# F I S C A L  I M P A C T  R E P O R T

**SPONSOR** Ortiz y Pino **ORIGINAL DATE** 03/03/15 **LAST UPDATED** 03/13/15 **HB**

**SHORT TITLE** Medicaid Dental Health Care Pilot **SB** 451

**ANALYST** Boerner

## REVENUE (dollars in thousands)

| Estimated Revenue | | | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|
| FY15 | FY16 | FY17 | | |
| | | $1,732.5 | Recurring | Federal Medicaid Revenues |
| | | | | |

(Parenthesis ( ) Indicate Revenue Decreases)

## ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

| | FY15 | FY16 | FY17 | 3 Year Total Cost | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|---|---|
| | | Minimal Administrative Costs* | | | | HSD Operating Funds |
| | | | $567.0 | $567.0 | Recurring | General Fund |
| | | | $1,683.0 | $1,683.0 | Recurring | Federal Medicaid |
| **Total** | | | $2,250.0 | $2,250.0 | | |

(Parenthesis ( ) Indicate Expenditure Decreases)

*Administrative costs associated with amending the state Medicaid plan, promulgating rules, potential adjustments to managed care organization contracts, etc.

## SOURCES OF INFORMATION

LFC Files

Responses Received From
Human Services Department (HSD)

## SUMMARY

Senate Bill 451 directs HSD to establish a year-long dental health care pilot program in a subset of New Mexico counties. For the selected counties, dental coverage provided through the pilot project will replace any dental health coverage currently offered through the existing Medicaid

state plan or waiver.

The bill outlines some benefits of the proposed pilot such as a larger dental health care provider network, shorter distance between providers and recipients, and enhanced Medicaid reimbursement for participating providers.

The pilot project is to be established by January 1, 2017.

## FISCAL IMPLICATIONS

HSD points out the bill requires enhanced Medicaid reimbursement for the participating dental providers which would have an impact on the state's general fund and a larger impact on the Medicaid program over time if the new rates serve as the model for future expansion of the pilot.

For the pilot counties, HSD paid $20.3 million (state and federal) for calendar year 2014 through a combination of Medicaid managed care and Medicaid fee-for-service payments.

HSD compared the current Medicaid dental fee schedule with commercial dental fee schedules that would represent an "enhanced Medicaid reimbursement" and found commercial rates are on average 20 percent higher than the Medicaid fee schedule. Based on this, HSD estimates an annual expenditure increase of $4.06 million (state and federal, based on 2014 expenditures). The estimate considers increased fee schedule amounts but not increased utilization that might occur as access to dental care is expanded; HSD estimates an 11 percent increase in utilization and participants for a total increased in expenditures of $4.5 million for calendar year 2017.

The estimated federal financial participation for the increase dental expenditures for calendar year 2017 is 74.8 percent. This is higher than the standard federal match of 70.37 percent because the federal match for the Medicaid expansion group is 100 percent until January 1, 2017, when it drops to 95 percent. Additionally, the federal match for the Children's Health Insurance Initiative (CHIP) recipients beginning in October 2016 will be 100 percent unless congress fails to reauthorize the enhanced federal match of 100 percent.

In summary, the estimated annual increase for calendar year 2017 is $4.5 million, 3.37 million from federal matching funds and 1.13 million from general fund; the impact for New Mexico's *fiscal year* 2017 is reflected in the Operating Budget Impact table above. The estimated federal match for the increased expenditure is significantly higher than the standard federal match of approximately 70.37 percent because of the high use of dental services by the patients newly eligible with Medicaid expansion under the federal Patient Protection and Affordable Care Act. Typically, individuals who are newly eligible for Medicaid have gone without dental services and the utilization is high initially.

The FQHCs that provide dental services in those counties would have to continue to be paid for the dental services.

## SIGNIFICANT ISSUES

In September 2013, the Centers for Medicare and Medicaid released a strategy guide titled *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents (http://www.deltadentalmi.com/MediaLibraries/Global/documents/HKD-Fact-Sheet.pdf)*

The report provided examples of successful approaches to improving oral health access and utilization for children enrolled in Medicaid. The guide offers a variety of approaches for states to choose from to best fit local needs and resources.

- One strategy noted was finding ways to maximize provider participation. The reported noted provider participation in Medicaid is critical to ensuring children and adolescents have sufficient access to dental care but that Medicaid participation among dentists tends to be low, with a 2010 study indicating less than half of dental providers saw Medicaid patients in 25 of the 39 states that reported data. Barriers to participation reported by providers include:
    - low reimbursement rates,
    - administrative burdens, and
    - poor patient compliance

The report noted reimbursement rates can be a factor in securing dentist participation in Medicaid. Low reimbursement can affect the formation and maintenance of adequate provider networks. Dental overhead costs have been estimated to demand 60–65 percent of providers' gross income (depending on state taxes). Thus providers in states where Medicaid does not reimburse at least at this break-even level have little financial incentive to participate.

- A second strategy noted was to reduce the administrative burden for providers. According to CMS, dentists report that Medicaid often involves lengthy and complex provider enrollment procedures, lack of clarity in determining patients' Medicaid eligibility, cumbersome prior authorization requirements, and difficult procedures for claims submissions.

However, states can take a variety of approaches to reduce administrative burdens including:

- Make enrollment easier for dentists by reducing the length of enrollment applications (e.g., in Maryland, dental provider credentialing forms were reduced to half of the length of forms currently used by private insurance carriers).
- Keep Kids Smiling: Promoting Oral Health 19
- Eliminate or greatly reduce the need for prior authorization requirements for children except for the most costly services.
- Choose to keep prior authorization but streamline the process by ensuring that the requirements are publicized in a format that is easy to both access and comprehend.
- Reduce the amount of information that providers must deliver to the state, and simplify the means of delivery (e.g. providing an option for electronic submission).

CMS points out that in 2000, Michigan rolled out its Medicaid Healthy Kids Dental Program in 22 counties. The program was administered through a commercial dental plan that was well established among Michigan's dentists, with the same network, the same reimbursement rates, and similar administrative policies. Within the first twelve months, enrolled children increased their utilization of dental services by 31.4 percent. Gradually, the program has been expanded to cover 78 of Michigan's 83 counties.

LFC staff research indicates the commercial dental plan teamed up with the Michigan Department of Community Health to help improve the dental health of those in greatest need. With the support of Michigan dentists, the Healthy Kids Dental (HKD) program was launched to improve access to dental care for Medicaid-eligible children under the age of 21. Today, more than 565,000 Michigan children residing in 80 of Michigan's 83 counties are enrolled in HKD.

HSD notes also that the southern counties identified by the legislation are designated as "Health Professional Shortage Areas (HPSA) Dental" by the federal Health Resources Services Administration. Additionally, the federal government has designated all or part of 32 counties of New Mexico as Dental Health Professional Shortage Areas; therefore, the counties do not have sufficient dental providers to serve the needs of the community. Currently, with the exception of Catron County, the remaining counties have FQHCs, community clinics, and private dentists serving Medicaid clients. State initiatives for low-income children enrolled in public programs have shown that progress can be made in improving access to and utilization of oral health services. (http://hpsafind.hrsa.gov/HPSASearch.aspx).
(http://www.nhpf.org/library/issue-briefs/IB836_OralHealthCheckup_03-29-2010.pdf).

The 2012 New Mexico Behavioral Risk Factor Surveillance Survey found that 67 percent of those 55 years of age had seen a dentist within the past year.
(http://ibistest.health.state.nm.us/ibisphview/indicator/view/OralHealthDentVisit.NM_US.html)

New Mexico faces workforce challenges. More than 40 percent of the population lives in federally designated Dental Health Professional Shortage Areas.
(http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2011/05/11/childrens-dental-health-new-mexico).

## ADMINISTRATIVE IMPLICATIONS

SB 451 would require HSD to adopt and promulgate rules for medical assistance programs; to amend the managed care contracts; and amend the Medicaid State Plan. The state would need to develop new waiver authority, procure a dental contractor to oversee and manage the network, develop rates, and ensure that the contractor is able to pay claims, submit encounters and all required reports. HSD notes it may not be possible to ensure the state plan amendments, rules and federal approvals could be in place by January 1, 2017.

HSD also notes SB 451 may require replacing the current network of dentists with a different network. If so, it would entail operating a separate dental managed care organization with a specific network of providers, similar to the Behavioral Health Single Entity. This involves justification to the federal Centers for Medicare and Medicaid Services (CMS) and changing of existing managed care organization contracts and rate structure. HSD argues it is not likely that CMS would approve requiring Native Americans to participate in the new dental MCO; therefore, it may be necessary to keep the existing network in place.

CEB/bb/aml