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STATE OF MINNESOTA

Evaluation Report Summary / March 2013

Medical Assistance Payment Rates for Dental Services

Minnesota's payment policies and methods to reimburse dental providers are poorly coordinated and inconsistently applied across Medical Assistance programs.

Key Facts and Findings:

- Minnesota provides more dental benefits in its state Medicaid program (called Medical Assistance, or MA) than required by federal law. Still, dental services represent just 3 percent of MA program expenditures.
- Minnesota uses a myriad of policies and methods to reimburse MA dental providers. These payment methods and policies are poorly coordinated and inconsistently applied across MA programs.
- Minnesota's MA fee-for-service rates for paying dentists were lower in 2012 than in 2000, and lower than rates of most other states. In addition, the rates are based on an adjustment to 1989 dentist charges and not the costs of current dental services.
- Managed care organizations that contract with the state for MA often reimburse their dental providers more than the fee-for-service base rates, although the differences are sometimes small.
- Although the share of Minnesota dentists participating in MA has been steady in recent years, many dentists report that they have limited or ceased treating MA enrollees due primarily to low state payments.
- Some low-income individuals—particularly those with special needs or located in sparsely populated areas—face challenges accessing MA dental providers.

Key Recommendations:

- The Department of Human Services (DHS) should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits.
- DHS should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.
- The Legislature and DHS should better coordinate payment policies and rate-setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental services.
- The Legislature and DHS should implement a separate benefit and payment structure for Minnesota's Medical Assistance population with special needs.
- DHS should more closely monitor Medical Assistance recipients' access to dental services.

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Minnesota's fee-for-service dental payment rates rank relatively low among states.

Report Summary

Minnesota's Medicaid program—called Medical Assistance (MA)—is Minnesota's largest publicly funded health care program. It provided medical and dental services to 910,000 individuals in 2011. Federal Medicaid law requires dental services for children, but states can provide additional benefits. Minnesota requires that some limited dental services be made available to adults.

The state's 2011 expansion of MA eligibility to additional low-income individuals affected program costs. Spending for dental services totaled about $131 million in 2011—a 9-percent annual increase since 2006. However, when considering changes in enrollment, average spending grew just 2 percent annually.

Like other MA health care services, MA dental services are provided through both fee-for-service and managed care programs. DHS administers dental services through fee-for-service, primarily for individuals who are disabled or have special needs. In 2012, DHS also contracted with eight managed care organizations (MCOs) to provide MA health care and dental services through several managed care programs.

Minnesota's fee-for-service dental rates are not based on the current costs and resources needed to provide dental care.

Federal law requires that MA payment rates be consistent with efficiency, economy, and quality of care. The rates also must be sufficient to enlist enough providers so that care and services are available to the extent that care and services are available to the general population. The federal Centers for Medicare & Medicaid Services allows states some flexibility to determine how much to pay MA dentists. Minnesota's Legislature authorizes the method for setting MA fee-for-service base rates for dental services.

Minnesota's fee-for-service base rates for most dental procedures are based on how much dentists charged in 1989. (The most recent across-the-board rate increase was a 3-percent increase in 2000; however, the 2011 Legislature imposed a 22-month, 3-percent reduction in the rates.) In contrast, Minnesota uses Medicare cost-based reimbursement principals to determine and update payment rates for physicians and some other health care providers. Unlike dental fee-for-service rates, the Medicare-based rates are more closely related to the actual costs of providing care.

According to national research, Minnesota's fee-for-service rates have ranked in the lower one-third of all states, and Minnesota's rates today are lower than they were a decade ago. Minnesota's 2012 rates were mostly lower than those of neighboring states. For example, North Dakota paid an average of 185 percent of Minnesota's rates for select procedures, while Wisconsin paid an average of 104 percent.

Minnesota supplements its fee-for-service rates with other payments, but payment policies and eligibility criteria vary.

In lieu of increasing its fee-for-service base rates, Minnesota uses several types of targeted payments and other approaches to determining payment amounts. These payment policies and the related payment rates were each independently developed through state or federal law, DHS policy, or negotiation between the managed care organizations and their dentists. That is, the state's payment policies for dental services were not developed through a systematic, coordinated

Minnesota's Medical Assistance payment policies were not systematically developed to ensure that MA patients across the state have access to a dentist.

assessment of rates to achieve a goal of dentist participation and patient access statewide.

For example, the Legislature made one type of supplemental payment—"critical access" payments—available to dental providers in 2002. We estimated that about 17 percent of dentists worked for clinics that were eligible to receive critical access payments in 2011. DHS also pays all fee-for-service dentists an additional 2 percent of the fee-for-service rate (as reimbursement for Minnesota's provider tax) and pays community clinics an additional 20 percent, but MCOs are not required to make similar payments. It is difficult to determine whether any of the state's supplemental payments supplant rates otherwise negotiated between dentists and MCOs.

On average, dental payments by MCOs exceeded Minnesota's fee-for-service rates, although the differences were sometimes small.

MCOs—and not DHS—determine how much they pay their dental providers. The MCOs often have used the fee-for-service rates as the starting point for setting rates, but MCOs often pay dentists in their network more. For example, the median MCO payment per dental procedure for the Prepaid Medical Assistance Program was 121 percent of the fee-for-service rates. On average, MCOs paid dentists more for the services they provided to MA enrollees with special needs. They also paid higher rates to specialists.

Historically, DHS has added "dental trend" increases into the payments made to MCOs to cover forecasted increases in the price of dental services. However, many dentists were sometimes reimbursed by MCOs at payment rates that were at or near the fee-for-service base rates, and the fee-for-service rates have not increased since 2000.

The share of dentists participating in MA has not changed much since 2006, due partly to newly licensed dentists enrolling in MA.

In Minnesota, dental providers have the option to participate in Medical Assistance and treat MA enrollees. State law requires that dentists who treat public employees must provide dental care to individuals who are enrolled in MA (or other public health care programs).

Between 2006 and 2011, about 65 percent of dentists licensed in Minnesota served at least one MA enrollee. However, dentists' MA patient caseloads greatly varied and the proportion of dentists with large caseloads increased during this time period. On the other hand, 24 percent of dentists responding to our survey said they stopped serving MA patients after 2010.

Among all MA recipients, individuals with special needs and those in sparsely populated areas have had particular difficulties finding dental providers. According to dentists and other stakeholders, the scope of benefits and payment rates are inadequate relative to the amount of time and resources necessary to appropriately care for individuals with special needs.

Most dentists who limit or cease serving MA recipients do so because of insufficient payments.

Low payment rates were most often cited as the reason dentists have stopped treating MA patients, but there were other reasons, too. Recently imposed limits on MA dental benefits for non-pregnant adults mean there are fewer services for which dentists may be reimbursed. Dentists report that the payment is often insufficient relative to the amount of administrative work required to participate in MA. Administrative costs could be reduced

Total payment rates for MA dental services varied considerably among dental providers.

if DHS would improve its automated information system (MN-ITS) to better facilitate provider inquiries about patients' treatment histories and eligibility for care. Without upgrades to MN-ITS, restrictions on benefits are likely to be poorly implemented.

DHS also should better communicate to dental providers the service authorization criteria and rationale for benefit changes and exclusion of dental coverage. The Dental Services Advisory Committee was established as a venue to address these and other issues; we think the department should make better use of this venue.

The Legislature and DHS should better coordinate payment policies and rate setting for Medical Assistance dental services.

Minnesota's array of payment policies and rate-setting practices for MA dental services has likely had opposing and negative outcomes for the state and its MA recipients. The state's approach of targeting higher payments to certain dental providers has likely improved access for many MA recipients in some parts of the state. However, not all dental providers are eligible for higher payments, the cumulative payment rates vary, and many dentists are often reimbursed at the relatively low fee-for-service rates.

For more transparency and equity in payments, the Legislature should increase the fee-for-service base rates. Any increases should relate to the costs for providing services and should occur in a measured and incremental way, one that monitors the impact of rate increases on both dentist participation and MA recipient access. DHS also should coordinate these increases with other rate setting and payment policies—such as those applied through managed care—to ensure that the fee-for-service rate increases supplement and do not supplant other payments.

To address concerns about the impact of recent benefit restrictions on individuals with special needs (and long-term costs to the state), DHS should develop separate benefit coverage and payment rates for serving this population. Many of these individuals have limited ability to care for themselves and they often need more expensive, specialized dental care. Higher payments for treating these individuals should help facilitate their access to dental care.

Summary of Agency Response

In a letter dated March 4, 2013, Minnesota Department of Human Services Assistant Commissioner Scott Leitz said the department supports the report's key recommendations and understands that "the rate structure for dental services has changed frequently and that clarity in these structures will be important as we manage dental services for our participants." He said the department has begun to address the issues identified in the report, and the department has included a rate increase proposed in the Governor's biennial budget. He also said the department has created a new "chief rates officer" position to address rates for dental and other health care services, and to consider the relationship of rates to adequate access in both the fee-for-service and managed care program. The assistant commissioner noted that other factors also may impact access, and the department supports the need to monitor the impact of all efforts on access to services.

The full evaluation report, *Medical Assistance Payment Rates for Dental Services*, is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/ped/2013/madentalrates.htm**