Medicaid Reform

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Goal

Identify federal legislative opportunities to improve public dental coverage for children

Objectives

Describe temporal trends in terms of federalism and commercialism

Consider options for improving dental access through new state options

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History of public dental coverage

1965	Medicaid enacted with no dental guarantee
1967	Early and Periodic Screening Diagnostic and Treatment (EPSDT) *benefit* that includes comprehensive dental services
1989	OBRA tightened dental benefits & enhanced guarantees
19xx	1115 Waivers cost neutral expansions that spurred managed care adoption
1997	State Children's Health Insurance Program (SCHIP) created as response to Medicaid - no dental guarantee ("The New Medicaid")
2001	Health Insurance Flexibility and Accountability (HIFA) waivers mimicked commercial coverage in Medicaid
2006	Deficit Reduction Act of 2005 (DRA) expanded state flexibility and allowed end of "statewideness"
2007	(S) CHIP reauthorization – pending dental benefit through dental benchmarks

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Evolution of Public Programs

Themes

- Increased federalism
  1. Greater state autonomy
  2. Decreased federal oversight
  3. More opportunities for state experimentation

- Increased commercialism
  1. Options and incentives for mimicking commercial plans
  2. Advent of “Benchmarking”

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Philosophy by party-in-control

Year	Program	President	Congress	Approach
1965	Medicaid	Democrat	Democrat	Nationalist
1967	EPSDT	Democrat	Democrat	Nationalist
1989	OBRA	Republican		Nationalist
19xx	1115			Federalist
1997	SCHIP	Democrat	Republican	Federalist
2001	HIFA	Republican	Republican	Federalist
2006	DRA	Republican	Republican	Federalist
2007	SCHIP II	Republican	Democrat	Nationalist??

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Comparing approaches

Nationalist

1. Children's needs are the same no matter where they live
2. Federal government has predominant role in policymaking
3. Individual entitlement is appropriate
4. States must be accountable to the federal government
5. Vulnerable children are exceptional and require their own approach to coverage
6. Government shares responsibility with parents

Federalist

1. States vary so substantially that coverage must be tailored to state opportunities
2. State government has predominant role in policymaking
3. State entitlement is appropriate
4. States are accountable to their citizenry
5. Vulnerable children should be "mainstreamed" and have same coverage as private
6. Parents have overwhelming responsibility

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EPSDT & OBRA 89

- Individual entitlement
- Benefit is for any and all services needed by children to address health problem that is identified on screening
- Dental examination by a dentist is required
- Comprehensive dental is required
- States must annually report number of children by age who receive dental services including any, preventive, and treatment services (“416 report”)
- Virtually no cost-sharing allowed
- One-size-fits all – single statewide program
- Significant federal oversight
- State flexibility only in income group to be covered

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1115 Waivers

- Cost neutrality: more children covered with same benefit and same dollars through managed care
- First mimicking of commercial coverage
  - Beginning of provider networks & credentialing
  - FFS replaced by capitation and/or flexible negotiated fee schedules
  - Risk contracting induced perverse incentives
  - Erosion of reporting validity
  - Efforts to manage stigma through name changes and direct marketing
- Intense and trying federal review with transparency

Dental

- Typically subcontracted with or without financial risk
- Erosion of dentist participation due to managed care antipathy (?)
- Benefit unchanged

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SCHIP

- "Medicaid light"
  - *State* entitlement
  - Constrained benefit, dental as option
  - Minimal reporting requirements
- Mimicking commercial coverage through benchmarks
  - Federal or state health plan
  - Largest HMO in the state
  - Actuarial equivalent plan
  - Secretary approved

Dental

- Limitations, caps, prior authorizations, waiting periods, cost-sharing allowed
- Benefits vary by state
- Minimal reporting making evaluation difficult

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HIFA

- Allows states to apply benchmark benefit packages to non-mandatory Medicaid recipients (aka “expansion populations”)
  - Undermines EPSDT requirement but allows experimentation
  - Retained waiver process

Dental

- No state applied HIFA to dental coverage

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DRA

- Allow states to apply benchmark benefit packages to all Medicaid recipients
  - Allows alternative benefit packages and cost sharing
  - Undermines EPSDT requirement but promotes experimentation
  - Ends statewideness requirement
  - Eliminates waiver process at cost of lost transparency and public comment
  - Promotes “Health Savings Accounts” for Medicaid recipients (“Health Opportunity Accounts”)
  - Provides grants to states to “reform” Medicaid

Dental

- Experiments in KY, WV, ID

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(S) CHIP

Turn away from federalism but vetoed by president

- Partial reversal of Federalism approaches
  - DRA clarified to require EPSDT benefit for “mandatories”

Dental

- Dental requirement added to benefit package using “dental benchmarks”
  - Federal and State Employee plan, Largest dental plan with dependent coverage, Actuarial equivalen, Secretary approved
- Fate of caps uncertain
- Enhanced accountability: 416 reporting requirements extended to CHIP
- Additional dental measures
  - Required reporting on sealants
  - Newborn family oral health counseling
  - Access study including midlevels
  - Dental included in federal quality initiatives
  - Facilitates public-private contracting

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Options and opportunities

- City or county level demonstrations
- Different fee schedules
- Targeted benefits to specific subpopulations
- Pay for performance trials
- Integrated delivery systems
- Contracting private dentists to health centers

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