2016 National Medicaid & CHIP Oral Health Symposium

Session # 3
Smart Contracting

Myra Shook, MPH
Dental Program Manager
Virginia Department of Medical Assistance Services

Washington Marriott Wardman Park
June 13th-14th, 2016
Learning Objective(s)

Participants will gain knowledge in:

- The rationale for and history of the Virginia *Smiles for Children* program;
- The benefits of using a dental administrator to increase provider networks and member utilization;
- Administrative components of using a dental benefits administrator; and
- And lessons learned over the past ten years of Virginia’s *Smiles For Children* program
Disclosure and Conflict of Interest Declaration

I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
History of Contracting

- Implemented on July 1, 2005, *Smiles For Children (SFC)* operates as a fee-for-service dental health benefit plan with a single benefits administrator.

- The program was created through a collaborative between Virginia dentists, the Virginia Dental Association (VDA), the Dental Advisory Committee (DAC) and DMAS.

- Second contract awarded in 2011
  - Four year contract with four annual contract extensions

http://www.dmas.virginia.gov
History of Contracting

- The collaborative (VDA, DMAS, DAC, VA Dentists) developed the model:
  - DBA vendor and MCO carve out
  - Simplified administration
  - Extensive outreach and recruitment
- Support from the Governor and the General Assembly
  - Included an overall 30 percent increase in funding for the reimbursement of dental services in 2005
History of Program

- **KEY** component— direct involvement of the Agency Director

- Agency Head and VDA Executive Director championed the concept with Virginia dentists.
  - Gained provider input and support for the program by attending at least one meeting of each component in the Commonwealth.
  - Engaged the providers in ‘branding’ the program.

- Surveyed all providers to gain input on program model.
  - Asked what would it take to for them to join a Medicaid dental program
    - Reduced administrative burden
    - Single payer – Went from six payers to ONE!
Covered Services
(Beneficiaries Under 21)

- Regular dental checkups – every 6 months
- X-rays-when needed
- Cleaning and fluoride – every 6 months
- Sealants
- Braces and space maintainers
- Anesthesia
- Extractions
- Root canal treatment
- Crowns

http://www.dmas.virginia.gov
Limited Adult Dental Coverage

- Medically necessary oral surgery and the associated diagnostics are the only covered services for adults under *Smiles For Children*.

- Medically necessary oral surgery that may qualify for reimbursement are conditions which are compromising a patient’s general health. Such conditions must be documented by the dentist or medical provider.

- The exception is the March 2015 implementation of comprehensive (except orthodontic) coverage for pregnant women.

http://www.dmas.virginia.gov
Goal #1: Increase Provider Participation

- In SFY 2015, approximately 2,000 dental providers participated in the *Smiles For Children* (SFC) network
- This represents approximately 32.5% of the 6,151 licensed dentists in Virginia

Goal #2: Increase Member Utilization

- In SFY 2015, 54% of the eligible Medicaid members ages 0-19 years utilized dental services through the SFC program.

Goal #3: Utilize Innovative Strategy to Improve and Increase Utilization: Dental Coverage for Pregnant Women Enrolled in *Medicaid* and *FAMIS MOMS*

- Coverage for pregnant women began on March 1, 2015.
Smiles For Children Provider Participation

- 620 dentists in 2005 → 2,031 dentists in 2016
- 79% of providers are servicing clients.

http://www.dmas.virginia.gov
Smiles For Children
Member Utilization

- 24% → 54% for members 0-20 years old
- 29% → 61% for members 3-20 years old

http://www.dmas.virginia.gov
Roles and Responsibilities

DMAS:
• Overall Program Management
• Policies
• Program Integrity
• 2nd level appeal

Contractor: DentaQuest:
• Provider Network (Credentialing, payments, network adequacy)
• Member and Provider Services/Outreach
• Training
• Reporting
• Program Integrity
• Appeals

http://www.dmas.virginia.gov
Department of Medical Assistance Services

- DMAS retains policymaking authority and closely monitors contractor activities.
  - DMAS Dental Program staff:
    - One FT Program Manager
    - One FT Contract Monitor
    - One PT Dental Consultant - DDS
    - One PT Administrative Assistant

- The Dental Advisory Committee (DAC) provides input on programmatic and clinical guidelines.
Contractor Staffing

- FT *Smiles For Children (SFC)* Executive Director
- FT SFC Outreach Coordinator
- Two FT Provider Relations Positions

http://www.dmas.virginia.gov
Risk Sharing
Financial Relationship Between State and Contractor

- *Smiles for Children* program → fee for service.
- Virginia DMAS bears all of the financial risk
- DBA is reimbursed for administrative services via PM/PM
- All dental service claims are paid by DMAS on a pass-through basis.

http://www.dmas.virginia.gov
Contract Compliance

- Checklist for report submissions – weekly, monthly, quarterly, annual

- Monthly report card
  - A valuable tool for documenting metrics

- Less than 5% abandonment rate for calls

- Wait time prior to abandonment is < 3 minutes for 95% of calls – member and providers

- Average time for appeals resolution or grievance is less than 30 days.
Quality of Care

- Dental Consultant review
- Quality Monitoring
- Dental Advisory Committee
- Peer Review Committee
- Standards
- Performance Reviews
Contract Deliverables

- Ninety percent (90%) of claims processed within 30 days
- Claims accuracy greater than 97%
- Prior authorizations within four business days
- DMAS imposes liquidated damages
  - Missed reporting deadline; not reporting in a timely fashion
  - Fines for timeliness/accuracy of payments to providers
  - Missing an appeals hearing
Network Development

Contractor is responsible for:

- Training
- Enrollment Process
- Credentialing Process
- Provider Termination
- Network Deficiency
- Submission of regular reporting as outlined in the contract

http://www.dmas.virginia.gov
Provider Relationships

- Contractor’s responsibilities include:
  - Provider Agreements
  - Provider Requirements, Federal, State and Local
  - Policies and Procedures
  - Complaints and Appeals
  - Requirements of Provider Dental Practices
  - Provider Reimbursements

Outlined in the Office Reference Manual (ORM)

http://www.dmas.virginia.gov
Provider Manual

- Eligibility
- Authorization for Treatment
- Claims Submission Processes
- Grievances and Appeals
- Credentialing
- Clinical Criteria

DENTAL SERVICES

OVERVIEW

The Smiles For Children (effective July 1, 2005) program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS and FAMIS Plus children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). DentaQuest is the single dental benefits administrator that will coordinate the delivery of all Smiles For Children dental services. For additional information about the Smiles For Children program please call DentaQuest at 1-888-912-3456.

♦ Enrollee Information
♦ Locate a Dentist

A HEALTHY VIRGINIA PLAN – DENTAL BENEFITS FOR PREGNANT WOMEN

As a part of Governor McAuliffe’s A Healthy Virginia Program, Virginia’s nationally recognized Smiles For Children dental program will “provide dental services to pregnant women age 21 and over enrolled in Medicaid and FAMIS MOMS”. As of March 1, 2015, pregnant women enrolled in Medicaid and FAMIS MOMS who are 21 years of age and older are eligible to receive appropriate dental benefits covered through the Smiles For Children program.

♦ Medicaid Memo – Dental Coverage for Medicaid Enrolled Adult Pregnant Women and FAMIS MOMS - Effective March 1, 2015
♦ Frequently Asked Questions – Adult Pregnant Women Benefits
♦ Fact Sheet for Members – Pregnant Women Enrolled in Medicaid and FAMIS MOMS
♦ Fact Sheet for Providers – Pregnant Women Enrolled in Medicaid and FAMIS MOMS
♦ Smiles For Children Coverage for Pregnant Women Brochure
♦ A Guide to Dental Coverage for Pregnant Members
♦ A Guide to Dental Coverage for Pregnant Members – Spanish Version

SMILES FOR CHILDREN CONTRACT & CDC CODES

In an effort to simplify access to dental information that may be copyright protected, please follow below link and accept the "End User License Agreement" for access to all Smiles For Children program information.
Welcome, DentaQuest Dentist

We respect the contributions of its providers. By providing you with advanced technological tools, we eliminate the administrative burden associated with participating in government-sponsored programs. Beyond representing an act of public service in your community, we want your participation in our network to represent a sound business decision.

Information For Enrollment:

» VA Smiles For Children Application
» W-9
» VA Dual Eligible & Marketplace Application
» W-9

Important Dentist Information:

» **Smiles for Children Provider Relations**: 800-936-0913
» Smiles For Children Office Reference Manual
» New Provider Web Portal Demonstration
» New Web Portal Self-Registration Instructions
» Pregnant Woman Provider Training 2015
Next Steps!

With the success in meeting the original SFC program goals, **SFC** has added goals focusing on:

- **Medical and Dental Collaboration**
  - MCO engagement to promote dental referral
  - Prevention strategies
  - Fluoride Varnish
  - Sealants

- **Program Integrity**
  - Fraud, Waste and Abuse

- **Savings/Edits**
Keys to Success

- **Clearly defined roles and responsibilities** for DMAS and contractor staff.

- **Strong contract** outlining deliverables and reporting requirements.

- Strong **contract monitoring** with checks/balances/reporting systems

- Open, two-way communication
  - Quarterly staff meetings
  - Required Reporting
  - Engagement of the Dental Advisory Committee (DAC)
  - Addressing “hiccups” as they occur!

http://www.dmas.virginia.gov
Strong Partnership!

Dental Coverage for Pregnant Women

In September 2014, Governor Terry McAuliffe’s announced his A Healthy Virginia 10-Step Plan to increase healthcare services to over 200,000 Virginians.

The plan included the provision of dental care for pregnant women enrolled in Medicaid and FAMIS MOMS.

The services began March 1, 2015!
Strong Partnership

- Five month prep-time; and start date—> March 1st
- Internal DMAS team included: MCH, Systems and Reporting, Managed Care, Transportation and Special Populations
- DentaQuest staff were part of the implementation team
- Provider Training (dental and medical)
  - Educational and promotional materials for providers and members
  - Systems development
  - Data collection and reporting
Speaker Biosketch

Myra Shook, MPH, currently serves as the Dental Program Manager for Virginia’s Medicaid Smiles For Children program. Ms. Shook holds a B.S. in health education from the University of North Carolina Greensboro and a Master of Public Health from the University of North Carolina-Chapel Hill. She has over 30 years of experience in program management and contracting. Ms. Shook also has extensive experience in program planning, grant writing, and community outreach and engagement. She has served on numerous state and national workgroups and coalitions.
Contact Information

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For more information on the Smiles For Children program:
2016 National Medicaid & CHIP Oral Health Symposium

Session # 3
Smart Contracting

Ms. Sabrina Johnson
Iowa Medicaid - Dental Program Manager

Washington Marriott Wardman Park
June 13th-14th, 2016
Learning Objective(s)

Participants will gain knowledge in:

- An innovative way to provide dental benefits; and
- Policy, regulatory & oversight considerations when contracting with a Dental Benefit Administrator
Disclosure and Conflict of Interest Declaration

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Why Something Different?

- Iowa Legislature passed the Iowa Health and Wellness Plan.
  - Adults ages 19-64
  - Income between 0-133% Federal Poverty Level
  - Not otherwise eligible for Medicaid or Medicare

- The Plan called for a comprehensive dental benefit equivalent to the Medicaid benefit.
  - The Iowa Department of Human Services, in partnership with key stakeholders and Delta Dental of Iowa, designed the Dental Wellness Plan (DWP).
Dental Wellness Plan (DWP)

- **Access** - Ensure adequate access to services

- **Outcomes Focused** –
  - Improve the oral health of members
  - Incentivize members and providers

- **Sustainability** – Ultimately bend the cost curve by moving population to a preventative orientation
Regulatory Requirements

- Pre-paid Ambulatory Health Plan (PAHP)
- New CMS Managed Care FINAL RULE
- 1115 waiver authority
What the 1115 Allows

- Ability to do something other than FFS (PAHP contract)
- Allows for premiums that can be waived through demonstrating healthy behaviors (including dental exams)
- Earned benefit design, to influence behavior over time (emphasize preventative)
Key Design Components

• 3 Tiers of Benefit
  ○ Total coverage is equivalent to the full coverage of the Medicaid state plan benefit, including EPSDT

• Education and Outreach
  ○ Non Emergent dental ER utilization data is shared with contractor

• Provider incentive for completing risk assessments

• “PPO like rates”
  ○ Paid through a fee schedule
  ○ FQHC is settled to cost
Medical Loss Ratio (MLR)

- What is MLR?
  - Component of Actuarial Soundness (§438.4 and 438.5)
  - The ratio of medical costs to capitation revenue
  - Health care services, covered benefits, and quality improvement efforts

- What is the standard?
  - At least 85% is industry standard (§438.4(b)(8))
  - States establish and justify a maximum MLR threshold
Sharing Risk

- What is risk-corridor arrangement?
  - Definition §438.6(a)
  - Is a risk sharing mechanism that “caps” maximum possible profit or loss

- Our risk-corridor range is +/- 2.5%

- How does it work?

- How does Iowa monitor the risk?
Monitoring at a Glance

Sample Contract Management Tool

- Encounter Payments
- * Admin Cost (15% of Cap Pymts)
- Capitation Pymts
- Lower Risk Corridor
- Upper Risk Corridor
DWP Network

• State-wide provider network

• Independent of the Medicaid or Commercial network.
  o Why?
  o Barriers

• Credentialing completed by Dental Benefits Manager (DBM)
  o Provider Challenges
  o Controls around service provision for the first time for dentists in Iowa
  o Specialty providers
Quality of Care

- Advisory Council
- Linkage between medical Managed Care Organization (MCO) and Dental Benefit Manager (DBM)
- Quality Monitoring
  - Contract changes
  - Access to services
  - Member behavior: claims profile
Performance Measurement
Performance Monitoring

At Least 75% of Members Will Return For Follow-Up Within Six to Twelve Month

12+ Month Coverage Indicator

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of First and follow-up within coverage range</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Within 12 Month and Within Coverage Period</td>
<td>19915</td>
<td>55%</td>
</tr>
<tr>
<td>No Follow-up</td>
<td>15353</td>
<td>42%</td>
</tr>
<tr>
<td>Skip Follow-up Greater Than 12 Month</td>
<td>1196</td>
<td>3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>36464</td>
<td>100%</td>
</tr>
</tbody>
</table>

Stabilization Services Paid Amount

Patients with 7+ Month of Consecutive Coverage

<table>
<thead>
<tr>
<th>Patients</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of patients 7+ Month Coverage</td>
<td>177718</td>
<td>36.8%</td>
</tr>
<tr>
<td>Patients with utilization</td>
<td>65385</td>
<td>85.8%</td>
</tr>
</tbody>
</table>

Unique Member/Date Emergency Care

Stabilization Payment Ratio

<table>
<thead>
<tr>
<th>Stabilization Payment Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Paid</td>
</tr>
<tr>
<td>Stabilization Paid</td>
</tr>
<tr>
<td>Stabilization Percent</td>
</tr>
</tbody>
</table>

Emergency Payment Ratio

<table>
<thead>
<tr>
<th>Emergency Payment Ratio</th>
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</thead>
<tbody>
<tr>
<td>Total Paid</td>
</tr>
<tr>
<td>Emergency Paid</td>
</tr>
<tr>
<td>Emergency Percent</td>
</tr>
</tbody>
</table>
Education and Training

• Member outreach and referrals
• Dedicated member website
• Branding
  o Member educational materials
  o Communications
Training for Professionals

- Staff
  - Call center, clinical criteria for reviews, IT systems

- Provider
  - Website
  - Training webinars

- Branding
  - Provider training materials
  - Communications
Data and Reporting Requirements

- File Formats
  - As specified by the department

- Eligibility
  - Daily
  - Monthly

- Reporting Manual
  - Designated templates
  - Monthly, quarterly, annually
Program Integrity

- Program Integrity (PI)
  - Policies and procedures
  - Monthly fraud reporting

- Investigation coordination
  - Training upon request
  - Bi-weekly meetings
  - Medicaid PI, Medicaid Fraud Control Unit (MFCU), Medical MCOs
Questions
References


- 42 CFR Parts 431, 433, 438, 440, 457 and 495
Speaker Biosketch

In 2013, Ms. Sabrina Johnson began her career as an Education and Outreach Coordinator with the Iowa Medicaid Program. Having 13 years of healthcare experience as both a provider and a payer, Ms. Johnson was instrumental in assisting others navigate the payment policy infrastructure. She also assisted in problem resolution. In 2014, Ms. Johnson became the Dental Program Manager. While somewhat new in this role, she has emerged as a national leader, and has already contributed significantly toward helping Iowa’s dental program achieve measurable improvements.
Contact Information

Sabrina Johnson
Dental Program Manager
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
Email: sjohnso1@dhs.state.ia.us
Telephone: 515-256-4650
Learning Objectives

Participants will gain knowledge in:

- The history of the transition of the Louisiana Medicaid dental program delivery system
- The various federal requirements for Medicaid Managed Care Organizations
- Contract Compliance
Program Goals

• First and Foremost...
  ➢ Improve the health of Medicaid/LaCHIP recipients

• How?
  ➢ Improved access to dental services
  ➢ Better oral health outcomes
  ➢ Increased quality of dental care
  ➢ Increased personal responsibility and self-management
  ➢ A more financially sustainable system
  ➢ Outreach and education to promote dental health
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History of Contracting

- **June 2012**, moved to a statewide managed care model to provide coordinated care for certain eligibility groups. Currently, five managed care organizations provide a comprehensive array of services (dental services carved out).

- **July 2014**, transitioned to the provision of dental services for 1.2 million children and adults enrolled in the Louisiana Medicaid program to a single statewide Dental Benefit Program Manager.
Dental Benefit Program Manager

• Contract Period: July 1, 2014 – June 30, 2017
  3 year contract with the option to extend for up to 24 months

• Operates as a Prepaid Ambulatory Health Plan (PAHP)
  • Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation)

• Implemented under the 1915(b)(1)(4) waiver authority to mandate dental services be obtained by a single managed care entity statewide.
  • 1915(b)(1) - Freedom of Choice
  • 1915(b)(4) - Selective Contracting
## Excluded Members

<table>
<thead>
<tr>
<th>Dental Benefit Plan</th>
<th>Medical MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents of Intermediate Care Facilities for the Developmentally Disabled</td>
<td>Residents of a long-term care</td>
</tr>
<tr>
<td>Beneficiaries enrolled for specialty service Medicaid programs</td>
<td>Residents of Intermediate Care Facilities for the Developmentally Disabled</td>
</tr>
<tr>
<td></td>
<td>Medicare/Medicaid dual eligibles</td>
</tr>
<tr>
<td></td>
<td>Beneficiaries enrolled for specialty service Medicaid programs</td>
</tr>
</tbody>
</table>
Dual Eligibles

Individuals who are entitled to Medicare and eligible for some level of assistance from their state Medicaid program.

- **Full Dual Eligibles – Included**
  - qualify for entire package of state Medicaid benefits
  - receive assistance from Medicaid with their Medicare premiums and cost sharing

- **Partial Dual Eligibles – Excluded**
  - receive assistance with some or all of their Medicare premiums, deductibles, and other cost-sharing requirements
Regulatory Requirements

- 42 CFR Part 438 – Managed Care
  - New CMS Managed Care FINAL RULE (applies existing Medicaid managed care standards to PAHPs such as the requirement to have an external quality review, Medical Loss Ratio, State Quality Strategy and a grievance system)

- Waiver Authority
  - Independent Assessment
  - Cost Effectiveness
  - Quality Monitoring Activities

- State Dental Practice Act
  - Levels of Supervision
  - Mobile/Portal Dental Providers

- State Requirements
  - Transparency Report
Relationship with the State
Risk Sharing

- Full Risk - Bears all financial risk

- Contractor—
  (1) Assumes risk for the cost of the services covered under the contract; and
  (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

- Receives capitated a per member per month fee per enrollee on an monthly basis, which factors in service and administrative costs.
Payment Model

- Network providers are reimbursed at no less than the Medicaid fee-for-service rate (FFS), unless an extension is granted by the Department.
- Network providers may enter into alternative reimbursement arrangements with the plan, if the network provider initiates the request and it is approved in advance by Department.
- FQHC/RHC and American Indian Facilities paid at the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

LDH

• PMPM

DBP

• FFS
• PPS
• Alternative Reimbursement Agreement

Provider
Medical Loss Ratio

- The first year Medical Loss Ratio was **87.28%** with the Administrative Cost Ratio at 13.52%, which is well within nationally accepted ratios for Medicaid managed care plans.

- 85% MLR LDH standard
Contractual Requirements

- Programmatic Requirements
- Operational Requirements
  - Provider Network
  - Utilization and Quality Management
  - Member and provider relations and education
  - Grievances and Appeals
- Staffing Requirements
- Reporting Requirements
- Technical Requirements
  - Claims Management
  - Offsite storage and remote backup
  - Network and back-up capabilities
- Fraud and Abuse
- Subcontracting
- Insurance Requirements
- Disaster Preparedness
Core Benefits and Services

EPSDT Dental Medicaid and CHIP (under 21)

- Oral Exams
- Radiographs
- Cleanings
- Sealants
- Fluoride
- Amalgam and composite fillings
- Stainless steel and polycarbonate crowns
- Gingivectomy, periodontal scaling and root planning, full mouth debridement
- Root Canals
- Extractions
- TMJ procedures
- Orthodontic Services
- Behavior Management
- Conscious Sedation

Adult Denture Program (21 and over)

- Exam (1x 8yrs)
- X-rays (1x 8yrs)
- Removable complete dentures and partial dentures (1x 8yrs)
- Denture Repairs
- Denture Relines

42 CFR§438.210
# DBP Staffing Requirements

<table>
<thead>
<tr>
<th>In State</th>
<th>Out of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Executive Director</td>
<td>• Key Management Personnel</td>
</tr>
<tr>
<td>• Dental Director</td>
<td>• Member Services;</td>
</tr>
<tr>
<td>• LA licensed dentist</td>
<td>• Management Information Systems;</td>
</tr>
<tr>
<td>• Provider Network Development and Management Staff</td>
<td>• Claims Processing;</td>
</tr>
<tr>
<td></td>
<td>• Provider Network Development and Management</td>
</tr>
<tr>
<td></td>
<td>• Benefit Administration and Utilization and Care Management</td>
</tr>
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<td></td>
<td>• Quality Improvement</td>
</tr>
<tr>
<td></td>
<td>• Financial Functions</td>
</tr>
<tr>
<td></td>
<td>• Reporting</td>
</tr>
</tbody>
</table>
Network Development

- The Contractor is responsible for:
  - Provider enrollment and termination
  - Credentialing (in accordance with NCQA requirements)
  - Training (initial and ongoing training requirements)
  - Network adequacy requirements
  - Reporting
    - annual Network Provider Development Management Plan,
    - quarterly Network-adequacy related reports, and
    - quarterly GeoAccess reports

42 CFR§438.206 – 438.208
Network Adequacy Reporting

### Network Adequacy Review GEO Mapping Dental Report
**Ratio of Members to One Network Provider**

<table>
<thead>
<tr>
<th>Parish</th>
<th>WCO Plan Network</th>
<th>Total Number of Members</th>
<th>Total Number of Members Residing in Urban Parishes</th>
<th>Total Number of Members Residing in Rural Parishes</th>
<th>Percent of Total Members Residing in Urban Parishes</th>
<th>Percent of Total Members Residing in Rural Parishes</th>
<th>Percent of Total Members Residing within 0.40 Miles of One PC</th>
<th>Percent of Total Members Residing within 0.40 Miles of One Oral Surgeon</th>
<th>Percent of Total Members Residing within 0.40 Miles of One Orthodontist</th>
<th>Percent of Total Members Residing within 60 Miles of One PC</th>
<th>Percent of Total Members Residing within 60 Miles of One Oral Surgeon</th>
<th>Percent of Total Members Residing within 60 Miles of One Orthodontist</th>
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<tr>
<td>Acadia</td>
<td>LA</td>
<td>17,235</td>
<td>0.00%</td>
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<td>0.00%</td>
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<tr>
<td>Allen</td>
<td>LA</td>
<td>5,076</td>
<td>N/A</td>
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<td>0.00%</td>
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<td>Ascension</td>
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<tr>
<td>Avoyelles</td>
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</table>

### GeoAccess Maps: Louisiana EPSDT and Adult Denture Program (Q1 2016)
- Provider Access on March 31, 2016
- Region Map

[Map showing geographic access to dental providers in Louisiana]
Provider Manual

- Description of the DBPM
- Core dental benefits and services the DBPM must provide
- Emergency dental service responsibilities
- Policies and procedures that cover the provider complaint system
- Information about the Grievance System,
- Medical necessity standards
- Primary care dentist responsibilities
- Quality performance requirements
- Provider rights and responsibilities
- Provider responsibilities under the subcontract with the DBPM
- Prior authorization and referral procedures
- Dental records standards
- Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims
- DBP prompt pay requirements
- Notice that provider complaints regarding claims payment shall be sent to the DBPM
- Fee schedule
- Dental periodicity schedule
Practice Guidelines

Contract requirement for practice guidelines:

- Are adopted in consultation with contracting dental care professionals;
- Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;
- Are considering the needs of the members; and
- Are reviewed annually and updated periodically as appropriate

42 CFR$438.236
Education and Training

- **Staff**
  - Ensure all staff members have appropriate training, education, experience, and orientation.
  - Provide initial and ongoing training that includes an overview of Department policy/procedures, contract requirements, identification and handling of quality of care concerns.
  - Ensure PA staff and member services representatives are knowledgeable of Louisiana geography.

- **Providers**
  - Responsible for providing initial and ongoing training to providers.
  - Required to develop and submit a Provider Training Manual and training schedule.
Quality of Care

- **Routine quality monitoring,** including **provider record reviews** and **appointment availability surveys** are conducted to ensure compliance with state and federal requirements (quarterly and annually respectively).

- **LDH Quality committees,** including DBP QAPI Committee (quarterly meetings).

- **Member and provider surveys** are conducted annually to assess satisfaction.
  - Member survey reports indicate a high degree of satisfaction.

- **Performance improvement project** was implemented to focus on improving/increasing utilization of available dental services, with a focus on preventative services. Current metrics include:
  - Increasing the annual dental visit (HEDIS measure)
  - Increasing the percentage of eligible age 1-20 who received preventative dental services (Oral Health Initiative)
  - Increase the percentage of EPSDT enrollees age 6-9 who received a dental sealant on permanent first molars and second molars (Oral Health Initiative).

42 CFR§438 Subpart D
Performance Measurement

- **Clinical performance measures**
The state may deduct up to 0.5 percent of the total monthly capitation payment to a plan for each of measures that fall below established benchmarks.
  - Increase % of EPSDT members receiving at least one dental preventive service
  - Increase % of EPSDT members, age 6-9 years, receiving 1 or more sealant on permanent molar teeth

- **Administrative performance measures**, related to service authorization timelines, call center statistics, appeal and state fair hearing rates, clean claims payment, and denied claims.
  
  Fixed monetary penalties are assessed each incident of non-compliance.

42 CFR§438 Subpart D
Activities Related to External Quality Review

Required Activities

- Performance Measure Validation
- Performance Improvement Project Validation
- Compliance Review
  - EQRO found the DBPM was 97% in compliance with state and federal regulations. Considering both full and substantial review elements, the DBPM was 100% compliant.

Optional Activities

- Validation of encounter data
  EQR Protocol 4 - Validation of Encounter Data Reports

42 CFR § 438 Subpart E
# Contract Monitoring

**DENTAL BENEFIT PLAN REPORT GRID**

## Monthly (Due 15 calendar days of the end of each month)

- 022 Post Payment Recoveries (existence of TPL) - M
- 107 Member Service Call Center M
- 109 Marketing and Member Education Materials Distributed - M
- 113 Grievance, Appeal and Fair Hearing Log - M
- 148 Exclusion Database Attestation
- 167 Claims Payment Accuracy Report - M
- 173 Denied Claims Report - M
- 181 Provider Call Center - M
- 218 Provider Complaint & Appeal Summary Report - M
- 221 Claims Payment Summary - M

## Quarterly (Due April 30th, July 30th, October 30th, and January 30th)

- 026 EPDOT Report (CMS 418) - Q/A
- 066 Utilization Management Committee Meeting Minutes - Q
- 069 Utilization Management Dental Record Review Report - Q
- 072 QAPI PCD Profile Reports - Q
- 082 PCO Linkages - Q
- 114 Grievance, Appeal and Fair Hearing Log (redacted Q/A)
- 119 QAPI Committee (minutes) - Q
- 139 Member Advisory Council (minutes) - Q
- 145 Fraud and Abuse Activity Report - Q
- 147 Sampling of Paid Claims Report
- 149 FWA Functional Organizational Chart - Location Listing
- 188 Claims Processing Interest Payments - Q
- 185 Quarterly Unaudited Financial Statement - Q (60 days after QTR)*
- 188 PA Summary - Q
- 217 QAPI Early Warning System Performance Measures - M
- 220 Network Adequacy Review - Q
- 225 Network Summary Dental Report - Q

## Annual

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<th>Item Number</th>
<th>Description</th>
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<td>016</td>
<td>Functional Organizational Chart - Location Listing and Key Staff Job Description - A</td>
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<td>QAPI Performance Reporting Measures (HEDIS Levels I and Level II) - A/B</td>
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<td>Systems Refresh Plan - A</td>
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<td>Independent-Subcontractor EDP Audit (SSAE16) - A</td>
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<td>QAPI Impact and Effectiveness of QAPI Program Evaluation - A</td>
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*QA means Quarterly and Annually

*Template not provided. Will accept Dental Plan’s corporate standard.
Non-Compliance

- Administrative Actions
- Corrective Action Plan
- Monetary Penalties

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<th>Daily Amount for Days 31-60</th>
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## Sanctions

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<td><strong>Encounter Data</strong></td>
<td>➢ $10,000 per day each day after the due date of monthly encounter data submission or the failure to resubmit data after it was returned to the DBP for corrections</td>
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| **Claims Payment**                  | ➢ $5,000 1\textsuperscript{st} quarter standards not met  
                   ➢ 25,000 2\textsuperscript{nd} quarter standards not met |
| • 90% clean claims paid within 15 calendar days  
• 99% of all clean claims paid within 30 calendar days |                                                                 |
| **Member Call Center**              | ➢ $100 for each percentage point each standard fails to meet requirements  
                   ➢ $100 for each 30 second time increment the average hold time exceeds the max acceptable hold time |
| • Answer 90% of calls within 30 seconds  
• Average hold time of 3 minutes or less  
• Abandoned rate of calls of not more than 5% |                                                                 |
| **Member File Updates**             | ➢ 5,000.00 for each occurrence of non-compliance.                          |
| Failure to upload all Member File updates prior to end of month reconciliation process with files submitted to the DBP by the FI |                                                                 |
| **Covered Service**                 | ➢ $1,000 plus the cost of the service for a member in which the DBP was asked to provide the service by DLDH and refused to provide the core benefit or service |
Program Integrity

- Fraud Waste and Abuse (FWA) Reporting
  - Internal and external tips with potential, confirmed, or suspected FWA
  - Audits Performed
  - Referrals Made
  - Overpayments Identified and Recovered
  - New PI Actions

- Quarterly in person meetings with the Medicaid Fraud Control Unit (MFCU)

42 CFR§438 Subpart H
Next Steps??

- Medicaid Expansion, Healthy Louisiana
- Improvement of network adequacy review
- Internal reorganization of structure of the Medicaid program
- New Managed Care Rule
Questions

For the Latest Information

www.MakingMedicaidBetter.com
References

- Dental Benefit Management Program Request for Proposal (RFP)
  http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2935
- Dental Benefit Management Program RPF Evaluation Materials
  http://new.dhh.louisiana.gov/index.cfm/page/1815
- Louisiana Dental Practice Act
  http://www.lsbd.org/dentalact.htm
- LDH Transparency Reports
  http://new.dhh.louisiana.gov/index.cfm/page/1582/n/313
- CMS Wavier Authorities
  https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html
- State Waiver Documents
  https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html
Cordelia Clay is the Medicaid Dental Program Manager of Medicaid Dental Program at the Louisiana Department of Health (LDH). The Department provides dental services to over 1.3 million members expending over $140 million a year. In her current position, she is responsible for program oversight, contract compliance, development and implementation of policies, quality management and accountability. She received a B.S. in Biology and a Masters of Public Administration from Southern University. Cordelia joined LDH as a Management Intern of the Dental Program in 2007 and now serves as the primary contact for all aspects of the program. During her tenure she has also held the responsibility of managing the Medicaid vision and family planning programs along with primary oversight of the development, approval, and implementation of LDH’s transition to a statewide Dental Benefit Management Program. Cordelia also collaborates on various health care projects and committees.
Contact Information

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