Access to Dental Services in Medicaid: The Effect of Reimbursement Rates and Administrative Streamlining

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Overview

• The importance of dental Medicaid
• How dental and medical economics differ
• Study findings
• Implications for California
Children’s Dental Problems

• The most common unmet health need
  – 59% of all children experience caries (cavities), compared to 11% for asthma and 8% for hay fever*
• Only one in three Medicaid-enrolled children uses dental services in a year**


**Source: Centers for Medicare and Medicaid Services, Annual EPSDT Participation Report: Form CMS-416.
Poor Oral Health Affects General Health*

Periodontal (gum) disease is associated with…

• Pre-term delivery/low birth weight infants
• Atherosclerosis and vascular disease
• Diabetes and increased prevalence and severity of gingivitis and periodontitis

Dental Services Are Less than 2% of Medicaid Spending

Dental Services Are 5% of National Health Care Expenditures

Dentists’ Participation in Medicaid

• Fewer than 1 in 4 dentists report seeing at least 100 Medicaid patients in a year.*

• Reasons for low dentist participation:
  – Low reimbursement
  – Burdensome administrative requirements
  – Problematic patient behaviors

Medicaid Adult Dental Benefits

![Graph showing Medicaid Adult Dental Benefits from 2002 to 2006. The graph illustrates the number of states offering full, limited, emergency, and none dental benefits over the years. The y-axis represents the number of states, ranging from 0 to 25. The x-axis represents the years 2002 to 2006. The graph shows trends in the availability of dental benefits in different states.]
Update on SCHIP Dental Coverage
## Dentist and Physician Practice Patterns

**Dentists:**
- 90% in private practice
- 76% solo practitioners
- 80% are in general practice
- Average net income $125K for generalists; $192 for specialists
- 33.3 hours per week treating patients

**Physicians:**
- 50% in private practice
- 25% solo practitioners
- 30% are primary care practitioners
- Average net income $164K for primary care; $120K - $205K for specialists
- 51.6 hours per week treating patients
Economic Backdrop for Dental Practice

- Average debt for graduating dentists: $119,000 in 2003
- Cost to lease/hold equipment may be $150,000/year; costs for space and staff about $200,000/year
- Dental services: 57% inflation since 1997

- Average debt for graduating doctors: $104,000 in 2003
- Most physicians practice without purchase of expensive equipment
- Physician services: 36% inflation since 1997
Dental Practice Income

• About 45% of patient visits are for hygiene services
• About half from insurance, half cash
• Very sensitive to downturns in the economy
• Overhead averages about $.60 to $.65 of each dollar earned
California Landscape

• About 40% of licensed dentists are Denti-Cal providers
  – 75% see 50 or more Medicaid patients

• In 2006, 28% children enrolled in Medicaid received a dental service

• Reimbursement rates are well below usual fees of dentists in the state
  – Denti-Cal rates are 30-50% of dentists’ fees
Fee-for-Service Rates for Dental Exams (2005)

- National 75th Percentile: $40
- Tennessee: $25
- Washington: $25
- South Carolina: $25
- Virginia: $20
- Alabama: $15
- California: $15
- Michigan: $15

$0 $10 $20 $30 $40 $50
Fee-for-Service Rates for Extractions (2005)

- National 75th Percentile
- Virginia
- Tennessee
- South Carolina
- Washington
- Alabama
- California
- Michigan

Price Range: $0 - $140
Study Methodology

- Literature review on effects of reimbursement rate increases in Medicaid
- Interviews with 23 stakeholders from six states that enacted dental reforms: AL, MI, SC, TN, VA, and WA
- Interviews with comparable California stakeholders
Common Elements

• Catalyst for reform
• Reimbursement rate increases
• Collaboration with dentists, dental associations
• Administrative improvements, different vehicles
  – Individual programs managed by Medicaid agencies (SC, AL)
  – Statewide dental carve-outs to a single dental benefit administrator (TN, VA)
  – Contract with dental insurer for several counties (MI)
Alabama: *Smile Alabama!*

- Change in Medicaid leadership
- Raised rates to 100% of Blue Cross/Blue Shield dental fees
- $1 million of private funding in outreach activities
- Collaborated with dental association
- Administrative processes—forms online, quick payment
## Effects of Alabama Reforms

<table>
<thead>
<tr>
<th>Enrolled Children Ages 0-20 Utilizing Services</th>
<th>Initial Year of Reform (2000)</th>
<th>Two Years After Reform</th>
<th>Current Year</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Providers</td>
<td>21%</td>
<td>28%</td>
<td>37%</td>
<td>76%</td>
</tr>
<tr>
<td>Enrolled Providers</td>
<td>441</td>
<td>586</td>
<td>778</td>
<td>76%</td>
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</tbody>
</table>
South Carolina

- Reforms spurred by special needs advocates, coalition
- Reimbursement rates raised to 75th percentile of a commercially available fee survey
- RWJF grant for outreach, especially to rural areas, patient navigator model
- Instituted administrative improvements
  - Streamlined pre-authorizations
  - Standardized claims forms
## Effects of South Carolina Reforms

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<th>Percent Increase</th>
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</thead>
<tbody>
<tr>
<td>Enrolled Providers</td>
<td>28 %</td>
<td>35%</td>
<td>43%</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>619</td>
<td>886</td>
<td>1,197</td>
<td>93%</td>
</tr>
</tbody>
</table>
Tennessee: TennCare

- Lawsuit, court order
- Statewide administrative “carve out” to Doral Dental
  - State pays claims, Doral administers provider and enrollee outreach, claims processing
- Rates increased to 75th percentile of 1999 ADA regional fee survey
  - Equal to 55th percentile of dentists’ 2001 fees
## Effects of Tennessee Reforms

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<tbody>
<tr>
<td></td>
<td>26%</td>
<td>36%</td>
<td>36%</td>
<td>38%</td>
</tr>
</tbody>
</table>

| Enrolled Providers                           | 386                           | 700                    | 851           | 120%             |
Virginia: Smiles for Children

- Close partnership between Medicaid director and VDA executive director
- In 2005, 28% increase in reimbursement for all dental procedures
- Additional 2% rate increase in 2006 for oral surgery procedures
- Statewide “carve out” contract with Doral Dental
Effects of Virginia Reforms

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<thead>
<tr>
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<th>Current Year</th>
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<tbody>
<tr>
<td>Enrolled Children Ages 0-20 Utilizing Services</td>
<td>24%</td>
<td>-</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Enrolled Providers</td>
<td>620</td>
<td>-</td>
<td>1,007</td>
<td>62%</td>
</tr>
</tbody>
</table>
Michigan: Healthy Kids Dental

- Interest of key legislators, building on successful SCHIP program
- Capitated contract with Delta Dental of Michigan for kids in non-urban counties
- Initially, Delta Premier plan, 22 pilot counties
  - Providers reimbursed at 100% of usual charges
- Later, Delta Preferred Option, expanded to 59 of 83 Michigan counties
  - Fixed fee schedule, lower rates
  - 14% decline in number of providers
## Effects of Michigan Reforms

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<tr>
<td>Enrolled Providers</td>
<td>21%</td>
<td>29%</td>
<td>30%</td>
<td>43%</td>
</tr>
<tr>
<td>Enrolled Providers</td>
<td>769</td>
<td>1,624</td>
<td>1,926 (2005)</td>
<td>150%</td>
</tr>
</tbody>
</table>
Washington: Access to Baby and Child Dentistry (ABCD)

• Educated enrollees, trained general practice dentists to manage children ages 0 to 5
• Raised rates for certain procedures to 75th percentile of usual charges for participating providers
• Included administrative reforms: limiting preauthorization and increasing use of electronic claims submission
Utilization Improvements in Context

• AL, MI, SC, TN, VA, and WA made significant strides: 30% to 43% of children ages 0-20 had a dental visit
• 58% of children ages 0-20 with private insurance had a dental visit in 2004
• More action is needed to close access gaps
# Budget Impact for Three States

<table>
<thead>
<tr>
<th>State</th>
<th>Spending in 2000 (millions)</th>
<th>Spending in 2004 (millions)</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$11.47</td>
<td>$44.45</td>
<td>+ 288%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>$48.15</td>
<td>$89.30</td>
<td>+ 85%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$28.66 (2002)</td>
<td>$130.28</td>
<td>+ 355%</td>
</tr>
</tbody>
</table>
Lessons Learned

- Rate increases are necessary—but not sufficient—to improve access
- “There is no magic fee percentile” as long as overhead costs are met
- Administrative reforms to reduce hassle factor are critical
- Education and case management for patients and families reduce problematic behaviors (but hard evidence of impact is lacking)
Lessons Learned

- Involve state dental societies and individual dentists as active partners
  - Helps to maximize the benefit of smaller rate increases, and mitigates the effect of budget cuts
- State oral health coalitions help make rate increases about patients, not providers
Recent and Proposed State Action, Despite Weak Economy

- **KY**: Cut orthodontia, raised rates 30% for children’s services (2006)
- **NJ**: Increased Medicaid reimbursement rates for children dental services from $18 to $64 per exam (Jan. 2008)
- **FL**: Gov. Crist is proposing raising reimbursement rates to dentists by 20% (2008)
- **MD**: Gov. O’Malley budget includes $16 million in fee increases for dentists and dental clinics (FY 2009)
Ideas for Future Action

- Lowering administrative barriers
  - X-ray documentation
  - Preauthorization
  - Provider enrollment processes
- Targeted rate increases
  - For young children (Washington ABCD model)
  - For rural populations (UT, MI model)
  - For special needs patients (NM model)
Full report “The Effects of Medicaid Reimbursement Rates on Access to Dental Care” is available at
www.nashp.org/Files/CHCF_dental_rates.pdf

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