More Rhode Island Adults Have Dental Coverage After the Medicaid Expansion: Did More Adults Receive Dental Services? Did More Dentists Provide Services?

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ABSTRACT

OBJECTIVE: Under the Affordable Care Act (ACA) Medicaid expansion since 2014, 68,000 more adults under age 65 years were enrolled in Rhode Island Medicaid as of December 2015, a 78% increase from 2013 enrollment. This report assesses changes in dental utilization associated with this expansion.

METHODS: Medicaid enrollment and dental claims for calendar years 2012–2015 were extracted from the RI Medicaid Management Information System. Among adults aged 18–64 years, annual numbers and percentages of Medicaid enrollees who received any dental service were summarized. Additionally, dental service claims were assessed by provider type (private practice or health center).

RESULTS: Although 15,000 more adults utilized dental services by the end of 2015, the annual percentage of Medicaid enrollees who received any dental services decreased over the reporting periods, compared to pre-ACA years (2012–13: 39%, 2014: 35%, 2015: 32%). From 2012 to 2015, dental patient increases in community health centers were larger than in private dental offices (78% vs. 34%). Contrary to the Medicaid population increase, the number of dentists that submitted Medicaid claims decreased, particularly among dentists in private dental offices; the percentage of RI private dentists who provided any dental service to adult Medicaid enrollees decreased from 29% in 2012 to 21% in 2015.

CONCLUSION: Implementation of Medicaid expansion has played a critical role in increasing the number of Rhode Islanders with dental coverage, particularly among low-income adults under age 65. However, policymakers must address the persistent and worsening shortage of dental providers that accept Medicaid to provide a more accessible source of oral healthcare for all Rhode Islanders.

INTRODUCTION

According to statewide health behavior surveys in 2012, more than one quarter of Rhode Island adults younger than 65 years were estimated to be without dental insurance coverage, and they were more likely not to have received preventive or treatment dental care than insured adults.[1]

Beginning in January 2014, all Rhode Island adults with incomes at or below 138% of the federal poverty level became eligible through the ACA for Medicaid that includes a comprehensive adult dental benefit, with diagnostic, preventive, restorative, periodontal, surgical, prosthetic, and limited endodontic services. Unlike commercial dental insurance, there are no patient deductibles or co-pays. Before this expansion, Rhode Island Medicaid eligibility for adults was limited to adults with disabilities, pregnant women, and parents of Medicaid-enrolled children. Attributed mostly to the Medicaid expansion, approximately 68,000 more adults, aged 18–64 years, were enrolled in Medicaid in 2015, compared to 2013 enrollment. This number represents 8% of Rhode Island adults who were most likely medically and dentally uninsured before the ACA.

Expectations of the impact of ACA coverage expansion on dental care usage were tempered nationally with the understanding that the capacity to treat patients with Medicaid coverage is low.[2] With the goals of addressing barriers in obtaining dental care among Rhode Island Medicaid enrollees, this report assesses: (1) to what extent Medicaid expansion improved utilization of Medicaid-covered dental services; (2) where these services were received, in private or public dental care settings; and (3) if Medicaid participating dentists increased in the post-expansion era, in parallel with the enrollment change.

METHODS

For calendar years 2012–2015, Medicaid enrollment, among adults aged 18-64 years, and dental claims were extracted from the Rhode Island Medicaid Management Information System. Annual *unduplicated* numbers and percentages of Medicaid enrollees who received any dental service were summarized by calendar year. Additionally, dental services claims were assessed by provider type (private practice or health center). The Rhode Island Dental Safety Net Survey[3] and Health Resources and Services Administration (HRSA) Health Center Report[4] were used to determine FTE dentists at federally qualified health centers (FQHCs). The Rhode Island Licensure Database[5] was used to determine the total number of licensed dentists in private offices, for the corresponding study period. Based on these data, the ratios were calculated of Medicaid enrollees who received dental services to dentists who provided dental services.

RESULTS

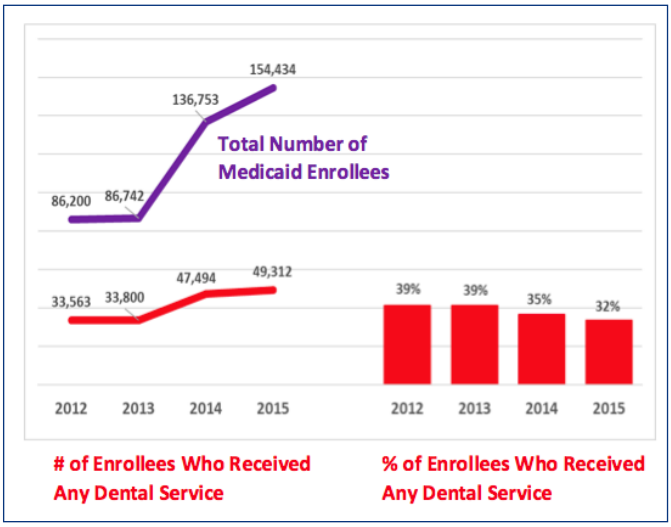
The number of adult Medicaid enrollees increased from 86,742 in 2013 to 136,753 in 2014, and to 154,434 in 2015, a total increase of 78% (**Figure 1**). However, between 2013 and 2015, the change in the number of enrollees who received any dental service at least once in a year was a 46% increase (33,800 to 49,312), not parallel with that of the enrollment change (**Figure 1**). Accordingly, the percentage of enrollees who received dental care dropped from 39% in 2013 to 32% in 2015 (**Figure 1**).

In the post-expansion years, the volume of patients with Medicaid increased both in private dental offices and the FQHCs. While more patients received dental treatment from private dental providers across the study period, the extent of increase in patient numbers at the FQHCs was far greater (78% increase from 2012 to 2015) than at private practices (34% increase) (**Figure 2**).

FQHCs typically see three times more Medicaid enrollees per dentist than private practice dental offices. Rhode Island FQHCs increased their number of dentists from 29 FTEs in 2012 to 35 FTEs in 2015 (**Figure 3**, graph in left). Compared to 2013, the year before the expansion, 250 and 170 more Medicaid-enrollees were treated per dentist in FQHCs in 2014 and 2015, respectively (**Figure 4**, graph in left).

Meanwhile, the number of dentists in dental offices who submitted any Medicaid claim dropped from 163 (29% of all RI licensed dentists) to 121 (21%) (**Figure 3**, graph in right). Consequently, the Medicaid-enrolled patient allocation to each Medicaid participating dentist increased from 132 enrollees per dentist in 2012 to 238 in 2015 (**Figure 4**, graph in right).

Figure 1. Rhode Island Adults' (age 18–64 years) Medicaid Enrollment* and Number & Percentage of Enrollees Who Received Any Dental Service, 2012–2015



* calendar year monthly enrollments averaged

Figure 2. Rhode Island Adult Medicaid Enrollees Age 18–64 Years Who Received Any Dental Service by Provider Type, 2012–2015

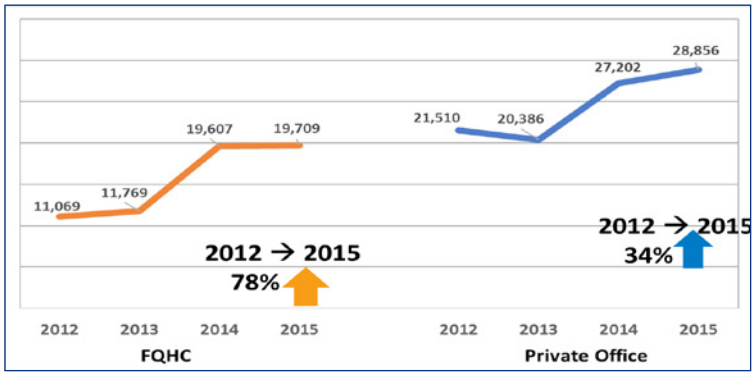


Figure 3. Number of Dentist FTEs in FQHCs (left) and Number of Dentists Practicing in Private Office Who Submitted Any Medicaid Claim (right)

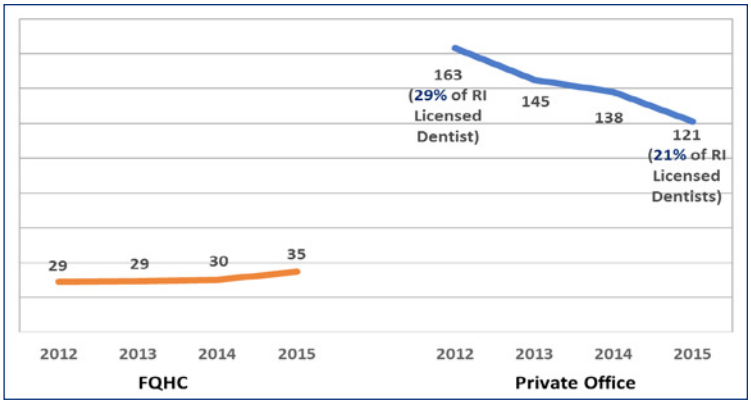
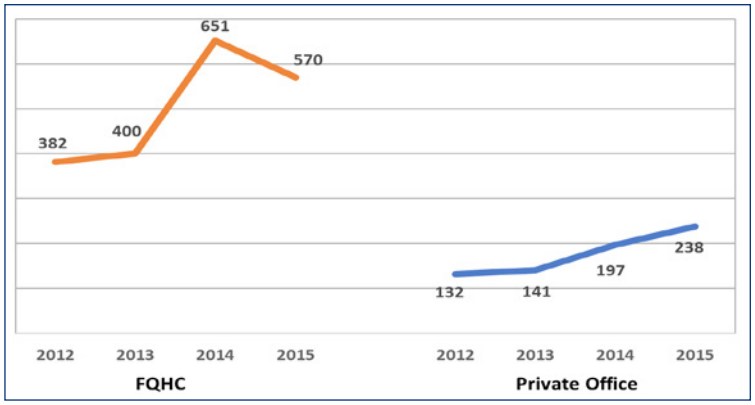


Figure 4. Ratios of [Medicaid enrollees who received any dental service] to [Dentists who submitted any claim] by Provider Type



DISCUSSION

As anticipated, the number of Medicaid enrollees increased after expansion, and so did the number of enrollees receiving dental services. Unfortunately, even with a comprehensive dental benefit, Medicaid enrollees' low dental service utilization has been a persistent issue in the post-expansion years. The fact that the percentage of enrollees receiving dental services *decreased* could be due to a combination of several factors: enrollees' insufficient knowledge of their dental benefits, including information on how and where dental services are obtained, and dental providers' reduced participation in Medicaid program.

Dentists in private practice have not observed an increase in reimbursement rates since 1992. With current reimbursement at roughly 25% of dental fees,[6] dentists have little incentive to accept Medicaid in their dental offices. Fortunately, a network of Rhode Island FQHCs have taken on an important dental safety net role.[3,7] FQHCs' dental providers perform a disproportionately large volume of services to Medicaid enrollees. This, again, is likely due to economics, as the reimbursement rate for dentists in private practice via fee-for-service tends to be lower than the FQHC's encounter rate.

When dentists have little financial incentive to participate in Medicaid, as reflected by the decreasing number of Medicaid participating dentists in this report, those remaining will see more requests for care. Without a balanced supply of dentists in Medicaid to meet the increasing demand of care, it is likely that many dentists have reached their capacity and have little motivation to bring in new patients. Dentists participating in Medicaid strive for a patient mix in their schedule which allows them to maintain financial viability. They may choose to provide care for as few or as many patients with Medicaid as they wish, largely dictated by appointment availability.

The FQHC situation is dissimilar in that they receive rates that allow them to survive financially, and are incentivized to provide care and hire additional staff to meet rising needs. The increase in the number of dentists at FQHCs does not give the full picture, as recent safety net data also show increases in dental hygienists and dental assistants at these sites.[7] All of these efforts improve capacity to address the needs of the growing population of Medicaid enrollees seeking care. FQHCs may also have incentives to focus their payor mix on certain populations based on their mission and their grant funder requirements. Some have focused more on children, some have sought to increase access to infants and pregnant women, while others conform to the needs and demographics of their community or agency. This targeted-population approach may be a barrier to improved access for some adult Medicaid beneficiaries.

Finally, limitations of this study should be acknowledged. Reasons for dental visit, types of dental service provided (such as preventive vs. treatment, simple vs. complicated, or routine vs. emergent), and frequency of visits were not weighted in differentiation. Therefore, further studies to understand the true driving forces in dental utilization change that followed the Medicaid expansion are warranted. In addition, the extent of charity care, or unreimbursed care that is known anecdotally to contribute to bridging the dental service gap for low-income underserved population is not quantifiable.

CONCLUSIONS

While the ACA did increase the number of adult enrollees, the dental system did not see as great an upturn as may have been expected. This is likely a reflection of capacity and reimbursement, with dentists in private offices reducing their participation and having little incentive to take on more patients due to low reimbursement. While it is anticipated that the FQHCs will continue to attempt to meet demand, their ability to do so may be more difficult due to challenges in growth, primarily related to dentist and dental auxiliary recruitment and retention. Ideally, the private practices would respond to increased demand, but this will likely only come with increased reimbursement rates. The patient awareness of dental benefits is still unknown, and likely increased medical-dental integration will encourage non-dental providers to refer in greater numbers for dental care. If that happens, the overarching question of concern is whether the dental community will be able to meet that demand.

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