Scope of Services Related to Providers

Session 2

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Description

All states must create and document in their contracts, a scope of services for the vendor, which delineates the specific responsibilities of the contractor. In addition, all states and contractors must create a scope of services for participating dental providers. This session will address both kinds of contracts and include the following: Access and Availability to Care and Network Development; Provider Agreements; Provider Services; Training, Manual and Guidelines; Provider Payment; Performance Objectives and Utilization Review.

Disclaimer

- All opinions given today are the personal views of David Weeks and do not represent the position of the State of Tennessee or any of its Agencies.

Session Objectives

Participants will gain knowledge and skill regarding:

- the responsibilities of the states and contractors that relate to the scope of services for participating dental providers;
  - Topics include access and availability to care; network development; provider agreements; provider contracts; provider services; provider training; the provider manual; guidelines and provider reimbursement; and
- the development of an RFP for dental services administration; and
- Tennessee's experience with two key committees related to participating providers and mandated by every DBM contract with the State since 2002.

Robyn Olson, PhD

Boston Benefit Partners

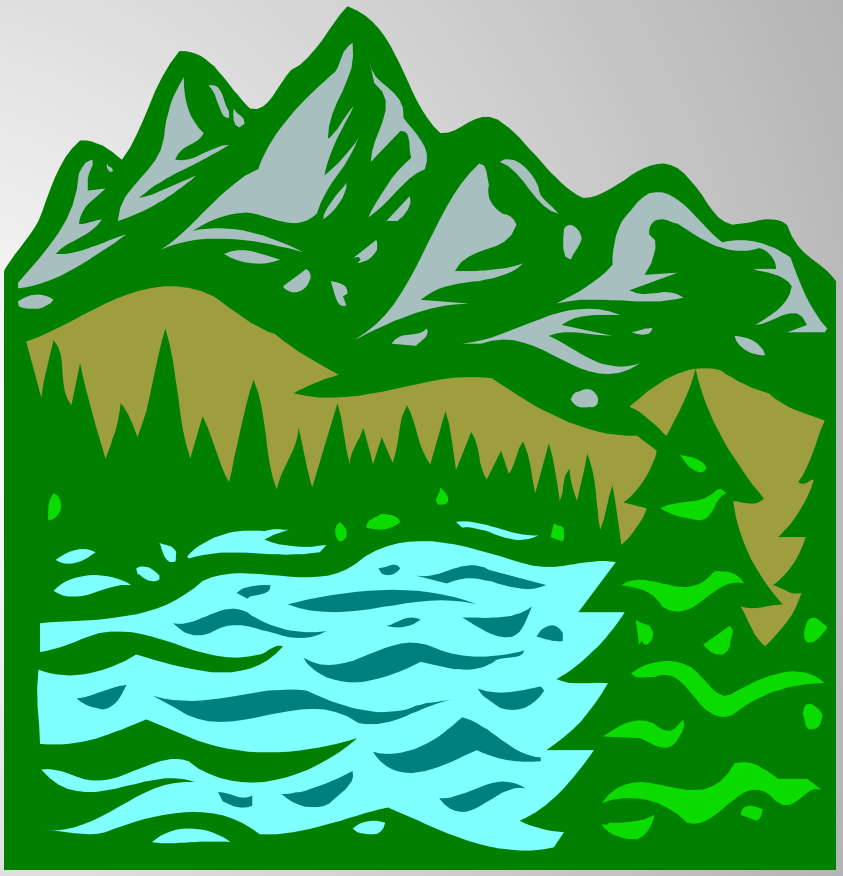
Managing Consultant

Developing Request for Proposals (RFPs)

- Be Proactive
  - Plan ahead
- Be Collaborative
  - Seek input from stakeholders
    - Best Practices
    - New and emerging concepts/models
- Be Strategic
  - Identify important program components
  - Request for Information (RFI)?
- Be Open, Flexible, and Innovative
  - Think out of the box

The Current Landscape

- Medicaid population is expanding
- State budgets are constrained
- Focusing solely on higher reimbursement may not be a sustainable solution
- Consider alternative approaches to contracting, funding, administration and treatment to maintain successful programs



General Goals/Objectives of Medicaid Dental Programs

- Maintain a network of quality dental providers who provide comprehensive, accessible, coordinated, patient-centered care to members of all ages
- Meet federal requirements and goals of CMS for accessibility and utilization standards
- Meet state requirements and internal goals
- Maintain an affordable program
- Improve oral health

A Sufficient Provider Network is Essential to Meeting Goals!

Providers and Provider Networks

- Determine where network gaps and/or issues exist
- Current reimbursement strategy
- Available budget
- Use RFP process to solicit ideas regarding network building and maintenance
- Let vendors and stakeholders help you to improve your program!

Building and Maintaining an Adequate Provider Network : What Should You Know Before You Issue Your RFP ?

- No standard agreed upon measures, but important to outline your requirements
- Know your membership
  - Geographic distribution
  - Demographics
  - Special needs
- Understand available providers in your state
  - Number of providers in state
  - Types of providers
  - Distribution of providers

Providers and Provider Networks

- RFR must include questions regarding:
  - Network Development and Maintenance
  - Network Adequacy
  - Credentialing and Other Requirements
  - Provider Relations/Services
  - Provider Manual
  - Provider Training
  - Provider Agreements
  - Provider Reimbursement

Network Growth and Maintenance

- Request detailed plan for network growth and maintenance including:
  - Overall approach
  - Employees assigned
    - Location
  - Goals and timeline
  - Evaluation and Reporting
    - List of all reports
  - Performance Guarantees
- How will dental “desert” areas be addressed?
  - Ideas/plan of attack for addressing areas where there are no or few dentists
- Process of addressing network deficiency

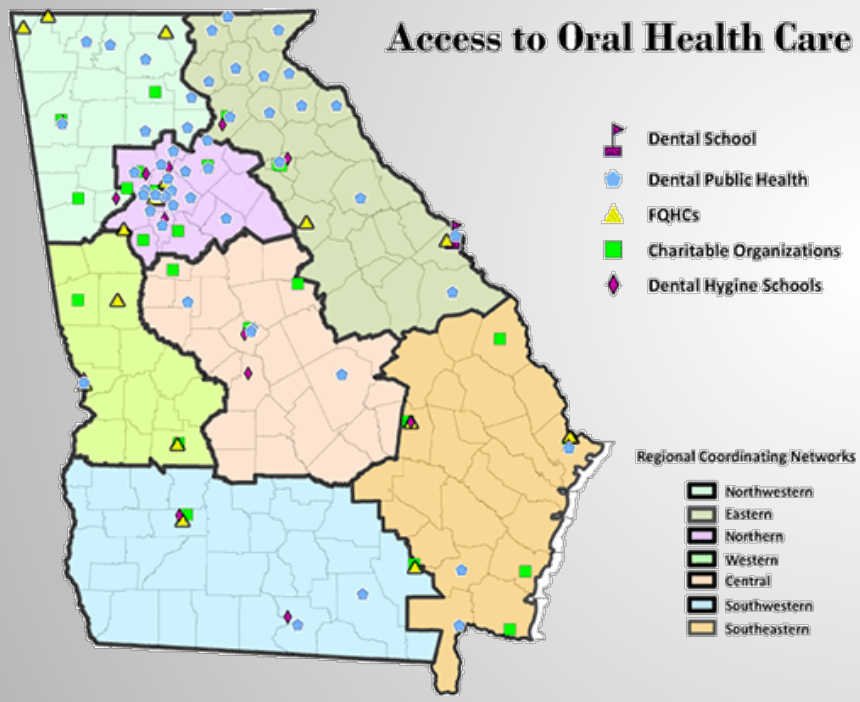
Network Size is a Balancing Act

- Growth for the sake of the growth is not appropriate
  - Adequate number of quality providers, but at an affordable price
  - Network size is related to reimbursement, but reimbursement is not the only issue for providers
- Other factors may be preventing members from seeking care. RFP should address those issues too

How Can Network Adequacy be Measured?

- Request **number of providers by provider type** and include the following:
  - Unique providers
  - Locations
  - Access points
    - Multiply unique dentist by each location practicing in
  - Network size as a percentage of total practicing/active/licensed providers
- Request **Geo-Access** report
  - Measures availability of providers to individual members in specific geographic regions by using zip codes
  - Measures should be agreed upon
    - Urban, rural, suburban could be different
    - Example: 1 or 2 providers within certain driving time/s or distance/s
      - GPs vs. Specialists
- Request **Network Match**

How Can Network Adequacy be Measured? (continued)



- Contracting of safety net providers /essential community providers
- Contracting with mobile and other alternative (non-dentist) providers
- Set minimum thresholds or goals
  - % of total available

Source: Georgia Oral health Coalition (GOHC) www.gaohcoalition.org

Network Size Comparison

	State	Carrier A	Carrier B	Carrier C
Total Access Points	4,797	3,217	1,260	680
% of State Total	100%	67%	26%	14%
Total Unique Providers	2,175	1,662	777	382
% of State Total	100%	52%	36%	18%
Access Points/Providers	2.2	1.9	1.6	1.8
General Practitioners Access Points	3,534	2,317	932	565
% of State Total	100%	66%	26%	16%
Total Unique Providers	1,670	1,237	578	325
% of State Total	100%	74%	35%	19%
Access Points/Providers	2.1	1.9	1.6	1.7
Endo Access Points	324	196	45	33
% of State Total	100%	60%	14%	10%
Total Unique Providers	112	65	26	13
% of State Total	100%	58%	23%	12%
Access Points/Providers	2.9	3.0	1.7	2.5

Selection, Credentialing and Other Provider Attributes

- Selection/Recruitment
  - Process
  - Targeted providers / “high performance” network based on utilization patterns
- Credentialing
  - Requirements
  - Process
  - Timeframes
- What type of information will vendors collect regarding providers?
  - Languages spoken
  - Americans with Disabilities (ADA) Compliance
  - Office hours

Provider Services

- Request information regarding provider services:
  - Call Center Staffing
    - Response Time
  - Handling of escalated provider issues
  - Dentist or other providers/staff available to discuss problems/issues
  - Location of staff
  - Toll-free number/helpline
- How will vendor monitor provider satisfaction?
  - Surveys
  - Ongoing tracking of provider questions/complaints?
- Will vendor provide “performance” reports to providers?
  - Incentives

Provider Manual

- Confirm that provider manual will address the following issues:
  - Covered services, limitations and exclusions
  - Utilization management procedures
    - Prior approval, medical necessity, other
  - Billing requirements
  - Practice guidelines
  - Required forms
  - Performance measurement and reporting
- Confirm how and when manual will be distributed and updated
- Request sample copy of provider manual and all updates for review and approval

Training

- Training for network providers should include any/all of the following:
  - All items found within the Provider Manual
  - State and federal laws and other rules
    - Specific rules regarding dental and orthodontic coverage including medical necessity
    - Referrals
    - Meeting EPSDT requirements
    - Behavior management
  - Practice guidelines
  - Monitoring of compliance
    - Corrective action
  - Provider termination process
  - Other
- Request information regarding training requirements for providers, training methods, number of sessions, locations etc.

Provider Reimbursement

- Method of Reimbursement
  - Fee for Service
  - Capitation
  - Hybrid
  - Other
- Development of Capitation Rates and/or Fee Schedules
- Incentives
- Timing of payment
- Other requirements

Examples from the Panel!

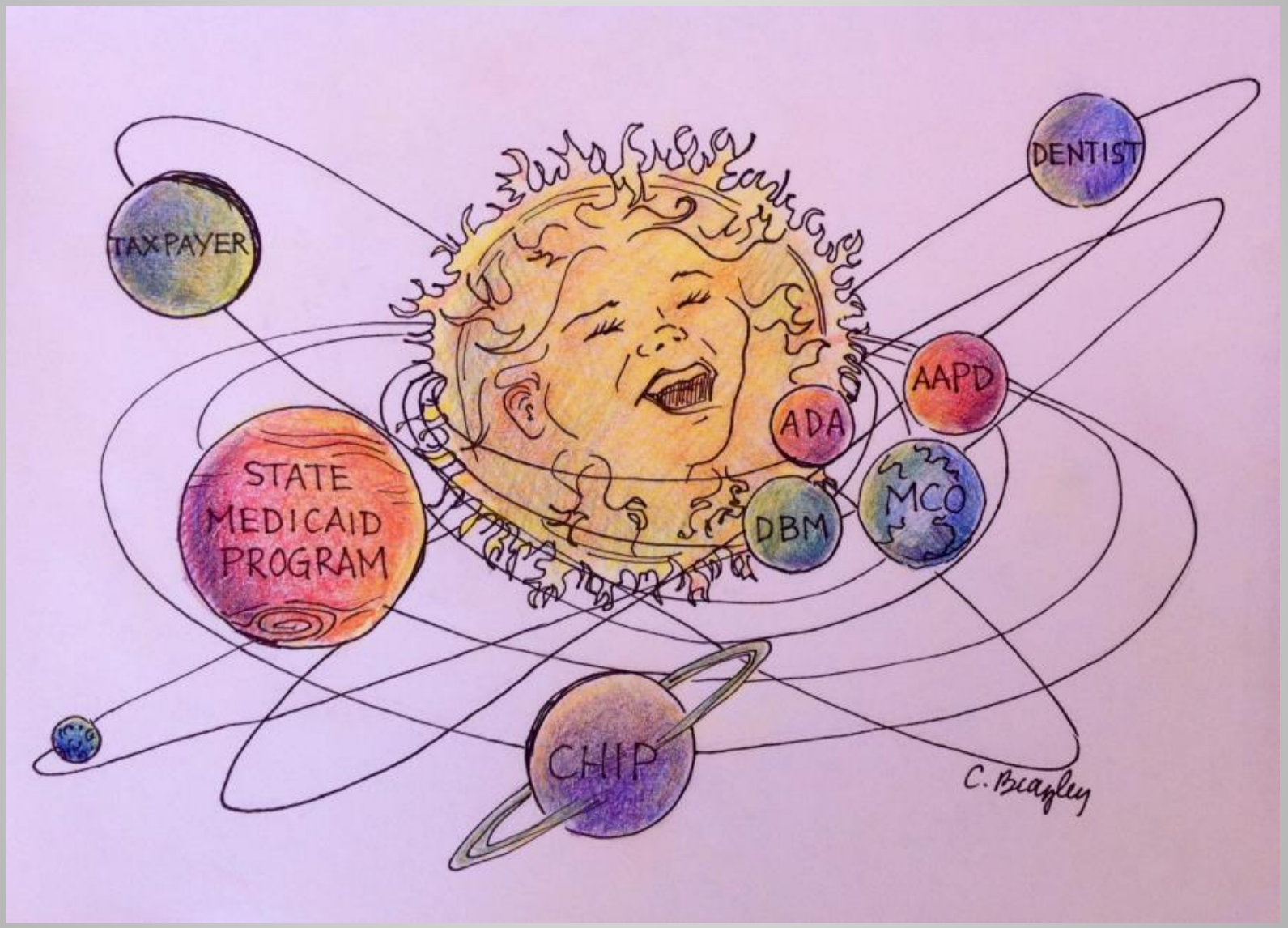
Thomas Underwood, DDS

TennCare Medicaid Advisory

If you want to know what dental providers need, … ask them.

If you want to know what dental providers can do for your program,… ask them.

Public Insurance Solar System



TennCare's Dental Advisory Committee

- Makes recommendations to the State about the dental program
- Recommendations are not binding on the State
- Committee recommendations that improve quality, cost and/ or enrollee utilization are usually adopted by State
- Allows a forum for discussion of issues brought by participating providers
- Committee chairperson appointed by State
- Meeting schedule established by State
- Composed of no more than 20 members

TennCare's Dental Advisory Committee

- DBM appoints two members
- Other members represent organized dentistry, dental public health, dental schools, dental specialties, dental hygienists, TNPCA and Head Start
- Professionally weighted (majority dentists), active committee
- Provides input related to dental necessity guidelines consistent with State MN Rules
- Provides consultation regarding dental periodicity

If You Are Not At The Table, You May be On The Menu

Provider Peer Review Committee (PPRC)

- Contract requires DBM to establish and maintain a professional peer review committee
- Is a function of the DBM based on it's individual contract with dental providers
- PPRC must meet at least quarterly
- Reviews suspected cases of fraud, waste or abuse by participating providers
- Reviews cases involving enrollee quality of care
- Corroborates audit findings, issues detailed factual findings, makes recommendations and proposes corrective action for non-compliant dentist(s)

Provider Peer Review Committee (PPRC)

- At the time the DBM submits a provider to PPRC for review, a referral should be made to TennCare's Office of Program Integrity (PI)
- DBM must coordinate with PI prior to taking action against a provider including recoupment, termination, CAP and or education
- DBM must coordinate with PI in regard to issues involving suspected fraud, waste or abuse
- DBM must coordinate with PI regarding provider recoupment related to suspected fraud, waste or abuse
- Must coordinate with PI before stopping provider payment for credible allegation of fraud

R. Mike Shirtcliff, DMD

Advantage Dental

20 Year History
Medicaid Issues in Oregon

- Limited providers
- Administrative issues
- Beneficiary issues
- Benefit issues
- Reimbursement issues
- Lack of communication between providers and Medicaid

Provider Perspective

- Social responsibility
- Professional responsibility
- Providers as leaders
  - Less independent
  - More community oriented
- Needs for less complaining
- Need to organize and be a part of efforts to make improvements

Providers Stepped Up → Organization Formed

- Became a part of the solution
- Developed a Mission and Vision Statement
  - Guiding principals
  - Guiding direction in areas we could all agree upon
- New efforts centered around "problem solving"
- Essential need to halt provider emotional response

Questions to Answer

- How do we get care to everyone?
- Where do we go to do this?
- What can we do as dentists?
- How do we engage the community?

Began Holding Provider Meetings

Need to understand:

- The needs of the dentists
- What we agreed/disagreed on?
- What can we do as an organization to solve these dental access problems in our community?
- We soon recognized…
  - *We are not individual siloes in dental practice. We are part of a community. We need to ask the community.*
  - *State gives us license to take care of our community. How are we making good on that privilege?*

We Engaged the Oregon Medicaid Agency
Oregon Health Plan

- In 1994 State issued RFP for dental services
- We had no experience in how to respond to an RFP
- Step 1-We obtained and studied copies of responses from other public documents
- Step 2-We used them to learn how to a develop a contract proposal
- Step 3-Obtained technical assistance from the state Medicaid agency
  - State offered support for contract development

Engaged the Oregon Medicaid Agency Oregon Health Plan

- Step 4-We recognized the RFP was about prevention and prioritizing care
  - *Couldn't drill and fill out of the problem any more.*
- Step 5-We worked with State agency to develop our contract response
- Step 6-In 1995 received 1st state contract
- Since 1995, we have developed a number of contract proposals, and have received numerous contract awards
- **Today we have 15 CCO contracts**

Solution to the Problem: Providers Joined Together, Owned the Problem and Became a Provider & Payer Organization

- Initially, Key– know what you want; know what you need.
- Ultimately we built the systems we needed to manage them the way we wanted

What exactly did we do?

- We responded to the State RFP
- We worked with the state to develop a collaborative contract that worked for both the state and the providers
- As a collective entity, we subcontracted with payer because we lacked administrative infrastructure and capacity
  - We had to develop that contract too

What exactly did we do?

- Our provider group expanded and became a “payer” as well
- In Oregon- two ways
  - As a provider network- work as a provider for payers

  or

  - Apply to become an insurer--We became a payer

Today – A New Environment in Oregon

16 Coordinated Care Organizations (CCOs)

- What is a CCO?
- What does this mean for our organization?
- Contracting has become more complex:
  - We now must contract with 16 different CCOs
  - There are 16 interpretations of what the law says; plus our own interpretation
  - **State must intervene as the interpreter of the law
- We now have a system that works for us
- We can now engage the CCOs, and provide our expertise to them and to the state
- Working with all of them to develop consistency across the state

Contract Management

with

States, CCOs, and Providers

- There's always going to be issues that arise on all sides
- Contract amendments in the middle of year can be problematic
  - Results loss of providers
- Contract management with providers:
  - Monitor recording of services by provider in patient records
  - Inaccurate records jeopardizes patient, provider, payer and the contract
  - Making sure dentists are really doing what they say
  - Continuous monitoring for patterns of behaviors
    - Example- We can always know when a dentist get new receptionist
- Need for ongoing training

Successful Outcomes

- Expanded provider network across Oregon
- Improved access
- Improved provider relations
- Better understanding by provider network of what is needed
- Better integration of health care
- Improved oral health and overall health for Oregon residents

David Weeks, JD

Tennessee Health Care Financing Agency

Assistant General Council

Chain of Authority

Provider Focus

Provider Focused

- Protect your Brand
- 90% of battle is provider payment and "Provider Hassle Factor"
- Predictable budget is a balance between *$ and Utilization Management*, so…
- *Fees* and *Medical Necessity* are key
- "We don't manage the network!"

Provider Issues

- Are we an “any willing provider” state?
- Are providers taking new patients?
- Can we encourage provider participation by tying Medicaid/CHIP to participation in State Employee plan?
- How can we reduce Provider Hassle?
  - Online registration ?
  - Flexible prior auth requirements?

Provider Issues (Continued)

- How do we handle mobile dentistry/corporate dentistry if we want to create dental homes?
- Can we reward Providers for quality of care?
  - Financial incentives?
  - Non-financial incentives?
- How can we get /keep provider community involved in program?

Final Thought

- Government funded healthcare is a given.
- Beneficiaries needing healthcare is a given.
- Providers willing to see the patients for what the government will pay *is not a given*.

Robyn Olson, PhD

Robyn Olson is currently a Managing Consultant at Boston Benefit Partners LLC (BBP), a health and welfare benefits consulting firm. At BBP, Robyn has worked on Requests for Proposals (RFPs) for dental insurance for the Commonwealth of Massachusetts Group Insurance Commission, the organization responsible for providing state employee and retiree dental insurance, and the Commonwealth Connector Authority, the Commonwealth's ACA Marketplace. In addition, Robyn currently serves on a consulting team assisting the MA Special Legislative Commission on Dental Insurance.

Thomas S. Underwood

Dr. Thomas Underwood received his dental degree (DDS) from the University of Tennessee, College of Dentistry, and a Masters for research on implants in Rhesus Monkeys from what is now Vanderbilt University. He has served on numerous councils and committees of the Nashville Dental Society and the Tennessee Dental Association, being President of both organizations. He is the founder of the Interfaith Dental Clinic which serves the working poor. He has worked to improve the TennCare (Tennessee's Medicaid program) from its onset and helped develop the TennCare Dental Carve-Out. Dr. Underwood serves as a member of TennCare's Dental Advisory Committee. He also currently serves on the American Dental Association's (ADA's) Medicaid Advisory Council and as a Delegate to the ADA. He has received the highest award given by the Tennessee Dental Association and the first Humanitarian award given by the ADA.

R. Mike Shirtciff

Dr. Mike Shirtcliff has 20 years of experience practicing general dentistry in a small rural Oregon Community and was instrumental in organizing Advantage Dental, an independent practice association of over 300 network dentists, treating almost 300,000 Oregon Medicaid recipients. Advantage Dental has been a direct contractor for over 18 years with the Oregon Department of Medical Assistance Programs. Dr. Shirtcliff has served on numerous committees including, but not limited to: the Oregon Medicaid Advisory Committee, the Medicaid Medical Directors workgroup, the Governor's transformation committee, the Oregon Health Fund Board subcommittee on medical delivery systems, among others.

David Weeks, JD

David Weeks, J.D. is currently an Attorney in TennCare's OGC and has oversight responsibility for both contracting and the Bureau's Program Integrity programs. In this role he was involved with setting up programmatic components of TennCare's enhanced Program Integrity functions such as the Provider Review Committee (PRC), implementation of the Recovery Audit Contractor (RAC) program and drafting the MOU between the Bureau and several other State agencies and coordinates investigations with the U.S. HHS-OIG, the FBI, the U.S. Attorney General's Office and others. In addition, Mr. Weeks works on the review and drafting of the many contracts required to keep the TennCare's system functioning. Mr. Weeks is also a current faculty member at The CMS Medicaid Integrity Institute.

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