Strategies to Enhance Dentists' Participation in Medicaid

A Review of Current Practices

SPRING 2017

INTRODUCTION

In 2016, Missouri Foundation for Health – Oral Health initiative commissioned an analysis of the national oral health landscape to investigate which policy levers (e.g., Medicaid reimbursement rate increases, changes to the Medicaid administrative requirements, and/or other strategies) have had an impact on increasing the number of private dentists who participate in Medicaid and provide oral health services to previously underserved dental patients. The investigation undertaken was designed to assess what specific approaches increase the rate of participation of dentists in Medicaid and what impact an enhanced participation rate has on both increasing the number of Medicaid enrollees receiving care and the number of services received by individual enrollees.

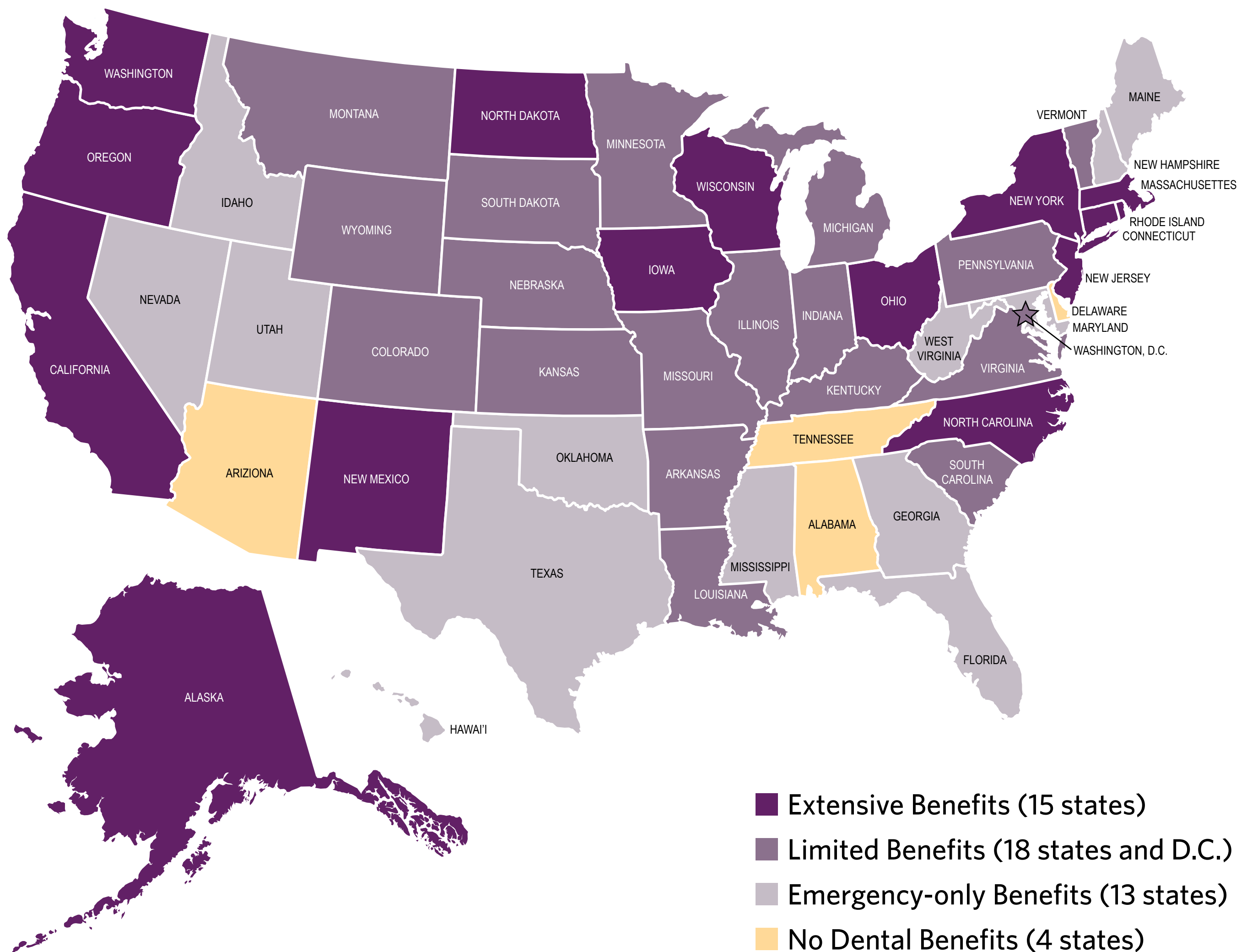
The analysis that was conducted included a review of the current literature, including the body of research briefs published by the Health Policy Institute of the American Dental Association, in addition to a survey of and/or interviews with state Medicaid dental program officers. While there have been studies (published and unpublished) produced in the last several years that address the policy levers that may impact dentists' participation in Medicaid, many of these have relied on data from 2013 or earlier. For that reason, a brief survey of state Medicaid dental programs was undertaken to elicit any additional data relevant to the questions posed by the Foundation. While surveys were sent to all 50 states and the District of Columbia, only 16 responses were received.[1] Of those 16, 12 states reported Medicaid reimbursement increases;[2] 7 of the 12 respondents also reported changes to the administrative requirements and/or education and outreach efforts of the Medicaid program;[3] of the six states that reported no changes to reimbursement, one reported changes to Medicaid administrative requirements.[4]

BACKGROUND

In 2012, it was reported that expenditures for Medicaid dental services grew dramatically from 1990 to 2010—$765.1 million to 7.4 billion.[5] But the downturn in the U.S. economy at the end of the last decade put pressure on states to cut costs, resulting in reduced dental fee reimbursement, a shift of beneficiaries to managed care plans, and reduction or elimination of dental benefits for adults in many states. While there are mandatory comprehensive benefits for children in Medicaid that include oral health screening, diagnosis, and treatment services; Medicaid dental coverage by states is optional for adults. According to Hinton and Paradise, as of February 2016, only 15 states provided extensive dental benefits through their Medicaid programs, 18 states and the District of Columbia provided limited benefits, 13 provided emergency only, and four provided no benefits (see Figure 1).[6]

Figure 1

Medicaid Coverage of Adult Dental Benefits, February 2016



Source: Medicaid Adult Dental Benefits: An Overview, Center for Health Care Strategies, Inc., February 2016, http://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/

The landscape of utilization of dental services has changed significantly between 2005 and 2013. Utilization is affected by many factors including the age, insurance status, and income of the population, as well as the number, distribution, and insurance participation status of dental professionals. Over the past several years, patterns of utilization among children and working age adults have shifted, seemingly affected by changes in access to dental benefits, both public and private. According to the American Dental Association's Health Policy Institute, in 2012 dental care utilization among children was at its highest point since the Medical Expenditure Panel Survey (MEPS) began including dental services (in 1996), but at its lowest level among working age adults.[7] The differences in utilization between low-income and high-income children narrowed, which was likely caused by increases in utilization among Medicaid enrolled children.[8] The gains in utilization among children declined slightly from 2013 to 2014, but this shift was not considered statistically significant.[9]

This contrasts to the working-age adult population, where in the same period, utilization showed small declines among both privately insured and uninsured, but the gap in utilization between low and high income adults widened more significantly. While the latter may be due in part to the decline in private dental benefits for working adults in certain sectors of the economy, by 2014, the percentage of working adults with public

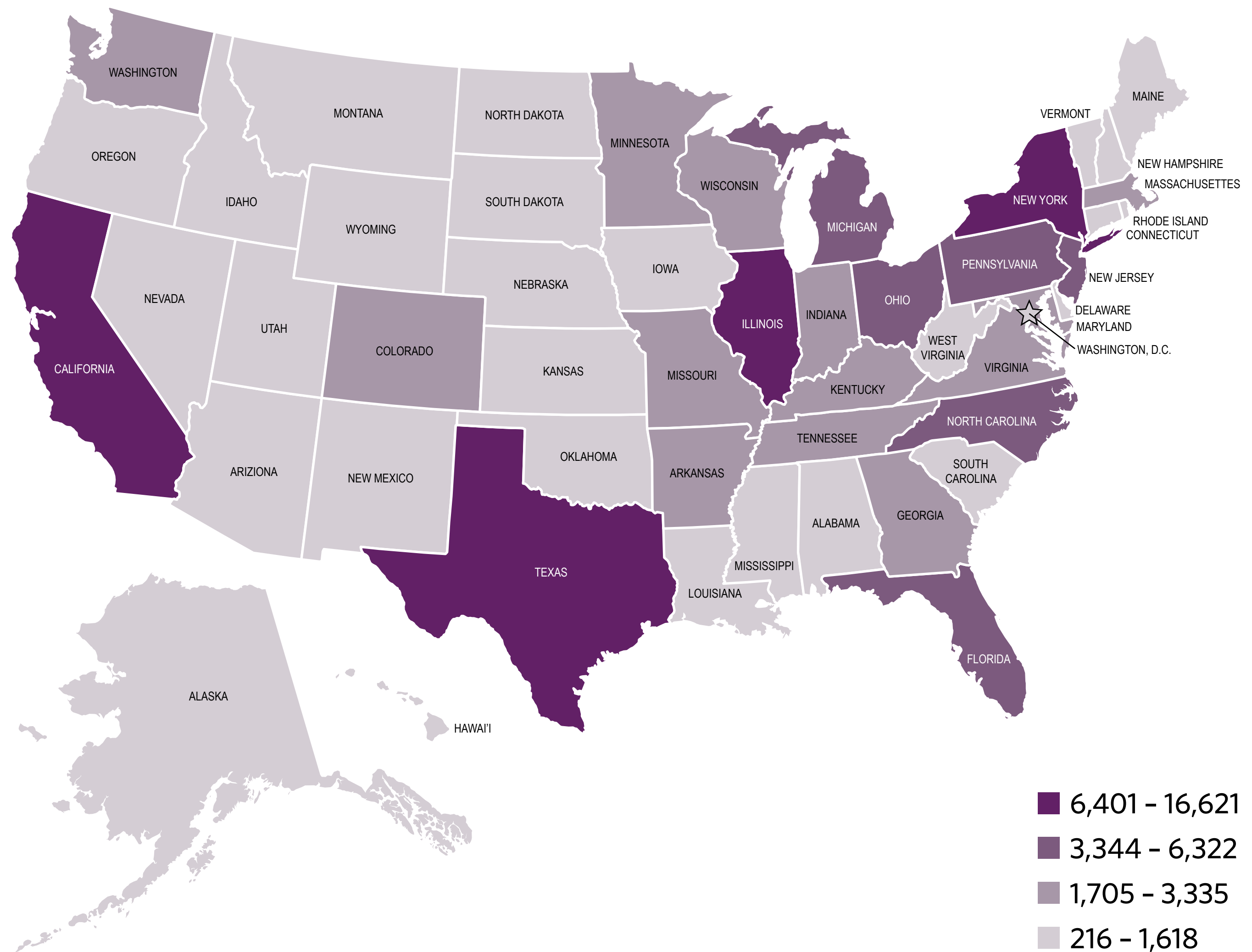
dental coverage increased by 2 percent, due to Medicaid Expansion under the ACA. In 2015, approximately 5.4 million adults gained dental benefits through Medicaid.[10] Tracking this change in access to dental coverage will be important to understand how it actually affects utilization in this segment of the population. Among the elderly, utilization rose 5 percent from 2000 to 2013, but there has been a small downward trend in dental utilization among low-income elderly since 2010.[11]

As noted previously, the supply of dentists providing oral health services also plays an important role in utilization of those services. Concerns about a looming shortage of dentists has been driven by a number of factors including predictions of impending retirement rates for dentists across the country and an overall reduction in hours worked by dentists. The Health Resources and Services Administration (HRSA) estimated that there is presently a shortage of 7,300 dentists across the country,[12] while Munson and Vujicic at the ADA Health Policy Institute are projecting a per capita increase in the supply of dentists through 2035.[13] But whether there is or will be a shortage of dentists regionally or across the country, where dentists actually practice and what types of reimbursement arrangements they accept have a potentially greater impact on access to care for specific populations than the raw number of dentists regionally or nationally (see Figure 2).

In 2000, the Government Accounting Office (GAO) conducted a survey of Medicaid and CHIP programs across the country to shed light on access problems, analyzing data on dentists' participation rates in those programs, the use of dental services by program beneficiaries, and Medicaid reimbursement rates. They reported that the major factor that contributes to the

Figure 2

Distribution of Professionally Active Dentists[14]



low use of services among low-income individuals is the individuals' inability of locating a dentist to treat them. Whether there is an actual supply issue or not, participation in Medicaid and CHIP was a significant factor in limiting access. Dentists reported that dissatisfaction with reimbursement, cumbersome administrative requirements, and patient behaviors as the reasons they did not accept, participate, or only participate on a limited basis with Medicaid and/or CHIP. The GAO report also noted that while many states had initiated strategies to address the dentists' concerns, utilization of services by program enrollees remained low. And while many states had raised Medicaid reimbursement rates, only a marginal increase in utilization resulted (see Figure 3).[15]

Further discussion regarding the impact of the supply of dentists on access to care for low-income populations can be found in a 2013 issue brief published by the Pew Charitable Trusts where it was reported that an uneven geographic distribution of dentists results in constrained access to care in many communities, regardless of income or insurance status.[17] This brief goes on to suggest that many low-income individuals do not receive oral health care because of the relatively low number of dentists who participate in Medicaid. Additionally, further assessment of the issue was published by Wall, Nasseh, and Vujicic in a 2013 analysis of data collected by the National Health and Nutrition Examination Survey (NHANES), where it was reported that financial barriers, rather than supply related barriers, were cited most frequently among a list of barriers to obtaining dental care by low-income working age adults.[18]

How coverage through the ACA and Medicaid expansion will affect these data will be important to continue to monitor over time. While the ACA does not require states to offer dental benefits to adults under Medicaid, it does offer states that have chosen to expand Medicaid a potential financial incentive to add dental benefits. That said, Medicaid is a principal mechanism for creating access to dental care for an increasing number of low-income individuals, boosting the number of dentists who accept Medicaid and provide routine care to Medicaid recipients is a critical challenge across the country.

THE POLICY LEVERS

To encourage an increase in dentists' participation in Medicaid, there has been strong advocacy for raising Medicaid fee for service (FFS) reimbursement rates, from dentists as well as advocacy groups. The approach to raising Medicaid dental rates has taken many forms—from across the board increases, to raising reimbursement for a limited set of dental codes, to changing the mix of services that are reimbursable—and there is a different impact associated with each of these strategies. An overall increase in dental fees would seem to have the greatest impact, as it allows dentists to provide comprehensive care, as opposed to an increase associated with only preventive and/or diagnostic codes.

According to Nasseh, Vujicic, and Yarbrough, in a research brief published by the ADA in 2014, Medicaid

Figure 3

State Reported Data on Dentists' Participation in Medicaid and CHIP[16]

	State officials' responses to 2009 Association of State and Territorial Dental Director (ASTDD) survey	
Level of Dentist Participation in Medicaid or CHIP	**Medicaid or CHIP expansion***	**CHIP only**
States reporting more than half of dentists in the state treat any patients	14 of 39 states (36%)	4 of 11 states (36%)
States reporting more than half of the dentists in the state treat 100 or more patients	1 of 41 states (2%)	0 of 12 states (0%)

Source: GAO analysis of ASTDD survey data

rates vary greatly across the country. Benchmarking against commercial dental insurance reimbursement, the authors report that for adult dental services those numbers ranged from a low in Illinois of 13.8 percent to a high in Arkansas of 60.5 percent. The brief goes on to state that,

"In 2013, the average Medicaid fee-for-service reimbursement rate was 48.8 percent of commercial dental insurance charges for pediatric dental care services.

In 2014, the average Medicaid fee-for-service reimbursement rate was 40.7 percent of commercial dental insurance charges for adult dental care services in states that provide at least limited adult dental benefits in their Medicaid program.

From 2003 to 2013, for pediatric dental care services, Medicaid fee-for-service reimbursement relative to commercial dental insurance charges fell in 39 states and rose in seven states and the District of Columbia."[19]

The following figures show the Medicaid fee-for-service reimbursement as a percentage of commercial dental insurance charges for children (Figure 4) and adults (Figure 5) for each state.

The utility of these data has limitations, as they are only representative of Medicaid fee-for-service reimbursement and do not address the significant number of Medicaid beneficiaries who receive care through a managed care arrangement, as there is a dearth of information on managed care reimbursement

Figure 4

Pediatric Dental Medicaid Fee for Service Reimbursement as a Percentage of Commercial Dental Insurance Charges in 2013[20]

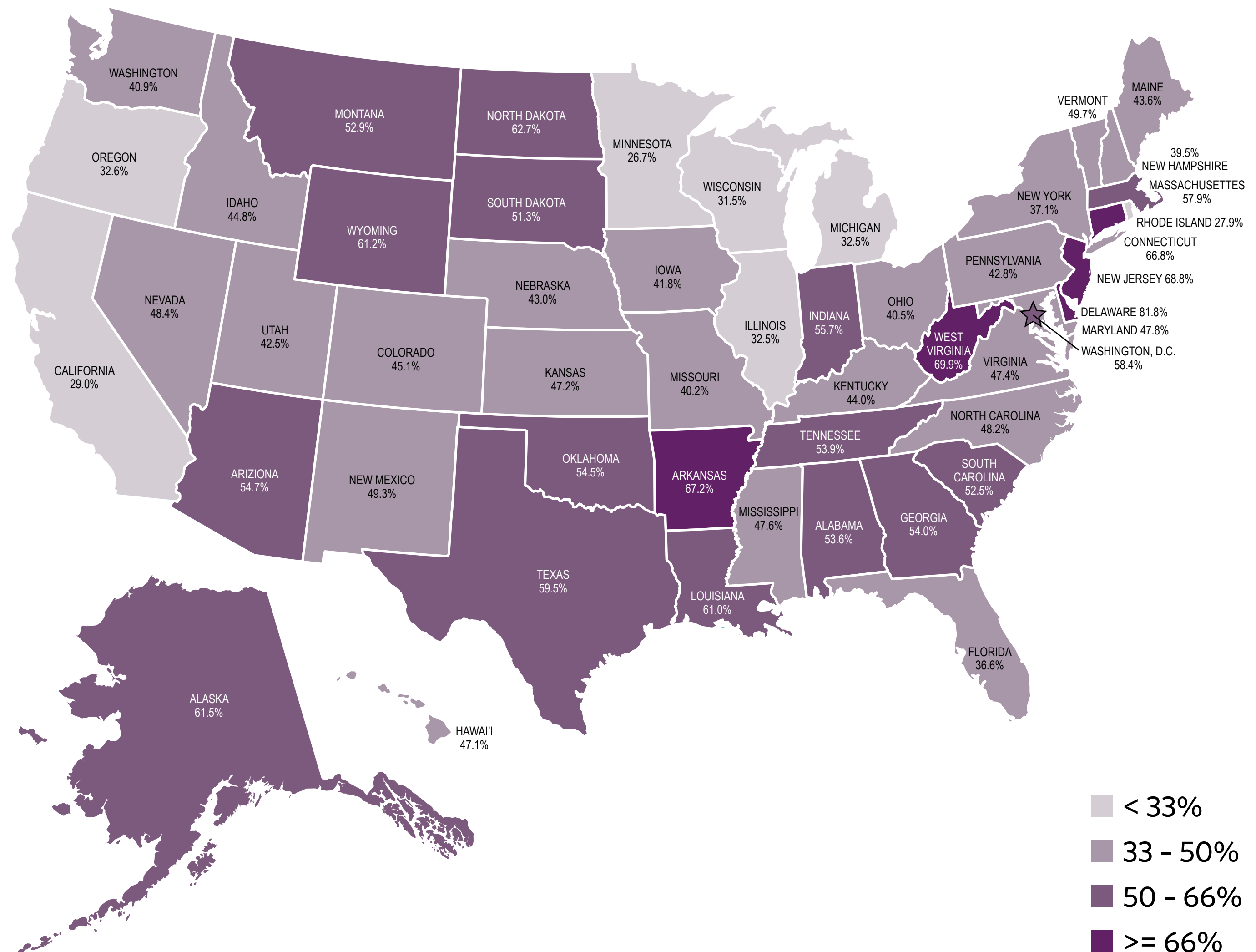
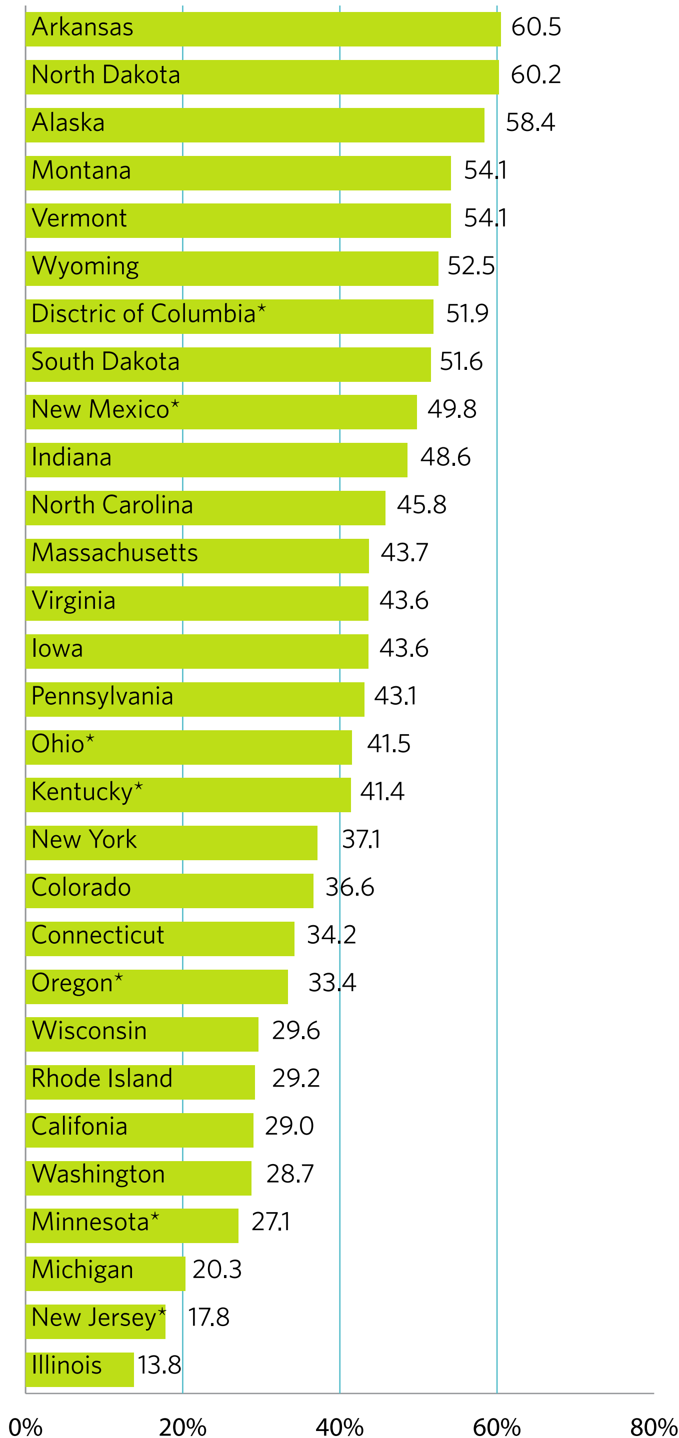


Figure5

Medicaid Fee for Service Reimbursement as a Percentage of Commercial Dental Insurance for Adult Dental Services[21]



*These states enroll the majority of their adult Medicaid beneficiaries in managed care programs for dental services; for these states, the data in this figure may not be representative of typical dentist reimbursement in Medicaid.

rates. Anecdotal information obtained through surveys of state Medicaid dental programs indicate that in many instances, managed care plans administered by dental benefits administrators often seek to mirror commercial reimbursement rates, but these data cannot be extrapolated as representative of managed care plans overall. The Medicaid Medicare Chip Services Dental Association (MSDA) has recently posted results of their 2015 survey of states' Dental Provider Payment Methodology, which is summarized in Figure 6.

Figure 6

Variability in Medicaid Dental Provider Reimbursement National - 2015[22]

	Number of States		
	Fee for Service	**Capitation**	**Other**
Direct	23	-	-
Fiscal Agent	21	-	-
DBA	12	1	-
D-MCO	8	5	2
D-MCO	8	9	1
ACO	-	-	-
CCO	1	-	1
Other	2	-	-

Additionally, there is little current information regarding enrollment in managed dental care plans. While in 2010, 62 percent of Medicaid children were enrolled in a managed care plan that included both medical and dental benefits,[23] it is uncertain as to how many of these children actually receive their dental benefits through one of these managed care plans.

An analysis of the policy levers that may improve Medicaid participation rates among private dentists makes it clear that the establishment of competitive reimbursement rates is one of the elements that must be considered. Edelstein, El-Youssef, and Ma note in a paper presented at an American Association for Dental Research conference that "payment levels above 60 percent [of dentists' commercial fees] are significantly associated with increased utilization compared to

payment levels below 40 percent." And they conclude that, "Dental utilization by child Medicaid beneficiaries is positively associated with payment rates to dentists when payment rates exceed 60 percent of dentists' commercial charges. Medicaid fee increases hold potential to increase utilization by low-income children and reduce dental access disparities."[24] There is a caveat, however, regarding how far beyond 60 percent of charges to increase reimbursement as Edelstein noted in personal correspondence, "As you increase payment beyond 60 percent of Usual and Customary Rates (UCR), incremental increases in utilization are modest while incremental costs are significant."[25] Edelstein also states that adequate provider payment is a necessary, but insufficient, condition for improving access for Medicaid recipients.[26]

Wall cites a 2000 GAO survey of state Medicaid Directors regarding the factors that contribute to low use of dental services in Figure 7.[27]

Figure 7

Barriers that Hinder State Initiatives to Improve Access to Medicaid Dental Services

Barriers to State Initiatives	States Responding (51 States)
Lack of available funding	44
Lack of provider participation	40
Lack of beneficiary participation	38
Administrative burden on providers	31
Difficulty coordinating with other state agencies	13
Lack of CMS approval for state initiatives	5
Other barriers	6

Achieving the desired outcomes associated with raising reimbursement is much more complicated than it may appear. Gehshan writes in an unpublished memo to the Pew Charitable Trusts that the impact of raising rates may be less than anticipated, as many states raise rates on a smaller set of services or reduce the overall number of services covered. This may result in commonly used services being reimbursed at a higher rate, which may mean that preventive and diagnostic services are enhanced, while more "technically demanding services, and those that might require more complex behavior management of patients, are reimbursed at lower levels."[28]

Indeed, states across the country have initiated a variety of strategies to induce dentists to participate in Medicaid programs and increase access to care for underserved populations. In Wyoming, the D0191 code can be billed [at a fee of $10] for nursing home clients, so that dentists have an incentive to go to nursing facilities to screen and potentially identify clients who need additional dental care.[29]

Figure 8

Number of States Changing Medicaid Dental Payment Rates, FY2011 and FY 2012[31]

	Fiscal Year 2011		Fiscal Year 2012	
	Increase	Decrease	Increase	Decrease
Dentists	4	11	3	13

While the correlation between fee increases and increased utilization is supported with evidence from states that have significantly raised Medicaid dental rates, sustaining those rates can prove to be challenging. Gehshan also notes that, "...rates are raised and then lowered often in response to budget pressures, or raised and then not adjusted for inflation for many years, giving rise to renewed calls for change."[30] As Wall reported in 2012, Medicaid dental rates change often in response to economic pressures on state governments. He states that in addition to moving Medicaid dental to managed care and eliminating benefits, many states have/are cutting reimbursement rates in an effort to state expenses. Figure 8 is a snapshot of how the landscape has shifted from year to year.

In response to the survey conducted for this report, the respondent from Alaska reflected on this issue:

"Alaska has typically been among the top 1 – 2 states for Medicaid reimbursement even during the 1999 – 2007 period where most dental reimbursement for procedures did not increase (the exception is those that have a

corresponding CPT code and are adjusted each year even if more typical dental codes aren't changing). In the 2008 and 2009 legislative sessions, we had funds authorized and/or appropriated to increase dental reimbursement and in those years got back to reimbursement at about 80 percent of the median dental fee.

You can see the increase in children utilizing any dental service and dental treatment periods going up more in the FFY2010 – FFY2011 periods and then it has flattened off again. The only other increase was with the FY2012 fee schedule with a 1.8 percent increase. Even without increases in state fiscal year 2013 – 2017 we have seen some increase in children utilizing dental services (both for any dental service and dental treatment services). Tribal programs and FQHCs had an easier time of recruiting dentists in the 2009 – 2012 period with the national recession and while Alaska was benefitting from high oil prices.

It will be interesting to see how things go with Alaska teetering on a significant recession with two years of low oil prices—it is possible dental participation in Medicaid will remain stable as those with private dental insurance might decrease and/or we see some loss in state population."[32]

In West Virginia, rate increases improved access to specialists, especially oral surgeons. According to the survey respondent, over 70 percent of the state's dentists are now Medicaid providers, but not all submit an abundance of claims or accept new patients.[33]

It is interesting to note however, that while reimbursement rate adjustments are a key lever to increase access to care for Medicaid beneficiaries, it is a lever that may achieve sustained success only if it is coupled with non-fee related strategies. In a study published in 2008, the National Academy for State Health Policy (NASHP) examined the effects of increasing reimbursement rates on access to care for Medicaid beneficiaries. While the study acknowledged the importance of rate increases, it concluded that among the six "front runner" states examined (i.e., Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington), that other policy levers were necessary to maximize the impact.

Key findings from that study included:

- Rate increases are necessary—but not sufficient on their own—to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.
- While dentists often seek reimbursement rates that mirror their usual charges, states have seen gains in dentists' participation and patient utilization with rate increases that do not meet that threshold. However, rates need to at least cover the cost of providing service, which is estimated to be 60 to 65 percent of dentists' charges.
- Working with patients and their families about how to use dental services is a core element of reforms. States have successfully used case management, educational brochures, and patient support provided by contractors to reduce barriers and address one of dentists' chief complaints.
- In the six states examined, provider participation increased by at least one-third, and sometimes more than doubled, following rate increases. Not only did the number of enrolled providers rise, but so did the number of patients treated. Patients' access to care, as measured by the number of enrollees using dental services, also increased after rates rose.
- Despite meaningful gains in provider participation and access achieved by these "frontrunner" states, the portion of children receiving services is still far below the experience of privately insured children. Data from 2004 show that 58 percent of privately insured children received dental services, while in these six states—after substantial effort and investment—32 to 43 percent of children covered under Medicaid received dental care. This points to the need to explore other solutions as well.[34]

Nasseh, Vujicic, and Yarbrough also conclude that, "Research has shown that a variety of reasons, including a high rate of cancelled appointments among Medicaid enrollees, low reimbursement rates, low compliance with recommended treatment, and cumbersome administrative procedures, limit the number of dentists that accept Medicaid."[35]

While this study was conducted in 2008, the findings were generally corroborated by the survey conducted to support this report. Twelve of the 16 respondents

reported increases to reimbursement over the last decade, with 10 of the 12 also introducing other strategies to improve provider participation, and one state, which did not increase reimbursement, did undertake administrative changes in the Medicaid program. By and large, these non-financial strategies can be categorized as administrative simplification, patient navigation, and education (of both providers and patients).

In the arena of administrative simplification, states have focused on creating program uniformity for both benefits and reimbursement rates. Others have sought to streamline the application and credentialing processes for dentists who seek to participate in the Medicaid and/or managed care programs, the systems for determining patient eligibility for services, and the process for submitting claims. Some states have also reduced requirements for prior authorization, eliminating the need for prior authorization for specific commonly approved procedures and by creating a uniform set of codes for prior authorization across all Medicaid/managed care products. Encouraging and supporting electronic claims submission has allowed states to process claims more efficiently and expedite payment turnaround times. In addition, the electronic systems have allowed states to improve their reporting processes.

But many states reported that it was not sufficient to focus on the administrative and financial pieces—increased reimbursement, faster claims turnaround, streamlined policies and procedures, etc. For them, it has become clear that both patients and providers need education and support to make the system function effectively and efficiently. The state of Connecticut coupled an innovative approach that engages both the provider community and other stakeholders in policy decisions regarding system changes with fee increases of up to 20+ percent, and conducts outreach to both providers and patients to improve performance and understanding. The respondent from Connecticut provided a summary of the comprehensive approach they have taken to addressing the need to increase provider participation in Medicaid, which addresses the interdependence of the factors discussed above:

"There are a multitude of events that lead to an increase in provider enrollment and the utilization of services by members. First, we had to work very hard to overcome decades of an adversarial relationship with the provider community, second we engaged all interested stakeholders including the advocacy community. We listened to their demands, suggestions, and ideas and where feasible, we incorporated all of their requests into the program—if we could not [meet their requests] then we clearly articulated why and communicated it back to them personally and then globally.

We have very extensive outreach activities specifically geared to both the providers and to members. We collect data on our methodologies to ensure these activities produce a return on investment (ROI). We also use the same methodology for organization outreach activities, community partner outreach activities, and member outreach activities. We use metrics to evaluate all of our outreach initiatives to ensure ROI.

We provide our members with a tri-lingual call center and provide provider location assistance, appointment scheduling and coordination assistance, language translation, and assistance with scheduling transportation. We get our members seen for emergency appointments within 24 hours, urgent appointments within 48 hours, and routine appointments within eight weeks. We perform Mystery Shopper surveys to ensure our providers meet our metrics. In addition, we survey all offices every three to four months to ensure their hours of operation are the same (or changed), they are still willing to accept new patients, and a host of other member-related interest questions. We allow our providers to dismiss members from care for a variety of reasons or to close their panels from accepting new members (either short term or long term).

We employ Dental Health Care Specialists (DHCS) which is Connecticut's 'brand' of community support workers (from the ADA). These DHCS conduct our community outreach activities in a specified geographical area. They work with clients who have difficulty navigating the system in these areas and have developed relationships with both the dental and pediatrician/PCP communities for ease of cross referral and care coordination activities. These DHCS also provide intensive case management/care coordination services to members who have special health care needs or are unable to handle the challenges posed by the health care system. In addition, they perform targeted outreach calls and interventions to people who may need their services.

We remain in constant contact with our providers, members, and community partners through automated

and personal phone calls, newsletters, written and personalized communications, and through meetings. We treat everyone with respect and dignity and ensure we are easily accessible to people who wish to speak with us – good customer service which makes all of the difference. That is all people really want from a Medicaid Program. We see this on the medical and behavioral health sides as well as with our non–emergency transportation."[36]

New Hampshire's program administrator noted that direct outreach to engage and enroll dentists, in addition to having a good client services process available, has been a key to that state's success. The importance of strong client services was summarized in the following comments.

"If the client services personnel are trained well, they can identify available benefits and help patients navigate to the right source of care for those benefits, but while the "no wrong door" model is great, if these individuals don't have the appropriate training, the system won't work—as incorrect information is counterproductive for both patients and providers."[37]

California is another state that has undertaken a multi-pronged approach to increasing access to care for its Medicaid population.

California's Medi-Cal Dental Program (Denti-Cal) is in the process of improving how it promotes access to dental services in a number of ways including:

Dental Transformation Initiative (DTI), also known as 1115 Medicaid Waiver, part of the Medi-Cal 2020 Waiver, through financial incentive programs aims to:

- Increase use of preventive dental services for children
- Prevent and treat more early childhood caries
- Increase continuity of care for children
- Address the above areas through pilot projects

Beneficiary outreach plans for 0 – 3 year olds and the general Medi-Cal population

- Mail and call campaigns to educate Medi-Cal members about the need for dental services
- Tips about oral care
- How to access dental services

Denti-Cal website redesign

- Denti-Cal is in the process of redesigning the Medi-Cal Dental website to make it easier for beneficiaries to read, understand, and maneuver through

Mobile App created for phones and other electronic devices, which provides information such as:

- County phone numbers and addresses
- How to enroll in Medi-Cal preventive health information
- Reminders for appointments[38]

As noted earlier, many states have moved some or all of their Medicaid recipients to managed care products. Michigan created a partnership with Delta Dental in 2000, through which a managed dental care program, Healthy Kids Dental (HKD), was implemented in 63 of the state's 83 counties. This effort required that dentists who participated in Delta Dental's commercial network also participate in the managed care Medicaid program, which reimburses providers at rates at or close to those used for the commercial product members. The Medicaid program also utilized the same administrative protocols as the commercial plans. In addition, the identification cards that were issued to HKD children were identical to those of children in Delta's commercial products, so dentists could not tell the difference between those children on Medicaid and those that were privately insured. In an assessment of the first 12 months of the program, it was reported that there was a 31.4 percent increase in utilization of dental services by enrollees. Additionally, dentists' participation in the program increased substantially, and patients' travel time to dental appointments was cut in half.[39] The Altarum Institute conducted a study in 2012 to determine whether access to preventive services for children had been increased through this programmatic innovation, and concluded that because the program had the effect of increasing the participation of dentists in treating Medicaid children, more children received preventive dental care services.[40]

In Iowa, where managed care plays a significant role in the delivery of dental benefits, the survey respondent noted that the Medicaid dental program needs to be simple and reflective of how commercial products are administered, as dentists are already familiar with certain policies, procedures, and protocols. Eliminating barriers associated with the submission of claims and enhancing member education were seen as key strategies to improving access to care.[41]

As one absorbs the lessons from various states, there is evidence that a balance must be struck between financial and non-financial reforms, but the non-financial pieces appear to have less impact on access if not linked to sufficient increases in payment rates to dentists.[42]

CONCLUSIONS

The literature provides significant evidence that while increased reimbursement for dental services is a key factor in increasing access to care and utilization of services for Medicaid recipients, increased reimbursement alone may not be enough to create the desired impact. More likely, it is a combination of variables that will encourage improved access, and in order to sustain that access, an ongoing effort to evaluate results and fine tune the interventions will be required.

Based on a review of the literature and input from state Medicaid dental programs, the following strategies, when engaged in combination, may have the most successful impact on improving and maintaining access to care.

- Competitive reimbursement rates at +/- 60% of usual and customary charges on a key set of services
- Periodic reimbursement rate review and rate update
- Simplification of administrative requirements
- Direct outreach to dentists to build participation
- Education and outreach to beneficiaries
- Navigation and care coordination services for beneficiaries

While these strategies, employed individually or in combination, may indeed increase dentists' participation in Medicaid, the distribution of dentists across a geography may continue to affect patient access to comprehensive dental care. Ultimately, a thorough analysis of the environment and the factors limiting access to care, coupled with a multi-pronged strategic intervention will have the best chance of improving access to oral health care for historically underserved populations.

ENDNOTES

1. Surveys were returned by the following states: AK, AZ, CA, CT, DC, IA, ID, KS, KY, MD, ME, NH, NV, VA, WV, WY
2. AK, AZ, CA, CT, DC, IA, ID, KY, MD, NH, WV, WY
3. AK, AZ, CA, CT, IA, MD, NH
4. NV
5. Wall TP. Dental Medicaid - 2012. Dental Health Policy Analysis Series. American Dental Association Health Policy Resources Center. 2012
6. Hinton E, Paradise J. Access to Dental Care in Medicaid: Spotlight on Non-Elderly Adults. Kaiser Family Foundation. March 2016. Available at: http://kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/ Accessed: 10/2016
7. Nasseh K, Vujicic M. Dental care utilization rate highest ever among children, continues to decline among working-age adults. Health Policy Institute Research Brief. American Dental Association. October 2014. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_4.pdf?la=en Accessed: 10/2016
8. Vujicic M, Nasseh K. Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults . Health Policy Institute Research Brief. American Dental Association. December 2015. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0915_1.pdf?la=en Accessed: 10/2016
9. Nasseh K, Vujicic M. Dental Care Utilization Steady Among Working-Age Adults and Children, Up Slightly Among the Elderly. Health Policy Research Brief. American Dental Association. October 2016. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1016_1.pdf?la=en Accessed: 10/2016.
10. Ibid
11. Nasseh K, Vujicic M. Dental Care Utilization Rate Continues to Increase among Children, Holds Steady among Working-Age Adults and the Elderly. Health Policy Institute Research Brief. American Dental Association. October 2015. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1015_1.pdf?la=en Accessed: 10/2016
12. U.S. Department of Health and Human Services, Health Resources and Services Administration. Available at: http://www.hrsa.gov/shortage/ Accessed: 10/2016
13. Munson B, Vujicic, M. Number of Practicing Dentists per Capita in the United States Will Grow Steadily. Health Policy Institute Research Brief. American Dental Association. June 2016. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0616_1.pdf?la=en Accessed: 10/2016
14. State Health Facts. Kaiser Family Foundation. September 2016. Available at: http://kff.org/other/state-indicator/dentists-by-specialty-field/?activeTab=map¤tTimeframe=0&selectedDistributions=general-dentistry&sortModel=%7B%22colId%22:%22Location%22,%22-sort%22:%22asc%22%7D Accessed: 10/2016
15. GAO. Factors Contributing to Low Use of Dental Services by Low Income Populations. September 2000. Available at: http://www.gao.gov/assets/240/230602.pdf Accessed: 10/2016
16. GAO. Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns. 2010. Available at: http://www.gao.gov/new.items/d1196.pdf Accessed: 10/2016
17. Dental Campaign, Pew Charitable Trusts. In Search of Dental Care: Two Types of Dental Shortages Limit Children's Access to Care. June, 2013. Available at: http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2013/insearchofdentalcarepdf.pdf Accessed: 10/2016
18. Wall T, Nasseh K, Vujicic M. Most Important Barriers to Care Are Financial, Not Supply Related. Health Policy Institute Research Brief. American Dental Association. October 2014. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_2.pdf?la=en Accessed: 10/2016
19. Nasseh K, Vujicic M, Yarbrough C. A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services. Health Policy Institute Research Brief. American Dental Association. October 2014. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx Accessed: 10/2016
20. Ibid
21. Ibid
22. Medicaid Medicare Chip Services Dental Association. Dental Provider Payment Methodology. Available at: http://www.msdanationalprofile.com/2015-profile/financing/dental-provider-payment-methodology/? Accessed: 10/2016
23. Nasseh K, Vujicic M, Yarbrough C. October 2014. Op Cit
24. Edelstein B, El-Youssef L, Ma S. Impact of Medicaid Reimbursement Rates on Pediatric Dental Utilization," Conference paper, 4th AADR Fall Focused Symposium: Oral Health Disparities Research and the Future Face of America. 2011
25. Edelstein B. Personal correspondence. August 2016
26. Edelstein B. Understanding the Connecticut Dental Medicaid Reform Proposal. Connecticut Health Foundation. March 2003. Available at: https://www.cthealth.org/wp-content/uploads/2011/04/understanding-the-ct-dental-medicaid-reform-proposal.pdf Accessed October 2016
27. Wall T. Dental Health Policy Analysis Series - Dental Medicaid 2012. American Dental Association Health Policy Resources Center. 2012
28. Gehshan S. Best practices that make Medicaid work better, specifically ways to increase DDS participation to treat adults. Internal memo to Pew Charitable Trusts. Unpublished. 2015
29. Burton A. Personal correspondence. September 2016
30. Ibid
31. Wall T. Dental Health Policy Analysis Series - Dental Medicaid 2012. American Dental Association Health Policy Resources Center. 2012
32. Whistler B. Survey response and personal correspondence. June 2016

33. Roush J. Personal correspondence. June 2016

34. Borchgrevink A, Gehshan S, Snyder A. The Effects of Medicaid Reimbursement Rates on Access to Dental Care. National Academy for State Health Policy. 2008

35. Nasseh K, Vujicic M, Yarbrough C. October 2014. Op Cit

36. Balaski D. Survey response. September 2016

37. Finne Sarah. Personal interview . September 2016

38. Alcala-Beshara A. Survey response. October 2016

39. Eklund S, Pitman A, Clark S. Michigan Medicaid's Healthy Kids Dental Program - An Assessment of the First 12 Months. JADA 2003. 134(11)

40. DeLandsheer A, Taylor T. When Payment Reform Alone is Not Enough: Increasing Use of Preventive Oral Health Services Among Children Enrolled in Medicaid. Altarum Institute. September 2016. Available at: http://altarum.org/health-policy-blog/when-payment-reform-alone-is-not-enough-increasing-use-of-preventive-oral-health-services-among Accessed October 2016

41. Johnson S. Personal interview. September 2016

42. Edelstein B. Understanding the Connecticut Dental Medicaid Reform Proposal. Connecticut Health Foundation. March 2003. Available at: https://www.cthealth.org/wp-content/uploads/2011/04/understanding-the-ct-dental-medicaid-reform-proposal.pdf Accessed October 2016

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