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October 28, 2013

Clyde L. Reese, III, Esq.
Commissioner
Georgia Department of Community Health
2 Peachtree St. NW
Atlanta, GA 30303

Response Details: State Plan Amendment for ABD Care Coordination, October 2013

Dear Commissioner Reese,

The Georgia Dental Association (GDA), on behalf of its 3,400 members supports the CARE-M coalition's positions for improvements in dental services in the State Plan Amendment for ABD Care Coordination for these eligible services categories. As a member of CARE-M, we wanted to provide additional expertise on the issues specifically related to oral health.

Good oral health and dental care are critical to overall health and coordination with medical care is especially important for the ABD population. **We support the recommendations by CARE-M to:**

1. **Cover non-emergency dental services for adults, such as basic preventive and restorative treatment.**
2. **Consider a dental carve out to one CMO, or at a minimum requiring all CMOs to utilize a single dental administrator.**
3. **A requirement for uniform, standardized, quarterly dental utilization reports.**
4. **The use of annual dental utilization measures other than HEDIS measures, such as the measures from the Dental Quality Alliance.**

The GDA believes these recommendations would be beneficial to the entire Medicaid and PeachCare programs, improve access to dental services, and improve patient outcomes.

1. Non-emergency dental services for adults

We strongly support the inclusion of basic preventive and restorative services, especially for this population of ABD adults who may have increased oral health needs as a result of other health issues. Current adult dental services only provide for emergency care, which is extracting teeth and relief of pain. Due to funding issues and lack of basic services for adults, the ABD population often goes without needed dental care which can further exacerbate or contribute to other ongoing health issues, like diabetes or heart disease.

2. **Dental carve out to one CMO, or at a minimum requiring all CMOs to utilize a single dental administrator.**

A single administrator for the dental Medicaid program will eliminate multiple layers of administrative costs and profits which are significantly higher than commercial norms. The current system of three CMOs, each with a different dental administrator, along with the state fee-for-service program is cumbersome and difficult to navigate for many dental offices and is a huge deterrent to participation. A single administrator would also reduce administrative costs and allow more patients to receive care. It will allow the state to receive more uniform data sets, timelier utilization and claims data since this information will not be filtered through several entities. By instituting a single administrator, more dentists will be encouraged to participate as Medicaid providers. Under the CMOs dentists have seen drastic cuts to Medicaid and PeachCare fees. Economic viability is an issue and several dentists have closed their practices or gone bankrupt. In addition, a recent census of all dentists in Georgia found 104 dentists that would like to be a Medicaid provider but cannot gain entry into the CMO networks.

Additionally, a single CMO or single dental administrator will be able to provide for care coordination with the medical plan to enhance and optimize patient care and outcomes. It would also lessen patient confusion about the plans and how to access care.

3. **Requirement for uniform, standardized, quarterly dental utilization reports.**

Currently each CMO reports dental utilization data to DCH, but the Performance, Quality and Outcomes unit of DCH only presents this dental utilization information once per year to the Care Management Committee of the Board of Community Health. While we recognize that there may be ongoing internal discussions between DCH, the CMOs and their dental administrators, this information is not made public but once a year or through an official open records request, which limits the ability to work with the department and CMOs to improve the program. Information that should be included in these uniform, standardized reports includes, but is not limited to, and broken down by age groups starting at age 1 and by CMO and FFS: annual dental visit, preventive dental visits, restorative dental visits, and dental provider shortage areas including geo-access shortages and specialty provider shortage areas.

4. **The use of annual dental utilization measurements other than HEDIS measures.**

The GDA is concerned that continued reliance upon the Health Care Effectiveness Data and Information Set (HEDIS) scores for dental utilization through the single dental measure in the HEDIS set commonly known as the Annual Dental Visit (ADV) is misleading and does not identify the level of care received by children enrolled in Medicaid. The GDA proposes using the CMS-416 EPSDT data as a more reliable data source or the ADA Dental Quality Alliance (DQA) measures that provide a mechanism to evaluate the complementary aspects of utilization, quality and cost.

The CMS-416 is a form state programs must submit annually to the Centers for Medicare and Medicaid Services (CMS) that details utilization of a scope of services for children who receive services through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). The 416 form includes a number of specific dental questions including ñtotal eligible receiving any dental services,ò ñtotal eligible receiving any preventive dental service,ò and ñtotal eligible receiving any dental treatment service,ò among other dental questions. The 416 categories use CDT billing codes to categorize the services that are reported.

The Dental Quality Alliance (DQA) measure set aims to overcome the limitations of both HEDIS and the 416. The DQA measures provide a mechanism to evaluate the complementary aspects of utilization, quality and cost. They were developed by the dental community and have been validated through a number of studies. These measures are based on administrative (enrollment, claims and encounters) data and are applicable for health plan/program assessment. DQA Measures can be used to: 1. uniformly assess quality of care across private/public sectors and across state/community and national levels; 2. uniformly assess utilization of certain services that are not supported by evidence that they indicate better or worse care, but which may be important in the context of providing a standard of care; 3. inform performance improvement projects longitudinally and monitor improvements in care; 4. identify variations in care; and 5. develop benchmarks for comparison.

We thank you for the opportunity to provide this information and welcome the opportunity to discuss this matter with you and to work together for the betterment of the oral health of all Georgians.

Sincerely,

Marshall H. Mann, DDS
President

Nelda H. Greene
Executive Director

Cc: GDA Board of Trustees