



## Dental Public Health Activities & Practices

**Practice Number:** 17002  
**Submitted By:** Oral Health Division, Indiana State Department of Health  
**Submission Date:** June 2002  
**Last Updated:** June 2002

<b>SECTION I: PRACTICE OVERVIEW</b>		
<b>Name of the Practice:</b> Reforms in Indiana's Medicaid Dental Program		
<b>Public Health Functions:</b> Assessment – Use of Data Policy Development – Collaboration & Partnership for Planning and Integration Assurance – Building Linkages & Partnerships for Interventions Assurance – Building Community Capacity for Interventions Assurance – Access to Care and Health System Interventions		
<b>HP 2010 Objectives:</b> 21-1 Reduce dental caries experience in children. 21-2 Reduce untreated dental decay in children and adults. 21-3 Increase adults with teeth who have never lost a tooth. 21-4 Reduce adults who have lost all their teeth. 21-5a Reduce gingivitis among adults. 21-5b Reduce periodontal disease among adults. 21-10 Increase utilization of oral health system. 21-12 Increase preventive dental services for low-income children and adolescents.		
<b>State:</b> Indiana	<b>Region:</b> Midwest Region V	<b>Key Words:</b> Medicaid, access, utilization, low-income, Medicaid providers, Medicaid dentists, Medicaid reimbursement, Medicaid reforms
<b>Abstract:</b> Indiana dentists did not escape the backlash from the soaring cost of health care in the early 1990's. In response to double-digit inflation in the total Medicaid budget in Indiana, the state slashed Medicaid dental reimbursements in 1994. The cuts left dentists coping with Medicaid reimbursements averaging 30% of UCR, while also facing implementation of a managed-care plan for Medicaid dental care. The result was that fewer dentists participated as Medicaid providers with utilization falling to under 10% in the "risk-based" managed care program by 1997. This practice highlights the dramatic and sweeping reforms that occurred in Indiana's Medicaid dental program in 1998 resulting in an increased number of patients accessing dental services in the program. In March 1997, only 751 dentists were still listed as participating in the Medicaid program due to the mass exodus that occurred in 1994. After changes in the program, this number rose to 1,446 dentists as of December 2001. Medicaid patients receiving dental services went from 94,815 in 1997 to 250,354 in 2001. The number of claims went from 707,617 to 2,044,701 and the total dollar amounts paid went from \$14,061,586 to \$110,632,533 (1997-2001).		
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## SECTION II: PRACTICE DESCRIPTION

### **History of the Practice:**

In an effort to constrain Medicaid expenditures, the Office of Medicaid Policy and Planning (OMPP) significantly dropped dental reimbursement rates in January 1994 to 56.8% of the average 1992 statewide charge (ADA Department of State Government Affairs – How the Indiana Dental Association Met the Access Challenge, August 1998). This was done without consultation or input from the Indiana Dental Association (IDA). The resultant mass exodus of dentists from the program was swift and significant. As Medicaid participation by dentists plummeted, it was dentists who received the blame. Understanding the effects of negative public relations, the Indiana Dental Association knew that any effort to reform the state Medicaid program would have to focus on access to care issues.

While IDA began discussion with OMPP about the dental access problem and its causes, the IDA Council on Government Affairs approved a Medicaid dental reform agenda. The reform mechanism was designed to (1) increase reimbursement; (2) carve dental care out as a distinct delivery program for Medicaid; (3) give Medicaid patients the freedom to choose their dentists; (4) let any dentist willing to participate do so without joining a network; and (5) provide dental input into the Medicaid policy making process.

At the same time, Dr. Virginia Caine, a Marion County (Indianapolis) Health Officer, contacted the IDA for assistance to form the Marion County Dental Health Coalition. Recommendations offered by the Coalition were consistent with those of the IDA. With a broader coalition behind the IDA reforms, it became clear that dentists were serious about addressing the question of Medicaid access and came to the table prepared to offer concrete, constructive solutions to the question.

With the dawn of the 1997 legislative session, the IDA/Dental Health Coalition's reforms for the Medicaid dental program were introduced in the House of Representatives. With the Chair of the House Public Health Committee as the sponsor, the IDA's bill, HB 1975, sailed through the Public Health committee. However, when the fiscal impact of \$20 million was attached to the bill, it died in the House Ways and Means. Despite the untimely death of HB 1975, policymakers began to take notice of the access problems dentistry had brought to the table. Many observers were surprised when the House Public Health Committee unanimously approved the bill. One observer was OMPP, which after the session contacted IDA concerning the formation of a Dental Advisory panel within OMPP. With the cooperation of the IDA, the Dental Advisory Panel of the OMPP was formed. Working throughout 1997, the committee reviewed every aspect of the Medicaid dental program. While the Dental Advisory Panel grappled with Medicaid dental reforms for Indiana, CHIP was enacted at the federal level in 1997. To foster implementation of CHIP, the Governor formed a CHIP advisory panel. Understanding how CHIP would play a major role in the future of Medicaid, the IDA gained representation on the CHIP committee.

As the 1998 legislative session dawned, IDA again sought legislative introduction of its reform package. The result was SB 1380 and was assigned to the Senate Ways & Means committee. Despite that SB 1380 never received a hearing, the bill provided the necessary political capital to keep the Medicaid program reform process moving.

When the Dental Advisory Panel of OMPP issued its recommendations, the OMPP Director took the recommendations forward to the state budget agency for approval. Included among the suggestions were recommendations that resulted in an average increase of 119% for Medicaid dental reimbursements. The IDA's efforts had managed to turn the Medicaid issue from which organized dentistry often receives negative publicity into a victory that will improve dental care access for Medicaid patients.

### **Justification of the Practice:**

Indiana is similar to other states in that there are the "haves" and the "have nots". The "haves" are doing fine – they have preventive services available, experience no or minimal level of dental disease, and do not have a problem in accessing care. However, the "have nots" bear the brunt of the disease because of socioeconomic considerations that results in lack of insurance and lack of access to care. Nationally, it is estimated that 20% of the children account for 80% of dental disease and that only one in five Medicaid children see a dentists on a yearly basis.

The need to access dental care in Indiana is well demonstrated by the number of calls received by the 1-800 state Family Helpline. Dental-related calls are the number one reason people call the Helpline, and it has been the top reason for every month of every year since July of 1994. The 1-800 statewide Family Helpline received 57 dental-related calls during June 1993. In four weeks the number of calls jumped to 189, mainly because of the sudden departure of providers after the Medicaid dental reimbursement rates were cut in January 1994. The total number of calls for 1994 was 759. This skyrocketed to 3,689 in 1995 and 5,319 in 1999.

**Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:**

The OMPP is part of the Indiana Family and Social Services Administration and although they are responsible for the overall administration of the Medicaid program, they subcontracted the day-to-day operations to EDS (Medicaid's fiscal agent contractor) and Hoosier Healthwise.

Because of the exodus of dentists from the program in 1994 and the resultant crisis of unmet needs and access to care availability, OMPP was forced to implement sweeping and dramatic changes in the Medicaid dental program in 1998. These included:

- 1) A 119% increase in Medicaid dental reimbursement. This means that the vast majority of Indiana dentists will receive their full private practice fee when treating Medicaid patients.
- 2) Removal of pre-authorization for most procedures.
- 3) Instructions to EDS for rapid and timely reimbursement.
- 4) A "carve out" from the risk-based managed care program. This means that most patients can go to any Medicaid enrolled dentist of their choice.
- 5) Reinstitution of coverage of complete and partial dentures. (These do require pre-authorization for Medicaid enrollees 21 years of age and over.) The Dental Advisory Panel is currently working with OMPP to develop coverage criteria, which will expand coverage of partial dentures for nutritional needs.
- 6) Issuing directives to Medicaid recipients on the importance of keeping their appointments.

In 1997, there were 751 dentists participating in the Medicaid program (who treated at least one Medicaid patient/year). This jumped to 1,443 at the end of 2001. During this same time, Medicaid recipients of dental services went from 94,815 to 250,354, the number of dental claims went from 707,617 to 2,044,701, and total Medicaid dental dollars paid went from \$14,061,586 to \$110,632,533. The total dental expenditures account for about 3% of the total Medicaid budget.

**Budget Estimates and Formulas of the Practice:**

When reimbursement rates were increased by 119% in May 1998, the vast majority of Indiana dentists received their full private practice fee: 100% of the 75<sup>th</sup> percentile of rates reported by the ADA for the East North Central region of the U.S.

**Lessons Learned and/or Plans for Improvement:**

Even though the dental expenditures (3% of total budget) are low compared to medical and pharmaceutical expenditures for Indiana's Medicaid program, approximately 2.6 times more people received dental services in 2001 compared to 1997 as a result of increased reimbursement rates and other reforms of the Medicaid dental program.

**Available Resources - Models, Tools and Guidelines Relevant to the practice:**

- ADA Department of State Government Affairs – How the Indiana Dental Association Met the Access Challenge, August 1998
- ADA survey of fees for the East North Central region of the U.S.

## SECTION III: PRACTICE EVALUATION INFORMATION

### **Impact/Effectiveness**

*Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?*

The reforms in Indiana's Medicaid dental program resulted in an increased number of patients accessing dental services in the program. In March 1997, only 751 dentists were still listed as participating in the Medicaid program due to the mass exodus that occurred in 1994. After sweeping and dramatic changes in the program, this number rose to 1,446 dentists as of December 2001. Medicaid patients receiving dental services went from 94,815 in 1997 to 250,354 in 2001. The number of claims went from 707,617 to 2,044,701 and the total dollar amounts paid went from \$14,061,586 to \$110,632,533 (1997-2001).

### **Efficiency**

*Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?*

The amount of Medicaid dental expenditures went from 0.7% of the entire Medicaid budget to approximately 3.0% with the increased reimbursement rates. Even though dental expenditures are low compared to medical and pharmaceutical expenditures, approximately 2.6 times more people received dental services in 2001 compared to 1997.

### **Demonstrated Sustainability**

*Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?*

The reforms in the Indiana Medicaid dental program occurred in 1998. The budget crisis that exists currently in Indiana (2002) necessitates cutting expenses in many state agencies including the Office of Medicaid Policy and Planning. A modest decrease in reimbursement rates is proposed for the Medicaid dental program but it is uncertain if this will go into effect because of the lobbying of the Indiana Dental Association and the dental support in the legislature.

### **Collaboration/Integration**

*Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?*

Reforms achieved for Indiana's Medicaid dental program resulted from collaborative efforts, over an extended period of time, of the Indiana Dental Association, the Family and Social Services Administration, Marion County Dental Health Coalition, and the Dental Advisory Panel of the Office of Medicaid Policy and Planning. Other partners include the Indiana University School of Dentistry and supporters in the legislature.

### **Objectives/Rationale**

*Does the practice address HP 2010 objectives, the Surgeon General's Report on Oral Health, and/or build basic infrastructure and capacity for state/territorial oral health programs?*

The practice addresses at least nine of the Healthy People 2010 Oral Health Objectives including reducing caries experience and untreated decay among children, reducing gingivitis, periodontal disease and tooth lost among adults, increasing utilization of the oral health care system, and increasing preventive dental services for low-income children and adolescents.

### **Extent of Use Among States**

*Is the practice or aspects of the practice used in other states?*

A few other states have had success similar to Indiana in reforming Medicaid dental programs to increase participation by dental practitioners. Many states, however, are currently in the position that Indiana had in 1994.