

Legislative Process: OHCD

September 10, 2003



Federal/ State Programs



- Government accepts the paradigm of health care as a right- 1960's and 1970's
 - ◆ The War on Poverty
- The War on Poverty “ends” in 1980
 - ◆ Cost containment
- The 1990's Health Care as a Right re-examined within the context of cost

The War on Poverty

- Explosion of health legislation during the Nixon and Johnson years; broadened the federal role of aid to communities and individuals
 - ◆ OEO
 - ◆ Medicaid
 - ◆ Health Planning Acts
 - ◆ Migrant Health
 - ◆ Appalachian Regional Development
 - ◆ Model Cities



The War on Poverty and Dentistry

- Many of these programs required dental services, or at least preventive dental services, to be provided by grant-supported delivery systems.
- Federal guidelines and requirements acted to standardize services and methods across the nation, diminishing State opportunities to experiment in delivering services. As a result a network of health centers and programs grew up to encompass thousands of urban and rural communities

History of State and Federal Programs

- Before 1935 most federal grants in aid to states were awarded for specific purposes such as VD, TB
- Health services for the needy were provided through **philanthropic** and occasionally state and local clinics
- **Few Federal Funds**
- 1930 State Health Departments expended only \$37,000

History of State and Federal Programs

- **Social Security Act of 1935**, established federal matching grants in aid to state to provide assistance to the
 - ◆ Aged
 - ◆ Blind
 - ◆ Families with dependent children
- First time that federal funds were channeled through the states to provide income supplements for needy persons.



History of State and Federal Programs

- States were not required to spend dollars on dentistry
 - ◆ State dental departments competed for funding with other state health interests, and their dental programs grew quite slowly.
- 1955- 1.5 billion were expended for dental services in U.S.
 - ◆ 2.1 million by State dental programs; 42% of this came from federal grant in aid programs
- 1956- more favorable formulas for medical and dental payments
 - ◆ States started to look more favorably at dentistry



History of State and Federal Programs

- 1956-1966 slow growth
- **Mid-1960's federal involvement in the financing of health services expanded dramatically**
- SSA of 1965; amendments to the SSA act of 1935
 - ◆ Medicare Title 18
 - ◆ Medicaid Title 19



Medicaid

- Title XIX provides dental benefits for indigent Americans
- Individual States determine benefit eligibility, generally as a function of the federal poverty index and age of the recipient
- EPSDT- Early Periodic, Screening, Diagnosis and Testing(EPSDT) program
- Dental benefits for Medicaid eligibles vary from State to State

Medicaid

- Title 19: 50 Different State Programs
- **Medicaid spends less than 1% of its payments on dental care**
- Sliding scale of payments to states or medical services to persons who qualified for public assistance programs for
 - ◆ Blind, aged, disabled
 - ◆ Families with dependent children
- The act authorized matching funds for persons whose incomes while sufficient for normal purposes but were inadequate to cover medical services, a category of beneficiary known as the medically needy



Medicaid

- Fourteen services authorized
 - ◆ Five were mandatory
 - ↪ inpatient hospital services
 - ↪ laboratory and x-ray
 - ↪ skilled nursing home services for adults
 - ↪ physicians services
- Dental care and dentures were listed as optional along with drugs, eyeglasses, and physical therapy

Medicaid: EPSDT

- In 1967 Medicaid was amended to expand disease prevention activities for children by requiring states to screen diagnose and treat health problems of children eligible for medical assistance. This program was known as
- **Early Periodic Screening, Diagnosis and Treatment(EPSDT)**
 - ◆ Applied to everyone under age 21 and eligible for medical assistance.
 - ◆ Dental Services were mandatory.
- All States were required to have an operating program by 1972.



EPSDT



- The implementation of EPSDT proceeded so slowly that in 1972 Congress passed additional amendments penalizing states without functioning programs.
- In 1981 the Omnibus budget Act repealed the penalty for States without EPSDT programs.
- As of 1984 all States provide Medicaid, 30-32 provide dental care to all adults, under EPSDT all children are covered.

EPSDT and Dentistry

- Inspector General's report 1995: one in four children in the U.S. is currently covered under the program
 - ◆ Fewer than 20% of eligible children receive a dental service at all
 - ⇒ Multiple barriers to care
 - Rejection of low payments by dentists
 - Poor health behaviors by beneficiaries

Medicaid: Problems



- **Why Doesn't Medicaid Work?**
 - ◆ Conflicting and confusing policies
- New York State Thresholds- 1989
- Increased Fees- 1990; fees increased 50- 120 per cent, with emphasis on diagnosis and preventive services.

New York State and Medicaid

- Indecisive
- Letter from Deputy Commissioner 10/1/89
 - ◆ Thresholds on visits
 - ◆ Limits on selected medical equipment and supplies
 - ◆ Check medical assistance program to see whether a patient has gone over the limit for care or services

New York State and Medicaid

- 5/14/90 letter from Deputy Commissioner
 - ◆ To dentists, raising Medicaid reimbursement for children
 - ⇒ Fee increase of 50-120 percent with emphasis on diagnostic and preventive services

Medicaid: New York State- 1991

■ Examples

■ FMS	15.00	31.50
■ Child Prophylaxis	7.00	14.50
■ Pulpotomy	13.00	25.00
■ Orthodontics	1600.00	2500.00
■ Sealant, PCR		25.00

■ Diagnosis and Prevention

■ Oral Exam	10.00
■ Radiographs	31.50
■ Dental prophylaxis	15.40
■ Fluoride treatment	12.00

Medicaid: New York State

- Treatment Visits
- Amalgam Restoration 1 Surface 19.00
- Dental Sealants, per tooth 12.00
- Extraction, single tooth 25.00
- Root Canal Therapy, one canal 140.00
- Space Maintainer, Fixed Unilateral 97.50
- Therapeutic Pulpotomy 25.00
- Occlusal Sealant, PCR 25.00

Medicaid: California



- **MediCal Study**
- Physicians primarily influenced by financial considerations and factors that interfere with their professional judgment
- Low reimbursement rates and denial of payment, 1st and second reasons why dentists don't participate in Medicaid.
- Broken appointments are the third reason
 - ◆ Inability to treat Medicaid patients in a manner the dentists considered comprehensive

Medicaid: Problems

- Reasons for Not Participating in Medicaid
 - ◆ Low fees
 - ◆ Not enough services covered
 - ◆ Denial of payment
 - ◆ Broken appointment
 - ◆ Slow payment
 - ◆ Need for prior approval
 - ◆ Complicated paperwork

Medicaid

- Why participate?
 - ◆ altruism
 - ◆ income
- Medicaid Mills
 - ◆ High volume, low quality Medicaid practices
- ADA: "Health Care that works" Dentists provide over \$20,000 to patients in free or reduced fee services to their private practice patients. Do you agree?

Medicaid: Problems

- Poor Children missing basic dental care- Medicaid Study- American Medical News 1991
- Medicaid programs fail to provide basic dental services to poor children as required by "EPSDT"
 - ◆ -inadequate services
 - ◆ -fail to meet fed guidelines
- Evaluated NY, Texas, Michigan, Ohio, Mississippi, and Nevada, half of the children on Medicaid
- Medicaid patients received fewer services than those provided to other patients; reason cited low Medicaid reimbursement

Section 1115 Waivers

- State changes to the Medicaid Program
 - ◆ Eligibility requirements
 - ◆ The scope of services provided
 - ◆ Statewide uniformity of the program
 - ◆ The freedom to choose a provider
 - ◆ A provider's choice to participate in a plan
 - ◆ The method of reimbursing providers
 - ◆ Alternative delivery systems

Section 1115 Waivers

- Operationally feasible
- Budget neutral
- Leave the States Medicaid population at least as well off as it was before the plan was implemented
- Managed care 1115's (the majority)

Medicaid and the ADA

- “The federal government should assure comprehensive dental benefits for all no- and low-income individuals, regardless of age, by expanding Medicaid”
- “Medicaid should be administered in the private sector, rather than through a government agency. This private/ public sector cooperative effort would yield better administrative efficiency”

Medicaid and S-CHIP

- Dental caries remains the single most common chronic disease of childhood and is most severe amongst the low income children targeted by Medicaid and S-CHIP. National data confirm that pediatric oral health in the U.S. is worsening
- BBA of 1997 that created S-CHIP the largest child health insurance program since Medicaid.
- S-CHIP provides states with a higher federal match rate than Medicaid and leaves program design to the states

Medicaid and S-CHIP

- States may use these new funds for Medicaid expansions or new children health insurance programs.
- Most State financed plans and private plans, do not provide dental coverage
- Federal legislation does not mandate States to include dental coverage
- Publicly funded health insurance programs have strong potential to provide and assure necessary dental care of these children but have substantially failed to do so

Medicaid Managed Care

- Carve out dentistry
- Contract with dental managed care organizations directly
- Dental Medicaid managed care may further reduce the dismal EPSDT dental access figures

Medicaid Law Suits

- California, New Hampshire and New York
 - ◆ Charged with failing to fund Medicaid programs adequately to ensure sufficient provider participation
 - ⇒ Does increasing fees increase provider participation?
 - California post law suit

New York State Medicaid Suit



- In February 1999, the Dental Society of the State of New York and individual dentists and patients brought an action in the United States District Court against the Governor of New York State, the Acting Commissioner of Health and the Director of the Budget.
 - ◆ The complaint alleged that, "... (the) inadequate Medicaid fee schedule discourages dentists from participating in the program and frustrates the mandate of the Medicaid law (particularly for children)."
- In an out-of-court settlement in May 2000, an agreement was reached that called for "...\$573 million in increased funding over the next four years for Medicaid dental fees..."

New York State Medicaid

- 2000- \$206.7 million was expended for Medicaid dental services to provide care for 770,191 New York State residents (\$268 per recipient of care).
 - ◆ Approximately 70% (\$144 million) was spent for 523,361 New York City residents (at the rate of \$276 per recipient of care, compared to \$253 per other-than-New York City residents).
- 2000- almost 3.4 million New York State residents, including 1.6 million children, were eligible for Medicaid dental services. But:
- Approximately 770,000 individuals (22.7% of all eligible residents) received care.
- Less than 340,000 children (21% of all eligible children) received care.
- Approximately 69,500 elderly (15% of all eligible elderly) received care.

New York State Medicaid

- 1997, 3,534 New York State dentists participated in the Medicaid program (21.5% of the 16,458 individuals licensed and registered to practice dentistry in that year)
- 51% (1,810 dentists) of the participating dentists were in New York City.
- Five or fewer dentists participated in 12 counties (Allegany, Chenango, Cortland, Greene, Hamilton [none], Lewis, Orleans, Schuyler, Seneca, Tioga, Washington and Yates).

New York State Medicaid

- The Challenge (Dental Society Summary)
- "The increases in the fees for services (if they are adequate) and improvements in processes and procedures are essential components of any effort to maximize the delivery of Medicaid dental services. But so, too, are the responsibilities of patients to keep appointments, carry out home-care directions and participate in their general oral health care."
- "The challenge is to overcome long-held attitudes and the reluctance of individual practitioners to participate in the Medicaid program. The challenge is to provide care to more than the current 22% of residents eligible for Medicaid dentistry who are receiving service."

Medicare: Title 18



- Part A is a basic hospital insurance plan financed by payroll taxes that pays for inpatient hospital and related care for most people aged 65 and over
- Part B is a supplemental medical insurance plan available on a voluntary basis, that is financed by current premiums of enrollees and is matched by federal appropriations.
 - ◆ Dental services were not authorized under Part B, and only those surgical services related to the jaws and contiguous structure or to the reduction of any fracture of facial bone were authorized under Part A.
 - ⇒ Routine dental services have never been authorized under Medicare.

Medicare: Dental Coverage

- Inpatient hospital services, in connection with a dental procedure if the patient has severe impairments
- Severity of the condition requires hospitalization
- No coverage for treatment of teeth or structures directly supporting teeth

Medicare and the ADA

- 1960's Dr. Lawrence I. Kerr testimony, don't provide regardless of need, working people from the 1960's retiring in the 1980's and 90's will have health care benefits! Stick to the private sector
- 1980's "The Boat Passed" by "With Regard to Medicare, the Association notes that the elderly represent the fastest growing segment of the population. It is time to support an effective initiative to meet the total health care needs of elderly citizens.
- 1990's If included, should be fee for service and traditional dentistry. "The basic association policy which generally opposed using public monies to fund health care for a population considered largely self-sufficient: the aged"
- Only 30 per cent of older Americans use dental services; as opposed to 50% of the general population.



Medicare and the ADA

- Catastrophic Health Insurance
 - ◆ Medicare Part C
- Medicine and Medicare
 - ◆ A good deal for hospitals and physicians until cost containment
 - ☞ DRG's, RBRVUs



Diagnosis Related Groups (DRGs)



- Represent an average charge for discharges in specific diagnosis categories (rather than specific procedures) compared to the national average for all Medicare hospital discharges.

Medicare GME



- Medicare's share in funding teaching hospitals includes residency training support under Part A (hospital services) commonly referred to as Graduate Medical Education (GME)
- Medicare GME has two components: Direct Graduate Medical Education (D-GME) and Indirect Medical Education (IME)
 - ◆ IME was created to compensate for factors that increase teaching hospitals costs such as treating a more severely ill patient population, offering a wider range of services and technology, providing more diagnosis and therapeutic services to certain types of patients, and allowing clinical inefficiencies as residents learn their profession (such as the ordering of more tests than the norm)

Medicare GME

- As dental and medical residency programs have grown in number, interns and residents became increasingly important to the services delivered and a significant part of teaching hospitals budgets.
- The basis of Medicare reimbursement for residency training was a direct or reasonable cost basis which is the forerunner of today's D-GME.

Medicare GME

- 1995 total funds disbursed to teaching hospitals under Medicare GME was 5.8 billion dollars (2 billion dollars under D-GME) and 3.8 billion dollars under IME
- Hospitals have been reimbursed for GME costs from the inception of Medicare in 1965
- Medicare has shared in the cost of approved education activities that take place in teaching hospitals

Medicare GME Reimbursement

- Increasingly important option for dental graduates to pursue careers in general dentistry, the dental specialties, hospital dentistry and geriatric dentistry
- 31% of dentists graduating within the last five years have received a hospital based training experience

Medicare GME

- Medicare D-GME payments cover costs related to the training of residents, such as residents' stipends and fringe benefits, salaries and fringe benefits for supervising faculty and allocated overhead for direct costs (malpractice) and institutional(maintenance and utilities)items.

Medicare GME



- The Balanced Budget Act of 1997(BBA) placed a cap or freeze on the number of residency positions supported by D-GME. The number of residents for a cost reporting period beginning on or after October 1, 1997 could not exceed the number of full-time equivalent residents or the hospital's most recent cost reporting period ending on or before 12/31/96
- This was enacted as a Medicare cost saving measure and in reaction to the perceived oversupply of physicians
 - ◆ Dental advocacy by AADS and supported by the ADA and AAHD convinced Congress to exempt dental positions from this residency cap

Medicare and Managed Care

- Oxford
 - ◆ “You may think that Oxford is too good to be true, but believe me it’s for real”
↳ “Cherry Picking”
- Often include basic dental services to entice patients to join a plan

Summary

- Federal support of health services delivery has been closely tied to social welfare and economic assistance legislation.
- Underlying premise has been that health services should be provided by government only when individuals and families are unable to cope with health problems on their own.
- Dental care has never drawn a major share of health and welfare resources.

Summary

- Dentistry has been authorized in general terms by various statutes but seldom have funds been earmarked specifically for dental services.
- Before 1965 states received little federal support for dental services, except for funds provide through maternal and child health or crippled children’s programs. Although Social Security authorized other public assistance funds that could be used for dental services, these were used principally to provide health services for the elderly.

Using the Legislative Process to Promote Public Health

- State Government, federal Government, local Government
- Industry, insurance companies
- The role of the practitioner
- The role of organized dentistry
- The role of specialty organizations

Legislative Influence- The AMA

- Medicaid- 1989 Health Policy Agenda for the American People
 - ◆ The program should be restructured so it is based on national standards for eligibility rules, benefits and rates of reimbursement
 - ◆ Medicaid eligibility should be set at the federal poverty level
 - ◆ Each state should provide a federally mandated standard benefits package
 - ◆ Reimbursement to MD's and other health care providers should be increased to encourage more of them to treat Medicaid patients
 - ◆ Steps to improve cost-effectiveness should be incorporated into Medicaid

Insurance Industry and Health Care Reform

- Opposed government providing coverage
 - ◆ Believed that government would invade the insurance field "competing" directly with private firms for business and possibly eventually widening the general scope of the types of federal insurance provided.

Industry and Health Care Reform

- Most in industry opposed fearing increases in payroll taxes
- Organized Labor- AFL- CIO strongly supported

Industry Support for Health Care Reform-1990's

- Mobil Ad- New York Times Op-Ed page
 - ◆ Influencing public opinion and federal and state legislators

The AMA and Medicare- 1964

- Opposition based upon fears of Government interference in medical practice
- A nationwide AMA publicity campaign, masterminded by the California public relations firm warned the nation that national health insurance would mean "socialized medicine"
- The AMA spent 1 million dollars in the first 3 months of 1965 to oppose the bill, mainly for broadcasts and advertisements, its advertisements the third highest amount ever recorded for lobby spending exceeded by only by the AMA's spending in 1949-50. Much of the AMA spending the first quarter of 1965 was for publicity for its own, alternative medical care bill "eldercare" plan



AMA and Medicare- 1960's

- In the second quarter of 1965, shortly before the senate vote on the Medicare bill, AMA ran advertisements in about 100 major daily newspapers opposing administration backed bill
 - ◆ The advertisements said passage of the bill would mean lower quality medical care and urged the public to let your senators, your congressman and the president know your views on this vital issue

The Medicare Debate- 1960's

- Pro
 - ◆ National Farmers Union
 - ◆ American Nurses Association
 - ◆ AFL-CIO
 - ◆ National council of Senior Citizens
 - ◆ National Medical Association
- Con
 - ◆ Chamber of Commerce of U.S.
 - ◆ AMA
 - ◆ American Farm Bureau Federation
 - ◆ ADA



AMA and Health Care Reform- 1990's

- Congress lobbied for:
 - ◆ Universal coverage
 - ◆ Insurance reform
 - ◆ Standard benefits package
- Include
 - ◆ Reduced bureaucracy, clinical autonomy, patient choice, liability reform, antitrust relief, quality assurance, and medical education

Political Action Committees

- Receives voluntary contributions which are used to support candidates in congressional races of persons favorable to the action committee