Health Issues

Connecticut Health FOUNDATION

IMPACT OF INCREASED DENTAL REIMBURSEMENT RATES ON HUSKY A-INSURED CHILDREN: 2006 – 2011

OVERVIEW

Over the past few decades Connecticut children enrolled in HUSKY A (Healthcare for UninSured Kids and Youth), the state's Medicaid program for low-income families, could not easily access dental health services for a variety of reasons including low private dentist participation. Many providers cited low reimbursement rates and cumbersome program administration as obstacles to treating children insured under Medicaid. Based on a 2008 lawsuit settlement agreement, program administration improved and reimbursement rates increased, moving closer to private insurance rates. An examination of Medicaid data between 2006 and 2011 will illustrate the impact of these changes on utilization rates, private dentist participation, and the relative contributions of private practices and dental safety net providers.

FINDINGS

1. Higher Medicaid reimbursement rates and improved administrative structure encouraged many more private practice dentists to treat children insured under HUSKY A.
2. Utilization rates of children continuously enrolled in HUSKY A increased from 46 percent in 2006 to nearly 70 percent in 2011.
3. Nearly all of Connecticut's 169 cities and towns, including the ten with the greatest concentration of children on HUSKY A, experienced significant utilization rate increases.
4. Increased private dentist participation in the Medicaid program directly contributed to greater access to oral health services among low-income children.

RECOMMENDATIONS

Children's access to dental care is linked to robust private provider participation in the Medicaid program and a strong dental safety net system. To ensure continued access to basic oral health services among low-income children insured under HUSKY A:

- Medicaid reimbursement rates must be periodically adjusted to mirror private insurance rates.
- The administrative structure and processes of the Medicaid dental program must remain streamlined.

Continued on page 2

POINTS OF INTEREST:

The 2011 utilization rate among children continuously enrolled in HUSKY A is similar to the rate of 65 percent for children enrolled in private insurance plans.

Approximately half of all pediatric and general dental practitioners now provide care in the Medicaid dental program.

More than twice as many children received treatment services in 2011 than 2006.

CONTEXT

Well-established research illustrates the consequences of inadequate access to basic dental care: more oral disease, more pain and infection, and more days lost from school. Historically, Connecticut's low-income children have difficulty accessing dental care due, in large part, to low Medicaid reimbursement rates that discouraged private providers from program participation.

In 2000, Greater Hartford Legal Aid and Connecticut Legal Services brought a lawsuit on behalf of Connecticut children enrolled in HUSKY A who could not access basic dental services. In April 2008, thanks to the advocacy efforts of the Connecticut State Dental Association (CSDA), the Connecticut Dental Hygienists' Association (CDHA), the Connecticut Health Foundation (CT Health), and other community partners, the lawsuit settlement agreement included increasing dental reimbursement rates to the 70th percentile of 2005 private insurance fees (see Table 1).

In addition to increasing fees, the Connecticut Department of Social Services (DSS) simplified Medicaid dental program administration. Rather than four companies administering the program and accepting financial risk, dental services are now managed by a single administrative services organization (ASO) that has no financial risk. The department also initiated an outreach effort designed to increase dental program participation of both patients and providers.

In response to these positive changes, the CSDA also made a commitment to increase private sector providers participating in HUSKY A. Along with frequent membership communications designed to answer questions about administrative changes, CSDA worked with HUSKY A dental program representatives to guide new providers through streamlined processes. "Word of mouth" endorsements from new HUSKY A dental providers were a big factor in successful recruitment efforts statewide.[i]

Many states with low oral health reimbursement rates are interested in Connecticut's efforts to provide Medicaid-enrolled children adequate access to dental care. Some experts argue that even with fees competitive with those of private insurance, private dentists still may not participate in Medicaid. Others suggest that families on Medicaid may not seek dental care, even if available, because of non-economic barriers, such as education, language, culture, and transportation. The positive results from Connecticut suggest that these assumptions are not true.

Table 1

Reimbursement Fees for Selected Services

Service	2006* Fees	2008 Fees
Initial exam	$24	$65
Cleaning	$22	$46
Two-surface amalgam (filling)	$39	$114
Stainless steel crown	$88	$230
Extraction (single tooth)	$33	$115

**Prior to reimbursement rate increase*

METHODOLOGY

Medicaid enrollment and encounter data, supplied by DSS, provides opportunities to compare utilization rates before (2006) and after (2009–2011) the reimbursement rate increase and implementation of the new administrative structure.

The year 2006 was chosen as the baseline because various administrative changes occurred in 2007 and fee increases did not occur until mid-2008. The results include HUSKY A children enrolled in Medicaid for at least one day ("ever enrolled") and for at least 11 months and one day ("continuously enrolled") within a calendar year.

Between 30 percent and 42 percent of ever-enrolled HUSKY A children who are enrolled in the Medicaid program for part of a full year have less time to access dental services. In contrast, most children covered under private insurance typically retain coverage for a full year. Therefore, data for children continuously enrolled in HUSKY A for a full year were examined to more accurately compare utilization rates of children insured under Medicaid to those insured under private insurance.

IMPACT ON DENTAL SERVICE UTILIZATION

The number of children enrolled in the Medicaid program at least one day (ever enrolled) grew 18.1 percent between 2006 and 2011. Thirty-six and 59 percent of these children had at least one visit per year in 2006 and 2011, respectively (see Table 2).

Table 2
Utilization Rates of Ever-Enrolled HUSKY A Children

Year	Number of Enrollees	Percent With Any Visit
2006*	265,114	35.9
2009	278,886	54.1
2010	303,941	58.5
2011	313,226	58.7

**Prior to reimbursement rate increase*

The number of children continuously enrolled in Medicaid grew nearly 37 percent between 2006 and 2011. In 2006, 46 percent of continuously enrolled children had at least one visit per year, compared with 69.5 percent in 2011 (see Table 3). The 2011 utilization rate among children continuously enrolled in HUSKY A is similar to the rate of 65 percent for children enrolled in private insurance plans.[ii]

The increase in utilization occurred across all three major service types (see Table 3): diagnostic (e.g., examinations and radiographs), preventive (e.g., cleanings, topical fluorides, and sealants), and treatment (e.g., fillings, root canals, extractions, and orthodontics).

Table 3
Utilization Rates of Continuously Enrolled HUSKY A Children Before and After the Fee Increase by Service Type

Year	Number of Enrollees	Percent With Any Visit	Percent With Diagnostic Visit	Percent With Preventive Visit	Percent With Treatment Visit
2006*	160,070	46.0	42.1	39.2	20.2
2009	163,697	65.1	59.8	58.8	29.1
2010	203,158	69.1	64.7	63.7	31.5
2011	219,215	69.5	65.4	64.5	31.5

**Prior to reimbursement rate increase*

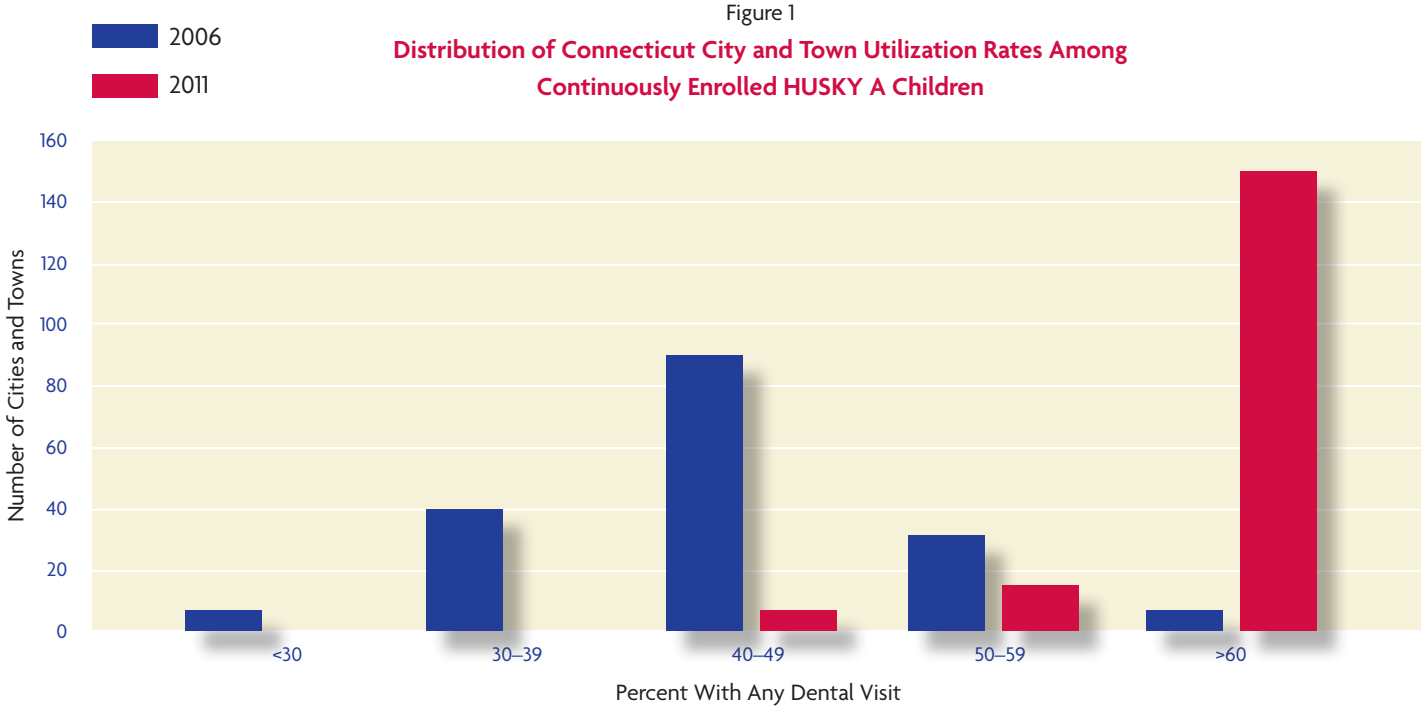
The utilization of treatment services is substantially lower than diagnostic and preventive services because not all children have caries or tooth decay. Even among those with caries, some may have previously received all required treatment. Data from national surveys show that approximately 30 percent of children at or below 100 percent of the federal poverty level ($23,050 for a family of four) need dental caries treatment.[iii]

This suggests that among continuously enrolled children a large percentage of those needing treatment are receiving it.

Utilization rates among continuously enrolled children increased in 167 of Connecticut's 169 cities and towns. A total of 158 towns experienced double-digit increases between 2006 and 2011 (see Figure 1).

Figure 1

Distribution of Connecticut City and Town Utilization Rates Among Continuously Enrolled HUSKY A Children



The ten cities with the highest concentration of HUSKY A children have the greatest need for dental services. In 2011, the utilization rates for continuously enrolled children averaged 70 percent across these cities, a rate higher than that of privately insured children (see Table 4).

Table 4

Utilization Rates for Continuously Enrolled HUSKY A Children in 10 Connecticut Cities With Highest Concentration of HUSKY A Children

City	Percent With Any Dental Visit	
	2006*	2011
Hartford	54	75
New Britain	52	75
East Hartford	51	73
New London	50	73
Bridgeport	45	69
New Haven	44	69
Meriden	42	69
Waterbury	43	68
Windham	44	67
Norwich	50	66

**Prior to reimbursement rate increase*

PRIVATE PROVIDER PARTICIPATION

Private dentist participation in the Medicaid program more than doubled between 2006 and 2010. A total of 416 private dentists submitted at least one Medicaid claim in 2006 versus 937 in 2010.[iv] The latter number represents approximately 38 percent of all (private and clinic) active practitioners (2,474) in Connecticut and about 50 percent of all active general and pediatric practitioners.

The expansion in the number of safety net system patients and visits is mainly the result of increased capacity (e.g., new clinics, additional dentists and hygienists, and enhanced productivity). Increased rates did not positively affect a safety net system dominated by FQHCs that receive cost-based and annually adjusted reimbursement. These clinics typically operate at full capacity and continue to face excess demand.

PRIVATE PRACTICES AND SAFETY NET CLINICS

In addition to contributions made by private dentists, the dental safety net is an important source of care for children on HUSKY A. The dental safety net, which includes public and nonprofit clinics providing care to low-income patients, is located in hospitals, dental schools, Federally Qualified Health Centers (FQHCs) and other community health centers.

In 2006, private practices accounted for about 60 percent of Medicaid dental patients, visits, services, and expenditures. After the reimbursement rate increase, private dentists accounted for over 70 percent of patients and visits (see Table 5).

As expected, private sector providers accounted for most of the increases. The strong response of private dentists is most likely the result of increased Medicaid reimbursement rates. The contributions of Medicaid program administrative improvements, strong recruitment by the CSDA, and the economic recession also have contributed to the increase in private dentist participation.

Table 5

Contribution of Private Practices and Dental Safety Net Dental Clinics to Increase in Patients and Visits

	Private Practices			Safety Net Clinics		
	2006*	2011	Percent Change	2006*	2011	Percent Change
Patients	58,645	142,592	143	41,959	59,593	42
Visits	124,617	385,827	210	83,510	131,012	57

**Prior to reimbursement rate increase*

Connecticut Health
FOUNDATION

100 Pearl Street
Hartford, CT 06103

NONPROFIT
ORGANIZATION
U.S. POSTAGE
PAID
NEW BRITAIN, CT
PERMIT NO. 16

RETURN SERVICE REQUESTED

IMPLICATIONS & RECOMMENDATIONS

The key provisions of the lawsuit settlement – increased reimbursement rates, improved program administration, and targeted provider recruitment – encouraged greater private dentist participation in the Medicaid program and reduced dental service access disparities. Children continuously enrolled under HUSKY A now have utilization rates – 65 percent to 70 percent – commonly seen in children enrolled in private dental insurance plans.

Three other states (Indiana, Michigan, and Tennessee) also have raised Medicaid reimbursement rates to a similar level. All reported a significant increase in utilization rates.[v] However, the increase in dentist participation and patient utilization in Connecticut exceeds that of these states, suggesting that program administration changes and strong state dental association recruitment efforts may have contributed to Connecticut's better results.

To maintain these utilization rates and ensure that low-income children continue to have access to oral health services, action is required:

- HUSKY A reimbursement rates must be increased periodically to offset the increasing cost of providing dental services. If HUSKY A reimbursement rates do not mirror those of private insurance, private providers may stop participating in the Medicaid program.
- Focus must be kept on removing administrative barriers to ensure that private providers continue to participate in HUSKY A.

REFERENCES

[i] C. Dingeldey, email correspondence, Nov. 6, 2012.

[ii] Eklund, S. Pittman, J. and Clark, S. Michigan Medicaid's Healthy Kids Dental program: An assessment of the first 12 months. *J Am Dent Assoc* 134(11): 1509-15, 2003.

[iii] http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/ Dec. 27, 2012.

[iv] The number of active general, pediatric and other dental practitioners in Connecticut was not available for the year 2011.

[v] Borchgrevink, A. Snyder, A. and Gehshan, S. The effects of Medicaid reimbursement rates on access to dental care. National Academy for State Health Policy, 2008.

ABOUT THE AUTHORS

Tryfon Beazoglou, PhD,
University of Connecticut School of Dental Medicine

Joanna Douglass, BDS, DDS,
University of Connecticut School of Dental Medicine

Howard Bailit, DMD, PhD,
University of Connecticut School of Dental Medicine

Veronica Myne-Joslin, BA,
University of Connecticut School of Dental Medicine

Credits:
Editor-in-Chief: Patricia Baker
Project Consultant: Monette Goodrich
Design: E.K. Weymouth Design
Printer: Hitchcock Printing
Proofreading: Karen Schader