FEASIBILITY STUDY: MEDICAID SINGLE DENTAL BENEFITS ADMINISTRATOR

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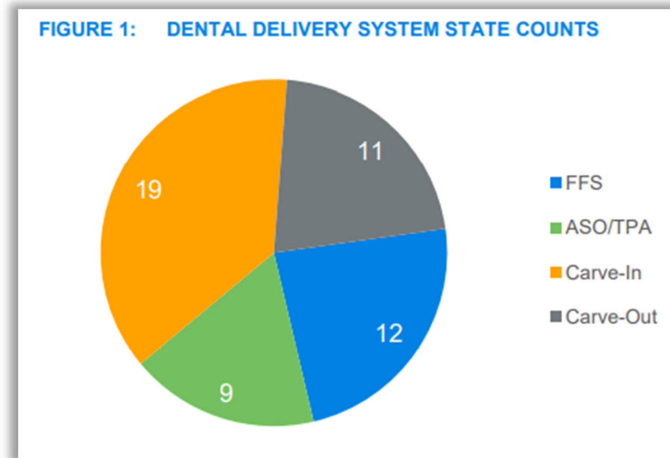
Section 1: Overview

The Mississippi Legislature directed the Mississippi Division of Medicaid (DOM) to conduct a feasibility study of adoption of a single dental benefits administrator for managed care Medicaid beneficiaries.[1] Managed care in Mississippi is delivered through two programs: the Mississippi Coordinated Access Network (MississippiCAN or MSCAN) and the Children's Health Insurance Program (CHIP). Currently, Mississippi delivers dental services to populations in these programs through a "carve-in" method, the details of which are further discussed in Section 3.



From: Milliman White Paper: Medicaid Dental Program Delivery Systems, page 2, Figure 1

A May 2020 white paper from Milliman presented an overview of current Medicaid dental delivery methods, as depicted in the chart from that paper herein.[2] As of the writing of the white paper, 12 states used fee-for-service (FFS) delivery, 11 used a carve-out method, 19 (including Mississippi) used a carve-in method, and nine used an administrative services organization/third-party administrator (ASO/TPA). For the purposes of this study, DOM focused on two methods: carve-in and carve-out. The rationale for that focus is discussed in Section 3.

It is the goal of this study to give the Mississippi Legislature and other stakeholders information relevant to deciding whether to adopt a single dental benefits administrator for Medicaid managed care beneficiaries at this time.

Section 2: Populations Covered

Managed Care in Mississippi is authorized through Miss. Code Ann. § 43-13-117(H)(7). Currently, there are two Managed Care programs in the State: MississippiCAN and CHIP. Both programs are statewide. These program delivery all services to Members, including dental care. MississippiCAN operates under the Mississippi Medicaid State Plan[3] and shares eligibility criteria with Fee-for-Service Mississippi Medicaid, with additional criteria as depicted in Tables

[1] *See* Miss. Code Ann. § 43-13-117(H)(9), in relevant part, "The division shall evaluate the feasibility of using a single vendor to administer dental benefits provided under a managed care delivery system established in this subsection (H)."

[2] Fontana, J., Hallum, A., & Lewis, C. (2020, May). *Milliman White Paper: Medicaid Dental Program Delivery Systems*, page 2, Figure 1. https://us.milliman.com/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx.

[3] Mississippi Division of Medicaid. *Mississippi Medicaid State Plan - Mississippi Division of Medicaid*. Retrieved from: https://medicaid.ms.gov/about/state-plan/.

1 and 2, below. CHIP operates under the Children's Health Insurance Program State Plan.[4] Eligibility criteria for CHIP is depicted in Table 3, below.

MississippiCAN Population

MississippiCAN is comprised of two (2) populations:

1. **Voluntary Population**: Members who have the option to disenroll and receive services through the Fee-for-Service delivery system, and
2. **Mandatory Population**: Members who may not disenroll and still receive Medicaid services. Assignment to this population depends on a Member's Category of Eligibility (COE) and age.

Table 1 specifies Medicaid populations that may voluntarily enroll in MississippiCAN. The Division will enroll eligible Members within these categories into MississippiCAN, and Members will have the option to disenroll within ninety (90) calendar days of initial Enrollment and thereafter during annual open enrollment periods.

Table 1. Voluntary Population: Populations Who Have the Option to Enroll

Populations Who Have the Option to Enroll	Age Categories*
SSI	0-19
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
American Indians	0-65
**The hyphen denotes "up to" the age listed. For instance, for SSI, the ability to optionally enroll ends on a Member's 19th birthday.*	

Table 2 specifies Medicaid populations that the Division enroll into MississippiCAN on a mandatory basis. These Members may voluntarily select or be automatically enrolled with a Contractor but may not opt out of MississippiCAN if they want to receive Medicaid services.

Table 2. Mandatory Population: Populations Who May Not Disenroll

Populations Who May not Disenroll	Age Categories*
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers	19-65
Medical Assistance Children (Populations other than those listed in Table 1)	0-19
**The hyphen denotes "up to" the age listed, and the categories run from birthday to birthday. For instance, for SSI, enrollment in MississippiCAN becomes mandatory on a Member's 19th birthday and ends on a Member's 65th birthday.*	

[4] Mississippi Division of Medicaid. *Children's Health Insurance Program (CHIP) State Plan - Mississippi Division of Medicaid*. Retrieved from: https://medicaid.ms.gov/childrens-health-insurance-program-chip-state-plan/.

CHIP Eligibility Criteria

CHIP eligibility criteria are based on citizenship, residency, age, and income requirements. Members must also meet additional requirements for enrollment as described below and in accordance with 42 C.F.R. § 457.305(a) and § 457.320(a), and the CHIP State Health Plan.

Table 3 specifies populations that must enroll in CHIP. The Division will enroll eligible Members within these categories into one of the Contractors participating in CHIP, and Members will have the option to disenroll or change Contractors within ninety (90) days of initial enrollment.

Table 3. Populations Who Are Eligible for CHIP

Populations*	Income Level
Birth - Age One (1) Year	194% FPL to 209% FPL
Ages One (1) - Six (6) Years	133% FPL to 209% FPL
Age Six (6) - Nineteen (19) Years	133% FPL to 209% FPL

FPL = Federal Poverty Level
**The hyphen denotes "up to" the age listed, and ages run from birthday to birthday. For instance, children in the Age 6 to Age 19 Population are eligible beginning on their 6th birthday and ending on their 19th birthday.*

Section 3: Dental Delivery Methods

In order to understand the implications of a single dental benefits administrator, DOM has assessed two of the above-referenced delivery methods: carve-in and carve-out. DOM also provides a brief summary of the other methods named above, clarifying the necessity of the focus on carve-in and carve-out.

Fee-for-Service and ASO/TPA

Fee-for-Service

Dental services are delivered in a pay-per-claim method. DOM's fiscal agent would handle claim processing and payment, and DOM's utilization management/quality improvement organization would conduct prior authorization activities. Mississippi Dentists have fewer points of contact, as they submit claims directly to DOM. However, the state cannot recoup a premium tax benefit for these services, and there is a lack of integration with medical care and other care management activities.

ASO/TPA

This method is a mix of FFS and a carve-out method (discussed below). The State would procure a vendor solely to administer dental benefits. Doing so would deprive the state of the benefit of the premium tax benefit, would only come after a long procurement cycle, and would not provide care management or quality management benefits. Providers would have the benefit of

simplicity in who they contracted with, but they would not have the potential for contracting above the FFS rate as they currently do with Managed Care vendors. This method adds an additional vendor for the state to manage without much benefit for any stakeholder.

Carve-Out and Carve-In

The best options for consideration are a carve-out or a carve-in. Both allow the state to continue to benefit from the premium benefit tax, and both come with the expectation of a focus on quality and quality improvement through care management and innovative value-based payment programs.

Carve-Out

Overview

Through this method, DOM would procure a dedicated dental managed care organization to administrate all aspects of managed care dental service delivery, mirroring the work done by current Coordinated Care Organizations (CCOs) as applied to dental care. It is the feasibility of this method that DOM has been directed to explore. Services include but are not limited to claims management, network recruitment and management, beneficiary services, care management, non-emergency transit, and appeals for both providers and beneficiaries.

To authorize the procurement of a DMCO, the Legislature would need to amend Miss. Code Ann. § 43-13-117(H) to allow for a separate managed care entity to delivery dental services, meaning DOM could not begin the process of procuring a DMCO until after the 2023 legislative session at the earliest. The decision to adopt this method hinges on whether there is evidence that it materially improves dental care and utilization. That matter is further discussed in Section 4.

Discussion

A single Dental Managed Care Organization (DMCO) can bring a more focused approach to dental care management. A DMCO also reduces administrative burden for dentists, giving them one entity with whom to contract and file claims. DMCOs are paid through a capitated rate, set and adjusted by actuaries.

There would be a lengthy procurement process, requiring several months of work to prepare, then several more to execute, followed by an implementation period, and a period of adjustment and transition from carved-in to carved-out dental managed care services. DOM would be tasked with management of an additional vendor, requiring the same detailed oversight as is given to managed care organizations on a smaller scale. DOM would require the assistance of an actuary to set and adjust rates as needed.

Burden would also shift to Members, potentially causing more confusion. They would need to understand that their dental benefits were separate, necessitating thorough education regarding whom to contact if they have a customer service issue or a grievance or appeal. They would benefit from the fact that all dentists would be part of a single network, but they would not benefit from the care integration that comes with a managed care plan providing care management for all medical issues instead of a single service.

Separating the care management of dental care from other medical care limits the value of care coordination. DOM created an aggressive care management policy for its next-cycle contract, and it would be to the benefit of the state to allow that strategy time to be implemented before partitioning services. Additionally, in the next-cycle CCO contract, DOM has aimed to reduce administrative burden on multiple stakeholders through the joint administration of the CHIP and MSCAN programs. The addition of another managed care program could offset the administrative gain made by combining oversight of the MSCAN and CHIP programs.

Carve-In

Overview

This is the method currently used for the managed care population in Mississippi. Each CCO handles all aspects of dental service delivery, with each using a subcontractor to do so. They receive payment for this work through their capitated rate, set by actuaries, that covers all services, including but not limited to the services listed in the Carve-Out Overview, above.

Discussion

Through the most recent Coordinate Care procurement, Offerors were asked specifically about their dental services, and all supplied answers to dental questions about experience in delivery of services, innovative methods that the Offeror would bring to dental care, and how the Offeror would approach disparities in delivery of services (something especially relevant in a state with a large rural population).[5] Each Offeror supplied answers to these questions, committing to prioritize dental healthcare. Once final contracts are executed, DOM plans to collaborate with contracted CCOs about their dental strategies, utilizing value-based payment and care management, which integrates dental and medical care, to ensure that costly social determinants of health issues are addressed by the MCOs. VBP can be used to drive Practice-Level Oral Health Reforms[6] through primary care, especially for children through their EPSDT screening visits. This level of integration is most easily supported through a unified MCO delivery system.

Section 4: Key Factors for Consideration

The following gives an overview of three key factors to consider in assessing whether to adopt a DMCO.

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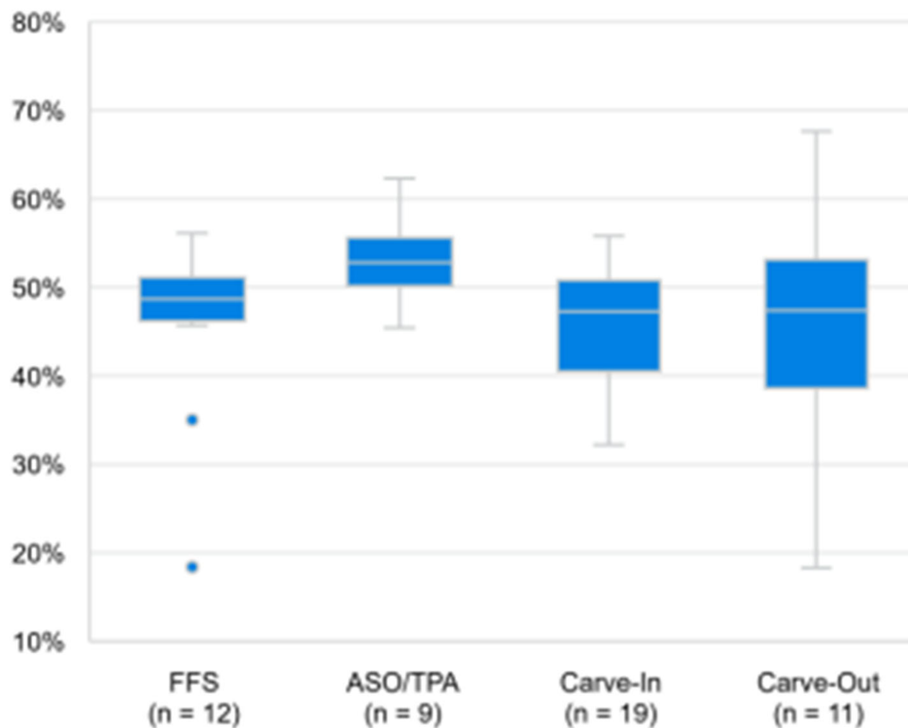
[5] Mississippi Division of Medicaid. (2021, December). *Mississippi Division of Medicaid Coordinated Care Request for Qualifications*, page 46. Retrieved from: https://medicaid.ms.gov/wp-content/uploads/2021/12/DOM-CCO-Procurement-RFQ-No.-20211210.pdf.

[6] Chazin, S., & Crawford, M. (2015, May). *Oral Health Integration in Statewide Delivery System and Payment Reform*. Center for Healthcare Strategies. https://www.chcs.org/media/Oral-Health-Integration-Opportunities-Brief-052516-FINAL.pdf.

Utilization

Utilization is a measure of success for Medicaid dental care. In the same Milliman white paper referenced above, Milliman assessed the pediatric utilization rate across Medicaid dental delivery systems. All systems delivered similar results, and carve-in and carve-out systems showed nearly identical levels of utilization.[7]



From: Milliman White Paper: Medicaid Dental Program Delivery Systems, page 3, Figure 3

As the box plot shows, the medians for carve-in and carve-out are virtually identical. Carve-out has a wider range of values, while carve-in has a more consolidated range of values, even though the sample size for carve-in is larger (n=19 versus n=11 for carve-out), indicating that the carve-in method may have more predictable results across applications.

Cost

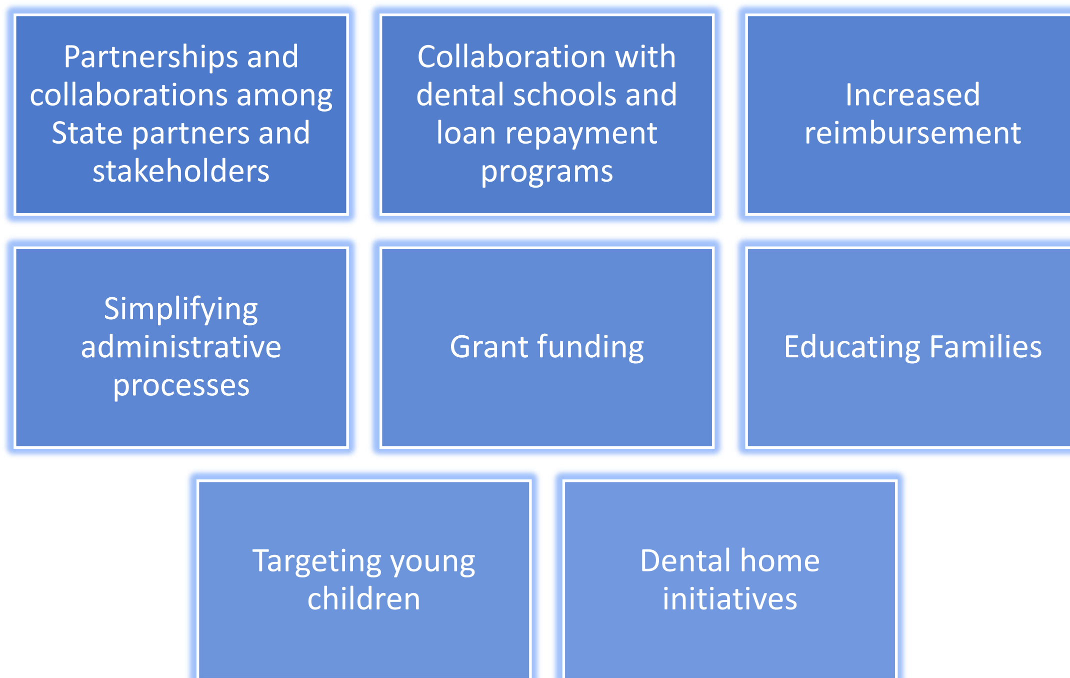
There are no known studies available on the cost of carve-in versus carve-out. However, the administrative investment required for carve-out would be higher than the current administrative carve-in cost out of necessity. Actuarial costs would have to be assessed for a DMCO, with separate expense for setting and resetting rates. There would also be a need for additional governmental oversight specific to the DMCO, which could offset the anticipated gains to be

[7] Fontana, J., Hallum, A., & Lewis, C. (2020, May). *Milliman White Paper: Medicaid Dental Program Delivery Systems*, page 3, Figure 3. Retrieved from: https://us.milliman.com/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx.

made through the administrative consolidation of the MSCAN and CHIP contracts during the next CCO contract cycle.

Quality

In 2011, CMS conducted a study of eight states, exploring ways to improve dental Medicaid delivery.[8] The study found eight leading methods for improvement of services:



Adoption of a DMCO would simplify the administrative process from its current state. However, several other methods are available to both DMCOs and CCOs: Partnerships and collaborations among State partners and stakeholders, educating families, targeting young children, and dental home initiatives.

Both DMCOs and CCOs can use care management to provide Members with education about the importance of dental care. They can both also use Member information to target and tailor that education to young children and their families. Both CCOs and a DMCO can also be required to collaborate with stakeholders as needed.

As to dental home initiatives, the delivery of these services would differ based on whether a DMCO or a CCO were administrating services. In the next-cycle CCO Contract, CCOs are required to develop Patient-Centered Medical Homes tied to a Value-Based Purchasing program. A PCMH requires primary care physicians to act as the "quarterback" of a patient's entire care, from medical needs to mental, dental, and vision, coordinating with other providers to ensure

[8] Medicaid.gov. (2011, January). *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).* Retrieved from: https://www.medicaid.gov/sites/default/files/2019-12/8statedentalreview.pdf.

that all of the patient's health needs are met. This would include ensuring that the patient had a regular dentist, or a "dental home."

A Dental Medical Home is defined as, "…the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way."[9] The American Association of Pediatric Dentistry states that, "Children who have a dental home are more likely to receive appropriate preventive and routine oral health care, thereby improving families' oral health knowledge and practices, especially in children at high risk for early childhood caries."[10] However, referral to a dental home is often made by a primary care doctor. A dental home alone, which is what would be required of a DMCO, does not provide for the same level of integrative care and service delivery as a PCMH, as it is only there to provide dental services.

Section 5: Conclusion

A DMCOs is feasible. The legislature can direct DOM to adopt this method through amendment to Miss. Code Ann. § 43-13-117(H)(7), and DOM can run a procurement and implement the vendor. However, without clear evidence of potential savings from the process, and without evidence that adoption of the delivery method produces higher quality results, it is in the best interest of the state to allow DOM to implement its next-cycle CCO contracts, after contract execution, with dental remaining carved-in.

If the legislature directed DOM to seek a DMCO in the next session, it would be Summer 2024 before the agency could realistically make award, which would put implementation after the expected operationalization period of the next-cycle CCO contract. That timeline does not consider the likelihood of the long delay of implementation for the DMCO due to protest of the award, as is now standard for managed care contracts nationally. The state is better served by allowing the next-cycle CCOs to implement their new care management, Social Determinants of Health, and Value-Based Purchasing policies and evaluating the success of those policies as applied to dental care after three operational contract years. If the state does not see measurable improvement and deems it necessary to explore the use of a DMCO after having clearer data about whether new CCO initiatives are improving dental care and costs, then there would be both a data-driven basis for procuring a DMCO and time to ensure that the operationalization of a DMCO would align with a new CCO Contract period, which would lessen confusion among CCOs, beneficiaries, and providers.

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[9] Rural Health Information Hub. (2019). Rural Oral Health Toolkit: Dental Home Model. Retrieved from: https://www.ruralhealthinfo.org/toolkits/oral-health/2/dental-home-model.

[10] American Academy of Pediatric Dentistry. *Policy on the dental home.* The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2021:43-4. Retrieved from: https://www.aapd.org/globalassets/media/policies_guidelines/p_dentalhome.pdf.