

Innovative State Practices for Improving  
The Provision of Medicaid Dental Services:

**SUMMARY OF EIGHT STATE REPORTS:**  
(Alabama, Arizona, Maryland, Nebraska, North Carolina,  
Rhode Island, Texas and Virginia)

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## Executive Summary

Despite considerable progress in pediatric oral health care achieved in recent years, tooth decay remains one of the most preventable common chronic diseases of childhood. Tooth decay can cause significant pain, loss of school days and lead to infections and even death. While all children covered by Medicaid and the Children's Health Insurance Program (CHIP) have coverage for dental services, ensuring access to these services remains a concern. The Centers for Medicare & Medicaid Services (CMS) has been working in coordination with State and Federal partners as well as the dental provider community, children's advocates and others to improve access to pediatric dental care. All parties agree that more needs to be done. To maintain and accelerate access to oral health services, CMS has developed a national oral health strategy in order to provide focus and visibility to our efforts.

Through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid eligible individuals under the age of 21 are provided coverage for preventive and comprehensive health services. The benefit entitles eligible individuals to regular check-ups and all medically necessary health services in order to ensure that their health and developmental needs are met. The EPSDT benefit includes screenings, dental services, vision services, hearing services, and other services necessary to correct or improve health conditions discovered through screenings. The benefit consists of two mutually supportive, operational components which States and the Federal government are responsible for ensuring: the availability and accessibility of medically necessary health care and assisting Medicaid enrollees and their parents or guardians to effectively use the services. CMS is committed to improving pediatric dental care in the Medicaid program and ensuring the appropriate provision of medically necessary dental services to children.

As part of an ongoing effort to identify best practices and opportunities for improvement in children's Medicaid dental programs, CMS conducted eight State Medicaid dental program reviews between December and March of 2010, focused on practices and program innovations that have successfully increased dental utilization in these states. The eight States reviewed were Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia. The States were selected based on a CMS review of State data and external partners' identification of Medicaid dental programs with promising initiatives. All of the States selected had an average utilization rate for children of at least 37 percent, with the national average being 38 percent for fiscal year 2008.

This report highlights some of the innovations and initiatives found in these eight States including:

- Partnerships and collaborations among State partners and stakeholders;
- Collaboration with dental schools and loan repayment programs;
- Increased reimbursement;
- Simplifying administrative processes;
- Grant funding;
- Educating families;
- Targeting young children; and
- Dental home initiatives

## Background

In 2008, at Congressional request, CMS conducted on-site reviews of children's dental services in 16 States with dental utilization rates for children of less than 30 percent based on data from the EPSDT CMS 416 annual report. These reviews were performed to determine what efforts States have made to improve children's dental utilization in their State, and to make recommendations on additional actions States can take to increase utilization rates and ensure compliance with Federal Medicaid regulations. Results of these 16 reviews were presented to Congress in 2009 and are available on the CMS website.

As a follow-up to that effort, CMS conducted reviews of States that reported higher dental utilization rates. The States were selected based on a CMS review of State data and external partners' identification of Medicaid dental programs with promising initiatives in oral health. The review teams consisted of staff representing the CMS Regional Offices and the Baltimore Central Office. All interviews were held via telephone. Participants interviewed varied by State, but every review included interviews with State Medicaid representatives and a sample of at least four dental providers. Additional participants varied due to State specific dental initiatives or dental delivery systems and may have included staff from State Public Health Departments, State Dental Associations, or managed care organizations. The reports, which will be available on the CMS website, were used to create this summary.

All of the States selected had an average utilization rate for children of at least 37 percent, with the national average being 38 percent. Eight States were reviewed, and information from those reviews is available to States for the purpose of improving the overall delivery of dental services. The eight States reviewed were Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia. In addition, the delivery system used to furnish dental services varied by State with two States operating fee-for-service dental programs and one State operating its dental program through a managed care risk arrangement. The other five States have carved their dental programs out of their medical managed care programs. These States either pay dental providers on a fee-for-service basis or use an administrative services organization or dental benefits manager to administer the program and reimburse dental providers.

### **Innovative Practices**

The eight States selected to be reviewed shared some similar innovative activities. In addition, there were also State specific activities noted. These innovative activities are summarized below.

#### Partnership and Collaborations

Five of the States reviewed indicated that partnerships and collaborations with other State agencies, State legislatures, State dental associations, other provider groups, and other interested organizations were critical to moving forward with improvements to their dental programs. These collaborations took various forms. For example, Alabama and Virginia noted that establishing and maintaining a good relationship with their State dental association was

extremely valuable in moving forward changes in their dental programs. The Alabama Medicaid Agency collaborated with the Alabama Dental Association, among other partners, as part of the 1<sup>st</sup> Look Program which is designed to reduce early childhood caries by encouraging involvement of primary care providers in a child's oral health care including referral to a dental home by age one. In addition, the State of Virginia and the Virginia Dental Association have worked to outreach to dental providers to increase provider enrollment rates. States such as North Carolina, Rhode Island and Texas have worked with their dental and medical communities to train and certify primary care physicians to perform dental risk assessments, furnish fluoride varnish applications, and make appropriate referrals to a dentist by age one. These States train and certify providers who are then able to be reimbursed for providing these services. Alabama also improved linkages and oral health education for pregnant women by working with the group representing obstetricians and gynecologists to provide education materials for the providers and their patients. Nebraska noted that it regularly requests and utilizes input from key stakeholders, including the State Dental Association, on administering rate adjustments.

Several States mentioned collaborating with Head Start programs in their State to improve education among participants on the importance of oral health care. Head Start programs are required to ensure that their children have received the required Medicaid EPSDT services, including dental services. This provides an ideal location for continued education for these services. Both North Carolina and Rhode Island have worked closely with their Head Start or Early Head Start programs and school districts to disseminate the same message on oral health that reinforces its importance to children and families. North Carolina developed "Zero Out all Early Childhood Tooth Decay" (ZOE), an initiative that trains Early Head Start staff to perform various basic oral health activities, such as wiping an infant's gums with a soft cloth, and sets performance standards for those activities.

Having a high profile dental "champion" in a State that is willing to take on a public leadership role has also been an effective strategy that States have used. Almost every State we reviewed indicated there was someone willing to step up and take the lead to improve access to dental services in their State. In some States, this may be the State Medicaid Director or State Dental Director; in other States, it may be the Governor's office or someone in the State legislature as in Maryland and Rhode Island. In Maryland, the Secretary of the Department of Health and Mental Hygiene was essential in gaining the acceptance of the dental provider community and a new willingness to service children enrolled in Medicaid. In Rhode Island, the Lieutenant Governor played a key role in promoting RItE Smiles and pediatric oral health care. Staff from the Commonwealth of Virginia indicated that a past State Medicaid Director took the lead on improving access to dental care and worked closely with the State Dental Association and other stakeholders on the issue. This included visiting all eight Congressional Districts across the State as well as Virginia Dental Association officials and members.

Public health departments can also play a large role in improving access to dental services as was noted in Maryland, North Carolina and Nebraska. In Nebraska, public health nurses employed by local health departments contracted with Medicaid to perform a variety of outreach activities. These activities include contacting new enrollees to inform families of benefits, educate them on the importance of utilizing benefits, and assistance with accessing those services. These nurses also provided support for providers, including dentists, by following up with patients who are

“no shows” or miss their dental appointments. Nebraska State law also requires that each local public health department have a governing board which must include a dentist. North Carolina’s Division of Public Health is the grantee for the North Carolina Dental Home Initiative which is funded by the Health Resources and Services Administration (HRSA). This initiative is a pilot program that operates in three counties in eastern North Carolina to provide primary care providers additional tools to identify children susceptible to early childhood caries to facilitate risk-based dental referrals. Partnering with public health departments can provide oral health visibility at the local level and expands opportunities for partnerships with local dentists and serves as an example of public/private partnerships addressing the challenges of serving low-income and Medicaid populations.

### Dental School Collaborations and Loan Repayment Programs

Many States have developed and continue to maintain partnerships with dental schools in their States. Six of the States reviewed have dental schools that participate in some way with the Medicaid dental program (Alabama, Arizona, Maryland, Nebraska, Rhode Island and Texas). The dental schools not only furnish dental services for the Medicaid population but also serve as important partners in increasing access to dental services by providing opportunities for outreach and education on the importance of dental services.

Several schools including Alabama, Nebraska, and North Carolina, operate dental clinics in other parts of the State, generally in underserved rural areas, and have dental students working in those clinics. This provides students with the opportunity to work with low income populations. Officials at the University of Nebraska College of Dentistry believe that exposing dental students to the oral health needs of the lower-income, rural populations increases the likelihood they will serve the needs of this population upon graduation. They also noted that they have seen an increase in the number of their graduates establishing practices outside the state’s urban areas.

Five States (Alabama, Maryland, Nebraska, North Carolina and Texas) noted that they have loan repayment programs for dental students or dentists. Maryland’s program offers up to five dentists per year an opportunity to receive up to \$99,000 in repayment in exchange for carrying a Medicaid patient load of at least 30 percent per year. Programs in the other States generally require a student to serve in a rural area for a specified period of time in order to receive an annual payment for their dental school loans. These programs are not directed specifically to Medicaid patients. Funding for these programs varies from State to State as do the number of slots available for dental students. One State did indicate that they have noticed students willing to set up practices outside of the traditional urban areas in the State though there were no statistics available to support that statement.

### Increased Reimbursement

Increased reimbursement was noted in six States that were reviewed (Alabama, North Carolina, Maryland, Rhode Island, Texas and Virginia). The level of increase varied as did the time period for that increase. One State increased its rates almost 10 years ago, but still considered that an important step for the improvement of its Medicaid dental program. Other States have increased their rates more recently as they have reevaluated their dental programs. The increased rates

were usually directed at the procedure codes used most by the pediatric population. Increasing rates in this way is seen as encouraging early interventions for children instead of reimbursing higher rates for treatment services once a child has tooth decay.

The State of Rhode Island changed its rate structure for the portion of its population that was placed under a dental benefits manager, while the fee-for-service rate for older children was not increased. This distinction was noted by providers in that State. However, the difference in the service rates did not appear to stop providers from serving the older children when they were also seeing younger children due to their satisfaction with the RIte Smiles program. Provider's appeared willing to see an older sibling for less reimbursement, when also treating the younger child who was eligible for the RIte Smiles program. While originally implemented to cover children ages zero through five, Rhode Island is annually increasing the age of the population covered by one year so children do not age out of the program. Two other States, Texas and North Carolina raised rates in accordance with requirements for complying with court orders.<sup>1</sup>

Rate increases alone were not the only way to improve access to oral health services. Many providers noted that while they appreciated the increased reimbursement, some of the other State strategies discussed were almost as important.

#### Simplifying Administrative Processes

Many of the States reviewed have undertaken activities to simplify the administrative process for Medicaid dental programs, which can reduce burden on providers and administrative costs to States. States have taken small steps such as moving from multiple claims forms to one universal claim form, or, as in Virginia, significantly reducing the prior authorizations necessary for dental services. These steps were viewed favorably by dental providers as reducing the burden on their office staff when working with Medicaid patients and improving their willingness to serve Medicaid patients.

Several States, such as Maryland and Virginia, have also moved dental services from their medical managed care plan to a separate carve-out program. These programs may be reimbursed either on a straight fee-for-service basis or through a single contractor to administer the dental program. This provides a single point of contact for providers and their office staff, reduces paperwork, and may improve the timeliness of reimbursement. In Maryland, the contractor has implemented a state-of-the-art electronic funds transfer for payments. In other States like Rhode Island, dental programs may be administered under both fee for service and managed care arrangements. States and providers interviewed say that these simplifications are extremely important to maintaining and increasing provider participation.

In the State of Alabama, the State adopted an outreach plan to increase provider participation in the Medicaid program. As part of this plan, the State visited dentists who accepted private

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<sup>1</sup> The State of Texas was required to appropriate \$150 million to improve access to EPSDT services and health outcomes for class members. A portion of these funds were used to increase reimbursement. The State of North Carolina was required to increase reimbursement to certain dental services as part of its settlement but no specific funding was allocated.

insurance but were not Medicaid participating providers and would assist dentists in filling out the application form on-site.

### Grant Funding

Many of the States used grant money from various sources, both private and governmental, to fund aspects of their dental programs. Alabama used grant money from a foundation as “start up” money for its State oral health initiative, as well as to assist in the production of education materials targeted to specific audiences. The State of Arizona used grant money to fund the creation of a Dental Director in the State. Additionally, one of the dental schools in Arizona received a grant to establish a dental clinic to serve special needs patients, which helps to fill an important provider need. The State of North Carolina also used federal grant money to develop a Dental Home Initiative pilot in three counties.

### Educating Families

State staff and providers noted in several States that there appeared to be a lack of education for families on the importance of preventive oral health care. Several States implemented education activities as part of the initiatives. In Rhode Island, the State, dental providers and dental stakeholders, including the pediatric community, work collectively to ensure that parents are aware of the importance of early and preventive treatment. The RIte Smiles program message is reinforced through its connections with the Head Start Program and school systems.

The State of Alabama utilized several strategies to increase patient education including developing brochures for patients to be distributed by dental providers and specific material developed for obstetricians/gynecologists to distribute to pregnant women to educate them about the importance of good dental care for pregnant women and infants. In the State of Arizona, some of the MCOs partnered with the Office of Oral Health to meet with physicians and emphasize their role during well-child exams to educate parents about the importance of dental care.

As part of its First Dental Home Initiative, the State of Texas has adopted a regimen of educating families, which necessitates the constant presence of a responsible adult during the complete oral health visit. Family members are educated about the effects of diet on early childhood caries, the habits of good oral hygiene, and encourages proper oral health practices for breast-feeding moms to promote dental health. The dental provider will review with the child’s responsible adult the child’s health history, and personal and family dental history. A dental risk assessment is then performed, along with dental prophylaxis, and the adult in attendance will receive oral hygiene instructions specific to that child.

Education for families regarding missing appointments without notifying the provider’s office was mentioned by every State. Specifically, State’s noted the impact on the willingness of providers to enroll as Medicaid providers due to Medicaid patient’s high rate of missed appointments compared to their private pay patients. This issue is particularly difficult as Medicaid does not allow for payment for missed appointments, nor for the patient to be charged. In the reviews, three States (Alabama, Arizona, and Nebraska) highlighted activities that they

have undertaken to address this issue. In all three States, there is follow-up with a family after an appointment is missed. That follow-up is provided by the MCO, a care coordinator, or a public health nurse.

### Targeting Young Children

In addition to the initiatives already addressed, many States have initiated unique programs that focus on improving access for children in specific age groups and in particular, reach out to very young patients to address dental caries. Some examples of these programs are Rhode Island's RItE Smiles program which is a dental carve out from the State's section 1115 demonstration waiver that provides dental benefits to children 0-9 years of age. The RItE Smiles program is administered by the State's Dental Benefit Administrator. The program annually increases the age of the population covered by one-year so children do not age out of the program. Older children receive their dental services through fee for service arrangements.

North Carolina's "Into the Mouth of Babes" program is another example. This program reimburses physicians for providing preventive dental services to children 0-3 ½ years of age. This program started in the Appalachian Mountain areas of North Carolina in 1998 and is now offered Statewide. Alabama's 1<sup>st</sup> look program, which was launched in January 2009, targets dental caries in young Medicaid-eligible children. The program also reimburses certified primary care providers to perform preventive oral health activities and provide referrals to a dental home. In Arizona, a mandated dental performance improvement plan (PIP) focused on children ages three to eight which was identified by the State as a crucial age in which children in Arizona experienced markedly increased tooth decay. A survey by their Office of Oral Health showed 40 percent of children in Arizona in this age range had untreated tooth decay. Generally, this may be because first molar teeth are the most likely to have tooth decay.

### Dental Home Initiatives

Several States noted they have undertaken the development of dental home initiatives in their States. As noted earlier, the State of North Carolina received funding from HRSA for a pilot program that operates in three counties in eastern North Carolina to provide primary care providers additional tools to identify children susceptible to early childhood caries to facilitate risk-based dental referrals.

The State of Texas implemented the *First Dental Home Initiative* which is focused on improving the overall health of all children by introducing preventive care in the early months of life. The two-pronged agenda utilizes a formal periodicity schedule addressing oral health for children ages 6-35 months of age and the total involvement and education of the child's parent or responsible adult.

## **Continuing Challenges**

Most States indicated they continue to face challenges in attracting dental specialists to provide services to their Medicaid patients. However, while most providers acknowledged referrals were sometimes difficult, they also noted that they were usually able to refer most children to a



specialist with the help of the State, or to a specialist they personally know who was willing to take a limited number of Medicaid patients. One State indicated that they have seen a slight increase in specialty providers willing to see Medicaid eligible children. Anecdotally, they attribute this to the current economy and non-Medicaid patients putting off services that are not of a serious or emergent nature.

Many States continue to struggle with access in their rural areas compared to their urban areas. While some States have been able to use dental school residents to staff clinics in rural areas, this is by no means a permanent solution. States continue to look for other ways to attract dental providers to those areas including the use of loan repayment programs.

While several of the States noted they had been able to increase dental reimbursement rates in recent years, the current economy is causing some of those States to either hold off on further increases or to consider decreasing dental rates. Rate decreases could cause a set back to the progress States have made in increasing access to dental providers since rates are already considered low.

We heard from several States and providers that providing dental services for special needs clients also remains a challenge. The term “special needs” may mean a child who uses a wheel chair or a child with a severe developmental disability. The availability of dental providers able to serve this population is limited and those enrolled as Medicaid providers is even smaller. As mentioned earlier, Arizona indicated one of its dental schools received a grant to establish a special needs dental clinic that allows dental students to gain experience treating patients with special needs. This fills an important provider need as the clinic contracts with two of the largest Medicaid health plans in the State and may influence these students to accept special needs patients once they are practicing independently.

During the eight State reviews, CMS did discover several issues that are not consistent with Medicaid program policies. States were notified of these issues and CMS will follow-up to ensure that any concerns are addressed.

### **Recommendations for CMS**

States and providers had a number of recommendations for CMS on ways to improve delivery of dental services. These ideas include:

- Additional forums on dental services;
- Allowing Medicaid reimbursement or patient billing for “missed appointments”;
- Mandate adult dental services so that the family unit would be eligible to receive services, and educate on the importance of oral health care;
- Increase the federal matching rate for dental services, such as is available for family planning services (90 percent match);

## **Conclusion**

While there are no simple answers to addressing the issue of improving access to dental care for Medicaid eligible children, States have demonstrated innovative actions that can be taken. By combining innovative ideas with support from provider associations, State legislatures and oral health stakeholders, progress can be made. Improving access to dental services and assessing the quality of those services will continue to be a focus of CMS, States, and all of the dental partners mentioned in this summary.

There is no “one size fits all” solution to increasing dental access for Medicaid eligible children. State variance of populations, available funding, and political will varies greatly across the nation. However, there are certain elements of the innovations we reviewed that could be replicated by other States. While not every State can increase its reimbursement rates, every State should be able to improve collaborations with State dental and medical partners to begin a conversation with the stakeholders needed to help address the issues. These discussions should focus on what the issues are, what can be done within your State to improve the situation, and what can be accomplished by working together.