2014 MSDA National Medicaid and CHIP Oral Health Symposium

State Contracting: Improving Program Quality and Value

Washington Marriott Wardman Park
Washington DC
June 9th-10th, 2014
State Contracting: Improving Program Quality and Value

Keynote

Ms. Marilyn Tavenner

Administrator, Centers for Medicare and Medicaid Services

June 9th-10th, 2014

Washington Marriott Wardman Park – Washington DC
Introduction to State Contracting

Opening Plenary

James Gillcrist, DDS
Robert Isman, DDS
David Fischer

2014 National Medicaid and CHIP Oral Health Symposium
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Description

This session will provide an overview of the emerging administrative models currently used by Medicaid and CHIP dental programs. Presenters will discuss the various payment models being implemented between states and contractors and between contractors and dental providers. The session will explore "carve-in" versus "carve out," as well as "risk-sharing" models and how these various models affect the states' and the contractors' roles and responsibilities.
Session Objectives

Participants will gain knowledge and understanding of:

• The emerging administrative models currently used by Medicaid and CHIP dental programs;

• To describe Tennessee’s experience with Medicaid managed care “dental” services over the past 20 years using 3 different contract models.

• To describe California’s experience with different payment models used in its Medicaid dental program
James Gillcrist, DDS

Tennessee Health Care Financing and Administration
Dental Director

Understanding How Risk Levels Influence Managed Care
Contract Development
Government Objectives

• Delivery of high quality care to enrollees
• Increase the number of enrollees utilizing care
• Predictability and sustainability of program costs
If You Don’t Know Where You’re Going, Any Road Will Take You There.
Managed Care Medical Model

Characteristics of MCO Contract:

• Full-risk bearing on MCO
• MCO receives a capitation payment from State per enrollee
• “Carve-in” integrates services (physical health, dental, behavioral health, pharmacy, etc.,)
• State has oversight of contract
• State has predictability in annual Medicaid costs
• MCO contracts directly with providers, manages network,
• MCO controls fees and negotiates rates individually with providers and hospitals (shifts risk to providers)
Managed Care Dental

Categories of Dental (DBM) Contracts:

• MCO(s) subcontracts with DBM for dental services, still considered a “carve-in”
• State contracts directly with DBM to administer dental services, considered a “carve-out”
  – Types of Dental Carve-outs:
    – Non-Risk Bearing (ASO)
    – Partial-Risk Bearing (Hybrid)
    – Full-Risk Bearing
Dental Carve-out: ASO

Characteristics of **Administrative Services Only (ASO)** dental contract:

- Non-risk bearing on DBM
- State bears all the risk (covers claim expenditures)
- Dedicated “dental” budget
- DBM processes and pays claims, contracts with providers, manages network, conducts UM/UR
- DBM receives an administrative fee
- State controls fee schedule
- State establishes contractual benchmarks
- State has oversight of contract
Dental Carve-out: Partial Risk

Characteristics of “Partial Risk” dental Contract:

• Shared financial risk between State and DBM
• Losses are shared between State and DBM
• Savings are shared between State and DBM
• DBM eligibility for shared savings is determined by a combination of total claim expenditures and enrollee participation ratio
• Enrollee participation is included in the calculation to ensure that utilization/access is not compromised in trying to deliver care economically
Dental Carve-out: Partial Risk

Characteristics of “Partial Risk” dental Contract:

• Dedicated “dental” budget
• State covers claims expenditures up to targeted amount
• DBM receives an administrative fee
• State controls fee schedule to shield dentists from risk
• DBM contracts directly with providers, manages network
• State has oversight of contract
• State imposes LDs if access to care or quality benchmarks are not met
TN Experience with Partial Risk Contract

- Launched on October 1, 2013
- Enrollee participation level trending above target
- Claims expenditures trending below target
- An Annual Quality Survey of DBM compliance with 17 contract standards conducted by an independent EQRO showed 100% compliance on 14 of 17 standards and substantial compliance on 3.
Dental Carve-out: Full Risk

Characteristics of “Full Risk” dental contract:

• Similar to MCO full risk contract, but includes “dental” services only;
• Provides state with predictability in annual dental costs because of capitated payment;
• DBM controls fees and negotiates rates individually with dentists (shifts the risk to participating dentists);
• DBM manages dental network, contracts directly with providers;
• State has oversight of the contract
TN Managed Care Dental Experience 1994 - 2014

1969 TN Medicaid program was launched

1994 State transitioned to Medicaid managed care, MCO “Full Risk”, Integrated model

2002 – 2013 Launched ASO carve-out single DBM

2013 Launched “Partial Risk” carve-out single DBM

2014 Year 1 Status

Traditional State-run program

Multiple MCOs poor dentist participation and enrollee dental utilization

DBM “No Risk”, contract; Good dentist and enrollee participation

Enrollee utilization trending above target while expenditures trending below target
“If you build it, they will come”

Dentists will participate in public programs if:

• Business friendly
• Simple to navigate
• Administratively streamlined
• Equitable
  o no sweetheart deals
  o reasonable fees
  o allows dentist input
Managing Care Through Dental Homes

- Assigns enrollees to participating dentists
- DBM rewards dentists who provide MN care and whose enrollees routinely access dental care with assignment of additional enrollees
- DBM shrinks enrollee pool for providers who don’t provide comprehensive care or promote enrollee utilization
- Controls for cost and quality
- Promotes oral disease prevention
- Utilizes a provider scorecard to encourage positive provider behavior and potential incentives.
## Payment: State to Health Plan

<table>
<thead>
<tr>
<th></th>
<th>MCO</th>
<th></th>
<th>DBM</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ASO</td>
<td>DBM</td>
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<tr>
<td>Capitated</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Admin Fee</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Shared Savings</td>
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<td>✓</td>
</tr>
<tr>
<td>Shared Loss</td>
<td></td>
<td></td>
<td>✓</td>
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</table>
## Payment: Health Plan To Provider

<table>
<thead>
<tr>
<th>MCO</th>
<th>DBM</th>
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<tbody>
<tr>
<td>Capitated</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Options include: Capitated, Fee-For-Service.
Contracts Are Only as Effective as Requirements Contained Therein
Are There Teeth In Your Contract (Sanctions/ LDs)?
Take Aways

• State has ultimate responsibility for the healthcare of its enrollees, not the contracted health plan(s);
• Design contracts so that State doesn’t cede its responsibility for oversight to the health plan(s);
• The greater the number of contracted health plans, the more challenging it is for the state to provide oversight;
• “Carve-out” has the wrong connotation. It is incorrectly perceived as an exception to managed care;
• Phrases such as “dental managed care” or “managed care dental model” convey the right message;
Take Aways - continued

- Managed care contracts are more effective when they are not AWP, unless state law requires AWP;
- Provider participation is a product of program design;
- Government prefers contracts where there is some risk bearing by the health plan(s);
- Risk bearing incentivizes health plans to manage better;
- Recognize challenges associated with implementation of risk bearing contracts.
Questions

Comments

Discussion
Robert Isman, DDS

California Department of Health Care Services
Dental Program Consultant

Payment Models in California’s Medicaid Dental Program
Government Objectives

• Delivery of high quality care to beneficiaries
• Increase the percentage of beneficiaries utilizing care
• Predictability and sustainability of program costs
• (Make CMS happy)
## California’s Medicaid Dental Population (May 2014)

<table>
<thead>
<tr>
<th>Model</th>
<th>&lt; 21</th>
<th></th>
<th>21+</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>&quot;Fee-for-Service&quot;</td>
<td>4,589,970</td>
<td>90.6</td>
<td>5,940,791</td>
<td>96.0</td>
<td>10,530,761</td>
<td>93.5</td>
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<td>Geographic Mgd Care</td>
<td>179,052</td>
<td>3.5</td>
<td>121,419</td>
<td>2.0</td>
<td>300,471</td>
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<td>Prepaid Health Plan</td>
<td>298,451</td>
<td>5.9</td>
<td>127,824</td>
<td>2.1</td>
<td>426,275</td>
<td>3.8</td>
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<tr>
<td>Total</td>
<td>5,067,473</td>
<td>100.0</td>
<td>6,190,034</td>
<td>100.0</td>
<td>11,257,507</td>
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California’s Medicaid Medical Population (May 2014)

<table>
<thead>
<tr>
<th>Model</th>
<th>&lt; 21</th>
<th>21+</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Fee-for-Service</td>
<td>832,624</td>
<td>16.3</td>
<td>3,188,610</td>
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<tr>
<td>Managed Care</td>
<td>4,269,272</td>
<td>83.7</td>
<td>3,132,141</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>5,101,896</strong></td>
<td><strong>100.0</strong></td>
<td><strong>6,320,751</strong></td>
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</table>
# Dental Carve-out: Partial Risk

## Characteristics of “Partial Risk” dental Contract:

<table>
<thead>
<tr>
<th>Feature</th>
<th>TN</th>
<th>CA</th>
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</thead>
<tbody>
<tr>
<td>Losses are shared between State and DBM</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Savings are shared between State and DBM</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Shared savings are contingent upon DBM meeting enrollee participation ratio</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>State covers claims expenditures up to targeted amount</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Dedicated “dental” budget</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>DBM receives an administrative fee</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>State controls fee schedule to shield dentists from risk</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Strict State oversight of contract including sanctions</td>
<td>Y</td>
<td>?</td>
</tr>
<tr>
<td>DBM contracts with providers, controls network, not “AWP”</td>
<td>Y</td>
<td>N</td>
</tr>
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</table>
# GMC vs. PHP

<table>
<thead>
<tr>
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<th>Counties Served</th>
<th>Number of Plans</th>
<th>Enrollment Type</th>
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<tr>
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<td>Mandatory</td>
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<tr>
<td>Prepaid Health Plan</td>
<td>Los Angeles</td>
<td>3</td>
<td>Voluntary</td>
</tr>
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</table>
Dental Carve-out: Full Risk

Characteristics of “Full Risk” dental contract:

• Similar to MCO full risk contract, but includes “dental” services only;

• Provides state with predictability in annual dental costs because of capitated payment;

• DBM controls fees and negotiates rates individually with dentists (shifts the risk to participating dentists);

• DBM manages dental network, contracts with providers, not AWP;

• Strict oversight by the state including sanctions for DBM failure to meet contract requirements.
## Payment: State to Health Plan

<table>
<thead>
<tr>
<th></th>
<th>ASO</th>
<th>DBM/Plan</th>
<th>Partial Risk</th>
<th>Full Risk</th>
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<tbody>
<tr>
<td>Capitated</td>
<td></td>
<td></td>
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<td>√</td>
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<tr>
<td>Admin Fee</td>
<td>√</td>
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Payment: Health Plan To Provider

DBM/Plan

Capitated

Fee-For-Service
Payment: Health Plan To Provider

<table>
<thead>
<tr>
<th>DBM/Plan</th>
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<tbody>
<tr>
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Immediate Action Expectations

• Beneficiary letter
• Phone call campaign
• Issue resolution reporting
• Informational flyer
• Utilization control with enrollment
• Education seminars

• FQHCs
• Timely access reports
• Increase provider and specialist enrollment
• Specialty referral process
• Pay to perform
• Withholds on provider payments
Take-Aways

• Government has ultimate oversight responsibility for the healthcare of the enrollee, not the contracted health plan(s);

• The greater the number of health plans contracted with the state, the more challenging it is for the state to provide oversight;

• The greater the number of MCOs contracted with the state, the more challenging it is to establish compliant dental networks;

• Government prefers managed care contracts where there is some risk bearing by the health plan;
Take-Aways - continued

• Risk bearing incentivizes health plans to manage better because it holds them accountable;
• Provider participation is a product of program design;
• Can’t enforce what’s not in the contract.
  o Can’t enforce what is in the contract without good staff who know it by heart
  o Can’t enforce what is in the contract without clear reporting requirements tied to contract provisions
Questions
Comments
Discussion
David Fischer

Oregon Health Authority, Medicaid Program Contract Administrator
Oregon’s Medicaid Contracting Models

“No, It Doesn’t Rain All the Time”
Oregon Fast Facts

• Total Populations is 3.9 million (2012)
• Urban, Rural and Frontier and Culturally Diverse
• 99,000 Total Square Miles
• Key Industries(Tourism, Fishing, Timber, Technology, Agriculture)
• Intel, Nike, Adidas Have Ties to Oregon
• Current Medicaid Eligible Enrollment 990,000 (April, 2014)
• 89% Managed, 11% FFS(Non-enrollables)
• ACA Medicaid Expansion Population is nearly 350,000 since 1/1/14
How is Oregon Medicaid Organized?

- Single State Agency
- Title 19 (Medicaid)
- Title 21 (S-CHIP)
- Multiple 1115 CMS Waivers (first was 1994)
- Latest Waiver Created Coordinated Care Organizations (July, 2012).
  - [https://cco.health.oregon.gov/Pages/Home.aspx](https://cco.health.oregon.gov/Pages/Home.aspx)
Oregon Medicaid Transformation

• Need for Overall Population Health Improvement
• Triple Aim(Improve Health, Improve Healthcare and Lower Costs)
• Legislative Direction(HB3650 and SB1580)
• Broad Stakeholder Involvement including community town halls, advocates, consumers, legislators, managed care plans, etc
• Agreement with CMS(Global Budgets and Risk Sharing)
• Strong Emphasis on Quality Metrics and Data
• New Federal Investment ($1.9 billion over 5 yr.)
Transformation and the Contracting Process

• Created new procurement using a Request for Application (RFA)
• Created Application Review and Certification Processes
• Created Internal Workstreams for Planning and Implementation (Inter-Agency)
• Created improved communication models with Contractors and Stakeholders
• Implemented over 4 Months (August to November, 2012)
• Created a Transformation Center and Innovator Agents
• Per CMS waiver, Oregon agreed to shared risk with CMS by limiting cost increases to 2% per year
Oregon Medicaid Contracting Models (Pre-Transformation before August, 2012)

- Heavy Managed Care (over 15 years)
- Fully Capitated Health Plans (FCHP) 15
  - Full Risk Sharing with Admin Load
- Mental Health Organizations (MHO) 10
  - Carve Out Model, Full Risk with Admin Load
- Dental Care Organizations (DCO) 8
  - Carve Out Model, Full Risk with Admin Load
- Physician Care Organization (PCO) 1
- Transportation Brokerages (NEMT) 8
- Disease Management (FFS populations) 1
Oregon Medicaid Contracting Models (Post-Transformation > August, 2012)

- Formed Coordinated Care Organizations (CCO) 16 Contracts with 15 Organizations
- Merged Physical and Behavioral Health
- Merged Dental
- Merged NEMT
- Transitioning Other Medicaid Services (per Waiver) to CCOs
- Continued using former contracting models
What Have We Learned?

• Transformation is hard and it takes time
• It costs money to transform (new infrastructure)
• Healthcare integration is hard work and it takes time and trust
• Maintaining institutional knowledge is critical
• Healthcare transformation includes cultural transformation (Organizational Dynamics)
• Playing field contains variety of CCO organizational models (Sub-contractor delegation and payment models)
• Just writing an integrated contract doesn’t make you an integrated system
• New legislative-directed contracting constraints and impact on contracting cycle
What Have We Learned? (cont’d)

- Timing is Important (i.e.: PPACA Impact)
- CMS is a great partner in our journey
- Communicate, communicate, communicate
- Be flexible, what we did yesterday may not be the process tomorrow
- Credible data is more important than ever
- Not everybody will be happy with the journey
- Understand, from a contracting point of view, everyone came together and agreed at first, then came “I have what in my contract?”
Questions
James Gillcrist, DDS

James Gillcrist received a dental degree (DDS) from the University of Tennessee, College of Dentistry, and a Master of Public Health (MPH) from the University of North Carolina at Chapel Hill. He is a diplomate of the American Board of Dental Public Health and currently serves as the Tennessee HCFA Dental Director. Prior to this, Dr. Gillcrist served as Director of Oral Health Services for the Tennessee Department of Health. He also served as Director of Dental Services for the Metropolitan/Davidson County Health Department. Dr. Gillcrist has been a member and officer of several professional associations, boards, and councils. He has authored a number of articles, some of which have been published in peer reviewed journals.
Robert Isman, DDS, MPH

Bob Isman, DDS, MPH, is a Dental Program Consultant for the California Department of Health Care Services in the unit that administers California’s Medicaid dental program. He is involved in a variety of activities related to administration of this program, including efforts to increase access to dental services for Medi-Cal beneficiaries, utilization monitoring, quality assurance, and liaison with public health programs inside and outside the Department.

Prior to assuming his current position, Dr. Isman was Chief of the Department's Dental Health Section—the State Dental Director—for 10 years. He is a past President of the Association of State and Territorial Dental Directors, past Chair of the Oral Health Section of the American Public Health Association, founder and past Chair of the Oral Health Section of the California Public Health Association--North, the first dentist in the U.S. to be selected as a Pew Fellow for Health Services Research, and a founding member of the Dental Health Foundation. He is also a founding member and Past Chairperson of the Medicaid-CHIP State Dental Association.

Dr. Isman received his DDS from the UCSF School of Dentistry and his MPH from the University of California at Berkeley.
David Fischer

David Fischer is the Contract Administrator for Oregon’s Medicaid managed care contracts. Oregon’s Medicaid managed care system utilizes Coordinated Care Organizations (CCO) to manage over 700,000 lives through 16 CCOs statewide. Oregon has been utilizing managed care for its Medicaid population for over 10 years. The Coordinated Care Organizations are the most recent structure approved through their 2012 CMS waiver. CCOs integrate the enrollee’s care including physical, behavioral and dental services.

David’s background has been as a medical practice administrator prior to joining Oregon’s Medicaid program in 2008. David and his wife, Alese, reside in Woodburn, Oregon, just south of Portland.
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MSDA National Profile: http://www.msdanationalprofile.com