalid telephone information for contacting the office staff members.
Recommendation: HSAG recommends that **BCD** conduct scheduled outreach to providers to ensure provider offices routinely submit accurate and up-to-date information, utilizing available data sources (e.g., claims) to identify inactive providers and potential network gaps.

Weakness #3: Of the total responsive cases, 68.6 percent confirmed the sampled provider was affiliated with the location, 64.6 percent confirmed the correct location, 63.2 percent confirmed the location offered the requested services, 55.6 percent of locations accepted the insurance, and 57.0 percent accepted new patients. [**Quality** and **Access**]
Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of 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 acceptance, and new patient acceptance information) to address the provider data deficiencies.

Weakness #4: Among the responsive cases, 50.2 percent were offered an appointment date. General provider locations had an appointment availability rate of 52.5 percent. Pediatric provider locations had an appointment availability rate of 40.0 percent. Of the cases that offered an appointment, 86.6 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 member 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 40.0 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 review provider office procedures to ensure appointment availability standards are being met, conduct a root cause analysis to identify causes of appointment delays, and evaluate whether additional access standards are warranted. Additionally, **BCD** should consider performing a phantom network analysis to identify and remove inactive or unavailable providers to more accurately assess network capacity and improve member access to care.

Encounter Data Validation

Performance Results

HSAG conducted a series of comparative analyses divided into three analytic sections: **Record Completeness**, **Data Element Completeness and Accuracy**, and **Overall Encounter Accuracy**. Table 3-25 summarizes the key findings for **BCD** based on the evaluation of whether encounters submitted by **BCD** and maintained in MDHHS' data warehouse—subsequently extracted and submitted by MDHHS to HSAG for the study—are accurate and complete when compared to the data submitted to HSAG by **BCD**. The analysis focused specifically on the dental encounter type, including encounters with dates of service from **July 1, 2023**, through **June 30, 2024**, that had final adjustment or paid dates as of **November 30, 2024**, and submitted to MDHHS on or before **December 31, 2024**.

Table 3-25—Key Findings for BCD

Comparative Analysis	Key Findings
Record Completeness	
Record Omission and Record Surplus	• The record omission and surplus rates were low at **3.9 percent** and **2.1 percent**, respectively. These results indicate a relatively high level of alignment between the data submitted by MDHHS and **BCD**, with no major concerns identified.
Data Element Completeness and Accuracy	
Element Omission and Element Surplus	• The data element omission and surplus rates were low (i.e., at or below 5.0 percent) for the majority of evaluated dental encounter data elements. The noted exceptions were: Element Omission: − *Rendering Provider NPI (***8.6 percent**) − *Service Provider Address* (**100 percent**) − *Tooth Surface (1 through 5)* (**10.9 percent)** Element Surplus: – *Oral Cavity Code (1 through 5*) (**25.7 percent**)
Element Accuracy	• The element accuracy rates were high for the majority of evaluated key data elements, indicating that values in the **BCD**-submitted data generally aligned with the MDHHS-submitted data. However, two data elements had accuracy rates below 95.0 percent: − *Billing Provider NPI* (**8.8 percent**) − *Tooth Number* (**93.8 percent**) • Additionally, **BCD** submitted no values for the *Oral Cavity* Code *(1 through 5)* data element, preventing HSAG from assessing accuracy for this field.
All-Element Accuracy	• The all-element accuracy rate was low at **0.2 percent**. It is important to note that all-element accuracy is influenced by record omission and surplus, data element omission and surplus, and individual data element accuracy; therefore, deficiencies across these areas collectively contributed to the low all-element results.

Comparative Analysis	Key Findings
Overall Encounter Accuracy	
Match, No Match, and Partial Match	• In both directions (**BCD** to MDHHS and MDHHS to **BCD**), **BCD** had low exact match rates of **0.2 percent**; however, when match and partial match rates were combined, the rates **exceeded 98.0 percent**. This indicates that differences existed between the **BCD**-submitted data and the MDHHS-submitted data; either not all record lines were present in both data sets or, for lines that did match, the exact match rate was negatively affected by high element omission and surplus rates, and low element accuracy rates.

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: BCD's data exhibited high record-level data completeness, with minimal record omission and surplus rates for dental encounters. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The *Rendering Provider NPI*, *Service Provider Address*, and *Tooth Surface (1 through 5)* data elements had more values present in the **BCD**-submitted data than in the MDHHS-submitted data (i.e., high element omission). Conversely, the *Oral Cavity Code (1 through 5)* data element had more values present in the MDHHS-submitted data than in the **BCD**-submitted data (i.e., high element surplus). Consequently, these elevated element-level omission and surplus rates negatively affected both the all-element accuracy rate and the overall encounter accuracy results. [**Quality**]

Why the weakness exists: For the *Rendering Provider NPI* data element, **BCD** noted that it is not always necessary to submit a value when it matches the *Billing Provider NPI* data element, and in nearly all affected records the *Rendering Provider NPI* and *Billing Provider NPI* data elements had identical values. Additionally, **BCD** reported that discrepancies for the other affected data elements were attributable to issues in its data extraction process, stating: "*We've identified that the issues stem from the method used to pull the data. Our team is actively working on improving the data extraction process to ensure this issue is resolved and does not occur in future audits.*"

Recommendation: **BCD** should strengthen and document its data extraction and validation procedures to ensure that all required data elements are consistently and accurately populated in accordance with MDHHS and HSAG reporting requirements. Prior to submission, **BCD** should implement enhanced pre-submission quality checks: reconciling record counts, validating key field distributions against claims data, and reviewing fields susceptible to omission or surplus. These checks can be used to identify and resolve extraction or mapping issues. In addition, **BCD** may also benefit from conducting internal test extracts to confirm that the corrected processes produce complete and accurate results, thereby reducing the likelihood of similar errors in future submissions.

Weakness #2: The element-level accuracy rates for the *Billing Provider NPI* and *Tooth Number* data elements were low, indicating that many records did not contain matching values between the **BCD**-submitted data and the MDHHS-submitted data for these fields. These low data element-level accuracy rates negatively affected both the all-element accuracy rate and the overall encounter accuracy results. [**Quality**]
Why the weakness exists: **BCD** reported that the discrepancies were attributable to issues during the data extraction process, stating: "*We've identified that the issues stem from the method used to pull the data. Our team is actively working on improving the data extraction process to ensure this issue is resolved and does not occur in future audits.*"

Recommendation: **BCD** should implement enhanced validation processes to ensure that all required data extractions are complete and accurate and are aligned with MDHHS and HSAG reporting requirements before submission. This should include targeted checks for key provider- and procedure-related fields such as *Billing Provider NPI* and *Tooth Number*, reconciliation of these fields against source claims data, and routine review of mismatch and error rates prior to file submission. **BCD** should also review and refine its extraction logic, mapping rules, and any transformation steps affecting these data elements, documenting the final processes for ongoing use. Strengthening these validation and extraction controls will help ensure more consistent reporting and reduce the likelihood of similar errors in future submissions.

Child Dental Survey

Performance Results

Table 3-26 presents **BCD**'s SFY 2024 and SFY 2025 top-box scores. The results were assessed to determine if the SFY 2025 score was statistically significantly higher or lower than the SFY 2024 score for each measure. Upward and downward triangles (▲ or ▼) indicate the SFY 2025 scores were statistically significantly higher or lower than the SFY 2024 scores.

Table 3-26—Summary of Top-Box Scores for BCD

	SFY 2024	SFY 2025
Global Ratings		
Rating of Regular Dentist	76.17%	70.52%
Rating of All Dental Care	71.86%	70.81%

	SFY 2024	SFY 2025
Rating of Finding a Dentist	50.00%+	51.85%+
Rating of Dental Plan	71.43%	67.21%
Composite Measures		
Care from Dentists and Staff	95.16%	95.27%
Access to Dental Care	73.53%	75.14%
Dental Plan Information and Services	89.87%	89.94%+
Individual Items		
Care from Regular Dentists	97.66%	95.32%
Would Recommend Regular Dentist	96.21%	97.06%
Would Recommend Dental Plan	95.91%	97.28%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
▲ Indicates the SFY 2025 score is statistically significantly higher than the SFY 2024 score.
▼ Indicates the SFY 2025 score is statistically significantly lower than the SFY 2024 score.
No triangle (▲ or ▼) indicates the SFY 2025 score is not statistically significantly higher or lower than the SFY 2024 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 2025 top-box scores for **BCD** were statistically significantly higher than the SFY 2024 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: None of the SFY 2025 top-box scores for **BCD** were statistically significantly lower than the SFY 2024 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 3-27 displays each MDHHS CQS goal and the EQR activity results that indicate whether the DHP positively (✓), negatively (✗), or minimally (●) 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 3-27—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**	☒ Quality ☐ Timeliness ☒ Access
1.2	The CQS does not include quality measures for the HKD program under this objective.	**NA**	
1.3	*Access to Dental Care—HKD Beneficiaries*: The DHP did not meet the established CQS performance target. While it increased from the prior year, the increase was not statistically significant.	●	
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**	☒ Quality ☐ Timeliness ☒ Access
2.2	The CQS does not include quality measures for the HKD program under this objective.	**NA**	
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**	☒ Quality ☐ Timeliness ☐ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	*Diagnostic Dental Visits—CMS 416-12*[2]	**NA**	☒ Quality ☒ Timeliness ☒ Access
	Preventive Dental Visits—CMS 416-12[2]	**NA**	

Objective	Program Quality Measure[1]	Overall Performance Impact	Performance Domain
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The EQR activities do not produce data to assess the impact of the *Average Percentage of Plan Payments to Providers Who Are in VBP Arrangements ("Big Numerator")* and *Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")* quality measures under this objective.	**NA**	☒ Quality ☐ Timeliness ☐ 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. Several quality measures applied to the adult population (i.e., *Emergency Dental Care Utilization in Adults, Recommend Dental Plan—Adults*, *Access to Dental Care—Adults*, *SDOH: Total Member Screening Rate for Transportation for Adult Dental Visits*, and *Follow-Up After Emergency Dental Visits in Adults*) and the CQS did not identify a specific population for three quality measures (i.e., *Prenatal and Postpartum Dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic Visits*, *Diabetes Dental Care: Preventive Dental Visit*, and *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360.* Therefore, HSAG could not determine the applicability to the HKD population. Additionally, 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 this table. Further, while the CQS did not specifically indicate that the two quality measures under Objective 5.1 pertained to the HKD population, MDHHS confirmed that the two objectives were applicable to the HKD program.

[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 2025 evaluated the technical methods of **DD**'s PIP, including an evaluation of the PIP design (Steps 1–6). 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 3-28 displays the outcomes for Validation Rating 1. Subsequent reports will include the baseline, Remeasurement 1, and Remeasurement 2 results for each PIP topic.

Table 3-28—Overall Validation Rating for DD

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Black/African American Dental Utilization Disparity	*High Confidence*	*Not Assessed*	Black/African American dental utilization percentage.	—	—	—
New Member Survey	*High Confidence*	*Not Assessed*	The percentage of Delta Dental of Michigan-eligible HKD members who answered at least one question within a dental risk assessment within 90 days of initial enrollment.	—	—	—

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
Not Assessed = HSAG did not assess Steps 7–9 for the SFY 2025 annual validation.
Gray shading with a dash (—) = The PIP had not progressed to reporting baseline, R1, or R2 results during SFY 2025.

The goal for the PIP is that **DD** will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. Once available, Table 3-29 will display 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 3-29—Barriers and Interventions for DD

Black/African American Dental Utilization Disparity	
Barriers	Interventions
—	—
New Member Survey	
Barriers	**Interventions**
—	—

Gray shading with a dash (—) = The PIP had not progressed to reporting barriers or interventions during SFY 2025.

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 designed a methodologically sound PIP. [**Quality**]

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** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission. **DD**'s interventions should also be tailored to address the focus population(s).

Performance Measure Validation

Performance Results

Table 3-30 demonstrates **DD**'s final reported rates for the CMS-416 Annual EPSDT performance measures for the SFY 2025 PMV activity measurement period (October 1, 2023–September 30, 2024), and Table 3-31 demonstrates **DD**'s final reported rates for the DQA dental quality performance measures for the SFY 2025 PMV activity measurement period (January 1, 2023–December 31, 2024). Table 3-32 provides a comparison of the SFY 2023 (October 1, 2022–September 30, 2023) and SFY 2024 (October 1, 2023–September 30, 2024) performance measure data and subsequent rates for the

CMS-416 Annual EPSDT measures, and the SFY 2023 (January 1, 2022–December 31, 2023) and SFY 2024 (January 1, 2023–December 31, 2024) rates for the DQA dental quality measures.

Table 3-30—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	19,612	276	132	88	0	203	0	132
Ages 1–2	57,402	12,307	10,939	812	0	11,671	0	10,939
Ages 3–5	63,895	33,953	31,823	9,141	0	32,787	0	31,823
Ages 6–9	179,970	115,500	109,322	50,695	28,104	111,862	0	109,322
Ages 10–14	222,508	127,533	120,576	51,443	24,628	122,566	0	120,576
Ages 15–18	173,852	83,111	74,184	39,199	0	78,546	0	74,184
Ages 19–20	58,178	17,585	14,024	8,596	0	16,091	0	14,024
Total	775,417[1] 402,478[2]	390,265	361,000	159,974	52,732	373,726	0	361,000
	Final Rate	**50.33%**	**46.56%**	**20.63%**	**13.10%**	**48.20%**	**0.00%[3]**	**46.56%**

[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 3-31—DD Final DQA Dental Quality Performance Measure Rates

	CCN-CH-A—*Total Care Continuity*	USS-CH-A—*Total Usual Source of Services*
Numerator	257,625	223,965
Denominator	603,141	603,141
Final Rate	**42.71%**	**37.13%**

Table 3-32—SFY 2023 Measurement Year and SFY 2024 Measurement Year Performance Measure Rate Comparisons

Performance Measures							
CMS-416 Annual EPSDT Performance Measure	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
12a—*Total Eligibles Receiving Any Dental Services*	426,628	835,067	51.09%	390,265	775,417	50.33%	-0.76%
12b—*Total Eligibles Receiving Preventive Dental Services*	394,297	835,067	47.22%	361,000	775,417	46.56%	-0.66%
12c—*Total Eligibles Receiving Dental Treatment Services*	178,321	835,067	21.35%	159,974	775,417	20.63%	-0.72%
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	57,287	425,705	13.46%	52,732	402,478	13.10%	-0.36%
12e—*Total Eligibles Receiving Dental Diagnostic Services*	409,046	835,067	48.98%	373,726	775,417	48.20%	-0.78%
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	0	835,067	0.00%[1]	0	775,417	0.00%[1]	+/-0.00%
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	394,297	835,067	47.22%	361,000	775,417	46.56%	-0.66%

Performance Measures							
DQA Dental Quality Measures	Numerator	Denominator	SFY 2023	Numerator	Denominator	SFY 2024	SFY 2023–SFY 2024 Comparison
CCN-CH-A—*Care Continuity*	301,820	749,801	40.25%	257,625	603,141	42.71%	+2.46%
USS-CH-A—*Usual Source of Services*	256,352	749,801	34.19%	223,965	603,141	37.13%	+2.94%

[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 had well-established processes for the capture of enrollment, claims, and provider data necessary to produce performance measure reporting. This included **DD**'s process for capturing multiple member identifiers and managing data across multiple payer sources. [**Quality**]

Strength #2: While multiple rates demonstrated a decrease, **DD** used several initiatives intended to improve performance measure results, including targeted member and provider outreach, education campaigns, and value-based payment projects, which should support rate improvements in the future, as research shows managed care plans can improve performance measure results by deploying multi-faceted interventions focusing on all aspects of member and provider touch points.[12] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **DD** was able to report valid performance measure rates, the audit review found that the originally submitted member-level detail file did not fully support the rate summary data counts. The auditor could not reproduce the data counts after de-duplicating the data detail. [**Quality**]

Why the weakness exists: DD had challenges populating the data detail for the enrollment start and end date columns, which resulted in **DD** including all enrollment spans.

[12] Oral health quality measurement and improvement in Medicaid and Children's Health Insurance Programs Sheen, Alex et al. *The Journal of the American Dental Association*, Volume 156, Issue 10, 825–837.

Recommendation: HSAG recommends that **DD** consider populating the member-level detail file to include unique and unduplicated members and the needed data for each member. **DD** could also consolidate enrollment start and end dates at the member level or leave the enrollment span columns blank in future years. The member-level detail file should allow the auditor to validate the total members in numerator and denominator, as appropriate.

Compliance Review

Performance Results

Table 3-33 presents an overview of the results of the standards reviewed during the SFY 2025 compliance review for **DD**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **DD** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-33—Compliance Review Results for DD

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	8	8	7	1	0	**88%**
Standard II—Member Rights and Member Information	21	21	16	5	0	**76%**
Standard III—Emergency and Poststabilization Services	13	13	10	3	0	**77%**
Standard IV—Availability of Services	11	11	11	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	7	7	5	2	0	**71%**
Standard VI—Coordination and Continuity of Care	8	8	7	1	0	**88%**
Standard VII—Coverage and Authorization of Services	21	21	10	11	0	**48%**
Total	**89**	**89**	**66**	**23**	**0**	**74%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

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 Availability of Services program area, demonstrating that the DHP maintained and monitored an adequate provider network to furnish services to members in adherence to timely access standards and cultural and accessibility considerations. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: DD received a score of 76 percent in the Member Rights and Member Information program area, indicating that the DHP had challenges ensuring critical member materials are provided timely and are easily understood and accessible. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: DD received a *Not Met* score for five elements, indicating gaps in the DHP's processes related to the minimum 12-point type requirement for member materials; the timely notification to members of provider terminations; the content of the member handbook; the content of the provider directory; and ensuring the machine-readable version of the provider directory is made available on the DHP's website.

Recommendation: As **DD** submitted a CAP to address the deficiencies identified within the Member Rights and Member Information program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency. HSAG also recommends that the DHP review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #2: DD received a score of 77 percent in the Emergency and Poststabilization Services program area, indicating that the DHP had challenges ensuring its policies and procedures included the definition of poststabilization care services and maintaining appropriate procedures for the coverage and payment for emergency and poststabilization services. [**Access**]

Why the weakness exists: DD received a *Not Met* score for three elements, indicating gaps in the DHP's processes related to having a definition of "poststabilization care services;" coverage and payment responsibilities for emergency services; and financial responsibility for poststabilization care services obtained by the member.

Recommendation: As **DD** submitted a CAP to address the deficiencies identified within the Emergency and Poststabilization Services program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address

each deficiency. HSAG also recommends that the DHP review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #3: **DD** received a score of 48 percent in the Coverage and Authorization of Services program area, indicating that the DHP had challenges implementing service authorization requirements and/or there were opportunities to enhance internal monitoring of these functions. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **DD** received a *Not Met* score for 11 elements, indicating gaps in the DHP's processes related to collecting all needed clinical information prior to rendering a denial decision; the content of ABD notices; a comprehensive definition of an ABD; the timely completion of standard and expedited service authorization decisions; the timely mailing of the ABD notice prior to the date of action; exceptions to the advance notice requirements; ABD notices for claim payment denials; and untimely service authorization decisions.

Recommendation: As **DD** submitted a CAP to address the deficiencies identified within the Coverage and Authorization of Services program area, which was approved by HSAG and MDHHS, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency. The DHP should also complete a thorough review of its internal service authorization review process and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements.

Weakness #4: No substantial weaknesses were identified for the Disenrollment: Requirements and Limitations, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care program areas.

Why the weakness exists: NA

Recommendation: While **DD**'s performance in the Disenrollment: Requirements and Limitations, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care program areas was not identified as being a substantial weakness, HSAG recommends that the DHP ensure full implementation of its action plan to address each deficiency and review and implement the additional recommendations made by HSAG throughout the compliance review report for program enhancements in these areas.

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 the CMS EQR

Protocol 4 and as defined in Table 3-5. Table 3-34 presents a summary of the NAV validation ratings for **DD** by network adequacy standard type.

Table 3-34—Indicator-Level Validation Rating Categories

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider-to-Enrollee Ratio	100%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 34 indicators for **DD**. Of these indicators, 100 percent received *High Confidence* ratings.

HSAG determined that **DD** was compliant with 100 percent of the time and distance standards and the ratio standard requirements within the scope of the NAV review or had an approved exception from MDHHS for any requirements, at the county level, that were not met. **DD** submitted a total of 140 exceptions across the seven provider specialties under the scope of the review. These exceptions demonstrated that **DD** was aware of existing gaps and had initiated corrective actions; however, the issues were not fully resolved at the time of reporting. Adequacy was assessed based on the DHP's compliance with MDHHS' time and distance (i.e., minutes/miles [min/mil]) and ratio standards, with evaluations conducted for each provider type at the county level. Results are presented by provider type and county in Table 3-35 through Table 3-39, with exceptions shaded in **orange**.

Table 3-35—DD Network Adequacy Compliance—Large Metro

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Macomb	Compliant	Compliant	Exception	Compliant	Exception	Exception	Exception
Oakland	Compliant	Compliant	Exception	Exception	Exception	Exception	Exception
Wayne	Compliant	Compliant	Exception	Exception	Exception	Exception	Exception

Table 3-36—DD Network Adequacy Compliance—Metro

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Allegan	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Barry	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Bay	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Berrien	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Calhoun	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Cass	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Clinton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Eaton	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Genesee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Grand Traverse	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Ingham	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Ionia	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Isabella	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
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
Lenawee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Livingston	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Midland	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Compliant
Monroe	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Muskegon	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Ottawa	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Saginaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Shiawassee	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
St. Clair	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
St. Joseph	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Van Buren	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Washtenaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

Table 3-37—DD Network Adequacy Compliance—Micro

County	General Dentistry Min/Mil	General Dentistry Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alpena	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Antrim	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Benzie	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Branch	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Charlevoix	Exception	Compliant	Exception	Exception	Compliant	Compliant	Exception
Clare	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Emmet	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Gladwin	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Gratiot	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Hillsdale	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Leelanau	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Marquette	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Mason	Compliant	Compliant	Compliant	Exception	Compliant	Exception	Exception

County	General Dentistry Min/Mil	General Dentistry Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Mecosta	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Montcalm	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Newaygo	Compliant	Compliant	Compliant	Compliant	Compliant	Exception	Exception
Oceana	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Tuscola	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Wexford	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

Table 3-38—DD Network Adequacy Compliance—Rural

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alcona	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Arenac	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Cheboygan	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Chippewa	Exception	Compliant	Exception	Exception	Compliant	Compliant	Exception
Crawford	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Delta	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Dickinson	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Gogebic	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Houghton	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Huron	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Iosco	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Kalkaska	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Lake	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Exception
Mackinac	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Manistee	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Exception
Menominee	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Missaukee	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Montmorency	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Ogemaw	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Osceola	Compliant	Exception	Compliant	Compliant	Compliant	Compliant	Compliant
Oscoda	Compliant	Exception	Compliant	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

Table 3-39—DD Network Adequacy Compliance—Counties with Extreme Access Considerations

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Alger	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception
Baraga	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Iron	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Keweenaw	Compliant	Exception	Exception	Compliant	Compliant	Exception	Exception
Luce	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

County	General Dentist Min/Mil	General Dentist Ratio	Endo-dontist Min/Mil	Oral Surgeon Min/Mil	Pediatric Dentist Min/Mil	Perio-dontist Min/Mil	Prostho-dontist Min/Mil
Ontonagon	Compliant	Compliant	Exception	Compliant	Compliant	Exception	Exception
Schoolcraft	Compliant	Compliant	Exception	Compliant	Compliant	Compliant	Exception

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 established a robust process to maintain accurate and up-to-date provider data through quarterly attestation reminders to providers, a thorough credentialing process, and monthly monitoring of multiple sanction and exclusion lists. **[Quality]**

Weaknesses and Recommendations

Weakness #1: DD applied a filter that excluded general dentists who did not meet the MDHHS requirement of providing at least 20 service hours per week at their practice location. This filter was applied to both the time and distance and ratio calculations in network adequacy reporting. **DD**'s interpretation was that the 20-hour-per-week requirement applied to all general dentist validation calculations rather than only to the ratio calculation. **[Quality]**

Why the weakness exists: DD reported using its interpretation of the network adequacy reporting requirements.

Recommendation: HSAG recommends that **DD** consult with MDHHS to clarify the intent of the reporting requirements, including to which provider types and services the 20-hour-per-week standard applies. This clarification will help **DD** ensure its monitoring approach aligns with MDHHS expectations and improve the accuracy and consistency of its network adequacy evaluations.

Network Validation Survey

Performance Results

HSAG's reviewers evaluated 405 randomly sampled cases by comparing provider data submitted to HSAG by **DD** against **DD**'s online directory. The sample included 309 general dental providers and 96 pediatric dental providers. Overall, 98.3 percent of the sampled providers were located in the online directory at the sampled location, while 0.2 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 1.5 percent of the total providers could not be located in the online directory.

Table 3-40 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 3-40—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	309	5	1.6%	0	0.0%	304	98.4%
Pediatric	96	1	1.0%	1	1.0%	94	97.9%
DD Total	**405**	**6**	**1.5%**	**1**	**0.2%**	**398**	**98.3%**

[1] The denominator includes the number of sampled providers.

Table 3-41 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 3-41—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 Street Address	304	100%	94	98.9%	**398**	**99.7%**
Provider Suite Number	304	100%	94	98.9%	**398**	**99.7%**
Provider City	304	100%	94	98.9%	**398**	**99.7%**
Provider State	304	100%	95	100%	**399**	**100%**

Indicator	General Dental Providers		Pediatric Dental Providers		Overall	
	Count	Rate[1]	Count	Rate[1]	Count	Rate[1]
Provider ZIP Code	304	100%	94	98.9%	**398**	**99.7%**
Provider Telephone Number	303	99.7%	94	98.9%	**397**	**99.5%**
Provider Type/Specialty	304	100%	94	98.9%	**398**	**99.7%**
Provider Accepting New Patients	304	100%	95	100%	**399**	**100%**

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

For the secret shopper telephone survey, HSAG attempted to contact 397 sampled provider locations for **DD**, with an overall response rate of 89.7 percent. Table 3-42 summarizes the survey response rates (i.e., cases reached) for both DHPs and for **DD**, by provider category.

Table 3-42—Response Rates

Provider Category	Total Number of Cases[1]	Cases Reached	Response Rate
General	303	272	89.8%
Pediatric	94	84	89.4%
DD Total	**397**	**356**	**89.7%**
Both DHPs Total	**684**	**579**	**84.6%**

[1] Total number of cases includes cases that were found in the directory and matched on all PDV indicators, except suite number.

Table 3-43 summarizes the provider data validation and accuracy results for both DHPs and **DD**, by provider category.

Table 3-43—Provider Data Validation and Accuracy Results

Provider Category	Denom[1]	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Requiring Member ID to Confirm Insurance	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
General	272	260	95.6%	259	95.2%	259	95.2%	243	89.3%	2	0.7%
Pediatric	84	77	91.7%	77	91.7%	72	85.7%	65	77.4%	3	3.6%
DD Total	**356**	**337**	**94.7%**	**336**	**94.4%**	**331**	**93.0%**	**308**	**86.5%**	**5**	**1.4%**
Both DHPs Total	**579**	**490**	**84.6%**	**480**	**82.9%**	**472**	**81.5%**	**432**	**74.6%**	**12**	**2.1%**

[1] The denominator includes cases reached.

Table 3-44 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 3-44—Appointment Availability for Routine Dental Care Visits[1]

Provider Category	Number of Cases Reached	Accepting New Patients		Cases Offered an Appointment	
		Count	Rate[1]	Count	Rate[1]
General	272	226	83.1%	204	75.0%
Pediatric	84	63	75.0%	43	51.2%
DD Total	**356**	**289**	**81.2%**	**247**	**69.4%**
Both DHPs Total	**579**	**416**	**71.8%**	**359**	**62.0%**

[1] The denominator includes cases reached.

Table 3-45 displays the new patient wait time results for routine dental care visits for both DHPs and **DD**, by provider category.

Table 3-45—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Calendar Days)				Rate of Cases Within Standard[1,2]
	Min	Max	Average	Median	
General	0	344	25	5	85.8%
Pediatric	0	200	42	7	72.1%
DD Total	**0**	**344**	**28**	**6**	**83.4%**
Both DHPs Total	**0**	**403**	**27**	**6**	**84.4%**

[1] The denominator includes cases offered an appointment.

[2] Percent of Cases Within Standard represents the percentage of appointments that were within MDHHS' appointment wait time standards (i.e., within eight weeks or 56-calendar-days 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: Of the locations reached, 94.7 percent of locations confirmed affiliation with the sampled provider, 94.4 percent confirmed the address information, and 93.0 percent offered the requested services. [**Quality** and **Access**]

Strength #3: Overall, 98.3 percent of the sampled providers listed in **DD**'s provider data were located in **DD**'s online provider directory. Among the provider categories, 97.9 percent of pediatric providers and 98.4 percent of general providers were located in the online provider directory. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Of the responsive cases, 86.5 percent of locations accepted the insurance, and 81.2 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, 69.4 percent were offered an appointment date. General provider locations had an appointment availability rate of 75.0 percent and pediatric provider locations had a notably lower appointment availability rate of 51.2 percent. Of the cases that offered an appointment, 83.4 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 a member 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 review provider office procedures to ensure appointment availability standards are being met, conduct a root cause analysis to identify causes of appointment delays, and evaluate whether additional access standards are warranted. Additionally, **DD** should consider performing a phantom network analysis to identify and remove inactive or unavailable providers to more accurately assess network capacity and improve member access to care.

Encounter Data Validation

Performance Results

Table 3-46 summarizes the key findings for **DD** based on the evaluation of whether encounters submitted by **DD** and maintained in MDHHS' data warehouse—subsequently extracted and submitted by MDHHS to HSAG for the study—are accurate and complete when compared to the data submitted to HSAG by **DD**. The analysis focused specifically on the dental encounter type, including encounters with dates of service from **July 1, 2023**, through **June 30, 2024**, that had final adjustment or paid dates as of **November 30, 2024**, and submitted to MDHHS on or before **December 31, 2024**.

Table 3-46—Key Findings for DD

Comparative Analysis	Key Findings
Record Completeness	
Record Omission and Record Surplus	• The record omission and surplus rates were extremely low at **less than 0.1 percent** and **0.1 percent,** respectively. These results indicate a high level of alignment between the data submitted by MDHHS and **DD**, with no major concerns identified.
Data Element Completeness and Accuracy	
Element Omission and Element Surplus	• The data element omission and surplus rates were low (i.e., at or below 5.0 percent) for nearly all evaluated dental encounter data elements. The only exception was the *Service Provider Address* data element. Element Omission: – *Service Provider Address* (**76.3 percent**)
Element Accuracy	• The element accuracy rates were above 95.0 percent for all evaluated key data elements. This indicates that all key data elements generally had the same values in both the **DD**-submitted data and the MDHHS-submitted data.
All-Element Accuracy	• The all-element accuracy rate was **92.7 percent**. This indicates that the same records were largely present in both data sources and that the key data elements generally had matching values, whether missing or non-missing.
Overall Encounter Accuracy	
Match, No Match, and Partial Match	• In both directions (**DD** to MDHHS and MDHHS to **DD**), **DD** achieved match rates **of 85.5 percent**, indicating that majority of claim numbers in the MDHHS file were also present in the **DD** data and vice versa, with associated detail lines and key data elements aligning.

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 **DD**-submitted data exhibited high record-level data completeness, with minimal record omission and surplus rates for dental encounters. [**Quality**]

Strength #2: Among dental encounters that could be matched between data extracted from MDHHS' data warehouse and data extracted from **DD**'s data system, data element-level completeness was high (i.e., low element omission and surplus rates) across nearly all evaluated key data elements. [**Quality**]

Strength #3: For records that could be matched between the two data sources (**DD** and MDHHS), data element-level accuracy was high, with all evaluated key data elements having largely the same values in both data sources when populated. [**Quality**]

Strength #4: The **DD**-submitted data had relatively high all-element accuracy for all evaluated key data elements, indicating that values (missing or non-missing) were the same in both data sources for almost all records. [**Quality**]

Strength #5: The **DD**-submitted data had relatively high overall encounter accuracy match rates in both directions (**DD** to MDHHS and MDHHS to **DD**), indicating that nearly the majority of claim numbers in the MDHHS file were also present in the **DD** data and vice versa, with all detail lines and key data elements aligning. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The *Service Provider Address* data element had more values present in the **DD**-submitted data than in the MDHHS-submitted data (i.e., high element omission). [**Quality]**

Why the weakness exists: **DD** reported it follows the X12 837D implementation guide, which states that when the service office address is the same as the billing provider address, the service office address is not required to be reported in the 837 file. HSAG understood that **DD** included *Service Provider Address* values in the data extract submitted for the EDV study but followed different data submission requirements when submitting encounters to MDHHS, resulting in fewer *Service Provider Address* values appearing in the MDHHS-submitted data.

Recommendation: **DD** should work with MDHHS to clarify and align encounter data submission requirements for the *Service Provider Address* field, particularly in scenarios where the service office address matches the billing provider's address. **DD** should also review and document its internal submission and extraction logic to ensure that *Service Provider Address* values are handled consistently across both EDV-specific extracts and ongoing submissions to MDHHS. Implementing pre-submission quality checks, such as comparing the presence of *Service Provider Address* values

in source claims, EDV extracts, and MDHHS-bound encounter files would help identify discrepancies early and reduce the likelihood of similar issues in future submissions.

Child Dental Survey

Performance Results

Table 3-47 presents **DD**'s SFY 2024 and SFY 2025 top-box scores. The results were assessed to determine if the SFY 2025 score was statistically significantly higher or lower than the SFY 2024 score for each measure. Upward and downward triangles (▲ or ▼) indicate SFY 2025 scores were statistically significantly higher or lower than the SFY 2024 scores.

Table 3-47—Summary of Top-Box Scores for DD

	SFY 2024	SFY 2025
Global Ratings		
Rating of Regular Dentist	77.18%	75.47%
Rating of All Dental Care	78.63%	75.73%
Rating of Finding a Dentist	52.94%+	58.33%+
Rating of Dental Plan	68.26%	67.51%
Composite Measures		
Care from Dentists and Staff	95.53%	94.92%
Access to Dental Care	75.14%	69.46%
Dental Plan Information and Services	89.56%	83.15%
Individual Items		
Care from Regular Dentists	93.24%	94.76%
Would Recommend Regular Dentist	95.17%	95.26%
Would Recommend Dental Plan	95.63%	95.76%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
▲ Indicates the SFY 2025 score is statistically significantly higher than the SFY 2024 score.
▼ Indicates the SFY 2025 score is statistically significantly lower than the SFY 2024 score.
No triangle (▲ or ▼) indicates the SFY 2025 score is not statistically significantly higher or lower than the SFY 2024 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 2025 top-box scores for **DD** were statistically significantly higher than the SFY 2024 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: None of the SFY 2025 top-box scores for **DD** were statistically significantly lower than the SFY 2024 top-box scores for any measure; therefore, no substantial strengths 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 3-48 displays each MDHHS CQS goal and the EQR activity results that indicate whether the DHP positively (✓), negatively (×), or minimally (●) 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 3-48—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**	☒ Quality ☐ Timeliness ☒ Access
1.2	The CQS does not include quality measures for the HKD program under this objective.	**NA**	
1.3	*Access to Dental Care—HKD Beneficiaries*: The DHP did not meet the established CQS performance target, and while not statistically significant, decreased in performance from the prior year.	×	

Objective	Program Quality Measure[1]	Overall Performance Impact	Performance Domain
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**	☒ Quality ☐ Timeliness ☒ Access
2.2	The CQS does not include quality measures for the HKD program under this objective.	**NA**	
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**	☒ Quality ☐ Timeliness ☐ Access
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	*Diagnostic Dental Visits—CMS 416-12*[2]	**NA**	☒ Quality ☒ Timeliness ☒ Access
	Preventive Dental Visits—CMS 416-12[2]	**NA**	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The EQR activities do not produce data to assess the impact of the *Average Percentage of Plan Payments to Providers Who Are in VBP Arrangements ("Big Numerator")* and *Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")* quality measures under this objective.	**NA**	☒ Quality ☐ Timeliness ☐ 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. Several quality measures applied to the adult population (i.e., *Emergency Dental Care Utilization in Adults, Recommend Dental Plan—Adults*, *Access to Dental Care—Adults*, *SDOH: Total Member Screening Rate for Transportation for Adult Dental Visits*, and *Follow-Up After Emergency Dental Visits in Adults*) and the CQS did not identify a specific population for three quality measures (i.e., *Prenatal and Postpartum Dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic Visits*, *Diabetes Dental Care: Preventive Dental Visit*, and *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360.* Therefore, HSAG could not determine the applicability to the HKD population. Additionally, 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 this table. Further, while the CQS did not specifically indicate that the two quality measures under Objective 5.1 pertained to the HKD population, MDHHS confirmed that the two objectives were applicable to the HKD program.

[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 2024 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 2025 External Quality Review Technical Report for Dental Health Plans* are summarized in this section. 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.

Blue Cross Blue Shield of Michigan Dental

Validation of Performance Improvement Projects

Prior Year Recommendations for BCD From the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • There were no substantial weaknesses. HSAG recommends **BCD** apply lessons learned and knowledge gained throughout the PIP to future PIPs and other quality improvement activities.
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)***: • Quality Improvement activities associated with increasing dental visits for members under age 5 will be considered for interventions. BCD will continue to use the Quality Improvement methodologies utilized in this PIP as applicable to drive improvements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Efforts to increase dental visits in members under the age of 5 were successful and will be continued. Success of these efforts will be applied to new PIPs.
c. Identify any barriers to implementing initiatives: • No current barriers to report.
HSAG Assessment: HSAG determined that **BCD** addressed the prior year's recommendations based on the DHP's reported initiatives.

Performance Measure Validation

Prior Year Recommendations for BCD From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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. 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.
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)***: • We will validate and submit the measures and supporting detail going forward. Source code review has been implemented and will be ongoing every year as per CMS-416 instructions reporting requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The numbers did fluctuate slightly; however, the change was not statistically significant. There was a decrease in members turning 15, accompanied by a slight increase due to the inclusion of members turning 6 as a result of the adjustment. Overall, the performance rates remained consistent with no notable variations.
c. Identify any barriers to implementing initiatives: • No current barriers to report.
HSAG Assessment: BCD did not address the prior year's recommendation. During the SFY 2025 PMV activity, HSAG found that the originally submitted member-level detail file did not fully support the rate summary data counts. The auditor could not reproduce the data counts using the data detail. DentaQuest identified an issue in the numerator detail, specifically with instances of the claim paid date being reported instead of the date of birth (DOB) for members, and a procedure code that was incorrectly captured for members reported in the numerator, which resulted in variances and missing data. As such, HSAG continues to recommend that **BCD**/DentaQuest consider including a final validation check in its process to validate the data from the member-level detail tab to ensure that the overall summary counts are supported by the data detail.

Compliance Review

Prior Year Recommendations for BCD From the EQR Technical Report for Compliance Review
HSAG recommended the following: • 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*. **BCD** was required

Prior Year Recommendations for BCD From the EQR Technical Report for Compliance Review
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. • 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*. 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.
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)***: • Element 2.21 – We are monitoring the number of providers that have responded to our requests for validation. Due to improvements outlined in our EQR follow up report which included updated validation processes and provider outreach/education, we have seen significant improvements in 2025 to the number of validation submissions from dental offices. • Element 5.13 – We have introduced new procedures to proactively identify and address file issues before they occur. Each day, we generate a report, log the files into a tracking system, and review each trading partner to identify any potentially missing files. We then reach out to the respective trading partners as necessary. These processes were implemented on January 1, 2024, and are functioning as intended. Additionally, a Standard Operating Procedure (SOP) has been established to ensure consistent adherence to these procedures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This new procedure is functioning effectively, and there have been no issues reported since its implementation.
c. Identify any barriers to implementing initiatives: • No current barriers to report.

Prior Year Recommendations for BCD From the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG has determined that **BCD** partially addressed the prior year's recommendations based on the DHP's reported initiatives for the Providers standard. The DHP's response addressed the gaps related to its monitoring processes to ensure that all dental offices are providing accurate information as outlined in the provider directory. However, HSAG has determined that **BCD** did not address the prior year's recommendation related to its 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 for the Providers standard. Further, HSAG has determined that **BCD** partially addressed the prior year's recommendations for the MIS/Financial standard. While **BCD** provided its reported initiatives, the DHP's response included new procedures to identify and address file issues before they occur but did not specifically address the timeliness of dental encounter submissions. HSAG was unable to confirm that the procedures to identify and address "file issues" were specifically related to timeliness of encounter submissions.

Network Adequacy Validation

Prior Year Recommendations for BCD From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • HSAG did not identify any substantial weaknesses for **BCD** through the NAV activity.
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)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: NA

Network Adequacy Validation Survey

Prior Year Recommendations for BCD From the EQR Technical Report for NAV Validation Survey
HSAG recommended the following: • 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. HSAG recommends that **BCD** use the case-level analytic data files containing provider deficiencies identified

Prior Year Recommendations for BCD From the EQR Technical Report for NAV Validation Survey
during the survey calls (e.g., incorrect addresses, provider specialty, plan name, program, and new patient acceptance information) to address the provider data deficiencies. • 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. 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.
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)***: • A representative reviewed each Case Disposition and final outcome of the secret shopper phone call to evaluate next steps to resolve/correct the issue. Most issues identified by the secret shopper were resolved through outreach/education and confirmation of plan and new patient acceptance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Analytic Dataset (SS) – 209 cases were reviewed by BCD (All case dispositions that did not lead to an appointment). – 62% of those cases were resolved through phone verification and data validation (address was valid, accepted plan and new patients). – 38% required further action on our part (update of provider data, removal from directory, termination, move to existing patients only). • Analytic Dataset (PDV) – 99 cases were marked as a no match with at least one data element not matching the online directory, all were reviewed for resolution. o We found 19 of those cases may have been marked incorrectly as a no match designation, data information was correct in system and directory. – The remaining cases required further explanation for the no match designation. o In 7 cases related to incorrect language displays, coding issues were identified as the root cause and were resolved. • The remaining 73 cases did not require an update to provider data as all issues were resolved prior to the SS data review.
c. Identify any barriers to implementing initiatives: • No current barriers to report.
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

Prior Year Recommendations for BCD From the EQR Technical Report for NAV Validation Survey
ensure data directory accuracy, and conducted provider outreach to validate contact information and training. HSAG recommends **BCD** continue to use the systems in place to improve data deficiencies and validate provider contact information. However, 2025 results for **BCD** indicate low appointment availability (50.2 percent), and although this is an improvement from the previous year's appointment availability rate (42.5 percent), it is still well below the 90 percent standard. HSAG further recommends that **BCD** review and implement the recommendations listed in Section 3.

Encounter Data Validation

Prior Year Recommendations for BCD From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **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. **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. • 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. **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 [dental record reviews] 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.
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)***: • We do perform claims payment audits which are performed by the Quality Assurance Auditor to ensure claims are processed timely and accurately. A statistically relevant sample of claims to audit is obtained through random selection. This sample includes set and manually priced claims that have been adjudicated. – Specific key fields are reviewed for accuracy. This includes, but is not limited, to the following: o Patient/Subscriber Information o Provider Location Information o Network Affiliation (in network or out of network) o Provider Payee Information o Place of Treatment

Prior Year Recommendations for BCD From the EQR Technical Report for Encounter Data Validation
○ Provider Signature/Date ○ Status of Line ○ Date of Service ○ Submitted Code ○ Tooth/Quad/Arch (dental only) ○ Billed Amounts ○ Reject Codes • We also perform monthly micro-learn sessions for providers that include topics such as Submitting for Success, Documentation Requirements, Proper Claim Submissions, and Billing Practices. We also provide training and overviews of our Office Reference Manuals which contain education around appropriate billing and documentation requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The process of collecting dental records from providers has not been requested from HSAG this year. As a result, we are currently unable to assess whether there has been any improvement.
c. Identify any barriers to implementing initiatives: • Currently no barriers with implementing the initiatives.
HSAG Assessment: HSAG has determined that **BCD** has partially addressed the prior year's recommendations. **BCD** described existing activities, such as conducting statistically based claims payment audits and delivering ongoing provider education through monthly micro-learning sessions covering documentation requirements, billing practices, and proper claim submissions. These activities indicate an effort to strengthen provider knowledge and monitor claim accuracy. However, the response did not directly address the core issues identified in the EDV review, which were high rates of unsupported *Date of Service* and *CDT Code* values and significant challenges obtaining dental records from contracted providers. **BCD** did not describe new or strengthened contractual enforcement mechanisms, enhanced record procurement processes, targeted root-cause investigation into documentation and coding discrepancies, or periodic DRRs, all of which were central to HSAG's recommendations. Because the initiatives described are general operational practices rather than targeted corrective actions implemented in response to the EDV findings, the recommendations remain incompletely addressed. **Barriers** **BCD** reported no barriers to implementing initiatives. However, because HSAG did not request dental records this year, **BCD** was unable to assess whether its efforts have translated into improved provider responsiveness or increased accuracy of encounter submissions. This lack of performance feedback represents an indirect barrier to evaluating the effectiveness of corrective actions. **Suggestions for Improvement** To fully address the recommendations, **BCD** should: • Strengthen provider accountability measures by revising or enforcing contractual requirements to ensure timely and complete submission of dental records during audit and review periods. • Implement structured record procurement protocols, including escalation pathways and documented follow-up procedures for non-responsive providers.

Prior Year Recommendations for BCD From the EQR Technical Report for Encounter Data Validation
• Conduct focused DRRs to identify root causes of unsupported *Date of Service* and *CDT Code* values, linking audit findings directly to corrective action and targeted provider training. • Develop targeted education based on audit findings, rather than general documentation training, to specifically address CDT coding errors, date accuracy issues, and documentation completeness. • Enhance data validation and pre-adjudication checks to minimize data handling or system errors contributing to unsupported values. • Monitor measurable performance improvements, such as reductions in missing or inaccurate CDT codes and improved provider response rates, to evaluate the effectiveness of interventions. Overall, **BCD** partially addressed the prior year's recommendations. **BCD** continues to conduct claims audits and provide general provider education; however, it has not demonstrated targeted actions to resolve the high rates of unsupported dates of service and CDT codes or strengthen provider compliance with dental record requests. More focused interventions, such as enhanced record procurement processes, root-cause analysis, and DRRs tied to EDV findings, are needed before the recommendation can be considered fully addressed.

Child Dental Survey

Prior Year Recommendations for BCD From the EQR Technical Report for Child Dental Survey
HSAG recommended the following: • 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. HSAG recommends that **BCD** monitor the measures to ensure significant decreases in scores over time do not occur.
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): • Our objective is to sustain or improve score levels over time, preventing any significant declines. In the event of a notable decrease in scores, we will develop and implement a plan to address and enhance performance. Regarding SFY 2025 scores, no statistically significant decline was observed in the trend year score.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The "Would Recommend Dental Plan" measure has shown a notable improvement from 2023 to 2025, with a gain of six points over the past three years.
c. Identify any barriers to implementing initiatives: • No current barriers to report.
HSAG Assessment: HSAG determined that **BCD** met the prior year's recommendation, as none of the SFY 2025 top-box scores for **BCD** were statistically significantly lower than the SFY 2024 top-box scores for any measure.

HSAG HEALTH SERVICES ADVISORY GROUP

Delta Dental of Michigan

Validation of Performance Improvement Projects

Prior Year Recommendations for DD From the EQR Technical Report for Validation of Performance Improvement Projects
HSAG recommended the following: • 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.
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 of Michigan (Delta Dental) noted several lessons learned from the previous PIP activities that will be, or have been, applied to the new PIP and quality improvement activities commencing in the next fiscal year. • For example, Delta Dental learned that a two-pronged performance indicator complicated the focus of the project and should not be used in the future. Dividing the focus of the team between providers and members resulted in less opportunity to directly impact members who benefit the most from a PIP-type of process. • Also, Delta Dental noted that more specificity to the data pull methodology is critical for achieving consistent results, maintaining compliance with the contract, and requires less adjustment in future years for reporting. • Both of the above were implemented in the most recent PIP submission to HSAG. From the perspective of knowledge gained, Delta Dental saw a significant amount of success through dental screening days and member incentives to visit the dentist. Additionally, establishment of a strong community partner drove more members to the dentist than outreach techniques alone, indicating the need for a layered approach. Delta Dental intends to use both lessons learned for the upcoming PIP activities.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Delta Dental does not have any PIP performance improvement data to share at this time but is confident the necessary changes above will contribute to success.
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 determined that **DD** addressed the prior year's recommendations based on the DHP's reported initiatives

Performance Measure Validation

Prior Year Recommendations for DD From the EQR Technical Report for Performance Measure Validation
HSAG recommended the following: • 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 DOBs. 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.
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's data team is continually enhancing its validation checks to ensure data accuracy and timely identification of potential issues, including checking for any dental service dates that occur prior to member DOBs. • In addition, to further ensure data accuracy and timely identification of potential issues, Delta Dental continues to require a secondary level of review of the member detail file. This review is conducted by a separate coder/reviewer who was not involved in the initial data pull.
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 SFY24 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 dental service dates occurring prior to member DOBs during the current year PMV activity.

Compliance Review

Prior Year Recommendations for DD From the EQR Technical Report for Compliance Review
HSAG recommended the following: • 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. **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.

Prior Year Recommendations for DD From the EQR Technical Report for Compliance Review
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's logic was updated to find and use the earliest "accepted" encounter TCN [Transaction Control Number] to populate the original claim, as opposed to finding and using the first original submission. Also, additional manual validation is conducted prior to submission of the report to MDHHS. • A revised report for the period was provided and accepted by MDHHS Office of Inspector General (OIG).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Delta Dental has consistently met the criteria for the encounter adjustment validation for the OIG.
c. Identify any barriers to implementing initiatives: • Delta Dental did not identify any barriers to implementing the initiatives noted above.
HSAG Assessment: HSAG has determined that **DD** addressed the prior year's recommendations based on the DHP's reported initiatives for the OIG/Program Integrity standard. The DHP's response addressed the gaps related to its logic to meet the minimum match requirements for encounter adjustments submitted to the DHP.

Network Adequacy Validation

Prior Year Recommendations for DD From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • HSAG did not identify any substantial weaknesses for **DD** through the NAV activity.
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)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: NA

Network Adequacy Validation Survey

Prior Year Recommendations for DD From the EQR Technical Report for NAV Validation Survey
HSAG recommended the following: • Of the responsive cases, 68.0 percent of locations accepted the insurance, and 62.0 percent accepted new patients. 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. • 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. 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.
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 conducted phone outreach to multiple providers where a deficiency was noted on the case-level analytic data file. Based on these result, Delta Dental either removed the provider from the network, hid them from the directory, or educated them on the appointment wait time standards. • Delta Dental also 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, including name, date of birth, or Medicaid ID, before the staff member can offer and/or schedule an appointment. Delta Dental is in the process of updating its verbiage used to remind dental offices of appointment availability to ensure office are not being restrictive in the information they provide to either current or prospective members.
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 FY25 to use for data comparison 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 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. HSAG recommends **DD** continue to use the systems in place to improve data deficiencies and validate provider contact information. However, 2025 results for **DD** indicate low appointment availability (69.4 percent), and although this is an improvement from the previous year's appointment availability rate (47.1 percent), it is still well below the 90 percent standard. HSAG further recommends that **DD** review and implement the recommendations listed in Section 3.

Encounter Data Validation

Prior Year Recommendations for DD From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • HSAG did not identify any substantial weaknesses for **DD** through the EDV activity.
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)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG determined that **DD** fully addressed the prior year's recommendation because no substantial weaknesses were identified in the EDV review, and therefore no corrective actions were required. **DD**'s results indicate strong performance in documentation accuracy, coding alignment, and data submission processes. Although no follow-up initiatives were needed, **DD** should continue its current monitoring and quality assurance practices to maintain performance in future review cycles. HSAG did not identify any barriers or areas requiring additional improvement at this time.

Child Dental Survey

Prior Year Recommendations for DD From the EQR Technical Report for Child Dental Survey
HSAG recommended the following: • 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. HSAG recommends that **DD** monitor the measures to ensure significant decreases in scores over time do not occur.
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 monitor all Child Dental Survey results, as well as utilization and access data contained in the EQR Technical Report. The care coordination and outreach team prioritizes member access to dental services through strategic collaboration with dental providers and community partners, including non-profit dental practices, Federally Qualified Health Centers, PA-161 [Public Dental Prevention Program] mobile dental hygiene organizations, as well as private practitioners. Delta Dental

Prior Year Recommendations for DD From the EQR Technical Report for Child Dental Survey
has always maintained close relationships with community partners and key providers in areas with decreased access to ensure members receive necessary services. • 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 maintains monthly outreach to members, 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.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In the recently released 2025 Healthy Kids Dental (HKD) Child Dental Survey Report, Delta Dental increased performance from 52.94% in 2024 to 58.33% in 2025 for the Rating of Finding a Dentist measure, which is an increase of nearly 6%. Delta Dental also demonstrated an increase in performance for three other measures, including Care from Dentists and Staff, Would Recommend Regular Dentist and Would Recommend Dental Plan. Overall, Delta Dental did not see any statistically significant changes in trend from 2023 through 2025, either decreases or increases. • 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.
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 determined that **DD** met the prior year's recommendation, as none of the SFY 2025 top-box scores for **DD** were statistically significantly lower than the SFY 2024 top-box scores for any measure.

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 2025 validation, the DHPs submitted the project methodologies for the two newly initiated PIP topics. Table 5-1 displays each PIP and provides a comparison of the PIP validation rating and 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	*Improving Access to Care for Members Ages 15–20*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Improving Dental Risk Assessment Response Rate	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
DD	*Black/African American Dental Utilization Disparity*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	New Member Survey	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.

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, 2023–September 30, 2024) or for the DQA dental quality measures during the January 1, 2023–December 31, 2024 measurement period, Table 5-2 displays the comparison of performance between the two DHPs and the statewide weighted average (SWA) for the SFY 2025 performance measure activity. Table 5-2 includes data from the SFY 2024 measurement period (October 1, 2023–September 30, 2024) and the January 1, 2023–December 31, 2024 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 and Statewide Rate Comparisons

Performance Measures			
CMS-416 EPSDT Performance Measures	**BCD**	**DD**	**SWA**
12a—*Total Eligibles Receiving Any Dental Services*	**34.47%**	**50.33%▲**	**45.05%**
12b—*Total Eligibles Receiving Preventive Dental Services*	**31.50%**	**46.56%▲**	**41.54%**
12c—Total Eligibles Receiving Dental Treatment Services	**11.33%**	**20.63%▲**	**17.53%**
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	**13.58%▲**	**13.10%**	**13.22%**
12e—*Total Eligibles Receiving Dental Diagnostic Services*	**33.89%**	**48.20%▲**	**43.43%**
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	**0.00%[1]**	**0.00%[1]**	**0.00%[1]**
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	**31.50%**	**46.56%▲**	**41.54%**
DQA Dental Performance Measures	**BCD**	**DD**	**SWA**
CCN-CH-A—*Care Continuity*	**27.73%**	**42.71%▲**	**39.70%**
USS-CH-A—*Usual Source of Services*	**21.35%**	**37.13%▲**	**33.96%**

[1] The rate is reported as 0 percent due to the DHPs 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.

Blue shading with one upward-facing triangle (▲) indicates the DHP performed at or above the SWA.

Table 5-3 displays the performance measure rate comparisons for **BCD**, **DD**, and the SWA from the SFY 2023 to SFY 2024 measurement periods (i.e., validated through the SFY 2024 and SFY 2025 PMV activities). Negative values in the *SFY 2023–SFY 2024 Comparison* column indicate a rate decrease from SFY 2023 to SFY 2024. Positive values in the *SFY 2023–SFY 2024 Comparison* column indicate a rate increase from SFY 2023 to SFY 2024. Rate increases or decreases of 5 percentage points or more are denoted by shading and either ▲ or ▼, respectively, within the applicable field.

Table 5-3—SFY 2023 and SFY 2024 Performance Measure Rate Comparisons

Performance Measures							
BCD							
CMS-416 EPSDT Performance Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
12a—*Total Eligibles Receiving Any Dental Services*	121,928	392,871	31.04%	133,427	387,057	34.47%	+3.43%
12b—*Total Eligibles Receiving Preventive Dental Services*	110,891	392,871	28.23%	121,916	387,057	31.50%	+3.27%
12c—*Total Eligibles Receiving Dental Treatment Services*	39,912	392,871	10.16%	43,850	387,057	11.33%	+1.17%
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	16,380	127,940	12.80%	17,405	128,145	13.58%	+0.78%
12e—*Total Eligibles Receiving Dental Diagnostic Services*	119,359	392,871	30.38%	131,180	387,057	33.89%	+3.51%
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	0	392,871	0.00%[1]	0	387,057	0.00%[1]	+/-0.00%
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	110,891	392,871	28.23%	121,916	387,057	31.50%	+3.27%
DQA Dental Quality Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
CCN-CH-A—*Care Continuity*	1,505	3,191	47.16%	42,103	151,823	27.73%	**-19.43% ▼**
USS-CH-A—*Usual Source of Services*	1,309	3,191	41.02%	32,411	151,823	21.35%	**-19.67% ▼**
DD							
CMS-416 EPSDT Performance Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
12a—*Total Eligibles Receiving Any Dental Services*	426,628	835,067	51.09%	390,265	775,417	50.33%	-0.76%
12b—*Total Eligibles Receiving Preventive Dental Services*	394,297	835,067	47.22%	361,000	775,417	46.56%	-0.66%
12c—*Total Eligibles Receiving Dental Treatment Services*	178,321	835,067	21.35%	159,974	775,417	20.63%	-0.72%
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	57,287	425,705	13.46%	52,732	402,478	13.10%	-0.36%
12e—*Total Eligibles Receiving Dental Diagnostic Services*	409,046	835,067	48.98%	373,726	775,417	48.20%	-0.78%

Performance Measures							
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	0	835,067	0.00%[1]	0	775,417	0.00%[1]	+/-0.00%
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	394,297	835,067	47.22%	361,000	775,417	46.56%	-0.66%
DQA Dental Quality Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
CCN-CH-A—*Care Continuity*	301,820	749,801	40.25%	257,625	603,141	42.71%	+2.46%
USS-CH-A—*Usual Source of Services*	256,352	749,801	34.19%	223,965	603,141	37.13%	+2.94%
SWA							
CMS-416 EPSDT Performance Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
12a—*Total Eligibles Receiving Any Dental Services*	548,556	1,227,938	44.67%	523,692	1,162,474	45.05%	+0.38%
12b—*Total Eligibles Receiving Preventive Dental Services*	505,188	1,227,938	41.14%	482,916	1,162,474	41.54%	+0.40%
12c—*Total Eligibles Receiving Dental Treatment Services*	218,233	1,227,938	17.77%	203,824	1,162,474	17.53%	-0.24%
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	73,667	553,645	13.31%	70,137	530,623	13.22%	-0.09%
12e—*Total Eligibles Receiving Dental Diagnostic Services*	528,405	1,227,938	43.03%	504,906	1,162,474	43.43%	+0.40%
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	0	1,227,938	0.00%[1]	0	1,162,474	0.00%[1]	+/-0.00%
12g—*Total Eligibles Receiving Any Preventive Dental or Oral Health Services*	505,188	1,227,938	41.14%	482,916	1,162,474	41.54%	+0.40%
DQA Dental Quality Measures	**Numerator**	**Denominator**	**SFY 2023**	**Numerator**	**Denominator**	**SFY 2024**	**SFY 2023–SFY 2024 Comparison**
CCN-CH-A—*Care Continuity*	303,325	752,992	40.28%	299,728	754,964	39.70%	-0.58%
USS-CH-A—*Usual Source of Services*	257,661	752,992	34.22%	256,376	754,964	33.96%	-0.26%

Blue Shading + ▲	Indicates a rate increase of 5 percentage points or more.
Orange Shading - ▼	Indicates a rate decrease of 5 percentage points or more.

[1] The rate is reported as 0 percent due to the DHPs 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

HSAG calculated the HKD program's overall performance in each of the seven standards reviewed during SFY 2025. Table 5-4 compares the statewide average compliance score with the compliance score achieved by each DHP.

Table 5-4—Compliance Monitoring Comparative Results

Standard	BCD	DD	Statewide
Standard I—Disenrollment: Requirements and Limitations	50%	88%	**69%**
Standard II—Member Rights and Member Information	76%	76%	**76%**
Standard III—Emergency and Poststabilization Services	85%	77%	**81%**
Standard IV—Availability of Services	100%	100%	**100%**
Standard V—Assurances of Adequate Capacity and Services	86%	71%	**79%**
Standard VI—Coordination and Continuity of Care	88%	88%	**88%**
Standard VII—Coverage and Authorization of Services	48%	48%	**48%**
Overall	**73%**	**74%**	**74%**

Network Adequacy Validation

Network Adequacy Analysis

Each DHP was assessed based on its respective methodologies and interpretations of MDHHS' expectations; however, opportunities remain for closer collaboration with MDHHS to ensure provider network reporting is standardized across both DHPs. Differences in how the DHPs interpreted and applied MDHHS' network adequacy reporting guidance, particularly for the general dentistry provider type, limited HSAG's ability to aggregate and compare programwide results. Variations were identified in both the categorization of pediatric specialists providing comprehensive care and the application of the 20-hour service requirement for general dentists. These inconsistencies demonstrate an opportunity to further align DHP reporting methodologies to promote programwide consistency.

Despite these methodological differences, both DHPs demonstrated strong data integrity through comprehensive provider data validation and monitoring processes, including quarterly attestations, credentialing oversight, and routine sanction and exclusion reviews. As a result, both DHPs achieved *High Confidence* ratings for 100 percent of the indicators within the scope of review and demonstrated full compliance with all applicable time and distance and ratio standards or maintained an approved MDHHS exception where requirements were not met.

Network Validation Survey

During April through June 2025, 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	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]
BCD	355	29	8.2%	31	8.7%	295	83.1%
DD	405	6	1.5%	1	0.2%	398	98.3%
DHP Total	**760**	**35**	**4.6%**	**32**	**4.2%**	**693**	**91.2%**

[1] The denominator includes the number of sampled providers.

Table 5-6—PDV Study Indicator Aggregate Match Rates

Indicator	BCD		DD		Overall	
	Count	Rate[1]	Count	Rate[1]	Count	Rate[1]
Provider Street Address	295	90.5%	398	99.7%	**693**	**95.6%**
Provider Suite Number	311	95.4%	398	99.7%	**709**	**97.8%**
Provider City	299	91.7%	398	99.7%	**697**	**96.1%**
Provider State	325	99.7%	399	100%	**724**	**99.9%**
Provider ZIP Code	298	91.4%	398	99.7%	**696**	**96.0%**
Provider Telephone Number	294	90.2%	397	99.5%	**691**	**95.3%**
Provider Type/Specialty	326	100%	398	99.7%	**724**	**99.9%**
Provider Accepting New Patients	326	100%	399	100%	**725**	**100%**

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

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 Requiring Member ID to Confirm Requested Insurance[2]	Rate of Cases Accepting New Patients[2]
BCD	77.7%	68.6%	64.6%	63.2%	55.6%	3.1%	57.0%
DD	89.7%	94.7%	94.4%	93.0%	86.5%	1.4%	81.2%
DHP Total	**84.6%**	**84.6%**	**82.9%**	**81.5%**	**74.6%**	**2.1%**	**71.8%**

[1] The denominator includes the total number of survey cases (i.e., cases that were found in the directory and matched on all PDV indicators, except suite number).

[2] The denominator includes cases reached.

Table 5-8—Appointment Availability and Wait Time Results

DHP	Rate of Cases Offered Appointment[1]	Rate of Cases Within Standard[2]	Average Appointment Wait Time (Calendar Days)
BCD	50.2%	86.6%	25
DD	69.4%	83.4%	28
DHP Total	**62.0%**	**84.4%**	**27**

[1] The denominator includes cases reached.

[2] Rates were calculated using the total number of respondents to the survey who offered an appointment as the denominator and respondents to the survey who offered an initial routine dental appointment that was within eight weeks (or 56 calendar days) of the request as the numerator.

Encounter Data Validation

HSAG requested that both MDHHS and the DHPs submit final, fully adjudicated claims and encounters with dates of service from July 1, 2023, through June 30, 2024, for the study. To compare the data submitted by MDHHS and each DHP, HSAG developed a comparable match key using elements from both data sources. Specifically, the TCN or the Encounter Reference Number (ERN), along with the associated detail line number, were concatenated to create a unique match key. This match key served as the unique identifier for each encounter detail line in both MDHHS' and the DHPs' data. HSAG then conducted comparative analyses across three main analytical areas:

- **Record Completeness**
- **Data Element Completeness and Accuracy**
- **Overall Encounter Accuracy**

Table 5-9 through Table 5-11 summarize the overall comparative results across these three analytical areas.

Record Completeness

HSAG evaluated the record-level data completeness of MDHHS' encounter data by examining the record omission (i.e., records present in the DHP-submitted data but absent in the MDHHS-submitted data) and record surplus (i.e., records present in the MDHHS-submitted data but absent in the DHP-submitted data), comparing MDHHS' data to each DHP's data. Table 5-9 presents the overall DHP rates, as well as DHP performance for dental encounters. The record omission and surplus rates were assessed using the following performance thresholds:

- Rates of 5.0 percent and below were considered as high performance.
- Rates exceeding 5.0 percent were considered as low performance.

Table 5-9—Record Omission and Surplus: Dental Encounters

DHP	Record Omission Rate	Record Surplus Rate
BCD	3.9%	2.1%
DD	<0.1%	0.1
Overall	**0.9%**	**0.5%**

Data Element Completeness and Accuracy

HSAG evaluated the element-level completeness of MDHHS' encounter data by assessing element omission (i.e., records with values present in the DHPs' submitted files but not in MDHHS' data warehouse) and element surplus (i.e., records with values present in MDHHS' data warehouse but not in

the DHPs' submitted files) rates for key data elements relevant to the dental encounter type. Table 5-10 displays the number of key data elements with element omission rates at or below 5.0 percent, as well as the number of key data elements with element surplus rates at or below 5.0 percent.

HSAG evaluated element-level accuracy by comparing the values of key data elements for DHP encounter records with data present in both MDHHS' and the DHPs' records. Table 5-10 also shows the number of key data elements with element accuracy rates at or above 95.0 percent.

In addition, Table 5-10 presents the all-element accuracy results, representing the percentage of records that were present in both data sources and contained the same values (whether missing or non-missing) for all key data elements relevant to dental encounters. For this indicator, higher rates indicate better performance.

Due to the non-standardized formatting of values in both the *Service Provider Address* and *Billing Provider Address* data elements (e.g., variations such as "Road" versus "Rd"), these fields were not assessed as part of the element-level data accuracy or all-element accuracy.

Table 5-10—DHP Comparison of Key Data Element Completeness (Omission and Surplus Rates) and Accuracy: Dental Encounters

DHP	Number of Key Data Elements With Element Omission ≤ 5.0 Percent (N= 16)[1]	Number of Key Data Elements With Element Surplus Rates ≤ 5.0 Percent (N= 16)[1]	Number of Key Data Elements With Element Accuracy ≥ 95.0 Percent (N= 14)[2, 3]	All-Element Accuracy
BCD	13	15	11	0.2%
DD	15	16	14	92.7%

[1] N indicates the number of key data elements included in the completeness calculations.
[2] N indicates the number of key data elements included in the accuracy calculations.
[3] **BCD** had no records with oral cavity code values present in both data sources to assess accuracy.

Overall Encounter Accuracy

HSAG assessed overall encounter accuracy by evaluating claim contents across all claim lines, regardless of line number. The analysis compared each DHP's data file to the respective MDHHS data file and vice versa, capturing any discrepancies that may not have been apparent in the individual comparisons. Table 5-11 displays the overall encounter accuracy rates by DHP for dental encounters.

Table 5-11—Overall Encounter Accuracy: Dental Encounters

DHP	MDHHS to DHP			DHP to MDHHS		
	Match	No Match	Partial Match	Match	No Match	Partial Match
BCD	0.2%	1.8%	98.0%	0.2%	0.6%	99.2%
DD	85.5%	<0.1%	14.5%	85.5%	<0.1%	14.4%
Overall	**67.0%**	**0.4%**	**32.6%**	**67.2%**	**0.1%**	**32.7%**

Note: The sum of Match, No Match, and Partial Match rates may not equal 100 percent due to rounding.

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 2025 HKD Program top-box scores were statistically significantly higher or lower than the SFY 2024 HKD Program top-box scores.

Table 5-12 presents the SFY 2025 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 2025 HKD Program top-box scores compared to the SFY 2024 HKD Program top-box scores. SFY 2024 **BCD** and **DD** scores are presented for comparative purposes. Upward and downward arrows (↑ or ↓) indicate DHP SFY 2025 scores were statistically significantly higher or lower, respectively, than the SFY 2025 HKD Program scores. Upward and downward triangles (▲ or ▼) indicate SFY 2025 HKD Program scores were statistically significantly higher or lower, respectively, than the SFY 2024 HKD Program scores.

Table 5-12—DHP and HKD Program Comparisons

	SFY 2024 DHP Results		SFY 2025 DHP Results		HKD Program Results	
	BCD	DD	BCD	DD	SFY 2024	SFY 2025
Global Ratings						
Rating of Regular Dentist	76.17%	77.18%	70.52%	75.47%	76.67%	73.25%
Rating of All Dental Care	71.86%	78.63%	70.81%	75.73%	75.27%	73.58%
Rating of Finding a Dentist	50.00%[+]	52.94%[+]	51.85%[+]	58.33%[+]	50.98%[+]	54.90%[+]
Rating of Dental Plan	71.43%	68.26%	67.21%	67.51%	69.82%	67.38%
Composite Measures						
Care from Dentists and Staff	95.16%	95.53%	95.27%	94.92%	95.35%	95.08%
Access to Dental Care	73.53%	75.14%	75.14%	69.46%	74.36%	72.11%
Dental Plan Information and Services	89.87%	89.56%	89.94%[+] ↑	83.15% ↓	89.10%	86.74%

	SFY 2024 DHP Results		SFY 2025 DHP Results		HKD Program Results	
	BCD	DD	BCD	DD	SFY 2024	SFY 2025
Individual Items						
Care from Regular Dentists	97.66%	93.24%	95.32%	94.76%	95.49%	95.01%
Would Recommend Regular Dentist	96.21%	95.17%	97.06%	95.26%	95.69%	96.06%
Would Recommend Dental Plan	95.91%	95.63%	97.28%	95.76%	95.77%	96.43%

\+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
▲ Indicates the SFY 2025 HKD Program score is statistically significantly higher than the SFY 2024 HKD Program score.
▼ Indicates the SFY 2025 HKD Program score is statistically significantly lower than the SFY 2024 HKD Program score.
No triangle (▲ or ▼) indicates the SFY 2025 HKD Program score is not statistically significantly higher or lower than the SFY 2024 HKD Program score.
↑ Indicates the DHP SFY 2025 score is statistically significantly higher than the SFY 2025 HKD Program score.
↓ Indicates the DHP SFY 2025 score is statistically significantly lower than the SFY 2025 HKD Program score.
No arrow (↑ or ↓) indicates the 2025 score is not statistically significantly higher or lower than the SFY 2025 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 (●) 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[13]		Performance Domain
Goal #1—Ensure high quality and high levels of access to care		
–	**CQS Objective 1.1:** The CQS does not include quality measures for the HKD program under this objective.	☒ Quality ☒ Timeliness ☒ Access
–	**CQS Objective 1.2:** The CQS does not include quality measures for the HKD program under this objective.	
×	**CQS Objective 1.3:** The aggregated rate for the *Access to Dental Care—HKD Beneficiaries* quality measure did not meet the CQS performance target. Additionally, while not statistically significant, the rate decreased from the prior year.	

[13] HSAG's analysis did not include all the results of EQR activities without a corresponding CQS quality measure. However, all EQR activities were considered in HSAG's recommendations for program improvement. Additionally, 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. Further, several quality measures applied to the adult population (i.e., *Emergency Dental Care Utilization in Adults, Recommend Dental Plan—Adults*, *Access to Dental Care—Adults*, *SDOH: Total Member Screening Rate for Transportation for Adult Dental Visits*, and *Follow-Up After Emergency Dental Visits in Adults*) and the CQS did not identify a specific population for three quality measures (i.e., *Prenatal and Postpartum Dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic Visits*, *Diabetes Dental Care: Preventive Dental Visit*, and *Implementation of Dental Visit Outreach in Non-Utilizers Using Enrollment Files and CC360*). Therefore, HSAG could not determine the applicability to the HKD population.

	Performance Impact on Goals and Objectives	Performance Domain
Goal #2—Strengthen person and family-centered approaches		
–	**CQS Objective 2.1:** The CQS does not include quality measures for the HKD program under this objective.	☒ Quality ☐ Timeliness ☒ Access
–	**CQS Objective 2.2:** The CQS does not include quality measures for the HKD program under this objective.	
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 does not include quality measures for the HKD program under this objective.	☒ Quality ☒ Timeliness ☒ Access
–	**CQS Objective 3.2:** The CQS does not include quality measures for the HKD program under this objective.	
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 *Diagnostic Dental Visits—CMS 416-12* and *Preventive Dental Visits—CMS 416-12* quality measures under this objective.[14] While these measures are included in the PMV activity, the data reported are not stratified by race and ethnicity. Additionally, while one DHP implemented a PIP focused on eliminating a disparity within its population, the performance indicator is based on a retired HEDIS measure and not specifically a CMS 416-12 measure.	☒ Quality ☒ Timeliness ☒ Access
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	**CQS Objective 5.1:** The EQR activities do not produce data to assess the impact of the *Average Percentage of Plan Payments to Providers Who Are in VBP Arrangements ("Big Numerator")* and *Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")* quality measures under this objective.	☒ Quality ☐ Timeliness ☐ Access

Recommendations

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:

- As HSAG had challenges in determining the applicability of dental program CQS quality measures to the HKD program, 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. MDHHS indicated that it intends to clearly identify the populations to which each measure applies in the next iteration of the CQS.

[14] MDHHS reported that it initiated a phased-in approach for the quality measures for which MDHHS initially focused on increasing overall utilization and will focus on disparities for future reporting.

Recommendations
• Based on the results of the compliance review activity, there is a significant need for MDHHS to enhance its State monitoring activities over the DHPs' service authorization review process. MDHHS has already drafted a new quarterly PA reporting template to increase its oversight in this area. HSAG recommends that MDHHS continue with its intent to implement the new PA reporting template and use the data to identify potential opportunities for improvement related to timeliness of decisions and trends related to authorization denial rates. In addition to addressing any concerns with individual DHPs, as applicable, MDHHS should consider presenting aggregated data to both DHPs during quality improvement meetings and/or other committee meetings. • HSAG recommends that MDHHS develop an ABD model notice template that both DHPs are required to use. This will ensure consistency in the information communicated to members regardless of DHP enrollment. A model notice will also help support adherence to language requirements for member materials (e.g., easily understood language and format). • The compliance review activity identified potential opportunities to clarify MDHHS' care management expectations for the HKD program; specifically related to the required number of attempts to complete the initial health risk screening, completing comprehensive assessments, and developing care plans. HSAG recommends that MDHHS update its contracts with the DHPs to outline care management requirements as determined by MDHHS. Further, 42 CFR §438.208(a)(2) allows states to exempt PAHPs from the requirements of 42 CFR §438.208(c) based on applicability (identification of members who need LTSS or have special health care needs, comprehensive assessments, and care plans [i.e., treatment/service plans]). As such, MDHHS could determine if it will exempt the DHPs from these provisions. • While the DHPs reported according to their own network adequacy standards' methodologies and interpretations of MDHHS' expectations, there is an opportunity for closer collaboration with MDHHS to establish standardized reporting methods across both DHPs. HSAG identified differences in how pediatric specialists providing comprehensive care were categorized and measured. For example, one DHP listed PCDs as a separate category in its analysis, while the other DHP grouped them under the General Dentist category. HSAG recommends that MDHHS issue formal guidance on how DHPs should display ratios for general dentists and pediatric specialists providing comprehensive care and how DHPs should apply the 20-hour service threshold requirement for general dentists and pediatric specialists providing comprehensive care when preparing GeoAccess summaries and other network analyses. • As the results of the NAV survey suggest that some members may be experiencing limited appointment availability and long wait times for appointments, MDHHS should also consider conducting a phantom network analysis to support additional network oversight monitoring. A "phantom network" refers to provider directories that list providers who are not actually available—either because they are not accepting new patients, have outdated contact information, or do not offer the advertised services. The analysis would identify providers who are incorrectly listed or no longer practicing. By removing phantom providers, the DHPs can assess true network capacity and areas that are inadequately served.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

For SFY 2025, 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 2025 submissions, the DHPs reported PIP Design and were validated for Steps 1 through 6 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 EQR 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.

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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**
   - *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**
   - *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 2025, the DHPs submitted each PIP's design. 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 both PIPs are listed below.

Table A-1—Measurement Period Dates

Data Obtained	Measurement Period	Reporting Year (Measurement Period)
Administrative	Baseline	January 1, 2025–December 31, 2025
Administrative	Remeasurement 1	January 1, 2026–December 31, 2026
Administrative	Remeasurement 2	January 1, 2027–December 31, 2027

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 2025 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 2025 and reported data for performance measures selected by MDHHS for the SFY 2024 (October 1, 2023–September 30, 2024) measurement period for the CMS-416 Annual EPSDT measures and January 1, 2023–December 31, 2024, 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 2024 performance measure rates were compared to their corresponding SFY 2023 performance measure rates to determine whether there were significant differences. Significant differences between the SFY 2024 performance measure rates and the SFY 2023 performance measure rates are denoted with shading and a

corresponding symbol. Performance measure rates that increased by more than 5 percentage points are denoted with blue shading with an upward-facing triangle (▲). Performance measure rates that decreased by more than 5 percentage points are denoted with orange shading with a downward-facing triangle (▼).

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 standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the DHPs contracted with MDHHS to deliver services to HKD members.

MDHHS requires its DHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. SFY 2025 is the first year HSAG conducted the compliance reviews on behalf of MDHHS. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan DHPs consist of 14 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2025 through SFY 2027. MDHHS requested that HSAG conduct a review of the first half of the standards in Year One (SFY 2025) and a review of the remaining half of the standards in Year Two (SFY 2026). The Year Three (SFY 2027) compliance review will consist of a review of the standards and elements that required a CAP during the Year One (SFY 2025) and Year Two (SFY 2026) compliance review activities. Table A-2 outlines the standards that will be reviewed over the three-year review cycle.

Table A-2—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (SFY 2025)	Year Two (SFY 2026)	Year Three (SFY 2027)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of the DHP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		

Standard	Associated Federal Citation[1]		Year One (SFY 2025)	Year Two (SFY 2026)	Year Three (SFY 2027)
	Medicaid	CHIP			
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of the DHP's IS capabilities.

This report presents the results of the SFY 2025 review period. MDHHS and the individual DHPs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the DHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the tools was selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between MDHHS and the DHP as they related to the scope of the review. The review processes used by HSAG to evaluate the DHP's compliance were consistent with CMS EQR Protocol 3.

HSAG's review consisted of the following activities for each of the DHPs:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.

- Prepared and forwarded to the DHP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review documentation tracker.
- Scheduled the site review with the DHP.
- Hosted a pre-site review preparation session with all DHPs.
- Generated a list of 10 sample records for service and payment denials case file reviews.
- Conducted a desk review of supporting documentation that the DHP submitted to HSAG.
- Followed up with the DHP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the one-day site review interview session and provided the agenda to the DHP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed DHP key program staff members.
- Conducted a review of service and payment denials records.
- Conducted an IS review of the data systems that the DHP used in its operations, applicable to the standards/elements under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the DHP.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared a report and CAP template for the DHP to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the DHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the DHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the DHP were scored *NA* and were not included in the denominator of the total score.

HSAG 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).

HSAG conducted file reviews of the DHP's records for service and payment denials to verify that the DHP had implemented what the DHP had documented in its policy. HSAG selected 10 service and payment denials records from the full universe of records provided by the DHP. The file reviews were not intended to be a statistically significant representation of all the DHP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by the DHP staff members. Based on the results of the file reviews, the DHP must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews and the universe files were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the DHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the DHP's progress in achieving compliance with State and federal requirements.

- Scores assigned to the DHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained and Related Time Period

To assess the DHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the DHP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for service and payment denials.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the DHP's key staff members. Table A-3 lists the major data sources HSAG used to determine the DHP's performance in complying with requirements and the time period to which the data applied.

Table A-3—Description of DHP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	October 1, 2024, through March 31, 2025
Information obtained from a review of a sample of service and payment denials case files	October 1, 2024, through March 31, 2025
Information obtained through interviews	September 8, 2025, and September 12, 2025

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each DHP individually, HSAG used the results of the program areas reviewed, including comprehensive case file reviews for two program areas. As any element not achieving compliance required a formal action plan, HSAG determined each DHP's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)

- Weakness—Any program area with three or more elements with a *Not Met* 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 the 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 the DHP's Medicaid members.

Network Adequacy Validation

Network Adequacy Analysis

Activity Objectives

Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires states that contract with MCOs, PAHPs, and PIHPs to have a qualified EQRO perform an 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.

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
- 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 2024 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-4.

Table A-4—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Score = A / (A + B) x 100%
Number of *Not Met* 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-5 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-5—Indicator-Level Validation Rating Categories

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

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the DHPs provide a root cause analysis of the finding.
- Working with the DHPs to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

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-6.

Table A-6—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance		✓	✓
Ratio		✓	✓

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 2025 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 2025 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 2025.
- 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.
- 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 2025. 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 DHPs 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 2025, MDHHS contracted with HSAG to conduct an EDV activity. HSAG conducted the following core evaluation activity for the two DHPs:

- Comparative analysis—analysis of MDHHS' electronic encounter data completeness and accuracy through a comparison between MDHHS' electronic encounter data and the data extracted from the DHPs' data systems. The goal of this activity was to assess the extent to which the data in MDHHS' data warehouse that were submitted by the DHPs are complete and accurate. This activity corresponds to Activity 3: Analyze Electronic Encounter Data, in the CMS EQR Protocol 5.

The goal of the comparative analysis was to evaluate the extent to which encounters submitted to MDHHS by the DHPs were complete and accurate, based on corresponding information maintained in the DHPs' data systems.

Technical Methods of Data Collection and Analysis

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

- **Data Submission Requirements**: HSAG developed data submission requirements (DSR) documents to request claims/encounter data from both MDHHS and the DHPs. HSAG used data from both MDHHS and the DHPs with dates of service from **July 1, 2023**, through **June 30, 2024**, to assess the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources (i.e., MDHHS and the DHPs) represented the same universe of encounters, the analysis focused on the dental encounter types with final adjustment/paid dates as of **November 30, 2024**, and submitted to MDHHS on or before **December 31, 2024**.
- **Preliminary File Review**: HSAG verified that the submitted data were sufficient to conduct the evaluation by performing a preliminary file review, which included checks for data extraction accuracy, the percentage of present and valid values, and the evaluation of matching claim numbers. Based on the preliminary file review results, HSAG generated a report highlighting any major findings that required MDHHS and/or the DHPs to resubmit data, as necessary. Once final data were

received from MDHHS and the DHPs, HSAG conducted a series of comparative analyses divided into three analytic sections: **Record Completeness**, **Data Element Completeness and Accuracy**, and **Overall Encounter Accuracy**.

- **Comparative Analysis—Record Completeness**: HSAG assessed record-level data completeness using the following metrics for each encounter data type:
  - **Record Omission**: Records present in the DHPs' submitted files but not in MDHHS' data warehouse.
  - **Record Surplus**: Records present in MDHHS' data warehouse but not in the DHPs' submitted files.
- **Comparative Analysis—Data Element Completeness and Accuracy**: For records found in both data sources (i.e., MDHHS and DHP), HSAG further examined the completeness and accuracy for key data elements listed below in Table A-7. The analyses focused on an element-level comparison for each data element, where HSAG assessed the following metrics:
  - **Element Omission**: Values present in the DHPs' submitted files but not in MDHHS' data warehouse.
  - **Element Surplus**: Values present in MDHHS' data warehouse but not in the DHPs' submitted files.
  - **Missing Values**: Values missing from both MDHHS' data warehouse and the DHPs' submitted files.
  - **Element Accuracy**: For records with values present in both data sources, the values for a given data element are identical in the DHP and MDHHS' data files.
  - **All-Element Accuracy**: For records present in both data sources, all key data elements contained the same values (whether missing or non-missing) in both the MDHHS and DHP data files.
- **Comparative Analysis—Overall Encounter Accuracy**: HSAG assessed overall encounter accuracy by evaluating the claim contents across all claim lines, regardless of line number. The analysis compared each DHP's data file to the respective MDHHS data file and vice versa. The overall encounter accuracy metrics were calculated for dental encounters based on the following measures:
  - **Match**: All claim numbers were present in both data files with all associated detail lines and key data elements fully matching.
  - **No Match**: Claim numbers were present in one data file and not the other.
  - **Partial Match**: Claim numbers were present in both data files, with one or more detail lines/data elements that were not found in the other data file.

- **Technical Assistance**: Following completion of the analyses, technical assistance was provided to MDHHS and the DHPs regarding the issues identified from the comparative analysis. HSAG developed DHP-specific encounter data discrepancy reports that highlighted key areas requiring investigation. HSAG then collaborated with MDHHS and the DHPs to review the potential root cause(s) of the identified issues and requested written responses from each DHP to explain the discrepancies based on its internal review. Lastly, HSAG reviewed the written responses and followed up with the DHPs as needed to request clarification or additional information. This collaborative approach ensured that data discrepancies were addressed systematically and that any underlying issues were resolved to improve encounter data quality.

Table A-7—Key Data Elements for Comparative Analysis

Key Data Elements	Dental
Member Identification (ID)	✓
Date of Service	
Detail Service From Date	✓
Detail Service To Date	✓
Header Service From Date	✓
Header Service To Date	✓
Provider Information	
Billing Provider National Provider Identifier (NPI)	✓
Rendering Provider NPI	✓
Billing Location[1]	
Billing Provider Address (including ZIP Code)	✓
Service Location[2]	
Service Provider Address (including ZIP Code)	✓
Diagnosis and Procedure Codes Information	
Procedure Code (Current Dental Terminology [CDT])	✓
Units of Service	✓
Tooth Specific Information	
Tooth Number	✓
Tooth Surface (1 through 5)	✓
Oral Cavity Code (1 through 5)	✓

Key Data Elements	Dental
Payment Information	
Detail Paid Amount	✓
Header Paid Amount	✓

[1] The *Billing Location* field is associated with known data quality concerns within MDHHS. Due to the non-standardized formatting of values in this field (e.g., variations such as "Road" versus "Rd"), the assessment focused solely on whether the field was populated rather than on the specific content of the values.

[2] The *Service Location* field is associated with known data quality concerns within MDHHS. Due to the non-standardized formatting of values in this field (e.g., variations such as "Road" versus "Rd"), the assessment focused solely on whether the field was populated rather than on the specific content of the values.

Description of Data Obtained and Related Time Period

Data obtained from MDHHS and the DHPs included:

- Claims and encounter data with dates of service from July 1, 2023, through June 30, 2024.
- Encounter type: Dental

Process for Drawing Conclusions

To draw conclusions about the encounter data completeness and accuracy between each DHP's and MDHHS' encounter data, HSAG analyzed the results using the key metrics previously described. To identify areas of strengths and weaknesses, HSAG leveraged its extensive experience working with other states on encounter data activities. This benchmarking approach provided a comparative framework that supported a comprehensive evaluation of each DHP's data quality. 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 effective data management approaches implemented by the DHPs.
- Weakness—Highlighted areas where recurring data errors or omissions were identified, potentially impacting data reliability and compliance with MDHHS requirements.

Additionally, for each identified weakness, HSAG provided recommendations for improvements to support enhanced encounter data submissions to MDHHS. These recommendations were designed to help DHPs improve data integrity, align with State requirements, and strengthen overall encounter data reporting.

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."[15] 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.

[15] 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.

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 2024 to April 2025.

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 2025 scores were compared to their corresponding SFY 2024 scores to determine whether there were statistically significant differences. Statistically significant differences between the SFY 2025 top-box scores and the SFY 2024 top-box scores are denoted with directional triangles. Scores that were statistically significantly higher in SFY 2025 than SFY 2024 are denoted with upward triangles (▲). Scores that were statistically significantly lower in SFY 2025 than SFY 2024 are denoted with downward triangles (▼). Scores that were not statistically significantly different between years are not denoted with triangles.

Additionally, 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 denote statistically significant differences. An upward arrow (↑) indicates a top-box score for one DHP that was statistically significantly higher than the other DHP. Conversely, a 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-8.

Table A-8—Assignment of Survey Measures to the Quality, Timeliness, and Access Domains

Dental Survey Topic	Quality	Timeliness	Access
Rating of Regular Dentist	✓		
Rating of All Dental Care	✓		
Rating of Finding a Dentist	✓		✓
Rating of Dental Plan	✓		
Care from Dentists and Staff	✓		
Access to Dental Care	✓	✓	✓
Dental Plan Information and Services	✓		
Care from Regular Dentist	✓		
Would Recommend Regular Dentist	✓		
Would Recommend Dental Plan	✓		