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

Bureau of Health Care Quality & Compliance (HCQC)
4220 S Maryland Parkway, Bldg. D, Suite 810
Las Vegas, NV 89154
(702) 895-3011

AT&T Conferencing
Dial-In Toll Free Number 1-877-336-1831
Participant Code: 4756895

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 (7^{th}) in the Nation in percentage increase on progress for preventive dental services. In FFY 2013 Nevada ranked 32^{nd} 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 43^{rd} 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 or 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 significate 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 though 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.

Overview of Opportunity Village

- **More than 475 people with disabilities received assessment, training and placement services while another 250+ people are employed by Opportunity Village in service contracts throughout southern Nevada.**
- **Programs include PRIDE, Enable, ERC, Fine and Performing Arts, the Thrift Store, as well as contracts with Nellis airforce base, Mccarran Airport, and several casinos throughout southern Nevada.**

PRIDE and Enable:

- **PRIDE stands for "People's Rights to Independence, Dignity, and Equality"**
- **The PRIDE and Enable programs have more than 150 individuals**
- **These individuals are sometimes cared for by family, but often times cared for by long term care facilities, group homes, or public guardians.**
- **Dental care is entirely left up to those caring for the individuals.**
- **Lack of education regarding the importance of Dental Hygiene**
- **When asked, families give one of a few answers explaining why regular dental care is not a necessity-These answers include:**
    - **Convenience**
    - **Transportation**
    - **Hours of operation of dental clinics**
    - **Ease of access and wait times**

What we can do:

- **The most important aspect of obtaining dental care is breaking down the barriers of communication and educating about the importance of dental hygiene**
- **Brainstorming how to make access to care easier to those individuals in group homes or long term care facilities with limited access to transportation and personnel**

What we are currently doing

- **Working with the Dr. Martin and the University of Nevada, School of Medicine and dental students to provide teaching sessions to some of the higher functioning OVIP's regarding dental care**

Northern Nevada Dental Coalition for Underserved Population (CUSP)

Coalition Report for AC4OH March 2016

Community Health Alliance (Brandi DuPont, DDS) has grown as a strong oral health advocate integrating medical and dental, through innovative ways: Oral Health Assessments and Referrals are being conducted in all of CHA's Medical Centers and in the CHA's Pediatric Clinic. Medical screenings are performed in CHA's Dental Clinics and programs as dental professionals screen for hypertension, head/neck and oral cancers, and can extend influence in to behavioral health for better compliance and engagement. It is extending outreach with its mobile vans to unique area facilities. CHA graciously hosts a meeting room with conference phone capabilities for the CUSP **quarterly** meetings and is much appreciated.

TMCC (Julie Stage-Rosenburg, RDH) continues to have a positive oral health presence of students, faculty, services, education and supplies in its clinic and at several local facilities and events. TMCC is promoting continued community health activities and involvement long after graduation.

Northern Nevada Dental Society (Lori Benvin) has 2 strong community programs, the Adopt-A-Vet program and is experiencing marked success with the rekindled the Healthy Smile Healthy Child program.

Incline Screening and Fl Varnish/Education Program (**Pam Straley, RN)** has been extended to 91 Incline Elementary pre-K and K students and is getting favorable response from families, school administration, teachers, school nurses and supporters.

Healthy Communities Coalition (Wendy Madson) integrates oral health, medical, gardens, food banks, schools with education and community involvement. One hundred and eight Silver Springs Elementary School students received screening, fluoride varnish, sealants, referrals and follow-up care provisions in January 2016. Resources are being developed for mobile dental vans and/or transportation to dental facilities.

Compassion Community Clinic (Kathy Secrist) is starting their 3rd year. With a wait list of 200 patients (4-15 month wait for dental care depending on severity) it is partnering with TMCC, NNDS, and other community organizations to successufully lessen the load.

CUSP remains open to suggestions and partnering and being inclusive of medical, mental, legal, pharmaceutical and employment modalities and continues efforts for more outreach for Oral Health with coalitions in sync with spreading the same strong oral health connection to general health message.

CUSP membership expressed desire and commitment to be involved with the upcoming Legislative Day, Thursday March 23, 2017, 7am - 6pm.

Reminder: NV Community Needs Assessment Survey (Grants Management Advisory Committee) - Be sure to list Dental Care as a #1 priority! Due by April 15, 20161

Respectfully submitted by Syd McKenzie, CUSP Chair syd@oralhealthnevada.com

UNLV School of Dental Medicine

Community Outreach

CCOH Update

November 8, 2015 – March 7, 2016

The UNLV School of Dental Medicine (SDM) has been actively participating in various community events including health fairs, career days and the school-based sealant program (Seal Nevada South). Preventive services have been offered to children, adults, teens and seniors. From the period November 8, 2015 through March 7, 2016, a total of **$ 31,627** in donated services was offered to the community (children, adults, seniors) at 37 separate events. We had several educational events where a value was not assessed for the services provided.

Number of children: 549

Number of adults (>18): 191

Number of seniors (>65): 0

Informational events: 1196

Seal Nevada South (SNS): Seal Nevada South visited 7 schools during this time frame.

Children receiving OHI: 301

Children screened: 301

Sealants placed (teeth): 817

Children receiving sealants: 248

Children receiving fluoride varnish: 297

SDM continues to offer the free Saturday Morning Children's Clinic (SMCC) sessions for children, veterans, homeless teens and women's clinic. SDM has established an agreement with the Huntridge Teen Clinic to offer preventive/restorative treatment for the homeless teens/adults.

The first year dental students have been offering OHI/OHE at Title 1 elementary schools on Thursday mornings. They have also been distributing toothbrush, floss, and toothpaste to each of

the children. The figures for this class will be offered at the next meeting. They will have visited just over 40 schools by the end of the semester with some schools having more than 1 day of presentations.

The first year dental students have also been visiting the 4 campuses of Opportunity Village for OHI/OHE. Each campuses will be visited twice during this Spring semester. Information on the sessions will be offered at the next meeting.

The GKAS event is scheduled for May 21, 2016. I have attached a volunteer form for anyone that wants to volunteer.

Exhibit D

PARTNERSHIP CARSON CITY
1711 NORTH ROOP STREET
CARSON CITY, NEVADA 89703
(775) 841-4730
WWW.PARTNERSHIPCARSONCITY.ORG
501(c)3 non-profit organization

Partnership Carson City (PCC) has a Dental Referral Program which is a pilot program targeting children; 5-10 year olds for School Year 2015-2016.

This pilot program is to provide quality oral health care for uninsured and economically disadvantaged school age children who reside in the Carson City area.

We have a Memorandum of Understanding with Kevin Olson DMD; Carson City Pediatric Dentistry who will serve as the dental provider for this referral program. Dental services for children who have been referred may include the following: Examinations, x-rays, cleaning, sealants, fillings, and extractions. All services approved by PCC will be reimbursed by PCC to Carson City Pediatric Dentistry.

When a child is identified at your school/organization as needing dental services, please fill out the attached PCC Dental Referral Program form, and return it to Valerie Cain at fax (775) 841-4733. If you have any questions you can call me at: (775) 841-4730 or e-mail me at Valerie@partnershipcarsoncity.org.

Sincerely,

Valerie R Cain, BS, RN
Partnership Carson City-PCC
Prescription Monitoring Program Coordinator
Dental Referral Program
1711 N Roop St.
Carson City, NV 89706
Phone: (775) 841-4730
Fax: (775) 841-4733

ALERT: Two Decisions from the Federal Court of Appeals Confirm Longstanding FQHC Medicaid Payment Rights

Edward T. Waters, Managing Partner
Feldesman Tucker Leifer Fidell LLP

Just this month, the U.S. Court of Appeals for the Third and Ninth Circuits issued decisions on two important aspects of FQHC Medicaid payment rights. The Ninth Circuit decision answered for the first time a critical question about what exactly are "FQHC Services" and confirmed that FQHC Services are a broader set of services than those delivered by other providers. This decision means, at least in the states within the jurisdiction of the Ninth Circuit (California, Arizona, Nevada, Washington, Oregon, Idaho, Montana, Alaska and Hawaii), that states must pay for services such as adult dental to Medicaid beneficiaries served by a Health Center regardless of whether the State has opted in for adult dental in its state plan. This is because dental services are included in the definition of "FQHC Services." The Third Circuit, in another important decision, confirmed that a state cannot adopt a "paid claim" policy when calculating wrap-around payments and soundly rejected the notion that a state does not owe a wraparound payment for visits that have not been paid for, in part at least, by a managed care organization ("MCO"). The Third Circuit also agreed with prior decisions in other Federal courts that it is the State Medicaid program that is responsible for ensuring that Health Centers receive "fully compensatory" wraparound payments not the MCOs.

Ninth Circuit Decision

On July 5, 2013, the U.S. Court of Appeals for the Ninth Circuit issued its long-awaited decision in *California Association of Rural Health Clinics et al. v. Douglas* (the "*CARHC*" case). The genesis of the *CARHC* case was a law passed by the California legislature in February of 2009 that directed the California Medicaid program ("Medi-Cal") to eliminate any optional Medicaid services in order to help address the State's budget crisis. The California Medicaid agency, consistent with the state statute, eliminated from coverage, among other services, adult dental, podiatry, optometry and chiropractic. Medi-Cal also refused to pay rural health clinics ("RHCs") or a federally-qualified health centers ("FQHCs") for those services. CARHC and Avenal Community Health Center sued the State arguing, among other things, that federal law required California to continue to cover these services to the extent that they are provided by an RHC or an FQHC. CARCH argued that such services fell within the definition of "FQHC Services" and, as such, these services are not optional but mandatory Medicaid services.

By way of background, under § 1902(bb) of the Social Security Act, states must pay FQHCs (and RHCs) at their individual "PPS" rate for two service categories: 1) FQHC Services and 2) "any other ambulatory services" provided by a Health Center "which are otherwise included in the [Medicaid state] plan." Quite clearly, under the second prong of this requirement, a state only has to pay a Health Center for services that are included in the state plan. If a state does not opt, for example, to include adult dental services in its state plan, it does not have to pay for those services under the second prong because those services would not be "otherwise included" in the state plan.

The *CARHC* case, however, involved the first prong of the payment requirement, "FQHC Services." The Medi*caid* provisions of the Social Security Act define the term FQHC Services by cross referencing back to the Medi*care* definition of RHC services. Often referred to as "core services," the Medicare definition and consequently the Medicaid definition includes "physician services" and services furnished by a physician's assistant, nurse practitioner, clinical psychologist or clinical social worker.

The crucial question in *CARHC* was which definition -- Medicare or Medicaid -- of the term "physician services" should be used when interpreting the Medicaid scope of services contained in the term "FQHC Services?" Needless to say, the two definitions are substantially different. The Medi*caid* definition of physician services includes only MDs and DOs while the Medi*care* definition includes not only MDs and DOs but also dentists, podiatrists, optometrists and chiropractors. The lower court agreed with California in an apparently common-sense decision that the Medicaid definition should be used. The CARHC plaintiffs appealed and NACHC filed an amicus or "friend of the court" brief in support of overturning the lower court's decision.

The Court of Appeals reversed the lower court holding that the Social Security Act is clear and unambiguous. The Medi*care* not the Medi*caid* definition of physician services should be used when interpreting the scope of what are mandatory, FQHC Services. Accordingly, services provided in an FQHC or RHC by a Medicare-defined physician (MDs, DOs, dentists, podiatrists, optometrists and chiropractors) must be paid for by, in that case, Medi-Cal at each Center's PPS rate regardless of whether the State has opted to cover these services when delivered by other providers. The rationale for the Court's decision was simple and straightforward: the Medicaid provisions of the Social Security Act explicitly state that FQHC Services "*mean[]* services of the type described [in the Medicare provisions]." Accordingly, federal law was clear that Congress "meant" that the entire scope of the Medicare language, *definitions included*, were to be incorporated into the Medicaid FQHC provisions. The Court therefore found the California legislation that attempted to narrow the scope of "FQHC Services" to be unlawful.

The importance of this decision for Health Centers is hard to overstate. It makes clear for the first time that the term "FQHC Services" does mean something, specifically, that the term "FQHC Services" includes dental, podiatry, optometry and chiropractic services and that a Medicaid program must pay for those services regardless of whether the state includes those specific services for coverage in its state plan when delivered by other types of providers.

A copy of the decision can be found here:
http://cdn.ca9.uscourts.gov/datastore/opinions/2013/07/05/10-17574.pdf

Third Circuit Decision

In another decision of significant importance to Health Centers, on July 9, 2013, the U.S. Court of Appeals for the Third Circuit issued a decision in the *New Jersey Primary Care Association v. State of New Jersey Department of Human Services, et al.* While this decision

affirmed in part and reversed in part a lower court decision in favor of the New Jersey Primary Care Association ("NJPCA"), the Court affirmed the most important aspects of the lower court's decision.

The underlying dispute concerned a decision by the State to make wraparound payments on managed care encounters (*i.e.* patient visits) only if the MCO had first paid a claim arising out of the encounter. This so-called "paid claim" policy is common in many states and has been the source of considerable frustration for many Health Centers since MCOs often reject claims for reasons that have nothing to do with whether or not there was an otherwise valid Medicaid encounter. Common examples of such rejections include: a) MCO credentialing, where a provider would have been able to bill Medicaid directly under a fee-for-service system but since he or she is not credentialed by the MCO, the MCO will not recognize services delivered by that provider; b) some MCOs "time out" certain claims for arbitrary reasons; and c) some MCOs reject claims from the same provider number but at different locations on the faulty premise that a provider could not see patients at more than one site. Clearly, none of these sample rejections have anything to do with whether or not there has been a face-to-face encounter between a provider and patient (the common definition of a patient visit or encounter).

In the NJPCA decision, the Court found that although as a theoretical matter, a state can use various resources including information from MCOs to determine if valid encounters were provided to Medicaid beneficiaries and calculate wrap-around payments, that is not what the State of New Jersey did. The Court found that the State, by making the calculation of a wraparound payment dependent upon the payment of a claim by an MCO (which the State admitted could result in denial of valid encounters), violated the PPS payment requirements found in § 1902(bb)(5). Specifically, the Court wrote in upholding the injunction by the lower court that it was able to "conclude that requiring prior MCO payment before processing wraparound payments will result in the State's failure to meet [the statutory payment] requirement." The Court further clarified that prior MCO payment could not serve as a "proxy for Medicaid eligibility."

The Court also reiterated two other points of law that are important to Health Centers.

First, it wholly rejected the argument that the language of § 1902(bb)(5) only requires a state to make a wraparound payment when an MCO pays a health center claim. The Court also reiterated (relying heavily on past interpretations by CMS) that the obligation to make wraparound payments (at least once every four months) is a state obligation that cannot be avoided by faulting the claims processing function of an MCO. Put another way, if the MCO fails to pay a proper claim it is the state that bears the cost of that failure not the Health Center. On this issue, the Court wrote, "while the statutory language is perhaps not as clear as one would wish, the tenor of the subsequent interpretations and the limited case law is clear: where MCOs do not pay out valid Medicaid claims, the FQHC should not be left holding the bag."

Second, and perhaps most importantly, the Court made clear that the focus of any encounter review process must be on whether an encounter is a "Medicaid eligible" encounter and that even if a state provides an administrative appeal process through an MCO or other third party, the focus of that process cannot be whether the MCO's requirements were followed but

whether the encounter was a Medicaid eligible encounter. Additionally, any administrative appeal process would have to take place "within the statutorily mandated time period" (meaning within the four-month time period to make a wraparound payment).

A copy of the decision can be found here: http://www2.ca3.uscourts.gov/opinarch/123220p.pdf