Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHILDREN'S DENTAL SERVICES UNDER MEDICAID

ACCESS AND UTILIZATION

JUNE GIBBS BROWN
Inspector General

APRIL 1996
OEI-09-93-00240

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. This report was prepared in the San Francisco regional office under the direction of Kaye D. Kidwell, Regional Inspector General, and Paul A. Gottlober, Deputy Regional Inspector General. Project staff included:

SAN FRANCISCO	HEADQUARTERS
Elizabeth Celniker	Winnie Walker, Program Specialist
Thomas Purvis	

For additional copies of this report, please contact the San Francisco office at (415) 437-7900.

E X E C U T I V E S U M M A R Y

PURPOSE

This inspection (1) identifies the reasons why many children are not receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services and (2) describes State activities to improve access and utilization.

BACKGROUND

Medicaid's EPSDT is a comprehensive health program that provides for initial and periodic examinations and medically necessary follow-up care. Federal law requires that States provide EPSDT services to eligible children from birth through age 20. The two primary operational premises of EPSDT are *access* and *utilization*. That is, States must (1) assure that health care providers are available and accessible and (2) teach Medicaid families how to use available resources effectively.

Specifically, States must (1) recruit physicians, dentists, and other providers to participate in EPSDT; (2) assure that these providers perform the medical and dental examinations, diagnoses, and treatments; (3) locate eligible families and inform them about EPSDT; (4) issue schedules specifying the desired frequency of medical, dental, vision, and hearing screenings, based on professional practice standards; (5) report information on use of EPSDT services to the Health Care Financing Administration (HCFA); and (6) provide all services needed to treat any condition identified by a screen even if the State does not include this service in its Medicaid plan.

In recent years, a number of States, as well as HCFA, the Administration for Children and Families (ACF), the Public Health Service (PHS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) have expressed concern about the number of dentists who are willing to see EPSDT enrollees. (As a result of a recent Departmental reorganization, responsibilities for oral health within the former PHS have been transferred to both the Office of Public Health and Science [OPHS] within the Office of the Secretary and the Health Resources and Services Administration [HRSA].)

We interviewed Medicaid and dental public health officials in all 50 States and the District of Columbia. We also contacted a sample of Head Start health directors, State and national dental society representatives, private practice dentists, advocates, and other experts.

FINDINGS

Few eligible children receive preventive dental services

Our interviews confirmed what the HCFA data show--few children receive EPSDT dental services, and the extent of the problem varies significantly from State to State. In fact,

HCFA data show that only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children received preventive dental services in 1993, a slight decrease from the 22 percent who received services in 1992. Also in 1993, three-fourths of the States provided preventive services to fewer than 30 percent, and none of the States provided them to more than 50 percent, of all eligible children. The States' statistics of children participating in the EPSDT program are unreliable, because States vary in what data they collect and report to HCFA.

The reasons few children receive dental care are complex

Approximately 80 percent of the States attribute the low utilization rate to a shortage of dentists who are willing to accept Medicaid patients. Head Start grantees also report increasing difficulty in obtaining dental services for their children. States report that inadequate reimbursement is the most significant reason why dentists don't accept Medicaid patients. However, preliminary data from a few States that have raised fees show that, at least initially, access and utilization do not increase proportionally. Dentists also are dissatisfied with slow Medicaid payments, arbitrary denials, and prior authorization requirements for routine services. Many dentists have difficulty treating Medicaid families, and many non-pediatric dentists are unwilling to treat young children.

Medicaid families give dental services a low priority. Respondents report that Medicaid families have competing family priorities, and many of them are unaware of the importance of good oral health. Families often are unwilling to wait for appointments or make necessary travel or child care arrangements which increases the likelihood of missed appointments and failure to seek services.

The youngest children are the most difficult to serve and frequently are not screened at all. Although the American Academy of Pediatric Dentists (AAPD) recommends that dentists examine all children before their first birthday, only a small fraction of Medicaid children receive these services. Twenty States have adopted the AAPD standard, another 12 States recommend screening beginning during the second year, and the rest start at age 3.

State, local, and private agencies are experimenting to improve access and utilization

In the past few years, State, local, and private agencies have begun initiatives to improve the participation of dentists in Medicaid and to encourage children and families to use dental services. State initiatives include: (1) increased reimbursement, (2) managed care arrangements, (3) streamlined claims processing, (4) outreach and beneficiary education, (5) mandated provider participation, (6) training general dentists and non-dental health providers, (7) clinics for dental care, and (8) voluntary efforts by dentists. While some States are planning to evaluate their projects, most do not yet have data to show whether they are effective.

RECOMMENDATION

We recognize that there is significant legislation before Congress and the Administration that would alter the relationship between the Federal government and the States on matters discussed in this report. Nonetheless, we believe the following recommendation and the options discussed for implementing it remain relevant under the current or future Federal-State relationship.

The Department should convene a work group that, at a minimum, would include HCFA, HRSA, ACF, OPHS, and ASPE to develop an integrated approach to improve dental access and utilization for EPSDT eligible children.

With expanded membership, the existing PHS Oral Health Coordinating Committee Working Group could fulfill this need. We suggest that the work group consider the following issues:

- Should a special conference with State participants be convened to facilitate an exchange of ideas on existing and possible demonstrations, evaluation strategies, and dissemination protocols?

- Can a coordinated approach be developed to identify demonstration projects, grants, and other activities that would improve access and utilization?

- Are there ways to encourage professional volunteerism that would increase the availability of dentists to this underserved population?

- How can the Department support, promote, and improve education and outreach to Medicaid beneficiaries, their families, and the dental community?

- What incentives and demonstration projects can be developed or promoted at the State and local levels to increase provider participation?

- How can existing community organizations, many of which are supported by the Department, become involved in providing access to children's dental services?

AGENCY COMMENTS

We received comments on the draft report from the Assistant Secretary for Health, the Centers for Disease Control and Prevention, the National Institutes of Health (NIH), HRSA, and HCFA. Both the Assistant Secretary for Health and NIH suggested that the existing PHS Oral Health Coordinating Committee Working Group, with expanded membership, could adequately address our recommendation and obviate the need for a new Departmental work group. We agree that this is a viable alternative and have amended our recommendation accordingly. The full text of the comments is contained in appendix C.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

This inspection (1) identifies the reasons why many children are not receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services and (2) describes State activities to improve access and utilization.

BACKGROUND

The EPSDT Program

Enacted by Congress in 1967, Medicaid's EPSDT is a comprehensive health program that provides for initial and periodic examinations and medically necessary follow-up care. Federal law requires that States provide EPSDT services to eligible children from birth through age 20.

The two primary operational premises of EPSDT are *access* and *utilization*. That is, States must (1) assure that health care providers are available and accessible and (2) teach Medicaid families how to use available resources effectively. Specifically, States must

- recruit physicians, dentists, and other providers to participate in EPSDT;
- locate eligible families and inform them about EPSDT services; and
- assure that Medicaid-certified physicians, dentists, or other providers perform the medical and dental examinations, diagnoses, and treatments.

In other words, States are required to (1) inform all persons who are Medicaid eligible about EPSDT services, (2) provide or arrange for the provision of screening services, and (3) arrange for all corrective treatment needed as a result of the screening.

Congress significantly amended EPSDT as part of the Omnibus Reconciliation Act of 1989 (OBRA 1989). The amendments require States to:

- issue schedules specifying the desired frequency of medical, dental, vision, and hearing screenings, based on professional practice standards (i.e., schedules developed in consultation with recognized professional associations such as the American Dental Association);
- report more detailed information on use of EPSDT services to the Health Care Financing Administration (HCFA); and
- provide all services needed to treat any condition identified by a screen even if the State does not include this service in its Medicaid plan.

Another OBRA 1989 amendment, which applies to the Medicaid program in general, requires States to set reimbursement rates at a level sufficient to assure that Medicaid

beneficiaries have access to providers equal to that of the general population in the same geographic area. Prior to OBRA 1989, this requirement existed only in regulation.

Frequency and Content of EPSDT Dental Screening

States must establish and maintain schedules that specify how frequently children should be screened. A physician or nurse practitioner usually conducts a general medical examination when a child is born or when the family enrolls in Medicaid. The general examination includes an oral health assessment. This oral assessment cannot substitute for an examination by a dentist. Furthermore, States must assure that dentists examine children at least as often as their dental screening schedules require.

States must establish the screening schedules in consultation with a recognized dental association. For example, they may choose to follow the American Academy of Pediatric Dentists (AAPD) screening guidelines that call for an initial examination by a dentist during the first year of life and subsequently at least twice a year. The AAPD schedule specifies that the initial screening should include a clinical oral examination and cleaning for the child plus dental health counseling for the family. This initial screening also may include fluoride treatments and the application of dental sealants. According to the AAPD, early screening and education can prevent "baby bottle tooth decay" and other causes of later childhood caries. Untreated, the conditions can produce severe tooth decay and gum infection that may require specialized treatment or hospitalization.

EPSDT and the Head Start Program

Head Start requires that enrolled children receive dental examinations and treatment. Most Head Start children are eligible for EPSDT services. The initial Head Start screening usually is conducted by dental hygienists or trained paraprofessionals rather than dentists. In addition, all Head Start children must receive an examination by a dentist at least once during the school year and must be treated for any problems found.

In a previous study, the Office of Inspector General (OIG) reviewed a random sample of 80 Head Start grantees for the 1991-92 program year and found that approximately 85 percent received the required dental examination. Of the children requiring follow-up dental treatment, the OIG found that 67 percent had all their dental needs met, 7 percent had only some needs met, and 26 percent received no treatment.[1] Nevertheless, these figures are substantially higher than States report for all of their EPSDT enrollees.

Access to EPSDT Children's Dental Services

In recent years, a number of States, as well as HCFA, the Administration for Children and Families, the Public Health Service (PHS), and the Office of the Assistant Secretary for Planning and Evaluation have expressed concern about the number of dentists who are

[1]Office of Inspector General, Evaluating Head Start Expansion Through Performance Indicators (OEI-09-91-00762), May 1993

willing to serve EPSDT enrollees. (As a result of a recent Departmental reorganization, responsibilities for oral health within the former PHS have been transferred to both the Office of Public Health and Science [OPHS] within the Office of the Secretary and the Health Resources and Services Administration [HRSA].) Several recent studies have focused on access problems and identified some of the reasons why few Medicaid children receive dental services. For example:

- The Congressional Office of Technology Assessment reported in 1990 that none of the State Medicaid programs adequately covered children's basic dental services and that a variety of barriers, identified by both dentists and State staff, restrict access.[2]
- A 1990 California Policy Seminar report found that most California county EPSDT programs were having trouble finding any dentists who were willing to see eligible children.[3]
- A series of oral health workshops sponsored in 1990 and 1991 by the PHS Maternal and Child Health Bureau described regulatory, administrative, and economic barriers that inhibit the delivery of dental services to children.

These studies identified inadequate reimbursement rates, complicated claims processing, prior authorization requirements, and dentists' actual or perceived problems with beneficiaries as the reasons why so few dentists are willing to serve Medicaid children.

Data concerning provider participation are not available

National reporting requirements that would provide data concerning the number of dentists participating in Medicaid do not exist. Also, adequate access has not been defined. Many States look at only how quickly families or staff can find a dentist, rather than the number who are getting services. Some States consider dentists to be participating if they file at least one Medicaid claim during the year. This is misleading because many of these dentists may refuse to take new Medicaid patients. Most States also lack data to track referrals from EPSDT screenings to determine if needed diagnoses and treatment were completed. A few States are beginning to compare the ratio of dentists willing to take Medicaid patients to the Medicaid-eligible population, but most lack access data or common measures.

The HCFA plans to collect and analyze data from selected States to provide information on the participation rate among dentists and the impact this has on Medicaid children's use of dental services.

---

[2]Congress of the United States, Office of Technology Assessment, Children's Dental Services Under the Medicaid Program, September 1990

[3]California Policy Seminar, Access to Dental Care for Medi-Cal Recipients, Research Report, University of California, Berkeley, 1990

Federal Oral Health 2000 Goals

Although approximately 21.2 million children were eligible for EPSDT services in 1993 (the last year for which data are available), only 1 in 5 received the required preventive dental services.[4] As part of its efforts to mitigate this problem, PHS launched the Oral Health 2000 project in 1991 as a collaborative effort with a number of private and voluntary health agencies. (The Office of Public Health and Science now has oversight responsibilities for this project.) The primary goal of Oral Health 2000 is to raise public awareness and improve access to oral health care services. Specific objectives are designed to:

- reduce the occurrence and severity of oral diseases,
- reduce the unnecessary loss of teeth from disease, neglect, or trauma, and
- alleviate barriers that prevent individuals from achieving oral health.

Oral Health 2000 addresses the 16 oral health objectives that PHS developed as part of "Healthy People 2000," a broader national health promotion initiative. One objective specifically related to EPSDT is "to increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow up for necessary diagnostic, preventive, and treatment services." Other issues concern increased use of fluorides, cessation of tobacco use, and the oral health of handicapped and minority populations.

METHODOLOGY

Our study methodology was four-fold. Basically, we:

- gathered existing EPSDT data from HCFA records,
- conducted telephone and in-person interviews to gather new information about the status of EPSDT dental services in the States,
- conducted telephone and in-person interviews to gather new information about State and local initiates to improve access and utilization, and
- presented the existing and new information in a single document. .

We interviewed officials in all 50 States and the District of Columbia. In most States, we interviewed EPSDT coordinators and Medicaid dental consultants as well as the State's chief dental officer. We also contacted a sample of Head Start health directors, State dental society representatives, private practice dentists, advocates, and other experts. The

[4]Health Care Financing Administration, EPSDT Program Indicators, Fiscal Year 1993, HCFA-416 Performance Reports, Early and Periodic Screening, Diagnostic and Treatment Program, 50 States and District of Columbia

American Dental Association and the American Academy of Pediatric Dentists helped facilitate contacts with State organizations and provided other information and assistance.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

FEW ELIGIBLE CHILDREN RECEIVE PREVENTIVE DENTAL SERVICES

Our interviews confirmed what the HCFA data show[5]--few children receive EPSDT dental services, and the extent of the problem varies significantly from State to State. (See appendix A for a State-by-State breakdown of the 1993 data.) In fact, HCFA data show that only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children received preventive dental services in 1993. This was a slight decrease from the 1992 data as shown in the following table:

PERCENT OF EPSDT CHILDREN WHO RECEIVED
PREVENTIVE DENTAL SERVICES
BY AGE GROUP, 1992 AND 1993[6]

Year	All Ages	< 1 Year	1-5 Years	6-14 Years	15-20 Years
1992	22.0	0.3	18.1	33.7	22.2
1993	19.7	0.4	16.0	30.0	19.5

Also in 1993, three-fourths of the States provided preventive services to fewer than 30 percent, and none of the States provided them to more than 50 percent of all eligible children. Since some of the States only began using HCFA's dental prevention service codes in 1993, they may have under-reported the care actually given.

The States' statistics of children participating in the EPSDT program are unreliable, because States vary in what data they collect and report to HCFA. A 1992 OIG inspection found that the screening and participant ratios used to measure States' performance were inaccurate.[7] Therefore, it is difficult to accurately assess States' success in reaching and screening Medicaid children under EPSDT. The HCFA has issued guidelines clarifying how to compute the screening and participant ratios more accurately, but no information is

[5]For data collection purposes, HCFA defines preventive dental services as the unduplicated count of individuals who receive (1) instruction in self-care oral hygiene procedures, (2) a teeth cleaning, and (3) when appropriate, an application of dental sealants to prevent decay.

[6]This table is based on data from HCFA reports on EPSDT program indicators for fiscal years 1992 and 1993, the most recent years available.

[7]Office of Inspector General, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- Performance Measurement, OEI-07-90-00130.

available to determine whether the guidelines are improving the accuracy and consistency of the reported data.

THE REASONS FEW CHILDREN RECEIVE DENTAL CARE ARE COMPLEX

Children do not receive preventive dental services for three basic reasons:

- few dentists serve Medicaid children,
- Medicaid families give dental services a low priority, and
- the youngest children are the most difficult to serve and frequently are not screened at all.

Respondents report that few dentists serve Medicaid children

Despite the paucity of data, approximately 80 percent of the States attribute the low utilization rate to the shortage of dentists who are willing to accept Medicaid patients. In many communities, families and EPSDT staff have difficulty getting timely dental appointments for Medicaid children. They often have to wait 6 to 8 weeks or travel long distances. Even among the 9 States reporting an adequate supply of dentists, 5 provided preventive services for fewer than 20 percent of eligible children. Although shortages are usually more severe in rural areas or isolated locations, 13 States report statewide shortages.

States report that inadequate reimbursement is the most significant reason why dentists don't accept Medicaid patients. Respondents in some States report that Medicaid fees do not even cover overhead costs, and dentists lose money on each patient served. Despite this, reimbursement increases do not guarantee greater provider participation immediately. (See the discussion of increased reimbursement incentives on page 9.) The OIG did not verify respondents' assertions that Medicaid reimbursement is inadequate.

Like other health care providers, dentists are dissatisfied with the complex Medicaid claims process, slow payments, arbitrary denials, and prior authorization requirements for routine services. While many States have taken steps to streamline claims processing, dentists may not be aware of these reforms because of inadequate provider outreach. Some respondents say that the small size of solo dental practices keeps many dentists from fully utilizing claims processing improvements such as electronic billing.

Many dentists also have difficulty treating Medicaid families and young children. They find that Medicaid families are more likely than others to break appointments at the last minute or not show up at all. Dentists claim that because of office scheduling practices, missed appointments are a more serious problem for them than for most physicians. Dentists also claim that Medicaid families sometimes create difficulties in their offices, for example, when a parent brings three children in addition to the child with the appointment and allows them to play raucously and disrupt others in the waiting room. Furthermore, many non-pediatric dentists are unwilling to treat young children, because these youngsters often take more time to examine than older patients and may require sedation.

Head Start grantees also report increasing difficulty in obtaining dental services for their children. Even though grantees eventually get a majority of their children examined and treated, their health directors have to spend more time and effort to accomplish this than in the past. The enrollment of 3-year-old children has made many dentists reluctant to serve Head Start. Grantees often transport children long distances to see a dentist because local dentists refuse to accept Medicaid. Some grantees persuade a local dental clinic or individual dentist to block off half a day for their children or persuade a dentist and hygienist to come to the Head Start site. A few grantees locate available dentists, but then insist that the parents themselves make and keep the appointments so they can learn responsibility. When a dental emergency precludes waiting or travel, some grantees spend funds from their own budgets to pay for treatment.

Medicaid families give dental services a low priority

Respondents report that Medicaid families have competing family priorities, and many of them are unaware of the importance of good oral health. Some States are increasing efforts to educate families, but they still give less attention to dental issues than to medical services such as immunizations. The result is that families give a lower priority to dental care than to medical care.

Medicaid families often miss appointments or forgo dental services. Because dental services are not a priority, many families are unwilling to wait for appointments or make necessary travel or child care arrangements. This increases the likelihood of missed appointments and failure to seek services. Many families will not make an effort to see a dentist even though they might to see a physician. Despite reminders and offers of transportation, beneficiaries often do not keep their appointments unless their children are in pain on the day of the appointment. Because dental care is a low priority, families often fail to follow dentists' instructions.

The youngest children are the most difficult to serve and frequently are not screened

Although the American Academy of Pediatric Dentists (AAPD) recommends that dentists examine all children before their first birthday, only a small fraction of Medicaid children receive these services. Twenty States have adopted the AAPD standard, another 12 States recommend that screening begin during the second year, and the rest start screening at age 3. States will pay for screening if a parent suspects a problem and takes the child to a dentist, even if the child is younger than the State's screening schedule specifies.

Even States adopting the AAPD standard often are unable to find dentists who will examine and treat children who are less than 3 years old. Non-pediatric dentists often are unfamiliar with the EPSDT program and are unsure of the protocol to follow in examining very young children. Because of this, a few State EPSDT staff question whether States should consume resources trying to find a dentist to examine children under age 3 unless they are at high risk or the general medical screening identifies an oral health problem.

A few States are developing training programs and videotapes on techniques for detecting oral health problems of very young children. These materials are primarily for general dentists and non-dental health care providers. Dental experts in these and other States recognize the importance of careful oral examination in early infancy and oral health counseling to prevent conditions such as baby bottle tooth decay. They believe that pediatricians and other non-dental personnel are more likely than dentists to screen children who are less than 3 years old. They contend that with careful training non-dental health care providers are competent to detect oral health problems and refer children to dentists for diagnosis and treatment. They hope to change some providers' attitudes about oral examinations, such as the physician who liked to boast, "Oral exams are no problem. I look past the teeth to the tonsils."

STATE, LOCAL, AND PRIVATE AGENCIES ARE EXPERIMENTING TO IMPROVE ACCESS AND UTILIZATION

State and local governments and private agencies have begun initiatives to improve the participation of dentists in Medicaid and to encourage children and families to use dental services. Their initiatives include:

Increased reimbursement or other financial incentives

In the past few years, more than half the States have increased dental reimbursement or taken steps to provide other financial incentives. Fifteen States raised fees significantly, and another 11 by smaller amounts. Several States are proposing additional financial incentives. For example, Georgia legislators introduced a proposal to authorize State tax credits to dentists and other providers who agree to serve poor children.

Preliminary data from a few States that have raised fees show that initially access and utilization do not increase proportionally. Although Connecticut raised fees by 80 percent, the overall increase in the number of services provided may not be substantial. California raised rates to 80 percent of the average amount billed in the previous year, but utilization still lags even though more dentists are available. Costs for Medicaid dental services in California have gone from about $150 million in 1991 to a projected $750 million in 1995. Other States report that fee increases have not been sufficient to bring fees close to the dentists' usual and customary charges. Several respondents note that dentists who drop Medicaid are frequently reluctant to return even if States raise fees or eliminate red tape.

A few States have restricted coverage of some dental procedures and used the savings to increase payments for the rest. For example, in response to a proposal from the State dental association, Indiana eliminated routine coverage for half of its children's dental procedures and used the savings to increase fees for the remaining basic preventive and restorative services. The State will still cover these procedures for EPSDT children when medically necessary, but at a lower rate and subject to prior authorization to justify medical necessity. Other States have dropped or plan to drop most adult Medicaid dental services, some claiming this is necessary to keep children's services fully funded.

Managed care arrangements

To facilitate access and contain costs, almost all the States are establishing managed care arrangements for Medicaid beneficiaries. Only 22 States have set up some form of dental managed care, either statewide or pilot projects. The rest either explicitly exclude dental services or have not yet decided because their plans are at a preliminary stage. Those who are explicitly excluding dental services report they will reconsider at a future date. Some States attempted to contract for dental managed care benefits but did not get any satisfactory bids because the fees they could pay were too low. Respondents report that dentists' resistance to managed care arrangements is a factor limiting implementation.

Among the approaches States are using to acquire dental services under managed care plans are: capitated risk plans, primary care case management, fee-for-service programs, and a mixture of capitation and fee-for-service. None of these is mutually exclusive. In some States, a physician serves as a gatekeeper to medical and dental services. In Arizona and Tennessee, dentists contract with local or statewide health plans to provide services either through a capitated rate or a fee for service arrangement. Illinois has a statewide contract with Delta Dental to provide all EPSDT services at a fixed price. Several respondents are critical of plans that subcontract dental managed care arrangements through health plans, claiming that the extra administrative costs reduce funds available to dentists providing actual services and therefore limit access. States are just beginning to develop monitoring procedures for dental services under managed care arrangements.

Streamlined claims processing

Nineteen States report taking recent steps to streamline claims processing, speed up payment, and reduce denials. Many other States already have taken these steps. States are:

- replacing HCFA claims forms with universal forms issued by the American Dental Association (ADA),
- removing prior authorization requirements,
- reducing denials,
- setting up electronic billing, and
- speeding up payments.

New Mexico, for example, is adopting the ADA claims forms and will supply dentists with the software for electronic claims processing. Florida has set up electronic billing but reports dentists are resistant to it. Arizona eliminated most prior authorization requirements. North Carolina worked with its dental association to establish use of ADA claims forms and electronic billing. Some respondents praise State steps to streamline claims processing but maintain this factor will not significantly improve access if States do not also raise fees and help families to make and keep appointments.

Outreach and beneficiary education

States report a wide range of new outreach and education efforts, either working directly with families or through dentists' offices. The Alaska Head Start dental initiative funds indigenous staff to provide oral health education and outreach to rural, remote Alaska native communities. Illinois contracts with Delta Dental to educate beneficiaries about the importance of dental screening services. Coupling Medicaid and private funding, New Hampshire established an access-to-care project to increase public and provider acceptance of Medicaid and EPSDT and to assure that every eligible child gets needed medical and dental services.

Mandated provider participation

A few States are mandating provider participation directly or through State plans for provider distribution. Minnesota mandates that dentists treat Medicaid patients up to a specific threshold as a condition of participating as providers in health plans for State employees. As part of a statewide health improvement initiative, Washington established a Health Personnel Resource Plan for regulating the supply and distribution of dentists and other health personnel.

Training general dentists and non-dental health providers

A few States have begun pilot projects to train non-pediatric dentists and non-dental health providers about pediatric oral health problems. The Texas Medicaid program is developing a videotape for use by non-dental health workers who screen young children. The video will explain techniques for adequate oral screening, describe necessary elements for oral health counseling, and specify that each child should be referred to a dentist if any decay or abnormality is found. Washington is developing a pilot project to train non-pediatric dentists about new pediatric dental screening and treatment techniques. With the University of Iowa pediatric dental department, Iowa established an educational task force to educate general dentists on pediatric dental issues and to assure that at least one dentist in each county is willing to examine year-old children. Iowa has produced a monograph on children's dental examinations and is reviewing data to determine how many children under age one dentists actually examine.

Clinics for dental care

Respondents from 20 States report efforts are under way to set up new dental clinics or expand existing ones to increase dental services available to Medicaid and other low-income beneficiaries. Expansion of dental clinic capacity is underway in a variety of clinic settings, including Federally Qualified Health Centers, hospital-based clinics, and clinics operated by State and local health departments. In Delaware, for example, all Medicaid beneficiaries are served in State-operated clinics; almost no private practice dentists participate in Medicaid. In Alabama, some local health or primary care clinics make a block of time available for dental services and treat clients on a first-come, first-served basis. The New Mexico and Nevada legislatures decided to expand clinics to assure

greater availability of dental services to low-income clients. Some respondents point out that legislators and others see clinics as a way to expand or maintain services without significant dental fee increases.

Voluntary efforts by dentists

Several States, localities, and dental associations are encouraging dentists to serve their fair share of Medicaid children. Starting about 1990, California's Contra Costa County dental society and EPSDT staff began a "share-the-care" project. Participating dentists agree to take one to three new Medicaid cases yearly or quarterly. County EPSDT staff make the referrals and ensure that participating dentists receive no more patients than they have agreed to. Other counties, not only in California but also in States such as Wisconsin, Colorado, and Texas, have started similar programs. North Dakota encourages dentists to accept a fair share of Medicaid patients and may provide non-monetary public recognition through "exemplary service" awards. Respondents report that while these voluntary programs are worthwhile, they usually reach only a small percentage of eligible children.

While some States are planning to evaluate their projects, most do not yet have data to show whether they are effective. A description of selected projects to improve access and utilization is contained in appendix B.

RECOMMENDATION

We recognize that there is significant legislation pending before Congress and the Administration that would alter the relationship between the Federal government and the States on matters discussed in this report. Nonetheless, we believe the following recommendation and the options discussed for implementing it remain relevant under the current or future Federal-State relationship.

THE DEPARTMENT SHOULD CONVENE A WORK GROUP THAT, AT A MINIMUM, WOULD INCLUDE HCFA, HRSA, ACF, OPHS, AND ASPE TO DEVELOP AN INTEGRATED APPROACH TO IMPROVE DENTAL ACCESS AND UTILIZATION FOR EPSDT ELIGIBLE CHILDREN

With expanded membership, the existing PHS Oral Health Coordinating Committee Working Group could fulfill this need. We suggest the work group consider the following issues:

- Should a special conference with State participants be convened to facilitate an exchange of ideas on existing and possible demonstrations, evaluation strategies, and dissemination protocols?

- Can a coordinated approach be developed to identify demonstration projects, grants, and other activities that would improve access and utilization?

- Are there ways to encourage professional volunteerism that would increase the availability of dentists to this underserved population?

- How can the Department support, promote, and improve education and outreach to Medicaid beneficiaries, their families, and the dental community?

- What incentives and demonstration projects can be developed or promoted at the State and local levels to increase provider participation?

- How can existing community organizations, many of which are supported by the Department, become involved in providing access to children's dental services?

AGENCY COMMENTS

We received comments on the draft report from the Assistant Secretary for Health, the Centers for Disease Control and Prevention, the National Institutes of Health, HRSA, and HCFA. Both the Assistant Secretary for Health and the National Institutes of Health suggested that the existing PHS Oral Health Coordinating Committee Working Group, with expanded membership, could adequately address our recommendation and obviate the need for a new Departmental work group. We agree that this is a viable alternative and have amended our recommendation accordingly.

We also would like to draw the reader's attention to the full text of the comments, which is contained in appendix C. In addition to some technical comments, they provide valuable information concerning issues that are not discussed in our report as well as other activities that the Department has undertaken to address children's oral health.

APPENDIX A

NUMBER AND PERCENT OF CHILDREN WHO RECEIVED EPSDT PREVENTIVE DENTAL SERVICES IN 1993, BY STATE[1]

STATE	NUMBER OF EPSDT ELIGIBLE CHILDREN	NUMBER WHO RECEIVED PREVENTIVE SERVICES	PERCENT OF ELIGIBLES
Connecticut	193094	52543	27.2
Maine	106828	36819	34.5
Massachusetts	404857	139414	34.4
Rhode Island	66136	21003	31.8
New Hampshire	40011	17905	44.8
Vermont	52251	17636	33.8
Region I Total	**863177**	**285320**	**33.1**
New Jersey	447272	101410	22.7
New York	1585786	283453	17.9
Region II Total	**2033058**	**384863**	**18.9**
Delaware	50585	6283	12.4
Maryland	229146	33129	14.5
Pennsylvania	880017	185289	21.1
Virginia	328090	64718	19.7
District of Columbia	73837	11800	16.0
West Virginia	135594	41452	30.6
Region III Total	**1697269**	**342671**	**20.2**
Alabama	279138	31369	11.2
Florida	1355013	222493	16.4
Georgia	643424	161496	25.1
Mississippi	470032	56843	12.1
Kentucky	293083	27604	9.4
North Carolina	550567	75794	13.8
South Carolina	302471	37876	12.5
Tennessee	534231	129886	24.3
Region IV Total	**4427959**	**743361**	**16.8**

[1]This table is based on data from the HCFA-416 performance report on EPSDT program indicators for fiscal year 1993.

Illinois	1027303	214810	20.9
Indiana	345751	144005	41.6
Michigan	823052	215885	26.2
Minnesota	291466	73539	25.2
Ohio	948612	216584	22.8
Wisconsin	342664	77103	22.5
Region V Total	**3778848**	**941926**	**24.9**
Arkansas	207085	35062	16.9
Louisiana	498389	128199	25.7
New Mexico	133524	8290	6.2
Oklahoma	162598	30949	19.0
Texas	1330465	160284	12.0
Region VI Total	**2332061**	**362784**	**15.6**
Iowa	169516	56210	33.2
Kansas	113286	40106	35.4
Missouri	403702	86619	21.5
Nebraska	102285	34267	33.5
Region VII Total	**788789**	**217202**	**27.5**
Colorado	210749	44305	21.0
Montana	57019	5119	9.0
North Dakota	32799	2625	8.0
South Dakota	47702	8543	17.9
Utah	123966	19186	15.5
Wyoming	34976	15157	43.3
Region VIII Total	**507211**	**94935**	**18.7**
Arizona	413100	1153	0.3
California	3583936	601451	16.8
Hawaii	68008	503	0.7
Nevada	34845	5010	14.4
Region IX Total	**4099889**	**608117**	**14.8**
Alaska	51691	14468	28.0
Idaho	71269	14967	21.0
Oregon	206524	71661	34.7
Washington	304257	89128	29.3
Region X Total	**633741**	**190224**	**30.0**
TOTAL	**21162002**	**4171403**	**19.7**

APPENDIX B

STATE AND LOCAL INITIATIVES TO IMPROVE DENTAL SERVICES FOR CHILDREN

INTRODUCTION

The activities described in this appendix are representative of initiatives to improve children's access to and utilization of dental services. Some are designed to increase the supply of available dentists by increasing fees or reducing red tape, while others are designed to help families with access, education, and outreach or to train professionals. Some were initiated by State Medicaid or public health agencies and others by professional and community organizations in cooperation with the States.

The listing is not a complete catalog of all State or local initiatives or a complete description of each project. More detailed information can be obtained from the contact person listed.

This listing does not constitute an OIG endorsement of any of the initiatives. While some States or other entities are planning to evaluate these projects, most do not yet have data to show whether they are effective.

BENEFICIARY ACCESS, EDUCATION, AND OUTREACH

Alaska Head Start Collaboration Project's Dental Initiative

The Alaska Head Start Health Improvement Initiative, which began in 1991, is designed to improve the dental health of children living in remote Alaskan villages across the State. Native Alaskan children have one of the highest rates of tooth decay in the United States. This is a result of factors such as infrequent and intermittent access to care, detrimental nutrition patterns, and child rearing traditions that do not include oral hygiene. Historically, Head Start programs serving rural Alaska communities have not been able to comply with the dental screening standard.

The project (1) established a provider network of culturally-sensitive dentists who travel to the villages to screen and treat children and (2) trained community staff in the villages to provide oral health education and outreach to children and families. While the target population is primarily native Alaskan children, the project includes all Medicaid-eligible children from birth to age 6.

The State Medicaid agency, the tribal health corporation in Nome, the State Head Start Association, and the State dental association have formed a coalition to work with the project and seek its continuation. The project will attempt to generate data showing that village-based care is cost effective and will distribute a manual for providers and others seeking to set up similar networks.

For more information contact:

Sally Mead, Director
Alaska Head Start Health Improvement Initiative
Prevention Associates
101 East 9th Avenue, Suite 10B
Anchorage, AK 99501
907-272-6925

Illinois Statewide Dental Contract

Beginning in 1992, Illinois contracted for a fixed price with the Delta Dental Plan of Illinois to provide all EPSDT dental services statewide, including outreach, oral health education, screening, follow-up treatment, and tracking the children and families to assure they get the required services. Delta contacts all families who have children between the ages of 3 to 20 who have not been screened in the past year. Names and addresses are also provided to the local EPSDT offices for follow-up. Other outreach efforts include press releases, public service announcements, and messages about dental services targeted to specific communities. Delta will refer families to dentists and make appointments, if necessary, for the initial screening or follow-up treatment.

Delta contracts with dentists, paying a fee based on the dentist's usual and customary charges. Delta also contracts with schools, health centers, and other clinics to make dentists available for group screenings and preventive services. A Delta manual specifies provider responsibilities and a protocol for screening in schools.

The contract requires Delta to provide services to at least one-half of the EPSDT-eligible children in Illinois. Delta must assure that screening goals are met, screening results are recorded, and referrals for treatment are issued. The State conducts compliance reviews and fiscal audits.

For more information contact:

Michael Berger, Vice President
of Government Programs
Delta Dental Plan of Illinois
2001 Butterfield Road, Suite 900
Downers Grove, IL 60515
708-964-2400

Deborah Saunders, Coordinator
Illinois Department of Public Aid
201 South Grand Avenue, East
Springfield, IL 62763-0001
217-524-7163

Maryland Head Start Collaboration Project's Dental Initiative

The Maryland Head Start Collaboration Project was initiated in 1993 to eliminate barriers to health care for Head Start children. To identify problems and develop statewide solutions, the project formed a coalition of representatives from public and private agencies. The project is part of the governor's office and, because of its location, project staff not only work closely with the Medicaid program but also have access to State policymakers.

One of the project's early initiatives was to survey Head Start grantee staff. The survey found that 38 percent of grantees have difficulty obtaining dental care for their children. According to grantees, only about 12 percent of dentists in their areas accept Medicaid. As a result of the survey, the project is recommending early outreach and oral health education for parents and children.

Recruiting dentists for Medicaid has been very difficult largely because the Maryland Medicaid program pays lower fees than almost any other State. The project will initiate a survey to clarify dentists' concerns about reimbursement and other issues. The survey will ask about dentists' problems with the claims process and about difficulties they may have in examining and treating young children. Staff will work with Medicaid, other State agencies, and dentists to determine appropriate solutions. The project will then undertake educational efforts to encourage more dentists to treat 3- and 4-year-olds.

For more information contact:

Gayla Sanders, Head Start Collaborator
Division of Policy and Planning
Governor's Office for Children, Youth, and Families
301 West Preston Street, 15th Floor
Baltimore, MD 21201
410-225-4160

Michigan Projects to Improve Dental Access

Michigan funded eight oral health outreach projects in 1994 as part of its "Healthy Kids" program. The projects include such initiatives as:

- utilizing mobile dental vans and portable equipment,
- establishing county dental clinics,
- coordinating efforts with schools regarding dental hygiene education, and
- improving data collection and dissemination.

Michigan formed a statewide oral health coalition to help generate legislative support for these projects and for other oral health improvement activities.

For more information contact:

Christine Cascaddan, Senior Policy Analyst
Medical Services Administration
Michigan Department of Social Services
Bureau of Policy and Management Information
400 South Pine Street
P.O. Box 30037
Lansing, MI 48909
517-335-5129

New Hampshire Access to Care Project

New Hampshire established the Access to Care Project in 1992 to increase public acceptance of Medicaid and EPSDT and to insure that every eligible child receives needed medical and dental services. The project is jointly sponsored by the State Medicaid program, the New Hampshire Alliance for Children, and the New Hampshire Pediatric Society. Funding is provided by the Jessie B. Cox Charitable Trust in Boston and matched with New Hampshire Medicaid funds.

The project (1) seeks support from the general public for increased children's services through outreach and education about EPSDT, (2) insures that all eligible children have a primary care physician to serve as an oral health advocate for the child and family in addition to providing other care, and (3) explains EPSDT mandates and benefits to dentists and other health professionals and persuades them to participate.

For more information contact:

Carol Currier, Administrator
Division of Human Services
Office of Medical Services
6 Hazen Drive
Concord, NH 03301-6521
603-271-4350

Washington Oral Health Improvement Plan

In 1993, Washington enacted the Public Health Improvement Plan to improve general health status in Washington through prevention and improved public health services capacity. Among other goals, the plan seeks to ensure universal access to needed health services for all State residents. Oral health is a key component of the health improvement initiative. The oral health component emphasizes that lack of access to dental care is at crisis levels, especially for low income and Medicaid-eligible children. Because of the lack of early preventive care and family education, hospital emergency rooms are handling cases of baby bottle tooth decay with charges up to $3000 per child. The Oral Health

Improvement Plan has developed several strategies to address these problems. They include:

- programs to screen children in the first year of life,
- universal dental screening of school children,
- increasing Medicaid dental fees,
- training non-dental medical professionals to recognize oral health problems,
- innovative interventions to prevent caries in infants and young children, and
- increasing families' willingness to see dentists by getting parents to understand that dental care is as important as medical care.

One goal of the plan has been to sensitize doctors and nurses to begin to see dental issues in a medical framework. State dental staff say that getting health professionals to think of dental caries as a preventable infectious disease fits very well into their medical orientation. This also fits into the University of Washington dental school's program to educate health professionals and make them more responsive about oral health issues. For example, staff designed an oral health training program for public health nurses so the nurses understand how to integrate oral health into their public health work. Ultimately, the State believes this understanding will result in better access to dentists and earlier intervention with dental problems.

For more information contact:

Elizabeth Hines, Oral Health Service Administrator
Community and Family Health
Washington Department of Health
P.O. Box 47880
Olympia, WA 98504-7880
360-753-5423

PROVIDER PARTICIPATION

California Dental Access Program

Beginning in 1992, the California EPSDT program conducted a statewide dental access improvement program which resulted in 40 county volunteer dental coalitions and the wide distribution of dental access resource manuals. The project established 9 regional workshops which were attended by more than 700 individuals representing private practice dentists, local public health programs, community clinics, professional organizations, universities and others concerned about children's oral health issues. Community dental providers were introduced to their county EPSDT program, Head Start, and other local children's programs.

The local coalitions developed specific strategies and activities for improving access to dental care in their respective communities. The most widespread strategy has been the

establishment of volunteer share-the-care programs similar to those started in Contra Costa and other counties. Some coalitions have become involved with preventive strategies including baby bottle tooth decay, community water fluoridation campaigns, and the planning of community health fairs.

For more information contact:

Renee Nolte-Newton, Dental Hygienist Consultant
Children's Medical Services Branch
California Department of Health Services
714 P Street, Room 400
Sacramento, CA 95814
916-653-4860

Delaware Clinic Program

Because almost none of Delaware's approximately 400 private practice dentists participate in Medicaid, nearly all EPSDT dental services are provided through clinics. For some years, the State has provided dental services to approximately 50,000 EPSDT-eligible children in 8 public health clinics. The State pays each clinic a monthly fee of $111 for each enrolled child to cover all medical and dental services. Each clinic is staffed with one dentist and one assistant. For specialized care, the clinic may refer children to a pediatric dentist and pay fee-for-service rates. In addition to the clinics, a few hospitals and a community college employ dentists who provide Medicaid services.

For more information contact:

David Mihalik, Social Service Senior Administrator
Delaware Department of Health and Social Services
1901 North DuPont Highway
New Castle, DE 19720
302-577-4900

Georgia Tax Credit

Georgia legislators introduced a proposal in 1995 (House Bill LC-10-0948) to authorize State tax credits to dentists and other providers who agree to serve poor children. The bill would have given a credit of $50 against State income taxes due from physicians or dentists for each indigent patient treated in a public clinic and from whom no compensation is received. Providers could carry forward indefinitely unused credits. The proponents of the legislation believe that the amount of the credit is enough to partially overcome losses for treating indigent patients, but it is not high enough to cause providers to substitute non-paying for paying patients. The bill was not passed in 1995, but legislators plan to re-introduce it in the 1996 legislative session.

For more information contact:

Tim Burgess, Director
Office of Planning and Budget
254 Washington Street SW, Suite 614
Atlanta, GA 30334
404-656-3820

Indiana Dental Procedure Priorities

In 1995, to retain participation of dentists in the EPSDT program, Indiana eliminated many adult dental services and reduced the number of children's procedures that will be reimbursed routinely. With the savings, the State increased fees for the remaining procedures which are the most important preventive and restorative services for children. The State will continue to cover all procedures deemed medically necessary for EPSDT children but will require prior authorization and pay only current rates for any procedures that have been eliminated for adults. These actions were based on discussions with and recommendations from the State dental association.

For more information contact:

Carol Gable, Consultant
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street, Room W382
Indianapolis, IN 46204
317-232-2091

Minnesota Medicaid Provider Mandate

In 1994, Minnesota enacted legislation (Rule 101) requiring that dentists and other providers treat Medicaid beneficiaries as a condition of participation in health insurance and workers' compensation plans for State employees. Minnesota EPSDT staff believe that Rule 101 has improved children's access to dental services by increasing the supply of available dentists.

Rule 101 requires that providers accept new Medicaid patients on a continuing basis, using the same acceptance criteria they would use for non-Medicaid patients, up to a threshold of 20 percent. If a provider's active Medicaid patient case load exceeds 20 percent, the provider may refuse to accept new beneficiaries. The rule includes a formula for determining this threshold. The formula includes such factors as active patient caseload, number of patient visits, and length of time enrolled as a Medicaid provider. Providers must notify the State when they have reached the threshold and will not take new Medicaid patients.

For more information contact:

Lawrence D. Grewach, Manager
Dental Demonstration Project
Minnesota Department of Human Services
444 Lafayette Road, 6th Floor
St. Paul, MN 55155
612-296-1481

New Mexico Patient Management Assistance

New Mexico worked closely with its State dental association in 1994 and 1995 to streamline claims processing and help dentists better manage Medicaid families and children. For example, as part of a training program on improving claims processing, New Mexico offered suggestions to dentists on how to manage young children in the dental office. State officials also are seeking to allow dentists who participate in this training to receive continuing education credits.

For more information contact:

Dr. Ken Padilla, Planner
Ambulatory Care Section
Medical Assistance Division
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
505-827-3177

North Carolina Clinic Program

North Carolina is enabling local health departments and other clinics to contract with local dentists for EPSDT services. In some localities, State staff believe this is the only way to assure the availability of dental services for EPSDT-eligible children. The State clinic program also will improve access for Head Start programs and initiate or expand dental services in rural, community, and migrant health centers. By enlisting the support of local dental societies, the State is hoping to attract dentists who might otherwise not participate to work full or part time in the clinics.

For more information contact:

Dr. C. Jean Spratt, Director
Division of Dental Health
North Carolina Department of Environment, Health and Natural Resources
P.O. Box 27687
Raleigh, NC 27611
919-733-3853

Wisconsin Access and Utilization Initiatives

In 1993, the Wisconsin Dental Association, in cooperation with State Medicaid and dental public health staff, initiated projects to help dentists deal with problems such as "no-show patients." By alleviating such problems, dentists may be more willing to participate in the EPSDT program.

To formulate recommendations, the dental association and the State formed a task force of Medicaid staff and dentists who provide EPSDT services. The task force interviewed dentists and their support staff and developed suggestions to deal with "no-show patients." The suggestions include:

- mailing reminders to patients and following up with phone calls a day in advance;
- requiring patients to call the office and confirm their appointment 24 hours in advance or their appointment will go to someone else;
- explaining why keeping appointments is important;
- setting aside a specific block of time or certain days for Medicaid patients and treating patients on a first-come, first-served basis during those times; and
- letting patients know where they can get help with transportation or child care so they can keep appointments.

The dental association has prepared an informational pamphlet describing these suggestions and others. Other informational materials describe county dental society clinic and volunteer programs in Wisconsin.

For more information contact:

Maryann Dillon, Director of Dental Services
Wisconsin Dental Association
111 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202
414-276-4520

Dr. Warren LeMay, Oral Health Consultant
Bureau of Public Health
Division of Health
1414 East Washington Avenue
Madison, WI 53703
608-266-5152

Wisconsin Fee Increases

In addition to general dental fee increases over the past few years, which have raised payments to approximately 61 percent of Statewide average charges, Wisconsin was paying a $3.50 "bonus payment" for 20 dental procedures most frequently performed on children under 21. Beginning in 1995, these additional payments have been folded into a further fee increase which applies only to claims for EPSDT services. These fees are now set at

approximately 75 percent of average charges. In part, these increases were possible because of the State's decision to eliminate some adult dental benefits and hold the line on increasing fees for non-EPSDT dental services.

For more information contact:

Dr. Warren LeMay, Oral Health Consultant
Bureau of Public Health
Division of Health
1414 East Washington Avenue
Madison, WI 53703
608-266-5152

Contra Costa County (CA) "Share-the-Care" Dental Access Project

In 1990, the county dental society and the EPSDT staff in Contra Costa County, California, initiated a voluntary "share-the-care" project. Participating dentists agree to take one to three new EPSDT cases, with the understanding that they will not be put on a list requiring them to see all referred children. County EPSDT staff insure that participating dentists receive no more patients than they have agreed to treat. Some dentists choose to bill Medicaid for services; others treat without charge. Some low-income patients who are not eligible for Medicaid are included.

County staff provide education and outreach to insure that patients keep their appointments. Staff schedule initial appointments and provide transportation and translation, if needed. They instruct families about proper hygiene and behavior in the dentist's office and strive to overcome any fear of dentists on the part of children or their parents. Some dentists will drop a family for breaking an appointment without calling to cancel. The Contra Costa program claims to have an 85 percent "kept-appointment" rate. County staff and the dental association continue to support the Contra Costa program. It is a model. Similar programs have been established in other counties in California and in other States, such as Colorado and Wisconsin.

For more information contact:

Robert Isom, Deputy Director
Child Health and Disability Prevention Program
Contra Costa County
595 Center Avenue, Suite 310
Martinez, CA 94553
510-313-6150

Dr. Colleen Zimmer
1004 McHugh Street
Fort Collins, CO 80524
303-221-4500

Maryann Dillon, Director of Dental Services
Wisconsin Dental Association
111 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202
414-276-4520

PROVIDER TRAINING AND EDUCATION

Iowa Pediatric Dental Education Program

Staff from State Medicaid and dental public health programs are collaborating with the pediatric dentistry department of the University of Iowa to develop training programs for general practitioners. They plan to (1) train dentists about pediatric dental issues, (2) determine how many dentists currently screen children under 3 years of age, and (3) produce a monograph about what should be included in a child's first dental exam.

The State will establish panels of dentists who are willing to treat very young or disabled children. Iowa's EPSDT screening schedule specifies an initial screening at 12 months of age, but parents in many communities find that few dentists are willing to examine children that young. In addition, few dentists are willing to serve children with disabilities. The State has established a panel of dentists who are willing to treat disabled children and hopes to set up a similar panel of dentists who are willing to see children before their first birthday. Among other methods to improve access for this age group, the State will (1) conduct a survey to find out how many children are screened before their first birthday, (2) assess dentists' attitudes about treating young children, and (3) locate dentists willing to staff Iowa's 25 child health clinics.

For more information contact:

Dr. William C. Maurer, Chief
Dental Health Bureau
Iowa Department of Public Health
Lucas State Office Building
Des Moines, IA 50319-0075
515-281-4916

Texas Oral Health Video Project

In 1995, the Texas Medicaid program began developing a videotape about oral health examinations for use by non-dental health workers who screen young children. The video will describe techniques for adequate oral screening, explain what should be included in oral health counseling, and specify that children should be referred to dentists if decay or abnormalities are found. To prepare the videotape, Texas staff consulted with the pediatric dental department of the University of Washington and others.

For more information contact:

Dr. Nana Lopez, Chief
Bureau of Dental Services
Texas Department of Health
1100 West 49th Street
Austin, TX 78756
512-458-7323

Spokane (WA) Dental Prevention Project: "Access to Baby and Child Dentistry"

Spokane, Washington is the site of a demonstration project that (1) provides dental prevention services to young, at-risk children from birth through age 5 and (2) trains dentists on recent developments in pediatric dentistry. Initiated in 1995, the project established a coalition of pediatric dentists from the University of Washington dental school, dentists in Spokane, and State Medicaid and dental public health staff. The project will:

- screen, diagnose and treat the children,
- provide family oral health education,
- calculate the direct costs and cost savings derived from the preventive program,
- study factors that determine children's utilization of dental services,
- determine if improved access changes parents attitudes so that they will visit dentists more frequently, and
- assess the cost effectiveness of a new technique to provide fluoride varnish.

Pediatric dentists from the dental school will train participating dentists in recent pediatric dental techniques. According to project staff, training is needed because most general practitioners lack pediatric dental knowledge. The Washington Department of Health Services will pay participating Spokane dentists higher fees than dentists get for similar services in the rest of the State.

Although the project will cost the State an estimated $3 million, project staff hope to demonstrate significant cost benefits. The project has submitted an application to the National Institute of Dental Research to fund a 4-year cost benefit and utilization study.

For more information contact:

Dr. Peter Milgrom, Director
Dental Fears Research Clinic
Dental Public Health Sciences
University of Washington School of Dentistry
Box #357475
Seattle, WA 98195
206-685-2453

Elizabeth Hines, Oral Health Service Administrator
Community and Family Health
Washington Department of Health
P.O. Box 47880
Olympia, WA 98504-7880
360-753-5423

APPENDIX C

AGENCY COMMENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES — Office of the Secretary

Assistant Secretary for Health
Office of Public Health and Science
Washington, D.C. 20201

MAR 18 1996

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Health

SUBJECT: OIG Draft Report: "Children's Dental Services Under Medicaid: Access and Utilization," OEI 09-93-00240

Thank you for the opportunity to review and comment on this draft report. The findings of this report were discussed last July in the Healthy People 2000 Progress Review on Oral Health. At that briefing, George Grob provided us with a useful summary of these disturbing findings that only one in five EPSDT children received an annual oral health service. As a result of that Progress Review, there were a number of follow-up action items including that CDC and NIH as co-leads for the Oral Health priority area work with HCFA in more effectively reaching minority and low income people, whether children or adults, particularly through the Medicaid program. Another action item was that the Medicaid program ensure coverage for dental services and identify ways to sustain enrollment in managed care arrangements. Another recommendation was to promote opportunities for oral health to be integral to general health services. I believe that the continued work of CDC and NIH as co-leads for the Healthy People 2000 objectives will help to address some of the concerns identified in this report.

The draft report recommends that the Department establish a work group to develop an integrated approach to improve dental access and utilization for eligible EPSDT children. There is a U.S. Public Health Service Oral Health Coordinating Committee chaired by the Chief Dental Officer, with representatives from AHCPR, CDC, FDA, HRSA, IHS, and NIH. That Committee has a subcommittee that I believe fulfills the elements of the work group you have recommended. I have asked the Chief Dental Officer to extend an invitation to representatives from the Health Care Financing Administration, the Administration on Children and Families, and the Assistant Secretary for Planning and Evaluation to join the Oral Health Coordinating Committee Working Group. For your information, I have attached the current membership of the committee.

My staff has informed me that a HRSA-sponsored meeting that will take place in Bethesda on April 12 and 13 with a focus on access to oral health services. This session will engage organized dentistry, public health dentistry at the Federal, State and community level, and dental researchers and will provide us with an excellent forum for addressing these concerns.

The release of your report will draw attention to the fact that Medicaid coverage for oral health doesn't necessarily equate with access to care. Therefore, we in the Office of Public Health and Science stand ready to address the oral health needs of American children through Healthy People 2000 and other national oral health initiatives.

Philip R. Lee, M.D.

Attachment

cc: Chief Dental Officer

TO: June Gibbs Brown
Inspector General, HHS

FROM: Deputy Director for Management, NIH

SUBJECT: Office of Inspector General (OIG) Draft Report *Children's Dental Services Under Medicaid: Access and Utilization*, OEI-09-93-00240

Attached are the NIH comments on the subject report which examines why many children are not receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services. We agree with the objective of the report's recommendation that the Department of Health and Human Services establish a work group to develop an integrated approach to improve dental access and utilization for eligible children. However, rather than creating a new Departmental work group, we recommend that this assignment be addressed by the existing PHS Oral Health Coordinating Committee. Our response also includes general comments.

Anthony L. Itteilag

Attachment

Comments of the National Institutes of Health (NIH) on the Office of Inspector General (OIG) Draft Report *Children's Dental Services Under Medicaid: Access and Utilization*, OEI-09-93-00240

General Comments

Thank you for the opportunity to review and comment on the draft report, "Children's Dental Services Under Medicaid: Access and Utilization." Staff from the National Institute of Dental Research (NIDR) participated in discussions regarding the findings of this report at the Healthy People 2000 Progress Review on Oral Health on July 28, 1995 and again at a November 6, 1995 exit conference at the Health Care Financing Administration (HCFA).

The findings of this draft report confirm results from other studies, particularly analyses of the first three years of the 1988-1994 National Health and Nutrition Examination Survey (NHANES III-Phase 1). The analyses of NHANES III-Phase 1, which NIDR staff prepared as progress indicators for Healthy People 2000, have been examined within the context of socioeconomic and infrastructure issues and will appear in a Spring, 1996 contribution to the Journal of Public Health Dentistry. Also, the discrepancies in access to examinations, diagnoses, preventive and treatment services among children living in poverty, and specifically Medicaid children, were addressed in presentations by NIDR staff in March at the International Association of Dental Research. Without exception, a variety of oral health status and access-to-service indicators, in a variety of age groups, demonstrate the disadvantages of the Medicaid population.

The more distressing component of these findings is the absence of potential for positive changes in the future. Discussions at the Healthy People 2000 Progress Review for Oral Health addressed several dimensions of this negative outlook. While many public and private sector programs have been directed toward the prevention of dental caries--promotion of community water fluoridation, community and school based fluoride and dental sealant programs--sustaining the level of oral health or additional progress will depend on the retention or improvement of infrastructure supporting these efforts. Inadequate funding and potential underutilization of oral health care services may be contributing to the continuation of inequities in oral health status and receipt of oral health care services by lower socioeconomic status children under Medicaid. The draft report addresses the impact of inadequate funding and the unwillingness of many dentists to accept Medicaid patients, but devotes less attention to other issues affecting dental services and oral health of Medicaid children. Other infrastructure challenges are seen in changes in the coordination and oversight of the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) and reductions in oral health activities in Maternal and Child Health Bureau (MCH) programs, Project Head Start, and migrant and other community health centers. Other concerns relate to changes in scholarships and loan repayments for dentists who serve in health professional shortage areas, as well as

legal restrictions that too often limit the provision of preventive dental services by dental hygienists and dental assistants.

It appears that knowledge levels, especially among household heads with less formal education, of (a) signs and symptoms of oral diseases, (b) available efficacious preventive strategies such as dental sealants, and (c) the importance of oral health care for young children are still limiting factors in improving the oral health of the nation. This also appears to be an outcome of weak infrastructure. For example, in the recently published results of the 1994 School Health Policies and Programs Study, data show that although 78 percent of all school districts require that oral health be taught, only 57 percent of schools actually teach related topics.

The lack of consideration of oral health as a fundamental and central public health function often excludes oral health in community health assessments, program planning, implementation and evaluation. Experts in dental public health are concerned that if persistence is not exercised in the combined public and private sectors to maintain focus on disease prevention activities, particularly in the Medicaid population, the gains observed in oral health earlier this century could revert to the earlier normative situation of pain, suffering and excessive costs associated with oral problems.

OIG Recommendation

The Department should convene a work group that, at a minimum, would include HCFA, HRSA, ACF, OPHS, and ASPE to develop an integrated approach to improve dental access and utilization for EPSDT eligible children.

NIH Comment

We concur with the objective of this recommendation, but believe that the U.S. Public Health Service Oral Health Coordinating Committee (OHCC) should be assigned this task. The OHCC is chaired by the Chief Dental Officer, and includes representatives from NIDR and other former PHS agencies. The OHCC is already facing access issues and has established working relations with the larger professional community, including the American Association of Community Dental Programs, American Association of State and Territorial Dental Directors, American Association of Public Health Dentistry, American Dental Association, American Dental Hygienists' Association, particularly through annual meetings and targeted forums. Since the impetus is already present within the OHCC, with some additions to its membership, forward direction could be achieved more readily by tasking the OHCC than by convening a new work group. As a co-lead for the Healthy People 2000 oral health priority area and a member of the OHCC, the NIDR remains committed to the understanding problems associated with discrepancies in oral health in the Medicaid population and in seeking solutions to the identified problems.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

MAR 25 1996

TO: Inspector General

FROM: Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report "Children's Dental Services Under Medicaid: Access and Utilization," OEI-09-93-00240

This is in response to your January 26, 1996, memorandum requesting comments to the draft report "Children's Dental Services Under Medicaid: Access and Utilization." Attached are the Health Resources and Services Administration's comments.

Staff questions may be referred to Sandy Seaton at (301) 443-2432.

John D. Mahoney

Attachment

Health Resources and Services Administration
Comments on the Office of Inspector General (OIG)
Draft Report "Children's Dental Services
Under Medicaid: Access and Utilization"
OEI-09-93-00240

GENERAL COMMENTS

The OIG recommends convening a work group that, at a minimum, includes the Health Care Financing Administration (HCFA), Health Resources and Services Administration (HRSA), Administration for Children and Families (ACF), Office of Public Health and Science (OPHS) within the Office of the Secretary and the Assistant Secretary for Planning and Evaluation (ASPE). HRSA believes that the OIG should consider expanding the group to include other Federal agencies, such as the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) and other outside dental and non-dental organizations interested in children's oral health. Such organizations might include the American Academy of Pediatric Dentists, the Association of State and Territorial Dental Directors, the American Dental Association and the National Dental Association.

Furthermore, the OIG should recognize pediatric HIV patients in the report. The number of children with HIV infection and children with AIDS continues to increase. Ninety percent of these children and adolescents may be eligible for Medicaid and EPSDT services. The availability of an effective oral health care component within Medicaid is particularly significant for the delivery of dental care to people with HIV infection and AIDS. Grantees supported by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, managed by the Bureau of Health Resources Development (BHRD), place substantial reliance upon the EPSDT program for the provision and reimbursement of oral health care to HIV infected children and adolescents.

We further note that the OIG states in its draft report that many dentists have difficulty treating Medicaid families; and many non-pediatric dentists are unwilling to treat young children. We believe that dentists without post-graduate residency training also have difficulty treating Medicaid families and young children due to lack of training and experience.

It is the OIG's position that the work group should consider holding a special conference with State participants to facilitate an exchange of ideas on existing and possible demonstrations, evaluation strategies, and dissemination protocols. We believe providers and consumer groups should be added as special conference participants. By expanding the group of participants, there will be more interaction and collaboration between the parties involved, which is essential to the effective and efficient delivery of services.

In addition, the OIG's report should more fully reflect the many ongoing activities of the Department designed to address this problem. For example, the following are HRSA's efforts to improve access and utilization to dental care.

-- The Dental Pilot project of HRSA's Bureau of Primary Health Care (BPHC) is a successful model that demonstrates how Federal, State and local resources are combined to increase access to oral health care services for underserved populations.

-- The BPHC's Division of Scholarships and Loan Repayment administers loan repayment programs that have successfully placed dentists and dental hygienists in Health Professional Shortage Areas. Since 1993, over 130 dentists have received loan repayment awards to work in community and migrant health centers, effectively increasing the capacity to provide EPSDT dental services.

-- The Bureau of Health Professions (BHPr) **"Grants for Residency Training and Advanced Education in the General Practice of Dentistry"** has, for the last several years, promoted and made great progress in this area. Dental schools and hospitals which received Federal funding in 1994 and 1995 through this grant program participated in off-site training, which linked academia, practice and training. Residents left their institutions and trained in other sites such as community/migrant health centers and nursing homes in underserved areas. For example, approximately 31 percent (34 out of 109) of those students who benefited from these federally funded programs and graduated in 1994, established their practice in underserved areas.

-- HRSA's BHPr, through a contract with the University of Iowa, is sponsoring a meeting titled "Oral Health Access: Public/Private Leadership" on April 12-13, 1996. This meeting will initiate discussion on how to increase access to oral health care. Other topics will include dental Medicaid, models of public/private access programs, coalitions of public/private programs and loan repayment issues.

Finally, with regard to the issues the OIG suggests that the work group should address, HRSA offers the following issues for consideration.

-- The impact of a Medicaid Block Grant Program to States, if enacted and implemented, and the role of the Department in supporting the States to effectively implement the concept of EPSDT under such a block grant program. The issue of whether the block grant should contain language that identifies oral health access as a priority and a possible set aside of special funding to promote delivery of oral health care services should be considered.

-- Ways the Department can develop better support for dental education and encourage dental providers to practice in high need Medicaid areas.

-- In order to increase provider participation the work group should consider the need for HCFA and HRSA to identify opportunities to pilot dental managed care programs, especially in States that have received Medicaid waivers.

-- The impact of the increasing number of pediatric AIDS cases and the availability of dental services to this population.

OIG Recommendation

The Department should convene a work group that, at a minimum, would include HCFA, HRSA, ACF, OPHS and ASPE to develop an integrated approach to improve dental access and utilization for EPSDT eligible children.

HRSA Comment

We agree that the Department should convene a work group to develop an integrated approach to improve dental access and utilization for EPSDT children. However, we believe that the work group should be expanded as reflected in our comments.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

COPY
3/23/96 -- Forwarded to Robert Thornton

Memorandum

Date

From Associate Director for Management and Operations, CDC

Subject CDC Comments on IG Draft Report

To George Grob
Deputy Inspector General
for Evaluation and Inspections

Per your request of January 26, 1996, attached are the CDC comments on the IG Draft Report: "Children's Dental Services Under Medicaid: Access and Utilization" (OEI-09-93-00240). The report was reviewed by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Division of Oral Health.

Arthur C. Jackson

Attachment

Centers for Disease Control and Prevention (CDC)
Comments Regarding OIG Draft Report:
"Children's Dental Services Under Medicaid:
Access and Utilization" (OEI-09-93-002-40)

- On page 1, under Background Section, in the third bullet (near the end of the page), a screen should be changed to an examination. Physicians and nurses screen, but dentists perform a thorough examination, utilize radiographs, and take an oral history, which results in treatment of many patients.

- On page 2, under EPSTD and the Head Start Program, it should be mentioned that Head Start guidelines require that the dentist who performs the examination should also be the dentist who provides treatment. The purpose is to link the provider with patient.

- On page 9, under the State, Local, and Private Agencies are Experimenting to Improve Access and Utilization, there is no mention about the difficulty many Head Start programs have in securing the services of private practitioners (dentists) to provide examinations and treatment. It should also be emphasized that each Head Start program is required to be proactive in securing such services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAR - 1 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: OIG Draft Report: "Children's Dental Services Under Medicaid: Access and Utilization," (OEI-09-93-00240)

We reviewed the subject draft report which examines the reasons many children are not receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services and describes State activities to improve access and utilization.

We have worked closely with your office in the preparation of this report and concur with the recommendation that a Departmental workgroup be convened to develop an approach to improve dental access and utilization for Medicaid-eligible children.

Thank you for the opportunity to review and comment on this report.