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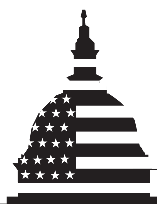
Report to Congressional Requesters

September 2009

MEDICAID

State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain



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GAO-09-723

Highlights of GAO-09-723, a report to congressional requesters

Why GAO Did This Study

Children's access to Medicaid dental services is a long-standing concern. The tragic case of a 12-year-old boy who died from an untreated infected tooth that led to a fatal brain infection renewed attention to this issue. He was enrolled in Medicaid—a joint federal and state program that provides health care coverage, including dental care, for 30 million low-income children—but, like many children in Medicaid, he experienced difficulty finding a dentist who would treat him. At the federal level, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), oversees Medicaid.

In this report, GAO examined (1) state strategies to monitor and improve access to dental care for children in Medicaid and (2) CMS actions since 2007 to improve oversight of Medicaid dental services for children. GAO surveyed all state Medicaid programs and interviewed state and federal officials, and dental researchers and associations.

What GAO Recommends

GAO recommends that CMS develop a plan to review dental services in states with low utilization rates, ensure that states found to have inadequate managed care provider networks strengthen their networks, develop additional guidance, and identify ways to improve sharing of promising practices among states. CMS generally concurred with GAO's recommendations.

View GAO-09-723 or key components.

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September 2009

MEDICAID

State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain

What GAO Found

State Medicaid programs reported that they use multiple strategies to monitor and improve access to dental services for children, but problems persist. Most states responding to our survey use a variety of tools, such as examining claims and utilization data, to monitor the provision of dental services to children in Medicaid. Although all 21 states that provide Medicaid dental services through managed care organizations (MCO) reported that they set measurable access standards for MCOs, 14 states reported that MCOs do not meet all of the state's dental access standards. Almost all states described initiatives to improve access to dental services, including simplifying claims processing, increasing reimbursement rates, recruiting providers, and educating beneficiaries. Nonetheless, access rates remain low and states reported that long-standing barriers hinder further improvement.

Number of States Reporting Barriers to Children Receiving Medicaid Dental Services and Barriers to Dental Providers Serving Medicaid Beneficiaries

To what extent do you believe the following are barriers to children receiving Medicaid dental services in your state?	Major/mod. barrier	Minor barrier	Not a barrier
Finding a dental provider that accepts Medicaid	43	6	2
Transportation to and from the dental provider's office	25	16	10
Distance between the dental provider's office and the family's home	34	14	3
Parents are unable to take time off work	27	22	2
Other barriers	23	1	7

To what extent do you believe the following are barriers to dental providers beginning to serve or serving more Medicaid beneficiaries?	Major/mod. barrier	Minor barrier	Not a barrier
Low reimbursement rates	36	9	6
Administrative requirements	28	17	6
Limited capacity to accept new patients	30	13	8
Beneficiary does not show up for appointments	45	6	0
Beneficiary does not follow treatment plan as advised by the provider	30	20	1
Other barriers	14	2	8

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Since May 2007, CMS has taken steps to strengthen its oversight of Medicaid dental services for children, but gaps remain. For example, CMS reviews of Medicaid dental services in 17 states identified a number of concerns and made recommendations for improvement. Nonetheless, at the time of our review CMS did not plan to perform more reviews, even though other states had utilization rates well below HHS's 2010 target for low-income children receiving a preventive dental service. CMS also provided guidance to states and facilitated collaboration among stakeholders, but states reported needing more CMS support, including guidance on setting dental payment rates, on quality initiatives, and on promoting outreach. States also reported wanting more information on other states' efforts to improve dental utilization.

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Abbreviations

AAPD	American Academy of Pediatric Dentistry
CMS	Centers for Medicare & Medicaid Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HHS	Department of Health and Human Services
MCO	managed care organization
NASMD	National Association of State Medicaid Directors
SCHIP	State Children's Health Insurance Program

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United States Government Accountability Office
Washington, DC 20548

September 30, 2009

The Honorable Dennis Kucinich
Chairman
Subcommittee on Domestic Policy
Committee on Oversight and Government Reform
House of Representatives

The Honorable Elijah Cummings
House of Representatives

Dental disease is a significant problem for children in Medicaid, a joint federal and state program that provides health care coverage, including dental care, for low-income children. Although dental services are a mandatory benefit for the 30 million children served by Medicaid,[1] these children often experience elevated levels of dental problems and have difficulty finding dentists to treat them. Attention to this subject became more acute after the widely publicized case of a 12-year-old boy who died in 2007 as a result of an untreated infected tooth, even though he was entitled to dental coverage under Medicaid. In testimony before the Subcommittee on Domestic Policy of the Committee on Oversight and Government Reform[2] last year, we reported that children in Medicaid were almost twice as likely to have untreated cavities as children with private insurance.[3] We also reported that the percentage of children in Medicaid ages 2 through 18 who received any dental care—37 percent according to national survey data—was far below the Department of Health and Human Services' (HHS) target of having 66 percent of low-income children under age 19 receive a preventive dental service.

Concerns about low-income children's poor oral health and inadequate access to dental services, low payment rates for dental services, and

[1]Low-income children eligible under a state Medicaid plan generally are entitled to coverage of screening, diagnostic, and treatment services—including dental services—under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit.

[2]We refer to the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives, as the Subcommittee throughout this report.

[3]GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased*, GAO-08-1176T (Washington, D.C.: Sept. 23, 2008).

insufficient federal and state efforts to address oral health access problems are long-standing. Our reports dating back to 2000 highlight the problem of chronic dental disease and the factors that contribute to low use of dental services by low-income populations, including children in Medicaid.[4] A major concern has been the adequacy of the network of dental providers who serve low-income populations, particularly for children who receive Medicaid dental services under managed care. This concern stems in part from investigations by the Subcommittee that found that some managed care organizations (MCO) did not have adequate provider networks—that is, a sufficient number and mix of dental providers—to provide timely access to covered Medicaid dental services. In September 2000, we reported that while several factors contributed to the low use of dental services among low-income persons who had coverage, the major factor was difficulty finding dentists to treat them.[5] During a Subcommittee hearing in May 2007, concerns were raised about federal oversight of state Medicaid dental services for children by the Centers for Medicare & Medicaid Services (CMS), the agency that oversees Medicaid at the federal level.

You expressed concern about the state and federal actions taken to ensure children in Medicaid receive recommended dental services. This report examines (1) the strategies that state Medicaid programs employ to monitor and improve access to dental services for children in Medicaid and (2) CMS actions since 2007 to improve oversight of state Medicaid dental services for children. To identify state strategies to improve children's access to Medicaid dental services, we conducted a Web-based survey of state Medicaid directors in all 50 states and the District of Columbia.[6] The survey included both closed-ended and open-ended questions regarding dental services for children, the methods states have used for promoting and monitoring dental utilization (the use of dental services), statewide goals for the delivery of dental services, and the federal support provided to states for the provision of dental services. To establish the reliability of our survey data, we consulted with knowledgeable state officials in developing the survey and pre-tested the

[4]A list of related GAO products can be found at the end of this report.

[5]GAO, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, D.C.: Sept. 11, 2000).

[6]We refer to the District of Columbia as a state and refer to the Medicaid director's survey response as the state Medicaid program's response or as the state's response throughout this report.

survey questions with Medicaid officials from two states. The survey was conducted from December 8, 2008, through January 30, 2009. We received responses from all 50 states and the District of Columbia. We reviewed survey responses for internal consistency and in certain cases where responses were absent, unclear, or inconsistent, we contacted state officials for clarification. We did not independently verify specific aspects of responses or the effectiveness of programs reported through the survey. We determined that the data submitted by states were sufficiently reliable for the purposes of our engagement. In addition to the Web-based survey, we reviewed studies and reports on state Medicaid dental-related initiatives and conducted a review of current literature to obtain information on these initiatives and on barriers to providing dental care in Medicaid. To describe contractual provisions between states and MCOs concerning network adequacy and timely access standards related to dental services for children, we obtained and reviewed a non-generalizable sample of contracts from the MCOs that covered dental services and that served the most Medicaid beneficiaries in 9 states, including 5 states whose dental programs had been reviewed by CMS in 2008.[7]

To examine CMS's oversight of state Medicaid dental services for children, we interviewed CMS officials; reviewed federal laws, regulations, and guidance that CMS provides to states; and interviewed key stakeholders, including the Medicaid/SCHIP Dental Association,[8] the National Association of State Medicaid Directors (NASMD), and experts involved with pediatric dental issues. We also reviewed data used by CMS to monitor provision of dental services to children in state Medicaid programs, including information in annual reports submitted by states on the provision of dental and other services provided under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. We also examined CMS's reviews of Medicaid dental programs in 17 states. To obtain states' perspectives of CMS oversight, we included several questions about CMS's guidance and activities in our survey of state Medicaid programs. We conducted this performance audit from July 2008 through August 2009 in accordance with generally accepted government

[7]We reviewed only those dental provisions that were specified in the contracts under sections titled *network adequacy*, *covered services*, *access standards*, or similar. We also searched each contract using key terms, such as *network* and *access*, to identify additional related provisions.

[8]The State Children's Health Insurance Program (SCHIP) provides health care coverage to children in low-income families who are not eligible for traditional Medicaid programs. CMS now refers to SCHIP as the Children's Health Insurance Program (CHIP).

auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In 2000, the Surgeon General noted that tooth decay is the most common chronic disease among children.[9] Left untreated, the pain and infections caused by tooth decay can lead to problems in eating, speaking, and learning. Proper dental care can prevent tooth decay and associated problems that can lead to dental disease and even death. Research has shown that preventive dental care is cost effective and can make a significant difference in health outcomes. For example, a 2004 study found that, over a 5-year period, low-income children who had their first preventive dental visit by age 1 had average dental-related costs of $262, compared to $546 for children who received their first preventive visit at age 4 through 5.[10]

The American Academy of Pediatric Dentistry (AAPD) recommends that each child see a dentist when the child's first tooth erupts and no later than the child's first birthday, with subsequent visits occurring at 6-month intervals or more frequently if recommended by a dentist. The early initial visit establishes a "dental home" for the child, creating an opportunity to build an ongoing relationship with a dental provider who can ensure comprehensive, continuously accessible care. Comprehensive dental visits can include both clinical assessments, such as for tooth decay and the need for sealants,[11] and appropriate discussion and counseling for oral hygiene, injury prevention, and speech and language development, among other topics. Because resistance to tooth decay is determined partly by genetics and partly by behavior, delaying the onset of tooth decay may also reduce long-term risk for decay.

[9]U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: A Report of the Surgeon General* (Rockville, Md.: 2000).

[10]Matthew F. Savage, Jessica Y. Lee, Jonathan B. Kotch, and William F. Vann Jr., "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs," *Pediatrics*, 114 (2004).

[11]Dental sealants, a plastic material put on the chewing surfaces of back teeth, have been shown to prevent decay on tooth surfaces where food and bacteria can build up. AAPD recommends sealants for 6-year and 12-year molars as soon as possible after eruption.

Recognizing the importance of good oral health, HHS in 1990 established oral health goals as part of its Healthy People 2000 initiative; and in 2000 updated these oral health goals for 2010. These include goals related to oral health in children, for example, reducing the proportion of children with untreated tooth decay. Another goal relates to the Medicaid population: to increase the proportion of low-income children and adolescents under the age of 19 who receive any preventive dental service each year to 66 percent in 2010.[12]

At the federal level, CMS oversees Medicaid, which provides health care coverage for low-income families and aged, blind, and disabled people. CMS oversight includes monitoring state Medicaid programs, issuing guidance to states, and facilitating communication and collaboration among stakeholders. Medicaid provided health coverage for over 30 million children under 21 in fiscal year 2008.[13] The states operate their Medicaid programs within broad federal requirements and may contract with MCOs to provide Medicaid benefits. CMS estimated that in 2006 about 65 percent of Medicaid beneficiaries received benefits through some form of managed care.[14] State Medicaid programs are required to cover certain populations and services under federal law. For instance, under the Medicaid EPSDT benefit, state Medicaid programs generally must provide coverage of dental screening, diagnostic, and related treatment services for all eligible Medicaid beneficiaries under the age of 21. Other federal requirements for the EPSDT benefit that are related to dental services include the following:

[12]The Healthy People 2010 goal was increased from 57 percent when it was first established in 2000 to 66 percent during a mid-course review in the mid-2000s. The goal defines preventive dental care to include examination, x-ray, fluoride treatment, cleaning, or sealant application. See U.S. Department of Health and Human Services, Public Health Service, *Progress Review: Oral Health* (Feb. 7, 2008).

[13]The 30 million children represent the 2008 unduplicated annual enrollment (the total number of children, each child counted once, who were enrolled in Medicaid at any point in federal fiscal year 2008) reported by CMS. See http://www.cms.hhs.gov/CapMarket Updates/02_CMSStatistics.asp#TopOfPage (accessed May 18, 2009).

[14]CMS's statistics include the Medicaid population enrolled in capitated plans (typically defined as plans that contract with states to receive a prepaid payment per enrollee for coverage of Medicaid services) and primary care case management models.

- **Developing dental periodicity schedules**. State Medicaid programs have some flexibility in determining the frequency and timing of dental screenings covered for children under the EPSDT benefit. Under federal law, however, state Medicaid programs must provide these dental services at intervals that meet reasonable standards of dental practice as determined by the state after consultation with recognized dental organizations involved in children's health care.[15] According to CMS guidance, as an alternative to developing a state-specific periodicity schedule, a state may adopt a nationally recognized dental periodicity standard, such as the schedule recommended by AAPD. CMS considers AAPD's periodicity schedule a model for comparison and it is published in CMS's *Guide to Children's Dental Care in Medicaid*.[16]

- **Reporting on delivery of EPSDT services**. Federal law requires states to report annually on the provision of EPSDT services, including dental services.[17] The annual EPSDT participation report, Form CMS-416 (hereafter called the CMS 416), is the agency's primary tool for gathering data on the provision of dental services to children in state Medicaid programs. It captures data on the number of children who received a preventive dental service, a dental treatment service, or any dental service each year. Information on the CMS 416 report is used to calculate a state's dental utilization rate—the percentage of children eligible for EPSDT that received any dental service in a given year.

Inadequate access to dental services for low-income children has been a longstanding concern. In April 2000, we reported that Medicaid beneficiaries and other low-income people had low rates of dental visits and high rates of dental disease relative to the rest of the population.[18] In a

[15]Dental services must also be provided as medically necessary to identify a suspected illness or condition and must include, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of dental health. 42 U.S.C. § 1396d(r)(3).

[16]CMS, *Guide to Children's Dental Care in Medicaid* (Washington, D.C.: October 2004). Under contract with CMS, AAPD developed the guide as a resource for states on clinical practice, evolving technologies, and recommendations in dental care.

[17]State Medicaid programs must annually report to the Secretary of HHS information on EPSDT services, including the number of children provided EPSDT screenings, the number of children referred for corrective treatment as a result of the screenings, the number of children receiving dental services, and the states' results in meeting annual goals for children's receipt of EPSDT services established by HHS. 42 U.S.C. § 1396a(a)(43).

[18]GAO, *Oral Health: Dental Disease Is a Chronic Problem among Low-Income Populations*, GAO/HEHS-00-72 (Washington, D.C.: Apr. 12, 2000).

September 2000 report, we identified factors influencing the access that low-income groups have to dental care: a primary factor was limited dentist participation in Medicaid.[19] As part of its oversight of state Medicaid dental services for children, in January 2001 CMS issued a letter to state Medicaid directors indicating that, through a series of state reviews, CMS would increase its oversight activities and assess state compliance with statutory requirements. CMS highlighted four areas for review: outreach and administrative case management, adequacy of Medicaid reimbursement rates, increasing provider participation, and claims reporting and processing. CMS did not complete this initiative. In September 2008, we reported that the extent of dental disease in Medicaid-enrolled children had not decreased between 1988 through 1994 and 1999 through 2004.[20] We also reported that millions of Medicaid-enrolled children were estimated to have untreated tooth decay, and that children in Medicaid were often not receiving dental services.

The American Recovery and Reinvestment Act of 2009 (Recovery Act) authorized an estimated $87 billion in additional federal Medicaid funding for states in the form of a temporary increase in the funds that the federal government contributes toward state Medicaid programs, including the provision of Medicaid dental services for children. The Recovery Act provides this money to states through a temporary, 27-month increase in the federal medical assistance percentage formula—the formula that determines the federal share of a state's Medicaid service expenditures.[21] In July 2009, we reported that the receipt of an increased federal share may reduce the states' share of expenditures for their Medicaid program, and states have reported using these available funds for a variety of

[19]GAO/HEHS-00-149.

[20]Although dental disease in the overall Medicaid population aged 2 through 18 did not decrease, the trends vary somewhat among different age groups. Younger children—those aged 2 through 5—had statistically significant higher rates of dental disease in the more recent time period examined as compared to earlier surveys. By contrast, data for adolescents—children in Medicaid aged 16 through 18—show declining rates of tooth decay, although the change was not statistically significant. GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

[21]See Pub. L. No. 111-5, div. B, tit. V § 5001, 123 Stat. 115, 496 (Feb. 17, 2009) (codified at 42 U.S.C. § 1396d note).

purposes, such as maintaining program eligibility, covering increased Medicaid caseloads, and maintaining local health care reform initiatives.[22]

State Medicaid Programs Reported They Employ Multiple Strategies to Monitor and Improve Access to Medicaid Dental Services, but Problems Persist

In response to our survey, most states reported using multiple strategies to monitor and improve access to Medicaid dental services, but they also reported that persistent barriers hinder improvements. All 21 states that provided Medicaid dental services under managed care arrangements reported that they set measurable access standards for MCOs, however more than half also reported that MCOs in their state do not meet any, or only meet some, of the state's dental access standards. Further, some states reported that they do not routinely verify the adequacy of MCO provider networks. Almost all states described initiatives to recruit dental providers and enhance outreach to beneficiaries' families, but barriers persist and access rates remain low.

State Medicaid Programs Reported They Use a Variety of Methods to Monitor Dental Services

In response to our survey, all 51 states reported that they monitor the provision of dental care to Medicaid-enrolled children, but how they do so varies. The majority (39 states) reported that they use multiple methods—often three or more—to monitor the provision of dental care. These methods included surveys of oral health, monitoring dental claims, and collecting utilization data (see table 1). See appendix I for a list of the monitoring methods reported by each state.

[22]GAO, *Recovery Act: States' and Localities' Current and Planned Uses of Funds While Facing Fiscal Stresses,* GAO-09-829 (Washington, D.C.: July 8, 2009).

Table 1: Number of State Medicaid Programs Employing Certain Methods to Monitor the Provision of Medicaid Dental Services to Children

Monitoring method	Number of states (51 states)
Track utilization by collecting CMS 416 data	50
Use claims data and/or encounter data provided by MCOs	23
Collect and analyze data from phone calls to the state or MCOs regarding concerns with dental care	16
Collect and analyze data from beneficiary satisfaction surveys	16
Use survey data to monitor problems obtaining needed dental services	11
Use survey data to monitor oral health of children	7
Other monitoring methods[a]	19

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one monitoring method and may be counted in more than one category.

[a]States reported using other methods to monitor the provision of Medicaid dental services, including generating ad hoc reports on various dental procedures and analyzing monthly budget reports by procedure code to monitor utilization trends.

States also reported using various measures to monitor children's access to Medicaid dental services. The most common reported measure—used by 40 (of 51) states for their fee-for-service programs and by 18 (of 21) states that also used managed care[23]—was the percentage of children who had a dental visit in the previous year (see table 2). In the 21 states where both fee-for-service and managed care programs are used to provide dental services to Medicaid-enrolled children, state monitoring can vary by service delivery method. For example, one state reported that it monitors the percentage of dentists who treat children through its managed care program, but does not monitor the percentage of dentists who treat children through its fee-for-service program. Conversely, another state reported the opposite—that it monitors this percentage for its fee-for-service program, but not for managed care.

[23]Twenty-one of the 51 state Medicaid programs reported using both managed care and fee-for-service to deliver dental services to Medicaid beneficiaries in their state. For our survey, we defined managed care as arrangements where the state pays an MCO a capitated (per member per month) payment and the MCO uses this payment to provide care. We defined dental care organizations as managed care organizations that provide only dental benefits.

Table 2: Number of State Medicaid Programs Employing Certain Measures to Monitor Children's Access to Dental Services, by Service Delivery Method

Measure	Fee-for-service (51 states)	Managed care (21 states)[a]
The percentage of children who had a dental visit in the previous year	40	18
The percentage of dentists who treat children in Medicaid	36	14
The extent to which provision of dental services is concentrated among a small number of providers	27	7
The percentage of children who did not visit a dentist in the last three years	12	5
Other analyses of claims data, utilization data, or both	19	8
Other monitoring efforts	6	4

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one monitoring measure and may be counted in more than one category.

[a]Twenty-one of the 51 state Medicaid programs reported using both managed care and fee-for-service to deliver dental services to Medicaid beneficiaries in their state.

States reported setting statewide dental utilization goals related to the provision of children's dental services. In response to our survey, 42 states reported that they have set at least one statewide utilization goal related to the provision of children's dental care in Medicaid and about half of these 42 states (20 states) have set three or more statewide goals (see table 3). Nine states reported they had no goals related to children's dental care. See appendix II for a list of the utilization goals reported by each state.

Table 3: Number of State Medicaid Programs That Reported Setting Statewide Utilization Goals for the Provision of Dental Services to Children

Statewide dental utilization goal	Number of states (51 states)
The percentage of children receiving **any dental care** in a given time period exceeds a certain threshold	31
The percentage of children receiving dental **preventive services**, such as sealants, exceeds a certain threshold	25
The ratio of participating dental providers to Medicaid children (provider to beneficiary ratio) exceeds a certain threshold	17
The percentage of children receiving **restorative procedures** for oral health problems, such as tooth decay, exceeds a certain threshold	14
The percentage of children who report difficulty finding dental care falls below a certain threshold	11
Other state goals[a]	16
Total number of states that set at least one statewide utilization goal	**42**

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one statewide dental utilization goal and may be counted in more than one category.

[a]States reported other goals, including a target percent of children who are continually enrolled in Medicaid and receive appropriate follow-up care, and increasing levels of provider participation.

All States with Managed Care Programs Reported They Set Measurable MCO Access Standards and about Half Routinely Verified Provider Networks

All of the 21 states that reported using managed care programs to deliver Medicaid dental services reported that they had established one or more measurable MCO access standards specific to each MCO dental network, such as specifying maximum waiting times for scheduling appointments or a minimum ratio of available providers to Medicaid beneficiaries (see table 4). However, more than half—14 of the 21 states—reported that the MCOs either did not meet any, or only met some, of their standards. Seventeen states reported that they used incentives or penalties to encourage the MCOs to meet or exceed state standards. However, potential incentives or penalties did not always produce the desired result. For example, one state reported MCOs had not met any of the established standards even though MCOs could be paid a bonus if they met some or all of the standards. Similarly, other states reported that only some standards were being met, despite potential financial penalties if MCOs did not meet all of the state's standards.

Table 4: MCO Access Standards Set by the 21 State Medicaid Programs That Provide Dental Services to Children under Managed Care

Dental access standards specific to MCO provider networks	States using MCOs (21 states)
Maximum waiting times when scheduling dental appointments	17
Maximum waiting times when scheduling emergency dental appointments	16
Maximum travel distances from beneficiaries' residences to the dental provider's office	15
Maximum travel times from beneficiaries' residences to the dental provider's office	11
Minimum provider to patient ratios (minimum number of dental providers for a given enrollment)	6
Other state standards[a]	10
Total number of states that established one or more MCO dental access standard	**21**

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one MCO access standard and may be counted in more than one category.

[a]States reported other standards, such as identifying and managing beneficiaries who use emergency room facilities to obtain dental services.

State oversight of MCO provider networks varied. Approximately half of the states using managed care—12 of 21 states—reported contacting a selection of providers in their MCO provider networks on a regular basis to determine if they accept new Medicaid patients. Eighteen states using managed care reported that they examined the adequacy of their dental networks in response to a complaint or concern.[24] Two of the 21 states using managed care did not report taking any action to verify MCO provider networks in their state. See appendix III for a list of MCO standards set by states and appendix IV for a description of the extent to which MCOs meet state standards and the methods states use to verify that MCO dental providers accept children in Medicaid.

State Medicaid agencies also set expectations for MCOs related to provider networks and access to services through the contracts they establish with the MCOs. We reported in 2001 that specific and comprehensive contract language helps ensure that MCOs know their responsibilities and that they can be held accountable for delivering covered services.[25] Our review of contracts between states and nine large

[24]Five of the 18 states reported that examining MCO networks in response to a complaint or concern was their only method to verify MCO networks, 13 states do so in combination with other verification methods.

[25]GAO, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

MCOs that provide Medicaid dental services illustrate variations in the specificity of the standards that states established in their contracts concerning network adequacy and access measures. Regarding one measure of network adequacy—the maximum number of beneficiaries per dental provider—some, but not all, contracts specified a maximum allowed number of Medicaid enrollees per dental provider. One contract, for example, specified a county-level maximum of 486 enrollees per dental provider, while other contracts did not specify any maximum. Standards related to timely access also varied; for example, one contract required that routine dental appointments be scheduled within 30 calendar days, or sooner if possible, while another contract required that routine dental appointments be scheduled within 90 days of a formal request. Finally, the specificity of the contracts with regard to standards for the proximity of dental providers to beneficiaries varied. One contract, for example, specified a maximum travel time of 30 minutes to a provider, while another contract had no proximity standards.

State Medicaid Programs Reported Efforts to Improve Access, but Also Reported That Persistent Barriers Hinder Further Improvement in Children's Access to Dental Care

Many of the 51 states we surveyed reported efforts to improve children's access to dental care, including efforts to provide outreach to the families of children in Medicaid and recruit dental providers. Forty-eight states reported that they have taken one or more actions to facilitate or encourage parents to take their children to a dentist, including publishing literature about the importance of oral health and establishing a hotline that families can call for help in finding a dentist (see table 5). Studies in the published literature have reported some successes in outreach programs. One such study reported on a state program where dental hygienist services provided in three schools resulted in an increase in the percentage of children who had seen a dentist at least once a year from 59 percent to 78 percent in the first year of the program.[26]

[26]Christina Melvin, "A Collaborative Community-based Oral Care Program for School-age Children," *Clinical Nurse Specialist*, vol. 20, no. 1 (2006): 18-22.

Table 5: Outreach Actions Taken to Educate Families on the Importance of Dental Care, as Reported by State Medicaid Programs

State actions to provide outreach to families	States responding (51 states)
Issued literature to Medicaid families discussing the importance of oral health	39
Established a hotline that families in Medicaid can call for help in finding a dental provider	35
Translated literature about the importance of oral health into other languages	29
Distributed an up-to-date list of dental providers who accept children in Medicaid	24
Required MCOs to assist families in finding a dental provider for their children	20
Launched a Web site for Medicaid families providing information about oral health care	18
Required MCOs to provide literature to their beneficiaries about the importance of oral health	18
Provided incentives to Medicaid families to bring their children to dental providers	5
Paid for advertisements aimed at Medicaid families that promote the importance of oral health	5
Other state actions[a]	17
Total number of states that have taken one or more outreach action	**48**

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one action to provide outreach to families and may be counted in more than one category.

[a]States reported other actions, such as outreach to families with children who have not received a dental service in the past year and free dental screening programs.

All but one of the 51 state Medicaid programs reported they have taken at least one action since 2000 to recruit Medicaid dental providers (see table 6), and some states provided evidence that their initiatives have enhanced their Medicaid dental provider networks. For example, one state Medicaid program implemented an initiative that included simplifying claims processing, increasing reimbursement rates, educating and recruiting providers, and educating beneficiaries. According to a study of this program published in the *Journal of Rural Health*, from fiscal year 1999 to 2002, this state Medicaid program saw a 39 percent increase in the number of dentists accepting Medicaid and a 57 percent increase in the number of Medicaid-enrolled children receiving dental services after implementing this initiative.[27]

[27]Mary Greene-McIntyre, Mary Hayes Finch, and John Searcy, "Smile Alabama! Initiative: Interim Results from a Program To Increase Children's Access to Dental Care," *Journal of Rural Health*, vol. 19 suppl. (2003): 407-15.

Table 6: Actions to Recruit Dental Providers since 2000, as Reported by State Medicaid Programs

State actions to recruit dental providers	States responding (51 states)
Met with dental provider groups to encourage them to see more children in Medicaid	45
Increased dental fee-for-service reimbursement rates	44
Streamlined fee-for-service claims processing	36
Reduced or eliminated administrative burdens, such as prior authorization requirements	35
Action by other state agencies, such as providing scholarships, loan repayment, or other funding to dental providers for serving low-income communities	34
Encouraged non-dental providers, such as pediatricians, to provide basic oral health care	31
Sent literature to dental providers to encourage them to see more children in Medicaid	21
Increased funding to clinics serving Medicaid children for hiring more dental providers	14
Increased dental managed care capitation payments to MCOs	11
Paid for advertisements aimed at dental providers to encourage them to see more children in Medicaid	5
Invested in health information technology that allows rural dental providers to consult with dentists in other areas on high risk cases	2
Other actions taken by the state Medicaid agency[a]	22
Total number of states that have taken one or more actions to recruit dental providers	**50**

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one action to recruit dental providers and may be counted in more than one category.

[a]States reported other actions by the state Medicaid agency, including investing in telemedicine, producing a guide of program procedure codes with descriptions of services and prior authorization requirements, and introducing eligibility verification systems with free online access.

Although nearly all states reported that since 2000 they have undertaken initiatives to improve children's access to dental care, CMS 416 data on children's access to dental care show that access rates remain low, and states report facing the same barriers they faced in 2000. CMS 416 data show dental utilization rates have improved since 2000, from a national average of 27 percent to 35 percent in 2007—but in 2007 only 1 state reported a dental utilization rate above 50 percent and 12 states' utilization rates remained below 30 percent. Less than half of the states that reported undertaking initiatives to improve children's access to dental care (21 states) reported that all their initiatives met their expectations. Nearly all (48 of 51 states) reported that the principal barriers that contributed to the low use of dental services by Medicaid beneficiaries in 2000—including low provider participation rates, administrative burdens, and insufficient funding—continue to impede their current efforts. Apart from funding concerns, states most often reported that a lack of provider and beneficiary participation hindered their efforts to improve access to Medicaid dental services in their state (see table 7). Twenty-six states

reported these and other barriers resulted in one or more of their improvement initiatives not being implemented or their expectations not being met.

Table 7: Barriers That Hinder State Initiatives to Improve Access to Medicaid Dental Services, as Reported by State Medicaid Programs

Barriers to state initiatives	States responding (51 states)
Lack of available funding	44
Lack of provider participation	40
Lack of beneficiary participation	38
Administrative burden on providers	31
Difficulty coordinating with other state agencies	13
Lack of CMS approval for state initiatives	5
Other barriers[a]	6

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

Note: States could select more than one barrier and may be counted in more than one category.

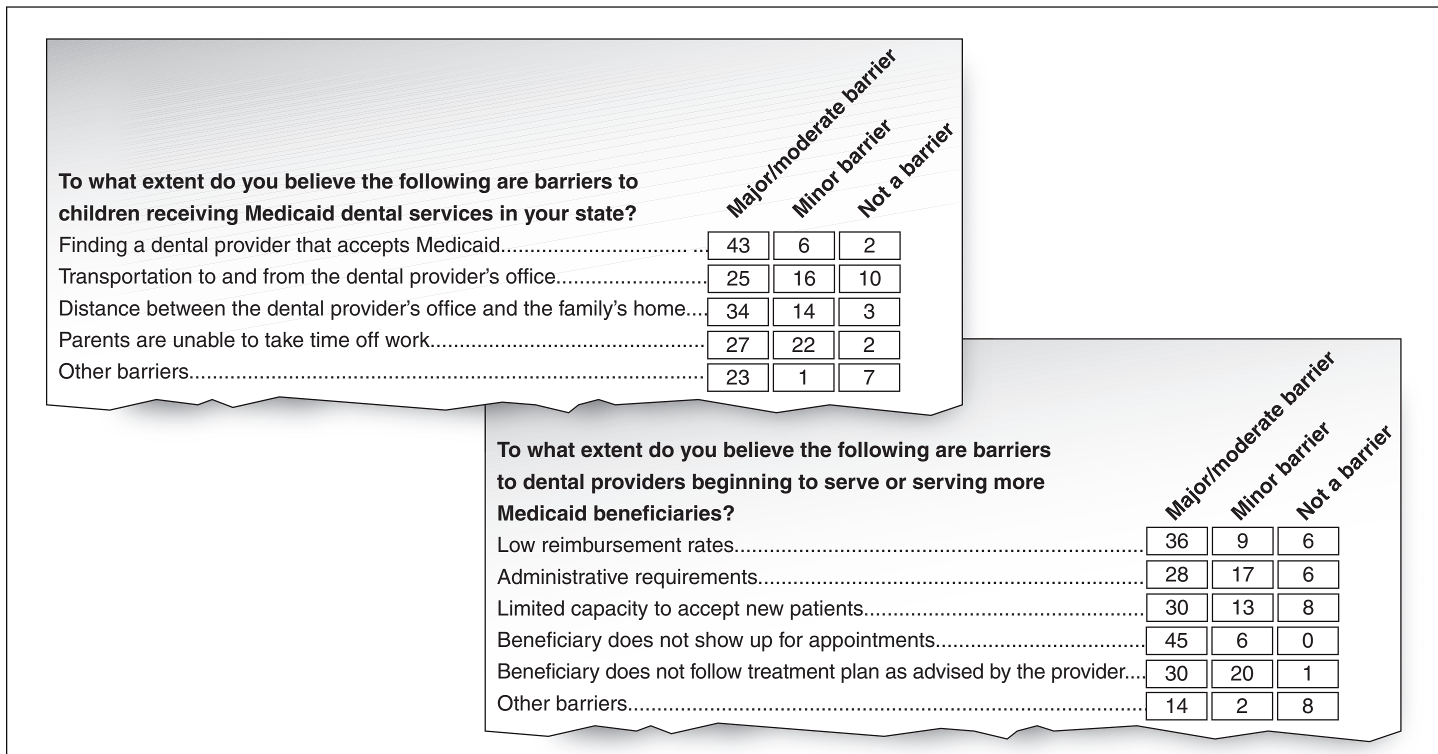
[a]States reported other barriers, including staffing shortages that limit the agencies' ability to take on additional projects and cultural competency barriers, such as translating oral health information into other languages.

When asked to describe the extent to which state goals were being met, some states reported that successes in increasing the numbers of providers enrolled in the Medicaid program have resulted in increasing rates of utilization by children, but that more needs to be done to increase the percentage of children receiving dental services beyond current levels. States also described other challenges to meeting their goals and improving children's access to dental care, such as fluctuations in eligibility for services, lack of beneficiary compliance, low oral health awareness among beneficiaries, and a lack of demand for routine dental care by beneficiaries.

In addition to barriers that hinder state initiatives, states report that access rates could also be affected by two other types of barriers: those faced by children seeking dental services and those faced by providers serving Medicaid beneficiaries. For children seeking dental services, most states reported that finding a provider that accepts Medicaid is a moderate or major barrier. Comparatively fewer states reported that obtaining transportation to and from the provider's office or the ability of parents to take time off work are moderate or major barriers for children seeking dental care. For providers, most states also reported that beneficiaries not showing up for appointments and a limited capacity to accept new

patients (reported by 45 and 30 states, respectively) are moderate to major barriers. One state noted that these issues are particularly significant when they are combined together, at which point they can become moderate to major barriers for dental providers. See figure 1 for barriers faced by children and providers.

Figure 1: Barriers to Children Seeking Medicaid Dental Services and Barriers to Dental Providers Serving Medicaid Beneficiaries, as Reported by State Medicaid Programs



To what extent do you believe the following are barriers to children receiving Medicaid dental services in your state?	Major/moderate barrier	Minor barrier	Not a barrier
Finding a dental provider that accepts Medicaid	43	6	2
Transportation to and from the dental provider's office	25	16	10
Distance between the dental provider's office and the family's home	34	14	3
Parents are unable to take time off work	27	22	2
Other barriers	23	1	7

To what extent do you believe the following are barriers to dental providers beginning to serve or serving more Medicaid beneficiaries?	Major/moderate barrier	Minor barrier	Not a barrier
Low reimbursement rates	36	9	6
Administrative requirements	28	17	6
Limited capacity to accept new patients	30	13	8
Beneficiary does not show up for appointments	45	6	0
Beneficiary does not follow treatment plan as advised by the provider	30	20	1
Other barriers	14	2	8

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

CMS Has Taken Action to Improve Federal Oversight of State Medicaid Dental Services for Children, but Gaps Remain

Responding to congressional concern about CMS oversight of state Medicaid dental services, CMS has taken a number of actions since May 2007 to strengthen its oversight of Medicaid dental services for children, but gaps remain in the agency's efforts.

CMS Has Taken Steps toward Improving Oversight of State Medicaid Dental Services for Children

In February 2008 and September 2008 Subcommittee hearings, CMS officials described several initiatives under way by CMS to improve monitoring of state programs and to provide guidance and facilitate collaboration. At the time of our review, some of these initiatives had been completed, while others were still under way. CMS initiatives include the following:

- **Focused dental reviews in 17 states**. Between October 2007 and May 2008, CMS conducted a series of focused dental reviews in 17 states.[28] The reviews were designed to examine state efforts to improve children's dental utilization rates, assess state compliance with federal Medicaid statutes and regulations, and identify promising or notable state practices to improve the delivery of oral health services. In January 2009, CMS published a summary report of its findings and recommendations in 16 states (in February 2008, CMS had published a separate report on Maryland).[29] CMS had concerns that 11 of the 17 states were not adhering to federal law or regulation, including multiple findings in some states. For example, CMS found that 6 states had inadequate dental networks in MCOs that provided Medicaid dental services, 2 states had not ensured that all medically necessary dental services were provided, and 1 state had inappropriately limited reimbursement for out-of-state emergency dental services, leaving the remainder of the costs to the beneficiaries.[30] CMS also

[28]Fifteen of the 17 states reviewed had reported dental utilization rates below 30 percent in fiscal year 2006: Arkansas, California, Delaware, District of Columbia, Florida, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, and Wisconsin. In addition, Maryland was reviewed in October 2007 and Georgia was reviewed in May 2008 at the request of the Subcommittee.

[29]CMS, *2008 National Dental Summary*, (January 2009) and *Final Report on Maryland's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program With a Focus on Dental Services for Children* (Feb. 5, 2008).

[30]CMS regional offices noted deficiencies for some states with respect to certain Medicaid requirements such as: (i) states must ensure, through their contracts, that MCOs maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services (see 42 C.F.R. 438.206(b)(1)); (ii) states must ensure that all covered services are available and accessible to MCO enrollees (see 42 C.F.R. § 438.206(a)); and (iii) Medicaid beneficiaries cannot be charged cost-sharing for EPSDT or emergency services (see 42 C.F.R. 447.53(b)).

made recommendations to all 17 states it reviewed and identified several promising practices, which it highlighted in its summary report.[31]

- **Improved collection of CMS 416 reports**. In June 2007, CMS began an initiative to improve reporting by states that had not submitted timely or reliable dental utilization data in their annual CMS 416 reports. CMS sent formal requests to 22 states that had failed to submit complete CMS 416 reports for one or more years. CMS also contacted the states and provided technical assistance on problems with data collection methodology. As of March 2009, all 51 states had submitted their 2007 CMS 416 reports to CMS. CMS 416 reports for 2008 were due to CMS in April 2009, however, as of early June 2009, only 42 states had submitted their 2008 reports.

- **Review of state periodicity schedules**. In 2008, CMS examined dental-related periodicity schedules from all states. CMS found that all but three states reported having some type of periodicity schedule, but not all schedules were in compliance with CMS requirements. For example, some schedules indicated when a primary care provider should refer a child to a dentist, but the schedule did not specify how often dental services should occur. CMS also found that periodicity schedules in several states were not readily accessible by providers or beneficiaries. For states that had not submitted separate dental periodicity schedules as required by CMS, CMS recommended that the states adopt AAPD's periodicity schedule for children.

- **Publication of a dental policy document**. CMS posted a 16-page document on Medicaid dental policy issues on its Web site in September 2008. This document covered a variety of questions from states on topics including periodicity schedules, dental referral requirements, covered services, and patient cost sharing.[32] For example, one question asked if the state could allow providers to bill patients for missed appointments. CMS responded that Medicaid policy did not permit such billing, in part because

[31]Provider reimbursement rates were not a specific part of CMS's focused dental reviews, even though some providers and others interviewed by CMS noted that low payment rates contributed to low provider participation in Medicaid. A CMS official indicated that the issue of low reimbursement rates would likely be part of ongoing discussions involving Medicaid dental topics such as delivery systems and administrative issues, but would not be the focus of its oversight efforts. The official reported that the agency plans to continue working with states and the American Dental Association on reimbursement issues.

[32]HHS, Centers for Medicare & Medicaid Services, *Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families* (Sept. 22, 2008); http://www.cms.hhs.gov/medicaiddentalcoverage/ (accessed Oct. 6, 2008).

no service was delivered. Further, missed appointments are not a distinct, reimbursable Medicaid service, but are instead considered part of a provider's overall cost of doing business.

- **Communications with states and stakeholders**. From 2007 through 2009, CMS held several meetings and conference calls with state dental representatives, provider associations, and other stakeholders to discuss issues concerning Medicaid dental services for children. For example, CMS presented information on Medicaid dental issues at the April 2008 National Oral Health Conference sponsored by the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors. Other groups involved in CMS partnership activities included AAPD, the American Dental Association, and the Association of Community Affiliated Plans.

- **Establishment of an Oral Health Technical Advisory Group**. In conjunction with NASMD, CMS established an Oral Health Technical Advisory Group to address issues related to oral health services, including access and quality. A NASMD member chairs the advisory group and, as of January 2009, other members included CMS representatives, state representatives from different regions of the country, and other NASMD staff. Advisory group projects include examining the effects on oral health programs of recent legislation, such as the Recovery Act and the Children's Health Insurance Program Reauthorization Act of 2009, considering improvements to the CMS 416 annual reports, and improving materials used to inform beneficiaries of their Medicaid dental benefits.

- **Sharing of promising state practices related to dental services**. CMS posted "promising practices"—described by CMS as successful state programs that reflect innovative approaches to meeting common problems—on its Web site.[33] As of May 2009, CMS had posted promising practices from 4 states related to Medicaid dental services:

  Delaware increased reimbursement, reduced administrative burden on providers, and increased provider outreach.

  South Carolina increased reimbursement rates, reduced administrative barriers, and began an outreach campaign to encourage dentists to participate in Medicaid.

[33]See http://www.cms.hhs.gov/MedicaidCHIPQualPrac/MCPPDL/list.asp (accessed May 20, 2009).

Tennessee increased reimbursement, separated (or “carved out”) the dental benefit from Medicaid managed care contracts, and hired a contractor to administer the dental benefit.

Virginia increased reimbursement, carved out the dental benefit from Medicaid managed care contracts, and adopted incentives to increase provider participation, such as establishment of a dedicated call center, new billing options and quicker payment, streamlined prior authorization for care, and simplified provider credentialing.

Gaps Remain in CMS Efforts to Monitor Provision of Dental Services to Children in Medicaid, Provide Guidance, and Facilitate Collaboration among States

Although CMS has taken a number of important steps, gaps in CMS oversight point to opportunities for further action to improve access to dental services for children in Medicaid. Remaining gaps in CMS oversight include the following:

- **CMS does not have plans to conduct focused dental reviews in additional states**. CMS’s focused dental reviews targeted 15 states with the lowest dental utilization rates, but 2006 CMS 416 reports showed that in 24 additional states (including Georgia and Maryland) in that year, between 31 and 40 percent of eligible children received any dental service—well below HHS’s Healthy People 2010 goal of having 66 percent of low-income children under age 19 receive a *preventive* dental service. According to CMS officials, CMS, at the time or our review, did not plan to conduct focused dental reviews in these states, potentially missing an opportunity to identify important areas for improvement.[34] When asked what additional assistance CMS could provide, 6 states responding to our survey reported that they believed that an independent review of dental services would be helpful to their Medicaid programs.

- **CMS did not require corrective action in states found to have inadequate MCO networks**. CMS’s focused dental reviews identified 8 states that provided dental services through managed care that did not ensure that MCO provider networks were adequate to afford access to covered dental services. In 6 states, CMS presented its concerns as a “finding,” that is, a concern that the state is not adhering to federal law or regulation. In the remaining 2 states, CMS cited deficiencies in MCO provider networks, but did not report its concerns as findings. CMS made recommendations to strengthen MCO provider networks in all 8 states;

[34]In commenting on a draft of this report, CMS indicated that it would consider additional focused dental reviews as part of a broader planning effort to review all EPSDT services.

however, CMS did not require these states to take corrective action—rather, agency officials indicated they would follow up with states on the status of CMS's recommendations.

- **CMS 416 reports provide limited information on dental service utilization**. The CMS 416 report only gathers data on the number of children who received a preventive dental service, a dental treatment service, or any dental service. We have reported in the past that these data are limited in their usefulness for oversight of Medicaid dental services for children.[35] For example, because dental services delivered to managed care enrollees are not reported separately from services to fee-for-service enrollees, the CMS 416 data does not provide information that could be used to flag problems with a specific service delivery method. Further, it is not possible to determine how many children in a state received all of the recommended dental services included in the state's periodicity schedule. According to the CMS Deputy Administrator, the Oral Health Technical Advisory Group has a project under way to consider improvements to the CMS 416.

- **States report that additional guidance from CMS is needed**. In response to our survey, 2 states reported that CMS's September 2008 policy paper on Medicaid dental issues was helpful, but nearly all states (49 of 51) reported that additional CMS guidance could help them improve delivery of Medicaid dental services. States cited a need for additional information in several areas: for example, guidance on standards for dental care, information on billing policies, better definitions for outreach and transportation services in Medicaid programs, establishing appropriate dental fee schedules, improving documentation and coding practices, and information on quality and preventive initiatives.

- **CMS has posted relatively few promising practices on its Web site**. When asked what CMS assistance would be helpful to their state Medicaid program, the most common answer (other than increasing the federal medical assistance percentage), cited by 37 states, was information on other states' efforts to improve dental utilization. Although CMS maintains a Web site to publicize promising state Medicaid dental practices, 11 states reported that they were unaware of the promising practices posted on CMS's Web site. The 4 promising practices posted as of May 2009 are just a few of the practices that could be shared with other states. For example, during its focused dental reviews, CMS identified 17 additional promising

[35]GAO, *Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services*, GAO-07-826T (Washington, D.C.: May 2, 2007).

and notable practices, none of which were included on the CMS promising practice Web site. Further, 26 states responding to our survey reported that their states had "best practices" that could be shared with other states, such as providing mobile dental vans, training and reimbursing physicians to do oral screens and apply fluoride varnish, and establishing a dental home for children (see app. V for brief descriptions of these practices).

Conclusions

CMS has begun several initiatives to strengthen its oversight of state Medicaid dental services for children, but information on the oral health of and receipt of dental services by Medicaid children show that much more needs to be done. Although many states have reported moderate increases in access to Medicaid dental services, we reported in September 2008 that the extent of dental disease in children had not decreased and that millions of children were estimated to have untreated tooth decay. States responding to our survey reported that a lack of available funding, low provider participation, and administrative burdens—many of the same factors that contributed to the low use of dental services in 2000—still present barriers to access today. Through a series of focused reviews of states' efforts to provide dental services to children in Medicaid, CMS has identified deficiencies in several state Medicaid programs. Although CMS made recommendations for improvement to the states, it required no corrective actions. Moreover, not all states with low rates of children's dental utilization have been reviewed, nor are such reviews planned. These reviews have not only identified problem areas, but have also helped identify information on promising state dental practices that could be useful to other states seeking to improve their own programs. Finally, for Medicaid-enrolled children who receive dental services through managed care programs, CMS has found that certain states have not ensured that MCOs have adequate provider networks to provide covered dental services to their enrollees. Although CMS and states have taken steps to address long-standing barriers, continued attention and action is needed to ensure children's access to Medicaid dental services.

Recommendations for Executive Action

To strengthen monitoring of state Medicaid dental services for children and help states improve children's access to Medicaid dental services, we are recommending that the Administrator of CMS take the following four actions:

- Develop a plan to review dental services for Medicaid children in all states with low utilization rates, such as those not meeting HHS's Healthy People 2010 targets.

- Ensure that states found to have inadequate MCO dental provider networks take action to strengthen these networks.

- Work with stakeholders to develop needed guidance on topics of concern to states.

- Identify ways to improve sharing of promising practices among states.

Agency Comments

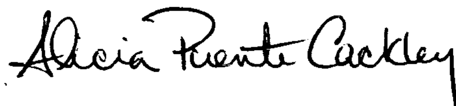
We provided a draft of this report for comment to HHS. Responding for HHS, CMS provided written comments. In summary, CMS concurred with three of our recommendations—specifically, to ensure that states found to have inadequate MCO provider networks take corrective action, to develop additional guidance on topics of concern to states, and to improve sharing of promising practices among states and other stakeholders. CMS described several initiatives planned or under way that would strengthen its oversight of state Medicaid dental services for children. CMS concurred in part with our fourth recommendation, to develop a plan to review Medicaid dental services in states with low utilization rates. In following up with CMS, an official clarified that CMS agreed with the need to review Medicaid dental services in these states but wanted this plan to be part of the agency's broader plan to review all EPSDT services. As part of this broader plan, CMS would consider additional focused dental reviews as well as comprehensive EPSDT service reviews.[36] We believe that CMS's action will meet the intent of our recommendation. CMS also noted that the Children's Health Insurance Program Reauthorization Act of 2009 included a number of provisions related to dental services that the agency was in the process of implementing, including requirements for states to post a listing of participating Medicaid and CHIP dental providers on HHS's www.insurekidsnow.gov Web site, to publish new quality measures for Medicaid and CHIP children, and to report additional information on

[36]In July 2009, CMS reported that it was developing a comprehensive workplan that included establishing a regular schedule for reviewing state EPSDT policy and implementation efforts. See *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*, GAO-09-578 (Washington, D.C.: August 14, 2009).

children receiving dental care under Medicaid.[37] Finally, CMS provided one technical comment, which we incorporated into the report. CMS's letter is reprinted in appendix VI.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of HHS and other interested parties.

In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cackleya@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff that made major contributions to this report are listed in appendix VII.



Alicia Puente Cackley
Director, Health Care

[37]The Children's Health Insurance Program Reauthorization Act of 2009 also mandates that GAO conduct a study on certain dental workforce and other Medicaid and CHIP dental issues and submit a report to Congress by August 2010. See Pub. L. No. 111-3, § 501(h), 123 Stat. 8, 88 (Feb. 4, 2009).

Appendix I: Methods Used by State Medicaid Programs to Monitor the Statewide Provision of Dental Care to Children

State	CMS 416 data	Claims and/or encounter data from MCOs	Phone calls to state and/or MCOs on concerns	Beneficiary satisfaction surveys	Survey for problems obtaining services	Survey to monitor oral health of children	Other methods[a]
Alaska	●	○	○	○	○	○	●
Ala.	●	○	○	○	○	○	●
Ark.	●	○	○	●	○	○	●
Ariz.	●	●	○	●	●	○	●
Calif.	●	●	○	○	○	○	○
Colo.	●	●	○	○	○	○	●
Conn.	●	●	○	○	○	○	○
D.C.	●	●	●	●	●	●	○
Del.	●	○	○	○	○	○	●
Fla.	●	○	○	○	○	○	○
Ga.	●	●	●	●	●	○	○
Hawaii	●	○	○	○	○	○	○
Iowa	●	○	●	●	○	○	○
Idaho	●	○	○	○	○	○	○
Ill.	●	○	○	●	●	○	●
Ind.	●	○	○	○	○	○	○
Kans.	●	○	●	○	○	○	○
Ky.	●	○	○	○	○	○	○
La.	●	●	○	○	○	○	●
Mass.	●	●	●	●	●	○	○
Md.	●	●	●	●	●	●	●
Maine	●	○	○	○	○	○	○
Mich.	●	●	○	○	○	○	○
Minn.	●	○	●	○	○	○	○
Mo.	●	○	○	○	○	○	○
Miss.	●	○	○	○	○	○	●
Mont.	●	●	○	○	○	○	○
N.C.	●	●	○	●	○	○	○
N.Dak.	●	○	○	○	○	○	●
Nebr.	●	○	○	○	○	○	○
N.H.	●	○	●	○	●	○	●
N.J.	●	●	○	●	○	○	○
N.Mex.	●	●	●	○	○	○	○

State	CMS 416 data	Claims and/or encounter data from MCOs	Phone calls to state and/or MCOs on concerns	Beneficiary satisfaction surveys	Survey for problems obtaining services	Survey to monitor oral health of children	Other methods[a]
Nev.	●	●	○	●	○	○	○
N.Y.	●	●	●	○	○	○	○
Ohio	●	●	●	●	●	●	○
Okla.	●	○	○	○	○	○	○
Ore.	●	●	●	○	○	○	●
Pa.	●	●	●	●	●	●	○
R.I.	●	●	●	●	●	○	○
S.C.	●	○	○	○	●	●	●
S.Dak.	○	○	○	○	○	○	●
Tenn.	●	●	○	●	○	○	○
Tex.	●	○	○	○	○	●	○
Utah	●	●	○	○	○	○	○
Va.	●	○	●	●	○	○	●
Vt.	●	○	○	○	○	○	○
Wash.	●	○	○	○	○	○	●
Wis.	●	●	●	○	○	●	●
W.Va.	●	○	○	○	○	○	○
Wyo.	●	○	○	○	○	○	●

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

● State did have this method of monitoring children’s dental care.

○ State did not have this method of monitoring children’s dental care.

[a]States reported using other methods to monitor the provision of Medicaid dental services, including generating ad hoc reports on various dental procedures and analyzing monthly budget reports by procedure code to monitor utilization trends.

Appendix II: Statewide Utilization Goals for the Provision of Dental Care to Children in State Medicaid Programs

State	Percentage of children who receive any dental care in a given time period is to exceed a certain threshold	Percentage of children who received dental preventive services is to exceed a certain threshold	Ratio of participating dental providers in Medicaid exceeds a certain threshold	Percentage of children who received restorative procedures for oral health problems exceeds a certain threshold	Percentage of children who report difficulty finding dental care is to fall below a certain threshold	Other state goals[a]
Alaska[b]	○	○	○	○	○	○
Ala.	●	●	○	○	○	○
Ark.	●	○	●	●	○	○
Ariz.	●	○	○	○	○	●
Calif.	○	○	○	○	○	●
Colo.	●	●	○	○	○	●
Conn.	●	●	●	●	○	●
D.C.	●	●	○	●	●	○
Del.	●	○	●	○	●	○
Fla.	○	●	●	○	●	○
Ga.	●	●	●	●	●	○
Hawaii	●	○	●	○	○	○
Iowa	●	●	○	●	○	○
Idaho	○	●	●	○	●	○
Ill.	●	●	○	○	○	○
Ind.[b]	○	○	○	○	○	○
Kans.	○	○	○	○	○	●
Ky.[b]	○	○	○	○	○	○
La.	○	○	●	○	○	○
Mass.	●	●	●	○	●	●
Md.	●	●	●	●	○	●
Maine	●	●	○	○	○	○
Mich.	●	●	○	●	○	○
Minn.[b]	○	○	○	○	○	○
Mo.[b]	○	○	○	○	○	○
Miss.[b]	○	○	○	○	○	○
Mont.	●	○	○	○	○	○
N.C.	●	●	●	○	○	●
N.Dak.	●	●	●	●	●	○
Nebr.[b]	○	○	○	○	○	○

State	Percentage of children who receive any dental care in a given time period is to exceed a certain threshold	Percentage of children who received dental preventive services is to exceed a certain threshold	Ratio of participating dental providers in Medicaid exceeds a certain threshold	Percentage of children who received restorative procedures for oral health problems exceeds a certain threshold	Percentage of children who report difficulty finding dental care is to fall below a certain threshold	Other state goals[a]
N.H.	●	●	○	●	●	●
N.J.	●	●	●	●	○	○
N.Mex.	●	●	●	●	●	○
Nev.	○	○	○	○	○	●
N.Y.	●	○	○	○	○	○
Ohio	●	○	○	○	○	●
Okla.	●	●	●	●	○	●
Ore.	○	○	○	○	○	●
Pa.	●	●	○	○	○	○
R.I.	○	○	○	○	○	●
S.C.	●	○	○	○	●	○
S.Dak.	●	●	○	○	○	○
Tenn.	●	○	●	○	○	○
Tex.	○	●	○	○	○	○
Utah	○	●	○	●	○	○
Va.	●	○	○	○	○	●
Vt.[b]	○	○	○	○	○	○
Wash.	○	○	○	○	○	●
Wis.	●	●	●	○	○	○
W.Va.[b]	○	○	○	○	○	○
Wyo.	●	●	○	●	●	○

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

● State did have this access goal for children's dental care.

○ State did not have this access goal for children's dental care.

[a]States reported other goals, including the percentage of children who are continually enrolled and receive appropriate follow-up or increasing levels of provider participation.

[b]These states reported they do not have goals related to the provision of dental care for children in state Medicaid programs.

Appendix III: Access Standards Set by the 21 States That Provide Dental Services through Managed Care Organizations (MCOs)

	Access Standards States Set For MCOs								
State	Percentage of children who should receive a dental visit	Minimum payment rates for dental services	Beneficiary satisfaction scores or ratings	Minimum provider to patient ratios	Maximum travel times	Maximum travel distances	Maximum waiting times when scheduling dental appointments	Maximum waiting times when scheduling emergency dental appointments	Other standards[a]
Ariz.	●	○	○	○	○	○	●	●	●
Calif.	○	●	●	●	●	●	●	●	●
D.C.	●	●	○	○	●	●	●	●	○
Fla.	●	○	○	●	●	●	●	●	○
Ga.	●	○	○	○	●	●	●	○	●
Idaho	○	●	○	○	○	●	○	○	○
Ky.	○	●	●	○	●	●	○	○	○
Md.	●	●	●	●	●	●	●	●	○
Mich.	○	○	○	○	○	○	●	●	○
Minn.	○	○	○	○	●	●	●	●	●
Mo.	○	○	○	○	○	●	●	●	●
N.J.	●	○	●	●	●	●	●	●	●
N.Mex.	○	○	○	○	○	○	●	●	○
Nev.	●	○	○	●	○	○	●	●	○
N.Y.	●	○	○	●	●	●	●	●	○
Ohio	●	○	●	○	○	●	○	○	●
Ore.	○	○	○	○	●	●	○	○	●
Pa.	●	○	●	○	●	○	●	●	○
R.I.	●	●	○	○	○	●	●	●	●
Tex.	○	○	○	○	○	●	●	●	●
Wis.	●	○	○	○	○	○	●	●	○

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

● State did have this standard for MCO networks in their state.

○ State did not have this standard for MCO networks in their state.

[a]States reported other standards, such as identifying and managing beneficiaries who use emergency room facilities to obtain dental services.

Appendix IV: Extent to Which Managed Care Organizations (MCO) Meet State Standards and State Verification of MCO Networks

	Extent to which MCOs meet established standards			Method used to verify that dental providers are accepting children in Medicaid		
State	**Meet all**	**Meet some**	**Meet none**	**Routinely contact a selection of providers to determine if they accept new Medicaid patients**	**Examine networks in responses to complaints or other concerns on an ad hoc basis**	**Other verification[a]**
Ariz.		✔		○	●	●
Calif.		✔		●	●	●
D.C.	✔			●	●	○
Fla.		✔		●	○	○
Ga.	✔			●	●	○
Idaho	✔			○	●	○
Ky.	✔			○	○	○
Md.		✔		●	●	○
Mich.		✔		○	○	○
Minn.		✔		○	●	○
Mo.		✔		○	●	○
N.J.		✔		○	●	●
N.Mex.		✔		●	●	○
Nev.	✔			●	●	○
N.Y.			✔	●	●	○
Ohio		✔		●	●	○
Ore.		✔		○	●	○
Pa.	✔			●	●	○
R.I.	✔			●	●	○
Tex.		✔		●	●	○
Wis.			✔	○	●	○

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

✔ Degree to which MCOs meet standards.

● State did report using this method to verify MCO provider networks.

○ State did not report using this method to verify MCO provider networks.

[a]States reported using other methods to verify MCO networks, including monthly spot checks, monitoring provider registration, and requiring annual network development plans.

Appendix V: CMS Promising Practices and State Reported Best Practices

To promote information sharing and collaboration among states, the Centers for Medicare & Medicaid Services (CMS) has created a Web site in which it publishes notable "Promising Practices" related to Medicaid and the State Children's Health Insurance Program (SCHIP). Dental care is one of the subject areas covered on this Web site. To nominate a promising practice, a state must complete an application describing the underlying problem, the approach taken, and the results obtained. A promising practice is defined by CMS as an approach to meeting a challenge related to Medicaid/SCHIP program operations, clinical practice, or functional level that serves to enhance quality of care and/or life and may be of interest to other states. Specifically, the practice must:

- Be related to the improvement of quality of care and/or life for Medicaid and/or SCHIP beneficiaries.
- Address a significant problem in health status or functioning based on trends in mortality, morbidity, quality of life, utilization, and/or costs.
- Reflect an innovative approach to meeting a common problem.
- Have been in operation for a sufficient period of time to demonstrate effectiveness (e.g., minimum 12 months).
- Have demonstrated success through tangible results (e.g., improvements in beneficiary physical or mental well-being, savings).
- Comply with federal Medicaid statute and regulations and CMS policy direction.

As of May 2009, there were five dental practices listed on CMS's "Promising Practices" Web site, four of which pertained to Medicaid.[1] Each of the 4 states cited as having promising practices also indicated on our survey of state Medicaid programs that they consider their state to have a dental best practice.

In addition to these 4 states, 22 states responding to our survey reported that they had best practices that could be shared with other states. See table 12 for brief descriptions of all 26 state-reported best practices.

[1]The additional promising practice was related to dental benefits under the SCHIP program.

Table 8: Description of State-Reported Best Practices for Improving Dental Care for Children in Medicaid

State	State-reported best practice
Ala.	The "Smile Alabama!" initiative encompassed administrative reforms, implemented a case management system, increased outreach to patients and dentists, and set reimbursement rates equal to rates paid by commercial insurers.
Ark.	The state contracted with an organization to assist with outreach, scheduling, reminders, and transportation for Medicaid beneficiaries needing dental care.
Ariz.	The Oral Health Performance Improvement Project assists health plans identify gaps in quality-improvement strategies and address those areas. Examples include collaboration with programs such as Head Start and using health plan staff or dental providers to make presentations in schools or at community health fairs.
Conn.	The state established dental healthcare specialists who interact with the community to stress the importance of a dental home and regular dental care. Specialists interact with dentists to ensure families and children make their 6-month checkups, and act as a point of contact for the dentists. Specialists also provide oral health counseling and assistance, such as obtaining transportation and addressing language barriers. The state also created a member outreach handbook, including information on office etiquette and making appointments.
Del.*	The state reimburses providers at 85 percent of usual and customary rates, which has encouraged dentists to participate in the state Medicaid program.
Fla.	The state provides coverage of fluoride varnish applications by non-dentists.
Ga.	A managed care organization implemented a program that transferred a significant percentage of patients receiving intravenous sedation from outpatient hospital settings to dental offices.
Iowa	As part of the I Smile Dental Home Plan, Oral Health Care Coordinators, who are dental hygienists employed by the Department of Public Health, work with counties to strengthen the public health dental system, link with local boards of health, provide training and oversight of health agency staff, and coordinate services for children ages 12 and under.
Ill.	The state implemented several initiatives; (1) the Dental Champions Program, a peer-to-peer provider recruitment/retention effort to enroll providers, particularly in underserved areas, and to encourage increased participation among enrolled providers; (2) dental administrators and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program outreach; (3) dental grants to build infrastructure in the public delivery system; and (4) fluoride varnish application in pediatric practices to promote a focus on oral health and appropriate referrals.
Mich.	In its Healthy Kids Dental Program, the state contracted with one dental insurer so that all beneficiaries have access to the insurer's dental network. Beneficiaries carry the insurer's card, so they are treated the same as other employer-sponsored subscribers.
N.C.	The state described two initiatives: (1) The Physician Fluoride Varnish Program, known as Into the Mouth of Babes, in which Medicaid recipients ages 6-42 months receive oral health services from participating primary care physicians; and (2) Carolina Dental Home Program, which is a pilot project that seeks to identify high-risk preschool Medicaid recipients and facilitates care coordination and referrals to general and pediatric dentists.
N.H.	The Statewide Sealant Project is a school based program in which volunteer dentists and dental hygienists provide examinations and sealant applications. Other initiatives include raising dental rates, promoting access through partnership building, reducing administrative burdens, hiring a dental director, educating primary care physicians and caregivers, working to reduce broken appointments, and establishing a liaison between the state Medicaid program and Medicaid providers.
N.J.	The state reported three dental initiatives: (1) the Pediatric Oral Health Forum and Committee, which developed and is implementing the Pediatric Oral Health Action Plan; (2) a Collaborative to Improve Birth Outcomes and Health Status of Children, which facilitates coordination of care between medical providers and dentists; and (3) the New Jersey Smiles initiative, which aims to increase the percentage of children up to age 6 who have a dental home and who receive annual dental visits.
N.Mex.	The state created a special needs code, a reimbursement strategy that allows for dental practitioners to be eligible for an encounter fee of $90 (in addition to other billable services) when providing dental care to a person with developmental disabilities, if the practitioner has been through the program training and has become certified.

State	State-reported best practice
Nev.	The Pay for Performance Program provides bonuses to health plans based on high performance and plan improvement, and has been incorporated into managed care contracts.
Ohio	The state reported two initiatives; (1) reimbursement of physicians for application of fluoride varnish for children from first tooth eruption to age 3; and (2) use of mobile dental vans to improve access in underserved areas.
Okla.	The state has implemented a student loan repayment program for dentists who agree to practice in identified areas and have at least 30 percent of their practice composed of Medicaid beneficiaries.
Ore.	The Early Childhood Cavities Prevention Program trains general medical practitioners to perform oral screenings and apply fluoride.
Pa.	The state described two initiatives: (1) the Dental Disease Management Program, which encourages dental practices to provide comprehensive preventive, routine, and follow-up dental care; and (2) a requirement that providers notify the Department's Intensive Care Management Unit or Access Plus contractor when a child is referred to a dentist in order to be reimbursed. Follow up is made to confirm that the recommended visit has occurred. For children in MCOs, the provider must notify the MCO that the child is due for a dental referral as part of a complete EPSDT screen.
R.I.	The Dental Benefits Manager Program is charged (among other things) with increasing reimbursement rates, ensuring there are sufficient dentists participating in the network, and assisting beneficiaries with finding dentists, securing transportation, and providing interpretation services.
S.C.*	The state increased fees to the 75th percentile of private-sector reimbursement rates and reduced administrative barriers for providers. The South Carolina Dental Association began an outreach campaign to encourage dentists to participate in Medicaid.
S.Dak.	The Accessing Better Children's Dentistry is an initiative in which certified dentists receive an enhanced reimbursement for certain procedures.
Tenn.*	The state carved out the dental benefit in a Medicaid managed care environment and selected a benefit manager to administer dental benefits and establish reasonable provider reimbursement rates. Other activities include gathering input through a dental advisory committee, recruiting community-based dentists, and additional education and outreach.
Tex.	The First Dental Home initiative expands preventive dental services to children 6 through 35 months of age by providing risk assessments, anticipatory guidance, and more frequent dental checkup visits, based on the child's risk of developing caries.
Va.*	The Smiles for Children Program includes an increase in dental fees, streamlined administration, and the reduction of prior authorization requirements. The program also includes a Broken Appointment initiative, which tracks broken appointments and provides assistance, such as transportation, to help families keep their appointments.
Wash.	The Access to Baby and Child Dentistry program focuses on providing dental benefits to children up to age 5 by conducting outreach to organizations in which Medicaid-eligible children receive services, identifying and enrolling children in the program, educating families and caregivers, and matching each child with a program-certified dentist.

Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

* Posted on CMS's Web site as a promising practice as of May 2009.

Appendix VI: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 18 2009

Alicia Puente Cackley
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Cackley:

Enclosed are the Department's comments on the U.S. Government Accountability Office's draft report entitled, "Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services but Gaps Remain" (GAO-09-723).

The Department appreciates the opportunity to review and comment on this draft report before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE AUG 1 4 2009

TO: Alicia Puente Cackley
Director, Health Care
Government Accountability Office

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: "Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services but Gaps Remain" (GAO-09-723)

Thank you for the opportunity to review and comment on the GAO Draft Report entitled, "Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services but Gaps Remain" (GAO-09-723). The report was prepared at the request of Congressman Dennis Kucinich, Chairman of the Subcommittee on Domestic Policy, and Congressman Elijah Cummings. The purpose of the report was to examine--

1) State strategies to monitor and improve access to dental care for children in Medicaid; and
2) The Centers for Medicare & Medicaid Services (CMS) actions since 2007 to improve oversight of Medicaid dental services for children.

The GAO Draft Report includes the following four recommendations for CMS:

1. Develop a plan to review dental services for Medicaid children in all States with low utilization rates, such as those not meeting HHS's Healthy People 2010 targets;
2. Ensure that States found to have inadequate managed care organization (MCO) dental provider networks take action to strengthen those networks;
3. Work with stakeholders to develop needed guidance on topics of concerns to States; and
4. Identify ways to improve sharing of promising practices among States.

CMS Response to Recommendation 1

The CMS agrees in part with the GAO recommendation to develop a plan to review Medicaid dental services. CMS recognizes the need to continue and increase our focus on improving access to dental services for Medicaid-eligible children and to ensure that children receive the full scope of services available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. As noted in the draft report, CMS has undertaken a number of

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activities related to improving access to dental services, such as focused dental reviews in 16 States, the release of the National Dental Summary in January 2009, and the National Medicaid Dental Town Hall Forum held on April 6, 2009. The purpose of the Town Hall Forum was to begin a dialogue between the interested stakeholders to discuss what steps can be taken to address issues related to and improve the delivery of dental services to Medicaid-eligible children. The National Association of State Medicaid Directors and the American Dental Association partnered with CMS for this event. A portion of the forum was devoted to presentations by States that provided examples of different approaches States have used to solve issues confronted by State Medicaid dental programs. CMS is in the process of preparing a summary of the Town Hall Forum that will be available to the public. The summary, including several best practices that have been identified, will be posted on the CMS Website when it has been completed.

In the larger context of the provision of EPSDT services, CMS has convened an internal workgroup to review the policies and procedures related to EPSDT, including the provision of dental services. Based on this review, we are developing a workplan in which we will solicit input and obtain recommendations from various stakeholders to provide updated, comprehensive guidance for State Medicaid programs. CMS is committed to releasing this guidance to States through State Medicaid Director letters by the end of this calendar year. As part of this review, the workgroup will consider additional focused reviews of State Dental programs, as well as comprehensive EPSDT service reviews.

The CMS is also in the process of implementing the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) legislation, which includes a number of provisions related to dental services for both Medicaid and the Children's Health Insurance Program (CHIP). In regards to the Medicaid program, CHIPRA requires additional reporting information and requires that the Secretary work with States and others to provide a current list of all dentists and providers that provide dental services to children under Medicaid or CHIP State plans or waivers. The Secretary is also required to work with States to provide a description of the dental services that each State provides under its Medicaid or CHIP State plan or waiver. CHIPRA requires that this information be reported on the Insure Kids Now (IKN) website. CMS is currently working with the Health Resources and Services Administration (HRSA) on these provisions to include this information on the website. CMS will also ensure that dental quality measures are built into the quality measures program as required under CHIPRA.

In terms of CHIP, CHIPRA requires the development of a dental education program for new parents of targeted low-income children. It also requires that targeted low-income children receive dental coverage; allows States to provide dental services through benchmark plans; and allows States with separate CHIP programs to provide dental-only supplemental coverage.

CMS Response to Recommendation 2

The CMS agrees that States found to have inadequate MCO dental networks should be required to address this problem. Implementing regulations found at 42 CFR 438.206(b)(1) requires States to ensure through their contracts with managed care entities that the entity "maintains and monitors a network of appropriate providers that is supported by written agreements and is

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sufficient to provide adequate access to all services covered under the contract." Section 438.207(a) of Federal regulations further requires States to obtain supporting documentation of the adequacy of a managed care entity's provider networks. CMS cannot approve contracts without these requirements being met. As GAO indicates, each of the 21 States reviewed applies measurable access standards to their MCO's dental networks.

However, once a network is verified for purposes of contract approval, previously open panels may become filled or providers may drop out of a network which could create an issue with ongoing provider availability. In order to address this issue CMS is working with States to implement the requirement that was included in CHIPRA that all States post a listing of participating Medicaid and CHIP dental providers on the Insure Kids Now (IKN) Website at www.insurekidsnow.gov. States' MCO dental networks will also be included on the Website as appropriate. This information became available on the IKN website beginning August 4, 2009, as required by CHIPRA.

Although making the lists of dental providers more publicly available will not necessarily address the problem of network inadequacy, it will give beneficiaries more accurate and updated information for the purpose of finding available providers. It will also give CMS the opportunity to assess where network adequacy problems may be occurring. In cases where an inadequate network is identified, CMS requires the State to impose a corrective action plan on the managed care entity to require an expansion of its dental network. If the problem is not corrected within a reasonable time frame, CMS could require the State to permit enrollees to access dental services outside of the managed care network.

With respect to the 16 State dental reviews in the CMS National Dental Summary, GAO notes that 6 States found that they were not ensuring that MCO provider networks were adequate to afford access to covered dental services. As noted in the Summary, CMS is following up with each State to address issues noted during the reviews and to ensure that the State is in compliance with Federal laws.

CMS Response to Recommendation 3

The CMS agrees with the recommendation to work with stakeholders to develop needed guidance on topics of concerns to States. As noted in our response to Recommendation 1, CMS is forming a workgroup on EPSDT services. The workgroup will provide an opportunity for CMS to involve interested stakeholders such as State Medicaid Agencies and organizations that work on child health care issues to assist us in this endeavor. We believe that input from these entities will be helpful in focusing the workgroup in areas of the most importance. While EPSDT will be the focus of the workgroup, access to dental services will continue to remain a high priority. As previously mentioned, guidance will be shared with the States as a result of the activities of this workgroup. We anticipate the workgroup will also focus on data reporting including dental reporting, as well as quality measurement. We will also issue guidance on the dental provisions of CHIPRA as we move forward with CHIPRA implementation.

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CMS Response to Recommendation 4

The CMS agrees with, and is committed to, the recommendation to improve sharing of promising practices among States and other stakeholders. The CMS Promising Practice Webpage contains information on the process for submitting a promising practice for consideration, as well as a list of promising practices that have been vetted for publication.

The CMS routinely requests that States submit information on promising practices through various avenues, such as our Technical Advisory Groups (TAGs) and calls our regional offices have with State EPSDT coordinators. CMS held a National Quality Call on Pediatric Oral Health on April 3, 2008, highlighting several State oral health initiatives. At that time we requested that the presenters and others in the audience submit any oral health promising practices to be shared with other States via our Webpage. In addition, in the National Medicaid Dental Summary of the 16 state dental reviews, CMS noted various promising or notable practices; some of these efforts were statewide and others were performed on the local level. We also used that opportunity to request those practices be submitted to us formally.

We will continue to highlight Promising Practices on our website and solicit additional input whenever opportunities arise. The Webpage is located at: http://www.cms.hhs.gov/MedicaidCHIPQualPrac/MCPPDL/list.asp#TopOfPage.

In addition, as required under title IV of the CHIPRA legislation on Quality of Care, CMS is responsible for identifying and disseminating information to States regarding best practices with respect to "measuring and reporting on the quality of health care for children." CMS is also responsible for facilitating the adoption of such best practices. CMS is currently developing a work plan for identification, dissemination, and technical assistance related to Medicaid promising practices.

Summary

In response to the ongoing problems related to access to dental care identified in this report, CMS is in the process of developing additional guidance and technical assistance to States on the provision of EPSDT services, with a particular focus on access to dental services. As part of our larger EPSDT initiative, CMS has undertaken a review of our policy guidance, policies and procedures and has convened an internal workgroup tasked with evaluating opportunities for working with States to improve access to and the consistent provision of EPSDT services.

The CMS expects to increase our efforts to reach out to States and other interested parties and stakeholders through a variety of mechanisms such as Websites, TAG (including the Oral Health TAG), public meetings, and focused reviews.

The CMS is working to implement the CHIPRA legislation, which includes a number of activities related to dental services. Dental measures will be included in the new quality measures program, and there will also be new reporting requirements. In addition, a list of dental providers will be available on the IKN Website. Finally, CMS will continue to focus our

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efforts on collecting and disseminating promising practices related to child health issues including oral health services. We will continue to use every opportunity to solicit input from States including a reminder in our guidance to States in State Medicaid Director letters on EPSDT services.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Alicia Puente Cackley, (202) 512-7114 or cackleya@gao.gov

Staff Acknowledgments

In addition to the contact named above, Katherine Iritani, Acting Director; Susannah Bloch; Sarah Burton; Martha Kelly; Ba Lin; Sarah Marshall; Terry Saiki; Jessica Cobert Smith; Teresa Tam; and Hemi Tewarson made key contributions to this report.

Related GAO Products

Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay. GAO-08-1121. Washington, D.C.: September 23, 2008.

Medicaid: Extent of Dental Disease in Children Has Not Decreased. GAO-08-1176T. Washington, D.C.: September 23, 2008.

Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services. GAO-07-826T. Washington, D.C.: May 2, 2007.

Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees. GAO-05-44R. Washington, D.C.: December 8, 2004.

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. GAO/HEHS-00-149. Washington, D.C.: September 11, 2000.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations. GAO/HEHS-00-72. Washington, D.C.: April 12, 2000.

Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort. GAO/HEHS-97-86. Washington, D.C.: May 16, 1997.

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