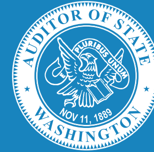

Office of the Washington State Auditor
Pat McCarthy

PERFORMANCE AUDIT

Medicaid Fluoride Cost Savings

September 12, 2019

Report Number: 1024506

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Executive Summary

Background (page 6)

Washington's Medicaid dental program gives children and adults access to preventive, diagnostic, restorative and other dental care. The Health Care Authority (HCA) administers the program which, in 2018, cost about $397 million in state and federal dollars. Preventive dental care is intended to keep more expensive problems from developing; it costs Washington about $42 million annually.

Fluoride, a naturally occurring mineral, is commonly used to help prevent tooth decay that can lead to cavities. Fluoride only poses risks such as fluorosis (a discoloring of teeth or weakening of bones) if consumed in extremely high amounts. HCA spends about $12 million a year for fluoride treatments, and typically pays $12 to $23 for each treatment, about one-third of the cost to fill a cavity (not including the cost of X-rays and other related services). Clients can receive fluoride treatments, and other preventive care, in a variety of settings, such as dental offices and mobile dental clinics which are often found at schools.

We conducted this audit as part of a pilot program to increase the number of short and focused audits of the state Medicaid program. This audit is the first of several shorter performance audits designed to identify efficiencies and cost savings in the program. The audit was prompted by previous audit issues that our Office wanted to explore further.

Could Washington's Medicaid program save money by following leading practices for the number of beneficial dental fluoride treatments?

(page 9)

Leading dental associations recommend fluoride treatments every three to six months, depending on the patient's risk for cavities. The number of fluoride treatments Washington's Medicaid program allows would fall within leading practices if HCA regulations did not include the "per provider or clinic" clause. The "per provider or clinic" clause cost about $290,000 annually in state and federal funds, about 2 percent of annual Medicaid fluoride treatment costs. Washington established the "per provider or clinic" clause to minimize the administrative burden on providers. Since adding the "per provider or clinic" clause, Washington has taken steps to limit fluoride treatments and costs.

However, establishing a separate allowance for school-based and mobile treatments could eliminate the need for the "per provider or clinic" clause, further lowering costs. Finally, under a managed-care model, Washington could save more money by completely limiting a patient's fluoride treatments to recommended amounts.

State Auditor's Conclusions (page 15)

This audit is the first in a series of focused performance audits the Office plans to conduct of the state's Medicaid program. The intent is to use what we learn in other audits we conduct of the program to identify areas of risk or opportunity that can be explored in greater depth through performance audits. We chose this area because a previous audit, which looked at compliance with federal requirements, suggested our state's Medicaid program may be paying for fluoride treatment beyond what is recommended by dentists.

Medicaid is indeed paying for additional fluoride treatments by including a "per provider or clinic" provision for treatments. However, these additional treatments and payments do not appear to be a significant problem. First, the Health Care Authority (HCA) has already taken steps to substantially limit the number of additional treatments and associated costs. Second, the total cost of the additional treatments we did identify — about $290,000 a year — is relatively small compared to the $12 million Medicaid spends annually on fluoride treatments. Finally, while there is general consensus in the dental community that additional fluoride treatments are not harmful to patients, there is little evidence such treatments are beneficial.

We do note at least one option that HCA should consider that can further limit the number of additional fluoride treatments in the short term. The real opportunity to eliminate additional treatments will present itself if the Legislature decides to move Medicaid dental services to a managed-care model. At that point, HCA should return to a stricter "per patient" provision in its contracts with managed care organizations.

Recommendations (page 16)

We recommended HCA take further steps to reduce the number of Medicaid fluoride treatments, by removing the "per provider or clinic" clause and instead establishing limits for school-based and mobile dental services that are separate from office-based dental services. We also recommended establishing contractual fluoride allowances only "per patient," rather than "per provider or clinic," if the dental program moves to a managed-care model.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology.

Background

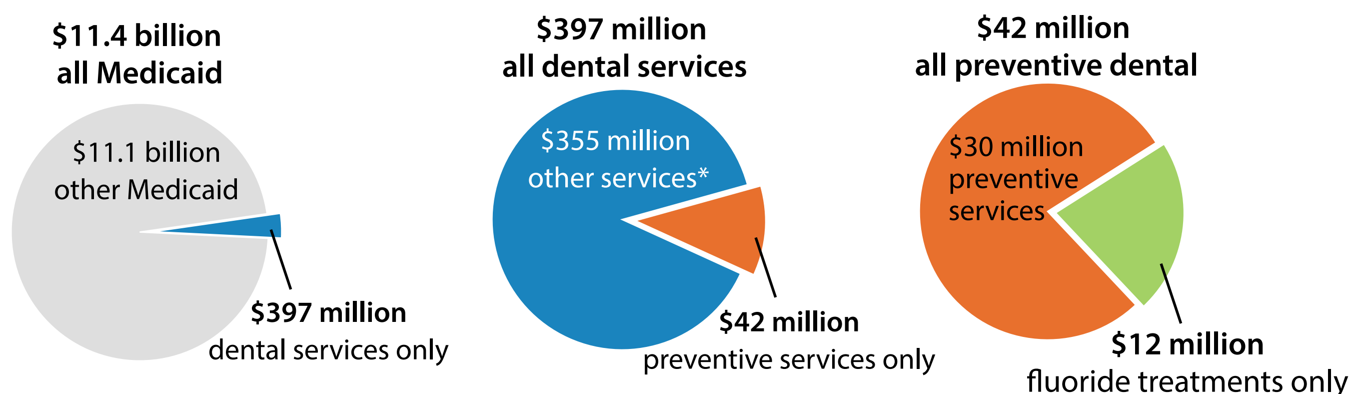
Medicaid helps ensure many Washington residents have access to dental services

Medicaid is Washington's largest public assistance program, providing health insurance to about 1.8 million people. The Health Care Authority (HCA) administers Washington's Medicaid program, which cost more than $11 billion in state and federal funds in fiscal year 2018. Medicaid's medical and dental insurance covers people who meet the program's primarily income-based criteria, including children, the elderly, those with certain disabilities and pregnant women.

In 2018, Washington spent about $397 million on dental expenses, including about $42 million for preventive services

The Medicaid dental program gives children and adults access to preventive, diagnostic, restorative and other dental care; it costs the state about $397 million annually in state and federal dollars, as shown in **Exhibit 1**.

Exhibit 1 – At $12 million annually, fluoride treatments are a very small proportion of all Medicaid spending



* Note: "Other services" includes diagnostic, restorative and other dental services.

Preventive care is intended to prevent more expensive problems from developing, and encompasses regular check-ups, cleanings, fluoride treatments, and counseling about proper oral hygiene. Preventive care costs Washington about $42 million in fiscal year 2018, which is about 11 percent of overall dental program expenses.

Washington's Medicaid program spends about $12 million a year on preventive fluoride treatments

Fluoride treatments supplement other fluoride sources to prevent tooth decay

Fluoride, a naturally occurring mineral, is commonly used to help prevent tooth decay that can lead to cavities. Fluoride is often added to public water systems to help improve a community's dental health. Dentists apply fluoride directly to teeth to supplement the fluoride in water, whether naturally occurring or added to a public water supply. Fluoride poses risks such as fluorosis (a discoloring of teeth or weakening of bones) only if consumed in extremely high amounts.

Washington pays for fluoride treatments for Medicaid clients in multiple settings

HCA spends about $12 million a year for fluoride treatments, and typically pays $12 to $23 for each treatment, about one-third of the cost to fill a cavity (not including the cost of X-rays and other related services).

To increase access to dental care, HCA allows Medicaid clients to receive treatment – including topical fluoride – in multiple settings, not just in a dentist's office. For example, some dental providers offer services at schools, treating children whose parents may be unable to bring them to an office appointment. Additionally, pediatricians and other medical doctors can apply fluoride as part of a routine check-up.

The state is exploring options for better access to dental care

Medicaid services are provided under two primary models: fee-for-service and managed care. Under the fee-for-service model, the state is directly responsible for the program, managing the provider network and the claims payment process, and working directly with providers. Under the managed-care model, the state contracts out these responsibilities to managed care organizations, paying them a set monthly premium amount for each client, and is responsible for ensuring the managed care organizations fulfill their contractual requirements.

Washington currently provides its Medicaid dental services through the fee-for-service model, but this may eventually change. In 2017, the Legislature directed HCA to move Medicaid dental services to a managed-care model by July 2019. HCA prepared to do so, but in May 2019, the Legislature directed HCA to keep Medicaid dental services under the fee-for-service model, and to instead deliver a report by November 2019 that recommends the best service delivery model for ensuring access to and coordination of dental care for Medicaid clients. This could include keeping the dental program under the current fee-for-service model, moving the program to managed care, or implementing another model. In response to that report, the Legislature may once again direct HCA to move Medicaid dental services to the managed-care model.

This audit determined whether there are possible cost savings by limiting fluoride treatments to recommended amounts

Preventive dental services are important to the health of Medicaid clients. However, additional fluoride treatments waste money that HCA could use for other Medicaid services. The audit was initiated due to previous audit issues that our Office wanted to explore further. We believe this audit can help HCA reduce its costs under either a fee-for-service or managed-care model.

The audit asked this question:

- Could Washington's Medicaid program save money by following leading practices for the number of beneficial dental fluoride treatments?

This audit is the first in a State Auditor's Office pilot program of short, focused Medicaid audits

Our Office is pursuing a pilot program to increase the number of short and focused audits of the state Medicaid program. This audit is the first of several shorter performance audits designed to identify efficiencies and cost savings in selected areas of the state Medicaid program.

Audit Results

Could Washington's Medicaid program save money by following leading practices for the number of beneficial dental fluoride treatments?

Answer in brief

Leading dental associations recommend fluoride treatments every three to six months, depending on the patient's risk for cavities. The number of fluoride treatments Washington's Medicaid program allows would fall within leading practices if HCA regulations did not include the "per provider or clinic" clause. The "per provider or clinic" clause cost about $290,000 annually in state and federal funds, about 2 percent of annual Medicaid fluoride treatment costs. Washington established the "per provider or clinic" clause to minimize the administrative burden on providers. Since adding the "per provider or clinic" clause, Washington has taken steps to limit fluoride treatments and costs. However, establishing a separate allowance for school-based and mobile treatments could eliminate the need for the "per provider or clinic" clause, further lowering costs. Finally, under a managed-care model, Washington could save more money by completely limiting a patient's fluoride treatments to recommended amounts.

Leading dental associations recommend fluoride treatments every three to six months, depending on the patient's risk for cavities

The American Dental Association and the American Academy of Pediatric Dentistry recommend patients receive fluoride treatments every three to six months, with more treatments reserved for those at higher risk of tooth decay. Evidence from their research also shows that low-risk individuals may not gain additional benefit from fluoride treatments because fluoride is widely present in drinking water and toothpaste. For this reason, the Centers for Disease Control and Prevention (CDC) does not recommend fluoride treatments for those at low risk for tooth decay. However, the Centers for Medicare and Medicaid Services recommend that state Medicaid programs allow patients under the age of 21 at least one fluoride treatment a year, if the child's dentist thinks it is warranted.

The number of fluoride treatments Washington's Medicaid program allows would fall within leading practices if HCA regulations did not include the "per provider or clinic" clause

Washington's fluoride allowances generally follow recommended guidelines, as shown in **Exhibit 2**, but allowing treatments "per provider or clinic" instead of only "per patient" allows people to possibly receive more fluoride treatments than the recommended number. HCA allows low- to moderate-risk individuals up to two fluoride treatments a year, and high-risk individuals up to three treatments a year, without prior approval from HCA. Patients can also receive additional fluoride treatments on a case-by-case basis if HCA pre-approves them.

Exhibit 2 – Leading practice fluoride recommendations compared to Washington Medicaid allowances

Client risk group	Leading practice allowance	Source[1]	Washington Medicaid allowance[2]	Client group subject to Washington allowance
High-risk patients	Once every 3 to 6 months	ADA, AAPD	Three times within a 12-month period, "per provider or clinic," with minimum time between treatments[3]	Ages 0-6; orthodontic; Alternate Living Facility residents (ALF); developmental disability clients (DD)
Low- to moderate-risk patients	Once every 6 months	ADA, AAPD	Two times within a 12-month period, "per provider or clinic," with minimum time between treatments[3]	Ages 7-18
Low-risk patients	None or once a year	CDC, CMS	Once a year, "per provider or clinic" [3]	Ages 19+

1. ADA – American Dental Association; AAPD – American Academy of Pediatric Dentistry; CDC – Centers for Disease Control and Prevention; CMS – Centers for Medicare and Medicaid Services.

2. Washington allowances for fluoride changed multiple times during the audit period.

3. Additional fluoride treatments are allowed if medically necessary, with prior approval from HCA.

Source: ADA, AAPD, CDC, CMS, Washington Administrative Code.

While these allowances fall within the range of leading practice recommendations, HCA's regulations specify that fluoride treatments are limited "per provider or clinic" instead of just "per patient." This allows patients to receive treatments beyond recommended allowances, without approval from HCA, if they visit multiple dental providers.

Washington is one of six states with a "per provider or clinic" clause for its Medicaid fluoride allowances. The other five states, which – like Washington – use a fee-for-service Medicaid dental delivery model are Maryland, Massachusetts, Nebraska, North Carolina and Virginia.

The "per provider or clinic" clause cost about $290,000 annually in state and federal funds, about 2 percent of annual Medicaid fluoride treatment costs

As a result of the "per provider or clinic" clause, we found HCA paid for fluoride treatments beyond the recommended number. Based on our analysis of more than 2 million Medicaid fluoride claims over a three-year period (2016-2018), we estimate Washington paid for about 50,000 additional fluoride treatments, for about 45,000 Medicaid clients, when compared to the recommended number of treatments. As **Exhibit 3** shows, we found clients most commonly received one fluoride treatment beyond leading practice recommendations. Additional treatments are not harmful in the quantities administered in Washington, because when administered correctly, the fluoride is not swallowed, but extra treatments likely do not provide additional medical benefit.

Nonetheless, at $12 to $23 for each treatment, Washington could save about $290,000 annually in state and federal dollars, about 2 percent of what the state spends on fluoride treatments. While additional fluoride treatments cost only a small amount in the context of the $12 million in total fluoride treatments, it represents money HCA could use for other Medicaid services.

Exhibit 3 – Number of additional treatments per person, fiscal years 2016-2018

Number of additional treatments	Number of patients receiving these treatments
1	41,094
2	3,676
3	396
4	75
5	19
6	2
7	2
8	0
9	0
10	1
Total	**45,265**

Source: Auditor analysis of HCA fluoride treatment data.

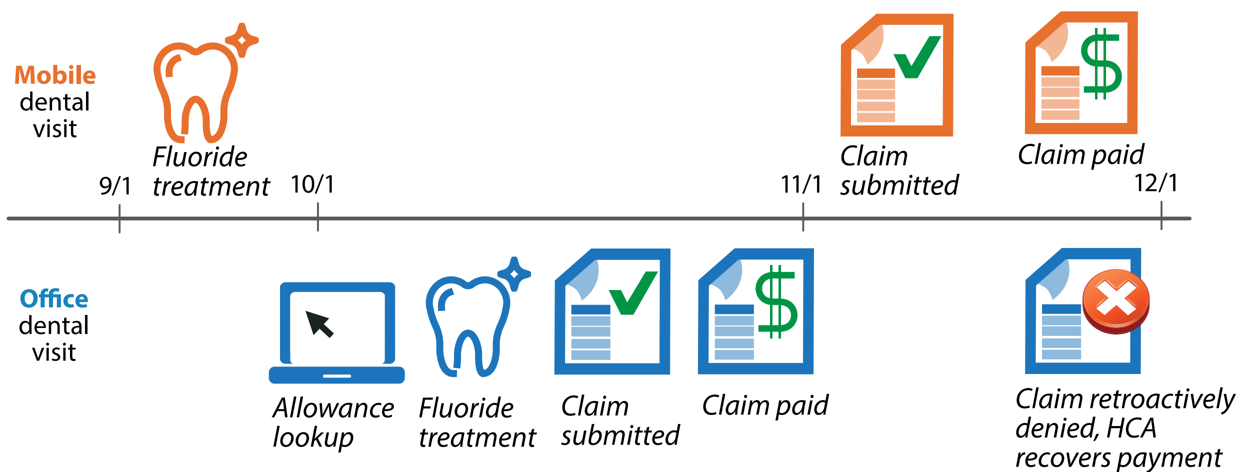
Washington established the "per provider or clinic" clause to minimize the administrative burden on providers

Washington's Medicaid program limited fluoride treatments to the provider level more than a decade ago after school-based dental services became more common, causing problems with the claims payment process. Under Washington Medicaid

rules, providers have one year to bill for services and if two providers give the same treatment to the same client, priority is given based on the date of service, not the date the claim was submitted. Some clients receive dental services from both a school-based or mobile provider and their routine-care dentist. These providers are not typically associated and have different patient records, so a provider does not know if a patient recently received a fluoride treatment, unless the other provider already submitted a claim and was paid for the service.

As shown in **Exhibit 4**, even if the second provider confirmed a patient's available fluoride allowances, HCA would retroactively deny some fluoride treatments, and recover the related funds, if it received a claim for an earlier date of service from a different dental provider. These delayed billings increased administrative work for dental providers, as well as HCA, in the form of claim adjustments and cost recovery efforts.

Exhibit 4 – Delayed billings can cause other providers to lose previously approved reimbursements



HCA added the "per provider or clinic" provision to its billing policies, and later to its administrative code, to address this administrative burden with the goal of retaining providers. The provision allows a provider or clinic to bill HCA for fluoride treatments it supplied without being affected later by a delayed billing from a different provider. In part, HCA did this because fluoride is a preventive treatment, and the agency would rather pay for inexpensive prevention than expensive dental work later. While this is reasonable, it does result in HCA paying for additional fluoride treatments.

Since adding the "per provider or clinic" clause, Washington has taken steps to limit fluoride treatments and costs

HCA has made an effort to reduce the number of additional treatments that are allowed because of the "per provider or clinic" clause, resulting in cost savings from fewer fluoride claims per person. For example, starting in 2007, patients were allowed one to three treatments a year "per provider or clinic," depending on their age and other risk factors. This sometimes resulted in HCA paying a provider for two treatments applied just days apart. HCA addressed this issue by placing time limits between fluoride treatments by the same provider. Although other factors may have contributed, after this policy change, the number of claims per client dropped about six percent from fiscal year 2015 to fiscal year 2018. We estimate this resulted in up to $640,000 in cost savings in fiscal year 2018.

Establishing a separate allowance for school-based and mobile treatments could eliminate the need for the "per provider or clinic" clause, further lowering costs

Instead of a "per provider or clinic" clause, another strategy could further reduce the number of fluoride treatments Medicaid pays for, saving money for other needs. HCA could remove the "per provider or clinic" clause from fluoride allowances, and then establish a separate allowance only for school-based and other mobile treatments. Doing so would prevent mobile and office providers from submitting competing claims, making the "per provider or clinic" clause unnecessary, while resulting in fewer additional fluoride treatments.

Separating the mobile and school-based fluoride treatments from those received elsewhere would only limit some additional fluoride treatments and requires implementation costs. In situations where retracting a claim because of a delayed billing causes more work than is saved by denying payment, it is reasonable for HCA to approve the additional fluoride treatment and pay the provider. We estimate this change could save about $130,000 a year, addressing almost one-half of the audit's identified cost savings. Implementing this change would require system changes and updates to administrative rules, and would likely add more customer service time due to questions related to the change. However, HCA said these costs would be minimal and should not require additional staff or overtime.

Under a managed-care model, Washington could save more money by completely limiting a patient's fluoride treatments to only recommended amounts

Under the current fee-for-service delivery model, HCA is responsible for managing Medicaid dental providers, including making and recovering payments, and ensuring patients have access to care. Under a managed-care delivery model, the state contracts out this responsibility to managed care organizations, paying them a set monthly premium amount for each client. If the Legislature moves Medicaid dental services to a managed-care delivery model, HCA will no longer need provisions in state regulation to relieve administrative burdens described above because it will be the responsibility of the managed care organizations to set and apply their own standards that adhere to HCA contractual requirements.

Since managed care organizations establish their own claims payment processes, they are responsible for decisions about which exceptions to include in their policies and procedures, as long as they comply with HCA requirements. This creates an opportunity for HCA if it eventually contracts with a managed care organization: the agency could only allow fluoride treatments "per patient." The managed care organization could still allow additional fluoride treatments, but there would be no cost to the state. Such a limit would address all of the audit's cost savings.

Aligning fluoride allowances with recommended leading practices will continue to be important under a managed-care model. Even though HCA would no longer make or recover provider payments, payments for additional treatments still affect the state's cost for care. In managed care, the monthly premiums the state pays the managed care organizations are partly based on the costs of services, so extra costs increase the state's future premiums. Multiple reports (see **Appendix C** for a full bibliography), including our 2014 audit of the HCA's monitoring efforts of the managed care organizations, found increased costs for managed care organizations can also increase the cost of future premiums. For example, an actuarial analysis during our 2014 audit found that for every $1 million in overpayments the managed care organizations paid to their providers, the state potentially paid an additional $1.26 million in future premiums. This means that only allowing fluoride treatments "per patient" in future contracts with managed care organizations could save more than the estimated $290,000 in costs savings identified by this audit.

Read the 2014 performance audit, Health Care Authority's Oversight of the Medicaid Managed Care Program, on our website at: bit.ly/2HltvsG

State Auditor's Conclusions

This audit is the first in a series of focused performance audits the Office plans to conduct of the state's Medicaid program. The intent is to use what we learn in other audits we conduct of the program to identify areas of risk or opportunity that can be explored in greater depth through performance audits. We chose this area because a previous audit, which looked at compliance with federal requirements, suggested our state's Medicaid program may be paying for fluoride treatment beyond what is recommended by dentists.

Medicaid is indeed paying for additional fluoride treatments by including a "per provider or clinic" provision for treatments. However, these additional treatments and payments do not appear to be a significant problem. First, the Health Care Authority (HCA) has already taken steps to substantially limit the number of additional treatments and associated costs. Second, the total cost of the additional treatments we did identify — about $290,000 a year — is relatively small compared to the $12 million Medicaid spends annually on fluoride treatments. Finally, while there is general consensus in the dental community that additional fluoride treatments are not harmful to patients, there is little evidence such treatments are beneficial.

We do note at least one option that HCA should consider that can further limit the number of additional fluoride treatments in the short term. The real opportunity to eliminate additional treatments will present itself if the state decides to move Medicaid dental services to a managed-care model. At that point, HCA should return to a stricter "per patient" provision in its contracts with managed care organizations.

Recommendations

To the Health Care Authority

To address possible cost savings in the Medicaid program and reduce additional fluoride treatments, we recommend HCA:

1. Limit the total number of fluoride services provided to clients to what is recommended by leading practice by removing the "per provider or clinic" clause, and establishing limits for school-based and mobile dental services that are separate from office-based dental services.
2. If the Medicaid dental program moves to a managed-care model, establish contractual fluoride allowances only "per patient," rather than "per provider or clinic."

Agency Response

STATE OF WASHINGTON

September 10, 2019

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to respond to the State Auditor's Office performance audit on cost savings in Medicaid fluoride treatment payments. The Office of Financial Management worked with the Health Care Authority to provide this response.

The audit was intended to determine whether the Medicaid program could save money by following leading practices for the number of fluoride treatments. This was prompted, in part, by the law allowing the number of treatments on a "per provider or clinic" basis, rather than a limited number of treatments per client.

Although potential cost savings were identified, as pointed out in the audit report, the additional treatments and payments identified do not appear to be a significant issue. We appreciate the Auditor's Office recognizing the policy and system changes made by the Health Care Authority to reduce the number of excess treatments, which have already resulted in major cost savings. Additional changes to the system for fluoride treatment under the current fee-for-service model would bring additional costs, including potentially negative downstream impacts on provider access, patient treatment, and higher costs due to provider disputes and recovery services.

Similar impacts would also be true for the recommended changes with managed care, if or when the Medicaid dental program moves to a managed-care model. Additional challenges under this model, such as higher contract monitoring and enforcement efforts, would further reduce and likely eliminate any potential cost savings. It is important to note that additional treatments do not cause harm and may prevent more costly cavities in a group at higher risk for developing them.

We will continue to look for ways to effectively reduce costs while ensuring our clients have access to the services and providers necessary to live their healthiest lives.

Sincerely,

Sue Birch
Director
Health Care Authority

David Schumacher
Director
Office of Financial Management

cc: David Postman, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Drew Shirk, Executive Director of Legislative Affairs, Office of the Governor
Pat Lashway, Deputy Director, Office of Financial Management
Scott Merriman, Legislative Liaison, Office of Financial Management
Keith Phillips, Director of Policy, Office of the Governor
Inger Brinck, Director, Results Washington, Office of the Governor
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Scott Frank, Director of Performance Audit, Office of the Washington State Auditor

Official State Cabinet Agency Response to Performance Audit on Medicaid Fluoride Cost Savings– July 26, 2019

This management response to the State Auditor's Office performance audit report received on July 26, 2019, is provided by the Office of Financial Management and the Health Care Authority.

SAO Performance Audit Objectives:

The SAO designed the audit to answer:

1. Could Washington's Medicaid program save money by following leading practices for the number of beneficial dental fluoride treatments?

SAO Recommendation 1: Limit the total number of fluoride services provided to clients to what is recommended by leading practice by removing the "per provider or clinic" clause, and establishing separate limits for school-based dental services.

STATE RESPONSE: We appreciate the creative thinking of separating limits for different types of locations, but don't think it is prudent to make this change for several reasons. First, the small annual cost savings proposed ($130,000) does not seem realistic after additional evaluation of what would be required to make the changes in the system, tracking the savings, educating providers and recouping payments. Second, implementing treatment limits when we do not always have up-to-date information on the number of treatments already provided can have an adverse impact on patient access. If providers are going to be penalized and carry the cost burden, they may discontinue the service, thereby compromising the child's dental health and a key oral health preventive service.

Finally, there is likely benefit from and no harm done to someone receiving more than the recommended number identified by the SAO. Billing limits are not put in place to determine clinical practice, which is based on individual risk factors and clinical judgment. The additional fluoride treatments identified in this report are provided mainly to children seven years and older, when the limit drops from three per year to two. A significant number of these treatments would be expected to fall under leading practice guidelines, as many of these children are at elevated risk for dental decay.

Action Steps and Time Frame: *Not applicable.*

SAO Recommendation 2: If the Medicaid dental program moves to a managed-care model, establish contractual fluoride allowances only "per patient," rather than "per provider or clinic."

STATE RESPONSE: The report identified an opportunity for the HCA to base a future managed care organization (MCO) contract on a "per patient" basis for payment methodology, but allow additional fluoride treatments based on the MCO's internal practices, if it so chooses, at no cost to the state. In practice, this would be a difficult recommendation to implement or enforce, and unlikely to lead to efficiencies that would lower treatment costs. It may be faulty to assume that requiring the MCOs to enforce "per patient" methodology in their payment systems would be easier to track or result in a less expensive administrative burden. Dental MCOs would face complexities in sharing data on additional claims as compared to the current fee-for-service system, as claims from physical health MCOs and other dental MCOs would need to be managed to enforce a "per patient" limit.

In practice, the dental MCOs will receive a capitated rate based on fee-for-service experience with the ability to set higher limits for services, if they choose. MCOs may believe it is more cost-effective not to set limits on this preventive service to offset future costs. Enforcing a "per patient" methodology with the MCOs could add an administrative burden that disincentivizes innovative strategies for promoting prevention. Additionally, contract monitoring and enforcement efforts to achieve such small potential savings would likely not be cost-effective.

Action Steps and Time Frame: *Not applicable at this time.*

2

State Auditor's Response

As part of the audit process, our Office gives a draft copy of the report to the audited agency and offers it the opportunity to respond. The response from the Health Care Authority (HCA) is included in this report. In its final response, HCA expressed concerns about our two recommendations and indicated that it did not plan to implement them. We summarize these concerns below along with our responses.

Agency Concern No. 1

HCA believes it would not be prudent to implement our first recommendation "after additional evaluation of what would be required to make the changes in the system, tracking the savings, educating providers and recouping payments."

Auditors' Response

Our recommendation is based on HCA's representations during the audit that the additional costs mentioned above would be minimal. If further evaluation shows these costs are higher, this may change the viability of the recommendation. However, if the Legislature determines that HCA must continue to use the fee-for-service model long-term, HCA should consider that needed system implementation costs would be incurred only once, and the opportunity for longer-term savings may still exist.

Agency Concern No. 2

The agency is also concerned that "implementing treatment limits when we do not always have up-to-date information on the number of treatments already provided can have an adverse impact on patient access."

Auditors' Response

Our recommendation is narrowly tailored for that reason. Most of the patients getting additional treatments get them from one school-based or mobile provider and one dental office, and most would continue to get additional treatments under our recommendation. This is why the recommendation eliminates only $130,000 of the $290,000 in costs associated with the additional treatments we identified.

Agency Concern No. 3

The agency notes that "(b)illing limits are not put in place to determine clinical practice, which is based on individual risk factors and clinical judgment."

Auditors' Response

For patients in need of additional treatments, the current system allows them as long as the provider has obtained HCA's prior authorization, and our recommendation would not change that. Our analysis excluded treatments for which prior authorization was obtained.

Agency Concern No. 4

The agency is concerned that "requiring the MCOs [managed care organizations] to enforce 'per patient' methodology in their payment systems" might not result in savings. "In practice, the dental MCOs will receive a capitated rate based on fee-for-service experience with the ability to set higher limits for services, if they choose." The agency notes that "contract monitoring and enforcement efforts to achieve such small potential savings would likely not be cost-effective."

Auditors' Response

We wish to clarify our recommendation. We do not propose that MCOs be required to enforce per-patient methodology. Based on our review of dental literature, there is no medical reason to pay for more than best practices. If there is an administrative reason, MCOs should absorb that. Contract monitoring efforts should be part of any contract, and were a part of the contract the agency had drafted this past spring as it prepared to switch to managed care.

We stand by Recommendation 2 and the estimated $290,000 it would save.

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**Yes.** This audit identified possible cost savings by limiting the number of fluoride treatments to leading practice amounts.
2. Identify services that can be reduced or eliminated	**Yes.** This audit identified opportunities to reduce the overall number of fluoride treatments provided.
3. Identify programs or services that can be transferred to the private sector	**No.** Medicaid dental services are already provided by private dental providers.
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**No.** This audit focused on identifying additional fluoride treatments, not gaps or overlaps in the dental program.
5. Assess feasibility of pooling information technology systems within the department	**No.** Medicaid services are already managed through a pooled information system.

I-900 element	Addressed in the audit
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**No.** This audit focused on identifying additional fluoride treatments, not departmental roles and functions.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**Yes.** This audit recommended regulatory changes to limit the number of fluoride treatments.
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.** This audit focused on identifying additional fluoride treatments, not analyzing performance related measures and self-assessment systems.
9. Identify relevant best practices	**Yes.** This audit identified leading practices and other state allowances for the frequency of fluoride treatments.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in Government Auditing Standards (December 2011 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Appendix B: Scope, Objectives and Methodology

Scope

This audit reviewed Medicaid fluoride claims for fiscal years 2016 through 2018 for the following Medicaid client groups:

- People aged 18 and younger
- Developmentally disabled people
- People living in Alternative Living Facilities

The audit did not review claims for people aged 19 or older, unless they were in one of the two sub-groups, and excluded orthodontic claims. Treatments received at Federally Qualified Health Centers or tribal centers were included in total counts of treatments for clients, but were excluded from cost savings results because providers receive a flat payment amount per visit, regardless of services provided.

Objectives

The purpose of the audit was to determine whether Washington's Medicaid dental program could save money by limiting the number of fluoride treatments to the number identified by leading practices. The audit answers the following question:

1. Could Washington's Medicaid program save money by following leading practices for the number of beneficial dental fluoride treatments?

Methodology

To answer the audit question, we identified leading practices for fluoride treatments, compared them to Washington's Medicaid fluoride allowances, and then determined if Washington paid for treatments beyond leading practices.

We identified leading practices by reviewing relevant literature and recommendations, and by reviewing other state Medicaid fluoride allowances. Primary resources consulted are listed in **Appendix C**.

To determine whether HCA paid for Medicaid fluoride treatments beyond leading practices and to identify possible cost savings, we analyzed Medicaid fluoride claims data from fiscal years 2016 through 2018. For each client, we reviewed every treatment received during the audit period to determine whether it exceeded leading practice recommendations. We then reviewed preliminary results with HCA staff to confirm results and made changes to our analysis, as necessary. To estimate cost savings for the recommendation to separate allowances for school-based fluoride treatments, we repeated the analysis for school-based and mobile dental services separately from office-based dental services, then combined the results.

Appendix C: Bibliography

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