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☞ Details: Proposed Audit: Medicaid Dental HMO Program, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (July 2012)

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

February 17, 2005

Representative Dean Kaufert
308 East, P.O. Box 8952
Madison, WI 53708

Dear Representative Kaufert:

We received the request that you recently submitted to the Joint Audit Committee. This letter serves as confirmation of that request.

Each request submitted receives serious consideration. As conscientious legislators, we all welcome new ways to do things less expensively or more efficiently. We, as co-chairs of the committee, aim to meet once a month to discuss all requests. Shortly after the meeting, one of us will follow-up with you directly to let you know the status of your request.

Thank you again for your request and we will be in touch soon.

Sincerely,

Senator Carol Roessler
Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-5300 • Fax (608) 266-0423

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624


FORWARD

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

February 17, 2005

Representative Samantha Kerkman
109 West, P.O. Box 8953
Madison, WI 53708

Dear Representative Kerkman:

We received the request that you recently submitted to the Joint Audit Committee. This letter serves as confirmation of that request.

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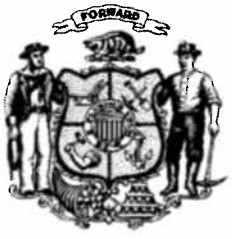
WISCONSIN STATE LEGISLATURE


FORWARD

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

February 17, 2005

Representative Dan Vrakas
119 West, P.O. Box 8953
Madison, WI 53708

Dear Representative Vrakas:

We received the request that you recently submitted to the Joint Audit Committee. This letter serves as confirmation of that request.

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Thank you again for your request and we will be in touch soon.

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Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

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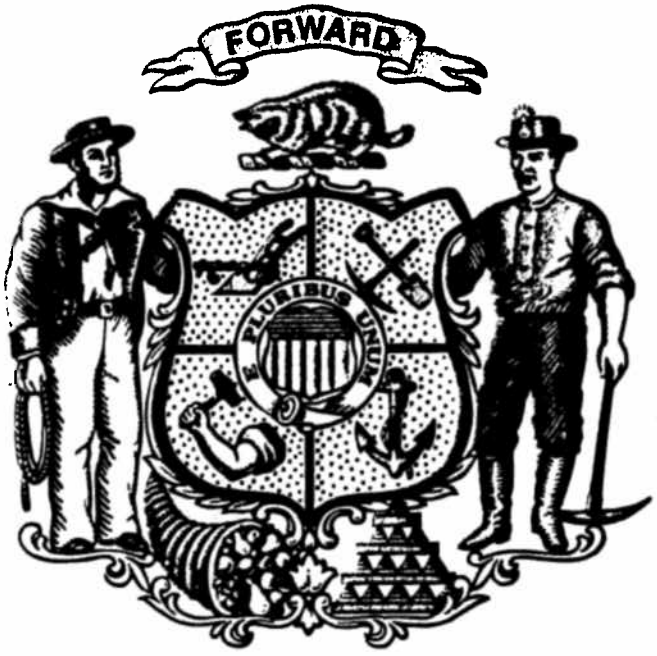
FORWARD
E PLURIBUS UNUM

Wisconsin State Senator
Ron Brown
District 31

February 24, 2005

The Honorable Carol Roessler, Co-Chair
Joint Legislative Audit Committee
Room 8 South, State Capitol
Madison, WI 53703

The Honorable Sue Jeskewitz, Co-Chair
Joint Legislative Audit Committee
Room 314 North, State Capitol
Madison, WI 53703

Dear Co-Chairs Roessler and Jeskewitz:

On behalf of dentists throughout the 31st Senate District, I write to request that the Legislative Audit Bureau (LAB) conduct an audit of the portion of the state's Medical Assistance (MA) contract utilizing an HMO to administer dental services in Racine, Kenosha, Milwaukee and Waukesha counties.

I understand that instead of the fee-for-service model used throughout the rest of the state, the state contracts with medical HMOs for provision of dental services to MA patients in these four counties by providing a flat monthly enrollment fee. The dental services are then subcontracted to a dental managed care organization, which in turn subcontracts directly with individual dentists who provide the services.

In addition to a general comparison of the costs and benefits of the HMO contract and the fee-for-service models, I request that the LAB review the record keeping procedures required under the two programs. In times of increased program needs and provider shortages, it is important that we ensure that the state is receiving the maximum benefit for the funds expended for the Medical Assistance program.

Thank you for your consideration of this request. Please don't hesitate to contact me if you have any questions regarding this issue.

Sincerely,

Ron Brown
State Senator
31st District

RB:km

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email: sen.brown@legis.state.wi.us • web: http://www.legis.state.wi.us/senate/sen31/news/

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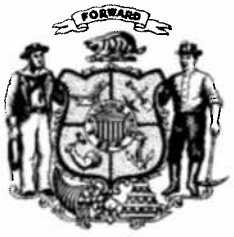

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 1, 2004

Ms. Helene Nelson, Secretary
Department of Health and Family Services
1 West Wilson Street, Room 650
Madison, Wisconsin 53703

Dear Ms. Nelson:

The Joint Legislative Audit Committee will hold a public hearing at 9:00 a.m. on Tuesday, March 8, 2005, in Room 417 North of the State Capitol. At that time, the Committee will consider a proposed audit of the Medicaid Dental HMO program administered by the Department of Health and Family Services.

As this proposed audit relates to the activities of your Department, we ask that you, or appropriate members of your staff, be present at the hearing to offer comments on the proposed audit and to respond to questions from committee members. The Legislative Audit Bureau will forward a memorandum outlining the scope of the proposed audit for your review in advance of the hearing.

Please contact Ms. Pam Mathews in the office of Representative Suzanne Jeskewitz at 266-3796 to confirm your participation at the hearing. Thank you for your cooperation and we look forward to seeing on you on March 8th.

Sincerely,

Carol Roessler

Senator Carol A. Roessler, Co-chair
Joint Legislative Audit Committee

Suzanne Jeskewitz

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Ms. Janice Mueller
State Auditor

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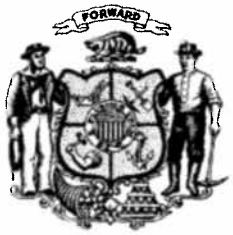

STATE OF WISCONSIN
Legislative Audit Bureau

22 E. Mifflin St., Ste. 500
Madison, Wisconsin 53703
(608) 266-2818
Fax (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

Janice Mueller
State Auditor

DATE: March 2, 2005

TO: Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee

FROM: Janice Mueller
State Auditor

SUBJECT: Proposed Audit of the Medicaid Dental HMO Program—Background Information

At your request, we have gathered some background information the Joint Legislative Audit Committee may find useful in considering requests from several legislators for an audit of the State's contracts with health maintenance organizations (HMOs) to provide dental care to Medicaid clients. The requestors have expressed concern that reimbursement payments for dental services through HMO plans may be less than those received through fee-for-service plans. There is also concern that low reimbursement payments are reducing the number of dentists willing to accept Medicaid clients, making it difficult for them to receive services.

In most counties, Medicaid dental services are reimbursed through traditional fee-for-service payments. However, the Department of Health and Family Services (DHFS) manages/administers the State's contracts with HMOs for the provision of Medicaid dental services in Kenosha, Milwaukee, Racine, and Waukesha counties. HMOs in these counties contract with dental managed care organizations. These organizations, in turn, contract with dentists. Some dentists have asserted that under this arrangement, an unnecessarily large amount of the State's contract costs support administrative expenses of the HMOs and dental managed care organizations, reducing the funds available to pay for dentists' services.

According to DHFS staff, the State pays a monthly capitation rate of approximately $5.00 per enrollee for dental services. However, the payments dentists actually receive from the HMOs can only be estimated, because the HMOs are not required to share proprietary information on their contractual agreements with dentists and other providers.

Currently, one of the issues being studied by a Governor's Task Force to Improve Access to Oral Health is access to dental care by Medicaid clients. DHFS staff are currently researching related issues, including compiling data on dental service delivery in the four HMO counties, estimating what these services would have cost in fee-for-service counties, and assessing client satisfaction with their dental services in the HMO counties. DHFS staff indicate they plan to provide a report

on their research to the department secretary by March 31, 2005, and that the information may be made available to the Task Force for discussions at its meeting on April 15.

An audit of the State's contracts with HMOs for dental services could include:

- a review of program participation statistics, by county, including the number of Medicaid clients enrolled, total dental visits annually, and other client information that may be available;

- a review of program participation by dentists, by county, including the number of dentists listed on provider rolls, the number accepting new patients, the length of patient wait for appointments, and other dental provider information that may be available;

- a survey of dentists to compare reimbursement rates for similar services in HMO counties and fee-for-service counties;

- a comparison of the per capita costs for dental services in fee-for-service counties with the contracted per capita costs paid in the HMO counties;

- an independent review of the expected data analyses prepared by DHFS; and

- a review of Medicaid dental programs in selected other states.

If you have any questions regarding this request, please contact me.

JM/DB/bm

cc: Senator Robert Cowles
Senator Scott Fitzgerald
Senator Mark Miller
Senator Julie Lassa

Senator Ronald Brown
Senator Dave Hansen
Senator Cathy Stepp

Representative Samantha Kerkman
Representative Dean Kaufert
Representative David Travis
Representative David Cullen

Representative Mary Hubler
Representative Gary Sherman
Representative Daniel Vrakas

Helene Nelson, Secretary
Department of Health and Family Services


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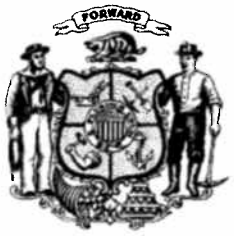

FORWARD

Wisconsin Dental Association, Inc.

Wisconsin Dental Association (WDA) Testimony to the Joint Audit Committee

Proposed Audit of the Dental Medicaid HMO Program

Public Hearing
March 8, 2005
Presented By: Dr. Michael Costello

My name is Dr. Michael Costello. I am a general dentist and have been practicing in the downtown Milwaukee area for 24 years. As an active member of the Wisconsin Dental Association (WDA), I would like to thank you for allowing me to speak at today's hearing. I am here to urge you, the members of the Joint Audit Committee, to conduct an audit of the Wisconsin Department of Health and Family Services (DHFS) Medicaid Dental HMO program.

During my 24 years in practice I have always cared for patients covered under the Wisconsin Medicaid Program. At times, up to 25% of my practice was involved in treating Medicaid patients. Rarely has this been a wise business decision or even a profitable one. In my early years of practice, prior to the contracting of HMO's, I at least knew what my reimbursement would be. It wasn't much, but I could count on a definite figure to cover operating expenses. Since that time it is more like gambling. You provide care and wait to see what you are dealt. Early in the HMO era, reimbursement generally covered overhead. Now with my overhead at 65% and reimbursement any where from 27% to 35% of my fees, my family subsidizes the state's program through my lost income. Since the first of this year I have restricted the Medicaid portion of my practice to children 18 and under or anyone with a dental emergency. This is my attempt to limit my losses, and still care for those most in need. Yet, it still remains a financial loss for my practice and my family. Some might call those of us caring for these folks good Samaritans or humanitarians but in the real world I am called a poor businessman and it's difficult to continue practicing when operating in this manner.

An audit is needed in order to determine if the program is adhering to its contract and providing its enrollees dental care as expected. We are hopeful that an audit of the dental HMO program will provide insight regarding utilization rates and the fiscal arrangements between the state and the medical HMOs. In my testimony, I will focus on the need for utilization data, while my colleague addressed the need for information on the cost-effectiveness of the HMO program, as compared to fee-for-service delivery.

Currently, the HMO program impacts four counties in the state (Racine, Kenosha, Milwaukee and Waukesha). Under the HMO program, the state contracts with medical

HMOs in exchange for a "promise" by the HMOs to take care of the dental care needs of their enrollees. Based on information we obtained from the DHFS website, the state appears to be paying the medical HMOs somewhere between $4.50 and $5.50 per month per enrollee in exchange for this "promise". Given the enrollment numbers of Medicaid recipients in these four counties, the dental-specific costs associated with the state's contract with medical HMOs end up costing the state approximately $10 million each year.

We hope that an audit will clarify what we suspect is the current financial arrangement; it is my understanding that after the medical HMOs take their "administrative fee" (which may be as much as 35% of the total contract), they pass the responsibility of providing the dental care on to a dental managed care organization that, in turn, takes another cut (because they actually do administer the program). The dental managed care organization then contracts with individual dentists to provide dental care. By the time the state's payments reach the individual dentist (who is actually absorbing the cost of the dental care treatment), the state's payments have been drastically reduced. As such, more and more dentists are dropping out, fewer patients are being seen and the state is still paying the medical HMO $10 million in exchange for its promise of providing dental care to their enrollees. The dental community would like to have the Legislative Fiscal Bureau conduct an audit of the HMOs in order to determine whether or not the services promised by the HMOs are actually being provided. It is our hope that an audit will uncover the types and volume of actual services the HMOs are providing to the Medicaid and BadgerCare community in exchange for their lump payment of $10 million. **It is important that the state obtain expenditures on the actual dental procedures performed for HMO Medicaid recipients, not a per capita cost.** Are the HMOs living up to their contract and ensuring that Medicaid and BadgerCare enrollees are receiving the dental care the medical HMOs have been paid for?

The HMOs continue to argue that the managed care delivery system is working well for dentistry; however, my colleagues and I are telling you a very different story. At the very least, the state should expect more thorough recordkeeping of the types and frequencies of dental services that Medicaid recipients are receiving in exchange for the $10 million the state pays out to the medical HMOs.

The audit should provide independent verification that the HMOs are each abiding by their contract with the state to provide a sufficient network of dentists to meet the demand for dental care by the HMOs enrollees.

The following is a list of specific data that would be beneficial for the state to obtain:

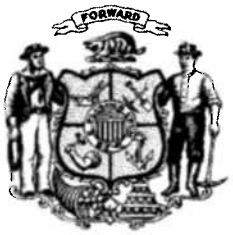
- The number of people enrolled for dental care in the entire HMO dental program.
- The number of people enrolled for dental care in each HMO by county.
- The number of dentists contracted to provide services for each HMO in each county.
- The number of dentists that are actively accepting new HMO Medicaid patients.
- How quickly an HMO patient can obtain a routine preventative service; a service for restorative care and an emergency service.
- The number of procedures performed for each covered dental code.

It is my hope that you, the Joint Audit Committee, will see the need to conduct an audit of the state's dental HMO program and will move forward with this request. As a practicing dentist and as a concerned taxpayer, it is my hope that the state will contract with entities that will provide specific clinical data as to the services HMOs are actually providing in exchange for receiving state-funded contracts.

Thanks you.

Michael Costello D.D.S

WISCONSIN STATE LEGISLATURE



Wisconsin Dental Association, Inc.

Wisconsin Dental Association (WDA) Testimony to the Joint Audit Committee

Proposed Audit of the Dental Medicaid HMO Program

Public Hearing
March 8, 2005
Presented By: Dr. Francesca De Rose

My name is Dr. Francesca De Rose. I am a general dentist and have been practicing in Racine, Wisconsin for 25 years. As chair of the Wisconsin Dental Association's (WDA) Dental Benefits Committee, I am here to encourage you, the Joint Audit Committee, to conduct an audit of the state's dental HMO Medicaid program. Given the state's current financial situation, and the lack of funds that are allocated to the fee-for-service dental Medicaid program, it is vital that the state conduct an audit in order to shed more light on the state's fiscal arrangements with the medical HMOs. It is my understanding that the information needed is not currently available from either DHFS, or the individual HMOs.

There are 72 counties in Wisconsin: 68 operate under a fee-for-service model and four (Waukesha, Racine, Kenosha and Milwaukee) operate under a medical HMO model. Each of these models is administered differently and, due to a lack of data, it is impossible to make an apples to apples comparison as to which model provides the greatest utilization to Medicaid and BadgerCare patients in the most cost-effective manner. I urge the state to conduct an audit in order to determine whether the enrollees of the state's Medicaid and BadgerCare program are actually receiving dental care in exchange for the pre-payment made by the state to the HMOs.

At this time, the state spends approximately $4.4 billion on its entire Medicaid and BadgerCare programs. Out of this $4.4 billion, only $36 million is spent on dental care ($26 million on fee-for service dental services and another $10 million on dental HMO services). Doing quick math, it is easy to see that less than one percent of the entire Medicaid budget is spent on dental services.

The state pays the medical HMOs up front for care and, in turn, relies on the HMOs to report that the care is being provided. The HMOs get the payment from the state and then take a cut off for their own "administrative costs". The HMOs then subcontract with one of the dental managed care organizations, who take another cut from the state's payment. The dentists then provide the care, and often do not know what they are getting paid for a procedure until **after** the procedure is done. Doral Dental uses a "global reimbursement" mechanism which means that the payment for each service decreases as the number of services provided increases; this payment discourages increased

utilization. SEDA (Southeast Dental Associates) uses a different mechanism that gets adjusted every six months and which weights certain procedures higher than others so as to discourage over-utilization of specific procedures within the program. Ultimately, these policies breed uncertainty and frustration for individual dentists who may otherwise join the program. Low participation by dentists results in a lack of access for Medicaid and BadgerCare patients, meanwhile the HMOs continue to receive the contracted payment of $10 million dollars.

There is little accountability on behalf of the HMOs to provide clinical data as to the services they are actually providing in exchange for receiving state-funded contracts. Regardless of whether Medicaid and BadgerCare patients receive dental care, the HMOs still receive payments from the state. While HMOs are required to report utilization of specific preventative services, there is no detailed accounting of all dental services provided by the HMOs. This is important because complaints regarding lack of access for Medicaid and BadgerCare patients are more likely to be associated with a need for more comprehensive, restorative-based dental care than with preventative care. This data should be available from the HMOs for both restorative and preventative services.

While the fee-for-service system is not perfect, my dental colleagues and I believe that the fee-for-service has three big advantages:

(1) The state does not pay a dime to anyone in the fee-for-service model until dental care has actually been provided. Under the managed care system, the HMOs get paid regardless of whether or not care is provided.

(2) In the fee for service system, every procedure that is performed is recorded and the state has a specific listing of the amount of money it is spending on every single dental procedure. Under the managed care model the state has no dental record of the types and volume of the specific dental procedures performed.

(3) While the fee-for-service payment schedule does not come close to meeting market rates (about 45% of average dentist fees), dentists at least know **up-front** what their payment is supposed to be; under the managed care model, dentists, who absorb the costs of the actual treatment, do not know what they will get paid until after services are performed.

This year our office is celebrating 50 years of dental service to our community. All 50 years we have been Medicaid providers. My mother, a pediatric dentist, started the practice. My sister, a pediatric dentist of 25 years, currently treats an average of 20 Medicaid patients per day.

We have seen the program change, but have continued to provide care under the fee-for-service model for foster care children, handicapped children, and handicapped adults. We have chosen to remain within the fee-for-service system for the reasons I have just described. Many patients covered by the HMO system call every day needing care. At this time, only one office remains that accepts HMO patients in Racine.

We feel bad for these children who are entitled to care and can not find it.

Thank you for providing me the opportunity to speak in favor of the proposal to conduct an audit of the state's HMO dental Medicaid program. The dental community is confident that an audit of the state's program will provide valuable analysis and we also hope that with these results, the state will be able to make more informed decisions regarding future administration of the dental Medicaid program. If you have any questions on dentistry's position regarding the audit of the Department of Health and Family Service dental HMO program, please do not hesitate to contact me.

Thank you.

Francesca De Rose D.D.S

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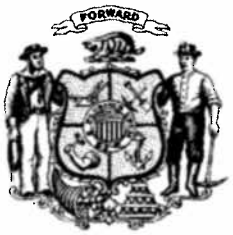


Talking Points for Joint Legislative Audit Committee Hearing
March 8, 2005
HMO Dental Issues
Diane Welsh, Health and Family Services

- In Wisconsin, we have a dental access issue. Governor Doyle, Secretary Helene Nelson and I, personally, have heard about problems accessing care from teachers, hospital administrators, social workers, Head Start coordinators, health care providers and from individuals seeking care. It is a problem for those who are on BadgerCare and Medicaid—and it an even bigger problem for poor individuals who do not qualify for BC or MA, or for those who are physical disabled or have mental health needs.

- Governor Doyle and this Administration are committed to improving access to dental care. In his KidsFirst initiative, Governor Doyle advances several items for improving access. And, he established a task force of dentists, hygienists, and other health professionals to provide further guidance on improving access to oral health care.

- The Governor's Task Force on Oral Health is examining a number of proposals to improve oral health and access to dental care for Wisconsin's children. That task force is scheduled to meet until May and will likely issue their recommendations this spring or early this summer.

- DHFS has also been working on the access issue—both through our Division of Public Health and Division of Health Care Financing (MA). We have implemented some changes—and are exploring other options—including how we use managed care organizations to provide dental services.

- Currently, three HMOs provide dental care to low-income family Medicaid and BadgerCare recipients in four counties in Wisconsin—Milwaukee, Racine, Waukesha and Kenosha. The HMOs are UnitedHealthcare, Managed Health Services, and

Network Health Plan. HMO enrollees in other counties receive their dental care on a fee-for-service basis.

- In those four counties, a total of 140,983 low-income family Medicaid and BadgerCare recipients are enrolled in HMOs. HMOs are paid a monthly capitation rate that includes dental care. Payments to HMOs for dental care are approximately $10 million all funds per year.

- The Department is in the process of completing a detailed analysis of dental care provided by the HMO in the four counties. A report will be completed in April 2005 and will cover the following areas:

  1. A comparative analysis of the Department's payments to HMOs for dental services using HMOs' encounter data priced at fee-for-service rates.

  2. An analysis of the adequacy of HMOs' dental provider networks and the availability of those providers.

  3. A review of grievances and complaints about dental services and access.

  4. A comparison of the rate of utilization of dental services in HMOs compared to Medicaid fee-for-service adjusted by length of enrollment.

  5. A review of customer satisfaction survey data of HMO enrollees.

  6. An analysis of specific performance measures regarding preventative dental care.

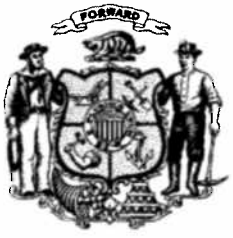
- The Department's analysis will include recommended actions based on our findings.

We intend to make changes to improve access to care—and we'll know more about how to do that when we see the report.

We are also looking forward to the Task Force recommendations.

Changes are needed to insure that people throughout the state have access to preventive and restorative dental care.


WISCONSIN STATE LEGISLATURE


FORWARD

DIVISION OF HEALTH CARE FINANCING

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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

MAY 23 2005

May 19, 2005

The Honorable Carol Roessler
Wisconsin Senate
Room 8 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

The Honorable Suzanne Jeskewitz
Wisconsin Assembly
Room 314 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952

Dear Senator Roessler and Representative Jeskewitz:

In testimony at the March 2005 meeting of the Joint Legislative Audit Committee, the Department of Health and Family Services' Chief Legal Counsel, Diane Welsh, mentioned the pending completion of an internal analysis of the managed care and fee-for-service dental delivery systems used in the Wisconsin Medicaid and BadgerCare programs. Attached, please find the latest draft version of this report, a copy of which has been provided to the Legislative Audit Bureau.

This report summarizes the findings of several months of collection and analysis of data from state fiscal year 2003. Key findings include:

- Neither the HMO nor the fee-for-service delivery system is operating at the level that the Department would desire; however, the HMO system is improving, and provides contractual guarantees for care that the fee-for-service system simply does not. Specifically, our contracts require HMOs to arrange emergency dental care within 24 hours and routine care within 90 days.

- Children enrolled in HMOs that provide dental care appear somewhat less likely than their fee-for-service counterparts to receive dental care. HMO-enrolled adults appear somewhat more likely than fee-for-service clients to be seen by a dentist.

- Continuous enrollment in the same HMO appears to improve access to preventive dental care for clients of all ages above the level attained under fee-for-service.

- Pricing HMO-reported dental encounters in 2003 at Medicaid fee-for-service reimbursement rates shows that the Department paid $2.7 million more than it would have, if the services had been provided in the fee-for-service system.

Based on our findings, the Department will undertake the following actions:

- Reform the HMO delivery system by realigning payments to HMOs to match utilization and strengthen contractual guarantees not available in the current fee-for-service delivery system to improve the level of service provided to clients.

- Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system.

- Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration.

- Support the efforts of the Governor's Task Force on Access to Oral Health Care to make children's oral health a priority.

Please let me know if you have questions or concerns regarding this analysis. I look forward to working with staff from the Legislative Audit Bureau as they complete their review.

Sincerely,

Mark B. Moody
Administrator

MBM:dd
PA04034.AS

Attachment

cc: Helene Nelson, DHFS Secretary
Diane Welsh, OS
James Vavra, DHCF
Jason Helgerson, OS
Angela Dombrowicki, DHCF

Analysis of Wisconsin Medicaid and BadgerCare Dental Service Delivery Systems

April 8, 2005

Introduction:

The Department of Health and Family Services (the Department) recognizes that many Wisconsin Medicaid and BadgerCare clients have great difficulty accessing needed dental care. This is a persistent problem that involves the amount of money budgeted to Medicaid dental services, but is also closely intertwined with larger issues of workforce, geography, and the economics of the dental profession.

Following the lead set by Governor Doyle, who set children's oral health as a priority in his KidsFirst agenda, the Department's Division of Health Care Financing (DHCF) began an extensive analysis in 2003 of the performance of Wisconsin's various dental delivery systems. Since it is not expected that substantial new funding will be available for dental reimbursement, it is imperative that the state use currently-budgeted funds on delivery systems that most effectively get services to the clients that need them. If other Wisconsin efforts, such as Governor Doyle's Task Force on Access to Oral Health Care, result in increased funding for dental care, the state must still have assurance that new investments result in increased performance.

This analysis compares the managed care dental delivery system that operates in the four southeastern counties around Milwaukee to the fee-for-service (FFS) system that operates in the rest of the state. In managed care, Health Maintenance Organizations (HMOs) are paid a monthly amount per person for every Medicaid or BadgerCare enrollee (capitation rate). In the FFS system, individual dentists submit claims to, and are paid by, the Department's fiscal agent according to a set schedule of fees. A comparison of the two reveals a complex picture of the situation facing Medicaid and BadgerCare clients.

Based on data from 2003, children enrolled in HMOs that provide dental care appear somewhat less likely than their FFS counterparts to receive dental care. HMO-enrolled adults, however, appear somewhat more likely than FFS clients to be seen by a dentist. Moreover, being enrolled continuously in the same HMO for more than ten months appears to improve access to preventive dental care for clients of all ages above the level attained under the FFS model.

The Division also analyzed the dental portion of the capitation revenues that the HMOs receive relative to the amount of dental care actually provided in 2003. Pricing HMO-reported dental encounters at Medicaid FFS reimbursement rates shows that, if the services reported by the HMOs were provided in the FFS system, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.

The Department believes that the HMO delivery system can be reformed to align payment rates with current levels of service utilization and to use the remainder as pay-for-performance incentives. Neither the HMO nor the FFS delivery system is operating at the level that the

Department would desire; however, the HMO system is improving, especially among continuously-enrolled clients, and there are notable advantages to a managed care model that advise its continuance. Most important are contractual guarantees that the Department can enforce to ensure that patients in need of dental care will be provided that care.

In the longer term, other dental delivery models exist that are worth further investigation. Most notable is the "carve-out" option, where the Department would contract with a specialized dental benefits administrator for claims processing and customer service. Several other states have pursued this option, which would likely incur administrative costs beyond the state's current fiscal agent contract. Although "carve-outs" seem to have their best results when accompanied by very large rate increases, such a strategy may be able to provide improvements that might warrant the additional expense.

Key Recommendations for Medicaid Dental Administration:

1. Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system.
2. Reform the HMO delivery system and strengthen contractual guarantees not available in the current FFS delivery system to improve the level of service provided to clients.
3. Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration.
4. Support the efforts of the Governor's Task Force on Access to Oral Health Care.

Background:

History

Medicaid Dental Benefit Overview

Under federal Medicaid rules, basic dental services are an optional benefit for adults and a required benefit for children when found necessary by an EPSDT (HealthCheck) screening. Wisconsin is one of about ten state Medicaid programs that maintains a fairly comprehensive dental benefit for both adults and children. Access to dental care, however, has been a persistent problem for Wisconsin Medicaid clients for more than 20 years. In any year during that period, no more than 30 percent of clients eligible for a dental benefit have actually received dental services, which is far below the 50 percent utilization rate for people with commercial dental insurance. It is not, however, out of line with the experience of most other state Medicaid programs. Overall, the Healthy People 2010 project reports that in 1996, 44 percent of persons aged 2 years and older visited a dentist during the previous year, indicating that access to dental care is not a problem limited solely to the Medicaid program.

Dentists' Practice and Workforce

Many of the problems that state Medicaid programs face in regard to dental care can be traced to differences between the economic and clinical realities of the medical and dental professions.

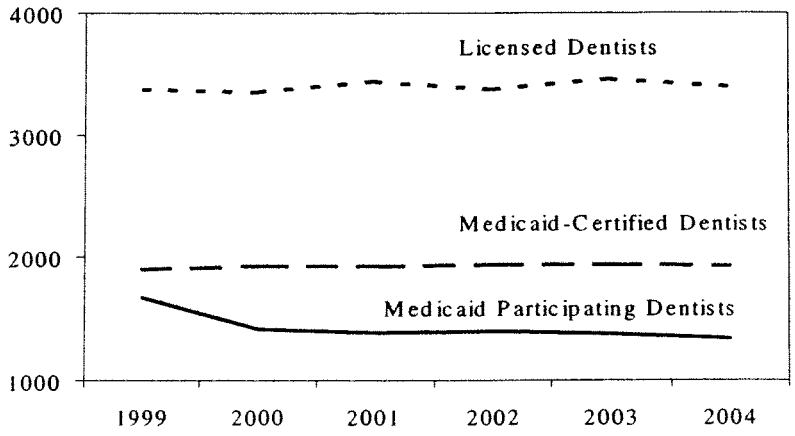
A large number of dentists are self-employed or work with only one partner, in small practices with limited patient pools and limited flexibility in scheduling. Forty-six percent of dentists responding to the 2001 Wisconsin Dentist Workforce survey report that they are "solo" practitioners. Presumably, such dentists must absorb any lost revenues whenever a lower-paying patient displaces a higher-paying one, or if patient appointments are missed without adequate prior notice.

Dentists also have a very different experience with insurance programs than physicians do. Only 44 percent of persons in the United States have some form of private dental insurance, most with limited coverage and with high copayments. Nine percent have dental insurance through state Medicaid programs, 2 percent have other dental insurance, and 45 percent – more than 100 million people – have no dental insurance at all.

Furthermore, there are important structural workforce issues at play. The ratio of dentists to the overall United States population has been falling for the last decade and has been exacerbated by the closure of several dental schools. In 2001, Wisconsin's ratio of dentists per 10,000 citizens ranged from 5.6 in the southeast to 4.2 in the south and southwest. The dentist workforce is also aging; fully 35 percent of the dentists responding to the 2001 Workforce Survey anticipated retiring by 2011.

In state fiscal year 2004, only 40 percent of Wisconsin's licensed dentists (about 1,300 dentists out of 3,400) submitted any claims to the FFS Medicaid program. Dentists continue to cite the same reasons for non-participation that they have for more than two decades: low reimbursement, administrative burden, and patient behaviors. Chart 1 below shows the decline in the number of dentists submitting Medicaid claims since 1999, even as the number of Wisconsin licensed dentists and Medicaid-certified dentists have stayed fairly constant.

Chart 1: Dentist Participation, Fee-for-Service Program, SFY 1999-2004



Previous Efforts

Wisconsin has made several attempts to improve dental access for Medicaid and BadgerCare clients. In the 1990s, dentists received multiple rate increases between 5 and 10 percent, some of

which were targeted specifically for children's dental services. The Department also engaged in joint provider recruitment and education efforts with the Wisconsin Dental Association (WDA). Additionally, from 2001 to 2003, the state's fiscal agent provided a specialized customer service unit to assist dentists billing Medicaid. These initiatives had no discernible impact on dentist participation in Medicaid. In the late 1990s, the Department attempted to start a managed care pilot for dental services in northern Wisconsin; however, capitation rates based on historic FFS costs, with an incentive component and an administrative allowance, were viewed as less than satisfactory by northern dentists. This initiative was never implemented. At the same time, the passage of SCHIP and EPSDT legislation, and release of the 2001 Surgeon General's report on oral health put new emphasis on dental care being essential to children's overall health.

In 2000, the Joint Legislative Council convened a study committee that produced two bills: a fiscal bill that would have raised fees to the level desired by WDA, and a non-fiscal bill comprised of several measures, including increased scope of practice for dental hygienists. Neither bill was enacted into law. In October 2004, Governor Doyle convened a Task Force on Access to Oral Health Care, which will report its recommendations in May.

It is expected that the Governor's Task Force will put forth recommendations including an expansion of the settings where dental hygienists can provide preventive care, an expansion of the number of Wisconsin students attending the Marquette University School of Dentistry, and increases to loan forgiveness opportunities for dentists and dental hygienists. They may also support a tax on soda that would provide program revenue to increase the Medicaid dental program's reimbursement rates.

Dental Care Delivery Systems

In SFY 2004, Wisconsin spent approximately $38 million for dental services provided to Medicaid and BadgerCare clients. Of this amount, approximately $28 million (75 percent) was for dental services provided under FFS. Approximately $10 million (25 percent) was distributed to health maintenance organizations (HMOs) for enrollees.

Medicaid HMOs have the option of offering dental services to their enrollees. Currently, only three HMOs serving in Milwaukee, Waukesha, Racine, and Kenosha counties cover dental services. Approximately 166,000 clients are enrolled in HMOs in these counties (48 percent of HMO enrollees, 25 percent of clients eligible for dental benefits). Approximately 493,000 clients (75 percent of clients eligible for dental benefits) in the other 68 Wisconsin counties receive FFS dental benefits administered by the state's fiscal agent, EDS.

Fee-for-Service

In the FFS system, clients are responsible for locating Medicaid-certified dentists and calling them to see whether they are accepting new patients. Very few dentists are, and most that do place restrictions on admissions by patient age or place of residence and dismiss patients from their practice for missed appointments.

Clients report significant frustration in finding dental care. The Medicaid fiscal agent receives more than 1,000 calls per month from clients seeking care. The Division, the Department, and the Office of the Governor receive between five and ten pieces of written correspondence per

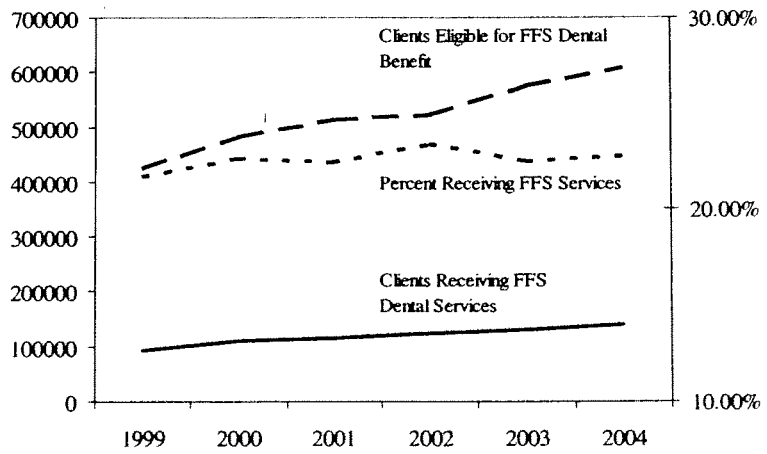
month regarding access to dental care. Staff of DHCF and the Department attempt to broker services for FFS clients in need, but their ability to do so is limited.

In state fiscal year 2004, about 23 percent of clients eligible for FFS dental benefits received at least one dental service. This percentage has remained steady for the last several years, even with caseload increases. In SFY 2004, Medicaid FFS payments were roughly equal to 46 percent of dentists' billed charges. Rates for dentists have not increased since SFY 2003, when dentists received a one percent increase.

The Division is pursuing several initiatives to improve the FFS program. The Division is recertifying dentists to ensure that contact information for only those dentists that are accepting new patients is provided to clients, in order to decrease clients' and providers' frustration with fruitless telephone calls. In addition, DHCF is advancing rule changes to reduce the number of services requiring prior authorization to address the "administrative burden" concern and to certify independently-practicing dental hygienists as Medicaid providers.

Chart 2 shows that the number of unduplicated FFS clients receiving dental services has increased slightly in each year since SFY 1999. However, the percent of clients receiving dental services has remained at approximately 23 percent because the number of unduplicated eligibles has been rising steadily. (Note that this is a count of every person who was eligible for Medicaid or BadgerCare FFS dental benefits in a year and will be much greater than the average enrollment for a year.)

Chart 2: Client Access to Care, Fee-for-Service Program, SFY 1999-2004



Because of the limited access to care in the FFS system, a set of volunteer and not-for-profit dental clinics has emerged across the state in recent years. These clinics are a major reason why access has kept pace with expanding enrollment, even with declining participation by private dentists. These clinics include state-subsidized clinics like the Rural Health Dental Clinic in Menomonie, which uses state and federal appropriations to employ dental staff; volunteer clinics like the Tri-County clinic in Appleton and the dental hygiene clinic at the Chippewa Valley Technical College, where volunteer dentists and students provide care to Medicaid clients, but

personally incur no overhead expenses; and Federally Qualified Health Centers (FQHCs) like those in Wausau and Ladysmith, which are eligible for cost-based reimbursement under Medicaid.

FQHCs are required to accept Medicaid clients and the uninsured, and are reimbursed for 100 percent of the allowable cost of providing care to Medicaid clients. Several rank among the most productive providers of dental services to Wisconsin Medicaid. The yearly cost settlements represent a significant expenditure by the Medicaid program. Based on the federal fiscal year 2003 experience of one FQHC dental clinic, the cost settlement can approximately double the payment made by Medicaid.

Managed Care

In the managed care system, the three HMOs serving southeastern Wisconsin (Network, UnitedHealthcare, and Managed Health Services) subcontract with two dental benefits managers, Doral Dental or Southeast Dental Associates (SEDA), to provide dental care for their Medicaid members.

The Division's contracts with HMOs include a number of provisions intended to ensure adequate access to dental services for enrollees. These requirements include maintaining adequate provider networks, informing enrollees of their dental benefits, and ensuring that they have access to routine care within 90 days and emergency care within 24 hours. In addition, enrollees have access to ombudsmen, who advocate on behalf of the enrollee to ensure that the enrollee receives needed services, and grievance processes at the HMO and the Department if they have problems obtaining dental services.

The Division monitors HMOs' performance on dental access and utilization in several ways. Encounter data in MEDDIC-MS is used to analyze utilization and consumer satisfaction is measured through use of the CAHPS® survey. Additionally, DHCF performs audits to determine the sufficiency of the HMOs' dental networks, monitors grievances filed by enrollees, requires HMOs to conduct additional dental outreach and case management services, and requires HMOs to implement a dental education initiative for parents and guardians.

Analysis of HMO Dental Encounters and Provider Revenue:

Background

Throughout 2003 and 2004, the Department has received complaints that HMOs have not been providing sufficient access to dental care. In early 2004, DHCF initiated a review of the cost of the managed care dental delivery system relative to services provided, to assess the extent to which the services provided corresponded to the capitation payments, and how utilization and access compared with FFS. The Governor has since convened a Task Force on Oral Health Care, where the HMO dental contracts became a major point of discussion. The issue was also brought before the Legislature's Joint Audit Committee. On March 8, 2005, that Committee directed the Legislative Audit Bureau to begin an inquiry into the matter in the near future.

Conclusions

The Department analyzed a variety of data about dental care provided to HMO enrollees and compared it to low-income family Medicaid and BadgerCare FFS clients. The analysis yielded the following conclusions:

- It appears that HMO-enrolled children were less likely to receive dental care than children receiving FFS dental benefits in 2003. HMO-enrolled adults, by comparison, were more likely to receive dental care than their FFS counterparts.
- Among clients receiving care, HMO enrollees received approximately the same number of dental services as FFS clients.
- Pricing HMO-reported dental encounters at FFS rates shows that if the services reported by the HMOs were provided in the FFS system, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.
- However, delivery of preventive dental care by HMOs to children who have been enrolled in the same HMO for at least ten months has increased over the last several years, to levels exceeding those of the comparable FFS population.
- HMO enrollees who receive dental services report high satisfaction with the service delivery system, and there is little evidence of unresolved grievances related to inability to access dental care.

Discussion

Comparing HMO and Fee-for-Service Users of Dental Services

Table 1 shows that, compared to the HMO Family Medicaid population, FFS clients are significantly more likely to use dental services than HMO enrollees. During SFY 2003, HMO Medicaid enrollees had 15.5 percent fewer dental users per 1,000 members than FFS clients did. The lower utilization was most pronounced in children between the ages of 6-14 years of age.

Table 2 shows that, for BadgerCare in SFY 2003, 7.4 percent more HMO enrollees per 1,000 members used dental services than did FFS enrollees. The higher utilization is most pronounced in adults ages 21-34 years, but for children ages 6-20 years, HMO utilization still fell below FFS levels.

Note that Tables 1 and 2 contain information on utilization rates. In terms of real users, HMO utilization was higher in every group except BadgerCare adults 35 years and older.

Table 1: Net Difference in Dental Users per 1,000 Members, AFDC/Healthy Start, SFY 2003

Age Range	HMO Users	FFS Users	HMO Users Per 1000 Members	FFS Users Per 1000 Members	Net HMO - FFS Difference	Percent Difference
0	15	18	1.58	2.66	(1.07)	-40.4%
1-5	8,105	6,719	218.75	264.81	(46.06)	-17.4%
6-14	13,743	10,257	328.47	445.29	(116.82)	-26.2%
15-20	3,814	2,889	240.68	334.49	(93.81)	-28.0%
21-34	5,845	2,918	330.56	303.38	27.18	9.0%
35+	2,701	1,588	321.33	316.69	4.64	1.5%
TOTAL	**34,223**	**24,389**	**262.64**	**310.87**	**(48.23)**	**-15.5%**

Table 2: Net Difference in Dental Users per 1,000 Members, BadgerCare, SFY 2003

Age Range	HMO Users	FFS Users	HMO Users Per 1000 Members	FFS Users Per 1000 Members	Net HMO - FFS Difference	Percent Difference
0	-	-	-	-	-	-
1-5	83	72	289.62	286.19	3.43	1.2%
6-14	3,335	2,818	452.44	479.71	(27.27)	-5.7%
15-20	915	937	312.68	349.02	(36.34)	-10.4%
21-34	3,437	2,571	354.18	288.29	65.90	22.9%
35+	2,498	3,345	334.38	317.96	16.42	5.2%
TOTAL	**10,268**	**9,743**	**369.90**	**344.58**	**25.33**	**7.4%**

Comparing the Number of Services Received by HMO and Fee-for-Service Dental Users

An analysis of the amount of dental services used by clients who had at least one dental service during SFY 2003 showed very similar utilization patterns between HMO and FFS clients of all ages. Family Medicaid clients used 5.16 dental services per user in FFS while HMO enrollees used 5.15 dental services per user. For BadgerCare, FFS clients used 4.81 services per user while HMO enrollees used 5.04 services per user.

Table 3: Services Per User, Fee-for-Service and HMO Clients, SFY 2003

AFDC /Healthy Start				BadgerCare			
Age Range	FFS	HMO	HMO less FFS	Age Range	FFS	HMO	HMO less FFS
0	1.17	1.60	0.43	0	-	-	-
1-5	4.67	5.18	0.51	1-5	3.47	4.28	0.81
6-14	5.34	5.28	(0.06)	6-14	4.76	5.09	0.33
15-20	5.21	4.89	(0.32)	15-20	5.17	4.72	(0.45)
21-34	5.12	4.95	(0.17)	21-34	4.81	5.05	0.24
35+	4.61	5.28	0.67	35+	4.72	5.08	0.36
All Ages	5.16	5.15	(0.01)	All Ages	4.81	5.04	0.23

Comparing HMO Revenue to Expected Fee-for-Service Payments

Capitation rates for dental services have been set using 1996 baseline data for the four southeastern counties, increased annually by the rate of growth in the FFS system in the rest of the state. Budgeted rate increases, like the 4.2 percent increase for AFDC/Healthy Start enrollees in 2003, have been proportionally applied to all portions of the rate – medical, dental and chiropractic. The recent improvement in the quality of dental encounter data has made possible a comparison of capitation payments and the expected cost of providing the same services under the FFS delivery system.

The Department assigned costs to the encounter data using FFS Medicaid Allowable Fees, priced the HMO encounter data using those fees plus a 15 percent administrative allowance, and compared the encounter data to revenues received by the HMOs that accept dental services. Chart 4 shows that the dental portion of HMOs' capitation rate is significantly higher than the cost of services the HMOs provide priced at FFS rates. If those same services reported by the HMOs were provided in FFS, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.

Table 4: Net HMO Dental Revenue, Including Administration Revenue, SFY 2003

	Kenosha	Milwaukee	Racine	Waukesha	Total
Total HMO Dental Revenue	$937,338	$8,217,411	$434,281	$484,583	$10,073,613
HMO Dental Encounters Priced at FFS	$767,923	$6,009,300	$306,479	$285,692	$7,369,394
Difference	$169,415	$2,208,111	$127,802	$198,891	$2,704,218
Difference as a percent of Revenue	18.1%	26.9%	29.4%	41.0%	26.8%

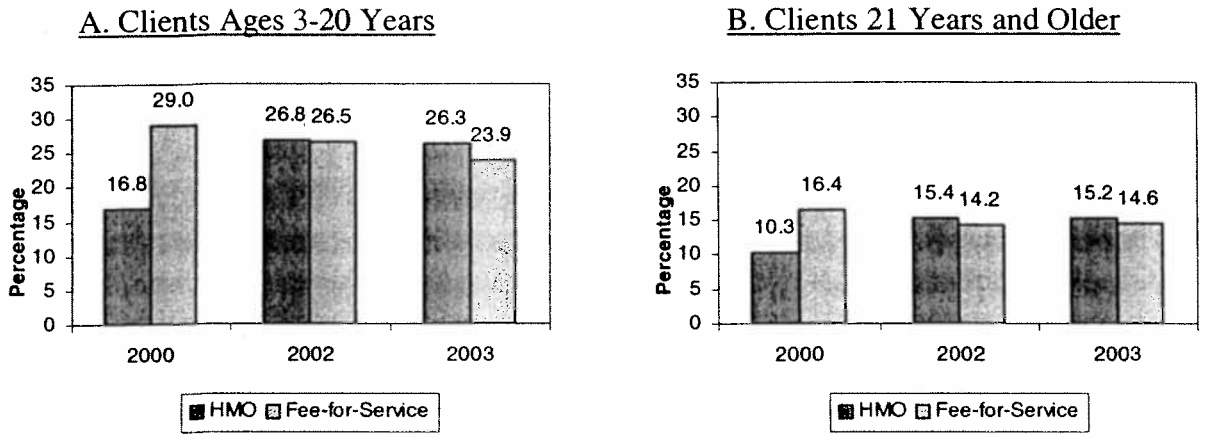
It should be noted that the priced encounter data represents what FFS would have paid, not what HMO actually paid for the services reported. HMO payment rates to providers constitute proprietary information and may not be related to FFS payment rates.

In addition, HMOs that provide dental services are paid one global capitation rate to manage all medical and dental services. The dental part of the capitation rate is less than 5 percent of the total rate. Effectively, the surplus realized in dental services may be subsidizing the cost of medical services.

Other Measures of HMO Service Delivery

The Department also examined three years of HMO dental preventive care performance measures for individuals enrolled for ten consecutive months using the MEDDIC-MS system. This review shows that utilization of preventive dental care among this population is trending upward. Chart 3 shows that from calendar year 2000 to 2003, dental care increased nearly 10 percentage points among children 3-21 years of age to 26.3 percent, and about 5 percent among enrollees over age 21 years to 15.2 percent. This is now better than the experience of clients enrolled for 10 consecutive months in the FFS system, where 23.9 percent of children aged 3-21 years and 14.6 percent of clients over age 21 received preventive dental care in 2003.

Chart 3: HMO and Fee-for-Service MEDDIC-MS Measures of Preventive Dental Care, SFY 2000, 2002, 2003



The Department also measures HMO enrollees' satisfaction with managed care every two years through the CAHPS® Satisfaction Survey. Survey results from 2000 and 2002 show that, for those enrollees who received dental care through HMOs, nearly 7 out of 10 rated the quality of the dental care they received 8 or higher on a scale of 0 (worst) to 10 (best). While most respondents said they visited a dentist once in the past six months, nearly a quarter of respondents who used dental services reported having two visits, about seven percent had three visits and about three percent had four visits. Some enrollees had ten or more visits.

HMO enrollees may file informal complaints by telephone or grievances in writing with their HMO. Enrollees may also file grievances directly to the Department or fair hearing. A review of the grievances the state received for dental care provided through HMOs shows that cases

elevated to the Department have been exclusively for denied orthodontic treatment and not related to access to preventive or restorative dental care. The number of grievances for orthodontic treatment is comparable to the number of grievances for denial of non-dental services.

A review of the HMOs' phone logs for calendar years 2002-2004 indicates that the majority of complaints were for enrollees looking for a dentist, which the HMO logs indicate were resolved. This is a very different experience from the FFS system, where care cannot be guaranteed.

Alternatives to the Managed Care Dental Care Delivery System

As the state and the Governor's Task Force on Access to Oral Health Care contemplate the conclusions to draw from this analysis, it is important to note several available courses of action.

Improve Managed Care

Under this scenario, the state could re-calculate the dental capitation rates to better reflect actual performance. The remainder could be withheld, and be paid to the HMOs only if they meet or exceed targets for improved utilization and access. This strategy, similar to the one used by DHCF for HealthCheck services, allows payments to be clearly linked to performance. If service delivery improves, then the HMOs earn back the additional funds. If it does not improve, DHCF can redirect the money to other initiatives to improve access to care.

Revert to Fee-for-Service

If the HMO delivery system were judged to be not worth improving, the state could remove dental services from the HMOs' contracts, and place all 166,000 Medicaid and BadgerCare clients in the four southeastern counties back into the FFS system administered by EDS. This would remove the concern of losing funds to administrative overhead that could be directed to service delivery. However, it would also remove the contractual guarantees that the HMO contracts provide and place responsibility for locating care squarely on the programs' clients. It seems unlikely at this point that sufficient capacity exists in the FFS dental network to absorb such a large influx of clients at current reimbursement rates.

The funds currently dedicated to administrative costs for the dental HMO contracts could be directed to fee increases in the FFS system. However, the amount of money involved is unlikely to constitute a large enough increase to attract significant interest from dentists. A study of North Carolina's experience in the late 1990s showed that even a 23 percent increase in fees only resulted in a 3 percent increase in participation among dentists. Several other states, including New York, had similar experiences, and Wisconsin's own history of rate increases tells a similar story.

It is the contention of national and state dental associations that very large rate increases are necessary to attract dentists to participate in Medicaid programs. There is evidence from several states, including Alabama and Indiana, that raising FFS rates close to full private practice rates does result in improved access for clients. This is, however, a very expensive option, which would require new investment of tens of millions of dollars in the Medicaid dental program.

"Carve-Out" Dental Administration

There is a third option to consider – a "carve-out" of dental administration that would remove dental claims processing and customer service from both the HMO and FFS systems. The state would contract with a specialized dental benefits administrator for provision of these services and maintenance of a dental provider network. Such a contract could better recognize the unique circumstances of the dental profession, and include greatly enhanced support in correcting dental billing errors and providing dentistry-specific clinical expertise. It could also include enforceable benchmarks regarding utilization and access targets, and expanded customer outreach and education requirements.

States such as Michigan, Illinois, Tennessee, and Kansas employ variations of this strategy. It seems to have been most effective in the cases of Michigan and Tennessee, when the administrative change was accompanied by a large increase in reimbursement.

A new contract would require new funding. Illinois' contract for dental administrative services costs approximately $.37 per enrollee per month, and Tennessee's costs approximately $.75 per child per month (they also pay $.10 per adult per month, but Tennessee has a very limited adult dental benefit). It is unlikely that significant funds could be recouped from the recently-bid fiscal agent contract because the amount of resources dedicated to dental administration is a very small proportion of the total.

In order to fully understand the costs and benefits of a "carve-out," the Department would need to engage in a formal request for information to gauge the level of interest from possible bidders and the extent of services they could bring to the table.

Recommendations

1. Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system. In a restrictive fiscal environment, it is imperative that every dollar of funding positively impact service delivery. The Department must ensure that money is spent appropriately, in ways that verifiably work for our clients.

2. Reform the HMO delivery system and strengthen contractual guarantees not available in the current FFS delivery system to improve the level of service provided to clients. In the short term, the Department should not abandon the HMO contracts, which provide valuable provisions that allow patients in need to access care. The Department can, however, make these contracts work better by realigning payments to HMOs to match utilization and withholding the remainder if utilization increases are not delivered.

3. Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration. Direct contracting with a dental benefits administrator is a strategy that has worked for several other states; the Department should determine whether investing in this strategy will produce positive results for Wisconsin's Medicaid and BadgerCare clients at an affordable price.

4. Support the efforts of the Governor's Task Force on Access to Oral Health Care. The Department fully supports Governor Doyle's ranking of children's oral health as a priority. We look forward to working to evaluate and implement the Task Force's recommendations.


FORWARD

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

June 7, 2005

Mr. Mark Moody, Administrator
Division of Health Care Financing
Department of Health and Family Services
1 West Wilson Street
Madison, Wisconsin 53703

Dear Mr. Moody: Mark

Thank you for your letter, dated May 19, which summarizes key findings of the Department of Health and Family Services' internal analysis of the managed care and fee-for-service dental delivery systems used in the Wisconsin Medicaid and BadgerCare programs. We appreciate receiving the latest draft of this report.

As noted in your letter, the Legislative Audit Bureau also received a copy of the report. We understand that the Bureau will consider these findings as it continues fieldwork for its evaluation of the Medicaid Dental HMO program, which was approved by the Joint Legislative Audit Committee in March 2005.

Thank you for your cooperation and assistance.

Sincerely,

Carol Roessler

Senator Carol A. Roessler, Co-chair
Joint Legislative Audit Committee

Suzanne Jeskewitz

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

cc: Helene Nelson, Secretary
Department of Health and Family Services

Janice Mueller
State Auditor

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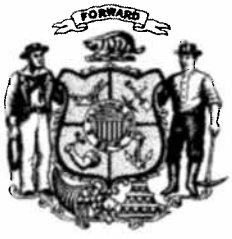
WISCONSIN STATE LEGISLATURE



Diane – asked to do a study
looking at a rural
area like Racine Co

- United
- Managed
-

140,983 low income medicaid
pd.
$10m all funds Medicaid

dental analysis
report by April 2005

1. comparative analysis
2. analysis for dental
3. review of grievance
4. " cust satisfaction
5. recommend. Gov's task force

Dental - WDA

directed at procedures rather than
per capita
not accurate apple to apples

$10M of 36 → only ones that can impact
change

only ones that can implement change
dentists + care provided needs to become
a priority
1. listened to
2. funded at break even —
not at a loss

Ch argument we hear from all providers.

we don't have the funds to raise the rates

they are attempting to give recommendations

1. standardized billing
2. " codes
3.

appreciate that list

→ fully intend to make changes
changes in May + June
could change in midstream

a reason to put on hold

Kerkman - Roessler

Miller -

Dan

- do have capacity for this one
- if changes down the road - could send ltr

J - A
R - A
C - A
M - A
L -
K - A
K - A
T -
C - A

7 - 0