



GEORGIA DENTAL ASSOCIATION

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Via U.S. Mail and Email at MyOpinion@dch.ga.gov

Commissioner Clyde Reese
Georgia Department of Community Health
2 Peachtree Street NW, 6th Floor
Atlanta, Georgia 30303

Dear Commissioner Reese:

Thank you for the opportunity to provide you with the Georgia Dental Association's (GDA) comments regarding the upcoming re-contracting for the Georgia Families Program. The GDA commends the Georgia Department of Community Health (DCH) for allowing interested stakeholders and provider groups to comment on the current managed care program for Georgia Medicaid and PeachCare.

In the past eight years under the Care Management Organization (CMO) program dental providers have faced numerous contractual and administrative changes and fee reductions. The fee reductions range from 15% to 59%. Several dentists who previously accepted Medicaid patients have closed their doors, filed for bankruptcy, or terminated their Medicaid provider number. The GDA hears regularly from dentists who are evaluating how much longer they can continue to provide services under the current program. With this in mind the GDA is pleased to offer the following comments and recommendations for consideration in any new contracts with the CMOs.

Some high-impact changes require minimal, if any, expense to DCH. These include:

Require dental provider credentialing to be performed by the Credentialing Verification Organization (CVO).

The successful streamlining of the physician credentialing process has reduced administrative time and expenses for those offices, resulting in significantly faster credentialing. This process should be easily replicable to dental practices. Provision of care is often delayed due to the lengthy, multi-tiered credentialing process that dentists are required to complete in order to participate in the Medicaid program.

Eliminate pre-authorization requirement for common dental procedures.

Prior authorizations in the current CMO system are much more onerous than what is typically seen in the commercial market. Each of the CMOs contracts with a different dental subcontractor, each with their own requirements and minimum standards for prior authorization for certain procedures like surgical extractions, use of nitrous oxide, or hospital cases. This is not an efficient use of limited resources for the CMOs or the dental providers and further delays patient care.

Standardize prior authorization requirements, reimbursement levels, administrative processes, etc. among all CMOs and/or dental subcontractors if there is more than one.

Streamlining and standardizing the administrative rules and processes across all CMOs and any dental subcontractors would reduce the administrative burdens dental offices face under the current system. The inevitable errors, omissions, and misdirection of information that result from disparate requirements and timelines are an undue and expensive burden on the CMOs, the subcontractors, and the dental professionals.

Develop a clear definition of Rural versus Urban county designation and an appeals process for providers who disagree with their county's designation.

The CMOs use these county designations to pay dental providers at a lesser reimbursement rate than the Fee For Service (FFS) program. Amerigroup and PeachState pay 15% less than the FFS rate in rural counties and 25% less than the FFS rate in urban designated counties. Wellcare enacted cuts in the two northern regions on a more arbitrary basis. The GDA has heard from dentists who accept Medicaid – often the only one in their county – that their county is deemed “urban” by a CMO when their area is rural by most standard definitions. They currently have no way to appeal this determination.

Require CMOs and any of their contractors to comply with Georgia's Open Records Act.

As a contracted vendor of the state, and with control of considerable state and Federal funds, the transparency and accessibility of information covered under Georgia's Open Records Act should be available regarding the CMO's selection by the state and their operations.

Require Contractual Privity between DCH and the CMOs, as well as DCH and any subcontractors.

There should be privity of contract between the DCH and any and all CMOs and any subcontractors the CMOs utilize to administer the Georgia Medicaid program. The DCH should be able to review and approve or deny any and all contracts, as well as have oversight of all contracted entities.

Recalculate the geo-access limits to more reasonable levels.

Current geo-access limits for dental providers – 45 miles or 45 minutes in a rural area, 30 miles or 30 minutes in an urban area – are unrealistic. Many Georgians on Medicaid have other barriers to care, such as transportation difficulties or employment that does not provide paid time off. Requiring travel times of up to an hour and a half roundtrip, plus the time spent in the dental office, is an insurmountable obstacle for many patients whose transportation, school, and/or employment needs preclude a half-day dental visit.

Require CMOs and/or dental subcontractors to audit the provider rolls each quarter to ensure accuracy.

The GDA has received reports that the number of providers is outdated, overstated, and incorrect. The provider rolls should be audited regularly to ensure each provider is still participating, accepting new patients, that their contact information is correct, etc. Audits should include the number of days and hours a provider is at a particular location; this will help to assess if geo-access is truly being met. Outdated contact information yields frustrated patients who are trying to locate dental care for their

child, and may result in necessary documents being sent to the wrong office address as well as incorrect geo-access assessments.

Require CMOs and the dental subcontractors to utilize CMS-416 EPSDT to measure performance targets for children's dental visits.

Assessing whether the CMOs are meeting or exceeding the performance target for children's dental visits is based exclusively upon review of HEDIS scores for dental utilization. This is problematic because the HEDIS scoring only measures the number of dental encounters, not the amount of "treatment" provided. In other words, HEDIS counts any dental visit, which could be anything from an exam to fluoride varnish by a pediatrician to a dental screening performed in a school-based program; the child may have multiple dental needs that are not identified or identified but left untreated and may not have ever seen a dentist. Furthermore, HEDIS is not an indicator of a dental home.

Other federal measurement tools exist that could paint a more accurate picture of the status of children's oral health. One such example is the CMS-416 EPSDT data. This is a much better, more reliable indicator of access and utilization as it breaks the data into categories including "total eligibles receiving any dental services," "total eligibles receiving preventive dental services," and "total eligibles receiving dental treatment services" among other dental specific measures. These measures also specify by CDT billing code which services are to be counted in which category to further help identify true comprehensive care utilization.

Other necessary fixes require an infusion of funding to maintain, and hopefully grow, the provider network.

Restrict further cuts to dental reimbursement fees. Dentists are the only provider group to experience numerous fee reductions in the past eight years, ranging from 15% to 59%.

The remaining network of Medicaid-accepting dentists can not sustain a viable dental practice at these rates. Reimbursement levels are below, and sometimes far below, the actual cost of providing those services.

Georgia has not had a dental Medicaid provider rate increase since FY2003 (a 3.5% cost of living increase). This was three years prior to the CMOs coming to Georgia in 2006. With high overhead, increasing cost of dental and treatment supplies, any further cuts to the reimbursement rates will be devastating to those dentists still participating in the Medicaid program and would likely prompt more providers to cease participating.

Require CMOs to increase reimbursement to 80% of market rates for all covered preventive codes.

A comparison of Georgia’s Medicaid reimbursement fees (FFS and CMO) and the Southeast Atlantic Region, as defined by the American Dental Association’s 2013 Survey of Dental Fees, shows that Georgia’s Medicaid reimbursement rates range from 40% less to 75% less than the regional (Southeast Atlantic) average fee charged for each procedure. A sampling of fee discrepancies is shown below.

	ADA SE Atlantic Mean 2013	Georgia Fee For Service	WC/ Avesis – Atlanta	WC/ Avesis (4 Regions)	PS/ Dentaquest (Rural)	PS/ Dentaquest (Urban)	AG/ Scion (Urban)	AG/ Scion (Rural)
Comprehensive oral evaluation (D0150)	72.98	39.33	20.06	29.50	25.08	22.13	33.43	29.50
Panoramic Film (D0330)	103.22	56.92	38.71	56.92	48.38	42.69	48.38	42.69
Extraction (D7140)	156.99	64.17	43.31	62.62	53.23	46.97	54.54	48.13
Bitewing X-rays (4) (D0274)	58.58	33.12	22.52	33.12	28.15	24.84	28.15	24.84

Fund Georgia’s Medicaid and PeachCare dental programs separately as a carve-out.

Dental care has been grossly underfunded since the inception of the CMOs in 2006. Dental providers have faced numerous fee cuts, from 15% to 59% below FFS rates, and have endured more than 20 contractual changes over the last eight years. The number of dental Medicaid providers in Georgia has declined from 1,800 in 2006 to approximately 600 actively providing the majority of care today.

Dental disease is largely predictable and preventable. Without preventive care dental disease is chronic, progressive, and destructive. By creating a carve-out for dentistry the state will signal its commitment to ensuring the dental health of low-income children. This care is proven to improve their performance in school as well as their attendance.

Dental costs can be budgeted accurately if based on sound actuarial data. With current utilization data, actuaries can determine an appropriate premium for dental services. The state allocates a “per member per month” premium to pay claims and administrative costs, which would include premiums for stop-loss coverage. To eliminate the risk to the state that exceeds the premiums reserved, the state would purchase stop-loss insurance marked to cap their individual risk. A dental carve-out provides long-term, fiscally responsible solution to provide dental services for at-risk children in Georgia. Virginia, Tennessee, South Carolina, and North Carolina are among the states that have successfully implemented a dental carve-out that resulted in significant cost savings.

Limit the CMOs’ administrative costs and profits to 8%, the industry average, and invest the savings in higher reimbursement rates and/or more covered procedure codes.

Average administrative fees and profit for all dental claims between the three CMOs and three dental subcontractors average between 17% and 23% combined.

Require a Dental Home for all members enrolled in the Georgia Families program.

Establishment of a dental home for all Medicaid and PeachCare members is a component of full access to care. The dental home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. A dental home may follow the medical home model as a cost-effective and higher quality healthcare alternative to emergency care situations. Children who have a dental home are more likely to receive appropriate preventive and routine healthcare.

The dental home provider should be listed on the member's Medicaid card, to help prevent duplication of services and to locate treatment records. Patients could be given the option to self-select a dental provider, with an auto-assignment option if they fail to make a selection.

Once again the GDA sincerely appreciates this opportunity to provide input on the re-contracting process for the Georgia Families Program. If the Department has any questions or wishes to explore any of the issues raised in the letter in further detail, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Frank J. Capaldo". The signature is fluid and cursive, with the first name "Frank" being the most prominent.

Frank J. Capaldo
Executive Director
Georgia Dental Association

Cc: Dr. Donna Thomas Moses, DCH Board Member
GDA Board of Trustees