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- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

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The Climate for Change

UNDERSTANDING THE DYNAMICS THAT LEAD TO
Statewide Dental Carve-Outs

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GLOSSARY OF TERMS

General

ADA American Dental Association

ASO Administrative Services Only

CHIP Children's Health Insurance Program. See SCHIP.

CMS CMS is the Centers for Medicare & Medicaid Services. Formerly known as the Health Care Financing Administration (HCFA), it is the federal agency responsible for administering the Medicare, Medicaid, SCHIP (State Children's Health Insurance Program), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs.

DBM Dental Benefits Manager (such as Doral Dental)

EPSDT Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services, including oral health.

FFS Fee-For-Service

MCO Managed Care Organization

MMIS Medicaid Management Information System. The MMIS is an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

RFP Request for Proposal

SCHIP As part of the Balanced Budget Act of 1997, Congress created title XXI, the State Children's Health Insurance Program (SCHIP), to address the growing problem of children without health insurance. SCHIP was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. CMS administers the State Children's Health Insurance Program.

TPA Third Party Administrator (such as Doral Dental)

Tennessee

Children's Oral Health Planning Committee Special Committee developed to spearhead the carve-out process

Pan TDA Pan Tennessee Dental Association (serves minority providers)

TDA Tennessee Dental Association

TDAC Tennessee Dental Advisory Committee

TennCare Medical Assistance Care Program for the State

Virginia

DAC Dental Advisory Committee

DMAS Department of Medical Assistance Services, Virginia Medical Assistance Program

DIAG Dental Implementation Advisory Group

ODDS Old Dominion Dental Society

Smiles For Children The Virginia dental initiative aimed at improving dental care

VDA Virginia Dental Association

VIADC Virginians for Improved Access to Dental Care

INTRODUCTION

Dental services are a mandatory Medicaid benefit for children. Section 1902(a)(43) of the Social Security Act specifically requires that state Medicaid plans provide or arrange for such services. In spite of this directive, meeting the oral health care needs of the underserved population continues to be a struggle. Many Medicaid programs are "typically under funded and poorly administered," according to a recent American Dental Association (ADA) white paper. Although federal law requires states to cover dental benefits for children at risk, most eligible children do not see a dentist in a given year. In order to address this issue, some states have employed a dental delivery model called the Dental Carve-out. This paper will focus on the "Hows" of that model by outlining the factors at the state level that influenced process and outcomes.

What is a Dental Carve-out?

Generally speaking, carve-out plan administration (or carve-outs) is designed to deliver a single benefit via a single administrator outside of the MMIS vendor or Medicaid managed care. Regarding state dental programs, the carve-out separates dental treatment from other Medicaid services by dedicating funds specifically for oral health care and by using a single benefits manager. The Dental Benefits Manager (DBM) a.k.a. Third Party Administrator (TPA) assumes the administration of the entire dental program including provider networks, claims processing, and benefits management.

The foundation of the carve-out rests on basic economic and business principles: the program is run efficiently so that using and providing dental services is no longer administratively burdensome, and more members can access care. This is accomplished by a) offering the dentists who treat members an economical way to recoup claim reimbursements, and b) allowing them to work with a single benefits manager (DBM or TPA).

The Trend Toward Dental Carve-outs

Research indicates there is a trend underway to implement government-funded dental carve-outs. While the majority of government dental programs are still administered by state fiscal agents or Managed Care Organizations (MCOs), a growing number of states have realized that effective dental administration is vastly different than medical administration. Thus they have carved out their dental services and awarded them to a TPA via Request For Proposals (RFPs). The following states are currently operating dental carve-outs with a single administrator:

- Tennessee (statewide)
- Virginia (statewide)
- California
- Illinois (statewide)
- Massachusetts (statewide)
- Kansas (statewide)
- Texas (CHIP)
- Michigan (Medicaid pilot for rural counties)
- Colorado (SCHIP program)
- Florida (Medicaid pilot)
- Idaho (statewide)

This paper highlights three of these statewide dental carve-out programs. They will be described in terms of political climate, how they were implemented, what factors were in play at the time the decision was made to carve-out dental services, key players, and process. A section will follow that is dedicated to defining best practices.

DENTAL CARVE-OUT CASE STUDIES *Tennessee*

The State of Tennessee

Tennessee's carve-out of dental services from the TennCare (Medicaid Managed Care) program was implemented in the fall of 2002 in an effort to improve access to dental services for enrollees. The carve-out ensured a separate dental budget, raised reimbursement rates for contracted providers, used a single dental plan administrator (Doral Dental of Tennessee), streamlined dental administration of processes and procedures, and allowed input from participating dentists through an Advisory Committee. Since the carve-out, the dental provider network has grown by 107 percent. Eighty-six percent of participating providers surveyed actively accept new TennCare patients into their practices. Access for children has increased by 48 percent. Additionally, all children who have not received dental services have been the subject of considerable outreach efforts. Since its inception, the carve-out has clearly been a resounding success.

Early Stages and the "Climate for Change" in Tennessee

Prior to the dental carve-out, participation of dental providers, both generalists and specialists, was less than optimal. At the time, the state was utilizing approximately ten MCOs to administer the dental program, six of whom were subcontracting dental services. Enrollees did not have access to the entire network of dental providers; they only had access to those who were contracted with their specific MCO. Utilization of dental services by child enrollees was poor, despite the fact that the state was operating under a Consent Decree which included extremely ambitious mandates with regard to EPSDT dental services. In addition, *Oral Health in America: A Report of the Surgeon General* revealed that the burden of oral diseases were found in poor Americans, especially children and the elderly. Findings from this report resulted in a heightened awareness toward dental care. Furthermore, the National Governors Association was offering technical assistance to states that applied for (and were awarded) a slot in a series of policy forums addressing oral health.

Process and Sequence Step #1: Identify Interested Parties

As momentum for the carve-out gained strength, the Children's Oral Health Planning Committee was constituted and included dental and non-dental stakeholders. The committee consisted of representatives from TennCare, Department of Health (DOH), Tennessee Primary Care Association, Tennessee Dental Association, Pan TDA, Head Start and dentists from each of the major specialties areas. This group met monthly to discuss, plan and gain consensus relative to a dental carve-out strategy and a dental benefit plan.

Step #2: Gather RFPs and Determine Scope of Services

Once the committee convened, and as the meetings progressed, it became clear that a Request for Proposal (RFP) was needed in order to best evaluate program administration. A TennCare official was assigned the task of gathering various state RFPs as examples and solidifying a list of covered services. Because the state was operating under a 1115 b waiver, large sections of the TennCare Managed Care Contractor Risk Agreement were incorporated into the Scope of Services section in order to comply with the waiver's special terms and conditions.

Step #3: Determine Financial Model

Concurrent with the above-noted discussions, a decision had to be made as to whether the potential TPA would assume risk, or would bill administrative services only. One significant challenge to this task was identifying utilization data specific to dental carve-outs that simply was not available at the time. Ultimately, the decision was made to go ASO with the option of moving to risk after three years. A dental fee schedule was developed code by code, using the 75 percentile of the 1999 ADA survey for the East South Central Region of the U.S., the most recent survey at that time.

Step #4: Develop an RFP

The writing and approval of the RFP took many months, from May 2001 to February 2002. The RFP was issued March 1, 2002 with the contract start date slated for October 1, 2002. The official most involved in the RFP process stated, "We probably had at least four false starts – thinking the RFP would be completed by "x" for start date of "y." The lesson learned is that states interested in developing an RFP for a dental carve-out need to give themselves adequate lead time to review and evaluate RFPs and models from states who have successfully conducted such programs. Once this has been done, sufficient time should also be allotted for drafting, finalizing and issuing the RFP.

Members of the Children's Oral Health Planning Committee had strong opinions and demands. To the extent it was possible, legitimate concerns were addressed in the RFP. One example was the conviction that dentists would not

participate unless they could control the number of Medicaid patients seen in their practices. Another was that only a single maximum allowable fee schedule be established and offered statewide with no exceptions made in certain geographic areas where dentists might hold out for higher fees. They were also adamant that the state program director be a dentist and not a bureaucrat. Drafts were submitted with the aforementioned stipulations and with mandatory information from the managed care contract.

Step #5: Centralize Communication

The Children's Oral Health Planning Committee served as the primary venue for all important communications. By meeting regularly, and following formal committee structure, all interested parties had a forum to air their concerns and issues. Motions were made, voted on, and approved. Minutes were drafted, approved and published. Agendas were developed and provided to members to keep the group on task and to solidify direction.

Step #6: Award RFP and Prep Prior to Start Date

After the RFP was awarded to Doral, TennCare hired a dentist to serve as the program director. This dentist had formerly served as the Director of Oral Health Services for DOH and had excellent rapport with organized dentistry. He served in leadership positions with the state dental association. TennCare also contracted with an experienced external quality review organization to assist the state in conducting a readiness review. Reevaluation of the fee schedule, benefit structure, prior authorization criteria, and provider recruitment strategies were conducted during the preparatory period.

The Keys to Success in Tennessee

- **Securing adequate funding** that allowed the fees at the time of the carve-out to be set at a level where over 50% of the dentists in Tennessee were reimbursed at their billed charges.
- **Garnering the support from the TDA** to actively recruit member dentists. The TDA and Pan TDA communicated via their newsletters, and through society and regional meetings, that TennCare performed per financial specifications. Because of this, the network grew substantially in the first few months of the program.
- **Securing a dental TPA experienced** in Medicaid dental benefits administration. Medicaid dental programs are not like commercial dental plans – working with a state government is different than working with a private company. Individuals who write and review the RFP must understand these subtleties and factor them into the rating system.
- **Building a relationship with DOH** to capitalize on their experience, relationships and rapport with communities and various agencies in conducting oral disease prevention and dental care programs. This was key in Tennessee because in many of the rural areas DOH was already operating dental facilities within local health departments. DOH was also involved in conducting statewide school-based oral disease prevention programs.

- **Communicating the message** that dental is just a small piece of the Medicaid pie. Therefore, sufficient funds should be allocated in an amount necessary to develop fees conducive to recruiting providers for a network enabling true access and availability for enrollees.
- **Recognizing the role of the state legislature** to ensure legislators are kept informed about the dental carve-out and any bills/legislation impacting the dental program. The legislature is more likely to be supportive of the state Medicaid agency and its initiatives if that agency responds to any inquiries raised.
- **Building flexibility into the contract** to enable quick resolution of problems. In Tennessee, a "without cause" provision was added to the provider agreements that allowed either party (provider or the DBM) to terminate their relationship with one another WITHOUT CAUSE with 30 days notice. This provision has proven critical in utilization management of the program by the DBM.
- **Establishing a robust credentialing process** that is very tightly constructed to ensure the quality of the dentists participating in the program.
- **Establishing an objective retro-utilization review process** to evaluate the dental provider's treatment practice within a network of individual providers performing similar processes. This would identify those whose treatment utilization pattern deviates from their peers' norm. The process should incorporate basic provider profiling, test edits, and Statistical Process Controls (SPC). If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a dental provider, the DBM is expected to perform a chart audit.

The DBM should also maintain a Peer Review Committee made up of licensed state dentists to review case files generated by the utilization review process. The utilization review process should include various options that safeguard children, improve quality of care, assure fiscal viability of the program, and comport with the program's mission. These options include issuance of corrective action plans, provider education, recoupment of provider payments, or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may also choose to exercise its prerogative to terminate a dental provider with or without cause with thirty days notice.

- **Ensuring an adequate data processing capacity**. States who undertake the carve-out must have an MMIS at an operational level that makes it easy to access utilization data (preferably one that uses a decision support/query based system). If the state's systems are not adequate, then it is critical that the TPA have such a system.

DENTAL CARVE-OUT CASE STUDIES *Virginia*

The Commonwealth of Virginia

On July 1, 2005, Virginia launched its new dental care initiative entitled *Smiles for Children.* In December 2006, the Department of Medical Assistance Services, Virginia Medical Assistance Program (DMAS) prepared a report to the Virginia General Assembly that outlined results of the initiative to date. The report stated that there had been "a major transformation over the last year" with regard to the Medicaid/FAMIS dental program. "The program is making excellent progress toward its goal of increasing the number of dentists in the network and increasing pediatric dental utilization." Here is a snapshot of the results cited in the report.

- 319 new dentists have joined the dental network, representing a 33% increase. There are eight localities that previously had no participating dentists and now have access to dental services.
- Utilization of dental services has increased significantly within the first year of program operations, with over 40,000 additional children receiving dental services.
- Participating dentists report that the new program compares very favorably to commercial dental plans.
- The program is becoming a nationally recognized model for State Medicaid dental programs.

Early Stages and the "Climate for Change" in Virginia

In 1996 DMAS began contracting with Managed Care Organizations to administer the Medicaid benefit package – including dental. DMAS was using an outside vendor to handle preauthorization of Fee-for-Service (FFS) benefits, including some dental benefits.

As in Tennessee, there were certain dynamics in play that led to a dental carve-out in Virginia, most notably, access-to-care issues and poor provider participation. Prior to the implementation of the *Smiles For Children Program*, DMAS administered dental services through two different delivery models. First, about 400,000 children were enrolled in one of the DMAS-contracted MCOs. For MCO enrollees, dental benefits were handled by the MCO or MCO dental subcontractor. Second, about 200,000 children were enrolled in the FFS program, where dental services were handled by DMAS. (Services requiring reauthorization under the FFS program, including dental and orthodontia, were handled by the DMAS FFS prior authorization contractor.)

In 2004, only 23% of all children eligible for DMAS-covered dental services actually received services, and less than 7% of all licensed dentists participated in the program. Virginia dentists cited several issues as reasons for the low participation in the Medicaid and FAMIS programs; low reimbursement, administrative "hassles", MCO concerns (i.e. varying coverage policies/procedures among MCOs and FFS, administrative requirements, and Medicaid clients

transitioning between MCOs and FFS), and patient no-shows. Other complaints included the lack of a dedicated dental customer service call center, patients switching plans, and different/multiple claim submission requirements. After a careful analysis of the issues, DMAS determined that consolidating dental services into a single program was needed to improve provider participation and increase utilization.

The Decision to Carve-out and Administer Under a Unified Dental Administrative Arrangement

In Virginia, there was a consensus that the delivery model which preceded *Smiles For Children* was not working. All agreed access and utilization was stagnant, and the carve-out model was the most viable option for the Commonwealth. Specific groups that favored the carve-out included legislators, advocacy groups, DAC (made up of statewide general and specialty dentists which included minority representation), Virginia Dental Association, Old Dominion Dental Society, and DMAS. The Agency Director of DMAS was "110%" behind the new program and provided unlimited guidance and support. It is important to realize that in Virginia, the program plan incorporated more than just a carve-out. A carve-out implies the services were simply carved-out of the MCO contracts. Importantly, in this instance, dental services for both the MCO and FFS populations were consolidated and administered as an entirely new program by a dental benefits administrator.

Thus in July 2003, collaborative discussions between the DMAS, DAC and the Virginia Dental Association (VDA) led to the recommendation that dental services should be consolidated under a unified dental administrative arrangement. The 2004 Appropriations Act authorized DMAS to officially carve-out dental services and to outsource to an administrative services contractor. The contractor would be selected via RFP.

Process and Sequence Step #1: Identify Interested Parties

The DAC had been up and operating for several years and was thus the natural venue for carveout, RFP and selection process discussions. It was also decided that the DAC's membership should be expanded to achieve better representation of minority and specialist providers, as well as better geographic balance. DAC members were instrumental in researching, writing and reviewing the RFP.

Step #2: Gather RFPs and Determine Scope of Services

Virginia's goal was (and continues to be) to increase pediatric dental utilization through an expansion of dental provider participation. The DAC researched other states such as Tennessee and Alabama. Alabama administered the program in-house while Tennessee submitted for an external dental administrator. Thus, the DAC spent months debating whether the carve-out should be administered in-house by DMAS, or by a vendor specializing in government dental TPA. DMAS reviewed the advantages and disadvantages, obtained information from dental program administrators, consulted with the dental community, and conducted internal analyses.

After months of debate, it was determined that DMAS did not have the internal infrastructure to administer the program. A program administrator would be hired that could offer provider recruitment, an up-to-date claims processing system, customer service, and flexible PA submission options. The collaborative decision (VDA, DMAS and DAC) was to pursue, via an RFP, a dental administrator with the experience, track record, and commitment to achieve access and utilization goals.

Dental Community Provides Input on Services—In order to understand and address provider needs and concerns, a survey was sent to all Virginia-licensed dental providers to find out what it would take to gain their participation in this government dental program. A survey was mailed to all licensed practitioners in Virginia. Of the 5,500 surveys submitted, DMAS collected more than 1,000 responses. Providers stated that the handling of billing, fees, prior authorizations and timeliness of payments were "very important", and would be the keys to attracting provider participation. It also noted that broken appointments and patient non-compliance were of major concern.

Step #3: Determine Financial Model

DMAS recognized that low reimbursement was a major concern. In fact, it was cited as the number one obstacle to successfully implementing the carve-out. In the 2003 Virginia Statewide Dental Summit, it was recommended that the Medicaid reimbursement rate be extended to the 75th percentile of usual and customary charges. The VDA and an advocacy group entitled *Virginians for Improved Access to Dental Care* (VIADC) also lobbied for increased reimbursements.

Step #4: Write the RFP

The RFP was a collaborative effort of DAC and DMAS. The actual writing, approval and procurement process took approximately 12 months. In April 2005 the RFP was awarded to Doral Dental USA, LLC, the largest multi-state dental administrator in the nation specializing in government dental programs.

Step #5: Implementation

Virginia set forth to implement the carve-out by moving on four initiatives:

1. Creating the DMAS Dental Implementation Advisory Group (DIAG) to coordinate the project plan with Doral;
2. Promoting and conducting two sets (before and after implementation) of meetings among the DMAS Director, VDA and ODDS representatives with various dental associations across the state to discuss the program changes and enhancements, and to encourage support and participation;
3. Naming the new program *Smiles for Children,* and launching it with a new logo and registered service mark;
4. Finalizing reimbursement levels by increasing rates by 28% on July 1, 2005, and increasing them an additional 2% for specialty services on May 1, 2006. It was a fee-for-service, ASO program with limited medically necessary oral surgery services for adults. Many principles of a managed care product were adopted such as credentialing, network development, member outreach, quality improvement, and coordination of care. The carve-out also ensured multiple linkages between dental and other services such as transportation, surgical services and member outreach initiatives.

The Keys to Success in Virginia

The keys to success were as follows:

- **Establishing Dental Advisory Committee** to lead policy development and gain consensus.
- **Establishing a Dental Implementation Advisory Group (DIAG)** to tackle the issues and obstacles to operating the program on a daily, monthly and yearly basis.
- **Working collaboratively** with the dental associations (VDA and ODDA).
- **Utilizing the DMAS Agency Director, VDA representatives and DAC members to market the program** at all local dental association meetings. Representatives visited all local dental associations, co-authored letters with the associations, and promoted the carve-out in all possible venues.
- **Streamlining the program** as much as possible. Here are specific examples:
  - Providers cited "administrative burden" as one of their top reasons for nonparticipation. DMAS looked at criteria and removed the PA requirement from over 80 dental procedures. DMAS also decided to accept any ADA dental claim and/or PA request form that the provider uses.
  - Providers mentioned poor reimbursement as a prime reason for non-participation. DMAS researched codes and allotted reimbursement increases wisely. For example, they applied increased reimbursements to codes most out-of-line relative to dentist charges. In addition, DMAS also applied reimbursement increases consistent with the providers that were most needed and hardest to recruit. For example, oral surgery reimbursement was out-of-line, which was obvious due to a major shortage of oral surgery providers.

DENTAL CARVE-OUT CASE STUDIES *Illinois*

The State of Illinois

Making the decision to move dental services to the carve-out model does not automatically translate into a better dental program. It is vital that the right TPA is engaged and the correct contract model is deployed.

Consider the experience of the State of Illinois. Although the State had been operating as a carve-out for many years, it really did not enjoy true success until it changed vendors and switched from a risk-based contract to an ASO contract. Under the risk agreement, the State contracted with a commercial dental administrator. As is the case with most risk arrangements, the vendor's profits were maximized when utilization was low or held in check. Thus, for many years the state's goal of increasing access to care was at odds with the vendor's goal of keeping utilization in check. In other words, incentives were misaligned. The State was under pressure to increase access to care and beneficiary utilization; the vendor was under pressure to maintain profits. The results in Illinois were not hard to predict: the State continued to experience low access and utilization, provider participation was dismal, and the vendor realized hefty profits.

In 1999, the State decided to put its dental program out to bid and switch from a risk contract to an ASO contract. The winning vendor would be paid on a per member per month basis, and the State would maintain the financial risk. After a competitive bidding process, the State awarded the ASO contract to Doral. With incentives now properly aligned, Doral was able to save the State over $5 million annually in administrative costs that were previously earmarked as profit for the prior administrator. Likewise, access to care increased by 37 percent within one year. Meanwhile, provider satisfaction grew and the network doubled. Here are highlights of what can happen when the right vendor is operating under the right contract and incentives are aligned.

HFS Service Highlights Cost Savings: Doral saved the Illinois Department of Public Aid (IDPA) (as it was in 2000) over $5 million in administrative services the first year versus the prior vendor. In addition, Doral returned an additional $1 million in administrative fees to the IDPA due to administrative efficiencies.

Claims Processing: Doral processed 99.9% of the 1,305,084 unique claims bills within 30 days. Illinois providers utilized an electronic claims processing option at a significantly higher rate.

Member Service Highlights HEDIS Scores: The percentages of Illinois Medicaid-enrolled children who made a visit to the dentist in 1998 and 1999 were 20.2% and 22.8%, respectively. In 2000, one year after Doral began program administration, the number increased to 34%. The 2006 HEDIS scores show access is above 40%.

Surveys and Satisfaction: In 2006, Doral staff made 4,649 calls to successfully complete 302 surveys. Results show that members who rated their experience as "very good" or "good" was at nearly 90%.

Provider Service Highlights Network Stats: Doral facilitates and maintains contracts with 1,967 unique dental practitioners at more than 3,000 access points. When Doral first began administrating the Illinois contract, the number of providers treating patients was at 869.

Communications and Education: Doral mails the Illinois Provider newsletter The Doral Digest quarterly, and the *Dental Office Reference Manual* annually to all provider locations. In addition, Doral conducts six provider seminars/workshops per year. Doral also provides ongoing provider education and training through mailings, site visits, and via telephonic outreach. Topics of training include electronic claims filing, billing and benefit refreshers, and enrollment processes.

Satisfaction Surveys: Provider satisfaction surveys are conducted annually. In 2006, there were 2,987 providers included in the mailing, and 456 surveys were returned to Doral. Results indicate that overall satisfaction is at 3.41, on a scale of 1 to 5, with 5 being best.

BEST PRACTICES AND CONCLUSIONS

In an effort to encourage dentists and dental specialists to participate at a level sufficient to make dental services accessible to all enrollees, many state dental administrators are exploring the feasibility of a dental carve-out. The chart below summarizes some of the advantages and disadvantages between a medical managed-care model versus a dental carve-out.

Managed Care Carve-out

Managed Care	Carve-out
Multiple vendors administering dental benefits	Single vendor administering dental benefits
Cumbersome credentialing	Streamlined credentialing
Authorization requirements dependent upon specific plan	One set of authorization requirements
Limited local representation on program policy decision	State-based Peer Review and State Agency Advisory Committees
Member transfer between plans can disrupt care and reimbursement	All enrollees in one program
Higher administrative costs	Lower administrative costs

As the case studies demonstrate, there are many unique dynamics that must be channeled appropriately in order to actually attain carve-out status. Through research, experience and drawing from a multitude of published studies and reports*, it is recommended that that the *Best Practices* found on the next pages be employed when pursing a statewide dental carve-out.

*From the Oral Healthcare Access for the Underserved and Uninsured in Miami-Dade County Report in February 2005

Best Practice	Description
Assess oral health status of state	It may be necessary to gain an accurate picture of how well oral health services are being accessed in the state. It is suggested that an oral health surveillance system is established to identify, investigate and monitor oral health programs. Key questions to be answered include:
	Are there issues with the delivery of oral health in the state?
	What are the current provider participation and member utilization statistics?
	Are these numbers acceptable? If so, by whom? If not, by whom?
	Is there pending or actual mandates (via litigation or legislation) to force change on how oral health is delivered to the underserved population?
Develop dental policy through a collaborative forum	As the case studies clearly indicated, involving the right people, and gaining consensus and buy-in, is fundamental to success. There are three facets to this best practice:
	1. Establish well-recognized leadership to address oral health problems. This can be accomplished by the creation of a strong oral health unit/team within the health agency such as a Dental Advisory Committee.

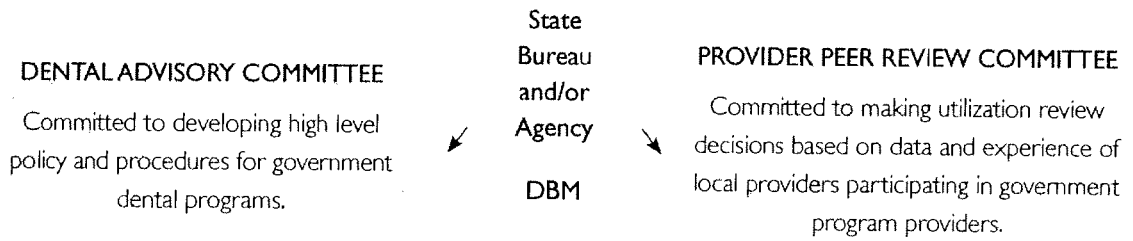
Best Practice	Description
Develop dental policy through a collaborative forum (continued)	2. Identify groups, individuals or other interested parties that support oral health and are advocates for improvement. Examples here would include the local, regional and state dental associations, advocates, and other members of the Health Department or relevant agencies.
	3. Mobilize community partnerships between and among policy makers, groups, and the public to identify, support and implement solutions to oral health problems. Again, advisory committees that meet consistently appear to be an excellent forum to achieve this goal and move people toward action.
	As the carve-out progresses, committees can be formed to focus on different elements of the program. **Please see the next section for more detail.**
Inform, educate and empower	Participants should be educated on oral health problems and solutions. It is particularly important to assure key players that the carve-out and selected TPA has the **capacity and expertise** to effectively address and improve oral health service.
Dental Associations and Societies	Gaining buy-in from local/state dental associations is crucial for program success. It is important to note that some states have several dental societies that need to be cultivated. For example, in Virginia, the Old Dominion Dental Society is comprised of many influential minority dentists. In Tennessee, there is Pan TDA, dedicated to serving minority dentists. Both of these groups were vital to their respective state's program.
Select a Qualified TPA via RFP	It is recommended that a state issues an RFP to find the best TPA, with the appropriate expertise. It is vital to allow enough time for the formulation of the RFP – 12 to 18 months is the average time frame to write, review and approve the procurement.

Best Practice	Description
Solicit Input from Providers	Providers must be consulted on covered benefits, and solving issues with participation. The three top reasons for not participating in government dental programs include: low reimbursements, administrative hassles, and missed appointments by members. It is very important that providers are asked for ideas on how to solve these issues and that their suggestions be incorporated into the RFP.
Collaborate with Selected TPA on Implementation Schedule	Implementing the carve-out will require a detailed plan and schedule. It is important that the selected TPA and the state agency collaborate on the best way to roll out the carve-out.
Publish Updates and Results on the Effectiveness of the Carve-out	Establish a venue by which updates and reports on the carve-out can be made public. This keeps all interested parties up to speed on progress, issues and successes.
Fee Schedule	Reimbursement schedules and fees do not have to be established prior to issuing the RFP. In both Tennessee and Virginia, this issue was not settled until **after** the RFP was awarded. In both cases the final fee schedule was determined just prior to the launch dates of the programs.

Advisory and Peer Review Committees:
Vital ways Providers May Participate in Government Dental Programs

Another key best practice of a successful government dental program is the recruitment and retention of providers. Research has shown that providers want programs to offer streamlined administration, increased accountability, improved technology, and more sophisticated reporting. Providers that participate in developing the solutions to achieve these objectives have greater ownership of the program and serve as a positive recruitment source.

States and DBMs that offer venues for provider participation are more likely to succeed over those who do not. It is recommended that two important committees for provider participation be established – The Advisory Committee and the Peer Review Committee. Through these committees, providers meet consistently to provide valuable contributions to overall administration, as well as deal with issues such as UM, quality, peer review, credentialing, profiling, pre-authorizations, benefit structures and more. It is vital that committee members have access to important data to help guide decisions.



The Advisory Committee

The Advisory Committee offers providers the opportunity for program recommendations at the highest level. It should be comprised of dental experts from various organizations throughout the state, as well as dentists from assorted geographic regions and specialties. This group focuses on big issues and helps to formulate the policies and procedures necessary to implement and run the state dental program.

Peer Review Committee

The Peer Review Committee is comprised of state-licensed practicing and participating network providers. An essential requirement for membership on this committee is that the dentist must be an active government dental provider who understands the benefits, limitations and fiscal responsibilities involved in the utilization of the limited funds. The committee reviews and recommends appropriate remedial action for any participating provider who has delivered poor quality of care, and/or manifested fraud and abuse. The committee coordinates with the DBM and the state regarding imposition of sanctions against a participating provider, including termination. This structure strengthens and builds consensus among the state, DBM and provider communities.

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Strides in Dental Access for Low-Income CHILDREN

LESSONS LEARNED FROM SIX STATES WITH MAJOR DENTAL-MEDICAID REFORMS

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INTRODUCTION

The February 2007 death of a Maryland child as a result of an infection that started with an abscessed tooth has renewed interest among policymakers, the press, the healthcare professions, and the public in assuring access to basic dental care for poor children. Twelve-year-old Deamonte Driver died after an infection from a molar spread to his brain. At the time he fell ill, his family's Medicaid coverage had lapsed. Even on the state plan, his mother said, her family lacked regular dental care and she had great difficulty finding a dentist.

The 25 million children and adolescents in Medicaid are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment benefit (EPSDT)[1] enacted by Congress in 1967, and strengthened in 1987. And yet, less than one in three child Medicaid beneficiaries receives any dental services in a given year. Utilization varies by age and type of services (see Figure 1). Nationally, utilization averaged only 32.4% for any dental visit in FY 2005 (the most recent year for which data are available), 27.6% for preventive visits, and 16.3% for reparative visits — despite federal law requiring that access be equivalent for Medicaid beneficiaries and others in the same geographic areas. Translating coverage into reliable access to dental care for low-income children remains a national challenge.

Organized dentistry has long advocated higher reimbursement rates in response to insufficient access rates, and no one could reasonably argue with the premise. Higher reimbursement rates could indeed contribute to the ultimate expansion of Medicaid provider networks. Bigger networks, however, do not guarantee higher utilization. More access points do not necessarily translate into greater member access, since members must first understand the critical importance of seeking preventive dental care, and unfortunately many do not. And even presented with competitive fee schedules, many dentists are reluctant to participate in government sponsored programs due to concerns about burdensome eligibility determinations, sluggish claims processing, broken appointments, and a host of other administrative obstacles.

A 2005 American Dental Association compendium[2], which cites positive results in a subset of state Medicaid programs, offers evidence that effective approaches to increased utilization exist. More extensive summaries[3] of selected state reports from this compendium were developed and updated by Donald Schneider, DDS MPH, with the support of Greater Hartford Legal Aid and the Children's Dental Health Project, a non-profit Washington DC-based organization advancing policies to increase children's access to oral health. These provide a basis of analysis for this paper. Conclusions drawn from these summaries are meant to assist state Medicaid directors seeking innovative solutions to improved dental access.

This paper illustrates approaches undertaken in six states recognized for increasing the number of enrolled children who obtain a dental visit — and from baselines considered extremely inadequate prior to reform. It focuses on five factors that influenced this key performance measurement, and they are:

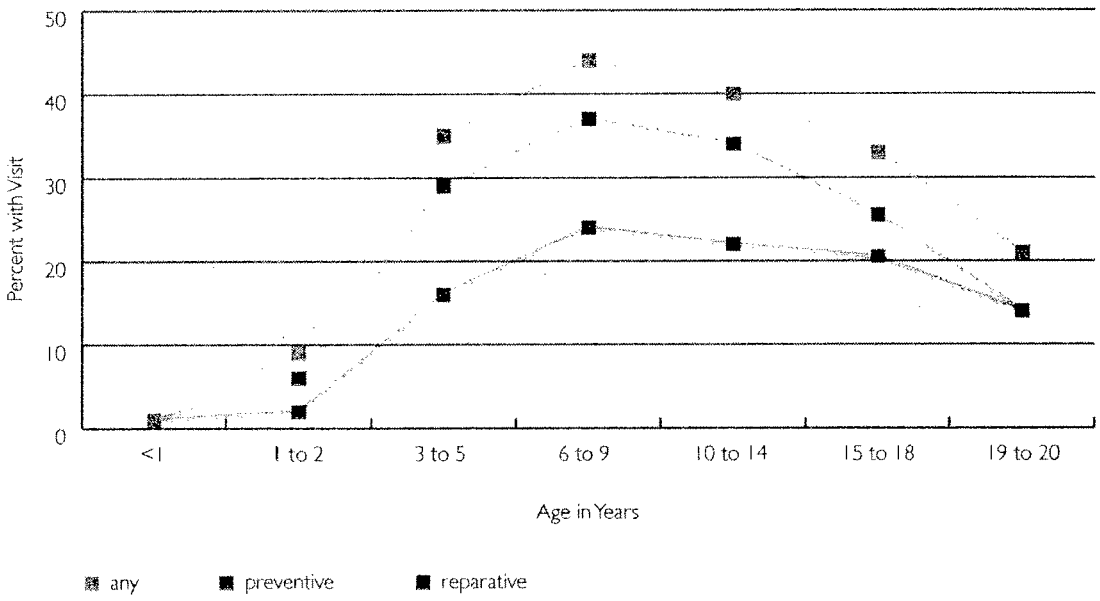
- Support of organized dentistry
- Competitive provider reimbursement rates
- Administrative support for providers
- Member outreach / education
- Dedicated provider recruitment

Each of these six state reports exhibits one overriding theme: increasing access posed a multifaceted problem requiring an equally multifaceted solution.

This paper is a collaborative effort between Doral Dental, the nation's largest administrator of government-sponsored dental programs, and the Children's Dental Health Project. All content, comments and conclusions in this paper are those of Doral.

FIGURE 1

% US Children in Medicaid with Dental Visits FY 2003 by Age



[1] For more information on ESPDT see http://www.hrsa.gov/espdt/

[2] State Innovations to Improve Access to Oral Health Care for Low-income Children: A Compendium. Chicago, American Dental Association. 2005. Available online at: http://www.prnewswire.com/mnr/ada/20973/#

[3] Dr. Schneider's summaries can be accessed on the CDHP web site: http://www.cdhp.org

CASE STUDY *South Carolina*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☑ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

In South Carolina's Medicaid program, dental care is delivered through a traditional fee-for-service mechanism and is administered by the South Carolina Department of Health and Human Services (DHHS). In 1998–99, the DHHS and the state Department of Health and Environmental Control (DHEC), along with the South Carolina Dental Association, began collaborating with other private and public partners to address the state's oral health access concerns.

In 1998, the DHHS contracted with an independent company to develop an analysis of implications of increasing dental reimbursement to the 75th percentile of commercial fees in the state. Based on that data, in 1999 the state legislature appropriated funds, effective January 2000, to increase fees to the 75th percentile of private-sector fees, thereby signaling a major change in the Medicaid dental program. Once the fee increase was implemented, the South Carolina Dental Association began a recruitment campaign to increase dentist participation in the Medicaid program, directly contacting individual licensed dentists.

From 1999-2001, DHHS adopted additional reforms designed to reduce administrative barriers and increase provider participation in Medicaid, including initiatives to:

- Streamline the prior authorization process
- Reimburse for additional time needed to treat children with special health care needs
- Use standardized dental procedure codes and claim forms
- Establish an intervention process to reduce broken patient appointments
- Introduce electronic options to reduce billing errors and speed claims processing

Results

From January 1998 through December 1999, there was a downward trend in the number (decline of 16,133) and percent (decline of 3.6 percent) of Medicaid children receiving any dental service. By the end of 2000—12

months after the change in Medicaid reimbursement—the trend had reversed, with 21,689 (4.3 percent) additional children receiving any dental service. Researchers reported that the number of services provided per enrollee was significantly greater in 2000 than would have been expected, given the declining trends for this statistic in 1998 and 1999. Additionally, the researchers noted that the percent of dentists who provided at least 10 Medicaid services per quarter stood at 26.1 percent in 1998, dropped to 25.8 percent in 1999, but then increased to 34 percent in 2000.

The report notes that the DHHS reforms encouraged about 160 dentists who had not offered Medicaid dental services prior to January 2000 to enroll as providers. The change in reimbursement was considered the primary reason for the reforms' success, although other aspects of the reform also contributed to it, according to interviews of South Carolina dentists conducted by the researchers. The study concluded that the state's "dental Medicaid reform of the year 2000 had an overwhelmingly positive effect on the accessibility of dental care to children enrolled in Medicaid." Using a different data set, another source confirmed that the number of Medicaid-participating dentists increased after the January 2000 reform—from 619 dentists in 1999 to 886 by June 2001. Provider enrollment continued climbing in most ensuing years, reaching 1197 dentists in FY 2006. In addition, the percent of enrolled children receiving any dental service increased in each year since 1999, when utilization stood at 26.1 percent. In FY 2005, utilization reached 38.5 percent.

Since the major fee increase in 2000, there have been no further reimbursement increases, and a rate decrease occurred for some non-core services in 2001. Without additional rate enhancements that compensate for the annual increase in the dental Consumer Price Index (about 4.5 percent per year), reimbursement levels achieved by a single large rate increase will, over time, no longer reflect dentists' fees in the commercial marketplace. A comparison of 2004 Medicaid dental fees with dental claims submitted that year to commercial payers in the state indicated that the "value" of Medicaid fees for 9 of 13 pediatric dental procedures studied had declined from January 2000 levels to the point where less than 40 percent of the state's dentists would view fees for those 9 Medicaid procedures as equal to or higher than their usual charges.

CASE STUDY *Indiana*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☐ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

In the late 1990s, at about the same time that Indiana was expanding Medicaid eligibility for families and aggressively using outreach to enroll children in Hoosier Healthwise (Indiana's SCHIP), many dentists were disenrolling from Medicaid participation. By 1997, only 751 dentists were still participating, compared to 1,500 in 1993, just prior to major reductions in provider reimbursement that occurred in January 1994.

To address continuing problems with dentist participation, the Medicaid agency—in close consultation with the Indiana Dental Association—implemented multiple changes in its dental program administration. These included changing reimbursement from a capitation-based system to fee-for-service (1996), eliminating prior authorization requirements for all dental services (1997), and entirely carving-out dental services from risk-based managed care (August 1998). Another critical change occurred in May 1998, when the state introduced marketplace-level dental reimbursement equivalent to the 75th percentile of rates reported by the 1995 ADA survey of dental fees for the East North Central Region.

Additional changes occurred in 2000, when the state's Medicaid fiscal agent, Electronic Data Systems (EDS), implemented a dental provider recruitment effort. EDS contacted dentists who were enrolled in Medicaid but not participating, as well as dentists who were licensed but not registered as Medicaid providers. To address dentist dissatisfaction, the Medicaid agency convened a Dental Advisory Panel of practicing dentists to provide guidance on policy decisions, review Medicaid bulletins, and make recommendations regarding service limitations needed to cope with the state's budget deficit.

Results

A group of investigators studied whether the major 1998 administrative changes, including higher fee schedules for dental services in the Indiana dental Medicaid program (and Hoosier Healthwise), were associated with improved dentist participation and utilization of dental services by children. They found that the number of dentists providing care for Medicaid-enrolled children increased from 770 in FY 1997 to 1,096 in FY 2000. The number of Medicaid-enrolled children with any dental visit increased substantially from 68,717 (18 percent) to 147,878 (32 percent) by FY 2000. Preliminary 2005 data indicate that utilization increased to almost 40 percent, but enrollment had declined to 589,857. Investigators also concluded "that the increase in fees and changes in administration of the Indiana dental Medicaid program were positively associated with improved dentist participation and children's use of dental services."

Without additional rate enhancements that compensate for the annual increase in the dental Consumer Price Index (about 4.5 percent per year), reimbursement levels achieved by a single large rate increase will, over time, no longer reflect dentists' fees in the commercial marketplace. Indeed, a comparison of 2004 Medicaid dental fees with dental claims submitted that year to commercial payers in Indiana indicated that the "value" of Medicaid reimbursement had declined from 1998 levels to the point where less than 25 percent of the state's dentists would view Medicaid reimbursement as equal to or higher than their usual fees for 11 of the 15 pediatric dental procedures studied.

CASE STUDY *Michigan*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☐ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

In 1997–98, the Michigan Department of Community Health (MDCH), which administers Michigan's Medicaid program and SCHIP (MIChild), convened a Task Force to evaluate long-standing problems in Medicaid's dental program. The Task Force proposed budgetary increases, new administrative options, and a new delivery system.

With political support from a broad array of stakeholders, including the Michigan Primary Care Association, University of Michigan Dental School and the Michigan Dental Association, the state legislature appropriated $10.9 million for FY 2000 to expand access to oral health services for Medicaid beneficiaries, focusing on rural areas. About half the appropriation was used to create a new Medicaid dental service delivery model, Healthy Kids Dental (HKD).

Prior to HKD, dentists provided Medicaid dental services on a fee-for-service basis outside of managed care arrangements that deliver medical care for most Medicaid clients. HKD, implemented in May 2000, was based on the dental component in Michigan's State Children's Health Insurance Program (MIChild), which began in 1998 and, after its first year of operation, had demonstrated dental access approaching that available for privately insured children. Like MIChild, HKD functions similar to commercial dental insurance.

In establishing HKD as a demonstration within specific counties, the MDCH contracted with a dental insurance carrier, Delta Dental Plan of Michigan—a nonprofit service corporation that administers group dental benefits for more than 3 million people—to administer the Medicaid dental benefit in accordance with its own standard procedures, claim form, payment levels and mechanisms. In May 2000, the state converted the traditional dental coverage of all Medicaid-enrolled children in 22 of Michigan's 83 counties to HKD. By October 2000, as a result of the early success of HKD, the project was expanded to 15 more counties, bringing to 37 the number of counties participating.

HKD and MIChild operate under a commercially competitive fee schedule which provides significantly higher reimbursement than was available to Medicaid providers in non-HKD counties. The program operates in a total of 59 counties, serving more than 200,000 children.

Results

An assessment of the first 12 months of HKD found:

- Substantially more Medicaid beneficiaries were receiving dental care under the project, with dental visits increasing from 18 percent to 44 percent, compared to the traditional fee-for-service Medicaid program
- More dentists were participating in HKD and providing care (up 300 percent), compared to the traditional fee-for-service Medicaid program
- More children were receiving needed dental restorative and reparative care, and children were more likely to begin a pattern of regular recall for routine preventive care, compared with Medicaid-enrolled children the previous year
- HKD had higher costs per user and per enrollee due to the higher reimbursement rates and, to a lesser extent, more children receiving care
- More children were receiving care in their county of residence, with the average travel distance to dental care cut by more than half, to 12.1 miles—virtually identical to the mean 12.2 miles traveled by privately insured children

During each succeeding year of HKD operation, dental utilization continued to increase. Children enrolled in the fourth year of the HKD achieved an average utilization rate of 58.6 percent (using different calculation methods) compared to the average use rate of 79.4 percent for children enrolled in the private sector Delta Dental program, and to 38.9 percent for traditional Medicaid, as measured prior to the program's inception.

CASE STUDY *Delaware*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☐ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

The Delaware Medicaid program is administered directly by the state agency, the Division of Medicaid & Medical Assistance within the Department of Health and Human Services (DHHS). From the 1970s until 1998, the dental program functioned almost exclusively through state-operated, school-linked public health clinics that employed a small number of full-time and contracted (part-time) dentists.

In 1997, the Dental Health Administrative and Consulting Service (a private consulting entity commissioned by the DHHS) released a report on dental care access for Medicaid beneficiaries and others who receive state services. The report's recommendations contributed to the subsequent appointment of a state dental director, passage of a statewide mandatory fluoridation law, and implementation of a major change in how the Medicaid dental program operates. Effective January 1, 1998, Medicaid began reimbursing dentists on a fee-for-services basis at 85 percent of each dentist's submitted charges. Additionally, Delaware implemented a number of Medicaid administrative changes aimed at enhancing participation of private dentists without producing undue administrative burden. These changes included:

- Provider enrollment forms capable of linking with clearinghouses and billing vendors
- Electronic claims processing
- Placing limits on and simplifying prior authorization, and facilitating dentists' determination of patient eligibility for Medicaid services through multiple web-based, electronic, and telephonic verification systems
- State fiscal agent staff visits to dental offices to assist in enrolling providers, and to resolve billing and eligibility verification problems
- Posting a dental provider manual on the Internet

To further stimulate dentist participation, the Medicaid program initiated efforts—in collaboration with the Delaware State Dental Society—to recruit dentists through representation at Dental Society conferences, presentations at monthly Society meetings, and meetings with the Society's Executive Committee.

Results

Since the program changes in January 1998, the number of dentists participating in Medicaid increased initially from 1 to 75. As of the end of calendar year 2006, 160 dentists were enrolled in the program.

The number of children treated in private dental offices has increased from 2,000 in 1998 to approximately 11,686 in FY 2003. As of August 2006, out of about 85,000 children enrolled in Medicaid for any time during the year, 25,520 children, or about 30 percent of the enrolled Medicaid child population, received at least one dental service.

Recently, the state of Delaware has requested approval to add dental benefits to its SCHIP plan. In addition to approximately 75,000 children who are on Medicaid in any given month, another 5,000 SCHIP children will become eligible for dental care. The addition of dental benefits to SCHIP has received strong support from the dental community, in contrast to its early reluctance to become involved with Medicaid.

Reimbursement no longer seems to be a barrier to provider enrollment. Barriers relate to participating in a government program, and to concerns about missed patient appointments.

CASE STUDY *Tennessee*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☑ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

Prior to 2002, TennCare (Tennessee's Medicaid program) MCOs either operated their own dental networks or subcontracted their dental program to Doral Dental of Tennessee, LLC, which engaged a network of private dentists. A pivotal point for children's oral health in Tennessee occurred in May 2001, when Tennessee participated in a National Governors Association Oral Health Policy Academy. Following this technical assistance convocation, separate initiatives of key stakeholder groups such as TennCare, Doral Dental, the Tennessee Dental Association (TDA), and the Tennessee Department of Health (DOH) were combined in a collaborative effort to develop a more comprehensive children's oral health strategy. The strategy called for a public health component, a dentist recruitment strategy and removal (carve-out) of the TennCare dental benefit from medical MCOs. Effective October 2002, the dental benefit was carved out from other Medicaid managed care services, funding was allocated, and program administration was awarded to a single dental benefit manager (DBM) following a competitive bid process. The TDA immediately began a recruitment initiative announcing these TennCare dental program changes.

Since October 2002, dental services statewide have functioned under one DBM, Doral Dental, using a single set of rules, a single claims processor, and a single organization responsible for contract deliverables. Under the contract, the DBM must:

- Maintain and manage an adequate dental provider network
- Process and make claims payment
- Manage data
- Provide beneficiary outreach and education
- Administrate case management (e.g., hotline and referrals)
- Achieve performance requirements spelled out in the contract, including utilization review, quality improvement, provider network standards, and prompt payment

Dentists signed a single provider agreement with Doral, were subjected to a single credentialing process, and used one maximum allowable fee schedule. Electronic claims were accepted and their submission was the preferred billing method. Dentists wishing to contract for Medicaid could participate at any level they chose. Electronic

beneficiary enrollment verification was provided. Doral facilitated securing appointments with network dentists on behalf of the MCO primary care provider or the parent.

As part of its contract with Tennessee, the DBM was responsible for outreach activities to educate enrollees and increase member participation. Doral participated in a Colgate-Palmolive initiative in which dentists volunteered their time to provide free dental screenings and referral for children at community-based events and through mobile dental clinics. A partnership between the Bureau of TennCare and the Tennessee Department of Health resulted in ongoing provision of statewide oral disease prevention services primarily targeted at low-income public elementary school children. The variety of DBM activities reported to TennCare included dental screening, referral, follow-up, sealant application, oral health education and TennCare outreach.

Before the dental program carve-out, each TennCare MCO (or its dental subcontractor) negotiated dental reimbursement rates individually with contracted dentists and fees were a private, contractual matter. Dentists were paid on average about 40 percent of their cost for each dental procedure. Effective October 1, 2002, dentists were reimbursed on a fee-for-service basis at the lesser of billed charges or the 75th percentile of the fees published in the 1999 American Dental Association (ADA) Survey of Fees for the East South Central Region.

Results

Since inception of the dental carve-out in 2002, the statewide dental provider network has grown by 112 per cent—from 386 to 817 contracted dentists—and continues to expand. During the same period, the number of participating providers in rural areas has increased by 118 percent—from 252 at the outset of the program to 549 currently. The general dental provider network is comprised of approximately 634 dentists, including 66 pediatric dentists.

In FY 2002, prior to the dental carve-out, 26.1 percent of eligible TennCare children received any dental service. In FY 2003, the first full year after the carve-out, utilization had increased to 31.9 percent and continued improving so that, by the end of FY 2005, 37.4 percent of eligible children had received at least one dental service. Using an alternate method of calculating utilization (in accordance with the specific court-ordered instructions that excludes very young children) TennCare reported a dental "screening" percentage of 35.7 percent in FY 2002, and 52.8 percent by the close of FY 2005.

CASE STUDY *Virginia*

Factors that contributed to a rise in access rates:

- ☑ Support of organized dentistry
- ☑ Competitive provider reimbursement rates
- ☑ Administrative support for providers
- ☑ Member outreach/education
- ☑ Dedicated provider recruitment

Historical Context

Since 1995, Virginia's Medicaid and SCHIP dental programs were administered by the Virginia Department of Medical Assistance Services (DMAS) in coordination with MCOs, or through a primary care case management (PCCM) program. Under the managed care programs, dental services were provided either through the MCO's own network of dentists or via an MCO subcontract with a dental vendor. Most MCOs or their vendors reimbursed dentists on a fee-for-service basis, although some MCOs used a global budgeting concept whereby dentists received a fee-for-service, with a pool of funds withheld each month for distribution based on overall dental utilization.

In 1997, concerned about low utilization of dental services in Medicaid, the Virginia General Assembly asked that a study be conducted to explain access problems. The study described reasons for dentists' nonparticipation in the Medicaid program. In 1998, the General Assembly issued a directive requiring the Medicaid agency to continue working with representatives of the dental community on access issues and report annually on efforts to expand dental services. In response to this directive, the Medicaid agency convened a Dental Advisory Committee to provide guidance on dental coverage and access issues.

By the summer of 2000, a coalition, Virginians for Improved Access to Dental Care (VIADC), had been formed to address dental access concerns. Coalition partners include DMAS, the Virginia Dental Association, Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Commonwealth University's School of Dentistry, the Division of Dental Health of the Virginia Department of Health (VDH), and other stakeholder organizations. In late 2000, several members of the coalition participated in a National Governors Association Oral Health Policy Academy to begin work on an oral health action plan for the state. Further work on the plan occurred in 2003 when VIADC conducted a dental summit, and also in 2005 during participation by DMAS and VIADC members at an Oral Health Purchasing Institute convened by the Center for Health Care Strategies.

A prescription for major change occurred in 2004 when the Virginia General Assembly approved legislation to carve out dental services from managed care in both the Medicaid program and SCHIP. The Assembly included an

unprecedented 30 percent increase in funds for enhancement of dental fees. Based on the positive experience of other states that use a dental vendor to service dental networks, the DMAS, in concert with the Dental Advisory Committee (DAC), agreed to contract administration of the dental program through a procurement process. In July 2005 a statewide fee-for-service dental program, "Smiles for Children," was implemented for both Medicaid and SCHIP using a single dental vendor, Doral Dental. This administrative change was designed to:

- Create a dedicated call center
- Offer more flexible billing and prompt provider payment
- Streamline prior authorization processes
- Simplify provider credentialing
- Implement a broken appointment reduction initiative

Critically, the dental fee schedule also was increased by 28 percent overall, with an additional two percent increase, effective May 2006, targeted toward some endodontic, oral surgery and conscious sedation services, as determined with the advice of DAC.

Results

During the first year of the new program—from July 1, 2005 through June 30, 2006—an additional 190 new dentists were credentialed to provide services in the Medicaid program and SCHIP, representing a network increase of more than 30 percent. Approximately 25 percent of licensed Virginia dentists currently are participating in Smiles for Children. The percentage of network providers who are submitting claims for rendered services has increased from 58 percent (528 providers) to 78 percent (665 providers).

As a result of the new program and the provider/member outreach efforts, there has been a significant increase in pediatric utilization of dental services. The percentage of children ages 0-20 receiving dental services has increased from 24 percent in FY 2005 to 29 percent in FY 2006, a 21 percent increase. Similarly, for children ages 3-20, utilization of dental services has increased from 29 percent in FY 2005 to 36 percent in FY 2006, a 24 percent increase.

DISCUSSION

While results in each of these six states represent a remarkable improvement in dental utilization, ultimate accomplishments remain modest relative to utilization rates by children enrolled in employer-sponsored dental coverage. Overall in 2004, over half (58%) of children with private dental coverage obtained at least one dental visit in the year, while a third (34%) of children covered by Medicaid and SCHIP did so, and only a quarter (28%) of children who lack any dental coverage had a visit. Across the five 'statewide' examples provided, average utilization increased a significant 68%, from 19% to 32%, yet these successes only brought these poorly performing states up to par.

Clearly, much work was involved in correcting sub-par performance, and yet much more needs to be done in order to meet federal requirements of "equal access" between Medicaid beneficiaries and their community peers. Despite the encouraging results reported here, additional reforms will require a better understanding of the dynamics of the dental delivery system, including factors that interfere with Medicaid families utilizing dental services when available, and factors that determine dentists' willingness to care for children in Medicaid. Commonly cited parental factors include transportation and translation difficulties, cultural dislocation, low valuation for oral health, and competing interests. Commonly cited provider factors include missed appointments, competing interests and opportunities, prejudice, and discomfort treating children—particularly young children with extensive dental disease.

Further efforts to substantially increase access will require major structural reforms that include incentivizing dentists to practice in underserved areas, strengthening the dental safety net, identifying appropriate roles for mid-level providers, coordinating care between medical and dental caregivers, expanding school-based preventive and therapeutic services, holding states responsible and accountable for their dental Medicaid performance, and building strong constituencies that promote dental reform.

Each state represented in this paper chose to reexamine its Medicaid delivery system in the face of declining beneficiary access, and as noted in the individual studies, each displayed most or all of the five factors defined as influencing higher access rates. The overall impact of these factors is summarized below.

Support of Organized Dentistry

In each state studied, organized dentistry participated as a change agent in the development of increased beneficiary access, in almost every case serving as a consultant in planning stages, and in some cases carrying the ball through program implementation and beyond. In Delaware, the State Dental Society recruited dentists through ongoing meetings and mailings. In South Carolina, the Dental Association, after participating for years in the formation of a comprehensive go-forward strategy, actively participated in recruitment efforts.

States offering ready venues for provider input increase their prospects of success.

Competitive Reimbursement Rates

Raising reimbursement rates to market-competitive levels was key to provider participation in each state. Observation across states where fee increases resulted in marked improvements in dentist engagement—and others where it did not—suggest that there may be two distinct reimbursement thresholds that govern dentists' participation in Medicaid.

The first threshold is the level of reimbursement at which dentists believe that their costs are being met. Given that dentists' overhead rates average approximately 60%, any state Medicaid fee schedule that generates reimbursements below 60% of customary charges may be regarded by dentists as so low as to cost them money when caring for Medicaid beneficiaries.

The second threshold is the rate at which dentists believe that they have accepted a significant discount on their fees as a public service to caring for the underserved. Judging from dentists' response to fee changes in states, this appears to range from a 20-30% discount. Those few states that have predicated their Medicaid fee levels on the 75th percentile—the rate charged by 75% of the state's dentists or a proxy for the state's dentists (e.g. regional ADA fees)—have shown the greatest success in attracting dentists' participation in Medicaid. Nonetheless, even at these truly 'market rates,' the percentage of dentists who elect to participate in Medicaid remains modest.

In certain states, higher reimbursement rates produced dramatic results, and rather quickly. For example, in Delaware, the number of participating dentists grew from 1 to 75 immediately following the program's inception. In Virginia, provider enrollment increased 30 percent in the first year.

Especially in states like Virginia, where Medicaid reimbursement rates were prohibitively lower than commercial rates, increased provider participation occurred rather swiftly. In 2004, a study comparing Virginia's Medicaid fee-for-service dental fees with dental claims submitted to commercial payers yielded telling results: no more than 3 percent of dentists would view Medicaid reimbursement levels to be equivalent to, or higher than their usual fees for 14 of the 15 pediatric dental procedures studied.

However, it's important to note that in the establishment of Virginia's provider enrollment increase, other factors were at play. Virginia elected to carve out dental services from managed care in both the Medicaid program and SCHIP, and deliver them through a single third-party administrator. So in addition to a boost in reimbursement rates, providers immediately realized robust operational support that contributed to the spike in enrollment. As part of its contract, Doral provided administrative help such as a dedicated call center, flexible billing options, prompt payment procedures, and streamlined prior authorization and credentialing processes.

Increased provider participation as a function of efficient third-party program administration was also in evidence in Tennessee's carve-out, where administrative support was equally vigorous. In a roughly three-year period following the implementation of the Tennessee dental carve-out, the statewide dental provider network grew by 112 percent—from 386 to 817 contracted dentists—and continues to expand. This can be attributed in part to a fee increase to the 75th percentile of ADA fees in the region, and also to comprehensive administrative support provided by the Dental Benefits Manager.

Maintaining fees at rates that reflect the market is essential, once accomplished. Indiana, the longest standing case study in this group, provides an excellent example as its failure to maintain reimbursement levels attained in its reform is now yielding declines in provider satisfaction.

It is clear that higher reimbursement rates were critical in attracting dentists formerly opposed to participation in Medicaid programs, especially in states where Medicaid rates were clearly uncompetitive in the marketplace. It is equally clear, however, through anecdotal evidence contained in these state studies, that administrative support aimed at helping providers navigate through the often involved Medicaid procedures contributed significantly to provider satisfaction.

Administrative Support for Providers

All six states paired reimbursement increases with enhanced administrative support. Issues such as claims processing, prior authorization, eligibility determination, prompt payment and missed appointments were identified and addressed. Administrative support was achieved either through state fiscal intermediaries, or, in the instance of carve-outs, through third-party administrators.

A compelling case can be made for provider benefits associated with the carve-out model, where programs are administered through a Dental Benefits Manager. A single administrative contact eliminates the confusion that can exist when providers interact day-to-day with multiple insurance vendors – i.e., varying fee schedules, varying claims processing procedures, etc.

In Tennessee, the myriad of support mechanisms inherent in sole third-party administration was particularly in evidence. Dentists signed a single provider agreement with Doral, chose their participation level, experienced streamlined credentialing and prior authorization processes, used one maximum allowable fee schedule, submitted claims electronically, accessed electronic beneficiary enrollment verification, and received prompt payment. In Michigan, Delta Dental similarly administered the Medicaid dental benefit to rural counties in accordance with its own standard procedures, claim forms and payment levels. Provider participation levels and member utilization expanded as a result.

Member Outreach / Education

Competitive fee schedules and comprehensive administrative support may assure the creation of a willing provider network, however increased member utilization may not necessarily follow. Compared to the average 54 percent utilization rate for the general population possessing dental insurance, average utilization levels in Medicaid populations throughout the country hover around 33 percent. There has been little fluctuation in this level over the past decade. Utilization is largely dependent on the Medicaid patient's election to visit the dentist. It might be assumed that the general population has greater economic ability to pay for dental care, and hence the higher

utilization rate. However, the standard Medicaid dental program has no co-insurance payments, and in fact, no payments whatsoever. The barriers to utilization are not essentially a financial issue, but may rather relate to limited healthcare awareness or long-standing frustration in accessing dental care.

In three of the six states surveyed, the issue of member education was addressed with varying emphasis. At minimum, member outreach was conducted to address broken appointments which preclude needed care for enrollees and result in empty chairs for providers.

Tennessee elevated outreach to a higher level. As part of its contract with its third-party administrator, outreach activities were mandated in order to educate enrollees and increase member participation. Doral was charged with reporting the results of these activities annually. Three years after the implementation of Tennessee's carve-out, during which Doral participated in dental screenings and other community-based events, member participation in Tennessee rose by nearly 43 percent (from 26.1 percent to 37.4 percent). Outreach efforts surely contributed to this significant rise in service utilization. Similar outreach efforts were employed in Virginia's carve-out where Doral served as sole third-party administrator. In the year after the 2005 implementation, the percentage of Virginia's children receiving dental services was up 21%.

As critical as competitive fees and administrative support are in establishing a network of dentists, beneficiary education posits another key prescriptive for increasing members' use of dental services. Informed parents can assume greater control of their families' dental health, and determined efforts to increase their knowledge will ultimately increase the likelihood of care-seeking in a dentist's office.

Dedicated Provider Recruitment

Provider recruitment efforts were executed in all six states. Primary hurdles to recruitment mentioned in detail above are further compounded by a nationwide shortage and/or maldistribution of dentists, including an acute shortage of pediatric dentists who participate in Medicaid.

The "baby boomer" generation, which is fast approaching retirement age, represents the largest segment of practicing dentists and portends further shortfalls in dentists available to care for the underserved. In addition, the number of dentists practicing part-time has increased substantially over the past 15 years. And as the "baby boomer" generation of patients retains their teeth, the demand for dental services by seniors will continue to grow—further displacing available care for low-income children. As the number of dentists declines, the Medicaid eligible population continues to grow.

Federal government involvement in addressing workforce and distribution shortcomings is essential. And as evidenced in nearly every state studied, the active participation of organized dentistry was and will remain instrumental in the recruitment of viable provider networks.

Two of the states studied, Virginia and Tennessee, employed statewide carve-outs to administer dental benefits. A third state, Michigan, employed a pilot carve-out in rural counties. Given the implied support of organized dentistry in any state determined to increase access to its Medicaid members, employing a carve-out model sets the stage for a strategy in which all five ingredients for success align. Virginia's carve-out, only recently implemented, has yielded impressive first-year results. Tennessee's program, established in 2002, exhibits similarly impressive results over a three-year period. Advantages to a carve-out stem from efficiencies implied by single party administration —tighter budgetary control, lower administrative costs, and streamlined procedures for providers. States realize additional advantages when they charge third-party administrators with vital outreach initiatives and ongoing network recruitment, as Tennessee and Virginia did.

CONCLUSION

Increasing access to dental care for low-income children is a challenge requiring a multifaceted approach. Daunting as it might be, each state surveyed in this report rose to the challenge through the determination of its Medicaid Directors, and through the equally determined efforts of its strategic healthcare partners. That these successes were achieved in relatively short time frames, and in the face of deteriorating healthcare environments, should offer hope to states facing similar challenges.

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