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☞ Details: Public Hearing: Audit Letter Report (April 2008), Dental Services for Medical Assistance Recipients, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(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) (October 2012)

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Jim Sullivan
State Representative Suzanne Jeskewitz

June 02, 2008

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

Dear Ms. Timberlake:

As indicated on the enclosed hearing notice, the Joint Legislative Audit Committee will hold a public hearing on the Legislative Audit Bureau's review of *Dental Services for Medical Assistance Recipients* (April 2008), on Tuesday, June 10, 2008, at 1:00 p.m. in Room 412 East of the State Capitol.

As this report relates to the activities of the Department of Health and Family Services, we ask you, or the appropriate members of your staff, to be present at the hearing to offer testimony in response to the audit findings and to respond to questions from committee members. Please plan to provide each committee member with a written copy of your testimony at the hearing.

Please contact Ms. Pamela Matthews in the office of Representative Suzanne Jeskewitz at 266-3796 to confirm your participation in the hearing. Thank you for your cooperation and we look forward to seeing you on June 10th.

Sincerely,

Senator Jim Sullivan, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Ms. Janice Mueller
State Auditor

SENATOR SULLIVAN
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-2512 • Fax (608) 267-0367

REPRESENTATIVE JESKEWITZ
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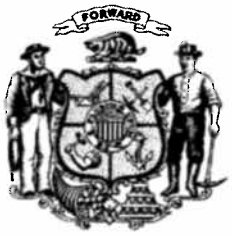
(608) 266-3796 • Fax (608) 282-3624


WISCONSIN STATE LEGISLATURE


FORWARD

Wisconsin Association of Health Plans

TO: **Senator James Sullivan, Co-Chair**
Representative Suzanne Jeskewitz, Co-Chair
Members, Joint Committee on Audit

FROM: **Joanne Alig, Senior Policy Director, Wisconsin Association of Health Plans**

CC: **Janice Mueller, State Auditor**
Jason Helgerson, State Medicaid Director

DATE: **June 5, 2008**

RE: **LAB Report, *Dental Services for Medical Assistance Recipients***

The Legislative Audit Bureau (LAB) report, *Dental Services for Medical Assistance Recipients,* dated April 18, recommends development of alternative dental service delivery models in the four southeast Wisconsin counties served during the audit period by five HMOs. These members of the Wisconsin Association of Health Plans appreciate the Legislature's interest in examining the delivery of dental care in Medicaid; however, members are concerned that the LAB analysis has significant flaws and fails to support its recommendation. Members acknowledge that there are challenges in providing dental services to Medicaid recipients, and suggest that further analysis is needed to determine the most appropriate course of action.

Flaws in the cost comparison: In its report, the LAB appropriately noted that making cost comparisons between managed care and fee-for-service dental is difficult. The population density and demographic characteristics of the counties served exclusively by HMO dental are different than the characteristics of the rest of the state, which is served by fee-for-service dental exclusively. *Further, payments to HMOs include the cost of administrative services HMOs are required to provide, such as transportation services; customer service activities including assistance in obtaining timely appointments and education about dental health; and data collection on provider performance.* Since dentists in fee-for-service dental are not accountable for the same administrative responsibilities, their reimbursement excludes such administrative expense. *The LAB made its cost comparison without accounting for these structural differences between managed care and fee-for-service.*

Flaws in the performance comparison: The LAB report also examines dental services data to draw performance comparisons between HMO dental and fee-for-service dental. The data show that a higher percentage of Medicaid recipients served by fee-for-service dental received dental services than those served by the five HMOs covered by the audit. Again, potentially significant differences between the regions are not considered in the

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608-255-8599 • Fax 608-255-8627 • www.wihealthplans.org

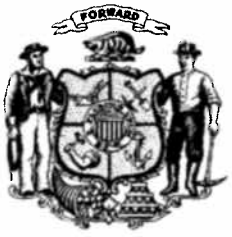
analysis. Also not considered are the types of dental services received by the populations analyzed. *A more in-depth look at the types of services could provide insights about the intensity of services provided in HMOs as well as the use of preventive care services in HMO dental. For example, do higher preventive care services result in lower utilization of the emergency room for dental services?* This information would be necessary for evaluating overall utilization and cost efficiency.

Analysis applicable to both HMO and fee-for-service dental: Given the problems of comparing two inherently different regions and systems of dental care delivery, perhaps the most useful information is the LAB's documentation of reimbursement problems applicable to all areas of the state and both HMO dental and fee-for-service dental. *The Medicaid population needing dental services has grown; however, dentist participation in Medicaid has declined.* Dentists repeatedly cite the dental fee schedule for this lack of participation.

The most significant challenges, and therefore the biggest opportunities for improvement in dental service delivery, are not found in contrasting HMO dental and fee-for-service dental. Like fee-for-service, HMO dental faces limited participation in Medicaid by dentists in Wisconsin. The reasons for this low participation by dentists are not fully examined in the LAB report. Nor is the data fully analyzed to support a conclusion that an alternative to HMO service delivery is warranted.

Association members who provide dental services to the Medicaid population encourage the Joint Audit Committee and the Department of Health and Family Services to explore options to improve these vital services. However, these Association members are not convinced that the underlying issues have been addressed in the LAB report. *Until such analysis is completed, members are concerned that any alternative model will fail to ensure better dental access and lower costs for Medicaid, and could generally increase medical costs and especially those associated with emergency room use for dental care.*

WISCONSIN STATE LEGISLATURE



Joint Legislative Audit Committee

January 08, 2008

June ??

I. Opening Remarks:

- Welcomes
  - Rep. Cullen is excused (daughter graduating from Middle School today)
  -

- How the committee works
  - If you want to testify, fill out a slip and hand it to the page.
  - **Prior** to testifying, if you have written testimony, please provide the page with copies for each committee member. If you don't have enough copies the page can make copies for you.

II. **Attendance** – clerk will call the roll

III. **Letter Report, Dental Services for Medical Assistance Recipients.**

A. Audit Bureau Staff – Jan Mueller & Kate Wade

B. DHFS – Karen Timberlake

C. Public Testimony

V. **Adjourn**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WISCONSIN STATE LEGISLATURE

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State Representative Suzanne Jeskewitz

June 02, 2008

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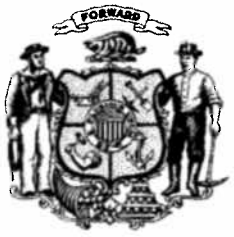
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Dental Services for Medical Assistance Recipients

Legislative Audit Bureau

June 2008

1

MA Dental Program Eligibility and Expenditures

- Federal law requires comprehensive services be provided to recipients under the age of 21
- Provision of comprehensive services to adults is optional
- Combined state and federal expenditures were $46.0 million for dental services provided in FY 2006-07

2

Program Participation

- Statewide participation reached 754,724 in 2007
- Family Medical Assistance participation increased 26.8 percent from 2003 to 2007
- Average monthly enrollment in Medical Assistance in the 4-county area was 175,458 in 2007

3

Number of Wisconsin Dentists

	FY 2002-03	FY 2006-07	Percentage Change Over Five-Year Period
Licensed Dentists	3,464	3,493	0.8%
Medical Assistance-Certified Dentists	1,944	1,342	(31.0)
Certified Dentists Submitting at Least One Claim	1,377	1,315	(4.5)

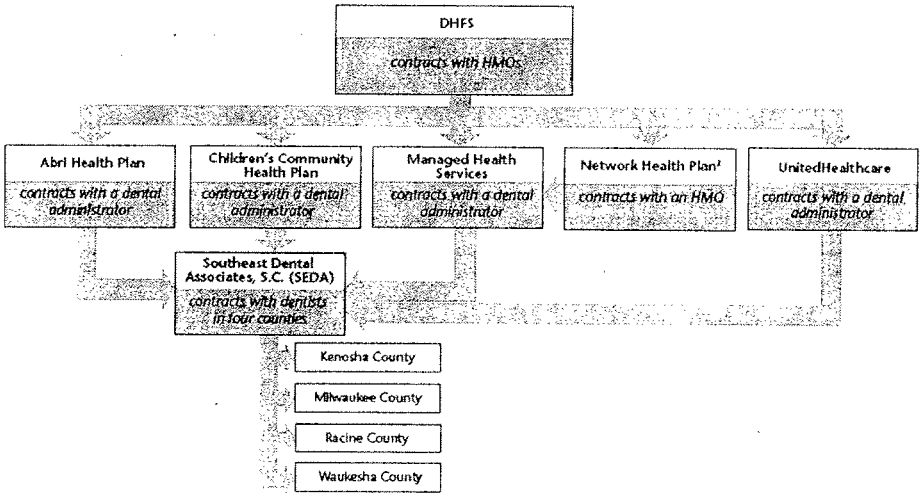
4

Providers of Dental Services in the MA Program

- Dentists provide services on a fee-for-service basis in 68 counties
- Health maintenance organizations (HMOs) arrange the delivery of dental services in Kenosha, Milwaukee, Racine, and Waukesha counties
  - DHFS contracts with each HMO
  - HMOs contract with a dental administrator
  - The dental administrator contracts with dentists

5

Managed Care Delivery Structure - 2007



6

Medical Assistance Capitation Payments for Dental Services

- HMOs decide whether they will offer dental as part of the overall package of health care services
- Monthly capitation amounts are based on factors such as county of residence, gender, age, and special needs
- Dental capitation payments ranged from $4.29 to $10.22 in the 4-county area in 2007

7

HMO Capitation Payments for Dental Services - 2006

HMO	Payments	Average Monthly Medical Assistance Enrollment
Abri Health Plan	$ 434,988	6,458
Children's Community Health Plan	140,192	2,102
Managed Health Services	5,312,804	74,081
Network Health Plan	1,528,028	21,892
UnitedHealthcare	4,898,399	69,483
Total	$12,314,411	174,016

8

Distribution of Dental Care Capitation Payments

HMO	Percentage of DHFS Capitation Payments Paid by HMOs to Dental Administrators
A	73.5%
B	75.6
C	76.0
D	101.1
E	110.3

9

Access and Utilization Under Managed Care

- Contractual standards govern access to routine and emergency dental care
- Utilization of services is monitored by DHFS under the terms of the contracts with the HMOs
  - Utilization is lower under managed care
  - Utilization has not increased under managed care

10

Cost Comparisons

- Cost comparisons of the fee-for-service and managed care show higher costs in the managed care system
- DHFS calculated higher costs under managed care in two successive years

11

Program Innovations in Other States

- Higher reimbursement rates are paid under specific circumstances
- Michigan pays higher rates in certain counties
- Minnesota pays higher rates to those who devote at least 20.0 percent of their practice to serving MA recipients

12

Medical Assistance Dental Claims at Community Health Centers

	FY 2002-03	FY 2006-07
Paid Claims	9,505	47,851
Unique Dental Patients	3,986	20,463
Payments	$655,907	$4,072,390

13

GPR Funding for Dental Clinics and Programs

	2005-2007	2007-2009
Marquette University School of Dentistry	$5,721,000	$5,721,000
Rural Health Clinics	1,575,200	2,010,200
School-Based Dental Sealant Programs	240,000	240,000
Technical College Dental Clinics	172,200	172,200
Donated Dental Program	120,000	120,000
Fluoride Mouth-Rinse Programs	50,000	50,000
Fluoride Supplement Programs	50,000	50,000
Total	$7,928,400	$8,363,400

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FORWARD

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

Testimony of Secretary Karen E. Timberlake
Department of Health and Family Services

Joint Legislative Audit Committee
June 10, 2008

Good afternoon. I would like to thank the Joint Legislative Audit Committee for giving the Department of Health and Family Services (the Department) the opportunity to comment on the Legislative Audit Bureau's report on Dental Services for Medical Assistance Recipients. The Department is committed to working with this Committee, the Legislature and all interested parties to find the best way to increase dental access for Wisconsin's Medicaid members.

Let me start by saying the Department concurs with the Audit Bureau report that the managed care delivery system for dental services that has been employed in Milwaukee, Racine, Kenosha, and Waukesha counties has not provided sufficient improvement in access to justify the higher costs associated with that delivery model.

It remains clear that there is, however, no one program or solution that on its own will guarantee significantly increased dental access throughout Wisconsin. Ensuring adequate access to dental services for Medicaid participants is a challenge faced by virtually every state. Correcting the current problem is likely to take a variety of strategies and a sustained, significant investment of new resources over a period of years. The Department is committed to developing and pursuing those strategies that have been proven to be most likely to realize significant improvements in dental access and that are most cost effective.

HMOs and Dental Access

In an internal analysis, the Department found results similar to the Audit Bureau's report: health maintenance organizations (HMOs) did not improve access over the fee-for-service delivery model, and dental care provided through the HMOs was slightly more costly than that care would have been in the fee-for-service delivery system.

In an effort to correct these trends, the Department froze HMO dental capitation rates in 2006 and required an HMO to terminate a contract with its dental administrator when it became clear that the HMO was not meeting its contractual obligations for an adequate provider network.

The Audit Bureau recommends that the Department develop one or more alternative dental service delivery models for the Medicaid program, and that we do so prior to the conclusion of the current HMO contracts in December 2009. As I said at the outset, we concur with this recommendation and are in the process of developing those alternative models.

It is important to note that HMO contracts for Medicaid members are awarded on a biennial basis. Current contracts are not up for renewal until January 2010. The Department is not inclined to seek to amend the contracts with the HMOs until we have developed alternative service delivery models for our members. There currently is no alternative for members that represents a significant improvement over the status quo. That is, if dental benefits were immediately carved out of the HMO contracts, members would have to be placed back in the fee-for-service system. While the fee-for-service system appears to be providing somewhat better access to dental services in southeastern Wisconsin, significant barriers to access remain in that part of the state and statewide.

It is not in the interest of preserving continuity of care for our members to make a precipitous change to the current arrangement without a viable alternative. Under the HMOs' current contracts, for example, the HMOs or their dental administrator are required to find access to emergency dental care within 24 hours for those members who need it. This is a protection not available in the fee-for-service delivery model.

While the Department believes that removing dental services from the HMO contracts is in the long-term best interest for both members and the State, doing so without a viable alternative for members would be irresponsible. Furthermore, HMOs would have to agree to amend their contracts before they expire in 2010; this is not a change the Department can make unilaterally during the term of the contracts.

Having said that, it is clear that delivering dental services through HMOs is unlikely to be the future direction of this program. Therefore, once a viable alternative is developed and can be implemented, I am committed to asking the six participating HMOs to voluntarily amend their contracts to remove dental services so that we can redirect these needed resources to a more successful set of strategies.

Successful Grant Program

There have been some successful programs that have been supported by Governor Doyle, the Legislature and stakeholders that have made modest gains against the problem of dental access.

Recently, the Department has awarded a number of grants to build a more robust dental infrastructure statewide. In 2006, the Department awarded, with the Legislature's approval, nine targeted grants with unused federal income augmentation funds. In 2007, the Department solicited applicants for the remaining income augmentation dollars. Not surprisingly, the response was overwhelming. The Department received 39 strong

applications totaling more than $6 million for the $1.9 million that was available. The Department awarded one-time grants to seven applicants (see attachment for full list of grantees). These efforts have been very successful.

In Green Bay, the Brown County United Way received $341,000 to expand the Brown County Oral Health Partnership, Inc.'s (OHP) clinic services to provide low-income un- or underinsured children and individuals with disabilities basic dental services. With the oral health improvement grant, OHP completed 2,400 dental appointments; it set up the infrastructure for an emergency clinic and two clinics for adults with development disabilities and it established a central OHP office.

In Milwaukee, the Marquette University School of Dentistry clinic on the city's south side received $1 million to increase dental services to low-income residents. From September 2007 to May 2008, the clinic saw 1,005 new patients. 772 were on Medicaid, 204 had no dental insurance and 592 were 18 or younger.

In the Chippewa Valley, the Chippewa Valley Technical College received $243,646 to add two chairs to provide preventive and restorative dental care to low-income residents in western Wisconsin. For this fiscal year, the Technical College will provide preventive services to 2,741 patients and restorative services to 3,886 patients. An increase of 24% and 43% respectively over the previous year.

In addition to these grants, the Department has made a number of modifications to the Medicaid program in recent years in an effort to streamline administration, remove barriers to dentists' participation in the program, and expand access for patients, including:

- Developing a list of dentists who are accepting new Medicaid patients;
- Reducing the number of services for which prior authorization is required;
- Allowing dentists to verify patients' eligibility for Medicaid over the Internet;
- Permitting dental hygienists to become certified as Medicaid providers and bill the program directly for the full range of services covered by their licensure.

National Experiences

Despite the success of the grants, it remains clear that no one idea or program can significantly increase dental access in Wisconsin.

National studies and experiences from other states highlight this fact with great clarity. According to a March 2008 report released by the National Academy for State Health Policy (NASHP), ensuring adequate provider rates is key to significantly improving access to dental services for Medicaid patients. But the report also indicated that rate increases are not sufficient on their own. The report found that streamlining administrative processes and involving dentists as active partners in program improvement are also critical.

The report reviewed successful dental programs in six states and found that these initiatives also included administrative simplification, case management, and provider outreach and education activities, which NASHP cited as critical to the initiatives' success.

While each of these states was able to significantly improve access, access for their children on Medicaid still remains below the rates for privately insured children (32 to 43 percent for the state programs versus 58 percent for privately insured children).

The NASHP report indicates that while dentists frequently seek reimbursement rates that mirror their usual charges, states have seen gains in dentists' participation and patient utilization even with rate increases that do not meet that threshold. The fact remains that while Wisconsin's dental reimbursement rates lag those of other states in a variety of categories, as the Audit Bureau noted, the Medicaid program does not experience such an acute shortage of access to care for any other specialty, even with reimbursement rates that would certainly be described as low or non-competitive by other types of health care providers. By way of illustration, for State Fiscal Year 2007, dentists were reimbursed by the Medicaid program at an average rate of 42.3% of their charges. Other professional providers were reimbursed at rates that ranged from a low of 23.9% of charges for physicians to a high of 59.9% of charges for audiologists.

Any increases in rates must be combined with further efforts to streamline administration, provider outreach, case management, provider and patient education activities, and a sustained commitment from dentists to expanded Medicaid access to primary and specialty dental services.

Current Initiatives

Currently, the Department is developing a strategy to utilize money allocated in Governor Doyle's 2007-2009 budget to improve the dental delivery system for BadgerCare Plus members. In the 2007-2009 biennial budget bill, the Governor set aside $8.8 million in Medicaid funding to expand dental access. The breakdown of these funds was $3.6 million GPR and $5.2 million matching federal funds.

The Legislature earmarked roughly $400,000 of these funds for dental expansion projects. This reduced the original $8.8 million by $1 million all funds because the Department cannot draw down federal matching funds on grants.

Recognizing that neither the fee-for-service nor the managed care delivery system was providing sufficient access to dental services, the Governor directed the Department to issue a request-for-information to solicit ideas for a new delivery system. DHFS received 19 responses to the RFI in July 2007.

As the Audit Bureau report noted, the responses were varied and included: eliminating HMOs from the dental delivery system and contracting with a third-party administrator, providing rate increases, expanding community-based clinics, expanding school-based programs, and introducing workforce-related initiatives. Many of the responses built off existing initiatives, while others were based on successful models used in other states.

Although the Department received responses to the RFI almost a year ago, we did not think it was responsible to distribute these funds until the biennial budget passed and we were assured that the funding was included in the final budget bill. Passage of the budget last October was followed shortly by news of a looming $650 million budget deficit that necessitated a budget repair bill, and the Department again delayed the decision about how to best utilize this one time funding until the resolution of that significant budget gap was known.

Despite ongoing budget pressures, the Department is firmly committed to utilizing these funds to increase dental access. However, as I stated earlier, there is no single, simple fix. The Department is in the final stages of developing a comprehensive approach that leverages our limited resources and maximizes the increase in dental access to Wisconsin residents.

The Department takes its responsibility to develop a scaleable, cost effective plan that will provide a meaningful, sustained increase in dental access very seriously. Building on Governor Doyle's vision of providing access to affordable health care for all Wisconsin residents, we have shown recently through the success of BadgerCare Plus that health care access problems that were once thought to be insurmountable can be overcome with ingenuity, open-mindedness, and a commitment to doing what is in the best interest of the people we are all here to serve. Providing access to dental services is one of the final challenges that we must overcome in to ensure that all Wisconsinites have equal opportunities to lead healthy, productive lives. We look forward to working with the Legislature and all interested parties to achieve our common goal of increased dental access. Thank you for the opportunity to be with you today.

2007 Oral Health Access Grant Awardees

Project Name	Location	Amount
New Darlington Community Dental Clinic	New Darlington	$500,000
Park Falls/Phillips Dental Home Project	Park Falls/Phillips	400,487
HIV Dental Care Access Expansion	Milwaukee/Green Bay	349,800
New Waukesha County Dental Clinic	Waukesha	331,470
Chippewa Valley Technical College Clinic	Eau Claire	243,646
Waushara County Shara Smile	Waushara County	29,260
Southern Wood County Dental Hygiene Program	Rome	21,637


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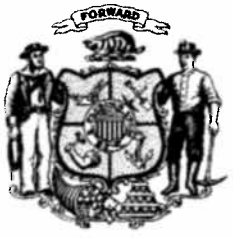
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WDA
WISCONSIN DENTAL ASSOCIATION, INC.
www.wda.org

WDA Testimony on Legislative Audit Bureau Report on "Dental Services for Medical Assistance Recipients"

Dr. Monica Hebl, WDA President
Joint Legislative Audit Committee
Tuesday, June 10, 2008 - 1:00 PM – 412 East

Good afternoon, Co-Chairs Jeskewitz and Sullivan and members of the Joint Legislative Audit Committee. My name is Dr. Monica Hebl and I am a general dentist practicing in Milwaukee who has been dedicated to serving the Medicaid population throughout my career. I grew up in Milwaukee and started as a dental assistant when just 14 years old; the practice in which I was first hired had a strong commitment to taking care of the Medicaid population. Due largely to my dental assisting experience at the office of Dr. Stanley Donohoo, I knew I wanted to be a dentist at a young age. I pursued my undergraduate studies at Ripon College and UW-Madison before graduating with my doctorate in dental surgery from Marquette's dental school in 1985. After graduating from dental school, I was hired as a dentist in the very same practice where I worked as a dental assistant; I am currently a partner in that practice with Dr. Stanley Donohoo's son Dr. Mike Donohoo.

I am here today representing organized dentistry as the current president of the Wisconsin Dental Association, but I also speak as a dentist who practices in one of the four counties currently operating under the HMO dental Medicaid system.

I compliment the Legislature and the Legislative Audit Bureau in their efforts to study this issue and to hold today's hearing. **I sincerely hope the legislators serving on this joint committee will see these audit results as a call to action and address the inadequacies of the state's dental Medicaid program.** These audit results confirm the suspicions the WDA has held for more than a decade – namely that the HMO delivery model for dental MA costs the state significantly more money to provide less care to those patients who need it most. For over a decade, the WDA has fought for removal of the HMO system in our state's four southeastern counties (Racine, Kenosha, Milwaukee and Waukesha); our request for this audit goes back to 2004 and has been just one part of our advocacy effort to bring what we believe are this system's inefficiencies to light.

Having personally treated thousands of Medicaid patients in the Milwaukee urban area, I fully believe in the truth of the statistic that 80 percent of dental decay exists in just 20 percent of the population. Unfortunately, the majority of individuals with the greatest rates of dental decay are covered by the state's dental Medicaid program. It has always amazed me the state has structured its dental Medicaid program without taking into consideration that the dental needs of this population can be quite extensive and complex and can take a great deal of time and resources for a dentist to fully address.

Our free-market system would naturally indicate that providers who participate in the dental Medicaid program should expect to receive reimbursement that fairly reflects the complexity and intensity of the care needed by this population. Unfortunately, for Medicaid patients, the state has structured its payments to providers at a rate far below

the actual costs of providing this level of care. As a result, Medicaid patients are forced to depend on the charity of dentists. I doubt any one of us in this room today would want the health care needs of our children to be so completely dependent on charity care.

The state has continued to expand the rolls of those covered by the Medicaid and BadgerCare programs but has frequently failed to fund the delivery of that care. Unfortunately, expanding coverage does not necessarily equate to an increase in access to the actual care. Currently, 80 to 90 percent of all care provided to the Medicaid population is delivered through traditional, private-sector dental practices. Those of us in small, private-sector dental offices who remain committed to taking care of Medicaid patients are frustrated by the state's continued dismissal of this problem. This is a societal problem and it will take more than just those of us in the dental community to adequately address it.

Over a year ago, a 12-year-old boy named Deamonte Driver died in the State of Maryland due to an untreated dental abscess. The state should have made it easier for that child to obtain a $100 tooth extraction; instead, they made it difficult to obtain the early dental care and instead paid more than $200,000 in medical costs to treat an infection that reached his brain and even more tragically, the infection was so advanced the young boy could not even be saved.

I hope everyone in this room understands dental care is not a cosmetic issue and dental disease, by its very nature, is infectious. If left untreated, dental disease can create systemic problems that can manifest themselves elsewhere in the body and can, in some circumstances, become life threatening. I don't think any one of us wants to wake up one morning to read the headlines that a child in Wisconsin has actually died because of untreated dental disease.

Returning to the report that is the subject of this public hearing, let me briefly review why dentists struggle with the HMO model. Under this model, the state first contracts with a medical HMO that takes a portion of the capitation rate. The pool of dollars are then passed down to the dental managed care organization, which is responsible for administering the program and contracting with dentists, also takes a portion of the capitation rate. These layers of administration explain why the state's below-market Medicaid capitation payments are further reduced by the time they reach the dentists who are actually providing the necessary dental care.

Since the 1990s, an HMO model has been heavily promoted for a statewide dental Medicaid delivery system, but the only counties in which the HMOs could identify the appropriate volume of providers to serve the Medicaid population were the four counties of Milwaukee, Racine, Kenosha and Waukesha. Unfortunately, the number of Medicaid providers in this area of the state has further decreased under the HMO model and these counties, which previously did not have a dental Medicaid access problem, now struggle to find providers willing to participate. As indicated by the LAB report, the utilization rate of dental services for children in these four counties falls below the rate of utilization in fee-for-service counties despite the state spending more per patient in the HMO model.

The report clearly shows that over the course of these contracts, the state paid the HMOs millions more than it would have paid to individual dentists had the exact same

number of patients received the exact same services under the fee-for-service model that exists in the rest of the state. Seeing in the report that the medical HMOs withhold 25 percent of the capitation rate before passing it on to the dental managed care organization is an extremely frustrating fact for those in the dental community.

Back in April 2005, DHFS did its own internal audit of the dental HMO system and issued similar findings as the report before you today. Both of these audit reports make the dental community wonder whether or not the state really wants to solve the dental Medicaid access issue. If the state is serious about solving this problem, how did this inefficient system manage to stay in place for so long? Is there anyone who truly believes this system benefits the patients who have been promised the care? What type of plans does the state now have to try to address these inadequacies?

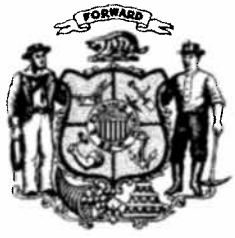
As president of the Wisconsin Dental Association, I urge you to look beyond the HMO dental Medicaid problems and try to address the dental Medicaid program statewide. As many of you know, Wisconsin has traditionally been a national leader in the creation of lasting solutions to very difficult policy problems. Fortunately, there are many other states who have already taken the lead in solving this problem and the WDA has been actively promoting the successful programs of other states that we believe could be replicated here with a certain level of success. WDA supported a pilot project that was proposed in Wisconsin during the last budget cycle; unfortunately, the pilot project failed to be included in the final budget agreement between the governor and the state Legislature. When the state fails to address this problem in a comprehensive fashion, it accepts the increased risks of losing a Wisconsin child due to dental infections. A pilot project will only help the children who are fortunate enough to live in one particular county; to protect all children, a statewide solution is necessary.

After reviewing successful activity in other states, it is clear that when a state gets serious about financially investing in the oral health of its Medicaid population, access to dental care for this segment of residents becomes similar to that of the general population. WDA welcomes a real partnership with any policy-maker or group interested in pursuing lasting solutions that recognize the extent and complexity of the oral health care needs of the state's Medicaid population.

I sincerely hope this report spurs the members of this committee to find a more lasting and meaningful solution to the state's current dental access problem. We all need to dedicate ourselves to working together in a cooperative fashion if we plan on successfully preventing a Deamonte Driver case from occurring in our state. The children and adults who depend on the Medicaid program deserve to have access to the dental services the state has promised them.

Thank you for holding this public hearing. I hope we leave here agreeing that major changes need to occur if this problem is ever going to be solved. I am happy to respond to any questions you might have.

WISCONSIN STATE LEGISLATURE



NEIDER & KNOELL DENTAL, S.C.
5707 Byrd Avenue
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Fax (262) 637-7633

06/06/2008

To Whom It May Concern:

On the morning of 05/01/2008, my office received a phone call from a social worker at a local elementary school. As in the past, we were asked if we could help a child who was suffering from a toothache that was preventing him from attending class. My office was informed that he had a Forward Card for dental. They were instructed to come right over that morning.

While assessing the child's condition, his mother informed me that the dental office he regularly goes to could not see him until mid July. I asked her what office he went to and was informed that it was the Dental Medicaid HMO clinic in Racine. She told me that she explained the severity of the situation to the receptionist, but was denied prompt treatment for her son.

I assessed his needs and treated him that morning despite a full schedule of patients. He had a grossly decayed tooth that required an extraction. In my opinion his treatment could not have waited until July. Furthermore, I advised the boy's mother to keep the July appointment at his regular dental office in order to address his other dental needs.

I am not a Dental Medicaid provider, but I regularly treat patients that are on that government program at no charge. On this occasion, I decided to file the Emergency Care Form in an attempt to recoup some of my expenses for the care that was provided. Much to my dismay, it was denied because the patient was only covered under the Dental Medicaid HMO. After some investigation, my office manager was told that only SEDA contracted dental providers would be paid for their services regardless of the circumstances.

Regards,

Lyndsay N. Knoell, D.D.S.

Ronald C. Neider, D.D.S.
Lyndsay N. Knoell, D.D.S.
Wendy M. Knoell, D.D.S.

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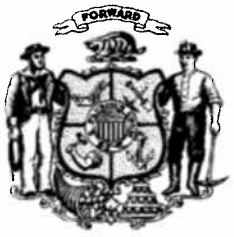

SEDA
Southeast Dental Associates

3520 W. Oklahoma Avenue
Milwaukee, WI 53215
414-389-9880

TO: Members of WI Legislative Audit Committee
FROM: Southeast Dental Associates
DATE: June 10, 2008

The purpose of this letter is to provide a written response to the Legislative Audit Bureau's Letter Report and its recommendations dated March 31, 2008. The Report states that LAB staff compared the cost and benefits of the managed care dental program vs. the fee for service dental program in Wisconsin.

Cost Comparison

The Report states on page 18 "We conducted our own cost analysis and confirmed that Medical Assistance dental services appear more costly under manage care." On page 10 the report states "certain administrative costs are expressly reflected in the managed care capitation payments received by HMOs but less expressly reflected in fee for service reimbursements received by dentists, and therefore cannot be readily compared." Our concern is that the audit included the administrative costs associated with dental delivery under the managed care model but the administrative costs incurred by DHFS and EDS to deliver the fee for service model were not included. A fair and balanced cost comparison, we believe, would include each model's administrative costs.

Access Comparison

The Report states on page 15 "It also found that throughout the four-county area, only 30 of 39 dental offices were willing to accept new HMO enrollees." The audit did not include the fee for service ratio comparison of number of dental offices accepting fee for service enrollees. The Report failed to indicate that SEDA will respond to any patients needs whether new or established. A fair and balanced comparison, we believe, would include access measurements from both models.

Utilization Comparison

The Report used utilization source data from EDS for the fee for service model, while it used non-source data from DHFS for the managed care model. While SEDA offered the auditors its utilization source data, the actual data used for the LAB report was obtained by DHFS from 5 different managed care organizations. Using this data the LAB concluded that fee for service had a 3 percent higher utilization than the managed care model. This 3 percent difference easily could be the margin of error incurred by not using original source data. SEDA's experience is that original source data does not always agree with DHFS data after it has been collected and compiled from several non-original data sources. Moreover, this data can be corrupted by changing utilization calculations to the user/eligible methodology without eligibility source verification.

The utilization calculations carried out by the LAB in the report use the 259 continuous day enrollment standard that is part of the MEDDIC quality measurement initiative. This definition of enrollment eligibility is clinically driven, and more longitudinal in nature than standard eligibility data. Given the "churning" T-19 membership, including frequent lapses in eligibility, a widely variant length of eligibility and frequent enrollee transfers from one HMO to another, counting members that have been consistently enrolled for almost 9 months under one HMO may undercount actual utilization. SEDA completed an internal utilization calculation for 2006, (the most recent year with complete claims data). During 2006, SEDA treated over 30,665 different individual patients (unique recipients) during which SEDA's average monthly enrollment was 105,000. This method of calculating utilization shows a level of above 30%, substantially higher than the Report. (Note that the State allows dental providers one year to submit claims. This means that utilization for the most recent year of service may be understated in the Report.)

Alternative Fee for Service Models

Throughout its history, SEDA has actively recruited dentists to treat managed care Medicaid enrollees. SEDA believes that for the most part, those dentists who want to participate in T-19 are currently participating. As it stands, SEDA must pay more than standard T-19 fees to get specialty dental providers to participate. More money in the form of increased fees may or may not increase the numbers of participating dentists, and therefore, may or may not improve access. Other issues such as patient compliance and accountability must be addressed in alternative models. The only certainty here is that fee for service would cost more.

Medical and Dental Comparison

As acute medical expenses are the lion's share of the T-19 health care budget, dental services are often thought of as a subspecialty medical service. SEDA's unique 25 year experience as an integrated dental network which provides coordinated care to enrolled patients has fostered some interesting insights in this regard. Improved access to dental care involves more than more sites. Since dental care is often deferrable, improved utilization requires patient advocacy. This is currently done by SEDA and/or HMO staff. These resources are not currently available in the fee for service setting, and are not addressed in the Report.

Dental claims are different than medical claims, and few medical insurance companies and almost no HMOs have IT systems that are competent to handle state Medicaid dental claims including its service limitations. SEDA has developed this IT infrastructure solely to support treatment of T-19 BadgerCare patients. IT development continues with the new Medicaid product line, BadgerCare Plus Benchmark Plan. SEDA has shown that it can provide excellent access and coordinated dental care to enrolled patients on an accountable basis. While collaborating with the HMOs for member outreach, SEDA has

provided the clinical leadership to deliver this service with a minimum of patient and enrollee complaints. It has never been SEDA's intent to be the only dental administrator in SE Wisconsin. It happened by default simply because competing dental networks could not accomplish State objectives while pleasing both the dental community and the patients.

At the end of the day, it is about the patients, who are not mentioned in the Report. If the LAB and the State are sincere about looking at alternative dental delivery and financing models, perhaps SEDA is a good place to start. Beginning with clinical efficiency, lowering access barriers, and finishing with fairly paying for dental service, we believe the SEDA model, in association with the HMOs, has delivered.

Finally, SEDA representatives would be pleased to pursue more detailed discussion about any and all of the issues addressed in the LAB Report. Please don't hesitate to contact us for this purpose. Providing accessible, accountable service in an environment of static or declining funding requires the cooperation of all parties and entities involved.

Sincerely

Southeast Dental Associates, S.C.


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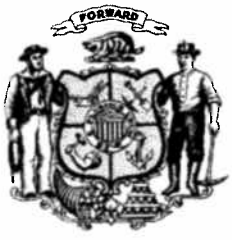
FORWARD

MHS
Managed Health Services
10700 W. Research Drive, Suite 300 • Milwaukee, WI 53226 • 1-800-547-1647 • Fax 1-866-646-6056

Date: June 10, 2008

To: Legislative Audit Committee

From: Katrina Jenkins, CHC, PAHM
Director of Member Services, Managed Health Services

Re: Legislative Audit Bureau Report on Dental Services for Medical Assistance Recipients, April 2008

Good afternoon. My name is Katrina Jenkins and I am the Director of Member Services for Managed Health Services. I came here today to speak with you about our programs for ensuring our members have access to dental care. It is a lot of work, but I know it is worth the effort. It would be an easy thing for me to tell you to take dental away from the HMOs, but it would not be the right thing to tell you. It would certainly not be the best thing for our members. I am not afraid of the work, but I am afraid of what will happen to the people of southeastern Wisconsin if we stop doing the work. I am here to tell you a little bit about what we do.

Connections

Within Member Services, I have an outreach department of six full time employees, which we call Connections. Our Connections staff contact new members by telephone or home visit during the first month of eligibility to inform them of their benefits, help them select primary doctors and dentists in those counties for which dental services are covered by the HMO. Our Connections staff helps our members make dental appointments and stress the importance of *keeping* dental appointments. We call to remind members the day before their appointment and we also arrange for transportation to and from appointments.

Still, we have trouble with members not keeping their appointments. So we work with our providers who identify members who have missed appointments in the past. We call them, schedule new visits, and ask them for their commitment to keep the appointments. We offer incentives because we find that a small gift can make the difference. We guarantee our members access to dental care and we let them know that they have access to us 24 hours a day.

Some of our smallest members have the biggest problems. When a baby is regularly allowed to suck on a bottle of milk or juice all night long, they can develop cavities in all of their developing teeth. You may have heard this referred to as baby-bottle-syndrome. There is no treatment for this, but to remove all of the baby's teeth under general anesthetic in a hospital setting. It used to be very hard to find an oral surgeon and an operating room for this procedure, because so very often the procedure had to be cancelled at the last minute. Families often didn't understand that the baby cannot eat or drink anything on the day of surgery, because of the risk of asphyxiation during the procedure. The MHS Connections staff works with our providers and the baby's family to ensure this goes as smoothly as possible. The Connections staff makes sure that the family understands the procedure and that they cannot feed the baby anything on the day of surgery or it will have to be cancelled. We also book transportation if needed and we walk the family through the whole process. Our providers trust that everything will go well, so we are able to coordinate these services. We have been able to achieve practically 100% compliance the first time, ensuring that hospitals and oral surgeons do not have blanks on their schedules (a very costly down time), and that our members get the care they need as quickly as possible.

Connections also takes incoming calls from members who need help finding a dentist. We offer dentists names, addresses, and phone numbers to our members and also offer to make an appointment with/for them. Even if a member is not in one of the counties where we provide dental coverage, we can sometimes arrange for them to come into Milwaukee for dentistry. Connections asks probing questions to assess the member's level of need in getting services. If a member says they are in pain, or are experiencing swelling, pain, etc.; Connections can make a same day appointment for the member. Our

24 nurse hotline can link our members to dental services or arrange transportation to the emergency room in the middle of the night, if needed. Our dental network will always make room for emergent or urgent needs, although they would prefer to see patients before they reach such a state. Dentists like prevention and so do HMOs.

Prevention Programs

MHS has other programs that ensure dental access for our members. Our prenatal care coordinators and child care coordinators link young moms to dentists and sealant programs. We worked with one of the state's dental consultants to develop the Open Roads program, where we bring families with small children into the HMO for fun, but educational meetings as well as conducting sealant applications right on site. For families who participate in the program we guarantee appointments within 6 weeks for routine care, as well as immediate appointments for problems that need more immediate attention – often, we see children that need significant work and can arrange an appointment to begin restorative care almost immediately. We participate in the Smart Smiles program which provides comprehensive dental exams and sealants within the Milwaukee Public Schools. This is followed by arranging appointments with participating dentists to ensure that follow up care is provided in a timely manner. Programs of this type often stop at that point, but members of ours who are identified as needing emergent or urgent follow up, get referred to our dental provider for immediate appointments. Members of ours who have healthy teeth get a call from our Connections workers, to schedule their next check-up, so we can keep those teeth healthy.

MHS integrates dental into our prevention programs. Dental is not separate from healthcare, it is a part of it. When we conduct a HealthCheck day at the FQHC in Kenosha, we combine it with a dental exam day. We have facilitated donations from our foundation to the Kenosha Community Health Center's dental program and to the Waukesha County Community Dental Clinic because we recognize the critical need to expand dental services in the communities we serve.

These are just a sampling of the things we do to make our dental program work well. I cannot imagine how people would access care, if we were not involved in the

process. I know that in other areas of the state, many of our members have to go without care, because we are not involved. I urge the committee to use careful judgment in making decisions on how members will receive care. I hope you can share my vision of making dental access a reality for the people of southeast Wisconsin. We stand ready to work with the Department of Health and Family Services to achieve this goal.

Thank you for the opportunity to address the committee.


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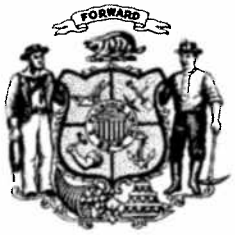
FORWARD

WPHCA
Wisconsin Primary Health Care Association

Testimony on LAB Audit of Dental Services for Medicaid Recipients

June 10, 2008

Good morning Co-Chairs Jeskewitz and Sullivan and members of the committee. I'm Tom Petri, Director of Policy and Communications for the Wisconsin Primary Health Care Association. For those who are unaware of our organization, we represent and advocate on behalf of our state's 17 Community Health Centers, which are cited in the audit at hand.

For those who are unfamiliar with Community Health Centers, each are individual non-profit, small businesses that provide needed primary and preventive health care services, largely to Wisconsin's underinsured and uninsured families who reside in medically underserved communities. Our Health Centers provide high-quality and cost-effective health care regardless of patients' insurance status or ability to pay. In 2007, for example, our 59 Health Center delivery sites served over 177,000 patients, 90% of which were considered low income (under 200% of FPL). 62% had a family income at or below the federal poverty level.

When the aforementioned audit was released last month, WPHCA took the opportunity to publicly comment, saying the disturbing findings and the recommendations demonstrate that there is still much work to be done in assuring access to dental care particularly for patients who use Medicaid. In particular, WPHCA affirms the chief recommendation of the report, that DHFS develop "alternative dental service deliver models to improve access to care and utilization of services" We feel it is clear that utilization rates by patients enrolled in managed care HMOs have not improved access to care and the $!2 million the state spent in 2006 could be better spent elsewhere.

This ongoing problem confirms what many of our southeastern Wisconsin member-Health Centers' have learned from experience; there are **identified alternatives** that might prove better for patients, including proposals to redesign the dental delivery system and to focus on a statewide pay-for-performance model that would ensure additional reimbursement payments to those dentists who are committed to treating Medicaid patients.

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For years, WPHCA has expressed our feeling that only an "all hands on deck" togetherness approach, where our belief is that more private and public dental providers participating in the Medicaid Program will improve care, both in southeast Wisconsin and statewide. In addition, WPHCA feels a big piece of this puzzle would be solved if the legislature develops new, or better finances current programs that will help attract and retain more dentists with a disposition to help the underserved with their oral health needs, either in private practice or in a Health Center.

As the audit highlights, over 47,000 people received dental care at one of our 17 unique delivery sites in 2007. Four of our Health Centers (3 in Milwaukee and 1 in Kenosha) served over 10,000 total dental patients in 2007. Table 10 of the audit shows just Approximately 5,000 of those patients seen were Medicaid enrollees not enrolled with the state-contracted HMOs. The audit also happened to reference the waiting list at Scenic Bluffs Community Health Center in Cashton, in rural Monroe County. I thought it appropriate to note that later today, Scenic Bluffs is hosting the grand opening of their newly expanded dental facility from 10 operatories to 14. The construction costs were largely funded with dollars appropriated by the Joint Committee on Finance back in December, 2006, when Governor Doyle directed that over $4 million in federal income augmentation funds be specifically earmarked for dental expansion opportunities (Appendix 1). That expansion is proof positive that state investment will result in higher numbers of uninsured and Medicaid recipients having increased access to care at Community Health Centers.

While the audit showed that Health Centers continue to play a significant role in providing dental access to uninsured and underinsured people in the Milwaukee-area and around the state, the barriers to care are too high for Health Centers to overcome alone. Last year, WPHCA promoted almost a dozen unique strategies to address the problem, and provided DHFS with a comprehensive list of alternative and collaborative methods for funding the state Dental Medicaid Program We believe the state could easily redirect the $12 million used in the dental HMO contracts to other options, many of which would yield immediate, positive results.

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Those options include:

- Continuing to invest in Community Health Centers;
- Providing higher reimbursement rates to private dentists who see a threshold level of Medicaid patients;
- Creating a tuition subsidy for in-state dental students who desire to practice in underserved areas and/or treat Medicaid patients for a time after graduation;
- Creating a bonus payment program (e.g., higher reimbursement) or incentive program (e.g. income tax credits, introduced as 2007 AB 748) for private dentists who see an above-average number of Medicaid patients; and
- Increasing the number of dentists practicing in Wisconsin, by funding a new public health school of dentistry and by increasing the enrollment at Marquette.

WPHCA has identified, and this audit has reaffirmed that numerous new strategies have already been identified and are needed to address this multi-pronged problem, including efforts that will boost the existing and future shortage of Medicaid-certified dentists (Table 3).

Properly fixing this problem will require collaboration between policy makers and private and public providers. Therefore we look forward to partnering with interested legislators and associations to ensure more less-fortunate families get the dental care they deserve. However, let me be clear, Health Centers are fighting this epidemic on the frontlines, and will stay there regardless of what occurs as a result of this audit.

Finally, our recommendations to the committee and the state Legislature are that more needs to be done to:

- Help administration officials design and manage an improved dental delivery system;
- Support an increase in state aid to providers who regularly treat MA patients; and
- Influence DEB policy rules related to provider licensing, regulation and scope of practice.

Thank you for your time and your consideration of our Association's feedback, ideas and recommendations.

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FORWARD
E PLURIBUS UNUM

Testimony of

Laura Freedy
Compliance Officer

AmeriChoice
A UnitedHealthcare of Wisconsin

For the
Joint Legislative Audit Committee
Regarding the State Auditors
The Dental Service for Medical Assistance Recipients Report

June 10, 2008

Introduction

Good Afternoon. Thank you for the opportunity to testify today about the important role of dental care for Medicaid-eligible children and adults. I am Laura Freedy, the Compliance Officer at UnitedHealthcare of Wisconsin in the Medicaid Division. With me today is Dr. Allen Finkelstein the Chief Dental Officer for Americhoice, A UnitedHealth Group Company.

I took on the role as Compliance Officer with UHC after having worked on the delivery side of medicine since I was in High School. Going to the insurance side I brought the perspective that I have obtained providing care, I have an understanding of the issues faced by providers and I am better able to integrate the business of medicine with the delivery of care.

As you all know we have a national crisis in healthcare. Dental care is a sub-specialty within healthcare that we need to pay particular attention to as it is integral in our members health. We need to continue treating the patient as a whole to obtain the best possible outcomes.

There are several flaws that we find in the conclusions made by the LAB in their recent review of the Managed Care Dental Program. The studies conclusions do not match the data provided in the areas of Cost, Access and Utilization Comparisons.

Cost Comparison

1. The report states that monthly capitation payments for every enrollee regardless of services received is made to the HMO.
    a. The problem with this is that the HMO pmpm rate is based on utilization not on every member actually receiving services.
2. The Audit Bureau acknowledges that comparing the cost of Fee for Service to HMO is problematic due to how administration fees are paid on FFS, the demographics of the 4 counties are drastically different than the rest of the State and therefore the program is inherently different for the HMO product compared to FFS.
    a. With all of these substantial problems, how can the Bureau make a conclusion that one is more expensive when you are purchasing different products?
3. Administrative fees are included in HMO but not in the FFS model so a comparison of costs is invalid based on the audit bureau's own information.
4. The claim that the MCOs kept an average of 25% of the cap payment is not substantiated by the data provided in that 2 of the payments were greater than 100% and 3 were at the 75% paid to administrator. This is an average of 87.3% paid to the dental administrator. This is a low average knowing that 50% of the SE region is with the MCO who paid 110% of their cap rate to the administrator and the other majority provider even if considered at the lowest rate would be a higher payment to the administrator as the rough average listed above indicates.

Access Comparison

1. Dentists who have provided services to Medicaid members are noted to be 38.4% of all licensed WI dentists. Most of the care is provided by significantly less than this. If active participation could be increased, fewer dentists would carry the burden of caring for the underserved population at a lower rate causing less financial loss to these practices.

2. Although dentists providing care to this population went down in 2007, the number of providers working with the HMOs went up in 2006 which is still higher than the 2005 HMO's participation. A comparable to the FFS was not provided.

Utilization Comparison

1. The Audit Bureau does not believe that the HMOs have made any improvements in utilization.
    a. UHC has had the following increases

        Preventative dental age 3-20
        DOS 2004: 26.1% 2005: 28.8% 2006: 31.8%

        Preventative dental age 21+
        2004: 14.9% 2005: 19.5% 2006: 21.3%

    b. Many initiatives have been undertaken by UHC to improve utilization such as instituting non-traditional modes of providing care to children. With only the traditional delivery modes used by FFS, many of the children in the 4 SE counties would not have received even a screening check-up at their schools.

1. Utilization patterns of the FFS area are different than the 4 SE counties. The assumption that FFS was more successful in providing care than the HMOs is not an accurate assumption. Two flaws exist,
    1.) FFS would have had the same success in the 4 SE counties; and
    2.) Data collected through encounter data is not all inclusive; the only way to ascertain this would be through chart review or source data which was not done in this study.

Now, and Moving Forward

UHC needs to partner with the State to determine which outreach mechanisms and strategies are most successful, and to escalate the already steadily increasing utilization that we have experienced.

UHC has:
1. A School-based Program that puts dental hygienists into the schools to perform evaluations, dental prophylaxis treatments, debridement and refer those that need restorative dental care to their HMO provider.
2. Smart Smiles – which is a community outreach program that reminds children to brush their teeth and provides free toothbrushes.

3. A full time Advocate + 24 hour on call assistance to answer any questions or arrange emergency care.
4. A Health Fair dental education demonstrator that will attend health fairs and teach children how to correctly brush their teeth and take care of them. Free tooth brushes are also provided.
5. A program that targets those that have not been to the dentist. This outreach event is held at the Zoo Safari building and provides zoo tickets for those that attend.
6. Back to school events that focus on dental outreach and education.

Moving forward, some of the programs we would like to partner with the State and explore the feasibility to improve access and dental utilization are:

1. Mobile Dental Clinics
2. Walk-in dental care centers
3. Incentives to Dentists to maintain Medicaid slots
4. Incentive programs for members to establish and maintain dental homes
5. Institute reminder calls for the dentist to decrease no-show issues

In Closing, I would like to thank this joint legislative committee for your willingness to review this hard issue of finding adequate care for the underserved. We are committed to partnering with the legislature, DHFS, our dental administrator, our providers, and all the participants to face the cost, access and utilization challenges. We are determined to do all we can through partnering to attain a higher level of quality dental care for our members.