Opportunities to Use Medicaid In Support of Oral Health Services

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December 2000

U.S. Department of Health & Human Services
Health Resources & Services Administration
Opportunities to Use Medicaid in Support of Oral Health Services

1. Purpose of this Document

The purpose of this document is to assist State and local health officials, as they work with State and local Medicaid officials, in understanding how Medicaid works, and how Medicaid can help improve access to oral health services for low-income and underserved populations. This document explains how Medicaid can be a source of support for State, local and community-based oral health services. The appropriate use of Medicaid funding can make these services more accessible and available to serve more persons who need services.

Medicaid is a critically important source of financing for health care services, especially for low-income children, adolescents and families. No other program supports more health care for this population group. For children and adolescents, comprehensive dental coverage is required in all Medicaid programs under the provisions of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. For adults, States have the option to cover various dental services, including dentures. States vary widely in their coverage of adult dental services, from no coverage or coverage for only emergency services to reasonably comprehensive care.

Many medical and dental providers, and health officials have found Medicaid rules complex and confusing. This should not discourage the pursuit of Medicaid funding. The goal of this document is to provide information, in simplified terms, that can help all parties understand what the opportunities are. This should help as agreements are negotiated, policy decisions made, and strategic plans formulated.

2. About Medicaid: A Brief Overview

Additional information about Medicaid is provided in the Attachment to this document.

Medicaid serves more people than any other U.S. health program. Over 40 million persons had Medicaid coverage during 1999. In general terms, about half were children, about a quarter were adults responsible for the care of the children, and about a quarter were adults who were disabled or elderly.

Medicaid is a Federal-State program for financing medical and long-term care services for low-income Americans. Established in 1965 as Title XIX under the Social Security Act, Medicaid was designed to provide health insurance for persons with low incomes and to help States pay for the costs of their health programs.

At the Federal level, the Health Care Financing Administration (HCFA) pays the Federal share of these costs by providing matching funds to the States. The Federal matching rate (the “Federal Medical Assistance Percentage,” or FMAP) for medical or dental services
is at least 50% and as much as 77% of these costs. The exact percentage in each State is recalculated each year based on a formula that considers the level of personal income in that State compared to the national average. The Federal share of Medicaid administrative costs is the same for all States at 50% for most administrative functions, with certain expenditures qualifying for higher matching rates. Federal Medicaid payments to States for services or administrative costs are not capped. Eligible individuals are entitled to services covered in their State, and State Medicaid programs are obligated to pay for covered services when they are provided and a claim is submitted in accordance with policies set by the State.

States design and administer Medicaid within Federally-defined boundaries. Within these guidelines, each State defines who is eligible for coverage, what medical services are covered, which medical providers can participate and the amount providers are paid when they provide a service. As a result, each State Medicaid program is unique. However, comprehensive dental care for children and adolescents is covered under Medicaid in all States under the requirements of EPSDT. EPSDT requires Medicaid coverage for treatment of any dental problem identified through an EPSDT medical or dental screening, regardless of whether the needed service is otherwise covered under that State’s Medicaid plan.

| Medicaid is the largest single expenditure item in most State budgets. Medicaid helps finance 77% of all State health-related expenditures. --National Association of State Budget Officers |

### 3. Oral Health Services: How Medicaid Can Help

Medicaid is a significant source of financing for oral health services, particularly for children and adolescents. Almost universally, however, Medicaid programs identify access to dental care as a significant and persistent problem for persons with Medicaid.

Oral health status and access to dental services are issues for all populations served by Medicaid. Certainly, oral health is a priority issue for all young children, but especially for those of low income where common dental diseases like tooth decay are concentrated. Since Medicaid is the health coverage for about one-fourth of all children in the U.S., Medicaid has a special role in dental coverage for this group. Oral health is no less a priority for other population groups served by Medicaid, including low-income women, pregnant women, disabled adults and the elderly.

According to a recent Report prepared by the Office of the Inspector General, U.S. Department of Health and Human Services (DHHS), only one-in-five Medicaid children received even one preventive dental service in 1996. Another study found that only 30% of all children in households under 200% of the Federal Poverty Level saw a dentist for

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any reason in 1996.\(^2\) According to the U.S. Surgeon General Report in 2000, dental caries is the single most common chronic disease of childhood, with a prevalence five times greater than asthma.\(^3\) Tooth decay (the most common oral health problem of children) is concentrated in low-income children, who are most likely eligible for Medicaid coverage. Recent surveys indicate that Medicaid eligible children have three times greater unmet need for dental care than children in higher income families.\(^4\)

Oral health presents a unique opportunity for beneficial collaboration between Medicaid, and HRSA-funded programs and other public health programs at the national, State and local levels. Public health programs can work with Medicaid to implement initiatives to improve access to dental services. At the same time, Medicaid can provide a source of financing for dental services that can enhance the success of public health efforts to improve oral health.

According to a survey of State Medicaid dental programs in 1999, all but two of 44 responding States indicated that there is a problem with access to dental care for Medicaid-enrolled children in their State. Reflecting the priority placed by States on improving access to dental services, almost every State has undertaken activities intended to improve access to dental care for Medicaid beneficiaries.\(^5\)

The issues in improving oral health and access to dental services are complex and challenging to address. Barriers include:

1) Low or declining participation of dentists in State Medicaid Programs;
2) Declining supply of dentists and dental hygienists for the general population, particularly in inner city and rural areas;
3) Dental service capacity of safety net providers which is inadequate;
4) Medicaid dental coverage, billing procedures and reimbursement levels that are not comparable to other dental insurance;
5) Dentists’ perceptions of Medicaid patients which are sometimes negative; and
6) State budget limitations that make it difficult for Medicaid programs to match mainstream dental insurance in terms of reimbursement levels, services covered, authorization procedures or billing requirements.

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Experience has shown that the situation in each State is unique, so the most appropriate approach in one State may not be the exactly the right one in another State. The problem is usually so significant that it will require a comprehensive set of strategies involving many different approaches.

Beginning on the next page are key strategies that Medicaid can use to help improve access to oral health services and improve the oral health of low-income adults and children. The specific strategies are organized as follows:

(A) Ensuring adequacy of coverage;
(B) Ensuring adequacy of payment;
(C) Improving dentist participation;
(D) Ensuring that eligible persons are enrolled; and
(E) Improving eligibility standards for Medicaid and the State Children’s Health Insurance Program.

Strategies to Expand Access to Oral Health Services

A. Ensuring Adequacy of Coverage

- Adult dental coverage
- Child dental coverage, including EPSDT requirements
- Services for children with special health care needs
- School-based health services

- Adult dental coverage: Under Medicaid law, dental services for adults are classified as an “optional service.” The most recent Federal report shows that dental services for adults were specifically listed as a covered service in the Medicaid State plan in 42 States in 1996.\(^6\) (Note: In some states, adult dental services may also be covered under another coverage, such as clinic services, or under a Section 1115 waiver program.)

However, the fact that a State covers adult dental services does not mean that all services are covered. A State can select the dental services it wishes to cover for adults. In some States coverage is comprehensive, including regular cleanings, X-rays and dental repair similar to employer-sponsored dental insurance. In other States, coverage is limited to the immediate relief of pain and infection.

It is important that Medicaid dental coverage is reviewed periodically. This review can focus on the extent Medicaid dental coverage can help to improve oral health among adults, whether the coverage reflects modern dental practice and how dental coverage can influence the willingness of dentists to serve Medicaid patients.

\(^6\) Health Care Financing Administration, Division of Intergovernmental Affairs. *Medicaid Services State by State, October 1, 1996.* HCFA Publication 02155-97.
Appropriate dental care and good oral health enhance employability among adults on Medicaid and increase the likelihood that they will get a job, keep their job and achieve independence from the welfare system. In this way good dental coverage for adults can contribute to increasing employment and success in welfare reform, and offset some of the costs of dental services for this population.

Under Medicaid law, coverage for dentures for adults is a separate optional coverage. The most recent information indicates that 34 States listed dentures for adults as a covered service in 1996. 7

Mainstream dental coverage for adults can also be expected to make the program more attractive to dentists and contribute to improved participation by dentists in the program. In this way improving dental coverage for adults can be both a strategy to improve oral health and improve access to needed services for persons of all ages.

- **Child dental coverage, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program requirements:** Under the requirements of EPSDT, Medicaid must provide comprehensive coverage of all needed dental services for children and adolescents from birth through age 20.

EPSDT is a specific program under Medicaid that provides well-child and comprehensive pediatric care for children and adolescents through age 20. EPSDT requires comprehensive coverage of physical and mental health, growth and developmental assessments, including lab and other diagnostic tests, immunizations, health education and anticipatory guidance. EPSDT also includes comprehensive dental, vision and hearing screenings. EPSDT screenings, including dental, are covered for each age group based on a clinically-sound periodicity schedule adopted by each State with consultation from professional medical and dental groups 8. The screenings are also covered “as needed” at any age.

EPSDT also requires coverage of any necessary medical or dental service reimbursable under Medicaid for the treatment of a condition identified under a periodic or “as needed” exam, even if the service is not otherwise a covered benefit in that State. Under EPSDT, dental coverage includes complete preventive care, restorative services, medically necessary orthodontic care, and emergency care.

A common complaint among dentists concerns patients who do not keep their appointments. Missed appointments cause resentment among dentists because of the office management and financial problems they create. More importantly, the patient

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8 The Academy of Pediatric Dentistry, the American Dental Association, the American Public Health Association and the Bright Futures Project all have adopted periodicity schedules by age. Currently, each one recommends the first dental visit be scheduled at the time of the child’s first birthday.
does not receive a needed service. The likelihood of a patient keeping a dental appointment is improved with a system of case management that addresses the logistical, cultural and behavioral barriers to dental care. Medicaid can pay for case management as a medical service or as an administrative activity.

Case management services are an integral component of EPSDT and (at the discretion of the State Medicaid agency) can be provided directly by the Medicaid agency, by participating providers, or by case managers employed by State or local public health agencies. State and local maternal and child health providers can and do play a very beneficial role in providing case management services. Case management can assist parents in scheduling appointments for screening, diagnosis or treatment, can arrange transportation and follow-up to ensure that appointments are kept, re-schedule missed appointments, and work with the parent and the dental office to be sure the child obtains care.

Under EPSDT, Medicaid can also reimburse the cost of transportation to and from a covered dental exam or service. Depending on how a State chooses to provide transportation, it can be reimbursed as a service or as a component of Medicaid administration.

- **Services for children with special health care needs:** Medicaid can play an important role in paying for portions of the required medical and dental services for children with special health care needs (CSHCN), many of whom are enrolled in the Title V Program. The Maternal and Child Health Program was enacted as Title V of the Social Security Act in 1935 as a health services safety net for all women and children. Today, Title V is administered by the Health Resources and Services Administration (HRSA).

Between 1967 and 1989, Congress added a number of requirements to Title V to work closely with and assist Medicaid in a number of activities, including finding and enrolling both children and providers. Title V State offices are required to establish memorandums of agreement with their State Medicaid offices. In 2000, the Administrators of HCFA and HRSA signed a data sharing agreement to enhance cooperation at the State level between the Medicaid and Title V programs and improve access to health care for low-income women and children. Cooperation between State Medicaid and Title V Programs can enhance the coordination and case management of sources, result in better care, and provide a financial resource for dental, primary, and specialty care.

Many children and adolescents with serious or complex health needs are enrolled both in Medicaid and in the Title V Maternal and Child Health Program. Medicaid is a key source of funding for most medically necessary services for CSHCN for conditions identified through an EPSDT screening. Medicaid is especially important for the coverage of services, such as durable medical equipment, medical supplies and prescription drugs. The Title V Program is able to provide other services, not
otherwise covered by Medicaid, which may include case management or other services or supplies not included in the Medicaid benefit package.

For children with special health care needs, it is sometimes difficult to locate a dentist who is equipped to serve those with certain conditions. The State Title V and Medicaid agencies may need to work together to make special arrangements with dentists so all Medicaid-enrolled children with special health care needs can receive needed preventive and specialty dental services.

- **Oral health services in Federally Qualified Health Centers (FQHCs):** FQHCs are able to provide dental services, and about one-in-three do. State Medicaid agencies are allowed to pay FQHCs up to 100% of reasonable costs, but must pay them at least 95% of reasonable costs in Fiscal Years (FY) 2001 and 2002, 90% in FY 2003 and 85% in FY 2004. FQHCs that provide dental services play a crucial role in the availability of these services, especially in underserved areas where they may be the only provider. Expanding the availability and capacity of dental services in FQHCs can be a significant strategy in increasing service availability for Medicaid populations, especially in areas where there are few dental providers.

- **School-based health services:** Medicaid can reimburse for medical and dental services covered under a State’s Medicaid program when they are provided in school-based health clinics or settings to children, including adolescents who are enrolled in Medicaid and are qualified for services under the Individuals with Disabilities Education Act (IDEA). However, school-based dental facilities face barriers because they may be expensive to operate, difficult to staff and may require substantial space commitment. For these reasons, a program of “school-linked” dental services may be preferred, where prevention programs and screenings are provided in schools and students are “linked” to community-based dental providers for any needed reparative and surgical care. These programs and services may qualify for Medicaid reimbursement, depending on how they are structured and provided and the extent the students are enrolled in Medicaid.

In addition to Medicaid, the Title V Maternal and Child Health Program and other HRSA funding supports nearly 150 dental sealant programs which utilize portable dental equipment to serve about 1000 classrooms consisting primarily of Medicaid eligible children. These programs provide dental sealants for underserved children, assist children in enrolling in Medicaid and SCHIP, and refer children for follow-up restorative care, if required.

Local public health early intervention programs and school districts may enroll as Medicaid providers and receive payment for covered services for eligible children and adolescents. Services often covered in school settings include: therapies; case management; transportation; screening and evaluation; health education; dental sealant application; and other services that may fall under EPSDT.
Schools may also assist the Medicaid program in certain administrative activities. Examples of Medicaid reimbursable administrative activities include: 1) Medicaid outreach; 2) providing information about how to enroll; 3) assisting parents in completing application forms; 4) assisting with documentation needed for enrollment; 5) referral to dentists or medical providers; 6) coordinating and monitoring of health services; or 7) assisting in arranging for or providing transportation for medical or dental services. These administrative activities must be part of the Medicaid State Plan that is approved by HCFA in order to qualify for Medicaid reimbursement. Schools and school districts do not submit claims for individual services for administrative activities. A cost allocation plan is used to determine the share of total costs for approved activities that is attributable to Medicaid-eligible children and adolescents. The Medicaid share is the amount that qualifies for Federal Medicaid matching funds.\(^9\)

Medicaid reimbursement for services in school settings may be limited when children are enrolled in a managed care organization (MCO) unless the State Medicaid agency has agreed to pay for these services on a fee-for-service basis. The key factor is what medical or dental services are included in the Medicaid capitation rate to the MCO. When a service is included in the capitation rate, a medical or dental provider will need to seek payment for services for an enrolled Medicaid patient from the MCO instead of the Medicaid agency. Some States “carve out” certain services from the MCO capitation rate, so payment may be made directly to schools on a fee-for-service basis.

Important issues have arisen in some States relating to the claim for Federal Medicaid reimbursement for services in schools. These issues have related both to medical services and for administrative activities. HCFA has disallowed certain claims for Medicaid reimbursement when it was found that all conditions for payment were not met. The lesson to be learned from these experiences is that Medicaid funding should be claimed only for services that are covered for children who are enrolled, and that administrative overhead costs associated with medical or dental services should not also be claimed as administrative costs.

### B. Ensuring Adequacy of Payment

- **Fee-for-service payment rates to dental providers**
- **Managed care payment rates to dental providers**

- **Fee-for-service payment rates to dental providers**: Participation in Medicaid and serving Medicaid patients is voluntary for all providers. Those who do participate must agree to accept Medicaid payment as payment in full. The amount that Medicaid pays for services is a key factor in a dentist’s decision to serve Medicaid patients. Low payment is one of the most frequently cited reasons for not

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participating in Medicaid. Dentists have indicated that Medicaid reimbursement often does not cover the direct cost of providing services. Federal law requires that State Medicaid payments to providers be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” To achieve the desired level of dental participation, dental services merit special attention in Medicaid rate setting.\(^\text{10}\)

For dental and medical services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Federal law requires Medicaid payment to be based on reasonable costs. Medicaid also has the option to pay local health departments, community mental health clinics or other public providers on a reasonable cost basis. However, many of these clinics and health centers do not provide dental services, and those that do are unlikely to have enough capacity to meet all the needs of the community. Substantial participation of dentists in the community will likely be required to achieve adequate coverage of oral health services.

To have Medicaid payment rates regarded as acceptable to dental providers is necessary to dental participation, but it is not likely to be sufficient. Dental providers are often concerned about program administrative requirements and procedures. Program improvements and administrative streamlining are an important adjunct to adequate reimbursement in increasing dentists’ service to Medicaid patients. (See Section C below for a discussion of these approaches.)

- **Managed care payment rates to dental providers:** In many States, almost all families on Medicaid receive medical care through a managed care organization. In these States, the Medicaid program has several options for covering dental services. Medicaid can include dental care as a service covered by the medical managed care organization, can contract directly with dental managed care vendors, or can “carve out” (exclude) dental services from managed care. When Medicaid decides to contract dental services through managed care, Medicaid must have a contract with the managed care organization that spells out the expected coverage, the required network of dental providers and the required levels of performance. The specific provisions of this contract are critical to the success of this approach to dental coverage.

A key issue is whether the amount Medicaid pays to the managed care organization for dental services is sufficient for the expected use of services, and whether payment rates used by the managed care organization to reimburse dentists are sufficient to assure access.

\(^{10}\) Section 1902(a)(30)(A) of the Social Security Act codified as 42 U.S.C.A. §1396a(a)(30)(A)
The amount in the managed care organization’s capitation rate targeted to dental services is usually based on an actuarial assumption that the use of dental services will be the same in managed care as it was under the state-administered fee-for-service program. This assumption will not be correct when the use of dental services was low due to limited access under the State-administered fee-for-service program, and where the managed care plan improves access and the use of dental services. In this case, the amount of money available to the managed care organization for dental care will be inadequate. The Medicaid agency must address this issue when the managed care rates are being set, and do so within the Federal “upper payment limit” requirements. The upper payment limit constrains the State Medicaid program’s capacity to enhance funding for a specific service such as dental in its managed care rate setting.

Managed care offers an opportunity to address several key issues relating to good oral health care. The Medicaid agency can use the contract with managed care organizations to address oral health standards of access, quality, utilization, reimbursement and data reporting, and can require a relationship with Title V and other public health agencies.

C. Improving Dentists’ Participation

In recent years, States have invested considerable resources in addressing low dental provider participation in Medicaid and poor access to dental services. Several strategies are being used in an effort to improve access and availability of dental services. The clear message from recent State experience is that the problem is complex, multifaceted and difficult to resolve. Reimbursement issues are important, yet improving reimbursement alone may not improve dental access.

• Strategies to Improve Dentists’ Participation in Medicaid: A number of issues need to be addressed to successfully establish and improve dentists’ participation in Medicaid. These include the issues cited above relating to adequate coverage and reimbursement, plus others that relate to improving the business relationship between Medicaid and the dentist. Success requires a comprehensive set of strategies. Strategies identified in a recent survey of all States include the following:11

• Improved reimbursement: Three-fourths of States increased payment rates to dental providers in 1998 or 1999. Dentists often cite low reimbursement as a primary reason for not serving Medicaid patients. Small increases may not improve payment levels to a point that a dentist believes actual costs are covered by Medicaid payment.

• **Administrative streamlining**: Many States have tried to improve the business relationship with dentists by minimizing the hassle of being a provider with Medicaid. Actions have included: 1) simplifying the process of becoming a Medicaid provider; 2) providing a simple process to verify patient enrollment with Medicaid; 3) simplifying the process for prior authorization for services, or eliminating prior authorization entirely for many services; 4) reducing the number of services requiring prior authorization; 5) adopting the American Dental Association coding structure and standard claim forms; 6) establishing provider hot-lines; 7) establishing patient ombudsmen; and 8) simplifying provider manuals and program requirements.

• **Creating mainstream benefit structure**: The more Medicaid dental coverage is comparable to employer-sponsored dental insurance, the greater likelihood dentists will participate and serve Medicaid patients. Achieving dental coverage regarded as mainstream by the dental community may involve adding or updating covered services and procedures so they reflect modern dental practice and terminology.

• **Creating a special advisory committee or task force to recommend strategies**: Participation in an advisory committee or task force can raise awareness within the dental community of the urgency and need to serve this population. Significant contributions of a State oral health coalitions include: 1) helping to educate beneficiaries about the importance of oral health; 2) working with the dental community to improve participation and availability of services; 3) bringing the problems and issues to the attention of State officials and legislators; 4) engaging the public in advocacy for oral health; and 5) identifying best practices that can be adopted for State and local use.

• **Outreach and marketing to dental providers**: The distribution and supply of dental providers is often problematic. Many inner city and rural areas (where large numbers of Medicaid beneficiaries reside) may have few or no dental providers. Special efforts need to be focused where there is a shortage of dental providers. These efforts may include: 1) special articles in dental journals; 2) letters to individual dentists; 3) meeting with local dental societies; 4) seeking input from dentists on how to recruit additional providers; 5) improving the conditions of participation in Medicaid; and 6) using Head Start and WIC programs to assist in recruiting dentists for Medicaid.

• **Case management to reduce missed appointments**: Missed appointments are a serious issue for dentists. Reducing the rate of “no shows” for scheduled dental appointments can be a very important part of an overall strategy to improve dentists’ participation. Medicaid can pay for case management provided by health departments, managed care organizations, state and local maternal and child health programs, FQHCs, other providers, enrollment
brokers or the Medicaid agency can provide case management itself. Case management can include: 1) sending reminder postcards; 2) using case managers to assist in setting up appointments and emphasizing the importance of keeping their appointments; 3) following up on appointments whether kept or missed; and 4) creating a toll-free hotline for dentists to call if a patient misses an appointment.

- **Outreach to parents of children**: Medicaid can help educate parents about the importance of oral health, the need for early care to prevent common dental problems and how to use the dental delivery system. Medicaid can provide this outreach directly or contract with other organizations, such as local health departments, schools, managed care organizations or dental provider groups.

- **Transportation and making appointments**: Medicaid can pay for transportation and the scheduling of appointments. A State agency or a private provider can provide both, and both can be classified as a service or an administrative activity.

- **Working with schools and Head Start programs**: Medicaid can provide schools and Head Start programs with literature and information to encourage early and continuing good oral health and dental check ups.

- **Working with managed care**: Managed care organizations under contract with Medicaid must guarantee access and quality, and comply with specific contract performance requirements. Medicaid is obliged to enforce these requirements.

Where dental services are the responsibility of managed care organizations, Medicaid can facilitate good oral health services through adequate capitation rates and contract requirements for access and quality that are that are clear and enforceable.

- **Working with safety net providers**: Dental services often are available through community providers. FQHCs, Rural Health Clinics and hospitals may serve as safety net providers of dental care. Encouraging safety net providers to offer dental services can be an important part of an overall strategy, together with measures to encourage good participation of community-based dentists.

**D. Ensuring that Eligible Persons are Enrolled**

- **Adults and children eligible for Medicaid**
- **Children eligible for the State Children’s Health Insurance Program**

- **Adults and children eligible for Medicaid**: A primary strategy for fully utilizing Medicaid is to enroll all persons who are eligible under existing eligibility standards.
Medicaid cannot pay for services for persons who are not enrolled, even if they are eligible. Experience has shown that many eligible persons are not enrolled. A number of strategies can increase the likelihood of their enrollment. These strategies include: 1) outreach, public service announcements and paid radio and TV ads; 2) simplified application forms and enrollment procedures; and 3) assistance for persons applying for Medicaid. These strategies apply to enrollment of adults, as well as children.

The key to getting children enrolled seems to be providing good information and making the process as easy as possible for the parent. Research has shown the following strategies improve the likelihood that parents will enroll their child: 12

- Allowing enrollment by mail or phone;
- Permitting immediate enrollment ("Presumptive Eligibility") with forms completed later;
- Extending enrollment office hours;
- Improving the way applicants believe they are treated at enrollment centers;
- Allowing enrollment at a clinic, doctor’s office or dentist’s office;
- Allowing enrollment at Head Start programs, WIC clinics and faith centers;
- Allowing enrollment at school or day care center;
- Using a toll-free telephone information line; and/or
- Simplifying and shortening the enrollment form.

Other policies adopted by many States include:

- Dropping the assets test;
- Adopting presumptive eligibility;
- Not requiring a face-to-face interview;
- Providing continuous 12-month eligibility;
- Providing information and outreach;
- Adopting common policies for both Medicaid and the State Children’s Health Insurance Program (SCHIP); and
- Making the program as much like mainstream health and dental insurance as possible. States have found that creating an image of Medicaid that is more like private health and dental insurance can help overcome a lingering stigma in the minds of some potential beneficiaries.

E. Improving Eligibility Standards for Medicaid or the State Children’s Health Insurance Program

- Medicaid Eligibility for Children to Age 18: States have the opportunity to expand eligibility specifically for children. Federal law requires that States cover children to age 6 at 133% of the Federal Poverty Level (FPL). For children age six and above, 12

Federal law specifies eligibility at 100% of the FPL for children born after September 30, 1983. This provision will fully phase in eligibility at 100% of the FPL for children to their 19th birthday in the year 2002.

Many States have taken advantage of the opportunity to expand Medicaid eligibility above the levels required by Federal law. Under Section 1902(r)(2) or Section 1931 of the Social Security Act, a State can expand eligibility to the level it chooses. A few States have expanded eligibility under Medicaid to 275% or 300% of the FPL using this approach. Other States are using their State Children’s Health Insurance Program as the vehicle to expand coverage for children.

State Children’s Health Insurance Program (SCHIP): SCHIP has provided an excellent opportunity to expand access to needed health and dental care for children.

Background: Since enactment of SCHIP as Title XXI of the Social Security Act in 1997, States have focused on implementing their SCHIP programs and getting eligible children enrolled. In the year from December 1998 to December 1999, the number of children enrolled in SCHIP programs more than doubled, from about 0.8 million to 1.8 million. An estimated 2.6 million children are eligible for SCHIP nationally. Many States have found that SCHIP outreach and enrollment has a Medicaid case-finding effect, with one or more children enrolled in Medicaid for every child enrolled in SCHIP.

SCHIP programs qualify for an enhanced Federal matching rate that is higher than the Medicaid. Federal matching rates for SCHIP range from 65% up to 84%.

Children, including adolescents who are eligible for Medicaid (whether they are enrolled or not) are by law not allowed to be enrolled in SCHIP. Similarly, children with any other health insurance coverage are not eligible to enroll in SCHIP. This is a serious issue for oral health services, since some children are excluded from SCHIP because they have health insurance coverage, but their health insurance does not cover dental care. Under current law, it is not possible for SCHIP to provide dental coverage for these children.

A State can implement SCHIP as a Medicaid expansion, or as a separate program based in the private health insurance market, or it can implement both. To the beneficiary, a Medicaid expansion SCHIP program is often indistinguishable from Medicaid, and it includes the same comprehensive dental services covered by Medicaid. A separate SCHIP program may be based on private health insurance coverage, and unlike Medicaid, have a nominal premium, copayments for children and limits on benefits, including limits on dental services.

Enrolling children in SCHIP provides significant coverage that can bridge the gap between Medicaid and private employer-sponsored health insurance. A State can include a different benefit package and pay different reimbursement levels for dental services under SCHIP than under Medicaid. Some States have seen improvements in dental access under a more mainstream SCHIP coverage and payment arrangement. From these experiences, States can learn important lessons about how to improve dental participation and access to oral health services.

**Note:** SCHIP programs that are Medicaid expansions are required to cover dental services, but separate SCHIP programs are not. All separate SCHIP programs (except one) offer dental coverage even though the SCHIP dental coverage may not be comparable to that provided under Medicaid. Dental coverage under separate SCHIP programs may have premiums, copayments, annual service limits, exclusions or other restrictions.

States can also provide medical and dental coverage for the adults associated with SCHIP-covered children. Until recently, this coverage could only be arranged under a Medicaid expansion or a Section 1115 Medicaid waiver. HCFA announced on July 31, 2000 that it would consider waiver requests under Title XXI to provide coverage under SCHIP. This would allow States to provide “family coverage” as an extension of SCHIP coverage for children.

**Conclusion**

There is great potential for State and local health programs to work with Medicaid to improve access to dental services and improve oral health. Medicaid can be a source of financing for dental services for children and adults. Public health services can assist Medicaid in addressing issues of access and dental provider participation.

Medicaid has become a significant source of funding for almost every health-related service in the U.S. that serves low-income persons. A State should conduct a review periodically to be sure it is fully using Medicaid as a source of support to help finance these services.

**Other Opportunities to Use Medicaid**

In addition to oral health, Medicaid is a potential source of financing for a number of other State and local health services. Specific areas where Medicaid can be a source of funding include: maternal and child health services, rural health services, services for persons living with HIV/AIDS, and mental health and substance abuse services.

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Contact for More Information

If you have questions or wish to obtain additional information on implementation strategies, contact HRSA at:

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OR

Visit the HRSA Website at: www.hrsa.gov/medicaidprimer.

HRSA has an Oral Health Initiative. For more information on this Initiative, see Website: www.hrsa.gov/oralhealth.

The coordinator of the HRSA Oral Health Initiative is Jim Sutherland and the HRSA consultant for oral health is Burton Edelstein.

This document was prepared by Health Management Associates under a contract with HRSA.
Attachment:

A Basic Description of the Medicaid Program

Federal law provides that a State may qualify for Federal Medicaid matching funds only if it designs its program within specific Federal requirements. These include eligibility for specific population groups, coverage for certain medical services and medical providers, and adherence to specific rules relating to payment methodologies, payment amounts, and cost-sharing for Medicaid beneficiaries.

To qualify for Federal Medicaid matching funds, a State must obtain the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) approval of its Medicaid State Plan. The State Plan is the contract between the Federal government and the State, which spells out the terms and conditions under which the State will receive Federal Medicaid matching funds. Every change in eligibility for beneficiaries, change in coverage of services or change in methodology of reimbursement in a State’s Medicaid program requires a State Plan Amendment that must be approved by HCFA.

Waivers of Federal Requirements

Federal law requires that Medicaid beneficiaries have freedom of choice of providers, that the program is statewide, and that services are available in an amount, duration and scope sufficient to achieve their purpose.

The Federal law provides flexibility to States to cover optional services and eligibility groups. Some options are specifically described in the Federal law. Other options may be available through “waivers.” HCFA has authority to “waive” certain statutory requirements so a State can, for example, cover certain benefits or eligibility groups that could not otherwise be covered under Medicaid.

HCFA may grant “program waivers” or “research and demonstration waivers”. The most common program waiver is under Section 1915(b), which waives the freedom of choice requirement so a State can implement a managed care program. Recently, the Balanced Budget Act of 1997 provided that a State has a choice of a managed care waiver or a State Plan Amendment. Either approach will be approved with a set of specific terms and conditions. Section 1915(c) waivers provide for Home and Community Based Services waivers. Research and demonstration waivers are granted under Section 1115 for more comprehensive programs of health reform. Section 1115 waivers may involve restructuring the State’s Medicaid program, as well as the terms and conditions of Federal funding.
The Impact of Medicaid Managed Care

Increasingly, Medicaid programs have moved toward the use of managed care arrangements as delivery systems for Medicaid beneficiaries. Medicaid managed care may involve enrollment with health maintenance organizations (HMOs) and managed care organizations (MCOs) which are paid on a capitated basis, or a Primary Care Case Management (PCCM) system, which is a fee-for-service program that the state develops and manages itself. Some states have found that a PCCM works well in rural areas that may be served by few or no HMOs.

An HMO, a MCO or a PCCM system will require the Medicaid beneficiary to enroll with a specific primary care provider, who by contract with the Medicaid agency accepts certain responsibilities for providing and authorizing needed medical care. Providers not in the HMO network, or not referred by the primary care provider in a PCCM system, may not be able to be reimbursed for services provided to Medicaid beneficiaries.

The use of managed care can raise significant issues for Medicaid reimbursement of services delivered by public health agencies, mental health agencies, health centers or other publicly assisted agencies. This is particularly true for care provided through capitated HMOs and MCOs. Public providers may need to negotiate participation and reimbursement arrangements with an HMO instead of with the Medicaid agency. Public providers would be well served to monitor the development of State Medicaid policy to be sure their interests are taken into account as managed care policy is developed. It is sometimes possible and advantageous to the State agency and the State budget to arrange for certain services to be “carved out” of capitated managed care contracts and directly reimbursed by Medicaid. Services often considered for a carve-out include: family planning; prenatal care and other pregnancy services; selected Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; immunizations; or mental health services.

Qualifying for Federal Medicaid Matching Funds

Medicaid is a program that provides open-ended Federal contributions according to a statutory formula to participating States with approved plans. HCFA reimburses the State Medicaid Agency for a portion of actual expenditures made under the provisions of the State Plan. Federal reimbursements (Federal financial participation, or “FFP”) are based on qualifying expenditures for either “medical assistance” (i.e., medical services) or for program administration.

The amount of Federal payments to a State for medical services depends on two factors. The first is the actual amount spent that qualifies as matchable under Medicaid. In general, this means that:

- The expenditure is for a covered service;
- Provided by a qualified provider enrolled with the Medicaid program; and
- To a person eligible for and enrolled in Medicaid at the time of service.
The second factor is the Federal Medical Assistance Percentage (FMAP) for each State. The FMAP percentage is computed from a formula that takes into account the average per capita income for each State relative to the national average. By law, the FMAP cannot be less than 50%. States with per capita personal incomes below the national average have a FMAP rate as high as 77% in fiscal year 2000. This means, for example, for every $1 in qualifying Medicaid expenditures made by a State, the State is able to claim and receive at least $0.50 and as much as $0.77, depending on the State FMAP. Expenditures for Medicaid-related administrative activities also qualify for Federal matching funds. For administrative expenditures to qualify, the activities must be related to the administration of the State Medicaid program. Unlike the FMAP for medical services, which is different for each State, the administrative matching rates are the same for all States. Expenditures necessary for the administration of the program generally are reimbursed at 50%. Certain administrative expenditures qualify for higher Federal matching rates. For example, certain activities requiring skilled medical professionals qualify for 75% Federal matching. Some expenditures relating to the development of new information technology systems may qualify for Federal matching rates of 75% or 90%.

Medicaid allows State and local agencies that provide or arrange for covered services to Medicaid enrollees to receive Federal payments toward the cost of such services. For these expenditures to qualify for Federal Medicaid payments, service delivery and administrative activities must be carried out under the terms of an inter-agency agreement with the Medicaid agency. The agreement is a contract that spells out the medical and administrative services that will be treated by the Medicaid agency as Medicaid expenditures; and thus, will qualify for Federal funds. The Medicaid agency will include those qualifying expenditures identified in the agreement in its claim for Federal funds. The agreement usually holds the service delivery agency responsible for any potential future recoveries if an audit should find the claim for Federal matching funds included non-qualifying expenditures.

**Opportunities to Use Medicaid**

Federal Medicaid matching funds have proven to be a rich source of financing for many State and local health programs. Federal Medicaid funds may help finance a new program or coverage, or the expansion of an existing program. In some cases, where an existing health program was previously financed entirely from State or local funds, the availability of Federal Medicaid matching funds may reduce the cost of general fund dollars borne by State or local government.

The opportunity to use Medicaid as a source of financing for State or local health programs depends on the ability of policymakers to design programs (or redefine ongoing programs) that meet the Medicaid requirements.
How to Increase Medicaid Funding for State and Local Health Services

Policy changes that will permit a State program to qualify its expenditures for Medicaid matching funds can be classified as follows:

- **Increase the Number of Persons Who Qualify for Medicaid Coverage:** Expenditures cannot qualify for Federal Medicaid matching funds when services are provided to persons who are not enrolled in Medicaid. Thus, one avenue for increasing Medicaid support for a program is for eligibility to be expanded so a greater number of persons served by a program may qualify. Many persons who are eligible for Medicaid do not apply because they do not know they are eligible, or they regard the application process as difficult.

State residency requirements are not allowed under Medicaid. This means, for example, that migrant workers and their children are able to qualify on the same terms as any other person in a specific State.

Medicaid eligibility is determined in general by two key factors. First, persons must be in a qualifying category. Second, persons must meet State-defined income and asset criteria. (Other requirements also apply, such as being a legal U.S. resident.) Each Medicaid program must cover certain groups of persons, but has the opportunity to offer coverage to other optional eligibility categories.

Medicaid eligibility rules are complex. The following is a general description of Medicaid eligibility categories and rules:

**Mandatory Eligibility Groups:** Federal law specifies that States must cover certain eligibility categories, including:

- Low-income families with children who would have qualified for Aid to Families with Dependent Children (AFDC) cash assistance in July 1996. These persons may or may not be receiving Temporary Assistance to Needy Families (TANF) cash assistance now.
- Children under age 6 in families with incomes below 133% of the federal poverty level (FPL).
- Children ages 6 to 17 in families with incomes below 100% of the FPL (to age 18 in 2001).
- Pregnant women with family income below 133% of the FPL.
- Elderly, blind or disabled adults and children receiving Supplemental Security Income (SSI) payments.
- Children receiving foster care or adoption assistance under Title IV of the Social Security Act.
- Persons who lose eligibility for AFDC/TANF due to earnings (i.e., leave welfare for work) may continue on Medicaid for up to a year; those who leave due to increases in child support payments, may continue on Medicaid up to four months.
Certain Medicare beneficiaries, with benefits depending upon income up to 175% of FPL are also eligible for Medicaid. “Dual Eligibles” are a group enrolled in both Medicaid and Medicare. Depending on the individual’s income, these persons qualify for various levels of Medicaid coverage and support. Persons who qualify under SSI income standards qualify for full Medicaid coverage. Persons above this level may not receive full Medicaid benefits. Medicaid pays for all or a portion of Medicare premiums, deductibles, and coinsurance, depending on the income level of the beneficiary. (An asset test also applies such that countable assets cannot exceed $4,000 for an individual, or $6,000 for a couple.)

- Qualified Medicare Beneficiaries (QMBs): Income up to 100% of the FPL. Medicaid pays Medicare part A and B premiums, deductibles and cost sharing related to Medicare covered benefits.
- Specified Low-Income Medicare Beneficiaries (SLIMBs): Income between 100% and 120% of the FPL. Medicaid pays only for the Medicare Part B premium.
- Qualified Individuals (QIs): Medicaid pays all or part of the Medicare Part B premium for persons who would be eligible to be a QMB except their income is between 120% and 135%, or at state option up to 175% of the FPL.
- Qualified Disabled and Working Individuals (QDWIs): Persons who are disabled, but who lost their Medicare Part A benefit due to increased earnings, and whose income is between 100% and 200% of the FPL. Medicaid pays the only the Part A premium.

Optional Eligibility Groups: Federal law specifies that States may, at the option of the State, cover low-income persons in a number of specified eligibility groups. These include (but are not limited to) the following:

- Pregnant women, infants, children and parents of any Medicaid-eligible child, including parents in two-parent families with income and assets at or below state-defined levels.
- Disabled children who would be eligible under criteria in effect in July 1996.
- Persons in institutions with incomes less than 300% of the SSI Federal benefit level.
- Recipients of SSI payments, and disabled or elderly persons with incomes below 100% of the FPL.
- Certain working disabled persons who would qualify for SSI if they were not working, up to 250% of the FPL.
- Children under a “Medicaid Expansion” State Child Health Insurance Program.
- Persons who are “Medically Needy”.

The “Medically Needy” category provides for a different method of determining eligibility, based on actual medical expenses incurred by an individual. Medically needy persons are individuals who fall within one of the mandatory or optional

In 1999, 42 states had a Medically Needy Program.
eligibility groups, but have income and resources that would make them ineligible, except when the cost of their medical care is taken into account. When they incur medical expenses they “spend down” their income, and become eligible for the balance of the eligibility period from the point in time they spend down their income to the eligibility level. The process begins again at the beginning of the next state-defined eligibility period.

**Income Eligibility Levels:** States have considerable flexibility in setting permissible income levels. Income eligibility levels can be set separately for specific groups, such as children, families, pregnant women, the disabled and the elderly.

States can increase effective eligibility levels for pregnant women, children, families with children, elderly and disabled persons by “disregarding” a certain amount of income. In this way, eligibility for children could be extended above 185% of the FPL (technically the upper limit for pregnant women and infants), by setting the disregarded amount to a level that would bring countable income down to 185% of the FPL. To extend the eligibility level to 285% of the FPL, for example, a State would set the disregarded amount at 100% of the FPL.

The income disregard provisions can also be used to effectively increase the income limits for Qualified Medicare Beneficiaries (who receive Medicaid assistance with their Medicare premiums, deductibles, and coinsurance), and some aged, blind and disabled Medicaid groups. This flexibility over countable income is found in Section 1902 (r)(2) and Section 1931 of the Social Security Act.

**State Children’s Health Insurance Program (SCHIP):** A State can implement its SCHIP program as a Medicaid expansion, or as a separate health insurance program. Another option is for a State to have both a Medicaid expansion and a separate program operating at the same time with each one targeted at health coverage for different groups of children. SCHIP has an enhanced Federal matching rate, ranging from 65 percent to about 85 percent. Because the matching rate is higher, a State can extend coverage to children at a lower State cost through SCHIP than through regular Medicaid.

A key feature of SCHIP is its focus on finding children who are eligible, but not yet enrolled in either Medicaid or a separate SCHIP program. Matching funds are available specifically for the purpose of marketing, outreach and determining eligibility.

- **Increase Services Covered by Medicaid:** Each State determines what medical services will be covered under Medicaid. By defining services appropriately, a State can be sure services provided by other State agencies qualify for Medicaid reimbursement. Typically, medical services provided through public health, mental health, disability, substance abuse treatment, aging, or education agencies can qualify for Federal Medicaid matching funds. Federal Medicaid matching funds can help
finance capacity expansion in these programs or reduce the net cost to the State for these services, if they are specifically covered in the State Plan.

Mandatory coverage includes the following services:

- Hospital services, inpatient and outpatient
- Physician services
- Lab and X-ray
- Immunizations and other well-child services listed under the Early and Periodic Screening, Diagnostic and Treatment requirements, including any medically necessary diagnostic and treatment services, plus vision, dental and hearing services for children.
- Family planning services
- Nurse midwife, pediatric and family nurse practitioner serves
- Federally-qualified health center (FQHC) and rural health clinic (RHC) services
- Home health care services
- Nursing home services
- Transportation for medical services

Optional coverages include 34 specific services, including the following:

- Prescription drugs
- Clinic series
- Rehabilitation and physical therapy services
- Prosthetic and orthotic devices
- Optometrist services and eyeglasses
- Hearing services
- Dental Services
- Home and community based care for persons with certain impairments

**Set Medicaid Reimbursement Rates at Appropriate Levels:** State Medicaid programs are required by Federal law to set their payment rates at a levels sufficient to achieve access to needed care. Medicaid may want to set rates to achieve specific public policy objectives, such as access to primary care, well-child care, prenatal care or deliveries.

Rates for safety net providers, including FQHCs and RHCs, can be set to assure their financial viability. Federal law specifies cost-related reimbursement methods for FQHCs, but meeting the minimum legal requirement may not assure full reimbursement of costs for Medicaid patients. Medicaid has the option under the law to provide full-cost reimbursement for these providers.

The maximum amount that the State Medicaid Programs are allowed to pay is defined by the Upper Payment Limit, which is generally the amount Medicare would have paid for the same services and patients. If a Medicaid program were to pay an
amount greater than the upper payment limit, the amount above the limit would not qualify for Federal Medicaid matching funds.

Special “Disproportionate Share Hospital” (DSH) payments can be made to hospitals that qualify on the basis of their service to Medicaid and the uninsured. Each State is able to define the specific criteria these hospitals must meet to qualify. Funds are distributed based on a state-defined formula. DSH payments are limited to inpatient and outpatient hospital providers.

- **Find and Enroll Potential Eligibles:** Medicaid, Title V Maternal and Child Health Program or Temporary Assistance to Needy Families (TANF) funding can support administrative activities that are directed at case-finding, education and outreach initiatives that help locate and enroll persons who are eligible for Medicaid. Medicaid funding also is available to create the systems needed to determine eligibility and to enroll individuals into Medicaid. Federal Medicaid funds can be used to support outstationed enrollment services of FQHCs, DSH payment hospitals, health departments and other community sites.

Medicaid can also reimburse for case management as an administrative activity. Case management may apply in situations where enrolled persons have complex medical conditions; and it is beneficial to set up a process to systematically manage their medical care.
Sources of Information About Medicaid

Excellent information on Medicaid is available from several sources. These sources may provide more detailed information on specific areas of interest. Medicaid is constantly changing and responding to new issues. The following sources may be useful in obtaining up to date information.

Health Care Financing Administration (HCFA)
  Web site: www.hcfa.gov
  • Medicaid, Medicare, and State Child Health Insurance (SHCIP)
    Program descriptions and data sections
  • State Medicaid Director Letters (specific direction to Medicaid agencies on a range of issues)
  • Federal Medical Assistance Percentages (FMAP) for each state

Bureau of Primary Health Care, Health Resources and Services Administration
  Web site: www.bphc.hrsa.gov

Center for Managed Care, Health Resources and Services Administration
  Web site: www.hrsa.gov/cmc

Kaiser Commission on Medicaid and the Uninsured
  Web site: www.kff.org

National Academy for State Health Policy
  Web site: www.nashp.org

National Health Law Program
  Web site: www.healthlaw.org/medicaid.shtml

Center on Budget and Policy Priorities
  Web site: www.cbpp.org

Urban Institute New Federalism Project
  Web site: newfederalism.urban.org

Rural Policy Research Institute
  Web site: www.rupri.org