CONNECTING KIDS TO COVERAGE NATIONAL CAMPAIGN

Oral Health Webinar Attendee Questions – Sept. 26, 2013

Questions for Dr. Lee

Q1: Might Dr. Lee describe how Connecticut informs HUSKY-eligible families about how they can access dental services, particularly families with infancy-aged offspring? – *Robyn Hoffman, QI Consulting Manager, Xerox/RI EOHHS*
A1: Dental health benefits are described along with other HUSKY Program benefits at www.huskyhealth.com. The Connecticut Dental Health Partnership (CT DHP; the state's administrative services contractor: Benecare, Inc.) sends out brochures to new members. CT DHP follows up with families annually if they haven't received care. CT DHP has a Facebook account and maintains a webpage. CT DHP sends community-based Dental Health Care Specialists to visit community-based organizations and health fairs around the state whenever the opportunity arises. CT DHP currently conducts a state-sponsored pilot project to address the comprehensive oral health needs of pregnant women and infants in two cities; with a grant from HRSA, this project will expand to 15 targeted cities over the next four years.

Q2: You had mentioned that part of the enhancements to the program were that dental care was "carved out." Can you expound on what this looked like? – *Krysta Titel, Public Health Educator, San Joaquin County Public Health Services*
A2: From 1995 to 2008, children and families who qualified for HUSKY Program coverage (Medicaid, CHIP) were enrolled in managed care (mandatory, statewide enrollment). The State of Connecticut contracted with insurers who managed their care and were at risk for all medical, dental and ancillary services for their members. Connecticut paid these insurers per member per month and held them accountable for providing all necessary health care, including EPSDT services. This managed care arrangement did little to increase access to dental care and utilization. Under the terms of a law suit settlement in 2008, Connecticut agreed to "carve-out" dental care from managed care. This meant that managed care plans were no longer "at risk" for dental care expenditures and that the Medicaid agency would pay fee-for-service for dental care at the enhanced rates that were part of the settlement. The state also contracted for administrative services, including provider recruitment and provider relations, outreach and education of members, targeted initiatives to increase utilization (see answer #1), and program monitoring.

Q3: What does it mean that 2008 Connecticut dental services were "carved out of managed care?" – *Marlene Barnett, Program Coordinator, MDPH Office of Oral Health*
A3: See answer #2.

Q4: Can you speculate why Hispanic parents/children utilize services more than other ethnic groups? – *Marjorie Chema, Dental Consultant; VA Department of Medical Assistance Services*
A4: I do not know why utilization is higher among Hispanic parents and children (largely Puerto Rican in Connecticut), but I certainly think it warrants further investigation. I would be interested in knowing whether other states have noticed this difference in their Medicaid and CHIP programs.

Q5: Are Connecticut reimbursement increases supported by state general funds? – *Cheryl Terpak, Consultant, CA Dept. of Public Health*
A5: Yes, with the usual 50% FMAP.

Questions for Dr. Chi

Q6: Do you see a benefit with adding a dental hygienist to the medical staff to increase the number of baby first dental visits? – *Barbara Thompson, Dental Hygienist, Winning Smiles, Inc.*
A6: I think there are potential benefits associated with having a dental hygienist as part of a medical practice. The hygienist could refer infants and provide anticipatory guidance and direct preventive care, though the scope of practice would depend on state practice laws.

Q7: Please expand on the relationship between WBV and first dental visit and a child's subsequent oral health. – *Lynn Mouden, Chief Dental Officer, CMS*
A7: Our study focused on WBVs and first dental visits. The number of WBVs during the first year of life was not associated with earlier first dental visits. We interpret this as there being opportunities to improve the advice and education medical providers are giving parents regarding first dental visits. Our study did not examine subsequent outcomes associated with earlier first dental visits. We would hypothesize that for most children earlier first dental visits would lead to subsequently better oral health outcomes. We plan to examine subsequent oral health outcomes in future studies.

Q8: Do you know if there were any messages given to pregnant mothers about the importance of early dental visits? Or even if parents were given any messages during the early WBVs? – *Christine Farrell, Oral Health Director, MI Dept. of Community Health*
A8: We assume all health providers practice according to the American Academy of Pediatrics guidelines, but were not able to verify this.

Q9: Are physicians in your study compensated for any dental services in conjunction with the well-child visits? – *Lee Serola, President, BeneCare Dental Plans*
A9: In Iowa, physicians are reimbursed up to three times per year for fluoride varnish treatments provided during well baby visits.

Q10: Was there any way to determine how many dentists were willing to see 12-month-olds. Our community dentists continue to recommend 3-years-old and turned away pediatrician referrals. – *Louise Iwaishi, Director, Hawaii MCH LEND Program*
A10: Unfortunately, this is common. We could not assess willingness of dentists to see 12-month-olds.

Q10: Could we receive a link to any written materials about the OR program that uses motivational messages with pregnant women? – *Robyn Hoffman, QI Consulting Manager, Xerox/RI EOHHS*
A10: Yes. The following reference is available for free on the web – Milgrom P, Riedy CA, Weinstein P, Mancl LA, Garson G, Huebner CE, Smolen D, Sutherland M. Design of a community-based intergenerational oral health study: "Baby Smiles". BMC Oral Health. 2013 Aug 6;13(1):38.

Questions for Dr. Cheng

Q11: What have been the most successful strategies Maryland has used to promote oral health care for pregnant women? – *Marcia Manter, Community Development Specialist, Oral Health Kansas*
A11 (from Dr. Cheng): At the Maryland Department of Health and Mental Hygiene, our office (maternal and child health) has partnered very closely with the Office or Oral Health. We collaborated on a short provider guide for dentists and ob/gyns about oral health during pregnancy to confirm the safety and importance of routine oral health visits and habits. This document was sent out recently to all ob/gyns and oral health providers in the state along with the 2013 ACOG oral health committee opinion and a promotional magnet with contact information for referrals to local dentists. We have also partnered together on many radio and TV spots, articles, and presentations.
A11 (from CMS): In addition to these efforts, the Maryland Board of Dental Examiners mailed a copy of the National Consensus Statement on Oral Health Care During Pregnancy to every licensed dentist in the state.

Q12: Do you think OB/GYN training will/could/should change to include oral health competencies for OB/GYNs? – *David Krol, Senior Program Officer, RWJF*
A12: I believe that the ACOG committee opinion was the initial step in helping ob/gyns to think about oral health. Training should include a basic knowledge of oral health (as discussed in the committee opinion) and how to routinely assess for oral health during pregnancy and annual exams. Emphasis should be on the safety of dental visits during pregnancy as well as the importance of oral health to general health. Most importantly, ob/gyns should establish relationships with their oral health providers, just as they do with other medical specialists.

Questions for CMS

Q13: As a placeholder for future oral health webinars, are you aware of any states or territories that require an oral health exam to be conducted at the time of the physical exam for school entry and at any other intervals when a school physical is required at higher grade levels? – *Robyn Hoffman, QI Consulting Manager, Xerox/RI EOHHS*
A13: Yes. At least seven states require an oral health exam prior to school entry: CA, IA, IL, KY, NY, PA, RI. More information is available here: http://www.nasbe.org/healthy_schools/hs/bytopics.php?topicid=4100.

Q14: Will an oral screening, risk assessment, fluoride varnish application and referral by a medical provider (MD, CRNP, DO) count toward the 10% increase in utilization? – *Bonnie Magliochetti, Program Director, Healthy Teeth Healthy Children*
A14: These activities are counted on line 12f of the CMS Form 416 report as oral health services. They are not counted as preventive dental services on line 12b of the Form and thus they will not count toward the 10% increase goal. CMS values these activities very much, but due to data constraints we are unable to do so. The data constraints: Lines 12b and 12f each represent an unduplicated count of children who received a service in that particular category. If we combined the counts in those two lines the combined count would no longer be unduplicated. That is, a particular child could be counted once on line 12b and again on line 12f and thus be counted twice in the combined count. We are unable to compute a meaningful percentage with a duplicated count of children. CMS will be reporting separately on states' progress on line (providing oral health services), but there will not be a specific goal.

Q15: Do you know if New Mexico tracks Native Americans specifically or is it just inclusive of all children in the state? – *Catrina Louis, Health Coordinator, Haak'u Learning Center*
A15: CMS does not ask states to report their dental data broken down by ethnicity. The person to contact in New Mexico to see if they break the data down for their own purposes is Devi Gajapathi.

Q16: What percentage of pediatricians conducts a risk assessment during the well-baby visits? – *Marielle Pariseau, Founder/CEO/Dentist, Shaping the Future of Dentistry*
A16: CMS does not track this information, but it is our understanding that it is a small percentage of pediatricians at this time. The American Academy of Pediatrics' Bright Futures practice guidelines strongly recommend it at specific ages and intervals, but changing practitioner behavior is a challenge. Every state chapter of the American Academy of Pediatrics (AAP) has a trained Oral Health Advocate whose job it is to work on this with pediatricians in their state. You can find a list of the state AAP Oral Health Advocates here: http://www2.aap.org/oralhealth/COHA.html

Q17: Is there oral care for pregnant women in Texas? – *Mandy Reyna, ADRC Case Manager, North Central Texas Council of Governments*
A17: Quite a few states provide at least some dental coverage for pregnant women older than 21 enrolled in Medicaid, but Texas is not one of them. See answer #18.

Q18: Has coverage of dental benefits for women during pregnancy and post-partum increased earlier first dental visits? Which states provide such benefit? – *Alan Matsunami, Executive Director, Community Case Management Corp*
A18: The following states offer some level of dental coverage to adults (older than 21) enrolled in Medicaid, including pregnant women: AK, AR, CO, CT, DC, FL, GA, ID, IN, IA, KY, LA, ME, MA, MD, MI, MN, MT, NE, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SD, VT, WI. Pregnant women age 21 or younger get full dental benefits through EPSDT, the Medicaid benefit for children and adolescents. Unfortunately, CMS is not able to tell you at this juncture which of these states offers dental benefits to pregnant women post-partum. And we are not aware of research that addresses your question about a connection between a pregnant woman having dental coverage and the age at which she first takes her baby to the dentist.

Q19: How many states cover Medicaid dental services for pregnant women over age 21? – *Lynn Mouden, Chief Dental Officer, CMS*
A19: See answer #18.

Q20: Can you tell me how many states have Medicaid dental coverage specifically for adult pregnant women? – *Jodie Condon, Perinatal Oral Health Coordinator, Michigan Dept. of Community Health*
A20: See answer #18.

Q21: Has anyone done studies demonstrating usage (or lack thereof) that focuses on distance traveled for pediatric dental care – especially for rural communities? – *Nina Machado, E.D., First 5 Amador*
A21: We are not aware of any such research.

Q22: Does the increase in health coverage also mean an equal increase in dental coverage or is that just medical insurance for kids outside Medicaid and CHIP? – *David Krol, Senior Program Officer, RWJF*
A22: Under the Affordable Care Act, those states that choose to expand Medicaid to higher income adult populations can include dental benefits in their benefit package. If they do so they will receive the 100% federal funds for that dental care, but only for newly eligible adults. States that want to include dental coverage in the benefit package for newly eligible adults are not required to also cover dental benefits for previously eligible adult populations. We don't have exact figures but we believe some states are planning to include dental benefits for adults newly eligible under the Medicaid expansion.