A Comparison of Medicaid Dental Claims Data in Two States with Different Adult Dental Benefits

The *Oral Health Workforce Research Center* (OHWRC) is analyzing Medicaid dental claims data in comparable years from two states with different adult dental benefits. The Medicaid dental benefit for adults varies widely across states. Some states narrowly cover treatment of dental pain and infection for adults, while other states offer more comprehensive adult benefits. This variation will permit an assessment of utilization patterns of oral health services by Medicaid-insured people in each state and a comparison of the effects of expanded or restricted Medicaid dental benefits.

Background

There is strong evidence that dental insurance coverage is positively associated with access to and utilization of oral health services.[1] Variation in dental insurance benefits affects the behavior of patients and dental providers. For instance, a Medicaid patient with dental pain may only access care from a safety net provider because participating private practice dentists are unavailable. Treatment for a tooth infection may result in tooth extraction because a limited Medicaid benefit will not permit final restoration of the infected tooth and the patient cannot afford to pay out-of-pocket for the needed service. Dental claims data provides information about patients, services, settings and providers that can be used to describe utilization patterns.

All states are required to provide a comprehensive dental insurance benefit for children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in state Medicaid programs. While there is relatively consistent Medicaid dental coverage for children in the 50 states, there is significant variation across states in the dental benefit available to adults who qualify for Medicaid benefits. Many states have tried to control Medicaid dental expenditures by moving to managed care dental plans or by reducing reimbursement rates and/or reducing or eliminating dental benefits for adults.[2] Currently, 22 states offer either no adult dental benefit in Medicaid or limited coverage to care related to dental trauma.[2] Many of the remaining states that do provide an adult Medicaid benefit limit the number of permissible dental visits or limit benefits to treatment for dental pain and infection only. States are experiencing high costs for use of emergency rooms for dental problems and outpatient services for quadrant or sedation dentistry to address serious dental conditions. There is debate about the current Medicaid policy that pays only for expensive therapeutic services rather than supporting preventive and basic restorative care.

Social, economic, and geographic determinants also affect how and when patients access oral health services. In addition, the uneven distribution of dentists contributes to access issues, particularly in rural areas and small towns. People are often limited in obtaining oral health care by the lack of private dental practices or safety net oral health providers in their area. Some patients are limited by both geography and insurance status.

Not all dentists, even those in smaller population areas, participate in state Medicaid programs; this further limits availability of oral health services for patients insured by Medicaid. Workforce innovations in several states now permit registered dental hygienists (RDHs) to provide services directly to patients. RDHs may work in school-based oral health programs, nursing homes or independently. Claims data provides information about where services occurred, the professional who treated the patient, and the types of diagnostic, preventive, restorative or therapeutic services that were provided.

Hypothesis, Design and Analysis

The project will analyze Medicaid dental claims data from two states with different adult dental benefits in comparable years. One state will provide a narrow adult Medicaid benefit that only covers treatment for dental pain and infection while the other will offer a more comprehensive benefit. These differences will permit researchers to

compare and contrast dental claims data to understand differences in utilization patterns of Medicaid-eligibles based on the availability of providers and the extent of coverage provided by the adult Medicaid benefit.

There will be a special emphasis on analyses related to populations living in the small towns and rural areas of both states. If possible, the analyses will also describe the effect of expansions for allied dental personnel on access to oral health services for populations in rural areas of each state, especially for children. The analyses will examine rates of dental participation by state, describe the mean volume of services provided by dentists participating with Medicaid programs, and compare and contrast utilization patterns of oral health services by adults on Medicaid.

NY CHWS hypothesizes that the availability of dentists and a more inclusive Medicaid dental benefit for adults in a state will result in higher rates of utilization of oral health care services. The analysis will compare rural and urban populations in different age cohorts to describe differences in utilization of oral health services.

Data Sources

NY CHWS is currently developing data requests to two states for use of Medicaid data for the proposed research.

Deliverables

This research project will result in a research brief, final research report and a manuscript submitted to a peer-reviewed journal.

1. Institute of Medicine and National Research Council. 2011. *Improving access to oral health care for vulnerable and underserved populations*. Washington, DC: The National Academies Press.

2. Wall TP. Dental Medicaid - 2012. Dental Health Policy Analysis Series. Chicago: American Dental Association, Health Policy Resources Center; 2012.