

INTRODUCTION

- Appropriate treatment of patients with cleft lip and palate (CL/P) requires a multi-disciplinary team approach over many years of treatment.
- Access to these teams is made even more difficult for patients on government insurance as they continue to face multiple financial and geographic barriers to care.
- Although Medicaid expansion has sought to close care gaps by increasing eligibility for many and improving procedure cost-sharing, access to providers remains an obstacle for many low-income families.

AIM

- This study investigates the association between **Medicaid provider reimbursement** for CL/P related procedures and **state-level economic factors** that influence access to proper care.

METHODS

- Provider reimbursement rates for 2025 were collected from state websites for
 - D8020 (Phase 1/Limited Orthodontic Treatment of Transitional Dentition)
 - D8080 (Phase 2/Comprehensive Orthodontic Treatment of Adolescent Dentition)
 - 42210 (Palatoplasty for Cleft Palate with Bone Graft).
- State-level cost of living index, poverty index, and the number of children enrolled in Medicaid and Children's Health Insurance Program (CHIP) were obtained as of July 2025.
- Pearson correlation and linear regression assessed associations between provider reimbursement and demographic factors ($p < 0.05$).

RESULTS

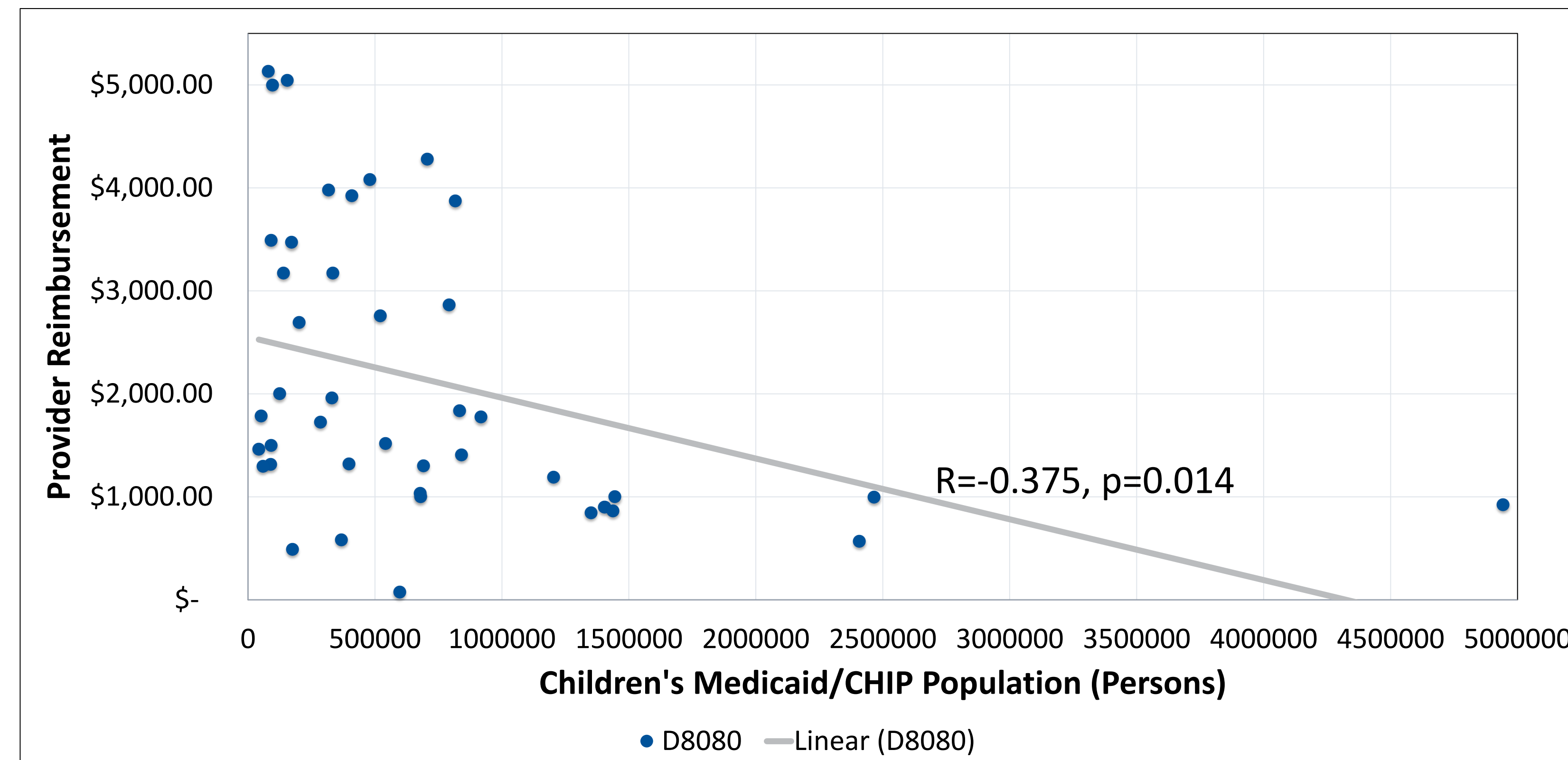


Figure 1. Pearson Correlation for D8080 Reimbursement vs. Pediatric Medicaid Population

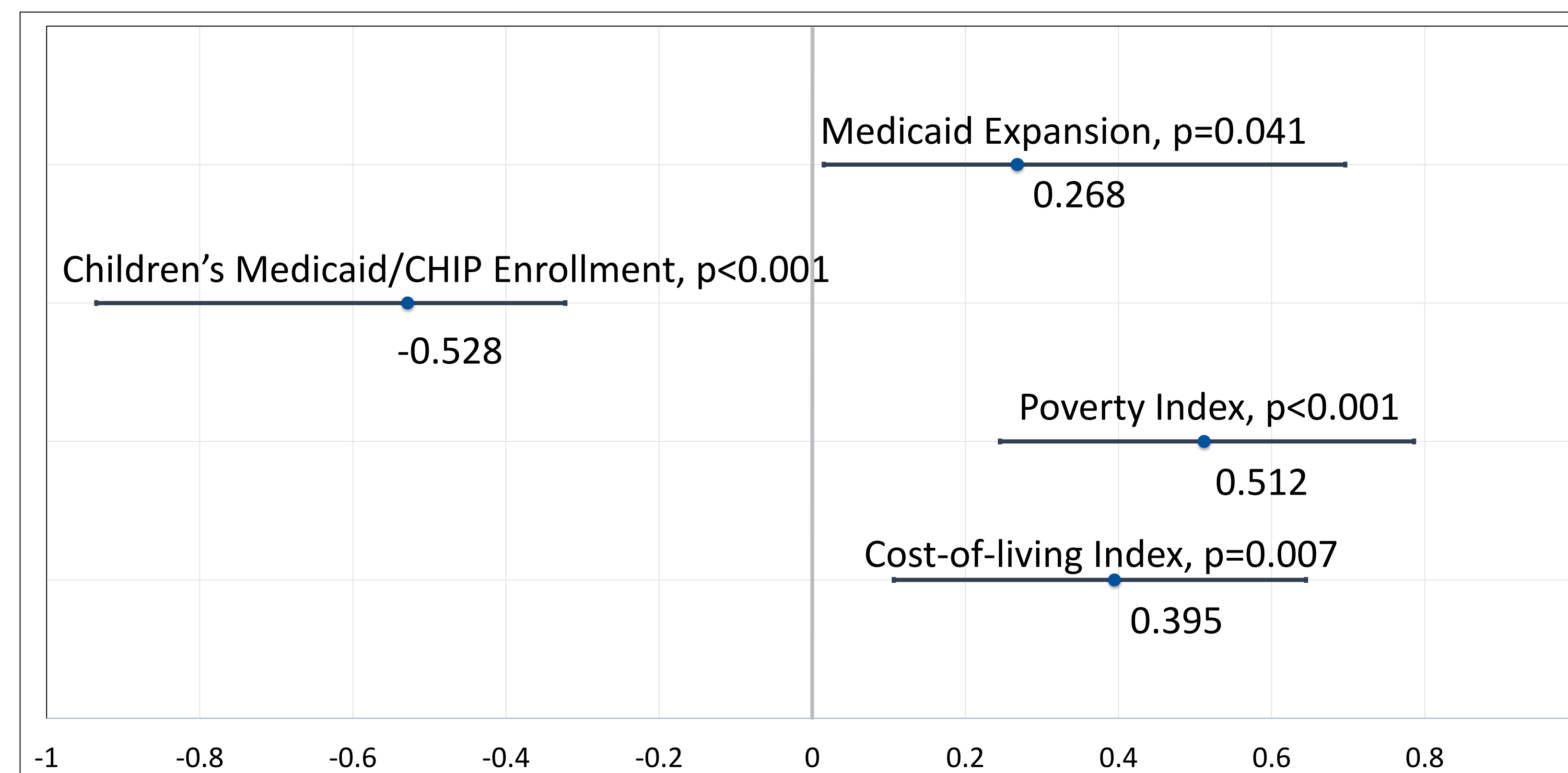


Figure 2. Coefficient Plot of Independent Predictors of D8080 Reimbursement

- D8080 exhibited significantly moderate negative association with child enrollees in Medicaid/CHIP.
- Weak negative associations were found for D8020 and 42210 between pediatric Medicaid enrollees (-0.113, $p=0.566$ vs. -0.134, $p=0.352$).
- A multiple linear regression model significantly predicted state-level D8080 Medicaid reimbursement rates explaining 41% of variance.
- Higher D8080 reimbursement was associated with higher cost of living, greater state poverty rates, and Medicaid expansion, while lower reimbursement was associated with higher pediatric Medicaid enrollment.

DISCUSSION

- **Paradoxically**, states with higher children enrolled in Medicaid reimburse less for orthodontic care. This may be due to **reimbursement lagging behind the increase in patient population** post-expansion.
- States that **have adopted Medicaid expansion or have greater economic hurdles**, such as increased cost-of-living and poverty index, **reimbursement seems to be higher**.
- This **mismatch** suggests that provider reimbursement is **not aligned with patient demand**, but rather with broader economic indicators.
- These findings may affect provider participation, as **lower reimbursement** in high-demand states **may disincentivize providers** from offering cleft-related orthodontic care.

CONTACT

Ron McCall, MS
University of Mississippi School of Medicine
rmccall@umc.edu
772-473-5258

