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October 17, 2000
Updated: June 2001

This memorandum lists a number of actions states have considered to improve access to dental care, particularly for individuals ensured through Medicaid. It includes actions taken, considered but rejected, and pending.

The activities are listed under four broad headings: reports, legislation, initiatives/projects, and title V agency. Resource lists are also included after each state. (Note that the Children's Health Dental Project, in Washington, DC, is an excellent source of information, <http://www.childent.org>.)

A few states have developed approaches that deserve mention: California (share-the-care project), Connecticut, Idaho, Indiana, Minnesota, North Dakota, South Carolina, Washington, and Wisconsin.

NOTE: The information in this memorandum has been taken from personal telephone conversations, hard copy research, and Web site postings. It is constantly changing. Please help us keep this memorandum up-to-date and accurate by forwarding any additional information you have to NHeLP's North Carolina office: perkins@healthlaw.org.

Alabama

Legislation

HB 367 (1999) passed: Accepts out-of-state licenses and/or clinical board examinations of

dental providers, including dentists and dental hygienists. (CPA) [\(1\)](#)

Initiatives/Projects

In September 2000, Alabama raised Medicaid reimbursements for dental services. AP/Alabama Live reported (11/25/00) that, in the first two months following the increase, 25 additional dentists began participating in Medicaid. The rate increase was supported by a letter from the Governor encouraging all licensed dentists to accept Medicaid patients. The Medicaid Agency is offering free software to allow dentists' claims to be processed in eight days. Case managers are being used by the agency to contact Medicaid beneficiaries and remind them to keep appointments; transportation assistance is provided if needed. The new fee schedule alone is expected to cost the state \$18 million next year, a \$6 million increase from this year.

In Alabama, local health and primary care clinics are increasing efforts to set aside blocks of time available for treating dental patients on a first-come, first-served basis. (OIG)

Programs

Title V

In Alabama, Title V is overseen by the Bureau of Family Health Services, which also oversees the Dental Health Services (DHS) Division. The state's dental program receives 23 percent of its budget from Title V funds. The mission of DHS is to improve the oral health of Alabama citizens through intervention strategies designed to prevent or reduce the incidence and prevalence of oral disease. Another integral component of the program's mission is support for dental clinical programs that provide direct patient care at local health departments (LHDs) and some school-based dental clinics. Ongoing dental programs that provide a positive impact for maternal and child populations include: community water fluoridation serving 3.2 million (81 percent) of Alabama citizens; school-based weekly fluoride mouth rinse programs reaching 23,000 students; LHD and school-based sealant programs providing 30,000 protective sealants; school-based dental health education, including tobacco education for 20,000 students; preliminary research with the University of Alabama School of Dentistry, through WIC clinics, regarding the cause of early childhood Caries/Baby Bottle Tooth Decay; and free distribution of pamphlets, posters, videos, slides and other educational materials.

The Alabama SCHIP program is promoted through activity with the Alabama Dental Association, county health departments, and dental clinics statewide. Promotional letters, newsletters, brochures, and videos are used. DHS also promotes access through a partnership with the Alabama Medicaid agency. A Dental Task Force comprised of private dental practitioners, DHS, and Medicaid staff has been organized to target the MCH population.

Identifying new eligible clients, increasing dental fees and streamlining the prior authorization, claim submission and reimbursement processes have increased provider participation and access. (AMCHP)

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Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

Alaska

Legislation

HB 121 passed: Gives consumers the right to bring civil action against insurer. (CPA)

Initiatives/Projects

Alaska Head Start dental initiative funds indigenous staff to provide oral health education and outreach to rural, remote Alaska native communities. (OIG)

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

The project has: (1) established a provider network of culturally-sensitive dentists who travel to the villages to screen and treat children and (2) trained community staff in the villages to provide oral health education and outreach to children and families. While the target population is primarily native Alaskan children, the project includes all Medicaid-eligible children from birth to age six. The State Medicaid agency, the tribal health corporation in Nome, the State Head Start Association, and the State dental association have formed a coalition to work with the project. The project will attempt to generate data showing that village-based care is cost effective and will distribute a manual for providers and others seeking to set up similar networks. (OIG)

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Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

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Arizona

Reports

Arizona Department of Health Services, Office of Oral Health, *Arizona's Early Childhood Caries Dental Survey 1993-1995*; Arizona
a Department of Health Services

Office of Oral Health, *AHCCCS Dental Survey -- Part II Arizona Dentists* (May 1994)

Between 1994 and 1995, a total of 5,171 children aged five months to four years were surveyed at Head Start and WIC programs, health fairs, and day care centers from a representative selection of Arizona communities with populations of more than 1,000. Of the 994 one-year-old children examined, 6.4 percent had caries, with a mean decayed, missing, and filled permanent teeth (dmft) of 0.18 or 2.8 decayed teeth per affected child. Nearly 25 percent of the two-year-olds had caries, with a mean dmft of 0.70, or 2.8 decayed teeth per affected child. Thirty-five percent of the three-year-olds and 49 percent of the four-year-olds had caries, with a mean dmft of 1.35 and 2.36 or 3.7 and 4.8 decayed teeth affected per child, respectively.

Children of caretakers reporting the lowest education category had three times the decay

experience of those caretakers reporting the highest education category. Similarly, children of caretakers reporting the lowest income category had four times the decay experience of those with caretakers reporting the highest category. Little dental treatment was present in children under age three. Independent of socioeconomic factors, the majority of children with caries in each age group had no evidence of dental treatment.

Because such young children have high dental treatment needs, it is clear that timing of diagnostic examinations and prevention strategies for preschool children needs to be reconsidered, especially for children identified as high caries risk. The lack of dental treatment for preschoolers may be due to failure to recognize caries prevalence in preschool children, inadequate recommendations from health care organizations, or unwillingness and inability of dentists to provide care for very young children.

In a 1994 survey, Arizona dentists reported problems with the Medicaid program including low fees, poor administration, difficult patient management, compromised standards of care, and "never got paid for treatment provided." Over half of the dentists said that they would be willing to provide dental services to Medicaid patients if program changes were made. (CHDP)

Legislation

HB 2520 (held in House committee): Gives the right to choose any professionally recognized dental restorative material and to replace that material. (CPA)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Prior authorization requirements were eliminated to streamline claims processing. (OIG)

Initiatives/Projects

Arizona Health Care Foundation (AHCF) sponsored a daylong program entitled, *Dental Care of Arizona's Seniors*, in September 1999. AHCF is a statewide, nonprofit, educational and charitable organization committed to enhancing the lives of needy elderly residents in Arizona nursing homes and assisted living facilities. (CHDP)

Title V Agency

Title V funds 36.1 percent of the activities of the Arizona Office of Oral Health. The Office of Oral Health has four primary areas of focus: (1) consultation and collaboration with various government agencies and private organizations. Services include developing oral health care standards, policies and systems; assessing oral health status; defining program coverage; conducting quality assurance reviews; and evaluating program provider/client needs; (2) professional development and training to dental and other health providers including students in health-related professions. Services include sponsoring conferences and conducting workshops, as well as providing periodic communications to health professionals on dental and other public health issues; (3) preventive dental services to indigent school-age children and other high-risk/special need groups at schools, community health fairs, and other settings. Services include dental sealant placement, fluoride mouth rinse, dental screens, oral health education, intervention programs and community promotional activities; and 4) preventive and basic dental treatment to special needs populations. Services include using mobile trailers and equipment to deliver treatment in needy areas and to support communities/agencies in setting up a dental system of care. The Arizona Office of Oral Health is also the dental consultant for the following state programs and agencies: Medicaid, Children's Rehabilitative Services, Comprehensive Medical and Dental Program (foster care), and Developmentally Disabled, which receives funding from the federal Developmental Disabilities Act. (AMCHP)

References

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available at:

<http://www.childent.org/StateSurveys/statesurveys.htm>.

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

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Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

Arkansas

Legislation

HB 2118 establishes patient choice in dental providers. (CPA)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Update from Lynn Douglas Mouden, DDS, MPH, Director, Office of Oral Health, Arkansas Department of Health (6/19/01)

In 2000, the Office of Oral Health completed the first-ever statewide oral health needs assessment survey. The random sample survey, replicated in 2001, the survey continues to show a high level of dental caries among third-grade children surveyed. Indicators of poor oral health in these students include a mean DMF (decayed, missing or filled teeth) of 2.9, a caries experience rate of 71% and untreated caries rate of 38%. These indicators are reflected in the fact that Arkansas has only 58% of its citizens enjoying the benefits of community water fluoridation and the children screened showed a dental sealant rate of only 21%.

A similar study was conducted with 3000 socio-economically disadvantaged students in the Little Rock School District in February 2001. Those results showed a DMF rate of 2.34 in a community that has been fluoridated since 1951. The high caries rate, even with the protection of fluoridation, is highlighted by the lack of access to oral health care as exhibited by the abysmal sealant rate of less than 2%.

Arkansas disparities in oral health are further exemplified by those adults 65 and over who are edentulous. Data from the BRFSS show that 30% of those older adults have lost all their permanent teeth. However, in those individuals with less than 12 years of education, the rate is 47%. With less than \$15,000 annual income, edentulism rises to 53%. Blacks have an edentulism rate of 38% as compared to only 28% of whites.

Legislation

HB 1563, passed and signed by the Governor as Act 785, mandates the Office of Oral Health within the Arkansas Department of Health and requires that it be headed by an experienced public health dentist licensed by the Arkansas State Board of Dental Examiners. SB 75, passed and signed by the Governor as Act 439, redefines the practice of dental hygiene and allows the Arkansas Board of Dental Examiners to determine the appropriate levels of supervision for various duties of dental hygiene.

Initiatives

The Delta Oral Health Initiative is pursuing funding through the Delta Regional Authority to increase access to dental services in the 42-county Mississippi River Delta of Arkansas. The initiative is a public-private coalition involving dental public health, social services, organized dentistry and dental hygiene, minority health, and local stakeholders. The Dental Health Action Team is committed to improving oral health, and reducing disparities in oral health outcomes, in the Little Rock School District. To that end, the Team completed a screening of 3000 low-income children in the school district and Head Start centers. Following that effort, the team prepares for a dental sealant project in early 2002. The Dental Health Action Team is composed of dental public health, Medicaid, two universities, and private dentists and dental hygienists in the Little Rock area.

California

Reports

California Department of Health Services Maternal and Child Health, *Beyond Brushing and Braces* (Sept. 1995); A. Watahara, L.O. Murphy, B.E. Isman (California Dept. of Health and Human Services Maternal and Child Health), *The Oral Health of California's Children -- A Neglected Epidemic California Oral Health Needs Assessment of Children, 1993-94* T

Between 1993-94 a series of dental needs assessments was conducted on 6,793 California

children from ten geographic areas. Three different age groups were assessed -- preschool, elementary school and high school children. Fourteen percent of all preschool children had Early Childhood Caries (ECC). Remarkably, only 0.4 percent of white, non-Head Start preschool children in fluoridated urban areas demonstrated Early Childhood Caries. Caries prevalence in the entire preschool population also showed racial disparities. Thirty-one percent of all preschool children had dental caries, with 79 percent of Asian Head Start children and 56 percent of Hispanic children affected. Asian preschool children had an average of 4.5 teeth affected, while Hispanic children had 2.3 affected teeth. Of those preschool children attending Head Start programs, 47 percent were found to have urgent needs, defined as extensive tooth decay, pain, or infection. (CDHP)

Legislation

SB 1259, Inactive: Health care service plans would cover dental services that are legally performed by a dental hygienist. (CPA)

SB 292, Inactive: Included insurance coverage for a second opinion and allows a participating dentist to represent a patient in a grievance process. (CPA)

A 1065, Active but Amended to Delete the Following Provision: Funding for research on dental care access by establishing a Children's Dental Care pilot project in three counties. The pilot will examine the cost-effectiveness of providing pediatric dental care services. (CPA)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Initiatives/Projects

In 1990, following litigation (Clark v. Kizer), dental reimbursement rates were increased to 80% UCR, with a cost of living adjustment, a separate dental claims processing unit was established to streamline payment, and a toll free telephone referral services was initiated to provide referrals to beneficiaries. According to Dr. Robert Isman, consultant to the California dental program, when the suit was filed in 1987, only about 30 percent of Medicaid beneficiaries used services; by 1998, 46% of beneficiaries used services.

In 1990, Contra Costa County dental society and EPSDT staff began a "share-the-care" project. Participating dentists agreed to take one to three new Medicaid cases yearly or quarterly. County EPSDT staff made the referrals and ensured that participating dentists receive no more patients than they agreed to. County staff provide education and outreach to insure that patients keep their appointments. Staff schedule initial appointments and provide transportation and translation, if needed. They instruct families about proper hygiene and behavior in the dentist's office and strive to overcome any fear of dentists on the part of children or their parents. The Contra Costa program says it has an 85 percent "kept-appointment" rate. County staff and the dental association continue to support the Contra Costa program. Similar programs have been established in other counties in California and in other States, such as Colorado and Wisconsin. (OIG)

BrightSmiles, a funding partnership to facilitate an expansion of dental health programs and services in Northern California, recently announced an expansion of its funding region to include 32 counties in Northern California. (SHF)

California Dental Access Program: Beginning in 1992, the California EPSDT program conducted a statewide dental access improvement program which resulted in 40 county volunteer dental coalitions and distribution of dental access resource manuals. The project held nine regional workshops which were attended by more than 700 individuals representing private practice dentists, local public health programs, community clinics, professional organizations, universities and others concerned about children's oral health issues. Community dental providers were introduced to their county EPSDT program, Head Start, and other local children's programs. Local coalitions developed specific strategies and activities for improving access to dental care in their respective communities. The most widespread strategy has been the establishment of volunteer share-the-care programs similar to those started in Contra Costa and other counties. Some coalitions have become involved with preventive strategies including baby bottle tooth decay, community water fluoridation campaigns, and the planning of community health fairs. (OIG)

References

National Health Law Program (NHeLP). Available at: <http://www.healthlaw.org>

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available at: <http://www.childent.org/StateSurveys/statesurveys.htm>.

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Colorado

Reports

Colorado Department of Public Health and Environment, *The Oral Health of Coloradans* (1994)

In 1994, data on 1,342 representative children were collected revealing that 31 percent of children 17 years old or younger had one or more decayed permanent teeth, lower than the comparable national figure. In 20 counties there was no dental Medicaid provider.

In 1993-94 there were over 210,000 children under the age of 21 eligible for Medicaid dental services, of which 24 percent received a dental service. In 1995 there were only 232 participating dental Medicaid providers. If Medicaid eligible children were evenly distributed over the number of participating dentists, each dentist would need to see over 900 children, four times the number that did receive care. Because there was essentially no access to dental care in many parts of the state, the primary patient concern was travel to reach a provider. Oral health screenings in conjunction with vision and hearing screenings were suggested to help improve services for those children without access to dental care. (CDHP)

Initiatives/Projects

National Center for Farmworker Health, funded by the federal Migrant Health Program, serves the dental needs of children of migrant farm workers. Available at:
<http://www.ncfh.org/catalog.htm>.

Efforts similar to California's "share-the-care" program have been implemented to encourage more dentists to take Medicaid patients. (OIG)

Community-Based Initiative: Denver's Howard Dental Center provides dental services to men, women and children infected with HIV/AIDS who are medically indigent or who have low incomes. (HD)

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<http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

Howard Dental (HD). Available at: <http://www.howarddental.org>

Connecticut

Legislation

1994-Increased dental reimbursement rates from 35% to 80% UCR. (Pediatric Dentistry)

SB 281 passed: Appropriates \$560,000 to provide funding to community dental clinics and school-based dental clinics for the purpose of providing dental services to the uninsured. (CPA)

SB 942 passed: Permits hygienists to practice without the oversight of a dentist under certain circumstances. (CPA)

Reports

Children's Health Council *Utilization of Preventive Dental Services by Children Enrolled in Medicaid Managed Care, 1996-97;* Connecticut State Department of Health, *Present and Projected Dental Providers Participation in the Connecticut Medicaid Managed Care Program: Impact on Dental Care Access* (1997)

In December 1994 the Connecticut Department of Social Services, with a lawsuit pending, raised reimbursement fees to 60 percent of UCR for restorative fees and 80 percent for preventive fees. However, before the change in access due to improved rates could be assessed, Connecticut transferred the management of Medicaid to managed care. Access further deteriorated under the private market because of concerns about low capitation rates, lack of information to providers, confusion regarding the new system and health plans' initial reluctance to conduct outreach initiatives.

Currently there appears to be a serious deficiency in the numbers of dental providers. Participating providers limit the number of Medicaid patients they see. Recent surveys show that besides the recurrent issue of reimbursement rates, providers are concerned about paperwork and are dissatisfied with the patient population because of non-compliance and missed appointments.

Analyses show that dental access is actually worse than utilization data suggest. Analysis-by-procedure for 1996-97 claims reveals that the average number of restorative procedures was only 0.3 per child, far fewer than unmet treatment needs suggest are necessary. Although many children are seeing a provider for the basic EPSDT evaluations and cleaning, few are actually having a second or third visit to take care of necessary restorative care. (CHDP)

Initiatives/Projects

In 1997, Connecticut lawmakers established a pilot program (P.A. 97-239) to increase access to preventive dental care, particularly for children receiving Medicaid, by allowing dental hygienists in public health settings to provide cleaning, fluoride, sealants and oral screening exams without the direct supervision of a dentist. In 1999, this program was made permanent. According to Judith Solomon, executive director of the Children's Health Council, access to dental care in Hartford is better than the rest of the state and other comparable cities. Solomon attributes this to the city's strong system of school-based dental services; the school district actually employs the dentists and hygienists. Hartford also has a community clinic that provides dental services with the assistance of professors and students from the local dental school. She also states that children receiving preventive services are more likely to receive additional corrective treatment for dental disease. (NCSL)

Title V Agency

The Oral Health Program in the Family Health Division is dedicated to meeting the oral health objectives of Healthy People 2000. Its highest priority is the enhancement of access and availability to quality dental care for underserved children. This work is supported by a federal HRSA/MCHB CISS grant, "Connecticut Community Oral Health Systems Development Project." Other program activities include: baby bottle tooth decay prevention, school-based dental clinics, tobacco use cessation, child abuse recognition and reporting, fluoridation surveillance, oral-facial anomalies registry and referral and a dental care providers directory. In 1998, the program completed a comprehensive survey and report of: (1) Dental Provider Access and Availability under the Connecticut Medicaid managed care program; (2) Dental Care Availability, Utilization, Capacity and Needs through Community-based Health Care Facilities; and (3) Oral Health Status and Needs Assessment of six to eight-year olds. Title V pays for the salary of the state oral health director which is the total funding for the state's Oral Health Program. (AMCHP)

References

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National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

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Delaware

Legislation

SB 73 passed: Accepts out-of-state licenses and/or clinical board examinations of dental providers, including dentists and dental hygienists. (CPA)

Initiatives/Projects

State-operated clinics serve all Medicaid beneficiaries. (OIG)

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

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Florida

Legislation

HB 2145 (status unknown) - Earmarked \$14.6 million for Healthy Kids Dental services. This benefit is available only to counties that provide or commit local match in excess of \$4,000

HB 1615 (Died, April 1999)- would have required each HMO to create a review process that includes an informal and formal internal appeal process and an external appeal process where an independent utilization review organization is utilized and would have provided freedom of choice for dental patients and others. (Florida Leg.)

Electronic billing set up to streamline claims processing. (OIG)

Programs/Initiatives

In 1999, the Florida Dental Association implemented, *Project: Dentists Care*, which give residents of certain counties access to volunteer dentists. The Dental Association developed a brochure to advertise the project. (AS)

References

Florida Legislature Website. Available at: <http://www.leg.state.fl.us>

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

Communication with Anne Swerlick, Florida Legal Services (Oct. 2000). (AS)

Georgia

Legislation

Legislation providing state tax credits to dentists and other providers who agree to serve poor children was passed in 1996. (OIG)

HB 634 passed: Increases educational options and qualifications for licenses for dental professionals, including hygienists and assistants. (CPA)

Legislation enacted to provide for anesthesia coverage. (CPA)

References

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

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Hawaii

Legislation

SB 157 passed: Appropriates funds to the Department of Health and Human Services and community health centers to provide preventive dental services for adults. (CPA)

HB 2156 passed: Appropriates funds to provide basic dental services for indigent adults. (CPA)

HB 1598 establishes patient choice in dental providers, permitting dental patients to authorize direct payment of their claims to their dentists, whether part of their insurance plan or not. (CPA)

Reports

M.H.K. Greer, Hawaii State Department of Health, Dental Health Division, *Statewide Oral Health Assessment Survey of Public School Children in Hawaii*

A 1989 dental survey of 30,582 children between ages six and eight revealed that 72 percent had one or more dental lesions. The proportion of children with one or more dental carious lesions was 72 percent. Children of Filipino, Southeast Asian, Native Hawaiian, and Other Pacific Islanders had the highest prevalence -- all over 80 percent. Thirty-six percent of the Hawaiian six-to-eight year olds had untreated disease. Those children from the Far East and Pacific Islands had the greatest proportion of untreated caries, between 44 and 61 percent.

Five-year-old children were also surveyed for Baby Bottle Tooth Decay (BBTD), defined as three or more decayed anterior maxillary teeth. Of the 8,593 children examined, the proportion of children with BBTD was 16 percent, with 36 percent of these children having unmet treatment needs. The prevalence of BBTD varied greatly among ethnic groups. Only 4 percent of Caucasians but 33 percent of children identified as Southeast Asian were affected, with an average of 6.8 and 1.5 decayed teeth respectively. (CHDP)

Initiatives/Projects

Community-Based Initiative: Kauai Dental Health Task Force created to provide a comprehensive countywide dental health program. (SHF)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

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Sierra Health Foundation (SHF). *Community Collaboration and Dental Health in the United States*; 2000. Available at: <http://www.sierrahealth.org>

Idaho

Legislation

SB 1265 passed: Appropriates \$2.2 million to increase dental reimbursements. (Idaho Leg.)

HB 781 passed: Allocates additional funding for the Idaho State Board of Dentistry. (CPA)

HB 753 passed: Allocates additional funding for Univ. of Idaho dental education programs.

Initiatives/Projects

Seal Idaho 2000, a plan proposed by the governor in January, is designed to give all second graders a free application of dental sealants. In cooperation with schools, communities, and public health groups, sealants will be provided free of charge by dentists and dental hygienists throughout the state.

Title V Agency

The state Oral Health Program has collaborated with other state programs and agencies, to funds the district health departments to conduct statewide school fluoride mouthrinse programs, dental health education and surveys/screenings.

An Idaho Oral Health Alliance includes state and local health departments, private and public dental insurers, health professional organizations, schools, educators and others. The alliance assisted in assuring that Medicaid dental reimbursement rates were increased effective July 1, 1999. Priority issues are to coordinate existing dental services and to increase early access to preventive and restorative dental care.

Through the WIC program, early childhood caries and baby bottle tooth decay education will reach 8,300 women and impact 27,000 infants and children.

Through participation in the Tobacco Free Idaho Alliance and collaboration with the State Tobacco Program, oral health is integrated with tobacco prevention and cessation efforts directed at youth.

The Oral Health Program has been working with the Idaho State Dental Association to increase communication, build support, and promote dental public health objectives. In partnership with the state dental association, data on basketball-related oral injuries is being collected, evidence-based dental care promoted, and a statewide sealant project is being developed.

In partnership with the state dental hygiene association and the state child protection agency, dentists, dental hygienists and dental and dental hygiene students will receive information on the extent of child abuse and neglect in Idaho and dental guidelines for recognizing and reporting abuse. (AMCHP)

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Illinois

Legislation

SR 80 passed: Establishes a task force to study feasibility of a loan forgiveness program. (CPA & Leg. Website)

SB 721 passed: Creates the Dental Care Patient Protection Act, managed by the Department of Insurance, to regulate dental managed care plans. The Act establishes requirements for

disclosure to enrollees and "credentialing and utilization review" standards. Rights include obtaining professional standards of practice, choice of provider, access to all information concerning his/her condition and proposed treatment, and privacy and confidentiality of records. (CPA)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Initiatives/Projects

State grant program to provide funds to communities for collaborative planning around oral health issues. The IFLOSS Coalition joins private and public advocates from across the state to raise awareness and work with legislative leaders and state agencies on oral health issues.

Illinois Statewide Dental Contract - Beginning in 1992, Illinois contracted for a fixed price with the Delta Dental Plan of Illinois to provide all EPSDT dental services statewide, including outreach, oral health education, screening, follow-up treatment, and tracking the children and families to assure they get the required services. Delta contacts all families who have children between the ages of 3 to 20 who have not been screened in the past year. Names and addresses are also provided to the local EPSDT offices for follow-up. Other outreach efforts include press releases, public service announcements, and messages about dental services targeted to specific communities. Delta will refer families to dentists and make appointments, if necessary, for the initial screening or follow-up treatment. Delta contracts with dentists, paying a fee based on the dentist's usual and customary charges. Delta also contracts with schools, health centers, and other clinics to make dentists available for group screenings and preventive services. A Delta manual specifies provider responsibilities and a protocol for screening in schools. The contract requires Delta to provide services to at least one-half of the EPSDT-eligible children in Illinois. Delta must assure that screening goals are met, screening results are recorded, and referrals for treatment are issued. The State conducts compliance reviews and fiscal audits. (OIG)

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Indiana

Legislation

1997: Increased reimbursement rates to 119% UCR for Medicaid dentists. (NCSL & Jefferson)

Legislation enacted to provide for anesthesia coverage. (CPA)

Indiana Dental Procedure Priorities (OIG) - In 1995, to retain participation of dentists in the EPSDT program, Indiana eliminated many adult dental services and reduced the number of children's procedures that will be reimbursed routinely. With the savings, the State increased fees for the remaining procedures which are the most important preventive and restorative services for children. These actions were based on discussions with and recommendations from the State dental association.

Initiatives/Projects

In early 1997, the Office of Medicaid Policy and Planning in Indiana formed a Dental Access

Working Committee to come up with recommendations to improve dentist participation in Medicaid. The Committee focused, early on, on organizational buy-in from the dental association, pediatric dental association, county health departments, state department of health and Medicaid, and the Indiana chapter of the American Academy of Pediatrics. The recommendations included: carving dental services out of managed care; an increase in reimbursement rates; reducing turnaround time for dental claim data entry and receipt of payment; removing prior authorization requirements for dental procedures; continuing the role of the dental advisory panel, and improving communications with dental providers concerning coverage policies, eligibility verification procedures, and common reasons for claims denials. Rates were increased by 119 percent, effective May 1, 1998. In 1999, about 20 percent more dentists participated in the program than the previous year. (Dr. Charles Poland III, DDS; NCSL)

Title V Agency

Title V funds help support the separate Oral Health Division of the Indiana State Department of Health by providing salaries for a dentist, dental hygienist, secretary, and field fluoride specialists. The Oral Health Program focuses on education and prevention with special emphasis on fluoridation. Indiana currently has 98.6 percent of the population served by over 700 municipal water systems receiving optimally fluoridated water. Title V also supports the division's community-based pit and fissure sealant program which was initiated in 1994, which targets low-income children who might not otherwise have access to dental care. The program's objectives include: (1) promoting the use of sealants throughout Indiana and working toward the national health objective of 50 percent of children having sealants by the year 2000; and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs. (AMCHP)

References

Dr. Charles Poland III, DDS, 7526 E. 82d St., Suite 125, Indianapolis, IN 46256.

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Iowa

Reports

P.C. Damiano, M.J. Kanellis, J.C. Willard, E.T. Momany, Public Policy Center and College of Dentistry, *A Report of the Iowa Title XIX Dental Program*, April 1996

During 1994, 14,889 Medicaid eligible children under age six were surveyed for dental disease and treatment costs. The overall average cost per child was \$129. The total cost for the 317 children who received dental care in a hospital setting was \$1,701 per case (inclusive of all dental admission costs, both medical and dental). The operating room-based dental care provided to those 2 percent of Medicaid eligible children under age six accounted for 29 percent of all payments for dental services.

Dentists' participation in Medicaid declined between 1992 and 1995, from 62 percent to 42 percent. The most important problems Iowa dentists indicated about the program were low fees, broken appointments, and patient noncompliance.

Suggestions regarding improving the program include increasing reimbursement levels and developing new methods to screen, educate, and refer children under age three. (CHDP)

Iowa has produced a monograph on children's dental examinations and is reviewing data to determine how many children under age one dentists actually examine. (OIG)

Legislation

H 1441: Amendment to increase reimbursement rates to 90% UCR withdrawn April 1999. (Iowa Leg.)

Initiatives/Projects

Task force was established to educate general dentists on pediatric dental issues and to assure that at least one dentist in each county is willing to examine year-old children. (OIG)

Iowa Pediatric Dental Education Program - Staff from State Medicaid and dental public health programs are collaborating with the pediatric dentistry department of the University of Iowa to

develop training programs for general practitioners. They plan to: (1) train dentists about pediatric dental issues, (2) determine how many dentists currently screen children under 3 years of age, and (3) produce a monograph about what should be included in a child's first dental exam. The State will establish panels of dentists who are willing to treat very young or disabled children. Iowa's EPSDT screening schedule specifies an initial screening at 12 months of age, but parents in many communities find that few dentists are willing to examine children that young. In addition, few dentists are willing to serve children with disabilities. The State has established a panel of dentists who are willing to treat disabled children and hopes to set up a similar panel of dentists who are willing to see children before their first birthday. Among other methods to improve access for this age group, the State will: (1) conduct a survey to find out how many children are screened before their first birthday, (2) assess dentists' attitudes about treating young children, and (3) locate dentists willing to staff Iowa's 25 child health clinics. (OIG)

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<http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

Kansas

Legislation

HB 2479, Died: Would have authorized loans for certain dental hygiene students. (Kansas Leg.)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Legislation enacted to provide for anesthesia coverage. (CPA)

References

Kansas Legislature. Available at: <http://www.ink.org/public/legislative/index.cgi>.

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Kentucky

Legislation

HB 267 pending: To raise rates to 75% UCR. (Kentucky Leg.)

An extra \$11 million was appropriated to the state Medicaid program to encourage more dentists to participate. (Lexington H-L)

Title V Agency

While the state Title V program does not administer the state's oral health program, the program supports a program to assure that all children in the state have access to fluoridated water in all communities or a fluoride rinsing solution for good oral health. (AMCHP)

References

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Louisiana

Legislation

Private Provider Payments total some \$2.27 billion. This amount is sufficient to restore the 7% rate cuts and some of the targeted cuts made in FY 1999-00. It also provides \$30.2 million for paying hospital cost settlements. Some \$9.4 million is appropriated for expanding LaCHIP (children's insurance) to include children from families with incomes up to 200% of Federal Poverty level (\$34,100 for a family of 4) beginning early in 2001. This expansion will provide coverage for an estimated 1,100 children who are on the MR/DD waiting list. Another \$9.1 million will fund a new waiver program for children under 19 who would meet TEFRA eligibility requirements. Some 500 to 800 children will be served in the first year. Other funded rate adjustments include nursing home and ICF/MR inflation, adult dentures and children's dental care, physicians, home health and ambulance transportation. Pharmacy is also funded, but will continue recent cuts to the retail drug cost reimbursement, which should not affect persons covered by Medicaid or LaCHIP. Available at:
<http://house.legis.state.la.us/session-high-2es.htm>

Initiatives/Projects

Louisiana Medicaid Task Force recommendations included the following:

Reversing the \$10 fee increase for Class 1 Deciduous Amalgam (procedure code 02110) and applying the revenue generated by this restoration to a rate increase for Stainless Steel Crown-Primary (02930).

Taking the \$1.6 million in unused funds for the Adult Denture Program and using it to raise reimbursement rates for dentures, partials and relines. (Dr. Robert Barsley will also investigate the possibility of slightly increasing the fees for repairs.)

Changing the reimbursement scale used in the LDA Dental Medicaid Program Position Paper from "85% of the BCBS-LA scale" to "85% of UCR" (basis to be determined later).

Sending an explanation of the Dental Medicaid Program Audit (i.e., talking points) to Dr. Eric Hovland for distribution to LSUSD students. - (LDA)

Title V Agency

The Title V oral health program has initiated the PANDA Program (Prevent Abuse and Neglect through Dental Awareness), providing training and materials to assist dentists and dental hygienists in recognizing child abuse and neglect and encouraging them to report suspected cases. (AMCHP)

Louisiana's oral health program currently is funded by Title V (60%) and the Preventive Health Block Grant (40%). The federal Health Resources and Services Administration detailed a U.S. Public Health Service Commissioned Corps Officer to reestablish the oral health program in 1995. The program is responsible for having conducted a comprehensive oral health needs assessment utilizing Medicaid Dental Claims Data, a statewide school nurse screening project, and a survey of general practice and pediatric dentists in the state. Secondary data from PRAMS, BRFSS and other sources were also utilized. The state dental director also reestablished the community water fluoridation program and initiated the PANDA program. (AMCHP)

References

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Louisiana Dental Association. Available at: <http://www.ladental.org/govbrief.htm>

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Maine

Legislation

As a result of litigation (*Spenser v. Concannon*), Medicaid provider reimbursement rates were increased. (NHeLP) There are reports that shortages of providers persist. (NCSL)

General Assembly passed Sec. 1-3. 22 MRSA §3174-U on March 9, 1999, to be effective September 1999. Department of Health Services will conduct an annual review of the adequacy of reimbursement rates for dental services for dentists who provide care for a disproportionate number of Medicaid beneficiaries and study the use of dental mobile vans to provide preventive care to underserved areas. The Finance Authority of Maine is to study the feasibility and costs of establishing a dental residency program. (Maine Leg.)

General Assembly passed MRSA § 3174-S, which increases access to comprehensive dental care for children under the Medicaid program so that services are received on a timely basis in the regions of the State in which they live, in accordance with this section. [RR 1997, c. 2, §§45 (a)-(d)]. Specific provisions of the law provide:

Increasing providers. The department shall work with a statewide dental association and dentists in the State to increase the number of providers of dental care and the number participating in the Medicaid program.

Goal. It is the goal of the Legislature that children enrolled in the Medicaid program in all regions of the State have the same access to dental care as children enrolled in private dental insurance programs.

Available at: <http://janus.state.me.us/legis/statutes/22/title22sec3174-S.html>

General Assembly passed § 12302, establishing the Maine Dental Education Loan Program. Under the program, a loan recipient who, upon conclusion of the recipient's professional education, including any fellowships, elects to serve as a practitioner of dental medicine in an underserved population area is forgiven 25% of the original outstanding indebtedness for each year of that practice.

Available at: <http://janus.state.me.us/legis/statutes/20-a/title20-asec12302.html>

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Initiatives/Projects

§ 3174-S establishes a telephone referral service. By April 1, 1998, the department shall establish a toll- free telephone referral service to provide individuals with information on dental services and assistance in accessing dental services. The telephone service must provide persons calling about dental services with oral notice of the availability of assistance in arranging for appointments for dental screening and necessary corrective treatment, transportation to dental appointments and other services necessary to ensure access.

Available at: <http://janus.state.me.us/legis/statutes/22/title22sec3174-S.html>

Title V Agency

The state's Oral Health Program, administered by the state Title V program, is utilizing oral health education programs and expanding services as well as data capability. An Oral Health Needs Assessment Task Force has been formed to critically evaluate current data sources, explore new options and assist with development of ongoing surveillance systems. (AMCHP)

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Maryland

Legislation

HB 1346 - Pending bill to increase reimbursement rate to 85% UCR by 2003. The rate would rise to 70% of UCR by 2001; 75% by 2002; and 85% by 2003. The bill received an unfavorable report in the Environmental Committee. Available at:
<http://mlis.state.md.us/2000rs/bills/hb/hb1346f.rtf>.

SB 672 waives educational requirements for a limited dentistry license. (CPA)**Reports**

M.L. Wagner, J.T. Rule, K. Quinlan, F.J. Hooper, Highsmith, University of Maryland and the Dept. of Health and Dental Hygiene, *Survey of the Oral Health Status of Maryland School Children*, 1994-95

A comprehensive, statewide dental survey of school-aged children was conducted during 1994-95. The survey targeted 3,500 children from kindergarten, third, sixth, ninth, and twelfth grades.

The study found that overall 60 percent of school-aged children have experienced dental caries, with an overall mean caries score of 2.3 DMFT/dmft. The mean caries score among five-year-olds was 1.9 teeth. The caries experience increases to 3.0 by the third grade and 3.1 among seventeen-year-olds.

With regard to the lack of treatment, 55 percent of the teeth having decay were untreated. The highest percentage of untreated decay, 75.4 percent was found in kindergarten children. National studies compare with an average of 21 percent untreated carious lesions. Children receiving Medicaid had 16 percent higher caries experience and 30 percent more untreated carious lesions than the state average. (CHDP)

Initiatives/Projects

Maryland Head Start Collaboration Project's Dental Initiative was initiated in 1993 to eliminate barriers to health care for Head Start children. To identify problems and develop statewide solutions, the project formed a coalition of representatives from public and private agencies. The project is part of the governor's office and, because of its location, project staff not only work closely with the Medicaid program but also have access to State policymakers. One of the project's early initiatives was to survey Head Start grantee staff. The survey found that 38 percent of grantees have difficulty obtaining dental care for their children. According to grantees, only about 12 percent of dentists in their areas accept Medicaid. As a result of the survey, the project is recommending early outreach and oral health education for parents and children. Recruiting dentists for Medicaid has been very difficult largely because the Maryland Medicaid program pays lower fees than almost any other State. The project will initiate a survey to clarify dentists' concerns about reimbursement and other issues. The survey will ask about dentists' problems with the claims process and about difficulties they may have in examining and treating young children. Staff will work with Medicaid, other State agencies, and dentists to determine appropriate solutions. The project will then undertake educational efforts to encourage more dentists to treat 3- and 4-year-olds. (OIG)

References

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<http://www.childent.org/StateSurveys/statesurveys.htm>.

Massachusetts

Legislation

In fiscal year 2001, the Legislature allocated \$19.4 million to increase the Medicaid rates for dental services by approximately 30%. Also allotted \$4.05 million to implement dental programs in nine community health centers in areas with limited access to dental care for the poor or uninsured. This funding will support the construction of dental units, the purchase of dental chairs, equipment and supplies, and the salaries of personnel. Also provided \$3.7 million to a dental care grant program. Communities serving high-risk, under-served populations, with a disproportionate number of non-English speaking residents, transportation barriers and a variety of other issues prohibitive to the provision of dental care would be eligible for the program. We also provide funding for upgrades at vocational high schools that provide dental services.

In addition, addressing the oral health needs of our developmentally disabled, we propose \$2 million for expansion of the Tufts Special Needs Dental Program, a partnership between Tufts, the Department of Public Health and the Department of Mental Retardation. (Mass. Leg. Executive Summary)

SB 591 pending: Establishes patient choice for health care coverage, including dental services. (Mass. Leg.)

1998 the Special Legislative Commission on Oral Health was initiated to investigate oral health status, community prevention programs, and access to dental care services for residents of Massachusetts. "The Oral Health Crisis In Massachusetts" report was completed in February 2000. (www.oralhealthcommission.homestead.com)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Title V Agency

The Title V program in Massachusetts works to obtain fluoridation of community water supplies, a school-based fluoride mouth rinse program, and dental disease prevention education. The fluoride rinse programs in 190 schools reach more than 40,000 students. The Office of Oral Health also maintains a clearinghouse of dental health education materials. The office also provides training and professional education to dentists and other dental health professionals, health educators, school administrators and boards of health. (AMCHP)

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Health Care for All; Greater Boston Legal Services

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Michigan

Legislation

HB 4802 died in committee: Tax credit to dentists of either \$5000 or the amount equal to uncompensated dental treatment of indigent individuals. (CPA & Leg. Website)

Initiatives/Projects

Michigan Projects to Improve Dental Access funded eight oral health outreach projects in 1994 as part of its "Healthy Kids" program. The projects include such initiatives as: utilizing mobile dental vans and portable equipment; establishing county dental clinics; coordinating efforts with schools regarding dental hygiene education; and improving data collection and dissemination. Michigan formed a statewide oral health coalition to help generate legislative support for these

projects and for other oral health improvement activities. (OIG)

Title V Agency

The state Title V program, Family and Community Health, oversees the Oral Health Program and contributes 33% of the program's budget. Forty-six local agencies, including local health departments, primary care centers, migrant health clinics, and Indian Health Services conduct public dental programs; 43 of these agencies provide direct clinical services and three refer to private dental offices. (AMCHP)

References

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Minnesota

Legislation

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

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

H 1121, S 1131 died in committee (1999 session): To provide grants to non-profit community dental clinics; permit dental hygienists to practice with limited supervision; increases reimbursement rate for dental services under Medicaid by 5% or by 20% to providers with "disproportionate share" of Medicaid patients. (CPA & Leg. Website)

HB 756 proposed to increase funding of current public dental services and/or clinics already established.

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Reports

Minnesota Dept. of Human Services issued "Dental Services Access Report" in 1999. Report was required by a 1998 law, Chapter 407, article 4, section 67(b) and by a 1997 law Chapter 203, article 4, section 71. (MDS)

Initiatives/Projects

Apple Tree, based in Minneapolis, provides services in community clinics that provide primary and preventive medical care to individuals and families with low and moderate incomes. Apple Tree also purchases mobile dental vehicles, expands existing clinics and purchases dental equipment to serve 24 northwestern Minnesota and metro counties. (AT)

Red River Region Community Dental Access Committee was created to discuss issues and possible solutions to dental access problems in the Fargo, ND and Moorhead, MN areas. The Committee is working to expand the capacity of the community health center, to develop a community system to improve access for low-income and special populations, and to ensure access to emergency dental services for all in the region. (RR)

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Apple Tree Dental Organization. (AT) Available at: <http://www.appletreedental.org>

Red River Region Community Dental Access Committee. (RR) Available at:
<http://www.med.und.nodak.edu/depts/rural/dental.rtf.htm>

Mississippi

Legislation

HB 1332 passed (1999) to increase reimbursement rate for dental services under Medicaid. (CPA) Effective July 1, 1999 the reimbursement rate was to be increased by 160% of the June 1999 rate. The Legislature stated its intent to encourage more dentists to participate in the Medicaid program. (Miss. Leg)

Legislation enacted to provide for anesthesia coverage. (CPA)

References

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Missouri

Legislation

2001 - SCS/SBS 46 & 47: (1) Allows physicians to administer the appropriate fluoride treatment to a child during an immunization visit. (2) The Bureau of Child Hygiene would issue educational literature on the importance of routine dental care for children. (3) The state would pay a portion of a student's dental school loans in exchange for his or her agreement to practice in a community in need. (4) A donated dental services program would be established to allow the department of health to contract with the Missouri Dental Board or other organizations to provide certain free dental services to needy, disabled elderly and medically-compromised individuals. (5) Dental hygienists would be allowed to practice in a public health setting to provide fluoride treatments, teeth cleaning, and sealants to children who are eligible for Medicaid without the supervision of a dentist. (6) Medicaid would reimburse dentists, dental hygienists, and pediatricians who provide the above services at 75% of the rural and customary rate. (CMC)

2000 -- Considered but not passed: (1) Legislation to allow dental hygienists to provide fluoride treatments, teeth cleaning, and sealants to children without supervision of a dentist and to allow physicians to administer the appropriate fluoride treatment to a child during an immunization visit and provides for donated services (SB 1027); (2) Legislation to establish a five member advisory commission for dental hygienists (HB 1413 and SB 815); (3) Legislation to allow dentists to access funds used for academic and financial support to serve in designated underserved areas (HB 1336); (4) Legislation to allow the department of health to contract with the Missouri Dental Board to establish a Donated Dental Services Program (HB 1947 and SB 974); (5) Legislation to require the University of Missouri to double the number of in-state students allowed to enter the dentistry school (HB 2048); (6) Legislation to authorize an income tax credit for dentists who provide dental services to Medicaid beneficiaries (HB 1317). (Missouri Leg.)

(1999) (Vetoed in part by Governor) -- Appropriated \$6.3 million to the Department of Social Services for a three-year phase-in of reimbursement levels to 75% (HB 11). (Missouri Leg.)

1999 -- General Assembly appropriated \$500,000 to launch an outreach program using mobile equipment to serve Medicaid-eligible children in rural, underserved areas.

HB 296 pending: To create a tax credit for dentists who provide services to Medicaid recipients. (CPA & Leg. Website)

Reports

2000 Dental Care Counts. Medicaid Dental Services in Decay: A Crisis for St. Louis Children report issued. Sponsored by Citizens for Missouri's Children. Eight issues were examined, including raising the reimbursement rate to 80% UCR. Other issues include:

Low Reimbursement Rates for Dental Care: Current fee-for-service Medicaid reimbursements average only 44 percent of usual, customary, and reasonable (UCR) charges.

Shortage of Dental Professionals:

In Missouri, there are 46 dentists per 100,000 total residents compared to the national rate of 60 dentists.

Low Provider Participation in MC+/Medicaid:

Missouri has 2,126 practicing dentists; only 8 percent actively serve MC+/Medicaid patients. Seventy-one percent of Missouri dentists do not take MC+/Medicaid patients at all.

Administrative Burdens: Complicated paper work, delays between the time dental services are rendered and the time MC+/Medicaid actually pays the claim, and frustration with the MC+/Medicaid toll-free number to check patient eligibility.

Broken Appointments: Thirty percent of Medicaid patients typically fail to keep appointments.

Problems with Managed Care: Only 15 percent of dentists in the managed care regions of Missouri report having a contract, and only half of the 15 percent are taking new patients.

Lack of EPSDT Compliance: The most current federal data shows only 22 percent of MC+/Medicaid-eligible Missouri children received preventive dental screenings in 1993.

Public Health: *Water Fluoridation* - Fluoridating water reduces dental caries by 26 percent. Currently, 3,250,000 Missouri citizens (75 percent) have the benefits of community water fluoridation.

Baby Bottle Tooth Decay - About 5-10 percent of infants and children develop baby bottle tooth decay. Medicaid pays \$100-\$900 million per year for operating room charges associated with the disease in addition to thousands of dollars in dental fees per case. (CMC)

Title V Agency

The Bureau of Dental Health receives 85 percent of its funding from Title V and supports the community fluoridation program, the sealant program, and bureau infrastructure. Program highlights include:

The bureau's Dental Sealant Program, utilizing private dentists under agreement with the local health department and contract dentists working in the St. Louis City schools, provides sealants for more than 5,700 children each year. Bureau staff also facilitate dental screens for school children with more than 42,000 children in 228 schools screened.

The Prevent Abuse and Neglect through Dental Awareness (PANDA) coalition, originally founded in Missouri, and now in place in 36 states, conducts training for health care professionals, teachers, day care workers, and others on the prevention of child abuse and neglect and other forms of family violence. Since the inception of the program in 1992, the reporting rate by dentists of suspected child abuse and neglect has risen 160 percent.

The bureau also sponsors the Mobile Dental Units Program, a cooperative effort with the ELKS' Benevolent Trust of Missouri, to provide comprehensive dental care for children with disabilities and children with special health care needs. Three 42-foot self-contained mobile units cover the entire state each year treating more the 2,100 children. (AMCHP)

References

Missouri Legislature. Available at: <http://www.moga.state.mo.us>

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>. Citizens for Missouri's Children. Report available at: <http://www.mokids.org>

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

Montana

Reports

Montana Department of Public Health and Human Services, *Montana Dental Needs Assessment Secondary Data*, August 1996

Aug

Of the 60,000 Children under the age of five, 19 percent live below the poverty level. Only 15 percent of the Medicaid-eligible preschool children received dental assessments through the EPSDT program. In the Head Start program, 35 percent needed dental treatment and of those who needed dental care, 65 percent completed care.

Montana's children between the ages of five and 17 appear to be healthier. Fifteen percent of

this age group lives below the poverty level. Fifty-five percent of the permanent teeth were caries-free in this age range. Notably, 69 percent of these children reportedly had visited a dentist in the past year. (CHDP)

References

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available:
<http://www.childent.org/StateSurveys/statesurveys.htm>.

Nebraska

Legislation

1998 increased its reimbursement rates from 54 to 80 percent UCR. A dramatic increase in participation occurred. "Increasing reimbursement rates is only one part of the solution. We want to go beyond the issue of money and in fact, fix the system," says Kim McFarland, the state's dental health director. (NCSL)

L 629 (Died): Allocates funds to facilitate the creation of a volunteer network of dentists ("Donated Dental Services" program). (Nebraska Leg)

Initiatives/Projects

University of Nebraska Medical Center College of Dentistry is taking several approaches to encourage students to consider rural practices and to enter specialties that are in short supply. (<http://www.omaha.com/Omaha>)

Nebraska is in the process of making several changes to its Medicaid dental services program, which will also affect SCHIP. The state is updating Medicaid's dental procedure manual for the first time in 30 years, according to Tom Bassett, executive director of the Nebraska Dental Association. The changes will add or subtract certain services based on clinical and pharmacological findings. The changes will also give more authority to participating dentists to make treatment decisions concerning their Medicaid patients and reduce the number of procedures that require preauthorization. (NCSL)

Title V Agency

Through the state's Dental Health Division, Title V purchases water fluoridation equipment when communities decide to implement such a system. Also, collaboration is provided with schools for fluoride mouthrinse in communities without fluoridated water. Dental sealant surveillance is also conducted. (AMCHP)

References

Nebraska Legislature. Available at: <http://www.unicam.state.ne.us/index.htm>

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Omaha World Herald Online. Available at: <http://www.omaha.com/Omaha>

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<http://www.amchp1.org/news/oralhealth.htm>.

Nevada

Legislation

SB 181 passed: Created new categories of dental and dental hygienist licenses to provide dental care in publicly funded settings. (CPA)

Stricter regulations were passed regarding the fluoridation of public water systems.

Due to legislative decisions, many local health clinics have been expanded to increase the availability of dental services to low-income clients. (OIG)

New Dental School at University of Nevada planned to receive Medicaid funding for teaching. Bill's sponsor hopes that the new school, which will open in 2001, will increase the number of dentists available to participate in the Medicaid and SCHIP programs. (NCSL)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

New Hampshire

Legislation

SB 134 Died: Increase Medicaid reimbursement rates for dental services to children to 80% UCR to take effect January 1, 2000. (CPA & Leg. Website)

SB 205, Died: To expand medical coverage to provide dental assistance for adults on Medicaid. (CPA & Leg. Website)

Reports

The Health, Human Services and Elderly Affairs Committee, *Access to Dental Care for Low-Income, Uninsured, and Under-Insured Persons in New Hampshire*, November, 1997

A 1997 New Hampshire dental study to address concerns raised by the Department of Health and Human Services found that 9 percent of New Hampshire residents are Medicaid beneficiaries and that only 27 percent of these beneficiaries accessed dental services, compared with 71 percent for the general population. The Medicaid program expended \$5 million for dental services, or 1 percent of the state's Medicaid budget.

Of interest was the finding that there were only a few dentists treating Medicaid children, but they were performing many procedures. In 1996, 2 percent of the New Hampshire dentists were seeing 37 percent of the Medicaid recipients. Surveys of dental providers suggest that cumbersome billing processes, poor compliance, and inadequate reimbursement levels are barriers for potential dental providers. The report also suggested that Medicaid is unique from other dental insurance programs, since it precludes all forms of co-payments typical of dental insurance, including balance billing, coinsurance, deductibles, and annual or lifetime limits. (CH DP)

Initiatives/Projects

July 21, 2000: Governor announced dental plan for the poor. The state-sponsored health insurance plan with Anthem Blue Cross and Blue Shield, Matthew Thornton Health Plan and Northeast Delta Dental, will provide dental care to 4,000 children under age 19 by Aug. 1, 2000. (<http://www.stateline.org>)

New Hampshire established the Access to Care Project in 1992 to increase public acceptance of Medicaid and EPSDT. The project is jointly sponsored by the State Medicaid program, the New Hampshire Alliance for Children, and the New Hampshire Pediatric Society. Funding is provided by the Jessie B. Cox Charitable Trust in Boston and matched with New Hampshire Medicaid funds. The project: (1) seeks support from the general public for increased children's services through outreach and education about EPSDT, (2) works to ensure that all eligible children have a primary care physician to serve as an oral health advocate for the child and family, and (3) explains EPSDT mandates and benefits to dentists and other health professionals and seeks to enroll them in Medicaid. (OIG)

In 1999, the state established a pilot program to allow hygienists practicing in a school setting to assume a broader scope of duties. The state reports that the pilot program children who were found to need a dentist's service had less difficulty getting an appointment because of the hygienist's relationship with the dentist. They are working on expanding the pilot statewide. (NCSL)

References

New Hampshire Legislature. Available at:
<http://www.gencourt.state.nh.us/ns/billstatus/quickbill.html>

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available:
<http://www.childent.org/StateSurveys/statesurveys.htm>.

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington, D.C.: United States Department of Health and Human Services; 1996. Available at:
<http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

New Jersey

Legislation

Legislation (SB 1492) (vetoed conditionally) creates a training program for dentists to meet special needs for persons with developmental disabilities. (NCSL)

A 1658 referred to committee: Allows covered persons with out-of network benefits in dental and health service corporations and dental plans to assign dental benefits to dentist of choice. (CPA)

Title V Agency

The program supports the Cavity Free Kids Program, a comprehensive program which includes daily classroom-based tooth brushing, staff training, parent education and dental screening, and referral and follow-up. Other oral health highlights include education activities for preschool and school-age children, and the school fluoride mouth rinse program. (AMCHP)

References

New Jersey Dental Association. Available at: <http://www.njda.org>

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

New Mexico

Legislation

HB 626 (Died): Appropriates \$200,000 to the governing board of San Juan College to establish a consortium of coordinated dental educational institutions to prepare graduates to serve as dental assistants, hygienists, or administrative aides. (NM Leg.)

HB 52 (Died): Appropriates funds for the support of dental services provided through the Rural Primary Health Care Act. (NM Leg.)

HB 265 permits hygienists to practice without the oversight of a dentist under certain circumstances. (NM Leg.)

Dental claims forms have been streamlined by adopting the ADA claims forms, and dentists have been supplied with the software for electronic claims processing. (OIG)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Due to legislative decisions, many local health clinics have been expanded to increase the availability of dental services to low-income clients. (OIG)

Initiatives/Projects

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

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington, D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

New Mexico Legislature. Available at: <http://legis.state.nm.us/lis/BillFinder.asp>.

New York

Legislation -- The following are bill considered in previous legislative sessions (status not verified)

A 4467: Eliminated the licensure requirement of citizenship or permanent residence for dentists.

A 5842: Provides dental coverage for retired state employees. (NCLS)

A 2970: Requires the State Univ. of New York hospitals to treat the dental needs of HIV/AIDS patients.

A 4352: Allows certain qualified dental hygienists to work with limited supervision. (NCLS)

The following are bills dealing with dental services for the 2001 session:

A1078 (in committee 2001): allows physician's assistants to perform dental services in a hospital under the supervision of a dentist.

S206 (in committee 2001): increases scope of practice for dental hygienists to allow provision of certain services without the supervision of a dentist.

Initiatives/Projects

Litigation (Dental Society of NY v. Pataki) settled in Spring 2000 was successful in raising reimbursement rates for dentists significantly. Available at:
<http://www.healthlaw.org/pubs/200011dentaldocket.htm>.

In 1994, Univ. of Rochester Eastman Dental Center partnered with local school districts, county health and social service agencies, N.Y. State Bureau of Dental Health, and the Rochester Primary Care Network to serve needy children in schools. (Roch. Prim. Care)

Title V Agency

The Bureau of Dental Health administers several programs that are 98% funded by title V, including:

The Dental Sealant Program provides oral health screenings and placement of sealants on selected children that meet program guidelines and refers children to immediate treatment when needed. Training of local professionals is provided to build the dental infrastructure; children, parents, and teachers receive dental health education.

The Preventive Dentistry for High-Risk and Underserved Children Program provides a point of entry for high-risk children into the dental delivery system.

Dental fluoride supplements are available to children in participating WIC, Child Health Clinic, school district or Head Start sites in fluoride- deficient areas of New York. (AMCHP)

References

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at:
<http://www.amchp1.org/news/oralhealth.htm>.

Rochester Primary Care Net. Available:
<http://www.hrsa.dhhs.gov/Newsroom/speeches/Rochester.htm>

North Carolina

Reports

The North Carolina Institute of Medicine Task Force on Dental Care Access Final Report was issued in 1999. Recommendations include increasing reimbursement rates to 80 percent of UCR; creating an outreach program to encourage dentists in private practice to participate in Medicaid; and improving communication between dentists, Medicaid and Medicaid clients with a dental advisory group. Several recommendations were crafted to increase the number of dentists and hygienists practicing in rural and underserved areas, including providing grants to communities to leverage private funds to establish community dental care facilities; establishing a foundation through the North Carolina Dental Society to help provide dental care in underserved areas; increasing the scope of practice for public health hygienists; studying the role of dental hygienists in preventive dental services; and creating a loan repayment and scholarship program for dentists practicing in underserved areas. Other recommendations include changing licensure laws by allowing licensure by credentialing; increasing the number of pediatric residencies available in the state; and increasing the training for dental professionals in providing services to kids with special health care needs. The Task Force also recommended funding a 10-year plan for prevention of oral disease in preschool age children. (NCSL)

Legislation

SB 1258 (in committee 1999-2000 session): To raise Medicaid reimbursement rates for dentists to 80% UCR. (NC Leg.)

HB 905 (postponed): Proposed additional dental benefits to those covered by the State Children's Health Insurance Program. (NC Leg.)

Legislation enacted to provide for anesthesia coverage.

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Initiatives/Projects

North Carolina is enabling local health departments and other clinics to contract with local dentists for EPSDT services. (OIG)

State worked with NCDS to establish use of ADA claims forms and electronic billing. (OIG)

Carolinas Mobile Dentistry program in Charlotte was started in 1997 and Access Dental Care in Greensboro was started in 2000. Both programs are affiliated with Apple Tree Dental Organization. A dental van program is also operating in Asheville-area schools to provide preventive care, sealants and dental education, and is operated from the Billy Graham Clinic. (Apple Tree)

The Moses Cone-Wesley Long Community Health Foundation has awarded a \$361,000 grant to Access Dental Care, a nonprofit sponsored by the North Carolina Dental Society and modeled after AppleTree Dental, a Minnesota-based nonprofit. Guilford County will be the first of nine North Carolina communities in which Access Dental Care will offer two dentists, a dental hygienist, and dental assistant to serve 20 nursing facilities, treating residents each month, providing 24-hour emergency coverage, and helping facility staff provide daily preventive oral hygiene. Partners in the project include the Piedmont Triad Area Agency on Aging, Guilford County Health Department, Guilford County Dental Society and Greensboro Area Health Education Center. Available at: <http://www.ncdental.org/gazette2.html>

Targeting Oral Health Promotion in a Minority Community Feasibility Study: This is the latest in a long succession of oral health studies conducted by Research Triangle Institute. It is a community-based oral health promotion intervention project targeted at the African-American community in Fayetteville, N.C. that includes working with the health department and dentist

and hygienist professions in private practice to develop a multifaceted oral health promotion strategies that include youth and parent oral health education, raising community awareness, and promoting pit and fissure sealant promotion. (www.rti.org/units/shsp/docs/pubhlth.cfm).

References

North Carolina Legislature. Available at: <http://www.ncga.state.nc.us>

Apple Tree Dental Organization. Available at: <http://www.appletreedental.org/FAQ.htm>

North Carolina Institute of Medicine. Report available at: <http://www.nciom.org>

Research Triangle Institute. Info available at: <http://www.rti.org>

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North Dakota

Legislation

Legislation enacted to provide for anesthesia coverage. (NCLS)

Reports

Holman, BL, *Access to Dental Care for Medicaid Patients in North Dakota*, January, 1992

In 1992 North Dakota Medicaid payments for dental care accounted for 2 percent of total Medicaid expenditures. All of the Head Start program health coordinators reported difficulty in accessing dental care for their children. Coordinators report that children on Medicaid are treated differently than other children.

A survey of North Dakota dentists in 1992 showed that over half of the dentists restrict Medicaid patients by limiting numbers of new patients, limiting appointments to patients of record, or by seeing only patients on an emergency basis. Reasons dentists report for limiting Medicaid patients include low fees, failure of patients to keep appointments, limited coverage of services, claim rejection, slow payments, and excessive paperwork. The majority of dentists stated that Medicaid covers 60 percent or less of their UCR, while their overhead expenses were in the 51-75 percent range. (CHDP)

Initiatives/Projects

Reimbursement levels for children's dental services were raised to equal the average fee charged by North Dakota's dentists. During FY 1998 an evaluation of the impact of a Medicaid fee increase showed only a very modest increase in provider participation. Focus groups with Medicaid clients found that the following barriers remain: an inability to find a dentist who would accept Medicaid, transportation, language and cultural barriers and a lack of understanding of their benefits and dental office procedures. A Medicaid task force was formed to develop strategies to improve access to dental care for this population. In addition, a special project called the Red River Valley Access Project is a local community effort of public, private and philanthropic groups working to develop strategies at the local level that will improve access to dental care and meet the needs of the community. (AMCHP)

State officials are encouraging more dentists to accept a fair share of Medicaid patients and may provide non-monetary public recognition through "exemplary service" awards. (OIG)

Project Will Show-targeted to increase Medicaid clients' awareness of their responsibilities regarding their child's dental care (status unknown).

Dental Association has developed a mentorship program in partnership with the National Health Service Corps SEARCH Program designed with the inclusion of a Dental Preceptor/Externship Program in underserved areas. (NDDA) (status unknown)

Fargo-Moorhead region of ND, Red River Region Community Dental Care Access Committee is working to expand the capacity of the community health center to improve access for low-income populations. (RR)

Title V Agency

North Dakota's Title V program contributes 56 percent of the state Oral Health Program budget.

A project initiating oral health in prenatal programs was initiated in October of 1997. The initiative focuses on education of prenatal providers and pregnant women about the importance of oral health care for pregnant women. (AMCHP)

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

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Community Healthcare Association. Available at: <http://www.communityhealthcare.net>

North Dakota Dental Association. Info available at: <http://www.nddental.com/>

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

Red River Region Community Dental Access Committee. (RR) Available at:
<http://www.med.und.nodak.edu/depts/rural/dental.rtf.htm>

Ohio

Reports

Ohio Department of Health, *The Oral Health of Ohioans, 1993, The Ohio Health Monograph Series*,
April 1995

Seventy-five percent of dental caries is concentrated in 17 percent of the Ohio children. Of the 28 percent of these children in need of dental care, half required immediate care due to large lesions, pain, or infection.

Although dental referral is mandated for children on Medicaid, 70 percent of the children did not receive any dental services. The average Ohio dental Medicaid expenditure was \$77 per child in 1993.

Approximately 16 percent of Ohio dentists were identified as Medicaid providers using the criteria of treating more than sixty patients per year. However, 63 percent of these providers report that they limit their treatment of Medicaid recipients in various ways. Inadequate reimbursement, difficult paperwork, slow payment, and broken appointments were the most common reasons that surveyed dentists offered for not accepting Medicaid patients. (CHDP)

Title V Agency

The Bureau of Oral Health Services in the Ohio Department of Health receives 83 percent of its funds from title V. The Bureau of Oral Health Services is organized into three sections, based on the following areas of focus:

The Oral Health Access Section administers OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services), a program funded with a combination of title V funds, state general revenue funds, and money from the Ohio Dental Association. OPTIONS links low-income, working poor, low-income seniors, and persons who are medically, mentally or physically challenged with volunteer dentists who have agreed to provide donated or discounted care in their offices. The Access Section provides technical assistance to communities interested in starting local dental care programs, including assistance in applying for federal designation as a dental health professional shortage area. Through a grant from the CDC, the Section is working with the state department of education to assess oral health activities in Ohio's highest risk schools.

The Oral Health Services Section provides grants, using title V funds, to 15 local agencies to provide dental sealants to children in schools that serve low-income families and to 7 local agencies to provide comprehensive dental services to high-risk children and/or women of childbearing age. The Services Section assists communities with water fluoridation efforts, providing technical assistance with water testing and administering a school-based fluoride mouth rinse program.

The Oral Health Consultation Section assists communities with local needs assessment and provides oral health training to staff of local programs such as Head Start, Child Health Clinics, WIC programs, and schools. The Consultation Section has also conducted an open mouth oral health screening of children in first, second and third grades with parental consent in 340 elementary schools in Ohio during the 1998-99 school year. (AMCHP)

References

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available:
<http://www.childent.org/StateSurveys/statesurveys.htm>.

Association of Maternal & Child Health Programs (AMCHP). Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs. Available at: <http://www.amchp1.org/news/oralhealth.htm>.

Oklahoma

Legislation

Legislation enacted to provide for anesthesia coverage. (NCLS)

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Oregon

Legislation

HB3123 passed: Accepts out-of-state licenses and/or clinical board examinations of dental providers, including dentists and dental hygienists. (CPA)

Reports

M.R. Skeels, D. Clark Health Division, Oregon Department of Human Resources, *1991-93 Oral Health Needs Assessment*

During 1991-92, dental screenings were conducted in selected Head Start and elementary schools throughout Oregon. A total of 788 Head Start children between the ages of three and five were examined. Forty-seven percent had a history of dental caries, with four percent needing urgent care because of pain or infection. Nineteen percent of these children were identified as having Early Childhood Caries. The highest prevalence of caries was found in Native American and Asian children.

The six-to-eight-year-olds in elementary school had a caries prevalence of 55 percent, with 2 percent of these children needing urgent dental care. Highest prevalence was also in the Native American and Asian children.

During 1992 only 12 percent of the Oregon dentists actively participated in Medicaid, defined as submitting more than fifty claims. (CHDP)

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available: <http://www.childent.org/StateSurveys/statesurveys.htm>.

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Pennsylvania

Legislation

SB 672 died in committee: Creates a donated dental services program through which volunteer dentists would provide comprehensive dental care for those in need or who are disabled, aged, or developmentally challenged. (NCLS)

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999.

Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Rhode Island

Legislation

1998 approved SB 2476 that allows dental hygienists with at least three years of clinical experience to perform dental screenings for children under the general supervision of a dentist. The law also requires the Department of Human Services to provide each community with a list containing the addresses and telephone numbers of dental practices that accept patients insured by Medicaid. The community and the Medicaid HMO are then responsible to provide the list to parents or guardians of children eligible for Medicaid. Rhode Island is also looking at the possibility of putting the Medicaid dental care program out for bid to a dental managed care organization.(NCLS).

Reports

Rhode Island Department of Human Services, *Assessment of Rhode Island's Medicaid Dental Services and Model for Increasing Access to Dental Care*
(June 1997)

In 1996, there were 148,489 individuals in Rhode Island covered by Medicaid and total expenditures were \$800 million. The percentage of total Medicaid expenditures directly related

to dental service was less than 1 percent.

Of 2,522 Head Start children who received dental examinations, 17 percent required dental care. Only 56 percent of children needing care received any treatment.

Surveys of Rhode Island dentists show 96 percent of respondents stating that Medicaid reimbursements are inadequate. Dentists indicate that the Medicaid no-show rate is as much as four times higher than the non-Medicaid population. Providers also say that paperwork issues are a deterrent for accepting new patients. Responding dentists also indicated that the complex medical and social issues of Medicaid recipients make them hesitant to see the covered children.

Besides few dental providers, individuals on Medicaid had other access issues. Seventy percent do not have their own vehicle; 40 percent of households do not have working phones; in approximately 20 percent English is not the primary language.

The dental "safety net" in Rhode Island consists of hospital-based, school-based, and community-based dental clinics. (CHDP)

Initiatives/Projects

Providence Smiles is privately funded by Robert Wood Johnson and the Rhode Island Foundations. *Providence Smiles* is a dental project run out of St. Joseph's Hospital which utilizes elementary school-based mobile dental teams to provide preventive and treatment services for children who are uninsured or who have no access to private dental care. (AMCHP)

References

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South Carolina

Legislation

In 1998, the South Carolina General Assembly adopted legislation (1998 HB4700) to encourage dentists to establish a "dental home" for Medicaid clients. The department is charged with establishing a program to accomplish this and to provide Medicaid clients with continuity of care, increase access to dental care services and ensure dentists' participation. Dentists agreeing to participate in this program and meeting the requirements receive an enhanced

reimbursement. (NCSL)

Effective January 1, 2000, fees were raised to the 75th percentile. South Carolina's Dental Health Coordinator reports the program is a model, with over 850 providers now in the program and an additional 40,500 unduplicated recipients served from January through September of 2000, when compared to the same time frame last year.

Initiatives/Projects

In partnership with UNC-CH Sheps Center for Health Services Research, the South Carolina Workforce Partnership project will employ utilization and other data to identify:

Rational dental service areas;

The number of oral health providers needed to effectively deliver services to all residents in South Carolina over the next ten years and to quantify the resulting under/over supply;

Barriers to producing and sustaining the optimal oral health work force; and

Recommendations to address predetermined barriers and a work plan to carry out recommendations. (SC Health Workforce Partnership)

References

Dr. Ray Lala, S.C Dental Health Coordinator.

South Carolina Health Workforce Partnership. Available at:
<http://bhpr.hrsa.gov/healthworkforce/partnership/southcarolina.htm>

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999.
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South Dakota

Legislation

H.B. 1135 passed to allow certain community-based primary health care organizations to provide publicly funded dental services. (CPA)

Legislation enacted to provide for anesthesia coverage. (CPA)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Tennessee

Legislation

HB 580 passed to increase educational options for dental professionals, including hygienists and assistants. (CPA)

SB 1376 expands the scope of duties for practical dental assistants to those of registered dental assistants and dental hygienists. (CPA)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

Texas

Legislation

Passed (H 3544) bill to establish a loan forgiveness program in which a portion of a recipient's loan may be forgiven in exchange for providing services in underserved areas-- May 1999 (CPA)

HB 1200pending: Allocates funding for research on dental care access. (NCLS)

Funding has been allocated for research and evaluation of dental plans, alternative payment mechanisms for dental care, and strategies and incentives for improving access to dental care for children and low-income populations. (CPA)

Initiatives/Projects

State Medicaid program has developed a series of videotapes for use by non-dental health workers who screen young children to better identify pediatric oral health problems. Video explains techniques for adequate oral screening, oral health counseling, and specific ways each child should be referred to a dentist if any decay or abnormality is found. (OIG)

Efforts similar to California's "share-the-care" program have been implemented to encourage more dentists to take more Medicaid patients. (OIG)

Title V Agency

The Division of Oral Health offers an education program titled Tattletooth II, A New Generation, designed to improve good oral hygiene habits among Texas school children, assist communities with fluoridation of their water supply systems, provide direct emergency dental care services for children of low income families, and provide pit and fissure sealants for children who qualify. Dental care services are provided in public health clinics, by private dentists in their offices and in mobile dental units. The mobile units serve counties where access to dental care services is limited. (AMCHP)

References

Center for Policy Alternatives (CPA). *State of the States: Overview of 1999 State Legislation on Access to Oral Health*. Washington D.C.; 1999. Available at: <http://www.stateaction.org/issues/healthcare/dental/legbrief.pdf>.

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Utah

Legislation

Legislation proposed in 1997 increased reimbursement on all covered services by 20% for participating providers who were willing to treat 100 or more individual Medicaid clients in a given year. (Status unknown)

Title V Agency

The Utah Department of Health's Title V staff conducted a statewide dental survey to document the decay rate in six to eight-year old children, as well as their sealant placement rate. (AMCHP)

References

Utah Legislature. Available at: <http://www.le.state.ut.us/>

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at:
<http://www.amchp1.org/news/oralhealth.htm>.

Vermont

Legislation

Increased funding for the Medicaid dental program by \$1.5 million in 1999 to increase reimbursement rates for participating dentists by 17 percent.(NCSL)

Initiatives/Projects

The state also allotted \$500,000 to be used for a competitive grant program. According to state dental director Tommy Ivey, \$400,000 of the grant money will be awarded on a competitive basis to dentists or clinics as incentives to change their existing business to improve their ability to serve Medicaid clients. A few of the dentists' proposals request money to train dental assistants to provide expanded services, which increases the capacity of the dentist to see more patients. The rest of the money may be used for retention and recruitment of dentists-a loan repayment program and out-of-state recruitment of dental students (Vermont has no dental schools). (NCSL)

References

National Conference of State Legislatures (NCSL). *SCHIP: Dental Care for Kids*; 1999. Available at: <http://www.ncsl.org/programs/health/CHIPDENT.htm>

Virginia

Legislation

HB 1023 allows volunteer dentists to obtain a restricted license to practice in free clinics. (CHDP)

HR 644pending: Allocates funding for research on dental care access. (CPA)

HB 1076, SB 489 (2000) passed: Establishes VA Dentist Loan Repayment Program, which provides for loan repayments in exchange for practicing in an underserved area for a given period of time. Available at: <http://legis.state.va.us/jchc/dentalbri.pdf>.

Reports

Availability of Dental Health Services - Virginia Medicaid Report

In 1993, there were 328,090 EPSDT-eligible children in Virginia of whom less than 20 percent received any preventive dental services. Inadequate reimbursement is the most commonly reported reason why dentists report not accepting Medicaid patients. The average reimbursement rate for Medicaid dental procedures is reported at approximately 44 percent of UCR; however, the average overhead of dental practices is estimated at 60-65 percent of fees. In addition to low reimbursement rates, dentists are dissatisfied with the complex Medicaid claims process, slow payments, arbitrary denials, and prior authorization requirements. Dentists also claim that Medicaid families sometimes create disruption in the waiting room by bringing a number of additional family members and are more likely to miss appointments.

The preschool population demonstrates a high incidence of Early Childhood Caries. Head Start programs report difficulty in obtaining dental services for children. Head Start children often are transported long distances to see a dentist. Access problems for the disabled population are similar. The majority of developmentally disabled beneficiaries do not receive regular dental care. (CDHP)

References

Children's Dental Health Project (CDHP). *State Surveys of Oral Health Needs and Dental Care Access for Children*. Available:
<http://www.childent.org/StateSurveys/statesurveys.htm>.

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Washington

Reports

Washington State Department of Health Community and Family Health, *Washington State Smile Survey: A Children's Oral Health Assessment Report* (Feb. 1996)

A state dental survey conducted between 1993-94 of preschool (six-to-eight-year-olds) and 15-year-olds showed that dental caries remain a significant health problem, especially for Hispanics, American Indians, and Asian children. With regard to Medicaid-eligible preschool children, 38 percent had a current or past history of dental caries. Of these 7 percent were in urgent need of care as evidenced by presence of pain or infection. Early Childhood Caries was found in 13 percent of the Medicaid-eligible children. Forty-six percent of children six-to-eight years old were found to have a current or past history of dental caries, with 2 percent requiring urgent care. Those children for whom English was a second language were more likely to have caries experience and rampant caries, defined as seven or more affected teeth. Only 19 percent of the second graders had at least one dental sealant. Fifty-seven percent of tenth graders had a current or past history of dental caries.

Suggestions for program improvements included: targeting communities where the need is the greatest; raising reimbursement rates for providing services to Medicaid-eligible clients; developing screening programs for children during the first year of life; and pilot innovative interventions to prevent caries in infants and young children. (CDHP)

Legislation

Anesthesia coverage introduced. (CPA)

Initiatives/Projects

Dentists who participate in the Medicaid program and provide care to children under age five receive enhanced payments. (NCSL)

Community Roots for Oral Health conference held and attended by members of 15 oral health coalitions to share solutions for improving dental health services for low-income children. (WDSF). The program works to improve access to dental prevention programs and dental services to all Washington state children who are not currently accessing these services.

(<http://www.childrensalliance.org/kidsteeth.htm>)

Washington Dental Service Foundation's Cavity Free Kids pilot program is operating in four counties in Washington. The program has been allocated \$1.5 million to prevent dental caries in children through education, improved access, and community development. Available at: http://www.ddpwa.com/oral_health/cavityfree.asp.

A Health Personnel Resource Plan was established to regulate the supply and distribution of dentists and other health personnel. (OIG)

A pilot project was created to train non-pediatric dentists about new pediatric dental screening and treatment techniques. (OIG)

Washington Oral Health Improvement Plan was adopted in 1993 to improve general health status in Washington through prevention and improved public health services capacity. The Plan seeks to ensure universal access to needed health services for all state residents. Oral health is a key component of the health improvement initiative. The oral health component emphasizes that lack of access to dental care is at crisis levels, especially for low income and Medicaid-eligible children. Because of the lack of early preventive care and family education, hospital emergency rooms are handling cases of baby bottle tooth decay with charges up to \$3000 per child. The Oral Health Improvement Plan has develop several strategies to address these problems. They include:

- programs to screen children in the first year of life,
- universal dental screening of school children
- increasing Medicaid dental fees,

- training non-dental medical professionals to recognize oral health problems,
- innovative interventions to prevent caries in infants and young children, and
- increasing families' willingness to see dentists by getting parents to understand that dental care is as important as medical care.

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

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

- screens and treat children

- provides family oral health education
- calculates the direct costs and cost savings derived from the preventive program
- studies factors that determine children's utilization of dental services
- determines if improved access changes parents attitudes so that they will visit dentists more frequently
- assesses the cost effectiveness of a new technique to provide fluoride varnish

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

childhood visits to the dentist, and works to minimize adverse personal behaviors, such as appointment failures. (OIG)

This program also trains pediatricians to deliver preventive dental services and it ties fluoride treatments to immunizations. A child enrolled in the program was 7.2 times as likely to have at least one dental visit than a child not enrolled. According to Dr. Peter Milgrom, private dentists will step forward to solve the problems that states have with dental care in Medicaid if the state (and other interested parties) helps them break the problem down into manageable pieces and if the dentists are treated fairly with respect to reimbursement rates. Although the project will cost the State an estimated \$3 million, project staff hope to demonstrate significant cost benefits. The project has submitted an application to the National Institute of Dental Research to fund a 4-year cost benefit and utilization study. (NCSL)

References

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<http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

West Virginia

Legislation

Randolph v. Weston settled when the state agreed not to reduce dental reimbursement rates. (www.healthlaw.org/pubs/200010dentaldocket.html)

Title V Agency

The Division of Infant, Child and Adolescent Health in the West Virginia Office of Maternal and Child Health (Title V) oversees children's dentistry services, which includes the sponsorship of a limited number of dental clinics that provide dental care to low income, non-Medicaid children. Title V also oversees the distribution of fluoride supplementation and provides public education and awareness of dental health issues, and distributes yearly a master listing of dentists who provide services to children served by Medicaid and Title V, as a vehicle for improving access. (AMCHP)

References

Association of Maternal & Child Health Programs (AMCHP). *Putting Teeth in Children's Oral Health Policy and Programs: The State Of Children's Oral Health And The Role Of State Title V Programs*. Available at:
<http://www.amchp1.org/news/oralhealth.htm>.

Wisconsin

Legislation

[Federal] US Representatives David Obey (D-WI) and Tom Barrett (D-WI), with the help of Senator Russ Feingold (D-WI), have introduced a bill to establish a program to provide grants to expand the availability of public health dentistry programs in medically underserved areas, health professional shortage areas, and other Federally-defined areas that lack primary dental services. (Complete text of proposed bill at: www.gao.gov/new.items/he00149.pdf)

Governor's State Budget Bill Act 27 (1997-98 legislature) increased reimbursement rate by 10

percent over two years.

Initiatives/Projects

Efforts similar to California's "share-the-care" program have been implemented to encourage more dentists to take more Medicaid patients. (OIG)

The Healthy Smiles for Wisconsin initiative is a program funded by the CDC to develop a statewide plan for improving children's oral health and to increase the use of school-based strategies for addressing dental access concerns. Available at:
<http://www.healthysmilesforwi.org>.

In 1993, the Wisconsin Dental Association, in cooperation with State Medicaid and dental public health staff, initiated Wisconsin Access and Utilization Initiatives to help dentists deal with problems such as no-show patients. To formulate recommendations, the dental association and the State formed a task force of Medicaid staff and dentists who provide EPSDT services. The task force interviewed dentists and their support staff and developed suggestions, including:

- mailing reminders to patients and following up with phone calls a day in advance

- requiring patients to call the office and confirm their appointment 24 hours in advance or their appointment will go to someone else

- explaining why keeping appointments is important

- setting aside a specific block of time or certain days for Medicaid patients and treating patients on a first-come, first-served basis during those times

- letting patients know where they can get help with transportation or child care so they can keep appointments.

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

The Wisconsin Partnership Program is a Medicaid managed care demonstration for individuals with disabilities funded by the Robert Wood Johnson Foundation. Partnership sites guarantee access to Medicaid enrollees. Every provider in the Partnership agrees to serve the physically disabled and frail elderly beneficiaries who are in the program. Beneficiaries are surveyed as part of the project. For example, as a result of comments, contracts were amended to provide that dentists will try to save teeth rather than pull them. At the four demonstration sites, utilization of dental services rose from 15 percent in June 1996 to 90 percent. Available at: <http://www.dhfs.state.wi.us/programs.htm>.

Wisconsin Fee Increases

In addition to general dental fee increases over the past few years, which have raised payments to approximately 61 percent of Statewide average charges, Wisconsin was paying a \$3.50 "bonus payment" for 20 dental procedures most frequently performed on children under 21.

Beginning in 1995, these additional payments have been folded into a further fee increase which applies only to claims for EPSDT services. These fees are now set at approximately 75 percent of average charges. (OIG)

References

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Community Catalyst, *Overcoming Problems with Dental Care for Medicaid Beneficiaries*, 8 States of Health 3-4 (Apr. 1998)

Office of Inspector General (OIG). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington, D.C.: United States Department of Health and Human Services; 1996. Available at: <http://www.hhs.gov/progorg/oei/reports/a10.pdf>.

1. Indicates source of the information. See resource listing.