

CMS Dental Town Hall Meeting
Monday, April 6, 2009
1:00-5:00pm

- **Welcoming remarks from:**
 - Jean Moody-Williams, Director of the Division of Quality, Evaluation and Health Outcomes, CMSO
 - Jackie Garner, CMSO Acting Director
 - Patrick Finnerty, Virginia Medicaid Director representing the National Association of State Medicaid Directors (NASMD)
 - Dr. Ron Tankersley, American Dental Association

- CMS will be preparing a summary of today's discussion that will be published and available online.
- CMS is working on guidance for the CHIPRA provisions related to oral health, but is not ready to discuss the provisions at today's meeting.

- **Presentation from Conan Davis (Chief Dental Officer at CMS) – An overview of Medicaid's Federal/State Partnership.**

- **Presentation from Patrick Finnerty and Terry Dickinson (Executive Director of Virginia's Dental Association) – Improving Access to Dental Care in Virginia's Medicaid/CHIP Program**
 - In 2003, only 23.4% of all eligible children actually received any dental services. Only 13% of private dentists were participating in Medicaid/CHIP, and probably less than half of those were providing meaningful services.
 - Low participation of dentists was a major problem due to: low reimbursement rates; administrative hassles; managed care concerns; and patient no-shows.
 - Virginia came up with the *Smiles for Children* program. It was an entirely new program designed with direct input from Virginia dentists. A Dental Advisory Committee was formed with dentists from all over the state who genuinely helped design the entire program.
 - Key program reforms included: moving from multiple vendors to a single vendor (Doral); streamlining credentialing processes; implementing easy, industry-standard administration; creating the Dental Advisory Committee to gain buy-in and insight from the dentists; having all enrollees in the *Smiles for Children* program instead of having disruptions in care in a fragmented system.
 - The providers benefited from the changes by having: a toll free number for all of their concerns; call center specialists who could deal with member placement and claims issues, etc.; multiple claim submissions options (including free, electronic filing); timely and accurate payments; and automated live eligibility verification.
 - Program reforms increased the provider network (92% increase in number of providers participating) and increased access to care for children ages 0-20 by 58%.

- The two presenters stressed the importance of the partnership between providers, Medicaid and all other stakeholders to make the reforms and the program function.
- Question & Answer Session for Virginia's Presentation:
 - *Question:* Where did the funding come from?
 - *Answer:* Reimbursement rates were raised by 30% as a specific appropriation by the legislature. With the increase in services, there was an increase in the budget for the program. The commitment from the Governor and Assembly has allowed there to be no cuts so far.

 - *Question:* What is the percentage of meaningful participation by providers now?
 - *Answer:* Over 80% of providers are actively billing. Of total dentists in the state, approximately 25% are participating.

 - *Question:* How did the 30% fee increase relate to market fees?
 - *Answer:* The fees are now a little less than 60% of market rates. We will want another increase to stay competitive due to inflation.

 - *Question:* What is being done about increasing oral health literacy?
 - *Answer:* In 2004 we formed the statewide Oral Health Coalition – and this is one of their goals. We have also partnered with the Virginia Rural Health Association to work on this issue. We also work with school nurses, Head Start and other programs for children, and send birthday cards that act as reminders to inform/remind patients and their families about appointments.
- **Presentation from Dr. Robert Birdwell (Dental Director of Arizona's AHCCCS) – A Managed Care Dental Success Story**
 - Arizona uses a managed care dental program, in which: providers are paid from negotiated fee schedules; no capitation is allowed at the provider level; there are health plan contractual requirements; and, a traditional FFS model is used.
 - There are comprehensive benefits for children (with Title XIX and XXI being identical) and limited dental benefits for adults.
 - Currently 44.8% of licensed dentists in Arizona are registered AHCCCS dental providers (1,563 of 3,487).
 - HEDIS measurements attest to improved children's access to oral health services as part of a Children's Oral Health Performance Improvement Project (more information available online).
 - Arizona has a changing workforce – with Affiliated Practice Dental Hygienists entering the scene and a fluoride varnish/PCP program pending. Access can be challenging in Arizona, where much of the state consists of frontier areas.
 - Arizona has had success due to: years of managed care experience; well-written contracts; identifying and addressing gaps; contractual oversight coupled with health plan accountability; meaningful performance measures with consequences for underperforming; AHCCCS collaboration with contracted health plans; strong health plan-provider relations; and a history of working with all oral health stakeholders.

- Question & Answer Session for Arizona's Presentation:
 - *Question:* What can the Affiliated Practice Dental Hygienists do?
 - *Answer:* They can provide services and see patients before a dentist does. They must be affiliated with an AHCCCS dentist.

 - *Question:* For the fluoride varnish/PCP program, would you have to readjust capitation rates?
 - *Answer:* Yes.

- **Presentation from Dr. Harry Goodman (Director of the Office of Oral Health within the Maryland Department of Health and Mental Hygiene) – Maryland Oral Health Reforms**
 - Death of Deamonte Driver was a tragedy that galvanized the state into action in 2007.
 - In 2007 the Dental Action Committee was convened by the Secretary of DHMH. Within a few months the committee published a report (available online http://www.fha.state.md.us/pdf/oralhealth/DAC_Final_Report.pdf) with seven main recommendations for reform (60+ in all). Recommendations were supported by both the Secretary and the Governor. By April 2008, the Governor's oral health budget initiatives were passed by the Maryland General Assembly and signed into law by the Governor.
 - The seven main recommendations were as follows:
 - > Enhance dental public health infrastructure (increased funding to Office of Oral Health, including funding for local health departments, FQHCs, and others; established new dental public health services in six Maryland counties; and, established school oral health programs).
 - > Scope of practice: public health dental hygienist (expanded the role of dental hygienists, allowing them to provide the full realm of their services without the need for a dentist to first see the child or be directly on the premises).
 - > Training for healthcare providers (mini-residency program and other continuing education efforts established and provided by the University of Maryland Dental School; fluoride varnish initiative would provide Medicaid reimbursement to EPSDT medical providers).
 - > Unified oral health message (launch a statewide oral health literacy campaign, targeting pregnant women and parents of young children with the message that good oral health happens at home and is an important part of overall health).
 - > Dental screenings in public schools (systematically conduct dental screenings in schools – will likely need legislation for the 2010 Maryland General Assembly session).
 - > Medicaid single dental vendor (awarded to Doral dental services, to begin in July 2009).
 - > Increase Medicaid dental reimbursement rates (the goal is to increase Medicaid rates to the 50th percentile of ADA South Atlantic region charges, with an incremental 3-year approach designed to attract dental providers).

- Question & Answer Session for Maryland presentation:
 - *Question:* Can you tell me more about the Maryland Loan Repayment Program?
 - *Answer:* This program was enacted in 2000-2001 and has had a wonderful impact. It provides \$100,000 of loan repayment to individuals whose patient mix consists of at least 30% Medicaid patients, for three years in any delivery site. We have 15 dentists doing this each year. We are doing an analysis of the program now.

 - *Question:* Can you speak to dentists in Maryland not seeing adults and children with disabilities?
 - *Answer:* This is a tough area. There are people representing those with disabilities on our Dental Action Committee.

 - *Question:* What is your current federal match?
 - *Answer:* We have a 50% match with the federal government.

 - *Question:* Why did you raise rates for diagnostic and extraction treatments instead of restorative treatments?
 - *Answer:* There were 11 restorative treatments whose rates had been increased within the few years beforehand. The diagnostic and extraction rates seemed particularly low.

 - *Question:* Will the public health dental hygienists be able to bill for their work under Doral?
 - *Answer:* No.

 - *Question:* Does Medicaid and CHIP money go to the school programs?
 - *Answer:* Yes, Medicaid money does go towards the school oral health programs.

CMS hosted an open commentary session in which audience members were able to use the microphone to contribute to the dialogue. CMS suggested discussion points based on three areas: 1) payment opportunities; 2) delivering dental services through managed care; and, 3) education and communication of information to dental providers and Medicaid beneficiaries.

- Kentucky Medicaid's Dental Director:
 - CMS should incentivize states to have/develop targeted programs to reach the most vulnerable.
 - The administrative burdens on dentists to participate in the Medicaid program are very counterproductive – you are asking them to jump through more hoops to be paid less.

- American Dental Education Association:
 - There should be models of care for PCPs for assessing and triaging patients.
 - There should be stronger linkages between PCPs as teams with dentists.

- There should be dental benefits for the ABAD population similar to those of the EPSDT benefits.
- Payments should be adjusted for providers with a disproportionate share of complex patients.
- Ensure adequate reimbursement for all dental services.
- Executive Director of the Dental Health Foundation (in California):
 - If we lose adult dental benefits in California it will be extremely difficult to keep providers in the program. We may have none. Maybe adult dental benefits should not be optional. Dentists often treat the entire family.
 - Find more creative ways to reimburse for prevention. In California, the services from most public programs are provided through some sort of public health entity that is not being reimbursed. It takes them a full year to become a provider. They should be allowed to be a provider and be reimbursed more quickly.
 - WIC is probably the best way to get treatment to the youngest and most vulnerable children, and is a setting in which the low reimbursement is not as bad as in other settings.
 - Expand FQHCs to allow them to work in schools, WIC, and other settings.
- National Network of Oral Health Access:
 - Think of a way to market Medicaid to the uninsured...billboards, what messages work best...
- American Dental Hygiene Association:
 - There are two key ingredients to a successful dental program: entry points into the delivery system and alternative workforce options.
 - Encourage states to do Medicaid reimbursement for hygienists.
 - Encourage the allowance of direct access with no prior authorization.
 - Hygiene is the fastest growing industry whereas the number of dentists is declining.
- Georgia Dental Association:
 - Medicaid managed care is not working well
 - CMOs subcontract to two dental administrators. We have had many problems with decreasing fees and dentists pulling out of the program. There has been a lack of oversight.
 - Dental carve out should be considered first.
 - Integrate all stakeholders at the beginning of the process.
 - There should be a uniform reporting system for quality assurance.
- American Dental Hygiene Association:
 - Hygienists are at a key place to help prevent oral health problems.
 - Over 50 countries use mid-levels to deliver dental services.
- Public Justice Center:

- Oral health literacy is critical, and is lacking in Medicaid beneficiaries. Health care providers and policymakers are also lacking.
 - Invest federal resources into training and education materials that are based on evidence-based research and data. Use the provisions in CHIPRA as a springboard to make evidence-based resources.
 - Urge states to reimburse for oral health education and counseling in clinical settings. There are codes for this.
 - Mandate adult dental benefits so parents have access, which will give their kids access.
- Pew Charitable Trust:
 - Produce materials for the state that show models for a dental benchmark.
 - Focus in on dental disease management for families.
 - Reimburse for toothpaste in Medicaid.
 - Focus on diagnosis coding.
- Children’s Dental Health Project:
 - Prevention and disease management are the keys. Pregnant women and young children should be the target audience.
 - Medicaid EPSDT is not delivering on its promise.
- University of Detroit, Mercy Dental School:
 - Want to reiterate the role of dental schools in both care and education.
 - A lack of state funding may adversely affect education. With the federal funding distribution being tied to cost-sharing with the state, a state’s inability to pay may undermine the educational system. The cost-sharing model may need to be re-evaluated due to the economic hardship the country is facing.
- Wyoming State Health Department:
 - In Wyoming, 186 of the 230 total licensed dentists are in the Medicaid program. Of those 186, approximately 150 provide significant amounts of care. There are almost no communities with no access to a dentist.
 - In 2003, the legislature increased the fee reimbursement to the 75th percentile.
 - I am concerned that if we do not maintain this level of reimbursement we will have fewer providers.
 - The dentists say that the no-show appointments are huge losses for them.
 - States/federal government should seriously consider making reimbursement at the 75th percentile.
 - Let dentists in Medicaid receive reimbursement for no-shows at the FQHC encounter rate.
 - Encourage a dental carve out. It offers a big improvement in payment of dental claims.
- Achieving Oral Health for People with Disabilities (*did not hear entire organization’s name correctly*):

- Providers are closing their panels and limiting the number of Medicaid patients, let alone those with disabilities.
 - 75% of people with disabilities can be seen in standard settings.
 - There should be a national agenda for eradicating this problem and for training providers to deliver oral health services to those with disabilities.
- Michigan Department of Community Health:
 - We have had amazing results in our Healthy Kids Dental, though it is not statewide.
 - We need to talk about beneficiaries – are they on the dental committees and councils? How do we make beneficiaries more accountable and responsible for their care? This includes the CHIPRA provision for educating the parents of newborns – we would like some direction.
- National Dental Association:
 - We need educational pediatric training for general dentists – they are reluctant to do anything but basic preventive treatments for the youngest patients. There are too few pediatric dentists accepting Medicaid. Perhaps we could establish a training for general dentists given by pediatric dentists in an apprenticeship-type program. The incentive to take the training could be something like a federal tax credit, waiving a one-time registration fee, giving a portion of loan repayment, etc.
 - We need to educate children in the classroom about oral health.
- American Academy of Pediatric Dentistry:
 - There is an unevenness in state efforts. There are 10-12 states that have made significant progress, but the others have not. Need to have all states submitting EPSDT periodicity schedules and they need to be held to a higher standard.
- Chief Dental Officer at HRSA:
 - There needs to be a development of quality measures for the Medicaid population. Hold states, providers, CMS, and HRSA accountable. We do not want to be measuring the number of patients seen, otherwise we are encouraging “Medicaid mills.”

Final Remarks from Panelists

- Patrick Finnerty:
 - We went beneficiaries on our committee, but they are not yet there.
 - What we have heard today is identical to the issues brought forward at a summit held a few weeks ago in Chicago.
 - There has to be a partnership with provider communities for there to be success in oral health reform.
 - The solutions are out there; we need to build on the momentum to reach the solutions.
- Dr. Ron Tankersley:

- Dentists will usually participate in the public program if you pay them what it costs to treat the patient.
 - ADA has a health literacy project. It is a pilot project with Community Dental Health Care Coordinators, whose primary function is to increase the oral health literacy of community members.
 - We need quality measurement to be able to track if, with a certain population over time and with money, the population's oral health actually improves. We need diagnostic codes and EHRs. Probably need an Oral Health Index (like the military has) to judge the overall health of a population.
 - In dealing with handicapped people, the biggest issue is education. Dentists are uncomfortable. We need to train the dentist to be comfortable providing services to those with disabilities.
- Dr. Robert Birdwell:
 - We need to engage the beneficiaries – the health plans do at some level, but more needs to be done.
 - We need to incentivize people to do the right thing.
 - Dr. Harry Goodman:
 - We need to get onto a path to make solutions real. Need to increase the oral health literacy among ourselves and work together. Partnerships are critical.
 - Dr. Conan Davis:
 - CMS will be developing a paper based on this meeting and will work on a strategic plan for next steps.