GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

State Fiscal Year 2020 Healthy Kids Dental Performance Measure Aggregate Report for Michigan Medicaid

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

MDHHS is seeking to further improve the quality and access of oral health services for its younger population through its prepaid ambulatory health plan managed care dental service delivery model, the Healthy Kids Dental (HKD) program. The Medical Services Administration (MSA) within MDHHS administers and oversees the HKD program, which provides Medicaid and Children's Health Insurance Program (CHIP) dental benefits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, to members 0 to 20 years of age.

The HKD program was developed in an effort to achieve improved oral health outcomes by 2020. The three program goals are:

- Enhance professional integration between providers across the lifespan.
- Increase knowledge and awareness of the importance of oral health to overall health.
- Increase access to oral healthcare among underserved and/or hard-to-reach populations.

The HKD program includes two dental health plans (DHPs) contracted with MDHHS to provide dental services to Medicaid members 0 to 20 years of age. The DHPs, reflected in Table 1-1, contracted with MDHHS during state fiscal year (SFY) 2019 and SFY 2020, and reported data for performance measures selected by MDHHS for the SFY 2019 (October 1, 2018–September 30, 2019) measurement period.

Table 1-1—DHPs in Michigan

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

HSAG conducted a comprehensive review of the DHPs' rates for six EPSDT dental and oral services performance measures that are reported to the Centers for Medicare & Medicaid Services (CMS) using Form CMS-416 (i.e., CMS-416 EPSDT performance measures). These six performance measures were calculated and reconciled by the DHPs in collaboration with MDHHS during the measurement period. Table 1-2 lists these performance measures.

Table 1-2—CMS-416 EPSDT Performance Measures for Validation

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

Summary of Performance

Table 1-3 and Table 1-4 demonstrate the DHPs' final reconciled and reported rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 1-3—BCBSM Final CMS-416 EPSDT Performance Measure Rates

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

Table 1-4—DDMI Final CMS-416 EPSDT Performance Measure Rates

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

Summary of Findings and Conclusions

HSAG used its analyses and evaluations of findings from the assessment of 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 DHP's performance, which can be found in Section 6 of this report.

Although no benchmarks are established for the CMS-416 EPSDT performance measures, DDMI had higher rates for each reported measure. DDMI also had higher numerators and denominators due to a greater number of enrolled members during the reporting period. While MDHHS has indicated some potential root causes for the rate variations, MDHHS may find value in further exploring if there are additional causes of the rate differences by working with both DHPs to provide an evaluation of the accessibility of EPSDT services.

The DHPs and MDHHS experienced challenges throughout the reporting process when calculating the pre- and post-reconciled rates for the CMS-416 EPSDT performance measures. Prior to 2020, MDHHS extracted the CMS-416 EPSDT performance measure rates through a vendor to report to CMS at a program level. While 2020 was the first year that data were extracted at the DHP level, the performance measure reconciliation process appeared to already add assurances related to the quality and completeness of the encounters upon which the CMS-416 EPSDT performance measure rates are based. Therefore, through this process, MDHHS was able to identify multiple data discrepancies that suggest some opportunities may still exist to improve the performance measure data accuracy. These data discrepancies were due to a variety of issues that were impactful to both the DHPs as well as MDHHS.

For SFY 2020 performance measure reporting, HSAG recommends that MDHHS focus on improving the accuracy and validity of performance measure rates by conducting performance measure validation (PMV) in alignment with CMS external quality review (EQR) *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019[1-1] (i.e., CMS EQR Protocol 2). By conducting PMV in alignment with CMS EQR Protocol 2, MDHHS would be able to reliably assess the accuracy of performance measures reported by the DHPs and to determine the extent to which performance measures reported by the DHPs follow federal specifications and reporting requirements.

Due to some DHP misinterpretation of the CMS-416 EPSDT performance measure specifications, HSAG further recommends that MDHHS work with the DHPs in the future to ensure they maintain consistency in specification interpretation, across all DHP reported measures. Additionally, the DHPs should review any codes that are used to identify the performance measure numerator counts to ensure they are appropriately and consistently applied for each reported performance measure.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 15, 2021.

MDHHS identified that only one of the DHPs reported the CMS-416 EPSDT performance measure rates to MDHHS by age group. HSAG recommends for future reporting of the CMS-416 EPSDT performance measures that both DHPs report their performance measure rates by age group to allow for a more detailed comparison of performance between the two DHPs.

2. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in interpreting and using the results presented in this report.

Data Collection Method

Administrative Method

The administrative method 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.

Data Sources and Performance Measure Audit Results

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

Evaluating Performance Measure Results

The CMS-416 EPSDT performance measure rates are not comparable to benchmarks due to data that are affected by states' periodicity schedules. While states are required to establish reasonable standards, in consultation with recognized dental child health organizations, for dental screening services, known as periodicity schedules, due to variability in periodicity schedules amongst states, no national benchmarks exist. A periodicity schedule sets the frequency by which certain services should be provided and be covered.[2-1] Although there are no benchmarks associated with the CMS-416 EPSDT performance

[2-1] United States Government Accountability Office. *Report to Congressional Requesters*: *Medicaid, Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings*, August 2019. Available at: https://www.gao.gov/assets/gao-19-481.pdf. Accessed on: Apr 15, 2021.

measures, in 2010 CMS established a target for each state to achieve at least a 10 percentage point improvement over a five-year period. No additional updated national benchmarks have been established since this five-year 2010 goal was set. Additionally, MDHHS has not established state-specific DHP benchmarks for these performance measures.

Interpreting Results Presented in This Report

As expected, performance results can differ to a greater or lesser extent among the DHPs and even across performance measures for the same DHP. The performance measure results presented in Section 4 include the final rates that were reconciled between MDHHS and the DHPs. Section 5 includes the following tables:

- Pre-reconciled rates provided by the individual DHPs to MDHHS as part of their initial calculation of the performance measures. These rates are prior to the reconciliation process that occurred between MDHHS and the DHPs to produce the final calculated rates.
- Pre-reconciled and calculated rates for each individual DHP by MDHHS. These rates are based on the encounter data files received from the DHPs and are prior to the reconciliation process that occurred between MDHHS and the DHPs to produce the final calculated rates.
- Final reconciled rates for each individual DHP based on the reconciliation process that occurred between MDHHS and the DHPs.

3. Performance Measure Reporting Process

MDHHS contracted with Optum Government Solutions (Optum) to generate and calculate initial performance measure rates for the six CMS-416 EPSDT performance measures based on aggregated encounter data submitted by the DHPs to MDHHS. The DHPs also generated initial performance measure rates for the six CMS-416 EPSDT performance measures. The DHPs submitted their initial rates to MDHHS, and the data generated by Optum were provided to the DHPs for reconciliation. To reconcile and verify the data, the DHPs compared their initial calculated rates to Optum's initial calculated rates. If discrepancies were identified, MDHHS and Optum worked with the DHPs to correct the data discrepancies by evaluating the member-level data for each of the six CMS-416 EPSDT performance measures and by checking each mismatched member record's eligibility criteria, ensuring alignment between the DHPs and MDHHS. Additionally, the data were checked to ensure DHP and MDHHS alignment with member-level birth dates and numerator/denominator inclusions as well as exclusions, as outlined in the CMS-416 EPSDT performance measure specifications. The measure summary data counts were then compared to the counts within the DHPs' member-level detailed data to ensure that the DHPs' source code queries were correctly extracting the data. Additionally, the DHPs received the aggregated performance measure data generated by Optum and compared these data to the encounter data the DHPs had submitted to MDHHS to ensure the data counts matched. The DHPs and MDHHS then worked together to finalize any additional data corrections or source code updates that were required to address all discrepancies identified throughout the entire process. Once all corrections were completed, the final performance measure rates were calculated and submitted to MDHHS by the DHPs, and approved by MDHHS for reporting.

BCBSM Reporting Process and Findings

To reconcile the data between the MDHHS encounter database and BCBSM's encounter database, BCBSM conducted a data comparison to identify Transaction Control Numbers (TCNs) for encounters that were only in the MDHHS database but not found in the DHP's database. The results of this data comparison are displayed in Table 3-1.

Table 3-1—TCN Comparison Results

Total TCNs	Total Matches	Total Discrepancies	Match Rate
33,502	**33,298**	**204**	**99.4%**

BCBSM was unable to match a TCN for 204 encounters to the MDHHS database, which was attributed to a missing 4950 Encounter Transaction Error Listing detailed response file (i.e., 4950 ETRR Error File), which included explanations for each file and encounter rejection that occurred. Since all missing encounters from BCBSM's database were for dates of service that occurred in October 2018, the missing 4950 ETRR Error File was for October 2018 services.

BCBSM provided a summary comparison to MDHHS during the preliminary rate calculation process, in which BCBSM had compared CMS member data from the MDHHS encounter data file with its internal encounter data file and matched each member record for members who met the 90-day continuous enrollment criteria between these two encounter data files for each of the CMS-416 EPSDT performance measures, as applicable (i.e., 90-day summary comparison). BCBSM then categorized the members as follows:

- If the member record was sent by MDHHS but not found in the BCBSM summary file, then the member record was categorized as *#N/A*.
- If the member record was sent by MDHHS and matched in the BCBSM summary file, then the member record was categorized as *MATCH*.
- If the member record was sent by MDHHS and was found in the BCBSM summary file but did not match between the two files, then the member record was categorized as *NO MATCH*.

The results of the 90-day summary comparison are displayed in Table 3-2.

Table 3-2—90-Day Summary Comparison Results

CMS-416	#N/A	MATCH	NO MATCH
12a—*Total Eligibles Receiving Any Dental Services*	**112,616**	**29,309**	**1,510**
12b—*Total Eligibles Receiving Preventive Dental Services*	**112,616**	**28,779**	**2,040**
12c—*Total Eligibles Receiving Dental Treatment Services*	**112,616**	**26,307**	**4,512**
12d—*Total Eligibles Receiving a Sealant on a Permanent Molar Tooth*	**112,616**	**24,174**	**6,645**
12e—*Total Eligibles Receiving Dental Diagnostic Services*	**112,616**	**29,069**	**1,750**
12f—*Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider*	**112,616**	**25,092**	**5,727**

During the process of calculating the pre-reconciled rates for performance measure 12d, BCBSM had a system issue that led to a much higher reported denominator of 142,200 in comparison with the final reported denominator of 47,958. This system issue resulted in inaccurate processing of 834-enrollment files and inaccuracies in the performance measure calculation query. Additionally, BCBSM did not put any qualifiers for non-dentist providers in its query when it calculated the numerator count for performance measure 12f, which resulted in 3,668 members reported in the numerator in error, since performance measure 12f should only include members who received services from a non-dentist provider.

During the final performance measure calculation process, BCBSM identified that member eligibility spans were not aligning with the file provided by MDHHS. BCBSM also identified the misassignment of members that occurred in May/June of SFY 2019, which resulted in eligibility span discrepancies

within BCBSM's system. Upon conducting a root cause analysis, BCBSM identified that its programming logic resulted in underreporting of continuously enrolled members because it was only including the four most recent member eligibility spans in its query parameters. For a majority of these members, the eligibility span reflected a month-to-month enrollment renewal creating multiple spans of enrollment, even though the members were continuously enrolled without enrollment gaps. This required BCBSM to update its programming logic to include each monthly enrollment span from its system for each member, to determine if the member met the 90-day enrollment criteria with no gaps during the measurement period. This resulted in lower than expected continuously enrolled members, lower than expected percentages of compliant members across each reported measure, and fewer matching claims and TCN numbers. Additionally, BCBSM worked with MDHHS to reconcile the misaligned member eligibility spans and misassigned members, correcting eligibility spans as mismatches were identified.

DDMI Reporting Process and Findings

MDHHS identified eligibility discrepancies upon receiving the encounter data file from DDMI. Upon DDMI's review of the eligibility discrepancies, DDMI was able to identify that the discrepant member records had failed to load in the DDMI performance measure reporting database due to discrepancies and errors within the data, or member eligibility terminating by omission (i.e., member record was not included in the file). Based on those findings, DDMI excluded those records from its final counts due to these member records being determined to be errors or eligibility terminations.

During the process of comparing MDHHS' pre-reconciled rates with DDMI's pre-reconciled rates, MDHHS noted that 75,187 unique members were in DDMI's encounters database but not in MDHHS' encounters database. Out of these unique members, 279 were not eligible for the 90-day continuous enrollment criteria, and 5,186 did not have associated claims.

DDMI identified during its initial validation efforts that removing two filters (i.e., denied claims and members older than 20 years of age at the end of SFY 2019), yielded results that more closely aligned with the validation file it received from MDHHS. When re-running the data files with these two filters removed, DDMI yielded the results displayed in Table 3-3.

Table 3-3—DDMI Initial Validation Results

Records in MDHHS Detail File	Records in Updated DDMI Detail File	Records Matched in Both MDHHS and DDMI Detail Files	Percentage Matching	Records in DDMI Detail File but Not in MDHHS Detail File
3,143,213	4,154,418	3,060,841	97.38%	1,093,577

DDMI indicated multiple underlying reasons for the records being included in MDHHS' detail file but not in DDMI's detail file. First, 77,814 records had a TCN date outside of SFY 2019. Second, 4,534 records were excluded due to the records not meeting the 90-day continuous enrollment criteria and the

member being 21 years of age or older at the end of SFY 2019. Additionally, DDMI further indicated that multiple claims that DDMI submitted to MDHHS resulted in MDHHS generating multiple TCNs for the same beneficiary identification number, service date, and procedure code. MDHHS indicated this was the expected outcome for claims rejections that were later resubmitted as a correction and, therefore, MDHHS did not consider these records to be errors.

DDMI also identified 443,324 records that matched between the MDHHS detail file and the DDMI detail file, when the record's TCN was not included in the logic to match the records. These records were able to be matched on other data points. Even with the TCN matching logic removed, 650,253 records were still identified by DDMI as included in DDMI's file, but missing from the MDHHS file. Finally, 194,882 records were able to be matched between the DDMI file and the MDHHS file when DDMI used the beneficiary ID, service date, and procedure code data points as its matching criteria. These records were originally unable to be matched due to either TCN mismatches or a service date or procedure code was missing from a claim. After completing these additional matching steps, DDMI conducted a new validation that used the beneficiary ID and the procedure code to identify missing data between the MDHHS and DDMI systems. The validation results are displayed in Table 3-4.

Table 3-4—DDMI Updated Validation Results

Records in MDHHS Detail File	Records in Updated DDMI Detail File	Distinct in MDHHS Detail File	Distinct in Updated DDMI Detail File	Records Match in Both MDHHS and DDMI Detail Files	Percentage Matching	Records in MDHHS Detail File but Not in DDMI Detail File
3,143,213	4,154,418	2,560,894	3,081,346	2,510,262	98.02%	50,632

Upon MDHHS providing HSAG with the DHPs' final performance measure rates, HSAG noted that there was a significant difference between the two DHPs' reported rates for performance measure 12f related to the number of reported members receiving oral health services from non-dentist providers. BCBSM's rate was 0.00 percent, whereas DDMI's rate was 26.77 percent. DDMI confirmed when originally reporting and calculating the rate for performance measure 12f, DDMI had included CDT codes D0190 and D1206, which are to be billed by a dentist or person under the supervision of a dentist and resulted in the reported rate of 26.77 percent. The Form CMS-416 Instructions define a *non-dentist provider* as any qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist. MDHHS and HSAG communicated this definition to DDMI, and as a result of this clarification, DDMI confirmed its reported rate of 26.77 percent for 12f f was inaccurate since DDMI did not reimburse any non-dentist providers for the applicable services in the measurement year. DDMI therefore reported a corrected rate of 0.00 percent, which aligned with BCBSM's rate for the same performance measure.

MDHHS Reporting Process and Findings

MDHHS and its contracted vendor, Optum, conducted a data reconciliation process and review of DHP-reported encounter data in comparison to the DHP-reported performance measure data. Various quality assurance steps were used throughout this process, including steps such as checking the TCNs' associated encounters, reviewing each TCN's related date, identifying encounter service dates, confirming member eligibility statuses, and reviewing applicable procedure codes. During this process, MDHHS specifically reviewed for TCN mismatches such as missing files, missing members, missing or mismatched TCNs, and conflicting procedure codes. As issues were identified, MDHHS followed up with each individual DHP to research the issues, as well as to reconcile and correct any confirmed data discrepancies.

During the process of calculating the pre-reconciled rates for performance measure 12d for both DHPs, MDHHS did not limit the age categories to 6 to 9 years of age and 10 to 14 years of age for eligibles that received a sealant on a permanent molar tooth. This led to a much higher reported denominator in comparison with the final reported denominator for both DHPs, in which these age categories were applied. Upon identification of this issue, when completing updated rate calculations, MDHHS subsequently applied corrections to include the age categories to align with performance measure 12d specifications.

Additionally, during the process of calculating the pre-reconciled rates for all performance measures for both DHPs, MDHHS identified that its programming logic did not capture retro-enrolled members to account for the 90-day continuous enrollment criteria, as required by the CMS-416 EPSDT performance measure specifications. Therefore, MDHHS had to correct its programming logic to include the full SFY 2019 data extract, in order to capture these members.

4. Performance Measure Results

Table 4-1 and Table 4-2 demonstrate the DHPs' final reconciled and reported rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 4-1—BCBSM Final CMS-416 EPSDT Performance Measure Rates

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

Table 4-2—DDMI Final CMS-416 EPSDT Performance Measure Rates

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

While not currently displayed by age group, MDHHS identified that only one of the DHPs, BCBSM, reported the CMS-416 EPSDT performance measure rates to MDHHS by age group. Reporting the performance measure rates by age group would allow for a more detailed comparison of performance between the two DHPs.

DDMI had higher rates than BCBSM for each reported measure for SFY 2019 services. DDMI also had higher numerators and denominators than BCBSM for all performance measure rates due to DDMI having a greater number of enrolled members during the reporting period. BCBSM's first year contracting with MDHHS to provide services was during the SFY 2019 reporting period (i.e., BCBSM

did not receive members for SFY 2018); therefore, BCBSM's lower membership count resulted in its lower numerator and denominator counts for the CMS-416 EPSDT performance measures for the SFY 2019 reporting period. Additionally, MDHHS indicated that DDMI has provided dental services to members for over two decades and, therefore, had more stability in its membership. Finally, MDHHS further clarified that there were challenges implementing the new BCBSM contract, as the MDHHS and BCBSM member eligibility data did not consistently match throughout the early portion of SFY 2019. MDHHS indicated this was due to system errors, which were later fixed; however, this may have created confusion during the BCBSM member outreach processes, resulting in the potential for delays in reaching enrolled members and, conversely, lower rates. MDHHS further indicated that the challenges faced with member eligibility also impacted DDMI; however, since BCBSM was a new DHP and, therefore, had a higher proportion of auto-assigned newly enrolled members in comparison to DDMI, it mostly impacted BCBSM and its new member outreach processes. While there are no state or national benchmarks established for these performance measures, the results are indicative that DDMI members are accessing dental services at a greater rate than BCBSM members.

MDHHS indicated there are likely key differences in the populations between the DHPs, as BCBSM had a higher proportion of membership ages 0 to 2 years old, which could be a contributing factor to BCBSM's lower rates since members under the age of 2 would be less likely to access the preventive dental services covered under their EPSDT benefits. Research has shown that a lower proportion of Medicaid members under the age of 36 months access preventive dental services and oral health services than Medicaid members over the age of 36 months.[4-1]

[4-1] Arthur T, Rozier RG. *Provision of Preventive Dental Services in Children Enrolled in Medicaid by Nondental Providers*. Pediatrics [serial online]. Feb 2016:137(2). Available at: https://pediatrics.aappublications.org/content/137/2/e20153436. Accessed on: Apr 15, 2021.

5. Performance Measure Reconciliation Results

Table 5-1 demonstrates BCBSM's pre-reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 5-1—BCBSM Pre-Reconciled CMS-416 EPSDT Performance Measure Rates

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	19,308	17,473	7,925	0	18,623	3,668
Denominator	142,200	142,200	142,200	142,200	142,200	142,200
Final Rate	13.58%	12.29%	5.57%	0.00%	13.10%	2.58%

Table 5-2 demonstrates MDHHS' BCBSM pre-reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 5-2—MDHHS Pre-Reconciled CMS-416 EPSDT Performance Measure Rates for BCBSM

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	19,387	17,545	7,949	0	18,698	3,682
Denominator	143,435	143,435	143,435	143,435	143,435	143,435
Final Rate	13.52%	12.23%	5.54%	0.00%	13.04%	2.57%

Table 5-3 demonstrates BCBSM's and MDHHS' final reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

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

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

Table 5-4 demonstrates DDMI's pre-reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 5-4—DDMI Pre-Reconciled CMS-416 EPSDT Performance Measure Rates

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	337,759	308,397	132,181	40,685	318,952	165,579
Denominator	961,823	961,823	961,823	359,691	961,823	961,823
Final Rate	35.12%	32.06%	13.74%	11.31%	33.16%	17.22%

Table 5-5 demonstrates MDHHS' DDMI pre-reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 5-5—MDHHS Pre-Reconciled CMS-416 EPSDT Performance Measure Rates for DDMI

	12a. Total Eligibles Receiving Any Dental Services	12b. Total Eligibles Receiving Preventive Dental Services	12c. Total Eligibles Receiving Dental Treatment Services	12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	12e. Total Eligibles Receiving Dental Diagnostic Services	12f. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider
Numerator	448,714	418,773	184,942	0	433,478	46,976
Denominator	962,177	962,177	962,177	962,177	962,177	962,177
Final Rate	46.64%	43.52%	19.22%	0.00%	45.05%	4.88%

Table 5-6 demonstrates DDMI's and MDHHS' final reconciled rates for the CMS-416 EPSDT performance measures for the measurement period.

Table 5-6—DDMI Final Reconciled CMS-416 EPSDT Performance Measure Rates

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

6. Opportunities for Improvement and Recommendations

By assessing the DHPs' performance and the performance measure reporting process, HSAG identified the following areas that demonstrate opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement.

Opportunities for Improvement

Weakness: The DHPs and MDHHS experienced challenges throughout the reporting process when calculating the pre- and post-reconciled rates for the CMS-416 EPSDT performance measures. While the 2020 performance measure reconciliation process appeared to add assurances related to the quality and completeness of the encounters upon which the CMS-416 EPSDT performance measure rates are based, MDHHS identified multiple data discrepancies that suggest opportunities still exist to improve the performance measure data accuracy.

Why the weakness exists: The DHPs and MDHHS experienced calculation and validation process difficulties when finalizing and reconciling the CMS-416 EPSDT performance measure rates. These difficulties appeared to be related to various factors, including source code inaccuracies, inadequate DHP oversight of vendors (i.e., due to errors identified during the 2020 performance measure reporting that were related to delegated entity processes), enrollment data gaps, encounter data inconsistencies, the DHPs' lack of understanding of some of the CMS-416 EPSDT performance measure specifications, and possible data integration gaps. Each of these factors is crucial to ensuring the accuracy of performance measure data through the validation process, which includes steps to provide assurance of data integration, data control, and documentation of performance measure calculations.

Recommendation: HSAG recommends for SFY 2020 DHP performance measure reporting that MDHHS focus on improving the accuracy and validity of performance measure rates by conducting PMV in alignment with CMS EQR Protocol 2. By following CMS EQR Protocol 2, MDHHS would be able to reliably assess the accuracy of performance measures reported by the DHPs and determine the extent to which performance measures reported by the DHPs follow federal specifications and reporting requirements.

To ensure reliability of PMV, PMV should be conducted for each DHP by following several steps in accordance with CMS EQR Protocol 2, including completing an assessment of the integrity of the DHPs' information systems and data extraction processes; conducting a review of source code for the performance measures; evaluating the DHPs' data mapping; reviewing each DHP's performance measure workflows; conducting a data review at each stage of the performance measure reporting process; and reviewing the member-specific record-level numerator and denominator data. Further, the PMV process could include selecting a sample of records across the performance measures that would allow for the identification of potential issues that the DHPs could then resolve during the data collection process, resulting in final, validated rates based on those improvements.

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

Why the weakness exists: Upon MDHHS providing HSAG with the DHPs' final performance measure rates, HSAG noted that there was a significant difference between the two DHPs' reported rates for performance measure 12f regarding the number of reported members receiving oral health services from non-dentist providers. BCBSM's rate was 0.00 percent, whereas DDMI's rate was 26.77 percent. DDMI confirmed that when originally compiling the rate for 12f, DDMI had included CDT codes D0190 and D1206, which are to be billed by a dentist or person under the supervision of a dentist and resulted in the reported rate of 26.77 percent. The Form CMS-416 Instructions define a *non-dentist provider* as any qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist. As a result of this clarification, DDMI indicated its reported rate of 26.77 percent for 12f was inaccurate since DDMI did not reimburse any non-dentist providers for the applicable services in the measurement year. DDMI indicated its corrected rate of 0.00 percent, which aligned with BCBSM's rate for the same performance measure.

Recommendation: HSAG recommends in future reporting for MDHHS to confirm the DHPs apply the same parameters as required by the specifications across all DHP reported rates. Additionally, the DHPs should review any codes that are used to identify the performance measure numerator counts to ensure they are appropriately applied for each reported performance measure.

Recommendation: While not identified as a weakness for the DHPs since no benchmarks are established for the CMS-416 EPSDT performance measures, the higher rates reported by DDMI in comparison to BCBSM are indicative of an opportunity to evaluate the root cause of these differences. While MDHHS had indicated some potential root causes for the rate variations, MDHHS may find value in further exploring if there are additional causes of rate differences by working with both DHPs to provide an evaluation of the accessibility of EPSDT services to determine if significant process, network, or policy differences exist between the two DHPs that could be resulting in the rate discrepancies.

Weakness: MDHHS identified that only one of the DHPs reported the CMS-416 EPSDT performance measure rates to MDHHS by age group.

Why the weakness exists: Only BCBSM provided its calculated rates for the CMS-416 EPSDT performance measures to MDHHS by age group. DDMI provided numerator and denominator counts for the performance measures that included all age groups under 21 combined into one rate for each performance measure.

Recommendation: HSAG recommends for future reporting of the CMS-416 EPSDT performance measures that both DHPs report their performance measure rates by age group to allow for a more detailed comparison of performance between the two DHPs.