



Policy Brief
December 2014

**The Public and Private Dental Safety Net:
Implementation of the ACA and their
Roles in Access to Care for Medicaid
and Expansion Populations**

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The University of Iowa, Public Policy Center* and College of Dentistry
This project was funded by the Commonwealth Fund and DentaQuest
Foundation (Boston, MA)

Abstract

The capacity of the public (community health centers) and private (private practitioners) dental safety net will be stretched through the expansion of dental coverage to an estimated 20.9 million primarily adults through the ACA's Medicaid expansion. Current and future capacity of the dental safety net was evaluated through a study of CHCs and private practice dentists in Iowa, as a way to model issues for other parts of the country. Access was found to be limited in the private dental safety net: only 16% of private practitioners accepted all new Medicaid patients, while the other 84% accepted either only some new (42%) or no new (42%) Medicaid patients. The public dental safety net was also limited in that there are only 14 clinics in the state and although they expected demand to increase, they reported limitations in their ability to respond. New programs may need to be developed so that access to dental care can meet the expected demand.

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Overview

The Affordable Care Act (ACA) is expected to increase the number of children and adults with dental insurance coverage by approximately 3.2 million and 17.7 million, respectively, as a result of the Medicaid expansion.¹ When Massachusetts expanded its Medicaid program in 2006, there was a significant increase in dental utilization, particularly among low-income adults.^{2,3} A similar pattern is likely to occur in states choosing to expand their Medicaid programs, although this will be mediated by the fact that only 11 states' Medicaid programs currently provide comprehensive dental benefits for adults.⁴ This influx of new Medicaid-enrolled adults will result in increased demand.

Additionally, the population of uninsured adults that are most likely to be entering Medicaid expansion programs have significant oral health problems and unmet need for dental care. A study of the population entering the Iowa Medicaid expansion indicated that their oral health status was rated significantly worse than adults in the Iowa Medicaid program (61% rated their oral health as fair or poor compared to 31% of adults in Medicaid) and "dental, tooth or mouth problems" were the most common health condition in this population that had lasted at least three months (39% of all adults).⁵

The dental safety net is the section of the healthcare system designed to provide dental services to

traditionally underserved populations, including low-income, institutionalized, medically complex, rural, publicly insured or uninsured.^{6,7} The two major components of the dental safety net are: 1) the public dental safety net—community health centers (CHCs), including federally qualified health centers (FQHCs), and 2) the private dental safety net—privately practicing dentists who accept patients from these underserved groups. Nationally, FQHCs provided dental care to approximately 4.3 million patients and 10.7 million visits in 2012, however this is only eight percent of all Medicaid enrollees prior to any ACA expansion.^{8,9} Even if the number and productivity of FQHCs increased considerably, they would still not have the capacity to care for the large population of dentally underserved in the United States.¹⁰ The private sector provides the majority of dental care for vulnerable populations; for example, 74 percent of Medicaid-enrolled children in 2009 received their dental services from private practitioners.¹¹ For this reason, understanding the capacity of both the public and private dental safety net is essential to ensure access to care for these vulnerable populations.

The Dental Safety Net in Iowa (DSNI) project evaluated the capacity of Iowa's public and private dental safety net to respond to the expected increased demand for dental services as a result of the ACA. First, we surveyed all private practice dentists in Iowa about their attitude toward and level of participation in the Medicaid program and caring for underserved populations. Second, we performed conjoint analysis to identify important factors in determining whether dentists will accept patients with Medicaid as potential policy levers to improve access. Third, we evaluated the capacity and organizational readiness of CHC dental clinics for ACA-related change.

Study Findings

The Private Dental Safety Net is Limited: Sixteen Percent of Dentists Accept All New Medicaid-Enrolled Patients

With 59 percent (n=671) of all Iowa private practice dentists reporting, only 16 percent accepted *all* new Medicaid-enrollees, 42 percent accept *a limited number of* new Medicaid patients (e.g. only children or only current patients who transition to Medicaid) and 42 percent *do not* accept any new Medicaid-enrolled patients.

There were important differences between dentists who accept *any* (some or all) new Medicaid patients and those who *do not*, regarding how they rank ordered the importance of common problems associated with Medicaid (Exhibit 1). Both groups ranked low reimbursement rates and broken appointments as the two most important problems. However, those *not* accepting any new Medicaid patients were significantly more likely to rank perceived problems with Medicaid administrative issues such as denial and slow payment, complicated paperwork, limited coverage of services, and frequently changing regulations as important compared to their counterparts who do accept at least some new Medicaid patients. Patient non-compliance and fear of government investigation were also rated statistically significantly different between the groups but at a lower level of importance.

	N	Mean Rating	Accepts any new Medicaid patients?		P value
			Yes	No	
Low reimbursement rates	658	3.80	3.78	3.82	.300
Broken appointments	656	3.77	3.76	3.78	.686
Denial of payment	634	3.44	3.34	3.57	<.0001*
Patient non-compliance with recommendations	643	3.20	3.11	3.33	.002*
Complicated paperwork	629	3.08	2.97	3.23	<.0001*
Frequently changing regulations	624	3.03	2.93	3.18	<.0001*
Limited services covered by Medicaid	640	3.03	2.92	3.18	<.0001*
Intermittent eligibility of Medicaid patients	629	2.98	2.93	3.06	.070
Not enough other practices in the area accept Medicaid	607	2.91	2.93	2.88	.514
Slow payment	630	2.82	2.68	3.03	<.0001*
Fear of government investigation (eg, chart audit)	609	1.91	1.80	2.06	.002*

*P<.05. Rated from 1 (not at all important) to 4 (extremely important).

Figure 1. Dentists' rating of the importance of commonly reported problems with Medicaid, 2013

Those accepting new Medicaid patients also had more favorable attitudes about the Medicaid patient population and significantly higher altruistic attitudes as compared to those who do not accept any Medicaid patients.

Medicaid Reimbursement Rates are the Strongest Predictive Factor of Whether Private Practice Dentists Will Accept Medicaid

Using conjoint survey scenarios, a key factor from each of the four domains in our ecological model were varied in the following manner: 1) reimbursement rates: 35%, 55% or 85% of usual fees; 2) missed appointments: often misses, sometimes misses or never misses; 3) claim approval on first submission: unlikely, may be or will be approved; and 4) others practices in area accepting Medicaid: none, a few or many others. The conjoint analysis reiterated that low reimbursement rates were the most important factor affecting dentists' acceptance of a Medicaid patient. In the scenario when all four factors were at their most ideal levels (85% reimbursement rate, claim approved on first submission, patient never misses appointments, and no other practices in the area accept Medicaid), the probability of Medicaid acceptance was 81 percent. If the reimbursement rate is lowered to 55% and all other factors are held constant, the probability of Medicaid acceptance was reduced to 56 percent. At the most undesirable levels, (35% reimbursement rate, claim is unlikely to be approved on first submission, patient often misses appointments, and many other practices in the area accept Medicaid), the probability of acceptance was eight percent.

CHC Dental Clinics Understood How the ACA Might Affect Their Operations, but Cited Limitations in Their Ability to Make Changes in Preparation for Increased Demand for Care

Regarding pre-ACA capacity in the public dental safety net, CHC dental clinics appeared to be operating at a high level of capacity, with very few vacancies for any category of dental staff or available space for growth; 92 percent of total dental operatory space was in use. The majority of clinics were able to treat all who requested appointments, however 36 percent reported long wait times for appointments and eight percent

reporting being too busy to treat all who needed care. Clinics had a mean broken appointment rate of 23 percent.

The highest proportion of CHC dental clinics expected the number of adult patients and their associated treatment needs to increase substantially as a result of the ACA insurance expansions (Exhibit 2). Additionally, the majority of clinics expected the number of child patients and their treatment needs to increase somewhat as well as the clinics' need for personnel and/or clinic space.

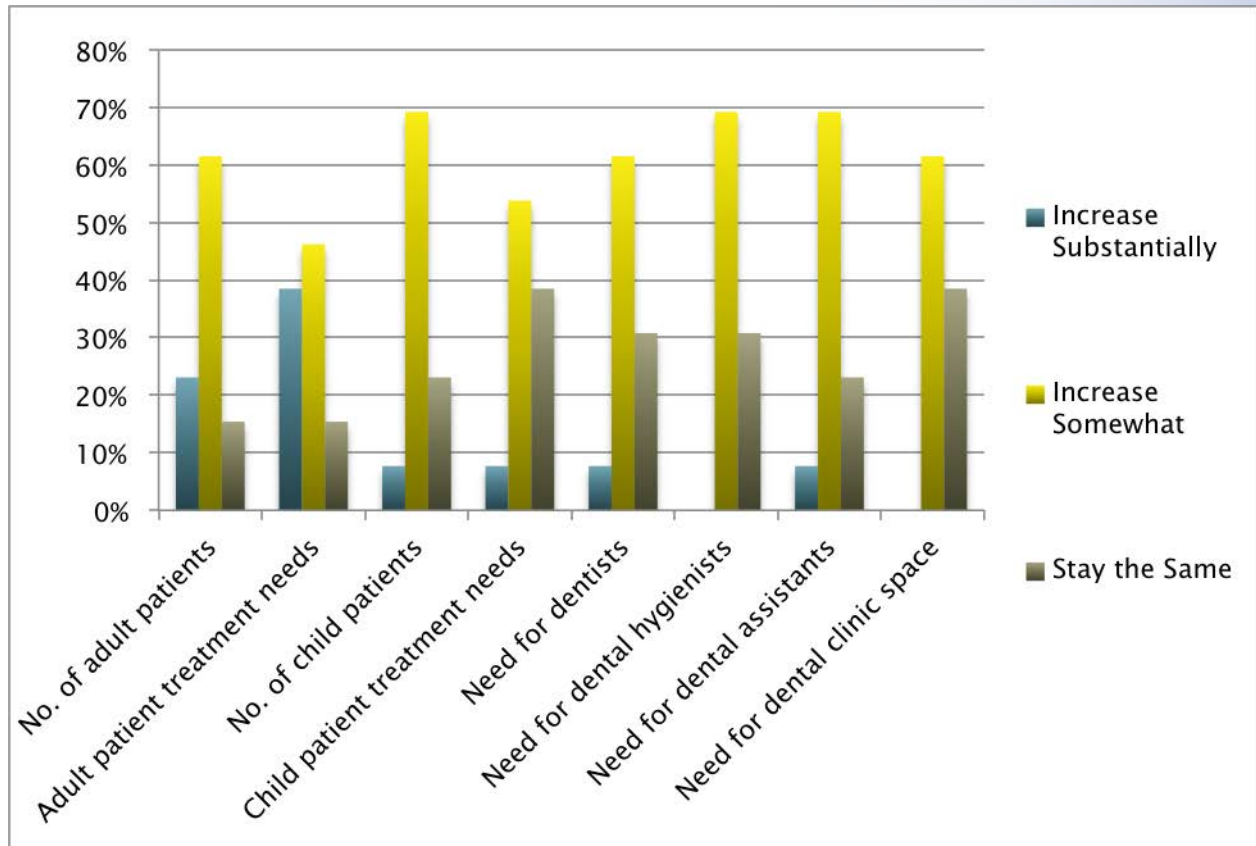


Figure 2. Expected impacts at Iowa CHC dental clinics following ACA implementation, 2013

When asked about what changes they would consider in order to accommodate increased demand for dental care, the most frequently reported changes were to expand clinic hours (100%), expand existing facilities (64%), and hire more general dentists (27%) (Exhibit 3).

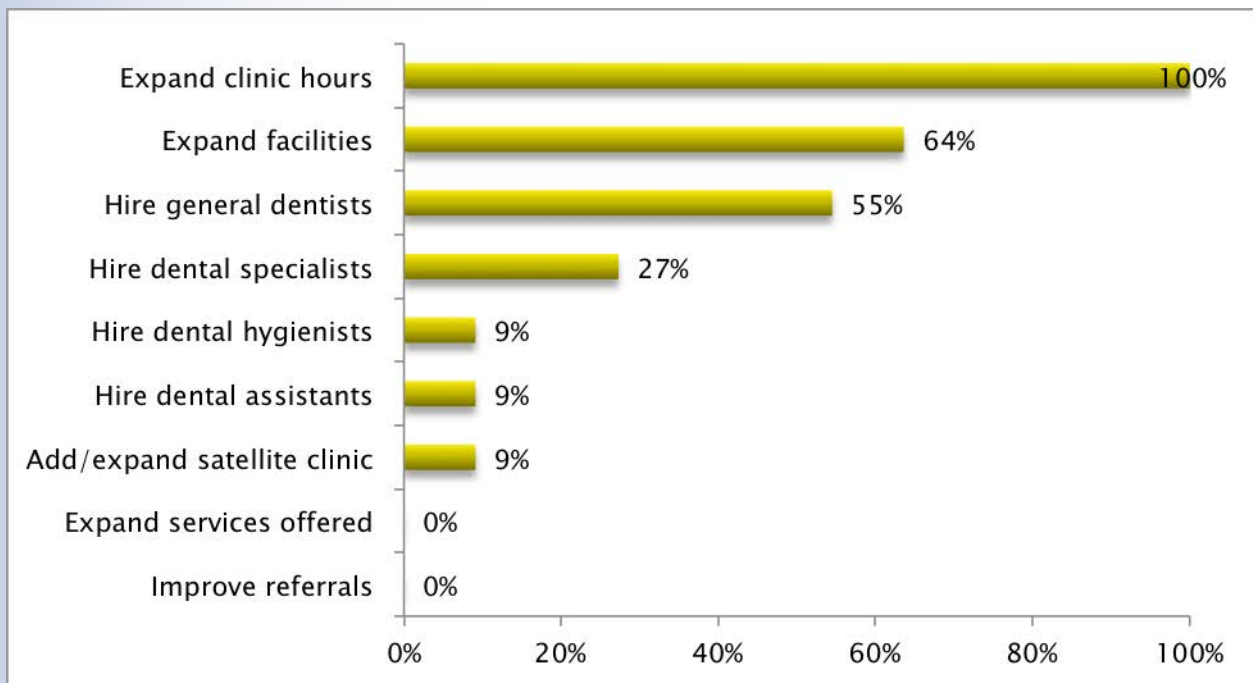


Figure 3. Changes that Iowa CHC dental directors would consider in order to accommodate increased demand for dental care, 2013

Policy Implications & Recommendations

ACA-related Medicaid expansion, particularly in the 11 states that provide comprehensive dental benefits for their adult Medicaid enrollees, has the potential to greatly improve access to dental care for low-income adults.¹² However, improved access to dental insurance coverage does not always result in improved access to care, as many other barriers prevent utilization. These barriers include limited capacity in the private (Medicaid acceptance by private practice dentists) and public (clinic space and provider availability in CHCs) dental safety net. An innovative new dental Medicaid carve-out program in Iowa, the Dental Wellness Plan (DWP) began May 1, 2014 to increase private dentist participation for the Medicaid expansion population (0-133% FPL). Administered by a commercial dental insurance company (Delta Dental of Iowa), the DWP provides increased reimbursement (about 50% higher than state Medicaid rates) to dentists and a tiered benefit structure that incentivizes patients to return for regular preventive care.¹³ The DWP is the first dental plan in the nation to provide this tiered coverage. However, DWP currently does not address factors like appointment-keeping behavior and certain administrative burdens such as claim approval concerns. The implementation and evaluation of this plan will provide an opportunity to assess the concordance between dentists' stated preferences and their actions with respect to Medicaid acceptance. If effective, it could also be used as a model for other states looking to improve access to dental care for low-income populations.

While CHC dental clinics appear to be near capacity with respect to dental personnel and clinic space, there may be opportunities for improving capacity by increasing clinic efficiency and reducing broken appointments. For example, the use of expanded function dental assistants (EFDAs) has been shown to increase clinic productivity and efficiency, and improved appointment reminder protocols may be effective in reducing broken appointments.^{14,15} Dental clinic supervisors were considering clinic hour expansion in order to meet increased demand as well.

DISCUSSION/CONCLUSION

There must be parallel improvements in the capacity of the public and private dental safety net in order to improve access to care, particularly for the large cohort of low-income adults who are newly enrolled in Medicaid. Improvement of CHC dental clinic capacity is needed, but CHCs alone cannot address the statewide needs of this previously uninsured population. Engaging the private sector, particularly through programs that address barriers to private practitioners' participation, is essential to ensure needed access to dental services for this newly insured population with significant oral health needs.

Endnotes

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