New DIRECTIONS

FOR MEDICAID AND CHIP DENTAL PROGRAMS

2011 National Medicaid and CHIP Oral Health Symposium

Compilation of 2011 Symposium Essays

MSDA
Medicaid–CHIP
State Dental Association

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The Historical Compass Points the Way

Michael Graham, ADA &
Christine Farrell, RDH, MPA

MICHAEL GRAHAM:

This article provides a "snap shot" of various federal legislative proposals being considered by Congress regarding Medicaid and CHIP programs and how they might impact state programs and policy. Emerging issues; legislation affecting policy, programs and oral health care services, including perspectives on health care reform and the Affordable Care Act; and innovative initiatives on public-private partnerships will be presented.

INTRODUCTION

This last week of June 2011 continues the stalemate between Democrats and Republicans on debt ceiling negotiations. Everything is on the table, except benefit cuts to Medicare by Democrats and tax hikes on the part of Republicans. Despite the rhetoric, the debt crisis is real. There is $14.3 trillion worth of debt currently. Raising the debt ceiling by as much as $2.5 trillion will require an equal amount in cuts. The clock is ticking, so what deals can be made? There are several options: reduce discretionary spending on appropriations; cut farm subsidies; trim back college aid programs; scale back federal worker retirement plans. Democrats want more defense cuts, while Republicans want to repeal or significantly amend the new health care reform law. Some would consider a new blended rate to cover the federal share of Medicaid. Regardless of the action, the future of Medicaid rests upon the outcome.

LOOKING AT MEDICAID

Several specific bills address Medicaid expansion and maintenance of effort. President Obama's FY 2012 budget proposal would cut $60 billion from Medicaid. Some Republicans believe Medicaid should be administered as a state block grant. Other bills would repeal Medicaid enrollment eligibility requirements and transition the program to a federal health grants model for the poor and those in long-term care. Another bill removes the maintenance of effort requirements and another would lift the restrictions that prevent states from setting stricter eligibility rules for adults and children. Most of these free-standing measures are not likely to move forward, as they lack sufficient support in the Senate, but they could be part of the debt limit negotiations.

THE AFFORDABLE CARE ACT (ACA)

Opposition to the ACA energized a conservative base, resulting in a Republican majority in the House of Representatives, one that believes it has a mandate to repeal and replace the law with what they view as more market friendly alternatives. More than sixty bills are pending that would change the ACA. Only a couple would overturn the

law in its entirety and these are not likely to succeed. Thus far, only one piece of legislation has passed that repeals a provision of the ACA, the *1099 form* requirement.

The ACA continues support of the Children's Health Insurance Program (CHIP) and expands the Medicaid program by immediately extending CHIP funding through 2015 and authorizing it through 2019. It also sets a Medicaid income eligibility ceiling of 133 percent of the federal poverty level, effective Jan. 1, 2014. This would necessitate the state picking up about 10 percent of the cost of those gaining coverage under the new law by 2020.

> "There will be opportunities for innovative initiatives on public-private partnerships to make a difference …"

THE SILVER LINING:

The American Dental Association is pursuing several initiatives to facilitate greater public- private partnering as a means of developing innovative ways to improve access to oral health care for Medicaid and CHIP beneficiaries. These include:

- ADA support for the "Breaking Barriers to Oral Health Act" (H.R. 1666), introduced by Rep. Michael Simpson (R-Idaho), that would provide grants to foster collaboration between state and local officials and oral health stakeholders' local communities. The focus is on reducing barriers to access while increasing provider participation in Medicaid and CHIP programs.

- In 2010, the Centers for Medicare and Medicaid Services reviewed state programs with the highest utilization rates, five of eight states mentioned the importance of public-private partnering. While dentists and state Medicaid agencies will not agree on everything, ensuring that all parties are in communication is essential for success.

- The ADA is working to increase familiarity among dentists working in health centers and those working in private practice within the community. It is seeking opportunities for experienced dentists to mentor inexperienced health center dental directors in order to increase efficiency, effectiveness and productivity within health centers, where a significant number of Medicaid and CHIP patients seek care.

- The ADA is partnering with the Association of State and Territorial Dental Directors to assist MSDA in creating a series of best practice approaches, so that state Medicaid dental programs can be more efficient and responsive to provider and public needs.

- The ADA in 2008 hosted a Medicaid Provider Symposium, which identified systemic challenges to private practices that see Medicaid patients. In 2010, a subsequent ADA symposium identified three practice models that could help private dentists maintain practice viability when adding greater numbers of Medicaid and CHIP beneficiaries to their patient rolls.

- Other opportunities to educate Medicaid beneficiaries exist through collaborative efforts within Head Start, WIC offices and OBGYN practices.

CONCLUSION

Various federal legislative proposals continue to be considered by Congress regarding Medicaid and CHIP programs, which may impact state programs and policy. Emerging issues and legislation affecting policy, programs and oral health care services will enhance, enlighten and possibly change perspectives on *health care reform* and the *Affordable Care Act*. There will be opportunities for innovative initiatives on public-private partnerships to make a difference in providing greater access to care for Medicaid and CHIP eligible individuals.

CHRIS FARRELL:
Over the past five decades, pertinent legislation, numerous policies and initiatives have impacted Medicaid dental services. Since the creation of Medicaid in 1965, under Title XIX of the Social Security Act, many Americans have benefitted from the oral health benefits authorized by Congress. Medicaid, an entitlement program, specifies legal requirements for health care to certain individuals. The passage of the Early Periodic Screening Diagnosis and Treatment (EPSDT) amendment in 1967 established benefits for eligible children up to age 21. The Omnibus Budget Reconciliation Act of 1989 again added required benefits. The Balanced Budget Act (BBA) of 1997 gave states discretion in the way Medicaid programs were administered. The Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Patient Protection and Affordability Act of 2010 also markedly increased available dental benefits.

"Medicaid has always been under-appreciated, particularly for the role that it plays in the lives of so many Americans."

As John Iglehart, the founding editor of *Health Affairs*, pointed out, "Medicaid has always been under-appreciated, particularly for the role that it plays in the lives of so many Americans." In many respects, the same is true for dental services. Historically, dental care has been separated from overall health care, offered as a supplement to health insurance packages. Dentists have traditionally been paid through a fee-for-service model. Innovative payment systems, even managed care models, have been slower to take hold in dentistry than in health care in general. Consumers may view dental care as unaffordable or even optional. And in 2003, the number of Americans without dental insurance was reported to be nearly 2.5 times the number without health insurance.

Many children who would otherwise be uninsured have coverage through Medicaid. Medicaid is a federal entitlement program; that is, a program that individuals meeting certain eligibility conditions have a legal right to access. Unlike certain other government programs, entitlement programs are available to an unlimited number of eligible persons.

Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS), a branch of the U.S. Department of Health and Human Services. The law originates from the 1935 Social Security Act. In 1965, an amendment established both Medicare and Medicaid, Titles XVIII and XIX, with the purpose of providing federal health insurance to elderly and poor families, respectively. Another amendment in 1967 established the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for eligible children up to age 21. During the 1980s, amendments passed that increased program eligibility by raising the income threshold, indicated as a percentage of the Federal Poverty Level (FPL). Because of that increased eligibility, more children were provided access to dental services due to increased enrollment in Medicaid.

The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239, often referred to as "OBRA'89") is considered one of the most important pieces of legislation regarding dental services in Medicaid because it codified previous regulatory requirements. In addition, the role of Federally Qualified Health Centers (FQHCs) in Medicare and Medicaid was initiated and states were required to cover services provided by FQHCs.

OBRA '89 mandated periodic vision, hearing, and dental screening and expanded the EPSDT benefit to included needed diagnostic and treatment services. It also required any medically necessary health care service to be provided to an EPSDT recipient. Specific dental provisions include the establishment of a block grant program administered by the Health Resources and Ser-

vices Administration's (HRSA's) Maternal and Child Health Bureau (MCHB) which included the promotion of dental sealants. It also mandated that dental services be provided at intervals, provide for relief of pain and infection, restore teeth, and maintain oral health. As the child health component of Medicaid, EPSDT is required in every state and finances appropriate and necessary pediatric services. For over forty five years, Medicaid has played a role in many American lives.

On September 9–12, 1989, the U.S. Public Health Service convened a workshop, "Equity and Access for Mothers and Children," to propose solutions to multiple issues affecting the oral health of the maternal and child health population. Seven regional workshops supported by HRSA and MCHB followed, focusing on collaborative strategic and action planning at the state and local levels.

In 1997, the Balanced Budget Act (BBA) became law. Provisions of the law provided substantial structural changes to the Medicaid program, expanding state discretion in administration, proposing broader managed care regulations, and expanding states' authority in their use of managed care. It allowed states to require most Medicaid beneficiaries to enroll in managed care organizations and allowed optional 12-month continuous eligibility for children and optional "presumptive" eligibility. Presumptive eligibility provides children immediate access to health services by giving them temporary health insurance through Medicaid if they appear to be eligible.

The Medicaid program continued to function as the largest health insurer for children, and the critical elements of the Medicaid program remained: entitlement to basic health care coverage, mandatory and optional eligibility categories, and the EPSDT benefit.

The BBA also established the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act. Different than Medicaid, SCHIP was meant to replicate employer-sponsored health insurance. The funding mechanism was also different than Medicaid. The legislation provided enhanced federal funding over a period of ten years and a higher match formula than Medicaid but it capped the allotments. In addition, the eligibility, coverage benefits, and administration were different than Medicaid. The SCHIP program targeted uninsured children under age 19 who met certain income requirements (below 200 percent of the FPL). Dental services were an optional benefit. All but one state offered a dental benefit.

In response to the 1996 Office of the Inspector General report, *Children's Dental Services Under Medicaid: Access and Utilization*, HRSA and the Medicaid agency, then called the Health Care Financing Administration (HCFA), launched an Oral Health Initiative from 1998-2001. It called for integrating activities among federal agencies, partnering with stakeholders, and sharing scientific data. This initiative was the roadmap that connected federal and state programs. Two U.S. Public Health Service champions drew this map: Don Schneider, D.D.S., at HCFA and John Rossetti, D.D.S., M.P.H., at MCHB. They collaborated to coordinate federal initiatives and to leverage funding and activities between the federal, state, policy, professional association and research communities.

One meeting co-sponsored by HRSA and HCFA was *Building Partnerships to Improve Children's Access to Medicaid Oral Health Services National Conference* held on June 2-4, 1998, at Lake Tahoe, Nevada. More than 200 people participated in this conference, including Federal staff, state Medicaid directors and staff, and dental stakeholders. This groundbreaking event documented barriers to, and strategies for, accessing oral health care.

As a follow-up, in 1999, the American Dental Association (ADA) hosted another conference, *Achieving Improvement in Medicaid*, and invited representatives from thirty three states to participate. As a national stakeholder, the ADA has continued to play a major role. The ADA hosted stakeholder meetings and published reports on innovative projects and recommendations for state Medicaid programs to review, including two editions of a state-by-state compendium, *State Innovations to Improve Dental Access for Low-Income Children*.

Safety net providers, such as public hospitals, community health centers, community behavioral health centers, local health departments, and other clinics, were serving a substantial number of uninsured and Medicaid individuals. Because they serve a high proportion of those enrolled in Medicaid as well as the uninsured, safety net providers are particularly affected by Medicaid payment policies. As a result, policies have been adopted to address these providers' financial stability. In 2000, the Benefits Improvement and Protection Act was enacted, changing the way both Rural Health Clinics and FQHCs were reimbursed under Medicaid. The cost-based reimbursement system was replaced by a prospective payment system methodology. The shift was intended to cover reasonable costs of the clinics or centers, so that health care would be available in communities where it might otherwise be difficult using fee-for-service or capitated payment methodologies.

A landmark major achievement occurred in 2000 that captured the attention of the dental public health community and brought the status of oral health to the public's attention. *Oral Health in America: A Report of the Surgeon General* was released on May 25, 2000. This was a major report that is as relevant today as when it was released. From this report, a *National Call to Action to Promote Oral Health* was developed and released in 2003 by the Office of the Surgeon General. The plan defined goals to reflect those of Healthy People 2010: promote oral health, improve quality of life, and eliminate health disparities. It called for a public-private partnership to pursue these goals.

In 2007 and 2008, other organizations, such as the National Academy for State Health Policy and the Kaiser Commission on Medicaid and the Uninsured, became involved in oral health activities and released reports that discussed access for oral health services and recommendations for improvement.

Another significant year for public dental benefit programs was 2009. The Children's Health Insurance Program Reauthorization Act (CHIPRA) was approved. The program is now known as the Children's Health Insurance Program (CHIP). The "state" was dropped from the name, bringing it more under federal control and aligning it closer to Medicaid regulations. Under SCHIP, dental benefits were optional. CHIPRA had a number of specific dental provisions and dental services that became mandatory benefits.

The new dental provisions included a dental coverage guarantee, a dental wrap-around option, new parent education guidelines, information for beneficiaries that provided a list of enrolled dentists in both the Medicaid and CHIP programs to be posted on the Insure Kids Now website, reporting of dental services on the annual

Medicaid EPSDT participation report (CMS-416), adding a dental sealant question to the annual report, and allowing FQHC contract provisions for private dental providers. These provisions reflected sustained stakeholder intervention; oral health had finally captured the attention of Congress.

Even with numerous changes to Medicaid over the past years, there has not been significant change in the dental benefit or payment rates. Managed care is playing a larger and more pivotal role in medical care but the dental delivery system has been slow to change. Reimbursement for dental services has remained primarily fee-for-service, although states are now beginning to look more to managed care plans. A variety of managed care models are now offered. Arizona has several managed care contracts (12) while other states are looking at dental carve-out models and the use of risk-based models. Through the use of managed care plans, states may offer innovation and creativity in benefit design.

"Managed care is playing a larger and more pivotal role in medical care but the dental delivery system has been slow to change."

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was passed. This represented major health care reform for all U.S. citizens. Broad provisions include a requirement that most U.S. citizens have insurance coverage. It expanded Medicaid to those adults not previously eligible with incomes up to 133 percent of the FPL. There were a number of health information technology provisions such as the implementation of electronic health records. Providers (including dentists) and hospitals who show they use EHR technology in ways that can be measured for quality and quantity ("meaningful use") may be eligible for incentive payments and may find improved practice management in error reduction, availability of data, clinical decision support and automation.

Under the PPACA, state exchanges are to be developed and become available so that individuals may have the opportunity to purchase health insurance. The essential pediatric benefit package requires that a pediatric dental benefit be available, but it is yet to be defined.

As a result of the PPACA, Medicaid enrollment will continue to grow. More Americans will receive health care from publicly-financed programs, as demonstrated by Medicaid and CHIP expansions, both before and as a result of healthcare reform. The trend is to incentivize providers to deliver coordinated, patient-centered managed systems of care that integrate physical health, including dental care and behavioral health. There is a greater emphasis on case management, disease management, measuring data, and improving quality and cost-effectiveness. All of these can be integrated with dental care for improved oral health status for many Americans.

SUMMARY

Over the past five decades, the work of Congress, Federal and state agencies and numerous advocacy groups have created a system of that provides for dental care to millions of Americans. Through enabling legislation, regulations at the state and Federal level, and increased understanding of the importance of oral health, many Americans, who otherwise might not have access to dental care have the opportunity to improve their oral health. The job is not done, but many stakeholders are working in partnership to write the next chapter in the story of health care, including oral health care, in America.

Surveying the Landscape: Mountains & Valleys

Patrick W. Finnerty, MPA

The economic crisis of the past several years has placed unprecedented stress on state Medicaid programs as governors and legislators struggle to balance their budgets. In most states, Medicaid represents at least the second largest expenditure of state general fund dollars, and, therefore, inevitably is required to produce cost-savings during economic downturns. Recent enrollment growth, prompted by the recession, has fueled a corresponding growth in expenditures and the program now serves approximately sixty million low-income Americans with total expenditures reaching an estimated $427 billion.

States are always looking for ways to make Medicaid as efficient and cost-effective as possible. During the past several years, these efforts intensified as Medicaid officials had to enact numerous programmatic and administrative changes to reduce costs. Among the most common strategies employed by the states are provider rate reductions or freezes, benefit limits, managed care expansions, delayed program initiatives, and prescription drug limits. Unfortunately, limiting adult dental coverage or eliminating it altogether has been among the budget-balancing actions taken by a number of states, leaving more adults without comprehensive oral health services.

The recent expiration of enhanced federal Medicaid funding states received through the American Recovery and Reinvestment Act (ARRA), lagging state revenues, and continuing enrollment growth are placing even greater fiscal strain on the states. In response, the dialogue of possible actions to further curtail Medicaid spending has changed such that states are now looking at more systemic and fundamental reform strategies.

Despite the stormy waters that Medicaid currently is navigating, there is great energy across the nation toward improving access to oral health services for underserved persons and the role that Medicaid and CHIP can play. There is an unprecedented emphasis on the importance of oral health as a critical component of overall health. Even in the face of severely limited resources, the federal government and many states are pushing forward with new initiatives to increase dental provider availability, utilization of services, and improved quality of care Perhaps even more encouraging is the involvement and partnerships among providers, advocates, payers, philanthropy and policymakers to make oral health a national priority. To ensure ongoing progress in providing optimal oral health to the underserved, it is critical that the current momentum and priority being given to oral health be continued, championed and celebrated.

ECONOMIC WOES & MEDICAID PROGRAM GROWTH

Medicaid is the nation's largest public health insurance program providing coverage in 2010 to more than sixty million low-income persons at an estimated total cost of $427 billion (including enrollment and expenditure of the Children's Health Insurance Program). As enrollment and costs continue to climb, the national debate of how to control Medicaid expenditures is entrenched as a key health policy issue. As one of the costlier federal entitlement programs and the second largest expenditure of state general fund revenues, federal and state government officials remain vigilant in identifying cost containment strategies. While controlling costs is vital to the program's long-term survival, it is important to understand the core reason why the program is so expensive. That core reason relates to the population that Medicaid serves.

Enrollees currently must meet both categorical as well as financial eligibility criteria. Figure 1 illustrates the composition of the Medicaid enrollee population and the corresponding percentage of Medicaid spending that each category of enrollees incurs. As seen below, while the elderly and disabled make up twenty eight percent of the enrollee population, they incur nearly seventy percent of the costs. These individuals, who cannot obtain and/or

"The economic crisis of the past several years has placed unprecedented stress on state Medicaid programs as governors & legislators struggle to balance their budgets."

afford coverage in the private market, are the most costly to insure due to their significant health issues. Thus, while every effort must be made to control Medicaid spending, as long as Medicaid is relied upon to do the "heavy lifting" for the health insurance industry (i.e., covering the most frail and costly populations), it will always be an expensive and vitally important enterprise.

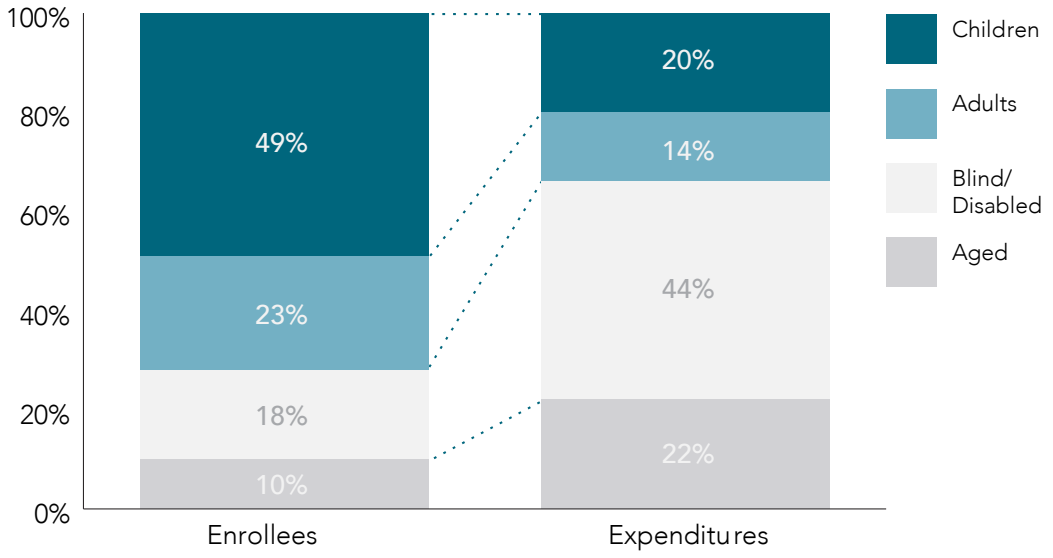
Another driving force that fuels Medicaid costs is enrollment. Due to the countercyclical nature of Medicaid, as the economy worsens, states experience significant enrollment growth and corresponding increases in spending. Between December 2007, and December 2009, an additional 48.7 million persons were enrolled in Medicaid. [Kaiser Commission on Medicaid and the Uninsured. 2011] During recessionary times, states essentially are "double-teamed" by revenue losses and program expenditure increases. A March 2009 article in the *New England Journal of Medicine* reported that for every one percentage point growth in unemployment, there is a corresponding increase of one million persons being enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as well as roughly a $6 million decline in state revenues to support these programs. [Rowland, D. 2009.]

As a result of the recent financial crisis, states experienced a 30.8 percent decline in state revenues between 2008 and 2009; revenues are still below pre-recession levels and growth remains weak in almost all states. The Kaiser Commission on Medicaid and the Uninsured reported in January 2011, that states had to close budget gaps of over $430 billion in fiscal years 2009, 2010, and 2011. For FY 2011, states reported budget gaps of $130 billion. Such startling numbers make it clear why states have struggled mightily in recent years to maintain their Medicaid programs and meet constitutional demands for balanced budgets.

As if the current economic conditions were not enough to challenge even the most creative approaches to maintaining Medicaid viability, states are now having to replace the loss of enhanced funding they had received through the American Recovery and Reinvestment Act (stimulus) to support their Medicaid budgets. Stimulus funding ended on June 30, 2011, and states now must replace a total of $66 billion in federal financing with state revenues. In the face of mounting pressure for cost savings, states have implemented a range of strategies as shown in Figure 2.

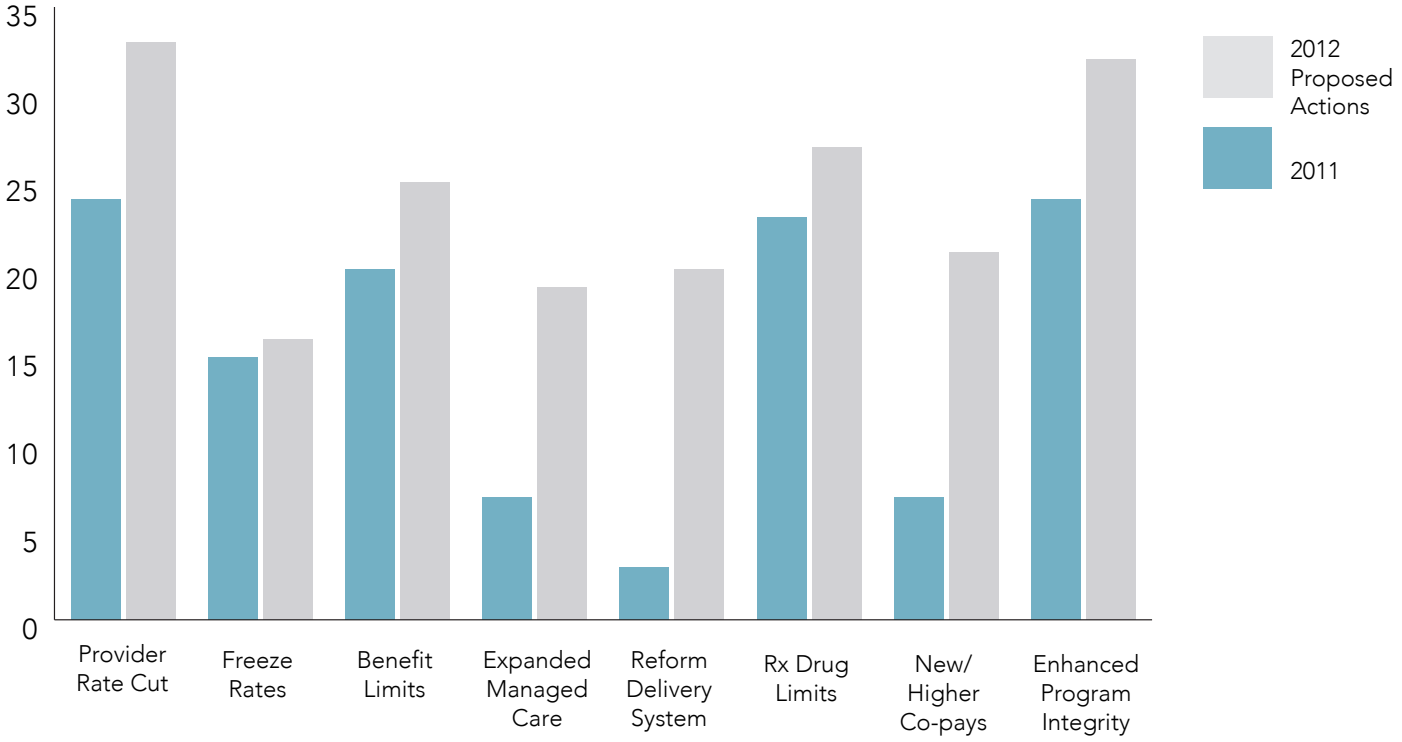
"Maintenance of eligibility" requirements contained in both the ARRA and the Patient Protection and Affordable Care Act (PPACA) have precluded the states from enacting eligibility restrictions to reduce program costs. Instead, states have focused primarily on freezing or reducing provider rates, benefit limits,

Figure 1: Medicaid Enrollment & Expenditures, FFY 2009



Source: Office of the Actuary Centers for Medicare and Medicaid Services. 2010. 2010 Actuarial Report on the Financial Outlook for Medicaid. Baltimore, MD: Centers for Medicare and Medicaid Services.

Figure 2: Medicaid Cost Containment Strategies



Source: Husch B, Cummings L, Mazer S, and Sigritz B. 2011. The Fiscal Survey of States, Spring 2011. Washington, DC: National Governors Association and the National Association of State Budget Officers.

managed care expansions and enhanced program integrity efforts to find savings. Unfortunately, reducing adult dental benefits or eliminating the coverage altogether has been among the benefit cuts that several states, which still offer more than emergency dental services, have put in place. As with most "optional" benefits (i.e., not a federally mandated Medicaid benefit), adult dental services are a frequent target of budget officials in search of savings.

As the weight of continued enrollment growth and depressed revenues have mounted, cost-cutting actions other than those highlighted in Figure 2 have crept into the national dialogue. "Block granting" of federal Medicaid funding has been proposed by the U.S. House of Representatives and a number of Republican governors. Moreover, there have been discussions, albeit preliminary, of potentially eliminating Medicaid altogether.

Despite the concerns over its long-term viability, Medicaid is poised for a significant expansion as the nation moves closer to health care reform. As provided in the PPACA, "categorical" eligibility requirements essentially will be eliminated in 2014 such that anyone with income at or below 133% of the federal poverty level (FPL) will be eligible for Medicaid. As a result, it is estimated that Medicaid enrollment will swell by 16 million persons equaling approximately one-half of the 32 million projected to be newly insured under the PPACA.

Medicaid has played somewhat of a "dual role" during the stressful economic times of the last several years. On the one hand, the burgeoning cost of maintaining Medicaid presents difficult fiscal challenges for federal and state officials. However, the program also has been a lifeline for those persons who lost their jobs (and health coverage) during the recession and became eligible for Medicaid. The program also has provided states a means of insuring and protecting the health and well-being of its citizens hit hardest by the recession.

FINANCIAL STRUGGLES ASIDE, THERE IS GREAT MOMENTUM IN ORAL HEALTH

Despite the deep financial trouble that has enveloped the nation and its health care system, there also has been an unprecedented focus on oral health. Several well-publicized events have clearly identified much needed improvements in our oral health system. The tragic death of Deamonte Driver (a young Medicaid enrollee in Maryland who died from complications of an infected tooth) and Mission of Mercy (MOM) projects (free dental clinics for underserved persons which have shown a bright light on the depth of unmet oral health needs) are constant reminders of how much needs to be done. However, the promising news is that much is happening across the country to respond to these issues.

> "...there has also been an unprecedented focus on oral health."

There is growing evidence and understanding of the critical relationship between oral health and general health. The impact that oral disease can have on other systems within the body and in exacerbating other health conditions is becoming clearer each day. There is greater awareness of the importance of maintaining good oral hygiene as a means of maintaining an overall healthy body. As a result, initiatives are underway across the nation, including collaborations between medical and dental providers, to provide more holistic and comprehensive care to patients.

In the face of severely limited resources, the federal government and many states are pushing forward with new initiatives to increase dental provider availability, utilization of services, and improved quality of care. The U.S. Department of Health and Human Services launched its Oral Health Initiative in April 2010, to expand oral health services, education and research. Through this initiative, the department is increasing its support of and expanding its emphasis on access to oral health care and the effective delivery of services to underserved populations. In addition, the Centers for Medicare and Medicaid Services (CMS) has developed an Oral Health Strategy aimed at improving oral health access for children enrolled in Medicaid and CHIP. The strategy centers on the establishment of new state and national oral health goals to increase use of preventive services for children. States also are developing new initiatives and strategies for increasing the number of children receiving needed oral health services, some of which are highlighted in other articles in this symposium.

Perhaps even more encouraging is the involvement and partnerships that have developed between providers, payers, policymakers, payers, philanthropy, and advocates to make oral health a national priority. There is a feeling across the country that the time is now for oral health. While there are policy issues about which there is disagreement among various groups, there are a far greater number of issues for which there is agreement and alignment among stakeholders. And, a commitment among stakeholders to address these issues, together, is growing each day. One example is the recent establishment of the U. S. National Oral Health Alliance. Formed in response to the 2009 Access to Dental Care Summit hosted by the American Dental Association, the Alliance provides a new platform for individuals and groups with multiple interests to develop shared solutions that promote optimal oral health through prevention and treatment for underserved children and adults across the country.

Financial and policy challenges in Medicaid and other programs geared toward assisting low-income and underserved persons are perhaps more daunting than ever before. However, in spite of these tough challenges, there is a newfound and growing recognition and enthusiasm for oral health. The energy being directed toward ensuring optimal oral health for all is amping up. To ensure ongoing progress, it is critical that the momentum and priority being given to oral health be continued, championed, and celebrated.

"There is growing evidence and understanding of the critical relationship between oral health and general health."

New Horizons: How Public Programs Can Leverage Medicaid Resources

Kathryn Dolan, RDH, MEd; Cathy Coppes & Greg Folse, DDS

This session presented several federal and state Medicaid policies and programs related to the delivery of oral health care services in school-based settings. Specific Medicaid issues related to mobile, portable and teledentistry were discussed. Strategies for meeting the 2010 Centers for Medicare and Medicaid Services (CMS) oral health goals were highlighted.

KATHRYN DOLAN, RDH, MED: A FISCALLY VIABLE MODEL FOR INCREASING ACCESS TO DENTAL CARE FOR MEDICAID BENEFICIARIES

In 2004, Oral Health Across the Commonwealth (OHAC) began as a pilot project in the Boston and Springfield areas of Massachusetts, serving the vulnerable population of adults and children with intellectual and developmental disabilities. After a pilot phase of one year, OHAC expanded its focus beyond this special needs population to include children enrolled in Head Start and other low-income families. A collaborative relationship between the Tufts Community Dental Program and the Commonwealth Mobile Oral Health Services was established in 2005, which allowed this comprehensive care model to deliver oral health care to underserved populations statewide. The cost of the Tufts Community Dental Program is approximately $730,000 annually with 80 percent of the program cost covered by Medicaid reimbursement and the remainder covered by private and public grants, as well as in kind support. The OHAC program has increased access to dental care to populations with significant access barriers through collaboration and development of public and private partnerships.

PROBLEM

In Massachusetts, a significant proportion of the state's children suffer from dental caries and many start school with dental disease. In 2003, a survey of third grade students found that 48 percent had a history of dental disease. In Boston, only 36 percent of low income third grade children had dental sealants compared to 70 percent of their higher income peers.

In 2004, a Massachusetts survey found that 33 percent of children screened in Early Head Start needed dental treatment. Keeping in mind that these programs enroll children from birth to age three, this is an incredible rate of disease among very young children from families with exceptionally low-income. More recently in 2008, an updated statewide survey found that 25 percent of kindergarten students had a history of disease. Furthermore, 40 percent of third grade students had a history of disease and only 45 percent of third grade students had sealants placing Massachusetts below the Health People 2010 objective. An oral disease intervention needs to occur to decrease the prevalence of oral diseases in low income children who are covered by Massachusetts Medicaid.

HISTORY

The development and expansion of the Oral Health Across the Commonwealth (OHAC), a portable dental program, includes the following milestones:

- In 1996, the Tufts Community Dental Program (TCDP) was incorporated into the Tufts Dental Facilities for Persons with Special Needs, a program of Tufts University School of Dental Medicine.
- From 1996-2003, children and adults with developmental disabilities were the target population for TCDP services, which included oral health screenings and education, referrals and case management.
- In 2004, TCDP initiated OHAC, as a pilot project, in the Boston and Springfield areas of Massachusetts, which targeted children with special needs, providing preventive dental services with portable equipment.
- In 2005, grant funding from the MassHealth Access Program (MAP), a program addressing access issues

of the state's Medicaid beneficiaries, allowed OHAC to expand to other populations with increased risk for dental disease including low-income children attending Head Start, schools and preschools.

- Also in 2005, OHAC collaborated with Commonwealth Mobile Oral Health Services (CMOHS) to expand capacity and offer comprehensive oral health services in all types of community based settings.
- From 2006-2008, additional MAP grant funding expanded the capacity of the OHAC program.
- In 2008, a three-year grant from the DentaQuest Foundation of Massachusetts allowed for further expansion and enhancement of the OHAC program, creating additional collaborations with community partners.
- In 2010, OHAC began another pilot project, the Fluoride Varnish Program for WIC, providing oral health screenings, anticipatory guidance, fluoride varnish and referral services to infants, children and their parents.

MASSHEALTH ACCESS PROGRAM (MAP)

MAP played a significant role in the creation and growth of the OHAC program. In 2005, Massachusetts reserved $1 million of the Medicaid budget for dental infrastructure to improve access to care and for a state tuition forgiveness program for graduating dentists who would work in Dental Health Professional Shortage Areas (HPSA). The MAP program was unique for Medicaid as it expanded capacity in addition to providing payment for services.

The MAP grant provided Tufts Community Dental Program with the initial funding to purchase seven portable dental units. With this equipment, TCDP began providing primary preventive services at the community programs and thus, became a safety net provider for low-income children. Because of the success of the OHAC program, additional grant funding was obtained from MAP in 2006 and 2007 to expand and serve a larger catchment area.

PROGRAM INFRASTRUCTURE

Currently, the OHAC program provides services at 233 community-based sites. The target population includes children with limited access to care, children with special health care needs and adults with intellectual disabilities.

OHAC targets schools with 50 percent or more of their students enrolled in the Free and Reduced Lunch (FRL) program. The TCDP staff consists of one dentist, ten dental hygienists, three certified dental assistants, six on-the-job trained dental assistants and two part-time billing coordinators.

In Massachusetts, the state Medicaid (MassHealth) policy aligns with the state dental practice acts reimbursing for services by dental professionals. This is important to note because all providers are encouraged to work to the top of their license. For example, certified dental assistants can provide fluoride varnish under general supervision and dental hygienists can place sealants in the school-based programs without a dentist present and be reimbursed for those services.

BUSINESS MODEL

AxiUm is an electronic health record system, similar to Dentrix and Eaglesoft, which is used at dental schools to track student progress with each patient. Tufts University uses this system for billing, but utilizes a paper record in the field because of the limitations with using AxiUm in a wireless setting. Dental providers mail their encounter forms weekly to the billing coordinators, who enter the services into the AxiUm system. AxiUm submits the claims electronically to MassHealth via a clearinghouse and Tufts University receives payment from MassHealth in approxi-

mately three to six weeks. During the 2010 – 2011 school year, TCDP billed for 5,284 dental prophylaxis, 12,361 fluoride varnish treatments, 6,215 dental sealants and 2,576 behavior management services.

IMPACT

During the 2010-2011 school year, 10,359 patients were served, which included: 9,792 children, 2,009 children disabilities, and 7,828 MassHealth beneficiaries. The table below depicts the growth of the program from fiscal year 2005 to 2011. The charged production and adjusted production totals reveal a significant differential as a result of lower Medicaid reimbursement. Even with the adjusted levels, Tufts has been unable to collect 100% of production. As long as there are children without dental coverage, this will continue to be a challenge.

Table: Tufts University Program Data FY05 to FY11

Fiscal Year	Charged Production	Adjusted Production (based on MassHealth Fees)	Collections	% Collections
FY'05	$103,305	$70,278	$49,225	70%
FY'06	$210.718	$143,288	$135,892	95%
FY'07	$462,550	$314,543	$224,773	72%
FY'08	$600,147	$408,010	$335,175	82%
FY'09	$682,111	$463,835	$313,335	68%
FY'10	$749,730	$509,816	$419,597	82%
FY'11	$1,054,397	$684,201	$553,092	81%

CHALLENGES

While billable procedures account for 80 percent of the revenues, additional gap funding is needed to assure that dental services are available for all children in the program. There are children receiving OHAC services who do not have coverage by MassHealth or third party carriers to reimburse services. Other funding sources include public and private grants, MDPH Office of Oral Health and Tufts University School of Dental Medicine.

Enrollment is another challenge with variations ranging from five to forty percent by school. To address this, Tufts has received grant funding to hire an Oral Health Advocate who will work with school nurses, teachers and families to increase participation in the school-based dental program.

Another challenge is the referral and case management of children who need specialty services. There is a significant need for more pediatric and other specialty dentists to accept Medicaid patients, especially in the rural areas. In Massachusetts, there are sixty one community-based low-income dental clinics that offer dental services, but many have long waiting lists and may have specific criteria to become a patient.

There are also concerns from community dentists about the quality and the services being provided in the school-based programs. Meeting with the community dentists and establishing protocols for referrals is important, as well as revisiting these policies annually to ensure that all parties are still in agreement.

POSITIVE OUTCOMES

There has been an increase in the involvement of dental, dental hygiene and nutrition students in the OHAC program during the past three years, allowing these students to gain experience with Medicaid beneficiaries and giving them exposure to a patient population that they may not other-wise experience. There are now 188 dental students, 55 dental hygiene students and eight nutrition interns who rotate through the OHAC community-based program annually.

A partnership was recently formed between TCDP and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to pilot an oral health program

that provides basic oral health screenings, anticipatory oral health guidance, referrals for dental service and fluoride varnish applications. During FY'11, over 800 families received services at selected WIC sites in Massachusetts.

One public school in Boston donated space for a three chair dental clinic and a second charter school donated space for a two chair clinic. Having dental services available year round has had a significant impact on the oral health and overall health of the students attending these two schools.

LESSONS LEARNED

1. Educating public and governmental agencies is extremely important to increase awareness of access to oral health care issues.

2. Sustainability of the OHAC program requires generating revenue from billable services as there are children receiving OHAC services who do not have coverage by MassHealth or third party carriers to reimburse services. Additional gap funding is needed to assure that dental services are available for all children in the program.

3. Partnering with private dental providers is critical to ensure appropriate referral for procedures that cannot be provided in the school setting, such as specialty services (orthodontics and oral surgery).

4. Maximizing the use of ancillary personnel in providing preventive services as allowed by the state Dental Practice Act has positive effect on the financial viability of the program.

5. Improved efficiency in billing, patient data management, and health record documentation leads to added incomes and better assessment of outcomes data.

CONCLUSION

The TCDP original model utilized dental hygienists for screenings, oral health education and referral services for children with special health care needs and adults with intellectual disabilities at schools and adult day programs. It was completely dependent on the state budget. The new model utilizes the entire dental team to provide comprehensive services to children, children with special health care needs and adults with intellectual disabilities at Head Start programs, preschools, schools, WIC programs and adult day programs. The new model is currently 80 percent sustainable by billing public and private insurance and strives to be completely sustainable by the end of 2012.

This program is an example of a successful oral health services model that resulted from collaborations with agencies within the Commonwealth and in the surrounding community. The program has shown improved access to oral health care outcomes as a result of its success.

CATHY COPPES: HOW TITLE V AND PUBLIC HEALTH PROGRAMS CAN LEVERAGE MEDICAID RESOURCES

Iowa provides an example of how Medicaid can partner with Title V public health agencies to provide preventive oral health care to Title V, Medicaid eligible and low income children and increase access to dentists. An interagency agreement between the Iowa Department of Human Services (Medicaid) and the Iowa Department of Public Health (IDPH) allows for components of the oral health mandate under the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) to be provided by dental hygienists contracted by Title V agencies. With the interagency agreement, specified preventive dental services provided by Title V agencies under the IDPH are reimbursed by Medicaid. Since the implementation, the numbers of Medicaid eligible children receiving preventive oral health services and accessing care from a dentist continues to rise each year.

BACKGROUND

When Congress authorized the Social Security Act in 1935, it included Title V in order to ensure the health of the nation's mothers and children. The Health Resources Service Administration (HRSA) is the federal agency that administers Title V. States receive funding from HRSA's Maternal and Child Health Bureau in the form of federal block grants, which are large sums of money from the federal government to states or regions with only a general requirement of how it is to be spent.

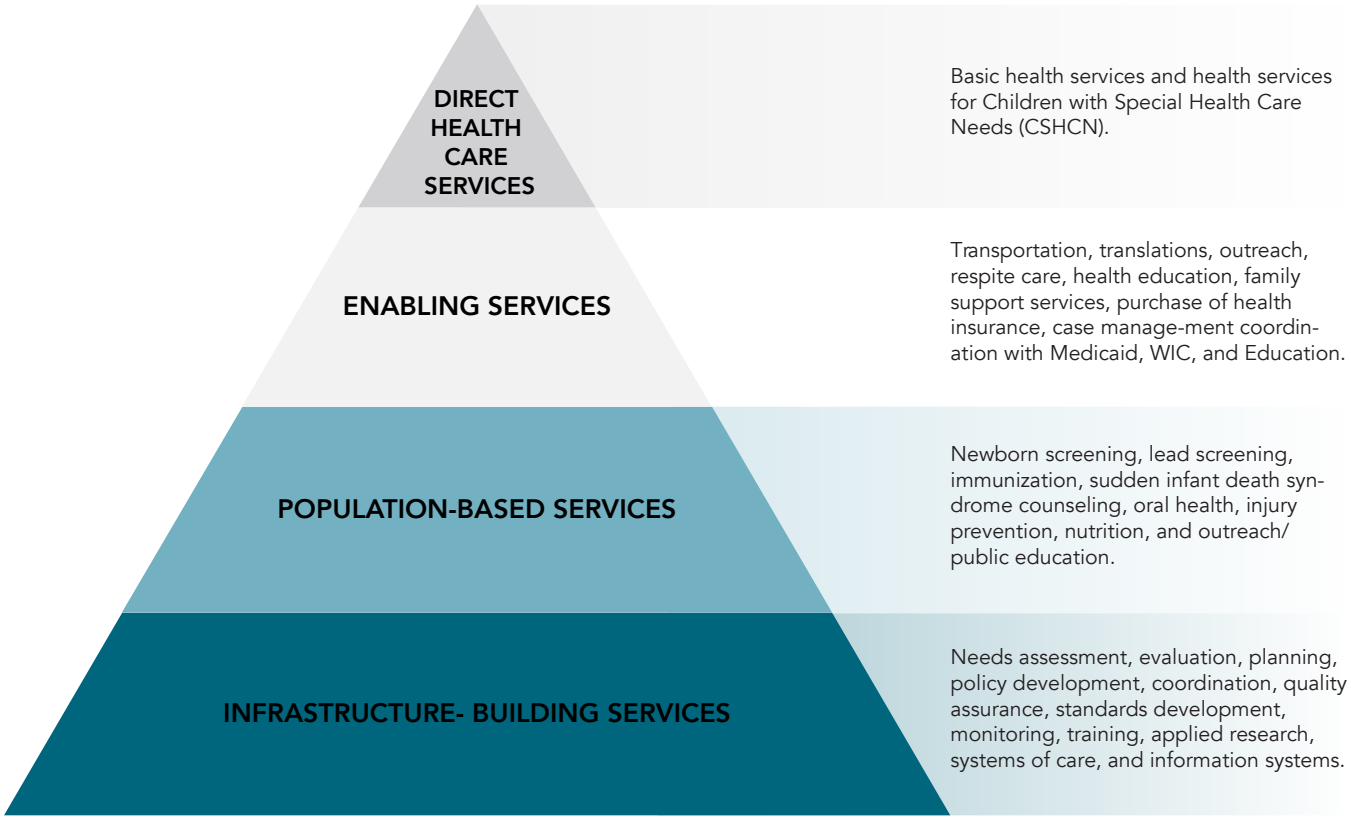
In comparison, Medicaid was created in 1965 through

Title XIX of the Social Security Act to provide medical assistance for low income families, children, and the aged, blind and disabled. The Medicaid program is administered by the Centers for Medicare and Medicaid Services (CMS). Medicaid funding is based on a federal to state dollar match, which varies from state to state but the equation is roughly two-thirds federal dollars and one-third state dollars. Each state must have a state Medicaid plan approved by CMS that specifies how the money will be spent. State plans include eligibility, services covered, and limitations. They must include coverage for Medicaid services mandated by CMS, but may also include optional services that the state elects to provide, such as dental services for adults. The EPSDT program is mandatory for children.

The conceptual framework for Title V Program is a pyramid with four tiers. At the base, there is infrastructure-building followed by population-based services, enabling services and direct healthcare or gap-filling services. Enabling services include care coordination with the Medicaid program and direct healthcare services are the Title V services that may be linked with Medicaid.

IOWA HISTORY

The Iowa state agency responsible for administration of the Title V Maternal and Child Health Program is the Iowa Department of Public Health (IDPH), Bureau of Family Health. The Iowa Department of Human Services (IDHS) administers the Iowa Medicaid program. IDPH contracts with public and private agencies for the Title V Maternal Child Health (MCH) services, which includes both the enabling and the direct care service categories. These agencies are county public health departments, visiting nurse associations, community action programs and hospital organizations.



Source: Understanding Title V of the Social Security Act, US Department of Health and Human Services, Maternal and Child Health Bureau

"Each state must have a state Medicaid plan approved by CMS that specifies how the money will be spent."

BACKGROUND AND STATEMENT OF THE PROBLEM

The EPSDT child health benefit under the Title V program requires screenings for vision, hearing and dental services for children. Over 20 years ago, there was an opportunity for change in Iowa. In 1992, a survey noted that only 14% of Iowa children received any kind of screening under EPSDT. Clearly that was a problem and certainly not compatible with the Title V mission of helping to ensure the health of children. At that time, the EPSDT outreach and care coordination services were provided at the local IDHS offices. These offices are also charged with eligibility determinations and providing child and adult protective services and services for the elderly and disabled. People in need of money for food and rent, people physically harmed or at risk for harm were their priority.

To address the need for better EPSDT outreach and care coordination, these services were transferred from IDHS to IDPH. This was accomplished by an interagency agreement that is updated annually and has expanded over time.

Also in 1992, Iowa adopted the American Academy of Pediatric Dentistry (AAPD) standard for dental visits for the EPSDT program highlighting necessary dental services. This adoption of the AAPD periodicity schedule brought a new found awareness of oral diseases and highlighted prevention strategies. What was once a "silent epidemic" had more visibility across Iowa.

PROBLEM

In 1995, one of the Iowa Title V agencies asked for and received permission from IDPH to employ a dental hygienist and was soon followed by most Title V agencies. Medicaid was asked to pay for the oral screenings provided by dental hygienists as a gap filling measure. However, Medicaid funding is not typically set up to reimburse Title V agencies funded with block grants. A funding mechanism for the screening services provided by a dental hygienist was not available. The Iowa state law that limits what services can be reimbursed under the Medicaid program did not include payments to Title V agencies.

SOLUTION

In Iowa, there are two ways to make a policy change in Medicaid to get coverage for traditionally non-covered services. One is the administration rule change and the other is *exception to policy process*. Changing the administrative rule in Iowa is a very lengthy process because it is essentially changing the law and is generally not implemented for about six months after the decision for change is made.

The more immediate solution is the *exception to policy process*. Iowa has a formalized process that allows consideration for an item or service not otherwise covered in unusual and exceptional situations and is an *exception to policy*. Each request must be in writing and only the Department Director can authorize an exception. The website for additional information is www.dhs.state.ia.us /dhs/appeals/exceptions-policy.html.

In 1998, Iowa received the first *exception to policy* request and authorized Medicaid to allow reimbursement to a Title V agency for oral health screenings for Medicaid-eligible children provided by dental hygienists. Medicaid policy staff regularly reviews what types of exception requests are received to determine whether a request can or should be placed under regular Medicaid policy. This often necessitates a change to the Administrative Rule as was the case in 2004 to allow Medicaid to pay the Title V agencies for dental hygienists' services in screening centers. Another issue that required policy attention was developing a methodology for the Title V agencies to bill Medicaid. A claim format needed to be determined. No *Current Dental Terminology* (CDT) dental code exists for an oral screening. The Medicaid billing issues were addressed by instructing the Title V agencies to use a claim format with which they were familiar (CMS 1500) when billing Iowa Medicaid. With the uniform billing requirements under the Health Insurance Portability and Accountability Act (HIPAA), the local codes were changed to CDT dental procedure codes with the use of a modifier, which reflects that the examination codes billed are actually oral screenings provided by a dental hygienist.

Table: Impact of Iowa Title V Program on Medicaid

FY	# Eligibles under 21	# Any dental service	% Any Dental Service	# Title V Oral Screening	% Eligibles with Screening	% Any Dental Service with Screening
1999	167,855	55,256	32%	517	0.3%	9.3%
2000	172,815	55,364	32%	1,910	1.1%	3.4%
2001	182,821	63,714	34%	3,164	1.7%	5.0%
2002	201,753	75,830	37%	4,372	2.2%	5.7%
2003	214,933	83,622	38%	5,764	2.7%	6.9%
2004	228,738	91,871	40%	7,114	3.1%	7.7%
2005	239,068	98,875	41%	8,582	3.6%	8.7%
2006	245,785	104,473	42%	9,990	4.0%	9.6%
2007	248,169	107,631	43%	14,887	6.0%	13.8%
2008	255,061	116,785	45%	16,522	6.5%	14.1%
2009	277,541	138,593	49%	20,572	7.4%	14.8%
2010	299,743	143,242	47%	20,496	6.8%	14.3%

Source: Iowa CMS 416 Reports

RESULTS

As a result of Title V and Medicaid collaboration, access to oral health care services for Medicaid beneficiaries has increased. Before Title V programs were reimbursed for oral screenings in Iowa, in 1999, only 32 percent of Medicaid enrolled children (birth to age twenty one) received any dental service. By 2009, the number had increased to 49 percent. The numbers are more striking when looking at the one to two year age group. In 1999, only 10 percent of those children received any dental service, but by 2009, that number had increased to 38 percent. The numbers in the chart above reflect the change.

DISCUSSION

Dental disease is entirely preventable. Early childhood preventive care can significantly reduce the lifetime costs for dental treatment. Lack of knowledge of the importance of oral health care, as well as the difficulties that Medicaid beneficiaries encounter finding a dentist, negatively affect their oral health across the lifespan. Iowa's use of dental hygienists in local Title V public health programs has resulted in significantly more Medicaid-enrolled children receiving dental care. Increased exposure to oral health services in non-traditional settings can result in improved access outcomes. Iowa has shown that relevant policy changes can lead to positive health outcomes for its Medicaid beneficiaries.

GREG FOLSE, DDS: SCHOOL-BASED DENTISTRY CAN BE DONE WELL

This presentation details critical and successful aspects of a school-based portable dental practice serving untreated, vulnerable Louisiana Medicaid eligible children. The program started in response to the serious access to care crisis in the state resulting in 505,000 untreated children in 2009. Even though the dental expenditures doubled in the state between 2004 and 2008, the effective number of children treated remained the same. Use of mobile or portable dentistry models increased the numbers of children receiving treatment, especially those most vulnerable in the Medicaid population.

BACKGROUND

The delivery model described uses twelve dentists (both full and part-time) going to 275 schools and providing portable In-School dental services. These services are comprehensive in nature, including provision of oral health/hygiene/dietary instructions, exams, x-rays, fillings, sealants, primary tooth extractions, stainless steel crowns, space maintainers, and fluoride treatments. From the inception of the program in November of 2008 to June 2011, over 17,000 children were seen. 14,000 children had all of their dental needs met (3000 were pending follow-up care), and 15,000 more children were signed up for services.

Please note that provision of oral health/hygiene/dietary instructions is the first step. Educationally, a great way to break the cycle of oral disease and neglect is to teach these children about their own oral health. This practice delivery model focuses on that teaching opportunity providing detailed instructions to every child who is seen, whether treated or not. The X-Ray technician's main job at every school visit is to provide that education first, then to take necessary radiographs. This lighthearted and fun educational experience sets the stage for a good dental visit for each child.

Several policies make school-based care function well. A well running and maintained emergency referral system and specialty referrals with follow-up protocols are crucial. This model developed partnerships with school districts and school nurses to identify both children in crisis needing emergency referral as well as the tracking of those who were routinely referred. These efforts ensure that all children receive the care they need outside of the school-based clinics.

With the introduction of the program into school systems, several educational opportunities presented themselves. Lectures to school-based nurses entitled *Oral Neglect: What it is, What to Do, and When to Act* were provided. Similar presentations were made to teachers, principals, and administrators. The inclusion of school-based dentistry into school districts has created an oral health awareness that positively affects oral health outcomes. All involved can have their concerns about oral health of this vulnerable population routinely addressed.

Providers working in the programs are continually amazed at how well the children behave during treatment. The school provides a structured and familiar environment. When combined with the aforementioned educational experience and seeing others receiving treatment, most children are compliant with treatment instructions and procedures. The current mobile dental equipment available to providers makes providing dentistry in portable clinics easy, with the standard of dental care provided in portable clinics equal to that provided in private offices. There is no difference in the care provided, only the location in which it is provided.

Understanding informed consent and parental contact is a crucial issue for all involved. This model uses a written general informed consent form to establish the dentist, parent (or guardian), and patient relationship. The form contains necessary legal and HIPPA wording, asks for all pertinent medical information, and gives the parent options to both attend all visits and opt out of any specific procedures. The general informed consent also obtains consent for specific routine procedures prior to seeing the child, allowing the dentist to work on the child at the first appointment. Although this type of consent is not the norm for most dental offices, many portable and in-office access to care practices throughout the country use general informed consent for their successful programs. This consent is viewed and interpreted legally as the complete agreement between the parent and the provider and actually would supersede history of a verbal conversation.

Requiring a phone contact with each parent to obtain consent seemed like a good idea until one attempts to put it in practice. It was reported in the Louisiana Legislature that in East Baton Rouge Parish 1.6 million phone calls were made to parents and only a 40-45 percent connection rate was achieved in the poorest areas. That relates to a substantial barrier to care for the most vulnerable children. Statistically on a state level, when one multiplies 505,000 untreated children with a 55 percent lack of

phone call connection rate the result is 277,000 children who would be denied care due to a required phone call.

If you want the most vulnerable and diseased children to receive care, it would be better to require access to care programs to only see those children whose parents couldn't be reached by phone. It is those children who need these services the most. Additionally, requiring parental presence at a school-based dental clinic, as some states have attempted to do, is a death knell to success.

Cherry-picking is a buzz word used by foes of school-based programs that makes payers, Medicaid Program Managers, and providers cringe. The term references programs that provide only preventive services in schools coupled with empty referrals for definitive restorative treatment. In these models, it is alleged that if the child makes it to a dental office, those providers get upset because they can't bill for the preventive and diagnostic services, making the typically low Medicaid reimbursement rates not cost effective for viably treating Medicaid patients.

Unfortunately, this term has been used against even the best programs in political arenas causing alarm. Although seemingly warranted in some situations, each individual school-based program should be analyzed on merit and the actual services and policies they implement. Besides providing a full complement of comprehensive services, the program presented refers children to other offices "Benefits Intact." No matter what services were provided up to the referral point, nothing is billed to Medicaid, allowing the receiving dentist to bill for all of the services they provide. Additionally, in Louisiana, Medicaid allows a twelve month look-back. The program presented searches the record of every child and if Medicaid received a bill from another dentist during the prior twelve months, an attempt is made to refer that child back to their dentist of record. Regardless of the success of a particular school-based program, the organizers/owners of that program should expect questions and attacks by those who don't understand, or feel they are in competition with that program.

Subsequent to the June 2011 presentation, the school-based program described has seen great success. Over 43,000 patient visits to over 20,000 individual patients occurred providing over 47,000 fillings and 3,000 specialty referrals. Perhaps the best accomplishment of all, however, is that oral health/hygiene/dietary instructions were given over 43,000 times. Breaking the cycle of oral disease and neglect can be done. Mobile and portable school-based oral health programs can be a vital part of the access to care infrastructure in the United States.

Program Integrity in State Medicaid and CHIP Programs

Martha Dellapenna, RDH, Med; David Kilber, DDS; James Thommes, DDS

This paper explores the issues related to Medicaid and CHIP dental program integrity. State Medicaid and CHIP Dental Program Managers, third-party administrators and others play a role in ensuring program integrity by developing and implementing policies, processes and tools that limit the overuse, underuse and misuse of services in the program for the purpose of safeguarding and improving the health and welfare of Medicaid and CHIP recipients.

In order for a Medicaid and/or CHIP program to be efficient and effective, all of the parties involved need to work together and understand program policies and processes and be aware of service utilization norms among patients and providers. The collection and utilization of data is essential to this effort. In both public and commercial dental insurance administration, states/companies are just beginning to embark on using more sophisticated data collection and analysis techniques. These techniques will not only allow the detection and prevention of fraud and abuse but also help all parties understand how practice patterns vary by providers and which patterns may lead to improved health outcomes.

BACKGROUND

It is the responsibility of all Medicaid and CHIP stakeholders (state and federal government policy makers and administrators, payers, providers, educators and patients) to ensure that the billions of dollars spent in the these programs are spent in the most efficient and effective way. The management of these dollars is a multi-pronged effort that should focus on preventing both the intentional mismanagement of program dollars as well as the unintentional mismanagement of program dollars caused by a lack of knowledge and/or education around current or standard processes and practices. Clearly, fraud and abuse are a problem that must be dealt with but the use of data for management of utilization for quality purposes should also be considered as an essential component of any plan for program integrity.

Fraud is defined by the Centers for Medicare and Medicaid Services(CMS) to be the intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. This includes any act that constitutes fraud under applicable Federal of State law. Abuse is further defined by the Centers for Medicare and Medicaid Services (CMS) to be: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. This includes recipient practices that result in unnecessary cost to the Medicaid program.

"In order for a Medicaid and CHIP program to be efficient and effective, all of the parties involved need to work together and understand program policies and processes."

State Medicaid dental programs are responsible for detecting and preventing fraud, waste and abuse program-wide. State Program Integrity Units (PIUs) and State Medicaid Fraud Control Units (MFCUs) protect Medicaid Program dollars. Provider, member and vendor actions are monitored, investigated, and if necessary referred to law enforcement. CMS offers States technical assistance, guidance and oversight on an ongoing basis.

"At a minimum, dental program managers should be aware of PIU and MFCU contacts and of their various procedures around investigating fraud and abuse."

From a federal perspective, Medicaid program integrity was impacted in 2006 by the passage of the Deficit Reduction Act (DRA), which created the Medicaid Integrity Program (MIP) under Section 1936 of the Social Security Act. The MIP is a comprehensive federal strategy to prevent and reduce fraud, waste and abuse in the $447 billion per year Medicaid program.

METHODS OF IMPROVING PROGRAM INTEGRITY IN MEDICAID AND CHIP DENTAL PROGRAMS

With increasing focus on Medicaid and CHIP program integrity, dental programs must also be an area where the scope and breath of policies, processes and procedure around fraud and abuse are well defined. Periodic program review and subsequent program improvements are essential to an organized and effective program.

STATE MEDICAID DENTAL DIRECTOR OR PROGRAM MANAGER'S ROLE

A State Medicaid Dental Program Manager's role around program integrity varies by state but usually includes one or some of the following functions:

- Oversight and monitoring of contractor/s
- Direct involvement in case review
- Policy and/or Program Integrity Plan revisions
- Dental provider education

Some degree of ongoing involvement by dental program managers in the identification of program integrity issues and trends fosters good communication between departments within the state. Whereas the sharing of timely and relevant information among PIUs, MFCUs and state agencies is essential, dental program managers can also be instrumental in creating linkages among parties involved in an investigation and lending critical program expertise when necessary. Dental program managers have a good understanding of dental claims databases, which are the most vital baseline component for gathering the essential data necessary to perform accurate and complete program monitoring.

Although a state Medicaid and CHIP program manager's interaction with PIUs and MFCUs does vary from one state to the next, at a minimum, dental program managers should be aware of PIU and MFCU contacts and of their various procedures around investigating fraud and abuse. There is also an opportunity for state dental program directors and managers to interact with CMS regarding program integrity issues.

A comprehensive Medicaid Program Integrity Program should include:

- Written policies and procedures for a consistent, documented approach
- Training and retraining for employees
- Periodic review of the Program's policies and procedures

THE ROLE OF THE PAYER/ADMINISTRATOR

The integrity of state Medicaid and CHIP dental programs must be maintained through ongoing efforts to combat Medicaid provider fraud, waste and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients.

As an integral part of state policies focused on program integrity, program surveillance data and sophisticated data mining processes are key elements. Very often this role is filled by the third party payer/administrator and their employees and contractors who are responsible for ensuring an adequate system to collect and analyze data for overall quality and utilization, fraud, and abuse management.

Payers use their claims systems, data analytics and fraud prevention tools and applications to monitor and develop provider networks, manage plan design, cost, and outcomes and to identify individual providers or members who may be gaming the system. They also use these systems to evaluate and enhance claims processing edits and to manage overall program integrity.

Payers work closely with state and federal agencies such as state dental program directors and the CMS and/or the Office of Inspector General. They may take referrals regarding suspicious or fraudulent activity from these entities or from members or other providers and their staff and will work together to determine if there is in fact fraud and/or abuse and to determine the appropriate intervention or action.

Payers' Claims payment systems most often have built in system edits that will deny duplicate services, services performed outside of time and/or frequency limitations, services that do not meet eligibility or age requirements, etc.

Payers may also have processes in place that help detect fraudulent activities such as:

- Billing for services that weren't provided. This can be detected through data analysis of the number of expected visits and/or services within a day between providers.
- Unbundling of charges. This is a practice where the provider separates the components of a procedure, billing them separately rather than using the appropriate code describing the total procedure. This practice usually results in a higher reimbursement.
- Services or upcoding of services. This is a practice where the provider bills for a service at a level higher than the one performed. One example of this is billing for a partial or full bony extraction rather than a simple extraction.

More mature and sophisticated systems can support fact based management and decision-making. Data is critical to managing Program Integrity, according to the National Healthcare Ant-Fraud Association. Companies like P&R Dental Strategies, Inc., a national dental cost containment consulting firm, have adopted "best practices" from the medical insurance marketplace. In the medical and commercial markets, the analytic tools incorporated in their data warehouse and dental data analytic applications provide users with depth and flexibility, enabling them to view both pre-formatted and customized reports specific to their needs. The program reporting available from these tools include some of the traditional fraud and abuse reporting mentioned above as well as more sophisticated analysis that can profile practice patterns and provide outcomes analysis compared to peers. These tools could and should be expanded for quality improvement purposes.

The purpose of all of the tools currently in place is to identify behaviors that are out of the norm, of questionable medical necessity or fraudulent. Once identified, payers begin to delve deeper into the data to determine the exact issue. This may be done by additional data review, focused review of particular providers and procedures and/or by conducting records audits, in-office audits and, in some cases, in-mouth reviews of patients. Once complete, the appropriate intervention can be implemented. This may include provider education and behavior modification, peer review to suggest different or additional recommendations and changes, financial recovery,

removal of the provider from the network and finally, recommendation back to the appropriate agencies for removal of licensure or for criminal prosecution.

ISSUES AND CONCLUSIONS

Although there are systems in place that aim to improve program integrity, all of the partners in the system clearly have additional work to do. This effort should be an ongoing evaluation process aimed at continuous process and quality improvement. Due to the levels of bureaucracy, a lack of clarity around the roles of federal and state agency and the state-to-state differences in plan design, funding and management, Medicaid may not be a system of care and financing that is as efficient as it could be. According to Steven Malanga of the Manhattan Institute, "At $300 billion, Medicaid is one of our federal government's biggest programs—one it shares with the states, which administer it. Unfortunately, Medicaid often also seems like one of our most-abused programs, the subject of an estimated $30 billion in waste and fraud each year by recipients, health-care providers and outright scam artists who target the program."

It should be noted that not all waste in the system is due to fraud and abuse and that most providers are not acting with the intent to manipulate or take advantage of the system. In fact, those that do game the system place a financial burden on all participating providers since the money spent on fraud and abuse could be spent to increase reimbursement and/ or pay for additional necessary services.

It also should be noted that there is data available that may help all of us to make decisions about what is quality care in dentistry- what services provided to whom and at what time produce the best outcomes at the best possible price. Again, the problem lies in that states have varying abilities to get at this data. States can and should require their vendors and contractors to meet certain standards around the ability to collect and analyze data for these purposes.

Data is the key to managing the problems that plague dental Medicaid. Not just data, but clean, comprehensive, nationwide data and state of the art data warehousing and analytic tools. There are no losers in establishing a powerful national Medicaid data warehouse and protocols for the use of data analytics that exist today to support fact based management and decision-making.

Medicaid data is currently fragmented and in some states considered of questionable quality by the highest levels in state Medicaid management. If the data in its current state is not accurate, how can it be used to make timely, fact-based decisions? There is a need for a nationwide system using existing technology to establish state of the art controls and best practices. State Medicaid departments, dental providers and the patients they serve are those that will benefit from the establishment of nationwide clean Medicaid data. State Medicaid directors, payers and other key stakeholders are in key positions to be able to share their data, collaborate in conducting studies, and support establishment of best practices from state to state. It is only with a collaborative approach that we can be proactive and better manage Medicaid plans, increase Medicaid program integrity, reduce unnecessary benefit costs and ultimately improve quality and service outcomes.

“Data is the key to managing the problems that plague dental Medicaid.”

Tuning up the Engine

William Bailey, DDS, MPH

An engine is a piece of complex machinery that only operates when all parts work in concert with one another. When applying the analogy of tuning an engine to improving public health, the first step is to perform an assessment to identify problems, define roles, and understand the context in which these roles exist. Once roles are clearly understood, they can be optimized and expanded through partnerships and other opportunities, and oral health can be advanced in an effective, coordinated, and synergistic way.

An assessment of oral health in the United States reveals that our public health engine is out of tune and needs attention. One out of four people over the age of sixty five is edentulous, and more than ninety percent of all adults over the age of twenty have experienced tooth decay (Dye et al., 2007). Fewer than half of third-grade schoolchildren in thirty states have dental sealants (Centers for Disease Control and Prevention, 2011). There are disparities in oral health by race-ethnicity, education, and socioeconomic status. Low-income and minority populations are twice as likely as other groups to have untreated tooth decay. For example, in children aged six to eight years, forty percent of Mexican American children versus twenty five percent of white non-Hispanic children have untreated tooth decay. In addition, adults with less than a high school education are approximately three times more likely to have periodontal disease than adults with more education (Dye et al., 2007).

The nation's economic health is also affected. In 2008, out-of-pocket health care expenditures for dental services by consumers was second only to pharmaceuticals and exceeded $30 billion, which is approximately fifty percent more than was spent for all hospital care and fifty percent more than was spent for all physician services (Bureau of Labor Statistics, 2010). Expenditures for overall dental services exceeded $100 billion in 2008, and these are expected to increase through 2020 (Keehan et al., 2011). And although every dollar spent on fluoridation saves about $40 in dental treatment costs (Griffin et al., 2001), more than eighty million people in the United States lack access to fluoridated water (Centers for Disease Control and Prevention, 2010).

Just as the components of a well-running engine are synchronized, it is important for dental public health professionals working to improve the oral health of Americans to clearly define and understand their roles. Appreciating the larger context of one's own contributions is essential to achieving optimal performance. We must not only perform our jobs well, but we must also understand how our contribution coordinates with what others are doing and integrates into the overall system. Because activities are taking place at the local, regional, territorial, tribal, state, and national levels, it is not easy to know what is happening at all levels. At a minimum, however, we should understand how our work integrates with intersecting or adjacent programs. Strong partnerships represent one of the best ways to optimize roles. For example, in 2011 the U.S. National Oral Health Alliance began to speak with one voice for oral health across the nation (http://www.usnoha.org). In 2008, the Dental Quality Alliance was established by the American Dental Association to advance performance measurement as a means to improving oral health, patient care, and safety (http://www.ada.org/5105.aspx). Within the federal government, in 2010 the Oral Health Coordinating Committee was revitalized with a new charter to coordinate oral health activities across the U.S. Department of Health and Human Services (HHS) (http://www.hrsa.gov/publichealth/clinical/oralhealth/hhsinitiative.html). And this symposium is a powerful venue for seeking ways in which the Medicaid-CHIP State Dental Association can partner with other groups on issues of mutual interest.

Over the past two years, new opportunities across both the public and private sectors have expanded efforts to promote oral health. Government initiatives launched

within the last two years include the Patient Protection and Affordable Care Act (http://www.healthcare.gov/law/index.html), the HHS Oral Health Initiative (http://www.hrsa.gov/publichealth/clinical/oralhealth/hhsinitiative.html), the Centers for Medicare & Medicaid Services (CMS) Oral Health Strategy (https://www.cms.gov/MedicaidDentalCoverage/Downloads/5_CMSDentalStrategy04112011.pdf), the National Prevention and Health Promotion Strategy (http://www.healthcare.gov/prevention/nphpphc), the National Partnership for Action to End Health Disparities (http://minorityhealth.hhs.gov/npa/), the National Action Plan to Improve Health Literacy (http://www.health.gov/communication/hlactionplan/), and the HHS Strategic Plan (http://www.hhs.gov/secretary/about/priorities/priorities.html). Examples of private initiatives include those that have been led by the Pew Center on the States and the DentaQuest Foundation. For example, the Pew Children's Dental Campaign is working to ensure that more children receive dental care and benefit from policies proven to prevent tooth decay (http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=42360). The Dentaquest Foundation just announced a funding opportunity to support their 2014 Oral Health Initiative (http://www.dentaquestfoundation.org/ourwork/oralhealth2014.php). In addition, with funding from the Health Resources and Services Administration, the Institute of Medicine undertook an examination of the current U.S. oral health care system and recommended strategic actions for HHS agencies and external partners. As part of this initiative, two reports were published in 2011, Advancing Oral Health in America (http://www.iom.edu/Reports/2011/Advancing-Oral-Health-in-America.aspx) and Improving Access to Oral Health Care for Vulnerable and Underserved Populations (http://iom.edu/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx). These reports serve as our new benchmark, with recommendations that can guide and give energy and emphasis to oral health efforts.

In addition, the CDC works with state oral health programs to build infrastructure and capacity to broaden the ability to prevent oral diseases and promote oral health. Currently, twenty states receive CDC cooperative agreement funding to improve their oral health services and reduce inequalities in the oral health of their residents. This funding can increase effective community preventive services. For example, during 2003–2008, the number of children served by dental sealant programs increased by 108 percent (from 111,550 to 232,205) in CDC grantee states, whereas states without CDC's cooperative agreement had an increase of forty eight percent (Centers for Disease Control and Prevention, internal analysis, 2008-2010). CDC also worked with the Children's Dental Health Project to develop an Oral Health Policy Tool that has been used by states to generate policy changes. For example, in 2008 the North Dakota Oral Health Coalition identified priorities for policy change. Subsequently, five laws were enacted to improve access to dental care in North Dakota (http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm).

In summary, there is a great deal of energy and opportunity surrounding oral health today. To take maximum advantage of these favorable conditions, we need to understand our roles and work together to become a more effective engine for oral health. The path forward includes strengthening and expanding partnerships, leveraging resources, capitalizing on opportunities, promoting oral health literacy, keeping a focus on oral health in the media, and making a compelling case for oral health so people understand its importance to overall physical, social, psychological, and economic health and quality of life (U.S. Department of Health and Human Services 2000, 2003). Moving forward, it would be helpful to develop a national oral health plan or strategic framework to identify priority areas and better coordinate efforts to advance oral health. There is much to do, and we have all the engine parts. We just need to understand what those parts are and how they could work together to make the engine really hum.

The authors would like to give special thanks to Marcy Frosh, JD, Associate Executive Director, Children's Dental Health Project; Mary Foley, RDH, MPH, Executive Director, Medicaid/SCHIP Dental Association; Laurie Barker, MSPH, Susan Griffin, PhD, Barbara Gooch, DMD, MPH, Division of Oral Health; and Kimberlie Yineman, RDH, Director, Oral Health Program, North Dakota Department of Health.

Asking for Directions and Building New Freeways : Report of the Medicaid and CHIP Stakeholder Group Breakout Session

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BACKGROUND

On Tuesday, June 27th as part of the 2011 National Medicaid and CHIP Oral Health Symposium: New Directions for Medicaid and CHIP Dental Programs, healthcare providers, payers, educators, state Medicaid and CHIP Dental Program administrators and policymakers came together following a breakout session entitled Asking for Directions. Each group was independently tasked with answering a series of questions regarding perceptions and experiences with their respective state Medicaid and CHIP dental programs. The five groups discussed key Medicaid and Children's Health Insurance Program (CHIP) issues, policies and program models. Building upon these discussions, each group then identified State and Federal program and/or policy gaps, and then offered recommendations that could potentially improve their relationship with state programs. Upon completion of the breakout session, in a subsequent session entitled Building New Freeways, all participants reconvened collectively to share information and to learn from each individual stakeholder group. The collective audience then delivered strategic recommendations for policy makers aimed at improving the national state Medicaid and CHIP oral health care delivery system.

HEALTHCARE PROVIDERS

This group included general dentists, dental hygienists, pediatric dentists, pediatricians and an oral radiologist. Those gathered cited the following members of the oral healthcare delivery system as missing and would have appreciated their presence: diverse medical colleagues, including family practitioners, internists, nurse practitioners, physician assistants and nurses; other members of the dental team, including dental assistants and office staff; social workers; case managers; community health workers; Head Start personnel; and speech pathologists.

What are your perceived roles, responsibilities, and mission as members of the oral healthcare delivery system?

The group perceived their roles and responsibilities as members of the oral healthcare delivery system to include the following:

- Ensuring *access* to *quality* oral health care across the lifespan
- Providing an integrated health home where medical, dental and behavioral health are viewed as essential primary care within an interdisciplinary approach to patient care
- Creating innovative service delivery models through collaboration and case management
- Ensuring practice sustainability
- Educating patients and the public about the importance of prevention
- Engaging whole communities to increase oral health awareness
- Advocating for change

How do you currently interface or engage with federal and/or state Medicaid and CHIP dental programs?

Discussions between providers and state and federal agencies often start within local health professional societies and

oral health coalitions and then percolate up to corresponding groups within the state level. There is not a standard form of communication employed across the states. Each state administers their own program and within that program, depending upon the program model, communication may be direct between the state and the provider or may be indirect via a contractor, such as a health maintenance organization (HMO), managed care organization (MCO) or other third party benefits administrator (TPA). In those dire circumstances whereby communication fails, litigation may become the avenue of last resort. Though often effective in raising awareness and getting action, such lawsuits tend to antagonize the very entity that providers most need to partner with. Litigation can be a two-edged sword. Most problems can be resolved through improved communication and training of providers, state administrators, third-party payers, and compliance officers.

In some cases, Medicaid providers try to communicate directly with the Centers for Medicare and Medicaid Services (CMS), which can be frustrating, especially if the provider is faced with an audit, an allegation of fraud, or is simply seeking clarification on eligibility requirements, medical necessity, or billing practices. The Medicaid-CHIP State Dental Association serves as an interface to facilitate greater communication at both the state and federal levels.

How have federal and/or state Medicaid programs helped to facilitate or advance your role and responsibilities as part of the oral healthcare delivery system?

Medicaid programs communicate with providers through a variety of means, such as direct communication to individual providers; face-to-face meetings with the leadership of professional organizations; meetings with a broad stakeholder groups; and through written communication and guidance.

In the case where providers are able to meet face-to-face with state administrators, providers report having the opportunity to offer "real" input and desired outcomes have been realized. Providers further reported that states with an established professional oral health advisory committee that convened annually provided for effective communication and improved program administration. It was also noted that state Medicaid agencies that participated in a state oral health coalition and collaborated more regularly with State Oral Health programs often experienced fewer problems.

RECOMMENDATION

National and state advisories to federal and State Programs are recommended to facilitate the transfer of information and improved program administration.

What problems (policies, legislation, rules and regulations, cultural or other) have you encountered with federal or state Medicaid/CHIP programs in attempting to carry out or advance your work?

Issues exist that affect providers and impede the administration of a well-oiled Medicaid oral healthcare delivery system. Navigation of the Medicaid system is by no means intuitive. State systems are complex and inconsistent. In some states, traditional fee-for-service administration exists; however in many states, the program infrastructure has become multi-dimensional. A combination of traditional fee-for-service, managed care, and third party administration is in place. In addition, there are inconsistencies regarding standard of care, and what is perceived or designated as "medically necessary". Mixed messages, burdensome credentialing processes, unrealistic timelines, and inconsistent communication can be frustrating. Though much data is generated, its analysis leaves much to be desired. Customer service can be poor at times and lead to an adversarial relationship between providers and the state dental Medicaid system.

What barriers exist that prohibit/interfere with the successful advancement of your work?

There are other challenges to assuring an effective Medicaid/CHIP oral healthcare delivery system. Patients sometimes cross state lines to receive services. Inconsistent state Medicaid dental policies and regulations limit the capacity of clinicians to provide consistent care across their practice. What might be deemed "medically necessary"

and thus a reimbursable service in one state may not be in another. In addition, eligibility criteria for both patients and providers can vary from state to state. State Dental Practice Acts can also limit what dentists and non-dentist providers can do. Often Medicaid agencies do align payment policies and regulations with State Dental Practice Acts, preventing all dental providers from practicing at the top of their license. Further, Medicaid policies do not support the delivery of oral health and disease prevention services by medical providers. Primary oral healthcare services such as thorough risk assessment, anticipatory guidance, and/or appropriate use of fluoride varnish are an essential part of early oral healthcare and primary prevention of oral diseases and conditions. Finally, the lack of standardized oral healthcare quality measures and dental diagnostic codes for use by both providers and Medicaid/CHIP administrators leaves the meaning of quality oral healthcare undefined.

What suggestions or recommendations would you offer to federal and/or state Medicaid/CHIP dental programs to improve your roles and responsibilities as critical members of the healthcare team?

The healthcare provider group envisioned a brighter future and offered the following recommendations for improvement of the Medicaid/CHIP oral healthcare delivery systems:

Federal:

- Provide a guidance to states for the development of consistent provider credentialing across the states
- Provide a guidance to states on "medically necessary" oral healthcare for the development of consistent oral health benefits and polices across the states
- Consider expanding Medicare to include payment of oral healthcare services for Medicare beneficiaries
- Ensure that all federal Medicaid/CHIP positions are filled with competent representatives of the dental profession
- Ensure that all federal Medicaid/CHIP dental officials are eager to communicate regularly with their constituents
- Assure that the CMS Chief Dental Officer position is filled and held by a representative of the dental/dental hygiene profession
- Collaborate more *regularly* with national dental professional organizations, such as AAPD, ADA, and MSDA

State:

- Establish presumptive eligibility for providers
- Implement simple provider credentialing processes
- Implement administrative policies that promote and support all members of the dental team *providing care at the top of their license*
- Implement and sustain policies that support the delivery of oral healthcare services across the lifespan
- Implement mechanisms that promote transparency across providers, payers and consumers of the oral health care delivery system
- Employ improved communication strategies between providers, state Medicaid dental program administrators, program integrity representatives, and consumers
- Provide timely feedback to inquiries
- Institutionalize a state Medicaid-CHIP dental advisory team
- Expand program improvement efforts using quality and performance metrics and measures developed in collaboration with professional organizations
- Employ MSDA Best Practices in program quality improvement efforts
- Institutionalize program improvement efforts using consistent metrics and measurement in-house and with state contractors such as HMOs, MCOs and TPAs
- Employ pay for performance strategies to promote quality driven oral healthcare
- Implement policies that promote and support the delivery of preventive and chronic disease management services
- Institute provider *preventive service reports* for self-assessment against peers

"Provide a guidance to states for the development of consistent provider credentialing across the states."

- Ensure that all state Medicaid positions are filled with competent officials who are eager to communicate regularly with their constituents
- Increase active participation on state oral health coalitions
- Collaborate with state Title V/Maternal and Child Health agencies to expand Medicaid and CHIP policies that increase access to oral healthcare services for shared program beneficiaries

POLICYMAKERS

Leadership from professional organizations, including AAPD, ADA, AGD, AAFP, ADEA, CMS, CDC, HRSA and MSDA, and others representing Medicaid and CHIP advocacy groups made up the Policymakers' Group. The following report represents the discussion that took place among in response to the questions asked to this group during the Breakout Session.

What are your perceived roles, responsibilities, and mission as members of the oral healthcare delivery system?

Policymakers perceived their roles and responsibilities as members of the oral healthcare delivery system to include:

- Advocating for oral health as a voice for those who cannot speak for themselves
- Encouraging the adoption of state policies that promote and support evidence-based oral healthcare and supportive legislation
- Facilitating the development of state policies that uphold Federal Medicaid and CHIPRA legislation
- Promoting and supporting innovative health services research to enhance oral healthcare
- Promoting and supporting MSDA Best Practices to enhance access to care
- Promoting and supporting quality driven oral health care services
- Seeking adequate appropriations to support such services
- Facilitating effective communication and collaboration among state programs, federal agencies and other interested oral health stakeholders

How do you currently interface or engage with federal and/or state Medicaid and CHIP dental programs?

Policymakers outside of government represent a critical role in facilitating policies that affect federal and state programs as well as legislation and regulation. Those policymakers outside of government interested in assuring quality driven oral healthcare services and improved oral health outcomes engage federal and state Medicaid program staff regularly. They often participate on advisory committees and provide expert opinion in the development of program policies and protocols. Several emerging Medicaid/CHIP dental issues have led policymakers to the table for engagement:

QUALITY IMPROVEMENT AND THE USE OF DATA

Policymakers are promoting the advanced use of data systems for program quality improvement. Such policymakers recognize the usefulness of organizing and analyzing data more effectively to evaluate federal and state policies, program administration, healthcare service delivery and program outcomes. On the federal level, CMS, CDC, and HRSA reported that efforts are underway to strengthen and enhance their respective data systems and those systems that interact with state programs. While these federal data systems are unique and independent, and interpretation of data is not transferrable, all three agencies collect and use their data to support each other's programs. CMS, HRSA and CDC have all noted their commitment to improving the quality of data available to the public and improving the data systems in place to collect and report on oral health related issues.

State policymakers and program administrators also noted the need to utilize data systems more effectively for program improvement. As such, many have increased their IT development efforts. The Patient Protection and Affordable Care Act (ACA) includes a provision for state IT development. Many states are seizing the opportunity of heightened funding that this Law provides to improve their data collection systems.

PROGRAM INTEGRITY

Program integrity comprises three main areas: fraud, abuse and waste. In recent years, state audits, enabled by the use

of advanced information technology systems, have uncovered fraud, abuse and waste by some providers. These unlawful practices have stirred policymakers, program administrators and other providers, creating mistrust in both directions and the need for greater accountability across systems. Policymakers from professional organizations often serve as the liaison between federal and state policymakers and dental providers caught up in such processes. More education and training regarding Medicaid/CHIP rules and regulations is needed to reduce the potential and observance of fraud, abuse and waste across the oral healthcare delivery system.

How have federal and/or state Medicaid programs helped to facilitate or advance your role and responsibilities as part of the oral health care delivery system?

CMS has implemented an Oral Health Technical Advisory Group (OHTAG). This group meets by conference call monthly. This monthly conference call provides an opportunity for state and professional policy makers to provide input, guidance and technical assistance to CMS administrators and for participants to ask questions of federal program policy makers. The dialog is well attended and provides a venue for education and professional development of the broader policymaker network as well as for state Medicaid and CHIP dental program administrators.

What problems (policies, legislation, rules and regulations, cultural or other) have you encountered with federal or state Medicaid/CHIP programs in attempting to carry out or advance your work?

The major problems that policymakers reported were related to Medicaid, EPSDT, CHIPRA and PPACA legislation and program operation. Policymakers reported the following problems:

- Lack of "user friendly" information available regarding the Laws
- Limited knowledge and understanding among policymakers about the Laws
- Lack of federal and state guidance defining operational policies and protocols
- Inconsistencies in legislative interpretation across state programs
- Variations in operational definitions and interpretation of "medically necessary"
- Inconsistencies across states in eligibility requirements and benefits
- Lack of an adult oral health benefit and the impact of this on Emergency Room utilization
- Complex state program design: blend of traditional, fee-for-service, managed care, and health maintenance organizations making it difficult for providers and beneficiaries to enroll, participate and navigate the system

What barriers exist that prohibit/interfere with the successful advancement of your work?

Policymakers reported an array of barriers that interfere with the advancement of oral health promotion and access to care

- Limited state Medicaid and CHIP oral health program infrastructure and capacity
- Confusion continues to exist regarding FMAP and the changes resulting from the ACA are uncertain
- State rules regarding beneficiary eligibility are complex and protocols concerning enrollment are cumbersome;
- Rules lack clarity and promote misunderstanding
- Law suits and audits interfere with the advancement of program and provider relations
- Rural areas are low priority

What suggestions or recommendations would you offer to federal and/or state Medicaid/CHIP dental programs to improve your roles and responsibilities as critical members of the healthcare team?

Many State policymakers are recognizing and promoting the integration of oral health care into primary health care. There are a growing number of states that have developed policies that support such integration. Recognition that

prevention and disease management strategies are key to advancing oral health is mounting and many State programs are now reimbursing physicians and other primary care providers for delivering preventive oral health care services to Medicaid/CHIP beneficiaries. More and more states are recognizing our medical colleagues as "members of the dental team" and reimbursing them appropriately for their service.

In recent years, many State Medicaid/CHIP dental programs have adopted professional guidelines and recommendations set forth by the American Association of Pediatric Dentistry (AAPD) and the American Dental Association. The AAPD's pediatric oral healthcare periodicity schedule is an example of one professional guideline that has been adopted by several states. Such guidelines or similar standards of care, when adopted by state Medicaid/CHIP dental programs, promote consistency across the profession and the national oral healthcare delivery system.

Policymakers continue to be diligent in their efforts to promote and enhance state Medicaid/CHIP oral health programs and have offered the following specific recommendations to federal and/or state Medicaid/CHIP dental programs:

- Change the oral health paradigm from treatment to prevention, emphasizing disease management across the lifespan, while incentivizing individual risk assessment to develop comprehensive treatment plans: *one size does not fit all*
- Define *essential benefits*, utilize dental diagnostic codes and develop consistent performance measures to track quality, while implementing evidence-based clinical guidelines
- Mandate adult dental Medicaid services in order to enhance a family-centric approach to oral health care
- Provide adequate staffing of state dental Medicaid programs with each state having a Medicaid dental director who collaborates freely with the state oral health director
- Establish a mandatory state Medicaid/CHIP advisory committee with representatives from all interested stakeholder groups to encourage collaborative advocacy for policymaking
- Develop effective communication networks that include federal partners, state dental Medicaid programs, state dental Medicaid advisory committees, individual providers and patient advocates
- Identify a national champion
- Update safety net reimbursement systems to current industry standards using improved data collection and analysis
- Mandate that states incorporate FQHC healthcare services data on annual CMS Form-416 report

STATE MEDICAID/CHIP DENTAL PROGRAM ADMINISTRATORS

Over 25 Medicaid/CHIP dental program administrators participated in the Program Administrator Breakout Session.

What are your perceived roles, responsibilities and mission as members of the oral healthcare delivery system?

Program administrators believe that their fundamental responsibility is to advocate for program policies that promote and support oral healthcare benefits for Medicaid/CHIP dental beneficiaries. To effectively achieve this, program administrators:

- Design and implement benefit structures that support the delivery of preventive oral healthcare
- Establish reimbursement rates that favor and promote preventive services
- Recruit and sustain a vibrant provider network by developing adequate coding, billing and rate setting policies
- Educate families to access and utilize dental services, especially preventive benefits
- Reach out to stakeholders to establish and maintain partnerships
- Establish compliance regulations
- Serve as a policy analyst

- Provide intelligence to claims processing and management
- Draft rules and manuals that support Medicaid and CHIP Laws
- Provide clinical expertise for investigations and hearings
- Train fiscal agents
- Train providers
- Analyze data, develop reports and manage program quality improvement efforts
- Design and develop RFPs for program contracting with HMOs, MCOs and TPAs

How do you currently interface or engage with federal and/or state Medicaid and CHIP dental programs?

State dental Medicaid administrators participate on the Oral Health Technical Advisory Group, consult with regional CMS specialists, interact with the American Dental Association's State Public Assistance program, and cooperate with the Office of the Inspector General. They collaborate with their respective state oral health programs in the development and implementation of state oral health plans. They interact with representatives of the Health Resources Services Administration, the Centers for Disease Prevention and Control, and provide intelligence to the Governor's Office and other state executive offices. Lastly, these program administrators contribute to the influence and success of the Medicaid/CHIP State Dental Association (MSDA).

Through collaboration with MSDA, state dental Medicaid administrators improve the recognition and importance of oral health by emphasizing quality through partnerships between states and CMS. Data collection is improved, new performance measures are established and "Promising Practices" are published.

What problems (policies, legislation, rules and regulations, cultural or other) have you encountered with federal or state Medicaid/CHIP programs in attempting to carry out or advance your work? What barriers exist that prohibit/interfere with the successful advancement of your work?

State program administrators have obstacles to surmount. During the Symposium Breakout Session the following challenges were noted:

- Variations in Medicaid/CHIP programs with their different benefit structures and rates
- Lack of integration between medical and dental services
- Lack of clarity in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) statute around the definition of *medical necessity*
- Inconsistencies between Medicaid and Medicare policies
- The paucity of significant performance measures and lack of CMS guidance on performance and quality
- Lack of mandated adult services
- Minimal accountability expectations of clients

What suggestions or recommendations would you offer to federal and/or state Medicaid/CHIP dental programs improve our roles and responsibilities critical members of the healthcare team?

The state Medicaid/CHIP oral health program administrators were extremely vocal in their recommendations to improve their dental programs, suggesting the following:

- Encourage CMS to promote greater collaboration with MSDA to state dental Medicaid and CHIP directors
- Encourage CDC to expand state infrastructure grants to include Medicaid/CHIP dental infrastructure
- Encourage HRSA, ACF and state Title V, Head Start, WIC, and school-based dental programs to promote and actively integrate program services with state Medicaid/CHIP dental programs and benefits
- Increase latitude in how the fiscal resources are spent

- Utilize greater *pay for performance* incentives
- Publish a clear definition of *dental and/or medical necessity* that would be consistent across the states
- Establish and sustain a 90% Federal FMAP match
- Establish benchmarks for rates

EDUCATORS

Few dental educators participated in the Symposium Educator Breakout Session. Of those that did participate, the group unanimously reported that the role and responsibility of dental, dental hygiene, and medical educators is significant.

In what capacity do you or your group currently serve as members of the oral healthcare delivery system?

Dental and dental hygiene educators contribute to the oral healthcare delivery system in a variety of ways, including training the future dental workforce and keeping current practitioners informed through continuing education. Clinical education, as well as cultural competency and minority health training through professional development, is crucial to sustaining the strength of the Medicaid/CHIP dental provider network. Oral health services research, which provides scientific evidence for the development of effective and efficient state Medicaid/CHIP dental policies, is also a significant contribution by dental educators. Dental students and faculty practices within dental educational institutions provide direct clinical services within academic settings, school-based programs, and Federally Qualified Health Centers to Medicaid/CHIP dental beneficiaries.

Educators also participate in state provider networks, serve on advisory committees and state coalitions, and assist in the development of state oral health plans. State Medicaid/CHIP dental programs often offer special rates and/or policies, such as removal of prior authorizations or the use of enhancement fees for dental schools.

How do you currently interface or engage with federal and/or state Medicaid and CHIP dental programs?

Dental, dental hygiene and medical educators typically engage with federal and state Medicaid/CHIP policymakers through their representative professional organization, the American Dental Education Association (ADEA).

How have federal and/or state Medicaid programs helped to facilitate or advance your role and responsibilities as part of the oral health care delivery system?

Participants of the Educator Group reported that they are unaware of any programs or services offered by CMS that supports their roles and responsibilities within the oral health care delivery system. At least one state Medicaid agency (MassHealth) however, has supported recent dental graduates by offering loan forgiveness to those dental providers who agree to work in federally designated professional shortage areas. These types of federal loans are generally granted via National Health Services Corp Loan Forgiveness program.

What problems (policies, legislation, rules and regulations, cultural or other) have you encountered with federal or state Medicaid/CHIP programs in attempting to carry out or advance your work?

The major issues that dental educators reported were: 1) limited benefit structure; and 2) low reimbursement rates. These issues hindered the ability of the dental institutions to provide dental services to many Medicaid beneficiaries. Specifically, adult dental is not a mandated service and thus dental benefits are generally not covered. Many low-income adults frequent the dental institutions for oral healthcare due to lower fee schedules. However, for Medicaid beneficiaries, even a reduced fee schedule may be prohibitive.

What suggestions or recommendations would you offer to federal and or state Medicaid/CHIP dental programs to improve your roles and responsibilities as critical members of the healthcare team?

Educators offered the following recommendations to state

and federal dental Medicaid/CHIP administrators to improve their programs:

- In conjunction with the American Dental Education Association and MSDA, establish a network of dental faculty to provide input on healthcare financing
- Integrate modules on healthcare reform and community-based programs into dental curricula
- Develop CODA competencies in public and private healthcare financing

PAYERS

The Payer Group was made up of private industry representatives that work for dental benefits companies, health maintenance organizations, and managed care organizations. This group supports many different roles within the oral healthcare delivery system, specifically:

- Creating a dental provider network by facilitating services to members and coordinating programs;
- Implementing policies and program design;
- Providing data to states;
- Providing expertise to state administrators for policy development and benefit structure design
- Facilitating services to beneficiaries
- Developing and maintaining a provider network; including credentialing, and enrollment;
- Educating providers and beneficiaries
- Manage state Medicaid and CHIP data systems including data collection, analysis, reports and program integrity
- Implement policies

What are your perceived roles, responsibilities and mission as members of the oral healthcare delivery system?

The group perceived their roles and responsibilities as members of the oral healthcare delivery system to include improving quality, serving as fiscal agents, and acting as a central intermediary among patients, providers, policy makers, state dental Medicaid program administrators, and state and federal agencies. This role can play out in many different ways depending upon the nature of the state contracts. Communication can be either enhanced or delayed depending on whether the contract is directly with the state or the payer acts as the intermediary.

How have federal and or state Medicaid programs helped to facilitate or advance your role and responsibilities as part of the oral health care delivery system?

Federal and/or state dental Medicaid programs can influence payers through a variety of means, such as:

- Educating payers about Medicaid and CHIPRA laws and regulations
- Requiring outreach efforts to eligible individuals
- Mandating policies related to eligibility, enrollment and provider networks
- Utilizing EPSDT as a legislative framework for programmatic goals and targets
- Encouraging partnerships with professional organizations, such as the American Dental Association and the American Association of Pediatric Dentistry, to promote evidence-based guidelines, standards and policies
- Promoting medical/dental collaboration and integration efforts

What problems (policies, legislation, rules and regulations, cultural or other) have you encountered with federal or state Medicaid/CHIP programs in attempting to carry out or advance your work?

Payers can equally be frustrated by federal and/or state dental Medicaid programs when attempting to make a difference. Such obstacles include a lack of understanding of the importance of oral health; lack of coverage for needy individuals, especially children; poor or insufficient state infrastructure to recruit and retain providers; and lack of incentives or penalties for recipients, though there are strict requirements for providers. Other hindrances include a lack of consistent non-discrimination requirements, lack of education or literacy of recipients, lack of published best

"Provide guidance to states on 'medically necessary' oral healthcare for the development of consistent oral health benefits and polices across the states."

practices or models for improvement, program integrity delays, multiple credentialing issues and generalized redundancies.

What suggestions or recommendations would you offer to federal and or state Medicaid/CHIP dental programs improve your roles and responsibilities critical members of the healthcare team?

The payers offered the following recommendations as a means to improve federal and state dental Medicaid programs by enhancing the collective roles of the healthcare team:

- Create mechanisms for two-way communication, including convening forums to bring the aforementioned oral health stakeholders to the table to find common ground, while establishing state dental Medicaid advisory committees
- Holding listening sessions when considering implementation of recommendations
- Require and monitor outreach activities to increase eligibility and access
- Encourage CMS to provide minimum requirements based on evidence-based best practices, while publishing said practices to improve all programs
- Legislate a state dental Medicaid/CHIP director position with an expectation of public health training
- Implementation of a 90% federal FMAP match

BUILDING NEW FREEWAYS

After the various stakeholder groups reported out their individual recommendations to improve state and federal Medicaid and CHIP dental programs, the assembled participants offered these common suggestions for action, including:

- Standardize EPSDT core benefit structures to establish consistency in care and eliminate variance from state to state
- Build communication among stakeholders, including participation and communication activities with MSDA, ADA, and AAPD
- Implement policies that provide comprehensive oral health coverage across the lifespan
- Implement policies that support and promote oral health anticipatory guidance with well-baby visits beginning at two weeks of age
- Establish and convene at least annually state Medicaid/CHIP oral health advisory committees
- Advocate for adequate appropriations to implement oral health care reform legislation
- Increase patient advocacy representation within MSDA and its symposia
- Support passage of the Special Care Dentistry Act, which seeks to increase oral health access and services for the *aged, blind and disabled*
- Collaborate with CMS, HRSA, CDC and the following programs to advance access to quality driven oral health care services: Title V, CMMI, Office of Head Start and the Maternal and Child Health Bureau

CONCLUSION

The 2011 National Medicaid and CHIP Oral Health Symposium: New Directions for Medicaid and CHIP Dental Programs brought together healthcare providers, payers, educators, state Medicaid/CHIP dental program administrators and policymakers to discuss key Medicaid/CHIP issues, policies and program models, as well as identifying gaps in those programs. Upon completion of each stakeholder group offering recommendations for improvement of the federal and state dental Medicaid/CHIP programs, all participants came together to strategize collectively to suggest additional ways to improve the dental Medicaid/CHIP delivery system. Attention to recommendations contributed by each group and by the collective audience will help advance oral health, oral healthcare, and reduce costs associated with both for Medicaid and CHIP dental programs.

Navigating with GPS: CMS Data Sources on the Use of Dental Services

Marsha Lillie-Blanton, DrPH

The Centers for Medicare and Medicaid Services (CMS) recognizes the role data plays in assessing quality in state Medicaid and CHIP programming. In order to adequately utilize data however, valid and reliable quality measures must first be established. CMS is working to help establish those measures so that the data collected from state Medicaid and CHIP programs may provide the insight needed for program improvement. This article discusses the multiple streams of data available to CMS, and how that multiplicity creates challenges. It identifies and describes four primary sources of dental data and a range of concerns about data quality and reporting. The author provides examples of how CMS has examined quality issues and how the agency has tried to use the data to begin to measure state progress on improving children's access to dental care.

In 2010, the Centers for Medicare and Medicaid Services (CMS) announced the Oral Health Strategy. This national initiative targeting all state Medicaid and CHIP programs has two main goals: To increase the rate of children ages one to twenty enrolled in Medicaid or CHIP who receive any preventive dental service by ten percentage points over a five year period; and to increase the rate of children ages six to nine enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by ten percentage points over a five year period (this goal will be phased in during year two or three of the initiative). The strategy is part of a larger effort by the agency which aims to improve the quality of health, health care, and lower costs associated with healthcare for Medicaid and CHIP populations.

CMS recognizes the vital role quality assessment via data collection and analysis plays in addressing quality improvement. Language included in the reauthorization of the Children's Health Insurance Program, in 2009, (CHIPRA 2009) specifically calls for the development of pediatric quality health measures, and further allocates resources to CMS and AHRQ for the identification of such measures. To date, twenty four measures have been selected, including two dental measures:

1. The number and percent of eligible children receiving a preventive dental service; and

2. The number and percent of eligible children receiving a dental treatment service.

CMS recognizes that these measures offer limited usefulness because they do not reflect health status, health outcomes, needs, or use of services relative to need.

Instead the measures only reveal access and utilization—and at that, interpretation may be inconsistent. In 2008, CMS proposed that the American Dental Association (ADA) take the lead in establishing a Dental Quality Alliance (DQA) to develop performance measures for oral health care. That effort is underway, and it is anticipated that the next iteration of oral health measures will bring strength in measurement to the process thereby successfully providing the means for improved oral health program quality assessment.

"Data collection presents many challenges and opportunities. CMS uses multiple data streams, from formalized program reporting to patient surveys and demonstrations."

Data collection presents many challenges and opportunities. CMS uses multiple data streams, from formalized program reporting to patient surveys and demonstrations. CMS is working to identify the best sources of information from what is available. Currently, the primary sources of Medicaid and CHIP dental data are:

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Annual Report (Form CMS-416)
All states that participate in the federal-state Medicaid program (all fifty plus the District of Columbia) must submit an annual program participation report for services provided through EPSDT, the Medicaid child health benefit program to CMS. States are required to submit this information using the CMS-416 Report. The report addresses 14 different health areas, stratifies the data by age, and includes 25 specific health care measures. Of the 25 measures described on the CMS-416 Report, seven reflect dental care participation. CMS uses the information collected annually to assess the utilization of services by eligible EPSDT beneficiaries, and the potential for program improvement and outreach activities to better reach those who are eligible and have not received services.

Medicaid Statistical Information System (MSIS)
MSIS is an electronic system through which states submit Medicaid eligibility and claims data to CMS. States provide CMS with five files (one which contains eligibility and demographic characteristics, and four separate quarterly files which contain claims adjudicated for payment). This data is made available to assist states in answering commonly asked statistical questions. This data mart, where MSIS data are stored was not developed to answer all research questions, but CMS believes that the mart will provide much needed support to States and others who have a need to obtain State-specific and/or national data quickly and efficiently.

CHIP Annual Reporting Template System (CARTS)
CARTS is a web-based data submission tool which was developed by CMS to help states meet their CHIP statutory reporting requirements. With the companion tool, Statistical Eligibility Data System (SEDS), CHIP program data on eligibility, enrollment, program operations, budget, and performance measures (including the CHIPRA initial core set of pediatric quality measures) are collected each fiscal year. CARTS has historically been a system for CHIP, but beginning in 2011, both Medicaid and CHIP programs will report into CARTS.

Electronic Health Records (EHR)
The Electronic Health Record or EHR is a relatively new term used to describe the repository of health and healthcare information on patients or a population in an electronic or computer format. An EHR system is one

that houses through an electronic data base, the independent and aggregate health and health care information of a population. To date, various EHR systems exist—some more sophisticated than others; some with significant technological limitations. CMS recognizes the value of the EHR and systems which support such records. In addition, CMS fully understands the limitations that currently exist across the states, including factors that impact improvements on such systems. As Health Care Reform takes shape, CMS will be working with state Medicaid and CHIP programs to address issues that will improve the capacity of states to support a meaningful and robust EHR system. One such example includes the effort by CMS with several CHIP programs. In February 2010, ten states were awarded CHIPRA Quality Demonstration Grants. As part of these awards, each state will develop and pilot a model pediatric EHR format. This format, which will incorporate dental services, will enable states to collect and report on quality and access measures with greater accuracy and efficiency.

Data Collection, Analysis and Reporting

Collecting, analyzing and reporting data are complex activities. Each process independently requires keen attention to precision and methodology in order to assure reliability and validity or accuracy and consistency across data reports. In recent years, concerns about accuracy, timeliness, and usefulness of the data have been noted. In particular, these deficiencies have been pointed out in reports issued by the Government Accounting Office, the Office of the Inspector General, the Institute of Medicine, and the Medicaid and CHIP Payment and Access Commission. These issues may be attributed to the widespread variability in technology and expertise across state Medicaid and CHIP programs. Data limitations also arise due to problems with verification and stratification issues. For example, the CMS Form-416 Report is an instrument that is retrieved electronically and is difficult to audit. CARTS data are reported and posted in aggregate, so analysis of subpopulations is also difficult. Another complicating factor is that different data sources often yield varied findings for

Table 1. Comparison of Data Sources: Receipt of Dental Preventive and Treatment Services Among Children Age 1-20* in 5 States, FY 2009.

	MSIS				416				CARTS			
	Preventive Services		Treatment Services		Preventive Services		Treatment Services		Preventive Services		Treatment Service	
	#	%	#	%	#	%	#	%	#	%	#	%
Alaska	28,189	35.9	18,875	24.0	27,327	31.8	18,023	21.0	27,327	31.8	18,023	21.0
Iowa	97,592	36.9	40,806	15.4	121,244	43.7	56,495	20.4	21,948†	Na	8,872†	Na
Maine	35,386	26.6	19,525	14.7	48,720	34.6	38,125	27.1	5,645‡	46.8‡	1,629‡	13.5‡
Montana	17,065	27.4	11,337	18.2	16,085	23.8	9,965	14.7	n./a	Na	Na	Na
Wyoming	18,679	36.2	10,383	20.1	20,011	35.4	11,532	20.4	3,762*	45.0*	1,838*	22.0*

Source : CMS analysis of data sources as of 6/2011

** 416 data include children under age 21.*
† CHIP only population.
‡ All MaineCare members whose coverage is funded by CHIP or the CHIP Medicaid Expansion and who were enrolled in MaineCare, at a minimum, during the last month of the report year and who had 11 months of MaineCare eligibility.

the same quality measure. There are also questions about completeness of managed care encounter data.

Both CMS and the states must have meaningful goals or metrics to use in evaluating performance, in designing interventions to improve performance, and in helping to foster competition between providers and plans to improve performance. Goals and metrics are also needed to help CMS inform states and enrollees about the choices they have in purchasing or obtaining health care so that improved value may be realized for dollars invested.

CMS is working to better understand the comparative quality of different data sources and compare results between them. For example, CMS recently compared the data for two specific quality measures in the initial core set of quality measures from five, fee-for-service states, using three separate data sources: MSIS, CMS Form 416 Report, and CARTS. Table 1 depicts the data by data source. Significant variability in data may be noted.

Information presented in Table 1 demonstrates that each data source has the capacity to generate information on the two measures; however, in some cases, the data sources yield comparable findings, (e.g., in Alaska, about 32% of children had a preventive visit), but in other cases the data sources differ greatly (e.g., in Maine, there is close to a 10 percentage point difference for preventive services). The challenge is this variability, and how to understand what is really happening at the state level. Different data sources sometimes provide similar results in some cases and different results in others. It is difficult to ascertain which data source, if any, provides a more accurate representation of "the truth." And being able to identify "the truth" is important as data are increasingly being used to track and evaluate program performance. In addition to selecting the best measure(s) to use, it will be equally important to understand the factors that explain or drive the improvement.

While there has been some progress in data collection, reporting and analysis in recent years, we are still in the early stages of having a system that will adequately support quality improvement and accountability. Payers and purchasers of health care and oral health care are beginning to use more of the available levers to prompt states and providers to pay attention to these issues. CMS is leading the way to achieving the three-part aim: better care for individuals, better health, and lower cost through improvement. CMS is committed to this effort and welcomes the opportunity to work with partners at the national, state and community levels to reach these goals.

To quote one of my favorite African proverbs: "If you want to go fast, you travel alone. If you want to go far, you travel with others." We want to go far. Using this analogy, we look forward to working with all of you to travel far in improving oral health.

Closing Session: Turning the Key

Dr. Kathleen O'Loughlin, DMD, MPH

Collaboration, cooperation and communication are the three keys necessary to improving the oral healthcare delivery system. Changes and improvements in the system will depend upon the extent to which Medicaid and Children's Health Insurance Program (CHIP) dental programs effectively collaborate, cooperate and communicate with their respective constituencies. This session will provide concrete examples for new ways to work with Medicaid and CHIP dental programs and how to advance policies that support improved care and access.

I applaud this meeting's goal, to improve the quality of the oral health care system for Medicaid/CHIP beneficiaries.

I am the executive director of the American Dental Association, but I am also a parent who has experienced the Medicaid system firsthand. I have three children who were adopted, years ago, and while they were our foster children they were on Medicaid. So, I am acquainted with the challenges of trying to navigate the Medicaid system: eligibility issues, claims issues, dates of coverage, the impossible task of finding a Medicaid provider that accepted new patients, canceled appointments, the humiliation of being treated like a second class citizen, mountains of paperwork. I also battled the fact that their previous foster mother, edentulous at age thirty, used being taken to the dentist as a punishment for bad behavior. I feel as though I have some competence in my life, but I tell you, I could not manage their lives as Medicaid recipients, trying to find them dental and medical care. You can imagine my relief the day our adoptions were official and my children moved onto our private insurance.

I know there are no easy answers. This group of committed stakeholders is here to connect, to brainstorm, and to look at the problem from a multitude of directions and perspectives. Diversity is wonderful, but there's a chance we are individually heading in numerous directions, convinced we have the answer, and a great solution might pass us by. We want to capture those solutions, keep their simplicity, and share them widely.

My goal is to help us collaborate and communicate, to align our compasses, and to make sure that we know our final destination. We'll get there by many different roads, but we'll all be heading in the same direction. Collaboration, cooperation and communication are the keys. And it's up to the people in this room to turn those keys, to lead in reframing the conversation to one that's based on solutions leading to demonstrable outcomes.

The bottom line is that we need to think differently. There will never be enough money, enough staff, or enough resources. But we can be more intelligent about how we allocate those resources. We can help streamline things. We can make one and one equal three.

I can feel a buzz, an excitement, an energy. We are moving in the right direction by proposing innovative solutions, bringing them to life and test driving them to see if they move us forward, in a timely manner. The status quo isn't working. It's not bad, it's just not getting us where we need to be: To make a difference and to impact those most in need of oral health care. The current system is a beginning, but we must take the risk of innovation and best practices to eventually reach our destination. With fresh thinking, we can deliver solutions to enhance the delivery of oral health care to the people who need it most.

The dental community shares a sense of mission. About seventy three percent of private dental practices provide 2.2 billion dollars in free and discounted care each year. The ever-growing Missions of Mercy have serves more than 100,000 needy patients in forty two states. The ADA's Give Kids A Smile program offers screening, prevention and dental services to 350,000 underprivileged children

"I applaud this meeting's goal, to improve the quality of the oral health care system for Medicaid/CHIP beneficiaries."

through 50,000 volunteer dental teams annually. Some Give Kids A Smile sponsors are actively fundraising to offset expenses. In addition, Donated Dental Services brings care to more than 100,000 disabled, elderly or medically at-risk patients. Fifty-six dental schools offer some form of emergency and/or primary care to underserved patients. And still it's not enough, because charity does not constitute a health care delivery system.

Yet, even though most Medicaid plans do not provide sufficient reimbursement to allow dentists to break even, about seventy percent of pediatric dentists participate. We, the dental profession, believe that caring for people is what we do. Even in the face of adversity where it's really complicated to participate.

To achieve solutions we must collaborate and communicate. This is not easy. When you're working at a breakneck pace, it's a challenge to remember to contact your counterpart in another state to share an idea for streamlining a claims process. You go home and realize you forgot to make time to schedule a conference call to move a program forward. That's why the Medicaid-CHIP State Dental Association is critical. There is strength in numbers, in finding a common voice. This first annual MSDA Symposium is a great idea, because it brings us together with a structure to share and to take a breath so we can think of these creative solutions. We can share our experiences and find out what's working well and what is not.

So, how can we improve Medicaid? How can we streamline the claims process? How can we remove the barriers, and make it easier for beneficiaries, easier for dentists, easier for dental hygienists, easier for pediatricians? How can we borrow a page from each other's playbooks to make this program better? Simpler?

I'll give you an example of how one state simplified its approach. Our 2010-2011 president, Ray Gist, D.D.S., is from Michigan. He tells us that one of his proudest achievements is working with the Michigan legislature to create a program that has a single provider that also provides mainstream dental insurance. Medicaid patients go in with the same card as other patients, and the reimbursement rate is considered pretty good, where dentists can do a little better than break even. It's a simple program. It's not perfect, because it doesn't serve all counties in the state, specifically urban areas with the most underserved. But it's moving in the right direction and we need to identify ways to make these programs better.

Some states have a Take Five program, which originated in Georgia, where they encourage each dentist to share the load by taking on five Medicaid families a piece. It divides the load and gets people to the dentist.

The U.S. Department of Health and Human Service's Centers for Medicaid and Medicare Services (CMS), has lauded eight states for their best practices: Alabama, Maryland, Nebraska, North Carolina, Rhode Island, Texas and Virginia.

- North Carolina has Into the Mouths of Babes, which targets early intervention with the very young, with parent education and fluoride varnish in children zero to three years old.
- Rhode Island has RIte Smiles, which provides dental benefits to children zero to ten and is administered by the state's dental benefit administrator.

I heard about another simple solution that gets the entire family involved in their dental care. The head of a dental clinic in Illinois created an innovative way to encourage compliance by using a reward system. A patient receives 200 points for an initial visit, and 20 more points for bringing a child to an appointment on time. They lose 20 points for being late. With 1,500 points, adults can "pay" for a dental cleaning. Ten thousand points gets a root canal. This can help parents get care if they have no insurance, even though their children are covered. And they are encouraged to stick with their dental home and keep coming back.

"There's plenty of work to be done & not all solutions are created equal."

There's plenty of work to be done, and not all solutions are created equal. We keep working. Another area we should be mindful of is communicating, not just among ourselves, but with the public.

One of our favorite topics in the halls at the ADA is oral health literacy. And of course everyone here knows that oral disease is much more dire in underserved populations. That might be because today Medicaid eligibility is child-centric, when it should be family-centric. And when we're talking about children, how many times do we hear that parents don't think baby teeth are important? We need to help everyone understand that good oral care needs to start early to pave the way for lifelong health.

So how can we simplify our messages to patients so they understand the importance of taking care of their mouths?

We have an exciting initiative brewing, backed by a coalition of more than twenty three oral health organizations, including MSDA, called the Partnership for Healthy Mouths, Healthy Lives. The program will be aimed at educating the public about the importance of prevention as the basis for ongoing oral health. Oral health literacy will be elevated in this country. This, I trust, will help our cause. Not only because better awareness leads to better prevention, but also that our elected officials are people too, and when they hear the messages we're delivering, they'll understand the importance of making oral health a priority for all Americans. The Dental Trade Alliance Foundation is the lead organization and the coalition has raised commitments of over $3.5 million dollars that will be leveraged into $200 million public service announcement campaign aimed at caregivers of young children that will inform and educate them as to the simple things a parent or caregiver can do to prevent childhood decay and promote a healthy mouth and a healthy life.

The ADA is collaborating with the Health Resources and Services Administration and the American College of Obstetricians and Gynecologists. The initiative established an expert panel to create national guidelines on perinatal oral health. It would be a terrific plus to help expectant mothers get oral care, and also capture the opportunity to educate them about how to care for those tiny teeth that will join the family soon.

The ADA is also working to secure funding for a program with Scholastic, the children's publishing, education and media company, to educate children about taking care of their mouths. This program would go into schools where many students qualify for free or reduced cost lunch, and children would get a book and a toothbrush, along with demonstrations on how to brush and instruction about what foods are good to eat. We heard stories about an event in DC that this was the first toothbrush for some children that they didn't need to share.

Here's what I'd like to leave you with. Our aim going forward is to shift up to the birds-eye level, zoom out to see where the opportunities are to streamline, to get there more simply. And to help each other along the way as we continue to collaborate and communicate.

Keep up the great work everyone. Thank you.

Editorial Review

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Acknowledgements

This report has been developed through the generous support of the following organizations:

- *Maternal and Child Health Bureau, Health Resources and Services Administration*
- *DentaQuest Foundation*
- *DentaQuest*
- *NuSmile*
- *P&R Dental Strategies, Inc.*
- *Delta Dental*
- *Aseptico*
- *Kool Smiles*

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