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A GUIDE TO CHILDREN'S DENTAL CARE IN MEDICAID

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A GUIDE TO CHILDREN'S DENTAL CARE IN MEDICAID

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Preface

In the early 1980's, the Centers for Medicare & Medicaid Services (CMS) (formally the Health Care Financing Administration, published "*A Guide to Dental Care: EPSDT/Medicaid.*" That Guide was intended to complement, supplement and expand upon policy information contained in CMS' State Medicaid Manual (SMM), which is available on the Internet at www.hcfa.gov/pubforms/pub45/pub_45.htm. The Guide was developed for the use of State Medicaid agencies, dental and other health care providers, and national, state and local policy makers involved in organizing and managing oral health care for children under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service. Now long out-of -print, photocopies of the original Guide continue to be requested frequently by individuals and organizations seeking information on children's oral health services and referred to the Guide by the SMM.

Deleted: (HCFA), hereafter referred to as the Centers for Medicare and Medicaid Services (CMS) to reflect administrative changes implemented in 2001,

Over the past two decades, however, dramatic changes have occurred in dental science and technology, in public policy approaches to dental care delivery, and in the Medicaid program itself. These changes have been of a magnitude such that much of the information in the original Guide no longer reflects the state-of-the-art of dental service delivery. In addition, CMS, in collaboration with state Medicaid agencies, had been developing initiatives aimed at addressing concerns about children's access to dental services in the Medicaid program. These concerns had been highlighted recently in two reports by the U. S. General Accounting Office and in the U. S. Surgeon General's report on oral health in the Nation. Substantial revision of the original Guide clearly was needed if it was to be of continued value to those seeking modern information about children's dental care in Medicaid.

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Consequently, CMS issued a contract to the American Academy of Pediatric Dentistry (AAPD) for the purpose of reviewing the original Guide and developing a revision for use by stakeholders concerned about children's oral health in Medicaid. The contractor was requested to incorporate information on the organization and financing of dental services, dental workforce and capacity, and accountability, along with other administrative issues which might be of assistance to state Medicaid agencies and stakeholders in their efforts to improve access to oral health services for children. In fulfillment of its contract, the AAPD developed a draft of the revised Guide, submitted the draft to wide review and comment by major national organizations concerned and knowledgeable about pediatric oral health, and produced the document provided here: "*A Guide to Children's Dental Care in Medicaid.*" The information in the revised Guide is based wherever possible on scientific evidence with appropriate citations provided, and on expert opinion where scientific evidence is inconclusive or not available.

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In addition to its contract with the Academy, CMS has been working with the Medicaid Maternal and Child Health Technical Advisory Group to clarify and consolidate in one place frequently asked questions and responses about policies in the delivery of dental services to Medicaid children and their families. These questions and responses are included as Appendix D of the Guide.

I believe that this Guide will be of assistance to program administrators, providers of dental care, and many others involved in developing and implementing programs designed to improve the oral health of children enrolled in Medicaid. The Guide is intended to serve as a resource of current information on clinical practice, evolving technologies and recommendations in dental care, and as a source for obtaining information on Medicaid program policies. The guide is not intended to change current Medicaid policies, nor is it intended to impose any new requirements on states. We hope that readers of the revised Guide will find that it provides practical, up-to-date information useful in the development of modern dental care delivery policies and programs for children enrolled in Medicaid and, where applicable, the State Children's Health Insurance Program.

Dennis G. Smith
Director
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

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Acknowledgments

The Guide was developed by James J. Crall, D.D.S., Sc.D., on behalf of the American Academy of Pediatric Dentistry. Dr. Charles Poland, III, was responsible for the development of Appendix A: Clinical Issues, with the assistance and input of AAPD members including Drs. Paul Casamassimo, Sue Seale, Ross Wezmar and Stephen Wilson. Drs. Paul Casamassimo, David Curtis, Cliff Hartman, Phil Hunke, Jerry Miller, Heber Simmons, Ray Stewart, Ron Venezie and Ross Wezmar also reviewed and commented on various drafts of the document.

Appendix D was developed by CMS staff on behalf of, and with the assistance and guidance of the Medicaid Maternal and Child Health (MCH) Technical Advisory Group (TAG), which is sponsored jointly by the National Association of State Medicaid Directors and the Association of Maternal and Child Health Programs. The MCH TAG was co-chaired by Bob Labbe, Director, Division of Medical Assistance, Alaska Department of Health and Social Services, and Christopher Kus, M.D., M.P.H., Director, Bureau of Child & Adolescent Health, New York State Department of Health.

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I. Children's Oral Health and Dental Care

A. Common Conditions Affecting Children's Oral Health

1. Overview

The recent U.S. Surgeon General's report on oral health[1] noted that children's oral health can be affected by a number of common conditions including problems related to tooth and jaw development, trauma, and bacteria-mediated infections such as dental caries (tooth decay) and periodontal diseases. The report further noted that, overall, the oral health of America's children has improved substantially over the past several decades. However, national surveys and federal[2] and state studies continue to demonstrate substantial disparities in both oral health and access to dental services.

Among the many dental conditions affecting children, dental caries is the preeminent concern in the context of Medicaid and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services because of its substantial prevalence, consequences and significance for pediatric dental care utilization. Tooth decay continues to be the single most common chronic disease among U.S. children – five times more common than asthma – despite the fact that it is highly preventable through early and sustained home care and regular professional preventive services.

The prevalence, severity and distribution of tooth decay in U.S. children have changed considerably over the past several decades. Once a disease of nearly universal prevalence and substantial severity for nearly all children, tooth decay is now generally bi-modally distributed in the pediatric population to the point that roughly 80 percent of caries experience in permanent teeth is concentrated in 25 percent of U. S. children.[3] Minority and low-income children also disproportionately experience decay in their primary teeth. The high-risk, high-prevalence, high-severity group, which currently represents nearly 20 million children, is largely comprised of low-income children (nearly all of whom are eligible for Medicaid or SCHIP), with higher levels of caries found in African-American and Hispanic groups at all ages.[4]

[1] U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U. S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[2] Office of the Inspector General (OIG), U.S. Department of Health and Human Services. Children's Dental Services Under Medicaid: Access and Utilization. San Francisco, CA: U. S. Department of Health and Human Services, OEI 09-93-00240, 1996.

[3] Kaste LM, Selwitz RH, Oldakowski RJ, Brunelle JA, Winn DM, Brown LJ. Coronal caries in the primary and permanent dentition of children and adolescents 1-17 years of age: United States, 1988-1991. J Dent Res. 1996 Feb;75 Spec No:631-41.

[4] Vargas C, Crall J, Schneider D. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988-1994. J Am Dent Assoc. 1998;129:1229-1238.

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Ironically, low-income children are much *more* likely to suffer this disease, but also are much *less* likely to obtain dental care. Three times more U.S. children are in need of dental services than medical services, and yet children with public insurance (Medicaid) are only one-quarter as likely to see a dentist as they are to see a physician. Across the country, an estimated four to five million children have severe dental problems that cause pain and infection, diminish the quality of their lives, and place additional strain on their families. These problems often result in costly visits to emergency departments and operating rooms to deal with the consequences of a disease process that could have been minimized through relatively low-cost early and periodic screening, diagnostic, preventive and treatment interventions.

Dental caries generally is considered to be reversible or capable of being arrested in its earliest stages through a variety of proven interventions. However, beyond its earliest stages, the decay process generally tends to advance and become more difficult and costly to repair the longer it remains untreated. Hence, treatment initiated early in the course of dental caries development will almost always be easier for both child and dentist, less expensive, and more successful than treatment begun at a later time.

2. Dental Caries (Tooth Decay) in U. S. Children

Prevalence and Risk – Data from recent national surveys reaffirm the persistence of dental caries as the single most prevalent chronic disease of childhood. Roughly half of U. S. children experience dental caries by age nine; and the proportion rises to about 80 percent by age 17. Overall, national epidemiologic surveys show that nearly one-in-five (18.7%) U.S. children two to four years of age have visually evident tooth decay. Since these surveys are conducted without the aid of dental radiographs (x-rays) typically used as part of dental diagnostic examinations to help detect decay in hard-to-visualize areas (e.g., between adjacent teeth), the actual prevalence is undoubtedly higher. Decay experience is closely tied to socioeconomic levels, with children from low-income families more likely to develop caries. Preschoolers in households with incomes less than 100% of the federal poverty level (FPL) are three to five times more likely to have cavities than children from families with incomes equal to or above 300 percent of the FPL. The Third National Health and Nutrition Examination Survey (NHANES III)[5] found visible decay in 30 percent of two to five year-old children in poverty and 24 percent of near-poor children (100%-200% of the FPL). Caries was present in only 12 percent of middle-income youngsters and six percent of those from families with highest income levels.

Severity – Within the highest-risk, lowest-income group, roughly one-quarter or four to five million children experience more severe levels of the disease, often with associated pain, infection and disruption of normal activities. These children generally acquire the disease early in childhood and often present as infants with multiple teeth in advanced stages of decay (a condition now referred to as "early childhood caries" or "ECC," and known previously as "baby bottle caries"). Children

[5] Vargas C, Crall J, Schneider D. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988-1994. J Am Dent Assoc. 1998;129:1229-1238.

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living in households below 200 percent of the poverty level – roughly half of U. S. children – have three and one half times more decayed teeth than do children in more affluent families.

Unmet Treatment Needs – Dental care is the most common unmet treatment need in children.[6] Lower-income children have more untreated dental disease than more affluent children who obtain care on a regular, periodic basis. Reasons for this disparity include the fact that low-income children are more likely to experience dental disease and frequently only access care on an episodic or urgent basis when decayed teeth cause pain or swelling. NHANES III, the most recent national survey, found that nearly 80 percent of the decayed teeth of poor two to five year olds and 40-50 percent of the decayed permanent and primary teeth in 6-14 year olds were unfilled (untreated).

Consequences – The consequences of severe, untreated dental disease and poor oral health in millions of American children are evident in many dimensions. Biologically, untreated dental disease can lead to pain, infection and destruction of teeth and surrounding tissues with associated dysfunction. Untreated tooth decay also may lead to delayed overall development among young children affected with severe forms of the disease. Dental diseases also have been shown to be associated with systemic health conditions. Socially, affected children have problems with school attendance and performance, and are often stigmatized because of their appearance. Health system consequences include frequent visits to emergency departments (often without definitive resolution of the presenting problem), hospital admissions, and treatment provided in operating rooms for conditions that are either largely preventable or amenable to less costly care had they been treated earlier.

B. Contemporary Dental Care for Children

1. Emphasis on Early Initiation of Oral Health Care

Science has provided a clear understanding that tooth decay is an infectious, transmissible, destructive disease caused by acid-forming bacteria acquired by toddlers shortly after their first teeth erupt (generally around six months of age) from their mothers. In its early stages, the effects of dental caries are largely reversible through existing interventions (e.g., fluorides) that promote replacement of lost minerals from the outer layer of the tooth (enamel). These findings, combined with epidemiologic data on the occurrence of tooth decay in infants and young children, suggest that true primary prevention must begin in the first to second year of life. This evidence also suggests that particular attention should be paid to the oral health of expectant and new mothers.

Early childhood also is marked by tremendous growth and development of the face, mouth and dentition with associated disturbances that may require the attention of dental professionals. Other common oral conditions of childhood (in addition to tooth decay) include gingivitis and mucosal (soft tissue) infections, accidental and intentional trauma, developmental disturbances associated

[6] Newachek PW, Hughes DC, Hung YY, Wong S, Stoddard JJ. The unmet health needs of America's children. Pediatrics 2000;105:989-997.

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with teething or tooth formation, poor alignment of teeth or jaws, and craniofacial abnormalities including clefts of the lip and/or palate. Additionally, parents frequently request information on a diverse array of concerns including sucking habits, fluoride usage, tooth alignment, timing and order of tooth eruption, and discolored teeth.

Infant Oral Health Care – Infant oral health care begins ideally with prenatal oral health counseling for parents, a service that should be provided by knowledgeable health care providers such as obstetricians, family physicians, pediatricians and nurse practitioners, as well as dental providers. Actual infant oral health care visits focusing on relevant history taking, clinical examination of oral structures, risk assessment, counseling, anticipatory guidance and necessary follow-up interventions should begin early, ideally before dental diseases are established. This early involvement is viewed as the foundation on which a lifetime of positive oral health and dental care experiences can be built, while minimizing costs associated with treatment of dental diseases.

First Dental Visit – Despite growing recognition of the above, a discrepancy exists between dental and public health organizations' versus the American Academy of Pediatrics' recommended age for a first dental visit. American Academy of Pediatric Dentistry (AAPD) policy, as reflected in its *"Periodicity of Examination, Preventive Dental Services, and Oral Treatment for Children,"* (see Appendix A) recommends that children be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. The AAPD recommendation is embraced by the Bright Futures consortium of 28 child health organizations and is consistent with policies of dental and public health groups including the American Dental Association, American Dental Hygienists Association and American Public Health Association. In contrast, the American Academy of Pediatrics (AAP) maintains a standard of referral to a dentist at age 3 years in its periodicity schedule, noting that pediatricians can provide appropriate oral health guidance until that age. A recent study by Lewis et al., however, suggests that while pediatricians demonstrate varying degrees of willingness to provide oral health guidance, they generally have little formal training and limited clinical pediatric oral health knowledge. Pediatricians, on the other hand, cite frequent difficulties in locating local dentists willing to provide care for very young children on referral. This issue is addressed further in the subsequent section on Direct Dental Referrals (Section II.C.1).

2. Successful Models for Achieving Oral Health

"Dental Primary Care" – Professional guidelines (and Medicaid statutory requirements) for addressing pediatric oral health needs are predicated on early and periodic clinical examinations to assess for evidence of pathologic changes or developmental abnormalities, diagnoses to determine treatment needs, and follow-up care for any conditions requiring treatment. These recurring periodic oral assessments ("dental check-ups") generally are coupled with the delivery of routine preventive services (self-care instructions, fluoride applications, dental sealants, etc.) and increasingly seek to incorporate assessments of risk factors that elevate the likelihood of destructive changes if allowed to

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[7] Lewis CW, Grossman DC, Domoto PK, Deyo RA. The role of the pediatrician in the oral health of children: a national survey. Pediatrics 2000;106:E84.

persist. This pattern of periodic assessments, preventive services, and necessary follow-up care also generally applies for adults, who collectively are more susceptible to the development of periodontal disease, oro-pharangeal cancers, and other soft tissue abnormalities. A large and growing proportion of the U.S. population has adopted this pattern of care, faces relatively few barriers to accessing services because of household income levels and/or private dental insurance, and enjoys unprecedented levels of oral health status. However, access for those with Medicaid coverage remains a chronic problem.[8]

Dentists generally are not recognized as primary care providers in a health policy context; however, "dental primary care" providers (general dentists and pediatric dentists) are considered to be important members of the "primary care team" for two principal reasons. First, the general model for the care they provide embodies the fundamental components of primary care: first point of contact, continuity of care, emphasis on prevention, and delivery of coordinated, comprehensive services. Second, the majority of the services they provide are not available from other types of health care practitioners.

"Dental Home" – Primary pediatric oral health care is best delivered in a "dental home" where competent oral health care practitioners, chosen by each child's parents or guardians, provide continuous and comprehensive services. Ideally a dental home should be established at a young age (i.e., by 12 months of age in most high-risk populations) while caries and other disease processes can be effectively managed with minimal or no restorative or surgical treatment. An adequate dental home should be expected to provide children and their parents with:

1. An accurate examination and risk assessment for dental diseases,
2. An individualized preventive dental health program based upon the examination and risk assessment,
3. Anticipatory guidance about growth and developmental issues (e.g., teething, thumb or pacifier habits),
4. Advice for injury prevention and a plan for dealing with dental emergencies,
5. Information about proper care of the child's teeth and supporting structures,
6. Information about proper diet and nutrition practices,
7. Pit and fissure sealants,
8. A continuing care provider that accomplishes restorative and surgical dental care when necessary in a manner consistent with the parents' and child's psychological needs,
9. Interceptive orthodontic care for children with developing malocclusions,
10. A place for the child and parent to establish a positive attitude about dental health,
11. Referrals to dental specialists such as endodontists, oral surgeons, orthodontists, pediatric dentists[9] and periodontists when care cannot be directly provided within the dental home.

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[8] United States General Accounting Office. Oral health: dental disease is a chronic problem among low-income populations. GAO/HEHS-00-72, Apr. 12, 2000.

[9] Pediatric dentists often function as primary dental care providers for children, but also may serve as referral outlets for difficult-to-treat children initially seen by general dentists.

12. Coordination of care with the infant/child's primary care medical provider, and
13. Cultural competency.

3. Periodicity of Services

Detailed recommendations regarding the periodicity of professional dental services for children can be found in the AAPD's Reference Manual section on *"Periodicity of Examination, Preventive Dental Services, and Oral Treatment of Children,"* and in Appendix A of this Guide. The AAPD's Reference Manual is available on the Internet at www.aapd.org. The AAPD periodicity schedule outlines the recommended content and periodicity of developmental assessments, clinical examinations, diagnostic tests including radiographic assessments, counseling and prevention activities, and periodic reevaluations. These recommendations generally call for procedures to be repeated at six-month intervals or as indicated by individual patient's needs or risk for disease.

Recommended policies and practices for general health supervision of children, including oral health, also have been promulgated in a series of *Bright Futures* publications developed with support of the U. S. Department of Health and Human Services. *Bright Futures* outlines activities related to oral health that physicians and other medical personnel should incorporate into their routine periodic child health supervision schedules (e.g., conducting oral health assessments as part of routine physical examinations), and contains sections on anticipatory guidance and recommendations for parental/child home care. *Bright Futures* also contains recommendations for scheduling dental appointments, including dental examinations beginning at age 1 and periodic dental appointments every 6 months or as indicated by each child's individual needs or susceptibility to disease. The Bright Futures oral health guide also can be found on the Internet at www.brightfutures.org/oralhealth/index.html.

4. Behavior Management

It has been estimated that 85 percent of children generally are cooperative in dental treatment settings, while the remaining 15 percent require more advanced behavior management approaches in order to provide dental care. Behavior management has been defined as purposeful application of accepted techniques – both pharmacologic and non-pharmacologic – to reduce fear and anxiety, enhance cooperation, and effect treatment. Descriptions of common behavior management techniques used in pediatric dentistry can be found in *Appendix A: Clinical Issues*. A more complete description of techniques, rationale and indications for various approaches can be found in the current Reference Manual of the American Academy of Pediatric Dentistry, available on the Internet at www.aapd.org.

Behavioral management of anxious children who are unable to readily accept even routine dental treatment often requires additional time on the part of practitioners and support personnel to provide dental procedures. Reluctance on the part of many dentists to treat very young children and those with disabling conditions can contribute to limited access to care for these groups. Therefore, it is important that dentists receive adequate training to be able to deal with these children and that they

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be adequately reimbursed for dealing with children who require extra time and resources for treatment.

Reimbursement for Behavior Management - Some forms of behavior management require administering medications that are not routinely used for dental care (e.g., sedatives). More difficult cases may also require additional professional personnel, such as trained dental support staff, anesthetists, or physician anesthesiologists. In many states, additional training and periodic re-training are required in order to provide certain pharmacologically based behavior management services. Even rudimentary behavior management may require additional instruments, equipment and liability coverage. Accordingly, reimbursement for behavior management services that permit the delivery of dental services for difficult-to-manage children should be provided on top of reimbursement for the dental services, as is common for medical and other forms of surgical and diagnostic care. It also bears noting that appropriate use of less intensive forms of behavior management, such as sedation and nitrous oxide analgesia, may reduce the need for more expensive and elaborate procedures such as general anesthesia.

Determining when such services should be reimbursable (i.e., when a child's behavior warrants special measures and compensation for additional time and/or resources) has been a common programmatic challenge. The key is to develop, adapt or adopt a reliable index or mechanism for classifying behavior in dental settings that is suitable for routine record keeping and claims adjudication. One common behavior classification index used in pediatric dentistry is the Frankl Scale, a system that categorizes behavior using a four-point scale. Some Medicaid programs also allow reimbursement for behavior management by report, for children with special health care needs because of the additional time typically needed to provide even routine dental services.

Treatment under general anesthesia is necessary when children require extensive dental services and cannot be managed with other approaches. Prompted by the reluctance of some third-party payers to cover general anesthesia and related costs in conjunction with dental treatment, several states have enacted legislation requiring third-party coverage for general anesthesia (by medical plans) when general anesthesia is necessary to provide dental care for children meeting specified criteria. Indexes such as the one developed for the Texas Medicaid program may serve as a guide for assessing whether multiple factors suggest the need for dental care under general anesthesia.

II. Policy and Program Considerations

A. Early and Periodic Screening, Diagnostic and Treatment Benefit

Early and periodic screening, diagnostic and treatment (EPSDT) services are required services under

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the Medicaid program for most individuals under age 21.[10] EPSDT was defined in Section 1905(r) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation, and includes periodic screening, vision, dental, hearing and other necessary health services.

The State Medicaid Manual (SMM), which may be found on the Internet at www.hcfa.gov/pubforms/pub45/pub_45.htm), points out that EPSDT services consist of two mutually supportive, operational components:

- assuring the availability and accessibility of required health care resources; and
- helping Medicaid beneficiaries and their parents or guardians to effectively use the resources.

These two components are intended to enable state Medicaid agencies to:

- manage a comprehensive child health program of prevention and treatment,
- seek out eligible children (and their families), and inform them of the benefits of prevention and the health services and assistance available, and
- help beneficiaries use health services.

Fundamental features of this service include the requirement that assessments of children's health needs be provided through initial and periodic examinations and evaluations, and that subsequent measures are taken to assure that health problems are diagnosed and treated early, before they become more complex and costly to treat.

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[10] In 2001, CMS introduced a new program, The Health Insurance Flexibility and Accountability (HIFA) Initiative (Section 1115 Model Waiver), to reduce the number of uninsured individuals, particularly those with incomes at or below 200 percent of the federal poverty level (FPL). This section 1115 demonstration initiative will enable states to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income uninsured individuals. As part of an overall approach to increase the number of individuals with health insurance, states will have increased latitude in designing benefit packages and cost sharing. Additional information on HIFA waivers is available from the Centers for Medicare and Medicaid Services.

B. Basic Program Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, states must provide for screening, vision, hearing and dental services at intervals that meet reasonable standards of medical and dental practice. Schedules specifying the content and periodicity of these services are to be established by each state after consultation with recognized medical organizations involved in child health care (in the case of screening, vision and hearing services) and dental organizations (in the case of dental services). States must also provide for medically necessary screening, vision, hearing and dental services at other intervals regardless of whether such services coincide with their established periodicity schedules for these services. The Act also requires that any service that states are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical or mental illness, or condition identified by a screen must be provided to Medicaid enrolled children, regardless of whether the service or item is otherwise included in the state's Medicaid plan.

C. Required Services

The EPSDT service, in accordance with section 1905(r) of the Act, must include screening, diagnostic and treatment services. Basic requirements are outlined below along with relevant SMM provisions and comments regarding dental and oral health services. Additional detail is provided in a subsequent section on Critical Clinical Care Elements and Responsibilities and in *Appendix A: Clinical Issues*.

1. Screening Services and Referrals

The SMM specifies that EPSDT services shall include:

- comprehensive health and developmental history,
- comprehensive unclothed physical examination,
- appropriate immunizations,
- appropriate laboratory tests, and
- health education.

When a screening examination indicates a need for further evaluation of a child's health, the child must receive diagnostic services necessary to fully evaluate any defects, illnesses or conditions discovered by the screening from a qualified provider without delay. Children found to have discernible need for treatment upon screening must also be referred for treatment without delay. Oral screenings may be and often are performed as part of physical examinations; however such screenings do not substitute for dental examinations provided through direct referral to a dentist which are required for every child in accordance with each state's dental periodicity schedule and at other intervals as medically necessary.

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Oral screening services, per se, are not required for Medicaid children. However, oral screenings are considered by many to be part of comprehensive general health screenings and are encouraged, especially for infants and young children. Oral screenings should be conducted by qualified providers according to state-specific periodicity schedules. States generally allow a variety of qualified health care and community-based service providers to conduct oral screenings. Oral screenings are further discussed below in Section II.E. Integration of Dental Services and EPSDT Screening Services.

Direct Dental Referral – Once each child reaches an age specified by the state in its dental periodicity schedule (typically between age one and three years), a direct dental referral is required. The state's dental periodicity schedule, developed after consultation with relevant dental organizations, specifies not only the age at which the initial referral commences, but also indicates other intervals at which children should receive dental services. Referrals to a dentist also may occur at times other than those described by the periodicity schedule when deemed medically necessary. The dental referral must be for an encounter with a licensed dentist for diagnosis and, if necessary, treatment. Services permitted by the state's practice act also may be obtained from a dental hygienist. Direct referral to a dentist may be met in settings other than a dentist's office. The necessary element is that referred children be evaluated by a dentist. In an area where dentists are scarce or not easily accessible, dental examinations in a clinic or group setting may make the service more appealing to recipients while meeting the state's dental periodicity schedule.

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- A direct dental referral is required for every child in accordance with each state's periodicity schedule and at other intervals as medically necessary.

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The discrepancy noted earlier between the AAP and other organizations regarding the recommended age for a child's first dental visit has left Medicaid program officials in somewhat of a quandary when developing their periodicity schedules. Faced with this discordance, state-derived dental periodicity schedules generally specify that an initial referral to a dentist be made somewhere within the range between the AAPD/ADA/ADHA/APHA/Bright Futures recommendation of age 1 and the AAP recommendation of age 3 unless clinical conditions indicate the need for an earlier referral. The rationale for direct referral for evaluations by dental personnel beginning at an early age includes:

- The relatively high prevalence of dental caries (tooth decay) in Medicaid-eligible infants and preschool-age children;
- Limited sensitivity of oral screening procedures conducted by non-dental personnel to detect decay at the level of individual teeth;
- Greater potential to arrest or reverse the decay process and minimize damage to teeth and supporting structures when caries is diagnosed and managed beginning in its early stages;
- The difficulty of detecting interproximal decay (decay on the surfaces between adjacent teeth) without the aid of dental radiographs once teeth erupt and are in contact (generally by age 2); and

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- Dental professional guidelines that call for initiation of dental care beginning by age 1, with periodic re-evaluation and preventive services at intervals based on the child's risk for oral diseases (generally every six months unless risk factors suggest alternative schedules).

Dental assistants, dental hygienists and expanded function dental assistants may perform substantial routine preventive, and certain other radiographic and treatment services when in compliance with state practice acts. However, since dental hygienists currently are not permitted by any state practice act to establish diagnoses, the diagnostic component of the EPSDT referral requirement cannot be achieved solely by a dental hygienist.

Health Education - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or oral screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Oral health education for children generally includes counseling about minimizing dietary sugar exposures, recommended daily oral hygiene practices (e.g., brushing with an appropriate amount of fluoride toothpaste), fluoride supplements if indicated, and regular dental care visits for periodic assessments and preventive services. Oral health education, particularly for adolescents, may also include education on how to prevent injuries by wearing protective gear and about the harm of using tobacco products and other drugs.

2. Diagnostic and Treatment Services

a) Dental Services

Medicaid regulations[11] define dental services as diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of (1) the teeth and associated structures of the oral cavity and (2) disease, injury or impairment that may affect the oral or general health of the recipient. Medicaid statutes[12] require that dental services for children shall, at a minimum, include relief of pain and infection, restoration of teeth, and maintenance of dental health.

Dental services are to be provided at intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or injury. Although not specified in the SMM, it is suggested that consultations with dental organizations, at a minimum, include the state unit of the professional organization representing dentists at large (i.e., state dental association) and pediatric dentists within the state. Each state's dental periodicity schedule also should include recommended intervals for

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[11] 42 CFR 440.100.
[12] P.L. 101-239, Sec. 6403.

routine dental services (e.g., periodic examinations and preventive services). States also may simply adopt a nationally recognized dental periodicity standard without substantial formal consultation. The periodicity schedule for other EPSDT services (e.g., general health screening services) may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.[13]

Medically Necessary Care – The concept of medically necessary care has several implications for pediatric healthcare in general and EPSDT dental services in particular. "Medically necessary care" has often been misinterpreted to mean care necessitated by a "medical condition." In the case of children, the narrowness of this interpretation is problematic because it generally ignores the importance of preventive services or services necessitated by developmental processes. Alternatively, "medically necessary care" can be viewed in a clinical sense as reasonable and appropriate diagnosis, preventive and treatment services, and follow-up care (including supplies, appliances and devices) as determined by qualified, appropriate health care providers in treating a condition, disease, injury, or congenital or developmental malformation that warrants attention. In the case of children's oral health, the determination of "medically necessary care" should be based on accepted standards of dental and oral health practice, and relevant policies developed by recognized dental organizations involved in children's oral health care. Contemporary health care policy development generally requires that such services meet recognized standards of appropriateness, determined when possible by evidenced-based research or when such findings are not available, by relevant professional policies and guidelines.

"Medically necessary care" also means medical care services that directly support the delivery of dental procedures that, in the judgment of the responsible dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with various medical, physical or behavioral conditions. With respect to pediatric oral health care, these services include but are not limited to sedation, general anesthesia, and utilization of outpatient and inpatient surgical facilities. Nearly 30 states have enacted legislation delineating criteria for use of general anesthesia as a medically necessary treatment for providing pediatric oral health care services and requiring medical plans to pay for general anesthesia and related services when indicated.

Federal Medicaid law provides a child-specific standard for "medical necessity" that applies to any service provided to an individual under the age of 21, including dental care, and emphasizes promotion of preventive services and good health outcomes, including dental health outcomes. This standard is found in Section 1905(r) of the Act. Because Medicaid is a state-administered program, it is the state Medicaid agency that ultimately makes medical necessity determinations, consistent with the broad federal framework for such determinations at 42 CFR 440.230. Medical necessity for purposes of EPSDT recipients must be determined on a case-by-case basis.

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[13] The source of this statement is Section 5140 – Periodicity Schedule – of the State Medicaid Manual. "Older" in this context appears to connote older than the age at which each state's periodicity schedule specifies that children must be seen by a dentist (typically age 2-3).

While a state may set *tentative* limits on EPSDT dental services, it may not set flat or arbitrary limits on the amount, duration or scope of services. For example, a state may not limit dental visits to one per year per child nor set a dollar cap (e.g., $200 annually) on the amount of services to be provided. A state may place a tentative limit on services and require additional services to be prior authorized or may use certain utilization controls, such as prior authorization or second opinions, but these utilization controls may not impede the delivery of needed services. Similarly, a state may decline to cover certain orthodontic services – for example, services that are purely for minor cosmetic purposes – but not orthodontic services that are medically necessary. In the case of malocclusion, "medically necessity" generally has limited orthodontic treatment to more severe conditions, as determined *tentatively* by use of various numerical scales for classifying malocclusions, with final determinations made after individual cases are reviewed by expert dental consultants.

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b) Hearing and Vision Services

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Hearing and vision services shall include diagnosis and treatment of defects in hearing and vision, including hearing aids and eyeglasses and, as with dental services, are subject to their own separate periodicity schedules. Where hearing and vision periodicity schedules coincide with (general health) screening schedules, states may include hearing and vision screenings as part of the required minimum (general health) screening services.

c) Other Necessary Health Care Services

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In addition to specified services, Medicaid programs are to provide other necessary health care, diagnostic services, treatment, and other measures described in §1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

D. Critical Clinical Elements of Dental Services

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<#>Emergency services,¶
<#>Preventive services, and¶
<#>Therapeutic services including pulp (root canal) therapy for primary and permanent teeth, restorations (fillings and crowns) for decayed teeth, periodontal services, space maintenance and prostheses to replace missing teeth, and orthodontic services deemed to be medically necessary to correct handicapping malocclusions.¶
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This section provides an overview of several critical clinical issues regarding children's dental services, as well as further elaboration of topics introduced in prior sections. A more in-depth discussion of clinical pediatric dental services is found at *Appendix A*.

Dental care includes diagnostic services, preventive services, therapeutic services and emergency services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. As noted in Section I, dental diseases and conditions of primary concern during childhood include dental caries (tooth decay) and problems or anomalies related to disturbances of growth and development. Periodontal diseases and other conditions affecting so-called soft tissues within the mouth and underlying bone, often related to systemic health problems, also affect oral health in a smaller percentage of children.

Because children remain at varying levels of risk for dental diseases and developmental disturbances, and because the best outcomes are achieved when these conditions are detected and treated early, periodic examinations at intervals commensurate with levels of risk are recommended for all children starting at an early age and continuing throughout childhood and adolescence. The often insidious onset of dental diseases requires that practitioners responsible for children's oral health understand underlying disease processes and have the training, experience, and equipment necessary to accurately diagnose and manage common dental diseases and, when necessary, provide a range of therapeutic services to restore damaged structures.

1. Diagnostic Services

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Accurate and early diagnosis is an essential prerequisite for successful control and treatment of dental diseases and developmental disturbances. The SMM notes that when a general screening examination indicates the need for further evaluation of an individual's health, a referral for

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diagnostic studies is to be provided without delay. However, the relatively high prevalence of dental diseases and abnormalities in Medicaid-eligible infants and children and the limited sensitivity of current screening procedures provide strong clinical justification for children receiving diagnostic examinations by a dentist beginning at an early age. The Medicaid program is ultimately responsible for ensuring that the referred beneficiary receives a complete diagnostic evaluation and for developing quality assurance procedures to assure comprehensive care following referrals.

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2. Preventive Services

Sound preventive strategies have been the key to improvements in oral health for a substantial proportion of American children over the past several decades. However, only a small percentage of children enrolled in Medicaid receive safe and effective preventive measures. The section below lists common preventive dental services for children and a brief summary of the findings of the 2001 National Institutes of Health (NIH) consensus development conference on dental caries or other evidence-based assessments, as noted.[14,15]

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- ***Dietary and oral hygiene counseling*** – The NIH conference indicates that current data provide some support for the efficacy of office-based interventions to modify behaviors, but did not comment specifically on the effectiveness of dietary or oral hygiene counseling. However, a Canadian Task Force on Preventive Health Care noted that although evidence of the effectiveness of dental counseling for inducing positive dietary changes is poor, counseling is recommended for patients at high risk for dental caries. Similarly, although the evidence for effectiveness in preventing tooth decay of daily plaque removal by toothbrushing alone is poor, toothbrushing is essential for self-application of fluoride toothpaste – which is highly recommended for preventing dental caries – and also helps to control gingival (gum) disease.
- ***Dietary fluoride supplements*** – The Canadian Task Force found good evidence of reductions in the incidence of dental caries (tooth decay) if the proper dosage schedule is carefully followed.
- ***Professional topical fluoride applications*** – Acidulated phosphate fluoride (APF) gels have consistent evidence of effectiveness when applied 1-2 times per year in a manner consistent with protocols under which they have been studied. Evidence for the benefit of fluoride varnish application to *permanent teeth* (which begin to erupt around 6 years of age) also is generally positive. The NIH consensus conference concluded that the evidence for effectiveness of fluoride varnish applied to *primary teeth* was incomplete and inconsistent at the time of the conference, generally reflecting a lack of well-controlled studies in younger – e.g., preschool – children. The problem of early childhood caries merits ongoing review of this preventive modality as additional evidence becomes available.
- ***Pit and fissure sealants*** – Dental sealants (plastic coatings that are applied to the grooves and fissures of primary and permanent teeth) have been demonstrated to be effective in the primary

[14] National Institutes of Health Consensus Development Statement "Diagnosis and Management of Dental Caries Throughout Life," National Institutes of Health/National Institute of Dental and Craniofacial Research, March 26-28, 2001.

[15] Lewis DW, Ismail AI, Canadian Task Force on Periodic Health Examination. Periodic health examination, 1995 update: 2. Prevention of dental caries. Can Med Assn J 1995;152:836-846.

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prevention of caries, and their effectiveness remains strong as long as they are maintained (i.e., through periodic evaluation and reapplication, if necessary).

- ***Topical antimicrobial agents*** – Evidence for the use of chlorhexidine gel is moderately strong (although many studies demonstrating its effectiveness used concomitant preventive measures). Concentrated (professional-strength) fluorides also have antibacterial properties.
- ***Combination interventions for primary caries prevention or for reversing or arresting the progression of carious lesions*** – Evidence concerning combinations of chlorhexidine and fluoride and/or sealants suggests they are effective.
- ***Space maintenance and habit discontinuation appliances*** – Space maintainers are removable or fixed passive appliances designed to prevent tooth movement and generally are placed following the extraction of teeth or in cases of congenitally missing teeth. Habit discontinuation appliances are used to eliminate habits that can adversely affect the development of anatomical structures or functions such as speech (e.g., thumb sucking or oral finger habits). Because they do not directly relate to dental caries, neither review process commented on these devices.
- ***Protective mouth and face guards for children engaged in sports activities*** – Many such devices have been tested and found to be effective in reducing the incidence and severity of sports injuries.

Additional details on preventive dental services can be found in *Appendix A: Clinical Issues* of this Guide.

3. Therapeutic (Treatment) Services

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Oral diseases are progressive and cumulative and, if left untreated, become more complex and difficult to manage over time. Medicaid statutes and the SMM state that dental therapeutic services must include dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Furthermore, any services necessary to correct or ameliorate defects, illnesses or conditions discovered by periodic screening services or inter-periodic screenings (including medical and dental examinations, or community-based screening activities) must be provided. A partial list of dental treatment services specified in the SMM includes:

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- Pulp therapy for permanent and primary teeth – e.g., root canal treatments;
- Restoration of carious (decayed) permanent and primary teeth with materials and techniques that meet current accepted practices – e.g., plastic and metal fillings and stainless steel crowns;
- Scaling to control gingival and periodontal diseases;
- Maintenance of space for missing posterior primary and permanent teeth to prevent or minimize problems in eruption of permanent teeth – e.g., fixed and removable space maintainers;
- Provision of removable prosthesis (partial and complete dentures) when masticatory (chewing) function is impaired, when an existing prosthesis is unserviceable or when the condition interferes with employment training or social development; and
- Orthodontic treatment when medically necessary to correct handicapping and other malocclusions.

Additional descriptions of various types of dental treatment services including, in many instances, indications for and objectives of various procedures and expected outcomes can be found in Appendix A: Clinical Issues of this Guide and in the AAPD Reference Manual, available at www.aapd.org. The AAPD's "*Scope of Dental and Oral Health Care Benefits for Infants, Children, Adolescents, and Young Adults Through Age 21 Year*" contains an extensive outline of dental and oral health services for children that are in accordance with professionally accepted standards of contemporary dental and oral health practice. The policy statement and accompanying list of procedures can be found in Appendix B of this Guide.

Categories of Dental Treatment – A categorization and discussion of various "levels" of dental care for children – diagnostic and preventive services, basic levels of treatment, advanced levels of treatment, and "catastrophic" levels of care – can be found in the Reforming States Group(RSG)/Milbank Memorial Fund publication "*Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments.*" The RSG/Milbank report also contains an interactive actuarial model that allows users to estimate the costs of care under different parameters and assumptions, and is available on the Internet at www.milbank.org/990716mpd.html.

The vast majority of dental treatment services are provided by dentists and allied dental personnel in ambulatory care facilities, generally with the aid of local anesthesia and communicative behavior management approaches. However, many children with extensive dental disease or treatment needs – especially those with early childhood caries, high levels of anxiety about dental treatment, or special health care needs – require additional behavior management approaches which may include various forms of conscious sedation or, in some cases, treatment under general anesthesia. Additional detail on issues related to behavior management for dental services can be found in Appendix A of this Guide.

4. Emergency Services

Emergency dental services include:

- procedures necessary to control bleeding, relieve pain, or eliminate acute infection – e.g., starting root canal treatment on infected teeth, draining abscesses and infected areas, treating soft tissue swellings associated with erupting teeth, palliative care for oral soft tissue infections such as herpes;
- procedures that are required to prevent "pulpal death" (infection of the nerves and blood vessels inside the tooth) and the imminent loss of teeth – e.g., decay removal, application of medications, temporary fillings; and
- treatment of injuries to the teeth or supporting structures (bone or soft tissues that surround the teeth) – e.g., temporary fillings for fractured teeth, stabilizing loose teeth and supporting bone, cleaning and suturing traumatic wounds; and palliative therapy for pericoronitis (swollen, inflamed tissues associated with impacted or erupting teeth) – e.g., irrigation of swellings, removing debris from infected areas, relieving trauma caused by opposing teeth.

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E. Integration of Dental Services and EPSDT Screening Services

1. Purpose of Screening and Relevance to Children's Oral Health and Dental Care

Periodic pediatric screenings generally are conducted for the purpose of identifying children within a population who have diseases or conditions that require management, definitive corrective treatment, or definitive diagnosis to either confirm or rule out the presence of a disease or condition that requires follow-up care. Children identified or suspected upon screening of having problems that require follow-up diagnosis or treatment are then referred to qualified professionals who are capable of conducting more thorough assessments, using instruments or tests that aid in establishing a definitive diagnosis, and making recommendations for subsequent services (i.e., a treatment plan). Children identified at an oral screening as needing additional follow-up services should be referred to qualified dental health personnel for clinical and, if necessary, radiographic examinations and further assessments of associated risk factors. Findings from these examinations and risk assessments should be used to establish diagnoses and treatment plans that include appropriate preventive services and disease management and/or therapeutic/restorative services, as well as plans for continuing oral health maintenance care. Guidelines for prescribing dental radiographs that were developed by an expert panel under the sponsorship of the U.S. Food and Drug Administration can be found in the Guidelines section of the AAPD's Reference Manual, available in hard copy or on the Internet at www.aapd.org, and in Appendix A of this Guide. Additional details concerning the diagnosis of common childhood oral diseases and conditions also may be found in Appendix A.

Although Medicaid regulation and policy do not require oral screenings as part of a general health screenings, oral screenings are strongly encouraged when children present for general health screenings. Periodic oral screenings as part of medical examinations or community-based health screening activities provide an opportunity to identify children who are at elevated risk for or exhibit overt signs of oral diseases, and children who are without a regular source of dental care (i.e., a "dental home"). Screening is particularly important for infants and very young children – especially high-risk children covered by Medicaid – because relatively few children in this age group currently access dental services, either because their caregivers do not seek dental care for them or because services are not available from local dentists. The emphasis on oral screening is supplanted once children reach the age threshold established by state-specific EPSDT periodicity schedules (generally somewhere between age 1 and 3 years) by a requirement for direct referral for evaluation by qualified dental personnel.

2. Limitations of Current Screening Approaches and Rationale for Recommendations for Direct Referral for Diagnostic Services

Although children experience a wide range of oral diseases, anomalies, and developmental conditions, this discussion of diagnostic services deals primarily with diagnosis of dental caries because of its prevalence, consequences, ongoing variable risk throughout childhood, and prominence as a reason for seeking dental care in children. Current recommendations call for

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children who exhibit signs of dental caries during dental screenings or who are suspected of being at elevated risk to be referred for more thorough evaluation and, if necessary, caries management and treatment by qualified dental personnel in appropriate settings. These recommendations reflect the limitations of current screening methods and the relatively high prevalence of dental caries in children. Current approaches for screening for dental caries in children generally rely on visual assessments conducted with limited lighting and equipment, often by individuals with limited oral health training. Although this approach is likely to prove satisfactory for detecting advanced carious lesions, relatively high false negative rates using this approach underscore the need for more thorough diagnostic measures.

The recent NIH consensus development conference on diagnosis and management of dental caries[16] noted that diagnostic and treatment paradigms differ significantly for large, cavitated carious lesions (cavities) *versus* early, small initial lesions and demineralized areas on tooth surfaces that may appear as indistinct discolorations. Given current technology, a variety of factors make it unlikely that any one diagnostic technique currently available will have adequate sensitivity and specificity to detect the range of large and small lesions at all sites at which decay may occur (pits and fissures, interproximal areas between teeth, etc.). Existing diagnostic methods – which include visual-tactile and radiographic examinations (particularly for interproximal lesions) – and a variety of other developing technologies appear to have satisfactory sensitivity and specificity in diagnosing substantial, cavitated carious lesions. However, these methods do not appear to have sufficient accuracy to efficaciously diagnose non-cavitated (early) caries, root caries (rare in children), or secondary caries (decay around existing restorations). Therefore, because it is highly advantageous to detect decay in its earliest stages from the standpoint of maximizing the potential to arrest, reverse or minimize the damage caused by the caries process, detecting earlier stages of decay requires strong diagnostic skills and the availability of multiple diagnostic techniques.

The NIH consensus development conference on the diagnosis and management of dental caries concluded that, although a variety of new methods for diagnosing and managing dental caries are being explored:

- The scientific evidence concerning these new technologies does not warrant their wide-spread adoption at this time.
- Consumers and health professionals should not depart from the practices which are likely to have contributed to oral health improvements, including the use of a variety of fluoride products, dietary modification, pit and fissure sealants, improved oral hygiene, and regular professional care.

The potential exists, however, for future technological developments to produce more reliable screening techniques based on relatively straightforward quantitative or visual readouts that could alter strategies for monitoring and managing early states of decay.

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[16] National Institutes of Health. National Institutes of Health Consensus Development Conference Statement: Diagnosis and Management of Dental Caries Throughout Life. National Institutes of Health. Accessed at www.nih.nidcr.gov, April 2, 2001.

3. Responsibility for Initial Referrals

In light of the early onset and recurring, progressive nature of dental diseases in children and the chronic pervasive nature of dental access problems for Medicaid-eligible children, it is essential that a wide range of health care providers be involved in monitoring children's oral health status on a regular basis. Yet, in spite of their importance, screening activities or programs that *lack effective linkages* to dental providers capable of providing needed diagnostic, disease management and treatment services are of little value and largely act as a drain on scarce resources.

"Referral" means more than advising someone – in this case a Medicaid-eligible child or family – that they need follow-up care. Within the health professions and health care delivery systems, "referral" means arranging for a patient to see another provider deemed capable of providing necessary follow-up services with the expectation that responsibility for that aspect of the patient's subsequent care is shared or transferred to the provider to whom the referral is made, with appropriate feedback to the referring provider.

State Medicaid programs are ultimately responsible for assuring that direct referrals are made in accordance with their respective dental periodicity schedules, that necessary follow-up for dental diagnostic and treatment services are made, and that children identified as needing such services get to dentists' offices or other suitable treatment facilities in a timely manner. Ideally, if initial screening providers are not able to arrange for referrals directly, they should inform the responsible program administrators or intermediaries (e.g., health plans) who then have the responsibility to see that necessary referrals are arranged and that care is initiated in a timely manner.

F. Program Administration

1. Informing Eligible Children and Families (Outreach Activities)

Families eligible for Medicaid often are not aware of the scope of benefits available to them or their prerogatives and responsibilities, and frequently do not understand the complexities of modern health care systems. In addition, many children and their parents face challenges related to language. Without adequate information and assistance in obtaining oral health services from a largely unorganized system of independent dental providers, children often miss out on services necessary to ensure their oral health. The result can be sub-optimal utilization of services characterized by irregular and episodic care-seeking patterns, failure to establish and maintain a regular source of care, failure to complete recommended treatment plans resulting in high levels of unmet treatment needs,

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The SMM states that therapeutic
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failure to gain control of disease processes necessitating more complex and more costly forms of care when treatment is finally sought, and poorer outcomes.

Informing all eligible children and their families about Medicaid services is a critical element for achieving optimal oral health and long-term cost savings for Medicaid-eligible children. All eligible Medicaid recipients under age 21 need to be informed about EPSDT services in a timely manner, generally within 60 days. The SMM, requires that states assure that various forms of effective communication are used. Community-based outreach strategies including health fairs, school programs, Head Start and WIC nutritional programs, faith-based organizations, ethic/cultural organizations, and public awareness campaigns (including common non-English language translations) may be particularly effective in disseminating information about services that children need, enrollment processes and available benefits. Placing program information in the offices and clinics of various types of health care providers also may help reach and inform eligible families.

2. Supportive Services (Scheduling and Transportation Assistance)

Medicaid program beneficiaries often require additional support services in order to access needed health services. If requested, programs must provide assistance with transportation and scheduling appointments for examinations as well as follow-up diagnostic and treatment services, and arrange for translation services for families that have difficulty communicating in English. Failure to make such arrangements often results in missed appointments that waste clinical care opportunities, discourage provider participation, and delay or interrupt courses of treatment. Such delays and interruptions in treatment generally result in more advanced, difficult and costly subsequent treatment due to the progressive nature of dental diseases, and often lead to poorer health outcomes.

3. Responsibility for Referrals for Specialty or Advanced-Level Care

The majority of U.S. children receive dental care from general dentists who comprise roughly 80 percent of all practicing dentists and constitute the vast majority of "primary care dentists." Pediatric dentists, the only primary care dental specialists, comprise about three to four percent of all dentists, but provide both basic and advanced-level care for a disproportionately large percentage of children relative to their numbers. Fortunately, of those children who do experience dental decay, most (roughly 80%) have fairly routine restorative treatment needs and are cooperative for dental treatment. However, the remainder – nearly four to five million American children – have advanced or "catastrophic" levels of disease and frequently present additional challenges due to medical co-morbidities, developmental problems or early onset of severe dental disease. These children often require advanced patient management skills on the part of the treating dentist, and frequently require treatment using conscious sedation, deep sedation or general anesthesia. Children with special health care needs, particularly those with developmental disabilities, also often require adaptive environments, modifications to the delivery of routine care, and/or specialized services. Dental care for these children generally is available through pediatric dentists or general dentists with advanced (residency-based) training or skills acquired through intensive professional continuing education.

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<#>Effective referral linkages among medical or community-based screening activities and dental care providers, and¶
<#>Effective referral linkages among dental care providers for children requiring specialty-level services or advanced levels of care.¶

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Some aspects of dental care, even for cooperative children, also may necessitate referrals to dental specialists (e.g., for endodontic/root canal, periodontal, surgical, prosthetic or orthodontic services). Failure to establish adequate provider networks or effective linkages among dental providers for these types of care frequently results in high levels of unmet treatment needs, and an ineffective and inefficient system that delivers a preponderance of diagnostic and preventive services at relatively high cost, while failing to meet the comprehensive needs of eligible children. State Medicaid programs or intermediaries with whom they may contract (i.e., dental plans) should ensure that adequate numbers of advanced-level dental care providers are available to Medicaid beneficiaries.

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4. Continuity of Care, Coordination and Case Management

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Providing continuity of care and necessary diagnostic, preventive and medically necessary treatment services is a prominent goal for Medicaid enrolled children. CMS recognizes and anticipates many of the challenges of engaging the contributions of a broad array of geographically distributed health care providers of various types to fulfill program requirements. Accordingly, it ascribes an active role for state Medicaid programs in working with both beneficiaries and providers to engage and coordinate the efforts of all participants.

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Although "case management" does not appear directly in the statutory provisions pertaining to EPSDT services, it is included as a required service under section 1905(a). The case management approach has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided efficiently and in a timely manner, and that duplicated and unnecessary services are avoided. A variety of case management approaches have been used, ranging from comprehensive case management for all services to community-based case management limited to dental services only. Effective case management also may be provided in collaboration with Head Start, WIC and maternal and child health (MCH/Title V) programs, or other community-based organizations or agencies such as those developed as part of Access to Baby and Child Dentistry (ABCD) programs.[19] Regardless of the approach, the functions carried out by effective case management programs include arranging for initial and subsequent appointments and referrals, following up with counseling activities, and arranging for support services for beneficiaries who have difficulty following through with recommended courses of treatment or periodic reassessments. Case management is particularly important where responsibility for assessments is shared by more than one provider or where the initial provider is unable to provide the full range of services a child requires.

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5. Dental Advisory Group

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Dental practices operate on a small-business model with limited staff and support services. Therefore, dental Medicaid programs need to be administered in a manner that does not place undue

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[19] Grembowski D, Milgrom PM. Increasing access to dental care for Medicaid preschool children: the Access to Baby and Child Dentistry (ABCD) program. Public Health Rep. 2000;115:448-59.

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administrative burden on participating dentists. If Medicaid services are administered directly by the state Medicaid agency, the agency should consider use of "mainstream" practices that mirror those of commercial carriers that are considered "user friendly" by dentists. If responsibilities are contracted to commercial third-parties health or dental plans, preference should be given to plans that have demonstrated good working relationships with dental providers as evidenced by robust provider networks. State Medicaid programs are encouraged to maintain ongoing communications with a dental advisory group to keep abreast of issues of concern to practitioners, changes in dental service delivery, and exemplary contemporary dental benefits program administration practices.

Medicaid programs are encouraged to maintain regular communications with dental professionals through formal dental advisory groups comprised of representatives of the pediatric dentistry state unit (society, association), state dental association and other organizations deemed to have an important role in children's dental services. Although not required, establishment of a formal dental Medicaid advisory group can help program officials to stay apprised of contemporary practice techniques and policies. Periodic meetings with dental professionals who actively participate in the Medicaid program also help Medicaid program administrators identify administrative issues of concern to dentists. Recent experience in several states has shown that ongoing communications with dental advisory groups has been critical to building improved relationships between Medicaid programs and practicing dentists, and to increasing dentist participation in Medicaid. Dental advisory groups can offer guidance to the state regarding issues such as appropriateness of certain services in specific situations, help in resolution of conflicts among providers, patients and the state Medicaid agency, and provide other practical assistance.

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6. Contracts Development and Enforcement

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Developing strong contracts is essential if responsibilities for administering children's benefits are to be delegated to third-party carriers or managed care organizations. Model contract provisions for contracting pediatric dental benefits under Medicaid have been developed by workers at George Washington University under a contract with the Centers for Disease Control and Prevention, and are available on the Internet at www.gwu.edu/~chsrp/sps/dental/intro.html. Equally critical, is a process to monitor program performance and enforce contract provisions to ensure accountability and provision of services needed by children covered by Medicaid.

7. Elements of Systems Capacity and Integration

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State Medicaid agencies increasingly are becoming involved in managing and organizing, rather than merely paying for, the services for which they are responsible for providing to program beneficiaries. As a result, many state Medicaid agencies are exploring approaches to broaden and integrate the contributions of dental and other health care providers to improve oral health status and enhance the delivery of dental care to Medicaid enrollees in their states. Medicaid agencies have substantial opportunity to influence the development of at least the following integrated system components:

- ***Universal, periodic assessments*** to determine risk, disease status, or need for treatment;
- ***Professionally grounded guidelines or protocols*** for reducing disease burden and appropriate

use of treatment services based on levels of risk, disease status, or indications for treatment;

- ***Effective health promotion, primary prevention, and disease management programs;***
- ***Effective referral mechanisms*** linking "non-dentist" assessors who do not provide additional services to prevention and disease management programs for those at risk, but without disease, and to dentists for those in need of disease management and/or reparative services;
- ***Effective dental referral mechanisms*** among general dentists and pediatric dentists or other specialists for children with advanced levels of disease or special management considerations;
- ***Case management and care coordination*** to facilitate completion of follow-up activities and episodes of care;
- ***Programs to develop service capacity in dental provider shortage areas***, including both workforce and facilities;
- ***Organized systems of care*** with defined and enforced performance standards for entities that are delegated responsibilities for specified populations or geographic areas; and
- ***Effective management information systems*** to monitor performance and support quality improvement.

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G. Program Financing and Payments[20]

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1. Funding Levels for Public Dental Programs for Children

The financing of public dental programs for children varies from state to state. Except for a few states that have made substantial recent changes, Medicaid funding and reimbursement levels have been widely regarded as a key factor in low participation by dentists. Ready sources of data have only recently become available to guide policy makers and program administrators in identifying the level of program funding that may be necessary to provide low- to moderate-income children with access to appropriate dental care.

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Historically, commercial dental plan databases have had limited applicability because they generally reflect the care provided to children from middle-to-upper income households. Children from these households tend to have good access to comprehensive dental services and use dental services according to recommended periodicity schedules. However, children from these households now have much less dental disease and treatment needs than do children from lower-income households. Conversely, data from public programs reflect the use of dental services by low-income children who have relatively high levels of disease and treatment needs, but who have had limited access to dental services. The problem of using raw data from public (e.g., Medicaid) programs is further confounded by historically low levels of program funding that, in turn, are reflected in reimbursement rates that often are well below dentists' normal fees.[21] Faced with the absence of

[20] This section draws largely on material prepared by James J. Crall, DDS, ScD, for a paper commissioned for the U.S. Surgeon General's Workshop on Children and Oral Health, currently in press in the *Journal of Ambulatory Pediatrics*, and work supported by the Children's Fund of Connecticut, Inc. and the Connecticut Health Foundation.

[21] United States General Accounting Office. Oral health: factors contributing to low use of dental services by low-income populations. GAO/HEHS-00-149. September, 2000.

suitable existing data sources, concerned parties have turned to actuarial approaches to develop program financing and cost estimates for publicly funded pediatric dental programs.

2. Actuarial Estimates of Necessary Funding Levels for Publicly-Financed Children's Dental Benefits Programs

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a) American Academy of Pediatrics Analysis

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The American Academy of Pediatrics (AAP) commissioned the firm of Towers Perrin to develop actuarial estimates of the costs of providing comprehensive health benefits, including dental services, for children covered by SCHIP. The Towers Perrin actuaries developed per-member-per-month (PMPM) estimates for what states should expect to pay health plans for services outlined in the AAP policy statement, "*Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years.*"[22]

The study included cost estimates for inpatient facility use, outpatient facility use, physician services, vision services, hearing aids, dental services, and pharmacy services based on regional utilization statistics. Results demonstrated that providing a comprehensive health benefits package, which is essential to children's optimal health and well-being, can be done at relatively moderate overall cost. The national average was calculated to be $101.47 per member/child per month (PMPM), or roughly 60 percent to 70 percent of the cost of providing similar health care benefits to the general U.S. population as a whole (i.e., adults and children). The cost of providing coverage for preventive, diagnostic and rehabilitative *dental services* (with orthodontic coverage limited to services deemed to be medically necessary) for SCHIP-eligible children eligible was estimated at $20.35 PMPM, or approximately 20% of the total cost of overall child health care benefits. Appendix C of this report contains national estimates from the AAP/Towers Perrin study. Separate cost estimates for urban and rural areas for all 50 states and Puerto Rico are included in the AAP analysis, which is available at the Academy's Internet site at www.aap.org/advocacy/towers/cstover.htm.

b) Reforming States Group Analysis

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The Reforming States Group (RSG), with support from the Milbank Memorial Fund, commissioned the firm of PriceWaterhouseCoopers to develop an interactive actuarial model that states can use to develop program funding requirements and cost estimates for dental benefits for children enrolled in public programs such as SCHIP and Medicaid. For this project, the actuaries used data from the California dental Medicaid (Denti-Cal) program to determine the costs of pediatric dental services at market-based fees (i.e., dentists' charges discounted by 20 percent) for a population of children whose use of services mirrored those enrolled in the California Medicaid program. The resultant estimate for the cost *for dental services* under this program was approximately $14 PMPM. The RSG model may be found on the Internet at www.milbank.org/990716mrpd.html.

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[22] Available on the Internet at www.aap.org/policy/re9730.html.

The AAP and RSG figures are not directly comparable. The AAP estimate reflects what states should expect to pay managed care health plans in the way of premiums, including program administration costs that typically range between 10-15 percent of total premiums. The RSG figure reflects the costs of dental services only (i.e., without program administration costs). Adding 15% program administration costs would result in an estimate of roughly $17 PMPM. The data and methods used to derive the respective estimates also differed. The AAP/Towers Perrin study started with data from commercially insured children and adjusted for additional treatment needs of SCHIP enrollees based on epidemiological data from the Third National Health and Nutrition Examination Survey (NHANES III). The RSG/PriceWaterhouseCoopers figure reflects use of services by California Medicaid enrollees without adjustments for unmet treatment needs; thus, the figure represents a conservative estimate of funding requirements. In spite of their differences, these models define a fairly consistent cost estimate of approximately $17 PMPM for premium costs, using a 15 percent cost estimate for program administration, for SCHIP-eligible children. Medicaid-eligible children have higher overall dental caries experience and higher levels of unmet treatment needs. Accordingly, cost estimates for Medicaid-eligible benefits would be expected to be somewhat higher initially (i.e., while the backlog of their unmet treatment needs are being addressed); thereafter, the ongoing costs of coverage for Medicaid-enrolled children obtaining continuing oral health maintenance services would be expected to decrease.

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3. Historic Funding Levels in Public Pediatric Dental Care Programs

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Funding requirements and cost estimates derived from the actuarial models highlighted above are generally consistent with estimates derived from a more general model developed by the American Dental Association and government surveys of actual expenditures for children not covered by public programs. Nevertheless, they generally represent multiples of current PMPM funding levels for Medicaid dental programs. These and other sources also indicate that 20-30 percent of pediatric health care expenditures in the private sector are attributable to dental care, depending on age group. Historic funding levels for public pediatric dental care programs stand in stark contrast to these figures. For example, Medicaid expenditures for pediatric dental services have only comprised slightly more than 2 percent of Medicaid pediatric health care expenditures – that is, roughly one tenth of the resources provided for non-Medicaid children. Although consideration must be given to the fact that many children with multiple or severe medical problems often are enrolled in Medicaid, a substantial gap in funding levels exists in most states between current Medicaid dental program allocations and market-based requirements.

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4. Reimbursement for Dental Services

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Dental services are produced and must be purchased within relatively small local areas. The prices that dentists charge for dental services reflect a multitude of supply and demand determinants, but generally vary according to differences in production costs, which in turn, vary by state and region.

a) U.S. General Accounting Office Study

In its evaluation of factors contributing to low use of dental services by low-income populations, the U.S. General Accounting Office (GAO) noted in April 2000 that the primary reason cited by dentists for not treating more Medicaid patients was "payment rates are too low." The GAO's survey of all 50 states plus the District of Columbia noted that "Medicaid payment rates are often well below dentists' normal fees." GAO comparisons of Medicaid payment rates also showed significant variation across states for different procedures relative to average regional fees.

On average, the mean Medicaid fees for all state programs were found to be equal to or slightly greater than the 10th percentile of fees charged by U.S. dentists for three of 15 procedures (new and periodic examinations and fluoride applications) selected for the GAO survey. That is to say that only about 10% of dentists would view the Medicaid rates as comparable to their usual fees. Mean Medicaid reimbursement rates for the other 12 procedures were *less than* the fees routinely charged by even the lowest 10 percent of dental providers, oftentimes by a considerable margin. Thus, it is not surprising from an economic perspective that, at the time of the GAO's survey, 10 percent of dentists or less were "meaningful" participants in most state Medicaid programs.

The GAO report also sought to determine whether fee levels following rate increases in many states had made a difference in a state's ability to improve access. The GAO findings showed that most of the states that reported improved utilization paid at rates that were at least two-thirds of average regional fees (which generally just cover production costs for ½ the state's dentists excluding dentist compensation), while most of the states without improvement had lower payment rates. Recent experience in several states (e.g., Georgia, Indiana, Michigan and South Carolina) suggests that raising reimbursement rate limits to levels that approximate the 75th percentile of prevailing fees in the state can significantly increase access and utilization of dental services by Medicaid-eligible children and participation by dentists in Medicaid, especially when such initiatives are actively promoted by state dental organizations and commercial plans (in those states that contract with commercial plans to administer benefits).

b) Comparisons of Medicaid Reimbursement Rates for Pediatric Dental Services to Prevailing Market Rates

The Table below summarizes data on Medicaid dental reimbursement rates for 15 selected procedures obtained as part of the previously noted GAO study. The column labeled "Medicaid Mean" shows average reimbursement rates for the 50 states and District of Columbia in 1999. The column labeled "National Mean" shows the average fees charged by U. S. dentists for those same procedures based on data obtained from the American Dental Association's 1999 Fee Survey. The Medicaid rates average 56 percent of the respective average fees charged by dentists. Dentists' overhead generally is reported to be in the range of 60-70 percent of practice charges, exclusive of dentist compensation. Reimbursements below this range may not cover the costs of providing services and thus are not likely to be viewed as positive incentives for dentist participation.

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The remaining columns show various fee percentiles for U. S. general dentists.[23] Comparing Medicaid payment rates to these percentiles provides an indication of the percent of dentists who might view Medicaid payments as comparable to their usual fees. For most of the selected procedures, Medicaid reimbursement rates are below the 10th percentile, meaning that fewer than 10 percent of dentists would view the fees as comparable to their usual fees. Since dentist's collections are reported to average nearly 95 percent of charges, reimbursement rates that are significantly below prevailing dentists' charges are not likely to attract large numbers of dentists. Although these national data serve to illustrate the nature and extent of the gaps between typical Medicaid reimbursement levels and prevailing dentist fees, analysis of state-level data is critical to developing relevant market-based reimbursement rates for specific state Medicaid programs.

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Procedure Code	Description	Medicaid Mean	1999 Natl Mean	1999 Natl 10th %-ile	1999 Natl 25th %-ile	1999 Natl 50th %-ile	1999 Natl 75th %-ile
	Diagnostic						
00120	Periodic oral exam	$ 16	$ 25	$ 16	$ 20	$ 23	$ 29
00110/00150	Initial/comp oral exam	$ 22	$ 39	$ 22	$ 27	$ 35	$ 46
00210	Introral compl w/ bwings	$ 43	$ 73	$ 53	$ 61	$ 71	$ 82
00272	Bitewings - 2films	$ 13	$ 24	$ 16	$ 19	$ 22	$ 27
00330	Panoramic film	$ 35	$ 63	$ 48	$ 53	$ 60	$ 71
	Preventive						
01120	Prophylaxis - child	$ 23	$ 39	$ 27	$ 31	$ 37	$ 44
01203	Topical F excl prophy	$ 13	$ 22	$ 11	$ 16	$ 20	$ 26
01351	Sealant- per tooth	$ 17	$ 29	$ 20	$ 22	$ 27	$ 33
	Restorative						
02150	Amalgam-2surf-perm	$ 47	$ 83	$ 59	$ 68	$ 78	$ 93
02331	Resin-2surf	$ 55	$ 100	$ 65	$ 78	$ 93	$ 113
02751	Crown - PFM Base	$ 316	$ 579	$ 439	$ 507	$ 573	$ 654
02930	Prefab SSC-primary	$ 80	$ 140	$ 83	$ 105	$ 136	$ 164
	Endodontics						
03220	Ther pulp exc final restor	$ 47	$ 91	$ 52	$ 65	$ 86	$ 106
03310	Anterior RCT	$ 193	$ 366	$ 263	$ 311	$ 356	$ 420
	Surgery						
07110	Extraction - singe tooth	$ 41	$ 79	$ 52	$ 64	$ 76	$ 93

c) Global vs Selective Reimbursement Rate Adjustments

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Many states reimburse at higher relative rates for selected procedures or categories of services (e.g., diagnostic and preventive services) within their Medicaid fee schedules. This well-intended strategy provides additional economic incentives for dentists or other providers to deliver these services and may increase crude access statistics. However, this strategy generally provides inadequate incentives

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[23] Fee **percentiles** demonstrate the distribution of fees charged by dentists in a particular area. For example, the fees shown in the column labeled "10th percentile" indicate that 10% of dentists charge that amount or less for the respective services. Conversely, 90% of dentists charge more than the amounts shown. The fees listed in the "25th percentile" column indicate that 25% of dentists charge that amount or less; and, conversely, 75% charge more than that amount, etc..

for dentists to provide the full scope of services required by Medicaid enrolled children (e.g., restorative treatment for decayed teeth) since procedures that are more technically demanding and often require advanced behavior management approaches to achieve a child's cooperation are reimbursed at relatively lower rates. This often results in Medicaid dental service profiles that are not consistent with data obtained from national, state-wide or regional surveys of low-income children's disease levels and treatment needs. In effect, the program may end up allocating most of its resources for diagnostic and preventive services while the restorative and surgical treatment needs of large numbers of children remain unmet.

d) Periodic Reimbursement Rate Adjustments

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The costs of dental services continue to increase as a result of increasing production costs (salaries, supplies, rent, etc.) and demand for services. The graph below, which uses data from the American Dental Association, depicts the annual incremental and cumulative effects of increases in the cost of dental services in recent years. Increases in dental costs have averaged between 4 and 5 percent annually during this period, with cumulative increases between 1993 and 2000 approaching nearly 40 percent. Historically, Medicaid programs have not adjusted reimbursement rates on a regular (e.g., annual) basis, contributing to Medicaid reimbursement schedules that fall further and further outside market conditions over time.

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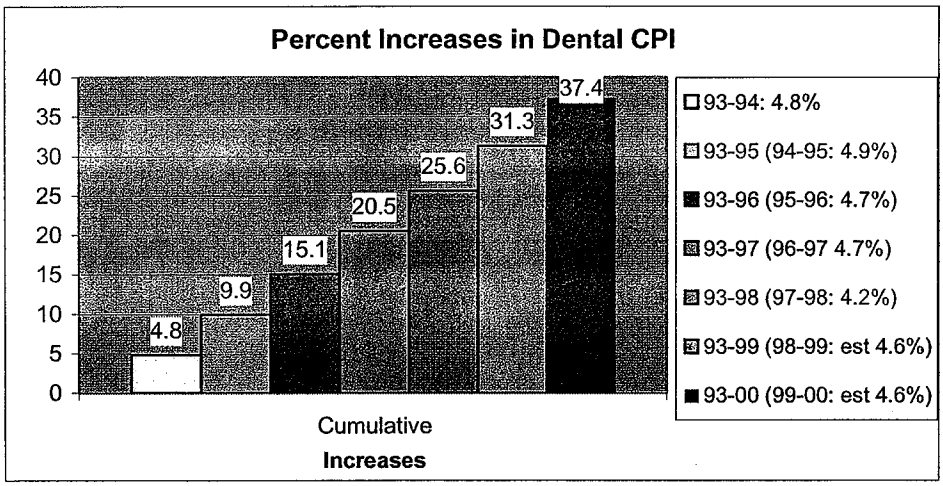

5. General Financing Considerations for Medicaid Children's Dental Program Improvements

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In anticipating the fiscal consequences of changes made to reimbursement for children's dental programs, the following considerations likely will apply, particularly in states where Medicaid

reimbursement rates vary considerably from current market rates.[24]

Improvements Will Cost More – Developing and sustaining an effective, market-based dental care system for underserved Medicaid populations may require the commitment of considerably more financial resources than may currently be allocated because:

- More children will be served and have more of their treatment needs met, thereby increasing expenditures for dental treatments.
- New and expanded systems capacity expenditures may increase as new or improved support functions are put on line (e.g., information systems, provider training, disease management, care coordination, outreach, and safety net improvements).

Ongoing Costs Will Be Less than Initial Costs - Expenditures usually will be higher initially than after the system has stabilized. This "front-loading" arises from pent-up demand and market-based purchasing adjustments on the treatment side and from initial capital costs for public health and systems capacity development. As children receive care, unmet need should decline and ongoing "maintenance" level costs should be less than initial costs.

Proportionality - The costs of market-based purchasing of dental services will continue to be very modest relative to total state Medicaid expenditures because current Medicaid expenditures for dental services comprise such a small portion of total program expenditures. Therefore, Medicaid dental program improvements will require significant increases over current spending levels on dental programs, but relatively little increase in overall public spending.

Potential Savings and Offsets - Dental program improvements can be expected to yield significant savings in treatment costs on an individual level – i.e., on average, ongoing treatment costs per individual to maintain oral health will be less over time. These savings at the individual level will accrue from reducing disease burden (and need for dental treatment) and tailoring dental prevention and treatment to levels of risk. This is particularly likely for very young children (i.e., the 5% of children with catastrophic treatment needs that often require costly hospital services in addition to significant dental treatment costs and account for approximately 30% of typical Medicaid dental program expenditures). Savings for these high-needs children also could be achieved by having some children treated with the aid of sedation, when appropriate, rather than general anesthesia. However, many state Medicaid programs do not reimburse or reimburse inadequately for sedation services.

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[24] The information in this section is drawn from work of J. Crall and B. Edelstein for the Children's Fund of Connecticut, Inc. and the Connecticut Health Foundation.

Similarly, enhancing private dentists' participation should reduce, over time, the overall need for total investments in "safety-net" clinic capacity. Nonetheless, enhancements of safety net facilities will continue to be needed in areas where there are no readily accessible providers. Engaging the capacity of private-sector dentists while targeting public health care infrastructure funding to dental health professional shortage areas will maximize efficiency while strategically using public funds to supplement "gaps" in the private sector delivery system.

Preliminary evidence for these projections comes from innovative programs implemented for Medicaid and low- income beneficiaries in Michigan[25] and western Pennsylvania[26] that engaged commercial dental plans with adequate networks and devoted funding levels that allowed purchasing of dental services at competitive market rates. Analyses of these programs conducted by university-based experts have demonstrated significant successes in relatively short time periods. These model programs have demonstrated substantial increases in individuals with a regular source of care, reductions in unmet treatment needs, increases in provider participation and geographic access, utilization patterns that stabilized per-enrollee costs, and high degrees of provider and enrollee satisfaction.

H. Performance Monitoring / Accountability

1. Performance Measurement

Health care practices and arrangements increasingly are being driven by an emphasis on performance with respect to cost and quality, growing demands for accountability, and consumer and purchaser choice in a market-driven health care system. In each of these areas, performance measurement – *the quantitative assessment of health care processes and outcomes for which an individual practitioner, provider organization, health plan or public benefit program (e.g., Medicaid) may be accountable* – plays a critical role.

Performance measurement should be a high priority for public benefit programs regardless of whether individual states choose to delegate a portion of their program administrative responsibility to managed care organizations (MCOs) or fully administer their own programs. Unfortunately, performance measurement has not been widely developed or applied in the area of pediatric oral health. Instead, program administrators have often focused on superficial comparisons of profiles of services provided to Medicaid children with those reflecting services provided to commercially insured populations. As these populations have substantially different treatment needs, such comparisons may result in inappropriate benchmarks, erroneous conclusions (e.g., that matching commercially insured population service profiles indicates delivery of services that are appropriate for Medicaid populations) and undue utilization review activities that discourage dentists' participation in Medicaid.

[25] Personal communication with Michigan Medicaid program administrators – Robert Smedes and Christine Farrell.
[26] Lave JR, Keane CR, Lin CJ, et al. Impact of a children's health insurance program on newly enrolled children. JAMA. 1998;279:1820-1825.

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Deleted: <#>¶ <#>Non-Financial Administrative Issues¶ <#>¶ <#>Non-financial program administration elements also are critical. Dental practices operate on a small-business model with limited staff and support services. Therefore, dental Medicaid
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2. Program Goals

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The goals of performance measurement and assuring program accountability are linked to the overall Medicaid goals of:

- assuring the availability and accessibility of required health care resources; and
- helping Medicaid recipients and their parents or guardians effectively use the resources.

The CMS Form 416 dental reporting requirements, as revised effective January 1999, were designed to reflect a maturation of program goals, enabling states to transition from emphasizing annual dental visits towards assessments of the types of services provided (e.g., the percentage of Medicaid-eligible beneficiaries receiving preventive and treatment services). Additional development and implementation of systems that track and link process measures (e.g., the percentage of children who are screened and subsequently referred for treatment) and outcomes (e.g., the percentage of children who complete recommended treatment plans or become caries-free, and assessments of consumer satisfaction) is a shared concern that needs to be promoted by both Medicaid programs and the dental profession.

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3. CMS/NCQA Pediatric Oral Health Performance Measures Project

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In view of its role as the primary public agency responsible for pediatric oral health services for children, CMS asked the National Committee on Quality Assurance (NCQA) in October 1998 to establish an Expert Panel to identify and evaluate current pediatric oral health performance measures, especially as they relate to managed care dental programs in Medicaid. The Panel's final report remains relevant today and provides findings and conclusions concerning the:

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- current state of pediatric oral health in the United States and the way dental care is delivered,
- current state of performance measurement in pediatric oral health,
- Panel's recommendations for immediate and future measure development, and
- current limitations facing measure development efforts in this area.

The report and recommendations (summarized below) were published in summary form in an issue of the *Journal of Public Health Dentistry*[27] and represent a resource for agencies, organizations and individuals interested in monitoring the performance of pediatric oral health care provided through public programs and commercial third-party arrangements.

a) Review of Current Measures

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In the expert panel's view, the single HEDIS (Health Plan Employer Data and Information Set) access measure currently applicable to Medicaid pediatric managed care dental programs – *Annual Dental Visit* – should be strengthened by adding age stratification, and should ultimately be replaced with a new measure – *Use of Dental Services by Children*. This proposed new measure profiles the

[27] Crall JJ, Szlyk CI, Schneider DA, et al. Pediatric oral health performance measurement: current capabilities and future directions. J Public Health Dent 1999;59:136-141.

use of different types of services – percentage of children receiving any service, any preventive service, and any "treatment" service (i.e., any service beyond diagnostic and preventive services) – and is similar to the revised Form 416 dental measure implemented for states reporting on their children's dental services, beginning in January 1999. NCQA currently is considering the panel's recommendation for inclusion in HEDIS.

b) Recommendations for Future Measures

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Measures of access and utilization provide only a limited basis for assessment of the degree to which health plans or programs address other important domains of performance measurement. The NCQA Panel's recommendations for future measures provide direction for the development of additional measures that begin to address the domains of effectiveness of care, satisfaction with the experience of care, involvement in decision making, and the cost and value of care. Although the Panel categorized these as future measures, a considerable amount of preliminary development is already underway.

Effectiveness of Care – Recommended measures include:

- **Assessment of Disease Status** – Percentage of all child enrollees who have had their periodontal and caries status assessed within the past year.
- **New Caries Among Caries-active Children** – Proportion of all caries-active child enrollees who receive treatment for caries-related reasons within the reporting year.
- **New Caries Among Caries-inactive Children** – Proportion of all previously caries-inactive child enrollees who receive treatment for caries-related reasons within the reporting year.
- **Preventive Treatment for Caries-active Children** – Percentage of all caries-active child enrollees who receive a dental sealant or a fluoride treatment within the reporting year.

Further development of these measures is tied to use of diagnostic codes in dentistry. Diagnostic codes have been issued recently by the American Dental Association, and a limited number are currently available in a set of newly released codes (Current Dental Terminology 2000, CDT-3).

Satisfaction with Services – Recommended measures include a pediatric oral health survey module that inquires about:

- Access to care,
- Availability of a regular source of care,
- Timeliness of care,
- Adequacy of information and extent of involvement in decision-making,
- Overall satisfaction with care, and
- The extent to which treatment needs have been met.

Initial development work on a pediatric dental module that parallels the Consumer Assessment of Health Plans Survey (CAHPS) that has been developed with support from the Agency for Healthcare Research and Quality has been conducted. Field testing of an initial set of measures is planned for the fall of 2001.

Value of Services – This measure is designed to provide information on the monetary value of services being delivered to Medicaid and SCHIP beneficiaries in order to facilitate assessments of how plans manage the resources allocated for providing oral health care for their enrollees. Data for the Value of Services measure are readily available from administrative data files for the majority of existing plans and programs.

I. Summary

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The development of this Guide was undertaken with the following premises in mind:

- that the Centers for Medicare & Medicaid Services, state Medicaid programs, and professional communities have a joint interest in developing and sustaining effective and efficient programs to meet the oral health needs of children covered by Medicaid, and
- that collaborative efforts among these stakeholders, both at the national and state levels, will help to produce and improve programs that meet those needs.

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We have attempted here to provide material concerning both key clinical aspects of oral health care for children and critical program administration issues. Additional information is available in the Appendixes and from various professional and governmental organizations cited in the text. Some of the information, especially details of clinical procedures contained in the appendix material, will change over time and need to be updated on a regular basis as professional guidelines evolve. However, most of the materials related to principles of Medicaid dental program administration should continue to apply regardless of changes in technologies.

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APPENDIX D.
POLICY ISSUES IN THE DELIVERY OF DENTAL SERVICES TO MEDICAID CHILDREN AND THEIR FAMILIES

This document is intended to address a number of Medicaid policy issues affecting the delivery of dental services to children and their families. It was developed on behalf of, and with the guidance and assistance of the Medicaid Maternal and Child Health Technical Advisory Group.

Policy Issue: Periodicity schedule

Question 1.a. Who establishes the periodicity schedule for dental service delivery, as required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service?

Answer: The state, in conjunction with recognized medical and dental organizations, is responsible for establishing state periodicity schedules for EPSDT services. Section 1905(r) of the Social Security Act (the Act) requires that each state provide general health *screening* and dental *services*. These services must be provided in accordance with a periodicity schedule which, for dental services, must be developed at intervals which meet reasonable standards of dental practice, *as determined by the state after consultation with recognized dental organizations involved in child health care*, and, at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

It has been recommended that CMS adopt a dental periodicity schedule and encourage states to use it. However, as noted above, CMS has no authority to do this.

Question 1.b. Does the dental periodicity schedule have to follow the schedule for medical examinations?

Answer: No. Especially in older children, the periodicity schedule for dental services, including dental diagnostic examinations, is not governed by the schedule for general health and physical examinations. Dental examinations of older children should occur with greater frequency than is the case with physical examinations. The dental diagnosis must be provided by a dentist. However, where any screening indicates, even as early as the neonatal examination, that oral health or dental services are needed at an earlier age, the needed services must be provided.

Policy Issue: Oral screening and direct referral

Question 2.a. If, for example, a five year old child receives an oral screening by a physician as part of a physical examination and is no dental problems are apparent, is the state able to claim that it has met the requirements of EPSDT with respect to oral health?

Answer: No. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist according to the state's dental periodicity schedule.

Question 2.b. Who is responsible for assuring that needed dental examination and treatment (which may be discovered at an EPSDT screening or in another setting) is received?

Answer: Ultimately, the state is responsible for providing or arranging for a direct referral to ensure that the child gets to the dentist in a timely manner. Prior to enactment of OBRA 1989, CMS, in consultation with the American Dental Association, the American Academy of Pediatrics, and the American Academy of Family Practice, among other organizations, required direct referral to a dentist at age 3 or an earlier age, if determined medically necessary. The law, as amended by OBRA 1989, requires that dental services (including initial direct referral to a dentist) conform to the state's periodicity schedule, and that the schedule must be established after consultation with recognized dental organizations involved in child health care.

Question 2.c. Under certain conditions, may alternative resources be used in assessing oral health status when there is an apparent lack of dental providers available to serve Medicaid-enrolled children? For example, if a physician has received training in oral health diagnostic procedures and if malpractice coverage and licensure permit, is a screening by the physician then considered sufficient for accomplishing an oral diagnosis?

Answer: No. Regulations at 42 CFR 440.100 require that diagnostic, preventive and corrective dental procedures must be "...provided by or under the supervision of a dentist." While oral health screening by a physician or other provider is encouraged and may be considered by many health professionals to be an integral component of a general physical examination, it does not substitute for a definitive dental examination by a dentist provided in accordance with the state's periodicity schedule. However, in some states where licensure allows, primary care practitioners (physicians, nurse practitioners, etc.) who have demonstrated successful completion of a special in-service training program are receiving separate Medicaid reimbursement, for example, for conducting a combination of oral health "risk-assessment," fluoride varnish application, and health educational services for young children. Children are then referred to a dentist for definitive oral diagnosis (which usually includes radiographs, as appropriate), and additional preventive and treatment services. Such programs should attempt to evaluate the accuracy of primary care providers' oral assessments, the effectiveness of fluoride varnish in reducing dental caries, the appropriateness of their referral recommendations, and children's success in obtaining additional dental services.

Policy Issue: Dental hygienists and EPSDT referral requirements.

Question 3. Some states allow dental hygienists to provide some services independent of a dentist's supervision. Can the state establish a program whereby the dental referral requirement for diagnostic, preventive and corrective procedures may be met *solely* through the services of dental hygienists **NOT** under the supervision of dentist?

Answer: No. Regulations at 42 CFR 440.100 require that diagnostic, preventive and corrective dental procedures must be "...provided by or under the supervision of a dentist." Additionally, dental paraprofessionals under the supervision of a dentist may perform routine services when in compliance with state practice acts. Since dental hygienists are not permitted by any state practice act to perform dental *examinations*, the diagnostic phase of the EPSDT referral requirement could not be achieved solely by the dental hygienist practicing without dentist supervision. Similarly, state practice acts require that most therapeutic services be provided by dentists. On the other hand, the regulation at 42 CFR 440.60 allows for the provision of "...medical care or any other type remedial care provided by licensed practitioners...within the scope of practice as defined by state law." This regulation is interpreted to permit Medicaid coverage of services defined by the state and provided by independently practicing, *licensed* dental hygienists. The word "licensed" is interpreted to mean that the state has provided legal authority (usually

through the state's Licensing Board) which enables dental hygienists to practice independently. The state elects to provide this coverage by submitting a state plan amendment (SPA) to CMS for approval. Such services are often principally preventive services, but some adjunctive diagnostic (e.g., x-ray) and therapeutic category procedures may also be provided and covered. Thus, some *portion* of the overall state EPSDT requirement may be met through unsupervised dental hygiene practice. Concerns about the incorporation of unsupervised dental hygiene practice into the state's Medicaid program relate mostly to assurance of an adequate referral mechanism between dentist and hygienist, and the prevention of duplication of services and reimbursement.

Policy Issue: Alteration of EPSDT benefits.

Question 4. Can EPSDT dental benefits be altered/reduced in scope?

Answer: Yes, in certain circumstances. EPSDT services must be provided in full, as required by section 1905(r) of the Act. However, section 1115 demonstration authority allows the Secretary to waive certain Medicaid provisions for specific eligible populations. One mechanism for states to request such waivers is through a Health Insurance Flexibility and Accountability (HIFA) Demonstration. Information on the HIFA Demonstration initiative is available on the Internet at http://www.hcfa.gov/medicaid/hifademo.htm.

Policy Issue: Medically necessary services

Question 5.a. If a state does not include a dental service in its Medicaid state plan, may a state refuse to provide that service to a child?

Answer: No. The state must provide or arrange for the provision of any medically necessary dental services, even if the service is not otherwise covered in the state plan for the rest of the Medicaid population.

Question 5. b. Are states required to provide or arrange for the provision of all *orthodontic* services that a child's dentist says are needed?

Answer: No, only those orthodontic services that are medically necessary, as determined by the state, must be provided. Although health care, diagnostic and treatment services to correct or ameliorate any defects and chronic conditions discovered are to be provided, the state is not required to provide or arrange for services which it deems are not "medically necessary." The state, not the dentist, has the responsibility for defining "medically necessity" on an individual, case-by-case basis (and not based solely on a pre-selected set of criteria) and must be able to support its decision with documentation of the individual case. State's often limit orthodontic services to more severe conditions, as determined *tentatively* by use of various numerical scales for classifying malocclusions, with final determinations made after individual cases are reviewed by expert consultants. States may wish to consider using a dental advisory committee, similar to the medical advisory committees required under the state plan and described in 42 CFR 431.12. to assist in applying appropriate standards of dental practice. Orthodontic services that are deemed "aesthetic," rather than medically necessary, may not be covered.

Policy Issue: Patient cost-sharing

Question 6. May a state require patient copays for EPSDT dental services?

Answer: Yes, under certain conditions. Normally, the state may not impose any cost-sharing (i.e., premiums, enrollment fees, deductibles, coinsurance, copayment, or similar cost-sharing charge) upon categorically or medically needy individuals under the age of 18, or, at state option, under age 21. However, section 1115 demonstration authority allows the Secretary to waive certain Medicaid provisions. One mechanism for states to request such waivers is through a Health Insurance Flexibility and Accountability (HIFA) Demonstration. Information on the HIFA Demonstration initiative is available on the Internet at http://www.hcfa.gov/medicaid/hifademo.htm.

Policy Issue: Billing patients for Medicaid-covered services.

Question 7.a. May a dentist place limits on the types of procedures he/she will provide for the Medicaid patient? For example, can the dentist *not* treat the patient in a hospital setting, although private patients may be treated in the hospital by that dentist? Or, can the dentist decline to provide a denture to a Medicaid patient, yet agree to provide that patient other Medicaid covered services?

Answer: Yes. A dentist may refuse to provide particular services. There is no federal law or regulation regarding this issue.

Question 7.b. Suppose a dentist provides a Medicaid-covered service to a patient who does not tell the dentist he/she is Medicaid-enrolled. When the dentist tries to bill the patient, the patient then admits to being enrolled in Medicaid. Is the provider unable to bill the patient directly for the service and not be paid by the patient the originally agreed-upon fee (i.e., must the provider accept the Medicaid payment)?

Answer: If a dentist agrees to provide a Medicaid covered service to a patient, then the dentist must bill Medicaid for the service and may collect directly only such cost-sharing as allowed under the State Medicaid plan. Certain types of services (e.g., emergency care) and beneficiary groups (e.g., children up to age 18) are exempt from copayments under federal law, unless the exemption has been specifically waived by the Secretetary (see Policy Issue: Patient cost sharing). Thus, for children under 18, the dentist is not required to accept Medicaid payment, but is limited to that payment if Medicaid is billed.

Further, dentists are not required by federal law or policy to bill Medicaid whether or not the patient misrepresented or otherwise did not advise the dentist of their Medicaid eligibility, unless state law stipulates a different requirement. If the provider expressly said to the patient (or in the case of a child, the patient's parent) that he/she would not accept Medicaid with respect to the patient--and there is no *state* law requiring the dentist to do otherwise--then the provider may bill the patient as a private pay client. Even if the dentist accepts Medicaid for the patient, the dentist can bill the patient for non-Medicaid covered services (see Policy Issue: Billing patients for non-Medicaid covered services).

Policy Issue: Billing patients for non-Medicaid covered services

Question 8. If a state does not provide a specific service (e.g., adult dentures) under its Medicaid program, can the dentist bill the patient for the non-covered service?

Answer: Yes. A provider may bill a recipient for a service as long as the service is not covered under the state's Medicaid program and the provider and recipient are both aware that Medicaid will not pay for the service. In the case of services for children, the state Medicaid agency must provide any service that it determines to be "medically necessary" for the child. A provider should be aware of any prior authorization requirements or other state procedures that must be followed before providing services to a child to ensure that the state does not deny the claim at a later date.

Policy Issue: Practice limits

Question 9.a. May the dentist limit the number of Medicaid patients he/she will accept into the practice? Or, stated another way, must the dentist accept other Medicaid clients if he/she accepts one Medicaid client (and thus is enrolled as a Medicaid provider)?

Answer: Dentists may limit the number of Medicaid patients to be accepted into the practice. The federal concept of "choice" holds for both provider and patients.

Question 9.b. Is it possible for dentists to limit their practice hours or schedules in a way which may be perceived as restricting patients' access to the dentist's practice?

Answer: There are no federal Medicaid laws or policies that prevent providers from limiting the number of Medicaid clients accepted into the practice. However, excluding legally protected groups (whether or not they are Medicaid beneficiaries) from the same office hours offered other clients may expose a dentist to litigation under Constitutional, federal and/or state anti-discrimination laws.

Policy Issue: Denial of dental services based on client "misbehavior/malfeasance."

Question 10. Can a dentist deny additional services to a Medicaid eligible child, i.e., can the dentist not complete a "treatment plan" (e.g., not complete orthodontic services), or can the patient be removed from the practice entirely if the patient is non-compliant with the provider's instructions or otherwise exhibits misbehavior or malfeasance? The misbehavior might include: failure to maintain oral hygiene, adverse behavior such as rudeness, illegal drug seeking behavior or use, missed appointments, etc.

Answer: Nothing in the federal law obligates a dental provider to serve any particular patient. However, the *state* is obligated to provide or arrange for EPSDT services, including required dental services, regardless of client misbehavior. Thus, if a particular dental provider refuses to accept a patient or complete a course of treatment, the state must have a process in place to arrange for an alternate dental provider to furnish the services. The federal obligation to arrange for continuing care does not reside with the dentist, but with the state, although the state is free to place an obligation on the dentist. As with non-Medicaid patients, however, a health care provider may be liable under a state's common law for "abandoning" a patient under care. The specific definition and interpretation of "abandonment" may vary from state to state.

Policy Issue: Direct patient billing for broken appointments

Question 11. May states permit providers to directly bill patients for missed appointments?

Answer: Current Medicaid policy does not allow for billing recipients for missed appointments. Missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business. The Medicaid reimbursement rate set by the state is designed to cover the cost of doing business and providers may not impose separate charges on recipients.

However, there may be two ways a state might allow payment for missed appointments.

1. In some states, managed care organizations (MCO pay providers for missed appointments. This practice may not present a concern to CMS as long as the payments are made out of the MCO profits, not with federal or state dollars.

2. A state may propose payment to a provider for the submission of a report (e.g., postcard sized) notifying the state that a patient has missed, for example, more than one appointment. Such reports could then be used by the state as part of its efforts to intervene, educate the patient, identify barriers and take action to assist the patient to make the appointments. Such an integrated and intervention based effort may be considered part of administrative case management.

Policy Issue: Loss of Medicaid eligibility during the course of treatment

Question 12. When a beneficiary loses eligibility for Medicaid during the course of treatment, treatment terminates abruptly. There is no recognition that a course of treatment is not complete and no way to pay for services, e.g., the removal of braces. The only recourse is to request payment by the family. Orthodontists, or other dentists doing multi-step procedures may be put in a position, for example, of having to take the appliances off (for free), or, if they stop treatment, they may be at risk of abandoning the patient. Could orthodontia be recognized as a long course of treatment and coverage (reimbursement) be allowed to continue for this service even when the individual becomes ineligible?

Answer: While there is a prohibition against federal financial participation (FFP) for services provided to an ineligible individual, CMS does have policy which allows states *to pre-pay* for orthodontia, in instances when it is a usual and customary medical practice. One example occurs when an individual is 19 or 20-years old and is receiving orthodontic services as part of EPSDT requirements. Because that individual will lose eligibility for EPSDT services upon turning 21, a state may elect to prepay up front for the entire course of treatment to avoid just the situation noted in the question. There are certain conditions that must be met. They are:

1. It is the usual and customary medical practice to prepay the fee for the service(s);
2. The services are considered as part of a single, indivisible course of treatment accomplished over time;
3. Treatment was initiated while the individual was Medicaid eligible; and

4. The nature of the service is that an appliance or device is attached to the patient and must be removed at a later point or else the patient will be harmed by the failure to remove the appliance or device.

Also, in a separate scenario in which an appliance or orthodontic device is ordered, and the patient then loses Medicaid eligibility, Medicaid may pay for the covered service so long as the device was ordered on a date when the patient was still Medicaid enrolled.

Policy Issue: Retroactive coverage

Question 13. An individual is involved in a car accident, is admitted to the hospital and receives extensive and various (medical/dental) treatment services. The individual applies for and receives Medicaid enrollment retroactively which covers the cost of the hospitalization. Is the hospital (and the physician or dentist) required to accept the Medicaid reimbursement?

Answer: Retroactive coverage does not demand that the provider accept Medicaid payment. The general rule of "choice" applies for both providers and patients--as described in policy issues elsewhere in this document. The dentist would not be required to accept Medicaid payment, unless there are state rules that govern this issue.

However, if the set of circumstance described above had occurred when the patient was already enrolled in Medicaid, a somewhat different outcome would occur. If the patient, or any other patient, *was admitted by the hospital as a Medicaid client*, then the *hospital* has the responsibility of assuring delivery of all services provided during the admittance. If the service is a Medicaid covered service, the dentist agreeing to treat the patient must accept Medicaid payment in full.

Policy Issue: Time limits for submitting claims

Question 14. May a state accept a dentist's "late" submission of a claim to Medicaid (submission after the time period set by the state)? If the state rejects the claim, may the dentist bill the patient directly as a fee-for-service patient?

Answer: Federal regulations at 42 CFR 447.45 require that providers submit all claims to the state Medicaid agency no later than 12 months from the date of service. There is no waiver authority in federal regulations for states to increase the time during which providers may submit claims. However, 12 months would seem a reasonable amount of time for a provider to submit a claim.

If a state rejects a claim for a service provided to a Medicaid recipient because it is not covered under the state Medicaid plan, the provider may bill the recipient for the service. However, if the state rejects the claim because it was not submitted in a timely manner by the provider, there is no authority allowing the dentist to bill the recipient for the service that was covered under the state's Medicaid program.

Policy Issue: Administrative Federal Match

Question 15.a. Can a state obtain administrative match for costs incurred in transporting dentists/mobile dental vans to the patient (rather than for costs of transporting the patient to the dentist)?

Answer: No. CMS does not consider transportation of a provider to be administration of the program. This would be a medical assistance service cost. State agencies may pay the cost of transportation of *recipients to providers* either through an administrative match, or as service cost.

However, it is possible that a state could have a higher payment rate for "mobile dental services" than for dental services furnished in the office setting. The state would need to have this payment rate approved by submitting a state plan amendment to CMS.

Question 15.b. Is it appropriate to use administrative match for the purpose of paying off dental student debt, in return for the dentist providing care in an area of provider shortage?

Answer: No. The applicable guideline for general administrative expenditures is found at 1903(a)(7) of the Act and in the regulations at 42 CFR 433.15(b)(7). These references state that Medicaid can pay 50 percent for amounts expended by the states "as found necessary by the Secretary for the proper and efficient administration of the state plan." The appropriate mechanism for reimbursing a provider for all allowable costs is through the service rate. CMS typically does not view providers as administering the Medicaid state plan and as eligible for Medicaid administrative reimbursement in addition to their regular service rate.

Question 15.c. Can states use administrative federal match to pay for electronic card readers or other devices that will help speed payment or confirm a patient's eligibility in the provider's office?

Answer: Yes. Under certain conditions, use of administrative match to pay for electronic card readers is appropriate. An electronic claims capture (ECC) system facilitates the submission of claims from providers through a direct link over telephone lines to the state's Medicaid Management Information System. If the ECC system *is for the dual purpose* of verifying eligibility and electronic claims capture, then the state may choose to furnish equipment to providers to make these transactions possible and this equipment may be eligible for 75 percent federal financial participation (FFP).

Policy Issue: Increase of Federal financial participation (FFP) for dental services.

Question 16. Can CMS increase the rate of FFP (or "federal match") for dental services to, for example, 75 or 90 percent FFP?

Answer: No. The FFP rate is established by law and based on a formula in the statute. CMS does not have the authority to change the rate either through waivers or other policy mechanisms.

Policy Issue: Need for "waivers" for dental innovations/pilot projects and for "payment incentives."

Question 17. Under what circumstances may a state test a different, innovative approach to dental care in only some parts of the state, rather than across the entire state? Can a state use special payment incentives to encourage dentists to practice in a specific location? When is a

1915(b) demonstration waiver needed and when is a state plan amendment (SPA) necessary in these situations?

Answer: The need for a waiver or a SPA depends upon whether the proposed innovative project may be characterized as a "payment" or a "coverage" innovation/pilot project. "Payment" activities require only a SPA; "coverage" innovations/pilots that are not statewide in scope require a waiver.

Most state proposals for altering the Medicaid dental program (which do not involve a managed care/at risk-based system) are of two general types: (1) they involve changes in provider reimbursement designed to enhance participation of dentists in the Medicaid program, or encourage provision of certain services over others (e.g., preventive/basic vs. rehabilitative services), either statewide or in a limited area; or (2) they expand the scope of Medicaid coverage by providing a new or not-yet standard benefit which is intended to demonstrate the effectiveness or improve care delivery, either statewide or in a limited geographic area.

The Medicaid statute provides that a "state plan for medical assistance must...be in effect in all political subdivisions of the state..." (Section 1902(a)(1) of the Act). CMS has interpreted this requirement to mean that eligibility and benefit policies must be applied statewide; except that service delivery and payment mechanisms are not required to be statewide (see 41 CFR 431.5(c)) (Statewide operation does not mean...that every source of service must furnish the service statewide..."). Given this interpretation, projects of either type noted above--*if provided statewide*--would need only a SPA.

However, if the activity is conducted in only a limited area of the state, then the distinction between a "payment" and "coverage" project becomes crucial. If the project includes only some form of increased payment in the pilot area, and Medicaid-eligible clients outside the area are entitled to the service (regardless of the state payment level, the method of reporting the claim, and client's ability to access the service), then this innovation may be characterized as a "payment" project and only a SPA is required. For example, using only a SPA, the state may increase dental payments in a specific region, or in a specific county, to a level greater than the Medicaid rates paid to dentist elsewhere in the state *(see italicized passage below for additional guidance)*. Such a program might be used, for example, in an area designated as having a shortage of dentists.

If, however, the project expands the scope of Medicaid coverage (e.g., a new benefit is added, or an existing benefit is enhanced or temporary limits on the number or scope of services are changed) in a specific area of the state, then this situation is not consistent with the requirement for statewide coverage and a waiver would be necessary. For example, if a project in the pilot area pays for three applications of fluoride varnish once a year during any three month period, but payment for these services is not available in the rest of the state, a waiver of statewideness would be required in order for the project to be undertaken. On the other hand, if the particular dental benefit (for children) already meets "reasonable standards of dental practice" or "medical necessity," then it may be argued that the benefit should be available statewide.

In the situation of a payment incentive in a specific area, the state may wish to take steps to avoid the perception that Medicaid might be paying excessively for dental services in that area. The following guides might be helpful in this regard: (1) the payment rate selected should be based on a prevailing rate (e.g., the private practice rate) in that area or in another area of the state, although that rate may be the highest of such prevailing rates; (2) the area rate should be available to any willing qualified provider who elects to serve the area; (3) the state should consider applying the rate to any other state-operated programs in the area; (4) the states should assure that an area-specific rate

does not conflict with any state-determined rules which require that state to pay "the lesser of the usual and customary rate or the Medicaid rate;" and (5) the state should consider other implications of an area dentist receiving a higher fee for a Medicaid patient then he/she receives from a non-Medicaid patient for the same services. Ideally, with respect to the latter caution, the provider's fee schedule should be the same for all patients in the area regardless of Medicaid eligibility, with discounts offered to those non-Medicaid beneficiaries unable to pay the established fees. (These caveats are based on CMS interpretation of related requirements contained in 1902(a)(30)(A) and 42 CFR 447.325).

In summary, and by extension:

- If the pilot project deals with payment, then a SPA is required.
- If the pilot project deals with a different or expanded benefit or coverage, then a waiver is required (if it is less than statewide).
- It may also be possible to have a pilot project with the same basic benefit and payment, but with a different way of delivering the service (i.e., service delivery in a school). No waiver would be required, but a SPA may be required if the service delivery system is specified in the state plan either directly or in provider qualifications.

Policy Issue: Free care

Question 18. Can the state allow dental providers to obtain Medicaid reimbursement in clinic settings (e.g., in dental schools, dental hygiene schools, public schools, etc.) if other patients serviced by the clinic receive services free-of-charge?

Answer: No. Medicaid reimbursement is not available for services provided to Medicaid beneficiaries if the services are provided without charge to non-Medicaid individuals. However, as discussed below, states and providers, including dental training institutions, schools, etc., may be able to receive payment, if certain procedures are followed.

If a dentist, school, or clinic (i.e., a provider) wants to bill the Medicaid agency for services provided to eligible beneficiaries, then the provider must bill for services provided to non-Medicaid individuals. The provider may do this by collecting third party insurance information from all facility patients and billing those third parties for any services delivered. For the uninsured patient, providers may develop a sliding scale fee schedule, based on the patient's (or patient's families') income, and charge accordingly. Whether the provider actually collects any monies from other (non-Medicaid) third party insurers or uninsured individuals is irrelevant, but the attempt at obtaining payment must be made. Alternative procedures and requirements may apply if the provider is covered by an agreement between the state Medicaid agency and the state Health, Vocational Rehabilitation, or Title V agency, as described in regulations at 42 CFR 431.

Policy Issue: Federally Qualified Health Centers (FQHC)

Question 19.a. Does the FQHC have to receive prospective payment system reimbursement?

Answer: Beginning in January 1, 2001, provisions of the Benefits Improvement and Protection Act of 2000 provide for a prospective payment system (PPS) for FQHCs. The PPS rate will be increased each year by the Medicare Economic Index and adjustments will be made

for increases/decreases in the scope of services. However, the center may be reimbursed using an alternative payment methodology. This alternative payment methodology must be 1) agreed to by the state and the center; and 2) results in a payment which is at least equal to the PPS rate.

Question 19.b. How are dentists reimbursed when they are employed by, or contracting with an FQHC?

Answer: It is the *facility* that receives the PPS encounter rate that encompasses services provided in the facility. The FQHC is responsible for deciding the mechanism and level of reimbursement to the dentist. The state Medicaid agency determines whether an "off-facility" dentist will be eligible for inclusion in the PPS rate. If the FQHC expects dental services to be included in the PPS encounter rate, then, at a minimum, the state must provide for the dental service (children are automatically covered; but the service must be included is the Medicaid state plan if an adult is receiving the care). Also, a contract must exist between the FQHC and the off-site dentist, and the FQHC must include dental services in its "scope of project." In making its determination, the state should also consider whether the off-site dentist is located geographically within the FQHC service area, and if the patient being served off-facility is a registered user of the FQHC's primary care services. Without such assurances, the FQHC merely becomes the billing agent, negating the rationale for special FQHC reimbursement considerations.

Question 19.c. If a dental service provided by the FQHC is not covered in the Medicaid state plan (e.g. dentures for adults are not covered in some states), will the FQHC be reimbursed?

Answer: If, for adults, the services are not covered in the state plan, Medicaid will not reimburse the FQHC. In the case of services for children, the state Medicaid agency must provide any service that it determines to be "medically necessary" for the child, even if the service is not otherwise covered in the state plan for the rest of the Medicaid population.

Question 19.d. Can state Medicaid agencies deduct section 330 federal grant funds when calculating Medicaid payments for an FQHC?

Answer: No. Deducting section 330 grant funds when calculating Medicaid payments is not permissible.

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