

DENTAL PLAN COMMENTS ON 2011-12 MODEL HFP CONTRACT

Section		Page	Type of Change	Comments	Comments from Plans	MRMIB Staff Recommendation(s)
					<ul style="list-style-type: none"> Overall, the Contract requires additional administrative responsibilities that impact the cost and could result in higher premiums. 	No change to proposed language.
IV. Covered Services and Benefits	B.9. California Children Services (CCS)	24	Substantive	<ul style="list-style-type: none"> Clarifies Contractor's responsibility to provide covered services to treat the CCS condition in the event the CCS Program does not provide the services needed to treat a CCS-eligible condition. 	<ul style="list-style-type: none"> Clarify what type of dental treatment is required if CCS does not cover the member's services. Could interpret as the Contractor being responsible for CCS covered services. 	No change to proposed language.
					<p style="text-align: center;">Plan Recommendation(s)</p> <ul style="list-style-type: none"> MRMIB should provide historic data to on the incidences related to Plan's responsibilities for CCS services. 	
IV. Covered Services and Benefits	F.3. Copayments	25	Substantive	<ul style="list-style-type: none"> Requires the Contractor to annually report the copayments paid by subscriber households in the previous benefit year. 	<ul style="list-style-type: none"> New reporting requirement not included in the current plan premiums. Difficult to track and report copayments paid by subscribers because they pay copays to Providers. Clarify if the report has average aggregate copayment cost or information at the enrollee level. 	No change to proposed language.

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IV. Covered Services and Benefits	G.2. Coordination of Benefits	25	Substantive	<ul style="list-style-type: none"> Adds a requirement that Contractor designate at least one employee as a Health Plan Liaison to coordinate benefits and services, and resolve issues with a subscriber's health plan. 	<ul style="list-style-type: none"> What is the role of the dental liaison? Are there reporting requirements for the liaison? New requirement for additional resources not included in the contractor's premiums. Provide historic estimates of these services needed to coordinate between dental plan and health plan. 	No change to proposed language.
V. Clinical Quality Measures and Management Practices	A.1. Measuring Clinical Quality	27	Substantive	<ul style="list-style-type: none"> Changes the title of Attachment III from "Quality Indicators" to "Performance Measures." Adds language stating that the dental performance measures may be amended to include core quality measures as required by CMS. 	<ul style="list-style-type: none"> Explain in greater detail the core quality measures that are applicable to dental plans. 	Delete language referencing potential changes to the performance measures.
V. Clinical Quality Measures and Management Practices	C. Dental Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to notify applicants twice a year of the benefits of periodic oral health exams. 	<ul style="list-style-type: none"> New requirement for second contact of members, "via a mailed notice". There is a high return rate of mail and as a result, this would be an ineffective measure. 	Add language to allow the second notice to be provided through telephone or e-mail contacts.
					<p style="text-align: center;">Plan Recommendation(s)</p> <ul style="list-style-type: none"> MRMIB should consider alternative means of communication (by telephone, email or website outreach). 	

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V. Clinical Quality Measures and Management Practices	D.3 Encounter and Claims Data	30	Substantive	<ul style="list-style-type: none"> Requires the Contractor to provide encounter and claims data retroactively to January 1, 2006. 	<ul style="list-style-type: none"> Plan has been historically supplying monthly encounter data. This is a duplication of work and no funds for this are included in the current premium rate. Clarify the need for retrospective data. 	Change the retroactive date to January 1, 2008.
V. Clinical Quality Measures and Management Practices	E.2.b. Quality Performance	31-32	Substantive	<ul style="list-style-type: none"> Requires Contractor to collaborate with the State and its contracted consultants to develop and implement quality improvement projects and provide all information requested by the State. The State may require the Contractor to submit a quality improvement plan and may take other actions including, but not limited to, restricting Contractor's enrollment if the Contractor's performance is not acceptable. 	<ul style="list-style-type: none"> Prescriptive process and burden on the plan which premium rates do not consider. Provide greater detail regarding the scope of information being requested by the State. Plans are forced to comply with externally created QI plans and programs under the threat of sanctions without consideration to requirements, costs or implementation time needed. Concern that Plan would be prematurely sanctioned because many of the performance indicators are behavioral based and may take time to achieve. Language is unclear and does not consider feasibility or cost for implementing new projects. Plans may be forced to make QI plans specific to HFP even though they have QI programs in place. 	No change to proposed language.

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V. Clinical Quality Measures and Management Practices (continued)	E.2.b. Quality Performance (continued)				<p>Plan Recommendation(s)</p> <ul style="list-style-type: none"> • Develop MPLs that incorporate the average “age” of Plan’s membership. • Develop MPLs on a County or regional basis. 	
V. Clinical Quality Measures and Management Practices	E.4.b. Performance Standards and Payments	32-33	Substantive	<ul style="list-style-type: none"> • Adds a new section establishing a Minimum Performance Level (MPL) for each performance measure. • Requires Contractor to submit a Performance Improvement Plan (PIP) for each measure for which Contractor does not meet the MPL. • Outlines the elements of the PIP. • Requires additional reporting by Contractor until improvement is demonstrated. 	<ul style="list-style-type: none"> • MPLs do not take into consideration any population norms or studies. • Compensation rates are different for dental HMOs and FFS yet both are expected to comply with MPLs. • Two important factors not taken into account: <ul style="list-style-type: none"> ✓ Length of time members have been enrolled in plan. ✓ Not all dental plans participate in all counties. 	<p>Clarify that plans will report performance measures based on calendar year 2011 data.</p> <p>Modify the MPL language to delete reference to how the MPLs are calculated.</p> <p>Specify that the PIP will be required if the plan does not meet the MPL for the OUDS 1 measure only.</p> <p>Amend the OUDS 1 minimum performance levels to have distinct levels for the dental HMOs and the dental EPOs.</p>
					<p>Plan Recommendation(s)</p>	
					<ul style="list-style-type: none"> • Establish distinct MPLs for each delivery model (Dental HMO and EPO). 	

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V. Clinical Quality Measures and Management Practices	E.4.c. Performance Standards and Payments	33-34	Substantive	<ul style="list-style-type: none"> Requires Contractor to show demonstrable improvement in each performance measure from year to year. Describes the steps the Contractor must take if performance in any measure declines. Indicates the State may take action if Contractor's performance has not improved to the State's satisfaction. The State will provide performance payments when the Contractor meets or exceeds the MPL, if sufficient funds are appropriated for this purpose. Performance Payments will be calculated based on the Contractor's level of performance above the MPL. 	<ul style="list-style-type: none"> Define "demonstrable improvement." Not permitted to include services from medical records under capitation agreement with providers. Concerns regarding: <ul style="list-style-type: none"> ✓ Locating the "root cause." ✓ Quality improvement may not occur within the 6 month timeframe. May under-report services due to low incentive. 	<p>Modify language to require the plan to maintain or show improvement in its performance each year and delete reference to "demonstrable" improvement.</p> <p>Require the plan to submit a report if the plan's performance on the OUDS 1 measure declines.</p>
					<p style="text-align: center;">Plan Recommendation(s)</p> <ul style="list-style-type: none"> MPLs should be established without anticipated punitive or disincentive impacts. Reinstate hybrid method for data collection and reporting. Expand time period for quality initiative to 12 months. Minimum MPL thresholds should be established with no punitive or disincentive impacts to high-performing plans. 	

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V. Clinical Quality Measures and Management Practices	E.4.d. Performance Standards and Payments	34	Substantive	<ul style="list-style-type: none"> Placeholder for performance payments. 	<ul style="list-style-type: none"> Provide the proposed Performance Payments language. Expensive to generate encounter data for reporting. 	Delete reference to performance payments.
V. Clinical Quality Measures and Management Practices	H. Group Needs Assessment	34	Substantive	<ul style="list-style-type: none"> Requires the Contractor to submit an update to the 2011 Group Needs Assessment no later than September 30, 2012. 	<ul style="list-style-type: none"> Provide clarification regarding scope and intent of the expected "update." Requirement for "a format determined by the State" is too prescriptive. Concern that additional requirements time and resource intensive for contractor and the time and resources are not included in current premium rates. 	No change to proposed language.

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Attachment XX			Substantive	<ul style="list-style-type: none"> Establishes the MPL for each dental performance measure. 	<ul style="list-style-type: none"> Concerned that statistics are used to “artificially, arbitrarily and capriciously” set requirements and are unsubstantiated by evidence-based research.” Comparison of capitation model reimbursement plans reported utilization rates are unclear on whether there is a true need or a true desire or for treatment. Provision of more dental services does not necessary equate to “better oral health.” Question the reliance on simple statistics to increase utilization. MRMIB does not engage in “root cause analysis” in problems with comparing FFS plans with capitation model plans. Decision to implement these changes may not be based on evidence. 	<p>Calculate the MPL for each measure based on 80% of the HFP weighted program average for 2009.</p> <p>Establish a distinct MPL for the dental HMOs another distinct MPL for the EPOs for the OUDS 1 measure</p>
					Plan Recommendation(s)	
					<ul style="list-style-type: none"> Use an accurate assessment for the true needs of the population to help achieve superior performance 	

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Attachment III: Dental Performance Measures		1	Substantive		<ul style="list-style-type: none"> Apply HEDIS metrics from the Annual Dental Visit uniformly across all measures for a single year period. Three distinct definitions for eligible populations within the specific measurements. Recommend consideration for use of a common definition for metrics based on a single year measurement. CDT2011 has established new treatment procedure code D1352 "preventive resin restoration that MRMIB should include in "treatment/prevention" of caries and filling to preventive services ratio" measures. 	Change the specifications for the OUDS 1 measure to reflect continuous enrollment in the plan for 11 out of the past 12 months.
Exhibit B	II.A.1	2			<ul style="list-style-type: none"> Provide the minimum loss ratio for the Contract. 	No change to proposed language.
Exhibit B	II.A.2	2	Substantive	<ul style="list-style-type: none"> Clarifies timeframe under which MRMIB will pay fee per member who was enrolled on or after the 16th of the month. 	<ul style="list-style-type: none"> Interim loss ratio date span has not adjusted to reflect Plan year changes. The date span of July-November does not align with October 1 benefit year. 	Change the timeframe to reflect the new benefit year.