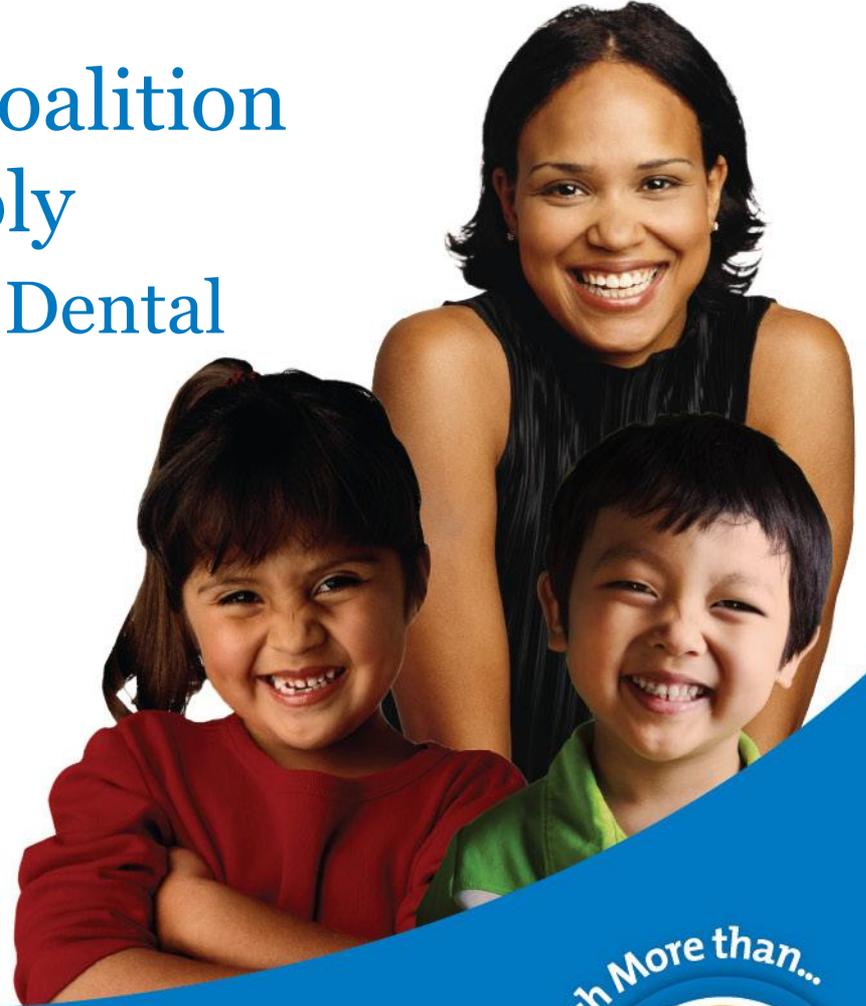


# Oral Health Florida Coalition General Assembly “The Future of Florida Dental Managed Care” January 23, 2013

DentaQuest

*Proven Experts in Dental  
Program Administration*



So Much More than...



## Agenda Items:

- History of Dental Managed Care in Florida
- Why Florida and Other States Moved Toward Managed Care
- Models of Dental Care Financing
- Future of Dental Care Financing in Florida

## Presenters:





# History of Managed Care in Florida

# Why are there Disparities?

- Disadvantaged groups lack access to care
  - Community Water Fluoridation and other Preventive Services
  - Education
  - Food and nutrition
  - **Income** - direct link between income and access to care.
  - **Insurance coverage** - The higher (or lower) a person's income, the more likely they were to have dental coverage.
    - Higher income – jobs or purchase insurance
    - Low income– government entitlement plans – Medicaid and CHIP primarily children
  - **Workforce Issues**
- Compounded by the views that:
  - “Dental diseases are not serious”
  - “Dental diseases are inevitable”
  - “Oral health is not important”



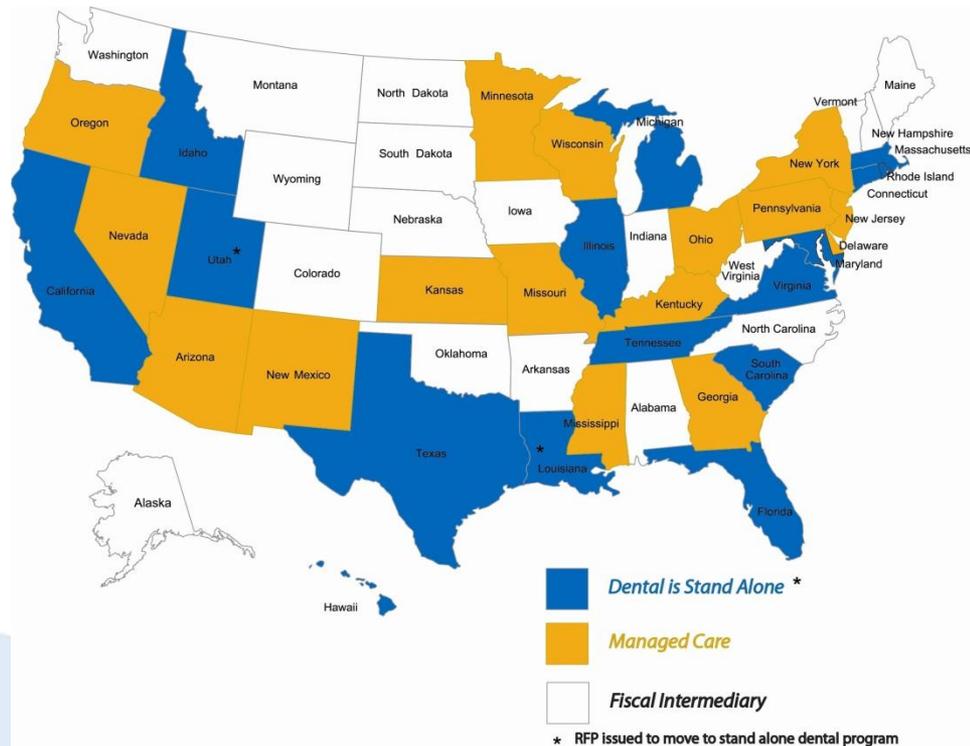
# National Health and Dental Insurance Data

- According to DHHS uninsured and inconsistently insured people are less likely to receive needed health care. Health insurance coverage helps patients get into the health care system and get the care they need. Children who have health insurance generally experience better overall health throughout their childhood and into their teens. They are less likely to get sick and more likely to get preventive care to keep them well and get the treatment they need when they are sick or injured.
- Approximately 1/3 of Americans are without dental insurance
- Historically more than twice as many Americans lack dental insurance than medical insurance (~108 million to 44 million)
- Perversely, those persons with insurance coverage that have the better scope of care have the least treatment needs and those persons with the greatest needs have no insurance coverage or coverage with the worst scope of care
  - When people are able to access oral health care, they are more likely to receive basic preventive services and education on how to attain and maintain good oral health. They are also more likely to have oral diseases detected in the earlier stages.
  - In contrast, lack of access to oral health care can result in delayed diagnosis, untreated oral diseases and conditions, compromised health status, and, occasionally, even death.

# Managed Care Models for Dental

- Dental independent of Health
  - Independent fiscal agent
  - Stand alone
  - Carved-out
  - **Dental Managed Care**
  - Florida –Prepaid Dental Health Plan, Miami Dade Pilot Program, FHK
- Dental included in Health
  - Global Services
  - Carved-in
  - Value added service
  - Florida – Reform Counties and some exempt classes

# National Trend toward Managed Care



# History of Dental Managed Care in Florida

- 2002: Florida Healthy Kids Corporation (FHKC) awarded Atlantic Dental Inc. (ADI), now DentaQuest, CompBenefits, Delta Dental, and United the statewide FHK dental contract (CHIP).
  - IN 2005-06, Delta Dental pulled out due to the annual max of \$800
  - CompBenefits and United Healthcare pulled out of FHK effective 06/01/10 when the CHIP program eliminated the annual max of \$1,000.
  - In 2004 FHKC awarded a contract to Managed Care of North America (MCNA).
- 2004: AHCA awarded the first Medicaid PDHP contract to ADI, now DentaQuest, to provide Medicaid covered dental services to recipients in Miami-Dade County (State Medicaid pilot program).
  - AHCA awarded a second contract to MCNA Dental Plans in 2009 to provide dental services in Miami-Dade County.
- 2011: AHCA awarded DentaQuest and MCNA the Statewide Prepaid Dental Health Plan contract to provide dental benefits administration for Medicaid children in non-reform counties
- 2013, FHK awarded DentaQuest, MCNA, and Argus the new dental contract.
- Presently, various dental benefits administrators contract with various Managed Care Organizations (MCOs) in Reform and Non-Reform counties to provide dental benefits administration to Medicaid children and adults in those MCO plans

# Florida Medicaid System

## ■ Children

- Miami Dade Pilot Program (contracts expire February 28, 2015, but have renewal periods of up to 3 years) – **Managed care – dental independent of health plans**
  - DQ
  - MCNA
- Statewide PDHP – non-reform counties; SSI and TANF (contracts expire September 30, 2013, but have renewal periods of up to 3 years) - **Managed care – dental independent of health plans**
  - DQ
  - MCNA
  - AHCA FFS – member opt out option only
- Reform counties (Broward, Duval, Baker, Nassau, and Clay) - **Managed care – dental included in health**
  - Health plans – subcontract dental to dental benefits administrators
- Exempt classes – **Mix of managed care and FFS**
  - Health plans – subcontract dental to dental benefits administrators
  - AHCA FFS

## ■ Adults

- Reform
  - Health plans – subcontract dental to dental benefits administrators
  - AHCA FFS

# Florida

- Approximately 3.6 million lives eligible for Government insurance (Medicaid and CHIP)
  - 3.34 million Medicaid (~9% increase from 2011)
  - 250,000 CHIP
- Approximately 2 million lives covered under dental managed care
  - Miami Dade – 280,000
  - Statewide PDHP – 1,200,000
  - FHKC – 230,000
  - Health plans – 300,000
- 2014 Health Care Reform will add approximately 1.5 million more lives to these systems

# Children's Medicaid vs. FHK

- Medicaid
  - Numerous health plans including PDHP
  - Medicaid – 100% and below Federal Poverty Level (FPL)
  - Dental benefit administered under various models
  - Members do not pay a monthly premium
- FL Healthy Kids (FHK)
  - CHIP program administered by FHKC
  - FHK - 100 – 200% FPL
  - Dental benefit administered separately from medical component and all other services by two dental benefit managers
  - Members are responsible for monthly premiums (\$15-20)



# Why Managed Care in Florida

# Florida Medicaid Facts

- Nine out of the past 10 years, Florida Medicaid expenditures amounted to more than 20% of the State's entire budget
- In 2009-10 Medicaid expenditures in Florida were 15.59 billion dollars which amounted to 23.4% of the Florida state budget
- Created a \$3.7 billion budget shortfall in 2010
- Annual Increase in Florida Dental Medicaid Expenditures are ~20% per year
- Increase from approximately 2.3 million Medicaid beneficiaries in 2010 to over 3.3 million in 2012
- The state loses millions to waste, fraud and abuse (primarily medical)
- Dental expenditures account for 4.2% of total health expenditures in the United States. This share has been declining steadily since 2001
  - Private Insurance: dental accounts for 9.0% of health expenditures
  - Medicaid: dental accounts for 2.1% of health expenditures
  - FL dental expenditures historically have been less than 1% of Medicaid expenditures

# The Public Insurance Environment

- States are under pressure to cut costs due to budget short falls
  - Increasing number of eligibles
  - Increasing utilization
  - Increasing costs (administrative - staffing, etc.)
  - Increase in reimbursement rates
- Health Care Reform threatens to strain an already stressed health care system by adding more patients
- States are looking for:
  - Increase utilization, but
  - Cost-containment and
  - Increase quality - innovation to improve member's oral health

# Four Pillars of Managed Care

- Reduces and produces predictable costs
- Vendor carries financial risk not the state
- Lives/Enrollees are being managed
- Program is Improving Outcomes

# Why Transition to Managed Care?

- Creates predictable costs for state agencies at reduced rates compared to a fee-for-service program
- Dental Benefits Administrators accept risk compared to the State (Risk vs. ASO arrangement)
- Reduction in administrative burden to the State
- Reduction of duplication and waste through coordination of care
- Reduction in over-utilization/inappropriate care
- Improve access to care and member oral health education



# Models of Dental Benefits Administration

# Three Common Dental Administration Models

- **Fee for Service:** Under this model, dental benefits are administered directly by a state Medicaid agency. The agency is responsible for all areas of program management
- **Global Services Managed Care:** In a standard managed care model, all benefits such as medical, vision, pharmacy, behavioral health, and dental are administered by a health plan, also known as MCOs or HMOs. Health plans typically subcontract ancillary benefits with vendors to administer programs
- **Independent Dental Managed Care:** Historically, an independent dental managed care (dental carve-out) model delivers a single benefit by a Dental Benefits Administrator (DBA) outside of MMIS or managed care vendors
  - Independent dental managed care (dental carve-out) is a form of managed care – Florida currently has this model in place with the Statewide PDHP and Miami Dade Pilot program
  - For state dental programs, this model separates dental treatment from other Medicaid services by dedicating funds for oral health care
  - The DBA, sometimes referred to as a third party administrator, assumes full administration of the dental program including provider network management, member and provider services, claims processing and utilization management
- Florida operates within a combination of all the above models depending on the population and areas throughout the state

# Contract Arrangements Between State (or Health Plans/MCOs) and DBAs

- **Risk:** Under a risk arrangement, the DBA is paid a fixed per member per month rate to cover both administrative and claim costs
- **Administrative Services Only:** Under an ASO arrangement, the DBA is paid a fixed per member per month rate to cover administrative costs. The client assumes financial responsibility for the cost of claims
- Both arrangements offer profitability for the DBA, while protecting the integrity of the program and ensuring recipients receive access to high quality care. Some clients are mandating medical loss ratios, which in turn places a cap on the DBA's profit margins
- DentaQuest and MCNA hold a risk contract with AHCA and are held to the mandated loss ratio threshold of 85% or higher

# Provider Reimbursement Models

- **Capitation**
  - Providers paid a set amount per member per month for the enrollees in which they are assigned regardless of services provided
  - Very few DentaQuest participating dentists receive a capitated payment; and those that do are mainly located in the Miami-Dade area
- **Fee For Service (FFS)**
  - Providers paid according to a contracted fee schedule for individual covered dental codes
  - Majority of DentaQuest participating dentists are contracted at 100% of Medicaid fee schedule approved and supported by AHCA
  - DentaQuest attempting to transition to one fee schedule for all providers statewide so reimbursement is consistent for the PDHP as well as the individual health plan programs
- **Encounter Rates**
  - Providers paid for each encounter/claim submitted
  - Applies mainly to FQHCs and County Health Departments

# Building a Successful Dental Program

- Assess oral health status of state
  - Are there issues with the delivery of oral health in the state; what are provider and member participation rates; are there existing mandates, etc.?
- Develop dental policy via a collaborative forum
  - Establish well-recognized leadership to address oral health problems. This is often achieved by creating a team within the health agency such as a dental advisory committee
  - Identify key stakeholders who support oral health. Examples would include dental associations, community advocates, and members of health departments and other agencies
  - Cultivate partnerships between policy makers, community groups, and the public to create solutions to oral health problems. Dental advisory committee meetings serve as a forum to discuss these issues
- Dental Associations and Societies Involvement
- Solicit input from dentists
  - One of the most common barriers to care is low provider participation. The three top reasons given are: low reimbursement, administrative “red tape,” and broken appointments. Involving dentists in the conversation from the start will help the state gain valuable insight into areas of dissatisfaction and ways to improve the system
  - Incorporate effective dental advisory and peer review committees
- Collaborate with DBA on implementation and other initiatives
- Publish results on the effectiveness of the dental program
  - Providing regular communications to keep stakeholders informed on the status of the program helps mitigate issues that may arise immediately after the go-live date

# Benefits of an Independent Dental Managed Care Model

- Streamlined administration
- Advanced technology
- Provider outreach, education and partnerships
- Reduce waste and unnecessary health care costs
- Emphasis on prevention and routine check ups
- Advanced disease management
  - Identify people at risk and intervene with ways to help them
  - Measure the impact of such efforts
- Increase quality of care and outreach for members
  - High quality networks of providers
  - Follow established standards and indices of performance – uniform clinical guidelines for all patients
  - Case management
  - Education and oral health initiatives

# Evidence to Support Expansion of an Independent Dental Managed Care Model

## ■ Miami-Dade Pilot Program - HEDIS scores

Measure	HEDIS Measure							Trend	National Mean**
	2005	2006	2007	2008	2009	2010	2011		
<b>Annual Dental Visit</b>									45.7%
Non-Reform Health Plans	n/a	n/a	n/a	n/a	n/a	***	16.1%		
Reform Health Plans	n/a	n/a	n/a	15.2%	28.5%	33.4%	34.0%	+	
DentaQuest Miami-Dade Pilot Program	20.0%	25.7%	30.0%	31.5%	32.9%	37.7%	39.1%		

## ■ Other states such as Maryland

- HEDIS scores increased to 63.9% from 19.9% in 1997 prior to managed care; and
- From 45.7% to 63.9% from 2010-2012 when Maryland went to a carve-out



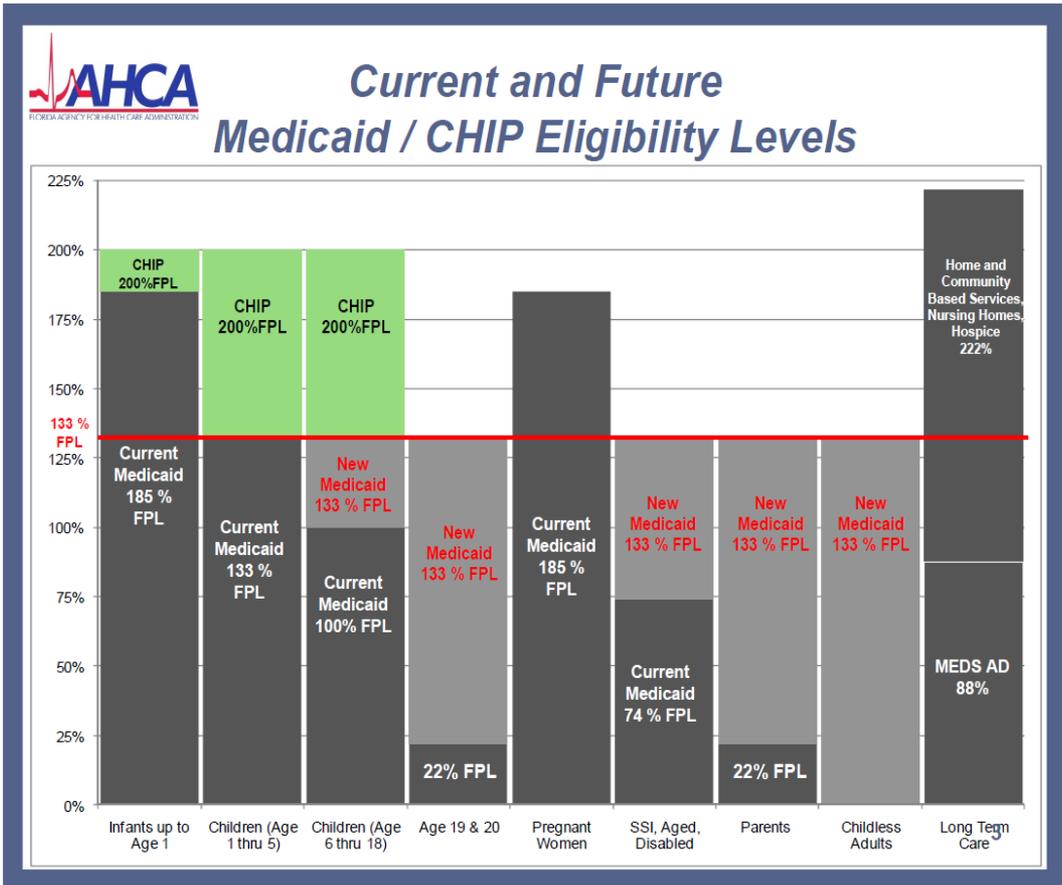
# The Future of Florida Dental Care

# National Health Care Reform Laws - CHIPRA

- States are required to provide dental coverage that is “necessary to prevent disease and promote oral health, restore oral structure to health and function and treat emergency conditions”
- States are required to provide the federal legislation’s full dental benefit to a child, even if the cost to the states exceeds \$1,000 in a year, with limited cost sharing by the parent – no cost sharing for preventive services
- State efforts to expand eligibility and outreach while simplifying administration will gain more federal funding

# National Health Care Reform Laws - ACA

- Requires nearly all Americans to obtain health insurance. This is referred to as the **individual mandate**.
  - **Must include pediatric (<19) dental benefits**
  - Probably will be based on pediatric dental benefits offered by the state's CHIP program or offered by the Federal Employees Dental and Vision Insurance Program (FEDVIP)
- Eligibility and Coverage:
  - **At or below 133% of the FPL**, public coverage – Medicaid (states can choose to expand coverage – fed pays cost initially)
  - **133% to 200% FPL**, public coverage – CHIP – Florida Healthy Kids program
  - **200% to 400%**, hybrid model:
    - government tax credits (sliding scale) to help pay for the cost of coverage if purchased from an exchange
    - Benefits (rates?) based upon CHIP or FEDVIP
  - **Above 400% FPL or employee sponsored or individual purchased**, commercial style model
- Open enrollment on exchanges beginning October 1, 2013



### Florida Healthy Kids Corporation Enrollment Projections Showing Impacts of Medicaid Expansion and Coverage Mandate

CHIP					Healthy Kids			
Month	CHIP SSEC Original	CHIP Medicaid Expansion	CHIP Mandate Only	CHIP Medicaid Expansion and Mandate	HK SSEC Original	HK Medicaid Expansion	HK Mandate Only	HK Medicaid Expansion and Mandate
Jul-13	259,832	0	0	259,832	209,005	0	0	209,005
Jan-14	263,072	(70,971)	15,960	208,061	211,921	(61,669)	12,848	163,100
Jul-14	266,480	(71,881)	51,965	246,564	214,994	(62,525)	41,832	194,301
Jan-15	270,725	(73,032)	51,965	249,658	218,852	(63,618)	41,832	197,066
Jul-15	275,152	(74,198)	75,905	276,859	222,882	(64,727)	61,104	219,258
Jan-16	280,494	(75,641)	75,905	280,758	227,772	(66,106)	61,104	222,770
Jul-16	285,789	(77,014)	79,895	288,670	232,619	(67,418)	64,315	229,516
Jan-17	290,849	(78,375)	79,895	292,369	237,251	(68,719)	64,315	232,848
Jul-17	295,942	(79,709)	79,895	296,128	241,915	(69,984)	64,315	236,247
Jan-18	301,264	(81,247)	79,895	299,911	246,793	(71,395)	64,315	239,714
Jul-18	306,688	(82,816)	79,895	303,767	251,771	(72,835)	64,315	243,251
Jan-19	312,216	(84,416)	79,895	307,695	256,848	(74,304)	64,315	246,860

# Florida's Managed Care Environment in 2014

- 2011 Legislation to overhaul Medicaid will move Florida's poor and elderly Medicaid beneficiaries into HMOs and other managed care plans for health insurance
- The plan will carve the state into 11 regions in which health plans would compete for contracts in each area
- Health plans will no longer operate in a limited number of counties, but participate in Medicaid statewide, thus eliminating the majority of the Fee For Service program
- The reformed Medicaid program may include features such as premiums and co-payments
- Awaiting approval from federal government
- Intent to Negotiate (ITN) was released in January, 2013 in which HMOs and other managed care plans will respond
- To date dental will be included in the Health Plan/HMO ITN for both adults and children

# Dental included in Global Services Managed Care Health Plan Expansion vs. Independent Dental Managed Care Model\*

- Global Services Managed Care
  - All dental fall under the HMO/health plans' oversight
  - HMOs can administer dental independently or most likely will subcontract to DBAs
  - Providers would have to contract with every HMO and/or subcontracted dental benefits manager in their area (Could be upwards of 25 HMOs and health plans that could participate in State)
- Independent Dental Managed Care
  - Dental administration will remain separate from the health plans
  - Dental administered by companies which are experienced dental benefits administrators
  - Providers only need to contract with Dental Benefits Manager (2 currently participate in Medicaid and FHK)

**\*DBAs will have business under either model**



It is up to  
you to  
help  
determine  
Florida's  
future  
path.