

Report to the Office of the Legislative Fiscal Analyst

Access to Care for Medicaid Managed Care Dental Clients

Prepared by the Division of Medicaid and Health Financing

October 1, 2017



EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in SB 2 by the 2017 Legislature:

“The Legislature intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by October 1, 2017 on access to care for Medicaid clients served under dental managed care contracts. At a minimum the report shall address: (1) how utilization of services under managed care arrangements has compared to utilization under fee for service arrangements in the same counties prior to implementation of managed care, (2) What current contractual obligations exist regarding access to care for Medicaid clients, (3) what changes could be made to improve client access to care under dental managed care and (4) recommendations for any statutory changes that would improve Medicaid member access to dental care.”

Comparison of Managed Care and Fee for Service Utilization in the Wasatch Front Counties

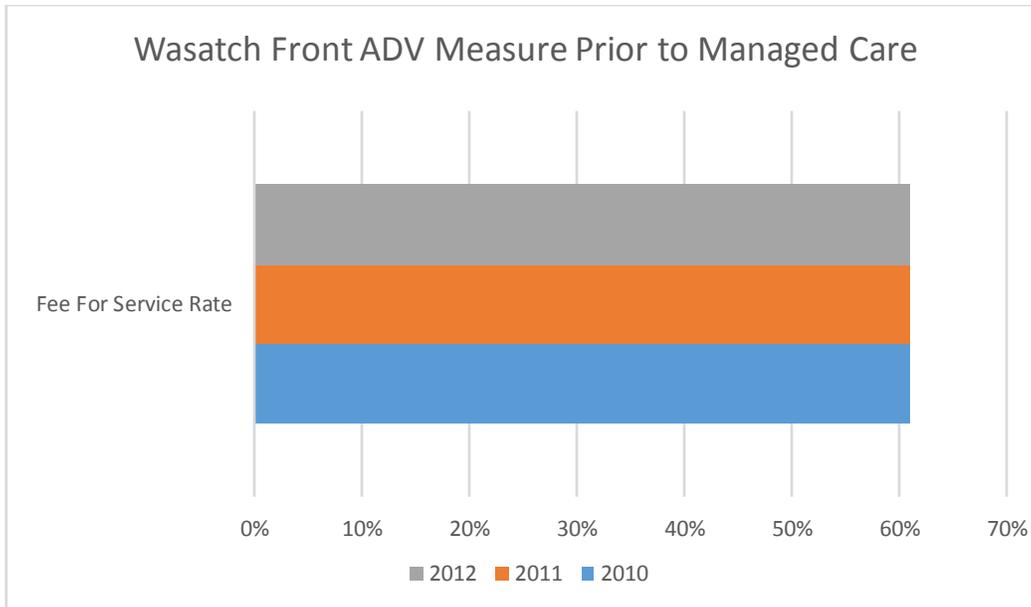
The Utah Department of Health implemented the dental managed care payment model in September 2013 when it executed contracts to two dental managed care plans: Premier Access and Delta Dental. The Service Areas for dental managed care was limited to Weber, Davis, Salt Lake, and Utah Counties (“Wasatch Front Counties.”) Prior to September 2013, the Wasatch Front Counties were paid on a fee for service delivery model.

To compare the utilization under the managed care payment model and utilization under the fee for service payment model in the Wasatch Front Counties, the state utilized two measures, the HEDIS adult dental measure and the CMS-416 report. Both measures show that while utilization dropped in the Four Wasatch Front Counties in 2014, the first year of the managed care payment model, by 2015, the second year of managed care, utilization exceeded that of the last fee for service year.

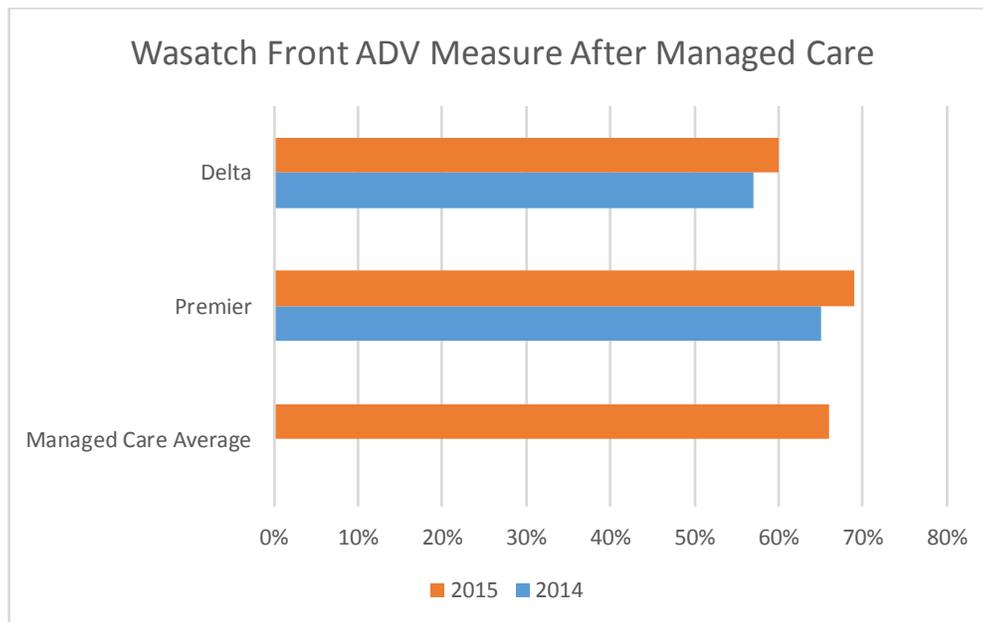
Percentage of members 2-20 who had at least one dental service

This HEDIS measure is calculated the percentage of members 2–20 years of age who had at least one dental visit during the measurement year. To be included in the sample size, the member must have 11 months of continuous eligibility.

When reviewing this HEDIS data note that Medicaid dental managed care was implemented in September 1, 2013. Because 2013 was a mixed fee for service/managed care year, 2013 data is not provided. Also, note that reporting of this measure lags one year, 2015 data is the most recent managed care HEDIS data available to the Department of Health.



The percentage of members 2-20 years old who had at least one dental visit in the Wasatch Front in the three years prior to managed care implementation was steady at 61% during all three years.



In, 2014, the first full year of managed care in the Wasatch front counties, Premier reported that 65% of its members 2-20 years old received a dental visit while Delta reported 57%. A statewide average is not available for 2014 because Premier did not report its numerator and denominator to the Office of Health Care Statistics that year. In 2015, Premier and Delta reported the annual dental visit measure at 69% and 60% respectively with a statewide average of 66%.

CMS-416 Data

The CMS-416 is a report that the state submits to the Center for Medicaid and Medicare Services on an annual basis. The CMS-416 report captures the percentage of clients who receive a diagnostic service and the percentage of clients who receive any dental service during the calendar year. To be eligible for inclusion in the sample size the Medicaid member must have 90 days of continuous eligibility.

	2012		2013		2014		2015	
	FFS Wasatch Front		FFS Wasatch Front		MC Wasatch Front		MC Wasatch Front	
	Total Eligible	152,933	Total Eligible	153,715	Total Eligible	160,035	Total Eligible	163,203
Diagnostic Service	70,062	46%	72,311	47%	61,897	39%	79,182	49%
Any Dental Services	72,074	47%	74,324	48%	64,876	40%	79,182	50%

The CMS-416 data shows a decline in utilization in both the diagnostic and the dental services categories in 2014, the first year of dental managed care. In 2015 the managed care utilization rates increased above 2013's fee for service rates.

Program considerations that may have impacted utilization from 2014-2015

During the first two years of the managed care payment model, there have been program changes which could have impacted utilization. In 2014, approximately 18,000 CHIP children were transitioned to the Medicaid program as a result of eligibility changes mandated by the Affordable Care Act. The Medicaid program offers a richer orthodontia benefit than the CHIP orthodontia benefit. As CHIP children were transitioned to Medicaid, the Department of Health observed increased utilization in the orthodontia benefit. Additionally, in 2015-2016 the Department of Health participated in a national Oral Health Initiative to increase awareness of the importance and availability of preventative dental services under the Medicaid program. Both of these program changes could have been a causal factor in the increase in utilization seen in 2015.

Managed Care Contractual Obligations Regarding Access to Care

The two Medicaid dental managed care plans have the following contractual obligations with regard to Access to Care:

- The managed care plans are required to have sufficient specialists in their network to serve the population of Enrollees while minimizing travel time for Enrollees. [Article 5.1.2(A)]
- The managed care plans must maintain at least one Participating Provider for every 600 Medicaid Enrollees. [Article 5.1.2(B)]
- The managed care plans must also ensure that there is one participating provider within 10 miles of each enrollee's residence. This requirement can be waived if the Contractor can demonstrate sufficient access. [Article 5.1.3(A)].
- The managed care plans must be able to ensure that Medicaid enrollees may make an appointment with a dentist within 21 days for routine, non-emergent appointments. [Article 5.1.3(A)].

- The managed care plans must ensure that if a Medicaid enrollee has an urgent care need, the Enrollee may be treated in a Provider's office the same day. [Article 5.1.3(B)].
- The managed care plans are required to offer to the enrollee, to the extent possible and appropriate, a choice in the selection of his or her dental provider. [Article 5.1.5]
- If the managed care plans' network of participating providers is unable to provide a medically necessary covered service required by an enrollee, the managed care plan must adequately and timely cover the enrollee's service using an out of network provider. [Article 5.1.7]
- The managed care plans must ensure that their Providers are offering hours of operation that are no less than the hours of operation offered to commercial enrollees. [Article 5.1.8].
- The managed care plans are required to pay for emergency services provided in a dental provider's office even if the service is by an out of network provider. [Article 4.3.1(A)].
- The managed care plans are required to have appropriate specialty providers who can provide medically necessary covered services to enrollees with special health care needs. If an enrollee with special health care needs requires a service by a specialty provider which is not in the managed care plans' provider network, the managed care plans are required to have a process in place by which the enrollee may request the service. [Article 4.4.3(A).]
- The managed care plans may not prohibit an enrollee with special health care needs from self-referring to a specialist. [Article 4.4.3(B)]

What changes could be made to improve client access to care under the Dental Managed Care Contracts?

During the first two years of the Medicaid dental managed care program, the program was subject to significant one-time changes which may have impacted the utilization of Medicaid dental services. Given that these first two years may have been outliers, the Department will continue to monitor these performance measures to ensure that utilization and access to care for Medicaid clients does not decrease.