MEMORANDUM

DATE: November 21, 2018

TO: Representative Richard Raymond, Chair House Human Services

FROM: Mr Jess Calvert and Ms Diane Rhodes

SUBJECT: Dental Services: Medicaid and Children's Health Insurance Program

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Overview

The Texas Dental Association (TDA) is the largest dental association in Texas, representing a majority of dentists participating in Texas' Medicaid and the Children's Health Insurance Program (CHIP).

Texas is currently the national leader for Medicaid and CHIP dental programs.

- According to the most recent Centers for Medicare & Medicaid Services (CMS) 416 report (2017), 69.22% of Medicaid or CHIP enrolled children had a dental visit in the past 12 months. This is higher than the national average of 50.4%. Texas has steadily trended upward since 2007 (2007: 52.1%; 2017: 69.22%).

- If you rack and stack that data, Texas has the highest Medicaid/CHIP dental care utilization in the United States.

- Texas also has a higher than national average of dentists participating in Medicaid/CHIP (national 38%, Texas 47.9%).

- 96% of the children in Medicaid and CHIP have access to a Medicaid/CHIP enrolled dentist within 15 minutes.

- Dental care utilization among Medicaid-enrolled children is higher than among children with private dental benefits.

- In 2014, 48% of Texas dentists participated in Medicaid. The national average was 42%.

Texas must continue to capitalize on its unprecedented success. To help with the state's efforts, TDA intends to continue working with the legislature and the Texas Health and Human Services Commission (HHSC) to improve dental service delivery models and maintain an appropriate number of actively participating dentists to meet the oral health needs of all program members.

Although Texas is the national leader in Medicaid and CHIP dental programs, it still needs to improve access to comprehensive dental care—especially preventive oral health care, which will save Texas money in the long-run by helping members avoid more costly dental treatment. A strong dental program not only saves the state money, it saves the lives of Texas' children by helping them to avoid dangerous disease progression that can lead to death, as was the case in the devastating story of Deamonte Driver in Maryland.

After an exhaustive review of the state's current dental delivery models, TDA presents the following targeted comments to improve members' access to Medicaid and CHIP dental services in Texas. These comments are designed to (1) improve the oral health of Texas' children enrolled in Medicaid and CHIP, and (2) address deficiencies and build upon successful aspects of Texas' dental service delivery models.

Dental Managed Care in Texas

1. Adequately reimbursing Medicaid dentists to market-based levels.

Medicaid fees paid to dentists have not increased since 2007. Prior to that, there had been decades of cuts and then partial restorations of program funding. In fact, HHSC recently cut 2.5% in fees for all therapeutic dental services. While Medicaid dental program enrollment growth continues to trend upward, the state expects dentists to care for more enrollees with less money. Low reimbursement rates are one of the most significant barriers to dentist participation in Medicaid and CHIP which strains member access to dental care.

Right now, Medicaid dental fees fail to cover the actual costs of delivering care. Medicaid participating dentists are in the position of trying to determine how to keep their doors open and continue treating children in their communities while managing Medicaid's financial shortcomings. Adequate Medicaid reimbursement rates are a crucial part of sustaining a viable Medicaid dental program.

TDA asks for an increase in Medicaid dental general revenue funding earmarked specifically for increases in dentist reimbursement rates. Without adequate reimbursement rates, dentists may be forced to leave Medicaid, which will jeopardize the dental health of the state's most vulnerable populations.

TDA asks that HHSC maintain authority in setting the minimum fee-for-service reimbursement rates for covered services and strongly encourage the DMOs to set competitive, market-based reimbursement rates for provider dentists. HHSC should encourage DMOs to exceed the minimum reimbursement rates paid to dentist providers as incentive for long term improved oral health outcomes.

The state must mandate that DMOs define in their provider contracts if they are using the Texas Medicaid Fee Schedule or another source for reimbursement purposes. Fee transparency is unquestionably essential for dentist providers to operate the business functions of their dental practice.

TDA strongly asks that HHSC prevent DMOs from implementing significant, non-negotiated, across-the-board reimbursement rate reductions *without* first gathering TDA's input.

Additionally, since fees are such important parts of the dental services delivery model, TDA asks that provider dentists receive 90 calendar days' written notification, instead of 30 calendar days' written notice, from the DMOs prior to any change in fees. Fee changes directly impact the dentist provider's ability to manage their office finances.

2. Eliminating arbitrary, confusing, and at times conflicting administrative requirements.

In addition to stagnant Medicaid dental fees, Medicaid dentists are also stressed by arbitrary, confusing, and at times conflicting administrative requirements.

For example, dentists struggle with prior authorization differences between the dental managed care organizations (DMOs). The DMOs appear to use prior authorization as a means of both controlling their own costs and attempting to prevent waste, fraud, and abuse program wide.

DMOs have access to the necessary data to individually review dentists and address possible waste, fraud, and abuse issues instead of applying across the board prior authorization mandates that impact every dentist in their network.

TDA asks that DMOs agree upon evidenced-based practices developed by the dental community to identify and standardize prior authorizations for certain dental services. This includes clearly written guidelines explaining when prior authorization for services is required. DMOs' prior authorization and utilization review processes must include the use of dentists with appropriate clinical expertise/specialty in treating the members' condition or disease. It is absolutely unacceptable for DMOs to use non-dentist staff, or, even worse, an automated computer system to make prior authorization determinations. Both lack the education and clinical expertise to make such crucial treatment decisions on behalf of the DMO.

It is extremely helpful for dentist providers when DMOs implement the same prior authorization requirements. Allowing DMOs to have different authorization practices increases administrative burdens for dentist participating in the *Texas Dental Program*. According to HHSC's Rider 60/61 report, the agency and the Texas Department of Insurance "… have plans to work together on aligning requirements regarding prior authorization and timeliness to notify requestors of prior authorization determinations for members under 21 years of age." TDA is very supportive of aligning requirements.

Utilization Management and Provider Manuals

TDA strongly asks that HHSC require that DMO utilization management decisions only be made by Texas-licensed dentists. Office staff can never be sufficiently trained to the same level of clinical expertise as a dentist.

TDA strongly asks the state to limit DMOs' provider manual changes to once every 6 months. Right now, DMOs are constantly changing processes and requirements within their systems. Thus, provider manuals are continuously changing. This is confusing and frustrating for dentist providers. Especially those dentist providers that are contracted with more than one DMO.

3. Securing the dentist-patient relationship by maintaining main dentist.

Texas must maintain the integrity of the dentist-patient relationship to ultimately achieve high-quality care. Patients must either self-select or be assigned to an individual dentist as their "main dentist" and not a dental practice.

In Texas, Medicaid and CHIP members must be the patient of an individual licensed by the state of Texas to practice dentistry. Thus, members are legally prohibited from being the patient of a dental support organization or dental corporation (Texas Occupations Code §§251.003, 256.001, 258.051, 258.952).

Compounding legal concerns, Texas must also consider the strong policy arguments in favor of maintaining the existing main dentist requirement. With the existing main dentist requirement, the member's oral health care is delivered in a complete, accessible and family-centered manner by a Texas-licensed dentist. An overwhelming majority of clinical evidence states that in order to make long-lasting substantive improvements in the dental health outcomes of children, coordinated preventive and comprehensive dental care must be delivered by the dentist in the dental home.

TDA believes that HHSC can improve upon the main dentist concept by more carefully noting when a member has an established history with a dentist (ie, dental home), and situations in which a dentist serves as the main dentist to other family in the member's household.

TDA continues to hear complaints about the accuracy of the enrollment file(s) and the sharing of that file with the DMOs. HHSC needs to make improvements in this area so that the file(s) are correct and electronically transmitted to the DMOs in a timely manner.

The present definition for main dentist (HHSC Dental Contract Terms & Conditions, V 1.15) is as follows: "A provider who has agreed with a Dental Contractor to provide a Dental Home to members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists."

In light of the main dentist requirement, the state should set an established percentage of dental care (eg, 90%) that must be provided to the member by the main dentist. Patients should not be shuffled among dentists in a practice. This defeats the entire purpose of main dentist.

In order to be a main dentist, the treating dentist must agree to provide a dental home to members and be responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. A treating dentist can only meet this definition if they are physically in the dental office, available to treat patients.

Therefore, the state needs to require DMOs to mandate that main dentists be physically present at office locations in which they are being identified as a main dentist. Additionally, the state should limit DMOs to assigning patients only to main dentists that are directly available to treat patients a minimum of 16 hours per week.

TDA asks that Texas hold the DMOs accountable to the definition of main dentist and assess penalties against a DMO when it does not follow the contract requirements for main dentist. Furthermore, the state must mandate that the DMOs rigorously enforce the requirement that the individual main dentist provide timely care to members.

4. Preventing illegal Medicaid solicitation.

Illegal Medicaid solicitation remains a considerable problem. When TDA's past president visited the Laredo Dental Society, they identified illegal Medicaid solicitation as their #1 problem. Medicaid dentists that diligently comply with federal and state solicitation regulations are being overrun by unscrupulous dental offices preying upon unsuspecting parents and care-givers by offering lucrative inducements as a ploy to lure patients to their particular dental practices.

Solicitation violation examples from the Office of Inspector General (OIG) include: (1) hiring drivers to canvas neighborhoods looking for Medicaid eligible children and paying those drivers based on the number of children transported for services; (2) advertising on websites, "Free transportation provided by our friendly drivers."; and (3) giving gift cards and other financial inducements to parents and care-givers who bring Medicaid-eligible patients into specific offices for treatment.

TDA is in ongoing discussions with OIG, HHSC, and the DMOs about how best to prevent illegal solicitation. Texas already has the ability to exclude providers from Medicaid for solicitation violations. However, better coordination and enforcement is needed between OIG, HHSC, and the DMOs.

Dentist providers that repeatedly refuse to adhere to the solicitation regulations should face administrative sanctions and possible exclusion from the *Texas Dental Program*.

HHSC must require DMOs to identify and take meaningful steps to prevent illegal Medicaid solicitation by network dentists. HHSC must also communicate to DMOs that they will not be penalized for removing bad actors from their networks.

Update: Following a meeting TDA had with the inspector general and her team in August, OIG formed an internal agency workgroup with HHSC to review dental issues. Current status of the recommendations brought by TDA to OIG in August are noted below.

1. The OIG/HHSC workgroup is looking at the feasibility of including an attestation for a regulatory program assessment, including a section on illegal Medicaid solicitation, that Medicaid dentist providers will be required to complete when enrolling for and renewing their Texas Provider Identifier Number. The workgroup will share its recommendations with TDA when they are finalized.

2. Although OIG declined to develop and implement a Medicaid program regulatory assessment for clients, OIG did offer TDA an opportunity to submit content suggestions for the client Medicaid enrollment package regarding fraud, waste, and abuse. TDA intends to submit illegal Medicaid solicitation content to OIG at the first of 2019.

3. Contrary to TDA's suggestion, OIG is not considering specific statutory language to prevent illegal Medicaid solicitation. OIG responded to TDA that it has current statutory authority to assess penalties related to program violations.

The ongoing number of statewide complaints about illegal Medicaid solicitation demonstrates that OIG appears unable to stop it. Strong statutory prohibitions and sanctions by the legislature send a clear message to potential violators that this behavior will not be tolerated.

4. Although OIG does not currently have a presentation on illegal Medicaid solicitation planned for the Texas District & County Attorneys Association (TDCAA), the agency regularly gives educational presentations and will ask TDCAA if a presentation on this topic interests them.

5. OIG is currently working with HHSC to create a Medicaid solicitation flyer that can be downloaded from the agency's website and shared by dentists with local business in their community to help educate business to refuse participation in illegal Medicaid solicitation activities. OIG is also working on a letter than can be given to dentist providers.

6. Due to its limited resources, OIG refused to implement a statewide public relations campaign on illegal Medicaid solicitation. Instead, the agency is developing the flyer and letter as stated above.

7. OIG refused to create regional dentist taskforces that could assist the agency in gathering factual information about Medicaid program violations including Medicaid solicitation. Instead, OIG asked that dentist providers, their staff, and the public report suspected fraud to the OIG hotline.

8. TDA and OIG are partnering on a series of articles on illegal Medicaid solicitation and other waste, fraud, and abuse topics for publication in the Association's newsletter and dental journal. These articles are intended to notify the dental community that illegal solicitation, overtreatment and inappropriate treatment will not be tolerated.

TDA asks Chair Raymond to help prevent illegal Medicaid solicitation in Texas.

5. Maintaining state authority to make Medicaid dental policy.

TDA supports retaining the state's singular authority to make dental policy. DMOs must be held accountable for adherence to Texas' program policy decisions.

TDA strongly feels that only the state, in conjunction with dental stakeholders including dentists and academia, should make any changes in medically necessary covered dental services. Such determinations must not be left to the will of the DMOs. This contravenes the state's singular authority to make dental policy.

6. Improving state oversight of dental managed care organizations.

TDA asks that Texas determine whether HHSC requires more resources for DMO oversight. Poorly performing DMOs/dentists should be penalized appropriately, and well performing DMOs/dentists should be rewarded.

TDA remains deeply concerned about the extensive staff turnover continuously occurring in HHSC's Managed Care Operations and Compliance division. DMOs must be held accountable for failures to perform under the contract.

More than once, it was TDA and not HHSC that identified and brought to the state's attention a DMO's contract failures. HHSC's performance review of DMOs must be completed at reasonable intervals to ensure program compliance. HHSC must exercise diligent oversight so that members receive medically necessary dental services and dental neglect is eliminated.

7. Preventing dental managed care organization conflicts of interest.

TDA considers it an unacceptable conflict of interest for a Medicaid/CHIP DMO, operating under contract with Texas, to own and operate dental clinics. It is TDA's understanding that a subsidiary of DentaQuest has an ownership interest, or at one time had an ownership interest, in "Community Dental Care" in the Dallas area (Forbes, August 20, 2015). This causes a number of potential problems including possibly unfairly steering patients to their clinics. This also appears to be a contract violation under (HHSC Dental Contract Terms & Conditions, V 1.15, Section 13.03 Organizational Conflicts of Interest).

TDA strongly asks the state to prohibit such conflicts of interest.

8. Creating workable value-based purchasing/alternative payment models for dentists.

TDA understands that one of the state's goals is to move away from fee-for-service delivery models into value-based purchasing models. Dentistry wants to see patients become better stewards of their oral health, and value-based incentive programs are one means of engaging patients.

TDA regularly meets with HHSC' quality team to discuss value-based purchasing as it applies to dentistry, but the Association continues to have concerns.

TDA asks that HHSC take into account the unique aspects of dentistry (eg, the limitations imposed by periodicity schedules) when aligning incentives.

TDA asks the state to recognize the traditionally low reimbursement rates paid to dentists and prevent value-based payment structures from further eroding provider payments. Also, dental billing is driven by individual procedure codes in very specific detail for the procedure(s) performed (ie, Code on Dental Procedures and Nomenclature). This is very unlike medicine.

TDA asks that the state prohibit provisions of Pay-For-Performance or other third-party financial incentive programs from interfering with the patient-dentist relationship by injecting factors unrelated to the patient's needs into treatment decisions. Treatment plans can vary based on a clinician's sound judgment, available evidence and the patient's needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans.

TDA asks that the state prohibit value-based payment models from discouraging dentists from treating complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases. Value-based purchasing cannot be utilized by the DMOs to incentivize patient neglect.

TDA asks that the state mandate the DMOs to implement value-based payment systems consistently.

TDA strongly requests that HHSC better define provider incentives within this section as it pertains to state protections. For example, if a DMO has offices associated through some sort of corporate association or ownership, there may be a conflict of interest both in the assignment of members and the awarding of incentives.

9. Assuring adequate patient access to dentists in the dental managed care delivery model.
There must be a sufficient number of general and pediatric dentists willing to accept new patients and fully participate in the Medicaid and CHIP dental programs. This ensures an acceptable proximity of general dentists and specialists to members, with reserve capacity for new member growth.

TDA asks that the state require the DMOs to allow any willing dentist to participate in their network.

DentaQuest already closed panels in Houston and Dallas for general dentists. According to information shared by DentaQuest with TDA, general dentists are only allowed to join a group in those areas if they are replacing a provider who left. Any new dental office or addition to current general dentist staff are not allowed in DentaQuest's Dallas and Houston networks unless there is critical access need that is approved by DentaQuest's Texas leadership.

Since TDA spends considerable effort to recruit and retain Medicaid and CHIP dentist providers, the Association strongly advises the state to prevent DMOs from closing dentist provider panels which prevent willing dentist providers from entering and participating in the dental program. Instead of limiting credentialing of willing dentist providers, TDA respectfully suggests that HHSC direct the DMOs to robustly recognize and remove bad actors from its panels and ensure that dentists credentialed as main dentists do in fact meet the definition of main dentist as stated in the program contract and applicable rules.

TDA asks that the state and HHSC understand the need to remove bad actors from the DMOs networks and to take that need into account when reviewing a DMO's network adequacy. More harm will come to enrolled children from the actions of bad actors than by possibly having to temporarily travel outside of the travel guidelines and appointment standards defined in the RFP to access a dentist.

TDA cautions the state to move thoughtfully and deliberately if considering teledentistry options within dental managed care. Stakeholder input is essential. Teledentistry is a complex process in which numerous factors at individual, infrastructure and organizational levels are involved. Teledentistry is a very new alternative delivery model presenting unique challenges for dentistry.

10. Requiring accurate DMO rosters.

TDA asks that the state mandate DMOs to keep accurate network rosters. This includes the "find a dentist" roster that is accessed by members and the "referring dentist" roster that is accessed by main dentists needing to refer a member to a dental specialist. The current DMOs have rosters that are a bloated, confusing mess of dentist providers' contact information.

Regarding the find a dentist roster, certain dentist providers are listed as a main dentist for locations in which it is logistically improbable for them to practice as a main dentist. Meaning, for example, that a dentist provider lives in Houston, but is shown in the roster as a main dentist for dental practices in Laredo, Mt Pleasant, El Paso, etc. The listing of main dentists in the roster should be limited to 3 locations.

Regarding the referring dentist roster, some provider dentists are listed upwards of 20 times at the same location/multiple locations while other dentists are listed only once at one location.

11. Requiring a Texas-licensed dental director for each dental managed care organization.

It is integral to the successful delivery of dental services that the DMOs be required to have a full-time, Texas-licensed dental director.

TDA asks that the state require the DMOs to have dental directors that are Texas-licensed dentists in good standing with no restrictions or other licensure limitations. Dental directors must have clinical practice experience treating Medicaid and CHIP members. Preferably, dental directors would have treated both populations in Texas. This expertise is needed for the DMOs to understand the Texas Dental Practice Act and Texas State Board of Dental Examiners' regulations impacting standard of care.

12. Requiring a suitable medical loss ratio.

TDA asks that HHSC establish a loss ratio/benefit distribution requirement for the dental managed care delivery model. This will require the DMOs to maximize the portion of program expense spent for direct delivery of dental services. This is an important incentive for insurance companies to improve efficiency and to help ensure that members receive the medically necessary dental services that are legally entitled to receive.

To monitor the loss ration/benefit distribution, Texas must require reports from the dental managed care organizations detailing administrative expenses versus expenses spent toward members' clinical care. At least 85% of the contracting fee should be used to directly offset the cost of providing direct patient care and expenditures for activities that improve health care quality. No more than 15% of the contracting fee should be spent on administrative costs (CMS federal medical-loss ratio; 42 CFR Parts 431, 433, 438, 440, 457 and 495).

13. Calculating DMOs experience rebate.

TDA asks that HHSC ensure DMOs do not defer net income before taxes into employee bonuses or other type payments as a means of inaccurately presenting total revenue for the purposes of calculating the experience rebate.

14. Mandating dental stakeholder input.

TDA asks that HHSC convene a consensus panel among provider dentists, dental professional organizations, and DMOs to catalog and evaluate evidence-based innovations with the intent of adopting the best of these solutions into the Texas dental managed care program.

15. Continuing TDA quarterly meetings with HHSC and DMOs.

TDA asks that the state require HHSC and the DMOs to continue the Association's established quarterly meeting protocol. These quarterly meetings, called by TDA, have consistently taken place since the start of the state's first managed care dental contract.

HHSC stopped hosting statewide dental stakeholder meetings in approximately 2017. As a result, the quarterly meetings between TDA, HHSC, and the DMOs serve as one of the only opportunities for the needs of participating dentists to be addressed and problems with the delivery system resolved.

16. Applying the Medicaid dental necessity definition in statute.

TDA asks that the state's medical necessity definition be augmented to include the definition for Medicaid dental necessity found in Human Resources Code §32.053, Dental Services. "Dental necessity for a dental service or product is based on whether a prudent dentist, acting in accordance with generally accepted practices of the professional dental community and within the American Dental Association's Parameters of Care for Dentistry and within the quality assurance criteria of the American Academy of Pediatric Dentistry, as applicable, would provide the service or product to a patient to diagnose, prevent, or treat orofacial pain, infection, disease, dysfunction, or disfiguration.

A dental service or product may not be provided under the medical assistance program unless there is a dental necessity for the service or product."

17. Retaining independent Medicaid dental program.

Dental services must remain an independent Medicaid program and not be a subcontracted part of members' Medicaid/CHIP medical plan. The state's contracts for medical and dental services must remain separate. This approach best supports open communication with the DMOs and Medicaid and CHIP participating dentists.

18. Selecting a reasonable number of dental contractors.

TDA strongly asks that, although HHSC may select 2 or more dental contractors, the state continue using preferably only 2 contractors, with an absolute maximum of no more than 3.

The data clearly shows that Texas became the national Medicaid and CHIP dental leader using only 2 DMOs. There is no advantage compared to the confusion and frustration members and dentist providers will experience if the state adds contractors.