

MARCH 29, 2018

GEORGETOWN UNIVERSITY LAW CENTER • WASHINGTON, D.C.

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ORAL HEALTH CONVENING FOCUSING ON CHILDREN WITH SPECIAL HEALTH CARE NEEDS



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ACKNOWLEDGEMENTS

The Oral Health Convening Focusing on Children with Special Health Care Needs and this Report were made possible through the generous support of the George E. Richmond Foundation as part of a two-year grant awarded to Dr. Lucile Adams-Campbell of the Georgetown Lombardi Comprehensive Cancer Center. The convening was hosted by Georgetown University's Health Justice Alliance (HJA), the Harrison Institute for Public Law, and the O'Neill Institute for National and Global Health Law and co-sponsored by the National Maternal and Child Oral Health Resource Center and Children's National Health System.

The HJA is a medical-legal partnership launched by Georgetown's Law and Medical Centers in 2016, which brings together students, faculty, clinicians, and policy experts to engage in service, education, advocacy, and research in pursuit of health, justice, and racial equity for people living in poverty in Washington, D.C. Working as an interprofessional team, the HJA helps promote health and well-being of vulnerable children and families by providing free legal services to help patients address issues that negatively impact their health and contribute to health disparities. In addition to our work with individuals, the HJA also uses law as a tool to improve health and well-being through policy projects such as this one on oral health. As a final note, we wish to acknowledge all the participants who joined us for the Convening. We are grateful to you for sharing your time, expertise, and suggestions and look forward to continuing to work with you in 2018-19.

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EXECUTIVE SUMMARY

Barriers to good oral health care pose a significant health threat to low-income individuals and families, which in extreme cases can result in fatal consequences. Lack of good oral health may also negatively impact social function and interaction, limiting verbal and nonverbal communication, and interfering with intimacy, nutrition, and sleep. Often ignored, oral care is the most prevalent unmet health care need among children and adolescents, and tooth decay is the most chronic illness in school-age children. Within this already vulnerable group, children with special health care needs (CSHCN) are especially at risk for a variety of economic, social, environmental, and other reasons that contribute to overall poor oral health care and negative health outcomes.

HJA began this oral health policy project with research to identify areas of unmet need where we would not duplicate efforts around oral health advocacy in the District. CSHCN emerged as a focus early on; although Medicaid eligibility standards are generous and enrollment is higher in Washington, D.C. than in many other jurisdictions, significant numbers of CSHCN in D.C. continue to face substantial barriers to high-quality oral health care. Outreach to other D.C. groups working in the oral health space also suggested that CSHCN was an area where gaps in data and advocacy around oral health existed and where HJA could contribute to efforts aimed at reducing disparities.

Armed with this preliminary information, the HJA organized students, faculty, and staff from Georgetown Law Center's Harrison Institute for Public Law (Harrison) and the O'Neill Institute for National & Global Health Law (O'Neill) into a formal "Oral Health Team" to develop a multi-phased oral health project focused on CSHCN. Starting in the 2016-17 academic year, students enrolled in the Harrison Institute's legal clinic worked with faculty and librarians to complete a national and local scan of medical and legal resources related to oral health policies with special emphasis on poor and underserved communities. Based on what they learned about some of the barriers to care, the HJA Oral Health Team also conducted a national scan of oral health best practices for this population to learn how some of these obstacles are being addressed. Legal and policy analysis of D.C. practices were also undertaken to see which of the practices might transfer to CSHCN and

work well here. Currently, the HJA Oral Health Team is focused on identifying policies that negatively impact access to oral health services in Washington, D.C. for CSHCN so that we can pursue efforts to design and implement changes in policies and programs to increase the number of children who receive quality oral health care under Medicaid.

The purpose of the 2018 Health Justice Alliance Oral Health Convening was, first, to bring together a multidisciplinary group of key stakeholders to share their expertise and insights regarding the issues contributing to oral health disparities and ways to improve the oral health of D.C.'s CSHCN. We wanted these experts to help assess and confirm our research findings on barriers to access and utilization thus far and to contribute their own ideas for possible solutions. We also wanted to see if we could create a shared interest among advocates, academics, and other oral health experts in future collaboration to improve oral health care for CSHCN and other vulnerable populations in the District.

To ground participants in the realities of the oral health needs of CSHCN, the Convening started with a panel that included personal stories from two parents of CSHCN and a dentist with a practice that treats many CSHCN. This panel provided participants with a vivid sense of the range of issues, concerns, and challenges facing parents and providers—even where the additional burdens of poverty are absent.

Participants then self-selected into four different breakout sessions to explore specific issues around oral health care and (1) transportation, (2) financial incentives for care, (3) case management, and (4) school-based health centers with dental suites. During those sessions, lists of potential strategies and solutions were captured on large posters that were used to create a gallery in the main meeting room. Participants were invited to continue their discussions over lunch, to review the gallery of posted lists, and to chat with

students about their individual posters (each of which reflected research and findings around the four barriers that formed the focus of the breakout sessions).

The Convening's afternoon panel, which included two dentists with extensive community-based program experience, provided a high-level perspective on potential steps to increase access to oral health care for vulnerable and low-income populations and included a robust Q&A exchange with participants. At the conclusion of the Convening, participants were invited to provide contact information and identify areas of interest for future outreach from and collaboration with the HJA Oral Health Team.

The Convening helped advance the team's knowledge about oral health and CSHCN in D.C. and forged some important ties to experts working in this area. Moving forward, we intend this project to serve as a vehicle for future policy work around oral health, with an emphasis on CSHCN. Ultimately, we hope to create a series of innovative models of action for increasing oral health care access and utilization for D.C.'s CSHCN and other underserved populations, as well as for similar populations across other states. The following Report provides some background on oral health care in the District and describes the substance discussed during each session of the convening, including roundtable discussion sessions. Where appropriate, we have also included a summary of the key policy solutions proposed as areas for future exploration by the HJA Oral Health Team.

BACKGROUND ON ORAL HEALTH & CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In 2004, the U.S. District Court for the District of Columbia declared D.C.'s record of providing Medicaid-enrolled children with dental services “abysmal” and ordered D.C. to improve its efforts. Since then, D.C. has increased access by Medicaid-enrolled children to oral health care tremendously, more than doubling the percentage receiving preventive dental services between 2004 and 2017. However, many of D.C.'s Medicaid-enrolled children, and particularly those with special health care needs, still have unmet oral health care needs. This section offers background on the children with special health care needs (CSHCN) living in D.C., the barriers to quality oral health care D.C. CSHCN face, and the consequences of these barriers.

CSHCN are defined by the Maternal and Child Health Bureau as children “who have one or more chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.” CSHCN includes, among other conditions, children with cerebral palsy, diabetes, Down syndrome, epilepsy, HIV, and autism spectrum disorders. According to the 2016 National Survey of Children's Health, 18.3% of D.C. children aged 0-17 have special health care needs (an estimated 21,380 children). The majority of D.C. CSHCN are enrolled in Medicaid.

Because of their health conditions, many CSHCN have difficulty maintaining optimal oral health. For example, children with mental, developmental, or physical disabilities may lack the ability to understand, assume responsibility for, or cooperate with preventive oral health practices. Some of these children may have difficulty verbally expressing oral pain, which can lead to oral health conditions going unnoticed for long periods of time. CSHCN who are especially vulnerable to the effects of oral diseases include those with cardiac conditions associated with endocarditis and patients with compromised immunity, including from leukemia or other malignancies and HIV. Additionally, CSHCN's oral health problems can be exacerbated by special diets, the need to eat frequently, medications containing sugar, and poor oral hygiene.

As a result of their health conditions, CSHCN also face a variety of other barriers to oral health care. The rising cost of oral health care, difficulty finding a dental office that is close to home, and locating an office that can accommodate a child's special needs and will accept a child's dental insurance all contribute to reduced access and care. Additionally, many dentists are reluctant to treat CSHCN due to lower reimbursement, inadequate training in treatment of CSHCN, and the additional time required to obtain CSHCN's medical history or medical consultations and provide their treatment. Other barriers include a child's and/or their parent's fear of the dentist, a child's oral defensiveness, and a child's inability to cooperate for the dentist. Together, these greatly increase CSHCN's difficulty in accessing and receiving high-quality oral health care.

CSHCN enrolled in D.C. Medicaid face additional barriers to oral health care. While D.C. has a higher than average number of dentists, as of 2015, only 20% of the 1,128 dentists in the D.C. metropolitan area participated in Medicaid and only 14% served at least one Medicaid-enrolled patient. Moreover, evidence suggests that many of D.C.'s dentists who do serve Medicaid-enrolled children, limit the number of those children they serve. In 2013, only 108 of the 185 dentists serving children enrolled in managed care and 43 of the 118 dentists serving children enrolled in the fee-for-service (FFS) program submitted at least \$10,000 worth of Medicaid claims. The same evidence also suggests there are very few pediatric dentists serving Medicaid-enrolled children in D.C. As indicated by data from Florida, this dearth of pediatric dentists is particularly significant for Medicaid-enrolled CSHCN because dentists who specialize in pediatric dentistry are more likely than general dentists to possess the training and experience required to care for CSHCN and to serve both Medicaid-enrolled children and CSHCN.

Even if appropriate oral health providers are technically available to D.C.'s Medicaid-enrolled CSHCN, these children are less likely to access oral health care if the providers are not located nearby. The majority of D.C.'s Medicaid-enrolled children live in Dental Health Professional Shortage Areas (HPSAs) as designated by the Health Resources & Services Administration (HRSA). Across D.C.'s Dental HPSAs, HRSA reports that dental providers are meeting only 9.30% of the need. And while living near a D.C. metro station has been shown to influence whether a Medicaid-enrolled CSHCN receives oral health services, the areas of D.C. with the highest concentrations of Medicaid-enrolled children have very few metro stations.

Overall, the data documenting D.C. CSHCN's access to oral health care is limited, but it does suggest that a significant number of D.C. CSHCN do not regularly receive essential oral health services. According to the 2009/10 National Survey of Children with Special Health Care Needs (NS-CSHCN), the need for preventive dental care is the greatest unmet health care need among D.C. CSHCN. More recent data indicates that D.C. CSHCN are more likely than their non-CSHCN counterparts to have an unmet dental care need.

The consequences of not receiving oral health care are frequently severe for CSHCN. D.C. CSHCN are more likely than their non-CSHCN counterparts to have oral health problems such as decayed teeth and cavities, and parents of CSHCN are less likely than parents of non-CSHCN to describe the condition of their child's teeth as "excellent or very good." D.C. CSHCN with the most complex health care needs face the most oral health problems. Poor oral health negatively impacts overall health, and poor oral health early in life can lead to significant health problems later in life.

THE CONVENING

Since January 2016, the Georgetown Health Justice Alliance (HJA) Oral Health Team has been working to identify barriers preventing D.C.'s Medicaid-enrolled children from accessing oral health care and the unique challenges facing CSHCN. As noted above, the purpose of the 2018 Oral Health Convening Focusing on Children with Special Health Care Needs was to bring together a multidisciplinary group of key stakeholders to share their expertise and insights regarding how to improve the oral health of D.C.'s CSHCN and identify concrete policy solutions to improve access to oral health care for CSHCN. The following sections describe the substance discussed during each session of the convening.

Panel #1—A Personal Impact: Stories of Barriers to Oral Health Care in the District:

MODERATOR:

- **Jessica Millward**, Clinical Teaching Fellow and Supervising Attorney at the Health Justice Alliance Law Clinic

PANELISTS:

- **Dr. Jonelle Grant-Anamelechi**, owner, Children's Choice Pediatric Dentistry & Orthodontics
- **Eva Scheer**, parent of Cade, a child with a disability
- **Jana Monaco**, parent of Steven, a child with a disability

The morning panel was designed to provide a more personal view of the issues around ensuring good oral health for CSHCN and provide a sense of the range and difference in barriers based on individual children's needs. The panel included two parents of CSHCN, Eva Scheer and Jana Monaco, and a practicing pediatric dentist, Dr. Jonelle Grant-Anamelechi, who works closely with CSHCN. The morning session was moderated by Jessica Millward from the Health Justice Alliance Law Clinic at the Law Center.

Dr. Grant's preliminary remarks demonstrated an acute awareness of the special attention required to treat patients with special health care needs. She shared some of the tools she has implemented at her practice to ensure a safe and enjoyable dental experience for CSHCN and their families, starting with scheduling the appointment -when her staff asks about special accommodations or requests that will help make the child feel more comfortable. She spoke on the importance of recognizing individual patient needs,

and how her office attempts to learn about and accommodate these preferences. For example, for patients who do not like noise, the staff turns off the televisions and radios to create a quiet and comfortable environment before the patient arrives. Dr. Grant also highlighted the importance of creating a familiar environment for CSHCN to get them used to the experience of going to the dentist. One of her methods is giving families a PowerPoint with photos of the dental office and staff to increase patient familiarity before they arrive for a visit. Dr. Grant reminded the audience that many CSHCN require more frequent dental visits than other children because they do not always have the best oral health care routine; not all insurance providers, however will cover additional visits.

Eva Scheer and Jana Monaco represented parents of CSHCN on the panel and gave a voice to the patients and their families. Eva recognized early on (before age 1) that her son Cade had autism. Jana's son, Stephen, now 20, was born with a rare metabolic disorder called Isovaleric Acidemia and suffered severe brain damage at age 3 ½, which left him with severe disabilities and complex medical issues. Representing a broad spectrum of CSHCN issues, Eva and Jana provided a real-life look at issues families with CSHCN face in their efforts to obtain oral health care. They serve as strong advocates for their children and experience first-hand on a daily basis the struggles and joys of raising a CSHCN.

Eva and Jana shared some of their stories of going to the dentist with their children—positive and negative. They explained that a lot of trial and error is necessary to identify what works for each individual child. For example, certain tools and devices, such as weighted blankets and toys, may be helpful while at the dentist's office. Eva said they discovered that her son, Cade, found the weighted x-ray blanket at the dentist soothing and comforting, which led them to use it as a regular part of every visit. Jana noted how much stress Stephen endured

early in his life from having his teeth cleaned every 6 months. She explained that it took a dental specialist at D.C.'s Children's National Hospital to inform them that the regular cleanings were actually removing the plaque that was protecting Stephen's teeth against decay. Eva and Jana also discussed the importance of routine for CSHCN but cautioned that routines may need to change over time as children grow and develop. Both mothers highlighted that good communication between a dentist office and the patient and their families is critical.

Overall, the discussion between panel members illustrated the benefits of good working relationships between providers and parents in ensuring that CSHCN receive good oral health care. All three panelists acknowledged, however that parents struggling financially or who lack other resources and social supports are less able to optimize their child's oral health care.

Breakout Sessions

Following the morning panel—which personalized some of the barriers to oral health care—and before the afternoon panel—designed to identify solutions to the barriers identified—conference organizers divided participants into breakout sessions based on their expressed preference and expertise. The four thematic areas for the breakout sessions were: transportation, financial incentives, case management oversight, and school-based health centers with dental suites. Background on each area as well as highlights from the breakout sessions are detailed below.

TRANSPORTATION

As discussed above, although D.C. may have a sufficient number of dental providers to serve all of D.C.'s children, not enough dentists currently serve Medicaid-enrolled children or practice in the areas where such children are located. One way the District is required to support access

to care is by providing Medicaid-enrolled children with non-emergency medical transportation (NEMT) to help ensure they can get to a provider's office for services. Quality NEMT services are vital to CSHCN, who may have health conditions that make travel using urban transportation systems seriously impractical or who may require the use of specially equipped vehicles. Both parents and providers commonly cite transportation as a barrier for D.C. Medicaid-enrolled children's access to oral health care.

A 2017 SURVEY OF D.C. ELDERLY ADULTS AND PEOPLE WITH DISABILITIES FOUND THAT ONLY 11% OF PARTICIPANTS USED MEDICAID TRANSPORTATION. FORTY-NINE PERCENT INDICATED THAT THEY WERE AWARE OF THE SERVICES BUT DID NOT USE THEM.

Before the convening, the HJA Oral Health Team identified two primary problems that prevent D.C. Medicaid-enrolled children from accessing needed NEMT services. The first is low levels of awareness regarding the availability of services and how they work. A 2017 survey of D.C. elderly adults and people with disabilities found that only 11% of participants used Medicaid transportation. Forty-nine percent indicated that they were aware of the services but did not use them; in general, a major reason for not using available services was lack of specific information on how the services work. Though the survey

participants were primarily older adults, these numbers are telling; if older adults are not using Medicaid NEMT services, parents and guardians of children likely are not using them either, for the same reasons.

The second problem is the actual practical difficulties of using Medicaid NEMT services. In the 2017 survey discussed above, only 2% of participants said they preferred Medicaid transportation to other transportation options. D.C. Medicaid providers have reported that patients must endure extensive procedures to arrange for transportation and that patients with Medicaid have had to cancel appointments because of inability to secure NEMT services. Additionally, D.C. oral health providers report that even when parents of Medicaid-enrolled children are able to secure NEMT services, they may experience wait times of up to three hours for the transportation to arrive.

Main Points of Discussion:

Breakout session participants discussed a number of barriers related to transportation. There was general agreement among participants that patients find access to and use of Medicaid provided NEMT transportation services unnecessarily difficult and confusing. Among the first hurdles D.C. patients face in accessing transportation assistance is awareness about NEMT services and determining whether they are entitled to such services. One possible solution suggested to address those issues was a more user-friendly website or handbook than those that currently exist. It was noted that the current handbooks are often too long for people to read. Creating a one-page or summary document that summarizes NEMT services and rights of patients in a short, easy to read document, which could be mailed to patients and Medicaid recipients, provided in dental offices, and made available online, was proposed.

Even for patients who know that NEMT services are available, participants agreed

that the process and frequency for requesting NEMT services was another significant barrier to use. In D.C., access to transportation services starts with a call to DHCF or the patient's Medicaid managed care organization, which precipitates a manual check of the Medicaid system's database to determine eligibility for services. D.C.'s NEMT requires a new qualification determination each time services are requested. Thus, if a patient is able to obtain a ride (e.g., the patient or the patient's family member owns a car) for a particular medical visit, the patient is not eligible for transportation services. The group also agreed that a better eligibility system would involve pre-qualification, with periodic updates, so that patients are not required to re-qualify each time they request services. Dentists and parents who work in other states shared with the group that these types of eligibility and qualification barriers are not universally imposed. In some states, patients receive a card with a member ID that they provide each time they schedule transportation, streamlining the scheduling process.

Once patients are determined to be eligible for NEMT services, another barrier to accessing those services is ease of use and availability. Currently, D.C. does not have an online portal to schedule transportation services. Instead, patients are required to call during normal business hours, which often subjects them to long wait times. It was suggested that an online portal would make it easier to schedule and change appointments and services. Aside from an online portal, the suggestion was also made that staffing the phone lines outside of business hours and creating a mobile app, to aid in scheduling and information sharing, would be helpful to improving use of the system. The point was made that another issue associated with the inconveniences of the current scheduling system is that it deters people from using the service, which can lead to additional oral health issues. Moreover, because NEMT services need to be scheduled days

ONCE PATIENTS ARE DETERMINED TO BE ELIGIBLE FOR NEMT SERVICES, ANOTHER BARRIER TO ACCESSING THOSE SERVICES IS EASE OF USE AND AVAILABILITY.

planned are particularly problematic (and may result in the use of emergency room services for treatment).

Once NEMT services are indicated and requested, another barrier for patients is the long wait times under the current system. Adjusting for long windows for pickups can mean that a simple dentist visit will take all day. One proposed solution was to establish a partnership with rideshare services such as Uber and Lyft. The group talked about how such partnerships are currently being discussed in the District and may reduce some of the barriers around timing; however, these partnerships may also encounter barriers in terms of catering to patients with special health care needs such as those with mobility issues and those who use wheelchairs. One participant noted that some issues in these areas are being addressed through services like Uber Assist and UberWAV, which allow riders to request vehicles that can accommodate riders with physical disabilities. Another suggestion involved the use of private ambulance services in the form of a partnership or a charitable contribution and/or tax write-off incentive.

In addition to the barriers that patients face in using NEMT services, the group discussed transportation from the dentists' perspective. Dentists tend to keep appointments short to see more patients, in order to run a more cost-efficient business. Because of the short appointment

times, however, some patients must come back three to four times, which equates to additional trips, inconveniencing the patient. The suggestion of scheduling longer appointments, especially for patients with special health care needs, was one proposed solution. One of the dentists in the room agreed that scheduling long appointments might actually benefit patients and providers. An incentive or compensation for dentists seeing CSHCN was another proposed solution. One such incentive would involve providers in the transportation process. Currently, the responsibility to get the patient to the appointment is on the brokers who provide services through the NEMT system, and they do not suffer consequences if the patient is late or misses an appointment. Shifting the responsibility to the transportation provider was seen as likely to increase efficiencies in the system. One dentist said she would gladly take on the responsibility at her practice for providing reimbursable transportation services for her patients because it would increase the patients' ability to be on time and her ability to see patients in a predictable way.

The final area of discussion around transportation focused on the location and distribution of dentists, which is a continuing major concern in D.C. For example, Wards 7 and 8, some of the poorest areas of the District, do not have enough dentists that accept Medicaid. One solution to the general transportation challenges would be to bring the dentists to where the people are, so patients do not need to travel as far. Currently, some facilities exist (such as school-based health center dental suites) but are not staffed. The group also discussed the option of increasing the use of mobile dentistry in D.C., although the consensus was that it is actually more cost effective to bring patients to the dentist. Finally, the group briefly discussed the potential for increasing oral health services in underserved areas by expanding the scope of practice rules in D.C. to allow dental

hygienists to practice preventive oral health care without direct supervision of a dentist. It was suggested that such a licensing change, which is a contentious political issue in D.C., might add to the number of oral health services available in Wards where there is a dearth of dental office options and transportation problems are especially acute.

Prioritized Solutions:

The main solutions identified by the group were:

1. Improve patient awareness of NEMT services and reduce the logistics around eligibility determinations.
2. Increase ease of use of transportation –make it mobile or online friendly by creating a website or an app so people can easily book transportation services without having to call during business hours.
3. Develop a rideshare partnership such as with Uber or Lyft. (The group believes such a partnership is already being discussed in D.C., in which case we should consider how to make it most accessible to users.)
4. Incentivize oral health providers to assume some responsibility for transportation of Medicaid and CSHCN patients (include them in the transportation discussion).
5. Promote policies that would bring more oral health providers that accept Medicaid to where people in need live (especially Wards 7 and 8).

FINANCIAL INCENTIVES

Across the country, reimbursement rates affect both dentists' and primary care providers' willingness to provide Medicaid-enrolled children with oral health care. Currently in the District, patients can enroll in one of two types of Medicaid programs. The first of those is traditional, fee-for-service (FFS) Medicaid, in which patients

can see providers that accept Medicaid payments and those providers receive a negotiated fee for those services, including oral health services. The second is Medicaid managed care, in which Medicaid recipients enroll in a managed care plan (like an HMO) that contracts with providers and helps to coordinate care (including oral health) among those providers for the patients. CSHCN in the District are encouraged to enroll in the Health Services for Children with Special Needs plan to receive care coordination appropriate for their complex medical needs.

In 2016, Medicaid FFS reimbursement rates for child dental services were less than half of the fees generally charged by dentists and only 61.8% of private dental insurance reimbursement rates. Commonly held concerns amongst providers about treating Medicaid-eligible patients that providers can make significantly more money serving non-Medicaid-enrolled children also have a significant impact on their willingness to treat Medicaid-enrolled children.

Even among providers who do serve Medicaid-enrolled children, many limit the number of CSHCN they see or refrain from serving CSHCN altogether. One of the primary reasons oral health providers do not serve CSHCN is inadequate financing and reimbursement for the direct and adjunctive oral health services CSHCN require.

In D.C., reimbursement rates for the most common oral health services that are included in the D.C. Medicaid Dental Fee Schedule and paid to primary care providers and dentists serving children enrolled in the D.C. FFS program are higher than both national and regional averages. Moreover, they represent a greater percentage of private dental insurance reimbursement rates than the national average (82.3% for D.C. vs. a national average of 61.8%).

However, the reimbursement rates paid to D.C. providers operating in managed care organization (MCO) networks

and Federally-Qualified Health Centers (FQHCs) are not required to be equal to the rates dictated by the D.C. Medicaid Dental Fee Schedule. For instance, while DHCF has required MCOs to keep the FFS rates paid to providers for offering oral health services somewhat close to the rates dictated in the dental fee schedule, three of four D.C. MCOs reimbursed their dentists at a lower rate than the FFS program in FY 2015. Considering that over 90% of D.C. Medicaid-enrolled children are enrolled in managed care, this lower reimbursement for MCO providers could be a factor contributing to the lack of dentists participating in D.C. Medicaid. Additionally, providers operating in MCO networks and FQHCs are potentially being paid in accordance with capitated or bundled fee agreements that may discourage them from providing certain oral health services.

For oral health providers who are willing

IN 2016, MEDICAID FFS REIMBURSEMENT RATES FOR CHILD DENTAL SERVICES WERE LESS THAN HALF OF THE FEES GENERALLY CHARGED BY DENTISTS AND ONLY 61.8% OF PRIVATE DENTAL INSURANCE REIMBURSEMENT RATES.

to accept Medicaid reimbursement rates but not willing to serve CSHCN, a primary financial disincentive to treating CSHCN is often that the providers do not receive increased reimbursement for serving CSHCN vs. non-CSHCN. Both managing CSHCNs' cases and treating CSHCN oftentimes requires more time and expertise than performing the same services for non-CSHCN. For instance, it

frequently takes providers additional time to obtain and understand CSHCN's complex medical history or perform medical consultations with CSHCN both before and after treatment. Moreover, treatment of CSHCN, and particularly treatment of those with developmental disabilities, complex health care issues, behavioral issues, or dental fears, may require additional time and involve the use of additional personnel or advanced techniques. Thus, some providers who treat Medicaid-enrolled children abstain from treating CSHCN because they are not reimbursed for those additional services (i.e., case management services, behavioral management services, etc.) or the additional time they spend—not because of the rates at which they are reimbursed.

For many years, a medical model has

PARTICIPANTS ACKNOWLEDGED THAT CSHCN ON MEDICAID WOULD BE AMONGST THE MOST EXPENSIVE AND HIGH-RISK PATIENTS FOR DENTISTS TO TREAT.

reimbursed primary care providers for the increased time and effort it takes to serve Medicaid-enrolled CSHCN vs. Medicaid-enrolled non-CSHCN. Partly in an effort to establish a similar model for oral health providers, the American Dental Association's Council on Dental Benefit Programs has adopted numerous Codes on Dental Procedures and Nomenclature (CDT Codes). While D.C. provides reimbursement for the Current Procedural Terminology (CPT) codes that comprise the medical model, it does not provide reimbursement for the CDT codes that comprise the dental model.

Main Points of Discussion:

During this breakout session, participants focused on issues associated with costs for dental services. Participants agreed that a central goal should be preventing oral health problems, rather than allowing issues to progress to where they are more significant and expensive to treat. The group brainstormed methods to increase financially viable options to encourage dentists to undergo the training necessary to treat CSHCN while also convincing more providers to accept Medicaid patients. Key themes of discussion during the session were the issues of risk adjustment, the role of the federal and state government in Medicaid reimbursement, and provider choice for users.

Participants acknowledged that CSHCN on Medicaid would be amongst the most expensive and high-risk patients for dentists to treat. The idea of incidence fees or bonus payments to dentists who accept children on Medicaid and/or CSHCN was discussed as a plausible incentive. Multiple participants suggested that such payments could increase provider participation and lead dentists to accept more CSHCN for less invasive or complicated procedures. Though not discussed by the group, two policies adopted by other states provide models of how D.C. might implement such an incentive. California, for example, established a Dental Transformation Initiative that supports payments to oral health providers who (1) increase the percentage of Medicaid-enrolled children they provide with preventive services, and (2) increase children's dental continuity of care by providing annual dental exams to children at the same service office location year after year. Additionally, 27 states have followed the recommendation of the American Academy of Pediatric Dentistry and adopted a dental behavior management code (CDT code D9920) into their state Medicaid plans. This new coding allows reimburses providers for helping CSHCN “identify appropriate and inappropriate behavior, learn problem-

solving strategies, and develop impulse control, empathy, and self-esteem.” The goal is to incentivize more providers to accept CSHCN and to decrease the use of general anesthesia to treat these patients.

The group also considered ways to ensure that MCO providers and FQHCs get reimbursed for oral health services at rates that cover their costs. Encouraging D.C. and the MCOs to cover new CDT codes to acknowledge special procedures with CSHCN, providing greater care coordination and transitional support to heads of FQHCs, and determining a way to bill at 100% of costs for oral health services at FQHCs were suggested as possible solutions by participants. A related recommendation was to rely on economists and business experts to help determine economical methods for unraveling the value chain for the issues associated with care of Medicaid-enrolled CSHCN.

One participant suggested that regardless of increased financial incentives, providers with inadequate training (e.g. around how to care for CSHCN) may still not open their practices to CSHCN out of a lack of comfort and/or fear of inducing a medical emergency. On the discussion of patient comfort, participants acknowledged that many families have difficulty finding oral health providers equipped with the requisite training and expertise to treat CSHCN. In addition, participants discussed how some families enrolled in managed care may have issues following through with oral health care for their CSHCN if they are assigned to primary dental providers with whom they lack any prior relationship. Similar considerations of patient comfort extended to the group’s conversations surrounding the transition from child-to-adult services for CSHCN.

The group decided that aggregating services through the creation of specialized centers or drop-in clinics could be a way to ensure that CSHCN receive quality care from well-equipped providers. Participants also suggested that such centers or clinics could be staffed with billing staff trained

to bill for oral health services in addition to medical services, in order to also aggregate and capitalize on their expertise.

Prioritized Solutions:

1. The main solutions identified by the group were:
2. Aggregate providers serving CSHCN and equip them with trained billing staff
3. Change reimbursement policies for MCO providers and FQHCs.

Create incidence fees/special payments for oral health providers serving CSHCN and/or Medicaid-enrolled children.

CASE MANAGEMENT OVERSIGHT

Case management services are an essential component of oral health for Medicaid-eligible CSHCN. Case managers alleviate some of the personal and systemic barriers ordinarily affecting Medicaid patients’ abilities to access necessary oral health services, such as income level, education, and familiarity with the Medicaid system. This ultimately results in higher usage rates of oral health services by CSHCN. Case managers assist with 1) assessing each patient’s individual needs for medical or other services covered by Medicaid; 2) developing a care plan customized to that particular patient that can include medical services, physical and other types of therapy, support at school, etc.; 3) referring the patient to the appropriate providers for those services; and 4) monitoring the patient over time to ensure that he or she is actually receiving those services and is progressing appropriately. For patients with special health care needs particularly, case managers can help to navigate a sometimes-large and bewildering array of providers, specialists, and support services. As a result, all children enrolled in HSCSN in the District are entitled to case management services; special needs children in other MCOs and in FFS Medicaid receive case management services as well, as would non-CSHCN after a health crisis.

PARTICIPANTS IN THE CASE MANAGEMENT SESSION DISCUSSED THE CHALLENGES WITH CASE MANAGEMENT BEING POORLY DEFINED, RESULTING IN INCONSISTENT SERVICES BEING PROVIDED TO PATIENTS.

In fulfilling these requirements a significant challenge case managers face is lack of data describing individuals' access to and need for oral health care. For example, in its D.C. Healthy People 2020 Framework, the D.C. Department of Health acknowledged the need to collect more data on children's access to oral health care, "especially vulnerable sub-populations such as children with special health care needs." Such need is consistent with the 2009/10 National Survey of CSHCN, which reported that 43.1% of parents of CSHCN who needed assistance coordinating their child's health care did not receive all the care coordination services they needed. Additionally, 21.1% of CSHCN who needed a referral for specialist care or services had difficulty getting it. More recent data from the Agency for Health Research and Quality's Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey also suggests that D.C. MCOs' case management services could be improved. The survey's "Coordination of Care Composite" measure, which evaluates MCO's case management services with a focus on criteria such as patient access to case managers and ability to schedule needed appointments, D.C. was below the national average in 2017 and dropped 3% from 2015 to 2017.

Main Points of Discussion:

Participants in the case management session discussed the challenges with case management being poorly defined, resulting in inconsistent services being provided to patients. They also identified a need to bridge the gap between dental and medical services through provider and case manager training, and the importance of communication in facilitating strong case management processes. Broader themes of the discussion included finding ways to empower case managers by providing them with more quality information about the children they manage and reducing the burden on case managers by enabling others, such as parents and providers, to help coordinate children's care.

At the beginning of the discussion, participants discussed case management as a federally defined service that is currently not universally available and discussed the differences in how to attain case management services. As discussed above, most CSHCN receive case management services, one way or another. Taking D.C. as an example, however, children enrolled in the District's managed care plan for CSHCN receive services automatically, while CSHCN in fee-for-service Medicaid need to opt in to receive those same services. Additionally, the scope of services covered by the term "case management" was the topic of some debate, with some participants asserting that helping to coordinate Individual Education Plans (IEPs) at school was within the scope and others arguing that only health care services were required. Because a clearer definition is not included in federal or D.C. regulations, clarity in managed care contracts would at least resolve the scope issues for children enrolled in HSCSN.

Participants acknowledged that case management services often focus on medical services and overlook oral health issues. One participant questioned whether the present eligibility criteria for receiving case management are too broad and

whether they should be narrowed to allow case managers to spend more time with children whose health conditions are especially complex. Another participant commented that a child's oral health is usually not considered during the determination of what case management services the child requires, and this should be changed. To these suggestions, another participant added that both case managers and medical professionals should also be trained to handle particular medical disabilities and understand the interaction between particular medical conditions and oral health.

To overcome discrepancies in oral and medical service provision, participants discussed potential ways to better integrate dental and medical care. Participants noted that while useful, case managers are not always able to bridge the gap between medical and dental services. In part, this was seen as the result of most individuals opting to go to small, general dental practices to obtain dental services in lieu of larger hospitals or medical centers where it is much easier to integrate a variety of types of services. Moreover, due to the Health Insurance Portability and Accountability Act (HIPAA) considerations and misinterpretations, participants noted that dentists and doctors do not always communicate effectively with each other regarding a particular patient.

One participant noted the usefulness of paper health passports, previously carried by patients and used as medical documentation systems to integrate and inform care between doctors and dentists, are almost obsolete now. The group considered whether there were any similar, modern alternatives available. However, participants quickly noted weaknesses of the data included in D.C.'s electronic medical record systems and how weak data can inhibit case managers from effectively managing children's care.

For example, one participant noted that available electronic medical record systems

data indicates that when D.C. primary care doctors provide required oral health assessments during well-child visits for children between the ages of zero and three, they are not correctly billing for such services. Though not discussed by the group, evidence suggests there are at least two ways D.C. primary care providers are incorrectly billing for oral health assessments during well-child visits. First, despite D.C.'s 2014 instruction to primary care providers to bill separately for each required component of a well-child visit (instead of using a single "lump sum" code for the visits), primary care providers have not widely adopted the practice. As a result, case managers are likely unable to easily obtain information about whether a child received an oral health assessment during his or her well-child visits and to coordinate the child's future care accordingly.

TO OVERCOME DISCREPANCIES IN ORAL AND MEDICAL SERVICE PROVISION, PARTICIPANTS DISCUSSED POTENTIAL WAYS TO BETTER INTEGRATE DENTAL AND MEDICAL CARE.

Second, despite D.C.'s 2014 instruction to primary care providers to begin using a "modifier" in their billing claims to indicate when a child needs follow-up care after a well-child visit, many providers have not adopted the practice of using the modifier, and the D.C. Department of Health Care Finance has experienced issues viewing claims with the modifier. As a result, case managers are likely unable to easily tell whether a primary care provider's oral health assessment revealed a condition that needs follow-up care and to create

individualized dental plans to ensure that children receive all necessary care.

One participant also expressed concern about some primary care providers' abilities to effectively perform oral health assessments in the first place. Finally, one participant noted that dentists have been billing for services using treatment codes without using diagnostic codes. As a result, it can be more difficult for case managers to decipher a child's conditions and to determine the patient's overall health and health needs. Though useful new dental diagnostic codes were implemented nationally in 2015, some payers have yet to require providers to report these codes in their dental claims.

ONE PARTICIPANT NOTED THAT DENTISTS HAVE BEEN BILLING FOR SERVICES USING TREATMENT CODES WITHOUT USING DIAGNOSTIC CODES.

Multiple participants suggested that training primary care providers to properly perform oral health assessments and both primary care providers and dentists to properly bill for services may be ways to help ameliorate these issues. A successful example of the benefits of provider training exists around mental health in D.C. and could serve as a model for oral health care. Beginning in 2014, a public-private partnership called the DC Collaborative for Mental Health in Pediatric Primary Care offered a free 16-month Quality Improvement Learning Collaborative for the pediatric primary care practices serving 80% of the Medicaid-enrolled children in the D.C. area. The partnership offered participating practices the training and support necessary to implement mental health screening with

approved screening tools during well-child visits, including technical assistance from quality assurance and mental health coaches, three plan-do-study-act cycles, monthly chart audits, team leader calls, practice team meetings, and webinars. As a result of this quality improvement structure, the percentage of the practices' well-child visits that included a mental health screening with an approved screening tool rose from 1% to 76%, this contributed to a 353% increase in the number of developmental and behavioral health screenings performed in D.C. from 2013 to 2015.

Participants also noted that even when all necessary data is available to case managers, some case managers may struggle to interpret the data and coordinate children's care if they are not well-versed in oral health issues and how they can affect CSHCN's overall health. Because of this, participants believed that creating and/or bolstering oral health training for case managers could be useful.

The session concluded with a discussion on the importance of communication in case management processes. Regardless of the presence of case managers, participants agreed that communication between parents, case managers, primary care doctors, and dentists is the cornerstone of effective care coordination for CSHCN. Participants noted that due to the current lack of institutional connections and coordination between physicians and dentists, parents often become the main communicators and advocates for their child. However, due to a lack of understanding and knowledge, they are often unable to best communicate the oral health needs of the child. Participants agreed that educating parents so that they can understand their child's oral health needs would empower them to effectively communicate these needs to others, including providers and case managers.

Prioritized Solutions:

The main solutions identified by the group were:

1. Better define case management and eligibility criteria for case management services.
2. Improve coordination between primary care doctors, case managers and oral health professionals through provider and case manager training.
3. Empower individuals other than case managers, such as parents and providers, to help ensure CSHCN receive the oral health care they need.

SCHOOL-BASED HEALTH CENTER LESSONS:

The D.C. Department of Health (DOH), in collaboration with D.C. Public Schools (DCPS), healthcare providers and other partner organizations, has created a network of programs to coordinate and deliver school-based health services. Among these programs is the School Based Health Center (SBHC) program, which funds three community-based medical providers who operate seven SBHCs in different D.C. public schools. Each SBHC serves as a primary care clinic, offering a range of health services, including dental services. Staffed with health professionals from a variety of fields, the SBHCs focus on “the prevention, early identification and treatment of medical and behavioral concerns that can interfere with a student’s learning.” The target areas of health provided by SBHCs include obesity, mental health, asthma, substance abuse, lead exposure, well-child care, oral health, and sexual health. Regarding the range of SBHC oral health services, the DOH recommends that services include basic oral examinations, teeth cleanings, education and counseling, as well as sealant applications.

As of February 2016, 27% of DCPS Medicaid children between the ages of 11 and 20

attended a school with a SBHC. To receive oral health care in a SBHC, students under the age of 18 must obtain parental consent. During school years 2015-16 and 2016-17, SBHCs were responsible for 364 and 358 oral health visits, respectively. Additionally, during 2016, SBHCs referred 259 children and youth to outside providers for preventive oral health services.

Despite a competitive process designed to ensure that each of the D.C. SBHCs would deliver the same minimum services, including oral health services, only four of seven D.C. SBHCs currently have an operating dental suite (Ballou Senior High School, Cardozo Learning Center, Dunbar Senior High School, and Woodson Senior High School). While some of these SBHC dental suites are relatively well staffed, all have experienced varying degrees of difficulty filling and operating their dental suites. Barriers to delivery of oral health care through SBHCs in the District include financial disincentives, administrative burdens, and D.C.’s relatively limited dental hygienist scope of practice rules.

For example, research by the HJA revealed that lengthy and slow sub-operator credentialing and Department of Healthcare Finance (DHCF) Medicaid Provider certification processes are significant barriers faced by SBHCs. SBHC operators often have to find external sub-operators for their dental suites for reasons such as a lack of dentists within their own organization. The sub-operators then must go through a comprehensive credentialing process within the operator’s organization. Additionally, each operator and sub-operator is required to establish a Medicaid Provider Agreement with DHCF. Even though this rigorous application process can take several months, federal regulations add to the burden by requiring providers with existing agreements to go through this process each time they want to service a new location, even if they are already credentialed in other locations within the District.

Additionally, in schools that currently operate dental suites, only about 40% of students have the consent needed to receive services from the SBHC. In 2018, DOH stated that “[w]ithout systematic changes to the [SBHC] enrollment process or to eligibility . . . improvements in service utilization and student health outcomes will be limited.”

Main Points of Discussion:

The group discussed financial disincentives to providing oral health services, such as inadequate SBHC funding and Medicaid reimbursement. The group discussed how current levels of funding for SBHCs inhibit them from being able to purchase sufficient equipment for the dental suites or to adequately staff them. One participant noted that SBHC’s dental suites only allow providers to serve one patient at a time; the participant suggested that this limitation contributes to SBHC’s financial and utilization issues.

The group also discussed the difficulty of finding oral health providers to work in SBHCs. Several participants felt that most problems around recruiting providers to work in school dental suites result from barriers related to the design of the suites (chairs, equipment, etc.), which reflect a lack of understanding about how practitioners need to work within a school space. Issues with Medicaid reimbursement for services provided in SBHC dental suites were also identified as a primary barrier to provider participation.

Beyond improving SBHC funding and Medicaid reimbursement, participants suggested offering loan repayment benefits or other financial incentives to dental school students and recent graduates who commit to work at SBHCs. D.C.’s Health Professional Loan Repayment Program (HPLRP) provides loan repayment benefits to dentists and dental hygienists who commit to practice at a certified service obligation site located in a Health Professional Shortage or Medically

Underserved Area. However, the HPLRP program currently only provides benefits to applicants who provide full-time service of at least 40 hours per week at a service obligation site certified by the HPLRP; dentists and dental hygienists currently only work at D.C. SBHCs one day per week, and the only SBHCs that have been certified as service obligation sites are those at Woodson Senior High School and the Cardozo Learning Center. Thus, in order to utilize the D.C. HPLRP to encourage oral health providers to work at SBHCs, it appears that exceptions to the program requirements or legislative amendments would be necessary.

Additionally, the group discussed the potential of partnering with local dental schools (such as the College of Dentistry at Howard University) to provide opportunities for students to both work in SBHCs and gain experience treating underserved patients and CHSCN. Participants suggested that schools could offer education credit to students who work at SBHCs or provide scholarships to students who commit to working at SBHCs.

The group also discussed how D.C. dental hygienists’ limited scope of practice is another barrier to operating efficient and effective SBHCs. D.C.’s dental hygienist scope of practice laws are some of the most restrictive in the country. According to the Pew Charitable Trusts’ Dental Campaign and others, these restrictive laws unnecessarily limit both the efficiency and effectiveness of school-based oral health programs by preventing dental hygienists from performing services they are trained to perform without the supervision of dentists, thereby increasing the program’s reliance on dentists.

After considering this issue, the group briefly discussed the viability of expanding D.C. dental hygienists’ scope of practice at least to allow them to provide dental sealants in school-based settings without the patient first seeing a dentist for an examination, diagnosis, and treatment

planning. This expansion was included in a bill introduced to the D.C. Council in 2013, but the bill did not pass. The group also briefly discussed whether midlevel dental providers, such as dental therapists (which are a category of practice in Alaska and Minnesota), should be authorized to work as part of oral health teams in D.C. Though there was some support for both of these ideas within the group, a participating expert described significant political barriers that would have to be navigated before action could be taken.

Finally, the group discussed the difficulties SBHCs have experienced in their efforts to enroll children and serve the children who are already enrolled. Multiple group members expressed concerns about both parents' and teachers' lack of awareness of available dental services at SBHCs. A participating parent mentioned that many students never bring home SBHC enrollment forms, and even when parents are able to sign them, many students never return the forms to the school. Another participant noted that because parents do not have to take their children in for dental treatment at SBHCs like they ordinarily would for treatment at dentists' offices, there is potentially less buy-in from parents of children receiving care at SBHCs. The group discussed the possibility that this may negatively impact the day-to-day priority some households place on dental care and that some parents may not receive information about the results of their child's dental visit from the school.

To help solve these issues, numerous participants suggested expanding and adding to current efforts to educate parents and teachers about the importance of oral health and the oral health services available at SBHCs. Already, as part of its efforts to increase the number of D.C. children receiving preventive dental visits, D.C. is providing a significant number of parent and teacher oral health education sessions at various Head Start locations and parent/teacher meetings to increase

TO HELP SOLVE THESE ISSUES, NUMEROUS PARTICIPANTS SUGGESTED EXPANDING AND ADDING TO CURRENT EFFORTS TO EDUCATE PARENTS AND TEACHERS ABOUT THE IMPORTANCE OF ORAL HEALTH AND THE ORAL HEALTH SERVICES AVAILABLE AT SBHCS.

awareness of oral health issues and prevention. The group believed education sessions such as these should be continued, and if they do not already include discussions of SBHCs, expanded to do so. Additionally, the group discussed the ideas of placing oral health peer educators at schools, encouraging schools to discuss oral health and SBHCs at school events like back to school nights, and incorporating discussions of oral health into different health-related classes.

Prioritized Solutions:

The main solutions identified by the group were:

1. Incentivize established oral health providers to work in SBHCs by improving Medicaid reimbursement and general SBHC funding.
2. Encourage dental school students and recent graduates to work at SBHCs by partnering with local dental schools and offering loan repayment or other financial incentives to dentists and dental hygienists.
3. Examine viability of expanding dental hygienists' scope of practice and/or authorizing midlevel dental providers to work as part of the dental team in D.C.

4. Partner with parents and teachers to better communicate about the importance of oral health and the oral health services available at SBHCs.

Panel #2—Where to go from Here: Improving Oral Health in the District and Beyond:

MODERATOR:

- **Sara Hoverter**, staff attorney and adjunct professor at the Harrison Institute for Public Law, Georgetown University Law Center

PANELISTS:

- **Dr. Joan I. Gluch**, Associate Dean for Academic Policies, and Chief of the Division of Community Oral Health, Penn Dental Medicine
- **Dr. Jay Balzer**, director of post-graduate training of dentists in the specialty of Dental Public Health at NYU Langone Hospital and Medical School

The afternoon panel was more a solutions-based panel and consisted of two practicing dentists, and public health professionals, Dr. Joan I. Gluch and Dr. Jay Balzer. The panel was moderated by Sara Hoverter, staff attorney and adjunct professor at the Harrison Institute for Public Law.

The panel highlighted some interesting points, including that access to services is one of the barriers to oral health care for CSHCN and that proximity does not equal access: just because you live near Harvard University does not mean you can go to school there. One possible solution to increase access is to use mobile vans. Dr. Gluch has experience working with a program in bringing oral health care to people in high need areas using mobile dental vans in Philadelphia. However, in Pennsylvania, hygienists and other health care professionals (as opposed to just dentists) are allowed to see patients independently, which makes it easier to

staff and run mobile clinics and vans. Other jurisdictions, including the District, have more restrictions only allowing dentists to provide dental services.

The panelists reminded us that in thinking about potential solutions and collaborators, it is essential to look at successful models as guides including community health centers like Mary's Center. Another idea to increase access to oral health services is to align with residency programs and large dental centers and universities to implement programs. Dr. Gluch shared stories of how campus-community partnerships have been successful at the University of Pennsylvania.

The panelists also discussed increasing the use of silver diamine fluoride (SDF), a non-surgical procedure liquid used to paint on teeth to arrest dental caries. SDF is a relatively new but increasingly popular procedure that helps manage tooth decay. From a safety perspective, SDF allows dentists to delay or avoid more traditional invasive restorative therapies that require general anesthesia. Additionally, from a financial perspective, SDF is a relatively low cost procedure that can reduce the need for more expensive treatments in the future. Some states allow dental hygienists to perform the procedure, which makes it even more affordable.

After performing a successful SDF pilot study in 2017, one of D.C.'s MCOs (AmeriHealth Caritas District of Columbia, Inc.) began to cover CDT code D1354 (Interim Caries Medicament), which is the code that oral health providers use to bill for applying SDF. However, contrary to the recommendations of the American Academy of Pediatric Dentistry (AAPD), D.C.'s broader Medicaid program still does not provide reimbursement for this code. D.C. oral health providers are, thus, disincentivized from offering the procedure. Moreover, evidence suggests that D.C.'s lack of reimbursement for the code may reduce its use in local pediatric dentistry training programs and subsequent use in private

practice by graduates of such programs.

The afternoon panel also discussed characteristics of an effective oral health care system, including transparency, accountability, and the sharing of information.

NEXT STEPS

In 2017-18, HJA staff and law students explored policy options to increase access to oral health services for children with special health care needs (CSHCN) enrolled in Medicaid. These options included:

- creating financial incentives to increase the number of dentists treating Medicaid patients,
- creating more capacity among dentists to treat children with special health care needs,
- improving managed care case management,
- improving transportation for patients,
- broadening the scope of practice for other health professionals such as dental hygienists, and
- creating more community-based locations for treatment (such as school-based health centers and federally-qualified health centers).

The convening provided an excellent opportunity to identify barriers as well as solutions to accessing oral health services for CSHCN in D.C. and to gather, ground-truth, and prioritize these and new solutions. Our research and the convening together have allowed HJA's oral health team to identify key areas of focus over the next academic year starting with ongoing advocacy on the following main policy levers (some of which will benefit not only CSHCN but also Medicaid patients generally):

(1) Improving D.C.'s contracts with managed care partners.

The District of Columbia government re-

bids its Medicaid managed care contract for CSHCN in fall 2019. Over the following year, we plan to influence the next contract to include:

- More robust transportation options for families (including adding more reliable options such as UberWAV, for people with physical disabilities)
- Better case management for patients in order to ensure they get the services to which they are legally entitled, by focusing on reporting patient outcomes in addition to case manager actions

Partners for this work could include the D.C. Department of Health Care Finance, the Children's Dental Health Project, and the D.C. Pediatric Oral Health Coalition.

(2) Establishing a dental collaboration network.

The HJA is interested in exploring the possibility of convening a group of school-based health centers, Howard dental school's clinicians, and federally-qualified health centers (FQHCs) to establish a collaborative network. Modeled after a program based at Tufts University, this network could:

- increase providers available to treat CSHCN (by training and enlisting Howard dental students and faculty),
- increase reimbursement for services through FQHCs' enhanced reimbursement rates, and

increase treatment options at school-based health centers by finding providers and affiliating those centers with the FQHCs to receive enhanced reimbursement.

Partners for this work could include the school-based health centers themselves, the D.C. Primary Care Association, Howard Dental School, Unity Health Care, and Mary's Center.

to bring more providers in to provide oral health services for CSHCN, increase reimbursement rates, and create

efficiencies of scale, and

(3) Training primary care providers about oral health.

Students in the HJA Law Clinic will collaborate with Georgetown School of Nursing and Health Studies faculty and students to develop a training program for nursing students who work with children in primary care settings. All DC Medicaid Managed Care primary care providers (PCPs) are responsible for providing HealthCheck screening services to patients up to age 21, which includes an oral health screening. This training could cover:

- Oral health risks in underserved populations,
- How to implement patient education and oral health risk assessment in a primary care setting serving high risk children and families , and/or
- PCPs oral health obligations under Medicaid and D.C.'s dental periodicity schedule.

PCPs in pediatric settings are the first line of defense against deteriorating oral

health and the first line of referral for parents. Increasing provider knowledge and understanding of their role in promoting their patients' oral health can improve children's access to oral healthcare.

Other possible advocacy efforts include adding a behavior management billing code in the District's Medicaid program (currently available in 27 other states) in order to mitigate the costs of treating CSHCN and addressing the needs of CSHCN who age out of the current system, move into fee-for-service Medicaid, and lose the support of policies aimed at children. Beyond these specific proposals, the HJA team will seek to:

(4) Continue to strengthen working relationships with key partners and stakeholders (including new partners and stakeholders) to help implement our action plan.

(5) Help to staff and open school-based health centers, beginning with the dental suite at Anacostia High School.

(6) Host and report on a second oral

health convening in 2019.

CONCLUSION

Access to oral health care for CSHCN in D.C. has improved drastically over the years, but we can do better. Issues that inhibit access to oral health care services under Medicaid, including transportation, financial incentives, case management oversight, and school-based health centers, may be daunting, but they are not unsolvable.

We know that the system is difficult to navigate and there are a variety of political and legal issues that must be addressed in order to make lasting change. While we have identified and begun to work with some key partners, we have connected with other potential stakeholders and partners through our research and the convening, and we look forward to collaborating with all interested parties as we move forward in our efforts to increase the number of D.C. CSHCN who receive quality oral health care under Medicaid.

APPENDIX 1: MEETING AGENDA

Agenda

8:30-8:45am | Check in (coffee, tea, & continental breakfast served)

8:45-9:15am | Welcoming Remarks

Jane Aiken, Vice Dean; Associate Dean for Academic Affairs, Georgetown University Law Center

Vicki Girard, Co-Director, Georgetown University Health Justice Alliance

9:15-10:30am | Panel 1 | A Personal Impact: Stories of Barriers to Oral Health Care in the District

10:30-10:45am | Coffee & Tea Break

10:45-12:00pm | Breakout Sessions | A Better Understanding of Barriers

Breakout sessions will identify barriers to oral health care for children with special needs in the District, including an examination of transportation issues, provider barriers, and scope of practice

12:00-12:45pm | Lunch | Poster Presentations

12:45-2:00pm | Panel 2 | Where to Go from Here: Improving Oral Health in the District and Beyond

2:00-2:10pm | Closing Remarks |

Vicki Girard

APPENDIX 2: PANELIST BIOGRAPHIES

Morning Panel: A Personal Impact: Stories of Barriers to Oral Health Care in the District

MODERATOR: **Jessica Millward**

Jessica Millward is a clinical teaching fellow and supervising attorney at the Health Justice Alliance Clinic. Prior to joining Georgetown Law, Jessica was a managing attorney at Montana Legal Services Association. As managing attorney, Jessica led staff and attorneys in high-quality, client-centered legal services in a high-volume practice. Jessica started at Montana Legal Services as an Equal Justice Works AmeriCorps Law Fellow, serving as an attorney in a Medical-Legal Partnership with a community-based health center. Throughout her five-year tenure at Montana Legal Services, Jessica primarily represented low-income clients in public benefits matters while performing other advocacy work including outreach to seasonal and migrant farmworkers and representation of individuals in landlord-tenant and end-of-life matters. As one of the only attorneys in the state practicing public benefits law, Jessica focused on impact driven cases that would change the lives of her clients and others utilizing benefits programs. Jessica graduated from American University Washington College of Law. As an undergraduate, she received dual degrees in Political Science and English Literature from Trinity College in Connecticut. She is licensed to practice in Washington, DC, Massachusetts, Montana, and New York.

Dr. Grant-Anamelechi

Dr. Jonelle Grant-Anamelechi is the owner of Children's Choice Pediatric Dentistry and Orthodontics in New Carrollton, MD and attending teaching faculty at Children's National Medical Center and Georgetown University Medical Center. Along with professional memberships locally, nationally and internationally, Dr. Grant-Anamelechi serves as the president of the D.C. American Academy of Pediatric Dentistry and a co-leader of the Medical and Dental Collaboration committee for the D.C. Pediatric Oral Health Coalition and the Maryland Dental Action Coalition as well as the D.C. Pediatric Oral Health Coalition. She is also a speaker for Colgate-Palmolive Oral Health Network Speakers Program. Dr. Grant-Anamelechi was recently named one of America's Top Pediatric Dentists by Consumers' Research Council of America.

Eva Scheer

Eva Scheer is a native Washingtonian who has a Masters Degree in Education from New York University. For the past 10 years, Eva was the director of operations at a nutritional supplement company which was recently sold to a Fortune 500 company. In May 2017, Eva graduated from the Institute of Integrative Nutrition as a certified health coach and is actively pursuing this new career.

Eva is married to Dr. Mark Scheer, an Orthopaedic Surgeon in Washington, D.C. and together they have two sons. Cade, 17, who has autism and attends high school in Montgomery County's autism program and Ben, 21, who attends Vanderbilt University. While in high school, they created Photobilities, a business that took pictures for families with special needs children.

Eva is one of the original members of Cure Autism Now, now known as Autism Speaks, an organization she was involved with for many years. Her committee had a feature story in Bethesda Magazine. Eva is also involved with Autism Ambassadors and is a member of Main Street, Inc., an intentional

inclusive apartment community being built in Rockville, MD. Eva has spoken at several events including the Dinner of Champions, an event raising money towards inclusion camp.

Jana Monaco

Jana is a state and national advocate for newborn screening and has helped to pass legislation to expand newborn screening laws in all 50 states. A former member of the Secretary's Advisory Committee for Heritable Disorders in Newborns and Children (SACHDNC), Jana now serves on its subcommittee for Follow Up and Treatment and the Virginia Genetics-Advisory Council. As Rare Action Network State Ambassador for NORD, Jana was instrumental in passing legislation declaring every February 28th in Virginia Rare Disease Day. Jana is the Advocacy Liaison for the Organic Acidemia Association and has presented on newborn screening and rare diseases on Capitol Hill, with NORD, Genetic Alliance, the FDA, and March of Dimes. She has also presented at the Advocate Leader's Program at the ACMG Conference. She is a member of the Children's National Health System Patient/Family Advisory Council in DC promoting patient and family centered care. Jana is published in Exceptional Parent Magazine, "My Poster Family", given media interviews and featured in Northern Virginia Magazine, September 2015. With her husband, Jana now hosts The Stephen Monaco Charity Golf and Dinner Event in Stephen's honor to support the Division of Genetics and Metabolism of the Children's National Rare Disease Institute. Jana serves on the external advisory board for the Clinical Translational Science Institute at Children's National (CTSI-CN) and holds a bachelor's of science degree in Therapeutic Recreation from Temple University.

Afternoon Panel: Where to Go from Here: Improving Oral Health in the District and Beyond

MODERATOR: Sara Hoverter

Sara Hoverter is a staff attorney and adjunct professor at the Harrison Institute for Public Law, Georgetown University Law Center. Her area of concentration is health policy, including climate change and public health, Medicaid, state and federal health reform, improving school nutrition, and the use of community health workers to reach vulnerable populations. Past positions include: law clerk at the National Partnership for Women and Families, research assistant for the Center for Law and the Public's Health, and program associate at the DC Appleseed Center.

Dr. Joan I. Gluch

At Penn Dental Medicine, Dr. Joan Gluch serves as Associate Dean for Academic Policies, and Chief of the Division of Community Oral Health. She directs the academically based community service learning courses and leads the three PDM clinical outreach programs: Penn Smiles, the mobile children's dental care program; the dental program at LIFE for low income elderly; and the dental program at Sayre Health Center, for low income children and adults. Dr. Gluch also coordinates the community health honors program, and the dual degree DMD/MPH program for pre-doctoral dental students at Penn.

Dr. Gluch's research interests focus on expanding access to oral health promotion and clinical care in community based settings. She is the principal investigator for the training grant to expand pediatric and community based training for pre-doctoral dental students, received from the Health Resources and Services Administration, 2017-2022. Dr. Gluch also serves as dental school coordinator and program faculty for the Penn community health inter-

professional education program, Bridging the Gaps.

Dr. Jay Balzer

Dr. Jay Balzer is a dentist with a specialty in Public Health. His expertise is not in the clinical care of patients with special needs, but rather with developing community-based programs that try to prevent or minimize dental problems before they get to the point of toothache or need for treatment in the hospital operating room. Examples include home visitation programs that incorporate dental screenings and parent education, parent-to-parent programs where experienced parents mentor new parents, and dentist training in medical, rather than surgical, management of dental decay that avoids the needle and drill.

Dr. Balzer was a career dental officer in the U.S. Public Health Service and worked in community health centers, Indian reservations, state public health departments, and the federal Title V program that supports services for children with special health care needs. His daughter, Allison, has significant intellectual and physical disabilities, so he can relate to the parent experience. Dr. Balzer currently is director of post-graduate training of dentists in the specialty of Dental Public Health at NYU Langone Hospital and Medical School in New York.

APPENDIX 3: IN ATTENDANCE/PARTICIPANTS

ATTENDEE	JOB TITLE	ORGANIZATION
Ms. Jane Aiken	Vice Dean; Associate Dean for Academic Affairs	Georgetown University Law Center
Ms. Ariel Ardura	Student	Georgetown University Law Center; Harrison Institute for Public Law
Dr. Jay Balzer	Panelist	Association of State and Territorial Dental Directors; Program Director, Dental Public Health (DPH)
Ms. Gwendolyn Bell-Foxworth	Program Analyst	Department of Health Care Finance
Dr. Sujana Bhattacharyya	Family Medicine Resident	Unity Health Care
Ms. Meg Booth	Executive Director	Children's Dental Health Project
Mr. Al Brennan	Event Sponsor	George E. Richmond Foundation
Ms. Yael Cannon	Co-Director	Georgetown University Health Justice Alliance
Dr. Ana Caskin	Associate Medical Director for Community Pediatrics; Medical Director of the School Health Center at Anacostia H.S.	MedStar/Georgetown University Hospital and Georgetown Health Justice Alliance
Ms. Allison Corr		The Pew Charitable Trusts
Ms. Amanda Corwin	Medical Student	Georgetown University School of Medicine
Mr. Jeremy Crandall	Officer	Pew Dental Campaign
Dr. Chiranjeev Dash	Associate Professor of Oncology and Assistant Director of Minority Health and Health Disparities Research	Georgetown University Medical Center, Lombardi Comprehensive Cancer Center
Ms. Carma Fautleroy	Senior Director, Corporate & Foundation Relations	Georgetown University
Ms. MayaFiellin	Program Manager, DC School-Based Health Centers	Children's National Medical Center
Ms. Mehgan Gallagher	Law Fellow	O'Neill Institute for National and Global Health Law; Georgetown Health Law Initiative
Ms. Vicki Girard	Co-Director and Professor of Law, Legal Practice	Georgetown University Health Justice Alliance
Dr. Joan Gluch	Panelist	UPenn Dental School
Ms. Katie Gottschalk	Deputy Director	O'Neill Institute for National and Global Health
Dr. Jonelle Grant-Anamelechi	Panelist	Children's Choice Pediatric Dentistry and Orthodontics; DC Pediatric Oral Health Coalition

ATTENDEE	JOB TITLE	ORGANIZATION
Ms. Sara Hoverter	Staff Attorney and Adjunct Professor	Harrison Institute for Public Law, Georgetown Law Center
Mr. Robert James	Policy Analyst	National Health Law Program
Ms. Lisa Kessler	Program Manager	Health Justice Alliance
Ms. Katherine Leopold	Oral Health Disparities Program Scholar	Georgetown Office of Minority Health & Health Disparities Research, Lombardi Comprehensive Cancer Center
Dr. Eric Levey	Chief Medical Officer	Health Services for Children with Special Needs, Inc.
Ms. Jessica Millward	Richmond Fellow	Georgetown University Health Justice Alliance
Ms. Jana Monaco	Panelist	Parent of a child with a disability
Mr. John Monahan	Senior Fellow; Senior Advisor to the President for Global Health	Georgetown University
Ms. Audrey Neff	Social Worker	Medstar Georgetown University Hospital, Community Pediatrics
Ms. Joanne Odom	Program Administrator	Medstar Georgetown University Hospital, Community Pediatrics
Ms. Betty Peebles	President	Jon C. Birr Foundation
Ms. Brigid Rayder	Program Coordinator	O'Neill Institute for National and Global Health Law
Ms. Maya Sandalow	Project Researcher	Georgetown University Center for Child and Human Development
Ms. Eva Scheer	Panelist	Parent of a child with a disability
Dr. Erik Scheifele	Chief, Division of Oral Health	Children's National Medical Center
Ms. Yugank Sikka	Richmond Scholar	Georgetown University Law Center
Mr. Neil Sircar		Georgetown University Law Center
Mr. Allen Tran	Law Student	Georgetown University Law Center; Harrison Institute of Public Policy
Ms. Nicole Tuchinda	Clinic Law Fellow	Georgetown University Law Center
Dr. Viviana Urban	Dentist	Viviana Urban DDS
Mr. Tim Westmoreland	Professor from Practice	Georgetown University Law Center
Ms. Tzuhsuan (Elodie) Yang	Research Assistant	O'Neill Institute for National and Global Health Law
Ms. Wei Zhang	Law Student	Georgetown University Law Center
Mr. Devan Zorn	Richmond Scholar	Georgetown University Law Center

APPENDIX 4: ORAL HEALTH CONVENING STUDENT POSTER PRESENTATIONS

Improving Transportation to Improve Access to Oral Health Care

Ariel Ardua – Harrison Institute Clinical Student

WHY TRANSPORTATION?

Every year, approximately 3.6 millions Americans miss or delay medical care as a result of transportation issues. 1 Nearly 950,000 of these are children. D.C. is no exception to the barriers to care that transportation issues create. 2

Because dentists that both accept Medicaid and treat children with special health care needs are not distributed proportionally to where children enrolled in Medicaid live, it is vitally important that patients be able to use NEMT services in order to access oral health care.

POLICY SOLUTIONS

Increase Awareness

- 1 **Get the word out (the right way):** DHCF could identify common modes of communication within the target community in order to determine the most effective ways to make information accessible to beneficiaries. 3 This would ensure that efforts to educate beneficiaries about the NEMT services available to them are more likely to actually reach the beneficiaries and are therefore more likely to be effective.
- 2 **Language & Technicality:** DHCF could ensure that member handbooks are available in the languages spoken by D.C. Medicaid beneficiaries and written at a reading level that beneficiaries can understand, in order to ensure that information about NEMT services is understood by CSHCN.

Improve Quality/Ease of Use

- 3 **Uber & Lyft:** DHCF could improve the NEMT provider network to ensure that services are timely and competent. One way to do this is through partnerships with transportation network companies (TNCs), such as Uber and Lyft, which allow drivers to use their own vehicles to provide ride services to customers. 4
- 4 **Advanced Technology:** D.C. could consider leveraging technology to improve service delivery, monitoring, and transparency. D.C.'s NEMT programs could benefit from requiring brokers and health plans to use more technologically advanced data collection systems to improve program oversight and quality assurance. Possible requirements include using technologies to improve efficiencies in route development, scheduling, providing automated ride reminders to beneficiaries, and determining the least expensive mode of transportation. 5

BARRIERS TO TRANSPORTATION USE

THEORY OF CHANGE

This Theory of Change illustrates how implementing transportation policy solutions will help to improve the oral health of CSHCN enrolled in D.C.'s Medicaid program. If some or all of the suggested transportation solutions are implemented, beneficiary awareness about NEMT services will increase and the quality of the services will improve. As a result, the use of transportation services to oral health services will increase, which will ultimately improve CSHCN oral health in D.C.

Evaluating the effectiveness of oral health training to improve medical student education and patient oral health care at Georgetown University School of Medicine

Amanda N. Corwin¹; Maya Sandalow²; Victoria Girard, JD³; Deborah Perry⁴; Eileen Moore, MD¹
¹Georgetown University School of Medicine, ²Georgetown University Center for Child and Human Development, ³Georgetown Law Center

Introduction

Research suggests that poor oral health is strongly associated with increased risk of cardiovascular disease, stroke, chronic obstructive pulmonary disease, bacterial pneumonia, and adverse pregnancy outcomes¹. It may also significantly impact social function and interaction, limiting verbal/nonverbal communication, intimacy, nutrition, and sleep². Given the significant impact of oral health on overall health, physicians should know about the medical significance of oral health and how to promote positive oral health practices in patients. However, oral health education is not uniformly provided at Georgetown University School of Medicine.

Oral Health Screening Process

The oral health screen is a three step process that was designed based on existing oral health assessment/ referral regional health organizations. These include the American Academy of Pediatrics, as well as a screening tool developed by the British National Health Service. Oral health education for providers and medical students is critical to the success and impact of this screening process, and thus was an important component of the oral health training program.

Step 1: Observe

This component of the oral health screen is intended to occur during the routine patient intake procedures. Take a history and establish rapport with the patient as you normally would, but take time to observe their oral cavity, noting any obvious abnormalities (missing teeth, lesions, decay, restorations, fillings, etc.)

Step 2: Assessment

As part of routine patient assessment, include questions about oral health and overall health practices. This is also the opportunity to ask the patient about any abnormalities observed in the previous step. Suggested questions include:

- 1 Do you brush your teeth twice daily?
- 2 Do you have a regular oral health care provider?
- 3 When was the last time you see a dental health care provider?
- 4 Do you have any concerns about your oral health?

Step 3: Oral Health Counseling

The final component of the screening process is to discuss positive oral health practices with the patient, as well as to ensure appropriate referrals to dental health care providers are made.

Results

104 respondents out of 152 student attendees (68% response rate) reported significant changes in all five measures. (Table 1).

Table 1. Examination of differences between student knowledge and agreement before and after oral health training. Key: * = Significant at $\alpha=0.05$, ** = Significant at $\alpha = 0.1$

Question	Mean scores before and after training	Interpretation of Results
Oral health knowledge	Before = 1.99 After = 2.50*	Students reported having significantly higher levels of knowledge about oral health as a result of this course.
Oral health is an important part of my health and well-being	Before = 4.67 After = 4.83*	Students were significantly more likely to agree with this statement after the training.
Oral health should be a part of my medical education	Before = 4.23 After = 4.56*	Students were significantly more likely to agree with this statement after the training.
I feel sufficiently knowledgeable about oral health and oral healthcare	Before = 2.79 After = 3.53*	Students were significantly more likely to agree with this statement after the training.
I feel comfortable discussing oral healthcare with my patients	Before = 2.95 After = 3.63**	Students were significantly more likely to agree with this statement after the training.

Objectives

This project was designed to increase medical students' knowledge about the importance of oral health and to teach them how to counsel patients on oral health through an "Oral Health Training Program." A secondary goal was to measure whether implementing the Training Program increased the number of patients counseled about oral health at Georgetown's student run medical clinic, the HOYA Clinic

Methods

Extensive oral health research and professional consultation was used to design the Oral Health Training Program, which emphasized the connections between oral health and overall health. We also developed an oral health screening process for students to assess the oral health status of patients. The Training Program was delivered to 152 first year medical students who signed up to volunteer at HOYA Clinic. The following day, students were surveyed and asked to rate their knowledge of oral health from (1) Not at all knowledgeable to (4) Extremely knowledgeable. Students also rated their agreement with statements about oral health from (1) Strongly disagree to (5) Strongly agree. A t-test was used to determine if the differences between students' responses before and after the training were statistically significant.

Discussion

Overall, the oral health training program accomplished our primary goal of educating students on the impact of oral, and providing students with the tools to discuss oral health care with patients. Data are currently being collected to determine how many HOYA Clinic patients now receive oral health counseling. The long-term goal is to improve the quality of patient care at HOYA Clinic by routinely assessing the oral health status of patients, counseling patients on positive oral health practices, and making appropriate dental referrals as needed.

Conclusions

The Oral Health Training Program successfully educated students on the impact of oral health on overall health and well-being and provided them with tools and confidence to discuss oral health with patients.

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APPENDIX 4: ORAL HEALTH CONVENING STUDENT POSTER PRESENTATIONS (CONTINUED)

Oral Health Lessons from D.C. School-Based Health Centers

Yugank Sunny Sikka – George E. Richmond Foundation Scholar, Georgetown JD, 2018

SBHCs Overview

The D.C. Department of Health (DOH), in collaboration with D.C. Public Schools (DCPS), healthcare providers, and other partner organizations, has created a network of programs to coordinate and deliver school-based health services.¹ Among these programs are the School Based Health Centers (SBHCs), which serve as primary care clinics located within schools, offering a range of health services, including dental services.² Staffed with health professionals from a variety of fields, SBHCs are “focused on the prevention, early identification and treatment of medical and behavioral concerns that can interfere with a student’s learning.”³ The target areas of health provided by SBHCs include obesity, mental health, asthma, substance abuse, lead exposure, well-child care, oral health, and sexual health.⁴ Regarding the range of oral health services made available at the SBHCs, the DOH recommends that services provided include basic oral examinations, teeth cleanings, education and counseling, as well as sealant applications.⁵ There are currently seven SBHCs in operation across the District.⁶

- A. Anacostia Senior High School
- B. Ballou Senior High School
- C. Cardozo Learning Center
- D. Coolidge Senior High School
- E. Dunbar Senior High School
- F. Roosevelt Senior High School
- G. Woodson Senior High School

Barriers to Operating Dental Suites and Possible Solutions

While some centers are relatively well staffed by dental professionals, the operators of these centers have all experienced varying degrees of difficulty filling and subsequently operating their dental suites. The barriers range across a wide range of issues including financial disincentives and administrative burdens. The following sections briefly summarize each barrier and provides a few best practice solutions that could be implemented to overcome or at least limit those barriers.

Medicaid Reimbursement Rates and Other Financial Disincentives

As the number of D.C. children eligible for Medicaid steadily increases to 100,000, the negative impact of Medicaid reimbursement rates increases as well. One result is that a substantial majority of dentists in D.C. do not accept Medicaid patients in general, and only 1 in 4 D.C. dentists participate in Medicaid for child dental services as of 2015.⁷ While a variety of reasons contribute to dental providers’ reluctance to accept Medicaid, they generally point to inadequate reimbursement rates as the primary barrier.⁸ Dentists lack any monetary incentive to see Medicaid patients as compared to patients with private insurance. Additionally, Medicaid children are unevenly distributed across the eight wards, thereby making it hard for providers at SBHCs to leverage the referral system efficiently because their primary practices are often located in other wards.⁹ And each SBHC only receives \$325,000 annually in DOH grant funding to operate the entire SBHC, a number that often inhibits them from being able to purchase sufficient equipment for the dental suites or to staff adequately them.¹⁰ Such financial disincentives discourage dental providers from attempting to work in SBHC dental suites.

Increasing reimbursement rates would at least monetarily encourage providers to accept Medicaid-eligible patients and might influence them to operate SBHC dental suites. For starters, single % increases in reimbursement rates for the limited number of services and procedures possible, and accompanied at SBHCs would be useful. Raising the Medicaid reimbursement rate increases providers currently receive when treating children could also improve the situation.¹¹ A more comprehensive solution would be an incidence fee model where Medicaid oral health providers become eligible for an incidence fee each time they treat children, in addition to any increased reimbursement as described above.¹² And SBHCs, stakeholders and engaged advocates could take a more fervent role in pushing the DOH to increase funding for at least the SBHCs with operational dental suites. Fundraising efforts by collaboration and advocates to raise money for SBHCs from private donors might at least help over one-time, fixed costs such as purchasing equipment for the dental suites.

Credentialing and Medicaid Provider Agreements

SBHC operators often have to find external sub-providers for their dental suites for reasons such as a lack of a dentist within their own organization. The sub-providers then must go through a comprehensive process to become credentialled within the operator’s organization.¹³ Additionally, each operator and sub-provider is required to establish a Medicaid Provider Agreement with DCH.¹⁴ Even though the rigorous application process can take several months, federal regulations require providers with existing agreements to go through this process each and every time they attempt to service new locations.¹⁵

While the requirements lists for both processes are extensive, and the process for approval quite slow, the materials requested are often very straightforward and intuitive. A streamlining of the administrative approval process, as well as a support team to help collect the data and assist in completing all of the forms could significantly reduce both of these barriers. Given the overlap in required documents for both processes, a uniform administrative process for collecting, storing, and accessing the data could be especially beneficial. Advocacy at the federal or state level to reduce the application requirements and streamline the approval process for providers with other Medicaid Provider Agreements in place would also help eliminate this barrier.

Oral Health & Case Management Services

Allen Tran – Harrison Institute Clinical Student, Georgetown JD, December 2018

Introduction

Case management services are an essential component of oral health for Medicaid-eligible children with special health care needs (CSHCN).¹ Case managers alleviate some of the personal and systemic barriers ordinarily affecting Medicaid patients’ abilities to access necessary oral health services, such as income level, education, and familiarity with the Medicaid system.² This ultimately results in higher usage rates of oral health services by CSHCN.³

Federal and DC laws require four essential elements for case management services.

Why is Case Management Important?

Studies show that case management intervention has a positive impact on Medicaid beneficiaries and oral health access.⁴ Case managers minimize some of the personal and systemic barriers that otherwise prevent a beneficiary from seeking oral health services, such as a lack of transportation options or education level, increasing beneficiaries’ usage rates of oral health services.⁵

In Kentucky, a group receiving case management intervention demonstrated an almost 20% increase in usage rate for oral health services compared to a control group who did not.⁶ The study also showed the case managers’ ability to mitigate some potential barriers for access to care, such as a patient’s income level or lack of familiarity with the Medicaid system.⁷ Other ways case managers mitigate barriers to service include:

- educating Medicaid patients on administrative issues (e.g. renewing Medicaid benefits)
- holding patients accountable for appointments,⁸
- recommending services based on patient assessments.⁹

Case management services produced a positive effect regardless whether it was conducted in person or over phone or email.¹⁰

Current Conditions in the District

CAHPS Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	TOP 2016 %	MCO Average 2016 %	MCO Average 2015 %
Coordination of Care Composite	78.7	80.2	73.3	71.8	88.2	79

Chief CAHPS (e)Experience with Care) Representative of Quality 2016 Medicaid Managed Care Organization Annual Technical Report

The coordination of care composite evaluates case management services, focusing on criteria such as patient access to case managers and ability to schedule needed appointments. Among MCOs partnered with DC’s Department of Healthcare Finance, HSCSN performed best in 2016, achieving a higher score than the MCO average.¹¹

Room for improvement still exists, however. Children with special needs are also served by three other MCOs in a smaller proportion compared to HSCSN where case coordination has not been as strongly rated as at HSCSN.¹² The MCO average score also dropped more than 9% from 2015 to 2016.¹³ This suggests case management reforms are still needed to improve the annual composite score for care coordination.

Conditions are even worse under fee-for-service (FFS) models. Case management services for CSHCN under FFS are much less substantive than under MCOs. CSHCN under FFS are also likely to have more complex issues and require services that cost more than CSHCN under MCOs. This exacerbates the lack of access to necessary care and highlights the need for greater case management services under FFS to match the comparatively better conditions under MCOs.

Innovative Practice Reforms and Pilot Programs

As part of the continuing effort to improve the District’s case management services, some MCOs implemented new practices and experimented with new models. Health Systems for Children with Special Needs (HSCSN), the primary MCO for children with special needs, has implemented a new practice and new pilot program, both of which show degrees of success for improving quality of care coordination within its control groups.

Under HSCSN’s new practice, beneficiaries are assigned case managers based on geographic location, instead of the traditional practice of assignment based on diagnosis. This practice makes case managers more accessible and conveniently located to their assigned beneficiaries.

HSCSN’s new pilot program co-locates its case managers directly in providers’ offices. This enables case managers to more easily meet with and monitor their assigned beneficiaries. It also facilitates the ability to identify and schedule necessary follow-up treatments for patients. These benefits combined are intended to improve flow for coordination of care and overall improved patient outcomes. HSCSN is testing this on a small-scale basis, but hopes to scale it up in the future.

¹ Collier, J. A. & Bhatia, S. (2017). *Increasing Dental Care Utilization by Medicaid-eligible Children: A Dental Care Coordinator Intervention*. (7) J. PUBLIC HEALTH (PH), 34-34 (2017).
² *Id.* at 34.
³ *Id.* at 34.
⁴ *Id.* at 34.
⁵ *Id.* at 34.
⁶ *Id.* at 34.
⁷ *Id.* at 34.
⁸ *Id.* at 34.
⁹ *Id.* at 34.
¹⁰ *Id.*
¹¹ *Id.*
¹² *Id.*
¹³ *Id.*
 This report was made possible by the George E. Richmond Foundation.

APPENDIX 4: ORAL HEALTH CONVENING STUDENT POSTER PRESENTATIONS (CONTINUED)



Improving Children's Oral Health in D.C. by Increasing Access to Dental Sealants

Devan Zorn – George E. Richmond Foundation Scholar, Georgetown JD, 2018

Overview of Dental Sealants

Dental sealants can prevent cavities when applied to molar teeth.



Dental sealants are thin plastic materials applied to the chewing surfaces of teeth to prevent decay and arrest incipient decay. Sealants on permanent molars reduce the risk of cavities by 80%,¹ and sealants placed on teeth with incipient decay reduced progression of the decay by 77% up to five years after placement.²

The Solution: Remove the General Supervision Requirement for Dental Hygienists Applying Sealants in D.C. Schools

D.C.'s Hygienists Can Safely Provide Dental Sealants Without Supervision of Dentists

Opponents of removing D.C.'s general supervision requirement have argued that dental hygienists who act without a dentist's instruction may inadvertently place sealants over teeth with cavitated caries lesions, thereby causing damage. However, cavitation is sufficiently recognizable that an unaided visual assessment (as opposed to a comprehensive dental exam) is the recommended method to determine whether a tooth has a cavitated caries lesion and whether a sealant should be placed.³ Hygienists are trained to perform these assessments,⁴ and research suggests that hygienist assessments are as effective as dentist.⁵ If a hygienist mistakenly seals a tooth with a cavitated caries lesion, permanent harm is unlikely. The placement of a sealant is a reversible procedure that easily allows a dentist to administer additional treatment strategies, such as placement of a restoration, if needed.⁶ Moreover, clinical research has found no evidence that placement of a sealant increases caries progression⁷ or causes any other adverse health effect.¹²

States' Restrictions on Dental Hygienists' Ability to Apply Sealants in Schools—2014



Allowing Hygienists to Operate Without Supervision Would:

- Increase underserved children's access to dental sealants.
- Improve the efficiency of D.C.'s school-based oral health programs;
 - One study concluded that removing general supervision requirements in school-based sealant programs reduces costs by 15-29%, depending on program size.¹⁴
- Enable hygienists to practice to the full extent of their education and training in accordance with the recommendations of the Institute of Medicine.
- Maximize the time dentists are able to spend to serving patients with complex cases and/or special needs, and
- Minimize the time students spend outside of class while receiving sealants.

Removing General Supervision Requirements Led to Positive Outcomes for Children in Maryland and Virginia



Maryland's Public Dental Hygiene Act of 2008 allows dental hygienists operating in public health settings (like schools) to apply sealants without the general supervision of dentists. The legislation has resulted in an increase in the number of children who received sealants in schools and an increase number of patients seen by a dentist and/or a dental hygienist.¹⁵

In 2009, Virginia passed legislation to allow hygienists to apply sealants without general supervision. The legislation reduced the cost of applying sealants by 25% per child.¹⁶ Virginia used these savings to significantly increase children's access to sealants; the number of children receiving sealants in its schools increased from 340 in 2009 to 2,883 in 2011.¹⁷

Acknowledgments
The author would like to thank the following individuals:

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ENDNOTES

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- 2 See Centers for Medicare & Medicaid Services (CMS), Form CMS-416 Data for the District of Columbia, available at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.
- 3 *A New Definition of Children with Special Health Care Needs*, 102 *Pediatrics* 137 (July 1998), available at <http://pediatrics.aappublications.org/content/102/1/137>.
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- 11 See *id.*; National Maternal & Child Oral Health Resource Center, *supra* note 9, at 2.
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- 13 D.C. Department of Health Care Finance (DHCF), *District of Columbia Fee-for-Service Medicaid: Access Monitoring Review Plan* (October 2016) at 24, available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/District%20of%20Columbia%202016%20Access%20Monitoring%20Review%20Plan%20%28002%29.pdf.
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- 15 In 2013, only 10 pediatric dentists serving children enrolled in managed care and 3 pediatric dentists serving children enrolled in the FFS program submitted at least \$10,000 worth of Medicaid claims. *Id.*
- 16 See, e.g., Paul S. Casamassimo, DDS, MS, *Children With Special Health Care Needs; Patient, Professional and Systems Issues* (2002) at 2-5, available at <http://www.astdd.org/docs/cshcn-systems-issues-backgroundcassamassimo.pdf>; *A Preliminary Analysis of the US Dental Health Care System's Capacity to Treat Children with Special Health Care Needs*, 33 *Pediatric Dentistry* 107 (April 2011), available at <https://www.ncbi.nlm.nih.gov/pubmed/21703059>.
- 17 See *Demographic and Practice Characteristics of Medicaid-Participating Dentists*, 74 *Journal of Public Health Dentistry* 139 (Spring 2014), available at <https://onlinelibrary.wiley.com/doi/abs/10.1111/jphd.12037>.
- 18 See *supra* note 16.
- 19 See, e.g., *Unmet Needs for Dental Care in Children with Special Health Care Needs*, 3 *Preventive Medicine Reports* 62, 66 (June 2016), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4733065/>; *The Effects of Distance to Dentists and Dentist Supply on Children's Use of Dental Care*, 52 *Health Services Research* 1817 (September 2016), available at <https://www.ncbi.nlm.nih.gov/pubmed/27716908>; *North Carolina Physician-Based Preventive Oral Health Services Improve Access And Use Among Young Medicaid Enrollees*, 33 *Health Affairs* 2144, 2147-49 (December 2014), available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0927>.
- 20 An area is considered a dental HPSA when the number of dentists available to serve the area's population is insufficient based on a population-to-provider ratio of 5,000 to 1 (or 4,000 to 1 where the population has unusually high needs). See Bureau of Health Workforce, Health Resources and Services Administration (HRSA), *Designated Health Professional Shortage Areas Statistics as of December 31, 2017* (December 2017) at endnote 5, available at https://ersr.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false.

ENDNOTES (CONTINUED)

- 21 For a map showing the distribution of children enrolled in D.C. Medicaid by neighborhood, see DC Action for Children, Data Tools 2.0, available at <http://datatools.dcactionforchildren.org/>; compare with HRSA, Map of D.C. Dental HPSAs, available at <https://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA>=State&cd=11&dp=DC>.
- 22 See HRSA, *supra* note 20, at 5.
- 23 See Jean M. Mitchell, Ph.D. and Darrell J. Gaskin, Ph.D., Dental Care Use and Access for Special Needs Children (March 2007) at 21, available at <https://mchb.hrsa.gov/research/documents/finalreports/mitchellR40mc04296FinalReport.pdf> (finding that Medicaid-enrolled D.C. CSHCN who reside more than one mile from a metro stop were 3.8 to 4.7% less likely to receive recommended oral exams).
- 24 See DC Action for Children, *supra* note 21; compare with The District of Columbia Healthy Communities Collaborative, DC Community Health Needs Assessment Appendices, 2016, Map of Metro Stations in DC – 2015 (2016) at 9, available at http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_Appendices_062416_FINAL.pdf.
- 25 There is little (if any) recent, publicly available data that accurately measures the entire population of D.C. Medicaid-enrolled CSHCN's access to or utilization of oral health care. However, there is a significant amount of recent data describing the number of children who are enrolled in Health Services for Children with Special Needs, Inc. (HSCSN) who receive oral health care; this data shows that while HSCSN provided oral health care to a greater percentage of its enrollees than any of D.C.'s other MCOs during FY 2017, there were still a significant number of CSHCN who did not receive oral health care. See FY 2017 Form CMS-416 Report for HSCSN, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. Apr. 17, 2018), ECF No. 2257, Ex. 3. Additionally, other recent data suggests that children enrolled in D.C.'s FFS program (which was responsible for serving 2,223 disabled children in FY 2015) receive substantially less oral health care than those enrolled in managed care. See DHCF, *supra* note 13, at 11, 31-32; FY 2017 Form CMS-416 Report for FFS Program, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. Apr. 17, 2018), ECF No. 2257, Ex. 6.
- 26 Where possible, this report utilizes data from the more recent 2011/12 and 2016 National Survey of Children's Health. However, the numbers of D.C. CSHCN who were surveyed in 2011/12 and 2016 were inadequate to produce accurate estimates for many of the surveys' measures. See, e.g., 2016 National Survey of Children's Health, Indicator 4.2a: Preventive Dental Care, Age 1-17 Years by Special Health Care Needs Status, available at <http://childhealthdata.org/browse/survey/results?q=4688&r=10&q=619&r2=10>.
- 27 See 2009/10 NS-CSHCN, Unmet Needs for Preventive Dental Care, Age 0-17, available at <http://childhealthdata.org/browse/survey/results?q=1938&r=10&r2=10>.
- 28 See 2011/12 National Survey of Children's Health, Unmet Need for Dental Care, Age 1-17 Years by Special Health Care Needs Status, available at <http://childhealthdata.org/browse/survey/results?q=2575&r=10&q=461&r2=10>.
- 29 See 2011/12 National Survey of Children's Health, Indicator 1.2a: Oral Health Problems, Age 1-17 Years by Special Health Care Needs Status, available at <http://childhealthdata.org/browse/survey/results?q=2587&r=10&q=461&r2=10>; 2016 National Survey of Children's Health, Indicator 1.2a: Oral Health Problems, Age 1-17 Years by Special Health Care Needs Status, available at <http://childhealthdata.org/browse/survey/results?q=4570&r=10&q=619&r2=10>.
- 30 See 2011/12 National Survey of Children's Health, Indicator 1.2: Condition of Teeth, Age 1-17 Years by Special Health Care Needs Status, available at <http://childhealthdata.org/browse/survey/results?q=2458&r=10&q=461&r2=10>.
- 31 See 2011/12 National Survey of Children's Health, Indicator 1.2a: Oral Health Problems, Age 1-17 Years by Complexity of Health Care Needs, available at <http://childhealthdata.org/browse/survey/results?q=2587&r=10&q=471&r2=10>.
- 32 See *Facilitators and Barriers to Twice Daily Tooth Brushing*, *supra* note 7.
- 33 See 42 U.S.C. § 1396d(a)(29); 42 C.F.R. §§ 440.170, 441.62.
- 34 See Lisa J. Chamberlain & Paul H. Wise, *Chronic Illness in Childhood*, in Nelson Textbook of Pediatrics 149, 149.e4 (Robert M. Kliegman et. al., 19th ed. 2011).
- 35 See RAND Health, Oral Health in the District of Columbia Parental and Provider Perspectives (2013) at 9, available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR179/RAND_RR179.pdf (“Both parents and providers cited transportation as a common barrier in accessing oral health care.”); RAND Health, *Health and Health Care Among District of Columbia Youth (2009)* at 103, available at https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR751.pdf.
- 36 See District Department of Transportation, accessDC Study (February 2017) at slide 26, available at https://ddot.dc.gov/sites/default/files/dc/sites/ddot/page_content/attachments/accessDC_PAC%20Meeting%20_ExistingConditions_1.31.17.pdf.
- 37 *Id.* at slide 27.
- 38 *Id.* at slide 28.

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- 39 *Id.* at slide 26.
- 40 See RAND Health, Health and Health Care Among District of Columbia Youth, *supra* note 36, at 103 (“One provider noted: ‘I had a patient who had to cancel five times because she wasn’t able to get transportation. We are seeing in our Medicaid population that the transportation system they are using isn’t very helpful . . . it takes three days to set up’”).
- 41 See RAND Health, Oral Health in the District of Columbia Parental and Provider Perspectives, *supra* note 36, at 9.
- 42 See <https://www.uber.com/ride/uberway/> and <https://www.uber.com/en-SG/drive/resources/uberassist/>
- 43 See, e.g., *Children’s Access to Dental Care Affected by Reimbursement Rates, Dentist Density, and Dentist Participation in Medicaid*, 107 American Journal of Public Health 1612 (October 2017), available at <https://www.ncbi.nlm.nih.gov/pubmed/28817336>; *The Effect of Medicaid Primary Care Provider Reimbursement on Access to Early Childhood Caries Preventive Services*, 50 Health Services Research 136 (February 2015), available at <https://www.ncbi.nlm.nih.gov/pubmed/25039907>; *Provision of Fluoride Varnish to Medicaid-Enrolled Children by Physicians: The Massachusetts Experience*, 46 Health Services Research 1843 available at <https://www.ncbi.nlm.nih.gov/pubmed/21762142>; National Academy for State Health Policy, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* (2008), available at https://nashp.org/wp-content/uploads/sites/default/files/CHCF_dental_rates.pdf.
- 44 D.C. Department of Health Care Finance, DC Healthy Families, available at <https://dhcf.dc.gov/service/dc-healthy-families>.
- 45 D.C. Department of Health Care Finance, Health Services for Children with Special Needs, Inc. (HSCSN), available at <https://dhcf.dc.gov/publication/health-services-children-special-needs-inc-hscsn>.
- 46 See American Dental Association: Health Policy Institute, *Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016* (April 2017) at 4-6, available at http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf.
- 47 See, e.g., *Barriers to Medicaid Participation Among Florida Dentists*, 26 Journal of Health Care for the Poor and Underserved 154 (February 2015), available at <https://www.ncbi.nlm.nih.gov/pubmed/25702734>; *Demographic and Practice Characteristics of Medicaid-Participating Dentists*, 74 Journal of Public Health Dentistry 139 (Spring 2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4469354/>; *Michigan Dentists’ Attitudes toward Medicaid and an Alternative Public Dental Insurance System for Children*, 36 Pediatric Dentistry 34 (January-February 2014), available at <https://www.ncbi.nlm.nih.gov/pubmed/24717707>; The University of Iowa Public Policy Center, *Factors Affecting Iowa Dentist Participation in Medicaid; Capacity of the Private Oral Health Safety Net* (December 2013), available at http://ir.uiowa.edu/cgi/viewcontent.cgi?article=1087&context=ppc_health.
- 48 In response to an open-ended question about the barriers to obtaining dental care for CSHCN, the most common response offered by parents from 36 states and D.C. was that dentists lacked the knowledge or were unwilling to treat children with special needs (67.4% of parents). See *Parents’ Perspectives on a Dental Home for Children with Special Health Care Needs*, 31 Special Care Dentistry 170, 172 (September-October 2011), available at <https://www.ncbi.nlm.nih.gov/pubmed/21950531>; see also Oral Health Care in CSHCN: *State Medicaid Policy Considerations*, 124 Pediatrics S384 (December 2009), available at http://pediatrics.aappublications.org/content/pediatrics/124/Supplement_4/S384.full.pdf?download=true; Paul S. Casamassimo, DDS, MS, *supra* note 16.
- 49 See, e.g., *Policy on Third-party Reimbursement for Management of Patients with Special Health Care Needs*, *supra* note 10, at 112; *Improving Oral Health for Individuals with Special Health Care Needs*, 29 Pediatric Dentistry 98, 101 (March-April 2007), available at <https://www.ncbi.nlm.nih.gov/pubmed/17566526>.
- 50 D.C. Department of Health Care Finance (DHCF), *Medicaid Dental Fee Schedule*, available at <https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload>.
- 51 See American Academy of Pediatrics (AAP), *Medicaid Reimbursement Survey—National Report* (2015), available at https://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/medicaid_reports_national_all.pdf.
- 52 See American Dental Association: Health Policy Institute, *Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016* (April 2017) at 6, available at http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf
- 53 See D.C. Department of Health Care Finance (DHCF), *District of Columbia’s Managed Care Quarterly Performance Report for January 2014 – March 2014* (October 2014) at slide 35, available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%203rd%20Quarter%20Report%20FY2014_0.pdf (“Due to growing concerns of low dental reimbursement rates by the health plans, DHCF and Mercer reviewed past utilization data submitted by DentaQuest and determined that the rates offered by the health plans were significantly below the rates paid within the District’s FFS Medicaid

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- program. DHCF increased the health plans overall capitation rates, *requiring each to adjust its dental fee schedule (children and adults) to no less than 80% of the District's dental FFS fee schedule*, retroactive to May 1, 2014 and on through April 30, 2015.”) (emphasis added); D.C. Department of Health Care Finance (DHCF), Transmittal No. 16-29—School-Based Health Center Participation in the DC Medicaid Program (November 2016) at 5, available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Revised%20Transmittal%2016-05_dtd%203-3-2016_O.pdf (“6. What are the MCO reimbursement rates for services delivered in [school-based health centers (SBHCs)]? SBHCs are reimbursed for services based on rates negotiated with each MCO during the provider enrollment process”).
- 54 See DHCF, *supra* note 13, at 21.
- 55 D.C. Children’s Law Center, Practice Kit 8: A Guide to Medicaid for Children in D.C.—Introduction (June 2017), available at https://www.childrenslawcenter.org/sites/default/files/attachments/resources/1.%20Introduction_3.pdf.
- 56 For example, as of 2014, one of D.C.’s MCOs (AmeriHealth Caritas District of Columbia, Inc.) was paying Children’s National Medical Center (CNMC) a capitated fee for the well-child visits offered by its providers at the same it was paying multiple FQHCs (Mary’s Center and the Unity Health Clinics) a bundled fix rate for well-child visits. See Plaintiffs’ Reply Memorandum in Support of Their Motion to Enforce Dental Order at 16, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. July 27, 2016), ECF No. 2165. This means that these providers were not receiving separate payment for performing components of a well-child visit (including oral health assessments and fluoride varnish applications), and D.C. is not maximizing the incentives for these providers to perform these services. See, e.g., Centers for Medicare & Medicaid Services (CMS), EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (June 2014) at 6-7, available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. Considering Children’s National, Mary’s Center, and the Unity Health Clinics represent three of the four largest pediatric primary care provider groups in D.C., this issue could be a contributing factor to D.C. primary care providers’ lack of provision of oral health assessments and fluoride varnish applications.
- 57 See *Policy on Third-party Reimbursement for Management of Patients with Special Health Care Needs*, *supra* note 10, at 112-113; *Oral Care for Special Needs Patients: A Survey of Nebraska General Dentists*, 33 *Pediatric Dentistry* 409, available at <https://www.ncbi.nlm.nih.gov/pubmed/22104709> (finding that “improved reimbursement” was the second most common response offered by general dentists to the question “What would improve your ability to care for special needs patients?”); *Oral Health Care in CSHCN*, *supra* note 47, at S389.
- 58 See *Policy on Third-party Reimbursement for Management of Patients with Special Health Care Needs*, *supra* note 10, at 112-113.
- 59 *Id.* at 113.
- 60 *Id.*; see also *Time Is on Your Side: Coding on the Basis of Time*, 15 *Family Practice Management* 17 (November-December 2008), available at <https://www.aafp.org/fpm/2008/1100/p17.html>.
- 61 *Pediatric Dentistry Today*, Sneak Peek at CDT 2017 (July 2016), available at <http://www.pediatricdentistrytoday.org/2016/July/LI/4/news/article/601/>.
- 62 D.C. covers the evaluation and management (E&M) codes (CPT codes 99201-99215) and the prolonged services codes (99354-99357). See DHCF, Medicaid Medical Fee Schedule, available at <https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload>.
- 63 D.C. does not cover any of the dental case management codes (CDT codes D9991-9994), the consultation with a medical health care professional code (CDT code D9311) or the dental behavior management code (CDT code D9920). See DHCF, *supra* note 48.
- 64 See California Department of Health Care Services, Dental Transformation Initiative (DTI), <http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx>. This work was initiated under a section 1115 waiver from CMS.
- 65 See American Academy of Pediatric Dentistry (AAPD), *Are Your Kids Covered? Medicaid Coverage for the Essential Oral Health Benefits* (2017) at 6, available at <http://www.aapd.org/assets/1/7/AreYourKidsCoveredfinal.pdf>.
- 66 *Id.*
- 67 See *Increasing Dental Care Utilization by Medicaid-Eligible Children: A Dental Care Coordinator Intervention*, 70 *Journal of Public Health Dentistry* 76 (Winter 2010), available at <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1752-7325.2009.00146.x>.
- 68 *Id.*
- 69 *Id.*
- 70 D.C. Department of Health (DOH), DC Healthy People 2020 Framework (April 2016) at 97, available at <https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/FINAL%20DC%20HP2020%20Framework%20Report%205-23-16.pdf>.

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- 71 See 2009/10 National Survey of Children with Special Health Care Needs, Received Help to Coordinate Child's Health Care, When Needed, Age 0-17, available at <http://childhealthdata.org/browse/survey/results?q=1862&r=10&r2=10>.
- 72 See 2009/10 National Survey of Children with Special Health Care Needs, CSHCN Needing a Referral Who Had Difficulty Getting It, Age 0-17, available at <http://childhealthdata.org/browse/survey/results?q=1627&r=10&r2=10>.
- 73 Qlarant, Medicaid Managed Care 2017 Annual Technical Report (April 2018) at 39-40, available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/FY%202017%20Annual%20Technical%20Report_FINAL.pdf.
- 74 In an effort "to better determine the care that children in [the D.C. Medicaid program] are receiving," D.C. changed its EPSDT policies in late 2014 to provide enhanced reimbursement to providers who bill separately for the required components of a well-child visit (including oral health assessments and fluoride varnish applications) instead of using a single "lump sum" code. See DHCF, Transmittal No. 14-29—EPSDT Well-Child Visits: New Billing Requirements and Rate Changes (October 2014) at 1, available at <https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2014-29.pdf>. However, as of January 2017, "providers have not widely adopted billing for individual components of a well-child visit." See Response of the District of Columbia to Plaintiffs' Notice Concerning Agenda for January 9, 2017 Status Conference at 5, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. Jan. 05, 2017), ECF No. 2194.
- 75 See EPSDT HealthCheck Utilization Report for Quarter 4 CY 2017 at 5, Line 6, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. Apr. 30, 2018), ECF No. 2251, Ex. 1.
- 76 Response of the District of Columbia to Plaintiffs' Notice Concerning Agenda for January 9, 2017 Status Conference at 5, *Salazar v. District of Columbia*, No. 93-cv-452 (D.D.C. Jan. 05, 2017), ECF No. 2194 ("Since implementation, DHCF saw few claims with the TS modifier and, after inquiring with specific providers, uncovered a potential issue with the way the TS modifier is accepted into MMIS [Medicaid Management Information System]. Though many providers are using the TS modifier, the modifier is not appearing in the MMIS system. DHCF is currently investigating the root cause for this issue.").
- 77 See American Dental Association (ADA), Answers to Frequently Asked Questions About ICD-10-CM, available at <https://www.ada.org/en/member-center/member-benefits/practice-resources/dental-informatics/standard-terminologies-and-codes/faq-icd-10-cm>.
- 78 D.C. Department of Behavioral Health, 2016 Committee Performance Oversight Responses (2016) at Q43, available at http://dccouncil.us/files/user_uploads/budget_responses/O50_1.pdf.
- 79 *Id.*
- 80 See Children's National, Mental Health Screening in Pediatric Primary Care: Results from a Quality Improvement Learning Collaborative (April 2016) at slide 21, available at https://www.sbm.org/UserFiles/file/Symposium50_Godoy.pdf.
- 81 See Children's Law Center, 2016 Children's Mental Health Update (May 2016) at 2, available at http://www.childrenslawcenter.org/sites/default/files/Childrens_Law_Center_MH_Update_2016.pdf.
- 82 See DOH, Community Health Administration, Family Health Bureau, <https://dchealth.dc.gov/page/community-health-administration>.
- 83 See DOH, Community Health Administration, 2018 Committee Performance Oversight Responses, Part 2 (2018) at Q24, available at http://dccouncil.us/files/user_uploads/budget_responses/doh_Part2.pdf.
- 84 *Id.*
- 85 See DCPS, School-Based Health Centers, <https://dcps.dc.gov/service/school-based-health-centers-dcps>.
- 86 *Id.*
- 87 See DOH, School-Based Health Center Fact Sheet (February 2018), available at <https://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/SBHC-Fact-Sheet.pdf>.
- 88 See D.C. Department of Health, DC: Bridging the Data Divide (2016) at slide 9, available at <http://www.ashaweb.org/wp-content/uploads/2016/10/ACL10.pdf>.
- 89 See DOH, Universal School-Based Health Center Form for SY 2017-18, https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/SBHC%20Consent%20Form%20SY%202017-2018%28October2017%29.pdf.
- 90 See DOH, Community Health Administration, 2017 Committee Performance Oversight Responses (2017) at Q21, available at http://dccouncil.us/files/user_uploads/budget_responses/dohpo.pdf.
- 91 See DOH, *supra* note 83.

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- 92 DOH, FY 2018 Maternal and Child Health Services Title V Block Grant Application and Annual Report for 2016 (September 2017) at 136, available at https://mchb.tvisdata.hrsa.gov/uploadedfiles/StateSubmittedFiles/2018/DC/DC_TitleV_PrintVersion.pdf.
- 93 In 2016, DOH solicited applications from community-based medical providers to operate the seven D.C. SBHCs from July 2016 through September 2020. Among the minimum services minimum services each of the SBHCs were intended to provide were a number of oral health services. See DOH, School Based Health Center Program Request for Applications (April 2016) at 14, available at https://opgs.dc.gov/sites/default/files/dc/sites/opgs/publication/attachments/RFA_CHA.5SBHC.04.01.16_FINAL.pdf. The RFA process was meant to “ensure all [SBHCs] would deliver the same minimum services while allowing each to be responsive to the individual school needs.” See DOH, *supra* note 90.
- 94 See, e.g., MedStar Georgetown University Hospital, Credentialing, <https://www.medstargeorgetown.org/for-physicians/credentialing/#q=%7B%7D>.
- 95 See D.C. Mun. Regs. 29 § 964.8(b).
- 96 See 42 C.F.R. § 455.450.
- 97 DOH, *supra* note 83.
- 98 *Id.*
- 99 See DOH, 2018 DC Health Professional Loan Repayment Program Guidelines (2018), available at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/HPLRP%20Bulletin%20Cycle%201%20FINAL.pdf.
- 100 See D.C. Code § 7-751.07.
- 101 See DOH, *supra* note 83.
- 102 For an example of how such a scholarship might be funded and operate, see Lincoln Journal Star, \$4 million contract to address state’s dentist shortage (Feb. 21, 2017), available at http://journalstar.com/news/local/million-contract-to-address-state-s-dentist-shortage/article_1db1bc61-fc33-5bd1-b1d3-c22bf0beadc5.html (“The University of Nebraska Medical Center College of Dentistry has been awarded a \$4 million, 10-year contract from the Nebraska Oral Health Training and Services fund to address a shortage of dentists in the state . . . Through the contract, UNMC graduating dentists who commit to practice for at least five years in areas with a shortage of dentists will be eligible for shortage-area scholarships to lower or even eliminate the cost of dental college.”).
- 103 See, e.g., Pew Charitable Trusts, *States Stalled on Dental Sealant Programs: A 50-State Report* (April 2015) at 7-8, available at http://www.pewtrusts.org/-/media/assets/2015/04/dental_sealantreport_final.pdf; *Oral Health Workforce Research Center, Development of a New Dental Hygiene Professional Practice Index by State*, 2016 (November 2016) at 32, available at http://www.chwsny.org/wp-content/uploads/2016/12/OHWRC_Dental_Hygiene_Scope_of_Practice_2016.pdf.
- 104 See Pew Charitable Trusts, *supra* note 105, at 7; *Using Registered Dental Hygienists to Promote a School-Based Approach to Dental Public Health*, 107 *American Journal of Public Health* S56, S57 (June 2017), available at <https://www.ncbi.nlm.nih.gov/pubmed/28661808>; *Public Health Sealant Delivery Programs: Optimal Delivery and the Cost of Practice Acts*, 27 *Medical Decision Making* 762 (November–December 2007), available at <https://www.ncbi.nlm.nih.gov/pubmed/17585006>.
- 105 See Children’s Oral Health Care Amendment Act of 2013, introduced April 9, 2013 (Bill 20-0227).
- 106 DOH, FY 2018 Maternal and Child Health Services Title V Block Grant Application and Annual Report for 2016 (September 2017) at 276, available at https://mchb.tvisdata.hrsa.gov/uploadedfiles/StateSubmittedFiles/2018/DC/DC_TitleV_PrintVersion.pdf (“Some of the topics [covered in the oral health education sessions] were: 1) You can’t learn well if your teeth hurt!, 2) Dental caries is a key contributor to school absences among children, 3) Untreated caries have untoward effects for general health, potentially leading to long-term absences. The target population includes all parents of Head Start (assume one parent for one child), all DCPS teachers, and all DCPCS teachers.”).
- 107 See AAPD, *supra* note 64, at 11.
- 108 *Id.*
- 109 AmeriHealth Caritas District of Columbia, Inc., Silver Diamine Fluoride Coverage, available at <https://www.amerihealthcaritasdc.com/pdf/provider/resources/silver-diamine-fluoride-coverage.pdf>.
- 110 See AAPD, *supra* note 64, at 11.
- 111 See DHCF, *supra* note 48.
- 112 See AAPD, *supra* note 64, at 11 (citing *Silver Diamine Fluoride in Pediatric Dentistry Training Programs: Survey of Graduate Program Directors*, 38 *Pediatric Dentistry* 212 (May-June 2016), available at <http://www.ingentaconnect.com/content/aapd/pd/2016/00000038/00000003/art00008>).

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