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Dental Action Plan Template
For Medicaid and CHIP Programs

State: PENNSYLVANIA

Program (please designate): Medicaid X CHIP Both

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In an effort to increase the number of Medicaid and CHIP children who have access to dental care and receive preventive dental services, CMS is working with States to implement two national oral health goals. While some States have undertaken oral health improvement activities in recent years, additional activities are needed to increase access and prevention in order to meet children's needs and these goals. CMS will provide States with technical assistance and opportunities to share best practices to assist them in meeting these goals.

The purpose of this Action Plan is to identify what activities States intend to undertake in order to achieve these dental goals. CMS will share each State's plan by posting them on the CMS website, but CMS will omit posting proprietary dental provider payment data upon State request. In addition, States are asked to provide baseline information on their existing programs, and to identify access issues and barriers to care that they are currently facing so CMS can help address these issues with technical assistance. While CMS is interested in learning about efforts or activities States have already undertaken as well as successes of those efforts and lessons learned, development of the Action Plan will primarily serve to assist States in their efforts to document their current activities and collaborations to improve access and to inform States about where their resources could best be devoted to achieve the goals. This information will also be used to assist other States in their efforts to increase access.

Medicaid and CHIP Dental Health Goals:

Increasing the proportion of children ages 1-20 enrolled in Medicaid or CHIP who received any preventive dental services by 10 percentage points over a five-year period.

To be phased-in:

Increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period.

Instructions & Next Steps:

- 1) Each State, including the District of Columbia, is to complete this Dental Action Plan Template in its entirety as a Word document. Please do not include graphics or charts in the Template itself, as these items are not compatible for posting on the CMS website. You may attach separate documentation if you want to submit additional information. CMS encourages the Territories to complete a dental action plan but the Territories will not be included in the dental goal.
- 2) If you are undertaking State-wide oral health improvement activities that impact both programs, you may submit one combined dental action plan. Separate dental action plans should be submitted in States that are addressing oral health improvement activities separately in their Medicaid and separate CHIP programs.
- 3) Once you have completed the template, please e-mail this information to your CMS Regional Office within six months of the date of the State Health Official letter.
- 4) CMS Regional Office staff will review the information and send it to CMS Central Office for further review. Regional Office staff will contact you for additional information, if appropriate or necessary.
- 5) After reviewing and compiling this information, CMS plans to post this information on the CMS website.
- 6) CMS Regional Office staff will follow up with States on a regular basis to track the progress of the State Action Plans and achievement towards the goal(s).

If you have any questions when filling out this template, please contact your CMS Regional Office.

Oral Health Program (Background)

Provide information on your current oral health program for children under Medicaid and/or CHIP. Include information about your State's current delivery system(s) (e.g., fee-for-service, managed care, administrative service organization, etc.). If your State has changed delivery systems in recent years, explain the reason for the change and the impact on access to dental services. Also include information on provider participation rates (including dental specialists and other providers, such as physicians, dental hygienists and other newer model mid-level practitioners) and issues with access to oral health services in underserved areas. "Underserved areas" would include areas of your State that you know are rural, frontier or where it is difficult to recruit providers as well as designated Dental Health Professional Shortage Areas (DHPSAs).

Access Issues/Barriers to Oral Health Services (please provide information on issues/barriers that you are aware of that impede access to providing oral health services to children through Medicaid or CHIP in your State generally, as well as in underserved areas, and any steps you have taken to address those issues or barriers):

Like most other states, Pennsylvania recognizes the existence of access issues/barriers to oral health services for the population served by the Medical Assistance (MA) program. As identified by CMS in the CMS Oral Health Strategy document released in 2011, those key barriers include:

- limited availability of dental providers;
- low reimbursement rates;
- administrative burdens for providers;
- lack of clear information for beneficiaries about dental benefits;
- missed dental appointments;
- transportation;
- cultural and language competency;
- need for consumer education about the benefits of dental care.

These identified barriers may be grouped into three interrelated, overlapping categories for the purpose of discussing steps taken to address them. Those suggested categories would be workforce/provider issues, care coordination issues, and awareness/educational issues that include both patient and provider cohorts. As will be discussed in more detail in the next section of this document, the MA program in Pennsylvania, both currently and historically, has existed with both managed care and fee for service component delivery systems. Multiple interventions have been implemented in both systems to address the access issues/barriers. Pertinent initiatives by barrier category include:

Workforce/Provider Issues

Streamlining Program Administration

So providers can spend less time on billing and coverage issues and, in turn, focus more attention on patient care, the Department of Public Welfare (department) has:

- Maintained minimal prior authorization requirements for dental services for children, using industry standard forms for authorization requests and paper claim filing, and provided electronic and on-line claim submission options.
- Implemented a payment methodology that allows for payment of services provided to consumers by newly-created public health mid-level dental providers when performed through Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Rewarding Providers and HealthChoices Managed Care Organizations

To reward providers and HealthChoices (Pennsylvania's mandatory managed care delivery system) managed care organizations (MCOs) which are helping the department to improve the delivery of Medical Assistance dental services, the department:

- Increased provider payment rates for a variety of dental preventive and treatment services.
- Implemented provider incentive payments to increase pediatric access to dental services.
- Extended financial rewards to MCOs for increasing children's and adolescents' appropriate use of dental services, leading multiple plans to institute performance improvement projects that have shown sustained increase in use of dental services by children and adolescents.

Enhancing Dental Services

To enhance the services it provides to consumers and the dental providers who serve those consumers, the department:

- Developed a schedule for dental screening and preventive services for children and adolescents – similar to schedules commonly used for childhood immunizations. This schedule was distributed through an official MA Bulletin to all dentists participating in the MA program as well as being publicly released at the Medical Assistance Advisory Committee (MAAC).
- Compensated primary care physicians for appropriate application of topical fluoride varnish to the teeth of high-risk patients up to four years of age as an early childhood preventive intervention service.
- Collaborated with state provider associations so physicians and dentists can more effectively coordinate when their patients need serious dental care.
- Surveyed dental providers enrolled in the Medical Assistance Program to determine dentist commitment, competency, and capacity to treat patients with special needs to make finding an appropriate practitioner to meet the specific needs of the patient more efficient and effective.

Care Coordination Issues

To outreach to consumers and providers to assist and improve logistics of care coordination, the department:

- Is using federal Children's Health Insurance Program Reauthorization Act (CHIPRA) grant funds awarded to Pennsylvania to help medical providers identify children and adolescents receiving Medical Assistance benefits who have or have not accessed dental services to facilitate appropriate referral. Grant partners receive electronic claim information to identify pediatric dental care gaps so they can prompt referral for dental services via their electronic health record. This will assist in determining how effective a dental referral is under Early, Periodic Screening Diagnosis and Treatment (EPSDT), closing the information loop to help ensure compliance and continuity of care.

- Has encouraged all the HealthChoices MCOs to participate with the PA Head Start program to ensure that those children who are served by Head Start and are enrolled in an MCO receive the appropriate dental care for their needs, and that the information is coordinated between both entities to optimize collaboration.
- Is collaborating, along with the HealthChoices MCOs, with the Healthy Teeth, Healthy Children project of the PA Chapter of the American Academy of Pediatrics (PA AAP) that is attempting to educate pediatricians and other primary care physicians in the area of oral health and the need for early preventive intervention, such as the application of topical fluoride varnish, and referral to a dental home for initial evaluation by age 1. The project also aims to establish local/regional referral networks to enhance the medical/dental linkage of provider communities emphasizing the importance of oral health in overall health.
- Is working with the Pennsylvania Association of Community Health Centers (PACHC), whose member organizations are FQHCs and Community/Rural health centers. The association is a grantee of the DentaQuest Foundation under the Strengthening the Oral Health Safety Net program. Objectives and associated activities for the PACHC project are intended to increase understanding of the importance of oral health to overall health, increase health center provider use of dental sealants, and to increase recognition of the importance of oral health care delivery in health centers across Pennsylvania. Activities are to be directed toward health center clinical staff and the patient community, as well.
- Has encouraged the HealthChoices MCOs to implement programs that support members' adoption of healthy behaviors. Several MCOs offer gift card incentives for the scheduling and keeping of oral health appointments. One MCO has recently implemented a dental-related member incentive utilizing Smart Card technology. All MCOs maintain a Special Needs Unit (SNU) that serves to provide members with enhanced care coordination, as necessary. Member assistance for scheduling of appointments and arrangement for transportation, when needed, are examples of available services provided through the SNUs and general Members Services departments.

Outreach/Educational Issues

To outreach to consumers to educate and help them use care appropriately, the department:

- Partners with the Centers for Medicare and Medicaid Services to maintain an on-line, searchable database of participating dental providers at <http://www.insurekidsnow.gov/> to assist consumers in finding a dentist.
- Conducts extensive member outreach efforts (performed by the MCOs) such as targeted mailings and member newsletter articles about the importance of children being seen by a dentist in order to maintain good oral health.

- Insured that ACCESS Plus enrollees were able to obtain information through the ACCESS Plus call center pertaining to covered services, including oral health services, based on enrollee Healthcare Benefit Packages. ACCESS Plus was the Primary Care Case Management (PCCM) program that operated in non-HealthChoices (mandatory managed care) counties (HealthChoices was expanded to all counties effective March 1, 2013.). The call center number was provided on the ACCESS Plus card, in the ACCESS Plus “Welcome” letter and in the ACCESS Plus handbook. ACCESS Plus also performed outreach calls for children who were in need of dental exams based on review of claims information. Additionally, a monthly file containing those enrollees who had been approved by prior authorization for orthodontic services was shared with the vendor; ACCESS Plus outreached to these individuals to make them aware of the approval, to assist in scheduling appointments, and to follow up on whether or not appointments had been kept.

To outreach to state provider associations to improve collaborative interactions on issues of mutual interest the department:

- Interacts frequently with both elected leadership and association staff of the dental and medical state associations to answer questions posed by association membership that relate to their interaction with the MA program as well as address larger issues that require combined action for resolution. For example, the development of the compensation of physicians for the application of topical fluoride varnish to the teeth of MA-enrolled children at high risk for dental caries was the result of multiple collaborative meetings between the Office of Medical Assistance Programs (OMAP), the Pennsylvania Dental Association (PDA), the PA Chapter of the American Academy of Pediatrics (PA AAP), and the PA Academy of Family Physicians (PAFP).

To outreach to providers in training to educate them on the needs of populations in underserved areas, the department:

- Has partnered with our HealthChoices MCOs and our sister agency the PA Department of Health to conduct yearly outreach “Lunch and Learn” sessions and to attend “career day” activities where department representatives explain the Medical Assistance program and encourage students to consider incorporating some percentage of MA recipients into their future practice patient population. Information is supplied on both the state and federal sponsored loan repayment programs with encouragement to consider practice in rural or other underserved areas in the state.
- Current Dental Delivery System (e.g., fee for service, managed care, use of administrative service organization or combination dental programs). If you have a combination dental delivery system, provide the number of children served by each system:

Pennsylvania provides children’s oral health care under MA through a combination of both state-administered fee-for-service (FFS) and Managed Care delivery systems. The name of Pennsylvania’s Managed Care delivery system, operating as a 1915(b) waiver demonstration

project is called HealthChoices. Unlike some states, which implemented mandatory managed care for Medicaid clients statewide in a short period of time, the department chose to implement HealthChoices incrementally over time in different geographic zones. The department researched and considered natural service patterns in order to define the zones and grouped urban with rural areas. HealthChoices first became operational in the Southeast region of the state (Philadelphia and the four surrounding suburban counties) in early 1997. The Southwest zone (with 10 contiguous counties surrounding Pittsburgh) was implemented in 1999. Next, the Lehigh/Capital zone (10 counties that encompassed the Harrisburg, York, and Lancaster urban communities and extended to include Lehigh Valley counties to the east) became operational in 2001. Between 2001 and July of 2012 there were 25 counties where enrollment in one of the HealthChoices MCO was the option for most of the Medicaid consumers and 42 counties in which HealthChoices was not available but dental service was provided through the FFS system. In 2005, in those 42 counties where HealthChoices was not available, the department implemented an enhanced primary care case management program, ACCESS Plus, also operating under a 1915(b) waiver. In 26 of the 42 ACCESS Plus counties, recipients had the option to alternately, voluntarily enroll in an MCO, as selected MCOs were permitted to operate there on a voluntary enrollment basis.

In 2011, the decision was made to expand the HealthChoices delivery system statewide. Effective March 1, 2013, the statewide HealthChoices delivery system is comprised of five geographic zones with a total of nine different MCOs operating across those zones, in varying combinations.

Delivery of oral health services under the HealthChoices delivery system is the responsibility of the individual MCOs operating within the designated geographic zones. The MCOs may subcontract with a Dental Benefits Manager or rely on internal resources within the MCO itself to recruit and maintain a dental provider network, provide case management services and process claims related to oral health services. In the ACCESS/ACCESS Plus delivery system, the department retained the administrative duties of provider enrollment, prior authorization review, and claim processing/payment.

As of November 1, 2012, there were 146,028 children actively enrolled under the ACCESS/ACCESS Plus FFS delivery system. There were 885,744 children served under the HealthChoices delivery system. As of March 1, 2013, with the implementation of the New East zone of HealthChoices, approximately 98% of all children enrolled in the MA program in Pennsylvania are served under HealthChoices.

Provider (Dentist) Participation Rates (For the most recent year data is available, include the number of dentists licensed in your State, the number of Medicaid and/or CHIP participating dentists (any claims filed), and number of active dentists (billing \$10,000 or more in a year. Please specify the time period the data represents as well as the specialty of the dentist):

Dental licensure in Pennsylvania is subject to a biennial renewal period that currently has a deadline for renewal on March 31 of odd-numbered calendar years. The PA Department of State has the licensing authority for the State. In recent years The PA Department of Health (DOH) has conducted a dental workforce survey in cooperation with the Department of State

during the licensing renewal process. The DOH survey report for the most recent renewal period, occurring in 2011, indicates that 9,428 dentists renewed their PA license. Many dentists maintain an active license to practice in more than one state. Others maintain an active license even though they have retired from practice or are not involved in active patient care. However, the DOH survey also supplies information on how many of those dentists who renewed their license in 2011 actually provided direct patient care in Pennsylvania. Using the survey-recommended calculation methodology based on the survey respondents, the number of licensed dentists in Pennsylvania who are involved in any delivery of direct patient care with the state as of the 2011 renewal cycle is estimated to be 7,175.

As requested by CMS, the number of MA participating dentists (submitting at least one claim between 1/1/2011 and 11/1/2012) is 2075. The number of MA active dentists (who billed \$10,000 or more during the same time period) is 1448. When compared to the number of dentists actively involved in direct patient care in the state, the percentage of dentists “participating” with MA is 28.9%, with 20.7% of dentists involved in direct patient care being “active” in the program. The following is a breakdown by specialty of participating and active dentists in Pennsylvania MA:

Dentist Specialty	Participating Status	Active Status
General Dentistry	1,820	1260
Oral/Maxillofacial Surgery	84	69
Pedodontics	71	46
Orthodontics	67	53
Endodontics	17	15
Periodontics	11	3
Prosthodontics	5	2

- **Non-Dentist Provider Participation Rates:** (Describe the participation of other providers, e.g., pediatricians, dental mid-level providers, dental hygienists, in your State to improve access to dental services for children. In addition, for the most recent year data is available (please specify), please provide the number of Medicaid and/or CHIP non-dentist providers, by provider type, participating in your Medicaid and/or CHIP programs. “Participating” is defined the same as for dentists (any claim filed).)

As of April 1, 2010, OMAP implemented a policy of compensation to provide to Physicians and independently practicing Certified Registered Nurse Practitioners (CRNPs) for the appropriate application of topical fluoride varnish when provided to MA eligible children under the age of 5. Providers are required to supply evidence of appropriate training in the proper technique of topical fluoride varnish application prior to receiving certification clearance for payment. Since that time (as of June 30, 2012) 3 independently practicing CRNPs and 199 physicians in Pennsylvania have received that certification status and submitted at least one claim to MA for topical fluoride varnish application.

On July 20, 2007, Act 51 (P.L. 327, No. 51) amended the act of May 1, 1933 (P.L. 216, No. 76) known as the Dental Law. Among other things, this amendment allows Public Health

Dental Hygiene Practitioners (PHDHP, a mid-level dental provider) to perform, in certain settings including the RHC and FQHC settings, educational, preventive, therapeutic and intra-oral procedures for which the hygienist is educated and which requires the hygienist’s professional competence and skill, but does not require the dentist’s professional competence and skill or examination of the patient. As such, PHDHPs may provide dental hygiene services in the RHC and FQHC settings, without the supervision of a dentist or examination of the MA recipient by the dentist.

On November 15, 2010, OMAP issued an MA Bulletin notifying RHCs and FQHCs that the MA Program would pay RHCs and FQHCs a prospective payment system (PPS) encounter rate for all dental services, including the services rendered by a dentist, dental hygienist and Public Health Dental Hygiene Practitioner (PHDHP), provided in the RHC or FQHC settings, effective with dates of service on and after November 1, 2010. This action established the first opportunity for PHDHPs to access a funding stream for their delivery of services. However, the PHDHP is not directly enrolled as a provider type with the MA program, and payments under the PPS encounter rate system do not identify that the service was performed by a PHDHP. Therefore, OMAP is currently unable to ascertain the “participation” rates for this mid-level provider type. As mentioned earlier in this document, OMAP is working in support of initiatives undertaken by the PACHC aimed at improving the delivery of oral health care services in FQHCs and other Community Health Centers in PA. That collaboration may improve the participation of PHDHPs for oral health service delivery in the FQHC/RHC setting.

- Additional information about program (please provide any additional information that is relevant or that you would like to share about your dental program):

OMAP has been focused on oral health issues in Pennsylvania for more than a decade, working with our MCO partners in the HealthChoices delivery system and, more recently, with our primary care case management vendor in the ACCESS Plus program. These efforts have succeeded in making significant improvements in the utilization rates of oral health services in the MA population, especially the pediatric population, despite the fact that the overall population covered by the program has ballooned over the same time period. In the year 2000, there were 856,900 children enrolled in the PA Medical Assistance Program, of those 182,337 received any type of dental service in the measurement year, with 144,975 receiving a preventive dental service. As of 2007, there were 1,120,184 enrolled, with 327,470 receiving any dental service, and 275,112 with a preventive service. Our most recent CMS-416 for FFY 2010-11 data reported 1,169,657 MA eligible children with at least 90 days of continuous eligibility, and 462,499 receiving a dental service, 400,737 of those received a preventive service. The corresponding percentage calculations for those years are presented in tabular format below:

CMS-416 Report Year	2000	2007	2012
Percentage receiving any dental service	21.28%	29.23%	39.54%
Percentage receiving a preventive dental service	16.92%	24.55%	34.26%

Despite the growth of the total population served under the MA program in Pennsylvania (increased by 36.5% during the 12-year period), the number of children receiving dental services grew by 176%, and those receiving a preventive dental service grew by 202%. That increase demonstrated a raw percentage point increase of 17.34 points over the span. OMAP is committed to achieving the goals proposed for the CMS Oral Health Strategic initiative. In fact, Pennsylvania recently achieved a 10 percentage point increase in the number of children receiving a preventive oral health service, based on CMS-416 reporting between the 2008 and 2010 reporting periods as a result of focused efforts in both the ACCESS Plus and HealthChoices delivery systems.

We have determined to follow a strategic policy with a strong orientation toward prevention of oral disease with both clinical and fiscal benefits. Prevention of disease onset and maintenance of healthy oral structures is the optimal state for the child in terms of quality of life. Preventive services are also more cost effective than treatment services, allowing more of the population at risk to receive appropriate treatment while maintaining a healthier existence. We have developed a three-pronged approach to our efforts in alignment with the CMS-stated goals. They are associated under the categories of identification, information, and intervention. The following sections will provide more detail on the efforts, both currently implemented, and proposed for implementation over the course of this initiative.

Activities to Achieve Goals:

Describe the activities you have underway and/or plan to implement in order to achieve the new dental goal(s).

Provide details on these activities, along with potential barriers, in the space provided (add additional space if needed). Examples of activities underway, or to be undertaken, to improve access and achieve the dental goals may include:

- Collaboration with dental schools and dental hygiene programs;
- Education/outreach to dentists, dental hygienists, and State/National dental associations;
- Education/outreach to pediatricians, family practitioners, and State/national medical associations
- Education/outreach to beneficiaries;
- Coordination with Federally Qualified Health Centers;
- Undertaking administrative simplifications;
- Using electronic health records and supporting Dental providers in their efforts to qualify for meaningful use incentive payments;
- If a CHIPRA quality demonstration grantee, describe how you are coordinating activities with those being undertaken under the CHIPRA demonstrations;
- Changing/increasing payment rates;
- Coordination with Maternal and Child Health (MCH) Title V programs (Title V is the Federal grant program focused solely on assuring the health of all mothers and children).

Pennsylvania Overview

OMAP has adopted the policy of prevention as the central priority for statewide activities in the delivery of oral health services and is endeavoring to align those activities to achieve the goals outlined in the CMS Oral Health Strategy. As previously noted, our approach to meeting the challenges that are presented is to address them through identification, information, and intervention as operational umbrellas for strategic efforts.

Identification activities are those efforts that assist in leveraging resources to the best advantage. They will be used to pinpoint populations (both patient and provider) to whom information and intervention efforts are required and best directed. By way of example, OMAP has developed and is refining quarterly monitoring tools to identify pediatric recipients who have or have not received appropriate preventive dental services. Recipients are currently identified by delivery system (HealthChoices, fee-for-service) so that the appropriate outreach efforts can be employed. Tracking utilization of services rates over time will allow identification of strengths in strategic efforts as well as opportunities for improvements in tactical planning and execution.

Information activities are those efforts that assist in communicating with our collaborative partners during all phases of this project -- planning, initial implementation and continued operation. Information distribution related to educating of appropriate stakeholder groups will also be essential. Professional provider network partners (dental and medical) will require education on the importance of early intervention (age 1) as well as information on employing age-appropriate techniques. Parents and other care-givers will require enhanced outreach efforts to educate them on the importance of prevention of dental disease in the primary teeth and the need to seek a dental home much earlier than most are currently aware.

Intervention activities are those involving changes in existing protocols and/or processes that will improve ability to prevent the onset of oral disease and improve the direct delivery of clinical preventive and treatment services. Maximizing primary care physician (PCP) awareness of the need to communicate the importance of oral health to expectant moms and make early referral to a dental home (by age 1) must/will be developed through MCO provider networks. Increased physician buy in and participation in preventive application of topical fluoride varnish with meaningful referral to a dental home will be encouraged, as well as dentist commitment and competency to provide appropriate preventive care to younger patients.

Focus of Activities

Although official Pennsylvania-specific baseline figures related to the Oral Health Strategic initiative goals have not been received from CMS, OMAP calculations based on our CMS-416 Report data submitted in 2012 estimate that in order to achieve the overall goal for preventive services utilization, approximately 112,000 additional children within the MA population must receive a preventive oral health service on a yearly basis. While activities to achieve the goals will not be limited to any one age cohort within the pediatric MA population, OMAP intends to focus efforts on delivery of preventive oral health services to the 1-5 year-old age band cohorts. There are multiple reasons for this focus. First, oral disease is highly preventable. Teeth erupting into the mouth are generally disease free. Maintenance of healthy teeth in a healthy oral

environment is both cost-effective for the MA program and provides the optimum quality of life for the MA consumer. This cohort has more than enough recipients to reach the numeric level of improvement necessary to achieve the CMS preventive oral health services goal. Historically, dental services have been underutilized in this segment of the pediatric population with provider practice behaviors having contributed to that underutilization. If efforts employed in this initiative are successful in ameliorating provider behaviors in serving this cohort, significant improvements in oral health levels will be perpetuated long-term. Specific efforts to educate parents and other caregivers of children in this age group about the importance of the primary dentition and the need for early preventive care that includes nutrition and professional evaluation are a priority. Another priority is the education of both medical and dental provider groups as to the importance of their collaborative and individual participation in evaluation and preventive interventions for the very young child. Multiple activities, both currently in the implementation stage or in development for implementation during the course of the CMS Oral Health Strategic initiative, will have focus on and are expected to impact these areas. The remainder of this section will describe the activities categorically in more specific detail.

Activities with Dental Schools

Pennsylvania is fortunate to have three dental schools within the state: the University of Pennsylvania School of Dental Medicine, and the Kornberg School of Dentistry at Temple University in Philadelphia, as well as the University of Pittsburgh School of Dental Medicine in Pittsburgh. All three schools are significant participating providers of oral health services to MA consumers in the urban centers and surrounding regions where the schools are located. The schools participate in both the fee-for-service and managed care delivery systems. As mentioned previously, the schools have historically been supportive of interactive sessions allowing representatives of both the PA Department of Health and the department to visit their campuses and share information with the doctoral students about the need for practitioners to locate in underserved areas and provide services to citizens who rely on government programs for access to healthcare benefits. The schools also provide opportunities for students to participate in community service outreach in satellite practices, FQHCs, mobile treatment units, as well as the central clinic locations.

OMAP has been in collaborative development of an innovative project with Dr. Amid Ismail, Dean of the Kornberg School of Dentistry of Temple University since 2010. This project was recently funded by the United Health Foundation. The following is an outline summary of the project that will be implemented over the next two years:

Temple University Kornberg School of Dentistry, in collaboration with the OMAP HealthChoices Managed Care Organizations, Foundations, Federally Qualified Health Centers, Outcome Sciences, Temple University School of Medicine, and other health and community organizations is proposing to implement Project ENGAGE.

The aims of this integrated model of dental care and oral health promotion project are to:

- Exchange information in real-time on oral health of children aged 0-5 years especially those with severe caries experience;

- Network with families using a registry to track/follow-up children in high risk areas (five zip codes in North Philadelphia);
- Guide young children's oral health through education, care navigation, and social support, And
- Guide dental care through implementation of evidence-based management protocols and novel workforce models; and
- Educate health team members (dentists, physicians, PHDHPs, CHWs) to prevent caries and arrest early carious lesions.

Caring for Children at Risk

Just seeing a dentist or another dental provider is not enough. Historically, the focus in dealing with early childhood caries (dental decay) has been on delivery of treatment and routine preventive care. There has been no or only limited effort to address social-behavioral determinants that contribute to the onset and progression of the disease process. Procedure-driven care has been the model up to now.

Improved Access and Outcomes

A new care model is needed that integrates tailored behavioral-social interventions, risk-based preventive management, minimally invasive dental treatments, and community engagement with families. This model also must include assistance in navigation of dental care for underserved children and their caregivers.

Project Goals

- Reduce the incidence of dental caries in children aged 0-5.
- Reduce the cost of dental care per child.
- Expand access to dental care for covered children, without increasing cost to OMAP.
- Increase the proportion of children who receive recommended preventive dental care.
- Ensure that children served have medical homes and receive scheduled vaccinations.

Target Population

Project ENGAGE targets Medicaid managed care enrollees in selected North Philadelphia neighborhoods:

- Children ages 0-5 who have received dental care under general anesthesia or IV sedation.
- Children ages 0-5 who have medical homes, but do not have any claims for dental care or only claims for services in ERs.
- Women who are using prenatal services, but do not have claims for dental care.

Proposed Registry Functions

Project ENGAGE includes the development and implementation of a HIPAA compliant, encrypted, and secure Registry for children in North Philadelphia that will be scalable to the

whole state and nation after the program is evaluated. The online Registry will capture information from field workers (CHWs/PDPHs), medical and dental providers, managed care organizations, and Medicaid databases that will offer the following functionalities:

- Capture administrative and outcomes data for target population
- Provide treatment guideline information to dentists
- Provide patient education materials (oral health and child dental care)
- Navigation of dental care to network dentists affiliated with Kornberg School of Dentistry
- Provide benchmark reports to clinicians comparing their practice performance to their peers and to evidenced based standards
- Provide reminders to community health workers regarding patients needing follow-up visits
- Utilize Medicaid claims data to pre-populate the registry
- Provide data for program evaluation to the Kornberg School of Dentistry
- Provide performance and outcomes data to Health Choices MCOs

Compensation Innovation

Project ENGAGE will offer innovative payment options to shift focus from procedures to desired outcomes. The model provides compensation for a holistic, team approach to treatment of oral disease that will include fees for conventional services as well as payment for activities that support health promotion and maintenance and demonstrated achievement of desired outcomes over specific timeframes. The following list outlines compensable services/activities/outcomes:

- Data collection (patient assessment and detailed clinical examinations, including valid risk assessment)
- Diagnosis and formulation of treatment plans in consultation with patients/caregivers
- Management of:
 - Primary prevention (keeping patients free from disease and preserving tooth structure)
 - Initial (incipient) carious lesions: secondary prevention
 - Moderate lesions: minimally invasive restorative care
 - Severe lesions: standard care to restore oral structures to health maintenance level
 - Monitoring the caries risk status of patients and individual teeth
- Additional care (endodontic, surgical therapy, prosthetics, etc.)
- Payment for maintaining oral health (requires examination at baseline and after one year)

Estimated Impact and Cost Saving Potential

Preliminary analysis for project impact indicates the potential for the following projected outcomes:

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- Decrease percentage of children needing care under GA/IV sedation from 10% to 4%
- Recidivism (need for retreatment within 18 to 24 months): decreased from 20% to 5%
- Increase in number of children accessing dental care services by 96%
- Decreased payment per beneficiary per year for oral health care by 46% (over a 3 yr. period)

Education/Outreach Activities

As part of OMAP's monitoring and compliance processes, it evaluates providers' and managed care organizations' effectiveness in implementing initiatives to improve oral health. Within OMAP, the Bureau of Managed Care Operations (BMCO) is responsible for the administration and oversight of the HealthChoices program, including monitoring managed care organizations (MCOs) to determine if MCOs are meeting program requirements and performance targets. The three main goals of the HealthChoices program hold true for oral health care as well as physical health care delivery:

1. Improve access to health care services for Medical Assistance recipients
2. Improve the quality of health care available for Medical Assistance recipients
3. Stabilize Pennsylvania's Medical Assistance spending

OMAP monitors compliance with reporting requirements and reviews selected measures and metrics to ensure that MCOs are operating in the most efficient and effective manner consistent with Federal and State requirements. OMAP's monitoring includes reviewing contract compliance, monitoring quality management and disease management initiatives and outcomes and administering the Pay-for-Performance program. The Pay-for-Performance (P4P) Program is aligned with HealthChoices program goals and provides financial incentives for MCOs to meet quality goals. In 2011, the department provided an incentive for improvement in twelve selected HEDIS[®] measures including Annual Dental Visits as one P4P measure. This P4P measure directly incents the MCOs to improve their HEDIS[®] dental measure for children. (See Attachment B for a link to more information on the P4P program impact on the HEDIS[®] measure.)

The department requires that each of the MCOs' Quality Management and Utilization Management Programs include methodologies that allow for the objective and systematic monitoring, measurement and evaluation of the quality and appropriateness of care and services. MCOs are required to submit NCQA performance improvement plans (PIPs). For 2012, dental was included as one of the required areas for the MCO Performance Improvement Projects (PIPs). In addition, the MCOs are asked to provide an overall quality workplan to describe their various initiatives, incentives and other outreach and education efforts that are geared towards achieving quality outcomes.

As part of the oversight process, OMAP has identified certain performance measures and contract requirements that reflect the clinical and operational priorities of the HealthChoices program, including the delivery of dental services. The department receives and reviews regular reports (i.e., monthly, quarterly, semi-annually or annually, depending on the measure) from

each of the MCOs regarding each of these performance measures. Staff then collectively discuss the reports and identifies trends and outliers, both positive and negative.

BMCO has recently implemented the Quality Improvement Unit (QIU) to synthesize monitoring findings so as to address concerns from a quality and performance improvement perspective. The QIU will facilitate both internal Quarterly Quality Review Meetings (QQRMs) with the Contractor's Management Team and external QQRMs with each HealthChoices MCO to discuss and summarize the following areas:

- Overall compliance, significant issues and any environmental changes
- Root cause and action plans to correct for variances
- High performers and best practices
- Progress with performance improvement or corrective action plans
- Strategies, progress and findings related to specific areas of interest for quality improvement such as improved access and delivery of dental services

Working together with the MCOs, OMAP is making quality improvement and delivery of high quality services a priority for all HealthChoices members.

Since CMS announced the Oral Health Strategy and associated goals in 2011, OMAP has been working with our MCO partners to build awareness of the initiative and to orient activities performed by the MCOs with the achievement of those goals. In June 2012, on-site visits were held with each of the HealthChoices MCOs and presentations on oral-health-related activities were requested to be a part of each review session. Alignment of MCO activities with the CMS Oral Health Strategic Goals was reinforced by OMAP during these on-site reviews. OMAP continues to communicate with MCO clinical and Utilization Management/Quality Management (UM/QM) staff and monitor health plan activities through our regularly scheduled MCO Medical Directors meetings. Those meetings have also been used to introduce and encourage MCO participation with OMAP-endorsed projects that are being implemented by other stakeholder entities and are synergistic with departmental efforts.

HealthChoices MCOs have implemented multiple educational/outreach efforts to their membership, and both their dental and medical provider networks. Noteworthy examples of such efforts include:

- Televox campaigns to outreach/educate members on oral health topics

EPSDT reminder postcard mailings to members

Oral health topical information included in regularly distributed member newsletters

- HealthChoices MCOs are exploring development of member-oriented incentive programs that will be effective in motivating appropriate utilization of oral health services. MCOs are seeking to use state of the art methods to reach their membership. One health plan has implemented a pilot member incentive program which provides rewards for completion of an annual dental visit using SMARTCARD technology for members aged 2-3 years and 19-21 years. These age groups were

selected as they are the lowest performing ages for the plan. The card will be loaded with dollars which can be used at various locations and limit purchases to health-related items, such as toothbrushes, floss, baby care supplies, etc. Members receive information on the program and the SMARTCARD. The card is loaded with monetary value once the dental visit has occurred. Potential barriers include incorrect member demographics and member perceptions regarding whether the amount placed on the card is adequate to justify a trip to the dentist.

- All HealthChoices MCOs are developing incentive programs for their medical and dental provider networks to support better utilization of oral health services. All MCO provider pay-for-performance programs were enhanced to include the HEDIS[®] Annual Dental Visit measure. The dental visit measure was added since it is one of the lower performing measures. Several MCOs are initiating a payment for both PCPs and dentists for each preventive service completed per member per year in children 2-21 years of age.
- In June of 2012, two of the HealthChoices MCOs sponsored a conference entitled Promoting Wellness through Collaboration: The Integration of Dental and Medical. This conference, offering continuing education credit to both medical and dental professionals, brought physicians and dentists together to address their cooperation in supporting a health home. This outreach directly supports OMAP's strategic goals of increased medical dental interaction, especially in treatment of the early childhood population. Better understanding of the relationship of oral health to overall health, earlier evaluation and preventive intervention with appropriate referral patterns are key practice protocols that will build synergy through effective interdisciplinary collaboration. A second conference to continue the discussion and support further integration activity is scheduled for 2013.

Purposeful communications are exemplified by collaborative activities related to recipient outreach under way in 2012. In May 2012, OMAP shared oral health utilization data with our primary care case management vendor for the ACCESS Plus program, that identified program members, under 21, who had no recent claim history of a dental visit. In July and October 2012, a total of 20 counties were moved from the ACCESS Plus program to HealthChoices. Updated enrollee data files and utilization data for all MCO membership was shared with the health plans. Again, this communication is meant to provide opportunity for more effective outreach/education efforts that will lead to enhanced levels of utilization of oral health services.

As mentioned previously, OMAP will continue to work collaboratively with our MCO partners throughout the course of the CMS Oral Health Strategic Initiative to achieve the goals outlined within the operations of the HealthChoices program. There are three other significant projects currently underway in Pennsylvania that are closely aligned with the goals of the CMS initiative. OMAP has been supportively involved in each of these projects and has encouraged synergistic participation by our HealthChoices MCOs, as well. Continued support for these projects is intended as their success will help to assure OMAP's success in achieving the state-specific goals set forth by CMS for Pennsylvania. The following subsections describe these collaborative projects in more detail:

EPIC Healthy Teeth, Healthy Children: A Pennsylvania Medical/Dental Partnership

The EPIC (Educating Practices/Physicians in their Communities) Healthy Teeth, Healthy Children (HTHC) program is promoting medical/dental collaboration to improve the oral healthcare delivery system in Pennsylvania and increase access to dental care for young children and adolescents, as well as improve oral health literacy for families across the state. Healthy Teeth Healthy Children is funded by the DentaQuest Foundation and part of the Oral Health 2014 Initiative.

The program is currently in the implementation phase and has begun work to accomplish the following goals:

1. Training of Primary Care Providers in Oral Health.
2. Collaboration with Early Childhood Education Linkage System and Head Start.
3. Development of culturally appropriate, low literacy oral health education materials and media.

The Healthy Teeth, Healthy Children Advisory Committee is comprised of active leaders and advocates for children's oral health, and includes Pediatricians, Dentists, the PA Medical Home Project, the PA Academy of Pediatric Dentists, the PA Dental Hygienists Association, the PA Association of Community Health Centers, the PA Medicaid MCO medical and dental directors, Head Start instructors, the Early Childhood Education Linkage System (ECELS), the PA Collaborative for Oral Health (PCOH), the Lehigh Valley Oral Health Initiative, medical and dental schools and residency programs across the state, and other community oral health advocates.

The following goals and supporting objectives outline the implementation phase work plan for the project related to Strengthening the Dental Care Delivery System:

- By 2014, HTHC will provide EPIC Oral Health training to 80 primary care medical practices in PA (intended to involve an estimated 200-300 individual practitioners).
 - Market EPIC Oral Health and Smiles for Life training to primary care providers throughout PA via brochures, newsletters, telephone calls, and conversations with stakeholders.
 - Continue to recruit and train at least 1 medical (physician, nurse, or physician assistant) and dental (dentist or dental hygienist) professional from each of the 5 regions to be EPIC Oral Health Trainers.
 - Complete in-office EPIC Oral Health Trainings in 80 practices by 2014.
 - Update and improve the delivery of EPIC Oral Health Trainings based on provider evaluations.
- By 2014, 70% of the primary care providers (PCPs) trained through EPIC Oral Health will have implemented oral health risk assessments, parent education, fluoride varnish application, and dental referral.
 - Survey/Interview, by telephone, the office manager or oral health champion at each of the EPIC Oral Health trained practices at 1 and 6 month intervals to assess if implementation has occurred and identify barriers to implementation. (Practices

that have not implemented by 1 month will have an additional survey at 2 months after training).

- Use Zoomerang to survey PCPs at each of the EPIC Oral Health trained practices at 1 and 6 month intervals to assess oral health knowledge and if implementation has occurred.
 - Use department data to determine the number of PCPs who implement after being trained from EPIC Oral Health.
 - Provide ongoing technical assistance to all EPIC Oral Health trained practices and to pediatric and family practices professionals in Pennsylvania.
- Provide shared context for integrating oral health as part of the medical home best practices.
 - Evaluate and track oral health implementation among medical home practices who attend October 5th conference.
 - Integrate feedback evaluations from Medical Home Conference into subsequent EPIC OH training and program implementation.
 - Provide ongoing technical assistance to all practices trained at October 5th Medical Home Conference.
 - Research best practices for integrating dental practitioners into medical homes.
 - Host an oral health Medical Home Webinar annually.

The following goals and supporting objectives outline the implementation phase work plan for the project related to Oral Health Literacy:

- The HTHC Advisory Committee will review and disseminate oral health education materials and media, including low literacy, multilingual, culturally appropriate messages, throughout the state.
 - Post and share information regarding appropriate oral health education materials and media on the HTHC website and on Basecamp.
 - HTHC will explore ways to promote oral health messages creatively via media channels including social media,
- HTHC will collaborate with the ECELS in order to increase access to culturally appropriate, multilingual, low-literacy oral health education materials and media for Early Care and Education Providers.
 - By November 2012, update the ECELS Oral Health Self-Learning Module using recommendations from the HTHC Advisory Committee members and materials and ideas from the Cavity Free Kids Curriculum.
 - Promote the use of the Oral Health Module to early childhood educators through ECELS' many communication channels.
 - Use HTHC grant funds to pay for 200 early childhood educators to take the Oral Health Module.
 - Provide ongoing technical assistance to those early childhood educators that take the Oral Health Module.

- Share and promote oral health education materials and media with ECELS.
- HTHC will collaborate with the PA Head Start Association (PHSA) in order to increase access to culturally appropriate, multilingual, low-literacy oral health education materials and media for PA Head Start staff.
 - Healthy Teeth, Healthy Children will continue to be an active member of the Pennsylvania Head Start Oral Health Task Force as long as the Task Force exists.
 - Include PA Head Start Oral Health Task Force Coordinator in HTHC Design Team.
 - Share and promote oral health education materials and media with PHSA.
- HTHC will collaborate with PCPs in order to increase access to culturally appropriate, multilingual, low-literacy oral health education materials and media for PCPs for distribution to their patients and families.
 - Primary care providers will have access to and promote low-literacy culturally appropriate oral health education and media.
- By 2014, families will have access to an interactive, web-based map that identifies Head Start and Early Head Start programs, dentists that accept MA and will treat children under the age of 5, and primary care providers that are trained in oral health throughout the 67 counties in PA.
 - First focus on the 10 dentally needy counties identified by PHSA and develop an interactive web-based map of the medical and dental homes of Medicaid enrolled children under the age of 5 and Head Start county contacts.
 - Promote the map through the PHSA communication channels, ECELS communication channels, HTHC website, PA AAP, and EPIC Oral Health trained practices.
 - Map the medical and dental homes of Medicaid enrolled children under the age of 5 and Head Start county contacts in the remainder 57 PA counties.
 - Continue to update the map with medical practices that are trained through EPIC Oral Health and with information about MA dental providers from the department and the AAPD website.
 - Research and if possible, incorporate a mechanism to track usage of the map among different populations (medical professionals, dental professionals, education professionals, parents/consumers, and others).
- By 2014, HTHC will advocate for the inclusion of dental information on school health forms (the Childcare Health Assessment Form [CD51] and the public school health form).
 - Collaborate with the Office of Child Development and Early Learning (OCDEL) and the department to learn about and influence the CD51.
 - Collaborate with PA AAP and PA DOH to learn about and influence the public school health form.
 - Initiate an Advisory Committee work group that will develop an action plan.

The following goals and supporting objectives outline the implementation phase work plan for the project related to Medical/Dental Collaboration:

- By 2014, the HTHC Advisory Committee will act as a statewide leader in promoting medical/dental collaboration.
 - Include statewide stakeholders representing government, community, education, medical and dental providers, public, third-party payers, policy, and higher education in the HTHC Advisory Committee.
 - Hold 2 HTHC Advisory Committee meetings per year, over the next two years, to facilitate medical/dental collaboration.
 - Host 2, 1-hour HTHC Advisory Committee webinars, per year, over the next 2 years to facilitate medical/dental collaboration.
 - Create committee functions that support collaboration.
 - HTHC Advisory Committee will continue to identify solutions to improve medical and dental collaboration.
- By 2014, HTHC will have created 5 regional networks of supportive and collaborative medical, dental, and educational professionals that influence the care of children less than or equal to 5 years of age.
 - Identify and recruit medical, dental, and educational stakeholders for each of the 5 regional networks.
 - Connect regional Medicaid physicians and dentists who serve children under 5 years old.
- By 2014, HTHC will advocate for the incorporation of interdisciplinary medical/dental training into the curriculum of 2 medical (pediatric and/or family) and 2 dental (pediatric and/or general) residency programs in PA.
 - Identify oral health champions that could influence interdisciplinary medical/dental training in residency programs.
 - Create a work group within the Advisory Committee that will promote interdisciplinary medical/dental training in medical and dental residency programs.
 - Research existing programs and best practices that encourage interdisciplinary medical/dental training in residency programs.
 - Create a document that discusses the need for, content of, and best practices in interdisciplinary medical/dental training in residency programs.

Healthy Smiles, Happy Children: Head Start Dental Home Initiative and MCO Liaison Project

In 2009, the Pennsylvania Head Start Association (a Title V program) created a Steering Committee to address identified issues within the Head Start programs in Pennsylvania. Those issues included:

- Limited oral health knowledge among families
- Lack of access to oral health care – especially children 12-36 months old
- Difficulty finding treatment services
- Need for more professional development

The Steering Committee included membership representing the Region III Administration for Children and Families and Technical Assistance System, the PA Head Start Association, the PA Head Start Collaboration Office, the Region III Dental Consultant, and OMAP. Activity resulting from the meetings of the Steering Committee led to 3 Oral Health Forums held regionally across the State. Local Head Start program staff, dental providers, and other community stakeholders were invited to the forums and were asked to provide their perspectives on challenges and potential solutions pertinent to Head Start and oral health services. Through the processing of the information gleaned from the forums, the Head Start Oral Health Task Force was established in 2011 with the following goals:

- Establish a dental home for every child in Head Start
- Educate adults (parents/caregivers) to prevent oral diseases starting early in life
- Forge collaborations that benefit children and providers
- Build lasting relationships with the dental community

The Task Force activity created the Head Start Dental Home Initiative with the goals of bringing about:

- More Head Start children receiving required follow-up dental treatment
- More pediatric dentists and general dentists serving infants, toddlers, and children 3-5 years of age
- Better understanding of proper oral health practices among Head Start children, staff and families

In 2011, the Massachusetts Head Start Association (MHSA) approached the Pennsylvania Head Start Association (PHSA) with an offer to work in partnership with them under a DentaQuest Foundation (DQF) Venture Fund for Oral Health grant to demonstrate that the Consortium model is a valuable blueprint for building an effective state-level systemic approach to addressing children's oral health disparities. An agreement was forged and initial funding under the DQF program was obtained for one year.

The following subsections are Pennsylvania-specific excerpts from the Year 2 Scope of Work portion of the MHSA DentaQuest Foundation Venture Fund Year 2 Grant Proposal that was successful in obtaining funding for continuation through 2013. They outline proposed activities under the project in the upcoming year.

Access to Care Subcommittee – MCO-Head Start Liaison Project.

The objectives of this initiative are to implement the MCO-Head Start Liaison Project, develop best practices for collaboration and communication between MCOs and Head

Start programs and build effective working relationships between each of the 9 MCOs and their Head Start Points of Contact. A key component of this work will be to develop best practices for standardized communication between MCOs and Head Start programs. This unique collaboration requires ongoing information, education, communication and engagement of the administrators in Head Start programs at regular intervals when they meet together, on teleconferences, and through the PHSA administrator's list-serv. The subcommittee will:

- Work with HTHC partners and partners at the department to obtain access if possible to department-unique patient data to determine the impact of the MCO-Head Start Liaison Project.
- Work with department partners to share updated MCO-Head Start Liaison and Dental Director contact lists with the Subcommittee members, PHSA members, Head Start Program Administrators, Head Start Oral Health contact persons, and the HTHC Implementation Team as part of network building efforts in local communities.
- Develop a MCO-Head Start Liaison Toolkit with specific resources, i.e. spreadsheets, forms, sample Memoranda of Agreement, etc.

Access to Care Subcommittee - Community Networks:

The objective of this effort is to build Community Networks (e.g. Pacemaker Groups) to ensure all Head Start children have access to a dental home. The subcommittee will:

- Develop a definition of community networks, identify key partners, groups and our vision for community networks, and will integrate this work with the goals and objectives of the DentaQuest HTHC Implementation Grant proposal (using the Pennsylvania Map with 5 Regions).
- Use the Task Force membership to help identify potential leaders.
- One of the areas in which we experienced a challenge that impeded the successful implementation of some of our Year 1 goals and objectives was related to the engagement of the Pennsylvania Dental Association (PDA). We have since had an encouraging response to our outreach efforts upon which we can build this year. Our relationship with the PDA will serve as a platform from which to launch efforts to promote age 1 care in Pennsylvania, incorporating our most recent work in Massachusetts targeted to changing attitudes and practices in the dental and medical communities regarding oral health care for the youngest patients. We had originally planned to survey PDA members in Year 1 as we have done in Massachusetts to learn about their attitudes regarding the age 1 dental exam regarding the age 1 dental exam and what would encourage more dentists to treat younger patients. Instead, our outreach strategies will be targeted to engage the PDA as a valued partner in our oral health coalition and health promotion efforts to connect Head Start children to dental

homes. We will work with the PDA to devise the best strategy to engage their membership. Possible strategies may include:

- Presenting the Healthy Smiles Initiative and DentaQuest goals at key stakeholder membership association meetings, such as District PDA meetings.
- Engaging MCOs in supporting and growing networks and continuing to build relationships with the MCOs through the MCO-Head Start Liaison Project.
- Building knowledge of Head Start.
- Continuing to identify key stakeholders and making connections with the “next 5” DentaQuest grant recipients of the PA Association of Community Health Centers (PACHC) DentaQuest Safety Net Grant.
- Participating on a regular basis in the PA Coalition for Oral Health meetings to network with new oral health champions and to recruit key stakeholders to join our Task Force.
- Continuing to identify synergies between the goals of the Healthy Smiles Task Force and the HTHC and the PACHC DentaQuest grantees through participation at respective Advisory Meetings and Task Force meetings.
- Continuing to communicate and share information between the Task Force and the HTHC Implementation Team and the PACHC Leadership Team.
- Participating regularly in the PAAAP’s HTHC Design Team meetings, planned Implementation Team meetings, and planned Advisory Committee meetings to ensure that our efforts complement each other and to avoid redundancy of effort, to leverage our efforts to build viable community networks at the local level in the 5 regions of the state.
- Cross-checking the clinical practices trained at the October 5th Medical Home Conference sponsored by HTHC to determine if they are working with Head Start grantees in local areas and assisting families enrolled in Head Start in making referrals to dentists in their communities.
- Assisting the HTHC Implementation Team in planning and developing an interactive web-based map of the medical and dental homes of Medicaid enrolled children in the top 10 dentally needy counties identified by PHSA through Head Start contacts in local areas.
- Promoting the interactive web-based map developed by HTHC through PHSA communication channels, the PHSA website, and the MCO-Head Start Liaison contacts being developed through interactions with Head Start programs at the local level.

Last year we needed to focus on successfully launching our initiative including introducing Cavity Free Kids oral health curriculum to the PA Head Start community and expanding the membership of the PA Healthy Smiles Task Force based on the results of our Year 1 gap analysis. In Year 2, we plan to produce the webinars that we had originally included in our Year 1 work plan. The 3 webinars will include:

- A Head Start 101 Introduction for health/dental providers and key stakeholders, such as the MCO-Head Start Liaisons
- Tips for Head Start programs on how to build successful partnerships with

medical/dental offices

- An Introduction to Age 1 Oral Health Care: what is it, why it is important, and how to find a provider

These webinars will be made available for dissemination via the Consortium and the Healthy Smiles Task Force and will be included in the Toolkit that we produce in Year 3. Finally, in the fall of 2013, we will convene a video-conference call for key stakeholders including but not limited to representatives from professional associations such as the AAP, ADA, AAPD, ASTDD, and Head Start Association leaders in other states in order to share our work to date and solicit suggestions for other resources that would be helpful to include in a toolkit for state oral health coalitions.

Pennsylvania Association of Community Health Centers

The Pennsylvania Association of Community Health Centers (PACHC) is the primary umbrella organization for FQHCs, FQHC Look-Alikes, and RHCs in Pennsylvania. Members of the PACHC have been long-standing participating provider facilities with PA Medical Assistance, delivering both medical and dental services.

In November 2010, in keeping with policy outlined in our State Plan, OMAP issued MA Bulletin 08-10-50, Dental Encounter Payment for Dental Services Rendered by Rural Health Clinics and Federally Qualified Health Centers. It served to notify RHCs and FQHCs that the MA Program would pay RHCs and FQHCs a prospective payment system (PPS) encounter rate for all dental services, including the services rendered by a dentist, dental hygienist and Public Health Dental Hygiene Practitioner (PHDHP), provided in the RHC or FQHC settings, effective with dates of service on and after November 1, 2010.

This change for payment of dental services to a dental PPS encounter rate was made to help ensure that the RHC or FQHC is appropriately paid for dental services, including PHDHP services that are performed independent of a dentist. The department established provider specific PPS dental encounter rates for those RHCs and FQHCs enrolled in the MA Program that provide dental services based on each RHC's Centers for Medicare and Medicaid Services (CMS) Designation letter or each FQHC's Health Resources and Services Administration (HRSA) approved Scope of Service letter and the RHC's or FQHC's submitted MA Program Cost Report (cost report). Since the department does not require prior authorization of any RHC and FQHC service, effective with dates of service on and after November 1, 2010, RHC and FQHC dental services are no longer subject to prior authorization requirements. Therefore, this action incorporated three positive changes for the safety net facilities: established a payment methodology to assure appropriate compensation rates, streamlined administrative procedures by simplifying claim submission to an encounter submission and eliminating prior authorization requirements, and providing an opportunity for FQHCs to employ the services of the mid-level dental provider type, the public health dental hygiene practitioner.

The PACHC is also the recipient of a DentaQuest Foundation Grant under the Strengthening the Oral Health Safety Net program, having been funded in 2012 and renewed for funding into 2013. The PACHC used some of that funding in 2012 to hold a Medical and Dental Integration Summit

in July. During that conference, OMAP was able to deliver to attendees a presentation that outlined the CMS Oral Health Strategic Initiative and the proposed goals for preventive dental services. The PACHC is planning for a second summit conference in 2013. OMAP has been invited to participate again.

The following information outlines goals and objectives with supporting activities intended by the PACHC as part of the work plan under the DentaQuest Foundation grant in 2013. Several of these activities should provide synergistic effort with OMAP activities for the CMS initiative, as well.

- Promote inter-professional activities among dental and medical programs in Community Health Centers
 - Increase understanding of the importance of oral health to overall health
 - Increase health center provider use of dental sealants
- Elevate the importance of oral health within the Primary Care Association (PCA), and develop executive leadership at Community Health Centers to promote optimal oral health
 - Increase all PCA staff recognition of importance of oral health
 - Increase PACHC board understanding of importance of oral health
 - Increase recognition of importance of oral health in health centers across PA
- Advance safety net oral health needs at the state level
 - Advocate for effective payment policy
 - Raise public awareness of oral health access issues and importance of oral health to overall health
- Optimize the management of dental programs to provide sustainable and effective oral health care
 - Work with Safety Net Solutions to select up to 5 FQHCs to receive technical assistance.
 - Ongoing monitoring of the TA process and outcomes
 - Strengthen the FQHC oral health workforce
- Support selected health centers in implementation of recommendations and sustainability of changes
 - Subsidize business redesign and other technical assistance recommendation implementation costs
 - Support selected health centers in spreading successful practices they have implemented to the "Community of Community Health Centers"

CHIPRA Grantee Activities

Pennsylvania's CHIPRA grant dental provisions are focused on enabling medical providers to identify MA consumers who have accessed dental services. Within the CHIPRA grant's twenty-four pediatric quality measures there are two dental measures. One measure focuses on the total eligible receiving preventive dental services and the other is the total EPSDT eligibles who

received dental treatment services. While the current EPSDT program stresses the need for dental care as part of proactive healthcare, it does not provide the information necessary to confirm that a dental visit has taken place. PA's CHIPRA grant activities will strive to close this open loop. The health systems participating in the grant will electronically provide OMAP with a list of their patients who are enrolled in MA. OMAP will access claims data for those children to identify those who have had preventive dental services and/or dental treatment services. That data will be electronically transmitted back to the health systems which will match the claims data to their patient records. The last step of the process will be to capture the dental visit information in the child's electronic health record so that medical personnel can verify that a dental visit has taken place.

Dental data is not currently stored in the primary care electronic health record (EHR) but OMAP is striving to garner increased engagement from the PCP concerning dental care. Using dental care claims data that identifies children who have received preventive dental care services and reporting this to the grantees, the grantees will be able to identify non-compliant children and engage the parent/caregiver. This will close the care gap.

The dental care plan of one of our state grantee partners, Children's Hospital of Philadelphia, includes having a dental health educator at a large inner city clinic. The educator will be available half days five days a week and will be present in the waiting room to prompt discussions about dental homes. Patients can be referred to the Kids Smiles non-profit Children's Dental Center, a participating provider in HealthChoices MCO dental networks. The Kids Smiles mission is to provide children in underserved communities with preventive and restorative dental healthcare and innovative education programs focusing on prevention and the development of positive behaviors. They provide services such as cleanings, exams, x-rays, sealants, fillings and root canal treatment. Four inner city PCP sites will also be asking patients about the presence of a dental home. Another of our grantees, St. Christopher's Hospital is planning to co-locate a hygienist within their large pediatric outpatient practice.

The CHIPRA grant has identified eight of the twenty-four core pediatric quality measures as pay for performance measures. Of the eight, one is a dental measure. Total eligibles who received preventive dental services has been selected as a focus measure by the seven CHIPRA grantees. Grantees will be incented to improve current preventive dental services rates over the last three years of the grant. Annual individual payments will be made for each 1% absolute improvement (capped at 5% yearly). The goal is to show improvement in the preventive service rates of 5-10% by the last year of the grant. At this time, each grantee is in the process of developing a dental quality improvement action plan.

Additional Background

Provide additional information on your current oral health program for children under Medicaid and/or CHIP.

Oral Health Improvement Initiatives: Has your State undertaken any initiatives within the last 5 years to increase the number of children covered under the Medicaid and CHIP program who receive access to oral health services? If so, please describe those activities.

- What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe.
- If the activities did not achieve the results that you had expected, please describe the lessons learned. These lessons can be a learning opportunity for other States.

Appropriate access to and utilization of oral health services, especially for EPSDT eligible recipients under the Medical Assistance program has been a priority concern in Pennsylvania for much more than a decade. The challenges presenting have been scrutinized nationally, with multiple barriers being identified and a variety of options to resolve the issues have been explored with varying levels of impact realized. Within the last 5 years, PA has continued to place a high degree of emphasis on access to dental services in both our ACCESS Plus and HealthChoices delivery systems. Two initiatives, one in each system, approached the issue from somewhat different perspectives, but both have demonstrated positive impact.

ACCESS Plus Dental Disease Management Program

The Dental Disease Management (DDM) Program, implemented in 2008 under ACCESS Plus, was intended to improve access to oral health services, enhance the coordination of medical and dental care, and thereby improve the quality of life for MA consumers. The broad program objective was to support the establishment of a dental home for selected patient populations that would meet their oral health needs and assist in establishment of better overall health status for patient populations with particular health needs. The program initially involved the implementation of targeted fee increases to selected ACCESS/ACCESS Plus dental fee schedule services and the establishment of a Pay for Performance (P4P) platform of opportunities for participating dentists to receive augmented payments for delivery of qualified diagnostic, preventive and treatment services to identified patient populations.

These patient populations included children (those under the age of 21 years), women who were pregnant, diabetics, and those who had been diagnosed with coronary artery disease (CAD). The selection of these populations related to the goal of prevention of the onset of dental caries as a disease process, or the medical research evidence that good oral health is either potentially or directly associated with improved overall health status for individuals with specific conditions or diseases. The selected oral health services eligible for qualified augmented payment opportunities included initial and periodic oral examinations, routine dental cleanings, topical fluoride applications, and when appropriate, periodontal scaling and root planning of the teeth.

Over the approximately 48 months of the DDM program's operation, there was an observed increase in both the number of dentists enrolled in the program (and receiving qualified P4P payments) as well as the number of MA consumers receiving qualified services through those dentists. The HEDIS[®] Annual Dental Visit measure (a related, nationally-recognized measurement tool that evaluates the number of children, ages 2-20, who had a dental visit during the measurement period) indicated that between 2008 and 2010, the percentage of children with a dental visit under the ACCESS Plus Program, increased from 48.90% to 51.68%. This represented an increase of over 9,000 children who had a dental visit within the measurement year.

Pennsylvania Pay for Performance Program for HealthChoices

OMAP initially implemented the Pennsylvania Pay for Performance (P4P) program for HealthChoices in July 2005. Through P4P, OMAP shifted from “paying for care” to “paying for quality care”. The idea for a P4P program originated in 2004 with the intent of encouraging continuous quality improvement among plans. The concept was discussed and refined with multiple stakeholders, including HealthChoices members, HealthChoices plans, the Medical Assistance Advisory Committee, industry experts and OMAP staff. The department adopted a collaborative approach to major design questions, such as the number and type of performance measures, development of a fair and effective methodology, reasonable performance expectations (goals), amount of incentive dollars at stake, and consideration of unintended consequences. Goals are set for each plan and measured based on previous year’s performance. Payouts are based on whether the goal was met and on performance relative to National Committee for Quality Assurance (NCQA) HEDIS[®] benchmarks. Payouts are financial incentives to the health plans (MCOs).

The current P4P program involves evaluation on 12 P4P measures. Considering access to oral health services a high profile health care issue, OMAP replaced one of the original P4P measures with the Annual Dental Visit (Ages 2-21) HEDIS[®] measure in the 2009/2010 P4P Program. The HealthChoices weighted average for the Annual Dental Visit measure increased 10.6 percentage points from CY 2008 to CY 2010 and exceeded the 50th percentile national benchmark in CY 2009, CY 2010, and CY 2011. In CY 2011, rates for 5 plans exceeded the 50th percentile national benchmark, as well.

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.” 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). 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. (NOTE: You are not required to report this data on the Template.)

OMAP does report HEDIS[®] data in both our FFS (ACCESS Plus) and Managed Care Programs. For our baseline year, HEDIS 2011 (CY 2010):

HealthChoices Managed Care (weighted average)	52.42%
ACCESS Plus	51.68%
CMS 416 (FFY 2010-11)	39.50%.

Probable factors affecting differences between reported HEDIS[®] rates and CMS-416 are:

- HEDIS[®] parameters require continuous enrollment with only one 45 -day gap in coverage allowable for recipient inclusion in the denominator.
- The CMS-416 parameters require 90 only days of continuous eligibility to be counted in the denominator.
- CMS-416 evaluation period is based on the federal fiscal year, whereas HEDIS[®] is based on the calendar year
- Codes to identify dental visits are more generous under the CMS-416
- Age bands: The CMS-416 focuses on all children under 21 for EPSDT services (birth to 21). The HEDIS[®] dental measure counts members ages 2-21 in the measurement year. Therefore, the CMS-416 incorporates a larger denominator that is comprised of a historically underserved age group facing challenges that include caregiver ignorance and provider resistance to treat.
- “Churn” in Medicaid: Children moving on/off MA coverage because of eligibility. . Churn rate might affect Medicaid more than the CMS-416 rate because HEDIS[®] requires continuous eligibility with only one gap in coverage allowed. A member might not be counted if there is more than one period (> 45 D) of ineligibility. Since the CMS 416 only requires a 90 D continuous eligibility the recipient is more likely to be “counted” in the denominator.
- Reimbursement Strategies: What are your current reimbursement rates for the following 10 procedures for services provided to children eligible for Medicaid and CHIP?

Diagnostic:	D0120	Periodic Oral Exam	\$ 20.00
	D0140	Limited Oral Evaluation, problem focused	NA*
	D0150	Comprehensive Oral Exam	\$20.00
	D0210	Complete X-rays with Bitewings	\$45.00
	D0272	Bitewing X-rays – 2 films	\$16.00
	D0330	Panoramic X-ray film	\$37.00
Preventive:	D1120	Prophylaxis (cleaning)	\$30.00
	D1203	Topical Fluoride (excluding cleaning)	\$18.00
	D1206	Topical Fluoride Varnish	\$18.00
	D1351	Dental Sealant	\$25.00

The fee amounts listed are those currently in place for the official PA Medical Assistance Dental Fee Schedule for the ACCESS (fee-for-service) delivery system.

D0140 is not currently listed on the PA Medical Assistance Dental Fee schedule. However, it may be covered by submission of a program exception request with evidence of medical necessity by dentists in the ACCESS (fee-for-service) delivery system. Review of encounter data submissions from the HealthChoices delivery system for SFY 2011/12 indicates that MCOs are compensating providers for this service at an average fee rate of approximately \$19.00.

- Please describe any increases or decreases in these reimbursement rates that have occurred in the last five years.

- November 2007 - Fee Schedule increases for multiple dental services were implemented including dental prophylaxis, topical fluoride treatments, endodontics, crowns, extractions. (See Attachment B for links to the MA Bulletin 27-07-08 that contains specific details for this fee increase.)
- July 2008 – While specific fees listed above were not adjusted at that time, there were significant additional fee increases to select services, including restorations, endodontics, crowns, dentures, extractions, and orthodontics in support of the Dental Disease Management Program. (See Attachment B for links to the MA Bulletin 27-08-06 that contains specific details for this fee increase.)
- ACCESS Plus Dental Disease Management Program, HealthChoices Delivery System Fee Negotiation Flexibility and MCO P4P Incentives (additional compensation incentives above the fee schedule) As has been discussed in previous sections of this document, there are additional sources of compensation for dental services that are available to dentists and other health care providers for the delivery of oral health preventive and treatment services that will augment those fees available directly through the MA Dental Fee Schedule.
 - The Dental Disease Management Program (DDM) offered bonus incentives to dentists who provided a dental home to children under the ACCESS Plus delivery system. Due to the expansion of the HealthChoices delivery system to state-wide status as of March 1, 2013, the DDM is no longer in effect for providers.
 - HealthChoices MCOs operating under the 1915 (b) waiver demonstration project have flexibility to negotiate fees with individual providers, including dentists, based on value-added factors pertinent to service delivery as determined by the MCO. These rates are proprietary to the particular MCO and are subject to variation by health plan and provider. However, indications are that payment levels exceeding the rates for dental services listed on the PA FFS Dental Fee Schedule are in effect in HealthChoices. MCOs have also instituted P4P incentives (variable by MCO) for dentists and physicians for selected services, similar to the ACCESS Plus DDM program. These incentives also augment fees paid directly from the MCO-specific fee schedule.
- Efforts Related to Dental Sealants: Do you encourage or plan to encourage dental providers in your State to provide dental sealants? If so, how do you communicate that information? Have you seen an increase in the number of children receiving sealants? Does your State support active school-based or school-linked dental sealant programs? If yes, how many Medicaid- or CHIP-enrolled children were served by these programs in the past year? How many sealants were placed in these programs in the past year? Are you continuing to see increases in the number of children served by these programs? Has funding from the Centers for Disease Control and Prevention [for oral health infrastructure development] contributed to these efforts? Please describe.

OMAP has been supportive of the placement of dental sealants as an effective preventive oral health service for more than two decades. In 2002, a Pennsylvania Performance Measure related to dental sealants was added as an evaluative measure to the HealthChoices delivery system. This measure, Dental Sealants for Children, shows the percentage of children who

turned eight years old and had a protective dental sealant applied to their teeth during the three years prior to their eighth birthday. Although this measure is not identical to the CMS-416 sealant measure on Line 12.d, it is a very reasonable facsimile. Over the past four measurement years there has been steady and significant progress in percentage increases of children in the pertinent cohort receiving dental sealants. In 2009, HealthChoices weighted average for the measure stood at 38.05%. In 2010, it was 45.56%; followed by 48.10% in 2011; and reached 56.38% in 2012.

In 2002, Pennsylvania also added the permanent first and second premolars, when appropriate based on clinical evaluation, to eligible teeth on which dental sealants are compensable through the FFS Dental Fee Schedule.

The DOH currently maintains a school-based dental sealant program in three counties in the State. The program funding is provided through the Preventive Health and Health Services block grant. In SFY 2011-12, 1399 children were served by the program with 6,506 sealants being placed.

Pennsylvania also has school-based clinics that include a dental component. Examples of urban settings where such clinics are located include Harrisburg, York, and Allentown. In addition, HealthChoices MCOs in the Southeast Zone have been supportive of an initiative of the School District of Philadelphia that has assigned a designated dental provider or provider group to each of the schools in the district to deliver on-site services using a mobile dental unit or portable equipment. Oral health services delivered include diagnostic, preventive, and treatment services to schoolchildren who supply parental permission documentation to participate in the program. Dental sealants are included among the preventive services supplied. Dentists involved in the program are MA-participating and submit claims for covered services to the appropriate commercial and government insurance carriers for compensation.

- Collaboration with Dental Schools: Do you have a dental school or dental hygiene school in your State? If yes, do you have any arrangement with the dental school or dental hygiene school to treat Medicaid beneficiaries, serve in rural areas, provide educational opportunities, etc.? Please describe.

Please see the previous section on Dental School collaboration under Activities to Achieve Goals.

OMAP has also been supportive of efforts by the dental schools in our state to increase the number of dentists competent and committed to treating children (and adults) with special needs through modification of curriculum and expansion of existing clinical facilities.

- Electronic Dental Records: Describe the use of electronic dental records in your State for your Medicaid and CHIP population. What is the take up rate by dental providers? Is the dental record integrated with the medical record? Will the State support dental provider efforts to qualify for meaningful use incentive payments?

Electronic Health Records (EHRs) are in the early stages of widespread adoption. Even though practices are adopting certified EHRs, the format, complexity, and level of detail that can be captured varies. Integration of dental records into medical records is not a requirement for certification of a dental EHR.

EHR use is not widespread among dental providers. There are 152 dentists participating in the EHR incentive program and who have received first year payments for Adopting, Implementing and Upgrading (AIU). No dentists have received Meaningful Use (MU) payments.

Dental data is not currently stored in the primary care EHR. The department is working with our Managed Care Organizations to promote increased engagement of our PCPs in assessing dental care in our pediatric population.

In FQHCs, capturing dental information is highly dependent on how their EHR is set up. Some FQHCs are actively pursuing incorporating dental visits into their EHRs either through work flow changes or making their medical and dental systems “talk” to each other (more integration).

Pennsylvania is one of 18 states participating in the CHIPRA Quality Demonstration Grant, and one of two states developing and implementing a model Pediatric EHR. The model format currently doesn't have a dedicated field to capture dental information but there is the potential for developing this field in the future.

The OMAP Health Information Technology (HIT) team provides assistance to dentists to promote participation and works directly with specific groups to review the MU requirements to determine what exclusions they might qualify for and evaluate how they could change existing practice workflow to meet the other MU requirements. The HIT team is reaching out to colleagues in other states to see how they are addressing the MU issue with dentists. The team is also currently evaluating the MA-participating dental provider network in Pennsylvania to identify qualifying solo practitioners and groups who for eligibility under the HIT incentive program. Outreach to qualified practitioners identified is planned to build awareness and promote wider participation by dentists in the initiative.

As mentioned earlier in this document, Project ENGAGE, that will be piloted in the Philadelphia area initially, includes the development of a registry that is intended to be fully integrated into an EHR network available to both physicians and dentists with input and reporting capabilities that can be accessed by the provider community, the department, and other designated stakeholders with appropriate security safeguards incorporated. Once the pilot has demonstrated effectiveness, scalable expansion of the registry and the information exchange is intended to be scalable to a regional and statewide status.

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Technical Assistance

CMS would like to provide ongoing technical assistance to States to assist in them in meeting the national dental goals. If you have specific areas and/or topics requiring technical assistance, please identify them here.

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

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information collection is estimated to average 65 hours per response. If you have any comments concerning the accuracy of time estimates or suggestions for improving this form, please contact: Cindy Ruff at cynthia.ruff@cms.hhs.gov.