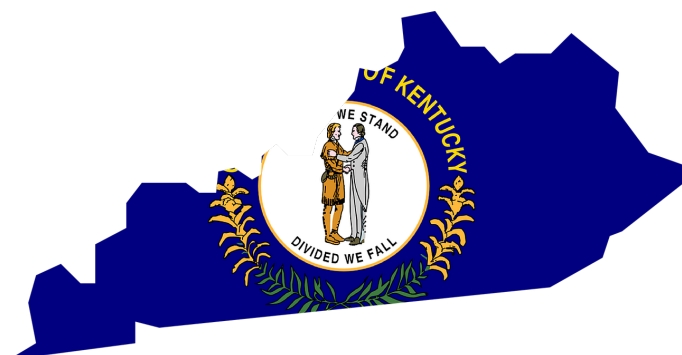




Managed Care for Medicaid Dental Services: Insights from Kentucky

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When Kentucky re-bid its Medicaid managed care contracts in 2015, dental services were identified as one of seven key areas where the state wanted to achieve measurable improvement, alongside issues like diabetes and behavioral health. Kentucky transitioned to statewide managed care for the majority of its Medicaid-enrolled population in 2011, and it decided to administer dental and medical benefits for children and adults in a single standard contract.

Since a growing number of states are using managed care approaches to deliver Medicaid dental services, this study highlights lessons from Kentucky's experiences that may inform other states' work. It examines the history of dental managed care in Kentucky and strategies that the state, its Medicaid managed care organizations (MCOs), and the MCOs' dental subcontractors are taking to achieve that measurable improvement. Key areas of inquiry include:

- Methods to assure network adequacy
- Supports to connect enrollees to dental care and support healthy behaviors
- Oversight mechanisms, including the Technical Advisory Committee that brings together the state, dentists, and MCOs
- Strategies MCOs are undertaking to connect dental care to medical care
- Performance Improvement Projects—supported by the state and the Centers for Medicare and Medicaid Services (CMS)—to improve children's use of preventive care

This brief describes Kentucky's experience administering a dental benefit through its managed care contract. It outlines evolution in the state's approach to dental benefits since 2011, highlights practices that state officials and managed care plans are taking to assure provider network adequacy and enrollee access to care, discusses challenges that the state, MCOs, and providers have encountered, and suggests potential options that the state could explore as it pursues future improvement.

Through a contract with the American Dental Association, NASHP reviewed publicly available documents, including oversight reports and contract materials from the state's 2015 re-bid. We conducted a 3-day site visit to Lexington, Frankfort, and Louisville to conduct interviews with more than 30 individuals, including state officials, representatives of Medicaid managed care organizations and their dental subcontractors, the Kentucky Dental Association and member dentists, researchers, and advocates. Unless otherwise noted, findings are drawn from these interviews. A list of interviewees is included in the Appendix.

Background

Kentucky transitioned to statewide Medicaid managed care in 2011, and in its 2015 managed care contract re-bid, identified oral health as one of seven key areas for measurable improvement, alongside issues like diabetes and behavioral health.¹ Kentucky opted to develop contracts that include both dental benefits and medical benefits. The state's experiences in administering those contracts, addressing challenges, and beginning to build supports for integrated medical and oral health care may be useful to other states as they consider their use of managed care strategies.

A growing number of states are using managed care contractors to deliver Medicaid benefits to the majority of their enrollees. Data from the Kaiser Family Foundation show that as of July 2015, 35 states and the District of Columbia delivered benefits to a majority of their Medicaid enrollees through risk-based managed care contracts.² States across the country are implementing strategies to integrate services like behavioral health with medical services in a single managed care contract. There has been less focus on integrating oral health services into overall care, even though oral health is important to overall health and to employability. This brief examines the experiences of one state—Kentucky—in administering a Medicaid dental benefit through integrated managed care contracts, and suggests lessons for other states considering this approach.

Dental services have historically been a challenging benefit for state Medicaid programs to administer – with low provider participation rates, and low utilization of care among enrollees. In the late 1990s and early 2000s, states like Tennessee and Michigan began successful experiments with “carving out” dental services through specialized contracts with dental managed care plans or administrative services vendors. In a “carve-out” arrangement, dental services are removed from overall MCO contracts, and provider and member services functions for dental care are assigned to a specialized vendor or vendors.³ In recent years, however, there has been a growing interest in bolstering states' ability to manage dental services inside of overall managed care contracts (a so-called “carve-in” approach). Data from the Medicaid/Medicare/CHIP State Dental Association show that in 2014, 18 states and the District of Columbia included dental services in risk-based contracts with managed care organizations.⁴ CMS has also developed support tools for states using an integrated managed care approach, including resources for states on designing dental-specific Performance Improvement Projects for MCOs.⁵ The American Dental Association (ADA) has also developed a guidance document to assess oral health provisions in managed care procurements and contract specifications.⁶

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Impacts of Poor Oral Health

Poor oral health—including high rates of tooth decay, missing teeth, and gum disease—and inadequate access to oral health services are persistent problems for low-income populations. More than 40 percent of adults below the Federal Poverty Level have at least one untreated decayed tooth,⁷ but fewer than 20 percent of poor adults aged 19-64 receive any dental services.⁸ This low level of access is costly. Many low-income individuals turn to the emergency department (ED) for oral health needs, and these visits for avoidable oral-health-related visits cost the U.S. health care system more than \$1 billion per year.⁹ Medicaid was the primary payer for 32 percent of dental-related ED visits by non-elderly adults, and 59 percent of visits by children.¹⁰

Oral health problems can also affect a person's ability to get and keep a job. An estimated 164 million work hours are lost each year because of oral disease, and customer service industry employees lose two to four times more work hours than executives or professional workers.¹¹ One study estimates that poor oral health results in a four percent reduction in earnings for women from low-income families, due to the effect of missing or damaged teeth.¹²

Oral Health in Kentucky

Kentucky faces significant oral health challenges for children and adults, particularly in more rural eastern and western regions of the state.

Medicaid-enrolled children are eligible for comprehensive dental services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. According to data submitted to CMS, 46.5 percent of Kentucky's Medicaid-enrolled children received a dental service in 2014 (250,504 of 538,182 children continuously enrolled for more than 90 days). This is very close to the 2014 national figure of 46.8 percent.¹³ Data from the National Oral Health Surveillance System shows that 34.6 percent of third-graders in the state had untreated decay in 2000-2001, putting Kentucky in the top quartile of states with the highest levels of untreated decay.¹⁴ (The state is currently in the process of conducting an oral health survey to update these data.)

Kentucky Medicaid offers a limited dental benefit to all adult enrollees. The state covers preventive, restorative, and oral surgery services for adults, but excludes adult coverage for root canals, crowns, dentures, and orthodontia. Nineteen states offer limited Medicaid adult dental benefits, and an additional 15 offer more extensive benefits.¹⁵ Data from the Centers for Disease Control and Prevention show that Kentucky is in the top quartile of states with the highest percentage of adults over age 65 missing more than six teeth, and also for complete tooth loss among adults over age 65.¹⁶ A 2012 Kentucky Behavioral Risk Factor Surveillance Survey report found that 39.7 percent of Kentucky adults did not visit the dentist in the preceding year, compared to 32.8 percent nationally. There were also significant racial and socioeconomic disparities in use of dental care; adults with incomes under \$25,000 were more than twice as likely as adults with incomes over \$50,000 (58.3 percent compared to 22.7 percent) to forego dental care.¹⁷ An analysis of Kentucky Medicaid data from the Appalachia Rural Dental Education Partnership (ARDEP) estimates that the number of Medicaid-enrolled adults receiving dental services more than doubled, from approximately 78,000 in 2013 to almost 164,000 in 2014; however, since this happened in the context of growing enrollment from Medicaid expansion, the percentage receiving care grew from 18 percent to 20 percent.¹⁸

The 2006 state oral health plan noted significant geographic oral health disparities, with residents of

rural eastern Kentucky bearing a disproportionate burden of unmet oral health needs, including decay, periodontal disease, and toothlessness compared to citizens in other regions of the state.¹⁹ A recent review of Kentucky oral health indicators reaffirmed these findings, noting that people living in areas of the state outside the Central Triangle of Covington, Lexington, and Louisville faced higher oral health needs, but also a more limited supply of dental providers, who are concentrated in the central part of the state.²⁰

Recent studies have also reflected a sense among key stakeholders that low oral health literacy and cultural beliefs create barriers to oral health for some Kentucky populations. This includes dietary habits, like excessive soda consumption; substance abuse that causes oral problems; and beliefs that adverse oral health outcomes, like having teeth extracted, are an unavoidable part of life.²¹ Stakeholders we interviewed made similar observations, noting a perception that many underserved residents preferred to seek dental care for urgent needs, rather than routine care.

Kentucky recognized these oral health issues as a key area of concern in *kyhealthnow*, a statewide planning effort in 2014 and 2015. The state set goals for progress in seven areas including obesity, cancer, cardiovascular disease, behavioral health, and oral health. The state set goals to reduce untreated decay among children and improve dental service utilization among adults. As of November 2015, the state reported expansion of Public Health Dental Hygienists and school-based fluoride varnish programs as progress on these goals.²² The *kyhealthnow* goals were also built into Kentucky's State Health System Innovation Plan (developed through a federal State Innovation Models grant from the CMS Innovation Center), which indicated a desire to build oral health into the state's plan for patient-centered medical homes and developing ACOs.²³

Medicaid Managed Care in Kentucky

The Medicaid program in Kentucky transitioned to statewide, risk-based managed care in 2011. Prior to this the state administered Medicaid benefits mainly through Kentucky Patient Access and Care (KenPAC), a primary care case management program, where primary care providers (PCPs) received a small monthly payment to manage Medicaid-enrolled patients' health care and referrals for specialty care. Enrollees could access basic dental services directly, without a referral from their PCP.²⁴ Risk-based managed care had been in use in only one region of the state – a 16-county region encompassing Louisville, served by the nonprofit Passport Health Plan since the late 1990s.²⁵

In 2011, KenPAC ended, and managed care contracts were awarded to three additional MCOs to cover approximately 550,000 Medicaid enrollees. An Urban Institute evaluation of the initial implementation noted significant problems, including financial difficulties for plans and administrative and financial burdens on providers, partly due to the rapid implementation of the change. The evaluators noted that in 2012 and 2013, plans' financial situation stabilized, and administrative and care coordination processes improved. The state also took steps to increase its oversight of managed care plans, and to bolster the state's capacity to provide behavioral health services.²⁶

Dental providers also encountered disruptions from the shift to managed care. One report from a Kentucky Dental Association member dentist to the state legislature lists prior authorization processes, complex denial and appeals processes, decreased payments and slow pay cycles as issues following the introduction of managed care.²⁷ Data from ARDEP indicate that in 2012, the first year of managed care, there was an 11 percent decrease in patient visits to dentists, a 23 percent decrease in paid dental claims, and a drop from 1,110 to 1,020 dentists participating in Medicaid. In 2013, patient visits and paid claims roughly rebounded to their 2011 levels, and grew steadily in 2014. Medicaid participation by dentists fell slightly in 2014, but the number of dentists receiving more than \$50,000 in paid Medicaid claims

rose from 520 to 609. Overall, University of Kentucky ARDEP reports concluded that 41 percent of the state's approximately 2,500 licensed dentists participated in Medicaid in 2014.²⁸ This is comparable to an ADA estimate that 42 percent of dentists nationally participate in Medicaid for children's services.²⁹ However, the ARDEP reports also indicated only 456 of 1990 general dentists (23 percent) received more than \$50,000 in paid Medicaid claims. Overall, dental specialists had much higher participation rates and levels of participation in Kentucky's Medicaid program.

In 2014, Kentucky expanded Medicaid to childless adults with incomes under 138 percent of the Federal Poverty Level. This increased Medicaid enrollment by approximately 400,000 individuals. The Medicaid expansion continues to be a subject of discussion in the state, with the administration considering the possibility of restructuring its Medicaid coverage policies.

In April and May 2015, the state re-bid its managed care contracts to enhance oversight provisions, and move to a single standard contract for all of its MCOs. Statewide contracts were awarded to five MCOs: Anthem, Coventry (since acquired by Aetna), Humana-CareSource, Passport, and WellCare. Awards were made for one year, with an option for the Medicaid agency to extend the contracts for up to four additional years.

According to the Request for Proposals (RFP) for the re-bid, most of the state's Medicaid population (more than one million individuals) is eligible for coverage through managed care, with only a small remainder receiving fee-for-service (FFS) benefits. Individuals eligible for managed care include Medicaid-enrolled children, parents, some individuals receiving Supplemental Security Income, current and former foster care children, Medicare-Medicaid dual eligibles, and Medicaid expansion adults. The remaining FFS population primarily includes individuals with disabilities or those who are 65 years of age or older residing in long-term care facilities, or are served by a Home and Community Based Waiver program.³⁰

Oral Health in Kentucky's Managed Care Strategy

Just as oral health had emerged as a statewide priority in the kyhealthnow planning effort, dental care was highlighted in the RFP for the re-bid. One of Kentucky's stated goals for the new round of contracting was to measurably improve healthcare outcomes for members in seven areas, including diabetes, coronary artery disease, colon cancer, cervical cancer, behavioral health, prenatal care, and oral health. Other goals in the RFP included reducing inappropriate emergency room utilization, improving care coordination, promoting healthy lifestyles, and lowering healthcare costs.³¹



To accompany that overall goal, the state's new standard MCO contract included several distinct provisions specific to dental services, summarized in Table 1.

Table 1. Kentucky Managed Care Contract Dental Provisions³²

Section	Topic	Summary
9.2B	Leadership	Each MCO must have a Chief Dental Officer licensed to practice dentistry in Kentucky. (This requirement may be fulfilled by a subcontractor.)
23.1P	Member Services	The MCO's Member Services unit must facilitate access to general dentists and specialists.
29.7F	Network adequacy	Members must have a provider for general dental services within 60 miles or 60 minutes' drive. Appointments must be available within 3 weeks for regular appointments, or 48 hours for urgent care.
30.11	Supplemental Payments	MCOs must make monthly supplemental payments to designated providers, including teaching hospitals operated as part of an approved School of Medicine or Dentistry.
31.2B	Provider choice	MCOs must assure free choice of any primary care dental or oral surgery provider in the MCO's network.
33.2	Benefits Assessment and Improvement	MCOs must provide primary and preventive dental care equal in amount, duration, and scope to benefits under fee-for-service Medicaid. (Section 31.1 allows MCOs to offer services that exceed what is offered in fee-for-service Medicaid.) MCOs must assess the oral health of their members and develop a plan for improving oral health in their membership, particularly in children and persons with special health care needs
39.1	Compliance assessment Utilization review Provider audits	MCOs must develop audit methodologies for assessing provider performance and compliance—including dental providers—every three years. This includes: <ul style="list-style-type: none"> • Tracking provider compliance with MCOs' clinical and preventive care guidelines • Tracking individual and plan-wide performance • Identifying and resolving quality of care concerns Detecting over- or under-utilization of services.

The following sections describe how Medicaid MCOs in Kentucky carry out these contract provisions, and how state officials conduct oversight of them.

Dental Subcontractors

Each MCO uses a specialized dental subcontractor to manage dental benefits. These subcontractors handle contracts with general and specialist dentists, maintain provider services call centers, and process dental claims and prior authorization requests. The MCOs themselves set payment and coverage policies for their subcontractors, and manage member services call centers for enrollees. The MCOs oversee their subcontracts through oversight committees, staff analysts who track subcontractor perfor-

mance, and regular reporting on provider networks, service utilization, call center, and claims processing measures.

In 2016, MCOs realigned their partnerships, and the number of dental subcontractors narrowed from four to two. Anthem now contracts with DentaQuest, and the other four MCOs each contract with Avesis. Many Kentucky Medicaid-enrolled dentists participate in multiple MCO provider networks. The MCOs' consolidation of dental subcontractors was perceived by providers we interviewed as a net positive, with several noting that having a single point of contact for questions about MCOs subcontracting with Avesis eased administrative complexity and helped to promote dentist satisfaction.

Avesis manages each of its MCO contractual relationships with the same staff, claims processing, and provider relations apparatus, with the exception of separate provider relations specialists for Passport issues, but maintains separate provider networks, payment schedules, and coverage and prior authorization processes according to each MCO's policies.

DentaQuest began its subcontract with Anthem in January 2015. Anthem's reporting requirements align with state requirements, including utilization review, utilization management, call center statistics, and network adequacy.

Table 2 below summarizes information on MCOs and subcontractors, drawn from the state's dashboard and reports to the Dental Technical Advisory Committee (TAC). Our interviews with Kentucky stakeholders highlighted two key areas of activity by dental subcontractors: building and maintaining an adequate provider network, and connecting Medicaid enrollees to care. The following sections explore each of these topics in depth.

Table 2. MCO and Subcontractor Summary Information

	Anthem	Coventry/Aetna	Humana-CareSource	Passport	WellCare
Average Membership, 7/15-1/16 ^a	84,183	289,374	119,843	269,181	433,896
Dental Subcontractor as of 2/16	DentaQuest	Avesis	Avesis	Avesis	Avesis
General dentists in network, Q3 2015 ^b	884 ^c	733	^d	692	750
Oral surgeons in network, Q3 2015 ^b	86 ^c	79	^d	64	71

^a Kentucky Cabinet for Health and Family Services, "Monthly MCO Dashboard Comparison", table, January 2016, Retrieved March 14, 2016. <http://chfs.ky.gov/NR/rdonlyres/C3244AB2-3C82-44DA-8C36-6ABD7E32D6DC/0/MCOComparisonDashboardJanuary2016.pdf>.

^b Kentucky Medicaid Dental Technical Advisory Committee Meeting, Coventry Cares of Kentucky; DentaQuest; Humana CareSource, Passport Health Plan; WellCare of Kentucky, presentations, December 2015.

^c Anthem reported "provider/location combinations," not an unduplicated count of providers, so these figures may include some providers practicing at multiple locations.

^d In December 2015, Humana-CareSource subcontracted to MCNA, which reported 519 general dentists and 27 oral surgeons in network. Avesis became the MCO's dental administrator on January 1, 2016.

Assuring Network Adequacy

MCOs must assure that every Medicaid enrollee has a general dentist within 60 miles or 60 minutes' drive, and that appointments be available within three weeks for routine care, and 48 hours for urgent care. Reports from the dental subcontractors to the state's Dental TAC use geomapping software to demonstrate compliance with this requirement. All MCOs reported that in December 2015, more than 99 percent of their enrollees were located within 60 miles of a network provider.³³ However, interviewees noted several ongoing challenges with assuring that providers are available to serve Medicaid enrollees.

- *Geographic distribution of enrollees and providers:* Several interviewees noted that, while the 60 miles standard may appear to be met by an MCO's network, the remoteness of some towns in eastern and western Kentucky, and the smaller number of dentists practicing in these communities strains access. In practice, residents of rural Kentucky towns may need to drive long distances to obtain care from dentists concentrated in the Central Triangle.
- *Strain on rural providers:* Providers reported that, due to a continuing economic downturn in eastern Kentucky (related to the declining coal industry) and expansion of Medicaid eligibility, some dentists in rural regions of the state have seen their Medicaid patient caseload rise as patients shifted from having no dental insurance to coverage through Medicaid, so that Medicaid constituted as much as 80 percent of their practice which they feel is unsustainable at current reimbursement rates.
- *Availability of specialty care:* All MCOs noted specialty care, particularly the availability of oral surgeons to perform extractions for medically complex adults, as an area of concern. There are 114 licensed oral surgeons in Kentucky,³⁴ and as Table 2 shows, MCOs contract with between 64 and 86 of them. Since extractions and other oral surgery services make up a large percentage of Medicaid-covered services for adults, recruitment and retention of oral surgeons has been a particular area of focus for MCOs. Dental providers we interviewed frequently reported referring complex cases to the University of Kentucky and University of Louisville dental schools, each of which reported serving patients from across the state.

MCOs oversee their provider networks through regular reports from their subcontractors, as well as “secret shopper” calls to offices to determine whether routine and urgent appointments can be made within contractual timeframes. If deficiencies are found, subcontractors address those issues with active recruitment, which can include offering payment incentives to certain providers to boost participation. Several MCOs, for example, offer enhanced fees to oral surgeons.

Providers that we spoke to perceived several state and MCO policies as deterrents to Medicaid participation. State officials and MCOs noted that they are attempting to implement strategies to address many of these barriers.

Reimbursement rates: Reimbursement rates were a major issue for providers we interviewed. They uniformly noted that MCO fees were far below their usual and customary charges, and several reported fees for some MCOs that were 10 percent below Medicaid fee-for-service rates. Several also expressed dissatisfaction with the ability of MCOs to negotiate fees with individual providers rather than using a single reimbursement schedule for all providers.

A recent ADA study finds Kentucky Medicaid fee-for-service fees (as a percentage of private dental plan payments) to be slightly lower than the national average—44 percent in Kentucky, compared to 49 per-

cent nationally.³⁵ Medicaid MCOs are not required to set reimbursement rates for network providers with any particular relationship to fee-for-service rates, or to spend a defined portion of the capitation rates they receive from the state on dental services³⁶; they are required only to maintain an adequate provider network. However, MCOs frequently use fee-for-service rates as a guide. For example, in early 2016, Kentucky raised fee-for-service reimbursement rates for a set of preventive and diagnostic services by 25 percent—the first adjustment to fee-for-service rates since 2005. At the time of our site visit, several MCOs were in the process of adjusting their provider reimbursements to follow suit for those services, though providers noted that some MCOs' rates overall were still discounted from Medicaid fee-for-service payments.

State credentialing: Many interviewees noted that applying for and receiving credentials to participate as a Medicaid provider was a cumbersome process that could take from several months to more than a year to complete. Most attributed these delays to manual processes at the state. State officials reported that they plan to move to an automated credentialing system in the future. State officials also noted that they had combined the process for being credentialed as a provider of EPSDT services for children with the regular credentialing process, so that providers no longer needed to obtain two separate Medicaid provider numbers.

MCO service limitations: Providers we interviewed noted that MCO rules around service limits and prior authorization requirements could be challenging, particularly for small dental offices. They noted that differences in coverage policy among the five MCOs could be confusing to navigate. The state recently adopted a common prior authorization form as an attempt to drive consistency among plans, and some dentists we interviewed noted that subcontractors' time to process prior authorizations had fallen, in some cases to less than 24 hours.

State limitations on adult services: State regulations prior to 2016 limited adult enrollees to one non-emergent dental visit per month.³⁷ Dentists identified this as a barrier to treatment, and the state recently changed regulations to allow 12 non-emergent dental visits per provider per year (a standard which the MCOs follow).³⁸ Providers still report that the limitation is an impediment to completing treatment plans for patients with extensive restorative needs.

Missed appointments: Providers noted a perceived higher rate of broken appointments for Medicaid enrollees than for other patients. Anthem and DentaQuest are attempting to quantify this issue by reimbursing providers a small amount (\$3) for reporting missed appointments. The plan hopes to use data from this project to develop outreach strategies to decrease missed appointments.

Federal audits and recoupments: Providers indicated that audits by federally-required contractors through the Recovery Audit Contractor (RAC) program where funds could be recouped years after services were provided, introduced unpredictability that deterred dentist participation in the program especially for smaller dental offices with limited administrative capacity. Kentucky uses OptumInsight as its vendor for Medicaid RAC audits. Optum reported in 2014 recovering approximately \$200,000 for dental coding issues, including services like x-rays and examinations being provided in excess of service limitations.³⁹ Several interviewees indicated that it was an area of concern because of potential effects on providers' willingness to participate in the program.

MCOs and their dental subcontractors noted provider outreach and recruitment as high priorities. For example, WellCare and Coventry/Aetna both reported network growth of about 50 general dentists between the third quarters of 2014 and 2015, and Passport reported contracting with 90 more general den-

tists in that time period.⁴⁰ All MCOs said that they were focused on network adequacy moving forward.

Connecting Enrollees to Care

The second major area of work for the MCOs and their dental subcontractors is to connect enrollees to regular and ongoing sources of preventive oral health care, as well as providing treatment for existing oral diseases. MCOs are also working on initiatives to integrate oral health into medical care.

Much of the MCOs' work focuses on increasing children's use of dental care, since the state uses the Healthcare Effectiveness Data and Information Set (HEDIS) Annual Dental Visit measure for children to assess MCO performance. MCOs have sought to bolster demand for dental services through strategies like sending mailers to enrollees and offering gift cards to parents who bring their children in for dental care. They are also working on strategies to bring oral health care closer to Medicaid-enrolled children. Avesis is working with the University of Kentucky and patient advocacy groups to improve policies for mobile dental programs that bring preventive oral health care to schools, and for case management of children with treatment needs by local Medicaid-participating dentists and Federally Qualified Health Centers (FQHCs).

DentaQuest is actively working on strategies to integrate pediatric medical and dental care, including through Community Dental of Kentucky, a DentaQuest-owned practice operated in partnership with the University of Louisville pediatric department, where pediatric dental and medical services are provided in a single location.

With respect to adults, all of the MCOs reported a major challenge with responding to the high level of pent-up need for dental care among newly enrolled adults. Dentists we interviewed reported (and other stakeholders confirmed) that many adults enrolled under Medicaid expansion had extensive dental disease, and may have gone years without accessing dental care. MCO reports to the Dental TAC show that as much as 38 percent of the total dollars that Coventry and WellCare spent on adult dental services in the third quarter of 2015 were for oral surgery services—that is, tooth extractions.⁴¹

Several MCOs have chosen to cover some preventive services for adults in addition to the benefits they are required to cover by contract. For example, Passport and Humana-CareSource offer a second annual exam and cleaning to enrolled adults, and Anthem offers additional services to treat gum disease, both to improve oral health, and to potentially improve outcomes for diabetes and cardiovascular health, which may be related to inflammation in the mouth.⁴²

MCOs were considering ways to use their care coordinators to encourage enrollees to utilize dental services. In contrast to states that “carve out” dental services from comprehensive managed care contracts, the MCOs in Kentucky, not their dental subcontractors, maintain responsibility for dental member services functions, including care coordination and outreach to members. WellCare, for example, has approximately 100 associates who work in a face-to-face care management program throughout the state. The MCOs are required to conduct oral health assessments of members, and currently MCOs report meeting this requirement by including oral health questions in their overall health assessment questionnaire for new enrollees. Some MCOs reported early work to push one step further, to profile and contact enrollees who have not sought dental care. However, because of the large level of pent-up demand for care that the plans are experiencing, their focus currently appears to be on improving provider satisfaction and maintaining provider networks—in order to manage the treatment needs of members currently seeking care—rather than on performing outreach to prompt more members to seek care.

Similarly, many interviewees, including MCOs, subcontractors, and state officials, expressed a desire to move toward a system where oral health care is well integrated with medical care, through shared electronic records, strong care management, and effective referral mechanisms. Each of the Medicaid MCOs said that they viewed oral health as an important benefit to integrate into a whole-person approach to overall health. Interviewees, however, expressed uncertainty about how best to move toward that vision, especially given limited access to dental providers in some areas of the state, and the fact that dental care has traditionally been separated from the medical care system—with separate provider training and care delivery systems. One MCO remarked “we need to convince everyone involved that [integration is] worth it financially and practically.” MCO initiatives to bridge the gap include efforts to promote the use of fluoride varnish by pediatric medical providers, and work with public health nurses and public health dental hygienists on school-based interventions. WellCare noted that its clinical HEDIS advisors are delivering reports to primary care providers to flag children who may need referrals to dentists. Many interviewees expressed an appetite to work collaboratively with providers to make further progress in this area.

State Tools for Oversight, Monitoring, and Guidance

As noted in the Urban Institute evaluation of Kentucky’s implementation of Medicaid managed care, the state has bolstered its oversight and reporting mechanisms over the last several years. The state uses monthly MCO dashboards and reports from its External Quality Review Organization to track compliance with contract specifications. Most of these reports do not have a specific focus on dental services; the Dental TAC is the forum where the MCOs report detailed, dental-specific information to the state. The state has also required each MCO to participate in a Performance Improvement Project (PIP) on utilization of dental services.

Oversight and Monitoring Reports

Kentucky requires each MCO to report a range of quality performance data to measure adherence to contract specifications, including timelines for claims processing, prior authorization, and provider credentialing, as well as member and provider call center contacts. A monthly dashboard collects high-level information across all health services, and MCOs also deliver regular encounter data reports to the state. When deficiencies are identified, the state can require an MCO to submit a corrective action plan, and can also levy sanctions of up to 0.5 percent of the capitation rate. The state also has the ability to tie incentive payments—up to one percent of the capitation rate—to MCO performance on HEDIS measures. The Annual Dental Visit measure is currently not in the incentive group.

The state’s high-level reports are supplemented with detailed managed care monitoring reports from IPRO, the state’s External Quality Review Organization. While these reports have not focused exclusively on dental services, reports on children’s use of services have included several findings related to their access to oral health services. One 2015 report found that Kentucky’s weighted statewide average for the HEDIS Annual Dental Visit measure for children met or exceeded the 2014 national Medicaid 50th percentile.⁴³ However, a separate EPSDT monitoring report found that more than half of Medicaid-enrolled children who received an EPSDT screen from a medical provider did not receive either an oral assessment or referral to a dentist. Three of the report’s five key recommendations included specific provisions related to improving oral health access: it recommended that MCOs continue to focus on increasing rates of oral health assessment and referral by medical providers; that EPSDT services for adolescents, including oral health, be the focus of future validation studies; and that further studies be undertaken of low oral health care utilization by children and adolescents.⁴⁴ Another monitoring report noted that MCOs could do better in collecting information on children’s receipt of preventive dental

services (a measure included in the Child Core Set of quality measures).⁴⁵ Adult use of dental services was not an area of focus in any report reviewed for this study.

Dental Technical Advisory Committee

The state's MCOs and their dental subcontractors are producing a range of detailed utilization and provider information for the state's Dental TAC. It is one of fifteen technical advisory committees that feed into the Advisory Council for Medical Assistance, which advises the Kentucky Cabinet for Health and Family Services on health services and policy development. The Dental TAC is made up of five dentists appointed by the Kentucky Dental Association. Additionally, one Kentucky Dental Association member sits on the Advisory Council, and a pediatric dentist sits on a Children's Health TAC, but all of the individuals we interviewed noted the Dental TAC as the primary venue for receiving input on oral health.⁴⁶

At the Dental TAC's request, the MCOs' dental subcontractors have produced detailed reports on dental provider networks and service utilization. Reports presented in December 2015 included information on call center performance, provider networks, volume of paid claims, distribution of claims by service category, and pre-authorizations, as well as several metrics on enrollees' utilization of preventive and emergency services. MCOs have collected some more specialized information in response to requests from the Dental TAC; for example, WellCare is measuring utilization of services by pregnant women, while Coventry and Passport are measuring dental-related emergency department visits. However, the MCOs did not indicate that this information was being used for program development purposes at this time.

Dentists we interviewed saw the Dental TAC as an important venue to hold the MCOs accountable for performance. Other interviewees, however, indicated a desire to refocus the Dental TAC toward discussion of strategic, systems-level policy options for the state and the MCOs to work on in order to improve beneficiaries' oral health, and away from what they perceived as a narrower focus on adjudicating individualized issues, such as a provider's denied claims. Several interviewees indicated that the Children's Health TAC might be a model for a more collaborative relationship between TAC members and MCOs. The Children's TAC includes members from several health professions, family and youth advocates, and a position (currently unfilled) for a parent of a Medicaid or CHIP enrollee. Meetings frequently engage members on PIPs and conclude with recommendations to the Advisory Council for Medical Assistance.⁴⁷

Performance Improvement Projects

Kentucky is pursuing another strategy to drive improvements in dental utilization – it is working with all of its contracted MCOs on a joint PIP to increase use of dental care. (Kentucky requires MCOs to undertake two PIPs per year.) As part of this effort, Kentucky has been accepted to participate in a CMS learning collaborative on designing effective oral health PIPs. This learning collaborative builds on resources developed by the CMS Oral Health Initiative, including a template for designing oral health PIPs, and detailed manuals for states and MCOs for designing these PIPs.⁴⁸ While this is the state's first joint PIP on oral health, Passport Health Plan conducted a PIP in 2013 on improving access to dental care for children with special health care needs.⁴⁹ Several MCOs reported that they had also identified oral health as an area for PIP development, but they are aligning those efforts with the joint PIP.

At the time of our site visit, the aim of the oral health PIP had not yet been defined, though interviewees indicated that it is likely to focus on children's use of preventive dental services—potentially including the Child Core Set quality measure on use of dental sealants among children ages 6-9 at elevated risk

of caries (tooth decay).⁵⁰ Several interviewees also noted that the PIP design process might provide a useful forum to foster a collaborative vision for oral health improvement among the MCOs, the dental subcontractors, the EQRO, and the Medicaid agency. It may also result in some best practices that can be shared among the MCOs, and potentially promote alignment among MCOs with respect to service or prior authorization limitations that may help to address dentists' concerns with differing requirements among MCOs.

Looking Ahead

Through our interviews, we identified several key themes that may inform future directions for Kentucky's implementation of dental benefits, as well as experiences from other states that may be informative as the state continues its work.

- Reestablishing a vision for oral health improvement: A clear theme through our conversations was that MCOs, subcontractors, and state officials would like active engagement with providers in developing policies to achieve the state's goal of measurable improvement in oral health for Medicaid enrollees, and the MCOs' goals of delivering integrated medical and dental care. The Dental TAC is a promising venue for this type of engagement, though leadership from state officials may be necessary to move the committee toward a discussion of the policy implications of the information that the TAC is requesting from MCOs. For example, the TAC has requested information on dental-related emergency room visits, and this information could be coupled with research from the American Dental Association⁵¹ and the Association of State and Territorial Dental Directors⁵² to generate policy options that may be workable in Kentucky. Iowa, for example, is using emergency room data as a metric to measure the effectiveness of its Dental Wellness Plan (described below).⁵³
- Implementing and evaluating current MCO initiatives: MCOs and their dental subcontractors are embarking on a number of initiatives to improve care that could be informed by work going on in other states, and several interviewees expressed interest in exploring these examples. The MCOs' work to bolster their provider network, for example, could be informed by Connecticut's success in growing their Medicaid provider network six-fold following a set of program reforms. The PIP learning collaborative on pediatric dental access could be informed by Oregon's experience adopting placement of dental sealants as one of thirteen performance measures linked to performance incentive payments for its Coordinated Care Organizations.⁵⁵ MCOs' work to develop mobile and school-based preventive dental programs linked to ongoing clinical care could be informed by California and Colorado's experience with implementing Virtual Dental Home pilots—telehealth-enabled pilots where expanded-function dental hygienists provide dental care in community settings, in coordination with collaborating dentists in hub FQHC dental clinics who provide restorative care for patients with more extensive needs.⁵⁶ This model could potentially leverage Kentucky's Public Health Dental Hygienists. Additionally, the state could take advantage of work being done by the Dental Quality Alliance to develop measures of oral health access and utilization that could be tied to performance standards or incentive payments, or to augment the data that the MCOs are reporting to the Dental TAC, as a way to assess the success of MCO initiatives.⁵⁷
- Considering adult benefits: Stakeholders recognized adults' need for dental care as a continuing issue; however, many were uncertain about the future of Medicaid adult dental coverage, given the state's current consideration of changes to its Medicaid program. If the state considers an alternative approach to Medicaid benefits that might change its approach to dental services, it

could look to Iowa's Dental Wellness Plan, an "earned benefit" model for its Medicaid expansion population, as a potentially useful example. Enrollees who establish and maintain an ongoing relationship with a dental provider qualify over time for more extensive benefits including, at the highest level, services like dentures, which Kentucky does not currently cover. Iowa supports this model with county-based dental care coordinators who help cultivate referral relationships with dentists and help patients make and keep appointments.⁵⁸

Lessons for Other States

Kentucky's experience offers several key lessons for other states considering an integrated managed care approach to medical and dental benefits.

- Prioritizing oral health in a statewide planning effort and including it as a target area for measurable improvement in the language of the RFP helped raise the profile of the benefit, similar to other states' experiences with respect to children's use of services and adult dental coverage.⁵⁹
- Kentucky's contract language requiring assessment of members' oral health status and development of a plan to improve oral health in their membership are promising tools to drive the prioritization of oral health by MCOs. States could look to quality measures like those being developed by the Dental Quality Alliance, or the sealant measures in the Child Core Set as ways to set benchmarks for measurable improvement.
- Provider reimbursement and administrative ease of participation are key factors in dentists' participation in MCO networks, just as they are in "carve-out" arrangements. With respect to fees, states may wish to examine whether they can adopt changes in their fee-for-service programs to set patterns that MCO contractors may follow.
- With respect to administrative processes, states can work with MCOs to standardize, to the extent possible, processes across plans. For example, Kentucky's use of a standardized prior authorization form and development of a uniform, automated credentialing system could be instructive, as could the single dental point of contact for four of Kentucky's MCOs.
- MCOs also have the flexibility to work with dental offices to monitor and address issues of concern, like tracking and developing responses to broken appointments, and to offer members "value add" benefits (like additional preventive coverage for adults) that can help members maintain oral health.
- An integrated medical-dental contract allows MCOs to use their member services resources, such as dedicated care coordinators, to integrate oral health into the other outreach, health literacy and health promotion that the plans provide to their members. States may wish to consider whether their contract provisions strongly support coordination of care across medical and dental providers, and facilitate strong referrals between providers for members with identified needs.
- PIPs represent a strong opportunity for states to drive oral health improvement, especially for children. New resources from CMS, as well as the experience of states like Kentucky, can help other states to design and execute oral health improvement projects.

Conclusion

Kentucky is using a managed care strategy to move toward a vision of an integrated system that delivers oral health as a part of whole-person care. However, it is still challenged by deep unmet oral health needs, as well as challenges common to Medicaid dental programs—barriers to access tied to low provider reimbursements, administrative burden, and oral health literacy. The state has adopted a goal for measurable improvement in dental service utilization and oral health status for children and adults, and achieving this goal will require strong commitments from and partnerships with MCOs, dental sub-contractors, state officials, medical and dental providers, universities, and stakeholders to prioritize oral health amidst competing issues, identify a vision for oral health, and use innovative strategies to achieve that vision.

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Appendix: Interviewee List

Aetna

David M. Hiestand MD, PhD
Medical Director

Director of the Medicaid Management Services-Care-Source

Candace Owens
Manger of the Dental Program-CareSource

Anthem

Jean O'Brien
Vendor Compliance Manager

Samantha Harrison
Director of Administration and Contract Administrator-CareSource

Avesis

Jerry Caudill, DMD
Kentucky State Dental Director

Cathy Stephens
Director of KY Medicaid-Humana

Nicole Allen
Account Executive for the Kentucky Market

Paige Greenwell
Account Executive-Humana

Dennis Arizin
Account Coordinator Avesis

Kentucky Dental Association
Dennis Price, DMD
President

Christie Vowels
Account Executive

Bill Collins, DMD
First Vice President

Centers for Medicare & Medicaid Services

Laurie Norris
Senior Policy Advisor

Richard Whitehouse, JD
Executive Director

DentaQuest

Rebekah Mathews
Regional Director, Client Engagement

Beverly Largent, DMD
Pediatric Dentist

Garth Bobrowski, DMD
General Dentist

Humana-CareSource

Beth McIntire

H. Fred Howard, DMD
General Dentist

**Kentucky Department for Medicaid Services,
Cabinet for Health and Family Services**

Cindy Arflack
Director
Division of Quality & Outcomes

Stephanie Bates
Branch Manager, Disease and Case Management Branch
Division of Program Quality & Outcomes

Veronica Cecil
Deputy Commissioner

Charles Douglass
Assistant Director
Division of Policy and Operations

Jessica Jackson
Medicaid Service Specialist II

William Rich, DMD
Dental Medicaid Director

Kentucky Department for Public Health

Julie McKee, DMD
State Dental Director
Division of Maternal & Child Health

Kentucky Oral Health Coalition

Lacey McNary
Member

Passport Health Plan

Kim Myers, CCEP
Compliance Director and Privacy Officer

Stephen Houghland, MD
Vice President, Chief Medical Officer

University of Kentucky College of Dentistry

Gregory Zeller, DDS, MS
Associate Dean, Clinical Affairs

Raynor Mullins, DMD, MPH
Center for Oral Health Research

WellCare

Rebecca Randall, MPA
Director of State Regulatory Affairs

Ronda Roberts
Senior Director, Quality Improvement

Howard Shaps, MD, MBA
Kentucky Market Medical Director

University of Louisville School of Dentistry

John J. Sauk, DDS, MS
Dean

Theresa G. Mayfield, DMD
Associate Dean for Clinical Affairs

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