State of Arizona

Medicaid Dental Review

October 2010

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to improving pediatric dental care in the Medicaid program reflecting broad national interest and ensuring the appropriate provision of medically necessary dental services to children covered by Medicaid. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children under the age of 21 enrolled in Medicaid is intended to assure the availability and accessibility of health care services for children and to help beneficiaries effectively use them. The EPSDT benefit includes coverage of dental care.

As part of an ongoing effort to identify best practices and opportunities for improvement in children's Medicaid dental programs, CMS conducted a review the week of January 11- 15, 2010, of the State of Arizona's Medicaid dental program. The review focused on discovering practices and program innovations that have successfully increased dental utilization. The review team consisted of staff representing the CMS San Francisco and Chicago Regional Offices. Specifically, the review team interviewed State officials and staff representing the Arizona Health Care Cost Containment System (AHCCCS), the agency responsible for the administration of Arizona's Medicaid program. In addition, the team interviewed three managed care organizations and a non-representative sample of four dental providers.

The intent of this review was to examine the utilization of the State's policies and procedures in fulfilling the requirements of the State's EPSDT benefit, with the focus on current practices that have contributed to Arizona's higher than average utilization of dental services.

The State of Arizona provides over 98 percent of its dental services through managed care risk arrangements, one of the few States to administer their dental program in this way.

This report identifies and explains the following innovative practices identified during the CMS review:

- State level accountability
- Managed care organization performance transparency
- Establishment of a State Medicaid dental director position
- Special Needs Dental Clinic

Arizona has demonstrated strong managed care design and proactive leadership; taken action to hold plans accountable; and increased utilization rates while allowing interventions to be established at the individual plan level. CMS looks forward to working with Arizona regarding children's dental issues.

INTRODUCTION

Background

In 2008, at Congressional request, CMS conducted on-site reviews of children's dental services in 16 States with dental utilization rates for children of less than 30 percent based on data from the EPSDT CMS 416 annual report. These reviews were performed to determine what efforts States have made to improve children's dental utilization in their State, and to make recommendations on additional actions States can take to increase utilization rates and ensure compliance with Federal Medicaid regulations. Results of these 16 reviews were presented to Congress in 2009.

As a follow-up to that effort, CMS conducted reviews of States that reported higher dental utilization rates. The States were selected based on a CMS review of State data and external partners' identification of Medicaid dental programs with promising initiatives in oral health. All of the States selected had an average utilization rate for children of at least 37 percent, with the national average being 38 percent. Eight States were reviewed, and information from those reviews is available to States for the purpose of improving the overall delivery of dental services.

Medicaid's Coverage of Dental Services

Through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid eligible individuals under the age of 21 are provided coverage for preventive and comprehensive health services. The benefit entitles eligible individuals to regular check-ups and all medically necessary health services in order to ensure that their health and developmental needs are met. The EPSDT benefit includes screenings, dental services, vision services, hearing services, and other services necessary to correct or improve health conditions discovered through screenings. The benefit consists of two mutually supportive, operational components which States and the Federal government are responsible for ensuring: the availability and accessibility of medically necessary health care and assisting Medicaid enrollees and their parents or guardians to effectively use the services. CMS is committed to improving pediatric dental care in the Medicaid program and ensuring the appropriate provision of medically necessary dental services to children.

Overview – Arizona EPSDT Dental Program

The Arizona Health Care Cost Containment System (AHCCCS) is the State agency that administers the Medicaid program. All Medicaid beneficiaries receive services through a managed Care Organization (MCO) except for tribal members who may choose to receive services from an Indian Health Services provider.[1] More than 98 percent of children enrolled in Medicaid in Arizona, including disabled children, are enrolled in managed care for their medical and dental care. The very small population of disabled children needing institutional or home and community based services receive medical and dental services coordinated through MCOs that exclusively serve this vulnerable population. The non-disabled population is served by nine MCOs across the State and member options vary by county of residence. Eight of these are competitively procured, with the ninth limited to children placed in foster care and administered by the State. Dental services and transportation to such services are included in the MCO

[1] Tribal members who opt to join a managed care plan continue to be able to access care on a fee-for-service basis if they wish to receive care from a provider who does not contract with their MCO.

contracts. In the two most populated counties in the State, members must have access to a dental provider within five miles of their home.

According to the 2008 CMS 416 report, more than 680,000 children age 20 years and younger were eligible for Medicaid in Arizona. Dental preventive and treatment services were provided to 284,364 children during the year, with a utilization rate of 39 percent. Children can visit any dentist enrolled with their MCO as a Medicaid provider, and no referral from the primary care provider is necessary.

The review team found innovative dental practices in place at the State and MCO level. A variety of strategies were used, all working toward the goal of increasing children's dental utilization.

INNOVATIVE PRACTICES

I. State Level Accountability

Federal regulations found at 42 CFR 438.240 require States, through their contracts, to have an ongoing quality assessment and performance improvement program within managed care. States generally select which measures will be tracked. States may mandate quality measures or allow plans to select their own quality measures, or some combination of the two. These performance measures are then validated by an external reviewer. Performance measures are often HEDIS measures, since these are the industry standard, specifically defined, and accredited by the National Committee for Quality Assurance (NCQA). Federal regulations also require states, through their contracts, to have an ongoing program of Performance Improvement Projects (PIPs). These are designed to measure an indicator, introduce interventions to improve, and evaluate the effectiveness of the interventions. PIPs must be reported annually by the plans, reviewed every year by the State, and completed in a reasonable time period.

More than a decade ago, Arizona stopped approving MCO dental subcontracts if the contract delegated risk for the cost of services, potentially incurring a loss to the MCO if services provided exceeded the cost of the contract. Thus, while an MCO can subcontract to gain access to an already-assembled network, all MCOs pay their dental providers fee-for-service negotiated rates. Despite this change aligning payment incentives with increased dental care, utilization rates remained below the national Medicaid mean.[2] While plans often establish their own PIPs to increase performance in identified areas, Arizona mandated MCO participation in a dental PIP in 2003.

The PIP focused on Medicaid dental services for children ages 3-8, as the Arizona Office of Oral Health identified this as a crucial age in which children in Arizona experienced markedly increased tooth decay (treatment beginning at age one was not yet the standard of care). An Office of Oral Health survey showed 40 percent of children in Arizona in this age range with untreated tooth decay. The State did not dictate how plans were to achieve improvement; only that they participate. Plans started with a baseline HEDIS measurement of children receiving at least one dental visit ranging from 50 to 61 percent of enrolled children. At the conclusion of the

[2] Arizona sets minimum performance standards based on the national mean for Medicaid MCOs or the Medicaid average for Arizona, if higher.

PIP, this range had increased from 59 to 72 percent of enrolled children, with the largest improvement by a health plan being a 31 percent increase from its baseline.

The highest success rate at the conclusion of the PIP was for the health care plan that served the children in foster care throughout the State. Seventy-two percent of the children in that plan received at least one annual dental visit. That plan has an open network, meaning that it must contract with all willing providers, so that foster families may take the children to any provider willing to contract with the plan. It also has direct contact with foster care case workers, and access to the same information as case workers. The plan explained to us that while they are proud of their dental rates, that dental is the performance measure on which they score the lowest, which they attribute to the crisis in which children enter their plan. While the uniqueness of this plan somewhat limits the applicability of their best practices to other plans or other states, the vulnerability of this population and their success with performance measures, make its success impressive.

II. Data Transparency

Arizona contractually requires MCOs to track 21 different performance standards, including one for Children's Dental Visits Age 2-21. In addition to operating a quality management program at the plan level, MCOs must meet a minimum performance standard. Penalties if this standard is not met include a corrective action plan and a financial penalty of up to $100,000 for each deficient measure, for a total of $2.1 million at risk per plan. If a contractor has already met the performance standard, they must strive for a higher mandated goal, and AHCCCS may sanction a contractor who shows a significant decrease in a measure even if it is above the minimum performance standard. Lastly, the State may require the MCO to show that they are allocating increased administrative resources to improving rates on a particular measure.

Plans compete with each other on several levels. When bidding for a contract to provide care for Medicaid members, AHCCCS requires plans to have a process in place to reduce member no-show rates for appointments, including dental appointments. Plans must describe how feedback from the network will be incorporated into MCO operations, how EPSDT oral health outreach and monitoring will be implemented, and strategies to increase utilization.

Arizona posts performance data publicly, so plans and members know where each MCO stands in relation to others in specific areas. Members can select another plan if dissatisfied, or if a plan has good results in an area. The State's algorithm to score bidding MCOs includes past performance on quality indicators, so sustaining success plays a role in winning future bids. Plans compete to advertise success, and thus have incentive to successfully complete the PIP in a timely manner, making improvement and sustaining it in order to remain competitive. The State's commitment to using encounter data, including dental encounters, in setting prospective capitation rates supports plan efforts to increase utilization. This helps counter traditional disincentives related to utilization associated with capitated managed care.

III. Establishment of a State Medicaid Dental Director Position

Arizona was the recipient of a Robert Wood Johnson Foundation grant to emphasize dental care, which the State used to create the AHCCCS Dental Director's position. Having an in-house dental director, not a contractor, appears to bring attention to dental utilization rates. Each plan

is contractually obligated to have a designated dental program manager, who meets three times a year with the AHCCCS Dental Director and the Arizona Office of Oral Health. These meetings seek to clarify policy, identify issues needing resolution, and compare best practices.

IV. Special Needs Dental Clinic

Dental care for special needs patients, including disabled children, can be difficult to attain nationwide. Many dentists do not have experience treating this population, nor do they necessarily have the facilities to do so. One of two dental schools in Arizona, the A.T. Still University, Arizona School of Dentistry and Oral Health, was the recipient of a grant from the United Health Foundation to establish a special needs dental clinic where dental students gain experience treating patients with special needs. This both fulfills an important provider need and may help influence these students to accept disabled patients once they are practicing independently. Currently, this clinic contracts with the two largest Medicaid health plans in the State.

PERSPECTIVES OF STAKEHOLDERS

The MCOs interviewed agreed that the State's elimination of dental risk subcontracts focused more attention on dental services, as many MCOs started directly contracting with providers. Plans made a decision to focus on provider satisfaction and highlighted their provider relations and outreach efforts in order to recruit and retain providers. Since plans negotiate payment rates with providers, payment rates vary among plans. Certain "hard to find" specialists or dental practitioners in remote areas may garner higher payments. Two of the plans we interviewed told us that while they cannot pay the highest rates, they do offer excellent provider relations, which was confirmed in our interviews with providers.

After meeting contractual requirements, MCO strategies to improve dental utilization varied. Some plans partnered with the Arizona Office of Oral Health to meet with physicians and emphasize their role during well child exams to educate parents about the importance of dental care. Others partnered with dentists to give specific outreach. Many plans, particularly larger ones, established an internal advisory board of dental providers to provide input to the plan. Plans we interviewed assigned specific provider relations staff to provider offices, so that providers would have a consistent contact for billing and claims issues. The accessibility and helpfulness of this action was reinforced by the providers interviewed. Almost all plans provided dental-specific education and outreach materials, in addition to sending reminders when appointments were due. Some plans looked at claims payment data to see who had not received dental care within a certain time frame and provided targeted outreach to those families.

An oft-cited barrier to provider participation in Medicaid is the number of patients who make an appointment and neither show up nor cancel, particularly for a major procedure using a substantial block of time. To address this issue and reassure providers, several plans utilize a "no show" list. Office staff complete a weekly list of patients who did not show up for their appointments and provide it to the MCOs. This addresses provider concerns in several ways: providers can tell patients their plans will be contacted if they "no show" again, plans can contact the names on the list and reinforce the importance of oral health and cancelling an appointment if the patient cannot make the appointment, and the dentist has recourse to drop a patient, while the

plan retains responsibility for ensuring access to dental care. Multiple reports on the "no show" list may trigger case management for additional help overcoming barriers to care at some plans. Another common intervention was plan staff calling families with reminders about appointments in addition to reminders regularly generated by the provider offices.

CONCLUSION

Arizona has demonstrated strong managed care design and proactive leadership, taking action to hold plans accountable and increase utilization rates while allowing interventions to be established at the individual plan level, without mandating how this should be achieved. Strong State oversight is just one component of a successful dental program; however, without it, a consistently successful dental program cannot exist. Plans used a variety of approaches to increase utilization rates, including efforts to prioritize provider relations and targeted outreach to members. Health plan data is available publicly, so plans and competitors can see utilization data. Financial sanctions for failing to meet performance goals serve to focus attention and resources of health plan management. While Arizona is constrained by budgetary shortfalls like so many States, CMS looks forward to working with the State to continue its progress on increasing access to children's dental services in Medicaid.