Medicaid-CHIP State Dental Association

Silver Tsunami

MARY E. FOLEY, MPH
Executive Director
Medicaid-CHIP State Dental Association

2013 National Oral Health Conference
April 2013
MSDA
Who We Are

• Directors, managers and staff of state Medicaid and Children’s Health Insurance Program (CHIP) Oral Health Programs

• Individuals and groups who collaborate or have an interest in Medicaid and CHIP Oral Health Programs and their beneficiaries
Vision: All Medicaid and Children’s Health Insurance Program beneficiaries receive quality oral health care services.

Mission: To develop and promote evidence-based Medicaid/Children’s Health Insurance Program (CHIP) oral health best practices and policies through innovative collaboration with a broad spectrum of stakeholders.
Understanding Oral Healthcare Delivery in Medicaid

Adults and Elders
Better Care, Better Health, Lower Costs

- Population Health
- Experience Of Care
- Per Capita Cost

Improving Oral Health Through Access
GOAL: To assure oral health in pregnant women.

Strategy: Triple Aim

- Improve Population Health
- Assure Quality Health Care
- Reduce - Control Per Capita Cost
Stakeholders of Healthcare Delivery

- EDUCATORS
- PROVIDERS
- POLICY MAKERS
- PROGRAM ADMINISTRATORS
- PAYERS
- PHILANTHROPY
- INDUSTRY
- CONSUMERS
Roles and Responsibilities
Medicaid and CHIP Program Administrators

- Program administration
- Eligibility
- Financing
- Coverage-Benefits
- Provider Network
- Evaluation
Program Administration

- Single state agency
- Varies by state
- Education
- Transportation
- Data collection and management
- Reporting-CMS Form 416
- Policy development
Basic Eligibility Requirement

• Financial
  – Income and resources

• Non-financial
  – State residence
  – Citizen or qualified alien
  – Social Security Number
  – Assignment of rights to medical support and payment
Medicaid Eligibility Criteria

- Target populations
  - Low-income
  - Disabled
  - Aged
  - Blind
  - Pregnant women
  - Children
  - Single parents
- Varies by state
  - States have discretion and control over their programs
State Level Financing Issues

- Formulas - Federal and State
- Economic environment
- State budgets
- Medicaid spending is the largest or second largest item in virtually every State budget
Drivers

- Benefits
- Provider rates
- Co-Pays
- Eligibility
Coverage

• Mandatory
  • Early Periodic Screening Diagnosis and Treatment Program [EPSDT]

• Optional
  • Adult Dental and Dentures
Payer Models

• Fee for Service
• Managed Care
• Hybrid Models
• Cost-based Reimbursement
  • FQHC Encounter Rates
  • Title V Agencies
Cost Sharing

- Cost sharing: [Co-payments]
- Maximum allowable charge
- Exclusions from cost sharing
  - Children under age 18
  - Pregnant women
  - Institutionalized individuals
  - Emergency services
  - Family planning services
- No provider may deny services due to inability to pay
Provider Networks

• Private
• Safety-net
  – Federally-Qualified Health Centers (FQHC)
  – Hospitals
  – Public Dental clinics
• Dental and dental hygiene schools
• Other non-dental providers
• School-based health centers
• School-based oral health programs
• Title V sponsored programs
Snapshot of State Programs

• Do states cover dental services for pregnant women?

• If so, does the state have a managed care arrangement?
States with Medicaid Dental Benefits for Adults (Includes Pregnant Women)
States with Medicaid Adult Dental Benefits by MCO Status
Strategies

• Identify potential dual eligibles (Medicare and Medicaid)
• Assist with Medicaid enrollment
• Proactively coordinate with Medicaid dental program managers
• Participate in Medicaid and Medicare policy development
  • Inform
  • Educate
  • Align policies and protocols
  • Improve access; improve health care; improve health; and lower costs
Contact Information

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Phone: 202-248-3993
U.S. National Oral Health Alliance
Fifth Leadership Colloquium

Financing Oral Health: Public Programs

Mary E. Foley, MPH
Executive Director
Medicaid-CHIP State Dental Association

April 2-3rd, 2013
Atlanta, GA
Financing Oral Health: A Health Systems Approach
U.S. Department of Health and Human Services

Stronger linkages and interconnectivity needed.
Better Care, Better Health, Lower Costs

CMS Triple Aim

- Population Health
- Experience Of Care
- Per Capita Cost
Medicare
Healthcare Delivery for Seniors 65+, Disabled and ESRD

Statutory Dental Exclusion

• Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

It’s time to reopen the conversation and expand oral healthcare to Medicare beneficiaries.
Medicaid and CHIP Costs

15% Total U.S. Healthcare Spending

Federal Output

0.00% 1.00% 2.00% 3.00% 4.00% 5.00% 6.00% 7.00% 8.00% 9.00%

FY1970 FY2010

1.4% 8.1%

Total Medicaid and CHIP Spending

Federal Output

0 $50 $100 $150 $200 $250 $300 $350 $400 $450

Total 2010 Medicaid Spending

$132B

Total 2010 CHIP Spending

$274B

$406B

State Federal Total

$3B $8B $11B

76 Million Beneficiaries * 68 Million Medicaid * 8 Million CHIP
Enrollment and Medicaid Spending

FIGURE 2-2. Distribution of Medicaid Enrollment and Benefit Spending by Basis of Eligibility, Estimated FY 2009

- Aged 10%
- Disabled 18%
- Adults 23%
- Children 49%
- Aged 22%
- Disabled 44%
- Adults 14%
- Children 20%

Estimated enrollment = 62 million
Actual benefit spending = $338 billion

Note: Adults and children are non-disabled enrollees under age 65 and 19, respectively. Reflects people ever enrolled during the year and includes federal and state dollars. Excludes territories, disproportionate share hospital (DSH) payments, and adjustments.

Source: OACT 2010
Medicaid Spending, Cost Containment and Cost Shifting

• Levers
  – Eligibility
  – Benefits
  – Cost-sharing (CHIP)
  – Provider payments
Medicaid Eligibility

Federal Mandates

2010

- Low-income children and their parents
- Pregnant women
- Individuals with disabilities
- Individuals ages 65 and over
- Income levels:
  - Children < age 6 = 133% of FPL
  - Children age 6 and older = 100% FPL *(Lower income thresholds)*
  - FPL = $18,310 for family of 3
  - Differs for other categories

2014 – PPACA*

- Low-income children and their parents
  - Raises eligibility for children ages 6-9 in 20 states
- Pregnant women
- Individuals with disabilities
- Individuals ages 65 and over
- Low-income adults who do not fall into one of these categories *(by 2014 or earlier at state option)*

*Patient Protection and Affordable Care Act
FIGURE 2-1. Medicaid and CHIP Income Eligibility by Major Populations Covered

Note: Dots on the chart generally represent state Medicaid or CHIP upper income eligibility thresholds for each population and may include employer-sponsored premium assistance and limited benefit packages; however, individuals with high medical expenses or long-term care needs may be eligible at higher income levels than those shown. Excludes eligibility for aged and disabled dual eligibles who only receive assistance with Medicare premiums and cost-sharing. In addition to meeting income criteria, individuals may be subject to an asset test and must meet additional eligibility criteria as noted in the text of Chapters 2 and 3.

Bars on the chart do not reflect Medicaid mandatory thresholds in all states. Exceptions include parents (varies by state, bar reflects U.S. median); pregnant women and infants (higher in 15 states than the generally applicable 133 percent FPL shown here); and aged and disabled individuals (11 states may use a threshold that differs from the SSI level shown here).

The mandatory thresholds for parents and disabled individuals will not change as of 2014; however, individuals above the current thresholds will gain mandatory status up to 133 percent FPL under the new eligibility group for other non-elderly adults who are not pregnant and do not have Medicare coverage.

Source: Social Security Act and Tables 9 through 11 in MACStats.
Medicaid Enrollment

2010

• 68 Million Beneficiaries
• 33 Million Children
  – 1/3 of all US children
• 11 Million Low-income with disabilities
• 6 Million Low-income seniors/long-term care

2014 and PPACA

• Additional 32 Million
• Maintenance of Effort (MOE)
  – State eligibility policies must remain in place until 2014 or until state Exchanges are fully operational for adults
  – For children – until 2019
• New formula for eligibility
  – “modified adjusted gross income
  – IT systems modifications

*Originally in American Recovery and Reinvestment Act (ARRA) H.R 3590
State Medicaid Spending

New Administrative Models

- Historically fee-for-service and “in-house” administration
- Changing to HMOs, MCOs, TPAs, Hybrid
- Increased complexity in state programs
  - Contracting with 1 or more MCOs
  - Dental carve outs
  - Subcontracting for administration of dental
  - Increase in use of risk-based models
Public Health Systems function as the Safety-net for Delivery Systems

Need to be Better Linked and Interconnected with Healthcare Delivery
Programs are only as strong as the policies and financing mechanisms in place to support them.

Health Reform -> Opportunity to Rebuild and Strengthen US Health Systems
Acknowledgement
Primary Reference for this Presentation

Medicaid and CHIP Payment and Access Commission (MACPAC)

Report to the Congress on Medicaid and CHIP, March 2011

Available at
www.kff.org/healthreform/upload/8061.pdf
Objectives

• To increase understanding of the systems that affect oral health and oral health care
• To increase knowledge and understanding of state and federal health programs
• To understand differences between various state and federal health programs
• To identify other key partners
• To identify opportunities for healthcare improvement through strategic systems linkages
Can States Strengthen Oral Health?
Health Systems
All overlap in interests- BUT FEW CONNECT!
Healthcare Delivery Systems

Public Health Systems

Delivery System Failure >> Safety-net

Public Health Systems
Cracks in Public Health System

Programs are only as good as the policies that support them. Funding limits sustainability.
Create Health Systems Linkages
CARE

Crossing the Quality Chasm: The IOM Health Care Quality Initiative and To Err is Human
Six Aims for Improvement

• **Safe:** avoiding injuries to patients them.
• **Effective:** providing services based on scientific knowledge
• **Patient-centered:** providing care that is respectful of and responsive to individual patient preferences, needs, and values
• **Timely:** reducing waits and sometimes harmful delays
• **Efficient:** avoiding waste
• **Equitable:** providing care that does not vary in quality
FINANCING
Policy

- Foundation of all Programs
Programs are only as good as the policies that support them.
Oral Health Care Delivery System
Public and Private

EDUCATORS
PROVIDERS
POLICY MAKERS
PROGRAM ADMINISTRATORS
PAYERS
PHILANTHROPY
INDUSTRY
CONSUMERS
# Public Programs: Medicaid and CHIP

## 76 Million Total Beneficiaries

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• $406 B Program</td>
<td>• $11 B Program</td>
</tr>
<tr>
<td>• 68 M Enrollees</td>
<td>• 8 M Children</td>
</tr>
<tr>
<td>• 33 M Children (under age 19)</td>
<td>• Pregnant women and adults</td>
</tr>
<tr>
<td>• 11 M Low-income with disabilities</td>
<td>• But- impose waiting periods and enrollment caps</td>
</tr>
<tr>
<td>• 6 M Low-income seniors/long-term care</td>
<td>• Income levels higher</td>
</tr>
<tr>
<td>• Eligibility: 100% FPL</td>
<td>– 89% were at or below 200% FPL</td>
</tr>
<tr>
<td></td>
<td>– 8% 201-250 % FPL</td>
</tr>
<tr>
<td></td>
<td>– 1.8% above 250% FPL</td>
</tr>
</tbody>
</table>

MACPAC Report June 2011
Dental Coverage in Medicaid

- Comprehensive for children- EPSDT
- Under the ACA-Estimated 5.3 M additional children
- Optional coverage for adults will continue
- Adult dental not included as part of “essential benefits package” offered in state Exchanges

MACPAC Report June 2011
Covered Services

• Federal Role: *Establish the Law*
  – EPSDT for children defined under statute- mandatory benefits

• State Role: *define services and benefits* based on amount, duration and scope
  – “Essential Benefits” are not defined under Medicaid
  – Highly variable among states
  – States may expand services (optional)
Medicaid and CHIP Costs
15% Total U.S. Healthcare Spending

FY1970 FY2010
Federal Output 1.4% 8.1%

Total 2010 Medicaid $406 B
• State: $132 Billion
• Federal: $274 Billion

Total 2010 CHIP $11 B
• State: $3 Billion
• Federal: $8 Billion

MACPAC Report June 2011
Medicaid and CHIP Costs

• Overarching costs include
  – Provider payments
  – Managed Care plans
  – Administrative tasks

• Disproportionate share
  – Individuals age 65 and older and seniors with disability make up 1/3 total eligible, yet... 2/3 total costs
  – Non-disabled Child @ $2900
  – Non-Disabled adult @ $4100
  – Person with disability @ $16,600
  – Person aged 65 or older $15,700 AFTER Medicare

• Major drivers: Medical practice patterns and new, high cost technologies
Medicaid Spending is

- Driven by enrollment growth, inflation and policy changes
- During economic downturn
  - Eligibles increase
  - Shortfalls in state budgets emerge
- Levers
  - Eligibility
  - Benefits* Risk-based prevention and disease management
  - Cost-sharing
  - Provider payments
- Key factors in federal expenditures
  - State coverage and payment decisions
80% - 20% Rule

20 % population carry 80% burden of disease
COMMUNITY
Reframe the Safety-Net

Change Role of Public Health Systems
Engage State Partners: State Oral Health Coalitions

• Federal Programs; Regional Offices
• State Programs
  – Medicaid and CHIP Dental Program(s)
  – State Oral Health Program
  – Title V Program
  – School Health
  – Early Childhood Programs
  – Head Start; WIC
  – Department of Education

• Professional Education Institutions
  – Dental and Dental Hygiene Schools
  – Medical and Health Sciences Schools
• Advocates; Community; Faith-based; Families
• Dental providers
• Non-dental providers
• FQHCs; SBHC; Look-a-like Health Centers
Collaboration Isn’t Enough

Identify Pathways and Establish Strategic Linkages
Can States Strengthen Oral Health?

Yes!

How? Reframe the Health Systems
We need YOUR help to get the word out.

Thank you~
Optimizing Program Impact through Innovation and Leadership: Preparing for 2014

June 2\textsuperscript{nd}-4\textsuperscript{th}, 2013
Washington Marriott Wardman Park
Washington DC 20008
www.medicaiddental.org
Contact Information

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202-248-3993
mfoley@medicaiddental.org
Medicaid and CHIP Market Overview

Mary E. Foley, RDH, MPH
Executive Director

AADMD Meeting
Mesa, Arizona
Friday, May 18th, 2012
Medicaid CHIP State Dental Association

Mission 2012

To develop and promote evidence-based Medicaid/Children’s Health Insurance Program oral health best practices and policies through innovative collaboration with a broad spectrum of stakeholders.
Objectives

- To increase knowledge and understanding of Medicaid and CHIPRA’09
- To share information about Medicaid and CHIP
- To raise awareness of current regarding public payment programs
Acknowledgement

Primary Reference for this Presentation

Medicaid and CHIP Payment and Access Commission (MACPAC)

*Report to the Congress on Medicaid and CHIP, March 2011*

Available at

[www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf)
Medicaid
“Entitlement Program”

• Enacted in 1965 under Title XIX of Social Security Act
• Jointly administered by federal and state governments
• Pays for “medically necessary” healthcare services defined in statute
  – EPSDT for children
  – Minimum income and eligibility criteria set by federal government
  – States may expand eligibility criteria
• State variability
  – Eligibility
  – Benefits
  – Payment
Medicaid
Federal and State Responsibility

• Provide appropriate access to care
• Maintain coverage of individuals and benefits
• Ensure adequate provider participation
• Coordinate care with Medicare (dual eligibles)
• Contain costs
• Maintain program integrity
• Maintain fiscal accountability
Medicaid Eligibility

- Varies by state
- Statute creates the mandate
- Federal government
  - Establishes minimum criteria - (FPL)
- State government
  - Upholds federal mandate
  - May opt to expand eligibility (i.e. Increase to 200% FPL)
- U.S. Citizenship, nationals or qualified aliens
Medicaid Eligibility
Federal Mandates

2010
• Low-income children and their parents
• Pregnant women
• Individuals with disabilities
• Individuals ages 65 and over
• Income levels:
  – Children < age 6 = 133% of FPL
  – Children age 6 and older = 100% FPL
  – FPL = $18,310 for family of 3
  – Differs for other categories

2014 – PPACA*
• Low-income children and their parents
  – Raises eligibility for children ages 6-9 in 20 states
• Pregnant women
• Individuals with disabilities
• Individuals ages 65 and over
• Low-income adults who do not fall into one of these categories (by 2014 or earlier at state option)*

*Patient Protection and Affordable Care Act
Medicaid Enrollment

2010
• 68 M Beneficiaries
  – 33 M Children (1/3 of all US children)
  – 11 M Low-income with disabilities
  – 17 M non-disabled adults
  – 6 M Low-income seniors/long-term care
  – 1M in US Territories

2014 and PPACA
• Additional 32 M
• Maintenance of Effort (MOE)*
  – State eligibility policies must remain in place until 2014 or until state Exchanges are fully operational for adults
  – For children – until 2019
• New formula for eligibility
  – “modified adjusted gross income
• IT systems modifications

*Originally in American Recovery and Reinvestment Act (ARRA) H.R 3590
# Medicaid and CHIP Costs

<table>
<thead>
<tr>
<th></th>
<th>FY1970</th>
<th>FY2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Output</td>
<td>1.4%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total 2010 Medicaid</td>
<td></td>
<td>$406 B</td>
</tr>
<tr>
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<td>$132 B</td>
<td></td>
</tr>
<tr>
<td>Federal:</td>
<td>$274 B</td>
<td></td>
</tr>
</tbody>
</table>

| Total 2010 CHIP |        | $11 B  |
| State:          | $ 3 B  |        |
| Federal:        | $8 B   |        |
Medicaid and CHIP Costs

• Overarching costs include
  – Provider payments
  – Managed care plans
  – Administrative tasks

• Disproportionate share
  – Individuals age 65 and older and seniors with disability make up 1/3 total eligible = 2/3 total costs

• Major drivers:
  – Medical practice patterns
  – New, high cost technologies
## Distribution of Medicaid Enrollment and Benefit Spending by Basis of Eligibility, Estimated FY 2009

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Enrollment</th>
<th>Actual Benefit Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>10%</td>
<td>22%</td>
</tr>
<tr>
<td>Disabled</td>
<td>18%</td>
<td>44%</td>
</tr>
<tr>
<td>Adults</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Children</td>
<td>49%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Enrollment- 62 M**

**Actual Benefit Spending $338 B**

MACPAC Report 3.2011
Medicaid Spending

• Driven by enrollment growth, inflation and policy changes

• During economic downturn
  – Eligibles increase
  – Shortfalls in state budgets emerge

• Levers*
  – Eligibility
  – Benefits
  – Cost-sharing
  – Provider payments
Dental Coverage in Medicaid

Children
- Comprehensive for under EPSDT
- 2014 - Estimated 5.3 M additional children
- Limitations under CHIP

Adults
- Optional coverage for states
- Not included as part of “essential benefits package” offered in state Exchanges
Annual Medicaid Costs by Age and Disability

• Non-disabled child @ $2900
• Non-Disabled adult @ $4100
• Person with disability @ $16,600
• Person aged 65 or older $15,700 AFTER Medicare (Primary payer for hospital, physician and other acute services)
Medicaid Spending

- Traditionally fee-for-service
- Changing more to Health Maintenance Organizations (HMO) and Managed Care Plans (MCO)
- Increase in use of risk-based models
- States contracting with 1 or more managed care organizations
  - AZ - 12 managed care contracts
  - Dental carve outs
  - HMOs Subcontracting with dental organizations
Changing Landscape

• Demographics changing

• Minorities officially are majority
  – Increased disparities in:
    • Disease risk
    • Disease status
    • Healthcare needs
  – Increased demands on the delivery system
  – Increased demands on payment systems
Broken Healthcare Delivery System

Problems:

• Health outcomes
• Healthcare
• Costs
Health Care Reform

• Awaiting Supreme Court Ruling
• Changes are imminent either way
• Costs are off the chart
• Something needs to change
Federal Government is Cracking Down

Public programs and states that receive federal dollars are being held accountable
Need for accountability is driving the national quality initiative

“Quality” is the new buzz word.
Quality Initiatives

• Health care administrators are defining quality
• Developing quality measures for healthcare delivery
• Medicine- 20 years
• Dentistry- just beginning
  – CHIPRA 2009 Legislative pediatric healthcare quality measures
Medicaid Evolution

• Quality era is forcing states to change the way they do business

• Variety of models exist across states
  – Traditional
  – Health Maintenance Organizations (HMO)
  – Managed Care Organizations (MCO)
  – Hybrid

• New decision makers in the game
Medicaid Program Policies

• Policies = Rules that apply to the 4 levers
• Policies vary by state
• Policies change overnight without warning
• Change in policies arise primarily due to increased costs; fraud and abuse within the system
Burden to States

• States must balance budget annually
• Medicaid is state budget buster
• Economic downturn stresses state budgets
• States must adjust the levers to remain whole:
  – Eligibility
  – Benefits
  – Cost-sharing
  – Provider payments
2011 MSDA National Medicaid and CHIP Oral Health Symposium: *Designing Quality in High Definition*

June 24<sup>th</sup>-26<sup>th</sup>, 2012
Washington Marriott Wardman Park
Washington DC 20008
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Telephone: 202-248-3993
Mobile: 508-322-0557
Email: mfoley@medicaiddental.org
Get Started by selecting a state to view Survey Details or choose a category.
Descriptive Program Information

Dental Benefits Administrations Models
Q: Please indicate ALL TYPES of dental benefits administration currently used by your Medicaid/CHIP program (check all that apply):

<table>
<thead>
<tr>
<th>Model</th>
<th>Medicaid</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MCO</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>DBA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Models for administering Medicaid and CHIP Oral Health Program Service Delivery
This information is associated with question numbers 5 and 6 of the 2012 MSDA Profile.

Methodology for Dental Provider Payments
Q: Please indicate next to each model that your state uses, the methodology for the dental provider in your Medicaid/CHIP program.

<table>
<thead>
<tr>
<th>Model</th>
<th>Payment Method</th>
<th>Medicaid</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>FFS</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Capitation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Salary</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PPS/Encounter Rate</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MCO</td>
<td>FFS</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Capitation</td>
<td>-</td>
<td>-</td>
</tr>
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<td>Salary</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PPS/Encounter Rate</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
FQHC Reimbursement Methodology and Rationale

Q. Regarding dental services provided at Federally Qualified Health Centers, please indicate which payment system your state currently uses. Why does your state use the method noted above?

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective Payment</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

State payment methodology for federally qualified health centers and rationale for using the payment structure

This information is associated with question numbers 40 and 41 of the 2012 MSOPA Profile.

Notes

Medicaid: Florida Medicaid reimburses a Prospective payment/Encounter for dental services provided at FQHCs.

FQHC Billing: CMS Form 416; and CARTS Reports

Q. Does your state receive CDT-level information for dental services delivered at Federally Qualified Health Centers (FQHCs)? Yes/No

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Billing system used by states for FQHC claims payment and whether the services are reported on the annual CMS- Form 416 and CARTS reports.
## Does your state include dental services provided to children at FQHCs as part of your reporting to CMS on the Form 416? Yes/No

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
<td>-</td>
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</table>

Billing system used by states for FQHC claims payment and whether the services are reported on the annual CMS-Form 416 and CARTS reports.

*This information is associated with question number 43 of the 2012 MSDA Profile.*

## Notes


## Does your state include dental services provided to children at FQHC facilities as part of your reporting to CMS on the CARTS Report? Yes/No

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
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</tbody>
</table>

Billing system used by states for FQHC claims payment and whether the services are reported on the annual CMS-Form 416 and CARTS reports.

*This information is associated with question number 44 of the 2012 MSDA Profile.*

### Notes

Hope to have this capability in the near future.
FQHC Reimbursement Methodology and Rationale

Regarding dental services provided at Federally Qualified Health Centers, please indicate which payment system your state currently uses. Why does your state use the method noted above?

<table>
<thead>
<tr>
<th>Payment System</th>
<th>AL</th>
<th>FL</th>
<th>GA</th>
<th>KY</th>
<th>MS</th>
<th>NC</th>
<th>SC</th>
<th>TN</th>
<th>Region</th>
<th>National</th>
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<td>X</td>
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</table>

State payment methodology for federally qualified health centers and rationale for using the payment structure

This information is associated with question numbers 40 and 41 of the 2012 MSDA Profile.

Notes
AL: Federal Mandate
FL: Florida Medicaid reimburses a Prospective payment/Encounter for dental services provided at FQHCs. Through the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) 2000, it is mandated by the federal government.
GA: NA
KY: To ensure that actual costs are paid to the FQHCs.
MS: The FQHC payment methodology has been the chosen system for many years and has not changed.
NC: FQHCs receive encounter payment off of our fee schedule and then cost settle at the end of the fiscal year based on an encounter rate or another cost-based methodology. My understanding is the state does not want public providers like FQHCs to operate in the red for the services they provide to Medicaid/CHIP beneficiaries. The aim is to have FQHCs at least break even on services provided to the publicly insured.
SC: All dental services are carved out of Managed Care: Payments are made FFS.
TN: Tennessee’s Medicaid program is 100% managed care, with all members enrolled in a managed care organization for acute care, pharmacy, and where applicable dental services. TennCare members receiving dental services in FQHCs are almost exclusively children, with the payment for those services provided via TennCare’s Dental Benefits Manager (DBM) according to the TennCare Dental Fee Schedule. For those FQHCs that provide dental services there is a separate PPS rate established for those services by facility. Quarterly the number of encounters is totaled along with the payment for those encounters; the difference in payment received and the PPS rate for those encounters is then provided to the FQHC as a “wraparound” payment. Tennessee has been a pioneer in Medicaid managed care since the mid-1990s. This system supports federal requirements for FQHC PPS payments within that framework."
Does your state receive CDT-level information for dental services delivered at Federally Qualified Health Centers (FQHCs)? Yes/No

<table>
<thead>
<tr>
<th>State</th>
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<th>No</th>
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</thead>
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<tr>
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Billing system used by states for FQHC claims payment and whether the services are reported on the annual CMS-Form 416 and CARTS reports. This information is associated with question number 42 of the 2012 MSDA Profile.

Does your state include dental services provided to children at FQHCs as part of your reporting to CMS on the Form 416? Yes/No

<table>
<thead>
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<th>State</th>
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<tr>
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<td>68%</td>
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</table>
### Management

**FQHC Reimbursement Methodology and Rationale**

Regarding dental services provided at Federally Qualified Health Centers, please indicate which payment system your state currently uses. Why does your state use the method noted above?

<table>
<thead>
<tr>
<th>State</th>
<th>Fee for Service</th>
<th>Prospective Payment</th>
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<td><strong>68%</strong></td>
<td><strong>20%</strong></td>
</tr>
</tbody>
</table>

State payment methodology for federally qualified health centers and rationale for using the payment structure. This information is associated with question numbers 40 and 41 of the 2012 NSDA Profile.
# States that Collect CDT Level Data

Does your state receive CDT-level information for dental services delivered at Federally Qualified Health Centers (FQHCs)? Yes/No

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Alabama</td>
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<td><strong>National</strong></td>
<td>88%</td>
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</tr>
</tbody>
</table>
States that Collect CDT Level Data

**Management**

* FQHC Billing: CMS Form 416, and CARTS Reports

- **Does your state receive CDT-level information for dental services delivered at Federally Qualified Health Centers (FQHCs)?** Yes/No

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>North Dakota</td>
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Billing system used by states for FQHC claims payment and whether the services are reported on the annual CMS Form 416 and CARTS reports. This information is associated with question number 42 of the 2012 MSOA Profile.