

CMS

National Medicaid Dental Town Hall Forum

April 6, 2009

JEAN MOODY-WILLIAMS: Thank you. We're going to get started as we have a very full afternoon and we want to get right to our -- the purpose for being here. I'm Jean Moody-Williams and it's my pleasure to serve as your moderator this afternoon. I'm the director of the quality improvement group here at CMS and had the pleasure of working with many of you in the area of children's dental care, both access and quality. This is going to be, as I mentioned, a great afternoon as we spend the first portion just examining some of the highlights of the great activity that is going on across the country. We'll have a few presentations to get us started to just showcase a few of the promising practices and activities that we can all learn from. In the latter part of the day, we want to hear from you. That's just as exciting and something that we're very much looking forward to. Now, if you have not signed up, we would ask that you please sign up to provide comments and after the break, we will have you come up. So if you haven't signed up as of yet, during our break we ask that you please sign up at the table so that we will have a record and will be able to call you up to receive your comments this afternoon. It's my pleasure at this point to turn the microphone over to MIS Jackie Garner serving as the Acting Center Director for the Center for Medicaid and State Operations. In this particular role she is responsible for the oversight of all the operations, the planning and leading the policy decisions for both the Medicaid program and the state child health insurance program. No small task, as you can well imagine. Especially at this period of time. But one thing you should know about Jackie is she was have you instrumental in leading many of the teams that took part in the review of dental care throughout the states last year. A lot of this was coordinated through the regional offices under her leadership. She has a truly vested interest in this topic and

very much interested in assuring that children have access to dental care. Without further adieu please welcome Jackie Garner to the stage.

Good afternoon, everyone. And welcome to all of you here in Baltimore who made it out on this rainy afternoon of opening day. I would add thank you for being here. And I want to say hello to everyone that is participating in this forum also through the webcast. And we hope that this will be a valuable and meaningful opportunity for you also. I want to welcome you all to this National Medicaid Dental Town Hall Forum, dental access, improving quality of care in the Medicaid program is something that we take very, very seriously at CMS. It speaks to all of the work that we have done over the past year in conducting an assessment to determine exactly what we can improve on, what is happening at the state level, what we can build on and how we go forward trying very hard to ensure that we not only improve upon access, but also quality of dental healthcare. I want to acknowledge and thank four people that are joining me on the stage right now. You'll be hearing from them as well as others throughout this afternoon. But they have really made not only this forum possible, but they have also been wonderful partners and share CMS's mission in dental health and oral health. You'll be hearing more today. I want to thank Patrick Finnerty, Virginia's Medicaid director and the chair of the oral health technical advisory group for CMS. Patrick, want to wave? I want to thank Dr. Ron Tankersly, the president-elect of the American Dental Association. I also want to thank CMS's own Dr. Conan Davis, the chief dental officer here at CMS and certainly but not least I do want to acknowledge and recognize and say thank you to Jean Moody-Williams. Jean is the director of the quality improvement group within the Office of clinical standards and quality and she has graciously agreed to be the moderator of today's forum. We really so appreciate the States and the American Dental Association's willingness to partner with us on this forum, as it really will take all of us to address the very and significant issue of

insuring that Medicaid children have access to an array of dental services and to demonstrate at the same time an improvement in the quality of those services. And while we don't expect today to solve all the problems or to make policy changes on the spot, we do want this to be an opportunity for you to hear what is going on throughout this country, what issues providers and others face regarding ensuring that children covered under the Medicaid program and CHIPRA, I might add, have access to dental services and maybe you'll take away some ideas that can help you address issues related in your own states regarding access and quality of oral health. After today we will prepare a summary of the issues that we discussed and those will be available. And as I mentioned earlier, we are making this program today available on webcast. Now, that webcast is available for viewing only and so therefore only those of you that are in the room today will be able to ask questions or to provide comments. And I want to underscore how very, very important that is. We really need to hear from you about what is working, your ideas, what we can build on. After my colleagues have an opportunity to provide opening remarks, we'll hear a quick overview of the Federal/State Partnership that's the basis of the Medicaid program and we'll have presentations from three states who have demonstrated success in their dental programs. After the state presentations, there is going to be a short break and then we'll ask you all to come back and I'm very -- I apologize to all the dentists in the room already. I notice that we have some chocolate and candy bars there. The irony was not lost on me but we did want to provide some sugar to get you back in the room and we'll have probably what may be one of the most important pieces of this program, which is an open discussion.

The discussion is going to focus on three basic areas. One, payment opportunities. Two, delivering dental services through managed care. And three, education and communication of information to dental providers and Medicaid beneficiaries. And I

believe that many of you in the room at this point in time have signed up to provide comments on the topics and we do look forward to that conversation. I'm now going to turn this over to Patrick Finnerty, Virginia's Medicaid director, who is also representing the National Association of State Medicaid Directors. Thank you very much for coming and I hope you enjoy the program.

PAT FINNERTY: Good afternoon, everyone. My name is Pat Finnerty. Not only am I the Medicaid director in Virginia but I'm here also today on behalf of the national institution of state Medicaid directors and I, too, want to welcome everyone to this important Town Hall Forum regarding dental care in the Medicaid program. Medicaid is jointly administered and funded by the Federal and State governments. Our association is a bipartisan professional non-profit organization representative of all the state Medicaid programs. All the states, District of Columbia and territories and serve as a focal point and provide information sharing network between the states on issues pertinent to the Medicaid program. I want to commend and thank CMS for hosting this forum and bringing greater attention to the need for improving access to dental care for Medicaid clients. And on behalf of our organization I want to thank you for making us part of this event. Nationally the Medicaid program finances healthcare services for nearly 60 million persons. That's one in about every five Americans and almost 1/4 of all children living in the United States. In addition there are several million more children who receive their services through the children's health insurance program which is administered in many states by the Medicaid program. Clearly, Medicaid and CHIP are major players in the delivery and financing of healthcare services and in our healthcare system there is an ever-growing body of research that clearly shows good oral health is critical to one's good overall health and given Medicaid's critical role in providing healthcare services throughout the country, one of the things we need to make sure we do is provide access to those necessary oral

health services. Our association and Medicaid programs across the country recognize the importance of good oral healthcare and are represented here today to bring greater awareness to this issue. We look forward to participating in today's proceedings and working with CMS, Medicaid and CHIP and dental providers in this regard. I will turn the Mike over to the president elect of the American Dental Association, Mike Tankersly.

MIKE TANKERSLY: Thank you, Pat. Good afternoon, to everyone. First thing I want to do is tell you I really appreciate the ADA being made part of this very historic CMS town hall on oral healthcare. This is really a historic occasion and we're just really happy that oral healthcare has been elevated to the point that we're having this type of discussion. I think all of us know that access to care is the primary driver for almost all the discussions concerning healthcare policy in this country. It is certainly one of the first priorities of the American Dental Association. Some of the factors that adversely affect access to oral healthcare are inadequate reimbursements, participation by private dentists, a shortage of dentists in areas without market power, inadequate support for oral healthcare by policymakers and the public health community. Geographic and cultural barriers, physical and mental disabilities, poor oral health literacy, and, of course, patient fear and anxiety. Some of the solutions that the ADA is proposing to help remedy this situation include simplified administrative procedures, increased reimbursement, developing more cost effective workforce models, developing non-market solutions to areas that have no market power, and more effective healthcare education through community outreach initiatives. The ADA recognizes that the collaboration of all communities of interests is the best way to accomplish these goals and our last effort to move this forward was an oral healthcare access summit that was hosted by the ADA in Chicago a few weeks ago. This CMS town hall on the heels of our summit should all really serve us very well. And with that said, currently dental Medicaid and CHIP programs are our most effective bridges between the

efforts of the public sector and the private sector to provide adequate, sustainable oral healthcare to our economically disadvantaged citizens. To increase the success of these programs, and to decrease the oral health disparities in this country there are three things we need to do. First, we need to increase the percentage of private practicing dentists that participate in federally-funded programs. Second we need to offer more quality oral healthcare through the public sector. And third, we need to assure that the use of taxpayer dollars is put to best advantage by developing objective tools to evaluate the cost effectiveness and the oral health programs in the public and private sector. I look forward to this afternoon's discussion and I hope it will lead to a collaboration that will result in coordinated public/private partnerships that will provide the needed oral healthcare to our economically disadvantaged citizens. Thank you very much. [Applause]

>> Good afternoon. I was looking at the slides down here and they don't look like mine. I'm going to share some slides in a minute but I wanted to welcome you to this first historic town hall session that CMS has held town hall meetings before but this is the first one to address Medicaid dental services. We're pleased you've joined us in person or by webcast to join. As you've already heard this forum is providing us at CMS as well as our partners an opportunity to hear from you about issues that concern you in relation to Medicaid dental services and address some of the points we're hoping to hear from you and posted in the discussion paper. Now, I've been tasked today to give a brief overview of the partnership that CMS shares with our state Medicaid agencies and we're queued up, good. I'll be brief. I know most of you are probably very familiar with this arrangement but some of you, especially watching by webcast, may not be completely aware so I'll cover a few points and turn it back over. Medicaid provides health and long-term care assistance to certain individuals with low income under the title 19 act of the Social Security act. Title 19 of the Social Security act enacted in 1965 as a joint partnership

between the Federal government and all 50 states, the District of Columbia and the five territories. It's the largest source of medical and health-related funding Fund America's poorest people.

On the Federal side, there are Federal statutes, regulations and policies that establish broad national guidelines that the states fit within. Each state, however, establishes their own eligibility standard, type and amount of duration, scope of services, set their own rate of payment for services and administer their own programs. So as you may have heard, if you've seen one state Medicaid program, you may have only seen one state Medicaid program. They're all very different. States can tailor their programs by enrollees and eligibility groups according to benefits, mandatory services and optional services. And payments they can design their own payment methodologies as long as they fit within certain Federal guidelines and service delivery, fee-for-service, managed care or through waivers. And, of course, dental services are mandatory under the EPSDT provisions. And may not be limited to emergency services and an oral screening, I want to point out, is part of a physical exam. Doesn't substitute for an examination and referral to a dentist. Also want to add that states have great flexibility to expand the scope of what they provide either in additional populations or in additional services. But regarding dental services, it's only mandatory for children under age 21 so the population above age 21 it's an optional service. Not every state has dental services covered. In the discussion paper that we posted earlier we noted the three topics we would like the address but we're also open to other topics if you have other subjects you would like to bring to the platform after our break this afternoon. And for example, we know that oral health services provided in schools by dental hygienists and fluoride varnish programs provided by pediatricians are an important aspect in a child gaining access through referral into a dental system of care. I believe some of our State speakers may touch on some of the programs in their states

relating to this. We also note there have been improvements made in the last 10 or so years when the Surgeon General's report was published on oral health in the year 2000, he noted in that report that only one in five children were all accessing Medicaid dental services. Well, in a recent posting of our state-reported EPSDT dental utilization rates from the States, we found we noted it was 34%, one in three. So we've seen some improvements. The States are doing a number of good things and we still have a long way to go and I'm sure you agree with me on that. We also, before I go any further with this, do want to make sure you know that our three-state speakers that we have coming to you are from three very different programs. They vary from each other in certain ways and they are highlighted in others. I think you should hear their presentations and you'll be able to see that and part of the reason we chose them to present for you today as well as the successes that they've encountered in their individual states and we really appreciate their coming being and with us today. Finally I'm sure there are questions that you may have about the dental services that are part of the CHIPRA law and right now I can tell you that CMS is working very hard on numerous projects that will be providing guidance to the states but we aren't prepared at this particular forum to address those questions. I did want to mention that to you. Thank you all for coming

>> Thank you to all the presenters thus far. As you just heard, it is truly a partnership we share with the states. So I think it's very appropriate that our next speaker would be a State Medicaid director. You've already been introduced to Pat Finnerty but let me tell you more about him. He's Virginia's Medicaid director serving in the position since 2002. He directs all aspects of Virginia's Medicaid and child health insurance program and they cover approximately 750,000 low income persons. He's worked in state government for 30 years. Prior to this appointment worked for the Virginia general assembly. Mr. Finnerty will be joined by Dr. Terry Dickinson and after 30 years of private practice in Houston, Texas,

Dr. Dickinson moved to Richmond Virginia and has been there since 1999 and moved there to become the executive director the of Virginia dental association. He serves as ADA's national spokesperson and the subject of access to care and as an advisory member of give kids a smile and the national board. He has a long list of other activities that he's participated but needless to say, he cares about children and cares about access. So I'm just going to turn it over to Mr. Finnerty and Dr. Dickinson at this point.

PAT FINNERTY: Thank you very much. You know normally when you put up a title slide to a presentation you kind of blow right past it and get to the meat of the presentation but there is some information on this slide that to me is the reason why we've had the successes in Virginia that we've had in improving access to oral healthcare and that is at the bottom left corner of the slide. That is that not only is the Medicaid director up here talking to you, but the executive director of the Virginia dental association is here as well. And I can tell you without question that Dr. Dickinson's commitment and the commitment of the Virginia dental association is why we've had the success we've had of the I'll intersperse that through my part of the presentation but I really want you to realize to me how important it is for the State Medicaid program and the dent provider community, to work together to accomplish this. It's not going to happen with one or the other at the table. That's not been my experience. You need to have both. So with that in mind, as was just mentioned, I became the Medicaid director in Virginia in 2002. And one of the first things that I wanted to address was our dental program. I had worked in the general assembly on the joint commission on healthcare and done some research on access to oral healthcare in the Medicaid program and knew we had problems to address. We have fewer -- only about 23% of our kids were getting access to dental care. One of the main reasons for that is Dr. Tankersly mentioned that we didn't have enough providers in the program. We had only about 13% of licensed dentists in Virginia participating in the

program and I would venture to say that they were providing a meaningful level of service to our clients. The reasons were plentiful, to be honest. Dr. Dickinson and I got together soon after I became the director of the program, what do we need to do to fix this program. Here are the things we identified. One is low reimbursement. Our fees were very, very low at the time. That is something that needed to be addressed but that wasn't the only thing. There were administrative hassles in the program. Our program is a very complicated one with a lot of different administrative hurdles for a dentist to get over. Not only are we paying less but put up roadblocks. Managed care concerns. Managed care in our state for the medical side of the program worked very well and our clients work very well within that system but in the dental benefit our dental provider community said we need to address a number of the concerns with managed care. The medical side was working fine. In order to address the concerns of our dentists we had to address that. The last one and every state Medicaid program deals with this, patient no-shows. With that in mind we started working together and what we ended up saying was we want to create a new day for dental in Virginia. We started with a brand-new program. We called it smiles for children. We branded it. We had a lot of energy behind this. And it was an entirely new program structure that I'll touch on in a minute. The key thing is it was designed with direct input from the dentists in a lot of different ways. One of the most meaningful ways is we have a dental advisory committee with dentists from across the state in different specialties. We didn't get them together and talk and have a lunch and go home. They helped design the program. Helped set up a structure for the program. When we went out to procure the services of an administrative contractor we had dentists participate in the review committee and just very much buy into the structure of our program. We had great support from our governor, both governor Warner, the governor when we launched the program and our current governor, strong supporters in improving access for kids. The legislature supported a 30% increase in fees. In July of 2005 we had a 30% increase in

fees and very strong support from organized dentistry. Dr. Dickinson went around the state two or three times to every component. He was as much an advocate of the program as I was. It was a critical part to our success. The key elements of our program. Under the old program we had several vendors. Each of the managed care organizations we were contracting with children who were enrolled with those programs were getting their dental benefits through them as well. The dentists had to deal with a number of different vendors. It was an issue for them. We consolidated that into one program. We went through a procurement process and selected Dural Dental as our administrator. Each plans had different credentialing process. Now we have one set of streamlining credentialing process. Different rules, different payment structures from the different plans and we had children in fee-for-service Medicaid before our new program. We didn't even accept the most current form of the ADA claim form. That's how difficult it was for the dentists. Now it's very easy administration. Standard like any commercial carrier. They have dentists in Virginia had very limited involvement in decision making and as I mentioned earlier we have a dental advisory committee now that they're actively participating in. We also have a Virginia peer review committee chaired by Virginia dentists. They have input into all facets of the program. Before when we had a member transfer between different plans it could have the potential of disrupting care for the children. Now all of the enrollees, regardless of what plan they're in for their healthcare services they're in smiles for children for their dental care program. A number of benefits for our providers. First a toll free phone number. One number gets you access to anything you need as a provider. You don't call one number for claims information, another for eligibility and another for this. One number gets you to wherever you need to go. Dural has call center specialists to place our members. Help them find a dentist, deal with eligibility and benefits issues, claims issues for the providers. We also have a program to address patient no-shows. If a dentist is having trouble with a particular client showing up they make a phone call to Dural and we

follow up with the family to tell them how important it is to keep that appointment. They can submit claims in multiple ways including free electronic filing. They get timely and accurate payments and automated web integrated eligibility information. We try to make this as trouble-free for the providers and now what I would like to do is invite Dr. Dickinson up to talk about the results of the program.

TERRY DICKINSON: I'm just a little tired of you being first all the time. He said that I'm the one that caused this. But let me make it clear, it was Pat Finnerty. He won't take that but I'll tell you that. Without somebody like Pat Finnerty it simply -- I couldn't have done it by myself. He is an incredible person. When I got to Virginia ten years ago, and I went to one of these dental advisory committees that Pat talks about, it was prior to him coming to the program, I walked out of that first one and said is this part of my job? I may want to reconsider because it was a dental complaint session and these kids had not learned how to play in the sand box together. And I tell you it's a dramatic turnaround today when you look at what that group has accomplished together, that have all come together and concentrated on one thing, to take care of those people that need the care. That's why we're there, that's why we're having the conversation. Forget all the other stuff. What can we do together to bring care to these kids. I fully spent 5% of my first several years on an annual basis dealing with complaints about the system.

Today the calls I get are more like I want to sign up, what can you do to help me? And I've got people like Sandy Brown somewhere in the audience that I call and we get the right folks for. We have this wonderful, cooperative, collaborative agreement with our third party administrator, Doral, that helps us. We're all in this together and that's part of the success of this program. You get the right people but you center it around something that we cannot separate ourselves from and that's bringing that care to these folks that really need

it. These are some of the things that you can judge what happens. As Pat said earlier, the 620 back in July 2005 really doesn't reflect what was there. Probably fully less than half of those people did any Medicaid of any significance. So it is truly a jump from those years to the 2008 year. That's just part of the story. It's more of a dramatic jump than what you're seeing on that slide. As far as the percentage of children receiving care, you can see ages 0-20 58% increase. It goes to 62% when you drop the 0 to 3. A dramatic upparticular in the number of kids seen by this program. Number of children receiving services. This is the key. You'll see that over the years where we're at now. Admittedly we have a 450,000-kid market base, so to speak. We've still got a long way to go. So it's not that we're going to stop any time soon. Pat and I and the team will work together to continue the make the journey around the and state carry the message. What are we here for? It's something that belongs to all of us. Not just to the profession, not just to Pat's job. It is all of us that are in this together. We must stand together, we must solve this together. That's the message that we will continue to carry. And it is not something that is going to go away easily in the future. One of the things I think that we're so fortunate about as the governor sent this letter out to every provider in the state and to those that were not providers. One, thanking those that stepped up to the plate and said thank you for being a part of this system. And yet at the same time asking those who had not yet become Medicaid providers to please step up and share the load. I think that's an outstanding attribute of the system that we have in Virginia. It's all of us focused on this immense issue that -- with so many complexities, yet sometimes a simple solution. National attention has been received by our program and these are just some of the organizations that Pat or Pat and I have spoken at. So it's -- kind of in summary it's just not about me and it's not just about Pat. It is about the people that have come together in the spirit of unity and cooperation and community and say we have a problem and we have children out there that cannot access the system. And what can we do about this together. Somehow we passed some of those

barriers that have kept this program from not being a success and I think we've become in so many ways a national model for providing care that is so needed for our most vulnerable populations. Thank you.

>> I would say 1,188 providers and 241,000 children served a pretty impressive. The partnership, I think, from the highest level of state government to the providers and families make for quite a success story. We have about five minutes for questions before we move to our next speaker. If you would like to ask a question, you can please come to the microphone in the front.

>> I think that was a remarkable increase in the number of people served. My question to you is you doubled the number of recipients, where did you get the double the funding?

>> Well, the funding comes in two different ways. The first increase, the 30% increase in dental fees was specifically appropriated for the program. That was a specific appropriation. The growth in the number of services is part of the overall budget for our program and that gets included in with all of the other costs, medical costs, pharmacy, long-term care and so forth and we're getting more kids. It has been a substantial increase but Leichter said it's been a commitment from the general assembly as well as the governor this is one of the places that we want to spend that money. So to date we have not had any cuts in the program. Terry and I were talking about before our legislative session, we were a little concerned about what might happen to the program. Again, we came through this session unscathed on dental. We've been very fortunate to have the level of support that we've had.

>> I'm Dr. Bill from Texas and I have two questions. In one of your early slides you said 13% of the dentists were enrolled and participating at various levels. What is that percentage now. And then you had a 30% increase in funding for the program. How does that relate to the overall marketplace for reimbursement?

>> Okay. First question was about the -- tell me what the first one was? 13%. It was about 13% back then and about I think less than half of those dentists were actually participating. Right now the percentage of dentists that are actively billing is well over 80%. I believe it's 88%. The second question was about the 30% increase in fees. And

>> How does that relate to market fees?

>> I know that when we first started the program, I think we were less than 50%. I think it was like in the 30s. And to be honest, I don't have an exact number. Do you know, Terry? I know -- I believe it's now under 60%. Sandy -- it's a little under 60%, I believe. I'll just take this question as an opportunity to say one of the things long term that we both feel like we need to address is we have a significant bump in fees back in 2005. But if we don't -- if we don't get a little bit of a bump on a gradual basis going forward inflation and everything eats away at that 30%. One of our long term goals is to try to keep the momentum with some inflation increases down the line, if you know what I mean.

>> I think one of the other things we're seeing our providers, we're seeing them do more procedures themselves. So one of the things I think to judge it by certainly is the raw numbers. But I also think if you dig down into that you'll see they're doing actually more Medicaid than a previous bunch when we first started looking at that system.

>> It's good that your providers are not participating at a higher level but my question was what percentage of the licensed dentists practicing in your state are currently enrolled as opposed to the original 13%.

>> 1200 and we probably have over 5,000. So what would that be? 20 something, 25%. We still have a long way to go.

>> Yeah, thank you.

>> Good afternoon, my name is Alice from the School of Public Health, University of Maryland. I want to thank you both for a wonderful presentation about an exciting program. My question has to do with I'm very curious about what you are doing in terms of increasing the level of oral health literacy among patients, healthcare providers, as well as the families and communities in Virginia.

>> We formed in 2004 a statewide oral health coalition. One of the goals of that coalition is exactly that, the literacy part. Dr. Tankersly talked about the access to care several weeks ago in Chicago. I was fortunate enough to be on the literacy sub task force out of that and I'm very hopeful that -- this is a group of 12 different stakeholders coming together that saying this is an important, critical issue that we need to address. Certainly better than we have in the past. So anything definite right now really can't tell you but I know our oral health coalition in Virginia, that's one of their key components. What are we doing? Well, that is a -- they had a meeting about two weeks ago. What we've done is partnered up with the Virginia rural health association because that -- those areas where we have the critical needs. Out of that meeting two weeks ago we'll be meeting again in --

Sandy, help me, two weeks, I think, and we'll be discussing that very issue. So right now nothing concrete, but it is certainly on the front burner.

>> One of the things that we do at Medicaid, I know we're running out of time. One of the things we do at Medicaid, we work with the school nurses quite a bit, Head Start programs and local departments of social services and one of the do in our Maternal and Child Health programs are sending birthday cards to kids. To the parents of course. Here are some things you want to be doing for your kids at such and such birthday and one is getting the required dental care. We have a lot of partners inside and outside of State government sharing a lot of printed material and again we do advertise the toll free number to our administrator that provides information as well.

>> We will have the opportunity for a few more questions after -- let us get through our presenters and we'll come back. If you could save your question, thank you. Let's move on now. We know that Arizona continues to be a leader across the country in the area of managed care overall. While dental care is no exception in this regard. I am happy to present to you Dr. Robert Birdwell. Dr. Birdwell has over 35 years experience in dental-related activities and spent several years in the U.S. Air Force dental Corp. After that he spent 26 years in private practice. He has a combined 24 years of active duty and he's also served in the military reserves as a chief dental officer. Before accepting the position as a dental director for Arizona healthcare cost containment system in 2004, he held the position of dental director for the New Mexico Human Services department. So you can see that he has both practical hands-on experience as well as experience in administering programs at the State level. Dr. Robert Birdwell.

>> Thank you very much and greetings from Arizona. I appreciate the opportunity, Ms. Garner and Dr. Davis. I appreciate the invitation and hopefully a few of these remarks will matter to you and there will be some substance to it. What I will be talking about is the polar opposite where Virginia was a few years ago and where Arizona still is. With that said, the acronym, access, is the Arizona healthcare cost containment system is the noun and verb access we're all talking about here today somewhere along the line and we'll get those mixed up a little bit. We'll figure it out. I would also like to thank my director, Mr. Tony Rogers, the director of the Arizona healthcare cost containment system for supporting me to come here as well as the Medicaid SCHIP dental association. With that said what I'll do is talk a little bit about the background of what -- give you a little background on where the history of access, description of the people that we serve, how our program works, a few words about the access dental program and an overview of a performance improvement project we worked with our managed care contractors, and then a few little more comments about measurements and conclusion. A lot of times going back to the previous speakers is that sometimes we simply look at -- there is a percent exception that managed care in oral care, the more people, the more cost. The more is more. We don't see the down side. More kids going in, the costs going down because we see early intervention, etc. It is hard to put your finger on those types of issues and I would -- you know, during this talk I would like to at least give some background into that as well. So that said, you know, a little background. In 1982, access got a waiver to provide healthcare for eligible population unit managed care model. Access was never a traditional model that transformed into a managed care model. It was managed care from day one. In 1994, just all counties were required to provide a choice of at least two health plans. Everybody in every county had a choice of two contracted health plans. And in 1998 Arizona implemented its kids care program which is Arizona's version of the SCHIP program. As far as who we serve right now about 1.15 million people with an estimate in

2010 for getting closer to 1.3 million in this one area in 2002 there was a proposition that increased the eligibility or changed the criteria for eligibility which made that curve there between 2002 and 2004 grow quite a bit. As far as enrollment, I'm going to try to give you some definitions here on this but the -- through our managed care we have two main categories under managed care. One is acute care and Bob and looking at my presentation today gave -- said that was somewhat of a misnomer, he also corrected me on a few of my other slides, too. If you know Bob Eisman. Thanks, Bob. The acute care is our primary group for children and women with children. So it's the basic what you would consider traditional member group. The -- there is, you know, close to 900,000 that our Arizona long-term care system which has those people that are in or at risk to be in long-term care facilities. Our fee-for-service population is about 160,000 that are 90 plus% Native American and we have quite a large sub population in Arizona, as you would understand. The kids care CHIP program is around 58,000. So the total again being 1.1 million. Just the -- this is just to show you we have geographical service areas. For the acute care program we have at this time about seven healthcare contractors, each of which are -- have to provide all healthcare services including oral health or dental services. There are geographical service areas that when we give RFPs and contracts are let that those areas are separate contract areas for the health plans. Again, looking at the population, about 90% are in our acute care which are primarily children, women with children. The CHIP program and those with developmental disability, physical disabilities or the elderly. Actually I'm one of the elderly now. The managed care program, again, Arizona's model is managed care.

On the acute side which I'll primarily talk about today there are nine acute care health plans contracted each of which have their own contracted provider networks. Again, some of the negatives that Pat discussed earlier that credentialing processes are by each

individual, health plan and for that process with registered providers. In other words they have to be registered with access first and then they can in access again, being the noun, in order to be credentialed with a health plan. Arizona is not an every willing provider state which means that providers can be registered, however, they can only bill Medicaid enrolled member if they are a credentialed provider for the health plan that that member is enrolled. So if that makes sense to everybody. I hope it does. I'll get back to it if I need to. Providers are paid from a negotiated fee schedule. In about the year 2000 there was a task force in Arizona that, because there were a lot of problems with provider accepting the Medicaid -- the access kids at that time, one of the things that came out of that, there is no capitation allowed at the provider level, which means that's only for dental. There are on the medical side some other forms of payment but in the dental we don't allow capitation so it's all paid -- all services are paid off fee schedules. Some of our contractual requirement we hold our health plans to we require access by healthcare and specialty. That has to do with zip code, with the area and how it's spread geographically. We require geographical access and we also include appointment availability times which means we hold them to a time line that we can access, get our kids into providers that somewhat mirrors the general population. We have the dental program has comprehensive dental benefits for children, title 19 and title 21 are identical under managed care with the same contractors and for the acute care program. We have limited dental benefits for adults, like many states do. Currently we have 3487 licensed dentist and 478 registered providers. It's about 45% of the dentists in Arizona are registered with access. In 2003 we started the children's oral health improvement project. All the information that I'm going to give you about this project is online and at the end of this presentation we'll give you the address and it is also in your handout. People in our Maternal and Child Health quality administration looking at -- and we're looking at the overall programs in identifying gaps and they recognized inaccess to dental care. First of all recognizing the gap is important

and the improvement project required the health plans to increase access to care using the goal for the Healthy People 2010 dental visits in targeting the children age 3-8. Recognizing that group of children are very at risk and very vulnerable for oral disease and trying to target take group just simply made sense at that time. Obviously since then we've also looked at getting kids at a younger age. Just in the big picture the baseline in looking at -- this is contract year ending, which is the same as Federal fiscal year. So in that year ending in 2002 the baseline measurement was 52.2%. At the end of the measurement period in 2007 for that age group it was 65.4%, a relative increase of 25.3%. And again we can directly look at the increase to oral healthcare as a result of that program, which partnered with our managed care -- contracted health plans and held them accountable to the outcomes.

This is kind of a -- this is one of Bob's glitch slides here but -- thanks, Bob, again. There should be another line across the top that says where our final outcome was. The dotted line being the Healthy People 2010 goals and that would have been an average. The solid line here would have been the average at the beginning, the baseline average and the dotted line again the Healthy People 2010 goal. This is just relative. If we looked at the overall average what did I say around 65% you can see where another line would go across there. Again, by 2006 there were -- methodology for the -- for the measurement was the HETIS measurement and looking at that and the thought being -- let me go back a step. That measurement looks at children that are continually enrolled for 11 months in the measurement time. And so looking at continuously enrolled, the idea being that it allows managed care to do managed care and to allow them to do their job. And at 61.1% in 2006 the measurement, the 90th percentile nationally was 61.3% and the mean was 43.5%. Our numbers simply are fairly high in comparison to those numbers. In looking at a more widely recognized EMS416 report looking at children age 3-20 in 1999 we started

about 20% and ultimately for that same age group in 2008 was 48.6%. You know, I have -
- you know, looking at 0 to 20 in 2008 the percentage was more like 39% of access to
care. Access to dental care we're also looking generally speaking, you know, like
everybody, changing workforce, what is new in Arizona. In 2004 the legislature passed a
different provider type, which is the affiliated practice dental hygienist and we continue to
work with dental hygienists to look at different methods of providing care to our enrolled
members. The fluoride varnish provided by primary care physicians, we have approved it
pending funding. It is always -- timing is everything and I'll just leave it there. We know
what the budgets are and how to say what we'd like to do and where we're going in any
given time is always a challenge. Like every state provider distribution presents a lot of
challenges as well. Many of our areas are basically frontier areas with widely distributed
centers where dentists might be providing the service and where the population is very
widely distributed in those -- as you saw earlier, very large counties in the state. So
looking at some conclusions, Arizona has years of managed care experience that with a
very hard working group of people in our quality area that understand it and how work very
cooperatively with our contracted health plans, that they have well written contracts with
expectations that are identified. Looking at gaps as they might occur, having contractual
oversight. Some meaningful performance measures, which means that again we hold
them accountable and have -- there are consequences if they don't perform. That the
access and again just repeating that the access in the health plans we contract with have
a strong relationship and a strong understanding and also on the other side, you know,
again, like Virginia was talking about, we also have not only an access provider
relationship but our health plans also have a very strong relationship and that each one -- I
say each one, most of them have their own advisory panel of providers that work directly
with them and to look at services and how services are provided. That they -- the
negotiated fee schedules are competitive and acceptable to the provider network and that

overall that we work with all oral health stakeholders including the American Dental Association, which in Arizona is the Arizona dental association, the dental hygiene association, the oral health coalition and Department of Health Services, the dental schools, just to name a few. To keep nurturing those relationships and trying to figure out how to better serve our members. This just going back to some of the references that were to get information is on our website and I appreciate your time very much. The -- I hope I didn't roll too much of that too quickly but it is working in Arizona and I'm not saying to anybody that there is not better ways we could continue to look for better ways to administer programs to make improvements in the program. All I can say is during that period of time, access has gone up by either method of measurement. So I appreciate your time. Thank you very much.

>> We have time for maybe one question. Would there be any questions? Please use the mic.

>> I'm a dental hygienist and serve as a chair of the dental committee in merchandise. What does the dental hygienist, what is that category?

>> They're defined by the state practice act. What they can do. Basically they can provide services and they can see a patient before they see a dentist and they have an affiliation with a dentist. One of the things that we require for our perspective is that the dentists they're affiliated with is an access provider but they can provide just basic services if they see anything before they see them a second time, they have to have the member referred to the dentist. I can talk to you later if you want.

>> I think I saw one other person that just had to get up. Go ahead and proceed to the mic.

>> I'm Chris from the Michigan Medicaid program. I want to ask you about the fluoride varnish and -- it's pending. Are you going to have to readjust your capitation rates to those health plans for the fluoride varnish since it will become a medical service?

>> Yes, the answer would be that would have to be looked at early to determine to the best we can what the cost would be on the front end in order to properly pay physicians for those services. Does that answer? Thanks.

>> Thank you. I think you can agree that nearly 50% of the licensed providers are participating. 25% improvement toward the Healthy People 2010 goal and measurement at the health plan level in accountability. I think they're all very key. Can we give him another hand, please? [Applause] Thank you. Over the past several years Maryland has really used the meaning when you say action plan, they put meaning to the word action. And Dr. Harold Goodman currently serves as the director of the Office of Oral Health at the Maryland Department of Health and Mental Hygiene. Prior to coming to the health department Dr. Goodman served as the co-chair for the Maryland dental action committee. This committee was very -- was very much responsible for developing the recommendations for reform in dental care in the State of Maryland. I know that those recommendations went on to the general assembly and many of them were passed. And so we're pleased to welcome Dr. Harold Goodman to the stage.

HAROLD GOODMAN: Good afternoon, thank you. I'm very flattered to be part of this panel. I want to thank everybody for the invitation. I especially want to thank Dr. Conan

Davis. He's highly regarded and respected in the dental community and we appreciate his presence here at CMS. I need to tell you out of informed consent these slides have not been reviewed by Bob. Our story is actually very similar to the Virginia story. Except we're a few years behind and we hope to have the same types of outcomes that Virginia has been experiencing. Of course, we all need to go further than that. As you can see, Maryland in the year -- the calendar year 2007 had about a third of our -- of all Medicaid enrollees having at least one dental service in a year. That's just one dental service. Actually the dental action committee, which I was proud to be part of actually drilled it down, excuse the pun, to kids actually receiving real restorative care and it was far less than that. One visit a year, which is the normal utilization number that we go by, was about a third. Maryland essentially has been in the middle of the pack, I think, recently. We've come a long way and actually prior to even the reforms there have been a lot of advocacy efforts here in Maryland to try to get those numbers up in partnerships have been forming and it's a key to the presentation even though we focus in on the recommendations that came out of this partnership. We actually were in the high teens back in the mid to late 1990s and we've made progress. Again, I think that comes to working with our Medicaid program, working with our dental associations and what have you to get there. But we still have a long way to go. As you can see in the most recent data that we have, only about 16, 17% of dentists participate in the program. Now, this is prior to the reforms that we'll be talking about. But any real care, we broke it down into billings of about \$10,000 or more in a year and it is almost half at about 9%. We have a long way to go in getting our dental community, our private dentist community involved. It is wonderful to see the partnership that -- if Virginia. Virginia is sort of our model in terms of the wonderful partnership between Medicaid and the Virginia dental association and I'm sure many other in making things beginning to happen. It just doesn't happen unless people work together. But all those efforts aside, really unfortunately 20 to 30 miles down the road in prince George's

county this is the state where a 12-year-old boy died due to a dental infection and an infection that was not treated and essentially spread to haste brain where eventually succumbed at a tremendous cost to the state. Not that we can put his death in any kind of value of dollars, but again, a highly, highly emotional event in the state. I don't know if people can realize it but even my boss, the secretary, when he speaks about that boy gets emotional. I think we all do. And we all along had been talking about that if you don't have access to good oral healthcare, quality of life suffers, readiness in school suffers, somatic health suffers but never did we focus in on this extreme example. It has had a galvanizing effect in the state. He died unexpectedly at the end of February. He wasn't just failed by not finding care. We always focus on that. He was failed it was the so-called back end of things. He was failed on the front end of things. He was failed because he never had access to care to begin with in terms of good prevention, good educational messages. So the reforms that eventually come forward really try to address both the front side of where he was failed and also the lack of treatment at the end of his trail. So our recommendations really encompass and work together. One really complements the other. If one doesn't happen, the others could fail in time and basically fall under their own weight. But because of his death and again the secretary who was only in office a few weeks when this event occurred, he really just took the bull by the horns and within a few months had already convened a dental action committee. This -- and I remember him at that very first meeting said you are going to give me a report that is not going to gather dust. This is going to be a living, breathing report and it has become that. And I think even more so than all our wildest dreams. The dental action committee is sort of again a committee that where so much is really -- the activities didn't end with the report. It continues to work as a true coalition for oral health and without it I shudder where we would be and it has led to partnerships all over the place. Between our Medicaid program and dental providers. Actually even the dentists and dental hygienists are working

together. The prize is not their own individual agendas but to get care to our population especially our low-income population and they've basically taken that message and run with it. You can see the repeats of where all this has gone. By September of 2007 a report was issued. It had seven main recommendations in all but 60 complete. By October 2007 these recommendations were supported, every one of them by the secretary. By January 2008 all funding recommendations in our governor's budget that was crucial came to fruition. And by April of 2008 all the governor's oral health budget initiatives were passed as far as oral-related bills passed by the assembly. Oral health is a high priority item in the State of Maryland and proud to be part of that effort. Let me quickly review the recommendations. I know there is -- the focus in this Town Hall Meeting is on Medicaid, medical assistance but as I said, if you just focus in on Medicaid side of the house, which would be essentially the private sector, and don't address the other issues, the public, the public health sector, it may not work. So the first thing, the first recommendation is that -- this is in a year, by the way, not as dire an economy as we have now but a year ago it still wasn't in good shape. \$2 million essentially to our office. We actually split the money with another office that deals with capital grants. This has led basically to try to bulk up our dental public health infrastructure. The State of Maryland, unlike Virginia with a local health department dental program in most counties in the State, Maryland did not. Only half. We were able to provide funding to our health departments, FQACs and other private non-profit programs and already since the funding has been given to us we've been able to establish six new public health programs in areas of the state where there had not been any before. Again, this also led to enhancements in our school Oral Health Program. It's not just about treatment. It's about prevention and education.

The school is a wonderful laboratory to do a whole lot of school health types of services and one of those programs has been a highly publicized program called the deMonte

driver dental project. A mobile van working within a county. The first school they worked at was in their county. We were pushing for fluorides, sealants and what have you. Here is a picture. We honored Governor O'Malley at this very prestigious event. It was an exciting time for everybody, it really was. We only expect great things with this project. Second we went to scope of practice and we basically said we need our hygienists who play a critical role to be able to be enabled to do what they do within their scope of practice. We didn't add any scope of practices, we just made them better able to provide what services they do provide. So this took legislation and it passed in October 2008 and what it does is allows our public health -- new public health dental hygienist category to provide care without a dentist first seeing the patient. That is critically needed. If you have those in place it slows down the process. Now they're enabled to do that and some of our new public health programs are being built around the public health dental hygienist category. Training for healthcare providers. This again is very critical. Training, education for both healthcare providers and for the public are really, really key. This is the healthcare provider's part and already -- really there are two populations that have been targets of this training. One are our general dentists. One of the big issues in finding access to care for low-income populations is the fact that not only they may not participate in Medicaid. Even if they do many of them will not see children under the age of five. They don't feel confident enough to do it. This training given by a doctor at the dental school in partnership with many others has begun the training of these folks.

The other group who plays a key role. Addressed a little bit already are the physicians. The this is absolutely key. What we're doing in Maryland as part of the dental action committee recommendations is initiating beginning in July a fluoride varnish reimbursement program. The key thing about that is varnish is the entree. The big thing is they'll be trained in doing an oral health assessment, early dentification, participatory

guidance and all the things that need to be done with children at the age of nine months when teeth first begin to erupt and only those providers who take a state-approved training course and again being developed by the dental school as well as the national Maternal and Child Health Resource Center will be able to be reimbursed. Again, there is an incentive but the key issue is they'll be trained and kids are -- more kids are going to get access to care. Here is one where we're still not doing so well but we need to do better.

Our unified oral health message. This is basically to launch a statewide oral health literacy campaign. We have a dental action committee that's actively working on this providing recommendations as we speak. But we need to focus on core messages that resonate with targeted populations. We still need Federal funding for this and working on a number of different areas to try to get that funding. Based on a very successful model we had here in Maryland on oral cancer prevention, where we developed sort of a systematic, scientific approach to developing key and quality types of oral health messages that again will resonate with the public and the public will turn around and say I need to get dental care.

That's basically the bottom line. We still need to get funding there. Kind of related is dental screenings in public schools. We won't mandate dental screenings. We looked at other states and it hasn't worked as well. So we're going to basically try to integrate it along with vision and hearing screenings that are ongoing and we're working very, very closely with the Maryland state Department of education on this and it is likely going to need legislation to add to the vision, hearing screening legislation next year. This is ongoing and the recommendations will be coming forward to the dental action committee at the end of this month. Here is the two Medicaid-related recommendations and they're both very provocative and needed. One is that we also are going to be carved out of the Medicaid program and we are going to be contracted with one single dental vendor, Doral dental. I don't know how many of you are aware what's in Maryland but we have seven managed care organizations now who subcontract to two or three dental subcontractors and it can

provide complexity for the public and providers. We're hoping this will be a more simple system. Far more accountable in terms of data and customer-friendly type of approaches from the company and offer certain transparency as well. We feel this was absolutely needed if we were going to almost rebrand the Medicaid dental program in Maryland. Finally, increase in our Medicaid dental reimbursement rates. And basically we set on a course and you saw there were \$14 million placed in the governor's budget in FY09 intended to be a three year incremental amounting to \$42 million all said. The goal was to increase the Medicaid rates to the 15th percentile in this region and that did occur. Most of the diagnostic and simple extractions and sedation increased as of July 2008 and as an example of where we are and are now, the dental sealant fee went from \$9 to \$33 for tooth application. It is intended with the recommendation of the dental action committee it be indexed to inflation as well. The second year rate increases are on hold. This decision did not come easily. And they're on hold, not out. Because of the dire economy and Maryland is -- has a multi-billion dollar deficit, this was one of the unfortunate things that have occurred.

There are a lot of people remaining keeping their eye on the prize and I feel that in time we will get that second -- that very critically needed second year rate increases. As a result of these types, the fee increase and itself we have had 100 new dentists sign up already. We're hoping once the bureaucratic issues are involved when we go to the single dental vendor in July we'll get far more dentists to participate. Ongoing efforts going on with the dental association and they're committed, all the dental associations in Maryland are committed to providing -- to participating and we have got leaders going throughout sort of a peer-to-peer type of relationship where they are going out and speaking to their peers saying you have to help these kids and that's sort of what it's all about. Our dental action committee report is located in our Office of Oral Health website. Feel free to look at

it. It is a wonderful report. A living, breathing document that will continually change. Has wonderful, a lot of good references and good data. Finally, this is the effect I usually have on my children after talking to them about dentistry, but I also told them that since this is being webcast unlike their daddy who would rather be in the back seat, they want to be famous and I said here they go. Thank you very much.

>> Thank you. I think the 12-year-old boy's life has impacted us all, including us here at CMS. You have implemented more private practice inclusion, public health approach and scope of practice for public health dental hygienists. I know there are several questions so we're going to take about five minutes and entertain any questions that you may have. Just a reminder if you could please use the microphone.

>> Hi, Dr. Goodman. Thank you so much for your work in Maryland.

>> Everybody's work. Thank you.

>> We're very touched by the death of the 12-year-old young man and pleased that a lot of good has come out of it. Could you talk about the Maryland loan repayment program you're working on and it's my first part to talk about if you think it's working, how that is going to work and if that will actually drive new dentists to sort of begin a practice of working in Medicaid from the beginning. And then my second piece would be can you talk a little bit about children with disabilities in your state or adults with disabilities in your state and how you're addressing their issues in terms of education and getting information out to dentists.

>> Thank you for the questions. The first question is about the Maryland loan assistance repayment program. It is actually -- remember, I said that there are a number of things we were doing over the past years prior to the galvanizing events of the last year and I believe -- and I may be mistaken. It was either 2000 or 2001 we actually passed legislation to enact a loan repayment program in Maryland. I think it's had a wonderful impact. I think personally I think we need to increase the amount of loan assistance to dentists. Provides \$100,000 in loan repayment for dentists who provide three years experience. We think that's what makes Maryland stand out. As long as they see 30% of their patient population base being Medicaid. It is a three year cycle. Five new dentists every year so we have a continuing cycle of 15. And I think given the low numbers that we've had in terms of the dentists participation, I think it's added significantly to the number of dentists in the system. Many of the dentists then, after their commitment, continue to provide care to Medicaid recipients. We actually are doing an analysis of this program as we speak and we hope to have some more information about it but it was one of the programs I think that helped us increase care. In terms of special needs kids and special needs adults, it's a really tough area. Right now there is a lot to be done. We have really not been very successful. I will tell you that there has been -- there are people representing those groups on our dental action committee. It is a question of continually coming up and I think it's one we'll probably get to more and more. The whole issue of adult health in Maryland over the age -- Maryland we only cover recipients through age -- up to age 21, our adults or senior citizens, what have you are a number of issues. Those are national issues. But a lot more has to be done, no question about it.

>> I'm Chris from the Michigan Medicaid program. I had a couple questions related to Medicaid and you talked about 42 million dollars total and 14 million each year. Was that your general fund and the other total?

>> Yes.

>> What is your current -- do you know what that rate is now and with the Federal stimulus package?

>> I have no information about the stimulus package whatsoever. I don't know what it S. We have a 50% match with the Federal government is all I can tell you.

>> I was wondering when you had said that you were on dire straits if with the increased Federal stimulus would have gone to help increase help with you.

>> There have been a lot of efforts going that direction. I'm not sure what the outcome of those efforts have been in terms of the Federal stimulus package. We have a lot of needs in Maryland.

>> Why did you just target diagnostic and simple extraction and why didn't you start at simple restoratives first?

>> Four years ago a bunch of us actually I was on the outside then as an advocate were able to get a lot of -- 11 key restorative rates increased. We didn't keep it indexed to inflation. They need to be increased again but they were addressed. The diagnostic services were low. It was an incremental thing, too. The target for the year would have been the restorative rates and others as well. Year three whatever appeared to be left over.

>> Hi, I'm Sheli with a few charitable trusts. And it's great to hear you speak and what you've brought to the state. One of the things that really good about your plan is the balance of personal health and preventive health and public health, which is too often neglected in states. What I'm wondering about moving forward, though, is whether or not your public health hygienists will be able to bill for the work they do under Doral. I'm also wondering if you could explain whether you use Medicaid and CHIP dollars for preventive health work in the schools.

>> The second one definitely. There is no question that Medicaid dollars go to providing services in schools and we have a few wonderful models actually in the Maryland eastern shore that highlight that. At this point there is no movement whatsoever to have hygienists bill for whatever their services are essentially.

>> I'm Pam and I'm a hygienist in Maryland but I'm representing the American dental hygienist association today. I know firsthand what a wonderful job the committee has done and I'm very excited about the public health hygienist and worked hard to help get that. My concern is by tying it just to public health that the -- we don't have a large number of public health hygienists and some counties don't have any. Does the committee have a goal to increase the number of public health hygienists in Maryland and also is there a goal to bring that back to that type of supervision to the private practice office?

>> Our goal is to increase the number of public hygienist. They think they are a key part of this. You mentioned Kasper and even though she brings so much more to the table. Yeah, I mean I think, you knowing it's not something -- it's not an active goal of the dental action committee but it's a model. These are models others can look like when advocating for the

private sector. But our focus was on the public health arena and it's why we got the result we did.

>> Let's give Dr. Goodman another hand. Thank you. And before we go to our break I just want to stop for a minute and thank some people behind the scenes that you won't hear from today but they really did help to put this together. And names you'll probably recognize. Cindy Ruff. Barb Daley and Cindy Hennessey. They've worked hard the past several months on our dental work. Before we go to break, I just want to remind you if you would like to comment, please sign up and when we come back in we'll be going straight into our comment period. We have a 10-minute break. I'm going to ask if you could be back at 10 minutes to 3:00, at 2:50 in this location. Thank you.

>> If there's anyone that needs a taxi cab, could you let the people at the front desk know so they can have them waiting for you when we close out? There's a sign-up sheet and as soon as you do that, we're going to get started in one minute. Thank you.

>> Thank you. We're going to get started with the afternoon session with the last session which again is very important to us because we get to hear from you. We notice that there were three topic areas we were particularly interested in hearing about and that included payment which included some of the administrative things that go along with payment. It also included discussion about the delivery system. We've heard several different models discussed here today already. And we're also interested in hearing your thoughts about education for providers and beneficiaries. So we want to target many of our comments in those particular areas, but as Conan mentioned earlier, we're also interested in other areas that you would like to comment about. Our comment period, we will ask that you go to the microphone so that you could be heard by not only those in the room but we're be

joined by several on web cast. Additionally, we will be timing you because we have a limited amount of time and we know we have a number of people that need to get to the airport and we want to hear everybody that is signed up to talk. So when you do get to the 30-second point, I will say 30 seconds so that you know that it's time to conclude your remarks. To the extent that I know many of you just want to make a comment, some of you may have questions. We want to hear from you. Panelists have already spoken. However, if there's something that they can address quickly, I will turn to them and if you could just give me the sign that you would like to address the commentor, very briefly. So let's get started. We do have a sign-up list and forgive me if I mispronounce any names here. I think I can manage the first one. Ken rich, the Kentucky Medicaid director.

>> Yes. Thank you. I practice dentistry in northern Kentucky with my two sons. I'm a Medicaid provider and also serve as the Kentucky Medicaid director and a trustee of the American dental association. That doesn't make me an expert but certainly gives me an opinion and I would like to share that with you today shortly. First of all, it's pretty evident to me that there is no way that dentistry or the dental health community of providers will treat themselves out of this predicament we're in. This issue is much broader than that. With that in mind, I would much rather see us or like to encourage us to take a look at targeted programs, to reach the most vulnerable victims in poor oral health that exists in this population. I want to make this really under three minutes or try very hard to and the other thing that's an issue is the rat's nest that seems to be present of administrative garble. You know, it's very, very difficult, and I think I've come to believe this is more of a state issue than a federal issue but to ask people to jump through more hoops, to deal with more administrative problems that occur in order to pay them less is not ideal to say the least. Those two issues seem to hit me more than anything. The first one, the issue of

targeted programs, I would really hope that C.M.S. could incentivize and encourage states to proceed along those lines.

>> We'll hear from the American dental education association.

>> Thank you. I do represent the American dental education association which represents all of the 58 dental schools in the United States, more than 700 dental residency training programs and nearly 600 allied dental programs. These institutions serve as dental homes for racially and ethnically diverse patients, many of whom are uninsured, underinsured or reliant on Medicaid and the chip program. Every U.S. Dental school operates an on-site dental clinic and many provide dental services through other off-site locations in partnerships with state dental programs, community health centers, private practitioners, Head Start programs, communities of faith, public school health systems and nursing home facilities. Nearly half of all of the patients treated at dental school clinics are covered by public assistance. We have recommended eight different provisions that we think could help improve the Medicaid program. Let me just highlight four of them. We believe that Medicaid should develop models of care that allow primary care providers to gather data, assess, triage and refer patients to appropriate dental professionals for diagnosis and treatment. States should develop stronger linkages between pediatricians, family physicians, geriatricians and other providers as team members with dentists in assessing oral health status. Second, Medicaid should require a basic dental benefit for aged, blind and disabled individuals similar to the one available through the EPSDT program. That would help reduce widespread infection, problems with dentures and poor oral hygiene that occur in nearly 70% of the nation's elderly nursing home population. Almost 2/3 of community based residential facilities report having inadequate access to dental care. Thirdly, Medicaid should adjust payments to dental providers who provide care to a

disproportionate number of Medicaid patients, particularly those with complex medical and other special needs. Reimbursement for oral health and dental care should reflect the additional burden of disease and complexity of treatment for beneficiaries with cognitive and physical disabilities and lastly, Medicaid should ensure adequate reimbursement for dental services. In 2002 total combined state and federal spending on Medicaid dental services was just 1.1% of the total Medicaid spending. This is to dentists take longer than standard physician visits and require sophisticated technology, costly equipment and materials. Medicaid rarely takes these differences into account when establishing reimbursement rates for the provision of oral health services. We're prepared to work with D.H.S. to develop policies that access dental care while at the same time providing affordable options that save Medicaid money. Thank you very much.

>> Thank you. And we invite to the microphone Lynn Grossman from the Dental Health Foundation and as win comes, we are taking notes of all of these comments and we at C.M.S. will be going back, removing them as we make future policy decisions.

LYNN GROSSMAN: I'm Lynn Grossman. I am the executive director of the Dental Health Foundation. Bob was one of the finders of my organization. But I'm here today representing our oral health access council, our statewide coalition. We have a few comments that we wanted to make. Number one, it's really hard to -- aside from low reimbursement rates in California, we're at the first percentile for most rates, a really good program here, we're now losing our adult dental benefits most likely. Not really good to keep providers as part of our program. We've had a low rate of providers participating in this program. We'll probably have almost none once we lose adults dental benefits so I would like to urge you to consider maybe adult benefits should not be an optional benefit. I don't see how you can provide really good services to children unless their parents have

access to treatment as well. Plus dentists, very few general dentists just treat children. They treat -- most of them have a family practice and they treat multiple people in the family and that's the way they practice. As I said, I don't know how many dentists we'll have left in our program, but it's going to be very few. This is going to really pretty much wipe us out. The second thing that we really would like to urge is finding more creative ways to reimburse providers for early prevention. We do have -- we have programs and schools and also programs in head start and we have programs where we're actually providing dental visits at W.I.C. Most of these are provided through a public health entity, whether it's a county based program. For the most part, those services are not being reimbursed through the dental program. They could be except the problem is that it's taking about a year to become a provider in California so the public health groups who want to provide these services and expand them aren't able to do that because it takes, again, about a year and a lot of hoops to jump through. So there should be some more creative way, at least on the public health side, of allowing these people to become providers quickly. The other thing by doing these programs in the schools or head start or in W.I.C. is that there's essentially no problem with missed appointments. The kids are there. You know, you line them up, they come in and it's a very quick, efficient way of providing the services. And even though our rates are only at the first percentile, particularly in W.I.C., they work for a 1-year-old or a 2-year-old and there's no other way of getting 1-year-olds or 2-year-olds into dental offices. The mothers won't take them and there's no dentist that will take them, either. So W.I.C. is probably the way to get lots of low income kids there and --

>> 30 seconds, please.

>> The visit doesn't require much. The reimbursement rates work. The last thing is really to consider -- it's an expansion of the four walls concept for federally qualified health centers, allowing them to work in public health settings like schools and W.I.C. and head start and be able to build their rates for those services. Thank you for allowing me to testify.

>> Thank you. We will now bring forth Jerris -- I'll let him pronounce his last name from the national network for oral health access.

>> Thank you. I'm the Dental Director at Cam Care Health Services and also I'm an executive member of the oral health access. And our mission really at N.O.A.H. is to provide for the underserved. We were founded in 1990 by dentists that realize that dentistry was kind of going downhill in community health centers and needed a boost. One of our founders is here who is the Chief Dental Officer and under him, luckily he can convince them that there should be a dental component. A couple of good things is that it increases access to patients. Most of the people that staff community health services are like the community. If we have bilingual people in the community, a good half of our state is bilingual in that language and also just a cultural access of things make it comfortable for patients to come there. We also have a large volume of open access patients. In other words, we anticipate that many patients in under conserved areas will wake up with the idea that today is the day to get their tooth fixed and they want to come in there. We have access to them. Maybe 50% of our appointments are open access. So we actually become a very good dental home for a lot of patients in the underserved areas. But the thing that kind of impede us in terms of having good access, number one, I would say not in all states but in some states, our organization covers all 50 states and the Commonwealth is that not all states have adult dental care. As one of our colleagues said

that children has no access to oral health care. A child cannot going to the dentist and knock on the door and say I need my teeth cleaned unless a parent or surrogate takes them. In those states that don't have adult health care are missing the boat. If one works in the suburban community, one knows that people moving into the area will send their kids to the test case. If it is, the adults go, too. It's a family kind of thing. When you have families where only the kids are eligible, the family suffers and don't pay as much attention to the child. Number two, there are a lot of code limitations for services and for our providers, we have to have a crib sheet that has lots of grids on there and they have to know that, for example, emergency exam with one H.M.O. is once every three months. Another H.M.O., it may be whenever and they really have a hard time figuring out which services will be covered. The patient gets seen and it's a noncovered service, the whole thing is nonbillable. The third thing, I think that I would recommend for Medicaid, think of some way to market oral health care to our underserved recipients. When I drive through our community, the community that we service, on the way home I'll see a billboard that says things like get in your zone. Drink 100 proof vodka, you know. You say, gee, what does zone mean in that kind of thing? After awhile you learn this is marketing to that community and those folks --

>> 30 seconds, please.

>> OK. And probably all have heard of this -- I'm not sure what the source for it is but actually humans take about 14 times to hear a message before they'll say, OK. This is something I should do. It's not enough to go to a dentist and say you need to come here. If we had things for marketing on the part of Medicaid, your child should be seen at age one. You're entitled to a dental examination once a year accident every six months. Those

kinds of things may seem like simple things but I think they would help a lot for those recipients. Thanks a lot.

>> Thank you. We have Sharon Zealander from the American dental hygienists association.

>> Thanks so much. We believe that two key ingredients to any successful strategy is improve access are one, opening up additional entry points into the delivery system and two, enhancing dental work force capacity and flexibility through the exploration of new provider models. Merging these strategies, we're wok to go shape the future in which Medicaid children and other vulnerable populations will be able to directly access dental services from advanced practicing hygienists who will be working with dentists. A quick look at four trends across the country will confirm that states are improving access and that real progress is being made to bring in advanced practiced hygienists. One, hygienists as Medicaid providers. California and Washington were the first states to recognize and reimburse hygienists as Medicaid providers. Today 14 states recognize and reimburse hygienists as Medicaid providers. Soon Massachusetts will make 15. C.M.S. could encourage other states to adopt this approach. Two, direct access to dental hygiene services. Currently 29 states enable direct access to hygiene services meaning that patients can access preventive services provided by hygienists without a prior visit to or authorization from a dentist. Direct access efficiently streamlines care by providing additional entry points into the delivery system while also striving to ensure that referrals to dentists are made for those patients in need of direct care. One direct access success story is that public/private partnership in South Carolina which provides hygiene services in schools. The program has 12 restorative providers, dentists who agree to see the children in their offices. The positive impact of the program is revealed in a recent South

Carolina oral health needs assessment which revealed that in the five years since the program was effectively in place that one, untreated care rates declined. Two, treatment urgency rates declined and sealant rates increased. Three, work force demographics. According to the B.L.S., the number of hygienists is expected to grow by more than 30% between 2006 and 2016 making hygiene one of the fastest growing professions in the country. By contrast, the population of dentist \$growing at a much slower pace and not expected to keep up with the need for dental care in coming years. These work force realities must be reflected and access solutions. We need to answer the question, what do we do if the dentist can't be there? Four, increasing state and federal interest in new dental providers. States are performing their traditional role of serving as laboratories changed. In Minnesota, a coalition worked to pass legislation last year, creating a work force to establish an oral health practitioner, a new scope of practice very similar to the advanced hygiene practitioner. Following legislation is now pending to launch this and another new provider. Expert testimony at a hearing last month in Minnesota reminded us that the Minnesota oral health practitioner concept is neither new nor untested. Alaska and 53 countries utilize nondentists to provide restorative and other dental services. Research shows the primary care dental professionals serve as competently as dentists. However, they do not provide the full array of services that dentists provide. No other person will seek to replace the dentist. They work with dentists and put patients in pipelines to see dentists. The first program will begin in St. Paul, Minnesota this fall. Eastern Washington university in Spokane is working toward enrollment in the fall of 2010. Other states are evaluating what new provider models would work in their states. The summary released in January of this year calls for further review of alternative providers. A forthcoming GAO report --

>> Time, please.

>> Will examine dental access. We welcome the opportunity to work with those who care in the oral care. In particular we hope to capitalize ongoing efforts with systemic health reforms. This presents a historic opportunity to provide a delivery system that truly reflects the fact that the mouth is part of the body. We're committed to working with everyone here and all who want to make oral health part of total health. Thank you.

>> Thank you. Can we have Courtney Layfield, please?

>> Hello. I'm the director of administrative services for the soldier dental association and I appreciate this opportunity today. Let me tell you how Medicaid managed care has worked in Georgia. Simply, not well. Medicaid started as a program and moved to manage care 2 1/2 years ago and has been fraught with problems ever since. The mirror mirrors the program that's in the managed care. In an effort to offer patients a provider, the state awarded contracts to three different care management organizations or CMOs. With little experience with dental, the CMO. subcontracted the dental administration to two subcontractors. Since the implementation of the CMOs, the dental program has experienced numerous fee reductions, frequency in age limitations on services, closed provider panels and provider terminations without cause. There have also been problems evaluating the programs due to an inconsistency and reliability of data, concerns about the viability of the network and a lack of oversight of these companies. The move to managed care in Georgia was one of the most ambitious of any state we have learned so far and we've learned some very valuable lessons. First, the state mandated three CMOs. They had to subcontract to two dental administrators which created a complicated process for dentistry. The approach should be considered first. At the very least, a pilot program should have been considered with the smaller segment of the population. Second, two

achieve a higher level of success, integration of all of the interested stake holders in the process. The recipient, the providers, advocates and government officials. This would have led to more of a buy-in of the program and an opportunity to foresee some of the potential pitfalls and three, the CMOs were given broad authority in administering the program. Uniform reporting systems were lacking. Lesson we've learned is there needs to be a unified and defined process in place for quality a insurance. The objective of the program has been to provide quality dental care to Medicaid and SCHIP children but children may have difficulty in accessing care due to fewer number of providers brought by the program. Thank you.

>> Thank you. We have Pam from the American Dental Hygienists Association.

>> On behalf of the American hygienists association, I would like to thank you C.M.S. for this town hall meeting. I'm a licensed dental hygienist who lives and works in Maryland but today I'm representing the board of trustees. As we are all well aware, oral health is a vital component to total health. Virtually all dental diseases preventable. Yet in spite of that, tooth decay remains the most chronic childhood disease. HDHA is committed to advocating for solutions that increase coverage for and access care to oral health care services. We are committed to working with other health care stake holders such as the American dental association to work collectively on issues impacting oral health. In recent years, ADHA has had the opportunity to work with a host of stake holders to advocate in support of access initiatives. We worked alongside A.D.A., the children's dental health project, the American dental association and others as part of the dental access coalition to advocate for the recent passage of the chip program. As a member of the dental care team focused on prevention, dental hygienists are well placed to play a key role in the delivery of services that prevent decay and help treat oral disease while it's still

manageable. Dental hygienists throughout the country play an active role in the delivery of care to Medicaid populations in a range of settings. Schools, public health clinics, private dental office just to name a few. As one of the top 10 fastest growing health professions in the country, the hygienist's work force is a great resource for states to draw upon as they increase and streamline the delivery of the oral health care services. Another opportunity to optimize the existing dental hygiene work force is through the development of the advanced dental hygiene practitioner. A master level provider focused on education, preventive therapeutic and minimally evasive oral health care services to the population. They are in practice in over 50 countries internationally. The introduction of advanced nursing providers and other medical mid levels has bolstered the health care work force and increased patients' ability to access quality health care services. ADHA fully recognizes the importance of implementing a host of solutions to address the oral health care crisis from raising Medicaid reimbursement rates to expanding the importance of oral health, to increasing grant and loan forgiveness opportunities for dental providers who work with underserved populations. A number of policies must be considered and applied. HDHA looks forward to working with C.M.S., organized dentistry and others on efforts to increase access to vital oral health care services. As national efforts to improve the delivery of health care services get underway, oral health stake holders have another opportunity to collectively support the inclusion of dental benefits and any comprehensive health reform effort. Thank you for this opportunity.

>> Thank you. We now have Lori Norris from the public justice center.

>> Thank you and good afternoon. I'm here today representing myself as well as Alice Horowitz and others who are all with the University of Maryland School of Public Health. The four of us have been active in Maryland, working in collaboration are Dr. Goodman on

the reforms happening there through the Maryland dental action committee. We have written testimony which we'll leave with you. I'll summarize. We agree with Dr. Rich that we will never treat our way out of this predicament. We believe that oral health literacy is critical and the simple truth is if you don't know what to do and how to do it, it's not going to get done. And I think that there's probably a general consensus that Medicaid beneficiaries have a lack of oral health literacy. They don't know what causes oral disease, they don't know how to prevent it and they don't have good home care habits for themselves and their children because they don't have this information. In addition to that, we say that health care providers of all stripes as well as policy makers all have low oral health literacy and that needs to be addressed. In addition to that, dental care providers, although they may have high oral health literacy, we think they have a difficult time communicating effectively with their patients to help their patients have better oral health literacy. So these are the shortcomings that our recommendations address and we have three recommendations for you today. The first recommendation is to invest federal resources to ensure that oral health literacy training and educational materials, delivering mechanisms are matched on qualitative and quantitative assessments of health care providers and beneficiaries. Most of you probably know that the secretary of health and human services was recently charged by Congress with developing and implementing a program to deliver oral health education services to new parents, concerning risks for and prevention of early childhood and we applaud this as a terrific first step and we urge C.M.S. to use this as a spring board to develop resources and strategies for all of these populations. Beneficiaries, policy makers, all medical care providers as well as dentists. And we urge C.M.S. to recognize that these resources must be research based and evidence based. In order to create effective strategies, it has been shown by research that we first must understand what people know, what they think and what they do. So we urge C.M.S. to -- themselves and perhaps in cooperation with sister agencies to develop and

disseminate effective strategies that are in plain language, are culturally appropriate and will fill the gaps. The second recommendation is for C.M.S. to urge states to reimburse Medicaid health care providers for providing patients and caregivers with oral health education and counseling services in a clinical setting.

>>30 seconds, please.

>> Currently there are only four states that provide this care and be willing and reimburse for it. We think that this can be broadened. There are dental codes to provide for this and we urge C.M.S. to broaden this mandate. Third recommendation is as several others have indicated, if the parents don't have access to dental care, the children aren't going to get as good of care. So our recommendation is to that the parents also have access to dental care and there are research studies that show that if the parents have access to medical care, the children go to the doctor more often and are more healthy and we think that that message is translatable to the oral health arena. So we recommend mandating adult dental throughout the country. Thank you very much.

>> Thank you. We will now hear from Andrew Snyder.

>> Good afternoon. I appreciate C.M.S. leadership in convening this town hall. The reason why we're brought here today was because there was a report that was generated of a review done on 16 states fully accorded with a third of the states who had utilization rates for dental services under 30% so we really need continued leadership from C.M.S. in helping states to move forward. Some of my remarks I've heard other people mention parts of them. I think it would be useful to start thinking about the production of materials that states can use to push forward not just on utilization but on quality care that helps

children obtain oral health. An item to consider might include models for dental benchmark states. I'm envisioning a plan that uses payment incentives or the community health centers to prevent dental disease management of family units. Specialized coverage to parents and children. Dental providers to provide their range of clinical services and pharmacies to dispense toothpaste. The over the counter drug that is our basic tool for dental disease management but which Medicaid isn't paying for. We also need to combine enhanced payments with the adoption of real risk assessment and diagnosis coding so we can tell when procedures actually translate into improved oral health. States have been chase that go utilization number and it's the number that we have available but it's not terribly instructive. I agree with Dr. Tanker's statement at the outset. We need objective goals and codes are essential. Thanks for your consideration.

>> Thank you. OK. We are halfway through our list and we will hear from Meg booth from the children's dental health project.

>> Good afternoon. Thank you for this opportunity to speak to you. My name is Meg booth. I'm the Deputy Executive Director at the Children's Dental Health Project. We identify and promote innovative policy solutions to provide dental health. We believe our expertise is best used to work with policy makers to identify upstream public health approaches. It's from this perspective that the following three points I would like to make. First is that prevention and disease management are the best opportunities for eliminating current dental access problems. Second, current law and regulations for public programs are sufficient to meet children's needs but the commitment to enforce these remain inconsistent. And lastly, any improvements are dependent on the ability to collaboratively address problems among policy makers, health professionals and families and all of these are essential to improve the health of our nation. Recognizing that today's children are the

next generation of employees, parents, military personnel and leaders, there's much to be gained by preventing disease by providing appropriate care to pregnant women and young children. We should manage dental care the same as other chronic conditions, with systems support by preventing disease that can manage the same with system supports for individualized care plans, and risk based care. By reducing the disease burden, we can eliminate much of the unnecessary suffering and financial burden placed on families and our nation. Perpetuating a situation without getting to the source of the problem is a losing battle. We want to focus on prevention and disease management. It could relieve stress on the currently inadequate system by allowing dentists to use their expertise to treat children in the most urgent need of care. This is the only approach that holds the potential for improving health and reducing costs. The Medicaid benefit was established 42 years ago and unfortunately has yet to deliver on its original promise to children and families. Although current laws and regulations exist to provide children adequate dental care, it's the responsibility to ensure the states have both benefits available to them. Medicaid is a partner between federal and state agencies, there are substantial opportunities for states to adopt the best practices in those reports. However, if C.M.S. had maintained the oversight the last 40 years, the cycles of E.P.S.D.T. reform which damaged the program could have been avoided. The children's dental health project is committed to sustaining our work with C.M.S. and all of our federal and state policy makers to assure that attention remains fixed on the oral health of children and families and the Medicaid and CHIP program. My final comment is that improvements, whether greater focus on prevention or maintaining a commitment to children's oral health are a shared responsibility of everyone interested in children's health and development. The burden and success of achieving Medicaid program with healthier children buildings partnerships that share the same commitment. At a minimum, dentistry, social services, educators and families must agree to jointly advance innovative solutions and systems change. Therefore, CDHM calls on

C.M.A. to focus engaging partners to prevent and manage dental disease, to provide adequate oversight. Thank you.

>> Thank you. We will hear from Richard from the University of Detroit, Mercy Dental School.

>> Thank you very much for this opportunity to speak. I just wanted to reinforce what the gentleman said with regard to the part that dental schools play in the delivery of care. I don't want to focus on the care part. But rather, the education part. In states where the economy is particularly bad and certainly in Michigan where it's a forefront of that so I can speak to that issue, and state funding to match Medicaid dollars may be reduced. This not only affected care and delivery but has the potential to very adversely affect education. If there are no patients, there is no clinical education framework. I respectfully request that the federal funding distribution be carefully reviewed, not only with respect to care delivery but also to take into consideration the effect that its current cost sharing model with the states may have on the state's ability to supply matching funds. Although the federal government may have funds, the problem at the state level may be the Achilles' heel. The mechanism may have to be reevaluated. If education as well as patient care is to be properly supported. We may well have reached the time when Medicaid moneys should be allocated to dentistry.

>> Thank you. We will now go to grant and I believe it's Christianson from the Wyoming state health department.

>> Thank you. I am a part time administrator with the department of health with responsibilities of consulting with the Medicaid director. I also have been a Medicaid

provider since just the day after the earth cooled. We've kind of danced around a few issues here and some issues were mentioned in the paper and one of those is fee reimbursement. In Wyoming we -- I was hired about five years ago and my primary charge was to increase the number of providers and the access to care for children in Wyoming. Now, Wyoming is a large state geographically with few people. We talked about Wyoming being a small town of long streets. We have 500,000 people spread out over 100,000 square miles. And in some instances it's 200 miles between dentists. And that's -- that creates some unique challenges for providing access. In spite of that, in Wyoming we have 230 practicing dentists, 186 of them that are enrolled in Medicaid providers and about 150 of that 230 provide significant services to children. Since 2003 we have almost no communities now that are not -- that do not have Medicaid providers and have access - - that children have access. We've gone from 25% to right around 40% in that five years. I would like to take any credit for that but I won't take any credit for that because in 2003 our legislature increased our fee reimbursement to about -- to the 75th percentile, most commonly performed codes. Since that time we've had no significant increases. My concern is that if we don't maintain our fees that -- especially with the economic climate we're all facing, that we're going to see fewer and fewer providers. When people say it's not about the money, they almost always mean it's about the money. And I think that that is an issue that has to be addressed. As I speak to the dentists around Wyoming, ask them about their concerns and Wyoming is a small enough state that I know almost all of them by first name and they tell me that besides fees, one of their big issues is failed appointments because that represents a huge loss in a dental practice. If a dentist has an hour set aside for a family of children on Medicaid and they don't show up for their appointment, there's no reimbursement for that hour. I would suggest a couple of things. First of all, in fees that states and federal government seriously consider paying -- making reimbursements at the 75th percentile of usual and customary, reasonable fees and also

on the issue of missed appointments, that dentists be able to bill for missed appointments and possibly be reimbursed at the same rate as others get for an encounter. That would encourage more providers and be fair to those who are providing. The other thing that -- we just went to a carve out administration just this last year. I would encourage that. We've seen some -- in other states. We have seen a real improvement in the administration payment of dental claims just in the short time we've been in a carve out situation. Thank you.

>> Thank you. Mary Hartley from advancing oral health access and oral health for people with disabilities.

>> Thank you. My name is Mary and I'm here representing working on the statewide access to oral health care in Pennsylvania for people with disabilities. I'm also the mother of a child with autism. While we understand that dentists have to limit or restrict their panels as Medicaid providers in order to survive financially, many people seeking access, particularly in rural areas are befuddled by the fact that that panel is so closed or limited in a severe way that they can no longer access the dentist. For people with disabilities, the dentist doesn't take all people, just the ones they feel competent to treat. We know that 75% of people with disabilities can be treated in a typical dentist office. And needs to be done to address this at a national level. C.M.S. needs to show leadership in promoting oral health for people and adults and children with disabilities and I think this could happen in many, many ways, many of which were mentioned today. And one of those things, just initially that was mentioned was, you know, why are we doing oral training and education at state level? Why is there a national agenda for that? And including people with disabilities in that training for both children and adults and also for dentists? Thank you.

>> Thank you. We will move on to Chris Furrow from the Michigan department of community health.

>> Hi. Thank you for letting me take a few minutes of your time and I'm going to wing it with some different things that I've heard today. I'm with the Michigan Medicaid program and we were one of the 16 states that were reviewed by C.M.S. for an E.P.S.D.T. review. Part of that was because we have our utilization rate was at 30% but I do want to tell you that we do have one of the programs that we are very proud of in our state called healthy kids dental and it is a 1915 B-4 waiver to select a contractor with provider, Delta Dentals plan in Michigan but it's not statewide and only covers about a quarter of the children that we have. But we have found amazing results, too, with the utilization and access to providers in getting care. But what I've heard today, too, while we talk about providers, what I have not heard about is the completion of the triangle is the beneficiaries. And I've heard that you talk about a champion, that you need a champion in your state within the state program to help with Medicaid. You need a champion in the dental association or dental group but how do you pull in the beneficiary? You have -- do you have dental advisory councils, the three states that have presented today and do you have representation on there from beneficiaries or consumers? If so, how do you get those? And how do you get them in a meaningful way to address oral health and education? And then we've also heard -- we did not get too many disallowances from C.M.S. on it but it had to do with education and what I have heard from others is how do we make beneficiaries and consumers, how do we make them responsibility for their care? How do we make them accountable for their care? How do we provide better education through students, dental students, through the communities? I am aware also of the language in the chip bill regarding education for newborn parents so I think we would like some direction, at least I would with our state, in terms of how to provide education, oral health education and at

least market it to providers. Those are my comments. I probably could go on and on but I want others to take time, too.

>> Thank you, Chris. I think we have four more speakers. I'm going to have them come up first and then I'm going to come back to the panel and ask if you could be thinking about the question of how do you include the beneficiary in your reform process as well as in your education and outreach. While you're thinking I'm going to bring up Winifred from the National Dental Association.

>> Good afternoon. I represent the national dental association, the society of American Indian dentists. I'm also a member of the American academy of pediatric dentistry. I also signed up as the executive director of the Maryland children's oral health institute. I'm responding to the beneficiary and provider comment about education. I feel Maryland dentists clearly understand the desperate oral health care needs of children and families that are covered by Medicaid. The educational challenge for the provider seems to be the lack of a much needed supplemental pediatric dentistry training program to increase the pediatric skills of the general dentist. Dentists who do not routinely provide specific pediatric treatment are reluctant to offer more than preventive care to children. General dentists often refer children to pediatric dentists when they present with early childhood problems, tooth decay or special needs. This is due in part to the necessary dentistry training and many of the child friendly skills that are needed to address the dire treatment requirements, more often identified in the Medicaid population today. However, there are far too few pediatric dentists readily available who accept beneficiaries covered by Medicaid. In 2005, the American academy of pediatric dentistry reported that only 18.1% of pediatric dentists accept Medicaid insured patients. As a possible solution to consider, a possible solution to consider might be to establish an incentive structure apprenticeship

continuing education program offered by practicing pediatric dentists or practicing general dentists. Reward the pediatric dentist for making this supplemental training available to general dentists. Reward the general dentist for learning some of the core fields to better treat children and become more comfortable with providing the actual restorative care so desperately needed. The apprenticeship program will offer on the ground, grassroots, first hand instruction by practicing shoulder to shoulder with a program set aside pediatric dentist. The instruction -- the program will help dentists better to understand. It might also encourage more pediatric dentists to enroll as Medicaid providers. This 40 to 80-hour apprenticeship continuing education training will help to improve the chances that more children receive the actual dental treatment they need, allow dentists to earn a required continuing education credit and encourage more dentists to accept state covered insurance plans. The possibility of earning continuing education requirements, being offered a state or federal tax credit, a one time waiver for the state licensing renewal fees and unrestrictive student loan repayment in exchange for the contractual commitment to complete comprehensive treatment on children covered by Medicaid for an agreed upon enrollment period may be the type of incentive that could help out efforts to improve the oral health of children in our nation.

>> 30 seconds, please.

>> I do think beneficiaries receive sufficient information on the importance of their children's oral health. But it does not relate to their overall health. A woman that is well informed about the possibility that she could lose her baby or deliver a low birth weight baby secondary to having poor health care may become proactive about her oral health. I think that we need to now start to educate children in the classrooms and have some -- and have teachers do instruction in the classroom about oral health just as much as we do

physical education. I have some additional comments but I don't want to take time from other people. The Maryland children's oral health institute is working on a project for the oral health crisis in the classroom and we met with the department of education after learning that in the state of Maryland, there is one hour oral health education requirement in second grade and 30 minutes in -- between nine and 12. So we think that educating children in the classroom will also be of benefit. Thank you for convening the meeting.

>> Thank you. We will hear from Jim Crawl from the American Academy of Pediatric Dentistry.

>> Thank you. Good afternoon. Thank you for the opportunity to comment today. I would like to start by commending C.M.S. for its recent attention to Medicaid E.P.S.D.T. programs. The emphasis on adequate market based reimbursement, the emphasis on Medicaid E.P.S.D.T., scrutiny of states with low levels of utilization of the dental services I think are all commendable. I would like to also speak, though, to two concerns I have. The first deals with the unevenness of state efforts to address what has been recognized for over a decade now as a serious problem for this nation. Often characterized as a system failure in many states that unfortunately still ends up being addressed through the judicial system. Particularly with respect to provider payments which primarily is a function of state priorities and political will. Some 10 to 12 states in this country have made significant progress over the course of the last decade or so but many, if not most of the rest have not. And some are still trying to purchase dental services at 1980's prices. The second example I would like to address has to do with E.P.S.D.T. period schedules. I've been involved in the last few weeks and months in a number of what we call state launches for the AAPD Head Start Dental Initiative and I've learned significant -- acquired significant information. C.M.S., I think, stepped up and within the course of the last year has asked

states to submit true dental period schedules, something that was required as part of over 89 legislation but hadn't been followed up on. But I did learn in my travels that in one state, and I don't feel shy about mentioning Rhode Island, I think they've done an exemplary job of the schedule that outlines preventive services and when services should be initiated. I also learned last week of another state that essentially their dental period schedules calls for a referral to the dentist at age three and that the rest of the details are left up to the professional provider community. It's that unevenness in enforcement of what are requirements in Medicaid law and regulations that I think deserves additional attention. So in summary, I hope that the current economic situation does not become an excuse to ignore or further defer this critical issue of children's oral health and access to Medicaid E.P.S.D.T. services. After all, what was the excuse in the good times when many states had budget surpluses and still did nothing? I hope that C.M.S. will continue its recent commitment to work on this issue with all states and to make known what E.P.S.D.T. period schedules are for all the states so we can examine those schedules and disseminate that information and continue to work with states to improve what really is required through the Medicaid EPSDT program. Thank you.

>> Thank you. We have Allen Finkelstein.

>> Thank you for the opportunity and Jim, it seems like mo is following you and I have to steal his slides when I have to lecture. It seems like only yesterday but it was two years ago almost to the date that the subcommittee on domestic oversight held hearings. Lori Norris was on the panel with myself and a professor from the University of Maryland out of a tragedy. And been spending a lot of time thinking about it. I'm responsible for 2.5 million children through -- with the Medicaid division and we're failing. Failing miserably. We cannot accept 30%, 40%, 50%. There are other little children that are vulnerable to health

care. We can't get it straight. Tim just hit it on the nose. Those tables have to be uniform. C.M.S. has to do something about it. Six months of age, nothing lists the eruption of the first tooth. We're dealing with an infectious, transmissible, socio and environmental disease and we're not getting it straight. We're not addressing the needs of our children. We're falling far, far short of it. And the only way we're going to do this is by getting together, dropping agendas and we have too many agendas here today. We have to look at our children. They're helpless. A lot of them are homeless. And we have to develop the right way to reach those socio, environmental barriers and that's going to take a collaborative effort. With the Jim Crawls of the world and Lori Norris who is eloquently is an advocate of these children, we must do the right thing. We've done it with Maryland, combining and partnering with Maryland. It's not enough. This will shock you. Just did 100 phone calls, my own network. I just moved into the area. I want to make an appointment. My network, my child is 18 months old. I want him to see the dentist. Less than 5% said come on in. If he's OK, wait until three years of age. Where is our dental education? Where is our medical education? It's wonderful to have a single vendor but is anyone addressing integrated medical and dental care? The correlation of diabetes and obesity, this is not just dental. This is far more than that. I haven't heard answers. It's very, very disturbing. The only thing we must keep after one another. We're not even close to the answer. But we're starting. You know, 41 years of dentistry, I see the same thing over and over again. Backlogs to the O.R., that's a preventable disease. Backlogs to the O.R., putting kids under risk, not addressing the social barrier. It's easy to bring child one, two and three into the O.R., yet our statistics show 18 months later they're back with disease.

>> 30 seconds, please.

>> The codes have to change. We need diagnostic codes and we have to put in literacy and reimburse for that. Thank you for the opportunity to speak to you. Thank you for being part of our partnership. Let's get this done.

>> Thank you. And we will now hear from Jay Anderson from HRSA.

JAY ANDERSON: Hello. I'm Dr. Anderson. I am very happy to be here today. I think this is a momentous occasion. I also applaud C.M.S. for having me at a town hall meeting. At HRSA, we feel that we are a partner with C.M.S. in addressing many issues for low income populations. Our programs, community health center program, the bureau of health professions that provide grants to institutions of medical and dental education, the national health service core that gets loan repayment and scholarships to providers who go out in many of the communities that are impacted by the devastation of poverty and the lack of access to care. The maternal child health bureau has worked with states to build and support the public health infrastructure and also to provide learning materials for providers and patients around critical issues related to access to care and quality. One of my issues I would like to address with at the town hall meeting is the development of quality measures for Medicaid populations. In terms of treatment outcomes, it's one thing to measure the number of patients seen who have had one visit. In many cases one visit might do the job, but unfortunately, Medicaid populations need five, six, seven visits and when we look at access, we look at having an adequate work force and looking at the number of providers available to see Medicaid. We also have to address those same providers in dealing with up to 10 million more patients than the chip programs. Developing equality measures, I think, is critical to the success of our program. I think developing measures holds states, providers, C.M.S., HRSA, everyone involved accountable for improving the outcomes of our patient population. I think if we look at just

numbers of patients seen, we're going to continue to have situations where we have Medicaid mills that turn patients through without improving their outcomes. We're going to have people who work the system in terms of trying to gain financial gain to this unfortunate population that really needs true care. I think that working with C.M.S., HRSA can partner with you and everyone here to address some of these issues as we go forward. I think that we need to look more toward treatment outcomes and prevention as a way of doing business as opposed to just counting members and providers. Thanks.

>> Thank you. I would like to now go to our panel and ask that you address the specific question, but then any other comments that you would have and I'll ask that Dr. Davis goes last because I think he has a few more things he would like to say. We'll start on the end and then work our way down.

>> Just as a reminder, I'm the Medicaid director in Virginia and before I forget to answer the question about beneficiary on our dental advisory committee, it's interesting you ask that because Dr. Dickinson and I were talking about that on the train up here, that that is something we wanted to do and we're in the process of doing. We don't have one yet. We have had a beneficiary on a transportation advisory committee where we have providers from across the state and we have had beneficiaries on it and it is a useful thing to do. We will be adding that. In terms of just some -- I think we were asked to just talk about some general themes and so forth. I am very struck by the fact that so many of the things that we've heard here today are almost identical to the things that we heard from those of us who were this Chicago two weeks ago, and there are a lot of us here in this same room. It's the same things we heard then. Reimbursement issues, administrative issues, involvement of nondental professionals in providing dental related services to clients, the need for adult dental Medicaid services, expanding the dental work force in terms of the

types of things that they're able to do and licensed to do, work force issues, trying to get providers in underserved areas so it's just -- diagnosis codes, quality measurements. I'm struck by the fact that it seems like we know what the answers are. It's just moving from putting them in place and I know that's always where it becomes the most difficult thing to do, but it does strike me that at least it seems to me like we know where we need to be and what the answers are. I think the thing that probably somewhat frustrates policy makers is that when you hear all of those things, I use the term boiling the ocean. You know, it's like trying to do all of that is like trying to boil the ocean and so somewhere you have to start and try to make a difference and I don't mean to sound clichés but you have to crawl before you walk. That's why we put in place the kinds of things we have in Virginia. We've talked, there's long been a desire to add adult Medicaid services in Virginia but adding adult Medicaid services four years ago was a joke, to be honest and to me, it was a hollow promise. You give somebody a card and now you have Medicaid services as an adult for your teeth. Now try to find a dentist. The program was broken. Before you take the second step, if the second step is providing adult Medicaid services, you've got to fix the system. You have to do some basic infrastructure first and then hopefully maintain that momentum and then add to it. And that's the approach that we've taken in Virginia. There is no one single solution. The managed care program in Arizona is working as the doctor told you. There are different ways to do this. I think my emphasis is that it really has to be a partnership with your dental community. You know a number of speakers spoke about reimbursement and the need to do that and that is absolutely true. And I'll let the doctors correct me if they think otherwise, but that was not the sole solution in Virginia. It simply wasn't. The program administratively was broken for them and it really -- you know, both of those things were necessary but insufficient. I mean, neither one of them by itself was going to make a difference. You had to do both of them. Again, I guess my theme from this is I think the solutions are out there. We just somehow have to take

the moment you mean that has, I think, built with the A.D.A.'s emphasis on this, C.M.S.' refund interest and I know from talking to my counterparts from across the country, Medicaid programs are starting to notice more dental services and hopefully, I think we can maintain the momentum and get some things done. I don't think we're going to solve this in a year or two years or even three years. The key is going to maintain the momentum, make some strides and then build off of that success. And I hope we can do it. It's sorely needed.

>> I'll start off elaborating a little bit on the Virginia Medicaid system. The reimbursement figure of 30%, but they're still not great reimbursement but you know our dental economic advisory group has pretty well demonstrated on average, dentists will participate in Medicaid. All you pay them what it costs to treatment patient and that's what's happened in Virginia. The dentists are willing to treat these patients so long as they're not having to pay to treat them. It would be nice if it was a little better but we get participants that way. And I also would like to add what he said about the adult Medicaid program. My practice has been Medicaid patients since its inception. The adult Medicaid program was -- had administrative hurdles that would not permit you to get a phone authorization for treatment and of course, if you didn't get an authorization, you didn't get paid. It took somewhere in the area of a week or week and a half to get authorization. I'm an oral surgeon. When I have people infected and have an immediate need, I'm placed in an ethical bind. I either have to just do it free or I have to give someone that may be a drug addict pain medications for a few weeks until I get authorization. Those programs don't work. So as dedicated as I am to this type of program, our practice withdrew from adult Medicaid and it was painful to me but my partners said it was in a bad ethical condition. It takes funding to fix these things. Obviously, all of these types of hurdles are just a method of rationing what needs to be done when you don't have adequate funding. A few other areas to address

and I'll be glad to answer any other questions that you may have after everyone is finished about A.D.A. policy but the area of health literacy was mentioned. And there's no question. We do know that the dental disease is preventable and transmissible and the health literacy is the ultimate answer. The A.D.A. does have a health and literacy project that's very active and we have good corporate sponsors and it's in its infancy but we're progressive in that area. And we also have private project for a community health care coordinator whose purpose is to work with public health and their primary mission is indeed health literacy to be culturally competent to go into the community and try to give health care education. They have other functions but that's the primary function. Another thing that was mentioned which I mentioned in my opening remarks was evaluations of the programs for cost effectiveness and the actual health care outcomes. Now, one of the problems is we've never actually developed proper tools to do this. The A.D.A. is now working with C.M.S. on a dental quality alliance where we will bring in the different communities much as we do with some other organizations that deal with global dental problems to try to determine what kind of indicators we can have that are programs working. This will be problematic but what we really want to know is whether with a given patient population, over a given period of time, with a given amount of money, whether their oral health improves. That's really what you need to know is some people said, if you're doing nothing but drilling and filling but you're not really increasing overall health, you're not accomplishing anything. We do need diagnostic codes. A.D.A. knows that and we are working on diagnostic codes. We also have to have them anyway because we're going to electronic health records and that will require diagnostic coding so that will happen. And probably -- I'm not trying to prejudge what's going to happen with this alliance but we probably need some sort of an oral health index. Probably similar to what the military uses and that will be kind of an easy thing to teach, pretty reliable where we can actually look at a patient and say, OK. This patient is a class one, two, three, four, five

or whatever. You can take population groups and actually judge whether they're oral health of the population has improved or not improved. You know, with the resources that have been used. And then the other thing I would like to comment on just briefly is the issue of the typical private practitioner and dentistry, taking care of people with mental and physical handicaps and I believe that the biggest issue here, quite frankly, is education. The dentists by and large, it's not that they're not caring, compassionate people. They're just very uncomfortable treating these people and I think that, you know, the D.S. spokesman spoke of expanding education into some of these areas of dentists have been comfortable working in and I think we need to be proactive in training dentists to be comfortable treating people with the mental and dental and physical handicaps. Thank you.

>> Thank you.

>> Well, I've got a bunch of notes but I don't know which one starts first. I think the first question was from Chris asked a question about engaging members. Is that a question, I think?

>> Yes.

>> And, you know, my -- through this state Medicaid advisory committee, there is member representation on that group, I think, and at least in our state. And so it's there. Now, is it designated for oral health? No. Again, with managed care health plans also engage the members at different levels and I don't have all of the answers on that but it is -- you know, your point is well taken. You know, I don't know that we don't do it. I don't know that we do it good enough. So that is something that to me is a good question. But also with

advocacies group like the governor's council for development of disabilities and other advocacy groups like that, you know, the parents are there and often members themselves are there to talk about oral health needs from their perspective as members. The part on health literacy, I think that, you know, again, great points. The department of health services often takes that part up in various states and how good do they do and do they share best practices for organizations? I think there's a lot out there. I think that how it goes through, back to the -- back to our clients and the Medicaid population and then gets disseminated back sometimes gets washed and I think that that, you know, even with a better way to go about that, you know, is out there. The point earlier, the zone or the billboards, there's good ways to do it. I think that figuring that out through, you know, the American dental association and academy of pediatric dentistry, you know, groups like that are -- you know, have the resources, I think. Just a couple of other comments, you know, I think that as we look at -- you know, I would speak for myself. Number one, the state legislators, when they look at what do we have, what do we need, right now whatever we pay those guys, it's not enough in every state. Running a program from my perspective, you know, I want to know the science. I want to know the science that says it's the right thing to put a composite on a posterior tooth. You know, is that a good thing to do? You know, or is it not? I want -- how are we spending our money? What's the best way to spend the money? So the question becomes are we incentivizing the providers to do the right thing. Is paying for sedation or other mechanisms to go from a to z, get all of the treatment done in one appointment that all of a sudden takes out the risk of broken appointments the best way to provide the service? You know, and I think that we can answer that a lot of ways. Individual cases are individual cases and we look at each one. In some cases are we incentivizing the right way? I don't know. That's the question. You know, going to Dr. Anderson, you know, in Arizona, they're paid on a fee schedule. Not on a counter base. So is that a better way? Are encounters a better way or are we

incentivizing repeated dental appointments in order to maximize paying? I'm just asking a question. I don't know. Going back last, you know, just kind of -- my comments are more questions than they are answers. You know, again, getting the A.D.A. and the A.P.D. involved I think is important because they have a lot of resources. I think looking at expanding work force saying that, you know, on the very young, I think that's a tremendous opportunity to get bind by the parents at a young age. If the doctor says this is important, the doctor rather than the dentist, all of a sudden they sit up and listen. I think that's a good thing. And I think that, you know, getting them referred to at a younger age is important. I think that, you know, the fluoride is a very effective mechanism. I've got a lot of other comments, but thank you.

>> Thanks. I heard a lot of answers in here today, a lot of folks coming up and giving a lot of solutions. Solutions are in this room. I've been listening to solutions for probably -- I've been public health now for 30 years. I'm still waiting for how we get to resolving and making and actually getting to the path of making these solutions real. And I'm still listening. We have to do this. We have to do that. We have to -- you know, oral health literacy is the common theme but we need to have oral health literacy among each other and not work within our own agenda as and only when that happens is something tangible going to happen. And I speak from -- maybe this is an Obama type of feeling but I think we have to break down the barriers and work together. As one who in Maryland was once -- at one point a one person show, I know. There are folks in this room who know that. We built a program in this state, and we're not even close to being there. I'm not going to be so presumptuous to say we built a program because we started to talk about each other and not at each other through partnerships. I approach partnerships as almost a survival. I didn't have a choice. I didn't get at it cerebrally at all. I had to do it. I was by myself. And you know something, it takes a while and it takes a lot of caressing and what have you but

it truly works and we have a number of coalitions now, not real coalitions. I'll say alliances, what have you, in the state that are beginning to work together and it's just amazing to walk into a room now where there was maybe just five or six and now there's 20 or 30 and people are asking, how can I get into the meeting? I want to be heard and that gets to Chris' question because that's the one population. And I go to many meetings throughout the country of supposedly diverse committees and parents are always underrepresented and they're underrepresented in Maryland. We have one parent on the dental action committee but one of the things we're going to be doing is to develop a more formal coalition and basically change the whole dynamic of it and certainly parents are going to be part of that. But we really have to start working together and take -- someone said small baby steps and not try to get into that big ocean but just take one step at a time, get your success, show success and then move on to the next thing and work together as a group and not as 25 or 50 or 100 different silos which is why we are in the situation we still are in. I got into dental public health in the late 1980's and I'll bet if we go to the issues represented here with a couple of new innovations, we've been saying the same things all these years. We need to figure out how to get there now. Not what the answers are but how to get there.

>> Thank you. We'll let Dr. Davis close us out and again, thanks to all of you for coming and for those who helped put this together, I didn't recognize Michelle mill and there's my good friend mark nearing who cares a lot about children's dental care and others in the room. We do appreciate everything you tell us. We're listening and we look forward to working with you.

>> Thanks to all of you for coming. I'm encouraged. I don't know that we've ever had -- this is a historic first for us. I hope we're able to have some more of these type of forums in

the future but I really appreciate you turning out for this event. I also appreciate our leadership for hosting the meeting in the beginning and sanctioning everything to go forward. It's been an interesting couple of years and we're making progress. We still have a long way to go but the comments that you brought to us today, we're going to go back and review them, we're going to look at them closely and review the tapes in case my notes aren't as good as your words were and we're going to develop a paper that will be posted online later and we're going to take the information that you've brought forward to work on a strategic plan for next steps. So your time has been very valuable to us and we really appreciate it and like I say, I really am encouraged because it takes people coming together to make it happen. And it takes a diverse group like this to come together. There's been a few other forums like this but you came to the beltway of outside of Maryland to participate in this thing and we really do appreciate that. Also want to thank HRSA, the NCSB has a contract with HRSA to do web casting and we appreciate you folks that stayed with us on the web cast. We appreciate that capability for the folks that weren't able to travel here as well. There are a number of specific things that we really do need to look at closely. Some things that were suggested are things that are beyond our scope, but we'll be taking a look at it and we'll be definitely making recommendations to the new leadership when they get into place as far as next steps that we can take and like I said, I think we've thanked and covered all the waterfronts. I'll turn it back to you.

>> OK. So I think we are ready to close out. We've called for cabs for those who need them and you can find assistance at the front desk if you're still in need of assistance and we'll be back in touch soon.