Dental Benefits in the Medicaid/CHP+ Streamlining HIFA Waiver
Colorado Department of Health Care Policy and Financing

Children's Dental Health Project

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Background and Assumptions

The Colorado Department of Health Care Policy and Financing (HCPF) has engaged the Children's Dental Health Project (CDHP) to develop materials in support of a pediatric dental benefit package for a proposed Health Insurance Flexibility and Accountability (HIFA) waiver which will streamline Medicaid and Child Health Plan + (CO SCHIP). The main body of this report provides the rationale for the proposed benefit design. Appendix A details the proposed benefit design at three levels as requested by the HCPF: "Core", "Core Plus," and "enhancements."

CDHP understands that HCPF has adopted the three-tiered benefit approach in order to prioritize basic preventive and therapeutic health services ("Core") for all enrollees in its Medicaid and SCHIP plans while providing increasing levels of oversight for successively more intense and less common "wrap around" services ("Core Plus"). Core services are described by HCPF[1] to "feature a single benefit package that is sufficiently comprehensive for all children and ensures access to appropriate care." Core services reflect the current CHP+ benefits which are described as "sufficiently comprehensive so as to meet the needs of the majority of children enrolled who currently receive either CHP+ or Medicaid benefits." Preventive and restorative dental services included in Core benefits are described as including "periodic cleanings, exams, x-rays, fillings, root canals, and orthodontia; $500 maximum per year."

Core Plus is described as a "wrap-around structure, over-and-above a set of common Core benefits [that] further enhances the Department's ability to ensure the delivery of appropriate, cost-effective care…to consumers with special needs who are likely to require additional care management and coordination." While CHP+ does not feature any "Core Plus" wrap around dental services, those children who require more than $500 in dental services in a year are currently provided such care through payments by the Delta Dental of Colorado Foundation. "Enhancements" include those services that may further increase efficiency, range of services, coordination of care, disease management or other services and/or approaches that make care more effective for patients, families, and the program. HCPF also seeks to realize efficiencies and associated cost savings from administration, contracting and oversight by creating a single program for both Medicaid and SCHIP beneficiaries.

[1] MDF Associates, Design of a Streamlined Program for CHP+ and Medicaid, Commissioned by HCPF, February 2004, Executive Summary.

Rationale for Proposed Benefit Design

Backdrop: The inherent natures of dental disease and dental care define both opportunities and limitations in applying the three-tier benefit design to oral health services for children. This is particularly so at this time when a sea change is occurring within dentistry. New technologies and materials are increasingly attracting the public's and profession's attention to adult cosmetic dentistry and dental implants – expensive, elective services that distract the limited dental delivery system from providing more basic dental care. Simultaneously, dentistry is gaining a greater understanding and facility at applying principles of evidence-based and risk-based care. Meanwhile, the distribution of dental disease within the US population (particularly dental caries in children) is becoming increasingly skewed with more disease concentrated in fewer high-cost, treatment-intensive patients. The impact of these dental "mega-trends" is modified by concurrent changes in the dental delivery system –(wherein the dentist-to-population ratio is poised to decline) and changes in population demography (wherein increasing proportions of children are being born into poor and minority families).

Distinctions from medical care for children: In addition to trends in dental care, a pivotal factor in designing a dental benefit for children relates to sharp distinctions between medical and dental care systems for children. Among critical differences are that the medical system provides robust access to pediatric specialists (pediatricians) while the dental system depends primarily upon generalists (general dentists) who have relatively modest training, orientation, and time dedicated to care of children – particularly very young children who have significant dental disease. The nation's 4000 pediatric dentists (compared to 60,000 pediatricians) represent only 3-4% of dentists nationally. This is reflected in CO where there are about 200-250 pediatric dentists out of more than 3000 dentists representing approximately 6-8% of the state's dentists. Dentistry, compared to medicine, is much more commonly provided in solo, independent, small-business model practices wherein each individual dentist decides independently about which patients to serve, what services to provide, what charges to levy, and which insurance plans, if any, to participate in. Additionally, dentistry, compared to medicine, involves little inter-professional care coordination, little use of the hospital, and more emphasis on preventive procedures. Dentistry lacks a mid-level provider like the nurse practitioner or physician assistant who provides the same services as a physician but within a lesser scope of practice. Instead, dentistry has a unique therapist, the dental hygienist, who provides the same range of preventive services as a dentist, but is not trained to provide restorative services. Combined with the relative paucity of dentists, this environment creates a situation in which benefits implementation requires HCPF's concomitant consideration of plan and vendor selection, network capacity, provider education and incentives, and care coordination between medical and dental systems that serve children.

The proposed benefit design is predicated on an understanding of the nature of pediatric dental disease and dental care as well as requirements of both the Medicaid and SCHIP programs:

1. *Pediatric dental care as primary care that involves few procedures:* Dental care for children is overwhelmingly primary care[2] which includes basic "first contact" diagnostic, preventive, reparative, and development-related services (e.g. space maintenance, oral habit management, and interceptive orthodontics, i.e., intervention in the incipient stages of a developing orthodontic problem). Care is typically provided by general dentists and pediatric dentists with dental hygienists and dental assistants offering preventive services and/or supportive services. In the US, only CO licenses dental hygienists as independent practitioners.

Unlike adult dental care, pediatric dental care typically entails a very limited range of services. For example, our analysis of Colorado aggregated Medicaid claims data reveals that only 10 of 181 dental procedures[3] billed in 6 months of 2004 account for 50% of all Medicaid expenditures and only 26 procedures account for 80% of these expenditures. Similarly only 7 distinct procedures[4] account for 50% of all Medicaid services and 24 procedures account for 80% of services.

Dental care for children tends to be more routine, predictable, and uniform than care for adults. Each individual child's clinical presentation (disease state) determines the *amounts* but not the *types* of services that need to be provided to manage or restore oral health.

In terms of the Medicaid program requirements that care must be sufficient in "amount, duration, and scope" to meet each child's needs, the "amount" varies significantly by child. The duration needed for dental care overall is throughout the period from birth to age 21 while the duration of each particular dental procedure reflects the interaction

[2] The concept of primary dental care is a derivative of primary medical care which "focuses on the point at which a patient ideally first seeks assistance….is comprehensive….[and in which] the primary provider takes responsibility for the overall coordination of the patient's health problems" (Alpha Center Glossary of Terms Commonly Used in Health Care).

[3] The 10 procedures that account for half of all Medicaid pediatric dental spending are:

D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIM
D1201	TOPICAL APPL FLUORIDE (INCL PROPHYLAXIS)
D2140	AMALGAM ONE SURFACE PERMANENT
D2391	RESIN RESTORATION ONE SURFACE POSTERIOR
D3220	THERAPEUTIC PULPOTOMY
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT
D0272	RADIOGRAPHS-BITEWINGS-TWO FILMS
D2150	AMALGAM TWO SURFACE PERMANENT
D0120	PERIODIC ORAL EXAM
D0150	COMP ORAL EVALUATION

[4] The seven procedures that account for 50% of all dental "units" are:

D1330	ORAL HYGIENE INSTRUCTION
D0272	RADIOGRAPHS-BITEWINGS-TWO FILMS
D0220	RADIOGRAPHS-ITRAORAL PERIAPICAL-FIRST F
D0120	PERIODIC ORAL EXAM
D0230	RADIOGRAPHS-INTRAORAL PERIAPICAL-EA ADDL
D1201	TOPICAL APPL FLUORIDE (INCL PROPHYLAXIS)
D2140	AMALGAM ONE SURFACE PERMANENT
D1351	SEALANT - 1ST PERM MOLAR

between a child's stage of development and the nature of the procedure. (For example, dental sealants become appropriate only after the eruption of certain teeth and have a significant duration of their own before requiring replacement.) The scope of dental procedures, as described, is wide in possibility (e.g. 181 procedures were billed to CO Medicaid in 6 months of 2004) but narrow in practice (e.g. the two dozen procedures that constituted over 80% of services). Each particular procedure, however, has associated with it a set of characteristics that impact its effectiveness in each particular case and a new benefit design should consider greater flexibility to meet each child's needs cost effectively. For example, CO Medicaid provides for two preventive visits annually regardless of the child's risk for ongoing cavities. Depending upon individual risk, this may be adequate (or even more than adequate) for some, while others would realize less ongoing disease by having access to more intensive and frequent preventive visits.

Often overlooked is the occurrence of early periodontal disease in adolescents. Core services extend to provision of periodontal care for these beneficiaries, including maintenance prophylaxis twice per year.

Recommendation

> *Implications for benefit design:* There is little opportunity to distinguish basic ("Core") from more intense ("Core Plus") services because few pediatric dental procedures, in contrast to adult dental services, are elective, optional, or a matter of choice based on provider or patient preference. However, while the overall set of services required by children is relatively modest compared with the range of services in medical care, the *number* of services required by different children varies markedly. Thus, the *intensity* rather than the content of care required by children provides an appropriate alternative rationale for distinguishing "Core" from "Core Plus" benefits. Based on this, we recommend that the first two tiers be distinguished by dollar amounts rather than procedures lists.

2. *Age and caries pathogenesis:* As an infectious disease that is acquired by children before age two and expressed throughout life, a child's experience with tooth decay during toddler and preschool years is highly predictive of future disease and associated expense to the State. Thus, true primary prevention can only be accomplished early in a child's life and the longer the delay in providing comprehensive dental services, the higher the cost of providing care to the child over the subsequent years. If untreated, caries is a chronic and progressive disease that cannot be "healed" once a tooth's integrity is damaged. For this reason, past caries experience tends to be a powerful predictor of future caries experience, affected teeth continue to become more damaged over time, and cavities in primary ("baby") teeth lead to cavities in permanent teeth. The decay process (caries), being essentially steady state within each child but variable in intensity between children, plays out in an orderly and therefore predictable way as each child first develops and then replaces the first set of teeth with the second. This predictability *increases* opportunities for effective anticipatory guidance and prevention. Taken together, these characteristics of dental caries explain the American Academy of Pediatrics and American Academy of Pediatric Dentistry professional recommendations that dental care be initiated during a child's first year of life in a "dental home" that

provides ongoing supervision. A number of states have enhanced dental Medicaid with programs that build on this knowledge including the Washington State Access to Baby and Child Dental Care (ABCD) program and its replicates and the North Carolina "Into the Mouths of Babes" program.

Evidence of cost savings that can be generated through early and sufficient preventive interventions have been studied and are summarized in the attached brief from the Children's Dental Health Project entitled, *Cost Effectiveness of Preventive Dental Services* (Appendix F).

Recommendation

> *Implication for benefit design:* Greatest programmatic savings, and improved health outcomes for covered children, can be generated through aggressive primary prevention that begins early and continues with intensity for highest-risk children. We therefore recommend replication of the ABCD program or similar efforts as a component of the third tier, "enhancements," portion of the CO Medicaid/CHP+ Streamlining HIFA Waiver.

3. *Importance of dental disease distribution on Medicaid/SCHIP dental programming:* Tooth decay remains the single most common chronic disease of children with 1-in-4 (23%[5]) US preschoolers and half (52%) of second graders having experienced cavities. But the disease is not evenly distributed in intensity across all children. Eighty percent of all decayed teeth are found in the mouths of only 25% of children[6]. This caries epidemiology is particularly important to Medicaid and SCHIP planners as low income is the primary population-level predictor of disease occurrence; low income children suffer considerably higher levels of cavities than higher income children. For example, poor children under age five are five times more likely to have cavities than children from families with incomes three times the poverty level. In the National Health and Nutrition Examination Survey III (NHANES III), caries was visually evident in 30 percent of 2- to 5-year-old children in poverty, 24 percent of near-poor young children, 12 percent of middle income young children and only 6 percent of young children from families with incomes at least three times the poverty level.

Children of poverty not only experience higher rates of decay but also more extensive disease experience. For example, children living in households below 200% of the Federal Poverty Level (FPL) have 3.5 times more decayed teeth than young children from more affluent families. Surprisingly, the percentages of young children of various income levels who have experienced dental repair is far more consistent across income groups. However, since low-income children experience more disease, their unmet need remains higher than that of more affluent children. Seventy-nine percent of the decayed teeth in poor 2- to 5-year-old children are unfilled while 45 percent of decayed teeth in the highest income group are unfilled. These findings validate the claim that low-income children suffer from significant disparities in both dental disease and dental care. Similar

[5] Healthy People 2010 March 2004 Update as reported by the Centers for Disease Control and Prevention, Division of Oral Health.
[6] National Health Information Survey data secondary analysis by Vargas, Crall, and Schneider

statistics are reported across various ages of children and across a variety of state-level surveys.[7]

Race, ethnicity, and special needs also impact dental benefits programs. Latino, and particularly Mexican American children demonstrate higher caries levels than White or Black children. For this reason, demographic trends (with higher population composition by Latinos) presages increases in caries experience and demand for dental treatment. Income, separately from race, is an independent predictor of caries prevalence. With the proportion of children who are from poor families also increasing in proportion of newborns, caries prevalence among Medicaid and SCHIP beneficiaries can be expected to rise.

Despite cavities being more common among low-income children such as those that qualify for Medicaid and SCHIP, even within this subpopulation the majority of children require few dental services while only a small subset require extensive care.[8] For example, an actuarial projection based on Medicaid data in California suggests that 5% of children account for 30% of expenditures; 15% of children account for 45% of expenditures; and 80% of children account for only 25% of expenditures. Identifying those children who are most susceptible to the most extreme dental disease may hold strong promise for cost effective early interventions.

Recommendation

> *Implications for benefit design*: Overall, demographic and epidemiologic trends predict increasing disease rates among CO's Medicaid and SCHIP beneficiaries. Early intervention by dental *and medical* providers, risk-based therapies and protocols, anticipatory guidance, and application of principles of "disease management" to dental care for children all hold promise to reduce both disease and costs and should be explored within the context of program enhancements.

4. *Pediatric oral health conditions that are unrelated to dental caries:* While caries overwhelmingly is the most common pediatric oral health problem, children require dental treatment for additional conditions including, in estimated order of prevalence, problems associated with dental eruption and dentition exchange, oral habits, trauma, and soft tissue pathologies.

Recommendation

> *Implications for benefit design:* Except in cases of abuse by practitioners, non-caries related services comprise a small portion of dental services for children and do not need to be considered independently in benefit design. Using a dollar amount to distinguish between Core and Core Plus services will suffice to accommodate these procedures as well as procedures related to caries.

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[7] Edelstein, Special Care Dentistry

[8] Reforming States Group. *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments*, Milbank Memorial Fund, 1999.

5. *CO baseline utilization in Medicaid and SCHIP:* As the state considers the dental benefit and its implications on anticipated program costs and management, a historical perspective of dental utilization provides useful trend information. The following chart details Medicaid Form-416 Report findings of dental care utilization for fiscal years 1998 to 2003.

	1998	1999	2000	2001	2002	2003
# of beneficiaries with at least one dental visit	43,859	52,521	41,591	60,891	74,512	89,350
# enrolled	201,910	198,897	221,796	229,944	257,877	262,321
% with visit	21.7%	26.4%	18.8%	26.5%	28.9%	34.1%
% change in visits		4.7%	-7.7%	7.7%	2.4%	5.2%

Historical increases in the absolute numbers of children who obtain dental care each year (1999-2003) suggest that the program has been increasingly effective for beneficiaries. Similarly, utilization *rates* have increased since 2000 after adjusting for the increase in enrollees. However, given that all children require dental services and dental disease is concentrated in low income children, the proportion who obtained at least one dental visit remains very low.

Recommendation

Implications for benefit design: Proposed enhancements that reduce disease experience can only be effective if they reach the majority of beneficiaries. Fortunately, cost modeling suggests that early, intensive, risk-based preventive care and disease management are cost-saving in the aggregate[9]. Because the effectiveness of benefits, particularly preventive benefits, depends upon access to dental services, issues of benefit design and access cannot be substantially disaggregated. The extended appendix provides relevant information about state experiences in effectively expanding access to covered services.

Well known to HCPF, the dental benefit in CO SCHIP, CHP+, was late in coming but effectively administered as a commercial "look-alike," differing only from commercial and Medicaid plans by establishing a $500 cap on service payments. Experience revealed[10] that only a modest number of 62,142 individuals enrolled in the first year of the dental benefit required treatment during that year that met or exceeded this cap (2027 children representing 3.3% of enrollees). These high-needs children received the balance of treatment through funding provided by the non-profit vendor's foundation. Overall, more than a third (34.3%) of enrolled children received one or more dental services in the first 12 months of the dental program – 10% more than the percentage of Medicaid enrollees who received care during the prior fiscal year. The report, developed by the University of Colorado School of Dentistry, found that the CHP+ dental program "should be considered a successful first step toward improving the oral health of uninsured families" and recommended attention to three domains: (1) improving the provider

[9] Zavras T, Edelstein B, Vamvakidis T. Health care savings from microbiologic caries risk screening of toddlers: a cost estimation model. Journal of Public Health Dentistry 60:182-188, 2000.
[10] State of CO, CHP+ Dental Plan Analysis 2/1/02-1/31/03, October 28, 2003.

network to eliminate "pockets" with limited or no providers; (2) revisiting the $500 cap as a projected "7-10% [were] rapidly reaching the $500 limit and still [had] additional treatment needs"; and (3) further consideration of covered services "to maximize the financial investment in the program." With the proposed combination of Medicaid and SCHIP, items (2) and (3) become moot since Medicaid EPSDT requires comprehensive care and CMS has allowed, to date, waivers of medically necessary dental benefits only in special and very limited circumstances.

Another study of treatment completion[11] sought to review treatment completion status over a six month period in early 2002, finding that over two-thirds (68.6%) had completed treatment and only ~6% reached the $500 cap. The authors reported that they "cannot presume that approaching or having reached the $500 cap causes the incomplete treatment listed by the practitioner" and conjecture that most children can have incomplete treatment provided within the capped benefit level. Given, however, that both studies reviewed data for the implementation year of the CHP+ dental component, it is possible that slow initial enrollment of children into a dental home might have produced artificially high completion status levels; the percentage of children who might reach the $500 cap may be expected to rise somewhat in subsequent years

Recommendation

> *Implications for a dental benefit:* CHP+ dental program successes validate that contracting directly with a single highly qualified dental vendor can realize a robust network of providers, rapid increase in access for previously underserved children, and Core benefits that meet the vast majority of children's dental care needs within a $500 cap. (Note: Experience in multiple states substantiates that failure to index dental fees and the annual cap to inflation results in rapid erosion of provider participation as the value of these dollar amounts diminishes over time.)

6. *Medicaid pediatric dental service requirements*: CMS' website[12] describes the EPSDT dental benefit as:

> "At a minimum, includes relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule developed by the state and at other intervals as medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial direct referral to a dentist) conform to the state periodicity schedule which must be established after consultation with recognized dental organizations involved in child health care."

[11] Draft report prepared by the Colorado Prevention Center, Data Coordinating Center dated 9/8/03.
[12] CMS EPSDT information available at: http://www.cms.hhs.gov/medicaid/epsdt/default.asp

The Medicaid EPSDT benefit requires that states provide Early and Periodic Screening, Diagnostic, and Treatment services for enrolled children from birth until age 21 consistent with periodicity schedules established in consultation with "recognized [medical and dental state] organizations involved in child health care" (Section 1905(r)(1)). The statute defines EPSDT services in four sections: screening, vision, dental, and hearing. Each is a separate and individual requirement. Dental is not specified as part of the minimum requirement for "screening" services but is specified as a set of services in its own right. OBRA 89 (Section 1905(r)(3) and following) states that dental services "shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health." Further, "these services are to be provided at intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care and at other such intervals indicated as medically necessary to determine the existence of a suspected illness or condition."

EPSDT may exclude services as being non medically-necessary services based on such standards as state-of–the-science, efficacy, professional recommendations, and relative cost effectiveness. As such, it routinely excludes particular services (e.g. purely cosmetic services), may limit the frequency of services (e.g. one dental prophylaxis per six months), can exclude coverage for particular materials (e.g. silicates), and establish other limitations. These present the only set of opportunities for constraining the range of dental services within current requirements.

Waivers to Medicaid requirements allow the Secretary to grant exceptions to non-statutorily defined EPSDT services. However, to date, CMS has established a consistent history of not waiving EPSDT dental requirements. The only known approved waivers affecting dental services in EPSDT are the 1993 Oregon 1115 Health Plan Demonstration and a Utah waiver that excluded dental coverage for older teenagers who are not otherwise included in a mandatory population.

To date, CMS has not waived the OBRA 89 EPSDT requirement or allowed any administrative procedure that effectively reduces the comprehensiveness of this benefit. For example, CMS has not allowed premium assistance programs to exchange the EPSDT package of benefits for an employers' commercial benefit package. CMS has required states to provide "wrap around coverage" whenever proposed benefits would be lesser than those provided by EPSDT, e.g. in dollar-capped benefit structures. Since employer-based plans (including many state employee plans) often do not provide a benefit for dependent dental coverage, a "wrap" is necessary even under terms of the HIFA waiver program.

Recommendation

Implications for benefit design: In combining Medicaid and CHP+, HCPF may establish a dollar limit that defines dental services in tier one (Core) and distinguishes these services from additional volume of services provided in tier two (Core Plus) but may not cap the dental benefit at a preset dollar amount as is currently done in CHP+. Therefore, the dollar limit that separates Core from Core

Plus benefits provides an administrative opportunity for intensive oversight and creates a provider incentive to spread treatment over two years (thereby avoiding the need for providers to obtain permission to provide Core Plus services); however the dollar "limit" *does not* provide the state with the opportunity to cap costs.

Within EPSDT are a number of nuances that distinguish dental from medical care for children.

1. *Screening:* The portion of the federal statute referencing dental care requires that services be provided by dental professionals while remaining silent on screening—which presumably occurs either simultaneously with dental treatment or as part of the child's medical evaluation. The dental service requirement is further defined in CMS Form 416 tri-partite reporting requirements on the numbers of children by age who receive (1) any dental services (CMS 416 report item 12a), (2) any preventive services (12b) and (3) any treatment services (12c).[13] Because of the high prevalence of dental disease in Medicaid-eligible children and the recommendation by pediatric medical and dental associations that all children obtain dental care, it is assumed that *all* children should obtain routine and ongoing dental services.

2. *Diagnosis:* Diagnostic services include oral physical and radiographic examination and, increasingly, "risk assessment" geared to identifying those children who are more likely to develop cavities over time. This assessment may include salivary microbiologic evaluation as noted in the AAPD "Caries risk Assessment Tool." While AAPD recommends that all children undergo a risk assessment, few Medicaid or SCHIP plans currently adjust service periodicity to diagnosed risk. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry both endorse dental care beginning at age 1, with pediatricians specifying that care should be prioritized for children noted to be at risk for early childhood caries. Implementing a risk-based benefit structure holds strong potential for cost savings through intensive prevention but requires that medical and dental providers be offered the training and incentives to conduct caries risk assessments. Early findings of North Carolina's study of physicians' involvement with oral health risk assessment are equivocal regarding cost savings but stronger regarding integration of medical and dental systems of care.

3. *Prevention:* Preventive dental services are professionally recommended for all children and include counseling, appropriate exposure to topical and systemic fluorides, placement of sealants (at least on permanent teeth), and dental prophylaxis (although this traditional biannual tooth cleaning has been challenged for efficacy and effectiveness). Because dental caries is a behavioral disease that is dependent upon parental and child control over diet and hygiene, many dentists believe that oral health education which typically takes place simultaneous with

[13] Centers for Medicare and Medicaid Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Report (Form CMS-416). Available at http://www.cms.hhs.gov/medicaid/epsdt/416inst.asp.

provision of these services is the most powerful component of preventive care. Health educators, however, recognize the need for regular reinforcement and culturally-appropriate messages. Washington State's dental Medicaid program has strongly promoted early oral health education to enhance prevention effectiveness through its ABCD program which trains dentists in the care of young children and provides these trainees with a supplemental Medicaid fee to incentivize their provision of early care. However, past Medicaid experience suggests caution in incentivizing payments for prevention while keeping payments for reparative services low as this creates a disincentive for comprehensive care.

4. *Repair:* Dental repair is comprised of a series of surgical services that include extractions, restorations, endodontics treatments (various types of pulp and root canal services), and periodontic services. Dental restorations replace tooth surfaces that are carious (decayed), developmentally disrupted, or traumatically damaged. Because dentistry does not use diagnostic codes in billing for procedures, it is not possible for payers to determine the underlying reason for repair, although most is due to caries. Typical restorative materials for children include amalgam, composite, glass ionomer, and stainless steel (particularly in the case of primary molar crowns). Materials are typically chosen based on extent of damage, strength needs, and esthetics rather than on provider or parental preference. Studies conducted by Dr. Carole Haynes at the Medical University of South Carolina reveal few differences in dentists' choice of materials or procedures once a need for intervention has been determined. The appropriateness of stainless steel crowns (SSCs) in pediatric dentistry has been raised by Medicaid authorities, particularly in Texas. The American Academy of Pediatric Dentistry has responded with formal guidelines on the indications for SSCs (guideline available at www.aapd.org). SSCs are used uniquely in pediatric dentistry to repair primary teeth that have either multiple surfaces of decay or extensive decay on one surface, leaving the remaining tooth structure susceptible to fracture. SSCs are efficient in sustaining the primary tooth until normal exfoliation without the need for re-repair. Although teeth that have been treated by pulpotomy (a partial root canal treatment for primary teeth) require subsequent repair by SSC, not all crowned teeth require pulpotomy. Arguably, SSCs are also indicated as a more aggressive form of repair in the mouths of children who demonstrate very high caries risk and associated disease progression

9. *Lessons learned from State SCHIP dental programs:* In contrast to Medicaid, SCHIP dental benefits are optional at the state's discretion. Despite this, all states except Delaware have elected pediatric dental benefits in SCHIP. Texas has dropped its benefit (with restatement likely to occur late in 2005[14] under advocacy pressure on legislators) and policymakers in other states, including Georgia's governor, have sought to end this benefit as a cost-saving measure. Dental benefits in SCHIP parallel states' decisions about the overall SCHIP program. In those states that implemented SCHIP as a Medicaid expansion, all EPSDT benefits, including dental services, were incorporated in the

[14] Request for proposals. Children's Health Insurance Program, Dental Insurance Services. May 16, 2005. Available at: http://www.hhsc.state.tx.us/Contract/52905138/rfp_home.html

program as required. States that opted for separate (non-Medicaid) programs, have developed a variety of dental programs. Although these programs differ in details regarding level of cost sharing and language describing covered services, the uniformity of children's needs is reflected in all providing basic dental services that meet the majority of children's oral health needs. While some states have also developed SCHIP premium assistance programs, these rarely have included dental benefits.

Although relatively few studies of dental care components of SCHIP have been published, most observe that access to dental care has improved. In Pennsylvania, after 12 months of SCHIP, the proportion of children with a regular source of dental care increased 41%, while the proportion that had a preventive dental visit increased 50%. Unmet need and delayed dental care fell from 43% to 10%.[15] After one year of SCHIP enrollment in Iowa, parents of beneficiaries reported that access to and utilization of dental services improved for all ages studied, but 1 in 6 adolescents still had unmet need or delayed dental care.[16] However, an assessment of SCHIP's affect on access to care for teens in five states (California, Connecticut, Maryland, Missouri and Utah) found that dental services for adolescents were seriously affected by limited provider participation.[17]

In a survey of parents of New York State enrollees, conducted pre- and one year post-enrollment in SCHIP, a 13% reduction in unmet need for dental care was reported.[18] A study of Colorado's SCHIP produced a surprising finding: after one year of enrollment, families reported a decrease in unmet dental needs despite Colorado then offering no SCHIP dental benefit. The report speculates that, as a result of coverage of other health needs by the SCHIP program, families had more disposable income available for purchasing dental care.[19] An ancillary explanation is that expanded access to medical services raised awareness of the need for dental care.

While each of these reports provides reason for optimism regarding the effectiveness of SCHIP on dental care (if not health outcomes), SCHIP provides few lessons for Medicaid or for understanding the mechanisms behind successful outcomes. Three reports, however, provide useful information. A 2001 report by the Urban Institute[20] suggests that improvements in dental utilization and provider participation may be occurring in separate SCHIP programs that pay dental providers at market rates, as compared to Medicaid that typically pays at deeply discounted rates. A second study looked at the separate SCHIP program in North Carolina that is administered by a single commercial

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[15] Lave JR, Keane CR, Lin CJ, Ricci EM. The impact of dental benefits on the utilization of dental services by low income children in western Pennsylvania. Pediatr Dent. 2002 May-Jun;(24(3):234-40.
[16] McBroome K, Damiano PC, Willard JC. Impact of Iowa S-SCHIP program on access to dental care for adolescents. Pediatr Dent. 2005 Jan-Feb;27(1):47-53.
[17] Fox HB McManus MA, Limb SJ. J. Adolesc Health. 2003 Jun;32(6 Suppl);40-52.
[18] Szilagyi PG, et al. Improved access and quality of care after enrollment in the New York State Children's Health Insurance Program (SCHIP). Pediatrics. 2004 May;113(5)e365-404.
[19] Kempe A, et al. Changes in access, utilization, and quality of care after enrollment into a state child health insurance plan. Pediatrics 2005;115;364-71.
[20] Almeida R, Hill I, Kenney G. Does SCHIP spell better dental care access for children? An early look at new initiative. Occasional paper number 50. The Urban Institute. Jul 2001. Available at: http://www.urban.org/urlprint.cfm?ID=7375.

contractor and found that the percentage of children with a visit to the dentist increased from 48% to 65% one year after enrollment in the program, with many parents reporting that private dentists were serving as their child's usual source of care. In contrast, only 20% of state dentists see 40 or more Medicaid-enrolled children. The report concludes that SCHIP dental models that resemble private insurance and reimburse dentists at market rates hold the potential to address problems associated with dental care for low-income children.[21] Thirdly, investigators studying a Medicaid and Medicaid-expansion SCHIP dental program in Indiana, conclude that a dental fee increase in 1998 to 100% of the 75th percentile of commercial fees (along with administrative changes that included contracting the program to a single dental benefits provider) resulted in an increase in the number of dentists seeing a Medicaid child and an increase in the percentage of children receiving any dental visit from 18% to 32%. The study also notes that there was relatively little difference in utilization rates among children in the traditional Medicaid program and more affluent children enrolled in the Medicaid SCHIP expansion. Dentists did not appear to be preferentially allowing children enrolled in the Medicaid expansion SCHIP into their practices at the expense of lower income Medicaid patients.[22] A recent report on physicians' provision of well child care and immunizations also substantiates the positive impact of market-based reimbursement on care for publicly funded children[23].

At this time, the American Dental Association is developing a compilation and analysis of State SCHIP dental plans' eligibility levels, administration, cost sharing, and dental benefit – but not performance or outcomes. This descriptive information will allow further comparisons among states but will not provide information about the relationship between program structure and care utilization or oral health outcomes.

Recommendation

> *Implication for benefit design:* SCHIP programs that mimic commercial insurance (in payment rates, administration, dental benefits, and/or provider availability -- either in contractual networks or through widespread acceptance by provider community), utilize a single robust vendor, and provide the full range of dental services typically needed by children have been effective in improving dental utilization and parental reports of improved oral health.

8. *American Dental Association Service tiers*: The American Dental Association's *Dental Terminology Code on Dental Procedures and Nomenclature* defines 12 categories of dental services. Those that encompass the vast majority of pediatric services for children fall within 8 categories:

1. Diagnostic, typically clinical and radiographic examination (ADA I)

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[21] Mofidi M, Slifkin R, Freeman V, Silberman P. The impact of a state children's health insurance program on access to dental care. JADA 2002 Jun;133;707-14.

[22] Hughes RJ et al. Ibid.

[23] McInerny TK, Cull WL, Yudkowsky BK. Physician reimbursement levels and adherence to American Academy of Pediatrics well-visit and immunization recommendations. Pediatrics 2005, 115(4): 833-838.

2. Preventive, typically cleaning, fluoride treatment, space maintenance, counseling, and sealants (ADA II)
3. Restorative, typically all types of fillings and pediatric crowns (ADA III)
4. Endodontics, typically pulpotomy for primary teeth and pulpectomy for permanent teeth (ADA IV)
5. Periodontics, typically only for older adolescents (ADA V)
6. Oral surgery, typically extractions (ADA X)
7. Orthodontics, as determined by each state's standard for malocclusion severity (ADA XI)
8. Adjunctive services, e.g. hospital care as needed (ADA XII)

Recommendation

Implications for benefits design: Practicing dentists are familiar with the ADA's procedure code rubric and best understand dental plans that reflect these categories of services. Our proposed benefit structure integrates seamlessly with this rubric.

9. *Cost sharing:* Federal requirements prohibit cost sharing (premiums, deductibles, or co-pays) in EPSDT and define limits in SCHIP services[24]. Medicaid does allow cost sharing, however, for adult populations. The Center on Budget and Policy Priorities reports that "a substantial and rigorous body of research has demonstrated that low-income individuals are more vulnerable to the adverse effects of cost-sharing than other groups are" – causing reductions in appropriate use of services and adverse health outcomes[25]. A number of SCHIP programs include modest cost sharing provisions for dental reparative services, including CO's reported $5 visit copayment for some CHP+ beneficiaries. Commercial dental coverage typically involves no copay for diagnostic and preventive services, 20% copayments for basic reparative services, and 50% for more involved covered services such as prosthetics. Arguments for cost sharing in Medicaid focus on increasing parental responsibility while arguments against focus on eliminating financial barriers to access.

Recommendation

Implications for benefits design: As now in place for CHP+, we recommend that there be no cost sharing for preventive or reparative services for lowest income beneficiaries and only modest co-payments for all but diagnostic and preventive services for higher income families.

10. *Professional guidelines and the "evidence-base" in pediatric dentistry:* Guidelines for the oral health care of children are more extensive than for oral health care of other populations and include authoritative professional and governmental recommendations. In the US, the primary authority within the dental profession is the American Academy of Pediatric Dentistry whose regularly-updated policies and guidelines are increasingly

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[24] Sec.42 CFR 457.520 Cost sharing for well-baby and well-child care. Code of Federal Regulations. Oct 1, 2001. Available at http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=457&SECTION=520&YEAR=2001&TYPE=TEXT

[25] Ku L. Charging the poor more for health care: cost-sharing in Medicaid. Center on Budget and Policy Priorities, Washington DC, May 7, 2003.

evidence-based or, alternatively, supported by expert consensus.[26] These guidelines are developed and regularly reviewed by AAPD through its Council on Clinical Affairs. Similarly, the American Academy of Pediatrics has recently promulgated an oral health guideline that promotes establishment of a dental home, emphasizes the importance of "infant oral health care," and details the role of the primary care medical provider in advancing children's oral health through screening, counseling, referral, and provision of some preventive services[27]. The Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse[28] cites both of these guidelines together with others focused on specific subpopulations of children such as those with cleft-lip or palate. A federally-sponsored consortium of pediatric health care practitioner organizations has developed a consumer-friendly set of oral health guidelines through the Bright Futures program[29] that combines professional recommendations from a variety of groups. In association with release of its report, "Oral Health in America," the Office of the US Surgeon General sponsored an invitational "Workshop on Children and Oral Health"[30] and a public conference entitled "Face of the Child," both of which provided further guidance regarding children's oral health needs, disparities in oral health status, and access to appropriate care.

Additional guidelines, policies, and clinical recommendations that reflect current thinking in pediatric dental practice include:

- The Centers for Disease Control and Prevention 2001 oral health care recommendations for professionals, consumers, and industry that focused on use of fluorides and promoted medical-dental collaborations.
- The National Institutes of Health's 2001 recommendations based on its *Consensus Development Conference on Diagnosis and Management of Dental Caries Throughout Life*[31] which advanced the concept of risk-based individualized fluoride therapies for children.
- The Children's Dental Health Project, an independent pediatric oral health policy agency in Washington DC, provides principles and recommendations that support its public policy agenda. These include targeting prevention and treatment to children at highest risk of disease; implementing programs that develop and refine *bona fide* approaches to non-surgical caries management; preparing a multifaceted workforce to promote and integrate oral health as a component of general health; conducting social marketing on behalf of children's oral health and parental empowerment to manage caries risk; and developing systems of care that are competent to meet each child's unique needs.

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[26] AAPD policies and guidelines are available to the public at: http://www.aapd.org/media/policies.asp
[27] AAP oral health policy is available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113
[28] See: http://www.guideline.gov/search/detailedsearch.aspx
[29] Bright Futures Oral Health homepage is located at http://www.brightfutures.org/oralhealth/about.html
[30] Edelstein BL. Forward to the Background papers from the US Surgeon General's Workshop on Children and Oral Health. Amb Pediatr, 2(2 Supplement) 2002.
[31] National Institutes of Health. Consensus Development Conference on Diagnosis and Management of Dental Caries Throughout Life. Accessed 2/2/05 at http://www.lib.umich.edu/dentlib/nihcdc/

A recent review of international recommendations for children's dental care advance very similar guidelines. The World Dental Federation posts more than 50 guidelines (including those promulgated in the US) on its website. Major organizational recommendations have been recently reported.[32]

Most germane to HCPF's current effort, the Centers for Medicare and Medicaid Services released in October 2004 its *Guide to Children's Dental Care in Medicaid*[33] which contains information on clinical practice, evolving technologies, and recommendations in dental care for children and families receiving Medicaid. The new document replaces a 1970's version and includes chapter headings and appendices on dental caries in US children, contemporary dental care for children, policy and program considerations, clinical issues, and an AAPD model dental benefits statement and list of procedures. The evidence base for this document includes sources sited above plus additional professional and governmental sources for particular services, e.g. use of fluorides, sealants, and dental radiographs. Full text of the model benefit statement is provided in Appendix C.

In shortened form, the CMS statement calls for the following dental benefits in Medicaid:

a. Basic obligation – For enrollees under age 21, the dental and oral health services described in this section in accordance with professionally accepted standards of dental and oral health practice and applicable standards set forth in the *American Academy of Pediatric Dentistry Reference Manual; Guide to Clinical Preventive Services; Workshop on Guidelines for Sealant Use: Recommendations; a*nd *Bright Futures in Practice: Oral Health.*

b. Preventive services:

(1) Preventive dental education
(2) Oral screening by primary care practitioners for children under age 3 years
(3) Initial and periodic examinations
(4) Fluoride therapies
(5) Dental sealants
(6) Dental prophylaxis
(7) Space maintainers

c. Diagnostic, treatment and restorative services

(1) Radiographs
(2) Other diagnostic procedures
(3) Restorative services (fillings and pre-formed crowns)
(4) Orthodontic services
(5) Endodontic services
(6) Dental and oral surgery
(7) Periodontic services
(8) Prosthodontic services
(9) Drugs

[32] Edelstein B. Pediatric Caries Worldwide, Implications for Oral Hygiene Products. Compendium, in press.
[33] CMS Guide to Children's Dental Care in Medicaid is available at http://www.cms.hhs.gov/medicaid/epsdt/dentalguide.pdf

(10) Medically necessary adjunctive services

Recommendation

Implications for dental benefits: An accelerating and ever expanding literature provides extensive evidence base, professional expert opinion, and federal guidance regarding essential dental services for children. These policy documents also establish a standard of care that reflects the professions' conceptualization of medical necessity as applied to oral health services. In short, these various statements further support the finding that comprehensive care for children may entail a wide range of services but typically involves only a modest set of services.

11. *Past efforts at tiered care for Medicaid dental services:* The Milbank Memorial Fund's publication, *Pediatric Dental Care in CHIP and Medicaid: Paying for what kids need, getting value for state payments* suggests that care can be tiered programmatically into four "levels". This model was developed by a group of state health policy and program experts in consultation with pediatric dentistry experts. It calls for:

a. Level 1: "diagnostic, preventive, and disease management services." These services are extended to all enrolled children without prior authorization and are to be paid at a single "fixed case management fee."
b. Level 2: "basic restorative care." This level is also extended to all enrolled children without prior authorization up to $400 in charges (in 1999 dollars)
c. Level three: "advanced restorative care," All services in this tier require prior authorization for non-emergency services that cost in aggregate between $400 in charges and $1000 in charges.
d. Level 4: "catastrophic care." This level is for children with exceptional treatment needs and applies to those whose estimated reparative service costs exceed $1000. This tier engages an even higher level of prior review that includes consultation with a specialist in pediatric dentistry. (Most typically, this applies to young children requiring extensive care for Early Childhood Caries under general anesthesia.)

Because orthodontic services by their nature are uniquely different from dental repair, the model segregates orthodontic services by requiring prior authorization, requiring that care be provided by a "suitably qualified dentist," and including orthodontics within level four.

In keeping with children's needs and EPSDT requirements, the model does not anticipate that states would cover less than all four levels. The primary intention of developing the tiers was to provide increasing levels of state oversight and control to ensure appropriateness of services and avoidance of fraud and abuse.

A companion cost estimation tool developed in consultation with healthcare actuaries provides the opportunity to cost out this benefit design.

Recommendation

Implications for benefit design: The Milbank model, although not implemented by any state to date, strongly parallels HCPF's intentions and provides the benefit of a thoroughly vetted approach. The cost estimation tool may be of use in predicting dental costs under a tiered program.

Note on assessing program performance: Measures that have been used to evaluate the effectiveness of dental Medicaid and SCHIP programs most commonly include age-stratified utilization rates for "any," "preventive," and "restorative" dental procedures (as required by CMS); dentist participation rates; aggregate billings and/or payments; parental reports of unmet need or delay for dental care (i.e., client satisfaction surveys); and percentage of children reported by their parents to have a regular source of dental care.

While these are all descriptive of program impact, none objectively assesses improvements in oral health status that may be attributed to coverage. Established measures of oral health status are used in epidemiologic studies of caries and in Healthy People 2010 (HP2010) to track oral health objectives. HP2010 objectives include the percentage of children with past caries experience and the percentage who have unfilled cavities. Few states conduct representative studies of oral health status in children and national studies generally cannot be used to determine children's oral health status within any particular state. As of 2004 the federal National Health and Nutrition Examination Survey (NHANES), from which most oral health burden information is gleaned, will no longer include an oral examination, thereby eliminating states' access to national reference data. In sum, unless the CO health department's oral health program conducts a representative "open-mouth" dental surveillance study, HCPF will be unable to utilize oral health outcomes measures in analyzing the impact of its dental coverage program but will be able to use process measures.

Appendices

Appendix A. Recommendation for a Tiered Pediatric Benefit Structure

Appendix B. Medicaid and SCHIP Dental Program Background

Appendix C: AAPD Model Dental Benefits Statement from the CMS Guide to Children's Dental Care in Medicaid

Appendix D: Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers: A Handbook

Appendix E: Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid

Appendix F: CDHP Policy Brief: Cost-Effectiveness of Preventive Dental Services

Appendix A. Recommendation for a Tiered Pediatric Benefit Structure

Based on the above considerations, an appropriate application of the proposed Core, Core Plus, and Enhancements structure to dental services is shown in the table below:

Content	*Comments*
Core Dental Services for Children	
All primary care dental services for children consistent with medical necessity (as currently provided in CO EPSDT) up to a dollar value of at least $500 to be determined based on an actuarial analysis. Note: Based on current standards of care as promulgated by AAP and AAPD, Core benefits should include specific coverage of Infant Oral Health Care and enhancements should support institutionalization of early dental care among CO providers.	Services and oversight: Medically necessary dental services for children are typically provided through about 20 specific procedures. Efficient program management approaches include no prior authorization, at least for these common procedures, and adoption of commercial approaches to post-treatment reviews for fraud and abuse control. Cap: We recommend a cap in the range of $750 - $1000 based on the typical range of charges for primary medically necessary dental care while retaining enhanced oversight for the minority of care intensive cases. Actuarial Analysis: Determination of the capped amount will involve analysis of past claims experience (particularly of those children who exceeded the current $500 cap to determine whether that cutoff was most efficient); anticipated utilization; allowable provider charges; and the impact of a cap on provider behavior (extending treatment over more than one fiscal year.)
Core Plus Dental Services for Children	
Additional primary care dental services provided to children whose medically necessary dental services, including orthodontics, exceed the dollar amount limit in Core dental services.	Services: As in Core benefits. As orthodontic services typically exceed the level of the anticipated cap, all comprehensive orthodontic care will be subject to prior authorization. Oversight: Assuming an appropriately set cap, enhanced prior-treatment review and authorization should be applied to Core Plus services, in addition to post-utilization review processes. .
Enhancements Impacting Children	
Program enhancements that hold strong promise to reduce dental disease burden in children and thereby decrease program costs while improving oral health.	Detailed below are suggested enhancements including extending coverage to very low income adults; extending coverage for pregnant women and new mothers; authorizing fluoride varnish application and oral health counseling by physicians; replicating the WA state ABCD Program; Extending administrative case management and disease management programs to pediatric oral healthcare; and extending “pay for performance” methodologies from commercial dental coverage to CO Medicaid and SCHIP.

Enhancements

Various state and commercial approaches to be considered by HCPF in enhancing the dental program to reduce burden and increase efficiency include:

1. Dental care for very low-income adults: If the State's waiver extends healthcare services to very low-income adults, these additional beneficiaries should be provided with a dental benefit that *at least* provides for dental services that relieve pain and infection. Additional services that will minimize pain and infection include stabilization of the existing dentition through primary restorative and periodontal care.

2. Dental coverage for income-qualified pregnant women and new mothers (i.e., "pregnancy-related dental services.")
   About half of the states provide coverage for pregnant women thereby affording the opportunity to provide instruction regarding the (1) transmissibility of dental caries-causing bacteria from parent to child; (2) establishment of the dental home; and (3) appropriateness of infant oral health care as recommended by AAP, AAPD, and Bright Futures. As guidelines are increasingly becoming available for dental care of pregnant women (e.g. New York State Department of Health guidelines to be released in late 2005 and information to be generated from a new HRSA-supported grant to AAPD on perinatal oral health), CO can implement recommended approaches including maternal risk assessment for caries transmission. For these approaches to be successful in reducing the incidence of Early Childhood Caries and associated high treatment costs, care needs to be extended for these women until their child's first birthday. A unique parental incentive may be state-payment for a limited set of dental procedures for these women conditional upon their securing a dental appointment for their child. Additional potential benefit to the State may be reduced incidence of premature and low-birth weight babies if the relationship between dental intervention during pregnancy and unfavorable birth outcomes is substantiated in current clinical trials.

3. Fluoride varnish application by physicians: A NC project, *Into the Mouths of Babes*, is currently evaluating the impact of physician training in oral health counseling coupled with application of fluoride varnish to the teeth of young low-income children. Early findings are positive. This program should be monitored for impact and replicated if found to be successful in reducing disease burden and increasing early preventive dental care.

4. Washington ABCD Program: The Washington State Medicaid authority in cooperation with the WA Dental Service Foundation (Delta Dental of WA) has conducted a multi-county effort to increase preventive and primary dental care for low-income toddlers and preschoolers and demonstrated increased access to care. The program involves financial incentives to providers who participate in formal training and provides enhanced administrative case support services for parents.

5. Administrative case management: As missed appointments are a significant deterrent to provider participation in dentistry, extension of administrative case management that facilitates appointment making and compliance with appointment keeping would

enhance the efficiency of the program, increase provider willingness, and improve children's health outcomes.

6. Disease management: While low-income children tend to have higher dental disease rates, only 5% of children in Medicaid (based on DentaCal information) account for extremely high expenses. Enhancing the program through provider incentives to become trained in risk-assessment and to deliver preventive services with an intensity matched to each child's risk holds strong promise to improve oral health at lower cost. The commercial dental industry, like dental education, is currently experimenting with these variable-benefit approaches that match care intensity to risk rather than to disease manifestation. As noted in Part I, economic modeling suggests strong cost savings from early risk assessment and associated disease management. Dental hygienists, specially trained for this approach, may provide a valuable human resource in implementing such an enhancement.

7. Pay for performance: The Colorado Delta Dental Plan has begun a model "pay for performance" program which provides financial bonuses to dentists whose practice patterns suggest efficiency, comprehensiveness of care, and compliance with professional standards. Providers whose claims patterns suggest provision of continuing, comprehensive, prevention-oriented care that does not reflect over-treatment are financially rewarded while others are encouraged to modify their practices to qualify for the incentive. Practitioners whose claims suggest inappropriate care can be identified and removed from the network should they not modify their practice to better meet professional standards. As this approach is further refined, it can be applied to the Medicaid and SCHIP programs as readily as to commercial plans.

8. Access enhancements: Non-benefit enhancements that may increase access to care and thereby improve the effectiveness of the program include public-private contracting between community health centers and private dentists (Appendix C); loan repayment incentives for practitioners who devote at least 30% of their practice volume to care of Medicaid and SCHIP enrollees; and other approaches detailed in Appendix B.

Note on contracting: States have multiple options in administering Medicaid and SCHIP programs. The benefits and risks of each option are extensively described in the attached monograph, *State Options in Contracting Dental Care in Medicaid,* and reviewed in Appendix B, Medicaid and SCHIP Dental Program Background. As described in that publication, particular success has been noted in states that have contracted with a single commercial vendor that has an extensive provider network.

APPENDIX B. Medicaid and SCHIP Dental Program Background

I. Lessons learned

There have been numerous analyses of barriers to dental access for children in the Medicaid program.[1] [2] [3] Generally, the three most commonly cited barriers are (1) inadequate reimbursement of providers, (2) burdensome administrative processes, and (3) insufficient recognition of the importance of oral health and care coordination resulting in high rates of patient appointments, decreased compliance with oral health care instruction, and failure to follow-up for needed treatment. To a great extent, the effect of of these barriers has been to drive many dental providers away from participating in Medicaid. Since 1998—when the Centers for Medicare and Medicaid Services (formally the Health Care Financing Administration) brought together key policy-makers at a first-ever national conference on improving oral health in Medicaid—the focus of state Medicaid agencies, health departments, the dental professional community, and other pubic and private stakeholders has been on ways to eliminate access barriers.[4]

States' activities subsequent to this conference have been extensive and directed towards a multitude of objectives; many of these activities have been implemented simultaneously, with numerous variables interacting and creating difficulties in assessing the influence of a specific intervention. Nevertheless, much of what we know today about enhancing dental access in the Medicaid program stems from reports and analyses of those innovative activities undertaken in both the Medicaid program and, since 1997, SCHIP. [5]

Observation of states' efforts reveals, ultimately, that only a few factors relate to a state's capacity to obtain dental care for child beneficiaries and engage sufficient numbers of providers:[6]

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[1] U.S. Office of the Inspector General. Children's dental services under Medicaid: access and utilization. Washington: U.S. Department of Health and Human Services, Office of the Inspector General. 1996. DHHS publication OEI-09-93-00240. Available at: http://oig.hhs.gov/oei/reports/oei-09-93-00240.pdf

[2] U.S Congress, Office of Technology Assessment. Children's dental services under the Medicaid program: background paper. Washington: U.S. Congress; 1990. Report OTA-BP-H-78

[3] Oral health: factors contributing to low use of dental services by low-income populations. April 12, 2000. GAO/HEHS-00-72. United States General Accounting Office. Available at: http://www.gao.gov/new.items/he00072.pdf.

[4] Building partnerships to improve children's access to Medicaid oral health services. National conference proceedings. June 2-4, 1998. National Center for Education in Maternal and Child Health. Available at: http://www.mchoralhealth.org/PDFs/OHproceedings.pdf.

[5] American Dental Association. State innovations to improve access to oral health care for low income children: A Compendium Update. Chicago: American Dental Association: 2005. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp

[6] Connecticut Health Foundation: Understanding the Connecticut dental Medicaid reform proposal: State options in contracting dental care in Medicaid. March 2003. Available at: http://www.cthealth.org/matriarch/documents/medicaid_carveout.pdf.

1. Market-based payment rates to dental providers,
2. Use of "dentist friendly" administrative procedures and policies that mirror those used in the private sector,
3. Coordination of care for beneficiaries, and
4. Effective program oversight.

This section of this paper seeks to:

- Describe and comment on lessons learned from state innovative efforts to improve dental access.
- Describe various program options and related decisions facing states as they consider issues of reimbursement, administrative program management, care coordination and program oversight, and,
- As appropriate, present arguments (pro and con) for various decisions.

A. Market-based Purchasing Reforms in State Dental Medicaid Programs

Analyses of dental access barriers routinely have cited the lack of adequate Medicaid reimbursement for services as the primary reason for poor dentist participation and dismal utilization of oral health services in the Medicaid program. While recognition of the problem is almost universal, only in the past few years has a better understanding of the relationship between dental reimbursement and access emerged. Earlier investigators worked in an environment where state Medicaid programs traditionally provided small fee enhancments to reimbursement rates that were dramatically lower than contemporary fees in the private dental sector. Not surprisingly, these studies found fee increases to be ineffective in increasing dentist participation in Medicaid.[7] Recently, however, a number of states have increased Medicaid dental reimbursement to prevailing private sector market levels, providing an opportunity to view how more extensive reimbursement changes affect access to children's dental services.

- In four states (Georgia, Indiana, South Carolina, and Tennessee) dentists fees were increased to a level that reflected (at the time of the fee increase) fees equal to or greater than those charged by 75% of dentists in the private sector –that is, the reimbursement level was set to the 75th percentile[8] of prevailing private sector fees.[9]
- In Alabama and in 37 rural counties in Michigan, reimbursement rates were tied to rates paid by major commercial insurers in the states (Delta Dental, Inc. and Blue Cross Blue Shield respectively).

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[7] Mayer ML, Stearns SC, Norton EC, Rozier RG. The effects of Medicaid expansions and reimbursement increases on dentists' participation. Inquiry. 2000; 37(1): 33-44.

[8] Fee percentiles represent the distribution of fees charged by dentists in a particular area and can be used for estimating the proportion of dentists who might participate in a Medicaid program at selected payment levels. From: *Medicaid reimbursement—using marketplace principles to increase access to dental service*. American Dental Association. 2004. Issue Brief. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp

[9] In 2004, Wyoming increased Medicaid rates to the 75th percentile of marketplace reimbursement. No results of that change are available at this time.

- In Delaware, each Medicaid dentist receives 85% of each billed charge. This payment mechanism is similar to the "reasonable and customary" payment mechanism used in commercial dental insurance.[10]

The following table shows the percent change in participation of dentists in these states' Medicaid programs in the months following implementation of the major fee increase (as of March 2005) .

State	Months After Major Fee Increase	Change in Medicaid Participating Dentists In Percent (%)
AL	**44**	**+ 117%**
DE	**48**	**From one private dentist to 34% (130/378) of state dentists.**
GA	**48**	**+ 825% (60% of state dentists participating)**
IN	**54**	**+ 58% (Level participation since 7/02)**
MI *Healthy Kids Dental*	**48**	**+ 300%**
SC	**42**	**+ 88%**
TN	**20**	**+ 81% (Urban recruiting suspended due to adequate network)**

These participation rates may fluctuate from month-to-month and year-to-year. In some cases, participation appears to be continuing to grow (e.g. Delaware and Tennessee), while in other states the initial rapid expansion of the Medicaid dental provider participant base is continuing to increase, albeit at a slower rate than experienced immediately after the fee increase. In Indiana, which experienced increased provider participation (and children's use of dental services) after the major fee increase, contraction of participation towards levels existing prior to the fee increase is occurring. This phenomon may be related to whether or not the reimbursement rate continues to reflect fees in the private sector.[11] A single major rate increase that fails to be followed by additional rate enhancements that take into account the annual increase in the dental consumer price index (CPI), will result, over time, in reimbursement levels that no longer reflect fees dentists charge in the private sector or commercial marketplace. For example,

[10] The term "reasonable and customary," when used in Medicaid programs, does not have the same meaning when used in commercial dental insurance. In the commercial dental benefits sector, the "usual customary and reasonable" concept (UCR) usually means that dentists submit claims reflecting their usual charges (fees) and are reimbursed up to a maximum rate determined by the carrier to be customarily charged by dentists in the area (customary fee). The "Medicaid UCR" rate usually refers to the establishment of reimbursement schedules based on mean (average) fees submitted by dentists for services provided to Medicaid enrollees in a prior fiscal year (as derived from the Medicaid claims data base). The rate, therefore, actually is less than the fees charged by roughly 50% of all dentists who submit Medicaid claims. If additional discounts are applied, as is often the case, the resulting Medicaid reimbursement rates will be substantially less than the 50th percentile of fees prevailing in the private sector. From: *Medicaid reimbursement—using marketplace principles to increase access to dental service*. Issue Brief. American Dental Association. 2004. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp.

[11] Hughes RJ et al. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: assessing the impact of increased fees and administrative changes. JADA 2005(136)517-23. Available at: http://www.ada.org/prof/resources/pubs/jada/index.asp.

a single major fee increase that occurred in 1994 will be worth 44% less in 2001, simply because of failure to account for changes in the CPI. In Indiana, no additional fee increases have been provided since its major fee increase in 1998.

The impact of a substantial fee increase and other Medicaid program changes on dental utilization in 37 Michigan counties has been reported. In 2000, the Michigan Medicaid program contracted with Delta Dental Plan of Michigan—a nonprofit service corporation that administers group dental benefits for more than 3 million people in the state—to provide the Medicaid dental benefit for children under age 21 who reside in those counties. Delta Dental manages the benefit, called *Healthy Kids Dental*, in accordance with their standard procedures, claim form, and payment rates and mechanisms.[12] An assessment of the first 12 months of the *Healthy Kids Dental* project found:[13]

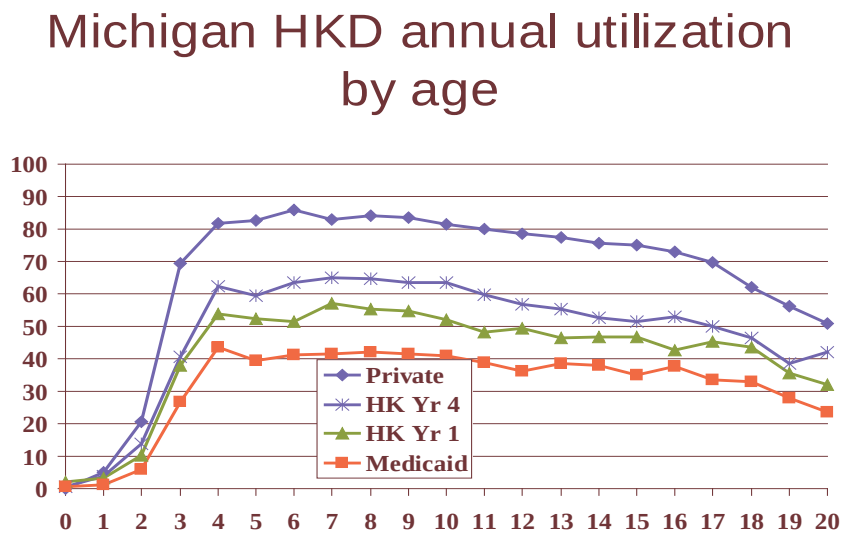
- More dentists are participating in *Healthy Kids Dental* and providing care (up 300%), compared to the traditional fee-for-service Medicaid program.
- Substantially more Medicaid beneficiaries were receiving dental care under the project, with dental visits increasing from 18% to 44% in comparison to the traditional fee-for-service Medicaid program (as measured using the CMS 416 methodology).
  - More children were receiving needed dental restorative and reparative care and were more likely to begin a pattern of regular recall for routine preventive care, compared with Medicaid-enrolled children the previous year.
  - Higher costs per user and per enrollee for *Healthy Kids Dental* resulted from the increased reimbursement rates and, to a lesser extent, to more children receiving care. The study predicted that the cost per user per year was likely to decline as the backlog in treatment need was eliminated.
  - More children were receiving care in their county of residence, rather than traveling long distances to receive care.

After four years of operation of the *Healthy Kids Dental* project, increases in dental utilization continue to be demonstrated, as shown in the following chart:[14]

[12] Michigan state summary. American Dental Association. State innovations to improve access to oral health care for low income children: A compendium Update. Chicago: American Dental Association: 2005. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp (Click Michigan on U.S. map).

[13] Eklund SA, Pittman JL, Clark SJ. Michigan Medicaid's Healthy Kids Dental program: an assessment of the first 12 months. JADA. 2003(134):1509-1515.

[14] Data provided by C Farrell, Michigan Department of Community Health. Data analysis provided by S Eklund, University of Michigan School of Dentistry. Personal Communication, 2005.



Using the HEDIS© method of calculating utilization (which differs from the CMS 416 method), *Healthy Kid Dental* children enrolled in the fourth year of the program achieved an average utilization rate of 58.6%, compared to a 38.9% rate for traditional Medicaid prior to the beginning of the program, and in comparison to an average rate of 54.3% for children in the program after only one year. The average rate for children enrolled in the private sector Delta Dental program was 79.4%.

The results from these studies (as well as results observed in SCHIP dental programs in which reimbursement attained levels prevailing in the private sector—see below), suggest that market-based purchasing—paying dentists at Medicaid rates that respect the economic realities of the dental market—is the *sine qua non* of effective improvement in access to Medicaid dental services.[15] This purchasing concept recognizes that the dental care system is overwhelmingly comprised of autonomous private offices in which dentists independently determine charges, payments, and participation in public and private insurance. Since dental offices typically are also small, there are few opportunities for cost shifting or accommodation of large numbers of fee-discounted patients. As demand for dental care begins to exceed supply, dentists' participation in low-fee programs is dampened further. These forces also help explain why managed care has been unable to expand into the dental environment in the same way as medicine.

While market-based rates will induce a significant proportion of available providers to participate, these rates do not necessarily have to be as high as the typical market rates incurred by self-paying or commercial insured patients. Dentists appear willing to accept modestly discounted fees when caring for Medicaid beneficiaries. The level of discount that is acceptable in a market is contingent upon dentist supply, overall demand for care,

[15] Edelstein B. Getting value for state dollars through market-based purchasing: analysis of state dental Medicaid payment reforms. Unpublished manuscript.

and social norms regarding commitment to vulnerable people. Demand is predicated upon the overall state of the economy and consumer confidence, as many consumers consider uninsured dental procedures to be elective. Social norms and commitment to the underserved vary across the states. For example, in North Dakota, which has a culture of inter-dependence, payments approximate the 50th percentile, and a substantial percentage of dentists are engaged in Medicaid; in other states, however, similar rates may not be expected to stimulate provider participation. Dentists' responses to discounted-fee program are also explained by two thresholds:

- Overhead Threshold: Dentists report overhead costs of 60-70% and regard programs that pay at lesser rates to be charitable care in which they contribute their expenses toward the beneficiaries' care.
- Discount Threshold: The experience of commercial dental preferred provider networks in heavily competitive markets indicated that some providers may accept fee discounts in the range of 15-20 percent off their usual fees. This method is being used by the Delaware Medicaid program.

B. Administrative Options and Reforms in State Medicaid Programs

Historically, Medicaid dental programs have used administrative processes that are much more complex than those found in private dental offices or private sector commercial dental benefit plans. Dentists often perceive these processes as onerous, burdensome, time consuming, or at wide variance from processes with which they are familiar. As a result, many states have sought to eradicate this perception through improvements in their handling of key administrative processes, with many states attempting to mirror private sector procedures. Some of these reforms—labeled "general administrative" reforms in the section that follows—may be implemented regardless of the way in which the state organizes and administers the overall dental program. Broader reform options for arranging dental services—such as whether or not the dental program is managed directly or contracted out, or, if contracted out, whether or not a single contractor or multiple vendors are used—are limited only by the creativity of Medicaid officials, the receptivity of the marketplace, and, in some cases, the approval of federal authorities.[16] Each of these organizational options may be viewed as having the potential for creating positive or negative consequences with respect to dental access, hence, a discussion of arguments for and against each option is offered in the "organizational" reform section below.

1. General Administrative Reforms.

Almost all states are addressing administrative barriers to dentist participation through one or more of the following efforts:[17]

- Many states are reducing or **eliminating prior authorization** requirements to which dentists must adhere before beginning children's dental services. Where states retain prior authorization—often for higher cost services—they are simplifying procedures,

[16] Connecticut Health Foundation. Ibid.
[17] Medicaid program administration: Issue Brief. American Dental Association. 2004. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp.

such as reducing documentation providers must transmit, or adding staff to review requests, in order to speed response time.

- To speed processing of dental transactions, all states have converted, or are in the process of converting from state-only procedure codes to the **use of standard reimbursement codes** (i.e., the ADA's Code on Dental Procedures and Nomenclature). This process has been accelerated under the Health Insurance Portability and Accountability Act (HIPAA) which requires that electronic claims transactions use a standardized format, i.e., ADA Codes. Most states also are moving towards use of the ADA's standard paper claim forms.
- States are **implementing electronic claims processing** and web-based claims transmission to reduce payment times. Some systems interface with electronic clearinghouses to speed payment, while others are able to accept electronic attachments (such as radiographic and intraoral photographic images). Some states can electronically scan paper claim forms into electronic versions, expediting processing and adjudication of claims. Others allow direct transfer of claims reimbursement to providers' financial accounts (i.e., direct electronic deposit). Providers almost always retain the option of submitting claims in paper format.
- States have been **streamlining provider enrollment** by reducing the complexity and length of Medicaid provider enrollment processes and forms that, in the past, may have deterred practitioners from even considering enrolling in Medicaid. States also are publishing their enrollment forms in state dental association journals or on the Internet, where providers may enroll online or directly update their enrollment information.
- States are **simplifying beneficiary enrollment verification**, enabling providers to obtain prompt, continuous access to accurate information, through:
    - **Automated Voice Response Systems**, which provide toll-free telephone connectivity without a "live" operator and are available at any time of day or night, every day of the year.
    - **Beneficiary membership cards** modeled after private insurance identification, including using "swipe card readers" (also known as "point-of-service devices" or "terminals") that are installed in providers' offices to read eligibility information imbedded in the magnetic stripe on the membership card. Although these devices may be available 'at cost' to the provider—the expense may still be deemed to be substantial, and thus a potential deterrent to provider enrollment, especially for dentists with small numbers of Medicaid clients.
    - **Computer software** installed at the provider's office that links providers through a modem to enrollment databases and, in a few states, Internet sites through which program information that may be accessed.

2. Organizational Reforms

This section discusses four decisions that states may face as they consider broad options for organizing and delivering dental services in Medicaid programs for children.[18]

[18] This section is derived substantially from the Connecticut Health Foundation. Ibid

- *Decision 1. Whether or not to retain the dental program in-house or contract out.*

Proponents of contracting-out suggest that the corporate culture of dental insurers is better suited to successful program management than the culture of state bureaucracies. Outsourcing, they believe, dispels dentists' antipathy and frustration with state-administered Medicaid. Proponents also cite such advantages to beneficiaries as: improved customer service, integration of health and enabling services, and recourse to assistance in obtaining care. Providers perceive advantages that include streamlined claims processing, the potential to negotiate fees and have steadier cash flow. If the contactor is a managed care plan, some proponents believe that it holds promise to utilize protocols and guidelines that may enhance care quality while controlling costs (See section on Effective Program Oversight below).

Critics of Medicaid contracting, however, view this option as inherently flawed. They perceive contracting as containing a perverse incentive related to inadequate financing; that is, it includes an incentive to minimize service delivery in order to maximize profits. Opponents also point out that states lose control of the program, but retain responsibility for Medicaid requirements that are not explicitly contracted. If dental services are subcontracted by a *medical* managed care vendor that is otherwise performing well, poor performance by dental vendors may be difficult to redress, especially if enforceable sanctions are *not* included in the contracts—or if a state's capacity and political will is not sufficient to enforce those sanctions. Even where effective sanctions exist, the costs of redressing poor performance may be greater than the savings generated through sanction enforcement, particularly if legal action is necessary. Furthermore, dental Medicaid programs frequently are regarded as too small to warrant intensive oversight. The greatest criticism expressed about outsourcing, however, is this: Outsourcing shifts some Medicaid funds to vendor profits rather than client services—profits that may be in excess of savings generated by privatization.

- *Decision 2: Whether or Not to Carve-out Dental Services*

While almost every state has contracted some part of its Medicaid program to managed care, as of May 2005, 33 states have carved-out dental programs and retained them under state management.[19] The remaining 17 states and the District of Columbia contract for dental services. Only a few of these 18 governments currently exclude dental services from medical vendors' responsibility and contract exclusively with dental vendors.

When states carve-out programs either at the state or the medical vendor levels, they are able to select the dental contractors, establish the terms and conditions of program

[19] In 2003, the Connecticut Health Foundation's *Understanding the Connecticut dental Medicaid reform proposal: State options in contracting dental care in Medicaid*, noted that 27 states had carved dental care out of managed care. In 2004, the ADA's *Medicaid program administration: Issue Brief*, indicated that 31 states plus the District of Columbia had carved out dental services. Since 2004, Oklahoma has discontinued its managed care dental program and, in July 2005, Virginia also is scheduled to end its dental managed care component. At least two states which currently operate in-house programs may be considering contracting-out dental services to managed care plans in 2006.

delivery, establish clear and enforceable incentives and sanctions, and directly access information on program performance. As a result, this option holds promise for enhanced program accountability. This approach also reflects differences between medical and dental care, including different provider types, delivery systems, and financing norms.

When identifying a suitable contractor, a state can carefully assess whether or not the vendor's existing provider network is of sufficient size and breadth. It can also explore how the providers are distributed, how actively providers participate, and if there is a network in the state. If the dental vendor has no network for a Medicaid contract, the state and other interested parties can closely examine the vendor's commercial experience or performance in other states. Similarly, the state can exercise due diligence when examining a vendor's past claims-administration performance as well as dentists' and beneficiaries' satisfaction.

Proponents of dental carve-outs point out several elements that may enhance access:

- accessing ready-made provider networks;
- encouraging participation of community health centers;
- contracting for case management strategies (e.g. clinical protocols, risk assessment, and disease management guidelines);
- contracting for care integration between primary and specialty dentists;
- empowering vendors to implement their own access initiatives (e.g. case managers, school-linked services, and private dentist contracting to health centers); and allowing dentists to negotiate terms of participation.

Critics of carving-out dental care argue that states will shoulder the additional cost and responsibility of managing separate contracts for a very small component of the larger Medicaid program, typically less than 5%. This is the primary disadvantage of the carve-out option.

- *Decision 3: Whether or Not to Assign Financial Risk to the Vendor*

As care utilization increases, so, too, do program costs. States may attempt to guard against this by contracting with managed care vendors at a *specified* payment for each covered beneficiary. In so doing, states prospectively establish their dental program cost *and* put their vendors at financial risk, should utilization exceed anticipated levels. Among the states that contract for dental services, all but two assign some level of financial risk to their vendors.

Fixed rate contracting puts the vendor at financial risk because it caps the total dollars available for claims, program administration, and profit. Because Medicaid is an individual entitlement, neither states nor vendors can deny care when funds are depleted.

Dental managed care vendors have addressed this potential financial liability in a number of ways. Some will not accept full-risk contracts. Some have attempted, with notably little success, to pass risk onto dentists through capitation arrangements. One multi-state

dental Medicaid vendor utilizes a "global" approach--it pays itself first, and then prorates any remaining funds across providers to reflect the volume of claims. All utilize re-insurance to protect against "adverse utilization."

According to opponents, assigning full financial risk eliminates any incentive for increased utilization, an inherent problem. Proponents, on the other hand, claim that improved provider networks and greater efficiency warrant vendor profitability. Proponents also maintain that the onus is on the state to ensure performance through strong and enforceable contract sanctions. Failure to do so is evident in a Maryland program where legislated increases in dental funding reportedly increased payments to vendors, not providers, thereby increasing vendor profits without increasing service to beneficiaries.

- *Decision 4: A Single-Vendor or Multiple-Vendor Program*

Proponents of multiple-vendor programs believe multiple vendors stimulate competition and, therefore, better customer and provider service because both groups will seek out the best plans. Proponents also maintain that vendor competition generates true market rates, if there is sufficient state funding in the program. In those states where multiple vendors failed to develop sufficient networks to meet the needs of beneficiaries, the states did not provide sufficient funding to reflect market conditions. Advantages of inter-plan competition include opportunities for performance comparison across plans, emergence and identification of "best practices," and stimulus for plans to provide the best possible service.

On the other hand, opponents of multiple-vendor arrangements assert that beneficiaries are confused by multiple options. They suggest that dental providers are not sufficiently interested in Medicaid to negotiate multiple contracts, tolerate multiple credentialing procedures, or institute multiple claims-management procedures in their offices. Opponents cite the increased difficulty and cost for states to oversee multiple vendors.

According to proponents of single-vendor arrangements, these problems are eliminated when states contract with only one vendor and engage only the "best" vendor by carefully assessing solicited proposals. Single-vendor advocates also note that commercial dental plans with large provider networks are more likely to bid on Medicaid contracts only if the population to be covered is large enough to allow for efficiency. The primary disadvantage of single-vendor contracting is dependence on one source.

C. Coordination of Care for Beneficiaries

Failure to effectively link children and their families to Medicaid oral health services has been cited as being largely responsible for high rates of missed dental appointments by beneficiaries, lack of adherence to oral health instruction, and failure of clients to follow-up for needed preventive and treatment services.[20] Improving coordination of care

[20] Enhancing dental Medicaid outreach and care coordination: Issue Brief. American Dental Association. 2004. Available at: http://www.ada.org/prof/resources/topics/medicaid_reports.asp

recognizes that making care available is often not enough to link high-risk and high-needs children to the care they need.[21] An array of strategies and related activities are being tested by states seeking to better coordinate care, engage client families in oral health awareness and encourage families to use services that meet their children's unique needs.[22] The strategies include:

- **Enhancing consumer outreach** during client application and enrollment periods to provide information that explain dental benefits and available resources that may aid people with language or cultural barriers to better navigate a complex health bureaucracy.
- Providing beneficiaries with assistance in **locating participating dentists** that are accepting new patients.
- **Encouraging physicians,** primary care and other trained health professionals to conduct oral assessments and routinely refer children to dental providers.
- Focusing specifically on ways to **reduce missed appointments** through, for example, patient counseling about dental office etiquette and procedures, and by making available toll-free numbers and staff to assist clients in completing appointments.
- **Using administrative case management programs** in which trained care coordinators help beneficiaries to find a dentist, provide client outreach and education, and arrange assistance such as translation, transportation and other community support services that better the chance that the child will receive services, and
- Emphasizing ways to **improve access to care for preschool children** by, for example, creating programs specific to young children and establishing better links between programs for pregnant women and the oral health of their children.

D. Effective Program Oversight

Development of effective, data-driven systems are absolutely essential in defining priorities, enhancing accountability and continuously improving performance in Medicaid dental programs.[23] The ability to track key processes (e.g., the use of dental services following periodic assessments and referrals by primary care providers) are indispensable for evaluating performance of public programs and private contractors, and also can help in assuring better health outcomes. Conceptually, development of effective oversight systems is straightforward—policy makers need to know:

- The magnitude and scope of oral health problems among beneficiaries
- Where progress is being made and where persistent problems require innovative approaches
- Whether public expenditures are being use effectively, and
- What needs to be done to improve program performance, and, ultimately, the oral health of program beneficiaries.

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[21] Crall JJ,,Edelstein BL. Elements of effective action to improve oral health and access to dental care for Connecticut's children and families. Connecticut Health Foundation and Children's Fund of Connecticut. 2001. Available at: http://www.cthealth.org/matriarch/MultiPiecePage.asp?PageID=150&PageName=2001reports.

[22] Enhancing dental Medicaid outreach and care coordination: Issue Brief. Ibid

[23] Crall JJ,,Edelstein BL. 2001. Ibid.

Unfortunately, collection of some of the data that Medicaid agencies need for this system—such as information about client health status—has traditionally been within the primary purview of the state health department, which, at least in part, often is administered and operated independently of the Medicaid agency. Since resources for mounting periodic surveys of oral health status often are very limited and general surveys conducted by health agencies may not focus specifically on Medicaid beneficiaries, it is usually necessary, if oral health outcome measurement of Medicaid beneficiaries is to occur, for Medicaid agencies and state health departments to collaborate in resource allocation and program planning.

Obtaining other data necessary for program oversight is well within the Medicaid agency's core set of responsibilities. In some states, measurement of performance of the dental program historically has been based on a single rudimentary measure—the number of enrolled children receiving a dental service in a fiscal year. This measure—captured in the federally mandated Form-416 Report[24]—is a crude indicator of whether enrolled children had any contact with the dental care delivery system. In 1998, the measure was enhanced somewhat to include data on the number of enrolled children who not only received any annual dental services, but also on those who received a preventive service and any treatment for disease or dental abnormality. While an improvement over the prior measure, the enhanced indicators fall far short of providing information as to whether children's needs are being adequately met through existing programs. It is perhaps surprising, then, that an Expert Panel of the National Committee on Quality Assurance (NCQA) recommended, in 2001, an expanded version of the Form-416 measures for immediate incorporation into the HEDIS© quality reporting system (that inclusion ultimately did not occur).[25] Although several new measures also were proposed—and may be useful in Colorado's Medicaid program, the Panel's work highlights the reality that existing performance measures for pediatric oral health care are extremely limited.[26]

Despite shortcomings of Form-416 measures, states may use them in tracking dental utilization rates over time and observing variation in rates by preventive and treatment service categories. These variability observations can become a starting point for continuous quality improvement programs and other program oversight activities. Additionally, increasing submission of electronic claims by providers and other enhancements in administrative data sets have made such sets more reliable and powerful for use in measuring variation. States can now drill down into their data sets to observe variability over a wide range of individual data elements (e.g., by individual provider, specific service, expenditures, geography, etc.). This ability suggests that post-utilization review may become a more valuable tool in performance monitoring, substantially replacing prior authorization in many instances.

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[24] Medicaid and EPSDT. Centers for Medicare and Medicaid Services. Available at: http://www.cms.hhs.gov/medicaid/epsdt/default.asp?

[25] Currently, only one dental performance measure, the "annual dental visit," is included in the Medicaid (only) version of HEDIS© 2005. Available at: http://www.ncqa.org/Programs/HEDIS/HEDIS%202005%20Info.htm.

[26] Crall JJ, Szlyk CI, Schneider DA. Pediatric oral health performance measures: current capabilities and future directions. J Pub Health Dentistry. 1999(59):136-41.

Despite challenges, to facilitate meaningful program assessment and quality improvement, a concerted effort must be made to develop reliable data and reporting systems.

III. Medicaid and SCHIP Dental Benefit Design

1. Medicaid/EPSDT Dental Benefits

As noted earlier, under the provisions of the EPSDT benefit, children must receive a comprehensive array of dental services. These services must be provided, as stated in Section 1905(r)(3)(A) of the Social Security Act: "(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." By and large, states attempt to abide by the broad service requirements inherent in the Medicaid standard of "medical necessity" and offer a wide array of dental services in the EPSDT benefit package. Under "medical necessity" requirements, states may conclude that some dental conditions are not medically necessary since, for example, they are cosmetic and may not be reimbursed under Medicaid (e.g., minor occlusal discrepancies in the adult dentition), experimental, or investigational, or they are not efficacious in relation to the "state-of-the-science" (e.g., use of silicate restorations).

In reality, however, most states also place "temporary limits" on dental conditions and services that may serve to restrict utilization of specific services, thereby avoiding state expenditures for these services. As is quickly apparent from any review of state Medicaid dental provider manuals, most states have incorporated into their benefit package many categories of limitations, including, for example, limits based on the child's age; type of tooth (permanent or deciduous); tooth surface; frequency that a service may be provided (daily, monthly, yearly or lifetime); and dental materials and devices that may or may not be used. Often, it is not clear if these limits were developed after consultation with recognized dental organizations, meet reasonable standards of dental practice, or encroach on other Medicaid prohibitions, such being arbitrary applied and failing to provide for individualized assessment of service need. The degree to which states are in non-compliance with Medicaid's medical necessity provisions is unclear, but a substantial number of disputes about states' failure to provide required dental services occurred and have been litigated.[27]

Additional barriers to the delivery of medically necessary service may arise from over use of prior authorization requirements—especially if the state's response time to provider requests is slow and burdensome for providers. An additional technique that may curtail services (and perhaps the most insidious) occurs when states simply omit from their dental fee schedules the reimbursable amount for a coded dental service, while

[27] Docket of Medicaid cases filed to improve dental access. National Health Law Project. October 19, 2001. Available at: http://www.healthlaw.org/library.cfm?fa=download&resourceID=63861&appView=folder&folderID=43166&print

failing to advise providers that the service indeed may be reimbursed if specifically requested by the dentist.

Colorado's Medical Assistance dental program relies substantially on the use of prior authorization for confirmation on medical necessity (more than 150 pediatric dental codes require prior authorization). To a lesser degree Colorado Medical Assistance uses other limit categories such as frequency limits (e.g. only five crowns permitted in a single dental office visit) or tooth limits (e.g., sealants only for permanent molars).[28]

Under current Medicaid regulations, it should be noted, patient cost-sharing for children under age 21 is not permitted.

2. SCHIP Dental Benefits and Lessons Learned

(a) SCHIP Dental Benefits

In contrast, under the Title XXI program, dental benefits are optional at the state's discretion (but, if the state elects to provide dental benefits, preventive services may not incur patient cost-sharing).[29] Despite this purely optional status, only two states, Texas and Delaware, do not currently include an SCHIP dental benefit (although it is likely that Texas will reinstate its SCHIP dental benefit in 2005[30]). As is the case with their overall programs, states have SCHIP dental programs that expand Medicaid eligibility, have elected to create separate, non-Medicaid programs and have combined an expansion of Medicaid with a separate SCHIP program for eligible children of higher income families. While some states have also developed SCHIP premium assistance programs, these rarely have included dental benefits.

Except if the case where the state elects to use its SCHIP funding to expand Medicaid eligibility, the Medicaid definition of medical necessity does not apply to SCHIP. As a result, the dental benefits that states have constructed vary widely.

(b) Lessons Learned from SCHIP

Near-poor children are 2.6 times more likely to be uninsured for dental care than for medical care.[31] The broad range of SCHIP dental programs now in operation across the nation offer multiple opportunities to assess how different program constructs might address dental coverage issues and shed light on mechanisms that enhance access for this

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[28] Colorado Title XIX Medical Assistance Bulletin. Dental Program Updates and Revisions. December 2004.

[29] Sec.42 CFR 457.520 Cost sharing for well-baby and well-child care. Code of Federal Regulations. Oct 1, 2001. Available at http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=457&SECTION=520&YEAR=2001&TYPE=TEXT

[30] Request for proposals. Children's Health Insurance Program, Dental Insurance Services. May 16, 2005. Available at: http://www.hhsc.state.tx.us/Contract/52905138/rfp_home.html

[31] Vargas, CM, Isman RE, Crall JJ. Comparison of children's medical and dental insurance coverage by sociodemographic characteristics, United States, 1995. J. Pub Health Dent. 2002 Winter;62(1):38-44

population. Although relatively few studies of dental care components of SCHIP have been published, most conclude that access to dental care has improved. In Pennsylvania, after 12 months of SCHIP enrollment, the proportion of children with a regular source of dental care increased 41%, while the proportion that had a preventive dental visit increased 50%. Unmet need and delayed dental care fell from 43% to 10%.[32] After one year of SCHIP enrollment in Iowa, parents of beneficiaries reported that access to and utilization of dental services improved for all ages studied, but 1 in 6 adolescents still had unmet need or delayed dental care.[33] Similarly, an assessment of SCHIP's affect on access to care in five states (California, Connecticut, Maryland, Missouri and Utah) found that access to dental (and mental health) services for adolescents were seriously affected by limited provider participation.[34]

In a survey of parents of New York State enrollees, conducted pre- and one year post-enrollment in SCHIP, a 13% reduction in unmet need for dental care was reported.[35] A study of Colorado's SCHIP produced surprising findings: after one year enrollment, families reported a decrease in unmet dental needs, despite the fact that Colorado had no SCHIP dental benefit during the period studied. The report speculates that, as a result of coverage of other health needs by the SCHIP program, families had more of their own financial assets available for purchasing dental care.[36]

While each of these reports provides reason for optimism, few lessons have been provided for Medicaid dental program operation, or for understanding the mechanisms behind the successful outcome. Three reports, however, have begun to address this need. A 2001 report by the Urban Institute[37] suggests, for example, that improvements in dental utilization and provider participation may be occurring in separate SCHIP programs that pay dental providers at market rates, as compared to Medicaid. Although states tend to use general managed care in their SCHIP programs to a greater degree than is typical in Medicaid, subcontracting results most children receiving care from a dental benefits provider. Whether services were offered through a general managed care or a dental plan, it was reported that individual dentists were paid on a fee for-service basis. Plans were also taking steps to avoid the administrative barriers that undermine support for Medicaid from the provider community. Lastly, the report concludes that widespread improvement in oral health of low-income children will occur only if the improvements seen in some separate SCHIP programs also occur in Medicaid.

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[32] Lave JR, Keane CR, Lin CJ, Ricci EM. The impact of dental benefits on the utilization of dental services by low income children in western Pennsylvania. Pediat Dent. 2002 May-Jun;(24(3):234-40.
[33] McBroome K, Damiano PC, Willard JC. Impact of Iowa S-SCHIP program on access to dental care for adolescents.
[34] Fox HB McManus MA, Limb SJ. J. Adolesc Health. 2003 Jun;32(6 Suppl);40-52.
[35] Szilagyi PG, et al. Improved access and quality of care after enrollment in the New York State Children's Health Insurance Program (SCHIP). Pediatrics. 2004 May;113(5)e365-404.
[36] Kempe A, et al. Changes in access, utilization, and quality of care after enrollment into a state child health insurance plan. Pediatrics 2005;115;364-71.
[37] Almeida R, Hill I, Kenney G. Does SCHIP spell better dental care access for children? An early look at new initiative. Occasional paper number 50. The Urban Institute. Jul 2001. Available at: http://www.urban.org/urlprint.cfm?ID=7375.

A second study looked at the separate SCHIP program in North Carolina (that is administered by a single commercial contractor) and found that the percentage of children with a visit to the dentist increased from 48% to 65% one year after enrollment in the program, with many parents reporting that private dentists were serving as the children's usual source of care. In contrast, only 20% of state dentists see more than 40 or more Medicaid children. The report concludes that SCHIP dental models that resemble private insurance and reimburse dentists at market rates hold the potential to address problems associated with dental access for low-income children.[38] Lastly, investigators studied a Medicaid and Medicaid-expansion SCHIP dental program in Indiana. They conclude that a dental fee increase in 1998 to 100% of the 75th percentile of commercial fees (along with administrative changes that included contracting the program to a single dental benefits provider) resulted in an increase in the number of dentists seeing a Medicaid child and an increase in the percentage of children receiving any dental visit from 18% to 32%. The study also notes that there was relatively little difference in utilization rates among children in the traditional Medicaid program and more affluent children enrolled in the Medicaid SCHIP expansion. Dentists did not appear to be preferentially allowing children enrolled in the Medicaid expansion SCHIP into their practices at the expense of lower income Medicaid patients.[39]

[38] Mofidi M, Slifkin R, Freeman V, Silberman P. The impact of a state children's health insurance program on access to dental care. JADA 2002 Jun:133;707-14.
[39] Hughes RJ et al. Ibid.

Appendix C: AAPD Model Dental Benefits Statement

American Academy of Pediatric Dentistry
Dental Care Committee

Scope of Dental and Oral Health Care Benefits for Infants, Children, Adolescents, and Young Adults Through Age 21 Years

ABSTRACT: The optimal oral health of children can best be achieved by providing access to comprehensive dental and oral health care benefits. These services should be delivered by appropriately trained pediatric care providers, including primary dental care providers and specialists. This policy statement by the American Academy of Pediatric Dentistry is intended to complement similar policy statements concerning general pediatric health which have been issued by the American Academy of Pediatrics and provide supplementary information for dental and oral health care.

All infants, children, adolescents, and young adult patients through age 21 must have access to comprehensive dental and oral health care benefits that will contribute to their optimal health and well-being. The following services should be included in the health benefit plans offered by all private and public insurers. These services should be delivered by appropriately trained pediatric care providers, including primary dental care providers and specialists. These services should be delivered in a variety of appropriate settings, and coordinated through the child's primary dental care provider. The care also should be delivered and the benefits administered in an efficient manner that does not compromise the quality of care. **Services and benefits should include but are not limited to all of the following:**

Benefits and Coverage

a. Basic obligation – For enrollees under age 21, the dental and oral health services described in this section in accordance with professionally accepted standards of dental and oral health practice and applicable standards set forth in the *American Academy of Pediatric Dentistry Reference Manual*[1]*; Guide to Clinical Preventive Services*[2]*; Workshop on Guidelines for Sealant Use: Recommendations*[3]*; a*nd *Bright Futures in Practice: Oral Health.*[4]

b. Preventive services:

(1) Education for the enrollee and, for younger children, the enrollee's family or caregiver on measures to promote the enrollee's dental and oral health and prevent dental and oral disease which shall be furnished by primary care practitioners as

[1] American Academy of Pediatric Dentistry Reference Manual, Chicago, IL: American Academy of Pediatric Dentistry.

part of initial and periodic well-child assessments and by dentists and other dental professionals as part of dental and oral health examinations;

(2) In the case of enrollees from birth until age three, oral screening by primary care practitioners which shall be furnished as part of initial and periodic well-child assessments, and dentists as part of initial and periodic examinations of the teeth and oral cavity and other dental and oral health services;

(3) Initial and periodic examinations of the teeth and oral cavity by dentists which shall include a medical and dental history to determine the presence of oral and dental health risk factors; and which shall be furnished in accordance with the dental periodicity schedule in the *American Academy of Pediatric Dentistry Reference Manual*[1] or when an oral screening indicates a risk of caries or other dental or oral disease;

(4) Fluoride therapies which shall include the following:

(A) Application of topical fluoride which shall be furnished at least annually and more frequently when medically indicated in the opinion of the enrollee's treating dental professional; and

(B) In the case of enrollees ages six months to sixteen years residing in an area with an inadequately fluoridated water supply, dietary fluoride supplements prescribed by a primary care practitioner or dentist in accordance with current policy recommendations of the American Dental Association, [2] and the American Academy of Pediatrics (AAP).;[3]

(5) In the case of children at risk for caries in pits and fissures of the teeth because of tooth morphology or other risk factors identified by an assessment, application of dental sealants;

(6) Dental prophylactic services which shall be furnished at least annually and more frequently when medically indicated in the opinion of the enrollee's treating dental professional;

(7) Space maintainers.

c. Diagnostic, treatment and restorative services to relieve pain, resolve infection, restore teeth and maintain dental function and oral health, which shall be furnished in accordance with accepted standards of practice by dentists and other dental professionals acting within the scope of state law:

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[2] U.S. Preventive Services Task Force Guide to Clinical Preventive Services, 2nd ed., International Medical Publishing, 1996. New Fluoride Guidelines Proposed. J Am Dent Assoc 1994: 125:366.
[3] Workshop on Guidelines for Sealant Use: Recommendations. J Pub Health Dent 1995; 55:263-273..

(1) Radiographs in accordance with recommendations of the U.S. Food and Drug Administration[4] and the American Dental Association;[5]

(2) Other diagnostic procedures as are medically indicated in the opinion of the treating dental professional;

(3) Restorative services (fillings and pre-formed crowns) including restoration for permanent teeth and for primary teeth not nearing exfoliation;

(4) Orthodontic services which shall include services for enrollees diagnosed with severe malocclusion, and for enrollees following repair of cleft palate; and for enrollees with other congenital or developmental defects or injury resulting in mal-alignment or severe malocclusion of teeth;

(5) Endodontic services including root canal therapy and/or apicoectomy and apexification;

(6) Dental and oral surgery which shall include anesthesia and adjunctive services and which shall be furnished on an inpatient basis when medically necessary;

(7) Periodontic services;

(8) Prosthodontic services;

(9) Drugs prescribed (A) for relief of pain associated with dental or oral disease, condition or injury and (B) in conjunction with services described in this subsection;

(10) Medically necessary adjunctive services that directly support the delivery of dental procedures which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities.

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[4] Casamassimo P. 1996. Bright Futures in Practice: Oral Health. Arlington, VA: National Center for Education in Maternal and Child Health.
The Selection of Patients for X-Ray Examination: Dental Radiographic Examinations. Rockville, Md.: Food and Drug Administration, 1998; HHS Publication Number 88-8273.

[5] Council on Dental Materials, Instruments and Equipment. Recommendations in Radiographic Practices: An Update, 1988. J Amer Dent Assoc 1989 118:115-117.

Increasing Access to Dental Care Through Public/Private Partnerships:

Contracting Between Private Dentists and Federally Qualified Health Centers

A Handbook

Developed for the Connecticut Health Foundation

By Burton L. Edelstein, D.D.S., M.P.H., of the
Children's Dental Health Project

September 2003

Connecticut Health
Foundation

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9/10/03

Leo Canty, Chair Board of Directors
Patricia Baker, President
Connecticut Health Foundation
270 Farmington Avenue, Suite 357
Farmington, Connecticut 06032

Dear Mr. Canty and Ms. Baker:

On behalf of the American Dental Association, I congratulate the Connecticut Health Foundation for recognizing the important role that private contracting between private sector dentists and Community Health Centers can play in ensuring that CHC patients are provided with cost-effective, high quality oral health care services. ADA policy supports increased private contracting and the Handbook developed by the Children's Dental Health Project for the Connecticut Health Foundation is an important step in furthering this policy.

The ADA welcomes the introduction of the Handbook. It will be a valuable tool for both dentists and Community Health Centers to understand how to encourage contracts between private dentists and health centers.

The ADA is mindful of the numerous, state-specific issues which must be addressed in these contracts and that dentists and health centers need to carefully review with their attorneys both their individual needs and state law requirements. Nevertheless, the Handbook highlights some key issues, which will need to be addressed in order to improve access to dental care through increased private contracting between Community Health Centers and private sector dentists.

Again, congratulations and thanks for your efforts.

Sincerely,

T. Howard Jones DMD

T. Howard Jones, DMD
President

cc: Dr. Burton Edelstein, founding director, Children's Dental Health Project

National Association of
Community Health Centers, Inc.

Mr. Leo Canty, Chair, Board of Directors
Ms. Patricia Baker, President
Connecticut Health Foundation
270 Farmington Avenue, Suite 357
Farmington, CT 06032

September 2003

Dear Leo and Patricia,

On behalf of health centers all across the country and the 12 million Americans who rely on them for health care, I am pleased to offer our strong support for "Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers," a handbook developed for the Connecticut Health Foundation by the Children's Dental Project. We very much appreciate the efforts of the Children's Dental Health Project to involve NACHC and our legal counsel in the development of the Handbook. We hope that the use of this publication will contribute to expanded access to dental health care services for poor, uninsured and underserved individuals across the country.

This publication, including the model contract, reflects the extensive review and input by our staff and legal counsel; in our view, it thoroughly and accurately conforms to current statutory and regulatory requirements for federally-supported health centers. NACHC believes that the establishment of contractual arrangements for oral health care services represents a viable option for many health centers that wish to establish or expand their oral health service capacity. As such, we believe the Handbook is and will be an indispensable aid to health centers interested in that option and we strongly support its being made available to every health center across the country.

Once again, thank you for the opportunity to work with your foundation and the Children's Dental Health Project on this important project.

Sincerely,

Daniel R. Hawkins, Jr.
Vice-President for Federal, State, and Public Affairs

cc: Burton L. Edelstein, D.D.S., M.P.H., Anne De Biasi, MHA, Children's Dental Health Project

PARTNERSHIPS

Introduction

The Connecticut Health Foundation (CHF) vigorously supports the goal of improving equity in access to dental care. As part of a multi-stage strategy to improve access, the Foundation commissioned the Children's Dental Health Project (CDHP) to investigate strategies to improve access to dental services for underserved populations. One such strategy of wide interest and potential application involves establishing contractual arrangements between Federally Qualified Health Centers (FQHCs) and "FQHC Look Alikes" (both herein referenced as "FQHCs" or "health centers")[1] and private-practice dentists ("dentists")[2] for the purpose of providing dental services to health center patients, either in the dentists' private offices or in designated areas within health center facilities.

PARTNERSHIPS

There are many advantages to both the dentist and health center when they contract to provide care to FQHC patients. Dentists can provide services to Medicaid patients without necessarily registering as Medicaid providers[3]; are relieved of most responsibility to bill FQHC patients or their insurers[4]; can predetermine blocks of time, numbers of patients, or numbers of visits they wish to provide for care of the underserved; and can answer the needs of those in their community who have the most need and least access to care. For health centers, contracting allows them to meet their requirement that they provide dental services to their patients, reduce their need for expensive capitalization of dental facilities and equipment, reduce their direct staff costs, expand the number of available dental providers, reduce the length of waiting times for patients to receive services and may help make dental service costs more predictable.

...answer the needs of those in their community who have the most need and least access to care.

Most FQHCs have experience entering contractual agreements with private providers to increase their capacity to provide specific medical services to health center patients. For example, some contract with obstetricians to increase their capacity for prenatal care. To date, however, this approach has not been widely explored in the area of dental services.

Contracting for dental services in a comparable way is an approach that is not only permitted by federal regulators, but also endorsed and promoted in concept by national organizations such as the American Dental Association (ADA) and the National Association of Community Health Centers (NACHC) that represent the interests of dentists and health centers.

As FQHCs are subject to a myriad of federal laws, regulations, and policies, the primary sources of information in this Handbook are the rules, regulations, and policies of the U.S. Department of Health and Human Services (DHHS) and, in particular, the Bureau of Primary Health Care (BPHC), located within the Health Resources and Services Administration (HRSA)[5]. BPHC is the agency responsible for administering the

PARTNERSHIPS

FQHC program and the "Section 330" grant funds that support them. Officials from HRSA and from the Centers for Medicare and Medicaid Services (CMS)[6] provided invaluable assistance to this project regarding federal requirements on health centers. Every effort was made to create a Handbook that balances the interests of both dentists and health centers.

Currently, there exists little, and sometimes seemingly contradictory, regulation and guidance on how FQHCs can contract with private providers. As a result, there is controversy and inconsistency among regional federal offices about this practice. In the absence of comprehensive official policy, this document reflects the best available information and answers many essential implementation questions. This Handbook explains the contracting opportunities available and the process to engage in these opportunities. It also provides dentists and health center administrators with a step-by-step decision chart for establishing and implementing contractual arrangements that meet current federal rules and policy. A companion document, a model "Dental Services Agreement" between private dentists and health centers, is intended to facilitate this process further.

...a Handbook that balances the interests of both dentists and health centers.

This Handbook and the model contract reflect information gained from federal authorities, the ADA's Council on Governmental Affairs staff, and dentists and health centers that support this practice. We acknowledge legal contributions, guidance, and review from the Connecticut Appleseed Center for Law and Justice, Inc., and NACHC's attorneys, the firm of Feldesman Tucker Leifer Fidell LLP in Washington, D.C.

These documents are intended as guidance, based on federal law and policy, for those dentists and centers desiring to pursue the opportunities described herein. Prior to entering into any contractual arrangements, both parties should consult with legal counsel to determine the nature of the relationship best suited to them and review all legal documents for compliance with all current federal, state, and local laws and regulations.

PARTNERSHIPS

Getting Started

1. REQUIREMENTS TO PROVIDE DENTAL SERVICES AND AUTHORITY TO CONTRACT

All FQHCs are required by the Section 330 grant program to provide "primary health services," which are defined in the statute to include "preventive dental services" [42 U.S.C. §254b(a)(1) and §254 (b)(1)(A)(i)(III)(hh)]. "Preventive dental services" are further defined by regulation [42 C.F.R. §51c.102(h)(6)] to include "services provided by a licensed dentist or other qualified personnel, including:

- oral hygiene instruction;
- oral prophylaxis, as necessary;
- topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply."

Further, FQHCs can obtain federal approval to provide "supplemental health services" which can include "dental services other than those provided as primary health services" [42 C.F.R. §51c.102(j)(6)]. Centers may be required to provide additional oral health services pursuant to their participation in a federal oral health initiative or receipt of supplemental grant funding to expand the range and type of dental services available (see Section 3 below).

Once a health center includes certain services as part of its *Scope of Project* (see Section 2 below), it is obligated to offer such care to all residents of its service area, including those persons who are publicly or privately insured and those who are uninsured, regardless of ability to pay or payor source.

Each health center is required to establish a fee schedule for its services that is consistent with locally prevailing rates and reflects the health center's reasonable costs of providing services. Centers also must establish a schedule of discounts, based on patient income, which are utilized for underinsured and uninsured patients when these patients incur out-of-pocket costs.

EACH HEALTH CENTER IS REQUIRED TO ESTABLISH A FEE SCHEDULE FOR ITS SERVICES THAT IS CONSISTENT WITH LOCALLY PREVAILING RATES.

An FQHC that does not have sufficient internal capacity to provide directly the required and, as necessary, additional health care services included within its *Scope of Project* (including preventive dental services) to all patients served by the health center, is expected to contract with community providers to ensure sufficient service availability for its patients. Under such circumstances,

- the FQHC operates as the licensed billing provider of services;
- all patients served by the contracted provider are the FQHC's patients; and
- the FQHC assumes full financial risk for the services provided.

Further, the FQHC must ensure that all of its patients have access to the contracted services, regardless of individuals' ability to pay or their payor source. Each of these elements is addressed below.

2. OBTAINING AUTHORITY TO PROVIDE DENTAL SERVICES: *SCOPE OF PROJECT*

FQHCs define their *Scope of Project* in two ways. First, the FQHC defines its scope as part of its original Section 330 grant application (or its initial application for supplemental expansion funds), by designating whether it intends to provide certain services directly, through contract, or by referral (for which the health center may or may not pay the referral provider). Second, once a health center's scope has been approved by BPHC, it can request a change in its scope to either add or delete specified sites or services in accordance with BPHC Policy Information Notice #2002-07, provided that the health center does not request any additional federal funds to implement the change. This request can be submitted at any time, but must be submitted separate from the health center's continuation grant. If, however, additional federal funds are needed to implement the change, a request for additional grant funds should be submitted as part of a grant application to expand services (see Section 3 below).

The *Scope of Project* defines, among other things, the services for which the health center can utilize its Section 330 grant funds and for which additional program benefits are available. It also defines the services that must be offered to all health center patients, regardless of whether such services are provided directly or by contract. Accordingly, if dental services are not included in a health center's existing *Scope of Project*, the center should request and obtain a "change in scope" from BPHC prior to contracting for dental services if the health center intends to use grant funds and access additional benefits in connection with the provision of these services.

SCOPE OF PROJECT
1. INITIAL APPLICATION FOR SUPPLEMENTAL EXPANSION FUNDS
2. REQUEST CHANGE IN SCOPE

3. OBTAINING NEW FUNDING FROM HRSA FOR DENTAL SERVICES

New FQHCs and those that are expanding their services or establishing new health center sites can seek federal funding to support services through competitive applications to HRSA. Receipt of such an award automatically defines or, in the case of expansion grants, revises, that center's *Scope of Project* to reflect the new funding. For example, a competitive grant opportunity may provide supplemental funding to expand various services, including dental care.

4. DEFINING THE "PATIENT"

In the past, CMS utilized a stringent set of criteria to define a patient. It specified that the FQHC patient have a "medical record" at the center, uses the center as a "medical home," and "obtains primary care services at the center that meet the patient's needs" (the so-called "four walls test"). In general, the central office of CMS has now adopted a less stringent HRSA definition. It now defines a health center patient as someone who uses the services of the health center as his or her principal source of primary health care. A patient typically resides in the center's service area and is able to "reasonably" access primary and preventive care services at the center.

In addition to being regulated by federal authorities, health centers are regulated by various state agencies. For example, health centers must negotiate with state Medicaid agencies to determine payment rates for Medicaid-enrolled patients. As regulators, states also have authority to define the term "patient" for purposes of determining whether contracted services qualify as "FQHC services." It is therefore advisable that health centers check with their respective state Medicaid agencies prior to entering into contracting arrangements for services.

FOUR WALLS TEST

1. MEDICAL RECORD
2. CENTER AS MEDICAL HOME
3. OBTAINS PRIMARY CARE SERVICES
4. MEET PATIENT'S NEEDS

5. SOURCES OF FUNDING FOR DENTAL CARE

Health centers may receive direct payment for dental services from public and private dental insurance, as well as full and sliding-fee scale payments directly from patients. HRSA-supported FQHCs also may use a portion of their Section 330 funds to subsidize the otherwise uncompensated costs of providing services to underinsured or uninsured patients. In addition, centers may receive supplementary funding, for example from state government, local government, foundations, and other philanthropies.

In particular, many health center patients are beneficiaries of the Medicaid program, which covers certain dental services. Dental coverage in Medicaid is currently comprehensive for children through age 21 years under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. State Medicaid programs vary widely, however, in the range of dental services they cover, if any, for adults. As of mid-2003, only 12 states were providing reasonably comprehensive dental services to adults in Medicaid, and further cutbacks were under consideration in many states. As a result, many low-income adults who seek care in FQHCs have neither public insurance nor personal resources to pay for dental care.

States also insure children and, in some cases, some adults, through the State Children's Health Insurance Program (SCHIP). As of mid-2003, all states except Delaware and Texas offer some dental coverage through SCHIP but additional states are considering dropping dental benefits in this program.

6. RATE SETTING FOR THE PURCHASE OF CONTRACTED SERVICES

Rate setting for the purchase of services provided by contracted providers is perhaps the most complex and indeterminate component of the contracting process. In general, HRSA permits health centers to contract for services based on any payment rate or payment mechanism that is reasonable, in accordance with the federal cost principles contained in Office of Management and Budget Notice A-122. For example, health centers can contract with dentists to provide services either in the dentists' private offices or in the health center facility. For such care, payments to the dentist may be on a dollar amount per-service, per-patient, per-visit, per-block of time, or any other basis agreeable to the parties.

For purposes of federal anti-kickback law, the payment amount should reflect an "arm's length," negotiated fair market dollar value for services provided under the contract.

The payment provided by the health center to the contracted dentist should not be equivalent to the "enhanced reimbursement rate" that the FQHC receives from the state's Medicaid program. Similarly, it should not be the same as the payment rate that the FQHC receives from other payors, or equivalent to a specified portion of its Section 330 grant funds. That is, the health center is not permitted to "pass-through" its Medicaid or Medicare reimbursement or a specified portion of its Section 330 grant funds to another provider. Therefore, the health center's Medicaid reimbursement rate cannot directly determine the rate payable to contracting dentists.

IT IS ADVISABLE FOR THE HEALTH CENTER TO PARTNER EARLY WITH ITS STATE MEDICAID AGENCY.

To establish their own internal Medicaid enhanced reimbursement rates, health centers provide estimated cost data to their state Medicaid authorities. Medicaid agencies use these estimates to calculate an adjusted visit rate by employing formulas that vary somewhat by state and within states over time. State Medicaid agencies have considerable discretion to determine reasonable costs and are granted much flexibility in their negotiations with FQHCs by federal oversight agencies. It is therefore advisable for the health center to partner early with its state Medicaid agency to ensure that the agency accepts the service being added and the payment structure that is sought.

The rate setting process between the dentist and the health center may be scrutinized by a Medicaid agency for the reasonableness of the proposed costs, and the agency may limit its payment to the health center accordingly. While the Medicaid agency will not disallow a properly structured contractual arrangement between the health center and a dentist, it may disallow certain costs associated with the arrangement, thereby reducing the amount of reimbursement made available to the health center.

7. SATELLITES VERSUS "OFF-SITE" SERVICE LOCATIONS AND APPLICABLE POLICIES AND PROCEDURES

When private dentists contract with FQHCs to provide services to health center patients within their own dental offices, their offices may be considered by HRSA to be either satellites of the center or off-site locations for contracted services.

It may be preferable to characterize the dental office as an off-site location for services, rather than a satellite location, under terms of the contract. If a dental office is established as a satellite of the health center, rather than simply as an off-site service location, it would need to comply with a range of facility requirements that may be incumbent on health centers, for example, by the Joint Commission on the Accreditation of Healthcare Organizations and others. While most dental offices already offer handicapped access and prohibit smoking on premises, additional facility requirements that may pertain to health centers (e.g., width of hallways) may be onerous or inappropriate for private offices.

Both dentists and health centers are required to provide all services in accordance with applicable federal, state, and local laws, regulations, and policies and generally accepted principles of professional conduct.

Patient protections that are typically afforded by dentists to all patients served in their offices extend to health center patients. Similarly protections afforded by health centers to patients seen in their sites extend to health center patients served at the private dental offices as well. These protections include, by example, non-discrimination policies and practices, proper sterilization techniques, appropriate radiation safety procedures, and other quality-assurance standards. Since the contracting private dentist acts as "agent" for the health center, the dentist is required to provide services to health center patients in a manner that is consistent with applicable health center policies and procedures. Both parties should carefully review their established policies and procedures including, but not limited to clinical protocols and guidelines, quality assurance standards and practices, standards of conduct, and productivity standards to ensure or establish common expectations.

BOTH PARTIES SHOULD CAREFULLY REVIEW ESTABLISHED POLICIES AND PRACTICES.

Patient grievance procedures vary somewhat between private dentistry and FQHC practice. Private dentists typically address patient grievances directly and seek to satisfy patients' concerns within their offices. A patient who remains unsatisfied may seek additional satisfaction, adjudication, or remedy from the state's dental licensing board, local dental society's grievance committee, or through the courts. In contrast, FQHCs are required to establish formal patient grievance procedures. FQHC patients served by private dentists may access these procedures to address any grievance they may have. Dentists should become familiar with pertinent health center policies and procedures before contracting with health centers.

Health centers are required to ensure that their in-house and contracted health care providers meet professional requirements including appropriate state licensure, certifications and registrations (e.g., a particular states' requirement for radiation training, child abuse identification, specialty licensure, etc.), are appropriately credentialed, and maintain appropriate insurance coverage. Contracting dentists will need to provide health centers with required credentialing information, including evidence of professional insurance coverage, so that the health center can, in turn, meet its regulatory obligations.

8. PAYMENT MECHANISMS AND SCOPE OF CONTRACTED SERVICES

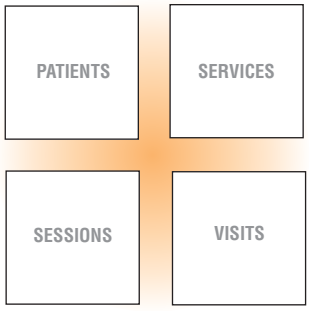
When contracting to provide services to health center patients, dentists and health centers may elect to contract based on the:

- specific services provided to the FQHC patient using a negotiated fee schedule;
- number of patients to be seen;
- number of visits available to FQHC patients;
- number of sessions (hours or days) to be committed to FQHC patients; or
- any other mutually agreeable basis.

In all cases, the dentist and the health center negotiate payment rates for an agreed-upon range of services. Services are provided to individual health center patients without regard to the patient's ability to pay or payor source. Therefore, a dentist who is not registered or enrolled as a Medicaid provider with the applicable state Medicaid agency or its managed care contractor can see the health center's Medicaid patients without becoming obligated to see all patients enrolled in Medicaid (see Section 8 below).

When contracting by service, patient, visit, or session, the dentist and the health center negotiate a fixed payment for each such contracting unit. For example, contracting "by patient" obligates the dentist to provide a specified range of services for a specific number of patients over a designated period of time for a fixed charge per patient. Contracting "by visit" establishes a fixed payment rate for a visit regardless of the services provided or length of visit. Contracting "by session" obligates the parties to a specified number of clinical sessions which may be defined, for example, as a specified half-day each week or each month with "half-day" defined by agreed-upon hours.

CONTRACTING OPTIONS



Regardless of approach, both the dentist and health center should seek to determine anticipated costs and income when deciding on a payment methodology in order to limit financial risk to both parties. Ideally, the FQHC will limit its financial risk while still assuring the dentist a predictable income for care of FQHC patients.

Specific services to be provided by the contracted dentist also are negotiable by the parties. As the FQHC "agent," the dentist is not obligated to provide dental services that are not included in the agreement. Centers vary widely in the range of dental services they provide. This variation reflects differences in their *Scopes of Project*, population needs, participation in a supplemental expansion grant or oral health initiative to expand oral health services, and whether they elect to use discretionary and fungible resources for dental care (e.g., foundation or local government support).

Regardless of the range of services negotiated between the dentist and the health center, FQHCs are required to ensure all services defined by their scope to all patients of the health center, regardless of individual patients' ability to pay and, therefore, the health center's ability to recoup costs of contracted care. Health centers may elect to provide services beyond those required by law or included in their scope. For example, centers that have not expanded their scope to include restorative dental services, may nonetheless elect to provide these services.

It is important to note again that dentists who contract with FQHCs do not do so under the Medicaid program, even though they may provide services to individuals who are enrolled in Medicaid. Rather, dentists are contracting to provide services on behalf of the FQHC under the terms and conditions of their joint contract. Therefore, Medicaid program dental benefits do not govern the range of services that a dentist and FQHC may agree to provide for an FQHC patient, nor do they determine the payment arrangement between the dentist and health center.

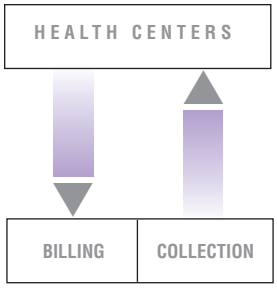
PARTNERSHIPS

Roles, Responsibilities and Resources

9. BILLING PATIENTS, MEDICAID, AND OTHER THIRD PARTIES

When dentists contract to health centers to care for FQHC patients, they are freed of any obligation to bill insurers, Medicaid, or patients (beyond collection of payments or co-payments routinely due at the time of service); and they need only provide information on all of their FQHC patient services to the health center. Under this arrangement, health centers are responsible for all billing, collection, and payment functions.

For purposes of billing Medicaid, FQHCs typically obtain and maintain Medicaid provider numbers for each of their service departments or for the health center entity as a whole, rather than for each of their in-house and privately contracted providers. In this way, turnovers or expansions in professional personnel do not require FQHCs to re-credential each new provider for purposes of Medicaid, although each new provider will need to be initially credentialed under the health center's professional credentialing policies.



HEALTH CENTERS ARE RESPONSIBLE FOR ALL BILLING, COLLECTION, AND PAYMENT FUNCTIONS.

Dentists may elect to become or remain Medicaid providers independent of their contracting arrangement with a health center. Dentists who are Medicaid providers outside of their contracts with FQHCs should not provide their individual or corporate Medicaid identifier number(s) to the FQHC as this number should not be used by the FQHC for billing Medicaid. When providing services to FQHC-contracted patients, the dentist will simply bill the health center based on the agreed-upon payment methodology. When caring for Medicaid-enrolled patients who access their offices directly (i.e., not through the health center), the dentist will bill Medicaid, or its billing agent, directly.

10. RISKS

For dentists, contracting with an FQHC does not entail financial risk beyond the possibilities of FQHC insolvency or of incurring higher than anticipated costs in providing services. However, depending on the payment methodology chosen by the parties, health centers may bear significant financial risk if they are unable to recoup adequate funding from their various payors to cover the contracted costs. It is therefore essential that dentists and centers carefully project the numbers of services, patients, visits, or sessions to be provided and monitor experience carefully. For example, the dentist and the health center may elect to institute a utilization and cost review during the initial contracting term to evaluate the accuracy of their initial projections.

Non-financial risks may arise in relation to failure of either party to meet requirements of the contract or function effectively together, or due to patient dissatisfaction with the services provided. Therefore contracts should include suitable "hold harmless" and termination clauses that can be triggered by either party. Again, it is essential that contract documents well protect the interests and needs of both dentists and FQHCs.

11. ACCOUNTABILITY

Good practice requires that both parties remain accountable to each other and address each other's needs in an ongoing way. Accordingly, good communication between the parties is essential to ensure satisfaction and program accountability. Additionally, federal regulation and policy mandate that FQHCs be accountable for oversight of all contracted services provided to health center patients. For example, it is important that dentists provide centers with information regarding progress in meeting the contracted goal — whether that be a specified number of patients, availability of care for specified sessions or visits, or numbers and types of services provided. Further, because payments made by health centers to contracted providers must be reasonable as they relate to services provided, it is important that dentists provide a sufficient dollar-value of services to substantiate the contracted payment amount. To ensure this, the dentist and the health center can negotiate a fee-for-service equivalent charge when contracting on a per-patient, per-visit, or per-session basis or the dentist can report the value of services provided in terms of customary charges.

GOOD PRACTICE REQUIRES THAT BOTH PARTIES REMAIN ACCOUNTABLE TO EACH OTHER AND ADDRESS EACH OTHER'S NEEDS IN AN ONGOING WAY.

Monitoring and oversight duties required of health centers extend to assurances regarding the dentist's professional qualifications. At the outset of contracting, the dentist needs to provide the health center with information validating that he or she has the professional qualifications and authority to provide care. While these requirements will vary somewhat, they typically include evidence needed to support credentialing, assurance that the dentist has not been disqualified as a provider under federal health care programs, such as the Medicaid program or SCHIP, and evidence of sufficient liability insurance.

Both the dentist and health center should reserve the right to determine whether the other party continues to meet all contractual requirements and is performing satisfactorily and, if not, to terminate the contractual arrangement, subject to obligations to complete patient care.

Under typical contracting arrangements, the health center guarantees the dentist timely payment and the dentist agrees to provide health centers with necessary service delivery and financial reports reflecting his or her care of health center patients. Health centers may need to access records maintained by the dentist that pertain to services provided to health center patients in order to meet their performance, quality assurance, and general monitoring and oversight requirements. Since the contract is expected to be typically paid with federal funds, the dentist also may be asked by appropriate governmental funding agencies to provide access to pertinent records.

12. ROLES FOR FEDERAL AND STATE AGENCIES

HRSA (www.hrsa.gov): HRSA is the federal public health and "access agency" that, through its Bureau of Primary Health Care, has primary responsibility for awarding and administering Section 330 grant funds, and the health center program. HRSA maintains ten Field Offices that support its various programs in the states including providing assistance to health centers and monitoring their compliance with federal requirements.

CMS (www.cms.gov): CMS administers publicly financed health insurance programs including the federal Medicaid and Medicare programs and the State Children's Health Insurance Program (SCHIP). It, too, currently maintains ten regional offices around the country. These Regional Offices are co-located with the HRSA Field Offices and are responsible for designating entities as FQHC "Look Alikes" upon recommendation of HRSA.

State Medicaid authorities: Because both Medicaid and SCHIP are federal/state partnership programs, each state's Medicaid authority interacts directly with FQHCs on Medicaid rate setting and other programmatic compliance issues.

13. ALTERNATIVE DENTAL ARRANGEMENTS

Beyond contracting with independent dentists to provide care for health center patients either in their private offices or in designated areas within the health center facility, FQHCs can hire dentists as full- or part-time staff, or dentists can provide volunteer services within or outside the health center facilities. As paid staff, dentists can be remunerated based on salary, patients seen, sessions (time), and/or productivity. Although these arrangements are more common than contracting with private dentists for patient care, these arrangements are beyond the scope of this Handbook.

14. TECHNICAL ASSISTANCE

HRSA, CMS, ADA, NACHC, and CDHP are all familiar with issues typically involved in contracting between dentists and health centers and all can provide technical assistance. CDHP, which developed this Handbook, can be contacted at 202-833-8288, by email at cdhp@cdhp.org, or on the web at www.cdhp.org.

15. MODEL CONTRACT

A companion document, a model "Dental Services Agreement" between private dentists and health centers, is appended for informational purposes. It also is available from the Connecticut Health Foundation at www.cthealth.org and from the Children's Dental Health Project at www.cdhp.org. This contract, which was developed by the law firm of Jones Day for the Connecticut Appleseed Center for Law and Justice, Inc., was commented on extensively and revised based on input from the Washington, D.C., firm of Feldesman Tucker Leifer Fidell LLP, general counsel for NACHC. This contract also was provided to the ADA for review and comment.

The attached model contract is intended for dentists and FQHCs to use as a starting point in drafting and negotiating a final agreement. It should not be used as the definitive document without first consulting legal counsel because state-specific regulations and other considerations may impact the proper structuring of an agreement. Where appropriate, the document provides options for parties to select how they wish to work together.

16. DECISION CHART

As health centers and dentists develop relationships to better serve the oral health needs of underserved individuals in their communities, many key decision need to be made. The appended Decision Chart for Contracting between Private Dentists and Federally Qualified Health Centers reviews these decisions step-by-step. The Chart is designed to help both parties understand options as well as determine what steps need to be taken to develop an effective, sustainable, and productive relationship.

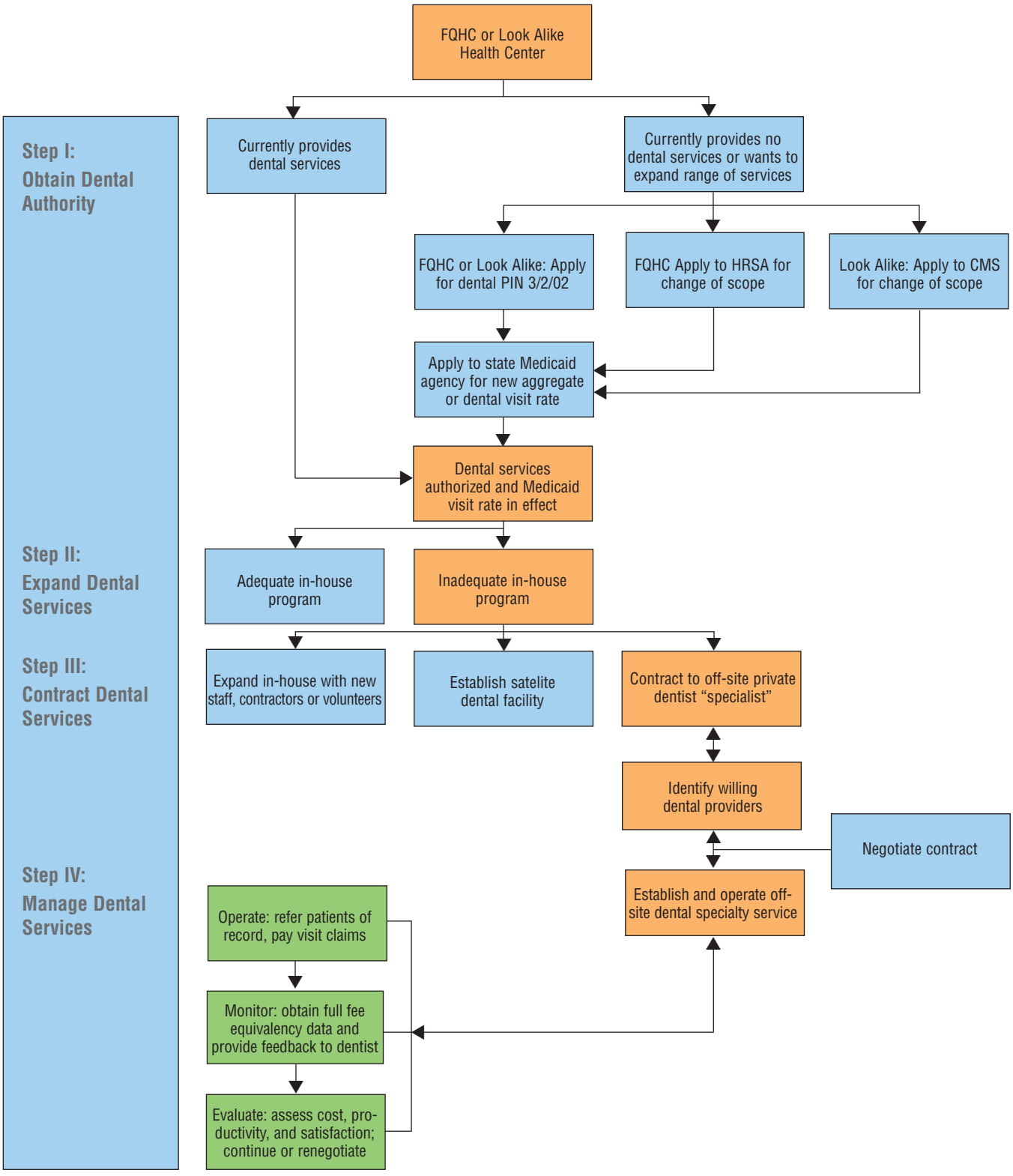
MODEL CONTRACT

IS AVAILABLE AT

WWW.CTHEALTH.ORG

AND WWW.CDHP.ORG.

DECISION FLOW CHART OF NECESSARY STEPS TO ESTABLISH OFF-SITE DENTAL SERVICES



ACKNOWLEDGEMENTS

The Connecticut Health Foundation (CHF) and the Children's Dental Health Project (CDHP) are grateful for the support of many authorities that have contributed information for this challenging project. We particularly appreciate the informal consultation and document review provided by CMS Regional Office and HRSA Field Office staff in Boston, Mass., and by the Bureau of Primary Health Care staff in Bethesda, Md.

At CHF, President & CEO Patricia Baker provided project guidance and direction, and Board Member Peter Libassi provided wide-ranging technical assistance and arranged for contract drafting by attorneys from the firm of Jones Day as part of their work in support of the Connecticut Appleseed Center for Law and Justice, Inc.

At the Connecticut Primary Care Association, Executive Director Evelyn Barnum arranged for meetings with health center CEOs and dental personnel at which the items in this Handbook were discussed in detail.

At the Connecticut State Dental Association (CSDA), Executive Director Noel Bishop and Immediate Past President Michael Egan, D.D.S., provided the opportunity to discuss health center contracting to private dentists at a meeting of its Executive Committee where the perspective of the practicing community was well represented.

Gail Bellamy, Ph.D., Director of Community Studies at the West Virginia Institute for Health Policy Research, facilitated initial review and feedback by local communities of interest.

The National Association of Community Health Centers (NACHC) and the American Dental Association's Washington, D.C., Office (ADA) provided comments and suggestions, which were incorporated into the document. We thank NACHC for arranging for the services of its general counsel, Feldesman Tucker Leifer Fidell LLP, who reviewed and commented on both this Handbook and the model contract in connection with each document's compliance with pertinent federal law, regulation, and policy.

CDHP's Washington, D.C., Director Anne De Biasi worked extensively with both NACHC and the ADA in obtaining their feedback. De Biasi and CDHP's editor, Joanna Parzakonis, worked together to ensure that the highly technical information provided is both accurate and balanced and is readily understandable to the target audiences of dentists, health center directors, and advocates for equity in health care.

END NOTES

[1] FQHCs are health centers that have met federal requirements for services, programs, and structure and, as a result, have been awarded funding through Section 330 of the Public Health Service Act. These grants support the provision of health care and related enabling services to medically underserved and vulnerable populations residing in their communities, regardless of the individual's or family's ability to pay. FQHCs are also eligible for additional benefits, such as, enhanced reimbursement under Medicaid and Medicare, professional malpractice coverage under the Federal Tort Claims Act (FTCA), and discount drug pricing under Section 340B of the Public Health Service Act. FQHC "Look Alikes" are entities that do not receive federal grant funds under Section 330, but comply with the same functional characteristics, operate under the same regulatory requirements, and are eligible for some, but not all, of the additional benefits available to grantee health centers. Throughout this Handbook, the terms "FQHC" and "health centers" denote both FQHC "Look Alike" entities and grantee organizations.

[2] The terms "dentist" and "contracted dentists" refer exclusively to private dentists who provide dental services, on behalf of the health center, to health center patients, either in the dentists' private offices or in a dedicated space located within the health center facility.

[3] To contract with health centers, dentists must be eligible to participate in federal health care programs, including Medicare and Medicaid and cannot be debarred or suspended.

[4] If the FQHC patient is seen in the dentist's private office, the health center and the dentist may negotiate terms under which the dentist will collect at the time of service applicable co-pays, including sliding fee payments, and remit those payments to the health center.

[5] The Health Resources and Services Administration (HRSA) is an operating division of the U.S. Department of Health and Human Services responsible for issues of access, particularly for underserved populations.

[6] The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for administering the federal Medicaid, Medicare, and State Child Health Insurance Programs and for designating, upon recommendation of HRSA, certain health centers as FQHC "Look Alike" entities.

About the Author:

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Model Dental Services Agreement

The following model dental services agreement between a private practice dentist and a community health center was developed for the Connecticut Health Foundation through the Connecticut Appleseed Center for Law and Justice, Inc., a nonprofit public interest law center, by Jones Day Attorneys at Law of Washington, D.C. It was provided to the American Dental Association and the National Association of Community Health Centers (NACH). It was extensively reviewed and modified by Attorney Marcie Zakheim of Feldesman Tucker Leifer Fidell LLP, general counsel to the NACH.

The language provides guidance to dentists and health center executives as they explore a contractual arrangement. In addition to model language, a number of notations are provided to address specific circumstances and/or options available to the contracting parties.

The model contract is intended for dentists and FQHCs to use as a starting point in drafting and negotiating a final agreement. It should not be used as the definitive document without first consulting legal counsel because state-specific regulations and other considerations may impact the proper structuring of a particular agreement.

THIS DENTAL SERVICES AGREEMENT (this "Agreement") is entered into this _____day of _____ , 200_, between _____ (the Community Health Center, or "CHC"), a nonstock corporation, and _____, a licensed Doctor of Dental Surgery, or Doctor of Medical Dentistry, or dental professional corporation ("Dentist").

I. PARTIES

"CHC" is an entity described in Section 501(c)(3) of the Internal Revenue Code (IRC) of 1986, as amended, and that (i) meets the definition of a Community Health Center under [insert applicable State statute]; and (ii) meets the definition of a Federally-Qualified Health Center ("FQHC") under Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. §1396d(l)(2)(B)), and whose scope of services, as approved by the Bureau of Primary Health Care ("BPHC") within the United States Department of Health and Human Services ("DHHS"), includes the performance of primary preventive dental services. (NOTE: If the health center is a public entity model, the reference to the IRC should be deleted.)

"Dentist" is an individual licensed to perform dentistry under [insert applicable State statute], meets the applicable provisions thereunder, and is not the subject of any Medicaid/Medicare related actions, suspensions, exclusions or debarments that would disqualify him or her from providing services under this Agreement.

II. PURPOSE

The purpose of this Agreement is to assist CHC in providing access to dental services to all patients of the CHC by entering into agreements with various Dentists to provide dental services for the CHC at an arm's length negotiated rate reflective of the fair market value for such services. (NOTE: As these services could be provided either off-site or on-site, depending on the specific arrangement negotiated between the individual CHC and the Dentist, insert either: at the Dentists' practice location [specify] or at the following CHC site [specify].)

III. PROVISION OF COVERED SERVICES

A. Participating Patients. A "Participating Patient" who is eligible to receive dental services under this Agreement is defined as any individual whose primary health care needs are served by the CHC. (NOTE: To be included in the scope of project, the health center needs to offer these services to all residents of the service area or members of the special population served under grant, e.g., homeless persons, as applicable.)

B Covered Services. Dentist agrees to provide the dental services described in Exhibit B (Covered Services), as required, to Participating Patients, in accordance with the attached Payment Schedule (Exhibit A). CHC is responsible for contacting Dentist to make initial appointments for Participating Patients. Notwithstanding, CHC is under no obligation to utilize Dentist to provide dental services to any or all Participating Patients who require such services, in accordance with Section V of this Agreement.

C. Description of Services. Consistent with Section XI.C of this Agreement, Dentist agrees to establish and maintain dental records that will contain descriptions of any dental services provided to Participating Patients, as well as proposed follow-up treatment plans for subsequent visits (if any). The descriptions of the services will be made using American Dental Association CDT-3 Standard Claims Codes, and will include the Dentist's customary charge for each service provided. In the event that such records are housed in a location other than the health center facility, CHC shall have reasonable access to such records.

D. Special Services. For dental services needing individual consideration or prior approval from the [insert applicable Federal/State agency], Dentist must provide CHC with documentation necessary to seek such approval, and may not render such services until CHC notifies Dentist that approval has been obtained. A list of services requiring prior approval is attached (Exhibit C).

E. Agreement Not to Charge Patients. The parties agree that all Participating Patients receiving services from Dentist pursuant to this Agreement shall be considered patients of CHC. Accordingly, CHC shall be responsible for the billing of such patients, as applicable, as well as the billing of Federal, State and private payors, and the collection of any and all payments. Dentist agrees not to bill, charge or collect from Participating Patients or payors any amount for any dental services provided under this Agreement. If Dentist should receive any payment from Participating Patients or payors for services provided hereunder, Dentist agrees to remit such payment to CHC within ten (10) days of receipt.

(NOTE: If the services are provided at an off-site location, e.g., dental office, insert the following provision: Notwithstanding the aforementioned, Dentist recognizes that certain Participating Patients may be charged at the time of service, in accordance with a fee schedule and, as applicable, schedule of sliding fee discounts established by CHC pursuant to 42 C.F.R. §51c.303(f). Dentist shall, on behalf of CHC and consistent with CHC's

guidelines, schedules and procedures, make every reasonable effort to collect fees from eligible Participating Patients at the time services are provided to such patients and to remit such payments to CHC within ten (10) days of receipt. CHC shall perform the follow-up activities necessary to collect patient fees not collected by Dentist at the time of service.)

F. Non-discrimination. Dentist agrees to provide dental services to Participating Patients in the same professional manner and pursuant to the same professional standards as generally provided by Dentist to his or her patients. This section shall not be read to prevent Dentist from limiting the number of hours and/or days during which Dentist agrees to see Participating Patients (see Section IX.A below). Dentist also agrees not to differentiate or discriminate in the provision of services provided to Participating Patients on the basis of race, color, religious creed, age, marital status, national origin, alienage, sex, blindness, mental or physical disability or sexual orientation pursuant to Title 45 of the Code of Federal Regulations, §§ 80.3–80.4, and [insert applicable State statute].

IV. OVERSIGHT AND EVALUATION OF SERVICES BY CHC

A. CHC, through its governing Board of Directors and its Executive Director, shall, consistent with the Board's authorities and CHC's scope of project (as approved by BPHC), establish and implement clinical and personnel policies and procedures relevant to the provision of services by Dentist pursuant to this Agreement (e.g., qualifications and credentials, clinical guidelines, standards of conduct, quality assurance standards, productivity standards, patient and provider grievance and complaint procedures). Notwithstanding, nothing herein is intended to interfere with Dentist's professional judgment in connection with the provision of such services.

B. CHC, through its Executive Director and/or Medical Director, shall retain and exercise ultimate authority and responsibility for the services provided to Participating Patients pursuant to this Agreement, consistent with the policies, procedures and standards set forth above. In particular, CHC shall retain ultimate authority over the following:

1. Determination as to whether Dentist meets CHC's qualifications and credentials;
2. Interpretation of CHC's health care, personnel and other policies and procedures, clinical guidelines, quality assurance standards, productivity standards, standards of conduct and provider and patient grievance and complaint resolution procedures, and their applicability to Dentist; and
3. Determination with respect to whether Dentist is performing satisfactorily and consistent with CHC's policies, procedures and standards, in accordance with this Section and Section X below.

If CHC's Executive Director is dissatisfied with the performance of Dentist, the Executive Director may terminate this Agreement, in accordance with Section VIII below. If Dentist believes CHC's termination has not been made reasonably and in good faith, Dentist may avail him or herself of the dispute resolution provisions set forth in Section XIV of this Agreement.

C. Dentist shall, as soon as reasonably practicable, notify CHC of any action, event, claim, proceeding, or investigation (including, but not limited to, any report made to the National Practitioner Data Bank) that could result in the revocation, termination, suspension, limitation or restriction of Dentist's licensure, certification, or qualification to provide such services. CHC may suspend this Agreement, until such time as a final determination has been made with respect to the applicable action, event, claim, proceeding, or investigation.

V. NO OBLIGATION TO REFER AND NON-SOLICITATION OF PATIENTS

A. It is specifically agreed and understood between the parties that nothing in this Agreement is intended to require, nor requires, nor provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party.

B. Dentist agrees that during the term of this Agreement, he or she shall not, directly or indirectly, solicit or attempt to solicit or treat, for his or her own account or for the account of any other person or entity, any patient of CHC. Dentist further agrees that for a period of two (2) years following termination of this Agreement (however such termination is effected, whether by Dentist or CHC, with or without cause, or the expiration of this Agreement), Dentist shall not, and Dentist shall not cause any entity or individual he or she is employed by or with whom he or she is professionally associated to, directly or indirectly, solicit or attempt to solicit for his or her own account or for the account of any other person or entity, any patient of CHC for whom Dentist provided care during the term of the Agreement. For purposes of this paragraph, a "patient of CHC" shall mean any patient seen or treated by CHC (whether by its employees or independent contractors) during the one (1) year period immediately preceding the termination or expiration of this Agreement, including, but not limited to, those patients treated by Dentist hereunder.

VI. CONTRACTS WITH OTHERS

CHC retains the authority to contract with other dentists or dental practices, if, and to the extent that, CHC's Executive Director reasonably determines that such contracts are necessary in order to implement the Board's policies and procedures, or as otherwise may be necessary to assure appropriate collaboration with other local providers (as required by Section 330 (j)(3)(B)), to enhance patient freedom of choice, and/or to enhance accessibility, availability, quality and comprehensiveness of care.

VII. COMPENSATION

A. Fee Schedule. Dentist will be compensated for providing dental services under this Agreement in accordance with the attached Payment Schedule (Exhibit A). (NOTE: Payment methodology/rate will be based on whether the CHC purchases blocks of the Dentist's time (i.e., # hours during certain days/times) or a certain number of appointments. In either circumstance, the actual payment should reflect fair market value for services and should not differentiate based on ultimate payor source.)

B. Timing of Payment. No later than the tenth day of each month, Dentist will submit to CHC a Request for Payment, which details the specific services provided to Participating Patients during the previous month and other information reasonably required by CHC to verify the provision of services and, as applicable, to submit claims for such services to appropriate Federal, State and/or private payors. CHC agrees to reimburse Dentist (in accordance with rates set forth in Exhibit A) for all Requests for Payment properly submitted by Dentist to CHC within [_____] days of CHC's receipt of such requests.

VIII. TERM AND TERMINATION

A. Term. This Agreement begins on [_____] and shall remain in effect until [_____], unless terminated earlier in accordance with the terms contained herein. This Agreement may be renewed for additional terms, subject to CHC's determination that Dentist performed satisfactorily and successful re-negotiation by the parties of key terms, as applicable.

B. Termination Without Cause. Either Dentist or CHC may terminate this agreement, for any reason, at any time upon thirty (30) days written notice.

C. Termination for Convenience. This Agreement may be terminated at any time upon the mutual agreement of the parties.

D. Termination For Breach. This Agreement may be terminated by either party upon written notice to the other party of such other party's material breach of any term of this Agreement, subject to a thirty (30) day opportunity to cure and failure to cure by the end of the thirty (30) day period.

E. Immediate Termination. In addition, CHC may terminate this Agreement immediately upon written notice to Dentist of: (1) Dentist's violation of, or inability to comply with, his or her obligations set forth in Sections X, XI, or XII(A) herein; or (2) the good faith determination of CHC that the health, welfare and/or safety of Participating Patients receiving care from Dentist is or will be jeopardized by the continuation of this Agreement.

F. Survival. Upon termination, the rights of Dentist and CHC under this Agreement will terminate, except as otherwise noted in this Agreement. That termination, however, will not release Dentist from his or her obligation to complete any multi-step dental treatment which Dentist began prior to the effective date of the termination, provided that such termination did not result from a determination by CHC that the health, welfare and/or safety of Participating Patients would be jeopardized by continuing this Agreement. Dentist is not obligated to provide any other services. Termination of this Agreement does not release CHC from its obligation to reimburse Dentist for any dental services provided on or before the effective date of the termination.

IX. CASE MANAGEMENT

A. Agreement to Provide Designated Number of Services. Dentist agrees to provide services to the CHC in one or both of the following manners (check one or both as applicable):

_____ # of Participating Patients per [TIME PERIOD]; and/or

_____ hours per week during the following specified times: _____.

The above parameters may be modified by mutual agreement of Dentist and CHC.

B. Verification of Patient Status. CHC agrees to verify each Participating Patient's status as a CHC patient on the day on which an appointment is made for such patient with Dentist. Dentist agrees to verify information regarding the patient's status as a CHC patient on the date of service, or shall establish an alternative mutually-acceptable method of verifying with CHC the status of patients presenting to Dentist. If it is determined that the Participating Patient is not a CHC patient on the date of service, CHC, in consultation with Dentist, will decide whether or not to authorize Dentist to proceed with treatment. If CHC authorizes Dentist to proceed with treatment, CHC will be responsible for payment for the services provided by Dentist according to the compensation provisions in this Agreement.

C. Enabling Services. To assist Dentist in treating Participating Patients, CHC agrees to provide appropriate interpreter services as reasonably needed, unless CHC and Dentist otherwise agree.

D. Refusal to Provide Services. Dentist has the right to refuse services to any Participating Patient who has a history of breaking appointments with Dentist, or who has behaved in a disruptive or grossly discourteous manner towards Dentist, Dentist's employees or other patients. Dentist must promptly report all such instances to CHC, who will notify the Participating Patient that, unless the Participating Patient corrects such behavior immediately, he or she will no longer be eligible to receive dental services from the Dentist. In such a case, Dentist has no obligation to provide further services for that Participating Patient.

X. LICENSURE, QUALITY, POLICIES AND PROCEDURES

A. Licensure, Certification and Other Qualification. Dentist will provide CHC with evidence of current licensure within the State of [insert applicable State] (as well as any other certification or qualification necessary to provide the services hereunder) prior to entering into this Agreement, and annually upon request of CHC, and will maintain unrestricted licensure and/or certification and qualification as a Medicaid and, as applicable, Medicare participating provider during the term of this Agreement. Dentist agrees to have such additional qualifications and credentials as CHC may reasonably require to provide services pursuant to this Agreement and shall maintain such qualifications and credentials during the term of this Agreement.

B. Referral for Specialty Services. Dentist agrees to provide to Participating Patients all reasonable and necessary dental services, as listed in Exhibit A (Covered Services), that are within the Dentist's knowledge, skill and training. To the extent that Dentist is not able or qualified to provide a necessary dental service to a Participating Patient, Dentist has no obligation to provide such specialized treatment, but must contact the CHC as soon as practical so that alternative arrangements can be made.

C. Compliance with Law. Dentist will practice in accordance with the all Federal, State and local laws, regulations, and generally accepted principles applicable to the practice of dentistry. Failure to comply with this provision is grounds for immediate termination under Section VIII.E of this Agreement.

D. CHC Policies and Procedures. Dentist will provide services pursuant to this Agreement in accordance with CHC's Section 330 grant and applicable grant-related expectations and requirements, as well as policies and procedures established by CHC's governing Board of Directors with respect to health care services, clinical guidelines, standards of conduct, productivity standards and provider grievance and complaint resolution, as may be amended from time to time, to the extent that such policies, procedures and standards apply to the services provided. CHC will provide Dentist with such requirements, policies, procedures and standards, upon request. Notwithstanding, nothing herein is intended to interfere with Dentist's professional judgment in connection with the provision of such services.

E. Quality Assurance and Patient Grievance Procedures. Dentist agrees to participate in CHC's quality assurance programs, as described in Exhibit D, to the extent required of all providers providing services to CHC. Dentist also agrees to be bound by CHC's patient grievance procedures, as outlined in Exhibit E. CHC may amend these procedures from time to time and will provide Dentist with notice of such amendment. Dentist shall have an opportunity to discuss any proposed amendments to CHC's quality assurance and grievance procedures prior to proposed amendments becoming effective. If Dentist does not agree to CHC's proposed amendments, Dentist may terminate this Agreement pursuant to Section VIII.B above.

XI. RECORD-KEEPING AND REPORTING, AND COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

A. Programmatic Records. Dentist agrees to prepare and maintain programmatic, administrative and other records and information that pertain to the services provided hereunder and that CHC and/or DHHS may reasonably deem appropriate and necessary for the monitoring and auditing of this Agreement, and to provide them to CHC as reasonably requested. In addition, Dentist will maintain such records and provide such information to CHC or to regulatory agencies as may be necessary for CHC to comply with State or Federal laws, regulations or accreditation requirements.

B. Financial Records. Dentist shall prepare and maintain financial records and reports, supporting documents, statistical records, and all other books, documents, papers or other records related and pertinent to this Agreement for a period of four (4) years from the date this Agreement expires or is terminated. If an audit, litigation, or other action involving the records is started before the end of the four (4) year period, Dentist agrees to maintain the records until the end of the four (4) year period or until the audit, litigation, or other action is completed, whichever is later. Dentist shall make available to CHC, DHHS and the Comptroller General of the United States, or any of their duly authorized representatives, upon appropriate notice, such financial systems, records, reports, books, documents, and papers as may be necessary for audit, examination, excerpt, transcription, and copy purposes, for as long as such systems, records, reports, books, documents, and papers are retained. This right also includes timely and reasonable access to Dentist personnel for the purpose of interview and discussion related to such documents. Dentist shall, upon request, transfer identified records to the custody of CHC or DHHS when either CHC or DHHS determine that such records possess long term retention value.

C. Participating Patient Records. Dentist agrees to establish and maintain dental records relating to the diagnosis and treatment of Participating Patients served pursuant to this Agreement. All such records shall be prepared in a mutually agreed upon format that is consistent with the clinical guidelines and standards established by CHC. Dentist and CHC agree to maintain the privacy and confidentiality of such records, in compliance with all applicable Federal, State and local law (including, but not limited to, the Health Insurance Portability and Accountability Act) and consistent with CHC's policies and procedures regarding the privacy and confidentiality of patient records.

D. Retention of Patient Records. Dentist will retain dental records for seven (7) years beyond the last date of delivery of the services, or, upon the death of the patient, for three (3) years. X-Ray films must be kept for three (3) years. In the event that Dentist retires or discontinues his or her practice, Dentist must comply with the public and private notice provisions set forth in Conn. Agencies Regs. § 19a-14-44, and must retain medical records for at least sixty (60) days following both the public and private notice to patients. Record retention obligations survive the termination of this Agreement.

E. Ownership of Patient Records. Dentist and CHC agree that CHC shall retain ownership of all dental records established in accordance with Section XI.C of this Agreement, regardless of the physical location in which such records are housed. Dentist and CHC agree that Dentist, upon reasonable notice to CHC and consistent with applicable Federal and State laws and regulations and CHC's policies and procedures regarding the privacy and confidentiality of patient records, shall have timely and reasonable access to patient records to inspect and/or duplicate at Dentist's expense, any individual chart or record produced and/or maintained by Dentist to the extent necessary to: (i) meet responsibilities to patients for whom Dentist provides services pursuant to this Agreement; (ii) respond to any government or payor audits; (iii) assist in the defense of any malpractice or other claims to which such chart or record may be pertinent; and (iv) for any other legitimate business purpose, consistent with patient confidentiality and to the extent permitted by law.

F. Misrepresentation. Dentist acknowledges and agrees that willful misrepresentation of the type, frequency, reasonableness and/or necessity of dental services provided to Participating Patients may constitute a fraudulent act and may be referred by CHC to the applicable Federal or State regulatory agency, and will be cause for immediate termination under Section VIII.E of this Agreement.

G. Compliance With Other Laws. In connection with the provision of services pursuant to this Agreement, Dentist agrees to the following requirements, to the extent that such requirements are applicable:

1. To comply with the Civil Rights Act of 1964 and all other Federal, State or local laws, rules and orders prohibiting discrimination, as well as Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented by U.S. Department of Labor regulations at 41 C.F.R. Part 60;
2. To make positive efforts to utilize small businesses, minority-owned firms and women's business enterprises in connection with the work performed hereunder, whenever possible;
3. To comply with all applicable standards, orders, and regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. § 7401 et. seq.) and the Federal Water Pollution Control Act (33 U.S.C. § 1251 et seq.), as amended;
4. To comply with the certification and disclosure requirements of the Byrd Anti-Lobbying Amendment (31 U.S.C. § 1352), and any applicable implementing regulations, as may be applicable; and
5. To certify that neither it, nor any of its principal employees, has been debarred or suspended from participation in federally-funded contracts, in accordance with Executive Order 12549 and Executive Order 12689, entitled "Debarment and Suspension," and any applicable implementing regulations.

XII. INSURANCE

A. Proof of Coverage. Dentist will provide CHC with sufficient evidence of professional liability coverage in the amount of at least [$_____] per claim and [$_____] in the aggregate, and general liability coverage of at least [$_____]. If requested by CHC, Dentist will submit proof of such insurance to CHC on an annual basis, and in all cases will notify CHC immediately of any termination, suspension or material change in coverage.

B. Indemnity. Dentist will indemnify and hold harmless CHC against any and all liabilities, claims, causes of action and losses, including attorney fees, arising out of any act or omission of Dentist or his or her employees or agents, including any professional negligent action or professionally negligent failure to act of Dentist or his or her employees or agents. CHC similarly agrees to indemnify and hold harmless Dentist against any and all liabilities, claims, causes of action and losses, including attorney fees, arising out of any action or failure to act of CHC or its employees or agents. (NOTE: This Section assumes that CHC has appropriate insurance to cover indemnification (FTCA does not cover indemnification of third parties). If that is not the case, the second sentence of Section B should be deleted. If the Dentist will not agree to indemnify CHC without a reciprocal indemnification, it is best to delete the entire Section B.)

XIII. CONFIDENTIALITY

A. Except as is necessary in the performance of this Agreement, or as authorized in writing by a party or by law, neither party (nor its directors, officers, employees, agents, and contractors) shall disclose to any person, institution, entity, company, or any other party, any information which is directly or indirectly related to the other party that it (or its directors, officers, employees, agents, and contractors) receives in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) as a result of performing obligations under this Agreement, or of which it is otherwise aware. The parties (and their directors, officers, employees, agents, and contractors) also agree not to disclose, except to each other, any proprietary information, professional secrets or other information obtained in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) during the course of carrying out the responsibilities under this Agreement, unless the disclosing party receives prior written authorization to do so from the other party or as authorized by law.

B. The parties agree that their obligations and representations regarding confidential and proprietary information (including the continued confidentiality of information transmitted orally), shall be in effect during the term of this Agreement and shall survive the expiration or termination (regardless of the cause of termination) of this Agreement.

XIV. GENERAL PROVISIONS

A. Amendment/Modification. This Agreement may be amended or modified from time to time upon the mutual written agreement of the parties. Any amendment or modification shall not affect the remaining provisions of the Agreement and, except for the specific provision amended or modified, this Agreement shall remain in full force and effect as originally executed.

B. Assignment. This Agreement may not be assigned, delegated, or transferred by either party without the express written consent and authorization of the other party, provided prior to such action.

C. Effect of Waiver. A party to this Agreement may waive the other party's breach of a provision of this Agreement, but such a waiver does not constitute a waiver of any future breaches.

D. Effect of Invalidity. The invalidity or unenforceability of any provision of this Agreement in no way affects the validly or enforceability of any other provision, unless otherwise agreed.

E. Notice. Any notice required to be provided under this Agreement must be in writing and delivered in person or sent by registered or certified mail or by next business day delivery service to each party at the address set forth on the signature page.

F. Independent Contractor Status. The relationship of Dentist to CHC at all times will be of an independent contractor. None of the provisions of this Agreement will be interpreted to create a relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Dentist nor CHC, nor their employees or agents, will be construed to be the agent, employer or representative of the other.

G. Dispute Resolution. Any dispute arising under this Agreement shall first be resolved by informal discussions between the parties, subject to good cause exceptions, including, but not limited to, disputes determined by either party to require immediate relief (i.e., circumstances under which an extended resolution procedure may endanger the health and safety of the Participating Patients). Any dispute that has failed to be resolved by informal discussions between the parties within a reasonable period of time of the commencement of such discussions (not to exceed thirty (30) days), may be resolved through any and all means available.

H. Choice of Law. This Agreement shall be governed in accordance with the laws of the State of [insert applicable State]. Any disputes arising under this Agreement will be settled in accordance with the law of the State of [insert applicable State].

I. Entire Agreement. This Agreement represents the complete understanding of the parties with regard to the subject matter herein and, as such, supersedes any and all other agreements or understandings between the parties, whether oral or written, relating to such subject matter. No such other agreements or understandings may be enforced by either party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

ACCEPTED AND AGREED TO THIS _____ DAY of_____, 20__.

Signatures:

_____	_____
Date:_____	Date:_____
Name of Dentist:_____	Name of CHC:_____
Practice Name:_____	Exec. Dir._____
Address:_____	Address:_____
Phone:_____	Phone:_____
Facsimile:_____	Facsimile: _____
Contact:_____	Contact:_____

EXHIBITS

Exhibit A: Payment Schedule (to be inserted)

Exhibit B: Covered Services:

A. Preventive Dental Services Required Under Section 330 of the Public Health Service Act

1. Oral hygiene instruction
2. Oral Prophylaxis
3. Topical application of fluorides
4. Prescription of fluorides
5. Children's dental screening
6. Other

B. Supplemental Dental Services [add additional dental services (1) required by earmarked, expansion grants; (2) required due to participation in a BPHC-funded oral health initiative; or (3) not required, but negotiated between the health center and the dentist, e.g., certain restorative services]

Exhibit C: Services requiring prior approval (to be inserted)

Exhibit D: Description of CHC quality assurance programs (to be inserted)

Exhibit E: Description of CHC grievance procedures (to be inserted)

UNDERSTANDING THE CONNECTICUT DENTAL MEDICAID REFORM PROPOSAL: STATE OPTIONS IN CONTRACTING DENTAL CARE IN MEDICAID

Connecticut Health Foundation

March 2003

CONTENTS

Program Options Available to States

In today's ever-evolving health care marketplace, states have multiple options for arranging dental services in their Medicaid programs.

For example, states may:

- Administer dental Medicaid programs directly or contract them through medical or dental managed care organizations;
- Retain administrative responsibility or not and opt to pass financial risk onto outside vendors;
- Include dental services in medical managed care contracting or carve-out dental services for separate management; or
- Contract with a single vendor or with multiple vendors for all or part of their enrolled populations or geographic areas.

In fact, options are limited only by the creativity of Medicaid officials, the receptivity of the marketplace, and, in some cases, the approval of federal authorities. Indeed, in their efforts to secure dental care for beneficiaries, states have experimented with various combinations of these options.

Regardless of the options selected, states must currently meet – or obtain federal waivers not to meet – requirements that include a guarantee of access to needed dental services for covered children.

As an observation of states' efforts reveals, ultimately, only three factors relate to a state's capacity to obtain dental care for beneficiaries:

1. Market-based payment rates to dental providers,
2. Engagement of sufficient numbers of providers, and
3. Effective program oversight.

The Connecticut Health Foundation (CHF), the state's largest private, independent foundation dedicated to improving the health status of all Connecticut residents, has prepared this policy brief to:

- Describe the various program options and related decisions facing states as they determine how to obtain dental care for their beneficiaries,
- Present arguments (pro and con) for each decision, and
- Comment on the lessons to be derived from various states' efforts.

Decision 1: Whether or Not to Retain Medicaid In-House or Contract Out

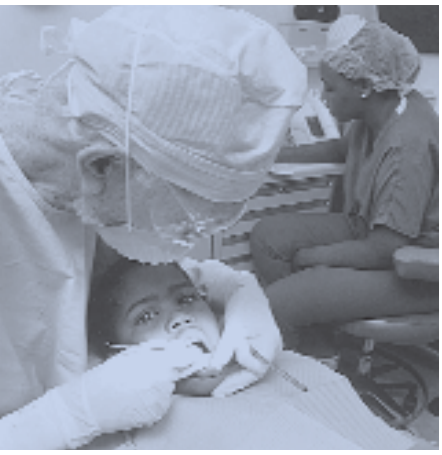
one

States interest in contracting-out Medicaid services stems from a desire to increase access, contain costs, and improve program performance.

Proponents of contracting suggest that the corporate culture of dental insurers is better suited to successful program management than the culture of state bureaucracies. They believe that outsourcing dispels dentists' antipathy and frustration with state-administered Medicaid. Proponents also cite such advantages to beneficiaries as: improved customer service, integration of health and enabling services, and recourse to assistance in obtaining care. For providers, advantages appear to be the potential to negotiate fees, streamlined claims processing, and a steadier cash flow. In addition, managed care plans may utilize protocols and guidelines that can enhance care quality while controlling costs.

Critics of Medicaid contracting, however, assert that this option is inherently flawed. They characterize this flaw as a perverse incentive related to inadequate financing, that is, an incentive to minimize service delivery in order to maximize profits. Opponents also point out that states lose control of the program but retain responsibility for Medicaid requirements that are not explicitly contracted. If dental services are subcontracted by a medical managed care vendor that is otherwise performing well, poor performance by dental vendors may be difficult to redress, especially if enforceable sanctions are not included in the contracts – or if a state's capacity and political will is not sufficient to enforce those sanctions. Even where effective sanctions exist, the costs of redressing poor performance may be greater than the savings generated through sanction enforcement, particularly if legal action is necessary. Furthermore, dental Medicaid programs are frequently regarded as too small to warrant intensive oversight. The greatest criticism expressed about outsourcing, however, is this: outsourcing shifts some Medicaid funds to vendor profits rather than client services – profits that may be in excess of savings generated by privatization.

The 1995 Medicaid reform in Connecticut contracted Medicaid services, including dental services, to managed care. The new proposal segregates the dental program for separate contracting.



Decision 2: Whether or Not to Carve-Out Dental Services

two

While almost every state has contracted some part of its Medicaid program to managed care, 27 have retained them under state management. The remaining 23 states and the District of Columbia contract for dental services. Only six of these governments carve-out dental services from medical vendors' responsibility to contract exclusively with dental vendors.

When the states carve-out dental programs from medical vendors, they are able to select the dental contractors, establish the terms and conditions of program delivery, establish clear and enforceable incentives and sanctions, and directly access information on program performance. As a result, this option holds promise for enhanced program accountability. This approach also reflects differences between medical and dental care including different provider types, delivery systems, and financing norms.

When identifying a suitable contractor, a state can carefully assess whether or not the vendor's existing provider network contains a sufficient number of providers. It also can explore how the providers are distributed and how actively providers participate, if there is a network in the state. If the dental vendor has no network for a Medicaid contract, the state and other interested parties can closely examine the vendor's commercial experience or performance in other states. Similarly, the state can exercise due diligence when examining a vendor's past claims-administration performance as well as dentists' and beneficiaries' satisfaction.

When carving-out dental care, states will shoulder the additional cost and responsibility of managing separate contracts for a very small component of the larger Medicaid program, typically less than 5 percent. This is the primary disadvantage of the carve-out option.

There are several ideas that hold potential for success in dental carve-outs:

- Accessing ready-made provider networks;
- Encouraging participation of safety-net providers;
- Contracting for case management strategies (e.g. clinical protocols, risk assessment, and disease management guidelines);
- Contracting for care integration between primary and specialty dentists;
- Empowering vendors to implement their own access initiatives (e.g. case managers, school-linked services, and private dentist contracting to health centers); and
- Allowing dentists to negotiate terms of participation.

The 1995 Medicaid reform in Connecticut did not carve-out the dental program and assigned responsibility to the medical managed care vendors. The new proposal carves-out the dental program for separate management.

Decision 3: Whether or Not to Assign Financial Risk to the Vendor

three

As care utilization increases, so, too, do program costs. States may guard against this by contracting with managed care vendors at a specified payment for each covered beneficiary. In so doing, states establish their dental program cost and put their vendors at financial risk, should utilization exceed anticipated levels. Among the 23 states and the District of Columbia that contract for dental services, all but two assign some level of financial risk to their vendors.

Fixed rate contracting puts the vendor at financial risk because it caps the total dollars available for claims, program administration, and profit. Because Medicaid is currently an individual entitlement, neither states nor vendors can deny care when funds are depleted.

Dental managed care vendors have addressed this potential financial liability in a number of ways. Some will not accept full-risk contracts. Some have attempted, with notably little success, to pass risk onto dentists through capitation arrangements. One multi-state dental Medicaid vendor utilizes a "global" approach – it pays itself first, and then prorates any remaining funds across providers to reflect the volume of claims. Re-insurance is used to protect against "adverse utilization."

According to opponents, assigning full financial risk eliminates any incentive for increased utilization, an inherent problem. Proponents, on the other hand, claim that improved provider networks and greater efficiency warrant vendor profitability. Proponents also maintain that the onus is on the state to ensure performance through strong and enforceable contract sanctions.

The 1995 Medicaid reform in Connecticut assigned some financial risk to vendors. The new proposal curtails that risk.

Decision 4: A Single-Vendor or Multiple-Vendor Program

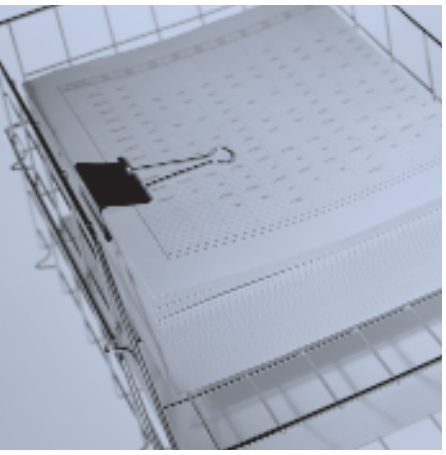
four

Proponents claim that multiple vendors stimulate competition and, therefore, better customer and provider service because both groups will seek out the best plans. Proponents also maintain that vendor competition generates true market rates if there is sufficient state funding in the program. In those states where multiple vendors failed to develop sufficient networks to meet the needs of beneficiaries, the states did not provide sufficient funding to reflect market conditions. Advantages of inter-plan competition include opportunities for performance comparison across plans, emergence and identification of "best practices," and stimulus for plans to provide the best possible service.

On the other hand, opponents of multiple-vendor arrangements assert that beneficiaries are confused by multiple options. They suggest that providers are not sufficiently interested in Medicaid to negotiate multiple contracts, tolerate multiple credentialing procedures, or institute multiple claims-management procedures in their offices. Opponents cite the increased difficulty and cost for states to oversee multiple vendors.

According to proponents of single-vendor arrangements, these problems are eliminated when states contract with only one vendor and engage only the "best" vendor by carefully assessing solicited proposals. Single-vendor advocates also note that commercial dental plans with large provider networks are more likely to bid on Medicaid contracts only if the population to be covered is large enough to allow for efficiency. The primary disadvantage of single-vendor contracting is dependence on one source.

The 1995 Medicaid reform in Connecticut engaged multiple medical managed care vendors and multiple dental managed care subcontractors. The new proposal calls for contracting with a single Administrative Services Organization (ASO).



five

Decision 5: Selecting a Plan

States solicit vendors through "Requests for Proposals" (RFPs), ranging from highly detailed and specific requests to broad and conceptual ones. Specific RFPs focus on process requirements and delineate terms and conditions to be met by the bidder. Conceptual RFPs, in contrast, focus on program goals and provide bidders with some flexibility in how to attain those goals. Because the form, content, and specificity of proposals are critical to program management, it is useful for communities of interest – and particularly for stakeholders directly impacted by programs – to be engaged in RFP development and evaluation.

Typical terms of responsibility for contracting include:

- Provider network development including safety-net providers;
- Delineation of procedures for addressing the needs of special populations, for example, young children, the medically or psychologically compromised, and non-English speaking patients;
- Case management and provision of enabling services;
- Care coordination;
- Fraud and abuse management;
- Performance measurement and accountability;
- Client and professional support services including redress of complaints; and
- Compliance with federal requirements.

Each of these terms can have significant impact on access and utilization. States also are obliged to carefully assess the business practices, program incentives, and overall reputation and reliability of the applicants' plans. Applicants may be either for-profit or tax exempt organizations. There is no recognized difference in performance between these two types of organizations.

Connecticut's current plan is to identify the single ASO through a conceptual RFP and to negotiate specific terms thereafter.

Decision 6: Setting a Payment Rate

six

Observers of Medicaid dental programs generally agree that private sector commercial insurers do not respond to Medicaid RFPs often enough; primarily, this is due to the fact that Medicaid pays too far below market rates. While little pricing information is available, the majority of state dental programs – as well as rates paid to dental vendors in Connecticut – are thought to be supported with monthly per member payments (pmpm) of $5 to $10. These rates fall well below a 1999 actuarial estimate of a reasonable market rate of $17 pmpm. Dental insurance executives interviewed for this project suggest that minimally acceptable rates would fall in the range of $12 to $15, assuming that vendors are willing to accept initial losses from "pent-up" demand for care. In Michigan, a partial-state Medicaid demonstration has generated remarkable success in increasing access and utilization at a pmpm of $12.60. Low rates are believed to correlate with higher levels of provider fraud and abuse, higher levels of "skimming" (defined as inappropriately high levels of preventive services and inadequate levels of less profitable reparative care), and program dependency on a small numbers of dentists.

In addition to low payment rates, commercial plans with well-established provider networks cite the following reasons for staying out of the Medicaid market:

- A concern about states' cash flow reliability,
- Public relations risk with existing clients,
- A belief that Medicaid is a riskier book of business than employment-based plans because of significant "pent-up" treatment needs,
- Less predictable utilization, and
- A lack of data on how dentist availability is affected by fee levels.

Dental insurers also are adamant that Medicaid programs should not be supported by cost shifting from more profitable commercial plans.

Increasing access in Medicaid may, in large measure, depend upon offering excellent service to both dentists (so that they are available) and beneficiaries (so that they can utilize the system). Such service is expensive to provide, especially to dentists who are generally negative about Medicaid programs and beneficiaries who require extensive support services.

Connecticut's current plan is "cost neutral." It does not increase dental program funding.

Decision 7: Managing Program Oversight

seven

State contracts define performance requirements and typically provide incentives for strong performance and sanctions for failures. These may pertain to network development, provider and beneficiary satisfaction, timeliness and accuracy of claims management, levels of utilization by beneficiaries, timeliness and accuracy of performance reports to the state, and other contract terms. To be enforceable, a program's contract requirements should be clear, and the state should be willing to prosecute infractions of those requirements. When a state knowingly under funds its program, it has little recourse when plans do not deliver as promised.

Effective oversight requires regular and timely data, provider and beneficiary input, and proactive engagement of administrators and legislators responsible for these programs. Commercial dental programs typically provide employers with a specific list of program performance measures as well as actions it will take if these measures are not met. States may benefit from emulating these contract provisions or referencing the Centers for Disease Control and Prevention's "Sample Purchasing Specifications for Medicaid Pediatric Dental and Oral Health Services."

Connecticut's plan to engage a single ASO vendor for both the State Employee Health Program and public insurance programs may improve oversight for two reasons:

1) The total number of covered lives will be great enough to warrant close management by the state and

2) It is expected that state employees will be more critical of inadequacies than low-income beneficiaries of public insurance programs.

Active and effective program oversight, like sufficient payment rates to adequate numbers of providers, is essential to ensuring accessible dental services in Medicaid.

Lessons Learned from Other States

lessons

As noted above, states can configure their Medicaid programs in a number of ways. Their ability to increase access, however, correlates with three interrelated approaches: market-based payment rates, sufficiency of providers, and effective program oversight.

Since the mid 1990s, fewer than ten states have made programmatic investments that have increased dental access or that are poised to increase access. All have sufficient financing to effectively engage the dental marketplace. Yet each "fix" is different, and each reform involves more than simply raising fees. Taken together, these reforms suggest that it is possible to improve access through program reform and that a combination of sufficient funding and administrative reform appears necessary to do so – whether program improvements are instituted by the state or through managed care contracting.

In contrast, the majority of states have instituted one or more dental program reforms that have yielded little access improvement. One characteristic that these reforms have in common is an insufficient increase in payment rates to dentists, despite other reforms in contracting arrangements or program management. Non-financial reforms appear to have little impact on access if not linked to sufficient increases in payment rates to dentists. As a result, adequate provider payment is regarded as a necessary, but not sufficient, condition for improving Medicaid.

Sufficient payment rates to dentists can be characterized as those rates that cover, at least, the providers' cost of delivering care. Market-based rates to dentists are those rates that will induce a significant portion of available providers to participate. Market-based rates do not necessarily have to be as high as the typical market rates incurred by self-paying or commercially insured patients, because dentists appear to be willing to accept modestly discounted fees when caring for Medicaid beneficiaries. The level of discount that is acceptable in a market is contingent upon dentist supply, overall demand for care, and social norms regarding commitment to vulnerable people. Demand is predicated upon the overall state of the economy and consumer confidence, as many dental procedures are considered elective. Social norms and commitment to the underserved vary nationwide. For example, in North Dakota, which has a culture of interdependence, payments approximate the 50th percentile, and a substantial percentage of dentists are engaged in Medicaid; in other states, however, similar rates do not stimulate provider participation.

Increases in program funding that do not "trickle down" to providers will have little impact on access. If increases in program funding, even substantial increases, do not offer payments that cover dentists' overhead costs, the increases will have minimal impact on access.

Connecticut's current proposal does not include any new monies to raise provider payments. Since vendors' current payment rates in Connecticut reflect the fees of less than 10 percent of the state's dentists (i.e. less than the 10th percentile), payment levels are considered inadequate. As such, administrative reforms and single-vendor ASO contracting may not, based on other states' experiences, significantly improve access.

In contrast, Michigan was able to demonstrate substantial increases in access in demonstration counties. They achieved these increases through a federally approved waiver demonstration: they markedly increased payments to dentists (paying at the 80th percentile) and engaged a well-established commercial vendor, Delta Dental of Michigan. Delta brought its pre-existing, large, and active network of providers to the Medicaid program and offered dentists the same administrative terms and experiences as offered to commercially insured patients. As a result, the state's dental Medicaid program manager reports that utilization in demonstration counties is approximating commercial rates, thereby meeting Medicaid requirements of equal access. Participating dentists are required to accept new patients, see them within three weeks of initial office contact, and provide emergency services within 24 hours of contact. The lesson learned from this Michigan demonstration is that paying market rates and utilizing an existing, robust provider network (under the same terms and conditions as commercial participation) combined to markedly increase access.

South Carolina's legislature committed to market-based purchasing by setting fees to approximate the 75th percentile. The unique lesson learned in South Carolina was that its success in developing a sufficient provider network was directly linked to the fee increases as a quid pro quo. Fee increases were specifically predicated on the state dental society's success in recruiting dentists for the program. This approach engaged a key stakeholder – private dentists – in designing and implementing successful reform.

Alabama has elected to retain dental program management in-house at the state Medicaid agency rather than contracting to managed care. This state has demonstrated successful provider recruitment in its "Smile Alabama" program utilizing a combined strategy of market-based fees (approximately the 75th percentile), a direct appeal to dentists by former Governor Don Siegalman, simplified claims administration, enhanced provider and beneficiary services, and a marketing campaign. The lesson learned from Alabama is that provider and beneficiary relations – whether instituted by the state or a vendor – are critically important to program success.

In Delaware, payment of sufficient, yet discounted rates, with little other programmatic change, yielded an increase in access. Delaware adjusted its payment rate to 85 percent of dentist-submitted customary charges while retaining administrative responsibility within the state's Medicaid agency. The state's Medicaid director, however, has suggested that further access improvements will require non-financial administrative reforms that make the program easier for a provider's business staff to manage. For example, the state is considering replacing its current proprietary claim form with a universal commercial form.

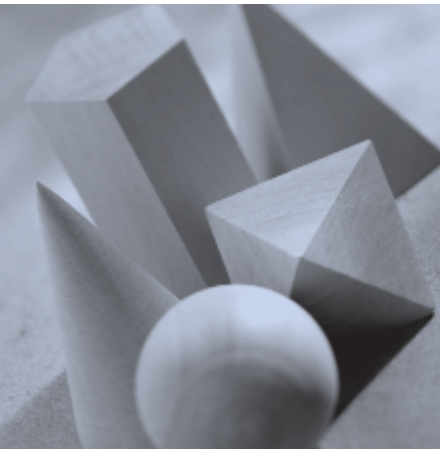
Although Georgia has less information available than other states about the impact of its fee enhancements, reports from practitioners in that state suggest that market-based fee increases have had less impact than anticipated. In order to make the program more workable for office staff, dentists would like Georgia to streamline its administrative and claims-management procedures. The lesson here is that administrative streamlining may be, like sufficient fees, a necessary, but not sufficient, condition for improving access.

Although Indiana's 1998 reform first succeeded in increasing access, it lost momentum and slipped backwards because it failed to maintain market-based fees through regular adjustments for inflation. The lesson here is that meaningful fee improvements, once made, need to be sustained or the provider network will degrade.

Tennessee is the most recent state to implement major reforms that include, but are not limited to, market-based payment rates. Like Connecticut, Tennessee turned to mandatory managed care contracting in the mid 1990s. When TennCare was established in 1994, the state contracted with multiple vendors who assumed financial risk and subcontracted dental care to dental plans. Having failed to generate sufficient access for beneficiaries, in 2000, the state reversed most of its 1990 decisions. It elected to carve-out dental from medical managed care and issued an RFP for direct non-risk contracting with a single dental ASO, Doral Dental. Tennessee raised fees to approximate the 75th percentile, developed a substantive alliance with the state's dental association to recruit providers, and implemented a social marketing campaign. The new program also features improved accountability by requiring the ASO to provide information on numbers of members served, numbers and types of procedures delivered, referrals, and information on quality improvement activities. The state's new program, which began October 2002, is believed to hold strong promise for success because it addresses payment, partnerships, beneficiary support, dentist support, and accountability issues.

The Connecticut experience and current proposal appear to be very similar to that of Tennessee except that Connecticut does not plan to increase fees to market levels, does not engage stakeholders in program reform, and does plan to assign its ASO vendor with some level of financial risk. As sufficient fees are considered a necessary condition for program success, risk contracting may introduce a perverse incentive against access enhancement; and since multiple states have demonstrated the utility of engaging the dental community, Connecticut's reform appears to hold less promise than Tennessee's dental carve-out program. A number of administrative "best practices" have evolved from efforts to improve access, including:

- Ongoing and meaningful collaboration of all stakeholders, including dentists and hygienists, safety-net providers, hospitals, advocates for the poor, and beneficiaries;
- Streamlined of administration including electronic eligibility verification and claims management, elimination of most prior authorization requirements, rapid claims payment, use of professionally accepted coding systems and claim forms, and facile mechanisms for rapid conflict resolution;
- Improved performance reporting;
- Strong vendors incentives that are regularly awarded and sanctions that are routinely enforced;
- Engagement of community health centers, school-based clinics, and other safety-net providers;
- Integration of medical and dental care through tracking forms and facilitated referrals; and
- Strong provider and beneficiary support.



Summary

summary

Experience across the nation suggests that options in program administration, in and of themselves, hold little promise of improving access. For states, each decision – whether or not to contract to managed care, carve dental in or out, put contractors at risk, or engage single or multiple vendors – has its benefits and advantages.

Evidence suggests, however, that these decisions are not the primary determinants of success in increasing access to dental care for low-income beneficiaries. Rather, success depends primarily upon:

- Sufficiency of payments,
- Sufficiency of provider availability, and
- Strong program oversight.

A handful of states that have significantly increased access have done so by utilizing a variety of program arrangements. Yet, these diverse programs share several common elements that lead to their success, namely:

- Funding at market rates,
- Simplified program administration,
- Active engagement of stakeholders in designing and implementing reform, and
- Rewarding access improvements.

This document was prepared under contract with
the Children's Dental Health Project of Washington, D.C.,
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The Connecticut Health Foundation (CHF) is the state's largest independent, non-profit grantmaking foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. For additional information, click onto www.cthealth.org.

CDHP Policy Brief

Cost Effectiveness of Preventive Dental Services

Preventive Dental Interventions Reduce Disease Burden and Save Money

Preventive dental interventions, including early and routine preventive care, fluoridation, and sealants are cost-effective in reducing disease burden and associated expenditures.[i,ii,iii,iv] While millions of children in the United States benefit from routine preventive dental care, there are still millions of additional children who needlessly suffer from avoidable dental disease. As a result, tooth decay continues to remain the single most common chronic disease of childhood, causing untold misery for children and their families.

Preventive Care: Low-income children who have their first preventive dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40% lower ($263 compared to $447) over a five year period than children who receive their first preventive visit after age one.[i]

Fluoridation: The Centers for Disease Control and Prevention reports that for every $1 invested in fluoridation, $38 in dental treatment costs is saved.[ii] In addition, Medicaid dental programs costs as much as 50% less in fluoridated communities compared to non-fluoridated communities.[iii]

Sealants: Sealants prevent cavities and reduce associated dental treatment costs, especially among high-risk children, where sealants applied to permanent molars have been shown to avert tooth decay over an average of 5-7 years.[iv,v,vi]

Lack of Dental Care Leads to Costly Emergency Department Visits and Temporary Solutions

Without access to regular preventive dental services, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency departments.[vii] This frequent consequence of failed prevention is not only wasteful and costly to the health care system, but it rarely addresses the problem, as few emergency departments deliver definitive dental services. As a result, patients typically receive only temporary relief of pain through medication and in some acute cases, highly costly, but inefficient surgical care. A three-year aggregate comparison of Medicaid reimbursement for inpatient emergency department treatment ($6,498) versus preventive treatment ($660) revealed that on average, the cost to manage symptoms related to dental caries on an inpatient basis is approximately 10 times more than to provide dental care for these same patients in a dental office.[vii]

The Connection Between Access and Preventive Care

Multiple interrelated social and demographic factors, including income, race, and education can limit children's access to preventive dental care.[viii,ix] Low-income children are only half as likely to access preventive dental services as middle or high-income children, despite their higher occurrence of dental problems. They are also two to three times more likely to suffer from untreated dental disease.[viii, ix] Minority children are less likely to have access to dental services than their white counterparts, as are children whose primary caregivers have limited education.[viii, ix,x]

Dental insurance coverage plays an integral role in accessing preventive care. Children with private or public dental coverage are 30 percentage points more likely than low-income uninsured children to have a preventive dental visit in the previous year.[x] Children with Medicaid coverage are significantly more likely to have a usual source of care.[xi]

For many low-income children, Medicaid's EPSDT program provides public coverage and access to dental care, including routine preventive services, such as sealants and fluoride treatments. Parents of children covered by Medicaid are 3.5 times less likely to report that their child has an unmet dental need than uninsured children.[xii] In addition, cost-estimation modeling of preventive interventions predict cost savings of $66-$73 per tooth surface prevented from needing repair among young Medicaid-enrolled children.[xiii] Further estimates reveal a savings of 7.3 percent from regular screening and early intervention.[xiv]

The Consequence: Untreated Dental Disease Affects General Health

The progressive nature of dental diseases coupled with lack of access to preventive care can significantly diminish the general health and quality of life for affected children. Failure to prevent dental problems has long-term adverse effects that are consequential and costly. In particular, unchecked dental disease compromises children's growth and function (including their ability to attend to learning, to develop positive self-esteem, to eat and to speak), thereby making the cost of preventive dental care low compared to alternatives of suffering, dysfunction, and expensive repair.[viii,xv]

Despite historic achievements in oral health, such as community water fluoridation and other preventive measures, millions of children are still without basic dental care. Oral health promotion and prevention is critical to reducing disease burden and increasing quality of life. Failure to provide access to preventive dental care almost always results in quick fixes that are short-lived and high-priced, especially among low-income children and their families who are without the resources necessary to access dental services. Recognizing that dental insurance, including Medicaid coverage, is an essential part of accessing care may be the first step to reducing barriers to care and eliminating oral health disparities by ensuring that low-income children gain access to the preventive dental services they need.

Credits: Shelly-Ann Sinclair MPH, Burton Edelstein DDS MPH
February 23, 2005

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