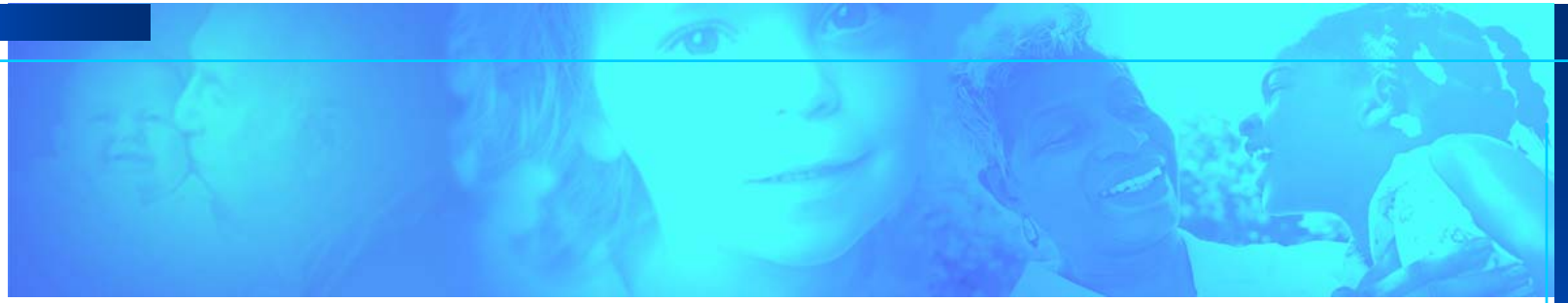

Medicaid Dental Programs: Successful / Unsuccessful Reforms

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2007 APHA Annual Meeting

November 6, 2007

Washington, DC

Presentation Outline

- Medicaid challenges
  - Disease burden
  - Historical shortcomings
    - Financing / Program Administration / Outreach & Care Coordination
- Brief overview of factors contributing to limited access to dental services for children covered by Medicaid
- Key elements that need to be considered in strategies for improving access to Medicaid dental services for children
- Examples of successful State dental Medicaid initiatives
- Why some efforts to improve provider participation and expand access to dental services have produced limited results.

Challenges

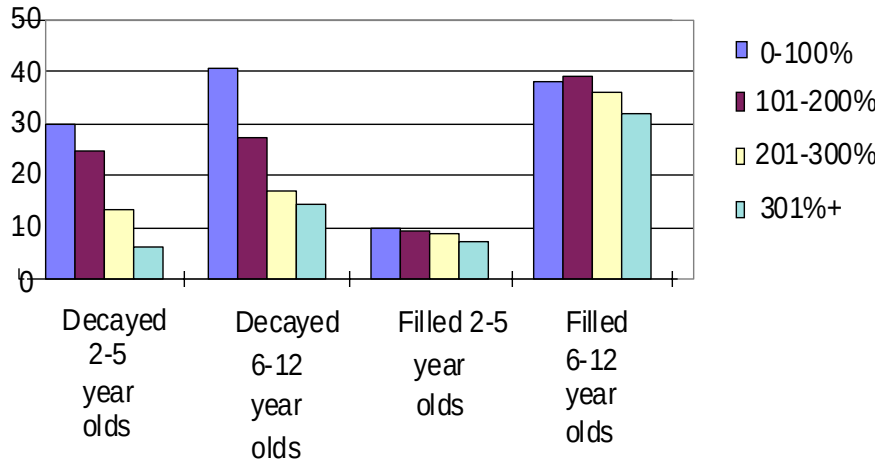
- Medicaid/SCHIP children have 3-5x more disease [*NHANES*]
- Access to dental services for children covered by Medicaid has been a chronic problem [*OIG, 1996; GAO, 2000*] -- funding is not the only issue, but it IS a major issue
- Dental decay is highly preventable, but not simply or uniformly preventable [*SGROH, 2000*]
- Medicaid EPSDT requires prevention **AND** treatment (**NOT** instead of treatment) [*Federal statutes, regulations and guidelines*]

- Dental workforce is busy and declining relative to the population, but the population is increasing, especially groups at higher risk for dental disease [HRSA *& Census Data*]

Low-Income / Racial-Ethnic Minority Children & CSHCN Have Higher More Untreated Decay

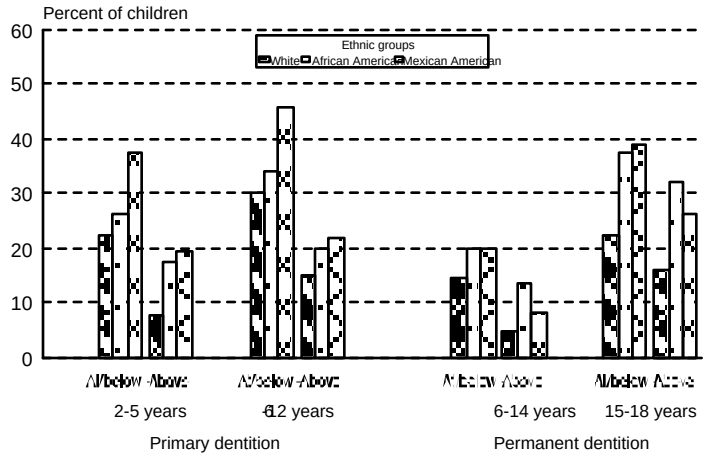
Percent of Children with Decayed and Filled Primary Teeth by Household Income Level

(by % of Federal Poverty Level)



Vargas, Crall, Schneider. Analysis of NHANES III data. JADA, 1998.

Percent of Children with Caries by Income Level and Ethnicity



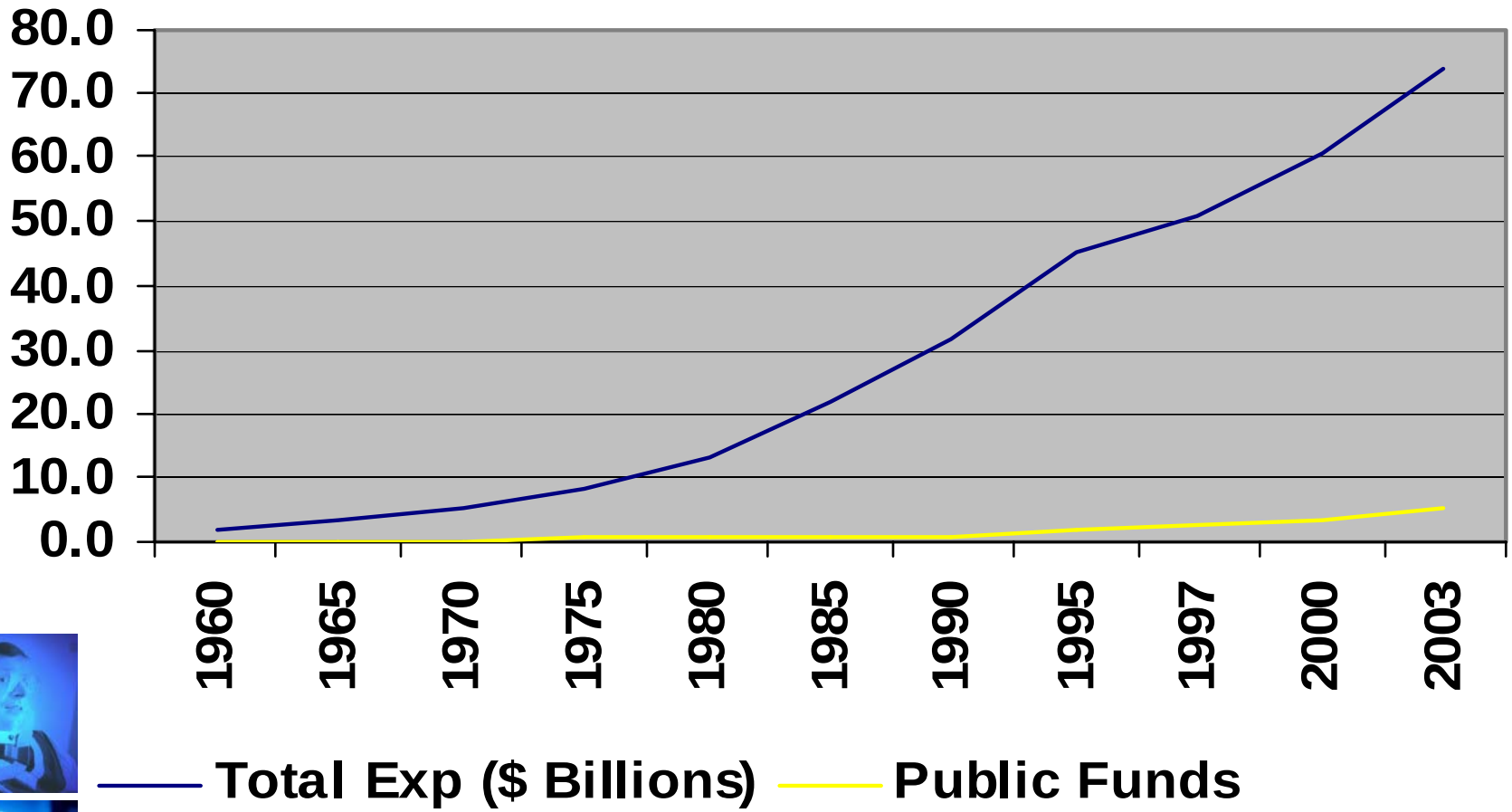
Vargas, Crall, Schneider: JADA 1998;129:1229-1238.

Increases in Low-Income, Racial/Ethnic Minority Children

- 65% of Latino children under age 6 — 3.1 million—live in low-income families
- 64% of black children under age 6 — 2.1 million—live in low-income families
- 23% of Asian children under age 6 —0.2 million—live in low-income families
- 29% of white children under age 6 —3.8 million—live in low-income families

So, . . .
how did this get to be such a mess?

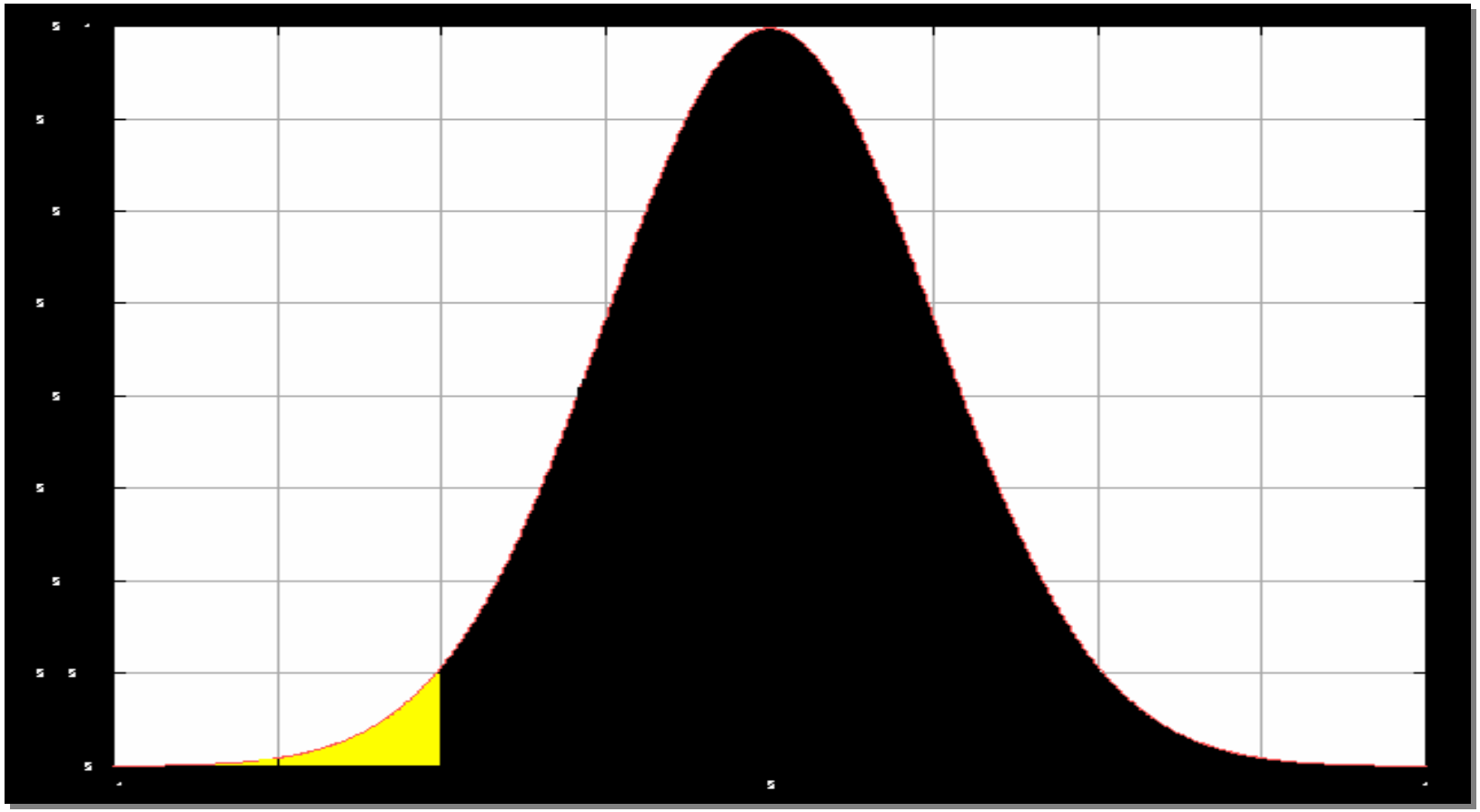
U.S. Dental Care Financing Trends: Total and Public Funding ($ Billions)



Medicaid Fee Comparisons

NJ Medicaid Payment Rates for Selected Procedures to General Dental Practitioners			Comparisons with Dentists' Claims for Insured Patients in the ADA Middle Atlantic (MA) Region and in the State of New Jersey			
CDT4 Procedure Code	Procedure Description	NJ Medicaid Payment Rate	MA Region 50th Percentile	NJ State 50th Percentile	NJ State 75th Percentile	State Percentile Corresponding to NJ Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	$14.00	$30.00	$35.00	$42.00	< 1st
D0150	Comprehensive Oral Exam	$21.00	$45.00	$50.00	$60.00	< 1st
D0210	Complete X-rays, with Bitewings	$22.00	$85.00	$90.00	$100.00	2nd
D0272	Bitewing X-rays - 2 Films	$5.00	$27.00	$30.00	$32.00	< 1st
D0330	Panoramic X-ray Film	$15.75	$75.00	$80.00	$90.00	< 1st
Preventive						
D1120	Prophylaxis (cleaning)	$13.00	$43.00	$48.00	$55.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	$9.00	$24.00	$25.00	$30.00	< 1st
D1351	Dental Sealant	$9.00	$35.00	$40.00	$47.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	$35.50	$89.00	$95.00	$124.00	3rd
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	$39.00	$115.00	$135.00	$150.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	$253.00	$670.00	$670.00	$670.00	< 1st
D2930	Prefabricated Steel Crown, Primary Tooth	$70.00	$174.00	$180.00	$180.00	1st
Endodontics						
D3220	Removal of Tooth Pulp	$26.00	$110.00	$120.00	$125.00	< 1st
D3310	Anterior Endodontic Therapy	$135.00	$475.00	$530.00	$650.00	< 1st
Oral Surgery						
D7110	Extraction, Single Tooth	$30.00	$95.00	$100.00	$125.00	1st

Expected provider base at 3rd percentile rates (ceteris paribus)



Financing Considerations: Bottom Line

- Most States' Medicaid payment rates are substantially below market rates
- Results of 3 actuarial analyses:
  - $14-$20 PMPM for services
  - $17-$25 PMPM for premiums

- Programs that don't start with adequate funding cannot succeed in meeting program requirements or the needs of children

Ceteris Paribus
"All else being equal"

MEDICAID???

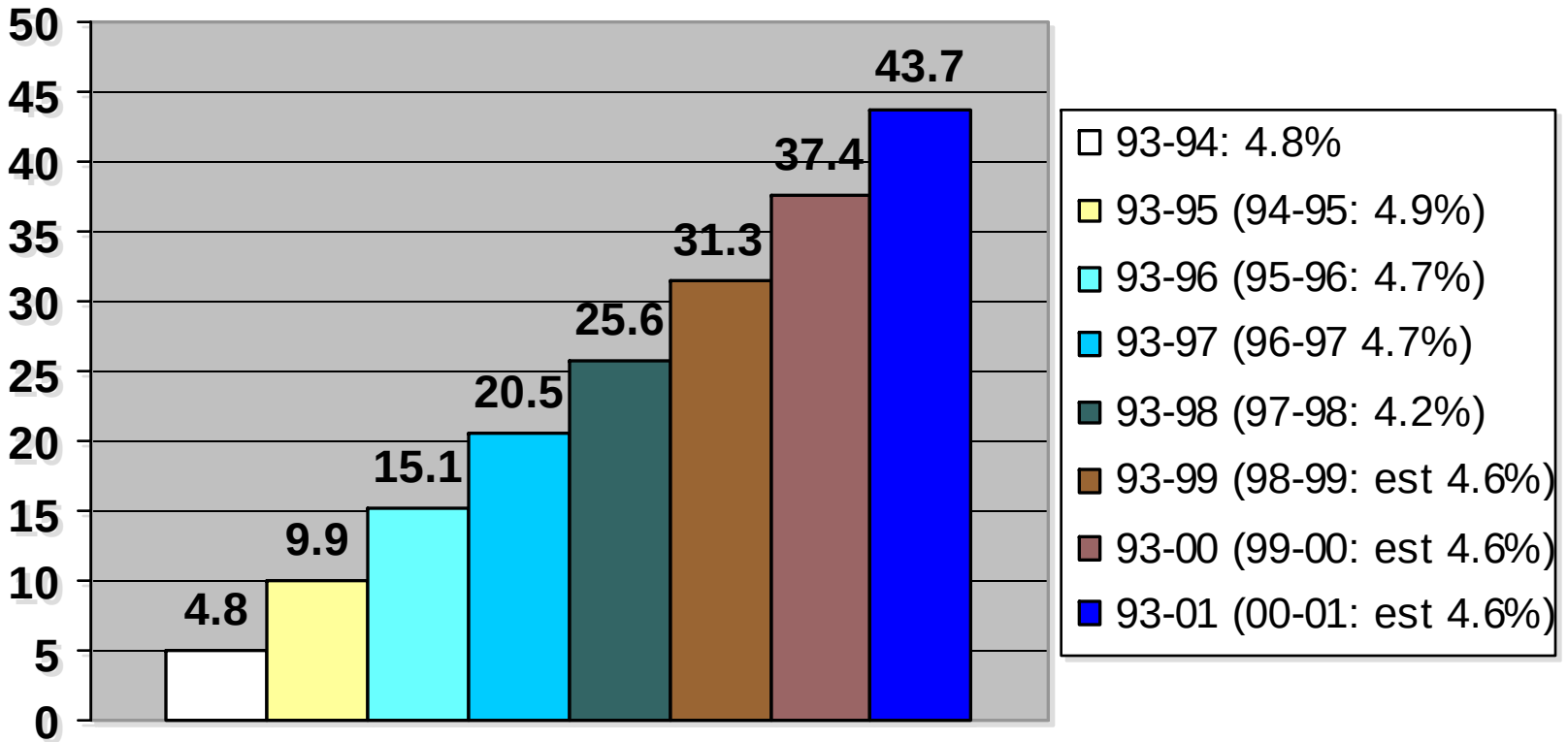
NOT !!!

- Treatment difficulty
- Staffing & management considerations
- Case management considerations
  - Broken appointments, translation, etc.

Loss of Purchasing Power in the Marketplace:

Cumulative Effects of Not Adjusting Rates for Inflation

Annual & Cumulative Increases in Dental CPI



Recent Medicaid Dental Program Changes

STATE	Adjustments Made to Medicaid Rates (Market-based Benchmarks)	Changes in Dentists' Participation in Medicaid Following Rate Increases	Intervals (mos.) Between Rate Increases and Changes in Provider Participation
Alabama	100% of Blue Cross rates	+39%	24
Delaware	85% of each dentist's submitted charges	From 1 private dentist to 108 (of 302 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% (to 1,674 of 4,000)	27
Indiana	75th percentile of dentists' fees	+58%	54
Michigan (Healthy Kids Dental Program)	100% of Delta Dental Premier rates	+300%	12
South Carolina	75th percentile of dentists' fees	+73%	36
Tennessee	75th percentile of dentists' fees	+60%	4
Virginia	30% increase	>+30%	12

State Medicaid Innovations: Alabama

- Dental Task Force → Dental Partner Work Group –> Oral Health Access Coalition → NGA Oral Health Policy Academy → "Smile Alabama"
- State-administered program
- Added coverage for several pediatric dental procs
- Targeted case management
- 1/99: Preventive/restorative rate increase of 10%
- 2000: Rates increased to 100% of BC/BS
- ~40% (>150) more participating providers

	1998	1999	2000	2001
Number with any Dental Visit (Form 416- line 12A)	**41,659**	**82,062**	**81,293**	**105,522**
Number Enrolled (Form 416 – line 1)	**330,885**	**379,282**	**391,322**	**422,938**

State Medicaid Innovations: Indiana*

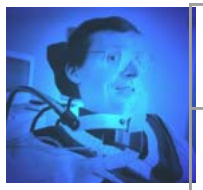
- State-administered program (dental "carve out")
- Dental Advisory Panel → policy and payments
- 1998: 147% rate increases to 75th percentile, but no increases since
- Provider participation increased from 916 dentists in 1997 to 1443 dentists in 2002

	1998	1999	2000	2001
Number with any Visit (Form 416- line 12A)	**47,730**	**104,111**	**132,563**	**160,627**
Number Enrolled (Form 416 – line 1)	**352,589**	**391,954**	**451,535**	**500,916**

* Georgia and South Carolina have adopted similar strategies

State Medicaid Innovations: Delaware

- State-administered program
- Access report (1997) → Dental Care Access Improvement Committee (1998) → NGA Policy Academy → Vision and Program Changes
- Electronic eligibility and claims submission; DE Dental Society Medicaid recruitment program; New provider office manual
- 1/1/98: Medicaid pays 85% of dentist's usual charges
- Medicaid participation: 1 → 108 (of 302) dentists



	1998	1999	2000	2001
Number with any Visit (Form 416-12A)	**8,428**	**9,699**	**13,403**	**15,430**
Number Enrolled (Form 416 – line 1)	**60,577**	**61,028**	**64,814**	**67,836**

State Medicaid Innovations: Tennessee Preliminary Progress

- 1115A Medicaid managed care → litigation → NGA Policy Academy → Comprehensive Children's Oral Health Plan → special needs project / school-based & mobile unit projects / dental "carve out" with ASO contract awarded to Doral → TDA promotion → Dental Advisory Committee
- School-based program (2001-2002):
  - 25,490 referred → 15,141 exams
- Dental "carve out" with 75th percentile fees:
  - # providers went from 386 → 618
  - > 85,930 unique TennCare enrollees < age 21 received dental treatment from 10/1 through 12/31

MI Healthy Kids Dental Program Demonstration Program Elements

- Based on success with MI-CHILD program
- Delta Dental engaged as TPA
  - Delta PPO
  - Delta Premier
- Promoted by Delta Dental and MDA

MI Healthy Kids Dental Program
Increase in Access: 1st 12 mos.

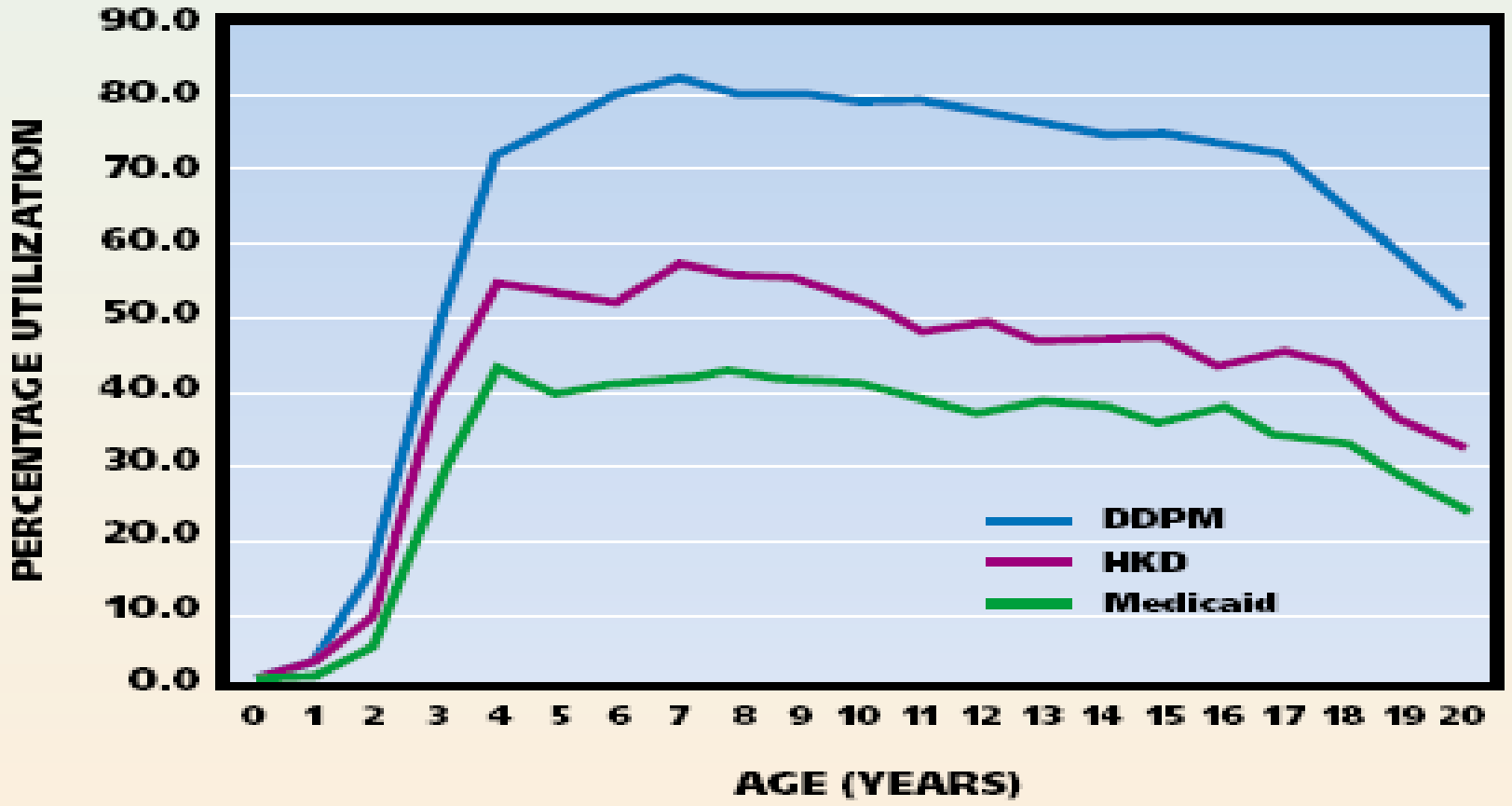
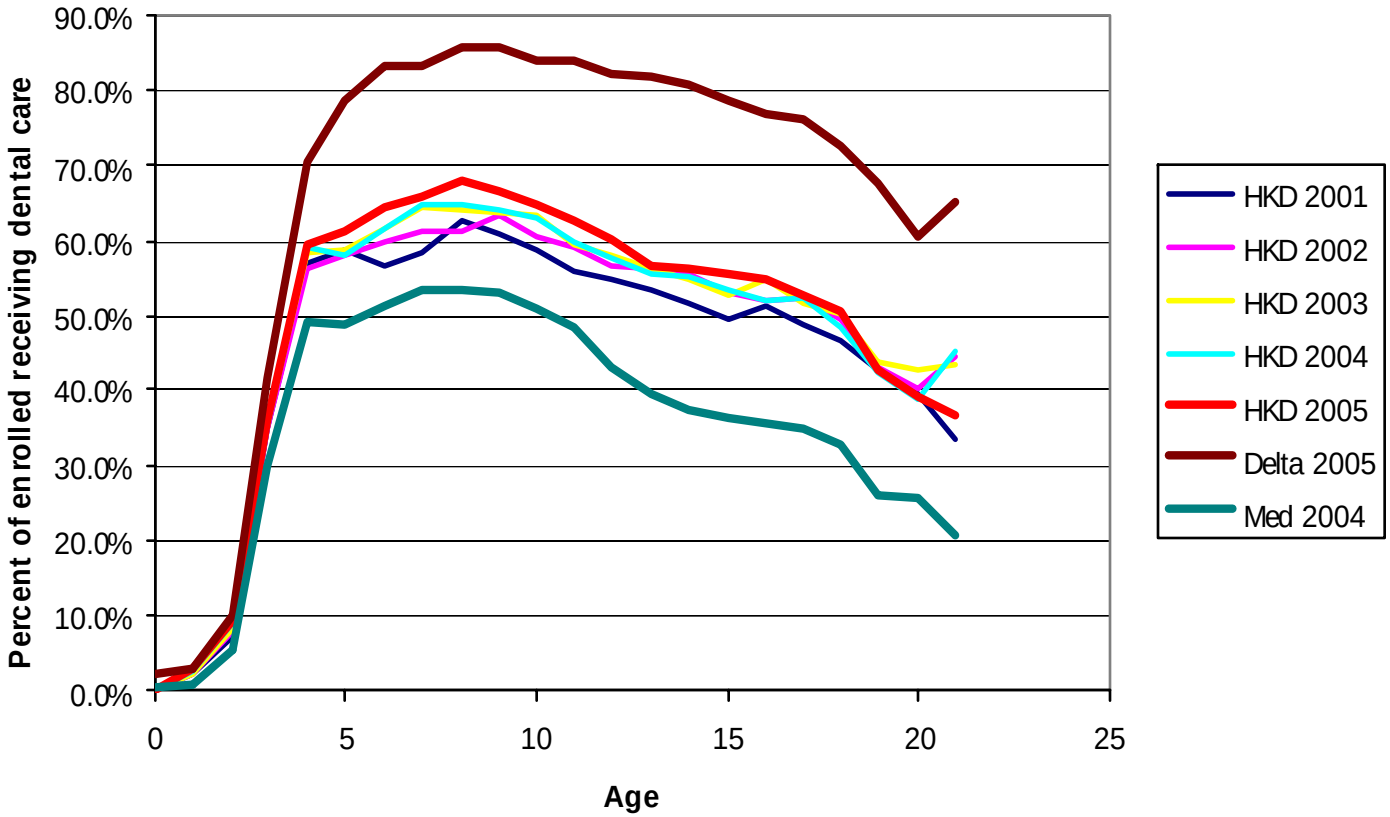


Figure. Utilization in 12 months by continuously enrolled children in 22 Michigan counties. DDPM: Delta Dental Plan of Michigan. HKD: Healthy Kids Dental demonstration program of Michigan Medicaid.

Eklund et al., JADA 2003:134:1509-1515.

Ongoing Progress: Now Approved for 59 Counties

HKD, Medicaid, and Delta private utilization of dental care, 12 month enrollment in calendar year, by age



CONCLUSION

- *HKD* has been increasing access to dental care for the child Medicaid population in the 37 demonstration counties by addressing 2 key dentist barriers (reimbursement rates, claims administration).
- More children have enrolled each year, and more local dentists are participating in the program and integrating these children into their practices and providing comprehensive treatment.

Finlayson TL, Eklund SA, 2007

Medicaid Financing in Times of State Fiscal Constraints: Don't let the perfect become the enemy of the good!

- Targeted rate increases for basic diagnostic, preventive and treatment procedures that comprise the majority of services that children on Medicaid need
  - SC → preserve rate increases and network
  - RI → RWJF SAOHA Initiative for Birth to 6 + → . . .
  - TX (litigation) → 100% increase to ~ 50th percentile
  - CT (litigation) → increase to ~ 50th percentile

SAOHA State Strategies

- Rhode Island:
  - Performance–based Dental Benefit Managers for new program targeted to providing dental homes for young children (Yr. 1: Birth – 6, with increases in the upper age limit in subsequent years due to Medicaid spending trend)
  - Partnership with community foundations for expansions of safety–net and pediatric dentistry residency training programs
  - Welfare to work dental assistant training program

Compelling Arguments

Earlier Interventions → Lower Costs

Savage MF, et al. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. *Pediatrics October, 2004.*


Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs

Matthew F. Savage, DDS, MS*; Jessica Y. Lee, DDS, MPH, PhD‡§; Jonathan B. Kotch, MD, MPH‖; and William F. Vann, Jr, DMD, PhD‡

- "The age at the first preventive dental visit had a significant positive effect on dentally related expenditures."
- **1st dental visit / Total cost:**
  - **Before age 1 $262**
  - **Age 1-2 $339**
  - **Age 2-3 $449**
  - **Age 3-4 $492**
  - **Age 4-5 $546**

'Spill Over' Into Medical Sector Costs: The effects of a dental infection are wide-ranging and long-lasting....

A week or more of pain and sleeplessness, her parents' lost work days and productivity, her own missed schooling, a futile and expensive use of a hospital emergency room, and a life-long external scar are among the ripple effects of this preventable infection.

Consequences of Limited Oral Health Access

For want of a dentist

Maryland boy, 12, dies after bacteria from tooth spread to his brain

NBC VIDEO

A deadly toothache?
Feb. 28: A 12-year-old Maryland boy is dead after a dental infection spread to his brain. NBC's John Yang reports.

Nightly News

Linda Davidson / The Washington Post

Deamonte Driver, aged 12, is shown with his mother, Alyce, at Children's Hospital in Washington, D.C., after emergency brain surgery.

By Mary Otto

washingtonpost.com

Updated: 2:20 p.m. ET Feb. 28, 2007

WASHINGTON - Twelve-year-old Deamonte Driver died of a toothache Sunday.

Summary

- Significant improvements have been achieved in several State Medicaid dental programs in recent years, but most States have not implemented systematic program reform
  - CMS 416 data show an increase from < 1-in-5 eligible children getting services in 1993 to ~30% of a much larger # of eligible children in 2005
- Critical issues to address as part of reform efforts include:
  - Financing and reimbursement
  - Program administration (private sector processes)
  - Outreach and care coordination
  - Establishing durable relationships with key stakeholders
- Progress toward achieving comprehensive reform must be guided by broad-based strategic planning, fundamental market principles, and ongoing adjustments based on evaluations of program changes or conditions