Dental TPA RFI Responses

(RFI-MQD-2021-012)

- **DentaQuest**
- **HDS**
- **Liberty Dental**

Introduction

DentaQuest appreciates the opportunity to respond to the Dental Third Party Administrator (TPA) Services for the State of Hawaii Medicaid Population, Request For Information No. RFI-MQD-2021-012.

As the largest Medicaid dental benefit administrator (DBA)/dental managed care organization (DMO) in the country serving nearly 23 million Medicaid recipients across 21 states, DentaQuest respectfully offers its insights into industry trends, coupled with its firsthand experience (serving as a major subcontractor to Hawaii Dental Service for the bulk of its operational functions from 2013 through 2015), to inform the Department of Human Services (DHS), Med-QUEST Division (MQD) on ways it could improve its dental program.

Like most states in the country, Hawaii and its residents have been hit hard by the COVID-19 pandemic. States are simultaneously facing compressed budgets and higher Medicaid enrollment. We understand that Hawaii is facing an unprecedented budget shortfall coupled with the highest rate of unemployment nationally.

While the Medicaid dental benefit is one piece of the state's overall Medicaid budget, we are confident that the ideas presented in this RFI response can yield meaningful savings, while increasing access to care. The ideas we present are not theoretical – we have implemented them across several states successfully, and would welcome the opportunity to share more information with Hawaii, and/or conduct a deeper dive analysis into your claims expenditures to quantify tangible savings available to Hawaii.

Understanding and Defining the Three Core Dental Delivery Models

Before we delve into our recommendations, we believe it is important to define the three dental delivery models employed across the country at a macro level, as well as industry trends across these models. The three models include:

- Carve in model: State carves dental benefit into its comprehensive risk-based contracts with managed care organizations.
- Carve out model: State creates a separate budget and program for its Medicaid dental benefit and contracts directly with DBAs or DMOs. This model has been used in Hawaii since 2013.
- Fee for service model: State pays for and administers the dental benefit itself.

Figure 1 on the next page delineates some of the key nuances between the models.

Figure 1: Different Medicaid dental delivery models

	FEE-FOR-SERVICE MODEL	DENTAL CARVE IN MODEL	DENTAL CARVE OUT MODEL 40% of all states employ this model	
			ASO carve out	Capitated carve out
Percentage of states using model	27%	33%	Among states employing carve out – 48% use ASO model	Among states employing carve out – 52% use capitated model
Delivery system definition	State administers its own Medicaid dental in-house using agency staff.	Dental is included as part of the state's overall Medicaid managed care program. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services including dental through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.	The Medicaid dental benefit is carved out of the overall state Medicaid budget. The administration of the program is handled by a DBA (see definition below) that accepts a set per member per month payment to cover the administrative services only expenses of the program.	The Medicaid dental benefit is carved out of the overall state Medicaid budget. The state contracts with a single or multiple DMO(s) (see definition below) that accept a set per member per month payment covering the cost of administrative services, as well as claims cost (also referred to as the "financial risk" or "cost of care" of a program).
Key terminology used within this model	N/A	Managed care organization (MCO): Companies contracted directly with the state to manage a comprehensive Medicaid program. Dental benefit administrator (DBA): In the context of this model, a DBA is an organization that an MCO may subcontract with to administer the dental portion of the managed care contract.	Dental benefit administrator*: In the context of this model, a DBA is an organization that contracts directly with the state agency to administer the carved out dental benefit. The DBA is not accountable for managing claims costs.	Dental managed care organization (DMO)*: A company that contracts directly with the state agency to provide for the delivery of Medicaid dental benefits.
Responsible for administering dental benefit	State	MCO or DBA	DBA	DMO
Number of organizations managing dental benefit	One	Varies by state. For example, in Arizona three of the MCOs manage dental in-house, and the other four subcontract to DentaQuest.	One	One to three
Responsible for claims costs	State	MCO or DBA depending on contract terns between the two entities.	State	DMO
Contracts with the provider network	State	MCO or DBA depending on contract terns between the two entities.	Per state's discretion could be state or DBA.	DMO
Financial contracting arrangement	N/A	ASO or capitated between MCO and DBA	ASO	Capitated

*An organization such as DentaQuest is both a dental benefit administrator and a dental managed care organization depending on what financial contracting arrangement they have with their clients. Many times, these terms are used interchangeably.

As noted in Figure 1, today, 40% of states provide their Medicaid dental benefits through a dental carve out. Furthermore, in the last decade alone, 10 states have moved to this model; four of which moved their dental program out of the state's overall managed care program to a carve out model (Figure 2). In addition, the state of Oklahoma will be moving to a capitated dental carve out later this year.

Dental Carve Outs: ASO vs. Capitation

As noted in Figure 1, within the dental carve out model, we can further delineate between two program types: an ASO carve out versus a capitated carve out. Both of those models are defined above. What's important to note here is that since 2010, 80% of states that have moved to a dental carve out model have done so using a capitated financial arrangement. Prior to 2010, it was the exact opposite – 80% of states contracted with DBAs under an ASO financial arrangement.

Figure 2: States that moved to dental carve out in past decade

State	Carve out model	Number of DBA/DMOs managing dental carve out		
		One	Two	Three
Arkansas	Capitated		✓	
Colorado	ASO	✓		
Florida	Capitated			✓
Hawaii	ASO	✓		
Louisiana	Capitated		✓	
Michigan	Capitated		✓	
Nebraska	Capitated	✓		
Nevada	Capitated	✓		
Texas	Capitated			✓
Utah	Capitated		✓	
Oklahoma	Capitated	Award pending; go-live 9/1/2021		

It's important to recognize the evolution of the dental carve out throughout the past two decades to fully understand why states have moved to the fully capitated structure.

2000 – 2009: Focus on Administrative Efficiencies

Did You Know?
Since 2014, no state that chose to move to a dental carve out has selected the ASO financial structure.

Early state adapters of the dental carve out model were focused on improving core administrative functions such as claims processing efficiencies, and increasing provider participation as a means to increase access to dental care. Several states, such as Illinois, Tennessee, and Massachusetts were subject to class action lawsuits due to non-compliance with EPSDT requirements specific to dental care. The dental carve out model was widely acknowledged as the approach that could help states address very complex challenges. Near the end of the decade, states became increasingly focused on efforts to improve overall utilization of dental services.

2010 – 2014: Focus on Triple Aim

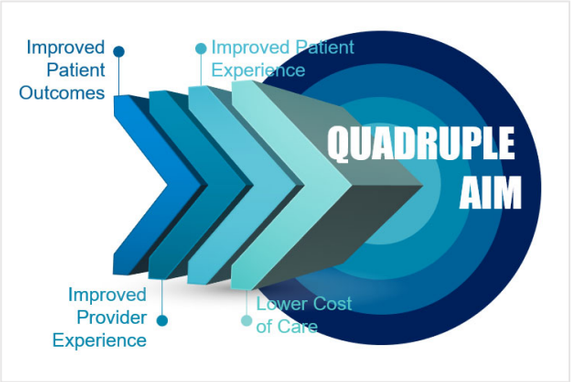
As the decade turned, so did the expectations of states. State agencies started looking to their dental partner to strike the right balance between core administrative services and creative ways to improve quality and manage costs. It was the beginning stages of a trend in which states focused on achieving the Triple Aim – the simultaneous pursuit of better health outcomes, reducing costs, and improving the patient experience.

States began leveraging best practices from their Medicaid managed care programs to create similar program structures for their carved out dental programs. They began viewing and treating their DBAs as managed care plans, and as such, shifted all of the program costs – both administrative and claims costs – to their dental partner. Thus the

idea of “dental managed care” came to be. Just as states do with their MCOs, the DMOs were expected to achieve the desired results within the set capitated rate.

2015 – Today: Focus on Quadruple Aim

This leads us to the most recent few years, where states have again evolved based on new goals. Today the Quadruple Aim is becoming a standard method by which states gauge the success and efficiency of their Medicaid dental programs.



Additionally, the majority of states implementing a capitated carve out model today are mirroring best practices in the managed care programs – requirements around population health management, case management, integration with medical, and value-based care, among others.

The bottom line: The Medicaid dental carve out model using a fully capitated arrangement has emerged as the dominant model.

One again, we appreciate this opportunity to share information with DHS. Should DHS have additional questions, please reach out to our Vice President of Government Sales Lawless Barrientos at Lawless.Barrientos@dentaquest.com or 303.877.0929.

1. What recommendations can you make to the DHS about how best to administer dental benefits to our eligible Medicaid beneficiaries? Are there any special considerations that should be taken into account and included in this RFP?

DentaQuest respectfully offers the following recommendations:

- Transition from an ASO arrangement to a fully capitated arrangement (see our response to #5 for more detail) to establish greater accountability for the DMO, better cost predictability, and lower overall program costs.
- We encourage the state to add contractual goals related to operational efficiencies for Medicaid dental programs. This would include, but not limited to: claims processing; utilization management; customer service; complaints and grievances; fraud, waste and abuse prevention and detection; reporting; etc.
- Most dentists are apprehensive about signing contracts or LOIs with bidders during a procurement process. Therefore, we recommend DHS not require signed contracts or LOIs during the RFP, and instead, score bidders based on their plans to build a network. To ensure the network complies, DHS should review and validate network adequacy during the readiness review process prior to go-live.
- The rates should be actuarily sound and set by the state. Bidders should not submit nor be scored on rate proposals. This allows the state to get a true apples to apples picture of the value each bidder could bring to the table within the confines of the same rate.

2. What recommendations do you have regarding appropriate staffing in the program, needed infrastructure, or organization?

DentaQuest understands the nuances and challenges of delivering dental benefits for Hawaii's Medicaid population. As such, we recognize the importance of having a core, team of staff dedicated to this contract located in Hawaii. Key roles that should be located in proximity to the capital include the leader and day-to-day contact for DHS, a dental director, provider relations staff, and beneficiary outreach staff.

The current incumbent partners with Community Case Management Corporation to coordinate access to dental services across the state. Having worked with this organization in the past, DentaQuest is strong proponent of ensuring bidders have the option to leverage this group (or other such organizations) for coordinating dental access. As such, we recommend that DHS allow bidders the latitude to partner with a company such as this, or alternatively, allow bidders to stand up their own beneficiary support center located in state.

As it relates to all other operational functions, experienced DMOs employ national infrastructure and organizational models to leverage economies of scale for non-beneficiary-facing and non-provider-facing transactional services.

This type of structure offers a win-win for state agencies and DMOs. Benefits include:

- States can access DMOs leadership and unprecedented industry experience and leadership who can help guide a state Medicaid dental program to further success.
- States can tap into best practices implemented in other Medicaid dental programs served by the DMO to benefit their own program.
- Lower overhead and administrative expense.

DentaQuest, as well as all of its national competitors, have demonstrated time and again that this model is efficient and effective across the country.

3. Based you or your organization's experience of Medicaid, please provide DHS with any suggestions or recommendations that may assist in developing a realistic and reasonable RFP that can improve the oral health of the eligible Medicaid beneficiaries.

DentaQuest recommends that DHS develop an RFP that outlines how the ultimate selected DMO would be held accountable for their performance. This is not limited to just operational performance, but also includes performance against clearly stated goals designed to improve the oral health of Medicaid beneficiaries. Many other states leverage capitation withholds that can be earned each year for achieving specific benchmarks. We would recommend looking at RFPs from the states of Florida and Louisiana for examples on how DHS could structure such requirements.

We also believe it is important to provide transparency into the evaluation process so bidders understand how their RFP will be scored.

Lastly, if DHS is looking for the DBA to achieve specific goals, it is important to ensure point allocation properly reflects the importance of each goal. For example, if DHS places significant importance on improved outcomes and lower costs, then questions related to core TPA functions should be weighed lower than questions related to these critical goals.

4. Are there new ideas or technologies that could maintain and improve dental services to Medicaid beneficiaries and if so, how would it be utilized?

DentaQuest has leveraged several new ideas to help maintain and improve dental services, including teledentistry, a quality-focused dental home program, and using an array of quality measures to assess the quality of the dental program.

Teledentistry

Teledentistry provides an array of benefits for states looking to increase access and lower costs. In its white paper "Fast-Track to Teledentistry" the DentaQuest Partnership for Oral Health Advancement notes the following benefits of teledentistry:

- In times of crisis, teledentistry can prevent disruptions in case that would otherwise send people to already overwhelmed clinics and hospitals. For example, as a result of the COVID-19 pandemic, the dental industry was thrust into a quick adaption of teledentistry as a viable option to ensure Medicaid beneficiaries have access to care.
- Even in normal times, Medicaid beneficiaries are not getting the dental care they need
- When people do not receive dental care, both oral and health and overall health deteriorate
- Teledentistry offers multiple forms of technology to improve health
- Teledentistry helps close gaps in access to dental services
- Teledentistry can save money for states
- Teledentistry and other telehealth initiatives can create and preserve jobs, especially in rural areas.

Many states across the country, as well as DentaQuest, implemented varying strategies during the pandemic to support the use of teledentistry to provide opportunities for patients to receive services when they are in a different location than their care provider.

Some of the ways DentaQuest enhanced its teledentistry strategy included:

- Designing bundled payment options for both emergency and preventive dental care
- Designed a unique alterative payment model to support our dental providers during COVID, further described in our answer to question #7.
- Aligning with a preferred teledentistry platform, MouthWatch
- Supporting providers through webinars and training

We understand there have been pilot programs already implemented in Hawaii for teledentistry, even prior to COVID. However, according to the published fee schedule online, teledentistry is not a reimbursed code under the Medicaid program. We would suggest DHS reconsider this, especially given how important teledentistry has become in the last year.

Dental Home Program

Inexperienced and commercially-focused DBAs typically overpromise and underdeliver in terms of network. DentaQuest focuses on **quality**, **not just quantity** of its providers. Providers selected for our network must be adept at serving the Medicaid population and be high performing providers. Simply adding dentists to a network will not yield improved access, especially in dental health professional shortage areas.

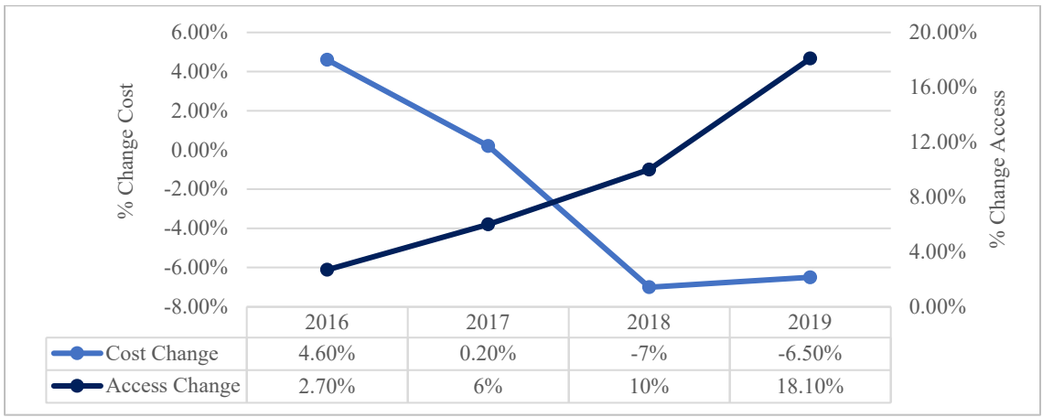
DentaQuest has proven that selecting high performing providers, and assigning beneficiaries to their offices through our **dental home program yields better access to care and lower costs**.

Under our model, all beneficiaries will have an assigned primary care dentist (PCD) who will serve as the dental home. For beneficiaries who do not select a PCD and do not have claims history in the past year with a PCD, we auto-assign the beneficiary to a nearby PCD delivering higher quality care based on our analysis of utilization and quality data. We monitor PCD performance through quarterly Provider Performance Reports, and provide support such as gaps in care reports to help PCDs improve their performance.

Case Study on the Effectiveness of DentaQuest's Dental Home Model

We have found that higher performing providers are more effective in getting their assigned beneficiaries in for care, as compared to lower performing providers. Beginning in 2016, we began assigning new beneficiaries in a large state without an existing provider relationship to higher performing locations and compared access and cost results to beneficiaries who were assigned without taking provider performance into account. At 6-months, the pilot group's access increased by 2.7%, and costs increased by 4.6%. This cost increase was expected because many beneficiaries were gaining access to dental care for the first time, and because higher performing locations have a track record of getting their beneficiaries in and providing appropriate care. At the 1-year mark, the pilot group's access increased by 6%; and the cost leveled off (increase of .2%). At the 3-year mark, the pilot group's access increased by 18% while costs decreased by 6.5% (Figure 3).

Figure 3: Quality Based PCD Assignment



Best Practices for Outcome Measures

Historically, states have relied on measures such as CMS-416 EPSDT and HEDIS Annual Dental Visit to evaluate oral health outcomes. While these measures are still used and remain relevant today, the industry is aligning with more sophisticated measures that cover a much broader spectrum and therefore, can yield a more holistic view of the quality of outcomes. These measures are aligned with the objectives of the Quadruple Aim. Measures put forth by the ADA's Dental Quality Alliance, for example, demonstrate the depth and breadth of outcome measures available. They include:

- Utilization of Services
- Preventive Services for Children at Elevated Caries Risk
- Treatment Services
- Oral Evaluation
- Topical Fluoride for Children at Elevated Caries Risk
- Sealants for 6–9 Year-Old Children at Elevated Caries Risk
- Sealants for 10–14 Year-Old Children at Elevated Caries Risk
- Care Continuity
- Usual Source of Services
- Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
- Follow-Up after Emergency Department Visit for Dental Caries in Children
- Per Member Per Month Cost of Clinical Services Related Health Care Delivery
- Periodontal Evaluation in Adults with Periodontitis
- Ongoing Care in Adults with Periodontitis
- Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Related Reasons in Adults
- Follow-up after Ambulatory Care Sensitive Emergency
- Department Visits for Non-Traumatic Dental related Reasons in Adults.

As part of its own best practices, DentaQuest has developed proprietary methodology, drawn from more than 100 specific data points to measure providers, their location, and performance across quality dimensions, compared to providers in peer and regional

groups. We draw from disparate data sources to perform smart analytics including risk adjustment. We evaluate and can share consolidated and statistically valid performance data for a provider against local and national benchmarks.

5. COVID-19 has impact on the State economy, what innovative ideas do you have to reduce spending and ensure the most efficient and appropriate use of resources to maintain dental services while demonstrating value?

DentaQuest respectfully asserts that the best way to maximize program dollars, while demonstrating value (i.e. better access and outcomes) is for DHS to move to a capitated dental program.

The primary cost driver of a Medicaid dental program lies within claims expenditures, which makes up **90% or more of the cost of an overall program**. Therefore, to derive meaningful savings, best practices and innovations to reduce the cost of care while still achieving better outcomes must be considered.

Historically, states cannot achieve these savings on their own; it requires a skilled DMO to fully manage and own the decisions to address the cost drivers. In other words, to be most effective it is important that the DMO shoulder the program costs through a capitated program, has Medicaid-specific dental management experience, and retain ownership of the network. This allows the DMO to:

- Focus on a quality, low cost network
- Implement the most effective dental home distribution to the highest quality, lowest cost providers
- Redistribute funds where there is crucial need
- Emphasis for needs in rural areas
- Tightening of the network in saturated areas
- Have flexibility in provider contract negotiation and alternative reimbursement model discussions
- Have more accessibility to pull leavers that focus on prevention, assist with cost containment, and can be leveraged to build in capital for provider incentives. Such levers include:
    - Utilization management and robust claims edits: ensures only medically necessary services are approved and paid for
    - Network composition and management: compliant right-sized networks, compromised of high quality, low cost providers
    - Patient-centered dental home model: Under this model, beneficiaries are assigned to high quality, low cost providers, who are accountable for producing better outcomes
- Value-based care reimbursement strategies: Described in greater detail in answer #7.

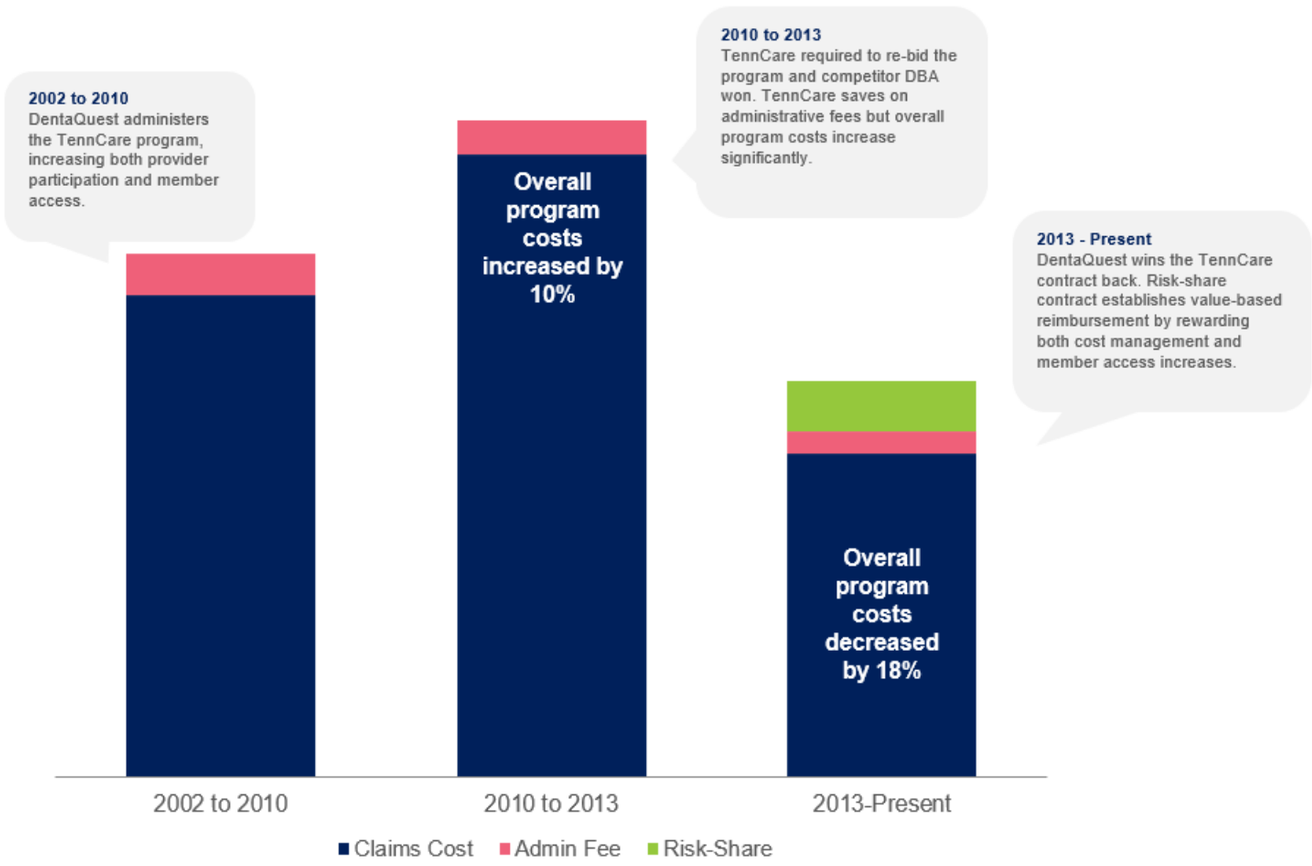
Case Study: Leveraging Best Practices for Tennessee

Many DBAs focus on managing administrative costs because they are not equipped to manage the claims costs. They have neither the data nor the expertise to develop workable cost containment strategies. The state of Tennessee experienced firsthand the importance of selecting a DBA with the ability to manage program costs.

After eight years of managing the TennCare Medicaid dental program, DentaQuest was replaced by another DBA through a competitive bidding process in 2010. The contract was won on price – the winning DBA undercut our FFS rate by $0.14 pmpm. This would generate an annual savings of approximately $1.1 million in administrative costs to Tennessee. However, the state very quickly realized that under the new DBA's management, their claims costs were rapidly increasing. The DBA did not have the expertise to properly manage program costs, which essentially negated any savings realized through the lower administrative rate.

The state released an RFP after the initial three-year contract period ended and DentaQuest was re-awarded this contract through a competitive bidding process. **By switching back to DentaQuest, the state's claims costs decreased by 18%** (Figure 4).

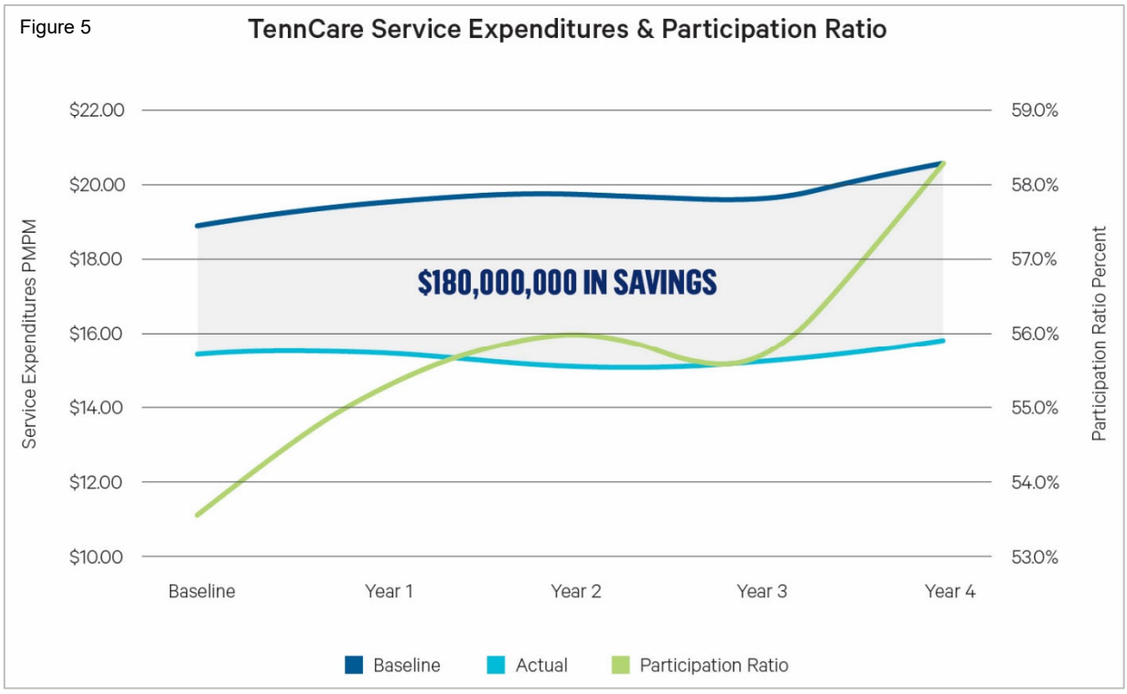
Figure 4: Tennessee Medicaid Dental Carve Out Case Study



What's more, as a result of a unique risk-share arrangement between the state of Tennessee and DentaQuest, we have been able to increase quality, while simultaneously reducing program costs. The chart in Figure 5 demonstrates cost of care trends immediately prior to DentaQuest being re-awarded the TennCare dental contract in 2013 (dark blue line). Using levers to promote high quality care within a predictable

budget, DentaQuest significantly reduced the cost of care (teal line), while simultaneously increasing the Participation Ratio (green line). Compared to the cost trend established prior to October 2013 (dark blue line), we have saved the state nearly $180,000,000 and increased the Participation Ratio (a unique Tennessee quality measure) by 9% in a four-year period.

Figure 5



6. How should the TPA collaborate with the QUEST Integration Health Plans to improve outcomes of the health and wellness of the eligible Medicaid beneficiaries.

There are a number of ways that other states require DMOs and health plans to work together to improve outcomes of the health and wellness of Medicaid beneficiaries that DHS could look to for best practices.

One of the most comprehensive ways comes from Florida, where the Medicaid DMOs are required to maintain a robust case management program similar to those required of Medicaid managed care organizations. In Florida, DBAs are contractually obligated to:

- Conduct health risk assessments
- Stratify beneficiary risk level
- Identify needs (holistic – such as physical and behavior health, barriers to care, social supports, etc.)
- Develop individualized plans of care for beneficiaries that qualify for case management support
- Work in collaboration with the beneficiary's MCO, primary care providers, specialists, other service providers, and community partners
- Use strategies to promote self-management and treatment adherence and motivational interviewing

As one of three DBAs in Florida, DentaQuest has seen firsthand how our case management program has helped improve oral and overall health outcomes of our beneficiaries. Given the geographical and cultural nuances in Hawaii, we would recommend DHS adapt a similar model to promote stronger coordination of care among the DMO and the health plans.

7. What strategies should DHS consider adopting that could maintain or expand the current Medicaid dentists' participation.

DentaQuest believes they key to maintained and expanded participation centers on rewarding Medicaid dentists for providing quality care. Value-based care (VBC) delivery and enabling alternative payment models (APM) are quickly becoming are an important mechanism to engage providers, support a person-centered approach to care, and support the "Quadruple Aim" of reducing costs while improving health, enhancing the patient experience, and improving provider satisfaction. To shift to a more value-over-volume and outcomes-oriented approach, Medicaid agencies are activating cost-control measures and benefit redesign.

In 2014, the Center for Health Care Strategies noted "states may be able to use their purchasing power to encourage better access, quality and accountability in oral health care for children in Medicaid — particularly through contracting with dental plans."1 In fact, many state Medicaid agencies are utilizing alternative payment models (APMs) to drive improvements in oral health care.

Dental data from 2013 through 2017 reviewed by the DentaQuest Partnership for Oral Health Advancement shows an increase in the number of Medicaid APM claims, with lower spending over the lifetime than fee-for-service provider reimbursement plans. Utilization of dental services under APMs also improved from 2013 to 2017, surpassing utilization with a traditional fee-for-service provider reimbursement model.

DentaQuest leverages VBC best practices and has designed various APMs for its providers in other states. Our current APMs are focused on not just promoting and rewarding high quality care, but were also designed to support dental providers during the COVID-19 pandemic. Benefits of our APMs include:

- Financial stability through predictable monthly partial capitation payments (which proved to be critical during the COVID-19 utilization changes).
- Potential upside revenue through financial incentives for strong performance and opportunities for enhanced assignment for new beneficiaries.
- Improved understanding of practice performance through transparent reporting and benchmarking that leads to the opportunity to drive improvements in quality and efficiency in order to outperform competitors.
- Improved collaboration with DentaQuest that advances our shared goal to transform Oral Health for All, as well as training and education opportunities to enhance knowledge of best practices under a value-based model.

[1] Chazin, Stacey. Medicaid Contracting Strategies to Improve Children's Oral Health Care Access. Available at: https://www.aapd.org/assets/1/7/Medicaid-Contracting-Strategies-to-Improve-Childrens-Oral-Health-Access.pdf. Accessed on February 6, 2020.

8. What interventions and services that can effectively address the cultural and language barriers to the delivery of appropriate dental services? What strategies should the TPA devise to develop focused interactions, communications and supports to meet culturally diverse member needs?

DentaQuest understands how language and culture can lead to barriers to care. For example in Hawaii, we know that Asians and Pacific Islander children have significantly higher rates of dental caries compared to other groups.

DentaQuest establishes customized solutions to meet beneficiaries where they are from a cultural, language, and literal perspective. Our strategies for educating beneficiaries are designed to respect and honor the ways in which they prefer to receive oral health information and education.

There are a number of best practices that can be leveraged to effectively address cultural and language barriers to the delivery of appropriate dental services. Some of the strategies could include:

- Providing culturally sensitive educational materials. Beneficiary-facing materials should reflect the populations served, and be available in beneficiaries' preferred languages, and as appropriate, nuanced to targeted populations.
- Linking beneficiaries to community supports to address social determinants of health. The DBA/DMO should be required to coordinate with community service organizations that can provide additional support to beneficiaries and their families for a variety of needs, such as dental care not covered by Medicaid, food insecurity, rent assistance, social support, transportation, and low literacy.
- Partnering with community organizations that already serve beneficiaries experiencing health disparities as a result of cultural and language barriers. This has been a hallmark of our successful approach in other states. Through these partnerships, we identify and train organizations to serve as Medicaid dental program ambassadors. We know that when oral health information and education comes from entities and individuals who have a close understanding of the member's background and experience, and come from the communities served, the message is more effective..
- The DBA/DMO's case management program should be a vehicle used to identify high risk beneficiaries by assessing and addressing social determinants of health, including health, culture, language, race/ethnicity, health literacy, support systems, environment, physical limitations, and transportation needs.

Discrimination Reduces Utilization of Routine Dental Care

Discrimination tied to immutable characteristics such as race, gender identity, and sexual orientation exists as both a symptom and a driver of inequities in health and oral health.

The DentaQuest Partnership for Oral Health Advancement found that increased exposure to lifetime discrimination experiences is associated with a decreasing likelihood of having a routine dental visit in the past 12 months.

- The DBA/DMO should ensure for the provision of written materials in alterative languages and formats, support and coordinate in-office language interpretation as needed, recruit and employ a diverse staff, and provide training to all employees and providers on cultural competency.

DELTA DENTAL

HDS
Hawaii Dental Service

January 7, 2020

Mr. Jon Fujii
c/o Eric Nouchi
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Kapolei, HI 96707
QUEST_Integration@dhs.hawaii.gov

Re: Medicaid Dental Services RFI Response / RFI-MQD-2021-012

Dear Mr. Fujii,

Hawaii Dental Service (**HDS**) would like to thank the Med-QUEST Division (MQD) of the Department of Human Services (DHS) for the opportunity to comment on this **Request for Information** to prepare a **Request for Proposal (RFP) for Third Party Administrator (TPA) and dental claims processing services for eligible beneficiaries covered by the Hawaii Medicaid Program.** As the current holder of the Dental TPA Services for the State of Hawaii Medicaid Population contract, HDS is committed to improving the oral health of the State's Medicaid beneficiaries.

The following is our response to **Request for Information No. RFI-MQD-2021-012:**

1. **What recommendations can you make to the DHS about how best to administer dental benefits to our eligible Medicaid beneficiaries? Are there any special considerations that should be taken into account and included in this RFP?**

   In order to improve the oral health and access to dental services for its Medicaid beneficiaries, DHS must ensure the contracted TPA is a dedicated partner to all stakeholders and has a demonstrable record and commitment to provide locally based services to Hawaii Medicaid beneficiaries.

   Serving the vulnerable Medicaid population requires the selected TPA's attributes to exceed the standard responsibility criteria imposed on government contractors. Therefore, DHS's RFP should ask all offerors to provide documentation regarding the following:

Hawaii Dental Service
900 Fort Street Mall, Suite 1900
Honolulu, Hawaii 96813-3705

Telephone: (808) 521-1431
Toll-Free: 1-800-232-2533
Fax: (808) 529-9368

- At least 5 years of a demonstrated specialization in locally administering dental benefits in Hawaii, including experience with Hawaii Medicaid programs.

- At least 10 years history of community outreach, philanthropy, and supported programs that improved the oral health and access to dental care for underserved populations in Hawaii.

- Experience identifying and addressing cultural (and other) barriers to dental health access and care among Hawaii's Medicaid population.

- Demonstrated knowledge and structure of a mature cyber security program that protects health information.

- Demonstrated knowledge of potential pitfalls in dental claims processing within the existing system, and procedures to be implemented to prevent and address such issues.

2. What recommendations do you have regarding appropriate staffing in the program, needed infrastructure, or organization?

DHS and MQD should be focused on the highest level of service with minimal disruption of services to Medicaid beneficiaries, whether services are an extension of the current TPA system or a transition to managed care. Therefore, offerors should be asked to demonstrate that it possesses the following:

- Local staff familiar with the Hawaii network of dentists and its beneficiaries.

- Local staff who possess cultural knowledge and sensitivity to facilitate communication and service delivery to all stakeholders.

- Demonstrated history of improving dental care statewide.

- Demonstrated experience providing both managed care and third-party administration within the State of Hawaii.

- Demonstrated history of operating a Hawaii-based call center for beneficiaries and dentists.

- Hawaii-based claims review and processing, performed by licensed Hawaii dentists.

- A comprehensive dental management team experienced in both commercial and managed care business who can address the needs of Med-QUEST's Dental TPA Services RFP and the program's beneficiaries. Offerors should not be required to allocate 100% of their available time for "dedicated

positions" towards fulfillment of the contract, which would allow flexibility and help to maximize allocation of resources and potentially reduce costs.

3. **Based on you or your organization's experience of Medicaid, please provide DHS with any suggestions or recommendations that may assist in developing a realistic and reasonable RFP that can improve the oral health of the eligible Medicaid beneficiaries.**

   The RFP should secure TPA services that are cost-effective, efficient, minimizes disruption to stakeholders and ultimately, results in quality care for as many beneficiaries as possible. As such, DHS should award the contract to an offeror with:

   - A demonstrated history of administering dental benefits under Hawaii Medicaid.

   - A demonstrated history of how it services and communicates with its existing network of Hawaii dental providers.

   - An existing local claims processing and review infrastructure.

   We suggest that offerors also have the option to submit more than one (1) alternatively structured and priced TPA services solution (within their consolidated RFP response), provided each solution meets the requirements set forth in the RFP.

4. **Are there new ideas or technologies that could maintain and improve dental services to Medicaid beneficiaries and if so, how would it be utilized?**

   RFP questions related to the improvement of dental services to beneficiaries should:

   - Specify whether DHS and MQD are willing to consider new ideas or technologies regarding administration or treatment (or both).

   - Invite offerors to present innovative ideas or technology strategies and describe what improvements will be made.

5. **COVID-19 has impact on the State economy, what innovative ideas do you have to reduce spending and ensure the most efficient and appropriate use of resources to maintain dental services while demonstrating value?**

   HDS understands that due to the economic impact of the ongoing pandemic, DHS and MQD are focused on maximizing the finite resources allocated to the

Medicaid program. HDS has previously helped to reduce costs by expanding the provider network and lowering inter-island beneficiary transportation costs—so more program dollars can be spent on dental services.

Disruptions to the current system should be considered as a cost when performing any cost-benefit analysis of alternative TPAs. Offerors should:

- Demonstrate experience and strive to establish cost-effective processes and appropriate staffing to ensure the program's success.

- Demonstrate knowledge about service delivery, capacity, and potential system constraints, in order to scale its program effectively depending on allocated funding for the program.

- Share details on programs, initiatives, or policies developed during the pandemic that maintained operations, kept employees engaged and productive, helped to improve the health and wellness of Medicaid beneficiaries, and supported the operational wellbeing of Hawaii dentists.

6. How should the TPA collaborate with the QUEST Integration Health Plans to improve outcomes of the health and wellness of the eligible Medicaid beneficiaries?

In seeking to improve collaboration between *multiple* health plans, while improving outcomes to beneficiaries, offerors should:

- Demonstrate their data analytics capabilities and provide examples of reporting solutions and learned insights that may improve the oral health or service provision to Medicaid beneficiaries.

- Advise which health plans they are willing to securely share information with and demonstrate existing relationships with health plans, provided any collaboration is directed by Med-QUEST and there is no disclosure of competitive or proprietary information.

- Share existing Medicaid system capabilities and any applicable experience in developing programs between medical and dental carriers.

7. What strategies should DHS consider adopting that could maintain or expand the current Medicaid dentists' participation.

While we understand the fiscal limitations in funding Medicaid annually, dentists have regularly provided feedback that higher Medicaid fees and additional preventive services for Medicaid adult beneficiaries would help to bring more dentists into the network.

Aside from fees, creating efficiencies and streamlining processes for dentists is the best way to make joining the program more appealing, such as:

- Streamlining the claims submission process, and formally dismissing the need for a pre-authorization prior to treatment.

- Simplifying eligibility details for dentists – e.g. beneficiaries have two cleanings and exams per service period and not per calendar year, so there may be some confusion and difficulty for dentists in knowing which benefits are available. Offeror should demonstrate their system's ability to accommodate different benefit period structures.

- Continuing to finalize clear and fair reimbursement rules for dental services that increase beneficiaries' access to care, especially on the Neighbor Islands where there may be less general and specialized dentists.

8. **What interventions and services that can effectively address the cultural and language barriers to the delivery of appropriate dental services? What strategies should the TPA devise to develop focused interactions, communications and supports to meet culturally diverse member needs?**

   Ensuring cultural and language barriers are addressed to properly deliver dental services and oral health information is important, especially considering that nearly 20% of US adults struggle to understand basic health terms and how it applies to their dental benefits.

   Providing professional language assistance is required under Federal Civil Rights law, but offerors should go beyond what the law requires and:

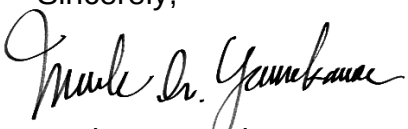
   - Demonstrate locally-based operations in Hawaii that employ a culturally diverse employee population that understands the needs and varied demographics of Hawaii's Medicaid population.

   - Determine with Med-QUEST the primary Medicaid collateral items required for the program, i.e. Medicaid Brochure, and provide translated materials for all most-prevalent foreign languages in Hawaii.

CONFIDENTIAL INFORMATION REQUEST: Page 5 of the RFI allows offerors to request that portions of their responses be kept confidential. Pursuant to the foregoing provision, HDS requests that the **RFI responses to questions 1 - 3 and 5 - 7** should remain confidential since it includes specific suggestions from HDS based on experience gained by serving the Medicaid population – disclosure may provide an unfair advantage to competing offerors who may emulate shared details in their response to the RFP. If DHS determines HDS's responses must be publicly disclosed prior to the proposal due date, HDS respectfully requests that it be given notice of anticipated disclosure and the opportunity to contest such disclosure.

HDS looks forward to receiving the RFP and providing our proposal to continue as the dental TPA for Hawaii's Medicaid beneficiaries.

Sincerely,



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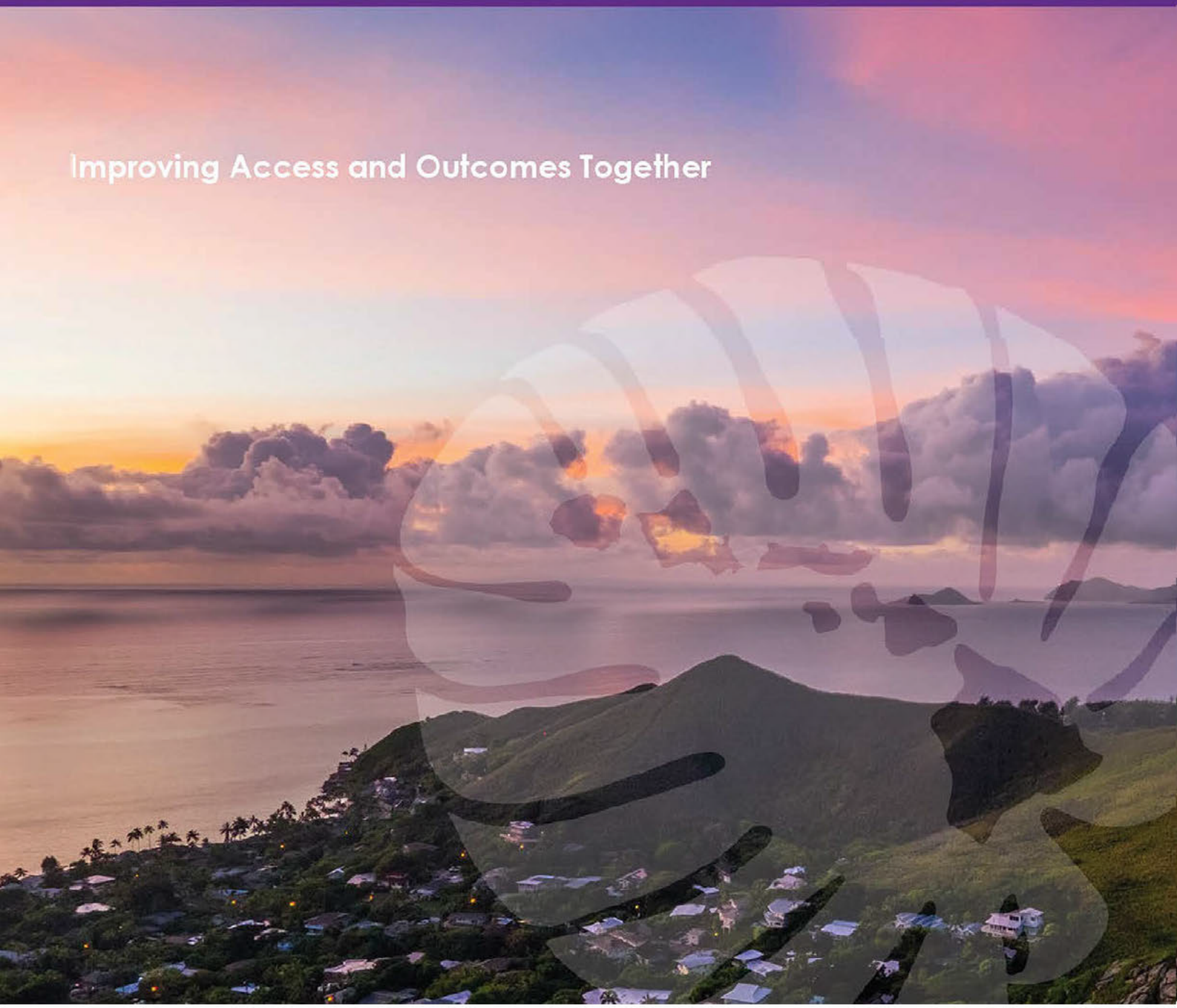

State of Hawai'i Department of Human Services

Med-QUEST Division

Redacted Copy

Dental Third Party Administrator (TPA) Services for the
State of Hawaii Medicaid Population
Request for Information (RFI) No. RFI-MQD-2021-012

LIBERTY DENTAL PLAN.

January 8, 2021

Mr. Jon Fujii
c/o Eric Nouchi
Department of Human Services/Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707

RE: Request for Information No. RFI-MQD-2021-012 regarding Dental Third Party Administrator (TPA) Services for the State of Hawaii Medicaid Population

Dear Mr. Fujii,

LIBERTY Dental Plan, Inc. ("LIBERTY") is pleased to submit this response to the Department of Human Services Med-QUEST Division's Request for Information Number RFI-MQD-2021-012 regarding Dental Third Party Administrator Services for the State of Hawaii Medicaid Population.

Over the last 20 years, LIBERTY's leadership team, originated and led by a dentist, built our company into one of the nation's largest Medicaid and Children's Health Insurance Plan (CHIP) dental insurers. We currently administer dental benefits to approximately [redacted] members in public, commercial and government programs, of whom over [redacted] are Medicaid and CHIP members in [redacted] LIBERTY has had a market presence in Hawaii since [redacted] and over the years, LIBERTY has been proud partners of [redacted] in administering both Medicare Advantage and Medicaid adult value-added benefits. From this experience, we have developed a deep understanding of the Hawaiian dental delivery system, established strong relationships with the local dental provider community, and gained an acute understanding of the challenges members face in accessing care across all of Hawaii's islands.

Through this RFI response, we hope to demonstrate our experience and knowledge gained through our other state Medicaid and CHIP programs and our creativity in designing and implementing program and policy improvements consistent with the Department of Human Services Med-QUEST Division's goals. Hawaii has a significant opportunity to build on the current success of the state's fee-for-service (FFS) program by considering implementation of a fully capitated model for Medicaid and CHIP dental services as an alternative to the current model which uses a third-party administrator (TPA). The risk arrangement would allow the state to hold vendors accountable for a variety of different requirements and would introduce innovation to the program. It would support a paradigm shift from a FFS program that rewards providers in treating dental disease, to a more cost-effective program focused on wellness and prevention. Finally, while under a FFS model the TPA is a vendor, under a capitated program, the state can find a partner (or partners) to help in the achievement of its goals.

If you have any questions about the information contained within our response to the Request for Information, or require additional clarification, please do not hesitate to contact me at (888) 273-2997 [redacted] or on my direct line at [redacted] or by email at [redacted]

Sincerely,

Amir Neshat, DDS
Chairman and CEO
[redacted]

QUESTIONS FOR RESPONDENTS

1. What recommendations can you make to the DHS about how best to administer dental benefits to our eligible Medicaid beneficiaries? Are there any special considerations that should be taken into account and included in this RFP?

Recommendation to consider full capitation – In the upcoming procurement, Hawaii has an opportunity to shift from fee-for-service (FFS) program using a third party administrator (TPA) to a full-risk capitated model for its dental program. There could be significant benefits for Hawaii in moving to full capitation. The existing program rewards the volume of services delivered and not value, and it is designed to incentivize providers to treat symptoms instead of promoting prevention and wellness. A shift to a full-risk capitated model would support a focus on member engagement and increased utilization of preventive dental services that reduce cost and improve outcomes. In addition, the model would provide managed dental plans with the flexibility to use different provider compensation levels and strategies such as value-based payment to improve access to care and outcomes, whereas in FFS, the state must pay every participating provider the same fees. Managed dental plans can also use their Utilization Management Programs to apply utilization management requirements at the provider level and to ease administrative burden for high performing providers. This is a strategy that can increase participation in the program, while FFS programs must treat all providers the same and do not have the ability to tailor requirements.

We recommend that the state contract with dental plans on a statewide basis, similar to how health benefits are delivered through QUEST Integration Program, and allow dental plans to compete based on quality outcomes, availability and accessibility of services, member and provider satisfaction, transparency, and accountability. Such a model, used in other states such as Florida, Nevada, and Texas, will provide the state with partner dental plans that can be held accountable to provide higher quality outcomes, enable members to access specialists and other providers that many fee-for-service members have difficulty accessing today, and offer the state greater fiscal predictability and cost-effectiveness.

Texas' experience is illustrative of the cost savings potential related to a full-risk capitated dental program. Texas has shifted from a state-administered FFS dental program, to a TPA model, to a managed dental program. Over the last several years, enrollment has been stable, but the state has seen reduced per member/per month capitated payments for several years. Cost containment has occurred due to efficiencies in care coordination, reduced fraud/waste/abuse, and improved utilization

review. In a 2015 report, Milliman estimated the state saved a total of $1.5 billion in all funds ($670 million in state funds) related to the implementation of managed dental care.

The figure below summarizes key tasks and the responsible entity for performing them under traditional FFS, FFS with a TPA, and capitated models. Certain functions such as claims processing and service authorization are performed no matter how a dental program is structured, by whoever administers the program: the state, a TPA, or an MCO. However, there are several functions that are only present in a managed care model including: case management, member education and outreach, provider network/access and timeliness of care requirements, and provider network management.

Model	Traditional Fee-for-Service (FFS)	Fee-for-Service with Third Party Administrator (TPA)	Full-Risk Capitation
Tasks	**Responsible Entity**		
Claims Processing	State	TPA	Managed Care Organization
Service Authorization	State	TPA	Managed Care Organization
Member Services (complaints and inquiries)	State	State	Managed Care Organization
Case Management/Care Coordination	N/A	N/A	Managed Care Organization
Member Education and Outreach	N/A	N/A	Managed Care Organization
Dental Home	N/A	N/A	Managed Care Organization
Quality Management/ Management of Provider Network	N/A	N/A	Managed Care Organization

Model	Traditional Fee-for-Service (FFS)	Fee-for-Service with Third Party Administrator (TPA)	Full-Risk Capitation
Tasks	**Responsible Entity**		
Provider Network – Access and Timeliness to Care	N/A	N/A	Managed Care Organization
Provider Network Management – Training and Quality Improvement	N/A	N/A	Managed Care Organization
Fraud, Waste, and Abuse	N/A	Tends to be focused on enrollment	Managed Care Organization operates comprehensive program

Under a capitated model, the financial risk and access to care requirements are the twin levers that incentivize dental plans to manage the provider network effectively to ensure the delivery of quality care. Dental plans can be the drivers of the shift in the industry from treatment-focused dentistry, which is reactive and costly, to prevention focused dentistry. Dental plans can use strategies including financial incentives, provider education, and quality improvement projects, among others, to bring about this change. A capitated model also enables member assignment to a dental home, which facilitates deeper beneficiary and provider engagement and results in early intervention rather than assessment and treatment.

Managed dental care also facilitates enhanced member engagement. Plans have established member services infrastructure to respond to member inquiries and engage members. Plans have been able to implement individualized member outreach and communication strategies linked to improved utilization, due to high rates of mobile technology adoption.

2. What recommendations do you have regarding appropriate staffing in the program, needed infrastructure, or organization?

We believe health care is regional and health care decisions are best made locally. That is our model and why we typically assemble a local team of Account Management/Executive, Member Services, Provider Relations, Network Development, Network Management, Claims, Utilization Management, Clinical Team/Dental Directors, Quality Management, Case Management, Community Outreach, Program Integrity (Fraud, Waste, and Abuse), and Compliance staff, among others to deliver the scope of services included in our full-risk capitated programs. Staff across these functional areas work in tandem to deliver high quality, cost-effective dental services; meet the needs of members and providers; and improve access to care. In addition, we also leverage economies of scale with certain operational functions that can be centralized and shared. The local functions identified above are supported by the capitated rate structure, but are not typically available in state FFS programs and are outside the scope of Hawaii's TPA's claims processing responsibility.

3. **Based you or your organization's experience of Medicaid, please provide DHS with any suggestions or recommendations that may assist in developing a realistic and reasonable RFP that can improve the oral health of the eligible Medicaid beneficiaries.**

DHS has an opportunity to shift to a managed care dental program in this procurement, any may incorporate program features already in place in the QUEST Integration Program for Medicaid health plans. Hawaii's RFP would have to be structured to identify partners with the experience, expertise and required systems for member engagement, interoperability, improved medical-dental integration, quality improvement, and network management, among other functions. Other states have recently signaled a shift to managed dental programs, including Oklahoma, and their recent requests for proposals may be helpful for Hawaii's consideration in seeking to improve the oral health of eligible Medicaid beneficiaries.

In addition, several of the effective innovations we have implemented in our full-risk capitated programs are focused on improving the oral health of eligible Medicaid beneficiaries and DHS could specifically consider adding relevant requirements in these areas, including:

- Value-Based Programs;
- Teledentistry and Emergency Department Diversion;
- Case Management;
- Community Outreach; and,
- School-Based Programs.

4. Are there new ideas or technologies that could maintain and improve dental services to Medicaid beneficiaries and if so, how would it be utilized?

If Hawaii makes the shift to a capitated program, the state has an opportunity to realize many benefits for beneficiaries and providers, supported by IT infrastructure. LIBERTY recommends consideration of the following ideas and technologies, as implemented in our Medicaid programs:

Teledentistry: Given the geographic constraints affecting access to care (availability of certain specialist providers on certain islands only), Teledentistry offers a powerful solution not only to address urgent dental issues, but also as a means to provide a virtual dental home for Medicaid beneficiaries. Teledentistry can support creation of a risk profile for each beneficiary, which supports customized case management and outreach based on beneficiary needs. LIBERTY is a national leader in the development of Teledental solutions to address gaps in access and reduce non-emergent dental-related Emergency Department visits (growing in many states among the uninsured and Medicaid populations).

With the managed care model, comes additional responsibilities for beneficiary education and engagement. We have developed multiple channels to engage beneficiaries and to enable them to communicate with us or seek information in the modality they prefer. Some of the innovations developed include:

- **Strong Beneficiary Portals** – The use of a real--time web portal allows beneficiaries to access and submit information in an easy-to-use manner, increasing convenience and satisfaction. Beneficiaries should be able to easily see what benefits they have and what services they have received without having to make lengthy phone calls
- **Modern Mobile App** – Research establishes Medicaid beneficiaries use smartphones at comparable rates to the general public and many rely on their phones as the primary means of accessing the Internet. Beneficiaries should be able to select and change their provider through their mobile application or through a portal.

Contractual access to care requirements in the managed care model necessitate operation of a Provider Engagement model to recruit, manage, and retain network dental providers and the development of innovations that promote transparency and improve customer service including:

- **Strong Provider Portal to improve self-service** – The use of web portals gives providers real-time, ready access to critical information and allows them to submit information easily, which increases provider satisfaction by

increasing the speed of payment and reducing administrative costs. Providers should be able to obtain eligibility, utilization, and history at their fingertips. Providers should be able to submit referral requests and claims through these portals, and the best of breed systems allow for direct system-to-system communication, which further reduces administrative costs and mistakes.

- **Interoperability** – The federal government and many states are encouraging, incentivizing, or requiring greater managed care organizations to invest in the systems infrastructure to support interoperability and health information exchange. In addition, requirements to ensure interoperability with providers are critical to ensure that providers, DSOs, and dental groups can focus on providing quality care to their patients. Web services reduce the time spent on administrative activities and allow more time to be spent helping the patient. Examples include integrating the provider's office system with the payor's eligibility system so that the provider does not need to initiate any activity to ensure that the beneficiary is eligible for services and benefits.

Program Integrity (Fraud, Waste, and Abuse Prevention): Managed dental plans are contractually required and incentivized to identify, prevent, and resolve fraud, waste, and abuse. The prevention of FWA leads to improved quality and cost outcomes for beneficiaries (discussed in greater detail in Question #5).

5. COVID-19 has impact on the State economy, what innovative ideas do you have to reduce spending and ensure the most efficient and appropriate use of resources to maintain dental services while demonstrating value?

In the uncertain financial times resulting from the COVID-19 pandemic, the ability to predict and control costs is a great benefit. A full-risk, capitated dental managed care model would provide Hawaii with increased cost predictability, while shifting financial risk to the dental plans. States can consider program design features to cap dental plan profits and recoup savings. In addition, under managed care, Hawaii can expect to negotiate value-added benefits with the plan(s) selected, which could result in the development of additional benefits for the children and low-income adults served. Some of these benefits, which would be offered at no cost to the state, could include member incentives for completion of preventive care, extra cleanings for pregnant women, and enhanced adult dental benefits.

The financial risk taken on in a capitated model incentivizes dental plans to innovate to further reduce program costs. Some examples of these programs include:

Cost Savings and Improved Quality through Value-Based Programs: Over the last several years, Value-Based Programs (VBPs, also known as Alternative Payment Models) have become more common in dental managed care. Well-designed, value-based reimbursement models reward providers for prevention and healthier outcomes, administrative efficiency, and most importantly, empower the members with education, provider ratings, and actionable data. This not only assures beneficiaries receive care that is medically necessary and appropriate at the right time by the right provider, but also results in the most cost-effective care.

In some states where we do business, the state Medicaid agency contractually mandates the use of such agreements. At least one state requires that a certain percentage of expenditures be tied to some type of VBP agreement. In these states and others, LIBERTY has incorporated various types of VBPs. We have implemented this even independent of state requirements because we have been able to use these arrangements to improve the quality and cost-effectiveness of care delivered.

Improved Program Outcomes through Case Management: Requirements to provide case management have recently migrated from Medicaid health plan contracts to dental managed care contracts in states such as Florida, as a strategy to improve program quality outcomes. As a result, LIBERTY has an established Case Management Program for our Medicaid population in several states. Case Management assists beneficiaries who have complex overall or oral health needs and require a wide variety of resources to manage health and improve their quality of life. We have found case management to be critical to the provision of “whole person” care, addressing barriers to care and the social determinants of oral health, and connecting members to other relevant community service providers.

Quantitative and Qualitative Outcome Measures: Under a capitated model, the dental plan has the contractual relationship with providers, the authority, and the incentive to manage the performance of network dentists. Building on the dental home model, dental plans offer providers data, scorecards, and clinical support to improve quality performance and cost-effectiveness.

We have observed use of the following performance measures in state managed care Medicaid programs to measure quality and utilization:

- HEDIS - Annual Dental Visit;
- CMS-416 Measures 12a - 12f (EPSDT measures);
- Dental Quality Alliance (DQA)-specific measures; and,
- State-specific quality measures such as reducing potentially preventable emergency department utilization.

Best Practices in Program Integrity: LIBERTY estimates that fraud, waste, and abuse in dentistry could be involved in as much as 17-20% of claims. As the dental benefits administrator to over 5.0 million members across multiple states, LIBERTY has a well-established, fully implemented, Fraud, Waste, and Abuse (FWA) Compliance Program that complies with federal and state law, and contractual requirements for the programs we administer. States typically include requirements for dental plans to maintain a FWA program and annual plan and have a dedicated unit to investigate potential FWA. These requirements could also incentivize further innovation such as data-driven strategies and machine learning to identify potential FWA, among others.

6. How should the TPA collaborate with the QUEST Integration Health Plans to improve outcomes of the health and wellness of the eligible Medicaid beneficiaries.

Out of recognition that oral and overall health are linked and that effective delivery of preventive dental services can not only improve whole person health, but also help Hawaii achieve cost savings on dental (from reduced treatment services) and the medical side (such as through reduced non-emergent dental-related Emergency Department utilization and reduced costs from treatment of chronic diseases), LIBERTY recommends Hawaii foster greater collaboration between its Medicaid dental and medical programs regardless of the model used (TPA or MCO). However, options for TPA collaboration with the QUEST Integration Health Plans are limited. A capitated dental program allows for greater collaboration to improve outcomes of the health and wellness of the eligible Medicaid beneficiaries.

With the Department of Human Services Med-QUEST Division's approval, LIBERTY recommends the TPA enter into comprehensive care coordination and data-sharing agreements with QUEST Integration Health Plans. The QUEST Integration Health Plans can use dental claims data to inform beneficiary outreach and improve coordination of members' care.

Under a capitated model, opportunities for further collaboration are possible as we have experienced in our other state programs. For example, dental and medical Case Management programs work together using an inter-disciplinary approach to coordinate care. Data exchange between dental and health plans provides both plans with a more comprehensive understanding of a beneficiary's health which assists in Case Management and risk stratification. This collaboration improves whole person heath and results in improved outcomes and cost-effective care.

7. What strategies should DHS consider adopting that could maintain or expand the current Medicaid dentists' participation.

DHS could consider using a variety of monetary and non-monetary provider incentives to encourage participation in Medicaid and expand access to care.

Monetary: One of the many benefits of a dental managed care program is the flexibility to use different provider compensation levels and strategies to incentivize participation or expansion into underserved areas, which could be beneficial in Hawaii where there are geographic access issues and provider shortages, and also to reward providers for improved quality performance through value-based programs.

Non-monetary: Enhanced provider relations functions and strategies to reduce provider administrative burden and support increased provider participation and retention in Medicaid. Managed dental plans have experience with provider recruitment, engagement, and retention strategies. In addition, plans have the flexibility to tailor utilization management requirements at the provider level based on provider performance data, and to ease administrative burden for high performing providers. This is a strategy that can increase participation in the program, while FFS programs must treat all providers the same and do not have the ability to tailor requirements.

8. What interventions and services that can effectively address the cultural and language barriers to the delivery of appropriate dental services? What strategies should the TPA devise to develop focused interactions, communications and supports to meet culturally diverse member needs?

As a Medicaid-focused dental benefits administrator, LIBERTY has a long-standing commitment, as a core value of our organization, to provide equitable and culturally competent health care and improve population health in the communities we serve. We have developed interventions to ensure delivery of appropriate dental services and meet the diverse needs of our beneficiaries, driven by our contract requirements to ensure all beneficiaries can access their dental benefits and supported through the capitated rate structure. It may be possible to incorporate some of the following program requirements, but most are more typical in a capitated model:

- Build accessible networks, track provider language capabilities, and publish language capabilities in provider directories;
- Offer in-person and telephonic translation services;
- Require provider completion of Cultural Competency Training;

- Monitor data for disparities in utilization;
- Provide case management to help beneficiaries overcome barriers to care, including the social determinants of health; and,
- Conduct community outreach activities to engage beneficiaries and community organizations they frequent.