Open Wide: State Innovations in Oral Health Policy

8:00 am- 4:00pm
Monday October 17, 2016

Wyndham Grand Pittsburgh
King’s Garden 1 & 2
600 Commonwealth Place
Pittsburgh, PA

Being Held in Conjunction with NASHP’s 29th Annual State Health Policy Conference

Supported by the DentaQuest Foundation
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Promoting Access to Oral Health through Benefit and Care Delivery Design
  • Presentation from Kneka Smith
  • Presentation from Ann Lopes

Creating Accountability for Oral Health
  • Presentation from Dr. Bruce Austin
  • Presentation from Karen Davis

Identifying What’s Next: A Roundtable Discussion
  • A Discussion with Senator Judy Lee, Cheryl Roberts, and Victoria Veltri, moderated by Patrick Finnerty
  • Background Materials from Senator Judy Lee
  • Minnesota Department of Health Handout on Dental Therapy
With tremendous changes in health care coverage, payment and delivery underway, states have new opportunities to tackle costly, preventable oral health and dental care needs. This preconference focuses on trends and emerging issues in oral health policy. Sessions will highlight strategies for promoting oral health through benefit design and creating accountability for oral health to achieve better outcomes and lower costs. The preconference will close with a discussion of implications and next steps for policymakers to support continued innovation and improvement.

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00am</td>
<td>Breakfast and Registration</td>
</tr>
<tr>
<td>8:30am</td>
<td><strong>Welcome: The Opportunity for Innovation</strong></td>
</tr>
<tr>
<td></td>
<td>Our opening session will provide an overview of emerging trends in oral health and dental care to set the stage for the day's discussion about new opportunities in oral health policy.</td>
</tr>
<tr>
<td></td>
<td><strong>Moderator:</strong> Carrie Hanlon, Project Director, National Academy for State Health Policy</td>
</tr>
</tbody>
</table>
|        | **Speakers:** Trish Riley, Executive Director, National Academy for State Health Policy  
|        | Dr. Marko Vujicic, Chief Economist and Vice President, Health Policy Institute, American Dental Association |
| 9:30am | **Driving Innovation with New Science and Tools**                  |
|        | This panel session will dive into the frontier of oral health science and Medicaid opportunities that open the door for different models of care that encourage preventive care and healthy behaviors. Speakers will address one state’s new Medicaid waiver and another state’s plans for Medicaid reimbursement for silver diamine fluoride. |
|        | **Morning Moderator:** Cheryl Roberts, Deputy Director of Programs, Virginia Department of Medical Assistance Services |
|        | **Speakers:** Alani Jackson, Chief, Medi-Cal Dental Services Division, California Department of Health Care Services  
<p>|        | Dr. Leon Bragg, Chief Dental Officer, Oklahoma Health Care Authority |
| 10:45am| Break                                                               |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00am</td>
<td>Promoting Access to Oral Health through Benefit and Care Delivery Design</td>
</tr>
<tr>
<td></td>
<td>This session will explore additional strategies to increase access to oral health. Speakers will discuss integration of oral health into pediatric primary care and inclusion of pediatric dental benefits in an insurance exchange.</td>
</tr>
</tbody>
</table>
|             | *Speakers:* Kneka Smith, Associate Dean for Education and Assessment, A.T. Still University's Missouri School of Dentistry and Oral Health  
Ann Lopes, Carrier Product Manager, Access Health Connecticut |
| 12:15pm     | Networking Lunch                                                                            |
| 1:15pm      | Creating Accountability for Oral Health                                                     |
|             | This session will highlight early efforts to incorporate oral health into payment and delivery system reforms to achieve better outcomes and lower costs. Speakers will describe progress and lessons from local and statewide accountable care initiatives and emergency room diversion efforts. |
|             | *Moderator:* Dr. David Kelley, Chief Medical Officer, Office of Medical Assistance Programs, Pennsylvania Department of Human Services |
|             | *Speakers:* Dr. Bruce Austin, Statewide Dental Director, Oregon Health Authority  
Karen Davis, Dental Emergencies Needing Treatment (DENT) Network Manager, Better Health Together |
| 2:30pm      | Break                                                                                       |
| 2:45pm      | Identifying What’s Next: A Roundtable Discussion                                            |
|             | Our closing panel of state policymakers will reflect on the ideas presented today in the context of questions such as: How can state policymakers use today's information to continue promoting oral health? What are next steps? What information do state officials need from the research and professional communities to take those steps? |
|             | *Moderator:* Patrick Finnerty, Senior Advisor, DentaQuest                                   |
|             | *Panelists:* Judy Lee, Senator, North Dakota Legislature  
Cheryl Roberts, Deputy Director of Programs, Virginia Department of Medical Assistance Services  
Victoria Veltri, Chief Health Policy Advisor, Office of the Lieutenant Governor, State of Connecticut |
| 3:45-4:00pm | Wrap-up and Thank You                                                                       |
Dr. Bruce Austin
Statewide Dental Director
Oregon Health Authority

Dr. Bruce Austin is a lifelong Oregonian, graduating from Oregon Health Sciences University School of Dentistry in 1985. After four years as an Army dentist, he treated patients for Permanente Dental Associates in Salem and Portland for twenty years, and was then in other groups, including a clinic in a Boys and Girls Club. Bruce has taught at the dental school and in other assisting and hygiene programs, and still teaches one half day/week in an EPDH hygiene program. After doing part-time dentistry and part-time massage for five years, he was hired as Oregon’s Statewide Dental Director in 2015.

Dr. Leon Bragg
Chief Dental Officer
Oklahoma Health Care Authority

Dr. Bragg has private practice expertise of over 24 years and currently has an active Oklahoma Dental License. He served as Assistant Professor in Departments of Operative Dentistry and Dental Materials as a full time faculty member at the University of Oklahoma College of Dentistry for five years. He was Assistant Dean for Clinic prior to joining the Oklahoma Health Care Authority and is currently Chief Dental Officer. Dr. Bragg has received numerous awards and recently received the Governor’s Commendation for Service to Oklahoma. He has the following credentials: 1970 Bachelor of Science, Langston University; 1977 Doctor of Dental Surgery, University of Oklahoma College of Dentistry; 1990 certified as a Geriatric Oral Health Consultant at the University of Missouri School of Dentistry and in 2001 received the Master of Education degree from University of Central Oklahoma.

Karen Davis
Better Health Together
DENT Network Manager

Karen Davis, a Spokane native, joined the team of Better Health Together in April 2014. Karen currently serves her community as the Dental Emergencies Needing Treatment (DENT) Program Network Manager. Ms. Davis has extensive healthcare experience, with specific experience in oral health and non-profit organizations. Karen advanced her education and career at Eastern Washington University (EWU) where she holds a BA in Health Services Administration. Ms. Davis began her career in the non-profit sector at the Spokane Regional Health District in the Oral Health Program, supporting the ABCD and ABCD“E” Programs. During this time, Karen co-wrote a March of Dimes grant project, Treatment, Education and Resources for Mothers (T.E.R.M. Project), for 500 First Steps pregnant women and their families to prevent pre-term

**Patrick Finnerty**  
Senior Advisor  
DentaQuest

Patrick Finnerty is a Senior Advisor for DentaQuest and assists the enterprise in achieving its mission of improving the oral health of all. Prior to his association with DentaQuest, Patrick worked for the Commonwealth of Virginia for 32 years, including eight years as Virginia’s Medicaid Director. Improving access to oral health services was a hallmark of Patrick’s tenure as Medicaid Director. His prior work within Virginia government included serving as the Executive Director of a legislative health policy commission within the Virginia General Assembly. Patrick serves on several non-profit boards that promote access to care for uninsured and low-income persons, including the Virginia Oral Health Coalition. He currently is the President of the Virginia Dental Association Foundation Board of Directors. He volunteers at Mission of Mercy (MOM) Projects which provide free dental care to those in underserved areas of Virginia. Patrick earned both a Bachelor of Science Degree in Psychology and a Master of Public Administration Degree from Virginia Commonwealth University.

**Alani Jackson**  
Chief of Medi-Cal Dental Services Division  
California Department of Health Care Services

Alani Jackson is the Chief of the Medi-Cal Dental Services Division within the Department of Health Care Services (DHCS). She has full management responsibility for administering the Medi-Cal Dental Services Program (Denti-Cal and Dental Managed Care), which provides dental services to nearly 14 million Medi-Cal beneficiaries. Prior to joining DHCS, Ms. Jackson had over eight years of administrative and managerial experience with the California Department of Corrections and Rehabilitation, California Correctional Health Care Services. She has extensive experience and knowledge working in health care policy planning, development, and implementation, as well as interacting with high-level executives amongst various state departments. She has over 10-years of experience serving Californians as a public servant and additional years of experience working in the legislature and children’s advocacy. Ms. Jackson has a Master’s in Public Administration from the University of Southern California, and two Bachelor’s in Community and Regional Development and Political Science from the University of California, Davis.

**Dr. David Kelley**  
Chief Medical Officer  
Office of Medical Assistance Programs  
Pennsylvania Department of Human Services

Dr. David Kelley is the Chief Medical Officer for the Pennsylvania Department of Human Service’s Office of Medical Assistance Programs. He oversees the clinical and quality aspects of the Medical Assistance Programs that provide health benefits to over 2.6 million recipients. The
Office includes oversight of eight managed care organizations and the Access fee-for-service program. In the past ten years the Office has participated in a multi-payer medical home collaborative, initiated four pay for performance programs, developed a multi-state application for the Medicaid electronic health record incentive program, established nonpayment policies for readmissions and preventable serious adverse events in hospitals, developed telemedicine payment policies, implemented a pharmacy preferred drug management program, and expanded the HealthChoices mandatory physical health managed care program statewide.

**Senator Judy Lee**
Senator
North Dakota Legislature

Senator Judy Lee from West Fargo, ND was first elected to the North Dakota Senate in 1994. She has been a member of the Human Services Committee since then and has served as chair since 2001. She also has been a member of the Political Subdivisions and Government and Veterans Affairs Committees. Senator Lee was elected President Pro Tempore of the Senate in 2007. She is a graduate of the University of North Dakota with a bachelor’s degree in medical technology. Senator Lee was in the real estate business for 34 years and has been involved in many community activities. She and her late husband Duane have 2 grown children and 3 grandchildren.

**Ann Lopes**
Carrier Product Manager
Access Health CT

Ms. Ann Lopes joined the Plan Management Team of the Connecticut Health Insurance Exchange in November, 2012, where she contributed to the successful implementation of the state’s marketplace with initial enrollment surpassing expected goals. While a Product Manager at Aetna, she gained expertise in government health insurance programs through the launch of the Medicare Part D program. Additionally, Ms. Lopes has over 15 years of health insurance plan experience in financial underwriting. A Connecticut native, she was awarded a bachelor’s degree in Administrative Science from Central Connecticut State University.

**Trish Riley**
Executive Director
National Academy for State Health Policy

Trish Riley is Executive Director of the National Academy for State Health Policy and president of its corporate Board. She helped build NASHP as CEO from 1988-2003. Previously she was a Senior Fellow at the Muskie School of Public Service, University of Southern Maine and a Lecturer in State Health Policy at George Washington University. From 2003-2011 she served as Director of Governor Baldacci’s Office of Health Policy and Finance, leading the effort to develop a comprehensive, coordinated health system in Maine including access to affordable health insurance. She was the principal architect of Dirigo Health Reform and served as the state’s liaison to the federal government and Congress, particularly during deliberations around
Ms. Riley has also held appointive positions under five Maine governors – directing the aging office, Medicaid and state health agencies, and health planning and licensing programs. Ms. Riley has published and presented widely about state health reform. She serves as a member of the Kaiser Commission on Medicaid and the Uninsured, the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Academy for Social Insurance and the Board of Directors of Maine’s Co-Op insurance plan. She was a member of the Institute of Medicine’s Subcommittee on Creating an External Environment for Quality. She also previously served as a member of the Board of Directors of the National Committee on Quality Assurance. Riley holds a B.S. & M.S. from the University of Maine.

Cheryl Roberts
Deputy Director of Programs
Virginia Department of Medical Assistance Services

Cheryl J. Roberts is Deputy Director of Programs for the Department of Medical Assistance Services in the Commonwealth of Virginia which provides Medicaid and SCHIP services for over 1,000,000 clients in the Commonwealth expending $9 billion a year. In her current position, she is responsible for the program development and executive oversight of the Medicaid managed care delivery system which covers 700,000 members, dental and pharmacy services, quality management, and program integrity operations for the agency. Previous responsibilities included oversight of service and provider operations, long term care services and behavioral health. Prior to working with the Department, Ms. Roberts served as the Chief Operations Officer of a Virginia based Medicaid health plan and was the Assistant Vice President of Operations for a large health insurance company in New York City. Ms. Roberts received her Juris Doctorate from Rutgers’s State University of New Jersey Law School. She serves as an executive committee vice chair for NASHP and also works on various national health care projects, collaborative and committees.

Kneka Smith
Associate Dean for Academic Affairs
A.T. Still University’s Missouri School of Dentistry & Oral Health

Kneka P. Smith, is the Associate Dean for Academic Affairs at A.T. Still University’s Missouri School of Dentistry & Oral Health. Prior to joining ATSU-MOSDOH, she served as director for From the First Tooth. Administered through MaineHealth in Portland, Maine, From the First Tooth is an oral health initiative promoting the health of infants, toddlers, preschool children and pregnant and postnatal women. She has also served as associate dean in two other dental schools (Maine and Arizona) and the dental director for the state of Maine. She received her master’s in public health from the University of North Carolina-Chapel Hill. She is a member of the American Dental Education Association, American Public Health Association, American Academy of Pediatrics, and Association of State and Territorial Dental Directors.
Victoria Veltri
Chief Health Policy Advisor
Office of the Lieutenant Governor of the State of Connecticut

Victoria Veltri, JD, LLM, is the Chief Health Policy Advisor in the Office of Lt. Governor Nancy Wyman, coordinating the state’s health reform initiatives, including the State Innovation Model Initiative, the Healthcare Cabinet and other initiatives. She acts as the Lt. Governor’s liaison on healthcare issues with state agencies, community organizations and the private sector. She currently serves as a member of the Board of Directors on the Connecticut Health Insurance Exchange (d/b/a Access Health CT) and the All Payer Claims Database Advisory Council.

Prior to joining Lt. Governor Wyman’s staff in June 2016, Ms. Veltri was the state's Healthcare Advocate, overseeing OHA in: assisting health insurance consumers with health plan selection; educating consumers about their health care rights; directly assisting healthcare consumers with grievances and appeals; acting as a watchdog of Connecticut’s healthcare marketplace; pursuing healthcare policy activities, and; serving as Connecticut’s federally designated independent health insurance consumer assistance program under the Affordable Care Act.

Dr. Marko Vujicic
Chief Economist and Vice President
Health Policy Institute at the American Dental Association

Dr. Marko Vujicic is Chief Economist and Vice President, Health Policy Institute at the American Dental Association where he is responsible for overseeing all of the Association’s policy research activities. Prior to joining the American Dental Association, he was Senior Economist with The World Bank in Washington D.C. where he directed the global health workforce policy program. He was also a Health Economist with the World Health Organization in Geneva, Switzerland.

Dr. Vujicic is the lead author of the book, Working in Health, and has written several book chapters on various health policy issues. He has published extensively in peer-reviewed journals such as Health Affairs, The New England Journal of Medicine, Health Services Research, Health Policy and Planning, Social Science and Medicine, and Medical Care. He has worked on broad health care reform issues in Africa, East Asia, the Caribbean and Eastern Europe. He is a visiting assistant professor at Tufts University in Boston.

Dr. Vujicic obtained his Ph.D. in Economics from the University of British Columbia and a Bachelor’s degree in Business from McGill University in Montreal.
Welcome: The Opportunity for Innovation

8:30-9:30am

**Speaker**
Trish Riley  
Executive Director  
NASHP

**Speaker**
Dr. Marko Vujicic  
Chief Economist and Vice President  
Health Policy Institute  
American Dental Association
Improving Oral Health:

Tools for Policy Makers

Marko Vujicic, PhD
Chief Economist & Vice President
Health Policy Institute

The ADA Health Policy Institute

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Today

1. Just the Facts

2. Tools for Policymakers
**Just the Facts…**

**Number of Dentists per 100,000 Population**
- **Colorado**: 64.3 in 2001, 60.5 in 2013
- **U.S.**: 57.3 in 2001, 60.5 in 2013

![Graph showing the number of dentists per 100,000 population for Colorado and the U.S.]()

**Percentage of Dentists Participating in Medicaid for Child Dental Services in 2014**
- **Colorado**: 53%
- **U.S.**: 42%

**Just the Facts…**

**U.S. Dentist Workforce by Age Group**

**Health Policy Institute**

**Just the Facts…**

**Dentist Migration Across State Lines**

**Health Policy Institute**
Just the Facts...

Percentage with a Dental Visit in the Past 12 Months

- **Children with Medicaid Coverage**
  - 2000: 19% (Colorado) vs. 25% (U.S.)
  - 2005: 37% (Colorado) vs. 29% (U.S.)
  - 2013: 48% (Colorado) vs. 28% (U.S.)

- **Children with Private Dental Benefits Coverage**
  - 2000: 77% (Colorado) vs. 68% (U.S.)
  - 2005: 64% (Colorado) vs. 60% (U.S.)
  - 2013: 67% (Colorado) vs. 62% (U.S.)

- **Adults with Private Dental Benefits Coverage**
  - 2000: 60% (Colorado) vs. 60% (U.S.)
  - 2005: 60% (Colorado) vs. 59% (U.S.)

Just the Facts...

**Unmet Caries Needs Rising Among Low-Income Adults and Seniors**

**Prevalence of Untreated Caries, by Income Level and Age Group**

- Untreated caries rates are declining for children, especially low-income children.

*Indicates changes from 1999-2004 to 2011-2014 are statistically significant at the 5% confidence level.
**Indicates changes from 1999-2004 to 2011-2014 are statistically significant at the 10% confidence level.
PREVALENCE OF UNTREATED CARIES, BY INCOME LEVEL AND AGE GROUP

*Indicates changes from 1999-2004 to 2011-2014 are statistically significant at the 5% confidence level.
**Indicates changes from 1999-2004 to 2011-2014 are statistically significant at the 10% confidence level.

Just the Facts...

How Often Have You Experienced the Following Problems in the Last 12 Months Due to the Condition of Your Mouth and Teeth?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Very Often</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DROUGHT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>18%</td>
<td>28%</td>
<td>4%</td>
<td>46%</td>
</tr>
<tr>
<td>High</td>
<td>5%</td>
<td>23%</td>
<td>9%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>DIFFICULTY BITING/CHWING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
<td>69%</td>
</tr>
<tr>
<td>High</td>
<td>10%</td>
<td>30%</td>
<td>5%</td>
<td>59%</td>
</tr>
<tr>
<td><strong>EXPERIENCE PAIN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>10%</td>
<td>8%</td>
<td>1%</td>
<td>81%</td>
</tr>
<tr>
<td>High</td>
<td>5%</td>
<td>31%</td>
<td>4%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>AVOID SMILING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>14%</td>
<td>3%</td>
<td>4%</td>
<td>71%</td>
</tr>
<tr>
<td>High</td>
<td>10%</td>
<td>15%</td>
<td>9%</td>
<td>66%</td>
</tr>
</tbody>
</table>

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Tools for Policymakers

The Health Policy Institute compiled a number of useful tools for policymakers focused on improving the oral health care system.

- Oral Health and Well-Being in Your State and for the U.S.
- The Oral Health Care System in Your States and for the U.S.
- Projecting the Supply of Practicing Dentists in Your State and for the U.S.
- Estimating the Cost of a Medicaid Adult Dental Benefit in Your State
- Assessing the Accuracy of Medicaid Provider Lists
- Medicaid Dental Care Reimbursement Rates in Your State
- Developing an Effective RFP/Dental Benefits Contract in Medicaid in Your State

Estimating Cost of Adult Dental Benefit

States with Adult Dental Benefits

- States with Adult Dental Benefits that Expanded Eligibility Under the ACA
- States with Adult Dental Benefits that Did Not Expand Eligibility Under the ACA
Estimating Cost of Adult Dental Benefit

Example: Alabama

- Formula: Enrollment x Utilization x Spending/User x State Share
- Scenario 1: 234,582 adults x 0.249 x $818.47 x 0.311 = $14.9 million
- The cost of adding an adult dental benefit under Scenario 1 represents about 0.9% of Alabama’s total Medicaid budget.

<table>
<thead>
<tr>
<th>State</th>
<th>Adult Medicaid Enrollment</th>
<th>Utilization Rate (% with a dental visit)</th>
<th>Spending per Dental Care User per Year ($2015)</th>
<th>State Share of Medicaid Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Scenario 1</td>
<td>Scenario 2</td>
<td>Scenario 3</td>
</tr>
<tr>
<td>Alabama</td>
<td>234,582</td>
<td>24.9%</td>
<td>24.9%</td>
<td>49.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Total Medicaid Expenditure</th>
<th>Increase in Expenditure ($)</th>
<th>As Percentage of Total Medicaid Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,570,364,045.64</td>
<td>$14,896,360.31</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in Expenditure ($)</td>
<td>$13,307,415.21</td>
<td>$26,566,789.21</td>
<td>0.8%</td>
<td>0.8%</td>
<td>1.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example: Missouri

- Formula: Enrollment x Utilization x Spending/User x State Share
- Scenario 2: 301,540 adults x 0.249 x $548.37 x 0.372 = $15.3 million
- The cost of adding an adult dental benefit under Scenario 2 represents about 0.4% of Missouri’s total Medicaid budget.

<table>
<thead>
<tr>
<th>State</th>
<th>Adult Medicaid Enrollment</th>
<th>Utilization Rate (% with a dental visit)</th>
<th>Spending per Dental Care User per Year ($2015)</th>
<th>State Share of Medicaid Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri</td>
<td>301,540</td>
<td>24.9% Scenario 1</td>
<td>$818.47</td>
<td>37.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24.9% Scenario 2</td>
<td>$548.37</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>58.1% Scenario 3</td>
<td>$548.37</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Total Medicaid Expenditure</td>
<td>Increase in Expenditure ($)</td>
<td>As Percentage of Total Medicaid Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,411,896,825.25</td>
<td>$22,883,654.10</td>
<td>0.7% Scenario 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15,332,048.25</td>
<td>0.4% Scenario 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$35,713,278.85</td>
<td>1.0% Scenario 3</td>
<td></td>
</tr>
</tbody>
</table>

Projecting the Supply of Dentists

Graduates → Practicing Dentist

Moved in → Practicing Dentist

Foreign-trained → Practicing Dentist

License lapse

Retired

Moved out

Death

Un-retirement

Re-licensure

Exit labor force

Emigration
Projecting the Supply of Dentists

Figure 1: Historical and Projected Dentists per 100,000 Population in the U.S., Baseline Scenario

Sources: ADA Health Policy Institute analysis of ADA masterfile; ADA Survey of Dental Practice; ADA Survey of Dental Education; U.S. Census Bureau, Interannual Estimates and National Population Projections. Notes: Data for 2005, 2010 and 2015 are based on the ADA masterfile. Results after 2015 are projected. Assumes (a) U.S. total annual dental school graduates will increase until 2020 and then remain constant (b) future outflow rates are same as 2010-15 historical percentages.

Understanding Access
### Understanding Access

#### Appendix Figure 3a (Missouri)

![Missouri Map](image)

#### Figure 3a (Missouri)

![Missouri Map](image)

### Missouri vs. North Dakota

<table>
<thead>
<tr>
<th></th>
<th>Missouri</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entire Population</td>
<td>Medicaid Children</td>
</tr>
<tr>
<td>Maximum Travel Time</td>
<td>15 minutes</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>30 minutes</td>
<td>99%</td>
</tr>
</tbody>
</table>

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As the Surgeon General said, “you can’t be healthy without good oral health.” It is time to re-engineer the health care system so it actually delivers oral health and well-being. We need to put more effort (and perhaps money) where our mouth is.
Driving Innovation with New Science and Tools

9:30-10:45am

Morning Moderator
Cheryl Roberts
Deputy Director of Programs
Virginia Department of Medical Assistance Services

Speaker
Alani Jackson
Chief of Medi-Cal Services Division
California Department of Health Care Services

Speaker
Dr. Leon Bragg
Chief Dental Officer
Oklahoma Health Care Authority
Medi-Cal 2020 Waiver:
Dental Transformation Initiative

Alani Jackson, MPA
Chief, Medi-Cal Dental Services Division
California Department of Health Care Services

October 17, 2016

• Improve the oral health of Medi-Cal beneficiaries
• Provide high-quality oral health care services
• Improve and maintain access to dental care for Medi-Cal beneficiaries
• Maintain provider network
• Utilize performance measures to drive dental delivery system reform
• Focus on the delivery of preventive services in lieu of more invasive and costly procedures
• Reduce administrative burdens for new and existing providers
• Increase accountability and transparency of program management and oversight
Dental Transformation Initiative: Purpose and Goals

**Purpose**
- Improve the dental health of children to achieve overall better health outcomes
- Focus on high-quality care and improving access to dental care for Medi-Cal children
- Utilize performance measures to drive dental delivery system reform
- Encourage Continuity of Care
- Prevent and mitigate oral disease through the delivery of preventive services in lieu of more invasive and costly procedures

**Goals**
- Increase the utilization of preventive dental and oral health services among children
- Expand prevention and risk assessment model to prevent and treat early childhood caries
- Increase dental continuity of care for children

Core Components
- Promotes overall utilization of preventive services and oral health disease management
- Providers may qualify for each provider incentive program (3 domains) simultaneously

Required Project Metrics
- Baseline data and active data tracking of preventive and restorative services provided
- Tracking effectiveness of caries management based on positive changes relative to the beneficiary “risk” level
- Baseline data and active monitoring of participating dental providers
- 90 days continuous eligibility as parameters for beneficiaries ages 20 and under

Incentive Payments
- Total of $750 million in total funds over 5-year period with $10 million in total funds contingent on achieving statewide metrics
**Dental Transformation Initiative: Dental Initiative Domain Areas**

- Domain 1: Increase Preventive Services Utilization for Children
- Domain 2: Caries Risk Assessment and Disease Management
- Domain 3: Increase Continuity of Care
- Domain 4: Local Dental Pilot Programs (LDPPs)

**Domain 1: Increase Preventive Service Utilization for Children**

**Domain Goal**
- Increase statewide proportion of children ages 20 and under enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period.

**Metric Benchmarking**
- Performance targets will be set based on the most recent completed year preceding implementation of the waiver. Incentive payments will be made to service office locations for increasing utilization and will be re-evaluated throughout the demonstration to determine subsequent year’s thresholds.
Domain 1: Increase Preventive Service Utilization for Children

- Waiver Amendment Changes
  - Revises the methodology DHCS uses to determine the baseline metrics for incentive payments to new and existing dental service office locations; and
  - Adds authority to provide partial incentive payments to provider service office locations that partially meet annual increases in the preventive services provided to children above the pre-determined baseline.
- Why?
  - To ensure new and existing dental provider service office locations are not disadvantaged by having to reach unrealistic increases in the number of children provided preventive services.
- DHCS sent out a Tribal Notice to begin the 30 day review process for questions and comments as required for waiver amendments on July 14th – received no comments.
- Submitted to CMS on August 15th and they posted on CMS website on September 1st.
- Letters will be sent to the service office locations with baseline and benchmarks once amendment has been approved.

Dental Transformation Initiative: Domain Area, Benchmarking & Criteria

Domain 2: Caries Risk Assessment and Disease Management

Domain Goal
- Diagnose early childhood caries by utilizing Caries Risk Assessments (CRA) to treat it as a chronic disease.
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventative services in lieu of more invasive and costly procedures (restorative services).
- Identify the effectiveness of CRA and treatment plans for children ages 6 and under in select pilot counties (11).
- Treatment plans are prescribed based on caries risk level and include: CRA (globally includes motivational interviewing, nutritional counseling, and use of antimicrobials), topical fluoride varnish application, toothbrush prophylaxis, and exams.
Metric Benchmarking

- DHCS will track and report the following measures:
  1. Number of, and percentage change in, restorative services;
  2. Number of, and percentage change in, preventive dental services;
  3. Utilization of CRA CDT codes and reduction of caries risk levels (not available in the baseline year prior to the Waiver implementation);
  4. Change in use of emergency rooms for dental related reasons among the targeted children for this domain; and
  5. Change in number and proportion of children receiving dental surgery under general anesthesia.

Criteria

- Caries Risk Assessment (CRA) tool
  - The tool has been designed and we had 11 dentists pilot
    - We received positive feedback - it followed a logical sequence and was simple and easy to carry out
    - 9 dentists submitted comments to improve the form and we are working to incorporate many of the suggestions.
  - The tool will be released following revisions

- Training
  - CRA training is being developed
  - Potential participants will be required to complete the training

- Caries Treatments
  - Caries-arresting treatments have been added to the protocol

- Opt-in Process
  - A process for potential participants to opt-in and complete the prerequisites is being developed

- Incentive payments will be made to providers for successful completion of caries treatment plan and improvement in “elevated risk” levels.
Domain 3: Increase Continuity of Care

**Domain Goal**
- Increase continuity of care for beneficiaries ages 20 and under for 2, 3, 4, 5, and 6 continuous periods in select pilot counties (17).

**Metric Benchmarking**
- Baseline year will be based on data from the most recent complete state fiscal year (2015). Claims data will determine number of beneficiaries who received at an examination each year from the same service office location for 2, 3, 4, 5, and 6 year continuous periods.

**Criteria**
- Incentive payments will be available to service office locations that provide examinations to an enrolled Medi-Cal child for 2, 3, 4, 5, and 6 continuous periods.
- The incentive payment will be an annual flat payment for providing continuity of care to the beneficiary.
Dental Transformation Initiative: Domain Area, Benchmarking & Criteria

Domain 4: Local Dental Pilot Programs (LDPPs)

Project Goal
• LDPPS will address 1 or more of the 3 domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships
  • DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments for LDPPs in accordance with the requirements stipulated in the Medi-Cal 2020 Waiver
  • A maximum of 15 LDPPs shall be approved

Metric Benchmarking
• LDPPs will be evaluated consistent with the performance metric of the aforementioned dental domains and the goals outlined in the individual proposals

Criteria
• The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department.
  • DHCS shall approve only those applications that meet the requirements to further the goals of 1 or more of the 3 dental domains.
• Each pilot application shall designate a responsible county, Tribe, Indian Health Program, UC or CSU campus as the entity that will coordinate the pilot.
Domain 4: Local Dental Pilot Programs (LDPPs)

- Letter of Intent (LOI)
  - 25 non-binding LOIs were received in May 2016
  - List of LOIs can be viewed on our DTI dedicated website
- Application Process
  - Application was released on June 1, 2016
  - An LDPP budget template has been developed, posted, and discussed on webinar
  - Process has been developed for collecting and scoring applications
  - Revised application timeline was released on July 28, 2016
    - Application due date: September 30, 2016
    - LDPP programs commence: February 15, 2017

Constant Communication & Engagement is Key

- Lots of Stakeholder Engagement
  - 5 webinars
  - 1 small workgroup with monthly meetings
    - 2 small sub-workgroups with monthly meetings
- Continuous posting of updated FAQs
- Updates Across Domain Fact Sheets
For more information

- DHCS Webpage dedicated to DTI publications, FAQs and public information:
  http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx

Questions/Comments

Please email DTI@dhcs.ca.gov for questions or comments.
Silver Diamine Fluoride for Oklahoma

Leon D. Bragg, DDS, M.Ed.
Chief Dental Officer

SDF IS A HOT TOPIC IN DENTISTRY
THE FIRST AND ONLY SILVER DIAMINE FLUORIDE AVAILABLE IN THE UNITED STATES

ADVANTAGE ARREST

SILVER DIAMINE FLUORIDE 38%

*Before and after SDF
After SDF application

Progression
HOW SDF WORKS

- Ag-protein in decayed surfaces
- Increases resistance to acid.\textsuperscript{11}
- Increases density and hardness.\textsuperscript{5}
- Ag inhibits DNA replication. \textsuperscript{13,14}
- Ag and fl. ions penetrate approximately 25 microns into enamel,\textsuperscript{16} deeper into dentin \textsuperscript{17}
- Fluoride promotes remineralization
- Ag is available for antimicrobial action
HOW SDF WORKS, CONT.

Does **not** stain sound enamel or dentin

The color changes are like naturally arrested caries or darker. These signal both clinician and patient that something is happening.

Discolors soft tissue and any other objects it touches (it takes a few **hours** to appear; soft tissue fades in a few days)

*TOXICITY?*

- One drop should treat 1-5 teeth and contains about 11.88 mg of SDF.
- LD of oral administration is approximately 520 mg/kg body weight.
- A child of 10 kg (22lbs) would receive 1.185 mg/kg.
- According to Vasquez et. al., the highest applied dose of 2.37 mg would enable 400+ applications over a lifetime.

(http://www.biomedcentral.com/content/pdf/1472-6831-12-60.pdf)
PER APPLICATION COST

- $130/8 ml bottle = 250 drops at $0.52/drop
- $9.95/100 applicators = $0.095/ applicator
- One-drop application = $0.62 per application
- Equal to or less than the cost of fluoride varnish

CDT CODES

- D1208 – Fluoride application
- D9910 – Application of a desensitizing medicament
- D1351- Sealant
- D1354 – Interim application of arresting medicament
PROGRAM SPECIFICS FOR D1354

- Two applications per tooth per year
- Four applications per tooth per lifetime
- Reimburses once every 184 days
- Documentation requires clinical indications for this service be clearly supported in the record
- Allow D2940 – protective restoration ($42.29)

PROGRAM SPECIFICS, CONT.

- This code is based per tooth and applies to all primary and permanent teeth
- Restricts any tooth treated with SDF from additional restoration for six months
- Reimbursement for removal of a tooth treated is not available for 90 days
- Reimbursement is equal to that of a D1351 ($22.56)
D1354 FINANCIAL CONSIDERATIONS

- Six applications per year (@ $22.56 each) = $135.36; four lower and two upper teeth
- Total $135.36 X 1000 children = $135,360
- If each application prevented the need for one pulpotomy D3220($84.57) and one stainless steel crown D2930 ($112.76) = $197.33
- Prevent two teeth/child ($394.66) x 1000 = $394,660
- Potential savings of $259,300 per 1000 children/applications

FINANCIAL CONSIDERATIONS, CONT.

- If used for young children with rampant decay on primary teeth who otherwise will require general anesthesia, SDF could delay or eliminate the medical costs for outpatient surgery facility and general anesthesia fees.
SUMMARY

- Recommended application frequency of SDF for caries control is six months to one year.
- SDF should not be placed on exposed pulps.
- Topical fluorides (e.g., fluoride varnish) should not be used in the same appointment.
- Treating carious areas with SDF 38% acts as a whole-mouth fluoride treatment.

SUMMARY, CONT.

- FDA-approved as hypersensitivity treatment (similar to fluoride varnishes) for use in adults over the age of 21
- Used in Japan, China, India, New Zealand, Australia and many other countries as caries arresting agent for more than 50 years
- Affordable for medicaid dental programs
Promoting Access to Oral Health through Benefit and Care Delivery Design

11:00am-12:15pm

Moderator
Cheryl Roberts
Deputy Director of Programs
Virginia Department of Medical Assistance Services

Speaker
Kneka Smith
Associate Dean for Academic Affairs
A.T. Still University’s Missouri School of Dentistry & Oral Health

Speaker
Ann Lopes
Carrier Product Manager
Access Health CT
Objectives

1. Discuss rationale for integration of oral health into primary care.

2. Briefly discuss the elements of *From the First Tooth*™ including policy approaches

3. Identify policy options for maximizing Medicaid programs to improve children’s oral health
Children’s Oral Health

Dental Caries (tooth decay) is preventable
- Infectious disease – mom to child via saliva

Dental Caries is a progressive chronic disease
- Children with cavities in baby teeth are 3x more likely for adult decay
- 53-79% of children experience new cavities within 2 years of OR treatment for early childhood caries

Medicaid EPSDT Dental Services
- Typically designed similar to commercial insurance (cleaning 2X/year, 2 fluoride tx, fillings, etc.)

PRIMARY PREVENTION

- **Mothers:**
  prior/during/immediately following pregnancy to reduce/eliminate transition of bacteria

- **Babies, Toddlers, Preschoolers:**
  Risk assessment, early prevention, dental referrals
PREVENTIVE SERVICES Comparison

Medicaid-enrolled children 1-2 years of age Receiving Preventive Services (National)

ACCESS TO DENTAL CARE: Young Children

National Recommendation: 1st dental visit by age 1 year

Babies’ Access to Dental Care
- Traditional access issues ($, transportation)
- Referral model to dental differs from all other pediatric health issues
- Lack of available dentists for <3 years
- Lack of parental demand

from the first tooth
www.FromTheFirstTooth.org

https://www.youtube.com/watch?v=ARkehLHmb44
**Standard of care in primary care:**

1. Oral evaluations
2. Fluoride varnish
3. Anticipatory guidance
4. Referrals to dentists

**INTEGRATION of Pediatric Oral Health into Primary Care**

**Recruitment**
- Outreach:
  - Clinical Champions
  - Outreach by FTFT
  - AAP Outreach
- Readiness to Change

**Preparing to Launch**
- Team
- In-Person Meeting
  - EHR Integration
  - Measures & Targets
  - Charging/Billing
- Workflow
  - Clinical Roles
  - Periodicity
  - Supplies/Storage

**Launch**
- Training (CME)
- Documentation with EHR Screen Shots
- Demonstration
- Clinical Competencies

**Sustaining Change**
- Follow-Ups
- Periodic (Transparent) Data Review
- Practice Visits
- Collaboration across Practices
- Chart Reviews
- Learning Collaborative
- Quality Metrics
- MOC
- Meaningful Use
- Provider Messaging
- CME via Professional Associations
- Dental Referrals
- Consumer Demand

**Target Practices***: 246
**Active Practices Trained**: 169
**Practices Implementing**: 144
**Practices with EMR Integrated**: 108

* *Pediatric & Family Medicine; FQHCs
**Includes 8 never trained but implementing
CLINIC FLOW FOR CHILDREN UNDER 6 YEARS OLD

Parent/Child Arrives to the PCP
Posters and educational materials in reception area

Parent Checks in with Receptionist
Parent receives information about fluoride

Vitals Signs Taken
Medical assistant initiates the caries risk screening with parent/caregiver and parent/caregiver education

Well Child Exam
Medical Provider - Oral evaluation and oral health plan completed, application of fluoride varnish and parent/caregiver education

Medical Assistant
Fluoride varnish can be applied at the same time as immunizations with provider orders.

After Visit Summary:
Anticipatory Guidance (all) includes recommendations to take child to dentist.

Dental Home:
Make Referrals as needed (fax)

STANDARD DATA ELEMENTS

Risk Assessment
- Teeth?
- Dentist?
- Brushed?
- Disease?
- Mom?
- Plaque?
- Visible Dz?
- Other?
From the First Tooth: Measuring Access to Prevention

4 by 4 (Under 48 months):

<table>
<thead>
<tr>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014:</td>
<td>19%</td>
</tr>
<tr>
<td>2015:</td>
<td>45%</td>
</tr>
</tbody>
</table>

Well Child Visits:

<table>
<thead>
<tr>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014: 19.35%</td>
<td>20%</td>
</tr>
<tr>
<td>2015: 50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

USM, Muskie Analysis of MaineCare Claims

Sample Pediatrics Group
Early Pediatric Oral Health by Practice
August 2014-2015
Population: All patients with teeth, ages 9 through 47 months
Source: Clinical Improvement Registry
Policies: Practice Acts

- Application of Fluoride Varnish:
  - MD/DO
  - NP/PA?
  - RN/LPN?
  - MA?

Policies: Payment
(Medicaid, Self-Insured, Exchange)

FV Applications:
- D1206 – FV application (or 99188)
- Applied 2-4 X/year from 6 months through 5 years – all risk levels
  - 9m, 15m, 24m, 30m, 3y, 4y, 5y
  - 12m, 18m, 24m, 30m, 3y, 4y, 5y
  - 15m, 18m, 24m, 30m, 3y, 4y, 5y

Oral Evaluation:
- D0145 – OE <3 years/counseling

Most private/commercial payers cover until age 6 per USPSTF recommendation-Level B
Proposed Policy: FQHC Benefits

All Young Children with Medicaid:
- More likely to receive FV from medical providers (53%) than dental providers (47%).

All Young Children with Medicaid Who Obtain Routine Medical at FQHCs:
- >5X less likely to receive preventive oral health services as part of medical care than their children obtaining routine medical in private medical offices (2% vs. 11%).

1MaineCare data analysis, USM Muskie School, 11/15/2013
2MaineCare data analysis, USM Muskie School, 2/2014
Proposed Policy: FQHC Benefits

Proposed Addition to MaineCare Benefits, Chapter II, Section 31 – FQHC (Ambulatory Services)

- Oral evaluations for patients under 3 years of age and counseling with primary caregivers (D0145) will be reimbursable twice per calendar year, per member, when provided by a physician, physician assistant or advanced practice registered nurse as part of routine medical care.

- Fluoride Varnish applications (D1206) will be reimbursable twice per calendar year, per member, when provided by or under the supervision of a physician or by a physician assistant or advanced practice registered nurse as part of routine medical care.

- D0145 and D1206 procedure codes may be billed alone or in combination with other FQHC services. Documentation of an oral evaluation must be contained in the medical record and must include all of the following:
  - The existence of current dental home/dental provider.
  - Risk screening questions based on oral health history.
  - Risk assessment of the mouth and teeth performed by a licensed provider (MD, DO, PA, NP).
  - Oral health plan including parent/patient education about establishing a dental home and referral to a dentist, when possible.

Future Policy: BENEFITS BY RISK?

Caries Risk Assessments – new benefit?
- D0601 – low caries risk
- D0602 – moderate caries risk
- D603 – high caries risk

Designing benefits based on risk?
- Oral prophylaxis (<12 years) – routine; not evidence based
- F/FV applications >2x/year for moderate & higher risk?
- Silver Diamine Fluoride?
- Maternal benefits?
From the First Tooth: Phase II

- **Moms:** OB, Family Medicine, Midwives
  - Screen and refer?
  - Workflow?
  - Payment?

- **Policy:**
  - Adult Medicaid benefit?
  - Maternal dental benefit?

“Dental services including diagnostic and preventive services to pregnant women and postpartum women for one year after delivery to ameliorate conditions or reduce complications that exist because of or are exacerbated by the pregnancy or that, if left untreated, could adversely affect fetal or child development; 1”

1LD474 An Act To Improve Access to Dental Care in Maine, 127th Legislature

Acknowledgements: 

MaineHealth

The Sadie and Harry Davis Foundation

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cotes4@mainehealth.org | 207-662-6309

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Agenda

A. Affordable Care Act (ACA): Essential Health Benefits (EHBs)
B. State EHB Benchmark Plan Options
C. EHB Benchmark Plan: CT Selection Process
D. Plan Design Requirements
E. AHCT Plan Submission
F. AHCT Standardized Plans
   A. Individual Market – Medical with Embedded Pediatric Dental
   B. Individual/Small Group Markets – Stand-Alone Dental Plan (SAPD)
G. SADP Competitive Landscape: Individual Market in Connecticut
**Essential Health Benefits (EHB)**

§1302(b)(1) of the Affordable Care Act (ACA) provides that the EHB must include coverage in these categories of services:

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory patient services</td>
</tr>
<tr>
<td>Emergency services</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse disorder services, including behavioral health treatment</td>
</tr>
<tr>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Rehabilitative &amp; habilitative services and devices</td>
</tr>
<tr>
<td>Laboratory services</td>
</tr>
<tr>
<td>Preventative and wellness services and chronic disease management</td>
</tr>
<tr>
<td>Pediatric services, <strong>including oral</strong> and vision care</td>
</tr>
</tbody>
</table>

**State EHB Benchmark Plan Options**

- **SG**: Largest plan by enrollment in any of the 3 largest small group insurance products in the state’s small group market
- **State**: Largest 3 state employee benefit plans by enrollment
- **HMO**: Largest insured commercial HMO in the state
- **FEHBP**: Largest 3 Federal Employee Health Benefit Plan options by enrollment

If a benchmark plan was selected that did not include pediatric oral or pediatric vision care, supplemental coverage was required to be added so that all 10 EHBs were incorporated.
**EHB Benchmark Plan: CT Selection Process**

- **Incorporated federal and state regulations and guidance**
- **State of CT insurance mandates taken into account**
- **Benefits reviewed to ensure they were non-discriminatory**
- **Compared benefits of the 10 different plan options**
- **Advisory Committee meetings: recommendation for BOD**
- **Pediatric dental coverage: supplemented from either largest Federal Vision (FEDVIP) plan or state’s CHIP program**
- **Plans not including CT mandates, or with lifetime max’s or unlimited benefits eliminated**
- **Feedback from public was reviewed**
- **SELECTION: largest commercial HMO plan beginning in 2014, with pediatric dental coverage based on the CHIP program**
- **CHIP Dental plan included preventive and basic dental services, as well as major services & and medically necessary orthodontia**
- **Process repeated in 2015 for 2017 plan year**
- **SELECTION: 1 of the 3 largest SG ins products available during the 2014 plan year**
- **Supplemental coverage for pediatric dental not required, as it was incorporated into the SG plans effective in 2014**

---

**Plan Design Requirements**

- **Federal ACA Regulations include...**
  - Essential Health Benefits (EHBs)
  - Actuarial Value Calculator (AVC)
  - Maximum Out-of-Pocket (MOOP)
  - Elimination of Lifetime and Dollar Maximums

- **State of Connecticut Insurance Department Guidance includes...**
  - Form and rate filings
  - Cost-sharing maximums

- **AHCT Issuer Participation Requirements include...**
  - AHCT “standardized” plans for various metal levels must be offered with pediatric dental embedded within the medical plan
  - Submission of non-standard plan designs optional, with pediatric dental not required when a stand-alone dental plan (SADP) offering is available
**AHCT Plan Submission**

<table>
<thead>
<tr>
<th>PLAN TYPE</th>
<th>Individual Market*</th>
<th>Small Group Market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>Standardized plan is optional &amp; up to 2 non-standard plans can be submitted</td>
<td>Standardized plan plus up to 2 non-standard plans</td>
</tr>
<tr>
<td>Gold</td>
<td>Standardized plan plus up to 3 non-standard plans</td>
<td>Standardized plan plus up to 3 non-standard plans</td>
</tr>
<tr>
<td>Silver</td>
<td>Standardized plan and up to 3 non-standard plans</td>
<td>Standardized plan and standardized HSA compatible plan plus up to 3 non-standard plans</td>
</tr>
<tr>
<td>Bronze</td>
<td>Standardized plan and standardized HSA compatible plan plus up to 3 non-standard plans</td>
<td>Standardized plan and standardized HSA compatible plan plus up to 3 non-standard plans</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Optional</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

| High (85% AV) / Low (70% AV) | 1 High Level AV & up to 3 additional high and/or low plans | 1 High Level AV & up to 3 additional high and/or low plans |

*Cost Sharing Reduction (CSR) plans are also required for Individual Market (Medical)*

**AHCT Standardized Plans – 2017**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>Platinum</th>
<th>Gold</th>
<th>Silver</th>
<th>Silver 73%</th>
<th>Silver 87%</th>
<th>Silver 94%</th>
<th>Bronze</th>
<th>Bronze HSA</th>
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<tbody>
<tr>
<td>Deductible</td>
<td>$150</td>
<td>$1550</td>
<td>$4000</td>
<td>$3400</td>
<td>$700</td>
<td>$0</td>
<td>$6000</td>
<td>$5685</td>
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<tr>
<td>MOOP</td>
<td>$2000</td>
<td>$3500</td>
<td>$7150</td>
<td>$5700</td>
<td>$1800</td>
<td>$1000</td>
<td>$7150</td>
<td>$6550</td>
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Enrollee Cost Sharing: Embedded Pediatric Dental Benefits

<table>
<thead>
<tr>
<th></th>
<th>No Cost</th>
<th>No Cost</th>
<th>No Cost</th>
<th>No Cost</th>
<th>No Cost</th>
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</thead>
<tbody>
<tr>
<td>Preventive Dental Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Dental Services</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>45% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Major Dental Services</td>
<td>40%</td>
<td>40%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Medically Necessary Orthodontia</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

*Individual Market Medical/Embedded Pediatric Dental: In-Network Cost Sharing for AHCT Standardized Plans for 2017*
AHCT Standardized SADP – 2017*

<table>
<thead>
<tr>
<th>Plan Overview</th>
<th>In-Network (INET) Member Pays</th>
<th>Out-of-Network (DON) Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Does not apply to Preventive &amp; Diagnostic Services for In-Network Services)</td>
<td>$60 per member, up to 3 family members</td>
<td>$60 per member, up to 3 family members</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum for children under age 19 only</td>
<td></td>
<td>$350</td>
</tr>
<tr>
<td>For one child</td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Two or more children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Exams / X-Rays / Cleanings (2 visits per year)</td>
<td>$0</td>
<td>20% after DON deductible is met</td>
</tr>
<tr>
<td>Basic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filings / Simple Extractions</td>
<td>20% after INET deductible is met</td>
<td>40% after DON deductible is met</td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Extractions, Endodontic Therapy, Periodontal Therapy, Crowns, Prosthodontics</td>
<td>40% after INET deductible is met</td>
<td>50% after DON deductible is met</td>
</tr>
<tr>
<td>Other Services (for children under age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary Orthodontic Services</td>
<td>50% after INET deductible is met</td>
<td>50% after DON deductible is met</td>
</tr>
<tr>
<td>Waiting Periods and Plan Maximums (age 19 and older only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicable Waiting Period before benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>No waiting period</td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>6 months</td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>12 months</td>
<td></td>
</tr>
<tr>
<td>Plan Maximum</td>
<td>$2,000 per adult member age 19 and over (combined INET and DON)</td>
<td></td>
</tr>
</tbody>
</table>

*Individual & Small Group Markets – Adult & Pediatric Dental: Cost Sharing for AHCT Standardized SADP for 2017

ACA Compliant SADPs must include the following for children < age 19:
- $350 out-of-pocket maximum for in-network coverage;
- no annual maximum on plan services;

SADP Competitive Landscape: CT*

<table>
<thead>
<tr>
<th>AHCT Standard SADP Plan Features</th>
<th>Summary of Primary Differences between AHCT Standard SADP and Dental Plans Available in the Individual “Off-Exchange” Market</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA Compliant Pediatric Dental</td>
<td>No plans included ACA compliant pediatric dental coverage (i.e., $350 MOOP and no dollar maximums on coverage) other than the plans offered both “On” &amp; “Off” the Exchange</td>
</tr>
</tbody>
</table>
| Deductible – $60                  | ● Most plans included a $50 deductible<jumps>
|                                   | ● Some plans required a separate $50 deductible for both Basic and Major Services<jumps>
|                                   | ● Some plans required a deductible prior to coverage of preventive services<jumps>
| Preventive Care – 100%           | The AHCT plan was similar to most other plans, although some plans did not waive the deductible for preventive care, some plans included 50% coinsurance and others had a “scheduled” amount payable<jumps>
| Basic Services – 20% after deductible | ● Most plans provided Basic Services with member coinsurance of 20%, but others included member coinsurance ranging from 30% - 60%; some plans did not include this coverage<jumps>
|                                   | ● Some plans included a “scheduled” amount payable as coverage for specified services, and others provided only “non-insurance” discounts<br><br>Major Services – 40% after deductible | ● Most plans included coinsurance of 50% for Major Services, but many did not include this coverage<jumps>
|                                   | ● Some plans included a “scheduled” amount payable as coverage for specified services, and others provided only “non-insurance” discounts<br><br>*Stand-Alone Dental Plans available for purchase in Individual Market in CT for 2016
### SADP Competitive Landscape: CT*

<table>
<thead>
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</tr>
</thead>
</table>
| Calendar Year (CY) Maximum for Adults - $2000 | - No plans identified the calendar year maximum as applying to adult coverage only; most plans had a CY Maximum of $1000, but others included $500, with others having a range from $1200 – $1500  
- Some plans included provisions where the CY Maximum would increase in the 2nd and/or 3rd year of enrollment, or an “annual award” for subsequent plan years to increase the CY Maximum when payable claims were below a specified threshold, or an increased maximum for Basic Services for an additional premium |
| Waiting Period (WP) for Adults – 6 months for Basic Services* | - For plans including coverage for these services:  
  - Most included a 6 month WP, but others included WPs of 3 or 4 months with increased member coinsurance, or 12 months (except for fillings)  
  - Some plans did not include a WP, but had limited coverage (such as a scheduled dollar amount payment) or higher coinsurance in year 1 and increasing plan coverage for services in years 2 & 3  
  - Some plans included waiver of the WP with proof of prior coverage  
  - Some plans did not include this coverage |
| Waiting Period (WP) for Adults – 12 months for Major Services* | - For plans including coverage for these services:  
  - Most included a 12 month WP, but one included a 6 month WP and others included WPs of 15 – 18 months; others did not include a WP but included only “scheduled” benefit coverage;  
  - Some plans included increased plan coverage for services in years 2 & 3  
  - Some plans included waiver of the WP with proof of prior coverage  
  - Some plans did not include this coverage |

*Stand-Alone Dental Plans available for purchase in Individual Market in CT for 2016

### Questions?
Creating Accountability for Oral Health

1:15-2:30pm

Moderator
Dr. David Kelley
Chief Medical Officer
Pennsylvania Department of Human Services

Speaker
Dr. Bruce Austin
Statewide Dental Director
Oregon Health Authority

Speaker
Karen Davis
Dental Emergencies Needing Treatment Network Manager
Better Health Together
Oregon’s Health System Transformation
Incorporating Oral Health into the Coordinated Care Model

Bruce Austin, DMD, Statewide Dental Director
National Academy for State Health Policy
October 2016
Oregon chose a new way

- Better Health, Better Care and Lower Costs
  - Transform the delivery system
  - Robust public process
  - Bipartisan support
  - Federal waiver approved - $1.9B investment tied to quality and reduction in costs

- Coordinated care model
  - Starting with coordinated care organizations in Medicaid
  - Aiming to spread to other state-purchased coverage, Oregon’s Health Insurance Exchange, private payers

Health System Transformation

- Coordinated care organization
  - Local accountability for health and resource allocation
  - Standards for safe and effective care
  - Integration and coordination of benefits and services
  - Global budget indexed to sustainable growth

PATIENT-CENTERED PRIMARY CARE HOME
Coordinated care organizations (CCOs)

- 16 CCOs serve 90% of Oregon Medicaid members
  - Since ACA expansion, Medicaid now serves about 1 in 4 Oregonians
- Governed by a partnership of health providers, community partners, consumers and those taking financial risk
- Consumer advisory councils
- Physical, mental and dental health care held to one budget
- Responsible for health outcomes
  - Paid for performance on 18 quality measures
  - State reports to CMS on additional measures

Dental care integration

- Prior to Oregon’s Health System Transformation, dental care organizations (DCOs) served the majority of the Medicaid population.
- As of July 1, 2014, CCOs began managing the dental benefit, primarily by contracting directly with DCOs.
  - CCOs had to contract with DCOs serving members in their service area. All CCOs met this requirement.
  - Nine DCOs work with 16 CCOs and community partners to improve oral health for adults and children.
  - CCOs contract with DCOs available in their region (in some cases, all nine).
### DCO contracts by payer (OHA and CCOs)

<table>
<thead>
<tr>
<th>DCO</th>
<th>OHA</th>
<th>Access Dental</th>
<th>Advantage Dental</th>
<th>Capitol Dental</th>
<th>Care Oregon</th>
<th>Family Dental Care</th>
<th>Kaiser Dental</th>
<th>Managed Dental</th>
<th>ODS</th>
<th>Willamette Dental</th>
<th>Total DCO contracts per payer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>9</td>
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<td></td>
<td></td>
<td></td>
<td><strong>Total contracts per payer</strong></td>
</tr>
</tbody>
</table>

**Total contracts per payer:** 68
Medicaid adult dental coverage


Oregon Medicaid dental benefits

- Adults who qualify for Medicaid now receive a comprehensive dental package.
- Pregnant women receive a slightly richer Medicaid package that includes molar endodontic therapy and additional crowns.
CCO Transformation Plans

- Eight CCOs have specific oral health strategies in their 2015-2017 Transformation Plans including:
  - Eliminate / minimize barriers to dental care for all members
  - Primary care integration, including implementing First Tooth early childhood prevention training, referral mechanisms, dental screenings for co-morbid severe and persistence mental illness (SPMI), diabetes populations
  - Value-based payments for dental
  - Dental / medical integration

State “test” for quality and access

- Annual assessment of Oregon’s statewide performance on 33 metrics, in 7 quality improvement focus areas
- Significant penalties if goals not achieved
Developing dental quality metrics

- In 2013, OHA convened the Dental Quality Metrics Workgroup, including dental and CCO stakeholders.
- Metrics and Scoring Committee adopted two incentive pool quality metrics as of 2015:
  1. Mental, physical and dental* health assessments within 60 days for children in Department of Human Services custody (e.g., foster care).
  2. Dental sealants on permanent molars for children (ages 6-14)

*Measure amended in 2015 to include dental along with mental/physical health assessment

Quality metric: Dental sealants on permanent molars for children
Childhood tooth decay causes needless pain and infection, and can affect a child’s nutrition and academic performance. The CDC says two interventions reduce caries in a community:

1. School-based sealant programs
2. Community water fluoridation

Metric:
- Percentage of children ages 6-14 who received a dental sealant during the measurement year.

Results:
- Preliminary 2015 data indicate improvement by all 16 CCOs
- Statewide change since 2014: +65%
- All racial and ethnic groups experienced improvement
Successes – Dental sealants

Influences:
- Financial incentive metric around dental sealants for CCOs
- Statewide coordination of sealant programs due to SB 660, which requires OHA to implement a mandatory certification program to ensure quality services are provided in a school setting

Goal:
- Provide dental sealants in schools that serve students at high risk of tooth decay

Results: Of schools eligible to participate in dental sealant programs:
- Elementary schools: 71% were served in the 2014-15 school year compared to 88% in the 2015-16 school year
- Middle schools: Just 8% were served in the 2014-15 school year and jumped to 65% in the 2015-16 school year

Next steps

- Evaluation of dental integration within CCOs
- State Health Improvement Plan: Improving oral health is one of seven goal areas.
Contact information

Bruce Austin, DMD, Statewide Dental Director
bruce.w.austin@state.or.us
Oral Health Access
Karen Davis
October 2016

What determines Health?

- Genetics: 33%
- Behavior: 33%
- Social Circumstances: 17%
- Environment: 7%
- Health Care: 11%

Source: www.icsi.org/_asset/qj7tk6/Commentary-Magnan.pdf
$4 Billion Dollars
Spent on health care in our Better Health Together region

With Poor Health Status

- More than 25% obesity rates in every county in our region
- 25% of adults report poor health in Adams County
- 21% of adults report excessive drinking in Spokane County
- 19% of adults report smoking in Ferry County
- 11% unemployment in Stevens County
- 37th in overall health outcomes in Pend Oreille

RWJ 2015 County Health Rankings
Our ACH Region
Accountable Community of Health

VISION: everyone will have longer, more productive, higher quality lives by ensuring access to:

- Stable housing, nutritious food and transportation.
- Opportunity to attain post secondary education and training to allow for meaningful employment that pays the bills with some left over for savings.
- Community resources and opportunities for recreational and leisure-time activities.
- Social support networks that allow for emotional, social and psychological well-being.

PRIORITIES:

• Dramatically improve whole-person care through the integration of behavioral, physical and oral health systems.
• Expand oral health access.
• Develop strong community systems that link housing, food security and income stability.
• Dramatically decrease obesity rates across all populations through prevention.
• Scaling community-based care coordination to improve health.
Dental Emergencies Needing Treatment

Program Overview

Utilizes Community Health Workers to divert patients seeking treatment at the ER for Dental Emergencies

- Receives referral from Providence ER and Urgent Care Clinics
- Contacts patient and assess needs to pair with an appropriate dental provider
- Provides behavioral coaching and reminder calls to clients to ensure they are ready to seek treatment
- Expands dental provider network through on the ground outreach and effort

In first 14 months of operation, 2300 patients served

- 93% of referred patients received dental appointments
- No show rate below 10%, average is over 30%
- Increased available dental appointment for emergency care from 51 to 264 monthly
- Increased number of Medicaid Accepting Dentists from 22 to 50

Outcomes

- 50% reduction in ER utilization for emergency dental care
- 100% increase in available appointments
- Retain a 10% or lower no show rate

DENT Behavioral Coaching Checklist

- **Dental Do's before the visit:**
  - Do seek dental treatment at a dentist of your choice when possible,
  - Do seek emergency dental care at an Urgent Care Clinic, NOT the ER,
  - Do schedule a visit the dentist ASAP if you receive care Urgent Care or ER,
  - Do have your insurance card number, ID & proof of income to take with you to your dental appointment,
  - Do call DENT with phone number & address change.

- **Dental Do’s at the Office:**
  - Do go to your appointment as scheduled & be on time,
  - Do cancel 24 hours in advance when unable to keep your appointment,
  - Do bring your insurance card with you to every appointment if possible,
  - Do tell the dentist about any bad dental experiences and/or fears,
  - Do present to the dental office with clean teeth & body,
  - Do bring support if needed but limit to one person,
  - Do bring your current medication list,
  - Do thank the dentist & their staff.
About the DENT Program:
• We match individuals having dental issues with a dentist through a formal referral process. DENT can help you efficiently receive the dental care you need

Who is eligible?
• All ages,
• Those with insurance to include Apple Health (Medicaid)
• Those without insurance & agree to self-pay
• Those who live in Washington State & Idaho

What DENT will provide:
• Individual access to dental care for unmet dental needs
• Support for scheduling & making your appointment
• Education before & after the dental visit
• A positive dental experience

DENT benefits you and your family:
• Dental care as needed
• Prevent future dental problems
• Receive prevention info to avoid dental disease & decay before it ever begins
• Improve your oral & overall health

DENT Referrals/Appointments/No Shows

<table>
<thead>
<tr>
<th></th>
<th>% Referrals w/Appointment Scheduled</th>
<th>% No Show Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>60%</td>
<td>5.3%</td>
</tr>
<tr>
<td>2015</td>
<td>93%</td>
<td>6.8%</td>
</tr>
<tr>
<td>2016 YTD</td>
<td>94%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Davis
Lessons Learned

• Truly effective health will require an integrated system of physical, behavioral AND oral health with strong community infrastructures
• The best health is delivered as locally as possible
• Our sectors of health don’t speak the same language--Community Health Workers are a translator between sectors and patients
• Reducing dental emergencies will require a new way of paying for oral health in Washington state
• Prudent and efficient use of community infrastructure will reduce costs AND improve health!
For More Information

Alison Carl White, Executive Director
alison@betterhealtogether.org

Karen Davis, DENT Care Manager
karen@betterhealtogether.org

Rita Mykelburg, Community Health Worker
rita@betterhealtogether.org

www.betterhealtogether.org
Identifying What’s Next: A Roundtable Discussion

2:45-3:45pm

Moderator
Patrick Finnerty
Senior Advisor
DentaQuest

Speaker
Cheryl Roberts
Deputy Director of Programs
Virginia Department of Medical Assistance Services

Speaker
Judy Lee
Senator
North Dakota Legislature

Speaker
Victoria Veltri
Chief Policy Advisor
Office of the Lieutenant Governor
State of Connecticut
ORAL HEALTH CHALLENGES AND OPPORTUNITIES FOR CHANGE

Presentation for Sen. Lee

Oral Health Access in North Dakota

- Every year, thousands of North Dakotans do not receive regular, routine dental care
  - Not enough access to providers in rural areas
  - Not enough access for low-income individuals in urban centers
  - Not enough access to services on Indian reservations (6-month waiting period)

Source: University of North Dakota, Center for Rural Health (2014).
Oral Health Disparities in North Dakota

- 47% of dentists in ND do not accept Medicaid patients according to a 2011-12 survey.
- 64% of children enrolled in Medicaid did not see a dentist in 2015.
- Rural third-graders had significantly worse oral health than their urban peers in 2009-2010. AI children had more than twice the need for treatment than their white peers in 2009-2010.
- One-third of all seniors have dental problems.

Sources: ND DOH (2013); CMS (2016) ND DOH (2010); UND Center for Rural Health (2014).


Source: University of North Dakota, Center for Rural Health (2014).
Beyond the data...

“"The reality for the kids that I work with is that dental coverage does not necessarily translate to dental access. A teacher recently called me and asked if I knew any resources for taking care of an abscessed tooth. A student was in so much pain, his face was swollen, and he didn’t have insurance. We looked at the emergency care that was available in Moorhead. It wasn’t available on that day and he couldn’t wait. The teacher took the student to the walk-in dentist at Family Health and he wasn’t able to get in. They then went to the ER. He basically got antibiotics and pain meds to hold him until he could be seen. The ER doctor was not happy when he saw the shape this student was in. Unfortunately, this kind of call comes way too often. Most of the students and families that I work usually call for reactive services, not preventative ones. Seeing the dentist for preventative measures is so far removed from their day-to-day life that something needs to change for the health of these children.”

—Fargo Public Schools Homeless Liaison Jan Anderson

Source: Jan Anderson, Fargo Public Schools, testimony to Senate Health Services Committee on Oct. 9, 2014.
Oral Health Access Disparities/Challenges

- More than 49 million people live in dental shortage areas nationally.
  - Even with insurance, individuals living in dental shortage areas have difficulty accessing a dentist
- HRSA projects that by 2025, the shortage of dentists will more than double from 7,000 to 15,600.
- Half of all children on Medicaid (over 18 million) did not receive dental care in 2015.
- Nearly 2/3 of general dentists have no patients on Medicaid.


Oral Health Access Disparities/Challenges

- More than 1 out of 3 of Americans (115 million) have no form of dental insurance – public or private.
- In 2012 there were more than two million dental-related visits to hospital ERs nationally.
  - Most visits could have been addressed in a dental office
  - Cost for this care was approximately $1.6 billion

Sources: NADP (2015); Wall and Vujicic (2015); Allareddy et al (2014).
Proposed Solution: Advanced Practice Dental Hygienists

- A stakeholder group in North Dakota recommended several solutions:
  - Expand the scope of practice for dental hygienists
  - Use models such as Apple Tree Dental and Children’s Dental Services in MN (both of which use dental therapists)

- **SB 2354** introduced (ND Legislative Assembly)
  - Allows dentists to hire Advanced Practice Dental Hygienists (similar to mid-level medical providers)
  - Advanced Practice Dental Hygienists receive additional education and training on dental procedures such as filling cavities
  - Operate under the supervision of the dentist
  - Passed Senate Human Services Committee, but not full Senate
Initial Partners

- **Supporters:**
  - Multiple Legislators
  - North Dakota AARP
  - North Dakota Dental Hygienists’ Association
  - North Dakota Nurse Practitioners
  - The Pew Charitable Trusts

Endorsements In the Press

- *Your News Leader*
  - Some ND Lawmakers Push for More Dental Hygienist Training
    - Updated: Thu 8:47 PM, Feb 05, 2015

- *Inforum*
  - Proposed bill would ease shortage of dental care in rural ND, supporters say
    - By Patrick Springer on Feb 7, 2015 at 11:30 pm
Challenges

- Despite evidence of the quality of care and increased access in a neighboring state:
  - The opposition claims: lack of evidence for model
- Despite Commission on Dental Accreditation implementing standards of training and the Dean of the U of MN Dental School endorsement:
  - The opposition claims: advanced hygienists will be allowed to perform irreversible procedures
  - The opposition claims: advanced hygienists will not have enough supervision
- Despite evidence showing that nearly half of North Dakota counties have one dentist or none at all:
  - The opposition claims: North Dakota does not have a shortage of dentists

Misrepresentation of evidence

<table>
<thead>
<tr>
<th>Claims</th>
<th>Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Despite authorizing dental therapists in MN in 2009, Minnesotans still experiencing the same barriers to obtaining dental care</td>
<td>100% of the 64 dental therapists are either in dental shortage areas or 50% of their patients were underserved.</td>
</tr>
<tr>
<td></td>
<td>47% worked throughout the state outside of the Twin Cities metro area. Recent shift to more rural areas since 2014, when 69% worked in the Twin Cities.</td>
</tr>
</tbody>
</table>

Sources: Minnesota Department of Health (2016)
### Misrepresentation of evidence

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Many people who lack access to dental care also suffer from serious underlying oral and medical conditions that complicate the process of treating them. They only should be seen by a fully trained dentist.</td>
<td>The U of MN educates these dental providers and dentists side by side. Both must meet the same clinical competency on the dental procedures that both are qualified to perform.</td>
</tr>
</tbody>
</table>

Sources: Minnesota Dental Association (2013).

### Misrepresentation of evidence

<table>
<thead>
<tr>
<th>Claims</th>
<th>Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-level provider models are an “experiment”</td>
<td>Mid-levels are successfully employed in 50 other countries and have been part of the dental care team for nearly 100 years.</td>
</tr>
</tbody>
</table>

Sources: Nash et al. (2012)
More on education and scope...

• “...in MN, the therapists take the same exam as the dental students, limited to those procedures within their scope of practice. They take a large regional exam called CRDTS Central Regional Dental Testing Service; they only perform the procedures within their scope of practice and the examiners use identical grading criteria for dentists and for Therapists.”

  —Dr. Frank Catalanotto
  University of Florida School of Dentistry

Sources: Dr. Frank Catalanotto, Testimony to the Health Services Committee on July 27, 2016

Outcomes

• Bill was defeated in ND Senate

• The efforts of the stakeholder group and the issue, however, are not defeated.
Next Steps/Strategies

- Legislature’s interim health committee currently looking into dental access
- More education - who else can be helped and how
- Connect with Minnesota dentists currently using mid-levels—address financial considerations
- More personal stories from people (voters) about the impact and suffering caused by less access and less services

Final thoughts from former U.S. HHS Secretary
Dr. Louis Sullivan...

- “The reality is, if we are to meet the oral health needs of our citizens, we must consider new models of care. One proven model is that of the Dental Therapist. Similar to nurse practitioners and physician assistants in medicine, dental therapists are professionally trained, midlevel dental providers who can help people get the dental care they need. They support the work of a dentist and can work in different locations, often using telehealth technology, while under a dentist’s supervision.”

Sources: Dr. Louis Sullivan, testimony to the Interim Health Services Committee, April 13, 2016
Final thoughts from former U.S. HHS Secretary Dr. Louis Sullivan...

“Dental therapists are not a threat to dentists or, more importantly, to the quality of care provided to patients. Dental Therapists should be seen as an asset to a dental practice. They can bring increased revenue into a dental practice and free up dentists to focus on more complex procedures. Dental Therapists work under the supervision of a dentist. DTs are part of a care delivery team. Dental therapists have the potential to significantly improve access to care and transform how dental care is delivered and managed.”

Sources: Dr. Louis Sullivan, testimony to the Interim Health Services Committee, April 13, 2016
DENTAL THERAPISTS IN MINNESOTA:

Emerging Health Professions in MN
Licensed/certified + Reimbursed by Medicaid

- Community Health Workers (2007)
- Peer Support Specialists (2007)
- Dental Therapists (2009)
- Community Paramedics (2011 -12)
- Doulas (2013)
Definitions

- **Dental Therapists** - evaluative, preventive, restorative and minor surgical dental care under the direction of a dentist.

- **Advanced Dental Therapists** - After 2,000 hours, dental therapists eligible for certification as ADTs.
  - May provide additional services - oral evaluation and assessment, treatment plan formulation, non-surgical extraction of certain diseased teeth
  - Also practice under the supervision of a dentist, but dentist need not be on site or see patients before they receive care.

- **Education** - Either a Bachelors or Masters degree; Advanced Dental Therapists need a Masters degree.
  - Two education programs
  - Many are also dental hygienists.

History Recap

- **2008**  
  *Leg. charters Work Group*  
  International site visits

- **2009**  
  *Licensing law, education begins*

- **2011**  
  *First graduates, practice begins*

- **2014**  
  *First state evaluation published*  
  2012-13 data

- **2016**  
  *Education changes*  
  Dual dental hygiene/dental therapy at both schools
Early Impacts of Dental Therapists in Minnesota

Minnesota Department of Health
Minnesota Board of Dentistry
Report to the Minnesota Legislature 2014

Methods

• Dental therapist licensing data
• Survey of 1,382 dental therapist patients
• Interviews with clinics employing dental therapists
• Clinic administrative data
• Oral health-related emergency room usage data
Findings

- DT workforce is growing & appears to be serving low-income, uninsured and underserved patients.
- DTs appear to be practicing safely. Clinics report improved quality and high patient satisfaction.
- Clinics with DTs seeing more new patients, most underserved.
- DTs have made it possible to decrease travel time and wait times for some patients, increasing access.
- Benefits include direct costs savings, team productivity, improved patient satisfaction and lower fail rates.

Findings, continued

- Savings making it more possible to expand capacity.
- Start-up is varied: employers expect continuing evolution.
- Most considering hiring additional DTs after 1 year.
- DTs have potential to reduce unnecessary ER visits.
- With same rates for DDS & DT, not necessarily an immediate savings to the state on each claim paid; however, differential between state rates and clinics’ lower costs for DTs appears to be contributing to more patients being seen.
Health Care Workforce Reports

In 1993, the Minnesota Legislature mandated collection of a variety of information from many licensed or registered health care providers. Working with Minnesota’s licensing boards, the Office of Rural Health and Primary Care collects practice data for health professionals in conjunction with regular licensing renewals.

Survey response rates vary between 60 percent and 90 percent, depending on the profession surveyed. Data include major professional activities; hours per week in each major professional activity; practice location and setting; specialties; race and ethnicity (added in 2005).

Reports

- Dental Assistants
- Dental Hygienists
- Dental Therapists
- Dentists
- Licensed Practical Nurses
- Pharmacists, Pharmacy Technicians and Pharmacies
- Physical Therapists
- Physical Therapist Assistants
- Physicians
- Physician Assistants
- Registered Nurses
- Respiratory Therapists
- Social Workers
- Workforce Demand
- Other professions and reports with multiple professions

---

**Minnesota’s Dental Therapist Workforce, 2015**

**Highlights from the 2015 Dental Therapist Workforce Survey**

**Overall**

Dental therapists were first authorized to practice in Minnesota in 2000, with the Minnesota Board of Dentistry licensing its first dental therapist in 2001. Dental therapists are a member of the dental team providing preventive and basic restorative services. By law, they are required to practice in settings serving primarily low-income, uninsured and underserved patients, or practices in areas designated as Health Professional Shortage Areas (HPSAs). According to the Minnesota Board of Dentistry, as of October 2015 (at the start of the survey process), there were 55 actively licensed dental therapists, of which 15 are advanced dental therapists (ADTs) who have a more advanced scope of practice. As of August 2016 there were 54 dental therapists of which 20 are ADTs.

**Demographics**

- **Sex**: In general, health care professions tend to be female-dominated, including dental therapy. Ninety percent of Minnesota dental therapists are female.

- **Age**: Dental therapy is a young profession, with 82 percent of dental therapists age 44 and under. The average age of dental therapists is 32.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>44 and under</td>
<td>32%</td>
</tr>
<tr>
<td>35-44</td>
<td>16%</td>
</tr>
<tr>
<td>24 and younger</td>
<td>52%</td>
</tr>
</tbody>
</table>

**Race**: The majority (93.7 percent) of dental therapists indicated they were white, typical of racial patterns among most health care professionals. The second most common race for dental therapists is Asian with 14 percent in one of three Asian categories (Southeast Asian, South Asian, or some other Asian race). Twelve percent are more than one race.

**Race of Minnesota Dental Therapists**

Minnesota’s Dental Therapist Workforce, Published August 2016
Dental Therapist Survey

- November to December 2015
- Based on 51 actively licensed dental therapists
- 83 percent response rate

Dental Therapy Workforce

As of August 2016:

- 64 Dental therapists
- 26 Advanced dental therapists

Data from Minnesota Board of Dentistry
Practice Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>25</td>
</tr>
<tr>
<td>Community based clinic/outreach clinic</td>
<td>23</td>
</tr>
<tr>
<td>FQHC</td>
<td>8</td>
</tr>
<tr>
<td>HMO</td>
<td>4</td>
</tr>
<tr>
<td>Mobile dental clinic</td>
<td>2</td>
</tr>
<tr>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td>DSO</td>
<td>1</td>
</tr>
</tbody>
</table>

Data from Minnesota Board of Dentistry, August 2016: only those with work setting information

N = 58
May work at more than one location

Work Status

- Working in a position related to my license: 86%
- Not working in a position related to my professional license: 14%

- If not working, 3 are working in another field, 1 is seeking a DT position and 1 is temporarily not working

MDH Minnesota Department of Health
### Hours Worked

<table>
<thead>
<tr>
<th>Hours Worked</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>3%</td>
</tr>
<tr>
<td>16-35</td>
<td>41%</td>
</tr>
<tr>
<td>36+</td>
<td>57%</td>
</tr>
</tbody>
</table>

### Changes Since 2014

- More dental therapists were working in 2015 (86 percent) compared to 2014 (74 percent).
- Dental therapists are working more hours in 2015
  - In 2014, 47 percent worked 36 or more hours compared to 57 percent in 2015
Number of Locations

- One: 65%
- Two: 22%
- Three or more: 13%

Patient Care

- More than three-quarters: 89%
- Between a quarter and a half: 8%
- Up to a quarter: 3%
Additional Licenses/Certifications

- ADT: 28%
- In Process of ADT: 42%
- Dental Hygienist & DT: 36%

Career Satisfaction

- The survey asked about satisfaction both in the last 12 months and career overall

  Career in last 12 months:
  - Very Satisfied: 40%
  - Satisfied: 49%
  - Dissatisfied: 6%
  - Very Dissatisfied: 6%

  Career overall:
  - Very Satisfied: 46%
  - Satisfied: 43%
  - Dissatisfied: 6%
  - Very Dissatisfied: 6%
Employer findings
Excerpt
From SIM Grant DT Toolkit, 2016

- **Clinics see an economic benefit of hiring DT/ADTs.**
  - Allows dentists to delegate duties and focus on advanced procedures
  - DTs are reimbursed at the same rate but are paid less than dentists.
  - DT/ADTs can be equally as productive as dentists but do not get paid the same.
  - Very helpful to fill in when dentists are out.
  - Roughly $62,500 is saved annually per ADT employed.

- **There may be a lag in time before economic benefits are realized while new hires or new graduates are training.**
  - Most saw adequate production levels after 6 months, which is comparable to hiring a new dentist.

**Other Research**

- **Dental therapy practice patterns in Minnesota: a baseline study.** Community Dental Oral Epidemiology 2016.
  - Dental therapists are treating a high number of uninsured and underinsured patients, suggesting that they are expanding access to dental care in rural and metropolitan areas of Minnesota. Dentists appear to have an adequate workload for dental therapists and are delegating a full range of procedures within their scope of practice.

- **Dental Therapy Toolkit.** MN Department of Health, 2016.
  - Completed topics include a literature review, environmental scan, dental therapist and advanced dental therapist interviews, current employer interviews, potential employer interviews, and summary of dental therapy regulatory and payment processes.
  - Final Toolkit, due in October, will also cover patient acceptance, office staff acceptance, dentist-dental therapist relationships, reimbursement, oral health team integration, economic benefits, etc.

- **Rural Private Practice case studies.** Delta Dental of Minnesota, forthcoming.
Ongoing

- **Board of Dentistry**
  - Manages licensing and regulatory process

- **Health Department**
  - Routine data collection and analysis – license/survey data
    - Same as dentists, hygienists, assistants
    - Emerging professions support
    - Loan forgiveness for dental therapists

- **Education programs**

- **Profession**
  - MN Dental Therapy Association
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