Report to

United Methodist Health Ministry Fund

Status and Prospects for Medicaid Beneficiaries' Access to Dental Services in Kansas

Submitted by
The Health Services Research Group
University of Kansas

Raymond G. Davis Ph.D., Principal Investigator
Michael Fox Sc.D, Co-Principal Investigator
Jocelyn Johnston Ph.D., Co-Principal Investigator
Barbara Langner Ph.D., Co-Principal Investigator
Rod McAdams Ph.D., Co-Principal Investigator
Jan Moore, LMSW, MBA, Research Associate
Tim Redmond BA, Research Assistant

Michael McCunniff DDS, Consultant
Karen Williams ABD, Consultant
University of Missouri, Kansas City
School of Dentistry

June 30, 1999

FEIN #48-0680117

Status and Prospects for Medicaid Beneficiaries' Access to Dental Services in Kansas

Table of Contents

Project summary .... A

I. Description of grant 3

II. Review of present environment 4

III. Learning from other states 14

IV. Dentist survey summary 20

V. Dentist focus groups 33

VI. Medicaid beneficiary survey summary 35

VII. Beneficiary focus group and pediatrician feedback 42

VIII. Policymakers' views 44

IX. Policy Options 48

X. Annotated bibliography 52

Appendices:

A. Dentist focus groups 57
B. Dentist comments from survey 63
C. Beneficiary questionnaire 78
D. Dentist questionnaire 84
E. Beneficiary survey frequencies 93
F. Dentist survey frequencies 109
G. SRS Medicaid provider application 138

Project Summary
The Fund provided support to the Health Services Research Group, University of Kansas to better understand problems of access to dental services by Medicaid beneficiaries (children) in Kansas. The research examined access issues from the following perspectives.

- Assessed the current access situation in the State
- Canvassed other states both from literature searches and on-site visits
- Used a mail survey of dentists in Kansas along with followup focus groups to understand the supply perspective
- Conducted a telephone survey of Medicaid beneficiaries with additional focus groups to assess access from the user perspective and
- Interviewed policy makers about their perception of the problems and possible solutions.

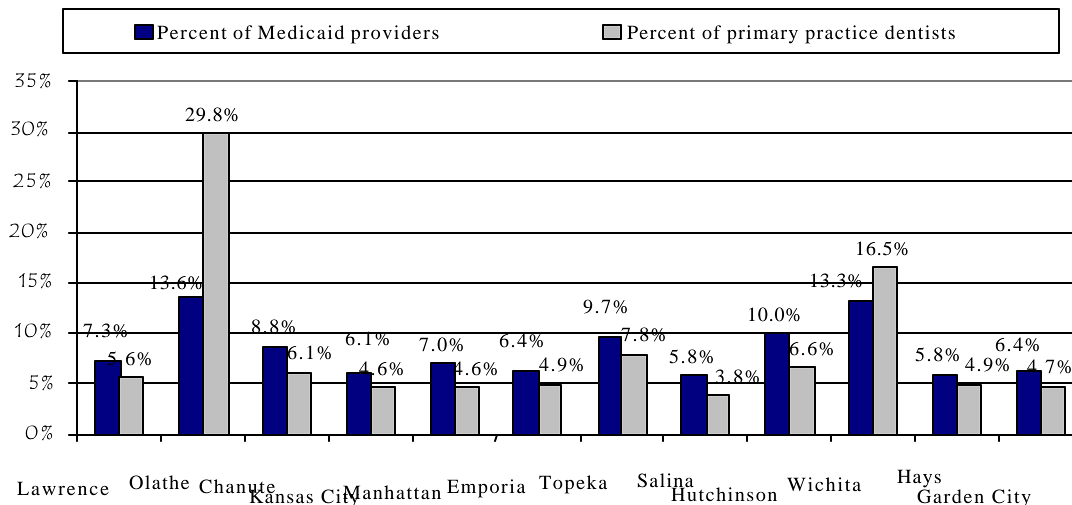
The research found a substantial demand by Medicaid children for dental services and an undersupply of service opportunities. More particularly:

Current situation

- Although the number of Kansas dentists per 100,000 residents is comparable to national (50 per 100,000) and Medicaid norms (one dental provider per 2,000 enrollees), this ratio is not meaningful as a measure of dental access for Medicaid beneficiaries because of the small number of dentists that accept Medicaid enrollees and the even smaller number that serve significant numbers of Medicaid enrollees.

- The issue in Kansas is less one of the number of dentists and more one of how they are distributed within the State (see Chart II.2).

Chart II.2 Locations of Medicaid Providers in Proportion to Dentists (by SRS area)



Other states

The critical issues gleaned from other states that may have applicability in Kansas include improving data, using dental extenders (hygienists, assistants, nurses, etc.), and improving education.

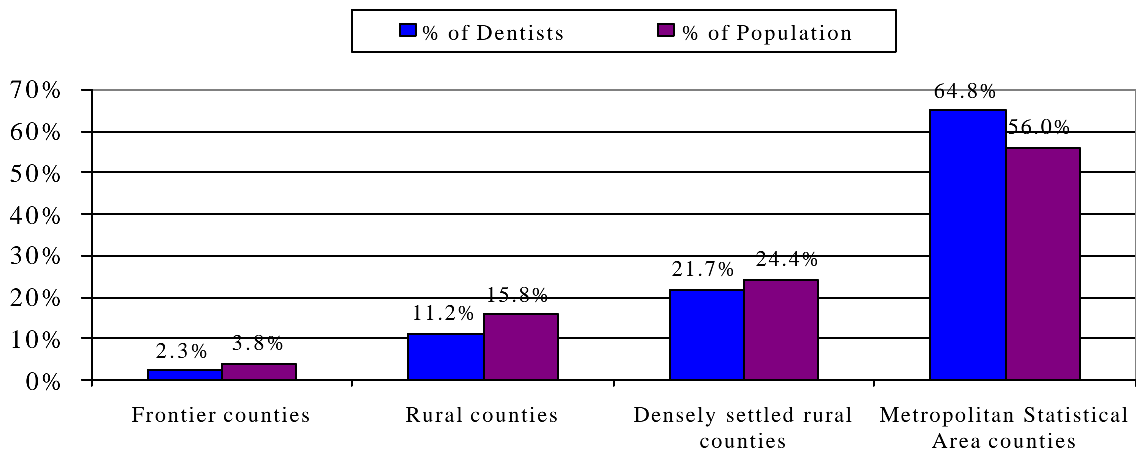
- Other states demonstrate that there is a need for data that can effectively assess the degree of need for dental services by Medicaid enrollees. Many other states are establishing a data baseline that can then be used to measure the effectiveness of any policy changes, including the effectiveness of the new CHIP ("HealthWave") program in improving dental service access.
- To improve screening and access to preventive care, several states have used extenders (primarily hygienists) to bring clinical services to underserved (mainly rural) areas through existing health care providers such as WIC, Head Start, and Parents as Teachers. Because Kansas is a rural state and because most of the Medicaid dentists are in urban or densely settled rural areas, the problem of access can in part be addressed by enhancing some form of dental extender.
- Many states provide greater focus to state dental issues and more particularly for education through a state dental office.

Dentist survey

The important issues identified from the dental survey include the location of dental practices (urban/rural), the type of practice (general dentistry and specialization), the percentage of dentists that participate in Medicaid and, within that number, the percentage serving most of the beneficiaries. The focus groups provided another means to identify problems with Medicaid.

Not too surprisingly, dentists were found to be clustered more in urban than rural areas (see Chart IV.1).

Chart IV.1 Locations of Kansas Dentists Relative to Population



Frontier and rural areas of the state are underserved and undersupplied, and dental specialists (e.g., pediatric dentists) are particularly scarce.

Of the dentists in the State, fewer than 27% participate in Medicaid (see Chart IV.4). Of those who participate, an even smaller number of dentists serve a disproportionate number of beneficiaries (see Chart IV.5). Thirty five dentists provide services to half of the beneficiaries in the State.

Chart IV.4 Proportion of Kansas Dentists Who Participate in Medicaid
(n=1151, does not include "other specialists")

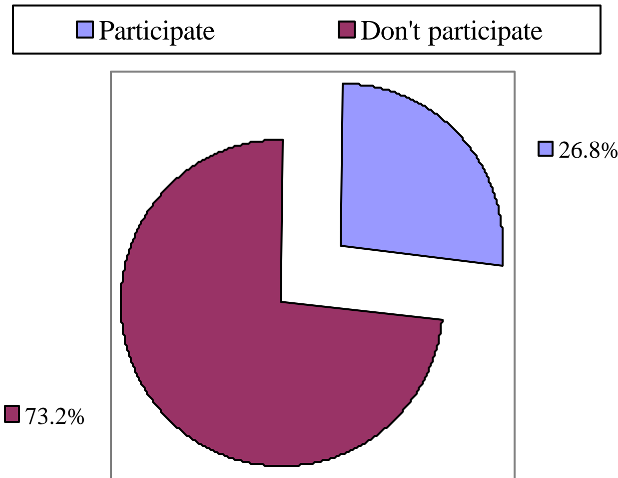
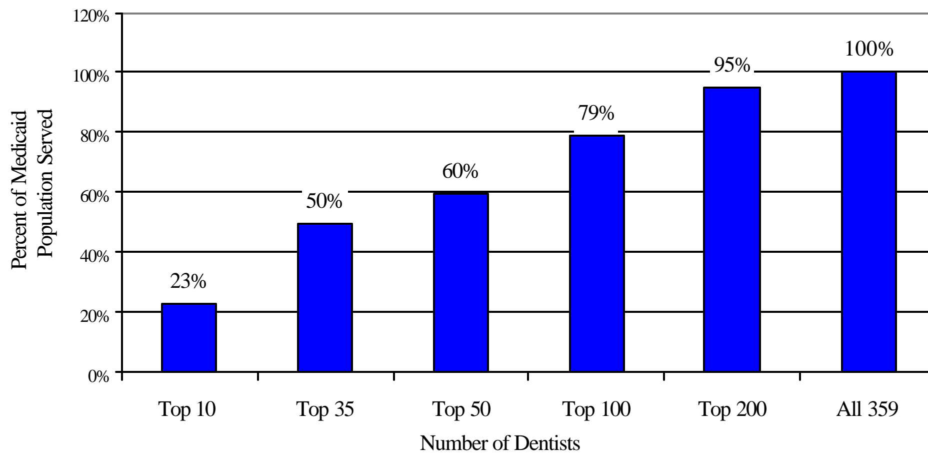


Chart IV.5 Number of Dentists Serving Child Medicaid Beneficiaries (FY98)



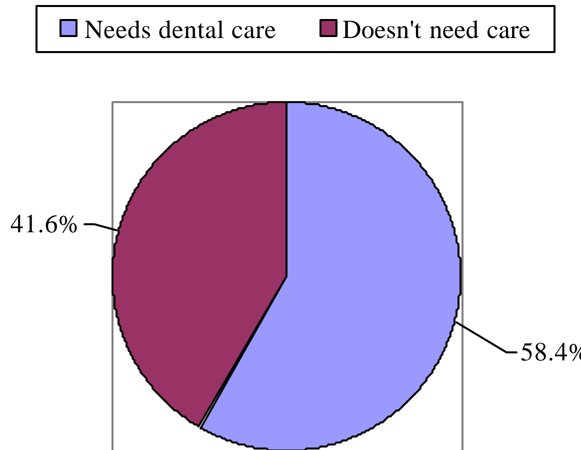
(Note: n=359 includes 29 out-of-state dentists)

Beneficiary survey

The beneficiary survey provided information from the perspective of the user. Important issues are why they have or have not visited a dentist, what is their current need for dental services, and whether they could or could not access services.

Over half of the beneficiaries surveyed thought that their child currently needed dental care (see Chart VI.2).

Chart VI.2 Do you feel that your child currently needs dental care?



The overwhelming type of service needed is primary—cleaning and checkup. These data argue strongly for primary dental services need in the State (see Chart VI.4). For almost one-third of the beneficiaries, the major problem in accessing dental services was the inability to find a dentist who would accept Medicaid patients (see Table VI.1).

Chart VI.4 Type of Care Needed (n=211)

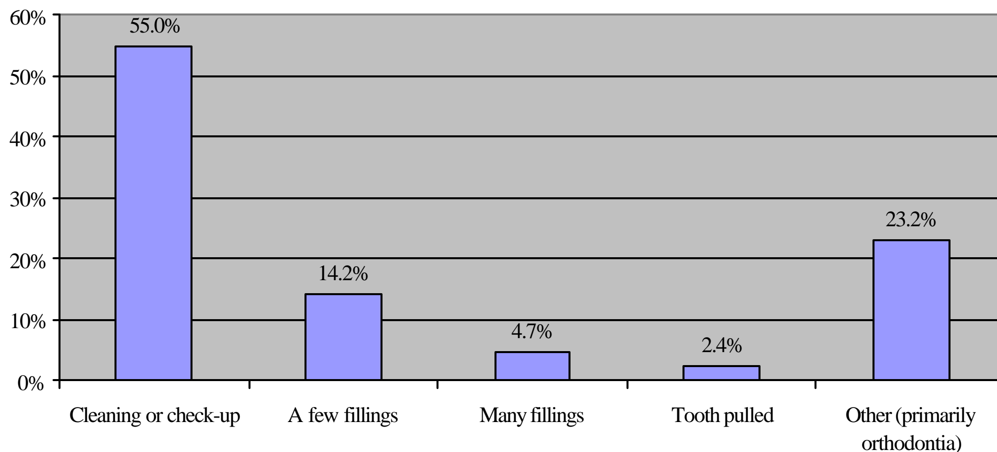


Table VI.1 Medicaid Beneficiaries' Problems with Access		
	Some Problem	**Not a Problem**
Q10a Couldn't find a dentist who would take a Medicaid patient	31.1%	68.9%
Q10b Didn't have transportation	9.0%	91.0%
Q10c Couldn't get off work	11.3%	88.7%
Q10d Child was afraid to go to dentist	16.6%	83.4%
Q10e Had to travel too far to see dentist	11.6%	88.4%
Q10f Couldn't find a dentist of my own cultural/ethnic background	3.7%	96.3%
Q10g Had to wait to get an appointment	29.7%	70.3%
Q10h Child wouldn't cooperate for dental care	11.4%	88.6%

A risk analysis to determine which demographic factors put Medicaid beneficiaries at greater risk in accessing dental services pointed to just one factor. When adjusting for family size, the age of children, and the educational level of parents, a child living in a rural area of the State faces a greater risk of having difficulty in accessing dental services than does an urban child.

Policymakers

The issues mentioned in the policymakers' interviews clustered into the following areas.

- Many policymakers saw the problem as provider supply. Access to dental services has been compounded by the ample supply of patients, which gives dentists little incentive to open their practices to additional patients for lower reimbursement.
- Many policymakers commented that if the number of dentists cannot be increased, the numbers of alternative providers should be examined. More particularly, health care clinics around the state should be encouraged to provide dental services to the Medicaid population.
- Many policymakers commented that the Legislature may find changes in dental funding attractive if there is an emphasis on prevention and the possibility of redistributing funding rather than a call for increasing funding.

Policy options

Improving access to dental services is a complex issue not easily addressed by single, discrete changes. The changes that were recommended from the research:

1. **Change the delivery structure**
   - There is a need for additional public clinics in cooperation with private dentists that can serve an additional demand.
   - Clinics and private dentists need to extend hours to better serve this population.

2. **Change reimbursement**
   - Three tiered reimbursement with higher reimbursement for preventive services
   - Capitation with competitive bidding for bundled services
   - Increase fees

3. **Increase the supply of dentists and dentist extenders**
   - Create a school of dentistry
   - Incentives for dentists to practice in rural areas and improved recruitment strategies
   - Explore use of telemetry (remote supervision of dental extenders)
   - Negotiate role for hygienists

4. **Re-engineer a new Medicaid dental program**
   - Privatize services
   - Bidding process for proposed new system

5. Expand prevention and education efforts

- Coordinate school, public health, and Medicaid education efforts
- Create an Office of Dental Health in KDHE seeded by foundation support
- Improve implementation of EPSDT

Change cannot be accomplished without negotiation and consensus building. Recommendations are:

- Each of the recommendations needs to be reviewed by a panel of experts for feasibility.
- The recommendation of the panel should be implemented under the direct authority of the Governor.
- The United Methodist Health Ministry Fund should continue to play a leadership role in dental policy initiatives.
- The underlying framework should rest on prevention and promotion.
- EPSDT provides the administrative home for improved service delivery for dental services to Medicaid children.
- Greater cooperation between KDHE and SRS-Medicaid is required if EPSDT is to work effectively.

Part I. Description of Grant

The United Methodist Health Ministry Fund, seeking to improve dental health in the State of Kansas–especially among children–has contracted with the Health Services Research Group (HSRG), University of Kansas to better understand Medicaid children's access to dental services in Kansas. More particularly, the Fund has asked the group to: 1) assess the present environment in the State; 2) survey Kansas dentists about their views of the access problem and their suggestions for improvement; 3) explore the access problem from the viewpoint of the beneficiary and those who observe beneficiaries closely; 4) assess experimental approaches that have succeeded in other states; 5) obtain policymakers' views of the access problem and what changes are possible and probable; and 6) suggest options for improving dental access for children.

The HSRG consists of Ray Davis, Ph.D. principal investigator, and co-principal investigators Michael Fox, Sc.D; Jocelyn Johnston, Ph.D.; Barbara Langner, Ph.D.; and Rod McAdams, Ph.D. Assisting the research from the University of Missouri School of Dentistry are Michael McCunniff, D.D.S., and Karen Williams, A.B.D. The Group's research director is Jan Moore, L.M.S.W., M.B.A., assisted by research assistant Tim Redmond, B.A.

Part II. Review of Present Environment

The Problem of Access

Ensuring Medicaid-dependent children access to adequate oral health care is recognized nationally as a major public health challenge. Despite federal requirements that all Medicaid children receive periodic dental screenings as part of their ongoing health care, a variety of barriers exist that discourage regular and comprehensive dental follow-up.

Medicaid dental claims records in Kansas show that only 29% of eligible enrolled children (39,820 of 137,424) received dental services in 1998—a rate that, unfortunately, is typical of the low rates of service across the nation. A recent analysis of the North Carolina Medicaid program indicated that between 1984 and 1992, half of the state's child enrollees never used dental services (Robinson et. al., 1998). The Health Care Financing Administration (HCFA) reported that in 1996, under twenty percent of the nation's Medicaid enrollees received dental care (HCFA, 1996). Another national study of Medicaid dental use in 1993 concluded that on average, less than 30% of Medicaid children received dental services, and that in all states, fewer than half of all Medicaid children received dental services (Celniker et al, 1996). However, it is important to recognize that Medicaid dental utilization rates may mirror low use among the overall population. There is evidence that the majority of Americans—over fifty percent—do not receive annual dental care (Manski et al, 1987).

The Problem of Provider Participation

There are two primary explanations of low Medicaid dental utilization rates. According to one nationwide study, those explanations include "a lack of dentists willing to serve Medicaid beneficiaries, and the low priority many Medicaid families place on obtaining dental care" (Kaye and Pernice, 1998). The lack of willing providers appears to be an important factor in Kansas, according to state Medicaid officials. The Kansas dental provider/population ratio (defined as the number of dentists per 100,000 residents) is 50, indicating that there are 50 dentists for each 100,000 residents.[1] Among states in the central plains region, the Kansas ratio is comparable to the dental provider ratio for Missouri (50), Iowa (53), and Oklahoma (49). There are higher provider ratios in Nebraska (64) and Colorado (66). These ratios compare to a national average of 58 dentists for each 100,000 residents (HRSA, 1999). Several states use variations of these ratios to determine whether Medicaid access problems exist. The most commonly used standard requires one dental provider for each 2,000 Medicaid enrollees (Kaye and Pernice, 1998.) By that standard, Kansas' ratio of 1 dentist to119 Medicaid enrollees might seem even abundant. However, the presence of dentists in and of itself does not guarantee access to dental care, since dentists' participation in the Medicaid program is very limited—even more limited than the list of registered providers might suggest. SRS

[1] Kansas has guidelines that designate areas that have dental shortages. In addition, the Department of Health and Human Services has revised its procedures for designating shortage areas by calculating provider supply in full-time-equivalents. Their formula takes into account not only the total number of dentists but also the number of dental extenders in each practice and a number of other factors.

records show that 676 of Kansas' 1,229 dentists have a Medicaid provider number[2]; however, only 330 (plus 29 dentists from surrounding states) filed Medicaid claims in 1998, and the number of claims was generally small. The number of children who actually received treatment may, indeed, have been somewhat larger: several dentists who responded to the Medicaid dental survey indicated that they occasionally see Medicaid patients without filing claims because of their frustration with administrative claims processes. However, it is impossible to determine the extent of this practice since no billing records exist. For those who filed Medicaid claims in 1998, the vast majority saw very minimal numbers of patients. The median caseload was 41, meaning that half saw 41 or fewer Medicaid enrollees, while the mean was 111. The latter figure is skewed by a few high-volume providers, the highest three of whom saw 1,200 to 1,600 patients. Kansas officials provide several reasons for low provider participation in the Medicaid program. These reasons tend to reflect explanations offered by other states with low participation rates. According to previous research, dentists tend to blame their reluctance to serve Medicaid patients on the following factors (Kaye and Pernice, 1998; Damiano et al., 1990; Milgrom and Reidy, 1998):

- low Medicaid reimbursement rates
- high administrative burdens associated with Medicaid
- high rates of missed appointments among Medicaid patients

Medicaid reimbursement rates to dental providers in Kansas were raised in 1997 to 50% of the usual, customary, and reasonable (UCR) dental fee rates (up from 28%) with no discernable increase in participation. While reimbursement may explain part of the providers' reluctance to serve Medicaid patients, it should be noted that many states use alternative reimbursement strategies, primarily as a result of including dental care in managed care plans. One study indicates that among neighboring states, only Colorado uses the UCR approach, reimbursing dentists at 65% of the UCR rate (American Dental Association, 1998). Reimbursement rates tend to be heavily scrutinized by dentists. One study notes that "unlike physicians, dentists are usually in solo practices with high overhead and may have little ability to "cost shift" to reduce the financial burden" of caring for patients who pay lower fees (Spisak and Holt, 1998).

Another frequently mentioned explanation for low provider participation is that dental providers prefer to avoid treating Medicaid patients because of the stigma associated with Medicaid. Only a small minority of dentists responding to our survey admitted to unease between Medicaid patients and other patients in their practice (20% agreed with the statement "Medicaid patients make other patients in the office feel uncomfortable"), although some focus group participants were more willing to disclose their discomfort with this population. Complaints included too many family members accompanying the Medicaid beneficiary in the waiting room and parental noncompliance with supervising oral hygiene and keeping appointments. Survey questions also revealed the general view of the Medicaid population as difficult to treat. A large majority of

---

[2] Some dentists have more than one Medicaid number, reflecting multiple practice sites. Kansas dentists have a total of 800 Medicaid numbers, with 676 representing an unduplicated count. In addition, a number of out of state dentists have Medicaid numbers, but their utilization is minimal.

dentists surveyed agreed that “It is difficult to provide comprehensive care to Medicaid patients” (83%) and “Oral health problems of Medicaid patients are more severe than those of other patients in my practice” (63%). Those who did not provide care to Medicaid patients in 1998 were significantly more likely to express such sentiments (Table II.1).

Table II.1: Percent of Survey Respondents Agreeing with Questions Regarding Difficulty of Treating Medicaid Patients		
	Medicaid Participants	Non-Participants
Low-income patients are more difficult to treat than others	34.1% (84)	65.9% (162)
It is difficult to provide comprehensive care to Medicaid patients	31.7% (137)	68.3% (295)
Oral health care problems of Medicaid patients are more severe than those of other patients in my practice	38.8% (125)	61.2% (197)

Other research also suggests that the attitudes of dentists’ office staffs are important determinants of access for Medicaid children (Lam et al., 1999). Data from the beneficiary survey suggest that this is not a problem for most (87.7%) of Medicaid beneficiaries in Kansas. However, when the survey is considered as representing the total Kansas Medicaid-enrolled population, the 12.3% who rated the respect they received from dental office staff as “fair” or “poor” represents a substantial number of people who feel stigmatized by their status as Medicaid beneficiaries (12.3% of the 137,424 beneficiaries enrolled in 1998 =16,903 beneficiaries). It seems highly unlikely that private insurance companies would be satisfied with 12.3% of their beneficiaries reporting that they feel stigmatized by their providers.

The second factor behind low child Medicaid dental utilization rates is the low priority placed on dental care by Medicaid families (Kaye and Pernice, 1998; Spisak and Holt, 1998). According to the National Academy for State Health Policy, a recent study by the Office of the Inspector General, (Celniker et al., 1996) concluded that “many Medicaid families are not aware of the importance of oral health care and are often unwilling to wait for appointments or arrange transportation to a dental appointment” (Kaye and Pernice, 1998). Medicaid families may view dental care as “elective,” and they may focus more on acute care at the expense of preventive treatment (Spisak and Holt, 1998).

Low utilization of preventive dental care is not limited to Medicaid patients. Low utilization rates are also prevalent among the general population (Manski et al., 1999) and among the working poor without Medicaid or other insurance coverage (Rizk and Christen, 1994). It is likely that the low priority placed on dental care by Medicaid families is reflective of priorities found in the general population.

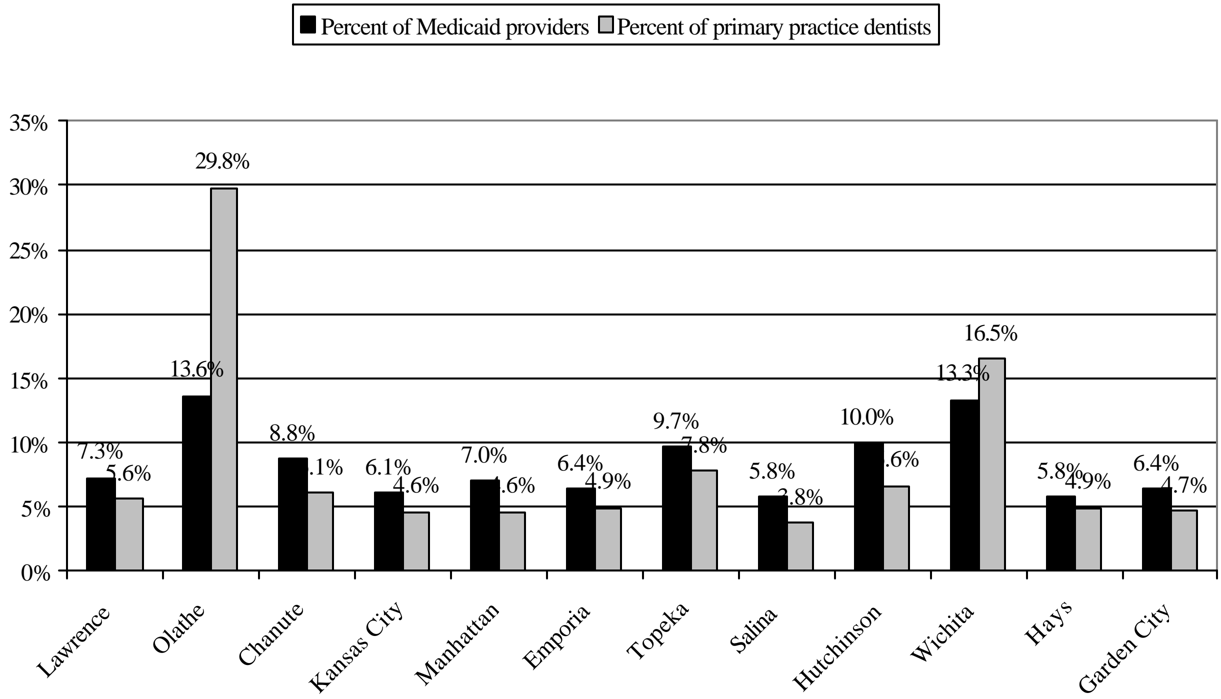
The Problem of Geographical Distribution of Willing Providers

Kansas dentists are concentrated in two regions of the state, Northeast Kansas—primarily Johnson County—and South Central Kansas—primarily Wichita. Approximately 70 percent of all active dentists are located in thirteen cities, 41% in Shawnee Mission (Johnson County) and Wichita (Sedgwick County) alone (see Table II.2 below).

Table II.2: Kansas Cities with at least 1% of Total Dentists (not including specialists)		
Shawnee Mission (including Olathe)	25.9%	(310)
Wichita	15.1%	(173)
Topeka	7.4%	(85)
Kansas City	4.1%	(47)
Lawrence	3.7%	(42)
Hutchinson	2.4%	(28)
Manhattan	2.2%	(25)
Salina	2.0%	(23)
Leavenworth	1.6%	(18)
Garden City	1.2%	(14)
Hays	1.1%	(13)
Pittsburg	1.1%	(13)

Although dentists tend to be concentrated in cities and most Medicaid dental care is delivered in cities (because most high-volume providers are there), urban dentists are less likely than rural dentists to participate in the Medicaid program. Another way of saying this is that a smaller proportion of dentists in MSAs than in rural areas participate in Medicaid. Viewed by SRS administrative area (see SRS map on page 9 for SRS administrative regions), only two of thirteen regions, both urban, had a smaller percentage of total Medicaid providers than percent of total dentists practicing in that region. The Olathe SRS region (Johnson, Leavenworth and Miami counties) includes nearly 30% of all dentists in the state but only 14% who provided Medicaid services in 1998. The Wichita region (Sedgwick county) includes nearly 17% of all dentists but only 13% who participate in Medicaid (Chart II.1). The low participation in Johnson County is especially noteworthy—only 37 of 310 (12%) dentists saw Medicaid patients. The lack of interest in serving Medicaid patients may be at least in part due to the higher overhead costs of practicing in a city, where real estate and rental costs are higher. However, there are exceptions to the rule. In Kansas City, Kansas, where a large proportion of the population is poor and the ratio of dentists to population is relatively small, a much larger proportion of dentists (38%) serve the Medicaid population. This suggests that those locating their practice in low-income areas may have a high level of commitment to serving the local population.

Chart II.1 Locations of Medicaid Providers in Proportion to Dentists (by SRS area)



Currently, 3 percent (n=35) of all Kansas dental providers serve 49.6% percent of Medicaid enrollees, indicating that Medicaid dental patients are concentrated among a very small number of providers. These providers tend to be located in metropolitan statistical areas, although some are in smaller cities. Each of the cities listed below has at least one dentist participating in Medicaid at a relatively high level—at least 336 patients (the minimum caseload of Medicaid providers who treat half of all Medicaid patients). Table II.3 below shows the top 35 Medicaid providers by SRS region and city and the percentage of the total number of Medicaid beneficiaries they treat. (Note: Because of other Medicaid providers in these regions, the percentage of patients treated will not equal the regional totals shown elsewhere.)

Table II.3:Locations of Kansas' 35 Top Medicaid Providers and Percent of Medicaid Patients Treated by City and SRS Region

City	SRS Region	Percent Medicaid Patients Treated	Number Medicaid Dentists
Kansas City	Kansas City	7.83%	5
Topeka	Topeka	5.84%	5
Olathe Leavenworth	Olathe	2.23%	2
Lawrence	Lawrence	3.29%	2
Manhattan	Manhattan	0.92%	1
Emporia Eureka	Emporia	1.99%	2
Pittsburg Independence	Chanute	3.21%	2
Salina	Salina	1.60%	1
Wichita	Wichita	15.77%	8
Hutchinson Newton Wellington	Hutchinson	3.01%	3
Hays Great Bend	Hays	1.88%	2
Garden City	Garden City	0.98%	1
Joplin, MO	N/A	1.02%	1
Total		49.57%	35

Geographically, there is great variation across the state in how dentists are distributed. This can be expressed as the ratio of providers to total residents and Medicaid providers to Medicaid beneficiaries. The Kansas City SRS region had the highest ratio of Medicaid providers to beneficiaries (1:250), followed by Wichita (1:194), Chanute (1:153), Lawrence (1:138), and Emporia (1:137). These ratios—even those of Medicaid

providers to Medicaid beneficiaries—are not an adequate measure of access, however, since most Medicaid providers treat relatively few Medicaid beneficiaries. The distribution of the 35 top providers is probably more reflective of the cities where Medicaid beneficiaries stand the best chance of securing treatment.

Some Medicaid beneficiaries clearly have to travel in order to receive services. Although a detailed analysis of travel distances was not done, an approximation can be obtained by aggregating the total number of beneficiaries living in a region compared to the total number receiving care there (see Chart II.2). By SRS region, there was a net out-migration of patients from most regions with higher than average Medicaid provider to beneficiary ratios, though in many cases the difference was small. Most of the regions that have few Medicaid providers also have relatively few dentists, suggesting that the supply of Medicaid providers to some extent parallels total number of dentists. However, a plentiful supply of dentists in the region does not necessarily translate into access for Medicaid patients, as illustrated by the Olathe region, where the ratio of dentists to beneficiaries was 1 to 8 while the ratio of Medicaid-participating dentists to beneficiaries was 1 to 58, and the Wichita region, where the ratio of dentists to beneficiaries was 1 to 44 and the ratio of Medicaid-participating dentists to beneficiaries was 1 to 194.

Table II.4 Provider Beneficiary Ratios, Medicaid Beneficiaries to Total Dentists and Medicaid Beneficiaries to Medicaid Providers*

SRS Region	Medicaid Beneficiaries Treated in 1998	Total Primary Care Dentists (without specialists)	Total Medicaid Providers in 1998	Ratio of Medicaid Beneficiaries to Total Primary Care Dentists	Ratio of Medicaid Beneficiaries to Medicaid Providers
Lawrence	3313	65	24	51	138
Olathe	2593	342	45	8	58
Chanute	4443	71	29	63	153
Kansas City	4990	53	20	94	250
Manhattan	1467	54	23	27	64
Emporia	2887	57	21	51	137
Topeka	3174	89	32	36	99
Salina	1615	43	19	38	85
Hutchinson	2767	72	33	38	84
Wichita	8535	194	44	44	194
Hays	1570	44	19	36	83
Garden City	2465	67	21	37	117
State	39819	1151	330	35	121

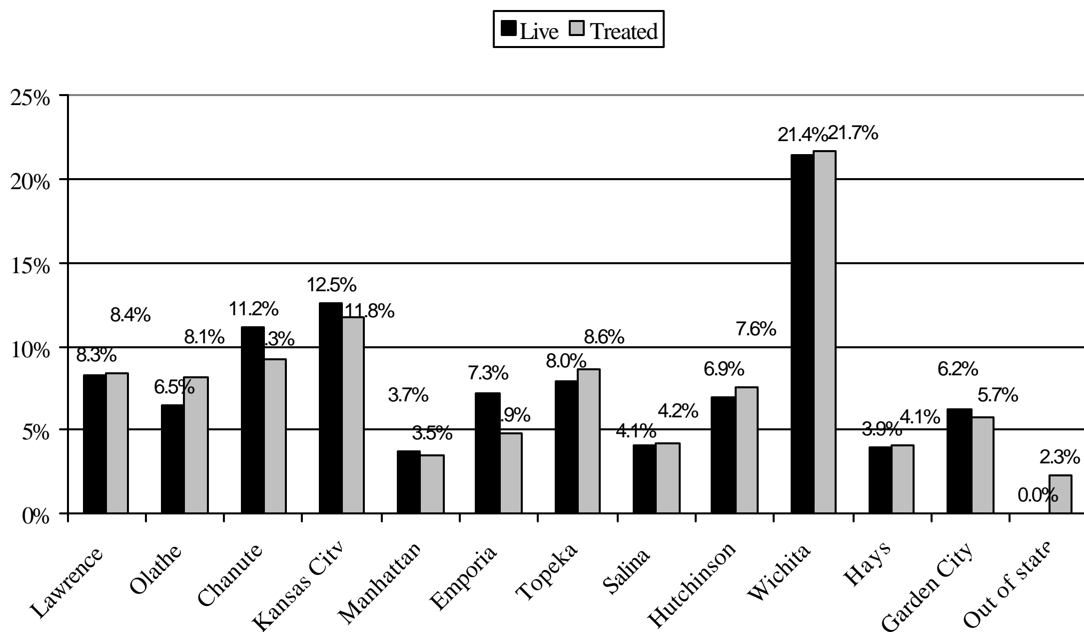
*Beneficiaries include only those actually treated, not those eligible.

The lack access to a nearby dentist may also account for the fact that 2% of beneficiaries (897) left the state for treatment. The vast majority of these (70% or 620)

sought treatment in Joplin, Missouri. Most were from Southeast Kansas. Forty-five percent of all out-of-state visits (n=407) involved a single Joplin-based provider, with 213 other beneficiaries receiving care from seven other Joplin dentists. The remaining beneficiaries sought care in Kansas City (n=193), St. Joseph (n=36) and Maryville (n=29), Missouri; Beatrice (n=1), Franklin (n=2), and Hastings (n=6), Nebraska; Bartlesville, Oklahoma (n=3); and Pueblo, Colorado (n=7).

Over all, for most Medicaid beneficiaries, travel does not seem to be a major access barrier (at least for primary care). Data from the beneficiary survey showed that 11.4% of patients experienced some delay because of the distance they had to travel to get care. Only 14.4% reported traveling more than 30 minutes to reach the dentist. As

Chart II.2 Where Medicaid Patients Lived and Where They Received Dental Care in 1998 (by SRS Region)



with the perception of stigma, however, 11.4% to 14.4% of Medicaid consumers, when considered as a percentage of the 137,424 eligible enrollees, represents a large group—15,666 and 19,789 beneficiaries with geographical barriers to access.

*Includes only beneficiaries who actually received service. The number who lived in region and did not receive service is unknown.

A Summary of Current State Efforts to Improve Access

States have adopted a variety of strategies designed to enhance the access of Medicaid children to dental care. One strategy which attempts to deal with both utilization factors discussed above—provider willingness to serve Medicaid patients and the low priority placed on dental care by Medicaid families—is the use of managed care arrangements for dental care (Kaye and Pernice, 1998). As of 1998, nineteen states had

adopted some form of managed care for their Medicaid dental programs.[3] Three types of managed care programs predominate. First, dental services are delivered through a comprehensive Medicaid managed care plan; second, dental services are delivered through a dental-only Medicaid managed care plan; third, dental services are delivered on a fee-for-service basis through a primary care case management (PCCM) program. Of the nineteen states using managed care delivery systems for the Medicaid dental services, sixteen states use a comprehensive Medicaid managed care plan model of delivery.

The potential benefits of using a comprehensive managed care model include using the health and/or dental plans to provide outreach and education to Medicaid clients. In the managed care states, plans are required to reach some threshold (usually 80% or higher) of required EPSDT (Early, Periodic Screening, Detection and Treatment) encounters. In addition, this strategy may be more successful in terms of increasing provider participation, according to the National Academy for State Health Policy. However, to date there is little empirical evidence available to indicate that this strategy is effective in reducing barriers to care.

Other state strategies that will be discussed in more detail in Part III include reduction/simplification of provider administrative burdens (e.g., paperwork, adjustment of reimbursement rates), enhancing transportation alternatives for Medicaid patients seeking dental care, and education/outreach efforts directed at Medicaid enrollees (Kaye and Pernice, 1998). In Kansas, a number of strategies have been discussed, including a state-operated mobile dental "van" for low provider areas. However, Kansas Medicaid officials interviewed for this study seem to place their greatest hope for increased access in the comprehensive plan model; they note that their Children's Health Insurance Program (CHIP, known in Kansas as *Healthwave*) plans appear to be relatively successful in terms of persuading dental providers to treat CHIP eligible children. Kansas Medicaid officials also continue their ongoing "dialogue" with dental providers concerning reimbursement and other issues that may hinder access.

---

[3]These states include Arizona, California, Connecticut, Florida, Hawaii, Indiana, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Wisconsin, and the District of Columbia.

Part III Learning from Other States

States have developed a variety of approaches to address Medicaid access problems. These include forming stakeholder groups and establishing state-level dental offices to plan and coordinate policy, developing better data systems for monitoring the status of children's oral health, targeting particular at-risk populations, using hygienists as dentist extenders in underserved areas for routine cleaning and examinations, and streamlining administrative practices to make Medicaid more user-friendly. The following sections outline several innovative approaches.

State Examples

Nebraska

Nebraska used a multi-step approach that was aimed at eliminating the barriers of Medicaid, including the "Medicaid stigma", administrative barriers, and unwillingness of dentists to provide dental services to this population. In an effort to destigmatize the Medicaid program, Nebraska formulated a single program approach to providing health care to children called the Kid's Connection. This program represents a seamless approach to application for and provision of health care for children eligible for Medicaid and CHIP programs. A single card is used for children, and providers are unaware of whether funds for provided services come from Medicaid or CHIP monies. Additionally, public service announcements and a video "Children's Health Insurance" have been used to inform the public about the Kid's Connection program.

Specifically, the several steps were implemented and resulted in an increased participation rate for dentists to approximately 63% statewide, with 33% of 150,000 beneficiaries receiving care (compared to a 26.9% participation rate for Kansas, with 29% of 137,424 beneficiaries receiving care).

Players from Medicaid, organized dentistry, academia and the State Dental Health Director participated in a task force to examine current funding structures and policies regarding oral health services. It was determined that the existing policies were outdated and no longer served to improve the oral health of this population. From this consortium, several changes in policy were implemented.

- An internal decision was made to increase reimbursement rates from 53% to 80% UCR.
- The Medicaid Policy Manual was rewritten and is currently undergoing public review. Specifically, policy changes included the decision to use new ADA codes for billing of services, as well as changing coverage to include more preventive services, such as allowing dental sealants on primary teeth and for non-coronal areas like central and lateral incisor pits.
- An active "educational" program was implemented to provide dentists with information about the Medicaid program, beneficiaries within their region, and answers to common questions regarding billing and reimbursement. Medicaid personnel attend a regional dental meeting, have a booth at the Nebraska Dental Association State Meeting, and have an ongoing newsletter that goes out to dentists in an effort to reduced administrative barriers.
- A recognition program is being developed to showcase humanitarian efforts,

including showcasing people's activities in a Public Health Week Showcase, presenting plaques and awards at the state level, enlisting the governor's office to recognize individuals, and having gift certificates to bed and breakfasts, restaurants, etc.

Iowa

As with other states that have effectively enacted changes to improve access to care for Medicaid eligible children, Iowa has formed a statewide committee charged with addressing access to care and dental service issues. The Oral Health Action Committee, composed of individuals from the State Board of Health, Iowa Dental Association, Public Health researchers from the University of Iowa, private practice dentists, and Iowa Medicaid personnel, has worked to identify problems and propose solutions. Initially, the committee anecdotally identified access issues in order to make recommendations to the State Department of Health. Additionally, the State Dental Director surveyed each early childhood health center and Head Start program to roughly assess the need for preventive and restorative services for Iowa children. This led to a legislative report on Title XIX with specific policy recommendations. Recommendations related to children's oral health included increasing reimbursement levels for dentists who provide routine care, including EPSDT screening to young children, and developing alternative methods of providing dental screening, education and referrals to Title XIX-enrolled children under age 3. Subsequently, several initiatives were undertaken to increase reimbursement for Medicaid dental services, increase education for dentists regarding Medicaid procedures, and change Medicaid policy to allow dental hygienists to provide screening and care to children in underserved areas.

Specific Actions:

- Medicaid service codes were changed to ADA service codes, and an electronic submission process for reimbursement was implemented to improve timeliness of reimbursement.
- The Department of Public Health meets regularly with dentists at dental society meetings to inform practitioners about Medicaid procedures and be available to answer questions.
- Medicaid reimbursement for children's preventive dental services has been increased, and there is a second round effort to increase fees for restorative services. Data obtained from a Department of Human Services Ad Hoc Committee were used to stimulate change in reimbursement rates for preventive services.
- In 22 of the 99 counties in Iowa, an "Exception to Medicaid Policy" has been granted to allow dental hygienists to bill for children's oral health screenings as part of the Early Periodic Screening Diagnosis and Treatment program (EPSDT) in public health clinics.

The EPSDT program encourages early regular oral health screening and referral in order to prevent significant problems from developing. Oral screening for Medicaid-eligible children is mandated by federal law. The state of California was successfully sued for failing to provide the EPSDT services, making this the landmark case to which

all other states will be held. Although the Iowa Dental Association was not initially in favor of the program, it has grown to support it. The Iowa Legislature recent allocated $50,000 as part of the annual budget to fund a pilot project that gives dental hygienists more training to provide additional services in the "Exception to Policy" program. This pilot program will provide for assessment of risk indicators for early childhood caries that includes assessment of S. mutans, plaque on incisors, and presence of white spot lesions or caries, especially on anterior teeth. Those children determined to be at high risk will receive fluoride varnish applications 3 times a year, and parents will be enrolled in a preventive educational program.

Washington State

Washington state has been very proactive in implementing novel programs to address the oral health needs of the medically underserved population. Two elements that have been cited as critical to the state's success have been a state oral health survey on 3rd graders that provided the data needed for legislative support and the formation and actions of the Washington State Oral Health Coalition, a group of stakeholders from Medicaid, the Washington Dental Foundation, the University of Washington, state and regional dental associations, and the Washington Department of Health. The Coalition has been instrumental in using a multi-faceted, proactive approach for improving access to care for Medicaid children in the state.

The following actions have been successful:

- Three studies were undertaken to provide information on the oral health status of children and characterize problems related to dental demographics and distribution of dentists and Medicaid beneficiaries. Data from these surveys along with the ESPDT lawsuit from California were used to get the attention of legislators. Subsequently, the Washington Legislature increased Medicaid funding from 35% UCR to 75% UCR. More critically, they weighted the funding for Medicaid services to favor prevention for children less than 6 years of age and to favor restoration for children older than 7. Additionally, they allocated $5,000,000 to fund community projects aimed at improving access for this population.
- Medicaid personnel visit community coalitions every 6 months and have hired 4 trainers who go out to providers in the state to work with dentists in their offices to reduce the administrative barriers to providing Medicaid services. They have assumed a "business approach" rather than "philanthropic approach" to enlisting dental participation and are teaching dentists how to increase income by efficient provision of services to individuals with high need.
- Medicaid has reduced barriers related to authorization for care by expediting the claims process and establishing exemptions to prior authorization for certain procedures.
- An administrative match program between the Washington Dental Service and Medicaid has been used to fund public agencies to provide care in underserved areas..
- Innovative community-based projects have been implemented as part of the

statewide coalition to improve the oral health of children. Most notable is the 5 year old ABCD program, a collaborative project between local dental groups, the Washington Dental Service, Medicaid and the University of Washington. The program targets children ages birth to 5 and emphasizes prevention through the development of good oral health habits. The program has seen an increase from 20% to 42% of Medicaid-eligible children receiving at least one dental visit. The program involves an active recruitment component to enroll Medicaid eligible children in the program through health fairs, food banks, WIC programs, Head Start programs and anywhere else Medicaid parents might frequent.

- The program also targets removing a frequently cited barrier to dentists' willingness to provide Medicaid services—parental compliance in keeping appointments and in appropriate dental office behavior. Parents receive basic education on oral health habits for their children and are trained on proper dental office protocol. To encourage dentists' participation, Medicaid pays add-on fees for ABCD services, making fees close to 70% UCR. Dentists are also provided with additional training in managing very young children and in providing preventive and atraumatic dental care. Of particular interest, recent research (Lam, 1999) suggests major factors affecting practices' participation in Medicaid were office policy on seeing Medicaid-insured patients, staff members' personal connection to Medicaid-insured patients, staff members' attitudes about Medicaid-insured patients, and staff members' perceptions of Medicaid-insured patients' barriers to care. This suggests a need to educate staff as well as dentists on issues related to Medicaid. While no long-term data are available on overall program effectiveness, anecdotal information from dental providers and Medicaid administrators suggests the program is effective in at least reducing common barriers and encouraging provider participation.
- The Washington Recruitment Group (Department of Health, Office of Rural Health) has implemented a loan repayment program for newly graduating dentists that links them with private offices in underserved areas, rather than FQHC's or 330 clinics, with the hope that they will remain in the area once the repayment phase has expired. New dentists must provide a certain percentage of services to Medicaid children.
- Currently, dental hygienists can provide dental hygiene services at 330 clinics and FQHC's without dental supervision. Again, like the Iowa project, the purpose is to improve access to care where dentists are either unwilling or unavailable to provide services.

Illinois

An inherent barrier to dentist participation in Medicaid is low reimbursement rates coupled with very high overhead for provision of dental services. A six-month needs assessment in Bureau County indicated a real need for dental services in the region. In response, Illinois opened a state-supported dental clinic to provide dental care for Medicaid eligible children ages 3 to 21. The building and dental equipment were donated by the family of a deceased dentist as a memorial. Local dentists have overwhelmingly

volunteered to provide some time to see patients. Seven other projects are being considered to address the oral needs of medically underserved populations in the state.

Additionally, Illinois is in the process of securing a Health Professional Shortage Area designation for the clinic that would allow dentists and dental hygienists to work at the clinic while paying off their loans.

New Mexico

In New Mexico, there was a great awareness among legislators and other health agencies regarding the unmet oral health care needs of New Mexicans and much pressure for a remedy. Thus, the New Mexico Health Policy Commission proposed a solution based on using well-qualified dental hygienists to provide the much needed preventive services and educational and therapeutic interventions in unsupervised settings. On April 8, 1999, HB265 was signed into law by New Mexico's governor as a proposed solution to the critical shortage of Medicaid providers and the need for preventive services for underserved populations in the state. This legislation established a new category of dental hygiene licensure called "Collaborative Dental Hygiene Practice," which is defined as the science of the prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and other therapeutic services in a cooperative working relationship with a consulting dentistry but without general supervision.

California

California employs a tiered reimbursement plan with the first $400 per beneficiary going for a bundled group of services (cleaning, sealants etc.) and allows up to $400 for restorative care. Dentists receive payment for this tier of services at 80% of the reasonable and customary rate. Restorative costs exceeding $400 would require preauthorization. Total dental costs up to $1000 would be paid at the 80% rate and for costs exceeding that annual amount the reimbursement rate would be at 60% of the reasonable and customary rate. Eligibility for dental care is to include indigent adults.

Recommendations Based on Other States

- **Establish Stakeholder Group/State Dental Director to Oversee Policy**

States that have been most effective in improving care to Medicaid-eligible children have created infrastructures of critical stakeholders to comprehensively assess problems and pose solutions that meet the specific needs of the target population. Many states have established a state dental director or official state appointed committee (standing committee, not ad hoc) charged with overseeing oral health issues in the state. This also represents a recommendation from Healthy People 2010.

As such, a coalition of stakeholders in Kansas needs to be formalized. Among other tasks, the group should be charged with undertaking a study of Kansas Medicaid policy to determine what areas can be streamlined and/or improved. Currently, Medicaid personnel in Kansas do attempt to educate dentists about the program. Additional funds should be requested to replicate the type of program Nebraska uses to increase dentist participation. In alignment with recent research, educational efforts should include dentists as well as office staff.

- **Improve Data on Children's Oral Health Needs and Care Outcomes**

There is a critical need for valid data on oral health needs of children in order to effectively assess real needs, plan programs, and have benchmarks for measuring success of interventions. An Oral Health Surveillance program should be implemented to survey the oral health status of WIC-enrolled children, children covered under the ESPDT program, and school age children statewide in order to provide cross-sectional data. Without data to assess need and distribution of problems, posing effective solutions and assessing effectiveness will be impossible. Some states are using the state's Healthy People 2010 initiative to achieve this goal. However, these states have included the Healthy People 2010 in past initiatives and have a preexisting infrastructure. Unfortunately, Healthy Kansans 2000 did not address oral issues, and Healthy Kansans 2010 has targeted four cross-cutting priorities but has not included oral health.

A data example is the need to establish and monitor the effectiveness of Title XIX dental program. Iowa uses specific utilization rates, such as percentage of children who receive an initial exam or receive treatment in a hospital operating room. Similarly, since a primary focus should be related to very young children (under the age of 3), dental utilization rates along with other indicators such as immunizations and prenatal care rates should be evaluated regularly.

- **Use Dental Hygienists as Dentist Extenders**

Use dental hygienists to improve access to care by providing screening, preventive, and clinical services in underserved areas using either the "Exception to Policy" example from Iowa or the New Mexico model for Service Delivery.

- **Target At-Risk Children Through Cooperative Programs**

Target existing programs (WIC, Head Start, Parents as Teachers) to identify Medicaid-eligible children and increase access to care. The ABCD program provides a template for meeting the needs of those identified while addressing many of the concerns related to non-participation voiced by Kansas dentists.

- **Integrate Medicaid and CHIP to Destigmatize Medicaid**.

Encourage the development of a seamless program between Medicaid and CHIP with the intent to destigmatize Medicaid. Such a movement would hopefully encourage parents of eligible children to enroll their kids. The program should include a single application process with funds allocated to providers without indication of which program is funding the child.

Part IV. Dentist survey summary

Survey Methodology

In spring 1999, the KU Health Policy Research Group mailed a questionnaire to all dentists identified by the Kansas Dental Association as Kansas practitioners. Except for dentists with out-of-state addresses and those associated with military bases or veterans hospitals, the sample was as close to universal as possible. The final sample of n=1337 included general practitioners, pediatric dentists, public health dentists, oral surgeons, and other specialists. However, those specialists who have little or no contact with Medicaid patients, i.e., orthodontists, endodontists, periodontists, etc., were asked only to indicate their area of practice and return the form without completing it.

Because the intent was to measure perception as well as practice, providers were asked to respond whether or not they actually had any experience with the Medicaid program and whether or not their experience was current. For those areas in which they did not feel knowledgeable enough to answer, they were instructed simply to skip the question. Retired or nonpracticing dentists were not excluded from the sample, although all but one of the respondents (n=34) declined on the grounds that they had limited knowledge of the current Medicaid program. Dentists with multiple practice sites were asked to answer the questions in the survey as they pertained to their primary practice location.

The eight-page instrument, replicated from a Missouri study conducted in 1998, asked about the dentist's participation in, and opinions of, the Kansas Medicaid dental program for children as well as current treatment protocols for all children in their practice. Questions covered issues commonly believed to be problematic for Medicaid providers: the severity of dental disease, patient noncompliance with treatment and appointments, satisfaction with reimbursement levels and program administration, concerns about being able to deliver quality care, reasons for participating/not participating, and the effects on their practice of treating Medicaid patients. The questions were framed in multiple choice and Likert-scale formats, with a section for general comments at the end of the questionnaire. Providers were informed that the survey was confidential (the instrument was marked only with a number to allow for tracking and follow-up mailings), but a few demographic questions were asked to facilitate analysis by subgroup. Several respondents signed their questionnaire (although no space was provided for a signature) and even invited follow-up phone calls.

Preparation for engaging provider cooperation began well before the mailing of the questionnaire. An article in an issue of the KDA journal announced the survey and encouraged participation. In mid-January, a postcard was sent out to all dentists in the state announcing that they would be receiving a survey and the reasons for the survey. The postcard was signed by KDA executive director Kevin Robertson and UMKC assistant professor Michael McCunniff, DDS, MS, the questionnaire's author and Principal Investigator of the Missouri survey. The instrument was mailed January 29, with a cover letter also signed by the two, and yielded an immediate response rate of 22.2% (297 forms) within the first week and 33.1% (443) within the first month. A follow-up, second mailing on March 5 produced an additional 14.1% (189) responses, for a total response rate of 47.3% (632) by April 5, the survey cutoff date. Of these 632 questionnaires, 597 (94.5%) were completed, 34 (5.4%) were returned blank by retired or

inactive providers, and 1 (0.2%) was returned blank with no explanation. Three of the completed surveys proved to be Missouri practitioners with Kansas mailing addresses and were eliminated, for a final total of 594 completed questionnaires (response rate of 44.4%).

The completed questionnaires further broke into two groups: those completed by the primary survey group, with all variables answered (n = 516), and those completed by specialists with who were only to indicate their area of practice (n = 78). Despite the latter instruction, 12 other specialists and one retired practitioner actually completed at least some portions of the form, for a total of 529 completed forms (response rate of 39.6%). These questionnaires were the basis of the analysis included in this report.

Descriptive analysis

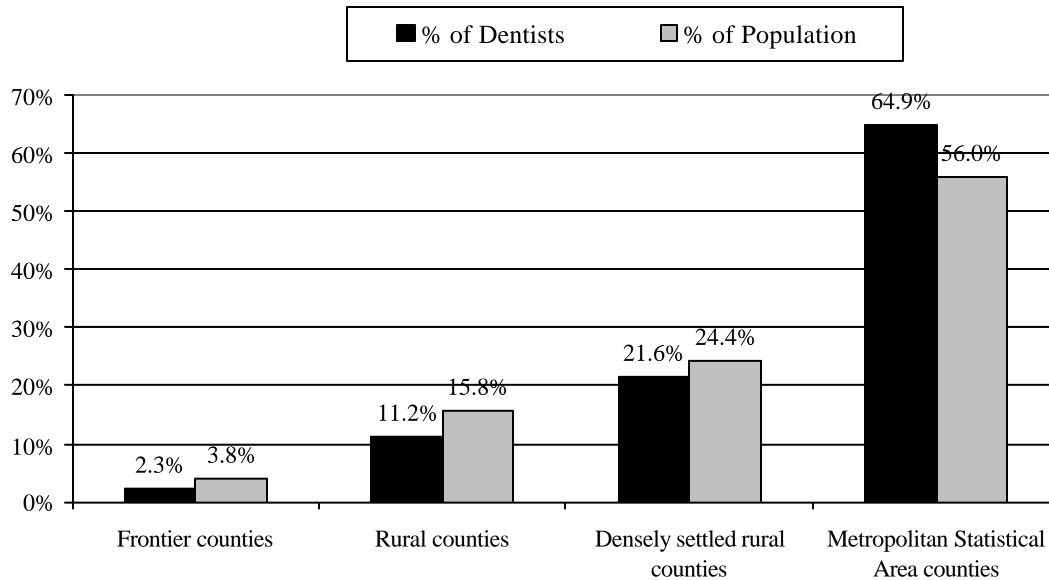
The data collected through a survey of Kansas dentists were collected to answer three questions: 1) "What does the dental community in Kansas look like? 2) What do Kansas dentists think about the Kansas Medicaid dental program? and 3) What distinguishes those who serve Medicaid beneficiaries from those who do not?" The first question includes the location of dentists within the state, their areas of practice, their extent of practice, and their status as a Medicaid provider or non-provider. The second describes dentists' relationships with, and attitude towards, the Medicaid dental program and its beneficiaries. It includes dentist's views on problems with the program, fee and reimbursement issues, services provided to children, and service access. The third compares dentists who participate at different levels in Medicaid with those who do not. The purpose of this area of inquiry is to investigate how greater participation in Medicaid might be enhanced.

Please note that the survey yields much more data than can be reported here. A summary of the data frequencies is in the appendices for those who seek more detailed information.

Kansas Dentist Array

Dentists in Kansas tend to be located where the population is, although there is an under-representation of dentists in frontier and rural areas (Chart IV.1). These data reinforce the findings that large scale Medicaid dental providers are much more prominent in urban than frontier and rural areas of the state. Rural Medicaid beneficiaries' problems in accessing dental specialists would appear to be even greater.

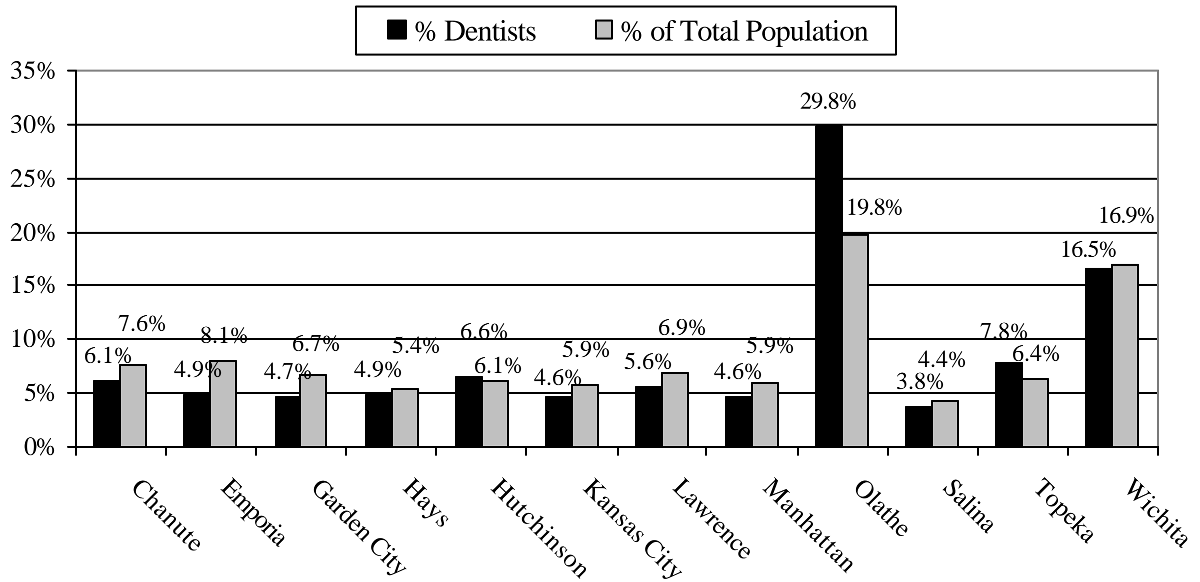
Chart IV.1 Locations of Dentists
Relative to Population



Not too surprisingly, the majority of dentists practice in either metropolitan or densely settled rural (86.5%) areas, with only 13.5% in rural or frontier counties. The implications for dental health, however, are that not only are most dentists in urban areas, but so also are Medicaid providers and dental specialists. In rural areas of the State the important factor is the availability of Medicaid dentists, specialists, and/or dental hygienists (in the absence of services by dentists) within reachable distances for specific care issues and basic dental services.

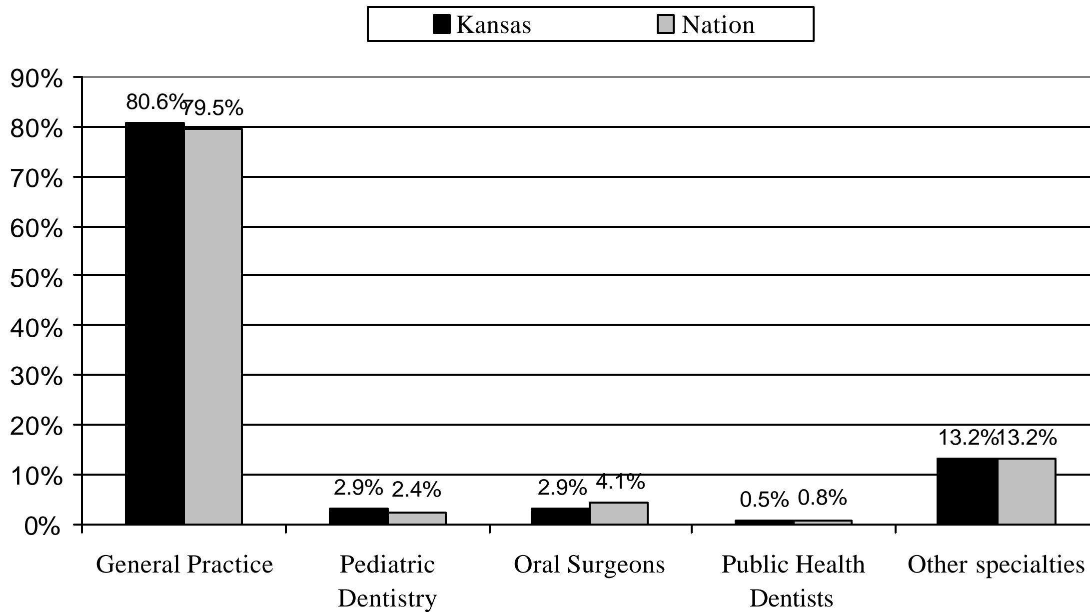
Another way of showing this rural/urban split is by SRS administrative region. As Chart IV.2 demonstrates, not only does the Olathe region (Johnson County) have the largest concentration of dentists in the state, it also has a disproportionately large share relative to the population. One other urban area, Topeka, also has a relatively high concentration, while Kansas City and Wichita both have relatively lower concentrations (though in the case of Wichita, the difference is slight). The relationship between the presence of dentists and Medicaid access to dentists is not a clear one. Although the presence of dentists does not mean that Medicaid beneficiaries have access to them, a relative *shortage* of dentists is likely to exacerbate access problems since dentists already have full caseloads. Interestingly, we saw in Chart II.2 that Kansas City and Wichita were the only two SRS regions where more residents left the region for service than were served there (0.3% out-migration for Wichita and 0.7% for Kansas City).

Chart IV.2: Location of Active Kansas Dentists Compared
to Location of Total Population
(n=1151, does not include "other specialists")



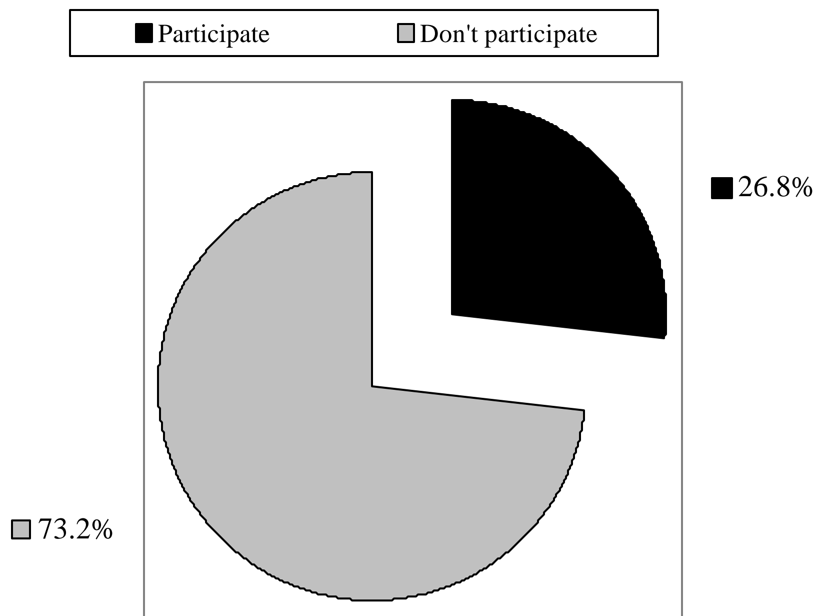
Most (80.6%) dentists report that they are in general practice (Chart IV.3) and practice alone (71.7%) (Chart IV.7). These data are significant for a number of reasons. The problem of access as reported by the survey of dentists and reinforced by the focus groups suggests that a major problem in access is the paucity of staff in a solo practice to deal with administrative and reimbursement complexity. In addition, solo practice dentists have less ability to offset low reimbursement to other payers. The percentage of dental specialists is a problem in the state because of the unmet demand. Solo practice dentists cite the difficulty in getting access, in a timely fashion, to specialists, especially pediatric dentists.

Chart IV.3 Dentists by Practice Type
(Survey Respondents Only, n= 591)
(source of national data: American Dental Association)



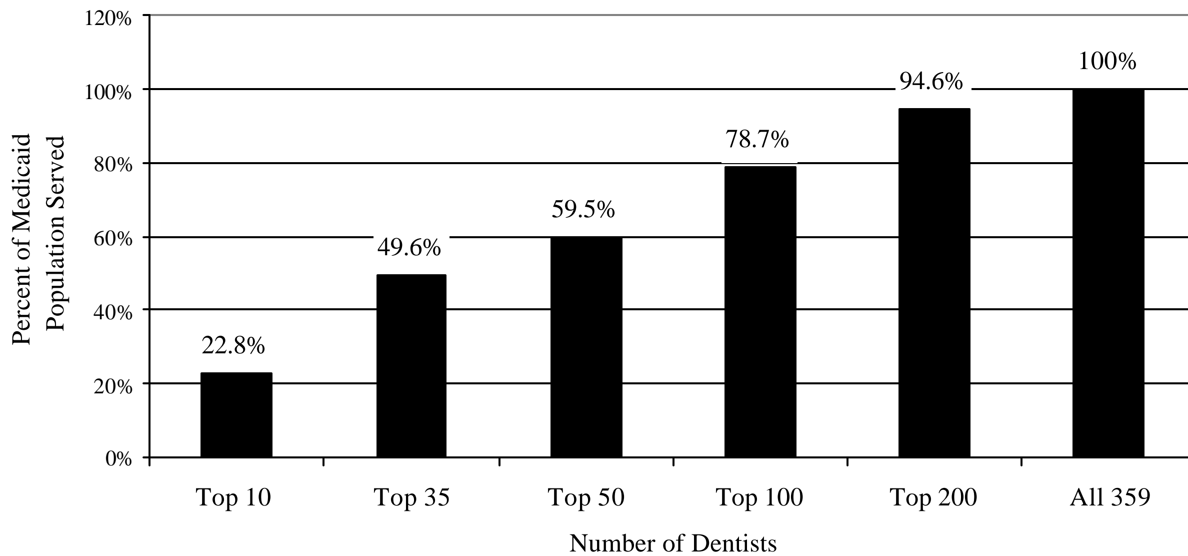
Only a minority of dentists participates in Medicaid. This proportion is in keeping, in general, with other state participation rates. The reasons why many dentists do not participate in Medicaid will be explored later in Part IV. The small percentage of providers is, in turn, an even smaller number because of the tiny fraction of dentists who serve a disproportionate share of Medicaid beneficiaries (just under a third of the 330 dentists who participate serve 80% of children). This relatively small number of providers suggests a significant dimension of the problem of children's access to Medicaid services.

Chart IV.4 Proportion of Kansas Dentists
Who Participate in Medicaid
(n=1151, does not include "other specialists")



Relatively few dentists are involved in the care of Medicaid children. Among those who have Medicaid provider numbers, those who serve the bulk of Medicaid children are disproportionately small in number and tend to practice in urban areas. As illustrated, thirty-five dentists serve half of all the Medicaid children in the state. Two hundred serve virtually the entire population (95%).

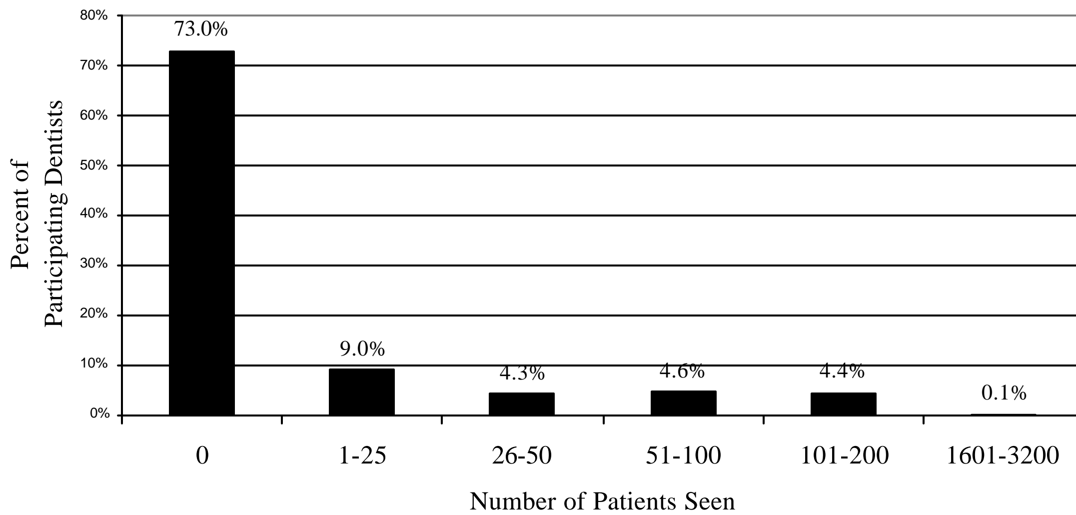
Chart IV.5 Number of Dentists Serving Child Medicaid Beneficiaries (FY98)



(Note: n=359 includes 29 out-of-state dentists)

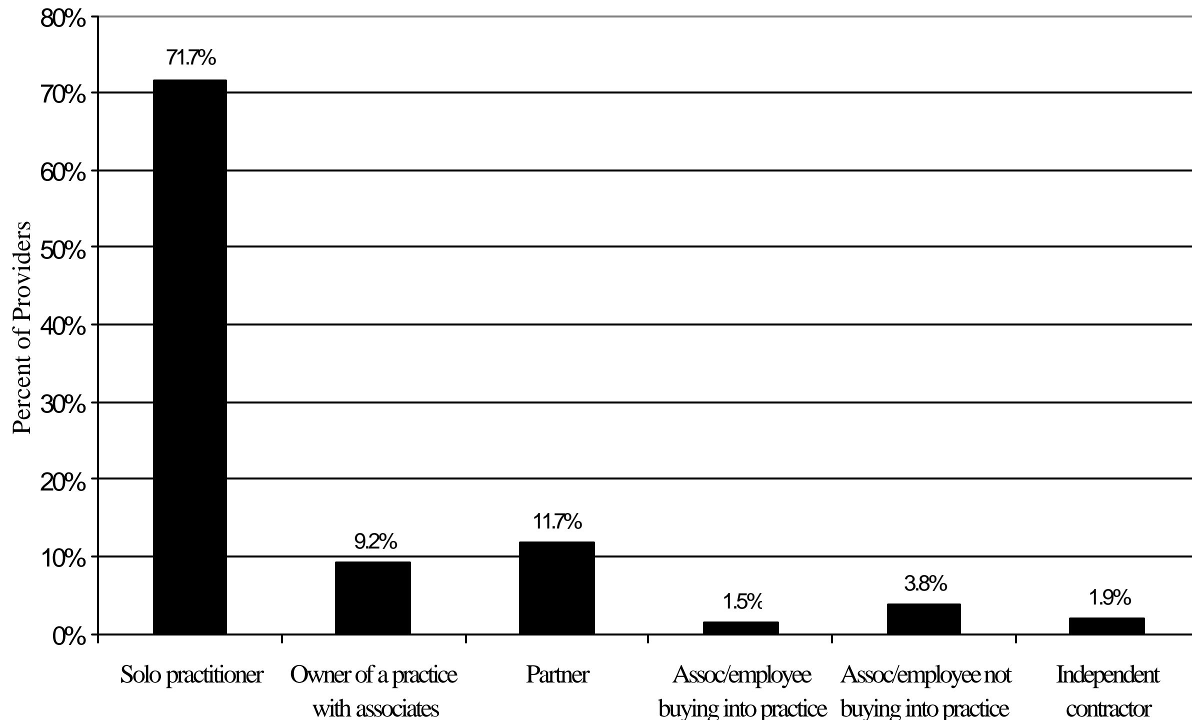
It is interesting to look at how the caseload is distributed among the Medicaid dental providers in the state (Chart IV.6). The vast majority of dentists have relatively light caseloads of Medicaid children. Of the 330 Kansas providers, the median caseload was 41 Medicaid patients. The mean was 111, although it is skewed by a small number of large-volume providers, the top three of whom saw over 1,000 patients.

Chart IV.6 1998 Caseload Size of Kansas Dentists Participating in Medicaid (n=330)



Dentists by a clear majority suggest that more dentists would participate in Medicaid if reimbursement were closer to one-hundred percent of the usual and customary rate. Dentists who participated in focus groups were more optimistic that an increase in rates would increase participation. However, past experience with rate increases suggested that they have had marginal effects.[4]

As Chart IV.7 shows, dentists are overwhelmingly in solo practice (71.7%), which contrasts sharply with physicians, who left solo practice for group practice 35 years ago. The implications of a solo practice pattern tend to be twofold. Dentists have to bear administrative and other overhead costs on their own, with little ability to cost shift. Dentists in solo practice also are very concerned with any change that impinges upon their independence and prerogatives.



[4] It should be noted that the decrease in dentists participating in Medicaid after SRS increased the reimbursement percentage of usual and customary to 50% in 1997 was greatly affected by another factor. SRS changed fiscal intermediaries, and BCBS purged a number of dentists from the participating list because of inactivity.

Medicaid Views

The views of Kansas dentists concerning Medicaid might best be compared by dividing dentists into groups according to whether or not they serve Medicaid beneficiaries and, within the latter, into subgroups according to whether they serve low, medium or high numbers of Medicaid beneficiaries. Since the designation of what constitutes “low, medium and high” is subjective, the categories were derived by dividing the total number of Medicaid providers into approximately three equal groups. By arraying the caseload size in numerical order and setting the cutpoint at the case size of the first third (120 dentists), the first group consists of dentists with 1 to 20 patients (2% of 1998 total Medicaid beneficiaries), the second 21 to 90 patients (14 of 1998 total Medicaid beneficiaries), and the third at 91 patients and above (84% of Medicaid patients) (see Table IV.1). While the two lower categories might seem to be set unusually low, they can be justified by the fact that two-thirds of all Medicaid providers fall within those ranges. In fact, the median caseload size was 41, meaning that 50% of all Medicaid providers saw 41 or fewer Medicaid beneficiaries.

Only 197 of the 330 Kansas Medicaid providers returned questionnaires (37.2% of total questionnaires received). Therefore, data are available only for a sample of participants from each provider level. (The sample sizes were 53, 64, and 80, respectively.) The remaining 332 dentists who responded to the survey (62.7% of total questionnaires received) were not Medicaid providers. The responses of these four groups to key survey questions are provided in Table IV.1 that follows.

Table IV.1 Characteristics of Dentists Serving High, Medium, and Low Volumes of Medicaid Patients and Those Not Serving Medicaid Patients*
(answers reflect survey respondents only, n=529)

	No Medicaid Patients (n=332)	Medicaid Providers: Low (1-20 patients) (n=53)	Medium (21-90 patients) (n=64)	High (91+ patients) (n=80)	Signifi-cant
Median years practice at current location	15 years	14 years	18 years	13 years	NS
Solo practitioner	71.3%	59.1%	74.2%	78.5%	NS
Previously a Medicaid provider	45.7%	N/A	N/A	N/A	N/A
Believe Medicaid patients in office make other patients feel uncomfortable	18.2%	22.2%	21.0%	22.8%	NS
Feel their professional judgment is respected by the Medicaid program	22.4%	33.3	40.3%	50.6%	p < .000
Believe Medicaid patients' oral health problems are more severe than those of their other patients	57.9%	77.8%	67.7%	60.8%	p < .003
Believe dentists cannot impact policies of Medicaid program	57.9%	55.6%	58.1%	62.0%	NS
Say low fees are the most important problem with the Medicaid program	35.5%	22.2%	27.4%	21.5%	p < .000
Say broken appointments are the most important problem with the Medicaid program	18.3%	17.8%	25.8%	34.2%	p < .000
Say complicated paperwork is the most important problem with the Medicaid program	18.3%	17.8%	8.1%	8.9%	p < .000
Believe Medicaid children will get care even without program	31.2%	8.9%	3.2%	2.5%	p < .000
Dentists have an ethical obligation to treat Medicaid patients	18.2%	42.2%	58.1%	57.0%	p < .000
Recommend greater public health involvement as solution	29.0%	22.2%	8.1%	6.3%	p < .000
Have seriously considered eliminating Medicaid patients from their practice	N/A	89.5%	75.9%	61.5%	p < .015
Modal age recommended for child's first visit to dentist	3 years	3 years	3 years	3 years	NS

*Categories were constructed by dividing all dentists filing Medicaid claims in 1998 (n=359) into three equal-sized cohorts. Only cohort members who responded to the questions are included in the table (n=197).

Discussion

Dentists' responses were compared using statistical tests to detect significant differences in attitude between different levels of providers. Significant differences were found between groups on several survey questions.

A number of these findings are difficult to interpret because they could be either a cause or effect of not participating in the Medicaid program. For instance, more medium- to high-volume providers say that the Medicaid program respects their professional judgment, possibly reflecting a more positive view of the program and, therefore, a greater willingness to participate—or possibly reflecting a more positive past experience with the program. More nonparticipants said that low fees are the most important problem, possibly accounting for their unwillingness to become a participant, or possibly reflecting a negative past experience—46% of nonparticipants previously participated.

Other relationships can be more easily explained. For instance, high-volume providers rated broken appointments as the most important problem. They are the group most likely to have experienced this problem and also the group that stands to lose the most revenue. Low-volume providers, on the other hand, say that complicated paperwork is most important. They are the group likely to be least familiar with claims procedures or to have electronic claims submission. Dentists with greater patient volume were also more likely to favor a fee-for-service reimbursement scheme over a public health plan, possibly reflecting their greater familiarity with the present system and also, for a small number, the potential loss of revenue.

Also remarkable is the contrast in views between participants and non-participants about the role of Medicaid in providing dental access to low-income persons. A much larger proportion of non-participants said that patients will get care even without the program, and they overwhelmingly disagree that they have an ethical obligation to provide Medicaid services ($p < .000$). Most alarming is that a majority of providers in all three categories (62 to 90 percent) had "somewhat to very" seriously considered eliminating Medicaid from their practice in the past year, although the frequencies declined with increasing patient volume.

The only issue upon which there was virtual consensus was the recommended age for the first dental visit of 3 years. Because of the latter finding, we eliminated all children under age 3 from the beneficiary survey needs analysis as being too young to need most dental services. However, there is still a need to target very young children for early screening and prevention.

Analysis

The picture of the access problem that can be drawn from the survey of Kansas dentists has been concentrated on where dentists are in the State and who tends to provide most of the dental care to Medicaid children. According to SRS records, 676[5] of Kansas' 1151 primary practice[6] dentists have Medicaid provider numbers. However, as

[5] Unduplicated totals. Over 800 are on the books; however, many providers have multiple numbers for different practice sites. In addition, some out-of-state providers have practice numbers.

[6] Includes only general practice, pediatric, public health, and oral surgery dentists who responded to the survey and other active dentists who did not respond, who are presumed to be primarily in general practice. Another 78 dentists responding to the survey identified themselves as specialists (total n=1229). They are excluded from the analysis, since they see Medicaid patients only by referral. The remaining dentists who did not respond to the survey mailing were later identified as retired, inactive, deceased, or out-of-state.

mentioned before, just 330 (26.8% of primary-care dentists) provided Medicaid services in 1998. Another 29 dentists who see Kansas Medicaid patients are in adjoining states, primarily Missouri. The total number of 1998 Medicaid providers, both within and out-of-state, was 359.

Among the 359, just over 10% (n=35) served just under 50% of the Medicaid beneficiaries in the State, while 200 (60%) served 95%. Dentists tend to see the solution to improving access as a problem of attracting providers and improving children's access in the structure of the Medicaid program. More specifically, dentists define the problem as low and slow reimbursement, undue administrative complexity, unresponsive bureaucracy, and a difficult patient population to manage.

The data suggest an additional explanation. The access problem is also a function of the relatively small number of dentists who participate in the program and the difficulty that beneficiaries have in accessing primary care dentists and specialists.

Dentists did express great interest in Medicaid issues, however, through their personal participation in the survey process. 94.2% of respondents completed the eight-page questionnaire themselves, rather than delegating it to a staff member. About a third also took time to write comments. The predominant themes were economic losses associated with including Medicaid patients in their practice (discounted reimbursement levels, missed appointments); frustration with administrative procedures (unique claim forms, claims rejected for minor errors, the need for pre-approval); patient noncompliance; inability to deliver comprehensive care; and perceptions that many parents are unappreciative of their services and/or oblivious to the importance of oral care as part of their children's general health. The analysis of dentists' comments (see Appendix B for a complete list of comments) lists three predominant issues—reimbursement, paperwork/management, and patient behavior.

Over all, the comments reveal that dentists are interested in the issue of providing care for low-income populations, but there is little consensus on how best to do it.

Table IV.2 Summary of Major Themes of Dentist Comments
(see Appendix B for full text)

Positive/Suggestions	Number	**Negative/complaints**	Number
Appreciative	15	Reimbursement/funding	72
Better Education	8	Paperwork/management	70
Accept ADA form	6	Patient noncompliance	46
Expand program to adults	3	Program objectives	27
Better Medicaid cards	2	Access to specialists	10
Involve more specialists	2		
Offer tax credits	1		
Privatize insurance	1		

Part V. Summary of Dentist Focus Groups

Introduction

A series of focus group meetings for dentists was conducted around the State of Kansas in March to identify issues that affect participation in the Medicaid program. Sessions were conducted in Garden City, Wichita, Salina, Kansas City and Lawrence, with a total of 22 dentists participating.

Properly conducted focus group interviews can provide researchers and decision-makers with a rich understanding of perceptions about the issues being investigated. Unlike structured survey methods that require strict adherence to a set procedure to ensure the scientific accuracy of the results, focus group interviewing techniques are less rigid and concentrate more on revealing issues and underlying reasoning rather than on quantifying public attitudes and behavior (Mountain States Group, 1994). Focus group interaction and small size allows for discussion, exchange of information, and clarification about questions being considered.

In each of the focus groups, the facilitators began with a set of 9 or 10 questions to which the group was asked to respond. After presenting the questions, the facilitators gave each focus group member an opportunity to respond, ask for clarification, or modify the question. Through a give-and-take process, participants arrived at a consensus as to the meaning of the questions and, as defined by the group, a set of acceptable responses. The facilitators encouraged participants to provide information on their experiences, actively listened to all responses, and recorded the information as it was given. Once a question was presented, participants were given ample time to offer their observations and opinions. If participants did not respond, silence was used to elicit their comments. When silence proved ineffective, a series of probing clarifying questions was asked. Each focus group lasted between 60 and 90 minutes.

Major Themes from Dentist Focus Groups

The major themes that emerged from the dental focus groups tended to cluster into four issues.

- First, dentists say there are problems in the administration of the Medicaid program. Dentists complained that they could not get questions answered in an expeditious manner and that billing is consistently a problem. They found the pre-approval process too slow and cumbersome and, in general, poorly administered.
- Second, dentists complain that the program lacks an effective strategy to deliver comprehensive care to Medicaid children. Services are piecemeal and fragmented. There is no effective way for specialized services to be integrated into primary care that deals with unique problems too often found among children. Specialists often will not treat Medicaid children because they are not enrolled in the program.
- Third, children often miss appointments and lack follow up to dental visits. Parents are often ineffective in encouraging good dental cleaning habits as well as making sure that their children meet regularly scheduled appointments. Dentists complain that Medicaid beneficiaries don't value dental services. Dental services have a low priority compared to other health

care needs.

- Fourth, dentists see the low reimbursement rates as problematic. A common theme is that reimbursement is not worth the hassle because of the paperwork and even after the paperwork, payment is slow. Medicaid has high rates of claim denial often based on minor issues, which are maddening to office personnel. Dentists think that reimbursement should include some overhead costs as well. The reimbursement system treats dentists with suspicion.

See Appendix A for more detailed data.

Part VI. Medicaid beneficiaries survey

Survey Methodology

A telephone survey of Medicaid beneficiaries was conducted between February 15 and February 21, 1999, by the University of Kansas Institute for Public Policy and Business Research. From a sample of 9,000 families with children enrolled in Medicaid and eligible for dental services, provided by the Kansas Department of Social and Rehabilitation Services, 3,000 names were drawn through random selection. The sample included beneficiaries in 74 of the state's 105 counties, with slight over-sampling in rural areas.

The questionnaire was replicated from a mail-administered instrument used in Missouri in 1998, adapted for telephone use. The 18 questions used a multiple-choice and Likert-scale format and covered issues relevant to utilization, access to, and satisfaction with Medicaid dental services: history of care, availability of a regular provider, ability to obtain an appointment (including whether an attempt had been made), potential barriers to access (Medicaid status, transportation, work schedules, distance to provider, child's level of cooperation, etc.), perceptions of current dental needs, and rating of overall dental health. Participants were asked to answer the questions for their oldest child. Although the survey was confidential, minimal demographic information was gathered, such as number of children in the household and their ages, respondent's age and level of education, and respondent's relationship to the child for which they were answering.

From the sample of 3,000 families, 1,231 (41%) of the telephone numbers proved unusable for reasons ranging from disconnected lines to wrong numbers. Of the remaining 1,769 families, 622 (35.2%) were contacted within ten telephone calls. Of those respondents contacted, 499 agreed to complete the survey, for a response rate of 80.2%. The margin of error for the survey is less than 4%.

Descriptive Analysis

Demographics

For confidentiality reasons, little demographic data was available on the beneficiary sample. The information obtained included number and ages of children, age and educational level of respondent, relationship of respondent to the child beneficiary, and city and county of residence.

Family size was relatively small. On average, there were 2.5 children in each household, with most families having two children. The number of children ranged from 1 to 8, and the aggregate number of children represented by the 492 households was 1217. The number of adults in the household was not asked.

The children's ages ranged from a few months to 21 years, with a mean and median of 9 years for the "oldest child" about whom the survey questions were asked. Only 1.4% (7) of the 492 "oldest child" beneficiaries in the sample were over 18, while 9.6% (47) were one year or less.

Eighty-eight percent of respondents were related to the beneficiary as parents. Ten percent were other relatives, predominantly grandmothers, aunts and step-parents. The parent (or caregiver's) average age was 32.8, with a median of 31 and a mode of 27.

8.2% (39) of caregivers were under 21 and 6.5% (36) were over 50, including 7 people over 65, two over 70, and one over 80.

Twenty-one percent of caregivers (102) had completed less than high school, 38.6% (185) high school, 26.5% (127) some college, and 13.6% (65) at least two years of college. 2.1% (10) had more than a four-year degree.

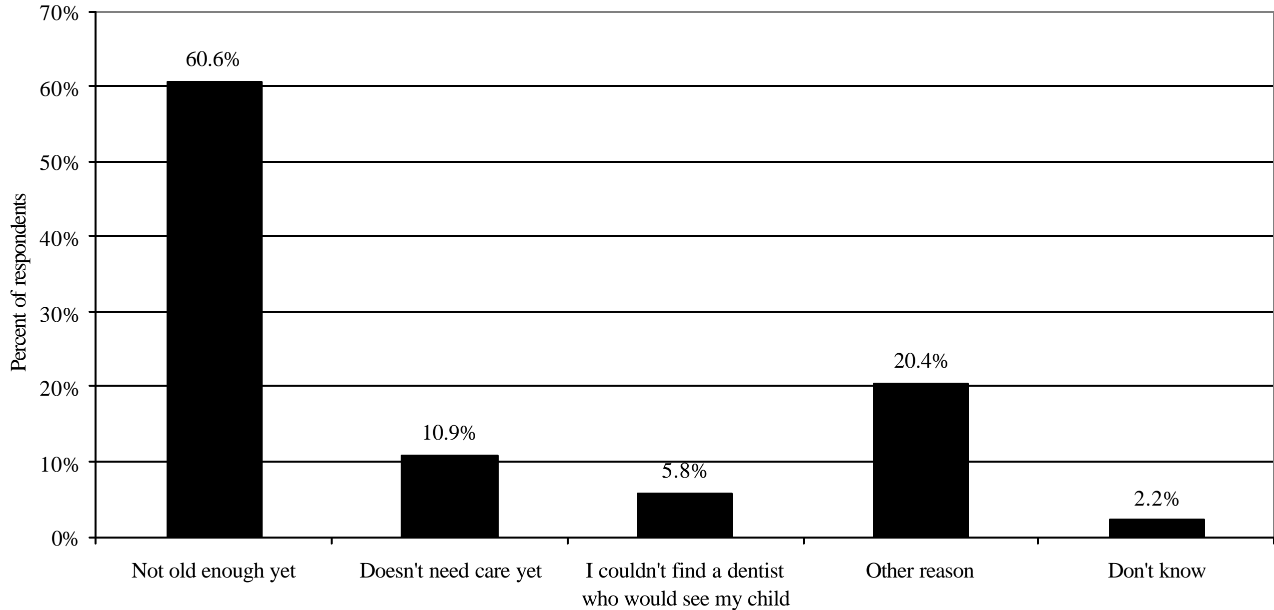
Nineteen percent (93) of the sample lived in frontier or rural communities, 35.7% (175) densely settled rural areas, and 45.3% (222) metropolitan statistical areas. Respondents represented 160 cities and towns of various sizes in all geographical regions.

Survey Content

The survey of Medicaid families with children beneficiaries was concerned with learning about the characteristics of at-risk families with children who are Medicaid dental services beneficiaries. The analysis examines several dimensions drawn from the survey: the behavior of children surveyed (e.g., how long since they've seen a dentist, do they go regularly, etc.); the parent/caregivers' views of the barriers they experience when attempting to access services; and the characteristics of the population subgroup that is most "at risk" of having access problems. This last section draws on sophisticated statistical tools, such as logistic regression, to attempt to identify risk factors and calculate the relative risk ratios. For example, a young, unemployed mother with two children under age three who is uncertain when she should seek dental care and who has had problems finding a provider may be at much greater risk of not receiving services than an employed mother with one child who has some knowledge of where to seek care.

Beneficiary behavior

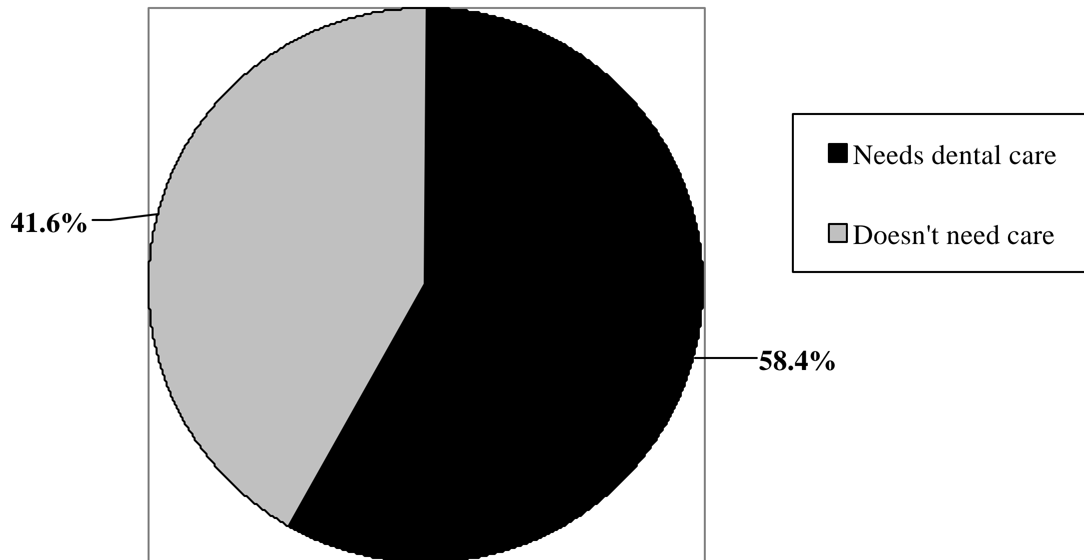
One of the prominent questions asked of Medicaid beneficiaries was about barriers to care. The most significant reason that parents with eligible children have not been to the dentist is that their children are not old enough–although there is ambiguity among parents about what age children need to make their first visit to the dentist. In the



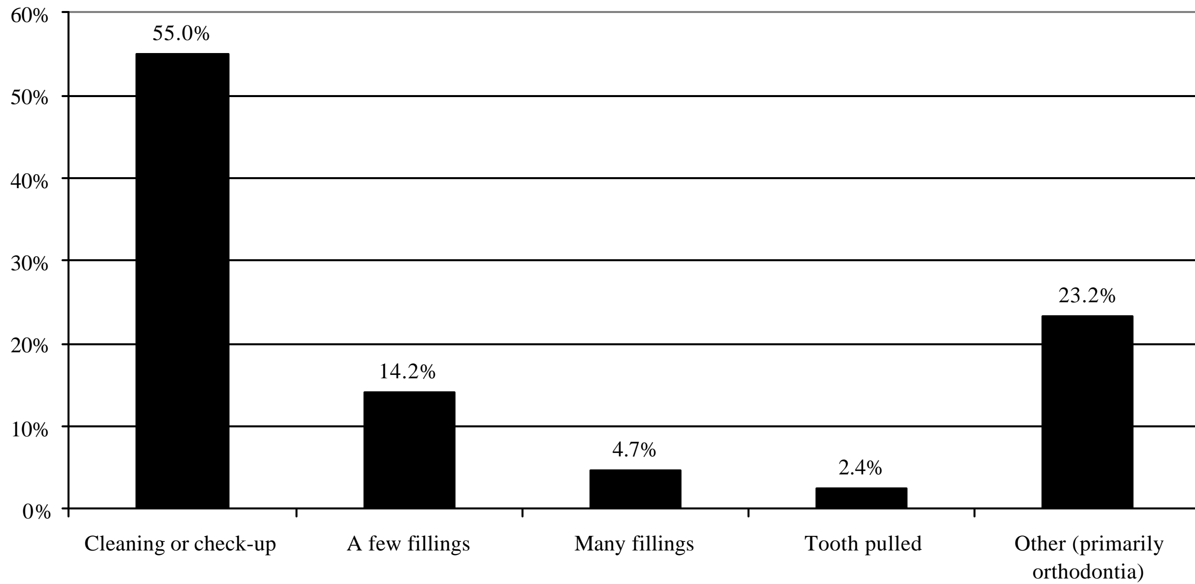
policymakers' interviews, there were questions from well-educated respondents about the appropriate time to take a child to a dentist. What this question appears to suggest is that there is a need to educate not only Medicaid beneficiaries but also the population in general on this subject.

Related to why children do not access dental care is parents' attitudes about need. The survey asked parents/others about the current dental needs of their children. The response to this question was that well over a majority (58.4%) of children currently needed care. However, this question was asked only of children who had had previous dental visits (n=350). Of the 135 who had never been to the dentist, the most common reason (71.5%) was that the parent considered them too young or not in need of care.

Chart VI.2 Do you feel that your child currently needs dental care?



As Chart VI.4 shows, for those children that caregivers consider in need of service, the type of care needed is fairly basic. The clear majority (55%) need a check-up and cleaning. These data are interesting because of their relationship to access. The greatest need is for maintenance and prevention visits, while, as reported in Table VI.1, the most significant access issue is finding a dentist who will see a Medicaid child.



Views about access

Questions about access suggest that the most serious problem facing Medicaid children is finding a dentist who will take them (31.1% have some form of problem) and waiting (29.7% faced some form of problem). Against that issue, the problems of transportation (91% not a problem), getting off work (88.7% not a problem), child afraid (83.4% not a problem), too far to trave1 (88.4% not a problem), cultural and ethnic match (96.3% not a problem), and child would not cooperate (88.6% not a problem) appear to pale.

A separate survey of HealthWave participants (Kansas' version of the children's health initiative, CHIP), found early in that project's history that 34.5% of its survey population children needed but were not able to find dental care (the highest area of unmet need).[7] This is a slightly higher percentage than found in this survey.

Table VI.1 Medicaid Beneficiaries' Problems with Access

	Some Problem	**Not a Problem**
Q10a Couldn't find a dentist who would take a Medicaid patient	31.1%	68.9%
Q10b Didn't have transportation	9.0%	91.0%
Q10c Couldn't get off work	11.3%	88.7%
Q10d Child was afraid to go to dentist	16.6%	83.4%
Q10e Had to travel too far to see dentist	11.6%	88.4%
Q10f Couldn't find a dentist of my own cultural/ethnic background	3.7%	96.3%
Q10g Had to wait to get an appointment	29.7%	70.3%
Q10h Child wouldn't cooperate for dental care	11.4%	88.6%

Problems

The survey data suggest that the issue to Medicaid children is gaining access. Once in the system, satisfaction rates rise significantly. After finding a dentist who will accept Medicaid children and waiting for an appointment, Medicaid beneficiaries are fairly satisfied with their care.

1. Health Services Research Group, University of Kansas, Survey of HealthWave beneficiaries, 1999.

Table VI.2 Beneficiary Experience with Medicaid Program					
	Excellent	Very good	Good	Fair	Poor
Q12b Satisfaction with care (n=348)	31.0%	21.0%	33.3%	10.3%	4.3%
Q12c Treated with respect by office staff (n=349)	35.8%	21.2%	30.7%	8.3%	4.0%
Q12d Overall quality of care (n=349)	33.0%	22.6%	36.1%	6.9%	1.4%
Q12e Amount of time waiting in office (n=345)	23.8%	20.3%	29.9%	21.2%	4.9%
Q12f Ability to get an appointment when needed (n=348)	26.1%	19.5%	29.0%	15.8%	9.5%
Q15 Child's overall dental health (n=469)	22.6%	22.4%	36.9%	14.1%	4.1%

These data strongly suggest that access to care is the key problem. Once into the dental health system, the quality and treatment level of care in the view of the parents/others of beneficiaries is quite high. In other words, once into the system, most beneficiaries are very satisfied with the care they receive. It is worth noting, however, that 12.3% of Medicaid beneficiaries who did not feel that they were treated with respect by dental office staff equates to a rather large number of people when considered as representative of the Medicaid population as a whole. (For 1998, the number is137,424 * 12.3% = 16,903.)

Beneficiaries are less than satisfied with gaining access to a provider and managing waiting times. The problem remains one of getting into the dental health care system.

Risk Ratios

Risk analysis is a way of asking which beneficiaries are most likely to be at risk. A risk analysis to determine which demographic factors were associated with greater risk in accessing dental services pointed to just one factor. When adjusting for family size, the age of children, and the educational level of parents, a child living in a rural area of the state faces a greater risk of having difficulty in accessing dental services than does an urban child.

What these data suggest is the importance of rural issues in dental service delivery.

Discussion and Analysis

Medicaid beneficiaries report that about a third of the time they have problems of one type or another in accessing dental services for children. The overwhelming reason for difficult in access is finding a dentist that will accept Medicaid patients. Most obtain care from private dentists and go there for primary dental care—cleaning and a checkup. Those who appear to be a greatest risk are those who live in rural areas. However lower levels of education and difficulty in understanding how to obtain access complicate this.

Part VII Summary of Beneficiary Focus Group and Pediatrician Feedback

A beneficiary focus group was held in Garden City, with 6 individuals participating. Participants included not only Medicaid beneficiaries, but also advocates and directors of medical and dental clinics. Logistics prevented us from convening the second beneficiary focus group (planned for April in Kansas City), as well as a pediatrician focus group. However, feedback was sought from pediatricians by way of a written survey and telephone interviews. From the perspective of these beneficiaries and those who work most closely with them, the following issues emerged.

- There is a serious under-service problem in the state, especially in rural areas. With a steady demand for dental services, it is difficult for dentists to be attracted to Medicaid, with its comparatively cumbersome eligibility/reimbursement procedures and unpredictable patient behavior (e.g., missing appointments). In the view of many, the dental profession is interested less in access problems and more in Medicaid reimbursement and management.
- It is difficult to identify participating providers from year to year. Only a small number of dentists accept Medicaid, they tend to limit the number of Medicaid beneficiaries they are willing to see, and they have very full practices. This creates long waiting times for an appointment.
- The stigma of being a Medicaid beneficiary deters some people from seeking care. Medicaid should be rolled into a traditional insurance package so that providers cannot differentiate beneficiaries from the privately insured.
- The state needs to inform beneficiaries about preventive dental services and how to access them. Many people do not view oral health as important to their overall health status. In the words of one participant, "Individuals do not assign the same importance to dental health care as they do to other types of physical health, such as immunizations."
- The state should create program incentives to encourage dentists to provide more preventive and educational services.
- The law prohibiting dentists who work in clinic settings from serving anyone over the 200% of poverty level prohibits clinics from becoming financially viable because there is no opportunity to cost shift. In addition, the provision of the law that requires hygienists to be under direct supervision of a dentist restricts the ability of clinics to provide basic preventive and cleaning services that are most in demand.
- In some rural areas of the State, there is very limited access to dental services and oftentimes no specialist services at all. The seeming only solution is to attract a Public Health Service Corps dentist, but they are hard to find and tend to stay only for short periods.
- An alternative system is needed in order to address the needs of many of Medicaid families. The private system cannot be relied upon to provide services, even if reimbursement rates are improved. Many solo providers do not have additional services needed by some Medicaid beneficiaries, such as bilingual reception and assistance in transportation.
- Clinics should offer extended hours to accommodate those who do not have daytime transportation or cannot get off work..

- There is always a demand for developing alternative ways of delivering health care. But there are restrictions that limit competition that tend to maintain the status quo rather than allowing the development of alternative, complementary systems. The two most prominent alternatives are the development of dental clinics and dentist extenders with greater authority to improve access to dental services.

Part VIII. Policymakers' Views

Summary of the Legislative Interviews

Legislators from both majority and minority parties with membership on Senate and House committees with jurisdiction over health related legislation or the funding of that type legislation were interviewed. In addition, the legislative research analysts staffing the health committees were also interviewed.

Each person was asked for his/her opinion on the following questions about dental care access for Medicaid recipients: Medicaid recipients in the state have difficulty accessing dental services: what are the barriers they encounter in accessing dental services; how might these barriers be minimized or eliminated; what policy approaches would reduce these access barriers? Those interviewed acknowledged that barriers existed that prevented children with Medicaid coverage from accessing the dental care services included in the benefit package. Those interviewed stated that prevention and dental health promotion services were the category of dental services most underutilized. This underutilization was attributed to a variety of factors, including failure of parents to seek dental care for their child, unwillingness of dentists to provide services to Medicaid beneficiaries, and at times an inhospitable environment. Most respondents indicated that they perceived the supply of dentists to be adequate but that the distribution statewide could be a barrier to access, particularly in sparsely populated counties. The required paperwork was repeatedly mentioned as being a deterrent to increasing provider participation.

Several of the legislators noted that this issue lacked visibility within the legislature, with the majority of members having limited understanding of the problem. Policy solutions suggested by legislative respondents sorted into three primary categories: provider workforce, delivery of services, and payment mechanisms.

- Increases in provider workforce: Increase the pool of dental hygienists through expansion of training programs. Dental hygienists can provide preventive care under the supervision of dentists but in locations physically disparate. Develop reciprocal educational slots with states having dental schools and allocate those to individuals willing to provide care to the underserved population for a stipulated period of time.

- Delivery of services: Provide grants to startup clinics to provide dental services to the indigent and modify the dental practice act to allow employment of dentists in these grant supported clinics. Improve the delivery of dental services to Medicaid clients in ways utilized in the Health Wave program via contract community grants to foster local solutions to improve access to dental services. Expand the educational campaign for beneficiaries to emphasize the importance of dental health care and patient responsibilities in acquiring services

- Payment: Provide mechanisms to improve the dollar amount paid for preventive services.

A state approach that seems to be working in California employs a tiered reimbursement plan with the first $400 per beneficiary going for a bundled group of

services (cleaning, sealants etc.) and allows up to $400 for restorative care. Dentists receive payment for this tier of services at 80% of the reasonable and customary rate. Restorative costs exceeding $400 would require preauthorization. Total dental costs up to $1000 would be paid at the 80% rate and for costs exceeding that annual amount the reimbursement rate would be at 60% of the reasonable and customary rate. Eligibility for dental care to include indigent adults.

Summary of Association Interviews

Improving dental care for children has an appeal to the Legislature. Right now the Legislature is sympathetic to children's issues, although the initiative for change might be well received if it comes from a third party rather than from the dentists. Part of the reason the Legislature is interested in dental services is because it is an efficient use of state dollars in delivering beneficial services that are effective…"it is good bang for the buck." The problem of underservice is a real problem and one that needs to be addressed realistically. One way to address the problem is to bring dental services to children through other means, schools as one answer. At least, the schools ought to be a place where kids can get fluoride treatments or rinses. EPSDT's screening requirement for kids might include licensed day care centers. A significant issue is how to staff these clinics. Dentists will be concerned because they want to maintain the independent practice model and thus are not receptive to the possibility of losing patients. But dentists, at the same time, want to be part of the solution. There would appear to be sufficient leverage to serve as the basis for a compromise—on hygienists, for example. It is critical that the dentists are involved in any change.

Another issue is education. Dentists need to do a better job of educating the public as to when is an appropriate time for children to visit the dentists. Parents need more information about when to schedule a visit and what problems to look for. A related issue is educating parents that dental services may be less urgent but they are no less important. If there are compelling data that suggest that there is a problem in the supply of dentists, there could be some interest in the Legislature, but it would all depend on cost. In addition, if it were an issue that is part of the development of primary care in the State, it would be well received.

The issue of fluoridation is probably better received now than in the past, although it is still a local control issue and will need local support.

Summary of Government Interviews, Including Kansas Medicaid Officials

Medicaid officials in Kansas characterize current Medicaid child access to dental services as "poor." The common theme that emerged from interviews was the frustration in finding a way to address the access problem. Dentists are a difficult group to entice into the delivery system in part because of their practice in non-group arrangements and their inability to shift overhead and treatment costs of the uninsured onto other payers. (Spisak and Holt, 1998).

When asked to provide explanations of low access, Kansas Medicaid officials cite the following:

- Inadequate provider supply, which is driven in part by the absence of a dental school in the state, by the fact that in Kansas, most dentists can "pick and choose patients," and by the absence of a "charity" care interest, relative to other providers.

- Low reimbursement rates. As of 1997, Kansas reimburses dentists at 50% of the usual, customary, and reasonable (UCR) dental fee rates (up from 28%), but most officials note that there has been minimal increase in provider to patient ratios since the rate increase.

- The stigma associated with Medicaid patients and the frustration of dentists with Medicaid patients who fail to keep appointments.

These explanations for inadequate Medicaid dental utilization rates are consistent with those offered by other states and by national Medicaid officials. On a positive note, officials seem satisfied with the quality of care offered by those dental providers who do offer care to Medicaid patients.

The state legislature appears to demonstrate minimal interest in the access issue. One official notes that a few dentists are complaining about reimbursement rates, the Medicaid provider application and renewal process, and other Medicaid issues.

Officials seem to be particularly discouraged by responses to a recent SRS mailed request that all Medicaid dental providers update information such as their provider tax ID#, contact information (address, phone number), etc. One quarter of the queried providers failed to respond to the information request, prompting state officials to speculate that these non-respondents may no longer be willing to provide services.

State Medicaid officials maintain regular communication with the Kansas Dental Association, and the state's Medicaid fiscal agent – Blue Cross Blue Shield of Kansas – engages in ongoing efforts to recruit and maintain dental providers. However, interviews with state officials give rise to the impression that these communication forums (meetings with state provider representatives) are a source of ongoing frustration to both state officials and providers.

Potential Solutions

Interviewed officials seem to concur that the Child Health Insurance Program (CHIP, or *HealthWave* in Kansas) might induce more dentists to provide services to Medicaid children. They note that *HealthWave* managed care plans have been "comparatively successful" in recruiting dental providers, and that the state's plan to fully integrate Medicaid and CHIP children into a "seamless program" (by July 2000) may mitigate current access problems among Medicaid children.

One of the two *HealthWave* managed care plans (HMOs) subcontracts with *Delta*, a dental plan that enrolls roughly 80% of the state's dentists. The second *HealthWave* plan also subcontracts with another dental plan. These two *HealthWave* plans reimburse dental services on a fee-for-service basis. In the view of Medicaid officials, the *HealthWave* dental reimbursement rates are probably not all that different from those paid to Medicaid dental providers. The plans may be attempting to keep the *HealthWave*

rates as close as possible to current Medicaid rates in order to maximize the potential success of the future "seamless program" approach.

Although state dental providers do provide services through *HealthWave*, they are "unhappy . . . with managed care." Nonetheless, state Medicaid officials note that "having managed care organizations manage dental [services] has helped a lot." What remains unclear is whether such an approach will be viable when plans are asked to provide dental services under a Medicaid-*HealthWave* capitation rate. Although child access problems may be better addressed by the "seamless" Medicaid-*HealthWave* program, one challenge facing the state is how to fold Medicaid dental services and *HealthWave* into one coherent program.

A variety of other potential solutions have been cited by Medicaid officials:

- Explore options designed to encourage Kansas youths to attend dental school and then provide services to state Medicaid enrollees.
- Consider selective rate adjustments. For example, provide higher reimbursement rates for sealants and other preventive services that state dentists prioritize.
- Consider the operation of a mobile dental van, which can provide services throughout the state, with a focus on remote areas.
- Use alternative funds (such as United Methodist Health Ministry funds for fluoride and sealants) for some current needs.

The views of Kansas Medicaid officials tend to reflect the conventional wisdom and the empirical evidence found in other states experiencing dental access problems for Medicaid children. In Kansas, low provider supply is driven in part by a relatively low provider to population ratio (50 per 100,000), and is exacerbated by a tradition of relatively low reimbursement rates, the absence of a state dental school, and provider reluctance to serve Medicaid patients. Although recently increased, provider dissatisfaction with reimbursement rates continues to dominate discussions between dental providers and state Medicaid representatives. The perceived "stigma" of Medicaid patients and the program's administrative requirements further suppress provider participation.

As in other states, Kansas Medicaid officials appear to rely on the potential improvements offered by managed care systems.

Summary

Common themes among policy makers are:

- Prevention that also offers cost efficiencies will be well received by the Legislature
- HealthWave offers possibilities of improved access and merits careful monitoring.
- Nothing meaningful happens without the cooperation of the dental community.
- A restructuring of Medicaid reimbursement that gives greater emphasis to prevention could be well received in the Legislature.

Part IX. Policy Options

The focus of this study is access. The research has been focused on trying to understand what factors affect Medicaid children's access to dental services. The research has been driven by the following questions:

- What dentists participate or decline to participate in Medicaid and why? What are their recommendations for change?
- Among those who do participate, what are the access problems for Medicaid children?
- How do Medicaid beneficiaries view access? What specifically are the barriers to access seen by the parent and by others?
- What changes might be possible in the program by policy makers?
- What are the successes in improving access in other states?

Introduction

The present system for providing dental services for eligible Medicaid children is not working. Roughly a third of the children seeking care are finding problems in access. The degree of the problem is confirmed by other survey data in Kansas (HealthWave) as well as research in other states. Compounding the problem is the relatively few number of dentists who participate in Medicaid. Even more indicative is the very small number of dentists (35) who are serving a majority of the eligible population. A third of dentists in the State serve less than 2% of all eligible children. As problematic is the lack of any viable way for Medicaid children to gain access to specialized dental care on their own or through a primary care dentist. Perhaps also compounding the problem is the lack of dental coverage for those over 21 and under 65. A majority of the states cover adults, which may assist in enrolling children when their parents are also affected.

The notion that an increase in Medicaid reimbursement alone will solve the problem appears to be problematic. SRS raised reimbursement in 1997 and the number of dentists participating from 1997 to 1998 decreased slightly rather than increasing. The experience that the State had in raising Medicaid reimbursement rates in 1997-98 suggests that reimbursement in and of itself is not the issue. It could be that the issue is reimbursement linked to overall administrative complexity, delay in reimbursement, or other related issues, but it appears that reimbursement by itself is not a demonstrable issue.

Medicaid children use health clinics almost as much as they use private dentists to access dental services (49% and 51% respectively). These data suggest that in addition to private dentists, there needs to be other types of provider networks to serve the children who are eligible for services. There is general support (especially by dentists in focus groups) that some new service system needs to be created to allow greater access and to forestall more serious dental problems later on. If a system were to evolve, it would also need to include access to dental specialty services in order to meet needs.

The research results suggests the following five policy options.

Policy Options:

1. **Change Delivery Structure**
   a. Creation of public health clinics
      1. Joint participation of local health departments and private providers
      2. State funded block grants, both Medicaid and public health
      3. Salaried employees
   b. Creation of extended clinic hours within private dental practices
      1. Accommodate low income persons through extended hours clinic
      2. Receipt of grant funds from Medicaid to maintain extended hours with Medicaid clients having first "priority" for these slots
      3. Improved outreach to maintain better compliance
      4. Reduced paperwork, improved management, faster reimbursement

2. **Change Reimbursement**
   a. Three tier reimbursement
      1. 100% of cost for expenses up to $400
      2. 80% of cost for expenses between $400 - $1,000
      3. 60% of cost for expenses over $1,000 per year
   b. Capitation
      1. Competitive bidding for bundled services for Medicaid clients
      2. Reimbursement that provides added incentives for prevention and promotion
      3. Actuarially sound payment estimates that have risk corridor built in during first two-three years so that neither Medicaid nor providers have complete risk
   c. Increase fees
      1. Bring all preventive services into identical payments as private payers do
      2. Selectively contract with specialists for more intensive care
      3. Case management for Medicaid clients with especially high anticipated resource use

3. **Increase Supply of Dentists and Dentist "Extenders"**
   a. Legislatively create a new dental school in Kansas
   b. Medicaid and KDHE to initiate program to provide financial incentives for dentists to practice in areas - both urban and rural – of greatest need
   c. Work with KDA and KDHE to increase recruitment of dentists upon graduation from dental school through better human resource marketing or through a scholarship that recruit graduates to underserved areas.
   d. Work with KUMC and KDA to expand telemetry to include dental services in remote or underserved areas
   e. Seriously undertake negotiations with professional organizations to identify where and how dental hygienists and technicians may have greater role in providing selected services to Medicaid clients

4. Undertake Re-engineering Process to Create New Medicaid Dental Program in Kansas

a. Medicaid to initiate process that would "privatize" services.
b. All proposals for new dental system would be solicited by bidding process and reviewed in a public forum before acceptance/enactment
c. New system could conceivably be product of consensus process
d. Administrative safeguards would be primary responsibility of Medicaid program

5. Expand Prevention and Education Efforts

a. Expand and improve visibility of dental health statewide through improved Coordination between schools, public health, and Medicaid
    1. External grant funding to promote dental health among high risk populations in state
    2. Dental screenings at schools with participation and cooperation of local health departments and local dental providers (both dentists and hygienists/technicians)
    3. Medicaid funding of dental health in school health clinics
b. Creation of an Office of Dental Health within KDHE
    1. Two .5 positions that would oversee information dissemination, assessment, policy development, and assurance functions for dental health state-wide
    2. Seed funding for these positions to be sought from Foundation support or other external funding
    3. A public health oriented dental newsletter that would be created in coordination with KDA and be sent to all dentists statewide
c. More efficient implementation of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for dental screening
    1. Use of EPSDT program to more intensively and comprehensively screen for dental health
    2. Use of EPSDT funding to provide financial incentives for dental providers to be more involved in the program.
    3. Use of dental extenders where appropriate to provide services
    4. Federal assistance in redesigning program to improve dental health based on successful models in other states

The problem of Medicaid children's access to dental services is too complex for this research to prescribe solutions. Health services research can suggest touch points but solutions depend on stakeholders' participation and consensus. The following processes are specific suggestions suggesting how the access issue can be engaged.

Policy Recommendations

1. Each of the above policy options needs to be analyzed and fully discussed in depth by a panel of experts to assess for feasibility. This panel should include representatives of Foundations, researchers, advocates, consumers, and providers (both dentists and dental "extenders"). It should be convened at the special request of the Governor's Office upon recommendation by the Secretaries of KDHE and SRS, KDA, and consumer groups and its report to provide specific recommendations.

2. Recommendations of this expert panel should be implemented by a intergovernmental task force directly reporting to the Governor's Office, with line delegation to both the Secretaries of the Departments of Health and Environment, and Social and Rehabilitation Services.

3. The United Methodist Health Ministry Fund should continue to fund information needs required to facilitate legislative activity that implements the above recommendations

4. The underlying framework on which any policy should be built should be prevention and promotion, with a special emphasis on children

5. EPSDT (Kan-Be-Healthy), because of its emphasis on prevention and promotion, should be utilized first as an administrative home to improved dental health for Medicaid children in Kansas.

6. Greater cooperation between KDHE, Kansas Medicaid, and HealthWave is necessary in order for EPSDT to be fully implemented in order to meet the needs of Medicaid children

Because the issues that affect Medicaid children's access to dental services are many and simultaneous, a policy recommendation that reflects only one dimension is fraught with problems. Effective policy change, in complicated environments like this one requires research, consensus building, and implementation on many fronts in order to arrive at solutions.

Part X. Annotated Bibliographic Citations

American Dental Association (1998). *1998 survey of state dental programs in Medicaid..* Chicago, American Dental Association, August, 1998.

A survey and highlights of a study of state dental programs in Medicaid comparing states in terms of enrollment, service array, cost sharing, and pending state legislation.

Amstutz RD, Rozier RG (1995). Community risk indicators for dental caries in school children: an ecologic study. *Community Dent Oral Epidemiol*. Jun: 23(3): 129-37.

Results of a statewide survey of NC schoolchildren suggest that a risk assessment model based on community rather than on individual variables is feasible and further refinement may reveal factors useful in identifying high-risk communities.

Celnicker, Elizabeth, Thomas Purvis and Winnie Walker (1996). *Children's Dental Services Under Medicaid: Access and Utilization*. (Washington, DC: Office of the Inspector General, 1996).

Chawla AJ, Adams EK, Graver L. (1997). Medicaid-enrolled children's access to dental care: did access increase after OBRA-89? *Abstr Book Assoc Health Serv Res:* 14: 54-5.

Program objectives of OBRA-89 to increase dental provider participation and thus increase access, were only partially achieved in three of four states studied.

Damiano PC, Brown ER, Johnson JD, Scheetz JP (1990). Factors affecting dentists participation in a state Medicaid program. *J Dent Educ.* Nov; 54(11): 638-43.

In this 1990 study, dentists identified low fees, denial of payment, and broken appointments as the three most important factors relating to participation and non-participating dentists were more concerned with broken appointments and complicated paperwork while participating dentists cited the lack of covered services as their main concern.

Fox, ML, Zimmerman, M., Hill, S., and Moore J. (1999*). The effects of a consumer health plan comparison guide on decision-making by women enrolled in Medicaid.* Lawrence, KS: University of Kansas, Department of Health Policy & Management & the Kansas Department of Social and Rehabilitation Services.

Gavin NI, Adams EK, Herz EJ, Chawla AJ, Ellwood MR, Hill IT, Zimmerman BL, Wasserman J. (1998). The use of EPSDT and other health care services by children enrolled in Medicaid: the impact of OBRA-89. *Milbank Quarterly*: 76(2): 207-50.

The authors found evidence of a significant impact on provider participation and caseloads and on children's use of preventive care and diagnostic and treatment services, but the effects were modest in terms of the mandated progress levels.

Gift HC, Drury TF, Nowjack-Raymer RE, Selwith RH. (1996). The state of the nation's oral health: Mid-decade assessment of Healthy people 2000. *J Pub Health Dent*. 1996; 56(2): 84-91.

HCFA Center for Medicaid and State Operations, *2082 Report*.

Kanellis MJ, Damiano PC, Momany ET. (1997). Utilization of dental services by Iowa Medicaid-enrolled children younger than 6 years old. *Pediatric Dent*. Jul-Aug: 19(5): 310-4.

Utilization of dental services by Medicaid-enrolled children in Iowa fall short of federal regulations, which currently require that 80% of enrollees receive EPSDT screenings, referrals, and treatment by age 3.

Kaste LM, Selwitz RH, Oldakowski RJ, Brunelle JA, Winn DM, Brown LJ (1996). Coronal caries in the primary and permanent dentition of children and adolescents 1-17 years of age: United States, 1988-1991. *J Dent Res.* 75: 631-641.

Kaye, Neva and Cynthia Pernice (1998). *Dental care in Medicaid managed care: Report from a 19-state survey*. National Academy for State Health Policy, Portland, ME. November.

Lam M, Riedy CA, Milgrom P. Improving access for Medicaid-insured children: focus on front-office personnel. J Am Dent Assoc. 1999 Mar: 130(3): 365-73.

Contrary to often-stated barriers to provider participation, the major factors affecting practices' participation are: office policy on seeing Medicaid patients, staff members' personal connection to Medicaid patients, staff-members' attitudes, and staff-members' perceptions of the patient's barriers to care.

Manski RJ, Moeller JF, Maas WR (1999). Dental services use, expenditures and sources of payment, 1987. *J Am Dent Assoc* Apr; 130(4): 500-8.

During 1987, less than 50 percent of Americans visited a dental office; they made over 292 million visits and received approximately $30 billion worth of dental care, over half of which, $17 billion was paid by insurers and Medicaid.

Mayer ML (1997). The effects of Medicaid policy on dentist participation. *Abstr Book Assoc Health Serv Res*.14: 333-4.

Policy changes intended to induce increased provider participation have little effect, however, increased reimbursement levels and demand may cause dentists already participating to increase their Medicaid patient volumes.

Milgrom P, Hujoel P, Grembowski D, Ward JM (1997). Making Medicaid child dental services work: a partnership in Washington state. *J Am Dent Assoc*. Oct; 128(10): 1440-6.

Over 80% of both general and pediatric dentists in Spokane County, Washington participated in a pilot program to provide dental care in their offices; the percent of enrolled children making at least one visit in the first year was 37% vs. 12% for those children not enrolled.

Milgrom P, Reidy C (1998). Survey of Medicaid child dental services in Washington state: preparation for a marketing program. *J Am Dent Assoc*. Jun; 129(6): 753-63.

A survey of Washington DDS found that concerns about fees and administrative aspects predominated while concerns about client behaviors were expressed less often. The DDS were willing to learn more about the program.

Mountain States Group (1994). Conducting key informant and focus group interviews. Boise, Idaho: Author.

Mueller CD, Schur CL, and Paramore LC (1998). Access to Dental Care in the United States. *J Am Dent Assoc*. Apr; 129(4): 429-37.

An analysis of 1994 National Access to Care Survey data showed that 8.5% of the population wanted, but did not readily obtain, dental care in 1994 and the findings suggest that financial barriers are significant in explaining the unmet needs.

Nainar SM (1998). Longitudinal analysis of dental services provided to urban low-income (Medicaid) preschool children seeking initial dental care. *J Dent Child*. Sep-Oct; 65(5): 339-43, 355-6.

Children four years of age and older at initial visit had greater caries prevalence, required more dental visits and incurred greater annual expenditure.

Nainar SM, Tinanoff N (1997). Effect of Medicaid reimbursement rates on children's access to dental care. *Pediatric Dent*. 19:315-316.

Nainar SM, Edelstein B, Tinanoff N (1996). Access to dental care for Medicaid children in Connecticut. *Pediatric Dent*. 18: 152-153.

National Institute of Dental Research. Oral Health of the United States Children, 1986-1987. Bethesda, MD National Institutes of Health; 1989. Publication no. 89-2247.

Rizk SP, Christen AG (1994). Falling between the cracks: oral health survey of school children ages five to thirteen having limited access to dental services. *J Dent Child*. Sep-Dec; 61(5-6): 356-60.

Category 2 children who are eligible for free school lunches, but ineligible for Medicaid coverage, have the highest caries and gingivitis scores compared to the rest of the examined children in this Indianapolis study.

Robinson, Valerie A.; Gary Rozier and Jane Weintraub (1998), "A longitudinal study of schoolchildren's experience in the North Carolina dental Medicaid program, 1984-1992," *American Journal of Public Health*, 88, November, 11: 1669-73.

Robinson VA, Rozier RG, Weintraub JA (1997). Dental caries and treatment need in schoolchildren related to Medicaid enrollment. *J Public Health Dent*. Summer; 57(3): 163-70.

Caries prevalence in over 6,000 NC schoolchildren between the ages of 5 and 18 did not differ substantially among groups; however, while the level of unmet treatment did vary, some Medicaid-enrolled children had a significant portion of their restorative treatment needs met.

Spisak, Shelley and Katrina Holt (1998), "Building partnerships to improve children's access to Medicaid oral health services," National Conference Proceedings from Conference sponsored by the Health Care Financing Administration, the Health Resources and Services Administration, and the National Center for Education in Maternal and Child Health, Lake Tahoe, NV, June 2-4.

Data from the third NHANES showed that for 10,332 children ages 2-18 years of age, lower income children and Mexican-American and African-American children are more likely to have a higher prevalence of caries and more unmet treatment needs than their higher income and non-Hispanic white counterparts.

Venezie RD, Vann WF Jr, Cashion SW, Rozier RG (1997). Pediatric and general dentists' participation in the North Carolina Medicaid program: Trends from 1986-1992. *Pediatric Dent.* Mar-Apr; 19(2): 114-7.

The study evaluating trends over a seven year period found intensity of participation, measured by mean annual reimbursement and mean number of children treated per dentist increased for both general and pediatric providers, and pediatric specialists treated a larger portion of the youngest patients over time.

Waldman HB (1997). Mid-1990's review of Medicaid and Medicaid Dentistry. *J Dent Child.* 1997 Mar-Apr; 64(2): 141-8.

A review of the evolving comparative share of expenditures spent on dental services indicates that during the 1990s, dentistry in general and within the Medicaid program holds a continuing decreasing share of expenditures.