
RHODE ISLAND'S LEAD SAFE CENTER

Lead poisoning has been recognized as one of Rhode Island's most critical health problems affecting young children. It is estimated that approximately 700 children are lead poisoned each year in Rhode Island. Lead poisoning has serious implications for these children's present and future health status, with known serious adverse effects on future growth and development.

It is also recognized that lead poisoning is both treatable and preventable. With respect to the latter, many environments can be made lead safe through the use of various lead-reduction strategies. Window replacement has been shown to be of particular benefit. Studies have shown that in many cases replacing windows can reduce lead exposure by as much as 80 percent.

The Rhode Island Department of Human Services has established a new Lead Safe Center for children on Medicaid who have been diagnosed with lead poisoning. Comprehensive and intensive case management services will be coordinated at the Lead Safe Center to ensure that children with lead poisoning receive the services they need and to ensure that they are not re-poisoned by continued exposure to environmental lead.

Services that are provided by the Lead Safe Center include:

- Intensive case management, including assistance with relocation or finding temporary housing, as needed
- Family education on establishing and maintaining a lead-safe environment, including training in cleaning techniques
- Coordination and scheduling of housing inspections
- Referrals to and coordination with other health and social service programs (WIC, Head Start, Early Intervention, domestic violence shelters, etc.)
- Replacement of windows based on a housing inspection's documentation of need (for children enrolled in RIte Care)

The Lead Safe Center is coordinated with the Rhode Island Department of Health's Lead program which provides case management, assessments, environmental interventions, and consultation to providers. In terms of case management, the Department of Health's Lead program will refer cases to the Lead Safe Center.

The Department of Human Services certifies vendors as Lead Centers to provide intensive case management and education services to families with children who have been diagnosed with lead

poisoning. The State has received an amendment to its Section 1115 waiver for RIte Care to permit window replacement to be a covered out-of-plan benefit (paid for under the Medicaid fee-for-service system), when a housing inspection determines it would effectively reduce the affected child's future exposure to lead.

There is currently one Lead Safe Center certified by the Department of Human Services in Providence, Rhode Island. The Center is funded by the Health and Education Leadership for Providence (H.E.L.P.), and the Department of Human Services.

EXPANDING ACCESS TO DENTAL SERVICES FOR RHODE ISLAND'S MEDICAID RECIPIENTS

Background

Approximately 130,000 Rhode Islanders receive dental coverage through the State's Medical Assistance program. A number of surveys and focus groups conducted in 1997 indicated difficulty obtaining dental services. The most frequently cited barriers in obtaining dental services include: inability to find a participating dentist, lack of transportation, attitude of dentist and staff, money and fear.

Steps Taken to Improve Access

- **Dental Advisory Committee Established**
 - In the fall of 1998, the Department of Human Services established a Dental Advisory Committee. The Committee's purpose is to develop recommendations for improving access to dental services for individuals covered by the Medical Assistance program. Committee members included: state agencies, dentists, the RI Dental Society, Health Plans, advocate and other private organizations.
- **Results of Dental Advisory Committee to Date**
 - Developed and reviewed 3 options for improving access to dental services for the Medicaid population: (1) including dental services in the RIte Care benefits packages, (2) improving the existing fee-for-service system, (3) using a dental benefit manager to manage and administer the dental services.
 - Consensus on developing a *Dental Benefits Manager* program to manage and administer Medicaid-funded dental services
 - Developed principles for the Dental Benefit Manager program (see attached page)
- RFP for a Medicaid Dental Benefits Manager written
- Requested the Health Care Financing Administration to utilize Title XXI funds to pay for dental services

PRINCIPLES FOR RHODE ISLAND'S MEDICAID DENTAL SYSTEM

The DHS Dental Advisory Committee has set forth the following principles for Rhode Island's improved Medicaid dental system. Medicaid's dental system will:

- Be accessible to all Medicaid enrollees.
- Address the special needs of the entire Medicaid population.
- Provide access to an adequate network of primary care and specialty dentists who can assure members access to timely and geographically available services.
- Include school based dental services.
- Include dental providers with experience serving Rhode Island's Medicaid population, including community health centers, hospital dental clinics, and Traveler's Aid.
- Explore ways to build new capacity in high need, underserved areas.
- Provide choice of participating dental providers.
- Provide access to transportation and interpreter services.
- Include a provider directory which identifies all providers and indicates handicap access, language capacity and location of offices on the bus route.
- Provide user-friendly member services including:
 - Multi-lingual telephone assistance for dental referrals and information.
 - Information and educational materials written at the appropriate reading levels and language.
 - Member education about using preventive dental care.
- Include services to assist participating dental providers, including: provider education, explanation of benefits, responsive provider line to address questions and problems, timely payments, reduction of administrative burden by reducing paperwork, and use of billing codes consistent with current dental practice.
- Provide adequate reimbursement on a fee-for-service basis to dentists, using rates which are adjusted to keep up with the practice changes and costs.
- Allow voluntary participation of dental practices.
- Implement creative interventions to manage the problem of no-shows.
- Have an active advisory committee with consumer and provider participation.

The successful Medicaid Dental Benefit Manager will address the principles outlined above.

**CEDARR SYSTEM OF CARE
FOR CHILDREN WITH
SPECIAL HEALTH CARE NEEDS
ENROLLED IN RHODE ISLAND'S MEDICAID PROGRAM**

The Rhode Island Medicaid Program is planning to expand benefits and assure timely access to services for children with special health care needs enrolled in Medicaid. The following is a summary of frequently asked questions about this Medicaid expansion initiative.

Why is Rhode Island's Medicaid Program planning to expand benefits to children with special health care needs?

In 1997 the Medicaid Program conducted a survey of 400 parents of children with special health care needs enrolled in Medicaid. Over 20 percent of these parents described significant unmet needs for the following health and health-related services:

- Over-the-counter medications
- Support groups and information related to their child's health condition
- Respite services
- Transportation to medical visits
- Children's mental health counseling
- Dental care
- Assistance in navigating the health care system

What was done as a result of these survey results?

Medicaid's Center for Child and Family Health, which has responsibility for all children enrolled in Medicaid and RIte Care, formed a planning group in 1998 called the Children's Leadership Roundtable. This group is composed primarily of parents, and also includes advocates, providers, State agencies and policy makers. The Roundtable met five times during 1998 and 1999 to assist DHS in constructing a plan to improve services for children. Approximately 75 people attended each meeting.

What did the Roundtable recommend?

In addition to the unmet needs identified in the survey, the Leadership Roundtable process concluded that Rhode Island families with children with special needs participating in Medicaid have unmet needs for information, objective professional assessment, care planning, assistance with referral to services and family support. Families reported difficulty in knowing where to enter the system, how to obtain quality diagnosis, evaluation and health care for their children.

The Roundtable established the following vision for Rhode Island children and families:

- "All Rhode Island children and their families have an evolving, family-centered strength based system of care, dedicated to excellence, so they can reach their full potential and thrive in their own communities."

The Roundtable recommended that Medicaid expand its services to provide a family-centered system of evaluation, care planning, family support, and timely access to health services needed by children and their families. This expanded system of services to be offered to Medicaid enrollees is called CEDARR System of Care:

- Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation, Services and Supports.

How will families access these expanded CEDARR services?

There will be two parts of the CEDARR system:

1. CEDARR Family Centers, which will provide the following family-centered and family-directed services:
 - CEDARR Family Center Basic Services and Supports
 - Initial Family Assessment (IFA)
 - Initial Triage
 - Special Needs Library and Info-Line
 - Resource Identification
 - System Mapping and Navigation
 - Peer Family Guidance
 - CEDARR Family Center Specialized Services
 - Clinical Capacity in a designated specialty area
 - Crisis Intervention and Management 24 hrs/day
 - Comprehensive Evaluation, Diagnosis and Assessment
 - Family Care Planning
 - Family Care Coordination
 - Re-evaluation of Care Plans
 - Quality Assurance/Data Collection/Outcome Measures

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2. CEDARR certified treatment providers will provide a flexible scope of comprehensive family-centered health services, including enhanced treatment services beyond Rhode Island's current scope and capacity of Medicaid covered services. Medicaid will expand capacity by purchasing these services from existing providers already serving children with special needs. Many of these quality providers face resource constraints. By purchasing a flexible scope of needed services with new dollars Medicaid will greatly strengthen the system of care for children with special health care needs.

How will Medicaid expand to encompass the CEDARR system of care?

Medicaid will expand its scope of covered benefits to include all the new services to be provided by CEDARR Family Centers, as well as new or expanded treatment services, such as intensive behavioral therapies, and in-home supportive services.

Medicaid will enroll providers of new services, such as CEDARR Family Centers, and will expand its current provider network for treatment services. This will be done by issuing certification standards for providers. Certification standards will specify the requirements for providers. Any provider who can meet the certification standard requirements for a service will be able to enroll as a Medicaid provider at any time.

It is anticipated that current Rhode Island community based providers serving these families will be part of the CEDARR System of Care.

Will CEDARR Family Centers be specialized?

All CEDARR Family Centers will provide both (1) basic intake and support functions, and, (2) specialized professional services in at least one of the following areas of special needs:

- Autism spectrum disorders
- Behavioral health
- Developmental disabilities
- Medical or physical disabilities
- Technology dependent care

How will families access the CEDARR System of Care? Where will these services be located?

CEDARR services, including Family Center services and treatment services will be available in local, convenient familiar community setting as CEDARR is intended to build on, fund, and enhance the capacity of the current community-based system of care.

DHS is requiring that CEDARR Family Centers have the capacity to serve families in their community, while also requiring one statewide point of accountability for administrative functions.

How will CEDARR coordinate with other State supported programs serving children with special health care needs, (e.g. Special Education, Early Intervention)?

In developing care plans with families, CEDARR Family Centers will be required to actively work with other providers to ensure that treatment programs are comprehensive and consistent.

When are CEDARR expected to be operational?

DHS has issued draft certification standards for CEDARR Family Centers for comment by the Leadership Roundtable and others. Certification standards for treatment providers are in development. It is anticipated that final certification standards will be issued this winter, and providers can be certified and operational by Spring 2000.



ARTICLE 3

SURVEY OF MEDICAID CHILD DENTAL SERVICES IN WASHINGTON STATE: PREPARATION FOR A MARKETING PROGRAM

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ABSTRACT

The authors surveyed Washington state dentists to gain an understanding of their participation in the Medicaid dental program, their willingness to learn more about the program and the degree of importance they attached to preventive care for preschool-aged children. They found that concerns about fees and administrative aspects predominated and concerns about client behaviors were expressed less often. Many dentists indicated a willingness to learn more about the program. These findings will be used to develop a plan to market the Medicaid program to Washington state dentists.

Approximately one-fourth of the children in Washington state are eligible for Medicaid dental services. This includes the children in the traditional low-income population, as well as the children of the working poor covered by Medicaid through Washington state's Basic Health Plan. Children in families having incomes of up to 200 percent of the federal poverty levels are eligible. In theory, dental treatment benefits should be extended to more than half a million children in Washington state who will benefit from it the most. According to recommendations from the American Academy of Pediatric Dentistry, all children should have at least biannual dental visits.¹ Nevertheless, only 28 percent of children from birth to 17 years of age made at least one visit to the dentist in 1996. Thus, utilization rates for Medicaid children's dental services are particularly low. The utilization rates are similar in most other states.²

Nominally, two-thirds of Washington states' active dentists serve the Medicaid-insured population; 25 percent of the dentists, however, care for 89 percent of the children who are seen (Carree Moore, Dental Program Manager, Department of Social and Health Services Medical Assistance Administration, personal communication, 1998). This disparity is a key factor in the limited access to dental services for children from low-income families. In addition, the number of dentists in some rural counties, in which a large number of Medicaid-eligible children may live, ranges from zero to four, thus further exacerbating the access problem.³

In the areas with large supplies of dentists, the reasons that more dentists do not see Medicaid clients are complex. The typical reasons dentists gave for their personal lack of participation were that the reimbursement fee levels are low, payment is not timely and the system is bureaucratic, and the population is difficult to work with; they are no-shows, cancel appointments or do not comply with care instructions.^{4,7}

The law mandates the provision of certain preventive services for Medicaid-eligible children. The federal Early Periodic Screening, Diagnostic and Treatment, or EPSDT, program enacted in 1967 requires that under the Medicaid program all states make provisions for preventive dental services to children. The states' two primary

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responsibilities under this program are to ensure that there will be providers who are available and accessible to eligible children and to make families of Medicaid-eligible children aware of the available resources and to help them use those resources. Although federally mandated, the success of the EPSDT program requires implementation and continual assessment by the states. There is little evidence of serious efforts made by many states to fulfill this mandate, suggesting that the problem of underutilization will not be solved by broad legislative action.^{2,8,9}

It is obvious that use of dental services by Medicaid-eligible children needs to increase dramatically. It is, however, unclear what the best approach is to accomplish this feat. A number of states including Washington have appropriated funds to raise the low reimbursement fees—a widely held concern of many dentists in Washington state. However, fee increases alone have little impact on access to dental care. Raising fees appears necessary, but not sufficient, for increasing participation among providers not seeing Medicaid clients.^{10,11}

This suggests that other barriers are involved in creating the access problem. For example, dentists hold stereotypes of the Medicaid program and its clients.^{4,6} In the absence of a concerted effort to address the dentists' concerns and to market a program based on alleviating these concerns, little change can be expected. At the same time, many Medicaid recipients have little experience effectively using the dental care system and may be unaware of the need for regular dental care.¹² It

is unlikely that the problem will be solved by broad legislative action. As in other businesses, the dental community may not wish to be forced to conduct their business based on governmental regulations. It will take communitywide action to combat this problem.

The purpose of our study was to learn more about the opinions and views of Washington state dentists regarding the Medicaid dental program with special attention paid to the program for young children. Disease prevention in preschool-aged children is the state legislature's and Medicaid program's highest dental priority.

The use of dental services by Medicaid-eligible children needs to increase dramatically. It is, however, unclear what the best approach is to accomplish this feat.

We conducted this study in preparation for developing a marketing plan for the children's program. Our objectives were as follows:

- describe dentists' participation in the Medicaid children's dental program;
- determine the willingness of dentists to learn more about the Medicaid children's dental program;
- assess the degree of importance dentists placed on care and priority of funding for very young children;
- understand the concerns and stereotypes about the program

held by dentists that might be addressed in a marketing program.

SUBJECTS AND METHODS

Sample. We drew a random sample of 531 Washington state dentists from the ADA Masterfile. We separated the sample into 10 replicates of 50 potential respondents each and one replicate of 31 potential respondents. We used the latter replicate during pretesting, but did not include its results in our data.

Instrumentation. The telephone interview instrument was constructed in consultation with the staff of the Washington state Department of Social and Health Services, or DSHS, Medical Assistance Administration and the Washington State Dental Association. The questionnaire consisted of 136 questions in four general areas: general opinions on the treatment of children, general information on Medicaid child clients treated, administration of the Medicaid program, and usual and customary fees charged vs. the amount of DSHS reimbursement. In addition, the questionnaire included a demographic section.

Survey procedure. Telephone interviews were conducted by interviewers at the Social and Economic Sciences Research Center, or SESRC, at Washington State University. Potential respondents were notified of the study by mail to inform them that they would be called by an SESRC interviewer and asked to participate in an important study on their opinions about Medicaid dental services. The letter assured the respondents that their participation

was voluntary and that any information they provided would be kept confidential. Because the questionnaire included many questions that could be answered by front-office staff members, the initial mailing also included a copy of the questions that would be asked during the telephone interview. This was done to reduce the length of the interview and to improve the quality of the data obtained. Some dentists chose to complete and mail in the questionnaire.

Interviewers made a minimum of eight call attempts to reach each dentist. Most telephone interviews were conducted during normal business hours; dentists were given the opportunity to reschedule the interview if they were reached at an inconvenient time. The interviews were conducted during February 1997 and averaged 25 minutes each. The study protocol was approved by the human subjects review boards of Washington State University and the DSHS.

Response rate. We determined that 480 dentists in the random sample were eligible for the study. A total of 317 eligible dentists completed telephone interviews, and 19 mailed in completed questionnaires. A total of 68 eligible dentists refused to complete the interview. A total of 18 dentists were ineligible as they were retired, and 58 could not be reached or had nonworking telephone numbers. The three primary reasons the 68 dentists who refused to participate gave were that the study was too long or they did not have enough time; they did not treat Medicaid clients or children; or they did not participate in surveys. The response

TABLE 1

LEVEL OF MEDICAID PARTICIPATION, BY SPECIALTY

SPECIALTY	NUMBER OF MEDICAID PATIENTS SEEN IN 1996 (%)					
	0	1-25	26-50	51-100	101-200	> 200
General Dentists N = 245*	74 (30)	79 (32)	29 (12)	22 (9)	19 (8)	18 (7)
Pediatric Dentists N = 10†	0 (0)	1 (10)	0 (0)	0 (0)	2 (20)	6 (60)

* Four general dentists did not know the level of Medicaid participation in the office.

† One pediatric dentist did not know the level of Medicaid participation in the office.

rate was 70 percent (336/480).

The final respondent pool of 336 dentists was composed of 76.2 percent (256) in general practice, 8.9 percent (30) in orthodontics, 4.2 percent (14) in oral surgery, 3.3 percent (11) in pediatric dentistry, 2.4 percent (eight) in periodontics, 2.1 percent (seven) in endodontics and 3 percent (10) in other specialty practices. This study focuses on general and pediatric dentists who are the primary dental caregivers for children.

The typical respondent had been in practice 21 years and had practiced in the same office for 14 years. A total of 308 dentists of the 331 who answered the question reported being willing to accept new clients, including those whose fees were paid by Medicaid.

Data management and analysis. The interviews were conducted from the Public Opinion Laboratory of the SESRC. The interviewers used the SESRC's Micro-Computer Assisted Interviewing, or MATI, computer program. The MATI program displayed questions on a computer monitor from which the interviewer read the question to the respondent and entered the appropriate response directly into the computer for

data storage. The interview data were then converted into Statistical Package for the Social Sciences (SPSS Inc.) format for analysis. The analyses were performed on general or pediatric dentists' responses including descriptive analysis, as well as Pearson's correlation coefficient (r) and comparing means (Student's t -test). The descriptive statistics performed were frequencies of a particular response by general dentists or pediatric dentists and cross-tabulations of the response frequencies by willingness to receive information. Not all respondents answered every question. Therefore, we calculated percentages based only on the number of dentists who responded to a particular question.

RESULTS

Participation in the Medicaid children's program. We found that 62 percent (153/245) of the general dentists who responded to the question saw 25 or fewer Medicaid-enrolled children in 1996. In contrast, 60 percent (6/10) of the pediatric dentists who responded to the question reported seeing 200 or more Medicaid-enrolled children (Table 1). The dentists were

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TABLE 2

GENERAL DENTISTS' MEAN FEE LEVELS BY PRACTICE LOCATION COMPARED WITH MEDICAID REIMBURSEMENT MEAN FEE LEVELS, 1997 DOLLARS.

FEE CATEGORY	MEAN FEE LEVELS (\$)			
	Child Initial Oral Examination ($\pm$ SD)*	Bitewing Radiographs and Four Films ($\pm$ SD)	One Primary Surface Amalgam ($\pm$ SD)	One Permanent Surface Amalgam ($\pm$ SD)
Downtown/City	36.50 ($\pm$ 12.6)	34.21 ($\pm$ 5.7)	56.45 ($\pm$ 14.6)	71.52 ($\pm$ 13.7)
Suburban	37.34 ($\pm$ 9.7)	34.15 ($\pm$ 6.6)	50.43 ($\pm$ 12.0)	72.97 ($\pm$ 12.1)
Rural	33.83 ($\pm$ 6.8)	32.34 ($\pm$ 5.3)	53.83 ($\pm$ 15.5)	66.34 ($\pm$ 15.6)
Medicaid Reimbursement	30.80†	10.10†	50.00†	50.80†

* SD: Standard deviation.

† Standard deviation not necessary.

asked to identify the single most important factor influencing their decision whether to provide care to Medicaid child clients. The factor they identified most was low fees paid by Medicaid.

The typical general dentist surveyed received two or fewer calls per week from Medicaid clients seeking emergency or routine dental care, and the typical pediatric dentist received five or fewer calls per week. About 15 percent of the general dentists reported receiving more than 10 calls per week for both types of care, while one-third of the pediatric dentists reported receiving more than 10 calls per week for both types of care. General dentists who saw more than 25 Medicaid clients per week received more calls for both types of care than did general dentists who saw fewer Medicaid clients ($r = .30$, $P = .00$; and $r = .369$, $P = .00$; respectively). We did not find a correlation between the number of Medicaid

clients and the number of calls for care made to pediatric dentists.

Relationship between fees and participation. We created a fee index by summing the usual and customary fees reported by dentists for child initial oral examination, bitewing radiographs with four films and one primary surface amalgam and one permanent surface amalgam. In 1997 dollars, this fee index ranged from \$65 to \$320 with a mean of \$200 (standard deviation, or SD, = \$32) for general dentists and from \$177 to \$237 with a mean of \$212 (SD = \$22) for pediatric dentists.

In the fee index, there was a significant difference by location of practice for the general dentists but not the pediatric dentists (respectively, F statistic [2,218] = 5.48, $P = .01$; F statistic [2,5] = .70, [P = not statistically significant, or NS]. Post hoc analyses revealed that mean fee levels were significantly different between general dentists in suburban practices and general

dentists in rural practices; mean fee levels were lower in rural settings than in suburban settings (Table 2). The mean Medicaid reimbursement fee levels were fairly comparable to the mean fees of general dentists in rural settings, except for bitewing radiographs and permanent amalgams. We found no differences in the Medicaid child participation rate by practice location: downtown/city, suburban or rural.

For general dentists, we found a significant difference in the fee index between those who saw 25 or fewer Medicaid child clients and those who saw more than 25 Medicaid child clients in 1996 (mean = \$204, SD = \$33 vs. mean = \$193, SD = \$29; t [217] = 2.5, $P = .01$). That is, practices with higher fees were less likely to see Medicaid children. The number of pediatric dentists participating in this study was too small for us to conduct this statistical analysis, although we found that this trend appeared to be identical.

General dentists who saw 25 or fewer Medicaid child clients did not differ in their length of time practicing dentistry compared with those dentists who saw more than 25 Medicaid child clients (t [239] = 1.1, $P = \text{NS}$). Older dentists, however, were less likely to see Medicaid children.

For those general dentists who saw any Medicaid child clients in 1996, the largest percentage of their clients were in elementary school (mean = 43 percent, SD = 25 percent) and middle school (mean = 23 percent, SD = 19.5 percent). A mean of 15 percent (SD = 21.2 percent) of these Medicaid child clients were preschoolers. Approximately one-third of these gener-

al dentists saw no preschoolers.

Of those children seen, the general dentists reported entering 74 percent into regular recall programs. About one in seven dentists did not enter any children into the regular recall system. There was no significant difference in the percentage of children who were placed on a regular recall schedule between dentists who saw 25 or fewer Medicaid child clients and those who saw more than 25 Medicaid child clients in 1996 (mean = 69 percent, SD = 44 percent, vs. mean = 79 percent, SD = 32 percent; $t [157] = -1.7$, $P = \text{NS}$).

General dentists were asked if they would be accepting new patients, patients of family members or no patients in the following year. Most dentists (92 percent) indicated a willingness to accept new patients, regardless of the number of Medicaid clients seen.

Importance of care of young children. Respondents were asked whether it was appropriate for dentists to care for infants and toddlers and whether funds should be prioritized by Medicaid for them. Fifty-five percent (130/237) of the general dentists and all the pediatric dentists who responded to the question said they felt that it was definitely or probably appropriate to provide care to young children (Table 3). A total of 41 percent of general dentists (99/239) and 78 percent (7/9) of the pediatric dentists who responded to the question said they thought Medicaid funds should be prioritized for dental care for young children (Table 4). Fifty-nine percent of the general dentists surveyed thought Medicaid funds probably or definitely should not be

TABLE 3

APPROPRIATENESS OF PROVIDING CARE TO YOUNG CHILDREN, BY PERCENTAGE.

SPECIALTY	DEFINITELY YES N (%)	PROBABLY YES N (%)	PROBABLY NO N (%)	DEFINITELY NO N (%)
General Dentists N = 237*	58 (25)	72 (30)	87 (37)	20 (8)
Pediatric Dentists N = 10†	8 (80)	2 (20)	0 (0)	0 (0)

* Nineteen general dentists did not respond to the question.

† One pediatric dentist did not respond to the question.

TABLE 4

APPROPRIATENESS OF PRIORITIZING FUNDING FOR YOUNG CHILDREN, BY PERCENTAGE.

SPECIALTY	DEFINITELY YES N (%)	PROBABLY YES N (%)	PROBABLY NO N (%)	DEFINITELY NO N (%)
General Dentists N = 239*	36 (15)	63 (26)	109 (46)	31 (13)
Pediatric Dentists N = 9†	2 (22)	5 (56)	1 (11)	1 (11)

* Seventeen general dentists did not respond to the question.

† Two pediatric dentists did not respond to the question.

prioritized for this population.

We found that the higher the proportion of preschoolers in the general dentist's Medicaid caseload, the higher the priority assigned to children's care ($r = -.21$, $P = .01$). Dentists who saw more preschoolers, however, did not assign a higher priority to funding that care ($r = -.04$, $P = \text{NS}$). Also, dentists who received more calls for emergency and routine care did not assign a higher priority to children's care and funding ($r = -.12$, $P = \text{NS}$; $r = -.11$, $P = \text{NS}$, respectively) than did dentists who received fewer calls. In addition, we found that the priority level the dentists assigned to dental care for children was unrelated to the dentists' fee levels.

Willingness to receive more information. Of all the dentists surveyed, most general dentists who responded to the question knew a lot (37 percent, or 124/335) or something (39 percent, or 129/335) about the Medicaid program. A majority of those general dentists who responded to the question felt that the program was moderately effective (57 percent, or 171/302) or very effective (10 percent, or 29/302) in improving the health of children.

To determine a dentist's likelihood to begin or increase participation in the Medicaid dental program, the interviewers asked each dentist about his or her willingness to receive more information about the program.

TABLE 5

ASSESSMENT OF THE MEDICAID PROGRAM'S ADMINISTRATIVE PROBLEMS.

ADMINISTRATIVE PROBLEMS	MAJOR PROBLEM		MINOR PROBLEM		NOT A PROBLEM	
	General Dentists % (n)	Pediatric Dentists % (n)	General Dentists % (n)	Pediatric Dentists % (n)	General Dentists % (n)	Pediatric Dentists % (n)
Knowing a patient is covered by Washington state's Department of Social and Health Services, or DSHS, children's program	17 (17/102)	0 (0/4)	55 (56/102)	50 (2/4)	28 (29/102)	50 (2/4)
Fee levels in the children's program	52 (53/101)	75 (3/4)	33 (33/101)	0 (0/4)	15 (15/101)	25 (1/4)
Payment speed	57 (59/103)	50 (2/4)	24 (25/103)	50 (2/4)	18 (19/103)	0 (0/4)
Mistakes on payments by DSHS	20 (19/97)	25 (1/4)	47 (46/97)	75 (3/4)	33 (32/97)	0 (0/4)
Dealing with third-party coverage	34 (34/100)	50 (2/4)	36 (36/100)	50 (2/4)	30 (30/100)	0 (0/4)
Getting prior authorizations	30 (30/101)	25 (1/4)	36 (36/101)	25 (1/4)	35 (35/101)	50 (2/4)
Getting questions answered	50 (51/103)	50 (2/4)	34 (36/103)	25 (1/4)	17 (17/103)	25 (1/4)

Fifty-two percent (129/246) of general dentists and 40 percent (4/10) of pediatric dentists who responded to the question said they were willing to receive more information. Irrespective of practice type, we found that 79 percent of dentists who were willing to receive information already saw Medicaid children compared with 62 percent of their peers who were not willing to receive more information (Mann-Whitney U test = 5,495, $P = .01$). However, among the 129 general dentists who were willing to receive information, 22 percent (28/129) saw no Medicaid child clients in 1996 and 33 percent (43/129) saw 25 or fewer child clients in 1996, indicating the opportunity to increase their participation.

Characteristics of general dentists willing to receive more information. Having identified a group of 127 general dentists and two pediatric

dentists who could increase their participation and who were willing to receive more information, we conducted analyses to better understand their views about Medicaid.

Importance of care for infants and toddlers. Within this subset of general dentists, 54 percent (69/127) of general dentists who responded to the question felt that it was definitely or probably appropriate to provide care to very young children. Forty-five percent (56/125) of the respondents to the question felt that funds should be prioritized for the care of young children.

The general dentists were asked to rate their skills in pediatric dentistry relative to those of other dentists. Of the 127 dentists who responded to the question, 67 percent (85/127) rated themselves as much more skilled or somewhat more skilled than their peers;

31 percent (40/127) rated themselves as about the same, and 2 percent (2/127) rated themselves as somewhat less skilled or much less skilled. We found no relationship between how dentists rated their skills and whether they believed that providing care and funding to children was appropriate.

The Medicaid program's administrative problems. The interviewers asked those 129 general dentists who were willing to receive information to rate whether several areas associated with the Medicaid program were problems and the degree to which they were a problem. The areas they were asked to rate were knowing a client was covered by DSHS children's program, fee levels in the children's program, payment speed, mistakes on payments by DSHS, dealing with third-party coverage, getting prior authoriza-

TABLE 6

ASSESSMENT OF MEDICAID CLIENT BEHAVIORS.

CLIENT BEHAVIORS	MAJOR PROBLEM		MINOR PROBLEM		NOT A PROBLEM	
	General Dentists % (n)	Pediatric Dentists % (n)	General Dentists % (n)	Pediatric Dentists % (n)	General Dentists % (n)	Pediatric Dentists % (n)
No-shows	23 (29/128)	75 (3/4)	64 (82/128)	25 (1/4)	13 (78/128)	0 (0/4)
Last-minute cancellations	25 (32/128)	0 (0/4)	64 (82/128)	100 (4/4)	11 (14/128)	0 (0/4)
Being late	20 (25/128)	25 (1/4)	59 (76/128)	50 (2/4)	21 (27/128)	25 (1/4)
No follow-through	21 (27/128)	25 (1/4)	61 (77/128)	75 (3/4)	19 (24/128)	0 (0/4)
Unruly children	9 (11/127)	50 (2/4)	57 (72/127)	50 (2/4)	35 (44/127)	0 (0/4)
Language difficulties	9 (11/128)	0 (0/4)	41 (53/128)	75 (3/4)	50 (64/128)	25 (1/4)
Not bringing program identification	8 (10/121)	25 (1/4)	47 (57/121)	50 (2/4)	45 (54/121)	25 (1/4)
Not coming back for recall appointments	13 (17/128)	0 (0/4)	58 (74/128)	75 (3/4)	29 (37/128)	25 (1/4)

tion and getting questions answered. The areas associated with the Medicaid program that were considered major problems by most general dentists who responded to the question were fee levels in the children's program (52 percent, or 53/101; and 75 percent, or 3/4; respectively), payment speed (57 percent, or 59/103; and 50 percent, or 2/4; respectively) and getting questions answered (50 percent, or 51/103; and 50 percent, or 2/4; respectively) (Table 5).

The majority of both types of dentists who responded to the question reported that the fees in the Medicaid children's program were lower than their usual fees (93 percent, or 107/115; and 100 percent, or 4/4; respectively). They also reported being aware of the recent increase in fees to dentists for child services (81 percent, or

104/129; and 100 percent, or 4/4; respectively). An index of the maximum allowable Medicaid child fees was created by summing the maximums for the same services as the previously computed fee index—child's initial oral examination, bitewing radiographs with four films, one surface primary amalgam and one surface permanent amalgam. When the dentists were divided into those who indicated that fees were a problem and those who did not, the difference between the individual fee index minus the Medicaid index for each practice was not significantly different between the two groups (t [164] = .68, P = NS). The mean difference in fee index for those who did not feel fees were a problem was \$55 (SD = \$31) compared with \$58 (SD = \$32) for those who felt fees were a problem.

Client behaviors. The inter-

viewers asked the general and pediatric dentists to rate whether several areas associated with parent or child client behavior were considered problems and the degree to which they were a problem. The areas they were asked to rate were no-shows, last-minute cancellations, being late, no follow-through, unruly children, language difficulties, not bringing program identification and not coming back for recalls. Most Medicaid client behaviors were considered to be minor problems for the majority of general and pediatric dentists (Table 6).

DISCUSSION

Level of participation. Data from our survey confirm that a majority of Washington state general dentists cared for 25 or fewer Medicaid children during 1996. We also found that most of these children were school-

aged, pediatric dentists saw more Medicaid-eligible children than did general dentists, and, overall, all dentists with higher fees saw fewer Medicaid-enrolled children. These data suggest that adjustments to individual fees rather than the whole fee schedule might reduce the disparity between the Medicaid fee schedule and the fees charged by general and pediatric dentists. For example, we found that the mean fee for bitewing radiographs with four films was between \$32.34 and \$34.21, while the maximum Medicaid reimbursement was only \$10.10. Also, because of federal guidelines, the fee schedule fails to recognize the difference in fees between downtown/city and suburban areas and rural areas. The disparity between fees and the allowances is much greater in the downtown/city and suburban areas than in rural communities. Fees have not been regularly adjusted for cost-of-living increases for the program to appear equitable to the dentist.

We also found that general dentists who reported seeing fewer Medicaid-enrolled children received fewer emergency and routine care calls. This may be because they are not located where Medicaid clients live or because they have reputations for not seeing many Medicaid clients. We believe it is likely that both elements are factors in this problem. A 1995 survey of parents of Medicaid children in Washington state indicated that obtaining dental care is the biggest health care access problem they face. (P. Milgrom, D.D.S., unpublished data, 1995).

Most dentists indicated that they were willing to accept new patients, suggesting that they

had the ability to expand their patient caseload. Fifty-two percent of general dentists and 40 percent (4/10) of pediatric dentists indicated that they were willing to receive more information about the Medicaid dental program. Many of these general dentists already are providers in the program, but a sizable number see relatively few clients—25 or fewer per year. We believe marketing efforts should target these dentists to increase participation rather than focus on the more difficult

Most dentists indicated that they were willing to accept new patients, suggesting that they had the ability to expand their patient caseload.

problem of converting dentists who are not already providers. In addition, focusing on general dentists is important, as most pediatric dentists already have a large caseload of Medicaid child clients and many underserved communities do not have pediatric dentists.

Importance of care and funding. A much larger problem revealed by this survey is the degree of importance dentists assigned to providing care to and prioritizing funding of care for very young children. While most dentists recognize the importance of providing preventive care for young children, 45 percent of the general dentists polled felt that it was definitely or probably not important to care for infants and toddlers and 59 percent felt that it was definitely or probably not impor-

tant to prioritize funding for this population. This is in contrast to the views of most pediatric dentists. This attitude is reflected in the low percentage (14 percent, SD = 21.2) of Medicaid preschool-aged children who are seen by general dentists.

Many poor children do not visit a dental office until they reach elementary school.² Only in special-interest communities, such as the Head Start/Early Childhood Education and Assistance Program in which dental examinations are mandated, do Medicaid-eligible preschool-aged children have access to a dentist. These findings underscore the need to spread understanding of the high incidence of early childhood caries in young children among general dentists and to make available to these dentists the newest preventive technologies and effective techniques. Otherwise, disease progression creates an expensive and difficult-to-solve public health problem. This issue of priorities reflects a crisis of conscience in dentistry rather than being a problem of the Medicaid program per se. The 1997 Early Childhood Caries Conference in Bethesda, Md., addressed this problem.

Reimbursement fee levels. The data from this survey also indicate that dentists hold views about the Medicaid program that are sometimes incorrect or oversimplified. Low reimbursement fees were the single most important factor communicated by both general and pediatric dentists for determining whether they would provide care to a Medicaid child client. Even with a recent increase in maximum allowable fees, many dentists said they

felt that the Medicaid fees were lower than their usual charges. We found, however, that not all dentists whose regular fees were higher than the Medicaid allowances saw this as a major problem. Nevertheless, we feel that fine-tuning the Medicaid dental program to eliminate medically ineffective or less-needed services to allow key fees to be raised within the range of available funds should be considered. In doing so, there needs to be adequate peer review to protect unwary clients from being charged directly for eliminated services.

Administrative issues. A major concern that 50 percent of general and pediatric dentists reported having was getting questions about billing issues answered. The toll-free number that Washington state dentists are asked to use to obtain billing information functions poorly. Most dentists feel that not only are they on hold for an extended period of time but that their questions are not answered satisfactorily. We feel that before the Medicaid dental program marketing efforts begin, efforts need to be made to correct this problem. For example, the views of many of the dentists who were surveyed about billing speed appear to be incorrect. When the program is marketed, this misunderstanding can be addressed and methods can be found to reduce errors.

In a demonstration project we are conducting with the children's Medicaid dental program in one Washington state county, we decentralized the help function by training a local dental society employee to answer questions and giving her access to key staff members in the Medicaid program.¹³ This strat-

egy eliminated most problems. In addition, the Medicaid field staff members have offered on-site training for dental office staff.

Client behavior. In contrast to other literature,⁹ the dentists responding to our survey did not report having major problems with their clients' behavior. This may be because front-office staff members most often screen potential Medicaid-enrolled clients and protect dentists from these problems, or dental office systems may have evolved that reduce the magnitude of these difficulties.¹² In any case, the positive tech-

Raising reimbursement fee levels will not be sufficient to induce dentists to change the nature of their practices.

niques these dental office staff members use should be made available to those for whom clients' behavior is a problem.

We feel that most Medicaid clients could use dental care more optimally. One of the primary components of the EPSDT program is to make eligible clients aware of available resources and to help them use those resources.³

Some of the client-behavior problems dentists reported having—no-shows, being late, unruly children and not bringing program identification cards—can be solved by client education. For example, a Medicaid client may be more warmly received if he or she keeps the designated appointment and does not bring along additional

children to be examined who do not have scheduled appointments. As having dental office staff members try to confirm appointments by calling Medicaid clients can be time-consuming and inefficient because clients frequently move and change phone numbers, staff members can ask Medicaid clients to call and confirm their appointments the day before or day of an appointment. This will allow the office to use the time slot for another patient if the client does not confirm. Staff members also can become familiar with local transportation services and make sure that clients have made transportation arrangements before confirming their appointments.

Regulatory vs. market solutions. A regulatory approach in which licensed dentists are mandated by the state legislature to provide care to Medicaid recipients is not likely to be successful. Nevertheless, the dental community controls all the dental services available and requiring all licensed dentists to see their share of Medicaid clients is an option.

Raising reimbursement fee levels, however, will not be sufficient to induce dentists to change the nature of their practices, as providing care to Medicaid-eligible clients may require extending office hours and hiring expanded-duty personnel. Many dentists also may be unwilling to practice in this style and may see the financial uncertainties of a higher overhead as unattractive.

Also, many Medicaid-eligible clients feel that dentists are uncaring and do not feel dentists are available to them.¹⁴ It is unclear, however, whether individual dentists are aware that this

TRENDS

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population is underserved in their communities. According to this survey, most dentists report receiving few calls requesting care.

We feel that a market solution, as opposed to government regulation, must be developed at the community level. Dentists should feel that they are part of their communities, and communities should assign a high priority to providing dental care to children. Where there are insufficient numbers of dentists, the community leaders should play a role in recruiting new dentists to the area.

We feel, however, that just increasing access will not be sufficient to prevent dental disease. Many parents of Medicaid-eligible children have had little access to dental care themselves and are unaware of the causes of dental disease and the appropriate use of dental services. Most of their own care has been symptomatic. Community-based efforts to increase parents' knowledge about how to reduce disease levels will be needed. These efforts will need to be sustained and intensified to be successful. They could be carried out by state and local dental societies in cooperation with community groups.

CONCLUSIONS

From these survey data it is clear that, for 45 percent of the general dentists, the care of very young children is not a priority. In spite of this finding, most dentists who participated in this survey rated themselves as fairly skilled in the care of children. We feel that dentists' attitudes will not be changed through legislative means, but instead through professional education. In addition, if community leaders make efforts to make local dentists aware of this problem, an environment in which dentists may revise their priorities can be created.

State program administrative problems, such as fees, and local problems, such as a scarcity of dentists in some areas who are available to see Medicaid child clients, need to be addressed to successfully market

the dental care program and increase access and use. At the state level, fees can be adjusted, and the information and billing problems can be resolved. At the local level, community coalition building and awareness can be increased. Community leaders should let local dentists know that dental access is a priority and preventive care for children is a major issue.

Dentists also may have to increase their skills to focus on younger children. Preventive technologies are changing, and the most effective strategies will be needed to control dental disease in this high-risk population. Dental societies, local community and business groups and the Medicaid program will need to be involved. The state dental association and the state's dental insurers could provide staff members with help and a venue for these efforts. Volunteer efforts to broker new relationships between dentists and Medicaid-eligible clients will reflect a need for both groups to adjust and accommodate each other.

Once a marketing approach is formulated, local community focus groups in the areas of greatest need should be conducted. The focus groups should consist of key dentists whose opinions are respected by others in the community and business and community leaders. The discussions resulting from these focus groups will allow marketers to refine and re-evaluate the initial marketing plan and allow the communities to address their individual problems. Given the willingness of many dentists to learn more about the Medicaid program, we feel that participation and access can be increased. ■



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A copy of the survey instrument used in this study can be obtained from Dr. Milgrom.

This article was supported, in part, by NIDR/NIH grants DE 0982 and DE 07132 and funds from the Medical Assistance Administration, Department of Social and Health Services, Washington. The authors acknowledge the assistance of Gary Coats, Dan Conlon, Gayleen Davis, Michael Garrick, Diana Larsen-Mills, Carree Moore, Bill McCandless and Jeanne M. Ward of the Medical Assistance Administration; Rick Larsen and Steven Hardyman of the Washington State Dental Association; and David Grembowski of the University of Washington.

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Trends in Children's Oral Health

Dental caries is the most prevalent chronic childhood disease. Over 50 percent of children have dental caries in their primary teeth by the first grade,¹ and over 80 percent of adolescents have dental caries by age 17.²

Access to Oral Health Care

Nearly 30 percent of all child health expenditures are devoted to children's oral health care.³

Fifty-five percent of all preschool-age children and 50 percent of all school-age children do not have private dental insurance; 70 percent of Hispanic preschool-age children and 65 percent of African-American preschool-age children lack such insurance.⁴

Children from families with low incomes are more likely to have dental caries. These families have more dental caries per child and more untreated caries.⁵



Early Childhood Caries/Baby Bottle Tooth Decay

Five to 10 percent of preschool-age children have early childhood caries (baby bottle tooth decay). This rate is even higher among families with low incomes and some racial/ethnic minorities.¹

The cost to treat early childhood caries is \$1,000–\$2,000 per child. If hospitalization is necessary, that cost is doubled.⁶

Children with early childhood caries weigh significantly less than their peers, according to preliminary studies. With comprehensive dental rehabilitation, these children can experience significant "catch-up" growth.⁷

Early childhood caries dramatically increases a child's risk of future dental caries.⁸

Infants should receive their first oral exam by 1 year of age so a health professional can assess risk and suggest preventive measures.¹

Fluoride

Fluoridation is the most effective way to prevent dental caries in all children, regardless of socioeconomic status or race/ethnicity. Community water fluoridation can reduce cavities in children by up to 40 percent.⁹

Providing fluoridated community water costs about 50 cents per person per year—much less than the cost of a single filling.⁹

More than 100 million Americans do not have an optimally fluoridated water supply.¹⁰

Bottled water may lack sufficient amounts of fluoride to prevent dental caries in children.

Dental Sealants

Over 80 percent of tooth decay in school children is on the chewing surfaces of the teeth, which dental sealants can protect.¹¹

Most dental sealants are placed in private-practice dental offices, but the children at greatest risk for problems resulting from tooth decay are those least likely to receive dental care in a private practice.¹¹



In 1995, the average fee for placing a dental sealant was 45 percent of the average cost of a one-surface filling.¹²

Only 18.5 percent of children and adolescents have at least one sealed permanent tooth.¹³

The rate of dental sealant placement is significantly lower for children in several minority populations than for white children.¹¹

Children with Special Health Care Needs

Many children with developmental disabilities are at high risk for enamel irregularities, gum infections, delays in tooth eruption, moderate-to-severe malocclusion, and oral infections.¹⁴

Certain medications and therapies, special diets, decreased saliva flow, difficulty in cleaning or inability to clean teeth thoroughly on a daily basis, and lack of access to preventive care can negatively impact the oral health of children with special health care needs.¹

Children with special health care needs must have comprehensive oral health care, including early identification, treatment, and education.

Injury and Violence

More than 65 percent of all cases of child abuse involve trauma to the mouth, face, or head.¹⁵ Dentists and dental hygienists are in a unique position to recognize child abuse and neglect.

Safety belts, car safety seats, bike helmets, and mouth guards can prevent a significant number of injuries to the head, face, jaw, mouth, teeth, and oral tissues.¹

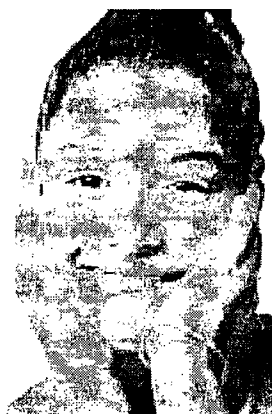
Tobacco

Five million children alive today will eventually die as a result of smoking.¹⁶

Each year, children smoke between 516 and 947 million packs of cigarettes and chew 26 million cans of spit tobacco.¹⁷

One can of chewing tobacco delivers as much nicotine as 60 cigarettes.¹⁸

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This publication has been produced by the National Maternal and Child Oral Health Resource Center supported at the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. January 1999.

Oral Disease: A Crisis Among Children of Poverty

"Bleeding gums, impacted teeth, rotting teeth are routine matters in the children. . . . Children get used to feeling the constant pain. They go to sleep with it. They go to school with it. . . . The gradual attrition of accepted pain erodes energy and aspiration."

Jonathan Kozol¹



Serious facial swelling from a tooth abscess resulting from decay.

Preventable oral diseases still afflict the majority of America's children. This is especially true for children from families with low incomes, children in minority groups, and children with special health care needs. These children experience greater levels of disease and unmet need, and bear most of the burden of unnecessary pain, suffering, and compromise to their total health. In the United States, 25 percent of children and adolescents—typically, the most vulnerable—experience 80 percent of all dental decay occurring in permanent teeth.²

Oral Health Status

An estimated 5–10 percent of preschool-age children have baby bottle tooth decay/early childhood caries, a severe form of tooth decay. The percentage is even higher in certain populations: Survey results show that 20 percent of children from families with low incomes and 43 percent of children in some American Indian populations have baby bottle tooth decay/early childhood caries.³



Grossly decayed teeth requiring extensive treatment.

Baby bottle tooth decay/early childhood caries increases a child's risk for future tooth decay.⁴

Children as young as age 1 experience untreated dental decay.⁵ Among children ages 6–8, 72 percent of American Indian/Alaskan Native children, 50 percent of Hispanic children, 34 percent of black children, and 31 percent of all children experience untreated dental decay.⁶

More than half of all children ages 6–8 and two-thirds of all 15-year-old adolescents experience dental decay.⁶

Sixty percent of adolescents have gum disease.⁷

Pain and Personal Suffering

Almost 52 million school hours are missed annually by children because of oral problems.⁸

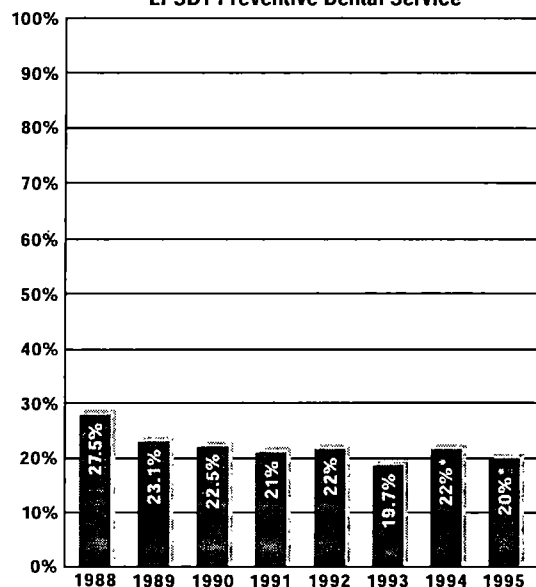
Extensive tooth decay, pain, or infection can cause eating, learning, and speech problems for children.

Many adolescents with oral problems such as decayed or missing teeth suffer embarrassment and diminished self-esteem.

Access

Vulnerable populations of children (especially children from families with low incomes, those who are homeless, those in families without dental insurance, and those with special health care needs) have more oral problems and less access to dental care than the general population. These children suffer from frequent—often urgent—oral problems and generally receive inadequate dental care.⁹

Percentage of Children Receiving an EPSDT Preventive Dental Service



*Preliminary estimate

Many children and adolescents from families with annual incomes of less than \$10,000 do not have access to dental services. In a national study, 66 percent of children ages 2–4 and 47 percent of adolescents ages 12–17 had not had a dental visit the preceding year.⁹

In 1995, fewer than one in five children eligible for dental services under Medicaid/EPSDT received a preventive dental service, and the trend is worsening.¹⁰

Approximately 80 percent of states attribute low utilization rates for dental services under Medicaid/EPSDT to the shortage of dentists willing to accept Medicaid patients.¹⁰

Unfortunately, as the population of children at higher risk for oral disease is increasing, the ratio of pediatric dentists to children is declining. Pediatric dentists—those most able to provide dental treatment to children at risk—are not being trained in sufficient numbers to meet the need.¹¹

The Cost of Care

Individuals with the greatest need for oral health services are also the least likely to have dental coverage or to have the personal resources to purchase dental care.⁹

Inability to pay is the main barrier to visiting a dentist. Only one-fourth of all children ages 8 years and younger have private dental insurance,⁹ and the number of publicly financed dental programs has not kept pace with the demand—and, in many cases, has declined.

In the United States, 30 percent of all children's health expenditures are devoted to children's dental care¹²—a spending rate more than 10 times that of the 2.3 percent expended by Medicaid for children's dental care.¹³

The new State Children's Health Insurance Program (CHIP) provides an opportunity to expand health services for children. However, some states are not including dental services as part of their plans, despite the fact that children from families with low incomes have the least access to dental care and the greatest unmet need.

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This publication has been produced by the National Maternal and Child Oral Health Resource Center supported at the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, in collaboration with the Children's Dental Health Project. May 1998.

Requested you view
this ASAP.

From: Donald Schneider
To: TWestmoreland
Date: 11/24/99 2:09pm
Subject: Materials for D. Adler

Tim: Per our conversation this morning, and after speaking with Deborah and Burt, I've put together the attached document which briefly outlines a "challenge grant" proposal designed to stimulate and document the efforts of state Medicaid agencies to improve oral health access. The document also includes an attachment containing key stats and facts about kids oral health status.

As promised to Deborah, I'm also attaching here a report on what state Medicaid programs have been doing with respect to dental reimbursement and other initiatives during the past two years.

Please look over these documents, and if you concur with the approach taken, please forward this to Deborah. Her e-mail address is ~~deborah.r.adler@OPD.EOP.gov~~ and her fax number is 202-456-5557.

deborah.r.adler@OPD.EOP

Don

CC: Internet:HMS.Harvard.edu:Burton_Edelstein, LAnders...

Proposal for Oral Health Challenge Grants to the States

Problem: State Medicaid (and CHIP) agencies have been struggling to overcome long-standing barriers in the delivery of dental care to children. Access barriers include problems involving financing and funding of dental services; Medicaid policies and administrative procedures; supply and distribution of providers; values, attitudes and knowledge of beneficiaries and dental providers; and lack of awareness of best practices and guidelines for oral health care. These barriers have resulted in a failure to improve the oral health status of millions of children (see attachment for specific barriers and statistics). Medicaid concerns impact on access to CHIP dental programs since the same dental networks usually provide care in both programs. Across the Nation, perhaps partly in response to Federal initiatives and expressions of concerns and partly because of the opportunities presented by CHIP, states are now embarking on new strategies which attempt to address identified barriers. Other states appear to require additional motivation before actions to address dental care access problems are triggered. Little is being done in any state to document the success or failure of new initiatives.

Proposal: The Federal Government will solicit "challenge grant" proposals that are designed to stimulate State Medicaid programs to develop strategies which improve access to dental care for children and demonstrate and document the results of these efforts.

Methodology: States will receive challenge grant awards based upon demonstrated success in enhancing children's access to dental diagnostic, preventive and treatment services subsequent to implementation of new strategies for eliminating barriers. Success over the grant period will be measured by: (1) improvement in the percentage of children enrolled in Medicaid who receive oral health services; and (2) increases in the number of dental providers actively participating in the Medicaid program. Percentage improvement in service delivery will be obtained from dental services data already required to be submitted to HCFA by state Medicaid agencies on the HCFA Form 416, and percentage improvement in dental provider participation will be calculated from verifiable state data, using a formula that combines both the number of providers participating in Medicaid and the number of beneficiaries they serve.

Attachment

The following issues and statistics provide additional information on concerns about oral health status and access to dental care for children. Please note that the Final Progress Report, Healthy People 2000, will cite multiple unmet goals in children's oral health, substantiating the continued high prevalence of oral disease in children.

Health Insurance Coverage: While over 43 million Americans including over 10 million children are without health insurance, over 100 million are without dental coverage including over 25 million children (or 36% of US children) .(Source: National Health Interview Survey 1995)

Population Trends: The disproportionate growth rate of minority populations relative to entire population is increasing the prevalence of disease and decreasing the proportion of disease that is treated.

Workforce: A small and declining dental workforce is placing additional stress on both public and private delivery systems and reducing access in rural and central city locations.

Delivery Systems: Publicly funded and "safety-net" dental delivery system is in very short supply. Private delivery system is also providing excellent care but is inaccessible to many vulnerable and disadvantaged Americans.

Disease Prevention and Health Promotion/ Personal Health Behaviors: Most oral diseases and conditions are behaviorally induced and generally preventable (including tooth decay, gum diseases, traumatic injuries, and tobacco associated lesions and cancers) through health promoting behaviors.

Oral and Dental Diseases are Significant to Individuals and Society: Oral and dental diseases impact children's functions including eating/growth, speaking, and learning while oral diseases in adults negatively impact employability and systemic health.

Science to Practice: As with many other chronic diseases, new research has identified preventive interventions and significant therapies which, if incorporated into practice, could reduce disease burden, limit disease induced dysfunctions and improve rehabilitation.

Realizing Potential: Oral health is a significant component of children's abilities to realize their growth, functional, behavioral and educational potentials.

Dental Caries Trends: Dramatic declines in dental caries rates has occurred over the past several decades, but many U.S. children still suffer needlessly from preventable oral diseases and conditions. Dental caries (tooth decay) remains one of the most common infectious diseases among U.S. children. It is a transmissible disease, which can be acquired before age two, primarily from our mothers. This preventable health problem begins early in life and has become increasingly concentrated in a small portion of the

population; although the vast majority of children and adolescents experience dental caries by the time they finish high school.

80% of tooth decay is now found in only 25% of school-age children. (Source: National Institute of Dental and Craniofacial Research.)

By ages 2-4 years, 17 % of U.S. children have already experienced tooth decay.

By ages 6-8 years, 52 % of U.S. children have tooth decay - making it 5-8 times more common than asthma, which is usually cited as the most chronic condition of childhood.

More than 80% of the adolescent population is affected by dental caries by age 17.

Racial Disparities Minority children in the U.S. have more dental decay than white children.

African American children have 1.4 times more decay than white children;

Hispanic children have 1.7 times more decay than white children;

Asian and Native American children have 2.7 times more decay than white children.

Income Impact: Low-income children do not get the dental services they need.

less than 1 child in every 5 Medicaid-eligible children received any preventive dental services (Source: 1996 Office of the Inspector General, DHHS)

1 in 4 Native American children received any dental care in FY 98.

America's youngest and poorest children (ages 2-5 and living below the poverty level) have almost 5 times as much tooth decay as children of higher income families (>300% poverty).

For poor children with decay, almost 80% of it remains untreated. (Source: National Health and Nutrition Examination Survey (NHANES III 1988-94)

Dental Sealants Dental sealants are proven to be 100% effective in preventing dental caries on the chewing surfaces of teeth.

Despite the effectiveness of dental sealants, less than 25% of U.S. children have received them.

Only 1 in 20 African American children have sealants.

For 8 and 14 year olds, living below the Federal poverty level, only 3% and 12%,

respectively have dental sealants. (Source: NHANES III 1988-1994)

Craniofacial Conditions: Cleft lip and cleft palate comprise the fourth most common birth defect in the United States.

Cleft lip and/or cleft palate affect 1 of every 700 newborns. (Source: American Cleft Palate-Craniofacial Association and Cleft Palate Foundation)

Failure to thrive: The consequences of poor oral health include diminished growth, eating and speaking dysfunction, low self-esteem, distraction, and negative behaviors that interfere with learning and family life.

School Children: Approximately 52 million school hours are lost due to dental pain and suffering each year.

Fluoridation: Fluoridation of community drinking water is the major factor responsible for the decline of dental caries.

Adolescents living in fluoridated communities had on average 25% less decay than children living in non-fluoridated communities. (Source: 1986-87 NIDR Survey of U.S. School Children).

The cost of preventing one cavity through water fluoridation is about \$4 vs. \$64 for the cost of a simple dental restoration. (Source: CDC unpublished data)

Medicaid-eligible preschool children in communities without fluoridated water were three times more likely than those in communities with fluoridated water to require dental treatment in a hospital operating room, and the cost of dental treatment per eligible child was approximately twice as high. (Source: MMWR, September 3, 1999, Vol. 48, No. 34)

Consequences of Poor Oral Health: Dental disease and unmet dental care needs are not trivial matters. Failure to prevent dental disease and to provide timely and appropriate treatment can result in expensive treatment and missed work days. Work readiness and worker productivity, particularly in service industries, relies on freedom from oral pain and an esthetically acceptable appearance.

Recent studies have shown that individuals with severe periodontal disease are more likely to develop heart disease and stroke than people without gum problems.

One study even suggested that individuals with severe periodontal disease may have twice the risk of fatal coronary artery disease as normal individuals, after controlling for other relevant risk factors, including diabetes.

Severe periodontal disease in a pregnant woman may lead to a seven-fold risk increase in that woman's risk of delivering a premature baby of low birth weight. This risk may even be greater for a woman with diabetes and severe gum disease.

Recent Medicaid Dental Program Activity

DRAFT October 23, 1999

State	Fee Change	Effective Date of Last Fee Increase	Comments & Future Plans
AL	Targeted dental rate increase aimed at preventive and restorative codes.		Formed a Dental Task Force on Medicaid. The following changes were made to Medicaid program: 1) Clarification of program limits. 2) Simplification of the prior authorization process. 3) Revised Medicaid manual for dental. 4) Coverage of additional procedures and codes consistent with current dental practice. Notice of changes sent to provider network. Information submitted to Alabama Dental Association newsletter and presentations at meetings and dental schools on changes in Medicaid program. In addition, a workgroup formed to address outreach and education efforts and conducted Provider Survey to assess concerns.
AK	All dental codes were updated to 80% of the average billed charge per code. Changed system to pend (rather than deny) and fiscal agent is actively assisting providers in making corrections to claims prior to processing, including piloting an easy to use "pend correction" sheet for this purpose. Removed system edits for oral exams and prophys for kids; fiscal agent accepting claims with minor errors such as formatting issues and placement of "D" with codes.	6/26/98	Medicaid agency is meeting with Alaska Dental Society on a regular basis to discuss areas of interest, including adoption of a universal dental claim form, dealing with the perception of Medicaid clients as "no shows," perception of billing problems with some providers, revising provider billing manual and augmenting dental provider training, using internet cabability for submitting dental claims--also discussing dental access issues
AR			

AZ			
CA	Estimated that the reimbursement rate is approx. 60% of UCR; increasing reimbursement from \$9 to \$15/tooth for sealants.	April 1998	Eliminated prior authorization requirements and age windows for sealants.
CO	Increased to 68% of the most current ADA Mean Survey for general practitioners in the mountain region.	July 1, 1999	Colorado continues in the attempt to increase rates to 75-80% of the most current ADA mean. CO Dept. of Health Care Policy and Financing requested \$100,000 in "seed money" to establish or expand a large dental clinic. The funding stream was STATE ONLY dollars and was limited to capital equipment. Recipient of award is new 14 operator dental clinic in inner city of Denver. During 2 month-period, clinic saw almost 6,000 Medicaid-enrolled children.
CT	\$1M bonus grant is available to managed care plans that can demonstrate increased access to dental care.	1999	In June 1998, Department of Public Health held summit focusing on different delivery systems (school-based, health center based, hospital based, private offices, etc.) Breakout sessions were directly developed from last summer's HCFA meeting and were designed to identify solutions to both short-term and long-term problems facing oral health delivery to the poor in CT. ADA had participants from DSGA and DC office at conference at invitation of CT State Dental Association.
DC			
DE	Raised dental rates from 75% actual U&C charge to 85% actual U&C charge.	January 1, 1998	State is working with Dental Society to recruit dentists for Medicaid participation. have increased from 1 to over 70 dentists. No prior approval is needed for any dental service currently except orthodontia. Eventually plan to move to standard ADA claim form, CDT codes, and dental fee schedule.
FL	Increased dental fees by \$10 million (13.5%)	August 1, 1998	
GA	Rates increased an average of 33% of UCR (with some fees as high as 80% of UCR).	Spring 1998	

HI

IA

No major increase in 6 years except for a special allocation of \$230,676 in 1997. Iowa had a 2% increase for all dental procedures and another 2% later on 1/1/99. The UCR is 54% for dental services.

July 1, 1998

The Department of Public Health received a special \$50,000 allocation to implement an ABCD model pilot program in at least 2 areas from 10/1/99 to 6/30/2000. Iowa adopted the ADA codes (7/1/98) and also instituted electronic billing. Prior authorization was eliminated for 9 procedure codes. Has comprehensive program for adults. Since 12/97, approved 6 Exceptions to Medicaid Policy for Child Health Clinics covering 26 counties where access is severe problem. A 7th request covering 4 additional counties is pending to allow Medicaid reimbursements at 85% for dental hygienists employed by clinics to perform dental screenings.

ID

\$2.2 million budget increase to raise Medicaid dental fees. In addition, all Medicaid services received an across the board 2.7% increase. The biggest fee increases were for preventive and basic restorative services, which were raised 20-25% with a goal to raise fees to 75% of UCR. Prioritized services with preventive and basic restorative having greatest priority followed by prosthodontics and oral surgery.

July 1, 1999

The Medicaid program is holding back 10% of \$2.2 M to cover increased utilization. These rates were inflated to 1998 using the Consumer Price Index-Urban Dental. Dental services were carved out of risk-based managed care.

IL

In FY 1999-2000 budget negotiation, IL State Dental Society received \$6M more per year for children's dental Medicaid services with agreement for \$3M more in each of next 2 years. Adult Medicaid dental services have been added with \$14M agreed upon to reinstitute program.

IN

Dental rates increased to 100% of 75th percentile of rates reported by ADA for the East North Central region. These rates were inflated to 1998 using the CPI-UD.

May 1, 1998

Eliminated prior authorization for all dental services on 9/1/97. Dental services were carved out of risk-based managed care on 8/1/98. Report comparing dentists' participation, recipient participation and expenditures for 1997 - 1999 is available.

KS	Kansas legislature increased rates paid for dental services provided to children by appropriating \$3.8 million for Medicaid dental procedures. Rate increase brought rates to 50 th percentile of UCR.	1997	Uniform ADA claim form and ADA procedure codes were adopted. When the rates were increased BCBS mailed a bulletin to providers which included the new rates, which is not commonly done. In conjunction with KDA, sent letter to all dentists statewide promoting new rates. Inactive providers were contacted to try to recruit them back. Presentations at local and annual dental meetings on topic.
KY			
LA	No improvements to reimbursement rates in last 24 months.		Attempting to update provider manual. Medicaid has switched to using plastic swipe cards for ID eligibility.
MA			The MA Medicaid program, MassHealth, has been working on a multi-component multi-year reform of the dental program. On December 1, 1998, Medicaid removed prior authorization for fluoride treatments for members 18-20 (under 21) and for sealants for 16-20 (under 21). (Fluoride and sealants for younger children had not required prior authorization.) Prior authorization system to remove arbitrary limitations, update criteria, and streamline processes. The Division has improved its billing assistance for the dental community to make it easier for dentists to solve claims payment problems. It is also improving opportunities to electronically bill. The Division requested funding to increase program in FY 00 budget request. If approved, will raise fee schedule from 40-50% of ADA survey levels to about 60-70%.
MD		1998	MD added \$1.7M in 1998 to dental cap, which goes to managed care organizations that are contracted by the state to provide Medicaid medical & dental services. Pregnant women added in 1998 as mandated group to receive Medicaid dental services. Legislation was also passed in 98' to monitor the State Dental Medicaid program and establish an Oral Health Advisory Committee and setting of utilization targets for children from current 14% to 70% in 5 years.

ME	Increased funding in dental by \$4M and increased reimbursement from 35% UCR to 70% UCR. Rates for 167 procedures were raised to approx. 70% of Northeast Delta Dental's negotiated rate. For nearly half those procedures, this meant an increase of 81 to 200%.	1998	
MI	Increased funding for the dental Medicaid program by \$7.1M or 16%. Money was targeted for children under age 19 and went to raising preventive, diagnostic and restorative fees to 70% of UCR. Other fees for endodontics and oral surgery were raised to 50% of UCR.	January 1, 1999	Fee increase was largest ever received in dental Medicaid. Fees raised as result of recommendations of Michigan Medicaid Dental Task Force that was convened in 1997-98. Other recommendations such as changing to CDT-2 codes, accepting ADA claim form, eliminating some prior authorization also recommended but going through policy process. Fees went into effect in January 1999. Working with MDA to promote Medicaid program and rely on volunteers to promote participation. State's Department of Community Health will report back about impact of fee increase sometime during FY 2000 budget negotiations. For FY 2000, additional monies appropriated to fund projects in rural areas to increase access. Total dollars appropriated is \$9.9 million for projects, \$1 million for FQHC enhancements and a 4% increase in dental fees. Ongoing input from Task Force on recommendations proposed.
MN	3% increase to reimbursement rates for Medicaid dental and 2 other non-CHIP State health insurance programs. Current Medicaid dental rates are approx. 57% of UCR.	July 1, 1998	State report concludes there was 3% decrease in provider participation from 7/1/97 to 12/31/98 despite fee increase. In addition, Medicaid fee-for-service utilization decreased from 27.9% to 25.3% from FY 96 to FY 98, although there were declines in Medicaid eligibility also. Report contains several recommendations, including 1) overall payment increases, 2) disproportionate share payments, 3) extend phase-out of cost-based reimbursement for FQHCs and RHCs, 4) enhanced payment for improved access, 5) increase rates for preventive services for children, 6) pilot projects for community clinics and non-profit community organizations, 7) allow direct access to dental hygienists, and 8) administrative simplification.

MO	\$2.6M increase in 1998 and \$1.4M in 1999. Legislative interest in going to 80% across the board in 2000. Even after these increases, budget shortfall of \$15 – 20M still exists if goal of Dept. of Social Services (to raise rates to 75% of UCR) is going to be reached.	1998, 1999	The Medicaid program will accept the new ADA claim form when it comes out. Statewide study of Barriers to Access to Care completed by State Dental Program.
MS	All fees for dental care and surgery increased by 60% of rate in effect 6/30/99.	1999	
MT	Only a slight fee increase in 1998. but UCR is 72-95%.		
NC	Rates increased by 39% for 44 dental procedures (preventive, restorative and extractions for children) with increase in expenditures of 21.09%. Also effective with date of service January 1, 1999 there was a 1.9% annual inflationary increase for all procedures.	June 1, 1998 January 1, 1999	NC Institute of Medicine Task Force on Dental Care Access met on 4 occasions and took public comments. Had numerous recommendations to increase dentist participation in Medicaid program, top 5 of which include: increase rates to 80% UCR; develop outreach program; establish dental advisory committee to work with Div. Of Medical Assistance on ongoing basis to allow specially trained hygienists to perform screenings and preventive services outside school setting; and establish oral health resource program to enhance efforts for dental care to low-income populations. There are plans to add a couple of new services to coverage in a few months if all the details are worked out: 1) coverage of fluoride varnish under ADA 1203; 2) coverage of new service package on early caries screenings, dietary and oral hygiene education and administration of fluoride varnishes to be provided by physicians and physician extenders to children between ages of nine and 36 months.

ND	Raised fees by about 26% in 12/97 increasing from about \$3,850,000 per year to \$4,850,000 per year; fees paid to dentists for services provided to children averaged about 87% of billed charges in 1998; fees paid to dentists for services to adults averaged 74% of billed charges in 1998; then an additional increase of 2.2% in fees in August, 1998.	December, 1997; August, 1998	The legislature meets every two years in ND and it authorized additional inflation increases of 2% per year to be implemented in August 1999 and August 2000.
NE	Raised dental Medicaid reimbursement rates from approximately 53% to 80% of UCR.	1998	In 1997, NE Dental Medicaid program was removed from the state's managed care plan and went back to a fee-for-service program format. During 1999 the state has been working with the Nebraska Dental Assoc. and other key stakeholders to re-write the entire dental Medicaid Policy Manual. Public hearings will be held this fall and goal is to have new policies take effect in 2000.
NH			Working on increasing reimbursement fees. Have prioritized 12 most frequently used restorative procedures for children for increased fees (moved from orthodontic services). Have applied for fluoridation grants from HRSA to fluoridate Manchester and Nashua.
NJ			Have a contract as of 7/1/99 with 10 oral health programs to provide dental services. Currently in process of assigning all Medicaid clients to managed care organizations to be completed by mid-2000. A contract will be developed with dental providers to provide services. Details unknown. Also looking into outreach program to help Medicaid clients negotiate the system.
NM	NM Medicaid dental program will reimburse dental services at 85% of 1997 ADA average fees.	October 1, 1999	In November 1996, NM Medicaid implemented the use of the 1994 ADA dental claim form and ADA codes.
NV			

NY

OH

No fee increases in the last 24 months. Currently working on fee increase to be made effective 1/1/99 (?).

The recently passed Biennium Budget bill included funding to increase fees for dentists, physicians and ambulance drivers. The Medicaid program has met with representatives of the Ohio Dental Association and the Ohio Academy of Pediatric Dentists to discuss other improvements. Joint Medicaid and State Dental Program report on access to oral health care is targeted for early 2000.

OK

In FY 98, increase in \$2.3M for Medicaid dental program for a 45% increase of dental reimbursement. In FY 99, \$400,000 increase to cover composite restorations. Proposed 9% increase in FY 00, no appropriation received.

Expansion to include emergency extractions for adults. Removal of prior authorization for Panorex, pin retention and diagnostic casts. Expansion to include posterior composite restorations. Expansion of children's program to include second exam, prophylaxis and fluoride treatment. Removal of age restriction on dental sealants. Materials requirement for pulp caps expanded to include any ADA approved material. Procedure coding updated to include all current Medicare Level II HCPC codes. Provider eligibility rules amended to include all fully licensed dentists as well as those in interns, residents or fellows or in training if service is outside the training setting and no duplicative billing.

OR

Oregon had a 4% across-the-board increase for all providers, and some additional funding for adjustments to preventive, x-ray and amalgam services; some adjustments may amount to a 50% increase. The increase is for fee-for-service providers only. Capitation rate for Dental Care Organizations increased slightly.

10/1/99 or
1/1/200 for FFS

10/1/99 for
DCOs.

PA

Raised reimbursement rates for targeted children's dental services with the goal of increasing access to children's dental care. Total Fed/State increase was approximately \$6M.

(retroactive to)
January 1, 1999

Convened a day and a half "Dental Summit" in May 1999. Brought in key stakeholders, including State, Federal reps, dentists, consumers, & advocates to address dental issues & to establish a set of recommendations to improve access to dental care.

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PR

RI

1) Conducted survey of consumers and providers regarding barriers to care in Medicaid program. 2) Hired consultant to assist in developing policy changes on access to dental services. 3) Recommended 3% increase in COLA for dentists effective 7/1/99. 4) Eliminated prior authorization for certain procedures including orthodontics. 5) Expanded dental benefits for adults from 1 prophylaxis to 2 per year. 6) Established Dental Advisory Committee to assist in restructuring and redesigning Medicaid program for dental services.

SC

Raised rates to 75% of the statewide UCR for 6 months through additional \$4.9 million dollars to Medicaid dental budget.

October 1, 1999

SC Dental Assn. has task of increasing the number of enrolled dentists as well as greatly increasing access. If this occurs, full funding of rate increase will be granted next year. A goal of 200 additional dentists has been set for this year. This effort has been achieved through partnership with SCDA, Medicaid and many advocacy groups.

SD

TN

TX

The 76th Legislature appropriated \$4 million of General Revenue funds for a fee increase for dental providers. The actual amount of the increase is yet to be determined.

Enrolling new providers is a high priority. The Legislature also mandated that the Commissioner of Health report to them the number of newly enrolled providers each year.

UT

Increased dental fees by 20% for dentists who agreed to see 100 Medicaid patients per year (2 per week).

July, 1997

VA

Increased biennial funding for Medicaid dental services. Gov. Allen originally suggested \$6.4M but legislature appropriated \$10.1M.

Increase was supposed to help address inequities in program. Virginia Dental Asso. (VDA) submitted Freedom of Info. request to Dept. of Medical Assistance Services to find out whether # of Medicaid dental providers has increased.

VT	Increased dental fees by 19%	7/1/99	Last two years have had a joint team working on access to care issues. Medicaid has been developing data that dental health can bring to the dental society. UCR is approx. 75-80% and provider participation is approx. 60%. This year the legislature granted a sizable rate increase with the understanding that the dentists would expand access if better paid. Data are needed to see if in fact there is any expansion of access. The legislature also appropriated funds for a one time grant program to any entity to assist in the expansion of access.
WA	\$37 million in increased children's rates which brought fees to 65-75% of UCR in 1995. Now dropped behind the UCR and are probably at 60% overall.	1995	Access to Baby and Child Dentistry (ABCD) continues to expand as provider societies indicate interest in their counties. Spokane, where ABCD was first implemented now has over 12,000 children enrolled. New dental billing instructions were released in April moving to more ADA coding. Implementing optical scanning for dental claims this year (1999). Removed prior authorization of most codes and simplified process for items that require prior authorization (PA). Experimenting with providers developing own PA for cleft palate, orthodontics under a one-year "expedited PA" system. Stopped covering "white" posterior crowns and stainless steel posterior crowns covered without PA requirements.
WI	If approved by both legislative chambers in 1999, changes in Medicaid program will considerably increase dental reimbursement rates. Rates will be 65% of 1998 filed fees for adults and 69% of 1998 filed fees for children. Current payments are based on 1991 fees and 1995 fees for children.		Other improvements (pending final legislative approval) include requiring Dept. of Health and Family Services to develop a statewide plan for patients and dentists regarding patient compliance and getting fee-for-service for dental Medicaid services. (HMOs were in 4 counties.)
WV			
WY			
	imprv.fin		



HealthGate Document

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Title

Making Medicaid child dental services work: a partnership in Washington state.

Author

Milgrom P; Hujoel P; Grembowski D; Ward JM

Address

Department of Dental Public Health Sciences, University of Washington, Seattle 98195-7475, USA.

Source

J Am Dent Assoc, 1997 Oct, 128:10, 1440-6

Abstract

Eighty-one percent of general dentists and 86 percent of pediatric dentists who are members of the local dental society in Spokane County, Washington, participated in a pilot program to provide dental care in private offices to children up to 5 years of age from low-income families served by the Medicaid program. Outreach staff from the local public health agency recruited and enrolled families in the program. University faculty provided special training in the care of young children to the dentists participating in the program. In the program's first year, 37 percent of the enrolled children had made at least one visit to the dentist, in contrast to 12 percent of children who were not enrolled in the program.

Language of Publication

English

Unique Identifier

97473284



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MeSH Heading (Major)

Dental Care for Children|SN/*UT; Medicaid|SN/*UT

MeSH Heading

Child, Preschool; Fees, Dental|SN; Health Services Accessibility|SN; Human; Infant; Poverty|SN; Program Evaluation|SN; Support, Non-U.S. Gov't; Support, U.S. Gov't, P.H.S.; United States; Washington

Publication Type

JOURNAL ARTICLE

ISSN

0002-8177

Country of Publication

UNITED STATES



HealthGate Document

Record 1 from database: **MEDLINE**



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Title

Survey of Medicaid child dental services in Washington state: preparation for a marketing program.

Author

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Department of Dental Public Health Sciences, University of Washington, Seattle 98195-7475, USA.

Source

J Am Dent Assoc, 1998 Jun, 129:6, 753-63

Abstract

The authors surveyed Washington state dentists to gain an understanding of their participation in the Medicaid dental program, their willingness to learn more about the program and the degree of importance they attached to preventive care for preschool-aged children. They found that concerns about fees and administrative aspects predominated and concerns about client behaviors were expressed less often. Many dentists indicated a willingness to learn more about the program. These findings will be used to develop a plan to market the Medicaid program to Washington state dentists.

Language of Publication

English

Unique Identifier

98295095



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MeSH Heading (Major)

Child Health Services|*/EC/OG; Dental Care for Children|*/EC/OG; Marketing of Health Services|*; Medicaid|*/EC/OG

MeSH Heading

Attitude of Health Personnel; Child; Child, Preschool; Dentist-Patient Relations; Dentists; Fees, Dental; General Practice, Dental; Human; Infant; Pediatric Dentistry; Preventive Dentistry; Reimbursement Mechanisms; Support, Non-U.S. Gov't; Support, U.S. Gov't, Non-P.H.S.; Support, U.S. Gov't, P.H.S.; United States; Washington

Publication Type

JOURNAL ARTICLE

ISSN

0002-8177

Country of Publication

A Community Dental Sealant Project

Richard W. Rubin

- Objectives:** This program was established to help address the dental needs of the rural communities surrounding the Pittsburgh area.
- Methods:** Partnerships were established between the University of Pittsburgh School of Dental Medicine, Cornerstone Care (a community health center), Area Health Education Centers (AHEC), Community Actions SW and others in order to provide free dental sealants to the children (ages 7-17) of Greene County and Burgettstown. [Forty five dental and dental hygiene students placed sealants on the first permanent molars of any appropriately aged child who came to Cornerstone Care in Burgettstown} (during four days in February) or Greensboro (during six days in May).
- Result:** Approximately 250 children, representing 37 different schools, had dental sealants placed on their permanent molars. This represents over 1,000 molars covered with sealant material. A high percentage of the children treated had no dental insurance coverage (56% in Burgettstown and 50% in Greensboro) or were on a medical assistance program (Med Plus, Access, Gateway, etc.). The cost of treatment was only \$7.00 per child – compared to the known range of community sealant programs of \$11.00 - \$15.00.
- Conclusions:** The combined efforts of multiple organizations not only provided a successful and inexpensive service for these communities but also strengthened ties among the health organizations. This project has served as a model for ongoing sealant programs in surrounding communities.

Lauren M. Governale, DMD, MPH, Department of Pediatric Dentistry, University of Florida.

EAST COAST AREA DENTAL SEALANT PROGRAM

The purpose of the program was to develop a public-private partnership involving a caries preventive program in South Florida. This program was a collaborative effort of the East Coast District Dental Society of the Florida Dental Association involving private practitioners, as well as Miami Children's Hospital and the University of Florida, College of Dentistry and other organizations. This collaboration provided a caries preventive dental sealant program in a primarily fluoridated area that benefitted school aged children with poor access to clinic-based services. Children enrolled in the second grade of two Miami-Dade County (Florida) Elementary Schools participated in the program. The chosen schools had a high percentage (over 80%) of their students enrolled in the free/reduced lunch program. A total of 515 children participated in the program. Over 90% of the children were Hispanic. All of the examinations and sealant placements were performed by a Florida licensed dentist with a team of auxiliaries in the schools using portable equipment. Informed consent was obtained for initial sealant placement and for the retention check/reapplication phase of the program which was conducted the following school year. A total of 275 students received sealants on 989 permanent molars. With public resources becoming scarcer, strengthening relationships with public and private sectors to collaboratively address oral health problems are needed. This program proved to be a successful collaboration of efforts providing a valuable preventive service to a group of low income children who otherwise may not have had the opportunity to receive this effective preventive service.

Seal a Smile Portfolio: A Guide to Sealant Program Implementation

*Patti Bavinka, RDH, M.Ed., Author, Oral Health Consultant, Healthy Smiles for Wisconsin;
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Advisors: Dave Gundersen, Mph, Director, School Health Programs, Wisconsin Department of
Health and Family Services; Warren LeMay, DDS, Chief Dental Officer, State of Wisconsin,
Theresa Reagan, Executive Director, Children's Health Alliance of Wisconsin.

Funding: Grant awarded to the Department of Public Instruction and Department of Health and Family Services by the Centers for Disease Control and Prevention.

Healthy Smiles for Wisconsin, is a collaborative effort to improve the oral health of children through community and school partnerships. **Back to School for Healthy Smiles**, part of **Healthy Smiles for Wisconsin**, was developed to plan for incorporating school-based and school-linked oral health services into dental hygiene education programs and communities. Through meetings with academic and community partners, strategies for dental sealant program development were shared, the **Seal-a-Smile Portfolio** was created.

Seal-a-Smile Portfolio is a step by step guideline for developing school-based or school-linked sealant programs. Comprehensive information is contained in **Seal-a-Smile Portfolio's** eleven modules. Module information is currently being used in sealant programs throughout Wisconsin. It includes: an Overview, Community Partners, Selecting Children/ Forms, Program Preparation, Implementation, Referral, Program Evaluation, Equipment, Grants/Funding Sources, Occupational Safety and Health/First Aid, Problems and Solutions. **Seal-a-Smile Portfolio** is available to anyone interested in initiating a sealant program.

The Most Important Unanswered Questions About Children's Oral Health Needs: What Are They, How Can They Be Answered, and How Can We Ensure That These Answers Influence Clinical and Public Policy and Practice?

Michael Weitzman

This presentation summarizes what is known about the health and living conditions of children in the USA, and about the intricate and inextricable relationship between the social context in which children live, the development of behaviors that place their health at risk or promote their resilience and health, and their physical health and functioning and access to needed services. Racial and economic disparities in children's health and access to services, especially as they may relate to children's oral health are discussed and many of the important unanswered questions about ways to reduce these disparities and ensure access to quality services for all our nation's children are discussed.

An action-oriented health services research agenda for children's oral health needs is presented, including a pediatric perspective on the most important unanswered questions about ways to improve our children's oral health. The American Academy of Pediatrics' new Center for Child Health Research and its potential role in helping to facilitate research that will provide answers to these profoundly important questions and help translate such new information into informed and rational clinical and public policy and practice are discussed.

The Oral Health Advisory Committee: Strategies to Improve Access

Warren A. Brill, Norman Tinanoff, Harold Goodman

In 1997 the U.S. Department of Health and Human Services approved Maryland's application to convert its fee for service Medicaid program to a managed care model. One year later the Maryland General Assembly passed SB 590, which mandated dental care utilization rates increase from the then 14% to 70% over the next 5 years. In response, the Secretary of the Department of Health and Mental Hygiene (DHMH) chartered the Oral Health Advisory Committee (OHAC) to advise DHMH about access to care and provider participation issues, as well as to oversee demonstration projects aimed at identifying barriers to access and recommending solutions. The OHAC is composed of the Deputy Secretary for Medicaid, private dentists, managed care organizations, organized dentistry, the dental school and state and local health officers. The OHAC has developed and coordinated utilization data protocols, provider recruitment strategies, outreach methodologies, case management oversight, dental procedure remuneration rate assessment and legislative initiatives, including direct briefing with the Governor. It serves as a model as to how disparate groups can work together to solve shared problems such as access to oral health care, and resolve differences associated with individual interests that may be in conflict with public health aims. This unique partnership advises the Secretary, with special insights, on how the State can best direct its resources to optimize oral health care for the underserved populations.

**Dental Access for Children on Medicaid—Impact of the North Carolina Institute of
Medicine Task Force Recommendations
Sharon Nicholson Harrell**

- Background:** The Health Care Financing Administration (HCFA) reports that only 20% of eligible Medicaid children received preventive dental services in 1993. North Carolina figures parallel this dismal statistic—The North Carolina Department of Health and Human Services reports that only 20% of Medicaid recipients visited the dentist in 1998. Strategic planning on the local, state, and national level is critical in reversing this trend.
- Method:** The NC Institute of Medicine convened a Task Force of dental professionals, public health practitioners, physicians, and other interested citizens to study the problem of access and to make recommendations to the General Assembly.
- Objective:** The charge of the Task Force was to develop strategies to increase the level of participation of dentists in the Medicaid dental program and to improve the program's provision of preventive services.
- Results:** The General Assembly adopted several of the 23 recommendations presented: expansion of preventive dental services by public health hygienists outside the public school setting, establishment of a new service package to cover early dental decay screenings, education, and administration of a new fluoride varnish by physicians and physician extenders to children between the ages of nine and 36 months, and expansion of the NC Health Choice (CHIP) program. The General Assembly directed further study of other recommendations which will increase the pool of providers available to treat this population.
- Conclusions:** The consensus building which resulted in the development of a defined plan of policy recommendations will have a far-reaching impact on improving services for Medicaid recipients statewide.

Dental Care Utilization By Medicaid Children Before Five Years

Jy Lee, JB Kotch, RG Rozier, WF Vann, Jr.

Access to oral health care under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a nationwide program. Few studies have examined utilization patterns in Medicaid-eligible children, especially in the pre-school aged group. The purpose of this study is to report the use of dental care in the North Carolina (NC) Medicaid Program by a cohort of children during ages 1-4 years (YO).

This study is an analysis of three linked statewide databases: birth certificates for 1992, Medicaid enrollment files for 1992-97 and Medicaid claims files for 1992-97. Birth certificates for 1992 were linked with Medicaid enrollment files for 1992 to identify all children born in that year who were enrolled in Medicaid at their time of birth. Children continuously enrolled during each of four ages (1,2,3, & 4 YO) were matched to claims filed by person identifiers and age. We defined four service categories: diagnostic/preventive (D/P), restorative (RES), extractions (EXT) and hospital emergency room (ER) visit and use of one or more services in each category and overall was determined.

Of the 81,518 births in 1992, 53,591 were enrolled in Medicaid. Forty-three percent of 1 YO were enrolled for the entire year and 5% received some dental services. At 2 YO, 38% were continuously enrolled, 16% received any dental services, 9% D/P, 3% EXT and 1% had an emergency room (ER) visit with the primary diagnosis of a dental condition. At 3YO, 37% were continuous enrolled, 37% received some dental services, 22% D/P, and 5% EXT. At 4YO, 31% were continuously enrolled and 58% received some dental services, 33% D/P, 17% RES and 7% EXT.

This analysis suggests that in the Medicaid population the overall use of dental services is low, but may be affected by enrollment. Of those continuously enrolled, utilization of dental services increase with age and diagnostic/preventive services make up the largest percentage of dental care rendered. Supported by The USDA Special Projects Grant, MCH Grant MCJ379494 and AHCPR Grant T32-HS-00032

Medicaid, SCHIP & Adolescent Dental Health: State Prevention Policies

Molly McNulty, JD,

Objectives: The purpose of this study was to identify the extent to which state Medicaid and SCHIP programs have developed laws and regulations to support the delivery of adolescent preventive services, including counseling, screening, and referral to dental providers.

Methods: In recent years several professional organizations have developed guidelines for adolescent preventive services (AAP, Bright Futures, USPSTF), and these guidelines contain strong support for preventive dental services. With funding from the Center for Health Care Strategies, Inc., and the U.S. Maternal Child Health Bureau, this project surveyed state Medicaid and SCHIP officials responsible for preventive benefits for children and state managed care officials responsible for quality assurance. The survey asked whether states require or recommend that PCPs screen for certain dental conditions, counsel adolescents on avoiding dental injury and tobacco use, counsel parents on the need for regular dental care including sealants, and make annual referrals to dentists. The survey also asked whether states were using or considering a range of quality measures, including those recommended by the NCQA Expert Panel on the Future of Pediatric Oral Health Performance Measurement.

Results: At present, the survey has been reviewed by HCFA and MCHB officials, and has been field tested in Massachusetts, Ohio, and Arizona. The survey is scheduled to be mailed in December, to respondents identified by HCFA Regional Office Maternal Child Health Coordinators.

Using Medicaid Managed Care Contract Specifications to Improve Pediatric Oral Health

E. Wehr, JD, Gooch, BF, DMD, MPH

Objective: This session will describe a new intervention tool, in the form of sample Medicaid managed care purchasing (contract) specifications for pediatric oral and dental health services. Medicaid and public health agencies, family advocacy groups and providers may use the specifications in negotiating for and monitoring oral and dental health services for Medicaid children and youth enrolled in managed care organizations (MCOs).

Methods: Analysis of existing Medicaid managed care contract documents' approaches to coverage of pediatric oral health and dental services and related issues. Development of sample specifications consistent with recognized clinical guidelines, Medicaid law, peer-reviewed literature and expert opinion.

Intervention: The specifications document, to be available without charge on the Internet, provides "sample" language on benefits, quality assurance, access, data collection and reporting and other elements of managed care relating to pediatric oral and dental health services for enrollees.

Relevance: Federal and state laws have for decades entitled low-income children and youth enrolled in Medicaid to comprehensive coverage for oral and dental health services. But use of these services has remained low, for multiple reasons. States' increasing use of managed care for Medicaid populations creates new opportunities to improve oral and dental health in low income children and youth, because MCOs can be held accountable for providing oral and dental health services to their young enrollees, monitoring the quality of such services, and furnishing these services in the context of comprehensive pediatric health care.

Medicaid on the Mend in Ohio

L. F. Hill

A Medicaid workgroup of the Ohio Dental Association (ODA) and representatives of the Ohio Academy of Pediatric Dentistry (OAPD) worked together in 1996 with the Ohio Department of Human Services (ODHS) to realize a modest fee increase in the Medicaid Dental Program. Utilization was not effected. The new fees were based on a 3 year old Medicaid UCR. With no further increases by 1999, fees were only about 35-40% of the community UCR. The HCFA/HRSA Dental Medicaid conference was attended by Ohio's state health department dental director and the director of Medicaid policy for the Ohio Department of Human Services. In August of 1998 members of the ODA Workgroup met again to develop recommendations. The group identified problem areas faced by patients, dentists, and ODHS. Recommendations were made to address each of the problem areas and sent to Medicaid. In September '98 the Workgroup met with key staff of the ODHS Medicaid fee for service and managed care sections to review the recommendations. A commitment was made by all present to work towards program improvements, to include a revision of the Medicaid dental guidelines, use of the ADA standard claim forms, a review of the prior authorization process and an increase in fees. In June '99 the Ohio Legislature approved a budget increase for Medicaid recommended by ODHS. Dental fees will significantly increase by 1/1/2000 with an emphasis on effective preventive and restorative treatments. A clause in the budget bill which would have indexed fees annually was vetoed by the Governor. Improvements in the guidelines were also made and the Dental Association has committed to take steps to encourage provider participation. All parties have agreed to continue work to increase participation and utilization.

Crying for a Smile

T. Reagan

Crying for a Smile is a forty-minute, pediatric oral health grand rounds presentation for medical providers. The program's goal is to improve children's health by informing medical providers about their important role in the prevention of early childhood caries (ECC). This enables the providers to better educate and assist families in the prevention of the disease and in obtaining dental care.

Many medical practitioners are unaware of just how critical their role is in the detection of early childhood caries. *Crying for a Smile* encourages medical providers to "lift-the-lip" to check for ECC as part of all well-baby exams. *Crying for a Smile* explains the signs, symptoms and prevention of dental caries by explaining both the etiology and the consequences of ECC. The program also enlightens the practitioners as to the long-term costs of untreated ECC. Clinical slides of early, moderate, and severe ECC are reviewed so the medical provider knows the "who, what, why, and how" to include ECC screening ("lift-the-lip") as a part of every well-baby exam.

The *Crying for a Smile* program was developed through a collaborative effort involving representatives of private and public health dentistry, dental hygiene, pediatrics, and others. Significant research publications were reviewed and utilized in the design of the program. *Crying for a Smile* was pilot-tested in a community hospital outside of Milwaukee, Wisconsin and was very well-received. Future presentations are planned for 2000.

Crying for a Smile is a slide presentation. A companion resource directory (for Wisconsin only) is also provided.

The Role of the Pediatrician in the Oral Health of Children: A National Survey

CW Lewis, DC Grossman, PK Domota, RA Deyo

- Background:** Dental caries are the most common chronic disease of childhood. Poor and minority children suffer disproportionately from dental decay and have limited access to dental care. Pediatricians may be able to play a role in enhancing preventive dental care, however their current level of involvement in oral health is unknown.
- Methods:** A national survey of 1400 randomly selected pediatricians to assess their knowledge, attitudes, and experience with oral health in pediatric practice.
- Results:** The response rate was 62% (N=862). More than 90% of the pediatrician agreed that they had an important role in identifying dental problems and counseling families on their prevention. Moreover, respondents were interested in increasing their involvement; 74% expressed a willingness to apply fluoride varnish in their practice. However, knowledge and previous training in dental health were limited. Respondents reported seeing dental problems on a regular basis. Those with more training in dental issues and those who cared for more the Medicaid patients were significantly more likely to report seeing dental problems frequently. Of the respondents, 55% reported difficulty achieving successful dental referrals for their uninsured patients and 38% reported difficulty referring their Medicaid patients.
- Conclusion:** Pediatricians are actively involved in the preventive oral health of their patients, but they have difficulty referring some groups of patients for dental care. Despite encountering dental problems relatively frequently, they have little formal training and do not have up-to-date knowledge. Efforts to train pediatricians in oral health may improve access to preventive dental care for underserved patients.

S. Sabatini

Primary care providers are much more likely than dental providers to consistently see children at high risk for early childhood caries (ECC). Those providers need to understand the importance of good oral health and how to evaluate dental health during their patient examinations. Prevention and early identification can result in avoidance or arrest of ECC. Once providers identify ECC, referral for treatment is necessary, but can be challenging in areas lacking oral health care providers that see children or Medicaid-accepting practitioners or clinics.

The Children's Dental Program of Mission+St. Joseph's Hospital in Asheville, North Carolina has developed a multifaceted program designed to improve the oral health of the region's children. The program consists of: a mobile, school-based outpatient practice, a hospital-based OR practice, and an education program targeting care providers, patients, and parents.

Our program educates physicians, hospital staff, health departments, and Department of Social Services offices about caries etiology, effects of diet, the role of fluoride, proper hygiene, early dental care, the importance of primary dentition, the consequences of ECC in western NC, and possible referral sources. We also emphasize the importance of educating parents on these same topics.

Feedback from presentations has helped us cater our programs to what providers want and need to know. Posters, mirror stickers, and oral health primer booklets have been created to help disseminate information about oral health to practitioners and their patients. We also use visual aids emphasizing the critical role care providers can play in disease prevention and identification.

Dental Health Initiative Integrated Into a Medical Model for Children Having HIV/AIDS

B. Berentsen, D. Myers, F. Ferguson, S. Nachman

The Pediatric Dental Infectious Disease Clinic (PDIDC) was instituted in January, 1992 as an integral program within the Pediatric AIDS Unit at University Hospital Center Stony Brook. Initial oral screening of 51 dentate children provided diagnosis of 17 (33.3%) caries active including 9 (47.1%) presenting with nursing bottle caries. It was evident that a oral disease preventive program was essential to be integrated within the medical model to address the oral health risks of this population at the earliest age possible. The program began with incorporation of a Dental Hygienist present at each ambulatory medical clinic three mornings a week to train parents and the medical team in preventative oral health practice. Eleven (11) children became patients before 36 months of age and have been followed in the PDIDC during the time span of April, 1995 to the present time, November, 1999.

Sample = 11 Children = 7 males, 4 females

Median age at Intake visit – 14.09 months

Status:

A1	6	B1	0	C1	0
A2	1	B2	0	C2	1
A3	1	B3	0	C3	2

Present Age Range – 2.90 years to 7.08 years

Results: Two (2) children presented with dental caries at intake visit.
 One (1) child has recurrent caries.
 One (1) child is caries free.
 Nine (9) children remain caries free.

Medical team provides oral health instruction to parents. Parents are able to establish health oral health.

Project funded in part by Ryan White, Title II, through BHPr, DADPHP, DESI

Children's Dental Health Initiative (CDHI) of San Diego

Amethyst C. Cureg,
Peggy Yamagata

The goal of CDHI is to improve the dental health status of low-income children, especially ethnic minorities. Objectives are to improve access to oral health services, develop educational modules that emphasize prevention, and link children to a medical/dental home.

To accomplish these objectives, CDHI maintains a systematic dental referral system to link low-income children who have no other health care resources to volunteer dentists; provides culturally appropriate educational materials and trains health professionals, parents, youths participating in peer-to-peer program and families; and integrates dental outreach strategies with established coordinated community-wide medical outreach to connect children to a medical/dental home.

In collaboration with the American Academy of Pediatrics, San Diego Dental Society, and San Diego Pediatric Dental Society, joint annual meetings to address pediatric dental disease have been institutionalized; as well as monthly oral health lecture series for physicians-in-training.

Pediatric dental disease is a community problem that requires a community based solution. Mobilizing our community was a challenge and demanded building partnerships, education, collaboration, outreach and funding. CDHI demonstrates that communities can work together to construct relevant innovative successful solutions.

Integrating An Oral Health Program in a Pediatric Cardiology Clinic to Increase Access to Dental Services

Olderog-Hermiston, E., Nowak A.J., Slayton R.L., University of Iowa College of Dentistry, Iowa City, Iowa.*

Problem: Children with congenital heart defects have oral health care needs that have not been met. (Franco 1996, Hayes 1999)

Purpose: The aim of this study is to determine if the integration of an oral health care program in a pediatric cardiology clinic increases the likelihood that children with congenital heart defects will access dental services.

Methods: A six month oral health care pilot program has been initiated in the Pediatric Cardiology Division, University of Iowa Hospitals and Clinics. The program consists of providing oral screenings and education about oral health and infective endocarditis. Children with unmet oral health care needs are encouraged to seek dental services. When necessary, patients are provided with a list of dentists in their area who accept young children in their practice and are informed about programs that provide financial assistance for dental care.

Results: The data will include the number of children who were referred for dental treatment, the reason for the referral, and the number of children who followed-up with dental treatment when a referral was made.

Conclusion: Data collection is ongoing for this program and will be analyzed at the completion of the pilot project.

Assuring Access to Care For Children With Developmental Disabilities: The UAP Model

Nancy Dougherty, DMD, Maureen Romer, DDS, Shaunon Moten, DMD

Dental care for children with developmental disabilities (DD) may be one of this country's great unmet health needs. The trend over the last 20 years to mainstream children with DD into community settings necessitates accessible community-based medical and dental services for this population. Unfortunately, the availability of these services has not kept pace with the need. Two important causes for this have been reported:

1. A lack of dental professionals who have received adequate educational experiences in the management of children with disabilities, and
2. Financial barriers: The vast majority of children with significant DD have their dental care covered by state Medicaid programs. Many private practitioners are unwilling to accept the low Medicaid fee-for-service reimbursements. The financial barriers to access have been exacerbated in the last few years, as many states have mandated the enrollment of individuals who receive Medicaid benefits into managed care programs.

University Affiliated Programs (UAPS) were initially funded in 1963 through the Mental Retardation Facilities and Community Mental Health Center Construction Act. They are located in all 50 states, each affiliated with a major research university. The mission of UAPs is to positively impact the lives of people with DD by increasing their inclusion into the community. This is accomplished in a number of ways: academic training, community training and technical assistance, research, working for systems change and providing direct care services. UAPS that include dental services and training of dental personnel have, for a number of years, produced dentists that are able to provide services for children with DD in a variety of settings. The increase of financial barriers to dental and medical care for people with DD have become a focus of study for many of the UAPs nationwide. UAPs that include dental services as a part of their programs can provide a model for community-based centers that are attempting to integrate medical and dental needs for children with DD.

Public Health Benefits of Prenatal Dental Care Services

Cassandra Henderson, MD

Perinatal outcome is an important determinate of public health. Perinatal outcome is improved by reducing the incidence of low birth weight. One tool to reduce low birth weight incidence is to diminish the prevalence and severity of material oral and genital infections. Addressing these perinatal infections is difficult for public health professionals serving minority, immigrant and socially disenfranchised populations.

At MIC-Women's Health Services, dentistry is an integral part of the prenatal services provided to over 7,000 women through a network of centers in New York City. MIC serves a multinational, multicultural and multilingual population. MIC successfully enrolls pregnant patients in PCAP (Medicaid) which reimburses dental care on a fee-for-service basis. MIC wants to expand integration of dental services with prenatal care by addressing the long-term oral health needs of women and their infants. Toward this, assessment of the incidence of bacterial vaginosis (BV) and periodontitis in MIC's prenatal population is needed, as are increased material awareness of the importance of maintaining adult and childhood oral health and facilitated access to regular adult and pediatric dental care through organized referral networks.

Dental programs co-located with prenatal services in community based practices, such as MIC's, are threatened by insufficient reimbursement rates as mandatory enrollment in Medicaid managed care takes effect. Diminishing reimbursement demands that public policy become creative and support maintaining the viability of such programs. MIC's program offers a rare opportunity to educate and provide preventive medical and dental services to an at-risk population.

Collaborative Partnership to Improve Preschoolers' Dental Health

RS King, RG Rozier (NC Division of Public Health, Dental Health Section and UNC School of Public Health) and other partners

A 1996 *Smart Start* health assessment resulted in consensus that improved dental health was the primary need of preschool children in the NC Appalachian Mountains. Collaborative agreement on a common goal resulted in greater public awareness and support and a critical mass for action. Efforts include state and local health agencies, university schools of public health and dentistry, private sector pediatric offices and non-profit agencies, each with unique knowledge and perspective. Partners share responsibility, some more instrumental in initiation, with others playing a larger role in development and implementation. Shared commitment and planning help insure sustainability, and shared monitoring and evaluation help ensure accountability. An Appalachian Regional Commission grant provides partial funding, with the remainder from in-kind contributions from state, local and non-profit agencies. We are in year 2 of a 3-year, 11 county, community-based dental health promotion initiative targeted toward reducing dental problems in very young, high-risk children. The state Medicaid program joined the partnership, reimbursing physicians to provide a clinical package of dental health education, oral screening and fluoride varnish applications every six months for children $\leq 200\%$ poverty level, age 9-36 months, assisting with program sustainability. A multidisciplinary advisory committee meets regularly to develop guidelines, materials and evaluation. Public health dental hygienists working with community leaders developed county plans, and are training physicians offices to provide the dental package. The preventive emphasis aims to reduce access to dental care problems by reducing the need for costly treatment. Funds are sought to evaluate attributable declines in dental disease levels.

The North Carolina Medicaid Dental Program Makes an Attempt to Improve Access to Dental Care for the Indigent through Two very Exciting Initiatives:

B.K. Sutton

1. Creation of a new oral screening preventive package for very young children to be provided by physicians or physician-extenders in primary care settings (i.e., physician offices, health departments, FQHCs, migrant and rural health clinics)

2. Pilot test a Dental Health Care Co-ordination System for Medicaid Eligibles

The objective of the aforementioned initiatives is to dramatically improve access to dental care for NC Medicaid eligibles, especially children, during a period when it is very difficult to obtain legislative appropriation to increase fees for dental services. Low Medicaid reimbursement to dentists for the provision of care is a main barrier to dental care access for entitlement program recipients. Hence, alternative approaches for ameliorating this dilemma have to be creatively crafted.

In order to create these alternative approaches-collaboration, partnering and coalitions are being built with other health care provider groups as well as with interested, non-health related groups in addition to the traditional dentists provider group. These collaborations now include: Physicians (pediatricians, family practitioners,) physician-extenders and nurses, health-check coordinators, managed care representatives, dentists and especially pediatric dentists, UNC School of Dentistry and School of Public Health, NC Dental Public Health and Colgate.

Once these initiatives are in place, the NC Medicaid Program would like to observe after five years, 22% more eligibles accessing care and utilizing more dental services and 10% more dentists participating in the Medicaid Dental Program seeing at least five or more new Medicaid patients per year. Also with the provision of the new oral screening preventive package which includes the application of a fluoride varnish, the program should observe a 40% reduction of early childhood caries in children from 6-36 months of age over a relatively short period of time which would finally obviate the need for extensive and more expensive dental care.

LaSalle University Neighborhood Nursing Center's CHIPLINK Initiative:
Meeting the Needs of Vulnerable Uninsured Children

A high percentage of uninsured children (40%) presented for health services at our nurse-managed family health center during 1997 despite availability of coverage through CHIP and Medicaid. The highest number of uninsured Philadelphia children and families resided in LaSalle's service areas (Health Commissioner, 1997). The Pediatric Nurse Practitioner and the Director were awarded funding (\$50,000) by a foundation* for one year to LINK children with health insurance and provide comprehensive health care to enable a "jumpstart" on meeting their health needs. CHIPLINK provided essential primary health care to this underserved group and linked eligible children with health insurance and with access to dental care. Funds were used primarily to support staff salaries.

Community Health Outreach Workers and Americorps Volunteers identified uninsured children through a variety of community outreach activities. Case management was provided throughout completion of insurance applications, coverage verification, and confirmation of medical and dental homes, for a total of 960 outreach worker contacts.

Three hundred children from birth through 18 years were enrolled in CHIPLINK; nurse practitioner encounters ranged from one to 12 visits per child. Most were African-American children from low income households residing in Northwest Philadelphia. Immunization status and age appropriate lead screenings were updated for over 30% of those children behind at program enrollment. Dental caries were common despite Philadelphia's fluoridated water. Children with significant health and dental problems were referred appropriately.

Our innovative CHIPLINK initiative exemplifies how an academic based nurse managed center improved health status for vulnerable children in this urban community.

*funded by the Patricia Kind Family Foundation

Addressing the needs of underserved children: integration of dental services into medical well child examinations.

Deinard A, Rose T, Grayden J, Conry J

OBJECTIVE: To develop and evaluate a model of integrated dental and medical services for a population of culturally diverse children receiving medical and dental care in a community health clinic. This oral health program is designed to meet the needs of underserved children at significant risk for dental decay. **SETTING:** The clinic, located in the neighborhood with the highest medical and social risk factors in Minneapolis, Minnesota, provides medical, dental and social services to 8,600 patients annually. **INTERVENTION:** Children, ages 12-60 months who attended medical well child examinations were evaluated for plaque, dental decay and presence of oral streptococcus mutans. A dentist joined the medical examination to conduct the assessment and to provide education to caregivers regarding oral health and nutrition. Caregivers were also provided with a dental health kit that included toothbrush and tpee cup. Children who were found to have oral pathology were immediately scheduled for dental care in the dental clinic. **RESULTS:** Over 70% of the children had never received any dental care. And of this number, one-third were found to have dental pathology at the time of the screening. Of the children who had received dental care, 75% nonetheless had decay present. Caregivers recorded high satisfaction (95%) with the combined medical/dental screening. **CONCLUSIONS:** This study documented the alarmingly high degree of oral pathology and un-accessed services for children less than age six. This study also provides a model of integrated health care that increases access for oral health evaluation and education for underserved young children.

Presentation Information

Theme (I-IV): III; II

Topic (1-7): III, 4; II 7; II 4

Type of Presentation:

Health services

Community-based or outreach project

**Oral Health Program for Special Need and High Risk
Populations: Integrating Unmet Medical/Dental Needs. A Model
for Rural Based Oral Health Programs.**

J. Akamanti, E. Jurkowski

Substantial numbers of Medicaid eligible children living in rural communities do not receive dental care of any kind due to a host of barriers related to access. This problem is amplified in children from low income families. Despite empirical evidence which suggests that providing children with free dental care results in significantly fewer decayed teeth, rural based dentists are not eager to serve children from special and high risk populations. This study examined several barriers to dental care access within rural communities in Southern Illinois. These barriers included access to dental care, community education, and compliance with referrals. The purpose of the study was to find ways to remove barriers to care and emphasize the importance of dental care to all stakeholders. The methodology consisted of a needs assessment followed by meetings with stakeholders, public officials, and key delivery personnel. The outcome was a blueprint and recommendations for service delivery in rural Southern Illinois which were initiated through the State Health department, a local Federally Qualified Health Center, the academic and public health communities. Findings suggest that policy changes at the community program level, as well as state levels are key factors in increasing oral hygiene and dental health in rural and high risk school-aged populations. This experience serves as a case study for other rural health programs both in Illinois and rural venues.

DEVELOPMENT OF PARAMETERS OF HEALTHCARE PRACTICES

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The American Cleft Palate-Craniofacial Association held a multidisciplinary consensus conference funded by Maternal and Child Health Bureau. Objectives were to (1) identify appropriate assessment and treatment procedures for patients who have cleft lip/palate or other types of craniofacial anomalies, (2) define timing, from infancy to maturity, for conduct of these procedures, and (3) disseminate the conference results. Procedures: Seventy-one professionals experienced in diagnosis and treatment of craniofacial anomalies and representatives of families and patients participated in the conference. Experts presented rationales for parameters they proposed for healthcare practices. Each presentation was followed by small group discussions in which proposed statements were accepted, amended, rejected, or augmented. All of the participants voted on each of 386 statements. Those statements, which at least 75% of the participants agreed to accept, were organized into a draft document. The document was revised in response to comments, following select and widespread peer review. Results: The Parameters were unanimously approved by the conference participants and by the ACPA membership. Since publication in 1993, 20,000 copies of the *Parameters for Evaluation and Treatment of Cleft Lip/Palate or Other Craniofacial Anomalies* have been distributed to parents, patients, healthcare professionals, educators, researchers, funding and governmental agencies. Conclusion: This document, under continuous review and revision by an ACPA committee, provides a foundation for clinical practice and study of clinical outcomes. The multidisciplinary consensus conference is a model for identification of parameters for best healthcare practices.

(Grant# M CJ-425074)

Integrating Oral Health into Overall Health: Training in Infant/Toddler Oral Health Care for Non-Dental Health Professionals

N. G. Herman, J. Fernandez-Wilson, E. Colchamiro, L.R. Rosenberg

Many oral health problems that arise in infants and toddlers are preventable. Because dental disease can begin very early in childhood, caretakers need to know about simple interventions that can prevent the onset of disease. The key to oral health promotion and disease prevention lies in anticipatory guidance and education of the parent, early detection and timely referral for appropriate intervention. This is accomplished best by the non-dental health professionals to whom many women entrust their own health during pregnancy, and their newborn's health during infancy and early childhood. By the time a dentist becomes aware that a problem exists in a youngster, the situation may warrant invasive intervention – the time for secondary or tertiary, not primary prevention. Recent research establishes clear and strong linkages between oral health in pregnancy and premature and low birthweight infants. This hour-long presentation is geared toward primary care providers, e.g. obstetricians, pediatricians, residents, physician assistants, nurse practitioners, nurses, medical students, health educators, et al. Its theme is to position oral health as an integral component of overall health. The goal is to motivate them to transmit accurate infant oral health information to the focus population – pregnant women and new mothers. The anticipated outcomes are that participants will have a higher level of knowledge about oral health issues of pregnancy and early childhood; will be able to transmit these concepts effectively to their patients as part of their healthcare education programs; will see earlier attainment of year 2010 national oral health objectives.

Success Outcomes of Restorative Procedures Following Comprehensive Dental Rehabilitation Under General Anesthesia

A. Tate, MW Ng, H. Needleman and G. Acs

Objective: To assess the success rates of restorative procedures performed for children who have undergone dental rehabilitation under general anesthesia.

Methods: Dental records of children who had dental rehabilitation at the Children's Hospitals in Boston and Washington, DC were retrospectively reviewed in separate and independent studies. The Boston records were of children who had dental rehabilitation between 1990 to 1992. The DC records were of children who had dental rehabilitation between 1994 to 1998. In both studies, only records of children who returned were followed for at least six months were evaluated.

Results: Only 45% of Boston children and 50% of DC children who had dental rehabilitation returned and were followed for at least six months. 104 Boston dental records and 141 DC dental records were available for analysis. Mean time of follow-up was 29 months for the Boston group and 22 months for the DC group.

At the end of the review periods, stainless steel crowns were found to be the most successful restorative procedure for both the Boston and DC groups of children (89.2% for the Boston group; 94.2% for the DC group). Multiple surfaces and on surface amalgam restorations were less successful (70.7 to 87.5% successful) for both groups. For both groups, the least successful restorations were found to be the composite restorations (35.7 to 69.5%).

Discussion: Children who require dental rehabilitation under general anesthesia are typically young children or children who have medical or developmental disabilities. These children have extensive dental needs and are at high risk for new and recurrent caries. Our findings are consistent with previous studies demonstrating that full coverage restorations such as SSC's are the most durable, reliable restorations while composite restorations are the least durable. The next step would be to evaluate the difference in survival rates of restorative procedures performed under general anesthesia in order to predict the long-term success rates of the various procedures.

Conclusions: Full coverage stainless steel crowns were more successful than amalgam or composite restorations placed in children who had undergone dental rehabilitation under general anesthesia at two Children's Hospitals.

The Effect of Patient Medical History on the Success Outcomes of Restorative Procedures Following Comprehensive Rehabilitation Under General Anesthesia

A. Tate, MW Ng, H. Needleman and G. Acs

Objective: To assess whether the patient medical history affects the success rates of restorative procedures on primary teeth performed for children who have undergone dental rehabilitation under general anesthesia.

Methods: Dental records of children who had dental rehabilitation at the Children's Hospitals in Boston and Washington, DC were retrospectively reviewed in separate and independent studies. The Boston records were of children who had dental rehabilitation between 1990 to 1992. The DC records were of children who had dental rehabilitation between 1994 to 1998. In both studies, only records of children who returned were followed for at least six months were evaluated.

Results: A combined total of 207 children (N=98 for Boston; N=109 for DC) who were younger than 5.5 years of age at the time of their dental rehabilitation were available for analysis. Of these cases, 28% of Boston children and 29% of DC children were diagnosed with either significant medical history or developmental disability.

Children with medical and developmental disability were found to have higher failure rates of amalgam restorations and stainless steel crowns than children without disabilities ($p < 0.05$, $\text{ChiSq} = 4.16$ for SSC's and developmental disability).

Discussion: Children who require dental rehabilitation under general anesthesia are typically young children or children who have medical or developmental disabilities. These children are at high risk for new and recurrent caries development. Our findings suggest that young children with medical and developmental disabilities are more likely to have failures of amalgam restorations and stainless steel crowns. Dental professionals and caregivers need to be aware of the increased risk of failures. Children with special needs should be given individualized preventive protocols including more frequent recalls. Research to develop dental materials that would be more durable for children with medical and developmental disabilities should be encouraged.

Conclusions: After dental rehabilitation, children younger than 5.5 years who have medical or developmental disabilities were found to have a higher risk of amalgam restoration and stainless steel crown failures than children without these disabilities.

Parental Satisfaction and Patient Outcomes Following Comprehensive Dental Rehabilitation in the Management of Early Childhood Caries

A. Tate, MW Ng, H. Needleman and G. Acs

Objective: To assess quality of life indicators following comprehensive restoration of rampant carious lesions in children undergoing treatment with general anesthesia and parental satisfaction with outcomes.

Methods: A simple survey tool was completed by parents of children that had undergone comprehensive dental rehabilitation under general anesthesia for the management of severe early childhood caries. Data was collected at either routine follow-up examination, re-care visits or via mail, regarding such outcome criteria as ability to eat, sleep and presence of dental pain. Internal coding mechanisms identified the presence or absence of medical or developmental compromises among the children treated in such a manner.

Results: Surveys were returned by 115 parents (N=400). Overall, 63.5% and 38.2% reported improved abilities to eat and sleep, respectively, while 82.6% of patients reported an improvement in pain experience. Only a single patient reported worsening experiences. 71.3% of the parents believed that the overall health of their child had improved following dental treatment. Additionally, 98.2% of the parents reported that their experience was positive, while 94.7% reported that expectations had been met.

Among parents of children with medical or developmental disabilities, 88.1% reported a perceived improvement in overall health, as compared to 61.1% of children with non-contributory medical histories ($p<0.01$)

Discussion: In children with early childhood caries, the comprehensive restoration of dental health through the elimination of dental disease and chronic infection allows improved ability for children to eat and sleep and frees them of chronic pain. The impact on overall health, as perceived by parents, is even greater for children with medically or developmentally compromising conditions. These findings are consistent with a different parent cohort that reported on the presence of such indicators prior to dental intervention and their expectations for resolution following dental treatment.

Conclusions: The return of dental health in patients with severe early childhood caries, is perceived by parents as restoring components of overall health to their children by improving quality of life parameters, such as freedom from pain and the ability to eat and sleep without disruption.

Parental Expectations Regarding Patient Outcomes Prior to Comprehensive Dental Rehabilitation in the Management of Early Childhood Caries

A. Tate, MW Ng, H. Needleman and G. Acs

Objective: To assess pre-existing quality of life indicators and parental expectations prior to comprehensive restoration of rampant carious lesions in children undergoing treatment with general anesthesia.

Methods: A survey was completed by parents of children prior to comprehensive dental rehabilitation under general anesthesia for the management of severe early childhood caries. Data was collected regarding such criteria as ability to eat, sleep and presence of dental pain. Additional outcome expectations were surveyed. Children were also categorized on the basis of medically compromising conditions.

Results: Surveys were returned by 60 parents. No individuals declined to complete the survey. Overall, 56.7%, 41.7%, 83.3% and 50.0% reported worsened eating, sleeping, pain and overall health to be related to their child's decay. Following dental treatment, 70.0% and 58.3%, 93.3% and 73.3% of the parents believed that the abilities to eat and sleep would improve, respectively. Furthermore, 93.3% and 73.3% felt that their child's pain burden and overall health would improve following treatment.

Among parents of children with medical or developmental disabilities (n=21), there were no statistically significant differences in perception regarding the effect of dental caries on pain, eating or sleeping. However, when compared to other patients, parents of children with medically or developmentally compromising conditions were significantly less likely to believe that overall health was worsened due to dental caries. Outcome expectations did not differ on the basis of medical compromise

Discussion: In children with early childhood caries, parents commonly report the adverse effects of dental caries on their child's ability to eat, sleep or be free of pain, while also negatively impacting upon overall health. Parents expect improvement in all of these areas following comprehensive treatment through the elimination of dental disease and chronic infection. The perceived impact on overall health is greater for children that are free of significant disabling conditions. These findings are consistent with data from another cohort that reported post-operative quality of life outcomes.

Conclusions: Parents of children with early childhood caries report adverse impact in quality of life indicators, while anticipating beneficial impact on these factors and overall health, as a result of comprehensive oral health care.

Why Do Young Children from Low Socioeconomic Families in Flagstaff, Arizona Experience a Higher Burden of Decay than the Overall Population?

This research project was designed to answer the question: Why do young children from low socioeconomic families in Flagstaff, Arizona experience a higher burden of decay than the overall population? Early childhood caries (ECC) is a health issue, which is subject to cultural, social, political, and economic influences. Information was gathered regarding social and cultural factors relating to dental disease in children ages one through five, residing in Flagstaff, Arizona, using applied ethnographic research techniques. Interview and focus group participants were low-income parents/caregivers. Questions regarding knowledge, attitudes, behavior, dental problems, and experiences accessing dental care were asked during sessions. The study found that an overwhelming concern was the difficulty that participants had accessing dental care. Participants were knowledgeable about the causes of dental decay and the behaviors and measures that prevent it. Participants talked about the reality of dealing with children's oral health in the context of their daily lives. The information collected from the interviews and focus groups can help dental health professionals gain greater understanding of parents' and caregivers' perception of dental health, dental disease and prevention. The information can also guide comprehensive, culturally sensitive, dental health promotion programs to benefit the dental health of young children in Flagstaff and throughout Arizona.

Caries in the primary and mixed dentition: a longitudinal study.

J.M. DOUGLASS*, (University of Connecticut School of Dental Medicine, Farmington, CT, U.S.A.).

This study aimed to examine the development and relationship of primary and permanent dentition caries, and the level of treatment received. In 1991 168 Head Start children in Hartford, Connecticut were recruited. Of these children, 79 received clinical dental examinations at baseline (mean age 3.9 ± 0.4 yr-s) and years two, four, six and seven. No radiographs were taken. The baseline mean dmfs was 2.9 with a caries prevalence of 47%. Primary dentition caries peaked in year two, with a mean dmfs of 4.7 and a prevalence of 63%. Permanent dentition caries presented soon after tooth eruption and mostly involved first molar fissures. In year seven the mean DMFS was 2.4 with a caries prevalence of 60%. Children who presented with baseline primary dentition caries had a mean DMFS of 4.2 in year seven compared to 2.0 in those who developed primary dentition caries after baseline and 0.39 in those who had no primary dentition caries ($P < 0.01$). Further, children at baseline with maxillary anterior caries had a mean DMFS of 6.3 in year seven, compared to 2.4 in those with just posterior caries and 1.0 in caries free children ($P < 0.01$). Only 57% of children with primary dentition caries and 41 % of children with permanent dentition caries ever received complete treatment. During the study 57% of first permanent molars received sealants. Of these 83% remained caries free compared to 47% of unsealed teeth. The age of onset and Daftem of primary dentition caries affected the caries risk of the permanent dentition. Sealants were effective, but like treatment, were underutilized. Supported in part by NIH/NIDR grant DE10592.

Severe ECC and Blood Lead Levels Among American Indian Head Start Children

Bonnie Bruerd

Because elevated lead blood levels are common among low income inner city children, it has been suggested that lead is a contributing factor in the development of severe Early Childhood Caries. Retrospective data were gathered from a 1995 state-sponsored program to identify children with high blood lead levels. The data were used to assess the correlation of blood lead levels and dental caries among American Indian children.

In 1995, the Blackfeet Tribe in Browning, Montana participated in "The Montana Lead Program." Blood drawn from 193 Head Start students age 3-5 years old. Program criteria stated that <10 micrograms/deciliter was within normal limits and 15 or more micrograms/deciliter would require a home visit from the nutritionist. Of the 193 blood samples, 190 were <10mcg/dcl, one was 10mcg/dcl, and one was 12mcg/dcl. Only one child had a lead level well above normal limits (26mcg/dcl). This child's family received a home visit where it was discovered that the father was cleaning a car engine in the living room.

During the same period of time, the same 193 Head Start students received dental exams. The prevalence of ECC among these children was 48 percent. ECC was defined as two affected maxillary primary teeth. There appears to be no correlation among American Indian Head Start children in Browning, Montana.

The State Children's Health Insurance Program

insuring more kids

OPTIONS FOR LAWMAKERS

CHIP: DENTAL CARE FOR KIDS

By Laura Tobler

August 1999

State legislatures across the country have been busy enacting legislation to create, monitor and fund the new State Children's Health Insurance Program (CHIP). The Balanced Budget Act of 1997 authorized more than \$20 billion over five years to help states cover uninsured low-income children (see appendix A for details). As legislators deliberated about the benefits that the newly insured children should receive, a critical unmet need of poor children discussed was oral health.

This report briefly outlines the oral health status of America's children; highlights the two publicly funded programs that provide the most money for dental coverage for children living in poor to moderate income households; offers lessons learned from years of Medicaid experience; describes a few state programs to improve access to care; and lists additional federal programs that relate to pediatric oral health. The appendices provide a brief summary of CHIP, and list CHIP programs and CHIP dental health services.

*Oral health is
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Background

Tooth decay is the most prevalent preventable chronic disease of childhood. Despite the improvements in children's oral health care in the last few decades, many American children still suffer the pain of untreated dental disease. It can lead to poor nutrition and growth in young children and missed school days, needless pain, poor self-esteem and medical complications in older children. More than one-half of all children ages 6 to 8 experience tooth decay and about one-third of these cavities are not repaired. The National Institute of Dental Research reports that 80 percent of tooth decay is found in just 25 percent of children. The amount of tooth decay in a child is inversely related to income level—kids from poor and moderate-income families have more tooth decay and a large percentage of these kids go untreated. Many of these children are eligible for publicly funded health programs such as the state's Medicaid program and CHIP.

CHIP and Oral Health

The Balanced Budget Act of 1997 (P.L. 105-33) added a new Title XXI to the Social Security Act, creating the State Children's Health Insurance Program (see appendix A). The program is



designed to help states cover more uninsured children with new federal money that must be matched with state dollars. By June 1999, 52 state and territorial CHIP plans had been approved by the Health Care Financing Administration (HCFA).

Generally, states can extend coverage to uninsured children under age 19 if they do not qualify for Medicaid and their family income is below 200 percent of federal poverty guidelines (\$27,760 for a family of three in 1999)—or 50 percentage points higher than the existing Medicaid eligibility level if the threshold already exceeds 150 percent. State plans to cover these kids can expand Medicaid, create a new state insurance program or combine the two approaches.

If a state chooses to expand Medicaid, it must provide Medicaid's full package of services, including dental services that are described in the following section. If a state elects to create a state insurance program, it is free to decide if dental services should be included in the benefit package.

*Forty-eight
state CHIP
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Two state CHIP programs do not presently include dental health services in the approved benefit package—Colorado and Delaware. Dental services in Florida are covered on a county-by-county basis. New York's original benefit package did not include dental services but the Legislature passed a law in 1998 requiring dental services that are now provided. In Colorado, the board that governs CHIP requested that the year 2001 budget include dental benefits, which requires endorsement from the governor's office and approval by the General Assembly. Montana did not include dental benefits in the original program design but passed legislation in 1999 (SB 81) that requires dental health benefits for CHIP, by October 1999—the benefit is limited to \$200 annually per enrollee. The 48 remaining CHIP programs provide some type of dental services (see appendix B for more details).

Research shows that almost 30 percent of our nation's child health expenditures, including both public and private payers, are attributable to dental care. Less than 1 percent of Medicaid's total budget and about 2.3 percent of the money spent on children's health care goes for dental services. If CHIP programs aspire to provide better access to dental services for children, policymakers need to understand how to budget for them.

According to costing models developed independently by the American Academy of Pediatrics and the Reforming States Group of the Milbank Memorial Fund, CHIP dental services will require \$16 to \$20 per child monthly to provide discounted but market based payments for dental services.

States have learned from their experience in providing dental health services to low-income children enrolled in Medicaid. The research and lessons learned over the years of confronting obstacles and barriers to delivering dental services in Medicaid can be used to design and improve the CHIP programs.

Medicaid's Role in Pediatric Oral Health

All children enrolled in Medicaid are entitled to comprehensive dental services. Medicaid's "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" program, the nation's primary source of well-child care for low-income youth through age 20, must provide dental examinations for all children. The program must also provide necessary treatment or services to correct or ameliorate defects found, regardless of whether the follow-up services are otherwise covered under the state Medicaid plan. The states have some flexibility in determining when the first dental examination occurs under EPSDT. Current recommendations by the American Academy of Pediatric Dentistry, the American Dental Association and the Bright Futures Project recommend the first dental visit at about age 1.

But being entitled to services and actually receiving them are two different things. In 1996, only about 17 percent of Medicaid-enrolled children received the required EPSDT dental services, down from 18 percent in 1994 and 1995. Only one in five children eligible for a dental screening actually gets it. When children do not receive the appropriate dental screenings, Medicaid pays the higher price of treating advanced dental disease in children—5 percent of the kids eligible for services consume 30 percent of the dollars spent on dental care. For example:

One in five children eligible for dental screening under EPSDT actually gets it.

- ◆ Children with swollen faces, painful toothaches and abscessed teeth may end up in the emergency room. The treatments they receive in this setting generally address their infection and pain, but not the underlying disease—tooth decay. A visit to the emergency room averages about \$100 and children may walk out the door with their teeth untouched.
- ◆ Baby-bottle tooth decay, a preventable disease, requires very expensive treatment if not identified and managed early. HCFA estimates that Medicaid pays at least \$100 million and as much as \$900 million per year for operating room charges associated with this disease on top of thousands of dollars in dental fees per case.

The Medicaid Experience: Obstacles to Care

Despite the efforts of EPSDT programs across the country, many eligible children lack access to comprehensive dental care. Many barriers contribute to this failure—provider participation, geographical barriers, personal behavior and the transition to Medicaid managed care.

Understanding these known Medicaid barriers and the potential solutions is an important step in creating CHIP dental plans that will work.

Provider Participation

Only one in six dentists participating in Medicaid receive \$10,000 or more in Medicaid payments per year. This statistic indicates that few dentists substantially participate in the Medicaid program. "What good does a Medicaid card do if you can't find a dentist who will accept

it?” asks Owen McCusker, executive director of Community Living Alliance in Madison, Wisconsin. State legislators are asking the same question.

Reimbursement rates. Dentists claim that the Medicaid reimbursement rates for dental care are too low. “The fees paid by the Medicaid program in many states do not meet the aggregate cost of delivering the services,” asserts Burton Edelstein, a dentist and director of the Children’s Dental Health Project. Medicaid reimbursement rates to dentists range widely among states and typically are significantly lower than non-Medicaid payments. Colorado reimburses dentists about 68 percent of their usual fee for caring for Medicaid patients. Tom Oberle, spokesman for the Colorado Dental Association, says that it takes 70 percent of a dentist’s income just to cover operating costs.

Increasing provider reimbursement rates may be necessary but it is not sufficient for increasing dentist participation or increasing service delivery. Maine increased reimbursement rates and found that it had very little impact on the number of dentists in their tight dental market. In Connecticut, an increase in reimbursement rates did lead to an increased number of procedures by the same participating dentists.

Red tape. Complex enrollment forms, nonstandard billing forms, excessive prior authorization requirements, slow payments, inefficient eligibility determination and other administrative problems can discourage dentist participation. The states of Washington and Indiana do everything possible to mimic the private sector insurer in an effort to streamline the administrative work of the participating dentists, with resultant positive response from dentists.

Because of good communication between dentists, health professionals and legislators, 77 percent of Vermont dentists participate in Medicaid.

Vermont has a good track record of dentists participating in Medicaid—77 percent of dentists participate. According to George Richardson, a Vermont dentist, the number one reason for this high participation is good, ongoing, responsive communication between dentists, health officials and legislators. He claims that the Medicaid department’s full-time dental director, who understands and facilitates resolutions to problems, is a positive force in effecting dentist participation. Also, the state has made an effort to streamline claims processing and payment by allowing dentists to use the standard American Dental Association billing form, reducing the number of services that require prior approval, and creating a rapid electronic payment system. But Vermont is not free of problems. According to Richardson, the state’s recent expansion of Medicaid to children in families up to 300 percent of poverty has increased the number of patients seeking services without increasing the number of dentists willing to take on more clients.

States have also used continuous eligibility and swift and simple eligibility verification (electronic or “800” telephone number) to significantly reduce wasted time and frustration in the offices of the providers, including participating dentists.

Broken appointments. According to the American Dental Association, one-third of Medicaid dental appointments result in “no-shows”. Broken appointments are common and profoundly

problematic for dentists, says Dr. Edelstein. The families of children eligible for Medicaid may not be familiar with or honor the common behavioral structures of the dental delivery system. They may lack reliable transportation to the dental office, have difficulty with child care or lack leave from work, all which can lead to broken appointments. "Broken appointments cause dentists near hysteria and the reason for that is that dentists bear the ongoing operating cost of their facilities—facilities that are extremely expensive to run. So a broken appointment really means significant down time and a financial loss," warns Edelstein.

Geographical Barriers

An estimated 152,000 dentists practice in the United States—that is about one dentist for every 1,750 citizens. The dentist-to-population ratio is declining as fewer dentists graduate and the population grows. Only about 4,000 specialize in pediatric dentistry, a specialty prepared to address the extreme needs of many low-income children. Clearly a tight dental market exists in this country. According to Richardson, not only is there competition for patients to get appointments with the short supply of dentists, but there is competition among states and communities to keep dentists practicing in their locale. And practicing dentists are not evenly distributed among the population. Dr. Edelstein says dentists tend to be concentrated in "affluent" rings around cities. The traditionally underserved areas—rural and low-income neighborhoods—have particular scarcity. Of the rural counties in the United States, 38 percent have no dentist.

The dentist-to-population ratio—1:1,750—is declining in the United States.

"I am the only dentist in La Plata County, Colorado, who accepts Medicaid," states Dr. Larry Suazo, a pediatric dentist in this rural county. "Several times during the past year I've gotten so ridiculously booked up that I couldn't take new patients," Suazo says, which means that the Medicaid patients just wait.

Personal Behaviors

According to Richardson, a part of the problem is the motivation and background of the parents. In Vermont recently, the families of 40 school-age children identified to need dental services were sent letters indicating that their child could receive free dental care if the family responded to the letter—the state received only four responses.

The families whose children are eligible for Medicaid and CHIP may not be familiar with the dental delivery system, which makes navigation of the system a challenge. They also may not realize the value of preventive dental care because of their own history of poor dental care. Also, parents with inflexible workplaces may find it difficult to take time off from work to take their children to the dentist.

Medicaid Managed Care

The movement of Medicaid clients into managed care also affects access to dental services. According to Edelstein, about 20 states have moved their Medicaid dental services, in whole or part, to managed care. Less than half of all practicing dentists in the United States participate in

*Managed care
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a managed care network, which significantly reduces the number of dentists willing to take Medicaid clients. Edelstein believes that the infrastructure necessary to make managed oral health services a success is inadequate, particularly if states attempt to capitate payments.

States are slowly gaining expertise in contracting with managed care organizations. An early survey of Medicaid managed care contracts showed that many states failed to explicitly transfer the full range of EPSDT requirements to managed care companies. This leads to confusion and controversy among the Medicaid client, Medicaid program and the HMO, while leaving the state with legal responsibility for care. As states become more savvy purchasers of managed care, these contracting problems will be resolved.

However, managed care could hold great promise for improving services. Truly managing a child's oral health care—providing a “dental home”—could open the door to preventive services, which in the long run will improve the child's health and save the state money. But many unanswered questions remain about the dental managed care delivery system and experience with medical managed care cannot be directly extrapolated to dental care.

State Activities

A number of states recently took action to improve access to dental care for children eligible for Medicaid and CHIP. The reforms—which include increasing reimbursement rates, simplifying administrative tasks, expanding the scope of practice for dental hygienists, creating school-based dental clinics, and forgiving loans for new dentists—show the commitment and creativity of the states in dealing with this problem. The following are a few examples of these initiatives.

- ◆ Vermont increased funding for the Medicaid dental program by \$1.5 million in 1999 to increase reimbursement rates for participating dentists by 17 percent. The state also allotted \$500,000 to be used for a competitive grant program. According to state dental director Tommy Ivey, \$400,000 of the grant money will be awarded on a competitive basis to dentists or clinics as incentives to change their existing business to improve their ability to serve Medicaid clients. A few of the dentists' proposals request money to train dental assistants to provide expanded services, which increases the capacity of the dentist to see more patients. The rest of the money may be used for retention and recruitment of dentists—a loan repayment program and out-of-state recruitment of dental students (Vermont has no dental schools).
- ◆ Nevada enacted two bills during the 1999 session to improve access to dental health care. AB 527 authorized financing to create a dental school and SB 181 created a limited license for dentists and dental hygienists. The bill sponsor, Senator Raymond Rawson, hopes that the new school, which will open in 2001, will increase the number of oral health practitioners in the state and the number of dentists available to participate in the state's Medicaid and CHIP programs.

- ◆ In 1998, Maine's P.L. 667 established a toll-free telephone referral service. The phone line, which generates about 300 calls per month, provides individuals with information on dental services and assistance in accessing dental services. Dentists can also use the phone line to request assistance in dealing with Medicaid clients. The law also requires Medicaid to work with a statewide dental association to increase the number of providers. Maine recently raised provider reimbursement rates but still has an inadequate number of providers participating in Medicaid. This fall the state dental advisory committee will convene to discuss problems and solutions.
- ◆ North Carolina's 1998 CHIP legislation (S 1366) required the Department of Health and Human Services to evaluate and recommend strategies to encourage dentists to increase their Medicaid patients. The recommendations were presented to the General Assembly in April 1999—and as yet, the legislature has not acted on them. Some of the recommendations were created to increase provider participation, such as increasing reimbursement rates to 80 percent of usual and customary; creating an outreach program to encourage dentists in private practice to participate in Medicaid; and improving communication between dentists, Medicaid and Medicaid clients with a dental advisory group. Several recommendations were crafted to increase the number of dentists and hygienists practicing in rural and underserved areas. These include: providing grants to communities to leverage private funds to establish community dental care facilities; establishing a foundation through the North Carolina Dental Society to help establish dental care in underserved areas; increasing the scope of practice for public health hygienists; studying the role of dental hygienists in preventive dental services; and creating a loan repayment and scholarship program for dentists practicing in underserved areas. Other recommendations include changing licensure laws by allowing licensure by credentialing; increasing the number of pediatric residencies available in the state; and increasing the training for dental professionals in providing services to kids with special health care needs. The task force also recommended funding a 10-year plan for prevention of oral disease in preschool age children.
- ◆ In 1998, the South Carolina General Assembly adopted legislation (1998 HB 4700) to encourage dentists to establish a “dental home” for Medicaid clients. The department is charged with establishing a program to accomplish this and to provide Medicaid clients with continuity of care, increase access to dental care services and ensure dentists' participation. Dentists agreeing to participate in this program and meeting the requirements receive an enhanced reimbursement.
- ◆ In 1997, Connecticut lawmakers established a pilot program (P.A. 97-239) to increase access to preventive dental care, particularly for children receiving Medicaid, by allowing dental hygienists in public health settings to provide cleanings, fluoride, sealants and oral screening exams without the direct supervision of a dentist. In 1999, this program was made permanent. According to Judith Solomon, executive director of the Children's Health Council, access to dental care in Hartford is better than the rest of the state. In this large

State reforms to dental care access for children eligible for CHIP and Medicaid have included increasing reimbursement rates, simplifying administrative tasks and creating school-based dental clinics.

city, utilization rates are higher than other comparable cities. Solomon attributes this to the city's strong system of school-based dental services—the school district actually employs the dentists and hygienists. Hartford also has a community clinic that provides dental services with the assistance of professors and students from the local dental school. Solomon claims that children receiving preventive services are more likely to receive additional corrective treatment for dental disease.

Under a dentist's supervision, qualified dental hygienists in Rhode Island can perform dental screenings for children.

- ◆ New Hampshire also dealt with the scope of practice of dental hygienists in 1999. The state established a pilot to allow hygienists practicing in a school setting to assume a broader scope of duties. The state reports that the pilot program children who were found to need a dentist's service had less difficulty getting an appointment because of the hygienist's relationship with the dentist. They are working on expanding the pilot statewide.
- ◆ Legislators in Rhode Island approved a 1998 bill (S 2476) that allows dental hygienists with at least three years of clinical experience to perform dental screenings for children under the general supervision of a dentist. The law also requires the Department of Human Services to provide each community with a list containing the addresses and telephone numbers of dental practices that accept patients insured by Medicaid. The community and the Medicaid HMO are then responsible to provide the list to parents or guardians of children eligible for Medicaid. Rhode Island is also looking at the possibility of putting the Medicaid dental care program out for bid to a dental managed care organization.
- ◆ A new public/private partnership program in Washington brings together the Medicaid program, local dental societies, local health jurisdictions, Washington State Dental Association, a major dental insurance foundation and the University of Washington. This new program, called the "ABCD Program," is in place in three counties to improve preventive dental services and access to dental care. The intent is to expand this program statewide. In the program, dentists are trained and certified in early pediatric techniques since the children are referred with their first tooth. The dentists receive enhanced payment to provide an array of dental services for children less than 5 years of age and enrolled in Medicaid. A successful outreach program is carried out to notify eligible families of the availability of services, to encourage early childhood visits to the dentist and to minimize adverse personal behaviors, such as appointment failures.

This program also trains pediatricians to deliver preventive dental services and it ties fluoride treatments to immunizations. A child enrolled in the program was 7.2 times as likely to have at least one dental visit than a child not enrolled. According to Dr. Peter Milgrom, private dentists will step forward to solve the problems that states have with dental care in Medicaid if the state (and other interested parties) helps them break the problem down into manageable pieces and if the dentists are treated fairly with respect to reimbursement rates. "Dentists know they look bad—but nobody is presenting alternatives to them that are working," claims Dr. Milgrom.

- ◆ Nebraska is in the process of making several changes to its Medicaid dental services program, which will also affect CHIP. The state is updating Medicaid's dental procedure manual for the first time in 30 years, according to Tom Bassett, executive director of the Nebraska Dental Association. The changes will add or subtract certain services based on clinical and pharmacological findings. The changes will also give more authority to participating dentists to make treatment decisions concerning their Medicaid patients and reduce the number of procedures that require preauthorization. In 1998, Nebraska increased its reimbursement rates to participating dentists from 54 percent of usual and customary fees to about 80 percent, and a dramatic increase in participation occurred. "Increasing reimbursement rates is only one part of the solution. We want to go beyond the issue of money and in fact, fix the system," says Kim McFarland, the state's dental health director.
- ◆ In early 1997, the Office of Medicaid Policy and Planning in Indiana formed a Dental Access Working Committee to come up with recommendations to improve dentist participation in Medicaid. The recommendations resulted in a number of changes: reduced turnaround time for dental claim data entry and receipt of payment; removal of all prior authorization requirements for dental procedures; an increase in reimbursement rates; and improved communications with dental providers concerning coverage policies, eligibility verification procedures and common reasons for claims denials. In 1999, about 20 percent more dentists participated in the program than the previous year.

Other Federal/State Programs that Impact Oral Health Care for Children

The federal law that created CHIP requires that states make an effort to coordinate with both private and public sector programs. In addition to Medicaid, other federally funded programs have an impact on dental care for kids, most notably, Head Start, the Maternal and Child Health Services Block Grant (Title V) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Many states have also enacted laws to encourage dentists to volunteer their services to free or subsidized dental clinics and to protect these volunteers from liability.

Head Start

More than 37,000 Head Start centers provide nutrition education, dental examinations and oral hygiene efforts for three to five year-olds. A 1993 Department of Health and Human Services inspector general's report on a sampling of Head Start programs noted that EPSDT screening and treatment rates were higher for Head Start enrollees than for the general pediatric Medicaid population. In some states that use a managed care system for Medicaid, the Head Start programs are assuring that the children are receiving the dental services contracted for by the state with the HMO and collaborating with the HMO to better the health of the child.

Many states encourage dentists to volunteer their services to free or subsidized dental clinics and protect the volunteers from liability.

CHIP and Medicaid have the potential to ensure necessary dental care for children from low-income families.

Title V Block Grants

These grants support state health departments and contractors to improve the health of mothers and children. Block grants can be used for infrastructure building such as oral health needs assessments, policy development, quality assurance, information systems, community fluoridation, public information and resource referral and other services. In Nebraska, the Title V block grant funds a successful community-based dental health care program for low-income children, which includes a school-based dental sealant program. The program uses volunteer dentists and dental hygienists to provide dental care to communities and schools in rural Nebraska, especially those without a dentist.

The Maternal and Child Health Bureau also funds infant oral health training programs for dental students and a small number of pediatric dentistry training programs.

WIC

This program reaches low-income mothers and their children under age 5. WIC supports nutrition and feeding practices as well as education and health promotion including necessary referrals for dental treatment. WIC also provides beneficiaries with educational information on fluoride supplementation and preventing baby-bottle tooth decay.

Other

The federal Health Resources and Services Administration's direct care programs provide dental services to subgroups with high levels of early childhood dental disease including rural, migrant and homeless children. These programs provide preventive and restorative care and they fund infrastructure development and demonstration projects.

The Centers for Disease Control and Prevention's Division of Oral Health is involved with community-based programs to prevent oral disease and promote oral health.

Conclusion

The children eligible for Medicaid and CHIP have the highest incidence of dental disease and the least access to dental care. CHIP and Medicaid have the potential to ensure necessary dental care for children from low-income families. States are creatively examining, evaluating and modifying their programs in an effort to improve the oral health of our nation's children but there are still too few dentists willing to participate in the programs and many challenges.

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Appendix A. Major Title XXI Provisions Under the Balanced Budget Act of 1997

State options

States may a) expand Medicaid; b) obtain health insurance coverage through another mechanism such as a separate insurance program or other mechanism—sometimes referred to as the “state plan option”; c) combine the first two options; d) use up to 10 percent of program funds (combined federal and state) for administration, outreach and direct purchase of services through community-based delivery systems, such as community health centers and public hospitals; or e) seek a waiver or variance for another option, such as purchasing family coverage under a group plan.

Eligibility

Title XXI defines eligibility for “targeted low-income children,” meaning children who meet all of the following criteria:

- ◆ Uninsured even those with existing minimal coverage may not qualify;
- ◆ Family income below 200 percent of federal poverty guidelines (\$27,300 for a family of three in 1998), or 50 percentage points higher than a state’s existing Medicaid eligibility ceiling when it exceeds 150 percent of poverty;
- ◆ Under age 19; and
- ◆ Not eligible for Medicaid under a state’s rules in effect on June 1, 1997, or any other federal health insurance program; uninsured children who meet a state’s Medicaid eligibility criteria must be enrolled in Medicaid and not an alternative state insurance program under CHIP.

Children of public agency employees eligible for a state employee benefit plan or children in institutions may not qualify for assistance under the state plan option, but may qualify for Medicaid if they meet the state’s Medicaid eligibility criteria.

State plan

States must submit a plan to the U.S. Department of Health and Human Services (DHHS) that specifies objectives and performance goals; benefits; the service delivery method, such as managed care; cost-sharing requirements; data collection and reporting mechanisms; the program budget; utilization control systems; and the process used to involve the public. State plans must be reviewed within 90 days, or they become effective without approval. However, HCFA has implemented a “stop the clock” provision that puts the 90-day review period on hold when it refers questions or a request for additional information to a state. Washington and Wyoming are the only states that have not submitted a state plan. States may begin with a modest initial plan to cover more uninsured children and then build incrementally to a more comprehensive plan as they have more time to study their own situations and also learn from other states. A state may submit an amendment to its plan at any time. An amendment that restricts or eliminates eligibility may not take effect unless the state certifies that it has provided

prior public notice of the change. A plan amendment is deemed approved unless HCFA notifies the state in writing within 90 days after receiving the amendment that it is not approved or that additional information is needed.

Payments to the states

Federal allotments require a state match, which is about 30 percent less than a state's normal Medicaid match. Of the total \$23.9 billion authorized over five years, about \$20 billion is available for state grants to implement new Title XXI initiatives; an estimated \$3.9 billion will be needed for Medicaid changes (described in appendix C); and \$300 million is earmarked for diabetes grant programs.

CHIP coverage requirements

If a state chooses to expand Medicaid under Title XXI, Medicaid's usual benefit requirements must be met. If a state chooses the "state plan option," benefits under the state plan must be consistent with any of the following:

- ◆ A benchmark plan, which can be any of the following:
 1. the Federal Employees Health Benefits Program (FEHBP), which is the standard Blue Cross/Blue Shield preferred provider option;
 2. a state employee health benefits coverage plan; or
 3. a health maintenance organization (HMO) plan that covers the largest number of commercial, non-Medicaid clients.
- ◆ The "actuarial equivalent" of a benchmark plan;
- ◆ An existing comprehensive state-based program in Florida, New York or Pennsylvania; or
- ◆ An alternative plan approved by the secretary of DHHS.

Benefits must include inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care, including immunizations. In addition, a state-designed plan must cover prescription drugs, mental health services, and vision and hearing services at a level equal to at least 75 percent of the actuarial value of a selected benchmark plan. States may include additional benefits, including many of the services that benefit children with special health care needs, such as medical equipment, home health nursing, physical and occupational therapy, dental services and many others.

Cost-sharing

States may not impose cost-sharing requirements on preventive services, including well-child care and immunizations. For other services, if a state chooses to expand Medicaid, normal Medicaid rules on cost-sharing apply. Under the state plan option, a state can impose nominal cost-sharing amounts based on family income at or below 150 percent of poverty. For families with higher incomes, states can impose cost-sharing (e.g., premiums and deductibles) on a sliding fee scale, not to exceed 5 percent of family income.

Source: National Conference of State Legislatures, 1999.

Appendix B. Children's Health Insurance Program: Dental Health Care Services

Updated September 13, 1999

States choosing a Medicaid expansion under CHIP (including the Medicaid portion of a combination plan) must provide standard Medicaid dental benefits for children. Those states and territories are Alaska, Arkansas, American Samoa, the District of Columbia, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Minnesota, Missouri, Nebraska, New Mexico, North Dakota, the Northern Mariana Islands, Ohio, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Texas, the U.S. Virgin Islands and Wisconsin. Tennessee is anticipating a Medicaid expansion.

For the purpose of this chart, dental services have been categorized into two groups: 1) preventive, diagnostic, basic and restorative services; and 2) advanced treatment services. In the first category, services may include topical fluoride treatment, x-rays, fillings, sealants and acute emergency dental services. In the latter category, services may include crowns, bridges and surgery such as root canals. Copayments for advanced treatment services vary from state to state.

Table 1. CHIP Dental Health Care Services

State/ Jurisdiction	Provider	◆ Preventive, Diagnostic, Basic and Restorative Services	◆ Advanced Treatment Services	Copayments (Non- preventive or Diagnostic Services)	Orthodontics
Alabama (combination plan)	Network	Yes	Yes	Yes	Special needs only
Alaska	MEDICAID EXPANSION - EPSDT COVERAGE				
Arizona (state-designed plan)	HMO	Yes	Yes	Yes (above 150% of poverty)	Medically necessary only
Arkansas	MEDICAID EXPANSION - EPSDT COVERAGE				
American Samoa	MEDICAID EXPANSION - EPSDT COVERAGE				
California (combination plan)	HMO/PPO	Yes	Yes	Yes	Prior approval required
Colorado (state-designed plan)	NA	No	No	NA	No
Connecticut (combination plan)	HMO	Yes	Yes	Yes (extractions, root canals etc.)	Yes (with limits)
Delaware (state-designed plan)	NA	No	No	NA	NA

Table 1. CHIP Dental Health Care Services
(continued)

State/ Jurisdiction	Provider	◆ Preventive, Diagnostic, Basic and Restorative Services	◆ Advanced Treatment Services	Copayments (Non- preventive or Diagnostic Services)	Orthodontics
District of Columbia	MEDICAID EXPANSION - EPSDT COVERAGE				
*Florida (combination plan)	NA	No	No	NA	NA
Georgia (state-designed plan)	Existing Medicaid system	Yes	Prior approval required	No	Prior approval required
Guam	MEDICAID EXPANSION - EPSDT COVERAGE				
Hawaii	MEDICAID EXPANSION - EPSDT COVERAGE				
Idaho	MEDICAID EXPANSION - EPSDT COVERAGE				
Illinois	MEDICAID EXPANSION - EPSDT COVERAGE				
Indiana	MEDICAID EXPANSION - EPSDT COVERAGE				
Iowa	MEDICAID EXPANSION - EPSDT COVERAGE				
Kansas (state-designed plan)	Private contractors	Yes	No (some exceptions)	No	No
Kentucky (combination plan)	Plan providers	Yes	Yes	Yes	No
Louisiana	MEDICAID EXPANSION - EPSDT COVERAGE				
Maine (combination plan)	Existing Medicaid system	Yes	Yes	No	Prior approval required
Maryland	MEDICAID EXPANSION - EPSDT COVERAGE				
Massachusetts (combination plan)	BC/BS/PPO	Yes	Yes	No	Yes
Michigan (combination plan)	HMO/PPO	Yes	Yes	Only extractions and crowns	No
Minnesota	MEDICAID EXPANSION - EPSDT COVERAGE				
Mississippi (combination plan)	Will accept bids	Yes	Yes	No	No
Missouri	MEDICAID EXPANSION - EPSDT COVERAGE				
**Montana (state-designed plan)	In planning stage	Planning to provide	In planning stage	In planing stage	Not planning to provide
Nebraska	MEDICAID EXPANSION - EPSDT COVERAGE				
Nevada (state-designed plan)	Maybe HMO	Yes	Yes	Yes	Medically necessary only
New Hampshire (combination plan)	HMO	Yes	No (some exceptions)	Yes	No

Table 1. CHIP Dental Health Care Services
(continued)

State/ Jurisdiction	Provider	◆ Preventive, Diagnostic, Basic and Restorative Services	◆ Advanced Treatment Services	Copayments (Non- preventive or Diagnostic Services)	Orthodontics
New Jersey (combination plan)	HMO	Yes	Yes	Yes	Prior authorization
New Mexico	MEDICAID EXPANSION - EPSDT COVERAGE				
New York (state-designed plan)	Network or sub-contractors	Yes	Yes (as appropriate)	No	No
North Carolina (state-designed plan)	Existing delivery system	Yes	Yes	Yes	No
North Dakota	MEDICAID EXPANSION - EPSDT COVERAGE				
N. Mariana Islands	MEDICAID EXPANSION - EPSDT COVERAGE				
Ohio	MEDICAID EXPANSION - EPSDT COVERAGE				
Oklahoma	MEDICAID EXPANSION - EPSDT COVERAGE				
Oregon (state-designed plan)	DCO	Yes	Yes	No	No
Pennsylvania (state-designed plan)	HMO	Yes	Yes	No	No
Puerto Rico	MEDICAID EXPANSION - EPSDT COVERAGE				
Rhode Island	MEDICAID EXPANSION - EPSDT COVERAGE				
South Carolina	MEDICAID EXPANSION - EPSDT COVERAGE				
South Dakota	MEDICAID EXPANSION - EPSDT COVERAGE				
Tennessee	MEDICAID EXPANSION - EPSDT COVERAGE				
Texas	MEDICAID EXPANSION - EPSDT COVERAGE				
U.S. Virgin Island	MEDICAID EXPANSION - EPSDT COVERAGE				
Utah (state-designed plan)	Public Employees Dental Network	Yes	Yes	Yes (co- insurance)	No
Vermont (state-designed plan)	Existing Medicaid system	Yes	Yes	Yes	Prior approval required
Virginia (state-designed plan)	Existing system	Yes	Yes	No	Prior approval required
Washington (state-designed plan)	Existing Medicaid system	Yes	Medically necessary only	No	Medically necessary only

Table 1. CHIP Dental Health Care Services
(continued)

State/ Jurisdiction	Provider	◆ Preventive, Diagnostic, Basic and Restorative Services	◆ Advanced Treatment Services	Copayments (Non- preventive or Diagnostic Services)	Orthodontics
West Virginia (combination plan)	FFS-Essential Community Health Care Providers	Yes	Yes	No	Medically necessary only
Wisconsin	MEDICAID EXPANSION				
Wyoming (state-designed plan)	Not available	Yes	Not available	Not available	Medically necessary only

Key

◆ Services may include topical fluoride treatment, x-rays, fillings, sealants and acute emergency dental services

◆ Services may include crowns, bridges and surgery such as root canals

* Dental services in Florida may be covered at each county's option.

** Montana governor signed legislation on May 6, 1999, establishing CHIP, providing for dental benefits. Benefits begin in October 1999. Dental coverage will not exceed \$200 per child per year. The state is in the process of designing the dental benefit package.

DCO = Dental care organization

FFS = fee for service

HMO = health maintenance organization

PPO = preferred provider organization

NA = not applicable

Source: Health Care Financing Administration (HCFA) state CHIP fact sheets, National Conference of State Legislatures and National Governors' Association *State Children's Health Insurance Program Annual Report*, and personal communication with state CHIP program contacts. Information is based on plans that have been approved.

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IMPROVING ACCESS TO DENTAL SERVICES FOR CHILDREN ENROLLED IN THE MEDICAID PROGRAM

BACKGROUND

Tooth decay is the single most common chronic disease of childhood. The tremendous improvements in children's oral health over the last generation ~~have not been extended to all children.~~ *Millions of children still suffer from untreated cavities. The percentage of children with untreated cavities has increased, and the percentage of children seeing a dentist before entering kindergarten has decreased. Almost 850,000 school days are missed each year because of dental concerns. Childhood dental disease has become a significant public health problem.*

Low-income, minority children suffer disproportionately from untreated cavities and oral disease. Extensive caries experience has shifted from an almost universal condition of childhood fifty years ago to an affliction of low income children today. Eighty percent of tooth decay is estimated to occur in only 25 percent of children. *Black, etc.*

Low provider reimbursement rates. Medicaid reimbursement rates to dentists for common pediatric dental procedures are overwhelmingly lower than dentists' average cost of operation. When evaluated, the average regional Medicaid payment rarely exceeded 60% of dentists' usual fees. ~~It is clear that payment rates are inadequate to assure access.~~ *With Medicaid discounts for common pediatric dental procedures frequently exceeding 50 percent, there is little expectation that dentists will actively participate in Medicaid.*

Low provider participation rates. ~~Medicaid officials claim that dentist participation in Medicaid is so low that it constitutes an access barrier. More than half of reporting States have less than 50% of professionally active dentists providing any Medicaid dental care and 2/3rds report that less than 20% provide sufficient care to be paid more than \$10,000 annually. It is clear that this constitutes an access barrier.~~

Low income children are not receiving the dental benefits provided to them by Medicaid. All children enrolled in Medicaid are entitled to comprehensive dental services under EPSDT. However, only 18 percent of Medicaid eligible children received even one preventive dental service. *Research indicated that nearly 30% of all child health expenditures are devoted to children's dental care, a spending rate over 10 times the 2.3 percent expended by Medicaid for dental care provided to enrolled children.* *SAY THIS BETTER.*

Children who are unable to receive preventive dental care often end up receiving costly emergency room treatment. Dental emergencies account for a significant percentage of all emergency room visits among children younger than six. One third of these children have abscessed teeth; one quarter of them have draining lesions. Many toddlers with early childhood caries must be ~~treated in a hospital for comprehensive dental treatment~~ *provided in the operating room.* *More than 25 percent of the children presenting at the emergency room with a dental emergency have never been to the dentist before. HCFA estimates that the*

Medicaid program pays between \$100 million and \$400 million each year to treat these children, each of whom could have avoided the operating room if they had been able to access early and aggressive preventive dental care.

Untreated cavities and oral disease have devastating effects on children. Often viewed as an innocuous and trivial disease, tooth decay and its consequences have larger systemic impact. Chronically poor oral health is associated with diminished growth in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunction in adults.

POLICY OPTIONS

specifying MCO or State responsibility for services

raising reimbursement rates for dental services

conducting an outreach program through Head Start, WIC, and MCHB

creating provider education grants for pediatric dentists

disseminating managed care treatment guidelines for pediatric dental care

Bill Summary & Status for the 105th Congress**Item 1 of 49**

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:DIGEST | NEXT BILL:DIGEST
NEW SEARCH | HOME | HELP | ABOUT DIGESTS

S.2583SPONSOR: Sen Bingaman (introduced 10/08/98)**SUMMARY:**

(AS INTRODUCED)

[Jump to Search Words/Phrases](#)**TABLE OF CONTENTS:**

- Title I: Expanded Opportunities for Training Pediatric **Dental** Health Care Providers
- Title II: Ensuring Delivery of Pediatric **dental** Services Under the Medicaid and Schip Programs
- Title III: Pediatric **dental** Research
- Title IV: Surveillance and Accountability
- Title V: Miscellaneous

Children's **dental** Health Improvement Act of 1998 - **Title I: Expanded Opportunities for Training Pediatric **dental** Health Care Providers** - Amends the Public Health Service Act (PHSA) to direct the Secretary of Health and Human Services (HHS) to: (1) develop training materials for use by health professionals to promote oral health through health education; (2) make grants to schools that train pediatric **dental** health providers to meet the costs of projects for developing or improving training programs in providing **dental** health services to children; (3) increase the number of **dental** health providers skilled in treating children who become members of the National Health Service Corps so that there are specified numbers of additional dentists and **dental** hygienists, ensuring that at least 20 percent of dentists in the Corps are pediatric dentists and another 20 percent have general practice residency training; and (4) establish 36 additional training positions annually for pediatric dentists at centers of excellence. Authorizes appropriations.

(Sec. 104) Provides for a **dental** officer multiyear retention bonus for the Indian Health Service.

(Sec. 105) Amends title XVIII (Medicare) of the Social Security Act (SSA) to direct the Secretary to make Medicare payments for their direct and indirect operating expenses to approved nonhospital based dentistry residency training programs providing oral health care to children.

Provides for a permanent **dental** exemption from voluntary residency reduction incentive payment programs under Medicare.

(Sec. 106) Amends PHSA to allow the Secretary to designate **dental** health professional shortage areas. Includes **dental** hygienists in PHSA's loan repayment program.

Title II: Ensuring Delivery of Pediatric **dental Services Under the Medicaid and Schip Programs** - Amends SSA title XIX (Medicaid) to: (1) provide for quarterly payment to a State of an amount equal to the greater of the Federal medical assistance percentage or 75 per cent of the sums expended during the quarter attributable to **dental** services for children; (2) require a State Medicaid plan to provide for payment for **dental** services for children at a rate designed to create an incentive for providers of such services (but that does not result in a reduction or other adverse impact on the extent to which the State provides **dental** services to adults); (3) set the required minimum Medicaid expenditures each year for **dental** health services for children; (4) require the State to verify annually

sufficient numbers of Medicaid-participating dentists; (5) provide for inclusion of the recommended age for the first **q dental** visit in the definition of early and periodic screening, diagnostic, and treatment services; and (6) PROVIDE for use of State Children's Health Insurance Program (SCHIP) funds to treat low-income children with special oral health needs who reside in certain States.

(Sec. 207) Amends SSA title V (Maternal and Child Health Services) to direct the Secretary to award grants to States to supplement payments made under State Medicaid and SCHIP programs for the treatment of children with special oral health care needs. Authorizes appropriations.

(Sec. 208) Directs the Secretary to establish demonstration projects designed to increase access to **q dental** services for children in underserved areas. Authorizes appropriations.

Title III: Pediatric q Dental Research - Directs the Secretary to: (1) support community based research designed to improve our understanding of the etiology, pathogenesis, diagnosis, prevention, and treatment of pediatric oral, **q dental**, craniofacial diseases and conditions and their sequelae in high risk populations; and (2) develop clinical approaches for pediatric **q dental** disease risk assessment. Authorizes appropriations.

(Sec. 302) Amends PHSA to direct the Administrator for Health Care Policy and Research to conduct and support activities with respect to existing barriers to **q dental** care for children and establishment of measures of oral health quality, including access to oral health care for children.

(Sec. 303) Directs the Secretary to convene a Consensus Development Conference to: (1) examine the management of early childhood caries; and (2) support research on the biology and physiologic dynamics of infectious transmission of **q dental** caries. Authorizes appropriations.

Title IV: Surveillance and Accountability - Requires the Director of the Centers for Disease Control and Prevention to collect and report annually to the appropriate congressional committees on the **q dental**, craniofacial, and oral health of residents of at least one State from each HHS region.

(Sec. 402) Amends SSA title XIX (Medicaid) to require a State Medicaid plan to provide for reporting to the Secretary: (1) the percentage of expenditures for early and periodic **q dental** screening, diagnostic, and treatment services; and (2) the percentage of general and pediatric dentists licensed in the State and providing services commensurate with State plan eligibility.

(Sec. 403) Directs the Administrator of the Administration on Children, Youth, and Families to report annually to the appropriate congressional committees the percentage of children enrolled in a Head Start or Early Start program who have access to and who obtain **q dental** care, including children with special oral, **q dental**, and craniofacial health needs.

Title V: Miscellaneous - Sets forth effective dates for this Act.



Covered benefits:

doctor's visits
prescriptions
lab tests
immunizations
mental health services
drug or alcohol treatment
referrals to specialists
hospital care
transportation
dental care
and more

Interpreter services are available

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análisis de laboratorio
inmunizaciones
servicios de salud mental
tratamiento relacionado con alcohol o drogas
recomendaciones a especialistas
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transporte
servicio dental
y más

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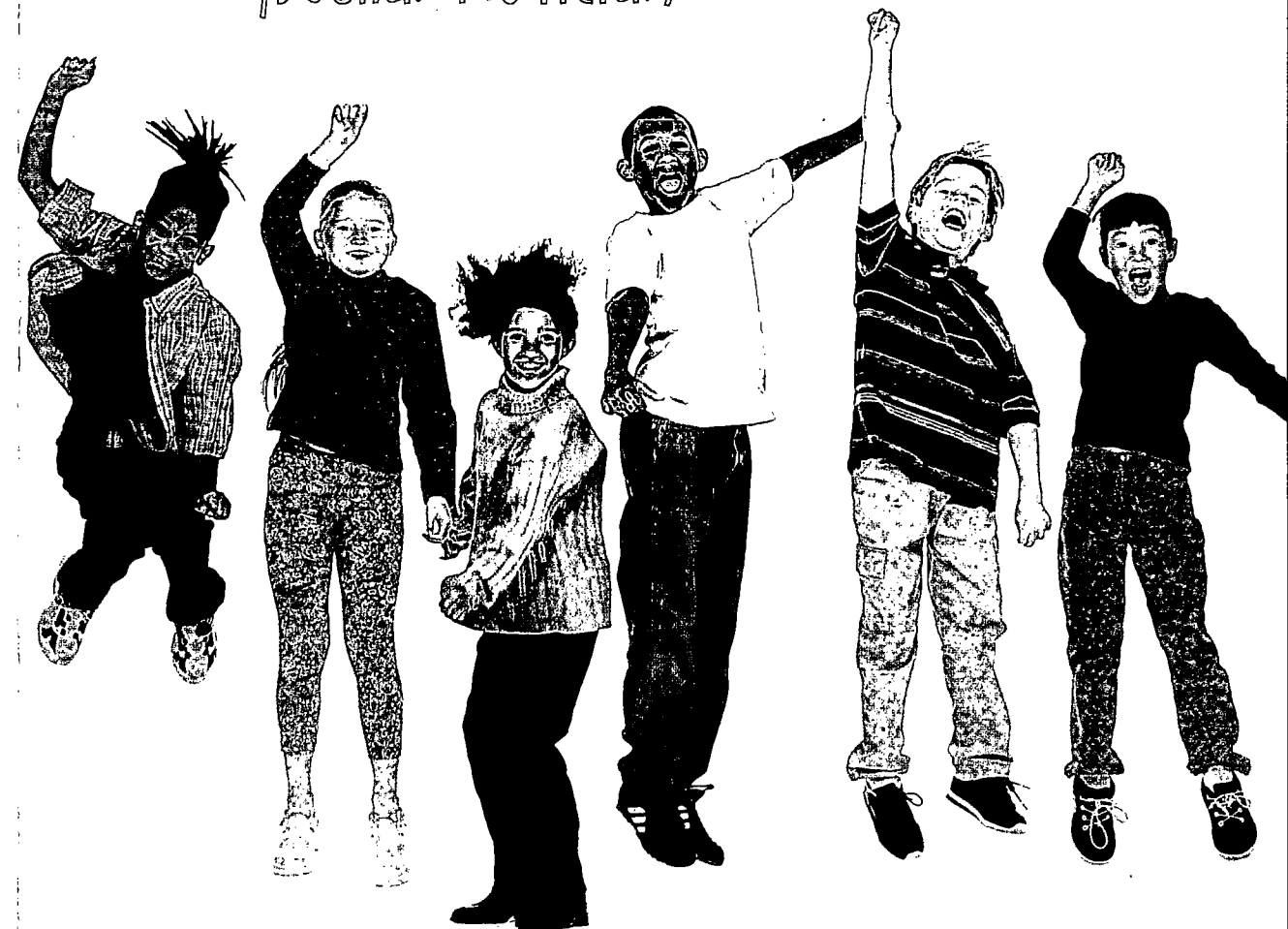
Laotian

ຢາກຮູ້ວ່າເດັກທ່ານສາມາດໄດ້ປະກັນພັນສະພາບບໍ່ເສັຍເງິນຫລືຈ່າຍຮາດຕ່ຳ, ໂທ ໙໔໑-໗໔໒໒

Portuguese

Para saber se seus filhos podem receber seguro de
saúde de graça ou por um preço baixo, telefone para
José Barros no número 728-5920.

Kids' lives should be worry free.
Their health care should be too.
There's good news!
¡Buenas Noticias!



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 200 PROVIDENCE, RI

POSTAGE WILL BE PAID BY ADDRESSEE

RIte Care Program
Forand Building
600 New London Ave
Cranston, RI 02920-9990

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



RI Department of Human Services
Christine C. Ferguson, Director
Lincoln Almond, Governor of Rhode Island

covering
Kids

Covering Kids in Rhode Island
sponsored by the
Robert Wood Johnson Foundation
and the Rhode Island Foundation

Now every child in Rhode Island
can have health insurance!

Ahora cada niño o niña en Rhode Island
puede tener seguro médico.





La vida de los niños debería
transcurrir sin problemas.
El cuidado de la salud
no debería ser uno de ellos.

Ofrecemos seguro médico **gratis, o de bajo costo**, para niños,
para jóvenes, y para muchas de las familias de Rhode Island. Los
servicios cubiertos por este programa incluyen visitas al médico,
medicinas bajo receta, anteojos, dentista, intérprete, cuidado en el
hospital, y otros servicios importantes para el cuidado de la salud.

Afiliarse es fácil. Averigue
hoy mismo si usted es elegible.

No espere a padecer una
enfermedad o a que ocurra una
emergencia para llamar.



Free or low-cost health insurance is available for every child, teen
and many families in Rhode Island. Covered services include:
doctor's office visits, prescription drugs, dental services, hospital
care, eyeglasses, and other important health care services.

It's easy to apply.
Find out if you are eligible today.
Don't wait until an
illness or emergency to call.

For an application, send in this
form today. Please write your name,
address and phone number below:

Para recibir una solicitud, envíe hoy
mismo este formulario. Por favor,
escriba su nombre, dirección y
número de teléfono a continuación:

Name Nombre

Address Dirección

City Ciudad

State Estado

Zip Code Código Postal

Phone Teléfono



1-800-299-8444 ESPAÑOL

1-800-346-1004 ENGLISH

1-800-745-5555 TDD



Covered benefits:

doctor's visits
prescriptions
lab tests
immunizations
mental health services
drug or alcohol treatment
referrals to specialists
hospital care
transportation
dental care
and more

Interpreter services are available

Cubre los siguientes beneficios:

visitas al médico
medicinas por receta
análisis de laboratorio
inmunizaciones
servicios de salud mental
tratamiento relacionado con alcohol o drogas
recomendaciones a especialistas
servicio hospitalario
transporte
servicio dental
y más

Tenemos disponible servicio de intérpretes

Cambodian

សូមទាក់ទង បើសិនជាកូនលោកអ្នកអាចទទួលបានប័ណ្ណសំរាប់ពិនិត្យសុខភាពបានដោយមិនបាច់
បង់ប្រាក់ឬបង់ប្រាក់បន្តិចបន្តួច សូមទូរស័ព្ទមក លេខ ៩៤១-៨៤២២ ។

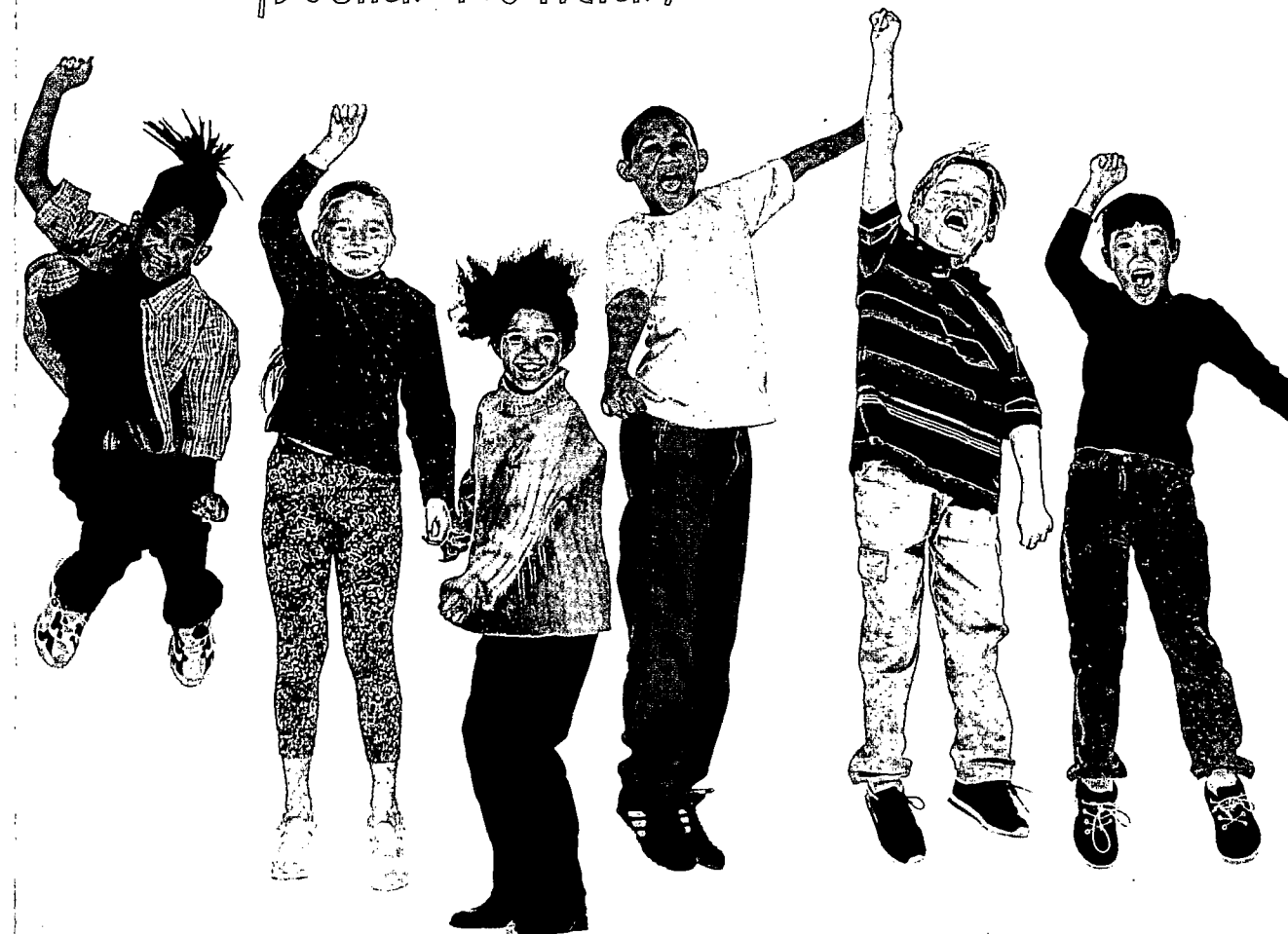
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Portuguese

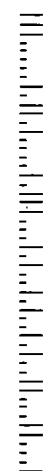
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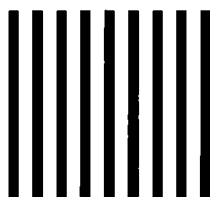
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Address Dirección

City Ciudad

State Estado

Zip Code Código Postal

Phone Teléfono

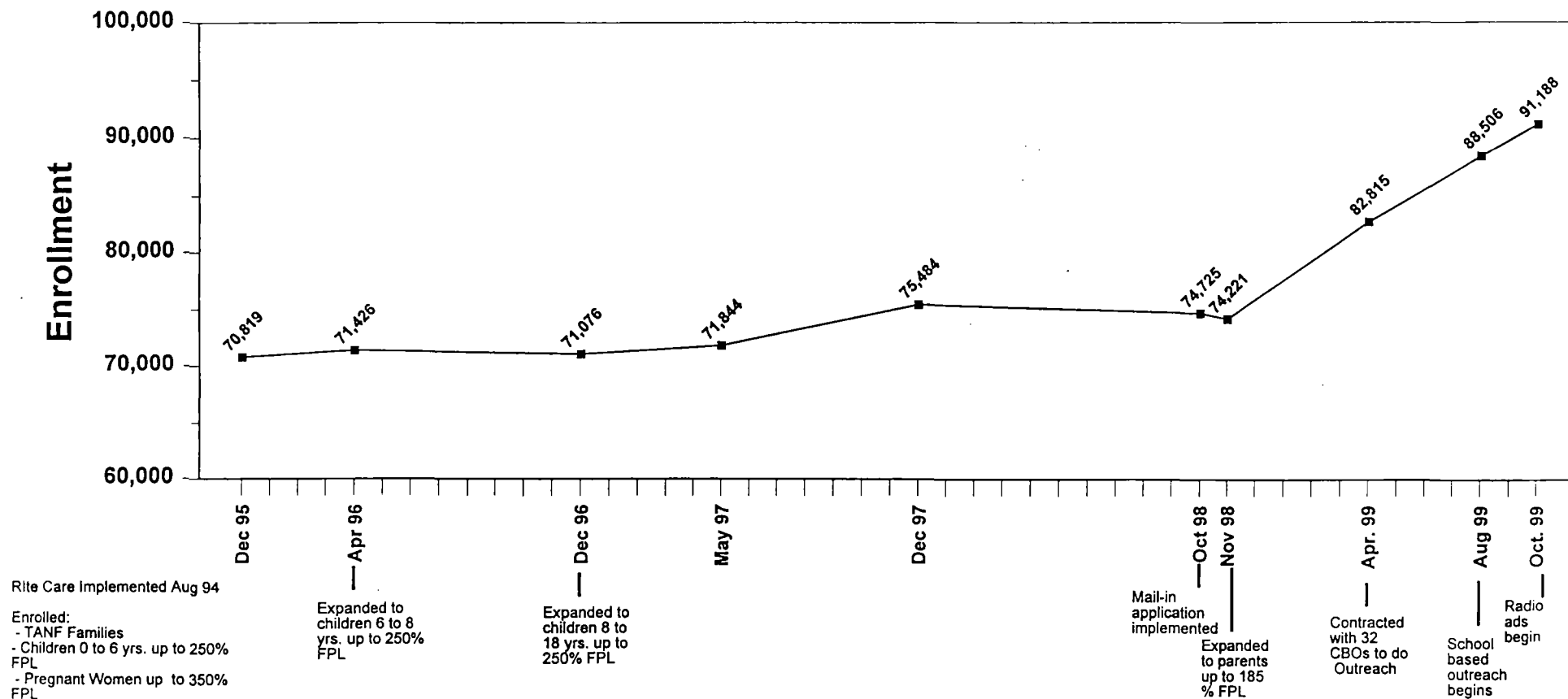


1-800-299-8444 ESPAÑOL

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RITE CARE ENROLLMENT 1994 - 1999 **IMPACT OF RITE CARE OUTREACH AND EXPANSIONS**





RIte Care Outreach in Rhode Island

SCHOOL BASED STRATEGIES

- **SUPERINTENDENTS' AND PRINCIPALS' LETTER**

The Commissioner of Education sent a letter to all RI superintendents and principals to inform them about available health insurance for children. A CHIP contact list and a summary of planned outreach activities in schools was also included.

- **FREE AND REDUCED SCHOOL LUNCH APPLICATION**

This year, the school lunch application was modified to include a question about health insurance. The Department of Human Services' (DHS) outreach workers will contact school principals to review school lunch applications. Outreach workers will send a RIte Care application by mail and follow-up with families who are interested in receiving more information.

- **RITE CARE BROCHURE DISTRIBUTED IN SCHOOLS**

A RIte Care brochure will be sent home with every child (Kindergarten through 6th grade) in Rhode Island. The brochure will include information on RIte Care and a postcard that can be sent to the Department of Human Services to request a RIte Care application.

- **MAILINGS TO SCHOOL PERSONNEL ON RITE CARE**

Information on RIte Care will be sent to school personnel including: school nurses, social workers, and guidance counselors.

- **RITE CARE RADIO ADS**

Radio ads will run 6 English and Spanish stations this fall during school based outreach activities.

- **OUTREACH AT SCHOOL BASED HEALTH CENTERS**

The Department of Health will fund 5 outreach positions at school based health centers to help enroll families in RIte Care.

- **COVERING KIDS**

One of the pilot sites for Covering Kids in Rhode Island will focus on school based strategies. The goal will be to work with the designated school district and school linked programs to set up systems for RIte Care enrollment that extend beyond the grant period. Effective strategies will be replicated in other school districts and statewide.

- **BOOK COVERS**
The Department of Health developed book covers as part of its health education campaign to middle and high school students. Information on RItE Care was included.
- **REGISTRATION FOR SCHOOL**
DHS outreach workers were available on site during new student registration in August. School districts that enroll new students in a central location were targeted.
- **KINDERGARTEN REGISTRATION**
RItE Care applications and/or information will be available at Kindergarten Registration in all schools. Outreach workers will also be available to help enroll families.

OTHER OUTREACH STRATEGIES

- **OUTREACH WORKERS AT COMMUNITY BASED AGENCIES**
The Department of Human Services has contracted with 32 community based agencies statewide to enroll eligible families and children in RItE Care. Thirteen agencies have hired a total of 16 full time outreach workers that will target communities with the highest number of uninsured children. Nineteen additional agencies are using existing staff to enroll families. A total of 250 individuals have been trained to assist families fill out the RItE Care application statewide. DHS has established performance based contracts with the 32 agencies and pays agencies an incentive for each successfully enrolled child.
- **FAMILY RESOURCE COUNSELOR PROGRAM**
The Department of Human Services and the Department of Health both support the Family Resource Counselor Program. There are 30 Family Resource Counselors (FRC) at 14 Community Health Centers and 3 Hospitals. FRCs assist families with the enrollment process and may coordinate with DHS on RItE Care outreach in schools.

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Rlte Care Application Solicitud de Rlte Care



HEALTH INSURANCE FOR FAMILIES AND CHILDREN
Seguro Médico para Familias y Niños

1. APPLICANT NAME (Head of Household) NOMBRE DEL SOLICITANTE (Jefe[a] de Familia) Last Apellido First Nombre Initial Inicial		Social Security Number Numero de seguro social	
YOUR PHONE NUMBER SU NÚMERO DE TELÉFONO		☐ Married Casado(a) ☐ Separated Separado(a)	☐ Divorced Divorciado(a) ☐ Single Soltero(a)
ADDRESS DOMICILIO Street Calle y número		City/Town Ciudad o pueblo	State Estado Zip Code Código postal
MAILING ADDRESS DIRECCIÓN POSTAL (If different) (si es distinta)			

- 2.** Do you or any adult in your household speak English? ☐ Yes ☐ No
¿Hay un adulto (incluyendo usted) que habla inglés en su casa? Sí No
- If no, what language is spoken in your home?
Si respondió "no", ¿Qué idioma hablan en su casa? _____

IF YOU NEED HELP WITH THIS FORM, SEE THE INSTRUCTION BOOKLET OR CALL 1-888-DHS-3322.
Si usted necesita ayuda para completar esta solicitud, consulte el folleto de instrucciones o llame al
1-888-DHS-3322.

 indicates that you must send in copies of documents with your completed application.
significa que usted—junto con la solicitud completa—debe enviar copia de algunos
documentos.