Testimony
Of
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Domestic Policy Subcommittee
Oversight and Government Reform Committee
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"Hearing on Necessary Reforms to Pediatric Dental Care under Medicaid"

Good morning, Chairman Kucinich, Ranking Member Issa and Members of the Subcommittee. My name is Linda Lowe. I am the Health Policy Specialist for the Georgia Legal Services Program which serves 154 of Georgia's 159 counties, including the small cities and rural areas of the state. I have worked with GLSP for 29 years (now part-time) focusing on health issues, particularly Medicaid and PeachCare for Kids, our State Child Health Insurance Program. I also work outside GLSP with other nonprofits on these matters and serve on the boards of several community organizations.

You have received information from many other sources about the disgraceful truth that poor oral health among low-income children in our nation is all too common. Although Medicaid's EPSDT program is a powerful tool for addressing children's needs, most states have not yet fulfilled the promise of adequate dental care. The need to hold ourselves and our state programs to high standards is great, but we often lack the analytical data to facilitate meaningful evaluation, oversight and planning. In this light, my testimony will address Georgia's efforts to improve dental care during the past decade after long neglect of the oral health of its children.

Context.

Some comment about Georgia's situation is warranted. Medicaid and PeachCare are major insurers of Georgia's children. Their success in addressing dental needs is crucial to child well-being.[1] In 2005, nearly half (49.5%) of our children had Medicaid, and another 13.3% had PeachCare.[2] (The numbers of enrolled children declined beginning in 2006, due in large part to new federal and state verification requirements that erected barriers for the families of many eligible children. Even before then, at least 200,000 children were eligible, but not enrolled.) Geographically, Georgia is the largest state east of the Mississippi River and suffers from a maldistribution of health care providers that restricts access for many people regardless of income or insurance. High fuel prices and the dearth of public transportation in rural areas mean ancillary services like Medicaid transportation are essential to achieving meaningful access to care. Parents' own inexperience with regular dental care likely hinders access for children; Georgia Medicaid pays only for emergency dental care for adults and covers relatively few parents at all because of restrictive financial eligibility criteria. Another impediment is that many parents work at low-wage jobs offering no paid leave, so taking a child to a dentist during business hours can mean a smaller paycheck or even job loss in our employment-at-will state. Additionally, because Georgia provides no guaranteed period of eligibility, interruptions in care occur. Despite Georgia's ranking in per capita income near the middle nationally, it is a low-tax state.

Past Trends in Children's Dental Care.

Georgia began to raise payments to providers in FY 1999 in hopes of enticing more of them to participate in Medicaid. (See the detailed discussion in the next section.) The positive news so far from Georgia is

that the proportion of Medicaid-covered children receiving any dental service doubled from 18% in FY 2001 to 36% in FY 2007, a noteworthy improvement, but still very short of what the numbers would be if children received the semi-annual visits dentists recommend. While only 16% received preventive dental services in FY 2001, by FY 2007, 34% received such services. The more discouraging news for that period is about treatment: although the proportion of children receiving dental treatment rose steadily from 18% in FY 2001 to a high of 34% in FY 2004, it fell sharply to 19% in FY 2005 and then back to 18% in FY 2007. [3] DCH has said it also is concerned about these trends and is planning a conference with various stakeholders (DCH, CMOs, dental providers and associations, public health, and advocates) to look at the issues and begin steps to improve dental access and care.

Teachers continued to report dental problems as a major reason for students' absences from school and poor academic performance. Georgia's Third Grade Oral Health Survey in 2005 documented that 56% of all the children surveyed had tooth decay, and 27% had untreated decay. Researchers noted that low-income children were far more likely to have decayed teeth than others and also found that children with health coverage and those with a dental visit in the prior year were more likely to have good oral health.[4] About 40% of all the children had dental sealants. Augmenting Medicaid and PeachCare, Georgia's Department of Human Resources Public Health Division operates a dental sealant program for schools and Head-Start centers providing sealants for about 8,100 low-income children in FY 2007. For Medicaid and PeachCare, utilization data are limited after FY 2007 (July 2006-June 2007), but will be of great interest because of several factors, including Georgia's mandatory enrollment of most children in Medicaid/PeachCare-only capitated managed care beginning in June of 2006. A chronology of changes follows.

A Decade of Change Affecting Children's Dental Care.[5]

- From the mid-1980s until FY1999, Medicaid dental reimbursement was flat. Dentists' reimbursements dropped to 30 to 40% of average customary fees. The POWERline, a statewide referral service, conducted a survey and found only 257 dentists providing services to Medicaid recipients.[6]
- State officials became aware that a lawsuit over the lack of access could result in federal sanctions. Advocacy groups joined with dentists to raise an alarm over the poor oral health conditions of Georgia children. The state enacted a 33% increase on 64 codes and a 10% increase on the remainder of the codes for FY 1999. This raised reimbursement to about 50 cents on the dollar, and DCH also made several administrative changes like using the standard ADA claim form and CDT codes.
- Also in 1999, Georgia began enrolling children in PeachCare for Kids, the then new SCHIP program. Dental coverage and fees were equal to those for Medicaid, and providers were deemed enrolled in both programs if they were enrolled in Medicaid.
- The FY 2001 budget increased fees to the 75th percentile, equaling South Carolina's Medicaid reimbursement. In exchange for this more realistic payment, the Georgia Dental Association committed to increase the number of participating providers and initiated the "Take Five Program" which succeeded in greatly expanding the enrollment.
- Despite a tight budget, the state continued its commitment to improving access, raising fees again by 3.5% for FY 2003.
- In 2003 and 2004, Georgia transitioned from EDS to ACS for processing and paying claims. The result was a better system with more electronic claims processing and easier-to-access online information about patient eligibility and claims. However, the

lengthy and rocky start-up discouraged providers in all categories who received late or no payments for long periods and had claims denied without justification.

- For FY 2004, a budget crisis led the state to eliminate 11 dental codes for restorative services from Medicaid and PeachCare, cutting a total of 7.5% from the dental budget.
- Advocates and GDA had to fend off a threat to eliminate PeachCare dental coverage in FY 2005 due to budget shortfalls. Children were locked out of coverage for three months for allegedly late premium payments until public outcry resulted in the policy's finally being relaxed.
- In FY 2006, the state cut PeachCare dental services, making them far less comprehensive than Medicaid's. Two children in the same family with the same needs seeing the same dentist might be eligible for different services because the six year-old had PeachCare and the five year-old had Medicaid.
- Beginning June 1, 2006 and phasing in by October, Georgia required most children with Medicaid and all children with PeachCare to enroll in capitated managed care organizations ("CMOs") responsible for almost all their services, including dental care. (Children receiving Medicaid based on disability and those in foster care or receiving adoption assistance are excluded and continue to receive care under the fee-for-service system.) A benefit of the new system was that the CMOs planned to again cover the same services for children with PeachCare as for children with Medicaid, but the transition to CMOs created other problems for patients and providers that are discussed in the next section.
- In FY 2007, the GDA and advocates persuaded the state to fund essential dental services for pregnant women based on research

findings that treating the mother's dental infections leads to healthier babies and fewer problem births.

- Federal delays in reauthorizing and funding SCHIP created major consternation about the FY 2007 and 2008 PeachCare budgets. The legislature came close to making major cuts in PeachCare eligibility, dental services and other aspects of the program, although after major advocacy efforts, the legislation died on the last night of the session. As it was, enrollment was frozen for a time and finally capped, although the cap has not yet been reached.
- In 2008, the General Assembly also passed HB 1234 which, among other things, requires CMOs to pay claims promptly and to allow additional dentists into their networks in defined shortage areas. It attempts to clarify who pays when there is confusion over which CMO has responsibility for the patient.[7]
- For FY 2009, legislators authorized a 2.5% dental fee increase and required that it be passed along to dentists by the CMOs. Although Gov. Perdue signed the budget bill, he is delaying the rate increases for at least a year due to a sharp downturn in tax receipts that has created a large deficit for FY 2009 and FY 2010.
- A new budget threat in addition to the state revenue shortfall now looms. Georgia has been collecting about $90 million a year in quality assessment fees from the CMOs. Because the Deficit Reduction Act and accompanying regulations require the state to collect fees from commercial managed care entities if it wants to continue collecting from the Medicaid/PeachCare CMOs after September 2009, the state now faces the choice to expand the base for the fee, raise taxes, or make cuts. Once again, dental care for PeachCare members would be on the chopping block, as would any Medicaid fee increases.

Despite the budget ups and downs, this period reflected a commitment on the part of state officials to improve dental access by raising reimbursement rates. A study from the Georgia Health Policy Center and the Department of Human Resources cited earlier indicates that between 2000 and 2005, the number of Medicaid "participating" dentists increased by 65.2% from 839 to 1,287 and the number of "active" dentists increased by 56.6% from 598 to 1,056. Participating dentists filed at least one claim per year, and active dentists filed at least one per week.[8] DCH's figures show that In FY 2006, 1,641 dentists filed at least one claim for children's dental care.[9]

Dental Care under CMOs.

When Georgia embarked on its plan in 2006 to enroll most Medicaid patients and all children with PeachCare in capitated managed care, officials stated goals of saving money, making the budget more predictable and improving health by increasing access to appropriate health care services. Officials divided the state into six regions and awarded contracts to three bidders, Amerigroup, Peach State (Centene Corporation) and WellCare. WellCare operates statewide. Both of the other two operate in the Atlanta region, thus allowing patient there to choose among three. Patients in the other regions must choose either WellCare or one of the other two. If patients fail to choose within 30 days, they are assigned automatically.

All of the CMOs opted to sub-contract their dental services either to Avesis or Doral. CMOs required dentists to sign contracts with these two providers if they wished to participate in Medicaid and PeachCare. Fees remained unchanged at first, but would soon be altered.

Whether or not the new arrangement adds value, it created two extra layers of bureaucracy, both of which siphon off money that could

have gone to compensate providers of care. It also means that instead of dealing with the single entity that used to handle all Medicaid and PeachCare coverage policy and claims, they now have to cope with two or three. One dentist with a substantial Medicaid practice says he has three color-coded charts on his treatment room walls so that he can tell how to provide services for each patient: red for Doral, blue for Avesis and black for "not covered." He also treats some children with SSI who remain in regular fee-for-service Medicaid, but he says it is much easier to understand the regular Medicaid rules and to get claims paid. To deal with the CMOs, he also says he has had to hire better educated hygienists and dental assistants at higher rates of pay so that they can understand and apply the complicated rules.

The CMO startup involved many "glitches," and some of them persist. An obstacle that has continued is the difficulty providers have faced in confirming at the time of service a patient's eligibility for Medicaid or PeachCare and verifying that patient's enrollment in a particular CMO. Patients carry plastic cards that must be recognized in both the state's system (the Georgia Health Partnership or GHP system) and the CMOs, where there is often a delay. Too often patients have learned upon arriving for their appointments that the system does not show them as eligible. Some have been turned away. The dentist referred to above describes the problem this way:

> Before the advent of the CMOs, ACS handled the management of the Medicaid program in the state of Georgia. When ACS took over the Medicaid program in 2003, there were issues that, at first, were huge bumps in the road but eventually were ironed out. By the end of 2003, ACS ran the Medicaid program smoothly with few errors in payment and never a question regarding eligibility. Checking a member's eligibility was easy through the GHP web portal. Active status and limitations were

readily available through one easy step. Eligibility for patients was checked by one front office staff member the day before the patient's appointment. If a child was not eligible, they were not seen as we knew that ACS would not pay if the GHP website stated their status was inactive.

Since the CMOs have taken over the management of the Medicaid program, checking eligibility has turned into a job that requires two to three front desk staff members. A child's eligibility must be checked through the GHP website as well as the Doral website (for WellCare and Amerigroup patients) or the Avesis website. It requires a total of three printouts as opposed to one, which consumes more time and resources. When a child is showing active on the GHP website but inactive on the CMO website, we still see the patient because the GHP site is accurate while the CMO site might not have been updated. When this occurs, though, we have to bypass the transmission of an electronic claim for payment and revert to a paper claim with a copy of the child's eligibility attached to show the CMO that the child is active according to the state. Many times, the claim is still denied by the CMO, despite the attachment of GHP eligibility, which as of July 1, 2008 must be honored as evidence of a child's active or inactive status (because of HB 1234), regardless of what the CMO website states. It is very time consuming to re-file two or three times a claim that should have been paid the first time with an attachment. It requires the employment of one person whose job is dedicated to Medicaid posting and re-filing. The verification of eligibility requires the time of two to three front desk staff members throughout the course of the day.

The confusion over eligibility is one problem the General Assembly seeks to address through this year's passage of HB 1234. It designates the GHP website as the authoritative source on eligibility.

After beginning operations, the CMOs quickly became alarmed by what they saw as excessive utilization of dental services that threatened their profitability, claiming they had budgeted for lower amounts based on data the state had provided for their bids. Beginning in early 2007, Doral and Avesis, on behalf of the CMOs, started sending letters to dentists outlining significant changes designed to drive down service use and payments. They listed services for which they would begin requiring prior approval, announced fee reductions for certain procedures, closed enrollment of new providers except for specialists, and soon began terminating contracts for some dentists. In September of 2007, for example, both WellCare and Peach State terminated from their networks Kool Smiles PC, a dental group provider that had served a total of 44,500 of their patients. Amerigroup announced a plan to subcapitate dental services in some counties and for some patients, but later withdrew it and cut reimbursements instead. It later rescinded the rate cuts. (A summary of announced changes prepared by the Georgia Dental Association and copies of letters are available.)

Assessing the adequacy of the current networks and the degree of meaningful access is difficult because of lack of information, such as encounter data and detailed monitoring reports. According to the Department of Community Health, the CMOs claim the following slates of providers: [10]

Dental Specialty Types	**Peach State**	**Amerigroup**	**WellCare**
Anesthesiology*	20	32	27
Endodontics	9	3	3
General Dentistry	1,368	463	1,724

Oral and Maxillofacial Surgery	137	66	100
Orthodontics and Dentofacial Orthopedics	32	22	21
Pediatric Dentistry	345	78	307
Periodontics	37	5	27
Prosthodontics	11	4	4
Total	1,959	673	2,213

*The GDA says anesthesiology is not a recognized dental specialty

Other information sheds additional light on the extent to which dentists are actually providing care to Medicaid patients. GDA reports that in the fall of 2007, it surveyed the 870 dentists listed as dental providers by the CMOs. It concluded that about 19% were no longer accepting any new Medicaid or PeachCare patients, 55% were not accepting new Amerigroup patients, 58% were not accepting new Peach State patients, and 64% were not accepting new WellCare patients. Citing the results of the survey, the Georgia Dental Task Force recommended obtaining claims and encounter data to further document actual participation.[11]

In May 2008, the Department of Community Health, responding to an open records request from a dentist, supplied data on the numbers of dental claims filed per provider from July 1, 2006 through June 30, 2007 (FY 2007) in fee-for-service Medicaid and under each CMO. The numbers are broken down as 1-50, 51-250, 251-500, and 500+ claims. In all cases, a small proportion of dentists performed a large percentage of the dental procedures. In fee-for-service, 20% of dentists performed

90% of procedures. Proportions for the CMOs were Amerigroup,15%; Peach State, 24%; and WellCare, 26%. It is noteworthy that for two of the CMOs, the numbers of dentists who filed at least one claim (Peach State – 654 and WellCare – 854) were far lower than the numbers they listed in their networks as shown in the table above. Amerigroup's numbers were close to the same, with 644 dentists filing at least one claim. Advocates have heard reports of CMO members having difficulty locating providers on the CMO lists who will accept them as patients. However, DCH says it has not been able to substantiate the majority of complaints about inability to locate providers who will accept CMO patients; staff have made "secret shopper" calls and report they would have been able to schedule appointments. Rigorous data gathering would be helpful. A prominent dentist from a north Georgia community whose practice used to consist of a quarter Medicaid patients says he has discontinued accepting Medicaid, but still gets referrals from the CMOs even though he has not participated in over a year.

A matter that Georgia should address for patients who require dental care is Medicaid transportation. For some years, Georgia has used a capitated broker system which sometimes fails to respond to practical needs. A dentist complained last week that some of his patients who have to come from miles away must be ready for their transport at 3:00 a.m. and arrive at his office at 6:30 a.m., long before he opens for business.

Obtaining specialty care is another difficulty. A dentist in a small town whose practice is 25-30% Medicaid says that since the entry of CMOs, he has to send children needing a pediatric dentist an hour and a half to two hours away now because the closer-to-home practitioner who used to take his patients refuses to deal with the CMOs. Calls to the

POWERline seeking pediatric dentists in rural areas reinforce the concern about specialty care.

One promising practice that bears evaluating is a model called Help a Child Smile, the innovation of a Georgia dentist who still maintains his original practice. HCS reports that its mobile dental offices deliver services to children at school in 84 school systems (76 counties), providing screening, preventive care and treatment.[12] HCS accepts Medicaid and PeachCare, private insurance, and cash. It reports a high rate of completed treatment and has earned enthusiastic support from school counselors and nurses who say children are benefitting greatly from the care. An attempt by CMOs to restrict HCS's reach as part of last year's cutbacks met with a major campaign of resistance from school personnel and parents. The shortcoming of the model is that the mobile offices are not always present in the community as a dental home for the children. It can be difficult to get a child's records to a local dentist when care is urgently needed (although electronic records could be a remedy), and some dentists in fixed practices dislike the competition. However, it may be a creative solution to the problems of inadequate transportation, a parent having to forego a day of earnings to take children to the dentist, and the "no-shows" that hinder efficient operations in a dentist's office.

We do not know yet whether outcomes for children are better or worse under CMOs. Their contracts with the state require them to comply with EPSDT requirements and to submit plans for how they will do so. The CMOs are required to undertake internal quality assessment and improvement measures and to submit data that could help the state determine whether or not they are meeting their obligations and how patients are faring, but little is publicly available so far. DCH has conducted surveys of providers and reports that their complaints about

access to CMO staff who can resolve problems, claims payment, and web site concerns are being addressed. It also reports that CMOs' internal reviews have identified quality of care issues such as undiagnosed decay, multiple fillings of the same tooth, and injury to tooth or gums during procedures.[13] (At the same time, peer consultants reviewing fee-for-service provider records found use of excessive amounts of local anesthesia for low-weight patients, use of stainless steel crowns instead of less expensive restorations, lack of documented medical history, and improper billings.)[14] Last year, DCH fined Peach State $3.7 million for improperly delaying care by failing to act timely on prior approval requests. We are aware that CMS has conducted an audit here, but we have not seen a draft. Voices for Georgia's Children has a study underway to examine and evaluate process data from the CMOs and is including a measure for the number of children receiving a preventive dental visit in the course of a year.[15] Advocates hope to begin in this third year of CMO implementation to see encounter data and other information to enable us to understand better whether or not the state is making progress in improving children's oral health.

<u>Recommendations:</u>

- Make oral health for children a high priority for CMS and address it as such with states.
- Encourage states to adopt options such as 12 months' continuous eligibility for children so that their care is not interrupted by episodic loss of coverage. No matter how good dentists and CMOs are, they cannot manage care effectively without being able to complete screenings and treatment.
- Similarly, encourage states to smooth out income limits so that children in the same family can qualify for Medicaid or SCHIP regardless of age. In Georgia, a family with income at 125% of

poverty can have a four year-old in Medicaid and a six year-old in PeachCare. Even though Georgia wisely has matched the two programs as to services and payments, there are still two different eligibility systems, and children can experience breaks in coverage when they age from one program to the other. Raising Medicaid limits to 150% of poverty, for example, could help resolve the problem at least for families with children over age one. (Advocates worked successfully for passage of a measure to do this, but a previous governor impounded the funds to deal with a budget shortfall.) In addition, require states to create seamless transitions between Medicaid and SCHIP.

- Encourage states to make it possible for more parents to qualify for Medicaid and to cover essential dental services for them so that the family is more likely to understand the importance of and seek regular dental care.
- Hold states to "equal access" payment rate requirements and accessibility standards sufficient to achieve maximal oral health for children whether they use fee-for-service or capitated managed care.
- Require states to show that their ancillary systems like Medicaid non-emergency transportation and case management support adequate access to services for all patients.
- Require states to publicly report data measured against goals on a regular basis to enable advocates and other stakeholders to track progress, raise questions, and identify opportunities for improvement. This should include information regarding focused studies and improvement plans.
- Expand the focus of data collection to examine oral health outcomes for children rather than just process measures.

- Improve monitoring of the "treatment" feature of EPSDT for which there is little systematically collected data in every category of service, including dental care.
- Evaluate promising practices, share findings with states , and offer technical assistance.

Once again, thank you for this opportunity to speak with you today. I join many others in being gratified and encouraged by your concern and commitment regarding this critical issue for children.

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[1] Georgia's Medicaid income limits for children are as follows: Infants < 1, 200% of FPL (185% if not born to a mother with Medicaid for the birth); Ages 1-5, 133% of FPL; Ages 6-18, 100% of FPL. PeachCare covers children over these limits, but below 235% of FPL. (Georgia also covers children who qualify for Medicaid because they receive SSI, children in foster care or receiving adoption assistance, and Katie Beckett children.)

[2] *Analysis of Access to Dental Care Provided though Medicaid and PeachCare (SCHIP), Service Trends and Patterns, CY2000/SFY2001 through CY2005/SFY2006*, Georgia Health Policy Center with Georgia Department of Human Resources, Division of Public Health, December 2006, p. 7.

[3] Georgia Department of Community Health, Division of Medical Assistance, "Historical Utilization Trends Based on CMS 416 Data," 2008.

[4] It should be noted that utilization for the higher-income PeachCare children is better than for Medicaid children, although service coverage and payment rates have been exactly the same during most years. For example, in FY 2003, utilization of any dental service for PeachCare children was 49% versus 31% for children with Medicaid. Other years show similar differences. Utilization rates for both vary considerably among sections of the state.

[5] Compiled with assistance from the Georgia Dental Association.

[6] The POWERline is operated by the Healthy Mothers Healthy Babies Coalition of Georgia and receives thousands of calls per year from people having difficulty finding health services. Calls seeking dental services are among the most frequent, and it was their overwhelming numbers in the late 1990s that led to successful advocacy to raise Medicaid dental fees. Current callers include parents seeking care for children during the month or so it takes to complete entry into a CMO after becoming eligible for Medicaid or PeachCare.

[7] HB 1234 signed as Act 585. http://www.legis.ga.gov/legis/2007_08/sum/hb1234.htm

[8] *Analysis of Access to Dental Care*, p. 7.

[9] Georgia Department of Community Health, Annual Report, Fiscal Year 2006.

[10] Georgia Department of Community Health, September 18, 2008.

[11] Georgia Dental Task Force, *Shining the Light on the State's Dental Education Needs*, A report and recommendations submitted by the Georgia Dental Task Force to Medical College of Georgia President Daniel W. Rahn, MD, 2008.

[12] Help a Child Smile Mobile Dental Program. http://www.helpachildsmile.org .

[13] Data supplied by the Department of Community Health, September 17, 2008.

[14] *Ibid.*

[15] Jennifer Edwards, Lisa Duchon, and Jodi Bitterman, Health Management Associates, *Quality of Care and Health Outcomes for Children in the Georgia Families Program*, Report for Voices for Georgia's Children, August 1, 2008 (draft for review, not yet published).