Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Contracting Out Dental Services Administration

2016 supplemental budget, Second Engrossed Substitute House Bill 2376, Chapter 36, Laws of 2016, Section 213 (1) (vv)

December 1, 2016

Contracting out Dental Services Administration

This report was created at the request of the State Legislature and includes the history of Washington State's Medicaid dental program as well as information on how other states administer their programs and how they have sought to improve access to dental benefits. The report includes options to improve service delivery of the program, a plan for how to convert program administration to a third party or administrative services organization, information on the cost and technological requirements of the shift, and a listof stakeholders who contributed to the report.

Washington State Health Care Authority

Central Services Administration
P.O. Box 45502
Olympia, WA 98504-5502
Phone: [(360) 725-1703)
Fax: [(360) 586-9551]
www.hca.wa.gov

Table of Contents

Executive Summary

The Health Care Authority (HCA) was directed to develop a plan for contracting out administration of the Washington Medicaid (Apple Health) dental program in a proviso in the 2015-2017 supplemental budget bill—Second Engrossed Substitute House Bill (2ESHB) 2376, Section 213 (1)(vv). The intent is to increase enrollee access to dental services.

HCA reviewed the history and utilization patterns of the program, researched other state practices, solicited stakeholder input and explored three options for outsourcing. This report details the findings, explores the benefits, costs and risks of outsourcing options and presents a high-level implementation plan.

In the current fee-for-service (FFS) system, dental access is limited for many Apple Health clients. Stakeholders cite low reimbursement rates, administratively burdensome program requirements, and uneven geographic distribution of dentists as contributors. Many Apple Health enrollees with access are served by those Community Health Centers and Indian Health Clinics which provide dental services. The children's program, Access to Baby and Child Dentistry (ABCD), is also a successful program resulting in better access for children under age 6.

Administration of the Apple Health dental benefit may be contracted out to a third party organization through different methods. The options include contracting the administration of the dental benefit to an Administrative Service Organization (ASO), contracting the entire dental program to one or more Managed Care Organizations (MCOs), or fully integrating dental care with physical health through MCOs that are also contracted for physical health care. In the ASO model, the contractor is only at financial risk for their administrative fees and not for changes in utilization or for the costs incurred. In contrast, MCOs typically accept the full financial risk associated with delivering the benefit.

Research indicates that increased access is accomplished most effectively by:

- Increasing provider rates,
- Improving education and outreach to enrollees,
- Streamlining administration,
- Better use of technology,
- Expanding dental teams through workforce innovations, and
- Enhancing participation of providers and stakeholders in the operation of the program.

We must consider these elements, including the fee structure, in order to successfully transition to a new model. Many of the stakeholders we consulted during this process indicated concern with full integration into MCOs, at least initially. Taking this input into account, we believe implementing an ASO model prior to full integration into MCOs would be most viable. This would allow for a slower,

more deliberative approach for transitioning the complex system. At this time, we are not able to move in this direction without additional resources to support the costs identified in this report.

HCA strongly recommends that, if a decision to move forward is made, the chosen approach must improve the existing dental program infrastructure. This includes expanding the provider network, increasing individual providers' capacity, and retaining innovative programs such as the ABCD program.

Regardless of the service delivery model chosen, the maintenance and future development of a system that provides evidence-based and promising practice dental services focused on whole-person care must remain a priority. Through quality review and performance monitoring of dental providers, the contracting entity will ensure the care received by Apple Health clients is necessary and contributes to improved outcomes.

Introduction

2ESHB 2376, Section 213 (1)(vv) directs HCA as follows:

> *The health care authority in cooperation with the Washington dental services foundation, the Washington state dental association, and other interested stakeholders shall develop a plan to increase access to care by expanding the Medicaid dental network through contracting out the administration of the Medicaid dental program. This plan shall include but not be limited to engaging dental expertise in the administration, improving the provider and patient experience, aligning the benefit package with evidence-based care, and beginning to test innovative models of delivery consistent with the goals of the healthier Washington initiative. The authority shall also review options to include contracting with one or more Medicaid managed care plans or a third-party administrator. The report summarizing the authority's implementation plan and an estimate of the cost to execute this plan must be submitted to the governor and the appropriate committees of the legislature by December 1, 2016. The plan shall not be implemented until specifically authorized by the legislature.*

In summary, HCA is to create a plan to achieve better access to dental care through expansion of the Medicaid dental network. This expansion is to be accomplished by contracting out the administration of the program to an entity known as an ASO or MCO(s). The plan must address the following factors:

- engaging dental expertise in the administration,
- improving provider and patient experience,
- using evidence-based care to improve the benefit package, and
- testing more innovative delivery models.

HCA is to report to the Legislature the implementation plan and its estimated costs by December 1, 2016.

Again, HCA strongly recommends that, if a decision to move forward is made, the chosen delivery system approach improves the existing dental program and, in addition to expanding access:

- furthers whole-person care.
- advances evidence-based dental treatment.
- supports transparency and efficiency. and
- retains innovative programs such as the ABCD program.

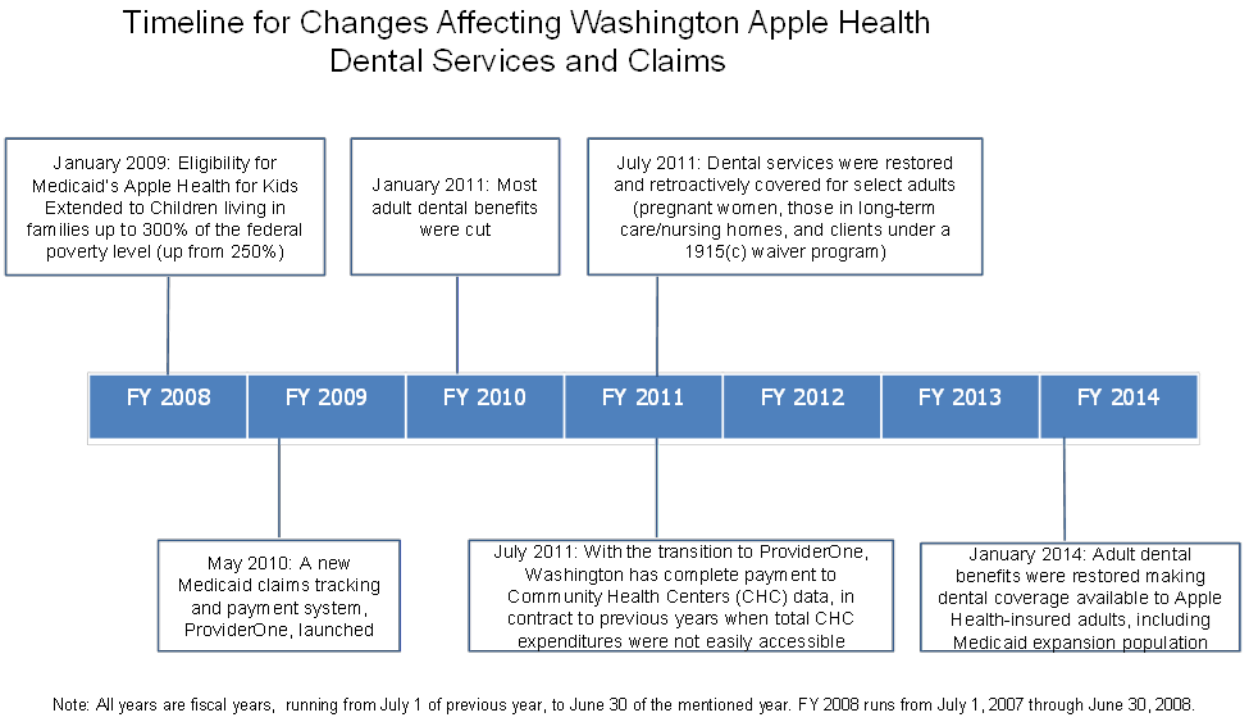
Background

Apple Health Dental Services: Washington State

More than one in four Washingtonians receive their dental care insurance coverage through Apple Health. This includes nearly 850,000 children and more than 1 million adults in the state. While Apple Health has been moving away from a fee-for-service (FFS) model of health care purchasing to a managed care model since the early 1990s, the dental health program remains carved out of managed care. Thus, the potential advantages associated with MCO coverage, such as care coordination and improved access, are not realized by the State or clients receiving dental care.

Dental program expenditures have grown from $220.3 million in 2011, when benefits were limited, to the 2015 expenditures of $343.8 million. The number of clients receiving coverage for dental care sharply increased in 2014 when comprehensive benefits were restored for adults at the same time the Medicaid expansion was implemented. Further cost and utilization data are detailed in Appendix A. The dental program history and timeline are outlined in Appendix B.

Figure 1: Program Timeline



Note: All years are fiscal years, running from July 1 of previous year, to June 30 of the mentioned year. FY 2008 runs from July 1, 2007 through June 30, 2008.

Infographic source: Washington Dental Services Foundation report on Medicaid claims data

Overview of Adult Coverage

Budget cuts led to Apple Health limiting the adult dental benefit to emergency services only in 2011. Between 2011 and 2014, adult comprehensive dental coverage was only available to pregnant women, those in long-term care/nursing homes, and those who were eligible under a 1915 (c) waiver program. In January 2014, adult comprehensive dental coverage was restored.

Overview of Children's Coverage

Apple Health dental coverage for children is a comprehensive benefit focusing on prevention, early diagnosis and treatment. Children from birth through age 20 are eligible for a complete range of dental services, including preventive and restorative procedures. Apple Health provides enhanced reimbursement for children under age six to dentists trained through the Access to Baby and Child Dentistry (ABCD) program to address oral health in young children. Initiated in 1995, ABCD focuses on expanding children's access to dental services in Washington State by providing preventive and restorative dental care to Apple Health children from birth through age five, with the emphasis on connecting these children with care by the time they are one year old. It is based on the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping to reduce the development of dental caries and the need for costly restorative work in the future.

Contracting out the Medicaid Dental Services Program: Three Options

Three options exist for contracting out the Dental Services program. Each option is defined and compared below. The greatest difference between an ASO model versus an MCO model is the allocation of risk. In an ASO model, the contractor is only at risk for their administrative fees, and not at financial risk for changes in utilization or for the benefit costs incurred under the contract. In an MCO model, the MCO bears all the financial risk. Additionally, the MCO model is a more comprehensive model created around the idea of using preventive care and coordination of care to increase the health of the individual with the overall intent of reducing the use of higher cost services such as emergency room treatment. An MCO model may contract for dental service separate from medical care, or it may combine medical and dental care into one contract. The ASO model contracts out the administrative functions to increase administrative effectiveness and alleviate the administrative burden on providers and the State. The ASO model and the separate dental MCO model recognize a difference between dental and medical services, allowing operating and clinical differences between the programs. Some states have moved toward the ASO model and some operate under an MCO model; it appears that more states operate with the ASO model today.

Options

Option 1: Contract for one ASO to operate program administration

Under this option dental services remain in a FFS structure, paid according to the rate structure and levels of the current program. One contractor is selected to administer the program according to HCA rules, policies and approval requirements.

The ASO is paid an administrative fee for its work. Claims are submitted to and paid by the contractor. The ASO is responsible for building and maintaining the provider network. HCA continues to credential and enroll providers into the program but providers communicate directly with the ASO regarding claims questions, issues, and complaints. The ASO conducts all prior authorization, communicates with clients about the program, and provides call center services and assistance to providers. In addition, the ASO brings expertise in benefit design to advise the program in effective service delivery and evidence-based dental practices. The ASO administers the dental program for all Medicaid enrollees.

Option 2: Contract with at least two MCOs that specialize in dental services to operate the Medicaid dental services program

Under this option HCA contracts with two or more MCOs as per federal regulation. Ideally, the selected MCOs should provide services throughout the state, although regional plans may be necessary, depending on the results of the procurement process for dental services. The MCOs administer all programmatic aspects of dental service delivery for the Medicaid population, with a focus on quality and efficient operations. The MCOs use ongoing quality improvement mechanisms, collect and analyze data, direct and redirect financial resources as needed across the system, focus on evidence-based preventive services, credential providers, manage utilization, and pay claims.

The MCOs are paid a fixed monthly fee per enrollee (capitated payments) by the State. In exchange, the MCOs agree to assume the financial risk for delivering a set of predetermined services. Rates are set by HCA's actuaries in an actuarially sound manner. The MCOs create networks of providers to serve Medicaid clients. Providers work directly with the MCOs on all issues, including contracting, rate setting, prior authorization policies, claims submission and payment, complaints and questions. Under this option, unless specifically exempted from managed care (e.g., tribal members), Medicaid enrollees are in managed care for dental services, with the State maintaining a small FFS program for exempted enrollees.

Option 3: Contract with each of the existing Medicaid MCOs to add a dental benefit to their current benefit structure

Characteristics of this option are similar to those in Option 2, except that each MCO has both medical and dental benefits in its plan. Under this option, Medicaid enrollees not currently in a managed care plan continue to receive dental care in a FFS structure, administered either by HCA or through an ASO arrangement as described in Option 1. The alternative ASO arrangement applies only to clients not enrolled in managed care. An exception process is available for clients whose dental treatment needs are not being met in a managed care service delivery structure.

Comparing the Options

Table 1 highlights the differences between each of the options.

Table 1: Differences between options

Option 1 – ASO	Option 2 – Dental MCOs	Option 3 – Integrated MCOs
What functions does the contractor perform?		
Administrative functions including: Provider networking, communication, support; quality assurance, utilization management, and utilization review; prior authorization, claims processing, and program integrity; client and provider calls and complaints; administration of the ABCD program; maintaining, publishing, and communicating provider guides and billing instructions	Service delivery and administrative functions	
How is the contractor paid?		
Administrative fee	Per member per month rates that must be actuarially sound	
How are payment levels determined for providers?		
Claims paid on a FFS basis; rates set by HCA according to budgeted funding	Payment levels set by MCO in contract with providers; may be FFS or on a per member basis	
Who takes on risk for operating the dental services program?		
State Medicaid agency	MCO	
Which entity does the provider contract with?		
ASO (one firm)	MCO (at least two firms)	MCO (current plans under contract)
Who does the provider work with?		
ASO (one firm)	MCO (at least two firms)	MCO (current plans under contract)

Stakeholders have different preferences between the three options for contracting out Medicaid dental services, and they are detailed in Appendix D. A summary of the various effects each option has on the state, providers and clients is provided on the next page (Table 2).

Table 2: Impacts of each option

Option 1 – ASO	Option 2 – Dental MCOs	Option 3 – Integrated MCOs
Is the cost of this option estimated to be higher than HCA currently spends?		
Yes, the cost of this option is estimated to be more than HCA currently spends on dental benefit administration. See cost section (page 22) for estimates on cost, based on available information.	Yes, the cost of services and administering the managed care benefit is likely to be higher than HCA currently spends. Dental service rates may increase if rates are not actuarially sound and managed care administrative rates in current contracts are higher than HCA currently spends to administer the dental benefit.	
How does the option affect dental hygienists working in specific settings such as assisted living centers?		
No change. Claims continue to be paid as they are now.	HCA contract would mandate allowing hygienists to fill this role.	
What benefits do clients receive under this option?		
HCA can require performance guarantees giving more access to clients. Vendor would be selected if they have a larger base of operation and infrastructure allowing for higher efficiency, access to specialists and existing networks to rely upon.	A contractor with dental expertise should be more efficient and flexible, similar to Option 1, and more effective than the current structure at providing access.	Integration of medical and dental health care may result in more coordinated care for clients, along with Option 2 benefits.
What benefits do providers receive under this option?		
Faster payment, less burdensome, more sophisticated technology, more dental expertise, able to be more flexible to meet demand, case management makes provider's experience better.		Integration with medical care may provide a better connection between dental providers/systems and medical systems, creating a more holistic program.
What costs does the State incur under this option?		
As stated above, it is likely the cost to contract with the ASO is higher than HCA's current administrative cost. While HCA will reduce its cost, this is not sufficient to offset the higher cost of an ASO. See cost section (page 22).	Cost to contract with plan is same as Option 1. Cost to implement actuarially sound rates may result in higher services cost.	Same as Option 2 but split five ways under current managed care plan structure.
What workload do providers bear under this option?		
Must work with new ASO to submit claims and prior authorization information. Providers will contact ASO.	Must negotiate with at least two plans that have authority over the dental program; must work with these entities to negotiate rates and payment policies.	Must negotiate and work with up to five plans or choose which to contract with; must negotiate rates and understand payment policies from all plans.

Research

Medicaid Dental Benefit Structures in Other States

Information Review

Across the nation states have worked to improve Medicaid client access to dental services. Methods to increase client access include increasing payment levels for providers, creating new payment methods to drive treatment levels and programs, authorizing new provider types to extend the reach of dentists, improving processes and policies for provider engagement and contracting with managed care or ASO organizations to improve provider and client experience. HCA has received information on the experience of other states through discussions with stakeholders, review of studies and reports and information produced by other states. A summary of this information is provided below, including results of program changes in other states and lessons learned by other states as improvements to Medicaid dental programs are implemented. While no comprehensive list of every state's delivery system and recent changes to the program exists, the information below is a summary of states' experience with Medicaid dental programs.

Research on Improving Enrollee Access to Medicaid Dental Services

The Centers for Medicare & Medicaid Services (CMS) conducted research on how states are improving Medicaid dental provider networks and enrollee access to care.[1] The states examined in this research have adopted one of the three structures being considered by Washington—FFS, an ASO or managed care. One state operates dental benefits through a managed care structure and five states utilize an ASO structure. Some states have carved out the dental benefit from the managed care programs. This research identified a combination of actions that result in improved access to dental care for Medicaid enrollees:

- Partnerships and collaborations with stakeholders including provider groups and state dental associations, and providers focused on serving rural and underserved populations, including Federally Qualified Health Centers (FQHCs) and Indian health care providers.
- Collaboration with dental schools to create outreach and education on the importance of dental services and loan repayment programs to increase provider networks.
- Increased reimbursement overall or targeted at certain populations or specialties.
- Simplified administrative processes including fewer claim forms, reducing prior authorization complexity or levels, and improving claims technology to reduce time to payment.
- Expansion of dental teams through workforce innovations.
- Use of grants to fund specific aspects of the dental program, such as "startup" funds for oral health initiatives.

[1] Innovative State Practices for Improving the Provision of Medicaid Dental Services: SUMMARY OF EIGHT STATE REPORTS (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas and Virginia); Centers for Medicare and Medicaid Services; January 2011.

- Education of clients and patients on the importance of dental services.
- Creation of programs targeting young children (similar to Washington's ABCD program).

The National Academy for State Health Policy (NASHP) conducted an examination of six states (Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington), along with a literature review, to examine what steps are effective in improving provider networks and enrollee access for dental services.[2] Actions examined included increasing reimbursement rates, improving administrative efficiency and conducting outreach and education.

Two states changed the administrative structure of their programs to "carve out" dental services from managed care to a dental-specific administrator, intended to improve administrative efficiency for providers. Key findings indicate that rate increases coupled with reducing administrative burdens increase provider networks. Involving state dental societies and individual dentists as active partners is also an important factor in improving access. The study found that enrolled providers increased as well as the number of patients treated.

Carve-out models are preferred by dentistry advocates and providers due to the "commercial-like administration" of the ASO structure. These stakeholders cite significant differences between medicine and dentistry, making the ASO model preferable to a structure that combines medical and dental managed care. In Michigan the ASO already had a presence, making conversion to an ASO structure more seamless. Providers were already enrolled with the ASO and Medicaid enrollees were able to access the dentist of their choice within the ASO's network. Patient access increased 24 percent in the first 12 months of this structure. In two other states, shifting to an ASO structure was combined with a rate increase, simplification of administrative requirements, and increasing enrollee outreach and education activities; these changes resulted in material increases in access.

The conclusion reached by NASHP is that increasing rates alone does not improve access to dental services. Improving administrative efficiency, reducing the provider's burden when dealing with Medicaid clients, and building on strong relationships with dental providers and advocacy groups are also vital to improving access. Research shows the need for improvements to administrative process, policy and technology must occur in preparation for a shift to an ASO structure. Innovative practices in the dental program result in improved network access especially when combined with increases in service rates.

Washington's dental program for children (ABCD) is identified as one of the nation's most effective dental programs; this program can be expanded within Washington to take advantage of an already existing structure.

Also, some research indicates that mid-level dental providers (e.g., dental health aide therapists, dental therapists, expanded function dental hygienists, and expanded function dental assistants) under dental supervision can expand dental care capacity at lower cost without a reduction in quality of service.

[2] The Effects of Medicaid Reimbursement Rates on Access to Dental Care; Alison Borchgrevink, Andrew Snyder, and Shelly Gehshan; National Academy for State Health Policy; March 2008.

Medicaid Dental Service Delivery Structures in Select States

Tennessee – Dental services were moved from a managed care to an ASO structure in the early 2000s. The new structure incorporated risk sharing with the contractor. Contract provisions included performance measurement, quality monitoring, participation requirements, and cost control mandates. Performance reporting allows providers and the State program to monitor program effectiveness. Contract provisions cover quality payments to providers. Positive results of the new contract structure included a reduction in overall medical costs due to reduced emergency room visits; utilization of dental services was not reduced but emergency visits due to a lack of dental service utilization did occur.

Texas – Dental managed care is provided through two Dental MCOs. A Dental dashboard for quality measures is used to monitor program effectiveness. The program structure is to capitate payments to plans but pay dental providers on a fee-for-service basis. The program uses incentives and quality measures to promote prevention services rather than invasive services.

Rhode Island – Service delivery structure is an MCO with a single program administrator for clients born after mid-2000. A FFS structure is in place for those born before that date. The contract is multi-year and partially risk-based. The program includes ongoing member outreach and community support, quality improvement initiatives, and development of new program quality measures.

Louisiana – The State issued a Request for Proposals (RFP) for a coordinated care network for dental services to serve as a state dental benefit program manager (health plan). Program structure includes an RFP for dental managed care entities.

Maryland – The State issued an RFP and established an ASO contract. The contractor must maintain a statewide dental home program, and establish administrative procedures and systems to ensure that participants seeking and providers rendering dental services do not face undue barriers or burdens. The ASO is responsible for increasing the number of children, adult pregnant women, and adult rare and expensive case management program participants.

Hawaii – Service delivery is an ASO contract. The contractor must work with a state Medicaid program partner to provide outreach to enrollees. ASO responsibilities include providing dental claims processing and dental care administrative services; administering both managed care and FFS administration and care coordination; covering both preventive and emergency dental services for adults and all dental services for children; providing web applications and online applications for processing and adjudication of claims; operating a telephone help desk during extended hours; recruiting and maintaining a sufficient number of dental care providers, producing brochures and pamphlets to communicate the dental program; administering prior authorization process and billing/reimbursement activities; administering quality assurance monitoring and fraud/abuse detection and prevention; and providing claims information to state's Medicaid Management Information System.

Connecticut – Operated under an ASO service delivery structure. The financial structure includes payment of indirect and direct costs with a 10% withhold to be released as an incentive payment. The contractor provides development of the provider network, member services, member outreach, prior authorization of services (including appeal process), utilization management, and quality assurance and improvement as well as supportive functions. The contractor also manages all dental services listed on dental fee schedule except hospital and some surgeries; implements a prevention and intervention strategy for members and their families to reduce poor oral health; establishes and staffs a member services office; provides brochures and a website for providers and enrollees; provides orientation and technical assistance for providers; implements and maintains procedures to manage grievances and appeals; and establishes and maintains a HIPAA-compliant computer system to accommodate all operational and reporting functions.

Connecting with Stakeholders: Actions Taken and Feedback Received

HCA was directed to create this report in cooperation with dental community stakeholders including, but not necessarily limited to, the Washington Dental Services Foundation and the Washington State Dental Association. (A list of stakeholders is included in Appendix C.) Stakeholders were included throughout report development and review to comply with this requirement. Feedback from stakeholders was included in the report to ensure balanced information that takes the broad range of opinions into account. HCA conducted the following activities to ensure stakeholder involvement:

- Group meetings with the Washington Dental Services Foundation; Washington State Dental Association; the Dental Advisory Board; managed care plans; ABCD program partners, providers, champions, and coordinators; community clinics; and other stakeholders. Meetings were held in person and over the telephone.
- Presentations at dental conferences both in person and over the telephone.
- Conference calls to collect feedback and to review the draft report.
- Webinars to review draft reports in detail; feedback was taken at these meetings.
- An email box was set up to collect feedback, recommendations and information from stakeholders.
- Draft reports were distributed to known stakeholders for feedback and review. This process occurred between July and October 2016 to provide sufficient time and opportunity for feedback and recommendations.
- A tribal consultation was held in-person and by webinar to receive feedback from tribal governments and Indian health care providers.

Stakeholders expressed different preferences between the three options for contracting out Medicaid dental services. Appendix D provides a summary of stakeholder input.

Plan for Contracting Out Dental Services Administration

Moving to an ASO Structure: Strategic Considerations

The legislative directive for this report requires development of a plan for contracting Medicaid dental administration to an ASO. Some other states use a managed care approach for dental services and it is possible that Washington's Medicaid dental benefit may move toward a managed care structure in the longer term. Feedback from some stakeholders and HCA management is that the service delivery infrastructure in Washington State can support implementation of the ASO approach in the immediate future, but a managed care approach should be identified as a longer term solution. HCA and many stakeholders agree that the ASO structure should be implemented with Washington's child dentistry program, ABCD dental, continuing operation as it is currently structured (including eligibility, program rules and rate structure). The ABCD program can be used as a model for the entire dental program as the shift to an ASO model is planned.

Caution is advised when considering an immediate structure change for the Medicaid dental program due to large changes already occurring in Washington's Medicaid system. Healthier Washington is transforming the way care is delivered and reimbursed. Value-based purchasing strategies are being developed. Behavioral health is becoming integrated with physical health service delivery. CMS recently agreed in principle to a Medicaid transformation demonstration waiver. These efforts are stretching the service delivery infrastructure for Medicaid; any shift in dental service delivery to an ASO structure should take into account these broader changes. Further transformation to a managed care structure must be examined carefully and any decision should be undertaken over a longer time frame with expressed intent to move in this direction.

Moving forward with an ASO model for the Apple Health dental program has the potential to serve two important purposes. First, HCA could leverage the resources and capacity of an outside organization to remove the administrative barriers that may be preventing dental providers from enrolling in the program. The HCA dental program is stretched beyond capacity; consequently many providers experience long phone wait times, difficulty registering as a Medicaid provider, an outdated benefits package, and frustrating preauthorization requirements. An ASO can offer proactive efforts to recruit, engage and support providers; outreach and support for patients; expeditious claims processing and prior authorization reviews; and benefit package recommendations and other services that ensure the best outcomes for the dollars invested.

Second, a competitive RFP process and subsequent partnership with an outside entity presents an opportunity to test innovative models in dental care delivery and integration. Once HCA is no longer responsible for claims processing and prior authorization, the agency will have increased capacity to utilize its strengths as a first mover and convener for dental care, in addition to overseeing contracts, incentivizing quality and monitoring performance. The RFP can include requirements to pilot programs on primary health integration, value-based purchasing and other

concepts that build on the forward momentum of Healthier Washington, such as testing strategies for bringing high risk populations (for example, patients with diabetes and pregnant women) into care.

> *Currently, there is not sufficient adult dental capacity to incorporate adult dental services into managed care plans. Further, Medicaid Plans are likely to need time to develop strategies and systems before they are prepared to incorporate oral health care into their services. I therefore propose that a target date of 2022 be established for the integration of Medicaid dental services with behavioral health and medical services through Medicaid managed care plans to permit time for the operational, quality improvement, and risk management challenges of this transformation to be studied, understood, and resolved. Pilot projects might be established prior to 2022 in selected counties or regions to gain experience with such fully integrated services before it is spread to the state as a whole.*
>
> *~ Executive Director, Unity Care Northwest, advocating for a long-term approach*

The ASO structure would provide benefits to Medicaid providers and clients, including communication and marketing efforts; more flexible prior approval and call center options for providers; use of more sophisticated technology to support administration (electronic file transfer, automated prior authorization etc.); better access to dental expertise; and better communication of prior authorization and benefit changes. HCA can impose service and performance-level guarantees on the contractor to expand the dental provider network over a phased period of time, increasing access to dental services for Apple Health adults. While an ASO service delivery structure may be beneficial for Washington's Medicaid population there are additional options to consider in improving access to benefits.

> *"It is really difficult to recruit dentists to move to rural areas. We should be exploring all kinds of options for increasing access to dental care, such as mobile dental programs, DHATs (dental health aide therapists), and student loan forgiveness based on the percentage of clients on Medicaid."*
>
> *~ Tribal government representative*

The child dental program, ABCD dental, should not be affected in any way. Feedback from some stakeholders identified an increase in provider rates as the most significant improvement to access. Stakeholders felt strongly that the dental benefit should not be reduced to fund an ASO contract.

> "*The sole reason there are so few professional participants is the low reimbursement rates. In other states (for example, Alabama) the dental Medicaid reimbursement rates are much closer to the dental insurance rates. Fees need to be increased to gain more participation."*
>
> *~ Thurston County provider*

The shift to an ASO structure for dental service can be implemented in 18 to 24 months following approval and funding by the Legislature and Governor. A high-level plan for implementation is included below. This plan must be refined at a detailed level if the new structure moves forward.

Characteristics of the ASO Structure

An ASO program structure can provide innovative service delivery models referenced in the proviso. Contract requirements will be monitored by HCA. Specific innovations and improvements are discussed below.

Engaging dental expertise in the administration of the program – The ASO will be required to have onsite dental expertise through employed dentists and hygienists. During procurement, HCA will require submittal of evidence that the ASO has worked with dental programs and tribal health programs previously, has sufficient dental experts on staff, and uses evidence-based policies and procedures in its operations.

Improving the provider and patient experience – HCA will set requirements in the ASO contract to ensure calls are answered within a reasonable time for both clients and providers, call center staff are trained in the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) and in the specific rules and requirements applicable to American Indians/Alaska Natives and Indian health care providers, prior authorization utilizes technology and processes to ensure reasonable response times, and prior authorization is limited to necessary services and is designed to ensure access to medically necessary treatment. The ASO would benefit Washington State to the extent a significantly expanded network of providers could be formed to serve Medicaid clients.

Benefit package is aligned with evidence-based care – HCA is committed to a standard of measurable, high-quality, evidence-based care. HCA will put requirements for continual improvement in the quality of care, efficiency of administration, and client access to services. Requirements must be based on evidence and promising practices, including evidence from rural and underserved populations where appropriate. HCA will continually collaborate with the ASO to improve the use of evidence-based care and promising practices where appropriate (including trauma-informed and culturally competent care) in the Medicaid dental program.

Taking steps to broaden the dental network of providers – As part of the ASO implementation, HCA will examine innovative provider support mechanisms to expand the provider network. Suggestions include new payment mechanisms such as including bonus payments for providers serving Medicaid patients, educational debt repayment, and quality enhancement programs. Support programs should include risk reduction related to audit activities, thorough education and support to improve provider performance, educational opportunities for providers new to Medicaid patients, and assistance with electronic health record implementation and HIPAA compliance. HCA will work with the ASO contractor to streamline prior authorization processes, better utilizing automated systems and technology and connecting prior authorization to quality treatment outcomes. HCA will contractually require the ASO to expand the service delivery network

on a specific timeframe, with measures included to ensure compliance. HCA will also contractually require the ASO to collaborate with FQHCs, Indian health care providers, and other providers focused on serving rural or underserved populations, in the development of programs and systems, including provider- and beneficiary-facing systems.

A shift to the ASO structure requires improvements to the administrative function before the new structure is activated. Research has shown that administrative improvements can significantly improve access, and fee increases without administrative improvements are less effective at producing change.

Administrative improvements should include:

- An assessment of the benefit package by dental experts and experts on working with populations with dental health disparities, including FQHCs and Indian health care providers, and a comparison with benefits offered to the Medicaid-insured in other states.
- Clear and consistent policies delineating the types and quantities of procedures that will remain subject to prior authorization. Increased clarity on the prior authorization policies, requirements and process would be helpful for providers.
- A streamlined and efficient system for submitting and reviewing prior authorization requests. This would remove a significant administrative barrier for dental providers, as well as mitigate delays in care for beneficiaries.
- Quick, expedient assistance with claims processing and questions raised by providers. This should include a fully staffed call center that uses state-of-the-art call center software solutions, with staff who are trained to respond to providers, including FQHC clinics and Indian health care providers, with accurate information.
- A third-party administrator can establish an innovation-friendly environment and bring the resources, experience and capacity to test new models to increase access to care and improve health outcomes, including value-based payments. There can be increased alignment with Healthier Washington goals and initiatives. For example, current efforts to engage primary care systems in oral health can be bolstered by an Apple Health dental program administrator that engages in targeted patient outreach through a partnership with a health system, an Accountable Community of Health (ACH), or an MCO. These efforts could focus on beneficiaries in particular need of dental care, such as people with diabetes or pregnant women, and beneficiary populations with disparities in access to dental care or dental health outcomes, which would drive improvements in oral and systemic health.

These improvements require an administrator that has technological capabilities, dental expertise and experience with dental claims processing, provider recruitment and relationship management, and providers serving populations with dental health disparities, including FQHCs and Indian health care providers. The successful ASO must have the ability to maintain robust beneficiary outreach and engagement, with expertise in culturally and linguistically appropriate services, in order to improve health literacy, access to care, and oral and overall health outcomes for enrollees.

It is vital to include key stakeholders from the dental community and tribal communities in the conversion. These stakeholders should advise on the conversion, as well as metrics to determine success, and provide feedback on implementation.

Furthermore, the administrator should have an understanding of and appreciation for the critical role that community health centers (CHCs) and the ABCD program play in providing access to care for the Medicaid-insured.

High-Level Plan to Implement the ASO Structure

A plan to implement the contract with an ASO for dental benefit administration is provided below. This high-level plan is only a first step; if the shift to contracting out dental benefit administration is mandated, a detailed work breakdown structure would need to be prepared. The total time necessary for implementation of the plan is likely to be 18-24 months due to the time required for procurement, system change requirements, and approval of a State Plan Amendment (SPA) by CMS. HCA will require adjustments to its operating budget, delaying implementation at least through the next Legislative session. HCA will also consult with tribes and solicit advice from Indian health care providers throughout planning and implementation. This information is provided in detail below, specifying costs incurred to shift to a new service delivery structure. While this overall plan is related to contracting out the administration of dental benefits, it could be adjusted to relate to placing the dental benefit into a managed care structure.

Table 3: Development Plan

Estimated number of months to execute step	Concurrent steps in plan to implement ASO structure
Detailed Planning and Building Support – **Total time: 1-2 months**	
1 month	Create and communicate an overall detailed plan to implement the ASO structure. Conduct discussions and tribal consultations, identify and communicate impacts to stakeholders, federal requirements, and steps to implement.
1 month	Develop process and outcome measures on the benefit of the ASO structure.
Labor and Staffing – **Total time: 4-5 months**	
3 months	Notify union and employees of contracting out activity, consistent with RCW 41.06.142. Notification must occur at least ninety days before contract starts.
1-2 months	Notify staff who may be impacted; conduct layoff process consistent with the collective bargaining agreement. HCA would take actions necessary to avoid staff layoffs to the extent possible.

Table 3: Development Plan (cont'd.)

Estimated number of months to execute step	Concurrent steps in plan to implement ASO structure
Procurement and Contract Development – **Total time: 11-14 months**	
1-3 months	Gather information and stakeholder and tribal input including ensuring dental expertise, performance metrics, data retention and payment structures, and provider and client communications.
3-4 months	Create procurement requirements and draft contract, including clinical, operations and process, and financial and system requirements.
2 months	Host pre-proposal conference, release procurement, answer bidder questions, and receive responses.
1.5 months	Evaluate proposals, announce apparently successful bidder, hold debrief conferences, and allow for protest period.
1.5 months	Negotiate and sign contract.
2 months	Implement new structure for ASO, including a monitoring plan for the contract, training and communication of providers, terminating existing contracts, training staff, and amending the ASO contract if necessary.
Information Systems Changes (Provider One) – **Total time: 9-12 months**	
1 -2 months	Identify ProviderOne system changes required, set release date, and program and test system changes.
1 month	Submit Change Request, and receive Firm Offer and Release Date from ProviderOne vendor.
6-9 months	ProviderOne enhancements, development, user acceptance testing and release.
2 months	Conduct ASO vendor testing and train providers, ASO vendor and staff on system changes.
ongoing	Implement and monitor system changes.
2 months	Create data receipt and storage protocols for ASO vendor.
Communication with Providers and Clients – **Total time: 6 months**	
2 months	Create communication plan for providers, clients, tribes, and stakeholders.
1 month	Review standard letters and other communication; update or change if necessary.
1 month	Develop scripts for call center staff, and update or change HCA website content, including FAQs for stakeholders.
2 months	Set up regular meetings with stakeholders, giving updates and status; include tribal organizations, advocates, ABCD providers and other provider organizations.
Legal Requirements – **Total time: 11-14 months**	
4-5 months	Prepare and submit State Plan Amendment, including tribal review.
5-6 months	Amend state rules.
2-3 months	Update provider guides and billing instructions, and communicate change to clients.

Table 3: Development Plan (cont'd.)

Estimated number of months to execute step	Concurrent steps in plan to implement ASO structure
Financial Structure Development – **Total time: 12-13 months**	
1 month	Create cost and payment model for ASO.
9 months	Set payment levels, request budget adjustment for administrative changes and services changes (includes time needed to move request through budget process). Cost estimates for development, implementation and operation of the ASO structure are below.
2 months	Identify billing and payment procedure for ASO.
1 month	Identify changes to Chart of Accounts, AFRS data, forecast process, and expenditure reporting.

Potential Risks

Significant risks and issues must be dealt with throughout implementation. The definition of a "risk" is an issue that may arise, reducing the likelihood of successful implementation of the new structure. The list below cites possible risks but these situations may not actually occur. The plan identifies risks so that HCA can reduce the chance of these situations occurring by taking actions to mitigate the risks. This list is not all-inclusive as more risks may arise as implementation occurs. A mitigation strategy for each risk has been identified. When a more detailed plan is developed, each risk must be handled through a more detailed mitigation plan to be executed by HCA.

- Resources to implement the new structure may be insufficient to effectively shift to an ASO model.
  - *Mitigation: Delay implementation or request resources.*
- Providers and other stakeholders may not be ready for the change involved in moving to a new structure.
  - *Mitigation: Frequent communication with stakeholders and use of change management expertise in development of the new structure.*
- The change may not address basic needs of the delivery system including rate levels, provider coverage in rural areas of the state or insufficient providers/clinics to meet the needs of Medicaid clients, including clients with disparities in access to care.
  - *Mitigation: Monitor implementation, request funding to address shortages.*
- Communication from HCA on the shift may not mitigate the fears and concerns of providers and clients, resulting in a continued lack of sufficient provider networks.
  - *Mitigation: Plan on communication levels and strategies to meet provider and client needs.*

- A new structure could adversely affect parts of the Medicaid dental benefit that are working well today, including the children's ABCD program and community clinics.
    - *Mitigation: Mandate adherence to ABCD and clinic requirements in ASO contracts; monitor compliance with contract and issues arising in ABCD or with clinics.*
- Shifting to an ASO structure as an interim step to moving the delivery system to managed care may cause inertia; once the first step is taken there may be resistance to another shift.
    - *Mitigation: Propose legislative intent in law to shift the Medicaid dental program to a managed care structure at a future, identified date.*
- Moving to an ASO model may impact existing staffing levels.
    - *Mitigation: Attempt to avoid staff layoffs to the extent possible and follow layoff process consistent with the collective bargaining agreement, if layoffs are required.*

Cost Projections for Plan Implementation and Program Operations

Expenditures on the Medicaid dental benefit total approximately $350 million per year. This amount has been increasing each year since 2011. During the last two years HCA has spent approximately $1.9 million each year to administer the dental program; this is 0.56% of the service's cost.

Current HCA administrative costs include prior authorization and clinical program management staff and contracts for clinical dental expertise for review and approval of prior authorization cases.

Costs for claims processing, phone center and HCA infrastructure support the entire Medicaid program. Dental services are a small portion of the entire Medicaid administrative cost. Workload reductions in these areas from contracting out dental administration will be minor, allowing HCA to improve efficiency in supporting Medicaid clients and providers, but the overall cost will not be reduced.

Additional costs to execute the plan include one-time costs and ongoing costs. Specific cost categories and estimated costs are listed below, offset by savings realized in implementing the plan. Implementation of the plan results in an overall cost increase to administer the dental services benefit.

One-time costs to implement the plan

Implementation of an ASO service delivery structure must include examination, redesign and development of a new dental benefit. Work must include a revamp of the dental benefit structure, administrative improvements in prior authorization requirements, and improved communication with providers and clients. These improvements will take time, resources and significant effort by HCA and the contractor but changes are necessary to expand access to Medicaid clients.

Estimated costs to support this effort are:

1. Project management and project staffing based on recent project costs ($200,000)
2. Change management and provider engagement, as estimated by HCA staff (2 FTEs, $180,000)
3. IT system change costs, detailed in Appendix E ($1,000,000-$1,250,000)
4. Legal support and development costs (contractual, federal authority, state rule and law, appeals and hearing structure development), to be absorbed by HCA

One-time costs would range from $1,380,000 to $1,630,000, occurring in the two years before the program change begins.

Ongoing costs necessary to operate the program

Costs for new contract

Costs to operate an ASO structure cannot be identified specifically until procurement is conducted and a contract negotiated. Estimates of the overall cost can be identified based on other state contracts and the cost of Washington's Public Employees Benefits Board (PEBB) self-insured dental plan administration contract.

- HCA pays approximately $1.92 (or 4.25%) per adult unit per month (PAUPM) for administration of the PEBB self-insured Uniform Dental Plan (does not include PEBB managed care dental plans). While the PEBB and Medicaid dental programs differ, the PEBB administrative costs serve as one example of the cost that could be incurred in an ASO service delivery structure.
- Information from another state indicates that when the Medicaid dental benefits program is operated under an ASO, administration costs total 2% of services. Using this benchmark, an estimate of Washington's administrative costs would be $6.9 million per year.
- Using these examples allows a range of costs to be estimated for a Medicaid ASO contract. The cost of an ASO may be lower than the estimates above due to administrative and benefit improvements made by the ASO. For a lower level estimate, a 2% administrative cost level would total approximately $6.9 million per year. For a higher level estimate, a 5% administrative cost level would be approximately $17.1 million per year.

To summarize, the cost of shifting to an ASO service delivery structure include both one-time and ongoing costs. Table 5 summarizes costs and potential savings at HCA for this shift.

Table 5: HCA Dental Costs: ASO Implementation and Operation – $ in millions

	State Funds	Federal Funds	Total Funds
One-time costs (total)	$0.72 to $0.85 million	$0.66 to $0.78 million	$1.38 to $1.63 million
ASO Administrative Fee (annual)	$3.6 to $8.9 million	$3.3 to $8.2 million	$6.9 to $17.1 million

If work necessary to implement the new structure began on July 1, 2017, the shift could be complete by July 2019. It is important to note that these amounts do not include increases in dental services rates, a significant issue raised by stakeholders on access to care. Any potential cost offsets that may occur through the shift to the ASO model are indeterminate.

HCA Administrative Cost Reductions

HCA administrative costs would be reduced by the expenditure for clinical review and approval of prior authorization cases. However, a portion of the 13 prior authorization FTEs will need to be retained by HCA and realigned for ongoing support of the dental program and clinical oversight, program compliance, fiscal monitoring, and contracting related to the ASO.

Appendix A: Cost and Utilization Overview

The data used in this report comes from the following sources:

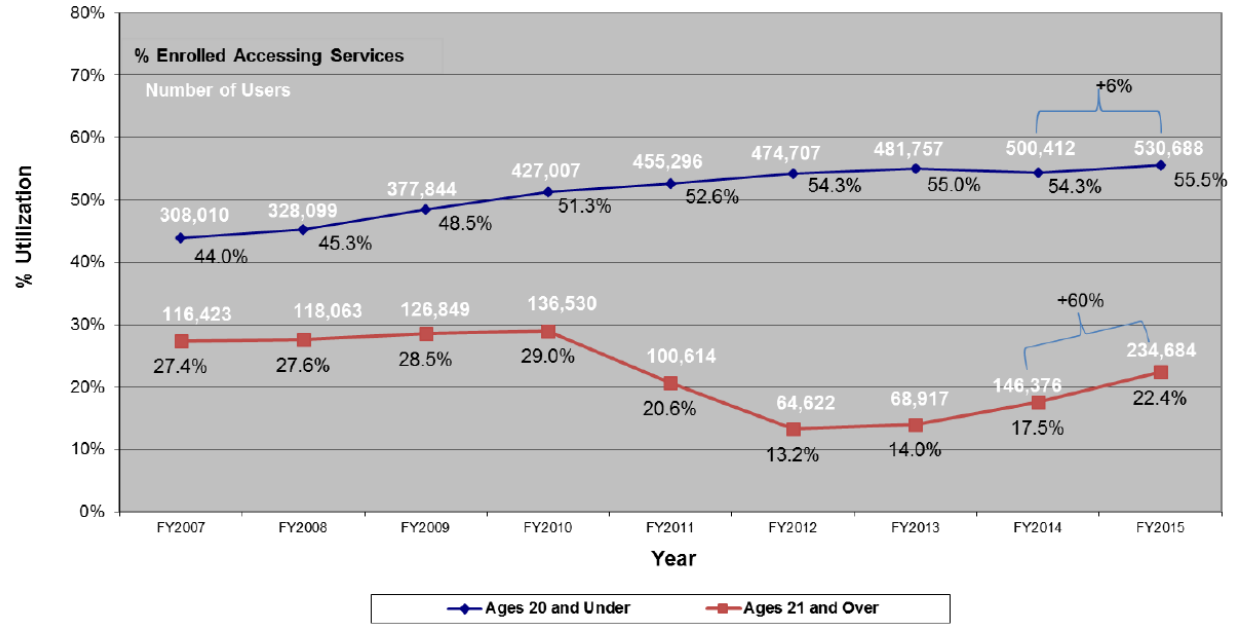
- Washington Dental Service Foundation report on Medicaid claims data,
- Apple Health Dental utilization rates by fiscal year and age, representing all counties, and
- FY 2013-15 data (includes services paid through mid-February 2016).

Table 6: Apple Health Dental Program: Expenditures by Year - Expenditures in millions

Calendar Years	General Fund State	General Fund Federal	Total Paid
2011	$102.7	$117.7	$220.3
2012	$114.2	$111.3	$225.5
2013	$122.9	$121.5	$244.4
2014	$129.1	$192.9	$322.1
2015	$128.8	$215.0	$343.8
2016 (YTD June)	$60.4	$114.0	$174.4

Dental (claim type 4) claims pulled 8/5/16; presented date range Jan 2011-Jun 2016. Encounter Differential includes both FQHC and Tribal payments. Adults defined as 21+. Professional claims includes dental procedures (D-Codes). 2016 figures run through June 2016 and have not been annualized; a lag factor has not been applied to these figures. Adult dental fully reinstated for all adults starting January 1, 2014.

Chart 1: Statewide Apple Health Dental Utilization - Children's and Adult Programs

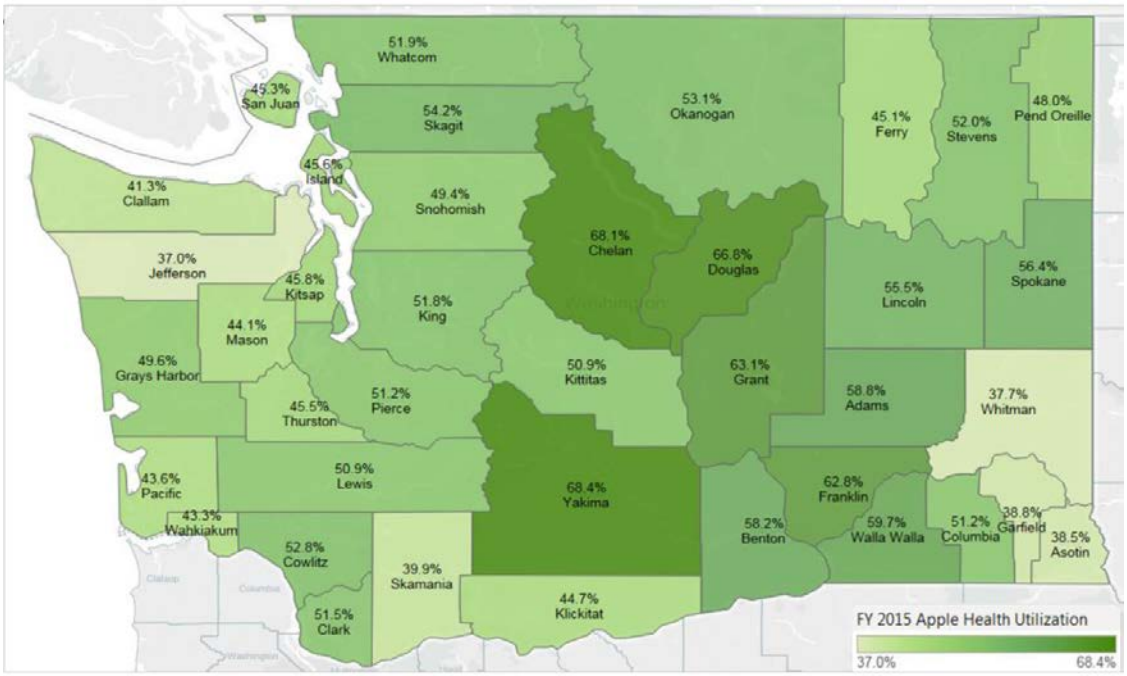


Data source: Washington Dental Service Foundation report on Medicaid claims data

Chart 2: Apple Health Service Category Expenditure Trends - Age 20 and under

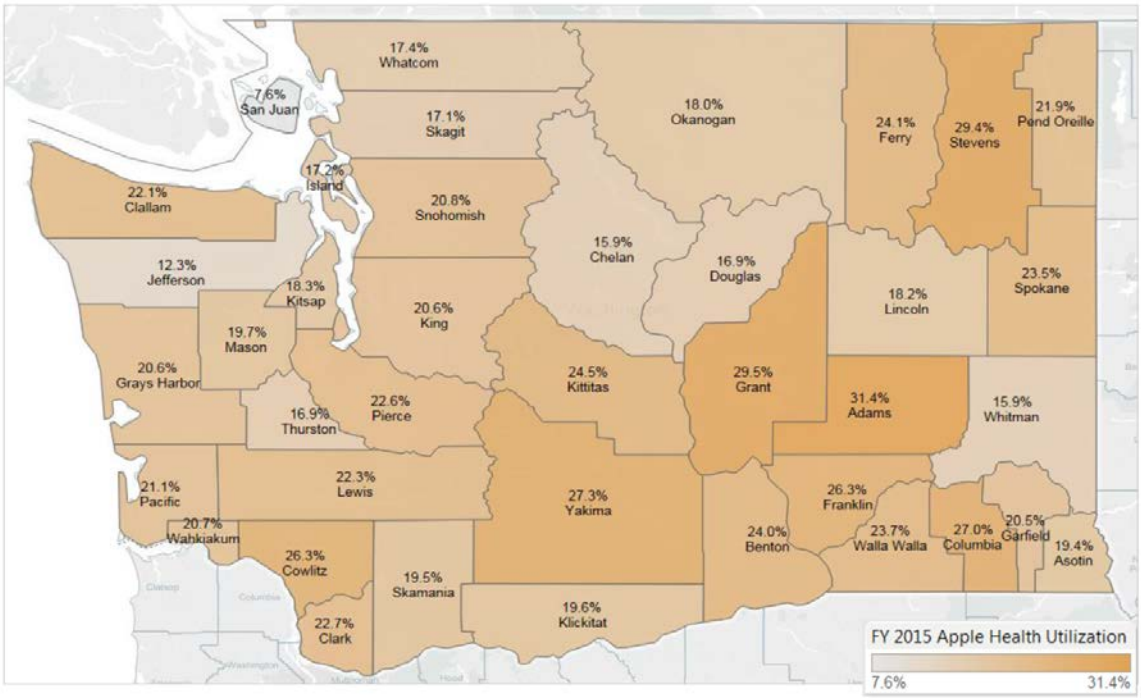
Percent of total age-group expenditures excluding procedure category "Other," which is mostly community health clinic (CHC) encounter payments.
Data source: Washington Dental Service Foundation report on Medicaid claims data.

Chart 3: FY 2015 Apple Health Dental Utilization by County - Children ages 20 and under



Statewide Utilization Total: 55.5%
Data source: Washington Dental Service Foundation report on Medicaid claims data.

Chart 4: FY 2015 Apple Health Dental Utilization by County - Adults Ages 21 and over



Statewide Utilization Total: 22.4%
Data source: Washington Dental Service Foundation report on Medicaid claims data

Appendix B: Program History

1999

Services were not as specifically defined as they are now, perhaps due to a limited Current Dental Terminology (CDT) code set. Service guidelines were more restrictive than today. For instance, dental providers could not request services for nursing home clients, the agency did not allow mass screenings in facilities (nursing homes), and routine fluoride and root planing were only covered for developmentally delayed (DD) clients. Prior authorization was required for replacement dentures, indirect crowns, and non-emergent hospital coverage for dental services.

2002

Guidelines become more descriptive, perhaps due to an expanded CDT code set. During this time the agency expanded coverage of fluoride to include adult clients with prior authorization, increased non-covered services, and removed prior authorization requirements for replacement dentures under specific clinical circumstances.

2003

Multiple changes in coverage parameters occurred, including prior authorization requirements for replacement dentures, greater separation between adult and pediatric benefits, and additional rules regarding services billed in conjunction with others.

2007

Several changes to program benefits and requirements were implemented. The agency increased rates for several services including ABCD, crowns for clients age 20 and younger, and orthodontic and endodontic therapy. Program changes included reinstatement of prior authorization requirements for some procedures. Certain benefits were added to the program early in the year and other benefits were removed from the program later in the year as budgetary pressures increased.

2010

Due to budget cuts, coverage of immediate dentures and cast metal partials were eliminated as covered services.

2011

In January, adult dental services were eliminated for all non-DD adults, with the exception of emergency services such as exams, palliative care and extractions. In July, comprehensive dental coverage was reinstated for pregnant clients, clients residing in a skilled nursing facility, or clients covered under a Community Options Program Entry System (COPES) waiver. In October, coverage was further reduced to cover only those DD adults who were pregnant, residing in a skilled nursing facility, or covered under the COPES waiver.

2014

Comprehensive dental services were reinstated for all adults in conjunction with Medicaid expansion under the Affordable Care Act (ACA). Under the act, the state of Washington enrolled 588,000 adults who were eligible for dental benefits under Medicaid.

Appendix C: External Stakeholders

Great effort was made to identify and capture stakeholder participation. As a result of extended stakeholder individual and group sharing, this list does not necessarily include names of all individuals who may have participated or made contributions during the stakeholder process. We acknowledge and appreciate the contributions of our many partners.

Stakeholder Name	Representing
1. ABCD Program	List serve for ABCD program partners, providers, champions, co-champions and coordinators
2. Adler, Peter	Molina HealthCare
3. Barrientos, Lawless	DentaQuest
4. Becker, Randi	Washington State Legislature
5. Benson, Tori	Washington State Legislature
6. Bogard-Johnson, Melissa	Willamette Dental
7. Bowes, Doug	United Healthcare of Washington
8. Bravo, Lilian	Washington Association of Community & Migrant Health Centers
9. Brinson, Ed	DDS, Bellingham Washington
10. Berglund, Karen	DDS, Retired
11. Caldier, Michelle	Washington State Legislature
12. Carlen, Diana	Gordon Thomas Honeywell Governmental Affairs, Lobbyist
13. Cebulla, Greg	DDS, Tokeland
14. Choi, Ji	DDS, Everett
15. Clifton, Jack	Stevenson Dental Care, ABCD Champion
16. Collette, James	Dentistry for Kids, Kennewick
17. Dansky, Tanya	Amerigroup of Washington
18. Edmonds, Daryl	Amerigroup of Washington
19. Eid, Hani	Happy Kids Dentistry
20. Evans, Jared	Kidds Dental, Liberty Lake
21. Fathi, Jay MD	President and CEO, Coordinated Care
22. Feingold, Glen	COO, MCNA Dental
23. Firth, Molly	Community Health Network of Washington
24. Gano, Kathy	MCNA Dental, Lobbyist
25. Gano, Steve	MCNA Dental, Lobbyist
26. Gil, Sylvia	Community Health Network of Washington
27. Gillis, Gretchen	Molina Healthcare
28. Gordin, Darin	Gordon & Associates, LLC
29. Hansen, Layne	SmilesSonrisa, Naches

Stakeholder Name	Representing
30. Hill, Sarah	DDS, MSD, Playhouse Dental Kids
31. Hsu, Ronald	Pediatric DDS, Vancouver
32. Hunke, Phil	President, MCNA Insurance Company
33. Johnson, Melissa	Bogard Johnson, Washington State Dental Hygienists' Association, and Alliance of Dental Hygiene Practitioners
34. Kaasa, Chris	Government Relations, Washington Association of Community & Migrant Health Centers
35. Kazim, Amir	DDS, Spokane
36. Killpack, Bracken	Washington State Dental Assoc.
37. Kirkpatrick, Steve	DDS, Olympia
38. Klee, Kristi	Medical/CSW Clinical Nurse Specialist, Seattle Children's
39. Knutson, David	DDS, Kent
40. Labberton, Wells Kurt	DDS, Yakima
41. Lacasa, Carlos	Senior Vice President & General Counsel, MCNA Dental Plans
42. Laroche, Kristin	Improving Oral Health
43. Late, Kat	Community Health Plan of Washington
44. Lawson, Kimberly	Director of Sales, Western Region, DentaQuest
45. Leggott, Penelope	DDS Kulshan Pediatric Dentistry , Mt. Vernon, Professor UW School of Dentistry
46. Lennox, Chad	Program Manager, Delta Dental
47. Leung, Hugh	DDS, Kent
48. Lewis, Amber	Lewis Consulting
49. Lovell, Emily	Washington State Dental Assoc.
50. Marsali, Bob	Washington Association of Community & Migrant Health Centers
51. McAleenan, Mellani	VP Government Affairs at Washington State Dental Assoc., Lobbyist
52. McGuire, Marilee	Community Health Plan of Washington
53. Merrill, Tom	Orthodontics DDS , East Wenatchee
54. Millwee, Billy	Millwee Consulting
55. Mondi, Alison	Delta Dental
56. Muck, Robin	Avesis, VP, Government Initiatives
57. Nunez, Christina	Kulshan Pediatric Dentistry Billing
58. Oakes, Diane	Washington Dental Service Foundation, President & CEO Delta Dental
59. O'Meara-Wyman, Kathy	Senior Program Officer, ABCD Program Managing Director, Delta Dental
60. Paris, Katy	United Healthcare of Washington

Stakeholder Name	Representing
61. Pickard, Sean	Government Relations, Delta Dental of Washington
62. Ravin, Jeron	Washington Association of Community & Migrant Health Centers
63. Robb, Deanna	Washington Association of Community & Migrant Health Centers
64. Rodriguez, Anita	Dental Hygienist, Bellingham
65. Rubenstein, Jeffrey	UW School of Dentistry, Professor and Director, Maxillofacial Prosthetic Service
66. Safford, Caitlin	Amerigroup Washington
67. Scheer, Melody	Executive Director, New Day Community Dental Clinic, Vancouver
68. Seib, Jonathan	Seib Policy & Public Affairs, Olympia
69. Serafin, Luanne	NW Justice Project
70. Sinnott, Matthew	Willamette Dental
71. Skubi, Des	Unity Care NW
72. St.Clair, Claudia	Molina Health Care
73. Stedman, Lynn	Director, Associate Professor, Columbia Basin College
74. Suchoski, Amina	United Healthcare of Washington
75. Swisher, Chris	Little Shredders Dental, Hood River, ABCD Champion
76. Tellefson, Carrie	Attorney, Government Affairs, Miller, Malone & Tellefson, Rep. WSDA
77. Thatcher, Lisa	DentaQuest
78. Turner, Shannon	JD, VP Operations, MCNA Insurance
79. Tull, Andrea	Coordinated Care
80. Vander Beek, Sarah	Neighbor Care
81. Varon, Janet	NW Health Law Advocates
82. Velis, Nick	DDS, Velis Family Dental, Spokane
83. Vesowate, Joe	DentaQuest
84. Walsh, Michael	WA State Dental Assoc.
85. Werner, Michael	South Sound Oral Surgery, PLLC
86. Williams, Paula	Operation Healthy Family
87. Wilson, Joe	DMD, Yakima Valley Farm Workers Clinic

Appendix D: Stakeholder and Tribal Input

1.

Who	Representing
James Collette, DDS	Dentistry for Kids, Kennewick, Washington
Type of Stakeholder	**Preferred Option**
Provider	ASO
Input	
Accepting of ASO, but wants the contract to have requirements that support both providers and clients.	

2.

Who	Representing
Melissa Bogard-Johnson	Alliance of Dental Hygiene Practitioners
Type of Stakeholder	**Preferred Option**
Provider Group	MCO
Input	
Believes the restructuring of Medicaid dental by a one-payer MCO, without multiple insurance carriers, to be best option. Multiple insurance vendors would only add to the burden of processing for reimbursement. Please continue dialogue with stakeholder providers and interested parties.	

3.

Who	Representing
Jeron Ravin & Bob Marsalli	Washington Association of Community & Migrant Health Centers
Type of Stakeholder	**Preferred Option**
Advocate	Other (no change)
Input	
Advocates no change; do not favor ASO or MCO approaches.	

4.

Who	Representing
David Hamilton, DDS	Dentistry for Kids, Kennewick
Type of Stakeholder	**Preferred Option**
Provider	ASO
Input	
Accepting of ASO, but wants the contract to have requirements that support both providers and clients. Increasing dental provider participation requires efforts to increase funding so they could support an increase in dental procedure fees. In other states this was done two ways: 1. Through an across-the-board increase in fees, or 2. A bonus for providers that see more patients. Confident that you will find these two issues at the top of the list for many of them.	

Would love to be considered a member of the team when it comes to providing these services as a state, and to be given the full support and protection of our state in carrying out these services in the form of:

1. Educational audits and certifications of compliance that assure state support in case of a federal audit.
2. Advice, support and credits for administering an effective compliance plan that effectively combats waste, abuse and fraud.
3. Credits or discounts to offset the increase cost of supplies and payroll that are associated with seeing DSHS patients.
4. Programs that defray the cost of maintaining and protecting large databases of patient records in accordance with HIPAA standards (this cost is increased by the increased number of patients it is necessary to see per unit time).
5. Help in paying off large student debts like those received by Federally funded clinics for providers that are seeing greater than 30-50% Medicaid in their clinic (we see 60%).
6. Programs that reward or at least recognize the quality of care and quality of the experience in accessing care as measured by end users of the benefit.
7. Programs that reward preventive services.

5.

Who	Representing
Chris Swisher, DDS	Little Shredders, Pediatric Dentistry, Hood River, Oregon
Type of Stakeholder	**Preferred Option**
Provider	ABCD Champions
Input	
Believes if WA is looking to establish something along the lines of CCO delivery system in OR, or move towards a capitation system, it would be disastrous to access to care, patient care, and likely end involvement of smaller private practices treating Medicaid patients. Does not advocate managed care system that is capitation-based only; delivery of care would become a huge issue (i.e. OR CCO delivery system);. The best we can hope for is an increase in reimbursement for providers and a single payer system.	

6.

Who	Representing
Diane Oakes	WA Dental Service Foundation
Type of Stakeholder	**Preferred Option**
Provider Group	ASO
Input	
Recommends: 1. ASO structure with non-profit firm that has prior dental experience in Washington. 2. Working on improvements to administrative processes before finalizing ASO contract. 3. Retaining ABCD program, recognizing the value of community health clinics, and emphasizing the value of technological tools at the contractor level.	

7.

Who	Representing
Laura Platero Vicki Lowe	Northwest Portland Area Indian Health Board American Indian Health Commission for Washington State
Type of Stakeholder	**Preferred Option**
Tribal Organization	Neither
Input	

Recommends:

1. HCA will include tribal consultation at every step in the planning and implementation of these changes and after implementation with quarterly reports.

Tribes were consulted very late in the process, and we request that through the remainder of the plan to remodel the Medicaid dental program that tribal consultation be a necessary step all through the process. Tribal communities in Washington are very invested in the oral health of our community members and are in the best position to advise on how proposed changes will impact our communities.

We call on the state to respect its government-to-government relationships with tribes, even when working with non-governmental entities, as required by RCW 43.376.020 and Section 1902(a)(73) of the Social Security Act. Long-standing relationships and partnerships between tribal governments and state governmental entities like HCA help facilitate the government-to-government consultation when major changes are made to programs that will impact tribal communities. Non-governmental organizations don't have that experience or understanding of tribal consultation, as reflected in the late inclusion of the tribes in this stakeholdering process which appears to have been largely coordinated by non-governmental entities. Moreover, the obligation is on the state – not on non-governmental organizations – to consult with tribes.

In many rural communities around the state, Tribes are often the only Medicaid provider for dental services. As noted by the report, the purpose of the plan is to increase access to care, improve provider and patient experience using evidence-based care to improve the benefits package and incorporate the testing of more innovative delivery models. In addition, there are many different policy proposals included in this report. Many of these proposals would be outside of the scope of an ASO and would require the legislature and HCA to actively engage in oral health delivery system reform or a shift to MCOs to manage that delivery system reform with concrete requirements and responsibilities set out by HCA. Such options offer much opportunity to improve care in some areas. Without tribal consultation, however, these options also run the risk of creating barriers to care for all clients of tribal dental providers.

After implementation of any of the options in the report, HCA needs to require quarterly reports from the ASO or MCO with disaggregated data on rural and racial/ethnic minority populations to enable sufficient oversight on the effectiveness of the ASO or MCO program for these populations with historic disparities in access to care and in health outcomes. For American Indian/Alaska Native patients, HCA needs to share this data with tribes and Indian health care providers and consult with them on a quarterly basis to review the data and consider program adjustments to improve access to care and quality of care.

2. To improve access to care, HCA will partner with tribal communities as much as HCA partners with dental community and dental societies.

Tribal governments have the responsibility to provide for the health and wellbeing of their communities. Tribal health centers are also often the only Medicaid provider for dental services in rural communities. A community's ability to develop public health policy solutions tailored for its needs and priorities is an essential part of achieving health equity. Policies to address health disparities are more likely to succeed when they come from and are supported by the communities they are meant to serve. In addition, policies that are built on authentic community engagement and tailored for community circumstances not only support innovative policymaking but also lead to laws that carry legitimacy and are sustainable over time. To more successfully address dental health disparities in Washington, HCA needs to partner with tribes and the Indian dental provider community as well as the dental community and dental societies.

3. While low provider reimbursement rates are one barrier to provider participation in Medicaid, other barriers include geographic isolation and lack of culturally competent dental services. HCA will provide analysis of these different barriers – not just low provider reimbursement rates – and the anticipated impact of measures to reduce these different barriers before making any recommendations.

We agree that streamlined administrative processes will make it easier for providers to participate in Medicaid and would encourage some providers to accept Medicaid. We also agree that increasing Medicaid rates paid to dentists would be a benefit to dentists and could encourage some providers to accept Medicaid. However, we do not see data in this report to support the conclusion that higher Medicaid rates paid to dentists will expand the network to make dental care more accessible to many communities, particularly tribal and rural communities. In other states, a modest increase in Medicaid rates has not been shown to increase the number of providers, even as it may make it easier for current Medicaid providers to accept more patients. There are many barriers to dental care, and we believe that many policy changes should be explored. Before jumping to a costly intervention like increasing provider reimbursement rates, we ask specifically for evidence that improving provider reimbursement rates will improve access for rural and currently underserved populations, including American Indian/Alaska Native populations.

Moreover, low reimbursement rates, while a barrier to participation for providers, are not the sole reason for low provider participation in Medicaid. The report repeatedly calls out low reimbursement while ignoring other factors like geographic isolation, stigma, racism, and lack of cultural competence. To truly improve the provider and client experience, we must implement changes that can and will address some of these other issues.

Indian health programs are often the only Medicaid provider for dental services in rural areas. Tribal health programs provide savings to the state when they provide care coordination for referrals out to specialty care for Medicaid enrollees. Targeted increased reimbursement for specialty providers in rural areas could increase access for tribal members through care coordination agreements. The 100% FMAP provides a savings to the state but supports better reimbursement for specialty providers. Indian health programs operate on thin margins and cannot accept any reduction in their applicable reimbursement rates, which would have a direct negative impact on access to dental care for Medicaid clients in rural communities.

4. HCA's contracts with an ASO or MCO will include requirements to collaborate with tribes and Indian health care providers in the development of programs and systems, to report disaggregated data on access and quality of dental services to rural and underserved populations and to train call center and other customer service providers on the legal and system requirements applicable to American Indians/Alaska Natives.

The most pressing concern for tribal communities is the impact any of the contemplated options will have on our clients. Option 1, the shift to the ASO, on the surface appears to have the least impact on clients. The biggest changes would be felt by the dental staff and HCA. However, as the HCA anticipates that the ASO would provide expertise on benefit design, service delivery, evidence based dental practices, and communication with clients, we believe strongly that HCA must set concrete requirements and responsibilities in its contracts with an ASO or MCO for ASO/MCO collaboration with tribes, reporting of disaggregated data, and effective and ongoing training for call center and other customer service providers on the legal and system requirements applicable to American Indians/Alaska Natives. Without these requirements in the contracts with an ASO or MCO, the state will repeat the mistakes and failures of the Regional Support Networks, Managed Care Organizations, and the Healthplanfinder. For example, the early experience of the Healthplanfinder call center highlights the need for expertise in non-traditional populations (populations with exceptions) to ensure that tribal members receive accurate and timely customer service.

5. HCA will consult with tribes on access to specialty dental care if the state pursues managed care for the dental program.

We understand from the report that HCA is not advocating for an immediate shift to managed care. The major concerns we have with the managed care options are around specialty care. As mentioned in the report, American Indians/Alaska Natives have an elective statutory exemption from managed care; however, we are still concerned about the availability of specialty care for clients who are not in managed care. If the state pursues managed care for dental services, we will seek consultation with HCA on strategies to ensure that American Indians/Alaska Natives have to access to specialty care.

6. HCA will recommend exploration of workforce solutions such as Dental Health Aide Therapists alongside calls for higher reimbursement.

We were disappointed to see that the summary of research doesn't include workforce solutions. We do not disagree with any of the findings of the research related to increased reimbursement and simplified administrative processes. We also agree that ABCD has been an effective policy for children. However, we disagree with the concept that increased reimbursement and education is enough to turn the tide on the oral health crisis facing tribal communities and other underserved communities in Washington. Clients and patients don't lack information; they lack access to services. Those gaps in access can only be plugged by innovative, community-led solutions. There is a large body of evidence that points to the critical role of mid-level dental providers, like Dental Health Aide Therapists (commonly called Dental Therapists), expanded function hygienists, and expanded function dental assistants, with or without the direct supervision of a dentist. There are simply not enough dentists, particularly in rural areas, to meet the needs of the population, and we strongly encourage HCA to fairly present the case for exploration of workforce solutions.

7. HCA will require ASOs/MCOs to develop expertise in Indian health care delivery systems.

This report details that contract requirements would be monitored by HCA and outlines specific innovations and improvements. We agree that engaging dental expertise in the administration of the program is essential. We would amend that to include expertise in the Indian health care delivery system. We ask that HCA require any ASO or MCO to submit evidence that it has worked with Indian health care and dental care programs and that it has sufficient expertise on staff to address the unique needs of tribal communities and American Indians/Alaska Natives when setting policies and procedures for its operations.

8. HCA will require ASO/MCO collaboration with Indian health care providers when they create provider- and patient-facing systems.

Improving the provider and patient experience will require specific training for the special requirements and circumstances applicable to American Indians/Alaska Natives. We ask that HCA require an ASO or MCO to engage and collaborate with tribes and Indian health care providers when creating client and patient facing systems so that American Indians/Alaska Natives have access to customer service representatives who can help them. Familiarity and positive relationships between the ASO/MCO and tribal communities are necessary conditions for the success of any change to the Medicaid dental care delivery system.

9. HCA will accept GPRA measure reporting from Indian health care providers.

We are concerned about the potential burden of provider quality reporting. Indian health care providers already have requirements to report to the federal government under the Government Performance and Results Act of 1993 (GPRA). We recommend that HCA accept GPRA measures in lieu of comparable provider reported measures where applicable.

10. HCA will require "evidence-based interventions" to be based on evidence for underserved populations, including rural and American Indian/Alaska Native populations.

In regards to the benefits package being aligned with evidence-based care, we ask that HCA require disaggregation of data based on race and ethnicity to ensure that evidence-based interventions can be targeted to specific populations. Too many evidence-based interventions have been developed without taking into account the needs of underserved populations, including American Indians/Alaska Natives. Adoption of these evidence-based practices without cultural competence or an understanding of their limitations can lead to real harm to underserved populations. "Practice based evidence" is often a better fit for tribes due to a lack of "evidence-based" solutions aimed at American Indian/Alaska Native populations. This is why consultation with Indian health care providers is so vital to any transformation of the health system. If the benefits packages are going to be amended and service delivery altered, we expect that HCA will require the ASOs/MCOs to apply evidence-based interventions based on evidence for specific populations and to report data to HCA to enable monitoring of effectiveness for specific sub-populations as well as for the population as a whole.

Appendix E: Dental MCO or ASO – Information System Impact Analysis

Current Payment System

Dental service claims are processed and paid through Washington's certified Medicaid Management Information System (MMIS) called ProviderOne. Medicaid eligibility for dental programs and services is housed in ProviderOne. Dental service providers are processed through Medicaid enrollment/screening processes and approved providers are maintained in the ProviderOne Provider subsystem. Dental benefits are defined, prior authorizations are processed, and dental claims are received and adjudicated through ProviderOne. Paid/denied dental claims are available for reporting through the ProviderOne Operational Data Store.

Dental Model Technical/Payment System Impacts

System impacts are evaluated below for the ASO service model. System impacts are based on high level dental model assumptions and are dependent on future detailed design requirements.

Dental Administrative Services Organization (ASO) or TPA: Under this model, the ASO administers services on behalf of HCA including claims processing, development of provider networks, and prior authorization functions. An ASO performs these functions for an administrative fee, and HCA pays for dental services provided. There are two high-level payment approaches to implementation of this model; these are noted below.

NOTE: ProviderOne currently processes dental claims according to multiple edits and audits that compare dental claims to claims in history. This allows the system to enforce limits on certain codes. The pricing estimates below assume that no data conversion would be done, making it impossible for a dental ASO system to process claims in accordance with current limit edits/audits.

Dental ASO Model System Impacts

The following impacts are noted for Dental ASO and for ProviderOne. It is assumed that the ASO system requirements would be included in the contracting process.

1. **Dental ASO Responsibilities:** The Dental ASO would be required to implement and maintain a Medicaid client eligibility interface, develop a data exchange function for dental providers, maintain a HIPAA-compliant payment system that accepts and processes dental claims, and develop dental payment processing functions for one of the following options:
    a. Payment processing Option 1: The Dental ASO would be responsible to adjudicate all dental claims to final disposition (pay or deny). Design and implement a daily interface to/from ProviderOne for ProviderOne payment processing to the State's Agency Financial Reporting System (AFRS).
    b. Payment processing Option 2: The Dental ASO would be responsible to adjudicate all dental claims to final disposition (pay or deny) and process payments. The Dental ASO would develop an interface file to AFRS summarizing dental provider payments; a batch file would be sent to HCA for transfer of dollars to the ASO and data transfer to ProviderOne Operational Data Store.

2. **ProviderOne Impacts:** Estimate $1 to $1.25 million to include the ProviderOne enhancements listed below:

   a. Development and maintenance of a near real-time eligibility interface with dental ASO to support timely transmission of Medicaid eligibility data.

   b. Development of an interface for exchange of dental provider information with MCO.

   c. Payment processing Option #1 above: Develop and maintain interface to/from ProviderOne to transfer adjudicated dental claims to ProviderOne for payment.

   d. Payment processing Option #2 above: Develop process for ASO to make payments and interface dental claims back to ProviderOne to be included in Data Warehouse and reporting processes.