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Dental Care for Medicaid- Enrolled Children

Tooth decay is one of the most common diseases among children in the United States. Numerous studies have shown that incidence of caries is highest among low-income children. Therefore, state Medicaid programs have a unique role in helping to stem this epidemic.

Many low-income children are eligible for dental coverage under Medicaid or the State Children's Health Insurance Program (SCHIP). Children's dental care is a required service under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, and it is a Medicaid-covered service in all states and territories. All but two states have included dental services in their SCHIP programs. Yet it is widely acknowledged among advocates, providers, and state and federal policymakers that many children enrolled in Medicaid and SCHIP are not receiving adequate dental services.

APHSA Survey on Access to Dental Care

In 1999, APHSA, under contract with the Health Care Financing Administration (HCFA), undertook a study of states' dental programs. The study was intended to provide an overview of states' Medicaid dental programs for children, with a particular focus on reimbursement and outreach. Surveys were sent to all 50 states and the District of Columbia. Forty-four responses were received. State respondents completed the survey with the understanding that the findings would be reported in the aggregate, and that no state-specific information would be shared. In certain sections of the report, however, there are references to outreach strategies in which states are identified by name. This information was gleaned from presentations at APHSA-sponsored conferences or from state outreach materials that are widely available.

Survey Methodology

The 1999 APHSA Survey on Access to Dental Care was divided into two parts. The first section was intended to elicit a general picture of states' current dental coverage for children. It asked about reimbursement rates for selected procedures, recent changes in reimbursement rates, dental coverage under SCHIP and managed care, and initiatives that states have undertaken to encourage appropriate client behavior. The second part of the survey focused on outreach. States were asked to describe

the outreach strategies they have used to increase access. They were also asked to rate the effectiveness of their outreach strategies and offer recommendations based on their experiences.

This report contains several tables that provide an “average rating” of specific outreach strategies. The rating represents the mean score, from one to five, that respondents gave in rating each tactic. It should be noted that the ratings represent the opinions of the individuals completing the survey, and should therefore be considered subjective. The ratings, while not necessarily ideal in judging overall effectiveness, can give the reader an idea of which outreach strategies are best when compared with one another.

It should also be noted that some respondents did not rate some outreach strategies even though they indicated that their state used those strategies. Nonresponses were not included when calculating the averages.

Access Barriers

There is very little disagreement among the survey respondents that there is a problem with access to dental care among Medicaid-enrolled children. Of the 44 Medicaid agencies who responded to the survey, 42 (96 percent) indicated that there was an access problem in their state.

When asked to list the major barriers to access in their state, responses included:

- low reimbursement to dental providers (45 percent of the respondents),
- an inadequate supply or poor distribution of dentists in the state (26 percent), and
- patient behavior, such as chronically missing appointments (12 percent).

Other common reasons for an access problem included:

- administrative hassles that deter dentists from participating in Medicaid; specifically, respondents indicated that dentists felt burdened by the Medicaid agencies' use of non-ADA codes and forms as well as prior approval requirements;
- a lack of commitment on the part of some Medicaid patients and their families to seek dental care and to follow through with treatment regimens; and
- an unwillingness on the part of dental providers to treat the Medicaid population or to compromise on reimbursement and other issues.

Recognizing dental access problems, state Medicaid officials have attempted to address the problem by altering reimbursement rates, creating or expanding outreach strategies, or reforming program requirements. The extent to which states have attempted to change their dental programs is detailed throughout the rest of this report.

Reimbursement Policy

Low reimbursement is one of the reasons many dentists are reluctant to treat Medicaid patients. State Medicaid program administrators acknowledge this fact and have been working with their state legislatures to raise reimbursement rates.

The movement to increase reimbursement rates in 1999 is part of a recent trend. When asked about the last time their states made a major change in dental reimbursement rates, 15 respondents indicated that their states raised rates in 1998, and an additional seven states raised rates in 1997. Two other states make small rate changes on a sporadic basis, according to their respondents.

Below is a table that contains the mean, median, and range of reimbursement rates in the 44 responding states for six common dental procedures performed on children in 1998. Some states reimburse separately for prophylaxis (cleaning) and fluoride treatments, as noted in the table.

Reimbursement Rates for Selected Dental Procedures, 1998				
<i>Procedure (ADA Code)</i>	<i>Mean Reimbursement</i>	<i>Median Reimbursement</i>	<i>Highest Rate</i>	<i>Lowest Rate</i>
Periodic Oral Exam (00120)	\$15.28	\$14.09	\$31.00	\$ 5.00
Prophylaxis & Fluoride (01201)	\$27.30	\$26.32	\$54.00	\$ 8.00
Prophylaxis	\$19.10	\$18.90	\$42.49	\$10.00
Fluoride	\$12.70	\$12.00	\$19.84	\$ 5.25
Sealant (01351)	\$16.90	\$16.00	\$30.50	\$ 3.00
One Surface Amalgam, Primary (02110)	\$30.91	\$29.50	\$69.00	\$11.00
Tooth Extraction (07110)	\$38.44	\$39.50	\$77.00	\$ 8.25
Bitewing X-Rays, 4 Films (00274)	\$17.81	\$16.90	\$35.00	\$ 5.00

When asked if their state was planning to increase dental reimbursement rates for procedures that affect children within calendar year 1999, 18 states (41 percent) responded affirmatively. One additional state planned an increase in 2000, while two others proposed a 1999 increase that had not been approved at the time of the survey.

Of the 41 states that planned to raise rates in 1999, 12 provided the new planned reimbursement rates for any given procedure. A summary of those states' reimbursement changes appears in the following table.

Changes in Reimbursement, 1998–99*			
<i>Procedure (ADA Code)</i>	<i>Mean Reimbursement (1998)</i>	<i>Mean Reimbursement (1999)</i>	<i>Percentage Change in 1999</i>
Periodic Oral Exam (00120)	\$14.12	\$17.54	24.2%
Prophylaxis & Fluoride (01201)	\$24.40	\$27.47	12.6%
Prophylaxis alone	\$19.02	\$25.84	35.9%
Fluoride alone	\$11.79	\$14.81	25.6%
Sealant (01351)	\$16.09	\$18.13	12.7%
One Surface Amalgam, Primary (02110)	\$29.60	\$36.85	24.5%
Tooth Extraction (07110)	\$34.99	\$47.08	34.5%
Bitewing X-Rays, 4 Films (00274)	\$16.65	\$21.18	27.2%
<i>* data for 12 states</i>			

The following table shows the new mean, median, and range of reimbursement rates for those states that raised their rates in 1999.

Reimbursement Rates for Selected Dental Procedures, 1999*				
Procedure (ADA Code)	Mean Reimbursement	Median Reimbursement	Highest Rate	Lowest Rate
Periodic Oral Exam (00120)	\$17.54	\$18.87	\$26.00	\$ 6.00
Prophylaxis & Fluoride (01201)	\$27.47	\$26.24	\$43.00	\$ 9.60
Prophylaxis Fluoride	\$25.84	\$28.00	\$31.00	\$18.50
Sealant (01351)	\$14.81	\$15.00	\$18.54	\$ 9.50
One Surface Amalgam, Primary (02110)	\$18.13	\$19.38	\$ 3.60	\$29.00
Tooth Extraction (07110)	\$36.85	\$39.78	\$13.60	\$55.00
Bitewing X-Rays, 4 Films (00274)	\$47.08	\$45.30	\$16.80	\$77.75
	\$21.18	\$21.88	\$10.30	\$34.50
* data for 12 states				

Twelve of the 44 states (27 percent) use or plan to use some type of formal system to keep their dental reimbursement rates current from year to year. One state annually negotiates with the state dental society to set rates for the coming year. Another state increases rates annually by 2 percent, but only if the state legislature authorizes the expenditure. A third state is developing a rate-review process that is tied to the American Dental Association's (ADA) annual fee survey.

Sixteen of the 44 responding states (36.4 percent) indicated that they use some type of fee incentive to encourage certain types of treatments or dentist participation. One other state is considering such an incentive. Some common examples used by the responding states include higher rates for preventive procedures, higher rates or lump-sum incentive payments for dentists who see a certain percentage of Medicaid patients, and special fees for treating patients with developmental disabilities or behavioral problems.

The most common targeted fee increases were for diagnostic, preventive, and restorative procedures. Two states indicated that they altered the reimbursement system by increasing fees only for children's procedures. Two other states increased fees for such commonly billed procedures as prophylaxis and sealants.

Thirty-seven states (84 percent) consulted provider groups either before or during the rate-setting process. Thirty-three of those states worked with the state dental association in setting the rates. Other groups some of the states worked with include the state academy of pediatric dentistry (three states) and the state dental school (two states).

To change its rates, Nebraska's Medicaid department worked with the dental community in a unique way. In 1998, representatives from the department met with a select group of providers to discuss changes in the fee schedule. The dentists brought in a fee schedule from a local preferred-provider organization (PPO) and, recognizing that the state could not raise rates on all dental services across the board, picked several services they wanted to be reimbursed at the PPO rate. The Medicaid department accepted their suggestion and raised rates for the selected procedures.

Nine states indicated that they were advised by a special dental task force or work group, which typically consisted of representatives from the dental community, the hygienists' community, the medical community, county health departments, and the Medicaid department. The North Carolina Department of Health and Human Services, at the request of the state legislature, convened a task force to evaluate and recommend strategies to increase dentists' participation in the Medicaid program and to improve the provision of preventive dental services to Medicaid patients. The task force was comprised of dentists and dental professionals, public health practitioners, physicians, and other interested citizens in the community. The task force met on four occasions and heard public comments on two of those occasions.

In the spring of 1999, the North Carolina Institute of Medicine task force released its findings in a 50-page report, which outlined the reasons for a dental access problem in the state and discussed numerous possible solutions. The report also detailed the financial appropriations and legislation that would be needed from the state legislature to fulfill the task force's recommendations. The state legislature authorized three of the task force's recommendations: expanding dental benefits under SCHIP, reimbursing for fluoride varnishes, and authorizing hygienists in public health clinics to provide certain dental services. The recommendation to raise dental reimbursement rates was not implemented, but the legislature may look at the issue again in 2000.

Managed Dental Care

Of the 44 states responding to the survey, 17 have at least some Medicaid-enrolled children in a dental managed care network or a medical managed care network that is responsible for dental care. Of the 17 states that indicated that they had dental managed care for children, 15 provided the percent of children in managed care. There appears to be a large dichotomy among the states in dental managed care enrollment. Of the 15 states that provided percentages, seven have less than 33 percent of their young Medicaid clients in managed care and six have at least 85 percent enrollment in managed care.

Only four states provided information concerning their dental capitation rates. Several other states indicated that their dental rate was tied into the overall capitation payment and it was impossible to separate the dental rate from that payment. All of the four states that responded to this question indicated that the dental capitation rates were in the range of \$5–\$10 per member, per month.

Working to Change Behavior

As discussed earlier, at least 12 percent of the survey respondents indicated that client behavior was a major barrier to dentist participation in state Medicaid programs. Eighteen states (41 percent) have undertaken special initiatives to reduce the problem of patients failing to keep dental appointments. Some of the states' strategies included:

- sending letters, postcards, or newsletters to clients reminding them of the importance of keeping dental appointments (seven states);
- relying on EPSDT case managers to inform patients of behavior standards expected in the dental community (six states);
- undertaking "care coordination" efforts in which caseworkers work with individual clients to make appointments, issue reminders, and follow-up with clients when they have missed an appointment (at least three states); and
- providing a toll-free hotline for dentists to call if a patient fails to show for an appointment; caseworkers follow-up with the client.

Several states have recognized the importance of outreach to young children, which can result in the early detection and prevention of caries, and can help to establish good oral hygiene habits in the first few years of life. Sixteen states (36 percent) have undertaken educational campaigns aimed at increasing dental visits for children under the age of five. Some of the outreach strategies included:

- direct mailings to families,
- education by Women, Infants and Children (WIC) providers on the importance of good oral health for babies,

- dental health screenings conducted in Head Start programs, and
- education packets provided to nondental providers.

Washington state's Access to Baby and Child Dentistry program is attempting to reduce the incidence of infant tooth decay through an innovative program. The state trains and pays dentists, physicians, and nurse practitioners to deliver fluoride varnishes to infants and toddlers. The inclusion of nondental providers in this program increases access among the youngest Medicaid clients.

The Role of Safety Net Providers

Federally qualified health centers, rural health centers, and hospitals often serve as safety net providers for dental care. According to the Health Resources and Services Administration's 1998 Uniform Data Set, 56 percent of the agency's community health grantees provide dental services. In 1998, community health centers saw a total of 1.2 million dental clients, approximately 33 percent of whom were Medicaid beneficiaries.

A majority of states responding to the survey indicated that they rely to some extent on safety net providers to address the dental needs of the children enrolled in Medicaid. When asked to specify the amount of reliance on safety net providers, 6 states (13.6 percent) indicated a great reliance, 25 states (56.8 percent) indicated some reliance, 12 states (27.3 percent) indicated little or no reliance, and 1 state did not answer.

The states that indicated a great amount of reliance on safety net providers tend to be in the South, in which there is a higher concentration of community health centers than in most other areas of the country.

Outreach to Children and Families

The majority of states are committed to reaching out to Medicaid-enrolled children and their families to educate them about their dental benefits and to assist them in seeking dental care. The most common tactic, used by 34 of the responding states (77 percent), is offering transportation services to dental clinics.

All the outreach strategies received similar scores on effectiveness. All strategies were rated between 2.87 and 3.28 on a five-point scale (see the table below). As noted earlier, the effectiveness ratings are reflections of individual respondents' opinions. Also, some respondents noted that they did not rate the strategies because their dental outreach began recently and it is too soon to provide an accurate assessment.

States' Outreach to Children and Families		
<i>Tactic</i>	<i>Number of States Using Tactic*</i>	<i>Average Rating**</i>
Signs/posters in public locations	15	2.87
Education efforts at Head Start or other child development centers	25	3.17
Training or providing materials to public health centers, dentists, pediatricians or other providers	27	3.28
Direct mailings to families	21	3.05
Transportation to dental providers	34	3.10
* Number of states using the tactic out of 44 respondents		
** Rating is on a scale of 1 to 5, with 5 being extremely effective		

States are employing a variety of other outreach strategies that were not listed in the survey. Some of the additional strategies included:

- “sealant projects” in elementary schools, in which hygienists travel to schools and put sealants on students’ teeth (two states);
- public service announcements on radio and television (three states);
- toll-free hotline to help families locate providers (five states); and
- telephone calls to remind patients they are due for an appointment (two states).

The survey asked respondents what advice they would offer to other states that are designing outreach campaigns for Medicaid-enrolled children and their families. The most common recommendations included:

- Maximize one-on-one contact between caseworkers and clients. This communication enhances the possibility that clients will seek care, keep appointments, and follow through with treatment regimens. Caseworkers can also assist clients in locating a dentist who accepts Medicaid patients.
- Emphasize outreach at the local level. Different communities respond to different messages. Public-private partnerships at the local level, especially with community service organizations, can facilitate this type of outreach.
- Target education to parents as well as children. Parents who value good dental care are far more likely to seek it for their children.
- Work with the dental community first to ensure that there is a capacity to meet dental needs before embarking on a large outreach initiative. Outreach is pointless unless those who are being targeted can actually access services.

Outreach to Providers

A key component of any state's effort to increase access to dental care is outreach to dental providers. Because there is such a low supply of Medicaid-participating dentists in most states, Medicaid programs must embark on aggressive campaigns to not only recruit dentists to participate in Medicaid, but also to keep them as participating providers each year.

The following table summarizes the survey results on outreach to dental providers. As the table shows, nearly all states have raised reimbursement rates and met with leaders in the dental community to increase provider participation in Medicaid. According to the average of the effectiveness ratings, meeting with leaders in the dental community is the most effective outreach strategy of those listed. As noted earlier, even though the ratings for these strategies are fairly close to one another, the ratings may be informative when comparing the strategies to one another.

States' Outreach to Dental Providers		
<i>Tactic</i>	<i>Number of States Using Tactic*</i>	<i>Average Rating**</i>
Direct mailings to providers	24	2.52
Meetings with leaders in the dental community	40	3.32
Increasing reimbursement rates	36	2.97
Provider training sessions	34	2.57
State commitment to educate beneficiaries on importance of keeping appointments and complying with treatment plans	17	2.50
Changes in prior authorization requirements/methods	32	2.90
* Number of states using the tactic out of 44 respondents		
** Rating is on a scale of 1 to 5, with 5 being extremely effective		

It is clear from the survey responses that most states are trying a multipronged approach to provider outreach that includes rate increases and other strategies. States also employ a variety of other outreach strategies not listed in the survey. Some of the strategies that were written in by respondents included:

- simplified contracting process;
- standardized credentialing tool;
- collaboration with state dental society to recruit dentists;
- simplified patient eligibility verification;
- one-on-one meetings between Medicaid staff and providers;
- “dental summit” involving key stakeholders such as providers, dental school representatives, consumers, and advocates; and
- adoption of fee incentives, such as bonuses for dentists who see a certain number of Medicaid patients.

Kansas has combined several of these strategies. When the Kansas Medicaid program increased its rates in 1997, it sent a letter with a new fee schedule to every dentist in the state. The letter read in part:

Over the past several years, the number of dentists providing treatment to children covered by Medicaid has decreased. With the recent rate increase, the adoption [by the Medicaid agency] of the uniform ADA claim form and ADA procedure codes, we hope to bring more dentists into the Medicaid program.

The letter also offered invitations for one-on-one informational visits in which dentists can speak to Medicaid representatives about participating in the program.

Vermont is another state using several strategies to encourage more provider participation. In July 1999, Vermont's Medicaid program increased its reimbursement rates to equal about 75 percent of the average customary fee dentists in the state charge. Its rates are now the second highest of all payers in the state (Blue Cross/Blue Shield is first). The state also allocated \$100,000 over two years to recruit and retain dentists to the Medicaid program and an additional \$400,000 for "regional dental initiatives," such as providing grants to providers who choose to see a certain number of Medicaid clients.

For many states, outreach to encourage provider participation is only part of their overall strategy. States must also work to retain those providers who participate in the Medicaid program. While there are fewer states adopting retention strategies than recruitment strategies, it is nonetheless an important component of a comprehensive outreach strategy for the majority of responding states.

The following table summarizes survey responses for five different outreach strategies aimed at retaining current providers in the Medicaid program. The two most popular techniques involve simplifying the claims system and offering a toll-free provider hotline. Although simplifying claims received an average rating on effectiveness, several respondents offered that this tactic is very important to any provider retention strategy. A crucial component of simplification is the adoption of standard ADA codes and billing forms that are used by most dental insurance companies.

States' Efforts to Retain Dental Providers		
<i>Tactic</i>	<i>Number of States Using Tactic*</i>	<i>Average Rating**</i>
Updates/articles in dental trade publications	12	2.82
Periodic surveys to assess provider satisfaction	18	2.73
Simplifying claims forms and claims submission process	31	2.96
Toll-free provider hotline	28	2.88
* Number of states using the tactic out of 44 respondents		
** Rating is on a scale of 1 to 5, with 5 being extremely effective		

Survey respondents added several outreach strategies, not listed in the survey, as being effective strategies in retaining dentists as Medicaid providers. These strategies included:

- creation of a simplified provider handbook,
- contract with local dental school to serve as liaison between Medicaid and provider community, and
- personal telephone calls from Medicaid personnel to dentists to thank them for their participation and solicit any concerns.

Only one state holds receptions or award ceremonies for dentists who have made significant contributions to the provision of dental care in the state. Several survey respondents noted that such events are not an effective outreach strategy because dentists do not want to be publicly recognized for fear of being inundated with new Medicaid patients seeking care.

Many respondents offered advice to other states designing outreach campaigns for providers. Some of the most common recommendations were:

- Involve provider groups at all stages of a dental reform initiative and follow their advice; if dentists feel they are part of the process they will be more likely to participate in the program.

- Raise reimbursement rates before undertaking any further outreach; this gives the impression that the state is serious about attracting dentists.
- Undertake a comprehensive public relations campaign that emphasizes personal contact with providers; most mailings (i.e., letters and brochures) and surveys do not make it past a dentist's front office staff. The Medicaid program should appear friendly, cooperative, and attentive to the dentists' concerns to overcome the bias that many providers may have against the program.
- If across-the-board rate increases are not possible, allow providers to express their preferences for where targeted increases should occur. This can be done through an advisory panel or task force that meets regularly with Medicaid staff.

State Children's Health Insurance Programs

Survey results show that the vast majority of states maintain the same levels of reimbursement under Medicaid and the SCHIP for the same dental services. When asked if the reimbursement rates were different between the two programs, 9 states (20.5 percent) said yes, 30 states (68.1 percent) said no, 3 states (6.8 percent) said the question was not applicable because they had not yet determined the rules in the SCHIP, 1 state (2.3 percent) did not know, and 1 state (2.3 percent) said their SCHIP does not include dental services.

The survey did not ask states with different rates to specify whether SCHIP reimbursement rates were higher or lower than rates for Medicaid.

When asked if the capitation rate for dental services in the SCHIP was equal to that for the Medicaid program, seven of the 15 states that have dental managed care programs indicated that the two rates were equal. The eight remaining states responded that the two rates were not equal. No state provided the SCHIP capitation rate, so there is no indication of how large the disparity is between Medicaid and SCHIP dental capitation rates, or if the SCHIP rate tends to be higher or lower than the Medicaid capitation rate.

Alleviating the Problem

This study shows that states recognize that there is a dental access problem and they have begun to implement an outreach campaign designed to alleviate this problem. For some states, dental outreach initiatives began in 1998 or 1999, and it is therefore difficult to assess the effective-

ness of many outreach strategies at this time. Further studies will be needed in coming years to more fully evaluate the success of dental outreach initiatives.

Several federal agencies are assisting states in their outreach and education programs. The Health Care Financing Administration and the Health Resources and Services Administration have undertaken a joint "Oral Health Initiative" to address the disparity in dental access among Medicaid-enrolled children. In the coming months, a technical advisory group, composed of state Medicaid and Title V officials, will work with HCFA, HRSA, and the provider community to formulate potential solutions to the access problem. In addition, the Surgeon General of the United States released a report in June 2000 that details the state of oral health in the nation, and the General Accounting Office is undertaking at least one study that examines dental access in the states.

The private sector is also taking a strong interest in oral health. The American Academy of Pediatric Dentistry (AAPD) has begun a project, titled "Filling Gaps: Integrating Service Systems to Improve Children's Access to Oral Health Care." The project will identify and develop "best practice" protocols and training materials that are designed to increase dental access and improve dental health for preschool-aged children. AAPD will work with federal and state governments as well as professional, business, and philanthropic organizations in this endeavor.

The recent focus on dental care at the state and federal levels, as well as in the private sector, will likely cause many states to invest even more time and resources into outreach initiatives. It is clear from the survey responses that raising reimbursement rates is not enough; states are committing to comprehensive outreach programs that encompass children, families, and the provider community. It is hoped that through this and other sources states can learn from each other's experiences as they move forward with program reforms and outreach initiatives.

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