



Medicaid Dental Programs: Successful / Unsuccessful Reforms

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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.



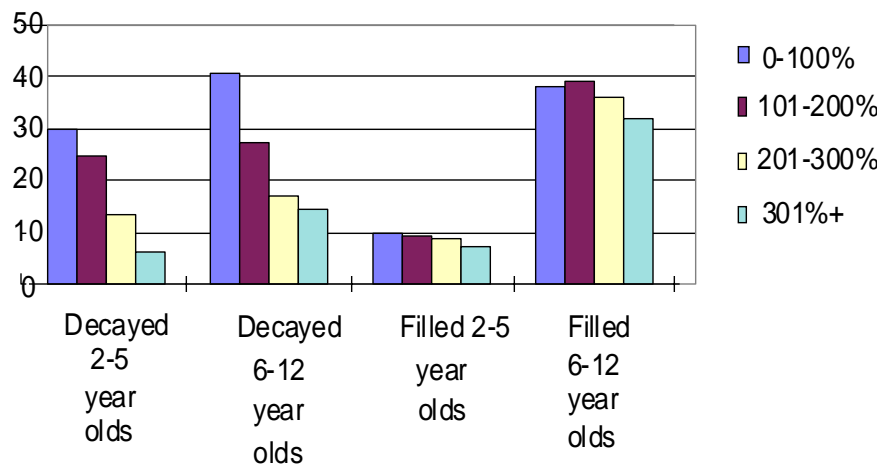
Challenges

- 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]



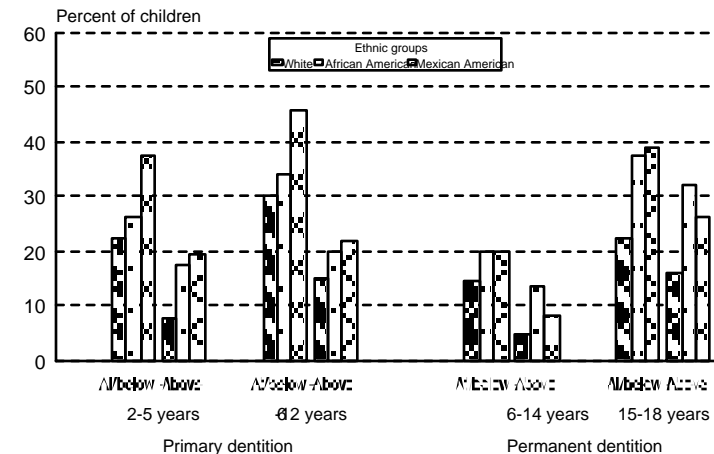
Low-Income / Racial-Ethnic Minority Children & CSHCN Have Higher More Untreated Decay

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



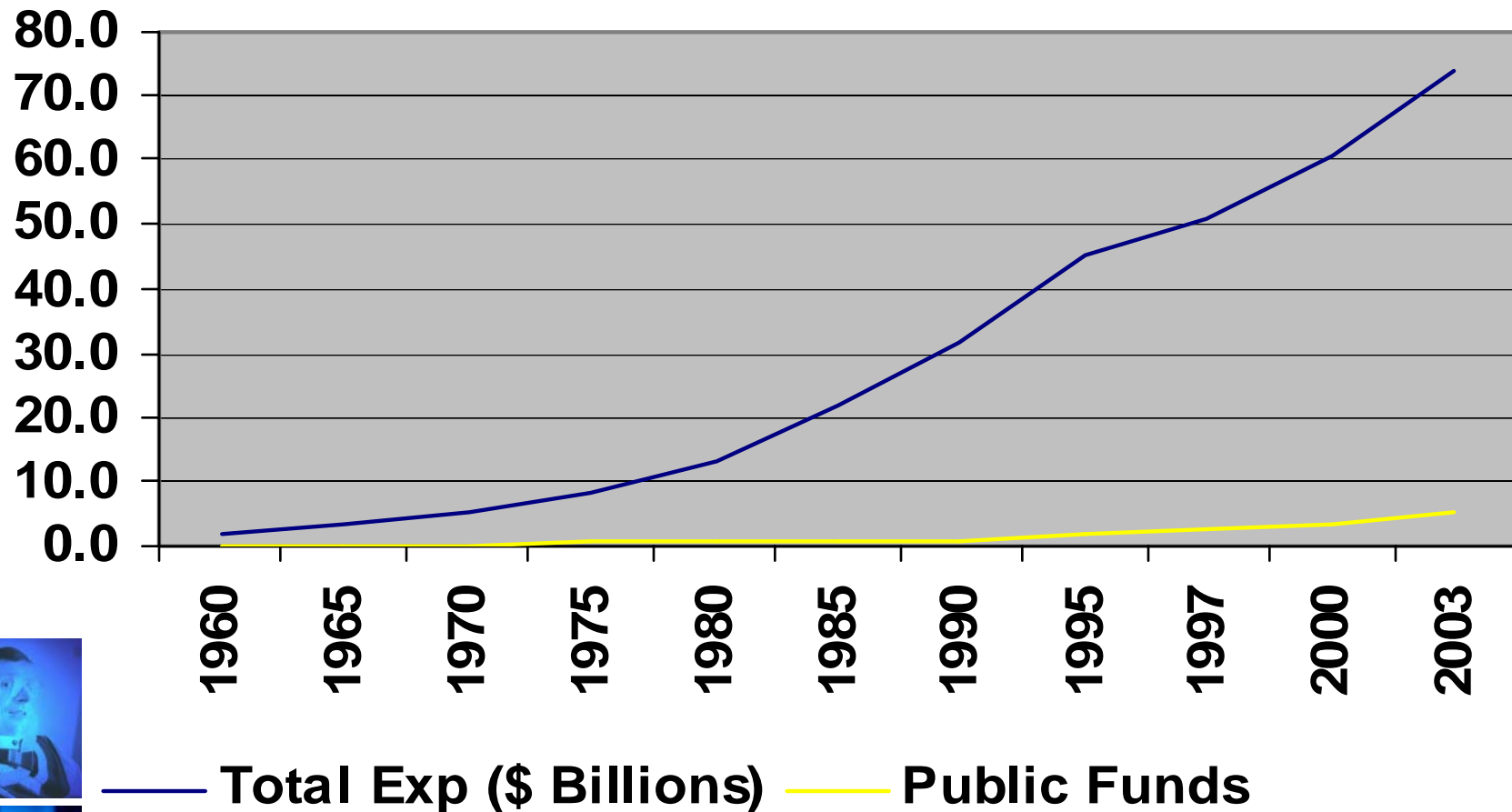
*So, . . .
how did this get to be such a mess?*



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

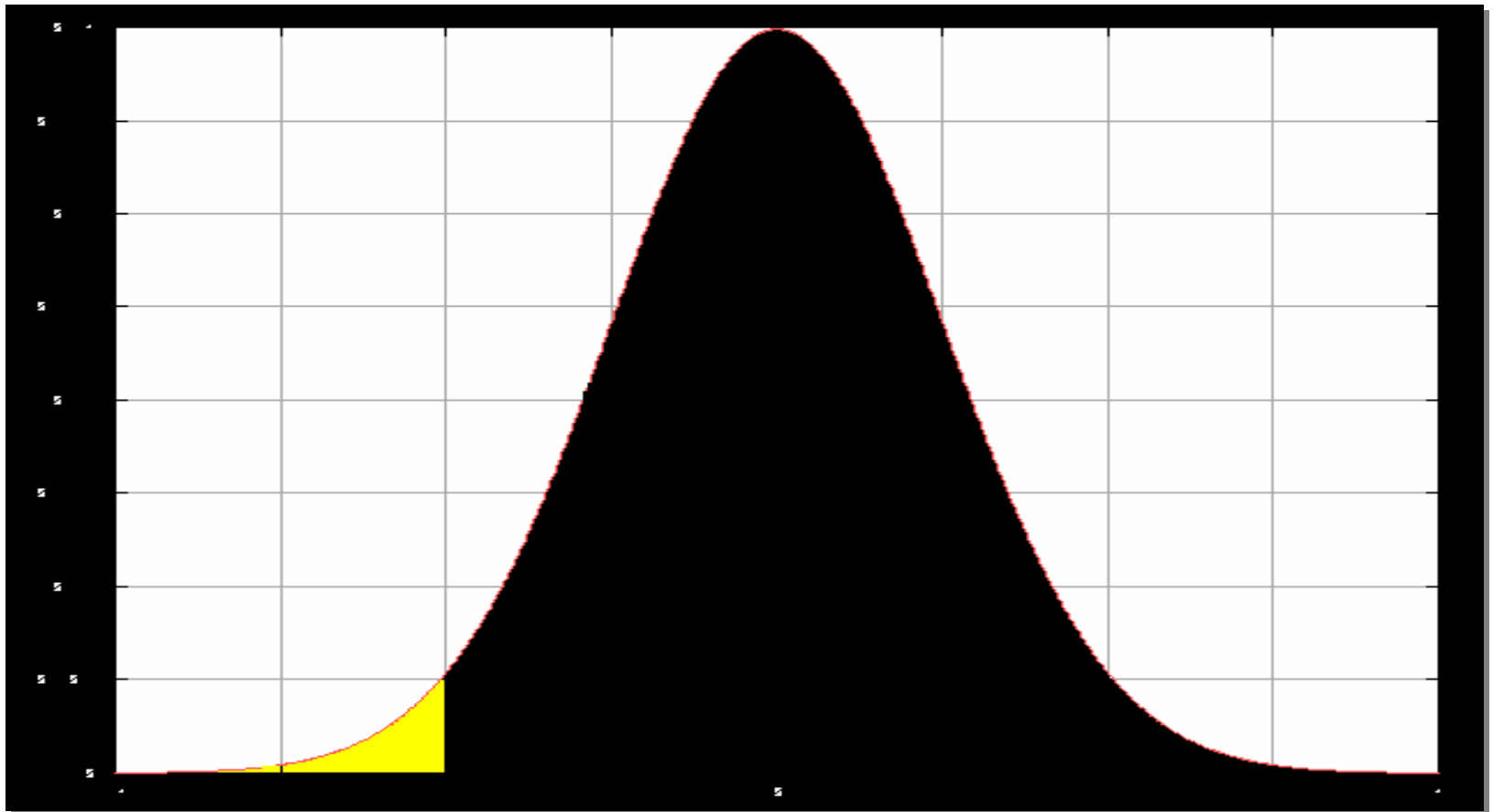


Medicaid Fee Comparisons

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 !!!

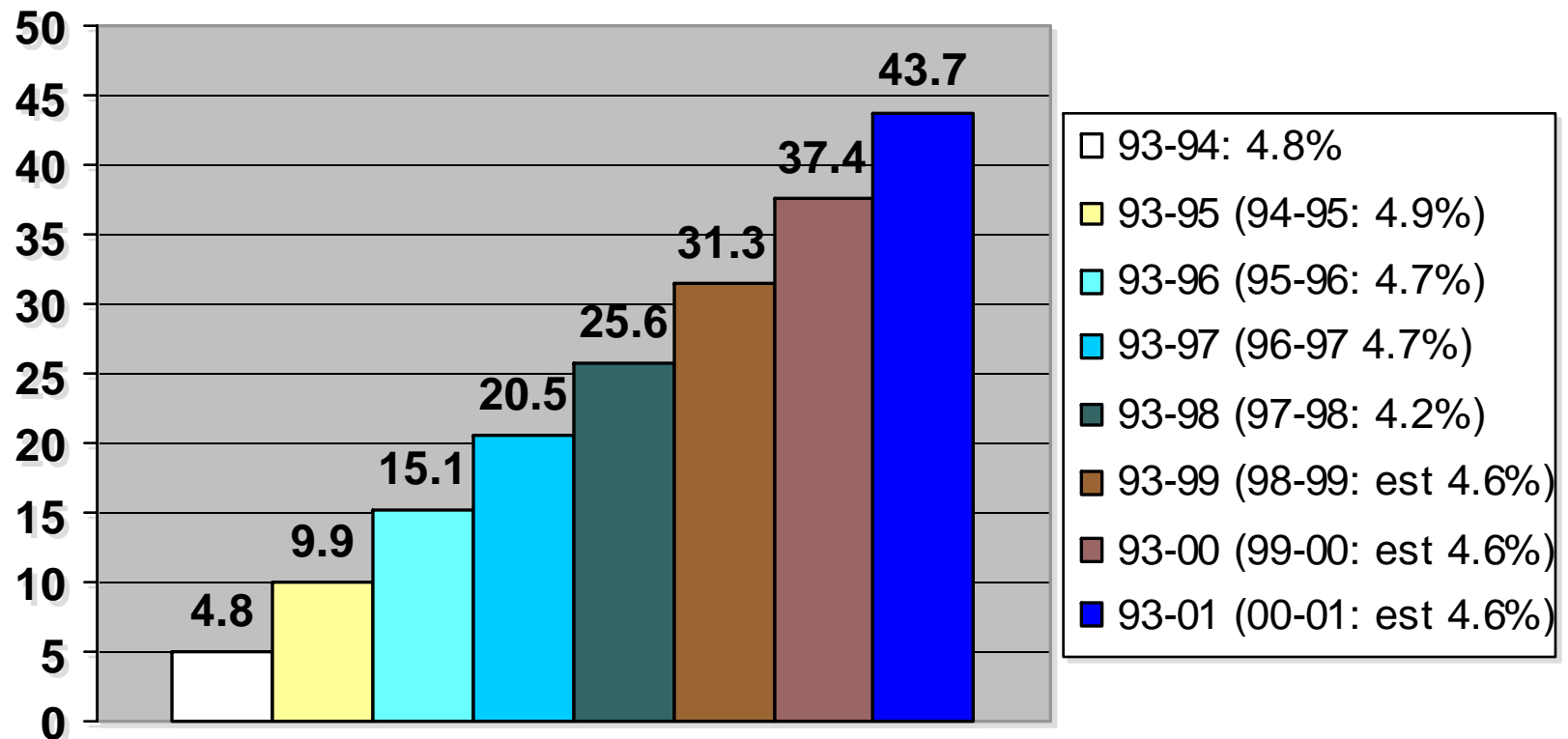
- Treatment difficulty
- Staffing & management considerations
- Case management considerations
 - Broken appointments, translation, etc.



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	75 th percentile of dentists' fees	+546% (to 1,674 of 4,000)	27
Indiana	75 th percentile of dentists' fees	+58%	54
Michigan (Healthy Kids Dental Program)	100% of Delta Dental Premier rates	+300%	12
South Carolina	75 th percentile of dentists' fees	+73%	36
Tennessee	75 th 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

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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

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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

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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.

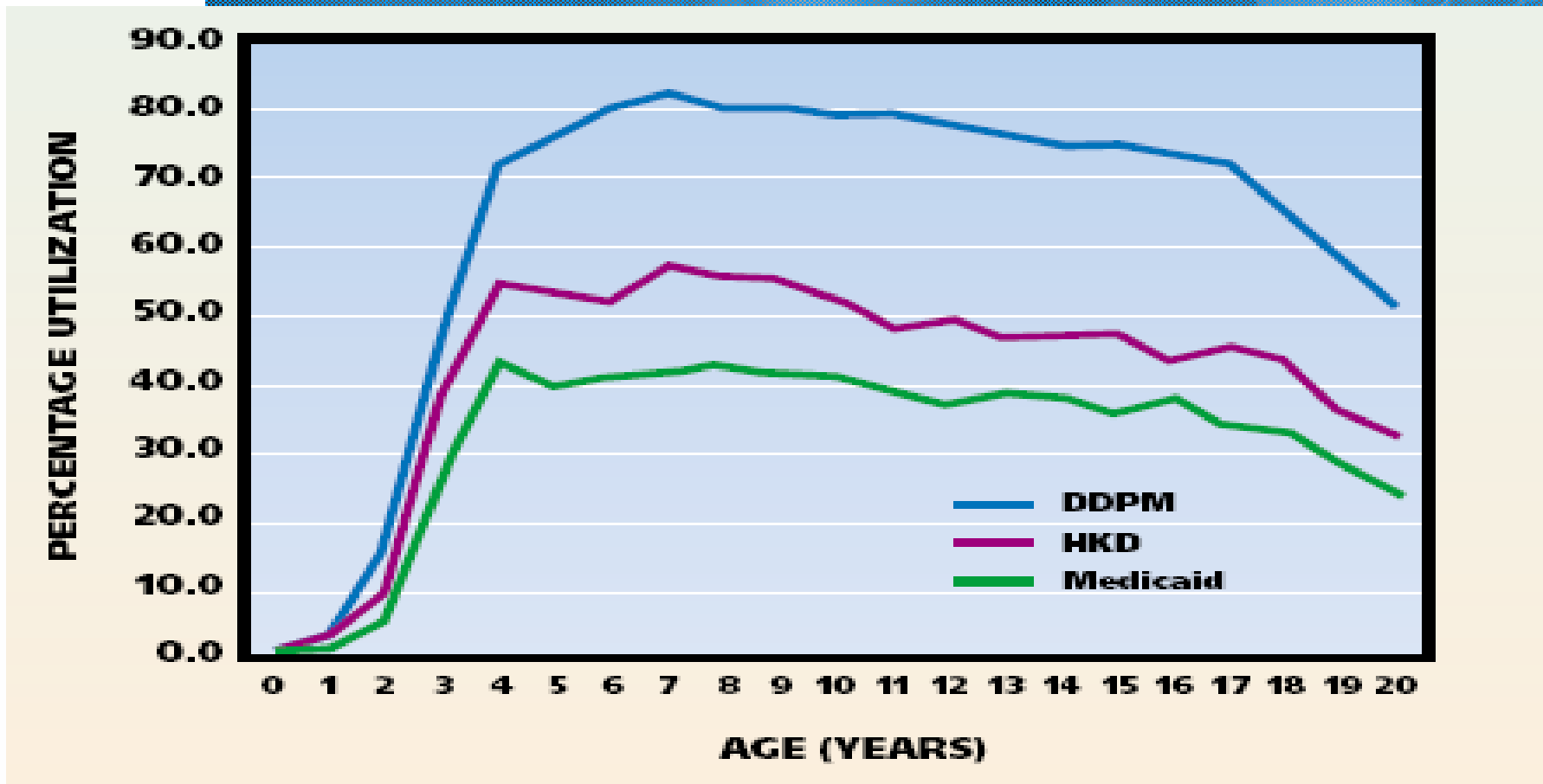
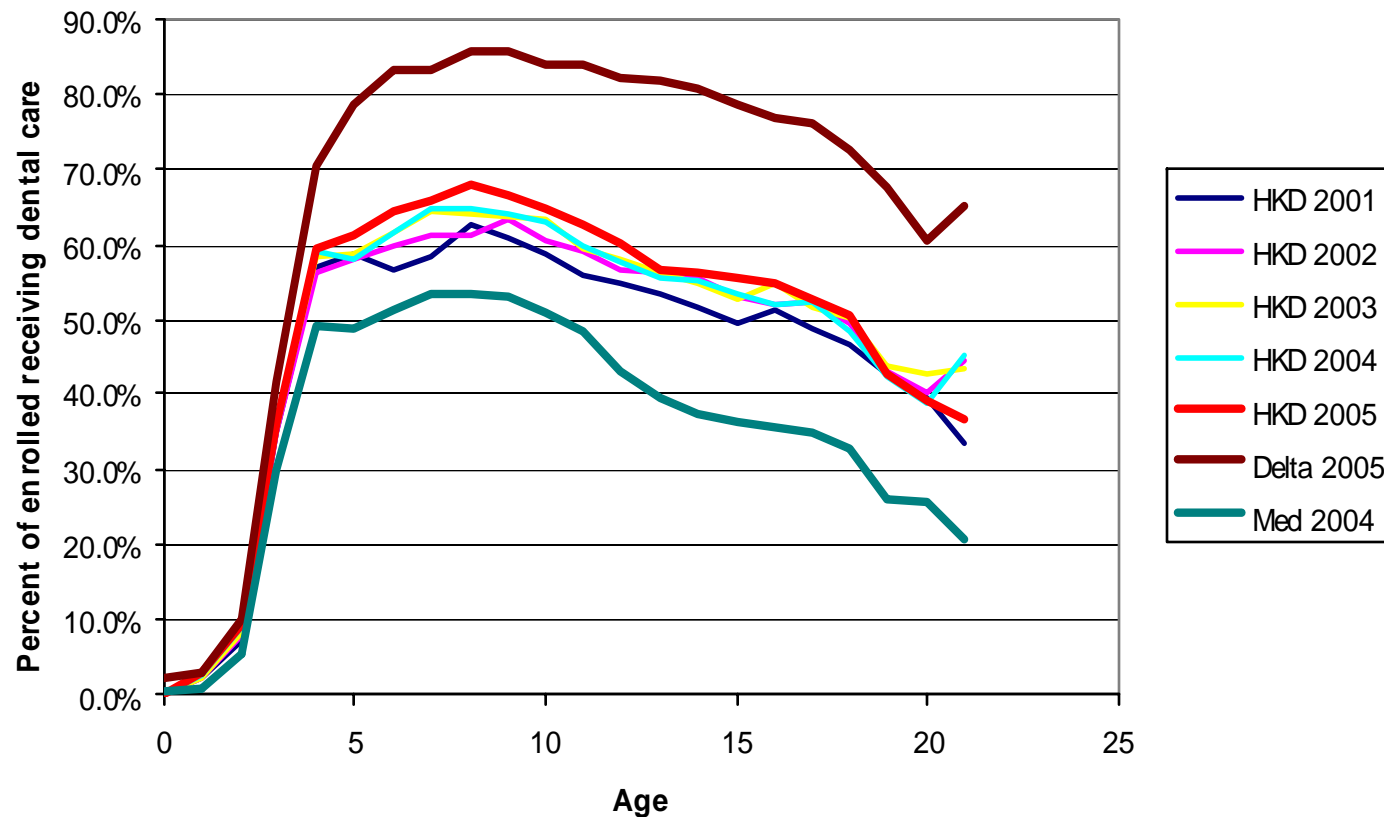


Figure. Utilization in 12 months by continuously enrolled children in 22 Michigan counties. DDPM: Delta Dental Plan of Michigan. HKD: Healthy Kids Dental demonstration program of Michigan Medicaid.

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

Maureen F. Savage, DDS, MPH, Jessica Y. Lee, DDS, MPH, PhD, Jonathan B. Kersh, MD, MPH, and William F. Vann, Jr, DMD, PhD

ABSTRACT **Objective:** To determine the effects of early preventive dental visits on subsequent utilization and costs of dental services among preschool-aged children.

Design: This investigation studied North Carolina children who were enrolled in our study in Medicaid from birth for a 3-year period. Our primary endpoint was a large national oral health study that relied on 4 large administrative datasets, including North Carolina comprehensive records from 1992, Medicaid records from 1992 to 1997, and the Area Resource File. Our outcome measures included types of care and dentally related costs.

Results: Of the 20 001 Medicaid-enrolled children born in 1992, 9284 were enrolled in Medicaid for 3 years, and one thousand five hundred and twenty-three had their first preventive dental visit before 1 year of age, 249 between 1 and 2 years, 400 between 2 and 3 years, 533 between 3 and 4 years, and 922 between 4 and 5 years. Children who had their first preventive dental visit by age 1 were more likely to have subsequent preventive visits, to have more restorative visits, to have fewer dental procedures at all ages 2 to 5, were more likely to have no hospital procedures, restorations, and emergency visits. The age at the first preventive dental visit had a significant positive effect on dentally related expenditures, with the average dentally related costs being less for children who received an early preventive care. The average dentally related costs per child according to age at the first preventive visit were as follows: before age 1, \$262; age 1 to 2, \$339; age 2 to 3, \$449; age 3 to 4, \$492; age 4 to 5, \$546.

Conclusions: Our results should be interpreted cautiously, because of the potential for selection bias; however, we concluded that preschool-aged, Medicaid-enrolled children who had an early preventive dental visit were more likely to use subsequent preventive services and procedures in a dentally related context. In addition, children from racial/ethnic minority groups had significantly more difficulty in finding access to dental care, as did those for children with lower education, per capita income. *Pediatrics* 2004;114:e117-125. DOI: 10.1542/peds.2003-0849-9, early childhood caries.

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Pediatrics (2004) 114:e117-125. Copyright © 2004 by the American Academy of Pediatrics.

preventive dental visit, cost, first dental visit, Medicaid dental use.

KEY WORDS: ECC, early childhood caries, Medicaid dental use, SPCED, coverage of dental care for Medicaid-enrolled children

Early childhood caries (ECC) is defined as dental decay among children <6 years of age.¹ It is estimated that 2% of children 12 to 24 months of age in the United States have at least 1 tooth with spontaneous decay, whereas 19% of children 24 to 60 months of age meet the criteria for ECC.²

ECC is much more prevalent among children from low-income families; for example, among children 2 to 5 years of age in Head Start, the prevalence of ECC has been reported to be as high as 80%.^{3,4} Unmet dental care is concentrated disproportionately among children from the lowest family income levels, and the incidence decreases as income increases.⁵ Among children 2 to 5 years of age whose living situation is below the federal poverty level, almost 80% of their decayed primary teeth have not been restored.⁶ Dental care is the most prevalent unmet health care need of poor US children of all ages, with preschool-aged children being especially vulnerable.⁷

ECC has far-reaching effects beyond the consequences of decayed teeth. Children with ECC are significantly more likely to weigh <80% of their ideal body weight and to experience failure to thrive.⁸ Tooth decay not only affects children's overall health, it has other ramifications, including children's loss of time from school and parents' loss of time from work. The loss of time disproportionately burdens lower-income, minority, and uninsured children.⁹

Anticipatory guidance is the process of providing practical, developmentally appropriate information about children's health to prepare parents for significant physical, emotional, and psychological milestones.¹⁰ It is well accepted among physicians that using anticipatory guidance during well-child medical visits is an effective tool for educating parents about how to ensure the best possible health for growing children. Recently the American Academy of Pediatrics adopted new recommendations regarding the inclusion of oral health in anticipatory guidance during well-child visits.¹¹ The recommendations specify that the first dental risk assessment should occur beginning at 6 months of age and that the establishment of a dental home should occur by 1

- “The age at the first preventive dental visit had a significant positive effect on dentally related expenditures.”

1 st 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](http://www.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

