REPORT TO THE GOVERNOR AND LEGISLATURE FROM THE ALABAMA MEDICAID DENTAL STUDY WORKGROUP

October 1, 2015

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Introduction

The Alabama Medicaid program provides health care for approximately 20 percent of Alabama's population. In recent years, the number enrolled in Medicaid has grown, as has the need for funds from the Alabama General Fund to accommodate the increased enrollment. Governor Robert Bentley in 2012 established the Alabama Medicaid Advisory Commission, tasked with evaluating the financial structure of the Alabama Medicaid Agency ("Agency") and recommending ways to increase efficiency while also improving patient care. In January 2013, the Commission made a number of recommendations to the Governor, including one to move the program to a managed care environment. Legislation was passed in 2013 to establish the Regional Care Organizations ("RCOs"). While the dental program was not initially included in RCO-covered services, the law required the Agency to evaluate the existing Medicaid dental program and report its findings on October 1, 2015.

A study group was convened in the summer of 2015 to hear reports and recommendations from dental providers and other stakeholders. This report summarizes the findings of the Dental Study Workgroup.

Current Medicaid Dental Program

More than a decade ago, dental care services for Medicaid-enrolled children in Alabama were difficult to obtain due to low reimbursement and a lack of enrolled providers. A statewide initiative known as "Smile Alabama!" played a pivotal role in boosting provider participation and reimbursement as well as utilization of services. The Medicaid Dental Task Force was formed to offer dental providers an opportunity for input and involvement in policy-making decisions. As a result, Alabama was recognized nationally for making significant progress in children's oral health.

Alabama Medicaid's dental services are currently delivered in a fee-for-service system. For FY 2014, the dental services budget was $90.1 million dollars, approximately 1.6% of the total Medicaid medical expenditures. The state paid $28.7 million of that cost. The federal government paid the remainder. There were 827 enrolled dental providers in FY 2014, including 743 active performing providers serving almost 316,000 eligibles who received dental services that year [The total number of eligibles was 697,418 or 45 percent].

Funds allocated for dental services are distributed among diagnostic, preventive, and treatment services. Diagnostic expenditures were $19.2 million, preventive expenditures were $19.2 million, and treatment expenditures were $49.6 million in FY 2014. The per-member-per-year (PMPY) costs in the same year were lowest at age 11, at $150, and highest at age 17, at $276.

The Dental program serves people 20 years of age or younger. The number of people who received dental services rose from 262,065 in FY 2010 to 315,926 in FY 2014, an increase of 20.6 percent. The number of people eligible for dental services also rose in that time, so the rate of eligible people using dental services stayed between 45.3 percent and 48.15 percent. The tables below shows statistics for this time period.

Figure 1: Eligibles and types of treatments

*FISCAL YEAR	ELIGIBLES UNDER 21	Recipients who had Dental Services Under 21	Recipients who had Diagnostic Services (D0100-D0999) under 21	Recipients who had Preventive Services (D1000-D1999) Under 21	Recipients who had Treatment Services (D2000-D9999) Under 21
2010	572,620	262,065	255,143	246,411	130,493
2011	601,092	280,478	273,065	265,066	136,908
2012	617,236	293,035	282,348	276,792	142,905
2013	614,659	295,938	282,026	280,413	143,134
2014	697,418	315,926	309,199	298,589	150,656

Figure 2: Medicaid Dental Providers

*FISCAL YEAR	Unduplicated Performing Providers	Significant Providers who had > or = 50 recipients	Significant providers who had > or =100 recipients	Significant Providers who had > or = $10,000 in paid claims	Enrolled Providers
2010	670	512	426	490	774
2011	677	543	450	525	837
2012	713	567	483	543	806
2013	738	578	484	551	788
2014	743	569	476	552	827

Changes in Medicaid appropriations from the Alabama General Fund through recent years have caused temporary reimbursement reductions to dental providers as well as other provider groups, most recently in 2013. The dental program has also changed procedure code fees in an effort to control costs, including recommendations from a Dental Task Force subcommittee in 2010 that resulted in 13 procedure code eliminations, four fee reductions, and four fee increases.

Medicaid's 1st Look Program began in 2009 and is a partnership with general pediatricians to provide screening and preventive services for children 6-35 months of age. The program is designed to reduce cavities by encouraging primary-care physicians to perform dental risk assessments, provide anticipatory guidance, apply fluoride varnish when indicated, and refer children to a dental home by age one. There are currently 191 enrolled pediatricians who are certified 1st Look providers who screen 1,700 children on average per quarter.

The dental program is currently supported by one full-time manager, one dental consultant, and two part-time administrative support staff members.

Information from Dental Programs of Other States

A review of Medicaid dental programs in other states provided important insight and data to the workgroup. A total of 17 states (Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, Nebraska, Oklahoma, Oregon, Pennsylvania, Tennessee, and Washington) responded to the Agency's inquiry of their experiences concerning their dental services delivery systems [fee-for-service (FFS) or Managed Care (MC)], managed care (if any), cost, and other factors. The results from this informal study, conducted in August 2015, are summarized in the table below and detailed in Appendix 2A:

Questions:	# of Total Responses	Responses:
In your state, how are the Dental services administered (MC, FFS, or combination)?	15	9 states: FFS 4 states: MC 2 states: combination of FFS and MC
If your state has changed from FFS to MC, have you found it to be more cost effective than FFS delivery?	5	3 states: program not in place long enough to determine cost efficacy 2 states: not been cost effective
If your state has changed from FFS to MC, have you found it to be better for recipients?	4	1 state: recipient report better access through MC 3 states: "struggling"; "changes has been difficult"; "neither have found it better"

The states' responses showed that states' needs vary widely. As a result, there does not appear to be one dental service delivery system approach that works in all locations. Some states use managed care or fee-for-service systems only, while others operate hybrid programs. Alabama is one of three Southern states not using some form of managed care for dental services. (See chart below.) States gave mixed answers for cost effectiveness of having dental managed care rather than fee for service, including lack of time to determine cost efficacy.

Most of the responsive states with managed care reported more advantages than disadvantages with managed care than fee for service including: better recipient access, care coordination, utilization rates, number of providers, and cost control.

Below is a chart showing dental service delivery systems among Southeastern states as of August of 2014 (Source: www.Medicaid.gov)

STATE	DELIVERY SYSTEM
Alabama	Fee for service/State Agency Directed
Arkansas	Not in managed care or fee for service/State Agency Directed
Florida	Managed care
Georgia	Managed care
Louisiana	Managed care
Mississippi	Managed care
North Carolina	Not in managed care or fee for service/State Agency Directed
South Carolina	Managed care
Tennessee	Managed care

Support of Current Program

The Alabama Dental Association, the University of Alabama at Birmingham (UAB) School of Dentistry, the Alabama chapter of the American Academy of Pediatric Dentistry, and Sarrell Dental Centers presented information supporting the current program. The following was presented by Dr. Steve Mitchell, Dr. Ric Simpson, Christine King, and Brandi Paris on behalf of the organizations.

Mitchell cited a brief by the American Dental Association's Health Policy Institute concerning Accountable Care Organizations (ACOs) and the involvement of dental services in them. He said that 14 of 20 (70 percent) current ACOs that include dental services have a Medicaid contract while 31 of 106 (30.2 percent) ACOs that do not include dental services have a Medicaid contract. Also, 45 percent of ACOs with dental services operate in the South

and just under 17 percent of ACOs that do not have dental services included operate in the South. Also, he mentioned ACOs participating with Federal Qualified Health Centers or Public Health Centers seem to function best.

Simpson continued the presentation by listing principles for building a successful program, including:

- early risk assessment and education
- fluoride varnish
- access to a dental home by age 1
- early intervention and treatment
- continuous preventive measures, anticipatory guidance, visits at regular intervals, and dental home.

Reforms, changes, and initiatives with involvement of providers, including the creation of the Dental Task Force, the "Smile Alabama!" initiative and the 1st Look Fluoride Varnish program, have advanced the success of the current program, he said. The increases of the number of dental providers between 1998 and 2010 by 121 percent and the utilization rate between 1997 and 2010 by 103 percent were pointed out. Changes to the program recommended by a subcommittee of the Dental Task Force in 2010, including 13 code eliminations, four fee reductions, and four fee increases, have contributed to the success of the current model, he said.

Mitchell said that Alabama ranked first among Medicaid dental programs that did not use managed care in the percentage of eligible people aged 1 to 20 who received a preventive dental service and 10th among all Medicaid dental programs.

He continued by showing within Alabama, 60 percent of recipients aged 3 to 15 who were eligible for dental services used them. He also said the average annual costs per treated patient has decreased from $314 in 2010 to $285 in 2014. He offered three options to address the issue of the rising costs due to the increasing number of eligibles: reduce provider reimbursement, restrict patient access, and eliminate waste. Mitchell then pointed out that if these options were

to be implemented, other issues could come about, including: risk of provider reductions overwhelming the system, access restrictions could prove to be resource intensive, and Alabama would eliminate needed care in an effort to eliminate waste to impact the budget.

Both Mitchell and Simpson recommended the Medicaid Dental program should stay as it is currently, remain separate from the RCOs and is the best option to continue quality dental care in an affordable way.

Christine King and Brandi Paris presented statistics that show the increase of patient numbers and the decrease of the reimbursement per patient between 2005 and 2014 for Sarrell Dental Centers. Their number of patients receiving services in 2005 was about 12,000 and in 2014 was near 150,000. Sarrell's reimbursement per patient visit average in 2005 was just above $50 and in 2014 was $360. Paris cited national journals in which Sarrell's service model was noted as an innovative health delivery system. (For a complete reading of the presentation, see Appendices 5B and 5C.)

Alternative Dental Programs

During the August 31, 2015 meeting, representatives of two vendors of managed care, MCNA and DentaQuest, made presentations on their respective programs as alternatives to traditional fee for service programs. The information presented was shown as cost-effective options for the best quality of care.

Per their presentation, MCNA's Shannon Boggs-Turner indicated MCNA serves over 3 million children in Texas, Louisiana, Florida, Kentucky, and Indiana. She suggested a hybrid model in which MCNA would oversee recipients' dental care and pay providers on a fee-for-service basis with money paid to MCNA by the Agency on a per-person-per-month basis. Savings would be seen in encouraging changes in provider and recipient behavior; review of current procedure utilization to prevent fraud, waste and abuse; community outreach; and care coordination to prevent missed appointments, among other

suggested changes. The model presented puts the risk of ensuring the quality of services provided and claims payments on MCNA.

On behalf of DentaQuest, Todd Cruise showed his company manages nine state dental programs including those in Maryland, Idaho Massachusetts, Texas (co-managed), Virginia, Colorado, Illinois, Tennessee, and South Carolina. DentaQuest's proposal includes tools and resources for providers to help with patient issues and broken appointments as well as clear clinical criteria. Per the presentation, through a proposed managed care model similar to that of Tennessee's, DentaQuest could bring savings through advanced technology, ensuring access to care, providing education, and good fiscal responsibility. He reported DentaQuest saved Tennessee $26 million in one year, provides one dentist per 857 patients, provides close proximity to dental providers for recipients, and offers oral health education and screenings.

Summary

The Dental Study Workgroup and Agency staff have met and worked together over the past few months to bring the findings in this report. The consensus of the Dental Study Workgroup is that the current system of dental care be continued while the Agency continues to gather input from Alabama dental providers and to evaluate options to provide the best possible oral health services for Medicaid recipients in Alabama.

Appendices

Appendix 1- Alabama Medicaid Dental Study Workgroup Members

Alabama Dental Association Appointments:

Dr. Zack Studstill

Dr. Art Steineker

Dr. Ric Simpson

Christine King – Sarrell Dental

Dr. Keri Miller

Dr. Steve Mitchell

Dr. Ben Ingram

Dr. Kim Kornegay

Dr. Mike Koslin

Dr. Jim Murphree

Alabama Medicaid Dental Task Force Members:

Dr. Max Mayer, Alabama Medicaid Dental Consultant

Dr. Otha Solomon

Dr. Dwight Williams

Dr. Robert Meador, State Dental Director, Alabama Department of Public Health

Sherry Goode, Oral Health Branch Associate

Dr. Iverson Hopson

Dr. Bennie Goggins

Dr. Michelle Bajjalieh

Dr. Rodney Michael Robinson

Dr. Conan Davis

Dr. Teri Chafin

Kim Williams

Jo Ann Harris

Michele Waren

Dave White, Health Policy Advisor

Appendix 2 – Minutes from Meetings

Appendix 2A – 8/14/15 Meeting Minutes

Alabama Medicaid Dental Workgroup Meeting

August 14, 2015 9:00 AM

Members present via conference call: Max Mayer, Ric Simpson, Steve Mitchell, and Anthony Daniels

Members present: Robert Meador, Sherry Goode, Conan Davis, Rodney Robinson, Zack Studtill, Christine King, and Keri Miller

Medicaid members/Workgroup members present: Melinda Rowe, Theresa Richburg, Beverly Churchwell, Kathy Hall, Drew Nelson, Robin Rawls, James Whitehead, Carolyn Miller, Beth Huckabee, Robert Meador, Sherry Goode, Conan Davis, Rodney Robinson, Zack Studstill, Keri Miller, Mary Hasselwander, Daneta Parker, Linda Segrest, Angela Williams, and Ron Macksoud

Other attendees: Melvin Maraman, Stuart Lockwood, Johnny Crawford, Drew Nelson, Anita Charles, and Doug O'Toole

HP members present: Cyndi Crocket

Call to Order: The Dental Workgroup Meeting was held today at 9:00 a.m. in the Alabama Medicaid, Lurleen Wallace State Office Building, Second Floor Auditorium. Don Williamson called the meeting to order and welcomed all attendees.

Welcome and Introduction: Beverly Churchwell welcomed members to the meeting and moved forward with introduction of the Dental Study Workgroup members as well as Medicaid team members in attendance.

Opening Comments: Don Williamson gave an update on the dental program as to where it is with the legislation. The legislation passed in 2013 specifically excluded dental from payment methodology and excluded them from RCO completely. The Agency is in the process of preparing a report to present to the Legislation and the Governor on October 1, 2015. The Agency is looking at options as to: do dental services get included in to the RCO capitation rate or dental ultimately remain outside the RCOs; does the dental delivery system and the payment system change; or do we pay for FFS or move it to a managed care or not. Neither is exclusive. There is a choice as to what dental would like.

Dental Program Budget Analysis: James Whitehead gave an overview of the dental program analysis. See attachments for comparisons. The attachments explained how much dentists were cut. This was because the cuts did not coincide with the fiscal year: In 2012-3.3 percent, 2013-2.5 percent, 2014-4.9 percent. In 2010 thru 2011 there were no cuts. In the state share, in order for Agency to go to what BCBS reimburses another $8.5m would have to be put up (See attachment). See all other attachments for analysis regarding FY 2014 by date of Service-Dental Claims only. This explains and gives a comparison as to how much is being claimed vs spent. Annual Growth gives a comparison of the percentages from FY 2010 thru 2014. Budgetary rate cut gives a comparison of the budget percentage rate cuts for FY 2010 to 2014 and the state share of actual paid vs adding BCBS rate to the Medicaid rate. This excludes claims with third party liability and BCBS rates are based on rates in effect at January 2015. The Age of Recipients analysis gives an overview of per-member-per-cost and the growth rate of eligibles for FY 2014. The utilization by age gives an overview of the utilization rate. At the age of 2 is 55 percent and at age 3 is 60

percent and holding. By age 9, the utilization rate begins to decline and by the age of 17 it's at 50 percent.

Other State Dental Program Update: Beth Huckabee gave an overview of information gathered from other states' dental programs and the role managed care (MC) plays in those programs:

The information comes from Kaiser Family Foundation, Oral Technical Advisory Group (OTAG) and The Kids Oral Health group members with CMS, and the American Dental Association's Health Policy Institute.

From the Kaiser Family Foundation website:

- 70% of Medicaid enrollees nationwide received services are in a MC delivery system
- 3 states do not have any type of MC: Wyoming, Delaware, and Alaska
- all other states have (some level of) MC involved in the delivery of services

According to CMS through Medicaid.gov website:

- 32 states' dental services are provided in MC
- 16 states' dental services are not provided in MC
- 4 states or territories did not report the information

Accountable Care Organizations (define) in the nation:

- brief published by the Health Policy Institute of the American Dental Association of information gathered between late 2012 through early 2014
- found over 600 ACOs that serve more than 18 million commercial and Medicaid patients in general health services

- of the ACOs surveyed in this study time period, the number of ACOs that provided commercial dental services increased from 8 percent to 26 percent
- found there are more ACOs that have a Medicaid contract if they are responsible for dental services than those that don't provide dental services
- of ACOs formed after Sept 2012, 47 percent of them had Medicaid dental services contracts in which they were responsible for the cost of quality of the services
- almost ½ of ACOs responsible for dental services are found in the South
- authors suggest that dental service incorporation is more likely to be adopted earlier by ACOs with Medicaid populations to serve

Three questions posed to the Kids Oral Health list serve members were:

1. In your state, how are the Dental services administered (MC, FFS, or combination)?
2. If your state has changed from FFS to MC, have you found it to more cost effective than FFS delivery?
3. If your state has changed from FFS to MC, have you found it to be better for recipients and providers?

As of the afternoon of 08/13/2015 afternoon:

Question #1 – 15 states responded:

- 9 states indicated their services are delivered through FFS (1 said they have plans to change to managed care soon)
- 4 states indicated services are through MC
- 2 states indicated a combination of FFS and MC

Question #2 – 5 states responded:

- 3 states have not had MC long enough to be determined if it's cost effective
- 2 states answered it has not been cost effective

Question #3- 4 states responded:

- 3 states answered their recipients and/or providers are: "struggling", "change has been difficult", and "neither have found it better".
- 1 state answered recipients have better access through MC than FFS

As we can see, the environment of other states Medicaid Dental programs are diverse and thought provoking amidst the many challenges that Dental providers and Medicaid programs face. The intention is to contact some states individually, research more in the next few weeks, and to bring an update to you at the next meeting.

Medicaid Financial Update: Don Williamson gave an overview of the budget.

For fiscal year 2015, the Agency received an appropriation of $685 million from the Alabama General Fund, an increase of $70 million (11 percent) over the prior year's appropriation. Almost 70 percent of dollars will come from the federal government. That is the highest match rate for a while. We are making the 2015 budget work because we are carrying some of the money that the hospitals of Alabama left over to supplement the general fund appropriation and because we are not paying back any money that is owe the federal government. Part of that will change in 2016 and all will change in 2017. In 2016 we no longer have the money that the hospitals have been using to supplement the General Fund, that's $50 million. In 2016 we will have to pay back at least $10 million. In fact, if the entire General Fund is put up as a state match, we would still be some $14m short of being able to adequately match the federal

dollars. Our current understanding is that the legislature did not pass a General Fund budget and will go into special session. The budget is the main concern at this point for Medicaid.

Regional Care Organization (RCO) Update: Williamson stated that currently we have 11 probationary RCOs approved. We are in the process of moving from the probationary RCO file certification of some number of those entities. In April, they begin the process of demonstrating network adequacy. Also they are in the process of working towards getting financial solvency by October 1. They have to demonstrate solvency on or by October 1, 2015. In the readiness review, which will begin in the spring, RCOs are going to have to demonstrate to Medicaid that they are able to manage their network, pay for funding, contract with providers and meet the quality measures. Robert Moon has done a phenomenal job. His work has come up with 42 quality measures, all but one of them are a part of the national net groups, and ten of them are actually pilot to reimbursement.

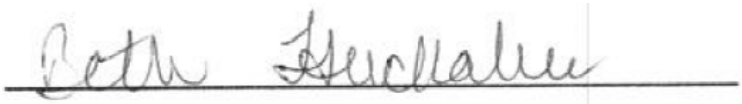
Some other issues we will be looking at is what is the final contract going to look that. The other is the 1115 Waiver. It's a waiver for the federal government to create money for a state. It cannot be used to replace existing state expenditures, it cannot be used to supplant state expenditures. It can only be used for service specific purposes that are agreed to between the state and CMS. In our case it is for implementation in transformation of the Medicaid program. It's to increase access to primary care providers around the state and to help maintain health care infrastructure in parts of Alabama. The ability of Medicaid is to go forward with the RCO transformation. The 1115 Waiver is still being discussed with CMS and conversations remain positive and consistent to get the 1115 Waiver approved.

The members entertained other discussion regarding provider taxes and how this may lower the Medicaid utilization rate the more debt money in cost. It helps the system in the algorithm but harms the provider as an individual if they take no Medicaid or if they take little Medicaid.

Don Williamson tasked the Dental Workgroup with gathering information and evaluating the current program in a report due to the Legislature and Governor on October 1, 2015

The meeting was adjourned.

Next Meeting Date: The next meeting was scheduled for August 31, 2015 1:30 p.m. CST.



Beth Huckabee

Alabama Medicaid Dental Program Manager

Appendix 2B – 8/31/2015 Meeting Minutes

Alabama Medicaid Agency Dental Study Workgroup Meeting

Monday, August 31, 2015

Members present: Zack Studstill, Ric Simpson, Steve Mitchell, Max Mayer, Jim McClendon, Keri Miller, Christine King, Robert Meador, Sherry Goode, Dave White, and Michele Waren

Members present via conference call: Dr. Mike Robinson, Nathan Smith, Jim Murphree, and Robin Rawls

Medicaid Staff members present: Stephanie Azar, Don Williamson, Beth Huckabee, Beverly Churchwell, Theresa Richburg, Kathy Hall, Robert Moon, Melinda Rowe, Drew Nelson, Mary Hasselwander, Ron Macksoud, Linda Segrest, Angela Williams, and Daneta Parker

HP staff present: Cyndi Crockett

Vendors and other public visitors present: Stuart Lockwood, Brandi Parris, Todd Cruise, Laura Overton, Jim Mercer, J. Crawford, Thomas Suehs, Ryan de Grettennid, Phil Hunke, Linda Lee, Bill Higdon, Glen Feingold, Dave Dagestin, Carlos Lacasa, Shannon Boggs-Turner

Welcome and Introductions: The Dental Study Workgroup was held today at 1:30 PM in the Alabama Medicaid Lurleen Wallace State Office Building,

Second Floor Auditorium. Kathy Hall welcomed all attendees. Beth Huckabee began introductions for members as well as visitors present.

Opening Comments: Kathy Hall opened the meeting restating the purpose of the Workgroup and the presentations to be made.

Medicaid Dental Program Update: Beth Huckabee followed up from the previous meeting's presentation with additional materials gathered from other states' Dental programs. She presented responses from three states to questions posed concerning Fee for Service (FFS) and Managed Care (MC) program changes and reasons for the change, pros and cons for providers and recipients of each model, increased or decreased utilization rates, per member per month (PMPM) costs, and number of providers in each model. She reported one FFS state responded that they have considered it, but did not find it cost effective to do so while two MC states overall reported more advantages than disadvantages with MC.

Presentations:

Alabama Dental Association, Alabama Academy of Pediatrics Dentistry, UAB School of Dentistry:

Steve Mitchell and Ric Simpson spoke on behalf of the organizations presenting statistics, delivery system models, and support for keeping the current Fee for Service delivery system.

Mitchell cited a brief by the American Dental Association's Health Policy Institute concerning Accountable Care Organizations and the involvement of dental services in them. Statistics were reported on the number of operating ACOs, the number of ACOs that include dental services, and the number of newly created ACOs. Simpson then offered reasons for success of the current model including: Early Risk Assessment and Education, Fluoride Varnish,

Access to a Dental Home (age 1), Early Intervention and Treatment, Continuous Preventive Measures, Anticipatory Guidance, Regular Intervals, and Dental Home. He also mentioned reforms, changes, and initiatives, including the creation of the Dental Task Force and the 1st Look Fluoride Varnish program, proposed by providers to lend to the success of the current program. Mitchell also cited statistics of how Alabama compares to other states with a FFS model. They concluded by stating the system should stay as it is currently.

Discussion followed the presentation by Williamson with Simpson and Mitchell regarding how missed appointments are dealt with in the office and health homes currently are not including dental providers. Jim McClendon stated the RCOs are a way of transferring risk from tax payers. Williamson also asked how the PMPM rate of Alabama dental compares with other states. Simpson cited the statistics in his presentation.

Sarrell Dental Corporation:

Brandi Parris and Christine King presented statistics that show their model of care is a cost effective model that has been mentioned in notable magazine articles. They cited Medicaid Agency reported figures and presented a model of patient growth and reimbursements per patient visit that showed a decrease in the cost per visit.

MCNA Dental:

Attendees for the MCNA vendor included Glen Feingold, Carlos Lacasa, Philip Hunke, Thomas Suehs, and Shannon Boggs-Turner. Shannon led the presentation with an overview of the company, certifications, member of national organizations and the founding owner.

The presentation continued to point out several benefits of the MCNA success:

- Formula

- Approach for Alabama
- The Dental home Advantage
- Access to Care
- Dedicated Customer Service
- Promoting Provider Satisfaction
- Targeted Member Outreach
- Increasing Operational Efficiency
- Cutting-Edge Technology

For complete reading of the materials presented by Shannon, please visit www.medicaid.alabama.gov.

Ric Simpson inquired about the reductions of fee schedules and how this would be done to help save costs on the front end. MCNA responded the savings would be achieved through behavior changes, reducing missed appointments, and reduced overutilization. The current Agency rates would be the floor for the provider reimbursement.

Other members exchanged dialogue regarding the cost reduction and how the savings may be achieved on the front end by the MCNA group.

DentaQuest:

Todd Cruise represented DentaQuest and presented the mission to improve the oral health care of all. This improvement is offered through the care delivery, care delivery improvement, policy and philanthropy, and benefits administration. DentaQuest manages 9 of the 13 states programs carved out in existence today. Maryland, Idaho, Massachusetts, Texas, Virginia, Colorado, Illinois, Tennessee, South Carolina.

The presentation targeted the benefits of dental administration for providers.

- Tools and Resources to Streamline Participation
- Advanced Technology to Save Time and Money
- Ensuring they can Access Care
- Providing Education

The benefits of dental administration for the State includes:

- Overcoming severe access to care issues, perception problems, and cure mandates
- Staying within a predictable budget without compromising quality of care and member utilization.

Todd focused on real results from the State of Tennessee.

For complete reading of the materials presented by Todd, please visit www.medicaid.alabama.gov.

Open Discussion:

Don Williamson asked how private practices deal with missed appointments and Ric Simpson responded: with forms, follow-up letters, if patient misses a second appointment the office investigates reasons to find out why the patient is not showing up for the dental appointment. Dental is currently not in the health home.

Jim McClendon made comments regarding the intent for RCOs is to allow Alabama to transfer risk from the taxpayers of Alabama.

Steve Mitchell offered comments regarding the RCO format is capitation for cost per recipient and Ric Simpson asked has consideration been made for the cost of the Waiver, legal, vendor services. Dialogue continued with Williamson, Simpson, Mitchell, and McClendon discussing where the dental per member per month rate ranks among other states.

Williamson continued to lead conversation regarding the FFS model and reimbursement will be maintained through RCOs as a minimum of what it is today.

- FFS will be the floor for the reimbursement
- May offer increase rate in reimbursement to get access not currently available
- Limit savings on the front end

Next Steps: Stephanie Azar suggested for encounter data sharing agreements with DentaQuest and MCNA. The findings from these vendors will be shared at a future date with the Dental Study Workgroup.

The next meeting for the Dental Study Workgroup will need to discuss proposed RCO, no RCO, or similar managed care model.

Other members of the Dental Study Workgroup suggested the RCO capitation rate is the same with dental out as a FFS. McClendon commented for dental services to be a separation similar to long term care.

It was noted that all presentations from the meeting on August 31, 2015, are available at the Agency website.

Next Meeting Date: Stephanie Azar announced the next meeting date at September 18, 2015. All information regarding this meeting will be posted to the Agency website and emailed out to the Dental Study Workgroup members.

Meeting adjourned.

Beth Huckabee

Alabama Medicaid Dental Program Manager

Appendix 2C – 9/18/15 Meeting Minutes

Alabama Medicaid Agency Dental Workgroup Meeting

Friday, September 18, 2015 1:00 PM

Members present: Dave White, Christine King, Steve Mitchell, Zack Studstill, and Robert Meador

Members present via conference call: Max Mayer, Conan Davis, and Dwight Williams

Medicaid Staff members present: Stephanie Azar, Beth Huckabee, Robert Moon, Beverly Churchwell, Theresa Richburg, Daneta Parker, Linda Segrest, and Drew Nelson

Vendor and other public visitors present: Johnny Crawford, Melvin Marraman, Mike Weeks, Lauren Overton, Jim Mercer, Brandi Parris, and Stuart Lockwood

Welcome and Introductions: The Dental Study Workgroup was held today at 1:10 PM in the Alabama Medicaid Lurleen Wallace State Office Building, Second Floor Auditorium. Beth Huckabee welcomed all and began introductions for members as well as visitors present.

Opening Comments: Beth Huckabee opened the comments with an apology for excluding information from the presentation by Alabama Dental Association, UAB School of Dentistry, and Alabama Association of Pediatric Dentistry and said a revised draft has been provided to include this. Commissioner Azar made comments regarding the General Fund appropriation for FY 2016. She stated Medicaid received level funding at $685 million. The Nursing Home and Pharmacy providers agreed to an increase in the provider taxes of $16 million for Medicaid putting the total amount at $701 million. $44 million was not appropriated as requested. The Governor and providers will work together for RCOs to go forward as current services continue.

Azar continued by stating RCO Legislation of 2013 required an evaluation report by the Agency on October 1, 2015. The report is to give an overview and evaluation of the dental program. The summary will include further research and the Workgroup meeting again.

Azar also referenced the Long Term Care legislation that required a report on the LTC program by October 1, 2015. Because a provision in new LTC legislation concerning the Integrated Care Network (ICN) passed in the regular Legislative session, the report no longer required.

Studstill asked Azar to review the reference to the LTC report and the ICN which she did.

Open Discussion: Azar then opened the floor for comments regarding the draft report posted on the website on 9/17/15.

Studstill brought several comments concerning the report:

- In the section "Comparison of Dental Program to Other States, first paragraph: a footnote is needed here saying this was not a formal study so assumptions would not be made from a scarce amount of data.

- In the same section, second paragraph, third sentence: there is no reference to Fee for service in other states. He suggested a reference be made here.

- In the same section, second paragraph, seventh sentence: He would like clarification of "overall states with managed care report a…" as the wording was not clear if it meant all states. Mitchell also asked for clarification if that statement means better than ours or better than their past experience.

- In the section "Alternative Dental Programs", second paragraph: Studstill questioned the listing of Kentucky in the list of states as he has learned that MCNA may not have that contract currently and asked Johnny Crawford of MCNA for clarification.

Crawford confirmed Kentucky's status but did not know the specific details. White suggested changing "serves" to "served".

- In the appendices section, Appendix 2A (8/14/15 minutes), "Other state Dental Program Update", "According to CMS through Medicaid.gov and OTAG" section: He asked for clarification of why the number of states do not add to 50.

- In the same section, "Question #3 – 4 states responded" section: Studstill asked for clarification of how providers are struggling.

Crawford states MCNA is prepared to make a report presentation and regrets not being able to present by October 1 to give all information possible.

Azar agreed that these points need clarifying and this was an informal study. Mitchell added there are national studies that show how Alabama compares to other states. She asked that written comments or questions be addressed to Beth Huckabee. Then a revised report including these points would be send out again to the members.

Next Steps: Azar shared that data sharing agreements are being worked out with vendors and they will be able to present their findings at another meeting. Then the group will have rationale for the decision made. Mitchell asked Azar regarding amount of provider input if the dental program goes into RCO. Azar answered providers will have a lot of input.

There were no other questions or comments.

Meeting was adjourned.

Beth Huckabee

Beth Huckabee

Alabama Medicaid Dental Program Manager

Appendix 3 - Alabama Dental Association Position Statement on Dental Medicaid Structure

ALABAMA DENTAL ASSOCIATION
ORGANIZED 1869

ZACK STUDSTILL, D.M.D.
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Alabama Dental Association Position Statement on Dental Medicaid Structure

September 18, 2015

Dental Medicaid, as presently structured, is a cost effective, dental care delivery system that efficiently brings needed dental care to eligible children. In our opinion, any perceived "savings" by transitioning to a managed care model will most likely come at the cost of reduced services for children or reduced reimbursement for providers.

Dental Medicaid and the dental provider community have a rich history of working collaboratively, which has resulted in a nationally recognized model for the delivery of Dental Medicaid Services.

In the past fifteen years, past and present Medicaid officials worked with the provider community to change the dental program from a national embarrassment to a Top 10 nationally recognized Dental Program.

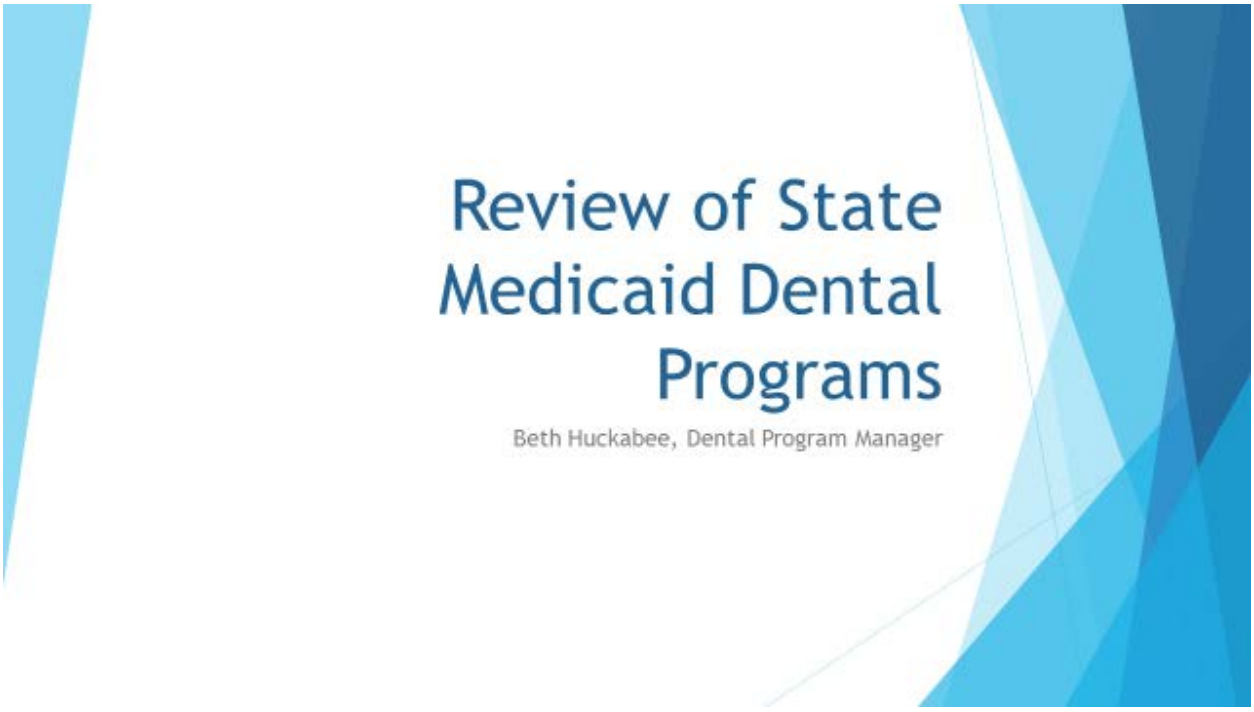
In the opinion of the Alabama Dental Association, any "perceived" reward for change to a managed care organization is far out-weighted by the risk of damaging the current program that is working so efficiently. Accountable Care or Managed Care Organizations are expected to return a profit. Additional organization expenses added to an already lean Dental Medicaid Budget has the unwelcome potential for decreasing dental services available to children and/or decreasing the number of willing dental providers.

The Alabama Dental Association strongly supports and recommends that the Alabama Dental Medicaid Program remain as currently configured as fee for service.

Dr. Zack Studstill
Executive Director
Alabama Dental Association

Appendix 4 – Presentations on 8/14/15

Appendix 4A - Presentation by Beth Huckabee, Dental Program Manager



The Dental program has researched other states' dental programs and the role that managed care (MC) plays in those programs, if any. This is a general overview.

The information gathered comes from the Kaiser Family Foundation, Oral Technical Advisory Group (OTAG) and The Kids Oral Health group members with CMS, and the American Dental Association's Health Policy Institute.

From the Kaiser Family Foundation website:

- 70% of Medicaid enrollees nationwide that receive medical services are in a MC delivery system
- 3 states do not have any type of MC: Wyoming, Delaware, and Alaska
- all other states have some level of MC involved in the delivery of services

According to CMS through Medicaid.gov and OTAG:

- 38 states provide dental services through a combination MC and others are FFS (Fee-for-service)
- 12 states provide dental services all in MC
- the remaining 9 states provide dental services through FFS

Accountable Care Organizations, (types of managed care organizations) in the nation:

- brief published by the Health Policy Institute of the American Dental Association conducted a survey in late 2012 through early 2014
- found over 600 ACOs that serve more than 18 million commercial and Medicaid patients in general health services

- of the ACOs surveyed in this study time period, the number of ACOs that provided commercial dental services increased from 8% to 26%
- found there are more ACOs that have a Medicaid contract if they are responsible for dental services than those that don't provide dental services

- of ACOs formed after Sept 2012, 47% of them had Medicaid dental services contracts in which they were responsible for the cost and quality of the services
- almost ½ of ACOs responsible for dental services are found in the South
- the authors suggest that ACOs are more likely to integrate dental services with Medicaid population bases

Three questions posed to the Kids Oral Health list serve members were:

1. In your state, how are the Dental services administered (MC, FFS, or combination)?
2. If your state has changed from FFS to MC, have you found it to more cost effective than FFS delivery?
3. If your state has changed from FFS to MC, have you found it to be better for recipients and providers?

As of the afternoon of 08/13/2015,

Question #1 – 14 states responded:

- 9 states indicated their services are delivered through FFS
- 4 states indicated services are through MC
- 2 states indicated a combination of FFS and MC
- 1 of the FFS states said they have plans to transition to managed care soon

Question #2 – 5 states responded:
- 3 states have not had MC long enough to be determined if it is cost effective
- two states answered it has not been cost effective

Question #3- 4 states responded:
- 3 states answered their recipients and/or providers are "struggling"
- 1 state answered recipients have better access through MC than FFS

As we can see, the environment of other states' Medicaid Dental programs are diverse and thought provoking amidst the many challenges that dental providers and Medicaid programs face. The intention is to contact some states individually, research more in the next few weeks, and to bring an update to you at the next meeting.

Appendix 4B - Presentation by James Whitehead, Quality Analytics, Analysis of the current Dental Program:

Dental Services Program Analysis

August 14, 2015

James Whitehead

Dental Services Program Analysis

For Fiscal Year 2014 By Date of Service
Dental Claims Only

	Diagnostic	Preventative	Treatment	FQHC	Total
Amount Paid (millions)	$19.2	$19.2	$49.6	$2.2	$90.1
Amount Paid Full Rate (millions)	$20.2	$20.2	$52.2	$2.2	$94.7
Amount Paid BCBS Rate (millions)	$24.0	$24.9	$70.4	$2.2	$121.5
Avg. Paid Per Unit	$20.03	$22.22	$71.97	$159.12	$35.71
Avg. Paid Per Unit Full Rate	$21.08	$23.39	$75.75	$159.12	$37.54
Unique Recipients	302,890	293,630	143,825	7,810	316,062
Unique Performing Providers	706	632	697	54	763
Unique Claims	474,847	438,699	236,488	13,541	689,139
Avg. Claims Per Performing Provider	673	694	339	251	903
Avg. Recipients Per Performing Provider	429	465	206	145	414
Avg. Claims Per Recipient	1.57	1.49	1.64	1.73	2.18
Avg. Paid Per Recipient Full Rate	$66.56	$68.88	$362.90	$275.88	$299.73

1) Excludes claims with third party liability.
2) BCBS rates based on rates in effect at January 2015.

Dental Services Program Analysis

Annual Growth Rate – 2010 to 2014
Dental Claims Only

	Diagnostic	Preventative	Treatment	FQHC	Total
Amount Paid	3.5%	2.7%	1.3%	9.3%	2.2%
Amount Paid Full Rate	4.8%	4.0%	2.6%	9.3%	3.5%
Amount Paid BCBS Rate	5.7%	6.3%	4.3%	9.3%	5.1%
Avg. Paid Per Unit	-1.0%	-1.4%	-1.1%	4.1%	-1.5%
Avg. Paid Per Unit Full Rate	0.3%	-0.1%	0.2%	4.1%	-0.3%
Unique Recipients	4.8%	4.9%	3.6%	4.4%	4.7%
Unique Performing Providers	2.8%	2.6%	2.7%	1.9%	2.7%
Unique Claims	4.7%	5.1%	2.5%	5.0%	4.1%
Avg. Claims Per Performing Provider	1.9%	2.4%	-0.2%	3.0%	1.5%
Avg. Recipients Per Performing Provider	1.9%	2.2%	0.9%	2.5%	2.0%
Avg. Claims Per Recipient	0.0%	0.2%	-1.0%	0.6%	-0.6%
Avg. Paid Per Recipient Full Rate	0.0%	-0.8%	-0.9%	4.7%	-1.2%

1) Excludes claims with third party liability.
2) BCBS rates based on rates in effect at January 2015.

Dental Services Program Analysis

Fiscal Years 2010 to 2014
Dental Claims Only

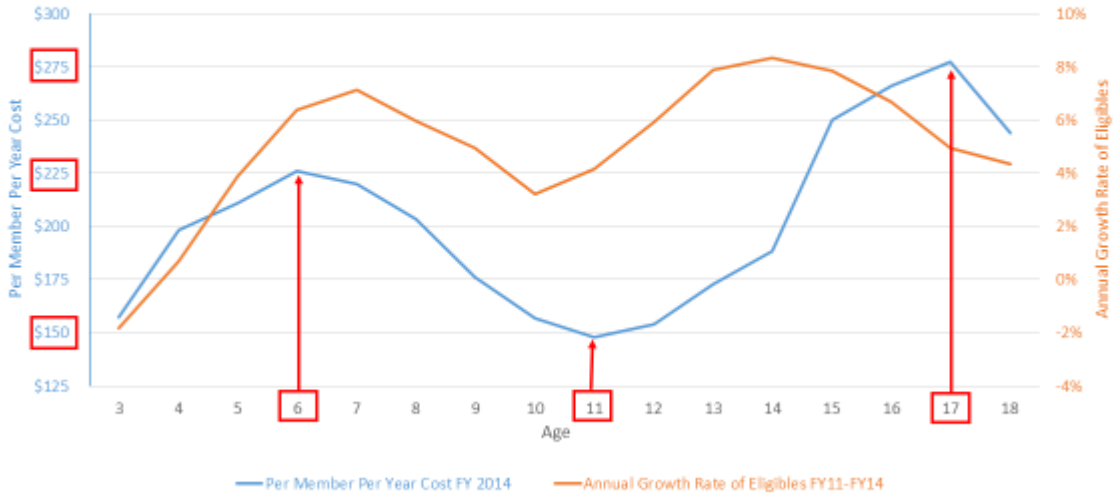
	2010	2011	2012	2013	2014
Effect of Budgetary Rate Cut	100.0%	100.0%	96.7%	97.5%	95.1%
BCBS Rate to Medicaid Full Rate	20.9%	29.5%	26.9%	28.1%	28.2%

State Share Required	2010	2011	2012	2013	2014
As Actually Paid (millions)	$26.4	$27.2	$27.5	$27.6	$28.7
To Add BCBS Rates (millions)	$5.5	$8.0	$7.7	$8.0	$8.5

1) Excludes claims with third party liability.
2) BCBS rates based on rates in effect at January 2015.

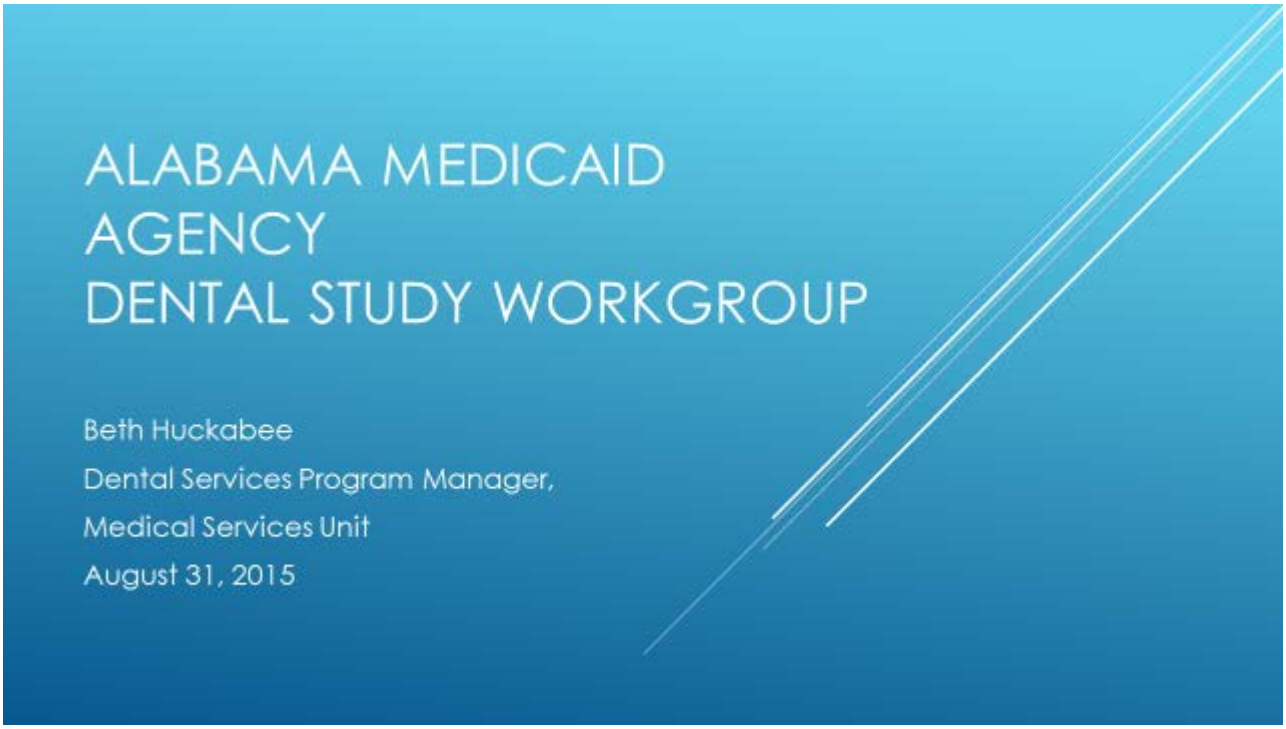
Dental Services Program Analysis

Age of Recipients Analysis
For Fiscal Year 2014 By Date of Service
Dental Claims Only



Appendix 5 – Presentations on 8/31/2015

Appendix 5A - Presentation by Beth Huckabee, Dental Program Manager



- Medicaid Dental Programs of Other States
- Responses to Questions about Delivery Systems of Dental Services

BEFORE THE AUGUST 14TH MEETING, 3 QUESTIONS POSED TO DENTAL PROGRAM MANAGERS/DIRECTORS OF OTHER STATES:

1. In your state, how are the dental services administered (MC, FFS, or combination)?
2. If your state has changed from FFS to MC, have you found it to be more cost effective than FFS delivery?
3. If your state has changed from FFS to MC, have you found it to be better for recipients and providers?

AS REPORTED AT THE PREVIOUS MEETING, 14 STATES RESPONDED:

Alaska	Illinois
Arkansas	Kentucky
California	Maine
Colorado	Nebraska
Connecticut	Oklahoma
Delaware	Oregon
Georgia	Washington State

Louisiana, Pennsylvania, and Tennessee responded after the meeting.

FOLLOW UP QUESTIONS TO 9 STATES - IF YOUR STATE HAS FFS DELIVERY SYSTEM:

1. Has your state considered changing from FFS to MC for any eligible groups?
2. What was your experience and brief reasons the change did not occur?
3. What are the pros and cons for recipients/enrollees and providers in the FFS system?
4. Do you utilize any quality measures for recipients/enrollees and providers? If so, what general types are they?

- One state has responded:

The state has considered including dental services in managed care, but has not found it cost effective at this time.

- FOLLOW UP QUESTIONS TO 10 STATES:
  IF YOUR STATE HAS MANAGED CARE DELIVERY SYSTEM:

1. Are your state dental services included in an integrated medical managed care organization (MCO) or separated in a dental MCO? Who bears the risk(s) in the MCO?
2. Have you seen an increase or decrease in the utilization rate and why do you think this has happened?
3. What pros and cons have resulted from dental being in a MCO for recipients? For providers?

4. Has the cost PMPM (per member, per month) increased or decreased since entering a MCO? What is the current PMPM rate?
5. Have the number of dental providers increased or decreased since entering a MCO?
6. Do you utilize any quality measures for providers and recipients/enrollees in the MCO? If so, what kind are they?

2 STATES RESPONDED WITH ANSWERS:

1. One state's Dental services were integrated with other medical services. The other state's Dental services were not integrated. In both states, the State and MCO shared the risk.

2. Both states have seen an increase in the utilization rate especially among the preventative services. Both states attributed the increase to the care coordination between recipients and dental providers.

3. Some pros:

-Higher utilization rate in preventative services, thus has decreased cost in restorative and treatment procedures.

3. continued:

- Found better cost control
- One state answered having one MCO is easier to manage than multiple MCOs.

Some cons:

-Both states reported a 2-3 year learning curve for the state, providers, and recipients.

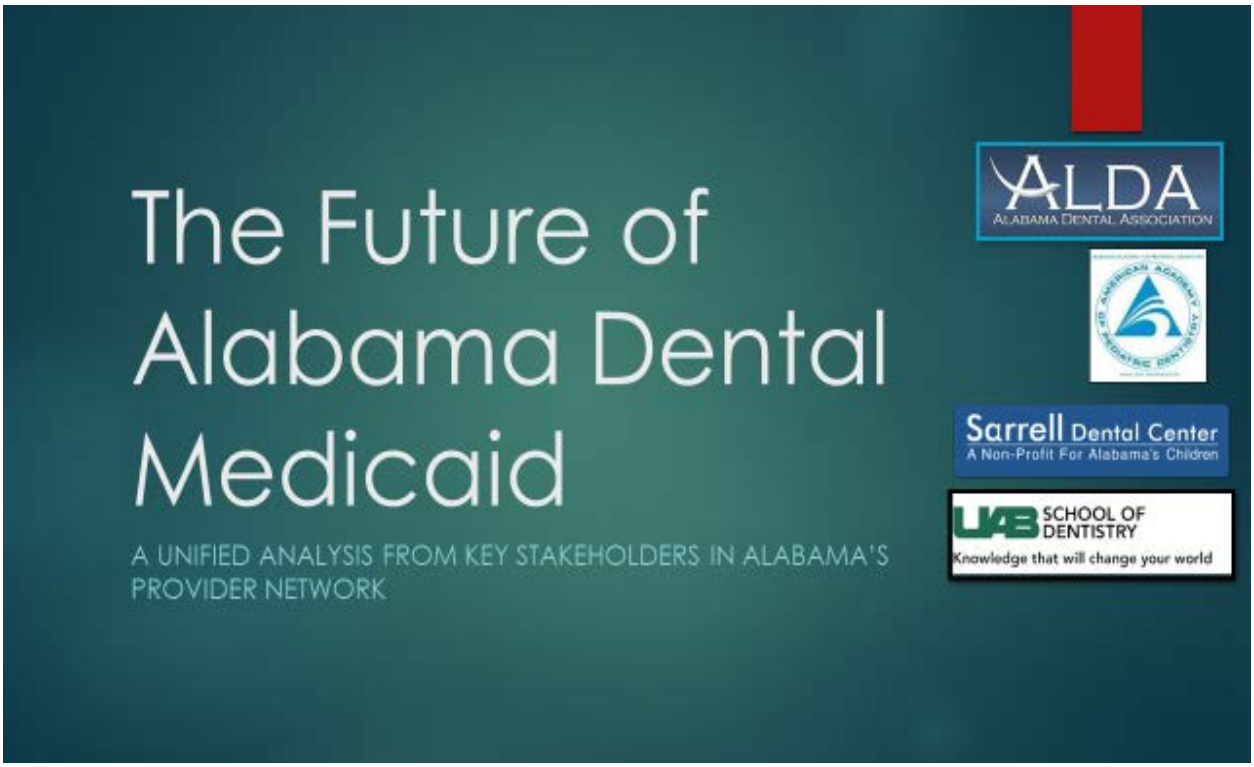
-One state reported with fragmentation of multiple MCOs, management is complicated and confusing.

-One state reports providers are paid differently between multiple MCOs, which causes some complaints.

4. The state whose Dental services are in a MCO has seen a significant decrease in the PMPM (per member, per month) rate. The other state's Dental services are included with other medical programs and could not be broken out.
5. Number of providers overall has significantly increased in one state and has stayed relatively consistent with a slow growth of number of providers in the other state.
6. Both states use benchmarks as incentives for providers and in one state for recipients. Both also use quality measures and hold quarterly meetings between MCO and Dental program managers to reinforce the measures.

- The two Dental MC reporting states have experienced more advantages than disadvantages with their current system.
- The one FFS reporting state has more cost efficiency with their current system.
- The state Medicaid Dental programs are in an ever changing environment.
- Available information needs to be carefully weighed to find what is best for the children of Alabama.

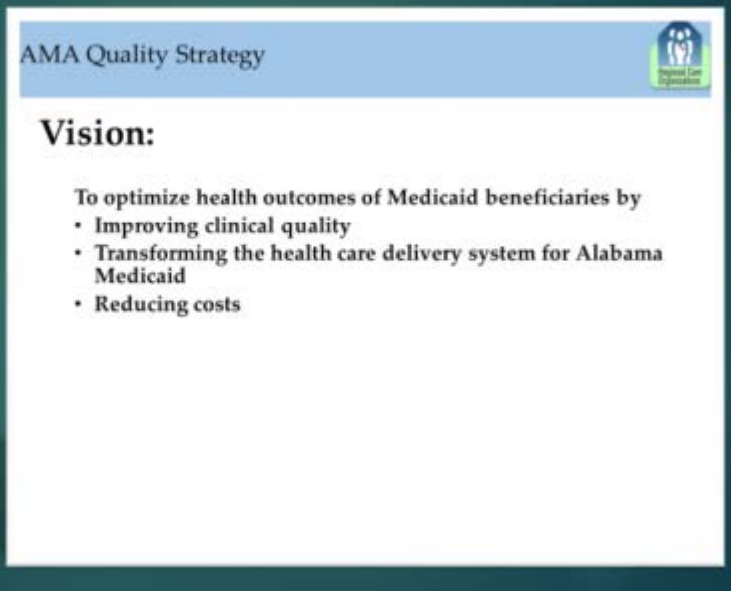
Appendix 5B - Presentation by the Alabama Dental Association, UAB School of Dentistry, American Academy of Pediatric Dentistry, and Sarrell Dental Centers



Outline

- Accountable Care Model:
  - Goals
  - Available Evidence in Dentistry
- Success of Current Model achieving ACO goals
  - History of the Alabama Dental Medicaid Program
  - Alabama Dental Medicaid National Standings
  - First Look Program
  - Provider involvement in program
- Evidence based predictions for other models functioning in Alabama

July 2015 RCO Quality Assurance Meeting



Accountable Care Organizations in Dentistry

- ADA report
- Descriptive report on rate of inclusion of dentistry in ACO
- No information on financial impact

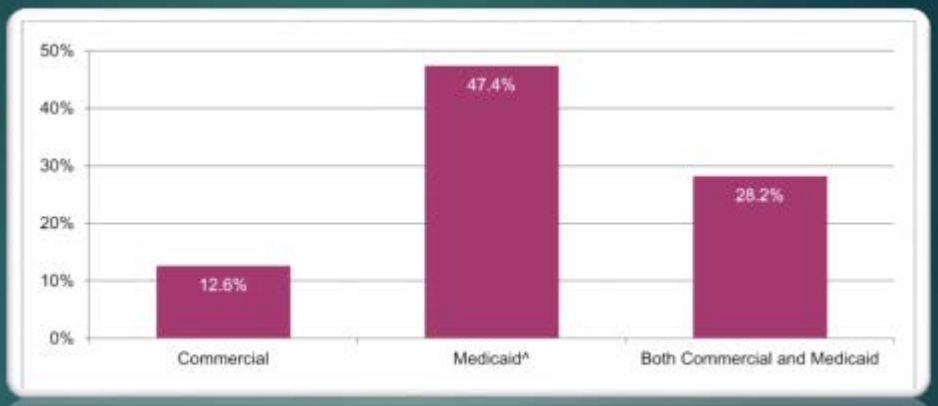

Health Policy Institute
ADA American Dental Association

Research Brief

Early Insights on Dental Care Services in Accountable Care Organizations

Key Messages

Introduction



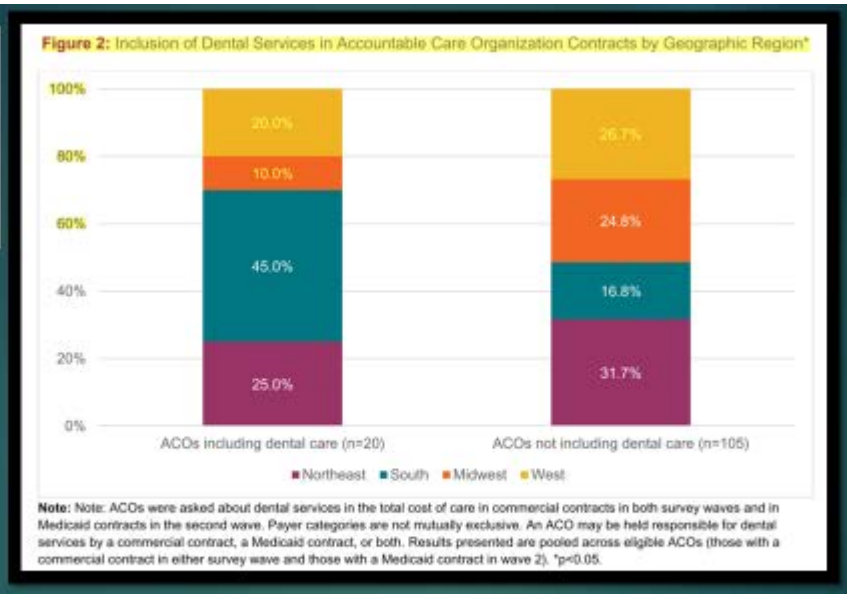
- Reports:
  - 70% of ACO with Dental Have Medicaid Contract
  - 30.2% of ACO without Dental have Medicaid Contract

ACOs including dental services (n=20)	ACOs not including dental services (n=106)

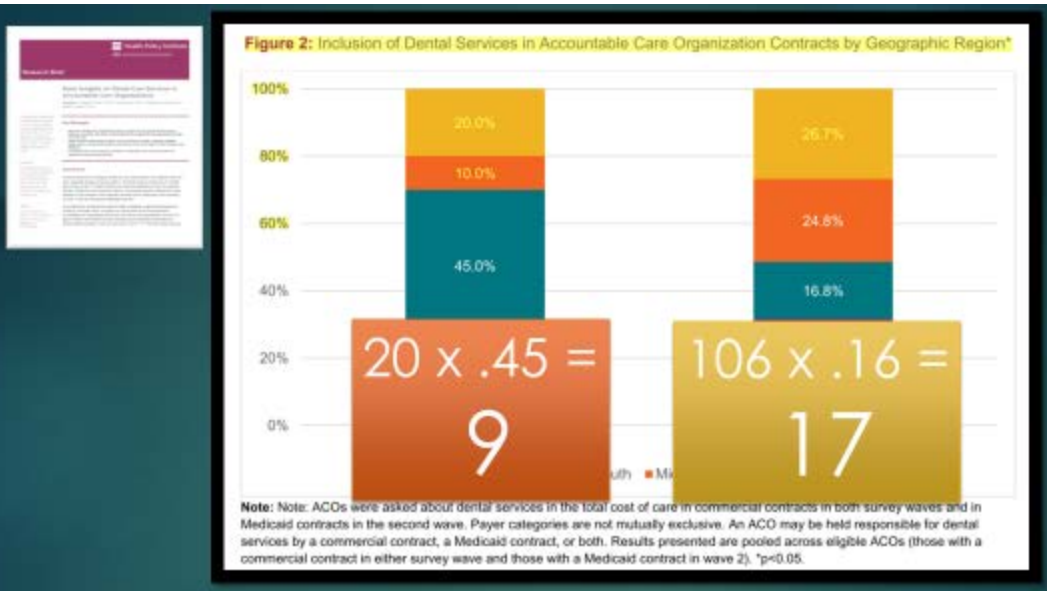
20 x .70 = 14

106 x .30 = 31

- Reports:
  - 70% of ACO with Dental Have Medicaid Contract
  - 30.2% of ACO without Dental have Medicaid Contract



Claim: 45% of ACOs with dental operate in the South



- Only 9 of 126 RCO operating in South
- 17 Southern RCOs do not have dental

Dental Care in Accountable Care Organizations: Insights from 5 Case Studies

LEAVITT PARTNERS

Health Policy Institute

ADA American Dental Association

Pediatric Oral Health

ADA and AAPD commissioned case report.

Five ACOs with dental evaluated

- No examples of ACOs functioning across entire state
- One ACO operating in Washington/Oregon since 1970s.
  - Part of Kaiser
  - Has NOT been rolled out to Kaiser across country
- ACOs operating with FQHCs or Public Health Clinics seem to function best

Evidence from the literature:

AMA Quality Strategy

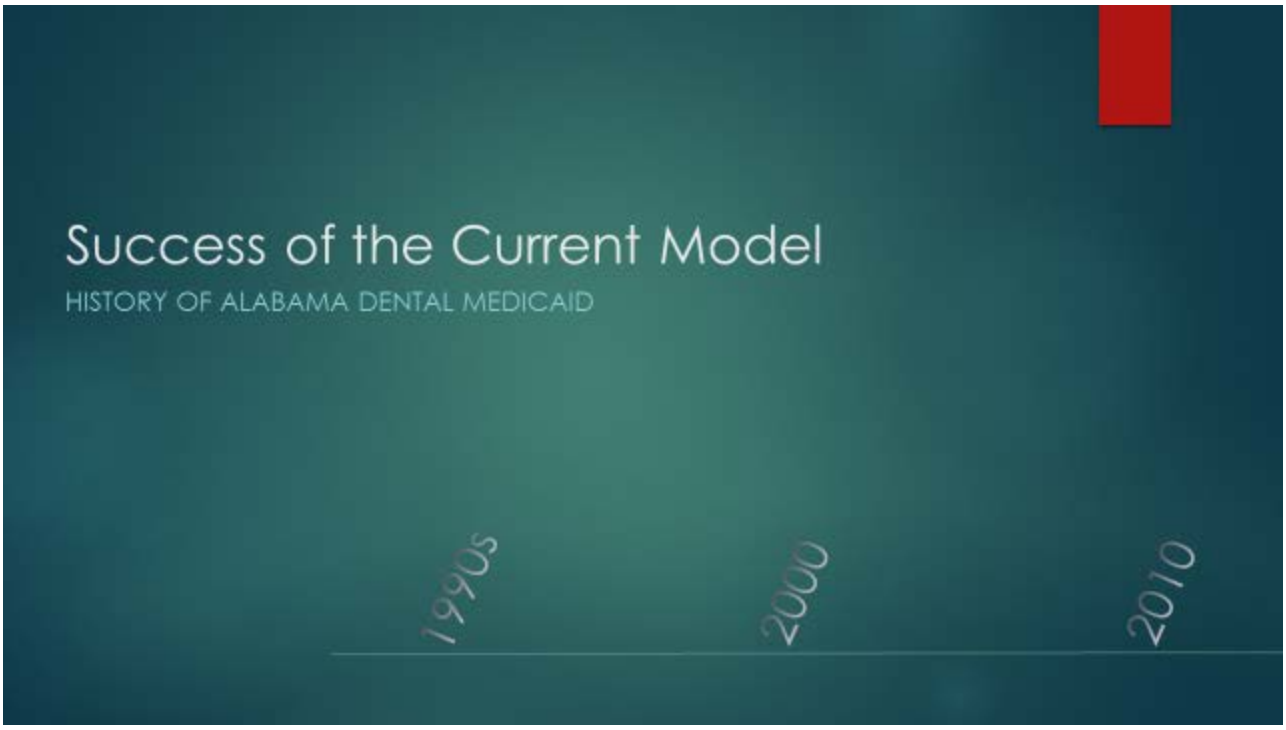
Vision:

To optimize health outcomes of Medicaid beneficiaries by

- **Improving clinical quality**
- **Transforming the health care delivery system for Alabama Medicaid**
- **Reducing costs**

1. Hope for improved care coordination
2. Multiple ACOs express concern over lack of validated metrics
3. Interdisciplinary interactions will take significant investment in electronic records and interdisciplinary communication tool

- No evidence available on financial impact of ACO model



Success of the Current Model:

A Story of Successful Public-Private Partnerships

"Only through effective disease reductions that markedly impact the Medicaid child population's disease burden of preventable tooth decay can better oral health at a lower cost be achieved"

CDHP Issue Brief, 2012

- A successful program controls costs by effectively reducing disease and emphasizing prevention

Success of the Current Model:

Principles for Building a Successful Program

- Early Risk Assessment and Education
- Fluoride Varnish
- Access to a Dental Home (age 1)
- Early Intervention and Treatment
- Continuous Preventive Measures, Anticipatory Guidance, Regular Intervals, Dental Home

Success of the Current Model:

Alabama Dental Medicaid Program

- Late 1990's…a broken system

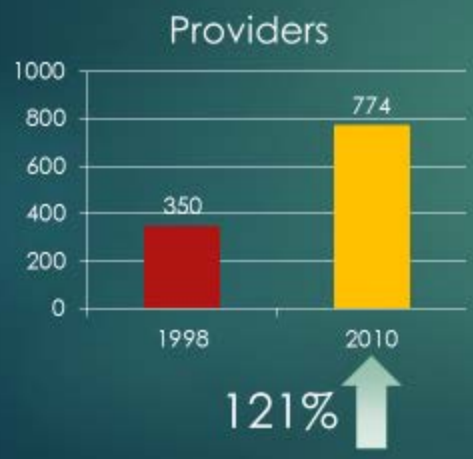
1997-98
350 Providers
25.2% Utilization

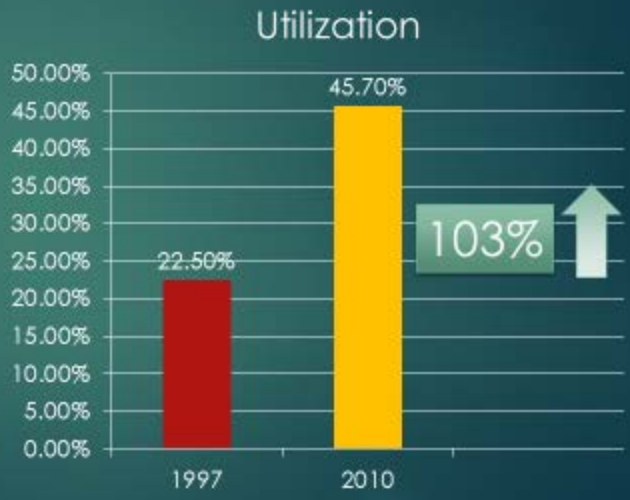
Actions Taken:

- Dental Task Force (DTF)
- Coalition of Public-Private Stakeholders
- *Alabama Smile* 2000

Success of the Current Model:

Results of Reform





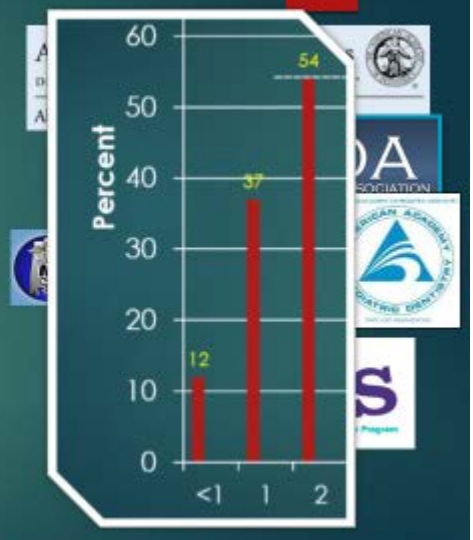
Take a 1st Look
A Healthy Smile = A Healthy Child

Success of the Current Model:

1st Look

- Collaboration
- Focus: Prevention and a dental home by age 1
- Trained over 400 physicians and other health care providers
- Results:

54% of Alabama Two Year olds have had a dental exam!



Success of the Current Model:

2010 Task Force on Program Improvement

- Initiated by Provider
- Commissioner formed committee of provider
- Task: Find cost neutral savings and make recommendations for reinvestment for program improvement
- FEB-JUL 2010, **Comprehensive Review** of all covered procedures
  - Scientific literature, provider surveys, academia
  - Standard of care, efficacy, age appropriateness, success rate

Success of the Current Model:

2010 Task Force Results

- 21 Evidenced based Recommendations:
  - 13 codes eliminated, 4 fee reductions, 4 fee increases
  - Examples:
    - Eliminated rubber cup prophy for under 3y
    - Reimbursement reduction to multi-surface restorations:
      - 41% reduction in this poor outcomes procedure

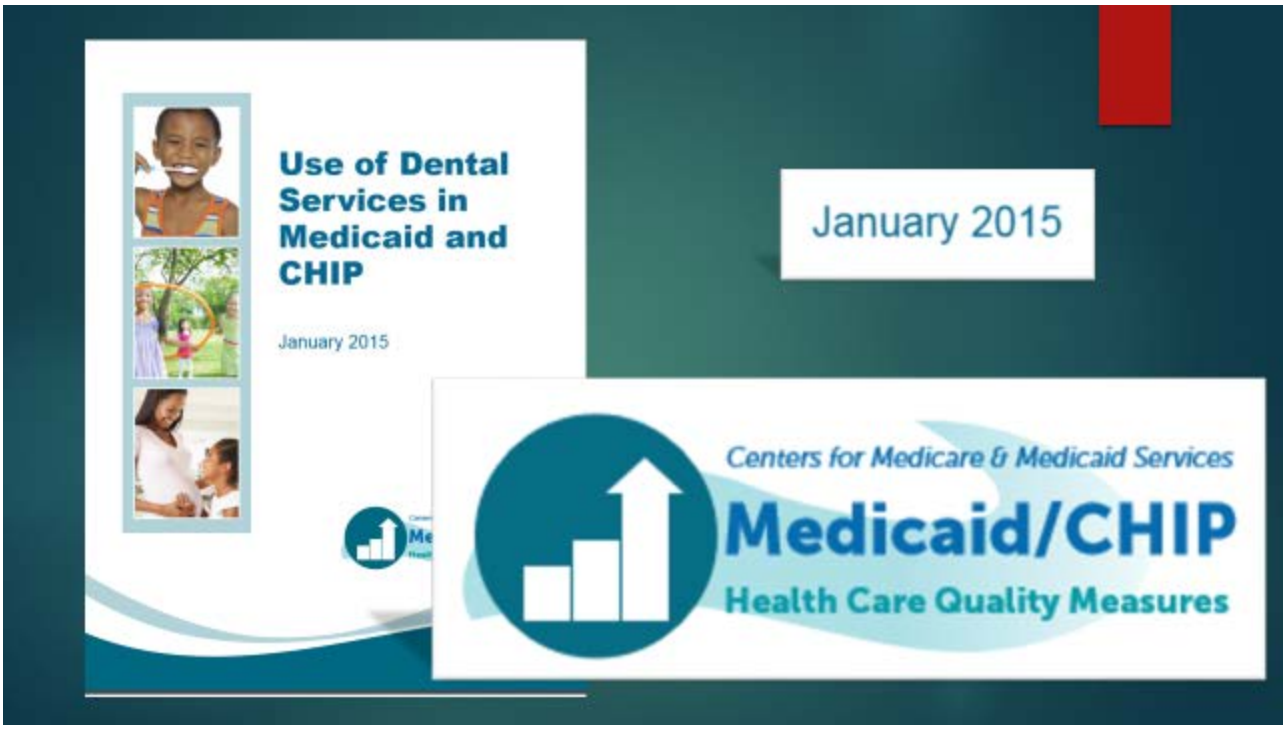
Success of the Current Model:

2010 Task Force Results

- Analysis by Lister Hill Center, SEP 2010
- Approved by Medicaid and DTF DEC 2010
- Implemented FEB 2011

	2011	2012
Net totals of projected savings	$4,977,372	$5,730,305
Net totals of projected new expenditures	$3,314,282	$3,546,694
Difference between projected savings and projected expenditures	$1,663,090	$2,183,611

Success of the Current Model


Use of Dental Services in Medicaid and CHIP
January 2015
January 2015
Centers for Medicare & Medicaid Services
Medicaid/CHIP
Health Care Quality Measures

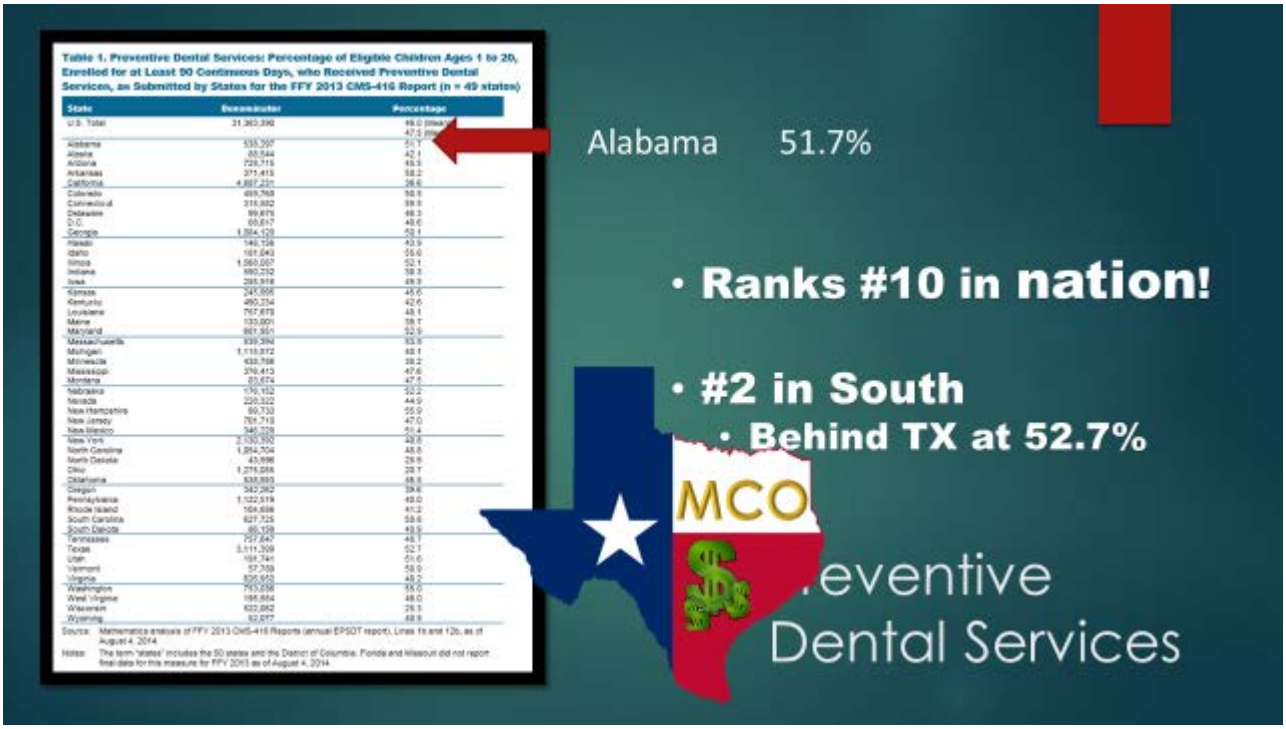


Table 1. Preventive Dental Services: Percentage of Eligible Children Ages 1 to 20, Enrolled for at Least 90 Continuous Days, who Received Preventive Dental Services, as Submitted by States for the FFY 2013 CMS-416 Report (n = 49 states)
State
Denominator
Percentage
Alabama 51.7%
• Ranks #10 in nation!
• #2 in South
• Behind TX at 52.7%
MCO
eventive
Dental Services

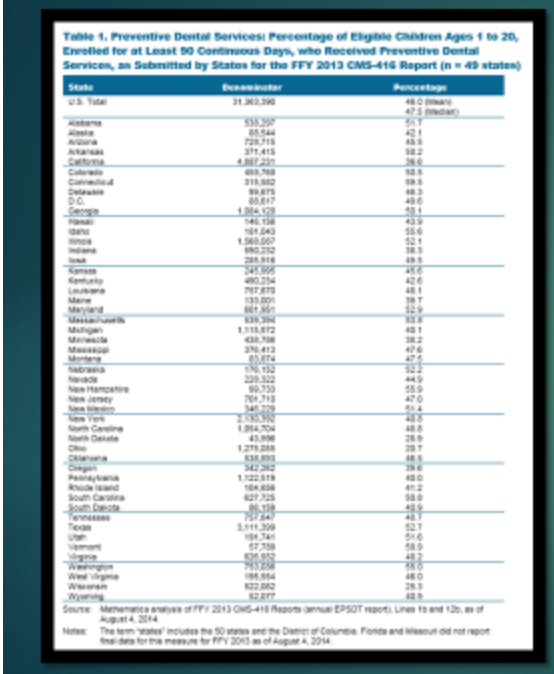


Table 1. Preventive Dental Services: Percentage of Eligible Children Ages 1 to 20, Enrolled for at Least 90 Continuous Days, who Received Preventive Dental Services, as Submitted by States for the FFY 2013 CMS-416 Report (n = 49 states)

State	Denominator	Percentage
U.S. Total	31,360,390	48.0 (Mean) 47.5 (Median)
Alabama	535,297	51.7
Alaska	85,544	42.1
Arizona	728,715	48.9
Arkansas	371,413	58.2
California	4,887,231	38.6
Colorado	469,768	52.9
Connecticut	315,882	59.9
Delaware	99,875	48.3
D.C.	85,617	49.6
Georgia	1,804,128	58.1
Hawaii	146,156	43.9
Idaho	161,643	55.6
Illinois	1,560,007	52.1
Indiana	980,252	38.3
Iowa	288,916	49.5
Kansas	245,995	45.6
Kentucky	480,234	42.6
Louisiana	767,873	48.1
Maine	133,001	39.7
Maryland	661,951	52.9
Massachusetts	539,394	53.8
Michigan	1,115,672	48.1
Minnesota	438,788	38.2
Mississippi	376,413	47.6
Montana	83,674	47.5
Nebraska	176,152	52.2
Nevada	220,322	44.9
New Hampshire	99,733	55.9
New Jersey	704,713	47.0
New Mexico	346,229	51.4
New York	2,130,550	48.6
North Carolina	1,054,704	48.6
North Dakota	43,996	28.9
Ohio	1,276,088	39.7
Oklahoma	538,893	48.5
Oregon	342,282	39.6
Pennsylvania	1,122,519	48.0
Rhode Island	104,936	41.2
South Carolina	627,725	58.8
South Dakota	86,128	48.9
Tennessee	757,647	48.7
Texas	3,111,399	52.7
Utah	164,741	51.6
Vermont	57,788	58.9
Virginia	526,552	48.2
Washington	783,658	56.0
West Virginia	186,664	48.0
Wisconsin	522,662	28.3
Wyoming	52,877	48.9

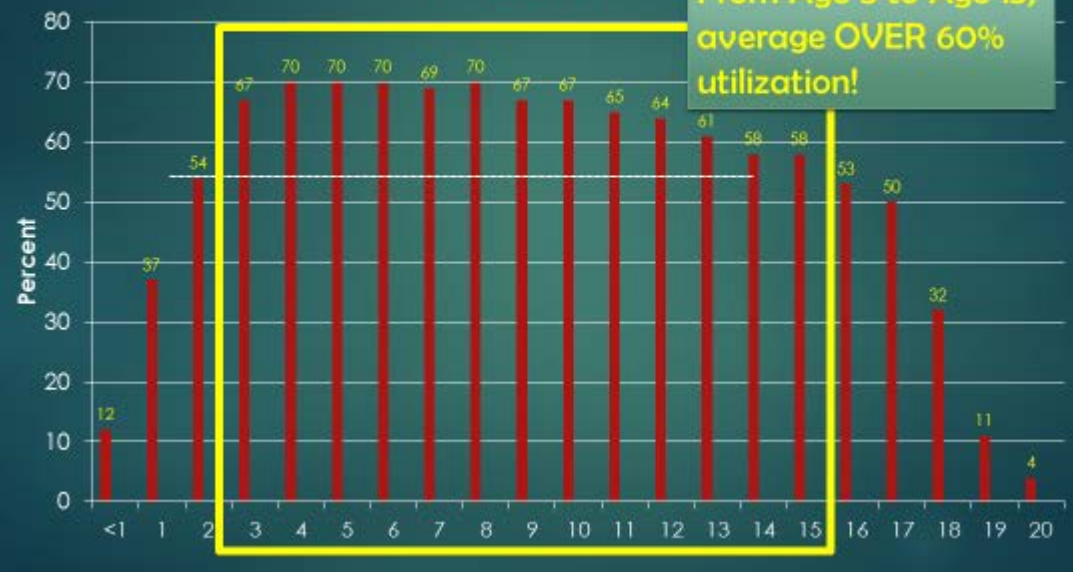
Source: Mathematica analysis of FFY 2013 CMS-416 Reports (annual EPSDT report), Lines 1b and 12b, as of August 4, 2014.

Notes: The term "states" includes the 50 states and the District of Columbia. Florida and Missouri did not report final data for this measure for FFY 2013 as of August 4, 2014.

States Not Contracting with Managed Care:

Rank	State	% Preventive Services
1	Alabama	51.7%
6	Arkansas	26.9%
8	Arizona	22.8%
3	Connecticut	29%
2	Idaho	29.1%
10	Maine	17.1%
4	Montana	27.6%
11	North Dakota	14.2%
7	Oklahoma	25.9%
5	Virginia	27.3%
9	Wyoming	22.6%

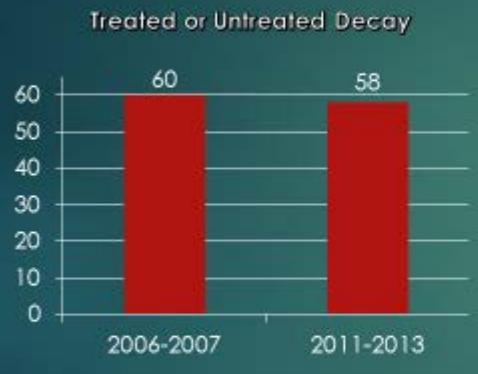
Medicaid Dental Utilization by Age FY 2014

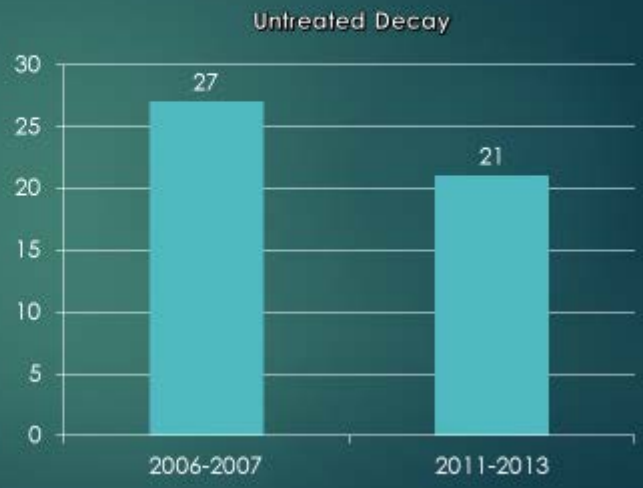


Children Receiving Restorative Care

- Fewer Alabama children require restorative care (lower 1/3rd)
- Next to lowest in South
  (Only Kentucky is lower)

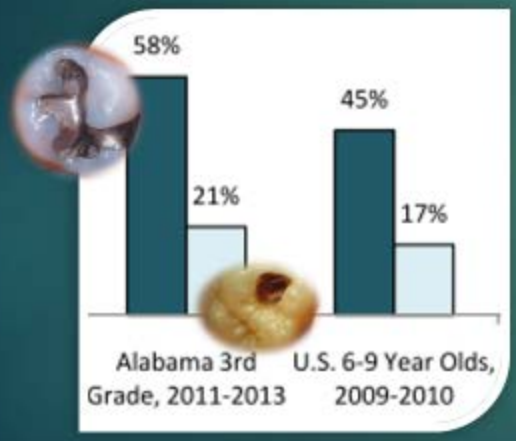
Alabama 3rd graders caries prevalence: Changes over time





ADPH Dental Surveys
2006-2007 & 2011-2013

Alabama 2013 report on caries prevalence in 3rd graders




Alabama Department of Public Health Data Brief ◊ February 2013

The Oral Health of Alabama's Kindergarten and Third Grade Children Compared to the General U.S. Population and Healthy People 2020 Targets

Data from the Alabama Oral Health Survey, 2011-2013

- About half of Alabama's kindergarten and third grade children (50%) had a history of decay in their primary or permanent teeth, compared to 45% of 6-9 year old children in the general U.S. population. The Healthy People (HP) 2020 for 6-9 year olds target is 49%.
- About one-fifth of Alabama's kindergarten and third grade children (20%) had untreated decay. This compares to 17% of 6-9 year-old children in the general U.S. population and a HP 2020 target of 26%.
- More than one out of four (28%) third grade children in Alabama had at least one dental sealant on a permanent tooth, similar to the prevalence among the general U.S. population and the HP 2020 target for 6-9 year olds (32% and 28% respectively).
- Some oral health disparities still exist in Alabama with low-income children having the highest prevalence of decay experience and untreated decay.

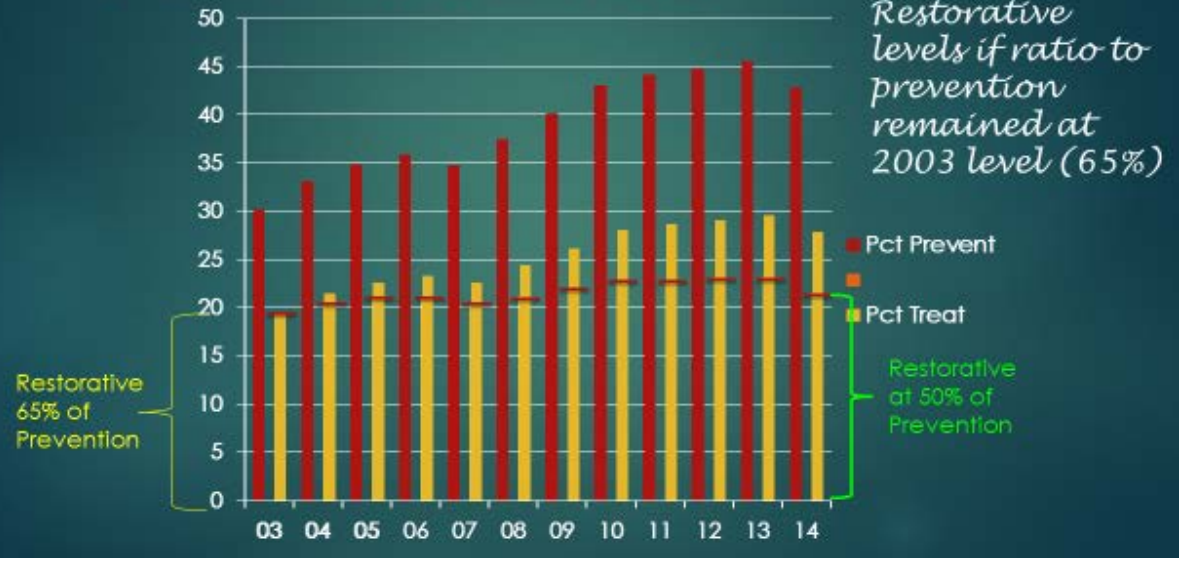
Good oral health is important to a child's social, physical and mental development. Even though tooth decay can be prevented, most children in Alabama still get cavities. To assess the current oral health status of Alabama's elementary school children, the Alabama Department of Public Health coordinated a statewide oral health survey of kindergarten and third grade children in Alabama's public schools. A total of 9,057 children received a dental screening at 68 schools during the 2011-2012 and 2012-2013 school years. The sampling frame for the survey consisted of all public schools in Alabama with 20 or more children in third grade. This data brief presents information on the prevalence of tooth decay in the primary and permanent teeth of Alabama's kindergarten and third grade children compared to 6-9 year old children in the general U.S. population and the targets for Healthy People 2020. It also describes the prevalence of dental sealants, a plastic-like coating applied to the chewing surfaces of children's teeth to prevent tooth decay.

Prevalence of decay experience and untreated decay.

Figure 1. Prevalence of decay experience and untreated tooth decay in the primary and permanent teeth of Alabama's kindergarten & third grade children compared to 6-9 year old children in the U.S. population and the Healthy People 2020 targets

Alabama Dental Medicaid 2003-2014

Preventive v Restorative Care

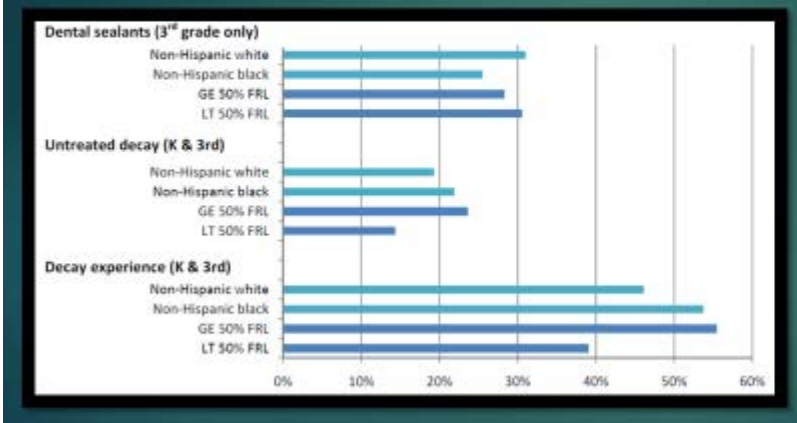


Children Receiving Restorative Care

- Why are fewer Alabama children requiring restorative care:

Prevention programs are **working**!

Health equity



"There was no difference in the prevalence of decay experience or untreated decay among racial/ethnic groups."

Success of the Current Model

TRANSFORMING THE HEALTH DELIVERY SYSTEM

Interdisciplinary Healthcare

"Early prevention of dental caries will ultimately result in improved oral health for high-risk Alabama children," said Medicaid Commissioner Carol Steckel. "This partnership between Patient 1st medical providers and the dental community is a win-win effort that will significantly impact the overall health and well-being of the children we serve."

Innovative Health Delivery Systems

Sarrell Dental Center
A Non-Profit For Alabama's Children

Forbes / Opinion

Making Medicaid Work: Dentists For The Poor

Systematic Screening an Assessment of Workforce Innovations in the Provision of Preventive Oral Health Services

Evaluability Assessment Site Visit Summary Report
Sarrell Dental Program
Anniston, Alabama

Forbes / Entrepreneurs

Disruptive Innovation: A Prescription For Better Health Care

Stakeholder Involvement

Dental Task Force/Subcommittee

The Dental Task Force was created in 1997 to review dental program policies and rules and to make recommendations of dental practice standards for incorporation into the policies. The Dental Task force also reviews surveys and makes recommendations for dental program evaluations as well as general recommendations to address misuse, abuse and fraud.

Oral Health Coalition of Alabama/ Alabama Oral Health Strategic Team

The Oral Health Coalition and The Alabama Oral Health Strategic Team are committed to the dissemination of oral health information in order to build public awareness on the importance of good oral health in overall health. With the vision "to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child."

Success of the Current Model

Provider Involvement

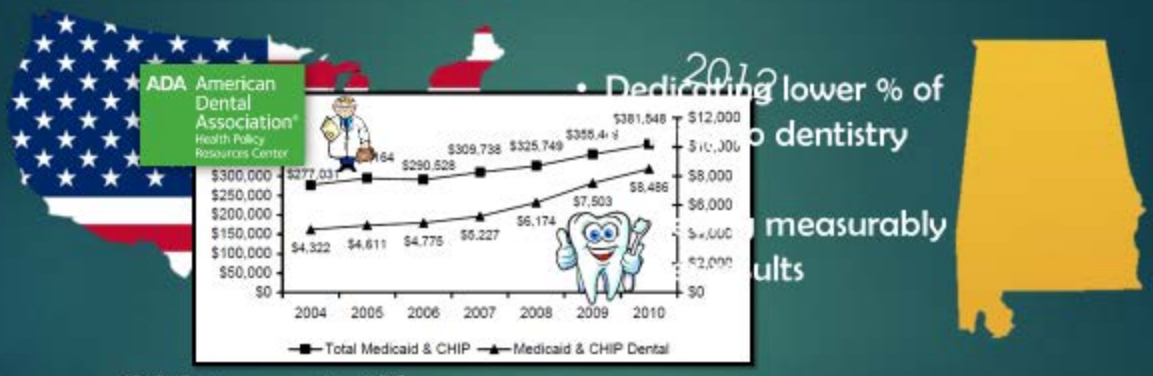
Dental Task Force/Subcommittee

The Dental Task Force was created in 1997 to review dental program policies and rules and to make recommendations of dental practice standards for incorporation into the policies. The Dental Task force also reviews surveys and makes recommendations for dental program evaluations as well as general recommendations to address misuse, abuse and fraud.

- 2011–$1,663,090 in savings
- 2012–$2,183,611 in savings

Medicaid responding to the voice of providers within the system

Cost as % of total budget



2004 1.6%
2010 2.2%
2015 2.8% (projected at 0.13%/y)

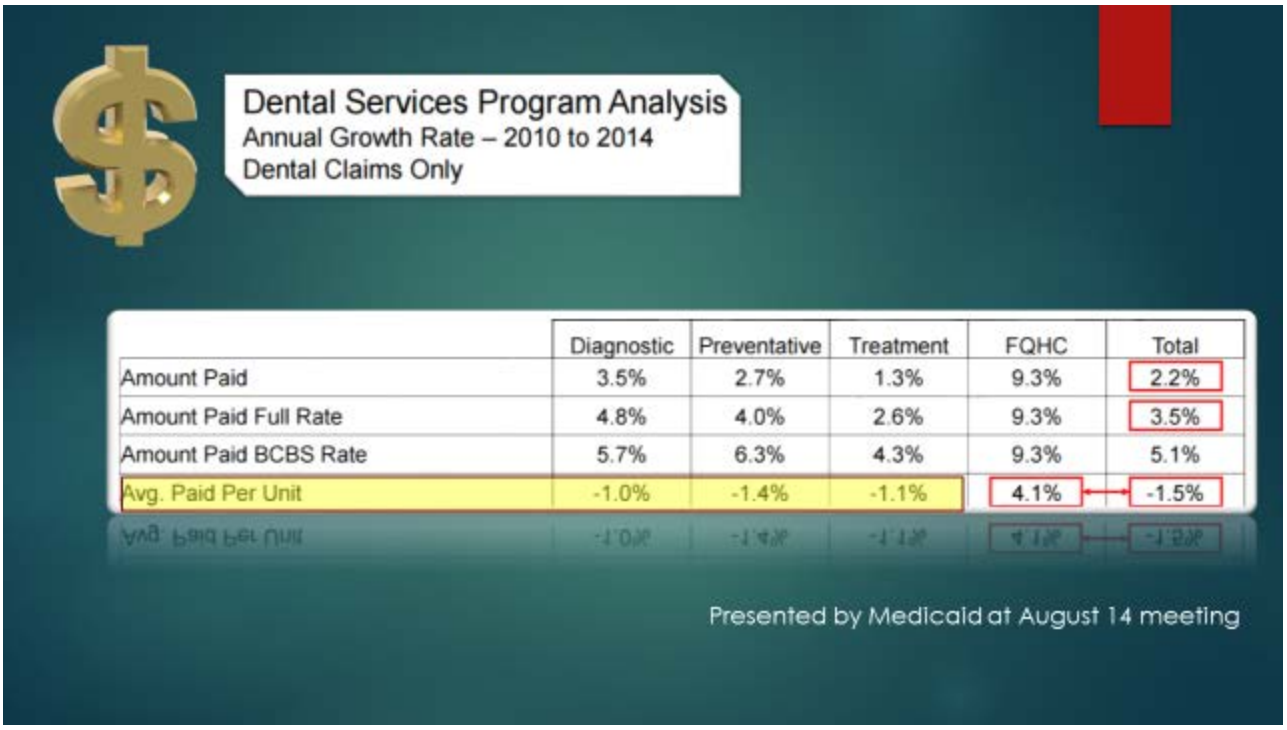
2014 1.6%

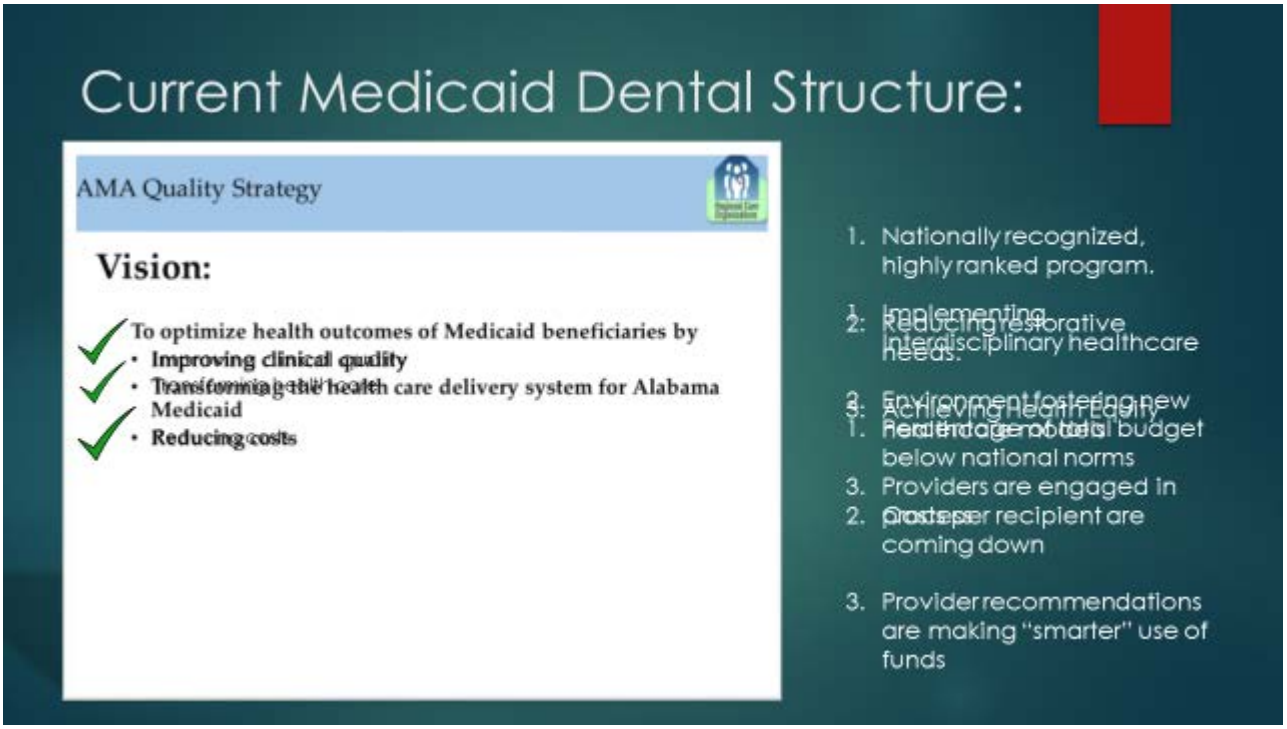
2010 to 2014

Costs per treated recipient:

2010 $314 to 2014 $285

2.4%/year


Dental Services Program Analysis
Annual Growth Rate – 2010 to 2014
Dental Claims Only
Diagnostic
Preventative
Treatment
FQHC
Total
Amount Paid
3.5%
2.7%
1.3%
9.3%
2.2%
Amount Paid Full Rate
4.8%
4.0%
2.6%
9.3%
3.5%
Amount Paid BCBS Rate
5.7%
6.3%
4.3%
9.3%
5.1%
Avg. Paid Per Unit
-1.0%
-1.4%
-1.1%
4.1%
-1.5%
Presented by Medicaid at August 14 meeting


Current Medicaid Dental Structure:
AMA Quality Strategy
Vision:
To optimize health outcomes of Medicaid beneficiaries by
Improving clinical quality
Transforming the health care delivery system for Alabama Medicaid
Reducing costs
1. Nationally recognized, highly ranked program.
2. Reducing restorative needs.
3. Achieving Health Equity
1. Percentage of total budget below national norms
2. Cost per recipient are coming down
3. Provider recommendations are making "smarter" use of funds

Evidence based predictions for other models functioning in Alabama

Rising costs in Medicaid due to increasing eligibles

- Medicaid reported 4.7% increase in unique recipients in 2014
  - Cost per recipient went DOWN
  - Claims per recipient went DOWN
- Overall costs went up

Bottom line:

Unless the number of eligible decreases, cost will increase no matter what form the program takes.

How can this be addressed? Option 1: Reduce Provider Reimbursement

- Multiple studies show that provider reimbursement is directly correlated with access to care
- Alabama is currently already operating with 16y old rates:
  - Results in our state are already "statistical outliers"
- If access drops below levels CMS accepts they will intervene
- Federal cases in multiple states have ruled rates must cover costs of dentist

Bottom line:

Provider reductions risk overwhelming the Alabama system

How can this be addressed? Option 2: Restrict patient access

- Federal rules regulate eligibility
- Two methods have been documented:
  - Limiting number of providers
  - Increasing bureaucracy
- Federal guidelines are currently being updated to respond to concerns about this issue
- Federal court rulings have stipulated programs must have "acceptable administrative burden"

Bottom line:

Access restrictions could prove to be resource intensive

How can this be addressed? Option 3: Eliminate waste

- Quality assurance is important

But to impact budget requires large scale wastes

- Alabama does not have:
  - Large corporate chains

- Alabama does not have orthodontic services

Texas saw 83% reduction in orthodontic service payments in first six months of managed care

How can this be addressed? Option 3: Eliminate waste

Bottom line:

Alabama would have to eliminate <u>needed</u> care and not waste to impact the budget

Administrative Costs

- Alabama currently pays ~3% in overhead
  - 97% of Alabama Medicaid dental funds goes directly to patient care
- Any program that increases that costs takes money from patient care

Bottom line:

We cannot identify any area where savings could be realized without harming Alabama's children

We conclude with one voice:

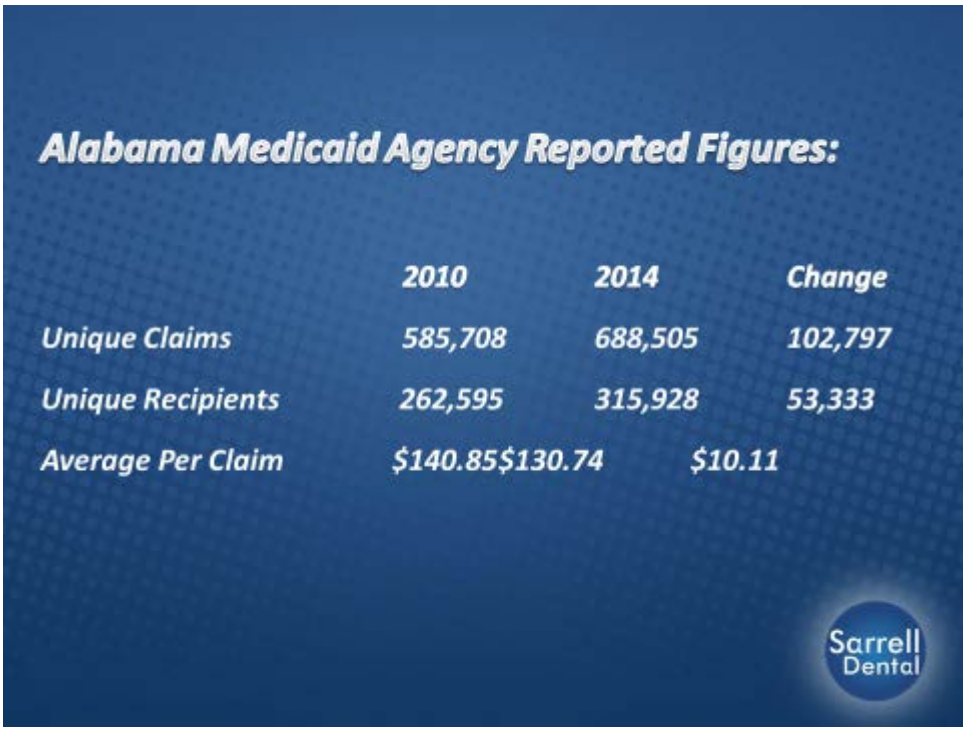
- The Alabama Dental Medicaid Program **as currently configured** has achieved the vision of the Alabama Medicaid Program
- The Alabama Dental Medicaid Program should **remain separate** from the current Medicaid restructure
- The Alabama Dental Medicaid as currently configured is **the best option** for continuing to **serve the children** of Alabama with quality dental care in an affordable way

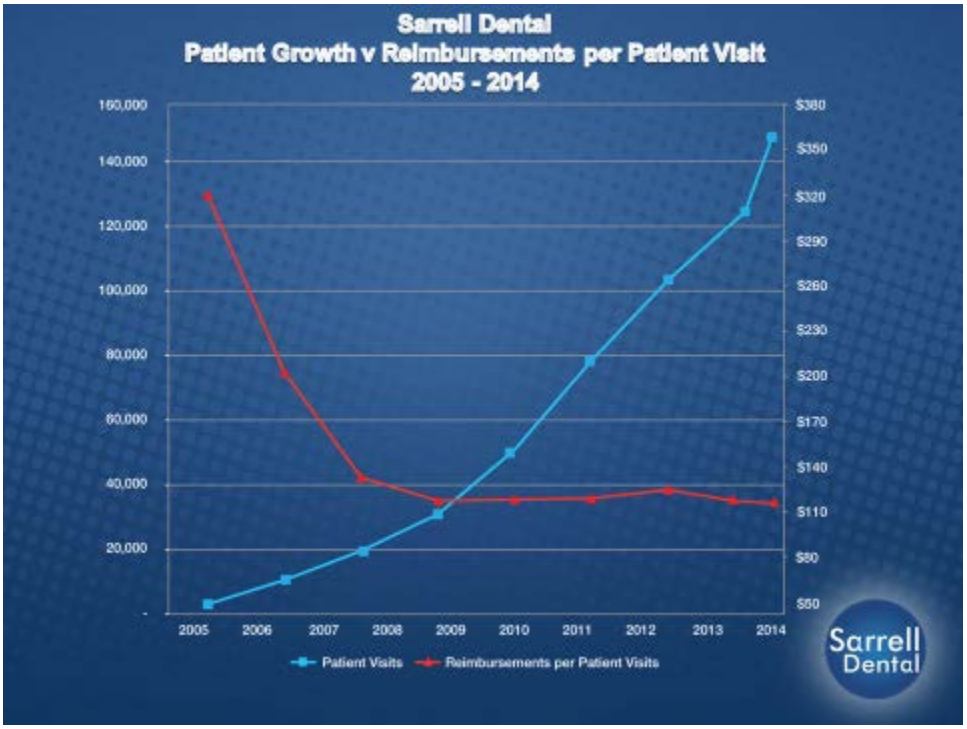
ALDA
Alabama Dental Association

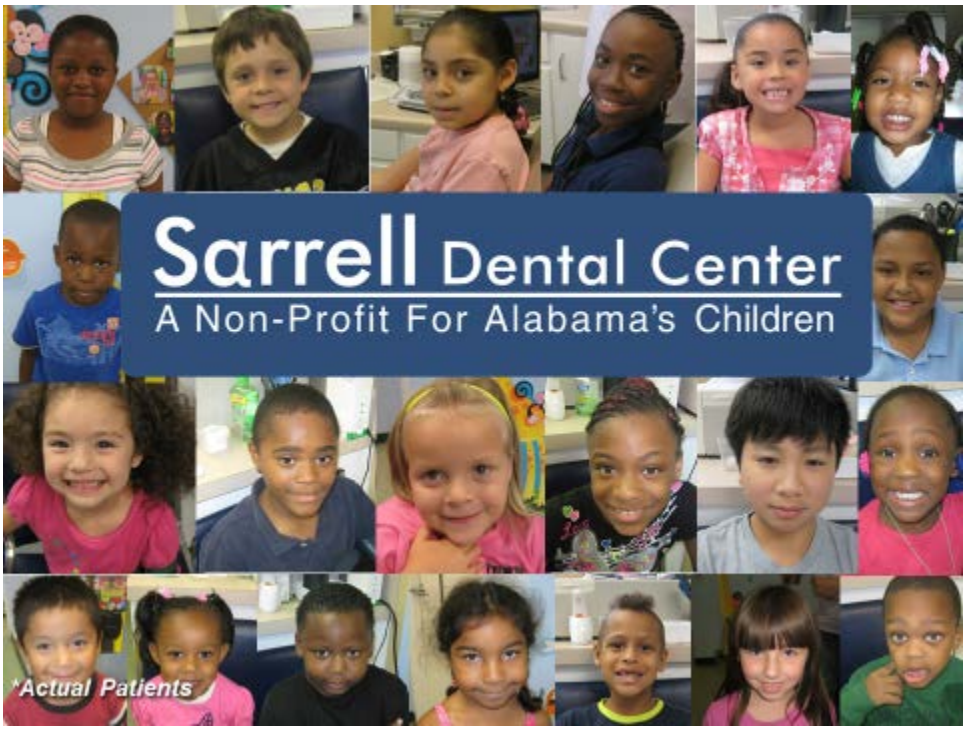
Sarrell Dental Center
A Non-Profit For Alabama's Children

UAB SCHOOL OF DENTISTRY
Knowledge that will change your world

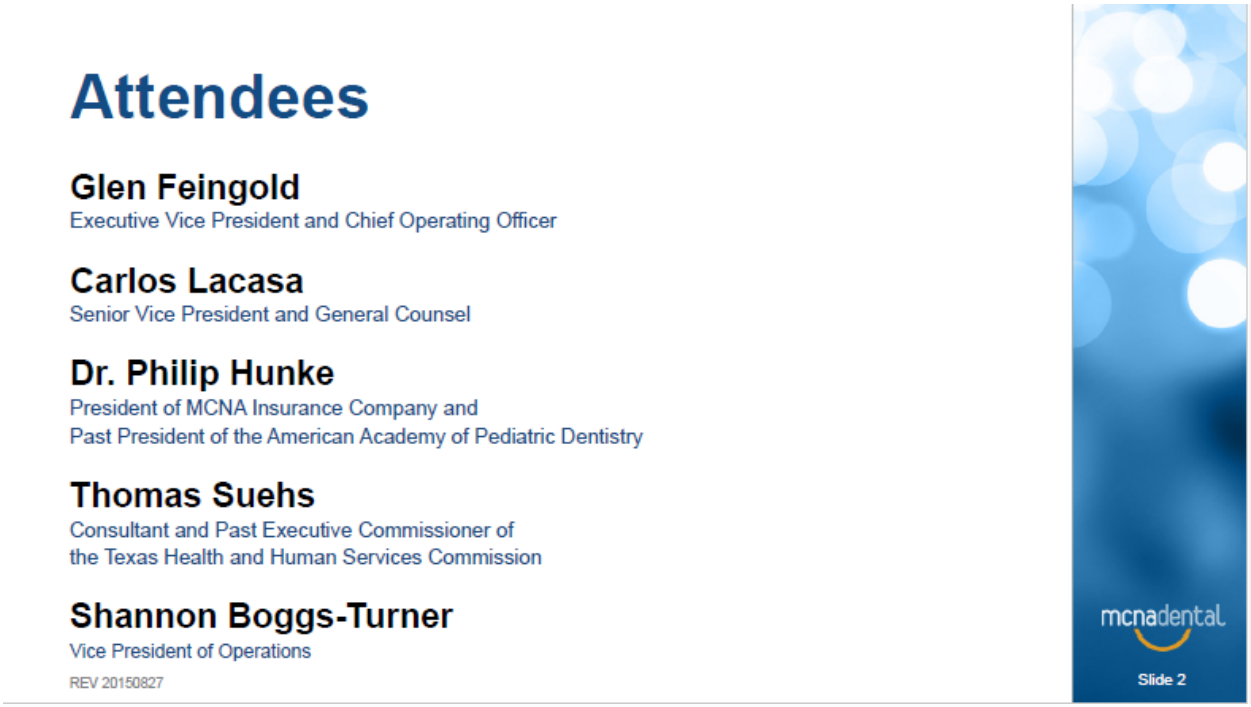
Appendix 5C - Presentation from Sarrell Dental:




Sarrell Dental
Patient Growth v Reimbursements per Patient Visit
2005 - 2014
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
$380
$350
$320
$290
$260
$230
$200
$170
$140
$110
$80
$50
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Patient Visits
Reimbursements per Patient Visits
Sarrell Dental


Sarrell Dental Center
A Non-Profit For Alabama's Children
*Actual Patients

Appendix 5D - Presentation from MCNA Managed Care:



Overview of MCNA

- For over 20 years, the MCNA organization has been a premier underwriter and administrator of dental benefits with a focus on providing exceptional service for **Medicaid**, **Children's Health Insurance Program** (CHIP), and **Medicare** members.
- MCNA serves over **3 million children and adults** nationwide, with operations in **Texas, Louisiana, Florida, Kentucky,** and **Indiana.**
  - MCNA is the sole dental benefit plan manager in Louisiana for Medicaid and CHIP.
  - MCNA administers dental benefits for half of the Medicaid and CHIP enrollees in Texas.
- Founded by Dr. Jeffrey P. Feingold, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology, we are a family-owned business headquartered in **Fort Lauderdale, Florida**, with regional offices in **San Antonio, Texas** and **Metairie, Louisiana**.

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Slide 3

Quality Assurance Focus

- In 2014, MCNA became the first dental plan in the nation to receive full **Dental Plan Accreditation** and **Claims Processing Accreditation** from **URAC**.
  - Our Chief Dental Officer, Dr. Ronald Ruth, currently serves on the URAC Advisory Board.
- We are certified by the **National Committee for Quality Assurance** (NCQA) in Credentialing and Recredentialing.
- MCNA is a member of the **Dental Quality Alliance (DQA)**, a national organization established by the **American Dental Association** to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

URAC ACCREDITED

urac ACCREDITED CLAIMS PROCESSING

NCQA CERTIFICATION

ADA American Dental Association

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Slide 4

Formula for Success

- The administration of dental benefits using managed care strategies has proven to be the most **effective** and **efficient** approach to providing **quality dental care**.
- The Medicaid population benefits most from the **active management** of their care. MCNA partners with providers to ensure that the financial resources invested by the state are available to pay for medically necessary covered services.
- MCNA uses **community outreach**, including health fairs, enrollment events, and technology resources to directly encourage the utilization of services and to provide oral health education to children and parents.
- Preventing fraud, waste, and abuse and reducing inefficiencies **leads to savings** that can be applied to **improving access to and utilization of dental services**.

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Slide 5

Approach for Alabama

- MCNA proposes a **hybrid model** for Alabama that combines the state budget advantage of capitated payments to a dental managed care organization with the provider friendly Fee-for-Service payment model.
- This hybrid model is a full risk, prepaid dental benefit program management (DBPM) model where the State places the dental benefit program manager "at-risk" for the provision of quality dental services and timely claims payment.
- Providers will be paid on a fee-for-service basis rather than capitation.

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Slide 6

The Dental Home Advantage

- The guidelines set by the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD) Dental Home Policy promote a **strong relationship between dentists and enrollees**.
- Dental Home providers assess the dental needs of our members, make prompt referrals for additional specialty care, and focus on ensuring preventive care is obtained.
- As past president of the AAPD, Dr. Philip Hunke provided leadership to the organization in the development of its national dental home guidelines.

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Slide 7

Access to Care

- Alabama must ensure that it has a **robust provider network** of General Dentists and Specialists skilled in delivering services to the Medicaid population.
- Dental managed care plans have **expertise** in developing provider networks capable of delivering specialized care and meeting stringent access standards in urban and rural areas.
- Our **strong relationships** within the provider community and **commitment to quality of care** for our members has made MCNA a national leader in dental benefits administration.

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Slide 8

Dedicated Customer Service

- MCNA has integrated call centers in both Florida and Texas, and all Member Service Representatives are cross-trained to handle multiple plans to minimize wait times for our members.
- Our robust training program emphasizes **First Call Resolution** and **Cultural Competency**; MCNA's **solutions-driven** Member Services Department is focused on the member's awareness of preventive services during all initial and follow-up phone calls.
- 75% of our Member Service Representatives are **multilingual** (English, and Spanish or Creole), and we offer translation services in **over 270 languages**.
- Recent Member Satisfaction Survey Results indicated that **99% of our Members** felt that MCNA's Member Services Department was **courteous** and **helpful**.

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Slide 9

Promoting Provider Satisfaction

- Promoting and assuring provider satisfaction is also essential to recruiting and retaining a strong network of participating providers. The dental program must:
  - Provide **state-of-the-art technology** to assist with credentialing, eligibility verification, claims submission, and prior authorizations.
  - Pay **fee-for-service rates** for each dental procedure.
  - Actively **assist providers** in reducing missed appointments and other patient related challenges.

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Slide 10

Targeted Member Outreach

- MCNA utilizes a variety of **education and outreach methods** to increase appropriate utilization, including:
  - An informative and interactive website
  - Social media platforms
  - Targeted outbound telephonic and text message campaigns
  - Appointment reminder postcards
  - Member handbooks
  - Oral health educational materials
  - Health fairs and community events
- Education and outreach approaches are **optimized for accessibility** for the vision or hearing impaired through the use of large-print, audio, Braille, and translation into other languages.

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Increasing Operational Efficiency

- Dental managed care **enhances operational efficiency** by providing:
  - A utilization management program overseen by general dentists and specialists.
  - Nationally accepted clinical guidelines.
  - A proactive quality improvement program to educate members and providers and to maintain benchmarks for clinical outcomes and operational efficiency.
  - Continuous provider support and ongoing education through an array of communications tools, phone hotlines, and dedicated representatives.

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Cutting-Edge Technology

- Additionally, dental managed care plans can provide **technology** to assist with daily administration.
- Dental managed care plans provide **web-based** member and provider portals. This allows providers to:
  - Submit claims, prior authorizations, and referrals.
  - Verify eligibility, view patient rosters, and view dental histories.
  - Download documentation and resources.
- This technology also benefits the state by **enabling ease of oversight** and **enhanced accountability** and **transparency** through detailed reporting.

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Slide 13

Conclusion

- MCNA recommends a **hybrid model** for Alabama which incorporates Dental Managed Care best practices and is a proven solution for states seeking to improve oral health outcomes.
- We appreciate this opportunity to provide input into your process as you evaluate potential options to enhance your Medicaid dental delivery system.

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Slide 14

Appendix 5E - Presentation from DentaQuest:

DentaQuest

Partnering with States to Achieve Excellence

DentaQuest

Experience you can count on.

About DentaQuest

DentaQuest

Our mission is to improve the oral health of all.

DentaQuest

Experience you can count on.

Dental Benefits Administration

20.7 million members

Dental Managed Care Health Plan

Manage **9** of the **13** state carve-outs in existence today

- Maryland
- Idaho
- Massachusetts
- Texas
- Virginia
- Colorado
- Illinois
- Tennessee
- South Carolina

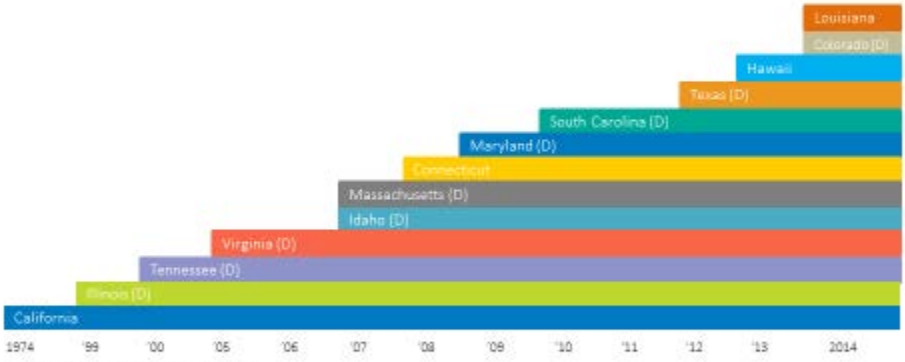
- 100 health plan partnerships in 28 states
- Medicaid/CHIP
- Medicare Advantage
- Exchange
- Commercial

DentaQuest

Experience you can count on.

3

Growth of the Dental Managed Care Model



(D) = signifies DentaQuest partnership

DentaQuest

Experience you can count on.

4

The Benefit of Dental Administration for Providers

Tools and Resources to Streamline Participation

- In-state Provider Relations Representative to help with day-to-day issues
- Dental Advisory Committee to ensure your voices are heard
- Consistent and Transparent Clinical Criteria used to determine medical necessity
- Broken Appointment Program to reduce the number of member no call/no shows

Advanced Technology to Save Time and Money

- Free Web Portal to manage entire Medicaid patient base from central location
  - Eligibility verification
  - Prior auth and claim submission
  - Attach X-rays and documents
  - Claim and auth status inquiry
  - Track payments
  - Access remit advices
  - Control what information you staff can access
- Online Enrollment and Credentialing to expedite initial and recredentialing process

DentaQuest

Experience you can count on.

6

The Benefit of Dental Administration for Members

Ensuring they can Access Care

- Appointment scheduling assistance and reminder calls
- Offering a network of dentist's close to home
- Providing culturally sensitive care

Providing Education

- Importance of preventive dental care
- Keeping appointments
- Importance of a dental home

DentaQuest

Experience you can count on.

6

The Benefit of Dental Administration for States

- Overcoming severe access to care issues, perception problems and cure mandates
- Staying within a predictable budget without compromising quality of care and member utilization

Fiscal responsibility | Without compromising access to care | Better patient outcomes

DentaQuest

Experience you can count on.

7

Real Results: State of Tennessee

In just one year, DentaQuest reduced program costs by over $26M.

$26,000,000

1/857

One dentist for every 857 patients. Exceeds Centers for Medicare & Medicaid Services recommendation of one dentist for every 1,500 patients.

On average, members are located 3.4 miles from the closest DentaQuest dentist, 4.5 miles to the second closest provider and 5.6 miles to the third closest provider.

75 screenings and oral health education events held across the state; **25 of these events held in rural areas** per contract.

90%

trending dental screening percentage (dsp), surpassing the state's requirement of 80 percent

DentaQuest

Experience you can count on.

8


Questions?
Contact Information:
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629-999-5009
todd.cruse@dentaquest.com
DentaQuest
Experience you can count on.

Appendix 6 – List of Sources Cited in the Report

www.Medicaid.gov

American Dental Association's Health Policy Institute's research brief "Early Insights in Dental Care Services in Accountable Care Organizations", April 2015

American Dental Association's Health Policy Institute's research brief "Dental Care in Accountable Care Organizations: Insights from 5 Case Studies"

Centers for Medicare and Medicaid Services' "Use of Dental Services in Medicaid and CHIP", January 2015

Alabama Department of Public Health Data Brief, February 2013

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Kaiser Family Foundation – www.kff.org

www.cms.gov

Kid's Oral Health Group