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Missouri's Early Periodic Screening and Diagnosis and Treatment Program Dental Services Management Review

March 31 – April 3, 2008 Site Visit

EXECUTIVE SUMMARY

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children effectively use them. During the week of March 31, 2008, representatives from the Centers for Medicare & Medicaid Services (CMS) Regions V and VII offices, conducted an onsite review of the Missouri EPSDT program with a focus on the dental requirements.

The purpose of the review was to determine what efforts Missouri had taken to address the rate of children's dental utilization in the State and to make recommendations on additional actions Missouri can take to increase these utilization rates. According to the CMS 416 report submitted by the State for FY 2006, the State of Missouri has a dental utilization rate of 20 percent. The CMS review team met with Missouri's Department of Social Services in the MO HealthNet Division (the State), the agency responsible for the administration of Missouri's Medicaid program. Additionally, CMS interviewed ten dental providers including two managed care organizations (MCOs), representatives of the Missouri Dental Association, and the MCOs' two dental benefits administrators.

The access to dental providers in Missouri is insufficient to serve the needs of the current Missouri Medicaid population and the State will need to develop a plan to improve access. The primary barrier to access appears to be the relatively low rate of provider participation which may be linked to the provider reimbursement rates. CMS reviewers observed other issues relating to inadequate access to services including insufficient information being provided to beneficiaries.

The CMS review team identified two promising practices as indicated by sufficient data to support claims of improvement in the program. Additionally, the review team identified one notable practice. The latter is noteworthy, but unsupported by substantial data to show effectiveness for Medicaid children at this time.

Promising practices

- A Federally Qualified Health Center (FQHC) with several sites in the St. Louis area reported a remarkably low rate of patients failing to attend scheduled appointments**.** The Chief Dental Officer provided data showing a trend of patients maintaining appointments correlating with the FQHC's demand for a sincere culture of mutual respect and other commercial business practices.

- In 2004, the State passed legislation that allowed dental hygienists limited ability to claim payment for Medicaid services in certain settings**.**

Notable practice

- In 2002, the State implemented the Oral Health Initiative to increase access in underserved areas**.** To fund this initiative, the State Legislature appropriated funds from

the general revenue to the State Medicaid Agency in partnership with the Missouri Primary Care Association. The State is able to demonstrate an increase in participating providers in underserved areas for individuals in Medicaid and the uninsured through this initiative.

The review team identified five findings with associated recommendations and has provided additional recommendations for the State to consider.

Regulatory findings

- **Finding #1:** The State Medicaid Manual [Chapter 5, Section 5121] requires the State to be effective in informing families of the EPSDT services. CMS reviewers found that the State is not adequately informing beneficiaries of EPSDT dental services in three categories: 1) beneficiaries do not get adequate information that dental services are a free covered service for Medicaid children; 2) children receiving dental services fee-for-service receive no written information on how to access providers; and 3) the State's main EPSDT brochure and fee-for-service handbook do not have any alternative means of accessing the information in different formats.

- **Recommendation:** Provide a separate dental handbook for beneficiaries written in appropriate linguistic style. The State should include the importance of preventive and routine dental care, age-appropriate dental services, how to access dental providers and transportation, and how to request assistance with any dental issues. Additionally, the State should make available alternative formats for individuals of Limited English Proficiency and individuals with special needs. Finally, to correct the notification procedures, the State should review all MCO handbooks and informational materials for compliance with the recommendations and require the MCOs to correct the handbooks and any other materials.

- **State Response:** We partially agree with this recommendation. MO HealthNet prefers to have only one member handbook that includes all services. The agency does not believe having separate handbooks based on service is an effective communication tool.

  It has been Missouri's experience that mailed written materials are not an effective communication tool with Missouri MO HealthNet Participants. We have found it more effective to have an updated internet website in conjunction with a participant hot line to address issues and concerns as they arise. While CMS has acknowledged that the information on the website adequately explains dental services, MO HealthNet will review its website material to ensure that it educates participants as to the importance of preventive and routine dental care in a appropriate linguistic style at a sixth grade reading level.

  The State does have translation services readily available through all of its hotlines. The State will develop a work plan to translate the online handbook into Spanish.

- **CMS Response:** CMS appreciates the generous information currently being provided to participants through MO HealthNet's website and the development of a plan to translate the online handbook into Spanish. However, CMS would strongly suggest that during the course of MO HealthNet reviewing its website materials, that State also ensure that the website's information regarding free covered dental services for Medicaid children and how to access dental services and providers, be stated in a concise and understandable format.

- **Finding #2:** The State has not notified managed care enrollees of their right to access a dental provider within the State's contractually mandated timeframes to guarantee access. Timely access to service is a managed care requirement under 42 CFR §438.206(c)(1) *et seq*. Additionally, per 42 CFR §438.66, the State must have policies and procedures in place to monitor all aspects of the contract.

- **Recommendation:** The State should notify the beneficiaries of the contractual time frames for appointments in conjunction of their rights for adverse action if they fail to obtain an appointment. Additionally, the State should implement a contract monitoring protocol for this access requirement.

- **State Response:** We partially agree with this recommendation. While appointment standards are included in the MCO handbook and the right of an appeal due to a failure to act within required time frames for getting a service is included in the MCO handbook, the MO HealthNet Division will review its language to ensure clarity regarding appointments to dental services and their right to grieve and appeal the actions of the MCO. The MO HealthNet Division has a contract monitoring tool that provides oversight of the health plans' compliance with contractual requirements. Additionally, the External Quality Review Organization (EQRO) evaluates MCO compliance in accordance with federal regulations.

- **CMS Response:** CMS agrees with the State's review of its handbook to ensure the clarity of the dental services appointments and grievance and appeals contractual language. CMS would appreciate the State notifying CMS and providing a copy of any additions or changes made to the handbook as a result of the State's review.

- **Finding #3:** The State does not set timeliness requirements for the provision of services for fee-for-service providers. The State Medicaid Manual [Chapter 5, Section 5330] directs the State to set standards for the timely provision of services which meet reasonable standards of medical and dental practice, and to ensure the provision of these services. Furthermore, the State does not notify the beneficiaries of their right to receive timely access to care, by way of ensuring the provision of these services as set forth in this requirement.

- **Recommendation:** The State should develop a standard for the timely provision of services within the guidelines developed in the State Medicaid Manual and ensure these standards are carried out. Corrective action will include informing providers and beneficiaries of any new requirements.

- **State Response:** We agree with this recommendation. The MO HealthNet Division will inform providers through its established communication channels that it is the strong intent of the MO HealthNet Division to ensure timely service delivery within the guidelines developed in the State Medicaid Manual, providing for the initiation of treatment no later than six months following a screening service. The information will be included in the participant material available through the Internet or through the mailed reminders of services needed.

- **CMS Response:** CMS has no adverse comments to this response.

- **Finding #4:** According to Federal requirements [42 CFR §438.206(b) *et seq.*] the State must ensure through its contracts that the provider network is adequate. The State currently verifies provider network adequacy for each MCO individually, including the dental network. Each MCO that uses a dental benefits administrator (DBA) submits the DBA provider's network as its own network for adequacy requirements and several MCOs share DBA's provider networks. Since the State does not evaluate the DBA's network for each service area's Medicaid population, the State is relying on the DBA's analyses of the network adequacy for all MCOs contracting with DBAs. Since the State does not have a contract with the DBAs and there is a known access problem, the State should take appropriate measures to fully address the adequacy of the DBA networks.

- **Recommendation:** The State should evaluate each DBA network based on the number of total Medicaid beneficiaries in the service area being covered. For example, the State should evaluate Bridgeport's network for adequacy showing that it supports all four contracting MCOs, not only each MCO's enrollment individually.

- **State Response:** We agree with this recommendation. The MO HealthNet Division annually evaluates the dental network for each health plan based on the total enrolled managed care population in the region. That has been the practice for analyzing network adequacy since the inception of the program in 1995. Based on this standard, 2008 geo-mapped dental network analysis results indicated that there was a dental provider within 60 miles of an enrolled participant in each MO HealthNet Managed Care region. In the next Request for Proposal for managed care services scheduled to be released December 2008, the state will require health plans to have a dental provider within 30 miles of participants unless the health plan can demonstrate that there is no licensed provider in the area, in which case, the health plan shall ensure members have access to those providers within 60 miles.

- **CMS Response:** CMS appreciates the State's efforts in utilizing existing resources to monitor network adequacy, as well as the analysis being done in this area to expand its dental network.

- **Finding #5:** The State requires providers to pay for interpreters for Medicaid beneficiaries receiving Medicaid State Plan services. According to Executive Order 13166 and the State Medicaid Director's Letter issued on August 31, 2000, any program

receiving Federal Financial Participation must provide interpreter services for people with Limited English Proficiency to further carry out the intent of the Civil Rights Act.

- **Recommendation:** The State should issue corrective guidance to all providers and beneficiaries stating that this service will be provided at no cost to the beneficiary or provider. The notices to beneficiaries should be sent with appropriate cultural and linguistic considerations.

- **State Response:** We are in compliance with this recommendation. The MO HealthNet Division requires all providers to provide necessary interpreter services as does Medicare and the majority of the other state Medicaid programs in the United States. No additional reimbursement for this service is provided as MO HealthNet considers payment for interpreter services included in the payment for the health care service reimbursement.

- **CMS Response:** CMS has no adverse comments to this response.

Additional Recommendations

- **Recommendation:** The State should create and contractually require all MCOs and their subcontractors to comply with increased cultural competency requirements.

- **State Response:** We are in compliance with this recommendation. The MO HealthNet Division and its contractors are fully committed to delivering services in a culturally competent manner to all participants, including those with limited English proficiency and those with diverse cultural and ethnic backgrounds. To support that belief, the MCO contracts have specific language regarding cultural competence in particular regarding mainstreaming the population. The health plan must ensure that all network providers accept all members for treatment and do not segregate members in any way in the delivery of services. Quality provisions in the contract also include cultural competence as a core value. The health plan is held accountable for the ongoing monitoring, evaluation and actions as necessary to improve the health of its participants and the health care delivery systems for those participants. The health plans annually analyze, evaluate, and report to MO HealthNet Division the extent to which cultural competence is incorporated into their overall quality strategy. The annual report must incorporate multiple years outcomes and strategies. The Department continues to provide training entitled, "Introduction to Civil Rights and Diversity" to all new MO HealthNet employees and every three years thereafter.

- **Recommendation:** The State should document oral health needs of special needs children and the adequacy of dental specialists and accommodations available in both rural and urban areas.

- **State Response:** We agree with this recommendation. The State is including stronger language in its upcoming RFP relating to case management for all children with special needs, including enhanced care coordination requirements. In addition, the state is enhancing care coordination for children with special health care needs in the fee-for-

service program through contracts with an administrative service organization to provide care coordination. The MO HealthNet Division will work with the State's Oral Health Program administered through Department of Health and Senior Services to further document oral health care needs of children with special needs. The MO HealthNet Division will annually continue to evaluate the adequacy dental networks through the use of geo-mapping software.

- **Recommendation:** The State should streamline the fragmentation of the delivery system; the complication of the fee-for-service system in the northern and southern areas of the State compounds the fact that six MCOs each contract with two different dental benefit administrators.

- **State Response:** We do not agree with this recommendation. There are only two service delivery models in the State of Missouri that have been approved by CMS and authorized by the Missouri General Assembly. The two service delivery models are Managed Care (for children, parent/caretaker, and pregnant women residing in certain counties) and Fee-for-Service (for the remaining populations). This report focused on delivery issues for children. Children in 54 of the 114 counties and City of St. Louis are enrolled in managed care organizations (MCOs) for the delivery of most health care services including dental services.

  Families and caretakers of children enrolled in managed care choose one MCO to meet their health care needs. MCOs do commonly subcontract with a dental vendor for delivery of dental services. As indicated in the report, the current MCOs subcontract with either Doral or Bridgeport for delivery of services.

  Those children enrolled in fee-for-service choose dental providers from the panel of Fee-for-Service network providers.

  It is our belief that the current MO HealthNet service delivery models are not the major contributing factor in the challenges in delivery of dental care to children within MO HealthNet. It is documented that the size of the dental workforce in Missouri is a major causal factor to this issue. As an August 2003 article, "*Addressing Dental Workforce Issues in Missouri and Kansas: One School's Initiative*," from the Journal of Dental Education pointed out, the dentist to population ratio has been decreasing and there is a serious and pervasive workforce problem in Missouri. The article noted as did your report that Missouri does allow hygienists to perform certain services that may help alleviate the problem but does not offer a total solution.

  Other reasons for low participation rates can be linked to reimbursement; current workload; difficulty in recruiting dentists in underserved areas (both urban and rural); and perceptions about the MO HealthNet population regarding treatment compliance, extent of unmet needs, and relatively high rate of missed appointments. Expansion of dental services available through FQHCs has provided significantly enhanced critical access to dental services in Missouri.

To attract more dentists to participate in the program, MO HealthNet has requested and received additional appropriation from the Missouri General Assembly to increase dental rates. RSMo 208.152.1(23) requires the MO HealthNet Division to provide the General Assembly a four-year plan by July 1, 2008 to achieve parity with usual, customary, and reasonable (UCR) dental rates. The Division is required to include the funding needed to complete the four-year plan in its annual budget request. The Division has requested in the Department of Social Services Fiscal Year 2010 budget request, a total of $14.7 million to bring MO HealthNet reimbursement rates for dental procedure codes up to 57% of reimbursement parity pursuant to the first year of the four-year plan.

In recent years, there has been legislation proposed for MO HealthNet to implement a dental carve out to manage dental benefits through an Administrative Service Organization (ASO) model as a means to increase access. Most recently, in the 2008 legislative session, an ASO pilot was proposed for the Southeast area of the State with some counties overlapping managed care regions. This effort did not gain final approval of the Missouri General Assembly. The MO HealthNet Division would appreciate the perspective of CMS in sharing best practices from other states that contract for dental services through ASO arrangements, especially in line with our desire to increase access and quality for these services.

Our preliminary view is that Administrative Services Only (ASO) arrangements can be a viable alternative to full risk capitation (MCO) and traditional Fee-for-Service (FFS) programs in certain situations. Under an ASO arrangement, managed care-like organizations can provide a continuum of services such as network management, member services, provider services, grievances and appeals, and care management activities for a fixed prepaid administrative fee. The fundamental difference between an ASO relationship and a full risk capitation arrangement lies in the entity assuming risk for dental expenses; in an ASO structure the state bears full risk for clinical service costs. Under the ASO model, a single entity would enter an agreement with the MO HealthNet Division (MHD) within the Department of Social Services to administer the program in exchange for a per participant per month fee. The MO HealthNet Division would appreciate the perspective of CMS in sharing best practices from other states that contract for dental services through ASO arrangements, especially in line with our desire to increase access and quality for these services.

- **Recommendation:** The State should enforce all contract requirements related to care management to ensure enrollees receive proper coordination of care for all EPSDT services, including dental services.

- **State Response:** We agree with this recommendation. The MO HealthNet Division has always maintained a strong commitment to EPSDT service coordination and case management through its MCO contracts. To further its commitment, the MO HealthNet Division has thoroughly examined its current contractual requirements to identify those provisions that would benefit from enhanced language regarding care coordination and case management in the next RFP scheduled to be released in December 2008. In addition, in the next release of CyberAccess MO HealthNet Division will have the

EPSDT screening forms available online. Providers will be able to complete each section of the form and it will be archived online for others to view. In the latest release MO HealthNet Division has the ability to deploy CyberAccess to the MCOs and only their participants' data is visible by them.

- **Recommendation:** The State should initiate leadership with the MCOs for a statewide oral health performance improvement project.

- **State Response:** In general, the MO HealthNet Division agrees with this recommendation. The Division will present this recommendation to the Quality Assessment and Improvement Advisory Committee for consideration of a statewide performance improvement project in balance with other proposed projects.

- **Recommendation:** The State should initiate outreach to increase the oral health for prenatal and perinatal mothers.

- **State Response:** We agree with this recommendation. The State is including stronger language in its upcoming RFP relating to case management for all pregnant women including enhanced care coordination requirements. The RFP will require health plans to offer case management to all pregnant members. All care plans shall have the following components:

  - Use of clinical practice guidelines;
  - Use of transportation, community resources and natural supports;
  - Specialized physician and other practitioner care targeted to meet members needs;
  - Member education on accessing services and assistance in making informed decisions about care;
  - Short-term and long-term goals that are measurable and achievable;
  - Emphasis on prevention, continuity of care and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings; and
  - Reviews to promote achievement of case management goals and use of the information for quality management.

  In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:

  - Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in case management;
  - Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment;
  - Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21);

- Referrals to WIC (if not already enrolled) within two (2) weeks of enrollment in case management;
- Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation;
- Assistance in making transportation arrangements for prenatal care, delivery and post partum care;
- Referrals to prenatal or childbirth education where available;
- Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment;
- Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for child if needed;
- Assistance in identifying and selecting a medical care provider for both the mother and the child;
- Identification of feeding method for the child;
- Notifications to current health care providers when case management services are discontinued;
- Referrals for family planning services if requested; and
- Directions to start taking folic acid vitamin before the next pregnancy.

- **Recommendation:** The State should consider reimbursing providers for more frequent applications of fluoride varnish for high risk children.

- **State Response:** We agree with this recommendation. Effective for dates of service on or after November 1, 2008, MO HealthNet Division allows physicians and nurse practitioners to bill using the applicable CDT code for the application of topical fluoride varnish for participants under six years of age when the need is identified through an EPSDT visit.

  The MO HealthNet Division will monitor the outcomes of this significant recent program change and going forward will periodically assess the potential fiscal and clinical impact of allowing providers to bill for the application of varnish more than the current twice yearly. The Division and Dental Advisory Committee will use evidence-based practice guidelines and outcomes in its assessment of a varnish application policy.

- **Recommendation:** The State should enforce its contract requirements that MCOs track and report on which children are not receiving dental services. The State should collect and use this data to follow-up with families who have not utilized services. The State should also collect similar information for the children who receive services in fee-for-service.

- **State Response:** We agree with this recommendation. The State enforces its contract in a variety of ways as outlined in previous responses. The State currently collects CMS 416 data semi-annually on each health plan to determine the extent to which EPSDT and

dental services are provided. Rate adjustments have been implemented based on their resulting performance.

The MO HealthNet Division will consider additional methods to track and follow-up with families that have not accessed dental services, both in managed care and in fee-for-service. MO HealthNet has recently awarded contracts to Missouri Care and APS Healthcare for a care management program that includes the design of a health education and disease prevention program to increase the participant's understanding of:

- ***Their health care needs;***
- The importance of routine preventative care,
- Coordinating care through their health care home, and
- Empowering the participant to be more effective in their self-care regimen.

The contractors shall provide a broad variety of educational materials and media options by mail, by telephone, and through the internet for participants, based on the participants' needs, risk stratification level, literacy level, PCP input, and POC.

The contractors shall design the health education and disease prevention program to empower participants to be:

- ***More effective partners in the care of their disease(s) - The contractor shall educate the participant on all aspects of personal health promotion, including proper diet and exercise, smoking cessation and stress management, and shall address co-morbidities such as depression, heart disease and obesity-related illnesses;***
- Better able to understand the appropriate use of resources needed to maintain their health or take care of their disease(s) - The contractor shall reinforce the need for routine tests and screenings such as blood tests, mammograms, foot exams, and eye exams;
- Able to identify when there are triggers affecting their health condition and able to identify the need to seek appropriate attention before they reach crisis level. The contractors shall accomplish this requirement by promoting early identification of symptoms of co-morbidities and appropriate treatments when the participant is healthy;
- Able to appropriately utilize the health care system, making and keeping scheduled appointments with their PCP or specialist, and coordinating these interactions through their health care home; and
- More compliant with medical recommendations by educating the participant about appropriate medication use and their disease specific treatment plan.

- **Recommendation:** The State should coordinate efforts with providers, MCOs, and other stakeholders to provide a dental home for children.

- **State Response:** We wholeheartedly agree with this recommendation to the extent that a public insurance program can impact decision-making in the context of public health advances. The MO HealthNet Division is undertaking a massive initiative to ensure that

all participants have a health care home. MO HealthNet has recently awarded contracts to Missouri Care and APS Healthcare for a care management program to provide care management services based upon the concept of a health care home, inclusive of access to needed dental services. Evaluations of its efforts will be conducted as the efforts are implemented.

- **Recommendation:** The State should utilize and analyze the CMS 416 data to inform policy decisions as part of ongoing planning and evaluations.

- **State Response:** We agree with this recommendation. The state will more thoroughly analyze CMS 416 data as part of its evaluation of health care delivery models beginning in state fiscal year 2010.

- **Recommendation:** The State should revisit certain operatives set forth in the 2001 State Dental Action Plan for guidance and goal setting to improve access to dental services for Medicaid eligible children.

- **State Response:** We agree with this recommendation. MO HealthNet will revisit the 2001 Missouri Action Plan for Oral Health Access.

  The first recommendation of that action plan was to increase dental fees. A $7 million dental rate increase was granted in state fiscal year 2009. In addition, as discussed in our response to Recommendation 1, the Division has and will include in its budget requests, funding to bring dental rates up to 100% UCR over four-years as required in RSMo 208.152.1(23).

  A second initiative from the 2001 Action Plan was to increase dental access through FQHCs. By 2005, FQHCs were providing 25% of the total Medicaid dental visits. The FQHCs were located in 21 of the most populous counties (for example, St. Louis, Jackson, Boone, Buchanan, Greene, Cape Girardeau, and Jasper) plus the City of St. Louis. FQHCs provide services to populations in the medically underserved areas, including rural areas. Medically underserved areas may be designated by county, but all eligible participants can and do seek services at any FQHC.

  In hopes of better engaging the dental provider community, the MO HealthNet Division is actively developing an implementation plan for reinstituting provider dental seminars in locations throughout the state in addition to existing webinars and seminars in Jefferson City.

MISSOURI EPSDT DENTAL FOCUS REVIEW, MARCH/APRIL 2008

I. Background

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children to effectively use them. Dental services are included in the EPSDT program coverage and there is a great deal of national interest in the provision of dental services to children covered by Medicaid.

The Centers for Medicare & Medicaid Services (CMS) conducted onsite reviews of children's dental services in 16 states. The States reviewed were selected based on the dental utilization rates reported by states to CMS on the CMS-416 annual report for the Federal fiscal year 2006. This report is used to collect data and report EPSDT program information. Primarily, the States reviewed had less than a 30 percent dental utilization rate for children. These reviews examine states' efforts to address the rate of children's dental utilization. CMS performed the reviews to offer recommendations on additional actions states can take to increase these utilization rates and ensure compliance with Federal Medicaid regulations.

In addition, Congress requested that CMS collect information regarding dental service utilization and delivery systems from all states. While CMS conducted onsite dental reviews in a number of states, CMS is also collecting more limited dental information by telephone from all states.

II. Scope of review

CMS staff interviewed the following individuals:

- Four urban providers[1];
- Four rural providers;
- two managed care organizations;
- the Missouri Dental Association;
- the two dental benefits administrators participating in the State (subcontracts with various MCOs); and
- State staff responsible for: implementing the EPSDT program, fee-for-service provider oversight, oral health initiatives, and with oversight of the managed care program.

CMS reviewers interviewed staff in Kansas City, Jefferson City, and by telephone. CMS acknowledges that the number of interviews is not a representative sample of the provider population and considers the information anecdotal. All review findings were based on the data and materials submitted by the State.

CMS staff used a seven-part protocol to evaluate State compliance with the dental portion of the Federal EPSDT requirements. CMS shared the protocol with the State prior to the review. The

[1] While we applied the designation "urban" and "rural" based on the geographic location of the providers' offices, most urban providers are likely to see rural patients as well due to the low number of participating dental providers in rural areas.

protocol incorporates the relevant portions of the *State Medicaid Manual* and the Social Security Act (the Act) requirements for EPSDT services. The seven areas reviewed include:

I - Informing beneficiaries and their families
II - Periodicity schedules and interperiodic services
III - Access to services
IV - Diagnosis and treatment
V - Support services
VI - Care coordination
VII - Data collection, analysis, and reporting

Additionally, due to the State's delivery of services in the managed care benefit, the CMS review team also used the Medicaid managed care regulations at 42 Code of Federal Regulations (CFR) Part 438. Specific citations are included in the findings throughout this report.

III. Introduction to Missouri provision of dental services for children

Missouri operates a large portion of its Medicaid program through a managed care program, MO HealthNet. The State requires that the majority of children in service areas with contracting MCOs enroll in managed care.[2] The State's EPSDT program is known as Healthy Children and Youth.[3]

Table 1

2008 (current) managed care service area applied against 2006 CMS-416 data			
	Managed care	**Fee-for-service**	**Total**
Service area	54 counties and City of St. Louis (non-county entity)	61 counties	115 counties and City of St. Louis
Population of children eligible per county	429,250 [67.7%]	205,240 [32.4%]	634,500

Anecdotally, State staff informed reviewers that by January 1, 2008, approximately half of the children received services fee-for-service and half receive services in a managed care delivery system.[4] As demonstrated between Tables 1 and 2, the State contracts with six MCOs to provide Medicaid State Plan services in 54 counties. Additionally, for the provision of dental services, the MCOs each subcontract for at least most or all of the requirements related to provider networks, adverse actions, and provider credentialing.

Table 2

[2] Some more medically compromised children are exempt from managed care, including, but not limited to: dually-eligible Medicare/Medicaid beneficiaries and other specifically qualifying disabled children. Most adult populations are required to enroll as well.

[3] While the State and some interviewees interchangeably referred to the EPSDT program as "Healthy Children and Youth," it is referred to as the EPSDT program herein.

[4] Although approximately 68 percent of the children live in managed care service areas, as noted previously, some children are eligible for voluntary enrollments or may be excluded from managed care due to prevailing health conditions. Due to the new service area changes effective in 2008, the data reported on the CMS-416 for managed care [Line 13] would not be trended to include the current additions to the managed care program.

MCO	Dental benefits administrator (DBA)
Blue-Advantage Plus of Kansas City	Doral Dental
Children's Mercy Family Health Partners	Bridgeport Dental
Harmony Health Plan of Missouri	Bridgeport Dental
HealthCare USA	Doral Dental
Mercy CarePlus	Bridgeport Dental
Missouri Care	Bridgeport Dental

In some of these situations, the DBA does not cover the MCO's entire service area, so the MCO may maintain an individual (i.e., non-subcontracted) provider network. The complication of the fee-for-service system in the northern and southern areas of the State is compounded by six MCOs each contracting with two different DBAs. Medicaid participating providers may need to contract with the State, the MCOs, and the DBAs to be able to provide services to all of their patients. This is partly because the access is inadequate and forces beneficiaries to drive several hours (and across several service areas) to reach a provider for treatment. This creates a further access barrier due to the complications for provider participation.

- **Recommendation:** The State should streamline the fragmentation of the delivery systems. The complication of the fee-for-service system in the northern and southern areas of the State compounds the fact that six MCOs each contract with two different dental benefits administrators**.**

Other issues

Based on provider interviews and information obtain from outside sources, it appears that the provider reimbursement rates in the State of Missouri are significantly lower than the providers' costs.[5] The current rates cause many participating providers to operate below their costs for Medicaid patients because the average Medicaid reimbursement is approximately one-third of the providers' costs. This information was repeated throughout most of the provider and MCO interviews. Providers that were interviewed for this report expressed that their participation in the Medicaid program was charitable and that their businesses operate at a loss to provide community care. The Medicaid reimbursement rates in Missouri are low and appear to be a contributing variable impacting beneficiaries' access.

Missouri participated in creating a State Dental Action Plan in 2001. CMS reviewers found that the State identified several goals related to Medicaid reimbursement rates, improvements to claim processing and related policy changes, outreach to providers, and the managed care initiative. Many of the State's conclusions are still relevant and would be useful for implementing changes to improve access to dental services.

[5] CMS reviewers examined the January 2008 American Dental Association report: *State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium Update.*

- **Recommendation:** The State should revisit the State Dental Action Plan created in 2001 for guidance and goal setting to improve provider participation and access to dental services for Medicaid eligible children**.**

Another significant barrier to oral health access in Missouri is that the State remains in the top tier nationally for states with the highest number of illicit methamphetamine users.[6] A co-morbidity of prolonged exposure to methamphetamine fumes is often referred to as "meth mouth" and has been addressed by the American Dental Association as a very serious oral health crisis. Children living in homes where methamphetamine is manufactured or abused may also develop the condition known as "meth mouth" because of the harsh chemicals. In many cases, all of the child's teeth need to be extracted as a result. Clearly State and Federal Medicaid agencies cannot be the forefront of this health crisis, but Medicaid is certainly a partner in prevention and treatment.

IV. Review descriptions, findings, and recommendations

Key Area I – Informing families of EPSDT dental services

Section 5121 provides the requirements for informing Medicaid beneficiaries of the EPSDT program, including dental services, in a timely manner. Based on section 1902(a)(43) of the Act, States are to assure there are effective methods to ensure that all eligible individuals and their families know what services are available under the EPSDT program; the benefits of preventive health care, where services are available, how to obtain them; and that necessary transportation and scheduling assistance is available. This is particularly important with respect to dental services since many families do not see dental services as a priority and may need additional information on these important services.

The State utilizes a one-page brochure to inform families about the entire EPSDT program. Since half of the State's families receive EPSDT services through MCOs they may also receive information about accessing EPSDT services in their managed care handbook and other MCO materials. Families receiving State Plan services on a fee-for-service basis will receive the State's *MO HealthNet Division Fee-for-Service Participant Handbook.*

CMS reviewers examined handbooks from three MCOs and found a number of concerns with the general information provided by MCOs to program enrollees. The MCOs use state-approved language in their informing materials and CMS reviewers identified concerns with the State-developed language as well.

Reviewers found some of the following issues with the managed care handbooks:

- Dental services were not always listed as a covered service in the Table of Contents;
- Information for emergent and urgent dental care procedures is often not discussed;

[6] Data confirmed on the Substance Abuse and Mental Health Authority website on April 4, 2008. http://oas.samhsa.gov/amphetamines.htm#New

- Minimal or no discussion linking the dental screening in the well-child visit to other covered dental services for preventive care and maintenance of conditions;
- Dental services are often handled in several sections; all dental coverage should be handled in the same section. Since dental services are not covered for most adults, unequivocal statements that dental is not covered in one section, then discussing children's coverage elsewhere requires advanced knowledge of the program;
- No information on appointment standards or timeliness of care requirements in any of the handbooks reviewed; and
- Lack of specificity in State's template language.

After reviewing the State's fee-for-service handbook, reviewers found that the State adequately explains the dental services to program beneficiaries. However, the beneficiaries do not receive a list of participating providers and must call the State's beneficiaries general assistance line to get information. The State's general assistance line does not offer an option for languages other than English or for individuals with special needs. Finally, while the fee-for-service handbook states that it may be available in alternative formats, the State policy staff stated that the handbook and EPSDT brochure are not available in other languages.

- **Finding:** The statute at section 1902(a) (43) of the Act and the *State Medicaid Manual* [Chapter 5, Section 5121] requires the State to be effective in informing families of the EPSDT services. CMS reviewers found that the State is not effective in informing beneficiaries of EPSDT dental services in three categories: 1) beneficiaries do not get adequate information that dental services are a free, covered service for Medicaid children; 2) children receiving dental services fee-for-service receive no written information on how to access providers; and 3) the State's main EPSDT brochure and fee-for-service handbook do not have any alternative means of accessing the information in different formats, although the *State Medicaid Manual* requires that the State "utilize accepted methods for informing persons who are illiterate, blind, deaf, or cannot understand the English language."

- **Recommendation:** Provide a separate dental handbook for recipients written in appropriate linguistic style. The State should include the importance of preventive and routine dental care, age-appropriate dental services, how to access dental providers and transportation, and how to request assistance with any dental issues. Additionally, the State should make available alternative formats for individuals of Limited English Proficiency and individuals with special needs. Finally, to correct the notification procedures, the State should review all MCO handbooks and informational materials for compliance with the recommendations and require the MCOs to correct the handbooks and any other materials.

The State contractually requires MCOs to maintain specific appointment timeframes for preventive care and also urgent and emergency services. The MCOs and DBAs stated that they primarily monitor the enrollee's ability to schedule an appointment within contractually mandated timeframes through the adverse actions (grievances, appeals, and State fair hearings) process. However, CMS staff determined that beneficiaries are not notified of these contractually mandated timeframes. While this is a noble effort on the State's part to address

access through MCO contracts, there is no compliance or monitoring mechanism if families are not notified of this right.

- **Finding:** The State does not notify managed care enrollees of their right to access a dental provider within the State's contractually mandated timeframes to guarantee access. Timely access to service is a managed care requirement under 42 CFR §438.206(c)(1) *et seq*. Additionally, per 42 CFR §438.66, the State must have in place policies and procedures to monitor all aspects of the contract.

- **Recommendation:** The State should notify the recipients of the contractual time frames for appointments in conjunction of their rights for adverse action if they fail to obtain an appointment. Additionally, the State should implement a contract monitoring protocol for this access requirement.

Furthermore, the State does not have an established standard for the timely provision of dental services for fee-for-service providers or monitor providers for the timeliness of services. The State indicated dental providers are expected to follow their licensure regulations as it relates to timely delivery of services.

- **Finding:** The State does not set timeliness requirements for the provision of services for fee-for-service providers. The *State Medicaid Manual* [Chapter 5, Section 5330] directs the State to set standards for the timely provision of services which meet reasonable standards of medical and dental practice, and to ensure the provision of these services. Furthermore, the State does not notify the beneficiaries of their right to receive timely access to care, by way of ensuring the provision of these services as set forth in this requirement.

- **Recommendation:** The State should develop a standard for the timely provision of services within the guidelines developed in the *State Medicaid Manual*, ensure these standards are carried out and inform providers and beneficiaries of these standards.

<u>Key Area II – Periodicity schedule and interperiodic services</u>

Section 5140 provides the requirements for periodic dental services and indicates that distinct periodicity schedules must be established for each of these services. Subpart C refers to sections 1905(a)(4)(B) and 1905(r) of the Act requirements that these periodicity schedules assure that at least a minimum number of examinations occur at critical points in a child's life.

The State's dental periodicity schedule is published separately from all other EPSDT required screenings. The primary care physician, through the required well-child visits, must provide a dental screening no later than twelve months of age, but it is recommended that oral treatment begin at age six to twelve months and repeated every six months or as otherwise medically indicated. The State's dental periodicity schedule is found in the *MO HealthNet Provider Handbook.* This is helpful for providers, but the periodicity schedule and its contents are not published in any of the beneficiaries informing materials. The State may find that educating

beneficiaries about the importance of clinically supported periodical preventive dental care will strengthen oral health outcomes.

There are no findings related to Key Area II – Periodicity schedule and interperiodic services. See Recommendation #3 regarding providing a separate dental handbook for beneficiaries.

Key Area III - Access to Services

Section 42 CFR 440.100 specifies that dental services are to be provided by, or under the supervision of, a dentist qualified under State law to furnish dental services. Section 5123.2.G provides the requirements for dental service delivery and content in line with section 1905(r)(3)(A) of the Act. The State must provide, in accordance with reasonable standards of dental practice, dental services that meet to eligible EPSDT beneficiaries who request them. The services are to be made available under a variety of arrangements, in either the private or public sector. States are to assure maximum utilization of available resources to optimize access to EPSDT dental services, with the greatest possible range and freedom of choice for the beneficiaries and encouraging families to develop permanent provider relationships. States may also utilize other oral health resources coverable under the Medicaid program.

The lack of dentists currently practicing in Missouri and the negligible number of new dental providers entering the health care delivery system was a primary concern of the State. The State has one dental school, the University of Missouri - Kansas City School of Dentistry. Providers interviewed by CMS stressed the barriers in the already extended system resulting from the lack of dental specialists accessible to Medicaid beneficiaries in the State.

To help alleviate access issues, the State allows dental hygienists to claim payment for certain Medicaid dental services in specified settings since July 1, 2004 [Missouri Revised Statutes, Chapter 332.311.2]. The law permits individually registered dental hygienists with three years experience, practicing in a public health setting, to provide fluoride treatment, teeth cleaning and sealants to Medicaid children. The State tracked this information for partial fiscal year 2006 and all of fiscal year 2007. Total dental units of service increased by 128 percent and payment of those services increased 144 percent, which demonstrates an increase in access through the utilization of hygienists. The State was not able to provide further information to delineate how the dental services provided by hygienists are distributed statewide. CMS reviewers noted this as a promising practice because the State was able to demonstrate an increase in access supported by data.

As demonstrated in Table 1, approximately 32 percent of the State's children live in counties where they must seek care fee-for-service. However, since managed care is not mandatory for specified children in managed care service areas, the State claims that approximately half of the State's children receive care fee-for-service. Table 1 shows a designation of where children live, since this is relevant to the access issue in terms of how children seek care and potentially from whom they seek care.

Using data provided by the State, CMS reviewers conducted a brief access analysis by evaluating the number of Medicaid children in each county, their care delivery system, and the number of

reported dentists for their care system. The provider access is fairly complex in Missouri due to the fragmented dental services delivery system. This analysis does not account for program beneficiaries accessing providers by driving through multiple counties, but rather examines how many Medicaid children have close proximity to a Medicaid dental provider.

Table 1 demonstrates the stratification of children receiving services in managed care and fee-for-service reimbursement systems, as well as the total population. CMS reviewers applied this data against the number of dentists that are reimbursed fee-for-service in the Medicaid program statewide since these dentists accept managed care enrollees and fee-for-service enrollees. However, it should be noted that there is a provider enrollment overlap between providers participating in the managed care networks and providers reimbursed fee-for-service since many providers accept reimbursement from both systems.

Since the managed care provider enrollment is unclear, reviewers were only able to provide a snapshot of the access problem for beneficiaries receiving dental care fee-for-service. At the time of the review, there were 489 general dentists accepting Medicaid fee-for-service Statewide. There are 28 counties without general dentists that accept Medicaid payment fee-for-service. The counties with the larger proportion of dentists accepting Medicaid fee-for-service are in the larger urban areas, which are part of the managed care service area.

Based on the recent geographical and enrollment information outlining that half of the children receiving Medicaid fee-for-service statewide, there is approximately one dentist per 1,300 children. Most counties using the fee-for-service reimbursement system have fewer than five dentists, so dental providers often supply services to the children in their county as well as the surrounding counties.

Additionally, there are only three orthodontists and 42 oral surgeons agreeing to Medicaid fee-for-service reimbursement for providing services to children throughout the State. The State did not provide information about the number of pedodotists or endodontists[7] accepting Medicaid patients, but the interviewees acknowledged that there is an access barrier for these services.

With respect to the MCOs, access is still unclear. However, Bridgeport, the DBA contracting with four of the six MCOs reported 89 general dentists in their 2006 network. Doral Dental, which contracts with only two MCOs, reported a total of 454 current providers statewide. Doral Dental also stated that they require a member have access within 30 miles for a general dentist. Both of these DBAs contract with dentists in the State's pool of fee-for-service providers and some of the providers contract with both Doral Dental and Bridgeport; in other words, there is reason to believe that these provider numbers represent a high volume of duplication. The State should conduct a review of the access statewide to more fully understand Medicaid beneficiaries' access issues in the State.

- **Finding:** According to Federal requirements [42 CFR §438.206(b) *et seq.*] the State must ensure through its contracts that the provider network is adequate. The State currently verifies provider network adequacy for each MCO, individually, including the dental

[7] Pedodontists provide specialty services to children; general dentists can provide most routine care, but occasionally need to refer patients to pedodontists for special procedures. Endodontists commonly perform root canals.

network. Each MCO that uses a dental benefits administrator (DBA) submits the DBA's network as its own network for adequacy requirements and several MCOs share DBAs' provider networks. Since the State does not evaluate the DBAs' networks for each service area's Medicaid population, the State is relying on the DBAs' analyses of the network adequacy for all MCOs contracting with DBAs. Since the State does not have a contract with the DBAs and there is a known access issue, this must be corrected.

- **Recommendation:** The State should evaluate each DBA network based on the number of total Medicaid beneficiaries in the service area being covered. For example, the State should evaluate Bridgeport's network for adequacy showing that it supports all four contracting MCOs, not only each MCO's enrollment individually.

The State implemented an Oral Health Initiative in July 2002 to help increase the dental network for Medicaid and the uninsured. Since individuals with Medicaid and without health insurance can receive health services (including dental services) at FQHCs, the State utilized FQHCs for the Oral Health Initiative. FQHC services are only available to residents of the county where the FQHC is located. In 2003, the State enrolled 16 additional FQHCs, serving approximately 20,000 individuals. Currently, there are approximately 37 FQHCs offering dental services to 86,400 individuals.[8] The number of dental directors, dentists, hygienists, and dental assistants increased by 280 percent between 2003 and State fiscal year 2007, which demonstrates a likely increased access to dental services. CMS reviewers considered this a notable practice because the data did not support this as an intervention exclusive to a dental access increase for Medicaid children. Since the implication is that Medicaid children receive services in FQHCs, this is a notable practice to strengthen the outlets for dental care in Missouri.

CMS reviewers experienced some provider and MCO interviewees as harboring stereotypes and making generalizations about the Medicaid population. This is a barrier to access because it potentially causes conflict at the reception area and further impedes the likelihood that the beneficiary will maintain the appointment.

- **Recommendation:** The State should contractually require all MCOs and their subcontractors to comply with increased cultural competency requirements and develop an internal cultural competency training program that is completed annually by the State staff and contractors having contact and decision making authority regarding a Medicaid beneficiary's access to treatment**.**

In direct contrast, the CMS review team interviewed the Chief Dental Officer of the St. Louis Family Care Health Centers. This provider was able to demonstrate a notable decrease in patients failing to attend appointments from 2004 through 2007. The clinic staff worked diligently to decrease the rate of patients failing to attend scheduled appointments and the provider spoke candidly about the high expectations placed on clinic staff to maintain mutual respect between patients and staff. This demonstration of regard, instilled from the Chief Executive Officer to the clinic staff, is closely monitored and enforced. The FQHC's cancellation policy is explained to patients and individuals sign a form at their first appointment

[8] FQHCs must provide care to all qualified individuals meeting certain income guidelines, which include Medicaid beneficiaries and the uninsured. These numbers include children and adults.

indicating they understand the clinic's "no-show" policy. Clinic staff sends letters to families of children who miss four appointments within twelve months. The fifth time a patient fails to attend a scheduled appointment the clinic generates a warning that the family will have to find a new dental clinic if there is a subsequent missed appointment. To help decrease the potential for missed appointments, Saturday and once weekly evening appointments are reserved for working parents and school-aged children.

In 2004, the Carondelet clinic began collecting data on patients failing to attend scheduled appointments. Staff discussed this data through a monthly report documenting the trends. The monthly percentages of patients failing to attend scheduled appointments demonstrate a steady and significant decline from an average of 18 percent in 2004 to ten percent in 2007. In 2007, the same staff opened the Forest Park clinic in St. Louis. During the first year, the Forest Park clinic demonstrated a notable appointment failure rate of 16 percent. Between January and March 2008, the Carondelet clinic demonstrated an impressive six percent no show average. The CMS reviewers highlighted this promising practice in conversations with the State and encouraged continued discussions to replicate these efforts in other locations.

Key Area IV - Diagnosis and treatment

Sections 5122(E) and (F), as well as section 5124 stipulate that follow-up diagnostic and treatment services within the scope defined by sections 1905 (a) and (r) of the Act are to be provided when indicated. Diagnostic services must fully evaluate the dental condition that was identified, while treatment services must ensure health care is provided to treat or ameliorate the dental condition. These services are limited by what is coverable under section 1905(a) of the Act but may not be limited to services included in the State's Medicaid Plan.

The providers and MCOs did not indicate that authorization for services was a specific impediment to provision for EPSDT. However, CMS reviewers noted that it was unusual that the MCOs had prior authorization requirements for more services than the State has for its fee-for-service providers. The State and MCOs may wish to evaluate the utilization management requirements for potential barriers to provider participation in the Medicaid program.

The State confirmed that they only allow providers to claim payment for fluoride varnish twice annually. During interviews several providers stated that this was an issue and they sometimes absorb the cost for at-risk children. Recent dental literature makes recommendations that young, at-risk children will benefit from more frequent applications of fluoride varnish and there is a Current Procedural Terminology (CPT) code for more frequent treatments.

- **Recommendation:** The State should consider reimbursing providers for fluoride varnish applications more frequently for at-risk children.

Key Area V - Support services

Section 5150 indicates that the State is required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and

necessary, assistance with scheduling appointments and non-emergency transportation. This includes the requirement of 42 CFR 431.53 mandating transportation assistance.

While the State has a process in place for transportation and scheduling services, CMS reviewers could not determine if these services are underutilized statewide. Anecdotal information from interviewees yielded inconclusive concerns, only supported by the underutilization.

The State does not have a specific policy to assist individuals with scheduling an appointment until the beneficiary has difficulty. State staff reported that beneficiaries may contact the State's beneficiary assistance line for a list of dental providers currently accepting patients geographically nearest to the beneficiary. The State will assist beneficiaries in scheduling appointments when the member is unable to secure an appointment with a provider from the list. CMS staff did not find this procedure stated in the beneficiaries informing materials. Additionally, as included in the first finding in *Key Area I – Informing beneficiaries and their families*, the State's general assistance line does not offer an option for assistance to individuals with special needs or Limited English Proficiency. Scheduling assistance for MCOs is handled through their customer service lines. The *State Medicaid Manual* requires that the State make available assistance with scheduling appointments for EPSDT services [Chapter 5, Section 5150]. The State appears to have an informal policy for assisting beneficiaries with knowledge of the program; however beneficiaries are not notified of this and if beneficiaries with language or other special needs call the State's assistance line, they may be unable to secure assistance with this service. Additionally, this service is only available during business hours.

- **Recommendation:** The State should immediately address the issue of providing scheduling assistance for beneficiaries with special needs, including Limited English Proficiency, who call the State assistance line by ensuring that an option is available for those who need special assistance.

Beneficiaries receiving care fee-for-service are directed to call the State's Non-Emergency Medical Transportation (NEMT) broker for scheduling transportation to medical appointments. The NEMT broker has an option for individuals needing Spanish language services, and also directs individuals to stay on the line to speak with a customer service representative. A three-day advanced notice is required to ensure timely arrangement of transportation services. However, if a dental provider submits documentation regarding an urgent or emergent appointment, transportation can be arranged in less than the standard three-day notice timeframe.

The MCOs notify families of the transportation benefit through member handbooks, websites, and other communications. The MCOs also use an NEMT subcontractor who appears to have several of the same procedures. The State and MCOs also have optional fuel and mileage reimbursement for qualifying enrollees and beneficiaries.

Some providers interviewed report that beneficiaries unable or failing to keep appointments impact dental access issues because it causes scheduling problems and influences the continuity of care. Additionally, it influences the providers' abilities accept new Medicaid patients into their practices. CMS acknowledges, as previously mentioned in *Key Area III – Access to services*, that cultural competency requirements are an important part of beneficiaries outreach

and appointment maintenance. CMS encourages the State to continue to educate MCOs, providers, and beneficiariess about issues that impact appointments. Also, the State should monitor and share promising provider practices that help address this issue.

Lastly, CMS reviewers found that the State requires providers to pay for interpreter services. The State policy staff confirmed that interpreting is a non-covered service. CMS requires states to pay for interpreter services and the most current medical literature on the subject supports providing trained medical interpreters for the best outcomes.

- **Finding:** The State requires providers to pay for interpreters for Medicaid beneficiaries receiving Medicaid State Plan services. According to Executive Order 13166 and the State Medicaid Director's Letter issued on August 31, 2000, any program receiving Federal Financial Participation must provide interpreter services for people with Limited English Proficiency to further carry out the intent of the Civil Rights Act.

- **Recommendation:** The State should issue corrective guidance to all providers and beneficiaries stating that this service will be provided at no cost to the beneficiaries or provider. The notices to beneficiaries should be sent with appropriate cultural and linguistic considerations.

Key Area VI - Care coordination

Section 5240 provides the requirements for coordinating a child's screening, treatment and referral services. Coordination between a primary provider and a dental provider does not generally occur. However since it is the usually the responsibility of the primary provider to make an initial dental referral, information should be available as to how and when that referral is made. Coordination may be particularly important for special needs children who may be receiving medications and treatments that may affect their oral health.

CMS reviewers found the State to be in compliance with the minimal Federal requirements for this Key Area. However, the review team made numerous recommendations relating to the managed care program and beneficiaries receiving care fee-for-service. Generally, there seemed to be very little genuine care coordination between the EPSDT well-child dental screening and the resulting dental care.

Since approximately half of the children in Missouri receive care through the managed care delivery system, many of the CMS reviewers' recommendations for this Key Area relate to enhanced case management requirements and MCO responsibility. The State has more control over contract deliverables in a managed care environment, which is one of the benefits to contracting with MCOs. Since all dental services are a covered EPSDT service under the managed care capitation rate, CMS reviewers focused on better connecting these services for managed care enrollees. The State should increase the coordination of care. Because this is included in the capitation payment, there is an expectation of care management for coordination of services when needed. For example, network provider lists should be readily available upon request to providers, especially for purposes of assisting patients with locating a specialist.

Also, although the State indicated that the MCOs have the decision making authority regarding which performance improvement projects (PIP) would be selected for a Statewide PIP the proposal could progress faster with commitment and collaboration from the State.

The State policy staff acknowledged that the State does not have a specific program for outreach to prenatal and perinatal mothers. Several states have undertaken efforts to reach this population and address their oral health needs because of the clinical link between a pregnant woman's oral health and pre-term delivery as well as addressing the child's oral health needs.

Most children identified with special needs receive Medicaid services fee-for-service. Determining network adequacy is a first step in developing an action plan to improve dental services utilization for the special needs population. Particular attention must be given to meeting the oral health needs of special needs children, particularly since their comprehensive medical needs are often chronic and complex.

Finally, the review team documented several efforts to ensure a dental home for children in Missouri. These efforts impacted children receiving care through MCOs and a fee-for-service reimbursement system. A dental home provides a place for a family to dependably access both preventive and acute oral health care services.

- **Recommendation:** The State should utilize the MCOs for better care coordination and case management to integrate EPSDT services and receipt of dental care.

- **Recommendation**: The State should provide oversight of MCOs so that providers' efforts to coordinate patients' care are without difficulty**.**

- **Recommendation**: The CMS recommends that the State consider a leadership role with the MCOs for a statewide performance improvement project.

- **Recommendation:** CMS recommends that the State consider an outreach program or statewide PIP for prenatal or perinatal mothers.

- **Recommendation**: The State should document the oral health needs of special needs children and the adequacy of dental specialists and accommodations available in both rural and urban areas**.**

- **Recommendation:** The State Medicaid agency should consider taking a leadership role in coordinating the various efforts that are underway to ensure a dental home for children in Missouri.

<u>Key Area VII - Data collection, analysis, and reporting</u>

Part 2 of the SMM, section 2700.4, delineates the EPSDT reporting requirements, including the annual CMS-416 report requiring the State to report the number of children receiving dental services. The CMS 416 includes three separate lines of data including: the number of children

receiving any dental service, the number of children receiving a preventive dental service and the number of children receiving a dental treatment services. The services are defined using the CDT codes. The CMS-416 report is to be submitted no later than April 1 after the end of the federal fiscal year. The Centers for Medicare and Medicaid services uses this report to monitor each State's progress in the provision of improving access to dental services.

The State submitted the required data to CMS and is in compliance with the Federal requirements for the annual submission of the CMS-416. The State does not currently validate the data collected for the CMS-416, but has stated that this will be a feature to the new Medicaid Management Information System, which is currently being implemented.

The State contractually requires MCOs to track and report which children are not receiving dental services. However, the State does not currently collect this information for analysis.

- **Recommendation**: The State should utilize the CMS 416 data to make informed decisions and analyze this data as part of ongoing planning and evaluation.

- **Recommendation:** The State should enforce its contract requirement that MCOs track and report on which children are not receiving dental services. The State should collect and use this data to follow-up with families who have not utilized dental services. The State should also collect similar information for the children who receive services in fee-for-service.

V. Conclusion

The majority of Missouri's Medicaid beneficiaries have a demonstrable challenge to accessing dental providers. CMS reviewers have acknowledged certain barriers for the State. However, it is the responsibility of the State Medicaid agency to provide access to oral health care under the EPSDT benefit to Medicaid eligible children.

In the State's response to the CMS Draft Report, the State responded to findings and recommendations, acknowledged areas of improvement, and their desire to initiate changes wherever possible. In addition to the report findings and recommendations, the CMS review team acknowledged the State's accomplishments and provided additional recommendations, which the State also responded to. CMS also appreciates the State's willingness to establish specific goals to increase access to dental care for the Medicaid population. CMS looks forward to working with Missouri to share these promising and notable practices with other States, as well as assisting them in obtaining similar practices from other States. Additionally, CMS anticipates a continued commitment with Missouri to address the issue of access to oral health and EPSDT dental services for Medicaid beneficiaries.