
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: National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 2000).

**Source: Centers for Medicare and Medicaid Services, Annual EPSDT Participation Report: Form CMS-416.

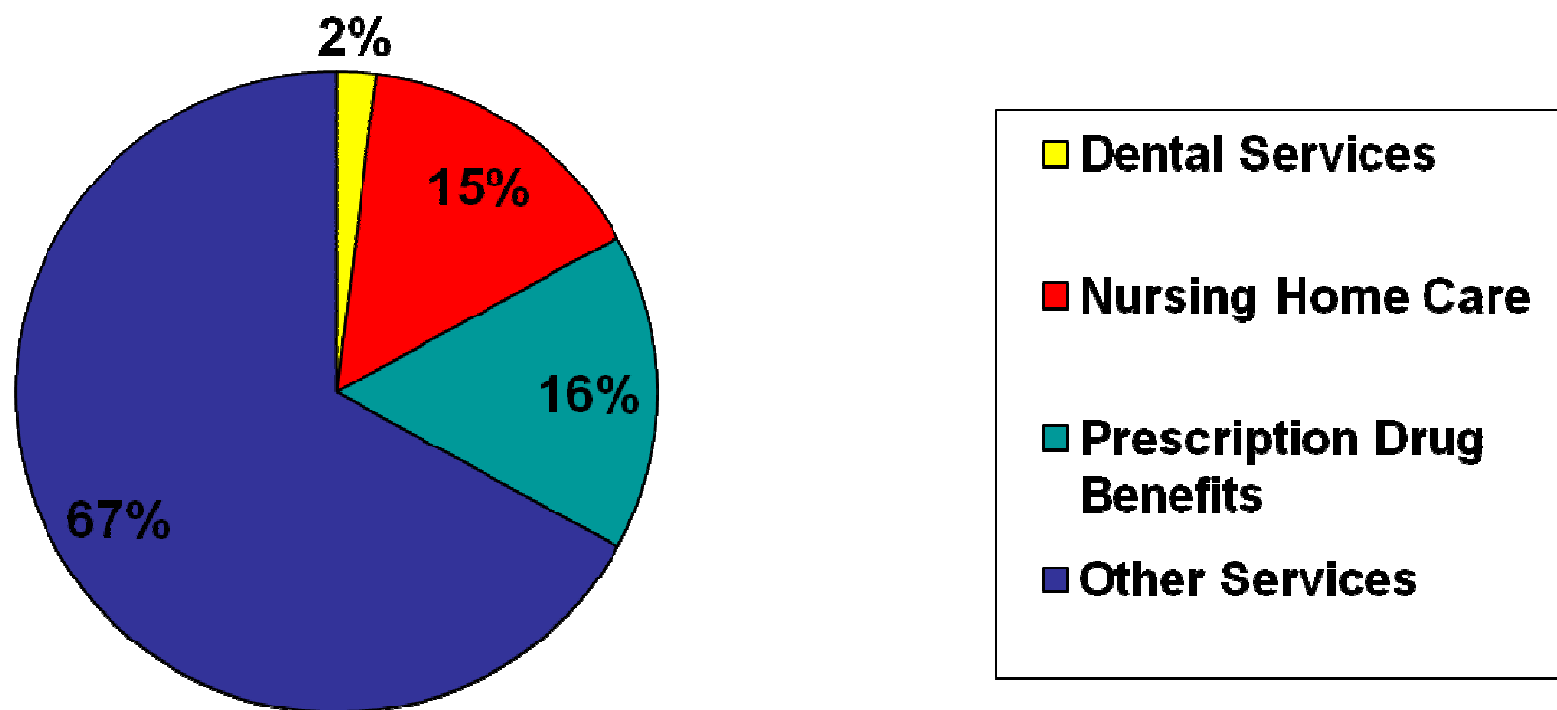
Poor Oral Health Affects General Health*

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

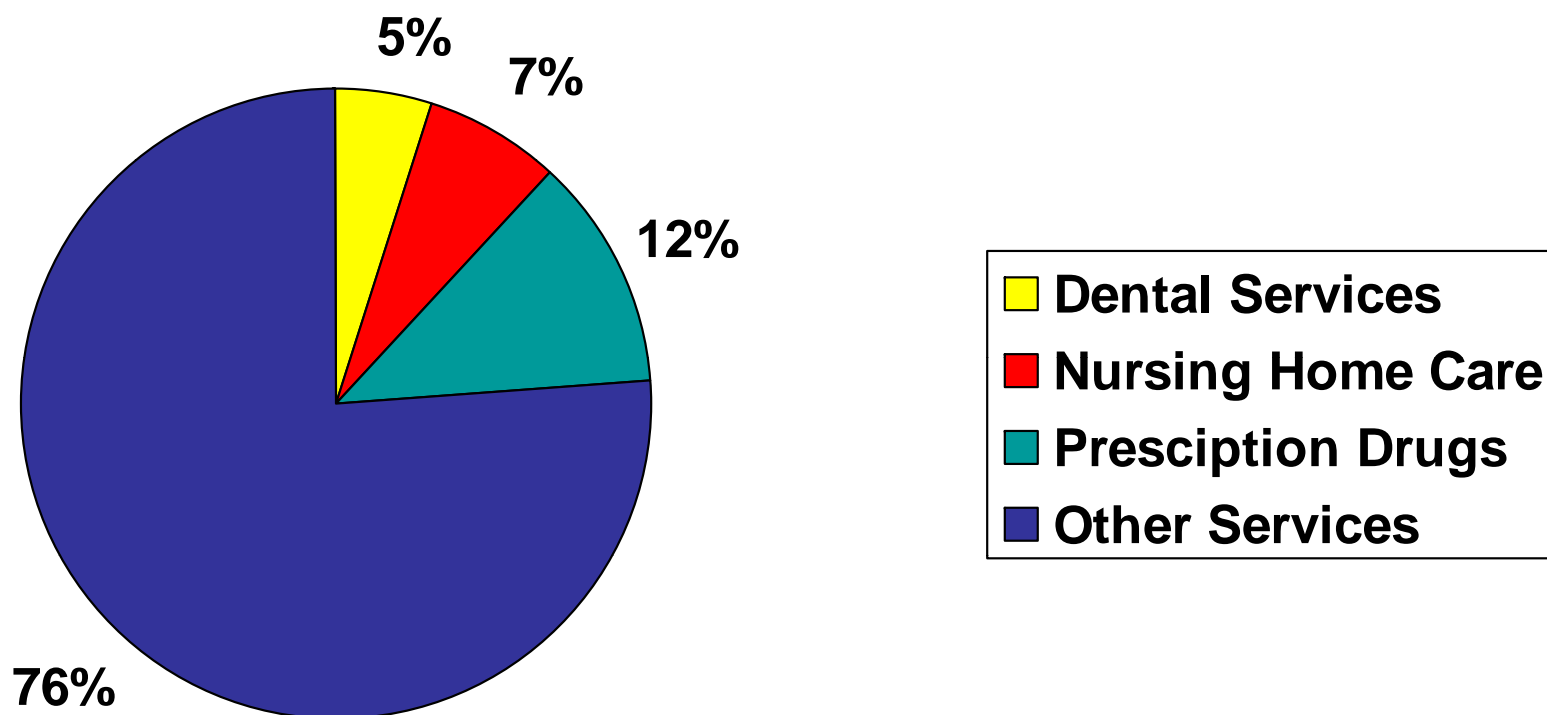
*October 1, 2006 special supplement issue of the *Journal of the American Dental Association* on the oral-systemic disease connection (vol. 137, supplement 2). Retrieved March 2, 2008. http://jada.ada.org/content/vol137/suppl_2/index.dtl

Dental Services Are Less than 2% of Medicaid Spending



Source: Centers for Medicare and Medicaid Services. MSIS State Summary, FY 2004: Table 17, FY 2004 Medicaid Medical Vendor Payments by Service Category (CMS, June 2007).

Dental Services Are 5% of National Health Care Expenditures



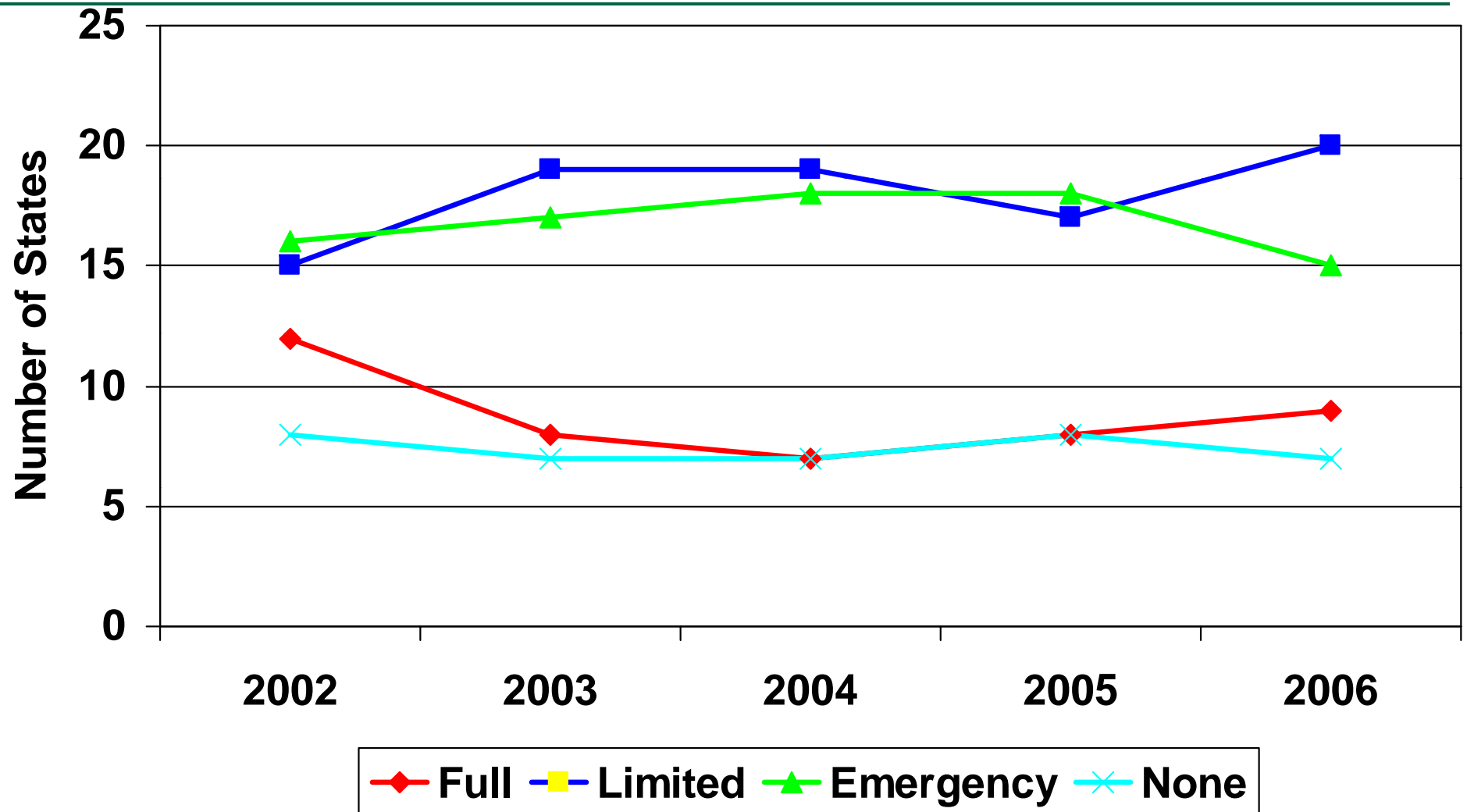
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. *National Health Expenditure Accounts: Total Personal Health Care Spending, By Age Group, Calendar Years 1987, 1996, 1999, 2002, 2004* (Baltimore, MD: U.S. Department of Health and Human Services, 2004).

Dentists' Participation in Medicaid

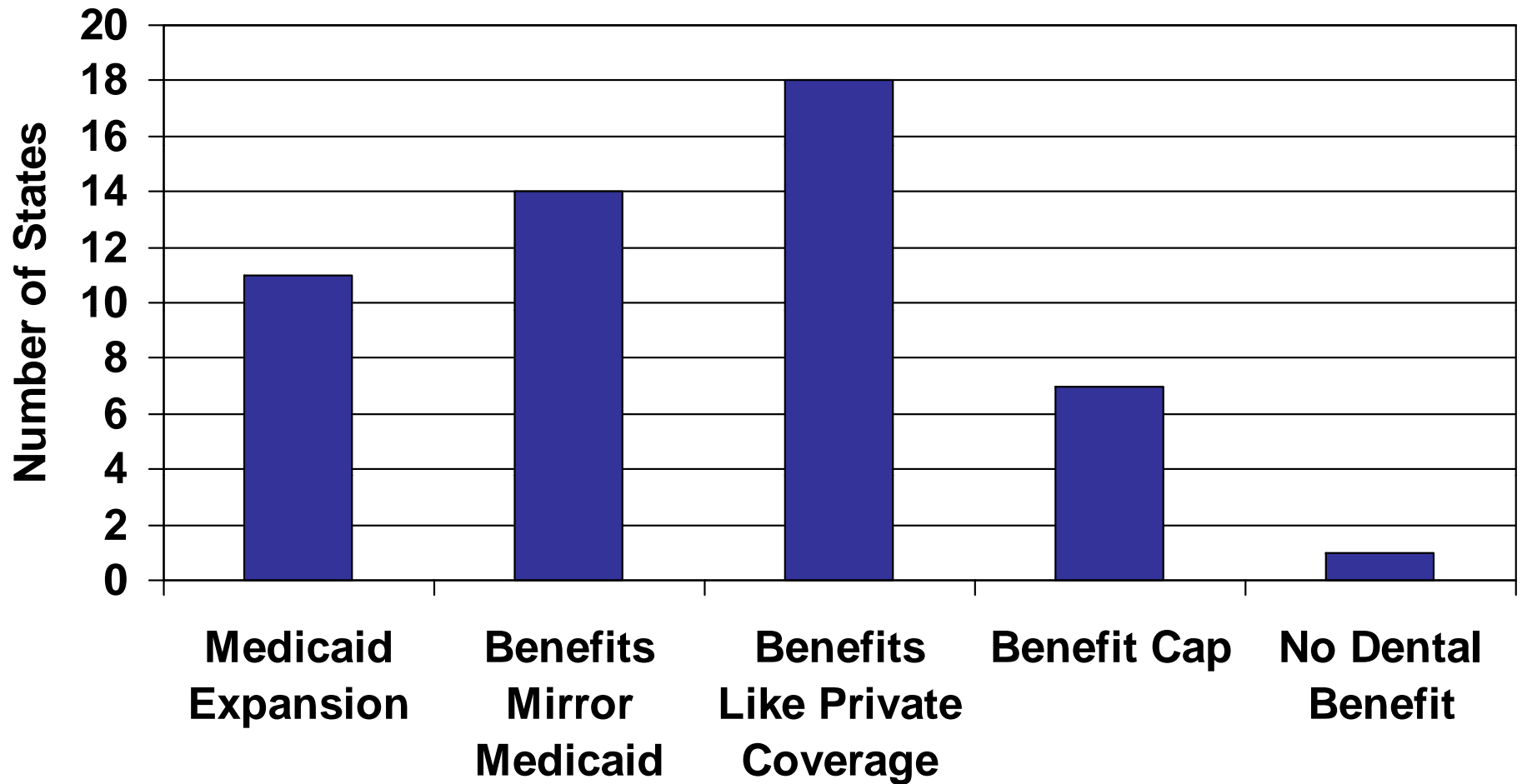
- Fewer than 1 in 4 dentists report seeing at least 100 Medicaid patients in a year.*
- Reasons for low dentist participation:
 - Low reimbursement
 - Burdensome administrative requirements
 - Problematic patient behaviors

*Source: Government Accountability Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations* (Washington, DC: U.S. Government Accountability Office, 2000), GAO/HEHS-00-149, 2000AO.

Medicaid Adult Dental Benefits



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:

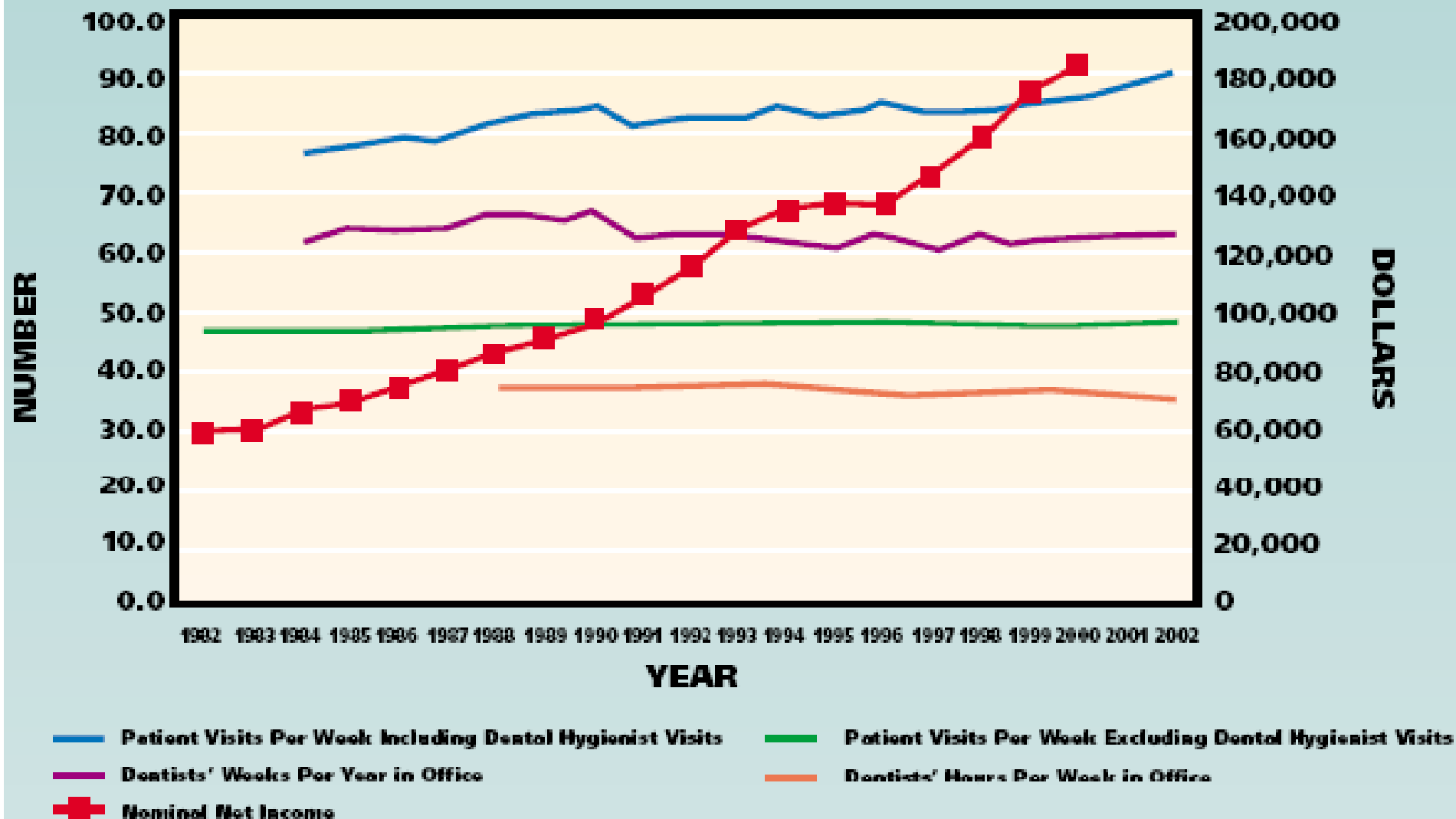
- 50% in private practice
- 25% solo practitioners
- 30% are primary care practitioners
- Average net income \$164K for primary care; \$120K - \$205K for specialists
- 51.6 hours per week treating patients

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

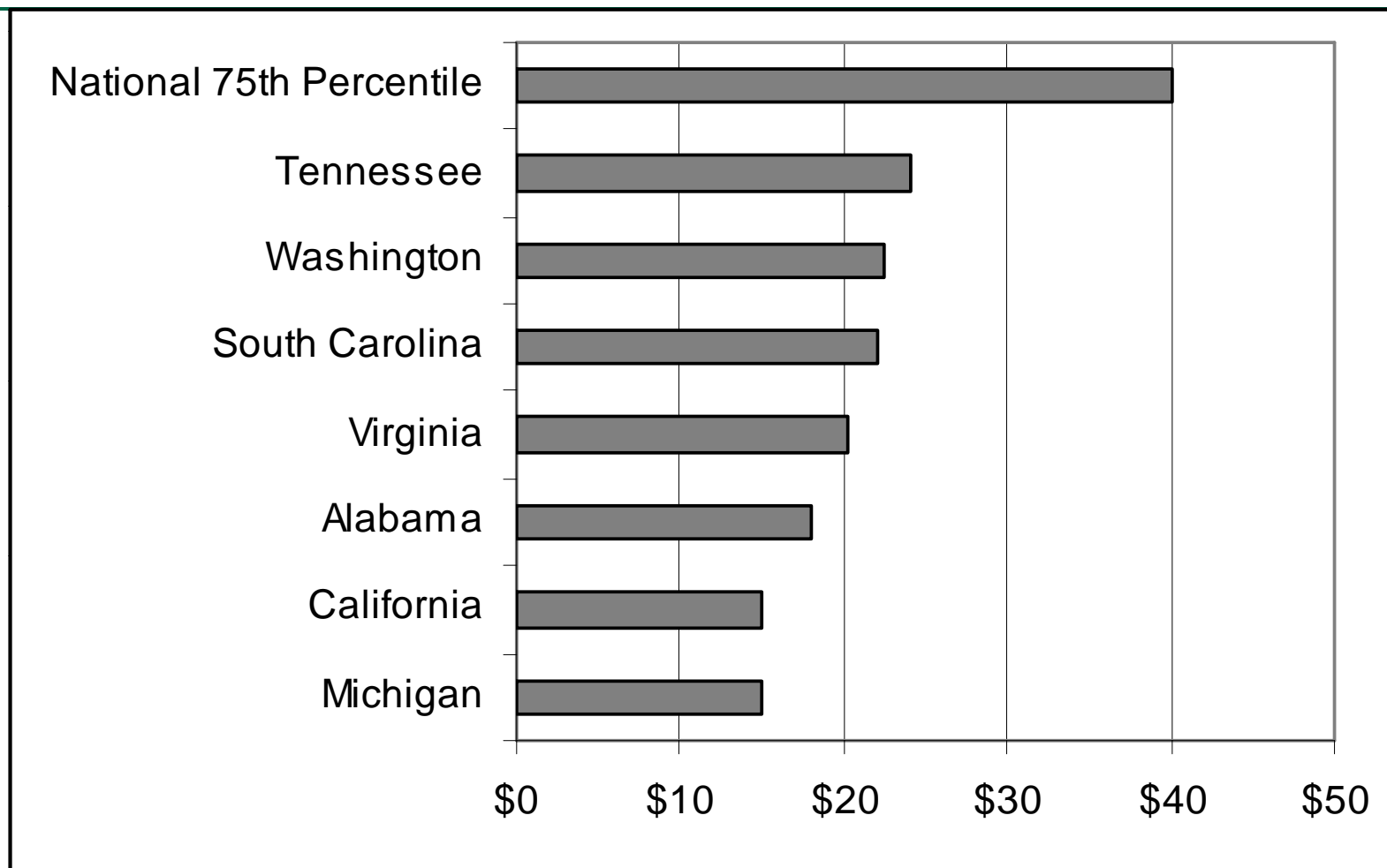


Source: Albert Guay, "Dental Practice: Prices, Production, and Profit," *JADA*, Vol. 136 (March 2005), 359.

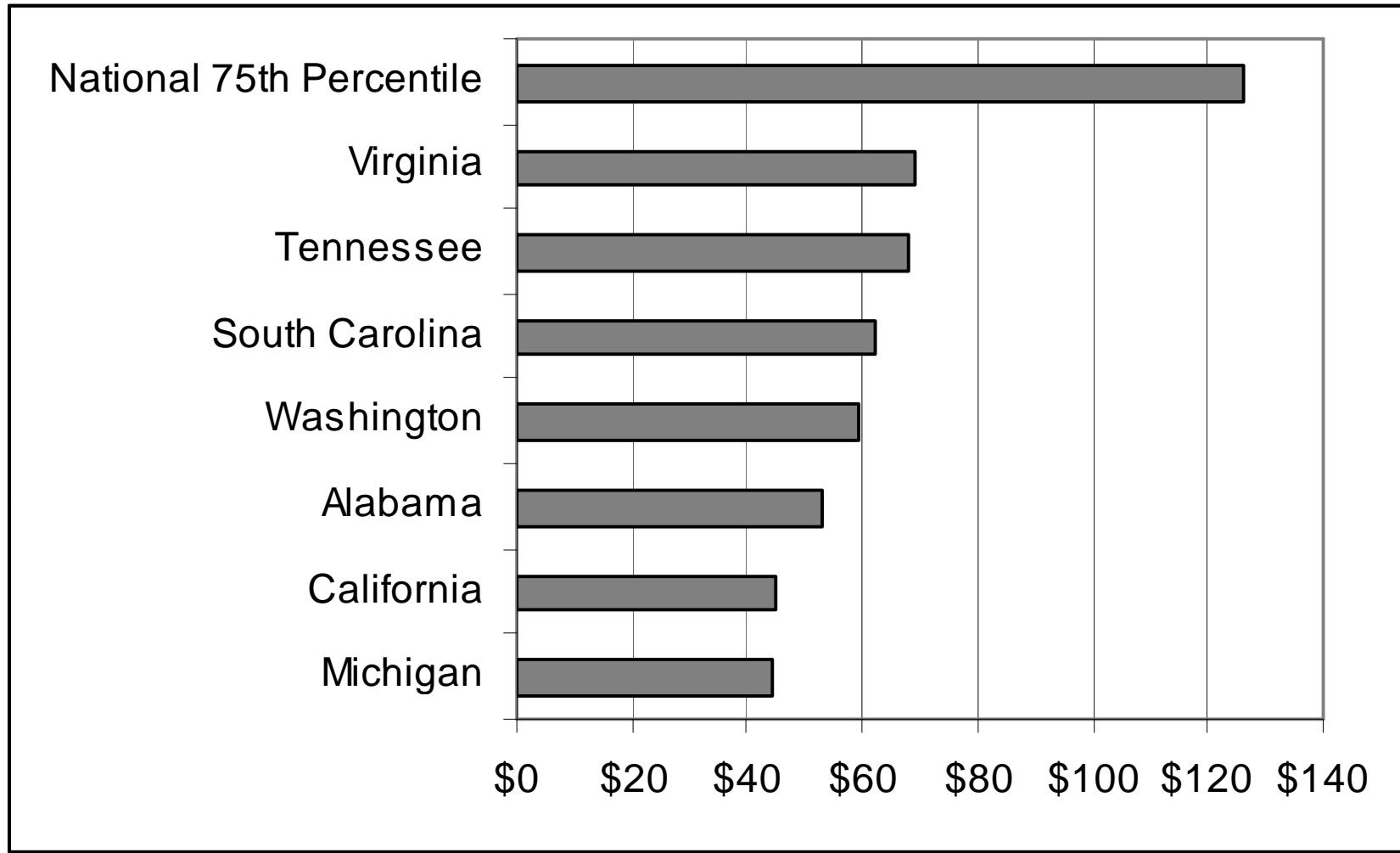
California Landscape

- 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)



Fee-for-Service Rates for Extractions (2005)



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

	Initial Year of Reform (2000)	Two Years After Reform	Current Year	Percent Increase
Enrolled Children Ages 0-20 Utilizing Services	21%	28%	37%	76%
Enrolled Providers	441	586	778	76%

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

	Initial Year of Reform (2000)	Two Years After Reform	Current Year	Percent Increase
Enrolled Children Ages 0-20 Utilizing Services	28 %	35%	43%	54%
Enrolled Providers	619	886	1,197	93%

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

	Initial Year of Reform (2002)	Two Years After Reform	Current Year	Percent Increase
Enrolled Children Ages 0-20 Utilizing Services	26%	36%	36%	38%
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

	Initial Year of Reform (2005)	Two Years After Reform	Current Year	Percent Increase
Enrolled Children Ages 0-20 Utilizing Services	24%	-	32%	33%
Enrolled Providers	620	-	1,007	62%

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

	Initial Year of Reform (2000)	Two Years After Reform	Current Year	Percent Increase
Enrolled Children Ages 0-20 Utilizing Services	21%	29%	30%	43%
Enrolled Providers	769	1,624	1,926 (2005)	150%

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

	Spending in 2000 (millions)	Spending in 2004 (millions)	Percent Change
Alabama	\$11.47	\$44.45	+ 288%
South Carolina	\$48.15	\$89.30	+ 85%
Tennessee	\$28.66 (2002)	\$130.28	+ 355%

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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