U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

2008 NATIONAL DENTAL SUMMARY

January 2009

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EXECUTIVE SUMMARY

The Medicaid program is jointly administered and funded by the Federal and State governments. Within broad federal guidelines, each State designs and operates its own Medicaid program based on the needs of its population and resources. However, a State must adhere to certain federal requirements. Under the Medicaid program, dental services are an optional service for adult Medicaid eligibles age 21 and older. States electing to provide dental benefits under their Medicaid program may determine the amount, duration and scope of dental services they will furnish. However, for most individuals under the age of 21, dental services are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service as defined in section 1905(r) of the Social Security Act.

In recent years there have been several national reports including the 2000 Surgeon General's report: "Oral Health in America" and the Healthy People 2010 report that note the continued problems low income families face accessing oral health care. In 2008, the Centers for Medicare & Medicaid Services (CMS) conducted 16 State dental reviews to obtain information on dental services provided to Medicaid beneficiaries to further enhance national initiatives to improve oral health care in the United States. The reviews were conducted between February and May 2008, and examined several variables on dental care provided to Medicaid beneficiaries under the age of 21. The reviews surveyed States' efforts to address the rate of children's dental utilization, to identify potential issues with adherence to Federal Medicaid statute or regulations, and to identify promising or notable practices States have implemented to improve the delivery of oral health services to Medicaid eligible children.

States with reported dental utilization rates of 30 percent or less as submitted on the CMS-416 annual report for fiscal year 2006 were selected for review. The States were: Arkansas, California, Delaware, District of Columbia, Florida, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, and Wisconsin. In addition, Georgia was reviewed at the request of the United States House of Representatives Committee on Oversight and Government Reform, Subcommittee on Domestic Policy. The State of Maryland's dental program was previously reviewed by CMS in October 2007 and because the State is in the process of implementing enhancements to their dental program, the State was not included in the national assessment that is the subject of this report.

CMS staff developed standard dental review protocols for use by the review teams in performing the reviews and provided training to the review teams prior to the site visits.

The review identified a number of areas of concern and some consistent issues. These are addressed in the State reports as either a "finding" or a "recommendation." A finding reflects a concern that the State is not adhering to federal law or regulation. A recommendation is a suggestion that CMS made regarding potential improvements that

could be made to provide access to dental services. The dental reviews were conducted to provide information and technical assistance to State Medicaid agencies and are not intended to impose punitive actions against States, but rather provide meaningful guidance to States to improve access to oral health care for Medicaid eligible children. CMS will follow up with each State that received a finding to determine what action the State has taken to address the issue.

In addition to the State-specific findings and recommendations, CMS identified several overarching policy issues that impact access to pediatric dental services which will require further evaluation by CMS. The CMS review teams also noted a number of promising or notable practices in the States that were reviewed and examples of those are included in this report. CMS has also included information on initiatives that have been undertaken to continue our efforts in the area of improving access to dental services for Medicaid eligible children.

CMS intends to use the information we learned in these reviews to focus our efforts in areas where we can provide technical assistance to States and beneficiaries. Furthermore, we plan to use this information to help set the stage for a more detailed discussion with States and other stakeholders on new and innovative ways CMS can improve the delivery of oral health services. We believe that improving the oral health of Medicaid eligible children will take time and commitment from CMS, States and other public health and private organizations. We are committed to continuing our efforts to achieve the goal of ensuring that every member of this vulnerable population has access to quality oral health care services.

INTRODUCTION

The Medicaid program is jointly administered and funded by the Federal and State governments. Within broad federal guidelines, each State designs and operates its own Medicaid program based on the needs of its population and resources. However, a State must adhere to certain federal requirements. Under the Medicaid program, dental services are an optional service for adult Medicaid eligibles age 21 and older. States electing to provide dental benefits under their Medicaid program may determine the amount, duration and scope of dental services they will furnish. However, for most individuals under the age of 21, dental services are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service.

As part of the national Medicaid program, EPSDT is defined in section 1905(r) of the Social Security Act (the Act) and includes periodic screening, vision, dental, and hearing services and other medically necessary health services. Dental services are required to be provided according to a State established periodicity schedule that meets reasonable standards of dental practice. The American Academy of Pediatric Dentistry (AAPD) publishes a recommended dental periodicity schedule. This schedule recommends that children see a dentist for their first visit starting at age one. While the AAPD schedule is not required to be used by State Medicaid agencies, many have adopted the schedule. Other States recommend that children have their first dental visit at age two or three, with a visit sooner if medically necessary. Any of these schedules are acceptable under the EPSDT requirement as long as the State has sufficiently consulted with recognized dental organizations involved in child health care in its State. A direct referral to a dentist is required for every child in accordance with the periodicity schedule developed by the State and at other intervals as medically necessary.

Required dental services include, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of dental health. Oral screening may be part of a physical examination; however, it does not substitute for examination through direct referral to a dentist. In addition, while a State may place limits on the amount, duration and scope of services for individuals age 21 and older, the only limit on services, including dental services for EPSDT eligible individuals, is medical necessity. All medically necessary services must be provided based on a case by case determination by the State.

BACKGROUND

Access to dental services is not an issue that solely affects Medicaid beneficiaries. Oral health issues such as fewer practicing dentists also affect the general population seeking dental services. The Department of Health and Human Services (HHS) Healthy People 2010 initiative established a set of health objectives built on scientific knowledge and designed to measure programs over time. Healthy People 2010 builds on initiatives over the past two decades including the 1979 Surgeon General's Report, *Healthy People,* and

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. The Healthy People 2010 oral health focus area contains several oral health objectives for children. One of the objectives sets a goal to increase the "proportion of persons aged 2 years and older who had a visited a dentist in the previous year". The goal for this objective is 56 percent. Another objective sought to increase annual preventive services "among low-income youth aged 19 years and younger, provision of annual preventive dental services." The goal for this objective is 66 percent. The latest progress review for these objectives shows that little has changed between 1996 and 2004 for the first objective with only a 1 percent increase being noted from 44 percent to 45 percent of the 56 percent goal. The second objective has shown an increase of 6 percent from 25 percent to 31 percent in the same period.

In 2000, the first report on oral health by the Surgeon General was released, "Oral Health in America: A Report of the Surgeon General." That report noted that oral health is essential to the general health and well being of all Americans. The burden of oral health problems is extensive and may be particularly severe in vulnerable populations. The report went on to say that children lose 51 million school hours each year to dental-related illness. The report also noted that Medicaid had not been successful in filling the gap of providing dental services, with less than one in five Medicaid eligible children receiving a dental service in a year. Although that number has now risen to approximately 37 percent, according to more recent CMS data it still falls short of the Healthy People 2010 goal and the requirement that all Medicaid eligible children receive dental services.

A Government Accountability Office (GAO) report from September 2008 [1] notes that dental disease and inadequate receipt of dental care remain a significant problem for children in Medicaid with only about one in three children in Medicaid receiving dental care in the prior year. By contrast, more than half of children with private insurance had received dental care in the prior year. The report also notes that survey data from the National Health and Nutrition Examination Survey (NHANES) shows improvement in some areas. For example, children age 6-18 in Medicaid who received at least one dental sealant increased nearly threefold from 1994 to 2004.

Finally, a recent article in Public Health Reports [2] cites Medical Expenditure Panel Survey (MEPS) data for 2003-2004 indicating that 49.6 percent of children aged 2 to 20 years of age of all income levels had a dental visit during the past year. The MEPS data are compared to 1996-1997 data for the same group of which 45.7 percent had a dental visit during the past year. This does indicate some improvement in dental health visits for all children however the number of Medicaid eligible children receiving dental services continues to be low.

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1 Government Accountability Office (GAO-08-1121) (September 2008). "Medicaid: Extent of Dental Disease in Children Has Note Decreased, and Millions Are Estimated to Have Untreated Tooth Decay"
2 Public Health Reports (Sept.-Oct. 2008). Public Dental Expenditures and Dental Visits Among Children in the U.S., 1996-2004

In 2008, the Centers for Medicare & Medicaid Services (CMS) conducted State dental reviews to obtain information on dental services provided to Medicaid beneficiaries that would further enhance national initiatives to improve oral health care in the United States. The reviews were conducted between February and May 2008, and examined several variables on dental care provided to Medicaid beneficiaries. The reviews surveyed States' efforts to address the rate of children's dental utilization, to identify potential issues with adherence to Federal Medicaid statute or regulations, and to identify promising or notable practices States have implemented to improve the delivery of oral health services to Medicaid eligible children.

METHODOLOGY FOR STATE REVIEW SELECTION

CMS conducted onsite reviews of children's dental services in 16 States. States with reported dental utilization rates of 30 percent or less, as submitted on the CMS-416 annual report for fiscal year 2006, were selected for review. The CMS-416 annual report is the mechanism used by States to collect and report EPSDT program data, including dental services. The methodology used to calculate the dental utilization rate was: Total eligibles receiving any dental services (line 12a of CMS 416) divided by Total individuals eligible for EPSDT (line 1 of CMS 416). [3]

The States selected for review were: Arkansas, California, Delaware, District of Columbia, Florida, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, and Wisconsin. In addition, the State of Georgia was reviewed at the request of the House Subcommittee on Domestic Policy. The State of Maryland's dental program was previously reviewed by CMS in October 2007 and because the State is in the process of implementing enhancements to their dental program, the State was not included in the national assessment that is the subject of this report.

SCOPE OF REVIEW

In order to assure consistency across States, CMS established review teams consisting of regional and central office staff with health care and Medicaid policy expertise. CMS staff developed a standard dental review protocol for use by the review teams in performing the reviews (Appendix A). Separate managed care and provider protocols were also developed.

The dental review protocol included standard questions to be addressed at each interview and focused on seven key areas:

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3 CMS notes that some States questioned the methodology by which we calculated the State dental utilization rates as it may over represent the actual number of children required to receive a dental service according to the State's dental periodicity schedule. CMS acknowledges this possibility for States that do not require a dental visit until age two or three but used this methodology for consistency and in the absence of information on each State's distinct periodicity schedule.

- Informing families of EPSDT dental services,
- Periodicity schedules,
- Access to dental services,
- Diagnosis and treatment services,
- Support services,
- Care coordination, and
- Data collection, analysis and reporting.

Each key area consisted of numerous questions on issues such as: methods for informing families of EPSDT dental services; methods used to ensure an adequate number of dental providers for serving Medicaid eligibles; and mechanisms used to provide support services such as appointment scheduling and transportation assistance. Each member of the review teams participated in training prior to conducting the reviews.

The dental review teams spent an average of three days in each State and interviewed a wide range of individuals:

- State Medicaid agency staff in all States,
- State EPSDT coordinators,
- State or county public health officials,
- State dental staff,
- State dental associations,
- A sample of at least four dental providers and/or their staff.

In States where dental services are provided under managed care arrangements, management and staff from at least one managed care organization were interviewed. Most interviews were performed in person in a State, county or provider's office. Due to the distance between State agencies and some rural providers, some provider interviews were performed by phone. In addition, some exit conferences with State staff were performed by phone due to time constraints.

To increase the sample size for provider interviews, CMS contacted providers in the eight review States with the largest Medicaid populations. Those additional provider calls are reflected in each report. A list of the States with the additional provider interviews can be found in Appendix B. The intent of this CMS initiative was to obtain qualitative information on the delivery of dental services in targeted States and not to conduct a research study; therefore, a statistically significant sampling methodology was not applied for this project.

CMS did not review States based on their delivery system. As noted, States were selected due to their low utilization rate according to CMS 416 State reported data. The State reports describe the dental delivery systems used in each State including where there are multiple delivery systems. CMS does not recommend or discourage the use of any particular dental service delivery system. Appendix C provides the list of States that received an onsite dental review and the delivery systems used in each State. In addition,

we are including information on innovative delivery systems in States that were not reviewed but that may be of interest to the reader.

In order to supplement information from the onsite interviews, the CMS review teams requested supporting documentation from the States such as organizational charts for State and managed care entities, State outreach and beneficiary informing materials, EPSDT and dental provider manuals, numbers of eligible individuals, number of participating providers, managed care contracts, managed care member handbooks, prior authorization requirements, analysis of performance and measurement activities, and dental periodicity schedules.

After the onsite reviews were completed and documents were reviewed, CMS produced a draft dental report for each State which included findings and recommendations. The reviews were not financial and therefore, the findings identified did not result in deferrals or disallowances for States. If appropriate based on the findings, formal financial management reviews may be considered. CMS will follow-up with the 10 States with findings to ensure that they have been addressed. CMS also provided recommendations to every review State on improvements that could be made to increase access to dental services in their State.

CMS provided each State reviewed a copy of their draft dental review report. States were given 30 days to provide CMS with comments or clarifications about the information contained in the report. All States responded to CMS with comments or clarifying information; that information is included in the final reports. While some States disagreed with one or more of CMS' findings or recommendations, most States agreed or partially agreed with many of the recommendations for improving access to dental services in their States. Many States noted projects or initiatives already underway or planned, such as improving outreach and informing material for beneficiaries to ensure that access and utilization of dental services is highlighted and improving outreach to dental providers to encourage participation in the State Medicaid program. A final report was produced and submitted to each of the 16 States that were subject to a dental review.

FINDINGS, RECOMMENDATIONS AND OTHER CONSIDERATIONS

In this National Summary, we provide an overview of the State-specific reports, discussing issues where we found a need for general improvement, along with practices to address those issues. Areas of concern or issues were consistently identified through these reviews and are included in the individual State reports. These issues were distinguished and presented in the reports as either a "finding" or a "recommendation." A finding reflects a concern that the State is not adhering to Federal law or regulation. A recommendation is a suggestion that CMS made regarding potential improvements that could be made to provide access to dental services. CMS will follow up with each State that received a finding to determine what action the State has taken to comply with Federal laws and regulations. As noted earlier, the purpose of the reviews is to provide technical assistance to States and is not intended to impose punitive actions.

Findings: CMS dental review teams made findings in 10 States, ranging from one finding to five findings. These findings were detailed in the State-specific reports. Below are some representative findings:

- Several States did not ensure that enrollees had access to services covered under the State plan; did not maintain and monitor a network of appropriate providers, and/or meet requirement for timely access standards for care and services.
- Several States were not in compliance with the requirement that States develop a separate dental periodicity schedule after appropriate consultations with dental experts involved in child health care.
- Not all States ensured that medically necessary services were provided to EPSDT eligibles. For example, one State set limits on the lifetime number of root canals per patient.
- Not all States met the requirement that programs that receive federal funding provide interpreter services for people with Limited English Proficiency.
- One State contract with a dental benefit administrator (DBA) only reimbursed Medicaid beneficiaries $50 for emergency dental services provided out-of-State, with the remaining balance to be paid by beneficiaries. This is inconsistent with the way payments are established in the Medicaid program, as all services are paid in full minus any established cost sharing.

CMS will work with every State that received a finding in its State dental report to address these issues and ensure that States are in complete compliance with federal laws.

Areas for Improvement: CMS also identified a number of areas where multiple States could make improvements by adopting better practices to increase access to dental services. Some of these areas are identified below:

- Beneficiaries were not adequately informed of EPSDT services and the availability of dental services.
- Some State (or MCOs) did not have one clear concise document that explained the importance of dental services and how to access the services in the State.
- Administrative processes were characterized by many providers as “burdensome”, which lessened the provider’s willingness to continue participating in Medicaid or to limit the number of beneficiaries the provider was willing to see.
- Dental provider lists were not updated on a regular basis and therefore beneficiaries were provided with inaccurate information.
- Providers and/or beneficiaries were not adequately informed of the State’s dental periodicity schedule.

- Some States were unable to produce data on the utilization of dental services by their beneficiaries
- Based on interviews with providers and other participants, some States appeared to lack reliable transportation, or transportation assistance appeared to hinder access to services.
- States lacked monitoring of the distribution of dental providers or active recruitment of dentists in areas where there are provider shortages.
- The concept of a "dental home," in which a provider or facility assumes responsibility for a coordinated system of oral health care for each beneficiary, was not apparent in most States. Many States (or MCOs) did not actively work to link a beneficiary with a specific dental provider to assure continuity of care.

In some States, there appeared to be no contact with the beneficiary specific to dental services after the initial notification of available EPSDT services. Therefore, CMS also made a general recommendation for most States that they should ensure that beneficiaries received 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.

Recommendations: CMS made recommendations to every State that received an onsite visit, which were based upon State-specific information collected during the interviews and the review of State-submitted documents. CMS identified similar issues within States and therefore many States received similar recommendations. CMS intends to follow up with States to determine if they have implemented any of the recommendations or other State initiatives to improve dental access to Medicaid eligible children. Some of those recommendations are noted below.

- The State or managed care organization (MCOs) could develop separate documents on the importance and availability of dental services as part of preventive health services.
- States could track, or require their MCOs or DBAs to track, and report which children have not received dental services and escalate steps to reach these families and ensure children get into care.
- States could consider reimbursing pediatricians and other non-dentists who provide oral health services such as fluoride varnishes.
- States or State legislatures could consider establishing loan repayment, tuition assistance or other incentives to encourage dental students to practice in areas of need. For States with a dental school, States could utilize incentives to encourage dental students to stay in-State and practice in areas where it is difficult to locate Medicaid dental providers.

POLICY ISSUES

In addition to the State-specific findings and recommendations, CMS identified several overarching policy issues that impact access to dental services which will require further

evaluation by CMS. States, managed care plans and providers, alike, in various forms expressed concern that Medicaid beneficiaries present unique challenges to providing accessible, efficient dental care. CMS understands that issues faced by this population can be unique and that there may be no easy answers to address them.

Availability of Information on Dental Care: It was noted during many of the interviews that dental care may not be a priority for many families given the variety of social and economic issues they face daily. In addition, parents may not fully understand the need for good preventive health care, particularly if they were not the recipient of dental care growing up. In conducting the reviews, CMS noted a lack of dental specific information available for Medicaid beneficiaries from State Medicaid agencies or managed care plans in States where dental is provided under managed care arrangements. Information regarding the importance of good oral health may be made available to the beneficiaries in many ways, including:

- A beneficiary handbook or information provided when an individual receives their eligibility determination.
- Reminders and referrals from a primary care provider at a regular well-child check up. [The American Academy of Pediatrics recently published a policy statement that, in part, defines recommendations for preventive oral health interventions by primary care pediatric practitioners. 4
- Reminders from States (or managed care plans) when the child is due for a dental examination according to the States periodicity schedule.
- Dental providers and their staff can also play a role by explaining to parents what types of services or procedures are being provide to their child as well as the importance of bringing a child back for subsequent treatments and examinations to avoid future possibly painful complications.
- Increased parental education to ensure the child continues on a lifetime of good oral health care.

Missed Appointments: Another concern raised in almost every review was the frequency of "missed appointments" by Medicaid beneficiaries. A missed appointment is when a patient does not arrive for a scheduled appointment without calling to cancel or reschedule the appointment. While this issue has the potential to negatively impact all providers, dental providers appear to be particularly disadvantaged when it comes to missed appointments. Dentists generally book only as many patients as they and their staff can serve. A provider may decide to bill a patient for a missed appointment. The Medicaid program does not permit a provider to bill a Medicaid beneficiary or the State Medicaid agency for a missed appointment. Therefore, providers are financially disadvantaged when missed appointments occur. MCOs may have more flexibility to pay providers directly for missed appointments; that is not the case for the large portion of the dental community paid under fee for service.

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4 Policy Statement from the American Academy of Pediatrics. "Preventive Oral Health Intervention for Pediatricians" Section on Pediatric Dentistry and Oral Health .PEDIATRICS Vol. 122 No. 6 December 2008, pp 1387-1394.

During the dental reviews, CMS discovered many different experiences with respect to missed appointments and how providers chose to deal with them. Most providers tried to confirm appointments with all of their patients prior to the day of the appointment. The contact varied from sending a post card to calling a day or two before the scheduled appointment date or both. However, in some instances, dental providers reported this issue as an ongoing challenge in the Medicaid population. Some providers have instituted policies to decrease the number of missed appointments. For example, some providers have a "three strikes you're out" policy. If an individual fails to keep an appointment or give advanced notice when they need to cancel an appointment three times, the provider will no longer accept them into their practice. Other providers continue to schedule patients but acknowledge that they double book patients knowing that a percentage of patients will not show up for the scheduled appointment. One health department provider indicated that they had a strict policy for patient's missing appointments. They allowed the patient to come in as a walk-in and wait for time in the dentist's schedule to be available. This was not a punitive action against Medicaid patients as they required it of all their patients. But the health department staff indicated when the patient had to wait to be seen by the dentist they seemed to better understand the need to keep appointments or cancel them timely; rarely did a person miss a second appointment.

Provider Recruitment: Several State Medicaid agencies and providers indicated that they had difficulty recruiting providers, particularly specialty providers, to treat Medicaid eligible children. Children with special needs posed even more problems. Rural areas faced greater challenges with specialists, such as waiting lists and travel time. Some dentists have one specialist (e.g. pediatric dentist or endodontist) that is willing to treat their Medicaid patients, but the referring dentist hesitates to send too many Medicaid-eligible children for fear the provider will limit the number of patients they are willing to treat. Several States that contract with MCOs to deliver dental services cite problems recruiting specialists. In one State, the MCO is required to reimburse out-of-network providers in the absence of a contracted dental provider within the network.

Reimbursement rates for dental services were not a specific part of the State dental reviews. However, low reimbursement rates were noted by providers and others interviewed as one reason there is low provider participation in Medicaid. Appendix D discusses financing and reimbursement for dental services. This information was previously developed by the American Academy of Pediatric Dentistry under a contract with CMS (previously the Health Care Financing Administration) in preparation of the CMS "Guide to Children's Dental Care in Medicaid" published in October 2004. . The Guide is available on the CMS website at http://www.cms.hhs.gov/MedicaidDentalCoverage/. This material is not related directly to the State dental reviews; however, due to increased interest in this area, CMS has had the information updated by the original author and is including the information as part of this Summary.

PROMISING AND NOTABLE PRACTICES

The CMS review teams noted a number of promising or notable practices in the States that were reviewed. A promising practice must have sufficient data to support claims of improvement in the program that can be replicated in other State dental programs. A notable practice appears to be effective, but unsupported by substantial data at this time. Promising practices were not necessarily a result of a statewide effort or initiative. In some cases, these practices were initiated by local health departments or individual providers and the State was unaware of the practice. We included the information in the State reports. Additionally, we recommend the State look to replicate the practice in order to have a greater effect on a State-wide basis.

Several examples of promising practices that were identified during the State reviews:

- In one State, two local county health departments utilized mobile dental vans to provide full diagnostic and treatment services to children, thus increasing the number of children receiving dental services. The Health Department worked closely with the local Board of Education to visits schools on a routine basis for the provision of dental services to children as well as, in one case, busing children to the health department for additional and ongoing dental services.
- A Federally Qualified Health Center (FQHC), with several different sites, reported a remarkably low rate of patients missing scheduled appointments. The Chief Dental Officer provided data showing a trend of patients maintaining appointments correlating with the FQHC's increased attention to a culture of "mutual respect".
- One State had a compliance rate of over 90 percent with respect to providing dental services to its Head Start population. The Federal Head Start program requires its grantees to ensure that all Medicaid eligible children receive EPSDT services, including dental.
- Several States significantly reduced the administrative burden for providers by reducing prior authorization requests or using an administrative service organization (ASO). Providers in those States noted these actions reduced the "hassle factor" of dealing with the State and improved their relationship with the State Medicaid agency.

Several notable practices were also identified:

- One State posted their dental provider manual and relevant provider updates online. Interviewed providers indicated that accessing this information was easy and convenient and regarded the State's provider informing procedures as timely, accurate and easily accessible.
- One dental provider initiated a practice called "Shared Medical Appointment" with a pediatric practice in the same building. Specifically, when children ages 12 to 24 months visited the pediatrician, arrangements were made for the child and parents to view an educational program on dental care.

- One dental provider instituted a program called Dental Detectives, which allows children to receive a diploma and qualifies them to "co-teach" their peers. The office is conducting a quality measure of this program to determine the impact on the oral health of the children.
- One State used a "secret shopper" program and uncovered concerns with a MCO dental benefit administrator (DBA), which resulted in action being taken against that DBA.
- In one State, the Medical Director was a practicing dentist, which was noted by provider interviews as having a positive effect with provider communications and interaction with the State Medicaid Agency.

As previously noted, not all of these practices were Statewide and some initiatives were undertaken by a single provider. However, CMS believes that States should take note of these initiatives to determine if similar actions may be useful in their State efforts to increase dental access.

PLANNED INITIATIVES IN RESPONSE TO STATE FINDINGS

State Dental Review Follow-up: CMS intends to follow up with each State that was reviewed to discuss findings and determine the steps the State has taken to improve access to oral health services. CMS will request additional information on initiatives the State has undertaken and identify ways to provide technical assistance to States. CMS will also continue to share promising practices with States for their consideration, as well as request corrective actions of States that had compliance findings in their reports. In addition to those noted in this report, the CMS Promising Practice website contains several oral health related items. These can be found at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage. As resources permit, CMS may consider reviewing other States in the future particularly, those that have been more successful in achieving dental utilization for their Medicaid children.

Town Hall Forum: CMS intends to convene a national meeting to discuss oral health issues. We will invite participants from national dental organizations, States and other interested parties to join us in this initiative. A set of discussion questions will be made available prior to the meeting covering the following topic areas: delivery of dental services through managed care organizations; issues regarding better reporting and additional data elements for the CMS form 416; payment issues (e.g. state payment rates, state payment methodologies, and assurance of market rates); development of new and innovative delivery models; and, education and outreach to those who are eligible for Medicaid.

State Reporting of Dental Services to CMS: CMS will continue to track the CMS 416 data for improvements in dental utilization. CMS is in the process of updating the CMS 416 to include more specific information on oral health services delivered by non-dentists in order to better understand the services that are actually being delivered to Medicaid eligible children.

Many States have been successful in collaborating with their State Medical Associations and other providers to allow non-dentist providers to furnish oral health services, such as providing fluoride varnish, to young children. This allows the medical provider the opportunity to begin the education process for the family on the importance of dental care, and provides the child a preventive service that may help deter decay until the child receives a dental examination. While these collaborations do not substitute for a dental examination by a dentist, CMS supports these State efforts as a way to ensure that Medicaid eligible children receive oral health services to which they are entitled.

In an effort to drive greater transparency of the information that is collected on the CMS 416, CMS plans to create new ways to compile, analyze and post that information in order to better inform states and various stakeholder groups. One example of possible future postings is represented in Appendix E. This table shows State-by-State EPSDT dental service rates for FY 2006 and FY 2007.

Finally, for managed care organizations, CMS believes additional reporting of information on network sufficiency and the availability of dental providers would significantly improve information of access to covered services. We intend to make this a topic of discussion during the Town Hall Forum to seek input from other stakeholders on this proposal.

Oral Health Technical Advisory Group: An Oral Health Technical Advisory Group (OTAG) has been formed for the purpose of furthering CMS' oral health initiatives. The OTAG consists of members from State Medicaid agencies and CMS staff. Since its inception the OTAG has collaborated with CMS in the release of the Guide to Children's Dental Care in Medicaid, which can be accessed at http://www.cms.hhs.gov/MedicaidDentalCoverage/. The OTAG also provided input to CMS on the revision of the CMS-416 to expand the data collected on dental services provided to Medicaid eligible children by including services provided by non-dentists. The OTAG continues to meet and work on oral health issues in collaboration with CMS.

Dental Quality Alliance: CMS is interested in forming a Dental Quality Alliance (DQA) and is currently in discussions with the American Dental Association (ADA) to begin this process. The DQA would bring together parties from many aspects of oral health fields including national dental organizations, Federal and State partners, payers and consumers to begin working together on measurements that could be used by States for purposes of improving the delivery of oral health services and the development of quality measures. These measures could ultimately be used to enhance reporting on the CMS form 416 or through state-based value based purchasing initiatives. While children eligible for Medicaid will be the primary area of concern, the DQA will also address dental services for the adult population.

CMS Website Updates: CMS strives to continually update our website to include new and important information. We intend to publish the final dental reports from each State as well as this National Dental Summary on the CMS dental webpage at

http://www.cms.hhs.gov/MedicaidDentalCoverage/ . We also intend to routinely update the policy issues paper on the website dated September 22, 2008 to address ongoing dental policy issues. We will also continue to publish other documents of interest from other organizations as we become of aware of them.

Additional information on oral health services may be found at several websites noted in Appendix F.

CONCLUSION

The Early and Periodic Screening, Diagnostic and Treatment service for children enrolled in Medicaid remains a viable mechanism for States to ensure the accessibility of dental and health care services. Consistent with previous CMS initiatives (Guide to Children's Dental Care in Medicaid, October 2004), CMS, State Medicaid programs, and professional communities have a joint interest in developing and sustaining effective and efficient programs to meet the oral health needs of children covered by Medicaid. These collaborative efforts among these stakeholders, both at the national and state levels, will help to produce and improve programs that meet those needs.

Based on CMS' review of 16 State dental programs, we found that many States were proactively working on initiatives to improve access to dental services. We expect that through these innovations in dental care for children, many promising practices will emerge, allowing other States and localities to replicate them. While some States acknowledged that they could do more and have agreed to step up their efforts, other States disagreed with our recommendations and we attempted to accommodate those concerns in the final reports.

However, for a more robust and comprehensive assessment of the provision of dental services to children enrolled in Medicaid, further studies are necessary in the areas of administrative structure, alternative providers of services, contracting and payment arrangements, access, utilization and quality.

As part of a broader initiative through the development of a national framework on Medicaid quality, CMS intends to use the information we collected in these reviews to focus our efforts in areas where we can provide technical assistance to States and beneficiaries. We also plan to use the upcoming Town Hall Forum to engage the States and the stakeholder community to partner on new or improved initiatives CMS can take to improve oral health.

We believe that improving the oral health of Medicaid eligible children will take time and commitment from CMS, States, and other public health and private organizations. CMS is committed to continuing its efforts to achieve the goal of ensuring that every member of this vulnerable population receives the right services to which they are entitled.

Appendix A – CMS Dental Review Tool

TECHNICAL ASSISTANCE TOOL FOR REVIEWING EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) DENTAL SERVICES

Introduction

The EPSDT dental review technical assistance tool has been developed to examine how State's operationalize the statutory requirements for the provision of dental services under sections 1902(a)(43) and 1905(r) of the Social Security Act (the Act). Section 1902(a)(43) establishes the requirements for ensuring all eligible Medicaid beneficiaries under 21 are informed of and have access to EPSDT services, and sets out the annual reporting requirement. Section 1905(r) sets forth the basic screening and coverage requirements for the EPSDT program including the provision of required dental services.

- The EPSDT program consists of two, mutually supportive, operational components:
- Assuring the availability of required health care resources and
- Helping Medicaid beneficiaries and their parents or guardians effectively use them.

- These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:
- Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- Assess the child's health needs through initial and periodic examinations and evaluation, and
- Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

This dental review protocol is based on instructions from the State Medicaid Manual (SMM) and the draft technical assistance guide developed for State EPSDT reviews. However the protocol has been modified to pertain only to the dental service requirements under EPSDT. The protocol is organized into the following key areas Appendices AI-AVIII:

Key Area I -	Informing
Key Area II –	Periodicity Schedule and Interperiodic Services
Key Area III -	Access to Services
Key Area IV -	Diagnosis and Treatment
Key Area V -	Support Services
Key Area VI -	Care Coordination

Key Area VII - Data Collection, Analysis & Reporting

When performing a review of the State's EPSDT dental program, Regional Office (RO) staff use these key areas as guidance for reviewing a Medicaid State Agency's dental program. Review elements differ depending on whether the State provides dental services under fee for service or managed care arrangements. Certain elements noted in the Method of Evaluation are examples and are not intended to be an inclusive list, such as who to interview and what materials to review to evaluate the State's operations should take into consideration regional office knowledge of the variations in State programs to make these determinations.

In an effort to ensure that the reviews are consistent as possible, we have attached several appendices to the Protocol. An Interview Guide for States (Appendix AI) should be used by the reviewer when interviewing various individuals noted in the Protocol including State management and enrollment staff, EPSDT staff and outreach workers. An Interview Guide for Dental Providers (Appendix II) should be used by the reviewer when interviewing providers and their staff. An Interview Guide for Managed Care Plans (Appendix III) should be used when interviewing managed care plan staff. While the use of these Guides is required, we continue to acknowledge that there may be some variations in the information due to differences in each State's Medicaid program. For purpose of these reviews, four dental providers and their staff will be interviewed in each States. If a State has both fee for service and managed care dental two of each provider should be interviewed. The estimated time to perform this review will also differ depending on the type of program, travel distance between the State agency and providers, plans, etc. However, a minimum of two to three days should be allowed.

NOTE: Unless specified otherwise, all references apply to Part 5 of the SMM.

Below is a list of materials that will be needed to perform a review though the items will vary depending on whether a State provides dental services under a fee for service or managed care arrangement. **NOTE: YOU MAY WANT TO REQUEST CERTAIN DOCUMENTS PRIOR TO THE REVIEW.** It may also be helpful to review the State's Dental Action Plan from **t**o determine if they have implemented any of the processes or programs noted in those plans.

List of Materials Needed for Review (FFS and MC) –

1. Organizational charts for the State and managed care entities (I)
2. State policy and procedures (I, II, III, VI,)
3. State outreach workers/guidance including their responsibilities (I)
4. EPSDT provider and dental provider manuals (I – VII)
5. All EPSDT informing material including dental informing (I)
6. State dental periodicity schedule and associated documentation including appropriate consultations (II)
7. Provider manuals/bulletins/guidance or other instructions/instruments:
    a. Regarding periodicity (II)
    b. Support/assistance responsibilities (V)

8. Beneficiary informing literature (I, II, IV, V)
9. Dental provider and utilization data by provider and managed care plan including:
    a. Number of EPSDT eligibles (by county or parish);
    b. Number of dental providers enrolled;
    c. Number of dental providers billing for services;
    d. Number of clients served by each;
    e. Geographic location of providers; and
    f. Total payments to each provider. (III, VII)
10. Contact information for State staff involved in EPSDT and oral health services (I)
11. CMS 416 data for last 3 years (VII)
12. State's internal instructions for completing CMS 416 (VII)
13. CMS 416 programming instructions (VII)
14. State defined dental performance goals (VII)
15. Provider instructions on performance goals and monitoring strategies (VII)
16. Evaluation documentation (III)
17. Analysis of performance monitoring and action plans for improvements (III, VII)
18. State plan pages, Section 3.1.A and 3.1.B identifying:
    a. Coverage of other licensed practitioners providing dental services (II)
    b. Any dental coverage limitations (including prior authorization requirements) (IV)
19. List of any dental related services requiring prior authorization and any other review mechanisms (IV)
20. List of any non-covered dental services (IV)
21. State-developed forms for authorizing services, with associated provider instructions for completing them (IV)
22. Any document identifying state-developed definition of medical necessity (IV)
23. Instructions to medical necessity reviewers (IV)
24. Report of dental-related care denied in the last six months, with documentation on factors and individuals involved in decision (IV)
25. Appeal forms, with associated instructions (IV)
26. Any reports or analysis of assistance or transportation provided (V)
27. Reporting forms (VI)
28. Monitoring reports (VI)
29. State dental action plan from 2001 (I, III, VII)

List of Materials for States with Dental Managed Care

30. Managed care contracts (I-VII)
31. Managed care organization member handbooks and health educational materials (I)
32. Managed care policies and procedures (I, VI)

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.

A. How is the initial informing of individuals eligible for EPSDT services performed and in particular the availability and importance of dental services?

Method of Evaluation:

1) Identify who is responsible for informing and the scope of that work.
2) Review State procedures and materials for training on EPSDT informing, including identification of the last training date.
3) Examine managed care contracts for identification of informing responsibility and state oversight requirements. (Determine if all or only some contracts should be examined based on the size of the State, number of plans and other State-specific factors.)
4) Identify the locations where informing materials can be obtained or contacts can be made.
5) Interview appropriate staff and individuals to see if informing complies with State procedures (e.g., State outreach workers, beneficiaries, advocates)
6) Identify whether the State maintains an 800 number for customer services to beneficiaries **including assistance with obtaining dental services**

B. What does the State specify the informing must include?

Method of Evaluation:

1) Review all informing materials used by the State or managed care entities.
2) Examine any training materials or other policies/procedures to identify the scope of informing**.**
3) Identify all methods of informing used by the State or managed care entities**.**
4) Interview appropriate staff and individuals to verify that the full scope of informing is performed (e.g., State outreach workers, beneficiaries, and advocates)

C. Does the State have any special initiatives toward target populations such as pregnant women or children with special health care needs with information on the importance of receiving dental services?

Method of Evaluation:

1) Identify any informing materials or other guidance specific to particular populations.
2) Interview appropriate staff and individuals to determine whether there is awareness of the materials and the effectiveness (e.g., State outreach workers, beneficiaries, and advocates).
3) Identify whether the materials are provide in languages other than English.
4) Inquire about the reading level of the materials and how the State makes the determination is it an appropriate level.

D. How does the State ensure that the informing process and materials used are effective?

Method of Evaluation:

1) Identify any State actions to determine whether beneficiaries understand the informing materials.
2) Interview appropriate individuals (e.g., beneficiaries, advocates) on the effectiveness of all outreach materials.

E. How does the State ensure that the EPSDT informing is provided in a timely manner?

Method of Evaluation:

1) Review State procedures and policies regarding timelines for informing.
2) Examine managed care contract specifications for the identification of informing timelines.
3) Identify any tracking systems or other documentation of timeliness monitoring.
4) Interview appropriate individuals (e.g., beneficiaries, advocates) to verify that information was provided in a timely manner.

F. What are the State procedures to ensure that children not accessing EPSDT dental services or declined EPSDT dental services are informed annually? Are there procedures to track the utilization of dental services separately from medical services?

Method of Evaluation:

1) Review State procedures/policies for identifying individuals in these two groups.
2) Identify the timelines for follow-up informing.
3) Examine any tracking mechanisms for timeliness of follow-up informing.

G. How are dental providers informed of the State's expectations for them under EPSDT?

Method of Evaluation:
1) Review any provider manuals, training components, bulletins, or other State guidance that address required provider activities/actions specific to dental.
2) Interview dental providers and/or their staff, particularly those entities performing EPSDT screens, to determine their understanding of their responsibilities, including linking beneficiaries to scheduling and transportation assistance, follow-up on referrals, and coordination with other State and federal programs.

H. Does the State dialogue with dental and/or dental hygiene associations through a coalition or directly to discuss program issues or requirements?

Method of Evaluation
1) Interview State staff, State dental manager, providers, etc., to determine what type of dental input and collaboration is occurring in the State.

List of Materials Needed

Organizational charts for the State and managed care entities
State policy and procedures
Managed care contracts
Managed care organization member handbooks and health educational materials
Contact information for State staff involved in EPSDT
All EPSDT informing materials

KEY AREA II
PERIODICITY SCHEDULES AND INTERPERIODIC SERVICES

Section 5140 the State Medicaid Manual 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® 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.

Method of Evaluation:

1) Identify and review the periodicity schedule established by the State for dental services and the background for developing it, including:
   - Evidence that consultation took place with recognized dental organizations or individuals,
   - Documentation of resources used and any discussion on these resources,
   - Evidence that services are to be provided at intervals meeting generally accepted standards of practice, and
   - Documentation of the latest review date.
2) Review provider manuals and other instructions regarding dental periodicity to ensure that the disseminated schedules conform to the approved recommendations.

List of Materials Needed

Dental periodicity schedules and associated documentation
Lists of parties involved in the development of each periodicity schedule
State register/rules
Medical policy and provider manuals and other instructions regarding dental periodicity
Provider bulletins or other informing instruments discussing dental periodicity

Section 5140, Subpart B provides the requirements for interperiodic screening as directed in section 1902(r) of the Act. In addition to periodic screenings, States must provide for dental services at other times when deemed medically necessary to determine the existence of any conditions.

B. How does the state define interperiodic dental services?

Method of Evaluation:

1) Review any State-developed definition for comparison with the federal scope.

C. How does the state monitor to ensure interperiodic dental services are being provided?

Method of Evaluation

1) Examine the State procedures and policies surrounding the provision of interperiodic dental services
2) Review claims processing system edits, audits, and other mechanisms monitoring receipt of services related to dental services.
3) Review provider manuals and other instructions regarding the provision of interperiodic dental services.

List of Materials Needed

State policy and procedures
Provider manuals and other instructions regarding interperiodic visits
Beneficiary informing literature

KEY AREA III
ACCESS TO DENTAL 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.

A. How does the State ensure children receive dental services according to the State periodicity schedule that includes at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health?

Method of Evaluation:

1) Review the following:
    - Written State policy describing dental services
    - Provider manuals and other instructions, and
    - Procedure manuals for dental services.
2) Identify any State processes for monitoring the completeness of services.
3) Identify any State actions to increase provider compliance with dental service requirements.

B. How does the State ensure an adequate number of dental providers are available to serve eligible children in all geographic areas of the State?

Method of Evaluation:

1) Review dental utilization data for all dental providers (fee for service and managed care dental providers.
2) Review the total number of Medicaid enrolled dental providers compared to the total number of practicing dentists.
3) Review the total number of Medicaid enrolled dental providers who have billed more that $10,000 in the past year to determine if the State is relying on a limited number of providers (clinics) for delivery of services.

C. What actions has the State taken to encourage families to establish a dental home?

Method of Evaluation:

1) Examine any training materials, procedures, manuals, or other State guidance that address the concept of dental homes.
2) Identify any State initiatives to establish dental homes.
3) Interview appropriate staff and individuals (e.g., State staff, beneficiaries and advocates) to determine if families are encouraged and/or assisted in linking to a regular source of dental care.

D. Does the State in any way limit who may provide EPSDT dental services?

Method of Evaluation:

1) Review State rules, provider manuals, policy manuals, and state issuances to include:
    - Any limitations the State has established,
    - The basis for the limitation, and
    - Any supervisory requirements of non-dental providers
2) Interview State EPSDT and provider enrollment staff.
3) Discuss provider limitations with dental provider associations (e.g., State dental and pediatric associations, etc.), managed care associations, beneficiaries, and advocates to identify any stated or perceived limitations on who may provide care.
4) Review any managed care contracts for limitations, including sub-contracting requirements.

E. How does the State ensure the availability of a variety of qualified dental specialists?

Method of Evaluation:

1) Interview State management and provider enrollment staff to determine actions taken to ensure a broad network of EDPST dental providers and any shortages of specific provider types
2) Identify how many pediatric dentists are participating Medicaid providers, how many children they see and how much they have been reimbursed.
3) Review the State's policies on accessing dental services to ensure access to a broad range of dental providers, including specialists, through a variety of avenues.
4) Identify and review any State analysis on dental provider network adequacy by specialty, geography, patient to provider ratio, or any other distribution.
5) Review the managed care contracts for adequacy of dental provider network requirements.
6) Determine how the State monitors managed care network dental adequacy.
7) Identify and review any State analysis of complaints from dental providers concerning enrollment problems or denials.
8) Review any analysis of beneficiary complaints on lack of provider access.

9) Determine how the State ensures that dually certified dentists can provide services under both medical and dental specialties.

F. Does the State utilize any providers other than licensed dentists to provide oral health services to children?

Method of Evaluation

1) Review the State plan to determine if the State has included non-dentists (e.g., dental hygienists) as other licensed practitioners for the provision of dental services?
2) Interview State staff to determine the extent to which these providers are utilized.
3) Determine what services these non-dentists are licensed to provide.
4) If independently practicing dental hygienists are utilized, determine if they have collaborative referral arrangements to insure the patients with treatment needs are referred appropriately to a dentist or dental clinic (FQHC, health department).

G. Does the State have any special procedures or processes for assisting families with children with special needs access dental services?

1) Identify any special programs or services directed to the special needs population to ensure that they receive information about and access to appropriate dental care.

H. Does the State have any formal agreements with other State programs to provide dental services (e.g., Health Departments)?

Method of Evaluation:

1) Review any inter-agency Memorandums of Understanding, other formal agreements, or guidance defining collaborative efforts, including special initiatives.
2) Examine each interagency agreement to identify Medicaid's responsibilities.
3) Identify who is responsible for carrying out Medicaid's responsibilities and how the State ensures they are undertaken.
4) Identify any regular interactions between the programs, and the scope of discussions, based on meeting schedules or other documentation.
5) Review the managed care contracts to identify whether any agreed upon Medicaid responsibilities are passed on to managed care organizations.

I. Does the State have any agreement with a Dental School for the provision of dental services to Medicaid eligible children?

1) Identify any dental schools in the State and the extent to which they provide services to Medicaid eligibles.

H. J. Does the State utilize any out of state dental providers?

Method of Evaluation:

1) Identify any dental services/providers that are not available in the State.
2) Identify the State's efforts to ensure that these services are available when determined medically necessary for an EPSDT eligible individual including the use of border state providers.

K. Has the State implemented any programs or systems to increase the number of Medicaid enrolled providers?

1) Identify any programs or systems such as loan repayment, tuition assistance or other programs linked to serving the oral health needs of Medicaid beneficiaries.
2) Identify any coalitions or collaborations with or including State dental associations that have been instrumental in improving provider participation in Medicaid.

List of Materials Needed

State policy and procedures
EPSDT Dental provider manuals
Provider data (numbers, participation, reimbursement, geographic locale)
Evaluation documentation
Managed care contracts
State analysis of dental performance measures
State plan coverage pages for other licensed practitioners
State dental action plan

KEY AREA IV
DIAGNOSIS AND TREATMENT SERVICES

Sections 5122(E) and (F), as well as section 5124 of the State Medicaid Manual 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.

A. How does the State ensure that the scope of dental services for children extends beyond that identified in the approved State plan?

Method of Evaluation:

1) Review State plan coverage sections to identify any dental service limitations.
2) Examine provider manuals for coverage limitations.
3) Catalog state mechanisms for ensuring follow-up care identified, either by the screening provider or referral is actually provided.
4) Identify any claims processing systems mechanisms for automatic denials of dental services for children**.**
5) Examine any instructions to families or providers to ensure that special needs children receive preventive dental care in addition to services for their diagnosed health problems.
6) Interview plan staff, providers, etc., to determine if they feel they can ask for services if they are not sure it is covered.
7) Are there any services that providers, staff, etc., would not ask for because they think it is not covered? .

B. Does the State have any authorization processes applicable to children's dental services?

Method of Evaluation:

1) Identify any dental services requiring prior authorization or other review mechanisms.
2) Review State billing forms and instructions to identify potential barriers or issues.
3) Interview plan staff, dental providers, etc., to determine if they are aware of the prior authorization process, how it works and if there are any potential barriers or issues.

C. Does the State have a definition of medical necessity specific to children or any sub-groups of children specific to dental services?

Method of Evaluation:

1) Examine any State-developed definition of medical necessity and how it was developed.
2) Identify any guidance to dental providers related to medical necessity.

D. What are the State procedures for making individual determinations of medical necessity with respect to the provision of dental services?

Method of Evaluation:

1) Examine the State procedures related to medical necessity decisions, to include:

    - Ways to ensure the appropriate individuals are involved in the decision making process,
    - Staff training in the general rules related to coverage for children,
    - How guidance on the scope of allowable services is developed for each service monitored,
    - State monitoring activities,
    - State processing timeline guidance,
    - Development of alternative recommendations on denied care/items, and
    - Appeal processes.

2) Review State guidance on advising families of alternative recommendations for denied care/items.

Section 5330 requires States to set standards for the timely provision of services which meet reasonable standards of medical and dental practice, as determined under consultation with recognized medical and dental organizations involved in child health care. States are to then employ processes to demonstrate that the required standards are employed through reports on beneficiaries overdue for services and action taken to ensure the provision of needed identified services.

E. Has the State established a standard for timely delivery of dental diagnostic and/or treatment services?

Method of Evaluation:

1) Identify any State register/rules on timely delivery of services.
2) Review any State-developed guidance on timeliness of care**.**

F. How does the State ensure timely delivery of dental diagnostic and/or treatment services?

Method of Evaluation:

1) Identify any State procedures or practices for monitoring timely delivery of care.
2) Examine any tracking statistics to define provider performance in relation to State standards.

G. Does the State utilize monitoring processes to ensure that dental services are provided

timely?

Method of Evaluation:

1) Determine whether the State has established a standard for timely provision of dental services, including referrals and treatments.
2) Interview State staff to identify any State monitoring processes, and its reporting timelines**;**
3) For States providing dental services under managed care contracts, determine if the State tracks serviced delivered out of plan services.

H. Has the State identified any problems with services that are needed but not provided (either because a provider was not available or did not know service was available?) If so, what action has the State taken?

1) Identify any services that have been noted as not readily available and what the State has done to ensure the availability of the service.

I. Has the State identified any problems with services provided that may not have been needed? If so, what action has the State taken?

1) Identify any issues in the State with a provider's over-utilization of services (e.g., Medicaid "mills").

List of Materials Needed

State register/rules
State plan pages, Sections 3.1 A and 3.1B, identifying dental coverage limitations
Provider manuals
Beneficiary informing materials
Appropriate newsletters and other guidance on children's dental services
List of non-covered dental services
Claims processing system edits or audits linked to children's dental services
List of EPSDT-related dental services requiring prior authorization or any other review mechanisms
State-developed forms for authorizing services, with the associated provider instructions for completing them
Any document identifying a state-developed definition of medical necessity related to the provision of dental services
Instructions to medical necessity reviewers
Report of EPSDT-related dental care denied in the last six months, with documentation on factors and individuals involved in the decision
Appeal forms, with the associated instructions

KEY AREA V
SUPPORT SERVICES

Section 5150 of the State Medicaid Manual indicates that the State is required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and necessary, assistance with scheduling appointments and non-emergency transportation. This includes the requirement of 42 CFR 431.53, mandating transportation assistance.

A. How does the State provide scheduling assistance for dental services?

Method of Evaluation:

1) Identify who is responsible for scheduling assistance including dental appointments.
2) Define the processes to obtain assistance and related tracking mechanisms.
3) Examine managed care contracts for identification of scheduling assistance responsibility and state oversight requirements.
4) Review informing materials to verify that adequate notice was provided to the beneficiaries.
5) Interview appropriate staff and individuals (e.g., State staff, managed care entities, providers, beneficiaries, and advocates) to verify that there is common knowledge of scheduling assistance and how to access it, as well as any barriers to obtaining it.
6) Review reports and/or statistical data relative to these services.

B. What are the State procedures to obtain non-emergency transportation assistance?

Method of Evaluation:

1) Review provider manuals, bulletins, policies and procedures manuals.
2) Examine managed care contracts for identification of transportation assistance responsibility and state oversight requirements.
3) Examine informing materials to verify that adequate notice was provided to the beneficiaries.
4) Interview appropriate individuals (e.g., State staff, managed care entities, providers, beneficiaries, and advocates) to verify that there is common knowledge of transportation assistance and how to access it, as well as any barriers to obtaining it.
5) Review reports and/or statistical data relative to these services.

List of Materials Needed

State outreach worker instructions/guidance
Any guidance to providers on their assistance responsibilities
Beneficiary informing materials
Any reports or analysis of assistance or transportation provided

KEY AREA VI

COORDINATION OF CARE

Section 5240 of the State Medicaid Manual 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.

A. Does the State coordinate a child's screening, treatment and referral services to include:

- The procedures for exchanging information between the primary and other providers, including dental providers, and
- How the requirement for the initial referral to a dentist is fulfilled by the primary care provider.

<u>Method of Evaluation:</u>

1) Identify any State-established guidance on care coordination and record maintenance.
2) Interview State EPSDT and managed care staff on care coordination procedures.
3) Discuss care coordination guidance with providers, including managed care organizations.
4) Evaluate the community's experience of the State's procedures to coordinate care through interviews with consumers and advocates.

B. What methods are used to assure providers comply with the procedures for coordination of care, if any, regarding dental?

<u>Method of Review:</u>

1) Identify any State monitoring procedures and/or systems.
2) Interview State staff to assess the effectiveness of monitoring requirements between the state and providers.
3) Interview providers and managed care plans to determine their knowledge of guidance and monitoring efforts.

C. Does the State have any dental service carve-outs?

<u>Method of Review:</u>

1) Identify any service carve-outs;
2) Review managed care contracts and other service arrangements to determine if carve-out are identified;

3) Interview appropriate staff and individuals (managed care staff, providers, beneficiaries) about knowledge of service carve-outs, process for obtaining services and any difficulties obtaining services that are not covered under the managed care contract.

D. How is out-of-network dental care obtained?

Method of Review:

1) Identify services provided out-of-network;
2) Review managed care contracts and other service arrangements to determine if out-of-network services are identified;
3) Interview appropriate staff and individuals (managed care staff, providers, beneficiaries) about know of out-of-network services, process for obtaining these services and any difficulties obtaining services that are not covered under the managed care plan.

List of Materials Needed

State plan section 3.1(a)(9)
State policy and procedures
Any other state guidance on care coordination or patient record maintenance
Managed care contracts
Managed care policies and procedures
Reporting forms
Monitoring reports

KEY AREA VII
DATA COLLECTION, ANALYSIS AND REPORTING

Part 2 of the State Medicaid Manual, 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.

A. Does the State develop their CMS-416 reports in accordance with the instructions in Section 2700.4?

Method of Evaluation:

1) Identify the source of the EPSDT dental data included in the CMS-416 report, including how screenings in federally qualified health centers, Indian Health Centers, and managed care programs are counted.
2) Meet with State EPSDT and programming staff to determine the processes and procedures used to validate the accuracy of the data.
3) Review the CMS-416 reports dental utilization data for a minimum of the two most recent years.

B. Does the State have any concerns with the data collection methodology?

1) Identify any issues or concerns the State has regarding the data collected for the CMS 416.

B. Does the State analyze the CMS-416 dental data in comparison to prior years to define areas for improvement?

Method of Evaluation:

1) Identify any CMS-416 data areas the State has monitored or analyzed including the types of analysis, (geographic, provider distribution, etc.).
2) Review any State analysis, including the identification of any defined follow-up actions.
3) Compare the three most recent CMS-416 reports for improvements in dental rates.

C. Has the State established performance goals for Medicaid or its managed care plans specific to the provision of dental services? If so, what are those goals?

Method of Evaluation:

1) Identify any performance goals the State has developed for the provision of dental services?
2) Review the managed care contracts to determine if goals are included in contracts.
3) Identify how goals are determined for dental services delivered fee for service as well as services delivered under managed care arrangements.

D. What programs or activities has the State initiated to meet the performance goals?

Method of Evaluation:

1) Identify any State strategies or procedures to increase the number of children receiving any dental services.
2) Examine the effectiveness and appropriateness of the State's actions.
3) Determine how the State is monitoring any strategies or procedures to improve dental access and the delivery of services.
4) Determine if the State has analyzed its reimbursement rates in relation to other insurers in the State or other States and any actions taken based on such analysis.

E. What other areas/types of data are monitored related to children's dental services (e.g., HEDIS)?

Method of Evaluation:

1) Identify other State monitored areas, the scope of the examination, and the use of the results.

List of Materials Needed

State-defined performance goals
Managed care contracts
Provider instructions on performance goals and monitoring strategies
CMS-416 programming instructions
Internal instructions for compiling the CMS-416 report
Any analysis of performance monitoring
Action plans for performance improvements
Dental action plan

Appendix B - Data Charts on Provider Interviews

Additional Provider Interviews in Eight Review States with Largest Medicaid Populations

State	Provider Interviews Onsite Review	Additional Calls Completed	Total Provider Interviews
California	4	19	23
Florida	5	2	7
Georgia *			15
Louisiana	8	3	11
Michigan	4	11	15
Missouri	6	4	10
New Jersey	6	4	10
New York	5	8	13
Pennsylvania	5	9	14

* The Georgia dental review team interviewed a total of 15 providers in a two week period, both onsite and by telephone.

APPENDIX C

Delivery Systems

There are many different models used by States to deliver and reimburse dental services for Medicaid eligible children. While the delivery system was not a focus of these reviews each report notes the variance among States. As was noted in some of the reviews, multiple delivery systems may be used in one State. In general, the various models fall into the following categories:

1. Fee for Service (no risk);
2. Single Dental Benefits Administrator or Administrative Services Organizations (ASOs) (generally no risk);
3. Managed Care Organizations which provide all services including dental. The plan receives a capitated payment but the dentist is paid through fee for service (risk to plan but not to dentist);
4. Managed Care Organizations which provide all services including dental. The dentist is paid a capitated rate (risk to dentist) and
5. Managed Care Organization that only provides dental services (may be risk or non-risk).

Below is a list of the States that received an onsite dental review and the dental delivery system in that State.

Delivery Systems in Review States

State	Dental Managed Care?	Risk-based (y/n)	Other (e.g., Dental Benefits Administrator)
AR	PCCM	Non-risk	
CA	5% MC 95% FFS	MCO-risk	FFS uses fiscal intermediary
DC	Yes	Risk	
DE	FFS/Carve out		
FL	FFS except for MC in 6 counties	MCO-Risk	
GA	Yes	Risk	
LA	PCCM/FFS	Non-risk	
MI	FFS in part; carve out in part	Carve out – non-risk	
MO	MC (6	MCOs - Risk	

State	Dental Managed Care?	Risk-based (y/n)	Other (e.g., Dental Benefits Administrator)
	counties) FFS –non-MC counties		
MT	No		
ND	No		
NJ	Yes	Risk	
NV	Yes	Risk	
NY	Yes	Risk	
PA	Yes	Risk	
WI	4 counties – MC; otherwise Carve out FFS	Risk	MCO's subcontract with DBA

Variation in State delivery systems can depend on geography of the State, rural vs. urban, availability of providers and funding issues. Based on the 16 States reviewed and additional information obtained by CMS, few States appear to deliver dental services through traditional managed care arrangements that are risk based and pay providers a capitated rate. Dental providers interviewed during the reviews were generally unwilling to provide dental services to Medicaid beneficiaries under a capitated arrangement in addition to acknowledging that payment rates were low under their fee for service arrangements. Of the review States, nine used some type of risk based managed care delivery system. The population served by each State using managed care ranged from 5 percent in one State to 80 percent another. Even States that deliver dental services though MCO's may exclude certain populations from this arrangement including children who are medically needy, children in State custody or those in home and community based waiver programs. Additionally four States used primarily fee for service reimbursement for dental services and the rest were some combination of several delivery system.

Some examples of the variations in delivery systems in the States reviewed are as follows:

- One State was primarily fee for service but had a component of managed care operating under a demonstration in several primarily rural counties. The demonstration in the rural counties seemed to be working successfully while an urban area continued to struggle with improving access.
- One State that provided services primarily fee for service, had managed care in several counties and a pilot program in another county. The pilot program was not part of the review but according to the State staff, appeared to be working well. However, the review team noted that implementation of managed care in

several counties had appeared to hinder the timely delivery of some services according to providers interviewed.

- Another State delivered dental services primarily under a managed care risk arrangement but providers were paid on a fee for service basis. This seemed to be working well according to the State and providers interviewed.

We also offer the following information from an American Dental Association study (http://www.ada.org/prof/resources/topics/topics_access_whitepaper.pdf) of innovative delivery modes. Only one of these States (Michigan) was reviewed by CMS.

Michigan's Healthy Kids Dental Program is administered by a single commercial vendor, Delta Dental Plan, partnered with the state Medicaid program. Delta manages benefits according to the same standard procedures and payment mechanisms as its private plans.

In the pilot program's first year, the proportion of Medicaid-eligible children who visited a dentist at least once increased from 32 to 44 percent — "nearly identical to the proportion of privately insured children," according to the white paper. Travel distance was cut in half, from 24.5 to 12.1 miles, and participating dentists report a reduction in missed appointments.

Tennessee's "carve-out" of dental services from the TennCare (Medicaid Managed Care) program was legislated to improve access when the number of participating dentists had dwindled from 1,700 down to 386 — to care for more than 600,000 eligible children.

The carve-out ensured a separate dental budget, raised reimbursements to the 75th percentile of fees and used a single dental plan administrator, Doral Dental of Tennessee.

In two years, utilization rates have almost doubled, from 24 to 47 percent. So, too, has the number of dental providers, to about 700 — 86 percent of whom are accepting new patients. With the dental network expanded by nearly 80 percent, travel distance from patient to provider has decreased to about four miles.

Alabama's "Smile Alabama!" initiative is an effective state-administered Medicaid program, the white paper asserts, because it is no more complex administratively than private and commercial plans. The state established market-based dental fees and aggressively improved its consumer outreach and care coordination.

Since 2000, 47 percent more dentists participate in Medicaid, the number of Medicaid-eligible children who received dental services increased by 68,969, and the Oral Health Coalition of Alabama has grown to more than 30 member organizations.

The **Connecticut** Health Foundation's unique contract with federally qualified health centers allows private-practice, non-Medicaid dentists to treat Medicaid patients. Each center and dentist negotiates their own arrangement, allowing for a market-based fee agreement and significant flexibility in dentist participation.

In rural **Vermont**, community stakeholders established a fee-for-service, for-profit dental center to treat all patients, including Medicaid, uninsured and private-paying. According to the white paper, this model is ideal when a community wants to develop and sustain a fee-for-service dental practice less vulnerable to public funding cycles. It also can create market-driven incentives to success without constant oversight or operational funding.

Since creation of the Estey Dental Center in Brattleboro, Vt., visits from Medicaid beneficiaries increased from 669 to 1,704, and the center has cleared a "huge backlog" of children with acute and chronic dental needs.

Finally we have reviewed information from a study done by the Congressional Research Service (CRS) on dental services delivered under risk-based managed care arrangements in specific counties in three States. As noted earlier, CMS did not focus their reviews based on delivery system though as noted above nine States reviewed did use this arrangement for at least part of their population. While the data used in the CRS study was only for three States with MCOs it was generally consistent with CMS' review findings. It did show that the longer a child stayed in the MCO the better chance the child had of receiving a dental visit. Depending on the MCO, it was as high at 57 percent which is close to the national average for commercial patients. In addition the report noted that in some instances a small number of providers saw the majority of Medicaid patients. This was noted as well with some providers interviewed during the State reviews. However, CMS does not believe that this is indicative of anything wrong with the services that provider furnishes. Some practices have set themselves up to serve the Medicaid population as part of their goal and have been very successful in serving the population well.

Given the variance of delivery system in the States reviewed as well as those studied by other organizations it is difficult to determine if one system works better than another. Since most of the States reviewed had dental utilization rates of 30 percent or less and the delivery systems varied from total fee for service reimbursement to services furnished under some type of managed care arrangement, it appears that States continue to need to look for the best system that works for them and their dental providers.

Appendix D – Financing and Reimbursement Assessment

Financing and Reimbursement

The information in the sections below was previously provided by the American Academy of Pediatric Dentistry under a contract with CMS (previously the Health Care Financing Administration) and was not related directly to the State dental reviews. The information has been updated where appropriate.

A. Program Financing and Payments[5]

1. Funding Levels for Public Dental Programs for Children

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

Historically, commercial dental plan databases have had limited applicability because they generally reflect the care provided to children from middle-to-upper income households. Children from these households tend to have good access to comprehensive dental services and use dental services according to recommended periodicity schedules. However, children from these households now have much less dental disease and treatment needs than do children from lower-income households. Conversely, data from public programs reflect the use of dental services by low-income children who have relatively high levels of disease and treatment needs, but who have had limited access to dental services. The problem of using raw data from public (e.g., Medicaid) programs is further confounded by historically low levels of program funding that, in turn, are reflected in reimbursement rates that often are well below dentists' normal fees.[6] Faced with the absence of suitable existing data sources, concerned parties have turned to actuarial approaches to develop program financing and cost estimates for publicly funded pediatric dental programs.

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

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

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

a) American Academy of Pediatrics Analysis

The American Academy of Pediatrics (AAP) commissioned the firm of Towers Perrin to develop actuarial estimates of the costs of providing comprehensive health benefits, including dental services, for children covered by SCHIP. The Towers Perrin actuaries developed per-member-per-month (PMPM) estimates for what States should expect to pay health plans for services outlined in an AAP policy statement, "*Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years*."[7] (Statement revised March 2006.[8])

The study included cost estimates for inpatient facility use, outpatient facility use, physician services, vision services, hearing aids, dental services, and pharmacy services based on regional utilization statistics. Results demonstrated that providing a comprehensive health benefits package, which is essential to children's optimal health and well-being, can be done at relatively moderate overall cost. The national average in 1998 was calculated to be $101.47 per member/child per month (PMPM), or roughly 60 percent to 70 percent of the cost of providing similar health care benefits to the general U.S. population as a whole (i.e., adults and children). The cost of providing coverage for preventive, diagnostic and rehabilitative *dental services* (with orthodontic coverage limited to services deemed to be medically necessary) for SCHIP-eligible children was estimated at $20.35 PMPM, or approximately 20% of the total cost of overall child health care benefits.

b) Reforming States Group Analysis

The Reforming States Group (RSG), with support from the Milbank Memorial Fund, commissioned the firm of PriceWaterhouseCoopers to develop an interactive actuarial model that States can use to develop program funding requirements and cost estimates for dental benefits for children enrolled in public programs such as SCHIP and Medicaid. For this project, the actuaries used data from the California dental Medicaid (Denti-Cal) program to determine the costs of pediatric dental services at market-based fees (i.e., dentists' charges discounted by 20 percent) for a population of children whose use of services mirrored those enrolled in the California Medicaid program. The resultant estimate for the cost *for dental services* under this program was approximately $14 PMPM in 1999. The RSG model may be found on the Internet at www.milbank.org/990716mrpd.html.

The AAP and RSG figures are not directly comparable. The AAP estimate reflects what States should expect to pay managed care health plans in the way of premiums, including program administration costs that typically range between 10-15 percent of total

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[7] Available on the Internet at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3b100/6/1040.

8 "Scope of Health Care Benefits for Children from Birth through Age 21" See http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;117/3/979

premiums. The RSG figure reflects the costs of dental services only (i.e., without program administration costs). Adding 15% program administration costs would result in an estimate of roughly $17 PMPM. The data and methods used to derive the respective estimates also differed. The AAP/Towers Perrin study started with data from commercially insured children and adjusted for additional treatment needs of SCHIP enrollees based on epidemiological data from the Third National Health and Nutrition Examination Survey (NHANES III). The RSG/PriceWaterhouseCoopers figure reflects use of services by California Medicaid enrollees without adjustments for unmet treatment needs; thus, the figure represents a conservative estimate of funding requirements. In spite of their differences, these models define a fairly consistent cost estimate of approximately $17 PMPM for premium costs in 1999, using a 15 percent cost estimate for program administration, for SCHIP-eligible children. Medicaid-eligible children have higher overall dental caries experience and higher levels of unmet treatment needs. Accordingly, cost estimates for Medicaid-eligible benefits would be expected to be somewhat higher initially (i.e., while the backlog of their unmet treatment needs are being addressed); thereafter, the ongoing costs of coverage for Medicaid-enrolled children obtaining continuing oral health maintenance services would be expected to decrease.

c) American Academy of Pediatric Dentistry Analysis

The American Academy of Pediatric Dentistry (AAPD) commissioned a major international consulting firm to conduct an actuarial analysis of dental benefits premium costs for children covered by commercial plans and Medicaid. The firm prepared utilization and price values for children's dental services by State for commercially insured and Medicaid-eligible children residing in urban and rural areas. Data provided by the actuaries reflected differences in commercial and Medicaid rates (payments) as well as differences in utilization of services by commercially insured and Medicaid eligible children. Results also reflected adjustments for differences in dental disease levels between the Medicaid population and the general population based on information provided by the AAPD. Continuance tables developed for each state indicated that national averages for dental benefits premiums for Medicaid-eligible children in 2005 were $19.79 PMPM for rural areas and $25.96 in urban areas in 2005. Additional details of the methodology and state-level premium costs are available from AAPD.

3. Historic Funding Levels in Public Pediatric Dental Care Programs

Funding requirements and cost estimates derived from the actuarial models highlighted above are generally consistent with estimates derived from a more general model developed by the American Dental Association and government surveys of actual expenditures for children not covered by public programs. However these recommended funding levels generally represent multiples of current PMPM funding levels for Medicaid dental programs. These and other sources also indicate that 15-30 percent of pediatric health care expenditures in the private sector are attributable to dental care,

depending on age group and the time period when the comparisons were made.9 Historic funding levels for public pediatric dental care programs stand in stark contrast to these figures. For example, Medicaid expenditures for pediatric dental services will comprise less than 5 percent of Medicaid pediatric health care expenditures according to CMS fiscal year 2009 estimates. That is, roughly 1/3 to 1/4 of the resources provided for non-Medicaid children. Although consideration must be given to the fact that many children with multiple or severe medical problems often are enrolled in Medicaid, a substantial gap in funding levels exists in most States between current Medicaid dental program allocations and market-based requirements.

4. Reimbursement for Dental Services

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

a) U.S. General Accounting Office Study

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

On average, the mean Medicaid reimbursement rates for all State programs were found to be equal to or slightly greater than the 10th percentile of fees charged by U.S. dentists for three of 15 procedures selected for the GAO survey (new and periodic examinations and fluoride applications). That is to say that only about 10% of dentists would view the Medicaid rates as comparable to their usual fees. Mean Medicaid reimbursement rates for the other 12 procedures used for the analysis were *less than* the fees routinely charged by even the lowest 10 percent of dental providers, oftentimes by a considerable margin. Thus, it is not surprising from an economic perspective that, at the time of the GAO's survey, 10 percent of dentists or less were "meaningful" participants in most State Medicaid programs. [NOTE: 'Meaningful' here refers to dentists who provide significant amounts of services to Medicaid beneficiaries -- e.g., >$10,000 in services]

The GAO report also sought to determine whether Medicaid reimbursement rate increases in many States had made a difference in a State's ability to improve access. The GAO findings showed that most of the States that reported improved utilization paid at rates that were at least two-thirds of average regional fees (a level which generally just

9 The proportion of total pediatric health care expenditures attributable to dental services has actually declined in recent years because pediatric dental care expenditures are increasing at lower rates than other pediatric health care expenditures (AAPD Dental Cost Model for Children by State, 2005).

covers production costs -- excluding dentist compensation -- for dentists who charge average fees and below production/overhead costs for dentists who charge higher-than-average fees). Most States without improvement had lower payment rates.

b) ADA Compendium

The American Dental Association (ADA) has published two editions of a report entitled, "State Innovations to Improve Dental Access for Low-Income Children: A Compendium."[10] This report provides a state-by-state overview of efforts to address barriers that impede access to oral health services for children served by Medicaid and the State Children's Health Insurance Program (SCHIP). The 2005 ADA Compendium Notes that experience in several States (e.g., Georgia, Indiana, Michigan and South Carolina) suggests that raising reimbursement rate limits to levels that approximate the 75th percentile of prevailing fees in the State can significantly increase access and utilization of dental services by Medicaid-eligible children and participation by dentists in Medicaid, especially when such initiatives are actively promoted by State dental organizations and commercial intermediaries in those States that contract with commercial plans to administer Medicaid benefits. More information on this subject can be found in a publication posted on the ADA website at: http://www.prnewswire.com/mnr/ada/20973/.

Although definitive results are not available, information on recent rate increases in several States suggests that higher levels of dentist participation in Medicaid can be expected when reimbursement rates for common pediatric dental procedures are raised to the 50th percentile of prevailing fees. For example, in January 2008 the State of Connecticut carved out dental benefits from its global Medicaid Managed Care program and contracted with a single Administrative Services Organization to administer Medicaid dental benefits for children under a no-risk arrangement. The changes in reimbursement rates and benefits administration resulted in an increase of more than 100 percent in the Connecticut Medicaid dental provider panel. A similar rate structure --i.e., reimbursement approximating the 50th percentile for over 50 pediatric dental procedures -- was implemented in the State of Texas in 2007.

The table below shows CT Medicaid reimbursement rates prior to the recent increase. Prior to the increase, Medicaid reimbursement rates were less than the 1st percentile of prevailing fees for 10 of the 15 selected procedures and below the 10th percentile for the remainder. A review of data compiled by the American Dental Association for its 2004 Compendium Update (see reference above) revealed that in 41 states, the majority of Medicaid dental reimbursement rates for common children's dental procedures remained below the 10th percentile and frequently were below even the 1st percentile of dentists' fees – meaning that the Medicaid rates were lower (and often substantially lower) than the fees charged by any dentist in the respective states. As noted above, the State of Connecticut raised Medicaid reimbursement rates to levels corresponding to approximately the 50th percentile of dentists' prevailing fees for the majority of dental

10 American Dental Association. State Innovations to Improve Access to Oral Health Care for Low Income Children: A Compendium Update. Chicago: American Dental Association: 2005.

procedures commonly provided for children in 2008.

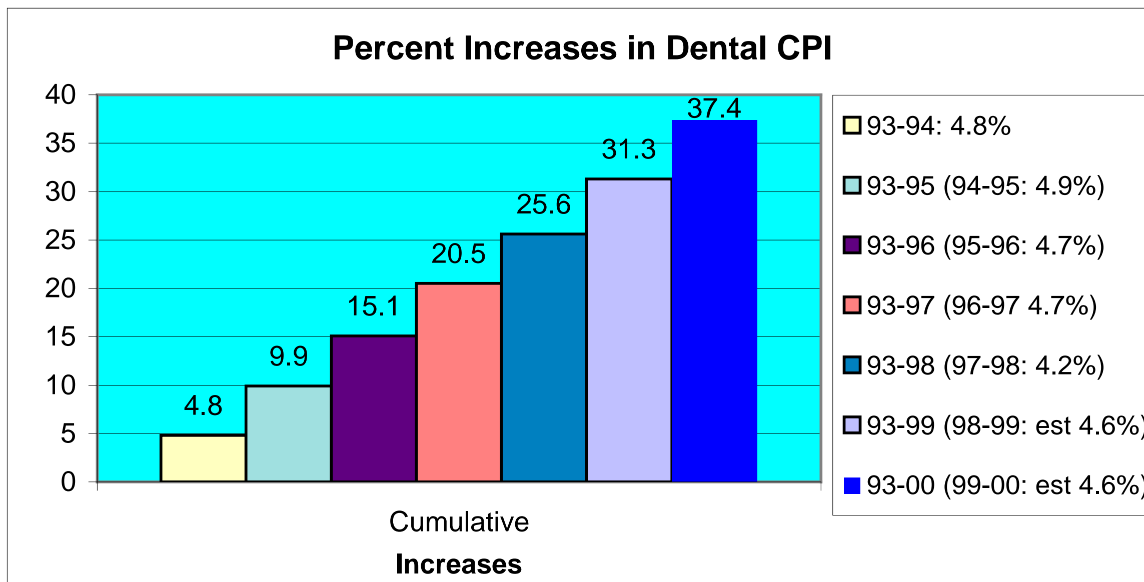
CT Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA New England (NE) Region and in the State of Connecticut			
CDT4 Procedure Code	Procedure Description	CT Medicaid Payment Rate	NE Region 50th Percentile	CT State 50th Percentile	CT State 75th Percentile	State Percentile Corresponding to CT Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	$18.08	$31.00	$37.00	$39.00	2nd
D0150	Comprehensive Oral Exam	$23.64	$50.00	$55.00	$70.00	3rd
D0210	Complete X-rays, with Bitewings	$45.00	$100.00	$109.00	$110.00	< 1st
D0272	Bitewing X-rays - 2 Films	$15.91	$33.00	$36.00	$38.00	7th
D0330	Panoramic X-ray Film	$35.00	$88.00	$95.00	$100.00	< 1st
Preventive						
D1120	Prophylaxis (cleaning)	$21.70	$48.00	$48.00	$50.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	$15.15	$27.00	$30.00	$32.00	4th
D1351	Dental Sealant	$17.75	$40.00	$40.00	$44.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	$37.64	$110.00	$115.00	$125.00	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	$46.20	$125.00	$132.00	$150.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	$328.48				**
D2930	Prefabricated Steel Crown, Primary Tooth	$85.01	$198.00	$222.00	$245.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	$45.46	$114.00	$120.00	$150.00	< 1st
D3310	Anterior Endodontic Therapy	$200.01	$630.00	$550.00	$650.00	< 1st
Oral Surgery						
D7140	Extraction, Single Tooth	$33.12	$105.00	$108.00	$120.00	< 1st

c) Global versus Selective Reimbursement Rate Adjustments

Many States reimburse at higher relative rates for selected procedures or categories of services (e.g., diagnostic and preventive services) within their Medicaid fee schedules. This well-intended strategy provides additional economic incentives for dentists or other providers to deliver these services and may increase crude access statistics. However, this strategy generally provides inadequate incentives for dentists to provide the full scope of services required by Medicaid enrolled children (e.g., restorative treatment for decayed teeth) since procedures that are more technically demanding and often require advanced behavior management approaches to achieve a child's cooperation are reimbursed at relatively lower rates. This often results in Medicaid dental service profiles that are not consistent with data obtained from national, State-wide or regional surveys of low-income children's disease levels and treatment needs. In effect, the program may end up allocating most of its resources for diagnostic and preventive services while the restorative and surgical treatment needs of large numbers of children remain unmet.

d) Periodic Reimbursement Rate Adjustments

The costs of dental services continue to increase as a result of increasing production costs (salaries, supplies, rent, etc.) and demand for services. The graph below, which uses data from the American Dental Association, depicts the annual incremental and cumulative effects of increases in the cost of dental services over a seven-year interval (1993-2000). Increases in dental costs averaged between 4 and 5 percent annually during this period, and data reported in the AAPD 2005 Cost Study indicate that annual increases between 1998 and 2005 have remained at approximately 4.5 percent. The cumulative effect of these rather modest annual increases over the relatively short time interval of seven years is cost increases approaching 40 percent. Historically, State Medicaid programs have not adjusted reimbursement rates on a regular (e.g., annual) basis, contributing to erosion of purchasing power and growing dentists' dissatisfaction as Medicaid reimbursement schedules that fall further and further outside market conditions over time.



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

In anticipating the fiscal consequences of changes made to reimbursement for children's dental programs, the following considerations likely will apply, particularly in States where Medicaid reimbursement rates vary considerably from current market rates:[11]

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

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

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

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

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

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

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

Preliminary evidence for these projections comes from innovative programs implemented for Medicaid and low- income beneficiaries in Michigan[12] and western Pennsylvania[13]

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[12] Personal communication with Michigan Medicaid program administrators – Robert Smedes and Christine Farrell.

that engaged commercial dental plans with adequate networks and devoted funding levels that allowed purchasing of dental services at competitive market rates. Analyses of these programs conducted by university-based experts have demonstrated significant successes in relatively short time periods. These model programs have demonstrated substantial increases in individuals with a regular source of care, reductions in unmet treatment needs, increases in provider participation and geographic access, utilization patterns that stabilized per-enrollee costs, and high degrees of provider and enrollee satisfaction.

[13] Lave JR, Keane CR, Lin CJ, et al. Impact of a children's health insurance program on newly enrolled children. JAMA. 1998;279:1820-1825.

Appendix E – EPSDT Dental Utilization Rates

State	FY2006 Report			FY2007 Report		
	Total Number of Dental Services (line 12a)	Total Eligibles (line 1)	Percent Receiving a Dental Service	Total Number of Dental Services (line 12a)	Total Eligibles (line 1)	Percent Receiving a Dental Service
Alabama	188,475	509,155	37%	226,476	503,051	45%
Alaska	34,494	87,800	39%	32,174	84,203	38%
Arizona	213,892	636,237	34%	228,238	644,688	35%
Arkansas	108,684	405,965	27%	93,299	387,393	24%
California	1,286,493	4,562,231	28%	1,287,113	4,547,735	28%
Colorado	118,119	342,229	35%	121,642	338,186	36%
Connecticut	93,578	281,910	33%	104,411	278,677	37%
Delaware	25,125	96,063	26%	18,586	87,502	21%
District of Columbia	24,973	85,669	29%	29,231	91,236	32%
Florida	352,741	1,691,146	21%	343,529	1,611,397	21%
Georgia	406,963	1,162,900	35%	388,554	1,069,682	36%
Hawaii	51,543	126,344	41%	NR		
Idaho	62,367	154,425	40%	62,408	157,656	40%
Illinois	475,994	1,336,033	36%	460,677	1,392,361	33%
Indiana	251,647	607,230	41%	261,654	670,468	39%
Iowa	104,473	245,865	42%	107,631	248,169	43%
Kansas	80,332	222,731	36%	79,964	218,498	37%
Kentucky	116,265	352,913	33%	74,935	348,376	22%
Louisiana	214,399	777,212	28%	225,185	770,723	29%
Maine	NR			NR		
Maryland	155,804	507,946	31%	172,247	514,777	33%
Massachusetts	196,485	521,528	38%	213,760	530,197	40%
Michigan	325,592	1,085,180	30%	346,356	1,103,459	31%
Minnesota	139,012	411,988	34%	140,132	410,610	34%
Mississippi	146,450	421,155	35%	140,346	400,507	35%
Missouri	157,869	664,330	24%	159,591	634,491	25%
Montana	15,066	61,369	25%	16,793	64,620	26%
Nebraska	71,221	161,000	44%	73,224	161,329	45%
Nevada	30,647	155,354	20%	36,803	154,025	24%
New Hampshire	37,504	89,725	42%	39,110	90,678	43%
New Jersey	151,026	582,257	26%	183,913	589,415	31%
New Mexico	132,692	321,608	41%	140,796	324,178	43%
New York	568,963	2,079,460	27%	616,375	2,021,928	30%
North Carolina	372,764	948,178	39%	402,645	973,650	41%
North Dakota	8,478	44,868	19%	11,148	44,470	25%
Ohio	432,005	1,214,245	36%	448,649	1,227,384	37%
Oklahoma	180,051	490,090	37%	194,777	504,458	39%

State	FY2006 Report			FY2007 Report		
	Total Number of Dental Services (line 12a)	Total Eligibles (line 1)	Percent Receiving a Dental Service	Total Number of Dental Services (line 12a)	Total Eligibles (line 1)	Percent Receiving a Dental Service
Oregon	86,811	279,809	31%	85,503	271,889	31%
Pennsylvania	301,965	1,111,384	27%	327,470	1,120,184	29%
Rhode Island	43,066	114,304	38%	45,196	113,005	40%
South Carolina	229,447	536,503	43%	225,014	528,336	43%
South Dakota	29,756	86,892	34%	29,618	88,107	34%
Tennessee	295,413	814,643	36%	293,391	816,486	36%
Texas	1,233,149	2,901,402	43%	1,318,017	2,900,959	45%
Utah	56,582	177,786	32%	57,111	167,691	34%
Vermont	30,705	58,682	52%	30,321	57,307	53%
Virginia	173,999	547,245	32%	200,857	548,518	37%
Washington	275,542	652,460	42%	281,031	646,521	43%
West Virginia	117,070	210,181	56%	85,108	207,606	41%
Wisconsin	105,394	498,162	21%	112,929	499,965	23%
Wyoming	17,919	54,357	33%	17,964	53,642	33%

Appendix F – National Dental Statistics and Study References

Additional information on dental care is available at the following websites:

- Guide to Children's Dental Care in Medicaid. Department of Health and Human Services, Centers for Medicare & Medicaid Services:
  http://www.cms.hhs.gov/medicaiddentalcoverage/downloads/dentalguide.pdf

- Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families
  http://www.cms.hhs.gov/MedicaidDentalCoverage/

- Centers for Disease Control and Prevention
  http://www.cdc.gov/OralHealth/index.htm

- American Dental Association:
  http://www.ada.org/

- American Academy of Pediatric Dentistry
  http://www.aapd.org

- Administration for Children & Families - Guide to Children's Dental Care in Medicaid:
  http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/Health/Oral%20Health/Oral%20Health%20Children%20(ages%200-5)/health_pub_13603_020907.html

- MedlinePlus: Child Dental Health.
  http://www.nlm.nih.gov/medlineplus/childdentalhealth.html#cat22

- National Center for Health Statistics – Oral and Dental Health:
  http://www.cdc.gov/nchs/fastats/dental.htm