



Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents



© ANETTE ROMANENKO | DREAMSTIME.COM



Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

September 2013

Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>

Table of Contents

Introducing Four Strategies for States	1
The Facts: Why is Oral Health Important?	3
The Medicaid Benefit for Children & Adolescents	3
<i>Details of the Medicaid Dental Benefit for Children & Adolescents</i>	3
The Basics of Children’s Oral Health	4
<i>What Is Early Childhood Caries?</i>	4
<i>The Importance of Preventing Early Childhood Caries</i>	5
Clinical Guidelines	5
Caries Risk Assessment & Risk-based Prevention	6
Strategies for Promoting Oral Health for Children	7
STRATEGY 1: Improve State Medicaid Program Performance Through Policy Changes.....	8
✓ <i>Align the dental periodicity schedule to clinical recommendations.</i>	8
✓ <i>Use dental delivery system contracts to improve dental program performance.</i>	9
✓ <i>Reimburse medical providers for preventive oral health services.</i>	10
✓ <i>Incentivize dental providers through new payment models.</i>	14
✓ <i>Address Form CMS-416 & core measure data collection challenges</i>	15
STRATEGY 2: Maximize Provider Participation	18
✓ <i>Reduce the administrative burden for providers.</i>	18
✓ <i>Help general dentists feel more comfortable treating young children.</i>	20
✓ <i>Maximize the capacity of the dental workforce.</i>	22
STRATEGY 3: Directly Address Children & Families	28
✓ <i>Address missed patient appointments.</i>	28

✓ <i>Educate children and families about oral health</i>	30
STRATEGY 4: Partner with Oral Health Stakeholders.....	32
✓ <i>Partner with the state’s Office of Oral Health</i>	32
✓ <i>Incorporate stakeholder perspectives in program planning</i>	33
✓ <i>Partner with Title V agencies</i>	34
Conclusion	36
What You Need to Know About EPSDT	37
Resources	38
<i>AAP Resources</i>	38
<i>AAPD Resources</i>	38
<i>ADA Resources</i>	38
<i>American Network of Oral Health Coalitions Resource</i>	38
<i>Educational Resources</i>	38
<i>Federal Resources</i>	39
<i>State Programs and Resources</i>	39
<i>Other Resources</i>	39
Citations	40

Produced in collaboration with NORC at the University of Chicago
www.NORC.org

Introducing Four Strategies for States

Dental coverage through Medicaid is a powerful tool that states can use to improve oral health for tens of millions of children and adolescents. Children covered by Medicaid have higher dental care utilization rates than do uninsured children. The percentage of Medicaid-enrolled children (ages 1 and older) who receive dental care continues to increase nationwide, from 37% in 2007 to 47% in 2011. The Centers for Medicare & Medicaid Services (CMS), working in partnership with states, is committed to building upon recent progress in improving access to oral health care among children and adolescents enrolled in Medicaid.

Quality dental care is essential to ensure a child’s overall well-being. Tooth decay remains the single most common chronic disease among children. Untreated decay affects [19.5% of 2 to 5 year olds and 22.9% of 6 to 19 year olds](#). Dental disease can impact all aspects of children’s lives, from their nutrition and sleep habits to their educational performance and self-esteem.

This strategy guide is intended to provide examples of successful approaches to improving oral health access and utilization for children enrolled in Medicaid. Recognizing that there is no “one-size-fits-all” solution to improving dental care access and quality, this guide offers a wide array of tactics from which states can choose to best fit local needs and resources. Strategies cover:

- ✓ Improving state Medicaid program performance through policy changes;
- ✓ Maximizing provider participation in Medicaid;
- ✓ Directly addressing children and families; and
- ✓ Partnering with oral health stakeholders.

The strategies in this guide also demonstrate opportunities for states to work toward meeting the CMS [Oral Health Initiative](#) goals. The [goals](#), announced in 2010 by CMS, are benchmarks to spur state level action:

- Increase the rate of children ages 1–20 enrolled in Medicaid for at least 90 continuous days who receive any preventive dental service by 10 percentage points by FY 2015; and
- Increase the rate of children ages 6–9 enrolled in Medicaid for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points over 5 years (this goal will be phased in).

The Oral Health Initiative also supports the Department of Health and Human Services (HHS) [National Quality Strategy](#), which established three aims to guide and assess local, state, and national efforts to improve the quality of health care. The specific aims of the National Quality Strategy include:

1. **Better Care:** Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.
2. **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

The strategies in this guide can help achieve the aims of the National Quality Strategy by helping states provide higher quality oral health care, improving the oral health of children and adolescents, and ensuring that all children and adolescents enrolled in Medicaid can access this care. Employing one or more of these strategies can positively impact the oral health of enrolled children, with the aim of keeping them healthy and pain free.

CMS is providing additional support to states in improving their Medicaid and Children's Health Insurance Program (CHIP) dental programs through quarterly technical assistance webinars, the [CMS Learning Lab: Improving Oral Health Through Access](#), as well as through participation in a [Medicaid Oral Health Learning Collaborative](#) run by the Center for Health Care Strategies. One-on-one technical assistance is also available from CMS upon request.



The Facts: Why is Oral Health Important?

The Medicaid Benefit for Children & Adolescents

In 1967, Congress introduced the Medicaid benefit for children and adolescents known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The goal of EPSDT (referred to in this guide as “the Medicaid benefit for children and adolescents”) is to ensure that children receive the health care they need at the time they need it—*the right care to the right child at the right time in the right setting*. This broad scope supports a comprehensive, high-quality health benefit for children under age 21 enrolled in Medicaid. States share responsibility for implementing the benefit, along with the CMS.

The Medicaid benefit for children and adolescents is more robust than the Medicaid benefit for adults. Children have coverage for all medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act, including dental care, regardless of whether such services are covered for adults or included in the state plan. States are responsible for informing families about the benefit and for providing children and adolescents access to the health care services they need. States also ensure that there are an adequate number and range of pediatric providers to meet the health care needs of the state’s enrolled children.

Details of the Medicaid Dental Benefit for Children & Adolescents

- Dental coverage requirements for children and adolescents enrolled in Medicaid include, at minimum, relief of pain and infections, restoration of teeth, maintenance of dental health, and medically necessary orthodontic services.¹
- Dental care for children and adolescents is subject to the same “medical necessity” parameters as is other health care for children in Medicaid. The benefit includes all services needed to correct or ameliorate oral health conditions.
- A periodicity schedule specific to dental services is required.² Dental and oral health services should occur at intervals that align with reasonable standards of dental practice. States establish this schedule after consultation with dental organizations involved in child health care.³

- Children and adolescents may also access dental and oral health services on an interperiodic basis which is more frequently than outlined in the periodicity schedule, as medically necessary.⁴
- Dental visits must be performed by a dentist, or other licensed dental professional working under the supervision of a dentist according to the provisions of a state's scope of practice laws, and can occur in settings other than a dentist's office, such as a clinic or a school.⁵
- While oral screenings by other health care providers, such as physicians, do not meet Medicaid's dental requirements under the Medicaid benefit for children and adolescents, physicians can provide, and in many states be [reimbursed](#) for, certain oral health services.
- Categorically needy children under the age of 18 (or under 19, 20, or 21 at state's option) are not subject to [co-payment, co-insurance, or premiums](#) for the covered dental and oral health services they receive. States and managed care plans may need to monitor providers to ensure that they do not charge for missed appointments, or bill patients for the difference between the provider's customary charge and the Medicaid payment.

The Basics of Children's Oral Health

Oral health is an essential component of a child's overall well-being. Dental disease in children is preventable, but once it sets in the disease can affect a child's physical development in the form of reduced body weight and interference with growth. It can also affect a child's school attendance and academic performance, leading to significant implications for a child's social development and future success.

What Is Early Childhood Caries?

The disease of "dental caries" is a bacteria-dependent plaque-induced process of acid demineralization of tooth structure, mediated by saliva. A child is considered to have "[early childhood caries](#)" when there is one or more decayed, missing (due to caries), or filled tooth surface in any primary tooth before the child turns six. The bacteria that cause caries are transmissible between individuals. For example, a caregiver can transmit the bacteria from her mouth to a baby's mouth by sharing eating utensils or by sucking on a baby's fingers which the baby then puts in her own mouth. The interaction in the mouth between the bacteria and carbohydrates from foods produces acid. The acid, if not sufficiently disrupted by brushing and flossing or by the natural production and swallowing of saliva, will eat away at tooth enamel. The presence of fluoride in the tooth surface mediates both the production of acid by bacteria and the tooth's susceptibility to demineralization. In short, tooth decay or cavities (the

result) is caused by dental caries (the disease). The disease is infectious, transmissible and diet-dependent.

The Importance of Preventing Early Childhood Caries

If left untreated, dental caries results in tooth decay and permanent cavitation, and children with active disease become adults with tooth decay. Fortunately, caries is both preventable and treatable. With effective home care and regular access to evidence-based preventive dental services, children can be spared the damage and suffering associated with this condition and they can grow into adults with healthy mouths.

Parents and caregivers play a critical role in maintaining good oral health and establishing proper oral hygiene habits. Once caregivers understand that tooth decay is caused by an infectious, transmissible and diet-dependent disease, they can take multiple steps to reduce their child's exposure to bacteria and its effects. From monitoring and minimizing intake of sugary foods to performing daily dental care for infants and young children to resisting the urge to share utensils or to engage in other activities that could transfer bacteria from the caregiver's saliva to the child's mouth, parental involvement is critical.

An emphasis on prevention is also fiscally sound policy. It is approximately [ten times](#) more expensive to provide inpatient dental care for caries-related conditions than to provide preventive care. Furthermore, Medicaid is the [most common payer](#) among children visiting the emergency room for a dental condition.

Clinical Guidelines

According to the [periodicity guidelines](#) issued by the American Academy of Pediatric Dentistry (AAPD), dental care should begin within six months of the eruption of a child's first tooth and no later than age one. This first dental visit is a critical time to educate parents about dental development and the importance of establishing good oral hygiene habits for their child and themselves. To ensure this connection to dental care is made as early as possible, the American Academy of Pediatrics [Bright Futures](#) periodicity guidelines recommend that primary care medical providers include an oral health assessment as part of the well-child check-up throughout childhood, starting at 6 months of age.

Also according to the AAPD, subsequent dental appointments should occur at minimum every six months and should include assessment (including radiographs), treatment, routine maintenance, and education. In particular:

- Topical fluoride treatment should begin after age one and may need to be applied every three to six months in children with high caries risk, as discussed below.
- Professional cleaning of teeth should begin at age two. Sealants for pits and fissures on caries-susceptible primary molars, permanent molars and premolars are recommended when those teeth first erupt.
- In late adolescence, third molars (“wisdom teeth”) should be assessed for their presence and position. According to the [policy statement](#) of the American Public Health Association Section on Oral Health, removal can be considered when there is diagnosed pathology or other demonstrable need. Early removal of third molars, for purely prophylactic purposes, is not based on current scientific evidence.

Oral health education should be a part of every dental visit. At first, this will be directed to the parent or caregiver. Individualized oral health education should be provided directly to the child as the child gets older and gains more responsibility for their own oral care and exposure to risk factors.

Caries Risk Assessment & Risk-based Prevention

The AAPD’s periodicity guidelines also encourage providers to customize care plans based on an assessment of each child’s individual risk for developing dental disease. Providers can identify factors that put children at a higher risk of developing caries and provide targeted guidance and treatment to address those factors. For example, a child who lacks regular access to optimally fluoridated water is at a higher risk of developing caries, so for such children dentists can prescribe fluoride supplements and have patients return for monitoring more frequently than children who have a lower caries risk. AAPD offers providers a [caries-risk assessment form](#) (see page 2 of link) including guidelines and treatment protocols.

Strategies for Promoting Oral Health for Children

States and other stakeholders are implementing a variety of approaches to increase oral health care visits and awareness of oral health for children and adolescents. While there is no one-size-fits-all approach to creating an effective oral health care delivery system, understanding other states' experiences provides an opportunity to explore what can be done to promote utilization of oral health care services, especially the most appropriate and cost-effective care.

The strategies presented in this guide represent a variety of approaches to using evidence-based policies and to engaging providers, families and other stakeholders:

STRATEGY 1 Improve state Medicaid program performance through policy changes: Match the state's periodicity schedule to clinical recommendations, use dental delivery system contracts to improve dental program performance, reimburse medical providers for preventive oral health services and address 416 and core measure data collection challenges.

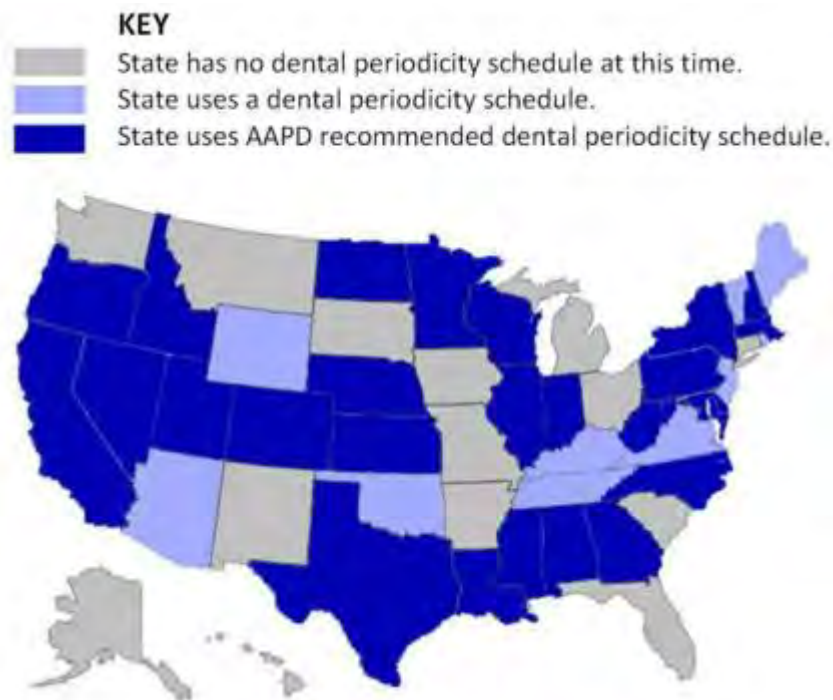
STRATEGY 2 Maximize provider participation: Reduce administrative burden for providers, help general dentists feel more comfortable treating young children, and maximize the capacity of the dental workforce by utilizing a variety of provider types.

STRATEGY 3 Directly address children and families: Promote the benefit, address missed patient appointments, and educate children and families about the importance of oral health and what part they play in maintaining it.

STRATEGY 4 Partner with oral health stakeholders: Partner with the state's Office of Oral Health, incorporate stakeholder perspectives in program planning, and partner with Title V agencies.

STRATEGY 1: Improve State Medicaid Program Performance Through Policy Changes

✓ **Align the dental periodicity schedule to clinical recommendations.** State Medicaid programs are required to adopt a dental-specific periodicity schedule for children, not just a medical periodicity schedule that references dental services. States should consult with professional dental organizations in developing their dental periodicity schedules, and should also keep in mind building in the flexibility for providers to follow [clinical guidelines](#) directed at providing evidence- and risk-based approaches to prevention.



Map available from [The American Academy of Pediatric Dentistry](#) (2013)

In order to provide effective care for children with a wide array of oral health needs and risks, state dental periodicity schedules should serve as a “floor,” the minimum recommended frequency for preventive oral health visits - rather than a “ceiling,” the maximum allowable frequency of preventive oral health visits. Such flexibility is consistent with the intent of the Medicaid benefit to meet the medical and dental needs of the individual child or adolescent. **Publication of state medical and dental periodicity schedules in an easily accessible location and format** can also help providers and families become more aware of the services covered by the Medicaid benefit for children and adolescents.

Adopting AAPD's Guideline on Periodicity: Louisiana

In 2009, Louisiana learned during a CMS review of its Medicaid dental program that the state was not fulfilling the requirement of maintaining a pediatric dental periodicity schedule. Louisiana needed to quickly address this deficiency and looked to the AAPD's Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children. Louisiana Medicaid adopted the AAPD recommended dental periodicity schedule and worked with Louisiana State University's School of Dentistry to make modifications based on the services offered by the state's Medicaid program. The state included the [dental periodicity schedule](#) in its Medicaid manual and ensured that the state's schedule was written at a reading level and formatted in a manner that the public could easily comprehend.

Adoption of a Dental Periodicity Schedule Led to Other Improvements

The development of the state's dental periodicity schedule prompted Louisiana to overhaul sections of its Medicaid website related to the dental benefit. Prior to the state's adopting the periodicity schedule, providers had to search through information on several webpages to find comprehensive information on the dental benefit. To address this issue, Louisiana created a [dental provider homepage](#) that was easily accessible from the [main Medicaid website](#). This webpage contains information and resources targeted specifically to dental providers, including the new periodicity schedule, the [dental services manual](#), the fee schedule, and instructions on submitting claims. The provider homepage also serves as a central location for posting program news, such as provider enrollment updates and guidance on electronic claims submission. In addition to offering the periodicity schedule on the new webpage, Louisiana promoted the schedule to providers via newsletters.

✓ **Use dental delivery system contracts to improve dental program performance.** States that contract with managed care organizations, dental benefits administrators or other third parties to administer their dental program may benefit from building accountability into their contracts. For example, states can require contractors to meet benchmarks, performance standards and reporting requirements. States can also build in bonuses for meeting or exceeding performance goals and disincentives for failing to meet them. State Medicaid programs can also:

- Align contractor requirements with Medicaid program goals or performance measure benchmarks;
- Add quality and access-to-care related requirements; and
- Include dental performance improvement projects as part of managed care external quality reviews.

Contract Modifications Improve Plan Performance: California

In response to low utilization rates, the California Department of Health Care Services made improvements in late 2010 to dental managed care contracts in two counties as a way to hold plans accountable for providing adequate access to quality oral health care. Through these contract modifications, the Department implemented financial incentives (for plans exceeding performance standards) and financial penalties, corrective action plans, and sanctions (for plans not meeting performance standards).

After introducing the changes, utilization rates rose in Sacramento County from 32.3% in 2011, to 43.7% in 2012, and in Los Angeles County from 24.6% in 2011, to 36.8% in 2012. This approach proved to be so successful that California incorporated into its next round of contract procurement the ability of dental plans to meet the Department's goals to improve the delivery of dental services to children. California awarded three contracts in the two counties based on these criteria.

As outlined in the Department's [Report to the Legislature](#), 2013 dental managed care contracts require plans to:

- Participate in and/or conduct two quality improvement projects;
- Appoint an external quality review organization to audit performance measures and conduct annual surveys of care timeliness and member satisfaction;
- Conduct provider monitoring based on quality improvement thresholds, (e.g., access and availability standards, encounter data submission, and dental record accuracy);
- Achieve benchmarks on 11 performance measures (which are tied to 10% monthly withholds of capitation payments);
- Allow the Department to review provider contracts and compensation arrangements (the Department may deny any inappropriate payment schedules);
- Adhere to Department standard appointment timeframes for preventive dental visits and emergent care visits;
- Conduct an annual "timely access" survey and monthly phone call campaigns to members who have not been to the dentist in the previous 12 months; and
- Conduct outreach to expand the provider network to include Federally Qualified Health Centers (FQHCs), Rural Health Centers, and Indian Health Service Facilities (and encourage them to provide incentive programs to dental providers).

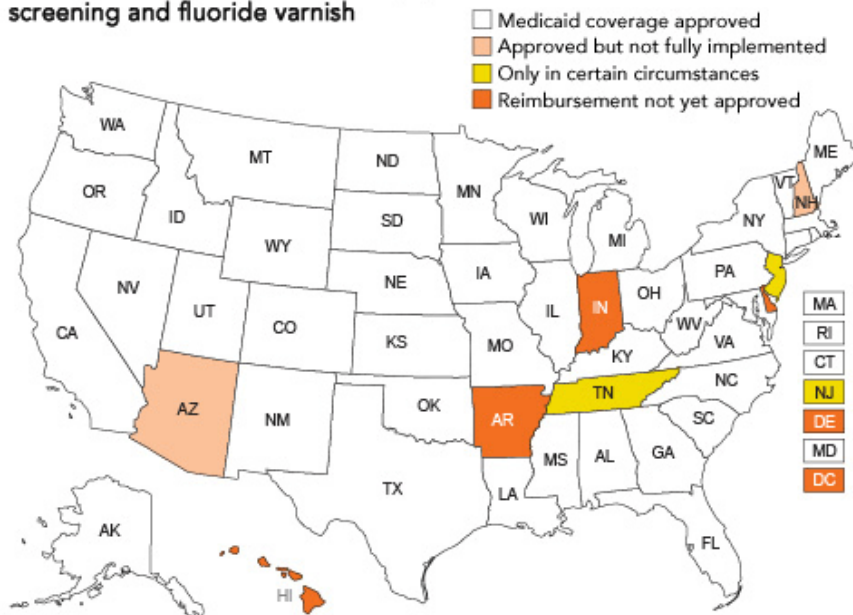
Additionally, the contracts allow the state to implement corrective action plans for dental plans with repeated deficiencies, and require dental plans to correct deficiencies in a timely manner. The State may also halt new enrollment of beneficiaries in a dental plan as a consequence of noncompliance.

Children with at least 4 fluoride varnish applications between ages 6 months and 35 months experienced the least decay.

✓ ***Reimburse medical providers for preventive oral health services.*** Primary care providers are well-positioned to offer children enrolled in Medicaid basic oral health education and preventive services at a most critical

time in their development. Children are at risk for caries from the moment of first tooth eruption, typically around six months of age. To most effectively prevent caries, parents must establish sound oral health habits at this early age. **Pediatricians have earlier, more frequent interactions with children and their parents than do dentists, and they participate in Medicaid at higher rates.** A recent [study](#) found that a higher frequency of well-child check-ups between ages one and three was associated with an earlier first dental exam.

States with Medicaid funding for physician oral health screening and fluoride varnish



SOURCE: http://www.mchoralhealth.org/feedback/reimbursementchart6_08.pdf

Map available from the [Pew Charitable Trusts](#). Per state Medicaid officials, DC will implement coverage October 1, 2013; Indiana plans to implement coverage in 2014.

Most states currently reimburse medical providers for performing oral health risk assessments, providing anticipatory guidance, and applying preventive fluoride varnish to children enrolled in Medicaid. These services are simple to perform and [recent studies](#) have found them to be highly effective in reducing the incidence of caries. **Starting fluoride varnish at or around the age of six months results in greater reduction of the disease of early childhood caries than starting after age two.** Additionally, starting fluoride varnish at 6 months (or at the eruption of the first tooth) pays back a larger percentage of program costs by reducing future restorative costs. Targeting the highest-risk children has a similar [effect](#) on the prevalence of early childhood caries as fluoride varnish for all children older than 24 months but at a lower program cost. Reimbursing medical providers for these services can significantly improve children's access to preventive oral health care.

It is about 10 times more expensive to provide inpatient dental care for caries-related conditions than to provide preventive care.

Reimbursing medical providers for certain oral health services and offering primary care practitioners access to a network of referring dentists helps to promote better oral health for children. For example, [Wisconsin](#) saw a 300% increase in the number of claims submitted for fluoride varnish treatment after changing its reimbursement policy to allow payment to medical providers for fluoride varnish treatment. Medical providers accounted for half of this overall increase and, significantly, were responsible for 83.5% of claims submitted for children ages one and two. Washington is another state utilizing primary care practitioners to promote access to dental care. In [Washington's Access to Baby and Child Dentistry](#) (ABCD) program, primary care medical providers contact local program administrators to connect children to dentists who have participated in ABCD trainings. Medical providers report that they are more willing to perform oral health assessments on children when there is an effective referral structure in place to ensure patient access to follow up dental care.

Ensuring Doctors Provide Preventive Care & Referrals: North Carolina & South Dakota

North Carolina's "[Into the Mouths of Babes](#)" program has been successful at facilitating the provision of preventive oral health services to young children by medical providers. Into the Mouths of Babes is a collaborative effort of the state's Academy of Family Physicians, the Pediatric Society, the Division of Medical Assistance Oral Health Section, and the University of North Carolina at Chapel Hill School of Dentistry and Gillings School of Global Public Health. The Oral Health Section of the North Carolina Department of Health and Human Services currently administers the program and continues to collaborate with the partner agencies.

Funding Sources

Past and current funding sources for the program include the Centers for Disease Control and Prevention, CMS, the Health Resources and Services Administration's State Oral Health Collaborative Systems and their Targeted State Maternal and Child Health Oral Health Service Systems Grant Program.

Program Targets and Details

North Carolina's Department of Health and Human Services offers training to medical providers in oral evaluation, anticipatory guidance, and application of fluoride varnish prophylaxis. Providers receive continuing medical education credit.

As part of the training, providers are given a [toolkit](#) that includes clinical guidelines for fluoride varnish application, North Carolina Medicaid billing and Dental Procedures and Nomenclature codes, a sample encounter form, supply information, educational materials for parents, and guidance on how to train others in their practice to qualify them for Medicaid reimbursement for varnish application. The toolkit also includes a tip sheet on how to refer patients to Medicaid-enrolled dental providers.

Program Results

Program data show that Medicaid-enrolled children who receive varnish through the Into the Mouths of Babes program have fewer caries-related treatments in dental offices than Medicaid-enrolled children who do not receive Into the Mouths of Babes preventive services. [The program](#) is most effective when children had 4-6 visits before their third birthday.

In **South Dakota**, Delta Dental of South Dakota, the state's Medicaid Administrative Services Only dental program contractor, received a HRSA grant to strengthen the connection between medical and dental providers. Over the three years of funding, Delta Dental held trainings with medical personnel on how to identify early signs of decay and administer fluoride varnish. Approximately halfway into the project, South Dakota Medicaid began reimbursing medical providers for applying fluoride varnish. In order to attract busy medical providers, the training sessions were limited to an hour or less and scheduled at convenient times and locations. Local dentists led the trainings in order to encourage personal connections between dental and medical providers and consequently increase medical to dental referral rates.

Program Results

Hundreds of primary care medical professionals were trained through the HRSA grant program. Dental and medical providers formed valuable connections, which stimulated referrals from primary care providers to dentists. After grant funding expired, Delta Dental of South Dakota continued the trainings with a staff dental hygienist.

The University of South Dakota incorporated similar training into its medical and allied health programs, ensuring that graduates begin their practice with basic oral health knowledge and an understanding of the importance of dental referral for young children.

Caries is a PREVENTABLE disease.

✓ *Incentivize dental providers through new payment models.*

One way states can encourage dental providers to do everything possible to prevent early childhood caries is by utilizing payment incentives that encourage the provision of preventive services according to evidence-based protocols. Payment arrangements can vary, but one approach is to reimburse providers via a bundled payment for an established set of preventative dental services to be delivered at each dental visit, starting at a very young age, with the frequency of visits set according to a child's assessed level of risk for developing early childhood caries.



Incentivizing Dental Providers Through a Payment Initiative: Texas

In 2008, Texas Medicaid launched its [First Dental Home](#) program. First Dental Home strives to improve the oral health of very young children by delivering a set of evidence-based preventive services during regular dental visits. Children can receive up to ten preventive visits between the ages of 6 months and 35 months. The visits consist of:

- Oral examination;
- Caries risk assessment;
- Dental prophylaxis;
- Application of topical fluoride varnish;
- Oral hygiene instruction with primary caregiver, with supporting take-home materials;
- Dental anticipatory guidance;
- Nutritional counseling; and
- Establishment of a recall schedule.

Dentists are reimbursed \$142 for this bundle of services. The frequency of recall is based on the results of the child's caries risk assessment. To be certified to participate in First Dental Home and bill for this enhanced rate, general and pediatric dentists must complete a free online continuing education [training course](#). Members of the dental team are also encouraged to complete the training.

For many children, this intensive prevention approach is effective at getting them off to a healthy start and preparing them to maintain good oral health as they get older. But for children who continue to be at high risk for caries after they turn age three, Texas Medicaid will cover preventive visits more frequently than twice each year.

First Dental Home has developed a number of [tools](#) to help providers and parents. For parents and caregivers there is both an oral health history questionnaire and a dental risk assessment questionnaire. There is also a caries risk assessment tool for providers.

An important aspect of First Dental Home is that the parent or caregiver is required to be in the room with the child during the entire dental visit. This supports the [education component](#) of First Dental Home, which was carefully constructed based on adult learning principles. There are eight suggested topics that can be covered; at least three topics are covered at each visit. By the end of ten visits, each topic has been discussed about three times. At the conclusion of each visit materials that reinforce the information are given to the parent. This structure helps parents absorb the information in small doses, learn by doing, and have correct behavior reinforced through positive results.

The enhanced payment rate and reduction in billing paperwork for the evidence-based bundle of services has begun to have the desired effect of increasing the number of dentists who provide these services and the number of children who receive them. As of August 2012, more than 2,750 general dentists had been certified as First Dental Home providers, and 814,717 children had established their First Dental Home. Though the formal evaluations of the project have so far focused only on process measures (e.g., how many dentists participate, how many children receive care), pediatric dentists have begun to report, anecdotally, that among participating children fewer need caries treatment in the operating room. The dentists have also reported a "halo effect" such that older siblings, too, are experiencing an improvement in their oral health status.

✓ **Address Form CMS-416 & core measure data collection challenges.** CMS utilizes the information that states report on the [Form CMS-416](#) to assess the effectiveness of the Medicaid benefit for children and adolescents. States are required to report on seven oral health related indicators,

including: the percentage of children ages 0-20 enrolled for at least 90 continuous days who received, in the last year: a) any dental service, b) a preventive dental service, c) a dental treatment service, d) a sealant on a permanent molar (ages 6 to 14 only), e) a dental diagnostic service, f) any oral health service, and g) any dental or oral health service. The information reported is derived largely from dental procedure codes recorded on Medicaid claims. The data reported on the Form CMS-416 is an important indicator of how effectively states are providing dental and oral health services to children and adolescents enrolled in Medicaid. Based on the information CMS collects via the Form CMS-416, trend patterns and projections are developed for individual states and the country, from which decisions and recommendations can be made to ensure that children receive the dental and oral health care they need.



© YEO2205 | DREAMSTIME.COM

Given the importance of the Form CMS-416 data to CMS, the states and other stakeholders, it is critical for states to ensure that the data are reported accurately and reflect the totality of the dental and oral health care Medicaid-enrolled children and adolescents receive. In 2010, CMS developed and implemented a set of criteria to identify data that raises concerns about the accuracy of information submitted on the Form CMS-416. Using these criteria, CMS [evaluates each state's](#) data and alerts any state whose data raises concerns.

States can face challenges in making sure their data is complete and accurate. [Two situations](#) where Medicaid claims information for dental services can be incomplete are (1) when dental services are included in a medical managed care arrangement for which the state pays a capitated rate to a managed care plan, and (2) when dental services are paid by encounter rather than by

procedure (e.g. through a Federally Qualified Health Center (FQHC). An approach to addressing incomplete Medicaid claims information is described below.

Accurately Reporting Dental and Oral Health Services Provided by FQHCs: Iowa

In 2009, Iowa recognized that it was collecting incomplete data from Federally Qualified Health Centers (FQHCs) and was consequently underreporting to CMS the dental services provided to Medicaid-enrolled children. To generate payment for dental visits, FQHCs were reporting a universal encounter code, T1015, and a code to indicate a dental visit, D0120, but they were not reporting additional codes for the specific dental services provided during the visit. As a result, Iowa could accurately report whether there was a dental visit, but it could not report whether the visit involved the provision of preventive, diagnostic or treatment services.

The state Medicaid staff approached the Iowa Primary Care Association and explained the data issue and the reasons it needed to be resolved. Both organizations then worked closely with FQHCs to develop a mechanism to begin collecting and reporting more detailed dental claims data by making minimal changes to the existing claims system. For example, the appropriate Current Dental Terminology (CDT) procedure codes were included on additional lines on the claim form at a payment rate of \$0.00 so that individual services could be identified without changing the claim format or cost structures.

Stakeholder Collaboration

With agreement from the Iowa Primary Care Association, Iowa Medicaid issued [initial](#) and [follow-up](#) Informational Letters explaining the changes to the reporting requirements. With these new requirements and modifications to previous requirements, Iowa shifted from only collecting data on the incidence of dental visits to collecting detailed data on all dental service provided, including the diagnostic, sealant and treatment services required for reporting to CMS. The collaboration with FQHCs early in the process facilitated the successful collection of new data elements.

Continued Efforts

In 2013, Iowa further refined FQHC billing by programming their Medicaid Management Information Systems (MMIS) to accept the [American Dental Association claim format](#). This will enable the state to capture even more detail on services provided, such as tooth number and quadrant. Such information could not be captured on the CMS claim [Form-1500](#), which had been used for billing dental encounters. Because the ADA claim only accepts CDT codes, FQHCs cannot use the T1015 encounter code to generate payment for the visit. To overcome this difficulty, the Iowa MMIS was programmed to acknowledge the miscellaneous CDT code (D9999), which, when reported on the first claim line, will generate the encounter payment. Collaboration with the state's Primary Care Association revealed that the FQHCs were already billing other insurers using the ADA claim and that many would prefer to also be able to use it when billing Medicaid. An [Informational Letter](#) was sent to the FQHCs advising of the change effective July 1, 2013.

STRATEGY 2: Maximize Provider Participation

Provider participation in Medicaid is critical to ensuring that children and adolescents have sufficient access to dental care. Unfortunately, Medicaid participation among dentists tends to be low, with a [2010 study](#) indicating that **less than half of dental providers saw Medicaid patients** in 25 of the 39 states that reported data. Barriers to participation reported by providers include:

- low reimbursement rates,
- administrative burdens, and
- poor patient compliance.

Reimbursement rates can be a factor in securing dentist participation in Medicaid. Low reimbursement can affect the formation and maintenance of adequate provider networks. Dental overhead costs have [been estimated](#) to demand 60–65% of providers' gross income (depending on state taxes). Thus providers in states where Medicaid does not reimburse at least at this break-even level have little financial incentive to participate.

Dental overhead costs can be 60% of a provider's gross income. Reimbursing at or above the break-even level provides an incentive to participate in Medicaid.

✓ ***Reduce the administrative burden for providers.*** Dentists [report](#) that Medicaid often involves lengthy and complex provider enrollment procedures, lack of clarity in determining patients' Medicaid eligibility, cumbersome prior authorization requirements, and difficult procedures for claims submissions.

States can take a variety of approaches to reduce administrative burdens including:

- Make enrollment easier for dentists by reducing the length of enrollment applications (e.g., in Maryland, dental provider credentialing forms were reduced to half of the length of forms currently used by private insurance carriers).

- Eliminate or greatly reduce the need for prior authorization requirements for children except for the most costly services.
- Choose to keep prior authorization but streamline the process by ensuring that the requirements are [publicized in a format](#) that is easy to both access and comprehend.
- Reduce the amount of information that providers must deliver to the state, and simplify the means of delivery (e.g. providing an option for electronic submission).

In 2000, **Michigan** rolled out its [Medicaid Healthy Kids Dental Program](#) in 22 counties. The program was administered through a commercial dental plan that was well established among Michigan’s dentists, with the same network, the same reimbursement rates, and similar administrative policies. Within the first twelve months, enrolled children increased their utilization of dental services by [31.4%](#). Gradually, the program has been expanded to cover 78 of Michigan’s 83 counties.

Simplifying and Expediting Provider Enrollment: Oklahoma

In 2010, the Oklahoma Health Care Authority launched its [Provider Secure Website](#) to serve as a one-stop shop for providers to:

- Enroll in Medicaid;
- File claims and receive remittance advice;
- Check patient eligibility and third party coverage;
- Secure prior authorization; and
- Communicate with the Medicaid agency.

In addition, the website allows providers to view up-to-date information about a patient’s clinical history based on claims and lab results.

The web portal has met with favorable reviews from Oklahoma’s dentists. They appreciate that the provider enrollment process, which had been paper-based and took as long as 3 months to complete, is now electronic and can yield a provider number in as little as 3 weeks. In addition, participating dentists have reported that the ability to see when and what treatments a member has received helps in treatment management.

Oklahoma Medicaid and its stakeholders agree that the web portal was a good investment. Oklahoma has plans to further enhance the web portal to provide information on medications as well as interface with the state’s hospitals and Health Insurance Marketplace.

Leveraging Contracts to Reduce Administrative Burden: Arizona

The [Arizona Health Care Cost Containment System](#) offers Medicaid dental services through 12 health plans. The state [has leveraged its contracts](#) with these plans to implement provider-friendly reforms with the goal of improving rates of provider participation.

The contracts prohibit plans from shifting risk onto providers through capitated payments, and instead mandate a fee-for-service structure. In addition, the state requires that all plans offer a minimum standard of care that aligns with the clinical recommendations of dentists, such as providing beneficiaries with preventive care at least twice per year. The state also sets standard prior authorization requirements applicable to all plans, so that dentists can easily understand which procedures require prior authorization regardless of the plan.

The system incorporates patient-centered efforts in its reforms as well. For example, plans must conduct follow-up activities with patients who miss appointments, and develop utilization profiles to provide feedback to providers about visit rates and to identify specific members requiring services.

✓ **Help general dentists feel more comfortable treating young children.** The [majority of general dentists](#) in the U.S. do not treat young children. These dentists often report discomfort with treating young children, especially the behavior management aspects, because they were trained only in adult dentistry. This, coupled with the lack in many locations of dentists who specialize in pediatric care, can negatively impact access to dental services for children. States can pursue a number of options to encourage general dentists to accept children as patients.



©ISTOCKPHOTO.COM | NJGPHOTO

- One option is to help general dentists learn more about treating children. The AAPD, for example, developed a [caries-risk assessment guide](#) for children

that providers can use to help them tailor clinical care to the needs of patients with varying levels of caries risk.

- Another option is to offer general dentists brief targeted training in pediatric care. As demonstrated in states such as **Washington** and **South Dakota** (see below), Medicaid programs can take an active role in educating and training general dentists to help them acquire the skills they need to treat children of all ages. In addition, states can also suggest that dentists take advantage of the widely available opportunities for continuing education provided by dental schools and other organizations. For example, the University of **Minnesota** School of Dentistry offers an annual “[Mini-residency in Pediatric Dentistry](#).”
- States can also consider enhanced payment structures targeted at certain ages groups to encourage providers to offer care to very young children (see, e.g., **Texas** First Dental Home, above).

Help General Dentists Be Comfortable Treating Young Children: Washington & South Dakota

Washington

The State of Washington’s [Access to Baby and Child Dentistry \(ABCD\) program](#) focuses on bringing together oral health stakeholders to address dental disease among Medicaid-enrolled children under age six. Started in 1995, the program aims to:

- Engage Medicaid-eligible children by age one;
- Educate families and caregivers about the importance of practicing good oral health care at home and how eating habits can impact oral health;
- Provide outreach and case management to connect families with dental offices;
- Train dentists in best practices for young children; and
- Create referral networks of pediatric dentists for children with more complex treatment needs.

Some of the [key components of the program](#) include identifying participating dentists and [educating](#) these dentists both on appropriate treatment practices and on cost-effective practices for serving young children.

Factors for Success

One contributing factor to Washington’s success is the payment of enhanced rates to dentists for certain preventive and restorative procedures performed for children under age six. These higher reimbursement rates have encouraged both general and pediatric dentists to participate in the program.

The program also focuses on streamlining Medicaid billing for dentists. The state’s Medicaid agency answers all program-related calls by dental offices to guarantee the quick resolution of reimbursement questions. The agency also offers training for participating dental practices on ABCD-related billing procedures.

The University of Washington (UW) School of Dentistry, a program partner, created a comprehensive teaching syllabus for ABCD. More information can be found at the [Learning Objective #1](#) section of the website. UW Pediatric Dentistry faculty and local ABCD dental champions provide hands-on training to dentists in early

Help General Dentists Be Comfortable Treating Young Children: Washington & South Dakota

childhood clinical care for children from birth to age six, including the knee-to-knee exam, lift-the-lip technique and fluoride varnish application. Dentists and staff also learn about the use of anticipatory guidance to advise parents about their child's oral health, nutrition and home care.

Program Results

The [success](#) of the program was evident after the first year: 37% of Medicaid-enrolled children enrolled in ABCD had seen a dentist, compared with 12% of Medicaid-enrolled not participating in ABCD. Additionally, children in the program averaged 2.4 preventive dental visits per year compared with 1 visit per year by non-enrolled children. As a result of this program, the number of Medicaid-enrolled children under age six who received annual dental care almost tripled between 1997 and 2008, from 40,000 to 107,000.

South Dakota

In 2002, Delta Dental of South Dakota launched an [ABCD-type program](#) in an effort to duplicate the successes in Washington. Unlike Washington, South Dakota did not have a strong county-level public health system or case management infrastructure, nor is there a dental school in the state. With only six practicing pediatric dentists and low Medicaid participation among other dentists, access for young children was extremely limited. Given these barriers, Delta Dental chose to adopt the aspect of Washington's ABCD program that focused on increasing general dentist participation in Medicaid as well as their willingness to treat children. In South Dakota's program, once participating dentists complete a training program, they qualify for enhanced Medicaid reimbursement via an add-on fee structure for procedures they perform on children under six years of age. With the direct assistance of staff from Washington's ABCD program, South Dakota held a state-wide ABCD training. By attending this event, dentists qualified for enhanced Medicaid reimbursement and received continuing education credit. The training was attended by 425 dental stakeholders including approximately 60% of the state's then-total of 235 dentists and dental office managers. Under the direction of Washington ABCD staff, pediatric dentists trained general dentists in effective techniques for treating young children. Office managers attended breakout sessions that focused on ABCD add-on fees, Medicaid's coverage of dental services, and coding and billing procedures. The state held two additional regional trainings in other geographic areas to sign up even more providers. New trainings are held every three to four years and the state has also developed a computer-based training module to temporarily qualify new providers for increased reimbursement until they can attend in-person training.

Results

South Dakota saw a number of positive outcomes associated with the launch of their ABCD program. The number of children ages one to two years receiving dental services rose from 6% in 2002 to 26.1% in 2012. Since inception of the program, the number of visits to pediatric dentists increased 159%, and pediatric visits to general dentists climbed 190%.

✓ **Maximize the capacity of the dental workforce.** Many states and communities across the U.S. currently experience a [shortage of dental providers](#). In 2000, there were approximately 1,275 areas, with a combined population of about 28 million people, with a shortage of dental health professionals. By 2012, that number rose to almost 4,450 dental health professional shortage areas with a combined population of more than 47.5 million. As discussed, low rates of Medicaid participation among dentists, and the unwillingness of general dentists to serve children exacerbates this shortage of providers for children enrolled in

Medicaid. Additionally, rural communities face particular challenges in ensuring access to oral health care. These communities face low provider-to-population ratios, as well as an inadequate number of dentists who accept Medicaid. To address these issues, and others, many rural communities are developing [oral health programs](#) that are responsive to the specific needs of their populations.

Ensuring a sufficient and high-functioning dental workforce is an important step in improving access for children in Medicaid. State Medicaid agencies can help maximize the capacity of the dental team to deliver care to enrollees by **reimbursing a broad range of providers** for performing dental and oral health services that fall within their scope of practice.

One strategy for bolstering the capacity of the dental team is to reduce supervision requirements for dental hygienists under certain conditions. Currently, [35 states](#) have policies that allow qualified dental hygienists to provide preventive oral health services in community-based settings (like public health clinics, schools, and nursing homes) without the presence or direct supervision of a dentist, and without the requirement of a dentist having first examined the patient. For example, Missouri dental hygienists with three years of experience who practice in a public health setting may provide fluoride treatments, oral prophylaxis, and sealants, if needed, to Medicaid-enrolled children without the supervision of dentist.

[California and Washington](#) began recognizing and directly reimbursing dental hygienists as Medicaid providers in 1998. As of 2012, [15 state Medicaid programs recognize and directly reimburse hygienists](#). States vary with regard to the services they will reimburse hygienists for (e.g. oral prophylaxis, fluoride, sealants and oral hygiene instructions) and the settings in which they can practice (e.g. nursing homes, group homes, schools, hospitals, and community health centers without dental clinics). In most instances, these hygienists have some level of supervision by a dentist (e.g., through a general dentistry practice, public health, or a dental collaborative), but need not submit their Medicaid claims through their supervising or cooperating dentist.

Many states also have [Expanded Function Dental Assistants](#) or similar types of dental assistants who can complete more complex procedures with reduced supervision after completing certain training and certification requirements. States can encourage the use of these types of providers for more routine care, allowing dentists to address more complex cases. Maine licenses three levels of dental assistants. Table 1 depicts their corresponding capabilities and practice requirements.

Table 1: Maine Dental Assisting [Requirements](#)

Type of Dental Assistant	Scope of Practice	Requirements
Dental Assistant	Various including coronal polishing, suture removal, pouring and trimming dental models, fabricating temporary restorations, removal of composite using slow-speed hand piece to de-bond brackets.	Supervision required (general or direct depending on task).
Certified Dental Assistant	Above duties plus: taking x-rays, temporary restorations.	General supervision and DANB RHS or CDA exam for eligibility for board licensure as Dental Radiographer operator. Board approved training program.
Expanded Function Dental Assistant	All of the above, plus: place and carve restoratives prior to final curing; apply topical fluorides and sealants.	Be a Certified Dental Assistant or licensed as a dental hygienist; and complete a Board approved CODA accredited EFDA program; jurisprudence exam; CPR certificate; certification as EFDA by endorsement approved. 50 hours CE every 5 years required.

In recent years, dental stakeholders and professional groups have proposed several new mid-level provider models, and are in the early stages of piloting or implementing them. Chief among these new models are: Dental therapists and advanced dental therapists in **Minnesota**; Dental Health Aide Therapists in **Alaska**; and, Community Dental Health Coordinators in **Oklahoma** and **Arizona**, described below.

More widespread use of these new mid-level roles may help improve access to Medicaid dental services for children by increasing the number of points of entry into a dental office and the availability of preventive and some restorative services.

Utilizing Dental Health Aide Therapists to Expand Access: Alaska

Scarcity of dental providers combined with a widely-dispersed population impedes regular access to oral health care for much of the population of rural **Alaska**. The Alaska Native Tribal Health Consortium partnered with tribal stakeholders and non-profit foundations to train a new type of dental provider, the [Dental Health Aide Therapist](#).

This provider model originated in [New Zealand](#) where the first Alaskan Dental Health Aide Therapists received two years of training. Since 2007, Alaska has been training this new type of dental provider at both the University of Alaska Anchorage and through rural clinical rotation. Dental Health Aide Therapist students are recruited from the communities they serve to ensure cultural competency and retention of graduates within communities most in need. Tribal health organizations subsidize the training costs which total approximately \$75,000 per student for the two-year program. [Medicaid reimbursements for services](#) sustain practicing Dental Health Aide Therapists in Alaska.

Dental Health Aide Therapists' scope of practice includes prevention services, fillings, and uncomplicated extractions while working under the general supervision of an off-site dentist. No changes to the Alaska State Medical Act or Dental Practice Act were required because the program was established as part of Alaska's Community Health Aide program, which is authorized by Section 121 of the [Indian Health Care Improvement Act](#).

[Three evaluations](#) of the program found that Dental Health Aide Therapists provide safe oral care that meets accepted standards of practice. Interviews with patients indicate their satisfaction with the quality of care. As of 2011, more than 35,000 Alaska Native people living in rural areas had improved access to regular dental care by 25 federally-certified Dental Health Aide Therapists.

Community Dental Health Coordinator: Multi-State Pilot

The American Dental Association (ADA) developed the model of [Community Dental Health Coordinators](#) (CDHCs) to serve as dental-specific community health workers who combine knowledge of oral health and basic preventive skills with a deep understanding of the communities they serve. The intention was for CDHCs to work in both health and community settings, and assist with patient education and connecting patients to care. They can also perform limited dental procedures under the supervision of a dentist, such as screenings, simple cleanings, fluoride prophylaxis, dental sealants, and preparation and placement of certain fillings.

In 2009, the ADA launched a [pilot project](#) that was designed to test the effectiveness and financial sustainability of the CDHC model in urban, rural, and Native American communities. Currently, **Arizona's** Rio Salado College provides the didactic portion of the curriculum via a 12-month online module. Students then undergo six months of clinical training at Temple University's Kornberg School of Dentistry (urban track), the University of **Oklahoma** College of Dentistry (rural track), and A.T. Still University, **Arizona** School of Dentistry & Oral Health (Native American track).

The third cohort of CDHCs completed their training in the fall of 2012. The ADA has estimated that CDHCs will be able to cover their cost of operation by recruiting Medicaid enrollees to the practices where they work. Though formal evaluations are underway to measure whether more children utilized services or if they missed fewer appointments, [preliminary results](#) indicate that the presence of a CDHC within a dental practice greatly increases the number of billable services and total value of services provided. Program data also demonstrate that CDHCs have successfully performed outreach and provided preventive services in schools, churches, Head Start programs, and diabetes clinics.

Expanding Workforce with Dental Therapists: Minnesota

In response to a statewide shortage of dental providers, especially those serving Medicaid enrollees, Metropolitan State University in St. Paul developed a master's level [advanced dental therapy program](#) for individuals who are already registered dental hygienists. The University of Minnesota Dental School subsequently developed its own [dental therapy program](#) that did not require registered dental hygienist licensure as a condition for admission.

Also concerned about the shortage of dental providers in the state, and in response to the availability of these programs, the Minnesota legislature added Dental Therapy to Minnesota's [Dental Practice Act](#) to define the scope of practice, so that graduates could perform at a level commensurate with their training. In addition, the legislation required that these new dental professionals practice in low-income or underserved settings and that 50% of their patient load must consist of traditionally underserved individuals.

Dental therapists must have at least a bachelor's degree in dental therapy and pass both clinical and jurisprudence examinations. Dental therapists practice with on-site supervision of a dentist, performing procedures such as:

- Application of fluoride varnish and sealants,
- Filling cavities,
- Placing crowns,
- Administering local anesthesia and,
- Extracting primary (baby) teeth.

Advanced dental therapists must also graduate from a master's-level dental therapy program, pass clinical and jurisprudence exams, and complete at least 2,000 hours of clinical dental therapy under the direct or indirect supervision of a dentist. Advanced dental therapists may perform all functions of a dental therapist without a dentist on-site and perform more complex procedures, such as adult tooth removal. The more flexible supervision requirements allow advanced dental therapists to practice in settings such as nursing homes, Head Start clinics, homeless shelters, or emergency rooms.

The first class of dental therapists graduated in 2011 and the first advanced dental therapists received certification in early 2013. Given the limited number of therapists, comprehensive evaluations of the effectiveness and care quality are not yet available. However, a [recent review](#) of mid-level dental therapy in other countries found that caries increment and the severity of caries decreased in populations with dental therapists. Furthermore, there was less untreated caries in populations that included dental therapists as part of the dental team compared with populations in which dentists provided all restorative treatment. A [recent study](#) of the economic viability of dental therapists in the U.S. found that dental therapists cost their employers 30 cents for every dollar of revenue they generate.



It's important to visit the dentist while you are pregnant. Why? Your oral health is important for your growing baby's health.

- Tooth decay is caused by bacteria. Your baby can "catch" the bacteria from you.
- Keeping *your* teeth and gums healthy now can help protect *your baby's* teeth later.
- Here's how you can prevent dental disease:
 - Brush and floss daily, and use fluoride toothpaste.
 - Eat a healthy diet.
 - Visit the dentist. Dental care during pregnancy is safe – this includes x-rays and local anesthesia.

Schedule a check-up today. If you need help finding a dentist, ask your doctor. Be sure to tell your dentist or hygienist that you are pregnant.

You could be eligible for free or low-cost health coverage through Medicaid. Some states have dental coverage for pregnant women.

To learn more, call 1-877-KIDS-NOW or visit InsureKidsNow.gov.

For more information about new, affordable health insurance options for the whole family through the Health Insurance Marketplace, visit HealthCare.gov.

NOTES:

 Health Insurance Marketplace



CMS Product No. 11664

Available at InsureKidsNow.gov in both English and Spanish

STRATEGY 3: Directly Address Children & Families

Parents and caregivers are often not aware that their children have dental coverage as part of their Medicaid benefits. They are also not familiar with the steps they can take to protect their children from dental disease. A survey of parents of young children in [Montana](#) found that nearly one in three caregivers either did not believe that they could prevent their child from getting caries or were unsure if prevention was possible. To make prevention an attainable goal, states can provide outreach and education to parents on the preventive care component in the Medicaid dental benefit for children and adolescents, as well as how simple home care steps, if performed daily, can help ensure their children's oral health.

Make prevention an attainable goal: educate parents on the preventive care component in their child's Medicaid dental benefit.

✓ ***Address missed patient appointments.*** Missed patient appointments are clearly detrimental to children who need dental services, and are a reason providers often cite for not wanting to accept Medicaid patients, since providers cannot charge for missed appointments. There are steps states can take to address missed appointments.

- Have state Medicaid staff (or Medicaid dental plan staff) provide an advance reminder call or text about upcoming appointments, and also follow up with families of patients who miss a dental appointment. These staff can also provide counseling on the importance of dental visits, and help reduce barriers for patients in keeping appointments, such as lack of transportation and lack of information about dental offices that have evening and weekend hours.
- Provide information to patients and dental providers about the state's Medicaid transportation policies. Families of children enrolled in Medicaid often cite transportation as a barrier for accessing dental services and a reason for missing scheduled appointments. The Medicaid benefit for children and adolescents requires states to cover the cost of transportation to and from dental appointments for enrollees without their own transportation.

- Disseminate to participating providers, and encourage them to implement, best practices to reduce missed patient appointments among their patients who are Medicaid enrollees. Maryland provides a list of such practices in section 1.07 of its Healthy Smiles Dental Program [Office Reference Manual](#).



**Think Teeth
Every Step of The Way**

Give your baby healthy teeth from the start.

It's easy!

- Gently brush baby's teeth twice a day. Use a tiny amount of fluoride toothpaste.
- Take your baby to the dentist by her first birthday. Continue regular check-ups as recommended.
- Tooth decay is caused by bacteria. Your baby can "catch" the bacteria from you.
 - Keep your mouth healthy.
 - Don't share cups or spoons.
- Put only water, milk or formula in bottles or sippy cups.
- Don't put your baby to bed with a bottle or sippy cup.
- Limit sweet snacks and sugary drinks, including juice.

Medicaid and CHIP cover children's dental services, such as teeth cleanings, check-ups, x-rays, fluoride, dental sealants and fillings. Your child could be eligible!

To enroll your child or find a dentist, call 1-877-KIDS-NOW or visit InsureKidsNow.gov. For more information about new, affordable health insurance options for the whole family through the Health Insurance Marketplace, visit HealthCare.gov.

Health Insurance Marketplace   

2015 PHS-100-11007

Available at InsureKidsNow.gov in both English and Spanish

Connecting With Providers & Patients to Reduce Missed Appointments: Arkansas

In 2007, Arkansas' Medicaid program implemented [ConnectCare](#), a dental coordinated care program, as part of their existing managed care contract with the state Department of Public Health. The goals of the program are two-fold: to help Medicaid families find dental care, and to assist providers with patient follow up. To address missed patient appointments, ConnectCare offers assistance aimed at both providers and patients or their families.

Dental providers can request assistance with both appointment reminders and rescheduling missed appointments. For appointment reminders, ConnectCare contacts patients by phone one business day prior to the appointment. Upon request, they send providers a weekly or monthly report describing the calls, including information on confirmed appointments, calls not answered, calls where a message was left for the patient, and whether the phone number remains a working number. These reports to providers can include whether a provider's patient has seen a different dental provider, is no longer eligible for Medicaid, or has moved to a new address.

If patients miss appointments, ConnectCare follows up with the family daily by phone for three business days in an attempt to reschedule the appointment. When they reach a family member, they assist them with rescheduling their appointment directly with the provider on a conference call. They send a follow-up letter to the provider if they could not reach the family via phone, or if the parent preferred to either not reschedule or to do so directly themselves. ConnectCare also assists [with initial appointment scheduling and arranging transportation](#).

Parents & caregivers are often not familiar with the simple home care steps they can take to protect their children from dental disease.

✓ ***Educate children and families about oral health.*** States can increase the rate at which parents seek dental care for their children, and keep their appointments, by educating children and their families about the importance of oral health and of oral health care. States can also look for opportunities to partner with other oral health stakeholders and programs in order to provide oral health education. Parents and caregivers may be more motivated to ensure their children receive oral health care if they understand the value of proper oral health care (including the need for early preventive dental care), good eating habits, the importance of making and keeping dental appointments, and what to expect during a dental visit. Oral health education for children and their families may include information on:

- Minimizing exposures to dietary sugars;

- Recommended daily oral hygiene practices (e.g., brushing with an appropriate amount of fluoride toothpaste);
- Bacterial transmission from caregivers to children;
- Fluoride supplements; and
- Regular dental care visits for periodic assessments and preventive services.

Adolescents may also [need education](#) on injury prevention and the harm from soda and energy drinks as well as from using tobacco products and other drugs. A number of organizations have developed [Educational Resources](#) on oral health, and some of these can be found at the end of this guide.

States can promote education about oral health by prominently featuring related information in all consumer materials. Every communication that mentions medical care or doctors should also mention dental care or dentists. States can also direct parents to [Insure Kids Now](#), a website designed to help them locate dentists in their communities who treat children enrolled in Medicaid. It lets users search for dentists in their geographic area, provides contact information, indicates if the dentist is accepting new Medicaid patients, and ability to accommodate children with special needs. Including the Insure Kids Now link in consumer materials will help ensure that parents not only know about the dental benefit but are able to identify an oral health care provider taking Medicaid in their community. Additionally, states and stakeholders can utilize [two materials](#), available in both Spanish and English, which CMS created to promote oral health literacy, one aimed at pregnant women and the other at parents and caregivers of children under age three.

A Comprehensive Oral Health Curriculum: Washington

The [Cavity Free Kids program](#), developed by the Washington Dental Service Foundation, is a comprehensive oral health curriculum. In response to a request from a large Head Start program that was frustrated with their inability to impact the cavity rate among the children they were serving, the Washington Dental Service Foundation brought together an experienced childhood and parent educator and a public health dental hygienist to develop this curriculum.

The curriculum was pilot tested in a multicultural setting with input from both parents and teachers, and their feedback on the cross-cultural health values and norms was incorporated into the curriculum. The parent handouts are available in six languages in addition to English.

This program can be offered in a variety of settings, such as provider offices, libraries, WIC centers, and classrooms. For expectant mothers, the curriculum focuses on the importance of maintaining their own oral health, how to care for a baby's teeth, and how to find dental care. Pre-school children learn proper tooth brushing methods, the effects of sugary foods on teeth, and what to expect from a visit to the dentist.

An independent evaluation conducted during the pilot found an increase in tooth brushing, the understanding of healthy foods and the need for regular dental care. Since 2000, through its train-the-trainer model, the Cavity Free Kids curriculum has expanded to twenty states and territories.

STRATEGY 4: Partner with Oral Health Stakeholders

✓ **Partner with the state's Office of Oral Health.** State public health and Medicaid officials can work together to develop strategies to improve the public health infrastructure to increase access to oral health services. Possible strategies are partnering with state oral health programs to enroll Medicaid-eligible children, and reinforcing parent oral health education and building strong linkages to a Medicaid dental home through collaboration with Head Start and Early Head Start oral health programs.

[State Oral Health Plans](#) can be a good source of opportunities for shared priorities and [collaboration](#). Ideally, the Plans are based on an oral health needs assessment and surveillance findings at the state and local levels, and use evidence-based interventions. The Children's Dental Health Project has developed a [State Oral Health Plan Comparison Tool](#), which allows users to compare plans developed by every state. The content of each plan has been categorized to allow users to compare across multiple states and find language around areas of interest. States can use this tool to see what their peers are doing and use the information as a source of ideas for their own state.



[The Partnership for Alignment Project](#) is also a potential resource for improving collaboration between a state's Medicaid program and its Office of Oral Health. The Partnership, led jointly by the [Medicaid-CHIP State Dental Association](#) and the [Association of State and Territorial Dental Directors](#) (ASTDD), has

developed two surveys (available [here](#) and [here](#)) and a process to support improved inter-agency and intra-agency collaboration.

Office of Oral Health Increases County-Level Dental Clinics: Maryland

A 2006 [Survey of the Oral Health Status of Maryland School Children](#) found that 31% of children in kindergarten and 3rd grade had untreated tooth decay in their primary teeth. At the time of the survey, only half of the state's 24 local health departments contained an on-site dental clinic. In an effort to treat more children by increasing access to oral health care, the [Office of Oral Health](#) proposed to overhaul the state's Dental Public Health infrastructure. The plan was to establish health department-linked dental clinics in those counties without one and to improve existing clinics.

The Office of Oral Health [identified](#) six counties to be at highest need and, through the Governor's budget, provided funding for the construction and/or operation of five new clinics and assisted one county to construct a new building to house an existing dental clinic.

While this effort was led and funded by the Office of Oral Health, Maryland Medicaid played an important role in the success of these clinics, particularly since Medicaid reimbursement accounts for most of the revenues that help to sustain the clinics. The partnership between public health and Medicaid was also important for the new clinics as they were able to work directly with Medicaid to quickly and efficiently address issues of provider credentialing and billing.

✓ ***Incorporate stakeholder perspectives in program planning.***

Creating and maintaining a high-functioning dental delivery system demands the active involvement of representatives from all sectors of the oral health community on a wide range of policy and programmatic issues and decisions. Stakeholders can offer insight into entrenched challenges that many dental programs face, and help shape Medicaid policy to more effectively meet the needs of patients and providers.

State Medicaid agencies can bring stakeholders together by convening a Medicaid Dental Advisory Committee. Another approach is to participate in statewide oral health coalitions. States can connect with their oral health coalitions through the [American Network of Oral Health Coalitions](#). Such coalitions can help support Medicaid agency goals when stakeholders work with the agency to identify needs and set priorities. In addition, by participating actively in the state's oral health coalition, a state Medicaid agency can secure broad support for its legislative initiatives. For example, [Georgia's Oral Health Coalition](#) was formed in 1996 in response to a threat to eliminate the state's oral health program. The coalition worked to raise awareness of the importance of oral health and as a result, the state legislature reinstated funding for the oral health program. The coalition has [worked to develop a state oral health plan](#), secure funding for the school-based Georgia Oral Health Prevention Program, and secure significant increases in Medicaid dental reimbursement rates. The

Children’s Dental Health Project is currently in the process of creating a state oral health coalition comparison tool. The State Oral Health Coalition Comparison Tool will be a web-based tool designed to support State Oral Health Coalition capacity building by providing systematic, verifiable information on coalition structure, activities, and priorities nationwide.

A Medicaid Dental Advisory Committee’s Role: Virginia

In 1997 the Virginia General Assembly asked their state Medicaid program to examine and explain low utilization of dental services in Medicaid. The Medicaid program consulted with dental providers to determine the reasons dentists were not seeing many Medicaid patients. In response to the study’s findings, the General Assembly issued a directive requiring the Medicaid agency to continue working with representatives of the dental community on access issues, and to report annually on the state’s efforts to increase access to oral health care. In response to this directive, the Medicaid agency [convened](#) a Dental Advisory Committee to provide guidance on dental coverage and access issues.

Accomplishments

The Virginia Dental Advisory Committee has played an active role in shaping the state’s Medicaid dental program. Composed predominantly of practicing providers, the Committee has 21 members, including representatives from the Virginia Dental Association, Virginia Primary Care Association, Virginia Commonwealth University School of Dentistry, and the Virginia Department of Health. The Dental Advisory Committee’s membership also reflects a cross section of minority and specialty providers. The Committee serves in a consultative role to the Department of Medical Assistance Services, meeting twice yearly and providing key input on a wide range of issues including strategies to increase provider participation and challenges of reducing dental disease in children enrolled in Medicaid.

In 2005 the Dental Advisory Committee helped craft Virginia’s request for proposal for a Medicaid dental benefits administrator. Dental program officials found that incorporating provider priorities into the bid criteria helped them select a vendor with provider-friendly systems, effectively eliminating many of the administrative barriers that previously discouraged Medicaid participation. Indeed, the number of providers participating in Medicaid has more than doubled, from 620 in 2005 to 1,571 in 2011. The Dental Advisory Committee also offered guidance on strategic rate increases to address the lack of specialty dental care.

✓ **Partner with Title V agencies.** Title V of the Social Security Act established the Maternal and Child Health Program to help ensure the health of mothers and children. State Title V agencies [are required](#) to work closely with Medicaid and can assist states in ensuring that enrolled children have access to the care they need. For example, [States can](#) use the relationships between Title V and Medicaid to improve child health and provide screening through Title V–funded pediatric clinics operated by local health departments. Additionally, Title V agencies in some states [have utilized](#) pediatric care settings to promote dental screening and preventive oral health services (e.g., fluoride varnish and dental sealants).

Utilizing Title V Agencies to Deliver Oral Health Services: Iowa

Iowa's Department of Human Services (IDHS) has successfully partnered with Title V agencies to improve access to oral health services for Medicaid-enrolled children. An interagency agreement between IDHS and the Iowa Department of Public Health facilitated the transfer of Medicaid-required outreach and care coordination services to Public Health and the Title V agencies. The Title V agencies then assumed responsibility for meeting the Medicaid screening requirements for children.

Title V agencies in Iowa have also worked with Medicaid to secure reimbursement for oral health services provided by Title V dental hygienists. Reimbursable services include oral health screening, application of sealants and topical fluoride applications. In 1997, one Title V agency submitted a request to IDHS to allow reimbursement for services of dental hygienists using an "exception to policy" (IDHS may grant [exceptions to policy](#) for services not otherwise covered by the state's administrative rules). Due to the critical shortage of dentists willing to treat low-income children, IDHS approved the Title V agency's exception to policy request, thus allowing reimbursement for services provided by Title V dental hygienists.

The success of the initial exception to policy with the provision of preventive oral health services and dentist referrals resulted in more Title V agencies submitting similar exception to policy requests. This ultimately led to a permanent change in the [administrative rules](#) and as of March 1, 2002, IDHS [made these services a standard of care](#), eliminating the need for Title V agencies to apply for an exception to policy in order to provide these services.

Conclusion

States have an important role to play in the adoption and implementation of strategies to increase the use of oral health care among children and adolescents enrolled in Medicaid. The strategies presented in this guide represent a variety of approaches to engage providers, families and other stakeholders. By increasing partnerships with stakeholders, states can identify and pilot innovative approaches to providing children with both more and better oral health care. States can be one of the most important drivers in keeping kids smiling through improved oral health by implementing the strategies outlined in this guide.

What You Need to Know About EPSDT

EARLY: Assessing and identifying problems early

Children covered by Medicaid are more likely to be born with low birth weights, have poor health, have developmental delays or learning disorders, or have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs. Medicaid helps these children and adolescents receive quality health care.

EPSDT is a key part of Medicaid for children and adolescents. EPSDT emphasizes preventive and comprehensive care. Prevention can help ensure the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. It is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

PERIODIC: Checking children’s health at age-appropriate intervals

As they grow, infants, children and adolescents should see their health care providers regularly. Each state develops its own “periodicity schedule” showing the check-ups recommended at each age. These are often based on the American Academy of Pediatrics’ Bright Futures guidelines: [Recommendations for Preventive Pediatric Health Care](#). Bright Futures helps doctors and families understand the types of care that infants, children and adolescents should get and when they should get it. The goal of Bright Futures is to help health care providers offer prevention-based, family-focused, and developmentally-oriented care for all children and adolescents. Children and adolescents are also entitled to receive additional check-ups when a condition or problem is suspected.

SCREENING: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

All infants, children and adolescents should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. *A well-child check-up includes:*

- A comprehensive health and developmental history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate immunizations;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education, including anticipatory guidance.

DIAGNOSTIC: Performing diagnostic tests to follow up when a health risk is identified

When a well-child check-up or other visit to a health care professional shows that a child or adolescent might have a health problem, follow up diagnostic testing and evaluations must be provided under EPSDT. Diagnosis of mental health, substance use, vision, hearing and dental problems is included. Also included are any necessary referrals so that the child or adolescent receives all needed treatment.

TREATMENT: Correct, reduce or control health problems found

EPSDT covers health care, treatment and other measures necessary to correct or ameliorate the child or adolescent’s physical or mental conditions found by a screening or a diagnostic procedure. In general, States must ensure the provision of, and pay for, any treatment that is considered “medically necessary” for the child or adolescent. This includes treatment for any vision and hearing problems, including eyeglasses and hearing aids. For children’s oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health. Some orthodontia is also covered.

Resources

AAP Resources

- [Bright Futures: Recommendations for Preventive Pediatric Health Care](#)
- [Bright Futures Oral Health Risk Assessment Tool](#)
- [Find Oral Health Advocates by State](#)
- [Guide to Children's Dental Health](#)
- [Oral Health Practice Tools](#)
- [Protecting all Children's Teeth \(PACT\): A Pediatric Oral Health Training Guide for Physicians](#)

AAPD Resources

- [Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children](#)
- [Caries-Risk Assessment](#) (see page 2 of link)

ADA Resources

- [ADA Claim form](#)
- [ADA's Mouth Healthy website](#)
- [Community Health Dental Coordinators](#)

American Network of Oral Health Coalitions Resource

- [American Network of Oral Health Coalitions Facebook page](#)

Educational Resources

- [ADA's Mouth Healthy website](#)
- [AAP's Guide to Children's Dental Health](#)
- [AAP's Oral Health Picture Handout for Families](#)
- [Cavity Free at Three's educational materials](#)
- [CDC Children's Oral Health Overview](#)
- [Children's Oral Health Institute website](#)
- [Maryland's Healthy Smiles Dental Program Member Handbook](#)
- [National Maternal & Child Oral Health Resource Center's Bright Futures Toolbox](#)
- [Texas' First Dental Home](#)
- [The University of Washington's General Dental Health Guidance for Parents and Caregivers](#)

Federal Resources

- [CDC Children's Oral Health Overview](#)
- [CDC State Oral Health Plans](#)
- [CMS Oral Health Initiative](#)
- [CMS Guide to Children's Dental Care in Medicaid \(2004\)](#)
- [CMS 416 Form](#)
- [CMS 416 Data \(National and State-by-State\): 1995 to present](#)
- [Insure Kids Now](#)
- [HHS Rural Assistance Center's Rural Oral Health Toolkit](#)
- [HHS National Quality Strategy](#)

State Programs and Resources

- [Georgia's Oral Health Coalition](#)
- [Maryland's Office of Oral Health](#)
- [Maryland's Healthy Smiles Dental Program Member Handbook](#)
- [Maryland's Healthy Smiles Dental Program Office Reference Manual](#)
- [Michigan's Healthy Kids Dental Program](#)
- [North Carolina's Into the Mouths of Babes program](#)
- [Texas' First Dental Home](#)
- [Washington's Access to Baby and Child Dentistry program \(ABCD\)](#)
- [Washington's Cavity Free Kids program](#)

Other Resources

- [Association of State and Territorial Dental Directors \(ASTDD\)](#)
- [Children's Dental Health Project](#)
- [Children's Dental Health Project State Oral Health Plan Comparison Tool](#)
- [Community Catalyst Dental Access Project](#)
- [Medicaid-CHIP State Dental Association](#)
- [Pew Children's Dental Campaign](#)
- [Pew Children's Dental Campaign Analysis of Reimbursing Physicians for Applying Fluoride Varnish](#)
- [The George Washington University's 2005 EPSDT Overview](#)

Citations

1. Section 1905(r)(3) of the Social Security Act
2. CMS State Medicaid Manual § 5140 (A)
3. Section 1905(r)(3) of the Social Security Act
4. CMS State Medicaid Manual § 5110
5. CMS State Medicaid Manual § 5123.2