



# THE MICHIGAN HEALTHY KIDS DENTAL MEDICAID PROGRAM

Background, Program Design,  
And Baseline Assessment



*Illinois Center for*

**Health**

**Workforce**

**Studies**

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## Executive Summary

Access to dental care for Michigan's young Medicaid beneficiaries has been a chronic problem. As in many states, these children have low dental care utilization rates. A commonly cited cause is the reluctance of dentists to participate in Medicaid programs. Dentists report low reimbursement rates, which are usually below overhead cost, as the primary reason for unwillingness to see Medicaid patients, with administrative hassles listed as a close second.

Michigan has tried to address this issue over the years by convening a Dental Taskforce first in 1988, and again in 1997 to assess the problem and propose solutions. Dental fees for children's services were increased in 1998 and again in 1999, when the Michigan legislature appropriated a total of \$10.9 million for two new oral health initiatives. The first was a \$5.9 million capacity building effort for oral health clinics, and the second was a \$5 million demonstration program to increase private dentists' participation in Medicaid. This demonstration program, named Healthy Kids Dental, is modeled after the State's CHIP dental program for children, known as MICHild. Effective May 2000, Healthy Kids Dental provides private insurance-like dental coverage for Medicaid beneficiaries under the age of 21 years that reside in selected counties in Michigan. Under the demonstration program, Medicaid beneficiaries are issued Delta Dental cards identical to the private subscriber's cards. Beneficiaries are treated as privately insured patients, although coverage limitations will remain the same as Medicaid's fee-for-service program. Reimbursement rates and claim submission procedures for dentists are identical to Delta's private pay counterparts.

This report describes the design and initial implementation stages of Michigan's Healthy Kids Dental program. The report covers the history of Michigan's approach to the dental access problem facing Medicaid beneficiaries in the State. It presents baseline county-level data from 1999 to allow comparison of the selected demonstration counties with the remainder of the State. These data show that the demonstration counties have low dental utilization rates and limited dentist participation in Medicaid, thus allowing testing of the intervention.

The State has contracted with the University of Michigan to evaluate the outcomes of the Healthy Kids Dental program in terms of children's utilization and dentists' participation. This demonstration should allow the State to assess the effectiveness of the program, and to decide whether to expand to other counties in the State.

## Introduction

Dental and oral health care services are a vital component of comprehensive primary care services for children. Overall, dental health has improved over the past several decades, yet dental problems still affect the health and well being of vulnerable groups of children. These problems include painful teeth due to caries and abscesses, missing teeth and poor appearance, and impairments in chewing resulting nutritional deficiencies. These problems can lead to missed school days and set the stage for ongoing dental problems in adulthood. A key cause of more serious dental problems for children is lack of early access to preventive and restorative dental care.

National studies have identified inequities in access to dental care and a higher disease burden among low-income children. Poor children have twice as many dental caries (cavities) and higher rates of untreated caries. Sixteen percent (16%) of people in families with low income (under 150% of poverty) report having unmet dental needs, compared to only 6% for those with higher family incomes. (1) Although Medicaid covers dental care, it does not reduce the disparity – almost twice as many individuals with Medicaid (12.2%) report having unmet dental care needs compared to privately insured individuals (5.9%). (1) A 1996 Department of Health and Human Services report estimated that only one in five Medicaid children saw a dentist for preventative care during the year in the mid-1990s. (2) Limited access to dental care for children with Medicaid is a well-documented problem that is most commonly attributed to low dentist participation in Medicaid programs. (3,4) Dentists often cite insufficient reimbursement rates and administrative burdens for their failure to participate.

Michigan has implemented a new program that addresses these two critical barriers to dentists' providing dental care for Medicaid children - the low fee schedules and complicated billing procedures. The goal of the program is to increase dental care access for children through increased participation by dentists in private practice. This new program, called Healthy Kids Dental, will provide the equivalent of private dental insurance for Medicaid children who are under the age of 21 years and who reside in one of the 22 selected demonstration counties. Effective May 2000, these children are automatically enrolled in the Delta Dental insurance plan currently offered in their county, and they will receive an insurance card similar to those with Delta's private insurance. The program is administered according to Delta's policies and procedures, and payments to dentists are the same as for Delta Dental's private insurance. The coverage limitations, however, are the same as the Medicaid fee-for-service program.

This report describes the new program and reviews a brief history of efforts in Michigan to expand the Medicaid dental program for children. This study also analyzes data from the Michigan Medicaid program for baseline year 1999, just prior to the implementation of the Healthy Kids Dental demonstration program. This information should assist those involved with the program as well as policymakers and other interested parties with future program evaluation.

## **Michigan Efforts to Expand Medicaid Dental Coverage for Children**

### **Michigan's Medicaid Program and the 1988 Michigan Dental Taskforce**

Michigan's Medicaid dental program began in 1973 after Congressional action made Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandatory for all Medicaid covered children and adolescents under 21 years old. Under EPSDT mandates, each state is required to inform all Medicaid eligible citizens under the age of 21 years of the availability of EPSDT services, which include physical exams, immunizations, laboratory tests, vision, hearing, and dental services. The dental services must include, at minimum, pain relief, treatment of infections, restoration of teeth, and maintenance of dental health. (5)

In spite of the national attention focused on dental care access for Medicaid beneficiaries, utilization remained low. In 1984, it was estimated that only one fourth of the more than one million Medicaid enrolled children and adults had received dental services. In 1983, a study examined the participation of general dentists in the Medicaid program. (6) Of the 240 responding dentists, about fifty percent reported that they did not treat Medicaid patients; 30 treated Medicaid patients but limited the number to fewer than ten percent of their practice; 23% of dentists reported Medicaid patients being more than ten percent of their practices.

In April 1987, the Michigan Department of Social Services convened a Dental Taskforce to review the Medicaid dental program and make recommendations for its improvement. The resulting 1988 Dental Taskforce Report noted that national expenditures per utilizing recipient increased from \$85 in 1978 to \$98 in 1985, yet Michigan's expenditures actually decreased from \$121 to \$84 over the same period. The Report also estimated that in 1986, only 29% of the 1.1 million Medicaid beneficiaries received dental care compared to about 55% of privately insured patients. This low utilization rate was linked to dentists' dissatisfaction with and failure to participate in the program. The Report noted that only 2,100 to 2,400 of the State's 7,000 to 8,000 dentists provided services to Medicaid patients, and identified several administrative issues that were deterring dentist participation. These included inadequate dental fee reimbursement, rigidity of the prior authorization system, the inability to be paid for services rendered, and the failure of Medicaid to recognize current standards of dental care. (7) Suggested changes included the elimination of selected prior authorization requests and the adoption of standard dental billing and procedure codes.

### **1989-1996 Michigan Medicaid Experience and Program Changes**

Nationally, Congress recognized the chronically low Medicaid participation by both dentists and physicians and the negative consequences on access to care, and passed legislation (OBRA '89) that required states to set reimbursement rates more comparable to the market rates. (8) A study of the effects of this mandate on states and providers examined the experience in four states, including Michigan, at baseline in 1989 and two years into the program in 1992. The impact on states was limited, with all states having medical fee rates that were substantially below market (36%-57%) in 1992. All four states had dental utilization rates below 30% for children in both 1989 and 1992, with Michigan rates at 26% both years. Michigan also reported a decline by ten percent in the number of dentists participating in the program.

State financial issues in part limited the response to the recommendations of the 1988 Dental Taskforce report. For example, in 1991 the State Medicaid program had a \$1.3 billion deficit, to some extent due to the economic recession. In a 1994 interview conducted by the Michigan Dental Association (MDA), the Director of the Michigan Department of Social Services, which operated Medicaid, discussed the financial and administrative problems facing the Medicaid program. (9) At that time, the MDA estimated that dental fees only paid about 42% of dental charges, while direct costs were about 76% of charges. The Department Director recognized the fee problem, and that the dental program was over-regulated. He noted that the Department needed to simplify the program to be more consistent with private insurance sector, specifically Delta Dental and Blue Cross / Blue Shield, and that they needed to expand the number of active dentists to increase access for recipients.

In October 1994, the Medicaid dental budget was increased by 3% for all dental services. This, coupled with additional administrative changes, resulted in increased payment to dentists, but failed to significantly change levels of dentist participation. (10)

In 1994, national Medicaid data showed that Michigan had an average utilization rate for children's dental services of 34%. This compared favorably to the regional rate of 21% (the region includes Illinois, Indiana, Michigan, Ohio, and Wisconsin), and the national rate of 22%. However, these rates have all been seen as inadequate to meet children's dental care needs. By comparison, utilization of dental services was far below the rate of medical care utilization. In 1994, rates for utilization of physician services by Medicaid recipients were 73% for Michigan, 68% for the region, and 70% for the nation. (11) See Table 1.

	<b>Michigan</b>	<b>Midwest</b>	<b>Nation</b>
<b>Utilization Rate for Dental Services by Under 21 year-olds</b>	<b>34%</b>	<b>21%</b>	<b>22%</b>
<b>Utilization Rate for Physician Services by Under 21 year-olds</b>	<b>73%</b>	<b>68%</b>	<b>70%</b>

American Academy of Pediatrics State Medicaid Reports, [www.aap.org](http://www.aap.org)

Low rates of dental service utilization have been linked to a shortage of dentists participating in the Medicaid program. (1,3,4) The Michigan Dental Association has reported a decrease in the number of dentists participating in the Michigan Medicaid dental program (participation is defined here as being paid for at least one Medicaid dental claim during the year) from 2,250 dentists in 1990 to 1,884 in 1997. Also disturbing was the trend of fewer numbers of dentists providing a greater share of the services. The number of dentists who, as a group, received 75% of the total Medicaid claims paid dropped from 463 in 1990 to 288 in 1997. (12)

In 1996, under an Executive Order from Governor Engler, the Department of Social Services was reorganized in an attempt to improve the management of health care costs and services. The Medical Services Administration, which oversees the Medicaid program, the Department of Mental Health, and the Department Public Health, formerly separate agencies, merged into the Department of Community Health.

### **1997 Michigan Dental Taskforce**

In 1997, the Medical Services Administration (MSA) of the Department of Community Health convened another Dental Taskforce to revisit the dental access problem. The 1997 Taskforce Report found that the chief reason for dentists not serving Medicaid had shifted from administrative burdens to low dental reimbursement rates. (10) The Report identified the most common reasons for dentists' lack of participation as low reimbursement rates, administrative burden, and lack of patient responsibility - a high rate of missed dental appointments. Patient's failure to use the dental services was attributed to three factors - limited oral health awareness, transportation problems, and a lack of dentists willing to see Medicaid beneficiaries.

In order to assess the dentists' perspective on Medicaid, the MSA conducted a phone survey of a number of Michigan dentists in private practice. The dentists were asked what changes would be necessary to increase their willingness to accept Medicaid beneficiaries. Approximately one third responded that they would see beneficiaries if the payments were increased to the usual, customary, and reasonable (UCR) rate, one third responded that they would accept beneficiaries if the fees were raised and administrative paperwork was reduced, and the last third reported that they were not interested in accepting Medicaid under any circumstances. (13)

### **1998 The Michigan CHIP Dental Program : MICHild**

When the US Congress passed the Child Health Insurance Program (CHIP) in 1997, it offered states funding assistance and options for designing health insurance coverage for additional low-income children. The Michigan CHIP program, called MICHild, offers comprehensive health care coverage to all children under the age of 19 whose family income is at or below 200% of poverty, and who are uninsured and not eligible for Medicaid. MICHild's dental plan, which was implemented in May 1998, provides up to \$600 of dental care per year. Families are required to pay a monthly premium of \$8 per month for one child, and \$16 per month for two or more children. Dental co-payments are \$5 for simple extractions and stainless steel crowns. Families whose incomes are at or below 150% of poverty are exempt from premiums and co-payments. (14)

Michigan designed this program to be similar to private dental insurance programs in terms of reimbursement and administration. Eligible children receive private insurance cards and can see dentists who participate in commercial dental programs such as Blue Cross, Delta Dental, Golden Dental, and DenCap. Eighty-five percent (85%) of Michigan dentists are estimated to be available to provide care. Eligible children are not identified as Medicaid recipients, but only as members of one of these plans. Early analysis has shown that expenditures for this program have been approximately \$9 per child per month, or \$108 per child per year. An estimated 95% of the nearly 27,000 enrolled children have their dental needs met by this plan. (15)

## **1999 and 2000 Michigan Legislative Funding Increases for the Medicaid Dental Programs**

The Michigan legislature increased the MSA oral health services budget by \$7.2 million for two years beginning FY 1999. This brought the total FY 1999 dental budget to \$43 million; and the total Medicaid budget to just over \$6 billion. The MSA used this increase to fund children's dental services, particularly to increase dental fees for selected dental procedure codes for those under 19 years of age. The increases in reimbursement levels were designed with a focus on diagnostic, restorative, and preventative services. Specifically, it was proposed that the dental reimbursement for preventative and diagnostic procedures increase from 43% to 60% of the UCR rate, restorative procedures from 55% to 70%, and endodontics from 21% to 50%. The cost of these increases was funded in part by limiting fees for adult procedures at 40% UCR for most codes. These changes reflect the recommendations of the 1997 Dental Taskforce.

In 2000, the Michigan legislature approved funding two initiatives for a total of \$10.9 million aimed at increasing dental care access for Medicaid children. The first initiative was a capacity building plan totaling \$5.9 million. This program offered payment for "developmental costs, infrastructure, and enhanced technology that is directly related to expanding the capacity of providers to service more Medicaid beneficiaries". A variety of public and private organizations including local health departments, dental schools, HMOs, community health centers, hospitals, and medical and dental societies were eligible to submit proposals. Twenty-three agencies were awarded funds to expand dental services. Most proposals included plans for new operatories or upgrades of existing equipment, and hiring of additional staff. Funding amounts ranged from \$15,000 up to just over \$1 million.

The second initiative allocated \$5.0 million to fund a Medicaid Demonstration Project called Healthy Kids Dental. This program is modeled after the successful MICHild dental program, and is described below.

### **Healthy Kids Dental – Design and Implementation**

#### **Overview**

Healthy Kids Dental was designed to improve access to dental care for Medicaid children by increasing the number of dentists available and willing to provide services to Medicaid clients. Like MICHild, Healthy Kids Dental participants automatically become members of a private dental plan, Delta Dental of Michigan (the selection of Delta as the intermediary is described below), and are issued a private dental insurance card with benefits comparable to private pay subscribers. Delta Dental administers the Medicaid covered services and contracts and pays dentists using the same policies and procedures, claim submission, and reimbursement methods as with its other commercial dental contracts. In contrast to MICHild, Healthy Kids Dental requires no co-payment, and there is no annual cap on spending. Covered benefits are the same as Medicaid's fee-for-service program, and include examinations, diagnostic, preventative, restorative, endodontic, and prosthodontic services.

Because of limited first year funding, the program was not implemented statewide, but only in 22 selected Michigan counties. Healthy Kids Dental eligible beneficiaries are children under 21

years old who are eligible for Medicaid, and whose families reside in one of the selected counties. Healthy Kids enrollees are allowed to visit any Delta dentist participating in the particular plan offered in the beneficiaries' county of residence. Medicaid beneficiaries not living in one of the 22 counties or who are over the age of 21 continued to receive benefits through the existing Medicaid program.

### **Selection of the Dental Intermediary**

In February 2000, the MSA solicited proposals from third-party carriers to contract provision of services with participating dentists. The MSA had several requirements for the intermediary: it must possess a state-wide network to administer dental services; have at least 50,000 subscribers; contract directly with its dentists; prohibit balance billing; demonstrate that at least 20% of dentists in each demonstration county were participating in the carrier's network; and be able to administer the program on a state-wide basis should the demonstration be expanded. Also, the carrier must accept the MSA's fixed rate in the range of \$10.50 to \$11.50 per child per month, based upon review of the Department's actuarial staff. Finally, the carrier must provide bi-monthly reports to the State that include at minimum the number of beneficiaries receiving services and the type of services performed. Delta Dental was the only third-party carrier responding to the request, and was awarded the contract.

Delta Dental was established in 1957 as a nonprofit service organization, and is Michigan's largest administrator of dental benefits. Delta currently covers more than 3.2 million residents, or approximately 32% of Michigan's population, and pays nearly \$640 million annually for dental treatment. Delta offers dental benefits to employee groups of 10 or more people, and is used by some of Michigan's most well known corporations, including General Motors, Daimler Chrysler, and Dow Chemical. The State of Michigan, various city and county governments, as well as universities and hospitals offer Delta Dental coverage to their employees. (16)

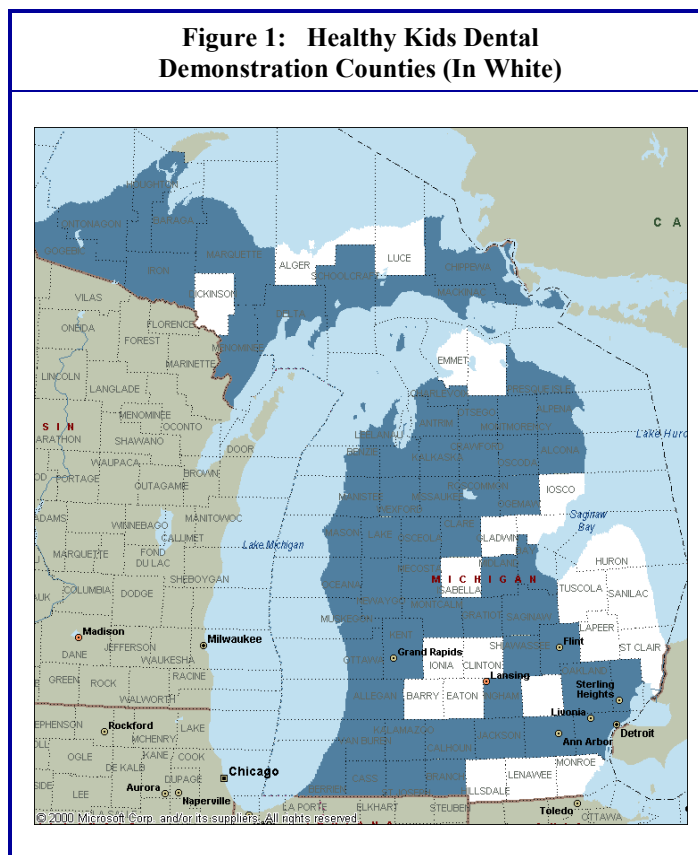
Delta Dental offers managed fee-for-service, preferred provider, and HMO-like programs. DeltaPremier (Premier), Delta's managed fee for service plan, has as participants 90% (or approximately 5,600) of Michigan's dentists. DeltaPreferredOption (DPO), the preferred provider plan, has approximately 1,000 dentists enrolled. (17) The Premier plan is a managed fee-for-service plan whose enrolled dentists are reimbursed on a fee-for-service basis. Reimbursement is estimated to be in the 80<sup>th</sup> percentile of ADA payments. The DPO plan is a preferred provider plan whose enrolled dentists agree to accept Delta's set reimbursement for services as payment in full. DPO participants are reimbursed at a rate lower than Premier, but higher than Medicaid fee-for-service rates.

Each demonstration county was designated as either DPO or Premier for dentists' contracting purposes. This meant that beneficiaries of that county would be required to see only Delta dentists participating in the designated plan. The plan offered in each county was determined by the MSA after examining the number of dentists participating in the two Delta plans offered. Counties were first evaluated based on the number of DPO dentists compared to the number of Medicaid dentists. If the increase in the number of DPO dentists over current Medicaid dental providers was sufficient to improve access, the DPO plan was designated, as it is more economical for the MSA than the Premier plan. If the number of DPO dentists was not

significantly higher than the number of Medicaid dentists, then the Premier plan, whose membership was more robust, was designated. Medicaid providers not previously participating in Delta Dental were required to sign on with Delta in order to be reimbursed for the treatment of children that qualify for Healthy Kids Dental.

### Selection of Counties

Implementation of the Healthy Kids Dental demonstration program was limited to 22 of Michigan's 83 counties because of limited first-year funding. Michigan's MSA selected the counties so as to maximize the effect of the program. Counties with low utilization, low numbers of Medicaid dentists, but with sufficient numbers of non-Medicaid dentists were chosen. The estimated number of total beneficiaries present dictated the number of counties chosen; the 22 demonstration counties have a total under 21 year-old eligible population of 50,945. With a cost of about \$11.00 per-member-per-month, a total allocation of \$5.0 million, and with an expected enrollee utilization rate of 75%, the program is designed to cover approximately 52,000 children. Demonstration counties are listed in Table 2 and shown geographically in Figure 1.



**Table 2: Michigan Demonstration Counties**

Alger	Arenac	Barry	Cheboygan
Clinton	Dickinson	Eaton	Emmet
Gladwin	Hillsdale	Huron	Ionia
Iosco	Isabella	Lapeer	Lenawee
Livingston	Luce	Monroe	Sanilac
St Clair	Tuscola		

### Outreach Efforts

Medicaid beneficiaries in the 22 demonstration counties were notified of the Healthy Kids Dental Program through a letter from the MSA. This letter, sent April 2000, briefly outlined beneficiary qualifications and the services to be covered. Beneficiaries were instructed to contact Delta Dental for assistance in finding a dentist in their area. Delta Dental produced brochures describing the program in more detail, including a section on how to use the program, and a list of the services covered. These brochures were also distributed to beneficiaries by mail.

Social workers at the Family Independence Agency, a state social service agency, also received information to pass on to potential beneficiaries.

The MSA notified dentists of the new program via an MSA Bulletin in April 2000. This bulletin outlined the program including participation requirements, counties included, plans offered in each county and other administrative information. Also included were dentists' frequently asked questions along with Delta's answers.

### **Program Evaluation**

Ongoing evaluation of Healthy Kids Dental will be conducted. The University of Michigan, School of Medicine, Department of Pediatrics has a contractual agreement with the MSA to provide an independent evaluation of the Healthy Kids Dental program as well as other programs of the Department. The MSA is in regular contact with Delta Dental, and receives feedback as to the ability of beneficiaries to obtain the needed care. In the six months since implementation of the program, changes have occurred based on feedback from both dentists and beneficiaries. For example, in two of the DPO designated counties, beneficiaries reported having difficulty finding necessary specialists. In response, the MSA changed the county designation from DPO to Premier, thereby increasing the number of available dentists.

## **Baseline (1999) Description of Michigan Counties**

### **Overview**

This baseline description of the demonstration counties includes measures of population, children's Medicaid enrollment, children's dental utilization and expenditures, and dentists' supply and participation at the county level for the demonstration and non-demonstration counties. The Michigan MSA provided all Medicaid and dentist data for this analysis. The data covers the 12-month period of January through December 1999. A Medicaid enrollee was considered to have used dental care if they received any service during the 12-month period. The total number of enrolled children was estimated as of December 31, 1999. Thus this analysis will include children who were enrolled for part of the year. Data for Keewenaw County was not supplied by the MSA because it had no dental providers or Medicaid recipients. Population counts and sociodemographic data (race, household income, poverty rate) were obtained from the US Census Bureau.

Counts of licensed dentists were obtained by the MSA from the Michigan Board of Dentistry, and counts of Delta participating dentists were obtained by the MSA from Delta Dental. A dentist was considered participating if they provided any billable service during the year. We recognize that the use of licensed dentists overestimates the number of active practicing dentists available to treat children.

### **County Population and Sociodemographic Characteristics**

Table 3 presents county population and sociodemographic data. While the demonstration counties have substantially smaller populations, on average, than the non-demonstration

counties, these numbers are skewed by a few large urban counties in the non-demonstration group. The average per county population for the demonstration counties was 61,044, compared to 141,978 for the non-demonstration counties, and 120,264 for the entire State. However, the median population for the demonstration counties was 50,845 compared to 36,676 for the non-demonstration counties, and 39,438 for the entire State.

Children and adolescents under 21 years of age make up about 30% of Michigan's total population, compared to 32% for the demonstration counties. The Black population is lower in the demonstration counties; 2% compared to 16% for the non-demonstration counties and 14% for the State. Demonstration county households had higher median household incomes than the rest of the State; \$35,492 compared to \$32,263 for the non-demonstration counties, and \$33,129 for the State. Demonstration counties also have lower rates of poverty than the non-demonstration counties. Poverty rates for all ages are ten percent for the demonstration counties, and 13% for both the non-demonstration counties and the State. Poverty rates for those under 18 years of age are similarly lower in the demonstration counties; 14% compared to 22% for the non-demonstration counties and 20% for the State. Thus, on average, the demonstration counties have a different sociodemographic picture than the non-demonstration counties. The demonstration counties have a higher median income, less poverty, and are more likely to be White.

**Table 3. 1999 County Level Population Data**

	<b>D</b>	<b>ND</b>	<b>State</b>
<b>Number of counties</b>	<b>22</b>	<b>61</b>	<b>83</b>
<b>Average County Population 1999 Census data</b>	<b>61,044</b>	<b>141,978</b>	<b>120,264</b>
<b>Median County Population</b>	<b>50,845</b>	<b>36,676</b>	<b>39,438</b>
<b>County Population Range per Category</b>	<b>6,754 - 161,755</b>	<b>7,668 - 2,106,495</b>	<b>6,754 - 2,106,495</b>
<b>Total Population per Category</b>	<b>1,342,969</b>	<b>8,518,664</b>	<b>9,861,633</b>
<b>Population percent under 21 years 1999 Census data</b>	<b>32%</b>	<b>30%</b>	<b>30%</b>
<b>Population: percent White 1999 Census data</b>	<b>97%</b>	<b>81%</b>	<b>83%</b>
<b>Population: percent Black 1999 Census data</b>	<b>2%</b>	<b>16%</b>	<b>14%</b>
<b>Median Household Income, 1995 Census data</b>	<b>\$35,492</b>	<b>\$32,263</b>	<b>\$33,129</b>
<b>Poverty Rate, all ages , 1995 Census data</b>	<b>10%</b>	<b>13%</b>	<b>13%</b>
<b>Poverty Rate, &lt; 18 Years, 1995 Census data</b>	<b>14%</b>	<b>22%</b>	<b>20%</b>
Demographic data from the Census website: <a href="http://www.census.gov">www.census.gov</a> Demonstration Counties ( <b>D</b> ), Non-Demonstration Counties ( <b>ND</b> ), State of Michigan ( <b>State</b> )			

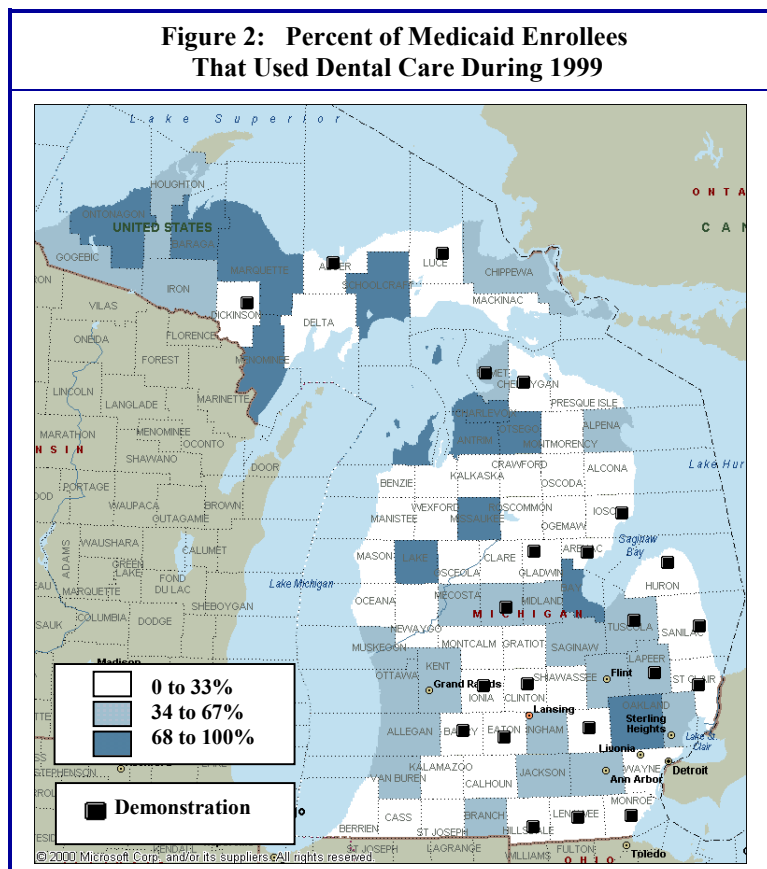
## Medicaid Enrollment and Utilization of Dental Care

Table 4 presents Medicaid enrollment and utilization data. The percent of the total population under 21 years of age and enrolled in Medicaid was lower in the demonstration counties (3.8%) than in the non-demonstration counties (5.8%), and the State (5.6%). The average number of Medicaid enrollees was 2,316 for demonstration counties and 8,296 for non-demonstration counties. The demonstration counties included about nine percent of the total Medicaid enrollees (50,945/548,713) and about five percent of the total Medicaid users of dental care (9,520/209,189).

For the baseline year 1999, the demonstration counties had much lower dental utilization rates (19%) compared to the non-demonstration counties (40%) and the State (38%).

Figure 2 illustrates this data geographically. Notice that most of the demonstration counties are shaded white, indicating they are in the lower third of utilization rates across the state.

However, when dental care expenditures per user were examined, the amounts were somewhat higher in the demonstration counties than the non-demonstration counties or the State (\$123 vs. \$118 per user).



**Table 4. 1999 Medicaid Dental Utilization Data for Beneficiaries Under 21 Years**

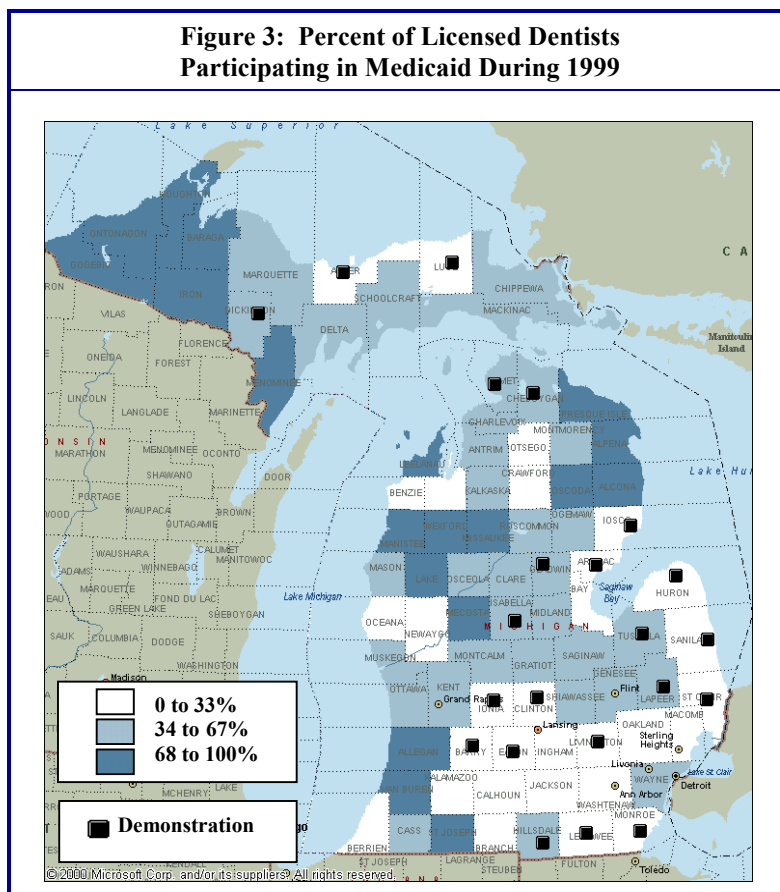
	<b>D</b>	<b>ND</b>	<b>State</b>
<b>Enrollees (total as of 12/31/99)</b>	<b>50,945</b>	<b>497,768</b>	<b>548,713</b>
<b>Enrollees that Used Dental Care</b>	<b>9,520</b>	<b>199,669</b>	<b>209,189</b>
<b>Enrollees (average per county)</b>	<b>2,316</b>	<b>8,296</b>	<b>6,692</b>
<b>Enrollees that Used Dental Care (average per county)</b>	<b>433</b>	<b>3,328</b>	<b>2,551</b>
<b>Percent Enrollees that Use Dental Care</b>	<b>19%</b>	<b>40%</b>	<b>38%</b>
<b>Expenditures for Dental Care (total)</b>	<b>\$1,170,162</b>	<b>\$23,540,214</b>	<b>\$24,710,375</b>
<b>Expenditures for Dental Care (average per county)</b>	<b>\$53,189</b>	<b>\$392,337</b>	<b>\$301,346</b>
<b>Expenditures per User</b>	<b>\$123</b>	<b>\$118</b>	<b>\$118</b>

1999 Medicaid utilization data from the Michigan Department of Community Health  
 Demonstration Counties (D), Non-Demonstration Counties (ND), State of Michigan (State)

## The Dentist Workforce

Analysis of the dentist information begins to shed light on the low utilization rate seen in the demonstration counties where the availability of dentists appears to be a factor. Table 5 presents county level dentist data. The supply of dentists was much lower in the demonstration counties (average count per county of 28 dentists vs. 93 dentists), however this reflects the smaller population base of these counties. To allow comparison across counties of different sizes, the supply of dentists was adjusted to a population base of 100,000. The adjusted ratio of dentists per county was also lower for the demonstration counties; 46 dentists per 100,000 compared to 66 for the non-demonstration counties, and 63 for the State as a whole.

The percent of dentists that participated in Medicaid was also lower in the demonstration counties as compared to the rest of the State. Figure 3 illustrates this geographically. Notice that 14 of the 22 demonstration counties are in the lowest third of statewide participation rates. Twenty-six percent of all demonstration county dentists participated in Medicaid compared to 31% of the non-demonstration county dentists and 30% of dentists statewide. This allows for a calculated estimate of the Medicaid participating dentists per 100,000 population, which was lower in demonstration counties (12 dentists/100,000) compared to non-demonstration counties (21 dentists/100,000) and the State (19 dentists/100,000).



	<b>D</b>	<b>ND</b>	<b>State</b>
<b>Total Number of Licensed Dentists all counties</b>	<b>613</b>	<b>5,606</b>	<b>6,219</b>
<b>Average Number of Licensed Dentists per County</b>	<b>28</b>	<b>93</b>	<b>76</b>
<b>Estimated Licensed Dentists per 100,000 Population</b>	<b>46</b>	<b>66</b>	<b>63</b>
<b>Total Number of Dentists Participating in Medicaid</b>	<b>157</b>	<b>1,728</b>	<b>1,885</b>
<b>% of Licensed Dentists that Participated in Medicaid</b>	<b>26%</b>	<b>31%</b>	<b>30%</b>
<b>Estimated Dentists Participating in Medicaid per 100,000 Population</b>	<b>12</b>	<b>21</b>	<b>19</b>

Dentist data from the Michigan Department of Community Health  
 Demonstration Counties (D), Non-Demonstration Counties (ND), State of Michigan (State)

## Discussion

The Michigan Healthy Kids Medicaid dental program represents a creative effort to increase access to dentists for Medicaid children by presenting dentists with an insurance program that is very similar to the private market. This program is expected to remove financial and administrative barriers currently facing dentists, and to increase their participation in Medicaid and willingness to treat Medicaid children. The ultimate goal of the program is to improve dental care rates and dental health status in the Medicaid child population of Michigan.

However, one must use caution with these assumptions. First, studies have shown that outreach efforts to recruit dentists into the program, and to inform parents of increased dentist availability is required to achieve higher use rates. Healthy Kids Dental outreach has been limited to mailings to Medicaid recipients describing the program. No media campaigns were planned. It is not yet clear if this level of notification will suffice.

Second, fee increases alone have been shown to have a limited effect on dentists' participation. A study of North Carolina dentists failed to demonstrate a relationship between very narrow fee increases and the number of dentists participating in Medicaid (18). Admittedly, the increased fees did not approach the level of private commercial rates. This study did, however, show an increased volume of services provided by dentists already seeing Medicaid beneficiaries in response to the fee increases.

In 2000, the General Accounting Office (GAO) reported on a survey study of all state Medicaid programs that analyzed Medicaid fees and dentist participation (3). Between 1997 and 1999, forty states had increased their dental fees, some with very low increases (1 to 5% per year), and others with a large one-time increase of 40%. Most of the reporting states had only limited increases in dentists' participation, generally less than 3% of dentists. This study found that states that reported a higher dentists' response had increased their fees to at least two-thirds of the average regional payments. The Healthy Kids Dental Program offers dentists payment at up to the 80<sup>th</sup> percentile; this is substantially higher than the fee increases in the GAO study.

By designing the program to contract with Delta Dental, the Healthy Kids Dental program has helped assure that the administrative difficulties associated with Medicaid should be reduced. Another positive consideration of the Healthy Kids Dental program relates to removing the stigma of Medicaid that inhibits some families from using their benefits. This program provides Medicaid beneficiaries with a private insurance card and a look-alike program.

The GAO study also noted that ten states had implemented their CHIP programs quite differently than their Medicaid programs, generally contracting with a private insurers and paying private insurance rates. This resembles the Michigan CHIP or MICHild program design, upon which the Healthy Kids Dental program is modeled. These states felt that the access problems for CHIP beneficiaries were much less than for their traditional Medicaid program counterparts, who continued to experience problems obtaining care. (3)

Because of limited first year funding, the Healthy Kids Dental program could only be implemented in about one fourth of Michigan's 83 counties. The MSA used participation and utilization data to identify counties where low levels of dentist participation existed in combination with adequate numbers of licensed dentists and Medicaid beneficiaries. This method resulted in the most underserved counties receiving assistance first. In addition, by rolling out the program in only a portion of the State, the potential for a controlled observation of the effect of the policy change exists. It will be possible to make comparisons between changes in dentist participation and beneficiary utilization rates between demonstration and non-demonstration counties over the same period of time.

## **The Illinois Center for Health Workforce Studies** **And the Michigan Primary Care Association Partnership**

The Illinois Center for Health Workforce Studies (ICHWS) at the University of Illinois at Chicago was established in 1998 through funding from a three-year cooperative agreement from the U.S. Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr). The Center is one of four state level health workforce study centers located at universities in Illinois, New York, California, and Washington State. The Illinois Center's mission is to conduct state and national policy related research on the supply, distribution, demand, competency, and diversity of the health professions workforce (physicians, dentists, nurses, pharmacists, allied health, and public health). The ICHWS is particularly active in the dental workforce arena, and has studied the dental workforce and access to dental care for low-income children in Illinois.

The Michigan Primary Care Association (MPCA) is a non-profit organization whose mission is to “promote, support, and develop comprehensive, accessible, and affordable quality primary health care services to everyone in Michigan, especially those traditionally underserved.” The MPCA accomplishes this goal through network development, information sharing, and advocacy. MPCA members include primary care providers, both individual and organizational, who support the MPCA mission. The MPCA collaborates with a variety of organizations at the local, state, and national level, including partnership with the US Department of Health and Human Services, and the Michigan Department of Community Health.

In July of 1999, two Bureaus within HRSA, the BHPr and the Bureau of Primary Health Care (BPHC) initiated a partnership program to provide funding for eight projects between workforce study centers and state primary care associations (PCAs) or primary care organizations (PCOs). The goal was for the workforce study centers to lend their expertise to the study of workforce issues of interest in the PCA / PCO's state. As a result, the MPCA contracted with the ICHWS in November of 1999 to conduct this study of the demonstration project in Michigan named Healthy Kids Dental.

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