



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

October 19, 2021

The Honorable Guy Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

Re: 2020 Joint Chairmen's Report (p. 117) – Delivery of Medicaid Dental Services

Dear Chairs Guzzone and McIntosh:

Pursuant to the requirements of the 2020 Joint Chairmen's Report (p. 117), the Maryland Department of Health (MDH) submits the attached report on the advantages and disadvantages of various service delivery models in place for dental services. Specifically, the committees requested that MDH:

...review the different models used by states for dental services, in particular the use of an independent managed care organization. In that review, MDH should look specifically at performance in delivering quality dental care, cost versus the current ASO model in place in Maryland, and how states have been able to expand dental services with savings generated by changing service delivery models.

Thank you for your consideration of this information. If you have any questions about this report, or would like additional information, please contact Heather Shek, Director, Office of Governmental Affairs, at heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)



Medicaid Dental Services Review

Submitted by the Maryland Department of Health

2020 Joint Chairmen's Report (pg. 117)

I. Introduction

In accordance with the 2020 Joint Chairmen's Report (page 117), the Maryland Department of Health (MDH) presents this analysis of different models used by states for dental services, in particular the use of an independent managed care organization. MDH looked specifically at performance in delivering quality dental care, cost versus the current administrative services organization (ASO) model in place in Maryland, and how states have been able to expand dental services with savings generated by changing service delivery models.

MDH reviewed multiple models, including fee-for-service (FFS) and managed care as well as carved-in and carved-out models. MDH spoke to three states, Florida, Texas, and Washington, to learn more about their experiences administering dental benefits, with a focus on costs and the rate-setting process. MDH also met with stakeholders to solicit their feedback on different dental delivery models.

MDH found advantages and disadvantages to all four dental delivery models analyzed. MDH is still evaluating whether shifting to a managed care model would result in cost savings, as findings by states in this regard were mixed. MDH will continue to research and analyze how potential model changes would affect the State with a focus on ensuring access to high quality dental services.

II. Dental Care Delivery Models

State Medicaid programs use several different models for delivering dental services to their participants. These models include the traditional fee-for-service (FFS) model, a carved-out dental model administered by a dental benefits administrator or administrative service organization (DBA or ASO), a carved-in managed care model, and a carved-out managed care model.

A. Fee-for-Service (FFS) Model

In a FFS model, participating Medicaid providers are reimbursed directly by the state for each unit of dental services they provide to Medicaid enrollees. The simplicity of the FFS model has certain advantages and disadvantages for enrollees, providers, and the state. Overall success of the model may vary depending on available in-house resources and expertise at the state level.

Accessing benefits may be simpler for enrollees as their interactions are limited to a single entity, the state. Additionally, FFS has no provider networks or tier coverage, which enhances enrollees' freedom of choice to choose from a wider pool of dental care service providers.

From the providers' perspective, participation and billing may be less administratively burdensome when they contract directly with the state compared to working in a model where more than one managed care plan may participate. Additionally, the FFS model can lead to lower expenditures as providers are only reimbursed for services actually delivered. However, absent sufficient administrative oversight by the state, FFS can result in a potential incentive for providers to deliver more services than may be medically necessary to meet financial goals if these goals depend on the number of covered services delivered.

Operating a FFS Program gives the state broad discretion with respect to operations and ability to control costs through rate setting and oversight, while placing the full administrative burden on the

state. The state sets provider payment rates for each covered dental care service based on a fee schedule and takes full financial risk for providing coverage to all enrollees. When developing provider payment rates, the state may consider certain factors including:

- The cost of providing the Medicaid covered benefits;
- What commercial payers pay in the private market for such benefits; and
- The percentage of what Medicare pays for the same covered benefits. However, note that Medicare is not available as a benchmark for dental services because dental services are not a covered benefit.¹

The overall success of benefits delivery through a FFS program is dependent on the in-house capabilities of the state, both with respect to quality, operations, and cost. In-house expertise in the areas of beneficiary outreach and coordination of medical and dental benefits may vary by state. Processing claims while ensuring sufficient oversight to reduce fraud and prevent inappropriate use of care through utilization management techniques such as coding edits, retrospective review, and prior authorization requirements can pose a significant administrative burden depending on available resources. Costs can also be managed through benefits management techniques such as service limits, for example setting a ceiling on the quantity of services an enrollee can receive within a specific time period.

B. Carve-Out Model: Administrative Services Organization (ASO)-Administered

Under an administrative services organization (ASO) carve-out model, the state contracts partial or full administrative functions to a third party to manage certain aspects of the dental program. As in the FFS model, the state assumes the full risk of insuring enrollees in the ASO model.² This model affords states the opportunity to leverage a vendor's expertise in order to increase administrative oversight, enhance enrollee outreach and engagement, and improve benefits delivery compared to a traditional FFS system where such expertise is not available in-house.

The contract between the state and the ASO determines the level of administrative responsibility that each party will undertake, and thus, dental ASO-carved out programs vary from state to state. Depending on the contract specifics, the state may retain partial administrative control or all operational functions may be solely managed by the ASO.³ Services that may be delegated to the ASO include processing and paying claims, recruiting and contracting with dental providers, managing provider networks, outreach to enrollees, and benefits coordination. In return, the state pays the ASO an administrative fee.⁴ Thus, the state has less control over the daily operations of the dental program and reduces administrative burden while relying on the ASO for program oversight.

¹ U.S Department of Health and Human Services; (2020) <https://aspe.hhs.gov/reports/7-medicaid-payment-mechanisms-and-innovative-service-delivery-structures/71-medicaid-fee-0>

² Medicaid Dental Program Delivery System, Millman; (2020) <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx>

³ Medicaid Dental Program Delivery System, Millman; (2020) <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx>

⁴ 2014 MSDA National Medicaid and CHIP Oral Health Symposium, MSDA; (2020) [https://www.medicaidental.org/files/Symposium%20Materials/2014%20Symposium/Presentations/2014MSDA Symposium_OpeningPlenary_FINAL6122014.pdf](https://www.medicaidental.org/files/Symposium%20Materials/2014%20Symposium/Presentations/2014MSDA%20Symposium_OpeningPlenary_FINAL6122014.pdf)

The state may consider numerous factors in its decision to recruit an ASO vendor. These factors include provider network adequacy, geographic distribution of network providers, and the ASO vendor's past dental administrative performances. Additionally, because the state enters into a contract with an ASO directly, the state maintains the ability to control fee schedules, set contractual benchmarks regarding utilization and other metrics, and conduct contract oversight to ensure program accountability. In this regard, the state can establish incentives that encourage quality dental care services delivery and measurable outcomes for ASO vendors to undertake while retaining the ability to sanction the ASO for failure to meet its contractual obligations.⁵

C. Dental Carve-In Managed Care

States contract with MCOs to manage Medicaid enrollees' medical care benefits for a variety of reasons, including creating budget predictability, controlling Medicaid spending, reducing administrative burden on the state, and increasing access to quality care.⁶ In a managed care dental carve-in model, the state enters into a contract with one or more managed care organizations (MCOs) to integrate or "carve-in" dental care benefits into the MCOs' existing managed care plans. Similar to the ASO contract, the state maintains the ability to set contractual benchmarks, engage in program performance oversight, and sanction the MCOs for failure to meet contractual obligations.

The MCOs assume full financial risk for medical care services, including dental services, provided to enrollees. The state reimburses MCOs based on capitation rates set at a fixed amount of money per member per month (PMPM).⁷ The MCOs are at financial risk if administrative and benefits costs exceed the capitated payment. In some circumstances, shifting risk to MCOs may cost more than a FFS model as a result. In some arrangements, MCOs share the savings with the state if actual costs are below the capitated payment. Generally, the state will seek actuary services from a third party who will assist the state in establishing sound payment rates to support a managed care plan. This is partly due to the intense resources required in rate-setting such as staffing, financial data management, and other obligations.

This model affords MCOs the opportunity to provide integrated health care benefits to enrollees who will receive dental, medical, and other health care benefits under a single entity.⁸ An integrated health care benefit managed by a single entity offers advantages to enrollees as it reduces enrollees engagement with multiple entities that operate disparate systems. This benefit may be compromised in cases where an MCO subcontracts the delivery of dental care benefits to another dental managed care entity. This could lead enrollees to interact with multiple entities managing different provider networks that have distinct processes, procedures, and requirements, which could potentially impact access to care.

⁵ Understanding the Connecticut Dental Medicaid Reform Proposal: State Options In Contracting Dental Care In Medicaid, Connecticut Health Foundation; (2020)

https://www.ada.org/~media/ADA/Public%20Programs/Files/StateLeg_Understanding_the_CT_Dental_Medicaid_Reform_Proposal.pdf?la=en

⁶ 10 Things To Know About Medicaid Managed Care, KFF; (2020) <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

⁷ Provider Payment and Delivery Systems, MACPAC; (202) <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/#:~:text=and%20delivery%20systems-Provider%20payment%20and%20delivery%20systems,received%20by%20a%20Medicaid%20beneficiary.>

⁸ Medicaid Dental Program Delivery System, Millman; (2020) <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx>

D. Dental Carved-Out Managed Care

In a managed care dental carve-out model, the state carves dental care benefits out of an integrated medical care plan and contracts dental care benefits management to separate dental MCOs. One or more dental MCOs may participate under this model with the state overseeing the contract(s). The state has the ability to set contractual benchmarks, engage in program performance oversight, and sanction the dental MCOs for failure to meet contractual obligations.

Similar to a carve-in managed care model, dental MCOs are paid a PMPM fee for services rendered to enrolled participants eligible for dental services. Dental MCOs may also be paid an administrative fee on top of the PMPM fee. Dental MCOs recruit providers, negotiate rates, directly pay dental providers, and manage dental provider networks.⁹ Dental MCOs may be subject to partial or full risk. Partial risk is where a limited package of dental services are delivered under a capitated rate and any other services are delivered FFS. A full risk model is when all services are delivered under the capitated rate. In some managed care carved-out models, dental MCOs assume all of the risk of delivering services alone, without the state sharing in their losses. The model also has the potential for shared savings between the dental MCO and the state.

The managed dental care carve-out model may attract vendors to the market whose focus and expertise are solely on dental benefits management. Dental MCOs may have made infrastructure and technology investments uniquely suited to facilitating efficient utilization management as it relates to dental services leading to improved cost management. Additionally, participation by multiple dental MCOs in the market can result in enhanced competition between participating providers, which may improve quality while lowering costs in addition to giving enrollees the ability to select the dental MCO best suited to their needs. However, these benefits may come at the expense of integrated care for enrollees as separate entities provide different services with distinct sets of processes and procedures. Further, where multiple dental MCOs operate in the same market, provider networks and covered benefits may vary by plan, creating a complex environment for enrollees to navigate.

III. Maryland's Model for Dental Care Delivery

The Maryland Medicaid program currently covers dental benefits through a carved-out ASO model, the Maryland Healthy Smiles Dental Program. Prior to 2009, HealthChoice MCOs provided dental services to enrollees through a carve-in model. Some MCOs contracted with third party vendors, who were responsible for administration of the dental portion of the MCO's benefit. Based on recommendations from the Dental Action Committee (DAC) convened by the Maryland Health Secretary in 2007, the State shifted to a single statewide dental vendor beginning in 2009. The Maryland Healthy Smiles ASO (also called a dental benefits administrator, or DBA) acts as a single point of contact for providers and handles billing, dental provider issues, and maintains a call center. SKYGEN USA, formerly known as Scion Dental, currently serves as the DBA.

The Maryland Healthy Smiles Dental Program covers services for children and youth ages 20 and younger under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and former foster

⁹ 2014 MSDA National Medicaid and CHIP Oral Health Symposium, MSDA; (2020)

https://www.medicaidental.org/files/Symposium%20Materials/2014%20Symposium/Presentations/2014MSDASymposium_OpeningPlenary_FINAL6122014.pdf

care youth until they turn 26 years old. Dental services for pregnant women, individuals enrolled in the Rare and Expensive Case Management (REM) program, and emergency dental services provided at hospital emergency departments for adults aged 21 years or older are also covered. Beginning January 1, 2021, MDH covers dental services for postpartum women for 60 days.

In June 2019, Maryland implemented an adult dental pilot program to provide limited dental benefits to adults from ages 21 to 64. The dental care benefits in the pilot package include diagnostic, preventive, extractions, and restorative services. Dental benefits are subject to an \$800 per person maximum benefit allowance per calendar year for the first year of the pilot, which may be reviewed for subsequent demonstration years. These benefits are carved-out and overseen by the DBA, which notifies enrollees once a member's maximum benefits have been exhausted. Dental providers are required to charge the Medicaid rate on the Adult Dental Pilot fee schedule, and if any service costs above the maximum benefit allowance of \$800, the provider may directly bill the remaining portion to the pilot participant, as long as participant consent is obtained prior to the service being rendered.

With the goal of increasing dental provider enrollment, MDH outlined pay-for-performance standards in February 2015 in the Maryland Medicaid DBA Request for Proposals. The pay-for-performance standards incentivize provider outreach and reward the DBA for increasing provider enrollment in target counties. The DBA must be able to demonstrate improvement across two ratios: 1) the general dentist provider-to-participant ratio and 2) the dental specialist provider-to-patient ratio.¹⁰ Performance payments are tiered and allow for continued demonstrations of improvement over the life of the contract. SKYGEN USA will continue outreach to dental providers to increase participation in the program.

Non-pregnant adults may receive dental benefits from their managed care organization (MCO) provided as an additional benefit. As of August 2020, all nine MCOs in the Maryland Medicaid program voluntarily cover limited adult dental services to their members as part of their benefit package at no costs to the state. The dental benefits covered, associated annual limits, and cost caps vary by MCO; however, benefits typically include x-rays, oral exams, and cleanings. MCOs may opt to drop coverage or change their coverage provisions and maximum benefit from year to year.¹¹

MDH spent \$198.7 million in total dental claims in Calendar Year (CY) 2019 on 4.4 million dental visits (see Table 1). A total of 523,841 participants received a dental visit.

¹⁰ The DBA is tasked with demonstrating improvement in counties that were not meeting the 1:500 general dentist provider-to-participant ratio and the 1:10,000 dental specialists provider-to-patient ratio as of January 1, 2016.

¹¹ Maryland MCO Comparison Chart, March 2020.

<https://mmcp.health.maryland.gov/healthchoice/Documents/MCO%20Comparison%20Chart%20March%202020.pdf>.

Table 1: Dental Utilization for Medicaid Participants Aged 0-64 Years with at Least One Day in Medicaid, CY 2019¹²

Total FFS Dental Claim Cost (FFS carved-out costs only)	\$198,696,427
Total Administrative Fees, CY 2019	\$3,202,790
Total number of Dental Visits (FFS and MCO)	4,392,979
Total number of participants receiving at least one (1) dental visit (FFS and MCO)	523,841
Total number of participants (FFS and MCO)	1,463,718

Maryland's reimbursement rates for dental services are comparable to the surrounding states' Medicaid programs. Compared to neighboring states (Delaware, Virginia, West Virginia, Pennsylvania, and Washington, D.C.), Maryland has the third highest reimbursement rates (Delaware and Washington, D.C. are highest and second highest, respectively). In state fiscal year 2015, the Maryland General Assembly allocated approximately \$940,000 in state general funds (\$2.15 million with matching federal funds) to increase fees for dental procedures in January through June 2015.

IV. Dental Service Delivery Models in Other States

MDH met with three states, Florida, Texas, and Washington, to learn more about their experiences administering dental benefits, with a focus on costs, quality, and the rate-setting process.

A. Florida—Carve-Out Managed Care

Florida's dental service delivery model has evolved over the years and the state currently operates a carve-out managed care model. In December 2003, the Centers for Medicare & Medicaid Services (CMS) granted Florida the authority to operate a Prepaid Dental Health Plan (PDHP) in order to advance the goals of improving access, containing costs, and eliminating fraud. The state implemented the model on a limited basis in July 2004 that primarily focused on Medicaid eligible children under the age of 21 in Miami-Dade County with services delivered through a single Prepaid Ambulatory Health Plan. Florida subsequently expanded coverage on a statewide basis to sixty-one counties in 2012, and dental services were delivered on a FFS basis by two competitively procured PDHPs.

In 2014, Florida implemented the Statewide Medicaid Managed Care (SMMC) program to manage all of its Medicaid benefits including dental care. The PDHP program was abolished. Under the SMMC, adults and children dental services were integrated into managed care plans called Medical Managed Assistance (MMA) plans. However, Medicaid enrollees who are not enrolled in a managed care plan receive dental services through a FFS model.¹³

¹² The following coverage groups were excluded from this analysis since they are not eligible for dental services: X02, W01, and P10

¹³ Florida Medicaid Managed Medical Assistance Waiver; <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa.pdf>

In 2016, the Florida Legislature directed the state Medicaid agency to carve-out dental services from their managed care plans. The dental carve-out transition was completed in March 2019 when Florida Medicaid removed their dental benefit package for both adults and children from the MMA plans and established separate statewide Medicaid PDHP to provide dental coverage to eligible Medicaid beneficiaries.¹⁴

Under the current statewide PDHP model, all Medicaid beneficiaries are required to select one of three statewide dental plans or are assigned a plan.¹⁵ The Florida Medicaid program covers dental benefits for children, pregnant women, and adults. Children receive a comprehensive dental care package, including medically necessary dental services. Pregnant women and adults have access to a limited standard dental package that includes preventive, diagnostic, and restorative services. Participants enrolled in a limited benefits plan, such as Family Planning program and partial duals, are not eligible for dental benefits.

Florida procured dental managed care plans through a competitive bidding process that involved several stages, including preliminary selection of submitted plans, negotiations, and finally, award of contracts to three managed care plans for five years.¹⁶ In MDH's conversations with Florida, state officials identified three main goals for the carve-out: making dental benefits management more budget neutral, decreasing emergency department (ED) utilization, and improving quality, specifically in the dental-related Healthcare Effectiveness Data and Information Set (HEDIS) measures.

To measure performance improvements and ensure accessibility, accountability, and quality of dental services, dental plans must:

- Have a minimum of one full time dental provider per 1,500 enrollees in each service area;
- Maintain at least 85 percent of annual medical loss ratios (MLR); and
- Meet HEDIS scores above 50 percent for pediatric dental services, among other requirements.¹⁷

In addition, Florida mandated plans to commit to three performance improvement projects:

1. Increase the rate of enrollees preventive dental services;
2. Reduce potentially preventable dental-related emergency department visits, and
3. Coordinate transportation services with health plans.¹⁸

There are penalties for plans that fail to meet contractual obligations, including monetary sanctions and/or enrollment freezes.

¹⁴ House Representatives Staff Analysis, Florida State;
<https://www.flsenate.gov/Session/Bill/2016/819/Analyses/h0819d.HHSC.PDF>

¹⁵ Agency for Health Care Administration, Florida Medicaid; Statewide Medicaid Managed Care Fundamentals;
https://ahca.myflorida.com/Medicaid/recent_presentations/October_2017/House_Health_Innovation_Managed_Care_Concepts_Final_100617.pdf

¹⁶ House Representatives Staff Analysis, Florida State;
<https://www.flsenate.gov/Session/Bill/2016/819/Analyses/h0819d.HHSC.PDF>

¹⁷ House Representatives Staff Analysis, Florida State;
<https://www.flsenate.gov/Session/Bill/2016/819/Analyses/h0819d.HHSC.PDF>

¹⁸ Agency for Health Care Administration, Florida Medicaid;
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Dental_Overview.pdf

The capitation rates for the statewide PDHP are calculated through a third-party actuary. The rate-setting process for dental takes place alongside the rate-setting process for other managed care programs. In comparison to the rate-setting process for other managed care plans, the process for dental is simpler; Florida Medicaid staff estimated that it takes approximately four months to set dental rates rather than the full year for other programs.

There are five main rate groups or rate cells under the Florida dental managed care program that makes the dental rate-setting process simpler. The Medically Needy group contains two rate cells, one for beneficiaries under 21 years of age and another for participants who are 21 years and older, and capitation rates for this group are set on a statewide basis. The three other rate groups are Medicaid-Only adults 21 years and older, Dual Eligibles (participants enrolled in Medicare and Medicaid) who are 21 years and older, and Medicaid-Only/Dual Eligibles who are 20 years old or younger, and the rates in each group vary based on the 11 different geographic regions of the state.¹⁹

Florida Medicaid is still in the process of assessing both the fiscal and quality of care impacts of their current carved-out managed dental care program.

B. Texas—Carve-Out Managed Care

Dental benefits in Texas are managed by two dental managed care benefit organizations, DentaQuest and MCNA Dental, which Texas refers to as Dental Health Maintenance Organizations (DHMOs). Both DHMOs operate on a statewide basis. The two DHMOs manage Medicaid and CHIP dental benefits for eligible children as part of a managed care dental carve-in that began in 2012. Texas Medicaid provides comprehensive dental care benefits to children and youth ages 20 and younger and extends the benefits to pregnant women up to three months postpartum. Dental benefits for children include fluoride treatment, restorative treatments, and sealant application, which are excluded from the pregnant women's benefit package.²⁰ Adult enrollees (21+) who are not pregnant are only covered for emergency department (ED) dental care services and not eligible for other preventive dental care benefits.

According to Texas officials, the two dental plans have somewhat unequal market shares with one DHMO serving 60 percent of participants while the other has 40 percent of the population. The DHMOs are reimbursed based on the capitation rates set by the state. Savings are shared with the state, while the plans bear full risk for any losses. There are fewer dental capitation rate cells in Texas when compared to their Medicaid and CHIP programs. Children enrolled in Medicaid and children enrolled in CHIP have separate rates and are grouped by age:

- Medicaid Dental program rate groups:
 - Children under age one-year old
 - Children ages 1-5
 - Children ages 6-14
 - Children ages 15-18
 - Children ages 19-20

¹⁹ Agency for Health Care Administration, Florida Medicaid: Statewide Medicaid Managed Care Dental Health Program; https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2020-02-01_Dental/Dental_Attachment_I_Feb-2020.pdf

²⁰ Title V Maternal & Child Health Fee-for-Service Program, Texas Health and Human Services; (2020) <https://hhs.texas.gov/services/health/title-v-maternal-child-health-fee-service-program>

- CHIP Dental Program rate groups:
 - Children under age one-year old
 - Children ages 1-5
 - Children ages 6-14
 - Children ages 15-18

The Texas rate-setting process takes up to a year, starting in the summer and ending in December while the rates take effect in March of the following year. The process begins with encounter data submitted by the dental managed care plans to the state data warehouse and these experience data are used to set the per member per month (PMPM) capitation rates for the plans. Additional adjustment factors include trend factors, removal of federally qualified health centers (FQHC), dental fee schedule change, and pay-for-quality (P4Q) along with provisions for administrative expenses, taxes, and risk margins to project the total cost for a rate period.²¹

Texas had prior experience setting provider rates for its CHIP managed care program, which made the transition to include dental managed care rate-setting into their system less burdensome.

The DHMO contracts also incorporate performance measures designed to improve quality and ensure appropriate utilization management. DHMOs must report certain HEDIS measures and participate in the P4Q program. Implemented in 2018, the P4Q program assesses the percentage of enrolled children in dental managed care plans who received the following dental services:

- Oral evaluation
- Topical fluoride for children at elevated caries risk
- Sealant at elevated risk
- Ambulatory care sensitive emergency department visits for dental caries in children

DHMOs are incentivized to meet these performance measures.²² The P4Q program places 1.5 percent of each DHMO's capitation at-risk for performance. If a DHMO's performance decreases beyond a certain threshold amount on the dental P4Q measures, the state recoups up to 1.5 percent of the original baseline capitation. Performance is based on changes from rates two years prior. If a DHMO's performance is maintained or improves on all measures, the DHMO's capitation is not at risk for recoupment. If one DHMO's performance decreases such that its capitation is subject to recoupment, the funds recouped are available as an additional distribution payment to other DHMO. A DHMO is only eligible to receive an additional disbursement if its performance improves beyond the upper threshold of the neutral zone.

Texas indicated dental expenditures have decreased year after year, suggesting savings may be realized under the managed care model. Texas officials further noted that use of a managed care model helped the state to enhance utilization management and better monitor providers who were outliers with respect to billing, leading to savings. In conversations with one DHMO, the plan indicated that the state saw a 25% reduction in costs over the course of seven years, which the DHMO attributed in large part to enhanced oversight in the area of utilization management (see further discussion below). Texas made rate refinements due to dental managed care plans profits in the early years of the program. In subsequent years, the state actuaries improved their rate-setting methodologies as they continued to receive better data from the plans. This has led to fee schedule

²¹ HHSC Uniform Managed Care Manual, Dental Pay-for-Quality (P4Q) program; Texas Health and Human Services. (2020) <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-15.pdf>

²²State of Texas Medicaid and CHIP Managed Care Dental Rate Setting, Texas Health and Human Services. (2020) <https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2020/2020-09-dental.pdf>

adjustments and other changes in the rate-setting process. In addition, the potential savings realized may be attributed to changes in other parts of the Medicaid program rather than the switch to a dental managed care plan for children in the CHIP and Medicaid.

C. Washington—FFS Model

The state of Washington delivers dental benefits through a FFS model. Washington historically furnished full dental benefits to limited sub-categories of enrollees, including children under 21 years old, pregnant women, individuals in long-term care, and 1915(c) waiver beneficiaries.²³ In January 2014, Washington reinstated its comprehensive adult dental benefits package, which covers diagnostic, preventive, and restorative care services. The state had previously cut the benefit in 2011 due to a shortfall in state revenues, and covered only emergency-based dental services for adults from 2011 to 2014.²⁴ The benefit package covers adult enrollees under 65 years old with a maximum income of 138 percent of the federal poverty level (FPL) including enrollees under the Affordable Care Act's (ACA) Medicaid Expansion program, and full dual beneficiaries above 65 years old.²⁵

The state of Washington's spending on dental care services grew from \$220.3 million in 2011 to \$387 million in fiscal year 2018, largely due to the restoration of comprehensive adult dental benefits and Medicaid Expansion. Although overall dental care expenditures increased, provider reimbursement rates have not increased for all covered populations and rates for adult enrollees have remained level since 2007. Static rates may have created a chilling effect on billing by providers, with the number of providers enrolled and billing for services dropped from 2014 to 2018 with only 1,385 of the 3,738 enrolled dental providers billing for services in 2018.²⁶

Washington explored transitioning its dental program to a carved-out managed care to help control costs. Following a competitive procurement process, three bidders submitted applications. Unfortunately, the state and the bidders could not agree on appropriate rates. Additionally, analysis of prospective costs by Milliman also suggested that shifting models and driving improved access to care, particularly for adults, would require increasing the existing FFS base rates and a corresponding increase in administrative expenditures based on enhanced service utilization. Increasing access for adults by just 5 percent was associated with an increased cost of \$6.1M annually (1.2 percent of the annual dental budget), while modeling to assess expected costs associated with increased access of 5 percent in tandem with a 10 percent increase in adult rates would cost \$9.5M annually (2.6 percent of the annual budget). The report further notes that increasing access for adults could have a downstream impact of increasing the number of children accessing benefits. As a result, enhanced access to services could result in better long-term outcomes, while mitigating savings potential in the near term. The report did not provide a comprehensive analysis of the timeline in which potential savings that might be achieved. Based on

²³ Washington State Medicaid Facts and Figures, Washington Dental Services Foundation . (2020) https://www.medicaidental.org/files/Resource%20Documents/WDSF_Medicaid_Facts_Figures2014.pdf

²⁴ Request for Proposal, Washington State Healthcare Authority; (2020). https://stateofreform.com/wp-content/uploads/2018/05/RFP-2516_MC-Dental.pdf

²⁵ Washington State Medicaid Facts and Figures, Washington Dental Services Foundation . (2020) https://www.medicaidental.org/files/Resource%20Documents/WDSF_Medicaid_Facts_Figures2014.pdf

²⁶ Apple Health Dental Program, Options for Improving Access, Washington State Healthcare Authority; (2020) https://www.hca.wa.gov/assets/program/apple_health_dental_program_20191115.pdf

the findings of the report and the challenges faced in the RFP process, the Washington State Legislature opted to require the Medicaid Program to retain its FFS model.

Although the state did not transition its delivery model, Washington has focused on two initiatives in recent years designed to enhance quality and improve access to care: the Oral Health Connection Pilot and the Access to Baby and Child Dentistry (ABCD) program. The Access to Baby and Child Dentistry (ABCD) program serves children who are 6 years old and younger, and the Oral Health Connection Pilot serves pregnant women and enrollees with diabetes between the ages of 21 to 64 years old. The ABCD program is a public-private partnership that identifies and enrolls high-risk children, and provides outreach to connect dental providers and families to increase children's access to dental care services among others.²⁷ The Oral Health Connection Pilot program has been implemented in three counties to examine the impact of enhanced oral health services on the overall health of Pilot participants.²⁸ The Pilot program provides additional dental benefits to participants and is delivered through dental benefit managed care organizations (DBM) with the aim of integrating dental and medical care, and fostering collaboration between medical providers and dentists to manage participants' overall health.²⁹

V. State Implementation Considerations

A. Dental Benefits Administrator (DBA) RFP Considerations

MDH has scheduled a request for proposal (RFP) for DBA's bidding in Spring 2021. The RFP contains a three-year base contract with the option of an annual renewal for the remaining two years of the contract. The new contract is currently scheduled to start on January 1, 2022.

In assessing adoption of different models in the future, MDH faces some key decision points. First, MDH will need to decide whether to have a single dental vendor or multiple dental vendors (regardless of whether MDH elects to switch to a managed care model) and how this would impact overall dental care delivery. Secondly, MDH has to determine if an §1115 waiver authority approval will be required by CMS to make any changes to its Healthy Smiles Dental Program; this would mandate a public process that involves two public hearings, submission of the waiver to CMS at least six months prior to the effective date, and other requirements. Third, MDH would need to decide on if or what requirements or factors would be considered for any managed care rate-setting (if MDH decided to move forward with a managed care model), such as the level of risk adjustment needed and the number of variables to include, whether contracts amendment with actuaries to have actuarially sound rates will be required, and determine the timeframe of setting rates. Lastly, MDH would need to evaluate total administrative costs and overall expected savings of any potential changes, and determine what operational changes would be need to be made, such as developing a timeline for operational changes, drafting new RFPs, and considering possible changes to COMAR.

²⁷ Washington State Medicaid Facts and Figures, Washington Dental Services Foundation . (2020)
https://www.medicaidental.org/files/Resource%20Documents/WDSF_Medicaid_Facts_Figures2014.pdf

²⁸ Washington State Healthcare Authority, Oral Health Connections (OHC)Pilot Project Billing Guide; (2020)
<https://www.hca.wa.gov/assets/billers-and-providers/Oral-Health-Conn-Pilot-Proj-BI-20190101.pdf>

²⁹ Washington State Healthcare Authority, Legislative Report-Oral Health Connections Pilot Project. (2020)
<https://www.hca.wa.gov/assets/ssb-5883-oral-health-connections-12-01-17.pdf>

B. Dental Benefits Administrators (DBA) Metrics Consideration

MDH continues to use various metrics to assess the success of its dental program. There are several quality measures under consideration for carved-out managed care dental services including network adequacy; HEDIS annual dental visits (ADV) to gauge utilization rates; and EPSDT report such as any dental services received, preventive/diagnostic dental services received, and restorative dental services received.

MDH may also implement additional evidence-based oral healthcare services performance measures in the future. The measures below are developed by Dental Quality Alliance (DQA), an organization established by the American Dental Association, and have been utilized by other states to evaluate managed care DBA performances. Some of the measures under consideration include the following:

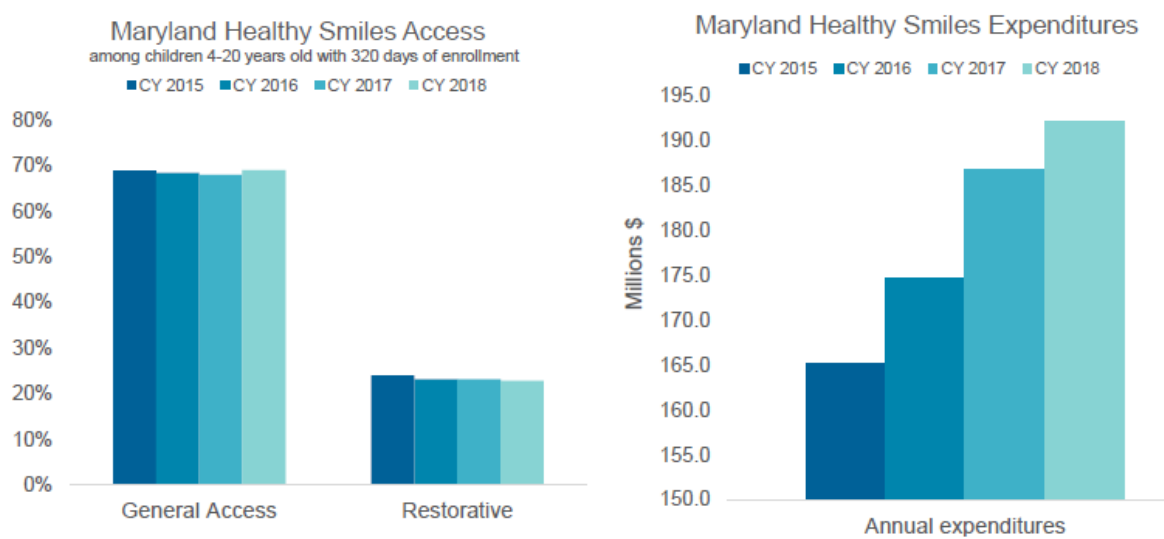
- **Sealant in 6-9 years:** Percent of members continuously enrolled for at least 180 days, who are at “elevated” risk for dental caries and who received a sealant on a permanent first molar tooth within the reporting year.
- **Sealant in 10-14 years:** Percent of members continuously enrolled for at least 180 days, who are at “elevated” risk for dental caries and who received a sealant on a permanent first molar tooth within the reporting year.
- **Topical Fluoride:** Percent of enrolled children aged 1-20 years, who are at “elevated” risk and who received at least two topical fluoride applications within the reporting year.
- **Care-Continuity:** Percent of members (1-20 years of age) enrolled during two consecutive years for at least six months in each year, who received a comprehensive or periodic oral evaluation in both years.
- **Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children:** Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children.
- **Follow-Up after Emergency Department Visits for Dental Caries in Children:** Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children 0–20 years, in the reporting period for which the member visited a dentist within 30 days of the ED visit.

VI. Stakeholder Engagement

MDH met with multiple stakeholders to review an outline of this report as well as different dental delivery systems. Stakeholders that participated in the process included representatives of the Maryland Dental Action Coalition (MDAC) and the Maryland Medicaid Advisory Committee (MMAC), as well as two different DBMs, Dentaquest and MCNA Dental. The stakeholders recommended that, regardless of what model MDH chose to implement moving forward, access to care and quality of care should be at the forefront of the decision making process. The two DBMs in attendance shared recent survey data showing high percentages of satisfaction from dental providers and Medicaid enrollees for their services in other states.

Stakeholders noted that Texas currently has a 15% lower fee schedule compared to Maryland, and an access rate that is 17% higher.

Figure 1: Maryland Access and Expenditures, CY 2015 through CY 2018



Stakeholders further noted that balancing the relative costs of service delivery and administrative oversight was associated with variable outcomes. Presenting a case study from Tennessee, stakeholders noted that when the state selected a contractor with lower administrative rates, it had the unexpected result of increasing service costs, likely due to less oversight on cost of care. Whereas more efficient management of services permits savings to be reinvested or accrued to the state in challenging fiscal time. Given the relative stability of access to services and a level fee schedule compared to rising costs, these findings suggest Maryland’s current delivery system could realize additional efficiencies through improved management. Overall, stakeholders cited several potential levers to improve efficiency and quality while controlling costs, including enhancing system edits annually; establishing more robust utilization management algorithms and other technological enhancements to control costs and reduce fraud; developing a dental home model that drives enrollment to the most cost effective and highest quality providers; improving third party liability (TPL) billing capabilities; and increasing the use of value-based care to align financial and quality outcomes at the provider level. As noted in the discussion above, the relative success of these levers in achieving the desired outcomes are dependent on the expertise of the entity implementing them. This expertise may be strongest in a specialized vendor like a DBM. Stakeholders also suggested that savings achieved from a capitated program could be used to further expand dental services in the Maryland Medicaid program.

VII. Conclusions and Next Steps

MDH remains dedicated to the continual evolution of its dental program to improve access to care and quality, while controlling costs. Based on a review of the different service delivery models, each one has unique benefits to offer the State, providers, and enrollees. Preliminary analysis suggests that there are opportunities to continue to make improvements to drive quality and reduce costs under the existing ASO/DBA model. The potential for savings to MDH through adoption of a managed care model—either carve-in or carve-out—may be greater still, but requires further evaluation. While findings by the stakeholder DBM suggest savings under the existing model have not been optimized and could be increased under managed care, fiscal models from other states

suggest further evaluation is needed. MDH will continue to work with stakeholders moving forward as these models and potential changes are evaluated.