Centers for Medicare & Medicaid Services
Region IV

Georgia EPSDT Review Report
Dental Services

Site Visit
May 20-30, 2008

Executive Summary

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program serves individuals under the age of 21 who are enrolled in Medicaid. It is intended to assure the availability and accessibility of required health care resources and to help Medicaid children make effective use of them. The purpose of the review was to determine what efforts Georgia has made to address the rate of children's dental utilization in the State, and to make recommendations on additional actions Georgia can take to increase these utilization rates. Specifically, between May 20 and May 30, 2008 a Centers for Medicare & Medicaid Services (CMS) EPSDT Review Team interviewed State staff, as well as a non-representative sample of providers and the three managed care organizations, and conducted extensive document review in the areas of informing, periodicity, access, diagnosis and treatment services, support services, and coordination of care.

There are 1,069,682 children enrolled in Georgia's Medicaid program, which is administered by The Georgia Department of Community Health.

Georgia provides Medicaid dental services primarily through three MCOs – Wellcare, Amerigroup and Peach State. Wellcare and Amerigroup operate statewide, while Peach Care is available in 61 counties in the State. Georgia Medicaid maintains a small number of fee for service recipients, primarily those in the medically needy group and those who are in state custody. Among the three MCOs in Georgia, none provided dental services to more than 28 percent of their population in FFY 2007.

Georgia has adopted the American Academy of Pediatric Dentists (AAPD) Recommendations for Preventive Pediatric Oral Healthcare. Each of the MCOs uses the same standard, though not required by the state plan. Periodic visits are covered every six months starting at first eruption.

The CMS review team has identified one finding and has nine recommendations for the State.

Regulatory Findings:

Section 42 CFR 438.206(b)(1) indicates that the State must ensure that each MCO "maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract." The State is responsible for overseeing the MCOs, and it is their responsibility to see that each MCO maintains a sufficient network. Further, the State must ensure that the MCOs maintain the required provider to patient ratio, not just in aggregate, but in all geographic areas of the State.

Recommendation:

The State must evaluate the dental provider networks in each MCO to ensure that adequate access exists for the provision of dental services to all Medicaid eligible children and if

necessary, explore additional avenues to reverse the trend of losing and/or terminating more providers than are being added.

Recommendations

1. The State or MCOs should provide a single, clear document that explains Medicaid dental benefits for children, such as information on the importance of preventative and routine dental care, and how they can get assistance in finding a dental provider.

2. The MCOs should send a dental specific reminder of the 6-month check up to beneficiaries similar to what is provided to the Georgia fee-for-service beneficiaries.

3. The State or the MCO should track and follow up on beneficiaries who have not received dental services in accordance with the periodicity schedule.

4. The State needs to guarantee that providers who treat Medicaid eligible children receive payment for the coverable services they provide.

5. The State and the MCOs should facilitate the sharing of information between the mobile dental units and the local providers in order to avoid non-payment for services provided by the local dentists.

6. The State should ensure that the online database is kept up to date, or have an alternative method for providers to use for verifying availability of services before providing them.

7. In addition to the list of available services, the State should explore making a patient history available to providers online.

8. The State should review its process for collecting data and find an independent way of verifying CMS 416 data.

Georgia EPSDT Dental Review
May 20-30, 2008

I. Background

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children to effectively use them. Dental services are included in the EPSDT program coverage and there is a great deal of national interest in the provision of dental services to children covered by Medicaid.

CMS has conducted on-site reviews of children's dental services in 16 states. The States reviewed were selected based on the dental utilization rates reported by States to CMS on the CMS-416 annual report for Federal Fiscal Year 2006, which is used to report EPSDT program information. These reviews were performed to determine what efforts States have made to address the rate of children's dental utilization in their State, and to make recommendations on additional actions States can take to increase these utilization rates and ensure compliance with Federal Medicaid regulations. Primarily, the States reviewed had less than a 30 percent dental utilization rate for children. Although Georgia's utilization rate was slightly higher, they were chosen for review based on a specific request from Congress.

In addition, Congress has requested that CMS collect information regarding dental service utilization and delivery systems from all states. While CMS has conducted a number of onsite dental reviews in some states, we are collecting more limited dental information by telephone from all states.

II. Scope of Review

The EPSDT program consists of two, mutually supportive, operational components:

- Assuring the availability and accessibility of required health care resources; and
- Helping Medicaid beneficiaries and their parents or guardians effectively use them.

The intent of this on-site review was to discuss and review with the appropriate State staff the policies and procedures being followed in fulfilling the requirements of the State's EPSDT program, with the focus on providing complete and comprehensive dental care to children. The review team gathered information to demonstrate how the EPSDT dental requirements were being implemented.

While in Georgia, the review team met with State officials as well as representatives from each of the State's three managed care organizations (MCOs); Wellcare, Amerigroup and Peach Care.

The review team spoke with 15 providers over a two week period. These providers represented urban, suburban and rural practices, large multi-provider practices and small single

provider practices and ranged from 10 percent Medicaid patients to nearly 100 percent Medicaid patients.

III. Introduction to Georgia Dental Services for Children

In FFY 2007, the State of Georgia had 1,069,682 EPSDT Medicaid recipients, 36 percent of whom received dental services. The prior year, there were 1,162,900 EPSDT recipients with 35 percent receiving dental services. Georgia phased in a managed care program state wide in 2006. The State provides Medicaid dental services primarily through three MCOs – Wellcare, Amerigroup and Peach State. Wellcare and Amerigroup operate statewide, while Peach Care is available in 61 counties in the State. Georgia Medicaid maintains a small number of fee-for-service recipients, primarily those in the medically needy group and those who are in state custody.

In FFY 2007, Wellcare reported having 608,248 recipients under the age of 21, of whom 154,794 (25 percent) received dental services from 2,315 providers for a total of $53,408,885.20 in claims. Amerigroup reported 271,310 recipients under 21, of whom 75,140 (28 percent) received dental services from 1964 providers totaling $24,768,984.75 in claims. During this time Peach State reported 368,665 recipients under the age of 21, of whom 97,214 (26 percent) received services from 1,756 providers for $24,209,933.68 in claims. These figures do include an unknown number of overlapping recipients.

The State pays a capitated rate to the MCOs for each recipient, but the MCOs pay providers on a fee-for-service basis. The MCOs indicated their payment structure would not be changing, but several providers indicated that they were contacted by the MCOs and questioned as to whether they would be willing to take a capitated rate in lieu of a fee-for-service payment (all providers we spoke with indicated that they would not continue to be Medicaid providers under those circumstances).

Both Wellcare and Amerigroup use Doral Dental to administer their dental program; Peach State uses Avesis as their dental benefits administrator.

IV. Review Description, Findings and Recommendations

Key Area I – Informing Families of EPSDT Dental Services

Section 5121 of the State Medicaid Manual provides the requirements for informing Medicaid beneficiaries of the EPSDT program, including dental services, in a timely manner. Based on section 1902(a)(43) of the Act, States are to assure there are effective methods to ensure that all eligible individuals and their families know what services are available under the EPSDT program; the benefits of preventive health care, where services are available, how to obtain them, and that necessary transportation and scheduling assistance is available. Regulations at 42 CFR 438.10 require the State, its contractor, or health plans to provide information to all enrollees about how and where to access Medicaid benefits that are not covered under the managed care contract. No methodology is mandated to states to determine the "effectiveness" of their methods, nor are States required to measure "effectiveness" of their informing

strategies. Informing is particularly important with respect to dental services since many families do not see dental services as a priority and may need additional information on these important services.

The State of Georgia uses enrollment broker Maximus to provide EPSDT education at the time the member enrolls. The information is generalized to all available Medicaid services in the member handbook, including dental. In addition to the information given to all Medicaid beneficiaries, fee-for-service Medicaid recipients receive a dental specific letter reminding them of their 6 month check-up. All three MCOs send out a general letter about benefits annually.

Materials are available in English and Spanish, and the AT&T Language assistance line is made available for limited English speakers.

Recommendation #1
The State or MCOs should provide a single, clear document that explains Medicaid dental benefits for children, such as information on the importance of preventative and routine dental care, and how they can get assistance in finding a dental provider.

Recommendation #2
The MCOs should send a dental specific reminder of the 6-month check up to beneficiaries similar to what is provided to the Georgia fee-for-service beneficiaries.

Recommendation #3
The State or the MCO should track and follow up on beneficiaries who have not received dental services in accordance with the periodicity schedule.

State Response: *DCH agrees that improvement can be made in the processes for informing members of their dental benefits and following up with those who miss appointments. We do not have any concerns with* ***Recommendations 1, 2, or 3*** *and will work with our CMO vendors to address the same. This may include developing a single Georgia Families (Medicaid) document that explains dental benefits and the importance of routine preventive care. In addition, we will work with CMOs to assure that reminders are sent twice a year and that follow-up occurs with those that miss periodic visits.*

Key Area II – Periodicity Schedules and Interperiodic Services

Section 5140 of the State Medicaid Manual provides the requirements for periodic dental services and indicates that distinct periodicity schedules must be established for each of these services. Subpart C refers to sections 1905(a)(4)(B) and 1905(r) of the Act require periodicity schedules to assure that at least a minimum number of examinations occur at critical points in a child's life.

Georgia has adopted the American Academy of Pediatric Dentists (AAPD) Recommendations for Preventive Pediatric Oral Healthcare. Each MCO uses the same standard, though this practice

is not required by the State plan. Periodic visits are covered every six months, starting at first eruption.

There are no recommendations in this area.

Key Area III – Access to Dental Services

Section 42 CFR 440.100 specifies that dental services are to be provided by, or under the supervision of, a dentist qualified under State law to furnish dental services. Section 5123.2.G of the State Medicaid Manual provides the requirements for dental service delivery and content in line with section 1905(r)(3)(A) of the Act. The State must provide, in accordance with reasonable standards of dental practice, dental services to eligible EPSDT beneficiaries who request them. The services are to be made available under a variety of arrangements, in either the private or public sector. States are to assure maximum utilization of available resources to optimize access to EPSDT dental services, with the greatest possible range and freedom of choice for the beneficiaries and encouraging families to develop permanent provider relationships. States may also utilize other oral health resources coverable under the Medicaid program.

Among the three MCOs in Georgia, none provided dental services to more than 28 percent of their population in FFY 2007. Amerigroup, which had 271,310 recipients during this period, reported that 28 percent of their recipients received services; Peach State, which had 368,665 recipients, reported a 26 percent dental utilization rate, while Wellcare, which had nearly as many as the other two plans combined at 608,248 recipients, reported only 25 percent of Medicaid eligible children received dental services during that period of time.

Despite the low participation rates, all three MCOs are losing or terminating providers. All three MCOs are terminating far more providers/provider locations than they are adding at a time when dental participation is already extremely low, including in areas that are already underserved. Between January 1 and June 11, 2008 all three MCOs lost more providers than they enrolled. For example, Peach State reported adding 14 providers during this period while losing 24. Further, of providers/locations listed in the FFY 2007 dental provider list, 69 were no longer active as of June 11, 2008.

Amerigroup reported gaining 29 providers between January 1 and June 11, 2008, and losing 54. Of the providers/locations on their FFY 2007 dental provider list, 266 were no longer active at the end of the period.

Of note was Wellcare's provider participation, serving the the largest Medicaid populations of the three MCOs. Despite having only 25 percent beneficiary utilization in FFY 2007, Wellcare was in the process of terminating their largest group provider, Kool Smiles, which has a presence throughout the State. Wellcare reported adding 33 providers during the period of January 1 – June 11, 2008, and losing 40 providers. But its list of providers/locations indicated a loss of 341 providers, and did not include 155 additional Kool Smiles providers/locations that were scheduled to be terminated as of July 1, 2008.

Wellcare maintains that they have sufficient providers, despite having terminated Kool Smiles which served Medicaid children throughout the state. Wellcare did not discuss with the reviewers its rationale for terminating Kool Smiles from its provider network, raising the possibility that termination was a result of Wellcare's dissatisfaction with provider service. Termination under these circumstances increases the possibility that Amerigroup (using the same provider group through Doral), Peach State, Georgia's FFS dental program, and the State's SCHIP plan Peach Care, should likewise examine their working relationships with Kool Smiles.

With dental utilization currently below 30 percent in the State, there is concern of the effect that the loss or termination of providers and provider locations may have on Medicaid eligible children. Table 1 describes the number of EPSDT beneficiaries who accessed care through Wellcare in FFY 2007 in several large counties in the Atlanta Metro area, as well as Columbus, Georgia, and the percent of those beneficiaries who were seen by providers who are no longer in their network as of July 1, 2008.

Table 1

County	**FFY 2007 Dental Utilization**	**Percent of recipients who received dental services in FFY 2007 from a provider no longer in the Wellcare Provider Network as of 7/1/2008**
Fulton	28%	22%
Gwinnett	27%	39%
DeKalb	27%	52%
Clayton	23%	55%
Cobb	26%	59%
Muscogee	28%	70%

Eligibility System Issues

Some providers interviewed indicated that they were told to use the State's eligibility system to confirm the Medicaid status of their patients. Almost all of these providers indicated that the MCOs updated their eligibility roles late in the month, and routinely rejected services as "not eligible", even though the State's eligibility system showed the recipient as an active Medicaid beneficiary. These providers indicated that later in the month after the MCOs updated their system, when they resubmitted for payment, the MCOs continued to reject the claim as "not eligible."

Finding #1

Section 42 CFR 438.206(b)(1) states that the State must ensure that each MCO "maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract." The State is responsible for overseeing the MCOs, and it is their responsibility to see that each MCO maintains a sufficient network. With participation below 30 percent, MCOs should carefully

weigh whether or not to terminate a provider. Further, the State must ensure that the MCOs maintain the required provider to patient ratio, not just in aggregate, but in all geographic areas of the State**.**

Recommendation #4
The State must evaluate the dental provider networks in each MCO to ensure that adequate access exists for the provision of dental services to all Medicaid eligible children and if necessary, explore additional avenues to reverse the trend of losing and/or terminating more providers than are being added.

State Response: *We disagree with* ***Finding #1*** *and believe that we do have adequate monitoring of the CMO provider networks. First, DCH has not established a specific member to provider ratio in its CMO contracts (as referenced in the finding) nor do we find that the CFR specifically requires this. DCH does currently evaluate the adequacy of the CMO provider networks through a review of geo-access reports, provider listings, termination reports, recruitment reports, participation denial reports, provider count reports, appointment wait time reports, and secret shopper calls to providers in areas that have a small number of network providers. The secret shopper calls are used to validate that the dentists listed on the CMO rosters are continuing to take new patients, and that they are able to offer appointment times within the contractual standard of 30 days. To date, DCH has not identified areas of network insufficiency.*

Additionally, the report raises concerns regarding the loss of network providers and notes that all three CMOs are losing more providers/provider location than they are adding. The report notes that during the calendar year 2008 Peach State had a net loss of 10 providers, and Amerigroup had a net loss of 25 providers, while indicating that Wellcare lost 341 providers not counting 155 Kool Smiles providers slated for termination in July 2008. The net loss of Peach State and Amerigroup providers reflects a small percentage of their entire network (1% of the Peach State network and 2% of the Amerigroup network). While not insignificant, Wellcare reports that the list of terminations reflected provider numbers terminated due to changes in location, tax id number, etc. and that the true number of provider terminations for calendar year 2008 was 97.

Regardless, we will continue to evaluate regional network adequacy and work with the CMOs to add dental providers as necessary.

Additionally, recent legislation (HB 1234) prohibits a CMO from closing their panels to a provider that meets their credentialing criteria if: 1) the provider is under a loan forgiveness program; or 2) the provider is practicing in a dental shortage area, as defined by HRSA; or 3) the CMO has failed to demonstrate that they have adequate access for their membership in that area. DCH has required modifications to CMO policies to comply with this law and will monitor the CMO credentialing and contracting process to assure compliance.

Recommendation #5
The State needs to guarantee that providers who treat Medicaid eligible children receive payment for the coverable services they provide. Many providers described to the reviewers their

struggles with getting paid accurately and timely for dental care provided to Medicaid eligible children.

State Response: *The current DCH contract requires CMOs to provide timely payment to all providers for covered services within 15 days. In addition recent state legislation (HB 1234) contained provisions that impact the reported issues with eligibility documentation and with allowing providers into the CMO networks. HB 1234 essentially states that neither a CMO nor DCH can refuse to pay a provider (or recoup funds) if the provider verifies eligibility through the DCH web portal within 72 hours of the date of service, even if this information is later found to be incorrect. DCH has required that the CMOs modify their policies and claim processing procedures to comply with this law and will monitor to assure compliance.*

In addition, a review of claim processing activity of the CMOs indicates that:

- *The overall average time for processing a claim is 9 days.*
- *Currently the CMOs are adjudicating over 98% of claims within 14 calendar days, as required by DCH contract and state law.*
    - *For those 2% of claims that exceed 14 days for payment, the CMOs are required to pay 18% interest for each additional day that payment is delayed.*
- *Of the claims received, over 90% of the billed services are paid and approximately 7-10% is denied.*
- *Some of the primary reasons for a claim or service to be denied include:*
    1. *The service is performed for a patient who is at an age where the service is not covered*
    2. *A duplicate claim is filed*
    3. *The requested service is not covered*
    4. *The service exceeds the maximum allowed*
    5. *The patient is not eligible at the time the service is rendered*

As noted above, denials for eligibility, when the eligibility information was incorrectly posted by DCH, will be paid per HB 1234. Therefore we do not believe that further action is required related to ***Recommendation #5****.*

Key Area IV – Diagnosis and Treatment Services

Children under the age of 21 may receive additional benefits under EPSDT when determined to be medically necessary by the State. Sections 5122(E) and (F), as well as section 5124 of the State Medicaid Manual stipulates that follow-up diagnostic and treatment services within the scope defined by sections 1905 (a) and (r) of the Act are to be provided when indicated. Diagnostic services must fully evaluate the dental condition that was identified, while treatment services must ensure health care is provided to treat or ameliorate the dental condition. These services are limited by what is coverable under section 1905(a) of the Act but may not be limited to services included in the State's Medicaid Plan.

While some providers indicated the past presence of problems securing authorization for needed services and lifetime maximums on services such as root canals, all but one indicated significant

improvement. Providers interviewed for this review stated that authorization is received within 2-3 weeks (response time depending upon electronic or mailed submission), but that rejections were generally determined in less time.

There are no recommendations in this area.

Key Area V – Support Services

Section 5150 of the State Medicaid Manual indicates that the State is required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and necessary, assistance with scheduling appointments and non-emergency transportation. This includes the requirement of 42 CFR 431.53 mandating transportation assistance.

Each MCO provides scheduling assistance upon request. Provider manuals list a phone number which recipients can call for assistance in scheduling appointments.

The State uses brokers for non-emergency transportation. While there were some anecdotal complaints of problems, they do not seem to be widespread or endemic. Some providers observed patients waiting several hours for transportation, but that it was not always the case. In the more rural areas, providers seemed less familiar with State transportation and indicated that their patients seemed to arrange their own transportation. There is no way to know if this was because the transportation in those areas of the State was unreliable, or it was just patient's preference to arrange for his/her own transportation.

There are no recommendations in this area.

Key Area VI – Coordination of Care

Regulations found at 42 CFR 438.208 require the coordination of health care services for all managed care enrollees. Section 5240 of the State Medicaid Manual describes the use of continuing care providers which encourages coordination of care. Coordination between a primary provider and a dental provider does not generally occur. However since it is usually the responsibility of the primary provider to make an initial dental referral, information should be available as to how and when that referral is made. Coordination may be particularly important for special needs children who may be receiving medications and treatments that may affect their oral health.

Although the medically needy population covered through the fee-for-service program has some case management, there seems to be little coordination of care through the MCOs for their recipients. All coordination of care is left to the individual doctors and dentists.

There are two mobile dental units in Georgia - one public and one private. These units bring screenings and treatment to children, usually in conjunction with schools, in underserved rural areas of the State. In some cases, however, children who have received services from the mobile units, i.e. x-rays or fillings, need follow-up treatment before the unit returns to the their

community. If a child who has been seen at a mobile dental unit site goes to a local dentist for such treatment, services such as x-rays and initial exam are often rejected because too short of a period of time has elapsed since those services were last provided to that child. Providers report that it is nearly impossible to get copies of x-rays or records in a timely manner from the mobile providers, the State or the MCOs.

The State provides a website for providers that captures MCO dental service utilization. The website tracks which dental services a beneficiary has obtained within a certain periodicity, for example over 6 months, and what routine services that beneficiary is still entitled to. Unfortunately, the providers interviewed for this review did not believe the website was kept current. For example, one provider showed the reviewer an Explanation of Benefits dated two weeks prior to the review with a number of services (such as x-rays and cleanings) for different recipients being rejected as over the annual/semi-annual maximum. The provider then brought up the State's website and showed the reviewer that the services were still (two weeks after the rejection) being displayed as available, and the maximum not met. More than one provider made similar claims.

Recommendation #6
The State and the MCOs should facilitate the sharing of information between the mobile dental units and the local providers in order to avoid non-payment for services provided by the local dentists.

State Response: *We agree that coordination of care between providers is important and that there are particular challenges in addressing this with the use of mobile dental providers. We will work with the CMOs to identify ways of improving the coordination of care.*

Recommendation #7
The State should ensure that the online database is kept up to date, or have an alternative method for providers to use for verifying availability of services before providing them. Providers should not be made to write off the cost of services based on the State's mistake. If the error is with the MCOs not providing up to date information, it is still the State's responsibility to correct.

State Response: *The DCH and each of the three CMOs currently have the capability for providers to look up the recent services provided to a member, or the number of services remaining under a particular benefit. However, these systems will only indicate a service has been provided once a claim has been filed. With 180 days to file a claim, it is possible that a provider may not see a dental check up listed when they provide a service, if the initial dental provider has not yet filed the claim. This problem is not unique to Georgia's managed care program, thus improved tracking can reduce these occurrences; however we will continue to find opportunities for improvement.*

CMS Response: The example sited above involved claims that had already been filed, rejected, and an EOB issued stating that the services were over the annual maximum – and yet those services still were not showing up on the system as having been utilized for that year.

Recommendation #8
In addition to the list of available services, the State should explore making a patient history available to providers online. This could help with coordination of dental care, especially since recipients are not required to have a "dental home."

State Response: *DCH will work toward developing the capacity to report patient history via a single tracking system. The capability for a unified display of services should be available when DCH implements a new MMIS in July 2010.*

Key Area VII – Data Collection, Analysis and Reporting

Part 2 of the SMM, section 2700.4, delineates the EPSDT reporting requirements, including the annual CMS-416 report requiring the State to report ***the number of children receiving dental services****. The CMS 416 includes three separate lines of data including: the number of children receiving any dental service, the number of children receiving a preventive dental service and the number of children receiving a dental treatment service. The services are defined using the CDT codes. The CMS-416 report is to be submitted no later than April 1 after the end of the federal fiscal year. The Centers for Medicare and Medicaid services uses this report to monitor each State's progress in the provision of improving access to dental services.*

In addition to consulting Georgia's 2007 CMS 416 report, the team reviewed other data sets to compile this report; the team found variation in the utilization data among the reports. As part of the review, an ad hoc report from each MCO was run with the number of recipients per county (supplied by the State) and the unduplicated number of recipients who received services in FFY 2007. The participation rate from this report for FFY 2007 would be 26 percent. It seems unlikely that the small number of fee for service recipients could account for the difference between that rate and the 36 percent participation rate reported on Georgia's FFY 2007 CMS 416 report.

Recommendation #9
The State should review the process for collecting data and find an independent way of verifying CMS 416 data.

State Response: *We believe that the participation rates calculated by the reviewers were not valid and thus disagree with the conclusions drawn that led to this recommendation, which also affects* ***Regulatory Finding #1*** *regarding network adequacy.*

The data requested by the reviewers cannot be used to calculate the rates reported in the report. The reviewers requested that each CMO produce a report that indicated the number of unique members by county that received a dental service. Because the report was grouped by county and by CMO, there was the potential to duplicate members that lived in more than one county

during the reporting year, or who were enrolled in more than one CMO during the reporting year. In addition, members that were enrolled in both FFS and a CMO during the reporting year could have received a dental service while enrolled in FFS that would not be accounted for in the data requested by the reviewers. This had the effect of decreasing the numerators and increasing the denominators and thus incorrectly calculating the participation rates.

*The Department of Community Health (DCH) requested that Thomson Reuters (the vendor that produced the FFY 2006 and 2007 416 reports) calculate the dental participation rates for each CMO, using the same data and methodology used for the 416 report. Based on their calculations, 34% of the members enrolled in managed care received at least one dental service; 34% in Amerigroup, 32% in Peach State, and 31% in Wellcare. Thus the differences between the two reports do not indicate a need for independent validation of the 416 results (**Recommendation #9)**, but rather are indicative of the different methodologies for the reports and the duplication of members in the denominator of the ad-hoc reports requested by the reviewers. We request that you substitute these number in your report for those calculate by the reviewers based upon ad hoc data requested by the CMOs.*

In addition we would also like to point out that the methodology utilized by the 416 report for participation includes every recipient that was eligible for even one month during the reporting period. This tends to underestimate the percentage of members that receive an annual dental visit, as it includes members that have not been enrolled for an entire 12 month period. As a point of comparison, using HEDIS methodology which looks at those members that have been enrolled for a twelve month period, the Georgia CMO data indicates that 58% to 63% of members enrolled for 12 months received at least one annual dental visit. This compares favorably with HEDIS national Medicaid data. For 2007 the mean for the annual dental visit measure was 42.5% with the 90th percentile at 57.3%.

CMS Response: The use of ad hoc reports, received from DCH and the CMOs, is represented as a review tool and is not meant to be substituted for the CMS 416 data. Those factors mentioned were taken into account, however even considering those factors the large difference between the different sets of data raised concerns. Additionally, the State's response does not give a complete mathematical support for the data reported on Georgia's FFY 2007 CMS 416 report.

V. Conclusion

Georgia's State Medicaid agency has examined access to oral health. In addition to the CMS report finding requiring corrective action, the CMS review team acknowledged the State's accomplishments and provided additional recommendations for the State to consider. Of concern is that all the MCOs are losing providers at a greater rate than they are adding them. Further, providers interviewed discussed being forced to write off services they have performed, either because recipients who are eligible for Medicaid are not recognized as such by their MCO or because of erroneous information given to providers about what services have previously been provided and when. It is important that the State work with their MCOs in communicating dental benefits to their recipients, following-up with recipients who have not received dental

services, and working to both expand their existing provider networks and pay for services provided by dental providers in good faith. The State must assert its MCO oversight role to ensure that recipients have adequate access to dental care.

State's Response: *DCH agrees that there are opportunities for improving access to and the delivery of preventive dental care in Georgia. Specifically we intend to take steps to improve outreach efforts to assure that recipients are aware of their dental benefits and the importance of regular preventive visits.*

We will work with our CMOs to assure that recipients are adequately informed and that there is outreach toward individuals that miss periodic visits. Additionally we will work with our CMOs to improve the coordination of care between practitioners and develop better mechanisms for communication where services are provided by mobile dental vans.

However, DCH disagrees with the methodology used to calculate the rates of dental utilization and we believe rates included in the report do not reflect our actual experience. We confident in our processes for monitoring CMO dental networks and will continue to be vigilant to assure their adequacy.