Increasing Access to Dental Care in Medicaid:
Does Raising Provider Rates Work?

California HealthCare Foundation

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Overview

Oral disease is the most prevalent chronic disease of childhood—five times more common than asthma—and is concentrated disproportionately among children in low-income families who are likely to be eligible for Medicaid and the State Children's Health Insurance Program.[1]

Dentist participation in Medicaid has been a persistent problem; fewer than one in four dentists reported seeing at least 100 Medicaid patients in a year.[2] Dentists typically cite several reasons for their low rate of participation in Medicaid. Chief among them is inadequate reimbursement, accompanied by concerns about burdensome administrative requirements and poor compliance among Medicaid patients in keeping appointments and following treatment regimens.

Beginning in the late 1990s, there was a national push to address the gaping disparities in oral health access for low-income children. Several states greatly increased the rates paid to dentists to bring them more closely in line with dentists' usual fees, and at the same time streamlined administrative processes and sought to build strong relationships with the dental community. This issue brief examines how the reforms unfolded, what happened as a result of these state actions, and whether advances in program administration and outreach mattered as much or more than the rate increases in improving access to Medicaid dental care.

The National Academy for State Health Policy conducted a review of all published literature on the experience of states regarding dental reimbursement rate increases, and the effect such increases have had on service utilization and provider participation. Following this review, key interviews were conducted with 23 stakeholders and experts from six states that enacted dental reforms: Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington. The findings were also compared with information on provider rates and participation in California.

The research concludes that reimbursement rate increases were a necessary, but not sufficient, part of making Medicaid dental reforms succeed. Experts in each state indicated that simply paying higher rates was not enough to substantially improve the program. Medicaid agencies must also revamp program administration and build partnerships with dental societies. Success in these areas can help promote gains in utilization and provider participation, even when rate increases are modest. Administrative improvements and building partnerships are also vital to sustaining this progress during fiscal downturns. The full NASHP report is available at www.nashp.org/_docdisp_page.cfm?LID=C1D52AEC-0239-4DCC-8B4C3232F278FC47.

The Importance of Reimbursement

Dentists' higher overhead costs mean that their willingness to participate in Medicaid is greatly influenced by rate levels. While most physicians practice in hospitals or corporate entities, more than 92 percent of dentists are in private practice, and 79 percent are sole proprietors.[3] Dental overhead costs have been estimated at 60 percent to 65 percent of providers' income, depending on state taxes. Medicaid reimbursement rates

Key Findings

- Oral disease disproportionately affects children in families with low income. Medicaid programs are required by federal law to provide dental services to children; however, beneficiaries' access to dental care is poor.
- Dentists cite three primary reasons for their low participation in state Medicaid programs: inadequate reimbursement, burdensome administrative requirements, and problematic patient behaviors.
- Beginning in the late 1990s, a number of states took dramatic steps to address these concerns, including reimbursement rate increases that brought Medicaid payments for children's dental services closer to dentists' usual charges. States such as Tennessee and Alabama roughly doubled Medicaid payment rates; other states made smaller or more narrowly targeted rate increases, such as those aimed at care for rural residents or young children. The experience of these six states indicates that reimbursement rates must at least meet dentists' overhead expenses.
- Rate increases are not sufficient on their own. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also essential. Administrative improvements and involving dentists can help maximize the benefit of smaller rate increases, and lessen the potential damage when state budgets contract.
- 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 states studied. Unlike most of the six states profiled here, California provides a full dental benefit for adults as well as children.
- 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, so did the number of patients treated. Patients' access to care, as measured by the number of beneficiaries using dental services, also increased after rates rose.

in many states are below 50 percent of a dentist's usual and customary charge. This fails to meet the providers' overhead costs of providing care and means that dentists lose money on every Medicaid patient they see. Organized dental groups and oral health coalitions advocate for Medicaid reimbursement rates that are competitive so that the program will be attractive to dental providers.[4] Specifically, the American Dental Association (ADA) has advanced the idea that fees set at the 75th percentile of regional dentists' fees (that is, rates equal to or greater than the usual charges of 75 percent of dentists in an area) should attract sufficient participation from dentists to provide access to care for program beneficiaries. This is especially true if these increases are coupled with improvements in program administration and patient education.

Each state studied made significant new investments in Medicaid dental reimbursement rates for children; some using the 75th percentile methodology, and others basing rate increases on other benchmarks. In Tennessee and Alabama, this meant that historically low fees were roughly doubled. Other states made smaller or more targeted increases. Virginia invested in a 28 percent rate increase across all procedures, but worked with an advisory committee of dentists to add a supplemental 2 percent rate increase for oral surgery, a crucial area of specialty care. Washington's Access to Baby and Child Dentistry initiative was even more narrowly focused on improving access to care for very young children. Michigan's Healthy Kids Dental program is aimed at children in 59 nonurban counties (of 83 total counties). This reform enrolls children in a dental benefit plan administered by a large dental insurer.

At the same time, the six states enacted dental administrative reforms to encourage dentists' participation in the program in several ways. Alabama and South Carolina worked within the existing framework of their Medicaid program, and maintained the state's direct control. Alabama simplified claims processing procedures,

added dental claims processing and provider relations staff, and engaged in intensive dentist recruitment and education efforts, including training sessions in dentists' offices to help staff bill properly for services. Tennessee and Virginia carved out dental benefits from their Medicaid programs and contracted with a specialized dental benefits vendor. These states used "administrative services only" contracts to purchase the vendor's call centers, expertise in working with dentists and dental office staff, and processes for resolving common claims errors. Under each of these systems, states worked to improve provider enrollment processes, outreach, and education; reduce the number of procedures that require pre-authorization; and adopt claims processes that were similar to the systems that dental offices use for their privately insured patients. These measures help to build dentists' confidence that the program is responsive to their needs, and can help to offset the negative effects of stagnating or falling reimbursement rates.

As Table 1 shows, in each state, the number of providers who participate in Medicaid or the State Children's Health Insurance Program (SCHIP) increased by at least one-third, and sometimes more than doubled, following the reimbursement rate increases. Not only did provider participation rise, but states also began seeing an increase in the number of patients treated. Patients' access to care, as measured by the number of beneficiaries using dental services, also increased after new rates were implemented. Although the gains in the percentage of beneficiaries using services are relatively modest (especially compared to children with private dental insurance, where utilization was 57.5 percent in 2004), it is important to note that this happened in an environment of expanding Medicaid enrollment.[5]

As Table 2 shows, the increases in utilization of services are generally in proportion to the percentage increases in state spending—that is, in states such as Tennessee and

Table 1. State Dental Reforms in Medicaid and Their Effects on Service Use and Provider Participation

	PERCENTAGE OF ENROLLED CHILDREN USING SERVICES				ENROLLED PROVIDERS			
STATE	INITIAL YEAR OF REFORM (YEAR)	TWO YEARS AFTER REFORM	FISCAL YEAR 2006	PERCENT INCREASE	PRIOR TO REFORM (YEAR)	TWO YEARS AFTER REFORM	MOST RECENT (YEAR)	PERCENT INCREASE
Alabama	21% (2000)	28%	37%	76%	441 (2000)	586	778 (2007)	76%
Michigan	21% (2000)	29%	30%	43%	769 (2000)	1624	1926 (2005)	150%
South Carolina	28% (2000)	35%	43%	54%	619 (2000)	886	1197 (2006)	93%
Tennessee	26% (2002)	36%	36%	38%	386 (2002)	700	817 (2005)	112%
Virginia	24% (2005)	—	32%	33%	620 (2005)	—	1007 (2007)	62%

Sources: Utilization data – Annual EPSDT Participation Report (CMS-416). Provider data – various state sources. See full report for a complete listing of sources.

Brief description of dental reforms/basis for reimbursement rate increases:

Alabama: Reimbursement rates were based on the Blue Cross/Blue Shield dental fee schedule. The state also received $1 million in private funding for outreach.

Michigan: Data are based only on the Healthy Kids Dental (HKD) program, a capitated contract with Delta Dental for children in certain nonurban counties. Providers in HKD initially received payments equal to those of the Delta Premier product, but this has recently been changed to the lower Delta Preferred Option PPO fee structure. Note that information presented here is for the entire state, including the fee-for-service population in urban counties, and not only HKD counties.

South Carolina: Reimbursement rates were based on the 75th percentile of a commercially available fee survey (called Medicode). The state also received private funding for outreach, especially to rural areas.

Tennessee: Reimbursement rates were based on the 75th percentile of the 1999 ADA Survey of Fees for the East South Central region of states. The state also contracts with Doral Dental for administrative services, which cost roughly $4.5 million per year.

Virginia: Prior to Virginia's rate increase, the state's reimbursement rates were less than 50 percent of usual, customary, and reasonable charges. The state legislature approved a 28 percent increase that was applied to all dental codes in 2005. An additional 2 percent increase, targeted to oral surgery procedures, followed in 2006. Virginia also has an administrative services contract with Doral Dental.

Note that Washington is not included, due to a lack of accessible data on utilization and provider participation prior to the institution of the Access to Baby and Child Dentistry program in 1995.

Alabama, the state roughly doubles its expenditures per child, and provides services to twice as many children. However, because the state is spending more for the previous level of utilization, as well as the larger number of procedures, this can result in relatively large increases in total expenditures. Despite this, Medicaid dental spending is still small—under 2 percent of total program expenditures—relative to other types of Medicaid-covered services such as prescription drugs or nursing home care, and relative to national health expenditures, where dental represents 5 percent of total spending.[6,7]

Table 2. Changes in Medicaid Dental Payments and Utilization in Selected States

	ALABAMA	SOUTH CAROLINA	TENNESSEE
Initial Year of Reform			
Year	2000	2000	2002
Number of Beneficiaries Using Services	72,287	162,567	131,899
Total Dental Payments	$11,465,011	$48,151,459	$28,660,471
Payment per User	$159	$296	$217
FFY 2004			
Number of Beneficiaries Using Services	155,541	256,782	286,314
Total Dental Payments	$44,449,030	$89,304,420	$130,284,595
Payment per User	$286	$348	$455
Percent Change in…			
Beneficiaries Using Services	115%	58%	117%
Total Payments	288%	85%	355%
Payment per User	80%	17%	109%

Source: CMS Medicaid Statistical Information System: www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp, October, 2007.

Even though states may increase their reimbursement rates and program spending, the gains in utilization and provider participation may level off or reverse if inflation overtakes the effect of the rate increase. Interviewees in each study state noted that regular rate increases are ideal. However, without them, close collaboration with dental societies and advisory groups has helped to avoid downturns in provider participation.

Setting the Stage for Reform

In each state studied for this analysis, the impetus for reforms to the Medicaid dental program can be traced to a trigger event, such as the enactment of the State Children's Health Insurance Program (Michigan), a court order to improve screening rates under the Early and Periodic Screening, Diagnosis, and Treatment benefit (Tennessee), new leadership in key positions (Alabama, Virginia), or policy academies sponsored by the National Governors Association (Alabama, Tennessee, Virginia).[8]

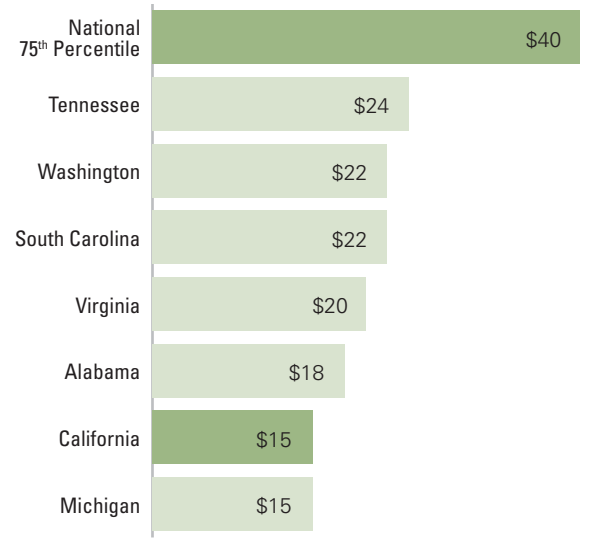
State dental societies were influential voices in states considering reform. They typically represent a high percentage of a state's practicing dentists, so their involvement and support is important in achieving the state's goals. Particularly crucial is the cultivation of strong relationships between the dental society and Medicaid officials. Open communication and collaboration toward a shared goal, even in times of disagreement, can convince legislators that proposed reforms have wide support and persuade individual dentists to set aside antipathy toward the Medicaid program.

State oral health coalitions were also very important contributors to most states' reforms. These coalitions provided broad-based support, including partners such as pediatricians, community health centers, children's advocates, and departments of education. Coalitions helped frame the reimbursement issue throughout the legislative process as mainly benefiting low-income patients, rather than dentists.

The California Landscape

Reimbursement rates for providers in California's Denti-Cal program are well below dentists' usual fees in the state. Denti-Cal rates for many commonly performed pediatric procedures are only one-half to one-third of dentists' fees. Figure 1 below compares California's fee-for-service reimbursement rates for a dental examination to the six states that implemented reforms, and also to the national 75th percentile of fees in 2005, as measured by an ADA survey of dentists. 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.

Figure 1. Comparison of Medicaid Fee-for-Service Reimbursement Rates for Dental Examinations



Note: Data is for Current Dental Terminology procedure code D0120, "periodic oral evaluation."

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In California, 40 percent of dentists in private practice do not treat Denti-Cal beneficiaries. The great majority of these are general practitioners. While California's participation rate is relatively high, the state's size and diversity mean that access challenges remain. A previous CHCF study found that only 26 percent of beneficiaries (which in California includes adults as well as children, unlike most of the study states) received dental services in 2004.[9] Like some study states, Denti-Cal contracts with a specialized vendor for program administration, provider services, and claims processing. Yet California dentists view certain additional administrative requirements (such as extensive pre-authorization and provider enrollment processes) as a barrier to participation.

In the wake of the 1990 *Clark v. Kizer* decision, California was to increase its provider rates for many procedures to 80 percent of average amount billed (with regular cost of living increases), and also to conduct enrollee outreach to increase Medicaid dental utilization. While California initially began to move toward rate increases, later actions of the state legislature in the 1990s prohibited their full implementation. Beginning in 2000, the legislature periodically enacted further restrictions on the Denti-Cal program in response to budget pressures. As of this writing, Governor Schwarzenegger's plan to address California's budget deficit includes the elimination of adult dental benefits and a possible $1,000 annual cap on dental benefits for children enrolled in the state's SCHIP program.[10] The legislature has already passed a 10 percent reduction in reimbursement rates for FY 2007–2008.

Conclusion

Survey research, academic literature, and interviews with key stakeholders in six states indicate that higher fees positively influence both dentists' willingness to participate in state Medicaid programs and Medicaid patients' access to oral health care. However, a majority of experts interviewed felt that while adequate reimbursement rates were necessary for improving access

to Medicaid dental services, they were not sufficient on their own. Higher rates must be combined with efforts to address administrative concerns and strengthen the state's relationships with community dentists.

As in most state Medicaid dental programs, California's patient utilization and provider participation rates are low. However, a number of states have succeeded in improving these measures by investing in provider reimbursement rates, building strong relationships with dental societies, working with oral health coalitions, and improving Medicaid program administration. Recent experience in Virginia has shown that budget increases that are more modest in scope can be successful if they are coupled with intensive efforts to partner with dentists and respond to their concerns. California can also consider smaller, targeted rate increases for selected services or special populations, as Virginia and Washington have done.

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About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about the foundation, visit us online at www.chcf.org.

Endnotes

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