

The Oral Health Advisory Committee: Strategies to Improve Access

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In 1997 the U.S. Department of Health and Human Services approved Maryland's application to convert its fee for service Medicaid program to a managed care model. One year later the Maryland General Assembly passed SB 590, which mandated dental care utilization rates increase from the then 14% to 70% over the next 5 years. In response, the Secretary of the Department of Health and Mental Hygiene (DHMH) chartered the Oral Health Advisory Committee (OHAC) to advise DHMH about access to care and provider participation issues, as well as to oversee demonstration projects aimed at identifying barriers to access and recommending solutions. The OHAC is composed of the Deputy Secretary for Medicaid, private dentists, managed care organizations, organized dentistry, the dental school and state and local health officers. The OHAC has developed and coordinated utilization data protocols, provider recruitment strategies, outreach methodologies, case management oversight, dental procedure remuneration rate assessment and legislative initiatives, including direct briefing with the Governor. It serves as a model as to how disparate groups can work together to solve shared problems such as access to oral health care, and resolve differences associated with individual interests that may be in conflict with public health aims. This unique partnership advises the Secretary, with special insights, on how the State can best direct its resources to optimize oral health care for the underserved populations.

**Dental Access for Children on Medicaid—Impact of the North Carolina Institute of
Medicine Task Force Recommendations**
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- Background:** The Health Care Financing Administration (HCFA) reports that only 20% of eligible Medicaid children received preventive dental services in 1993. North Carolina figures parallel this dismal statistic—The North Carolina Department of Health and Human Services reports that only 20% of Medicaid recipients visited the dentist in 1998. Strategic planning on the local, state, and national level is critical in reversing this trend.
- Method:** The NC Institute of Medicine convened a Task Force of dental professionals, public health practitioners, physicians, and other interested citizens to study the problem of access and to make recommendations to the General Assembly.
- Objective:** The charge of the Task Force was to develop strategies to increase the level of participation of dentists in the Medicaid dental program and to improve the program's provision of preventive services.
- Results:** The General Assembly adopted several of the 23 recommendations presented: expansion of preventive dental services by public health hygienists outside the public school setting, establishment of a new service package to cover early dental decay screenings, education, and administration of a new fluoride varnish by physicians and physician extenders to children between the ages of nine and 36 months, and expansion of the NC Health Choice (CHIP) program. The General Assembly directed further study of other recommendations which will increase the pool of providers available to treat this population.
- Conclusions:** The consensus building which resulted in the development of a defined plan of policy recommendations will have a far-reaching impact on improving services for Medicaid recipients statewide.

Dental Care Utilization By Medicaid Children Before Five Years

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Access to oral health care under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a nationwide program. Few studies have examined utilization patterns in Medicaid-eligible children, especially in the pre-school aged group. The purpose of this study is to report the use of dental care in the North Carolina (NC) Medicaid Program by a cohort of children during ages 1-4 years (YO).

This study is an analysis of three linked statewide databases: birth certificates for 1992, Medicaid enrollment files for 1992-97 and Medicaid claims files for 1992-97. Birth certificates for 1992 were linked with Medicaid enrollment files for 1992 to identify all children born in that year who were enrolled in Medicaid at their time of birth. Children continuously enrolled during each of four ages (1,2,3, & 4 YO) were matched to claims filed by person identifiers and age. We defined four service categories: diagnostic/preventive (D/P), restorative (RES), extractions (EXT) and hospital emergency room (ER) visit and use of one or more services in each category and overall was determined.

Of the 81,518 births in 1992, 53,591 were enrolled in Medicaid. Forty-three percent of 1 YO were enrolled for the entire year and 5% received some dental services. At 2 YO, 38% were continuously enrolled, 16% received any dental services, 9% D/P, 3% EXT and 1% had an emergency room (ER) visit with the primary diagnosis of a dental condition. At 3YO, 37% were continuous enrolled, 37% received some dental services, 22% D/P, and 5% EXT. At 4YO, 31% were continuously enrolled and 58% received some dental services, 33% D/P, 17% RES and 7% EXT.

This analysis suggests that in the Medicaid population the overall use of dental services is low, but may be affected by enrollment. Of those continuously enrolled, utilization of dental services increase with age and diagnostic/preventive services make up the largest percentage of dental care rendered. Supported by The USDA Special Projects Grant, MCH Grant MCJ379494 and AHCPR Grant T32-HS-00032

Medicaid, SCHIP & Adolescent Dental Health: State Prevention Policies

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Objectives: The purpose of this study was to identify the extent to which state Medicaid and SCHIP programs have developed laws and regulations to support the delivery of adolescent preventive services, including counseling, screening, and referral to dental providers.

Methods: In recent years several professional organizations have developed guidelines for adolescent preventive services (AAP, Bright Futures, USPSTF), and these guidelines contain strong support for preventive dental services. With funding from the Center for Health Care Strategies, Inc., and the U.S. Maternal Child Health Bureau, this project surveyed state Medicaid and SCHIP officials responsible for preventive benefits for children and state managed care officials responsible for quality assurance. The survey asked whether states require or recommend that PCPs screen for certain dental conditions, counsel adolescents on avoiding dental injury and tobacco use, counsel parents on the need for regular dental care including sealants, and make annual referrals to dentists. The survey also asked whether states were using or considering a range of quality measures, including those recommended by the NCQA Expert Panel on the Future of Pediatric Oral Health Performance Measurement.

Results: At present, the survey has been reviewed by HCFA and MCHB officials, and has been field tested in Massachusetts, Ohio, and Arizona. The survey is scheduled to be mailed in December, to respondents identified by HCFA Regional Office Maternal Child Health Coordinators.

Using Medicaid Managed Care Contract Specifications to Improve Pediatric Oral Health

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Objective: This session will describe a new intervention tool, in the form of sample Medicaid managed care purchasing (contract) specifications for pediatric oral and dental health services. Medicaid and public health agencies, family advocacy groups and providers may use the specifications in negotiating for and monitoring oral and dental health services for Medicaid children and youth enrolled in managed care organizations (MCOs).

Methods: Analysis of existing Medicaid managed care contract documents' approaches to coverage of pediatric oral health and dental services and related issues. Development of sample specifications consistent with recognized clinical guidelines, Medicaid law, peer-reviewed literature and expert opinion.

Intervention: The specifications document, to be available without charge on the Internet, provides "sample" language on benefits, quality assurance, access, data collection and reporting and other elements of managed care relating to pediatric oral and dental health services for enrollees.

Relevance: Federal and state laws have for decades entitled low-income children and youth enrolled in Medicaid to comprehensive coverage for oral and dental health services. But use of these services has remained low, for multiple reasons. States' increasing use of managed care for Medicaid populations creates new opportunities to improve oral and dental health in low income children and youth, because MCOs can be held accountable for providing oral and dental health services to their young enrollees, monitoring the quality of such services, and furnishing these services in the context of comprehensive pediatric health care.

Medicaid on the Mend in Ohio

L. F. Hill

A Medicaid workgroup of the Ohio Dental Association (ODA) and representatives of the Ohio Academy of Pediatric Dentistry (OAPD) worked together in 1996 with the Ohio Department of Human Services (ODHS) to realize a modest fee increase in the Medicaid Dental Program. Utilization was not effected. The new fees were based on a 3 year old Medicaid UCR. With no further increases by 1999, fees were only about 35-40% of the community UCR. The HCFA/HRSA Dental Medicaid conference was attended by Ohio's state health department dental director and the director of Medicaid policy for the Ohio Department of Human Services. In August of 1998 members of the ODA Workgroup met again to develop recommendations. The group identified problem areas faced by patients, dentists, and ODHS. Recommendations were made to address each of the problem areas and sent to Medicaid. In September '98 the Workgroup met with key staff of the ODHS Medicaid fee for service and managed care sections to review the recommendations. A commitment was made by all present to work towards program improvements, to include a revision of the Medicaid dental guidelines, use of the ADA standard claim forms, a review of the prior authorization process and an increase in fees. In June '99 the Ohio Legislature approved a budget increase for Medicaid recommended by ODHS. Dental fees will significantly increase by 1/1/2000 with an emphasis on effective preventive and restorative treatments. A clause in the budget bill which would have indexed fees annually was vetoed by the Governor. Improvements in the guidelines were also made and the Dental Association has committed to take steps to encourage provider participation. All parties have agreed to continue work to increase participation and utilization.

Oral Health Program for Special Need and High Risk Populations: Integrating Unmet Medical/Dental Needs. A Model for Rural Based Oral Health Programs.

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Substantial numbers of Medicaid eligible children living in rural communities do not receive dental care of any kind due to a host of barriers related to access. This problem is amplified in children from low income families. Despite empirical evidence which suggests that providing children with free dental care results in significantly fewer decayed teeth, rural based dentists are not eager to serve children from special and high risk populations. This study examined several barriers to dental care access within rural communities in Southern Illinois. These barriers included access to dental care, community education, and compliance with referrals. The purpose of the study was to find ways to remove barriers to care and emphasize the importance of dental care to all stakeholders. The methodology consisted of a needs assessment followed by meetings with stakeholders, public officials, and key delivery personnel. The outcome was a blueprint and recommendations for service delivery in rural Southern Illinois which were initiated through the State Health department, a local Federally Qualified Health Center, the academic and public health communities. Findings suggest that policy changes at the community program level, as well as state levels are key factors in increasing oral hygiene and dental health in rural and high risk school-aged populations. This experience serves as a case study for other rural health programs both in Illinois and rural venues.

DEVELOPMENT OF PARAMETERS OF HEALTHCARE PRACTICES

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The American Cleft Palate-Craniofacial Association held a multidisciplinary consensus conference funded by Maternal and Child Health Bureau. Objectives were to (1) identify appropriate assessment and treatment procedures for patients who have cleft lip/palate or other types of craniofacial anomalies, (2) define timing, from infancy to maturity, for conduct of these procedures, and (3) disseminate the conference results. Procedures: Seventy-one professionals experienced in diagnosis and treatment of craniofacial anomalies and representatives of families and patients participated in the conference. Experts presented rationales for parameters they proposed for healthcare practices. Each presentation was followed by small group discussions in which proposed statements were accepted, amended, rejected, or augmented. All of the participants voted on each of 386 statements. Those statements, which at least 75% of the participants agreed to accept, were organized into a draft document. The document was revised in response to comments, following select and widespread peer review. Results: The Parameters were unanimously approved by the conference participants and by the ACPA membership. Since publication in 1993, 20,000 copies of the *Parameters for Evaluation and Treatment of Cleft Lip/Palate or Other Craniofacial Anomalies* have been distributed to parents, patients, healthcare professionals, educators, researchers, funding and governmental agencies. Conclusion: This document, under continuous review and revision by an ACPA committee, provides a foundation for clinical practice and study of clinical outcomes. The multidisciplinary consensus conference is a model for identification of parameters for best healthcare practices.

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