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Oral Health Symposium
June 3rd- 4th, 2013 Washington DC

Operationalizing Dental Medicaid
Programs in a New Era:
Evolution of a Medicaid Managed Care Dental Program

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Session Objectives

• To describe how TennCare’s managed care dental program has evolved over time and the factors that influenced the transformation.
TennCare Dental Objectives

- High quality care within a sustainable and predictable budget
- Increase proportion of enrollees who receive dental care
- Primary focus is enrollees, versus providers
- Simplicity of the model is key
- Operate with single statewide DBM selected through an RFP process
- Up front competition of proposers versus contracting with multiple competing entities
Dental Objectives (Continued)

- DBM manages network, and selectively contracts with dentists ("right fits" the network)
- Establishment of a network of quality dental providers
- Monitor network adequacy using GeoNetworks software
- Prevention of problems by careful network development, composition, and management
- No stigma attached with being Medicaid dentist in TN
Is the dental network the right fit?

DBM should select dentists who:
- Provide medically necessary care,
- Provide quality care,
- Don’t game the system,
- Don’t exploit children

DBM should cull dentists who won’t conform
Tennessee Medicaid Timeline

1969 State Medicaid program started

1994 State transitions to Medicaid Managed Care, MCO “Full risk”, Integrated model

2002 Dental “Carve-out”

Poor dental provider participation

Statewide DBM ASO “No Risk”

2013 - 2016 Statewide DBM “Partial Risk”
“If you build it, they will come”
“If you build it, they will come”

Dentists will participate in public programs that are properly designed:

- Simple to navigate
- Fair (no sweetheart deals)
- Business friendly
- Administratively streamlined
- Include reasonable fees
- Allows input (non-binding recommendations) through the dental advisory committee
Features of Dental Carve-out

- Can be structured as no risk (ASO), partial risk or full risk
- Not AWP
- Dedicated dental budget
- If RFP designates a single statewide DBM, it simplifies everything:
  - one credentialing process
  - one set of policies and procedures
  - one provider agreement
  - one authorization process
  - one provider manual
- Enrollees have access to any dentist in the network
DBM Risk Bearing Spectrum

“No Risk”
2002 - 2013

Admin Services Only (ASO),
DBM receives admin fee,
Dedicated dental budget,
Strict state oversight,
State covers all claims,
State controls fee schedule,
State sets benchmarks,
DBM controls network,
Not AWP,
Contract between DBM and provider,

“Partial Risk”
2013

Shared risk for over-expend,
DBM receives admin fee,
Dedicated dental budget,
Strict state oversight,
State covers claims to target,
State controls fee schedule,
State sets benchmarks,
DBM controls network,
Not AWP,
Contract between DBM and provider,
Potential for profit sharing

“Full Risk”
?

At full risk for over-expend,
DBM receives cap rate,
Dedicated dental budget,
Strict state oversight,
DBM covers claims,
DBM controls fee schedule,
State sets benchmarks,
DBM controls network,
Not AWP,
Contract between DBM and provider,
Is “ASO” Managed Care?

Answer: “Yes”

- Contractual requirements and State oversight guides DBM management of:
  - Provider networks
  - Quality of Care
  - Fraud and abuse
  - Enrollee education and outreach, etc.

- There is also a misconception that “fee-for-service” reimbursement of providers is not managed care

- Managed care is improving quality while containing cost regardless of how the provider is reimbursed.
Limitations of ASO Contracts

- Little risk to DBM for mediocre management
- No risk to DBM for budget over-runs since claim payments are covered by state
- No financial incentive/ reward if DBM exceeds contract requirements
- Little incentive for DBM to “crack down” on bad providers
- Design may be a barrier for taking program to next level
Was Dental “ASO” model successful?

From FFY 2003-2012:

➤ Dental networks grew by 143%
➤ *Enrollee utilization increased by 29%
➤ Recent survey revealed that 94% of enrollees were “very” or “somewhat” happy with their DBM
➤ Recent survey revealed 97% of providers were satisfied with DBM

*DPR value for 2012 is an estimate given the official State 416 numbers have not been released.
Was Dental “ASO” model successful?

- Claims analysis reveals that in 2012, there was active dental provider participation in TennCare
  - 72% treated more than 100 children
  - 87% received $10,000 or more in paid claims

- There is network elasticity (additional capacity) with the majority of dentists reporting they are accepting new Medicaid patients into their practices.
Why go to “Partial Risk”?

- DBM has “skin” in the game
- DBM at shared risk with state for budget over-runs due to poor management
- Risk remains with State and DBM versus being shifted to providers (state controls fee schedule)
- Strong financial incentive for DBM to carefully build a quality dental provider network
- Strong financial incentive for DBM to remove bad actors
- Greater acceptance for risk bearing contracts
Ante up...
Put some skin in the game.
How was “Partial Risk” structured in TennCare’s RFP?

- Hybrid Model between “ASO” and “Full Risk”
- Shared risk and shared incentive for quality care at lower cost.
- Participating provider is shielded from poor management
- Includes both administrative fees and potential for shared savings or loss
## Proposer Selects Risk Level

<table>
<thead>
<tr>
<th>Risk Levels</th>
<th>% share of savings to DBM</th>
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<tbody>
<tr>
<td>% risk of loss DBM willing to assume</td>
<td>% share of savings to DBM</td>
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<td>DBM assumes 50% of loss</td>
<td>50% of any savings</td>
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<tr>
<td>DBM assumes 35% of loss</td>
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<tr>
<td>DBM assumes 20% of loss</td>
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# Aligning Incentives

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<tr>
<th>DBM % Risk Level</th>
<th>Target Participation</th>
<th>Service Expenditure</th>
<th>Profit</th>
<th>Loss</th>
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<tbody>
<tr>
<td></td>
<td>Year 1</td>
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<td>Year 3</td>
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<td>53.6%</td>
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Unique or Novel RFP Items
A.54. The Contractor shall not execute a Provider Agreement with any Provider Person or Provider Entity that does not have a valid TennCare Provider ID number. **The Contractor shall verify each individual and group TennCare Provider ID with TennCare electronically utilizing a means specified by TennCare.**

**TennCare will provide** demographic and other data for each individual and group provider authorized by TennCare to be used by the Contractor. Providers without a TennCare Provider ID number should be directed to the TennCare Provider Portal through which the provider can provide the necessary information to receive a valid TennCare ID number.
A.63. The Contractor is not required to contract with providers beyond the number necessary to meet the needs of the enrollees, nor precluded from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees. The Bureau of **TennCare requires that dental practices** providing services to TennCare enrollees **be controlled by licensed dentists**. No practice in which majority ownership or majority partnership interests are controlled by a non-licensed dentist(s) shall be allowed to contract with the program. Change in ownership of any practice requires a re-credentialing of the practice. A change in ownership which results in licensed dentist(s) having less than majority ownership will preclude the entity from being re-credentialled with the TennCare program.
E.22. The Contractor shall comply and submit to TennCare the disclosure of ownership and control information in accordance with the requirements specified in 42 C.F.R. Part 455, Subpart B, using the form approved by TennCare. **TennCare will collect** Ownership and Disclosure forms for individual dentists utilizing an automated system.

**TennCare will collect** Ownership and Disclosure forms for business entities (groups) using paper forms until such time as an electronic process is developed. TennCare will provide Ownership and Disclosure information to the DBM for both individual and business entity providers on request until such time as access to the automated system is available.
TennCare Provider Registration

- Breaks new ground in collecting, verifying and sharing provider information
- Eliminates provider submission of paper applications or update of forms by mail
- Minimizes administrative burden on providers, State, and DBM
- TennCare has partnered with the Council for Affordable Quality Healthcare (CAQH) for centralized collection of provider information
- Will eventually become a fully automated system eliminating manual processes
TennCare Dental Provider Registration

New DBM contract requires all dental providers interested in participating in TennCare to go through TennCare’s Provider Registration Portal:

- New dentists without a Medicaid ID,
- Re-validation of participating dentists with a Medicaid ID,
- New group practices without a Medicaid ID,
- Re-validation of group practices with a Medicaid ID,

TennCare will establish a pool of eligible providers that the DBM must choose from in making credentialing decisions and building a quality dental provider network.
New Dental Providers – (No Medicaid ID)

or

Dental Benefits Manager

Website

http://www.tn.gov/tenncare/pro-forms.shtml

Individual Provider

CAQH
120 day attestation

TennCare Provider Services Review

MMIS

Submitted to DBM weekly

DBM Credentialing Decision

Group Provider

TennCare Provider Services Review

MMIS

Pool of eligible providers
Current Dental Providers – (Active Medicaid ID)

Mail out to:
- Individual Providers
- Group Providers

Website
http://www.tn.gov/tenncare/pro-forms.shtml

Individual Provider

CAQH
120 day attestation

TennCare Provider Services Review

DBM Credentialing Decision

Submitted to DBM weekly

Pool of eligible providers

MMIS

Group Provider

TennCare Provider Services Review

MMIS
Contact Information

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- **BIOGRAPHICAL SKETCH:** I received my dental degree from the University of Tennessee, College of Dentistry, in 1981 and a Master of Public Health from the University of North Carolina at Chapel Hill in 1986. I became a Diplomate of the American Board of Dental Public Health in 1990. I became the first TennCare Dental Director in September, 2002. Prior to this, I served as Director of Oral Health Services for the Tennessee Department of Health from 1995 to 2002. I served as Director of Dental Services for the Metropolitan/Davidson County Health Department from 1989 to 1995. I have been a member and officer of several professional organizations and boards. I am also a member of the Tennessee Dental Association and past President of the Nashville Dental Society. I have authored a number of articles some of which have been published in peer reviewed journals.
THANK YOU