Testimony of Joe Ruiz, Vice President
State Government Programs for Delta Dental of California
Before the
Little Hoover Commission
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Good Morning, Chairman and Honorable Members of the Commission:

I am Joe Ruiz, Vice President of State Government Programs for Delta Dental of California. I would like to thank the Commission for the opportunity to meet with you. Today, I plan to discuss how collaborative work efforts with the Department of Health Care Services and the Legislature can continue to drive improvements and efficiencies in the Denti-Cal Program.

The Commission provided two primary objectives for today's meeting:

- Identify structural, financial and procedural obstacles that have constrained dental provider participation and minimized access to quality care for millions of Californians eligible to receive publicly-financed dental care.

AND

- Develop recommendations for the Legislature and Governor to make the Denti-Cal program more attractive to California dentists, raise their participation rates and improve the availability and ease of obtaining dental services for a significant portion of California's population.

The Commission also provided detailed areas of interest related to these primary objectives. I will share my responses with you and look forward to addressing any additional questions you have.

Delta Dental is the Denti-Cal fiscal intermediary for DHCS. In this role, we are responsible for variety of the Denti-Cal program's operations.

The Denti-Cal program serves over 12.3 million beneficiaries. In 2014, Delta Dental paid over 7.5 million claims for the state, totaling $750 million.

From May of 2005 through the end of 2014, Delta has distributed in excess of $6.3 billion dollars to providers for their services. The vast majority, or 95%, of the financial resources invested by the State are passed on to providers for providing care. Delta's profit margin

over this period has averaged approximately 1.5 percent. Such low margin, unacceptable to most for-profit carriers, aligns with Delta Dental of California's nonprofit mission to extend quality value-based dental benefits to as many Californians as possible.

Delta Dental has successfully partnered with the state for over forty years. Our role as fiscal intermediary, includes, but is not limited to:

- Customer Service. Delta Dental is responsible for both provider and beneficiary customer service; addressing inquiries from both constituencies regarding provider enrollment, appointment scheduling, dental benefit questions, referrals, etc.;
- Claims processing and payment;
- Provider and beneficiary outreach;
- Providing prior authorization for dental services;
- Utilization management and Surveillance and Utilization Reviews;
- Quality management;
- Information technology, systems maintenance and operations. Delta Dental maintains the State's California Dental Medicaid Management Information System, known as CDMMIS;
- Claims payment and check issuance to providers on behalf of the state.

The list of responsibilities continually evolves. Working closely with DHCS, we help to identify program enhancements that will further the state's efforts, such as enhancing access to care, particularly in rural areas.

An example of these efforts are the use of mobile clinics and portable technology. In 2014, Delta, on behalf of the state, reimbursed mobile providers over $ 5 million. In 2015, we are working with DHCS to deploy mobile vans beyond the current scope of their use, focusing efforts on counties specifically targeted to improve overall access rates.

Delta employs approximately 350 employees who are dedicated full-time to administering the Denti-Cal program. Approximately 200 are union members who provide the majority of direct customer service. In 2014, Delta handled over 2.5 million phone calls from beneficiaries and others for the Denti-Cal program.

Another role is serving providers while protecting state interests. As a fee-for-service program, prior authorization is required for many treatments, including: crowns, root canals, deep cleanings, dentures, implants, orthodontics and certain oral surgery procedures. Working with the state, we have been able to propose easing some prior

authorization requirements for providers, while maintaining program integrity. Later in my testimony, I will discuss ways to maintain program integrity without increasing front-end administrative burdens.

Delta views its relationship with the state as a partnership rather than a vendor/client relationship. We collaboratively identify and address opportunities to improve the program. Given the complexity and scale of the program, this partnering approach is invaluable. We have appreciated the recent addition of Director Jennifer Kent and Alani Jackson, Division Chief to the Medi-Cal Dental Services Division, both of whom work well in a partnering and collaborative environment, as well as the continued efforts of Mari Cantwell and Renee Mollow.

Recently, Delta and the state have revisited a number of process improvement recommendations. The Commission specifically inquired about provider enrollment and re-certification processes as well as the administrative process around restorative services. I will address these issues in the following section and share some examples of the collaborative approach that Delta and the state follow.

Provider Enrollment/Recertification

Significant opportunities exist for streamlining enrollment and improving our welcome process for new providers. Additionally, adjustments to the re-certification process will streamline the re-validation process for providers already in the program. Delta is working with the state to reduce the complexity of the enrollment and credentialing process. It has been suggested that the Denti-Cal processes should more closely reflect those of Delta's commercial program.

The current provider application for the Denti-Cal program is twenty-five pages long. The application consists of a two page application, fifteen pages of disclosures and an eight-page provider agreement. Providers can access and complete the document on the Denti-Cal website, but can't submit the application on-line. Once the application is completed and submitted, the provider's professional credentials need to be verified. In addition to commercial health plan requirements, the Denti-Cal program also requires proof of a valid driver's license or state issued ID card, lease agreements, sub- leases, and articles of incorporation.

The enrollment and credentialing document used in Delta's commercial program is thirteen pages long, nearly 50 percent smaller. This consists of a credentialing form, a three-page application and a provider agreement. These documents can easily be rebranded and modified to accommodate the Dent-Cal program. This proposed change could significantly reduce the amount of paperwork and documentation providers need

to complete. Some aspects of the proposed change will need to be addressed, such as changing the Denti-Cal website to accommodate attachments and links to facilitate on-line submission of the applications and forms. The issue of a wet versus e-signature on the application will also need to be assessed by the state's legal department.

For providers undergoing re-validation, the process is much the same, and will glean similar benefits by adopting the Delta commercial approach.

Administrative Process for Restorative Procedures

In order to protect the integrity of the Denti-Cal program, or any other state Medicaid dental program, a certain degree of utilization management is needed to ensure that provided services are medically necessary. Review by paraprofessionals and by dental consultants ensure that monies spent for dental services are spent appropriately for the patient and are fiscally responsible. This is critical to the long-term financial viability of the program.

Delta has proposed an administrative simplification that will greatly reduce the paperwork burden on providers, while maintaining necessary oversight. The proposed change reflects to some the degree the process followed by Delta's commercial division.

Currently, providers are required to submit copies of their radiographs along with many of their claims for fillings, technically referred to as restorations. In accordance with state directives, a relatively small subset of those documents are randomly selected for review to establish medical necessity. Restorations are a large percentage of the treatment that providers perform and, as a result, dental office staff spends significant time and expense duplicating or copying radiographs for inclusion with their claims, the majority of which are never selected for review.

As an alternative, we have proposed that providers no longer submit radiographs for these previously required situations. Instead, the received claims without radiographs will be randomly sampled and a subset equal to the number currently being reviewed will then require the submission of radiographs via a separate request to providers. This will have the benefit of reducing the upfront burden on all providers, affecting only a much smaller group. Program integrity will still be maintained as we will still be reviewing the same number of restorative claims as currently required. This proposal is currently under evaluation by MDSD.

A similar proposal recommending the elimination of a processing policy that required the review of photographs that were submitted along with restorative claims (even if the

restorations themselves were not being selected for review) was approved and implemented by MDSD. In these situations, providers are receiving fewer denials, the turnaround time for payment is shortened and unnecessary handling of documents has been significantly reduced.

In Delta's commercial plans, we do not require prior authorization. Rather, we perform an analysis on dentists' utilization and based on the outcome, the provider may be placed in what we refer to as 'Focused Review'. When a provider is placed on Focused Review, we require additional documentation beyond what is normally required, usually additional radiographs and/or documentation to substantiate the need for the treatment requested or to demonstrate that the service meets our policy and the guidelines outlined in our Provider Handbook. Focused review lasts for at least six months, at which time we will re-evaluate the provider's utilization of the procedures.

Retrospective review or focused review processes are common practices among commercial health plans. In a retrospective review, provider utilization is analyzed and random reviews are conducted. Providers who fall outside policies established by the plan are placed on Focused Review, the more restrictive review process.

Implementing a retrospective or focused review process requires a differentiation among providers, in that some will be held to a more restrictive process based on their history where as others will be held to a more lenient process based on their history. The approach is open to all providers who demonstrate compliance with the rules.

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The Commission specifically inquired about ideas, other than fee increases, that will increase provider participation and satisfaction. Delta has provided the state with a number of recommendations to address frequently voiced provider concerns around administrative barriers in the program.

In addition to the changes involving radiographs and photographs discussed above, the state adopted our recommendation to allow providers to submit an authorization request that included both a root canal and the subsequent crown at the same time. This eliminated the need to wait until the root canal was completed to then submit another treatment authorization request for the crown to protect the tooth. This resulted in greatly speeding up the delivery of care to beneficiaries and the resultant payment to providers.

In addition to the changes that have been implemented, several of other recommendations are currently being evaluated by MDSD.

One area that has not been extensively evaluated, but has been discussed with the Department, is network ownership. Currently, the provider network belongs to the state, and Delta administers the state's policies and procedures. Typically, in Medicaid dental plans, the dental services administrator or dental plan, not the state, is responsible for recruiting and maintaining the network, which is proprietary to the plan. The Medicaid approach addresses two issues. First, it provides for more efficient network management and administration; secondly, it allows the contractor (the plan) and the client (the state) to focus on their respective areas of expertise.

Delta Dental is the largest stand-alone dental insurer in the country, with over 32 million members who are covered under a variety of insurance programs, many of them similar to the financial structure of the Denti-Cal program. We act in a fiduciary capacity for most of our larger group clients, by paying claims using the client's funds. We are deeply skilled at managing to the needs of the provider, while at the same time maintaining the financial integrity of the employer group plan. This is evidenced by our retention rates, which at 98%, are among the highest in the industry. Said another way: We are a very cost-effective partner for our clients.

Nationally, our provider networks consists of over 328,000 dentist locations. In California, our covered network has over 25,000 dentists. Given our vast experience in provider network management while balancing the needs of providers and clients, we could work with the State to apply a similar model for the Denti-Cal program. In doing so, we can ensure the same program integrity, while greatly reducing barriers that keep providers on the sidelines.

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In addition to the items specifically addressed in the invitation, the commission also inquired as to how an increase in fees would impact providers, and asked for thoughts as to how the Commission, the Legislature, the Governor and DHCS could most effectively assess a rate increase.

The majority of providers understand that Medicaid program reimbursements are not the same as commercial reimbursements. Regardless, they express willingness to participate in the programs, either from an altruistic point of view, or as a business differentiator. In exchange for the lower reimbursements, providers expect administrative ease, as there are direct costs to providers for fulfilling the administrative requirements of the program. By implementing the administrative changes we have discussed, the administrative costs to providers will be reduced, which equates to a fee increase.

Since the reimbursement rates are set by the state, not by Delta, my recommendations focus on the business aspects that provider reimbursements have on Medicaid and commercial programs, not on the political or budgetary aspects of the reimbursements.

As the Governor and Legislature address the reimbursement levels in the program, I recommend they look beyond the traditional view of how states assess their reimbursement levels. Typically a state compares its reimbursement rates to other state's Medicaid reimbursements. This is an important benchmark, as it provides consistency when comparing program outcomes across the states. However, I suggest the Governor and Legislature also assess the program reimbursements against reimbursements for providers in commercial dental insurance plans.

Health care is locally delivered and consumed. For the typical provider in a Medicaid program, an important benchmark is how Medicaid reimbursements compare to commercial reimbursement within the state and local area where they practice dentistry. As Medicaid programs grow across the country in general, and in California in particular, providers risk seeing a disproportionate share of their practice shift to Medicaid, causing "commercial crowd-out". In this case, the provider's higher revenue, and higher margin, patient base shrinks as their Medicaid base grows. The implications of this phenomenon were evident earlier this year in California when Western Dental restricted its Medicaid practice in a number of locations. Benchmarking Medicaid reimbursements against commercial reimbursement rates allows for more informed decision making as providers decide on the degree of financing mix they are willing to accept.

In an October, 2014 study of Medicaid Fee for Service reimbursements, the American Dental Association highlighted the following key messages:

- In 2013, the average Medicaid Fee-For-Service reimbursement rate was 48.8 percent of the commercial reimbursement rate for insurance charges for pediatric dental services.
- In 2014, the average Medicaid FFS reimbursement rates was 40.7 percent of the commercial reimbursement rate for insurance charges for adult dental services in states that provided limited adult dental benefits in their Medicaid program.
- From 2013 to 2014, when compared to commercial reimbursement rates, Medicaid FFS reimbursements rates for pediatric dental care fell in 39 states

The study found that California's Medicaid FFS Dental reimbursements for children, as a percentage of commercial reimbursement, decreased from 40 percent in 2003 to 29 percent in 2013, a 28 percent decrease. Dental providers use these comparisons to determine how much, if any, Medicaid dental to accept.

Here is the take away—when assessing the impact of a change in reimbursements, we need to look at what is happening locally as well as nationally.

Another aspect commercial plans use to determine fee schedule changes is specific network needs based on geography. Areas of greater need, with fewer providers, may be considered for a higher fee increase than areas where the network is more robust and access to care is not a pressing issue.

Related to this latest point is the methodology used to allocate any fee increase across treatment types. Larger volume, preventive types of services can be increased at a greater rate, as a method of encouraging care that is more preventive in nature. This strategy mitigates more expensive services down the road.

The take away from these last two points is that fee increases do not have to be spread uniformly across the program. In fact, the converse is true, targeting the increases by procedure type, and by geography, allow for a lower aggregate increase, but concentrates the increases to a greater degree in areas where it is most needed.

In conclusion, a great many positive changes are underway in the Denti-Cal program, just since the release of the state auditor's report last year. These changes, being undertaken in partnership by Delta Dental and the Department of Health Care Services, offer to improve access to care, relieve some of the administrative costs and requirements faced by new and continuing dentists who participate in the program, and are in alignment with many of the state auditor's recommendations.

The state's willingness to consider our suggestions to bring many processes into the program that mimic our best practices in the commercial marketplace also make me hopeful that we will be seeing significant improvements to the program in the months ahead.

Thanks you for your time today, and I will be happy to answer any questions you have.