Carve-Out Report on Programs from Other States: The GDA compiled a background document of carve-out programs for dental services in several states to examine "best practices" and use these results as a precedent for the Georgia program. The document that follows, "Understanding the Connecticut Dental Medicaid Reform Proposal," provides a case study of the state's carve-out proposal, and was used as a reference in examining options for the Georgia program.

Carve-Out Report
October 4, 2007

There are currently seven states that have a pure carve-out for dental services. These states include Utah, Massachusetts, Delaware, Virginia, Hawaii, Indiana and Tennessee. Several other states, such as Michigan, have alternate forms of carve-outs for part of their dental Medicaid programs. Below is some basic information about each of the states with a pure carve-out.

PART 1

Delaware
- The state Medicaid program operates through a managed care system under a federal waiver. Dental services are not provided under the managed care system. Instead, dental services were carved out of the managed care program and run by the state.
- The managed care organizations advice the Medicaid beneficiaries that dental services are provided by participating dentists enrolled in the fee for service plan and eight, school linked- public health clinics.
- Delaware reimburses the dentists' claims for dental services to Medicaid beneficiaries at 85% of each dentist's submitted charges. (The state is working to create a standard reimbursement structure, but has yet to do so).
- Between 1998 and 2003, the number of Medicaid eligible children receiving an annual Medicaid dental visit increased from 8,428 to 18,269.
- Various administrative changes have been made to the program:
  1. a new provider enrollment form was implemented that is capable of linking to all clearinghouses and billing vendors,
  2. electronic claims processing software for ADA CDT coded claims is made available without charge to dentists,
  3. the number of procedures requiring prior authorization was limited, and
  4. dentists have numerous methods to determine patient eligibility.
- The covered services offered under the Delaware dental program are almost identical to those offered under the Georgia WellCare program.
- The State of Delaware bares the entire risk of the Medicaid dental program.
- The Delaware SCHIP program (Healthy Children Program) does not offer dental services.
- A copy of the dental provider manual was obtained.

Virginia
- Prior to July 2005, the state Medicaid and SCHIP programs were administered by 7 CMOs, each with different fee schedules, billing arrangements and administrative burdens.
- In 2005, the Virginia Department of Medical Assistance Services (DMAS) determined, after consultation with the VDA and Old Dominion Dental Society, that a carve-out represented the best chances for increased provider participation.
In July of 2005, Virginia contracted with a single dental administrator (Doral Dental) to administer its Smiles for Children program.

Within the first fiscal quarter after changing to the carve-out, there was an immediate increase in the number of children treated by a dentist and the number of dentists participating in the plan.

In 2005, the General Assembly approved a 28% increase in reimbursement rates for the plan. A second 2% increase was approved in May of 2006. DMAS consulted with the VDA and Old Dominion to determine the best methods of applying the increases to insure the highest level of provider participation.

The stated goal of the Smiles for Children plan is to increase access to dental care, by streamlining administrative processes and removing impediments to care.

The keys and stated benefits to encourage provider participation in the Smiles for Children plan include:

1. the plan operates as a fee-for-service plan;
2. dental services are delivered through a single administrator (Doral);
3. there is a dedicated call center for patients (most seeking a provider) and providers (most determining patient eligibility); and
4. industry standard program administration include flexible billing methods, prompt payment (99% within 30 days), streamlined authorization requirements and a simplified credentialing process.

DMAS retains policy making authority and continues to provide oversight to the program through a Dental Program Manager, DMAS Dental Consultant, and a Dental Contract Monitor. DMAS also work with the dental advisory committee (comprised of dentists in the state) to monitor the program.

In FY2003, only 28.9% of eligible children received dental care. In FY2006, an additional 40,000 eligible children received dental care.

In one year (2005-2006), an additional 235 new dentists (620 to 855) joined the network (a 38% increase). There is an increase from 50% of providers who submitted claims in 2005 to 78% of providers now submitting claims.

Instead of prior authorizations (number greatly reduced), the Doral program focuses on utilization criteria to manage utilization of criteria.

The manual outlines benefit limitations, clinical criteria for certain procedures and outlines various assessments for determining whether certain procedures are warranted. In addition, numerous forms are required to be completed prior to services being offered.

Problem- The Doral manual contains the same language as in Georgia, that verifying eligibility through means provided does not guarantee payment.

Massachusetts

Prior to 2007, the state Medicaid program was administered under a managed care delivery network. Dental care was carved out of the managed care and functioned on a fee for service basis. Beneficiaries sought care from any participating dentist.

In 2000, a lawsuit (Health Care for All v. Romney) was filed by Medicaid beneficiaries alleging that MassHealth violated EPSDT's requirements to inform individuals about EPSDT benefits and to provide necessary treatment.

In 2005, the court found in favor of the plaintiff's and specifically noted that by keeping reimbursement rates so low MassHealth essentially deterred dentists from participating in the plan and foreclosing enrollees from receiving medical assistance.

The court ordered the parties to confer and develop a joint remedial program. In February of 2006, the details of the remedial program required:
1. a program of member assistance and intervention, in making and keeping appointments;
2. developing and maintaining a provider network;
3. appropriations in FY2007 to increase provider reimbursement rates;
4. instituting a practice of sending out service information to enrollees for whom no Medicaid claim in the past year;
5. appointing a monitor; and
6. requiring reports to the court from the parties and monitor.

- In 2005, the state legislature authorized funding to study a move to a third party administrator for dental services. No legislation authorized the carve-out, which was done internally by MassHealth.
- Effective April 1, 2007, Doral Dental began as the sole administrator for MassHealth Dental Medicaid Program.
- Under the agreement, Doral will perform claims processing, dental provider network development, provider and member relations and utilization management services.
- As of October 2006, there were 1 million children and adults in the MassHealth dental program.
- The documents for Doral are made available only to participating providers.

**South Carolina**
- The SC Department of Health and Human Services runs the Medicaid Dental Program.
- The dental portion of Medicaid and SCHIP are carved out, and billing services are performed by BCBS of South Carolina. The services are delivered through a traditional fee-for-service basis.
- In 1999, the state legislature appropriated funds effective January 2000 to increase fees to the 75th percentile.
- Between 1999 and 2001, DHHS worked to reduce administrative barriers and increase provider participation (streamlining prior authorization, reimbursing for additional time spent with children with special health care needs, using standardized dental procedure codes and claim forms, establishing an intervention process to reduce patient broken appointments and introducing electronic billing options.
- In 2001, the state announced its intention to cut $7M from its Medicaid dental budget. The SCDA worked with the legislature to prevent the cuts from affecting the core set of dental services.
- A study in 2000, revealed that after the reimbursement increases went into effect 21,689 additional children received dental services. The percent of dentists who provided at least 10 Medicaid services a quarter increased to 34% in 2000 (up from 25.8% in 1999). The number of Medicaid dentists increased from 619 in 1999, 886 in 2001 and 1,197 in 2006.
- There have no additional fee increases since 2000.

**Utah**
- The state Medicaid dental plan is carved out of the managed care program and provided on a fee for service basis.
- Dental services are provided only for traditional Medicaid beneficiaries (0-6 with 133% of FPL, 6-18 at 100% of FPL) and pregnant women in traditional Medicaid. The CHIP program is managed under the state Public Employees Benefit program and covers basic dental services with a co-pay: (exams and fluoride- $0, selected crowns and fillings, etc. ($3 for CHIP A, $5 for CHIP B and 20% for CHIP C).
- Procedures and limitations are outlined in the Medicaid Provider Manual.
Medicaid enrollees either go to a Family Dental Plan Clinic or an enrolled provider.

- Errorless claims are paid within 7 days and can be submitted by paper or electronic means.
- Only eight children's procedures have a prior authorization requirement.
- In October 2002, there was a 15% increase in dental reimbursement rates (27% for orthodontic treatments). Then in 2004, another 4.3% increase was made.
- Reimbursement rates for CHIP A & B dental programs are significantly higher than the Medicaid fee for service program.
- After the initial reimbursement rate increases in 1997, the number of patients receiving a dental visit increased 16% and the number of dentists participating increased 10%. However, between 2000 and 2004, the number of dentists again decreased 9.5% (lower than the 1997 levels).

Indiana

- The dental plan in Medicaid and SCHIP programs are considered the purest form of a carve-out. Both are administered by EDS on a fee for service basis.
- The state bares all the risk in this program.
- The last increase in fees was a 134% increase in 1998. (However, no market based increases have occurred since that time).
- At the same time that the dental carve-out was done in 1998, all prior authorizations were eliminated for dental services in an effort to increase provider participation.
- Both adults and children are covered under the plans. While there is no annual maximum for children in Medicaid and SCHIP programs, adult Medicaid services are limited to a maximum of $600 per year.
- Currently, electronic claims submission is offered as well as patient eligibility verification for providers via swipe card, automated voice response system and the Internet.
- The lobbyist for the IDA indicated that there are serious concerns regarding the administration of the plan under EDS (he mentioned concerns regarding several corporate practices). However, the IDA feels that the administrative problems are less of a problem than the participation restrictions if a third party such as Doral was contracted.
- The number of children receiving an annual Medicaid dental visit increased from 47,730 in 1998 to 222,665 in 2003. Provider participation (those dentists submitting Medicaid claims) went from 916 dentists in 1997 to 1,443 in 2002.
- A copy of the current fee schedule was obtained.

Tennessee

- In 1998 and 1999, two class action lawsuits were brought against the state alleging failure to provide adequate Medicaid dental service to eligible children.
- In 2001, an initiative between TennCare, Doral Dental, TDA, the private dental community and the public health community joined together to develop a statewide children's oral health strategy. One of its main goals was to encourage dentists to participate.
- Prior to October 2002, ten MCOs managed their own dental networks or subcontracted their dental programs to Doral. Funding for the dental programs was based on what was left over from the entire TennCare medical budget.
- In October 2002, the dental benefit was carved out and subcontracted by a single dental benefit manager (Doral). The program under Doral operates in the following manner:
  1. The current program is run on a fee-for-service basis;
  2. Prior to 2005, the state assumed the risk of the program. In 2005, the state made the dental plan an at-risk program;
3. The program operates under a single set of rules, a single claims payer and a single entity responsible for other contract deliverables; 

4. Doral must maintain and manage an adequate dental provider network, process and pay claims, manage data, provide beneficiary outreach and education, administrative and case management, including utilization reports, quality improvement, provider network standards and prompt payment; 

5. Dentists sign one provider agreement, are credentialed once and operate with one maximum allowable fee schedule; 

6. Electronic claims are accepted and are the preferred method of billing; 

7. Dentists are permitted to treat at whatever level they choose; and 

8. Electronic beneficiary enrollment verification is available.

- Dr. Gillcrist, the state dental director, indicated that from October 2002 to October 2006, the program went from 386 providers to 817 (more than a 100% increase). Dentists have told him that they like the program and will accept new patients.

- The provider manual outlines the specific services that are required under EPSDT, member cost sharing responsibilities, prior authorization and utilization guidelines, hospitals included in its network, benefit limitations and clinical criteria for certain procedures.

- **Problem:** Similar to Virginia and Georgia, the provider manual indicates that due to possible eligibility status changes, the information provided regarding patient eligibility does not guarantee payment.

### Kansas

- In the late 1990s, the two key obstacles to provider participation included low reimbursement rates and administrative hassles.

- The state Medicaid (HealthWave 19) and SCHIP (HealthWave 21) programs both include comprehensive dental benefits (but orthodontic services are not covered).

- Depending on income, premiums for HealthWave 21 can be either $20 or $30.

- Contracted dentists provider services to Medicaid beneficiaries on a fee for service basis.

- Both programs utilize a single dental administrator, **Doral Dental**, to provide prior authorization, provider support and receipt of claims. EDS, however, is responsible for processing claims and paying providers.

- Several fee increases have been instituted since 1997. In 1997, an additional $3.8M went to increased reimbursements for dental services and in 2001 an additional fee increase for Medicaid reimbursement rates to 90% of the UCR.

- Between 1998 and 2003 the number of eligible children receiving an annual Medicaid dental visit went from 24,855 to 54,362.

- **Workforce issue**- In 2003, the state legislature passed a bill permitting dental hygienists to obtain extended care permits and practice in public health settings serving students, inmates and those eligible for the HealthWave 19 and HealthWave 21 programs. (Can work unsupervised but must have dentist sponsor).

### Hawaii

- The state has contracted with a managed care entity for medical services.

- Dental services for Hawaii QUEST members are not included in the managed care program, but are offered on a fee for service basis.

- The state operates several community based clinics and federally qualified health centers with dental clinic on several islands.

- Several administrative changes were made to increase provider participation:
1. An EPSDT dental periodicity schedule was established.
2. Prior authorizations were eliminated for all but three procedures.
3. Recipient eligibility, claim status, provider manuals, bulletins and fee schedules are available on-line.
4. Effective October 2001, the fee schedule was set at 75% of dentists' costs and new fee schedules are developed with input from private dentists.
   - The number of children receiving an annual Medicaid dental visit went from 34,223 in 1998 to 42,920 in 2003. Utilization went from 37.6% in 2002 to 37.8% in 2003.
   - Administrative changes resulted in 66.2% decrease in provider complaints.

PART 2

Additional states have programs that have carved out part of their dental Medicaid or SCHIP programs. In addition, many states have used a carve-out along with workforce changes to increase access.

Kentucky
- The KDA brought litigation against the state in 1994 for unacceptable dental reimbursement levels. This case was dismissed after negotiations to settle resulted in restoration of a previous reduction in dental Medicaid reimbursement rates.
- In Louisville (Jefferson County), the managed care entity running the state Medicaid and SCHIP programs subcontracts out its dental benefits to Doral Dental. The remaining portions of the state are run by traditional Medicaid.
- Doral reimburses dentists in this program at 110% of Medicaid reimbursement.
- Additional changes were made to increase provider participation:
  1. The program began using ADA CDT codes in 2003.
  2. Only 5 procedures now require prior authorization.
  3. Dental fee schedules, program manuals and enrollment are all online.
  4. Rates were increased 32.7% in 2000.
- The number of children receiving an annual Medicaid dental visit increased from 61,409 in 1998 to 142,532 in 2002.

Texas
- The state Medicaid and CHIP dental programs have always been a carve-out, administered jointly by the state and ACS. In September of 2003, dental benefits for CHIP enrollees were discontinued but restored in 2005. Delta Dental administers the CHIP dental program.
- In 1993, a federal lawsuit (Frew v. Hawkins) was brought against the state of Texas claiming that the state failed to provide those services required under EPSDT. While the suit settled in 1996, there have been several battles over enforcement of the consent decree settling the case.
- Finally, in 2007, the TDA (not named in the suit) worked with the state Attorney General to negotiate a final settlement.
- The goal of the settlement is to increase provider participation. This is done by a huge increase in fees for dental services.
- Over the next two years, Texas will use $259 million in state funds to increase fees for dental services. (This will be matched with federal funds).
- In addition, there will be another $150 million allocated for strategic medical and dental initiatives to increase access to care (programs for dental care in underserved areas).
• The state originally planned a 50% increase in fees for all dental services. However, pediatric dentists voiced opinions and had the rates increased by 100% for the 34 most common procedures. In addition, 14 additional codes will receive a substantial increase.
• Delta Dental typically matches Medicaid dental fees for most procedures under the CHIP dental program.
• The TDA reports that currently access for children seeing a dentist is at 50% (but cannot confirm that number).
• Also, since the fee increases were announced many dentists (existing providers and previous providers) have called the TDA to express a desire to participate.
• Contact: Dr. Jerry Felkner (512-506-7249) State Dental Director. www.tmhp.com

Iowa
• Dental services are carved out of the Medicaid managed care program. Under the SCHIP (hawk-i) program, dental services are offered by one of the managed care plans providing SCHIP services.
• Services are provided on a fee for service basis.
• ACS administers the Medicaid program.
• The state also created an ABCD program that foster access to Medicaid dental services through oral health task forces, education programs and the use of Spanish translators for dental visits.
• In 2000, the legislature increased dental fees to the 75%. However, budget short falls have returned fees to pre-2000 levels.
• Between 1998 and 2003, the number of children receiving a Medicaid dental visit increased from 55,817 to 83,662 respectively.

Idaho
• As of 2004, The Idaho Medicaid and SCHIP programs offer dental benefits to families with incomes up to 150% of the FPL. (The state CHIP B program does not include dental benefits).
• In 2002, the state cut dental benefits to adults enrolled in the Medicaid program.
• In 1998, dental prior authorizations requirements for Medicaid children were eliminated except for crowns, orthodontia, maxillofacial prosthetics and non-covered services.
• The Idaho Medicaid program implemented a patient education initiative through its managed care program that is designed to reduce patient no-shows.
• There are currently two dental plans in Idaho, the Basic plan and the Enhanced plan. The Basic plan covers low income children and low income adults. The Enhanced plan covers individuals with special needs, the aged, blind, disabled, refugees, foster children, qualified parents and CHIP children.
• In 2007, Blue Cross of Idaho (through Doral Dental) won the sole contract to provide dental services to its 140,000 eligible Medicaid (Idaho Smiles) members. This only includes those enrolled in the Basic plan. Those enrolled in the Enhanced plan remain under the program administered through the state.
• The representative at the Idaho Department of Health and Welfare indicated that the Doral plan is operated in an almost identical manner as the state Enhanced plan (same procedures, same limitations, etc.)
• A copy of the state dental provider manual was obtained, but the Doral manual was not available.
**Washington**

- Dental services are not included in the managed care system and are delivered on a fee for service basis through dentists enrolled as Medicaid providers with the state.
- In an effort to increase the number of providers, the state legislature established licensure by reciprocity for dentists and hygienists and granted hygienists to provide certain services under general supervision in coordination with public health programs.
- The state currently reimburses unsupervised hygienists practicing in accordance with state law.
- Administrative improvements to increase access include:
  1. Reducing the provider enrollment agreement to fewer than four pages;
  2. Claims and provider agreements can be submitted electronically;
  3. Prior authorizations were reduced for many procedures;
- In 1995 rates were increased 65 to 100% above prior year levels. Very small increases have occurred since that time.
- State established ABCD program where dentists take continuing education to become certified in early pediatric dental techniques and then receive enhanced reimbursement rates for Medicaid services.
- Dental specialist not wishing to participate in the Medicaid program are able to use ID-only provider numbers that enable them to participate as volunteers or subcontractors of public or other community health clinics.
- The number of children receiving an annual Medicaid dental visit increased from 35,571 in 1998 to 264,812 in 2003.

**Michigan**

- Dental services are operated outside of the medical health services (managed care plan).
- In 37 counties, the state has contracted with Delta Dental to administer its Medicaid dental program (Healthy Kids Dental). The state utilizes Delta Dental, BCBS and Golden Dental Plan for its SCHIP dental program (MIChild).
- Each plan uses the same benefits and plan used in its private programs.
- Delta Dental requires that any dentist participating in its commercial plan also accept the state funded plan in order to prevent discrimination.
- Numerous administrative changes have been implemented (electronic filing of claims, eligibility verification) and most prior authorizations were eliminated.
- Several fee increases were implemented between 1998 (up to 70% of UCR), in 1999 (4%) and in October 2000 (5%).
- The number of children receiving an annual Medicaid dental visit under the program increased from 26,063 (18%) in 1998 to 286,128 (44%) in 2003.
- The number of dentists increased 300% after changes implemented. Dentists are reporting increased satisfaction with the programs. Average appointment times decreased from 48 days to 36 days.

**North Carolina**

- Dental services are provided outside of the Medicaid and SCHIP managed care options. Health Check (Medicaid) provides dental services on a fee for service basis through providers enrolled with the state. Health Choice (SCHIP) provides dental services on a fee for service basis through providers enrolled with BCBS.
- In November of 2000, a class action lawsuit was brought against the state alleging dental services were not adequately available and accessible.
• A settlement was reached in March of 2003, the main element of which was to increase fees for 36 dental procedures (set at 73% of corresponding UNC dental faculty practice fees).

• Minor administrative changes have also occurred including:
  1. The DMA established a state dental director position in 2004.
  2. Electronic and paper claims processing is available for Medicaid claims.

• The number of children receiving an annual Medicaid dental visit increased from 112,892 in 1998 to 267,809 in 2003. In 2004, the average monthly number of Medicaid eligible members receiving one dental service increased 23%.

• Overall utilization for Health Check was 33% for FY2003. For Health Choice, the number stood at 39% in FY2003.

• The most recent data available (from 2006), reveals that the average monthly number of Medicaid recipients receiving at least one dental visit increased from 68,475 in FY2004 to 80,387 in FY2006. Dental services represent 3% of the total Medicaid expenditures for 2006. The number of enrolled providers increased from 4,234 in 2005 to 4,381 in 2006.
UNDERSTANDING THE CONNECTICUT DENTAL MEDICAID REFORM PROPOSAL:
STATE OPTIONS IN CONTRACTING DENTAL CARE IN MEDICAID
CONTENTS

Program Options Available to States

Decision 1: Whether or Not to Retain Medicaid In-House or Contract Out ............................................4
Decision 2: Whether or Not to Carve-Out Dental Services ..............................................................................5
Decision 3: Whether or Not to Assign Financial Risk to the Vendor ..............................................................6
Decision 4: A Single-Vendor or Multiple-Vendor Program ..............................................................................7
Decision 5: Selecting a Plan ...........................................................................................................................8
Decision 6: Setting a Payment Rate .................................................................................................................9
Decision 7: Managing Program Oversight .......................................................................................................10
Lessons Learned from Other States ...............................................................................................................11
Summary .....................................................................................................................................................14
In today’s ever-evolving health care marketplace, states have multiple options for arranging dental services in their Medicaid programs.

For example, states may:

- Administer dental Medicaid programs directly or contract them through medical or dental managed care organizations;
- Retain administrative responsibility or not and opt to pass financial risk onto outside vendors;
- Include dental services in medical managed care contracting or carve-out dental services for separate management; or
- Contract with a single vendor or with multiple vendors for all or part of their enrolled populations or geographic areas.

In fact, options are limited only by the creativity of Medicaid officials, the receptivity of the marketplace, and, in some cases, the approval of federal authorities. Indeed, in their efforts to secure dental care for beneficiaries, states have experimented with various combinations of these options.

Regardless of the options selected, states must currently meet – or obtain federal waivers not to meet – requirements that include a guarantee of access to needed dental services for covered children.

As an observation of states’ efforts reveals, ultimately, only three factors relate to a state’s capacity to obtain dental care for beneficiaries:

1. Market-based payment rates to dental providers,
2. Engagement of sufficient numbers of providers, and
3. Effective program oversight.

The Connecticut Health Foundation (CHF), the state’s largest private, independent foundation dedicated to improving the health status of all Connecticut residents, has prepared this policy brief to:

- Describe the various program options and related decisions facing states as they determine how to obtain dental care for their beneficiaries,
- Present arguments (pro and con) for each decision, and
- Comment on the lessons to be derived from various states’ efforts.
States interest in contracting-out Medicaid services stems from a desire to increase access, contain costs, and improve program performance.

Proponents of contracting suggest that the corporate culture of dental insurers is better suited to successful program management than the culture of state bureaucracies. They believe that outsourcing dispels dentists' antipathy and frustration with state-administered Medicaid. Proponents also cite such advantages to beneficiaries as: improved customer service, integration of health and enabling services, and recourse to assistance in obtaining care. For providers, advantages appear to be the potential to negotiate fees, streamlined claims processing, and a steadier cash flow. In addition, managed care plans may utilize protocols and guidelines that can enhance care quality while controlling costs.

Critics of Medicaid contracting, however, assert that this option is inherently flawed. They characterize this flaw as a perverse incentive related to inadequate financing, that is, an incentive to minimize service delivery in order to maximize profits. Opponents also point out that states lose control of the program but retain responsibility for Medicaid requirements that are not explicitly contracted. If dental services are subcontracted by a medical managed care vendor that is otherwise performing well, poor performance by dental vendors may be difficult to redress, especially if enforceable sanctions are not included in the contracts — or if a state's capacity and political will is not sufficient to enforce those sanctions. Even where effective sanctions exist, the costs of redressing poor performance may be greater than the savings generated through sanction enforcement, particularly if legal action is necessary. Furthermore, dental Medicaid programs are frequently regarded as too small to warrant intensive oversight. The greatest criticism expressed about outsourcing, however, is this: outsourcing shifts some Medicaid funds to vendor profits rather than client services — profits that may be in excess of savings generated by privatization.

The 1995 Medicaid reform in Connecticut contracted Medicaid services, including dental services, to managed care. The new proposal segregates the dental program for separate contracting.
Decision 2: Whether or Not to Carve-Out Dental Services

While almost every state has contracted some part of its Medicaid program to managed care, 27 have retained them under state management. The remaining 23 states and the District of Columbia contract for dental services. Only six of these governments carve-out dental services from medical vendors’ responsibility to contract exclusively with dental vendors.

When the states carve-out dental programs from medical vendors, they are able to select the dental contractors, establish the terms and conditions of program delivery, establish clear and enforceable incentives and sanctions, and directly access information on program performance. As a result, this option holds promise for enhanced program accountability. This approach also reflects differences between medical and dental care including different provider types, delivery systems, and financing norms.

When identifying a suitable contractor, a state can carefully assess whether or not the vendor’s existing provider network contains a sufficient number of providers. It also can explore how the providers are distributed and how actively providers participate, if there is a network in the state. If the dental vendor has no network for a Medicaid contract, the state and other interested parties can closely examine the vendor’s commercial experience or performance in other states. Similarly, the state can exercise due diligence when examining a vendor’s past claims-administration performance as well as dentists’ and beneficiaries’ satisfaction.

When carving-out dental care, states will shoulder the additional cost and responsibility of managing separate contracts for a very small component of the larger Medicaid program, typically less than 5 percent. This is the primary disadvantage of the carve-out option.

There are several ideas that hold potential for success in dental carve-outs:

- Accessing ready-made provider networks;
- Encouraging participation of safety-net providers;
- Contracting for case management strategies (e.g. clinical protocols, risk assessment, and disease management guidelines);
- Contracting for care integration between primary and specialty dentists;
- Empowering vendors to implement their own access initiatives (e.g. case managers, school-linked services, and private dentist contracting to health centers); and
- Allowing dentists to negotiate terms of participation.

The 1995 Medicaid reform in Connecticut did not carve-out the dental program and assigned responsibility to the medical managed care vendors. The new proposal carves-out the dental program for separate management.
Decision 3: Whether or Not to Assign Financial Risk to the Vendor

As care utilization increases, so, too, do program costs. States may guard against this by contracting with managed care vendors at a specified payment for each covered beneficiary. In so doing, states establish their dental program cost and put their vendors at financial risk, should utilization exceed anticipated levels. Among the 23 states and the District of Columbia that contract for dental services, all but two assign some level of financial risk to their vendors.

Fixed rate contracting puts the vendor at financial risk because it caps the total dollars available for claims, program administration, and profit. Because Medicaid is currently an individual entitlement, neither states nor vendors can deny care when funds are depleted.

Dental managed care vendors have addressed this potential financial liability in a number of ways. Some will not accept full-risk contracts. Some have attempted, with notably little success, to pass risk onto dentists through capitation arrangements. One multi-state dental Medicaid vendor utilizes a “global” approach – it pays itself first, and then prorates any remaining funds across providers to reflect the volume of claims. Re-insurance is used to protect against “adverse utilization.”

According to opponents, assigning full financial risk eliminates any incentive for increased utilization, an inherent problem. Proponents, on the other hand, claim that improved provider networks and greater efficiency warrant vendor profitability. Proponents also maintain that the onus is on the state to ensure performance through strong and enforceable contract sanctions.

The 1995 Medicaid reform in Connecticut assigned some financial risk to vendors. The new proposal curtails that risk.
Decision 4: A Single-Vendor or Multiple-Vendor Program

Proponents claim that multiple vendors stimulate competition and, therefore, better customer and provider service because both groups will seek out the best plans. Proponents also maintain that vendor competition generates true market rates if there is sufficient state funding in the program. In those states where multiple vendors failed to develop sufficient networks to meet the needs of beneficiaries, the states did not provide sufficient funding to reflect market conditions. Advantages of inter-plan competition include opportunities for performance comparison across plans, emergence and identification of "best practices," and stimulus for plans to provide the best possible service.

On the other hand, opponents of multiple-vendor arrangements assert that beneficiaries are confused by multiple options. They suggest that providers are not sufficiently interested in Medicaid to negotiate multiple contracts, tolerate multiple credentialing procedures, or institute multiple claims-management procedures in their offices. Opponents cite the increased difficulty and cost for states to oversee multiple vendors.

According to proponents of single-vendor arrangements, these problems are eliminated when states contract with only one vendor and engage only the "best" vendor by carefully assessing solicited proposals. Single-vendor advocates also note that commercial dental plans with large provider networks are more likely to bid on Medicaid contracts only if the population to be covered is large enough to allow for efficiency. The primary disadvantage of single-vendor contracting is dependence on one source.

States solicit vendors through “Requests for Proposals” (RFPs), ranging from highly detailed and specific requests to broad and conceptual ones. Specific RFPs focus on process requirements and delineate terms and conditions to be met by the bidder. Conceptual RFPs, in contrast, focus on program goals and provide bidders with some flexibility in how to attain those goals. Because the form, content, and specificity of proposals are critical to program management, it is useful for communities of interest – and particularly for stakeholders directly impacted by programs – to be engaged in RFP development and evaluation.

Each of these terms can have significant impact on access and utilization. States also are obliged to carefully assess the business practices, program incentives, and overall reputation and reliability of the applicants’ plans. Applicants may be either for-profit or tax exempt organizations. There is no recognized difference in performance between these two types of organizations.

Connecticut’s current plan is to identify the single ASO through a conceptual RFP and to negotiate specific terms thereafter.

Typical terms of responsibility for contracting include:

- Provider network development including safety-net providers;
- Delineation of procedures for addressing the needs of special populations, for example, young children, the medically or psychologically compromised, and non-English speaking patients;
- Case management and provision of enabling services;
- Care coordination;
- Fraud and abuse management;
- Performance measurement and accountability;
- Client and professional support services including redress of complaints; and
- Compliance with federal requirements.
Decision 6: Setting a Payment Rate

Observers of Medicaid dental programs generally agree that private sector commercial insurers do not respond to Medicaid RFPs often enough; primarily, this is due to the fact that Medicaid pays too far below market rates. While little pricing information is available, the majority of state dental programs – as well as rates paid to dental vendors in Connecticut – are thought to be supported with monthly per member payments (pmpm) of $5 to $10. These rates fall well below a 1999 actuarial estimate of a reasonable market rate of $17 pmpm. Dental insurance executives interviewed for this project suggest that minimally acceptable rates would fall in the range of $12 to $15, assuming that vendors are willing to accept initial losses from "pent-up" demand for care. In Michigan, a partial-state Medicaid demonstration has generated remarkable success in increasing access and utilization at a pmpm of $12.60. Low rates are believed to correlate with higher levels of provider fraud and abuse, higher levels of "skimming" (defined as inappropriately high levels of preventive services and inadequate levels of less profitable reparative care), and program dependency on a small numbers of dentists.

In addition to low payment rates, commercial plans with well-established provider networks cite the following reasons for staying out of the Medicaid market:

- A concern about states' cash flow reliability,
- Public relations risk with existing clients,
- A belief that Medicaid is a riskier book of business than employment-based plans because of significant "pent-up" treatment needs,
- Less predictable utilization, and
- A lack of data on how dentist availability is affected by fee levels.

Dental insurers also are adamant that Medicaid programs should not be supported by cost shifting from more profitable commercial plans.

Increasing access in Medicaid may, in large measure, depend upon offering excellent service to both dentists (so that they are available) and beneficiaries (so that they can utilize the system). Such service is expensive to provide, especially to dentists who are generally negative about Medicaid programs and beneficiaries who require extensive support services.

Connecticut's current plan is "cost neutral." It does not increase dental program funding.
State contracts define performance requirements and typically provide incentives for strong performance and sanctions for failures. These may pertain to network development, provider and beneficiary satisfaction, timeliness and accuracy of claims management, levels of utilization by beneficiaries, timeliness and accuracy of performance reports to the state, and other contract terms. To be enforceable, a program’s contract requirements should be clear, and the state should be willing to prosecute infractions of those requirements. When a state knowingly under funds its program, it has little recourse when plans do not deliver as promised.

Effective oversight requires regular and timely data, provider and beneficiary input, and proactive engagement of administrators and legislators responsible for these programs. Commercial dental programs typically provide employers with a specific list of program performance measures as well as actions it will take if these measures are not met. States may benefit from emulating these contract provisions or referencing the Centers for Disease Control and Prevention’s “Sample Purchasing Specifications for Medicaid Pediatric Dental and Oral Health Services.”

Connecticut’s plan to engage a single ASO vendor for both the State Employee Health Program and public insurance programs may improve oversight for two reasons:

1) The total number of covered lives will be great enough to warrant close management by the state and

2) It is expected that state employees will be more critical of inadequacies than low-income beneficiaries of public insurance programs.

Active and effective program oversight, like sufficient payment rates to adequate numbers of providers, is essential to ensuring accessible dental services in Medicaid.
Lessons Learned from Other States

As noted above, states can configure their Medicaid programs in a number of ways. Their ability to increase access, however, correlates with three interrelated approaches: market-based payment rates, sufficiency of providers, and effective program oversight.

Since the mid 1990s, fewer than ten states have made programmatic investments that have increased dental access or that are poised to increase access. All have sufficient financing to effectively engage the dental marketplace. Yet each “fix” is different, and each reform involves more than simply raising fees. Taken together, these reforms suggest that it is possible to improve access through program reform and that a combination of sufficient funding and administrative reform appears necessary to do so – whether program improvements are instituted by the state or through managed care contracting.

In contrast, the majority of states have instituted one or more dental program reforms that have yielded little access improvement. One characteristic that these reforms have in common is an insufficient increase in payment rates to dentists, despite other reforms in contracting arrangements or program management. Non-financial reforms appear to have little impact on access if not linked to sufficient increases in payment rates to dentists. As a result, adequate provider payment is regarded as a necessary, but not sufficient, condition for improving Medicaid.

Sufficient payment rates to dentists can be characterized as those rates that cover, at least, the providers’ cost of delivering care. Market-based rates to dentists are those rates that will induce a significant portion of available providers to participate. Market-based rates do not necessarily have to be as high as the typical market rates incurred by self-paying or commercially insured patients, because dentists appear to be willing to accept modestly discounted fees when caring for Medicaid beneficiaries. The level of discount that is acceptable in a market is contingent upon dentist supply, overall demand for care, and social norms regarding commitment to vulnerable people. Demand is predicated upon the overall state of the economy and consumer confidence, as many dental procedures are considered elective. Social norms and commitment to the underserved vary nationwide. For example, in North Dakota, which has a culture of interdependence, payments approximate the 50th percentile, and a substantial percentage of dentists are engaged in Medicaid; in other states, however, similar rates do not stimulate provider participation.

Increases in program funding that do not “trickle down” to providers will have little impact on access. If increases in program funding, even substantial increases, do not offer payments that cover dentists’ overhead costs, the increases will have minimal impact on access.
Connecticut’s current proposal does not include any new monies to raise provider payments. Since vendors’ current payment rates in Connecticut reflect the fees of less than 10 percent of the state’s dentists (i.e., less than the 10th percentile), payment levels are considered inadequate. As such, administrative reforms and single-vendor ASO contracting may not, based on other states’ experiences, significantly improve access.

In contrast, Michigan was able to demonstrate substantial increases in access in demonstration counties. They achieved these increases through a federally approved waiver demonstration: they markedly increased payments to dentists (paying at the 80th percentile) and engaged a well-established commercial vendor, Delta Dental of Michigan. Delta brought its pre-existing, large, and active network of providers to the Medicaid program and offered dentists the same administrative terms and experiences as offered to commercially insured patients. As a result, the state’s dental Medicaid program manager reports that utilization in demonstration counties is approximating commercial rates, thereby meeting Medicaid requirements of equal access. Participating dentists are required to accept new patients, see them within three weeks of initial office contact, and provide emergency services within 24 hours of contact. The lesson learned from this Michigan demonstration is that paying market rates and utilizing an existing, robust provider network (under the same terms and conditions as commercial participation) combined to markedly increase access.

South Carolina’s legislature committed to market-based purchasing by setting fees to approximate the 75th percentile. The unique lesson learned in South Carolina was that its success in developing a sufficient provider network was directly linked to the fee increases as a quid pro quo. Fee increases were specifically predicated on the state dental society’s success in recruiting dentists for the program. This approach engaged a key stakeholder – private dentists – in designing and implementing successful reform.

Alabama has elected to retain dental program management in-house at the state Medicaid agency rather than contracting to managed care. This state has demonstrated successful provider recruitment in its “Smile Alabama” program utilizing a combined strategy of market-based fees (approximately the 75th percentile), a direct appeal to dentists by former Governor Don Siegelman, simplified claims administration, enhanced provider and beneficiary services, and a marketing campaign. The lesson learned from Alabama is that provider and beneficiary relations – whether instituted by the state or a vendor – are critically important to program success.

In Delaware, payment of sufficient, yet discounted rates, with little other programmatic change, yielded an increase in access. Delaware adjusted its payment rate to 85 percent of dentist-submitted customary charges while retaining administrative responsibility within the state’s Medicaid agency. The state’s Medicaid director, however, has suggested that further access improvements will require non-financial administrative reforms that make the program easier for a provider’s business staff to manage. For example, the state is considering replacing its current proprietary claim form with a universal commercial form.

Although Georgia has less information available than other states about the impact of its fee enhancements, reports from practitioners in that state suggest that market-based fee increases have had less impact than anticipated. In order to make the program more workable for office staff, dentists would like Georgia to streamline its administrative and claims-management procedures. The lesson here is that administrative streamlining may be, like sufficient fees, a necessary, but not sufficient, condition for improving access.

Although Indiana’s 1998 reform first succeeded in increasing access, it lost momentum and slipped backwards because it failed to maintain market-based fees through regular adjustments for inflation. The lesson here is that meaningful fee improvements, once made, need to be sustained or the provider network will degrade.
Tennessee is the most recent state to implement major reforms that include, but are not limited to, market-based payment rates. Like Connecticut, Tennessee turned to mandatory managed care contracting in the mid 1990s. When TennCare was established in 1994, the state contracted with multiple vendors who assumed financial risk and subcontracted dental care to dental plans. Having failed to generate sufficient access for beneficiaries, in 2000, the state reversed most of its 1990 decisions. It elected to carve-out dental from medical managed care and issued an RFP for direct non-risk contracting with a single dental ASO, Doral Dental. Tennessee raised fees to approximate the 75th percentile, developed a substantive alliance with the state’s dental association to recruit providers, and implemented a social marketing campaign. The new program also features improved accountability by requiring the ASO to provide information on numbers of members served, numbers and types of procedures delivered, referrals, and information on quality improvement activities. The state’s new program, which began October 2002, is believed to hold strong promise for success because it addresses payment, partnerships, beneficiary support, dentist support, and accountability issues.

The Connecticut experience and current proposal appear to be very similar to that of Tennessee except that Connecticut does not plan to increase fees to market levels, does not engage stakeholders in program reform, and does plan to assign its ASO vendor with some level of financial risk. As sufficient fees are considered a necessary condition for program success, risk contracting may introduce a perverse incentive against access enhancement; and since multiple states have demonstrated the utility of engaging the dental community, Connecticut’s reform appears to hold less promise than Tennessee’s dental carve-out program. A number of administrative “best practices” have evolved from efforts to improve access, including:

- Ongoing and meaningful collaboration of all stakeholders, including dentists and hygienists, safety-net providers, hospitals, advocates for the poor, and beneficiaries;
- Streamlined administration including electronic eligibility verification and claims management, elimination of most prior authorization requirements, rapid claims payment, use of professionally accepted coding systems and claim forms, and facile mechanisms for rapid conflict resolution;
- Improved performance reporting;
- Strong vendors incentives that are regularly awarded and sanctions that are routinely enforced;
- Engagement of community health centers, school-based clinics, and other safety-net providers;
- Integration of medical and dental care through tracking forms and facilitated referrals; and
- Strong provider and beneficiary support.
Experience across the nation suggests that options in program administration, in and of themselves, hold little promise of improving access. For states, each decision – whether or not to contract to managed care, carve dental in or out, put contractors at risk, or engage single or multiple vendors – has its benefits and advantages.

Evidence suggests, however, that these decisions are not the primary determinants of success in increasing access to dental care for low-income beneficiaries. Rather, success depends primarily upon:

- Sufficiency of payments,
- Sufficiency of provider availability, and
- Strong program oversight.

A handful of states that have significantly increased access have done so by utilizing a variety of program arrangements. Yet, these diverse programs share several common elements that lead to their success, namely:

- Funding at market rates,
- Simplified program administration,
- Active engagement of stakeholders in designing and implementing reform, and
- Rewarding access improvements.
This document was prepared under contract with
the Children’s Dental Health Project of Washington, D.C.,
by Burton L. Edelstein, D.D.S., M.P.H.
The Connecticut Health Foundation (CHF) is the state’s largest independent, non-profit grantmaking foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. For additional information, click onto www.cthealth.org.
Provider Survey: A survey was distributed to a list of providers from Georgia's Department of Community Health, including both GDA members and nonmembers, to determine dentists' participation in Medicaid and PeachCare plans.

URGENT – PLEASE RESPOND IMMEDIATELY

TO: (NAME) (FAX NO.) (COUNTY)

DATE: September 10, 2007

Records from the Department of Community Health indicate that you are a participating provider with one or more of the Care Management Organizations (CMOs) that administer Medicaid and PeachCare. The Georgia Dental Association (GDA) is conducting a very important survey. The purpose of this survey is to obtain information about issues related to access to care in the Georgia Medicaid and PeachCare programs. Gathering this information is critical and your answers are very important, so please take the time to complete the survey immediately. Your personal information will not be shared with anyone. If you have more than one dentist in your practice, please answer this survey as a single practitioner for all practice locations.

1. Indicate if you are still a participating provider with the following Medicaid and PeachCare plans (place an X by all that apply):

   - Amerigroup (administered by Doral)
   - Peach State (administered by Avesis)
   - Well Care (administered by Doral)
   - None of the above

2. For each of the plans that you indicated above that you participate in, list the number of Medicaid and/or PeachCare patients that you have treated within the last six months:

   - Amerigroup (administered by Doral)
   - Peach State (administered by Avesis)
   - Well Care (administered by Doral)

3. Are you accepting ANY new patients (either private pay or any public or private insurance programs)?

   - Yes
For which of the following are you accepting new Medicaid and/or PeachCare patients (place an X by all that apply):

- Not accepting any new Medicaid or PeachCare patients
- Amerigroup (administered by Doral)
- Peach State (administered by Avesis)
- Well Care (administered by Doral)

5. If you are accepting NEW Medicaid and/or PeachCare patients, indicate the approximate number you could accept MONTHLY and continue to provide appropriate care:

6. Do you limit the number of Medicaid and PeachCare patients that you treat in your practice?

- Yes
- No

7. If you answered “yes” to question 6, what percentage of your practice is Medicaid and PeachCare?

Please fax your response to the GDA office (404.633.3943) immediately. If we do not hear from you within 10 days, a representative will be calling you. Thank you.
**Responses to Provider Survey:** The GDA compiled results from a survey conducted of members and non-members to determine dentists' participation in Medicaid and PeachCare plans. A large portion of its membership participated in the survey but it was difficult to locate and encourage non-members to respond.

**Responses to Medicaid Provider Participation Surveys October 2007**

For GDA members:
- Total 672 members
- 473 responses
- 199 no response
- **70% participation for members**

For Non-Members:
- Total Non-Members 197
- 79 responses
- 118 no response
- **40% participation for non-members**

Members and Non Members:
- Total Members and Non-Members 869
- 552 Responses
- 317 no response
- **Overall Participation of both Members and Non-Members 64%**

In an effort to contact non-members the following action was taken:
Lisa called both Amerigroup and Wellcare to see if she could locate a non-member dentist through their customer service department. With both Amerigroup and Wellcare you had to go through an automated system to locate a dentist. Then you had to enter your zip code and they would give you the names of the dentists closest to you. The system did not give you an option of searching for a particular dentist.

Lisa also called Peach State and did get through to a live person, however they wanted a member ID and a SS number before they would release any information

The no responses were for a variety of reasons:

**Members:**
- Left Messages 90 (DDS did not call back)
- No longer at this office 17
- Faxed survey 12
- Busy Signal 11
- Wrong Numbers 9
- Working on the survey 5
- Office Closed 6
- Disconnected Number 6
- Retired 4
- No longer participates in Medicaid 1
- Does not wish to participate 1
- Will be faxed back 1

**Non Member:**
- Left Messages 37 (DDS did not call back)
- No longer at this Office 18
- Busy Signal 9
- Disconnected Number 9
- Wrong Number 8
- No answer/no voicemail 5
- Faxed Survey 2
- Practice Sold 1
- Does not wish to participate 1
- Retired 1
MEDICAID SURVEY

REPORT OVERVIEW
Prepared October 2007

This report summarizes the results of the GDA Medicaid Survey, which was conducted in September/October 2007. Surveys were sent via fax to participating providers. Responses were received via fax, or by follow-up phone calls from GDA staff.

A total of 662 responses were received. Of these, 83 (12.5%) respondents indicated that they were no longer participating in any Medicaid dental plan (Amerigroup, Peach State, or Well Care). The remaining 579 respondents participated in at least one plan.

The results show that Well Care had the highest provider participation and the highest patient utilization among the Medicaid dental plans.

The results in this report are presented for the State of Georgia as a whole, and by county. Of the 159 counties in Georgia, 107 have at least one Medicaid dental provider. The survey results for the state of Georgia are shown on the next page and numbers of providers by county are shown in tabular form on the following page.
1. Indicate if you are still a participating provider with the following Medicaid and PeachCare plans:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>429</td>
<td>64.8%</td>
</tr>
<tr>
<td>Peach State</td>
<td>435</td>
<td>65.7%</td>
</tr>
<tr>
<td>Well Care</td>
<td>495</td>
<td>74.8%</td>
</tr>
<tr>
<td>None of the above</td>
<td>83</td>
<td>12.5%</td>
</tr>
<tr>
<td>NOT ANSWERED</td>
<td>2</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

2. For each of the plans that you indicated above that you participate in, list the number of Medicaid and/or PeachCare patients that you have treated within the last six months:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>126,806</td>
<td>295.6%</td>
</tr>
<tr>
<td>Peach State</td>
<td>138,372</td>
<td>318.1%</td>
</tr>
<tr>
<td>Well Care</td>
<td>204,353</td>
<td>412.8%</td>
</tr>
<tr>
<td>ALL PLANS COMBINED</td>
<td>469,531</td>
<td>345.5%</td>
</tr>
</tbody>
</table>

3. Are you accepting ANY new patients (either private pay or any public or private insurance programs)؟

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>593</td>
<td>89.6%</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>3.6%</td>
</tr>
<tr>
<td>NOT ANSWERED</td>
<td>45</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

4. For which of the following are you accepting new Medicaid and/or PeachCare patients:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not accepting any new Medicaid or PeachCare patients</td>
<td>124</td>
<td>18.7%</td>
</tr>
<tr>
<td>Amerigroup</td>
<td>365</td>
<td>55.1%</td>
</tr>
<tr>
<td>Peach State</td>
<td>383</td>
<td>57.9%</td>
</tr>
<tr>
<td>Well Care</td>
<td>427</td>
<td>64.5%</td>
</tr>
<tr>
<td>NOT ANSWERED</td>
<td>41</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

5. If you are accepting NEW Medicaid and/or PeachCare patients, indicate the approximate number you could accept MONTHLY and continue to provide appropriate care:

<table>
<thead>
<tr>
<th>Panel</th>
<th>Average per Provider</th>
<th>Total Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td></td>
<td>32,773</td>
</tr>
<tr>
<td>(B)</td>
<td></td>
<td>19,823</td>
</tr>
</tbody>
</table>

Panel (A) is based on actual values reported by providers. Panel (B) is based on an upper limit of 100 new patients per month with current dental office capacity (i.e., extremely high outliers were not included).

6. Do you limit the number of Medicaid and PeachCare patients that you treat in your practice?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>111</td>
<td>16.8%</td>
</tr>
<tr>
<td>No</td>
<td>473</td>
<td>71.5%</td>
</tr>
<tr>
<td>NOT ANSWERED</td>
<td>78</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

7. If you answered “yes” to question 6, what percentage of your practice is Medicaid and PeachCare?

<table>
<thead>
<tr>
<th>% of practice</th>
<th>Average</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22.4%</td>
<td>19.0%</td>
</tr>
<tr>
<td>County</td>
<td>Providers</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Fulton</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>Gwinnett</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>De Kalb</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Cobb</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Clayton</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Appling</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Baker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Baldwin</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Barrow</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bartow</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ben Hill</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bibb</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Bleckley</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bryan</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bulloch</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Burke</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Butts</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Calhoun</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Carroll</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Catoosa</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Chatham</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Chattooga</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cherokee</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Clarke</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Clinch</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Colquitt</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Columbia</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Coweta</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Crisp</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dawson</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Decatur</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dodge</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Dooley</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dougherty</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Douglas</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Effingham</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Emanuel</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Evans</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Fayette</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Floyd</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Forsyth</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Franklin</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gilmer</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Glynn</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Gordon</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Grady</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Greene</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Habersham</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hall</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Haralson</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hart</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Henry</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Houston</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Jackson</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Jasper</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lanier</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Laurens</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Lee</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Liberty</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Lincoln</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lowndes</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Macon</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Madison</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>McDuffie</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>McIntosh</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Meriwether</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Miller</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Mitchell</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Monroe</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Morgan</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Murray</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Muscogee</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Newton</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Oconee</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Paulding</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Peach</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pierce</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Polk</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Putnam</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Rabun</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Randolph</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Richmond</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Rockdale</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Schley</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Screven</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Seminole</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spalding</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sumter</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Tattnall</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Taylor</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Telfair</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Thomas</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Tift</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Toombs</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Treutlen</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Troup</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Turner</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Union</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Walton</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Ware</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Wayne</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Whitfield</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Wilkes</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Wilkinson</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Worth</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>NOT ANSWERED</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>662</td>
<td></td>
</tr>
</tbody>
</table>
TO: ADA / GDA / CLS
FROM: BILL McINTURFF / ROB AUTRY
RE: GEORGIA OPINION ELITE FOCUS GROUP RESEARCH FINDINGS
DATE: FEBRUARY 6, 2008

METHODOLOGY

Public Opinion Strategies conducted two sets of focus groups with opinion elites in Atlanta on January 29, 2008 and in Savannah on January 30, 2008. In each location, we conducted one group among Democratic opinion elite voters and one group among Republican opinion elite voters. The focus group discussion format was designed to gauge awareness of and reactions to the Medicaid dental funding situation, identify initial perceptions about a carve out proposal, and determine which messages work best in building support for the carve out plan.

As in any focus group study, the goal of this project is a qualitative assessment of the subject. As such, comments cannot be projected to the total population, as is the case if we conduct a quantitative survey among these audiences. In other words, we cannot claim the views and opinions of focus group participants in this project exactly match the entire universe of opinion elite voters. Therefore, we focus less on specific counts/tallies and more on broad observations of the language respondents use in the conversation.

Further, this report cannot accurately detail the wealth of information to be found in the non-verbal area, such as body language, or the amount of time lapsed between questions from the moderator and actual responses from the group. This summary also cannot report on the subtle area of peer pressure and the willingness to avoid offering a particular response because of the fear of what others might think, or to change a response when others in the group appear to oppose their original position.

This summary memo is designed to be read in conjunction with the PowerPoint slide deck.
KEY FINDINGS

The focus group research guide was segmented into four key discussion areas:

A. Gauging awareness of and familiarity with the S-CHIP, PeachCare, and Medicaid programs;
B. Understanding how opinion elites react to hearing about the Medicaid dental funding situation and dentists’ reasons for not participating in Medicaid;
C. Assessing support for a dental carve out plan for Medicaid in Georgia; and,
D. Determining which messages best resonate with opinion elites in support and in opposition of the carve out proposal.

A. Familiarity with S-CHIP, PeachCare, and Medicaid

- Despite the heated political rhetoric coming out of Washington recently on the S-CHIP issue, few opinion elites had heard enough about the program to form an opinion of it. In fact, even after they heard a brief description of the program, respondents had a hard time recalling anything about it.

- Republican and Democratic opinion elites were more aware of the state’s S-CHIP program, PeachCare, though. At least a majority in each group had heard of the program and were familiar enough to describe it. By and large, there was solid support for the program with most opinion elites recognizing the public health need for such a program. This sentiment was especially strong with the Democratic opinion elite audience.

- Across all four groups, there was quite a bit of confusion about the Medicaid program. Equal numbers of opinion elites regarded Medicaid as “that government program that provides health care for the elderly” as could correctly identify it as the health insurance program for low income Americans. Even after reading a definition of the program, it was easy for opinion elites to revert back to talking about Medicaid in terms of senior citizen care.

B. Medicaid Dental Funding / Reimbursement

- There was absolutely no recall or awareness about the state’s Medicaid dental funding crisis or the dentist reimbursement issue. This issue is very much a blank slate.

- Opinion elites were surprised to learn that dental coverage for Medicaid children is quite limited. Specifically, respondents expressed both shock and dismay that only one out of four Medicaid-eligible children receive dental care.
For the most part, opinion elites found the dentist rationale for not participating in the Medicaid program understandable. While Republican elites were clearly more supportive of the dentist position from a business perspective ("they have the right to run their practice as they see fit"), Democrats were more hedging in their acceptance of the dentist position. As one Democratic opinion elite in Savannah noted, "I understand where the dentists are coming from. Is it acceptable? Well, I understand it, I don't necessarily accept it." Democrats were also fairly split as to whether or not dentists should be providing dental services even if they are losing money on these Medicaid patients; Republicans wholeheartedly felt dentists deserved to receive the same payment that they would get from insurance companies.

The strongest elements of the dentist rationale were that the current system is highly inefficient ("there are three CMOs with three different rules and three different rates"), is riddled with bureaucratic hurdles ("complex and costly administrative burdens being placed on dentists in order for them to participate"), and is reducing provider fees ("one program recently slashed fees 25 percent for urban providers and 15 percent for rural providers"). These three factors were regarded as understandable reasons for why dentists were reluctant to participate.

Additionally, the more opinion elites heard about CMOs, the less they liked them. Prior to the start of our discussion, few had heard the term "Care Management Organization" or CMO; but after reading the dentist rationale for not participating in Medicaid and after reading a basic definition of the phrase, it was clear that few held these groups in high esteem. Respondents often used phrases like "the middleman," "pencil pushers," and "greedy corporate bureaucrats" to describe the role CMOs play in the Medicaid process.

In fact, we asked opinion elites to rate several health care terms on an imaginary thermometer from one degree to one hundred degrees, where one means they have a very cold/very unfavorable image of the term and one hundred means they have a very warm/very favorable image of the term (with fifty being neutral). The average thermometer rating across all four groups of CMOs prior to the start of the discussion was 46; at the end of the groups, the average rating dropped to 34.
C. Dental Carve Out Proposal

Regardless of partisanship, there was strong initial support for the carve out plan among opinion elites in both Atlanta and Savannah. As you can see from the table below, solid majorities in all four groups backed the proposal, with nearly half strongly favoring it:

<table>
<thead>
<tr>
<th></th>
<th>Atlanta DEM</th>
<th>Atlanta GOP</th>
<th>Savannah DEM</th>
<th>Savannah GOP</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Favor</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Somewhat Favor</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL FAVOR</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL OPPOSE</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Somewhat Oppose</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Strongly Oppose</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The primary reason for supporting the proposal was the belief that it would reduce CMO control from three companies to one company, bringing efficiencies to the program, and thereby resulting in more dentist participation.

There is an important finding here not to be taken lightly: Opinion elites of all political stripes agree that the objective of fixing this system should be to increase dentist participation.

D. Message Testing

Our strongest message points focus primarily on bringing efficiencies to the Medicaid program. Specifically, opinion elites were drawn to language that talks about how the proposal will:

- "use the money currently in the system more efficiently"
- "bringing efficiency and lower overhead to dental programs"
- "establish a single dental program administrator"
- "a single administrator and a more efficient system under the carve out"
- "will save the state money in the long run"
- "prevent runaway budget spending"
Republican and Democratic opinion elites both found the “using what we have” message to be one of the most effective arguments in support of the carve out proposal. In fact, 17 out of 32 opinion elites (eight Democrats and nine Republicans) selected this message as one of their top two most convincing messages in support of the plan:

Supporters of the carve out proposal say this proposal will not require an increase funding for dental care, but instead, it will use the money currently in the system more efficiently and prevent runaway budget spending. A carve-out would also establish a single dental program administrator, bringing efficiency and lower overhead to dental programs in great need of both. (Message H: 17 out of 32 top two selections)

Democratic opinion elites were also drawn to the “prevention is key” message (nine Democrats selected it as one of their top two, compared to only five Republicans). The discussion that followed found that most elites agreed with the message’s premise—that preventative dental care saves money in the long run—but they also acknowledged that the message doesn’t give an implicit rationale for why one should support the carve out proposal.

Supporters of the carve out proposal say it will save the state money in the long run. That’s because unlike other forms of health care, dental care places a greater focus on prevention. Regular dentist visits can identify, treat, and even prevent dental problems before they occur. Without this preventive care, Medicaid patients are forced to wait until the problem becomes so severe that they require emergency hospital attention. Not only is the hospital more expensive, but rarely does that visit solve the dental problem or prevent it from happening again. (Message G: 14 out of 32 top two selections)

Republicans were more approving of the “it’s worked elsewhere” message than their Democratic counterparts (eight Republicans selected it as one of their top two, compared to only four Democrats). That’s not to say Democrats didn’t find the message compelling—most did and remarked how it was one of their top three or four. And, elites found it comforting to learn that states nearby (and similar in demographics to Georgia) had tried this system and it was working. As one Savannah respondent noted, “It’s not as risky of an idea now.”

Supporters of the carve out proposal say the experience around the country shows dental carve outs work. Neighboring states like Tennessee, North Carolina, South Carolina, Virginia and Kentucky have adopted carve out programs and all have experienced an increase in preventive-care visits by low-income children and an increase in dentists participating in Medicaid dental programs. (Message I: 12 out of 32 top two selections)
The opposition’s best message really doesn’t tackle the carve out plan head-on or argue for the status quo. Instead, the only message from the opposing side that had any traction or got much reaction was “investing in more government programs and clinics.” This notion that private companies (or a private company in the case of the carve out plan) are involved conjured up images of having a “middleman” and “tax dollars going to greedy corporations.” Democratic opinion elites were more supportive of having the money go to public health programs and clinics for Medicaid patients, but Republicans weren’t opposed to the idea either.

Opponents of the carve out proposal say that instead of paying private for-profit companies, the government should be investing in more public health dental programs and community clinics that can provide the same high level dental care at a more reasonable rate. (Message M: 17 out of 32 top two selections)

**THE BOTTOM LINE**

These focus group findings do provide guidance in helping the American Dental Association and Georgia Dental Association better understand how opinion elites feel about the carve out proposal and what message elements effectively make the case for it.

First and foremost, assume nothing in this debate. Even highly educated, well informed, and very active voters have limited knowledge and familiarity with Medicaid, often confusing it with Medicare. If the general public becomes a target group for communications on this issue, part of our messaging must inform and educate about the role and importance of Medicaid.

Secondly, they must be informed about the problem (the declining number of dental care providers and one-in-four children not getting dental care). And, focusing this debate on children does get their attention.

Thirdly, the most effective messaging promotes the efficiencies of this carve out plan – having one administrator as opposed to three will bring lower overhead and fewer bureaucratic nightmares, end up costing the state less money (or no more money), and result in more dentists participating and providing care.

Finally, there is nothing we learned from these groups that suggest dentists or the Georgia Dental Association will take an image beating from advocating for a carve out proposal.* While certainly not statistically valid in any sense, the image ratings of dentists (from 63 to 72) and the Georgia Dental Association (from 45 to 50) did improve after this discussion took place. Moreover, opinion elites strongly believe dentists are a crucial part of solving this problem and finding a way to increase their participation must be the main objective of any type of reform.

* Of course, this is what we learned in a control environment (focus group setting). As is often the case in these sorts of public policy battles, the volume of the opposition sometimes gets louder than what respondents heard here.

---

Public Opinion Strategies