Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

Department of Health Policy

CHILDREN'S USE OF DENTAL CARE IN MEDICAID: FEDERAL FISCAL YEARS 2000 - 2012

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TABLE OF CONTENTS

Overview

This report presents with national and state-specific analyses about dental services received by children ages 1 to 20 under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in federal fiscal years (FFY) 2000-2012. These analyses are based on data reported by state Medicaid agencies using Form CMS-416 (Form 416); all data reflect updates received by CMS as of April 3, 2014. This report focuses on the number of children who received any dental service, any preventive dental service (e.g., dental cleaning or application of dental sealants) and any dental treatment service (e.g., filling a cavity). The national trend analyses at the beginning of this report focus on dental service trends for children ages 1 to 20 over the twelve-year period. (Data about children under 1 are excluded since teeth have just begun to erupt by that age and relatively little dental care is used before the first birthday.) To facilitate meaningful comparison over the study period, numbers reported by states for FFY 2010-2012 are adjusted to be more consistent with data from FFY 2000-2009, as described below. (Note: FFY 2012 data for Connecticut are not yet available as of April 3, 2014. We used FFY 2011 data as a conservative substitute, rather than omit that state.)

Summary. The key finding is that the number and percent of children receiving dental services under Medicaid has grown continuously since FFY 2000. In FFY 2000, 6.3 million children ages 1 to 20 were reported to receive any dental care (either preventive or treatment); the number more than doubled to 16.9 million by FFY 2012. Part of the increase was due to the overall growth in the number of children enrolled in Medicaid, but much was also due to a higher percentage of children receiving dental care. By FFY 2012, nearly half (48.1%) of all children ages 1 to 20 were reported to receive dental care, compared with 29.3% in FFY 2000, more than a decade earlier.

In that same time period, the number of children ages 1 to 20 receiving **preventive** dental services climbed from a reported 5.0 million to 14.9 million, while the percentage of children receiving preventive dental services rose from 23.2% to 42.4%.

For children ages 1 to 20 who received dental **treatment** services, the reported number rose from 3.3 million in FFY 2000 to 8.0 million in FFY 2012. The percentage of children who obtained dental treatment services increased from 15.3% to 22.9%.

While there is substantial variation from state to state, overall percentages of children who receive dental care have been rising steadily for over a decade, even while the total number of children in Medicaid increased substantially.

Methodology. These data correspond to items 12a, 12b, and 12c on the Form 416 report. From FFY 2000 to FFY 2009, the instructions for reporting dental services were consistent, but the instructions changed somewhat for FFY 2010 - FFY 2012. A particularly important change was that the universe of children for whom the receipt of dental services was to be reported shifted from all children to children enrolled in Medicaid for at least 90 continuous days and eligible for EPSDT services, whereas in prior years they were reported for all children regardless of length of enrollment. To make the FFY 2010 - FFY 2012 data consistent with earlier years for the variables 12a, 12b, and 12c, we adjusted the numbers reported for the years FFY 2010 - FFY 2012 by multiplying them by the ratio of the total number of children enrolled during the reporting period (line 1a) to the number of children enrolled for 90 continuous days (line 1b). For example, Alabama reported that 75,107 children ages 10 to 14 who were enrolled for at least 90 days (line 12b) received preventive dental services in FFY 2012. In the same year, the number of children in Alabama in this age range determined to be eligible for EPSDT services (line 1a) was 134,056 and the number of those children eligible for at least 90 days (line 1b) was 128,640 – a ratio of 1.04. Multiplying the number from line 12b by this ratio produces an estimate of 78,269 children ages 10 to 14 who were enrolled for any length of time that received preventive dental services. We applied the same method to all other age ranges and summed the results to create a total estimate for Alabama and all other states. As a result, the number of children receiving dental services in FFY 2010-2012 differs slightly from that reported by states, although the percentage of children served in each state remains the same. (The national percentage changes slightly because the numeric adjustment differs from state to state and we base the national percentage on the sum of all state numbers.)

In addition, Form 416 and the reporting instructions changed in FFY 2010. Four dental lines were added to the form: 12d (sealants), 12e (diagnostic services), 12f (oral health services) and 12g (dental and oral health services). The instructions were modified to specify that services counted on lines 12a, 12b, 12c were to be those provided "by or under the supervision of a dentist." These changes could have slightly reduced the numbers of children reported on lines 12a, 12b and 12c, as states shifted to new lines (12f and 12g) for their reporting of services performed by health care professionals other than dentists or those working under the supervision of dentists. We made no adjustment for these potential changes in reporting. These differences should have the effect of slightly lowering FFY 2010 - FFY 2012 estimates (even after the adjustment we described) for dental services on lines 12a, 12b, and 12c, compared to earlier years.

The Form 416 data are subject to reporting error, like most other forms of data, but represent the most comprehensive administrative data available on this topic for Medicaid. The data include services provided under both fee-for-service and managed care delivery systems. We report results for children under age 1 separately from data for children ages 1 to 20. Data for

Maine in FFY 2003, FFY 2004, and FFY 2005 were missing; we estimated those data by interpolating the trends based on FFY 2002 and FFY 2006 reports. Data for Connecticut were not available for FFY 2012 as of April 3, 2014. Rather than omit this state, we substituted FFY 2011 data as a conservative estimate and note this in the tables. We recognize that actual FFY 2012 data may be available at a later date.

National Trends for Children: FFY 2000-2012

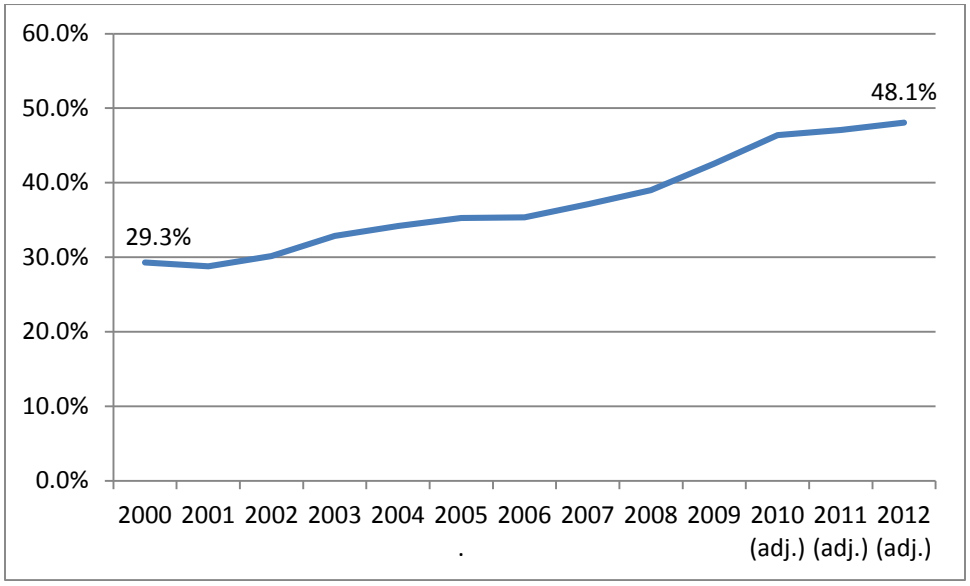
Any Dental Services. From FFY 2000 to FFY 2012, the number of children ages 1 to 20 who were reported as receiving any dental services (diagnostic, preventive or treatment) in Medicaid rose from 6.3 million to 16.9 million (Table 1). This change represents a 166% increase in the number of children receiving dental care over the study period. The average annual growth rate was 8.5%. (Again, please note that FFY 2010 - FFY 2012 data are adjusted to account for the reporting change in that year.) The change in total utilization reflects the steadily increasing capacity of the Medicaid dental delivery system to serve more children. The percentage of Medicaid children who obtained dental care rose from 29.3% to 48.1% (Chart 1).

Table 1: Children age 1-20 enrolled in Medicaid[1] who received any dental services, FFY 2000-2012

Year	2000	2001	2002	2003	2004	2005	2006	2007
# Children Who Received Any Dental Services	6,333,525	6,593,050	7,477,755	8,604,571	9,561,670	10,092,537	10,359,215	10,795,130
Year	2008	2009	2010 (adj.)	2011 (adj.)	2012 (adj.)	Average annual % growth	Overall % growth FFY 2000-2012 (adj.)	Overall % growth FFY 2000-2012 (adj.)
# Children Who Received Any Dental Services	11,634,314	13,368,421	15,419,670	16,163,601	16,851,346	8.5%	166.1%	166.1%

[1] Children enrolled in Medicaid AND eligible for EPSDT services.

Chart 1: Percentage of children age 1-20 enrolled in Medicaid who received any dental services, FFY 2000 – FFY 2012



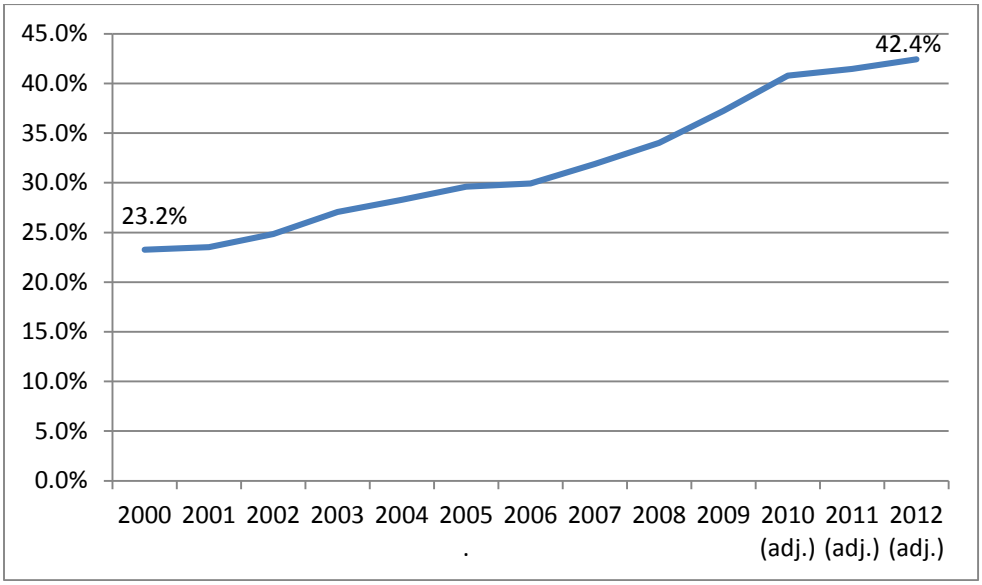
Source: FFY 2000-2012 Form 416 reports, Line 1, Line 1b, Line 12a, as adjusted by GW

Preventive Dental Services. The results are also positive for data reported about the receipt of preventive dental care. As seen in Table 2, the number of children ages 1 to 20 receiving at least one preventive dental service under Medicaid rose from 5.0 million in FFY 2000 to 14.9 million in FFY 2012 (adjusted). The number grew by 196% over a decade and the average annual growth rate was 9.5%. This represents a slightly faster rate of growth than for children receiving treatment services (see Table 3 below). The percentage of children who obtained preventive dental care climbed from 23.2% in FFY 2000 to 42.4% in FFY 2012 (Chart 2).

Table 2: Children age 1-20 enrolled in Medicaid who received preventive dental services, FFY 2000-2012

Year	2000	2001	2002	2003	2004	2005	2006	2007
# Children Who Received Preventive Dental Services	5,027,395	5,381,495	6,158,301	7,083,302	7,909,744	8,474,147	8,772,210	9,275,966
Year	2008	2009	2010 (adj.)	2011 (adj.)	2012 (adj.)	Average annual % growth	Overall % growth FFY 2000-2012 (adj.)	Overall % growth FFY 2000-2012 (adj.)
# Children Who Received Preventive Dental Services	10,142,684	11,688,076	13,557,599	14,233,675	14,874,111	9.46%	195.86%	195.86%

Chart 2: Percentage of children age 1-20 enrolled in Medicaid who received preventive dental services, FFY 2000-2012



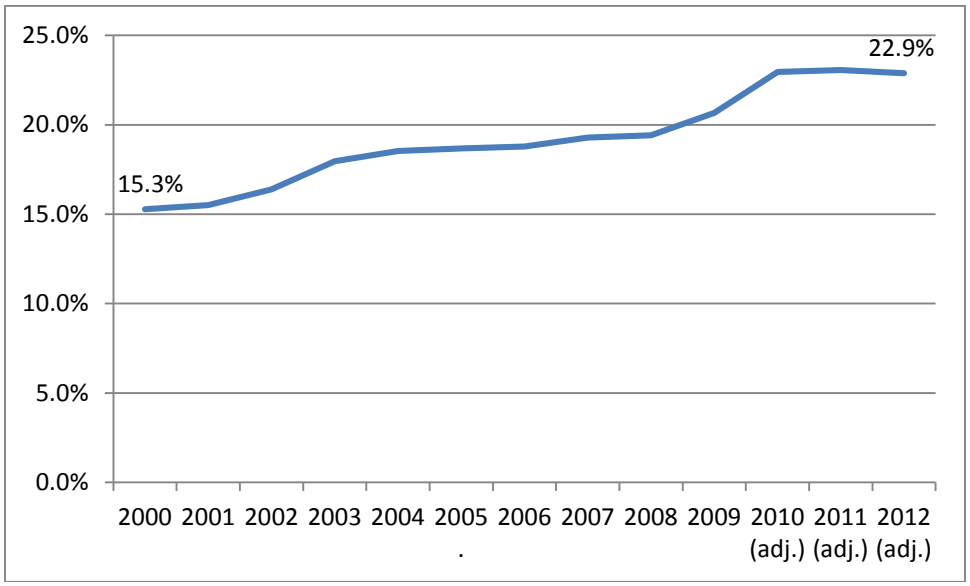
Source: FFY 2000-2012 Form 416 reports, Line 1, Line 1b, 12b, as adjusted by GW

Dental Treatment Services. Between FFY 2000 and FFY 2012 (adjusted), the number of children ages 1 to 20 who received at least one dental treatment service under Medicaid changed from 3.3 million to 8.0 million (Table 3). This represents a 143% increase over the study period. The annual growth rate averaged 7.7%. This growth rate was slightly less than the growth for preventive care. The percentage of Medicaid children who obtained dental treatment services rose from 15.3% in FFY 2000 to 22.9% in FFY 2012 (Chart 3).

Table 3: Children age 1-20 enrolled in Medicaid who received dental treatment services, FFY 2000-2012

Year	2000	2001	2002	2003	2004	2005	2006	2007
# Children Who Received Dental Treatment Services	3,303,971	3,548,745	4,062,069	4,704,768	5,186,416	5,345,997	5,506,873	5,611,363
Year	2008	2009	2010 (adj.)	2011 (adj.)	2012 (adj.)	Average annual % growth	Overall % growth FY 2000-2012 (adj.)	Overall % growth FY 2000-2012 (adj.)
# Children Who Received Dental Treatment Services	5,787,100	6,487,957	7,629,261	7,919,910	8,022,822	7.7%	142.8%	142.8%

Chart 3: Percentage of children age 1-20 enrolled in Medicaid who received dental treatment services, FFY 2000-2012



Source: FFY 2000-2012 Form 416 reports, Line 1, Line 1b, 12c, as adjusted by GW

State-Specific Data for FFY 2012

The next several pages include a state-specific table (Table 4) and charts that show data about any dental care (Chart 4), preventive dental care (Chart 5) and dental treatment services (Chart 6) received by children ages 1 to 20 on a state-by-state basis in FFY 2012. Since these data are not being used on a trend basis, we present the data as actually reported by states. Thus, the universe is for children enrolled for at least 90 continuous days in the fiscal year and the dental services are those provided by, or under the supervision of, a dentist.

The number of children receiving dental care varies widely from state to state, but some of this is because of wide differences in the total number of Medicaid children served in each state. While the overall national percentage of children receiving any dental care in FFY 2012 was 48.1%, it is noteworthy that 27 states provided dental care to 50% or more of their Medicaid children.

In FFY 2010, Form 416 was modified to collect several new elements of dental data, which are also summarized in the charts. Since these are newly reported items, states may have had greater difficulty reporting them, so they should be viewed in a preliminary sense. Sometimes it may take a few years before data are reported accurately or consistently. These include:

- The percentage of children 6-14 who had a dental sealant applied on a permanent molar (Chart 7). Almost one-sixth (14.1%) of Medicaid children in this age group were reported to have received a dental sealant nationwide in FFY 2012. Form 416 reports the unduplicated number of children, ages 6-14, who received at least one dental sealant on a permanent molar tooth, paid by Medicaid, regardless of whether a dentist or non-dentist provided the service.
- The percentage of children ages 1 to 20 who had any dental diagnostic service in FFY 2012 (Chart 8). Nationwide, about 44.1% of children were reported to have received a dental diagnostic service.
- The percentage of children ages 1 to 20 who received any oral health services by a non-dentist provider (or by a dental professional not working under the supervision of a dentist) in FFY 2012 (Chart 9). About 3.5% of children nationwide received care from a non-dentist or an unsupervised dental professional, but the percentages appeared to be much higher in a few states. Many states reported no or almost no children in this category.
- The provision of any dental or oral health service for children ages 1 to 20 by any type of provider (Chart 10). Nationwide, about 49.5% of children were reported to have received any dental or oral health care provided in FFY 2012. This is very close to the levels reported for any dental care provided by, or under the supervision of, a dentist.

Table 4: Children age 1-20 enrolled in Medicaid for at least 90 continuous days who received any dental services, a preventive dental service, or a dental treatment service in FFY 2012, by state

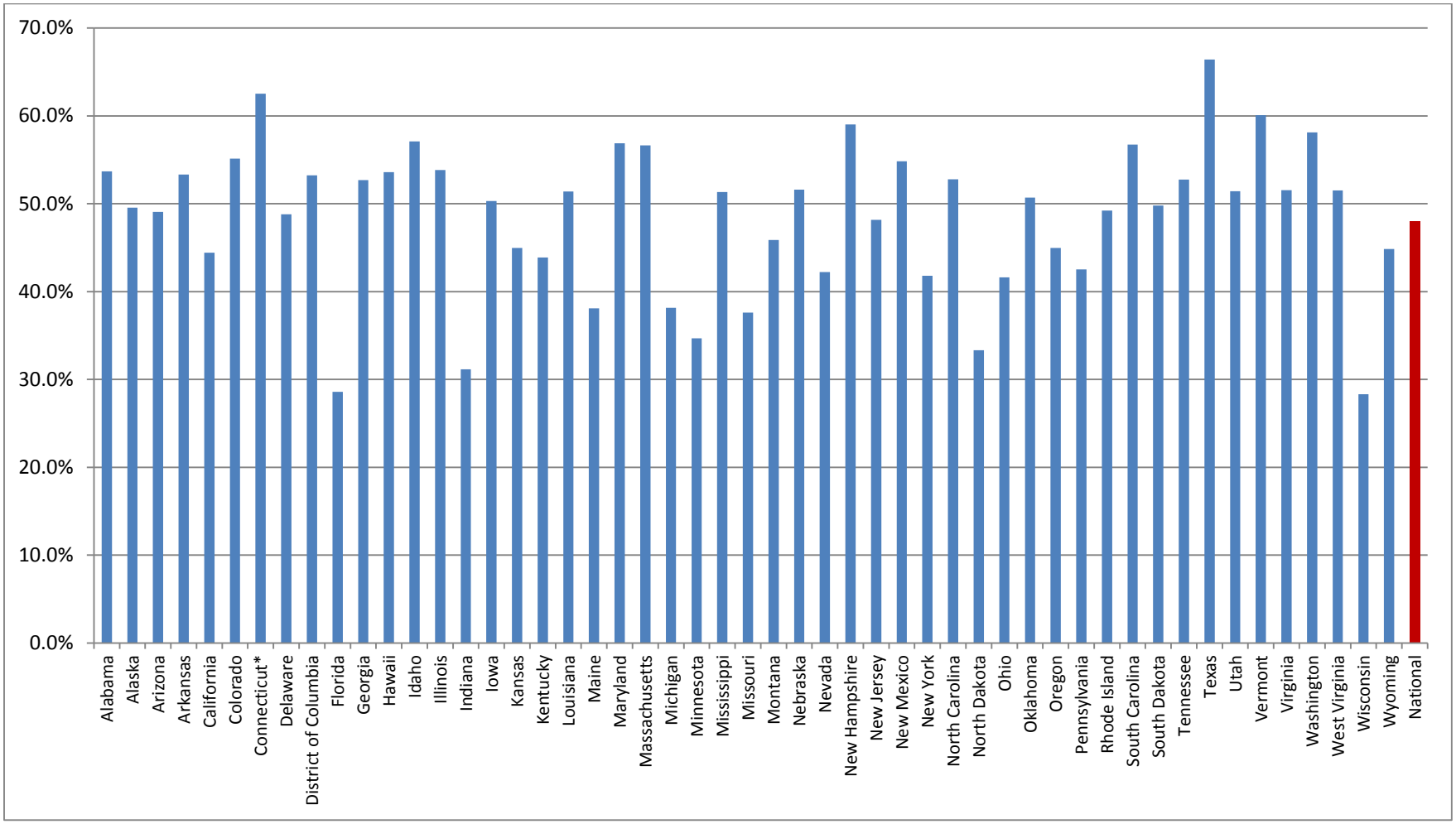
State	Total Children Receiving Any Dental Services	% of Children Receiving Any Dental Services	Total Children Receiving a Preventive Dental Service	% of Children Receiving a Preventive Dental Service	Total Children Receiving a Dental Treatment Service	% Of Children Receiving a Dental Treatment Service
Alabama	291,221	53.7%	275,595	50.8%	115,699	21.3%
Alaska	42,584	49.6%	37,510	43.7%	23,394	27.2%
Arizona	361,473	49.1%	324,674	44.1%	165,582	22.5%
Arkansas	196,567	53.3%	182,263	49.5%	98,242	26.7%
California	1,863,538	44.4%	1,516,577	36.2%	903,102	21.5%
Colorado	231,833	55.1%	214,793	51.1%	117,070	27.8%
Connecticut*	187,289	62.5%	170,942	57.1%	84,506	28.2%
Delaware	47,728	48.8%	45,055	46.1%	19,978	20.4%
District of Columbia	47,329	53.2%	42,906	48.3%	19,600	22.0%
Florida	555,399	28.6%	365,200	18.8%	200,224	10.3%
Georgia	594,443	52.7%	558,344	49.5%	263,902	23.4%
Hawaii	79,354	53.6%	60,412	40.8%	48,263	32.6%
Idaho	103,105	57.1%	95,093	52.7%	52,780	29.2%
Illinois	851,581	53.8%	798,269	50.5%	320,818	20.3%
Indiana	220,143	31.1%	195,031	27.6%	90,654	12.8%
Iowa	142,110	50.3%	128,417	45.5%	55,317	19.6%
Kansas	108,123	45.0%	101,065	42.0%	47,129	19.6%
Kentucky	213,460	43.9%	182,826	37.6%	94,805	19.5%
Louisiana	390,878	51.4%	365,767	48.1%	195,712	25.7%
Maine	46,933	38.1%	41,422	33.6%	22,537	18.3%
Maryland	332,265	56.9%	305,275	52.3%	148,240	25.4%
Massachusetts	301,620	56.6%	280,890	52.7%	163,672	30.7%
Michigan	428,139	38.2%	420,033	37.4%	176,586	15.7%
Minnesota	149,711	34.7%	129,900	30.1%	61,978	14.4%
Mississippi	193,291	51.3%	175,975	46.7%	87,060	23.1%
Missouri	229,276	37.6%	205,799	33.8%	103,494	17.0%
Montana	35,855	45.9%	31,778	40.7%	18,415	23.6%
Nebraska	80,010	51.6%	74,694	48.2%	33,994	21.9%
Nevada	93,677	42.2%	85,192	38.4%	48,385	21.8%
New Hampshire	56,241	59.0%	52,373	55.0%	22,781	23.9%
New Jersey	329,511	48.2%	302,937	44.3%	167,579	24.5%
New Mexico	189,646	54.8%	176,033	50.9%	187,595	54.3%
New York	851,338	41.8%	797,110	39.1%	391,037	19.2%
North Carolina	546,712	52.8%	504,554	48.7%	259,777	25.1%
North Dakota	14,736	33.3%	13,004	29.4%	6,530	14.8%
Ohio	535,267	41.6%	478,196	37.2%	215,099	16.7%

State	Total Children Receiving Any Dental Services	% of Children Receiving Any Dental Services	Total Children Receiving a Preventive Dental Service	% of Children Receiving a Preventive Dental Service	Total Children Receiving a Dental Treatment Service	% Of Children Receiving a Dental Treatment Service
Oklahoma	266,444	50.7%	242,596	46.2%	136,691	26.0%
Oregon	153,013	45.0%	136,200	40.0%	66,882	19.7%
Pennsylvania	476,081	42.5%	413,876	37.0%	218,008	19.5%
Rhode Island	51,383	49.2%	45,203	43.3%	21,111	20.2%
South Carolina	314,875	56.7%	301,307	54.3%	133,438	24.0%
South Dakota	40,953	49.8%	36,985	45.0%	16,293	19.8%
Tennessee	400,802	52.7%	365,974	48.2%	191,900	25.3%
Texas	2,090,606	66.4%	1,686,123	53.6%	1,084,979	34.5%
Utah	97,933	51.4%	94,916	49.8%	47,883	25.1%
Vermont	35,003	60.1%	34,400	59.1%	13,507	23.2%
Virginia	315,715	51.5%	293,851	48.0%	166,138	27.1%
Washington	436,062	58.1%	406,612	54.2%	261,570	34.9%
West Virginia	100,033	51.5%	86,760	44.7%	99,249	51.1%
Wisconsin	142,656	28.3%	129,287	25.7%	60,235	12.0%
Wyoming	23,475	44.8%	21,200	40.5%	11,953	22.8%
US Total	**15,887,420**	**48.1%**	**14,031,194**	**42.5%**	**7,561,373**	**22.9%**

Source: FFY 2012 Form 416 reports, Line 1b, Line 12a, Line 12b, Line 12c
Note: *FFY 2011 data were used for Connecticut.

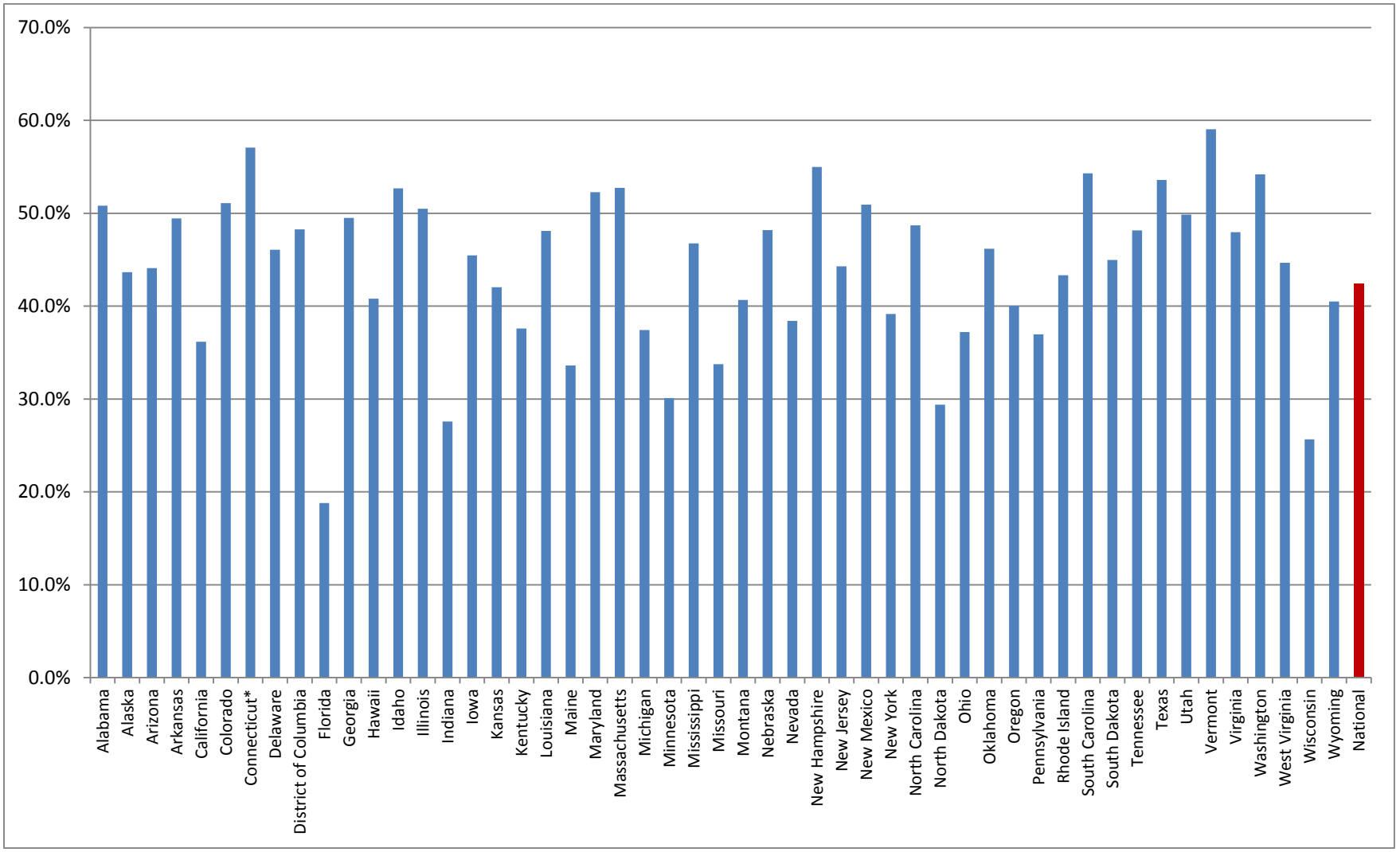
State Specific Charts—Children age 1-20

Chart 4: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving any dental services, FFY 2012



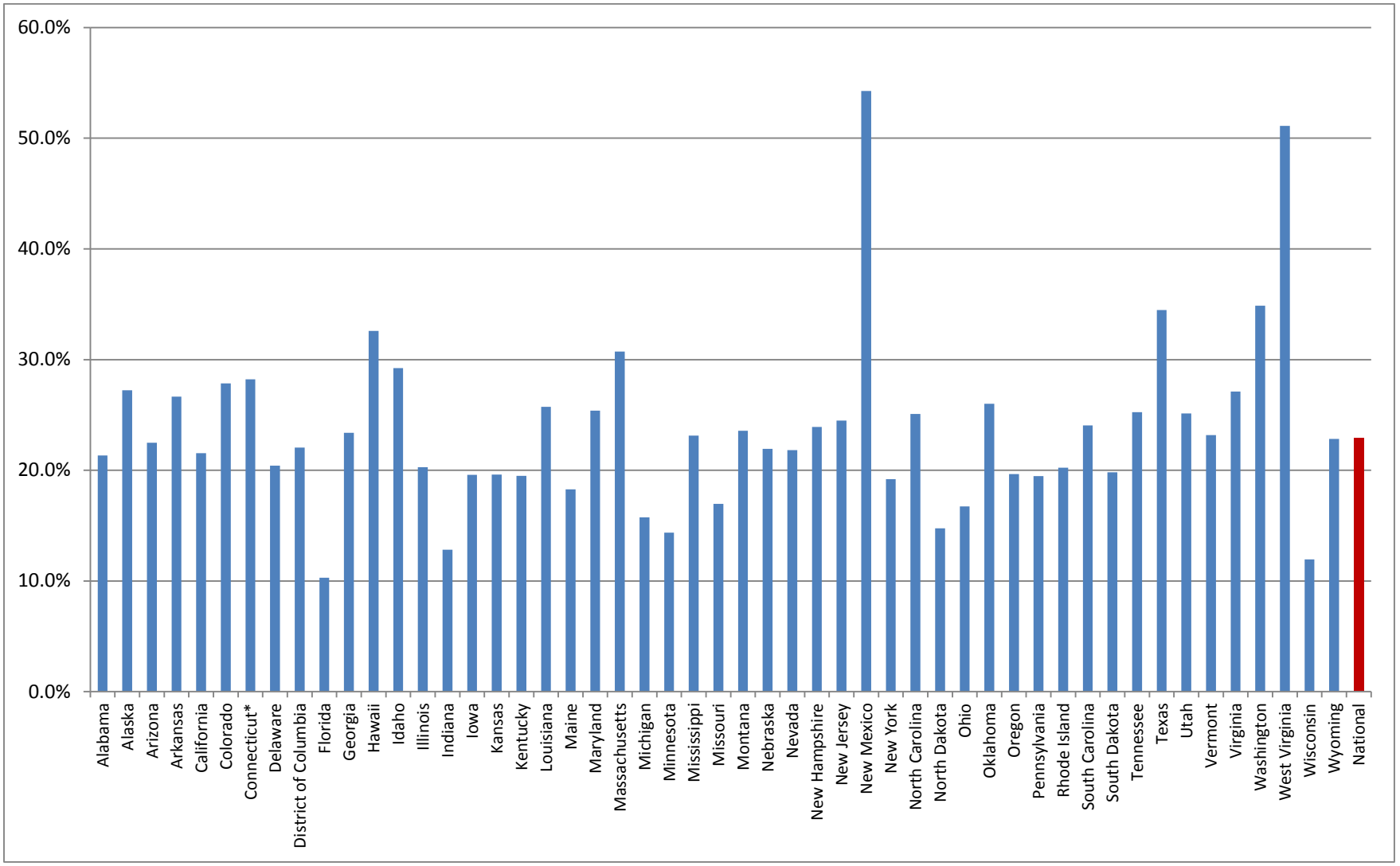
Source: FFY 2012 Form 416 reports, Line 1b and Line 12a
Note: *FFY 2011 data were used for Connecticut.

Chart 5: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving a preventive dental service, FFY 2012



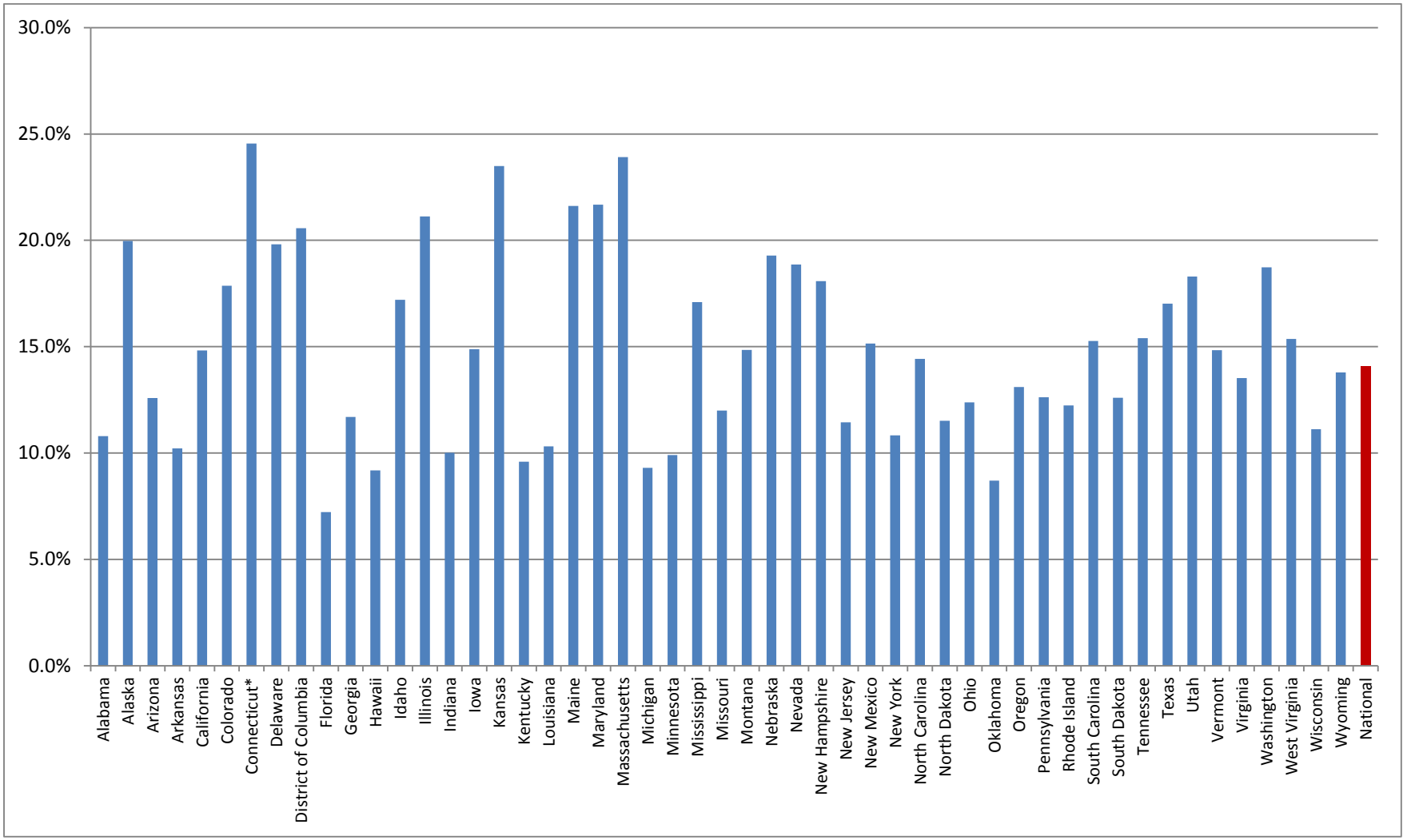
Source: FFY 2012 Form 416 reports, Line 1b and Line 12b
Note: *FFY 2011 data were used for Connecticut.

Chart 6: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving a dental treatment service, FFY 2012



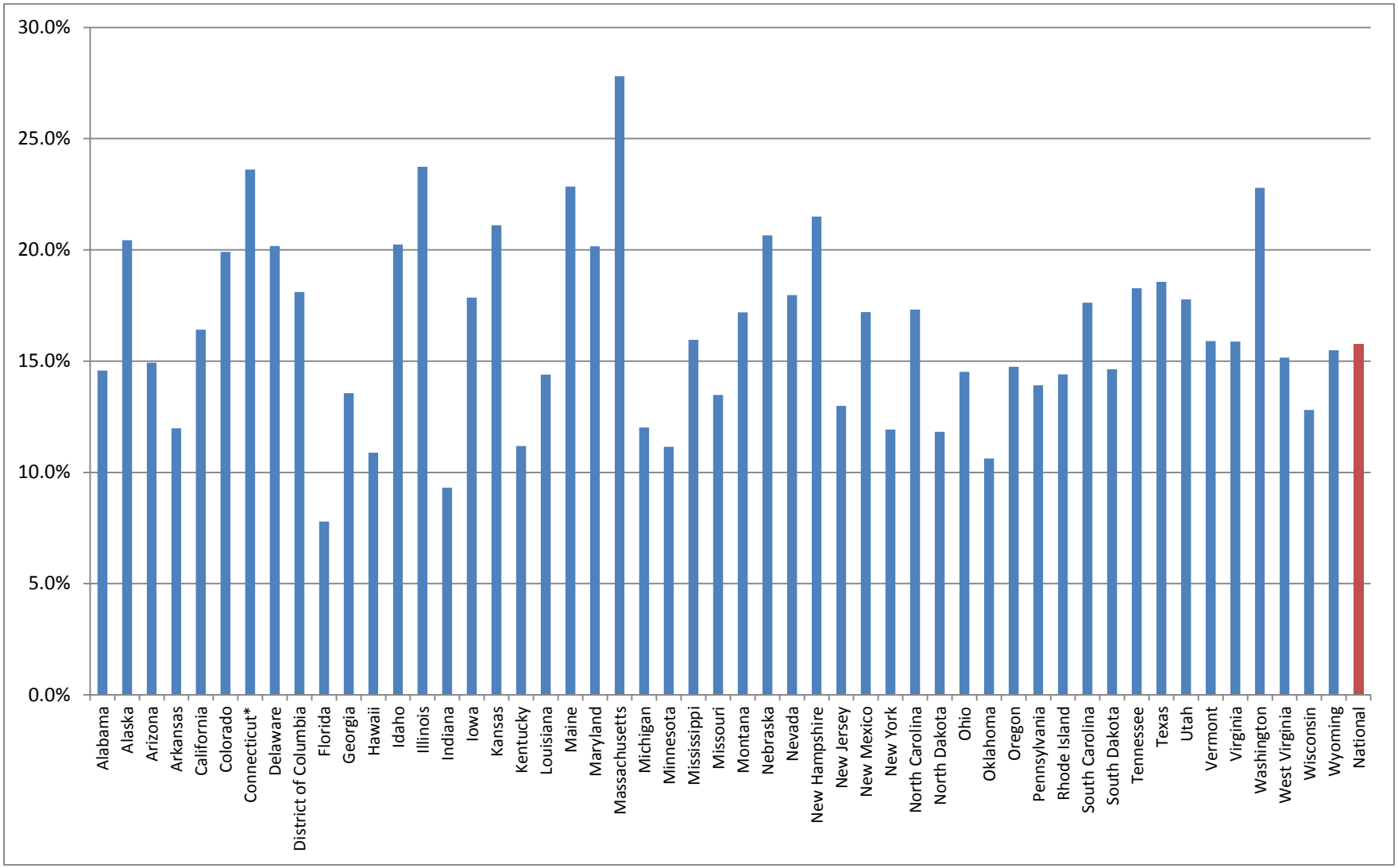
Source: FFY 2012 Form 416 reports, Line 1b and Line 12c
Note: *FFY 2011 data were used for Connecticut.

Chart 7: Percentage of children age 6-14 enrolled in Medicaid for at least 90 continuous days receiving a dental sealant on a permanent molar, FFY 2012



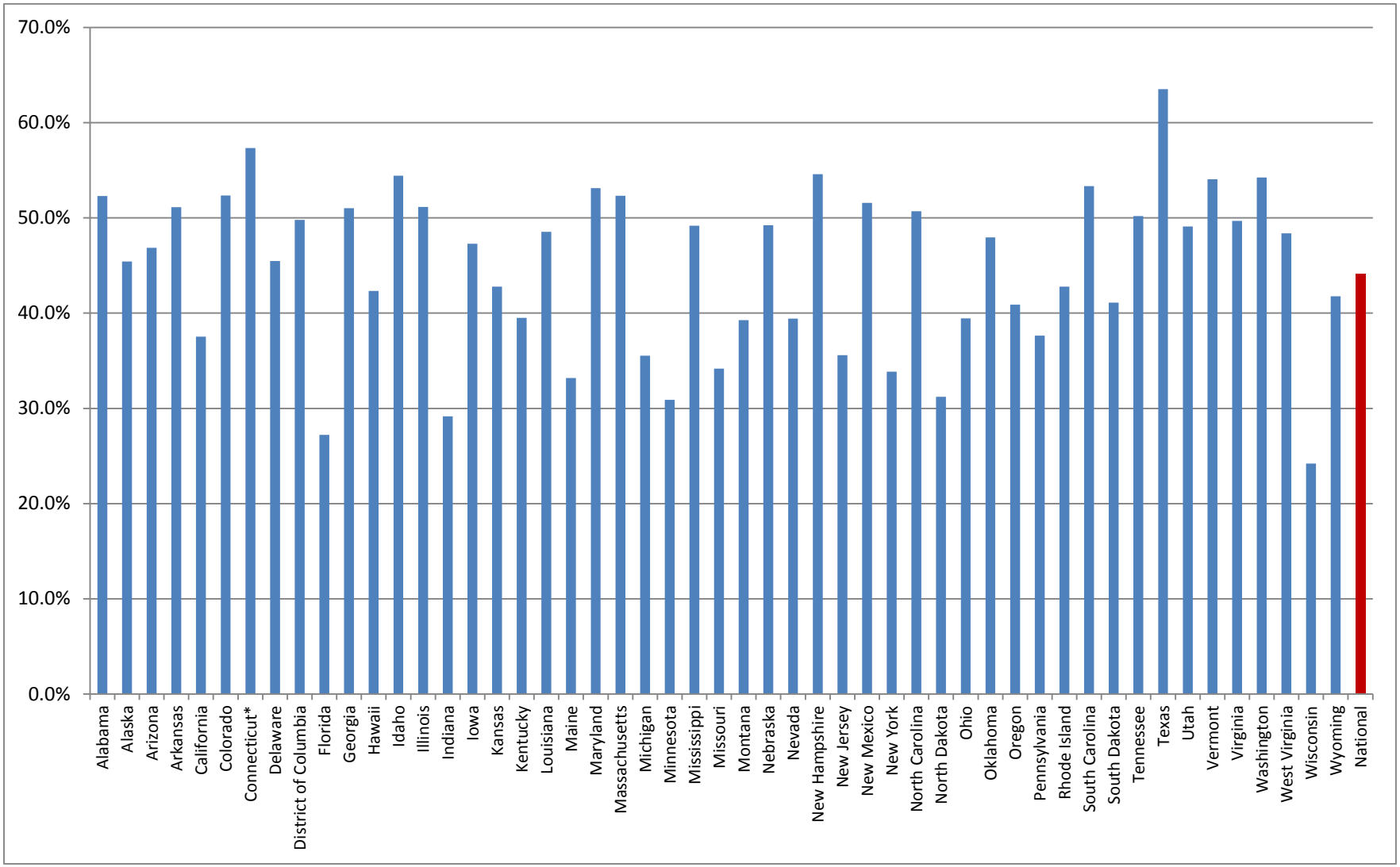
Source: FFY 2012 Form 416 reports, Line 1b and Line 12d
Note: *FFY 2011 data were used for Connecticut.

Chart 7a: Percentage of children age 6-9 enrolled in Medicaid for at least 90 continuous days receiving a dental sealant on a permanent molar, FFY 2012



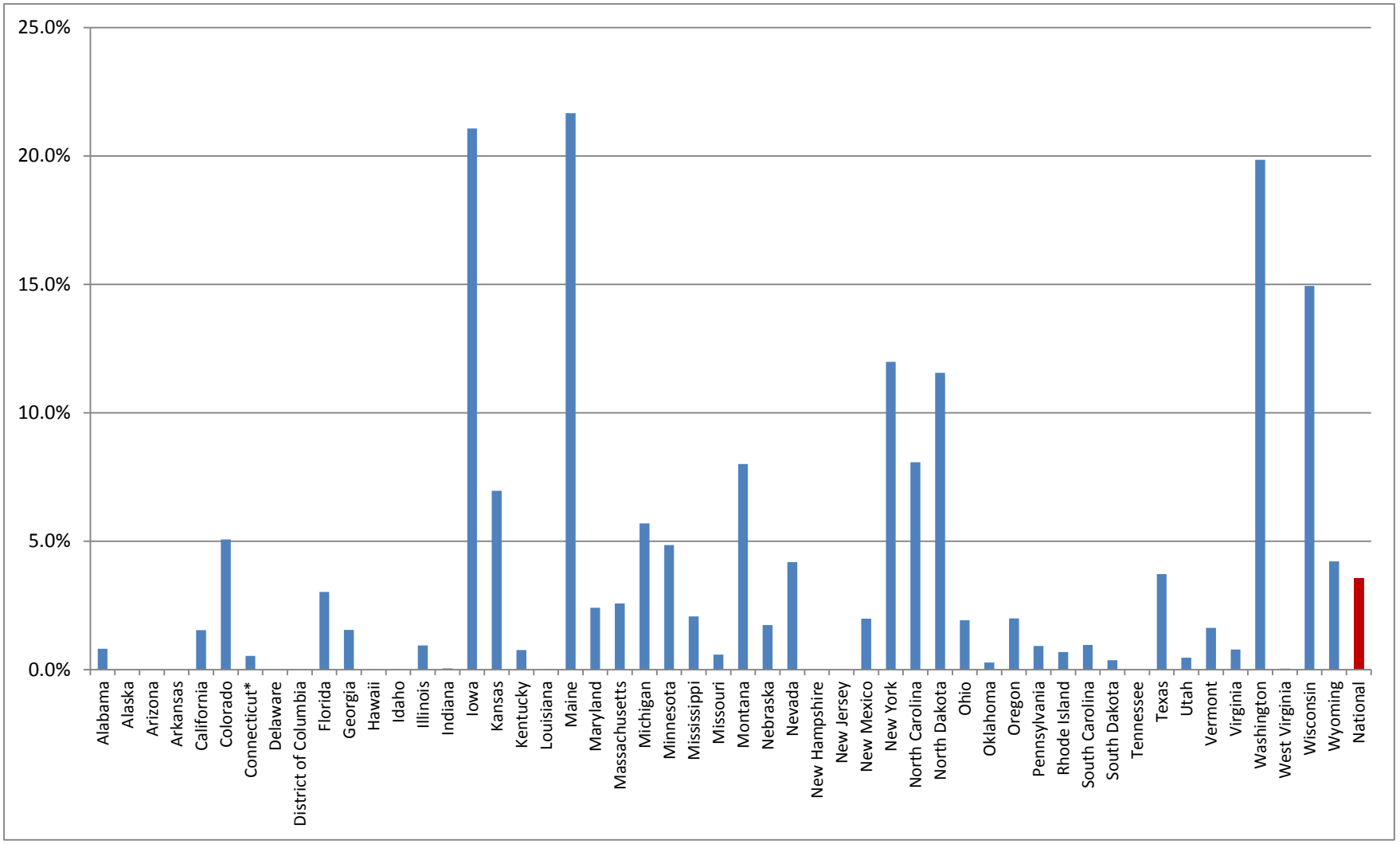
Source: FFY 2012 Form 416 reports, Line 1b and Line 12d
Note: *FFY 2011 data were used for Connecticut.

Chart 8: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving a dental diagnostic service, FFY 2012



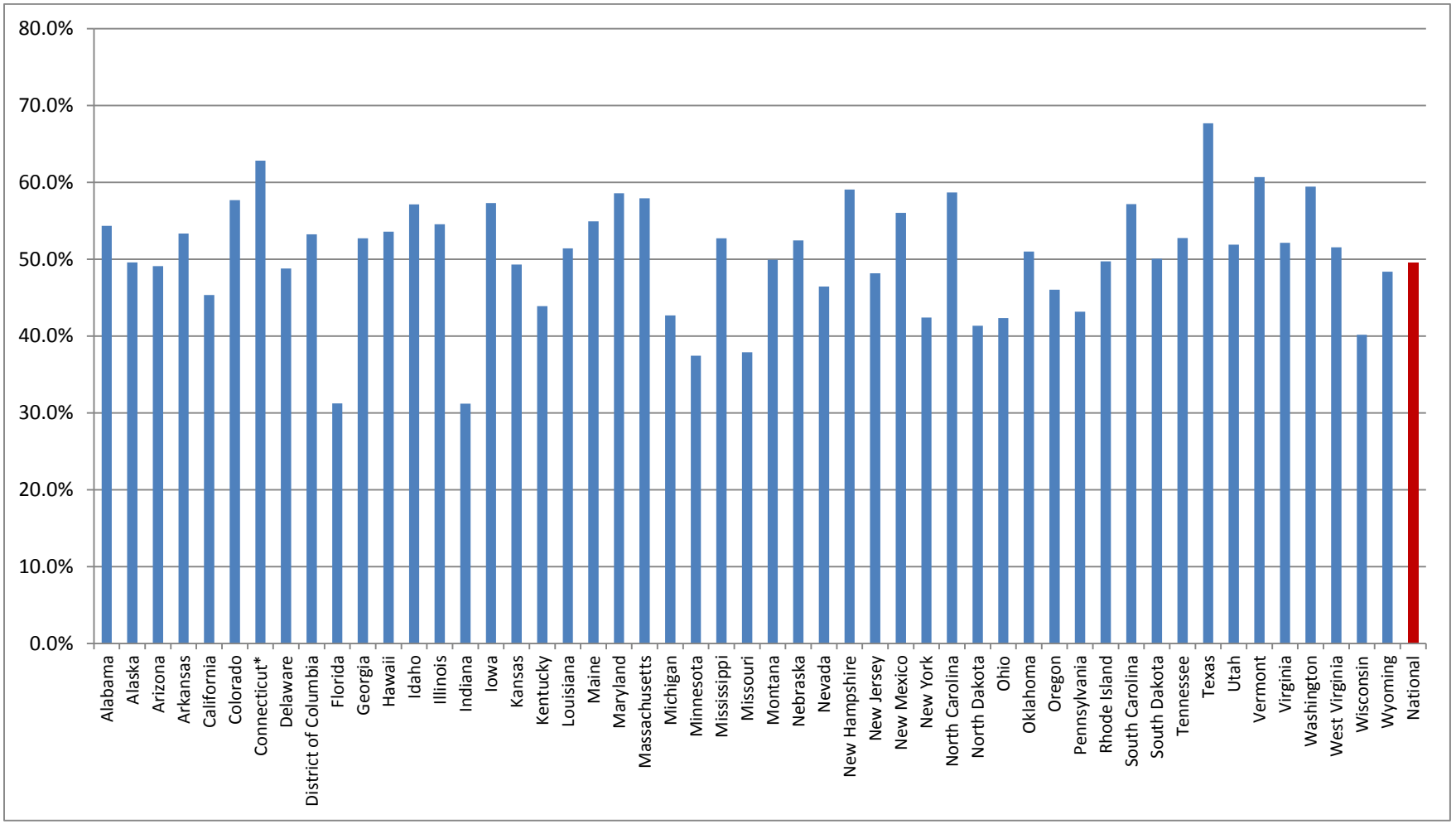
Source: FFY 2012 Form 416 reports, Line 1b and Line 12e
Note: *FFY 2011 data were used for Connecticut.

Chart 9: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving an oral health service provided by a health professional other than a dentist and not working under the supervision of a dentist, FFY 2012



Source: FFY 2012 Form 416 reports, Line 1b and Line 12f
Note: *FFY 2011 data were used for Connecticut.

Chart 10: Percentage of children age 1-20 enrolled in Medicaid for at least 90 continuous days receiving <u>any dental or oral health service</u>, FFY 2012



Source: FFY 2012 Form 416 reports, Line 1b and Line 12g
Note: *FFY 2011 data were used for Connecticut.

Appendix A – Form CMS-416: Annual EPSDT Participation Report

Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	**Fiscal Year**								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	0							
1a. Total individuals eligible for EPSDT	MN:	0							
1a. Total individuals eligible for EPSDT	Total:	0	0	0	0	0	0	0	0
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	CN:	0							
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	MN:	0							
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	Total:	0	0	0	0	0	0	0	0
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	0							
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	MN:	0							
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	Total:	0	0	0	0	0	0	0	0
2a. State Periodicity Schedule									
2b. Number of Years in Age Group			**1**	**2**	**3**	**4**	**5**	**4**	**2**
2c. Annualized State Periodicity Schedule			0.00	0.00	0.00	0.00	0.00	0.00	0.00
3a. Total Months of Eligibility	CN:	0							
3a. Total Months of Eligibility	MN:	0							
3a. Total Months of Eligibility	Total:	0	0	0	0	0	0	0	0
3b. Average Period of Eligibility	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3b. Average Period of Eligibility	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3b. Average Period of Eligibility	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Expected Number of Screenings per Eligible	CN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Expected Number of Screenings per Eligible	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Expected Number of Screenings per Eligible	Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
5. Expected Number of Screenings	CN:	0	0	0	0	0	0	0	0
5. Expected Number of Screenings	MN:	0	0	0	0	0	0	0	0
5. Expected Number of Screenings	Total:	0	0	0	0	0	0	0	0

State Code	Fiscal Year								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
6. Total Screens Received	CN:	0							
6. Total Screens Received	MN:	0							
6. Total Screens Received	Total:	0	0	0	0	0	0	0	0
7. SCREENING RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7. SCREENING RATIO	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7. SCREENING RATIO	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	0	0	0	0	0	0	0	0
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	MN:	0	0	0	0	0	0	0	0
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	Total:	0	0	0	0	0	0	0	0
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	0							
9. Total Eligibles Receiving at least One Initial or Periodic Screen	MN:	0							
9. Total Eligibles Receiving at least One Initial or Periodic Screen	Total:	0	0	0	0	0	0	0	0
10. PARTICIPANT RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10. PARTICIPANT RATIO	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10. PARTICIPANT RATIO	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11. Total Eligibles Referred for Corrective Treatment	CN:	0							
11. Total Eligibles Referred for Corrective Treatment	MN:	0							
11. Total Eligibles Referred for Corrective Treatment	Total:	0	0	0	0	0	0	0	0
12a. Total Eligibles Receiving Any Dental Services	CN:	0							
12a. Total Eligibles Receiving Any Dental Services	MN:	0							
12a. Total Eligibles Receiving Any Dental Services	Total:	0	0	0	0	0	0	0	0
12b. Total Eligibles Receiving Preventive Dental Services	CN:	0							
12b. Total Eligibles Receiving Preventive Dental Services	MN:	0							

State Code	**Fiscal Year**								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
12b. Total Eligibles Receiving Preventive Dental Services	Total:	0	0	0	0	0	0	0	0
12c. Total Eligibles Receiving Dental Treatment Services	CN:	0							
12c. Total Eligibles Receiving Dental Treatment Services	MN:	0							
12c. Total Eligibles Receiving Dental Treatment Services	Total:	0	0	0	0	0	0	0	0
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	0							
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	MN:	0							
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	Total:	0				0	0		
12e. Total Eligibles Receiving Dental Diagnostic Services	CN:	0							
12e. Total Eligibles Receiving Dental Diagnostic Services	MN:	0							
12e. Total Eligibles Receiving Dental Diagnostic Services	Total:	0	0	0	0	0	0	0	0
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0							
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	MN:	0							
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	CN:	0							
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	MN:	0							
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	Total:	0	0	0	0	0	0	0	0
13. Total Eligibles Enrolled in Managed Care	CN:	0							
13. Total Eligibles Enrolled in Managed Care	MN:	0							

State Code	Fiscal Year								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
13. Total Eligibles Enrolled in Managed Care	Total:	0	0	0	0	0	0	0	0
14. Total Number of Screening Blood Lead Tests	CN:	0							
14. Total Number of Screening Blood Lead Tests	MN:	0							
14. Total Number of Screening Blood Lead Tests	Total:	0	0	0	0				

* Includes 12-month visit

Note: "CN"=Categorically Needy, "MN"= Medically Needy

Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C7-26-05, Baltimore, Maryland 21244-1850.

Note: This form is current as of 6/3/2014 and can be downloaded at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

Appendix B – Form CMS-416 Instructions (as of June 2014)

2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

The completed report demonstrates the State's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each State that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. This data must include services provided under both fee-for-service and capitated managed care arrangements. Each State is required to collect encounter data (or other data as necessary) from managed care entities in sufficient detail to provide the information required by this report. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416 effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990. This version of the form must be used effective fiscal year 2010 for data due on or after April 1, 2011.

D. Submittal Procedure –– States should submit the annual form CMS–416 and your State periodicity schedule electronically to the CMS central office via the EPSDT mailbox at **EPSDT@cms.hhs.gov** not later than April 1 of the year following the end of the Federal fiscal year being reported. The electronic form and instructions are available on the CMS website at **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html**. States may **not** modify the electronic form. It must be submitted as downloaded. A "hard copy" submittal to CMS is no longer required.

E. Detailed Instructions – **Enter your State name and the federal fiscal year as directed below.** For each of the following line items, report total counts by the age groups indicated and by whether categorically and medically needy. In cases where calculations are

necessary, perform separate calculations for the total column and each age group. **You must enter a number in each line and column of data requested even if the number is "0."**

Report age based upon the child's age as of September 30.

State -- Enter the name of your State using two character State code in upper case format.

Fiscal Year -- Enter the Federal fiscal year (FY) being reported in YYYY format.
Note: The Federal fiscal year is from October 1 through September 30.

Line 1a -- Total Individuals Eligible for EPSDT-- Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age (based on age as of September 30) and by basis of eligibility. "Unduplicated" means that an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. Include all individuals regardless of whether the services are provided under fee-for-service arrangements or managed care arrangements. States should determine the basis of eligibility consistent with the instructions for form CMS-2082. Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services regardless of whether they have been informed about the availability of EPSDT services or whether they accept EPSDT services at the time of informing. Individuals for whom third-party liability is available should also be counted in the number.

Do not include in this count the following groups of individuals: 1) medically needy individuals under the age of 21 if you do not provide EPSDT services for the medically needy population; 2) individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available; 3) undocumented aliens who are eligible only for emergency Medicaid services; 4) children in separate State CHIP programs; or 5) other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

Line 1b -- Total Individuals Eligible for EPSDT for 90 Continuous Days -- Enter the total unduplicated number of individuals under the age of 21 from line 1a who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days in the Federal fiscal year and determined to be eligible for EPSDT services, distributed by age and by basis of eligibility. For example, if a child was enrolled from August 1st to September 30th and October 1st to November 30, the child would not be considered eligible for 90 continuous days in the Federal fiscal year.

Line 1c -- Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program – Enter the number of individuals **included in line 1b** who are under the age of 21 and eligible for EPSDT services as part of a CHIP Medicaid expansion program. For children who have been eligible for EPSDT under both Medicaid and a CHIP Medicaid expansion program during the report year, include the child on this line if they are enrolled in CHIP as of September 30.

Line 2a -- State Periodicity Schedule -- Enter the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the State's periodicity schedule. (Example: If your State periodicity schedule requires screening at 12, 18 and 24 months, the number 3 should be entered in the 1-2 age group column.) **Make no entry in the total column.**

Note: Use the State's most recent periodicity schedule and attach a copy to the completed report for submittal to CMS.

Line 2b -- Number of Years in Age Group -- Make no entries on this line. This is a fixed number reflecting the number of years included in each age group.

Line 2c -- Annualized State Periodicity Schedule -- Divide line 2a by the number in line 2b. Enter the quotient. This is the number of screenings expected to be received by an individual in each age group in one year. **Make no entry in the total column.**

Line 3a -- Total Months of Eligibility -- Enter the total months of eligibility for the individuals in each age group in line 1b during the reporting year. A child should only be counted once in the age group the child is in as of September 30. **Include the total months of eligibility in the age category where the child is reported, even if the child had months of eligibility in two age categories during the reporting period. For example, if a child was eligible 12 months, from October 1st through September 30th, but turned age 3 on August 1st, all 12 months of eligibility would be counted in the age 3-5 category.**

Line 3b -- Average Period of Eligibility -- Divide line 3a by the number in line 1b. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remain Medicaid eligible during the reporting year.

Line 4 -- Expected Number of Screenings per Eligible -- Multiply line 2c by line 3b. Enter the product. This number reflects the expected number of initial or periodic screenings per child per year based on the number required by the State-specific periodicity schedule and the average period of eligibility. **Make no entries in the total column.**

Line 5 -- Expected Number of Screenings -- Multiply line 4 by line 1b. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1b.

Line 6 -- Total Screens Received -- Enter the total number of initial or periodic screens furnished to eligible individuals on line 1b under either fee-for-service or managed care arrangements.

Note: States may use the CPT codes listed below as a proxy for reporting these initial or periodic screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.

This number should not reflect sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen

outside of the normal State periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch- up EPSDT screening is defined as a complete screening that is provided to bring a child up-to- date with the State's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) **Report all screening data in the age category reflecting the child's age at the end of the federal fiscal year even if the child received services in two age categories. For example, if a child turned age 3 on September 1st, but had a 30-month well-child visit in March, the 30-month visit would be counted in the age 3-5 category.** Use the codes below or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services *
99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)
99393 Established patient (ages 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant
99463 Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)

*These CPT codes do not require use of a "V" code. or

CPT-4 codes: Evaluation and Management Codes **
99202-99205 New Patient
99213-99215 Established Patient

**** These CPT-4 codes must be used in conjunction with codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-70.9.

Line 7 – Screening Ratio – Divide the actual number of initial and periodic screening services received (line 6) by the expected number of initial and periodic screening services (line 5). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule, prorated by the proportion of the year for which they are Medicaid eligible.

Note: In calculating Line 7, if the number exceeds 100 percent, enter 1.0 in this field.

Line 8 – Total Eligibles Who Should Receive at Least One Initial or Periodic Screen – The number of persons who should receive at least one initial or periodic screen is dependent on each State's periodicity schedule. Use the following calculations:

1. Look at the number entered in line 4 of this form. If that number is greater than 1, use the number 1. If the number on line 4 is less than or equal to 1, use the number in line 4. (This procedure will eliminate situations where more than one visit is expected in any age group in a year.).

2. Multiply the number from calculation 1 above by the number in line 1b of the form. Enter the product on line 8.

Line 9 – Total Eligibles Receiving at Least One Initial or Periodic Screen – Enter the unduplicated count of individuals from line 1b, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. **Refer to codes in line 6.**

Line 10 – Participant Ratio – Divide line 9 by line 8. Enter the quotient. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

Note: In calculating Line 10, if this number exceeds 100 percent, enter 1.0 in this field.

Line 11 – Total Eligibles Referred for Corrective Treatment – Enter the unduplicated number of individuals on line 1b, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic screening service, including vision and hearing screenings, were referred for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. This element does not include correction of health problems during the course of a screening examination.

Line 12a – Total Eligibles Receiving Any Dental Services – Enter the unduplicated number of children receiving at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (CDT codes D0100 - D9999).

Line 12b – Total Eligibles Receiving Preventive Dental Services – Enter the unduplicated number of children receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 -(CDT codes D1000 - D1999).

Line 12c – Total Eligibles Receiving Dental Treatment Services – Enter the unduplicated number of children receiving at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 - 09999).

Line 12d – Total Eligibles Receiving a Sealant on a Permanent Molar Tooth – Enter the unduplicated number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non- dentist, as defined by HCPCS code D1351 (CDT code D1351).

Line 12e – Total Eligibles Receiving Diagnostic Dental Services – Enter the unduplicated number of children receiving at least one diagnostic dental service by or under the supervision of a dentist, as defined by HCPCS codes D0120 – D0180 (CDT codes D0120 – D0180).

12f – Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider – Enter the unduplicated number of children receiving at least one oral health service as defined a HCPCS or CDT code furnished by a licensed practitioner that is not a dentist. For example, a pediatrician that applies a fluoride varnish or an independently practicing dental hygienist not under the supervision of a dentist furnishing a prophylaxis. These are only examples and are not intended to limit your reporting. NOTE: Due to the variance in State Practice Acts some States may not have data to report on this line.

12g – Total Eligibles Receiving any Dental or Oral Health Service – Enter the unduplicated number of children who received a dental service by or under the supervision of a dentist or an oral health service by a non-dentist. A child should only be counted **once** on this line even if the child received a dental service and an oral health service.

NOTES FOR LINE 12 DATA: For purposes of reporting the information on dental services in Lines 12a – 12g, use the total eligible individuals from line 1b. "Unduplicated" means that a child may only be counted once for each line of dental or oral health data. However, a child may be counted on two or more lines. For example, a child is counted once on line 12a for receiving any dental service, counted again on line 12c for receiving a dental treatment service and, if applicable, counted again on line 12f for receiving an oral health service by a non-dentist. These numbers should reflect services provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State. We refer to "dental services" when referring to services provided by or under the supervision of a dentist.

We refer to "oral health services" when the service is not provided by or under the supervision of a dentist.

Line 13 – Total Eligibles Enrolled in Managed Care – This number is reported for informational purposes only. This number represents all individuals eligible for EPSDT services in your State who are enrolled in any type of managed care arrangement at any time during the reporting year. It includes any capitated arrangements such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager regardless of whether reimbursement is fee-for-service or capitated. Include these individuals in the total number of eligibles on line 1a and b, as appropriate; include the number of initial or periodic screenings provided to these individuals in lines 6 and 8 for purposes of determining the State's screening and participation rates. The number of individuals referred for corrective treatment and receiving dental services are reflected in lines 11 and 12, respectively.

Line 14 -- Total Number of Screening Blood Lead Tests -- Enter the total number of screening blood lead tests furnished to eligible individuals **from line 1a** under fee-for-service or managed care arrangements. Follow-up blood tests performed on individuals who have

been diagnosed with or are being treated for lead poisoning should not be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:

1) Count the number of times CPT code 83655 ("lead") for a blood lead test is reported within certain ICD-9-CM codes (see Note below); or

2) You may include data collected from use of the HEDIS®[1] measure developed by the National Committee for Quality Assurance to report blood lead screenings if your State had elected to use this performance measure**.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5) (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984(.0-.9) (toxic effect of lead and its compounds) or **e861.5** (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

F. Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C4-26-05, Baltimore, Maryland 21244-1850.

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[1]Healthcare Effectiveness Data and Information Set

Note: This form is current as of 6/3/2014 and can be downloaded at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.