



The Deficit Reduction Act of 2005: What Does It Mean For Children's Dentists?

How does DRA change pediatric dental care?

The Deficit Reduction Act of 2005 (DRA) includes a number of changes in Medicaid that are designed to cut program spending by \$7 billion over the next five years. While making these cuts, Congress also stated its intention to keep the pediatric EPSDT¹ benefit intact. This is important to dentists because EPSDT contains Medicaid's comprehensive dental benefit for children from birth to age 21. Putting the projected savings side-by-side with the guarantee of continued coverage raises the question for dentists: "How can Medicaid both cut costs by billions and still keep benefits unchanged?"

DRA does not explicitly change EPSDT. In fact, it appears to strengthen EPSDT by requiring states to provide wrap around EPSDT benefits to any new Medicaid approach. However, dentist shouldn't dismiss potential changes. DRA provides states with many new options for designing and managing Medicaid programs that are intended to limit spending. The details of these changes are what may create significant problems for dentists in their daily practices.

Dentists have reported many problems with Medicaid in the past – particularly burdensome paperwork and low fees. DRA wasn't created to address either of these issues. In the 39 years between the start of EPSDT and enactment of DRA, dentists have been assured two things: 1) all children in Medicaid receive comprehensive dental coverage with few exclusions and little need for prior authorization and 2) dentists will be paid the full Medicaid fee by the state or its vendor (third party administrator or managed care company). DRA changes provisions for comprehensive coverage and full payment.

Comprehensive Coverage?

Under state options in DRA, dentists will need to know with certainty what Medicaid plan a child is on when the child presents to the office for care. States have new authority to 1) develop different plans in different parts of the state, 2) offer different benefits to different children, and 3) move children from one plan to another at any time during the year. Before starting care at any particular visit, dentists may need to find out which plan covers a particular child at the particular time so that they will know what dental services are covered.

This issue is expected to arise first in West Virginia because it was one of the first two states granted federal permission for a new Medicaid approach. This new approach shows how good intentions (increasing parent involvement in their children's care) can inadvertently lead to problems for dentists (knowing what coverage the child has on any given day).

West Virginia will place children from three rural counties into a new "basic" Medicaid plan. The "basic" plan includes only two dental exams a year. Parents may then take action by signing a "Medicaid membership agreement²" to qualify their children for the "enhanced" Medicaid benefit. The "enhanced" plan includes additional, but unspecified, dental services that will likely provide for comprehensive dental care. If parents fail to comply with their agreement, their children are reassigned back to the "basic" plan. Before starting treatment, the dentist would need to know whether that particular child obtained Medicaid in one of the three counties *and* whether the child was enrolled by their parent in the "enhanced" plan, *and* whether the child continues to be

¹ Created in 1967, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is the Medicaid benefit package for children under age 21. EPSDT includes comprehensive health and developmental assessments including vision, dental and hearing. Services include preventive screenings and diagnostic and treatment services to ameliorate any acute or chronic condition found during the assessment (even if the services would not otherwise be covered in Medicaid).

² By signing the Medicaid membership agreement the member (or parent) agrees to such things as staying healthy, read information given to them from their doctor, show up to appointments on time, use the emergency room only for emergencies and change your address and phone number.

covered by the “enhanced” plan – in order to know whether that child is insured for only two exams or for comprehensive care.

Full payment?

The second problem relates to collections and ethical responsibilities of the dentist.

States have new authority to expand and enforce cost-sharing for some beneficiaries. States can require some Medicaid families to pay premiums and to share in the cost of care through co-payments. These approaches are intended to expand coverage and increase parental involvement in their children’s care. In those states that elect these options, the greatest problem for dentists will be that their offices will need to collect part of the (already low) Medicaid fee directly from the parent in addition to the state or its vendor.

Dentists will also need to double check that the child continues to have coverage at the time of a visit as states can drop families in the premium-sharing plan that fail to pay their premiums.

Healthcare providers were also granted greater authority to terminate care when parents fail to pay deductibles, co-pays or fees. While helping stem bad collections, this also presents an ethical dilemma for dentists who will need to determine how they will balance their professional requirement to complete care with their business need to ensure collections from low-income families.

States also have the new option of establishing Health Opportunity Accounts through which low-income families will manage virtual health savings accounts to pay for some of their care. If states elect this option, dentists would need to know whether sufficient funds remain in the parent’s health account at any given time to pay for the child’s dental care. Because of the Congressional ESPDT wrap around assurance, there must be a plan for continuing coverage when an individual’s health account runs dry. While this meets Congressional intent to retain full EPSDT benefits, it will likely create difficulties for dentists as they seek to determine how to collect their fees while also depending on low-income parents to negotiate increasingly complex administrative policies and procedures.

What can pediatric dentists do now?

It is too early to know how these new state options will play out. For now, the only things certain for dentists is that nothing in Medicaid EPSDT will be certain and that states will explore ways to cut their costs. No longer will dentists automatically know that all children in Medicaid enjoy comprehensive dental coverage or that their full Medicaid fee will be paid directly by states or their third-party vendors.

For now, the best thing for dentists to do is to ask questions of their state Medicaid program officials and legislators about plans that their state may have for changing Medicaid. Since most states can now change their plans (through state plan amendments) without a public comment period, dentists will need to be proactive in working with their state policymakers. To help dentists work with their states, CDHP has developed a document entitled, “Top Ten Questions to Ask State Leaders About Medicaid and Coverage for Children’s Dental Care” available at www.cdhp.org.

For more information about DRA or assistance with educating policymakers in your state, please contact Meg Booth at the Children’s Dental Health Project at (202) 833-8288 x 206 or through our website at www.cdhp.org.