

The Effects of Medicaid Reimbursement Rates on Access to Dental Care

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National Academy for State Health Policy

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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

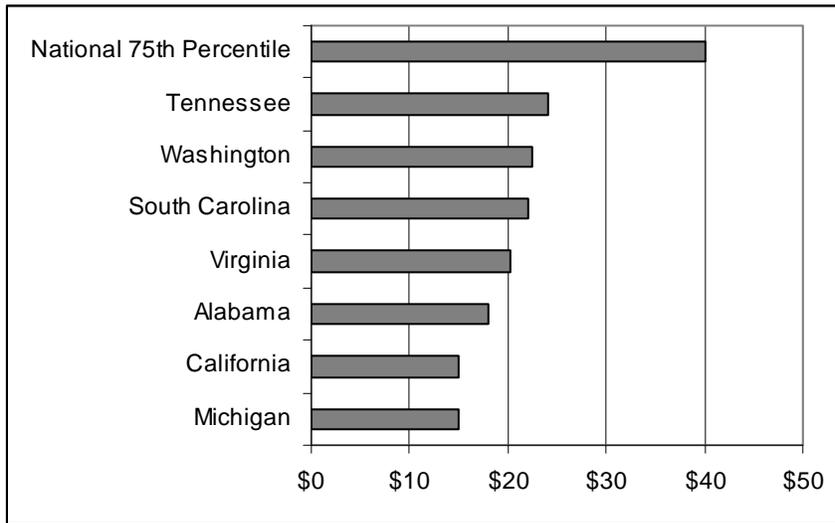
Source: Utilization data – calculated from Annual EPSDT Participation Report (CMS-416), 2000-2006. Provider data – Various state sources. See page 16 of this report for complete sources.

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.

American Dental Association. Survey of Dental Fees. Chicago: American Dental Association Survey Center: 2005.

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http://www.dmas.virginia.gov/downloads/pdfs/dental-feeSched_501-06.pdf. Accessed November 2007.

Washington Health Recovery Services Administration. Dental Program Fee Schedule.

http://fortress.wa.gov/dshs/maa/RBRVS/2007_Fee_Schedules/HRSA_August_1_2007_Dental_Fee_Schedule.xls. Accessed November 2007.

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INTRODUCTION

Medicaid is the major source of publicly-funded dental coverage in the United States, although spending on dental care is small compared to other services. Often, the amount Medicaid pays providers for services is well below what the provider would receive from the privately insured or uninsured. The adequacy of the Medicaid rates that states pay providers is a constant source of friction between providers, state agencies, and legislatures. However, in the majority of cases, the people who are enrolled in Medicaid programs can locate and utilize the services that they need. This is not true with respect to dental services.

Even though states are required to provide dental care to Medicaid-enrolled children (and may, at their option, cover adult dental services), only one in three of these children utilized services in 2006.¹ This is a particular problem because poor children (who are eligible for Medicaid if they meet program criteria) are more likely to have decayed teeth and unmet dental care needs than their wealthier counterparts.² Dentists' participation in Medicaid is also very low, with fewer than one in four dentists seeing at least 100 Medicaid patients in a year.³ Dentists cite several reasons for their low level of participation in Medicaid, and chief among them is the low level of reimbursement, accompanied by concerns about burdensome administrative requirements and a low level of compliance among Medicaid patients in regard to keeping appointments and following treatment regimens.

In the late 1990s and early 2000s, there was a national push to address the gaping disparities in oral health access that face low-income children. This followed, in part, from the enactment of the State Children's Health Insurance Program, lawsuits against states for failing to meet their federal obligations, and a Surgeon General's report that labeled oral disease as a "silent epidemic." Some states, including Alabama, Michigan, and Tennessee, overhauled their Medicaid dental programs, and a key part of their reforms was budget increases that brought provider reimbursement closer into line with dentists' usual fees. Often, this meant doubling the rates paid to providers as well as making reforms to administrative processes, improving the supportive services and education provided to program enrollees, and building partnerships with state dental societies.

Each of these states enjoyed successes in regard to increasing the number of dentists participating in their programs and the utilization of dental services by program enrollees. They are now held up by dentists and dental advocates as examples of model practices for states to emulate. However, the fiscal environment facing states today is decidedly more mixed than it was ten years ago. States such as Virginia are undertaking similar reforms, but with far fewer resources than were available previously. Also, there is a sobering realization that even in these front-running states, Medicaid-enrolled children's utilization of dental services is still below the rates of utilization of the privately insured.

This study, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, funded by the California HealthCare Foundation, attempts to evaluate several questions about dental reimbursement rate increases in order to guide states such as California as they chart their course over the next several years:

- What are the common elements among successful reforms to state Medicaid dental programs?
- Are reimbursement rate increases essential to improvements in access to care?
- What is the importance of rate increases relative to the other elements of dental reforms, such as administrative reforms?
- Is there a threshold level of reimbursement that must be met in order to attract a critical mass of community dentists to the program?
- How much improvement in access and provider participation do states purchase by raising rates? How much does it cost?
- How close do these improvements bring states to their utilization goals?
- What do states need to do to sustain their gains in subsequent years, as health care inflation and tightening budgets erode the impact of rate increases?
- How do the experiences of these states inform the decisions that California might make regarding dental service delivery?

To answer these questions, a review was conducted of all literature published on the experience of states regarding dental reimbursement rate increases, and the effect of these increases on service utilization and provider participation. Applicable studies from other disciplines were also evaluated. Following this review, phone interviews were conducted with 23 experts, including Medicaid staff, Medicaid directors, state dental society officers and staff, oral health coalitions, and key legislators from six states that enacted dental reforms: Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington. These interviews attempted to capture the details of the particular circumstances, personalities, and events at play in each state so as to provide a full picture of how the reforms actually unfolded.

(Continued on next page)

A Note about Terminology: Percentages and Percentiles

Throughout this paper, several terms related to reimbursement rates are used. Usual, Customary, and Reasonable (UCR) charges refers to a dentist's regular, non-discounted charge for a service. Dentists participating in Medicaid are required to list their UCR charge for a given service on a claim. Medicaid reimbursement rates routinely fall below these usual charges, and are often 30 to 50 percent of UCR rates. For example, if a dentist in a state charges \$120 for an extraction, and the state pays \$60, the Medicaid rate is at 50 percent of that dentist's UCR. In this paper, the terms "usual charges" and "usual fees" are used interchangeably with UCR.

When discussing organized dentistry's position regarding reimbursement rates, and the course that states have taken in instituting rate increases, there is a key distinction to be made between *percentages* and *percentiles*.

Several states such as Delaware have calculated their Medicaid rate increases as a *percentage* of UCR. In Delaware's case, Medicaid rates were set at 85 percent of dentists' billed charges, which appears to comport with the discounts dentists are willing to accept from commercial dental insurers.⁴ However, the American Dental Association and many state dental associations have advanced the idea of *percentiles* as the appropriate way of thinking about setting Medicaid rates. Specifically, they have advocated the 75th percentile of fees as a level of reimbursement that is adequate to attract participation from a state's dentists.⁵ This is a very different proposition than setting rates at 75 percent of UCR.

Percentiles compare a reimbursement rate to the fees charged by all of the dentists in a geographic area. It is similar to the way that standardized test scores like the SAT are reported; if, for example, you scored a 790 on the verbal section of the SAT, your results might indicate that you placed in the 95th percentile of all test takers. That means that your verbal score was **equal to or higher than** the scores of 95 percent of the people who took the test. For the example above, a Medicaid rate of \$60 for an extraction would fall well below the UCR charge of most dentists; it would likely place below the 5th percentile of fees, meaning that it meets or exceeds the UCR of only 5 percent of the state's dentists.

Setting Medicaid reimbursements at the 75th percentile means setting fees that are as high as or higher than the UCR charges of 75 percent of dentists in the state. So, for three-quarters of a state's dentists, Medicaid rates would equal or exceed the amount they normally charge.

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BACKGROUND

As a part of a Medicaid reform package in 1968, Congress acknowledged the importance of dental care through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. This provision required all states to include in their Medicaid programs dental care for individuals less than 21 years of age. EPSDT was further bolstered in 1989 with the Omnibus Budget Reconciliation Act, when states were required to provide all medically necessary dental services for children under EPSDT, even if these services were beyond the scope of coverage that the states' Medicaid plans previously afforded. These policy shifts were designed to address the generally poorer oral health status of Medicaid enrollees, compared to privately insured individuals, and to improve access to dental providers and utilization of services.⁶

For several reasons, though, the dental needs of Medicaid-enrolled children remain largely unmet in most states. In 1996, the Department of Health and Human Services' Office of the Inspector General reported that only 20 to 30 percent of children eligible for EPSDT received any dental services. According to the DHHS report, too few dentists are willing to accept Medicaid patients due to low provider reimbursement rates, cumbersome preauthorization and paperwork processes, and slow payment mechanisms. Dentists also cite patient behavior as a barrier to providing care, as Medicaid families are known to have high rates of broken appointments and their care-seeking behavior is inconsistent, due in part to competing family priorities.⁷

Low dental access and utilization rates among Medicaid families only compound existing dental problems. Among children, dental problems represent the most common unmet health need: almost 59 percent of all children experience dental caries (tooth decay). Compare this to the 11 percent of all children with asthma and 8 percent with hay fever.⁸ In addition to being painful, untreated dental conditions can impair activities such as eating and speaking,⁹ and may be associated with more serious health problems, such as cardiovascular disease and strokes in adults.¹⁰

In response to dental access problems, individuals began challenging states in court, arguing that states were not meeting EPSDT requirements and were hindering access to care by offering dental providers insufficient reimbursement rates. Throughout the 1990s and 2000s, a total of 27 cases from 21 jurisdictions were filed on the basis of inadequate dental provider participation.¹¹

In California, beneficiaries successfully argued that setting inadequate reimbursement rates was a violation of Medicaid's equal access provision.¹² The *Clark v. Kizer* (E.D. Ca. 1990) case set a precedent for the court's use of dental participation in Medicaid, as well as level of reimbursement, to determine the adequacy of states' Medicaid dental programs. The court order required California to increase provider rates to 80 percent of the average amount billed for 56 common procedures and develop a plan to increase beneficiary utilization in underserved areas.¹³ While California initially enacted these rate increases and conducted a provider and beneficiary outreach program, after one year the state persuaded the court to eliminate the 80 percent requirement and restore utilization controls on root canal procedures. Through the late 1990s and early 2000s, state budget deficits led the state to backtrack on some of its dental reforms. California decreased spending on dental reimbursements and discontinued its outreach unit.

Since 2003, there has been further tightening of utilization controls, and the introduction of annual limits on adult benefits.¹⁴

In 1998, four years before Tennessee's Medicaid program (TennCare) carved out its dental program, a class action lawsuit was brought against the state by legal advocates on behalf of Medicaid beneficiaries under the age of 21. The suit alleged failure of the state to provide adequate health services, including dental services for children. A settlement order followed, known as the *John B. Consent Decree*, in which ambitious standards regarding EPSDT services were established. The applicable performance standard required that 80 percent of children receive a dental screening or that all children who have not received complete screenings consistent with this requirement be the subject of outreach efforts reasonably calculated to ensure participation. TennCare continues to be involved in litigation concerning its compliance with the terms of the decree.¹⁵

While the earlier cases were settled in federal court in favor of Medicaid-eligible individuals, courts have begun to deny beneficiaries the right to privately challenge states' payment rates as well as other processes covered under the equal access requirement.¹⁶ This change in judicial thinking may affect the ability of lawsuits to serve as effective catalysts for Medicaid reform.

In addition to court involvement in the Medicaid program, local stories of inadequate dental access also raised the public's awareness of oral health disparities. Most recently, the February 2007 death of 12-year-old Deamonte Driver highlighted the gravity of poor oral health and its consequences. Deamonte's death, caused by a brain infection that spread from an abscessed tooth, led Congress to examine current federal oversight of Medicaid dental provisions and consider making dental benefits mandatory in the reauthorization of the State Children's Health Insurance Program (SCHIP).¹⁷ This mandate, as well as several other oral health provisions, is included in the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA), which, as of this writing, has failed to be enacted over presidential vetoes.¹⁸

With national attention focused increasingly on the importance of oral health, many states are now questioning what it will take to improve access to dental care among low-income populations and whether a change in dental reimbursement rates is the answer. This paper examines the impact on access to dental care of raising reimbursement rates to dentists. The actions of six key states that have attained rate increases, better provider participation, and better dental utilization, especially among children, were studied. Using key informant interviews and data supplied by state Medicaid officials, NASHP examined the similarities and common achievements among these states, as well as variations in their Medicaid dental administrative structures. We also examined what other factors affect utilization, such as administrative processes and patient education, and what the implications of the findings are for California.

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REFORMS IN THE SIX STUDY STATES

In the late 1990s and early 2000s, most states were confronted with poor dental access and utilization in their Medicaid programs, especially among children. State health officials and public health leaders in Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington recognized the need for action and each implemented a plan to remedy oral health disparities. An integral part of each state's approach was to increase dentists' reimbursement rates and encourage their participation in treating Medicaid patients, but the methods varied. Two states – Alabama and South Carolina – implemented programs through their Medicaid agencies, maintaining the state's responsibility for administering the program. Tennessee and Virginia implemented successful statewide dental carve-outs – removing dental benefits from medical managed care contracts and instead contracting with a third-party company with special expertise in administering dental benefits under public programs such as Medicaid and SCHIP – thus transitioning the management of their state Medicaid dental programs to a single dental benefit administrator. In many of its counties, Michigan implemented a successful contract with a dental insurer.

Organized dentistry often advocates for dental carve-out models over the inclusion of dental benefits in state contracts with medical managed care organizations (MCOs) or subcontracted arrangements with MCOs because of the distinct differences between medicine and dentistry. Organized dentistry also prefers the commercial-like administration of carved out programs to state-administered programs. However, state-run Medicaid programs have also proven successful when they incorporate good management and sufficient resources for provider education and enrollee outreach.

Providing Dental Benefits through State-Run Medicaid Programs

In response to an outcry from the public, as well as data that showed eroding provider participation and access to care, state health officials in Alabama, South Carolina, and Washington collaborated with state dental associations and other stakeholders to reform their Medicaid dental programs. State reports show that in 1998 only 25 percent of Alabama's Medicaid-enrolled children ages 0 through 20 had a dental visit.¹⁹ Similarly, in South Carolina only 28.5 percent of enrolled children ages 0 through 21 visited a dentist in 1999.²⁰

Alabama established its *Smile Alabama!* initiative in October 2000, which set dentists' fees at 100 percent of Blue Cross/Blue Shield rates, and enhanced the provider service functions of its fiscal agent. These shifts were designed to recruit and retain dentists. Additional outreach-driven efforts were undertaken to address patient behavior, such as keeping appointments.²¹ In addition to Alabama's increased fees, the state also sought local, foundation, and federal match funding to support patient outreach and education efforts that would lead to positive patient behaviors. Alabama's fiscal agent, state officials, and dental association worked collaboratively to address provider hesitancy and misunderstanding about administrative procedures such as billing and preauthorization. These efforts resulted in growth of more than 100 percent in provider participation, from 350 providers in 1998 to 778 in 2007. Of those participating, the percentage

of providers who saw more than 100 Medicaid patients per year also grew from 43 percent in 1998 to 63 percent in 2007.²²

From 1998 to 1999, South Carolina's Department of Health and Human Services began making administrative changes to its Medicaid processes, such as reducing preauthorizations and streamlining standardized claims forms. In response to the department's request for increased reimbursement rates, the state's legislature created a provisional six-month increase, accompanied by a mandate for Medicaid to raise the number of providers participating by 200. Due in part to dental association outreach, the state exceeded its half-year target by 50 providers²³ and obtained an annualized allowance for fees set at the 75th percentile of 1999 American Dental Association (ADA) regional fees. This was changed later by Medicaid to the 75th percentile of fees reported in an insurance company's survey.²⁴ According to a report issued by Doral Dental, South Carolina's provider participation has continued to grow from the 1999 base of 619: in 2006, 1,197 providers were enrolled, representing 37 percent of the state's licensed dentists.²⁵ Through these changes, as well as other patient education and support programs, South Carolina was able to reverse a downward trend in utilization rates from a low of 28.5 percent in 1999 to 31 percent in the following year.²⁶

Washington State designed a more targeted "Access to Baby and Child Dentistry" (ABCD) program in order to increase access to dental care specifically for children ages 0 to 5. In addition to outreach and training components, ABCD included enhanced rates on certain procedure codes to bring those rates to the 75th percentile of UCR fees.²⁷ The state has worked with the University of Washington to provide ABCD training to providers, especially around the protocol for treating young children. Patients and their families work with case managers on the importance of attending appointments. Case managers help reduce the barriers to care faced by families in Medicaid, and educate them about how to use dental services. The program was heralded by the ADA as a model for other states to replicate. Washington was included as part of this study because ABCD achieved substantial gains in provider participation and patient utilization. However, because ABCD is now over 10 years old, there are less available data and fewer informants knowledgeable about the conditions that brought about the state's reforms than for the other states in this study with more recent reforms.

Providing Dental Benefits through Carve-Out Programs

Michigan, Tennessee, and Virginia addressed dental access problems and low provider participation by pursuing a dental carve-out. These states also increased provider reimbursement rates and collaborated with state dental societies to reach out to providers and pinpoint other concerns, and established advisory committee mechanisms for providers to give input on program design.

In 2000, Michigan entered into a contract with Delta Dental of Michigan to administer a dental benefit for children in many non-urban counties in the state. (Children in the remaining urban counties, as well as Medicaid-enrolled adults, continue to be served by the preexisting fee-for-service Medicaid dental benefit.) This program, called Healthy Kids Dental (HKD), was developed on the model of the state's SCHIP dental program, and closely mirrors private dental

insurance. Delta is paid a set amount per enrollee per month, and assumes the financial responsibility of paying providers, as well as processing claims. Under HKD, dentists are paid for services provided to Medicaid enrollees at the same rates they would be paid for enrollees of one of Delta's private plans. At the program's inception, the Delta Premier product was used; it pays dentists 100 percent of their usual charges in most cases. Because Delta was already an established dental insurance corporation and the largest dental managed care organization in Michigan and administered the state's SCHIP dental program, many of the state's providers were already enrolled with Delta prior to Medicaid's Healthy Kids Dental contract. Medicaid enrollees gained automatic access to the dentist of their choice within Delta's network, and the number of providers giving care to HKD enrollees increased by 24 percent in the first 12 months.²⁸

Healthy Kids Dental has had a very positive impact on access, with utilization of dental services by HKD enrollees rising steadily by a variety of measures. Though initially designed as a pilot, the program has grown to include 59 of Michigan's 83 counties, covering 200,000 children, and will add two additional counties in summer 2008.²⁹ In order to finance this expansion, the payment structure of HKD has been shifted from the Delta Premier product to the Delta Preferred Option plan, a set schedule of fees which, while lower than the Premier fees, are still above those paid in the fee-for-service Medicaid program. As a result of this change, there was a 14 percent decline in the number of providers.³⁰

Tennessee carved out dental services from multiple medical managed care organizations in October 2002, shifting to a single dental benefits manager (DBM) and a dedicated dental budget. Doral Dental was awarded the original DBM contract and then won the contract when it was rebid in 2005. Under this "administrative services only" contract, the state covers expenditures for benefit claims and the DBM is paid an administrative fee for managing dental benefits.

Doral Dental is responsible for recruiting and maintaining a network of qualified dental providers adequate to make dental services available and accessible to beneficiaries. Doral processes claims and sends payments to providers. A maximum allowable dental fee schedule was established that was based upon the 75th percentile of fees published in the 1999 ADA survey of regional fees. In addition to conducting enrollee outreach and education activities, Doral must also conduct statewide provider training programs annually. It must manage data, provide mandatory reports, and conduct quality improvement programs and utilization review and management, as well as achieve specific performance requirements. Program improvements, including streamlined administrative processes, have made the program much more provider-friendly. As a result, provider participation grew by more than 120 percent from 386 providers immediately prior to the carve-out to 850 providers by 2007.³¹ Utilization by recipients ages 3 through 20 also increased from 36 percent in federal fiscal year (FFY) 2002 to 51 percent by FFY 2006.³²

Virginia also chose to carve out its Medicaid dental program, "Smiles for Children," in 2005 and enter into an administrative services contract with Doral. The contract was similar to Tennessee's program and based on Tennessee's template. Virginia also maintained its fee-for-service structure, and the state legislature allocated funding for an overall rate increase of 30 percent; 28 percent was approved for 2005, and an additional 2 percent was authorized for 2006. After consulting with its Dental Advisory Committee, Virginia Medicaid allocated the initial 28

percent for a general fee schedule increase, and the remaining 2 percent was applied to specialty service codes in order to attract more specialists to the program. Following efforts to enroll and inform providers of the new program changes, the number of providers enrolled in the program has grown steadily from 620 in 2005 to 1,007 in 2007, a 62 percent increase.³³ Utilization has also improved: for all children under age 21, utilization rose from 24 percent in 2004 to 35 percent in federal fiscal year 2007. For only those children above the age of 3, utilization was calculated to be 29 percent in state fiscal year 2005, and has risen to 43 percent by December 2007.³⁴

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COMMON ELEMENTS OF STATE REFORMS

Reimbursement rate increases were a key factor in the reforms undertaken in Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington. However, in all of these states, the fee increases took place in the context of other administrative modifications, new ways for Medicaid officials to interact with key stakeholders, and tide-shifting events or circumstances. Literature review and key informant interviews reveal several similarities among the states regarding the precipitating events and the processes through which new Medicaid dental programs were developed.

Catalysts

Before moving to reform their programs, each state studied had a trigger event that highlighted the issue of poor dental access and provider participation in Medicaid. In Alabama and Virginia, a change in leadership was the defining point. Dr. Mary McIntyre was promoted to Assistant Medical Director of Alabama's state Medicaid agency, where she learned first-hand about the serious problems beneficiaries had accessing dental care. She then created a focused movement with external stakeholders and state leaders to improve dental access. In Virginia, Pat Finnerty and Dr. Terry Dickinson's simultaneous transitions to lead the state's Department of Medical Assistance Services (DMAS) and the state dental association, respectively, created a window of opportunity for action. They each brought a passion to improve Virginians' access to dental care and quickly coalesced into a team.

In Tennessee, a confluence of events prompted change. The state needed to comply with a federal court order prompted by a lawsuit to improve EPSDT screening rates. The Tennessee Dental Association (TDA), responding to dentists' frustration with the medical managed care model, was vigorously working with legislators and advocates to get dental benefits carved out. The TDA surveyed its membership to understand what conditions would encourage more dentists to participate in TennCare. At the same time, the Tennessee Department of Health began working more closely with the Bureau of TennCare to strengthen the state's dental public health program. In May 2001, Tennessee was chosen to participate in the National Governors Association (NGA) Oral Health Policy Academy. What began as separate initiatives by key stakeholders evolved into a comprehensive children's oral health program for Tennessee.³⁵

In Michigan, it was the implementation of the State Children's Health Insurance Program (SCHIP) in 1997, in addition to a dental task force study, that sparked the development of Healthy Kids Dental. The state's dental task force made four recommendations, one of which was to raise reimbursement rates. This led to the legislature's appropriation of \$10.9 million to improve access to dental care for Medicaid enrollees in rural areas. About half of this money went to funding the Healthy Kids Dental pilot project. Delta Dental of Michigan had previously been successful in performing the dental benefits administrator role for MICHild, Michigan's SCHIP program, so the company was selected to work with the state to build the dental pilot project along the same lines.

Several other states had a dental task force, state summit, or a team that attended the 2000 and 2001 National Governors Association policy academy. Alabama, Tennessee, and Virginia all attended an NGA policy academy, which offered state teams technical assistance to improve their state Medicaid dental programs, including guidance for navigating the policy process. Alabama formed a Medicaid advisory group; South Carolina created a Children's Coalition; Tennessee established the Children's Oral Health Planning Group (which later became the TennCare Dental Advisory Committee); Virginia united its dental association with other community stakeholders; and Michigan formed its dental task force. Each of these was a valuable group that called attention to disparities in oral health access and developed appropriate solutions. Washington State's oral health coalition served the same purpose prior to the development of ABCD and conducted a surveillance study on the prevalence of dental caries in the state's children. This study was presented to the legislature, calling attention to the extent of the state's dental problems and the need for solutions.

Some states also were moved to action due to progress in other states. Seeing Indiana and Michigan increase reimbursement rates in the late 1990s and early 2000s boosted South Carolina's efforts to better its own state oral health program.

Collaboration between Medicaid, Organized Dentistry, and the Community

State dental societies are influential voices. They typically represent a high percentage of a state's practicing dentists, so a society's backing can be important in convincing legislators that proposed reforms have wide support, and in persuading individual dentists to set aside antipathy toward the Medicaid program.

Establishing a relationship between the dental association and Medicaid can be challenging. Prior to the state's carve-out, dentists in Tennessee said there was not a partnership with the state, and were leery of working with Medicaid. In Virginia, because Dr. Terry Dickinson, the state dental society Executive Director, and Pat Finnerty, the state Medicaid director, quickly formed a team focused on increasing access to dental care among the Medicaid population, they were able to work together to change the program. Dental society members and Medicaid staff worked hard to cultivate open communication, even in times of disagreement, and collaborate on a shared goal.

In all of the study states, the Medicaid agency and the dental association developed a very close relationship over time. After continued work together, the dental association realized that Medicaid agencies were willing to listen and communicate, and make changes to the program. Medicaid leaders realized that dentists were willing to make concessions when necessary. Relationships like this were prerequisites for improving dentists' willingness to participate in Alabama, South Carolina, Tennessee, and Virginia's Medicaid programs. Each of these states mounted a concerted effort to recruit dentists through dental society newsletters, Web sites, and at dental society meetings through presentations by Medicaid officials or dental benefit administrators.

Positive ties between the dental society and Medicaid were also useful in sustaining provider participation when undesirable program changes occurred. Both Washington and South Carolina worked closely with their state dental associations when funding for reimbursement rates was decreased by the legislature. Dental associations made recommendations to drop targeted procedures from the fee schedule, and provider participation did not significantly decline.

State oral health coalitions were also important contributors to reforms in Alabama, South Carolina, Virginia, and Washington. These coalitions provided broad-based support that helped throughout the legislative process. Two dentists who were interviewed both commented that it would have been very difficult for providers alone to convince the legislature of the importance of fee increases and their relationship to access. In South Carolina, special needs advocates relayed the importance of raising reimbursement rates to the legislature, so it was perceived as a genuine access issue, rather than a self-serving pay raise. Interviewees from Alabama, Michigan, South Carolina, Virginia, and Washington commonly cited medical, as well as dental, provider associations, safety-net providers, universities, and other administrative agencies, such as education and health departments, as important coalition partners.

Streamlined Program Administration

The states in this study all modified the administration of their programs to improve dentists' experience with Medicaid and reduce the paperwork and procedural barriers that they perceived as an obstacle to providing care. By moving to a carve-out, Michigan, Tennessee, and Virginia transferred the responsibilities of beneficiary outreach, patient education, provider outreach and enrollment, and claims processing to the dental benefits manager. Dentists were very receptive to the Healthy Kids Dental program, managed by Delta Dental, not only because of its higher rates, but also because they saw the administrative process would be familiar. Healthy Kids Dental tapped into Delta's existing provider base, benefiting from Delta's positive reputation among dentists. Moreover, two stakeholders felt that HKD de-stigmatized participation in Medicaid, helping Delta's existing provider network realize that seeing Medicaid patients would not necessarily be a negative experience.

Doral performed a similar role for Tennessee's TennCare and Virginia's Smiles for Children programs. Prior to the carve-out, providers in both states were unhappy with the managed care structure used to administer the Medicaid dental program. Each MCO developed its own fee schedule, benefit package, preauthorization requirements, claims processing systems, provider agreements, provider manuals, and network. Patients could also move between MCOs, which created administrative problems and claims denials for dentists who participated in one MCO and not another. Tennessee providers were especially dissatisfied with specific MCOs that went out of business, filed for bankruptcy, and left some contracted providers uncompensated for services performed. Four stakeholders from Tennessee, as well as two from Virginia, mentioned this MCO program structure as providers' biggest problem with Medicaid prior to the program change.

Once Doral became the dental benefits manager in Tennessee and Virginia, the burden of multiple conflicting administrative processes was immediately alleviated. Doral simplified

paperwork and provided one fee schedule and claims processing structure. Providers were able to communicate easily with Doral's customer service teams in case of problems. States also valued Doral's responsiveness, exemplified in Virginia by the company's willingness to create a Web-based billing option and a toll-free fast-tracked phone line for providers who wanted to enroll. Virginia's DMAS director noted that one of the most important things that Medicaid can do is to resemble other commercial carriers. Doral and Delta's administrative processes were consistent with those of commercial carriers, making participation in Medicaid as administratively simple for providers as working with commercial carriers would be.

States that decided to maintain state-administered Medicaid programs moved to ease administrative burdens on providers. Alabama worked with its billing agent to offer individualized training on claims submissions at dentists' offices, teaching dentists and office staff how to bill properly for Medicaid services. Once the 2000 reimbursement rate increase was in place, Alabama's Medicaid office and fiscal agent (EDS) committed themselves to working promptly to resolve provider concerns. This outreach and education was originally financed with foundation funding, coupled with local and federal matching dollars. In order to sustain the momentum of *Smile Alabama!* once the private money ran out, the state created a Medicaid office specifically to address dental provider outreach and education. Currently, since Alabama's budget has not allowed for another increase in reimbursement rates, one Medicaid official explained that the state dental Medicaid staff is developing more ways to simplify provider participation, such as emergency preauthorization, in hopes of retaining those dentists already treating Medicaid patients.

Patient Education

States have made patient education a key component in their reforms in order to address behaviors like inadequate personal hygiene practices, patient no-shows, and bringing many children to the waiting room.

Smile Alabama! created a booklet which explains how babies' teeth should be cared for, and the state's Medicaid office has worked with Head Start and pregnant women to urge parents to bring children in for treatment at a young age. South Carolina created a patient navigator who contacted Medicaid patients to inform them of upcoming appointments, check in with those who missed appointments, and help them with transportation or child-care problems.

In Tennessee and Virginia, Doral distributed enrollee handbooks, then coordinated efforts to reach out to patients after broken appointments. Federal rules prohibit Medicaid programs and providers from charging patients for no-shows, so Doral employees used the opportunity to educate patients on the importance of receiving adequate oral health care and keeping appointments. In Tennessee, Doral also works with the Colgate's Bright Smiles, Bright Futures program to provide patients with initial screenings, as well as a referral to a dentist for future care. In Washington, a key part of the ABCD program is patient education. Many providers refuse to see patients until they have completed the education component, which addresses topics like keeping appointments and calling if late.

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ASSESSING THE IMPACT OF INCREASED REIMBURSEMENT RATES

The reforms undertaken by the study states resulted in improvements in enrollees' utilization of services and the number of providers participating in the program. It is important, however, to balance the positive outcomes against the higher expenditures needed to attain them.

Raising rates can be thought of as a two-step process: first, the state is paying more for the services that are currently being provided, sometimes as much as doubling the payment for services to approach parity with dentists' usual rates. Second, if the state is successful in attracting more dentists and expanding the number of services performed, expenditures will rise further. Additionally, there may also be other administrative costs involved, such as the payments that Tennessee and Virginia make to their administrative services contractor, Doral.

All of these factors can combine to result in dental program spending that can be triple or quadruple the level preceding reform. However, dental spending is a small part of overall Medicaid spending – under two percent of total program expenditures³⁶ – so, even with large growth in expenditures, it will still be a tiny piece of the Medicaid pie relative to other Medicaid services such as prescription drugs or nursing home care. Increasing Medicaid dental expenditures would also bring them closer in line to overall national health expenditures, in which dental expenditures represent five percent of total spending.³⁷

Nonetheless, dental rate increases are investments that must be sustained over time, so it is important to gauge whether the benefit derived from rate increases is proportionate to the size of the investment. It is also important to assess whether there is a particular threshold level of reimbursement that produces and maintains the utilization and participation increases that states desire.

Positive Outcomes

In all of the six states examined, provider participation increased by at least one-third, and sometimes more than doubled, in the first two years following the rate increase. Not only did the number of enrolled providers rise, but states also saw an increase in the number of patients treated. Many state informants revealed that, prior to the rate increases, providers were enrolled in Medicaid but did not necessarily treat a significant number of Medicaid patients. In Michigan's fee-for-service program, which operates in the state's urban areas and is not as well-regarded as Healthy Kids Dental, only 22.8 percent of the state's 6,500 participating dentists submitted any dental claims in a year. Only 8.8 percent submitted annual claims worth more than \$10,000, meaning they treated approximately three to four Medicaid-enrolled children per week.³⁸ Following rate increases though, many providers who were already enrolled in Medicaid began treating more Medicaid patients. South Carolina and Tennessee both reported that existing providers began seeing Medicaid children after the rate increases. Doral of Virginia also said that the portion of providers submitting claims rose from about 50 percent, prior to the state's rate increase, to 80 to 85 percent today.

Patients' access to care also increased after new rates were implemented. This improvement is reflected in both the percentage of enrollees receiving services (which is shown in Table 1, and discussed below), and also in reports that enrollees encountered less difficulty finding care. Since their state program reforms, Alabama and Michigan received fewer calls from parents unable to find a dentist, according to Medicaid officials who were interviewed. In Michigan counties served by Healthy Kids Dental, provider participation not only increased, but providers were more geographically dispersed, and the distance that children had to travel for care was cut in half, from 24.5 miles to 12.1 miles.³⁹

Table 1 summarizes the outcomes that the study states experienced regarding increases in patient utilization of services (based on a common state Medicaid reporting tool) and provider enrollment.

Increased Patient Utilization of Services

There are several ways to gauge access to dental care. By any measure, the study states all experienced improvements in the percentage of their Medicaid enrollees who received dental care. However, states used several methods of measuring their progress. These different measurement methods can produce distinctions that are worth noting.

The most commonly cited measure for access to dental care in Medicaid uses the CMS-416, an annual report states provide to the federal government on the statewide performance of their EPSDT program for all children from birth through age 20. Dividing the total number of enrollees in the state receiving any dental service by the total number of children enrolled in Medicaid at any time during the year yields a percentage of children using dental services. This is the figure reported in Table 1, which shows progress in every state within two years of the reform that has continued through federal fiscal year 2006, the latest year available. This progress happened even though the reforms took place during a period of expansion in the number of people insured by Medicaid and SCHIP programs. (This means that the absolute number of receiving dental care increased faster than Medicaid enrollment expanded.)

Some states feel that the utilization rate for children ages 3 through 20 (rather than birth through 20) is a more appropriate measure. The use of services by children under age 3 is very low (nationally, 8 percent of Medicaid-enrolled children in this age range received a dental service in 2006), and general dentists usually do not see children below this age. Using this measure, patient utilization rates are higher for most states – for example, Alabama's utilization rate for this age group rises from 27 percent in 2000, to 35 percent in 2002, to 45 percent in 2006.

An alternative method of calculation available is similar to one used by managed care organizations. This method looks at services provided to beneficiaries who are continuously enrolled in the program for an entire year. The idea behind this measure is that it is fairer to count the utilization rate of enrollees whom the program has time to locate and reach, rather than anyone who dropped into and out of the program during the course of the year. Michigan researchers using this methodology have found that, in the counties served by Healthy Kids

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

Utilization data calculated from Annual EPSDT Participation Report (CMS-416), 2000-2006. Provider data from various state sources. 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.

Sources: American Dental Association, *State and Community Models for Improving Access to Dental Care for the Underserved- A White Paper* (Chicago: American Dental Association, October 2004);

(Alabama) Alabama Medicaid Dental Statistics, Fiscal Years 1998-2007 (available at http://www.medicaid.state.al.us/documents/ROBIN_5_16_05/3A_Dental/3-A-6_DENTAL_Stats_FY07_11-13-07.pdf); Key informant interview with Mary McIntyre; M. Greene-McIntyre, M.H. Finch, and J. Searcy, "Smile Alabama! Initiative: Interim Results from a Program to Increase Children's Access to Dental Care," *The Journal of Rural Health* 19 Supplement (2003): 407-415.

(Michigan) T. Finlayson and S. Eklund, "Michigan's Medicaid *Healthy Kids Dental* Program: Assessment of the First Five Years," presentation to UCSF DPH seminar (April 17, 2007). Retrieved March 3, 2008.

<http://www.ucsf.edu/dphtalk/Powerpoint%20Presentations/Finlayson%20Presentation%204-17-07.PPT>.

(South Carolina) P. Nietert, W.D. Bradford, and L. Kaste, "The Impact of an Innovative Reform to the South Carolina Dental Medicaid System," *Health Services Research* 40, no. 4 (August 2005): 1078-1091; D. Schneider, *CDHP State Summary: South Carolina Dental Medicaid* (Washington, D.C.: Children's Dental Health Project, January 2007).

(Tennessee) Doral USA, *Strides in Dental Access for Low-Income Children: Lessons Learned from Six States with Major Dental-Medicaid Reforms* (Mequon, WI: Doral USA, 2007); D. Schneider, *CDHP State Summary: Tennessee's TennCare Program* (Washington, D.C.: Children's Dental Health Project, January 2007); State of Tennessee, Bureau of TennCare press release, "TennCare Announces Dental Contract Winner, August 31, 2005."

http://www.tennessee.gov/tenncare/news/2005_releases/DBM_RFP_Awarded083105.pdf; M. Berthold, "Tennessee Winning: Dental Medicaid Provider Network Up 80 Percent," *ADA News* (May 21, 2004). Retrieved March 3, 2008.

<http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=895>.

(Virginia) Doral Dental, Presentation to the Virginia Dental Advisory Committee (October 26, 2007). Retrieved March 3, 2008. http://www.dmas.virginia.gov/downloads/dental-Doral_Presentation_updt.ppt.

Dental, utilization among the continuously-enrolled rose from 32 percent in 1999, before the program began, to 49 percent in 2001 (the first year of the program) and continued to rise to 53 percent in 2005.⁴⁰

Finally, some states have developed other ways to measure utilization. Tennessee, for example, developed an alternative measure for dental screenings in accordance with the agreements reached in its legal proceedings. By this measure, the state reported dental utilization ratios of 35.7 percent in 2002 and 52.8 percent in 2005.⁴¹

To put Medicaid utilization rates in context, a recent study of data from the Medical Expenditure Panel Survey found that in 2004, 58 percent of children ages 0 through 20 with private dental insurance received dental services.⁴² Even under the most generous measurement techniques, the states that are Medicaid “success stories” have dental utilization rates that still fall short of this mark. This does not negate the progress these states have achieved, but points to the need for states to continue their hard work, and to explore other solutions as well. This is especially true given that dental disease is particularly concentrated among people with low incomes, so it can be argued that states ought to be seeking Medicaid utilization levels that are higher than for the privately insured. On the other hand, the fact that 42 percent of children with private dental coverage do not receive annual dental care suggests there may be a limit to how high Medicaid utilization rates can go.

State Expenditures

The study states all succeeded in providing dental services to more of their enrollees, and they paid more per enrollee. The increases in utilization are generally in proportion to the percentage increases in state spending – that is, in states like Tennessee and Alabama, the state roughly doubled its expenditures per enrollee, and provided services to twice as many people. This is illustrated by Table 2, which shows data for three of the study states from the federal Medicaid Statistical Information System (MSIS). MSIS collects information on both service utilization and expenditures.⁴³ In Tennessee, the number of users of dental services more than doubled, and the payments per user also more than doubled. Combined, this meant an increase in total state spending of more than 350 percent.

Alabama’s story is similar, with increases in users that are comparable to (even somewhat greater than) the increase in payments per user, and total expenditure increases of almost 300 percent. Again, while this increase is small in comparison to the total size of a state’s Medicaid budget, it may complicate efforts to maintain rate increases in later years. Dr. Mary McIntyre, who was a main force behind *Smile Alabama!*, and other researchers, commented in an article that, “The ability to support further rate increases is questionable in light of budget problems occurring in the state, which are consistent with the budget experiences of most states.”⁴⁴

Table 2. Changes in dental payments and users in selected reform states, through federal fiscal year 2004

State	Alabama			South Carolina			Tennessee		
	2000	2004	Percent Change	2000	2004	Percent Change	2002	2004	Percent Change
Number of Enrollees Using Services	72,287	155,541	115	162,567	256,782	58	131,899	286,314	117
Total Dental Payments	\$11,465,011	\$44,449,030	288	\$48,151,459	\$89,304,420	85	\$28,660,471	\$130,284,595	355
Payment per User	\$159	\$286	80	\$296	\$348	18	\$217	\$455	110

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

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Rate Threshold

Interviewees agreed that, at a minimum, rate increases must be sufficient to raise payments to a level where the provider does not lose money by participating in Medicaid. There was less agreement, however, on whether there was a particular level of reimbursement that triggers interest in participation among providers.

The interviewees noted that rate levels greatly impact dental providers' willingness, more so than medical providers, to participate in Medicaid, due to the high overhead costs that are unique to dentistry. As compared to medical providers, most of whom practice in hospitals or corporate entities, "more than 92 percent of dentists are in private practices, and 79 percent are sole proprietors."⁴⁵ Dental overhead costs have been estimated to comprise 60 percent to 65 percent of providers' income – depending on state taxes. Interviews with dental associations in Michigan and Tennessee also mentioned this amount, noting that any reimbursement below 50 percent of UCR fails to even meet the provider's overhead costs of providing care. One former South Carolina Medicaid official said that if providers are reimbursed less than 65 percent of UCR, they are in fact subsidizing patients' care, which makes them less willing to work with Medicaid.

TennCare's Dental Director, Dr. James Gillcrist, stated that, despite the prevailing opinion that reimbursement rates need to be set at the 75th percentile of the fees currently charged by dentists in a state's geographic region to obtain provider participation, "there is no magic fee percentile." In fact, the states studied here instituted a variety of fee schedules that were often based on data that were already several years old. Under the 2002 rate increase in Tennessee, dentists' fees were increased to the 75th percentile of ADA's 1999 regional fee survey. Since the fee schedule was three years old, providers and the dental association lobbied for an increase to the 90th percentile of ADA's 1999 fees, theorizing that the difference between the 75th and 90th percentile would offset any inflation that had occurred since 1999.⁴⁶ Although Tennessee adopted the lower of the two percentiles, the rate increase and administrative changes were more than adequate to increase dentists' participation in the program by 120 percent. Dr. Gillcrist estimated that at the time of the TennCare dental carve-out, the fees were actually closer to the 55th percentile of the 2001 ADA fee survey. Based on Tennessee's experience, Dr. Gillcrist surmised that a sufficient number of community-based providers are likely to participate if fees are set at the 50th percentile or greater, and the 25th percentile may be a threshold at which these participating providers would become discouraged, and not accept new patients, and new providers be deterred from participating in Medicaid.

Sustaining Initial Impacts of Increased Rates

Even though states may increase their reimbursement rates and program spending, these interventions need to be sustained over time. The gains in utilization and provider participation may level off or reverse if inflation overtakes the effect of the rate increase. Interviewees in the study states said that there was no set time period after which the rate increases' initial impacts subsided. This is because, as states began to hear dissatisfaction among providers, they implemented creative strategies to sustain their provider participation and utilization gains in lieu of further rate increases.

In Washington, the state's pilot ABCD program was initially implemented in 1995. ABCD offers enhanced rates on about 20 procedure codes for children ages 0 to 5. Including the add-on, ABCD enhanced rates initially were set at the 75th percentile of dentists' rates; however, the state legislature has not adopted another large increase since 1995.⁴⁷ Since the program's enhanced rates were implemented more than a decade ago, provider participation in treating Medicaid recipients under 18 has begun to decline. According to ABCD's Medicaid data from 2004 to 2005, "statewide, the number of dental providers treating Medicaid patients under 18 decreased by 14.2 percent, but the rate of reduction was twice as high in non-ABCD counties (21.8 percent) as in ABCD counties (10.7 percent)."⁴⁸ According to Dr. John Davis, the Dental Administrator at Washington's Department of Social and Health Services, 40 percent of the state's dentists are willing to see children enrolled in the ABCD program.

While for Washington it took over a decade after the state's initial rate increase before provider participation began to decline, other states may hear providers' push for increases after a much shorter time span. Virginia's providers received a 28 percent increase in 2005 that was allocated across all dental codes, supplemented with an additional 2 percent increase in 2006 that was targeted to oral surgery codes. To date, provider participation has continued to grow; however, dentists have begun to ask for a cost of living increase of one or two percent. In Virginia's case, the 2007 shootings at Virginia Tech have focused the state's attention and finances on mental health, leaving few resources for other health provider increases. Aware of this, dentists have not yet begun formal lobbying efforts for another increase.

Michele Blackwell, Executive Director of Doral Dental of Tennessee, indicated that a portion of their annual client meetings with Tennessee has been devoted to provider networks and how inflation has impacted provider rates, program costs, and provider participation over time. She stated that the TennCare Bureau has always been receptive to recommendations for fee increases when such increases were well supported by sound data. In fact, the Bureau of TennCare has included dental provider fee increases among its improvement requests, although not all such requests have been approved. The Tennessee Dental Association also advocates for a proactive approach that entails building into the budget smaller annual inflationary increases rather than larger, but less frequent, fee increases.

Alabama, South Carolina, and Michigan all reported that providers have asked for fee increases as well.

The Alabama Dental Association said that providers are not yet leaving the Medicaid program because they understand that the state's budget has been too tight to allow for rate increases.

South Carolina has also not seen a drop in participation, although the dental association noted that some providers are limiting their intake of new Medicaid patients. It has been seven years since an increase was enacted, so the South Carolina Dental Association (SCDA) will offer a proposal this year for another increase. The SCDA is not hopeful that new rates will be approved, but a proposal will "plant the seeds for another increase," according to Phil Latham, SCDA's Executive Director.

In order to expand the number of Healthy Kids Dental pilot counties in Michigan, last year the state adopted Delta's fixed PPO reimbursement schedule, which is lower than the company's Premier rate. Even with the switch from the Delta Premier plan to the Delta Preferred Option plan, providers still receive fees that are higher than fee-for-service Medicaid. However, the Michigan Dental Association reports there was a 14 percent drop in participation associated with the change in plans. Some providers ended participation because they felt that the program was going backward; others misunderstood the nature of the shift, and believed that they would be newly responsible for seeing fee-for-service Medicaid patients. Since the change, the Michigan Dental Association has worked to educate providers about what the switch entails.

While oral health providers and their professional associations generally advocate for fee increases on par with dentists' usual charges, in the states studied they were understanding of state budget constraints. States have been largely able to minimize the number of providers leaving Medicaid, even seven years after fee increases, by maintaining open communication with dental societies and working with them to implement creative administrative and fee-related stopgap measures adapted to state needs. For example:

- Alabama has worked to improve claims forms and has removed preauthorization requirements for some procedures. The state also created an emergency preauthorization process for dentists with high need patients. Alabama works regularly with a dental task force to highlight other possible policy changes and program issues. Currently, the task force and Medicaid are considering shifting existing funds, eliminating funds for unused procedures, and providing higher reimbursement rates for ones that are more common.
- After a rate increase was enacted in 2000, one Medicaid official estimated that South Carolina had about 700 to 800 enrolled providers. Only one year after its increase, though, the state faced a budget crunch, and reduced the Medicaid dental program. Medicaid officials had planned an across-the-board rate cut, but presented this idea to the state's dental task force before enacting any changes. The dental association worked to develop an alternative proposal, generally maintaining the increased rates but eliminating reimbursement altogether for some procedures. Medicaid adopted the proposal, and publicized the changes as South Carolina Dental Association recommendations. The state was able to maintain dentists' participation, currently at over 1,200 providers, with only a "small blip," according to a former official of the state's Department of Health and Environmental Control.
- Washington State's ABCD program was originally based on targeted fee increases, coupled with provider education, family education, and streamlined administrative functions. Without funding for increases to all of ABCD's codes, the state's Medicaid agency is implementing a number of administrative changes in an effort to sustain providers' participation in the program: providers can now use an electronic clearinghouse to submit patient x-rays; the state may eliminate preauthorization requirements for several procedures; and the state is moving to a Web-based, user-friendly computer system this year. Regarding the adults' fee-for-service program, Washington has begun targeting increases to certain codes, like removable prosthetics and endodontics, rather than implementing minimal increases across all codes.

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THE CALIFORNIA LANDSCAPE

California has experienced many of the same pressures as the study states: a limited number of dentists who participate in the program, limited access to care for Medicaid enrollees, and even a class-action lawsuit on access to dental care. About 40 percent of the state's licensed dentists are enrolled as Denti-Cal providers, and about three-quarters of those see 50 or more Medicaid-enrolled patients in a year.⁴⁹ In 2006, 28 percent of children enrolled in Medicaid received a dental service, according to the annual CMS-416 report. This is a small decline from a recent high of 32 percent in 2003.⁵⁰

California has used many of the same approaches as the study states to address the issue of oral health access. Medi-Cal contracts with Delta Dental of California for dental program administration. The state also now requires an oral health screening within one year of a child's entering public school. Also, in contrast to most of the study states, Denti-Cal offers coverage of a wide range of dental services to Medicaid-enrolled adults.⁵¹

Agencies outside of state government are also focused on the issue. The Oral Health Access Council is a large and well-organized oral health coalition which works on many issues, including oral health financing. The California Dental Association is engaging legislators with recommendations on ways to improve the Denti-Cal program.⁵²

However, the actions taken by the study states – reimbursement increases and administrative simplification – have often not comported with California's budget realities and legislative priorities. Although reimbursement rate increases may not be feasible in this year's restrictive fiscal environment, it is possible that the lessons learned from the study states can at least inform the state's decisions on administrative processes and rate increases in the future.

Reimbursement Rates

Similar to the initial situation faced by the states in this study, reimbursement rates for California's Denti-Cal program providers are well below the usual fees of dentists in the state. Denti-Cal rates for many commonly performed pediatric procedures are only one-half to one-third of the 75th percentile of dentists' fees. A recent California HealthCare Foundation report called the state's reimbursement rates "among the lowest of all state Medicaid programs."⁵³ Figures 1 and 2 compare California's fee-for-service reimbursement rates for dental examinations and extractions to the six study states, and also to the national 75th percentile of fees, as measured by a 2005 ADA survey of dentists. When compared to the states in this study, only Michigan's fee-for-service rates were consistently lower than California's reimbursement rates, and a majority of Michigan's 83 counties use Delta Dental's higher fee schedule rather than fee-for-service rates.

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

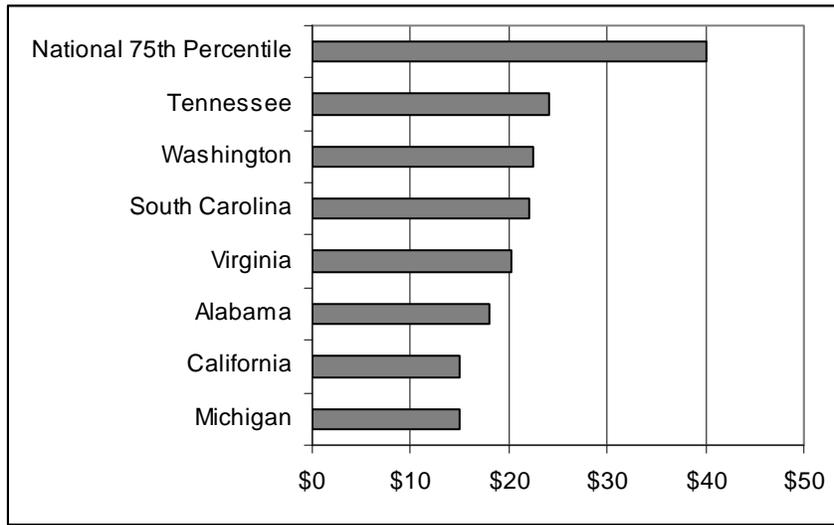
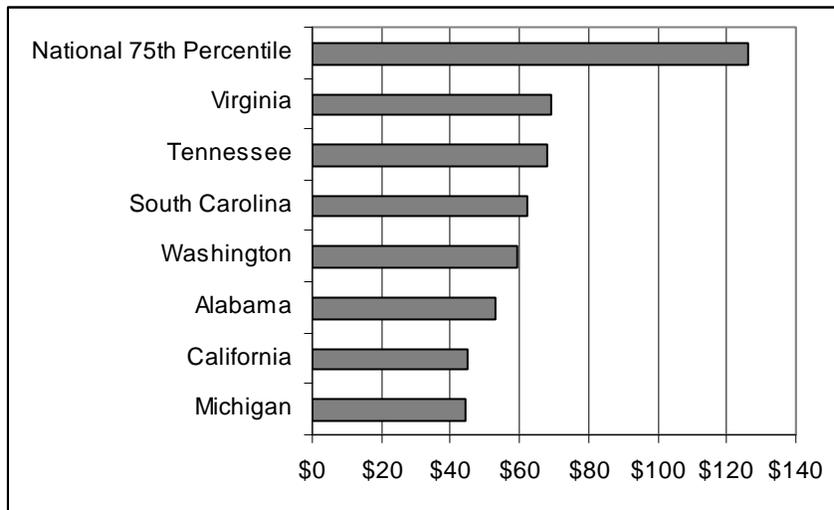


Figure 2. Comparison of fee-for-service reimbursements for tooth extractions



These tables use Current Dental Terminology procedure codes D0120 and D7140.

Sources for Figures 1 and 2: American Dental Association Survey Center, *Survey of Dental Fees* (Chicago, IL: American Dental Association, 2005). Virginia Department of Medical Assistance Services, Smiles For Children Current Dental Rates. http://www.dmas.virginia.gov/downloads/pdfs/dental-feeSched_501-06.pdf. Retrieved November 2007. Washington Health Recovery Services Administration. Dental Program Fee Schedule. http://fortress.wa.gov/dshs/maa/RBRVS/2007_Fee_Schedules/HRSA_August_1_2007_Dental_Fee_Schedule.xls. Retrieved November 2007. American Dental Association, *State Innovations to Improve Access to Oral Health Care for Low Income Children: A Compendium Update* (Chicago, IL: American Dental Association, 2005).

In the wake of the 1990 *Clark v. Kizer* decision, California was ordered to increase its provider rates for many procedures to 80 percent of average amount billed (with regular cost of living increases), and also conduct outreach to both enrollees and providers. While the enhanced outreach unit was established, and the rates for the targeted codes were gradually moved upward through the mid-1990s, later budgetary pressures and actions of the state legislature prohibited

their continuation.⁵⁴ In the 2000s, the legislature has periodically enacted further restrictions on the Denti-Cal program in response to budget pressures. Between 2003 and 2006, the legislature imposed increased requirements for x-ray documentation of medical necessity for restorative care; limitations on coverage for certain services, including crowns; an annual benefit cap of \$1,800 for adults (with a number of exceptions); and, briefly, a 5 percent rate reduction.⁵⁵ As of this writing, Governor Schwarzenegger's plan to address California's record budget deficit includes an elimination of adult dental benefits, a 10 percent rate reduction for providers (already enacted), a \$1,000 annual cap on dental benefits for children enrolled in the state's SCHIP program, and a 5 percent rate reduction for SCHIP dental plans.⁵⁶

Administrative Concerns

Although Denti-Cal engages a dental benefits administrator, as do many of the study states, California dentists express concerns that legislative actions and Denti-Cal program requirements impose barriers to their participation in the program. Particularly, they note:

- Dentists must submit pre-treatment x-rays to document medical necessity when four or more restorations are done in a year.
- Dentists can only be reimbursed for prefabricated stainless steel crowns (and not laboratory-processed crowns) on adult posterior teeth. Dentists may feel that this does not meet the accepted standard of care for dentistry, and perceive the restriction as “punitive and not in the best interest of the patient.”⁵⁷
- The Medi-Cal provider enrollment forms are paper-based, lengthy, not specific to dentists, and require supplemental information that may be confusing to dentists.

Easing administrative barriers such as these may not require a large expenditure of state funds, but might go some way to building trust in the provider community.

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FINDINGS AND CONCLUSIONS

Survey research, available literature, and interviews with key stakeholders in six study states indicate that higher fees positively influence: (1) dentists' willingness to accept new Medicaid-enrolled patients; and (2) Medicaid patients' access to and utilization of needed oral health care. The study states all enjoyed improvements in the percentage of children utilizing dental services (even in a period of expanding Medicaid enrollment), although they have not yet reached the utilization levels of privately insured children. The changes that these states made did mean they substantially increased their spending on dental services, but even so, dental spending is still only a small piece of total Medicaid expenditures.

In 23 informant interviews, the question was posed: "In hindsight, were reimbursement rates the most important thing in improving the functioning of the Medicaid dental program? Were other factors important?" Of the interviewees' responses:

- Four individuals said that reimbursement rates were indeed the most important thing.
- Sixteen individuals noted that reimbursement rates were necessary, but not sufficient, in and of themselves to improving Medicaid dental programs.
- Six individuals said that another factor, other than reimbursement rates, was most important. (Three of these respondents also concluded that reimbursement rates must accompany these reforms.) The factors that they noted included: moving to a dental benefits administrator or carve-out; streamlining administrative aspects of the Medicaid dental program; and changing providers' perception of participating in Medicaid so that they no longer view it as inherently burdensome.

A majority of experts interviewed felt that adequate reimbursement rates (meaning rates that at least met the overhead expenses of dentists in private practice) were necessary—but not sufficient on their own – to improve access to Medicaid dental services. Simply injecting funding into higher rates was not thought to be enough to substantially improve the program. Some dentists have had negative experiences with Medicaid, and enhanced fees alone may not convince them to start working with the program again. This finding is consistent with two surveys of dentists undertaken in Kansas and Ohio. Survey respondents in those states viewed low fees as the greatest problem with Medicaid; however, respondents in both studies also noted broken appointments and administrative hassles as significant problems. This led researchers to conclude that other actions beyond changing reimbursement rates may be necessary to influence dentists to begin or continue participation in Medicaid.⁵⁸

Many experts also noted the importance of a good relationship between Medicaid staff, the state dental society, and individual dentists in the community. Alabama, Michigan, South Carolina, Tennessee, Virginia and Washington's dental Medicaid officials all worked closely with the state dental society, as well as oral health coalitions, to determine the cause of low provider participation and utilization barriers. States developed proposals and program changes targeted to address provider concerns, and maintained open communication with providers throughout the program changes. Dental societies played a key role in recruiting providers to begin treating Medicaid enrollees, and continued to inform Medicaid of any known problems that should be

addressed. This relationship, as well as the dedication of Medicaid dental program staff, has allowed Medicaid to quickly respond to dentists' concerns and maintain their participation in the program, even in more restrictive budget environments.

As in most states' Medicaid dental programs, California has room to improve in its beneficiary utilization and provider participation. 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 even modest budget increases can be successful if they are coupled with intensive efforts to partner with dentists and respond to their concerns. To achieve access improvements, California can consider smaller, targeted rate increases for selected services or special populations, as Virginia and Washington have done, or measures to streamline administrative processes, that might incur very little cost.

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