

HEALTH POLICY PUBLICATION



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State Strategies to Improve Dental Compliance in Missouri's Medicaid Population

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Executive Summary

The problems associated with poor oral health in children are well documented and range from compromised nutrition and lost school hours in childhood to cardiac problems in adulthood. Poor oral health is overwhelmingly a problem of low-income children. Children living in households below 200 percent of the poverty level – roughly half of U.S. children – have three and one-half times more decayed teeth than do children in more affluent families. Thus, publicly financed health programs such as Medicaid and SCHIP, which cover an increasing proportion of low-income children, have made oral health a critical focus.

As states have sought to make improvements in oral health for children on Medicaid, strategies have focused both on improving access to dentists and on increasing children's utilization of recommended dental services. Considerable attention has been given to access to providers, in particular efforts to increase dentists' participation in the program. Access efforts have utilized a combination of strategies, such as rate increases, reductions in administrative requirements, and various recruitment initiatives. Generally, when enacted in meaningful ways, these efforts successfully increase access to dental care. However, the other side of the equation – utilization – has received less attention. Although a child may have access to a network of dentists, sound primary dental care requires that the child sits in the dentist's chair.

The American Dental Association estimates that, nationwide, 30 percent of Medicaid patients typically fail to keep their appointments. Missed appointments mean important dental care is not delivered. Additionally, missed appointments are a significant source of frustration for dental providers, impacting their willingness to participate in the Medicaid program. Missed patient appointments, lack of public awareness about the importance of oral health, and lack of care coordination within Medicaid programs are frequently cited as reasons for Medicaid-enrolled children's low use of oral health services.

This paper provides an overview of effective state strategies to improve dental compliance as a means to create a clinically sound pattern of primary dental care. States' efforts to address missed appointments vary; some states have addressed the issue as part of comprehensive dental reform. Others have pursued more focused strategies independent of, or without the benefit of, larger reform efforts. Independent efforts are clearly at some disadvantage in terms of achieving significant results, since the reasons for poor patient compliance are rooted in a variety of factors that require multiple solutions. However, given that many states are not currently in a position to undertake widespread dental reform efforts, these more targeted strategies can offer a starting point to improve the likelihood that Medicaid-enrolled children will keep dental appointments and establish sound oral health.

States that have accomplished successful comprehensive reforms are profiled, as are states that have used one or more of the following strategies:

- case management/care facilitation,
- focused follow-up contact to clients with missed appointments,
- coordination with primary care,

- education and outreach, and
- transportation assistance.

The paper also provides general recommendations related to strategies to improve dental compliance. These recommendations include the need to:

Use a broad-based coalition or task force as a springboard for dental improvements.

Within most states, successful reform efforts started with a broad-based coalition or task force. These bodies can be instrumental in helping state officials understand barriers, develop workable solutions, and build momentum for support. While such bodies clearly need dental providers, they also should have input from consumers and advocates, primary care providers and other players in the delivery system, such as managed care companies.

Build solutions that recognize and address barriers that impede good dental compliance.

The issue of poor dental compliance is usually multi-faceted, so solutions also need to address the issue from multiple angles. Programs to remind parents whose child has missed a scheduled appointment will be of limited use if the parent does not believe dental care is important, or if the parent cannot find a dentist in a convenient location. Generally, those states that significantly improved utilization of dental services employed multi-pronged strategies, such as broad education campaigns combined with focused interventions.

Identify opportunities to leverage related existing or new systems. Many states use either their managed care or administrative services contractors to assist in dental compliance interventions. Missouri may be able to build in new requirements in upcoming procurements to require that managed care organizations develop compliance initiatives. Similarly, claims payment vendor contracts, when renewed or re-procured, could include requirements that the system automatically generate a reminder letter to families whose child has not had a dental claim within a specified interval.

Importance of Dental Care

Dental care is the most common unmet treatment need in children. The problems associated with poor oral health are clear public health problems. Chronically poor oral health is associated with failure-to-thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.¹ Additionally, the social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness; untreated dental disease can lead to problems in eating, speaking, and attending to learning.² Finally, research has shown chronic oral infections can lead to heart and lung diseases, diabetes and stroke, and premature births³ in adulthood, highlighting the need to establish sound dental care practices in childhood.

The importance of access to oral health care was brought to the forefront of public awareness in 2007 when a 12-year-old boy from Maryland, Deamonte Driver, died from complications from an abscessed tooth. The cost of his care, which included two operations and six weeks of hospital care, exceeded \$250,000. While extreme, this case highlights the problems many low-income families face in securing dental care for their children. For low-income

families like the Drivers, the challenge of developing a successful pattern of dental care is often difficult. Frequently cited barriers to establishing sound dental care in Medicaid children include: low participation of dentists in state Medicaid programs – often tied to poor Medicaid reimbursement rates; an absence of case management or other strategies to help patients make and keep appointments; poor oral health literacy and awareness about the importance of oral health; and challenges associated with low-income children’s preparation for and willingness to tolerate dental care, which leads to missed appointments and a failure to follow treatment regimes.

While tooth decay was once a disease of nearly universal occurrence for children, it is now largely concentrated in low-income children.⁴ Children living in households below 200 percent of the poverty level – roughly half of U.S. children – have three and one-half times more decayed teeth than do children in more affluent families. Low-income children are more likely to experience dental disease and frequently only access care on an episodic or urgent basis when decayed teeth cause pain or swelling. This trend was noted by the Surgeon General’s Report on Oral Health, which reported that dental caries (tooth decay) is the most common chronic disease of childhood – five times as common as asthma.

There are two significant issues that affect the provision of dental care to Medicaid-enrolled children – access and utilization. Considerable attention has been given to access to providers, in particular efforts to increase dentists’ participation in the program through a combination of factors, such as rate increases, reductions in administrative requirements, and various recruitment strategies. Generally, when enacted in meaningful ways, these efforts successfully increase access to dental care. However, the other side of the equation – utilization – has received less attention. Although a child may have access to a network of dentists, sound primary dental care requires that the child is scheduled for and keeps appointments to deliver recommended dental care.

Thus, a critical component of many states’ efforts to improve utilization centers on developing strategies to reduce missed appointments. It is important to recognize at the outset that certain conditions must be present to ensure that dental appointments are kept. Improving patient compliance with scheduled appointments and follow-up care also requires that Medicaid children have adequate access to a dentist, which is frequently tied to issues of Medicaid reimbursement and their parents’ or caregivers’ understanding of the importance of dental care. To some degree, simply addressing these issues will improve patient compliance. However, more focused efforts are often required to ensure that Medicaid children receive recommended dental services.

This paper provides an overview of effective state strategies to improve dental compliance as a means to create a sound pattern of primary dental care. States’ efforts to address missed appointments vary; some states have addressed the issue of missed appointments as part of comprehensive dental reform, while others have pursued more focused strategies independent of or without the benefit of larger reform efforts. Independent efforts are clearly at some disadvantage in terms of achieving significant results, since the reasons for poor patient compliance are rooted in a variety of factors that require multiple solutions. However, given that many states are not currently in a position to undertake widespread

dental reform efforts, these isolated strategies can offer a starting point to improve Medicaid children’s likelihood of keeping appointments and establishing sound oral health.

Role of Medicaid

Given that the largest concentration of oral health problems exists in the low-income population, publicly financed health programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP), which provide coverage to an increasing proportion of this population, are a key component to oral health improvement efforts. Nationally, Medicaid is the primary source of health care for 28 million low-income children and provides coverage to millions of additional low-income families, the elderly, and the disabled. However, as a percentage of overall Medicaid spending, dental care accounts for less than 2 percent of program expenditures nationally.⁵ Since policy attention tends to follow spending patterns, the small role dental care plays in state Medicaid budgets can lead to minimal policy focus on Medicaid-funded dental programs. Medicaid spending for dental care in Missouri comprises a very small portion – less than 1 percent – of total Medicaid expenditures.⁶

State Medicaid programs are required by federal law to provide dental services to eligible children. Dental services for children enrolled in Medicaid are regulated through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The EPSDT provision requires all states to include dental care in their Medicaid programs for individuals under age 21. The 1989 Omnibus Budget Reconciliation Act further strengthened the EPSDT provision by requiring that states provide all medically necessary services (including dental care) for children, even if these services were beyond the scope of coverage in the state’s Medicaid plan.

Despite these requirements, the dental needs of Medicaid children in most states remain largely unmet. In 2006, only one in three children in Medicaid received a dental service.⁷ Since poor children are more likely to have tooth decay and unmet dental care needs than their wealthier counterparts, low utilization of dental care is particularly problematic. As a result of poor access to and utilization of dental services, advocates on behalf of Medicaid children began bringing lawsuits charging that states were not meeting the EPSDT requirements.⁸ These lawsuits, as well as increased awareness of the importance of dental care to children’s overall health and well-being, have prompted a number of states to redesign their Medicaid dental programs and develop strategies to improve children’s access to and utilization of dental services.

Dental Care in Missouri Medicaid

In Missouri, the Medicaid program for children was expanded under SCHIP and is known as MC+ for Kids. This program covers children under age 19 in families with gross incomes below 300 percent of the federal poverty level (FPL) – \$52,800 for a family of three in 2008. Children in MC+ for Kids receive the same health services as those covered under Medicaid, except that children under this program are not eligible for non-emergency medical transportation. Additionally, some children covered under the SCHIP program

must pay premiums, which range from 1 to 5 percent of a family’s income. There are approximately 395,000 low-income children covered under the Missouri Medicaid program and an additional 64,000 children covered under MC+ for Kids (SCHIP).⁹

Missouri Medicaid covers children in families with the following income levels:

- Ages birth to 1; 185 percent of FPL,
- Ages 1 to 5; 133 percent of FPL, and
- Ages 6 to 18; 100 percent of FPL.

MC+ for Kids covers all other low-income children with family income up to 300 percent of FPL. As noted earlier, the key difference between these groups is that children covered under MC+ for Kids are not eligible for non-emergency transportation services.

Dental Improvement Strategies in Missouri

Like many states, Missouri has focused attention on improving primary dental care for Medicaid enrollees, but has yet to fully implement comprehensive strategies for improving dental care overall or specific strategies for addressing missed appointments. However, in 2000, the Division of Medical Services (now known as the MO HealthNet Division) did create a dental procedure code to track dental appointment “no shows.” The original intent of the program was to track missed dental appointments so that state staff could contact clients to reschedule appointments and remind clients of the importance of keeping dental appointments. While the code, DNKAS, (Did Not Keep Appointment Scheduled) remains active in the MMIS system and a small number of providers continue to use it, staff resources to follow up on missed appointments were redirected to other areas.¹⁰

In more recent years, there has been significant attention paid to dental care, resulting in the re-convening of the Missouri Dental Advisory Committee, which was originally established in 2006. The Committee is charged with assisting MO HealthNet to incorporate best practice guidelines into the Dental Program and making recommendations to the Division on policy issues and potential program changes. This is a promising development, particularly since most effective dental reforms at the state level have been preceded by some form of dental task force or advisory committee. These task forces or committees help provide momentum and support for necessary changes and can be critical to providing accurate, on-the-ground input around specific problems and barriers related to improving dental health.

Missouri’s large rural areas will clearly need to be factored into any strategies to improve dental care. Rural populations tend to be marked by poverty, limited education, disparities in care and utilization, and lack of transportation to a greater degree than their more urban counterparts.¹¹ A number of states with large rural populations, such as Alabama, have successfully adopted dental reforms that have improved both access to and utilization of dental services for Medicaid children, despite the challenges posed by the rural nature of their state.

State Strategies to Promote Dental Appointment Compliance

The American Dental Association (ADA) reports that 30 percent of Medicaid patients typically fail to keep their appointments. Missed appointments mean important care is not delivered to an individual. They also are a significant source of frustration for dental providers, impacting their willingness to participate in the Medicaid program. From a dental provider's standpoint, missed appointments lead to revenue losses that cannot be easily replaced since a great deal of the care provided by dentists, unlike that provided by physicians, is surgical and rehabilitative rather than diagnostic and preventive, so a missed appointment cannot necessarily be filled with the next patient in the waiting room.¹²

Improving dental compliance also requires addressing the barriers to dental care frequently faced by Medicaid families, which can include: lack of transportation, bouts of homelessness, erratic telephone and mail service, trouble finding dental offices open when parents are off work, and gaps in Medicaid coverage due to minor fluctuations in family income or administrative barriers. Programs that acknowledge that some amount of focused intervention is required to improve patient compliance are more likely to demonstrate improvements. For example, providing assistance with transportation, helping to schedule appointments for examinations, and arranging for translation services for families that have difficulty communicating in English may all lead to improved patient dental compliance.

A handful of states have enacted comprehensive reform for Medicaid-funded dental services, all of which contain components relative to reducing missed appointments. Some states have used statewide dental carve-outs as a platform to support their reform efforts (e.g., Tennessee and Virginia). This approach is typically supported by organized dentistry since it eliminates the need for dentists (who are typically in solo or small practices) to navigate multiple managed care and fee-for-service agreements for their Medicaid patients. Instead, dentists have one fee schedule, one benefit design, and a single point of reference. Other states (e.g., Alabama and South Carolina) have achieved meaningful gains by continuing their state-run dental programs while also dedicating necessary attention and resources to improve access and utilization issues. Outlined below are some of the more successful strategies employed by states, categorized by whether or not the state pursued a dental carve-out.

Dental Reform Operating Under a Statewide Dental Carve-Out

Tennessee established a dental carve-out in 2002 that shifted the provision of dental services within the statewide Medicaid managed care program from multiple managed care organizations to a single dental benefits manager with a dedicated dental budget. In 1998, prior to the dental carve-out, class action litigation had been brought against the state (*John B. v. Menke*), alleging, among other things, failure of the state to provide adequate Medicaid dental services for children. This case was resolved through consent of all parties; the John B. Consent Decree continues to be monitored by the court. In addition to pursuing the dental carve-out, Tennessee also adopted rate increases as a means of improving dentists' participation in the program.

The dental vendor, Doral Dental, operates under an administrative services only (ASO) contract and is responsible for recruiting and maintaining a network of dental providers.

The state's agreement with Doral requires that the contractor conduct statewide provider training, develop quality improvement programs, and achieve specific performance requirements. Doral, with input from the state, has developed web-based patient eligibility and patient scheduling systems that allow dentists to have 24-hour access to this information via a secure website and an interactive voice response telephone system. Patients are able to locate any general and specialist dentist within any area of Tennessee 24 hours a day, every day, through the system.

Doral has also created a program focused specifically on dental compliance. Staff contact patients after broken appointments to educate them on the importance of receiving adequate oral health care and keeping scheduled appointments. Since Tennessee adopted a carve-out approach, provider participation has grown by more than 120 percent and utilization has increased by 38 percent.¹³

Virginia established a dental carve out in 2005, called "Smiles for Children," and like Tennessee, entered into an ASO contract with Doral based largely on Tennessee's contract. As part of the re-design of the dental program, Virginia enacted a 30 percent rate increase for dental services, expanded member outreach, initiated quality improvement activities, and provided service enhancements for dental providers. For example, the program developed a central phone line to help individuals locate participating dentists and make appointments.

Quality improvement activities have addressed the issue of broken appointments and some of the factors that may contribute to broken appointments. In 2006, the program instituted a broken appointment initiative to identify, track, trend, and understand the barriers patients face in keeping their scheduled dental visits. Providers are asked to complete and submit information on missed appointments so that enrollees can be identified for outreach efforts to educate them about the importance of keeping appointments and maintaining compliance with treatment plans. The state Medicaid agency intends to use the information gained from the broken appointment initiative to inform the development of a pilot to test interventions to reduce the incidence of broken appointments.¹⁴ The state is currently analyzing common characteristics of broken appointments and identifying providers with a low rate of broken appointments to determine if there are provider-based strategies that can be used to reduce the rate of broken appointments. Virginia plans to have the pilot in place by the end of 2008.¹⁵

Virginia is also investigating the number of stainless steel crowns and pulpotomies (a procedure usually used to help restore and save baby molars) performed in a single visit. Research has shown that an excessive number of these procedures can lead to trauma and acute pain for patients, which can impact their willingness to keep dental appointments and maintain their dental treatment plan. In response, Virginia began tracking utilization of these procedures to identify any excessive practice trends or patterns.¹⁶

As a result of these comprehensive reforms, the number of providers enrolled in Virginia's Medicaid dental program increased 62 percent from 2005 to 2007 and utilization of dental services for children under age 21 rose from 24 percent in 2004 to 35 percent in 2007.¹⁷

Dental Reforms Operating Without a Carve-out

Alabama established the *Smile Alabama!* program in October 2000. The program is composed of four specific components: claims processing, dental reimbursement, provider education and recruitment, and recipient education. The program uses state funds and has sought local, foundation, and federal match funding to augment outreach and education efforts. The program raised dentist's reimbursement rates to 100 percent of BlueCross/Blue Shield rates and enhanced the provider service functions of its fiscal agent as a means to recruit and retain dentists.

The program also undertook extensive outreach efforts to address patient behavior, including the use of patient contracts, videos, and other educational material for dentists to deliver to patients. The patient contracts detail both patient rights and responsibilities. In order to receive services, Medicaid patients are required to sign the contract and acknowledge that should they break appointments, not follow instructions or the Medicaid rules, the dentist then has the right to no longer treat that patient. These activities are supplemented by public service announcements on radio and television that stress the importance of early oral health care, keeping dental appointments, and office etiquette. Additionally, Alabama provides Targeted Case Management (TCM), using professional case managers, including social workers and nurses, to increase patient compliance by allowing dental providers to refer patients to the case managers. The case managers arrange transportation to and from the dental office, provide patient education, track and follow-up on children who frequently miss appointments, coordinate services, and provide crisis intervention, resource assistance and other services.¹⁸

Federal Medicaid Changes

New federal rules around the use of Medicaid-funded case management, which took effect in March 2008, may preclude federal match for some of the activities historically included in case management programs. Under the new rules, case management must be billed in 15-minute increments and can not include any other service. Additionally, within two years, states may only receive federal reimbursement for no more than one case manager per person. Thus, if a child receives case management for dental services, they would not be eligible for Medicaid-funded case management for other services, such as assistance with linking to mental health services.

The state's Medicaid agency also has engaged in dental promotion and education activities by providing materials and education to Head Start programs and school nurses across the state. The agency has also developed and distributed an obstetric/prenatal kit to encourage physicians to begin early education about oral health with expectant mothers. Agency maternity care coordinators deliver brochures entitled "*Taking Care of Baby's Teeth*" to mothers during prenatal visits. Additionally, a kit was developed and distributed to Medicaid-enrolled pediatricians, family practitioners and dentists titled "*1st Look*," focusing on oral health anticipatory guidance and risk assessment with referral to a dentist based on the determined risk of oral disease.¹⁹ The combination of these efforts by Alabama resulted in a 100 percent increase in provider participation and a 76 percent increase in enrolled children utilizing dental services.²⁰

South Carolina, starting in 1998, initiated comprehensive administrative improvements in its dental program. These improvements followed collaborations between the state and the South Carolina Dental Association and other public and private stakeholders. The focus on dental improvements led to a variety of interventions, including: reducing the number of procedures subject to preauthorization requirements; streamlining claim forms; and establishing a medical management code to allow dentists to be reimbursed for the additional time needed to treat children with special health care needs.²¹

South Carolina has adopted patient education and support programs as part of its comprehensive efforts to improve oral health. Under a three-year grant from the Robert Wood Johnson Foundation starting in 2003, the state launched a program, *More Smiling Faces in Beautiful Places*, with the stated goal of eliminating oral health disparities among minorities, children with special needs, and those economically disadvantaged who are uninsured or underinsured. A particular focus of the program was on the needs of children from birth to age 6 and children and adolescents with special needs. The program included four main components: creation of an integrated oral health network to increase access to oral health care; provision of pediatric oral health training programs for medical and dental professionals; establishment of a system to link medical homes with oral health care providers; and empowerment of parents and families through educational guidance and support to become effective managers of their children's oral health care needs.²²

A key feature of the *More Smiling Faces* program is the use of "patient navigators" in six rural pilot counties. The patient navigators contact Medicaid patients to inform them of upcoming appointments, follow up with those who missed appointments, and provide assistance with transportation or child-care problems that might prevent the individual from keeping their appointment. Patient navigators also worked with coordinators of existing organizations such as Healthy Start, Head Start, and First Steps that serve parents of young children to encourage that oral health education be added in these organizations' work with young and expectant mothers. Additionally, the state adopted a novel approach to rate increases for dentists, conditioning the increase on improvements in provider participation in the Medicaid dental program. Participation eventually exceeded the provider enrollment target and rates were increased.

In addition to the activities under the Smiling Faces grant, South Carolina also developed strategies to improve oral health education and facilitate access to care. Within the Department of Health and Environmental Control, the Family Support Services unit was charged with intervening when clients miss dental appointments. The Department encourages dentists whose patients missed their scheduled appointments to call or fax the unit, which then contacts the patient to stress the importance of keeping appointments. The Department has also instituted outreach strategies targeting new beneficiaries, which include informing new beneficiaries about their dental coverage and available services, and helping them identify a dental provider. County Department of Social Services also provides a list of enrolled Medicaid dental providers to Medicaid beneficiaries when they enroll in Medicaid to help Medicaid clients select a dentist.²³

As a result of this constellation of changes, South Carolina saw a 54 percent increase in children's utilization of dental services and a 93 percent increase in provider participation between 2000 to 2006.²⁴

Independent Approaches

While some states have attempted to improve appointment compliance as part of a package of comprehensive oral health care improvements, there are also a host of efforts being used by state Medicaid agencies to improve dental compliance which have occurred independent of comprehensive reform. Generally, these state approaches use one or more of the following strategies:

- case management /care facilitation,
- focused follow-up contact to clients with missed appointments,
- coordination with primary care,
- education and outreach on office etiquette and importance of keeping appointments, and
- transportation assistance.

Case Management / Care Facilitation

The reasons that Medicaid clients miss scheduled dental appointments are likely to be linked to a number of factors, from failure to locate a Medicaid dentist to inability to secure necessary transportation or child care. Additionally, parents of children who regularly miss appointments may be dealing with a number of other pressing concerns, such as lack of housing or employment, that distracts or prevents them from following up on their children’s oral health care. Some states have implemented case management or care facilitation programs to better facilitate care for dental clients or to assist a particular target population. These programs address the logistical, cultural, and behavioral barriers to dental care. Program staff may remind a patient of upcoming appointments, help a patient secure transportation, or work with a parent whose child has disruptive behaviors at dental appointments.

The funding for case management activities can come from a variety of sources. Medicaid can pay for case management as a medical service or as an administrative activity. Case management services are an integral component of the EPSDT program and can be provided by the Medicaid agency, participating providers, or case managers employed by state or local public health agencies.²⁵ Additionally, some states have used grant or private funds to develop case management programs, or have required or incentivized the use of case management within their managed care programs. In the future, these programs will likely need to be defined and named in a way that clearly distinguishes them from Medicaid case management, which is now, as a result of new federal rules, subject to a variety of limitations.

State	Case Management/Care Facilitation Strategies
Alabama	Provides TCM using professional case managers to increase patient compliance by allowing dental providers to refer patients to the case managers. The case managers arrange transportation to and from the dental office; provide patient education; track and follow-up on children who frequently miss appointments; coordinate services; and provide crisis intervention, resource assistance, and other services. ²⁶
South Carolina	As part of a three-year grant, the <i>More Smiling Faces</i> program has patient navigators that contact Medicaid patients to inform them of upcoming appointments, follow up with those who miss appointments, and provide assistance with transportation or child-care problems that might prevent the individual from keeping their appointment.
Arizona	Some of the state's health plans employ full time outreach coordinators who assist beneficiaries in making and keeping appointments or follow up with noncompliant families. ²⁷

Focused Follow-Up Contact to Clients with Missed Appointments

A number of states have implemented strategies to focus on clients who miss appointments. These initiatives typically rely on the dental provider to alert the state to missed appointments, and then either state or contracted staff contact the client to reschedule the appointment. In some cases, staff also provide counseling on the importance of dental care and work to address any barriers to keeping appointments. Additionally, some states have initiated follow up to missed appointments using automated systems (e.g. New Hampshire), minimizing what otherwise is an intensive demand on staff resources.

State	Focused Follow-Up
Maine	As of 2000, all dentists participating in MaineCare receive a business card with the Maine Bureau of Health's toll-free number to call for assistance in working with families who have a history of missing appointments. Bureau of Health staff and contractors then contact the family to discuss the importance of keeping appointments; review the policy for cancellation of appointments used by the family's dentist; and offer the family assistance with transportation, scheduling, or canceling appointments. Dentists also are advised that they need not continue to see a specific patient if the reason for dismissal is consistent with practice policies. ²⁸ Beginning in 2001, parents or caregivers of children not receiving a dental visit in the last year receive a letter encouraging them to make an appointment. ²⁹
Idaho, Iowa, and South Carolina	State staff or contractors follow up with patients who have demonstrated a need for additional education and assistance with keeping appointments. ³⁰
Texas	Texas' EPSDT program implemented a protocol and phone number that dentists may call in the event of a missed appointment. Staff follow-up with the beneficiary family to encourage appointment attendance and distribute fliers to beneficiaries with information on appropriate waiting room behavior and steps to take if an appointment is missed.
New Hampshire	Beginning in 2004, Medicaid recipients receive a reminder letter if there has been no dental visit for any Medicaid recipient under age 21 in the previous nine months. Reminders to schedule dental exams for children are automatically generated by the state's third-party administrator, Electronic Data Systems (EDS), based on the child's age and the EPSDT periodicity schedule for such exams. ³¹
Massachusetts	As part of the state's contract with its Dental Services Administrator, Doral, a broken appointment initiative was created. Providers complete and fax a short form to Doral when a patient breaks an appointment. This information is forwarded to Doral's Intervention Service Unit, which contacts the patient to identify the reason for the missed appointment (e.g., lack of transportation or child care), works to resolve the issue, and communicates the importance of routine dental care. ³²
New Jersey	The state's contracts with Managed Care Organizations (MCOs) include a requirement that the MCO have policies and procedures for identifying and rescheduling missed referral appointments. Mailers are used to advise enrollees about how to contact state agencies for assistance, and MCOs conduct EPSDT outreach to educate parents about the need to use health services, including dental services. ³³

Coordination with Primary Care

Pediatricians and other primary care providers can play an important role in educating families about the importance of oral health. Research has found that children who receive medical care are more likely to receive dental care than those who received no medical care.³⁴ While low-income families may be less aware of the importance of dental care and therefore have poor connections to dental providers, they generally have better connections to primary medical care providers.

With regular fluoride treatments and effective self-care (brushing and flossing, nutritional management), many children will never develop dental caries. Many of these preventive dental services can be provided by medical professionals – physicians, nurses and medical assistants. Some states have attempted to capitalize on the connection that many low-income families have with primary care as a means to promote and encourage primary dental care. These strategies can include greater coordination with primary care providers as well as encouraging and reimbursing primary care providers to offer preventative dental services such as education on how to brush and floss as part of comprehensive primary care.

State	Coordination with Primary Care
<i>Arizona</i>	<p>Revisions were made to the state's <i>Medical Policy Manual</i> regarding EPSDT oral health services that clarified to primary care providers their responsibilities for including oral health screening as part of a well-child exam and described referral guidelines to dentists based on preliminary findings.</p> <p>Managed care plans require primary care physicians to complete an oral evaluation of patients beginning at 6 months of age, with dental referrals permitted as needed based on the primary care physician's judgment. Routine referral to a dentist begins at age 3. Health plans expect primary care physicians to assist in identifying noncompliant patients or those overdue for dental care. Dentists are asked to report missed appointments to the health plan. Some plans have a full-time dental outreach coordinator to assist beneficiaries in making and keeping appointments or to follow up with noncompliant families.³⁵</p>
<i>Kansas</i>	As of 2002, Medicaid reimbursement is available for application of fluoride varnish by local health department registered nurses, advanced nurse practitioners, and physicians. ³⁶
<i>Nebraska and Pennsylvania</i>	Primary care providers are helped either by state staff or contractors with scheduling dental appointments for patients. These staff also follow up with dental providers to determine whether appointments were kept. Dental providers can notify these staff if the appointment was not kept and staff will then reschedule the appointment. ³⁷

Education and Outreach

A number of states have attempted to tackle dental compliance with broad education and outreach strategies that emphasize the importance of keeping dental appointments and provide information on expectations regarding office etiquette. These approaches are delivered to families at various points, including at outreach and enrollment, during office visits, or while receiving other Medicaid services.

State	Education and Outreach
<i>Alabama</i>	Medicaid dental providers are given a “rights and responsibilities” packet that includes a document for patients to sign, which describes patient rights (be treated with respect) and responsibilities (call if you cannot make your appointment). ³⁸
<i>Alaska</i>	Dental health education and information on the importance of keeping appointments have been included in state newsletters to parents of Medicaid enrolled children. ³⁹
<i>Arizona and Arkansas</i>	Medicaid beneficiaries are sent mail notices on the importance of keeping dental appointments and on appropriate behavior while in the dental office. ⁴⁰
<i>North Dakota</i>	A brochure and video were developed by the state, as part of project “Will Show” which stresses the importance of dental care and keeping scheduled appointments. The materials are used in agencies where Medicaid beneficiaries receive services. ⁴¹

Transportation

Transportation is frequently cited as a barrier to Medicaid patients keeping scheduled dental appointments. States can use Medicaid to help address this need. Under EPSDT, Medicaid can 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.⁴²

State	Transportation Assistance
<i>Rhode Island</i>	Established a special transportation hotline for special need beneficiaries at high risk of not receiving dental treatment based on a lack of alternative means of transportation. If set criteria are met, transportation to the provider’s office is arranged using an approved vendor. ⁴³
<i>Maine</i>	Instituted a toll-free number that beneficiaries can call for assistance in obtaining transportation, finding a dentist, and other appointment-related services.

Recommendations

States’ efforts during the previous decade have demonstrated that there are a variety of tools to increase dental compliance and overall oral health. As Missouri evaluates these efforts to inform future dental compliance strategies, there are a few fundamental questions that can help shape the scope and content of those strategies. These include:

1. *Are problems with dental compliance spread evenly across the Medicaid population or are there specific populations that warrant immediate or more focused attention?* For example, if compliance is particularly poor for children under the age of 6, strategies that target this population might build on HeadStart programs or coordinate with primary care providers to include counseling of families during the immunizations visits that occur regularly for children this age.
2. *Would there be advantages to developing a statewide dental carve-out?* A number of states have pursued carve-outs not only to ease the administrative burdens placed on dentists and secure wider networks of dentists, but also to assign an entity to tackle quality

improvement activities like improving dental compliance. While carve-outs have clear advantages in many areas, it is critical to realize that, like any vendor relationship, the outcome is largely dependent upon the amount and quality of resources that a state can devote to developing a contract that reflects the state’s needs and to managing and overseeing the contract to ensure performance is in line with expectations.

3. Are there particular factors that should be a key component or a prerequisite to efforts to improve compliance? Understanding why Medicaid clients in a particular state or region do not keep scheduled appointments is a critical issue in designing effective compliance strategies. If the predominant issue is lack of understanding of the importance of dental care, a very different type of intervention would be called for than if the issue is an inadequate supply of dentists in a particular area. For Medicaid managed care areas, a state’s External Quality Review Organization could be tasked with devising special studies to evaluate the most prevalent barriers to dental care. Additionally, Medicaid dentists and consumer advocates can be a rich source of information to more fully understand the scope of dental compliance problems.

Beyond developing a clear understanding of the scope and context of barriers to dental compliance, several key recommendations can help Missouri tailor a strategy to the state’s realities.

4. Use a broad-based coalition or task force as a springboard for dental improvements. Within most states, successful reform efforts started with a broad-based coalition or task force. These bodies can be instrumental in helping state officials understand barriers, develop workable solutions, and build momentum for support. While such bodies clearly need dental providers, they also should have input from consumers and advocates, primary care providers, and other players in the delivery system, such as managed care companies.

5. Build solutions that recognize and address barriers that impede good dental compliance. The issue of poor dental compliance is usually multi-faceted, so solutions also need to address the issue from multiple angles. Programs to remind parents whose child has missed a scheduled appointment will be of limited use if the parent does not believe dental care is important, or if the parent cannot find a dentist in a convenient location. Generally, those states that significantly improved utilization of dental services employed multi-pronged strategies, such as broad education campaigns combined with focused interventions.

6. Identify opportunities to leverage other existing or new systems. Many states use either their managed care or ASO contractors to assist in dental compliance interventions. Missouri may be able to build in new requirements in upcoming procurements to require that managed care organizations develop compliance initiatives. Similarly, claims payment vendor contracts, when renewed or re-procured, could include requirements that the system automatically generate a reminder letter to families whose child has not had a dental claim within a specified interval.

Dental care is currently the greatest unmet need in low-income children. The importance of sound dental care to children’s overall health and readiness to thrive calls for state ac-

tion. Fortunately, current state efforts have shown remarkable ability to make significant and measurable improvements in both access and utilization of dental services. These strategies can inform and shape Missouri’s future efforts to ensure low-income children receive recommended dental care.

Resources for Further Information

Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, US. Department of Health and Human Services. 2000. <http://www.surgeon-general.gov/library/oralhealth/>

American Dental Association:

- Access to Oral Health Care. <http://www.ada.org/prof/resources/topics/access.asp#nation>
- State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper <http://www.ada.org/prof/resources/topics/access.asp#white>

State Initiatives:

Alabama – Smile Alabama!

- Initiative Overview: http://www.medicaid.state.al.us/programs/dental/dental_educational_general.aspx?tab=4&sub=1
- Program Materials: http://www.medicaid.state.al.us/programs/dental/dental_smile_alabama.aspx?tab=4

South Carolina

- Children’s Dental Health Project State Summary: <http://www.cdhp.org/downloads/07StateSummaries/South%20Carolina%20State%20Summary.pdf>
- The impact of an innovative reform to the South Carolina Dental Medicaid system, Health Services Research, August, 2005, by Paul J. Netter, W. David Bradford, Linda M. Caste: http://findarticles.com/p/articles/mi_m4149/is_4_40/ai_n15338157

Tennessee

- Encore website for dental benefits, Doral Contract, program description: <http://tennessee.gov/tenncare/pro-dental.html>
- Children’s Dental Health Project State Summary: <http://www.cdhp.org/downloads/07StateSummaries/Tennessee%20State%20Summary.pdf>

Virginia – Smiles for Children

- Smiles for Children program website: <http://www.dmas.virginia.gov/dental-home.htm>.
- Smiles for Children annual report: http://www.dmas.virginia.gov/downloads/studies_reports/RD18-2008-Dental.pdf

Endnotes

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- 11 Dianna Gordon, *Where Have All the Dentists Gone?* Rural Health Brief, National Conference on State Legislatures, 2008.
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