

A number of states are increasing children's utilization of dental care through the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Targeting dental care, these states have implemented innovative programs. This paper reports on oral health screening data and briefly summarizes the initiations being carried out in six such states.

A word about methodology

The data presented in this paper are based on the states' own reports of participation rates on the CMS Form-416, the uniform EPSDT reporting form. Participation ratios are based on the "total number of eligible children who should have received at least one EPSDT screen" (line 8 of the CMS Form 416) and take into account the average period of eligibility, *i.e.*, the fact that not all children are enrolled with Medicaid for the continuous 12-month period of the fiscal year. Using the average period of eligibility (

i.e.

, line 8 from the Form 416), is the manner in which overall well-child screening EPSDT participation ratios, as defined by the federal

State Medicaid Manual

, are calculated.

The dental participation ratios cited below do not provide any information concerning whether an eligible child has received the number of biannual preventive visits that are recommended by the American Academy of Pediatric Dentistry. According to the instructions for the CMS Form 416, the data from lines 12a and 12b should consist of the unduplicated number of children who have received any dental services and the unduplicated number of children who have received preventive dental services, respectively. Because each child should be "counted" only once each fiscal year for each category, regardless of the number of dental services or preventive dental services they received in one year, these data from lines 12a and 12b do not reflect the total number of dental appointments each child had in any given year.

The figures below reflect use by all children birth through age 20 and for four discrete age groups: children age 3 to 5, 6 to 9, 10 to 14, and 15 to 21.

Participation ratios for selected states (2004 and 2005)

Tables 1 and 2 set forth the total percentage of children who should have received a well-child examination who received *any dental services* for fiscal years 2004 and 2005, for six states: Alabama, Indiana, North Carolina, South Carolina, Vermont, and Washington.

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TABLE 1: PERCENTAGE OF CHILDREN WHO SHOULD HAVE RECEIVED A WELL-CHILD SCREENING

STATE

All Ages

3-5 Years

6-9 Years

10-14 Years

15-21 Years

AL

40

56

59

52

33

IN

62

53

132

99

100

Nc

66

45

206

125

121

Sc

62

47

123

92

83

VT

103

84

216

168

156

WA

67

54

86

141

89

TABLE 2: PERCENTAGE OF CHILDREN WHO SHOULD HAVE RECEIVED A WELL-CHILD SCREENING

STATE

All Ages

3-5 Years

6-9 Years

10-14 Years

15-21 Years

AL

41

59

60

54

35

IN

N/A

N/A

N/A

N/A

N/A

NC

70

46

227

137

147

Sc

66

54

139

103

100

Vt

61

56

144

70

61

WA

68

57

87

144

90

Tables 3 and 4 set forth the total percentage of children who should have received a well-child examination who received *any preventive dental services* for fiscal years 2004 and 2005, for these six states.

TABLE 3: PERCENTAGE OF CHILDREN WHO SHOULD HAVE RECEIVED A WELL-CHILD SCREE

STATE

All Ages

3-5 Years

6-9 Years

10-14 Years

15-21 Years

AL

35

50

54

47

27

IN

54

47

121

91

79

Nc

57

40

187

109

87

Sc

62

46

128

93

78

VT

92

77

201

156

130

WA

60

51

79

130

73

TABLE 4: PERCENTAGE OF CHILDREN WHO SHOULD HAVE RECEIVED A WELL-CHILD SCREENING

STATE

All Ages

3-5 Years

6-9 Years

10-14 Years

15-21 Years

AL

37

53

56

50

29

IN

N/A

N/A

N/A

N/A

N/A

NC

62

41

208

122

108

Sc

67

54

147

106

94

VT

55

51

51

65

50

WA

62

54

81

134

Innovative activities in the states²

As the following information demonstrates, the states listed in the tables above have taken steps to implement programs and initiatives designed to increase access to oral health care for Medicaid eligible children. Among the activities by these states that have resulted in success are:

- Adequate payment levels tied to dentists' usual and customary charges and commercial products in the state;
- Administrative changes that streamline the program making it easier for dentists to participate and get paid;
- Appointment of a high level committee or departmental position to monitor and provide policy advice to the agency;
- Aggressive and effective outreach and marketing to beneficiaries;
- Case management that causes appointment no-shows to be reduced dramatically.

Alabama

In October 2000, the Governor of Alabama announced an Alabama Medicaid Agency dental initiative called *Smile Alabama!* Through this initiative Alabama has undertaken a number of activities aimed at encouraging dentists to participate in Medicaid and improving children's access to oral health care. The *Smile Alabama!* initiative includes comprehensive efforts aimed at providers, including dedicating personnel to assist dental providers with administrative issues, surveying all active providers, conducting a recruitment effort by having the governor request that all licensed dentists accept one new Medicaid child per week, and increasing reimbursement rates in 2000 to the same level as the BlueCross/BlueShield of Alabama rates. The *Smile Alabama!*

initiative also focuses on individual beneficiaries through a public awareness campaign, using radio and television public service announcements.

Since initiating the *Smile Alabama!* program, the Medicaid agency has reported a significant increase in both the percentage of participating dental providers and the overall percentage in utilization, despite a 14% increase in the total number of eligible EPSDT enrollees. By fiscal year 2005, the State reported that approximately 180,000 children over the age of three received any dental services. This number represents a 68% increase in utilization from fiscal year 2001, or an additional 69,000 total children receiving any dental care in fiscal year 2005 than in fiscal year 2001. This increase occurred despite having reimbursement rates that are less than that considered optimal for ensuring sufficient provider participation.

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Indiana

In May 1998, Medicaid dental reimbursement rates in Indiana were increased to 100 percent of the 75th percentile of usual and customary fees, which resulted in a 147 percent increase in fees. According to a report from the Journal of The American Dentistry Association, Indiana's significant improvements in reimbursement rates and administrative changes led to an increase in both the level of dentist participation and the number of children utilizing dental services during the three-year time period that was studied.

The first issue evaluated by the study group was whether or not the increase resulted in improved provider participation levels. The study found that the number of dentists enrolled in the Medicaid program increased by a total of 378 providers from fiscal year 1997 to 2000. Similarly, the number of dentists enrolled who billed for at least one Medicaid patient increased from 770 in 1997 to 1,096 in 2000.

The study group then evaluated the impact of the fee increase on access to dental care. During the study period, the overall enrollment of EPSDT-eligible children increased from 372,566 to 486,454. Despite the increase in total enrollment, the percentage of enrolled children (*i.e.*, those identified on line 1 of the CMS Form 416), who received any dental care, increased from 18 to 32 percent. Therefore, almost 80,000 more enrolled children received a dental visit by 2000 than prior to the fee increase. The study concluded that:

[A] positive relationship [exists] between the fee increase and dentist participation and enrollee dental care utilization. This finding supports the results of previous studies that showed that the

perceived low payment rates were one of the most important predictors of- if not the number 1 factor in determining- whether a dentist participates in Medicaid.

North Carolina

In 1999, North Carolina convened a Task Force on Dental Care Access, which developed a number of recommendations, among them a recommendation to increase the reimbursement rates for dental services and to develop an outreach campaign to encourage dental provider participation. The Task Force noted that more dentists would be willing to see more Medicaid patients if reimbursement rates were increased.

Dental reimbursement rates were increased slightly in 2002; however, by April 1, 2003, as a result of a dental care class action lawsuit settlement, reimbursement rates were significantly increased for certain procedures benefitting children. Dr. Mahyar Modifi reports that "preliminary evaluations suggest that increased rates have indeed coincided with improved participation and utilization levels." For example, from 2001 and 2004, the total number of actively participating dentists (providing more than \$10,000 in Medicaid care per year) increased 33%, from 644 to 855. Similarly, from 2003 (when rates were substantially increased) to 2004, 143 new dentists began actively participating in the Medicaid program.

A second element of the settlement agreement was the establishment of a Medicaid Dental Advisory Committee, under the auspices of a nonprofit organization of health care providers. This group has been charged by the North Carolina General Assembly to provide policy guidance to the state Medicaid agency.

In addition, in the fall of 1999, North Carolina began a pilot project to train and reimburse physicians for a three-part preventive oral health package, which includes an oral health screening, parent/caregiver education and fluoride varnish for children up to age three.

South Carolina

South Carolina has identified shortages of dentists in under-served areas - for example, the

rural counties of South Carolina have an average of 31 dentists per 100,000 people. These shortages result in very few providers being available to care for young children enrolled in the Medicaid program. As a result, South Carolina developed an initiative to train general dentists to treat pediatric and special needs children. The training has resulted in more general dentists in rural areas expanding their practices to include young children and those with special healthcare needs. Furthermore, according to a report by the American Dental Association (hereafter "ADA"), South Carolina reimburses Medicaid dental providers with rates that are at the 75th percentile of rates in that region. Thirty-six months after increasing the rates, the number of participating dental providers had increased by 73 percent.

South Carolina has also adopted programs designed to increase the level and effectiveness of recipient outreach. In designing its outreach campaign in 2003, the state Medicaid program entered a partnership with the African Methodist Episcopal Church, which is active in many rural areas. Members received a screening at more than 110 sponsored events and, if necessary, given a referral for follow-up care. The members given referrals were assigned a patient navigator to assist their parents in scheduling and keeping any additional appointments. More than 85 percent of those families kept their follow-up appointments. The patient navigator is also assigned to children who are identified as being at medium-to-high risk for dental disease. As a result, Oral Health America, an independent advocacy group, gave South Carolina's outreach efforts an "A."

Vermont

Vermont has the highest percentage of Medicaid participating dental providers in the country; approximately 43% of licensed dentists participate with the state Medicaid program. In addition, Vermont's coverage of oral health services and utilization rates by Medicaid eligible recipients is among the highest in the nation.

In an effort to improve further the provision of oral health services to Medicaid-eligible children, the state Medicaid program has aggressively expanded its efforts to increase dental provider participation. For example, in 2005, the State conducted a survey of dental providers, focusing on their attitudes toward reimbursement rates, administrative procedures, and case management. Based on the responses from the dental providers, the Department of Health developed assessment tools to help dental offices measure staffing, cost, and utilization under current and potential scenarios. These tools were distributed to every dentist in the State in the first quarter of 2006.

Vermont has also made substantial efforts to conduct outreach to eligible recipients through a "Smile Vermont" social marketing campaign. The campaign is based on results obtained through six focus groups conducted by an outside marketing firm. After condensing the findings, the marketing group developed a simple message -- "visit your dentist every six months" -- that has been communicated to recipients through print, radio, and television advertisements, dedicated a toll-free number through a partnership with the United Way, started a comprehensive website, and held various family events. Oral Health America has cited Vermont for these activities.

Washington

In 1995, Washington State initiated the Access to Baby and Child Dentistry (ABCD) program to address the high incidence of oral disease and limited access to dental services for young EPSDT-eligible children under age 6.

The ABCD program operates as a partnership between private dental practices, which provide services to enrolled children under the age of 6, and local health jurisdictions that identify and enroll families in the program. The providers are trained in childhood dental techniques and are paid enhanced reimbursement rates by the state Medicaid agency. The local health district or a nonprofit organization administers the program by conducting client outreach, case management services, and program promotion. Local dental societies encourage members to become ABCD providers. In addition to oral health education and an oral examination and treatment, if necessary, families are provided counseling to reduce the no-show rate, home care compliance, and prevention techniques.

The ABCD program has expanded since its inception; in 2005 approximately 20 counties participated in the program. Washington State has evaluated the program by analyzing Medicaid data and statistics and surveying clients and providers. The results of their evaluation "demonstrate improvement in access rates, especially for the youngest children, and attitude changes by families and dentists." For example, use of Medicaid dental services for children under the age of 6 rose an average of 39% in ABCD counties from 1999 to 2003. Likewise, in a 2003 survey, 48% of ABCD parents reported that their child had their first dental visit before the age of 2, compared to 23% in 2000. Nearly 80% of ABCD dental providers rated their experiences as "excellent" or "good."

Conclusion

Many states oral health screening rates are lagging. The six states highlighted, above, show that this need not be the case.

* This paper is an excerpt from Plaintiffs' Report Concerning Dental Participation Ratios, filed in February 2007 at the Court's request in *Salazar v. District of Columbia*, No. 93-452. Counsel for the Plaintiffs are Terris, Pravlik & Millian, LLP, . and the National Health Law Program.

Notes

1. Some of the percentages are greater than 100% because the data from line 8 of the CMS 416 is calculated based on the average period of eligibility. If a child was enrolled with the Medicaid program for a short period of time, but received a dental service during that time, that dental service would be counted for purposes of computing lines 12a and 12b. However, because the child was enrolled for less than one year, the child would only count as a percentage of an enrollee for line 8 purposes, calculated using the average period of eligibility for each age group.
2. Sources for information about state activities include the American Academy of Pediatric Dentists, Children's Dental Health Project, Center for Health Care Strategies, and Oral Health America.
3. These rates are lower than the 75th percentile of rates for the region.