

Building Partnerships to Improve

Children's Access to Medicaid

Oral Health Services

National Conference Proceedings

June 2–4, 1998 Lake Tahoe, Nevada

Cosponsors:

Health Care Financing Administration Health Resources and Services Administration National Center for Education in Maternal and Child Health





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Building Partnerships to Improve Children's Access to Medicaid Oral Health Services: National Conference Proceedings

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Preface

espite tremendous advances in prevention, dental caries remains the predominant chronic disease of childhood and continues to take a heavy toll on children's health and well-being. Increasingly, we are witnessing a concentration of dental disease—both in quantity and severity—among children living in poverty and children of racial and ethnic minorities. From all available data and based on many anecdotal reports, it is clear that inadequate access to dental care is commonplace among children of families living in poverty. It is tragic that the children most in need of dental preventive and treatment services are also those least able to adequately access the dental care they need.

One program that offers health services to indigent children is especially critical—the Medicaid program. In Medicaid problems of inadequate access to dental care have been a long-standing concern to beneficiaries and their advocates, including the dental professional community and policymakers at all levels of government. A 1996 report of the

Office of the Inspector General, U.S. Department of Health and Human Services, concluded that only about 20 percent of children who were eligible for Medicaid were receiving recommended dental preventive services. This report increased our collective awareness and concern. The urgency for addressing dental access issues was heightened further by the creation of the State Children's Health Insurance Program (CHIP) in 1997. In almost every state, CHIP offers the promise of increased coverage of needed dental care for thousands of uninsured children from families with modest incomes. Without concerted efforts to enhance dental access, children served by CHIP may face access barriers similar to those experienced by children in the Medicaid program.

As federal agencies with responsibility for addressing the health care needs of the indigent and underserved, the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA) are leading efforts to find solutions to oral health access problems for children

enrolled in the Medicaid program. These solutions may eventually benefit children covered under the CHIP program as well. To that end, on June 2–4, 1998, HCFA and HRSA, together with the National Center for Education in Maternal and Child Health, sponsored a historic conference entitled "Building Partnerships to Improve Children's Access to Medicaid Oral Health Services."

We believe that the ideas and suggestions developed by participants at the conference and documented in this volume will be of substantial value to individuals and organizations working to improve children's access to dental care at the state and local levels. We plan to disseminate these proceedings widely.

Clearly, this conference is only a first step in addressing a complex set of issues. We think that many of the barriers and strategies identified by conference participants are universal, but we recognize that specific remedies must be relevant to the particular circumstances in different regions of the country, individual states, and local communities. Innovative and successful improvements in dental care access will arise at the regional, state, and local levels. The agencies that sponsored this conference remain committed to working with each other, the dental professional community, Medicaid beneficiaries, and officials in states and local communities to seek ways to enhance children's access to Medicaid dental services. We are carefully reviewing the recommendations addressed to our agencies and hope to implement many of them in the days and months to come.

The conference was designed to recognize the reality that the federal agencies working with states alone cannot resolve the problems of children's access to oral health care. It is clear that HCFA, HRSA, and the states need to develop a relationship with many of the organizations that participated in the conference.

We believe that as a result of this conference participants more clearly understand the aspirations of and constraints faced by their colleagues in state and local government, practicing dental professionals, and beneficiaries and their families. It is our hope that this understanding will translate into a renewed sense of commitment as participants return with new optimism to their respective states and organizations and work together to seek solutions to common concerns.

Sally K. Richardson

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Introduction and Overview

he impetus for convening the conference "Building Partnerships to Improve Children's Access to Medicaid Oral Health Services" was the recognition of disturbing facts about the oral health status of children in the United States. More than half of all children ages 6-8 and two-thirds of all adolescents age 15 have dental decay. 1 It is estimated that 5-10 percent of young children have a severe form of tooth decay known as early childhood caries or baby bottle tooth decay, and the percentage is even higher for some populations. For example, 20 percent of children from families with low incomes have baby bottle tooth decay.² Among parents asked about their children's unmet health care needs, 57 percent reported unmet dental needs.³

Dental disease and unmet dental care needs are not trivial matters. Failure to prevent dental disease or provide timely and appropriate treatment can result in expensive treatment, missed school days (52 million school hours annually),⁴ dysfunctional speech, and compromised nutrition, not to mention pain and suffering.

Children from families with low incomes are particularly at risk for dental disease and are less likely to receive dental care than the general population.⁵ Medicaid, the federal-state program to finance health care services for people with low incomes, has the potential to provide important dental health services to millions of children across the country. However, a 1996 report by the Office of Inspector General, U.S. Department of Health and Human Services (DHHS), concluded that only about 20 percent of Medicaid-eligible children received any preventive dental services.

In response to the Office of Inspector General's report, two DHHS agencies—the Health Care Financing Administration (HCFA), which administers the Medicaid program, and the Health Resources and Services Administration (HRSA), which administers the federal Maternal and Child Health Block Grant Program—decided to act. Believing that primary problem solving should occur at the state and local levels, where the Medicaid program is implemented, HCFA and HRSA decided to convene a national conference of state-level policymakers and experts. The purpose was to bring together state and national leaders in Medicaid, maternal and child health, dentistry, and public health to discuss children's unmet dental needs and the lack of access to dental care. The hope was that the conference would not only document barriers and strategies but also empower attendees to serve as catalysts for developing and implementing action plans in their own states and organizations.

In the fall of 1997, HCFA and HRSA, in collaboration with the National Center for Education in Maternal and Child Health at Georgetown University, held a preconference planning meeting. The 25 participants included state dental directors as well as representatives from dental and dental hygienists' organizations, insurance organizations, and federal and state health agencies. This group provided suggestions for selecting conference speakers and structuring the agenda so that the conference objectives could be achieved.

The Building Partnerships conference was held June 2–4, 1998, at Lake Tahoe, Nevada. Two hundred people participated, including state Medicaid directors and/or staff from 36 states and 2 territories; state dental directors and/or staff from 39 states; and representatives from five federal agencies—the Centers for Disease Control and Prevention, the Indian Health Service, the National Institute of Dental and Craniofacial Research, and HCFA and HRSA. Nineteen national organi-

zations also were represented, including professional associations of dentists, pediatric dentists, dental hygienists, pediatricians, and state health officials; organizations of state maternal and child health programs, community dental programs, dental schools, state legislatures, and governors' offices; and dental insurance companies, managed care organizations, policy centers, advocacy groups, and foundations.

The conference consisted of two types of sessions: a series of plenary session presentations and smaller work groups devoted to identifying barriers and strategies.

Plenary Sessions

The plenary session presentations were intended to inform and prepare the participants for the work group discussions. (A briefing notebook of background materials was also provided.) In a series of four panel presentations, researchers, advocates, policymakers, consumers, Medicaid program administrators, and providers addressed various aspects of the problem of inadequate dental services for children. (Copies of speaker outlines and handouts may be obtained from the National Center for Education in Maternal and Child Health.⁶)

The first panel addressed the consequences to children of lack of access to dental care. Speakers discussed the range of children's oral diseases and their medical, devel-

opmental, and social consequences, as well as the population distribution of oral disease and risk factors for oral disease.

The second plenary session panel consisted of consumers, administrators, and providers, who gave their perspectives on why Medicaid-eligible children are not getting the dental care they need. The consumers discussed the particular difficulties of obtaining care for special needs children and children in rural areas, and addressed issues such as appointment making and keeping. eligibility criteria, treatment adherence, and respect from the Medicaid patient's point of view. Medicaid administrators outlined the legal and regulatory parameters of the Medicaid program, and discussed financing, reimbursement rates, and managed care. Finally, the providers offered their perspective on managed care, reimbursement rates, administrative hassles, and the particular needs and characteristics of the Medicaid population.

Speakers at the third plenary session were charged with addressing financial and organizational issues related to children's access to dental services. Presenters discussed Medicaid program costs and funding, managed care, the supply of dental services providers, and the differences between the dental and medical care delivery systems.

The fourth and final panel consisted of representatives from seven states, who discussed their experiences in trying to improve access to dental services among low-income

children. Presenters discussed approaches and programs related to managed care, efforts to target specific subsets of children and/or services (i.e., early childhood caries, sealants), and coalition and partnership building.

Work Groups

Participants were assigned to one of seven work groups. All participants from a given state were in the same work group, and for the most part states were grouped by DHHS region. In three sessions totaling 5 hours over the 2-day conference, the groups worked on identifying at least five key barriers to children's access to Medicaid oral health services, specific strategies to address each barrier, and the partners necessary to implement these strategies. The groups also developed recommendations for HCFA and HRSA on how these organizations might support the strategies.

The results of the work groups' deliberations appear in these proceedings. It is important to note that not every participant agreed with every barrier and strategy reported out by his or her work group. The diverse professions, geographic locations, and backgrounds of participants meant that this could not be a consensus conference, but the diversity added to the richness and usefulness of the work group results.

In addition to the results of the work group deliberations, a copy of the conference agenda and a list of conference participants

are included in these proceedings. To further facilitate communication, we have included lists of key regional and state oral health program contacts.

It is hoped that this document will serve as a resource for individuals working across the country to improve access to Medicaid oral health services for children.

- 1 U.S. Department of Health and Human Services, National Center for Health Statistics. 1997. Healthy People 2000 Review 1997. Hyattsville, MD: U.S. Department of Health and Human Services, National Center for Health Statistics.
- 2 Bruerd B, Jones C. 1996. Preventing baby bottle tooth decay: Eight-year results. *Public Health Reports* 111:63–65.
- 3 Simpson G, Bloom B, Cohen RA, Parson RE. 1997. Access to health care. Part I: Children. Vital Health Statistics 196:1–46.
- 4 Gift HC, Relsine ST, Larach DC. 1992. The social impact of dental problems and visits. *American Journal of Public Health* 82(12):1663–1668.
- 5 Vargas CM, Crall JJ, Schneider DA. 1998. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988–1994. Journal of the American Dental Association 129(9): 1229–1238.
- 6 National Center for Education in Maternal and Child Health, 2000 15th Street, North, Suite 701, Arlington, VA 22201-2617; telephone (703) 524-7802; fax (703) 524-9335; e-mail oralhealth@ncemch.org.

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Work Group Summary

s outlined previously, conference participants were assigned to one of seven work groups and were charged with identifying at least five key barriers to children's access to Medicaid oral health services, specific strategies to address each barrier, and the partners necessary to implement these strategies. They were also called upon to make recommendations to HRSA and HCFA on how these agencies could support the strategies. The discussion in the work groups was lively and touched on a wide variety of issues. The result was a rich, varied, and informative list of barriers, strategies, partners, and recommendations.

Barriers and Strategies

Although not every participant agreed on every issue, and some suggestions cannot be implemented unless there is a change in federal and/or state law, a number of common themes did emerge in the work groups. The following summary of the barriers and strategies is organized around these themes:

- Communication and understanding among major players,
- Financing and funding,
- Medicaid policies and administrative procedures,
- Supply and distribution of dental services providers,
- · Valuing oral health, and
- Best practices and guidelines.

Communication and **Understanding Among Major Players**

Barriers

Six of the seven work groups cited barriers related to a lack of understanding, respect, communication, and conflict resolution among families, dentists, Medicaid program staff, and others involved in the Medicaid program. One group specifically mentioned lack of collaboration among those concerned about oral health at the state level.

One set of barriers had to do with Medicaid recipients' lack of understanding about their responsibilities as parents seeking dental care for their children. These responsibilities include recognizing the importance of oral health and the need for dental services, adherence to treatment regimes, and in general meeting the expectations that dental providers have for patients. In particular, participants cited missed appointments as costly and disruptive to dental care providers.

Another set of barriers was related to dental care providers' lack of accommodation and understanding of the Medicaid population. Providers need to demonstrate greater cultural competency and sensitivity to the special needs of this at-risk population. Two work groups also cited as problematic the reluctance of many dentists to participate in managed care arrangements.

Strategies

Several work groups proposed providing forums for discussion, education, and action as a way to address misunderstandings. Specific ideas were to:

- Provide grants to support state-level team building to develop and implement action plans;
- Hold meetings in which people come together in a partnership atmosphere that is informal, nonthreatening, and focused on problem solving;

- Provide assistance to develop community partnerships among families; policymakers; dentists; local leaders; churches; businesses; schools; the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); practice management advisors; pediatricians; hygienists; etc.;
- Develop local and state Medicaid consumer advisory groups with broad representation, provide transportation and child care to facilitate consumer participation, and bring in state and local dental societies to work with the advisory groups after they are established; and
- Provide opportunities for dental students to become more familiar with the experiences of Medicaid families.

Participants also suggested focusing on the needs of children and families when problem solving, and working to solve problems at the local community level to encourage local ownership of the problems and solutions.

Strategies Related to the Medicaideligible Population

Work groups proposed a number of strategies to address barriers related to lack of information and understanding among the Medicaid population. Most of these strategies

¹ Although the word "compliance" is often used in the dental literature, the editors are using "adherence" instead because it implies a therapeutic alliance in which both the provider and the patient have responsibilities.

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related to providing education and outreach services.

The most frequently cited strategies involved providing education to Medicaid recipients about the importance of oral health for children and the parent's role in achieving it, how to access dental services, expectations and appropriate behavior in a dental office, and the importance of keeping scheduled appointments. Participants suggested using both printed and video materials and involving peers, community advocates, and former enrollees in providing the education. Other ideas included increasing funding to provide these education services, using welfare-to-work programs as a possible resource for education funds, and using other programs and professionals who come in contact with the Medicaid population (e.g., social workers, welfare workers, and WIC clinics) to provide information about these issues.

A number of strategies addressed outreach to the Medicaid-eligible population to raise awareness about the importance of oral health and how to access services. Two work groups recommended a public awareness multimedia campaign (using television, billboards, and brochures) that would be culturally sensitive, incorporate social marketing techniques, and include a positive view of dental services providers. Other ideas includ-

ed involving peers, community advocates, and former enrollees in the outreach activities and training social workers and others to give basic information about accessing dental care. One group specified that state outreach funded under the new State Children's Health Insurance Program (CHIP) should include a dental focus.²

To encourage patients to access dental care, several work groups recommended providing enabling services such as transportation and case management and coordination services. Other strategies to promote adherence to preventive treatment regimes among Medicaid patients were to:

- Require graduated copayments for noncompliance with preventive visits;³
- Have clients sign written agreements promising to keep appointments; and
- Explore integrating dental preventive services into school health programs.

Strategies Related to Dental Services Providers

Most of the strategies related to dental care providers also involved education. In particular, work groups recommended that efforts be made to enhance dental care providers' understanding of the oral health needs of Medicaid-eligible children. Providers should have the cultural awareness and sensi-

² The Children's Health Insurance Program was established by Title XXI of the Social Security Act, passed in 1997. It provides \$24 billion in federal matching funds over the next 5 years to assist states in providing coverage for an estimated 10 million uninsured children. States have the option of expanding the Medicaid coverage population; establishing a separate, non-Medicaid CHIP; or combining both models.

³ Editor's note: Copayments are permitted under Medicaid in very limited circumstances.

tivity necessary to effectively treat this population, and they need to understand the broad spectrum of options states are exercising in administering their Medicaid programs, including managed care contracting. The work groups also suggested educating providers about the details of each state's Medicaid program (including information about rate increases and student loan repayment programs) and the ethical and social aspects of the disjunction between dental providers and children in need of dental services. One group suggested that dentists could learn from the experiences of other health care disciplines that serve the Medicaid population. Another group recommended providing education for dentists through a partnership with the state dental associations, the Medicaid program, and other health disciplines. One group recommended that dental associations (American Dental Association, National Dental Association, Hispanic Dental Association, and others) take a leadership role in education through their regular communications with members.

Several work groups developed strategies to reduce the stigma many Medicaid clients feel in dentists' offices. These strategies included treating Medicaid patients the same as paying patients, using "transparent" insurance cards that resemble private insurance cards, and urging dental health workers to respect and maintain the dignity of Medicaid patients.

Finally, work groups recommended providing convenient appointment times to Medicaid patients and establishing a provider network that will accept Medicaid patients as ways dental services providers could make dental care more accessible.

Financing and Funding Issues

Barriers

Inadequate reimbursement for dental services was the most commonly mentioned obstacle to increasing the number of Medicaid-eligible children receiving dental services. But dentists and Medicaid officials tend to perceive the solutions differently. The dentists strongly believe that raising reimbursement rates is necessary. Medicaid officials are concerned that they may raise reimbursement rates only to find that few or no additional dentists will participate in the Medicaid program. This kind of concern highlights the need to form partnerships between states and the dental community so that the needs of both the dentists and the Medicaid programs can be addressed.

Participants pointed out that current reimbursement levels frequently do not even cover the cost of providing the services. Reimbursement rates that do not adjust for inflation over time contribute to the poor perception that many dentists have of the Medicaid program. The work groups discussed the impact of differences between

medical care delivery and dental care delivery on reimbursement issues. For example, unlike physicians, dentists are usually in solo practices with high overhead and may have little ability to "cost shift" to reduce the financial burden of uncompensated care.

It was noted that dentists need to make a fair profit in their practices and reimbursement rates are disproportionately low compared to rates for medical services. Unlike physicians delivering medical and surgical services in hospitals, dentists who provide care in privately owned offices bear the entire cost of personnel and facilities, including the cost of all infection controls recommended by the Centers for Disease Control and Prevention (CDC) and protections mandated by the Occupational Safety and Health Administration. These responsibilities place greater cost demands on dental providers than medical providers and make missed appointments particularly problematic.

Some work groups expanded their discussion beyond Medicaid reimbursement rates to lack of funding for dental health programs in general. Many of the strategies they identified related to this aspect of the funding barrier.

Strategies

Several work groups recommended undertaking a process to determine what level of reimbursement would be appropriate and attract sufficient numbers of providers. Suggestions included using the American Dental Association's survey on usual, customary, and reasonable (UCR) fees; evaluating actual costs, including cost-benefit and costeffectiveness issues; and conducting a valid evaluation that looks at how compensation impacts utilization.⁴

A number of work groups listed issues that should be taken into consideration when setting fee levels, including problems associated with using UCR fees as the baseline, adjusting compensation to reflect the more severe disease levels and treatment needs of the Medicaid population, recognizing that dentists' fees are market driven and dentists cannot easily make up for poorly compensated care, and requiring states to report whether they have sufficient payment levels to ensure adequate access.

Several work groups had very specific suggestions for changing the fee schedule:

- · Target fee changes based on UCR fee percentiles in order to predict the percentage of dentists who find a given fee acceptable and might participate in Medicaid:
- Adopt market fees that are linked to current fees charged to non-Medicaid patients;
- Issue a federal "directive" that states must pay 80 percent of the UCR;

⁴ Usual, customary, and reasonable (UCR) fees: The use of dental fee data to determine the lowest value of dental service reimbursement based on: (1) the dentist's usual charge for a given procedure, (2) the amount customarily charged for the service by other dentists in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after review of the case. (Source: Adapted from Alpha Center.)

- Weight benefits and fees toward procedures documented to be effective;
- Develop a minimum benefits package that reimburses selected services at 100 percent of UCR with no preauthorization and meets nationally established standards:
- Build cost-of-living increases into Medicaid payment formulas;
- Reimburse for parent education and case management services;
- Target early childhood caries/baby bottle tooth decay prevention services for higher reimbursement;
- Increase reimbursement for dentists
 who have higher participation in the
 Medicaid program, or pay providers a
 higher fee or bonus if a certain proportion or number of their patients are
 Medicaid clients; and
- Consider bundling related services under a unified fee, allowing dentists discretion to provide flexible care delivery while following reasonable guidelines and appropriate safeguards.

Discussion was not limited to reimbursement rates for dental services, but also included ways other than fee increases to compensate dentists for providing care to Medicaid patients. These included offering repayment of student loans and continuing education units and providing federal and state tax benefits. (A number of work groups

also included these and similar strategies in their discussions of how to overcome barriers related to insufficient dental work force supply and distribution.) Other suggested incentives were to provide training to providers on making program improvements, maximizing profitability, and managing Medicaid in the dental office, and education on the culture of poverty.

Additional strategies addressed more funding for the oral health component of Medicaid. These strategies included:

- Providing a higher federal match rate for Medicaid dental services (e.g., 90 percent federal/10 percent state);⁵
- Increasing the proportion of the Medicaid budget that goes to dental care to allow for provider and patient education, policy development, advocacy, and higher reimbursement rates for children's services;
- Redistributing Medicaid funds so that the proportion spent on dental services is increased to more closely reflect the national average for children's dental care expenditures;
- Decreasing program and provider administrative costs by using American Dental Association standard forms and codes, limiting the number of procedures requiring preauthorization, and using electronic "swipe" cards to a greater extent; and

⁵ The federal match rate is the number of federal dollars available to a state for each dollar the state spends on Medicaid services. The Federal Medical Assistance Percentage (FMAP) varies from 50 to 83 percent depending upon the state's per capita income.

· Legislating required levels of compensation and authorizing and appropriating funds at the state and federal levels.

Some work groups also developed strategies for increasing pediatric dental services through government programs other than Medicaid. Strategies included:

- · Increasing funding for public health clinics in areas that cannot attract private dental practices;
- Using the new CHIP program as a model for Medicaid by providing an enhanced federal match rate for CHIP oral health services (e.g., up to 85 percent federal/15 percent state);
- · Requiring dental services in community and migrant health centers (sites defined under section 330 of the Public Health Service Act):
- Deploying military reserve units to provide services in underserved areas:
- Exploring how the dental components of the migrant and community health centers and the National Health Service Corps (NHSC) can be expanded and improved through closer collaboration with state planning processes and state dental societies.

A final set of strategies was related to advocacy and collaboration. A number of work groups recommended developing stateand national-level coalitions that could advocate and educate at all levels of government.

Strategies included collaboration among the American Dental Association, state dental programs, and the Medicaid program in gathering data on access to Medicaid services, developing a strong and consistent message (e.g., about the current disparity between Medicaid reimbursement rates for medicine and dentistry), and preparing budget justifications for increasing dental services reimbursement. The work groups proposed specific strategies for developing communication and education between the state Medicaid agency, the governor's office, and the state legislature. These strategies involved identifying a core group that includes both dental societies and consumers, providing for regular and ongoing communication, and designating a state Medicaid staff person to track efforts.

Medicaid Policies and Administrative Procedures

Barriers

Five work groups cited barriers related to problematic Medicaid policies and difficult or cumbersome administrative processes that affect both providers and patients. Barriers included:

- · Complicated claims handling processes,
- · Burdensome eligibility and eligibilityverification processes,
- Burdensome preauthorization requirements.

- Burdensome and nonuniform provider enrollment processes,
- Overly strict interpretations of state antidiscrimination policies that serve to restrict dentists' ability to limit appointment times for Medicaid patients and limit the number of Medicaid patients they will see,
- Cumbersome Medicaid-specific policies and processes,
- Antifraud and antiabuse processes that are not always in balance with other program objectives, and
- Instability of the Medicaid reimbursement and coverage policy.

Strategies

Most of the strategies related to improving claims handling and eligibility/enrollment processes in the Medicaid program. Participants also made recommendations for implementing other changes in the administration of the Medicaid program, providing more information and more accountability, and interfacing with CHIP.

The most commonly cited strategy to improve claims handling was for Medicaid to move to computerized billing through online claims submission. One group also specified that dentists should upgrade their software to enable electronic claims submissions. Several groups recommended that Medicaid use standard claims forms and eliminate inconsistent federal requirements so that Medicaid claims processing is similar to that of private insurance. Two groups also stressed the impor-

tance of making timely payments to providers. Another group recommended providing customer-friendly technical assistance for providers on preparing claims.

Most of the strategies addressing enrollment and eligibility issues for Medicaid recipients focused on simplifying the process so that it is less cumbersome and recipients can receive more complete, continuous care. Recommendations included not requiring monthly eligibility certification, enrolling recipients in 1-year time periods, allowing other continuous eligibility policies, allowing presumptive eligibility, and developing an abbreviated enrollment form. Several work groups also recommended developing the capacity to obtain eligibility verification and coverage limits information electronically.

A majority of the work groups recommended other changes to Medicaid program administration, including adopting standard American Dental Association forms and codes, reducing or eliminating the need for prior authorization, and simplifying the provider enrollment process. One work group noted that if a state minimizes its prior approval requirements, dentists will need to know that it is legitimate for a state to question a claim when the utilization review suggests there may be a problem. Other suggested changes to the Medicaid program were to align federal policy with commercial dental insurance; use "primary care case management" models to assign beneficiaries to specific practices, enabling dentists to limit the number of Medicaid participants they see; work with state antidiscrimination laws to

allow limits on the number of Medicaid patients per practice; and use local public health agencies to provide care coordination and enabling services and identify, enroll, and educate beneficiaries.

Other suggested strategies were to:

- · Provide more information and education (establish a hotline to assist providers on administrative problems, educate providers and recipients on administrative procedures, and use focus groups to provide feedback on the content of the education and on the administrative procedures);
- Develop accountability (institute quality management, establish/enhance state consumer grievance hotlines to monitor and validate access status, and establish accountability indicators and mechanisms to ensure quality, access, and value, and promote quality improvement); and
- · Make the Medicaid program provider network, fee structure, and copays seamless with CHIP.

Supply and Distribution of **Providers**

Barriers

Five work groups cited barriers related to the supply and distribution of dental care providers. Participants perceived that an

inadequate supply of dentists (i.e., a decreasing ratio of dentists to consumers) existed in many states and perhaps nationally. The increasingly inadequate supply relative to population was attributed in part to a longterm decline in the number of dental school graduates and an aging dentist population, resulting in a "sellers' market." Another factor is the elastic nature of dental demand: More dental services are purchased when the economy improves and people have greater discretionary income, and fewer services are purchased when the economy takes a downturn and people have less discretionary income. The work groups also cited a lack of population-based services to preschoolers and an insufficient number of dentists trained in pediatric dental care and the care of children with special health needs. Several work groups highlighted the geographic distribution of providers as problematic, and two mentioned state practice act restrictions on licensure, utilization of auxiliaries, practice ownership, and the ability to deal with dental disease as an infectious disease (e.g., practice acts that restrict nondental health professionals from applying fluoride treatments).⁶

Strategies

Work groups developed strategies related to increasing the use of alternative delivery systems, increasing the number of general and pediatric dentists and dental hygienists,

⁶ State practice acts are state laws that govern licensing for health professionals; they specify which types of professionals can provide what kinds of services.

expanding the role of dental auxiliaries, providing incentives to providers, improving the ethnic and geographic distribution of providers, and using nondental health professionals to provide some education and preventive services.

Four work groups developed strategies to increase the use of alternative delivery systems as a response to the shortage of private sector providers. Suggestions included:

- Providing school-based and/or schoollinked oral health services;
- Increasing dental services in migrant and community health centers, in collaboration with state dental associations and based on a statewide access strategy;
- Enhancing the effectiveness of safety net providers, such as dental schools, school health programs, migrant and community health centers, the NHSC, hospitals, etc.;
- Developing additional safety net providers and facilities through publicprivate partnerships, by augmenting the public sector directly, or by recruiting new private sector providers through plans that contract with states to administer dental benefits for eligible children (e.g., the American Dental Association Access Program); and
- Having state legislatures reexamine regulations related to ownership of practices, since nondentist-owned community health centers are currently prohibited from employing dentists in some states.

Several work groups recommended expanding and improving NHSC and Health Provider Shortage Area (HPSA) programs by:

- Working with dental schools and regions in counties and states to identify provider shortage areas;
- Improving the identification of HPSAs so that the process is not dependent on someone from communities with provider shortages to come forward;
- Strengthening the NHSC scholarship and loan repayment programs to place new graduates in high-need areas as part of an overall state-planned program; and
- Increasing the use of Public Health Service commissioned officers within the NHSC to create an experienced dental work force that is able to develop new practices and support state health agency dental infrastructure development.

In addition to recommending expanding dental school enrollment and reinstituting NHSC scholarships, work groups recommended increasing the number of dental schools, increasing the number of pediatric and general practice dental residencies, dedicating state resources to training dentists, and providing stipends for graduate students in pediatric dentistry who see Medicaid patients in clinics and make a commitment to serving Medicaid patients in their practices. One group also recommended increas-

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ing the number of dental hygienist training programs.

Several groups developed strategies for increasing the use of dental hygienists and dental assistants and expanding or enhancing their functions. Suggestions included improving the education of dental hygienists in caries prevention and allowing general supervision of hygienists (i.e., a dentist authorizes a procedure, which can then be performed by a hygienist without the dentist being physically present on-site.)

Some work groups recommended providing incentives to providers who participate in the Medicaid program. Suggested incentives included tax credits, student loan repayments, bonuses for providers who see a certain number of Medicaid patients, and recognition for exemplary participation and performance in Medicaid programs. Another incentive strategy was to develop a mentoring program for dentists who go into underserved areas, to help them with Medicaid practice management and administration, treatment planning, cultural sensitivity, and the politics of being a dental professional in an interdisciplinary setting.

To improve the ethnic and geographic distribution of providers, work groups recommended:

· Recruiting students for dental and hygiene programs from areas and cultures that are underserved:

- Recruiting socially conscious individuals;
- Conducting recruitment outreach to rural and inner-city populations;
- Increasing the cultural sensitivity of providers, office staff, and training programs;
- Promoting Dental Enterprise Zones™;⁷
- Exploring the use of telemedicine for continuing education, especially in rural areas.

Work groups recommended using nondental health professionals to educate pediatric caregivers about the infectious nature of dental disease, train early childhood professionals (pediatricians, pediatric nurse practitioners, family practitioners, nutritionists, etc.) in preventive dental practices and interventions, and define and expand the role of community-based lay educators to increase health promotion activities and programs.

Other strategies to address the inadequate supply and distribution of providers were to:

- · Improve the dental public health infrastructure in states;
- Solve reimbursement problems;
- Eliminate statutes in states that prevent licensure by credentials (e.g., a dentist licensed in one state should be able to move to another state and practice without extensive licensing examinations);

⁷ Dental Enterprise Zones™ are community-generated public-private partnerships promoted by Oral Health America.

- Endorse the Bright Futures initiative;⁸
- Fully implement the dental opportunities in the Health Professionals
 Training Act (Title VII), including training of general dentists, public health dentists, and pediatric dentists;
- Require foreign-trained dentists who want to practice in the United States to perform 2 years of community service;
 and
- Have conference participants go back to their states and form state-level coalitions that will address the implications of the conference for dental schools.

Valuing Oral Health

Barriers

Five work groups cited a lack of value placed on oral health and dental services as an important barrier. Participants felt that many consumers, providers, and policymakers have the perception that dental care is elective, and there is little recognition that oral health is an important and integral part of overall health.

Strategies

Strategies focused on educating the public, nondental and dental health professionals, and policymakers on topics such as:

· The infectious and transmissible

- nature of pediatric dental diseases (tooth decay and gum disease);
- The importance of oral health in overall health;
- The possible links between oral disease and low birthweight births, coronary disease, stroke, etc., as the scientific evidence warrants; and
- The insufficient amount of dental services available to the Medicaid population.

Work groups also recommended that nondental health professionals be trained to screen for oral health problems and refer patients for appropriate care. Dental schools should take responsibility for educating dental students and graduate dentists in caring for very young children.

To educate the general public, work groups recommended emphasizing the connection between prevention and immunization on the one hand and prevention and fluoride and dental sealants on the other. Work groups also recommended raising expectations for a higher standard of oral health, developing public service announcements using celebrity spokespersons, and incorporating oral health education, prevention, and treatment programs into school health programs. For policymakers, it was recommended that unified and coordinated communication instruments (e.g., short fact

⁸ Bright Futures is an initiative sponsored by the Maternal and Child Health Bureau, HRSA, and the Center for Medicaid and State Operations (formerly the Medicaid Bureau), HCFA, to develop and implement health supervision guidelines for infancy, early childhood, middle childhood, and adolescence.

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sheets with photographs) be developed to educate legislators and state and federal agency leaders.

Recommendations for developing an education and public awareness campaign included:

- Building a coalition/collaboration with dental leadership;
- Developing tools and strategies for policy change;
- Translating information for policymakers, the public, and the media and developing an action agenda with policy options and alternatives;
- Using strong messengers such as dental leaders, child advocates, other policymakers, and consumers;
- Identifying opportunities to educate, and then delivering the message;
- Tracking and reporting on changes in opinions and attitudes about oral health:
- Training Medicaid recipients as advocates for oral health;
- Including this conference's results in the upcoming Surgeon General's report on oral health;
- Clarifying that oral health is more than just having fillings placed—oral health means to be healthy and free of disease.
- Communicating the message that oral health is an important part of total health:
- Piggybacking on other advocacy and lobbying efforts;

- Developing data and marketing issues based on that data; and
- Developing the political will to make oral health a national priority.

Additional work group strategies included adding appropriate dental coverage to the CHIP program and providing direct funding by the National Institute of Dental and Craniofacial Research to reflect the role of dental etiology in systemic disease.

Best Practices and Guidelines

Barriers

Three work groups cited barriers related to a lack of awareness about and underutilization of guidelines for oral health care, service delivery, and practice, including guidelines developed by relevant professional organizations (the American Academy of Pediatric Dentistry, Bright Futures). Other identified barriers were uncertainty about best practices related to prevention, early intervention for childhood caries, periodicity of dental visits, and lack of clarity under managed care programs about how to best manage dental care and identify inappropriate care.

Strategies

Participants had several strategies for defining best practices and guidelines:

 Research projects supported by HCFA and HRSA to examine preventive strategies,

- A technical assistance/best practices work group for the Medicaid pediatric dental program, and
- Demonstration projects on issues related to the implementation and evaluation of best practices (e.g., pilot programs that have all the players at the table and work to improve communication among them).

Strategies were also suggested that would help ensure that providers have access to the most up-to-date information. Work groups proposed a partnership between HCFA and HRSA and the American Association of Dental Schools, the American Dental Association, the American Academy of Pediatric Dentistry, the American Pediatric Association, the National Institute of Dental and Craniofacial Research, and other federal agencies (CDC, Agency for Health Care Policy and Research) to develop and implement science-based curriculum guidelines for dental training and continuing education. These guidelines would reflect current understandings of caries pathogenesis and management to ensure that modern treatment of dental disease is taught.

Work groups recommended developing an infrastructure for sharing information and data sets and determining what works and what does not work. Standard definitions of access, utilization, and other terms should be developed. Also, Bright Futures should be promoted throughout HRSA and U.S. Department of Health and Human Services (DHHS) programs.

To encourage the adaptation of best practices, one work group recommended that American Dental Association codes and Medicaid fee schedules include new preventive services and techniques so that providers can receive reimbursement.

Partners

As time permitted, work groups were asked to identify partners whose involvement would be essential in implementing the recommended strategies. Two work groups were not able to get to this step, and the other groups identified partners for only some of their strategies; thus, this is not a comprehensive list. However, the number and variety of the identified partners illustrate how much a broad-based, cooperative effort is needed to address the problem of children's lack of access to Medicaid dental services.

Partners were identified among dental and other health professionals; federal, state, and local governments; the public health community; all levels of the education system; funders; charities and service organizations; consumers; and local communities. The identified partners are detailed below:

Dental professionals. State dental associations; local dental societies; national professional organizations such as the American Academy of Pediatric Dentistry, American Association of Dental Examiners, American Association of Public Health Dentistry,

American Dental Association, American Dental Hygienists' Association, Association of State and Territorial Dental Directors, Hispanic Dental Association, and National Dental Association; organizations dealing with the oral health of children with special health needs; and individual dentists in the private and public sectors.

- Other health professionals. Pediatricians, nurses, public health nurses, family physicians, emergency room physicians, hospitals, and the state and national organizations that represent them.
- · Government—legislatures and policymakers. Congress, state legislatures, the National Conference of State Legislatures, governors' and budget offices, the National Governors' Association, local governments, policymakers, and politicians.
- Government—federal agencies. Agency for Health Care Policy and Research, CDC, Health Care Financing Administration, Health Resources and Services Administration (including the Bureau of Health Professions and NHSC), and the Surgeon General.
- · State and local agencies and programs. State Medicaid agencies, state and local health departments, state and local maternal and child health programs, state and local welfare departments, the Child and Adult Care

- Food Program, Head Start, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- **The public health community.** The American Public Health Association, Association of Maternal and Child Health Programs, Association of Schools of Public Health. Association of State and Territorial Health Officials. and the National Association of Community Health Centers.
- Education—higher education/academics. Postgraduate programs, general practice residencies, advanced education in general dentistry residencies, pediatric dentistry programs, boards of regents, dental hygiene schools, state commissions on higher education, health services researchers, American Association of Community Colleges. American Association of Dental Research. American Association of Dental Schools, American Student Dental Association, Association of Schools of Public Health, and the Western **Interstate Commission on Higher** Education.
- Education—primary and secondary education. Elementary, middle, and high schools; parent-teacher associations; school teachers; comprehensive school health education programs; American Federation of Teachers; and the National Education Association.

- *Funders.* The insurance industry, other payers, philanthropists, and foundations (W.K. Kellogg Foundation, Kaiser Family Foundation, The Robert Wood Johnson Foundation).
- Charities and service organizations.
 The Ad Council, Special Olympics,
 United Way, service organizations, and social and fraternal organizations.
- Consumers. Families, consumers, consumer advocates, child advocates,
 Children's Defense Fund, Families USA Foundation, and Family Voices.
- Communities. Religious organizations, community leaders, members of the business community, chambers of commerce, local health and oral health coalitions, and community-based organizations.
- Other players. Association of Daycare Centers, the media, practice management advisors, and fiscal intermediaries (e.g., middlemen who handle claims).

Recommendations to the Health Care Financing Administration and the Health Resources and Services Administration

Many work groups developed strategies that would require specific action on the part of HRSA and/or HCFA, as described in the previous sections. However, work groups were also asked to make general recommendations to HRSA and HCFA, and these are listed below.

Strategic Activities

- Initiate a DHHS interdepartmental oral health initiative.
- Inform the Administration and Congress of oral health access problems for children.
- Continue the HRSA/HCFA leadership role. Develop a 5-year strategic plan that is outcome oriented.
- Develop a broad-based HRSA team to coordinate HRSA dental health initiatives
- Ensure that all states have a state dental director.
- Support state demonstration projects that use work group-recommended strategies (e.g., incentives).

- Support research or demonstration projects to determine the costs and effectiveness of implementing new strategies, and develop and assess preventive strategies.
- Develop reporting measures for the Government Performance and Results Act regarding dental access.⁹

Technical Assistance

- Disseminate conference proceedings to all members of national dental associations (e.g., American Association of Dental Schools, American Academy of Pediatric Dentistry, American Academy of Pediatrics, American Dental Association, National Dental Association, and state dental associations).
- Include conference recommendations in the upcoming Surgeon General's Report on Oral Health.
- Inform national organizations named by the work groups that they have been identified as partners.
- Reconvene this conference as a national group within 18 months.
- Support regional and state continuation of this process leading to outcome-oriented action, and support state-level team-building efforts to develop and implement action plans.

- Develop an infrastructure to plan and follow up on conference recommendations on national and regional levels.
- Establish a technical assistance/best practices work group for Medicaid pediatric dental programs. Recognize models that work and best practices. Enhance infrastructure (e.g., promote sharing of information among states, including data sets, data standards, standard definitions of access, utilization, what works/what doesn't, and promising practices).

Policy Actions

- Emphasize oral health in the Maternal and Child Health Block Grant guidance (e.g., a fixed percentage targeted for oral health).
- Promote the Bright Futures initiative throughout programs.
- Recognize in policy issuances that the dental delivery system is a unique and essential component of overall health and health care.
- Provide a higher match rate for Medicaid dental services and for all children's services. Use a different match formula or mechanism—such as a 90 percent federal/10 percent state match—and tie it to the President's Initiative to Eliminate Racial and

⁹ The Government Performance and Results Act of 1993 (GPRA) requires that federal agencies plan, budget, and be accountable for program results.

- Ethnic Disparities in Health. Allow for a more flexible payment formula (e.g., eliminate dental services from the Medicaid "upper payment limit" requirement).
- Provide flexibility in implementing any new fraud and abuse policies so that these policies are based on each state's rate of/experience with fraud and abuse.
- Enforce existing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements regarding state efforts to increase provider participation.
- Change Medicaid policies to conform to those of commercial dental insurance.
- Clarify Medicaid rules and regulations at the federal and state levels.
- Clarify the responsibilities of federal and state health departments.
- Recognize—particularly in HRSA programs—that a full-time equivalent (FTE) for a dentist is 30 hours or less.
- Review policies on "personal patient responsibility issues" in Medicaid.

Dental Work Force Development Initiatives

 Enhance work force development efforts; support dental graduate medical education training programs (pedi-

- atric residencies, general practice residencies, advanced education in general dentistry); and work with dental schools to expand dental graduate medical education.
- Provide for continuing education through partnerships with dental associations (e.g., American Academy of Pediatric Dentistry, American Dental Association, American Dental Hygienist Association, Ambulatory Pediatric Association, Hispanic Dental Association, National Dental Association).
- Support the Health Career
 Opportunities Program. Develop initiatives to promote minorities in the dental work force.
- Support safety net providers, such as city and county programs, community and migrant health centers, and traditional Medicaid providers.
- Enhance HPSA site development and increase funding allocated for loan repayments for dental HPSAs. In collaboration with state agency and dental society planning processes, consider expanding the number of dentists and dental hygienists in the NHSC, especially in rural areas and sites that do not have community health centers.

Conference Agenda

Lake Tahoe, Nevada • June 2-4, 1998

Tuesday, June 2, 1998

12:00–4:00 pm Conference Registration Lakeside Lobby

4:00–6:00 pm Reception Lakeside Ballroom

Displays Open—Meet the Exhibitors

Welcoming Remarks

Sally Richardson, Health Care Financing Administration Doris Barnette, Health Resources and Services Administration

Wednesday, June 3, 1998

7:00–8:00 am Conference Registration Lakeside Lobby
Buffet Continental Breakfast Lakeside Ballroom

Displays Open—Meet the Exhibitors

William Hickman, Health Care Financing Administration

8:30–9:15 am Plenary Session I. What Happens to Children When

There Is Inadequate Access to Oral Health Services?
Sally Richardson, Health Care Financing Administration

(moderator)

Human Dimension

David Johnsen, University of Iowa

Social Dimension

Gregg Haifley, Children's Defense Fund

Oral Disease Dimension

Burton Edelstein, Children's Dental Health Project

9:15-9:30 am Break Lakeside Ballroom

Displays Open—Meet the Exhibitors

9:30–11:00 am Plenary Session II. Inadequate Access:

Why Aren't Children Getting Dental Care?
Doris Barnette, Health Resources and Services

Administration (moderator)

Consumer's Perspective

Sandra Vandenhoek, Advocate for Parents

Gina Pola-Money, Parent

Administrator's Perspective

John Searcy, State of Alabama Medicaid Agency Michael Deily, Utah Department of Health

Provider's Perspective

William (Ken) Rich, American Dental Association Ross Wezmar, American Academy of Pediatric Dentistry

11:00–12:00 pm Work Group Session A

Work Group 1, William Hickman (facilitator)

Work Group 2, Sally Richardson (facilitator)

Work Group 3, Doris Barnette (facilitator)

Work Group 4, Judy Moore (facilitator)

Salon F

Work Group 5, M. Ann Drum (facilitator)

Work Group 6, Donald Schneider (facilitator)

Tamarack B

Work Group 7, John Rossetti (facilitator)

Tamarack C

12:00–1:15 pm Luncheon

Lakeside Ballroom

Welcoming Remarks

David Whiston, American Dental Association *Along Comes CHIP: CHIP and Medicaid Interaction* Burton Edelstein, Children's Dental Health Project

1:15-2:15 pm

Plenary Session III. Improving Access: Financial and Organizational Issues

Kay Johnson, George Washington University (moderator)

Benefit and Costs

James Crall, University of Connecticut Health Center

The Landscape for Delivery and Financing of Dental Care Howard Bailit, University of Connecticut School of Medicine

Managed Care in the Market Place

Fred Horowitz, National Association of Dental Plans-Foundation

2:15-3:45 pm

Plenary Session IV. Improving Access: State Approaches

Karen Squarrell, New Jersey Department of Human Services (moderator)

David Parrella, Connecticut Department of Social Services Hersh Crawford, Oregon Department of Human Resources

Peter Milgrom, University of Washington Robert Isman, The Dental Health Foundation Mark Siegal, Ohio Department of Health

Ed Martinez, Community Health Centers of Southern Nevada

George "Spin" Richardson, Timberlane Dental Group

3:45-4:00 pm Break

4:00-6:00 pm	Work Group Session B			
_	Work Group 1	Salon B		
	Work Group 2	Salon C		
	Work Group 3	Salon D		
	Work Group 4	Salon F		
	Work Group 5	Tamarack A		
	Work Group 6	Tamarack B		
	Work Group 7	Tamarack C		

Thursday, June 4, 1998

mursuay, June 4	1770	
7:00-8:00 am	Buffet Continental Breakfast Displays Open—Meet the Exhibitors	Lakeside Ballroom
8:00–8:15 am	Charge for the Day William Hickman, Health Care Financing Administra	ation
8:15-10:15 am	Work Group Session C Work Group 1 Work Group 2 Work Group 3 Work Group 4 Work Group 5 Work Group 6 Work Group 7	Alder A Alder B Lakeside B Lakeside C Tamarack A Tamarack B Tamarack C
10:15-10:30 am	Break	
10:30-11:15 am	Plenary Session V. Work Group Reports William Hickman, Health Care Financing Administration (moderator)	Lakeside Ballroom
11:15-11:30 am	Concluding Remarks and Adjournment	

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