Dental Rates and Dental Cap

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AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

About Medicaid Dental Coverage

- Dental coverage is an optional Medicaid benefit for adults; states have the flexibility to determine what dental benefits are covered. Comprehensive dental coverage is mandatory for children and youth under the age of 21 with no cap.
- Medicare does not provide dental coverage other than very limited circumstances such as an emergency. Medicaid provides coverage for people who are covered by both Medicaid and Medicare.

Governor's Proposal

Dental Rates . . . . $13,109,475/$5,700,000 state

- In response to unprecedented statewide dental access challenges, DVHA is seeking appropriations to fund an increase in Medicaid dental reimbursements to align with 75% of Northeast Delta Dental 2023 commercial rates. While Medicaid rates for some services were updated in early 2022, the rates for most Medicaid-covered dental services have not been updated in many years, with current Medicaid rates being, on average, only 50% of commercial rates. This rate increase is intended to stabilize the statewide dental system and to promote continued access to dental care for Vermont Medicaid members.

What is the Dental Cap?

- The cap is determined by Medicaid reimbursement, not charges for services.
- The dental cap limits dental services to $1,000 per year, with exceptions:
  - Preventive dental services are not subject to the cap. If the proposed Medicaid dental rate increase is approved, preventive services will be paid at 75% of the Northeast Delta Dental fee schedule, and those payments will not count toward the cap.
    - The Department is in the process of editing our system to waive service limitations for specific services. As before, providers must be able to demonstrate that the service was medically necessary.
  - Pregnant individuals are not subject to the cap. Effective April 1, 2023, the eligibility period for pregnant individuals is expanding from 60-days to 12 months postpartum.
  - Children and youth under the age of 21 are not subject to the cap.

Dental Cap Budget Allocation

How much has been allocated for Medicaid dental spending under the $1,000 dental cap?

- Vermont Medicaid does not have an allocation of funds specific to dental spending under the $1,000 dental cap. The total anticipated dental expenditure for all members, including both those subject to the cap and those not subject to the cap, is:
  - SFY 2023: $26,565,399
  - SFY 2024: $39,873,696

Dental Cap Spending

How much has been spent in recent years for care under the cap?
What was the average spend under the cap?

Calendar Year	Total Paid Claims for Medicaid Members Subject to the Cap who Received Dental Services	Annual Avg Spend Per Medicaid Member Subject to the Cap who Received Dental Services
CY2022*	$9,648,503.86	$328.21
CY 2021	$9,631,591.85	$326.17
CY 2020	$7,124,309.56	$292.74
CY 2019	$7,235,754.55	$252.19

*This figure does not reflect full claims run-out for 2022 dental services.

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Adult Dental Cap Data

What percentage of Medicaid recipients exhaust their dental cap?

Medicaid Adult Dental Cap Data			
Calendar Year (CY) Date of Service	**# of adults > 21 subject to the cap who received dental services**	**# of adults > 21 subject to the cap who met the cap**	**Percent who met cap**
CY2022*	29,397	1,456	5.03%
CY 2021	29,052	1,358	4.67%
CY 2020	23,834	763	3.20%**
CY 2019	28,214	3,004	10.64%

*This figure does not reflect full claims run-out for 2022 dental services.
**The annual cap was raised from $510 to $1,000 in CY2020, and preventive services were removed from the cap. In 2020, dental offices were closed for several months due to the COVID-19 public health emergency.

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Effect of Cap Increase in CY2020

What was the result of the increase in the dental cap a few years ago? What was the impact on spending? Did it result in fewer people reaching the new cap?

- The annual cap was raised from $510 to $1,000 in CY2020, and preventive services were removed from the cap. In 2020, dental offices were closed for several months due to the COVID-19 public health emergency.
- Adults subject to the $1,000 cap are aged ≥ 21 and are not in the pregnancy or postpartum eligibility period.
- The 2021 and 2022 data indicate that a smaller percentage of Medicaid adults utilizing services reached the annual cap of $1,000 due to fewer adults reaching the cap. The long-term impact following the COVID-19 public health emergency (PHE) is yet to be fully recognized.

Proposal to Eliminate Cap for Specific Populations

Did the proposal from the administration eliminate the cap for the disabled population? How is that population being defined?

- DVHA is proposing eliminating the cap for Developmental Disabilities and Community Mental Health and Rehabilitative Treatment Medicaid programs served under Vermont's 1115 Global Commitment to Health Waiver in H.206. Emergency dental services to treat pain, infection, or bleeding will be covered after the annual $1,000 cap has been met. These services are currently covered for low-income adults via the general assistance voucher program and will be covered under Medicaid.
- These populations are defined by the departments providing these programs (Department of Aging and Independent Living Developmental Disabilities Waiver Program, and Department of Mental Health Community Rehabilitation and Treatment Waiver Program).

Removing the Cap

The Department is not able to confidently estimate the associated cost of eliminating the cap for adult dental services for the following reasons:

- After a member meets the cap, DVHA does not receive claims for that member. Claims activity would show services that were denied because a member met the cap and could serve as the foundation for an accurate projection.
- We do not have a way to predict member and provider behavior change.
    - If the cap were removed, it is reasonable to anticipate an effect on Medicaid member behavior in seeking dental services, and in dental providers' willingness to treat Medicaid members with complex dental needs. This change could be immediate or could take place over several years.

Increasing the Cap to $1500

The department recommends increasing the cap to $1,500 for the following reasons:

- DVHA has determined that the Governor's proposal of $13.1 million (gross) to increase the Medicaid dental fee schedule to 75% of Northeast Delta Dental rates, would allow for the cap to be increased to $1,500 without additional appropriations.
- Increasing the cap to $1,500 would allow the department to collect utilization data to make more accurate requests for additional appropriations in the future.

Tracking the Effect of Increasing Rates

- DVHA is able to track claims data for Medicaid members, as well as the number of dental providers enrolled in the Medicaid program, to monitor the effect of increasing dental rates to 75% of the Northeast Delta Dental fee schedule if the proposal passes.
- Please note that the rate increase is scheduled to take effect 7/1/23 and that there will be a delay in capturing this data due to the time it takes to receive and process claims.