



# CDHP State Summary: MICHIGAN HEALTHY KIDS DENTAL

## Historical Context<sup>i</sup>

In 1997–98, the Michigan Department of Community Health (MDCH), which administers Michigan's Medicaid program and SCHIP ("MIChild"), convened a Task Force to evaluate long standing problems in Medicaid's dental program. The Task Force proposed budgetary increases, new administrative options, and a new delivery system. With political support from a broad array of stakeholders, including primarily the Michigan Primary Care Association, University of Michigan Dental School and Michigan Dental Association, the state legislature appropriated \$10.9 million for FY 2000 to expand access to oral health services for Medicaid beneficiaries, focusing on rural areas. About half the appropriation was used to create a new Medicaid dental service delivery model, called *Healthy Kids Dental (HKD)*.

Prior to *HKD*, dentists provided Medicaid dental services on a fee-for-service basis outside of managed care arrangements that deliver medical care for most Medicaid clients. *Healthy Kids Dental*, implemented in May 2000, was based on the dental component in Michigan's State Children's Health Insurance Program (MIChild), which began in 1998 and, after its first year of operation had demonstrated dental access almost equal to that available for privately insured children. Like MIChild, *HKD* functions similar to commercial dental insurance. In establishing *HKD* as a demonstration within specific counties, the MDCH contracted with a dental insurance carrier, Delta Dental Plan of Michigan—a nonprofit service corporation that administers group dental benefits for more than 3 million people—to administer the Medicaid dental benefit in accordance with its own standard procedures, claim form, and payment levels and mechanisms. In May 2000, the state converted the traditional dental coverage of all Medicaid-enrolled children in 22 of Michigan's 83 counties to *HKD*.

By October 2000, as a result of the early success of *HKD*, the project was expanded to 15 more counties, bringing to 37 the number of counties participating. In 33 of the counties, Delta Dental used its DeltaPremier program; in remaining counties, the DeltaPreferred Option was used. Delta Dental pays individual dentists in its DeltaPremier network on a fee-for-service basis at 100 percent of each dentist's current usual and customary fee, (unless this amount exceeds the 80th percentile of the average reimbursement for that service for all participating dentists). In the DeltaPreferred Option network, dentists are reimbursed on a fee-for-service basis at a somewhat lower, but still commercially competitive rate using a fee schedule. *Healthy Kids Dental* enrollees receive a member identification card that looks very similar to that given to commercial enrollees and may use any Delta network dentist. In 2004, the number of *HKD* counties receiving the less costly DeltaPreferred Option was increased from four to eight, with a concomitant decrease in counties receiving DeltaPremier. Effective Jan 1 2006, MDCH announced that *HKD* and MIChild would utilize the Delta Preferred Option fee schedule (even if the dentist participated in the Premier network). The DeltaPreferred Option commercial fee schedule, though lower than DeltaPremier payments, provides significantly higher reimbursement than is available to Medicaid providers in non-*HKD* counties. On May 1, 2006, the MDCH announced it was expanding *HKD* to an additional 22 counties; the program now operates in a total of 59 Michigan counties, serving more than 200,000 children.

## Results

An assessment of the first 12 months of *HKD* found:<sup>ii</sup>

- Substantially more Medicaid beneficiaries were receiving dental care under the project, with dental visits increasing from 18 percent to 44 percent, compared to the traditional fee-for-service Medicaid program.
- More dentists were participating in *HKD* and providing care (up 300 percent), compared to the traditional fee-for-service Medicaid program.
- More children were receiving needed dental restorative and reparative care, and children are more likely to begin a pattern of regular recall for routine preventive care, compared with Medicaid-enrolled children the previous year.
- *HKD* had higher costs per user and per enrollee due to the higher reimbursement rates and, to a lesser extent, more children receiving care.

- More children were receiving care in their county of residence, with the average travel distance to dental care cut by more than half, to 12.1 miles—virtually identical to the mean 12.2 miles traveled by privately insured children.<sup>iii</sup>

During each succeeding year of *HKD* operation, dental utilization continued to increase.<sup>iv</sup> Children enrolled in the fourth year of the *HKD* achieved an average utilization rate of 58.6 percent (using different calculation methods) compared to the average use rate of 79.4 percent for children enrolled in the private sector Delta Dental program, and to 38.9 percent for traditional Medicaid, as measured prior to the program's inception. In August 2006, eight months after the change to payment under the DeltaPreferred Option, almost all previously enrolled dentists were continuing to participate in *HKD*.

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<sup>i</sup> Information for this summary was obtained primarily from the document: State innovations to improve access to oral health care for low income children: A Compendium Update. Chicago, American Dental Association. 2005. Available online at: <http://www.prnewswire.com/mnr/ada/20973/#>. Additional information was provided by the Michigan Medicaid Contact, Christine Farrell.

<sup>ii</sup> Eklund SA, Pittman JL, Clark SJ. Michigan Medicaid's Healthy Kids Dental program: an assessment of the first 12 months. JADA. 2003(134):1509–1515.

<sup>iii</sup> State and community models for improving access to dental care for the underserved: White Paper. October 2004. American Dental Association. Available at: [http://www.ada.org/prof/resources/topics/topics\\_access\\_whitepaper.pdf](http://www.ada.org/prof/resources/topics/topics_access_whitepaper.pdf)

<sup>iv</sup> Data provided by C Farrell, Michigan Department of Community Health. Data analysis provided by S Eklund, University of Michigan School of Dentistry. Personal Communication, 2005