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Dental Medicaid Reform: A Place for the Private Commercial Vendor

By Karl Baumle

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Without the assistance of Medicaid, more than twenty-five percent of all children in the United States would not have access to dental care.[1] However, mere eligibility does not guarantee good dental health. In fact, in many states, children enrolled in Medicaid rarely receive adequate dental care.[2] In 2007, twelve-year-old Deamonte Driver died as the result of an infection from a tooth abscess spreading to his brain.[3]

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[1] Shelly Gehshan, Andrew Snyder, & Julie Paradise, *Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP* (National Academy for State Health Policy, Washington, D.C.), July 2008 at 1. (*available at* http://www.kff.org/medicaid/upload/7792.pdf). An additional seven million children rely on the State Children's Health Insurance Program (SCHIP). *Id.* SCHIP covers some dental benefits for some children in families that do not qualify for Medicaid but cannot afford insurance. This note focuses primarily on Medicaid structures. For more information on how states administer SCHIP benefits, *see Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx). The Patient Protection and Accountable Care Act (PPACA) will extend dental coverage to 5.3 million more children by 2014 through expansions to both Medicaid and SCHIP. *The State of Children's Dental Health: Making Coverage Matter* (The Pew Center on the States, Washington, D.C.), May 2011 at 1 (*available at* http://www.pewcenteronthestates.org/uploadedFiles/The_State_of_Children's_Dental_health.pdf).

[2] Low-income children suffer approximately twice as many cavities as other children. These cavities are much more likely to go untreated as well. *Oral Health in America: A Report of the Surgeon General* (U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, Rockville, MD), 2000.

[3] Lindy McCollum-Broundley, *A Place to Call Home: Expanding Access to Dental Care for Children & Special Needs Patients*, Gatordentist Today (Fall 2007) at 8 (*available at* http://www.dental.ufl.edu/Offices/News/publications/GDTNewsletter_Fall07.pdf).

Deamonte visited physicians all of his life but had never visited a dentist.[4] The tooth abscess went undiagnosed until his mother, with the necessary help of one lawyer, one helpline supervisor, and three case management professionals, finally found a dentist in Maryland who accepted Medicaid.[5] Only 900 out of 5,500 dentists in Maryland accepted Medicaid at the time.[6] The cost of Deamonte's subsequent brain surgeries and hospital stay totaled over a quarter of a million dollars.[7] A simple tooth extraction would have cost approximately only eighty dollars and would have saved his life.[8]

Unfortunately, this story is not all too uncommon in the United States. Only 38.1% of Medicaid children received any dental care in 2009.[9] The consequences of so many children failing to see a dentist has consequences that extend beyond just poor health indications. Failing to encourage and provide adequate dental care results in far-reaching social consequences for Medicaid patients and financial consequences for states. Patients that do not receive adequate dental care face social stigma.[10] When a patient does not have access to preventive care, problems go untreated until the problem worsens enough to force the patient to seek emergency care. Emergency care often entails tooth extraction. Missing teeth signify poor social background. Patients must then fight this stigma every time they interview for a new job. This crisis also affects employers, as

[4] *Id.*
[5] *The Silent Epidemic* (Jan. 16, 2008), http://www.youtube.com/watch?v=08HVcfxRg-k&feature=related.
[6] June Thomas, *The American Way of Dentistry: Why poor folks are short on teeth.*, Slate Magazine (Oct. 1, 2009) (*available at* http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/10/the_american_way_of_dentistry_3.html).
[7] Mary Otto, *For Want of a Dentist*, The Washington Post (Feb. 28, 2007) (http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html).
[8] *Id.*
[9] *The State of Children's Dental Health: Making Coverage Matter*, *supra* note 1, at 10.
[10] S. Hyde, W.A. Satariano, & J.A. Weintraub, *Welfare Dental Intervention Improves Employment and Quality of Life*, J. OF DENTAL RES., no. 85 (2006) at 79-84.

poor dental health results in employees missing many hours of work each year.[11] In addition to patients and employers, states suffer when dental indications go undiagnosed and untreated. Emergency room visits for tooth decay-related indications are extremely expensive and, unfortunately, extremely common.[12] Poor dental health is linked to more serious, chronic, and expensive health conditions.[13] The earlier in life patients receive their first dental screening, the lower future treatment will cost the state.[14] Thus, the incentives exist for states to address this growing dental health crisis. However, the barriers to accomplishing this are not so easily overcome.

Medicaid beneficiaries face many challenges in accessing dental care even when it is available. Dentists often practice in affluent areas to where public transportation is extremely inconvenient.[15] Patients in rural areas face even greater challenges. In 2000, there were 224 counties where even private payers could not find a dentist.[16] Many Medicaid patients are often unable to schedule appointments as few dental assistants

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[11] An estimated 164 million work hours each year are lost due to oral disease. Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (2008) at 1 (*available at* http://nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf?q=files/Adult%20Dental%20Monitor.pdf).

[12] The amount of emergency room visits related to preventable dental conditions in 2009 rose sixteen percent to 830,590. A study revealed that 330,000 cases cost approximately $110 million. These costs are increasing. For example, the average charge per emergency visit for young children with dental conditions increased by thirty percent over the last five years. In Florida, approximately one-third of these visits in 2010 were paid through Medicaid. However, perhaps most alarmingly, the emergency room was the first "dental visit" for one in every four children in the state of Washington. *A Costly Dental Destination*, (The Pew Center on the States, Washington, D.C.), Feb. 2012 at 1-3. (*available at* http://www.pewcenteronthestates.org/uploadedFiles/A%20Costly%20Dental%20Destination.pdf).

[13] A study revealed that the average cost of care for children that received dental care before the age of one was more than half of the average cost of care for children that did not visit a dentist until ages four through five. Matthew F. Savage, Jessica Y. Lee, Jonathan B. Kotch, William F. Vann, Jr., *Early Preventive Dental Visits: Effects on Subsequent Utilization & Costs*, NEOREVIEWS, Vol. 114, No. 4 (October 1, 2004) at e418-e423.

[14] June Thomas, *The American Way of Dentistry: Why poor folks are short on teeth.*, *supra* note 6.

[15] *Id.*

[16] *Id.*

speak multiple languages.[17] Additionally, many Medicaid patients do not seek out dental care due to a lack of education about the importance of dental care and a lack of awareness that they actually have dental benefits. Many Medicaid patients rely primarily on emergency rooms for their medical needs due to this lack of education and awareness.[18] These barriers cause many Medicaid patients to miss appointments, further frustrating the few providers that will treat these patients.[19]

Another barrier is a lack of dentists who are willing to accept Medicaid. Apart from the inconveniences mentioned above, Medicaid administrative structures also frustrate providers. Dentists avoid treating Medicaid patients because of low payment rates, inconvenient claims procedures, and slow payment.[20] Dentists usually operate small businesses and incur high overhead costs.[21] These costs cover about sixty percent of revenue.[22] While increasing payment rates is the obvious first step, and perhaps a necessary step, in encouraging dentists to participate, it alone is not sufficient.[23] Through structural reforms, states can target the problems of inconvenient procedures and slow payment. Improvements in administrative efficiency will allow states to better allocate funds to pay dentists higher rates.

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[17] *Id.*
[18] Shelly Gehshan, Paetra Hauck, & Julie Scales, *Increasing Dentists' Participation in Medicaid and SCHIP*, NATIONAL CONFERENCE OF STATE LEGISLATURES (2001) (available at http://204.131.235.67/programs/health/Forum/oralhealth.htm#introbot).
[19] *Id.*
[20] Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (2008) at 1 (*available at* http://www.nashp.org/sites/default/files/CHCF_dental_rates.pdf)).
[21] Shelly Gehshan, Andrew Snyder, & Julie Paradise, *Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP*, *supra* note 1, at 9.
[22] *Id.*
[23] "A majority of experts interviewed felt that adequate reimbursement rates (meaning rates that at least met the overhead expenses of dentists in private practice) were necessary—but not sufficient on their own – to improve access to Medicaid dental services. Simply injecting funding into higher rates was not thought to be enough to substantially improve the program." Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 25.

In order to overcome barriers to utilization and access, states should adopt the following three-fold approach: 1) States should provide outreach and education, 2) States should increase reimbursement rates paid to dental providers, and 3) States should reform their Medicaid administrative structures.

States have many options in how they construct Medicaid administrative structures. Congress amended the Social Security Act several times to allow states a considerable amount of freedom in how states can administer Medicaid benefits.[24] Many states have taken advantage of these amendments by using managed care to improve the administrational of dental Medicaid benefits.[25] However, states must be careful to contract with dental maintenance organizations on terms best suited to the unique area of dental health.[26] To better serve the unique needs of dental providers and Medicaid patients, states should restructure their Medicaid structures by contracting with a single dental maintenance organization to exclusively provide dental benefits. The state should assume at least some degree of risk, while capitalizing on the dental maintenance organization's established network, expertise, and commonplace claims procedures. The state should also ensure that the vendor pays providers on a fee-for-service basis. Both

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[24] *See infra* Section I.

[25] Forty-two states contract with at least one third-party to help administer dental Medicaid benefits. Sixteen states administer at least some dental Medicaid benefits through typical managed care plans. Under the typical managed care model, the state transfers risk to the managed care organization (MCO) by paying the MCO on a per beneficiary per month basis. However, states have increasingly switched to a more tempered form of managed care. These vendors are often paid under administrative services only (ASO) contracts. Thus, these vendors do not bear any risk but are still responsible for processing claims, maintaining networks, and responding to provider inquiries. Thirty-one states administer at least some dental Medicaid benefits through nonrisk vendors. Notice that some states contract with both types of vendors. *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).

[26] If done improperly, administrative costs can increase while utilization and participation decline rapidly. This was the result of Florida's Miami-Dade County Pilot program. The state passed too much risk to both the vendor and providers, and providers did not receive adequate reimbursement. *See* Burton L. Edelstein, *Miami-Dade County Prepaid Dental Health Plan Demonstration: Less Value for State Dollars* (Collins Center for Public Policy, Miami, FL) Aug. 2006.

quantitative and qualitative reasons support this approach as the ideal administrative structure for dental Medicaid benefits.

Part I of this piece will outline the statutory framework through which states administer dental Medicaid benefits. Part II briefly touches on how patient outreach and assistance programs can increase the utilization of dental services, thereby indirectly increasing provider participation. Part III briefly discusses the need to increase reimbursement rates paid to providers in order to promote participation in Medicaid. Part IV will discuss recent state reforms designed to deal with this dental crisis. Part V evaluates how successful these different approaches have been in terms of the available quantitative data. Part VI proposes how states can reform Medicaid administrative structures to best increase provider participation and utilization of dental services.

I. Statutory Framework

Title XIX of the Social Security Act only requires states to cover dental benefits for Medicaid-eligible individuals under the age of twenty-one.[27] States have the option of whether or not to cover dental services for Medicaid-eligible adults.[28] Dental benefits are guaranteed for eligible children as part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.[29] Under the EPSDT program, states

[27] Title XIX of the Social Security Act, 42 U.S.C.S. §§ 1396 et seq. (2012).
[28] In 2007, six states offered no coverage for adult dental Medicaid benefits, sixteen states covered only emergency services, thirteen states excluded at least one service category from coverage, and only sixteen states offered comprehensive coverage. Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, *supra* note 11, at Figure 1.
[29] 42 U.S.C.S. §§ 1396 et seq. (2012).

determine the scope of covered dental services within certain parameters.[30] States also have considerable freedom in determining how these benefits are administered. In fact, many states do not administer dental Medicaid benefits themselves, but rather mandate that all beneficiaries enroll in a plan administered by a private commercial entity, either a Dental Maintenance Organization (DMO) that resembles a typical Managed Care Organization (MCO), a Dental Benefits Manager (DBM) that does not take on risk, or a fiscal agent that performs administrative functions but does not manage other private health insurance plans.[31] Other states administer dental benefits themselves through state agencies.[32] While the Social Security Act originally forbade states from requiring that a Medicaid beneficiary enroll in a managed care plan, these restrictions were later relaxed.[33] Section 2175 of the Omnibus Budget Reconciliation Act of 1981[34] ("OBRA")

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[30] At minimum, states must cover dental services for relief of pain and infections, restorative services, and services necessary for the maintenance of dental health. States are also required to develop a dental periodicity schedule with the advice of recognized dental organizations. A dental periodicity schedule determines when a screening is medically necessary. 42 U.S.C. §§§ 1396(r)(1)(B), 1396a(a)(43)(C), §1396d(r).

[31] Sixteen states (including the District of Columbia) enroll at least some Medicaid beneficiaries in typical managed care plans. States are more likely to rely on managed care plans in urban areas if they choose to operate an additional, separate traditional fee-for-service system. There has been a trend to move away from the global managed care system that about half of the states converted to in the 1990s. Some states have completely tried to move away from contracting through commercial vendors, such as Maryland, which initiated a pilot program in 2008 to experiment with state-administered benefits. Other states have retained managed care plans but mitigate the amount of risk borne by the vendor, such as Rhode Island, or prohibit plans from passing risk along to providers, such as Arizona. Nonrisk vendors are typically refered to as Dental Benefits Managers (DBMs). Other states similarly contract with nonrisk commercial agents but contract with agents that specialize in information technology rather than health network maintenance. For example, West Virginia contracts with Unisys, an information technology company that processes claims but also is responsible for provider enrollment. *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx); James J. Crall & Donald Schneider, *Medicaid Program Administration* (American Dental Assn., Chicago, IL), Mar. 2004 at 3 (*available at* http://www.ada.org/sections/professionalResources/pdfs/medicaid_administration.pdf).

[32] For example, the Washington State Health Care Authority, a state agency within the Washington State Department of Social and Health Services, administers dental Medicaid benefits in Washington state. The state does not contract with any fiscal agents. *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).

[33] For a discussion of the history of the use of managed care in Medicaid, *see* Nicolette Highsmith & Stephen A. Somers, *Medicaid Managed Care: From Cost Savings to Accountability and Quality Improvement*, EVAL. HEALTH PROF. Vol. 23, No. 4 (December 2000) at 385-396.

[34] The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357-933 (1981).

provided a waiver to allow states to mandate enrollment in managed care plans.[35] This § 1915(b) "freedom of choice" waiver became very popular. By 1997, forty states operated at least one program through the § 1915(b) waiver.[36] Another waiver also became popular in the early 1980s. The § 1115 "research and demonstration" waiver was added in 1962, but in the 1980s, the Secretary of the Department of Human Health Services (HHS) began to approve states' use of it to develop Medicaid managed care initiatives.[37] Through this section, the Secretary waived Medicaid's freedom of choice mandates as well as other provisions of the Act, such as eligibility, provider, and administrative requirements.[38] The Balanced Budget Act of 1997 now allows states to force beneficiaries to join managed care plans without obtaining a waiver.[39] Many states that have reformed their dental Medicaid programs have done so through § 1115 waivers.[40] Other states should look to these administrative reforms as examples of how to improve dental health among Medicaid beneficiaries. Along with raising reimbursement rates

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[35] 42 U.S.C. § 1396n(b).

[36] 42 U.S.C.S. § 1115; *see also* Sara Rosenbaum & Julie Darnell, *Medicaid Managed Care: An Analysis of the Health Care Financing Administration's Notice of Proposed Rulemaking*, (The George Washington University Medical Center – Center for Health Policy Research, Washington, D.C.), 1998 at 4 (*available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14947).

[37] Sara Rosenbaum & Julie Darnell, *Medicaid Managed Care: An Analysis of the Health Care Financing Administration's Notice of Proposed Rulemaking*, *supra* note 36, at 4-5.

[38] A § 1115 waiver permits the Secretary to approve programs that vary regionally, offer different benefits to different groups, expand eligibility standards, mandate enrollment in managed care, and make alterations to Medicaid payment requirements. However, plans must not reduce access or quality of care, must be budget neutral, must guard against unnecessary utilization, and must maintain quality assurance processes. However, the rate at which the Federal government contributes to Medicaid expenditures cannot be waived. For a summary of § 1115 requirements, *see 1115 Waiver*, (ITUP Los Angeles Regional Workgroup, Los Angeles, CA) (*available at* http://www.policyarchive.org/handle/10207/bitstreams/6267.pdf); *see also* Sara Rosenbaum & Julie Darnell, *Medicaid Managed Care: An Analysis of the Health Care Financing Administration's Notice of Proposed Rulemaking*, *supra* note 36, at 4-5.

[39] Balanced Budget Act of 1997, Pub. L. No. 105-33 (1997).

[40] *See* Leighton Ku, Marilyn Ellwood, Sheila Hoag, Barbara Ormond, & Judith Woolridge, *Evolution of Medicaid Managed Care System and Eligibility Expansions*, Health Care Financing Rev., Vol. 22, No. 2 (Winter 2000) (*available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads//00winterpg7.pdf); *see also 1115 Waiver*, *supra* note 38.

paid to providers and establishing outreach and assistance programs, structural reform is a necessary piece of the puzzle of ending the current dental health crisis.

II. Patient Outreach and Assistance

Medicaid beneficiaries face barriers beyond the mere lack of dentists willing to treat Medicaid patients. As previously explained, these barriers include: geographic barriers, language barriers, and social barriers.[41] These problems can be addressed by providing outreach and assistance to Medicaid patients. Examples include: conducting face-to-face meetings to discuss coverage and locate a dentist in the area,[42] distributing educational materials,[43] establishing hotlines and websites listing available providers,[44] and establishing a case management system to address cancellations and transportation problems.[45]

Addressing these concerns will not only encourage Medicaid enrollees to seek care, but it will relieve inconvenience for providers. As such, more providers will accept Medicaid patients, and then increased access to care will allow for greater utilization of that care. However, compliance issues are not the only inconveniences faced by providers. States must also address poor reimbursement and administrative hassles.

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[41] *See supra* text accompanying notes 15-19.
[42] For example, in South Carolina, Medicaid staff actually visits beneficiaries to discuss available benefits and to help locate a dentist. For similar examples used by states, *see* James J. Crall & Donald Schneider, *Enhancing Dental Medicaid Outreach and Care Coordination* (American Dental Assn., Chicago, IL), Mar. 2004 at 2.
[43] For example, brochures in Virginia and Washington are specifically tailored to the needs of Medicaid patients. *Id.*
[44] For examples, *see id.* at 3.
[45] For example, in Michigan, local health departments contact families with children that are due for dental care and schedule appointments. *Id.* at 2.

III. Reimbursement Rate Increases

States must take the additional step of increasing reimbursement rates paid to providers for services performed on Medicaid patients. Dentists incur high overhead costs but often do not receive sufficient reimbursement to cover these costs.[46] In most states, Medicaid reimburses dentists less than half of what dentists receive from private payers.[47] In some cases, dentists take a loss, and treating Medicaid patients becomes an act of charity.[48] While many dentists readily accept fifteen to twenty percent discounts when participating in a preferred provider network in competitive markets, many Medicaid programs discount seventeen percent from the fiftieth percentile of fees charged by dentists.[49] This results in fees that only twenty-five percent of area dentists would accept, without taking into account other Medicaid-specific burdens on providers.[50] Increasing this provider base would allow for more patients to receive care

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[46] Andrew Snyder, *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations* (National Academy for State Health Policy, Washington, D.C.), Mar. 2009. at 1.

[47] For example, in 2010, Medicaid only reimbursed California dentists 32.8% of the median regional average retail fee. The problem is worsened by the fact that the cost of living in California in 2010 was also over 30% higher than the national average cost of living. *See* Appendix C; *see also* Andrew Snyder, *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations*, *supra* note 46, at 1-2.

[48] For example, in Tennessee, prior to reform, dentists absorbed sixty percent of the cost of each procedure they performed on a Medicaid patient. Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 8.

Some scholars note the detrimental effects of a health system that relies on such benevolence. Through the willingness of providers to treat patients despite inadequate compensation, government programs have been able to shift the cost of this care to private insurers and providers. Political leaders then escape accountability for the health of the nation's uninsured poor. They are free to vote down initiatives that would offer more coverage to this population, as it is easier to rely on the benevolence of providers. Frank Pasquale, *Dental Dilemmas and the Limits of Charity*, Concurring Opinions, http://www.concurringopinions.com/archives/2007/12/dental_dilemmas.html (Dec. 24, 2007) (citing Uwe Reinhardt, *US Health Care Stands Adam Smith on His Head*, BMJ 335(7628), 1020 (Nov. 17, 2007)).

[49] James J. Crall & Donald Schneider, *Medicaid Reimbursement – Using Marketplace Principles to Increase Access to Dental Services*, (American Dental Association, Chicago, IL) 2004 at 1-2 (*available at* http://www.ada.org/sections/professionalResources/pdfs/medicaid_reimbursement.pdf).

[50] *Id.*

and would cut down on patient travel time.[51] Increasing rates is necessary for this to happen.[52]

While increasing payment rates is the obvious first step, and a necessary step, in encouraging dentists to participate, it alone is not sufficient.[53] Administrative burdens must also be addressed. Increasing rates is also the more difficult piece of the solution politically and can counteract gains if state spending spurs inflation.[54] Even states that have demonstrated a dedication to improving rates for dental services, such as Arizona, have had their efforts staunched by recent budgetary crises.[55] In order to sustain effective rates, states face the decision to allocate more funds to Medicaid budgets or to make Medicaid structures more efficient. The latter goal can be accomplished through administrative reforms. If states contract with private vendors on proper terms, these private vendors will more efficiently and effectively administer dental Medicaid benefits.

IV. Different State Approaches[56]

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[51] Michigan improved dental utilization and cut patient travel time in half by improving provider participation rates from about twenty-five percent to eighty percent from 2000 to 2001. *Medicaid*, American Dental Association, http://www.ada.org/2387.aspx (last visited May 4, 2012).
[52] Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 25.
[53] *Id.*
[54] *Id.*
[55] *See* Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, THE N.Y. TIMES, http://www.nytimes.com/2010/12/05/us/05transplant.html (Dec. 4, 2010).
[56] Of the fifty states and the District of Columbia, twenty-five states administer dental benefits together with medical benefits, twenty-two states employ carve-outs, and four states administer dental benefits partially through a carve-out. Nine states choose to administer dental Medicaid benefits themselves, while thirty-two states contract with fiscal agents and ten states contract with fiscal agents but still administer some benefits. These fiscal agents come in many forms, including DMOs, nonrisk DBMs, and claims processing agencies. Of those states that contracted out administrative responsibilities, twenty-four states did not transfer any risk to the contractor, eleven states transferred some degree of risk, and seven states transferred risk to some vendors but not others. Of the forty-two states that contract with third-party agents, twenty-one states contract with multiple agents and twenty-one states contract with only a single agent. Forty-two states reimburse providers on a fee-for-service basis, nine states employ both fee-for-service and capitation, and no states reimburse providers just through capitated payments. *Medicaid*

a. Tennessee

In 2002, Tennessee performed a complete overhaul of its Medicaid structure.[57] Prior to 2002, Tennessee used multiple managed care organizations to administer both medical and dental benefits.[58] Under this program, only 386 dental providers treated Medicaid beneficiaries, and only thirty-six percent of enrollees ages six through twenty received any dental care.[59] In *John B. v. Menke*,[60] the United States District Court for the Middle District of Tennessee held that Tennessee violated federal EPSDT requirements by failing to provide adequate dental care as well as other EPSDT benefits. The court ordered that the state carve out its under-twenty one population from the overall Medicaid structure.[61] Tennessee went even farther by further carving out the administration of dental services from the administration of other EPSDT services.[62] Where multiple managed care organizations continue to administer general Medicaid benefits, Tennessee contracted with only one dental benefits manager (DBM) to administer dental benefits.[63] Tennessee's DBM, Doral Dental, operates under an

Compendium Update (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx). Section IV offers a survey of these different approaches.

[57] Tennessee first implemented a Medicaid managed care in 1994 under a Section 1115 waiver from the Centers for Medicare and Medicaid (CMS). This program, named "TennCare" expired on June 30, 2002. The 2002 reforms resulted in a new demonstration program, named "TennCare II," which will operate through June 30, 2013. For an overview of TennCare, *see TennCare Overview* (last visited April 25, 2012), http://www.tn.gov/tenncare/news-about.html.

[58] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, HEALTH POLICY PUBLICATION (Missouri Foundation for Health, St. Louis, MO), Summer 2008 at 9 (*available at* http://www.mffh.org/mm/files/DentalComplianceMFH.pdf).

[59] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper* (American Dental Assn., Chicago, IL), Oct. 2004 at 15 (*available at* http://www.ada.org/sections/advocacy/pdfs/topics_access_whitepaper.pdf).

[60] 176 F. Supp. 2d 786 (M.D. Tenn. 2001)

[61] *Id.* at 807.

[62] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*, *supra* note 59, at 15.

[63] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 9.

administrative services only (ASO) contract.[64] Under an ASO contract, the state takes on full risk for the cost of benefit claims and pays the vendor an administrative fee. In return, the DBM maintains a network of providers, processes claims, pays providers, and performs review procedures.[65] Tennessee also increased the rate of reimbursement to the 75th percentile of regional commercial fees.[66]

By 2007, provider participation improved by approximately one hundred twenty percent.[67] Utilization of dental care by children improved from thirty-six percent to fifty-one percent within four years of these reforms.[68] Before these reforms, providers only received forty percent of their cost for each procedure.[69] In reforming the program, Tennessee followed the suggestions of the ADA and switched to rates matched to the seventy-fifth percentile of dental fees in the East South Central region.[70] Dentists now earn a profit rather than taking a loss for treating a Medicaid patient. Financing is determined year to year by state appropriations, so the legislature has ultimate control over the fee schedule.[71]

b. Arizona

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[64] *Id.*
[65] *Id.* at 9-10.
[66] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*, *supra* note 59, at 15.
[67] Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 8.
[68] *Id.*
[69] *Id.*
[70] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*, *supra* note 59, at 16.
[71] *Id.* at 17.

Arizona relies on eighteen different MCOs to administer both medical and dental services.[72] The state, therefore, does not rely on a carve-out. Arizona takes advantage of the integration of the administration dental and medical benefits by requiring physicians to screen for dental problems and refer patients to dentists.[73] Medicaid beneficiaries tend to rely more heavily on primary care than they do dental care.[74] Through this referral process, Arizona sought to work around this reliance on primary care in order to encourage utilization.[75] Arizona addressed the problems of access and utilization further by restricting MCOs in terms of how they pay dentists, what benefits they offer, and how they must maintain their networks. Arizona expressly prohibits plans from capitating providers.[76] The Interim Study Committee on Dental Care found that providers were attracted to plans that paid on a fee-for-service basis.[77] Arizona also requires that plans offer minimum dental benefits.[78] This includes ensuring that beneficiaries can see the dentist at least twice a year for preventive care and that the care that they receive is

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[72] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States* (California HealthCare Foundation, Oakland, CA), July 2009 at 9 (*available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MedicaidDentalLessonsStates.pdf).

[73] Arizona revised its *Medical Policy Manual* by imposing new mandates on physicians. Medical Policy Manual § 430(A)(7) (*available at* http://www.phxautism.org/wp-content/pdf/resources-advocacy/2.%20EPSDT%20Service,%20Policy%20430.pdf); *see also* Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 15.

[74] Many Medicaid patients have never been educated about the importance of preventive dental care. It is commonly the case that dental indications go unscreened and untreated until the indication has evolved into a more complex health issue. It is only then where the patient seeks care in the emergency room of a hospital, which are often ill-equipped to handle dental care. *See*, *e.g.*, Lindy McCollum-Broundley, *A Place to Call Home: Expanding Access to Dental Care for Children & Special Needs Patients*, *supra* note 3.

[75] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 15 ("Research has found that children who receive medical care are more likely to receive dental care than those who received no medical care.").

[76] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.

[77] ACCCHS DENTAL CARE TASK FORCE, FINAL REPORT (April 2008) (*available at http://azahcccs.gov/reporting/Downloads/DentalCareTaskForce_1998.pdf*) ("the majority of the health plans have implemented fee-for-service reimbursement arrangements effective October 1997 which have significantly increased the number of dental providers").

[78] For a list of benefits, *see* Medical Policy Manual § 430(A)(7).

consistent with the community standard of care.[79] The state also requires plans to meet minimum network requirements.[80] Dentists receive relatively high rates of reimbursement in Arizona. Of all of the states (including the District of Columbia), Arizona offered the fifth highest rate of reimbursement in 2010.[81] Dentists are currently paid 68.9 percent of median retail fees.[82] However, providers face future payment cuts in the wake of ongoing budget cuts.[83] Medicaid utilization increased from below thirty percent in 2000, when payment structure reform had just taken place, to 47.2% in 2009.[84] Dentists are currently paid 68.9 percent of median retail fees.[85] However, providers face future payment cuts in the wake of ongoing budget cuts.[86]

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[79] Medical Policy Manual §§ 430(A)(7)(b)(1), 430(C).

[80] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.

[81] *The State of Children's Dental Health: Making Coverage Matter* (The Pew Center on the States, Washington, D.C.), May 2011 at 25.

[82] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.

[83] Arizona reduced its Medicaid dental fee schedule by 5% in 2001. ACCCHS, PUBLIC NOTICE OF INFORMATION (April, 1, 2011) (*available at* http://www.azahcccs.gov/publicnotices/Downloads/rates/April2011FFSRates.pdf). However, the current governor seeks to restore these rates by 2013. *See* STATE AGENCY BUDGETS, EXEC. OFFICE OF THE GOVERNOR, EXECUTIVE BUDGET OF THE STATE OF ARIZONA, FISCAL YEAR 2013 (2012). Budget constraints have also led Arizona to eliminate coverage for emergency dental procedures. Such cuts are not all too uncommon. According to a report by the Kaiser Family Foundation, 29 states reduced payments to providers and 20 cut benefits not required by federal law in 2010. *See* Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, THE NEW YORK TIMES (Dec. 4, 2010) (*available at* http://www.nytimes.com/2010/12/05/us/05transplant.html).

[84] *The State of Children's Dental Health: Making Coverage Matter - Arizona* (The Pew Center on the States, Washington, D.C.), May 2011 (*available at* http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/Childrens_Dental_Health/048_11_DENT_50_State_Factsheets_Arizona_052311_web.pdf).

[85] *Id.*

[86] Arizona reduced its Medicaid dental fee schedule by 5% in 2001. ACCCHS, PUBLIC NOTICE OF INFORMATION (April, 1, 2011) (*available at* http://www.azahcccs.gov/publicnotices/Downloads/rates/April2011FFSRates.pdf). However, the current governor seeks to restore these rates by 2013. *See* STATE AGENCY BUDGETS, EXEC. OFFICE OF THE GOVERNOR, EXECUTIVE BUDGET OF THE STATE OF ARIZONA, FISCAL YEAR 2013 (2012). Budget constraints have also led Arizona to eliminate coverage for emergency dental procedures. Such cuts are not all too uncommon. According to a report by the Kaiser Family Foundation, 29 states reduced payments to providers and 20 cut benefits not required by federal law in 2010. *See* Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, THE NEW YORK TIMES (Dec. 4, 2010) (*available at* http://www.nytimes.com/2010/12/05/us/05transplant.html).

c. Rhode Island

In 2006, Rhode Island initiated its RIte Smiles program.[87] Rhode Island switched from a traditional state-administered fee-for-service structure to a managed care structure.[88] The state phased in the program at a relatively moderate pace. Currently, only thirty-one percent of Medicaid EPSDT-eligible children receive dental benefits under this managed care structure.[89] Rhode Island relies on only one commercial vendor.[90] Both the state and its vendor, UnitedHealthcare Dental, share the financial risk.[91] The DMO receives a fixed monthly payment per child enrolled.[92] However, risk-sharing and gain-sharing provisions ensure adequate coverage.[93] The vendor pays dentists on a fee-for-service basis.[94] Rhode Island issued several mandates to its vendor. The state charged the vendor with the responsibility of establishing and maintaining an adequate network of providers.[95] The state also charged the vendor with the task of increasing provider rates closer to those paid by private preferred-provider

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[87] Rhode Island implemented the RIte Smiles program originally under a § 1915(b) waiver, though it now operates under a § 1115 waiver. The program was designed to further the success of the Oral Health Access Project. Specifically, the state sought to eventually decrease Medicaid expenditures by encouraging more utilization of preventive dental care and decreasing reliance on emergency and restorative procedures. CHRISTINE A. PAYNE, MEDICAID RESEARCH AND EVALUATION PROJECT, RHODE ISLAND DEPT. OF HUMAN SERVICES, RITE SMILES EVALUATION REPORT: TRENDS FROM 2002-2008 (May 17, 2010) at 4 (*available at* http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Reports/ritesmiles_trends_2002_2008.pdf).

[88] *Id.* at 8 ("Rhode Island transitioned from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system").

[89] *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).

[90] *Id.*

[91] *Id.*

[92] *Id.*

[93] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.

[94] *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).

[95] CHRISTINE A. PAYNE, MEDICAID RESEARCH AND EVALUATION PROJECT, *supra* note 87, at 10-12.

organizations.[96] Provider reimbursement rates remain relatively low. In 2010, dentists received only 35.4 percent of average national median retail fees.[97]

Rhode Island successfully improved access and utilization. Only twenty-seven providers participated in Rhode Island's older Medicaid program.[98] This number increased to one hundred eighty by 2010.[99] More children also received more care. In 2005, before Rhode Island implemented its reforms, only 34.5 percent of children received at least one dental service per year.[100] In 2010, four years after implementation, this rate increased by 28.1 percent to 44.2 percent of children receiving at least one dental service.[101] Total preventive visits increased by thirty-three percent and total treatment visits increased by fifty percent.[102]

d. Florida's Miami-Dade County Pilot Program

Florida's attempt at reform proved not as successful.[103] Under Florida's traditional Medicaid dental structure, the state contracts directly with dentists.[104] The state typically pays dentists on a fee-for-service basis.[105] In 2004, Florida looked to

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[96] *Id.*
[97] *The State of Children's Dental Health: Making Coverage Matter* (The Pew Center on the States, Washington, D.C.), May 2011 at 25.
[98] CHRISTINE A. PAYNE, MEDICAID RESEARCH AND EVALUATION PROJECT, *supra* note 87, at 12.
[99] *Id.*
[100] *Assessing the Impact of RI's Managed Oral Health Program (RIte Smiles) on Access and Utilization of Dental Care among Medicaid Children Ages Ten Years and Younger*, MEDICINE & HEALTH RHODE ISLAND (Rhode Island Medical Society, Providence, RI), Aug. 2011 at 248.
[101] *Id.*
[102] *Id.*
[103] A study by Dr. Burton L. Edelstein concluded that the program failed in terms of value. The study defined value as "the benefit to the state in terms of quality of care for Medicaid dollars expended." Burton L. Edelstein, *Miami-Dade County Prepaid Dental Health Plan Demonstration: Less Value for State Dollars* (Collins Center for Public Policy, Miami, FL) Aug. 2006 (*available at* http://www.collinscenter.org/resource/resmgr/Health_Care_Docs/MDCoPrepdDentalAnalysis8-06.pdf).
[104] *See Understanding the Impacts of Florida's Medicaid Pre-Paid Dental Pilot*, ORAL HEALTH ISSUE BRIEF (2006) (*available at* http://www.collinscenter.org/resource/resmgr/Health_Care_Docs/Oral_Health_Pilot_Policy_Bri.pdf).
[105] *Id.*

managed care as a means of switching from being "payers" of dental care to being "purchasers."[106] In the *Medicaid Pre-Paid Dental Pilot*, Florida contracted with a single vendor, Atlantic Dental, Inc. (ADI).[107] ADI bore the full risk for the cost of claims.[108] In turn, ADI passed the risk on to dentists by paying them an average amount of $4.28 per patient per month instead of paying for individual services performed.[109]

This program failed to deliver value.[110] Costs increased by one percent as quality declined.[111] Enrolled children visited the dentist less.[112] Utilization declined by forty-two percent.[113] Dentist participation dropped by fifty-nine percent.[114]

e. South Carolina

South Carolina does not employ a carve-out. While beneficiaries have the option to receive medical benefits from either a primary care case management program or the state's traditional Medicaid fee-for-service structure, the state administers all dental

[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] *See supra* note 103.
[111] Total costs increased from $14.9 million to $15.1 million, a one percent increase. Quality of care declined as fewer patients received timely care. Interestingly, however, consumer satisfaction remained high. Burton L. Edelstein, *Miami-Dade County Prepaid Dental Health Plan Demonstration: Less Value for State Dollars*, *supra* note 103, at 3-5. The consumer satisfaction survey may be suspect because "[s]tates must take any positive feedback from Medicaid beneficiaries with a grain of salt…since many Medicaid beneficiaries have never had good care and are therefore not the best judges of the level of care they ought to receive." Lisa Axelrod, *The Trend Toward Medicaid Managed Care: Is the Government Selling Out the Medicaid Poor?*, 7 B.U. PUB. INT. L.J. 215, 267 (1998).
[112] Burton L. Edelstein, *Miami-Dade County Prepaid Dental Health Plan Demonstration: Less Value for State Dollars*, *supra* note 103, at 3 ("The average umber of dental visits per enrolled child decreased by 61% (from 0.60 visits to 0.24 visits)").
[113] *Id.* ("The percent of children "continuously" enrolled in the program who received at least one dental visit declined by 42% (from 29% to 16%)").
[114] *Id.* ("The number of Dade County dentists who provided services to at least one child declined 59% (from 669 dentists to 276 dentists)").

Medicaid benefits through its traditional Medicaid fee-for-service system.[115] South Carolina does not contract with any commercial agents to provide administrative services either.[116] The South Carolina Department of Health and Human Services (SCHHS) handles claim processing and directly enrolls dental providers.[117] SCHHS then pays providers on a fee-for-service basis.[118] In 2000, SCHHS did employ administrative reforms, however, in an effort to encourage provider participation.[119] SCHHS eased preauthorization requirements, streamlined claim procedures, and allowed extra reimbursement for additional time spent treating children with special needs.[120] The state also increased reimbursement to match the seventy-fifth percentile of regional commercial dental fees, but these rates have not been increased since.[121]

These reforms resulted in a 31.8% increase in provider participation within one year.[122] Utilization only increased 4.3% during this year.[123] However, within seven years of these reforms, utilization increased by 63.8% and provider participation increased by 93.4%.[124]

For a summary of these administrative approaches, see Appendix B. For a comparison of the effectiveness of these approaches, see Appendix A.

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[115] *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).
[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 9.
[120] *Id.*
[121] *Strides in Dental Access for Low-Income Children: Lessons Learned from Six States with Major Dental-Medicaid Reforms* (Doral), 2007 at 5.
[122] *See id.* at 4-5; *see also* Alison Borchgrevnik, Andrew Snyder, & Shelly Gehshan, *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?* (California Healthcare Foundation, Oakland, CA), March 2008, at 3.
[123] Alison Borchgrevnik, Andrew Snyder, & Shelly Gehshan, *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?, supra* note 122 at 3.
[124] *Id.*

V. Quantitative Evaluation of State Approaches[125]

While most states experienced improvement in utilization and provider participation between 2000 and 2009, some states experienced more success than others.[126] Additionally, some states experienced improvement in less time than others. These improvements can be attributed to numerous factors, including increased reimbursement rates, new assistance programs, and administrative reform. Most states incorporated all three changes into their reforms.[127] Though utilization and provider participation are influenced by more than just administrative reform, these administrative reforms may account for a considerable percentage of improvement.

While states with relatively high payment rates often experienced better than average rates of utilization,[128] the trend does not account for the experiences of all states. Some states succeeded in improving utilization without relying on significantly high rates of reimbursement. In 2007, of the twenty-seven states (including the District of Columbia but excluding Mississippi, Delaware, and Kentucky)[129] that demonstrated

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[125] In this section, I rely on rates of improvement in utilization and provider participation in states that employed different administrative models. I also rely on a comparison of 2007 utilization rates with 2007 reimbursement rates (as the percent of regional median retail fees reimbursed by Medicaid). I also compare 2009 utilization rates with 2010 average rates of reimbursement (as the percent of 2009 average regional retail fees reimbursed by Medicaid in 2010). Neither data set allows for any definite conclusions. The former data set may not reflect changes since 2007. The latter data set requires the assumption that the 2010 reimbursement rates were the same as in 2009.

[126] *See The State of Children's Dental Health: Making Coverage Matter*, supra note 1, at 22.

[127] *See Strides in Dental Access for Low-Income Children: Lessons Learned from Six States with Major Dental-Medicaid Reforms* (Doral), 2007.

[128] In 2007, eleven of twenty-one states that paid providers above the national average rate demonstrated above average rates of utilization. *See* Appendix D. In 2009/2010, eleven of the eighteen states that paid providers above the national average rate demonstrated above average rates of utilization. *See* Appendix C.

[129] Insufficient data exists to include these states in the 2007 study. New Jersey's statistics appear somewhat suspect because the 2007 study suggests that providers received 105.7% of regional retail fees and the 2009/2010 study suggests that providers received 42.8%. New Jersey also recently tried to improve

above average utilization rates, sixteen states did so with payment rates below the national average.[130] In 2009, of the twenty-seven states (including the District of Columbia) that demonstrated utilization rates above the national average, sixteen states also did so with 2010 payment rates below the national average.[131] This suggests that states can improve utilization without significantly raising reimbursement rates. These states used a variety of approaches in administering dental Medicaid benefits.[132] However, most rely on a single non-risk commercial agent to administer dental Medicaid benefits through a carve-out and pay providers on a fee-for-service basis.[133] In fact, all of

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participation by reducing claim processing duration rather than increasing reimbursement rates. Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 12. My analysis includes New Jersey for lack of a clear explanation to suggest that this data is incorrect, even though it seems suspect. *Compare* Appendix C *with* Appendix D.

[130] These states include: New Mexico, Hawaii, Indiana, Kansas, Colorado, Virginia, West Virginia, Alabama, Vermont, Idaho, Utah, Washington, Iowa, Ohio, Nebraska, and Rhode Island. *See* Appendix D.

[131] These states include: Virginia, Indiana, South Carolina, North Carolina, Kansas, Vermont, Alabama, New Mexico, Colorado, Nebraska, Illinois, Iowa, Washington, Idaho, Hawaii, and Rhode Island. *See* Appendix C.

[132] In 2007, the sixteen states with above average utilization and below average reimbursement rates followed the following approaches. Eleven states used carve outs, while five used integrated structures. Five states administered benefits themselves, nine contracted with some kind of outside agent, and two states did both. Of the eleven states that contracted with outside agents, four contracted with multiple agents, while seven only contracted with one agent. Of the eleven states that contracted with outside agents, only two assigned some degree of risk to the agents. All of the sixnteen states that demonstrated above average utilization with below average reimbursement rates paid providers on a fee-for-service basis. *See* Appendix D; *see also* Appendix E.

In 2009/2010, the sixteen states with above average utilization and below average reimbursement rates followed the following approaches. Eleven states used carve outs, while five used integrated structures. Four states administered benefits themselves, ten contracted with some kind of outside agent, and two states did both. Of the twelve states that contracted with outside agents, four contracted with multiple agents, while eight only contracted with one agent. Of the twelve states that contracted with outside agents, only two assigned some degree of risk to the agents. All of the seventeen states that demonstrated above average utilization with below average reimbursement rates paid providers on a fee-for-service basis. *See* Appendix C; *see also* Appendix E.

[133] The ratio of states with above average utilization rates and below average reimbursement rates that employ the approaches suggested by this note to those that do not, in most cases, exceeds the ratio of all states that employ these approaches to those that do not. This demonstrates that these results reflect a trend rather than just the national distribution of approaches. The ratio of these selected states that used carve-outs to those that did not is 11:5; the national ratio is 26:25. The ratio of these states that contracted out administrative duties to those that did not is 11:5; the national ratio is 14:3. The ratio of these states that contracted with just one third-party to those that contracted with multiple third parties is 7:4; the national ratio is 1:1. The ratio of these states that did not transfer risk to contractors to states that did transfer some degree of risk is 4:1; the national ratio is 4:3. The ratio of these states that paid providers on a fee-for-service basis to those that used some degree of capitation was 17:0; the national ratio is 14:3. The only

the sixteen states paid providers on a fee-for-service basis. Fee-for-service payment appears a better option than capitated payment also because none of the states using any degree of capitation demonstrated a utilization rate above the national average.[134] Thus, because states have demonstrated success without relying on significantly high reimbursement rates, this model appears to be the most preferable option.

Furthermore, trends in utilization rates following certain types of administrative reforms suggest that a single vendor system may be preferable. While every approach to reform resulted in improvement, states that contracted through a single vendor generally experienced more instantaneous progress than states that administrated dental Medicaid benefits through a state agency or through multiple managed care plans. Tennessee, Rhode Island, Virginia, and Indiana all experienced better initial results than did South Carolina, Arizona, and New Jersey.[135]

Data reflecting the failures of states to meet the national average utilization rate suggests that high reimbursement rates do not necessarily translate into high utilization rates. In 2007, of the twenty-one states that demonstrated below-average utilization rates,[136] eleven states did so with payments rates above the national average.[137] This

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ratio that did not exceed the national ratio was that of states that contracted out administrative duties to those that did not. However, the difference was not great enough to suggest that self-administration by states was a preferable option to contracting out these duties. *See* Appendix D; *see also* Appendix E.

[134] *See* Appendix C.

[135] *See* Appendix A.

[136] I exclude Delaware and Kentucky due to a lack of available data. In 2007, both Delaware and Kentucky failed to meet the national average utilization rate, so, in total twenty-three states did not meet the national average utilization rate in 2007. *See* Appendix D.

[137] These states include: New Jersey, the District of Columbia, South Dakota, Wyoming, Arkansas, Maryland, New York, Louisiana, North Dakota, Nevada, and Missouri. *See* Appendix D.

The data from 2009/2010 is less clear. In 2009/2010, of the twenty-three states that demonstrated below-average utilization rates, seven states did so with payment rates above the national average. These states include: Delaware, Alaska, North Dakota, Wyoming, Louisiana, and Connecticut. *See* Appendix C. Some of these states, such as Alaska, North Dakota, and Wyoming, face challenges related to geography. However, failures by Delaware and Connecticut to sustain high utilization rates do not allow for any conclusions to be drawn. Both states employ nearly polar opposite administrative approaches. Delaware's

suggests that reimbursement rates are not the only factor affecting utilization. Of these states that failed to meet the national average utilization rate with payment rates above the national average, most states used an integrated structure and contracted out at least some administrative duties.[138] However, most of these states contracted with multiple vendors, and most transferred risk to these vendors.[139] Far more of these states capitated providers than did the states that met the national average utilization rate without reimbursing providers higher than average rates.[140] This again suggests that a carve-out administered by a single nonrisk vendor that pays providers on a fee-for-service basis is a preferable mode of administration.

While some trends are discernible from this data, a quantitative approach may not be wholly sufficient. It is difficult to account for all of the many factors that affect utilization and provider participation. No state is the same as another, so one cannot expect reforms to encourage improvement at the same rate. Medicaid beneficiaries in some states may face more language barriers than others, while those in other states may face more geographical barriers. In many cases, factors that affect dentist participation

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state Medicaid agency administers dental Medicaid benefits without the help of an outside contractor. In fact, dental providers in Delaware interact more with the state agency than do providers in other states. Dental providers have to enroll directly with the fee-for-service program or with one of the eight state-operated clinics. Until 1997, in order to treat Medicaid patients, providers worked as direct employees of the state-run clinics. On the other hand, Connecticut's reforms in the early 2000s mirror those proposed by this note. Connecticut created a carve-out and reduced the amount of vendors it contracted with to one vendor. Connecticut also ceased transferring risk to its vendors. Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid* (Connecticut Health Foundation, Hartford, CT), Mar. 2003 (*available at* http://www.cthealth.org/wp-content/uploads/2011/04/understanding-the-ct-dental-medicaid-reform-proposal.pdf). Thus, the isolated experiences of two states may not offer sufficient data to draw any conclusion that one approach is better than the other.

[138] Eight states used integrated systems, while only three used carve-outs. Nine contracted out at least some administrative duties, while two did not. *See* Appendix D; *see also* Appendix E.

[139] Six contracted with multiple vendors, while only three contracted with a single vendor. Six states transferred at least some risk to these vendors, while only three did not.

[140] While no states that demonstrated above-average utilization rates with below-average reimbursement rates paid providers on a capitated basis, four of the eleven states that fell below the national average utilization rate with above-average reimbursement rates capitated at least some providers.

may not be easily quantifiable. For example, forces beyond payment and administrative ease encourage dentists to treat Medicaid patients. Many dentists feel a sense of obligation to their communities to help those in need despite low payment and administrative hassles.[141] This draw is difficult to quantify. The available research may simply not be comprehensive enough to account for all of these possible factors.[142] However, a single vendor system, in which the vendor takes on little or no risk and pays providers on a fee-for-service basis, presents itself as the ideal administrative structure for other more qualitative reasons.

VI. The Ideal Administrative Reform

States have increased participation by dentists and utilization by enrollees through administrative reforms. States can reform Medicaid structures across five dimensions. First, states can carve-out dental benefits from existing Medicaid administrative structures or integrate dental benefits with medical benefits. Second, states can administer Medicaid dental benefits themselves or do so through private vendors. Third, if a state adopts the latter approach, the state must decide whether to contract with a

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[141] *Dentists Not Impressed with Medicaid*, The Wealthy Dentist, http://thewealthydentist.com/surveyresults/084-dental-medicaid-patients.htm (last visited April 23, 2012).

[142] Social science assessments, such as these, are made difficult to quantify with empirical evidence because of a lack of research analyzing the human and social consequences of different approaches. This is certainly true, at least, in so far as it applies to the assessment of new technologies. Researchers mainly focus on whether new technologies perform as intended and on diagnostic accuracy. Often times, little is known about the actual impact on the patient's health or on social consequences, such as the cost effectiveness of the new technology. The question of cost effectiveness may be the most crucial inquiry when available health resources in the real world will limit the application of the new technology. Henry J. Aaron, *Health Care Rationing: Inevitable but Impossible?*, 96 GEO. L.J. 539, 540 (2008). Similarly, dental Medicaid reform success must be measured in terms of its total impact on individuals and society. High utilization rates may not necessarily translate into good dental health. Thus, this empirical evidence may not provide a complete picture of the state of dental health. The qualitative analysis provided in Section VI tries to fill some of these gaps.

single vendor or multiple vendors. Fourth, the state must then determine the amount of financial risk that the vendor or vendors should bear. Lastly, states have the option of limiting how much risk vendors can transfer to dental providers.

To best improve provider participation and utilization of care by enrollees, states should contract with a single commercial vendor to exclusively provide dental benefits. The state should assume at least some degree of risk, while capitalizing on the vendor's established network, expertise, and commonplace claims procedures. The state should also provide that the vendor must pay providers on a fee-for-service basis.

a. Carve-out vs. Integration

States should carve out their dental program from the traditional Medicaid structures. Carve-outs result in more effective administration of dental benefits.[143] Separate dental programs receive their own budget and own separate administrator. A separate budget prevents funds from being diverted from dental benefits to medical benefits.[144] Both courts and states have sponsored carve-outs as appropriate remedies for addressing previously unmet and overlooked needs.[145] Such was the impetus behind

[143] Of the sixteen states that demonstrated above average utilization in 2009 while still reimbursing providers less than average rates in 2010, eleven states used carve outs, while six used integrated structures. *See* Appendix C; *see also* Appendix E.

[144] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 9.

[145] While this piece focuses on failures by Medicaid programs to address dental health in underage populations, Medicaid programs may also have to address the special dental needs of other populations. For a discussion of the adjustments states must make to Medicaid structures to help young children, pregnant women, people with developmental disabilities, and people in rural areas, *see* Andrew Snyder, *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations*, *supra* note 46.

Tennessee's reforms.[146] These approaches suggest that carve-outs are better suited for addressing the needs of specific undertreated populations. Tennessee's carve-out now works within the state's budget. Legislators directly allocate funds each year to dental health.[147] Underfunding becomes a conscious act of resource allocation, not a mere oversight. These dental programs also benefit from an administrator whose expertise and focus relates just to dental health. Additionally, carve-outs allow for greater accountability when dental performance stands alone from medical performance.[148] Poor dental health cannot hide behind the cloak of improvement in other health measurements. Dental providers typically prefer carve-outs to both managed care structures and state-run structures that administer both medical and dental benefits.[149] Neither dentists nor doctors are trained to practice both medicine and dentistry.[150] Challenges may exist in creating systems that would allow the sharing of information between doctors and dentists.[151] Thus, carve-outs may allow for the more effective administration of dental Medicaid benefits.

On the other hand, integration of dental and health benefit administration does present some benefits. Integration allows for care coordination. For example, New Jersey's managed care organizations expedite organ transplants that require preliminary

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[146] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*, *supra* note 59, at 15.
[147] *Id.* at 17.
[148] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid* (Connecticut Health Foundation, Hartford, CT), Mar. 2003, at 5 (*available at* http://www.cthealth.org/wp-content/uploads/2011/04/understanding-the-ct-dental-medicaid-reform-proposal.pdf).
[149] Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 6.
[150] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 13.
[151] *Id.*

dental clearance.[152] States can also ensure that dental benefits receive proper funding by laying out specific minimum benefits in their contracts with MCOs. For example, Arizona sets minimum benefit standards for MCOs.[153] These benefits include ensuring that beneficiaries can see the dentist at least twice a year for preventive care and the care that they receive is consistent with the community standard of care.[154] Arizona also requires that MCOs maintain adequate networks.[155] These improvements in care coordination are possible in an integrated Medicaid structure.

Integration may also improve utilization by capitalizing off of Medicaid beneficiaries' tendencies to seek primary care more so than dental care. Arizona requires that physicians screen Medicaid enrollees for dental health problems and refer them to dentists.[156] In New Jersey, AmeriChoice pays physicians forty percent of their original reimbursement amount if the referral results in a dental visit.[157] The plan reported that utilization doubles for beneficiaries that see physicians that refer.[158] However, budgets are further strained by this reimbursement system as physicians need to reimbursed for screening patients. Additionally, just one trip to the dentist creates unique dilemmas for Medicaid enrollees. Enrollees usually lack access to transportation, cannot afford childcare and must pay public transportation rates for their children to make the trip as well, and must travel long distances to more affluent areas where dentists tend to

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[152] *Id.* at 10.
[153] *Id.* at 9; Medical Policy Manual §§ 430(A)(7)(b)(1), 430(C).
[154] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.
[155] *Id.*
[156] *Id.*
[157] *Id.* at 10.
[158] *Id.*

practice.[159] Facing these barriers twice may not be feasible for patients facing these barriers. Thus, carve-outs allow states to avoid these dilemmas.

In practice, states that have used carve-outs have experienced success in improving access and utilization. In Tennessee, provider participation improved by more than one hundred twenty percent following a series of reforms to the dental Medicaid program, including the switch to a carve-out.[160] Utilization by children improved from thirty-six percent to fifty-one percent within four years of these reforms.[161] On the other hand, Arizona, which relies on MCOs to administer both dental and medical benefits, has also experienced success. Medicaid utilization increased from below thirty percent in 2000 when payment structure reform had just taken place to 47.2% in 2009.[162] Both experience and reason suggest that carving out dental benefits from the administration of other Medicaid benefits can eventually lead to more Medicaid children receiving more dental care.

b. Administration through Private Vendor vs. Self-administration

States should hire private vendors to administer dental benefits, rather than administer benefits themselves. In fact, many states already use fiscal agents to handle

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[159] *See* Andrew Snyder, *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations*, *supra* note 46, at 5; *see also* June Thomas, *The American Way of Dentistry: Why poor folks are short on teeth.*, supra note 6.
[160] Alison Borchgrevink, Andrew Snyder, & Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, *supra* note 20, at 8.
[161] *Id.*
[162] *The State of Children's Dental Health: Making Coverage Matter – Arizona*, *supra* note 84.

administrative tasks, including processing claims and responding to provider inquiries.[163] However, these fiscal agents come in many forms, some specializing in information technology and others specializing in maintaining dental provider networks.[164] States should opt for commercial vendors that already maintain private networks. Fiscal agents specialized in information technology can effectively process claims, but they lack a personal connection to providers. Through private administration, states can build on already existing provider networks instantaneously while drawing on experience that transcends basic administrative tasks.[165] Managed care professionals have more experience in quality review and adjustment compared to state employees.[166] Additionally, dental providers prefer claims processes and payment systems that align with the commercial plans through which they are already paid.[167] Submitting claims to government agencies that use separate codes and take longer to process payments presents an unnecessary obstacle between the provider and the major financial incentives. Clearly, the use of a private commercial agent provides many benefits.

The involvement of managed care with Medicaid programs is not without its critics, however. Some argue that because a managed care contract builds in some degree of profit margin, contracting with a commercial vendor entails an unnecessary extra level of expense.[168] Others have criticized how haphazardly states entered into managed care agreements in the 1990s with plans that were not experienced in administering benefits to

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[163] Only nine states administer all dental Medicaid benefits themselves. The rest use some sort of a commercial agent to administer at least some benefits. *Medicaid Compendium Update* (American Dental Assn., Chicago, IL), 2008 (*available at* http://www.ada.org/2123.aspx).
[164] *See supra* notes 31-32 and accompanying text.
[165] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 4.
[166] *Id.*
[167] James J. Crall & Donald Schneider, *Medicaid Program Administration*, *supra* note 31, at 1.
[168] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 4.

Medicaid patients.[169] Because of the complexity of establishing effective oversight and review procedures, establishing these programs may take over two years.[170] States must also ensure that vendors have the resources to address the unique needs of Medicaid patients. Commercial vendors typically do not have enough staff capable of speaking other languages.[171] Commercial vendors also do not usually operate networks in poor areas, so transportation then becomes a new concern.[172] However, states can address these concerns without necessarily abandoning the option to contract with commercial vendors. The responsibility falls upon the state to not rush into these agreements without ensuring that the vendor can address these challenges. Contracting with only a single vendor will ease the burden of negotiation and later performance review. States can also adopt data collection, monitoring, and evaluation modules that have worked in states already using a private vendor system.[173] By adopting such measures, states can evaluate whether the administrative efficiencies of third-party administration have reduced costs or improved dental health enough to substantiate the extra profit margin built into the managed care contract.

Some states appealed to the needs of providers without contracting out administrative duties. For example, South Carolina eased administrative burdens without turning to a commercial vendor.[174] Provider participation in South Carolina subsequently

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[169] Axelrod, *supra* note 111, at.
[170] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 4.
[171] Axelrod, *supra* note 111, at 264.
[172] *Id.* at 265.
[173] For example, Rhode Island created an Oral Health Module to monitor the success of their managed care vendor. *See* Christine A. Payne, *Baseline Oral Health Indicators* (Rhode Island State Action for Oral Health Access Project), 2005 (*available at* http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Reports/baseline_oral_hlth_ind_2005.pdf).
[174] Kim McPherson, *State Strategies to Improve Dental Compliance in Missouri's Medicaid Population*, *supra* note 58, at 12.

increased by 93.4% in six years.[175] Alternatively, states that have contracted with private commercial vendors experienced similar improvements in less time. Rhode Island witnessed an over seven hundred percent increase in just two years.[176] In Tennessee, provider participation improved 111.7% in three years.[177] The use of private commercial vendors allows states to tap into already existing networks immediately. Given the state of dental health, many enrollees may not be able to wait six years until they can finally see a dentist.

c. Single Vendor vs. Multiple Vendors

States should contract with a single vendor rather than multiple vendors. This structure best addresses the interests of both providers and patients. Providers may not be interested in navigating through different claims processes.[178] In Tennessee, providers only deal with a single set of rules, a single claims payer, a single agreement, a single credentialing process, and a single fee schedule.[179] As each one of these procedures may be unique to each vendor, the potential for inconvenience is clear. Patients may also be confused by multiple different options.[180] Furthermore, by contracting with only a single vendor, the state will reduce administrative costs while allowing for stronger oversight.[181]

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[175] Alison Borchgrevnik, Andrew Snyder, & Shelly Gehshan, *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?*, *supra* note 122, at 3.
[176] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 8.
[177] Alison Borchgrevnik, Andrew Snyder, & Shelly Gehshan, *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?*, *supra* note 122, at 3.
[178] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 7.
[179] *Id.*
[180] *Id.*
[181] James J. Crall & Donald Schneider, *Medicaid Program Administration*, *supra* note 31, at 1.

Virginia relies on a single dental benefits administrator and benefits from the centralization of data.[182] Virginia works with the vendor to analyze the data.[183] A vendor competing within a multiple-vendor system does not have such an ability to assess the full scope of dental health within the state. The single-vendor system, thus, aligns with the interests of states, providers, and the patients.

Multiple-vendor systems offer some advantages as well, but these primarily help just the state rather than providers and patients. Multiple vendors can compete against each other, thus potentially lowering the cost of dental benefits for the state.[184] A multiple-vendor system also provides the state the benefit of cross-plan performance review.[185] This allows states to differentiate between plan-specific deficiencies and systemic deficiencies. Additionally, some note that the multiple-vendor systems that have failed in the past failed primarily due to a lack of funding, as opposed to any inherent flaw.[186] A multiple-vendor system provides the state with some unique advantages, but providers and patients may be left confused and frustrated.

Overall, a single-vendor system can most effectively and efficiently administer dental Medicaid benefits. A single-vendor system benefits all parties involved – the state, dental providers, and Medicaid beneficiaries. A multiple-vendor system benefits the state in some ways, but it inconveniences both providers and patients in others. Contracting and performance review also becomes a laborious process if done properly.

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[182] Shelly Gehshan, Andrew Snyder, & Julie Paradise, *Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP*, *supra* at note 1, at 21.
[183] *Id.*
[184] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 7.
[185] *Id.*
[186] *Id.*

d. Degree of Risk Placed on Vendor

In structuring the contract with the single vendor, states should refrain from placing the entire risk of the program on the vendor. Risk should be mitigated through risk-sharing and gain-sharing clauses or administrative services only contracts. As Medicaid is an individual entitlement, the entity at risk cannot deny care when funding is depleted.[187] This makes calculating risk difficult.[188] Because of this, managed care organizations often avoid accepting full-risk contracts.[189] Practically speaking, it may be the case that the state has no other option but to accept some degree of risk.

Even if a vendor wishes to accept full risk, the vendor may be conflicted between encouraging utilization and simultaneously cutting costs.[190] Historically, programs that have refrained from full-risk contracts have experienced more success. Rhode Island employed risk-sharing and gain-sharing.[191] On the other hand, Florida tried a similar program that differed in that it placed full risk on its vendor.[192] Florida's program failed, as providers dropped out and access became more limited.[193] Florida's program also failed to bring about the theoretical cost-savings, the purpose behind transferring full risk.[194] In Rhode Island, patients visited dentists fifty percent more frequently and

[187] *Understanding the Impacts of Florida's Medicaid Pre-Paid Dental Pilot*, ORAL HEALTH ISSUE BRIEF (Community Voices Miami, Miami, FL), *supra* note 104.
[188] *Id*.
[189] Burton L. Edelstein, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid*, *supra* note 148, at 6.
[190] *Id.*
[191] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 8.
[192] *Understanding the Impacts of Florida's Medicaid Pre-Paid Dental Pilot*, ORAL HEALTH ISSUE BRIEF (Community Voices Miami, Miami, FL), *supra* note 104.
[193] Burton L. Edelstein, *Miami-Dade County Prepaid Dental Health Plan Demonstration: Less Value for State Dollars*, *supra* note 103, at 6.
[194] Costs actually increased by one percent. *Id.*

provider participation increased by over seven hundred percent.[195] Tennessee and Virginia have used administrative services only contracts. Tennessee and Virginia have also improved access and utilization.[196] Successes in these states contrasted with Florida's less fortunate experience demonstrate the importance of the state retaining some risk. To ensure that dental Medicaid administration encourages the maximum amount of utilization, states should avoid creating adverse incentives. No-risk or mitigated-risk contracts would achieve better results.

e. Degree of Risk Placed on Provider

Just as vendors should not fully bear the burden of financial risk, providers should also not bear this risk. Arizona explicitly prohibited its managed care plans from passing risk on to providers by paying on a per beneficiary per month basis rather than on a fee-for-service basis.[197] Participation subsequently increased.[198] Most dental providers rely on fee-for-service payments from private insurers.[199] For this reason, capitation represents an inconvenience that most dentists have never had to adapt to. Additionally, under private plans that do capitate dental providers, access sometimes suffers because

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[195] CHRISTINE A. PAYNE, MEDICAID RESEARCH AND EVALUATION PROJECT, *supra* note 87.

[196] David Neumeister, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*, *supra* note 59; James A. Reed, *Dental Plan Performance with Medicaid Reform in Virginia*, (June 2011) (unpublished M.S.D. thesis, Virginia Commonwealth University) (*available at* https://digarchive.library.vcu.edu/bitstream/handle/10156/3336/Reed%20Final%205.10%20tb%20edits.pdf?sequence=2).

[197] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 9.

[198] ACCCHS DENTAL CARE TASK FORCE, FINAL REPORT, *supra* note 77.

[199] James J. Crall & Donald Schneider, *Medicaid Program Administration*, *supra* note 31, at 1.

dentists have no financial incentive to actually treat patients.[200] Capitation aligns incentives with current barriers to utilization of dental care by Medicaid patients. Dentists will be less likely to schedule follow-up appointments, reach out to patients who have not received preventive care in a long time, or try to solve the problems involved with missed appointments. Capitation has also resulted in decreased patient satisfaction in California. Under California's Healthy Family Program (HFP), the three dental maintenance organization plans that capitate providers have proven more cost-effective than the fee-for-service exclusive provider organization plans, but patient satisfaction remains lower in these plans.[201] Because states should avoid inconveniencing dental providers in order to encourage utilization, states should opt for the more familiar fee-for-service payment system and absorb the possible extra costs associated with it.

VII. Conclusion

Together with increases to reimbursement rates and the creation of new outreach initiatives, administrative reform can set states in a positive direction to improving dental health in the Medicaid population. States can customize administrative structures to the exact needs of Medicaid providers and patients. Any costs related to contracting out administrative duties and subsequent performance review will be recouped once a culture of proactive dental care is fostered in the minds of Medicaid patients and once these patients can actually find that care. A proactive system where patients receive early

[200] *What are HMO Dental Insurance Plans?*, Dental Insurance Helper, http://www.dentalinsurancehelper.com/dental-insurance-articles/hmo-dental-insurance.htm (last visited Feb. 29, 2012).
[201] Caroline Davis & Gretchen Brown, *Managing California's Medicaid Dental Program: Lessons from Other States*, *supra* note 72, at 11.

preventive care will prove much less costly than a reactive system where patients who have never seen a dentist rely on emergency room services. Both states and patients alike cannot afford to allow this dental health crisis to grow any worse by doing nothing to adapt Medicaid structures to the realities of the situation.

Appendix A
Trends in Utilization Provider Participation

State	Time Spa	Increases in Utilization	Increases in Participation	Rate Trend
National Avg.	9 Years	~46	N/A	
TN	2 Years	38.5	81.3	increased to 75th
2002-2009	3 Years	38.5	111.7	
	8 Years	~78.5	N/A	
SC	1 Year	4.3	31.8	75th percentile
2000-2011	2 Years	N/A	43.1	but not raised since
	6 Years	47.5	N/A	
	7 Years	63.8	93.4	
	11 Years	~98.9	N/A	
AZ	1 Year	10.5	N/A	2010 - 68.9% of dentists' median retail fees
2002-2009	5 Years	25.3	N/A	
	7 Years	~57.3	~70.3	
RI	1 Year	N/A	~500	2006 - $7.82 per kid per month
2005-2010	5 Years	28.1	703.7	2010 - 35.4% of dentists' median retail fees (weighted average)
MI	2 Years	~30	150	83-111% of average charges in region
2000-2009	6 Years	43	N/A	but $25 per service less than national 75th percentile
	9 Years	~75.2	N/A	
VA	1 Year	>30	21	fee schedule increased by 28%
2005-2007	2 Years	N/A	76.9	
IN	3 Years	77.8	42.3	Increased rates but haven't adjusted
1997-2007	8 Years	~122*	85.3	for inflation
	10 Years	N/A	87.4	
NJ	1 Year	1	N/A	Medicaid Rates are about 1st-3rd percentile of State Percentiles
2000-2006	3 Years	29.4	N/A	Resisted Increasing Rates
	6 Years	52.9	N/A	
Miami-Dade	2 Years	-42	-59	Only Paid $4.28 per patient per month
County Pilot				
2003-2005				

*(but enrollment declined)

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	ACCCHS Dental Care Task Force, Final Report (April 2008)
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IN	Strides in Dental Access for Low-Income Children: Lessons Learned from Six States with Major Dental-Medicaid Reforms (Doral), 2007.
NJ	The State of Children's Dental Health: Making Coverage Matter (The Pew Center on the States, Washington, D.C.), May 2011.
Miami-Dade County Pilot	Understanding the Impacts of Florida's Medicaid Pre-Paid Dental Pilot, Oral Health Issue Brief (Community Voices Miami, Miami, FL), Aug. 2006

Appendix B
Summary of State Approaches to Dental Medicaid Administration

	TN	SC	AZ	RI	MI	VA	IN	NJ	Dade County	Model Reform
Carve-out vs. Integration	Carve-out	Integration	Integration	Carve-Out	Still integrated but dental benefits are administered separately in the counties selected for the pilot program	Carve-out	Carve-Out	Integration	Carve-Out	Carve-Out
Managed Care vs. Self-Administration	Managed Care	Self-Administration	Managed Care	Managed Care	Managed Care	Managed Care	Self-Administered (other Medicaid benefits are administered through managed care)	Managed Care	Managed Care	Managed Care
Single Vendor vs. Multiple Vendors	Single DBM	-	18 MCOs	Single Vendor	Single DBM for counties participating in pilot	Single DBM	-		Single Vendor	Single Vendor
Degree of Risk on Vendor	ASO Contract	-	Full Risk on Vendors	Risk-Sharing & Gain-Sharing Provisions	ASO contract	ASO Contract	-	Full Risk on Vendors	Full Risk on Vendor	State retains some degree of risk
Provider Reimbursement Structure - FFS vs. Capitation	FFS	FFS	FFS (capitation explicitly prohibited)	FFS	FFS	FFS	FFS (changed from capitation)	Both FFS & Capitation	Capitation	FFS

Appendix C
2009 Utilization Rates and 2010 Payment Rates by State

State	Utilization Rate (2009)	Payment Rate (2010)
AK	42	91.4
DC	44.6	84.1
DE	41.1	80
CT	42.5	78.5
MD	41.8	70.7
AZ	47.2	68.9
MA	52.3	68.6
LA	41.8	67.9
TN	46.4	67.3
ND	36.9	66.2
WY	43.5	65.3
OK	46	64.4
AR	57.1	63.9
TX	59.8	63.8
WV	48.5	62.5
SD	46	62.4
MS	45.5	61.9
NH	54.2	61.8
NATIONAL	**43.8**	**60.5**
VA	45.7	59.4
IN	47.4	58
NY	38.4	57.3
SC	51.9	57.1
MT	29.9	55.6
NC	51.1	55.5
KS	45.4	55
NV	41.9	54.7
VT	57.3	54.5
AL	49.9	53.6
NM	49.8	53.5
KY	40.8	51.9
GA	42.5	51.9
CO	46.6	51.1
NE	52.5	49.4
PA	37.3	48.8
IL	46.5	48.4
IA	53.8	46.8
MO	30.3	46.7
WA	52.4	46.5
ME	40.3	46.5
MI	36.8	45.9
OH	42.7	43.9
OR	38.8	43.3
ID	67.7	43
NJ	40.9	42.8
MN	42.1	40.1
HW	45.8	37.7
WI	30.1	36.4
RI	46.7	35.4
UT	42.6	33.2
CA	38.9	32.8
FL	25.7	27.5

Note: Green shading indicates that state demonstrated above average rates of utilization.

Sources
The State of Children’s Dental Health: Making Coverage Matter (The Pew Center on the States, Washington, D.C.), May 2011.

Appendix D
2007 Utilization Rates and Payment Rates by State

State	Median Retail Fee	Medicaid Reimbursement Rates	Percent of Median Retail Fee Reimbursed by Medicaid	Utilization Rates
MS	33	N/A	N/A	38.1
DE	35	N/A	N/A	35.5
KY	33	N/A	N/A	24.5
NJ	35	37	105.71	33.9
DC	35	35	100.00	35.5
SD	35	34	97.14	37
NV	35	33.24	94.97	27.5
CT	37	35	94.59	41.4
TX	32	29.44	92.00	53.7
WY	35	32	91.43	37.3
AZ	35	29.5	84.29	40.1
AR	32	26.6	83.13	29.5
MD	35	29.08	83.09	36.1
NY	35	29	82.86	33.7
AK	46	38	82.61	41.9
NH	37	29	78.38	47
IL	36	28	77.78	40.1
LA	32	24.8	77.50	32.4
NC	35	27.01	77.17	45.7
TN	33	25	75.76	40.2
OK	32	23.5	73.44	42.7
MA	37	27	72.97	44.6
ND	35	24.1	68.86	28.1
MO	35	24	68.57	27.9
SC	35	23.4	66.86	46.9
National	N/A	N/A	**65.99**	**38.1**
NM	35	22.97	65.63	47.6
GA	35	22.77	65.06	23.8
HW	46	29.12	63.30	39.9
IN	36	22.58	62.72	43
MT	35	21.89	62.54	29.2
KS	35	21	60.00	41.2
CO	35	20.8	59.43	40.2
VA	35	20.15	57.57	40.8
WV	35	20	57.14	45.6
PA	35	20	57.14	32.2
AL	33	18	54.55	51.9
VT	37	20	54.05	57.1
MN	35	18.7	53.43	37.7
OR	46	24.07	52.33	34.9
ID	35	17.76	50.74	42.8
UT	35	17.55	50.14	39.5
WA	46	22.44	48.78	47.6
IA	35	16.63	47.51	46.9
OH	36	17.08	47.44	39.9
NE	35	16	45.71	49.9
WI	36	15.92	44.22	25.7
FL	35	15	42.86	23.5
MI	36	14.89	41.36	34.5
ME	37	13	35.14	37.1
CA	46	15	32.61	31.3
RI	37	10	27.03	43.8

Note: Green shading indicates that state
demonstrated above average rates of utilization.

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Cynthia Stark, *Oral Health Checkup: Progress in Tough Fiscal Times?*, National Health Policy Forum, Issue Brief No. 836 (March 29, 2010) (*available at* http://www.nhpf.org/library/issue-briefs/IB836_OralHealthCheckup_03-29-2010.pdf).
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Appendix E
State Approaches to Dental Medicaid Administration

State	Carve-out or Integration?	Administration	Payment Type
AL	Integrated	Single Nonrisk Contractor	FFS
AK	Integrated	Single Nonrisk Contractor	FFS
AZ	Integrated	MCOs	FFS
AR	Integrated	Single Nonrisk Contractor	FFS
CA	EPSDT services (including oral health assessments) administered by state agency / Dental provider diagnostic, preventative and treatment services are managed by Denti-Cal (through Delta Dental)	EPSDT services administered by state / Other preventative and restorative services - 95% FFS administator / 5% MCOs	Mostly FFS/Some Capitation in Populated Counties (dentists are employees in one plan)
CO	Integrated (but dentists directly enroll with state ffs program while physicians participate in managed care plans, primary care physician plans, or ffs plan)	State Agency	FFS
CT	Carve-out (Other benefits administered through managed care)	Single Nonrisk Contractor	FFS
DE	Carve-out (Other benefits administered through managed care)	State Agency (directly enroll with state under ffs program or in 8 state-operated clinics)	FFS (before 1997, dentists were hired as employees of clinics)
DC	Integrated (but MCOs subcontract with dental care organizations (DCOS) to managed program that pays on ffs basis)	MCOs	FFS
FL	Integrated	Both State Administered Plans & Managed Care Plans	FFS in State Administered Plans (except in a few counties) / Capitation in Managed Care Plans
GA	Integrated (but MCOs subcontract with dental care organizations (DCOS) to managed program that pays on ffs basis)	MCOs	FFS
HW	Carve-out (Other benefits administered through managed care)	Single Nonrisk Contractor	FFS
ID	Carve-out (Other benefits administered through primary care case management system)	Single Nonrisk Contractor	FFS
IL	Carve-out (Other benefits administered through primary care case management system)	Single Nonrisk Contractor	FFS
IN	Carve-out (Other benefits administered through managed care)	Multiple Nonrisk Contractors	FFS
IA	Carve-out (Other benefits administered through managed care)	Multiple Nonrisk Contractors	FFS
KS	Carve-out (Other benefits administered through both a ffs system and managed care)	Single Nonrisk Contractor	FFS

Appendix E
State Approaches to Dental Medicaid Administration

KY	Integrated (managed care plans subcontract with DCO and primary care case management manages through nonrisk fiscal agents)	Managed Care (25%) / Nonrisk Agents (75%)	FFS
LA	Integrated	State Agency	FFS
ME	Integrated	State Agency	FFS
MD	Integrated (but MCOs subcontract with dental care organizations (DCOS)) but state began initiative to start carve-out in 2008	Managed Care Plans (95%) / State-administered (5% but state seeks to develop)	FFS (All plans have to reimburse ffs if the benefit is covered by the ffs program, but MCOs are free to negotiate with providers if benefit is not covered by ffs program)
MA	Carve-out (Other benefits administered through mostly managed care)	Single Nonrisk Contractor (with Subcontractor)	FFS
MI	Carve-out (other benefits administered through MCOs or Medicaid Health Plans)	State Agency (68%) / Nonrisk Contractor (32%)	FFS
MN	Integrated (started a pilot program to experiment with a non-managed care carve-out but program is being phased out)	MCOs (and subcontractors) (83%) - except where pilot still operates (17%)	Both FFS & Capitation
MS	Integrated	Single Nonrisk Contractor	FFS
MO	Integrated	Single Managed Care Plan administered by 2 DCOs (63%) - except in counties without managed care (state administers ffs program w/ fiscal agent) (37%)	Capitated (63%) / FFS (37%)
MT	Integrated	Single Nonrisk Contractor	FFS
NE	Integrated	State administered managed care program	FFS
NV	Integrated (but ffs program is carved out of managed care in rural areas)	Nonrisk Contractor Administered in Rural Counties (32%) / 2 MCOs (68%)	FFS
NH	Integrated	Single Nonrisk Contractor	FFS
NJ	Integrated	Managed Care (91%) / State-administered (w/ fiscal agent) (9% - including special needs children)	Mostly FFS / Some Capitation
NM	Integrated	MCOs (w/ subcontractors) (80%) / State-administered (w/ fiscal agent) (20% - including Native American children) but shifting to managed care	FFS
NY	Integrated	28 MCOs (80%) / State-administered (w/ fiscal agent) (20%)	Both FFS & Capitation (and combination thereof)

Appendix E
State Approaches to Dental Medicaid Administration

NC	Carve-out (Medical benefits administered through 2 primary care care management programs but dental services are exempted)	Single Nonrisk Contractor	FFS
ND	Carve-out (medical benefits administered through primary care case management program but dental services are excluded)	State Agency	FFS
OH	Integrated	Managed Care (83%) / State-administered (17%)	FFS
OK	Integrated	State Agency (w/ fiscal agent)	FFS (before - 2004 - allowed capitation for nonrural areas)
OR	Integrated	MCOs (w/ subcontractors) (96%) / State-administered (4% - mostly Native American children)	Capitated (96%) / FFS (4%)
PA	Integrated	Nonrisk Contractor (27%) / Managed Care (73%)	FFS
RI	Carve-out (medical benefits administered through multiple managed care plans but transitioning from state-administered ffs program to single MCO w/ risk-sharing	Single MCO (31%) / State-administered (69%)	FFS
SC	Integrated	State Agency	FFS
SD	Carve-out (Medical benefits administered through primary care care management program)	Single Nonrisk Contractor (2007 - renegotiated contract to exclude risk)	FFS
TN	Carve-out (medical benefits administered through several managed care plans)	Single Nonrisk Contractor	FFS
TX	Carve-out (Medical benefits administered through primary care care management program or managed care plans)	Single Nonrisk Contractor	FFS
UT	Carve-out (rural counties - other benefits administered through primary care case management program, managed care or traditional ffs; urban counties - managed care)	State-administered	FSS
VT	Carve-out (Medical benefits administered through primary care care management program)	Two Nonrisk Contractors working together	FFS
VA	Carve-out (Medical benefits administered through primary care care management program, managed care, and some through traditional ffs)	Single Nonrisk Contractor	FFS
WA	Carve-out (medical benefits administered through several managed care plans)	State-administered	FFS

WV	Carve-out (Medical benefits administered through primary care care management program and managed care)	Single Nonrisk Contractor	FFS
WI	Partial carve-out (most receive medical benefits through managed care)	Single Nonrisk Contractor (60%) / MCOs (subcontracting w/ DCOs) (40% - urban counties)	FFS (Nonrisk Contractor) / Both FFS & Capitated (MCOs)
WY	Carve-out	Single Nonrisk Contractor	FFS

Source
Medicaid Compendium Update (American Dental Assn., Chicago, IL), 2008.

Are dental benefits administered separately?	
Integrated	25
Carve-out	22
Both	4
How many used contractors?	
State-administered	9
Commercial Vendor	32
Both	10
Of those using contractors, how many states transferred risk to vendors?	
Vendors assume some risk	11
Vendors assume no risk	24
Some vendors assume risk, but others do not	7
Of those using contractors, how many contactors are used?	
Used multiple vendors	21
Used only one vendor	21
Provider Reimbursement Type	
FSS	42
Just Capitation	0
Both	9