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# MA Dental Access Incentive Payments (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 267, #21]

## CURRENT LAW

The Medical Assistance (MA) program provides coverage for a comprehensive range of dental services for children and adults. This includes the following groups of services: (a) diagnostic, including radiographs; (b) preventative; (c) restorative, including fillings and crowns; (d) endodontic, including root canals; (e) periodontic, including gums disease treatments; (f) orthodontic; (g) prosthodontic, including fixed and removable dentures; (h) surgical; and (i) adjunctive, including numbing, sedation, and palliative care. These services can be provided by or under the supervision of licensed dentists and, with certain restrictions, dental hygienists.

MA provides reimbursement for most dental care on a fee-for-service basis, using a rate schedule established by the Department of Health Services (DHS). In several counties in southeastern Wisconsin, dental reimbursement is instead provided by health maintenance organizations (HMOs) under contract to serve MA patients. In four counties (Brown, Marathon, Polk, and Racine), MA provides enhanced reimbursement under a pilot program established by the 2015-17 biennial budget act. In these counties, all dental services provided to patients under 21 years of age and emergency dental services provided to adults are reimbursed at higher rates established in a separate fee schedule.

Dental benefits can be provided in a variety of settings, including private practices, hospital emergency rooms, and low-cost clinics. For-profit dental practices accounted for 46% of MA dental services expenditures in 2019-20, non-profit clinics accounted for 8%, and hospitals for 4%. The MA program expended the remaining 42% of dental expenditures in 2019-20 on dental care provided in federally qualified health centers (FQHCs), which receive reimbursement under a different methodology. FQHCs, a type of non-profit clinic meeting specific federal requirements and providing care to underserved populations and areas, receive MA reimbursement per patient

encounter at rates designed to reflect their actual costs of care.

The MA program expended a total of $154.2 million on dental benefits in 2019-20.

**DISCUSSION POINTS**

1. Assembly Bill 68 and Senate Bill 111 would provide $11,949,700 ($4,779,900 GPR and $7,169,800 FED) in 2021-22 and $23,899,300 ($9,559,700 GPR and $14,339,600 FED) in 2022-23 to increase reimbursement rates for dental providers that meet care quality standards and thresholds for the number of MA or uninsured patients they serve as a percentage of their total patient census. Specifically, the bill would increase rates by 50% for qualified non-profit providers for whom 50% or more of the patients they serve are uninsured or enrolled in MA, and increase rates by 30% for qualified for-profit providers for whom 5% or more of the patients they serve are enrolled in MA.

2. The Department estimates that non-profit facilities accounting for 65% of MA dental claims paid to non-profits, currently meet the threshold of serving at least 50% uninsured or MA-enrolled patients, while facilities accounting for 97% percent of claims paid to for-profit providers currently meet the threshold of serving at least 5% MA-enrolled patients. Based on these estimates of the share of qualifying providers in each group, the Department estimates that the 50% rate increase provided by AB 68/SB 111 for qualifying non-profit providers would have an annual cost of $7.6 million on an all-funds basis, and that the 30% rate increase for qualifying for-profit providers would have an annual cost of $16.3 million on an all-funds basis. The cost estimates for fiscal year 2021-22 reflect the anticipated implementation of this rate increase effective January 1, 2022 (Alternative A1).

3. Neighboring states' Medicaid programs provide reference points to evaluate the adequacy of MA rates in Wisconsin, although differences in economic factors, level of coverage for adults, and other variations between states make direct comparisons difficult. DHS reports that Wisconsin's dental reimbursement rates are 7% above rates in Iowa, 55% above Illinois, and 37% above Michigan, but 11% below reimbursement rates in Minnesota.

4. The rates paid by commercial insurance in Wisconsin can vary between insurers and between different regions and specific dental providers. Although negotiated rates are generally kept confidential between providers and insurance companies, commercial rates are commonly reported to be multiple times higher than the rates paid by MA.

5. With certain exceptions, MA reimbursement rates for dentists have remained fixed since 2008, when rates were increased by 1%. One exception is the pilot program discussed above, and another is a 200% increase provided in the 2017-19 biennial budget for facilities that provide at least 90% of their dental services to people with cognitive and physical disabilities.

6. In a 2020 report, the University of Wisconsin's Institute for Research on Poverty (UW IRP) finds significant shortages throughout the state in the capacity of the dental workforce to provide care to MA enrollees. The federal Health Resources and Services Administration (HRSA) designates dental health professional shortage areas (HPSAs) for grant-making purposes and analysis of healthcare access. Dental HPSAs include specific facilities, populations, and geographic areas where

the ratio of dentists to the population they serve is fewer than one to 5,000, or one to 4,000 for populations with unusually high needs. HRSA has identified 113 current dental HPSAs in Wisconsin. Of the state's 72 counties, 36 are wholly designated as HPSAs, including most counties in the north, northwest, and western parts of the state. Most of the remaining counties contain smaller regions or facilities designated as HPSAs. Overall, 21% of Wisconsin's population has insufficient access to dental professionals, as defined by HPSA designation.

7. Beyond a general shortage of dentists in the state, several factors may impact dentists' willingness to serve MA patients. The higher rates paid by commercial insurers may cause dentists to prioritize patients with commercial insurance, leaving insufficient capacity for MA patients. In addition, since accepting MA patients requires the dental practice to become certified for Medicaid, the enrollment process itself may discourage provider from participation, particularly if the dentist would only serve a relatively small number of MA patients. Finally, the Wisconsin Oral Health Coalition argues in their *Oral Health Roadmap* that the lack of diversity among the dental workforce may limit their effectiveness in reaching underserved communities.

8. The Department's latest MA access monitoring report (2016) reports that 17% of Wisconsin dentists actively serve MA patients, defined as serving more than 25 per year. A total of 37% of licensed dentists are enrolled as MA providers. For comparison, 61% of primary care providers actively serve MA patients, and a total of 85% are enrolled as MA providers.

9. Of Wisconsin children enrolled in MA, 42% received any dental services in 2018, the 43rd lowest utilization by state in the country, per data from federal utilization reports. The UW IRP report referenced above found that 21% of adults enrolled in MA received any dental service in the two-year period ending September, 2018. The Department's 2018 *Healthy Smiles Healthy Growth* survey of Wisconsin third-grade students found that 18% had untreated dental decay, and 5% had an urgent condition causing pain or infection.

10. The Department indicates that MA members in northern counties received an above average level of dental services compared to all MA enrollees, while members in southeastern counties received fewer services. FQHCs provide a significantly larger share of dental services in northern counties than in southeastern counties, which DHS argues contributes to the difference in service access. While this suggests that FQHCs are effective safety-net providers of dental care, they may also be acting as the default provider for many MA patients. Given the higher reimbursement paid to FQHCs, the Department suggests that reliance on them to provide dental care may be a more expensive alternative than providing care in dental offices.

11. The UW IRP report referenced above evaluated whether the increased reimbursement provided under the dental pilot program resulted in increased access to care for MA members. The pilot program reimburses dentists in the four pilot counties for pediatric dentistry and adult emergency dental services at rates on average 2.0 to 2.5 times the statewide MA rates. However, analysis in the report of claims and access data from the two years before and two years after the implementation of the pilot found that it did not consistently or reliably expand access to dental care for MA members. Variable underlying trends and other policy changes in the study period limited the ability to detect small changes in access resulting from the pilot rate increase.

12. The report notes a significant increase in the number of MA members served and total dental services delivered in Brown County, but not in the other three pilot counties. Three months after the implementation of the pilot program, the nonprofit Brown County Oral Health Partnership (BCOHP) received a donation from insurer Delta Dental to open a new clinic and expand services. The report credits this increase in grant funding, well-organized efforts led by BCOHP to increase dentist participation in MA, and the enhanced rates under the pilot program for reinforcing each other and together achieving the observed increase in the level of MA dental care provided. BCOHP primarily serves uninsured or MA-enrolled children, including in schools (using mobile and semi-permanent clinics), in area hospitals, and in several dedicated clinic locations.

13. To explain the weak and inconsistent link between increased reimbursement and increased participation in the MA program by dentists, the report describes the two possible ways to increase provider participation as either to expand the total capacity of dental providers or to re-allocate existing dental visit slots from commercially-insured patients to MA members. The report describes increasing total workforce capacity as "a challenge given existing provider shortages in areas throughout the state," and states that a significant re-allocation of visit slots remains unlikely as long as MA rates (even with the pilot enhancements) "remain substantially lower than commercial insurance payments."

14. The Department cites a number of studies that, consistent with the IRP evaluation of the dental pilot program, find that broad increases to dental reimbursement rates increases produce relatively small gains in dental service access. Given these findings, the administration argues that the targeted increase for providers that meet specified MA patient percentages, as proposed in AB 68/SB 111, may be more effective. The Department's estimate of the cost of the access incentive initiative includes an assumption that the payments would increase the volume of dental services delivered by 5%.

15. The Department argues that one of the reasons for taking the access payment approach is to create incentives for providers to increase their MA patient percentage, for those who currently fall below the applicable thresholds. In addition, this approach recognizes that providers that are already serving a higher percentage of MA patients may experience lower revenues overall than providers that serve relatively few MA patients.

16. While the administration's proposal takes the approach of targeting an increase to providers that meet certain MA access thresholds, some may prefer to treat all provider types the same, regardless of their status as a for-profit or non-profit provider, or the percentage of MA patients that they serve. Alternatives B1, B2, and B3 would increase all MA dental reimbursement rates by 50%, 30%, and 10%, respectively. These alternatives would have no impact on reimbursement paid under the FQHC encounter reimbursement system or the pilot program.

## ALTERNATIVES

### A. Access Incentive

1. Provide $11,949,700 ($4,779,900 GPR and $7,169,800 FED) in 2021-22 and

$23,899,300 ($9,559,700 GPR and $14,339,600 FED) in 2022-23 to increase reimbursement rates for dental providers that meet quality of care standards, as established by the Department, and that meet one of the following qualifications: (a) for a non-profit or public provider, 50 percent or more of the individuals served by the provider lack dental insurance or are enrolled in MA; or (b) for a for-profit provider, five percent or more of the individuals served by the provider are enrolled in MA. Require the Department to increase reimbursement in the following manner, for dental services rendered on or after January 1, 2022: (a) for a qualified non-profit or public provider, a 50 percent increase above the rate that would otherwise be paid to that provider; (b) for a qualified for-profit provider, a 30 percent increase above the rate that would otherwise be paid to that provider; and (c) for providers rendering services to individuals enrolled in managed care under the MA program, an increase to reimbursement on the basis of the rate that would have been paid to the provider had the individual not been enrolled in managed care. Specify that if a provider has more than one service location, the eligibility thresholds described above apply to each location, and payment for each service location would be determined separately. Specify that any provider receiving reimbursement through the enhanced dental reimbursement pilot program created by 2015 Act 55 is not eligible for increased reimbursement under this new program.

| ALT A1 | Change to Base |
|---|---|
| GPR | $14,339,600 |
| FED | 21,509,400 |
| Total | $35,849,000 |

2. Take no action.

**B. Uniform Rate Increase**

1. Provide $19,291,000 ($7,716,500 GPR and $11,574,500 FED) in 2021-22 and $38,582,300 ($15,432,900 GPR and $23,149,400 FED) in 2022-23 to increase MA dental reimbursement rates by 50%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

| ALT B1 | Change to Base |
|---|---|
| GPR | $23,149,400 |
| FED | 34,723,900 |
| Total | $57,873,300 |

2. Provide $11,574,600 ($4,629,900 GPR and $6,944,700 FED) in 2021-22 and $23,149,300 ($9,259,700 GPR and $13,889,600 FED) in 2022-23 to increase MA dental reimbursement rates by 30%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

| ALT B2 | Change to Base |
|---|---|
| GPR | $13,889,600 |
| FED | 20,834,300 |
| Total | $34,723,900 |

3. Provide $3,858,200 ($1,543,300 GPR and $2,314,900 FED) in 2021-22 and $7,716,300 ($3,086,500 GPR and $4,629,800 FED) in 2022-23 to increase MA dental reimbursement rates by 10%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

| ALT B3 | Change to Base |
|---|---|
| GPR | $4,629,800 |
| FED | 6,944,700 |
| Total | $11,574,500 |

4. Take no action.

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