U.S. National Oral Health Alliance
Fifth Leadership Colloquium

Financing Oral Health: Public Programs

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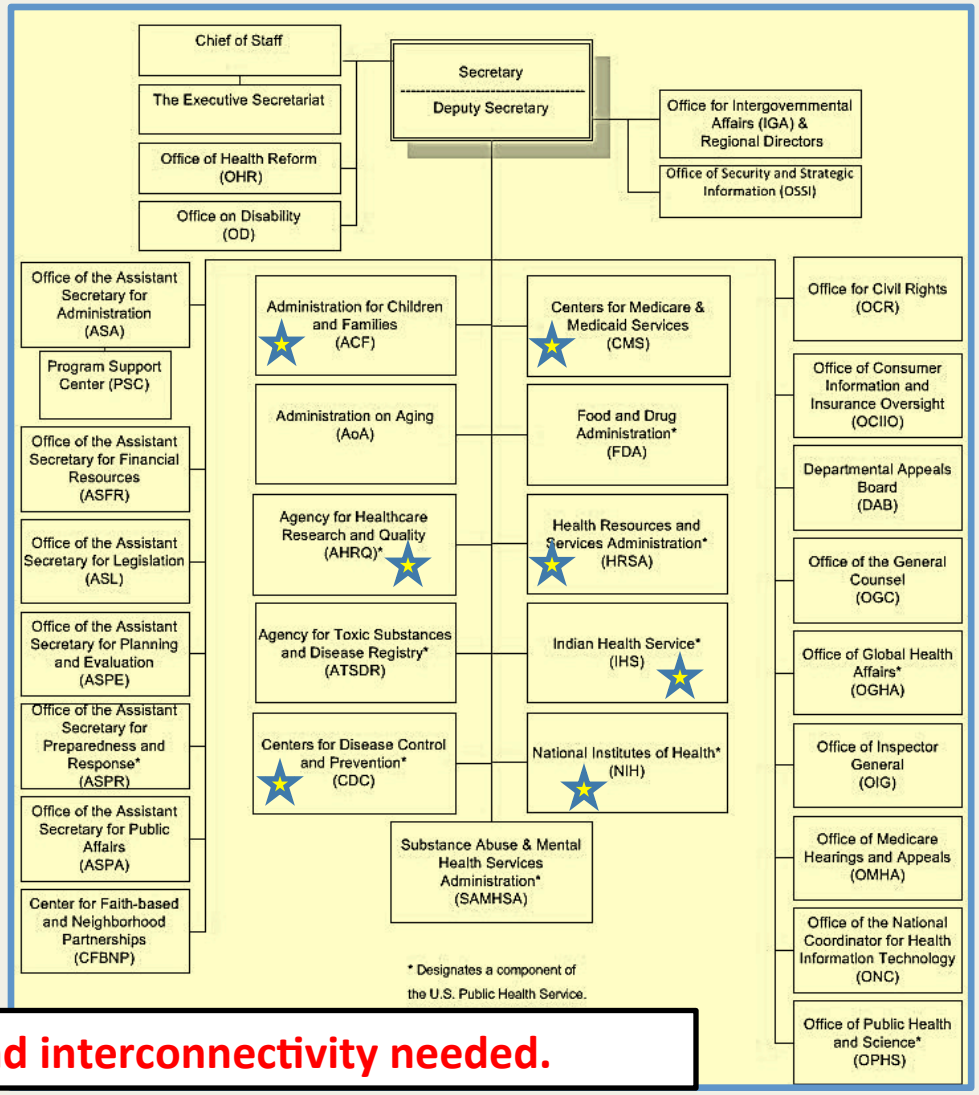
Financing Oral Health: A Health Systems Approach

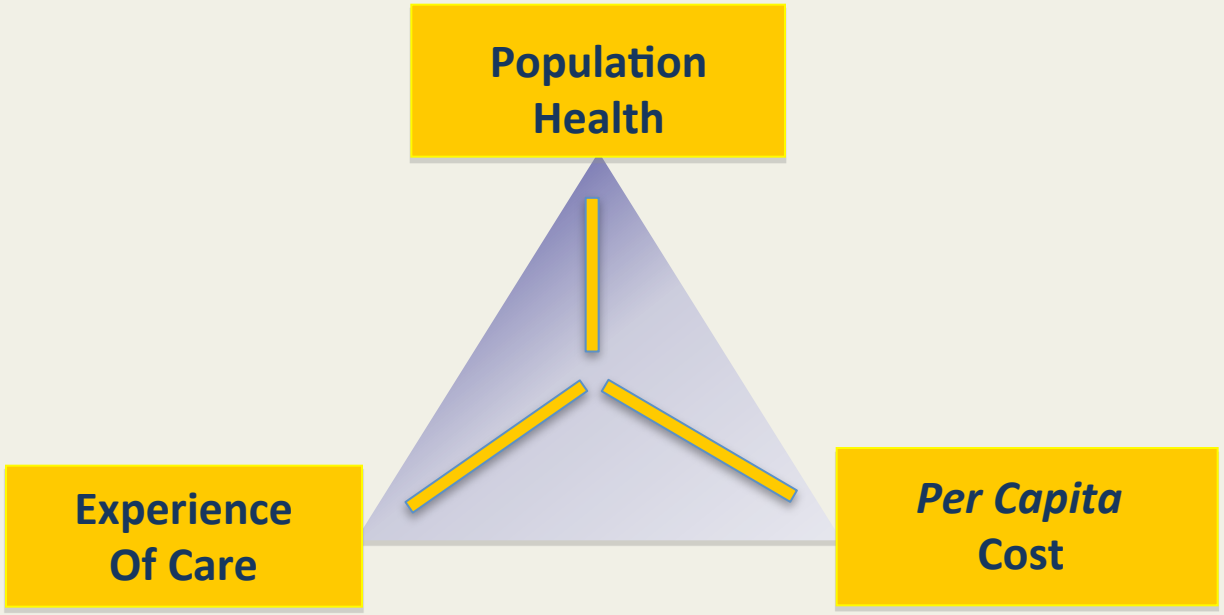
U.S. Department of Health and Human Services



Stronger linkages and interconnectivity needed.

MSDA
Medicaid–CHIP
State Dental Association

Better Care, Better Health, Lower Costs



CMS Triple Aim

Medicare

Healthcare Delivery for Seniors 65+, Disabled and ESRD

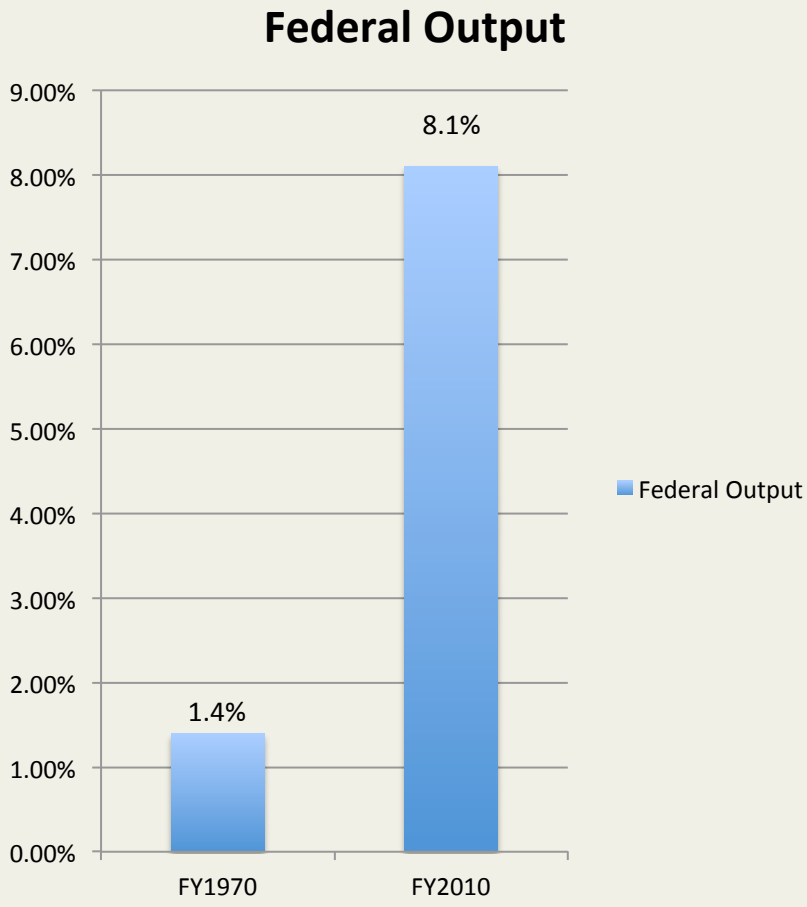
Statutory Dental Exclusion

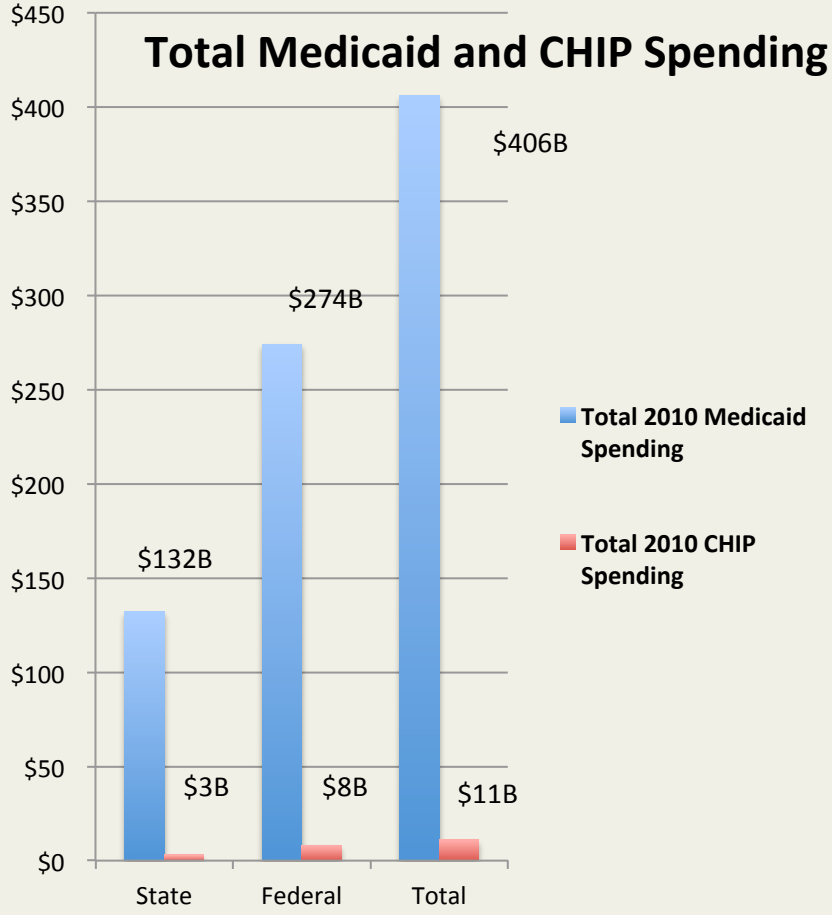
- Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

It's time to reopen the conversation and expand oral healthcare to Medicare beneficiaries.

Medicaid and CHIP Costs

15% Total U.S. Healthcare Spending

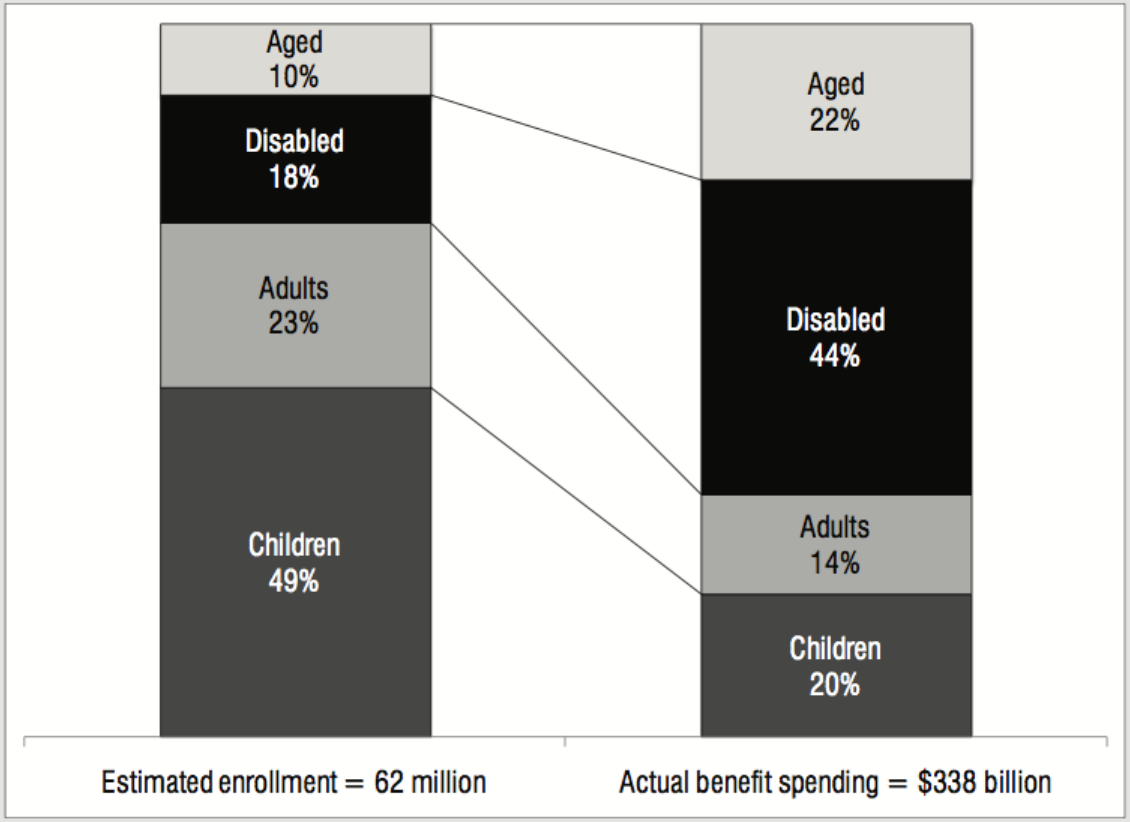




76 Million Beneficiaries * 68 Million Medicaid * 8 Million CHIP

Enrollment and Medicaid Spending

FIGURE 2-2. Distribution of Medicaid Enrollment and Benefit Spending by Basis of Eligibility, Estimated FY 2009



Note: Adults and children are non-disabled enrollees under age 65 and 19, respectively. Reflects people ever enrolled during the year and includes federal and state dollars. Excludes the territories, disproportionate share hospital (DSH) payments, and adjustments.

Source: OACT 2010

Medicaid Spending, Cost Containment and Cost Shifting

- Levers
  - Eligibility
  - Benefits
  - Cost-sharing (CHIP)
  - Provider payments

Medicaid Eligibility

Federal Mandates

2010

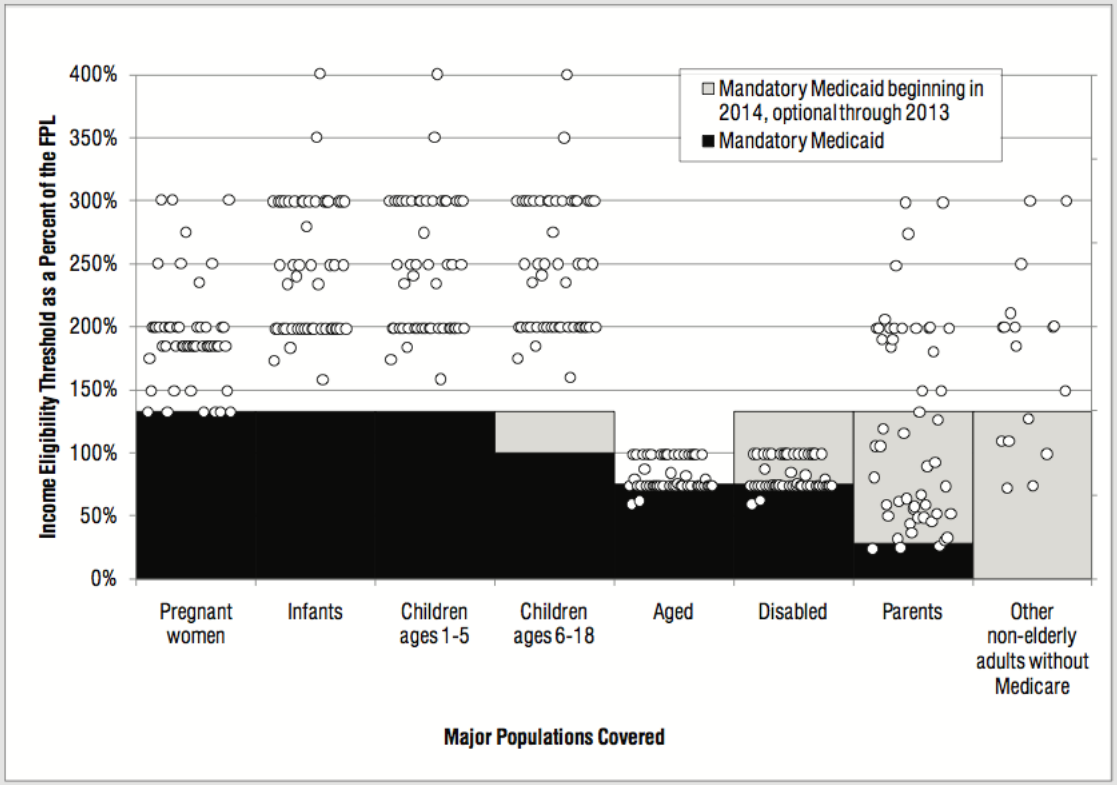
- Low-income children and their parents
- Pregnant women
- Individuals with disabilities
- Individuals ages 65 and over
- Income levels:
  - Children < age 6= 133% of FPL
  - Children age 6 and older=100% FPL *(Lower income thresholds)*
  - FPL=$18,310 for family of 3
  - Differs for other categories

2014 – PPACA*

- Low-income children and their parents
  - Raises eligibility for children ages 6-9 in 20 states
- Pregnant women
- Individuals with disabilities
- Individuals ages 65 and over
- Low-income adults who do not fall into one of these categories (by 2014 or earlier at state option)*

*Patient Protection and Affordable Care Act

FIGURE 2-1. Medicaid and CHIP Income Eligibility by Major Populations Covered



Note: Dots on the chart generally represent state Medicaid or CHIP upper income eligibility thresholds for each population and may include employer-sponsored premium assistance and limited benefit packages; however, individuals with high medical expenses or long-term care needs may be eligible at higher income levels than those shown. Excludes eligibility for aged and disabled dual eligibles who only receive assistance with Medicare premiums and cost-sharing. In addition to meeting income criteria, individuals may be subject to an asset test and must meet additional eligibility criteria as noted in the text of Chapters 2 and 3.

Bars on the chart do not reflect Medicaid mandatory thresholds in all states. Exceptions include parents (varies by state, bar reflects U.S. median); pregnant women and infants (higher in 15 states than the generally applicable 133 percent FPL shown here); and aged and disabled individuals (11 states may use a threshold that differs from the SSI level shown here).

The mandatory thresholds for parents and disabled individuals will not change as of 2014; however, individuals above the current thresholds will gain mandatory status up to 133 percent FPL under the new eligibility group for other non-elderly adults who are not pregnant and do not have Medicare coverage.

Source: Social Security Act and Tables 9 through 11 in MACStats.

Medicaid Enrollment

2010

- 68 Million Beneficiaries
- 33 Million Children
  - 1/3 of all US children
- 11 Million Low-income with disabilities
- 6 Million Low-income seniors/long-term care

*Originally in American Recovery and Reinvestment Act (ARRA)

H.R 3590

2014 and PPACA

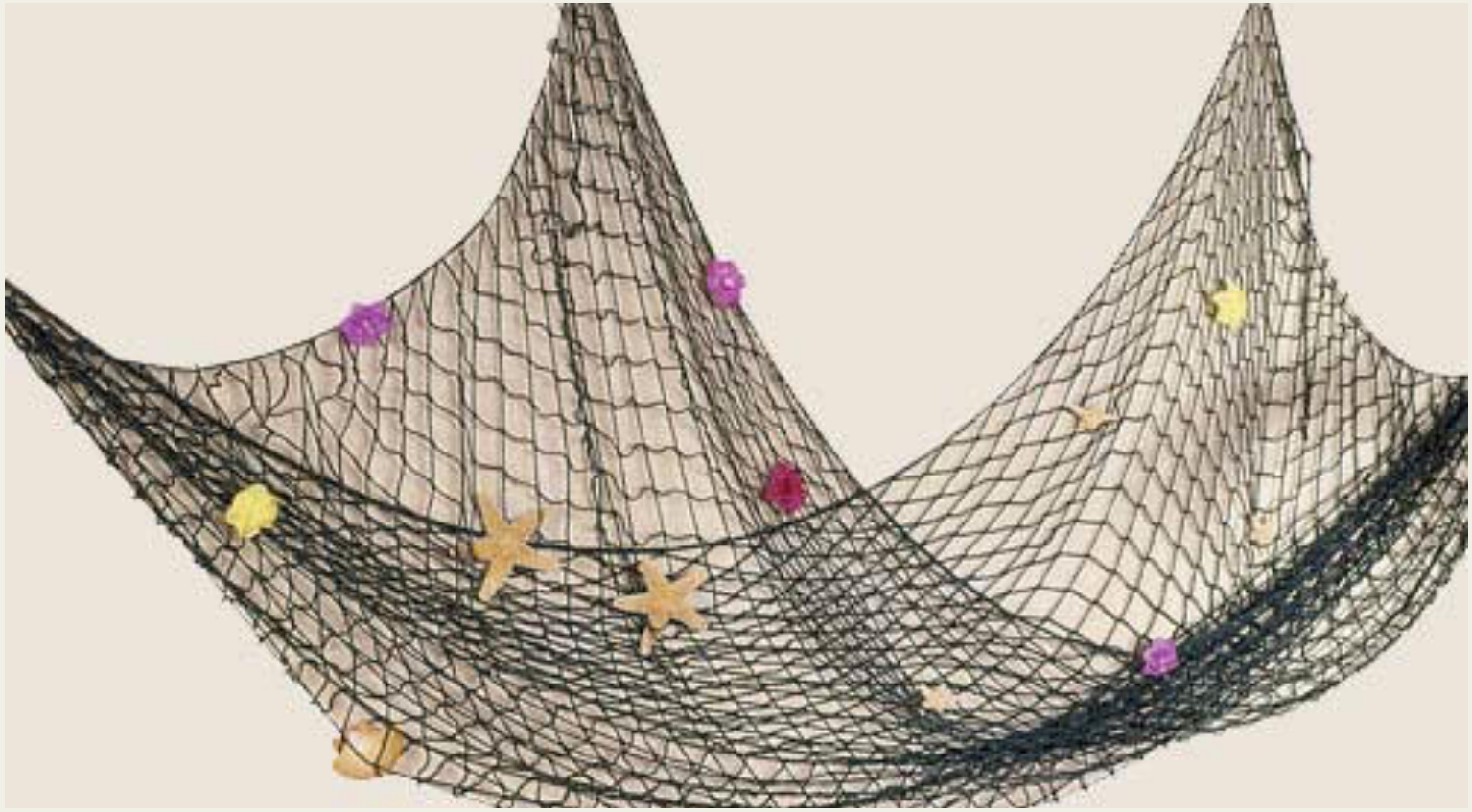
- Additional 32 Million
- Maintenance of Effort (MOE)
  - State eligibility policies must remain in place until 2014 or until state Exchanges are fully operational-for adults
  - For children –until 2019
- New formula for eligibility
  - "modified adjusted gross income
  - IT systems modifications

State Medicaid Spending

New Administrative Models

- Historically fee-for-service and "in-house" administration
- Changing to HMOs, MCOs, TPAs, Hybrid
- Increased complexity in state programs
  - Contracting with 1 or more MCOs
  - Dental carve outs
  - Subcontracting for administration of dental
  - Increase in use of risk-based models

Public Health Systems function as the Safety-net for Delivery Systems



Need to be Better Linked and Interconnected with Healthcare Delivery

Programs are only as strong as the policies and financing mechanisms in place to support them.

Health Reform -> Opportunity to Rebuild and Strengthen US Health Systems

Acknowledgement

Primary Reference for this Presentation

Medicaid and CHIP Payment and Access Commission (MACPAC)

Report to the Congress on Medicaid and CHIP, March 2011

Available at

*www.kff.org/**healthreform**/upload/8061.pdf*