Georgia Department of Audits and Accounts
Performance Audit Division
Greg S. Griffin, State Auditor
Leslie McGuire, Director

Why we did this review

Studies show that declining utilization of dental services, especially preventive care, may lead to increasing negative health outcomes for Medicaid children and ultimately higher health care costs. These include direct outcomes associated with tooth decay, as well as indirect outcomes associated with longer-term health problems such as heart disease, stroke, and obesity. Unlike other states, Georgia limits Medicaid coverage for adult members to emergency services and does not include routine care. Inadequate dental coverage increases members' risk for dental disease and the need for emergency services.

This audit examines the Fee-For-Service Medicaid Dental Program within the Georgia Department of Community Health (DCH).

About Medicaid Dental

Federal law requires that state Medicaid programs provide all children (members under 21 years of age) with full dental benefits. Such benefits include restorative, preventive, and emergency treatments.

Although federal law does not require state Medicaid programs to provide dental coverage to adults, the Georgia Medicaid program provides adults (members 21 years of age and older) with emergency-level coverage through the Adult Dental Program. This coverage includes pain mitigation as well as extractions but does not cover preventive treatments.

Medicaid Dental

Coordinated management needed to ensure oral health care is being delivered

What we found

While multiple units have responsibilities related to the Medicaid Dental Program, the Department of Community Health (DCH) lacks the coordinated, data-driven management approach recommended by the federal Centers for Medicare and Medicaid Services (CMS). As a result, the agency was unaware of declining utilization among children in its Fee-For-Service Program and has not sufficiently assessed the capacity of its provider network.

DCH does not analyze dental claims or provider networks to ensure adequate dental services are delivered.

CMS recommends the coordination of data analytics, planning, and monitoring when managing dental programs. This begins with an analysis of claims to evaluate the services provided and to identify differences between subpopulations and geographic areas. Reasons for the variations should be explored, including the potential for insufficient provider networks. Finally, strategies to address deficiencies should be implemented and monitored.

We found that DCH does not routinely analyze claims for the purposes above and, as a result, was unaware of declines in dental utilization among Fee-For-Service children. Without an analysis of claims, the agency is unaware of potential service gaps and trends, and it cannot develop informed strategies to improve dental care.

Provider networks meet federal standards but may not provide sufficient access to dental services.

CMS requires that states ensure that members have access to at least one in-network dental provider within 30 miles if residing in an urban area and within 45 miles if in a rural area. While Fee-For-

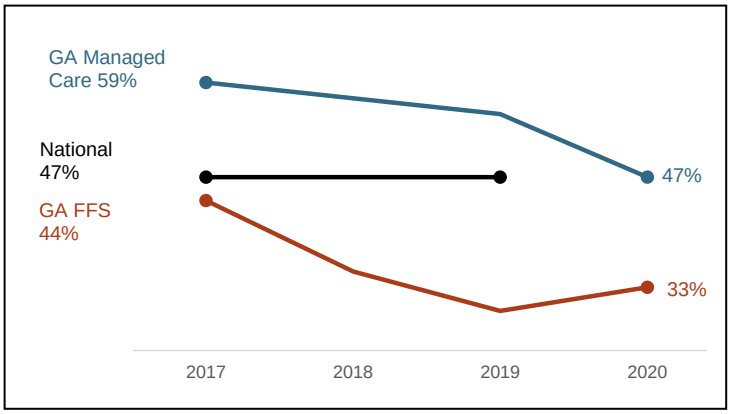
Service provider networks meet these standards, they do not meet the stricter standards that DCH requires of its care management organizations (CMOs). CMOs must also report the number of providers accepting new patients and the number actively participating in Medicaid.

When these criteria are applied to the Fee-For-Service provider network, members' access to care looks much more limited. Less than a quarter of providers accepted new patients in the last year, and less than one-fifth filed a claim indicating active participation. Nearly 30 counties have no providers accepting new patients.

We noted that Medicaid reimbursement rates for the Fee-For-Service population are lower than rates paid by the state's flexible benefit program providers. The rates may contribute to network issues for the Fee-For-Service population given the higher cost for providers to treat some children with physical or developmental disabilities.

Fee-for-service children are less likely to receive dental services than those in managed care or in many other states.

The percentage of children in Fee-For-Service who receive dental services has trailed the national average and Georgia managed care children during the last four years.



Georgia is one of 16 states that provides only emergency dental services for adults.

CMS requires that states provide children with comprehensive dental care, including cleanings, x-rays, fillings, and other services; however, states have greater flexibility when designing coverage for adults. While many states provide less coverage for their adult populations, Georgia is one of just 16 that limits coverage to emergency services such as pain relief and tooth removal.

Most states provide adults with preventive and diagnostic care, which can reduce hospital emergency room visits, improve healthcare, and increase employability of those with significant dental issues. Between fiscal years 2017 and 2020, Georgia spent nearly $7.8 million in Fee-For-Service hospital claims for dental diagnoses.

What we recommend

We recommend that DCH set goals for dental service utilization, review claims to assess utilization, and assess the reasons for any expectation gaps. DCH should also analyze the sufficiency of its provider network, considering more detailed geographic analyses and whether network providers are accepting new patients and remain active. We also recommend strategies that may increase the number of providers. Finally, we recommend that the General Assembly consider providing adult members access to preventive and diagnostic dental care with annual caps or co-payments.

See Appendix A for a detailed listing of recommendations.

Agency Response: *DCH generally agreed with the Findings and Recommendations and plans to start implementing recommendations by November.*

Table of Contents

Purpose of the Audit

This audit examines the Fee-For-Service Medicaid Dental Program within the Georgia Department of Community Health (DCH). Specifically, the audit examines the extent to which

1. DCH manages and monitors the Fee-For-Service Medicaid Dental Program to ensure adequate utilization and access;
2. Fee-For-Service Medicaid members utilize dental services; and
3. Limiting dental care to emergency services for the adult population adversely impacts the adult Fee-For-Service population.

A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to DCH, and pertinent responses were incorporated into the report.

Background

The Georgia Department of Community Health (DCH) serves as the single state agency to administer the Medicaid and PeachCare for Kids (PeachCare) programs, which are described below. During fiscal year 2019, DCH expended approximately $10.6 billion to provide access to health care and related services for more than 2.1 million individuals through the Medicaid and PeachCare programs.

- Medicaid is a joint federal and state program that provides free health coverage to low-income families and children, pregnant women, the elderly, and people with disabilities. DCH administers Medicaid under Title XIX of the Social Security Act.
- PeachCare is Georgia's Children's Health Insurance Program, which provides low-cost health coverage to uninsured children in families that earn too much income to qualify for Medicaid. To qualify for PeachCare, family income must be less than or equal to 235% of the federal poverty level.

Medicaid and PeachCare members are insured directly from DCH through the Fee-For-Service Program or through one of four managed care organizations—known as Care Management Organizations (CMOs)—contracted by DCH to provide services.

Fee-For-Service

Under the Fee-For-Service program, DCH pays providers directly for each covered service a Medicaid beneficiary receives. DCH also enrolls providers to participate in the Medicaid program and ensures beneficiaries statewide have access to care. DCH is responsible for setting provider payment rates, which federal law (Section 1902 (a)(30)(A) of the Social Security Act) requires to be consistent with efficiency, economy, and quality of care and sufficient to provide access equivalent to the general non-Medicaid population.

Georgia's Fee-For-Service program serves persons who are:

- aging, blind, and/or disabled,
- in long-term care facilities, or
- in nursing homes.

Managed Care

Effective June 1, 2006, the state of Georgia implemented Georgia Families®, a statewide managed care program through which health care services are delivered to certain members of Medicaid and PeachCare. Under managed care, Georgia pays a monthly fee to a CMO for each enrolled beneficiary. The CMO manages and finances the beneficiaries' health care, develops provider networks, and monitors the providers' compliance with Medicaid laws, rules, and regulations.

All PeachCare members and the following Medicaid populations are served through Georgia Families®:

- Parent/Caretaker with Children Medicaid (formerly known as Low Income Medicaid);
- Transitional Medicaid;
- Pregnant Women with Children Under 19;
- Newborns;
- Women Eligible Due to Breast and Cervical Cancer; and
- Children, Youth, and Young Adults in Foster Care, Adoption Assistance and Juvenile Justice System.

Georgia Families® members may enroll in the CMO of their choice. DCH contracts with the following three CMOs to manage health care benefits and pay providers for services to Georgia Families® members:

- Amerigroup;
- CareSource; and
- Peach State Health Plan.

The CMOs are responsible and accept full financial risk for providing and authorizing covered services. CMOs contract with and pay dentists, doctors, hospitals, and other care providers to establish a network that provides health care services for plan participants. DCH contracts with an independent actuarial firm to determine per-member monthly premium rates, referred to as capitation payments, that the state pays each CMO. Capitation rates are based on CMO-reported data and costs.

Medicaid Dental Program

Federal law (42 C.F.R. § 441.56) requires that state Medicaid programs provide all children (under 21 years of age) with full dental benefits. Such benefits include restorative, preventive, and emergency treatments. Children enrolled in the Fee-For-Service program and managed care receive dental coverage through the Health Check Dental Program. This program provides extensive dental coverage, including preventive care (cleanings, sealants, fluoride treatments), diagnostic care (comprehensive evaluations, radiographic imaging), and treatment (fillings, bonding, dental prosthetics).

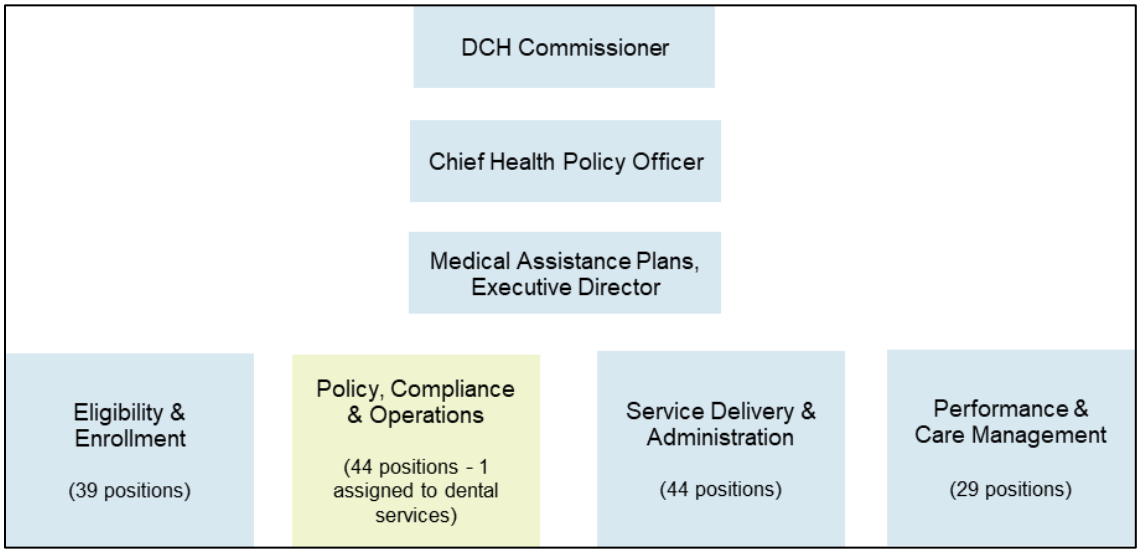
Although federal law does not require state Medicaid programs to provide dental coverage to adults, the Georgia Medicaid program provides adults (members 21 years of age and older) enrolled through the Fee-For-Service Program and managed care with emergency-level coverage through the Adult Dental Program. This coverage

includes pain mitigation as well as extractions but does not cover restorative or preventive treatments. Emergency dental services are typically provided in dental offices. However, some emergency services such as pain relief may also be provided in hospital emergency rooms.

As shown in **Exhibit 1**, DCH's Medical Assistance Plans Division has four offices that support the management of the dental program; however, only one office (Policy, Compliance & Operations) has a position that is specifically assigned dental program responsibilities. Each division is described below.

- The Policy Compliance & Operations Office updates Medicaid policy manuals and the State Medicaid Plan to ensure compliance with federal and state laws and regulations. One Program Specialist is responsible for maintaining and updating the Dental Program Policy Manual.
- The Eligibility & Enrollment Office manages the provider enrollment and recredentialing process.
- The Service Delivery & Administration Office sets performance standards (including those associated with dental services) in CMO contracts and monitors CMO performance.
- The Performance & Care Management Office oversees Medicaid quality initiatives, including DCH's Quality Improvement Plan for managed care.

Exhibit 1
Division of Medical Assistance Plans Organizational Chart, May 2020

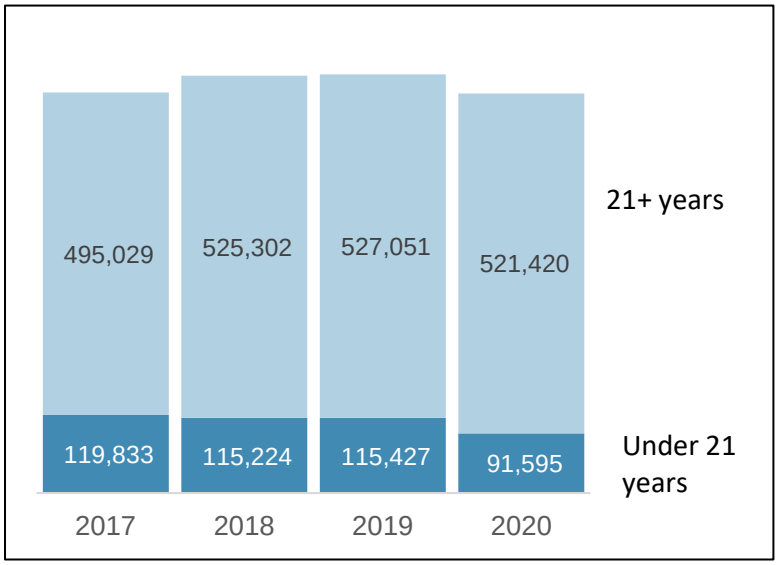


Source: DCH

Fee-For-Service Dental

As shown in **Exhibit 2**, Medicaid Fee-For-Service had approximately 613,000 members in fiscal year 2020. Most members are adults (21 years of age and older), which have on average comprised approximately 82% of total membership since fiscal year 2017. Adult membership increased by approximately 5% since fiscal year 2017—from approximately 495,000 members to 521,000. By contrast, membership for individuals under 21 years of age has decreased by approximately 24%—from nearly 120,000 in fiscal year 2017 to nearly 92,000 in fiscal year 2020.

Exhibit 2
Fee-For-Service Membership Increased 5% for Individuals 21 Years and Older and Decreased 24% for Individuals Under 21 Years, FY 2017-2020



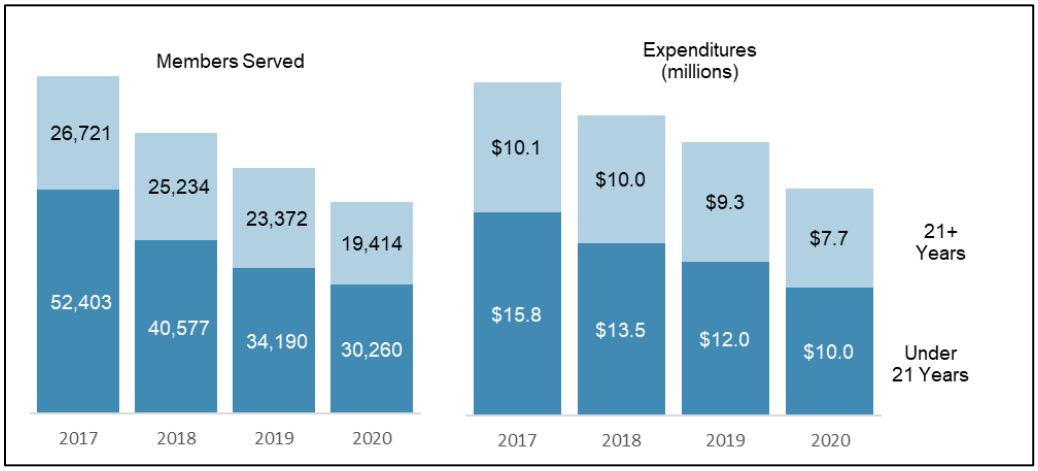
Source: DCH

While total enrollment in Medicaid Fee-For-Service has decreased by less than 1% since fiscal year 2017, annual participation in the Fee-For-Service Dental Program has declined by approximately 37%. As shown in **Exhibit 3,** approximately 50,000 members received at least one dental service in fiscal year 2020, compared to approximately 79,000 in fiscal year 2017. As a result, Dental Program expenditures have also declined by approximately 32%—from $26.0 million to $17.7 million.[1] More than half the expenditures (58% or $51.3 million) and participating members (62% or 157,430) were for members under 21 years of age even though this age group comprises on average only 18% of Fee-For-Service membership.

As previously explained, Georgia provides extensive dental benefits for members under 21 years of age and only emergency-level benefits for members 21 years and older.

[1] Dental services expenditures in both programs (Fee-For-Service and managed care) declined in fiscal year 2020. This is likely due to the effects of Covid-19 related quarantines.

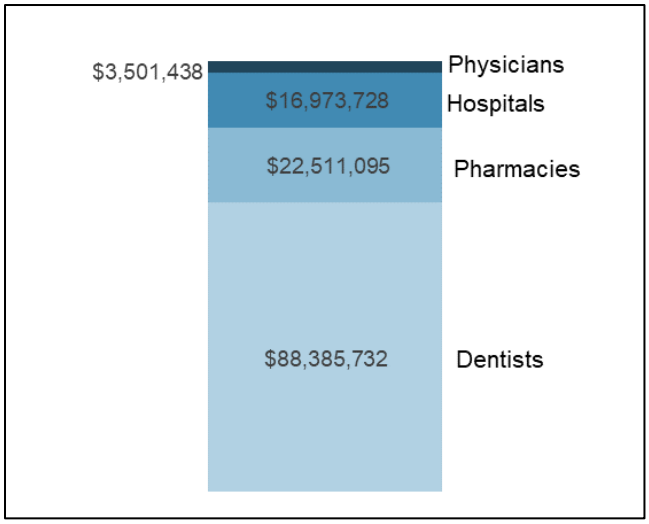
Exhibit 3
Dental Program Participation and Expenditures Have Declined, FY 2017-2020



Source: Georgia Medicaid Management Information System

While the majority of dental program expenditures are paid to dentists, Medicaid members may also receive dental services from providers enrolled in other service categories of service. For example, members may obtain care for dental-related diagnoses such as tooth infections in a physician's office or at a hospital emergency room. As shown in **Exhibit 4**, the Fee-For-Service program paid these providers $42.9 million for dental-related services during fiscal years 2017 through 2020—an additional 48.6% to the $88.4 million paid to dental providers.

Exhibit 4
Fee-For-Service Payments to Physicians, Hospitals, and Pharmacies for Dental-Related Services Increased Expenditures by 49%, FY 2017-2020



Source: Georgia Medicaid Management Information System

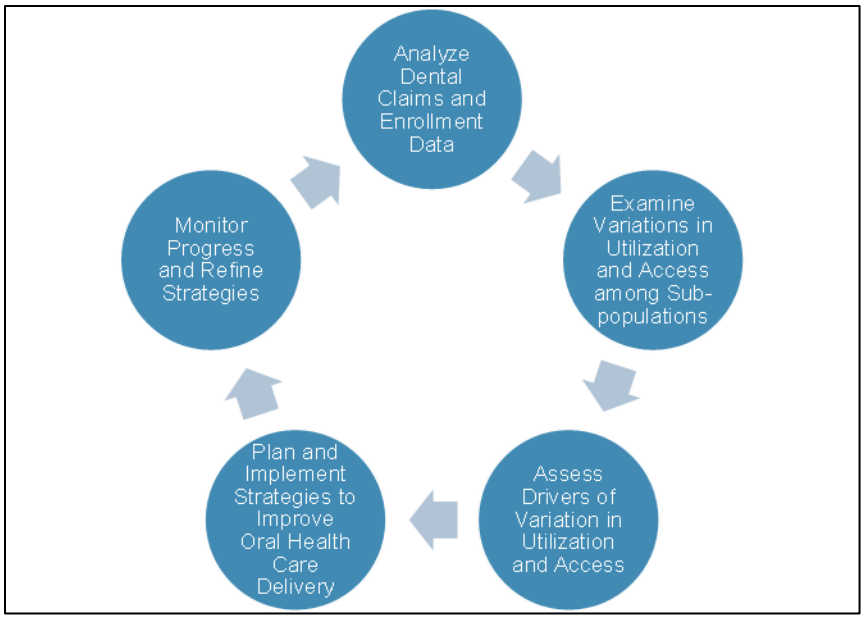
Findings and Recommendations

Finding 1: There is no coordinated management of the Medicaid Dental Program.

Multiple DCH units are involved in managing the Dental Program; however, none has assessed utilization rates and provider network capacity for the Fee-For-Service population. Additionally, DCH has not analyzed claims records or provider enrollment data to track trends. As a result, DCH was unaware of declining trends in utilization among Fee-For-Service children and had not sufficiently assessed provider network capacity.

The federal Centers for Medicare and Medicaid Services (CMS) recommends states adopt a coordinated data-driven approach to managing their Medicaid Dental programs. As shown in **Exhibit 5**, CMS recommends that states follow five basic steps to assess Medicaid Dental program performance and to plan and implement improvements. According to CMS, this process requires coordination among staff familiar with the Medicaid population and the structure of the Dental Program, as well as staff with data analytics experience.

Exhibit 5
Effective Program Management Includes Coordination of Data Analytics, Planning, and Monitoring Activities



Source: CMS

As described in the background, DCH has multiple units that manage various aspects of the Medicaid Dental Program. This includes units that maintain and update the dental program's policies and procedures, that monitor CMO performance in providing dental services to managed care members, that recruit and enroll dental providers, and that oversee various quality initiative across Medicaid programs.

Despite the multiple units assigned to the Dental Program, we found that DCH has not sufficiently implemented the coordinated, data-driven program management activities recommended by CMS. As discussed in subsequent findings, we identified

utilization and access gaps that DCH was unaware of and thus had not acted to improve. This reduces DCH's effectiveness in ensuring its Fee-For-Service members (both children and adults) receive needed dental care.

RECOMMENDATION

1. DCH should assign staff to implement a coordinated, data driven approach to managing the Medicaid Dental Program.

Agency Response: *DCH agrees with the recommendation. The Medical Assistance Plans Division has developed an internal process which involves the collaboration and coordination with multiple DCH Units. DCH reports that it plans on analyzing utilization rates to identify any trends, gaps, or variations. Standard quarterly reporting utilization metrics will be developed and monitored. The Units will meet quarterly to review the utilization metrics with the first quarterly meeting on or before November 1, 2021.*

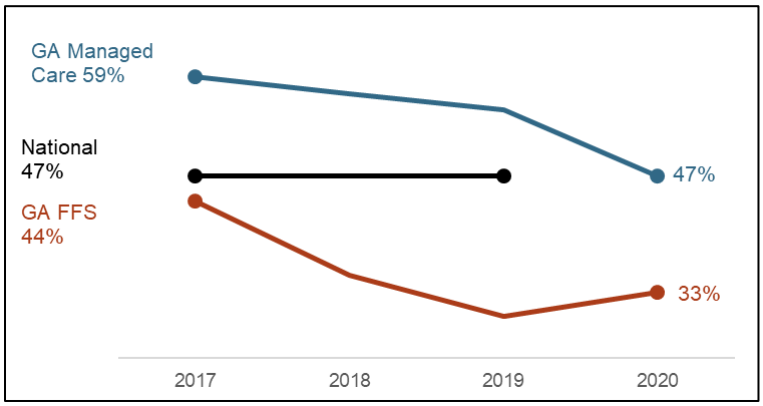
Finding 2: The rate at which Fee-For-Service children utilize dental services is decreasing and is lower than rates for managed care and other states.

The percent of Fee-For-Service children receiving dental care in Georgia decreased from 44% to 33% between fiscal years 2017 and 2020. Fee-for-service rates have been lower than rates among Georgia's managed care children, as well as rates in other states. DCH does not monitor dental program utilization or expenditures; as such, it was unaware of declining rates and had not investigated reasons for lower utilization.

Federal law (42 C.F.R. § 441.56) requires state Medicaid programs to provide all members under 21 years of age (known as "children") with full dental benefits. According to the law, these benefits should include preventive care (cleanings, fluoride treatments), diagnostic care (comprehensive evaluations, radiographic imaging), and treatment (fillings, sealants, bonding, dental prosthetics).

In fiscal year 2020, approximately 30,300 children in Georgia's Fee-For-Service Medicaid had received dental services, 42% lower than the 52,000 served in fiscal year 2017. While DCH staff initially speculated this is due to decreased membership overall (total membership decreased by 24% from 119,800 to 91,600), the proportion of members receiving services also decreased from 44% to 33%, as shown in **Exhibit 6**.

Exhibit 6
Fee-For-Service utilization rates have declined and are consistently lower than managed care rates, as well as the national average



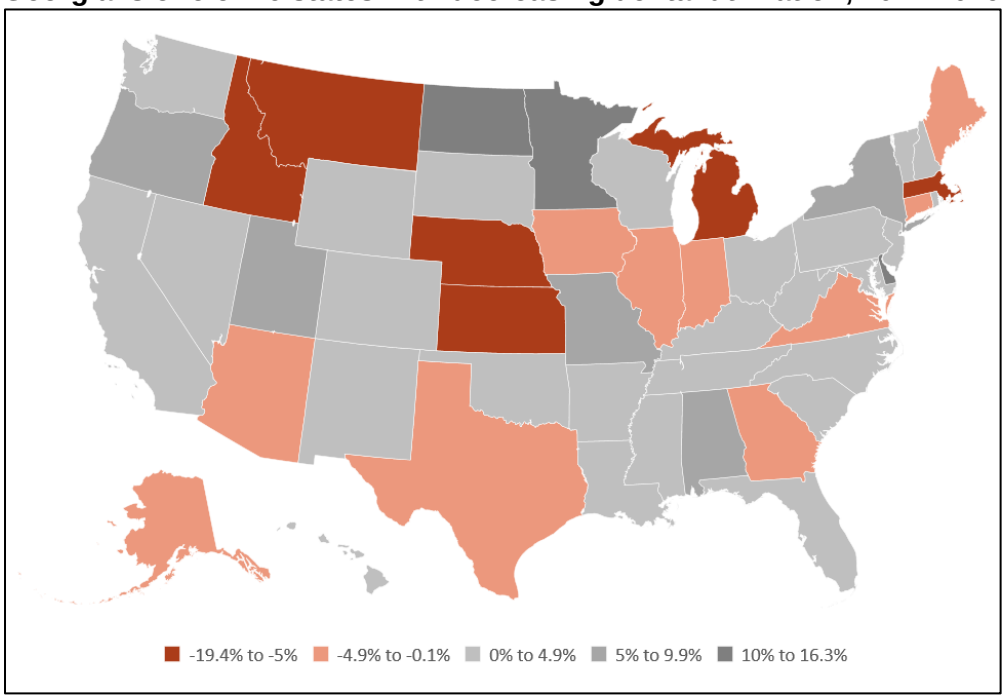
Source: DCH data, CMS

DCH has not determined what percent of Fee-For-Service members should be obtaining dental care; however, rates have been consistently lower than those of Georgia's managed care member children. In 2017, for example, 59% of managed care children (744,000 of 1.26 million) received dental services, compared to 44% of Fee-For-Service children. In the following three years, utilization declined for both populations, though the 47% rate under managed care still exceeds the 33% Fee-For-Service rate.[2] The differences are likely due to the populations served—while managed care children typically qualify because they are low-income, Fee-For-Service children are typically disabled, and literature suggests there is an insufficient supply of dental providers able to serve their unique needs.

As shown in **Exhibit 6**, Fee-For-Service utilization in Georgia is also lower than the national average for all Medicaid children (Fee-For-Service and managed care). Between 2017 and 2019, the national average has remained steady at 47%, compared to Georgia Fee-For-Service rate decline from 44% to 33%. As shown in **Exhibit 7**, Georgia is among the minority of states (16) with declining dental utilization among all Medicaid children.

[2] The COVID-19 pandemic likely reduced 2020 dental services utilization rates.

Exhibit 7
Georgia is one of 16 states with decreasing dental utilization, 2017-2019



Source: CMS data

Studies show that declining utilization of dental services, especially preventive care, may lead to increasing negative health outcomes for Medicaid children and ultimately higher health care costs. These include direct outcomes associated with tooth decay, as well as indirect outcomes associated with longer-term health problems such as heart disease, stroke, and obesity.

As previously mentioned, DCH has not set a goal for dental utilization or monitored trends over time. In addition, DCH was unaware of the lower rates and thus had not investigated potential reasons for the decline. As discussed in subsequent findings, these may include inadequate access to providers and/or inadequate member education and outreach.

RECOMMENDATIONS

1. DCH should establish goals for dental utilization among its Fee-For-Service member children, such as a minimum percent of members receiving dental care annually.

2. DCH should monitor dental service utilization among its Fee-For-Service member children and identify potential causes for declining or insufficient rates.

Agency Response: *DCH agrees with both recommendations. DCH indicated it will establish a goal for dental utilization, establish methods to measure progress, identify barriers, and develop strategies to meet the goal. It noted that many children enrolled in Fee-for-Service Medicaid are SSI/disabled or have special health care needs which can present challenges to obtaining dental*

services as noted in DOAA's findings. Also, the public health emergency may impact DCH's ability to meet its target goal.

Finding3: DCH's compliance with federal standards does not ensure that Fee-For-Service members have sufficient access to dental services.

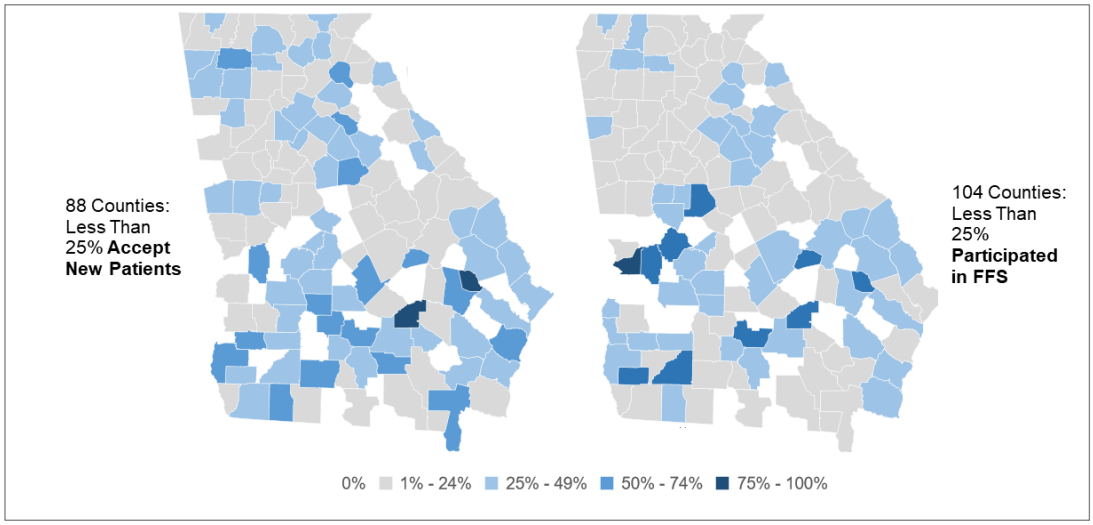
While Georgia's Fee-For-Service dental provider network meets federal access standards, DCH's network information includes inactive providers and providers who do not accept new patients. When these providers are excluded, access to dentists decreases in large portions of the state. Additionally, DCH has not assessed whether members can obtain dental appointments within a reasonable timeframe (a requirement for Georgia's CMOs).

The federal Centers for Medicare and Medicaid Services (CMS) requires state Medicaid programs to ensure that all beneficiaries have access to at least one in-network dental provider within 30 miles of residents in urban areas and 45 miles of residents in rural areas. DCH submits geographic access reports to CMS, and the most recent report (published in 2016) shows that its Fee-For-Service network met the outlined standards.

Though it strictly adheres to federal standards to assess Fee-For-Service members' access, DCH's requirements for managed care networks are more rigorous. To obtain an accurate representation of the sufficiency of their dental provider network, DCH requires each CMO to report the number of providers accepting new patients and DCH identifies the number of actively participating providers (defined as submitting a claim within the past 12 months).

When these criteria are applied to the Fee-For-Service dental provider network, members' access is lower than what DCH reports to CMS. Statewide, less than a quarter (23%, or 2,294) of the 9,832 enrolled providers accepted new patients in calendar year 2019, and only 17% (1,714) submitted a claim to the Medicaid Fee-For-Service program within the previous year. As shown in **Exhibit 8**, members living in certain parts of the state have lower access to active providers accepting new patients. Less than 25% of the providers in 88 counties accept new patients, and in 104 counties less than 25% actively participate in the Medicaid Fee-For-Service Program.

Exhibit 8
In Most of Georgia's 159 Counties, only a Portion of Providers Accept New Patients or Actively Participate in the Medicaid Fee-For-Service Program (CY2019)



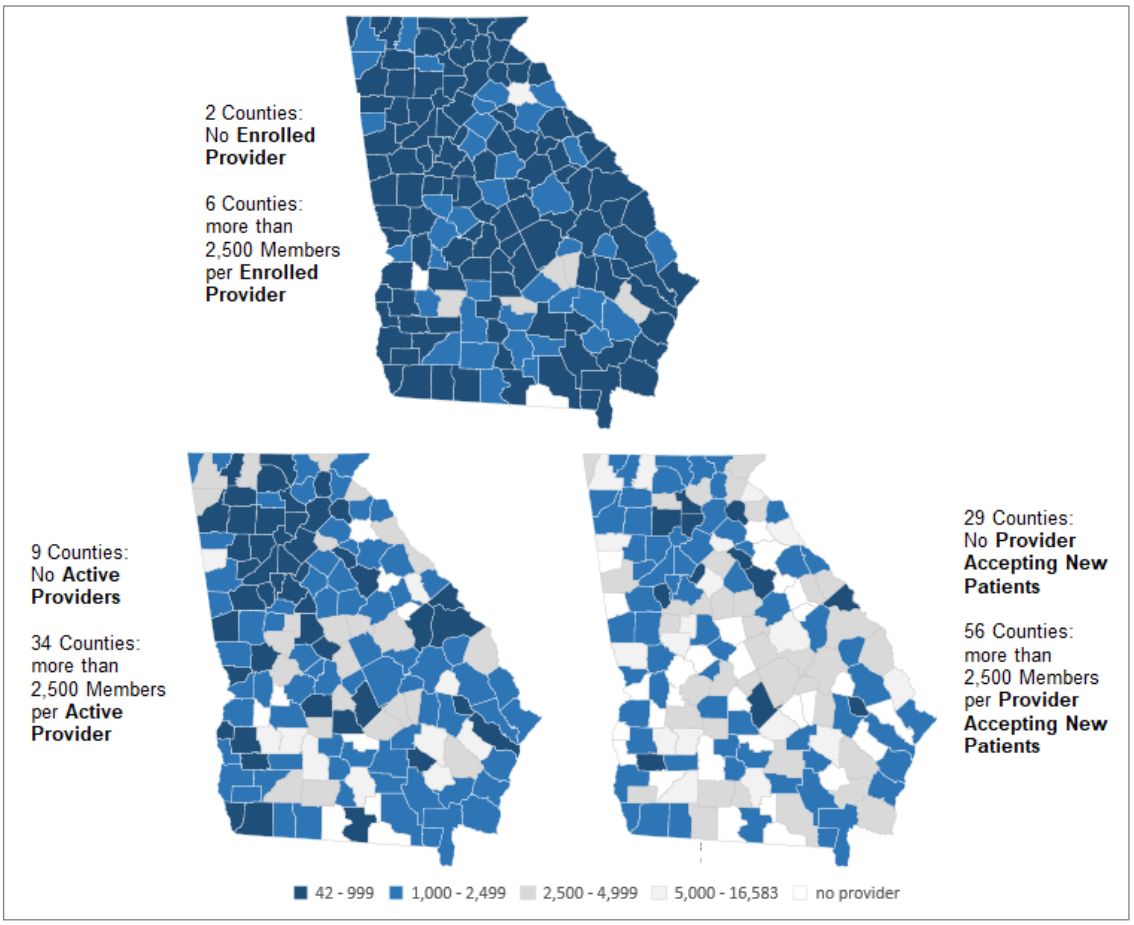
Source: DCH records

Not only should Medicaid beneficiaries have access to a dental provider within a reasonable distance of their residence (30 or 45 miles per the CMS standards), but an adequate number of participating providers should be available to serve the Fee-For-Service population. However, CMS only requires there to be at least one enrolled provider within the required distance of each beneficiary, regardless of the population in the area (e.g., Metro Atlanta vs. Southwest Georgia). Consequently, DCH does not measure how many beneficiaries compete for that provider and whether Fee-For-Service beneficiaries can obtain appointments in a reasonable timeframe.

While DCH has not established criteria for assessing whether there is a sufficient supply of dental providers for its Medicaid population (including Fee-For-Service and managed care), other states have established a maximum ratio of 1 primary care provider for every 2,500 beneficiaries. Applying these standards to dental services statewide, Georgia appears to have an adequate number of active dental providers (1 enrolled provider to 653 beneficiaries).

However, some counties lack dental providers or may not have enough providers to serve its Medicaid population. As shown in **Exhibit 9**, the ratio of Medicaid members to enrolled providers varies by county, and most counties have fewer than 2,500 members per enrolled provider. When considering only active providers or providers who accept new patients, the ratio increases, meaning that members compete for a smaller supply of providers who can or will serve them. In particular, nine counties have no active providers, and 34 counties have more than 2,500 members per active provider—affecting approximately 100,000 Fee-For-Service members. Access worsens when considering only providers who accept new patients; of Georgia's 159 counties 29 have no providers accepting new patients, and 56 counties have more than 2,500 members per provider—affecting approximately 230,000 Fee-For-Service members.

Exhibit 9
The Ratio of Medicaid Members to Providers Varies by County and Increases When Considering Only Providers Accepting New Patients (CY2019)



Source: DCH records

DCH has also recognized in its managed care contracts that the definition of access should include whether members can obtain an appointment within a reasonable timeframe (within 21 calendar days for routine visits and 48 hours for urgent visits). DCH tests this by conducting "secret shopper" calls in which staff request dental appointments with various CMO dental providers and then analyzing how many were made within the required standard. DCH has not conducted similar studies to test the availability of providers in its Fee-for-Service network, which would provide a more accurate assessment of whether an adequate number of providers operate in a particular area.

RECOMMENDATIONS

1. In assessing its Fee-For-Service provider network, DCH should analyze the number of providers who accept new patients and actively participate in Medicaid.

2. DCH should track the ratio of Fee-For-Service beneficiaries to active providers accepting new patients on a county level to identify areas of the state that lack meaningful access.

3. DCH should conduct "secret shopper" calls similar to those used for CMO provider network studies to determine whether Fee-For-Service beneficiaries can obtain dental appointments in a reasonable timeframe.

Agency Response: *DCH agrees with these recommendations. DCH indicated that it will review Fee-For-Service dental providers quarterly. "This analysis will include which dental providers are accepting new patients and actively participating as a Medicaid provider, an analysis of wait times, a county level review, and secret shopper calls. Additionally, we will map time and distance from members to providers to assess network adequacy. We acknowledge there will be areas within the state where there are gaps because of a shortage of providers. The first quarterly review will occur on or before November 1, 2021."*

Finding 4: DCH should increase its efforts to encourage provider participation in the Medicaid Dental program.

Fee-For-Service dental utilization has decreased since fiscal year 2017. Though studies have shown that access to dental providers is a major contributor to low and declining rates, DCH has not acted to increase its provider network membership.

As discussed below, DCH can increase the likelihood that providers will join the Medicaid network by offering competitive reimbursement rates and recruiting dentists able to serve disabled children. DCH could also coordinate with other state agencies to understand health shortage areas and develop solutions for increasing access to dental care.

Medicaid Reimbursement Rates

Although the state increased reimbursement rates for 32 dental procedures during fiscal years 2017-2020[3], DCH does not systematically or routinely review reimbursement rates for all dental services to ensure they are consistent with market trends. DCH staff stated the agency must adhere to budgetary guidelines, and the General Assembly must provide funding for rate increases.

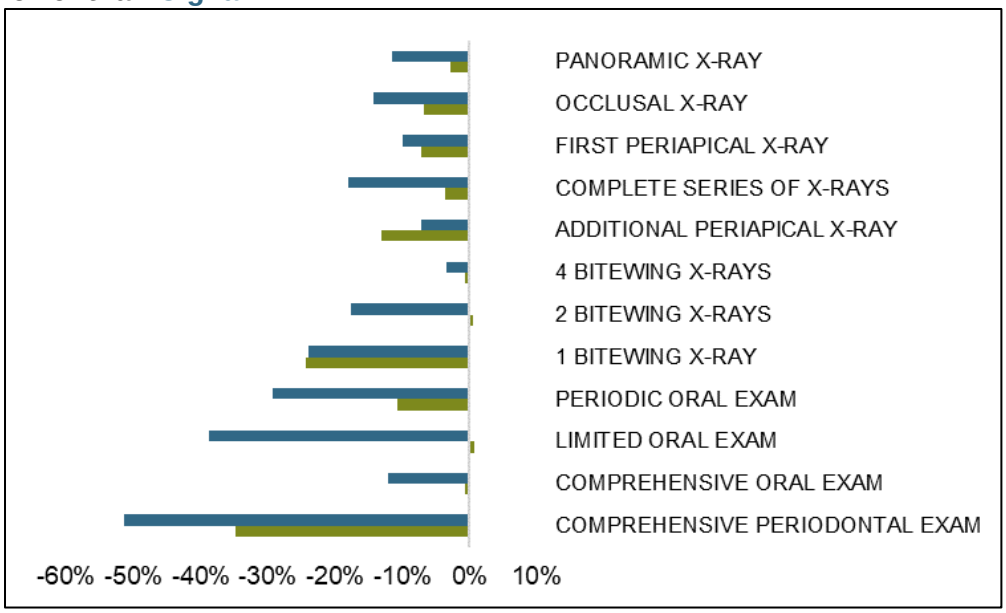
DCH does not have access to the CMO rates for dental services; as such, we were unable to compare Fee-For-Service rates to those offered to providers who have joined the managed care network. Additionally, we did not compare Fee-For-Service rates to those of private insurers or what dentists charge to uninsured populations. However, the Health Resources Administration within the state's Department of Administrative Services (DOAS) offers state, local school system, and county or regional library

[3] Effective fiscal year 2018, the legislature approved a 10% increase to reimbursement rates for 20 dental procedures. In the following year (fiscal year 2019), the legislature approved an additional 1% increase for these procedures. Effective fiscal year 2020, the legislature approved a 3% increase for 12 different dental procedures.

employees the option to purchase dental coverage through its flexible benefits program. DCH could compare the rates offered by the flexible benefit program's dental providers (Delta Dental and Cigna) to those offered by Fee-For-Service Medicaid.

Fee-For-Service reimbursement rates are often lower than rates provided under the flexible benefit program; as such, they may not be sufficient to attract providers who actively serve Medicaid members. As shown in **Exhibit 10**, Fee-For-Service rates are on average 9% and 20% lower than the two DOAS dental insurance providers for 12 common dental procedure codes. For example, the maximum Fee-For-Service reimbursement rate for comprehensive periodontal exams is $39.33, which is 51% lower than the average reimbursement rate reported by Cigna and 35% lower than the rate reported by Delta Dental.

Exhibit 10
Fee-For-Service rates are 9% lower overall than Delta Dental and 20% lower than Cigna.



Source: Georgia Department of Administrative Services

Based on a review of the flexible benefit program and Medicaid provider networks, it appears that the higher rates may incentivize more dentists to participate. For example, Delta Dental's premier network has more in-network providers than Fee-For-Service Medicaid in 74 counties, ranging from 1 to 452 additional providers. For example, Appling County has only two providers accepting Medicaid patients but 26 providers in the Delta Dental Premier network.

Access to Providers for Disabled Populations

Fee-For-Service children are less likely to receive dental care compared to children in managed care, likely due to the increased percentage of disabled children served by Fee-For-Service (in fiscal year 2020, approximately 87% of Fee-For-Service children were categorized as SSI/Disabled).

According to industry literature, dental providers are often not equipped—and in some cases not willing—to serve disabled populations. Dental providers often lack

the training and equipment necessary to serve patients with physical or developmental disabilities. In addition, dentists may incur higher costs associated with increased staffing needs and therapies (such as the use of general anesthesia) to treat patients with disabilities, which exceed the standard Medicaid reimbursement rate.

Although DCH staff affirmed the need for more providers available to treat Fee-For-Service patients, including those with disabilities, it has not worked to recruit providers to serve this population. Two states we reviewed (Washington and Arizona) have utilized Medicaid and federal grant funds to expand their dental network by training dental students to serve patients with physical or developmental disabilities.

State Program Collaboration

Although Medicaid serves similar populations as the State Office of Rural Health and the Department of Public Health (DPH), Georgia's Medicaid program does not collaborate with either to evaluate members' access to Medicaid dental providers or to recruit providers. As described below, this collaboration would likely assist DCH in identifying areas with an inadequate supply of dental providers, recruiting providers to serve populations in shortage areas, and developing programs to address the needs of under-served populations.

- **State Office of Rural Health** – This office, a DCH division, identifies dental Health Professional Shortage Areas (HPSAs) for low-income Georgians. In fiscal year 2020, the office identified 73 Georgia counties as low-income HPSAs; however, DCH has not identified any of these counties as Medicaid dental provider shortage areas due to limited geographic analysis and reliance on outdated provider enrollment data. By including the HPSA information in its assessment, DCH would have a more accurate and complete picture of Georgia's supply of Medicaid dental providers. DCH could also include in its recruitment activities the National Health Services Corps loan repayment and scholarship program, which requires providers to practice in a HPSA. The Office of Rural Health assists providers with becoming eligible for participation in the program.

- **Department of Public Health (DPH) Oral Health Office** – This office administers several programs including the school-based fluoride, dental sealant, education, and screening programs. DCH has not coordinated with the Oral Health Office to ensure that these programs are provided to populations who live in areas with a shortage of participating Medicaid providers or to populations with specific access concerns (e.g., children with disabilities).

- **DPH Public Health Clinics** – DPH's clinics may provide dental services to underserved populations—including Medicaid members—however, this is not provided in all counties. DCH does not coordinate with DPH to encourage the clinics to provide services in areas with limited access to dental providers. In fiscal year 2021, dental services were not provided in 4 of 18 public health districts, which include 16 counties with a shortage of active Medicaid providers and 23 counties with a shortage of Medicaid providers accepting new patients.

Additional Efforts

DCH could also research and emulate other states' efforts to increase the number of providers in the Medicaid network. In addition to the strategies listed above, we identified other states that have targeted recruitment activities specifically to increase dental access. For example, representatives from Alabama's Medicaid program identify and visit dentists who accept private insurance but not Medicaid to assist them in filling out the Medicaid application forms onsite.

Additionally, Maryland has developed a loan assistance repayment program for dentists who serve Medicaid recipients. The service obligation requires dentists to participate in Medicaid for three years and have at least 30% of their patient populations enrolled in Medicaid. It should be noted that such a program may require legislation or coordination with the Georgia Student Finance Commission.

RECOMMENDATIONS

1. DCH should systematically and routinely assess Fee-For-Service reimbursement rates for dental services. In these studies, DCH could compare Fee-For-Service to managed care, DOAS, and other state Medicaid rates. Based on the results, DCH should adjust rates to ensure they are competitive with other Medicaid programs and private insurers.

2. DCH's Medicaid program should consider collaborating with the State Office of Rural Health to recruit providers to practice in HPSAs by providing assistance to these providers in obtaining eligibility for the National Health Service Corps loan repayment and scholarship program.

3. DCH should consider collaborating with DPH to encourage local public health clinics to provide dental services in counties or areas with a shortage of Medicaid dental providers.

4. DCH should research and emulate other states' efforts to increase the number of dental providers in the Medicaid Fee-For-Service network, including providers that serve children with disabilities.

Agency Response: *DCH agrees with the recommendations in part. "Specifically, we agree with recommendations #3 and #4, but recommendations #1 and #2 have fiscal implications that would need to be more fully vetted prior to adoption..."*

DCH also indicated that it "will collaborate with DPH to encourage local public health clinics to provide dental services in counties or areas with a shortage of Medicaid dental providers. Further, we will notify Fee-for-Service members of available services and providers via social media, targeted mailings, and other modes of communication. We will engage DPH and set up a recurring quarterly meeting to assist with monitoring efforts no later than November 1, 2021. We will also research other states' efforts to increase the number of dental providers in the Medicaid Fee-For-Service network, including providers that serve children with disabilities."

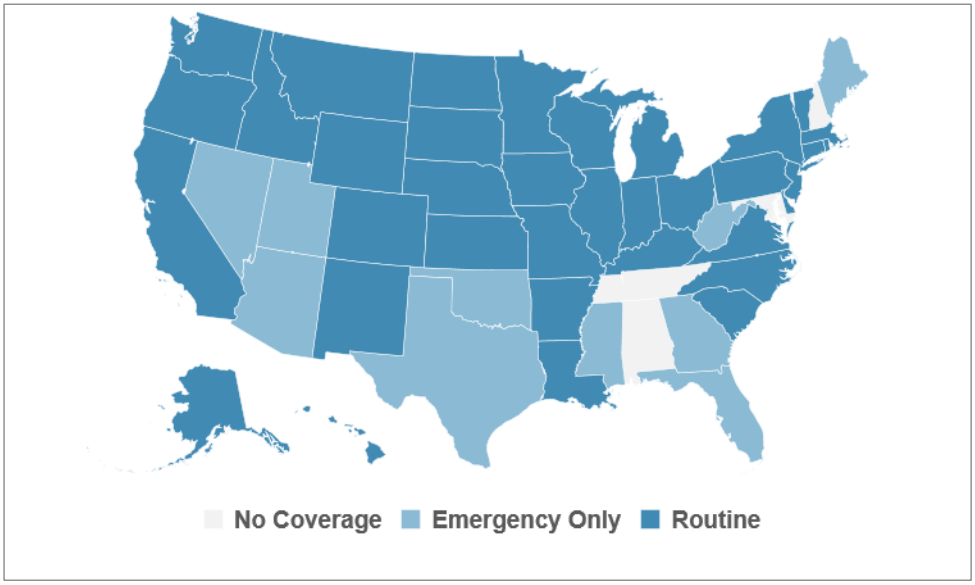
Finding 5: Georgia Medicaid does not cover adult members' preventive dental care, which can lead to untreated dental issues, higher medical costs, and avoidable hospital visits.

Unlike other states, Georgia limits Medicaid coverage for adult members to emergency services and does not include routine care. Inadequate dental coverage increases members' risk for dental disease and the need for emergency services, which cost approximately $7.8 million in fiscal years 2017-2020. By offering additional benefits with an annual cap, hospital expenses would likely decrease.

Federal law gives states flexibility in setting the scope of dental services covered for adults. As discussed in the previous finding, comprehensive dental coverage—including preventive care (cleanings, fluoride treatments), diagnostic care (comprehensive evaluations, radiographic imaging), and treatment (fillings, sealants, bonding, dental prosthetics)—is required for children.

While other states' dental coverage varies, most provide limited benefits (allowing only certain preventive and diagnostic services) or extensive benefits that include services such as root canals and oral surgery. As shown in **Exhibit 11**, Georgia is one of ten states that provide only emergency care such as pain relief or tooth removal. The remaining four states offer no dental benefits.

Exhibit 11
Georgia is One of 14 States that Do Not Provide Adult Dental Benefits Beyond Emergency Services, 2019[1]



[1] Information for select states updated as necessary

Sources: American Dental Association, Health Policy Institute, state laws

By including preventive and diagnostic care benefits to align itself with other states, Georgia would likely lower expenditures related to avoidable hospital visits and increase members' health outcomes and employability, as described below.

- **Fewer avoidable hospital visits for dental diagnoses** – Between fiscal years 2017 and 2020, Georgia Medicaid paid nearly $7.8 million in Fee-For-Service claims for adult hospital visits associated with dental diagnoses. Expanding benefits for adult members would likely decrease these hospital costs, particularly those associated with nontraumatic dental conditions such as tooth abscesses or cellulitis (types of infection) that studies have shown can be mitigated with preventive care.

  Additionally, members with an established dental provider are less likely to present at a hospital. We found that the three most common diagnoses in hospital claims were for unspecified disorders of the teeth, tooth decay, and tooth abscess, which a dentist can typically address at a lower cost. During fiscal years 2017-2020, the state expended approximately $5.5 million for hospital claims associated with these diagnoses.

- **Reduced medical costs** – In addition to higher expenditures related to avoidable hospital visits, Medicaid expenses may be higher for members at increased risk for medical problems associated with poor dental care. For example, periodontal disease (gum disease) has been linked to poor glycemic control among individuals with type 2 diabetes as well as increased risk for strokes. One study found that periodontal therapy reduced average annual medical costs by $2,800 for patients with diabetes and by $5,700 for patients with cerebral vascular disease.

- **Increased employability** – Studies have shown that poor oral health reduces employability due to lost work hours, as well as impaired appearance and speech associated with tooth decay and loss. Additionally, an American Dental Association survey of low-income Georgia residents reported that 18% believed the poor condition of their mouth and teeth affected their ability to interview for a job.

While providing access to routine dental care benefits may increase costs associated with the dental program, 22 of the 36 states with expanded benefits limit procedures or members' expenditures or require member co-payments, which would assist in limiting costs. For example, South Carolina requires members to pay a $3.40 co-payment for preventive care such as dental examinations and cleanings. Additionally, some states limit expenditures with caps ranging from $500 to $1,500.

RECOMMENDATION

1. The General Assembly should consider providing adult members access to preventive and diagnostic dental care. To control costs, the General Assembly should consider measures such as establishing annual caps or co-payments.

Agency Response: *DCH "defers to the General Assembly with regards to the recommendation."*

Appendix A: Table of Recommendations

There is no coordinated management of the Medicaid dental program. (p. 6)
1. DCH should assign staff to implement a coordinated, data driven approach to managing the Medicaid dental program.
The rate at which Fee-For-Service children utilize dental services is decreasing and is lower than rates for managed care and other states. (p. 7)
2. DCH should establish goals for dental utilization among its Fee-For-Service member children, such as a minimum percent of members receiving dental care annually.
3. DCH should monitor dental service utilization among its Fee-For-Service member children and identify potential causes for declining or insufficient rates.
DCH's compliance with federal standards does not ensure that Fee-For-Service members have sufficient access to dental services. (p. 10)
4. In assessing its Fee-For-Service provider network, DCH should analyze the number of providers who accept new patients and actively participate in Medicaid.
5. DCH should track the ratio of Fee-For-Service beneficiaries to active providers accepting new patients on a county level to identify areas of the state that lack meaningful access.
6. DCH should conduct "secret shopper" calls similar to those used for CMO provider network studies to determine whether Fee-For-Service beneficiaries can obtain dental appointments in a reasonable timeframe.
DCH should increase its efforts to encourage provider participation in the Medicaid Dental Program. (p. 13)
7. DCH should systematically and routinely assess Fee-For-Service reimbursement rates for dental services. In these studies, DCH could compare Fee-For-Service to managed care, DOAS, and other state Medicaid rates. Based on the results, DCH should adjust rates to ensure they are competitive with other Medicaid programs and private insurers.
8. DCH's Medicaid program should consider collaborating with the State Office of Rural Health to recruit providers to practice in HPSAs by providing assistance to these providers in obtaining eligibility for the National Health Service Corps loan repayment and scholarship program.
9. DCH should consider collaborating with DPH to encourage local public health clinics to provide dental services in counties or areas with a shortage of Medicaid dental providers.
10. DCH should research and emulate other states' efforts to increase the number of dental providers in the Medicaid Fee-For-Service network, including providers that serve children with disabilities.
Georgia Medicaid does not cover adults' preventive dental care, which can lead to untreated dental issues, higher medical costs, and avoidable hospital visits. (p. 17)
11. The General Assembly should consider providing adult members access to preventive and diagnostic dental care. To control costs, the General Assembly should consider measures such as establishing annual caps or co-payments.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the Department of Community Health's Fee-For-Service Medicaid Dental Program. Specifically, our audit set out to determine the extent to which:

- DCH manages and monitors the Fee-For-Service Medicaid Dental Program to ensure adequate utilization and access;
- Fee-For-Service Medicaid members utilize dental services; and
- Limiting dental care to emergency services for the adult population adversely impacts the adult Fee-For-Service population.

Scope

This audit generally covered activity related to the Fee-For-Service Medicaid Dental Program that occurred during calendar years 2017-2020 with consideration of earlier or later periods when relevant. Information used in this report was obtained by reviewing relevant laws, rules, and regulations; interviewing agency officials and staff from DCH and other state agencies as necessary; and analyzing data from the Georgia Medicaid Management Information System (GAMMIS).

The primary data set used to inform our objectives was GAMMIS, which is a database that includes a record of all Medicaid Fee-For-Service claims and Care Management Organizations' (CMO) encounter records, as well as beneficiaries and providers enrolled in Medicaid. DOAA obtains and maintains a monthly feed of this data directly from DCH's fiscal agent Gainwell. DOAA staff test the upload and test the data on a regular and continual basis. In addition, DCH ensures data reliability through its contractor, which conducts annual testing by tracing the FFS claims data to source documents such as medical records. DCH's contractor also routinely reviews managed care encounter data submitted by CMOs to the GAMMIS to ensure that data in the CMO claims system matches data submitted by CMOs to GAMMIS. We have determined that the data is sufficiently reliable for our analyses.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. We reviewed internal controls as part of our work on Objectives 1 and 2 in relation to managing and/or oversight of ensuring that Medicaid Fee-For-Service members have adequate access to dental services. Specific information related to the scope of our internal control work is described by objective in the methodology section below.

Methodology

To determine the extent to which DCH manages and monitors the Fee-For-Service Medicaid Dental Program to ensure adequate utilization and access, we reviewed federal and state laws and regulations specifying the state's responsibility for ensuring that Georgia's Fee-For-Service members have adequate utilization of and access to dental services. We interviewed DCH staff to identify the department's methods for establishing access and utilization goals and for monitoring the program's effectiveness in meeting these goals. We reviewed compliance reports submitted by DCH to CMS regarding provider enrollment and access to determine whether Georgia meets federal access standards for dental providers.

To calculate the ratio of providers to Medicaid members, we (1) analyzed Medicaid enrollment data in GAMMIS to identify the number of Medicaid members enrolled by Georgia county of residence, by age group (below 21 years of age and 21 years of age and older), and by coverage category (Fee-For-Service and managed care) and (2) analyzed Medicaid dental provider enrollment data in GAMMIS to identify the number of enrolled dental providers per county. To identify whether enrolled providers actively participate in the Fee-For-Service Medicaid Program, we analyzed Medicaid claims data in GAMMIS to determine whether the provider submitted a claim for service within the calendar year analyzed. To determine whether enrolled providers are accepting new patients, we analyzed provider enrollment reports provided by DCH, which include this indicator.

We compared Georgia Fee-For-Service Medicaid reimbursement rates for common dental procedures with average reimbursement rates provided by the state's flexible benefit program's two dental services contractors (Delta Dental and Cigna) to determine whether the Fee-For-Service program's rates are competitive with other payors. This information supports the **Background** section and **Findings 1-5.**

To determine the extent to which DCH Medicaid members utilize dental services, we interviewed DCH staff to determine whether and how DCH monitors dental service utilization. We reviewed national and state statistics compiled by federal CMS of dental service utilization among Medicaid children to compare Georgia's utilization trends with national trends. We analyzed Medicaid claims data in GAMMIS to determine the percentage of Medicaid members in each age and coverage category that received dental services during calendar years 2017 through 2020. We also analyzed Medicaid claims data in GAMMIS to identify the amount of dental-related services provided by providers enrolled in other categories of service including hospitals, physicians offices, and pharmacies. This information supports the **Background** section and **Findings 2 and 5.**

To determine the extent to which limiting dental care to emergency services for the adult population adversely impacts the adult Fee-For-Service population, we reviewed federal and state laws and regulations regarding dental coverage for the Medicaid adult population. We reviewed dental and public health industry literature to identify potential adverse impacts of lack of dental coverage for adult Medicaid populations. We analyzed Medicaid claims data in GAMMIS to assess hospital and emergency room costs associated with dental diagnoses and care for the adult Medicaid population. This information supports the **Background** section and **Finding 5.**

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.