1993

Study of Alternative Methods of Managing Dental Contract Health Services

Support Services International, Inc.

W. Hillabrant

A. Brown

C. Brutus

FINAL REPORT

STUDY OF ALTERNATIVE METHODS OF MANAGING DENTAL CONTRACT HEALTH SERVICES

Submitted to:

Division of Program Evaluation/Policy Analysis
Office of Planning, Evaluation, and Legislation
Dental Services Branch
Indian Health Service
Department of Health and Human Services

Submitted by:

SUPPORT SERVICES INTERNATIONAL, INC.

8609 SECOND AVENUE • SUITE 506B
SILVER SPRING, MARYLAND 20910-3362
(301) 587-9000 • (301) 587-9007 FAX

March 1993

FINAL REPORT

STUDY OF ALTERNATIVE METHODS OF MANAGING DENTAL CONTRACT HEALTH SERVICES

I. EXECUTIVE SUMMARY

1.0 Introduction

The Indian Health Service (IHS) has provided dental services to eligible American Indians and Alaska Natives since 1955, predominantly through the use of Federally employed staff. In the early years of the dental program, a contract care budget was established to supplement the direct care delivery program provided by Federal staff. Private practice dentists, working under contract to IHS, provided emergency and specialized dental services otherwise unavailable from the IHS direct care program. From a modest beginning ($280,000 in 1960), by 1970 dental contract care expenditures exceeded $1 million. In 1972, in order to improve the delivery and management of dental care, IHS began to manage direct and contract resources interchangeably. The dental contract budget exceeded $10 million by 1990 and represented approximately 30 percent of the total dental budget.

The IHS negotiated contracts with private practice dentists on a fee-per-service basis (when services were provided in their private offices) or, in limited instances, on a fee-per-clinic basis (when services were provided by private dentists in IHS facilities). No attempt was made to determine if the provider's fees were those *usually* charged other patients, *customary* with regard to fees charged by other dentists in the region, or *reasonable* with regard to the complexity of the procedures.

1.1 Background. During the 1980's, selected IHS Area Dental programs experimented with utilizing *Delta Dental Plans* (Delta) to manage the contract dental care program for IHS beneficiaries. Delta is a provider-sponsored, not-for-profit organization licensed within each state. In a study conducted by the IHS in the Portland Area, the cost benefit of using the Delta Dental Plan was determined to represent a 21 to 22 percent savings inclusive of the administrative costs of the Delta services.

In Fiscal Year (FY) 1986, the IHS contracted with Blue Cross/Blue Shield of New Mexico (BC/BSNM) as the FI for the Contract Health Service (CHS) program. Under the terms of the contract, BC/BSNM was to employ existing methodologies to process the claims from vendors providing medical care services to IHS beneficiaries. Following this contract, the IHS Dental Services Branch entered into an agreement with BC/BSNM to employ existing methodologies to process claims from Dentist providers. The Dental Branch was mandated to use BC/BSNM through FY 1994, based upon the existing medical CHS contract. Selected IHS Areas with existing Delta contracts were permitted to continue with those contracts in place.

Historically each IHS Area has approached the provision of dental CHS from an independent standpoint. Selected IHS Areas function as FIs, conducting all of the functions performed by an FI. Other Areas have chosen Administrative Services Only (ASO) contracts with state Delta Dental Plans to provide for FI services. Even where an FI is employed, there are numerous responsibilities required of the IHS Areas and Service facilities. In order to develop a SOW which accurately reflects the desires and needs of the IHS Areas, this study assessed those requirements and their relevance to a national contract.

There are four components within the IHS Areas and Service facilities which have responsibility for or impact upon the dental CHS function: 1) the CHS Branch, 2) the Dental Services Branch, 3) the Information Resources Management Branch, and 4) the Financial Management Branch. Data are required from the each of the identified branches and service facilities to accurately represent current activities with regard to CHS.

1.2 Statement of the Problem. There are differences in the scope of dental fiduciary services provided by the Blue Cross/Blue Shield (BC/BS) carriers, the for-profit dental insurance companies, and the Delta Dental Plans. Because of previous studies and experience with Delta organizations the IHS hypothesizes that a national contract with a third party administrator (TPA) including a fiscal intermediary (FI) could offer greater cost savings, assure that services meet appropriateness and quality standards, and provide for more equity of services among the IHS beneficiaries for whom contract care is provided.

1.3 Goals and Objectives of the Study. The following represent the objectives of this project:

- To evaluate the organization, capacity, capabilities, and functions of a sample of dental TPAs capable of managing a national contract for management of IHS dental CHS;

- To evaluate the organization, capacity, capabilities, functions, and willingness of the IHS Areas and service facilities with regard to managing the dental CHS program:

a) on an independent basis; b) through individual area contracts with a TPA, and c) through a national contract with a TPA;

- To determine, describe, analyze, and document the requirements of P.L. 93-638 tribes and tribal organizations with regard to the management of the dental CHS program;

- To develop a model Scope of Work (SOW) for a national TPA contract to manage reimbursement for IHS dental CHS resources;

- To develop a model SOW for FI contracts to manage reimbursement for tribally-managed Dental CHS resources;

- To develop a model Provider Agreement to facilitate contracting for dental services and assure the delivery of quality services and standards.

2.0 Methodology

2.1 Study Design. This project was a case study with interviews of key informants in a variety of organizations including 1) TPAs considered to be capable of managing a national CHS contract, 2) IHS Area Offices and Service Units, and 3) tribes operating dental programs under P.L. 93-638 contracts with the IHS. Site visits were made to BC/BS organizations in New Mexico and Michigan; Delta Dental Plans in California, Michigan, and Oklahoma; IHS Area offices and IHS and tribally-managed service facilities in the Albuquerque, Bemidji, California, Navajo, Oklahoma, and Portland Areas.

3.0 Findings

3.1 Capabilities of Third Party Administrators (TPAs). This study assessed the capabilities of TPAs to manage and pay for dental health services. Specific capabilities examined were 1) administration and management, 2) claims processing, and 3) quality assurance.

The TPAs were rated on each of these three areas of competence. The results indicated that the TPAs are generally strong in the three areas studied. In summary, while there is significant variation in the level of capabilities and of performance, the TPAs often provide services that cannot be duplicated by IHS. Furthermore, it seems likely that many TPAs would respond to an RFP to provide management and FI services for the IHS dental program.

3.2 Needs and Status of IHS Area Offices. Among IHS Areas, there is great variability in the approaches to providing and managing dental services. For example, the Navajo Area has large direct care clinics staffed with multiple clinicians. In contrast, the Portland Area has numerous tribally-operated dental programs, and the Area Office has provider agreements with many vendors. In 1988, the Portland Area contracted with Delta Dental of Oregon, but was dissatisfied with the level of service provided; these contracts were terminated. Conversely, the Oklahoma Area has access to thousands of providers through a contract with Delta Dental of Oklahoma. Staff in the Oklahoma Area Office and Service Units reported Delta's services to be exceptionally good. All these staff agreed that termination of the Delta contract would have catastrophic consequence for CHS dental program.

Quality assurance and data systems supporting dental CHR are uneven across IHS Areas. In general, these systems are far more advanced at TPAs.

3.3 Needs and Status of Tribal "638" Programs. The tribal programs in this study have utilized a wide range of approaches to managing Dental CHS. Some tribes have employed Delta Plans (e.g., Riverside-San Bernardino, Choctaw), some tribes used the IHS FI (Cedar City); however, most tribes manage their own dental CHS from referral to payment.

Despite the availability of contract providers and the satisfaction with the dental services provided, the study revealed four major problems associated with tribal programs: 1) inadequate information and reporting systems, 2) inadequate documentation of program procedures and associated dependence on individual program managers, 3) inadequate support for contracting and negotiating costs with local providers, and 4) a potential for fraud and abuse.

4.0 Recommendations

4.1 National FI Contract

Currently each IHS Area Dental Program can elect to participate in the FI contract for the management of CHS resources. Due to efficiencies of scale, FI costs decrease as the number of claims processed increase. These efficiencies of scale should be balanced against the need for flexibility associated with the special circumstances of each IHS Area including satisfaction with existing TPAs.

Recommendation 1: The IHS should consider mandating all IHS Area dental programs to participate in the eventual FI contract with provision for exceptions for special cases. Tribal Dental programs should also be encouraged to participate in the FI contract.

4.2 Valid Uses of Dental CHS Resources

During this study it became evident that great variability exists between Areas, and among Service Units within Areas, in the use of dental CHS resources. This variability leads to the inequity of service availability to American Indians and Alaska Natives (AI/AN) based upon geography and other factors such as accessibility, funding, etc. The medical program has developed priority rankings for various services, and has determined that urgent and emergent care is the number one priority, and the only priority for which CHS resources can be expended. This urgent and emergent priority does not fit the dental care delivery model. Historically, a dental contract care budget was established to support the direct care delivery program by providing emergency and specialized services. In 1972, an IHS policy decision directed that contract and direct resources should be managed interchangeably to provide the most advantageous service delivery for patients. Following this policy change, the dental CHS budget grew to represent approximately 30 percent of the total dental budget.

The dental program uses CHS resources to 1) support fee-for-clinic care by generalists in IHS facilities as an alternative to Federally employed staff, 2) to support fee-for-service in private dental offices for Level I services when the facility dentist is away from station on leave or training, 3) to provide fee-for-service care to populations with limited access to IHS direct care facilities, 4) to support the direct care program when the patient's requirements are beyond the capabilities of the facility dentist (i.e., specialist services are needed), 5) to purchase dental laboratory services, 6) to provide fee-for-service in private dental offices for Levels II and III when patient demand exceeds the capacity of the direct care staff, and 7) to provide for deferred services in Levels IV - VI.

Recommendation 2: The IHS Dental Services Branch, in consultation with the Areas should establish a priority listing of the valid uses of CHS dental resources.

4.3 Dental CHS Budget

Prior to the initial FI contract, the IHS Dental Branch was appropriated an annual CHS budget. This budget was allocated to the IHS Areas which then allocated funds to the Service Units. When the IHS entered into the FI contract, it was decided to pool all CHS resources and the Dental Branch lost the line-item designation.

This decision has left the IHS dental programs in a supplicant role with regard to the expenditure of CHS resources. The Areas exhibit extreme variability in their approach to expenditure of CHS resources for dental care. Some Areas carefully monitor the dental program, others do not. For those that do not manage dental expenditures, aggressive dental program managers could exploit the system with a first-come, first-served approach. Additionally, without a defined budget, the dental program lacks the incentive to manage the CHS resources effectively or efficiently.

After the Dental Branch develops the priority listing of valid uses of CHS resources, each Area should develop Service Unit and Area Office budgets sufficient to fund the CHS program. The Dental Branch would then submit the dental CHS budget to Headquarters for review and approval.

This budget process would have the following impact:

1. The AI/AN populations would be treated equitably with regard to services availability and delivery;
2. Tribes considering contracting through P.L. 93-638 would know the amount of CHS funds available to them;
3. Area Offices and Service Units would have an incentive to actively manage the CHS resources to provide for the maximum benefit to the population;
4. The potential offerors would have more complete data upon which to develop their cost estimates;
5. The eventual FI could develop automated systems of claims processing based upon the limitations in the valid uses of resources prioritization.

Recommendation 3: The IHS Dental Branch should be provided an identified amount of resources for funding dental CHS requirements.

Recommendation 4: The IHS Dental Branch should allocate the CHS dental resources to the Areas based upon their needs with regard to the valid uses of CHS resources.

Recommendation 5: The Area Offices should allocate the CHS dental resources to the Service Units based upon their needs with regard to the valid uses of CHS resources.

4.4 Provider Agreements

During the course of this study, the issue of responsibility for securing provider agreements has arisen. It has been argued by IHS procurement staff that only the IHS has the authority to enter into agreements with providers. Historically, the dental program negotiated contracts with high

volume providers. These contracts spell out the government responsibility and the provider responsibility. Included in the contracts were the fees the provider agreed to charge for various services. The contracts delineated the quality and appropriateness of the care to be provided. Payment was based on the fees the contractor had provided.

This study found that TPAs have sophisticated systems of developing panels of high quality dentists through a participating provider agreement process. The Delta Plans best exemplify the management of participating provider agreements. In the Delta system, participating contract providers agree to: 1) accept the "Usual, Customary, and Reasonable" fee or pre-approved fee as full payment for covered services provided to any beneficiary, 2) accept direct payment made by Delta for payment in full, 3) schedule and provide all dental treatment for beneficiaries in accordance with the applicable dental professional standards in their communities, 4) cooperate with the local committee or consultants designated by Delta and or the local plan to review the adequacy of care provided by participating contract providers, 5) remain bound to all of the terms of the Delta Plan as set forth in the coverage, limitations, exclusions, and processing policies, 6) take responsibility for the accuracy of all information shown on the claim submitted on the beneficiary's behalf, 7) complete and submit a quality assurance questionnaire to determine if office procedures meet accepted standards, 8) file any necessary forms at no charge, and 9) permit full audits of patient records in the dental office.

The TPAs that employ participating provider agreements have procedures in place to effectively administer their services. To require the offeror to encourage providers to become participants is to ask for what TPAs are routinely doing in their businesses. Requiring provider agreements should add little, if anything, to the cost of the FI contractor. The TPAs that utilize participating provider agreements generally pay participants at the 90th percentile and non-participants at the 50th percentile. Payment at these rates will save the Government money.

Requiring the IHS Area Offices and Service Units to negotiate participating provider agreements with vendors would represent a considerable additional workload. In such an instance, it would still be an FI responsibility to maintain the individual fee schedules negotiated by the IHS; however, payment would be at the level of the filed fees rather than the 90th or 50th percentile. This approach would cost the government twice as much as requiring the FI to establish provider agreements.

Recommendation 6: The IHS should include language in the FI Scope of Work to require the offeror to encourage participating provider agreements to the maximum extent possible.

4.5 Quality Assurance and Appropriateness of Care

The study provided evidence of innovative methods of utilizing computer aided quality assurance reviews to identify providers who are outside the pre-established parameters of normal practices. Michigan BC/BS, DDP*Delta, and HMS each utilize automated procedures to screen for aberrant provider practices. The exact methods employed can be found in the Site Visit Reports of this study (Volume 2). It is clear that the technology and the techniques exist to fully utilize automation to identify those few providers who would be candidates for further review.

Michigan BC/BS and DDP*Delta have formalized methods for conducting "in-mouth" reviews of the quality of the care rendered. Each has a proven track record of having conducted such reviews. The IHS has a proven methodology for evaluating the quality of care provided. This methodology has been used to evaluate private practice dentists and has met with success.

The ability of TPAs to identify aberrant providers should form the basis for determining the appropriateness of the care provided. The IHS Dental CHS database should be passed through an automated QA review such as those used by the TPAs in this study. The results of this quality assurance review should be provided to IHS by the FI. The evaluation of the technical quality of care should remain a responsibility of the IHS.

Recommendation 7: The FI Scope of Work should call for an advanced, computer-assisted quality assurance review process with submission of semi-annual reports on the CHS database.

Recommendation 8: The IHS should be responsible for determining the providers for whom further action is required. For technical quality of care issues, the IHS should have in place written policy, procedures and techniques for evaluating the technical quality of dental services and the process for appropriate action. These policies and procedures should not be a part of the FI's responsibilities.

4.6 Tribal Participation in FI Contract

The mandate that by 1997, 75 percent of the tribes and tribal organizations manage their health programs under P.L. 93-638 contracts has important consequences for an IHS FI. Currently, tribes that manage their own CHS programs are not mandated to utilize the FI. As more tribes "lock-in" their share of the CHS budget through 638 contracts, the remaining tribes are seeing their CHS budgets erode. This decrease in CHS funding will force more tribes to consider the operation and management of their own dental CHS programs.

Individual tribes may not see the advantages of an FI. In fact, one could hypothesize there are more disadvantages than advantages. If tribes were unable to "piggyback" onto the IHS procurement, their costs would not reflect the IHS economies of scale.

When a tribe takes over the management of the CHS program, it is often in a better position to negotiate with local vendors. Tribes are not bound by all federal procurement rules. The tribes can make prompt payment, and may seek corresponding prompt payment and other discounts from vendors. Furthermore, if tribes choose to manage the claims processing activities, they provide jobs for local members within the reservation boundaries. The tribes may prefer to hire additional staff or procure technology to permit the provision of services in the local facility.

If participation in the FI contract is to be perceived advantageous by tribes and tribal organizations, the costs and benefits must equate. It is difficult to envision such costs for individual tribes being reasonable unless the tribes are able to take advantage of the services of the IHS FI. Many issues need to be identified and resolved in order for the use of the IHS FI to be attractive to tribes with "638" programs. The SOW for the FI procurement should require the offeror to conduct a pilot project with one or more tribes to identify and resolve issues related to use of the FI by "638" programs.

Recommendation 9: The FI SOW should require offeror participation in a pilot project to study the issues of tribal participation in the FI contract and to encourage tribal participation.

The IHS Areas and Service Units are required to (or choose to) spend inordinate amounts of staff time in the management of the CHS program. Area Offices and Service Units have not implemented the components of the RPMS such as the Dental Data System and the CHS component. The functionality of these components can reduce the burden on the CHS staff. There is considerable time spent on contracting with vendors which could be accomplished more efficiently by the FI, at least in the case of dental contract services. Issuing individual HSA 57's when groups of eligible individuals can be identified and listed on a Master Delivery Order List is an inefficient use of staff resources and not cost-efficient for all parties involved—the IHS, the vendor, and the FI. Issuing "hard copies" rather than electronic documents increases the burden on all as well.

The development of a priority listing of the valid uses of CHS dental resources creates a de-facto benefits package around which the FI can develop limitations, exclusions, and exceptions. This will facilitate the claims processing function, reduce the number of pended claims, and assure prompt vendor payment. The establishment of Service Unit budgets, when communicated to, and managed by the FI would prevent the over-expenditure of funds.

Recommendation 10: The IHS Dental Branch should evaluate all aspects of IHS responsibility with regard to the CHS program and seek methods to transfer responsibility to the FI.

Recommendation 11: The IHS Dental Branch should work with the Office of Information Resources Management to develop plans for the application of advanced technology to the end of collecting, merging, and analyzing health statistics from disparate, often incompatible tribal, IHS, and other systems.

Acknowledgements

This study depended on the generous assistance of participating tribal staff and staff of Headquarters, Albuquerque Headquarters, Area Offices, and Service Units of the Indian Health Service (IHS).

Project Staff

Walter Hillabrant, Ph.D., Project Director
Athena Brown, Project Manager
Caleb Brutus, Document Production

Consultants

Walter Wolford, DDS, MPH, Consultant, Sundance Consulting
Margot LaBrasseur, Ph.D.

IHS Delivery Order Officer

Leo J. Nolan III, Director, Division of Program Evaluation and Policy Analysis

IHS Co-Project Officers

Eric Broderick, DDS, Assistant Chief, Headquarters, Dental Services Branch
William Niendorff, DDS, Director, Albuquerque Headquarters, Dental Information Standards

This report is made pursuant to Delivery Order No. 3, Contract No. 282-91-0053.

Table of Contents

List of Figures and Tables

FINAL REPORT
STUDY OF ALTERNATIVE METHODS OF MANAGING DENTAL CONTRACT HEALTH SERVICES

II. INTRODUCTION

1.0 Background

The Indian Health Service (IHS) has provided dental services to eligible American Indians and Alaska Natives since 1955, predominantly through the use of Federally employed staff. In the early years of the dental program, a contract care budget was established to supplement the direct care delivery program provided by Federal staff. Private practice dentists, working under contract to IHS, provided emergency and specialized dental services otherwise unavailable from the IHS direct care program. From a modest beginning ($280,000 in 1960), by 1970 dental contract care expenditures exceeded $1 million. In 1972, in order to improve the delivery and management of dental care, IHS began to manage direct and contract resources interchangeably. The dental contract budget grew to $10 million by 1990 and represented approximately 30 percent of the total dental budget (see Figure 1).

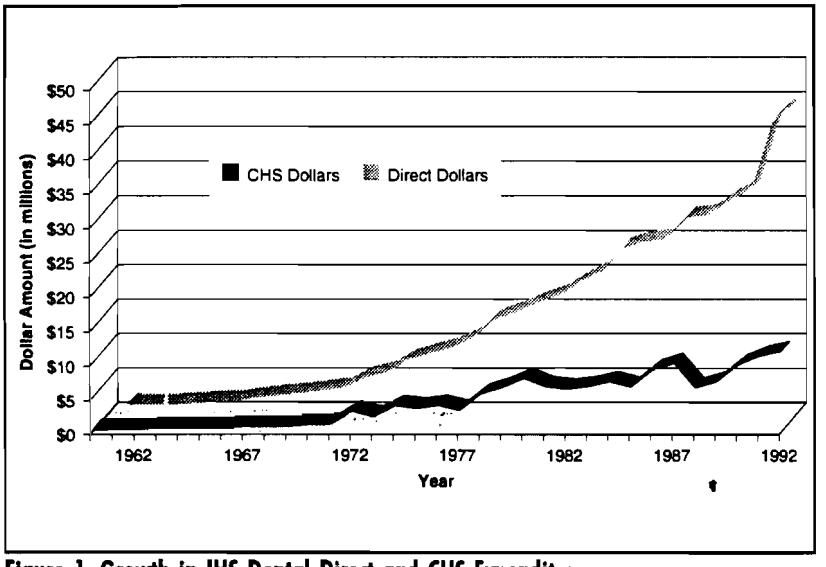

Figure 1. Growth in IHS Dental Direct and CHS Expenditures

The IHS negotiated contracts with private practice dentists on a fee-per-service basis (when services were provided in their private offices) or, in limited instances, on a fee-per-clinic basis (when services were provided by private dentists in IHS facilities). As part of the contract, the provider was required to submit to the IHS a fee schedule. No attempt was made to determine if the provider's fees were those *usually* charged other patients, *customary* with regard to fees charged by other dentists in the region, or *reasonable* with regard to the

complexity of the procedures. Theoretically, when a claim was submitted to the IHS for payment, the contract health service clerk was to compare the fees charged to those maintained in their fee schedule. In actuality, the fees claimed on the statement were routinely those paid without additional verification.

During the 1980's selected IHS Area Dental programs experimented with utilizing *Delta Dental Plans* (Delta) to manage the contract dental care program for IHS beneficiaries. Delta is a provider-sponsored, not-for-profit organization licensed within each state. The major advantage of Delta is the willingness of the majority of dentists within a state to participate with the Plan. To become a participating provider, each dentist must agree to a series of provisions, one including submission of a schedule of services, and the fees charged for each specific service. For each procedure, Delta determines the distribution of fees charged by the participating dentists. Delta reimburses dentists on their pre-filed fee, or the 90th percentile of the fees charged by participating providers, whichever is less.

In a study conducted by the IHS in the Portland Area, the cost benefit of using the Delta Dental Plan was determined to represent a 21 to 22 percent savings inclusive of the administrative costs of the Delta services. In their marketing material, the Delta Dental Plans quote a savings of 14 percent based on the components of the participating provider agreement.

In FY 1986, the IHS contracted with Blue Cross/Blue Shield of New Mexico (BC/BSNM) as the fiduciary for the Contract Health Service (CHS) program. Under the terms of the contract, BC/BSNM was to employ existing methodologies to process the claims from vendors providing medical care services to IHS beneficiaries. Following this contract, the IHS Dental Services Branch entered into an agreement with BC/BSNM to employ existing methodologies to process claims from Dentist providers. The Dental Branch was mandated to use BC/BSNM through FY 1994, based upon the existing medical CHS contract. Selected IHS Areas with existing Delta contracts were permitted to continue with those in place.

1.1 IHS Areas and Service Facilities. Each IHS Area has independently approached the provision of dental CHS services. Selected IHS Areas function as Fiscal Intermediaries (FIs), conducting all of the functions performed by an FI. Other Areas have chosen Administrative Services Only (ASO) contracts with state Delta Dental Plans to provide for FI services. Even where an FI is employed, there are numerous responsibilities required of the IHS Areas and Service facilities. In order to develop a SOW which accurately reflects the desires and needs of the IHS Areas, this study assessed these requirements and their relevance to a national FI contract.

There are four components within the IHS Areas and Service facilities which have responsibility for or impact upon the dental CHS function: 1) the CHS Branch, 2) the Dental Services Branch, 3) the Information Resources Management Branch, and 4) the Financial Management Branch. Data are required from the each of the identified branches and service facilities to accurately represent current activities with regard to CHS.

1.2 Tribes and Tribal Organizations. Under P.L. 93-638, the *Indian Self Determination and Education Assistance Act*, tribes and tribal organizations can contract with the IHS to assume the management of health services components. The tribes and tribal organizations have not been required to utilize the IHS FI. There is extreme variability in the 638 tribes approach to CHS. Some tribes utilize the Delta Dental Plans, some use the IHS FI and others make special arrangements with local fiduciaries. Many tribal contractors, especially in Alaska, are in competition with the private sector. and, therefore, do not send their patients to private practice dentists. In certain instances, tribes have chosen to utilize CHS resources to hire specialists, thereby eliminating the need for the purchase of these services.

This study examined the current approaches used in managing dental CHS, and the needs of tribes and tribal organizations with regard to a national dental FI contract.

2.0 Statement of the Problem

There are differences between the scope of dental third party administration provided between the Blue Cross/Blue Shield (BC/BS) carriers, the for-profit dental insurance companies, and the Delta Dental Plans. Because of previous studies and experience with Delta organizations, the IHS hypothesizes that a national contract with a dental third party administrator (TPA) could offer greater cost savings, assure that services meet appropriateness and quality standards, and provide for more equity of services among the IHS beneficiaries for whom contract care is provided.

3.0 Goals and Objectives of the Study

There were eight study objectives:

1. To evaluate the organization, capacity, capabilities, and functions of a sample of dental TPAs to determine their ability to manage IHS dental CHS;

2. To evaluate the organization, capacity, capabilities, functions, and willingness of the IHS Areas and service facilities with regard to managing the dental CHS program: a) on an independent basis, b) through individual Area contracts with a TPA, and c) through a national contract with a TPA.

3. To determine, describe, analyze, and document the requirements of P.L. 93-638 tribes and tribal organizations with regard to the management of the dental CHS program;

4. To analyze and compare the differences and similarities of the various organizations providing dental TPA services to determine their capabilities for managing a national FI contract;

5. To meet with the IHS officials to determine, describe, and document the scope of fiduciary services deemed appropriate and acceptable for the dental program;

6. To develop a model Scope of Work (SOW) for a national TPA contract to manage IHS dental CHS resources;

7. To develop a model SOW for a TPA contract to manage reimbursement for tribally-managed dental CHS resources;

8. To develop a model Provider Agreement to assist tribes in contracting for dental services and assure the delivery of quality services and standards.

III. METHODOLOGY

1.0 Study Design

This project was a case study based on interviews of key informants in a variety of settings including 1) TPAs considered to be capable of managing a national FI contract, 2) IHS Area Offices and Service Units, and 3) tribes operating dental programs under P.L. 93-638 contracts with the IHS. Site visits were made to Blue Cross/Blue Shield (BC/BS) organizations in New Mexico and Michigan; Delta Dental Plans in California, Michigan, and Oklahoma; IHS Area offices and IHS and tribally managed service facilities in the Albuquerque, Bemidji, California, Navajo, Oklahoma, and Portland Areas.

1.1 Case Study Sites. Four sets of considerations governed the selection of sites for this study.

1. BC/BS of New Mexico is the current FI for the IHS medical and dental CHS program. Indirectly, this study constituted an informal evaluation of the past performance of the organization as well as its capacity and capability to manage a national dental CHS services program. BC/BS of Michigan is recognized nationally as one of the most progressive dental TPAs, employing state-of-the-art approaches to client service, cost control and quality assurance.

2. The Delta Dental Plans of California and Michigan are the largest of the state Delta organizations, and currently manage national contracts for private industry and the Government. These Delta Plans represent the baseline for any analysis of TPA capabilities. Additionally, California Dental Services also manages the dental CHS program for five tribal programs in the California Area. The Oklahoma Area IHS currently contracts with the Delta Dental Plans of Oklahoma to manage the Area's dental contract care budget of approximately $1,000,000. Inclusion of these organizations in the study permitted an objective evaluation of the capacity and capabilities of a Delta organization in managing IHS dental CHS.

3. The site visit to a for-profit dental insurance company permitted the collection of information regarding this method of providing TPA services. If the IHS chooses to contract with an TPA, the for-profit organizations will, in all likelihood, submit proposals. Therefore, it is in the best interest of the IHS to have a working knowledge of the organization and orientation of private dental insurers.

4. The Albuquerque Area was included in the study because this Area uses dental CHS to purchase fee-for-clinic services from the private sector. Albuquerque does not utilize BC/BSNM nor does it have arrangements with other TPAs. The Bemidji Area was selected because the preponderance of its dental programs are tribally managed. Additionally, the Bemidji Area has contracts with state Delta Dental organizations for the management of dental CHS resources. The California and Oklahoma Areas were visited to determine the functions related to the conduct of a dental CHS program managed by an FI. The Navajo Area currently utilizes BC/BSNM for the management of their dental CHS program. This Area was selected to determine the functions at the Area and service facilities required to comply with the dictates of the FI. The Portland Area was chosen for three reasons: 1) it has, in the past, contracted with Delta Dental of Oregon to provide fiduciary services; 2) a broad-based dental CHS program is currently managed at the Area office; and 3) there are many tribally-managed programs which provide a basis for determining their requirements for a dental FI contract.

In accordance with the Site Visit Protocol (Appendix 1), structured interviews were conducted with key informants during the site visits. A questionnaire was mailed to each key informant at least two weeks prior to the site visit to ensure sufficient time to retrieve and organize the requested data and information. Figure 2 displays the case study sites.

As part of the study, the following procurement documents were reviewed: 1) the CHAMPUS Request for Proposal (RFP) for a Dependents Dental Plan, 2) the Denti-Cal RFP for the contract with Delta Dental Plan of California, 3) the United Auto Workers RFP for the contract with Delta Dental Plan of Michigan, and 4) the Scope of Work for the DELTA CARE program purchased by Honeywell and WalMart. These documents were reviewed to determine the requirements mandated by the various clients in contracts with a national orientation.

Based on the site visits and the information from the various procurement documents obtained and reviewed, two model SOWs were developed: one was for an IHS-managed national FI contract, and the other was for a Dental CHS contract between a tribally-managed program and an FI. The model SOWs are presented in Appendix 2.

2.0 Data Collection

To successfully accomplish the study objectives, distinct data collection efforts were conducted for 1) private sector organizations which provide dental TPA services, 2) IHS Area Offices and Service Units which manage dental CHS funds, and 3) tribes and tribal organizations which have contracted under P.L. 93-638 to manage dental CHS funds.

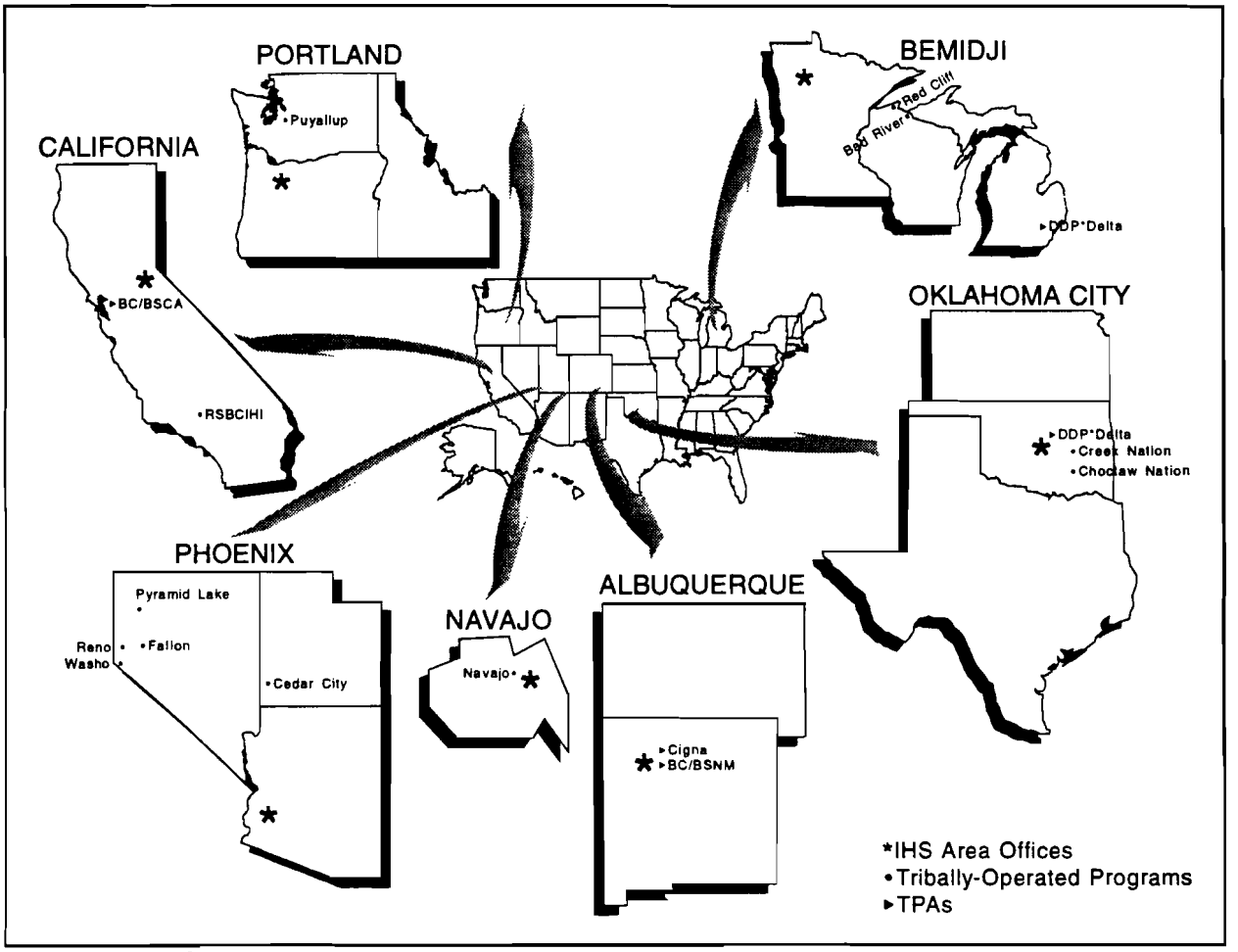

Figure 2. Case Study Sites

TPAs are organized to provide client services through administration and management, professional relations, claims processing, and assure the quality and appropriateness of the treatment services. These services are offered by the TPA 1) assuming the risk of assuring the prescribed services to the client enrollees for a stated premium, 2) providing administrative only services to clients on a cost reimbursement basis, or 3) arranging services through specified panels of providers, Health Maintenance Organizations (HMOs), or Preferred Provider Organizations (PPOs).

No matter the financial arrangement between the TPA and the client, the TPA must be organized to 1) administer the operation, 2) ensure there are sufficient dentist providers to serve the client enrollees, 3) process dentist requests for payment in accord with client-specified authorities, and 4) assure that enrollees are provided acceptable levels of quality services and appropriate treatment services.

In order to administer the operation, the TPA must meet appropriate levels of capacity and capability. To determine the organization's ability to administer a nationwide contract for the IHS, data were collected on three sets of TPA capabilities: 1) administration, 2) claims processing, and 3) quality assurance. Each of these sets of capabilities is discussed below.

2.1 Administrative Capabilities. The three major categories of a TPA have different approaches to providing and managing dental services. The Delta Dental Plan is a provider-sponsored, not-for-profit organization licensed within each state. The willingness of the majority of dentists within the state to participate make Delta Dental plans unique. BC/BS is a medical provider-sponsored, not-for-profit organization licensed within each state, some of which offer dental services to clients. Their approach to assuring adequate networks of dentist providers varies but, in all instances, it is less comprehensive than Delta. Proprietary insurance companies differ from Delta and BC/BS in that they are for-profit, and may not be limited to state boundaries. The approach of proprietary insurance companies to dentist providers is more "hands-off," predominately reimbursing billed charges.

2.2 Claims Processing Capabilities. The claims processing operation is the heart of the TPA's utility to clients. Following the client's determination of the scope of the services to be remunerated, and any limitations to be instituted, the TPA employs a variety of procedures, generally aided by extensive automation to assure compliance.

2.3 Quality Assurance Capabilities. The final component of TPA services is the assurance of quality care and appropriate treatment services. This is the most judicious of activities which the TPA must perform. Each of the TPA's approach quality assurance from differing perspectives, and have developed very different procedures to promote quality assurance. To effectively evaluate and compare these differences, as well as to determine the current state-of-the-art in quality assurance, the study examined all of the quality assurance aspects of each TPA.

3.0 Data Analysis

3.1 Content Analysis of Existing Dental Services Procurements. The contracts managed by BC/BS organizations or the Delta Dental Plans were collected and analyzed. The contracts analyzed included: 1) the CHAMPUS RFP for a Dependents Dental Plan, 2) the Denti-Cal RFP for the contract with Delta Dental Plan of California, 3) the United Auto Workers RFP for the contract with Delta Dental Plan of Michigan, and 4) the scope of the DELTA CARE program purchased by Honeywell and WalMart. These documents were reviewed to determine the

requirements mandated by the various clients in contracts with a national orientation. The review of the documents facilitated the formulation of the model SOW for the national IHS dental CHS procurement.

3.2 Ratings of TPAs. For each of the TPAs visited, the organization was rated on a set of 5-point scales ranging from (1) "Rudimentary/Minimal" to (5) "State of the Art/Extensive" (see Table 1). These ratings reflect an assessment of each organization's capacity and capabilities across 46 dimensions of dental TPA services.

For purposes of comparison, the Delta Dental Plan of California (CDS) was used as the baseline against which all other TPAs were compared. CDS was selected as the point of comparison for several reasons: 1) CDS is among the oldest and is the largest Delta organization in the country employing over 1,100 persons; 2) Delta is a profession-sponsored organization which, reportedly, represents the dental profession better than organizations with a different focus; 3) CDS offers a variety of product offerings through affiliations and in-house developed programs; and 4) CDS has a proven record in managing large scale contracts of a national nature, both commercial and governmental.

At the conclusion of the comparisons, an ideal organization was developed by taking the highest ranked from each of the organizations reviewed and incorporating it into an ideal of TPA functions. This ideal formed the basis of the IHS requirements for a national TPA contract to manage the IHS dental CHS program.

IV. FINDINGS

1.0 Third Party Administrators (TPAs)

1.1 Administrative Capabilities. Five TPAs were included in this study: 1) BC/BSNM, 2) BC/BS of Michigan, 3) California Dependents Dental Plan (DDP*Delta), 4) Health Management Systems, and 5) Cigna Corporation. The TPA capabilities of each of these five TPAs was assessed across three general areas 1) administrative capabilities, 2) claims processing capabilities, and 3) quality assurance capabilities. In total, 36 specific capabilities were rated. The total set of ratings are presented in Appendix 3, and individual ratings are presented and discussed throughout this section.

1.1.1 Role of Dental TPA Services. The relation of dental underwriting to the overall book of business was examined for each of the five TPAs, and they were rated using the 5-point scale. These ratings are summarized in Table 1. The DDP*Delta was organized exclusively to administer dental prepayment, therefore there are no other lines of business which compete with the administration of dental benefits. Health Management Systems, Inc. (HMS), is a full-service TPA of pre-paid dental programs and services. HMS is a subsidiary of Rocky Mountain Health Care Corporation (RMHCC)—a health care management company formed by New Mexico, Colorado, and Nevada BC/BS to manage the Plans and their subsidiaries. As a subsidiary, HMS enjoys great autonomy, both administratively and physically, from RMHCC and the individual Blues; however, as a subsidiary, HMS is subject to control from the administrators of the medical component.

The dental components of New Mexico and Michigan BC/BS and the Cigna Corporation are very much overshadowed by the size and scope of the medical components of the business.

Table 1. Role of Dental Services to Overall Business

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Relationship of dental services to overall business	1	1	5	5	1

SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive
NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated

1.1.1 Adequacy and Competency. Ratings of the adequacy and competency of executive staff of dental TPAs are presented in Table 2. DDP*Delta, HMS, and Michigan BC/BS each have well trained and seasoned dentists as their chief executive officers. The BC/BSNM dental component is managed by non-dental/non-medical administrators; however, they perform their duties in a professional and competent fashion. The Cigna Corporation did not provide an organization chart for top level management.

Table 2. Administrative Adequacy and Competency

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Adequacy of dental prepayment executive level staff	1	3	5	5	*B
Competency of dental prepayment executive level staff	3	4	4	4	*C
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

1.1.2 Scope of Dental Product Offerings. The scope of dental product offerings are best represented by the Michigan BC/BS and HMS since they provide the broadest scope of dental products. The majority of their dental business is conducted under the traditional fee-for-service mode. Traditional coverage offers subscribers more choices in the selection of a dentist while providing comprehensive coverage nationwide. Utilizing large and stable provider networks, this program maximizes flexibility while maintaining the employer's interest in controlling premiums and limiting the expense of treatment. A series of systems and programs are used to monitor and control the cost of care.

The Administrative Services Only (ASO) product offers clients routine claims processing and account billing services and, additionally, cost-containment programs that apply clinical experience to the adjudication of claims and pre-authorizations. These capabilities are supported by full-service marketing, provider relations, customer service, membership, product development, and utilization analysis units.

Both BC/BS of Michigan and HMS offer Dental Health Maintenance Organization (DHMO) programs as an alternative to traditional dental plans. DHMO's offer comprehensive care from a select network of dental health care providers. Hallmarks of this product are minimal out-of-pocket expense, reduction of paperwork, reasonable and predictable annual rate adjustments and emphasis on quality of treatment and preventive care.

Michigan BC/BS structures their HMO offering as a private practice model with all services provided in participating dentist's offices. In addition to general dentists, the network includes dental specialists in periodontics, oral surgery, and orthodontics. HMS prefers large group practices as the venue for their HMO product offerings. Both TPAs require prospective HMO providers to submit a written questionnaire, and pass a screening procedure. Additionally, providers must submit to an on-site inspection and evaluation of the structure and process of their care delivery system by credentialing staff. If approved, the practice is reviewed within 6 months and, if in compliance, yearly thereafter.

HMS has developed Preferred Provider Organization (PPO) programs for clients in the western United States. These products are built upon participating provider networks of generalists and specialists who accept a pre-set maximum allowance for covered procedures. Subscribers are encouraged to visit network providers through a series of incentives which reduce client's out-of-pocket costs through lower deductibles, higher benefit levels, and provider discounts for procedures not covered by the plan.

The Cigna Corporation standard product offering is dental fee-for-service indemnity insurance. In response to escalating dental prepayment costs, Cigna has developed dental HMO's in 136 locations throughout the country. These are developed around the private practice model.

DDP*Delta was formed exclusively to respond to the requirements of the CHAMPUS contract. This contract called for the provision of fee-for-service care in private dental offices nationwide. Other Delta plans offer ASO, PPO, and HMO programs to clients.

Table 3. Scope of Dental TPA Services

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Scope of dental product offerings	1	5	4	5	3
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

1.1.3 Capacity for Nationwide Service. Ratings of this capacity are presented on Table 4. BC/BSNM administers claims processing for seven selected IHS Areas as a function of their FI contract with the IHS. The dental unit was formed exclusively to administer and process claims from dentists providing CHS-funded care to eligible AI/ANs BC/BSNM does not have other dental third party administrative products to offer clients.

The TPAs in this study all had some experience with administering dental programs on a national basis. The two with the greatest breadth of scope, experience, and ability were DDP*Delta and the Cigna Corporation. DDP*Delta uses contractual arrangements, called Program Interplan Participation Agreements with local Delta Plans. Cigna Corporation manages their national program through regional offices. Both have had long-term experience in managing programs throughout the nation. The DDP*Delta Plan represents over 90,000 participating Delta dentists and approximately 50,000 additional non-participating providers in the United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. Cigna serves over 15 million persons in 136 markets nationwide.

Of the TPAs with lesser experience and scope, HMS currently administers dental benefit programs for BC/BS plans in Arizona, Colorado, Nevada, New Mexico, Oklahoma, Utah, and Virginia. HMS continues to gain market share, both locally and nationally, in pursuit of the goal to become the leading dental administrator for the BC/BS system. Over the past eight years, HMS has worked closely with client accounts nationwide, including major insurance carriers, TPAs, employer groups, and individuals to establish a comprehensive system of dental third party administration. The parent company of HMS, Rocky Mountain Health Care Corporation, has an extensive nationwide telecommunications network, therefore it is possible for HMS employees to process dental claims from any location in the country.

Michigan BC/BS dental manages one major contract with a national scope (Ford retirees). They have limited experience and limited ability to administer a national program. BC/BSNM provides services to seven IHS areas; however, their corporate orientation is to the state of New Mexico. The FI contract forced their consideration of programs outside of New Mexico.

The vendors use differing methods of managing distributed programs. BC/BSNM, Michigan BC/BS, HMS, and Cigna Corporation utilize centralized administration for claims processing and payment. BC/BSNM and HMS share the same computer system in Albuquerque; however, BC/BSNM provides all claims processing services (staff functions and data processing) in the Albuquerque facility. HMS uses claims processors in various locations through an on-line and/or batch approach to process the claims remotely. DDP*Delta processes claims in two locations (California and Michigan) with each accessing a computer system in Rhode Island.

Each of the TPAs visited have the ability and the desire to service client organizations. Of this group, HMS was the most willing to provide special consideration for individual clients. They have a small staff that functions effectively as a team to provide for the needs and desires of their client base. DDP*Delta was the other vendor that distinguished itself in terms of serving individual clients. Michigan BC/BS appeared to be more oriented to the dental profession than

to individual clients. This may occur because their clients are purchasing medical coverage predominately with dental coverage a much lower priority. BC/BSNM has only the IHS as a client for dental services; however, the dental component has a reputation of efficient and effective service to the IHS and Service Units.

Table 4. Capacity for Nationwide Service

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
National scope of dental programs	1	1	5	3	5
Experience with national dental programs	1	2	5	3	5
Ability to administer a national dental program	2	3	5	4	5
Ability to service individual clients	4	4	4	5	4
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the Art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

1.1.4 Capacity for Innovation. The TPAs visited were quite similar in terms of their capacity for innovation and creativity. Of this group, Michigan BC/BS had the most sophisticated techniques. Their activities in developing provider profiles to identify aberrant practitioners was quite advanced. With health care costs increasing exponentially, each of the administrators recognize the need for using their databases to aid in detecting fraud and abuse, assure appropriateness and quality, and in containing costs. HMS distinguishes itself in the area of creativity and innovation through exemplary service to the client rather than the profession. They have limited costs to the client by maintaining a small staff in relation to the book of business. Additionally, HMS makes full use of automation to reduce the clerical and claims processing staff requirements. Rather than incurring the expense of in-house experts, HMS contracts with private practice dentists on an as-needed basis.

Each of the TPAs offer clients HMO and Preferred Provider Organization (PPO) programs, in addition to the fee-for-service indemnity programs. HMS and Cigna Corporation emphasized dental HMO's to a greater extent than the others. Cigna's orientation to HMO's was as a major carrier for large corporations. Cigna recognizes the need to contain costs if corporations are to continue to provide dental coverage. HMS's orientation to HMO's was to the quality of care issue. Through a comprehensive practice screening and periodic evaluation methodology, HMS is able to ensure and market quality dental services to clients.

Each TPA produced internal reports sufficient to effectively and efficiently manage their operations. In addition, each provided a standard set of client reports which were adequate. They all were capable of producing specialized reports demanded by the client.

BC/BSNM has the most experience in serving minority populations through its role of an FI for the IHS. However, the issue is more towards one of experience in contracting with the Government. With this added emphasis, DDP*Delta would receive the most favorable rating since their tasks are exclusively in performance of a federal contract with the CHAMPUS program. The remaining vendors have limited exposure to minority populations as a group or with government contracts.

Table 5. Capacity for Innovation and Flexibility

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Capacity for innovation and creativity	2	4	3	3	2
Adequacy of internal management reports	3	3	4	3	3
Adequacy of client reports	3	3	4	4	3
Experience with minority populations	4	2	2	2	1
Experience with Government programs	5	2	5	2	2
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

When all of the administrative capabilities are considered, the DDP*Delta ranks the highest with an average score of 4.3. HMS ranked second with an average score of 3.7. The remaining vendors were grouped around an average score of 2.6.

1.1.5 Professional/Patient Relations. Professional and patient relations were significant components of each of the TPA's activities. The mission and functions statements provided by the vendors reflected this importance. Each TPA employed a significant number of well trained staff for the maintenance of good patient relations. The sentinel organization was Michigan BC/BS who make extensive use of automation to support professional and patient relations. A Computer Assisted Response Environment Network (CAREN) is accessed through a toll free 800 number, through which providers with a touch tone phone can receive patient eligibility and basic benefit information. Additionally, professional relations staff have an on-line reference system with all information currently available in a database available to the terminal operators. Through the use of sophisticated user-friendly graphic application, successive levels of detail can be provided to answer most client questions.

The HMS automated dental system contains a subsystem for tracking customer service inquiries. This provides access to data regarding claims, subscriber, provider, and patient tooth chart data. An on-line tooth chart, unique in third party administration, permits visualization of tooth specific procedures by customer relations staff when addressing telephone inquiry. The dental system provides the capability, on-line, to track all types of correspondence (written, telephone, walk-in) and who generated the call. The tracking system maintains a complete history file that can be retrieved and used for performance reporting. A daily backup report is generated that provides a detailed listing of each days activities.

Table 6. Professional-Patient Relations

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Average ratings of professional/patient relationships	1.2	3.2	4.8	3.9	1.2
Appropriateness of mission and function	3	3	4	4	*B
Adequacy of staff	2	3	5	4	1
Competency of staff (e.g., training and experience)	2	3	5	4	1
Appropriateness of participation agreements	*A	4	5	4	*A
Adequacy of management of participation agreements	*A	3	5	5	*A
Adequacy of interface with clients	4	4	5	5	4
Adequacy of interface with patients	*A	3	5	3	2
Adequacy of interface with dental organizations	*A	3	4	3	1
Acceptance by dental profession	*A	5	5	3	2

SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the Art/Extensive/Maximum/Extensive/Comprehensive
NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated

1.1.5.1 Provider Agreements. The study was designed to identify the state-of-the-art provider agreements (see Appendix 4). Provider agreements are the hallmark of the Delta organization. Delta is a profession-sponsored organization with their competitive advantage being the large number of participating providers. Delta has well-developed participating provider agreements and manages the agreements assiduously. Participating providers agree to 1) accept the "Usual, Customary, and Reasonable" fee, or pre-approved fee, as full payment for covered services provided to any beneficiary, 2) accept direct payment made by Delta for payment in full, 3) schedule and provide all dental treatment for beneficiaries in accordance with the applicable dental professional standards in their communities, 4) cooperate with the local committee (or consultants designated by Delta and/or the local plan) to review the adequacy of care provided by participating providers, 5) remain bound to all of the terms of the Delta Plan as set forth in

the coverage, limitations, exclusions, and processing policies, 6) take responsibility for the accuracy of all information shown on the claim submitted on the beneficiary's behalf, 7) complete and submit a quality assurance questionnaire to determine if office procedures meet accepted standards, 8) file any necessary forms at no charge, and 9) permit full audits of patient records in the dental office.

HMS has developed PPO programs for clients in the western United States. These products are built upon participating provider networks of generalists and specialists which accept a pre-set maximum allowance for covered procedures. HMS assesses the quality of care provided in the PPO networks through pre-qualification measures used during the contracting with providers phase of product implementation, and by monitoring utilization and treatment patterns from data submitted by the providers.

Dental Health Maintenance Organizations (DHMO's) offer comprehensive care from a select network of dental health care providers. HMS is most assiduous in assuring that only "quality" providers and practices are admitted into their DHMO network. Through the use of a dentist provided written pre-screen, initial and annual on-site inspection of facilities and records, and evaluation of service provision, HMS assures the quality and value of their HMO's.

The BC/BS organizations and the Cigna Corporation do not place great emphasis on provider agreements outside of their PPO and HMO networks. The Michigan Dental Association was successful in revising the dental insurance law to modify the participating dentist agreement procedure. Rather than a one-time participating provider agreement between the plan and the dentist, each claim form submitted represents the opportunity for the provider to select participating/non-participating status. This is accomplished by checking the appropriate box on the claim form. By checking the "payment to dentist" box, the provider agrees to accept BC/BS fees and subscriber co-payment as payment in full and to abide by the Plan's laws, rules, regulations, and policies. If the "non-participating status box" is checked, then BC/BS reimburses the patient who then must pay the dentist.

1.1.5.2 Relations with Dental Professional Organizations. There is considerable variation in the TPA's interface with dental organizations and their acceptance by the dental profession. Being a profession-sponsored dental program means that Delta would have the edge in interface and acceptance by the profession. Michigan BC/BS utilizes input from a Dentist Advisory Committee regarding product development, policy decisions, and establishment of program and patient limitations. This approach assures that changes which impact the profession are not implemented in a vacuum. The Dental Director of HMS has had a long and distinguished association with the profession, rising to Trustee of the American Dental Association (ADA).

HMS uses dentist advisory members in plan design and policy decisions which may impact the profession. Cigna and BC/BSNM had very little formal interaction with dental organizations and, therefore, their acceptance was of a lesser degree than the other TPAs.

Within the professional and patient relations scales, the DDP*Delta received an average score of 4.8 related to professional and patient relations. HMS scored an average 3.9 and Michigan BC/BS scored 3.2. Both BC/BSNM and Cigna Corporation average 1.2 reflecting their orientation to professional and patient relations.

1.2 Claims Processing. Claims processing is the main reason for the existence of the TPAs. Each of the TPAs had adequate staff in relation to the tasks. BC/BSNM had the fewest staff; however, the staffing was commensurate with the IHS workload. Turnover rates were within normal bounds. The staff of each TPA in the study had been provided extensive training and their experience levels were very high. DDP*Delta has a four week formal operator training program followed by on-the-job training which is state-of-the-art. The entry level claims processors can progress through successively more responsible steps in the operation with commensurate pay and prestige.

1.2.1 Claims Review. The TPA's approach to reviewing claims was based on the scope of the program. DDP*Delta and Michigan BC/BS each use in-house consultants to review dental claims. The CHAMPUS program, administered by DDP*Delta, has a very limited scope of benefits and, therefore, requires only general dentist capabilities. DDP*Delta had sufficient in-house consultant reviewers for the workload. Michigan BC/BS utilizes practicing dentists as consultants to review the most difficult cases.

Table 7. Claims Processing Capabilities

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Adequacy of automation	2	2	5	4	3
Competency of staff—training and experience	4	4	4	4	4
Adequacy of consultant review capabilities	*A	4	5	4	3
Adequacy of staff—numbers and turnover rates	2	2	5	5	4
Appropriateness of data base	4	4	5	5	4
Claims processing proficiency and timeliness	4	4	5	5	4

SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive
NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated

Cigna Corporation and HMS requires the treating dentist to send a form describing the services prescribed and an estimate of what the costs will be. Dental reviewers (former hygienists or dental assistants) examine the proposed treatment plans and either approve their appropriateness or refer questionable treatments to consultants, comprised of prominent local dentists. If the consultant has a question about a proposed treatment or wishes to suggest an alternate benefit, the attending dentist will be contacted directly to work out a course of action. If the dental consultant feels that less costly alternative is more appropriate, payment will be reduced in accordance with these common dental standards.

1.2.2 Use of Automation in Claims Processing. Each of the TPAs in this study made extensive use of automation in the processing of claims. DDP*Delta developed an automated dental claims processing system unique from all other Delta systems when they first were awarded the CHAMPUS contract. The system developed is quite similar to the HMS and the Cigna Corporation systems. These data processing systems are designed to maximize efficiencies in the claims and payment process. Using DDP*Delta as an example, the following is a basic description of the functionality of the aforementioned TPAs.

The DDP*Delta information system contains data tables and files ranging from information on beneficiaries, sponsors, providers, and procedures to complex pricing data for each participating contract provider. The system provides flexible, automated claims processing through a combination of on-line editing and batch processing. On-line editing validates data during its entry and "suspends" or holds claim data that appear invalid. In some instances, the system automatically applies the appropriate policies and proceeds with processing. In other cases, the system routes claims for further review and application of policies by trained resolution clerks, dental consultants, or by automatically creating a letter requesting more information from the provider. The batch process subjects claim data to more complex checks or edits, and may also result in suspending a claim for later resolution.

The magnitude of the data base permits many of functions in support of claims processing. The data base is composed of the following 11 subsystems:

1. Range Control System. This subsystem controls claims and correspondence from the earliest possible point in processing through final disposition.

2. Automated Correspondence Control Tracking System (ACCTS). This subsystem provides on-line control of correspondence, showing the location and age of all correspondence.

3. Claim Data Entry and Resolution System. This subsystem provides interactive claim data entry and resolution transactions unique for each resolution type. It highlights fields in error and automates system routing messages on each screen, allowing for rapid training, increased productivity, and maximum efficiency. On-line adjudication procedures include data validity/compatibility editing and pricing.

4. Provider Master File Inquiry and Maintenance System. This subsystem maintains provider data for efficient processing of claims. Included are the provider-filed fees which ensures that the appropriate fee reimbursements are applied to all paid claims.

5. Beneficiary Master File Inquiry and Maintenance System. This subsystem supports automated beneficiary eligibility verification to assure all claims are paid for beneficiaries of enrolled sponsors.

6. ADA Procedure Code Inquiry & Maintenance System. This subsystem supports automated ADA procedure code validation, assuring that all claims conform to authorized benefits, limitations, and exclusions according to the contract and benefits.

7. Batch Adjudication System. Batch adjudication procedures include duplicate checking, prepayment screening for utilization review activity, and payment calculations. Payment amounts are calculated by applicable reimbursement methods such as provider filed fees. Application of other insurance coverage and cost share provisions is automatic.

8. Check and Dental Explanation of Benefits (DEOB) Processing. The system reports payment on all beneficiary DEOB's and provider payment summaries. The subsystem produces all checks, DEOB's and mass mailings to providers and beneficiaries.

9. Automated Letter Development System. This subsystem generates the development and production of follow-up letters. Automatic claim denial for failure to respond to development letters reduces the need for manual intervention.

10. Check Control System. This subsystem supports complete fiscal control of all checks and bank reconciliation files. It provides on-line inquiry access to all check activity and update capability for check reissues, stop payments, and special check

requests. An inquiry screen displays the check number for each paid claim for ease in research.

11. Claim History Inquiry. This subsystem allows on-line access to at least 27 months of completed claims history, permitting rapid inquiry response and improving ability to check duplicate claims. It also provides inquiry transactions for suspended claim and audit trail information.

Clients and providers are especially concerned with efficient claims processing, adjudication proficiency and payment timeliness. All TPA contracts state a minimum number of days as acceptable for processing and payment of claims. Each of the TPAs evaluated were exceeding the minimum standards for proficiency. The TPAs ensure efficient and effective claims processing through a variety of means. Again DDP*Delta offers the best example of compliance organization.

To ensure maximum monitoring and control of all claims processing functions, each department receives reports customized to fulfill the requirements of the department. To provide greater flexibility, many reports accept user-input parameters. These parameters provide the capability to modify report contents in response to changes in workload and provide information for any given time period without requiring programming changes. DDP*Delta uses four general categories of reports that support claims processing:

1. System-generated error reports which detail all system data contributing to suspense. These reports facilitate error resolution and monitor claim aging/inventory.

2. Productivity and workload reports for claims and correspondence provide the ability to control and monitor performance standards and workflow volumes.

3. Postpayment utilization review reporting allows requests for reports showing statistics on any combination of rendering providers, benefits, and locations. This reporting allows users to screen provider utilization and refine edits for prepayment screening.

4. Actuarial reporting allows effective payment activity analysis by beneficiary and benefit categories. These reports facilitate monitoring of benefit utilization and aid in future forecasting of rates.

1.2.3 Communication with Providers. The adequacy of communication with providers is represented by the sentinel organizations—DDP*Delta, HMS, and Michigan BC/BS. Each are zealous in maintaining good relations with providers. Examples of information related to the processing of claims that is provided and made available to dentists include:

1. Check and Dental Explanation of Benefits (DEOB) which reports payment on all beneficiary DEOB's and provider payment summaries;

2. An automated letter development system which allows the TPA to generate letters informing the provider of discrepancies in the claim submitted and to generate the necessary follow-up letters; and

3. The check control system which supports complete fiscal control of all checks and bank reconciliation files.

This system provides on-line inquiry access to all check activity and update capability for check reissues, stop payments, and special check requests. The claim history inquiry system allows on-line access to at least 27 months of completed claims history, permitting rapid inquiry response and improving ability to check duplicate claims. It also provides inquiry transactions for suspended claim and audit trail information.

Table 8. Communication with Provider and Patients

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Adequacy of communication with providers	*A	4	4	4	3
Adequacy of reports to patients	*A	5	5	5	5

SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive
NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated

Provider manuals, handbooks, and beneficiary pamphlets are routinely provided. In addition, each TPA produces periodic newsletters for providers and their staff. Each has the capability of creating specialized letters and notifications, and including these in the provider payment envelops.

Each TPA has the capability of generating DEOBs which are sent to beneficiaries. The DEOB reports payment on all services provided the beneficiary. Additionally the systems produce mass

mailings to beneficiaries related to oral health, prevention, and processing changes which may impact the beneficiary.

1.2.4 Adequacy of cost control programs. The following describes HMS' approach to cost control. In general the approach is followed by each of the TPAs, however, HMS, DDP*Delta, and Michigan BC/BS have more comprehensive systems and subsystems. The Claims Entry Function accepts new claim entries, validates the information with the eligibility file, records pertinent historical patient information, integrates required provider information, and monitors daily claims entry activity.

Table 9. Cost Control Capabilities

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Adequacy of cost control programs	2	4	4	5	3
Adequacy of fraud and abuse detection programs	2	4	5	5	2
Willingness to detect and prosecute fraud and abuse	*C	5	5	3	1
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

The HMS dental system was designed to apply both processing and clinical logic to the resolution of each claim. There are currently over 100 processing rules and policies (e.g., edits) automatically tracked through the HMS dental system. Up to 15 rules or policy codes can be assigned to each dental procedure code and these in turn can be mapped to additional procedure codes before a decision is made to make payment or suspend the claim.

The system accesses the library of information each time a claim is processed and disallows payment for unnecessary, unusual or illogical treatment, fraudulent claims, and for procedures that are not covered benefits. For more complicated claims, manual reviews are conducted by personnel experienced in the application of dental benefits. They may request radiographs, study models, or written summaries from providers in order to approve payment for a questionable claim.

The TPAs are constantly on guard for the potential of fraud and abuse. The information systems allow on-line access to at least 27 months of completed claims history, permitting rapid inquiry response and improving ability to check duplicate claims. Edits built into the system automatically track rules or policies which suspend dental procedures before a decision to make payment is made.

The TPAs each have established policies and procedures for prosecuting fraud and abuse. The Delta's are not hesitant to suspend participating provider status for those dentists found to be outside the norm. Michigan BC/BS and DDP*Delta have developed sophisticated computer-based systems to detect provider aberrancy and to use the findings generated by these systems to prosecute. The systems are described in greater detail in the "Quality of Care" section.

When all of the factors within professional/patient relations are considered, the DDP*Delta ranks highest with an average score of 4.8. HMS ranked second with an average score of 3.9, and Michigan BC/BS ranked third at 3.2. The two remaining TPAs were rated near the average score of 1.2.

1.3 Quality Assurance. The quality of care provided is of great importance to clients and their beneficiaries. One of the major reasons for employing a TPA is to increase the ability to ensure quality services. Of the TPA's evaluated, DDP*Delta, Michigan BC/BS, and HMS take the quality of care provided by participating dentists very seriously. DDP*Delta has the more extensive quality assurance program for their fee-for-service book of business. Quality assurance begins with the participating provider agreement which has an extensive section on quality of care which the dentist must complete and submit prior to being granted participating status.

Table 10. Quality Assurance Capabilities

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Appropriateness of mission and functions statement	*C	3	4	4	2
Adequacy of staff	1	4	5	4	2
Competency of staff, e.g. training and experience	3	4	5	4	2
Adequacy of participation agreements	*A	2	5	4	*A
Appropriateness of approach to quality assurance	1	4	5	3	1
Adequacy of appropriateness of care assurance programs	1	4	5	3	1
Willingness to assure appropriateness of care	1	2	3	4	1
Adequacy of quality assurance programs	1	3	4	2	1
Willingness to assure quality of care	1	4	3	3	1
Ability to assure quality of care in a national program	1	3	5	4	1

SCALE: 1=Rudimentary/Minimol 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive
NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated

The Delta Dental Plans have established and employ a Post-Treatment Review Program as a long-standing quality assurance procedure. The Delta Plans subscribe to a Regional Consultant Network (RCN) which consists of a panel of dentists who have demonstrated ability to provide impartial determination on the quality of care, and the necessity and appropriateness of the care rendered. The RCN conducts post-treatment clinical patient examinations for one or more of the following six reasons 1) to respond to unsolicited complaints, 2) beneficiary response to audit letter, 3) observations by consultants in claims review, 4) utilization review reports, 5) consultation with other Delta Plans, and 6) on a random basis, when the state Delta Plan conducts such review.

The Delta Plans also employ in-office audits to verify provider compliance with proper billing procedures according to the terms of the law, the contract, and the participating provider agreement. Internal audits assist Delta Plans in protecting the integrity of the program, ensuring the usual fee concept, protecting the beneficiary from overcharges and out-of-pocket expenses, to prevent the waiver of beneficiary cost, and to encourage provider compliance with the participating agreement.

Radiographs have been determined to be a useful tool in evaluating the quality of dental care. The DDP*Delta program requests pre- and post-operative radiographs from providers when inappropriate care or billing practices are suspected. These radiographs are reviewed by trained professional dental auditing staff and dentist consultants to verify that the reported service was appropriate and rendered according to generally accepted standards.

1.3.1 Identification of Unusual Practices. Providers whose treatment patterns differ significantly from established norms are more thoroughly evaluated. If an unusual practice continues, all of the provider's claims are reviewed by a dental consultant prior to payment of benefits. This is referred to as placing the provider on "manual review or hold." If a local Delta Plan determines that a provider's treatment patterns, quality of care, or billing practices fail to meet Delta standards, removal of participating status may result. The threat of removal of participating status can be an effective deterrent to aberrant treatment patterns once Delta has brought a problem to a provider's attention.

DDP*Delta has developed an automated quality and appropriateness of care evaluation system. They use the Payment Review (PARE) program to select providers with uncommon practice patterns. The Professional Review Department establishes utilization review standards and develops selection criteria by assigning selected services to a "review area." This system runs semi-annually on a post-payment basis to generate reports that support utilization review and monitoring. A Provider Exception Report is developed by examining a 6-12 month period of

paid claims using the "review area" to evaluate the utilization of selected procedures (e.g., dollars paid to a provider, service procedures provided, beneficiaries treated per provider). The reports objectively identify providers with billing practices that deviate significantly (over the 80th or 90th percentiles) from other providers with comparable practices within the same region.

When a provider is identified as aberrant, History Select Reports can be generated for any beneficiary or provider. These are used to verify aberrant billing practices, evaluate unusual practice patterns (types of procedures done) and to evaluate unusual utilization (numbers of procedures done). The Professional Review Department uses these data to document suspected problems, identify records to be used in internal office audits, and identify beneficiaries for post-treatment reviews.

As the PARE program has progressed, Delta has established norms which are integrated into the automated claims processing system. This provides on-line screening for errors during claims processing by identifying discrepancies as they occur.

DDP*Delta has developed a personal computer (PC) based quality assurance application to aid in the assurance of quality, and to enhance utilization review. Information from all facets of utilization review and quality assurance are coordinated through professional review. Disparate information is entered into the Quality Assurance database to sort and compare utilization and quality assurance data to identify potential problem providers for follow-up and to generate watch lists for consultants.

1.3.2 In Mouth Review. The TPA's in this study have experience with "in-mouth" review of the quality of care. Michigan BC/BS client contracts have required BC/BSM to conduct in-mouth review of services provided to subscribers. To accommodate this requirement, BC/BSM utilizes in-house dentists and dental consultants. The normal modus is to use portable dental equipment in the work place or at social gatherings where employees congregate. Evaluatees are self-selected and volunteer for the screening examinations. Data entry forms have been developed, and are utilized to abstract the dental services information. To establish the quality of the care provided, the examiners score the procedures (R) exceptional, (S) acceptable, (T) poor quality/ serviceable, (V) unacceptable quality/to be replaced immediately. Following the in-mouth review, the subscriber's record from the BC/BSM data base is matched to the review data. This permits the assessment of accurate reporting of service provision by the provider. The providing dentist is notified by BC/BSM to remediate poor quality work that requires immediate resolution, or to provide remuneration for billed services which were found to be absent during in-mouth examination. Additionally, each case is evaluated for fraud and abuse, and, when found, such fraud and abuse may be referred to the proper authorities.

Dental HMO's and PPO's were established to contain the cost of care, and to assure the quality of the services provided. Dental Health Maintenance Organizations (DHMO's) offer comprehensive care from a select network of dental health care providers. Hallmarks of this product are minimal out-of-pocket expense, reduction of paperwork, reasonable and predictable annual rate adjustments, and emphasis on quality of treatment and preventive care. HMS is most assiduous in assuring that only "quality" providers and practices are admitted into their DHMO network.

Through the use of 1) a dentist provided written prescreen, 2) initial and annual on-site inspection of facilities and records, and 3) evaluation of service provision, HMS assures the quality and value of their HMO's. Each dentist requesting participation status must submit to a comprehensive questionnaire on all aspects of his/her dental practice. When received by HMS, these data are processed by a sub-routine of the dental system which produces a score based upon the responses. If the submission does not meet predetermined scores the agreement is rejected. To become a preferred provider or to participate as an HMO provider, practitioners must complete a written questionnaire, and pass the screening procedure. Additionally, they must submit to an on-site inspection and evaluation of the structure and process of their dental care delivery system. HMS employs a process and structure evaluation instrument developed by the American Academy of Dental Group Practice.

HMS has developed PPO programs for clients in the western U.S. These products are built upon participating provider networks of generalists and specialists which accept a pre-set maximum allowance for covered procedures. Subscribers are encouraged to visit network providers through a series of incentives which reduce out-of-pocket costs through lower deductibles, higher benefit levels, and provider discounts for procedures not covered by the plan. HMS assesses the quality of care provided in the PPO networks through pre-qualification measures used during the contracting with providers phase of product implementation and by monitoring utilization and treatment patterns from data submission.

Although they currently do not conduct in-mouth reviews of the quality of care provided, HMS could make available their dentist consultant network to implement on-site review of selected provider services.

When all of the factors within quality assurance are considered, the DDP*Delta ranks highest with an average score of 4.4. HMS ranked second with an average score of 3.5, Michigan BC/BS ranked third with an average score of 3.2. BC/BSNM and Cigna Corporation were rated near the average score of 1.1.

DDP*Delta ranked highest overall with an average score of 4.5 while HMS and Michigan BC/BS ranked 3.9 and 3.3 respectively. BC/BSNM and the Cigna Corporation were a far distant 2.0.

Table 11. Overall Quality Assurance Ratings

Capability	New Mexico BC/BS	Michigan BC/BS	California Dependents Dental Plan *Delta	Health Management Systems	Cigna Corporation
Average ratings of quality assurance	1.7	3.3	4.5	3.9	2.1
SCALE: 1=Rudimentary/Minimal 3=Average 5=State of the art/Extensive/Maximum/Extensive/Comprehensive NOTE: *A=Not Applicable *B=Not Provided *C=Not Evaluated					

2.0 IHS Area Offices

In accordance with the study design, site visits were conducted at three IHS Area Offices: Navajo, Portland, Oklahoma. Key informants interviewed included the Area Chief Dental Officer (CDO), the Area Contract Health Service Officer (CHSO), and other staff recommended by the key informants or their designees. These interviews were conducted to obtain the perspectives of Area Offices on the roles TPAs can, could, and do play in the provision and management of contract dental services. The results of these interviews are presented below.

2.1 Navajo Area. The IHS Navajo Area Office has a limited potential with regard to the use of CHS funds. Historically, a CHS budget was established to support the direct care delivery program by providing emergency and specialized services. In 1972, an IHS policy decision directed that contract and direct resources should be managed interchangeably to provide the most advantageous service delivery for patients. Following this policy change, the dental CHS budget grew to represent approximately 30 percent of the total dental budget.

As contrasted with Areas having one dentist per clinic, the Navajo Area has large clinics staffed with multiple dentists. These clinicians are available to provide coverage for provider absences such as illness, vacation, or off-site training. Other Areas use CHS funds to obtain emergency care coverage from dentists in the private sector. The Navajo Area uses the deferred services program to provide for specialty care in support of direct care. Historically, Areas have used CHS resources to provide this support. The Navajo Area, being more isolated than some Areas, lacks access to private providers over much of its population base. In addition, this limits dentists available and willing to provide services in IHS facilities on a fee-for-clinic basis. The use of CHS resources as a manpower and programming option is not as viable for the Navajo dental program as it is in other Areas.

The limited nature of the CHS resources has required the establishment of priorities for the expenditure of the funds. The policy of treating only urgent and emergent services was given priority one status. The impact of these actions has placed the Navajo Dental Services Branch in a supplicant role with regard to the expenditure of CHS resources. The Service Units have often lost their CHS dental budget allocation as most dental services do not fit the urgent/emergent priority ranking. Irrespective of these policies, the Navajo Area Dental program expended approximately $740,000 for CHS in FY 1991 and $697,000 in FY 92.

The Dental CHS program is managed from the IHS Navajo Area Office. The Deputy Chief, Area Dental Services Branch has performed in the capacity of Project Officer accomplishing all of the tasks necessary to assure that contracts are in place. The Navajo Area develops and negotiates multi-year contracts with firm fixed prices in year one and negotiable prices in the outlying years. The contracts further delineate the populations to be served, the services which the vendor is authorized to provide, and the quality and appropriateness standards to be employed.

The Navajo Area does not permit the procurement of dental CHS from open market vendors, e.g., the Service Units cannot issue HSA 57's on an individual basis. The Service Units do not have a discretionary CHS budget. These resources were obligated by the IHS Navajo Area based on predetermined amounts specified in the formal contracts. The resources were/are used to purchase services in Levels I through III predominantly for population groups distant from direct care delivery facilities. Selected Service Units expended an additional $200,000 from the deferred services account in FY 92 for dental services in Levels IV, V, and VI. All of these resources were processed through the IHS FI (BC/BSNM).

The Navajo Area Dental Branch has recently negotiated with the Area CHS Task Force, and received authorization to use CHS funds to purchase contract dental services for the Navajo Head Start program. Each Service Unit has the opportunity to determine which Head Start programs could best be served through the use of CHS funds. Their selection is based primarily on the program's access to private dental contractors and, secondarily, on the desires of the community. This authorization allows for increased expenditures of CHS resources for dental care, as well as allowing a greater proportion of different age groups access to dental care at IHS dental care facilities.

The Navajo Area has formalized contracts with five vendors: two organizations and three individual dentists. The program is currently considering contracts with individual dentists to provide services to Head Start children on a fee-for-clinic basis in direct care facilities. The

Deputy Chief estimates that managing the CHS program occupies approximately 20 percent of his time.

The Navajo Area has lagged behind other IHS Areas in the implementation of automation at the Service Unit level. This results in more labor in determining alternate resources--an important component of CHS authorization. The Navajo Area Dental Branch has estimated approximately 30 percent Medicare/Medicaid eligibility among the population served with approximately 60 percent of the Head Start students eligible for Medicaid. If eligibility were maintained on-line and updated on a per-visit basis, the patients and providers would be more efficiently served.

One Service Unit, Ft. Defiance, has implemented the CHS component of the IHS Resource and Patient Management System (RPMS) to better manage a contract with "Navajo Nation Health Foundation" (NNHF). The NNHF serves a population of approximately 12,000 persons residing within the Ganado dental catchment area. In FY 1992, the NNHF expended approximately $259,000 for contract dental services. An innovation employed by the Service Unit is to create a Master Delivery Order List (MDOL) for purchase orders, which effectively eliminates the individual HSA 57 form. The MDOL is sent to the NNHF and as services are rendered to those authorized patients listed on the MDOL, NNHF transmits the ADA claim forms either electronically or manually to the FI for payment and reporting. The system has proven efficient and effective in reducing clerical time for the IHS, NNHF, and the FI.

The Chief, Navajo Area Dental Services Branch assumed the position in December 1992. He has not had time to formulate an opinion on the performance of the FI. The Deputy Chief has been on board since July, 1992. He has had no prior experience with the IHS and the CHS program prior to the FI contract. However, the Deputy Chief is very pleased with the services provided by the FI. Additionally, the Deputy Chief reported that the providers were satisfied with the FI, especially with the timeliness of payments. The fact that the FI only has five vendors with whom to interact could contribute favorably to these satisfaction levels. The Deputy Chief suggested one improvement in the provision of FI services would be the creation of a "pend" report for the vendors to keep them abreast of the status of claims processing. In an Area with a limited number of high volume providers, this would appear to make sense.

The Dental program has formalized a committee to manage and man the quality of care evaluation program for the Navajo Area. Individuals are selected to conduct the annual evaluation of contract provider performance. Although the Dental program has a formalized Quality Care evaluation procedure with a documented manual, the Navajo Area has not used this procedure to evaluate contract vendors. Past practices have provided for evaluator and vendor interaction during a half day of provider performance evaluation, supplemented by ad hoc

reviews. Under the terms of the contracts, the Chief, Area Dental Services, must certify annually that services meet acceptable standards of practice. Past assurances have been based primarily on the evaluators' oral reports. Written reports, if provided, have not been inserted in the contract file as justification. The Navajo Area plans to implement a more formalized method of quality assurance this fiscal year.

2.2 Portland Area. The Portland Area makes extensive use of CHS funds. Contract and direct resources are managed interchangeably to provide the most advantageous service delivery for patients. The uses of CHS resources in the Portland Area dental program are myriad. The program uses CHS funds to:

1) Support fee-for-clinic care by generalists in IHS facilities. This is done on a limited basis and will be discontinued in the near future;
2) Support fee-for-clinic care by specialists providing the totality of specialty services; and,
3) Support fee-for-service in private dental offices.

The fee-for-service component provides for dental care services:

- when the facility dentist is away from station on leave or training;
- to populations with limited access to IHS direct care facilities;
- in support of the direct care program when the patients requirements are beyond the skill level of the facility dentist (specialist services);
- to purchase dental laboratory services;
- to provide for deferred services in Levels IV-VI; and in Levels I-III when the facility dentist is overwhelmed by the workload.

The Portland Area has continued to identify a separate dental CHS budget, and this budget is allocated to each of the Service Units. The system of allocation has changed little over the intervening years when the IHS Dental Branch had a line item budget for contract care services. The priorities for services remain 1) emergency coverage, 2) to provide access to populations distant from IHS facilities, 3) in support of direct care (specialty services), and 4) for deferred services.

The tribes in the Northwest have been vocal antagonists to the FI. This has contributed to numerous tribes developing their own P.L. 93-638 CHS programs. In all instances of tribes taking over the operation of their health programs, the dental components have been included. The Chief, Dental Services Branch reported that the tribes were managing the dental resources in an effective and efficient manner. All were either using the RPMS platform for claims

processing, or have implemented a PC-based system marketed in the northwest. None have chosen to utilize the FI.

The Portland Area Dental program expended approximately $740,000 for contract health care services in FY 1991 and $697,000 in FY 1992. The Dental CHS program is managed at the Service Units. The HSA 57 is the method of procurement on an as-needed basis. The HSA 57 is initiated at the Service Unit under the direction of the Chief Dental Officer. Formal contracts with vendors limit the Government's flexibility in terminating relationships when differences in treatment philosophy arise. He felt that the potential cost savings cannot be offset by the potential for protracted legal entanglements when the Government attempts to sever the contract. This is in stark contrast to the medical program which makes extensive use of exclusive provider agreements with hospitals and physician groups.

The Portland Area Dental Program does not conduct quality of care evaluations in any formalized sense. The Portland Area is fortunate in having many career dental chiefs with long tenure at the Service Units. This has led to a familiarity with the private dentists to whom they refer patients. This knowledge of the practices, and the fact they are treating the same population base, permits informal review of the contractor provided services. The program does insert the HSA 57 in the dental record so as to maintain a record of the CHS services that were provided/paid for.

In 1988, the Portland Area contracted with Oregon and Washington Dental Services (both Delta organizations) to manage the CHS dental program. These contracts were terminated in 1989 when it became evident that practitioner surveillance and practice patterns were not being monitored by Delta in keeping with the terms of the contract. There was an impression that a "good-old-boy" network was in place, and the Delta organizations were unwilling to take a firm stand in censuring aberrant providers.

Following the Delta contracts, the Portland Area Dental Branch managed the payment of dental CHS resources to providers. This led to the implementation of the CHS component of the RPMS at the Service Units. This essentially automated the total procurement process and led to effective capture of CHS workload data. At any time, the Portland Area can dial into the Service Unit computer and extract all of the current activity.

In FY 1992, the Portland Area Dental Branch began using the FI to process the HSA 57s. The Service Units continue to utilize the RPMS for the front end to determine eligibility, establish the obligation, and create the voucher. The vendor forwards the document to the FI for payment and data capture.

The Portland Area Dental Branch has been extremely pleased with the FI services. There are very few instances where claims are pended by the FI. When claims are pended, the FI quickly contacts the Area/Service Units to resolve the problem. The Portland Area reports that claims are paid in a timely manner and the vendors are pleased with the performance. Because the dental component of the FI is a small scale unit, they are able to provide extremely personalized services—especially in the case of Portland. The fact that the Chief Dental Officer took the opportunity to visit the FI, and to become familiar with their processes and procedures, may explain the favorable experience the Dental Branch has enjoyed with the FI.

2.3 Oklahoma Area. The Oklahoma Area makes extensive use of CHS funds. These funds are used to supplement the direct care provided at the Service Units. CHS funds are primarily used to provide 1) emergency care, 2) specialty services unavailable at IHS clinics, and 3) access to populations distant from IHS facilities.

The Oklahoma Area has contracted with the Delta Dental Plan of Oklahoma as a TPA for at least five years. All IHS staff interviewed (from the Area Dental Officer, the Area Contract Health Service Officer, to the Chief Dental Officer of a Service Unit) reported that the Delta program functions exceptionally well. It is rare to find a government agency so satisfied with a contractor as is the Oklahoma Area with Delta Dental. The informants stated that Delta pays the providers in a timely fashion. Prior to the Delta contract, slow payments to contract providers was said to be "a major, major problem."

Contracting with Delta not only "cured" the Oklahoma Area's slow payment problem, it resulted in more cost-efficient use of CHS funds. The rates charged by providers under the Delta Plan are often significantly lower than rates negotiated prior to the Delta contract. The Delta Plan was described as responsive and flexible. For example, Delta staff frequently recommend ways for IHS to reduce CHS expenditures and to increase the efficiency of the program. Perhaps most importantly, the informants said that IHS clients are satisfied with the care provided through the Delta Plan. Finally, the informants stated that Delta has a highly developed information system that provides *all* the data needed by IHS managers including Ad Hoc and special reports.

All these staff agreed that termination of the Delta contract would have catastrophic consequence for CHS dental program.

3.0 Tribally-Operated ("638") Programs

In accordance with the study design, data were collected from 10 tribal dental programs in five IHS Areas:

AREA	TRIBE/PROGRAM STUDIED
Bemidji	Bad River and Red Cliff Tribes
California	Riverside - San Bernardino Indian Health, Inc.
Oklahoma	Creek Nation and Choctaw Nation
Phoenix	Reno Sparks Indian Colony, Pyramid Lake and Washo Tribes, Cedar City
Portland	Puyallup Tribe

Site visits were conducted for the tribal programs in each of these Areas except Portland and Phoenix; telephone interviews were conducted with the key informants in these two Areas. In most cases, the key informants included 1) the Health Director of the tribal dental health program, 2) one or more dentists employed by the health program, 3) claims processing staff, and 4) IHS Area Office or Service Unit staff familiar with the tribal program (e.g., Area Dental Officer, the Area SU CHS Office staff).

3.1 Profile of the Tribal Programs. The 10 programs in the study reflect the great diversity of settings, needs, and service delivery and management of dental care in "Indian Country." Four of these programs (Riverside-San Bernardino, Creek Nation, and Choctaw Nation and Puyallup) independently operate their total dental programs (including CHS) under P.L. 93-638 ("638") contracts with IHS. These programs employ dentists who provide direct care in tribally operated facilities; in addition, the tribes use CHS funds to contract with providers in the private sector.

Two of the tribal programs (Bad River, Red Cliff,) operate dental programs with exclusive use of contract providers. These programs do not employ dentists to provide direct care.

The Phoenix Area tribes (Reno-Sparks, Fallon, Pyramid Lake, and Washo) process CHS claims through the Schurz Service Unit which utilizes the the IHS FI. These tribes employ dentists "on loan" from the Uniform Services Corps of the Public Health Services (PHS).

3.1.1 The Riverside-San Bernardino Indian Health, Inc. (RSBIHI) [California Area]. This program is organized by a consortium of eight tribes in Southern California. RSBIHI operates the entire health program (including dental) for the tribes under a P.L. 93-638 ("638") contract with IHS. As part of its health program, RSBIHI employs six dentists, providing direct care in eight clinics. In FY 1992, the consortium had a CHS budget for dental services of approximately $100,000. These funds were used primarily for obtaining specialty services (e.g., procedures requiring anesthesia, pediatric dentistry) unavailable directly from the tribal dentists. Although RSBCIHI expressed a need for better control of CHS expenditures, it is unlikely they would consider use of an IHS FI.

3.1.2 The Creek Nation (Oklahoma Area). The Creek Nation provides both direct and contract dental care under a "638" contract. The tribe operates three dental clinics. In FY 1992, the tribe had a dental CHS budget of $49,300. The Creeks manage their CHS from referrals to provider payments with "in-house" staff, and expressed little interest in using the services of a TPA or FI.

3.1.3 The Choctaw Nation (Oklahoma Area). Like the Creek Nation and RSBIHI, the Choctaw Nation provides both direct and contract dental care under a 638 contract. The Choctaws operate four dental clinics and, in FY 1992, had a dental CHS budget of $148,000. The Choctaws also manage all aspects of their CHS program without "outside" support. The tribe expressed little interest in the services of a TPA or FI.

3.1.4 The Bad River Tribe (Bemidji Area). The Bad River Tribe provides dental CHS under a 638 contract with IHS. The tribe has no clinic and provides no direct dental care. All dental services are provided through a TPA, Delta Dental of Minnesota. The tribal budget for dental care was $86,417 in FY 1992. The tribe is satisfied with the services provided by Delta.

3.1.5 Red Cliff Band of Lake Superior Indians (Bemidji Area). The Red Cliff Tribe operates a dental program under a 638 contract with IHS. Like the Bad River Tribe, Red Cliff does not employ a dentist and provides no direct dental care. The tribe contracts with local providers for all dental care, and had a dental budget of $41,300 for FY 1992. The tribe uses the RPMS to support processing and payment of provider bills, and reported little interest in using a TPA or an FI.

3.1.6 Reno Sparks Indian Colony (Phoenix Area). The Reno Sparks Indian Colony, located in Reno, Nevada, operates a dental program under a 638 contract with IHS. The tribe provides direct dental services at its clinic using two PHS dentists. One dentist is available at the tribal clinic full-time, 5 days per week, and the other rotates at another tribally operated clinic (Pyramid Lake) 3 days per weeks. Reno-Sparks uses CHS funds to obtain the services of private practice

dentists, and processes all CHS claims through the Schurz Service Unit which utilizes the IHS FI.

3.1.7 Pyramid Lake Tribe (Phoenix Area). Located in Northern Nevada, this tribe operates a dental program under a 638 contract with IHS. Direct care is provided 3 days each week at the tribal clinic by a dentist shared with the Reno Sparks Indian Colony. This dentist, a member of the Uniformed Service Corps of the PHS, is assigned to work at the tribal dental clinic. The tribe uses CHS funds to obtain the services of private sector dentists, and uses the Schurz SU and IHS FI to assist in claims processing.

3.1.8 Washo Tribe (Phoenix Area). The Washo Tribe is located in Southern Nevada. It operates a dental program under a 638 contract with IHS. Like Pyramid Lake, the Washo Tribe provide direct care at their clinic using the services of a full-time PHS Commissioned Corps dentist. Provider claims are processed by the tribe through the Schurz Service Unit. The tribe expressed some interest in the services of a TPA or FI through a national contract.

3.1.9 Cedar City Health Center (Phoenix Area). Cedar City is located in Utah south of Salt Lake City. The program serves the Paiute Tribe. The program employs no dentists and offers no direct services. All dental services are provided by private sector providers under contract to the tribe. The tribe handles all aspects of claims processing and management of the dental program. The dental budget was $51,000 in FY 1992. The tribe expressed little interest in FI or TPA services.

3.1.10 Puyallup Tribe (Portland Area). The Puyallup Tribal Health Facility manages and operates its medical and dental programs through a 638 contract with the IHS. The tribe employs four full-time dentists; two are PHS Commissioned Corps Officers whose salary is paid by the tribe; however, benefits are retained and paid by the Corps. The other two are recruited from the private sector.

The Puyallup Tribe operates an 8-chair clinic which will soon be expanded to a 12-chair clinic with expanded lab facilities. In FY 1992, a total of $10,000 was spent on contract care dental referrals, which is less than 1 percent of the total tribal CHS budget. Of a total of an estimated 5,000 CHS referrals, there were only 22 purchase orders used for dental CHS primarily, and a total of six referrals (for pedodontics). The dentists spend 100 percent of their time on providing dental services. There is minimal need for CHS referrals to local dentists, and those usually specializing in pedodontics. Located in the midst of a large urban area of Tacoma, there is more than a sufficient supply of dentists in the private sector to provide the needed and minimal level of contract care required for their dental program.

The Puyallup Tribe has no formal contracts with any private providers. Referrals are usually made directly through the tribal dentists to private sector specialty dentists who are regularly used as CHS providers, and there is good rapport among the tribal dentists and the private sector dentists.

All dental claims are processed by CHS. The funds used for dental CHS are not set aside or identified. There is one CHS budget that covers all dental referrals, and there is no line item in the budget for dental because the amount is so insignificant.

The referrals written by the tribal dentists are almost never questioned. The only specialty service needed is pedodontics and the dentists almost always refer to one dentist (Dr. Bain located in Tacoma).

The CHC staff reviews all referrals for third party payors. Funds are not obligated through a PO unless there are no other payors. The majority of referrals for pedodontics are covered by Medicaid. In the event of insurance, a PO is not issued until services are delivered and the insurance company is billed for the appropriate amount of coverage.

3.2 Experience with TPAs. Several tribal programs in this study used the current IHS FI, or a Delta Plan. Three programs (RSBIHI, the Choctaw Nation of Oklahoma, and the Bad River Tribe) had used Delta Plans (of California, Oklahoma, and Minnesota respectively), and the Nevada tribes in the Phoenix Area utilize the FI through the Schurz SU. Of the three programs that have used a Delta plan, the Bad River Tribe is currently using Delta. Bad River was generally very pleased with the services provided by Delta. The informants reported that Delta has greatly reduced their claims processing workload, and has helped the tribe to improve the management of dental CHS, especially with respect to enforcing the dental priority system.

Both RSBIHI and the Choctaw Nation reported unsatisfactory experiences with Delta Plans. Tribal informants were aware of the favorable experience their respective IHS Area Offices have with the same Delta Plans. The informants suggested that the treatment afforded by Delta to "big customers" like the Area Offices was significantly better than the treatment afforded to "small customers" like the tribes. Specific complaints were that Delta 1) was slow to pay providers, 2) lost treatment records of tribal members, and 3) was too expensive (i.e., administrative costs are too high).

The tribes using the IHS FI (Reno Sparks Indian Colony, Pyramid Lake Tribe, Washo Tribe) were generally satisfied with the service received.

3.3 Self-Determination Initiative. Without exception, the tribal programs in the study expressed the desire to maintain and expand control over their health (and other) programs. Management of health programs is viewed as a critical component of tribal self-determination. It was clear that the tribes would prefer to provide employment for staff as opposed to "contracting out" FI or TPA services, even if the contractor were more efficient at the activity than the tribe. Some tribes (e.g., Creek Nation) have expanded their health programs to provide services, on a fee-for-service basis, to individuals who are not eligible for IHS services. In such cases, the tribe not only provides health care to its members, it uses health care services to generate additional revenues.

3.3 Satisfaction with Tribal Program. While each tribally-operated dental program acknowledged specific problem areas and/or deficiencies in their dental CHS, the informants were generally satisfied with the overall performance of their dental programs, including management of dental CHS. Without exception, the tribal programs stated that 1) they were paying providers in a timely fashion, 2) they were getting good service from their contract providers at a reasonable cost, and 3) the contract providers were generally happy to work with the tribal dental program.

3.4 Quality Assurance. When asked about quality control and review, the tribal programs in this study that provide direct care (i.e., Choctaw, Creek, RSBIHI, Reno Sparks) reported that the tribal dentists almost always have occasion to review the work of contract dentists. In follow up or other examinations, the tribal dentists have the opportunity to perform informal in-mouth review of the work of the contract providers. The tribal dentists reported that, from time to time, dentistry performed by a contract provider was judged to be unsatisfactory. Under such circumstances, the tribal dentist discussed the case directly with the contract provider. Generally, a mutually agreeable solution is reached. If a solution is not achieved, the tribe ceases making referrals to the provider in question. Similarly, when examination of the tribal patient reveals work that seems to be less extensive than that billed by the contract provider, the tribal dentists attempt to resolve the discrepancy directly with the contract provider.

For tribal programs that do not provide direct dental care, quality assurance of the work of contract dentists is largely ignored.

3.5 Availability of Contract Providers. Except for the tribes in the Phoenix Area, the informants reported encountering few or no problems in identifying qualified dentists eager to work for the tribe. In fact, individual providers often view the tribe as a valuable referral source. Consequently, the providers are willing to provide dental services to the tribe at a significant discount. This circumstance is not limited to solo practitioners as tribes reported obtaining

discounts from organizations such as university dental clinics and group practices. One exception involves providers of dental specialty services such as pediatric dentistry. Providers of such services were said to be often unwilling to discount their fees.

While the tribes in this study reported little difficulty in contracting with providers, it is known that health care providers, especially dentists, are scarce in some IHS Areas, such as Alaska, Navajo, and Aberdeen.

3.6 Problems Confronting Tribal Programs. Despite the availability of contract providers and the general satisfaction with the dental services provided, the study revealed four major problems associated with tribal dental programs: 1) inadequate information and reporting systems, 2) inadequate documentation of program procedures and associated dependence on individual program managers, 3) a lack of support for contracting and negotiating costs with local providers, and 4) a potential for fraud and abuse. Each of these problems is discussed in turn below.

3.6.1 Inadequate Information Systems. No tribal program in this study reported satisfaction with its dental information system. Most tribes had only informal, undocumented, components of an information system. Generally, these components were spreadsheets or sample databases maintained on personal computers by staff in the dental program. Consequently, dental program managers did not know (and could not easily determine) basic facts such as the number of patients served, the distribution of procedures provided, or the amounts paid to contract providers. Since this information is unavailable to the tribes, it is, likewise, unavailable to the IHS. The absence of this information makes difficult the planning and management of dental services. This undesirable situation is likely to worsen as more tribes contract for their dental and other health programs.

Some tribes maintain well designed and proven information systems to support claims processing.[1] For example, the RSBIHI program has an in-house mini-computer networked to numerous terminals and personal computers. This system provides effective support to the processing of CHS claims; however, even this system has two major problems: 1) it provides little clinical or tribal health information needed by health planners and administrators, and 2) it is incompatible with IHS data systems. The incompatibility of IHS, tribal and other data systems is not unique to IHS. Advances in hardware and software are rapidly forging solutions to the problem of compatibility and communication among data systems. However, careful planning and coordination will be required to apply this technology to IHS.

[1]While these systems effectively meet the requirements specified by the tribe, these requirements are nowhere near the same scale as the systems used by TPAs.

3.6.2 Inadequate Documentation. The site visits revealed that many critical aspects of tribal dental programs reside only "in the head" of the program manager (generally dentists employed by the tribe), and health directors. For example, the manager knows which contract dentists "overcharge", which ones are "good working with children," or those who perform substandard dentistry. If this manager or dentist were to become unavailable (e.g., through retirement, leaving the area, or death), such information might easily be lost to the tribe.

The lack of documentation has a complex relation to quality assurance. When the tribe is big enough to be able to employ its own dentists (as do the Choctaws, Creeks, Puyallup, and RSBIHI), these dentists report that they generally see a patient before, and soon after, treatment by contract dentists. Tribal dentists see and evaluate (by an informal "in mouth" review) the work of the contract provider. This follow-up done by tribal dentists is probably more frequent and in-depth than the quality reviews conducted by most TPAs. On the other hand, because these follow-up examinations are unsystematic (i.e., there is no standard procedure) and undocumented, the critical information may not be organized and communicated to management. Because the results of the examinations are undocumented, the frequency and nature of problems with contract providers and of their resolution cannot be determined.

3.6.3 Lack of Contracting Support. Some tribal programs had only informal agreements with "contract" providers. Managers of tribal programs that had formal contracts complained that they lacked support staff needed to prepare, negotiate, consummate, and maintain provider contracts. Generally the manager of the tribal dental CHS program is a practicing dentist providing direct care to tribal members. The manager's contracting efforts represent an inefficient use of his or her valuable professional training. While the model Provider Agreement (Appendix 3) may provide some assistance in this area, more help is needed.

3.6.4 Potential for Fraud and Abuse. The tribal program managers interviewed in this study appeared to be outstanding individuals, dedicated to serving their tribal employers and the tribal members. They were cooperative in all aspects of the study despite their imposing workloads. Nevertheless, the system in which they work has the potential for fraud and abuse. For example, often the dental program manager makes a significant number of referrals to a small number of providers. Most of the providers know each other on a personal as well as a professional basis. Such a situation could create a biased network. The lack of CHS information systems would make it relatively easy for the person making referrals to receive illegal gratuities. Similarly, inadequate information systems plus the isolation of the tribal programs makes it difficult to detect billings for work not actually provided.

No accusations or improprieties are implied by the this discussion. The only point is that the study revealed the potential for fraud and abuse.

4.6.5 Coordination with IHS FI. Tribes with 638 health programs can use any or all of the services provided by the IHS FI including:

1) Quality assurance review of dental claims to identify providers with an unusual profile of services provided.

2) Claims processing to ensure that a) the charges billed do not exceed the provisions of the provider agreement, and b) incomplete claims are "pended" (i.e., not paid) until the information necessary to process the claim is obtained.

4) Payment to the provider for the charges claimed and approved. It is difficult for the FI to make payments for tribes because access to many tribal checking accounts would be needed. Alternatively, a mechanism would be required that would permit the FI to draw from a single source/account funded by participating tribes.

V. RECOMMENDATIONS

1.0 National FI Contract

Currently each IHS Area Dental Program can elect to participate in the FI contract for the management of CHS resources. Due to efficiencies of scale, FI costs decrease as the number of claims processed increase. These efficiencies of scale should be balanced against the need for flexibility associated with the special circumstances of each IHS Area including satisfaction with existing TPAs.

Recommendation 1: The IHS should consider mandating all IHS Area dental programs to participate in the eventual FI contract with provision for exceptions for special cases. Tribal dental programs should also be encouraged to participate in the FI contract.

2.0 Valid Uses of CHS Resources

During this study it became evident that great variability exists between Areas, and among Service Units within Areas, in the use of dental CHS resources. This variability leads to the inequality of service availability to American Indians and Alaska Natives based upon geography and other factors such as accessibility, funding, etc. The medical program has developed priority rankings for various services, and has determined that urgent and emergency care is the number one priority, and the only priority for which CHS resources can be expended. This urgent and emergency priority does not fit the dental care delivery model. Historically, a dental contract care budget was established to support the direct care delivery program by providing emergency and specialized services. In 1972, an IHS policy decision directed that contract and direct resources should be managed interchangeably to provide the most advantageous service delivery for patients. Following this policy change, the dental CHS budget grew to represent approximately 30 percent of the total dental budget.

The dental program uses CHS resources to 1) support fee-for-clinic care by generalists in IHS facilities as an alternative to Federally employed staff, 2) to support fee-for-service in private dental offices for Level I services when the facility dentist is away from station on leave or training, 3) to provide fee-for-service care to populations with limited access to IHS direct care facilities, 4) to support the direct care program when the patient's requirements are beyond the

capabilities of the facility dentist (i.e., specialist services are needed), 5) to purchase dental laboratory services, 6) to provide fee-for-service in private dental offices for Levels II and III when patient demand exceeds the capacity of the direct care staff, and 7) to provide for deferred services in Levels IV - VI.

Recommendation 2: The IHS Dental Services Branch, in consultation with the Areas should establish a priority listing of the valid uses of CHS resources.

3.0 Dental CHS Budget

Prior to the initial FI contract, the IHS Dental Branch was appropriated an annual CHS budget. This budget was allocated to the IHS Areas which then allocated funds to the Service Units. When the IHS entered into the FI contract, it was decided to pool all CHS resources and the Dental Branch lost the line-item designation.

This decision has left the Dental Program in a supplicant role with regard to the expenditure of CHS resources. The Areas exhibit extreme variability in their approach to expenditure of CHS resources for dental care. Some Areas closely monitor the dental program, others do not. For those that do not closely manage the dental expenditure, aggressive dental program managers could exploit the system with a first-come, first-served approach. Additionally, without a defined budget, the dental program lacks the incentive to manage the CHS resources effectively or efficiently.

After the Dental Branch develops the priority listing of valid uses of CHS resources, each Area should develop Service Unit and Area Office budgets sufficient to fund the CHS program. The Dental Branch would then submit the dental CHS budget to Headquarters for review and approval.

This budget process would have the following impact:

1. The AI/AN population would be treated equitably with regard to services availability and delivery;
2. Tribes considering contracting through P.L. 93-638 would know the amount of CHS funds available to them;
3. Area Offices and Service Units would have an incentive to actively manage the CHS resources to provide for the maximum benefit to the population;

4. The potential offerors would have more complete data upon which to develop their cost estimates;
5. The eventual FI could develop automated systems of claims processing based upon the limitations in the valid uses of resources prioritization.

Recommendation 3: The IHS Dental Branch should be provided an identified amount of resources for funding dental CHS requirements.

Recommendation 4: The IHS Dental Branch should allocate the dental CHS resources to the Areas based upon their needs with regard to the valid uses of CHS resources.

Recommendation 5: The Area Offices should allocate the dental CHS resources to the Service Units based upon their needs with regard to the valid uses of CHS resources.

4.0 Provider Agreements

During the course of this study, the issue of responsibility for securing provider agreements has arisen. It has been argued by IHS procurement staff that only the IHS has the authority to enter into agreements with providers. Historically, the dental program negotiated contracts with high volume providers. These contracts spell out the government responsibility and the provider responsibility. Included in the contracts were the fees the provider agreed to charge for various services. The contracts delineated the quality and appropriateness of the care to be provided. Payment was based on the fees the contractor had provided.

This study found that TPAs have sophisticated systems of developing panels of high quality dentists through a participating provider agreement process. The Delta Plans best exemplifies the management of participating provider agreements. In the Delta system, participating contract providers agree to: 1) accept the "Usual, Customary, and Reasonable" fee or pre-approved fee as full payment for covered services provided to any beneficiary, 2) accept direct payment made by Delta for payment in full, 3) schedule and provide all dental treatment for beneficiaries in accordance with the applicable dental professional standards in their communities, 4) cooperate with the local committee or consultants designated by Delta and or the local plan to review the adequacy of care provided by participating contract providers, 5) remain bound to all of the terms of the Delta Plan as set forth in the coverage, limitations, exclusions, and processing policies, 6) take responsibility for the accuracy of all information shown on the claim submitted on the beneficiary's behalf, 7) complete and submit a quality assurance questionnaire to determine if

office procedures meet accepted standards, 8) file any necessary forms at no charge, and 9) permit full audits of patient records in the dental office.

The TPAs that employ participating provider agreements have procedures in place to effectively administer their services. To require the offeror to encourage providers to become participants is to ask for what TPAs are routinely doing in their businesses. Requiring provider agreements should add little, if anything, to the cost of the FI contractor. The TPAs that utilize participating provider agreements generally pay participants at the 90th percentile and non-participants at the 50th percentile. Payment at these rates will save the Government money.

Requiring the IHS Area Offices and Service Units to negotiate participating provider agreements with vendors would represent a considerable additional workload. In such an instance, it would still be an FI responsibility to maintain the individual fee schedules negotiated by the IHS; however, payment would be at the level of the filed fees rather than the 90th or 50th percentile. This approach would cost the government twice as much as requiring the FI to establish provider agreements.

Recommendation 6: The IHS should include language in the FI Scope of Work to require the offeror to encourage participating provider agreements to the maximum extent possible.

5.0 Quality Assurance and Appropriateness of Care

The study provided evidence of innovative methods of utilizing computer aided quality assurance reviews to identify providers who are outside the pre-established parameters of normal practices. Michigan BC/BS, DDP*Delta, and HMS each utilize automated procedures to screen for aberrant provider practices. The exact methods employed can be found in the Site Visit Reports of this study (Volume 2). It is clear that the technology and the techniques exist to fully utilize automation to identify those few providers who would be candidates for further review.

Michigan BC/BS and DDP*Delta have formalized methods for conducting "in-mouth" reviews of the quality of the care rendered. Each has a proven track record of having conducted such reviews. The IHS has a proven methodology for evaluating the quality of care provided. This methodology has been used to evaluate private practice dentists and has met with success.

The ability of TPAs to identify aberrant providers should form the basis for determining the appropriateness of the care provided. The IHS Dental CHS database should be passed through an automated QA review such as those used by the TPAs in this study. The results of this

quality assurance review should be provided to IHS by the FI. The evaluation of the technical quality of care should remain a responsibility of the IHS.

Recommendation 7: The FI Scope of Work should call for an advanced, computer-assisted quality assurance review process with submission of semi-annual reports on the CHS database.

Recommendation 8: The IHS should be responsible for determining the providers for whom further action is required. For technical quality of care issues, the IHS should have in place written policy, procedures and techniques for evaluating the technical quality of dental services and the process for appropriate action. These policies and procedures should not be a part of the FI's responsibilities.

6.0 Tribal Participation in FI Contract

The mandate that by 1997, 75 percent of the tribes and tribal organizations manage their health programs under P.L. 93-638 contracts has important consequences for an IHS FI. Currently, tribes that manage their own CHS programs are not mandated to utilize the FI. As more tribes "lock-in" their share of the CHS budget through 638 contracts, the remaining tribes are seeing their CHS budgets erode. This decrease in CHS funding will force more tribes to consider the operation and management of their own dental CHS programs.

Individual tribes may not see the advantages of an FI. In fact, one could hypothesize there are more disadvantages than advantages. If tribes were unable to "piggyback" onto the IHS procurement, their costs would not reflect the IHS economies of scale.

When a tribe takes over the management of the CHS program, it is often in a better position to negotiate with local vendors. tribes are not bound by all government procurement rules nor are they subjected to the same political pressures that confront the IHS. The tribes can make prompt payment, and may seek corresponding prompt payment and other discounts from vendors. Furthermore, if tribes choose to manage the claims processing activities, they provide jobs for local members within the reservation boundaries. The tribes may prefer to hire additional staff or procure technology to permit the provision of services in the local facility.

If participation in the FI contract is to be perceived as advantageous by tribes and tribal organizations, the costs and benefits must equate. It is difficult to envision such costs for individual tribes being reasonable unless the tribes are able to take advantage of the services of

the IHS FI. Many issues need to be identified and resolved in order for the use of the IHS FI to be attractive to the tribes with "638" programs. The SOW for the FI procurement should require the offeror to conduct a pilot project with one or more tribes to identify and resolve issues related to use of the FI by "638" programs.

Recommendation 9: The FI SOW should require offeror participation in a pilot project to study the issues of tribal participation in the FI contract and to encourage tribal participation.

The IHS Areas and Service Units are required to (or choose to) spend inordinate amounts of staff time in the management of the CHS program. Area Offices and Service Units have not implemented the components of the RPMS such as the Dental Data System and the CHS component. The functionality of these components can reduce the burden on the CHS staff. There is considerable time spent on contracting with vendors which could be accomplished more cost-efficiently by the FI, at least in the case of dental CHS. Issuing individual HSA 57's when groups of eligible individuals can be identified and listed on a Master Delivery Order List is an inefficient use of staff resources and is not cost-effective for all parties involved—the IHS, the vendor, and the FI. Issuing "hard copies" rather than electronic documents increases the burden on all as well.

The development of a priority listing of the valid uses of CHS dental resources creates a de-facto benefits package around which the FI can develop limitations, exclusions, and exceptions. This will facilitate the claims processing function, reduce the number of pended claims, and assure prompt vendor payment. The establishment of Service Unit budgets, when communicated to, and managed by the FI would prevent the over-expenditure of funds.

Recommendation 10: The IHS Dental Branch should evaluate all aspects of IHS responsibility with regard to the CHS program and seek methods to transfer responsibility to the FI.

Recommendation 11: The IHS Dental Branch should work with the Office of Information Resources Management to develop plans for the application of advanced technology to the end of collecting, merging, and analyzing health statistics from disparate, often incompatible tribal, IHS, and other systems.

VI. INDEX

VII. APPENDICES

Appendix 1. Site Visit Protocol

Appendix 2. Model Statement of Work
- a. IHS Dental Program
- b. Tribal Dental Programs

Appendix 3. Ratings of TPA Capabilities

Appendix 4. Model Provider Agreement
- a. IHS Area Offices
- b. Tribal Dental Programs

Appendix 5. Site Visit Reports

Appendix 1. Site Visit Protocol

SITE VISIT PROTOCOL

Evaluation of the Delivery of Dental Contract Health Services Using Delta Dental Plan and Blue Cross/Blue Shield

A. Identify and Call Points of Contact (POC) for each study site. Explain study objectives and schedule interviews. POCs include:

- IHS Area Offices
  - Area Director (through Chief, Dental Services Branch)
  - Chief, Dental Services Branch
  - Chief, Financial Management Branch
  - Chief, Information Resources Management Branch

- Tribal Programs
  - Chief/Governor
  - Health Director
  - Director, Dental Program

- IHS Managed Facilities
  - SU Director
  - Chief, SU Dental Program
  - Chief, SU CHS Program
  - Chief, SU Financial Management Branch
  - Chief, SU Information Resources Management Branch

- Dental Fiscal Intermediaries
  - Manager, Dental FI Program
  - Supervisor and staff of Quality Care, Dental FI
  - Supervisor and staff of Dental FI Claims Processing

- Headquarters (West)
  - Dr. Niendorff
  - Data Center staff
  - CHS staff

- Headquarters (East)
  - Dr. Broderick
  - CHS Staff
  - ADP staff
  - PHS

- Other Federal Agencies using Dental FIs
  - DoD/CHAMPUS
  - PHS

B. Activities to Follow-up Initial Contact

- Send confirmation letter with information packet that includes:
  - Study Data Collection Guide
  - 2-page study description
  - Interview schedule with suggested interviewees
  - List of desired primary and secondary data

C. Conduct Interviews

- Confirm Itinerary by telephone prior to travel
- Check-in with POC on arrival to site
- Conduct interviews
- Conduct exit interview

D. Prepare Site Visit Report

- Develop outline
- Draft site visit report to Drs. Niendorff and Broderick, and Leo Nolan for review
- Final site visit report to incorporating input from IHS PO and Co-PO

INTRODUCTORY LETTER TO ORGANIZATIONS, TRIBES, IHS OFFICES

[to be edited by IHS]

Date

Name
Title
Address
City, state, zip

Reference: Evaluation of the Delivery of Dental Contract Health Services Using Delta Dental Plan and Blue Cross/Blue Shield

Dear _____:

Under contract to the Indian Health Service (IHS), Support Services Inc., (SSI) is conducting a study of ways of effectively and efficiently procuring, managing and paying for contract dental services. As part of this study, we would like to interview you (and any members of your staff/organization that you deem appropriate). The information you provide will be used to develop a set of recommendations to guide future procurements.

In accordance with our telephone conversation___(date)_, I have enclosed the following materials related to the study:

- a study data collection guide that shows the information needed from your organization
- a letter from Mr. Leo Nolan, IHS Project Officer, Office of Planning, Evaluation and Legislation (OPEL), and Dr. Eric Broderick, IHS Co-Project Officer, Dental Services Branch, describing the study

I would like to request your assistance in setting up the site visits. As part of the evaluation, it is critical that we obtain input from staff involved in managing dental contract health services.

If you have any questions, please do not hesitate to call me.

Sincerely,

Walter Hillabrant, Ph.D.
Project Director

cc: Leo Nolan, IHS PO
Eric Broderick, DDS

INTRODUCTORY LETTER FROM IHS

Date

Name
Title
Organization
Address
City, State, Zip

Reference: Evaluation of the Delivery of Dental Contract Health Services Using Delta Dental Plan and Blue Cross/Blue Shield

Dear _____:

The Indian Health Services (IHS), an agency of the U.S. Public Health Service, is conducting a study of current and evolving ways of procuring, managing and paying for dental services. The results of this study will be used to guide the development of IHS policy, programs and procurements. We have contracted with Support Services, Inc. (SSI) to conduct this study.

Because of the experience of your organization with respect to dental services, we have asked SSI to contact you to gather information about your policies, operations, and insights regarding alternative approaches to managing contract dental services. Your assistance will be of great value to the IHS.

We deeply appreciate your assistance in helping the IHS consultants collect the information which is needed to make this important project successful.

If you have questions or comments regarding the nature and scope of the project, please contact Leo Nolan at (301) 443-4700 or Eric Broderick, DDS at (301) 443-1106.

Sincerely,

Leo J. Nolan, Director
IHS Division of Program Evaluation and Policy Analysis

Eric Broderick, DDS, MPH
IHS Dental Services Branch

Appendix 2. Model Statement of Work

a. IHS Dental Program

b. Tribal Dental Programs