

Mathematica
Oral Health Webinar 1.30.2014

Thank you. And good afternoon, and good morning to some of you. Welcome to our first Learning Lab webinar of 2014. I know many of you have had some challenges in the last two days with the weather, and we're thrilled that so many people can participate with us. Actually we've had the largest registration for any of our webinars for today.

So a couple of quick notes, first of all I want to give our thanks to our partners at the Medicaid CHP State Dental Association and the Mathematica, who help us put these together.

A couple of housekeeping notes. We may go a little longer in the presentation part of today's webinar instead of just the anticipated 60 minutes, but we will do the Office Hour Q&A after that.

For those of you who will be asking about the slides, they are available and you should have received the link to those on your registration confirmation that went out yesterday or today.

We've had an exciting time here at CMS as we're working toward National Children's Dental Health Month, which starts on Saturday, February 1st. My recollection is that this is the 64th or 65th year of Children's Dental Health Month. Of course, those of us who have been around for a few decades remember when it was Children's Dental Health Week, but obviously the increased importance of what we're doing on dental health, and especially for children, has brought us to this point.

We've had several activities here at CMS that help us actually salute what's going on in Children's Dental Health Month. A series of columns from CMS and from the Chief Dental Officer will be going out in the coming weeks that we anticipate will be going from the state programs to individual providers and others throughout the country just highlighting a few areas that we think are most important when we're celebrating children's dental health.

We also have what's called a mat or a drop-in article that you may have already seen that has gone out on some of the web services and actually has a title of "Think Teeth, Help Your Children Reduce the Risk of Tooth Decay." And I know it has shown up in at least a couple of venues because it's already been forwarded back to me. So I'm thrilled that we're getting the message out so far and wide.

One other thing that you might be interested in is the Connecting Kids to Coverage boosters email. You can go onto the insurekidsnow.gov website and sign up to receive the series of booster emails to get additional hints on how to promote oral health and what's being done in Medicaid and CHP.

So I think that's all we need to do to get things started. I want to introduce our first speaker for today. Laurie Norris holds a law degree from New York University School of Law. She joined CMS in 2011 as the Senior Policy Advisor and Coordinator of the CMS Oral Health Initiative. Her portfolio also includes the EPSDT, the Early and Periodic Screening, Diagnosis and Treatment Program. Prior to joining CMS, Ms. Norris was the State Campaign Manager for the Children's Dental Campaign. Before that she served for 20 years as an advocate for low income children and families in California and Maryland, and in 2007, she began her foray into the world of oral health through the death of her client, Diamonte Driver, who died from a preventable dental abscess that spread to his brain.

So, thank you again for all of you being here, and I'll turn it over to Ms. Norris.

Thank you, Dr. Mouden and good afternoon, everyone. I'm real thrilled to be here with you today and to have an opportunity to introduce you to our Keep Kids Smiling, Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents guide. We have produced this guide at CMS with the intention of continuing to draw attention to the importance of children's oral health in Medicaid and CHP. And it's part of a diverse package of technical assistance that we offer to states in the context of our oral health initiatives to assist states and partner with states in improving utilization of dental services through the Medicaid program.

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This is one of a series of strategy guides that we have produced or are in the process of producing. And you can move to the next slide to see what the Keep Kids Smiling strategy guide looks like on the cover. You should have received a link to the strategy guide in your reminder email, so hopefully most of you have had a chance to open it up electronically and flip through it. It is the first in a series of strategy guides. Others that are under development focus on the adolescent well child visits, care coordination, outreach, and coverage in Medicaid and EPSDT.

So, what's in this guide? We open it with an overview of the Medicaid benefit for children in Medicaid. What some of the policy issues are in that benefit. What the coverage entails. We talk about early childhood caries and some of the policy decisions around that. But the bulk of the guide is really around four major approaches to improving utilization of dental care for children through the state Medicaid programs. And we include lots and lots of state examples for each of these four approaches to give you a sense of what options might be available in your state to improve your programs.

Next slide, please.

So the first approach is to improve the state Medicaid program performance through policy changes. And this has a number of potential dimensions. One of them is to adopt the dental periodicity schedule that is aligned with clinical recommendations. And we have the state of Louisiana as our state example for that one. We also talk about using contracts with dental delivery system providers as a way to leverage improvements in the program. And our strategy guide uses a California example of that approach.

We also feature reimbursing medical providers for preventative oral health services. And we're happy that 44 states have already adopted this approach, and we feature one of those states in the guide.

We also talk about incentivizing dental providers to serve Medicaid children through new payment models, and we feature the Texas First Dental Home approach for that strategy. And we also talk about improving our oral health surveillance on tracking how well we're doing through the CMS 416 and the core measure data collection. And we use Iowa for an example of a way specifically to collect data on perfected payment claims.

Next slide, please.

So our second major strategy is to maximize provider participation. As we all know, if we don't have dentists willing to serve Medicaid kids, we don't have a system. So we really need to have a system that's friendly to providers. And we do think administrative burden on providers is key. We'll be hearing from Arizona today in terms of one way in which they've approached that particular strategy.

We also feature a strategy, a way of helping general dentists feel more comfortable treating young children, and in the guide we feature Washington state and South Dakota, who you heard on an earlier CMS Learning Lab concerning the access to baby and child dentistry programs that they've implemented in their states.

We also believe it's really important to maximize the capacity of the dental workforce, and we're thrilled that so many states are exploring new dental provider models, and the guide features the Alaska work with a dental health aid therapist and Minnesota with the dental therapists and advanced practice dental therapists.

Next slide, please.

Just as we need providers in the program, we also need families in the program. We need parents and children to actively participate in seeking care and in maintaining their own oral health. And we're really pleased that CMS has been able to develop several oral health education materials that we have grouped together under our Think Teeth brand. Today we are announcing the one that you're seeing right now, is our third piece in that series. This one is intended to appeal to parents and children of all ages. We also

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have one that's targeted to pregnant women and another one that's targeted to parents of children under age three. All of these materials are available for bulk order, for free, at the link that you see there on your screen.

We also feature a strategy of addressing missed patient appointments in the strategy guide, and we use Arkansas as our example for that.

Next slide, please.

And our last strategy is partnering with others. We know that Medicaid can't do this ourselves and we need to reach out to our other state agencies as well as broadly to other stakeholders in the program. And this will be a segue to our actual first speaker for the day, who will be featuring his state's experience with working with oral health stakeholders. So I'm going to turn the mic over now to Elizabeth Hill, who will be moderating the rest of our webinar. Elizabeth?

Thank you, Laurie, for that high-level overview of strategies that states can use to promote oral health. Our next presenters will be sharing their state-specific examples that were implemented to improve oral health for children and adolescents. And if you're following along in a strategy guide, we're going to go slightly out of order because our next presenter needs to leave a bit early. So Patrick Finnerty, the former Virginia Medicaid Director, will share Virginia's activities and successes from strategy for partnering with oral health stakeholders. As part of a 32-year career in state government, Patrick Finnerty served as Virginia's Medicaid Director for two governors, from 2002 to 2010, improving access to oral health services for Medicaid and CHIP children with the hallmark of Patrick's tenure as Medicaid Governor. After retiring in 2010, Patrick formed his own consulting firm and now works with several healthcare organizations. In addition, he serves on several nonprofit boards that promote access to care for uninsured and low income people, including the Virginia Health Coalition, and he is currently the President of the Virginia Dental Association Foundation Board of Directors. And, again, since he has to leave a bit early, we'll take a few questions directly after his presentation, so enter your questions for him in the Q&A box that is located on the bottom right-hand side of your screen.

So welcome, Patrick, and please go ahead with your presentation.

Thanks, Elizabeth, and good afternoon. I guess good morning to our friends on the West Coast. It's great to be with everyone today, and it's really special for me as a former Medicaid director to talk a little bit about the success we enjoyed in Virginia improving our Medicaid and CHIP dental program. The topic I'm going to speak on today is how we in Virginia partnered with organized dentistry, the provider community at large, and others to help us design, implement and administer an entirely new dental program, and talk specifically about the Medicaid Dental Advisory Committee we created. So if I could get the next slide, please.

I want to start with just a little bit of background because I think it's important to know where we started from and what we were trying to accomplish. As you can see in this slide, prior to 2005 our dental program was really struggling. A small percentage of dentists were participating, and even fewer were submitting any claims. And while not noted on the slide, there was an even smaller subset of dentists who were seeing any appreciable number of Medicaid and CHIP kids. We received complaints from dentists about how difficult the program was to participate in. We kept losing providers, particularly specialists like oral surgeons, which actually led to fewer general dentists wanting to participate because there was a lack of a specialist referral network for them to pass along their more complicated cases. And we were receiving an increasing number of complaints from parents that they were unable to find a dentist to treat their children as evidenced by the statistics you see on this slide.

We just couldn't ignore this any longer. We needed to make some changes. And as I look back on this time, the saying that the stars were aligned really seemed to be true in the situation, and we were fortunate in that regard. Our Governor at the time, Mark Warner, was and still is very much an advocate and supporter of healthcare for Medicaid and CHIP enrollees. We also were very fortunate to have Dr. Terry Dickinson as the Executive Director of the Virginia Dental Association. He is still in that position.

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You may have heard his name. He started the Mission of Mercy, or MOM, projects that provide free dental care to underserved persons. He started that here in Virginia, and it's now in 26 states across the country. And he wasn't one just to complain about things, he wanted to fix them. I had been volunteering at MOM projects and seeing firsthand the impact that poor oral health can have on someone, so we sat down and committed to each other that we were going to do all we could to try and fix this program, the Medicaid agency, in dentistry and a lot of other groups. And with the ultimate goal to improve the oral health of Medicaid and CHIP children. Several of the key advocacy groups had been pushing us to fix the program, too, and so we certainly involved them and reached out to other groups as well. If I could have the next slide, please.

So together we built and launched an entirely new dental program that we called Smiles for Children. And while there are various improvements states can make in their dental programs, for us, carving out the dental program from the HMOs and having a single dental benefits administrator was the single most important improvement for the dental community. This allowed us to have one streamlined program, delivery system, authorization process, provider network credentialing, claim submission, and so forth. We were also very fortunate to have the Governor and legislature approve a significant rate increase at the same time the new program rolled out, and the legislature liked the fact that we were working with folks, rather than against them, and so they were very supportive as well.

Our focus was to try and be like everyone else. That sounds simple, but that's really what our mantra was, to have the Medicaid program mirror other forms of dental insurance that the provider community was comfortable with. As we marketed the program to dentists, we actually would say in program materials, this is not your mother or your father's Medicaid program. This is a whole new concept. And a cornerstone of our new program was the Medicaid Dental Advisory Committee. And you see on the bottom of the slide the membership of the committee. We have great diversity of dental interests and expertise as well as advocates on there as well.

While the VDA, the Virginia Dental Association, was a major contributor, we had many other groups including the Old Dominion Dental Society which represents minority dentists in the state, the Primary Care Association, Virginia Health Department, and others. The committee meets quarterly. The meetings are hosted by the Medicaid agency. And the committee is staffed, if you will, by the Medicaid Dental Program staff.

The dental benefits administrator makes presentations at each of the meetings on the status of the program regarding key statistics, issues, improvements, etc., and, along with the agency staff, responds to any issues the committee members may raise. Next slide, please.

I know it's very common to have advisory committees, and some may be thinking, well, so what, you know, everybody has that. But the real difference here for us is, as the title of the slide denotes, Involvement and Commitment. We were very purposeful in how we engaged our Dental Advisory Committee members because we wanted them to truly feel part ownership in the program. While we obviously retained final decision authority, we involved them in every facet of program development and operation. For example, we actually had two dentists on our committee participate in the procurement of the dental benefits administrator, and actually score proposals. We knew that this decision was going to be a very important one for the dental community, so we wanted to be sure the providers felt part of that decision.

When we received the rate increase that I mentioned earlier, we asked the committee, how do you think the funding should be distributed? Should we allocate the money in an across-the-board increase to every dental code, or should we allocate a greater amount to some codes and less to others based on how the rates compared to commercial rates?

And I remember, when I heard orthodontists and general dentists recommend higher rate increases for oral surgeons rather than for themselves, because these codes were so out of line and oral surgeons were at a great need within the program, I knew that we were going to have a solid program. I knew that they were committed to the larger good of improving care for our children.

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We also had the committee help in identifying quality measures for the program, and even program efficiencies or savings. When budget time comes and we have to look for some savings, we come to this committee for ideas and input.

One of the things the committee pushed us on was making more of the operations and program administration web based, and we had done that over time.

That involvement, trust and commitment generated strong support and cooperation between the Medicaid agency and the provider community. They've actually become a strong advocate of the program. The provider association has helped in terms of network development including finding dentists in some of the more difficult recruitment areas. When there is an urgent case in which a child needs a dentist in a hurry, there's cooperation between the dental benefits administrator and the VDA and others to find someone quickly. And similarly, if there's a dentist who's experiencing some difficulty or problems with the program, the provider association knows it can call the administrator or the agency for assistance in resolving the problem.

The end result is that the committee and its individual members are true champions that support and defend the program. I think one of the key reasons that the committee is still very much engaged is that they feel a sense of ownership in it. This is not just the state's Medicaid dental program, it's theirs as well. And they feel proud of what they've accomplished.

And speaking of accomplishments, if you could go on to the next slide, please.

The results of the program and the involvement of the different provider groups and advocates are pretty impressive. This slide shows pretty clearly how the provider community has responded to the program changes they helped to put in place. And since 2005, the network has increased from 620 to 721 providers. That's as of 2012. I know the network has continued to grow and provider satisfaction is very high as well.

Obviously the program is working for them, and as you'll see on the next slide, if we could have that please, it's working for us too. You can clearly see the substantial increases in the percentage of children receiving dental services. With this slide showing specifically increases for children ages zero to 20 who had received any dental service. And the last slide, if we could have that, showing similar increases for children ages three to 20.

So, in summation, I think the main message I'd like to leave with you today is that truly partnering with the provider community and advocacy groups and other stakeholders, and really listening to their concerns, involving them in the program design and operation when possible, and building a sense of ownership and trust and commitment can help you achieve great things. And I fully realize you can't just turn the keys to the car over to any provider group or any group. And there are times when there's going to be disagreement, and we experienced that as well. But, again, I think with strong partnerships and the right leadership and commitment to the ultimate goal of improving the oral health of Medicaid children, great things can happen.

I appreciate very much being on the webinar. I think we're going to maybe have one or two questions if anyone has those.

Yes, so thank you, Patrick, for your presentation, and we'll now take a couple of questions for you. The first question, were there any specific interventions undertaken to increase the participation of oral surgeons in Virginia Medicaid?

A couple. I mentioned the codes, the additional reimbursement. I mean, that was a big thing because when we looked at the dental codes and our rates for them, they were really out of line. I mean, far more so than the rest of them. So I think we showed a commitment to them by getting them an increase in the rates. But after we went through the process of developing the program and so forth, we actually went out

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to every local dental component in the state, and the head of the Virginia Dental Association, a representative from the Old Dominion Dental Society, went with us to every single local component and said, basically, we developed this program to respond to all of the things that you've mentioned, and we really need you to sign up for this program. And I think their involvement in the process of building it really paid dividends down the line.

Thank you. And just, I think one – we have time for one last question for you. Would you be able to provide a link to the quality measures that you established for your program?

Sure. I will get – I'm obviously the former Director of the agency, but I'm sure I can get with those folks and we can provide that information.

Okay, great. And then if you'll send that over to CMS, we'll make sure that everyone gets that information.

Be happy to do that.

Okay. So I know that you're pressed for time and we really appreciate you meeting with us today, and for everyone else who submitted questions, we'll make sure that they get to Patrick and send out his responses.

I'd be happy to do. Thank you for having me, and enjoy the rest of the seminar.

Okay, great. Thank you so much.

Thank you. Bye-bye.

Okay, so moving on, we're going to hold all of the questions for our next presenters until the end of the webinar. Actually, unfortunately our next presenter, Cordelia Clay, who is from Louisiana, is not able to be with us today because of inclement weather in the South, and she was going to be sharing Louisiana's activities and successes from Strategy One, improving state Medicaid performance through policy changes, but we'll still make her slides available when we post them on Medicaid.gov.

So we are going to shift to Strategy Two, where Dr. Kim Elliott is graciously filling in for Jakenna Lebsock on how Arizona works to maximize provider participation. And Dr. Elliott is the Administrator of the Clinical Quality Management Unit of the Arizona Healthcare Cost Containment System of the Arizona Medicaid and CHP agency. So welcome, Dr. Elliott, and please go ahead.

Great. I am very happy to happy to fill in Jakenna's big shoes. I hope I can give you as much information in as good a manner as Jakenna would.

Let's go to the next slide, please.

Arizona's delivery structure for Medicaid programs since the very beginning in 1982 is a managed care system. The only members that we serve in a fee-for-service environment through our fee-for-service program are the Native Americans, who have the option of selecting the managed care program or the fee for service program. And they can change every day if they choose to.

Currently our population is probably a little bit closer to the 1.4 million mark because of the expansion that happened in January, and we're expecting to grow between 300 and 400,000 members by the end of 2014. Currently we have approximately fifteen managed care organizations, which include those that serve our acute population, our long-term care population, and we have a carve out program for children's rehabilitative services which is children with chronic health conditions, and integrated behavioral healthcare programs.

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All of our requirements for our managed care organizations related to oral health or any other component of the delivery system are in the contracts with our managed care organizations, and those contracts are competitively bid at least every five years. We originally assign a two-year contract, and then every year we can authorize an extension up to that five year time period.

All of our managed care organizations are required to cover dental services and manage the utilization and related expectations around those service areas. It is also backed up, of course, by significant policy requirements that are incorporated as part of the contract expectations for our managed care organizations. And then our agency has an entire division dedicated to the management and oversight of our managed care organization, which has approximately 85 staff in it, and it monitors that all of the contractual requirements and policy requirements for NCOs are monitored and met.

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Some of the things that we have in our contracts and our policies as requirements related to oral healthcare is that our managed care organizations must have a dental director. Certainly we allow that to be a little bit more flexible. It could be part time or full time, and it does allow the health plans to use dental directors if they choose to put down the dental director from the dental network can also be considered for that key position. Going forward we expect to make quite a few changes in the dental requirements for that key position, so stay tuned for that.

We also require the MCOs to have an acceptable network of providers in every area that they serve, whether it's rural or urban. And they must meet a minimum performance standard for dental care measures, so it's the access and utilization of services.

We also require ongoing data analytics and quality improvement efforts from each of our MCOs, so we do require them to monitor appointment availability. And some of that is done through secret shoppers. Some of it's done through the state agency where we really audit, where we are the members calling for appointments based on the network that they've got published on their website.

We provide the opportunity for our dental providers to work with their managed care organizations that they're contracted with to report members that are not showing up for appointments, and it is an expectation that the managed care organizations follow up with those members to find out why they are missing their appointments and help get them reconnected to care.

We require member outreach, so reminder cards, of course, for when they are due for visits beginning at age one.

Utilization profiles and the utilization is provider utilization, or course. And what we look at are providers that have high utilization, low utilization, and the types of care and services that they are providing to see if there any trends that we would want to be concerned about such as doing every x-ray on every child at every appointment, or we have also identified things such as providers that have unusually high numbers of oral health visits during a time period, say a year, where they couldn't possibly have treated that many children. It appears that it's not always a fraudulent activity, but it sometimes is how they're billing, say they have ten other practitioners in their office and they bill under one. So we do a lot of monitoring of those sorts of things. And then referral for follow up, the community organization or school outreach program has identified a dental need in a child, we connect them to the EPSDT and oral health coordinators at our managed care organizations so that our health plan managed care contacts can do follow up with those families to get them connected to the referral care.

And then we do have a lot of stakeholder cooperation in our program, including with our dental association and the dental board. We have a dental director here at the state agency who helps keep us connected to those entities. We do involve some members in some of our activities to get their input and feedback, and we require our health plans to have member committees where they also provide input into the care and services being delivered including oral health. We include hygienists in our program as far

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as a stakeholder to get their feedback and input. And we extend out for oral health even into the Arizona Academy of Pediatrics because they, of course, are very interested in children's health overall.

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One of the things that we found really important in our MCO contracts was to not allow them to pay a capitated rate for oral health services, so we do require a fee-for-service payment structure with providers. Some of our health plans do contract with dental networks, and we do not require that they pay the dental network a fee-for-service payment, but the dental network, if they do receive a capitated payment, must pay fee-for-service for the services being delivered.

And we also require that there be no wrong door for dental care as long as it is with a network provider in the health plan. So if the oral health professional is a contracted provider for the MCO, whether the member is referred, self-referred, goes in because of identification at school that they need care, that claim will get paid.

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As far as contracting, any provider in the state of Arizona who meets minimum qualifications can register to be an active provider, but I want to make it real clear that we're not an any willing provider state, so even if they're registered as an active provider, they might not be able to see our members unless they are contracted with one of our managed care organizations, so that's an important thing to differentiate.

Our provider registration process as a state is an online process, and average turnaround time in provider registration right now is around 15 working days to bring them on as a registered provider. Once they are registered as an active provider, our managed care organization contractors can contract with those providers and use them for services.

The contractors have complete authority over their provider networks and can accept, terminate, or not accept providers as they deem appropriate for their network as long as they have adequate coverage in all of the areas that they are serving and they aren't experiencing any access to care issues. And we do require our health plans to submit annual reports to us on their network, and we look at that from a geographic perspective and population perspective to make sure that they have enough providers in their network to serve the population that they have.

We also monitor quality of care complaints for oral health, just like any physical health complaint that we receive, and we require our health plans to do that as well. So we intervene if necessary in access to care or any other quality of care issue that we identify for a member.

Access can also term providers for quality of care concerns, so if we identify a quality of care concern, we can refer to our Office of Inspector General and term those providers.

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One of the things that we have done to really make things better for our providers is work with a Prudential alliance and all of our managed care organizations are required to contract with this credentialing alliance which is in essence, a credential verification organization, a CVL. And that allows all providers to submit their required documentation to contract with our managed care organizations once, and then all of our health plans have access to that information.

And we also monitor credentialing timeframes. They are tracked separately for dental providers and physical health because we want to make sure that they have expedited processes, which we call a provisional credentialing process, which requires them to bring those providers on within 14 days if they meet certain minimum requirements. And that is monitored on a quarterly basis for delivery from health plans.

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We've really eased our prior authorization requirements. There's very little that requires prior authorization for oral healthcare services. And we also help plans to review annually all of their prior authorization requirements, and if they're not saying no or requiring other things for the authorization of the services, we ask them not to require authorization.

Some of our health plans do contract with dental networks, and that's primarily for their claims system, payment abilities, and their prior authorization expertise.

And then we always monitor the access to care, whether they use a dental network or whether they contract directly with our oral health practitioners. And we focus quality improvement efforts based on those results. But monitoring and oversight really is the key.

Next slide.

This shows you a little bit of the progress that we have made. In 2007, you'll see that our rates were around 40.5% in our Medicaid program and Kid's Care was a little bit lower at 32%. Now you'll see we had a little bit of a dip between 2011 and 2012, and we think that probably had to do with some of the rate cuts we had to take between 2010 and 2012 due to the economic downturn in our program. But overall, the things that we're doing we think have been pretty successful, and we've got quite a few new things planned for this coming year that we're hopeful drive that rate even higher.

Next speaker?

So thank you, Dr. Elliott, for sharing Arizona's efforts. It was very helpful information and definitely generated some questions for us to take at the end.

So moving on to our next speaker, finally, Sarah Borgida, who is the Program Manager for the Washington Dental Service Foundation, will feature Washington's work under Strategy Three directly addressing children and families. Sarah manages the Washington Dental Services Foundation's Pre-Natal, Children's, Latino, and Tribal initiatives, and develops innovative strategies for improving the oral health of children in Washington State and beyond. She has experience in strategic and program development in a variety of sectors, including health, early childhood, K through 12 education, and social services. So welcome, Sarah, and please go ahead with your presentation.

Thank you so much, and good morning everyone. I am really excited to be presenting today and talking about how we in Washington are partnering with some non-dental partners to increase access for young children and improve their oral health. Go ahead and advance the slide, please.

So just a little background about who we are as a foundation. The Washington Dental Service Foundation is a corporate foundation, so we are funded by the insurance agency, Delta Dental of Washington. Our mission is to prevent oral disease and improve overall health, and we do this through innovative programs and policies that produce permanent changes in the health environment so that over the long term oral disease is prevented.

And kind of what that looks like in real life is that we are actually a hybrid foundation. So for those of you who are familiar with philanthropy, we don't look like your traditional foundation. You know, a lot of foundations make investments, give grants to programs and projects, kind of sit back, watch how their investments grow, and then come back, do an evaluation and decide if they want to make further investment. We actually don't operate that way. We actually do a lot of partnering with agencies, organizations. We partner with tribes and community groups. We design innovative initiatives, and then we actually partner with these organizations to deliver the initiatives, evaluate them, and do a lot of improvement. So we are really at the forefront of service delivery with our partners.

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Go ahead and advance the slide, please.

So one of the programs that we developed back in 2001, and we are still working with partners in Washington and nationally to implement, is our Cavity Free Kids program. And the Cavity Free Kids program is aligned with most of the work we do as a foundation. The goal is to improve oral health of children zero to five. And we take the approach of addressing oral health in places where children spend their time, so in Head Start, Child Care, Home Visiting, WIC programs, and other. This is really a strategy where we know kids are spending a lot of time in early learning environments, and we want them to get the education that they need and are referred to care. And so what we've done is engaged the early learning providers and trained them to help children and families avoid dental decay, understand the value of good oral health, and then connect them with dental care.

And as I said, we launched this program in 2001, and it was actually at the request of one of our partners, so there was a large Head Start program in central Washington that was really getting frustrated about their inability to prevent the decay of the children in their care, and they came to us and said, what can you do to help us to improve those decay rates? And so Cavity Free Kids was born.

Please advance the slide.

So what is Cavity Free Kids and what does this program look like? It's a package of services and resources, and really it involves training curricula, resources for families, and a website that we are currently enhancing right now.

So the first thing is a training. And what we've done with the training is develop trainings that align with Head Start providers, professional development requirements, and then child care providers' continuing education requirements. And so we deliver it either in person, a train-the-trainer model, or we also are developing right now an online module where child care providers can go online, take our course, take a test, and then receive continuing education credit.

So we also have a curriculum that can be used in Head Start settings, in child care settings, that really is flexible. It's adaptable. It includes lessons and activities that really align with the way that Head Start and early childhood teachers deliver instruction in their classrooms.

It's also aligned with the Head Start learning domain and Washington's early learning guidelines. And those are guidelines that are being developed as part of Washington's early learning system. So this curriculum is really designed to complement all of the work that providers are doing in their classroom and meet the requirements that they are asked to meet by the governing body, whether that be Head Start or Washington state's professional development early childhood system.

We also are now developing home visiting modules, so what we've heard over the last ten-plus years is that as the early learning system has expanded, and then services have expanded to families, like Home Visiting, we have the ability to address oral health in these new environments. So we developed Home Visiting modules that are much more portable, much more flexible, and much more parent-child focused. They're organized by age, by theme, and they are structured in support of the way that home visits are delivered.

We've also been asked many times to develop more resources to share with parents because we know that what we do in a classroom is really, really important, but it's also really, really important to share messages with families so that behavior change can be translated into the home environment. And so what we've developed are a lot of resources that providers can use to start conversations with families and that families can actually use in the home to increase things like tooth brushing, eating healthy, drinking water, things like that.

And then we're enhancing our website right now because what we've heard is that, increasingly, providers and families are going online for resources, and we want to make sure that our resources are

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available. They can be updated regularly and then deployed to community members and providers as needed.

In terms of the annual budget and how much we spend in Cavity Free Kids, we've made a significant investment in the development of the program, so probably well over \$200,000.00 engaging dental science experts, early childhood experts, Head Start experts to develop the curriculum and the website. And then annually we invest money in training and dissemination of resources. Just to give you an example of what a training might cost a state, so we do this nationally as well as in Washington. Trainings cost between \$7,000.00 and \$8,000.00, if we were going out and training leaders in the state, and then those trainings can be used to disseminate Cavity Free Kids to providers across the state.

Next slide, please.

So the key message is that we deliver to children and families are that baby teeth are important. We send a message that children should be getting regular dental checkups from a dental or physician. Messages about brushing, flossing, pushing and swallowing. And then drinking water and eating tooth-healthy foods. And then not grazing, so not spending time snacking and eating all day because that does have a negative effect on oral health.

Next slide, please.

So the way that we've deployed the program in Washington and nationally is that we really leverage partnerships to maximize the reach of the program and to make sure that the most providers have the resources and that they are able to deliver them to children and families. So rather than go site-by-site and center-by-center, we're able to really capitalize on Washington State's increased systemization of Washington state's early learning system. And also national programs like Head Start.

So what we look to our partners like Head Start grantees and, actually, Washington State's Head Start Collaboration Office. We also look at state and regional child care organizations like Child Care Aware. For example, those are the resource and referral networks that are organized statewide and regionally in Washington State and they deliver trainings and resources to child care providers in those regions.

We also work with Washington's Department of Early Learning, and we've worked with other states' early learning divisions to make sure that Cavity Free Kids is developed and disseminated through those systems. And then, also, through some of the home visiting programs that are now be systematized in our state, so parents and teachers in our family partnership and others. And the way that we've developed these partnerships is a couple of different ways. So, first of all, if you listened to my bio, you heard that I have a background in Early Childhood Education, so kind of leveraging some folks, and hiring some folks on our team who have background in addition to oral health and health, who really have connections with state agencies and state leaders in early childhood. And going to having us go to those agencies and to make the case. And the way that we've made the case is to kind of figure out what's in it for these programs and align our services and offerings to meet their requirements. So, for example, Head Start. Addressing oral health is a requirement of Head Start, and so when we developed the program and as we refine it we figure out ways that we can provide tools to help them meet their requirements that they're already required to meet.

In child care, we are kind of doing the same thing. Washington State was lucky enough to receive an early learning challenge grant from the federal government where we are kind of systematizing our professional development and quality improvement in early learning, and so we've been able to talk with state agencies and say, hey, as you do these things, please health and please include oral health as measures of quality and also as requirements for what providers who are participating in these programs need to learn about. And so we have been able to include Cavity Free Kids in those systems.

The same is true of Home Visiting, so we have received federal funding to disseminate mixed (inaudible) or home visiting programs, so we've gone to them kind of as they've received that funding and said, what

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types of resources would you need and how can we provide them as you develop these systems and then send out resources and funding across the state? So we've done a really great job, and we've actually just been able to capitalize on all the good work that's been happening in terms of building an early learning system in Washington State.

Next slide, please.

So in terms of where we've worked with Cavity Free Kids in Washington and nationally, we, as I said, launched it in 2001, and since that time we have trained and disseminated resources in 20 states and in American Samoa. And so we've had requests from other state agencies, Department of Early Learning, state Head Start agencies, and actually a foundation and other health organizations to deliver the training and their resources, and we've done that.

And what we've done in terms of those relationships is we've developed MOUs where we will ask the agencies to cover our costs so we are not charging anything in excess of what it would cost to deliver the training, but we are going to states and doing that work there.

Please advance the slide.

And so what the impact of Cavity Free Kids is, we found that it has made an impact. So one of the partners that we've worked with to deliver Cavity Free Kids commissioned a study, that was the Health Foundation of Western and Central New York, they did an evaluation of Cavity Free Kids in 2012 and they found oral health knowledge and practices have increased. So parents were impacted. They learned that snacking throughout the day can increase the chance of cavities and that children should visit the dentist by the first tooth or first birthday.

Children's knowledge and behavior changed positively because of Cavity Free Kids. Children were more likely to be eating fruits and vegetables, using fluoride toothpaste, and drinking fluoridated water.

Go ahead and advance the slide.

And in terms of if you look at what's happened in the state in terms of dental Medicaid utilization, so this is for zero to five-year-olds. If you look beginning in 2003, utilization has increased. So we started at 30.4% percent, and now over 50% of Washington zero to five-year-olds are accessing services. So we're at 51.1% at this time.

So in terms of my closing, I would just say that, you know, all of these programs and services work, and, indeed, if I can use the term "it takes a village," it has really, really helped to get both traditional partners talking about access. And of course those who are able to actually increase access do so, and we've done a lot of that work in Washington State. But additionally, if we have been able to look at non-dental, non-traditional partners, and especially those who spend a great deal of time with the children that we're trying to reach and connect with care, it can have a really positive impact and get more kids in and get more kids' oral health improved.

So, glad to be with you today and would love to answer any questions that you have.

Great. Well, thank you, Sarah, for sharing Washington State's oral health education program. And I just wanted to thank all of our guest faculty for their time and for sharing how their states have made an impact on improving oral health for children and adolescents by implementing an actionable strategy. And we know that the information that you've shared is just an overview of the work and dedication that it took to move the needle forward.

And I think before we take questions for the rest of our presenters, Laurie wanted to say a few words.

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Thank you, Elizabeth. I wanted to add my thanks to Elizabeth, to all of our presenters, and Jessica pointed out that this incredibly – this has been incredibly rich material. I know there's been a lot to listen to today. You can multiply by seven or eight what you heard today in terms of what's in the strategy guide - what's in Keep Kids Smiling. So we really encourage you to take a look at that document and really dig deep and see what it has to offer you.

The online version of the guide does have live links in it that will take you to web-based resources for each of the programs and projects that are featured in the guide. So, for example, Cavity Free Kids, there's a link in the guide to take you to the Cavity Free Kids website, and you can get access to the various materials that they have posted for the public there. So please use this resource.

And, again, thanks so much to our presenters for their wonderful sharing. And back to Elizabeth now to go to the Office Hour Q&A.

Yes. Thanks, Laurie. So our first question is for Dr. Elliott in Arizona. And can you tell us what Arizona's minimum performance standards for the dental care measures are?

That's a very good question. It's 57%, I believe, that we've established for both Medicaid and the Kids Care line of business, so what we do when we're establishing that is we look at what the Medicaid national rates are, and we set minimally at the Medicaid mean. And if our health plans are performing at a higher rate than the Medicaid mean nationally, we raise our rates, our minimum performance standard, higher as they continue to improve.

Kim, could I ask a follow up to that? You said its 57%. It's 57% - do you use the 416 measure or the HEDIS annual dental visit measure, or what is it 57% of what?

It's the annual visit measure in HEDIS.

Thank you.

Okay, Dr. Elliott, another question for you. Were you able to get general dentists to see more young children under the age of three? And if so, do you have some strategies to recommend that helped you accomplish this?

Well, one of the things that we do is work very closely with more health plans in identifying dental practitioners that are interested and willing to serve that population age group. And some of our health plans have made huge efforts to contract with the pediatric dentists. And one of our health plans actually requires that all children be seen by a pediatric dentist rather than a general dentist. So I think some of those things have really steered them to providers that are anxious or willing to treat children in that zero to three age population.

One other thing I should mention about the performance measures, we also in our contracts have applied some pretty heavy sanctions ability so if our contractors are not meeting minimum performance standards that we've established, or if we see declines in any of the rates, even if they've met the minimum performance standards, we have the ability at the state level to sanction each of our health plans up to \$100,000.00 per measure for the rates that are not where we would like them to be.

Great. Thank you. Our next question is for Sarah. Do you have enough dental providers that are willing to take the referrals that are generated from your programs, and how is the access to care situation?

So that's a great question. You know, I say enough. Yes, we have almost enough. Of course it depends on the area of the state. But because of the access to the baby and child dentistry program, that the Washington Dental Service Foundation and some of our public partners at the University of Washington administer, we are really focused on the access to care, so we make sure that in each county we work to engage providers, we have enhanced reimbursement, we provide case management and coordination,

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so that there are enough providers willing to see children. And actually we connect our ABCD program in each county with the Cavity Free Kids work that we do. So every time we introduce Cavity Free Kids to a new set of early learning providers, we connect them with our ABCD program so that when providers are talking with children and families about accessing dental care, they have ready resources so that the providers can refer them to dentists who will see them.

Thank you. Back to Dr. Elliott. Did any of you have difficulties getting contractors to complete their delivery roles, and if so, how did you overcome those barriers?

Well, we have a lot of deliverables in our contract. I think that's one of the biggest complaints that we get from our managed care organization, just in the quality area, which includes oral health and EPSDT programs, there probably are over 40 or 50 deliverables that if you – some are quarterly, some monthly, some annually. And no, we really don't get any issues with getting our health plan to comply with sending us the reports that we required, and we have language in our contract that allows us to automatically sanction our health plans if they don't submit a deliverable on time, which means the close of business of the day it's due. Or if what they send us is not complete or accurate, we can auto-sanction them. I believe that rate is about \$5,000.00 per deliverable. And I have never had to apply that sanction to any of our managed care organizations. They have come in on time or they've requested an extension in advance if they were having difficulty getting or collecting the information.

Okay, thank you. Sarah, how is Cavity Free Kids funded?

So it's funded through us, the Washington Dental Service Foundation, and we pay for training time, our website, although we are working with, for example, Washington's Department of Early Learning to host an abbreviated version of our Cavity Free Kids training, so sometimes our partners will pick up some of the costs associated with hosting online trainings or things like that, or imbed them into their system. But we really fund the majority of it. And as I mentioned in my presentation, if we are working with another state, so an organization outside of Washington, that delivers Cavity Free Kids, we ask the organization to pick up the cost of training and materials, and then we will provide ongoing technical support and, again, connect into our web resources.

Thank you. And another question for you. How you validated that the developed resources demonstrate quantitative increases in increased knowledge, attitudes, practice, and most importantly, health?

So, yes. The Health Foundation of Western and Central New York did do that with the exception of the most important one, which is Health. And so we are going to be working on an outcome evaluation with the same organization that the Health Foundation of Western and Central New York contracted last year to develop an outcome evaluation that we are going to look at oral health status, and that will be conducted in 2015. So that's something that we are going to be doing.

Thank you. Laurie, is that evaluation posted on your website?

It is not, and I can find out about sharing, maybe, with you all, at least the executive summary if not the full evaluation. I probably have to talk with the Health Foundation of Western and Central New York, but we have shared it before, so I think we can do that.

Thank you. And back to Dr. Elliott, what do you think were the most effective factors in Arizona Medicaid?

In relation to improving rates?

Yes.

We were talking about that, and I think there were several things that were really important or really were relevant in improving rates. I think the first thing was moving from a capitated environment for our dental providers and requiring our health plans to pay fee-for-service. I think that that had a huge impact and

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really started to drive our rates up. I think some of the ease we did in both the registration process for oral health practitioners to get more of them into our program helped quite a bit. And I think the payment methodologies regarding the fee increases also helped encourage more dentists to provide care and services to our members, so I think there were a lot more dentists out there reaching out to members as much as they could to get them into care and services. And I think also following up on the no shows had some impact, but not as we had hoped it would. What it did was it created a lot more satisfaction with the providers.

Thank you. Another question for you. Has Arizona faced any challenges in recruiting and retaining oral surgeons?

We have not. The oral surgeons are actually under the physical health side of our program, and they're treated like any other type of surgeon from a rate perspective and from a profit perspective. So, no, we have not seen any issues in any of our health plan networks with oral surgeons.

Great. Thank you. Our next question, back to Sarah. Did you encounter any barriers working with Head Start programs in terms of them willing to share specific information for kids in their program who need dental services?

Can you say that one more time? Barriers to –

Working with Head Start programs in terms of them willing to share specific information for kids in their program who need dental services?

Oh, you mean sharing with us?

Yes.

No. And, in fact, we work with them and really let them keep – I mean, they share their program-level data with us, but in terms of child-by-child data, we don't ask them to share that data. We train them to provide resources to all families and really don't need that from our perspective. We just teach them how to address oral health and then figure out how to connect everyone with care. But certainly kind of triage those that need the care the most. Did that answer the question?

I think so.

Okay.

And another question for you. Could you explain a bit more about Home Visiting aspect? At what point and how often were visits done and were referrals a part of that as well?

So, the way that we have the Home Visiting module structured is that they can be used either proactively or reactively. And I should say that these are in the pilot phase right now, so we had some more informal resources that Early Head Start programs were using, and other parents and teachers, the nurse-family partnership and other home visiting models we're using, but we're actually piloting formal use of resources right now. And those resources are designed to be used in two ways. So they can be used to address emergent need, so if a family of a Home Visitor realizes that a family has an emergency, they can search by topic. So, example, you know, finding dental care, or home care, or eating or drinking water, and they can use them that way. Or they can be used proactively, so addressing by age, an oral health topic at each age and stage of a child's development, or a series of topics. And they can be usually flexible so you don't have to use a resource at a certain time. It can just be used within the age range, and then they include activities that promote child development and address the issue.

Great. Thank you. And switching back to Dr. Elliott. Do dental providers have to get a Medicaid number prior to becoming credentialed with your MCOs?

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Yes. Any provider that serves Medicaid members has to be registered with the state before they can contract with a managed care organization. We do most of the background checks on those providers to ensure that they are able to be contracted with and receive funding through Medicaid or Medicare, so we do all of that before we register them. Once they're registered, the NCOs can contract with them.

So Dr. Elliott, this is Laurie. I have a follow up to that. Does that process of getting a provider a Medicaid number add time to the 15 or 30-day credentialing turnaround that you showed on your slide?

Yes, it certainly would. Our health plans can't even begin the credentialing process when they contract with a provider until a provider is registered with the state. So the timelines that we measure are the timelines when a managed care organization receives a complete application from the dental provider to when they actually are able to start paying that provider for services.

And do you have a sense of how long it takes your Medicaid agency to provide a Medicaid number to a provider?

Yes. Currently we're running about 15 days with some exceptions for long-term care type providers that oral health is taking about 15 days.

Thank you.

Um hmm.

And also, again, Dr. Elliott. Do you offer increased fees if an area of the state is lacking enough dental providers?

The rates are established by the managed care organizations. Access has a fee-for-service rate for what we would pay for our American Indian population on the fee-for-service side. Most of our health plans base their fee schedules off of the fee-for-service rates, so percentage of or percentage on top of. So, yes, they have the flexibility in harder-to-serve areas where there may be a limited supply of providers to pay them an enhanced rate. Or if they are not able to negotiate an acceptable rate to those providers, they may choose to transport those to a nearby community for services where they can negotiate a rate with those oral health providers.

So thank you. If anyone has any additional questions, feel free to submit them in the Q&A box.

Okay, well I just want to thank everyone again for participating, and thanks again to our guest faculty.

Oh, actually we just had one last question come in. So this is for Sarah.

Okay.

Does the oral health education for parents during the first dental exam given by the provider include the billing code?

Say that again?

Does the oral health education for parents during the first dental exam that's given by the provider, what's included in that billing code? What services are included in that billing code?

I'm wondering – is this maybe a question for somebody else?

Well, actually, why don't we – we'll reach out to the person who submitted the question and we can get back to them with that information.

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Because I'm thinking it may be – that it sounds like something delivered in a dental office?

Okay.

And, again, I just want to remind – we've had several questions asking about the materials for the oral health education program. And all of that information is available on the Cavity Free website, and that link can be found in the strategy guide.

And can I add one thing to that? So we are actually doing right now a web, so we are uploading a lot of new resources onto that website right now that we are just developing. And we're translating a lot of our curriculum that was available in hard copy onto the website. So in the next few weeks and months, there are going to be a lot more resources that will be available. We don't have an Under Construction sign on our website at this point, but you will be seeing a lot more. And we should probably put a little bit of (inaudible), so check back often because more and more will be available.

Okay. And, again, so website for Cavity Free Kids can be found in the strategy guide. So we encourage everyone to check out our strategy guide for more information.

So we hope that everyone found this webinar helpful and that it has sparked thoughts about what your state can do to improve oral health. The webinar will be archived on Medicaid.gov. And just, again, the information presented today is just a snapshot of what is in the strategy guide. The strategy guide is also available on, in addition to Medicaid.gov, it is also on the Insure Kids Now dental health professionals' web page, which, as a reminder, we have additional information posted on how to access our free oral health education materials which includes the tear pads, flyers and posters, and will also be where you can find the new tear pads that Laurie mentioned in her earlier presentation.

And also, you know, feel free to reach out to CMS if we can be of any assistance.

And finally, when you exit the webinar, we hope that you will fill out the evaluation so we can continue to make these Learning Labs useful. And we look forward to seeing you in the next few months for our next Learning Lab. So thanks again to everyone. We really appreciated it.