



NC Medicaid Dental Program: Impact of Policy on Dental Care

Health Professional Workforce
Workgroup
North Carolina Institute of Medicine
Morrisville, NC
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Governor Beverly Eaves Perdue
Lanier M. Cansler, DHHS Secretary
Dr. Craigan L. Gray, DMA Director

A Word From My Sponsor.....



- Customer-focused
- Anticipatory
- Collaborative
- Transparent
- Results Oriented

Objectives of Presentation

- Introduction to NC Medicaid Dental Program
- Impact of reimbursement rates on dental utilization
- Medicaid no show rates—myths and realities
- Affects of health care reform on dental benefits—potential cuts to dental benefits to Medicaid recipients to produce cost savings?
- Possible dental home initiative/incorporation of dental services into CCNC

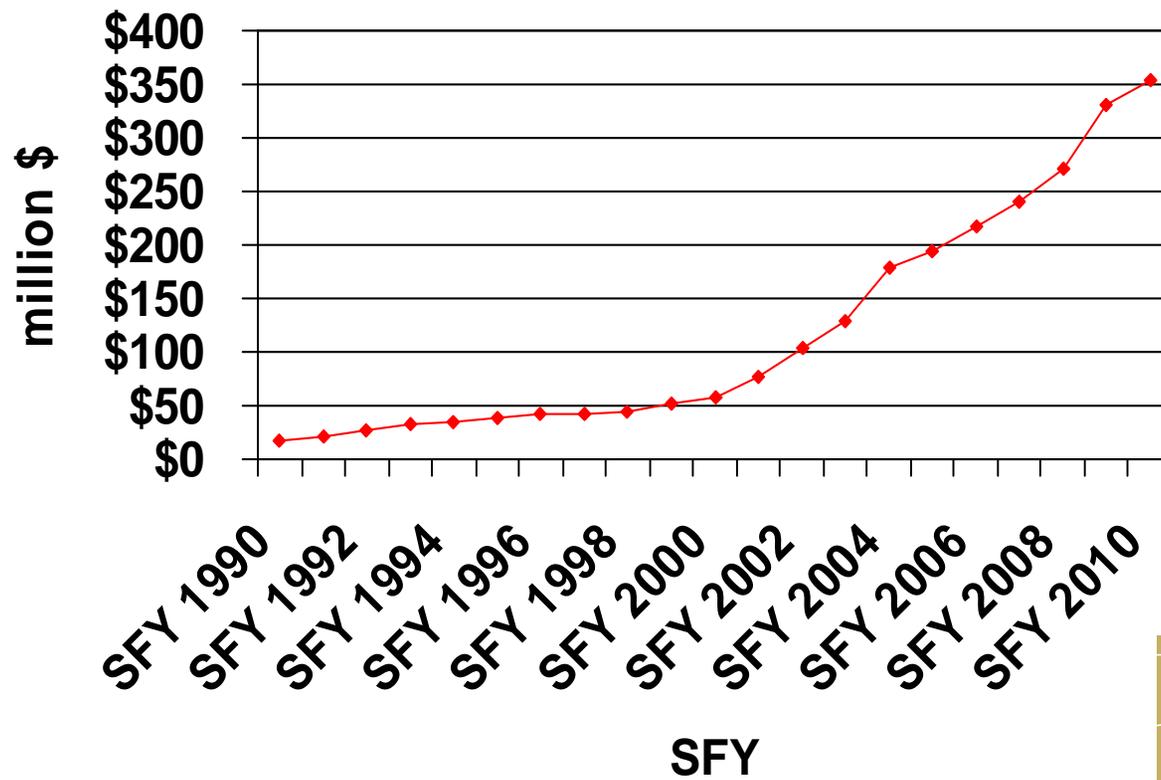


NC Medicaid Dental Program Budget Update

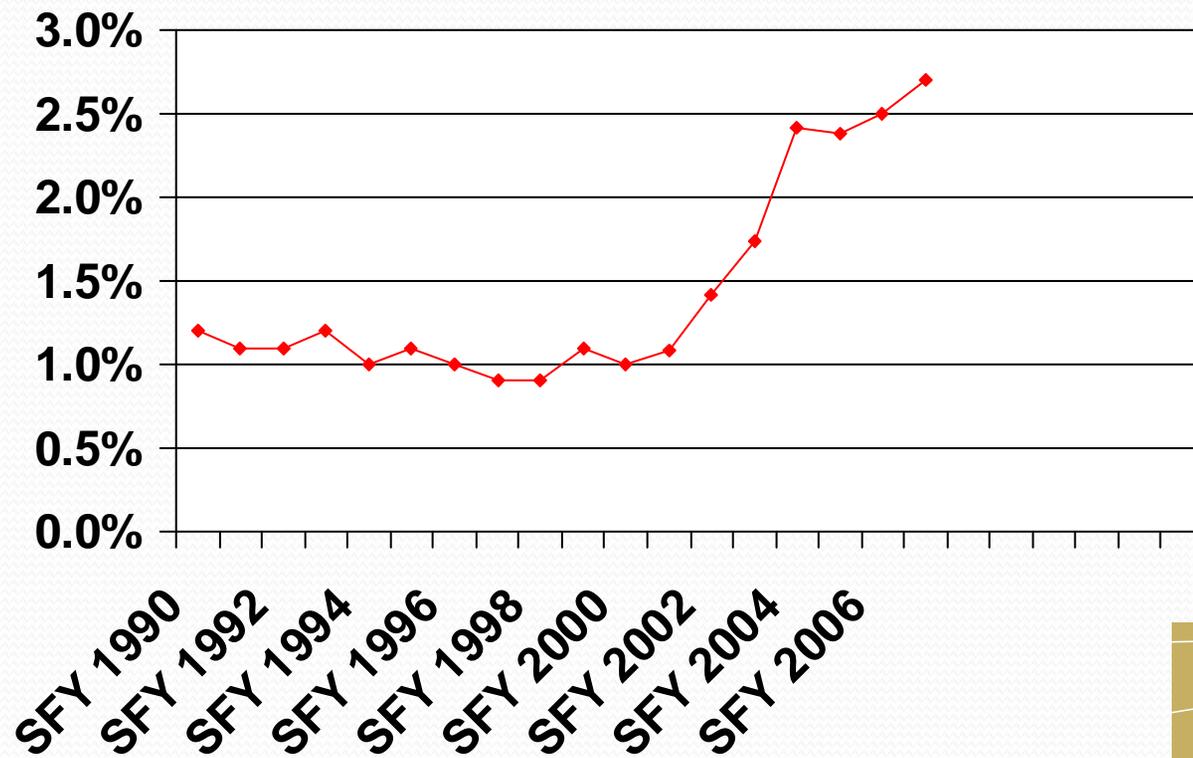
- SFY 2010 dental expenditures in SFY 2010 totaled approximately \$355 million dollars—\$210 million children’s dental services and \$145 million on adult dental services.
- Dental Program expenditures were over 3% of the overall SFY 2010 NC Medicaid Budget—growing at a faster rate than most other programs
- In SFY 2010 the number of Medicaid recipients receiving dental services grew by 12.7% when compared to SFY 2009 figures.
- While access/utilization improved, average cost per recipient for dental services declined by 1.5% when compared with SFY 2009 results.

Total Dental Expenditures

SFY 1990 – SFY 2010



Growth in Dental Program from SFY 1990-2007 (% of Total Medicaid Program Expenditures)





Recent Honors

- NC Medicaid was recognized by CMS as one of eight states with high utilization of pediatric oral health services and/or innovative methods of delivering oral health services to Medicaid children
- CMS reported that DMA and its partners are among a handful of State Medicaid agencies that have developed innovative initiatives to improve the delivery of services to publicly insured children
 - The “Into the Mouths of Babes”/Physician Fluoride Varnish Program has been specifically cited as an innovative service delivery model by CMS



Recent Honors

- In November 2010, CMS invited the DMA Dental Director to present information on the progress that NC Medicaid has made toward improving access and quality of oral health care for preschool Medicaid/CHIP recipients
- Please find more information about the NC Medicaid Dental Program at—
 - CMS's web site: <https://www.cms.gov/MedicaidDentalCoverage/>
 - DMA's web site: <http://www.ncdhhs.gov/dma/services/dental.htm>
 - Pew's web site:
http://www.pewcenteronthestates.org/report_detail.aspx?id=57407



Improving Utilization of Services—Reimbursement Rates

- More needs to be done to increase reimbursement rates with a target goal of 75-80% of a market-based benchmark (NDAS) median
- NC Medicaid dental rates average in the low to mid-50% range of the 2011 NDAS median for most commonly utilized services—exams, radiographs, preventive services, fillings, etc.
- Increases in reimbursement rates to reflect prevailing market rates should be sustained by annual rate increases to match the Dental CPI of 4.5% per year

Improving Utilization of Services— Reimbursement Rates

- Increasing rates will create a “Field of Dreams” effect – “Build it (and maintain it) and they will come (and remain active)” – provider enrollment will increase
 - Examples – Indiana (1998), South Carolina (2000), Alabama (2000), Tennessee (2002), Virginia (2005)
 - Lawsuit settlements – Tennessee (1999), North Carolina (2003), Texas and Connecticut (more recently)

Improving Utilization of Services—Reimbursement Rates

- Overhead expenses for an average dental office are approximately 65% of collections -- procedures reimbursed below 65% -- provider loses money
- Adult/specialty services (denture, oral surgery, endodontic and periodontal) still lag behind -- many of these procedures are at or near the current floor of 49% of the 2007 NDAS median
 - Increasing these rates should attract more specialists (oral surgeons, orthodontists, endodontists and periodontists) to enroll in Medicaid
- Many preventive and diagnostic services are reimbursed at higher levels – increased utilization of these services should lead to cost savings to the Medicaid program in the future



Strategies to Increase Reimbursement Rates

- Raise the floor from 49⁰% of NDAS median
 - Pros: will increase rates for procedures that are furthest behind market based benchmarks – oral surgery, removable pros, endo, perio, etc. – mostly adult services – at or near the floor of 49⁰% of the 2007 NDAS median.
 - Cons:
 - Will not address lawsuit settlement codes (children's services)
 - Will result in criticism from some circles in the provider community



Strategies to Increase Reimbursement Rates

- Targeted rate increases
 - Pros: allows increases in the rates for codes that program staff deem most worthy of increase based on utilization and other factors
 - Cons:
 - May not raise the floor for many services that lag far behind market based benchmarks
 - Will result in criticism from some circles in the provider community



Conclusions:

Reimbursement Rates

- “You can’t please all the people (providers) all the time”
- DMA has employed forms of both strategies in the last four rate increases since 9/2006.
 - “Zigging and zagging” to address needs with limited funding
- Kudos to NCGA for including rate increases in past budgets and to organized dentistry for successful lobbying efforts
- Rate cut of 4.52% in November 2009
 - Future rate cuts?

Medicaid Broken

Dental Appointments

- Difficult problem to overcome; not many successes to report
- Anecdotal evidence in NC of 50% or higher broken appointment rates in some dental practices
- Most studies concur that this is a problem that affects the publicly insured more so than private pay
 - Not to the degree reported by providers; research evidence indicate that it is around 1/3rd the rate of scheduled appts. or lower
- Federal regs prevent charging recipients broken appointment fees
- Leads to provider dissatisfaction with the program

Medicaid Broken

Dental Appointments

- Most innovative ways to overcome this problem arise from providers themselves—who knows better about strategies to deal with problem patients?
 - How to better educate folks from lower SES about the importance of preventive oral health care
- Some States (e.g.—VA Medicaid) pay a nominal admin fee to providers to report recipients with a high number of broken appointments
- For some tips, please go to ADA Medicaid Symposium Report:
 - <http://www.ada.org/2961.aspx?currentTab=1>
 - http://www.ada.org/sections/professionalResources/pdfs/topics_access_medicaid_symposium.pdf



Provider Participation

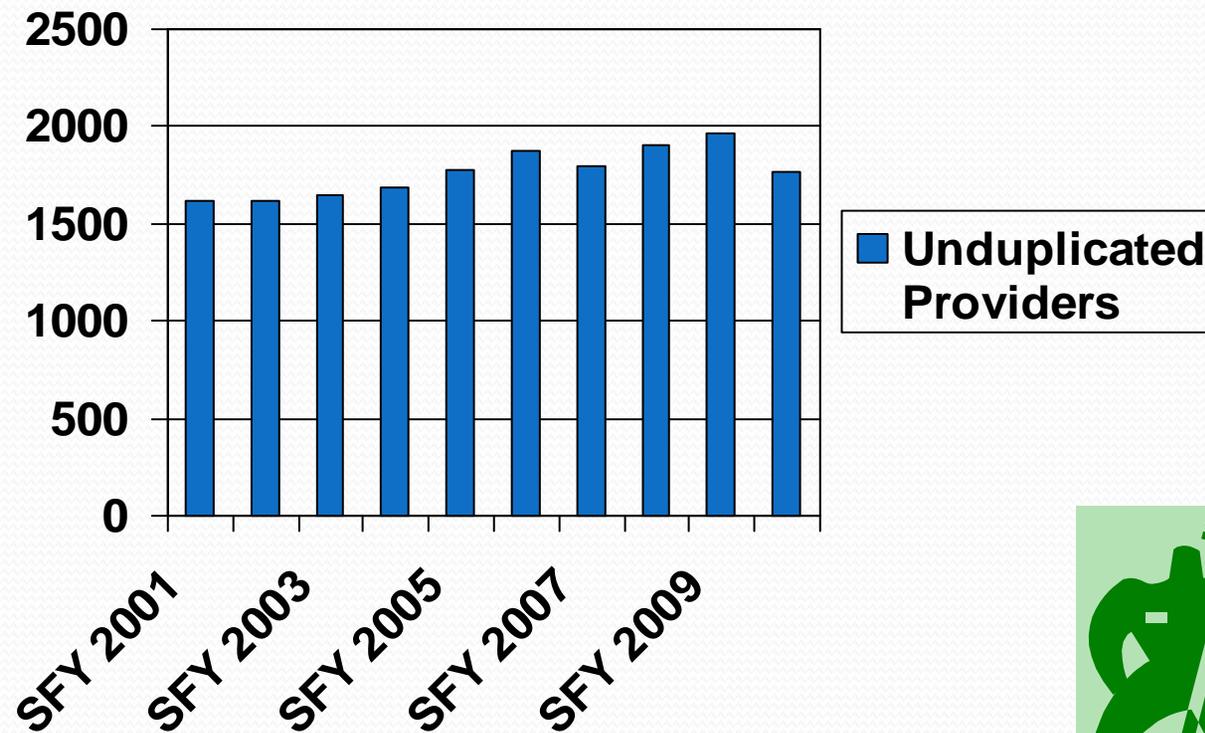
- From SFY 2009 to SFY 2010 the number of actively participating billing providers who had received payment for at least one claim dropped from 1964 to 1767
- It is a mistake to compare a numerator of “billing providers” to a denominator of the number of active licensed dentists
 - The traditional model of solo dental practice does not apply to NC Medicaid—many more group practices participate
- The number of participating “attending providers” (dentists rendering services) is estimated to be approximately 1900 – 2000; around 45% of active licensed NC dentists
 - Unable to come up with accurate figures due to MMIS limitations



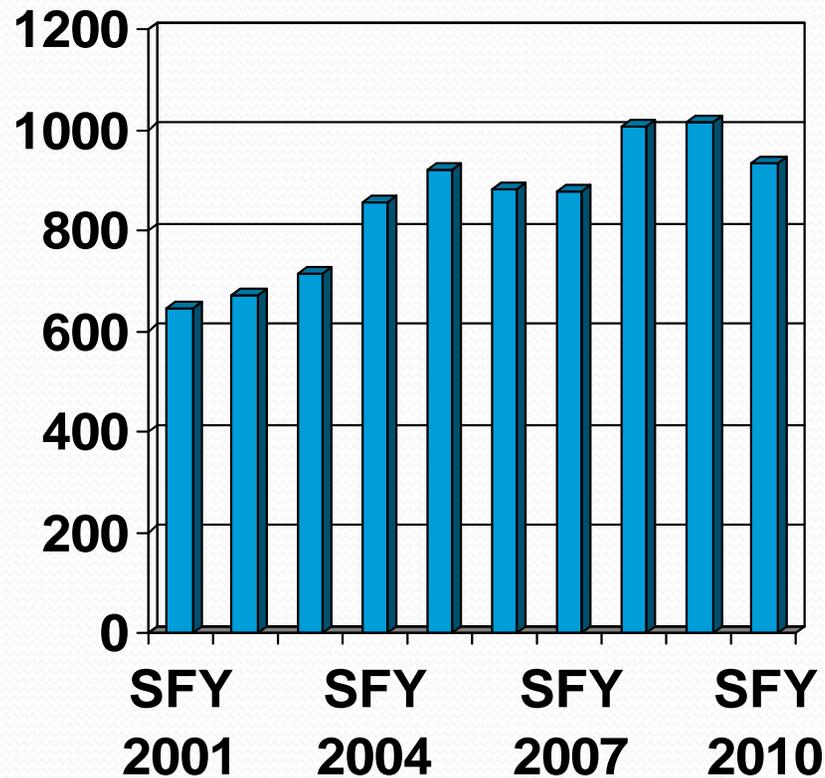
Provider Participation

- Why are we losing providers?
 - Preparation for reverification led to a decline in the number of participating providers; many dental providers were end dated for lack of activity over 12 months
 - Other providers objected to the State's administrative cost saving measures passed in the Budget Bill of 2009 (SL 2009-451)
 - Requirements to submit claims electronically (requires HIPAA compliance) and to receive payment through electronic funds transfers.
 - For the reasons stated above, coupled with a 4.52% reduction in dental reimbursement rates mandated in the 2009 Budget and implemented in November 2009

Trends in Number of Billing Providers



Trends in Number of Billing Providers



■ Significant Providers \geq \$10,000



Utilization/Access Rates

- Despite drop in participating billing providers, access for children continues to improve for children (for adults, it is about the same)
 - FFY 2010—54% of children ages 1-20 with continuous enrollment of least 90 days received one oral health care service
 - Excludes children < age 1
 - Excludes children with enrollment less than 90 days of continuous enrollment (should it be 180 days since dental visits are recommended every 6 months?)
 - Includes unduplicated children < age 3½ who received a preventive oral health care service from a PCP in the “Into the Mouths of Babes Program”
 - Pew and CMS advise that private dental benefit plans are reporting an average utilization rate of 58% for children—no word on how the private dental benefit plans calculate utilization (ages 0-20 or 1-20 or 2-20 and what about continuous enrollment?)

PPACA Impact on NC Medicaid/Health Choice Eligibility

- Creates a MANDATORY eligibility group that expands Medicaid to 133% FPL without regard to categorical eligibility effective 1/2014
- Increases mandatory eligibility of children 6-19 yrs to 133% FPL
- Approximately 1 out of every 4½ North Carolinians will be covered by NC Medicaid > 2 million recipients

PPACA Projected Impact to Medicaid/Health Choice Eligibility in 2014

New Enrollees
500,000 +

\$ 836,391,376 = Total Cost
in State Approps from
2014-2019

- Estimates include individuals who will become eligible because of mandatory Medicaid expansion (i.e. — “expansion” population)—Feds pick up 100% for first 3 years taper to 90% by 2020
- People who are currently eligible but not enrolled (i.e.— “woodwork” population)—regular FMAP applies to woodwork population
- There is a Maintenance of Effort (MOE) on standards, methodologies and procedures – **can't become more restrictive with eligibility**



The Future of Optional Services: Adult Dental Benefits

- Health care reform may place additional pressure on States to reduce optional Medicaid benefits because they can not change eligibility requirements
- Elimination of adult dental benefits
 - Optional service under Title XIX of the Social Security Act that created the Medicaid entitlement program
 - Several States have gone this route due to the current economic climate and declining revenues



The Future of Optional Services: Adult Dental Benefits

- Some reductions in services and/or rate cuts
 - Examples:
 - Deep cleaning allowed once every two years rather than once every year
 - No longer cover cast metal partial dentures—cover acrylic partials only
 - Across the board rate cuts to most Medicaid provider types, including dentists
- Reduce adult dental benefits to emergency services only—
 - exams, x-rays, extractions, biopsies, treatment of fractures, excision of tumors and adjunctive services necessary to complete this care



The Future of Optional Services: Adult Dental Benefits

- Adult Medicaid recipients will seek more oral health care in hospital EDs
 - Increases in the Medicaid medical budget and, in the long term, more inpatient care for dental problems
- Safety net dental clinics (Health Depts. and FQHCs) will have many more adult Medicaid patients without dental coverage
 - One of the missions of public providers is to treat the uninsured
 - Increased pressure on safety net clinics that do not provide care to adults to change their mission



The Future of Optional Services: Adult Dental Benefits

- Unknown effect on new East Carolina School of Dental Medicine—its mission includes treating the underserved including Medicaid eligible adults
- Many Medicaid enrolled adults and elderly live with significant chronic diseases
 - In the Medicaid population, adult recipients in the ABD program category make up around 25% of recipients yet use from 2/3rds to 3/4ths of the resources
 - Who will provide oral health care to these individuals to prevent exacerbation of diabetes, heart disease, etc.?
 - Physicians are not trained to provide oral health care
 - Oral health care is primary care—everyone needs it!

Proposed Models to Improve Access to Dental Services

- Dental Home Initiative—
 - Carolina Dental Home/CHIPRA Quality Demonstration Grant—
 - Pilot with preschool Medicaid children identified to be a high risk for early childhood decay
 - Builds on the success of IMB/Physician Fluoride Varnish Program
 - Facilitate referral from PCP to participating dentists; care coordination and health navigation strategies
 - Focuses on a population of children who have historically faced obstacles to care; older NC Medicaid children (ages 5-16) have utilization rates closer to private pay

Proposed Model to Improve Access to Dental Services

- CCNC-like model
 - Public-private partnership
 - Assign recipients to participating dentists
 - PMPM fees for care coordination and admin services
 - Makes good sense for Medicaid ABD population who utilize all health care services including dental services more than other eligibles
 - These recipients have chronic medical conditions which can be exacerbated by poor oral health
 - Seems to have support on a federal level at CMS and HRSA
 - Oral health care is primary care—everyone needs it!

Division of Medical Assistance NC Medicaid Dental Program

www.ncdhhs.gov/dma/dental.htm

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