

Administrative Model: ASO <i>Vendor responsibilities limited to administrative duties</i>	
Delegation of Responsibilities	
State <ul style="list-style-type: none"> Fiscal responsibility Provider enrollment 	Dental Vendor <ul style="list-style-type: none"> Claim adjudication Utilization management Utilization review Customer service Complaints and grievances Reporting
PROS	<ul style="list-style-type: none"> Minimal disruption to program participants if current model is ASO Limited resources required from state
CONS	<ul style="list-style-type: none"> Limited network oversight and lack of credentialing a risk for the state Complex file exchanges through MMIS extend claim turnaround times Structure could be impediment to improving care coordination

Administrative Model: ASO PLUS/Risk Share <i>Vendor assumes additional responsibilities, limiting state's participation in the program</i>	
Delegation of Responsibilities	
State <ul style="list-style-type: none"> Contract oversight 	Dental Vendor <ul style="list-style-type: none"> Cost of claims Claim payment Claim adjudication Network management and provider enrollment Enhanced utilization management Enhanced utilization review Customer service Member outreach Complaints and grievances Reporting
PROS	<ul style="list-style-type: none"> Increased efficiency for the state: less staff, less involvement Improved panel composition Addition of network responsibility permits vendor to manage credentialing as states move toward compliance with ACA provider enrollment standards Enhanced UM function reduces costs Removal of MMIS claim extract interface means faster payments to dentists, increasing their satisfaction with program Vendor assumes some financial risk

	<ul style="list-style-type: none">▪ Vendor is incentivized to maintain control over member access▪ Vendor is incentivized to monitor medical necessity of services▪ Network management will improve panel composition, reduce costs▪ Faster payments to providers
CONS	<ul style="list-style-type: none">▪ Provider credentialing would alter network composition and puts more attention on maintaining the access rate▪ Provider credentialing would alter network and could affect access rate▪ Experienced vendor is essential to manage cost of care

ASO PLUS/Risk Share Example
From the 2013 TennCare RFP

The Contractor shall operate as a partial risk-bearing entity for dental services with shared savings and losses as described below. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

a. Risk sharing calculations are influenced by three variables: annual service expenditures, annual dental participation ratio (Refer to Attachment E for a description and calculation of the annual dental participation ratio), and percentage risk level chosen by the DBM. To calculate the actual saving or loss amount, the difference between the target service expenditure baseline amount and the actual service expenditure for the period is calculated and savings or loss amounts are multiplied by the appropriate risk level percentage chosen by the DBM. In cases, where the DBM posts a savings, this initial gross bonus payment amount is then adjusted by the participation ratio achieved for the period. This adjustment is designed to ensure that any cost savings come from better management of the program and not from a reduction in the number of enrollees receiving services. If the participation ratio achieved is three (3) or more percentage points below the established target for the period, this would disqualify the DBM from any profit sharing for that period.

b. There can only be profit sharing if: a) there is a savings based on the established annual target service expenditure and, b) the Contractor achieves a participation ratio above a specified minimum. The specified minimum in year one (1) is 50.6% at or below which there is no profit sharing awarded despite any savings. Profit sharing will be based upon the following formula: Actual savings achieved, multiplied by the appropriate risk sharing percentage giving the gross bonus payment amount. The gross bonus payment amount will then be reduced at a proportional rate, within a tenth of a decimal point, for each reduction in the participation ratio below the target established. This proportional rate adjustment is called the adjustment factor. The adjustment factor is then applied to the gross savings bonus amount to yield the actual bonus payment amount. Refer to Tables 1 below for sample calculation under this process. There is an upper and lower limit of \$8 million per year in the amount of savings bonuses earned or loss payments made by the contractor.

c. An initial target service expenditure baseline will be established by TennCare based on historical trends. Appropriate adjustments to year one (1) target service expenditure baseline will be made if there are changes to the fee schedule, significant changes to enrollment, or TennCare directed changes to the medical necessity guidelines during the year. In year two (2) and in year three (3) the annual target service expenditure will be adjusted based on the target participation ratio, the prevailing fee schedule, overall utilization patterns, enrollment changes and other budgetary factors. Both the target service expenditure rate and the target participation ratio will be released to the Contractor no later than thirty (30) days after commencement of the fiscal year.

The Contractor will not be penalized for budget overruns, where the increase above target service expenditure amount is also accompanied by a participation ratio which also exceeds the target ratio and the service expenditure is attributable to the participation ratio achieved. Nevertheless, because this scenario does not meet the goal of budget predictability and there is no savings, there will be no bonus sharing either.

d. The Contractor must meet one of the following licensure requirements to operate as a risk bearing entity.

1. Dental Service Plan – licensed pursuant to TCA Title 56, Chapter 30;
2. Prepaid Limited Health Service Organization – licensed pursuant to TCA Title 56, Chapter 51;
3. Insurance Company – licensed pursuant to TCA Title 56, Chapter 2;
4. Hospital and Medical Service Corporation – licensed pursuant to TCA Title 56, Chapter 29, or
5. Health Maintenance Organization – licensed pursuant to TCA Title 56, Chapter 32.

Table 1 – Risk Level Scenario Calculations

DBM % Risk Level	Target Participation Ratio			Service Expenditure			Profit	Loss
	Year 1 53.6%	Year 2	Year 2	Year 1 \$174M	Year 2	Year 2		
50%	53.6%			\$164M			\$5M	
50%	52.1%			\$164M			\$2.5M	
50%	50.6%			\$164M			\$0	
50%	53.6%			\$184M				\$5M
50%	53.6%			\$194M				\$8M

Annual Dental Participation Ratio

Description

The weighted percentage of qualifying members 2 – 20 years of age who had one (1) or more qualifying dental services during the measurement year.

Eligible Population

Members age 2 – 20 with a minimum 90 days of program and benefit. Age is determined at the mid-point of the reporting period.

- Continuous Enrollment** - Eligibles must be continuously enrolled for a minimum of 90 days
- Anchor Date** - Mid-point of reporting period
- Benefit** - Dental

Qualifying Services

Claims with a qualifying paid service.

Codes to identify qualifying services¹ HCPCS/CDT: D0100 – D9999.

¹CDT (Current Dental Terminology) is the equivalent dental version of the CPT Physician Procedural Coding System

Metric Formulation

- Numerator** - The sum of the FTE for qualifying eligibles with 1 or more qualifying services in the measurement year
- Denominator** - Sum of FTE for all qualifying eligibles

FTE equals the number of days eligible divided by 365.25

Mathematical Formulation

- i. **Participant Ratio Weight for Individual *i***

$$W_i = Fte_i / \sum_{i=1}^I Fte_i; \quad \text{Where } I \text{ equals the total qualifying eligibles}$$

$$\text{Where } \sum_{i=1}^I W_i = 1$$

ii. **Qualifying Service Indicator**

$$f(s) = \begin{cases} 1, & \text{if received qualifying service} \\ 0, & \text{if not} \end{cases}$$

iii. **Participation Ratio for Individual i**

$$PR_i = W_i * f(s)$$

iv. **Overall Participant Ratio**

$$PR = \sum_{i=1}^I PR_i$$