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Dear Director E'lia:

Thank you for your invitation to offer testimony at the November 19, 2015 meeting of the Little Hoover Commission, it's always a pleasure to speak about innovative approaches to serving the Medicaid population. I had the pleasure of serving the Texas Medicaid program for over 20 years having last served as the Deputy Executive Health and Human Services Commissioner and Texas Medicaid Director. During that 20-year period the Texas Medicaid program evolved from a largely unaccountable fee-for-service program to a managed care program that is accountable and focused on results. Let me explain the design of Texas Medicaid dental benefits, the Frew Consent Decree, growth in Texas Medicaid expenditures, impetus for dental managed care, program design and results.

Texas Dental Benefits
Texas does not provide an adult dental benefit. Dental services are available only to children between the ages of 2 – 20.

Frew Consent Decree
The Frew Lawsuit was filed in 1993 on behalf of the children ages birth through 20 enrolled in Medicaid and eligible for EPSDT benefits. The class action lawsuit alleged the Texas EPSDT program did not meet the requirements of the Federal Medicaid Act. The parties resolved the litigation by entering into a consent decree, which the court approved in 1996. In 2007, the court approved 11 corrective action orders to address the state's alleged violation of the 1996 Frew Consent Decree. In 2007, in anticipation of the Court's approval of the corrective action plan, the 80th Legislature appropriated an estimated $1.8 billion AF, including $706.7 million GR for FY08-09. This included funds to increase dental reimbursement rates. The Corrective Action Order, "Adequate Supply of Health Care Providers," required an increase in reimbursement for dental providers and required funds to also be applied to strategic initiatives to improve access to dental services.

Growth in Texas Medicaid Dental Expenditures
Following the 2007 rate increase Medicaid dental costs grew more than 250% in only five years and orthodontia costs nearly doubled during that same time period. A fiscal agent that had no financial incentive to manage utilization, quality, access or member or provider satisfaction managed the program. The fiscal agent was paid simply for volume and not the quality or accuracy of service authorizations. The result was less scrutinized authorizations and that consequently led to overutilization of services. Under FFS, orthodontia spending alone grew from $102 million in FY 2008 to $185 million in FY 2010. The table below outlines Texas Medicaid Dental spending SFY 2007 – 2011.

Impetus for Dental Managed Care
After several years of explosive cost growth in the Medicaid dental program, the 2011 Legislature directed the Health and Human Services Commission (HHSC) to transition Medicaid dental benefits from the traditional fee-for-service (FFS) model to the dental managed care model to better manage costs and increase access and quality of care.

Program Design
Texas undertook significant efforts to design an optimal dental managed care program. Those efforts included:

- Assessing best practices for dental managed care
- Engaging the dental community in the development of Request for Proposals
- Developing fundamental guiding principals
    - Prohibitions on reimbursing less than the FFS rate (no prohibitions on reimbursing more)
    - Requirement to develop the "main dental home"
    - Inclusion of significant traditional providers
    - Quality metrics
    - Percent premium at risk—up to 4%
    - No managed care "carve-in" model
- Selection of multiple rather than a single DMO
    - Foster competition and choice for dental providers and members

Engagement with the Dental Community
Texas Medicaid maintained a high level of engagement with the dental community through professional associations and meetings with leaders within the dental community. Included ideas from the dental community in the RFP. Of great importance was developing an exclusive Dental Managed Care Organization (DMO) model rather than just carving dental into existing Managed Care Organization (MCO) contracts.

Dental Managed Care Organizations (DMOs)
DMOs must provide the same covered dental services to members as FFS. The only difference in benefit coverage of dental services by a DMO is the value DMOs add at no additional cost to the state. DMOs invest in value-added benefits that engage Medicaid consumers to make better decisions, increase the use of preventive care, reduce the need for invasive, high-cost services, and improve outcomes. DMOs are responsible for program oversight including determining necessity and appropriate utilization and authorizing services.

Program Results
Initially three DMOs were selected:

- Delta Dental*
- MCNA
- DentaQuest

After six months of operation Delta elected to withdraw from the program.

Savings
Within the first six months of managed care implementation, dental managed care organizations (DMOs) and HHSC began to address program concerns of overutilization, including reducing orthodontia utilization by a dramatic 72%. Overall, dental managed care has reduced Medicaid dental costs by nearly 30% compared to projected spending under the traditional FFS model. State spending on Medicaid dental services decreased by nearly $260 million during the first full two years of dental managed care implementation. Since 2012, the use of managed care for Medicaid dental services has successfully improved access to timely, preventive care for children in Texas while driving down dental costs. Since implementation in 2012, DMOs have produced substantial program savings in Medicaid compared to what the traditional FFS program would have spent. Between 2012 and 2015, actuaries estimate that dental managed care reduced Medicaid All Funds costs by nearly 30% or $1.5 billion compared to the traditional FFS program. Texas DMOs are expected to save another $1.5 billion in All Funds through 2018.

Increased Use of Preventative Services
There was an immediate shift toward prevention versus invasive and expensive dental treatment. Prior to dental managed care implementation, approximately 65% of services were associated with diagnostic and preventive services. After the implementation of dental managed care, this number increased to 73%—an 8% increase.

Main Dental Home and Dental Advocates
With the 2012 rollout of dental managed care, Texas became one of the first states to implement a main dental home requirement in its Medicaid program, which ensures continuity of care. Provider types that can serve as main dentists include federally qualified health centers (FQHCs) and individuals who are general or pediatric dentists. Members who receive their dental services through managed care are required to select a dental plan and a main dentist. The main dentist serves as the member's dental home and is responsible for:

- Providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care
- Maintaining the continuity of patient care
- Initiating referrals for specialty care

Each DMO is also required to have regionally-based member advocates. These advocates are responsible for outreach and education to members in areas such as member rights and responsibilities, complaints and appeals processes, accessing covered services, and oral health education. Many member advocates are also certified community health workers (promotoras). DMOs also partner with school districts and community organizations to promote the importance of oral health through outreach and oral health education activities.

Network Adequacy
Under dental managed care, DMOs are contractually required by the state to maintain an adequate network of dental providers. The dental managed care plans maintain networks of providers to serve Medicaid-eligible children. Texas continues to exceed the national average and that of other large states on outcomes such as the number of children receiving dental services and preventive dental services.

Member Satisfaction
Families report having good access to dental care from DMOs. More than 80% of Medicaid families reported having access to a dental appointment as soon as they wanted (Medicaid and CHIP Dental

Caregiver Survey conducted in 2013-EQRO). On a scale from 1 to 10, 82% of families gave their DMO a 9 or 10 for access to care and overall satisfaction.

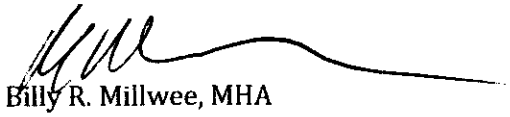
DMO Innovations

DMOs can approach service delivery in a more creative way than can services provided in FFS or under the Medicaid state plan.

- Target recruitment efforts
- Differential reimbursement rates
- Cater services to a community or region
- Develop innovative programs
- Preventistry
    - Program to ensure that a larger number of high-risk children receive preventive fluoride treatments and sealants and timely oral evaluations.
- Stellar Treatment and Recognition Reward (STARR) program
    - Pay-for-quality initiative program that focuses on improving the oral health of plan members by measuring key quality indicators: timeliness of getting members in office for an initial visit, recall visit adherence, sealant application, prophylaxis periodicity, participation in the First Dental Home initiative program, and fluoride application.

Conclusion

The Texas experience with dental managed care has been exceptional. The savings were near immediate, there has been no negative impact to access, services have been redirected to better focus on prevention and member and provider satisfaction have been good and the programmatic and financial integrity of the program have been dramatically improved.



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