Chapter 3: Dental Services

Executive Summary

Description

Kansas Medicaid and State Children's Health Insurance Program (SCHIP) provide a comprehensive dental benefit package for children, some developmentally disabled adults, and adults receiving services through Home and Community-Based Services (HCBS) waivers. In state fiscal year (FY) 2007, approximately 24,000 SCHIP beneficiaries received dental services totaling $7,330,140 with an average payment per beneficiary of $305.42. Approximately 70,500 Medicaid beneficiaries received dental services in FY 2007 totaling $27,115,769 with an average payment per beneficiary of $384.20.

Key Points

- *Lack of Adult Dental Coverage*

  As a result of health reforms included in Senate Bill 81, a comprehensive dental benefit will be offered to pregnant women beginning May 2009, pending confirmation of full funding through the consensus caseload appropriations process. However, other non-disabled adults on Medicaid (e.g., parents) continue to have access only to emergency dental services.

- *Need for Increased Rates*

  Kansas, like most other states, is facing a significant dental provider shortage and ranks 29th in the nation in the number of dentists per capita. Kansas has a dentist to population ratio of 1 to 2,127 compared to the national average of 1 to 1,888 residents. Reimbursement rates and administrative simplification are commonly thought to be critical factors in attracting and retaining Medicaid-participating dentists.

    - Kansas providers receive just over 60% of the average private reimbursement for our region. Participating dentists frequently raise the issue of reimbursement as a potential barrier to continuing to serve Medicaid and SCHIP beneficiaries

- *Need for Increased Access*

  Although in May 2008 the number of dental providers actively billing Medicaid increased, access remains a significant concern, especially in the context of the pending coverage expansion for pregnant women.

Kansas Health Policy Authority (KHPA) Staff Recommendation

- Expand more comprehensive dental coverage to adults enrolled in Medicaid. Non-emergent preventive and restorative care is not available under the current policy, creating more serious health issues and lower oral health status for poverty-level Kansans.
- Engage medical practitioners in addressing the oral health status of poverty-level Kansans.
- Explore potential options to expand the dental work force.
    - Recruit dentists to Kansas.
    - Promote changes to increase the dental work force with hygienists, mid-level practitioners and/or graduating dentists.
    - Continue support of dental hub model.

Additional Option Identified by KHPA Staff

- Increase dental reimbursement from the current level of 60% of usual and customary reimbursement to help increase dental service access for existing beneficiaries.

Program Overview

The dental program provides dental access to eligible Medicaid and State Children's Health Insurance Plan members. A variety of dental benefit packages are available to different Medicaid populations based on eligibility criteria.

Comprehensive dental coverage is available to:

- Medicaid eligible children under age 21
- SCHIP eligible children under age 19
- Adults with development disabilities, who reside in Intermediate Care Facilities (ICF/MR), age 21 or older
- Home and Community Based Waiver Services (HCBS) members age 21 or older
    A. Mental Retardation/Developmental Disabilities
    B. Traumatic Head Injury
    C. Physical Disability
    D. Frail Elderly (FE)-including dentures
- *Pregnant women, target implementation of May 2009*

Emergency services (only) are available to:

- Medicaid eligible adults age 21 or older

For populations with comprehensive coverage, the dental benefit packages are designed to be as similar as possible to ease provider burden. However some differences in prior authorizations and current dental terminology (CDT) codes exist between the benefit packages.

The children's benefit package provides most dental services; however, orthodontia is limited to children with genetic abnormalities or severe trauma. The benefit package for ICF/MR members provides most dental services but does not include coverage for dentures. The benefit package for the waiver programs covers most dental services; but only the FE waiver includes coverage for dentures.

Adults with Medicaid coverage receive emergency services only, such as, extractions for infected

teeth and the related diagnostic services, removal of oral lesions, and treatment of facial fractures. The benefit package for pregnant women is in development and will be comprehensive in nature.

The following providers are allowed to submit claims for dental services subject to applicable laws and regulations:

- Dentists (including all dental specialists)
- Intermediate Care Facilities for the Mentally Retarded
- Indian Health Clinics (IHC)
- Federally Qualified Health Centers (FQHC)
- Head Start
- Local Health Departments (LHD)

Unlike the medical profession, mid-level dental professionals are not allowed to practice independently and cannot submit claims to Medicaid directly for their services. Mid-level practitioners must bill through a supervising dentist. Claims can be filed up to a year after the service has been provided, for that reason FY 2007 data is not complete.

Recent Program Improvements

Several improvements have recently been made to increase access to dental care in Kansas. In response to provider complaints and difficulty with the claims process, the Kansas Health Policy Authority (KHPA) changed fiscal agents for the Medicaid and SCHIP dental program in July of 2006. Electronic Data Systems (EDS) began processing dental claims on July 1, 2006 which provided the opportunity for administrative changes. EDS provided a dental services team which was comprised of a dental assistant and three other trained personnel to focus solely on dental provider outreach and inquiries. The state web site was enhanced to give dental providers a five year client history of dental services that had been provided. It also has drop down boxes on the electronic claim form so providers need not submit additional documentation with claims.

Other changes have occurred in the dental program over the years to streamline the claims process for providers. On December 1, 2004, four dental codes for all populations had prior authorization (PA) status removed. On October 1, 2005, 20 dental codes for adults, six dental codes for children and all dental codes for members in ICF/MR facilities had their PA status removed. These PA status removals were prompted when a review showed that over 95% of the PAs submitted were being approved. The change of fiscal agent and administrative simplifications were made to increase access and provider participation, the programs' principle challenge.

Access to Dental Services

There are 561 dental providers enrolled in Medicaid and 348 dental providers enrolled in SCHIP. As of June 2007, the Kansas Dental Board reports 1,367 licensed dentists in Kansas, although some dentists are not active in providing clinical services. EDS contacted non-participating dental providers across the state in the fall of 2007 to recruit additional providers. A letter outlining the dental program was sent to these providers, and followed up with a phone call to the provider. Since July 1, 2007, 43 new dental providers have enrolled in the Medicaid program and 34 new dental providers enrolled in the SCHIP program.

Access issues are a problem for dental programs nationally. Although there has been a modest increase in the number of dental providers enrolled in Kansas Medicaid and SCHIP these issues continue to threaten the viability of our dental program. To advise the agency on matters of dental coverage and policy, KHPA convenes an advisory board on a quarterly basis that consists of KHPA staff, fiscal agent staff, dentists, and Kansas Dental Association staff. Their purpose is to give input on policy formation and relevant dental issues. The board has given recommendations regarding the recommended dental visit schedule, dental claim forms, benefits, and appropriate services to cover and reimbursement.

In Kansas, the Office of Oral Health with the Kansas Department of Health and Environment also collaborates with and provides technical assistance to communities, schools, health professionals, local health departments, professional groups, and various governmental agencies, both state and local. KHPA maintains an active link with the Office of Oral Health. The Office seeks to increase awareness regarding the importance of oral health and improve oral health status by providing education, consultation and training that focuses on health promotion and disease prevention. After consultation with the Association of State and Territorial Dental Directors (ASTDD), as well as meetings statewide with oral health advocates and state and community organizations, the Office of Oral Health issued an oral health plan.

The 2007 Kansas Oral Health plan addresses workforce issues with several strategies (See Attachment A):

- Develop a Statewide Recruitment System for Dentists and Dental Hygienists
- Improve Kansas Loan Re-Payment Programs
- Reduce Barriers to Rural Practice in the Kansas Dental Practice Act
- Explore Options to Assist Students Interested in Kansas Public Health Dentistry to enter Dental School and Finance their Dental Education
- Support and Encourage Community Based Extended Care Permit Hygienists
- Integrate Oral Health into Primary Care
- Evaluate the costs and benefits for a Kansas Dental School and/or more dental Residency Programs
- Support and Monitor the Wichita Advanced Education for General Dentistry program
- Provide Educational Opportunities for Dental and Dental Hygiene Students in underserved areas in Kansas

Analysis of Performance Data

As noted earlier there has been an increase in the number of providers enrolled in Medicaid and SCHIP. Analysis of claims data reveals that there have been other improvements to measured access to care as well. According to the monthly analysis (below), for both Medicaid and SCHIP, the number of providers actively billing Medicaid has increased. The number of beneficiaries being served has also increased.

Table 1
Medicaid Provider Participation

	FISCAL YEAR-TO-DATE	
	2008	**2007**
Providers Enrolled	550	602
Providers Participating	332	318
Percent Enrolled Providers Participating	60.34%	52.94%
Total Claims Paid	184,714	179,439
Claims Paid Per Participating Provider	556.52	563.47
Total Payments	$28,525,387.61	$28,311,945.11
Average Payment Per Participating Provider	$85,943.38	$88,904.20
Average Number of Services Per Participating Provider	2,181.96	2,202.28
Average Payment Per Service	$39.39	$40.37

Table 2
SCHIP Provider Participation

	FISCAL YEAR-TO-DATE	
	2008	**2007**
Providers Enrolled	331	327
Providers Participating	257	250
Percent Enrolled Providers Participating	77.84%	76.41%
Total Claims Paid	51,379	51,926
Claims Paid Per Participating Provider	200	208
Total Payments	$7,489,197.63	$7,096,431.06
Average Payment Per Participating Provider	$29,089.40	$28,427.07
Average Number of Services Per Participating Provider	795.66	818.89
Average Payment Per Service	$36.56	$34.71

Table 3
Medicaid Beneficiary Participation

	FISCAL YEAR-TO-DATE	
	2008	**2007**
Total Beneficiaries Served (duplicated)	148,602	143,444
Average Payment Per Beneficiary	$191.96	$197.37
Services Rendered	724,211	701,327
Average Number of Services Per Beneficiary	4.87	4.89

Table 4
SCHIP Beneficiary Participation

	FISCAL YEAR-TO-DATE	
	2008	**2007**
Total Beneficiaries Served (duplicated)	42,600	42,107
Average Payment Per Beneficiary	$175.80	$168.53
Services Rendered	204,846	204,424
Average Number of Services Per Beneficiary	4.81	4.85

Kansas has shown an increase in the percentage of children receiving any dental service over the last two years for both Medicaid and SCHIP. Kansas children receiving any dental service (tables 5 and 6) are above the national average of 33% participation. As the only population with comprehensive preventive and restorative care, counting the number of children in Medicaid who receive dental care gives us the clearest picture of potential access through Medicaid. Despite the welcome increases in FY 2007 and FY 2008, utilization is below levels recommended by the American Academy of Pediatric Dentistry which emphasizes early intervention and continuity of care based on the individual child (see table 7).

Table 5
Medicaid-Percentage of Participation

				Age Groups				
	Total	**<1**	**1–2**	**3–5**	**6–9**	**10–14**	**15-18**	**19-20**
FY 08	41%	3%	21%	54%	57%	52%	44%	19%
FY 07	40%	3%	18%	51%	55%	51%	42%	19%
FY 06	38%	3%	14%	50%	53%	50%	43%	19%

Table 6
SCHIP-Percentage of Participation

				Age Groups				
	Total	**<1**	**1–2**	**3–5**	**6–9**	**10–14**	**15-18**	**19-20**
FY 08	46%	3%	20%	46%	58%	52%	39%	2%
FY 07	44%	1%	18%	45%	56%	49%	37%	1%
FY 06	42%	1%	11%	41%	54%	46%	39%	2%

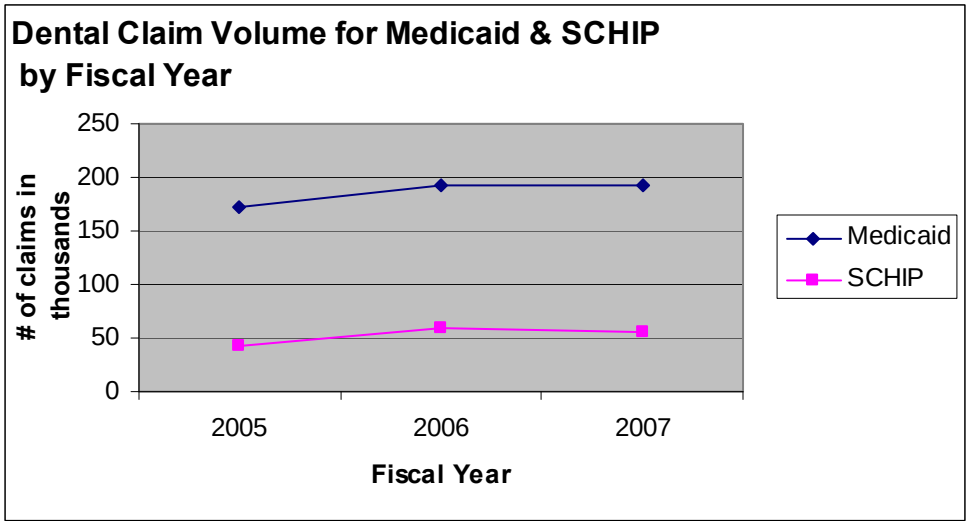
Table 7
American Academy of Pediatric Dentistry Recommendations

		Age Groups				
	6-12 months	12-24 months	2-6 years	6-12 years	12 years & older	
Oral Exam	x	x	x	x	x	x
X-ray Assessment	x	x	x	x	x	x
Cleaning/topical fluoride	x	x	x	x	x	x

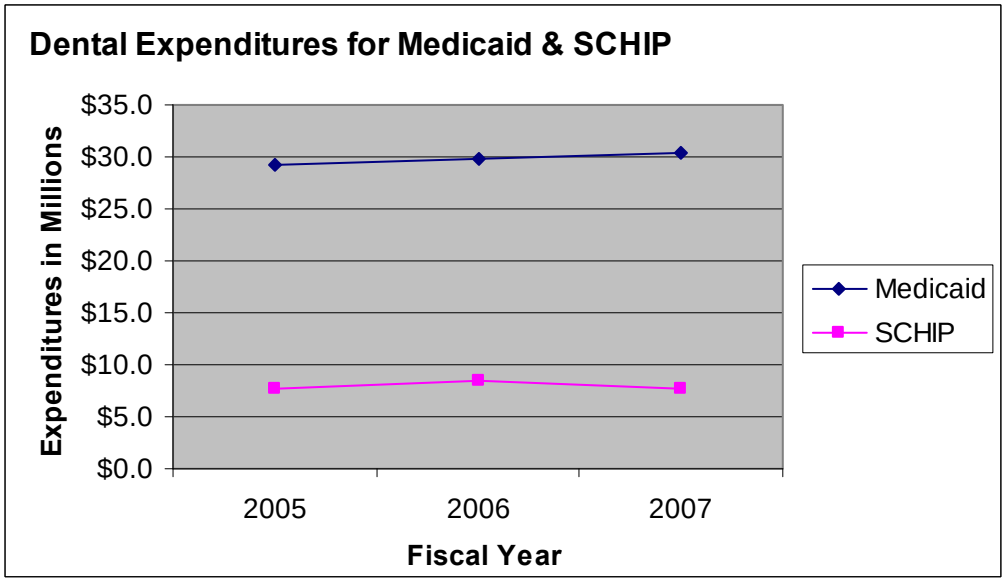
Analysis of Expenditures

In performing a yearly review of the dental program it is important to examine claims data and expenditures. The data show that expenditures for the dental program have slightly increased over the past three state fiscal years (Graphs 1 and 2).

Graph 1

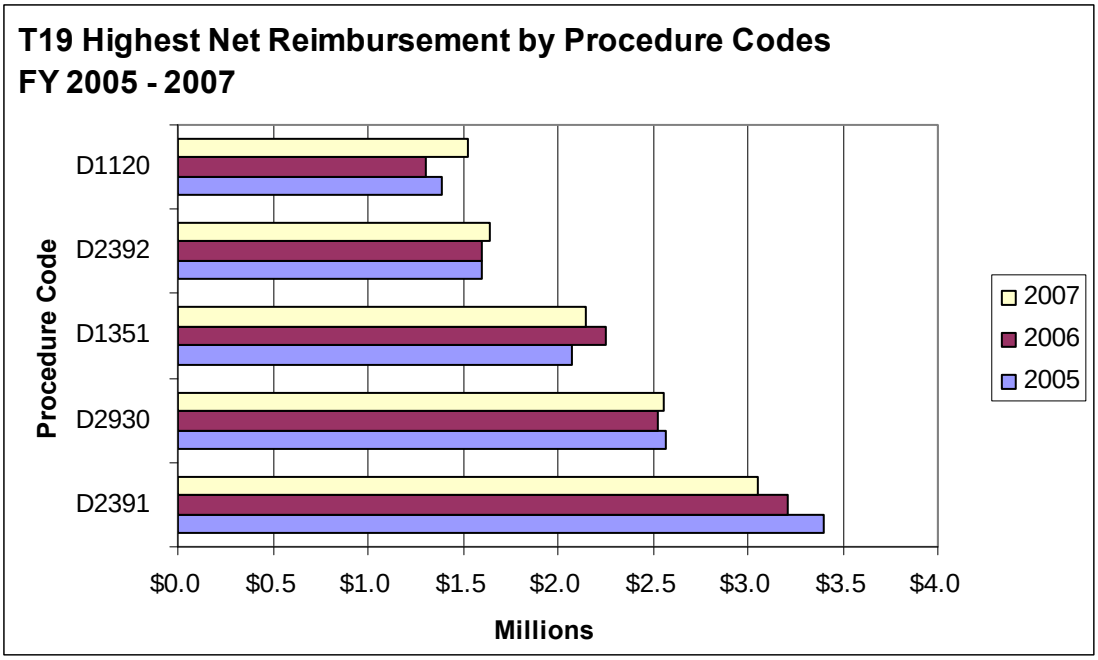


Graph 2



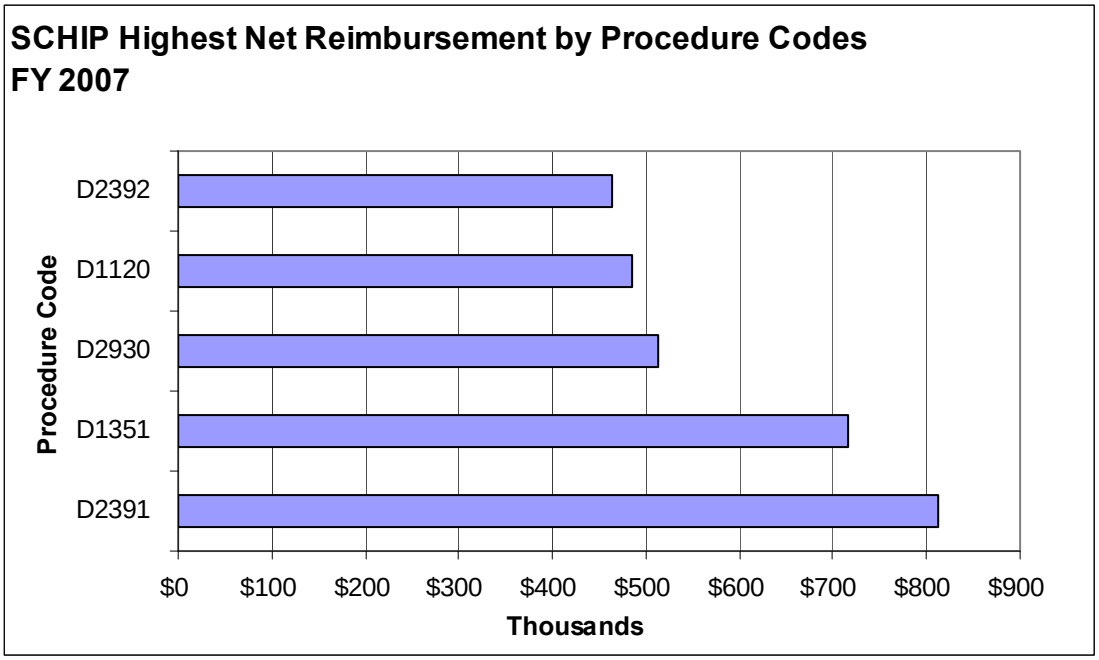
Analysis of the top five dental services reimbursed over the past fiscal years for Medicaid and SCHIP (Graphs 3 and 4) reveal that those services have remained the same over the review period. There have been some modest changes in utilization patterns over the FY 2005-2007 period however. In general, preventive services appear to have increased slightly while restorative services have either remained constant (crowns) or declined (fillings). Future analysis will help determine whether the data indicates a change or trend in the types of services provided. If trends are established they will be evaluated for potential program implications.

Graph 3



D1120 Child prophylaxis (cleaning of teeth)
D2392 Two-surface resin-based composite (filling)
D1351 Sealant, per tooth
D2930 Stainless steel crown, primary tooth
D2391 One-surface resin-based composite (filling)

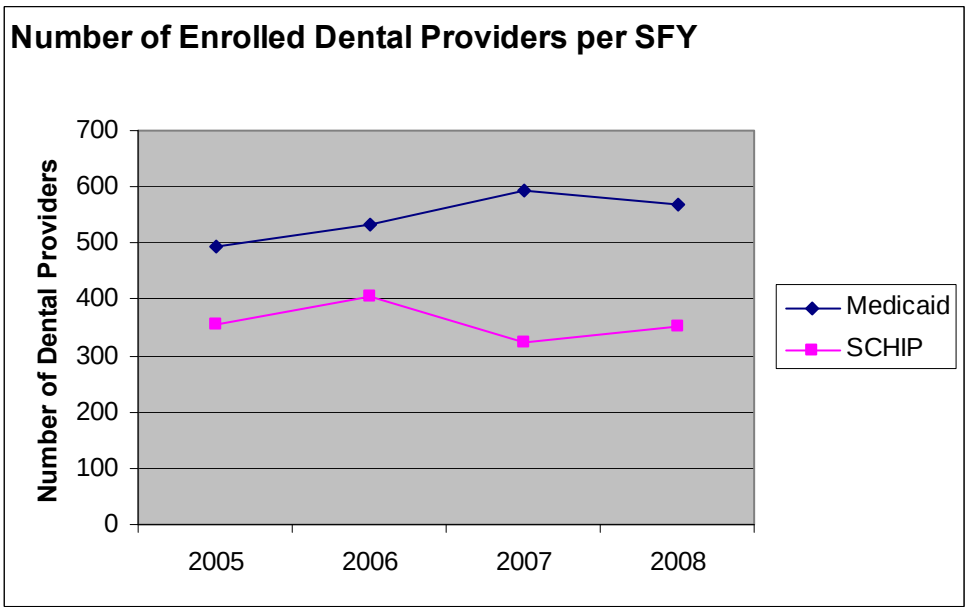
Graph 4



* *Encounter data (claims information supplied to our fiscal agent by the managed care organization) issues for SCHIP make the data before 2006 less reliable.*

The number of enrolled dental providers as seen in graph 5 suggests a decrease in providers serving SCHIP members in 2007. On July 1, 2006, KHPA changed fiscal agents for the dental program, and a thorough review of providers was conducted. KHPA discovered SCHIP had providers listed who had moved, retired or were no longer active providers. This artificially inflated the number of active SCHIP providers reported for 2006. Medicaid providers decreased slightly in 2008.

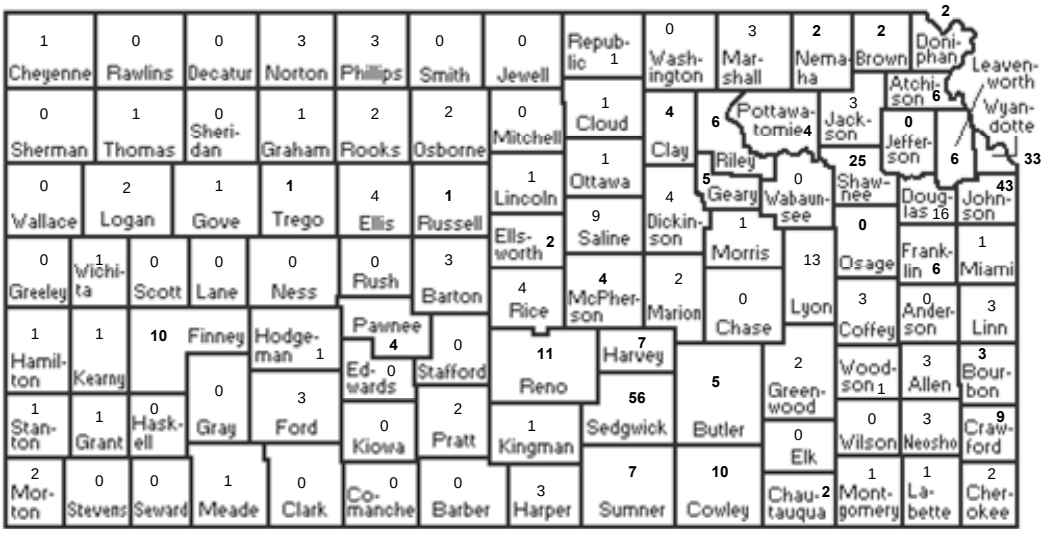
Graph 5



Provider Participation and Satisfaction

As access is an important issue in the Medicaid dental program, this review examined provider distribution. Illustrations 1 and 2 indicate the number of providers who billed for dental services in the first quarter of 2008. The data shows many counties in Kansas with no active billing providers.

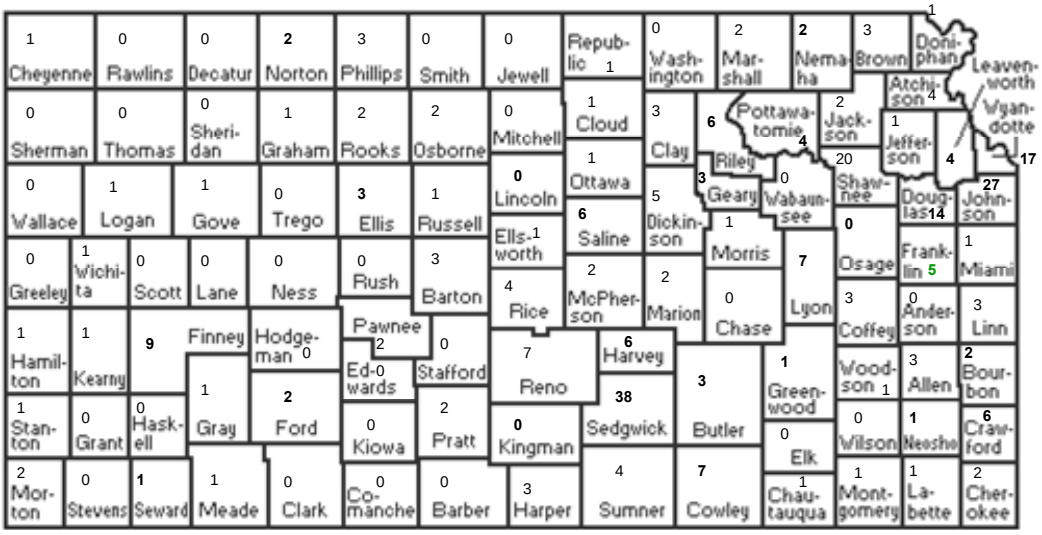
Illustration 1
Medicaid Provider Participation – 1st Quarter, 2008



Border State Providers:

- Missouri - 17
- Oklahoma - 1
- Nebraska - 0
- Colorado - 0

Illustration 2
SCHIP Provider Participation – 1st Quarter, 2008

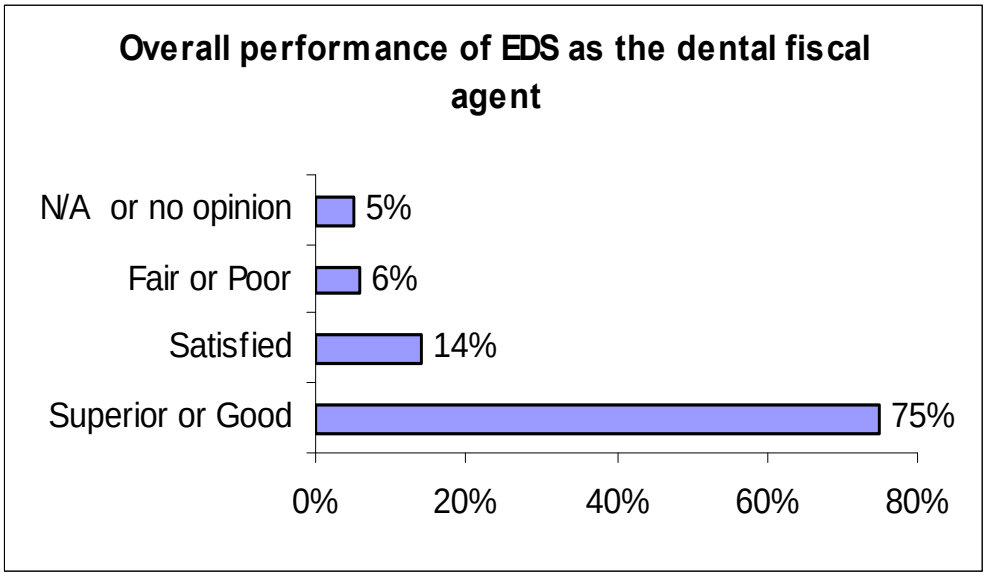


Border State Providers:

- Missouri - 13
- Oklahoma - 1
- Nebraska - 0
- Colorado - 0

KHPA has made a number of changes in the dental program to address this access issue for beneficiaries. The fiscal agent change in July 2006 was prompted, in part, by provider dissatisfaction with the claims process. Providers appear more satisfied with the current fiscal agent according to a survey fielded in November 2006 (repeat survey has not yet been conducted). Providers were asked to assess their experience with EDS operating as the dental fiscal agent. One hundred and seventy-nine of the five hundred and twenty surveyed dentists gave input. Eighty-nine percent of responding providers were satisfied with EDS as the dental fiscal agent, indicated by the graph below. Other changes to the dental program are listed below and were aimed at improving access and increasing provider satisfaction.

Graph 6



Program Improvements

- Since 2001, the Medicaid and SCHIP dental benefit packages for children have been made as similar as possible for provider ease
- Reimbursement for fluoride application was permitted for medical providers effective August 2005
- Review of all dental payment rules from program inception was accomplished by the dental program manager and master dental policies were written
- Appreciation letters to long-time providers from Governor sent May 2007
- Home and Community Based Services (HCBS) waiver dental program effective April 2007
- Frail and Elderly (FE) dental waiver program effective October 2007
- Provider community is embracing electronic claim filing as over 75% of dental claims are being filed electronically
- In June of 2005 a recommended dental visit schedule from the American Dental Association, American Academy of Pediatrics and the American Academy of Pediatric Dentists was adopted
- Pregnant women dental program targeted to be implemented May 2009

Key Points

- A national shortage of dental providers is well-documented. The number of Kansas dental providers is projected to decline without significant policy intervention in the next decade according to a report published in January 2005 by the Kansas Health Institute, "The Declining Supply of Dental Services in Kansas: Implications for Access and Options for Reform." Most dental providers in Kansas are in the urban areas, with fewer in the rural/frontier counties. Kansas is underserved by the dental workforce, according to the Kansas Oral Health Plan published in November 2007 by the Office of Oral Health at the Kansas Department of Health and Environment.

    - Kansas' shortage mirrors national trends and illustrates the need for federal leadership. Kansas is 29th in the nation in the number of dentists per capita, with a statewide Kansas dentist to population ratio of 1 to 2,127. This is under the national average of 1 dentist per 1,888 US residents. This disparity is significantly greater in the more rural areas of Kansas.

    - States have been attempting to compensate for the dental workforce shortage in various ways. Some states report increased dental access with the use of a managed care approach to dental, while other states report success with a traditional fee for service model. Administrative burdens have been reduced for providers by streamlining the contract/recredentialing process, reducing the number of prior authorizations, providing electronic verification of eligibility, and providing electronic claim and X-ray submission.

    - Pilot projects to provide case management, transportation or enhanced reimbursement to providers have shown increased access in some states. Mobile units have been utilized in less populated areas to increase access. Loan forgiveness to dental providers who serve low-income populations can increase dental access.

    - Medical practitioners have been allowed to provide oral assessments, fluoride applications or other dental services in some states. Extending the scope of practice of dental assistants and hygienists has been allowed in several states; some states allow dental hygienists to be a Medicaid provider and directly bill Medicaid.

- Reimbursement is also thought to be a critical factor in attracting and maintaining dental providers. Providers are receiving just over 60% of the average reimbursement for our region according to the American Dental Association (ADA) 2007 Survey of Dental Fees book. The ADA Survey of Dental Fees book gathers from a random sample of dentists the fee most often charged for commonly performed dental procedures.

- The Centers of Medicare and Medicaid Services (CMS) recently initiated an emphasis on Medicaid dental services nationally. CMS conducted on-site reviews of dental programs in 16 states with the lowest reported rates of dental utilization. All states have been asked to submit information on utilization, rates, recommended dental visit schedules, provider recruitment and beneficiary outreach. All states will receive an on-site audit of their dental program.

- The dental hub model operating in Federally Qualified Health Centers (FQHCs) throughout the state is a strategy to increase access to dental services for beneficiaries in a clinic service area. However FQHCs account for only 2.5% annual Medicaid dental expenditures.

- The issue of how Medicaid can support the dental hub model and increase its productivity needs to be addressed. FQHCs are faced with the dental provider shortage and attracting clinicians to their service model. The FQHC model is quite different from the typical dental provider who owns and operates his/her own office.

- FQHCs report that providing dental care to a large number of uninsured adults threatens the financial stability of their dental programs. Because of this problem, many clinics try to limit their patient pool to children, and do not provide adults with comprehensive restorative care. Offering an adult Medicaid dental benefit would provide these clinics with a source of payment for what is currently uncompensated care, and would increase access to safety net dental clinics for Medicaid adults.

- The long term sustainability of the "dental hub" program relies on Medicaid reimbursement. Without an adult Medicaid benefit plan, dental hubs will continue to reduce the scope of services available to adults in safely net clinics, and continue to perform high levels of uncompensated care.

This review has documented a modest increase in participating dentists and an associated increase in access to dental care for Medicaid beneficiaries. However, levels of use among Medicaid and SCHIP children are inadequate which may suggest that significant barriers to access remain. In the context of a nationwide decline in the availability of dental practitioners, solutions are difficult. KHPA has identified two areas for additional research and planning:

Recommendations

1. Pursue dental coverage for all adults in Kansas Medicaid. There are numerous reasons to add dental coverage to the benefit plan for adults. First, good dental health may improve overall health and decrease medical costs related to premature births, heart disease and cancer. Current research has shown a correlation between dental health and these conditions/diseases. For more on the status of the oral-systemic disease link, see the special supplement to the October 1, 2006 *Journal of the American Dental Association* available at http://jada.ada.org/content/vol137/suppl_2/index.dtl.

   Second, providing dental coverage for adults may improve the dental health of children with Medicaid coverage. Adults with poor dental health may not be able to model good oral health care to their children; therefore the cycle of poor oral health is continued. Also dental caries is an infectious disease, caused by bacteria and exacerbated by bad eating habits and poor oral hygiene. Adults with poor oral health can infect their children with dental caries through their saliva. Providing adults with education about caries prevention and nutrition as well as reducing the amount of bacteria in the parent's mouth could ultimately result in less dental disease in children as well as adults (based on discussions with Dr. Katherine Weno, Director, Kansas Office of Oral Health).

   Third, untreated dental disease results in pain, infection and tooth loss. Uninsured adults often seek dental emergency treatment in the hospital emergency room, often a costly and highly inefficient way to provide dental services.

   Finally, dental disease and tooth loss can undermine an individual's self-esteem making social interaction difficult and specifically creating another barrier to meaningful employ-

ment for beneficiaries with poor oral health. Providing Medicaid adults with a dental home will reduce costly dental emergency room visits and provide adults with options for tooth replacement to enhance self esteem through social interaction and self sufficiency.

2. Promote the application of fluoride by medical practitioners. Fluoride gel was found effective in preventing caries in school-aged children according to several studies cited in the August 2006 *Journal of the American Dental Association.*

3. KHPA will continue to support the expansion of the dental workforce through multiple avenues. This includes the promotion of the dental hub model and its expanded use of dental hygienists as a way to reach dentists practicing in Kansas. The dental workforce of Kansas is below the national average and shrinking. Additional options to consider should the dental workforce continue to shrink include a review of the pros and cons of the licensure and reimbursement of mid-level practitioners.

4. Pursue an increase in dental reimbursement greater than the current level of 60% of usual and customary reimbursement to help increase dental service access for existing beneficiaries. KHPA is aware that improving access is dependent upon addressing multiple barriers to care including reimbursement for services. Kansas has already made administrative changes to make the billing process more streamlined and less cumbersome. The next step may be an increase in reimbursement. Other states have increased rates and had an in crease in access to dental services. Michigan increased Medicaid rates close to commercial rates noted in the November 2003 *Journal of the American Dental Association.* Alabama increased rates to 100 percent of Blue Cross/Blue Shield regional rates noted in the 2003, 19 supplement, *Journal of Rural Health*. Both of these states saw an increase in access.

See Appendix A
Oral Health Plan