Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

May, 2019 Joint Committee on Finance Paper #365

Dental Access Incentives (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 173, #12]

CURRENT LAW

Wisconsin's MA program covers the following categories of dental services when the services are provided by or under the supervision of a dentist: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) palliative emergency services; and (i) general anesthesia, intravenous conscious sedation, nitrous oxide, and nonintravenous conscious sedation. The program also covers various services provided by dental hygienists, including oral screening and preliminary examinations, prophylaxis, pit and fissure sealants, and periodontal maintenance. Some dental services reimbursed under the MA program are provided by federally qualified health centers (FQHCs), which are reimbursed under a prospective payment system intended to approximate the full actual cost of providing services to individuals enrolled in MA. FQHCs primarily serve MA recipients and uninsured individuals. Dental services provided outside an FQHC, such as in a private office setting, are reimbursed by the MA program at the lesser of the provider's usual and customary charge or amounts prescribed under a maximum fee schedule established by the Department of Health Services (DHS).

The 2015-17 budget act established a pilot project which increased the MA reimbursement rate for pediatric dental care and adult emergency dental services provided in Brown, Marathon, Polk, and Racine Counties. The Department implemented the enhanced reimbursement rates in these counties on October 1, 2016.

GOVERNOR

Provide $18,290,900 ($7,894,700 GPR and $10,396,200 FED) in 2019-20 and $20,528,800 ($8,789,800 GPR and $11,739,000 FED) in 2020-21 to reflect the net effect of: (a) providing

enhanced reimbursement rates under the MA program to dental providers who meet certain qualifications; and (b) eliminating the dental reimbursement pilot project.

Dental Access Incentive Payments to Dental Providers. Provide $28,097,600 ($11,520,000 GPR and $16,577,600 FED) in 2019-20 and $30,335,500 ($12,437,600 GPR and $17,897,900 FED) 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, 2020 by a provider meeting the above criteria: (a) for a qualified non-profit 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, increase 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.

Elimination of the Dental Reimbursement Pilot Project. Reduce funding by $9,806,700 (-$3,625,300 GPR and -$6,181,400 FED) in 2019-20 and by $9,806,700 (-$3,647,800 GPR and -$6,158,900 FED) in 2020-21 to reflect the effect of repealing the provisions of 2015 Act 55, which created an enhanced dental reimbursement pilot program to increase MA reimbursement rates for pediatric dental care and adult emergency dental services provided in Brown, Marathon, Polk, and Racine counties. This funding reduction is based on the difference between the standard reimbursement rate and the enhanced rate for expenditures in the pilot program counties in 2017-18.

DISCUSSION POINTS

1. The enhanced dental services reimbursement pilot program was created by the 2015-17 budget act out of a concern that low MA reimbursement rates are a significant reason for low rates of participation in MA by dentists. According to the Department's 2016 MA access monitoring plan, only 37% of Wisconsin dentists are certified to participate in the MA program, and of these, only 47% are considered active providers, which is defined as serving more than 25 MA patients per year. This is in contrast to primary care physicians, of whom 85% are certified to participate in the MA program and 72% of those enrolled are considered active providers.

2. The low rate of participation in MA by dentists is one of the key reasons frequently cited for why utilization of dental services by MA beneficiaries is low. A lack of dentists willing to accept MA patients makes it more difficult for MA enrollees to make appointments for preventive or restorative services. This, in turn, may lead to poor overall oral health. Tooth decay and other oral conditions are often the result of lack of access to dental care and, if untreated, may lead to more

significant problems. Some of these problems reach the point of requiring costly emergency care.

3. Under the enhanced dental services reimbursement pilot program, dental providers rendering services in Brown, Marathon, Polk, and Racine counties are reimbursed for pediatric services and emergency dental procedures for adults using a fee schedule that is roughly double the reimbursement standard fee-for-service rate schedule. The program has been in operation for nearly three years.

4. Outside of the pilot counties, reimbursement rates for dental services were last increased in 2008, when the Legislature approved a 1% increase to the fee schedule for most non-institutional providers. Prior to that time, rates had not been increased since 2002, also a 1% increase. Because increases for dental provider rates have been infrequent and small, payments for dental providers have fallen significantly below dentists' usual and customary charges. According to the American Dental Association, Wisconsin's reimbursement for pediatric dental services is among the lowest in the country, equal to about 32% of dentists' charges on average.

5. The Department contracted with the University of Wisconsin Population Health Institute to conduct an evaluation of the impact of the dental pilot on utilization of dental services in the MA program in the one year before and one year after project initiation in 2016, comparing both pilot and non-pilot counties.

6. The evaluation found evidence of greater provider participation in MA in the year following the start of the pilot program. In the four pilot counties, the number of dental providers certified to participate in MA increased by 33%, while the number of MA-certified dentists increased by 7% in non-pilot counties. Not all certified providers actively serve MA patients, but the evaluation found that the number of providers seeing at least 100 MA patients during the year increased by 55% in pilot counties, compared to just 7% in non-pilot counties.

7. Utilization of any dental services during the year increased by 4.1 percentage points for children living in the pilot counties (from 40.0% to 44.1% of all enrolled children) and by 5.1 percentage points for adults living in the pilot counties (from 24.9% to 30.1% for all enrolled adults). By comparison, utilization of any dental services increased by 2.0 percentage points for children and by 1.4 percentage points for adults in non-pilot counties.

8. While the pilot program appears to have had a clear impact on provider participation, the evaluation authors noted that the impact of the program on utilization of dental services by MA beneficiaries is less clear, due in large part to data limitations. The evaluation team had access only to aggregate claims data, which did not distinguish between provider types. Therefore, the utilization data included visits to FQHCs, even though FQHC reimbursement rates are unaffected by the rate increases in the pilot program. Three of the four pilot counties (Brown, Marathon, and Polk) contain FQHCs that provide dental services that expanded their capacity in recent years. The authors concluded, therefore, that they could not rule out that the increases in utilization was due, at least in part, to increased use of FQHC dental services, rather than to dentists participating in the pilot program.

9. The Department argues that even if the increase in utilization can be attributed solely to

the pilot program, the effects have been relatively modest in comparison to the cost. In 2017-18, MA costs of funding the rate enhancement was $9.8 million, roughly doubling the cost relative to the standard rate, but the share of all enrolled children living in the pilot counties who received services as the result of the pilot program increased by, at most, just 4.1%.

10. Although the Department notes that a statewide expansion of the program could encourage greater participation and therefore increase utilization of dental services by all MA beneficiaries, it argues that the cost of such increases would be high relative to the impact on utilization. The Department estimates that a statewide expansion of the enhanced dental reimbursement rates would increase MA expenditures by approximately $57 million ($20 million GPR and $37 million FED) on an annualized basis.

11. In further support of the limited impact of reimbursement rate increases, the Department cites a 2013 National Bureau of Economic Research study that found that reimbursement rate increases have a statistically significant, but modest impact on utilization. Using data from various sources, the study estimated that an increase of about 40% in Medicaid reimbursement rates for dental preventive services results in approximately a 1% to 3% increase in utilization of preventive services.

12. Instead of broad-based reimbursement rate increases, the bill would establish a mechanism for targeting additional payments to providers that serve a high proportion of MA patients. Under the proposed access payment program, for-profit dentists with MA patients or uninsured patients composing at least 5% of their total would receive a 30% multiplier on all MA services. Non-profit providers for which MA or uninsured patients make up at least 50% of their patients would receive a 50% multiplier for all MA services.

13. The Department's staff believes that with this targeted access incentive payment approach, providers who already serve MA patients, but are just below the threshold for receiving enhanced payments, would seek to serve more MA patients. In addition, providers who are already meeting the criteria for enhanced payment would also benefit, making a high-MA patient business model more sustainable.

14. The administration's fiscal estimate assumes that all or most non-profits that currently serve MA patients and approximately 42% of certified for-profit dental service providers would qualify for an access incentive payment. Approximately two-thirds of the total funding would go to for-profit providers and one-third would go to non-profit providers.

15. The administration estimates that the proposed access incentive payment would increase MA benefits costs by approximately $30.3 million by the second year of the biennium, an increase of approximately 33% above the baseline estimate (excluding pilot program payments).

16. The dental access incentive payment would be similar in concept to disproportionate share hospital (DSH) supplement payments the MA program pays to hospitals that serve a higher percentage of MA patients. DSH payments have the effect of increasing the base hospital reimbursement rate, in rough proportion to each hospital's proportion of MA patients. Hospitals that have a greater reliance on MA patient revenue receive a higher payment to help offset the lower base reimbursement provided by MA. The dental access payments would use a simpler two-tier system,

but would have the effect of targeting funds to dental practices that have a higher number of MA patients.

17. Under the bill, the additional costs associated with the dental access incentive provision would be offset by savings associated with repealing the four-county pilot program. The table below shows the administration's estimate of the fiscal effect of both the creation of both provisions.

Administration's Estimate of Fiscal Effect of Dental Initiatives

	2019-20		2020-21		2019-21 Biennium	
	GPR	FED	GPR	FED	GPR	FED
Dental Access Incentive	$11,520,000	$16,577,600	$12,437,600	$17,897,900	$23,957,600	$34,475,500
Repeal Pilot Program	-3,625,300	-6,181,400	-3,647,800	-6,158,900	-7,273,100	-12,340,300
Net Effect	$7,894,700	$10,396,200	$8,789,800	$11,739,000	$16,684,500	$22,135,200

18. The bill's funding for the dental access incentive program is based on two full years of implementation. However, the bill specifies that the access incentive would first apply to services rendered after January 1, 2020, six months into the first year of the biennium. Consequently, if the Committee adopts the provision, funding for MA benefits should be reduced by $14,048,800 ($5,760,000 GPR and $8,288,800 FED) in 2019-20 to reflect a reestimate of the fiscal effect based on six months of incentive payments in that year (Alternative A1).

19. If the Committee approves the move toward a statewide approach to dental access through the proposed access incentive program, it may also decide to approve the repeal of the four-county pilot program (Alternative B1). However, given that the incentive access program would not take effect until January 1, 2020, the Committee may also wish to consider delaying the repeal of the pilot program until that date, to ease the transition for providers in those counties. In this case, the program should be funded for six months in 2019-20, which would increase MA costs by an estimated $4,903,400 ($1,812,700 GPR and $3,090,700 FED) in that year (Alternative B2).

20. Relative to the bill, the net fiscal effect of Alternative A1 (reestimate of dental access incentive) and Alternative B2 (six-month delay in the repeal of the pilot program) would be a funding decrease of $9,145,400 (-$3,947,300 GPR and -$5,198,100 FED) in 2019-20.

21. It is possible that with more time, combined with greater outreach efforts, the pilot program would lead to more substantial increases in utilization. The evaluation report notes that the effects on provider participation and utilization were greater in Brown County, which may be attributed to greater efforts to involve local dentists in education and outreach initiatives in an effort to improve participation and access. The percentage of Brown County children who received any services increased by 7.1% in the year following implementation. The Committee could decide to retain the enhanced dental reimbursement pilot program (take no action on the repeal) to allow more time to evaluate its impact, either in place of or in addition to the incentive access program. Relative to the bill, this would increase MA benefits funding by funding by $9,806,700 ($3,625,300 GPR and $6,181,400 FED) in 2019-20 and by $9,806,700 ($3,647,800 GPR and $6,158,900 FED) in 2020-21 (Alternative B3).

22. As passed by the Legislature, the period of enhanced payments for dental services provided in the four-county area would have ended after the 37th month following implementation. However, due to one of the Governor's partial vetoes in 2015 Act 55, the pilot program has no termination date.

23. 2017 Wisconsin Act 344 created provisions that establish ongoing, biennial reporting requirements for DHS to provide specified information on the pilot project, including: (a) the number of MA recipients who received services; (b) an estimate of the potential reduction in health care costs and emergency department use by MA recipients due to the pilot project; (c) the feasibility of continuing the pilot project in specific areas of the state; (d) program costs; and (e) an analysis of the MA populations who received services, and who may benefit, from the pilot project.

24. Several arguments could be offered to repeal the pilot program. First, as previously indicated, the program has already been evaluated by the University of Wisconsin Population Health Institute. If the pilot program is continued, DHS will incur additional staff and contracting expenses to conduct ongoing evaluations to meet the reporting requirements created in Act 344. Second, the current pilot program provides significantly higher reimbursement rates for pediatric and emergency dental services rendered by providers in four counties, which may be seen as unfair to dental providers in the rest of the state that provide these same services. Finally, although the evaluation showed significant increase in the number of dentists that were certified to serve MA recipients in the pilot counties, the significant cost of providing the enhanced rates did not significantly increase the number of pediatric and emergency services provided to MA recipients in these counties.

ALTERNATIVES

A. Dental Access Incentive Payment

1. Adopt the Governor's recommendation to create a dental access incentive payment program beginning January 1, 2020, but reduce funding in bill by $14,048,800 (-$5,760,000 GPR and -$8,288,800 FED in 2019-20 to reflect a reestimate of cost of the program based on six months of operation in that year, rather than 12 months. The total funding estimate would be $14,048,800 ($5,760,000 GPR and -$8,288,800 FED) in 2019-20 and $30,335,500 ($12,437,600 GPR and $17,897,900 FED) in 2020-21.

ALT A1	Change to Base	Change to Bill
GPR	$18,197,600	- $5,760,000
FED	26,186,700	- 8,288,8000
Total	$44,384,300	- $14,048,800

2. Take no action.

ALT A2	Change to Base	Change to Bill
GPR	$0	- $23,957,600
FED	0	- 34,475,500
Total	$0	- $58,433,100

B. Enhanced Dental Reimbursement Pilot Program

1. Approve the Governor's recommendation to reduce MA benefits funding by $9,806,700 ($3,625,300 GPR and -$6,181,400 FED) in 2019-20 and by $9,806,700 (-$3,647,800 GPR and -$6,158,900 FED) in 2020-21, and to repeal the enhanced dental reimbursement pilot program.

ALT B1	Change to Base	Change to Bill
GPR	- $7,273,100	$0
FED	- 12,340,300	0
Total	- $19,613,400	$0

2. Modify the Governor's recommendation by increasing funding for MA benefits by $4,903,400 ($1,812,700 GPR and $3,090,700 FED) in 2019-20 to reflect a delay in the repeal of the pilot program until January 1, 2020.

ALT B2	Change to Base	Change to Bill
GPR	- $5,460,400	$1,812,700
FED	- 9,249,600	3,090,700
Total	- $14,710,000	$4,903,400

3. Take no action.

ALT B3	Change to Base	Change to Bill
GPR	$0	$7,273,100
FED	0	12,340,300
Total	$0	$19,613,400

Prepared by: Jon Dyck