MN HOUSE RESEARCH

Public Program Dental Reimbursement and Other Changes: 2021 Session

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Overview

In 2021, the Minnesota Legislature changed some elements of reimbursement for dental care under the Medical Assistance and MinnesotaCare programs. This publication summarizes those changes and briefly describes other dental-related provisions adopted during the 2021 session. All of the provisions described below, and the accompanying section references, are from the health and human services finance bill (Laws 2021, First Special Session chapter 7, article 1).

Dental Rate Changes

The 2021 Legislature increased MA and MinnesotaCare base payment rates for dental services by 98 percent, and partially offset the cost of this rate increase by eliminating certain provider- or service-specific add-on payments and reducing the MA critical access dental payment to 20 percent above the rate that a provider would otherwise receive. The net additional cost to the state for MA and MinnesotaCare dental services after these changes is projected to be $8.2 million in fiscal year 2022 and $15.6 million in fiscal year 2023.

Increase in Base Rate

Effective January 1, 2022, MA fee-for-service base dental reimbursement rates will be increased by 98 percent, and MinnesotaCare payment rates to dental providers must equal the MA payment rate. This rate increase does not apply to state-operated dental clinics, federally qualified health centers (FQHCs), rural health clinics, or Indian health services (these providers are reimbursed under a cost-based or alternative rate that is higher than the regular MA/MinnesotaCare rate). (§§ 22, 28)

Managed care and county-based purchasing plans, subject to federal approval, are required to pay dental providers for services to MA and MinnesotaCare enrollees at levels at least equal to this fee-for-service rate (see below).

Elimination of Add-on Payments

Add-on payments are rate increases that are in addition to the base dental reimbursement rate. Effective January 1, 2022, the following dental rate add-on payments will be eliminated (§§ 22, 28):

- 5 percent general increase under MA fee-for-service (did not apply to dental services provided by state-operated dental clinics, FQHCs, rural health centers, and Indian

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health services). MA and MinnesotaCare payments to managed care and county-based purchasing plans were adjusted to reflect this payment increase.

- 9.65 percent increase under MA fee-for-service for dental services provided outside the seven-county metropolitan area (did not apply to state-operated dental clinics, FQHCs, rural health centers, and Indian health services). MA and MinnesotaCare payments to managed care and county-based purchasing plans were adjusted to reflect this payment increase.
- 23.8 percent increase under MA fee-for-service for dental services provided to enrollees under age 21 (did not apply to state-operated dental clinics, FQHCs, rural health centers, and Indian health services). This increase was not applied to services provided by managed care and county-based purchasing plans under MA and MinnesotaCare.
- 20 percent increase under MA and MinnesotaCare for dental services provided by public health and community health clinics (the 20 percent increase will continue to be applied to non-dental services provided by these entities).
- 54 percent increase in MinnesotaCare dental payment rates.

Payment by Managed Care and County-based Purchasing Plans

Capitation rates paid by DHS to managed care and county-based purchasing plans for providing services to MA and MinnesotaCare enrollees[1] are generally adjusted to reflect rate increases for dental and other services delivered under fee-for-service. Plans in most cases are not, however, required to pass on the specific rate increases to dental and other providers under contract.

The MinnesotaCare statute specifies that payment rates for dental services provided on or after January 1, 2022, must equal the MA dental payment rates, and also requires that capitation payments to the plans must reflect the MinnesotaCare dental payment rates specified in law. (§§ 28)

The legislation increasing dental rates requires managed care and county-based purchasing plans to reimburse dental providers under MA at a level at least equal to the fee-for-service rate for dental services. DHS will also apply this requirement to MinnesotaCare, given the linkage between MinnesotaCare and MA rates described in the preceding paragraph. If federal approval is not obtained for this fee-for-service provider payment rate floor for the plans, DHS must adjust capitation rates to reflect the removal of the provision, recover any amounts paid to plans under the provision, and not implement the provision in future years. (§ 23)

[1] MA enrollees who are parents or caretakers, children, adults without children, age 65 or over, or have disabilities are required to receive services from a managed care or county-based purchasing plan, except that MA enrollees with disabilities may opt out and receive services under the MA fee-for-service system. Nearly all MinnesotaCare enrollees receive care through a managed care or county-based purchasing plan.

Reduction in MA Critical Access Dental Rate

The MA and MinnesotaCare programs provide enhanced rates to providers classified as critical access dental providers.[2] The legislation reduced the critical access dental (CAD) add-on under MA from 37.5 percent (35 percent for a dental group owned or operated by a nonprofit corporation that meets specified criteria [HealthPartners]) to 20 percent, effective January 1, 2022. (§ 23)

Managed care and county-based purchasing plans are also required to increase reimbursement under MA to critical access dental providers by at least the amount of the critical access dental provider increase. If federal approval is not granted for this increase under MA, then DHS must adjust capitation rates to reflect the removal of this provision, recover any amounts paid to plans under this provision, and not implement this requirement in future years. (§§ 23, 29)

MinnesotaCare Critical Access Dental Rate

No change was made in the CAD payment rate under MinnesotaCare; the rate remains at the 20 percent add-on level as under current law. The legislation increasing dental rates retains in modified form the requirement in current law that managed care and county-based purchasing plans pass this add-on to critical access dental providers, but adds a requirement for federal approval. If federal approval is not obtained for this, DHS must adjust capitation rates to reflect the removal of this provision, recover any amounts paid to plans under this provision, and not implement this requirement in future years. (§ 29)

State Cost of Rate Changes

The cost of increasing the base dental reimbursement rate is partly offset by savings resulting from eliminating certain rate add-ons and reducing the MA critical access dental payment. The net state expenditure for dental reimbursement after these changes is:

Dental Rate Changes	FY 2022	FY 2023	FY 2024	FY 2025
General fund	$7.095 million	$13.675 million	$16.085 million	$16.432 million
Health care access fund	$1.138 million	$1.938 million	$2.472 million	$2.109 million

Source: Department of Human Services

Comparison to Prior Rates

DHS has estimated that the changes in dental reimbursement will increase fee-for-service dental reimbursement for all providers by differing percentages, depending upon the additional payments that a provider qualifies for. In general, providers receiving no or few additional payments will see a greater percentage increase than providers who receive multiple additional payments.

[2] See Minn. Stat. § 256B.765, subdivision 4, paragraph (f), for a list of dental provider and clinic types that the Commissioner of Human Services must designate as critical access dental providers.

The table below compares the impact on a hypothetical fee-for-service base rate of $10 of the rate add-ons under current law, relative to the increase in that base rate, elimination of rate add-ons, and reduction in the MA critical access dental payment under the new payment method. The table below illustrates that a provider that qualifies for all additional payments under current law would be paid under fee-for-service at a level 135 percent above the base rate. Under the new rate method, that provider would be paid at 138 percent above the base rate.

	Current Law (through 12-30-21)	New Rate Method (effective 1-1-22)
Base rate (hypothetical)	$10	$10
5% general increase	$10.50	---
9.65% rural increase	$11.51	---
23.8% children	$14.25	---
37.5% critical access dental	$19.60	---
20% community clinic	$23.52	---
98% increase to base rate	---	$19.80
20% critical access dental	---	$23.76
% change from base rate	135%	138%

Source: Department of Human Services

The effect of the reimbursement changes on dental reimbursement rates by managed care and county-based purchasing plans is less clear. If federal approval for the fee-for-service provider payment rate floor is obtained, then managed care and county-based purchasing plans must pay dental providers at rates at least equal to the fee-for-service rate. If federal approval for the rate floor is not obtained, there is still the possibility that managed care and county-based purchasing plans will increase their payment rates to dental providers, since these plans often base their provider payment rates on some percentage of the fee-for-service rate (which will have been significantly increased for many providers).

Dental Access and Contingent Dental Administrator

The legislature also directed the commissioner to set aggregate dental service utilization targets for managed care and county-based purchasing plans. If the plans do not meet this target, the commissioner is required to contract with a dental administrator to administer dental services for enrollees served by managed care and those served through fee-for-service. (§ 2)

Benchmark

The bill requires the commissioner to set a performance benchmark for coverage (calendar) years 2022 to 2024, under which at least 55 percent of children and adults continuously

enrolled for at least 11 months in either MA or MinnesotaCare through a managed care or county-based purchasing plan receive at least one dental visit during the coverage year.

Corrective Action Plan

If a managed care or county-based purchasing plan, during coverage years 2022 to 2024, has a dental utilization rate 10 percent or more below the benchmark, the plan is required to submit a corrective action plan to the commissioner that describes how it intends to increase dental utilization to meet the benchmark.

Contingent Contract for Administrator

If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark for coverage year 2024, the commissioner is required to contract with a dental administrator to administer dental services for all MA and MinnesotaCare enrollees, beginning January 1, 2026. The duties of the administrator include, but are not limited to, contracting with providers, utilization management and reviews of medical necessity, dental claims processing, and performance measurement and quality improvement. The administrator is required to pay dental providers at the MA and MinnesotaCare rates. If the administrator fails to meet the performance benchmark by calendar year 2029, the commissioner is required to terminate the contract and enter into a contract with a new administrator.

Dental Utilization Report

The commissioner is required to submit annual reports, beginning March 15, 2022, and ending March 15, 2026, to the legislature on the percentage of MA enrollees receiving a dental visit during the most recent calendar year, a description of any corrective action plans submitted by managed care or county-based purchasing plans, and other specified information on dental utilization.

Other Dental Provisions

The HHS finance bill also included a number of other provisions related to MA and MinnesotaCare dental services. These include expanding adult dental coverage for the treatment of periodontal disease, making fee schedules available, requiring development of a uniform credentialing process, and requiring various reports.

Treatment of Periodontal Disease

MA and MinnesotaCare coverage for nonpregnant adults is expanded to include nonsurgical treatment for periodontal disease, beginning July 1, 2021, or upon federal approval, whichever is later. (§ 7)

Making Fee Schedules Available

Managed care plans, county-based purchasing plans, and dental administrators are required to provide applicable fee schedules for dental services to individual dental providers under contract, upon request. (§ 18)

Uniform Credentialing Process

Managed care plans, county-based purchasing plans, and dental administrators are required to develop a uniform credentialing process for dental providers by January 1, 2022. This process must be available in electronic format and accessible online, allow applications to be submitted electronically, and be available to providers without charge. (§ 19)

Report Requirements

Report on provider payment rates. Dental services are one of the provider service categories for which the commissioner must annually report to the legislature, beginning December 15, 2021, using mean and median provider reimbursement rates by county for each managed care and county-based purchasing plan, for the five most common billing codes statewide. This information must also be reported in the aggregate for all plans, and for fee-for-service. (§ 20)

Report on dental home demonstration project. The Dental Services Advisory Committee is required to design a dental home demonstration project and present recommendations to the legislature by February 1, 2022. The demonstration project, among other things, must test payment methods that establish value-based incentives to: increase the extent to which dental providers serve MA and MinnesotaCare enrollees across their lifespan; develop service models that create equity and reduce disparities in access; advance alternative delivery models; and improve the quality of dental care. (§ 33)

Report on dental carve-out and provider enrollment. The Commissioner of Human Services is required to review Medicaid dental delivery systems in states that have carved out dental services from managed care and to analyze provider hesitancy to serve MA enrollees. The commissioner is to report to the legislature by February 1, 2022, and may combine this report with the report on the dental home demonstration project. (§ 37)

Report on dental rate rebasing. The Commissioner of Human Services is required to present recommendations on dental rate rebasing to the legislature by February 1, 2022. The recommendations must be consistent with the design of the dental home demonstration project and address the frequency of rebasing, the possible use of an inflation factor, and other relevant issues. (§ 38)

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