

Delivery System for Oral Health

Health Care Administration
February 2015

For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 64984
St. Paul, MN 55164-0984
(651) 431-2202



Minnesota Department of **Human Services**

Legislative Report

This information is available in accessible formats to individuals with disabilities by calling Health Care Administration, 651-431-2202

Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$5,000.

Printed with a minimum of 10 percent post-consumer material. Please recycle.



Table of Contents

I. Executive summary 4

II. Legislation..... 5

III. Introduction 6

IV. Base Rate Change 8

V. Administrative Simplification 9

VI. Critical Access Dental Program (CAD) 11

VII. Conclusion 14

I. Executive summary

Under the Laws of Minnesota 2014, Chapter 312, article 24, section 47, the Department was required to consult with stakeholders and provide recommendations to the legislature on a new delivery system for oral health and dental services. This report lays out the recommendations resulting from the most recent stakeholder engagement and also previous studies and reports that have examined dental services in the Medical Assistance (MA) and Minnesota Care programs, collectively referred to as the Minnesota Health Care Programs (MHCP).

The three fundamental areas that must be addressed are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary to increase access to dental services, helps ensure the services they provide are of good quality and are fairly compensated.

II. Legislation

Laws of Minnesota 2014, Chapter 312, article 24, section 47:

(a) The commissioner of human services, in consultation with the commissioner of health, shall convene a work group to develop a new delivery and reimbursement system for oral health and dental services that are provided to enrollees of the state public health care programs. The new system must ensure cost-effective delivery and an increase in access to services.

(b) The commissioner shall consult with dental providers enrolled in the state public health programs, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving critical access dental payments; private practicing dentists; nonprofit community clinics; managed care and county-based purchasing plans; and health plan companies that provide either directly or through contracts with providers dental services to enrollees of state public health care programs.

(c) The commissioner shall submit a report containing the proposed delivery and reimbursement system, including draft legislation to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by January 15, 2015.

III. Introduction

Minnesota's Medical Assistance program continues to rank extremely low compared to other states on important measures of access to dental services. For example, for several years Minnesota has ranked amongst the lowest group of states in percentage of children receiving a preventive dental service in a year. Over the past few years, several reports, including one specific to MHCP dental rates published by the Office of the Legislative Auditor (OLA) and another more comprehensive study presented to the legislature by the Department last year, have identified a variety of contributing factors that have both hindered access to and have limited the quality of dental services provided to MHCP enrollees. The major contributing factors identified in those previous studies have been confirmed again during recent discussions with stakeholders. The three factors most consistently identified are:

1. The base rates for dental services are too low. The rates are, in large part calculated from a set of base charges that are now more than 20 years old.
2. The administration of the dental program for MHCP is distributed among too many entities, which requires dental providers, most of which are small businesses, to navigate anywhere from three to nine different sets of administrative requirements.
3. The Critical Access Dental (CAD) program is a payment program that has not resulted in increased access. Instead, it creates a disincentive for private practice dentists to participate as public program providers. Furthermore, the CAD program makes payments based on volume without regard for quality or outcomes.

The Department, as part of the previous study provided to the legislature in 2014, interviewed over 75 stakeholders. The 2014 study conducted by the Department is included for your reference. In developing this report, the Department hosted a meeting with all interested stakeholders and the Department of Health to review and discuss the findings and recommendations laid out in the 2014 study. Several stakeholders also met individually with the Department to discuss issues further.

The Department was required to convene a workgroup for this report; however, a stakeholder workgroup was formed by Senator Rosen which took on the work of discussing these issues. As a result, a separate workgroup formed by the Department was not necessary. Through the course of Senator Rosen's workgroup meetings, a fourth item was discussed in addition to the three items noted above. The workgroup discussed whether a value-based payment system could be created to replace the current payment method that pays dental providers by individual service. Similar concepts had been brought up by one or two stakeholders during the Department's 2014 study, but were not identified by a majority of the dental industry as a major barrier to improving access and quality of care across MHCP. Although Senator Rosen's workgroup is continuing to meet, the three main drivers, low base rates, administrative burden, and CAD, remain the primary focus of the workgroup.

Delivery System for Oral Health

Considering all past reports and workgroup input, the Department puts forward the following recommendations which address the three main barriers to dental provider participation that have been consistently identified by stakeholders. Where consensus is lacking amongst the stakeholders for all or a portion of the Department's recommendation, that lack of consensus is noted. The recommendations for each of the three issues are outlined in detail below.

IV. Base Rate Change

The base rate for dental services should be increased. Raising the base rate is consistent with the recommendations in the OLA report and the 2014 DHS study. There is consensus on increasing the base rates; however, there is not full consensus regarding the amount of the increase. Dental providers have suggested an increase that would double the current base rates. The Department favors a more moderate increase of 15% above the current base rate. The 15% increase should be sufficient particularly if coupled with administrative simplification, since reducing the administrative burden will save money for providers, effectively translating into an additional rate increase. In addition, the base rate year should be updated to 2013, which means that rates would be updated to reflect the percentage of 2013 charges necessary to achieve the desired amount of the base rate increase. Updating the base rate year will better align payments with more current provider costs and will make the rate methodology more transparent and easier to understand for both new and existing dental providers.

V. Administrative Simplification

The administrative burden on dental providers needs to be reduced. Reducing the administrative burden resulting from multiple health plans and dental administrators has been noted by several providers to be of equal or even greater importance to those dental providers than the rates, particularly for smaller rural practices. Unlike medical providers, most of whom are affiliated with larger health systems; most dental practices do not have the administrative infrastructure and economies of scale to support multiple administrative rules, requirements, and systems. As a result, the current distributed model for administration translates to significant administrative costs for dental providers. Medicaid staff in other states have indicated that without making it easy for dental providers to do business with the Medicaid program, dental providers will not enroll as participating providers and will continue to refuse to treat Medicaid patients.

There is consensus on the need to ease the administrative burden for dental providers; however, there remains a good deal of debate amongst the stakeholders as to how to best alleviate the administrative burden. The Department, the majority of private practice dental providers and some non-profit providers favor a single administrator model. Under such a model, a single entity is contracted to administer the dental benefit for the entire MHCP population, including fee-for-service and managed care enrollees. The single administrator recruits and enrolls dental providers, pays claims, authorizes services, coordinates with health care services, tracks utilization of dental services, and monitors quality and outcomes. For dental providers, the result is one set of rules which apply to all MHCP enrollees and one method to receive the information necessary to do business, such as patient eligibility, coverage of services, and utilization limitations. As a result of a single point of contact for administrative activity, dental providers could expect to see a reduction in the administrative activities and costs related to MHCP enrollee care. The benefit to enrollees is having one contact for assistance to arrange for dental care and experiencing seamless dental benefits that follow them. Medicaid programs in several states have demonstrated that the single administrator model coupled with fair rates paid to providers is a successful strategy in improving access and health outcomes.

Not all stakeholders prefer the single administrator model. The managed care organizations and their contracted dental administrators along with some of the non-profit providers and many of the safety net dental providers favor an alternative strategy. The proposed alternative strategy consists of ongoing collaboration to reach mutual agreement on how to address the issues that have been raised by providers frustrated by the administrative burden. The Department is willing to work with stakeholders on exploring the viability of a uniform collaborative approach. However, in the absence of specific regulatory requirements the monitoring and enforcement around compliance will be extremely challenging and may not adequately address the concerns of providers.

Delivery System for Oral Health

The Department's conclusions from the 2014 study indicate that based on the success achieved in other states, a single administrator model is the option best positioned to accomplish the goal of administrative simplification. Given the lack of consensus among stakeholders on this particular issue, further discussion and ongoing review of any concrete solutions may be warranted.

VI. Critical Access Dental Program (CAD)

The CAD program needs to be restructured to better align the proportion of the total amount of payment that represents an add-on payment. The current 35% add-on payment is arguably an indicator that the base rate payment is too low. Moreover, if the base rate increases without any corresponding adjustments to the CAD payments, the dollar value of the gap between payment to private, non-CAD dental clinics and CAD clinics grows larger. The significant disparity in payment between CAD and non-CAD providers providing the same services has been identified as an issue that discourages private dentist participation. A realignment of CAD payments should be done in a manner that holds harmless the current CAD providers, but allows the payment gap between CAD and non-CAD to decrease.

In order to hold CAD providers harmless, providers that are both CAD designated and designated community clinics (CC) must be handled differently than CAD designated providers that are not community clinics. Under the current structure, a CAD provider that is also a community dental clinic receives the base rate plus 20% of the base rate as an add-on for being a community clinic and then 35% is added on to that total for CAD payment. The effect is a greater than 35% increase because the CAD add-on payment is also being applied to the CC add-on.

The following describes how the base rate increase and the CAD add-on would be adjusted together for each type of clinic:

- **For non-community clinic CAD providers**, the base rate increase can be made with a proportionate reduction in CAD payments. Therefore, with the 15% increase in base rate the department supports, the CAD rate for non-community clinic CAD providers would be adjusted to 20%. The result is no reduction in overall payment to those non-community clinic CAD providers.
- **For community clinic CAD providers**, the payment structure should ensure that CAD payments take into consideration the effect of the CC add-on and ensure that the combination of the CC and CAD payments no longer cumulatively inflate the total payment. To accomplish this goal, the base rate of 15% should be combined with the 17.4% CAD rate to account for the cumulative effect that results from the 20% community clinic add on. This would ensure no reduction in overall payments to these providers.

Current State

Dental Provider	Current CC add-on	Current CAD add-on	Total Value of add-on payments
Community Clinic CAD	20%	35%	62%
Non-Community Clinic CAD	0%	35%	35%

Proposed Future State

Dental Provider	Base Rate Increase	CC add-on	Proposed CAD add-on	Total value vs. current payment structure
Community Clinic CAD	15%	20%	17.4%	No change
Non-Community Clinic CAD	15%	0%	20%	No change
Non-CAD dental clinic	15%	0%	0%	15% increase

The OLA report was critical of the multiple payments made to dental providers under the current payment structure, and dental providers have stated that it is difficult for them to track these multiple payments and reconcile them to determine whether they were appropriately paid for a specific patient visit. Furthermore, the CAD payments for services provided to managed care enrollees are calculated quarterly and are paid by DHS through the MCOs. As a result, the CAD add-on payments are delayed by at least 2-3 months from when the service was delivered. Eliminating the CAD add-on payments is probably not feasible in the near term unless and until sufficient dental providers are participating and access is improved. Nonetheless, re-setting the proportionality is at least a step in the right direction toward reducing dental providers' reliance on the separate add-on payments.

Delivery System for Oral Health

The current CAD program has also been criticized as a payment for volume of services provided rather than payment for quality and outcomes. Another frequent criticism is that the criteria for designation are primarily based on non-profit status, affiliation with educational institutions, or ownership by a government entity. Recent provisions now allow private dental clinics to receive CAD payments, but many additional enrollment requirements apply: the private clinics must be located in a dental Health Provider Shortage Area (HPSA); at least 50% of their patients must be public program or uninsured; and they must not place a cap on the volume of MHCP patients they will see. In contrast, many of the non-profit CAD clinics are able to cap their MHCP patient volume to 10% of their total patient population. The CAD program criteria should be modified so that all or a significant portion of the payments are based on outcome measures that promote quality, efficiency, and improved oral health status for patients. Additionally, requirements should be similar for non-profit and private dental providers so that high performing providers are incented to participate in MHCP, regardless of their business model.

VII. Conclusion

Improvement in dental outcomes for MHCP enrollees cannot be accomplished without significant and fundamental changes to the current dental program. Although the stakeholder workgroup has more recently discussed possible large scale payment reforms, the dental provider community generally favors and has built their business models to accommodate payments made based on the services rendered to each patient. The Department welcomes the opportunity to continue discussions about longer-term reforms and how to move the dental community toward more innovative payment models. However, new large-scale innovations and reforms require ample time to adequately develop, test, and expand. In the interim, Minnesota should not wait for those larger plans to evolve - the need is immediate and steps must be taken now. The number of enrollees who want to access dental services is far greater than the currently enrolled providers can serve, particularly in rural Minnesota where dental providers are already scarce. In order to increase access, more private dentists must be willing to provide services to MHCP enrollees. The three fundamental areas that must be addressed immediately are the base rate payments, administrative burden, and critical access dental payments. Addressing these three areas provides the environment necessary for the number of enrolled dental providers to grow, and helps ensure the services they provide are of good quality and are fairly compensated.