

ADVISORY COMMITTEE ON THE STATE PROGRAM FOR ORAL HEALTH (AC4OH)

MINUTES

March 25, 2016

1:00 p.m.

Bureau of Child, Family & Community Wellness
(BCFCW)
4150 Technology Way, Room 204
Carson City, NV 89706
(775) 684-4285

AT&T Conferencing
Dial-In Toll Free Number 1-877-336-1831
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Bureau of Health Care Quality & Compliance
(HCQC)
4220 S Maryland Parkway, Bldg. D, Suite 810
Las Vegas, NV 89154
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BOARD MEMBERS PRESENT

Christine Garvey, Chair
Kelly Taylor, Vice-Chair
Dr. Christina Demopoulos
Julie Stage-Rosenberg
Dr. Brandi Dupont
Mary Liveratti
Dr. Robert Talley
Dr. Tyree Davis
Cathie Davenport

BOARD MEMBERS NOT PRESENT

Dr. Emily Whipple
Keith Clark
Niki Farris

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF

Julia Peek, Deputy Administrator, Community Services
Beth Handler, Bureau Chief, Bureau of Child, Family and Community Wellness (BCFCW)
Deborah Aquino, Oral Health Program Manager, BCFCW
Cailey Hardy, Administrative Assistant, Maternal, Child and Adolescent Health (MCAH), BCFCW

OTHERS PRESENT

Kathy Stoner, Medicaid, Division of Health Care Financing and Policy (DHCFP)
Chuck Damon, DHCFP
Sydney McKenzie, Oral Health Nevada
Sara Cholhagian, McMullen Strategic Group
Sam McMullen, McMullen Strategic Group
Tomomi Munalami, Sunrise Children Foundation
Valerie Cain, Partnership Carson City

Chair Christine Garvey called the Advisory Committee on the State Program for Oral Health (AC4OH) meeting to order at 1:05 p.m. Ms. Garvey indicated the meeting was properly posted at the locations listed on the agenda in accordance with the Nevada Open Meeting Law (OML).

1. ROLL CALL

Roll was taken and it was determined a quorum of the Advisory Committee on the State Program for Oral Health (AC4OH) was present.

2. APPROVE MINUTES FROM THE DECEMBER 4, 2015 AC4OH MEETING

Dr. Christina Demopoulos corrected page three (3) to correct the spelling of “Ray Rosen” to “Ray Rawson”. To also provide clarification on page five (5) for the Community Coalition for Oral Health developing a website.

DR. ROBERT TALLEY MADE A MOTION TO APPROVE THE MINUTES WITH THE CORRECTIONS FROM THE DECEMBER 4, 2016 AC4OH MEETING. DR. TYREE DAVIS SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

3. MEDICAID, DIVISION OF HEALTH CARE FINANCING AND POLICY – PRESENTATION AND DISCUSSION IN RESPONSE TO INQUIRY, “WHAT POSSIBLE FISCAL SAVINGS, HEALTH AND WORKFORCE OUTCOMES COULD BE REALIZED BY EXPANSION OF ADULT DENTAL MEDICAID BENEFITS, ESPECIALLY AS IT RELATES TO THE IMPACT OF CHRONIC DISEASE WITHIN THE STATE?”

Chuck Damon gave an outline of Nevada’s Childhood Dental Program and Nevada’s Adult Dental. Mr. Damon informed the members one of the goals for the Centers for Medicare and Medicaid Services (CMS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is to increase by 10% of the proportion of children ages one (1) to twenty (20) on Medicaid and Childrens Health Insurance Program (CHIP) who are enrolled for at least 90 days and receive a preventive dental service. Another goal is to increase 10% of Eligible children enrolled for at least 90 continuous days between the ages of six (6) to nine (9) who received a dental sealant on a permanent molar. Mr. Damon informed members in Federal Fiscal Year (FFY) 2011 – 2016 Nevada ranked seventh (7th) in the Nation in percentage increase on progress for preventive dental services. In FFY 2013 Nevada ranked 32nd in the Nation for the percentage of Children aged one (1) to twenty (20) who received any preventive dental service. From FFY 2011 - 2014 Nevada ranked 43rd for the percentage of children ages one (1) to twenty (20) enrolled in Medicaid for at least 90 days who have received a preventive dental service. In FFY 2014 Nevada dropped to less than 2% of children between ages one (1) to twenty (20) who received any preventive dental service. In FFY 2014 32.38% of recipients received preventive services and 34.84% of recipients received sealants between the ages of six (6) to nine (9).

Mr. Damon gave a brief background for adult dental informing the members low income adults are 40% less likely to have a dental visit in the past year, in comparison to adults with dental coverage. 42% of low income adults ages 20 to 64 have untreated tooth decay. Adults who are disabled, homebound or institutionalized are at a greater risk of dental disease. Mr. Damon outlined the challenges to oral health care access and utilization. There is limited Medicaid Dental Coverage. Providers who serve the Medicaid population are required to provide coverage for children but coverage for adults is optional. Dental coverage varies from state to state, there could be no coverage for adults or Extensive coverage. There are insufficient providers available, only 20% of Dentist nationwide accept Medicaid. Many providers do not want to accept Medicaid due to administrative requirements, recipients are more likely to miss appointments, the amount

of time to be reimbursed and the low reimbursement rates. Individuals may face barriers such as work or child care arrangements, transportation, cost of co-payments, lack of awareness of dental benefits and primary care providers may not encourage oral health care. Mr. Damon referenced the data for Nevada Medicaid pregnancy coverage and utilization. The total amount of preventative services in State Fiscal Year (SFY) 2015 was 559 units. The population in SFY 2015 was 5396 recipients which means there is only a 10.35% of utilization of Medicaid Pregnancy Coverage services.

Mr. Damon informed members of the estimated cost proposal for adult dental expansion. Phase one is to provide more preventive care such as examinations, x-rays, cleanings and oral hygiene. This could reduce the amount of emergency room visits for dental problems, as the potential for dental disease could be reduced or mitigated. Phase two is to provide diagnostic, preventive, endodontic and limited restorative care to reduce the costly adult dental diseases and decay which could be prevented or reduced, creating a cost savings. Utilizing fewer than 100 procedures recognized by the American Dental Association (ADA) with a per-person annual expenditure cap of \$500.00 to \$1,500.00. Mr. Damon informed the members some common strategies for adult dental expansion is to increase the recognition of the importance of oral health as it related to overall health. Prioritizing of spending can be challenging based on budgets and limited resources and the need for engagement from high-level state policymakers, including legislative leaders, governor's staff, etc. Other strategies is active legislative outreach by dental association, oral health coalitions to increase the profile of the issue, consider incremental phased expansion and leveraging of existing contractual relationships, provider networks and care coordination efforts.

Mr. Damon mentioned options the State may consider: Expanding Manage Care statewide, including additional services not currently covered by Managed Care, expanding the population served by managed care to include aged, blind, or disabled individuals and increasing the number of Managed Care Plans to offer greater choice and flexibility of services.

Chair Christine Garvey thanked Mr. Damon for the presentation and opened the floor for discussion between the members. Chair Garvey asked the possibility to expand Medicaid dental services. Kathy Stoner informed the members the budget concept paper has been submitted and there is nothing more staff can do at this time. Dr. Robert Talley suggested to the have committee write a recommendation letter requesting expansion and incorporate preventative and restorative services.

CHAIR CHRISTINE GARVEY ENTERTAINED A MOTION TO CRAFT A LETTER OF SUPPORT TO EXPAND ADULT DENTAL MEDICAID BENEFITS IN THE 2018-2019 GOVERNOR'S BUDGET. DR. BRANDI DUPONT MADE A MOTION TO CRAFT A LETTER OF SUPPORT. JULIE STAGE-ROSENBERG SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

Chair Garvey requested BCFCW staff to create a survey monkey to have members input for the letter and have the Chair compose the letter with the members input.

DR. ROBERT TALLEY MADE A MOTION TO HAVE THE CHAIR OF THE COMMITTEE COMPOSE THE RECOMMENDATION LETTER WITH THE MEMBERS INPUT. CATHIE DAVENPORT SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

4. Medicaid, Division of Health Care Financing and Policy – Update on Community Input meetings

Chuck Damon informed the members on May 9th 2016 a public workshop will be held for the Medicaid Chapter 1000 to solicit provider and public input to revise the orthodontia section to increase the HLD score.

5. ORAL HEALTH PROGRAM AND/OR DIVISION UPDATES

Chair Christine Garvey expressed some concerns with the job description's language for the State Dental Health Officer and the State Public Health Dental Hygienists. With the position requiring 10 years of experience managing a public health oral health program along with a required master's degree in public health, Chair Garvey questioned if job requirements are obtainable. Chair Garvey also mentioned there is not mention of grant writing for the Dental Officer. Julie Stage-Rosenberg recommended asking if it could be worded as master's degree is desired, but a bachelor's degree is the minimum requirement. Dr. Tyree Davis asked if the Board could make recommendation for the third person on the interview panel. Deborah Aquino stated all direction will be given by Administration from DPBH.

6. MANAGED CARE OF NORTH AMERICA (MCNA) PRESENTATION ON DENTAL MANAGED CARE MODELS

Shannon Turner gave a brief overview of the MCNA. For over 20 years, the MCNA organization has been a premier underwriter and administrator of dental benefits with a focus on providing exceptional service for CHIP and Medicare members. MCNA serves over three million children and adults nationwide. MCNA is a family-owned business and was founded by Dr. Jeffrey P. Feingold, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology. With nearly 600 employees, MCNA has the infrastructure and experience to deliver best-in-class dental benefits management to our clients. In 2014, MCNA became the first dental plan in the nation to receive full Dental Plan Accreditation and Claims Processing Accreditation from URAC. MCNA's Chief Dental Officer, Dr. Ronald Ruth, currently serves on the URAC Advisory Board. MCNA is certified by the National Committee for Quality Assurance (NCQA) in Credentialing and Recredentialing. MCNA is a member of the Dental Quality Alliance (DQA), a national organization established by the American Dental Association to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

Ms. Turner spoke on evaluation possible models, carved-in is provided by health plans and carved-out is Dental Managed Care. Model one (1): Carved-In to Health Plans includes dental in the service array offered by a beneficiary's health plan. The state incorporates into the PMPM amount paid to a medical managed care plan a premium for covered dental services. Most medical plans subcontract with dental managed care plans to administer their dental benefits, resulting in duplicative administrative costs. Dollars appropriated for dental care risk being diverted into medical plan cost categories, such as hospital care and pharmacy services. Ms. Turner further explained when medical plans manage the dental benefits of Medicaid children under an "integrated plan" the state's efforts to increase the effectiveness of its financial commitment to

dental services is diluted. Model one (1) is forcing dental providers to deal with the requirements of multiple medical plans and creates a significant administrative burden, increases their reluctance to participate in Medicaid and stresses their already thin resources. Medical managed care plans have minimal experience in administering dental networks, managing the utilization of dental treatment services, or increasing quality of care measures such as the use of preventive services.

Ms. Turner informed the members model two (2): Carved-out Dental Managed Care is a proven solution for states seeking to improve oral health outcomes compared to Carved-In models. This model can make a dramatic difference in the number of children receiving needed dental care. More than just an insure of dental benefits, dental managed care is focused on getting children back on the road to good oral health by increasing the appropriate utilization of medically necessary covered services and decreasing fraud, waste and abuse. Ms. Turner further explained allowing dental managed care to remain independent of the Medicaid health plans increases accountability by ensuring the funds appropriated for dental care remain separate from medical care, allowing for services and expenditures to be targeted, easily monitored and reported. Dental managed care focuses on dental metrics and quality improvement goals based on best practices and evidence-based standards. These goals are developed by the state and monitored by dental professionals.

Ms. Turner informed the members by selecting model two (2) it increases outreach and utilization by actively managing members relations by: encouraging members to utilize their dental benefits through outreach campaigns, targeting and specializing outreach for underserved areas, members missing appointments, migrant farmworkers, and children with special health care needs, and by reducing access to care barriers by providing services in a culturally competent manner which addresses the needs of the member's population and provider network. Ms. Turner informed the member the guidelines set by the American Academy of Pediatric Dentistry Dental Home Policy promotes a strong relationship between dentist and enrollees. Dental Home providers are obligated to assess the dental needs of our members and make prompt referrals for additional specialty care. Managed care plans utilize a variety of education and outreach methods to increase appropriate utilization including: an informative and interactive website, social media platforms, targeted outbound telephonic and text message campaigns, appointment reminder postcards, member handbooks, oral health education materials, and health fair and community events. Ms. Turner stated Nevada must ensure it has a robust provider network, including the full spectrum of specialty care providers, in order to address current and future demands for Medicaid dental services. Dental managed care plans have expertise in developing provider networks capable of meeting stringent access standards in urban and rural areas. Promoting and assuring provider satisfaction is also essential to recruiting and retaining a strong network of participating providers. The dental program must provide a state-of-the-art technology to assist with credentialing, eligibility verification, claims submission, and prior authorizations. MCNA offers twice weekly EFT or check based payment cycles. The dental program must also actively assist providers in reducing missed appointments and other patient related challenges. Ms. Turner informed the members MCNA has a team of Provider Relations Representatives who are regionally located throughout the states MCNA serves. The team educates providers about MCNA

and helps assist with any questions an office may have. MCNA continually updates their network providers through their monthly newsletter, *Dental Details*. There are also provider tutorials and training videos on MCNA's YouTube channel.

Ms. Turner explained dental managed care enhances operational efficiency by providing a utilization management program overseen by Nevada-licensed dentists, nationally accepted clinical guidelines with local review and approval by an advisory panel of key stakeholders (the Nevada Dental Association, dental academia, the Oral Health Advisory Board, and others). MCNA also provides a proactive quality improvement program to educate members and providers and to maintain benchmarks for clinical and operational efficiency along with continuous provider support and ongoing education through an array of communication tools, phone hotlines, and dedicated representatives. Additionally, dental managed care plans can provide technology to assist with daily administration. Dental managed care plans provide a web-based member and provider portals. This allows providers to: submit claims, prior authorizations and referrals. Verify eligibility, view patient rosters, and view dental histories, as well as download documentation and resources. This technology also benefits the state by enabling ease of oversight and enhanced accountability and transparency through detailed reporting. Dental managed care plans are committed to detecting, investigating, and reporting suspected or confirmed cases of fraud, waste, and abuse by participating and non-participating providers. Provider treatment patterns are scrutinized to detect activities such as: billing inconsistencies, abnormal service code utilization, peer outlier situations, and frequency anomalies. Investigations and management of fraud, waste or abuse scenarios enables dental managed care plans to ensure funds allocated to the Medicaid program are used efficiently.

Ms. Turner concluded her presentation with MCNA's formula for success explaining the administration of dental benefits using managed care strategies has proven to be the most effective and efficient approach to providing quality dental care. The Medicaid population benefits most from the active management of their care. MCNA partners with providers to ensure the financial resources invested by the state are available to pay for medically necessary covered services. MCNA's dental managed care approach is a hybrid model which pays providers on a fee-for-service basis rather than through capitation. Preventing fraud, waste and abuse and reducing inefficiencies leads to savings which can be applied for improving access to and utilization of dental services. MCNA partners with dental schools in order to utilize the experts in the states served and ensure the MCNA approach is up-to-date with the prevailing standard of care being taught. MCNA takes a proactive approach to utilization management and cost savings by evaluating the medical necessity of services before they are provided. MCNA uses community outreach, including health fairs, enrollment events, and technology resources to directly encourage the utilization of services and to provide oral health education to children and parents. Ms. Turner informed the members MCNA looks forward to continuing their dialogue with Nevada oral health stakeholders and the Oral Health Advisory Board about ways to improve oral health and health outcomes for Medicaid members.

Chair Christine Garvey thanked Ms. Turner for the presentation. It was requested from members to have Shannon's contact information sent out to individuals for follow up with any questions.

7. OPPORTUNITY VILLAGE PRESENTATION

Niki Farris was unavailable for her presentation. A report was provided in the packet (Exhibit A).

8. COALITION REPORTS

Reports were provided for the coalitions.

- Northern Nevada Dental Coalition for Underserved Population (CUSP) (Exhibit B)
- Community Coalition for Oral Health (CCOH) (Exhibit C)

9. SELECT AGENDA ITEMS FOR THE NEXT MEETING

Chair Christine Garvey requested to have an agenda item to look at the legislative calendar, and to review the letter of support.

10. PUBLIC COMMENT

Valerie Cain informed members of Partnership Carson City (PCC) has a Dental Referral Program which is a pilot program targeting children (Exhibit D).

Dr. Brandi Dupont shared information regarding two decisions from the Federal Court of Appeals (Exhibit E).

11. ADJOURNMENT

Meeting was adjourned at 4:15 P.M.