Testimony SB 2343
Darin Gordon

Good morning. My name is Darin Gordon and I am the President & CEO of Gordon & Associates, LLC, a healthcare consultancy based in Nashville, TN.

Thank you for allowing me to offer testimony today in support of SB 2343.

As background, I have been involved with Medicaid for nearly 25 years. For 20 years, I was fortunate enough to spend time in public service in the state of Tennessee. While in public service, I served in multiple roles related to Medicaid, but my final 10 years was as the Medicaid Director of Tennessee's program – TennCare. During my tenure, I was also elected by my peers from across the country first as Vice-President and later as President of the National Association of Medicaid Directors (NAMD). I have also had the pleasure of working on a variety of National Governors Association healthcare related task forces and with assisting states throughout the country on ways to improve and enhance their Medicaid programs.

In addition to my current role as a consultant, I also currently serve as a Commissioner on the Medicaid and CHIP Payment and Access Commission (MACPAC). MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). I am not speaking today in my role as a MACPAC Commissioner, but in my personal capacity as a Medicaid professional.

Today I want to share with the committee my experience with the Medicaid Dental program in Tennessee in hopes that it will provide the committee with additional information regarding the success of the program in our state as you consider SB 2343.

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I do recognize that each state is unique, and it is commonly said that "if you know one Medicaid program, you know one". With that said, I do think there are lessons learned that can be helpful across states.

TennCare's objectives with it's dental contract was threefold:

- deliver high-quality care to enrollees;
- increase the number of enrollees utilizing dental care; and,
- predictable and sustainable program costs.

Now the current risk-based dental contract in place in Tennessee is a departure from any other dental contracts Tennessee had in the past.

From 1994-2002, the dental services were carved into the managed care plans that the state contracted with for multiple Medicaid services. From 2002 – 2013, the dental contracts were administrative services organization (ASO) contracts where the dental benefits manager (DBM) was not at risk financially. TennCare shouldered all the risk relative to dental claims expenditures. Nevertheless, there were good things about the ASO model.

Over an 11-year period we saw an increase in the number of enrollees who received care and dentists who participated in the program.

The biggest negative with the old model for TennCare was its inability to predict annual dental expenditures since the DBM was not at risk and there was the desire to see more innovation than the ASO model produced.

Also, over twenty-two years of managed care experience had taught Tennessee some valuable lessons.

One of those lessons is that "risk bearing" incentivizes vendors to manage better in a couple of ways:

- It brings renewed focus; and,

- It allows the plans to invest in new initiatives if there is the potential for a return on the investment.

Contract Model

It is important to note that our risk-based model that we moved to also included performance expectations around quality and utilization benchmarks (increasing utilization).

At the end of contract year 1, the DBM not only posted significant savings in dental claims expenditures, they exceeded the target enrollee participation ratio in the process. This may sound counter-intuitive, but the model actually achieved better cost efficiencies while increasing dental participation amongst our members.

Internal and external analyses show that the new contracting approach resulted in the vendor:

- Exceeding network adequacy standards outlined in the contract;
- Exceeding the annual participation ratio; and,
- Achieving 100% compliance on 14 of 17 Quality Process Standards and substantial compliance on the remaining 3 standards.

At the end of Contract year 2, the contract continued to show expenditure savings and further increases in enrollee participation.

This trend continued in the years that followed.

Needless to say, we were excited with the results. It confirmed our hypothesis: if done correctly, moving from a fee for service or ASO relationship to an

appropriately designed risk-based arrangement can result in better overall performance, better utilization of services at predictable and sustainable levels.

This concludes my opening comments and am happy to answer any questions the committee may have.

Thank you.