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## HEALTH POLICY PERSPECTIVES

# Is the number of Medicaid providers really that important?

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One of the most significant trends within the US health care system in the past decade is the remarkable increase in dental care use among children enrolled in Medicaid. Nationally, the percentage of children enrolled in Medicaid who visited a dentist within the past 12 months increased from 29% in 2000 to 48% in 2013, the latest year for which data are available. The trend is widespread across states, with all but 1 state experiencing an increase over this time frame. As a result, the gap in dental care use between children enrolled in Medicaid and those who are privately insured has been narrowing steadily. In fact, there are 2 states—Hawaii and Texas—where children enrolled in Medicaid are more likely to visit a dentist than are children with private dental benefits. Perhaps most significantly, this shift has been happening during a time when the number of children enrolled in Medicaid and the Children's Health Insurance Program has been increasing steadily. In 2013, nearly 4 of 10 children in the United States were enrolled in Medicaid or the Children's Health Insurance Program compared with 2 of 10 in 2000.<sup>1</sup>

What enabled this widespread improvement in access to dental care for children enrolled in Medicaid?

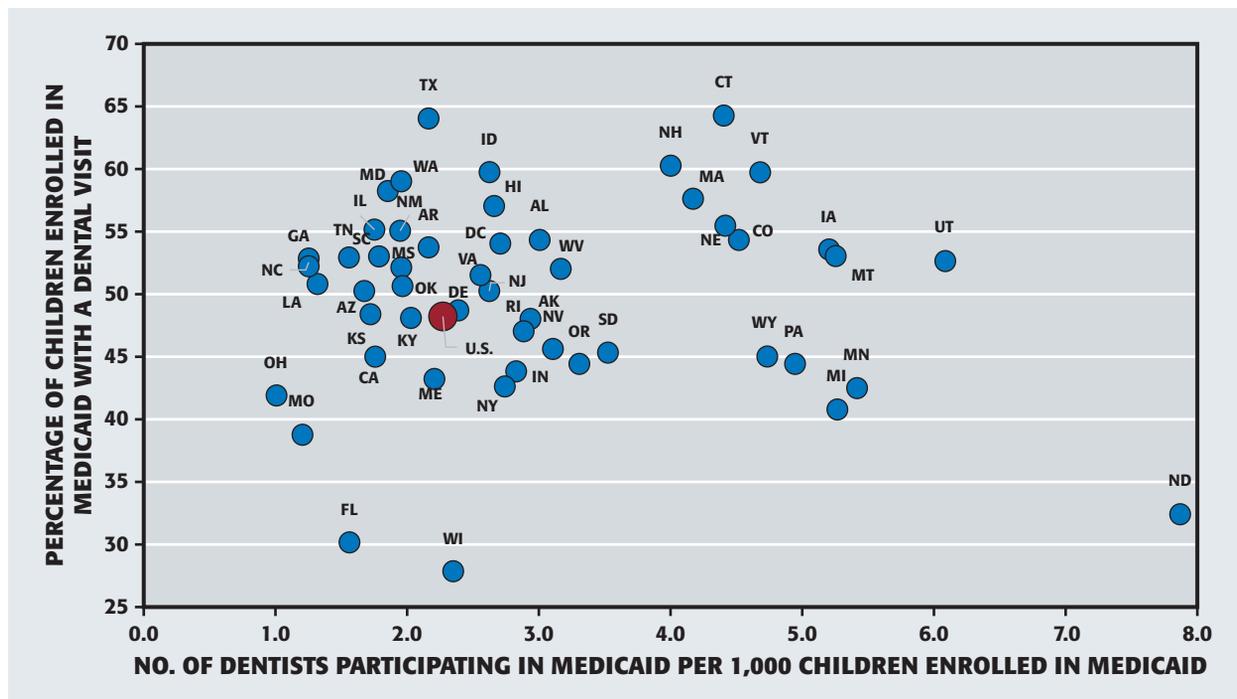
The evidence suggests a combination of things. Several states implemented comprehensive, multipronged reforms in their Medicaid dental programs. For example, the experiences in Connecticut, Maryland, and Texas have been well documented; the Medicaid programs in these states focused on provider and Medicaid beneficiary outreach, streamlining administrative procedures, and enhancing provider reimbursement.<sup>2</sup> In Michigan, the Healthy Kids Dental program integrated key aspects of the Medicaid program with private dental benefit plans and saw impressive gains.<sup>3</sup> In North Carolina, an innovative program increased collaboration between dentists and physicians.<sup>4</sup> Other policy reforms, such as increased reliance on managed care and the introduction of new types of dental care providers, have not been studied as thoroughly. Still, there were many innovations during the past decade that have been evaluated, and there is now a solid body of evidence for policy makers to draw on to make Medicaid work when it comes to improving access to dental care for children.

The topic I want to focus on in this month's column is the role the dentist workforce plays in driving access to care. During the past decade, although the number of children enrolled in Medicaid visiting a dentist has increased dramatically, the supply of dentists has not. In 2001, there were 57

dentists per 100,000 population in the United States, and this increased slightly to 60 by 2013.<sup>1</sup> There have been changes to the structure of dental practices over this period. Some commentators have argued that the growth of large group practices could be a key factor in expanding dental care use among low-income children,<sup>5</sup> along with the expansion of Federally Qualified Health Centers.<sup>6</sup> Some states, such as Alaska and Minnesota, have introduced new types of dental care providers, but it is still too early to tell whether this change has contributed to improvements in access to care.

An extremely important dentist workforce issue is the extent to which dentists participate in Medicaid. New data released by the American Dental Association Health Policy Institute indicate that, nationally, 42% of dentists participated in Medicaid for child dental services in 2014.<sup>1</sup> But it is when we look beyond national averages that the data start to tell an interesting—and surprising—story.

The figure summarizes data from *The Oral Health Care System: A State-by-State Analysis*,<sup>1</sup> a new initiative from the Health Policy Institute that compiles data from multiple sources on dental care use, sealant rates, access to fluoridated water, private dental benefit plan reimbursement, and, for the first time, the number of dentists participating in Medicaid. The figure<sup>1</sup> compares the number of dentists participating in Medicaid



**Figure.** Dental care use and the supply of Medicaid providers. AK: Alaska. AL: Alabama. AR: Arkansas. AZ: Arizona. CA: California. CO: Colorado. CT: Connecticut. DC: District of Columbia. DE: Delaware. FL: Florida. GA: Georgia. HI: Hawaii. IA: Iowa. ID: Idaho. IL: Illinois. IN: Indiana. KS: Kansas. KY: Kentucky. LA: Louisiana. MA: Massachusetts. MD: Maryland. ME: Maine. MI: Michigan. MN: Minnesota. MO: Missouri. MS: Mississippi. MT: Montana. NC: North Carolina. ND: North Dakota. NE: Nebraska. NH: New Hampshire. NJ: New Jersey. NM: New Mexico. NV: Nevada. NY: New York. OH: Ohio. OK: Oklahoma. OR: Oregon. PA: Pennsylvania. RI: Rhode Island. SC: South Carolina. SD: South Dakota. TN: Tennessee. TX: Texas. US: United States. UT: Utah. VA: Virginia. VT: Vermont. WA: Washington. WI: Wisconsin. WV: West Virginia. WY: Wyoming. *Source: American Dental Association.*<sup>1</sup>

(for child dental services) with the rate of dental care use among children enrolled in Medicaid for all states for which data are available. What is surprising, in my view, is that there is absolutely no correlation—in other words, there is a high degree of variation in the percentage of children enrolled in Medicaid who visit a dentist among states that have roughly the same supply of dentists participating in Medicaid. Take, for example, Texas and Wisconsin. These states have the same number of dentists participating in their Medicaid program, but dental care use among children enrolled in Medicaid in Texas is more than twice the rate in Wisconsin. Similarly, children enrolled in Medicaid in Georgia and Utah visit the dentist at a similar rate—above the national average—but the supply of dentists participating in Medicaid in Utah is 6 times higher than that in Georgia.

In my view, the [figure<sup>1</sup>](#) suggests that highly aggregated measures of the number of dentists participating in Medicaid are not that important on their own. There is no magic number of providers participating in Medicaid that is needed to reach some benchmark of access and use. Accordingly, policy makers ought to focus on a broader set of issues when thinking about how to improve access to dental care for children enrolled in Medicaid. I will get to what I think those are, but first, let us consider why the dots in the [figure<sup>1</sup>](#) are so scattered rather than along a smooth upward-sloping line. There are numerous factors to account for this, but I want to highlight the 3 that I think are most important.

First, there are limitations to the data. The definition of Medicaid participation in the [figure<sup>1</sup>](#) is based solely on whether a dentist enrolls in the Medicaid program. It is not

based on any sort of measure of the number of patients enrolled in Medicaid seen by the dentist, whether the dentist is accepting new patients, appointment waiting times, or anything of this nature. Study results show that dentists registered as Medicaid providers are not always available to patients enrolled in Medicaid.<sup>7,8</sup> There are other important shortcomings to the Medicaid participation data—as well as to the dental care use measure—that are noted elsewhere.<sup>1</sup> Nevertheless, the [figure<sup>1</sup>](#) draws on official Centers for Medicare and Medicaid Services data, and these data are the best that are available.

Second, the geographic distribution of dentists participating in Medicaid within a state is extremely important and is missing from the plot. Two states with a similar number of dentists participating in Medicaid might have those dentists

distributed differently within the state. Let us use Chicago, where I live, as an illustrative example. Suppose that a dentist located in Water Tower Place on Michigan Avenue decides to enroll as a Medicaid provider. This location probably will have less of an impact on access to dental care for children enrolled in Medicaid than if a dentist in Englewood on the south side of Chicago enrolls as a Medicaid provider. The proximity of Medicaid providers to Medicaid beneficiaries is critical, and this fact is lost in aggregated, state-wide data. Access is local.

Third, critical factors beyond provider availability play an important role in driving dental care use. For example, perceived need, convenience, and patient engagement are important reasons people do or do not seek dental care.<sup>9</sup> Imagine 2 households enrolled in Medicaid that are both less than 10 minutes from a dentist participating in Medicaid who is accepting new patients. One household takes their child for a dental checkup because the child's pediatrician strongly recommended it during the last well-child visit and helped the parents make an appointment. The other household does not take their child to the dentist, preferring to wait until the child's adult teeth start coming in. Access to a dentist participating in Medicaid is not an issue for either household, but dental care use patterns are different because of patient attitudes and behaviors.

Looking forward, there are 2 major areas that policy makers, researchers, and health care advocates need to focus on a lot more. First, when it comes to the supply side of the access equation, we need to start measuring the extent to which there are a sufficient number of dentists participating in Medicaid who are within reasonable travel times from Medicaid beneficiaries, who are accepting new patients, and who are

offering convenient appointment times. This trifecta needs to be the focus of future data and research efforts within the Centers for Medicare and Medicaid Services and other groups, including the Health Policy Institute. The provider adequacy debate is dominated by arcane concepts such as population-to-provider benchmarks at the county level that are outdated and largely uninformative.<sup>10</sup> We can do better, and we must develop data systems that measure and monitor what actually matters.

Second, along with the evidence-based comprehensive Medicaid program reforms needed to attract a sufficient supply of providers, we need to focus much more on policy interventions that target patient behavior—the demand side. This focus includes direct-to-beneficiary outreach, patient navigator services such as community dental health coordinators, and user-friendly tools to make it really easy to make an appointment with dentists participating in Medicaid.<sup>11</sup> These issues are particularly important for adults enrolled in Medicaid, who face much bigger challenges accessing dental care than do children. One account from 2015 of a Medicaid beneficiary's efforts to book a dental appointment is eye-opening.<sup>12</sup> Anecdotes aside, research shows that finding a dentist who accepts patients enrolled in Medicaid is a challenge, particularly for adults.<sup>9</sup> Numerous strategies can help beneficiaries better navigate the system, including interprofessional collaboration and cross-referrals between dental and medical professionals.<sup>13</sup> ■

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