Louisiana dentists' attitudes toward the dental Medicaid program

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Abstract

Purpose: *This study was performed to determine factors associated with Louisiana dentists' participation in the Dental Medicaid Program.*

Methods: *Surveys were mailed to all pediatric and general dentists as reported by the Louisiana State Board of Licensing. A second mailing was made to non-respondents.*

Results: *Surveys from 956 of 1,926 dentists (50%) were returned. Of 607 general dentists and 40 pediatric dentists who treated dental Medicaid-enrolled children in the past year, 269 (44%) and 18 (45%), respectively, treated all Medicaid-enrolled children. Newly graduated dentists were more likely to be actively enrolled than their more established counterparts ($\chi^2=10.67$; $p=0.01$). Medicaid reimbursement levels were viewed as "much less" than private fees by 62%, "less" by 33%, and "the same" by 4% of the respondents. Broken appointments were the most prevalent reported problem (80%), followed by low fees (61%), patient non-compliance (59%), unreasonable denial of payments (57%), slow payment (44%), and complicated paperwork (42%). With the exception of the perceived importance of Medicaid reimbursement levels, active and inactive general and pediatric dentists' perceptions of the importance of Medicaid issues were not significantly different. These findings indicated that significantly more Medicaid-active general dentists who allocated ≥10% of their office visits to Medicaid-eligible children felt that slow payment ($p=0.002$) and complicated paperwork ($p<0.001$) were more important problems than general dentists who allocated less time to Medicaid-eligible children.*

Conclusions: *Louisiana dentists' sources of dissatisfaction with Medicaid are similar to those of dentists in other states. Some of the issues are programmatic and are within the power of the dental Medicaid director and state legislature to address. Patient-related issues such as frequent broken appointments may be addressed by assigning case managers to Medicaid beneficiaries. (Pediatr Dent 23:395-400, 2001)*

Medicaid is a joint federal-state entitlement program that pays for health care for low-income persons. In 1967, Congress enacted *Public Law 20-248* establishing Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Service (EPSDT). An amendment in 1972 mandated the implementation, but specific guidelines for the dental component were not developed until 1980. Additional amendments (OBRA 1989, Omnibus Budget Reconciliation Act of 1989, Public Law 101-239) greatly strengthened the EPSDT provisions for services.[1,2]

According to the Department of Health and Human Services Office of Inspector General (OIG) report published in April 1996,[3] Louisiana, as all other states, failed to adequately provide preventive dental services to its Medicaid-eligible children under 21, as specified by the EPSDT program provisions. For example, in the 1993 Fiscal Year, preventive dental services were provided to 26% of eligible children in Louisiana, 12% in Mississippi, and 12% in Texas.[3] Only one in every five (4.2 million out of 21.2 million) Medicaid-enrolled children received EPSDT preventive dental services in 1993, a decrease from the 22% who received services in 1992.[3] In 1993, three-fourths of the states provided EPSDT preventive services to fewer than 30% of all Medicaid-eligible children. In a survey of dental Medicaid program managers in 41 states, Epstein[4] found that the percent of enrolled (registered with the program) dentists in 1998 ranged from zero to 100 with a mean of 60% (±27) (This category is not based on whether a dentist has treated a Medicaid-eligible child). Four states (Alabama, Delaware, Oklahoma, Tennessee, and Virginia) had less than a 25% enrollment rate. Louisiana reported an enrollment rate of 80%.[4]

The National Medical Expenditures Survey data show that health expenditures for U.S. children ages 6-18 has almost approached the 30% mark,[5] while only 2.3% of child health expenditures target dental care. A review of Medicaid State Reports demonstrated this trend for the period FY 1985-1995.[6] In Louisiana, the proportion of funding for children's dental services ages 1-19 represent, on average was less than 1% of the overall Louisiana Medicaid budget since 1990.[7]

Studies have been done in California,[8] Iowa,[9] Ohio,[10] Texas,[11] and Washington[12] on dentists' attitudes toward Medicaid programs with generally similar results. Many dentists limit their acceptance of Medicaid-enrolled children. Some of the reasons cited for this reluctance were low reimbursement rates, excessive paperwork, denial of reimbursement, bureaucratic complexities, significant coverage limitations, broken appointments, and need for prior approval.

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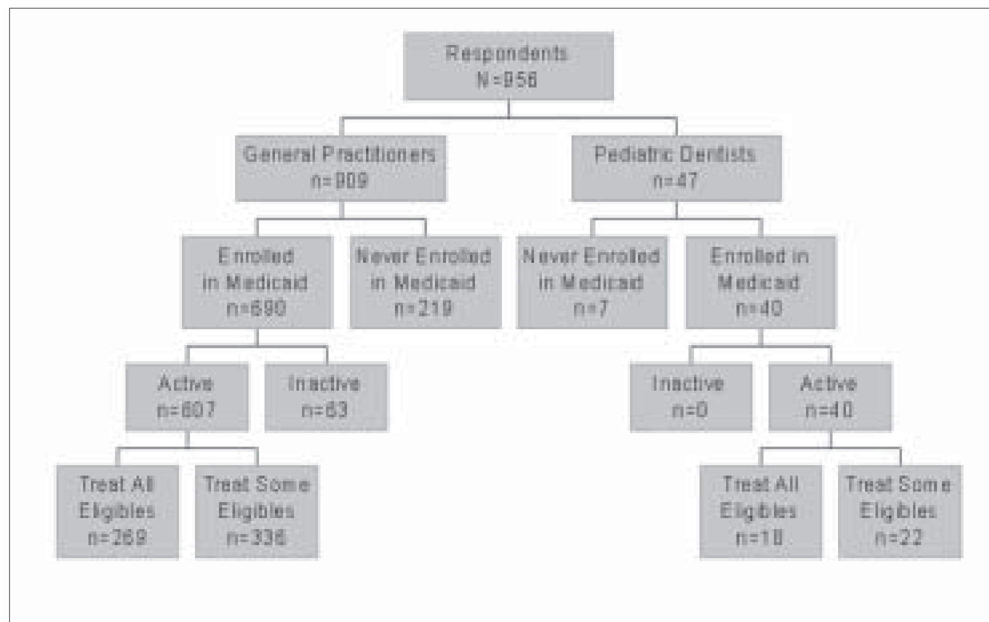

Fig 1. Medicaid enrollment and treatment practices of general practitioners and pediatric dentists

Table 1. Proportion of Active Provider* Office Visits by Medicaid-Eligible Children, By Practice Type

Percent of office visits	n	Percent
General practitioners	525	
< 1 %	76	15
1 %	62	12
1 to >5%	39	7
5 to >10 %	92	18
10 to >20%	167	32
20 to >30%	42	8
30 to > 40%	15	3
40 to > 50%	8	2
≥ 50%	24	5
Pediatric Dentists	40	
< 10%	4	10
10 to >20%	10	25
20 to >30%	10	25
30 to >50%	5	13
≥ 50%	11	28

*Treated at least one Medicaid-eligible child in past year

In response to the findings of the OIG Report and other state surveys, the Louisiana Oral Health Program Director and Dental Medicaid Director commissioned a survey of general and pediatric dentists to describe their perceptions of the EPSDT dental program and to solicit their suggestions to improve the program.

Methods

A self-administered 41-item questionnaire was developed for Louisiana using questions from the California,[8] Iowa,[9] Ohio,[10] and Texas[11] studies and questions suggested by the Oral Program Director, Dental Medicaid Director, and Louisiana Dental Society. The survey was pretested on 12 practicing dentists. After minor modifications were made, the survey was mailed to all licensed and practicing pediatric and general dentists. Since a national definition of dentists' Medicaid activity level coud not be identified, dentists were clasified as being active (treated at least one Medicaid-eligible child within the year), inactive (enrolled but did not treat a Medicaid-eligible child in the past year), and never enrolled in the Medicaid program.

The survey focused on pediatric and general dentists since they provide the majority of care covered by the Dental Medicaid Program. The mailing addresses for all dentists were obtained from the Louisiana State Board of Dentistry licensing database. The sampling frame comprised 1,608 dentists with 1) a Louisiana dental license 2) who listed Louisiana as a primary practice location and 3) who listed their specialty as pediatric dentistry (n=63) or were general dentists (n=1,545). In addition, 381 dentists who did not report their type of practice but met criteria 1 and 2 were included for a total sample of 1,926. Respondents who left the practice type blank were considered to be general practitioners. Crosschecking with the licensing database and the Dental Medicaid Director validated this decision. Mailing labels were produced for the dentists in the sampling frame and each was assigned a unique identification number to prevent duplicate mailings. Attached to the survey was a letter signed by the president of the Louisiana Dental Association that explained the goals of the survey and requested full participation. These were mailed with a postage-paid return envelope. The initial mailing was completed on January 22, 1997. A second mailing to all non-respondents was initiated on March 4, 1997, with a cover letter signed by

Table 2. Medicaid Providers' Perception of Issues as Important or Very Important *

	General dentists			Pediatric dentists		
	n	%	Rank	n	%	Rank
Broken appointments	728	90	1	41	95	1
Low fees	646	80	2	37	84	2
Patient non-compliance	614	78	3	36	84	3
Denial of payments	593	76	4	26	59	4
Slow payment	473	60	6	13	33	8
Complicated paperwork	457	57	7	23	52	5
Too few practices in area accept Medicaid-eligible children	147	19	10	11	26	10
Prior approval required	476	60	5	15	35	7
Frequently changing regulations	406	52	8	13	31	9
Intermittent patient eligibility	369	48	9	18	42	6

* Spearman's correlation=0.87; p<0.001

Table 3. General Dentists' Perceiving Problems with Dental Medicaid Program to Be Important by Proportion of Office Visits Allocated to Medicaid-Eligible Children

	≤10%				>10%					
	Yes	No	%	Rank*	Yes	No	%	Rank*	Chi square	*P*
Broken appointments	299	35	90	2	158	15	91	1	0.419	0.517
Low fees	257	78	77	3	136	37	79	2	2.770	0.096
Patient non-compliance	241	86	74	4	130	40	77	3	0.454	0.501
Denial of payments	237	90	73	5	125	47	73	4	0.002	0.963
Prior approval required	327	135	59	1	86	83	51	5	0.232	0.628
Slow payment	187	140	57	6	74	99	43	6	9.418	0.002
Frequently changing regulations	140	186	43	8	70	103	41	7	0.286	0.593
Intermittent patient eligibility	140	180	44	8	69	103	40	8	0.601	0.437
Complicated paperwork	180	151	54	7	55	118	32	9	23.29	<0.0001
Too few practices in area accept Medicaid-eligible children	45	269	14	9	14	158	8	10	3.99	0.046

* Spearman's Correlation = 0.834; p=0.003

the Dental Medicaid Director and the Louisiana Oral Health Program Director.

The data were entered in a Microsoft Excel® spreadsheet. Statistical analysis was performed using PC-SAS®. Approximately one quarter of all the data were verified for coding accuracy and the error rate was found to be less than one percent.

Results

Characteristics of the sample

Of 1,926 questionnaires sent out, 956 were returned for a 50% response rate. Of the 953 questionnaires for which there was no response, 827 were not returned, 76 were returned because of no forwarding address, and 21 because the addressee was deceased. Since respondents did not answer every question, the number of responses varies. General dentists and pediatric dentists comprised 909 (95%) and 47 (5%) of the respondents, respectively. Dentists' years in practice ranged from one to 56 ($\bar{x}$=14.6±10). Figure 1 shows the breakdown of the 956 respondents by enrollment status. Of the 909 general practitioners, 690 (76%) were enrolled with 607 (88%) having seen at least one Medicaid-eligible child in the past year. Of the 607 active general practitioners, 269 (44%) treated Medicaid-eligible children. Of the 47 pediatric dentists who responded, 40 (85%) were enrolled and active, with 18 (45%) not limiting the number of Medicaid-enrolled children they treat.

Active Dental Medicaid participants

Newly graduated general dentists were more likely to be actively enrolled than their more established counterparts. Years of practice were categorized as less than three, three to six, seven to 10, and over 10. The association between years of practice and active enrollment was statistically significant for all respondents (χ^2 =10.67; df=3; p=0.014). Pearson's correlation between years of practice and proportion of office visits by Medicaid-eligible children was weak for general practitioners (r=-0.17; p=0.27) and pediatric dentists (r=-0.04; p=0.02).

Table 1 shows the proportion of office visits by Medicaid-eligible children for dentists who saw at least one Medicaid-enrolled child in the past year. Forty of 45 (89%) pediatric dentists indicated they were active. Of these, more than half allocated 20% or more of their office visits to Medicaid-enrolled children. Approximately 25% of active general dentists allocated 1% or less of their office visits to Medicaid-enrolled children.

Dentists' Perception of Medicaid program

Respondents were asked to identify three barriers to access to dental care for Medicaid-eligible children. They were: 1) lack of money/insurance (75%); 2) low priority allocated to dental care (63%); and 3) patients' low dental IQ (61%). Almost two-thirds (64%) believed that Louisiana's Medicaid system is taking care of individuals who have difficulty obtaining dental care. The majority of respondents (72%) felt children should first be seen by two years of age.

Dentists were asked to rank a series of Medicated-related issues raised in other Medicaid surveys on a scale of 1 (not important) to 5 (very important). The issues were 1) broken appointments, 2) low fees, 3) patient non-compliance, 4) frequent denial of payments, 5) requirement for prior approval, 6) slow payment, 7) frequently changing regulations, 8) intermittent patient eligibility, 9) complicated paperwork, and 10) too few practices accept Medicaid-enrolled children. The chi square test was used to compare non-enrolled and enrolled dentists' perceived importance of the issues. With the exception of broken appointments (p=0.56), non-enrolled dentists felt that the issues were more important than enrolled dentists (p<0.001 for all tests).

Table 2 shows the proportion of respondents who rated Medicaid-related issues as important and very important. Broken appointments, low fees, and patient non-compliance, respectively, were the issues about which respondents felt most strongly. The rankings for general dentists and pediatric dentists were similar (Spearman's correlation = 0.872, p<0.001).

To examine the association between the extent of EPSDT participation and attitudes toward the program, general dentists were divided by the percent of their practice that is EPSDT (≥10% and <10%) and the five-level salience scale was compressed to two levels: important (very important and important) and not important (the remaining three levels). Table 3 shows general dentists' perceived importance of problems with the dental Medicaid program by the proportion of their office visits allocated to Medicaid-enrolled children. General dentists with ≥10% of their office visits allocated to Medicaid-enrolled children ranked the importance of problems similarly to those with less than 10% of their office visits allocated to Medicaid-

Table 4. Pediatric Dentists' Perceiving Problems with Dental Medicaid Program to Be Important by Proportion Office Visits Allocated to Medicaid-Eligible Children *

	≤10%				>10%			
	Yes	No	%	Rank**	Yes	No	%	Rank**
Broken appointments	5	0	100	1	31	2	94	1
Low fees	3	2	60	3	29	5	85	2
Patient non-compliance	3	2	60	3	28	5	85	3
Denial of payments	4	1	80	2	18	16	53	4
Prior approval required	1	4	20	5	10	23	30	7
Slow payment	1	3	25	5	9	23	28	8
Frequently changing regulations	2	2	50	4	7	26	21	10
Intermittent patient eligibility	2	3	40	4	13	20	39	6
Complicated paperwork	4	1	80	2	15	19	44	5
Too few practices in area accept Medicaid-eligible children	1	3	25	5	8	26	24	9

*No significant differences based on Fisher's Exact Test (p>0.1 for all tests)
** Spearman's Correlation = 0.839; p=0.002

enrolled children (Spearman's correlation = 0.834; p=0.003). While the rankings were similar, when the problems were looked at individually, significant differences were found in the proportions of general dentists who ranked three problems: slow payment (χ^2=9.42; p=0.002), complicated paperwork (χ^2=23.29; p=<0.001), and too few practices in the area accepting Medicaid-eligible children (χ^2=3.99; p=0.046).

Table 4 compares pediatric dentists' attitudes to the Medicaid program by proportion of office visits allocated to Medicaid-eligible children. As with the general dentists, the rankings of the importance of problems were substantially similar (Spearman's correlation = 0.839; p=0.002), however the proportions of pediatric dentists who felt the problems were important or very important in the two groups was not significantly different (Fisher's Exact Test, p<0.1 for all tests).

Table 5 presents dentists' comparisons of the Medicaid program to private dental insurance with respect to reimbursement levels, paperwork complexity, reimbursement speed, and number of services covered. Active and inactive general dentists' perceptions were not significantly different except for Medicaid reimbursement levels (χ^2=10.8; p<0.001). There was no significant difference between active and inactive pediatric dentists' comparisons (Fisher's exact test, p>0.1 for all tests).

Enrolled inactive dentists were asked whether they would consider participating in the Medicaid program if the fees were brought closer to a level to their usual and customary fees. Only 24% percent would consider participating while 49% would participate only if other changes were also made in the program. Twenty-seven percent of enrolled inactive dentists would not participate under any circumstances.

Table 6 compares dentists' attitudes toward EPSDT from statewide studies in Texas, Ohio, California, Iowa, and Washington to this Louisiana study. Dentists' rankings of Medicaid-related issues were not significantly different among the six studies (Kruskal-Wallis test, p=0.324).

Table 5. Comparison of Dental Medicaid Program to Private Dental Insurance

	General Dentists		Pediatric Dentists	
	Active	Inactive	Active	Inactive
Reimbursement much less	455/472 96%	45/48 94%	37/39 95%	2/2 100%
Paperwork more complex	232/473 49%	28/47 60%	22/39 56%	1/2 50%
Slower reimbursement	194/471 41%	30/45 67%	12/39 30%	2/2 100%
Fewer services covered	371/472 79%	34/46 74%	28/39 72%	2/2 100%

Discussion

The data show a low satisfaction level with the dental Medicaid program. Sources of dissatisfaction are in three dimensions: economic (low fees); patient-related (high broken appointment rates, non-compliance with instructions); and programmatic (denial of payments, slow payment, and complicated paperwork). These findings are consistent with the California,[8] Iowa,[9] Ohio,[10] Texas,[11] and Washington[12] surveys. While these problems may be endemic, the results of this survey suggest ways to make participation in the Dental Medicaid Program more attractive to Louisiana's private practitioners.

Dental Medicaid programs, due to the low level of funding in all states, often set reimbursements below what most private practitioners charge[3,4]. Louisiana dentists, as well as those in California,[8] Iowa,[9] Ohio,[10] Texas,[11] and Washington,[12] consistently reported that low fees were a major problem. While the data suggest that increasing fees would encourage dentists to increase their Medicaid activity level, a North Carolina study by Mayer *et al.*[13] found that small increases in rates did not materially improve access to care for Medicaid beneficiaries. However, Epstein,[4] makes the point that even dramatic rate increases may not be effective at increasing the number of participating dentists "if the resulting rates are inferior to prevailing market rates (less than the 70th percentile), or most importantly, less than the costs of delivering care."[4] Of 41 states surveyed, 34 indicated that raising rates was among their approaches to increasing access to dental care for Medicaid-eligible children.[4]

Increasing reimbursement levels alone will not increase dentist participation substantially. In the study, 24% of enrolled inactive dentists reported they would consider participating in the Medicaid program if the rates were brought to their usual and customary fees, 49% would participate only if changes in addition to raising rates were made in the program, and 27% would not participate under any circumstances.

Edelstein[14] describes five factors which may explain dentists' responses to fee increases: 1) whether the increase is considered sufficient; 2) whether the increase compensates for inflationary erosion; 3) dentist's level of satisfaction with past Medicaid experience; 4) concomitant changes in program design such as implementation of managed care or streamlining claims processing; and 5) strength of the economy and dentists' business.

In addition to low rates, dentists were concerned with Medicaid patients' behavior. Some respondents stated that Medicaid recipients are often unruly and bring too many family members

Table 6. Rank-Ordered Dentists' Sources of Dissatisfaction With Dental Medicaid Programs: A Comparison of Five Statewide Surveys

Sources of dissatisfaction	State					
	California[8]	Iowa[9]	Ohio[10]	Texas[11]	Washington[12]	Louisiana
Low reimbursement	1	1	1	2	2	2
Broken appointments	3	2	3	1	7	1
Patient noncompliance		3				3
Complicated paperwork	5	5	2	4		6
Slow payments	7	7	3	3	1	5
Denial of payments	2	4		5		
Need for prior approval	6	9			5	8
Hard to get questions answered					3	
Dealing with third party coverage					4	
Too few services covered	4					
Changing regulations		10				9
Intermittent eligibility		6				10
Co-payments		11				
Slow appeals process				6		
Payment errors					6	

to the appointment to the annoyance of other patients. Broken appointments and patient non-compliance with instructions ranked among the top three concerns of dentists in 5 of 6 states surveyed. Broken appointments could be the result of unreliable transportation or a patient's not having access to a telephone to cancel an appointment. Patient non-compliance could be due to low education level or patients' not understanding English. While EPSDT regulations require that states assist families to acquire care for their children through case management, often, states are underfunded and understaffed to address all of the case management needs.

The state Medicaid program could strengthen the case management contract language if appropriate and also consider targeted case management for populations of special needs. States could also enhance their informing processes required at enrollment and annually to stress what assistance is available. Translation service availability also needs to be provided. A case manager assigned to a Medicaid-eligible family could serve as a liaison between the patient or parent and the dentist.

Intermittent eligibility was also of concern as an administrative burden for billing practices. States have the option to define the frequency of eligibility renewal up to 1 year and to define the factors that affect it in the interim. Some states review eligibility as often as monthly or quarterly. Billing practices and rules can also be modified by the state to decrease the providers' financial risk/burden, e.g., allowing them to bill for a crown following the first appointment even though the process may take multiple visits.

The proportion of dentists enrolled in the Medicaid program does not tell the whole story. Active dentists allocate different proportions of their chair time to Medicaid-enrolled children. While general dentists' rankings of the importance of problems do not differ significantly by the proportion of office visits allocated to Medicaid-eligible children (Table 3), perception of slow payment, complicated paperwork, and too few patients accepting Medicaid-eligible children did differ. State policy makers can address programmatic characteristics. Damiano et al.[9] described these as the "hassle factor." In all cases, general dentists in the $\geq$ 10% Medicaid-eligible children group felt these issues were more important than those in the <10% Medicaid-eligible children group. Perhaps dentists with higher Medicaid volumes have trained their staffs to navigate the Medicaid system well so that payment delays are minimized.

Conclusion

Louisiana dentists reported a high level of dissatisfaction with the Medicaid Program, as have dentists with Medicaid programs in other states. This study and previous studies suggest that while reimbursement rates should be raised, that alone will not increase the number and activity level of active providers substantially. In addition 1) rates should be set at the market level, 2) programs should be streamlined by simplifying the claims process (using standard claims forms, terminology, and electronic filing and by reducing the amount of preauthorization), 3) the program's case management component should be strengthened, and 4) states should provide dentists with a contact to assist patients to navigate the health care system locally, usually through the eligibility contact specialist within the Medicaid program.

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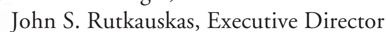

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