U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
Region V

Wisconsin's Early and Periodic Screening, Diagnostic and Treatment Program with a Focus on Dental Services Management Review Final Report

March 3-5, 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 3, 2008, representatives from the Centers for Medicare & Medicaid Services (CMS) Regions V, VII, and Central Office staff conducted an on-site review of the Wisconsin EPSDT program, with a focus on the dental requirements.

The purpose of the review was to determine what efforts Wisconsin has made to address the rate of children's dental utilization in the State, and to make recommendations on additional actions Wisconsin can take to increase these utilization rates. According to the CMS 416 data submitted by the State for fiscal year 2006, Wisconsin's dental utilization rate was 21 percent. The CMS review team met with officials at the Department of Health and Family Services (the State), the agency responsible for administration of Wisconsin's Medicaid program. Additionally, CMS interviewed four dental providers, the Wisconsin Dental Association, two managed care organizations (MCOs), and the MCOs' dental benefits administrator.

In 2005, Governor Jim Doyle convened a Task Force to Improve Access to Oral Health. The State clearly understands that dental access is critical and the key staff continues to look for creative ways to address this issue.

CMS acknowledges that the State has developed a number of collaborative strategies to address oral health issues. However, the provider interviews yielded substantial expression of frustration with State Medicaid reimbursements.

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 three notable practices, which are noteworthy but unsupported by data to show effectiveness at this time.

Promising practices

- The State significantly reduced the documentation required for prior authorization and urgent or emergency care dental providers.
- In 2006, the State passed legislation that allowed dental hygienists limited ability to claim payment for Medicaid services**.** This has increased access to services for Medicaid beneficiaries by increasing the types of providers able to bill for Medicaid dental services.

Notable practices

- The State Medicaid agency's Chief Medical Officer (CMO) is a dentist.
- The State initiated an MCO payment incentive program, or pay-for-performance, related to specific oral health outcomes**.** The MCO contract amendments initiating this change for the baseline data collection began in 2007 and the State will begin paying out incentives in 2008.
- The State took systematic action to address concerns with one of the MCO's dental benefits administrators (DBA) by using a secret shopper program.

The CMS review team also identified four findings and has made recommendations for the State. The State corrective actions, which were submitted by the State, are detailed below.

Regulatory Findings

- **Finding #1, relating to Informing:** 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 in place policies and procedures to monitor all aspects of the contract.
- **Recommendation**: The State should notify the beneficiaries of the contractual timeframes for appointments in conjunction with 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 corrective action #1**: The State indicated that they made the necessary amendments to the managed care contracts and developed a monitoring policy.
- **CMS response to State corrective action #1**: The State should submit contract amendments and policy changes to CMS for verification of compliance with this finding.
- **Finding #2, relating to Periodicity Schedule:** The State has not developed a separate periodicity schedule for the provision of dental services to individuals eligible for EPSDT as required by section 1905(r)(3) of the Social Security Act.
- **Recommendation**: The State must develop a distinct dental periodicity schedule as require by law after appropriate consultations with dental organizations involved in child health care. The State also needs to ensure that beneficiaries and providers are informed of the periodicity schedule and the availability of dental services.
- **State corrective action #2**: The State recently adapted a new periodicity schedule and CMS evaluated this schedule for compliance. The State will notify providers through a scheduled provider update in October 2008. Additionally, the

periodicity table will be available in the provider and member area of the State's website.

- **CMS response to State corrective action #2**: CMS finds that the State's plan for corrective action is acceptable. Further corrective action will require that the State begin immediately transitioning the new periodicity schedule into the recipient materials. The State should forward all notifications to providers to CMS for verification of compliance with this requirement.
- **Finding #3, relating to Access:** 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 Southeast Dental Association (SEDA) submits SEDA's network as its own network for adequacy requirements. The State does not evaluate SEDA's network for the four-county Medicaid population, and instead relies on SEDA's analysis of the network adequacy for the five MCOs contracting with SEDA. Since the State does not have a contract with SEDA, this is potentially problematic as providers may contract with multiple MCOs.
- **Recommendation:** The State should evaluate the SEDA network based on the number of total Medicaid beneficiaries in the service area since this is the dental provider network for all five MCOs.
- **State corrective action #3:** The State responded to CMS that they review the MCOs' provider networks as a biannual condition for recertification. Additionally, the State responded that they do not address subcontractual network issues, as it is the responsibility of the MCO to meet this requirement.
- **CMS response to State corrective action #3**: The State response to the draft report is insufficient and will require additional corrective action. The State should note the Federal regulations at 42 CFR 438.6(l) which states that all subcontracts must fulfill the requirements of the delegated contracted requirement. The State does not satisfactorily meet corrective action by referring CMS to their MCO contractors' responsibilities. The State should note that the confronting issue is that all MCOs contracting with SEDA submit the same dental provider network for certification to the State. Given the noted dental provider access issues, CMS requires for state corrective action, a procedure where the State evaluates the dental providers in the SEDA network, for adequacy across the four-county Medicaid population. The State should submit an alternative plan for corrective action with this finding.
- **Finding #4, relating to Support Services:** 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 (LEP) 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 written in appropriate cultural and linguistic style.
- **State corrective action #4:** The State responded that it does not interpret the requirements to provide full reimbursement for interpreter services.
- **CMS response to State corrective action #4:** CMS notes the State's objection to providing interpreter services to individuals with Limited English Proficiency; however, the State Medicaid Letter and Executive Order provide clear guidance on this issue. CMS will provide further technical assistance with implementing any payment policies, as needed.

Additional Recommendations

In addition to the compliance findings, CMS recommends that the following actions be taken to improve access to dental services for children based on the review results detailed in the full report:

- The State should provide a separate dental handbook for all beneficiaries written in appropriate cultural and linguistic style.
- The State should ensure that all MCOs and their subcontractors provide services with appropriate cultural competency.
- The State should utilize the MCOs for better care coordination and case management to integrate EPSDT services and receipt of dental care.
- The State should require MCOs to track and report on which children are not receiving dental services.
- The State should coordinate efforts to provide a dental home for children.
- 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.
- The State should continue implementation of State goals identified in 2005 Governor's Task Force to Improve Access to Oral Health and Healthiest Wisconsin 2010.

General Recommendation

The State should ensure that beneficiaries receive reminders regarding the need for periodic dental services either from the State Medicaid Agency as part of the annual EPSDT informing requirement or directly from dental service providers.

State Response to Additional Recommendations

The State mostly noted that it will consider the recommendations from the CMS draft report. Detailed responses to each recommendation are included throughout the report and the State's entire response is included in Appendix 1.

WISCONSIN EPSDT REVIEW WITH DENTAL FOCUS, MARCH 2008

I. Background

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 to effectively use them. Dental services are included in the EPSDT program coverage.

The Centers for Medicare & Medicaid Services (CMS) conducted on-site 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 a number of onsite dental reviews in some Sates, CMS is also collecting more limited dental information by telephone from all Sates.

II. Scope of review

CMS staff interviewed the following individuals:

- Two urban providers, one affiliated with the MCO dental benefits administrator subcontractor;
- two rural providers;
- two managed care organizations;
- the Wisconsin Dental Association;
- the dental benefits administrator (subcontract with all five MCOs); and
- the 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 Milwaukee and Madison. Providers were interviewed in person or for providers in more rural parts of the State, by telephone. CMS acknowledges that the number of interviews is not a representative sample of the provider population. All review findings are 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 protocol incorporates the relevant portions of the *State Medicaid Manual* and the Social Security 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 Wisconsin provision of dental services for children

As of February 2008, the State operates the majority of the Medicaid program, including the children's health programs, through the BadgerCare Plus program. The Federal authorities for this program include section 1932(a) State Plan authority, the section 1115 demonstration waiver that covers the majority of the SCHIP population, and several recent State Plan amendments modifying the eligibility and co-payment structure. These changes implemented the new benchmark benefit flexibilities, creating the BadgerCare Plus program.

The flexibilities of the benchmark authority allow for the State to offer a different set of services to certain eligibility groups. There are 13 MCOs contracted to provide Medicaid State Plan services statewide. Wisconsin primarily provides comprehensive health services for children through MCOs. In the four counties surrounding Milwaukee, dental services are also included in the managed care capitation rate. Five MCOs provide comprehensive Medicaid services in this service area, and are responsible for providing dental services as well. In the other service areas, the dental services are excluded from the capitation rate (carved-out) and provided fee-for-service. Aside from the dental services in certain service areas, all other EPSDT services are provided through the MCOs. The State's EPSDT program is known as HealthCheck.[1] According to data received from the State, there were 1,707 dentists enrolled in the Medicaid program as of January 2008. The State also indicated that there were 3,376 licensed dentists in the State as of April 2008.

In 2007, the CMS 416 shows that there were 499,965 individuals under the age of 21 eligible to receive EPSDT services in the State of Wisconsin. Approximately 132,000 were eligible to receive dental services in the managed care delivery system, while

[1] While the State and all interviewees referred to the EPSDT program as "HealthCheck," it is referred to as the EPSDT program herein.

approximately 297,000 were eligible to receive dental services fee-for-service.[2] A proportionally small number of children in Wisconsin are exempt from participating in managed care because they belong to a category that Federal statute protects from mandatory enrollments, such as the disabled or foster care children.

At the time of this report, the five MCOs delivering dental services in the managed care benefit package each had a contract with the same dental benefits administrator, Southeast Dental Association (SEDA). SEDA confirmed that it administers the dental network and pays providers at a proprietarily negotiated fee-for-service rate that is no less than the State's reimbursement. SEDA also assists with other outreach activities.

Over the last few years, the State addressed this issue in a few different venues. First, there were several oral health goals identified in Healthiest Wisconsin 2010. Additionally, in 2005 the Governor convened a Task Force to Improve Access to Oral Health. A subsequent report was issued from the Task Force that identified a number of State recommendations. CMS reviewers recommended that the State continue to implement the goals from these programs, including the possibility of using a statewide dental benefits administrator (DBA). The State has since issued a formal Request for Information regarding a statewide DBA contract.

The State Task Force identified barriers for provider participation, including burdensome Medicaid paperwork. The State streamlined the paperwork for prior authorization which is now only required for a limited number of procedures. The State also implemented an urgent and emergency care claim form for non-Medicaid providers so that they can provide urgent and emergency care on a limited basis and not become a Medicaid program provider. This change increased beneficiary access for urgent and emergency care. CMS reviewers identified a promising practice in the State's implementation of the Urgent Request Form.

Many of the providers interviewed by CMS accredited these advancements to the State's staffing of a practicing dentist as the Chief Medical Officer. The Chief Medical Officer maintains a practice at a Federally Qualified Health Center. The review team acknowledged this as a notable practice because of the expressions of positive communication and collaboration between the States Chief Medical Officer and the Medicaid dental provider community.

The CMS review team also identified the use of managed care incentives as a notable practice. The State initiated an MCO payment incentive program, or pay-for-performance, related to specific oral health outcomes. In 2003, the State identified that children receiving dental services in MCOs were less likely to receive dental benefits than children receiving dental benefits through fee-for-service. To correct this issue, the State offers incentives for specific increases in access to dental care. The MCO contract amendments initiating this change for the baseline data collection began in 2007 and the State will begin paying out incentives in 2008. The State's managed care incentives will

[2] These numbers are annualized approximations; the State did provide data with actual member months in managed care and fee-for-service since some children may have spent part of the year in each.

hopefully realize health outcomes for the program beneficiaries and also increase access as payment incentives are realized at the provider level.

Finally, CMS reviewers note that providers indicated that the WI Medicaid reimbursement rates for dental services are approximately one-third of the provider's costs. This information was repeated throughout every provider and MCO interview. Providers that were interviewed for this report expressed that their participation in the Medicaid program was charitable, but that their businesses operate at a loss to provide community care. Low reimbursement rates in WI may be a contributing factor to the beneficiary access issue.

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 all families receive EPSDT services through MCOs, they may also receive information about accessing EPSDT services in their managed care handbook. However, only five MCOs provide dental services, and the dental information is inconsistent. Additionally, at the time of the review, one of the MCO's materials had misleading information indicating that dental services were not covered if one lived outside of the four counties where dental services are included in the managed care benefit. Since the time of the draft report, the State required the MCO to correct the misleading information.

The State contractually requires MCOs to maintain specific appointment timeframes for preventive care, and also urgent and emergency services. CMS reviewers asked SEDA and the MCOs how these appointment timeframes were monitored to ensure that providers were meeting these standards. The response was that the monitoring was driven through the adverse actions (grievances, appeals, and State fair hearings) process; however, upon inquiry, 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 and, subsequently the SEDA subcontracts, there is no compliance or monitoring mechanism if families are not notified of this right.

Finding #1: 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. Since EPSDT services are delivered through a managed care arrangement in this case, managed care rules apply.

Recommendation #1: The State should notify beneficiaries of the contractual time frames for appointments in conjunction with 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.

Recommendation #2: CMS recommends that the State develop a separate dental handbook written in the appropriate cultural and 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 for receiving services. The State should ensure that every enrollee receive this handbook at enrollment.

State corrective action #1: The State indicated that they made the necessary amendments to the managed care contracts and developed a monitoring policy.

CMS response to State corrective action #1: The State should submit contract amendments and policy changes to CMS for verification of compliance with this finding.

Key Area II – Periodicity schedule and interperiodic services

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 current periodicity schedule is partly based on the requirements of 42 CFR Part 441, Subpart B, which is outdated. Additionally, the State relies on older guidance from the American Academy of Pediatrics which recommends a dental referral at age three, or earlier, if necessary.

At the time of the review, the State reported that some preventive services are covered for Medicaid reimbursement twice per year for children age one through twelve and once per year for children thirteen and older. Since the draft report was issued, the State reported that this policy was revised, effective March 1, 2008. The State now covers one oral exam every six months for individuals up to 20 years of age in the BadgercarePlus program, and for individuals up to 19 years of age in the benchmark plan group.

The State reports that dental services are available to children prior to age three, but concedes that this information is not readily distributed and available to providers, parents, and caregivers. At the time of the review, the State did not have a separate dental periodicity schedule, however, this was a corrected finding at the issuance of the final report. The burden lies on the primary care provider to identify needed dental services and refer the child for care prior to the State's mandatory EPSDT referral age of three. The State agreed to distribute the changes to the provider community in the October 2008 provider notifications.

The Department of Health and Human Services, Health Resources and Services Administration awarded the State a four-year grant to increase oral health awareness and utilization of dental services. Although the "Healthy Teeth for Mom and Me" program funded through this grant ended in 2006, the State reported that the training material, including anticipatory guidance, continues to be distributed to providers and caregivers. The age-appropriate interventions recommended by the State in this program do not correspond with the State's current EPSDT periodicity schedule and Wisconsin Administrative Code HFS 107.22. The "Healthy Teeth for Mom and Me" program takes a more assertive approach similar to the current nationally recognized dental periodicity standards.

The CMS reviewers documented efforts to increase awareness about more aggressive periodicity standards. However, the State has yet to codify this information for providers.

Finding #2: The State has not developed a separate and distinct periodicity schedule for the delivery of dental services to EPSDT eligibles as required by section 1905(r)(3).

Recommendation #3: The State should develop a distinct dental periodicity schedule as required by law after appropriate consultations with dental organizations involved in child health care and should assure for the provision of medically necessary dental services for all children under the age of twenty-one, as required through the EPSDT program. The State also needs to ensure that both beneficiaries and providers are informed of the periodicity schedule and availability of services.

State corrective action #2: The State recently adapted a new periodicity schedule and CMS evaluated this schedule for compliance. The State will notify providers through a scheduled provider update in October 2008. Additionally, the periodicity table will be available in the provider and member area of the State's website.

CMS response to State corrective action #2: CMS finds that the State's plan for corrective action is acceptable. Further corrective action will require that the State begin immediately transitioning the new periodicity schedule into the recipient materials. The State should forward all notifications to providers to CMS for verification of compliance with this requirement.

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 new dental providers entering the health care delivery system was a primary concern. The State of Wisconsin has one dental school, the Marquette University School of Dentistry. The 2003-2005 State budget decreased the tuition assistance for the dental school and State staff indicated that they are aware that the decrease in tuition funding may impact access. Providers interviewed by CMS stressed the barriers resulting from the lack of dental specialists, especially endodontists, accessible to Medicaid beneficiaries in the State. The 2005 Governor's Task Force to Improve Access to Oral Health addressed additional issues related to workforce recruitment and dental students. The State has implemented several of the Task Force recommendations. For example, the State has taken steps to have dental hygienists provide Medicaid dental services. Effective September 1, 2006, individually State-certified licensed dental hygienists can receive reimbursement for the provision of seven Medicaid dental services permitted within their scope of practice outlined in Wisconsin Administrative Code HFS 107.07(1m). Beginning February 2008, certain State Medicaid-certified Healthcheck Agencies can receive Medicaid reimbursement for additional services such as periodic oral exams performed by a dentist and services provided by licensed dental hygienists that are not certified by the State.

CMS found that the State currently verifies provider network adequacy for each MCO, individually, including the dental network. Each MCO that uses SEDA submits SEDA's network as its own network for adequacy requirements. The State does not evaluate SEDA's network for the four-county Medicaid population and instead relies on SEDA's analysis of the network adequacy for the five MCOs contracting with SEDA. Since the State does not have a contract with SEDA, this is potentially problematic since it is unclear how many providers in the SEDA network contract with multiple MCOs. CMS reviewers experienced some provider and MCO interviewees making generalizations about the Medicaid population. This is potentially a barrier and further impede the likelihood that the beneficiary will maintain the appointment if they feel they are not treated fairly or with respect.

However, CMS reviewers found noteworthy that the State initiated a secret shopper program and investigated the access issues with the MCO's subcontracting DBA and

eventually required the MCO to take action with the DBA. The State monitored a specific trend of adverse actions in this situation and used this data to address the problem within their managed care contract. CMS reviewers described this as a notable practice because the State used a secret shopper program to collect information regarding access and to validate beneficiary adverse actions and terminated its contract with the particular MCO.

Finding #3: According to Federal requirements [42 CFR §438.206(b) *et seq.*] the State must ensure through its contracts that the provider network is adequate. Adequacy of the SEDA provider network may be questionable due to the lack of a State contract with SEDA.

Recommendation #4: The State should evaluate the SEDA provider network based on the number of total Medicaid beneficiaries in the service area, since this is the dental provider network for all five MCOs.

State corrective action #3: The State responded to CMS that they review the MCOs' provider networks as a biannual condition for recertification. Additionally, the State responded that they do not address subcontractual network issues, as it is the responsibility of the MCO to meet this requirement.

CMS response to State corrective action #3: The State response to the draft report is insufficient and will require additional corrective action. The State should note the Federal regulations at 42 CFR 438.6(l) which states that all subcontracts must fulfill the requirements of the delegated contracted requirement. The State does not satisfactorily meet corrective action by referring CMS to their MCO contractors' responsibilities. The State should note that the confronting issue is that all MCOs contracting with SEDA submit the same dental provider network for certification to the State. Given the noted dental provider access issues, CMS requires for state corrective action, a procedure where the State evaluates the dental providers in the SEDA network, for adequacy across the four-county Medicaid population. The State should submit an alternative plan for corrective action with this finding.

Recommendation #5: The State should ensure that all MCOs and their subcontractors provide services with appropriate cultural competency.

State response to recommendation #5: The State will continue to explore new ways to implement cultural competency requirements, including using CAHPS survey questions to survey MCO members about MCO behavior. Additionally, the State provided further information about quality oversight audits and trainings.

Recommendation #6: The State should continue to explore and implement the recommendations of the 2005 Governor's Task Force to Improve Access to Oral Health and Healthiest Wisconsin 2010.

State response to recommendation #6: The State noted that it continues to look at the recommendations from this Task Force, but is limited to the programs under specific

State Medicaid Agency oversight. CMS encourages the State to continue partnering with other organizations impacted by oral health issues.

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 State indicated all services under the EPSDT benefit are comprehensive, including any non-routine dental services. With only a few exceptions, the State has eliminated most prior authorization requirements. This resulted in a significant reduction in paperwork, which was previously mentioned as a notable practice.

The providers and MCOs did not indicate that authorization for services was an impediment to provision for EPSDT. Furthermore, the State interviews yielded generous policies and procedures for providing EPSDT-related services for all eligible beneficiaries.

Electronic Data Systems (EDS) is contracted to make the dental medical necessity determinations, which fall under the Wisconsin Administrative Rule. If a service is denied, proper notification is sent to the beneficiary, which includes instructions regarding appeal rights. The State's CMO is one of the contacts on the appeal letter that may provide the denial explanations.

- **Key Area IV – Diagnosis and Treatment. – There are no concerns in this area.**

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 at 42 CFR §431.53 of mandating transportation assistance.

The State utilizes their county EPSDT outreach agencies' normal scheduling assistance process for scheduling dental services. Additionally, the State uses a Dental Ombudsman for troubleshooting with appointments. Transportation is arranged through State-funded private contractors. Managed care enrollees will receive transportation coordination

assistance from their MCOs in some counties. The State indicated that in most cases, the counties are responsible for arranging transportation. In either case, the individuals responding to the phone number on the Medicaid card should coordinate the transportation for the beneficiary.

Transportation is available to BadgerCare Plus program beneficiaries in the basic plan, which includes all Medicaid beneficiaries.[3] CMS reviewers found that the providers interviewed knew that transportation was available to beneficiaries. Additionally, the recipient materials from the State and MCOs explain that the county or MCO coordinate transportation.

Beneficiaries receiving dental services through fee-for-service are instructed to contact the State Medicaid customer services for assistance in locating a dentist if they are unable to access one through the provider directory sent upon enrollment. If they are unable to locate a provider through customer services, they are told to contact the State Dental Ombusman. Beneficiaries receiving dental services through an MCO may call the customer hotline to obtain a current list of dentists actively accepting new patients. If the individual is unable to locate a provider, the MCO will contact SEDA to help find a provider willing to accept the patient.

The State's manual for EPSDT outreach and case management services specifies the prevention services, scheduling assistance, and transportation available to help beneficiaries arrive at appointments. The State provides a list to providers and MCOs identifying targeted at-risk children under the age of 21 who have not received preventive dental care and are at risk of developing illness related to the lack of medical care. This list is sent monthly and categorizes the individuals by county and the urgency of services. After the State-specified at-risk children are contacted, all other eligible Medicaid children are attempted contact by the case manager to help link to required EPSDT services. If the child fails to attend the appointment, a total of two attempts are made to engage the caregiver and child into services. After two attempts to schedule a beneficiary's screening, the outreach requirement is considered met, even if the beneficiary connection is unsuccessful.

Beneficiaries unable or failing to keep appointments impact dental access as such patient behavior may influence providers' willingness to accept Medicaid patients. CMS encourages the State to continue to educate MCOs, providers, and beneficiaries about issues that impact appointments. Also, the State should continue monitoring and sharing promising provider practices that help this issue.

The provider interviews yielded information that led CMS reviewers to find that the State requires providers to pay for interpreter services. State policy staff confirmed this policy, and "translation services" is specifically listed as a non-covered service in the provider handbook. CMS requires states to pay for interpreter services and most current medical

[3] As previously mentioned, the BadgerCare Plus benchmark plan includes additional eligibility groups; transportation is not a covered service for the benchmark plan group.

literature on the subject supports providing trained medical interpreters for the best outcomes.

Finding #4: 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 #7: 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 containing appropriate cultural and linguistic considerations.

State corrective action #4: The State responded that it does not interpret the requirements to provide full reimbursement for interpreter services.

CMS response to State corrective action #4: CMS notes the State's objection to providing interpreter services to individuals with Limited English Proficiency; however, the State Medicaid Letter and Executive Order provide clear guidance on this issue. CMS will provide further technical assistance with implementing any payment policies, as needed.

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.

While most children in Wisconsin receive medical care through the managed care delivery system, the majority of the State's county dental services are not included in the MCO's capitation (carved-out). Hence, while MCOs should coordinate EPSDT services, they likely have no information about fee-for-service dental providers, claims, or referral follow-through, outside of enrollee self-report or State collaboration.

A comparatively small number of special needs children also receive all Medicaid State Plan services fee-for-service. These children have a case manager at the county office to assist with coordinating services. 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.

Since SEDA uses a network of providers, out-of-network dental care is obtained in cases of urgent and emergency care services. Additionally, dentists near the border, but outside of Wisconsin, may wish to provide services. This has been particularly critical to the access issue in northern Wisconsin, near the Upper Peninsula of Michigan.

The State permits emergency care by non-Medicaid providers. The State allows this process for approximately twenty-five services through the completion of the Urgent Request Form. This process helps reduce the time it takes for an individual to receive emergency care, but does not assist the individual with the continuation of subsequent follow-up care.

Currently, in the service areas where dental services are not included in the capitation rate, the MCOs are not expected to coordinate these services, despite the fact that receipt of dental services is an EPSDT requirement and coordination of EPSDT is included in the capitation rate.

MCOs are currently not required to track and/or report on children who have not received dental services in a period of time. MCOs should escalate steps to reach these families, and enroll the children into care. In the areas of the State where children receive dental services fee-for-service, the State should work with the MCOs using fee-for-service data to better coordinate services.

Finally, the review team documented several enthusiastic efforts to ensure a dental home for children in Wisconsin. A dental home provides a place for a family to dependably access both preventive and acute oral health care services. The providers and MCOs led some of these efforts; the State public health agency also had several initiatives in this area.

Recommendation #8: The State should improve the documentation for the oral health needs of special needs children as well as examine the adequacy of dental specialists and accommodations available in both rural and urban areas.

State response to recommendation #8: The State responded by highlighting a number of grants it has received to monitor and evaluate this issue. CMS encourages the State to make this information readily available to Medicaid providers and families.

Recommendation #9: The State should utilize the MCOs for better care coordination and case management to integrate EPSDT services and receipt of dental care when dental services are included in the capitation rate (carved-in) and when it is not included (carved-out).

State response to recommendation #9: The State responded that they will discuss this with the MCOs.

Recommendation #10: The State should require MCOs to track and report on which children are not receiving dental services.

State response to recommendation #10: The State responded that they will discuss this with the MCOs.

Recommendation #11: The State should take a leadership role to coordinate the various dental home initiatives.

State response to recommendation #11: The State responded that under direction of their State Secretary of Health and Human Services, they will take a leadership role in these activities.

Key Area VII - Data collection, analysis, and reporting

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 monitors MCOs to ensure periodic dental services are performed through the utilization of Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS). MEDDIC-MS is part of the State's comprehensive quality assessment and performance improvement strategy to produce automated performance measure data annually that is used as a benchmark for statewide improvement. The State has been able to conduct more advanced geographic analysis with the MEDDIC-MS data set than the CMS-416 data inquiries. Due to the CMS-416 requirements, the State collects data for both internal and external analyses.

Additionally, the State initiated an MCO payment incentive program, or pay-for-performance, related to specific oral health outcomes. In 2003, the State identified that children receiving dental services in MCOs were less likely to receive dental benefits than children receiving dental benefits through fee-for-service. To correct this issue, the State offers incentives for specific increases in access to dental care. The MCO contract amendments initiating this change for the baseline data collection began in 2006 and the State will begin paying out incentives in 2008.

- **Key Area VII - Data collection, analysis, and reporting – There are no concerns in this area.**

V. Conclusion

Wisconsin's State Medicaid agency has examined access to oral health with great concern for several years. In addition to the CMS report findings requiring corrective action, the CMS review team acknowledged the State's accomplishments and provided additional recommendations for the State to consider. CMS expects the State to establish specific goals to increase access to dental care for the Medicaid population. CMS looks forward to working with Wisconsin to share the promising and notable practices with other states to continue to address the issue of access to oral health and EPSDT dental services for Medicaid beneficiaries.