

State of Alabama Medicaid Dental Workgroup

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Background

- Delta Dental
 - Formed over sixty years ago by dentists
 - Provider centric
 - Board comprised of clinicians (DDS/DMD) and non clinicians
 - National footprint
 - 33 million covered lives
 - Over 300,000 providers across the country
 - Broad based experience in commercial insurance, individual insurance, state and federal government programs
 - The take away: One size does not fit all

Background

- Delta Dental State Government Programs
 - Business unit dedicated specifically to the needs of Medicaid dental members, providers, and state officials (legislative and departmental)
 - Not co-mingled with other lines of business
 - The buck stops with me on all Medicaid related issues
 - Operations
 - Network Management
 - Finance
 - Quality Assurance
 - Dental Policy

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- Recommend initially maintaining current program benefit structure (i.e., benefits and limitations) to minimize disruption and confusion
- Recommend implementing process to minimize unnecessary care—focus on Fraud Waste and Abuse (FWA), recognizing that services categorized in this category are not necessarily fraudulent
- Implement Utilization Management, with protocols developed conjunction with the Dental Association
- UM, FWA and Prior Authorization requirements can be tailored to state requirements and be as liberal or restrictive as desired
 - The more restrictive, the greater the potential savings

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- Addressing overall cost of care spend is the key
 - Must focus on increasing utilization for the right diagnostic codes and reducing utilization for over utilized codes
 - Nationally, Fraud, Waste and Abuse is estimated at 10%-20% of traditional FFS spends in Medicaid Dental programs
 - Importance of collaborative approach to developing Utilization Management and Prior Authorization programs
 - Collaboration with Alabama Dental Association
 - Care needs to be taken in transition
 - Avoiding Dentist/Patient disruption
 - As a provider centric organization, Delta's objective is to not interfere with the doctor/patient relationship

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- In FY 2013, the current program paid out approximately \$87.8 million
- Areas of potential efficiencies include:
 - Fraud Waste and Abuse (FWA). Nationally, indicators are in the 10%-20% range for FWA in traditional FFS programs
 - FWA does not necessarily mean illegal, fraudulent activity. In many cases, its driven by lack of familiarity with program requirements
 - Assuming a conservative estimate of 5%, savings on the order of \$4.0-\$5.0 million are reasonably expected
 - At the low end of the national range, the savings are estimated in the \$8.8 million range
 - Utilization Management
 - Can be prospective or retrospective
 - Prospective: lays out rules for which procedures require prior authorization/additional support documentation
 - Advantage is it drives greater savings initially
 - Retrospective: program sets parameters for random claim sampling
 - Advantage is it is less abrasive and intrusive
 - Estimated savings range from 3% - 7%, based on extent of requirements

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- The value of the “Sentinel Effect”
 - As program guidelines are socialized, treatment patterns change organically
 - Providers who deliberately over-utilize adjust treatment patterns to a more acceptable norm when they know someone is watching
- Claims run out funding
 - Depending on program construct and costs Delta will evaluate funding the claims run out for the State
 - As of the effective date of the program, Delta would pay claims regardless of date incurred (i.e., prior to effective date of new program) for a pre determined period
 - Avoids the state “double paying” during run out
 - Contingent upon thorough analysis of claims experience and costs
 - Details would need to be worked out with the State

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- Summary
 - The State of Alabama can recognize savings ranging from 8% to 15% of the current estimated expenditures, or \$7.0 million to \$13.0 million
 - The level of savings is contingent upon the type of program implemented
 - Delta recommends a strategy that initially drives more conservative savings projections
 - Less abrasive on providers
 - Weeds out truly unnecessary care, creating more upside potential
 - Allows providers providing clinically appropriate care to keep doing so

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- Summary
 - A modified RCO model enables care to be delivered and managed in a geographically appropriate manner, allowing for variations in clinical care patterns across the state
 - Acknowledges differences between metropolitan and rural areas
 - Fosters engagement and collaboration between payer and provider
 - Allows for provider access/network issues to be addressed based on local need
 - Creates a model that can be replicated elsewhere