Dentist Participation in Medicaid:
Key to Assuring Access for North Carolina's Most Underserved

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Dental care is essential to overall health.[1] Despite improvements in prevention and oral health status, millions of people still experience preventable dental disease.[1,2] There are glaring and persistent socioeconomic disparities in the distribution of oral health problems with persons from low-income families and minority backgrounds being affected to a much larger extent than their counterparts.[1,2]

Research has documented many factors, both complex and inter-related, that contribute to the persistence of oral health disparities.[1] Inadequate access to regular dental care represents a chronic, significant problem to achieving oral health.[1,2] Even though Medicaid has the potential to markedly improve access to dental care for millions of economically disadvantaged persons, this federal-state program has unfortunately not lived up to its potential. Less than one in every five children enrolled in Medicaid uses preventive services in a given year.[1,2]

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Among the primary reasons for poor utilization of dental services by Medicaid enrollees is scarcity of available dentists.[2] Numerous studies on access to dental care have been completed, including those of dentists who consistently cite three major issues for their lack of participation in the Medicaid program: (1) inadequate reimbursement rates; (2) broken appointments and patient non-compliance; and (3) burdensome paper work associated with Medicaid.[2] Of these, insufficient reimbursement rates, which are often less than what it costs to operate a dental practice, constitute the principal reason for keeping many dentists away from treating Medicaid enrollees.[2-4] In North Carolina, the 1999 North Carolina Institute of Medicine Task Force on Dental Care Access identified a significant increase in reimbursement rates as its number one recommendation for improving access to dental care.[5] It noted that more dentists would be willing to see more Medicaid patients if reimbursement rates were increased.

Increasing Medicaid Reimbursement Rates

Over the past several years, a number of states have developed comprehensive approaches to increase dentist participation in the Medicaid program.[4] Establishing competitive, market-based reimbursement rates has been a central strategy.[4] These efforts appear to have improved both the dentist participation rate in Medicaid and access to dental care for beneficiaries.

What has the experience in North Carolina been? There have been several rate changes since 1999. These payment rates, however, are still below dentists' fees charged to non-Medicaid patients and are not consistent with a market-based approach. Nonetheless, by April 1, 2003, as a result of a dental care law suit settlement, there was a significant reimbursement rate change for many dental procedures benefiting children.[6] The majority of targeted dental services affected by the reimbursement rate change also happen to be available to the adult Medicaid recipients. These services include, but are not limited to, comprehensive exams, radiographic x-rays, fillings, and extractions. Common adult procedures, however, such as scaling and root planning (i.e., deep cleanings) and dentures were not affected by the rate change.

How have increased reimbursement rates impacted dentists' participation in the Medicaid program and, more importantly, the beneficiaries' utilization of dental services? This question is a difficult one to answer as causality sequencing cannot be established with available data. Preliminary evaluations suggest that increased rates have indeed coincided with improved participation and utilization levels.[7] Following is a brief summary of results:

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Dentists' participation

- During 2001 and 2004, there was a 33% increase in the number of dentists "actively participating" in the Medicaid program (from 644 to 855, respectively). The 1999 North Carolina Institute of Medicine Task Force defined "active participation" in the Medicaid program as those dentists who received more than $10,000 in Medicaid reimbursements in a fiscal year.
- Between 2003 and 2004, 143 new dentists began actively participating in the Medicaid program bringing the overall active dentist participation rate to 24%.

Utilization

- The percentage of Medicaid enrollees receiving dental services increased from 20% in 1998 to 27% in 2004.
- From 2001 to 2004, utilization of dental services among children jumped from 28% to 31%, while utilization among adults aged 21-64, went from 24% to 25%.
- Utilization rates for older adults aged 65 and older remained relatively stable, going from 16% in 2001 to 17% in 2004.

Challenges and Concerns Associated with Reimbursement Rates

Notwithstanding the progress in dentist participation and dental access for the enrollees, a number of challenges and concerns associated with increasing reimbursement rates must be mentioned.[7]

- Increase in access to dental care is primarily attributable to those dentists who were participating in the Medicaid program, but who began to serve more patients after the reimbursement changes. While the number of these dentists is on the rise, it is important to note that among all providers who billed for Medicaid procedures in 2004, only half can be considered as "active" providers in the Medicaid program. In addition, over the past several years, the number of all dentists participating in the Medicaid program has remained relatively flat and may be decreasing as a proportion of all dentists in the state.[7]
- Despite an increase in the dental utilization rate for children, the 31% rate for 2004 still lags below utilization levels of children in the general population. For example, children between 200% to less than 400% of the federal poverty guideline (FPG) and children equal to and greater than 400% FPG have 49.4% and 65.2% dental utilization rates, respectively.[4] In addition, among children whose families can afford private dental insurance, 55.8% were reported to have at least one dental visit during the past year.[8] A more reasonable benchmark against which to compare the progress of the North Carolina Medicaid dental program for children may be the Healthy People 2010 goal that at least 57% of children from low-income families receive a preventive dental visit each year.[9]
- There has been little change in older adults' utilization levels. In fact, dental utilization rates for older adults in the Medicaid program falls far behind those of their counterparts in the general population. In a national study, among older adults with private insurance coverage, 65% reported at least one dental visit during the past year, while among those without private dental coverage, 33.9% had at least one visit.[8]
- The reimbursement rates for certain frequently used and needed services for Medicaid-eligible adults, such as deep cleaning and dentures are low.[7] For example, Medicaid pays $78.11 for a quadrant scaling and root planning, while the standard fee at University of North Carolina at Chapel Hill (UNC-Chapel Hill) dental faculty practice for the same procedure is $196. Medicaid also pays $309 for a complete denture, whereas the fee charged by UNC-Chapel Hill is $903. Such low reimbursement rates may discourage dentists from treating Medicaid-eligible adults who, in turn, without adequate access will be vulnerable to experiencing oral health problems.
- Although the state has taken action to address reimbursement concerns, stakeholders agree that a more comprehensive approach that strives to mirror market-based fees and regularly accounts for inflation is needed.[7] States such as Alabama, Michigan, and Tennessee have established competitive Medicaid reimbursement rates to significantly improve access to dental care.[4] For example, dentists in Tennessee are reimbursed at the 75th percentile of the East South Central region's fees, as determined by the American Dental Association's Survey of Dental Fees. The 75th percentile fee level for a particular region indicates that 75% of dentists in that market are charging that amount or less for a particular service, and 25% of dentists are charging more than that amount for that particular service. States that come close to the 75th percentile fee have experienced positive outcomes. For example, the number of Medicaid-participating dentists in Tennessee increased from about 380 before the rate change to approximately 700 participating dentists after the rate change. Access to dental care rose from 24% to 47%, approaching a range that is seen in the private sector in Tennessee.

At the 2005 North Carolina Oral Health Summit, it was generally agreed that, as an ultimate goal, Medicaid rates should reflect the 75th percentile of market-based fees in North Carolina.[10] Subsequent to the Oral Health Summit, the North Carolina General Assembly appropriated $2.0 million in each year of the biennium to increase Medicaid dental rates.[10] It remains to be seen whether Medicaid payments that approximate private sector markets will result in increased dentist participation in Medicaid and increased access above and beyond current levels.

Nonfinancial Factors in Dentists' Participation in Medicaid

Raising dental reimbursement rates is necessary, though not sufficient, in getting more dentists to treat Medicaid patients. As stated, dentists cite a number of nonfinancial barriers to treating Medicaid patients. Often cited are administrative burdens, including complex provider enrollment procedures, burdensome

patient eligibility processes, and prior authorization requirements. Several states have reported that administrative fixes in Medicaid operations combined with funding improvements have led to increased dentist participation.

North Carolina is illustrative. Medicaid now accepts both electronic and paper claims submissions.[11] Prompt payment mechanisms have been implemented, such that dentists are paid in 17 days and 35 days, respectively. To improve dentist participation and reduce Medicaid claim problems, the North Carolina Division of Medical Assistance (DMA) provides information and education to dental offices on how to file Medicaid claims.

A high "no-show" rate among Medicaid enrollees and patient noncompliance also explain dentists' reluctance to participate in Medicaid. These problems have often been attributed to lack of consumer awareness about the importance of oral health and lack of care coordination within the Medicaid program.[12] Two of the North Carolina Institute of Medicine Task Force's recommendations focused on these issues.[5]

No statewide action has been taken with respect to educational activities for Medicaid consumers.[6] North Carolina would be well advised to look at the oral health promotion programs of other states. In Michigan, for example, the state, collaborating with the Michigan Dental Association, developed an educational publication, *Don't Wait Until it Hurts*, to encourage enrolled beneficiaries to seek preventive dental care.[12] Other states have used a more targeted approach, focusing on populations that are at greater risk.[12] In Maine and Michigan, caregivers of children who have not had a dental visit in the previous year receive periodic reminder mailings to encourage them to schedule a dental exam for their children.

As for care coordination, case management services are needed to help some Medicaid beneficiaries access dental care services and adhere to treatment plans and oral hygiene protocols. The North Carolina DMA has pilot-tested dental care coordination models in some counties.[10] It has found that there are currently insufficient numbers of care coordinators to provide adequate dental care coordination for all Medicaid recipients. Again, our state would be well advised to learn from the experiences of other states. Medicaid agencies in some states have established innovative strategies to enhance care coordination, which include targeting preschool children in Head Start and Early Head Start programs and their families.[12] In Alabama, to improve patient attendance, a "Rights and Responsibilities" packet, which describes the patient's responsibilities and sanctions if the patient misses an appointment, has been developed for use by dentists.[12]

Among the suggestions offered at the 2005 North Carolina Oral Health Summit regarding dental care coordination, was to extend care coordination to beneficiaries with an enhanced risk for dental caries or for complications from dental disease.[10] Studies will be needed to assess whether more intense and organized assistance to beneficiaries will result in increased access to dental care.

Success in increasing dentist participation in the Medicaid program also hinges on successful outreach efforts targeting dentists.[4] Over the past several years, the North Carolina Dental Society, whose membership includes approximately 86% of private dentists in the state, has been at the forefront of encouraging private dentists to treat patients on Medicaid.[7] Through newsletters and statewide and regional meetings, the Dental Society has been actively promoting changes, financial (e.g., rate changes) and administrative (e.g., enhanced claim filing systems), which have been implemented within the Medicaid dental program.[7] In a joint effort with the DMA, a Frequently Asked Questions (FAQ) document, which addresses common provider questions and concerns, was developed and subsequently promoted within the membership. Similarly, seminars and workshops have been conducted not only to respond to provider inquiries and address misconceptions about Medicaid, but also to share the positive relationship that exists between the Dental Society and DMA. These and other outreach activities need to continue in an effort to increase dentist participation in Medicaid and improve access to dental care.

Provider Attitudes and Behaviors

An important aspect of dental care access, which has received little attention, is the reportedly negative attitudes and behaviors of some dentists and their staff toward patients who are insured by Medicaid.[13] Stigma associated with those on a public assistance program may keep some dentists away from treating Medicaid clients. It is not known if these dentists would see Medicaid patients even after addressing the financial and nonfinancial factors presented above.

In a North Carolina study, a diverse group of Medicaid beneficiaries explained that, after negotiating one barrier after another (e.g., finding a provider, obtaining convenient appointment times, securing transportation, etc.) to get a dental appointment, they faced what they perceived as judgmental, disrespectful, and discriminatory attitudes and behaviors from dentists and their staff because of either their race and/or public assistance status.[13] For some beneficiaries, such perceived treatment discouraged their efforts to pursue dental care. Quality patient care requires that health professionals be aware of and respond to individual differences among patients, evaluate information about them in an objective, unbiased manner, and develop relationships that promote open and trusting communication. The current proposals aimed at improving access to dental care for Medicaid enrollees (e.g., increased reimbursements, patient education) fall short of addressing the more vexing obstacles to dental care that beneficiaries face. Thus, strategies to improve dental care access for Medicaid enrollees should also focus on cultivation among dentists of more "patient-centered care" that is culturally respectful and responsive to patients' values and needs.

North Carolina Health Choice for Children

In October 1998, North Carolina implemented its State Children's Health Insurance Program (SCHIP), entitled North Carolina Health Choice for Children (NCHC). NCHC offers healthcare coverage to uninsured children who come from working families with incomes that are too high to qualify for Medicaid, but too low to afford private insurance. NCHC

provides comprehensive health insurance coverage, including dental, vision, and hearing services. A major feature of NCHC has been reimbursing dentists generally at 90 to 95% of usual, customary, and reasonable fees.[14]

NCHC has greatly improved access to dental care.[14,15] These children have experienced much better access to dental care when compared to children enrolled in Medicaid. Evidence shows that participation in NCHC is associated not only with increased dental utilization and regular dental care, but also reduced unmet dental needs. Improvement in access to dental services for low-income children in North Carolina is consistent with the results that other states have witnessed under SCHIP.[16] The success of state SCHIP programs in increasing access to dental care has been attributed to a variety of factors. Central among these has been paying dentists' fees close or equal to their usual private practice charges.

Despite these reported gains, because of budgetary constraints, the North Carolina General Assembly has recently enacted legislation to transfer coverage of children aged birth to five from NCHC to Medicaid.[10] The General Assembly also passed legislation to reduce all of the NCHC provider payments from the current reimbursement rates to the Medicaid rates for children aged 6-18 by July 1, 2006.[10]

Such actions prompt a number of questions and concerns. For example, how will the new changes impact access to dental care for the affected children? What type of effect will these changes have on dentists? Will affected children lose their usual source of dental care? It would seem that an important first step toward ensuring that low-income children have access to dental care is for the state to adopt the kind of Medicaid fees that will attract sufficient numbers of providers. Without such a commitment, we may well lose the important gains made by NCHC toward reducing the dental access gap for low-income children.

Conclusion

Issues surrounding participation of dentists in the Medicaid program are complex. Accordingly, increasing such participation requires a multifaceted strategy. Stakeholders in North Carolina have taken significant steps toward improving dentist participation in Medicaid. Notable among these has been a consistent increase in Medicaid reimbursement rates, which has been associated with improved participation and access to dental care. But, challenges remain with respect to attracting more dentists. Adequately addressing these and other challenges should significantly improve access to dental care for underserved populations and reduce oral health disparities. **NCMedJ**

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