GEORGIA DENTAL ASSOCIATION
Suite 200 • Building 17 • 7000 Peachtree Dunwoody Road N.E. • Atlanta, Georgia 30328-1655
(404) 636-7553 • (800) 432-4357 • Fax (404) 633-3943

July 3, 2012

Jerry Dubberly, Pharm.D, MBA
Medicaid Division Chief
Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303

RE: Medicaid Redesign Model – Dental Requirements for Consideration for Inclusion in the Request for Proposal (RFP)

Dear Dr. Dubberly:

The Georgia Dental Association (GDA) has been closely following the efforts of the Department of Community Health (DCH) in comprehensively reviewing all aspects of the current Georgia Medicaid and PeachCare for Kids Programs. The GDA commends DCH for taking additional time to listen to the concerns of the providers, advocates, and members in an effort to design a plan to best meet the needs of those who rely on these programs for their health care.

Since oral health is an integral part of overall health, the GDA is pleased that dental care has been included in the review process. However, we are disappointed in the limited review of oral health care in the Navigant report. We understand and acknowledge that some cost savings mechanisms are necessary in order for the state to continue providing much needed health care services to the populations that qualify. In fact, over the years the GDA has provided suggestions on ways to cut costs and retain a high level of access to oral health services.

The GDA has some concerns about the current Medicaid and PeachCare managed care plans that we feel need to be addressed in the forthcoming RFP for the Redesign Plan and offer the following recommendations for consideration.

Concern 1: Dental Services: Dental disease is preventable and the associated prevention costs are predictable. However, without preventive care, dental disease is chronic, progressive and destructive. The GDA understands and acknowledges that some cost savings are necessary to continue providing much needed health care services to the populations that qualify. However, we believe that the following recommendation can help in this regard.

> **Recommendation: Dental Services Carve Out:** The GDA supports and encourages separate funding for Georgia's Medicaid and PeachCare dental program so that low-income children will continue to have access to the dental care they need. By creating a funding carve out for dentistry, the state will signal to parents and families its commitment to ensuring the dental health of low-income children— oral heath that will improve their performance in school and enhance their potential for work and success. A number of other states have realized cost savings and have provided more access to dental care to their Medicaid and CHIP members through a dental carve out.

A carve out of dental services to one administrator will eliminate the confusions and administrative hassles for both the patients and providers as currently exists under the three (3) CMOs and their two (2) dental subcontractors (which will be increasing to three (3) subcontractors in November). If a single provider for dental services is not a viable option, a provision should be in place that each CMO entity that is awarded a contract is required to join together and contract with a single dental subcontractor vendor with one set of administrative rules, one set of reimbursement fees, and a single source credentialing for all CMOs.

Why is A Carve-Out Important?

In Georgia, the number of dental Medicaid providers has declined in recent years from 1,800 in 2006 to approximately 600 actively providing the majority of care today. Dentists have expressed concerns about the CMOs reducing fees, making numerous contractual changes, and placing administrative burdens required for participation in the plans. **Amerigroup and Peach State slashed fees 25% for urban providers and 15% for rural providers. Wellcare made much more onerous cuts as much as 59% in the Atlanta and North Regions,** which is one half of the patient population they serve.

While many dentists express a desire to provide dental services to Georgia's needy children, they **are constantly evaluating how much longer they can "hang on" under the current program and many fear that without significant changes they may have to withdraw as a provider in the program.** This could result in significantly fewer dentists participating in the dental programs and fewer children receiving needed dental care.

A single administrator for the dental Medicaid program will also eliminate the current multiple layers of administrative costs and profits which are significantly higher than commercial norms. **For the third quarter 2011 (YTD), Peach State's administrative costs and profit were 13.64%; Wellcare's were 11.39%; and Amerigroup's were 7.93%.** Since the CMOs do not have the capability of managing and paying dental claims, they **subcontract this administration to DentaQuest and SCION Dental, whose administrative fees and profit are around 10%.** That makes the **average administrative fees and profit for all dental claims between 17% and 23%**. Most commercial plans' administrative fees and profits are around 8% or less. (Source: Atlantic Information Services' *Health Business Da*ily, December 5, 2011).

Virginia's Smiles for Children is a prime example where a state instituted a dental carve out that has worked to improve their dental program and continues to work well to the satisfaction of the members, providers and the State. Virginia began a dental carve out program in July 2005, with a primary focus on increasing provider participation, access to care and pediatric dental utilization. By September 2006, 235 new dentists had joined the dental network, a 38% increase. Within the first year of the program, 40,000 additional children were receiving dental services, a 24% increase in service utilization.

How Would a Carve-Out Work?

- A carve-out would establish a single program administrator (either the state or a contracted third party) for both the Medicaid and PeachCare dental programs.
- The dental program administrator would be responsible for selecting dentists, setting incentives and remedies, and controlling program parameters based on the guidelines established by the state.

- A single dental program administrator would allow for more efficient program oversight and accountability while also realizing cost savings. Under a single administrator, providers would be credentialed only once; there would be only one set of contractual standards; a single administrative point of contact would help reduce confusion, duplication of compliance activities and paperwork; and there would be increased transparency. These **efficiencies** will result in cost savings for the state, which can be directed where it is needed the most—to the oral health care of Georgia's children.
- Dental care costs are predictable and can be budgeted accurately if based on sound actuarial data. With current utilization data and 6+ years of historical managed care 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 a risk to the state that exceeds the premiums reserved the state would purchase stop-loss insurance to handle any cost over runs, which is a practice used in the commercial insurance market to cap their individual risks.
- A dental carve-out provides a long-term, fiscally-responsible solution to pay for, and assure access to, dental services for at-risk children in Georgia.
- Any premiums that exceed the cost of claims would be retained by the state to offset future premiums.

Concern 2: Dental Utilization and Quality Performance Measurements:

- The assessment tool currently used for evaluating the quality of dental services in Medicaid and PeachCare are the HEDIS measures. The use of HEDIS measures for dental care is <u>not an accurate indicator</u> of whether children in Georgia are receiving comprehensive dental care as it <u>counts any dental encounter, which could be anything from an exam to fluoride varnish by a pediatrician to a dental screening</u>. While this may be a valuable measure for medical utilization, it is not appropriate for dental and appears to overestimate utilization rates. For dental specifically, HEDIS is more of a measure of access points, not true utilization, and other measures should be considered.

- In September 2011, Health and Human Services Secretary Sebelius released the *Annual Report on the Quality of Care of Children in Medicaid and CHIP.* In the report, CMS acknowledged that quality measurement tools are better in medicine, more established and more widespread than in dentistry. In fact, the report keys in on the use of the EPSDT CMS-416 reporting and its use of the additional breakdown in data collection into categories as a good measurement tool. CMS-416 reporting requirements break the data into categories by CDT billing code which allows services to be counted in a manner that better identifies true utilization of preventive and treatment services. While we acknowledge that there are some limitations to the use of CMS-416, specifically that it only accounts for 90-days of continuous enrollment rather than a longer time frame, it still provides a clearer picture of dental utilization in Georgia.

<u>Recommendation:</u> The CMS-416 reporting format should be considered as an alternate or additional measurement tool in reporting and analyzing <u>dental</u> utilization rates in Medicaid and PeachCare and should be used in conjunction with all available data in evaluating the dental services offered in these programs.

<u>Recommendation:</u> Uniform, standardized, <u>quarterly</u> dental utilization reporting requirements for the CMOs in reporting to DCH should be established and required. At a minimum, reports should include the number of unique dental encounters by age group and type of service performed (utilizing CDT codes as reported on dental claims).

Recommendation: The GDA additionally recommends for consideration a modification of the quality performance measures to capture the following specific dental measures:

- Number of child enrollees receiving preventive dental services
- Percent of child enrollees receiving one or more dental sealants (data reporting to include the location in which the sealant was placed, i.e. a dental office, school based program, or other setting).

Concern 3: Dental Provider Network – Choice, Capacity, Accessibility:

- Since 2007, the Dental Provider panels have been closed for General Dentists in the metro Atlanta and other urban areas under one dental subcontractor, DentaQuest. With the potential of 600,000+ new Medicaid members to be added in 2014, the State will need as many providers as possible to meet the demands of all their members.

- Current methods used by the CMOs and their dental subcontractors to ensure provider network accuracy is not working and alternate methods should be required. Members and referring providers alike routinely find the list of participating providers to be inaccurate, especially with regard to offices taking new patients and referrals to specialists in the program. In 2008, the Georgia Department of Audits and Accounts audit of the provider network found that the data "may overstate access to CMO network providers in some areas of the state." A 2010 GDA survey of Medicaid and PeachCare providers, as provided by DCH, found that 22% of the responding dentists reported that they were not a current provider.

Recommendation: The dental provider panels should be re-opened to allow any willing dentist who is properly credentialed to be allowed into the managed care networks. CMOs and/or their subcontractor should not be allowed to close the panels for Medicaid or PeachCare for any reason.

Recommendation: The GDA recommends that the CMOs be required to pull claims data and compare this to their provider lists to find those providers who have not filed a claim in the last 6 months. For those providers who have not filed a claim within the designated time frame, they should be notified and placed on an inactive provider list. Then if after 6 additional months they still have not filed a claim, their Medicaid number should be terminated and removed from the provider lists. Coordination of these activities should be mandated between DCH and the CMOs on a regularly established basis, just as they are with performance reporting mandates. This change as proposed would be more in line with the policies as outlined in DCH's Part I Policies and Procedures for Medicaid and PeachCare for Kids, sections 105.6 and 105.7 for FFS providers.

Recommendation: Require reporting on pediatric and pediatric subspecialists provider participation, including pediatric dentists.

Recommendation: Establish provider network standards, particularly for primary care pediatricians, behavioral health providers, dentists, hospitals, home health agencies, and ancillary therapists.

Recommendation: Establishment of medical and dental homes to improve care coordination.

Recommendation: As an entity contracted by the state to provide health services to the Medicaid and PeachCare members, the CMOs should be required to allow the professional associations to have access to the provider network lists, upon request, to allow them to verify accuracy with their membership lists.

Recommendation: The GDA supports a requirement that the dental provider network list be posted on the company(s) website and audited for accuracy at least every 12-months (every 6-months is the preferred requirement). In addition to including the provider name, office address and phone number, the CMO should also be required to post the office hours for the dental office, if the office is accepting new patients, and the age range of patients that they accept.

Recommendation: The GDA supports the continued use of utilization reviews, audits, and other appropriate efforts to ensure that dentists are adhering to appropriate standards of care, and policies and procedures for Medicaid and PeachCare.

Concern 4: Prior Authorizations and Claims Denials:

- Dentists face a higher number of prior authorization (PA) requirements on many dental procedures under Medicaid and PeachCare than are required by commercial dental insurance carriers. PA request denials are significantly higher in dental than for other services as reported by DCH in the December 2011 CMO Flash Report. Among the current CMOs, dental PA denials ranged from 20.8% to 23.7%. These high denial rates limit the dental care the member receives and contributes to higher administrative overhead costs involved with filing appeals.

Recommendation: DCH should establish a Dental Advisory Committee comprised of dentists, dental vendors/CMOs, DCH representatives, dental association/society representatives, and others as determined by the DCH Commissioner to review all PA requirements to find areas of compromise and change to best serve the needs of the members. Clear criteria for authorizations should be developed, given to the providers, and required for use by all dental contractors. We recommend that changes to these authorization requirements go before the Advisory Committee for approval, along with a period of public comment, prior to enactment.

Concern 5: Administrative Difficulties:

- Under the current CMO system, there are several layers of administrative rules, costs and profits, credentialing, and differing reimbursement fee schedules, across the three (3) CMOs and two (2) dental subcontractors. This convoluted and confusing system will be further complicated when a third dental subcontractor enters the field this fall when Wellcare changes to Avesis from DentaQuest. Add to this the rules and fee schedule for the FFS program and it's not difficult to understand why dental offices are continually re-evaluating their ability to participate in the Medicaid and PeachCare programs.

- Since the implementation of the CMOs, dentists have had to cope with over 30 contractual changes to the dental program, including numerous reimbursement fee reductions, many of which were enacted during the first 18 months and done so retroactively.

- Georgia is only one of 2 states without 12-month eligibility for Medicaid. This is not only a problem for parents in keeping up with maintaining eligibility, but also an additional administrative burden for dental offices which must verify eligibility every day for every child before every visit. This is especially problematic during the first few days of the month as the state, CMOs and dental subcontractors update their databases with eligibility information. Loss of eligibility can cause delays of days or months in children receiving needed dental care.

Recommendation: Any changes to policies, procedures, limitations, frequencies, and/or reimbursement rates should be sent to the providers no less than 30 business days prior to the

implementation of such changes to allow providers time to evaluate their continued participation under the new conditions as presented. This requirement should apply even when the CMO makes a change on a national basis across all the state plans they administer.

Recommendation: The GDA supports the adoption of 12-month continuous eligibility for Medicaid members.

Concern 6: Adult and Pregnant Women Dental Benefits:
The GDA is concerned that with the inclusion of the FFS populations in managed care and the expansion of Medicaid in 2014, dental coverage for pregnant women and the very limited adult dental benefits will be the first services to be cut from the program in an effort to find cost savings. While the GDA fully understands that cost savings measures are necessary, prevention is the best medicine, which is exactly what dentistry stands for. Spending a few dollars upfront on preventive dental care will save thousands down the line in more costly restorative and emergency room care.

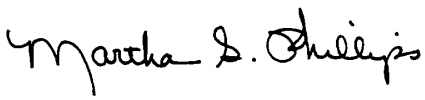
Recommendation: Dental benefits for pregnant women should remain at current levels under the new RFP and subsequent contracts.

Recommendation: CMOs should be required to offer "value-added enhanced adult benefits" to all enrolled members age 21 and older to encourage better oral health care. These benefits, with no co-pay requirement, should include at a minimum, but are not limited to: an oral exam every six months, bitewing x-rays once a year, simple extractions, prophylaxis treatment every six months, and no referral needed for other primary dental services.

As a final recommendation, the GDA supports the establishment of a Medical Loss Ratio (MLR) for the CMOs and has long advocated for a limit of 8%, which is the industry average. The savings can then be a mechanism to include more covered procedure codes and appropriate reimbursement levels for dentists.

The GDA appreciates the opportunity to present these recommendations and contends they align with the Mission and Core Values of DCH in offering better oral health care to the Medicaid and PeachCare for Kids members. We feel strongly that the recommendations, most importantly the dental carve out, will enable the Medicaid and PeachCare members to receive basic preventive and restorative dental services while still maintaining a viable program.

Sincerely,



Martha S. Phillips
Executive Director

Cc: David A. Cook, Commissioner, Department of Community Health
Dr. Michael O. Vernon, GDA President