



UNDERSTANDING THE CONNECTICUT DENTAL MEDICAID REFORM PROPOSAL:
STATE OPTIONS IN CONTRACTING DENTAL CARE IN MEDICAID

C O N T E N T S

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In today's ever-evolving health care marketplace, states have multiple options for arranging dental services in their Medicaid programs.

For example, states may:

- Administer dental Medicaid programs directly or contract them through medical or dental managed care organizations;
- Retain administrative responsibility or not and opt to pass financial risk onto outside vendors;
- Include dental services in medical managed care contracting or carve-out dental services for separate management; or
- Contract with a single vendor or with multiple vendors for all or part of their enrolled populations or geographic areas.

In fact, options are limited only by the creativity of Medicaid officials, the receptivity of the marketplace, and, in some cases, the approval of federal authorities. Indeed, in their efforts to secure dental care for beneficiaries, states have experimented with various combinations of these options.

Regardless of the options selected, states must currently meet – or obtain federal waivers not to meet – requirements that include a guarantee of access to needed dental services for covered children.

As an observation of states' efforts reveals, ultimately, only three factors relate to a state's capacity to obtain dental care for beneficiaries:

- 1. Market-based payment rates to dental providers,**
- 2. Engagement of sufficient numbers of providers, and**
- 3. Effective program oversight.**

The Connecticut Health Foundation (CHF), the state's largest private, independent foundation dedicated to improving the health status of all Connecticut residents, has prepared this policy brief to:

- Describe the various program options and related decisions facing states as they determine how to obtain dental care for their beneficiaries,
- Present arguments (pro and con) for each decision, and
- Comment on the lessons to be derived from various states' efforts.



PROGRAM OPTIONS AVAILABLE TO STATES

Decision 1: Whether or Not to Retain Medicaid In-House or Contract Out

One

States interest in contracting-out Medicaid services stems from a desire to increase access, contain costs, and improve program performance.

Proponents of contracting suggest that the corporate culture of dental insurers is better suited to successful program management than the culture of state bureaucracies. They believe that outsourcing dispels dentists' antipathy and frustration with state-administered Medicaid. Proponents also cite such advantages to beneficiaries as: improved customer service, integration of health and enabling services, and recourse to assistance in obtaining care. For providers, advantages appear to be the potential to negotiate fees, streamlined claims processing, and a steadier cash flow. In addition, managed care plans may utilize protocols and guidelines that can enhance care quality while controlling costs.

Critics of Medicaid contracting, however, assert that this option is inherently flawed. They characterize this flaw as a perverse incentive related to inadequate financing, that is, an incentive to minimize service delivery in order to maximize profits. Opponents also point out that states lose control of the program but retain responsibility for

Medicaid requirements that are not explicitly contracted. If dental services are subcontracted by a medical managed care vendor that is otherwise performing well, poor performance by dental vendors may be difficult to redress, especially if enforceable sanctions are not included in the contracts – or if a state's capacity and political will is not sufficient to enforce those sanctions. Even where effective sanctions exist, the costs of redressing poor performance may be greater than the savings generated through sanction enforcement, particularly if legal action is necessary. Furthermore, dental Medicaid programs are frequently regarded as too small to warrant intensive oversight. The greatest criticism expressed about outsourcing, however, is this: outsourcing shifts some Medicaid funds to vendor profits rather than client services – profits that may be in excess of savings generated by privatization.

The 1995 Medicaid reform in Connecticut contracted Medicaid services, including dental services, to managed care. The new proposal segregates the dental program for separate contracting.



Decision 2: Whether or Not to Carve-Out Dental Services

two

While almost every state has contracted some part of its Medicaid program to managed care, 27 have retained them under state management. The remaining 23 states and the District of Columbia contract for dental services. Only six of these governments carve-out dental services from medical vendors' responsibility to contract exclusively with dental vendors.

When the states carve-out dental programs from medical vendors, they are able to select the dental contractors, establish the terms and conditions of program delivery, establish clear and enforceable incentives and sanctions, and directly access information on program performance. As a result, this option holds promise for enhanced program accountability. This approach also reflects differences between medical and dental care including different provider types, delivery systems, and financing norms.

When identifying a suitable contractor, a state can carefully assess whether or not the vendor's existing provider network contains a sufficient number of providers. It also can explore how the providers are distributed and how actively providers participate, if there is a network in the state. If the dental vendor has no network for a Medicaid contract, the state and other interested parties can closely examine the vendor's commercial experience or performance in other states. Similarly, the state can exercise due diligence when

examining a vendor's past claims-administration performance as well as dentists' and beneficiaries' satisfaction.

When carving-out dental care, states will shoulder the additional cost and responsibility of managing separate contracts for a very small component of the larger Medicaid program, typically less than 5 percent. This is the primary disadvantage of the carve-out option.

There are several ideas that hold potential for success in dental carve-outs:

- Accessing ready-made provider networks;
- Encouraging participation of safety-net providers;
- Contracting for case management strategies (e.g. clinical protocols, risk assessment, and disease management guidelines);
- Contracting for care integration between primary and specialty dentists;
- Empowering vendors to implement their own access initiatives (e.g. case managers, school-linked services, and private dentist contracting to health centers); and
- Allowing dentists to negotiate terms of participation.

The 1995 Medicaid reform in Connecticut did not carve-out the dental program and assigned responsibility to the medical managed care vendors. The new proposal carves-out the dental program for separate management.



Decision 3: Whether or Not to Assign Financial Risk to the Vendor

three

As care utilization increases, so, too, do program costs. States may guard against this by contracting with managed care vendors at a specified payment for each covered beneficiary. In so doing, states establish their dental program cost and put their vendors at financial risk, should utilization exceed anticipated levels. Among the 23 states and the District of Columbia that contract for dental services, all but two assign some level of financial risk to their vendors.

Fixed rate contracting puts the vendor at financial risk because it caps the total dollars available for claims, program administration, and profit. Because Medicaid is currently an individual entitlement, neither states nor vendors can deny care when funds are depleted.

Dental managed care vendors have addressed this potential financial liability in a number of ways. Some will not accept full-risk contracts. Some have attempted, with notably little success, to pass risk onto dentists through capitation arrangements. One multi-state dental Medicaid vendor utilizes a “global” approach – it pays itself first, and then prorates any remaining funds across providers to reflect the volume of claims. Re-insurance is used to protect against “adverse utilization.”

According to opponents, assigning full financial risk eliminates any incentive for increased utilization, an inherent problem. Proponents, on the other hand, claim that improved provider networks and greater efficiency warrant vendor profitability. Proponents also maintain that the onus is on the state to ensure performance through strong and enforceable contract sanctions.

The 1995 Medicaid reform in Connecticut assigned some financial risk to vendors. The new proposal curtails that risk.



Decision 4: A Single-Vendor or Multiple-Vendor Program

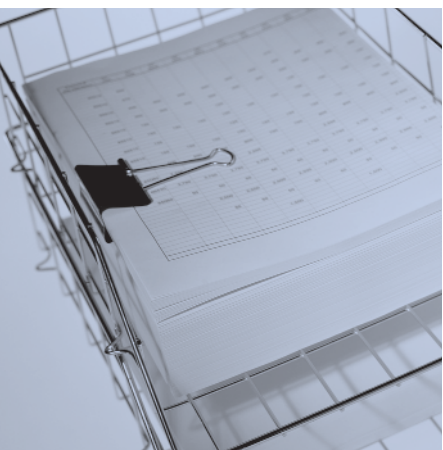
four

Proponents claim that multiple vendors stimulate competition and, therefore, better customer and provider service because both groups will seek out the best plans. Proponents also maintain that vendor competition generates true market rates if there is sufficient state funding in the program. In those states where multiple vendors failed to develop sufficient networks to meet the needs of beneficiaries, the states did not provide sufficient funding to reflect market conditions. Advantages of inter-plan competition include opportunities for performance comparison across plans, emergence and identification of “best practices,” and stimulus for plans to provide the best possible service.

On the other hand, opponents of multiple-vendor arrangements assert that beneficiaries are confused by multiple options. They suggest that providers are not sufficiently interested in Medicaid to negotiate multiple contracts, tolerate multiple credentialing procedures, or institute multiple claims-management procedures in their offices. Opponents cite the increased difficulty and cost for states to oversee multiple vendors.

According to proponents of single-vendor arrangements, these problems are eliminated when states contract with only one vendor and engage only the “best” vendor by carefully assessing solicited proposals. Single-vendor advocates also note that commercial dental plans with large provider networks are more likely to bid on Medicaid contracts only if the population to be covered is large enough to allow for efficiency. The primary disadvantage of single-vendor contracting is dependence on one source.

The 1995 Medicaid reform in Connecticut engaged multiple medical managed care vendors and multiple dental managed care subcontractors. The new proposal calls for contracting with a single Administrative Services Organization (ASO).



Decision 5: Selecting a Plan

five

States solicit vendors through “Requests for Proposals” (RFPs), ranging from highly detailed and specific requests to broad and conceptual ones. Specific RFPs focus on process requirements and delineate terms and conditions to be met by the bidder. Conceptual RFPs, in contrast, focus on program goals and provide bidders with some flexibility in how to attain those goals. Because the form, content, and specificity of proposals are critical to program management, it is useful for communities of interest – and particularly for stakeholders directly impacted by programs – to be engaged in RFP development and evaluation.

Typical terms of responsibility for contracting include:

- Provider network development including safety-net providers;
- Delineation of procedures for addressing the needs of special populations, for example, young children, the medically or psychologically compromised, and non-English speaking patients;
- Case management and provision of enabling services;
- Care coordination;
- Fraud and abuse management;
- Performance measurement and accountability;
- Client and professional support services including redress of complaints; and
- Compliance with federal requirements.

Each of these terms can have significant impact on access and utilization. States also are obliged to carefully assess the business practices, program incentives, and overall reputation and reliability of the applicants’ plans. Applicants may be either for-profit or tax exempt organizations. There is no recognized difference in performance between these two types of organizations.

Connecticut’s current plan is to identify the single ASO through a conceptual RFP and to negotiate specific terms thereafter.



Decision 6: Setting a Payment Rate

SIX

Observers of Medicaid dental programs generally agree that private sector commercial insurers do not respond to Medicaid RFPs often enough; primarily, this is due to the fact that Medicaid pays too far below market rates. While little pricing information is available, the majority of state dental programs – as well as rates paid to dental vendors in Connecticut – are thought to be supported with monthly per member payments (pmpm) of \$5 to \$10. These rates fall well below a 1999 actuarial estimate of a reasonable market rate of \$17 pmpm. Dental insurance executives interviewed for this project suggest that minimally acceptable rates would fall in the range of \$12 to \$15, assuming that vendors are willing to accept initial losses from “pent-up” demand for care. In Michigan, a partial-state Medicaid demonstration has generated remarkable success in increasing access and utilization at a pmpm of \$12.60. Low rates are believed to correlate with higher levels of provider fraud and abuse, higher levels of “skimming” (defined as inappropriately high levels of preventive services and inadequate levels of less profitable reparative care), and program dependency on a small numbers of dentists.

In addition to low payment rates, commercial plans with well-established provider networks cite the following reasons for staying out of the Medicaid market:

- A concern about states’ cash flow reliability,
- Public relations risk with existing clients,
- A belief that Medicaid is a riskier book of business than employment-based plans because of significant “pent-up” treatment needs,
- Less predictable utilization, and
- A lack of data on how dentist availability is affected by fee levels.

Dental insurers also are adamant that Medicaid programs should not be supported by cost shifting from more profitable commercial plans.

Increasing access in Medicaid may, in large measure, depend upon offering excellent service to both dentists (so that they are available) and beneficiaries (so that they can utilize the system). Such service is expensive to provide, especially to dentists who are generally negative about Medicaid programs and beneficiaries who require extensive support services.

Connecticut’s current plan is “cost neutral.” It does not increase dental program funding.



Decision 7: Managing Program Oversight

seven

State contracts define performance requirements and typically provide incentives for strong performance and sanctions for failures. These may pertain to network development, provider and beneficiary satisfaction, timeliness and accuracy of claims management, levels of utilization by beneficiaries, timeliness and accuracy of performance reports to the state, and other contract terms. To be enforceable, a program's contract requirements should be clear, and the state should be willing to prosecute infractions of those requirements. When a state knowingly under funds its program, it has little recourse when plans do not deliver as promised.

Effective oversight requires regular and timely data, provider and beneficiary input, and proactive engagement of administrators and legislators responsible for these programs. Commercial dental programs typically provide employers with a specific list of program performance measures as well as actions it will take if these measures are not met. States may benefit from emulating these contract provisions or referencing the Centers for Disease Control and Prevention's "Sample Purchasing Specifications for Medicaid Pediatric Dental and Oral Health Services."

Connecticut's plan to engage a single ASO vendor for both the State Employee Health Program and public insurance programs may improve oversight for two reasons:

- 1) The total number of covered lives will be great enough to warrant close management by the state and
- 2) It is expected that state employees will be more critical of inadequacies than low-income beneficiaries of public insurance programs.

Active and effective program oversight, like sufficient payment rates to adequate numbers of providers, is essential to ensuring accessible dental services in Medicaid.



Lessons Learned from Other States

Lessons

As noted above, states can configure their Medicaid programs in a number of ways. Their ability to increase access, however, correlates with three interrelated approaches: market-based payment rates, sufficiency of providers, and effective program oversight.

Since the mid 1990s, fewer than ten states have made programmatic investments that have increased dental access or that are poised to increase access. All have sufficient financing to effectively engage the dental marketplace. Yet each “fix” is different, and each reform involves more than simply raising fees. Taken together, these reforms suggest that it is possible to improve access through program reform and that a combination of sufficient funding and administrative reform appears necessary to do so – whether program improvements are instituted by the state or through managed care contracting.

In contrast, the majority of states have instituted one or more dental program reforms that have yielded little access improvement. One characteristic that these reforms have in common is an insufficient increase in payment rates to dentists, despite other reforms in contracting arrangements or program management. Non-financial reforms appear to have little impact on access if not linked to sufficient increases in payment rates to dentists. As a result, adequate provider payment is regarded as a necessary, but not sufficient, condition for improving Medicaid.

Sufficient payment rates to dentists can be characterized as those rates that cover, at least, the providers’ cost of delivering care. Market-based rates to dentists are those rates that will induce a significant portion of available providers to participate. Market-based rates do not necessarily have to be as high as the typical market rates incurred by self-paying or commercially insured patients, because dentists appear to be willing to accept modestly discounted fees when caring for Medicaid beneficiaries. The level of discount that is acceptable in a market is contingent upon dentist supply, overall demand for care, and social norms regarding commitment to vulnerable people. Demand is predicated upon the overall state of the economy and consumer confidence, as many dental procedures are considered elective. Social norms and commitment to the underserved vary nationwide. For example, in North Dakota, which has a culture of interdependence, payments approximate the 50th percentile, and a substantial percentage of dentists are engaged in Medicaid; in other states, however, similar rates do not stimulate provider participation.

Increases in program funding that do not “trickle down” to providers will have little impact on access. If increases in program funding, even substantial increases, do not offer payments that cover dentists’ overhead costs, the increases will have minimal impact on access.

Connecticut's current proposal does not include any new monies to raise provider payments. Since vendors' current payment rates in Connecticut reflect the fees of less than 10 percent of the state's dentists (i.e. less than the 10th percentile), payment levels are considered inadequate. As such, administrative reforms and single-vendor ASO contracting may not, based on other states' experiences, significantly improve access.

In contrast, Michigan was able to demonstrate substantial increases in access in demonstration counties. They achieved these increases through a federally approved waiver demonstration: they markedly increased payments to dentists (paying at the 80th percentile) and engaged a well-established commercial vendor, Delta Dental of Michigan. Delta brought its pre-existing, large, and active network of providers to the Medicaid program and offered dentists the same administrative terms and experiences as offered to commercially insured patients. As a result, the state's dental Medicaid program manager reports that utilization in demonstration counties is approximating commercial rates, thereby meeting Medicaid requirements of equal access. Participating dentists are required to accept new patients, see them within three weeks of initial office contact, and provide emergency services within 24 hours of contact. The lesson learned from this Michigan demonstration is that paying market rates and utilizing an existing, robust provider network (under the same terms and conditions as commercial participation) combined to markedly increase access.

South Carolina's legislature committed to market-based purchasing by setting fees to approximate the 75th percentile. The unique lesson learned in South Carolina was that its success in developing a sufficient provider network was directly linked to the fee increases as a quid pro quo. Fee increases were specifically predicated on the state dental society's success in recruiting dentists for the program. This approach engaged a key stakeholder – private dentists – in designing and implementing successful reform.

Alabama has elected to retain dental program management in-house at the state Medicaid agency rather than contracting to managed care. This state has demonstrated successful provider recruitment in its "Smile Alabama" program utilizing a combined strategy of market-based fees (approximately the 75th percentile), a direct appeal to dentists by former Governor Don Siegalman, simplified claims administration, enhanced provider and beneficiary services, and a marketing campaign. The lesson learned from Alabama is that provider and beneficiary relations – whether instituted by the state or a vendor – are critically important to program success.

In Delaware, payment of sufficient, yet discounted rates, with little other programmatic change, yielded an increase in access. Delaware adjusted its payment rate to 85 percent of dentist-submitted customary charges while retaining administrative responsibility within the state's Medicaid agency. The state's Medicaid director, however, has suggested that further access improvements will require non-financial administrative reforms that make the program easier for a provider's business staff to manage. For example, the state is considering replacing its current proprietary claim form with a universal commercial form.

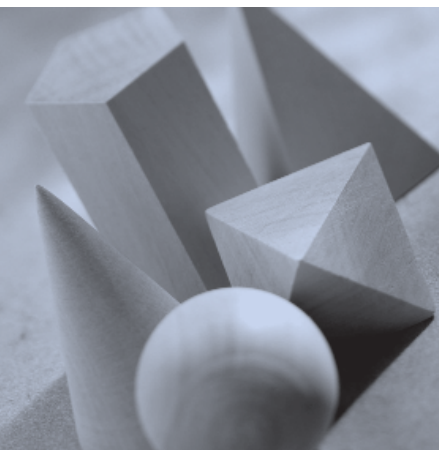
Although Georgia has less information available than other states about the impact of its fee enhancements, reports from practitioners in that state suggest that market-based fee increases have had less impact than anticipated. In order to make the program more workable for office staff, dentists would like Georgia to streamline its administrative and claims-management procedures. The lesson here is that administrative streamlining may be, like sufficient fees, a necessary, but not sufficient, condition for improving access.

Although Indiana's 1998 reform first succeeded in increasing access, it lost momentum and slipped backwards because it failed to maintain market-based fees through regular adjustments for inflation. The lesson here is that meaningful fee improvements, once made, need to be sustained or the provider network will degrade.

Tennessee is the most recent state to implement major reforms that include, but are not limited to, market-based payment rates. Like Connecticut, Tennessee turned to mandatory managed care contracting in the mid 1990s. When TennCare was established in 1994, the state contracted with multiple vendors who assumed financial risk and subcontracted dental care to dental plans. Having failed to generate sufficient access for beneficiaries, in 2000, the state reversed most of its 1990 decisions. It elected to carve-out dental from medical managed care and issued an RFP for direct non-risk contracting with a single dental ASO, Doral Dental. Tennessee raised fees to approximate the 75th percentile, developed a substantive alliance with the state's dental association to recruit providers, and implemented a social marketing campaign. The new program also features improved accountability by requiring the ASO to provide information on numbers of members served, numbers and types of procedures delivered, referrals, and information on quality improvement activities. The state's new program, which began October 2002, is believed to hold strong promise for success because it addresses payment, partnerships, beneficiary support, dentist support, and accountability issues.

The Connecticut experience and current proposal appear to be very similar to that of Tennessee except that Connecticut does not plan to increase fees to market levels, does not engage stakeholders in program reform, and does plan to assign its ASO vendor with some level of financial risk. As sufficient fees are considered a necessary condition for program success, risk contracting may introduce a perverse incentive against access enhancement; and since multiple states have demonstrated the utility of engaging the dental community, Connecticut's reform appears to hold less promise than Tennessee's dental carve-out program. A number of administrative "best practices" have evolved from efforts to improve access, including:

- Ongoing and meaningful collaboration of all stakeholders, including dentists and hygienists, safety-net providers, hospitals, advocates for the poor, and beneficiaries;
- Streamlined of administration including electronic eligibility verification and claims management, elimination of most prior authorization requirements, rapid claims payment, use of professionally accepted coding systems and claim forms, and facile mechanisms for rapid conflict resolution;
- Improved performance reporting;
- Strong vendors incentives that are regularly awarded and sanctions that are routinely enforced;
- Engagement of community health centers, school-based clinics, and other safety-net providers;
- Integration of medical and dental care through tracking forms and facilitated referrals; and
- Strong provider and beneficiary support.



Summary

summary

Experience across the nation suggests that options in program administration, in and of themselves, hold little promise of improving access. For states, each decision – whether or not to contract to managed care, carve dental in or out, put contractors at risk, or engage single or multiple vendors – has its benefits and advantages.

Evidence suggests, however, that these decisions are not the primary determinants of success in increasing access to dental care for low-income beneficiaries. Rather, success depends primarily upon:

- Sufficiency of payments,
- Sufficiency of provider availability, and
- Strong program oversight.

A handful of states that have significantly increased access have done so by utilizing a variety of program arrangements. Yet, these diverse programs share several common elements that lead to their success, namely:

- Funding at market rates,
- Simplified program administration,
- Active engagement of stakeholders in designing and implementing reform, and
- Rewarding access improvements.

This document was prepared under contract with
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