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OFFICE OF INSPECTOR GENERAL

MOST CHILDREN WITH MEDICAID IN FOUR STATES ARE NOT RECEIVING REQUIRED DENTAL SERVICES

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EXECUTIVE SUMMARY: MOST CHILDREN WITH MEDICAID IN FOUR STATES ARE NOT RECEIVING REQUIRED DENTAL SERVICES
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WHY WE DID THIS STUDY

Medicaid is the primary source of dental coverage for children in low-income families and provides access to dental care for approximately 37 million children. However, access to dental care for children with Medicaid has been a longstanding concern. When children lack dental care, untreated decay and infection in their mouths can result in preventable emergency room visits or more complicated and expensive dental and medical interventions later in life. Medicaid provides dental services to children through the Early and Periodic Screening, Diagnostic, and Treatment program. Under this program, States are required to cover all medically necessary dental services and these services must be provided at the intervals specified in States' pediatric dental periodicity schedules.

HOW WE DID THIS STUDY

This study focuses on four States: California, Indiana, Louisiana, and Maryland. We analyzed Medicaid dental claims with service dates in 2011 and 2012, analyzed Medicaid beneficiary enrollment files, and conducted structured interviews with State officials. We focused our analysis on three required dental services—biannual oral exams, dental cleanings, and fluoride treatments—for children continuously enrolled in Medicaid for 2 years.

WHAT WE FOUND

We found that three out of four children did not receive all required dental services, with one in four children failing to see a dentist at all. All four States reported that they do not routinely track whether children are receiving all the required services. In addition, two of the four States had policies that do not allow payment for particular services in accordance with their periodicity schedules. The States we reviewed reported facing shortages of participating dental providers and challenges in educating families about the importance of regular dental care. While the States reported that they employ a variety of strategies to address these problems and the Centers for Medicare & Medicaid Services (CMS) has taken some positive steps in this area, we continue to have concerns that children are not receiving required dental services.

WHAT WE RECOMMEND

We provided CMS with eight recommendations designed to monitor and ensure that children with Medicaid receive all of their EPSDT required dental services. Specifically, CMS should (1) develop a comprehensive plan to increase the number of children who receive required services; (2) develop benchmarks for dental services and require States to create mandatory action plans to meet them; (3) work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid; (4) work with States to analyze the effects of Medicaid payments on access to dental providers; (5) work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists; (6) work with States to track children's utilization of required dental services; (7) identify and share effective strategies with States; and (8) ensure that States pay for services in accordance with their periodicity schedules.

CMS concurred either fully or partially with all but one of our recommendations. With regard to our sixth recommendation—with which CMS did not concur—CMS does not agree that it is necessary to require additional data on dental services beyond the data collected on Form CMS-416. With regard to our second recommendation—with which CMS partially concurred—CMS does not agree that it is necessary to require mandatory action plans for meeting benchmarks for dental services. Also, in response to the first recommendation, CMS argued that children's dental services are not "one size fits all" and that a child who receives an exam may not need a second one during the year. While we agree that services should be customized, we do not agree that children with Medicaid should receive services less frequently than at the minimum frequency set by States in their periodicity schedules, which for the four States we reviewed is twice per year.

TABLE OF CONTENTS

OBJECTIVES

1. To describe the extent to which children enrolled in Medicaid in four States received pediatric dental services in 2011 and 2012.
2. To describe barriers and strategies to increase access in these States.

BACKGROUND

Tooth decay is one of the most common chronic diseases of children. The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services.

Medicaid is the primary source of dental coverage for children in low-income families, providing coverage to approximately 37 million children.[1] However, access to dental care for children with Medicaid has been a longstanding concern. According to a Government Accountability Office (GAO) report, millions of children with Medicaid are estimated to be living with untreated tooth decay and other dental issues.[2] In addition, the report found that inadequate receipt of services is a significant problem for children in Medicaid.

A lack of access to dental care can lead to serious health consequences. Preventable dental conditions were the primary cause of more than 850,000 emergency room visits in 2009.[3] Notably, in 2007 the family of a 12-year-old Maryland boy with tooth pain was unable to find a Medicaid dentist who would treat him. The family eventually sought treatment for the boy in an emergency room, but ultimately he died. Untreated dental disease has also been linked to various health issues such as ear and sinus infections, weakened immune systems, diabetes, and heart disease.[4]

Medicaid Coverage for Children's Dental Services

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires States to cover all medically necessary dental services for children 18 years of age and under, and States may choose to

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[1] Thomas P. Wall, *Dental Medicaid—2012*, American Dental Association (ADA), 2012. Centers for Medicare & Medicaid Services (CMS), *Annual EPSDT Participation Report, Form CMS-416 (National), Fiscal Year 2012*, April 3, 2014.

[2] GAO, *Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121, September 2008.

[3] The Pew Charitable Trusts, *A Costly Dental Destination: Hospital Care Means States Pay Dearly*, February 28, 2012.

[4] The Kaiser Family Foundation, *Children and Oral Health: Assessing Needs, Coverage, and Access*, June 2012.

extend this benefit up to age 20.[5] Medically necessary services include a variety of services intended to prevent tooth decay and dental disease. The benefit covers diagnostic and preventive services, as well as needed treatment and follow-up care. Diagnostic services include oral exams and x-rays of the mouth; preventive services include cleanings, topical fluoride treatments, and dental sealants. Dental treatment covers a wide range of services, such as fillings and tooth extractions.

The Social Security Act requires that EPSDT dental services be provided both (1) at intervals that meet reasonable standards of dental practice and (2) at other intervals as indicated by medical necessity.[6] Further, CMS states in its State Medicaid Manual that "[d]ental services must be provided at intervals [that States] determine meet reasonable standards of dental practice."[7] To establish these standards of dental practice, each State must develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health. In lieu of developing their own periodicity schedules, States may choose to adopt a nationally recognized periodicity schedule, such as the one developed by the American Academy of Pediatric Dentistry (AAPD).

The four States in our study adopted the AAPD periodicity schedule. This schedule recommends that children receive a number of services at a minimum of every 6 months to maintain oral health. These services include oral exams, dental cleanings, and fluoride treatments, among other services.

The Dental Home

The AAPD and the American Dental Association (ADA) define a "dental home" as an ongoing relationship between a child and a dentist that includes all aspects of oral health care delivered in a comprehensive and continuously accessible way.[8] According to the AAPD and ADA, a dental home assures continuity of care and assures that appropriate referral to dental specialists occurs when care cannot directly be provided by the dental home. They recommend that a child have a dental home no later than 1 year of age. Several studies found that dental visits at a very young age can improve health outcomes and reduce future dental costs.[9]

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[5] Social Security Act (SSA) § 1905(r)(3); 42 CFR § 441.56. All four States reviewed in this report provide coverage to children up to 20 years of age. California allows Medicaid coverage to continue until the last day of the month in which the child turns 21. See California Code of Regulations 22 CCR § 50193.

[6] SSA § 1905(r)(3)(A).

[7] State Medicaid Manual, Pub. No. 45, ch. 5, § 5140(A).

[8] AAPD Foundation, Dental Trade Alliance Foundation, and ADA, *The Dental Home—It's Never Too Early to Start*, February 2007.

[9] AAPD, *Early Preventive Dental Visits*, April 2014.

Federal Initiatives

Over the past several years, the Centers for Medicare & Medicaid Services (CMS) has worked to improve children's access to dental care. In April 2010, CMS created its Oral Health Initiative with the goal of increasing the number of children receiving preventive dental care.[10] As part of this initiative, CMS set State-specific goals for children's use of preventive dental services for FY 2015. CMS asked States to voluntarily submit Oral Health Action Plans as a roadmap to achieving these goals. CMS offered technical assistance to States to develop and implement these plans. The Oral Health Initiative ended in September 2015.

CMS also established the Core Set of Children's Health Care Quality Measures. These measures help States to monitor and improve the quality of health care provided to enrollees in Medicaid and in the Children's Health Insurance Program. The goals of this effort are (1) to encourage national reporting by States on a uniform set of measures and (2) to support States in using these measures to drive quality improvement. As a part of this initiative, CMS established two measures that track utilization of preventive dental services and sealants, respectively.[11]

Related Work

This report is a part of a series that also looked at Medicaid dental providers with questionable billing practices.[12] Our findings from those reports raise concerns that providers with questionable billing may be billing for services that are not medically necessary or were never provided, and the findings also raise concerns about the quality of care being provided.

This report is also part of a body of work that looks at utilization of services by children with Medicaid. In one report, we found that three out of four children did not receive all required EPSDT medical, vision, and hearing screenings in 2007.[13] In a followup report, we found that although

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[10] Specifically, CMS sets benchmarks for each State that, if met, would (1) increase by 10 percentage points the proportion of children in Medicaid and the Children's Health Insurance Program (CHIP) who receive a preventive dental service; and (2) increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 who receive a sealant on a permanent molar.

[11] A sealant is a plastic material applied to the surface of a tooth to help prevent cavities.

[12] See OIG, *Questionable Billing for Medicaid Pediatric Dental Services in New York*, OEI-02-12-00330, March 2014; OIG, *Questionable Billing for Medicaid Pediatric Dental Services in Louisiana*, OEI-02-14-00120, August 2014; OIG, *Questionable Billing for Medicaid Pediatric Dental Services in Indiana*, OEI-02-14-00250, October 2014; and *Questionable Billing for Medicaid Pediatric Dental Services in California*, OEI-02-14-00480, May 2015.

[13] OIG, *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, OEI-05-08-00520, May 2010.

CMS disseminated strategies aimed at improving participation in EPSDT screenings and made efforts to improve the delivery of medical screenings, there was evidence that children continued to receive fewer medical screenings than required.[14]

In another report, OIG found that nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening in 2011 and 2012.[15] Further, the reviews by the Administration for Children and Families (ACF) did not ensure that children in foster care receive the required screenings. OIG recommended that ACF identify and disseminate State strategies to ensure that all children in foster care receive required health screenings and that it expand the scope of its reviews to determine whether children in foster care receive these screenings. ACF concurred with the first recommendation and said that it was considering the second.

METHODOLOGY

Scope

This study focuses on four States: California, Indiana, Louisiana, and Maryland. We selected a mix of States based on the following factors: the number of children with Medicaid per State, geographic location, and input from CMS staff. The four States serve approximately 19 percent of all children with Medicaid.[16]

This report provides detailed information about dental services for children who were continuously enrolled in Medicaid for 2 years. The data in this report are not comparable to the data that States report annually to CMS about their utilization of services under the EPSDT benefit.[17] Specifically, we provide a more comprehensive look at whether children were receiving required dental services over a longer period of

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[14] OIG, *CMS Needs To Do More To Improve Medicaid Children's Utilization of Preventive Screening Services*, OEI-05-13-00690, November 2014.

[15] OIG, *Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings*, OEI-07-13-00460, March 2015.

[16] The percentage was derived from beneficiary enrollment data from the four States and from data collected from CMS's Form-416.

[17] States report this information on CMS's Form-416, which CMS uses to monitor EPSDT performance. The dental data collected are based on the number of children who were continuously enrolled in Medicaid for at least 90 days during the fiscal year of review. CMS does not collect information on the frequency of particular services. For further details on the data collected on Form-416, see http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf.

time and also determine whether they received required services at the intervals specified in their respective States' periodicity schedules.

All four States in this review adopted the AAPD schedule, which specifies that children should receive—at a minimum—biannual oral exams, dental cleanings, and fluoride treatments. We focused our review on these services because they are essential to maintaining oral health.

Data Sources

We based this study on (1) Medicaid dental claims with service dates in 2011 and 2012, (2) Medicaid beneficiary enrollment files, and (3) structured interviews with State officials. Appendix A provides a detailed description of the methodology.

Limitations

The study includes services paid for by Medicaid; it does not include services that these children may have received that were paid for by other sources. As a result, we may not be capturing all dental services that children received.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

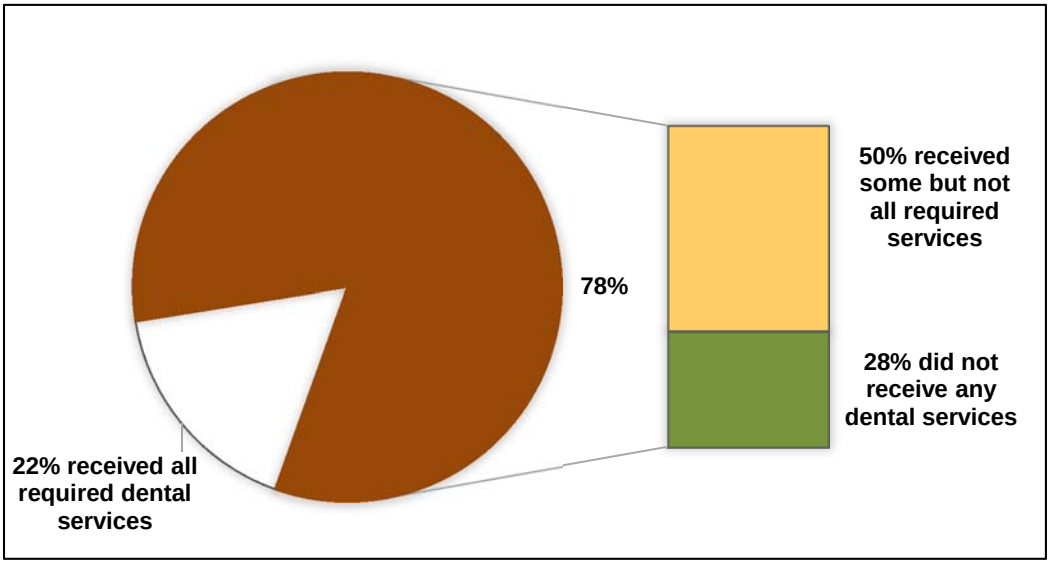
FINDINGS

In the four States we reviewed, 78 percent of children did not receive required dental services

All four States in this review adopted the AAPD schedule, which specifies that children should receive—at a minimum—biannual oral exams, dental cleanings, and fluoride treatments. Seventy-eight percent of children who were continuously enrolled in Medicaid in these four States did not receive these required services, representing 2.9 million children. See Chart 1.

The percentage varied by State, with a low of 73 percent in Maryland and a high of 81 percent in Louisiana. See Appendix B for detailed information about children who did not receive required services. Receiving dental services to identify and prevent tooth decay and other dental problems is critical for ensuring children's overall health.

Chart 1: Percentage of Children Who Did Not Receive Required Dental Services



Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

Over a quarter of children with Medicaid did not receive any dental services over a 2-year period

In the four States we reviewed, 28 percent of children with Medicaid who were continuously enrolled received no dental services over a 2-year period. This amounted to over 1 million children in these four States. An

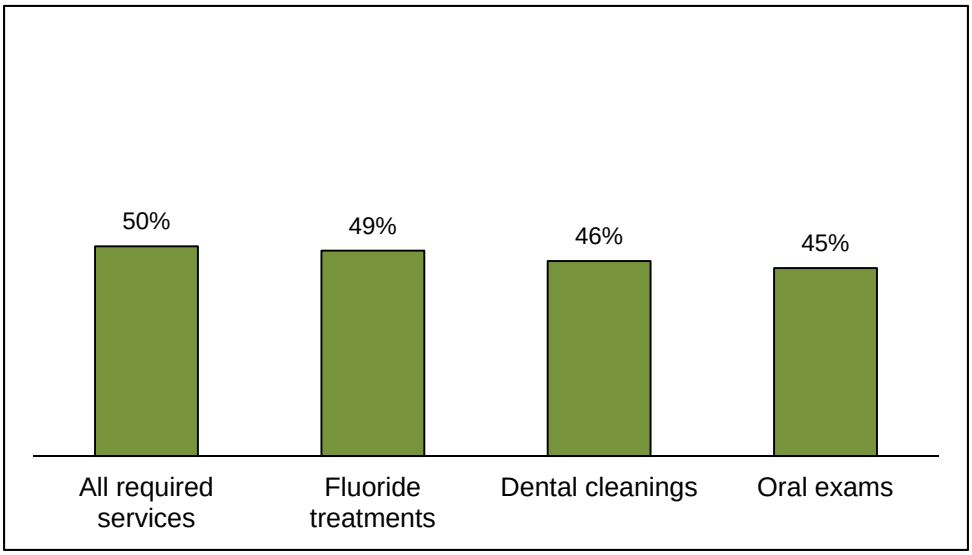
additional 14 percent of children had only one visit to the dentist during the 2-year period.

Children younger than 3 years old were the least likely to receive dental services when compared to children in the other age groups. Notably, 41 percent of children under 3 received no dental care over a 2-year period, compared to 21 percent of children 6 to 9 years of age.[18] In addition, children in rural areas were slightly less likely than children in urban areas to receive dental services.

Another 50 percent received some—but not all—of the required dental services over a 2-year period

Fifty percent of children who were continuously enrolled in Medicaid over a 2-year period received some, but not all of the required dental services. These services include biannual oral exams, dental cleanings, and fluoride treatments. As shown in Chart 2, children most commonly did not receive fluoride treatments at the intervals specified in their State's periodicity schedule, followed closely by dental cleanings and oral exams. See Appendix C for detailed information by State.

Chart 2: Percentage of Children Who Did Not Receive All the Required Dental Services, By Type of Service



Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

This raises concerns about the States' abilities to ensure that children are receiving the services they need. Although States have to report to CMS

[18] Our analysis of children under the age of 3 included children from the age of 1 year to 2 years.

the number of children receiving at least one preventive dental service, they do not have to report data on the frequency of any services. Notably, all four States reported that they do not routinely track whether children are receiving services at the intervals specified in their periodicity schedules. As a result, States may not be capturing critical data or monitoring whether children are getting the care needed to prevent disease and promote good oral hygiene.

Children who received required services appear to have a dental home

A dental home is an ongoing relationship between a child and a dentist that includes all aspects of oral health care delivered in a comprehensive and continuously accessible way. Eighty-six percent of the children who received all the required services visited the same practice over a period of 2 years.[19] Children who received only some of the required services were more likely to visit multiple practices. This suggests that children in an established dental home are more likely to receive the required services.

Two of the four States had coverage policies that may limit children's ability to receive the required services

As noted earlier, States must provide certain dental services at the intervals specified in their periodicity schedules. All four States adopted the AAPD schedule, specifying that children should receive—at a minimum—biannual oral exams, dental cleanings, and fluoride treatments. However, two States had policies that do not allow payment for particular services in accordance with the established schedules. One State had a schedule specifying that children should receive biannual fluoride treatments and dental cleanings beginning at 6 months of age; however, the State's coverage policy would pay for such services only for children 1 and older. Similarly, another State's schedule specified that children 6 months and older should receive biannual fluoride treatments; however, the State's coverage policy allowed payment for such treatment only for children up to 15 years of age.[20]

[19] Maryland was not included in this analysis. For more information, see Appendix A.

[20] Our analysis showed that despite its coverage policy, this State paid—at least in some cases—for fluoride treatments for children over 15 years of age.

The States we reviewed reported facing a shortage of participating dentists and reported challenges in educating families about the importance of regular dental care

Officials in each of the four States identified a number of barriers that impeded access to Medicaid dental services in each of their States, as well as strategies to address these barriers. When children lack access to dental care, untreated decay and infection in their mouths can result in more complicated and expensive dental and medical interventions later in life.[21]

Shortage of participating dentists: Officials in all four States expressed concerns about the lack of providers available to treat children with Medicaid, particularly very young children. They also reported shortages in certain geographic areas—typically, rural areas. Officials further noted a reluctance of some providers to participate in Medicaid because of low reimbursement rates and administrative burdens. They added that some providers are concerned that Medicaid patients are more likely to miss appointments, with providers in one State complaining of "no show" rates as high as 50 percent.

Officials described several strategies aimed at ameliorating these problems. Officials in one State reported that the State provides student loan repayments to dental providers who serve children with Medicaid in rural areas that have a shortage of providers. Providers can receive up to $30,000 annually for a 3-year commitment, with a possible extension of 2 additional years.

Pay-for-Performance Contracts

Maryland highlighted its contract with an administrative services organization (ASO) that focuses on building a robust network of dental providers. The ASO earns a significant additional payment if it meets specified targets in its contract, such as increasing the number of dental providers in certain geographic areas. To meet these targets, the ASO's staff visit dental providers to encourage them to participate in Medicaid.

In addition, States have implemented other strategies to encourage providers to participate in Medicaid. In two States, officials reported that their States had previously increased provider reimbursement rates. One of these States targeted their rate increases to a limited set of dental services that are more often provided to children, such as sealants and the application of fluoride, so that dental providers who treat young children

[21] CMS, *Guide to Children's Dental Care in Medicaid,* October 2004.

could particularly benefit. State officials also described efforts to reduce administrative burdens, particularly regarding their Medicaid enrollment process. For example, one State is creating a streamlined application form that automatically checks the provider's credentials, thus reducing the amount of time it takes to become a Medicaid provider. In addition, officials in two States reported following up with families when providers alerted them that a child had missed an appointment, which can help reduce the States' "no show" rates, thereby encouraging more providers to participate in Medicaid.

In spite of these efforts, officials noted that in some areas, there was an extremely limited number of dentists. To combat this problem, two States are allowing midlevel dental providers and other nondentists (e.g., hygienists, medical providers) to provide certain dental services. One State recently passed legislation that allows for teledentistry services, which helps expand access to dental services in remote and underserved areas. The law also expands the types of procedures that dental hygienists and certain dental assistants can perform without a dentist onsite. The other State is allowing pediatricians and primary care providers to provide a limited set of diagnostic and preventive services. In addition, officials in this State reported working to set up a dental health "safety net" clinic in each county.

To further combat provider shortages, another State analyzed how many providers submitted a high volume of Medicaid claims so that these providers could be targeted for outreach. Our analysis of providers in the four States showed that a small concentration of dentists served the majority of children with Medicaid in 2012. Notably, 896 dental providers in the 4 States served 55 percent of the children with Medicaid who received care.

Educating families about the importance of regular dental care: Officials in three States expressed concern that many caregivers were not aware of the importance of regular dental care. They highlighted particular concerns about a lack of awareness about the importance of dental care for children younger than 3. They noted that many families may not know that dental services are covered for children in this age group.

At the same time, State officials reported having strategies in place to reach out to families. One of these strategies is to ensure that children with Medicaid have a dental home. Officials in one State reported that they assign a dentist to each child at a very young age. Officials in another State noted that they assign a local dentist to each child who is not already seeing a particular provider. The State sends out information and makes calls to families when they join Medicaid. Officials stated that they have seen an influx of calls from families who did not know that Medicaid covered dental services for children.

Officials also emphasized the importance of tracking the number of children who are seeing dentists regularly. For example, one State identifies the children who have not seen a dental provider over the last 12 months and reaches out to their families to encourage them to seek care. Another State particularly targets children under 3. The State identifies those children who are not receiving care and provides information on the importance of early oral health care. Officials added that they plan to make system changes to increase their ability to track the effects of these outreach efforts.

Connecting Families with Dentists

California operates a call center that helps to make dental appointments for children with Medicaid. When a parent or caregiver of a child with Medicaid contacts the call center to obtain information about participating dental providers, the operator on the phone not only identifies a provider, but calls the provider's office to make an appointment for the child while the family member is on the phone.

California officials noted that they put this system in place because in the past—when the State only provided families with a list of dental providers—families often called back and reported that the providers on the list were no longer participating in Medicaid. By making appointments for children with Medicaid, the State not only ensures that more children are served, it is also able to track which providers are no longer serving children with Medicaid.

CONCLUSION AND RECOMMENDATIONS

Children's lack of Medicaid dental care has been a longstanding concern. Tooth decay—an almost entirely preventable disease—is one of the most common chronic diseases of children, and children in low-income families experience more tooth decay than their peers in other income groups. When children lack dental care, untreated decay and infection in their mouths can result in more complicated and expensive dental and medical interventions later in life. The goal of the EPSDT program is to ensure that children with Medicaid receive needed dental care to combat a wide range of oral health problems.

The EPSDT program requires each State to provide dental services to all children enrolled in Medicaid. However, we found that three out of four children with Medicaid in the four States are not receiving required dental services, with one in four children failing to see a dentist at all over a 2-year period. The States we reviewed reported facing shortages of participating dental providers and challenges in educating families about the importance of regular dental care. While the States reported that they employ a variety of strategies to address these problems, they need to do more to ensure that children receive needed dental care.

These findings pose a potentially larger problem, as the number of children with Medicaid is increasing as a result of the Affordable Care Act. CMS and States must work together to ensure that children receive the dental care they need.

We recognize that CMS has already taken some steps towards addressing the issues we found in this report. It has developed materials to educate consumers and providers about positive oral health practices, and it has shared strategies with States to improve access to and utilization of dental care. However, we continue to have concerns that children are not receiving required dental services.

We recommend that CMS take the following steps, in addition to those it has already taken:

Develop a comprehensive plan to increase the number of children who receive required services

CMS should develop a comprehensive plan for how it can help increase the number of children who receive required services, such as biannual exams, fluoride treatments, and cleanings. The plan should include strategies for working with States and cover short-term and long-term objectives, as well as timelines to meet these objectives. The plan should include the initiatives that CMS decides to pursue in response to the other

recommendations in this report as well as other initiatives that it develops to increase the number of children receiving required dental services.

Develop benchmarks for dental services and require States to create mandatory action plans to meet them

CMS should set State-specific benchmarks to increase in future years the number of children who are receiving preventive dental care. CMS should require States to create mandatory action plans to meet these benchmarks and should require States to submit their plans to CMS.

Work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid

To increase provider participation, CMS should help States identify where there are shortages of Medicaid providers and develop strategies to decrease barriers to participation. Such strategies could include provider outreach, improving the enrollment process, reducing the number of missed appointments, and evaluating whether certain dental services can be provided by other providers or in alternative settings.

Work with States to analyze the effects of Medicaid payments on access to dental providers

CMS should work with States to analyze Medicaid dental payments and ensure that States document whether their payment rates for providers are sufficient to encourage dental providers to participate in the program. To address this recommendation, CMS should work closely with States to effectively implement new regulations—finalized in November 2015—that are designed to assure access to covered Medicaid services, including dental care.[22] Specifically, it should ensure that States have a process to monitor access to dental care and that they take these data into account when setting Medicaid payment rates for dental providers.

Work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists

CMS should work with States to educate families about the importance of regular dental care. The outreach should focus on the importance of regular dental care, particularly for children under the age of 3. CMS should prepare materials and collaborate with States on media events. In addition, CMS should work with States to set up systems to pair children with participating dentists to help ensure that more children receive

[22] 42 CFR § 447.203; 80 Fed. Reg. 67575 (Nov. 2, 2015).

regular dental care. Such systems should encourage the establishment of dental homes. The goal of these efforts is to increase the number of children receiving dental care.

Work with States to track children's utilization of required dental services

Although the data in CMS's Form-416 provide important information about the dental services that children with Medicaid receive, they do not include comprehensive information about whether children receive required services at the appropriate intervals. CMS should work with States to monitor their claims data to identify and track children with Medicaid who are receiving the required services according to each State's periodicity schedule. One area of focus might be to look at children who have been continuously enrolled in Medicaid for an extended period of time, such as 18 months or 2 years, because these children in particular rely on Medicaid for these services. States should use the results of their tracking to target their educational and outreach efforts to the population of children who are not receiving required dental services at the intervals specified in States' periodicity schedules.

Identify and share effective strategies with States

As shown in this report, States have implemented different strategies to increase assess to pediatric dental care. CMS should identify and review States' strategies and share this information on an ongoing basis with all States. These strategies—which can encompass those identified in this report as well as others—should include ways to increase dental provider participation in States' Medicaid dental programs as well as ways to encourage and increase children's visits to the dentist. CMS could publish periodic reports or facilitate information sharing by creating a forum for States on its website.

Ensure that States pay for services in accordance with their periodicity schedules

CMS should ensure that States are paying for services in accordance with their periodicity schedules. As a part of this process, CMS should require that States review their periodicity schedules, and should ensure that States that adopted their schedules from professionally recognized associations (such as the AAPD) are relying on the most current guidelines. CMS should require States to conduct regular reviews to ensure that States are paying for services in accordance with their periodicity schedules.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with five of our recommendations, partially concurred with two recommendations, and did not concur with one recommendation.

CMS partially concurred with our first recommendation—that it develop a comprehensive plan to increase the number of children who receive required services—and stated that it will update its current plan to identify both new and continuing opportunities for collaboration with States to improve the use of preventive dental services among children. This plan would include strategies that focus on managed care organizations or other contracted entities that provide dental services in States.

CMS argued that children's dental services are not a "one size fits all" requirement and stated that a child who receives an exam, a cleaning, and a fluoride treatment may not need an additional exam, cleaning, or fluoride treatment within a year. While we agree that services should be customized, we do not agree that children with Medicaid should receive services less frequently than at the minimum frequency set by States. As we note in the background of this report, the EPSDT benefit requires that all medically necessary services be provided at intervals that meet reasonable standards of dental practice, as determined in each State's periodicity schedule. The four States we reviewed adopted the AAPD schedule, which sets as a reasonable standard of practice that oral exams, dental cleanings, and fluoride treatments be provided at a minimum of twice per year.

CMS partially concurred with our second recommendation—that it develop benchmarks for dental services and require States to create mandatory action plans to meet them—and said that it has already set improvement benchmarks for utilization of preventive dental services as part of the Oral Health Initiative. It also believes that continuing to work collaboratively with States on current successful initiatives to improve dental access, instead of requiring mandatory action plans, is an effective way to increase the number of children receiving needed dental services. Given the findings of this report, we continue to recommend that CMS require States to create mandatory action plans to meet their benchmarks.

CMS concurred with our third recommendation—that it work with States to identify areas with limited numbers of providers and the barriers preventing providers from participating in Medicaid—and said that it is currently working with States to identify such barriers. It also plans to work with States to address and decrease these barriers and to seek ways to increase the number of providers.

CMS concurred with our fourth recommendation—that it work with States to analyze the effects of Medicaid payments on access to dental providers—and said that it issued a final rule (with comment period) titled *Methods for Assuring Access to Covered Medicaid Services*. This rule, which will take effect in 2016, requires States to submit Access Monitoring Review Plans that must include methodologies for measuring access to care. The plans must include a core set of five services, including primary care, which includes dental services.

CMS concurred with our fifth recommendation—that it work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists—and stated that it has already taken many steps in educating families about the importance of dental care, such as creating consumer education materials. It agrees that additional actions are needed to highlight dental homes as a successful strategy because the dental home is an effective tool for making sure that children are receiving dental services.

CMS did not concur with our sixth recommendation—that it work with States to track children's utilization of required dental services—and stated that States are already required by law to report a variety of dental utilization data to CMS every year on the Form CMS-416. CMS also said that it must balance the need for additional data with current reporting expectations for States. Currently, Form CMS-416 collects summary information, such as the number of children who received a dental service and what type of service it was (i.e., preventive, diagnostic, or treatment). However, States do not have to track whether children are receiving all required EPSDT services. Given the findings of this report, we believe that it is essential to track whether children are receiving services according to each State's periodicity schedule to help States make improvements in this area.

CMS concurred with our seventh recommendation—that it identify and share effective strategies with States—and stated that it has published *Keep Kids Smiling*, which details dozens of successful approaches developed by States. CMS also said that it has conducted and published summaries of reviews of Medicaid dental programs and has provided periodic technical assistance Webinars to States on strategies to improve their dental programs.

CMS concurred with our eighth recommendation—that it ensure that States pay for services in accordance with their periodicity schedules—it stated that it will work with States to "crosswalk" their payment policies with the dental periodicity schedules and make any necessary adjustments to their payment policies.

The full text of CMS's comments is provided in Appendix D.

APPENDIX A

Detailed Data Sources and Analysis

State Medicaid Data. From each State, we requested Medicaid dental claims for children up to age 20 from its Medicaid Management Information Systems. These claims included fee-for-service claims, claims from Federally Qualified Health Centers (FQHCs), and in one State—which covers the dental benefit through managed care in part of the State—managed care claims.[23] They also included claims from nondental providers who are allowed to provide certain dental services, such as fluoride treatments. We also requested each State's Medicaid beneficiary files for these years.

Using information from the Medicaid beneficiary enrollment file for each State, we identified the children who were both (1) between the ages of 1 and 20 years old and (2) continuously enrolled in Medicaid in 2011 and 2012.[24] In total, we identified 2,091,343 children in California, 563,030 children in Indiana, 554,330 children in Louisiana, and 454,669 children in Maryland.

As a first step, for all four States, we calculated the total number and proportion of children who were continuously enrolled in Medicaid who did not receive required dental services in 2011 and 2012. This includes the proportion of children who did not receive any dental services and those who did not receive all the required services that we reviewed at the intervals specified in States' periodicity schedules. The services that we reviewed were biannual dental cleanings, fluoride treatments, and oral exams.[25] We considered a child to have not received all the required

[23] California provided managed care claims from Los Angeles County and Sacramento County. For the other counties, the State provided fee-for-service claims.

[24] For the purposes of this report, if a State offered a Medicaid expansion program under its Children's Health Insurance Program (commonly referred to as M-CHIP), we considered children in this program to be children with Medicaid and included their claims and their enrollment data in our analyses.

[25] These services are distinguished from each other in the claims by their Healthcare Common Procedure Coding System codes. We also considered reviewing the use of sealants as another important preventive service that is included in State periodicity schedules. However, we were not able to analyze the use of sealants because the claims data did not have sufficient information to accurately measure whether children received sealants appropriately.

services if he or she did not receive all of these services at least three times in the 2-year period.[26]

For the measures, we determined whether there were any differences by State. We also determined whether there were any differences by age group. We defined the age groups as follows: 1 to 2 years of age, 3 to 5 years of age, 6 to 9 years of age, 10 to 14 years of age, and 15 to 20 years of age.[27] Lastly, we determined whether there were any differences between children in urban and rural areas. We defined urban and rural areas based on the ZIP Code associated with the child during his or her most recent enrollment period.[28]

Next, we determined whether children who met the periodicity schedule appeared to have a dental home. To do this, we determined the proportion of children who received all the required services from the same practice (a likely indicator that a child has a "dental home"). For the purpose of this analysis, we used the billing provider identification number on the claim, rather than the rendering provider identification number, as an indicator that the child went to the same practice.[29] The billing provider identification number is typically the same for all providers in the same practice. In addition, we determined the percentage of children who received all the required services who visited multiple practices and compared it to the percentage of children who received only some of the required services and visited multiple practices.

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[26] In California and Maryland, FQHC dental claims did not include information on the specific services that were provided. For those who received services from FQHCs in these States, we considered a child to have received the required services if the child visited an FQHC three or more times or if the child visited an FQHC in addition to receiving required services in other practice settings at least three or more times.

[27] For children who fell into two age groups during the 2-year period, we included the child in the category that he or she was in for the longest amount of time. For example, if a child was 6 years old for more days in the period than he was 5 years old, we included the child in the category of 6 to 9 years of age.

[28] We matched ZIP Codes to the rural-urban commuting area codes (RUCAs), which classify counties using measures of population density, urbanization, and daily commuting distance. We defined an area as urban if 30 percent or more of its workers commute to or live within an area with 50,000 people or more. We considered all other areas to be rural. For further details on RUCAs, see the University of Washington's WWAMI [Washington, Wyoming, Alaska, Montana, and Idaho] Rural Health Research Center at http://depts.washington.edu/uwruca/.

[29] Almost all of Maryland's claims had the same billing identification number, which represents the administrator for the dental program in the State. Therefore, we were not able to include Maryland in this analysis.

Lastly, we analyzed the 2012 dental claims and identified the dentists who provided services to 1,000 or more children with Medicaid.[30] We considered this group to be high-volume dentists. We determined the number of high-volume dentists and the proportion of children with Medicaid that these dentists served in the four States.

Comparison of coverage policies to periodicity schedules. We compared each State's periodicity schedule to its coverage policy to determine whether there were any inconsistencies. We focused this analysis on the following required services: biannual oral exams, dental cleanings, and fluoride treatments.

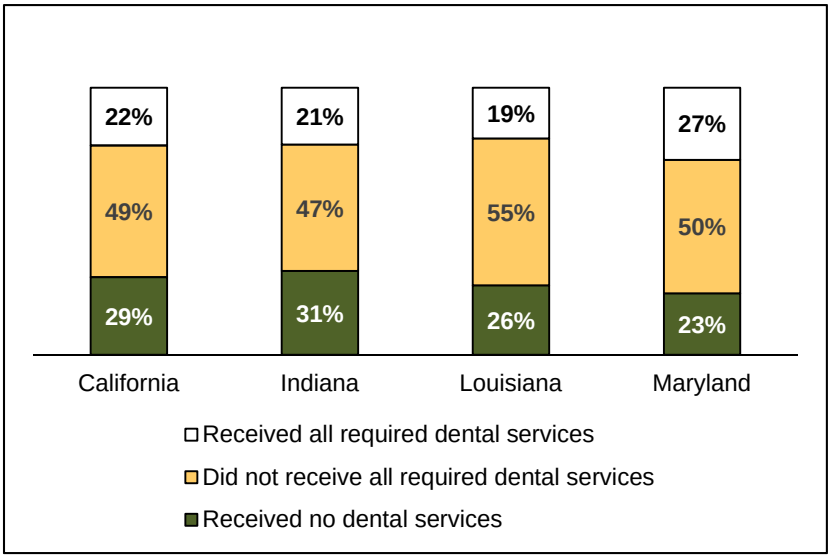
Structured Interviews with State Officials. We conducted structured interviews with officials in each State who were responsible for the State's Medicaid pediatric dental programs. Our questions focused on any barriers that the State faced in increasing access to Medicaid pediatric dental services. We also asked about any strategies that the State had implemented to improve access to dental services. We conducted these interviews in September 2014. We analyzed the responses from each State and identified common themes across States regarding the barriers and strategies to improve access to services.

[30] For the purpose of this analysis, we used rendering provider identification numbers to identify the dentists and we excluded FQHCs in California and Maryland that submit their claims by facility, rather than by individual provider.

APPENDIX B

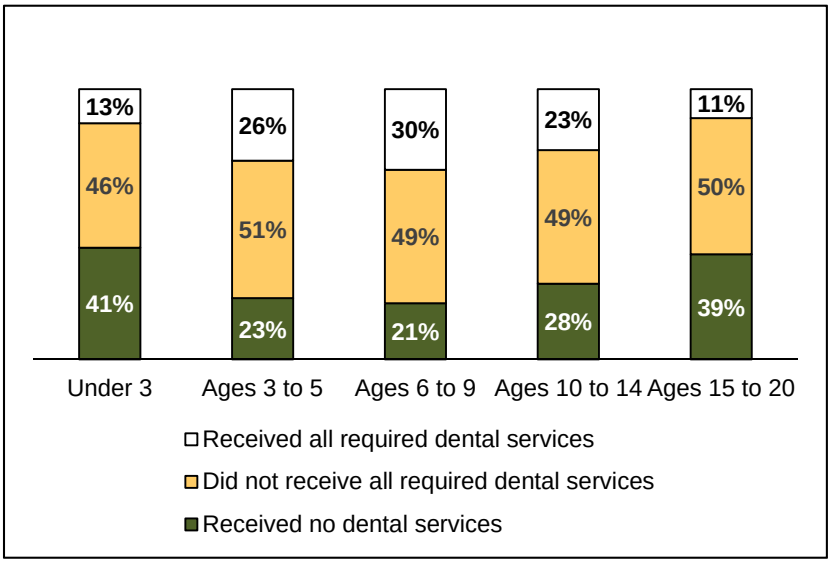
Percentages of Children Who Did Not Receive Required Dental Services

Chart B-1: Percentage of Children Who Did Not Receive Required Dental Services, by State



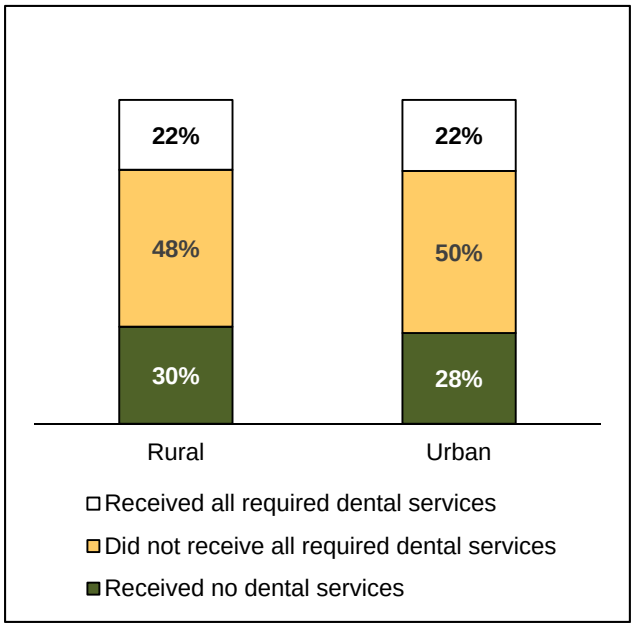
Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

Chart B-2: Percentage of Children Who Did Not Receive Required Dental Services, by Age



Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

Chart B-3: Percentage of Children Who Did Not Receive Required Dental Services, by Urban and Rural Areas

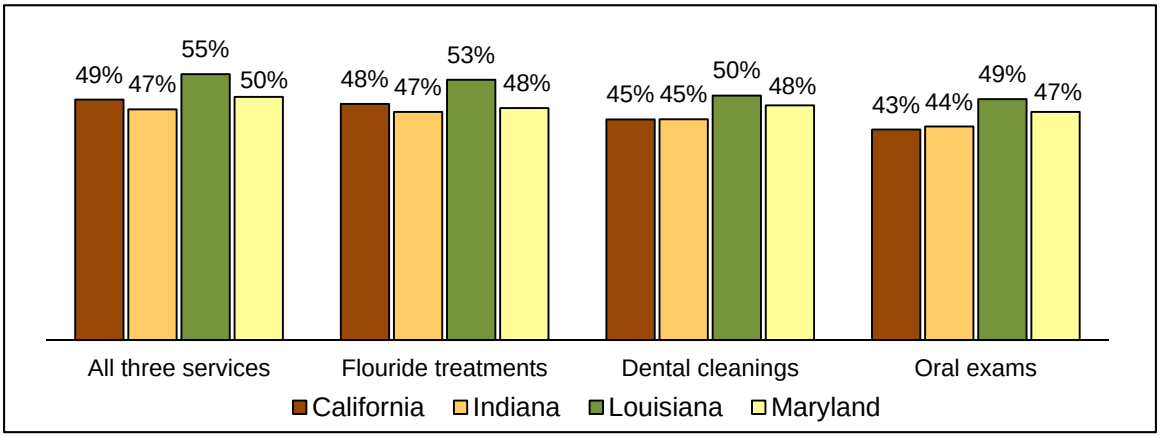


Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

APPENDIX C

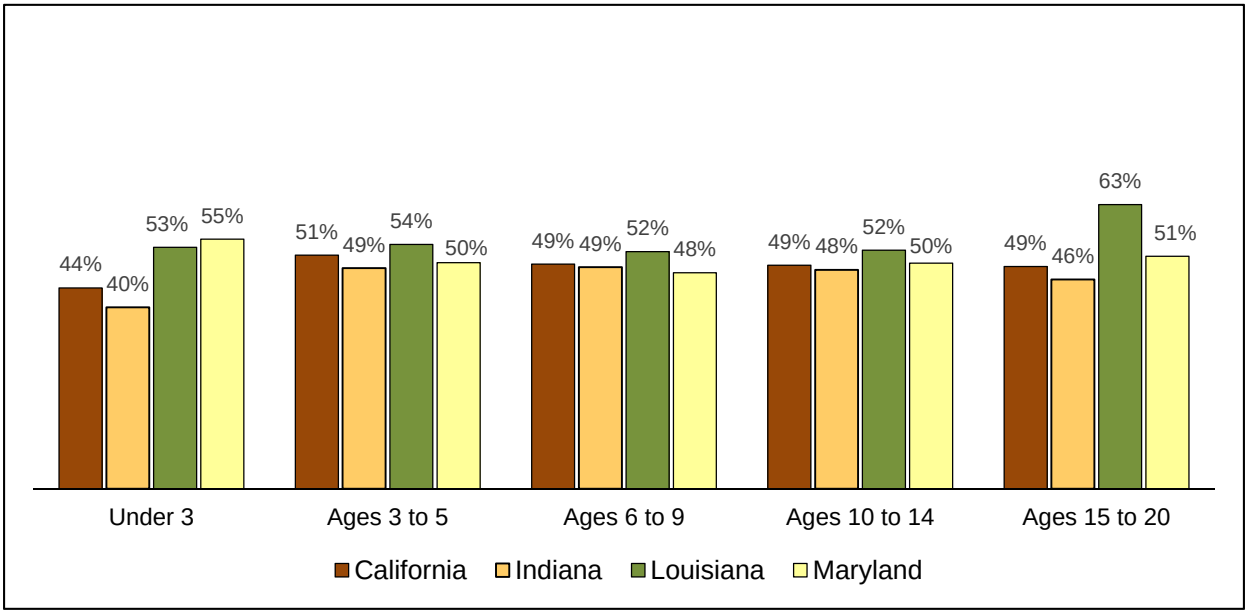
Percentages of Children Who Did Not Receive All Required Dental Services

Chart C-1: Percentage of Children Who Did Not Receive All Required Dental Services, by Service



Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012.

Chart C-2: Percentage of Children Who Did Not Receive All Required Dental Services, by Age



Source: OIG analysis of State Medicaid data, 2015.
Note: Includes all children who were at least 1 year of age and were continuously enrolled in Medicaid in 2011 and 2012. Required services include biannual oral exams, dental cleanings, and fluoride treatments.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: NOV 16 2015

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Andrew M. Slavitt
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Most Children With Medicaid in Four States Are Not Receiving Services" (OEI-02-14-00490)

The Centers for Medicare and Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS recognizes the need to continue and increase our focus on improving access to dental services for Medicaid-eligible children and to make sure children receive the full scope of services available under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

CMS is committed to improving access to dental and oral health services for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). CMS has made considerable progress in our efforts to make sure that low-income children have access to oral health care. From 2007 to 2014, sixty percent of all states achieved at least a ten percentage point increase in the proportion of children enrolled in Medicaid and CHIP that received a preventive dental service during the reporting year.

To support continued progress, CMS launched the Children's Oral Health Initiative and set goals for improvement. To achieve those goals, CMS has adopted a national oral health strategy[1] through which CMS is working diligently with states and federal partners, as well as the dental provider community, children's advocates, and other stakeholders to improve children's access to dental care.

To support state Medicaid and CHIP programs in achieving their improvement goals, CMS published *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents*. It provides an overview of the children's dental benefit in Medicaid, examples of evidence-based policies at the state level, and details of successful strategies with state examples.

In addition, CMS has developed two learning collaboratives: one to support states in developing and implementing state oral health action plans, and the other for states to develop oral health

[1] National Oral Health Strategy can be found on http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf

performance improvement projects in their Medicaid managed care dental delivery systems. The improvement project collaborative has been offered to all Medicaid and CHIP programs with oral health services as part of their managed care program to facilitate strategic thinking, share best practices, and walk states through keys steps of performance improvement project development and implementation. CMS also hosts a series of webinars to support States and their partners in their improvement efforts and has several on-line tools posted on Medicaid.gov to assist states in their efforts.[2]

OIG's recommendations and CMS' responses are below.

OIG Recommendation
Develop a comprehensive plan to increase the number of children who receive required services

CMS Response
CMS partially concurs with this recommendation. CMS recognizes the importance of dental services for children enrolled in Medicaid and agrees to develop a comprehensive plan to help increase the proportion of Medicaid enrolled children who receive at least one preventive dental service in a year. In 2010, CMS had already developed a set of goals and a plan to improve the use of preventive dental services in states, and we will continue to expand on this. Through the Oral Health Initiative (OHI), states have improved at delivering preventive dental services over the past five years. CMS is currently working to build on the success of the OHI by developing an updated comprehensive plan to continue to work with states to improve access to oral health care among children and adolescents enrolled in Medicaid.

CMS's updated comprehensive plan would identify both new and continuing opportunities for collaboration with states to improve the use of preventive dental services among children. Some strategies would leverage the fact that more than 75% of Medicaid-enrolled children get dental services through managed care or some other type of contracting arrangement. The plan would also build on CMS' recent successful initiatives and not duplicate activities already being conducted by states.

While CMS does require states to include preventive dental services for children in benefit packages, CMS acknowledges that services may be tailored to each child's need because children's dental services is not a one-size-fits-all requirement. Medicaid's Early and Periodic Screening Diagnostic Treatment (EPSDT) mandates that children receive all services as medically necessary because the frequency in which children receive services should be on an individualized basis. For example, a child who receives an exam, a cleaning, and a fluoride treatment may not need an additional exam, cleaning, or fluoride treatment within a year.

OIG Recommendation
Develop benchmarks for dental services and require States to create mandatory action plans to meet them

[2] Online tools can be found on our website http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html

CMS Response
CMS partially concurs with this recommendation. CMS agrees that establishing benchmarks are important for tracking progress toward increasing children who receive dental services. CMS has already set preventive dental service utilization improvement benchmarks for States as part of the OHI. CMS believes that continuing to work collaboratively with states on current successful dental access improvement initiatives, instead of requiring mandatory action plans, is an effective way to increase the number of children receiving needed dental services.

OIG Recommendation
Work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid

CMS Response
CMS concurs with this recommendation. CMS is currently working with states to identify barriers to dental service providers participating in Medicaid. CMS plans to work with states to address and decrease these barriers and seek ways to increase the number of providers.

OIG Recommendation
Work with States to analyze the effects of Medicaid payments on access to dental providers

CMS Response
CMS concurs with this recommendation. CMS issued a final rule with comment titled Methods for Assuring Access to Covered Medicaid Services on October 29, 2015, with an effective date of January 4, 2016. In order to improve the data with which states and CMS monitor access, the regulation requires states to submit Access Monitoring Review Plans. The plans must specify data sources that will support a finding of sufficient beneficiary access and will address:

- The extent to which beneficiary needs are met;
- The availability of care and providers;
- Changes in beneficiary service utilization; and
- Comparisons between Medicaid rates and rates paid by other public and private payers.

The Access Monitoring Review Plans must provide for state reviews of a core set of five services, including primary care, which, is defined to include dental services. Within the review plans, states will choose the appropriate measures, data sources, baselines and thresholds that take into account state-specific delivery systems, beneficiary characteristics, and geography. The review plans will need to be reviewed and updated at least every three years. Additionally, states are required to add additional services to the monitoring plan whenever states or CMS receive a significantly high number of complaints about access to care. CMS is requesting comments, through a 60 day comment period, on the access review requirements, including the service categories required for ongoing review.

OIG Recommendation
Work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists

CMS Response
CMS concurs with this recommendation. CMS has already taken many steps in educating families about the importance of dental care. In 2013, CMS developed a series of consumer education materials focused on oral health – Think Teeth! We will continue to promote these materials and to make them available at no cost to states and other stakeholders. Many states and their contracted Medicaid plans have also developed their own branded materials that they use for their educational purposes, and CMS must balance creating new materials with duplicating already successful efforts. CMS agrees that additional actions are needed to highlight dental homes as a successful strategy because they are effective tools for making sure children are receiving dental services. CMS will encourage states to connect children to dental homes so each child has an identified dentist.

OIG Recommendation
Work with States to track children's utilization of required dental services

CMS Response
CMS non-concurs with this recommendation. CMS recognizes the importance of tracking the number of children who receive dental services in order to make sure children are receiving quality care. States are already required by law to report a variety of dental utilization data to CMS every year on the Form CMS-416. This data includes the number of children receiving at least one (a) dental service of any type, (b) preventive dental service, (c) dental treatment service, (d) sealant on a permanent molar, or (e) dental diagnostic service. CMS publishes this data annually, making it available to states, stakeholders, and researchers. CMS uses the data to track states' performance on improvement goals, to compute the preventive dental services (PDENT) child core set measure, and to compare performance among states. States also use the data to understand trends and to target their outreach and enrollment efforts. The relatively high profile given to the dental data by CMS has been instrumental in creating momentum for improvement. In addition, CMS recently launched an effort to provide technical assistance to states in reporting on a Dental Quality Alliance developed and National Quality Forum endorsed measure on the use of sealants. This measure, added to the 2015 Child Core Set for Medicaid/CHIP enrollees, is to be reported to CMS in 2016. Reporting on the Child Core Set measures is voluntary, as defined by Congress, but CMS is required to publicly report data provided by states. CMS must balance the need for additional data with current reporting expectations for States.

OIG Recommendation
Identify and share effective strategies with States

CMS Response
CMS concurs with this recommendation. CMS published *Keep Kids Smiling*, which details dozens of successful approaches developed by States. CMS also conducted, and published summaries of reviews of Medicaid dental programs, along with several other tools to help states improve in delivering dental services to enrolled children.[3] We are also providing periodic technical assistance webinars to states on strategies to improve their dental programs.

[3] Information found on our website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html

OIG Recommendation
Ensure that States pay for services in accordance with their periodicity schedules

CMS Response
CMS concurs with this recommendation. CMS will work with states to crosswalk their payment polices with their dental periodicity schedules and make any necessary adjustments to their payment policies.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Kellis served as team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Lucia Fort. Central office staff who provided support include Clarence Arnold, Meghan Kearns, and Christine Moritz.

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