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DAWG Meeting: Quality Standards for Safety Net Dental Programs

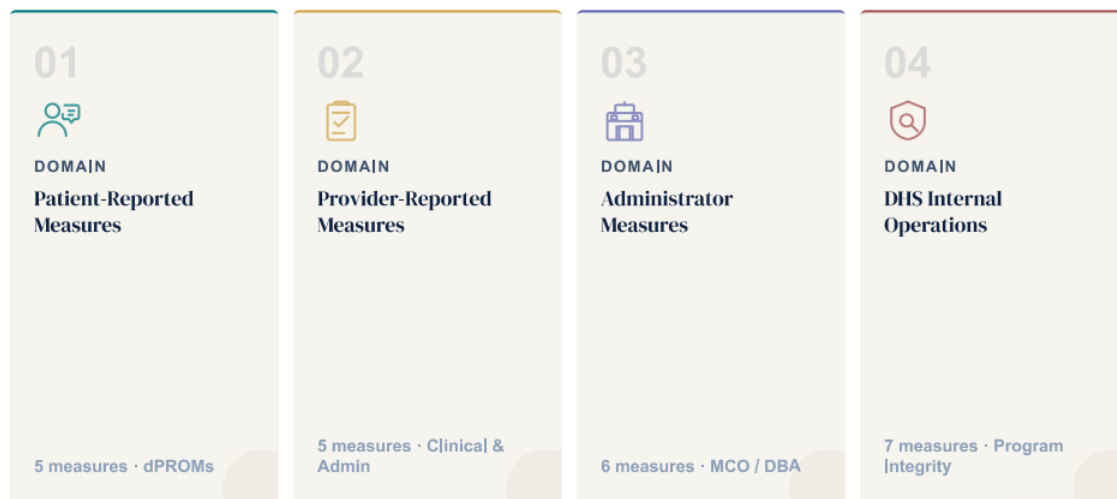
Quality measures are the compass that prevents healthcare from drifting into a sea of “we’ve always done it this way.” or flying without a radar. In dental administration, wisdom lies in the transition from simply counting procedures to measuring true clinical outcomes. By integrating patient experience with rigorous operational audits, these metrics provide a mirror for institutional integrity. They transform abstract concepts like “health equity” and “medical necessity” into actionable data.

We have compiled suggestions from members of CADMN (Critical Access Dental Providers of Minnesota), suggestions from Casamassimo/Crall/Nickman and DHS suggested measures (from their presentation to DAWG) in one master list for DAWG as input.

We realize that there is bandwidth for measurement. We also know one cannot improve what one does not measure.

We have divided these quality measures into 4 categories. The Medicaid dental delivery system is only as good as its weakest link. If any of these 4 elements fail, the odds of not delivering care to the patient dramatically increases.

Four Domains of Quality Measurement



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Quality measures are the compass that prevents healthcare from drifting into a sea of “we’ve always done it this way” or flying without a radar. In dental administration, wisdom lies in the transition from simply counting procedures to measuring true clinical outcomes. By integrating patient experience with rigorous operational audits, these metrics provide a mirror for institutional integrity. They transform abstract concepts like “health equity” and “medical necessity” into actionable data.

Quality measures must transition from simple procedure counts to meaningful clinical outcomes to ensure institutional integrity, patient health, and provider business continuity. Below is a condensed strategic summary for DHS as input. Actual quality measures are listed on the following pages.

1. Restore Data Integrity

- **Reconcile Provider Registries:** DHS must reconcile the ~4,000 active licensed dentists against the 7,000+ enrolled names to purge “ghost” entries that bias network adequacy and HPSA scores.
- **Track Meaningful Participation:** Implement reporting to identify “token” participation by flagging providers seeing fewer than 10 Medicaid patients annually.
- **Verify Workforce Mandates:** Monitor Dental Therapist (DT) compliance with the 50% Medicaid/uninsured mandate to ensure this workforce fulfills its legislative intent.

2. Shift to Value-Based Clinical Outcomes

- **Target High-Risk Care:** Use Caries Risk Assessments (CRA) to move toward a preventative model where funding follows high-risk populations.
- **Monitor Treatment Completion:** Utilize Electronic Clinical Quality Measures (eCQMs) to track the percentage of patients completing treatment plans within 30 days.
- **Measure Human Impact:** Integrate the Oral Health Impact Profile (OHIP) to quantify how care restores daily function and reduces social embarrassment.

3. Address Access Barriers and Equity

- **Track Social Determinants (SDoA):** Account for underlying barriers like transportation and language that drive missed appointments rather than penalizing based on binary “no-show” rates.
- **Standardize Fairness Metrics:** Use CAHPS surveys to monitor healthcare equity and whether enrollees feel judged based on race.
- **Support Specialized Models:** Develop specific metrics for school-based care that account for unique operational hurdles like consent and follow-up coordination.

4. Reduce Administrative Friction

- **Audit Credentialing Speed:** Routinely audit the DBA to ensure provider credentialing is completed within statutory timeframes to prevent access disruptions.
- **Protect Small Nonprofits:** Prioritize streamlined, simple reporting systems to prevent administrative burdens from diverting clinical resources in small organizations.

5. Strengthen Fiduciary Oversight

- **Maintain High-Stakes Benchmarks:** Use the 55% Utilization Benchmark as a hard trigger for benefit “carve-outs” to ensure administrators invest in member outreach and network adequacy.

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1. Patient-Reported Measures (dPROMs)

Historically, Medicaid has relied on claims data, but now CMS is prioritizing Patient-Reported Outcome Measures (PROMs) to capture the human experience of dental care beyond traditional claims data.

Clinical Quality of Life

1. **Oral Health Impact Profile (OHIP):** CMS accepted measure of the frequency of functional limitations (chewing difficulty), physical pain, and psychological discomfort (social embarrassment) due to teeth (CADMN).
Measuring this allows patients to communicate how care restores daily function and dignity, provides safety-net clinics with data to validate their social value, requires the DBA to report on meaningful life outcomes, and enables DHS to track the true human impact of public spending.

Health Equity & Cultural Competency

1. **Perceived "Cultural Humility" of Providers:** A survey-based measure asking if patients felt their provider understood their cultural background or primary language (CADMN).
This metric builds essential trust for patients navigating the system, enables safety-net providers to refine outreach strategies, requires the DBA to monitor contractual equity standards, and provides DHS with data to address state-wide health disparities.
2. **CAHPS Healthcare Equity and Fairness:** Surveying enrollees on whether they felt judged because of race and if they were able to access interpreters (DHS).
Standardizing this feedback ensures patients receive equitable treatment, provides safety-net providers with a framework to uphold their mission, requires the DBA to enforce civil rights compliance, and allows DHS to fulfill federal health equity reporting mandates.
3. **Social Determinants of Access (SDoA) Tracking:** Expanding reporting beyond "no-show" counts to capture and account for the underlying drivers of missed care, such as transportation reliability, linguistic barriers, and competing family priorities.
Measuring this ensures patients receive the specific social support needed to attend visits, provides safety-net providers with a data-driven defense for missed utilization targets, enables the DBA to design more effective transportation or language benefits, and allows DHS to better allocate state health equity resources.

System Navigability

1. **Access to Urgent Care:** Tracks the percentage of patients reporting they could get emergency appointments within 24–48 hours (CADMN).
Tracking this ensures patients receive rapid pain relief, allows safety-net providers to manage clinical flow, requires the DBA to maintain an elastic emergency network, and enables DHS to monitor network adequacy to prevent expensive ER diversions.
2. **Call Center and Service Responsiveness:** Monitoring response times, complaints, resolutions, and appeal volumes (DHS).
Ensuring high responsiveness removes administrative friction for patients, allows safety-net providers to focus on clinical delivery, requires the DBA to meet strict service-level agreements, and provides DHS with a transparent audit trail of member satisfaction.
3. **Appointment Availability Barriers:** Tracking no-shows, cancellations, and instances where appointments could not be scheduled (DHS).
Identifying these barriers help patients access logistical support, protects safety-net providers from operational disruptions, requires the DBA to implement corrective action for access failures, and provides DHS with insights into the systemic root causes of low utilization.
4. **Provider Cultural Concordance and Support:** Measuring the percentage of enrollees sharing race, ethnicity, or language with their provider (DHS).
Enhanced concordance improves communication for patients, ensures safety-net providers are recognized for workforce diversity, requires the DBA to recruit a representative network, and enables DHS to align workforce planning with community demographics.

Engagement Baselines

1. **Person-Level Engagement (Bodies in the Chair):** Tracking the total number of individuals receiving any dental service to establish a participation baseline (Casamassimo/Crall/Nickman).
Understanding true engagement helps identify patients successfully accessing the system, provides safety-net clinics with a baseline for their participation role, requires the DBA to hit volume benchmarks, and enables DHS to oversee the general health of the dental program.
2. **Family-Level Care Consistency:** Tracking the receipt of two preventive or diagnostic services within a set period to suggest regular family care (Casamassimo/Crall/Nickman).
Monitoring family patterns encourages dental homes for patients, helps safety-net providers measure multi-generational success, requires the DBA to track family-unit retention, and provides DHS with data to verify EPSDT program adherence.

2. Provider-Reported Measures

These measures go beyond claims and require providers to document clinical status or administrative hurdles.

Preventative & Clinical Excellence

1. **Caries Risk Assessment (CRA) Documentation:** Documentation of patient risk levels (Low, Moderate, High) to ensure proper fluoride application (CADMN).
Documenting risk levels ensures patients receive personalized care, allows safety-net providers to access targeted reimbursement, requires the DBA to verify clinical necessity for claims, and provides DHS with a high-level view of the state's preventative strategy.
2. **Evidence-Based Clinical Outcomes:** Tracking practice-level performance on fluoride, sealants, and caries at recall (Casamassimo/Crall/Nickman).
Standardizing these outcomes ensures patients receive high-quality care, validates that safety-net providers are meeting clinical benchmarks, requires the DBA to incentivize best practices, and provides DHS with proof of program effectiveness.

Medical-Dental Integration

1. **Post-ED Visit Follow-Up:** Measuring the percentage of non-traumatic dental ED visits followed by a dentist visit within 7 or 30 days (DHS).
High follow-up rates ensure patients transition from crisis to sustainable care, highlight the role of safety-net providers in ER diversion, requires the DBA to coordinate between medical and dental networks, and provides DHS with data to reduce overall system costs.
2. **Oral Evaluation During Pregnancy:** Measuring oral evaluations for enrolled persons with live birth deliveries (DHS).
This focus prevents periodontal complications for patients and infants, allows safety-net providers to highlight their maternal health contributions, requires the DBA to track HEDIS-aligned metrics, and enables DHS to improve public health outcomes.
3. **Adult Diabetic Oral Health Maintenance:** Monitoring oral evaluations for adults with diabetes (DHS).

Routine evaluations help patients manage systemic health, demonstrate the role of safety-net providers in chronic disease care, requires the DBA to integrate medical-dental data, and provides DHS with a metric for holistic population wellness.

4. **Children's Preventive and Diagnostic Benchmarks:** Tracking oral evaluations and fluoride/sealant applications for children under 21 (DHS).

Early tracking ensures pediatric patients receive a healthy start, allows safety-net providers to meet mandatory reporting standards, requires the DBA to manage mandatory Child Core Set metrics, and provides DHS with the data needed to secure federal funding.

Care Continuity & Treatment Integrity

1. **Electronic Clinical Quality Measures (eCOMs):** EDR reporting on the percentage of patients with a "Complete Treatment Plan" within 30 days of evaluation (CADMN).

Monitoring plan completion ensures patients move rapidly from diagnosis to healing, demonstrates safety-net provider efficiency, requires the DBA to invest in technical interoperability, and provides DHS with a real-time monitor of network quality.

2. **Disease Prevalence (Mouth Level):** Directly or indirectly measuring oral disease through clinical findings or restorative care surrogates (Casamassimo/Crall/Nickman).

Measuring disease levels provides patients with an indicator of their health progress, gives safety-net providers data to prove community impact, requires the DBA to shift from volume to value, and provides DHS with the evidence needed to adjust population health policies.

3. **Usual Source of Services (Continuity of Care):** Measuring children who visited the same practice in two consecutive years (DHS).

Continuity of care provides patients with personalized treatment, acknowledges the value of safety-net provider relationships, requires the DBA to promote member-provider loyalty, and provides DHS with a stability metric for the care delivery system.

4. **School-Based Delivery Model Metrics:** Developing specific measures that capture the unique operational realities of delivering care in schools, including the intricacies of consent processes, rigid academic scheduling, and the coordination of follow-up care in community settings. *Standardizing these metrics ensures patients receive convenient, school-linked care, allows safety-net providers to be recognized for the complex coordination required in non-traditional settings, requires the DBA to accurately track network reach in schools, and enables DHS to evaluate the impact of school-based oral health grants.*

5. **Multi-Visit Treatment Coordination Metrics:** Recognizing that care completion for safety-net populations is a continuum requiring multiple visits and cross-setting coordination rather than a single event.

Monitoring this continuum ensures patients benefit from consistent navigation throughout their healing journey, rewards safety-net providers for the intensive effort required for complex cases, requires the DBA to track throughput over time rather than per-visit, and enables DHS to verify that high-risk patients are not being lost during multi-stage treatment plans.

Operational Friction

1. **Provider Burnout & "No-Show" Rates:** Providers report "No-Show" rates to DHS to help adjust Corrective Action Plans (CAP) for MCOs (CADMN).

This data protects patients from being unfairly dismissed due to socioeconomic barriers, shields safety-net providers from punitive administrative actions, requires the DBA to adjust performance expectations based on reality, and provides DHS with context for utilization failures.

3. Administrator-Reported Measures (MCO/DBA)

Managed Care Organizations (like Medica, Blue Cross, etc.) or a potential third-party Dental Benefit Administrator (DBA) are now held to high-stakes benchmarks.

Network Adequacy & Accuracy

1. **Provider Directory Accuracy (The "Ghost Network" Audit):** Reporting providers actually accepting new Medicaid patients with accurate contact info (CADMN).
Auditing directories ensures patients aren't frustrated by dead-ends, protects the integrity of truly active safety-net providers, requires the DBA to comply with strict federal directory laws, and provides DHS with a verified map of the actual care network.
2. **Time and Distance Standards:** Reporting enrollees living within 30 miles or 30 minutes of a provider, stratified by county (CADMN).
Enforcing these standards guarantees patients in all counties have access, identifies where safety-net providers need more workforce support, requires the DBA to fill geographic gaps, and provides DHS with an equity-driven map of access.
3. **Systems-Level Dentist Participation:** Utilizing ADA Health Policy Institute (HPI) analysis to track the volume and distribution of participating dentists (Casamassimo/Crall/Nickman).
This analysis helps patients find care in underserved areas, provides safety-net providers with evidence for recruitment bonuses, requires the DBA to track system-wide capacity, and provides DHS with a workforce planning tool.

Operational Execution

1. **Claims Processing Efficiency:** Reporting paid/denied claim counts and processing times (DHS).
Efficient processing prevents billing surprises for patients, maintains the financial solvency of safety-net providers, requires the DBA to optimize administrative speed, and provides DHS with a metric for fiscal health.
2. **Prior Authorization Operational Performance:** Tracking request counts, approvals, denials, and decision times (DHS).
Streamlining this process ensures patients don't wait in pain, reduces red tape for safety-net providers, requires the DBA to operate transparently, and provides DHS with oversight of administrative service speed.
3. **Specialty Care Access Speed:** Measuring elapsed time between specialty referral and appointment (DHS).
Shortening this wait time prevents patient conditions from worsening, helps safety-net providers coordinate transitions, requires the DBA to maintain an adequate specialty network, and provides DHS with data on complex care access.

Fiscal & Contractual Stewardship

1. **The "55% Utilization" Benchmark:** Annual visit rate mandate for MCOs to avoid legislative "carve out" (CADMN).
This benchmark compels administrators to invest in patient outreach, ensures safety-net providers remain a central pillar of the network, requires the DBA to maintain high performance to keep their contract, and provides DHS with a clear legislative success metric.
2. **Annual Enrollee Utilization:** Reporting MHCP enrollees seen at least once per year (DHS).
This macro-view ensures the program reaches more patients, acknowledges the work of safety-net providers in meeting targets, requires the DBA to track annual participation, and provides DHS with a progress report on state-wide access.
3. **Per-Member Annual Cost:** Tracking average per member spending to monitor sustainability (DHS).
Monitoring costs helps the state protect the long-term availability of benefits for patients, ensures safety-net providers are funded sustainably, requires the DBA to manage funds responsibly, and provides DHS with the data needed for long-term budgeting.
4. **HEDIS Performance Metrics:** Collection and reporting of standardized quality data (Casamassimo/Crall/Nickman).
Standardized reporting allows patients to compare plans fairly, gives safety-net providers a platform for excellence, requires the DBA to follow national quality standards, and provides DHS with an objective plan evaluation tool.
5. **Contractual Quality Compliance (Systems Check):** Monitoring specific contract requirements (Casamassimo/Crall/Nickman).
Regular compliance checks ensure patients receive full value, holds administrators accountable to safety-net providers, requires the DBA to fulfill every contractual promise, and provides DHS with a robust fiduciary oversight mechanism.

Strategic Policy Development

1. **Delta Monthly Enrollment Reporting (2027):** Monthly reporting on provider types and distribution beginning in 2027 (DHS).
Frequent reporting provides patients with reliable care locations, requires safety-net providers to be accurately mapped, requires the DBA to maintain high reporting rigor, and provides DHS with real-time network oversight.
2. **Access Coordination Policy Development:** Mandated state-approved policies for transportation, interpreters, and medical coordination (DHS).
Formalizing these policies ensures patients receive logistical help, alleviates safety-net providers of social support costs, requires the DBA to implement standardized coordination protocols, and provides DHS with a framework for benefit expansion.
3. **Health Equity Best Practices Policy:** Approved policies for quality care for people with disabilities, varying backgrounds, and HIV (DHS).
Standardizing these practices ensures vulnerable patients receive specialized care, validates safety-net provider expertise in equity, requires the DBA to deliver a specialized care framework, and provides DHS with a tool for health equity compliance.

4. DHS Internal Operations Measures

Because of federal funding threats and audit findings, DHS is implementing "Internal Program Assessments".

Workforce Capacity & Integrity

1. **Network Composition and Demographic Analysis:** Tracking enrolled dentists by specialty and region (DHS).
This analysis helps patients find specialized care, enables the state to recruit providers who reflect safety-net communities, requires the DBA to track workforce diversity, and provides DHS with a targeted planning tool.
2. **Allied Health Professional Workforce Tracking:** Monitoring allied professionals and CAD providers by type (DHS).
Tracking the full team ensures patients can access mid-level care, recognizes the role of hygienists in safety-net models, requires the DBA to utilize the full workforce mix, and provides DHS with a workforce innovation metric.
3. **Active Network Capacity:** Measuring dentists actively taking new MHCP patients (DHS).
Validating active capacity gives patients an honest look at their options, provides safety-net providers with a realistic view of their peers, requires the DBA to perform capacity audits, and provides DHS with an accurate network adequacy assessment.
4. **Provider Intensity and Patient Volume Distribution:** Identifying providers seeing fewer than 10 patients annually (DHS).
Distinguishing participation ensures patients have real access, highlights that safety-net providers perform the bulk of the work, requires the DBA to audit meaningful participation, and provides DHS with the truth about network utilization.
5. **Provider Registry Integrity Reconciliation:** Comparing active licensed dentists against enrolled provider counts (DHS).
Cleaning up the registry provides patients with accurate care maps, ensures safety-net providers receive correct loan-forgiveness scores, requires the DBA to purge directory "ghosts," and provides DHS with high data integrity.
Dental Therapist (DT) Compliance and Billing Transparency: Specific tracking of the 50% Medicaid mandate and billing methods (DHS).
Ensuring DT compliance guarantees patient access as promised by law, enables safety-net providers to prove workforce utilization, requires the DBA to track mid-level billing accurately, and provides DHS with legislative enforcement data.
6. **Nonprofit Administrative Burden Mitigation:** Prioritizing the development of simple, streamlined reporting systems to ensure that small nonprofit providers can meet quality mandates without diverting limited staff and financial resources from direct patient care.
 - *Streamlining these systems ensures patients benefit from more staff time dedicated to clinical care, protects the operational sustainability of small safety-net providers, requires the DBA to provide user-friendly reporting interfaces, and enables DHS to maintain high program compliance across the entire provider network regardless of organization size.*

Credentialing & Enrollment Oversight

1. **Provider Enrollment Processing Time:** Tracking revalidation backlogs in 13 identified high-risk areas (CADMN).
Speeding up enrollment gets more dentists to patients faster, reduces delays for safety-net providers, requires the DBA to optimize onboarding speed, and provides DHS with a metric for backlog clearance.
2. **Credentialing Timeliness:** Tracking administrator completion of credentialing within defined timeframes (DHS).
Holding payers to a strict timeline ensures patients aren't waiting for clinics to open, prevents administrative delays for safety-net providers, requires the DBA to meet operational KPIs, and provides DHS with statutory oversight of payer performance.

Standardized State & Federal Reporting

1. **Mandatory CMS Child Core Set Reporting:** Reporting on Oral Evaluation and Topical Fluoride DQA measures (Casamassimo/Crall/Nickman).
Meeting these standards secures the federal funding patients rely on, ensures safety-net providers are measured against national standards, requires the DBA to align with federal metrics, and provides DHS with a mandatory compliance tool.
2. **CMS-416 EPSDT Performance Data:** Standardized reporting on state-level dental performance (Casamassimo/Crall/Nickman).
Detailed reporting identifies pediatric patients missing care, gives safety-net providers data to advocate for resources, requires the DBA to monitor service categories meticulously, and provides DHS with strategic program oversight.
3. **National Benchmarking (DQA Dashboard):** Comparing Minnesota outcomes against other states (Casamassimo/Crall/Nickman).
Benchmarking highlights how patients are faring compared to the nation, showcases the impact of safety-net providers, requires the DBA to compete for excellence, and provides DHS with a state-wide performance ranking.
4. **Optional CMS Adult Core Set Reporting:** Tracking adult dental emergency visits and outcomes (Casamassimo/Crall/Nickman).
This reporting provides patients with insights into adult care access, enables safety-net providers to demonstrate their role in crisis reduction, requires the DBA to track adult outcomes, and provides DHS with a care expansion metric.
5. **ED Visit Data Source Validation:** Disclosing the exact data source used for tracking ED visits (DHS).
Verifying data sources ensures patients' needs are monitored accurately, prevents safety-net providers from being judged on faulty data, requires the DBA to provide transparent data sources, and provides DHS with reporting truth.

Clinical & Fraud Audits

1. **Prior Authorization (PA) Consistency Audit:** Quarterly audit of PA approvals vs. denials for uniform policy application (CADMN).

Auditing for consistency ensures patients receive fair treatment, protects safety-net providers from biased denials, requires the DBA to operate with clinical uniformity, and provides DHS with audit integrity.

2. **Improperly Blocked Claims:** Measuring cost avoidance from improperly blocked claims by the administrator (CADMN).
Proactive detection preserves access and funds for patient care, protects the reputation of honest safety-net providers, requires the DBA to implement advanced cost-avoidance systems, and provides DHS with taxpayer protection.
3. **Prior Authorization CDT Analysis:** Quarterly vendor reporting of the "Top 10" CDT codes submitted for authorization (DHS).
Analyzing these specific codes identifies treatments patients are struggling to access, allows for policy changes that help safety-net providers, requires the DBA to perform deep-dive clinical reviews, and provides DHS with data on access hurdles.
4. **Tri-Setting Fluoride Stratification:** Stratifying delivery by provider type (MD vs. DDS office) (DHS).
This reveals how well medical-dental integration serves patients, identifies opportunities for safety-net provider partnerships, requires the DBA to design cross-sector benefits, and provides DHS with a multi-sector health strategy.

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