

The Effects of Medicaid Reimbursement Rates on Access to Dental Care

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EXECUTIVE SUMMARY

Overall, our nation's oral health is good, but children in families with low incomes suffer disproportionately from dental caries, the infectious disease that causes cavities. While state Medicaid programs are required by federal law to provide dental services to eligible children, enrollees' access to dental care is poor. In 2006, only one in three children in Medicaid received a dental service.

Since the great majority of dental care available in this country is delivered by private dentists, their participation is key to improving access in Medicaid. Dentists cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements, and problematic patient behaviors. In the late 1990s and early 2000s, a number of states took dramatic steps to improve access to dental care in Medicaid. Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington employed a variety of approaches to address access concerns: they raised reimbursement rates, revamped administrative structures and processes, and conducted outreach and education to both providers and patients.

This study, sponsored by the California HealthCare Foundation, focuses on the efforts of these six states and compares their experiences to California's. The National Academy for State Health Policy (NASHP) conducted a literature review and interviews with 26 key informants to answer the question: what effect does raising Medicaid reimbursement rates have on access to dental care?

- Alabama established *Smile Alabama!* in October 2000, after a change in Medicaid leadership. The state raised reimbursement rates to 100 percent of the Blue Cross/Blue Shield dental fee schedule and improved the provider services rendered by its fiscal contractor. The state invested \$1 million of private funding in outreach activities, partnered with a dental advisory group, and collaborated with the dental association to improve access.
- Michigan moved in 2000 to build upon a contract with a commercial dental insurer that had worked well in the state's SCHIP program to improve the Medicaid benefit for children in many of its non-urban counties. Under the Healthy Kids Dental program, most providers were reimbursed 100 percent of their usual charges. Enrollees gained access to the large pool of the insurer's participating dentists in their counties, and providers benefited from a program that used familiar administrative processes.
- South Carolina began in 1998 with administrative improvements, and a provisional rate increase conditioned on an improvement in provider participation. Because the Medicaid agency, working closely with the state dental association, exceeded its provider enrollment target, reimbursement rates were raised to the 75th percentile of a commercially-available fee survey (meaning that Medicaid reimbursement rates were as high or higher than the usual charges of 75 percent of dentists responding to the survey). The state also received private funding for outreach, especially to rural areas.
- Tennessee "carved out" dental services from its TennCare medical managed care contracts in 2002, and contracted with Doral Dental, a specialized dental benefits

manager. Reimbursement rates were increased to the 75th percentile of the 1999 ADA Survey of Fees for the East South Central region of states, and program administration was streamlined.

- Virginia instituted its *Smiles for Children* program in 2005, which involved a statewide “carve out” contract very similar to Tennessee’s. Leadership at the state Medicaid agency and the state dental association worked closely to secure a 28 percent increase in reimbursement for all dental procedures, and target an additional 2 percent rate increase in 2006 to oral surgery procedures, which were identified as an area of acute need.
- Washington created a model program called *Access to Baby and Child Dentistry* (ABCD) in 1995 to ensure that children ages 0-5 received services. The program provided case management for program enrollees and training for general dentists in caring for young children. In exchange for participating in ABCD, rates for certain procedures were raised to the 75th percentile of usual charges.

Key findings from this study include:

- Rate increases are necessary – but not sufficient on their own – to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.
- While dentists often seek reimbursement rates that mirror their usual charges, states have seen gains in dentists’ participation and patient utilization with rate increases that do not meet that threshold. However, rates need to at least cover the cost of providing service, which is estimated to be 60 to 65 percent of dentists’ charges.
- Working with patients and their families about how to use dental services is a core element of reforms. States have successfully used case management, educational brochures, and patient support provided by contractors to reduce barriers and address one of dentists’ chief complaints.
- In the six states examined, provider participation increased by at least one-third, and sometimes more than doubled, following rate increases. Not only did the number of enrolled providers rise, but so did the number of patients treated. Patients’ access to care, as measured by the number of enrollees using dental services, also increased after rates rose.
- Despite meaningful gains in provider participation and access achieved by these “front-runner” states, the portion of children receiving services is still far below the experience of privately-insured children. Data from 2004 show that 58 percent of privately insured children received dental services, while in these six states – after substantial effort and investment – 32 to 43 percent of children covered under Medicaid received dental care. This points to the need to explore other solutions as well.

Table 1. Effects of state reforms on service utilization and provider participation

State	Percentage of Enrolled Children Ages 0-20 Utilizing Services				Enrolled Providers			
	Initial Year of Reform (Year)	Two Years After Reform	Fiscal Year 2006	Percent Increase (Initial Year - 2006)	Initial Year of Reform (Year)	Two Years After Reform	Most Recent (Year)	Percent Increase (Initial Year - Most Recent year)
AL	21 (2000)	28	37	76	441 (2000)	586	778 (2007)	76
MI	21 (2000)	29	30	43	769 (2000)	1624	1926 (2005)	150
SC	28 (2000)	35	43	54	619 (2000)	886	1197 (2006)	93
TN	26 (2002)	36	36	38	386 (2002)	700	851 (2007)	120
VA	24 (2005)	-	32	33	620 (2005)	-	1007 (2007)	62

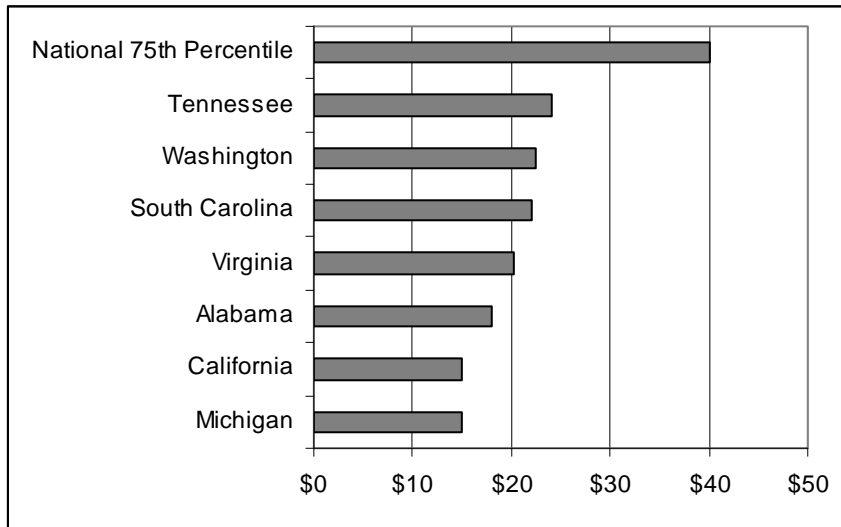
Source: Utilization data – calculated from Annual EPSDT Participation Report (CMS-416), 2000-2006. Provider data – Various state sources. See page 16 of this report for complete sources.

Note: Comparable data for Washington is not available for the period before and after reforms in 1995. Information presented for Michigan is for the entire state, including the fee-for-service population in urban counties, and Healthy Kids Dental counties.

California’s Denti-Cal program, which is administered by Delta Dental, has reimbursement rates for dental procedures that are one-half to one-third of dentists’ usual fees, similar to the initial experience of the study states. When compared to the states in this study, only Michigan’s fee-for-service rates are lower than California’s reimbursement rates (although many Michigan counties use Delta Dental’s higher fee schedule and not the lower fee-for-service rates). About 40 percent of California’s licensed dentists are enrolled as Denti-Cal providers, and they air the same complaints as dentists in the study states: low reimbursement, burdensome documentation requirements, and administrative processes. While reimbursement rate increases of the scale undertaken by study states like Alabama and Tennessee may not be possible in California, given the state’s current fiscal situation, the state might consider the lower-cost alternatives of reducing administrative barriers or crafting a more targeted rate increase.

(Continued on next page)

Figure 1. Comparison of fee-for-service reimbursements for dental examinations



Data are for Current Dental Terminology procedure code D0120, "periodic oral evaluation."

Sources: American Dental Association. *State Innovations to Improve Access to Oral Health Care for Low Income Children: A Compendium Update*. Chicago: American Dental Association: 2005.

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