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Oral Health Action Plan Template
For Medicaid and CHIP Programs

STATE: ALASKA
AGENCY: DIVISION OF HEALTH CARE SERVICES
PROGRAM NAME: MEDICAID-DENTAL-FEE FOR SERVICE
PROGRAM TYPE REFLECTED IN THIS TEMPLATE:
____MEDICAID
____CHIP
__X_COMBINED MEDICAID /CHIP

STATE CONTACT: BRAD WHISTLER, DMD
TITLE: DENTAL OFFICIAL
AGENCY: DIVISION OF PUBLIC HEALTH
PROGRAM: MEDICAID-FEE FOR SERVICE
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INSTRUCTIONS

It is best to complete separate templates for each of your State's Medicaid and CHIP dental programs. If your State has a combined Medicaid and CHIP dental program, or if you are implementing common improvements across both Medicaid and CHIP dental programs, you may complete a single template for both programs.

ORAL HEALTH INITIATIVE GOALS

1) To increase the proportion of children ages 1-20 enrolled in Medicaid or CHIP for at least 90 consecutive days who receive a preventive dental service by 10 percentage points over a five-year period. Target year is FY 2015.

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2) To increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period. Target year has not yet been determined.

TYPE OF DENTAL DELIVERY SYSTEM

SERVICE DELIVERY FOR DENTAL	Calendar year implemented	Number of children currently enrolled	If a new dental delivery system was launched since 2005, please explain why the new dental delivery system model was chosen.
Fee For Service			
Administered by the State agency, including CARVED OUT of medical managed care	1972	96,693 (FFY2012)	N/A
Administered by a contractor, including CARVED OUT of medical managed care			
Administered by a contractor or contractors, but CARVED IN to medical managed care			
Other FFS (describe)			
Dental Managed Care			
CARVED IN to medical managed care			
CARVED OUT of medical managed care			
Other dental managed care (describe)			

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"PARTICIPATING" DENTAL PROVIDERS

"Participating"= submitted at least one claim. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR:	NUMBER LICENSED IN STATE	Primary Dental Delivery System Type: Fee For Service # PARTICIPATING	Primary Dental Delivery System Type: Fee For Service # ACTIVE	Secondary Dental Delivery System Type: # PARTICIPATING	Secondary Dental Delivery System Type: # ACTIVE
DENTISTS (All Dentists) (i)	SFY2012	661 (457)	415 (ii)	340 (ii)		
DENTAL HYGIENISTS (i)	SFY2012	609(498)	N/A	N/A		
OTHER DENTAL MID-LEVEL (iii)	July 2012		12 (iv)	6 (iv)		
DENTAL SPECIALISTS (enumerated by type) (v)	SFY2012	Pediatric Oral Surgeon Orthodontist Prosthedontist Endodontist	26(10) 18(2) 10(3) 6(4) 4(2)	23(10) 17(2) 9(3) 6(4) 2(1)		

(i) The second number indicates the dentists/dental hygienists that list an in-state address on their license.

(ii) Includes 31 participating and 11 actively participating out-of-state dentists (payment went to an out-of-state address)

(iii) Dental health aides (including dental health aide therapists) are not licensed by the state (certification offered under federal provisions) – July 2012 there were 24 Primary Dental Health Aides, 11 Expanded Function Dental Health Aides and 27 Dental Health Aide Therapists.

(iv) 12 participating and 6 actively participating DHATs based on fee-for-service reimbursement (not the Tribal encounter rate), may not include all billings as some could be under dentists overseeing the DHATs and all billings for primary dental health aides would be under the dentist overseeing the PDHA.

(v) Alaska does not license as specialists however there are approximately 27 Pediatric Dentists, 22 Oral Surgeons, 26 Orthodontists,and 14 Endodontists. The second number above indicates the number of specialists that were working with Tribal programs (direct hire dental specialists or specialists where the payment went to a Tribal organization)

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"Participating"= submitted at least one claim for oral health services. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR:	NUMBER LICENSED IN STATE	# PARTICIPATING	# ACTIVE
MDs* (1,617 MD + 156 DO)	2012	1,773	0	0
NURSE PRACTITIONERS*	2012	552	0	0
PHYSICIAN ASSISTANTS*	2012	396	0	0
OTHER NON-DENTAL MID-LEVEL PROVIDERS**	2012		0	0
Number licensed above only lists those with in-state addresses – participating and active relate to oral health services. *MD/NP/PA can bill for D0145 and/or D1206 if they have completed a training and have documentation of the training. **Community Health Aide Practitioner) – CHA III, IV & Practitioner can bill for D0145 and/or D1206 if they have completed a training and have documentation of the training. The CHA/Ps are not licensed by the state but practice under certification. July 2013 there were 68 CHA III, 34 CHA IV and 199 CHP.				

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Describe any access challenges in your State, such as rural areas, dental health professional shortage areas, etc.

Alaska children living in rural/remote areas of the state face barriers to dental care include geographic isolation (access by air and/or marine transportation), small population size (won't support a dental practice so often served with itinerant dental services), Native dietary changes to a more western diet (e.g., frequent ingestion of sugar sweetened beverages) and lack of access to fluoridated drinking water (largely infrastructure issues in remote Alaskan villages). There is also high turnover in dental providers working for the regional Native health corporations. Alaska Native children may not be enrolled in Medicaid when services are provided in the village (transportation need for dental/medical services is often the stimulus for parents to get children enrolled/re-enrolled) – this aspect is important for documenting preventive dental services, including sealants, with Medicaid claims data.

Larger urban areas (e.g., Fairbanks, Juneau and Palmer) have voted against continued water fluoridation over the past six years and opponents to water fluoridation have been active in other communities (e.g., Anchorage).

Under reporting of dental sealant utilization from Medicaid claims data is significant.

Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.

Categories of Activities	Categories of Activities Underway or Planned
Education/outreach to dentists, dental hygienists, and state/national dental associations	The Oral Health Program will work to inform/educate Tribal Health Organization dental programs on current utilization of preventive dental services and dental sealants by region to encourage increased utilization. The Oral Health program will also work to inform other dentists through the Alaska Dental Society, Alaska State Dental Hygienists' Association and American Academy of Pediatric Dentistry – Alaska Chapter through the organizations participation in the Alaska Dental Action Coalition.

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Categories of Activities	Categories of Activities Underway or Planned
Education/outreach to pediatricians, family practitioners and state/national medical associations	The Oral Health Program and Alaska Native Medical Center has offered in-state trainings on oral evaluation and fluoride varnish and will continue to look for opportunities to educate physicians, nurse practitioners and physician assistants on these services as part of well child exams with young children. Medicaid program will discuss allowing delegation of provision of fluoride varnish by a nurse if the supervising MD/NP/PA has completed the required training.
Education/outreach to beneficiaries	Medicaid program provides educational newsletters to parents/caregivers of enrolled children which includes information on accessing dental care.
Coordination with Federally Qualified Health Centers	The Oral Health Program has coordinated with FQHCs in urban areas and/or communities on the road system (Anchorage, Fairbanks and Talkeetna) to implement school dental sealant programs in schools with high percentages of low-income children (e.g., where 50% or more of children in the school are eligible for the "Free and Reduced School Lunch Program) – the services have been provided under contracts but plans are to shift towards billing Medicaid for enrolled children.
Undertaking administrative simplifications	The Medicaid program adopted the ADA claim form as the standard for claims processing, however electronic billing software still has variations in that claim form – working to resolve this issue once the new MMIS is operational. Medicaid paid for fiscal agent dedicated staff to assist in resolving claims payment issues with dental providers and has a "pay and chase waiver" to reduce dentist office time in collecting 3rd party payment for Medicaid eligible. The Medicaid program is encouraging use of electronic billing with faster claim payment and electronic deposit of funds for those using electronic billing. Xerox, fiscal agent,

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Categories of Activities	Categories of Activities Underway or Planned
	includes information on electronic claims payment with training on the new MMIS. New system has a GUI interface and will allow some corrections of edit problems prior to electronic submission of claims – this will reduce claims denied during processing.
Using electronic health records and/or supporting dental providers in their efforts to qualify for meaningful use incentive payments	- See information on Electronic Dental Records on page 16 -
Coordination with Maternal and Child Health (MCH) Title V programs (Title V is the Federal/State program focused on assuring the health of all mothers and children, and Children with Special Health Care Needs (CSHCN).	The Medicaid Program does collaborate with the MCH Section (Women's, Children's and Family Health) The Oral Health Program (OHP) is in WCFH. Medicaid has participated in past CYSHCN dental action plan development – which spoke to Medicaid changes that have been implemented (Medicaid adult dental services for adults with disabilities and the need to increase Medicaid dental reimbursement that had largely been frozen during the 1999-2007 period). The OHP has provided continuing education workshops for dentists/dental hygienists on treating CYSHCN in the dental office (most recently in July 2013). OHP staff coordinates the specialty clinics for children with oral clefts. Main issues remaining include: 1) general dentists seeing medically complex children and/or children with severe disabilities; 2) general dentists taking medically complex adults and/or adults with severe disabilities (those that have aged out of a pediatric dental practice but no dentists taking referrals); and 3) dental access for CYSHCN living in more rural/remote areas of the state.
Collaboration with dental schools and dental hygiene programs	Limited – Alaska does not have a dental school. There are dental hygienist programs at the University of Alaska, Anchorage and University of Alaska, Fairbanks – the Medicaid program has not actively worked on collaboration with these programs (Anchorage and

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Categories of Activities	Categories of Activities Underway or Planned
	Fairbanks have not faced issues with lack of participating dentists.)
If your State is a CHIPRA quality demonstration grantee, describe how you are coordinating activities with those being undertaken under the CHIPRA demonstration.	The Alaska Department of Health and Social Services (DHSS) is collaborating with Oregon and West Virginia on the CHIPRA Quality Demonstration Project. This tri-state project, called T-CHIC, is funded by USDHHS CMS and is a medical home pilot initiative to identify and evaluate methods for expanding access to EPSDT services for children and adolescents enrolled in Alaska Medicaid and Denali KidCare. The medical home is defined in terms of addressing primary care needs and coordinating EPSDT services, (including dental, behavioral and other needs) of enrolled children. The T-CHIC project will: • Test measures of quality of children's care that have been proposed by the federal government (24 Recommended Core Set of Children's Health care Quality Measures for Voluntary use by Medicaid and CHIP Programs); • Develop, adopt and/or improve Health Information Technology, Electronic Health Records (EHR), and participation in Health Information Exchanges (HIE); and • Demonstrate the effectiveness of practice based models for improved care for children. The three clinical demonstration sites in Alaska are working toward patient centered medical home as described by seven core competencies, based on the NCQA PCMH standards. Each clinical grantee site is working to increase coordination of care, screening, identification of children with special health care needs, patient and family involvement; patient education and engagement materials about medical home; developing shared care plans with families; managing and

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Categories of Activities	Categories of Activities Underway or Planned
	tracking tests, referrals and outcomes; coaching patients and families; addressing sustainability in the practices; reporting on a subset of CMS core quality measures; and improving Health Information Technology, Electronic Health Records (EHR), and participating in the Health Information Exchanges (HIE) when it becomes workable. "Total eligibles receiving preventive dental services" is one of the CMS core quality measures that has been assessed by the Alaska TCHIC sites for its utility, relevance, and feasibility of reporting. Although important, this measure was not included in the subset of Core measures that the T-CHIC practices recently reported on. The T-CHIC project is working with Medicaid (CHIP is a Medicaid expansion in Alaska) and the State Oral Health Program with staff attending T-CHIC internal stakeholder meetings when needed. The Alaska practice sites already have oral health as part of their direct services or have referral systems in place. The project will be strengthening coordination with oral health services.
Changing or increasing reimbursement rates or approaches	The Alaska Medicaid program attempts to keep reimbursement at 80% of UCR (UCR = median fee). Reimbursement rates are increased annually based on changes in Anchorage CPI (so long as funding is available for the reimbursement increase)
Other Changing dental EPSDT guidance	The Division of Health Care Services (DHCS) and Oral Health Program will convene an advisory group to discuss changing EPSDT guidance to an age one dental exam or earlier if medically necessary (currently at age 3 or earlier if medically necessary) in SFY2014 with plans to adopt the change in guidance within the year. If adopted this has potential to increase preventive dental services in children under age 3 (typically a low-level of utilization of preventive services in this age group across the state.)

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Categories of Activities	Categories of Activities Underway or Planned
Other	
Other	

Other Oral Health Improvement Initiatives

Has your State undertaken any initiatives within the last 5 years to increase the number of children who receive oral health or dental services? If so, please describe those activities.

Expanding dental services to include preventive and routine restorative dental care for adults enrolled in the Medicaid program (implemented April 2007 and reauthorized in 2009). One aspect of support for these services was information that adults with dental coverage are more likely to take their children in for dental care.

Increasing dental reimbursement to encourage broader participation of dentists in the Medicaid/Denali KidCare Program. Dental reimbursement had largely been frozen in the 1999-2007 period – in 2008 and 2009 the Medicaid program received legislative authorization to increase Medicaid dental reimbursement. Over the two years the Medicaid program worked to get reimbursement at or near the 80% UCR level (UCR = median fee charged for the dental procedure in the Medicaid program). Subsequently the department adopted regulations to annually review (and possibly increase) Medicaid dental reimbursement based on changes in Anchorage CPI (increased so long as funding is available).

What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe.

Dental changes for adults enrolled in Medicaid: It is not clear that the change assisted with child dental utilization. Much of the adult services have been related to denture services and in the older age group of adults. Many of the Tribal Health Organization dental programs limit services to adults based on the program capacity and the priority for meeting child dental needs.

Changes in Medicaid dental reimbursement: The Division of Health Care Services analyzed changes in dentist participation following the 2008 dental reimbursement increase and did not find significant increased participation. However, with the increase in 2009 and subsequent increases there has been increased dental participation in the program and some of this is reflected in the increased child dental utilization on the FFY2011

and FFY2012 CMS 416 reports. However, for these periods other factors may have contributed to the increased child utilization besides the reimbursement increases including: 1) the national recession period in which Alaska has seen increases in dentists coming to Alaska (both for Tribal program vacancies and for private practice); 2) several new pediatric dentists practicing in Alaska as a result of the Alaska Native Medical Center (Southcentral Foundation) hospital-based pediatric dental residency program; 3) possibly some aspects of the national recession and slow-down in private dental practice in Alaska with more participation in Medicaid. Additionally, attention to the Tribal Dental Health Aide Program, development of FQHC dental programs and other factors have served to increase awareness of dental access issues especially for underserved populations (including Alaska Natives and low-income children and adults).

If the activities did not achieve the results that you had expected, please describe the lessons learned.

Dental Data Measurement

Does your State compute or report the National Committee for Quality Assurance's (NCQA) HEDIS dental measure or a modification of it? (Dental care: percentage of members 2 through 21 years of age who had at least one dental visit during the measurement year." Web site: http://www.qualitymeasures.ahrq.gov/content.aspx?id=47230&search=dental) If yes, describe how that data compares with the data submitted on line 12.a of the CMS-416 and/or Section III, G.1.a. of the CHIP Annual Report (Total Enrollees Receiving Any Dental Services). -NO-

If the HEDIS measure result differs from the result reported on CMS-416, line 12.a, or the CHIP Annual Report, Section III, G.1.a., please explain why you think there is a difference.

If you use a modification of the HEDIS measure, please describe the modification. N/A

R**eimbursement Strategies: What are your current reimbursement rates for the following 10 procedures for services provided to children eligible for Medicaid and CHIP? Please describe any increases or decreases in these reimbursement rates that have occurred in the last five years.**

July 2008: The Division of Health Care Services received legislative authorization to increase Medicaid dental reimbursement based on finding funds within the existing Medicaid budget.

July 2009: The Division of Health Care Services received legislative authorization (and approximately $2M in appropriations) to increase Medicaid dental reimbursement with a focus on CDT codes that had not been increased with funds available in 2008.

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The 2008 & 2009 increases set dental reimbursement at or near the 80% UCR reimbursement (UCR=median fee as reflected in claims submitted to the Medicaid/Denali KidCare Program).

2009: Regulations adopted in 2009 provided for annual **review** of dental reimbursement by the department based on changes in Anchorage CPI (dental reimbursement increase based on that method if available funding permits). Reimbursement changes annually since July 2010. Dental rate increased are done based on program budget constraints.

Rates below were set for FY2013 (Revised 8/9/2012) and will remain in effect for SFY2014.

Codes	Current Reimbursement Rates	Current Fees	Plans to Adjust
D0120	Periodic Oral Exam	$48.86	Reviewed annually based on Anchorage CPI (adequate Medicaid funding permitting)
D0140	Limited Oral Evaluation, problem focused	$65.15	As above
D0150	Comprehensive Oral Exam	$66.98	As above
D0210	Complete X-rays with Bitewings	$89.08	As above
D0272	Bitewing X-rays – 2 films	$40.72	As above
D0330	Panoramic X-ray film	$99.36	As above
D1120	Prophylaxis (cleaning)	$64.95	As above
D1203	Topical Fluoride (excluding cleaning)	$29.32	As above
D1206	Topical Fluoride Varnish	$28.50	As above
D1351	Dental Sealant	$49.68	As above

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Efforts Related to Dental Sealants

Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
Do you encourage or plan to encourage dental providers in your State to provide dental sealants?	Yes _X___ No ____
If yes, how do you communicate that information to providers?	Comment: Provider updates through the fiscal agent is one aspect of provider communication. Most of the communication for increasing preventive dental services and sealant utilization will be done by the Oral Health Program in direct communication and/or presentations with Tribal Health Organization dental program directors and pediatric dentists. Additionally, the Oral Health Program will attempt to encourage increased private dental participation for children enrolled in Medicaid through communication with the Alaska Dental Society (ADS is a member of the Alaska Dental Action Coalition).
Have you seen an increase in the number of children receiving sealants over the last year or years? If yes, please explain.	Yes ____ No _X__ Comment: There was a slight increase in the number of children with billed sealants each year (paid claims) during the FFY2010 – FFY2012 period but the percentage of children with billed sealants of those continuously enrolled for 90 continuous days or longer dropped slightly. Dental assessment data of 3rd graders by the Oral Health Program done in the 2007/2008 and 2010/2011 school years found a decrease in sealants in children reported to be eligible for Medicaid/CHIP from 57% in 2007/2008 to 44% in 2010/2011 (part of the decrease was related to a change in

Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
	sample design with fewer rural/remote school in the same and Alaska Native third-graders having a higher sealant utilization than other racial/ethnic groups. There also were lower percentages of children with active parental consent in urban schools for this project.)
Does your state support school-based or school-linked dental sealant programs?	Yes __X__ (Limited – see comments) No ____
If yes, how many Medicaid or CHIP enrolled children were served by these programs in the past year? Are you continuing to see increases in the number of children served by these programs?	# 57 children in the 2012/2013 school year Comment: The 2012/2013 school year was the first year of the programs in collaboration with the FQHC dental programs for all but one Anchorage school (only 4 schools in the project at this time.) The sealants provide were not billed to Medicaid for children enrolled in the Medicaid program . Current regulations preclude the FQHC billing for these services. It is anticipated the number of Medicaid children served will increase in the 2014/2015 school year as it will add 3rd grade children in all of the schools (3 schools were 2nd grade only in the 2012/2013 school year). .
How many sealants were placed in these programs in the past year?	#188 sealants on permanent molars (of these 114 sealants were on permanent molars of children enrolled in Medicaid/Denali KidCare)
Has funding from the Centers for Disease Control and Prevention (for oral health infrastructure development) contributed to these efforts? Please describe.	Yes __X__ (Limited) No ____ Comment: CDC has provided some funding (limited in SFY2013) for the position that serves as the sealant coordinator (primary funding is HRSA). The state match for a HRSA Dental Workforce Infrastructure grant, along with limited HRSA grant funds, has been the major funding source for the school dental sealant pilot programs and sealant coordinator position in

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Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
	SFY2013. CDC DOH supplies the software for data collection and reporting on the sealant activities (SEALS software).

Collaboration with Dental Schools or Dental Hygiene Schools

Do you have a dental school or dental hygiene program in your State? If yes, do you have any arrangement with the dental school or dental hygiene program to treat Medicaid beneficiaries, serve in rural areas, provide educational opportunities, etc.? Please describe.
Alaska has two university-based dental hygienist programs (University of Alaska Anchorage and University of Alaska Fairbanks). There is not a specific program or arrangement with the university to treat Medicaid beneficiaries, however a joint project with the Alaska Dental Action Coalition is providing at least 1 two-day free dental clinic for year targeted for low-income and/or individuals w/o dental coverage (most participants have been adults.)

Plans to Expand Dental School or Dental Hygiene Program Collaboration

Describe any plans to initiate or expand collaboration with dental school or dental hygiene program? None at this time

Electronic Dental Records

Describe the use of electronic dental records by providers in your State for the Medicaid and CHIP populations. Estimate the percentage of dental providers using electronic dental records. Is the dental record integrated with the medical record? How is the State supporting dental provider efforts to qualify for meaningful use incentive payments?

Tribal dental programs are using electronic dental records (EDRs) – most are moving to use of Dentrix. There is some integration of electronic dental with medical records and the programs are working to improve that integration. Additionally, Tribal programs still utilize the Resource and Patient Management System (RPMS) and there are integration problems with integration of EDRs and that system. Non-Tribal FQHC dental programs also are moving to use of EDRs and link with medical records within the FQHC setting. It is not certain how many private practice dental offices are moving to EDRs. When dental offices call on the Electronic Health Record (Electronic Dental Record) Incentive Program, they are provided information on the program and answers to questions. See: http://ak.arraincentive.com/

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Technical Assistance

Indicate areas of interest or topics about which you would be interested in receiving technical assistance.
Information on successful strategies from other states in increasing access to preventive dental services and/or dental sealant utilization (staff are familiar with the Washington State ABCD Program, North Carolina Into the Mouth of Babes and state experiences with increasing Medicaid dental reimbursement).

Other Materials or Links to Relevant Websites

If you would like to submit copies of materials or provide links to relevant websites for additional information, please do so as attachments to this template.

See attached for: 1) Trends in child dental utilization from CMS 416 reports; 2) summary of dentist participation in Medicaid 2010 & 2012;3) Dental assessment results from the 2004, 2007 and 2010/2011 Basic Screening Surveys; and 4) EPSDT analysis of dental services by Tribal Health Organization region.