Financing Oral Health Care for Medicaid and CHIP Beneficiaries: What States are Doing

Linda Altenhoff, Texas
Dan Plain, Virginia
Martha Dellapenna, Rhode Island
Mary E. Foley, Presenter and Facilitator

February 29, 2012
Learning Objectives

• To understand how states pay for oral health services in Medicaid and CHIP programs.
• To learn the history of oral health reimbursement
• To recognize the options available to fund oral health
• To acknowledge the oversight and limitations placed on such arrangements
The Law

- Title XIX
- Centers for Medicare and Medicaid Services
- State Medicaid and CHIP Programs
- State Administrative Plans
- EPSDT
- Medical Necessity
- Contracting
History of Medicaid Programs

Payment Models

• Traditional: “Fee For Service” Reimbursement

• Administrative Service Only (ASO)
  “Dental Benefits Administrator” (DBA)
  “Third Party Administrator” (TPA)

• Managed Care

• Hybrid
Traditional Model

“Fee for Service”

Member seeks dental care

Provider delivers care

Provider bills Medicaid directly

Medicaid agency processes claims

Medicaid agency pays the provider
Dental Benefits Administrator
“Third Party Administrators”

Member seeks dental care

Provider delivers care

Provider bills Medicaid agency directly

Medicaid agency contracts with vendor to administer claims processing

Contractor pays provider
“Managed Care”

• Term used to describe a variety of models of administrative health care delivery system management
  – Includes an assortment of administrative, quality and cost management activities
Managed Care Organizations (MCOs)

• Organizations that specialize in health care delivery

• Implement a *systems approach to* comprehensive health care delivery

• Aim to deliver high quality and efficient care, provided in the right setting, to the right individuals, for the best cost
Managed Care Organizations (MCOs)

• Administer all programmatic aspects of health care delivery for a target population
• Focus on quality ->> Efficient operating system
• Ongoing quality improvement mechanisms
  – Collect and study data
  – Direct and redirect financial resources as needed
  – Focus on evidenced based preventive services
  – Credentialing providers
  – Manage utilization
  – Pay claims and control costs
Managed Care Organizations (MCOs)

• Established provider network
• “Gatekeeper” - physician directing care
Major Types of Managed Care Health Plans

• Health Maintenance Organizations (HMO)
• Preferred Provider Organizations (PPO)
• Point-of-Service (POS) Plans
Health Maintenance Organizations (HMOs)

• Created by the Health Maintenance Organization Act of 1973

• A health plan to which employers or individuals pay a predetermined fee in return for a range of medical services from a specific group of physicians and healthcare providers who participate
Health Maintenance Organizations (HMOs)

- Most restrictive MCO model
- No out-of-network benefits except for emergencies
- Benefits are highly specific
- Networks are typically smaller than PPO and POS
Health Maintenance Organizations (HMOs)

**Member**
- Most restrictive in benefits
- Benefits are highly specific
- No out-of-network benefits except for emergencies

**Provider**
- Networks are smaller
- Agree to treat patients in accordance with guidelines and restrictions set forth by the HMO
- Return: Access to network of members/consumers
Preferred Provider Organizations (PPOs)

• Least restrictive Managed Care model
• A list of *in* and *out-of-network* providers is available to members
  – Preferred status versus non-preferred status
• Members may select any provider from list
• Allows access to both providers who participate (contract) with the MCO and providers who do not.
Preferred Provider Organizations (PPOs)

**Member**
- Least restrictive MCO
- May have higher out of pocket costs

**Provider**
- “Preferred provider” or opt out of “preferred status”
- Higher rate incentives to participate as a preferred provider
- Non-preferred provider: receive a lower reimbursement, but may balance bill up to full charge
Point of Service (POS)

• Moderately restrictive model for the Member
• Members must choose a Primary Care Provider (PCP) within a prescribed provider network
• Member must obtain specialist referrals from PCP
• Services obtained outside-of-the provider network are covered at a lower level of reimbursement
  – Provider may not receive the higher rate because he/she are not preferred; they accept the lower fee schedule, but not as payment in full- and they may balance bill the Member
• Members may need to submit their own claims
Hybrid

- Blended model
- Used when a single model is insufficient to meet special state specific needs.
Hybrid

Example #1

• Used by states to transition from Fee-for-Service to another model.
Hybrid
Example #2

• Used when a state chooses to retain responsibility of strategies that are successful, but transfer management of other responsibilities to a contractor to improve quality.
States may seek to:

• share risk up to a certain level; or

• retain payment management but introduce utilization management, network development, and or case management by a contractor.
Transition to Managed Care

• Recognized need for quality improvement
  • Health
  • Health Care -> Prevention
  • Lowered costs

• States are taking a “systems” approach

• States are moving from a payer of claims to purchaser of services

• Buying the delivery of health care
Purchasing Health Care Delivery Services
Health Care Delivery Domains

Health Care Delivery
- Process
- Access
- Outcomes
- Structure
- Patient Experience

Related Health Care Delivery
- Member Health State
- Management
- Use of Services
- Cost

Clinical Efficiency

Efficiency

Agency for Healthcare Research and Quality; National Quality Measures Clearinghouse
Risk Based Managed Care

• Model within the healthcare delivery system whereby states contract with MCOs to deliver benefits in exchange for a predetermined capitation ratio

• Approximately 30 states participate in risk based programs

• Financial arrangement contracts consider:
  – Health outcomes of members
  – Cost of services
  – Cost of program administration
  – Limiting the state’s financial exposure
  – Potential profit and loss
Risk Based Programs

- MCOs are paid (by the state) a fixed monthly fee per enrollee (capitation)
- MCOs agree to and assume the financial risk for delivering a set of predetermined services
- Risk may be full or partial
Profit Management

• A limitation in profit margin
• MCOs assume risk and accept the financial liability
• States pay a predetermined amount to MCO
• MCOs apply business models that emphasize preventive care
• Some state contracts allow managed care organizations to keep all profits; others cap profits at a certain percentage.
Waivers

- A waiver is an agreement between CMS and a state to exempt the state from a particular set of federal Medicaid regulations.
- Vehicles states may use to test new or existing ways to deliver and pay for health care services
Waivers

• Social Security Act contains *waiver authorities*
  – Increase state flexibility
  – Categorized as “program” or “research” waivers and “demonstration projects”
  – Federal spending under a “waiver” may not exceed what the costs “would have been” without the waiver.
Waivers Allow Flexibility

• CMS waivers offer states the flexibility to deliver services through alternative models
• Services may be provided in an alternate format as long as the member has choice and is receiving comparable services
• Examples include
  – Managed care
  – Long term care
Advantages of Using Waivers

• Provide alternative methods for states to:
  – Provide care
  – Control cost
  – Improve quality
  – Increase utilization
  – Provide choice or options to members

• Allows states to benefit from efficiencies of the private sector
### Single versus Multiple Vendors

<table>
<thead>
<tr>
<th>Single Vendor</th>
<th>Multiple Vendors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supports ease of administration</td>
<td>• Promotes patient and provider choice</td>
</tr>
<tr>
<td>• Supports program control</td>
<td>• Foster competition</td>
</tr>
<tr>
<td>• Allows for ease in implementing change(s)</td>
<td>• Allows access to multiple external resources</td>
</tr>
<tr>
<td>• Provides simplicity to members</td>
<td>• Addresses unique needs or specific regions</td>
</tr>
<tr>
<td></td>
<td>• Provides a safety-net for states if a vendor decides to leave</td>
</tr>
</tbody>
</table>
Others Issues and Considerations

• Provider Preference
  • Not all providers will want to work in alternate arrangements

• Geography
  • Not all areas are suitable for managed care

• Medicaid Member Population
  • Transitory
  • Unstable eligibility
  • Difficult to reach
  • Difficult to manage health
  • Difficult to incentivize
Common Contracting Considerations

• States must get CMS approval of MCO contract before implementation of the MCO delivery system
• Consider authority and cost of the program
• What population will be included?
• What services will be provided by the MCOs?
• Contract structure and procurement method?
• Oversight, monitoring and program integrity
• Reporting and program evaluation
What States are Doing

Rhode Island

Martha Dellapenna, RDH, MEd
Rhode Island

- “Ocean State”
- Smallest state in US
- 1,057,000 residents
- 1,500 square miles
- Five counties

- 193,000 Medicaid/CHIP enrollees
- CHIP = Medicaid Expansion
- 93,000 Adults ages 21+
- 100,000 Children under age 21
Rhode Island

• Two dental delivery systems:
  • Traditional FFS (fiscal agent)
  • Managed Care

• Limited adult dental benefits
Rhode Island

• RIte Smiles is the State’s first Medicaid Managed Care Dental Delivery Model
• Currently has 58,000 children enrolled
• AUTHORITY= 1115 Demonstration Compact Global Services Waiver
• Program was implemented in 2006 for children born on or after May 1, 2000
• Single Program Administrator (Contractor)
• Remainder of population born before May 1, 2000 currently in a traditional FFS delivery system
Rhode Island
RIte Smiles Specifics

• Contract with RIte Smiles MCO is a multi-year, partial risk-based
• Besides typical administrative functions, contract requires value-added services:
  - Network development & maintenance
  - Ongoing member outreach & community support
  - Quality Improvement initiatives
  - Utilization reporting and HEDIS-like scores
  - Develop new program quality measures
• Goals of improving access to care for children, increasing preventive service utilization and decreasing high cost restorative care have been met (See www.dhs.ri.gov Reports and Publications) and http://www.rimed.org/medhealthri/2011-08/2011-08-247.pdf
Rhode Island

**Future Focus**

- Continue RIte Smiles Program growth & success
- Maintain adult dental benefits
- Aging dental professional workforce
- Medical/Dental Collaborations
- Oral Health Literacy
What States are Doing

Virginia

Daniel Plain, BS
Virginia

- State Population: 8,096,062
- Medicaid & CHIP: 961,094
- Eligible for Dental: 653,000
  - Mostly children under 21
  - Limited adult benefits
Virginia

- *Pre 2005 - Multiple Service Delivery Models*
  - FFS/Multiple MCO Delivery
  - Few providers (600+) and few taking new patients
  - Eligibility changes and MCO switching
  - 29% utilization
  - Multiple payers
  - Rigorous administrative requirements
  - Provider and MCO frustration
Virginia

Impetus for change:

• In 2005 VA Dental Association, Medicaid Agency and Agency Director, Governor, MCOs, and General Assembly interests converged to address issues in the Medicaid program
Virginia

• Changes in program included:
  – Focus on children’s health
  – Carved out of MCOs
  – Single dental TPA payer reimbursed PM/PM fee
  – Medicaid assumes risk
  – Improved fee schedule with provider input on rates
  – Expanded Utilization Management, Network Development, QI, Provider Relations and Member Outreach
  – Dental Advisory Committee consisting of dentists to provide advice on program
  – TPA contract allows for flexibility and change as needed
Virginia

Results 2012

• Network of providers approaching 1700 with 80% accepting new patients
  – Includes safety net providers (FQHCs, RHCs, Health Departments) and private practitioners
• Utilization up from 29% to 56%
• 97% provider and member satisfaction
• Able to manage quality more effectively
• Recognized by CMS
Virginia

Challenges and Opportunities

• Health Reform
  – Influx of up to 450,000 new adults
• Improving adult network
• Assuring improved oral health in Exchanges
• Funding for safety-net providers
• Cost containment
What States are Doing

Texas

Linda Altenhoff, DDS
Number of Children Less Than 19 Years Old Enrolled in Medicaid by Region, August 2009

Note: The Texas Medicaid enrollment data are from August 2009. For the comparison states, Medicaid enrollment data from December 2009 were used.

Texas

• General Statistics
  – Population = 25 million
  – 254 counties
  – 11 Health Service Regions (HSR)

Note: Each HSR is equivalent to another state’s child population (0-18) and Medicaid (0-18) population

• Medicaid Statistics (FFY 2010 CMS)
  – FFY 2010 Medicaid/EPSDT
    • 3.34 million enrolled
  – FFY 2010 Dental Services
    • 1.95 million any dental service
    • 1.87 million diagnostic
    • 1.59 million preventive
    • 1.03 million treatment
    • 410,875 received sealants

• Anticipate 10-15% increase with ACA in 2014
Texas

- Fee-for-service (FFS) dental services
  - Fiscal agent
    - Dental services for children in foster care through dental managed care since 2008
  - Limited emergency adult dental services
    - Value added dental services offered by MCOs

- March 2012
  - Dental managed care through 3 DMOs
    - Capitated PMPM to Plans but FFS to dental providers
    - Profit limited to 5%
    - Dental Dashboard – quality measures
Lessons Learned in Financing Methodology

- States are varied and no one solution works for all.
- Best practices may include combinations of options or pieces of options.
- Need for more professional guidelines for states to use.
- Need for performance measurement tools to measure against professional guidelines, and to assess the inter-relatedness among cost, quality, and access dimensions.
- Need for consistency in measurement across programs and states for the discipline in general.
Quality

• Case Management
• Outcomes Recognition
• Reimbursement mechanisms
• Networks
• Focus on prevention
• Performance measures- inconsistent
• More on Quality
  – Webinar #2- May 2012
  – 2012 MSDA Symposium- June 24th-26th
Contact Information
Website:  www.medicaiddental.org

Martha Dellapenna, RDH, MEd
MSDA President
RI Dept. of Human Services
74 West Street-Hazard #74-1st Floor
Cranston RI 02920
Telephone: 401-462-6362
mdellapenna@dhs.ri.gov

Mary E. Foley, RDH, MPH
Executive Director
Medicaid/SCHIP Dental Association
4411 Connecticut Ave NW, Unit 302
Washington DC 20008
Telephone: 202-248-2315
mfoley@medicaiddental.org
Contact Information
Website:  www.medicaiddental.org

Daniel Plain, BS  
Dental Program Manager  
Smiles For Children  
Department of Medical Assistance Services  
600 E. Broad Street  
Richmond, VA  23219  
804-786-1567  
804-786-0414 FAX

Linda M. Altenhoff, D.D.S.  
Manager, Oral Health Branch/State Dental Director  
Family and Community Health Service Division  
Texas Department of State Health Services  
Street Address: 1100 W. 49th Street, Austin, TX 78756  
Mailing Address: P.O. Box 149347, Mail Code 1938  
Austin, TX 78714-9347  
Phone: 512.776.3001
Become a MSDA Member

Join Now!