CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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January 31, 2014

TO: Lawrence Kissner, Commissioner, Department for Medicaid Services

FROM: Erin Hoben, Chief Policy Advisor, Department for Medicaid Services
Dr. Ken Rich, Dental Director, Department for Medicaid Services

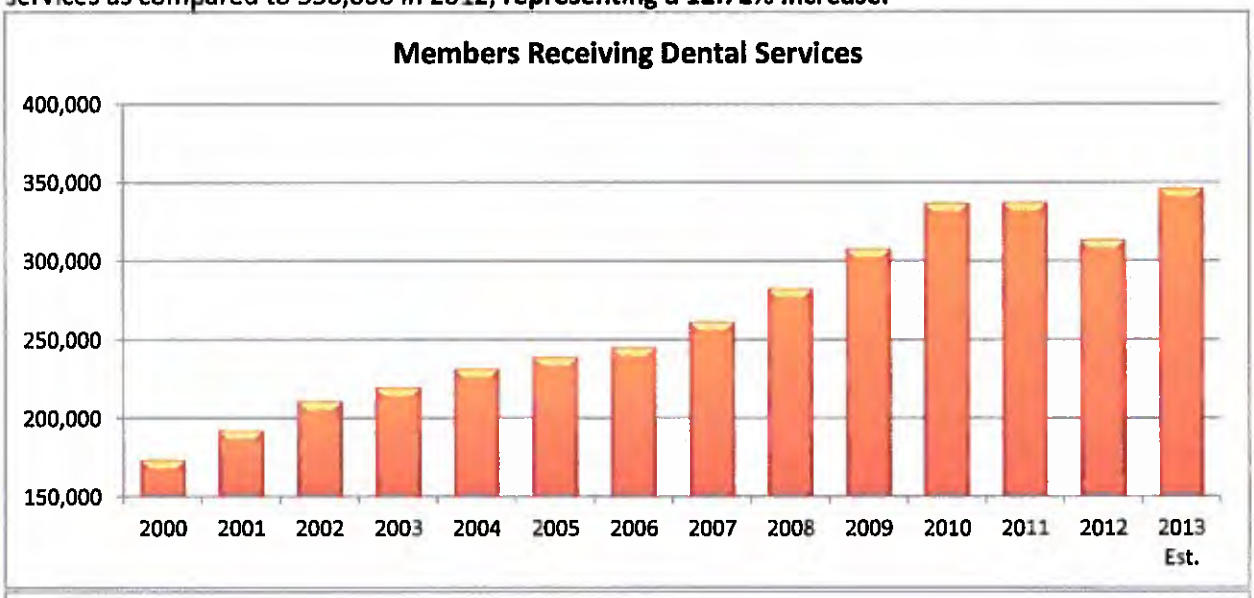
Dear Commissioner Kissner,

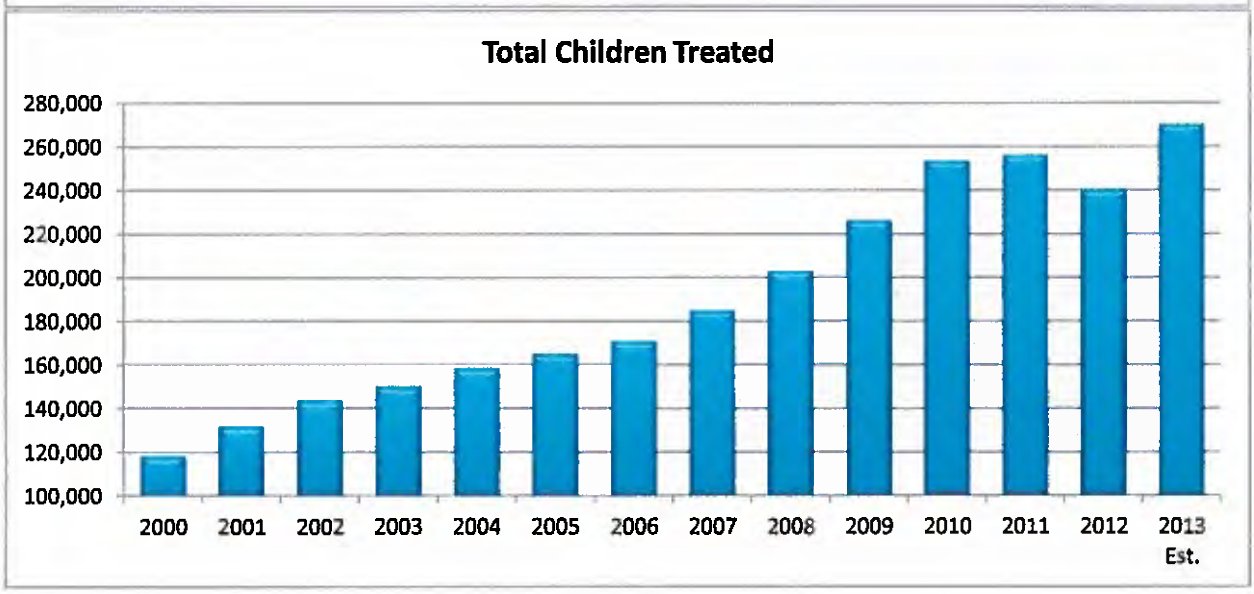
We received a copy of the December 19, 2013 letter to Governor Beshear from Dr. John Thompson which included the Executive Brief by Dr. Ray Mullins describing their view on the state of oral health in Kentucky and which also contained several recommendations. We agree that oral health is an important issue in Kentucky, especially as it relates to Medicaid recipients.

Although we provided the data that Dr. Mullins relied upon for his report, it did not represent the entire picture. For this we sincerely apologize since we provided the information requested. However, the data was only a partial picture of the dental picture of Kentucky Medicaid. More specifically, the data as summarized in the Executive Brief did not include 2013 data. The data from 2013 is particularly significant because it represents our second **full year** of managed care in Kentucky. It was in this year that we began to see the cost-savings and improved patient care that resulted from the implementation of managed care. Secondly, the report did not take into consideration that managed care was implemented on a short timeline, leading to initial hiccups in the beginning months. There were and continue to be challenges that are inherent in overhauling a system of care, but managed care is now operating much more smoothly, generating cost-savings and efficiency for the Medicaid program. Lastly, and most importantly, the interpretation of the data as described in Dr. Mullins' Executive Brief failed to account for increased enrollment due to the recession which resulted in escalating costs in the years immediately prior to managed care implementation. This economic path reached its high watermark for the Medicaid program in 2010 and 2011, when the Department of Medicaid Services (DMS) realized that costs were at a point that managed care became a necessity. The alternative to managed care would have been an across the board 30% reduction in rates. In response to managed care, some providers may have decreased service and some claims may have been denied due to failing medical/dental necessity requirements, but neither of these outcomes would have been better if Kentucky had instituted rate cuts of 30 percent. The interpretation below offers a full and accurate depiction of the data.

1) ***Patients Receiving Dental Services:*** In Dr. Mullins' report, it is stated that the number of Medicaid/KCHIP patients receiving dental services dropped significantly during 2012, with 34,813 fewer

Kentuckians receiving dental services compared to 2011.[1] There was a reduction in members receiving services from 2011 to 2012, but this number has started to increase now that managed care has had time to stabilize. In 2013, it is estimated that nearly 620,000 Medicaid/KCHIP patients received dental services as compared to 550,000 in 2012, **representing a 12.72% increase.**





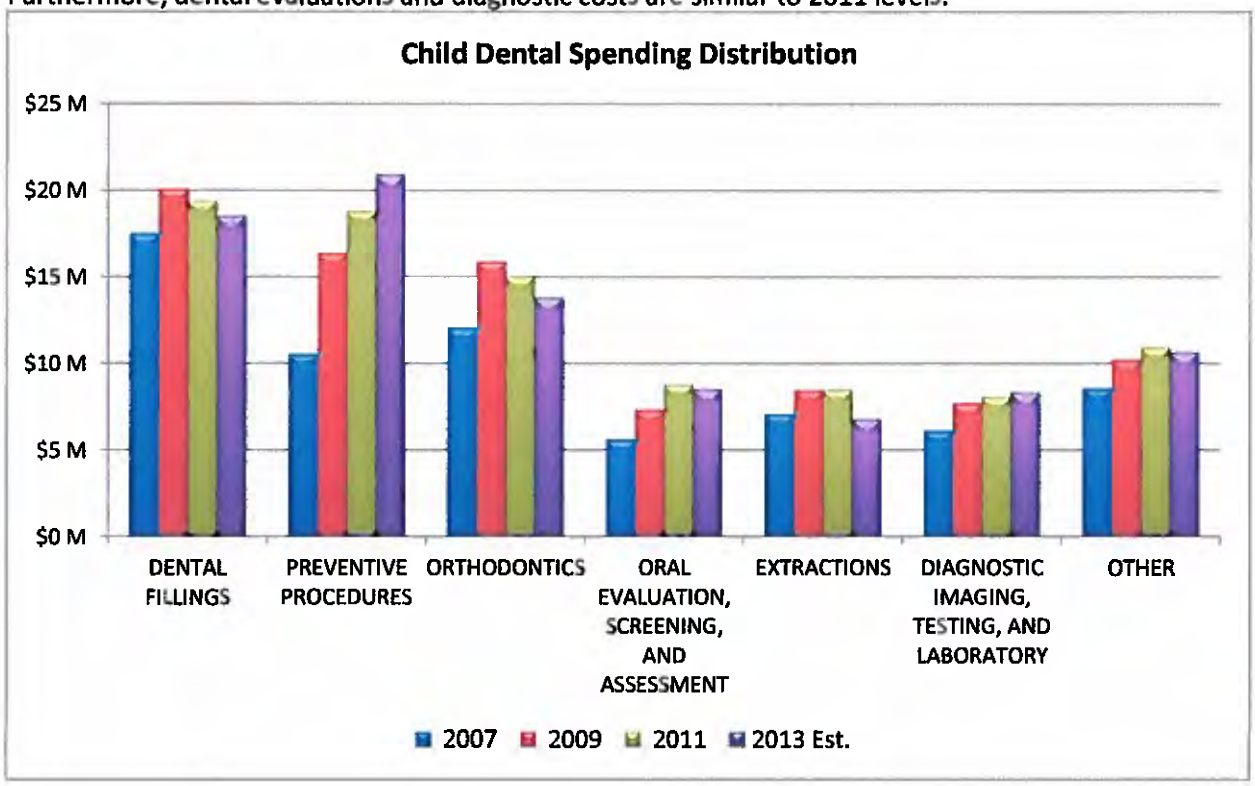
The report also states that the decrease in patients receiving services paid by Medicaid is particularly problematic for children between the ages of 0 and 4 years old because the enrollment for that age group during the same time period increased substantially. The author states that

[1] Dr. M. Raynor Mullins, DMD, MPH, "Executive Brief: Oral Health Services for Medicaid and KCHIP Eligible Populations in Kentucky." Attachment A. (December 16, 2013)

enrollment increased by 29.79% while those receiving services decreased by 12.74%. This conclusion is incorrect. From 2010 to 2013, the number of children ages 0-4 enrolled onto Medicaid actually **decreased by 3.4%.**

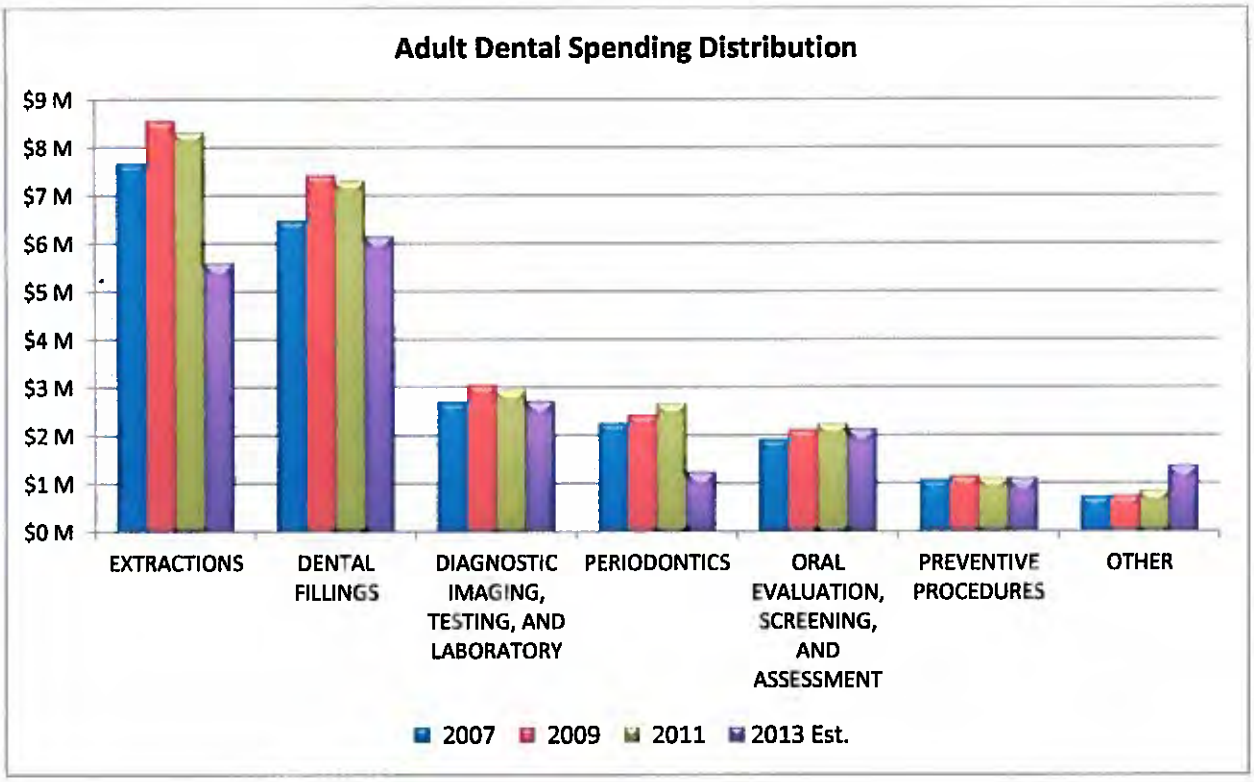
YEAR	Children Aged 0-4 Enrolled in Medicaid
2010	202,658
2011	204,906
2012	203,072
2013	195,762

It is also important to take note of the change in types of services. There has been a clear decrease in reimbursements for fillings, orthodontics, and extractions since the implementation of managed care. At the same time, there has been an unmistakable increase in preventive dentistry. Furthermore, dental evaluations and diagnostic costs are similar to 2011 levels.



Trends in the adult population are similar. There has been a marked decline in reimbursements for extractions, fillings and periodontics, and the reimbursements paid for evaluations and preventive procedures have been steady since 2011.

The bottom line is that the Commonwealth is paying less for procedures that are associated with poor dental health while **spending for preventive and evaluative dentistry is holding constant or increasing.** While it is too soon to see whether this increased spending on disease management will have an impact on overall oral health, it is notable that there seems to have been a shift in focus from surgical-based treatment to disease management and prevention.



2) ***Dental Utilization Rates***

The report asserts that for all children age 0-20, state dental utilization rates decreased from 46% in 2011 to 40% in 2012, with children's utilization rates decreasing in 115 of 120 counties. For adults over the age of 21, the author stated that utilization rates decreased by 17% in 2011 to 16% in 2012. It is true that there was a drop in semi-annual dental utilization from 2011 to 2012, **but this was followed by a marked increase in 2013.** The increase in the number of children receiving services combined with the slightly decreased enrollment has **resulted in a sizeable increase in the pediatric dental utilization rate.**

	2011	2012	2013
Children Receiving Dental Services	256,239	240,169	273,750
Total Eligible Children	582,122	586,022	578,042
Utilization Rate	44%	41%	47%

Utilization among adults does not appear to be rebounding. From 2011 to 2012, adults receiving dental services dropped by 1.8%. The rate has increased slightly, but we agree it has not reached pre-managed care levels (0.9% lower than 2011).

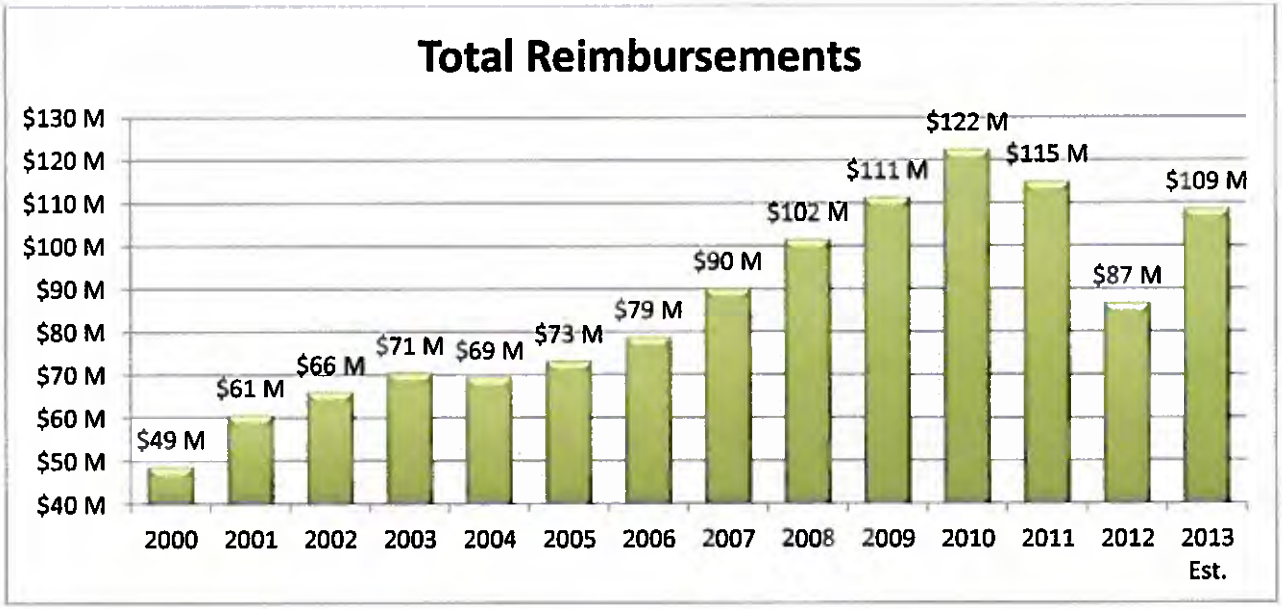
	2011	2012	2013
Adults Receiving Dental Services	81,259	73,434	75,414
Total Eligible Adults	431,249	432,705	421,126
Utilization Rate	18.8%	17.0%	17.9%

The decrease in utilization from 2012-2013 was widespread, occurring in nearly every county, but **there has been an increase above 2011 utilization levels in the majority of counties. Adult utilization rates have exceeded 2011 levels in 78 counties and pediatric utilization rates exceeded 2011 levels in 89 counties.** Despite the initial decrease during the first year of implementation, there has been resounding improvement in utilization rates in 2013.

	2011-2012		2011-2013	
	Adults	Children	Adults	Children
Counties with Decreased Utilization	104	101	42	31
Counties with Increased Utilization	16	19	78	89
Total Counties	**120**	**120**	**120**	**120**

3) ***Dental Expenditures***

In the Executive Brief, it states that dental expenditures had decreased from $124,391,191 in 2011 to $86,433,771 in 2012, representing a decrease of 30.5%. As discussed, the Commonwealth was confronted with rapidly escalating dental costs prior to managed care implementation. Dental costs declined in 2012 **but have rebounded somewhat in 2013.**



4) ***Dental Participation***

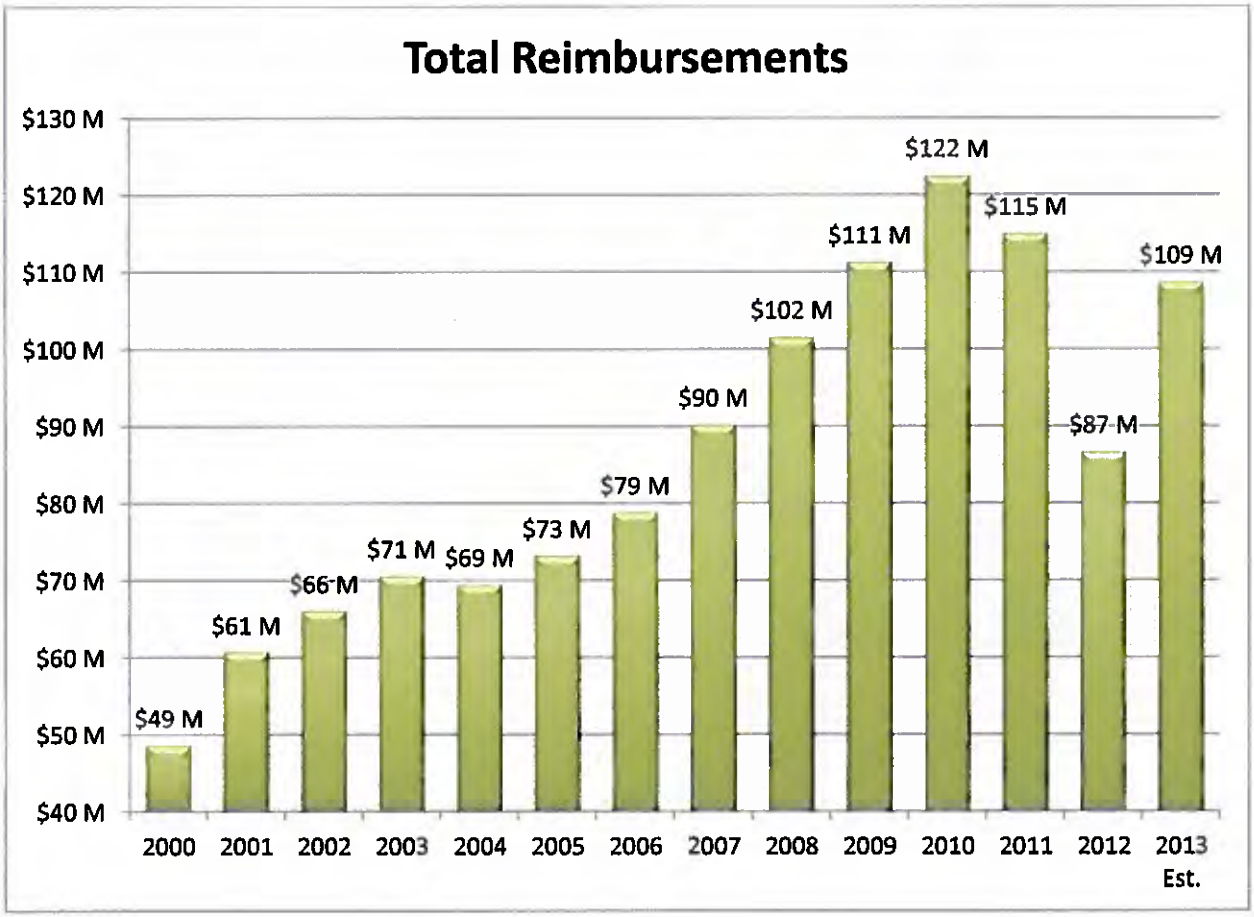
While there is some lack of clarity concerning how the Executive Brief classified certain types of dentists, the data clearly shows that there has been an increase in dental provider participation under managed care. The brief states that in 2012, only 20% of all practicing general dentists actively participated in Medicaid with annual paid claims of $50,000 or more. The author adds that 86% of practicing pediatric dentists, 48% of practicing oral surgeons and 43% of practicing orthodontists participated in Medicaid in 2012. According to the report, 78% of the participating pediatric dentists, 64% of the participating oral surgeons and 57% of the participating orthodontists had annual paid claims of $50,000 or more. The report also states that 192 practicing general dentists and dental specialists, who participated in the Medicaid/KCHIP programs in 2011, had no paid claims in 2012.

When the Cabinet looked at the data, **our analysis greatly departed from that of the report.** The table below shows only providers who are billing out of a Kentucky office and had at least one paid claim for 2012. All specialties are included.

Providers Receiving Payment for Dental Services			
Billing Provider Specialty	2011	2012	2013
Federally Qualified Health Clinic (FQHC)	8	8	9
Rural Health Clinic (RHC)	3	1	2
Medical Clinic	6	5	6
General Dentistry Practitioner	827	926	916
Oral Surgeon	56	67	64
Orthodontist	47	49	47

Pediatric Dentist	26	27	30
Dentist - Individual	66	90	122
Dental - Group	15	20	22
Multi Specialty Group - Dental	47	57	61

The Cabinet found that general dentist participation is certainly up, whether "General Dentistry Practitioner" or "Dentist-Individual" is considered. Of the 9,163 General dentistry practitioners enrolled in 2013, 392 (43%) were paid in excess of $50,000. 22 of the 122 individual dentists were paid more than $50,000 in 2013. Pediatric dentists in the Medicaid network have increased from 26 to 30 under managed care. This data presents a serious deviation from that of the Brief. The author of the Executive Brief may have a listing or registry of pediatric dentists unavailable to Medicaid. Of those 30 pediatric dentists, 21 (70%) had reimbursements exceeding $50,000. In regard to oral surgeons, 64 treated Medicaid patients in 2013, up from 56 in 2011. Of these participating surgeons, 40 (63%) had reimbursements exceeding $50,000. The number of orthodontists has not changed since 2011. In both years, 31 orthodontists had reimbursements exceeding $50,000. This number is lower than that presented in the Brief. It is likely that some orthodontists are practicing as part of a dental group or multi-specialty dental group.



Providers Receiving > $50,000 in Payment for Dental Services			
Billing Provider Specialty Code	2011	2012	2013
Federally Qualified Health Clinic (FQHC)	6	1	0
Rural Health Clinic (RHC)	3	1	0
Medical Clinic	4	1	0
General Dentistry Practitioner	372	385	392
Oral Surgeon	39	43	40
Orthodontist	31	33	31
Pediatric Dentist	18	20	21
Dentist - Individual	4	23	22
Dental - Group		2	3
Multi Specialty Group - Dental	30	17	17

This analysis is based on dentists who submitted claims in at least one of the three years, and therefore does not deal with those who have a Medicaid number but refuse to treat Medicaid patients. However, **it is clear that dentist participation has increased rather than decreased since managed care.**

Conclusion: The first and foremost recommendation in the report is that there should be a carve-out for dental care in Kentucky. This assertion is based almost entirely on data that did not take into account key information, such as the short timeline of managed care implementation, the improvement in cost-savings and patient care in 2013, and the escalating costs that made managed care a necessity. It is clear from our data that while the benefits of managed care were not immediately apparent, in this second full year after implementation there has been greater utilization, lower costs and more spending on preventive care. If Kentucky opts to move dental care back into a fee for service structure, this will only undo the successes for which managed care has been responsible, and potentially cause a detrimental disruption in service to Medicaid patients. DMS can build on the accomplishments of managed care by making changes to further improve preventive care and ensure provider network adequacy.

We worked with the Kentucky Dental Association (KDA) to analyze the Commonwealth's current benefit structure and determine what changes DMS could make that would have the greatest impact on utilization and overall dental health. We first determined what a "comprehensive oral health benefits package" looks like and how Kentucky compares to that model and to other states. We also solicited feedback from KDA through Dr. Rich, our Dental Director at DMS, to identify improvements that could be made to dental care and analyzed the fiscal impact of each recommendation.

The following represents the KDA feedback along these lines.

Comprehensive Oral Health Benefits Package:

A comprehensive oral health benefits package for adults includes the following service categories[2]:
-Exams: routine dental examinations including X-rays
-Preventive services: cleanings
-Emergency services: emergency exams, extractions, pain relief and treatment for infection
-Basic restorative services: amalgam fillings, resin fillings and stainless steel crowns
-Advanced restorative services: laboratory processed crowns, tooth replacement, root canal therapy
-Periodontal services: periodontal surgery, scaling and root planing
-Oral surgery services: non-emergency extractions, other oral surgical procedures

Nationwide: The Medicaid program in Kentucky offers oral exams, emergency services, preventive services, basic restorative services, periodontal services and oral surgery services. This encompasses one cleaning per year, x-rays, fillings and extractions. **Kentucky's dental benefits package is comparable to that of other states.**

Fifteen states offer coverage in all service categories. Another thirteen, including Kentucky, exclude coverage in at least one service category, typically advanced restorative and/or periodontal services. Six states do not offer any coverage at all, six states offer coverage with an annual limit on services, and sixteen offer only emergency services.[3] California recently reduced their benefit package from one that covered services in all categories with a dollar cap per year to only providing emergency services.[4]

One notable distinction is that Kentucky's dental benefit package under Medicaid does not provide coverage for root canal therapy while twenty-four other states nationwide include this service. Root canals and crowns may be ideal treatment for adults, there are some concerns regarding the practicality of these services. Root canals in posterior teeth and in many front teeth do not prolong the life or function of the tooth without being restored by a full coverage crown and in some cases, a post. Teeth that have been treated with root canals are almost always structurally weakened by the procedure and if a full coverage restoration such as a crown is not placed, will in the majority of cases, break beyond the ability to be restored in a year or two. To complicate the issue even more, endodontics and crowns are two of the more expensive dental procedures for which Medicaid reimburses. The rates for root canals range from $227 for an anterior tooth to $481 for a molar. We estimate that under EPSDT, crowns are paid for at $500. Over the years, Medicaid has paid for many root canals in children that have resulted with the extraction of the tooth within two years. There is some merit in providing root canals for anterior teeth as they are less likely to fracture and can many times be restored with composite restorations (fillings) as opposed to full coverage restoration such as crowns.

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[2] Mary McGuinn-Shapiro, "Medicaid Coverage of Adult Dental Services." State Health Policy Monitor. Vol. 2, Issue 2. (Portland, ME: National Academy for State Health Policy, October 2008).
[3] McGuinn-Shapiro, 4-5
[4] California Medi-Cal Dental Program, *"Denti-Cal FAQs: Elimination of Most Adult Dental Services Beneficiary Frequently Asked Questions (FAQs)." http://www.denti-cal.ca.gov/provsrvcs/FAQs/Bene_FAQs.pdf* (accessed January 24, 2014).

Bordering States: Illinois, Indiana and Ohio are comparable to Kentucky in that they also cover all services with exclusion of one or two services Illinois does not cover preventive services for adults. West Virginia and Virginia cover emergency services only. Missouri provides coverage in all services areas, but only to disabled, elderly and pregnant women in all but emergency services. Tennessee does not cover dental care for any adult Medicaid recipient.

States with similar health rankings: Kentucky is ranked 45th on America's Health Rankings.[5] In order to move up in the rankings, we thought it would be prudent to review the policy of states that are ranked just above Kentucky. In comparison with states which rank 35-45 on the health rankings, one offers no adult dental services, six offer emergency services only, two are comparable with Kentucky and only one offers all services to their Medicaid populations.

The bottom-line is that **Kentucky's dental benefit package is comprehensive and comparable to bordering states, states with similar rankings and to states nationwide**. In terms of what benefits Kentucky offers, the one benefit we could include that would bring us even more in line with states nationwide is root canal therapy for molars. We recommend that DMS offer reimbursement for anterior root canals and provide education and disease management to educate patients on home-case to ensure the root canal therapy would have a lasting impact should there be additional funding available in the current or future budgets.

We asked the KDA what they would recommend as the "Top Five Changes to Improve Oral Health in Kentucky." Below you will find their recommendations.

KDA Recommendation One: **Increase reimbursement to dental providers for covered services.**

DMS research provides that the states bordering Kentucky offer coverage beyond emergency services only for adults are Illinois, Ohio and Indiana. Illinois offers only limited exams, x-rays, extractions and some sedation in addition to emergency services. Among all services, **Kentucky reimburses at a higher rate than Ohio and Indiana only on cleanings for children.** Kentucky reimburses at a *lower rate than the average of Ohio, Indiana, and where applicable, Illinois for all of the following common procedures.* Nationwide, Kentucky fares a bit better for reimbursement rates for adult cleanings, with the average being only 12% more than Kentucky pays. But the average nationwide for the other four common procedures is at least 30% higher. The breakdown for commonly utilized procedures is as follows:

Procedure	Kentucky	Average	Difference	Average Nationwide**	Difference
Cleanings	$37	$47.75*	29%	$41.51	12%

[5] United Health Foundation, *America's Health Rankings, 2013* http://www.americashealthrankings.org/Rankings, accessed January 15, 2014.

Amalgam filling	$38	$49.70	31%	$51.44	35%
X-rays	$30	$44.48	48%	$50.29	67%
Extraction	$38	$56.45	48%	$61.30	61%
Impacted Extraction	$72	$105.80	47%	$110.48	53%

*Indiana is the only bordering state for which there is information regarding fee schedule for cleanings.
**Nationwide includes states offering similar services to traditional Medicaid populations.

Our DMS recommendation is to increase the reimbursement rates for providers for all procedures to more closely align Kentucky's rates with those of neighboring states. Obviously, this is contingent upon additional funding being procured in the next budget. Given our current revenue situation, this may not be feasible until additional sources of revenue can be secured. Another option is to create a few pilot projects that increase reimbursement rates in certain underserved counties to evaluate if increasing dental reimbursement actually results in attracting more providers.

The long-term goal is to encourage providers to remain in areas of the states where there is a high Medicaid population, providing dental care access for residents of that area. Kentucky does have a comprehensive benefit package in comparison to bordering states and most states across the country. But having access to these services is hindered when providers are not encouraged to accept Medicaid patients at a low reimbursement rate. In order to optimally serve Medicaid recipients, Kentucky needs to ensure that the provider network is robust and increasing reimbursement rates is the first step. However, per our contracts with the MCOs, there is no provision requiring the MCOs to reimburse providers at a higher rate if we raise our capitation rate. In fact, we have purposefully stayed *out* of the provider/MCO contract as we needed to save $1.3 billion from our 2013/2014 budget and encouraged the MCO's not to contract at Medicaid Fee-For-Service rates. We encouraged them to think outside the box and create modern pay-for-performance contracts that increased quality while reducing costs. It is a possibility that we can amend our contracts to include a provision that makes increased capitation rates contingent on an agreement that they will pass on the increased payment to their contracted providers, but this is something we believe requires significant research.

KDA Recommendation Two: **Remove the limit of one cleaning per adult member per year and allow providers to be reimbursed for two dental cleanings.**

Kentucky ranks 41st in annual dental visits and 45th in the percentage of adults with all teeth missing. However, only 7 states - Iowa, Michigan, Montana, New Jersey, North Carolina, Pennsylvania and Vermont - reimburse for more than one annual cleaning.[6] Logically, these states rank higher than

[6] The Kaiser Family Foundation, *State Health Facts: Dental Services, October 2010*, http://kff.org/medicaid/state-indicator/dental-services/, (accessed January 15, 2014).

Kentucky in annual dental visits.[7] A recent study in the Journal of Dental Research found that one cleaning per year may be enough for patients who are not at risk for gum disease. However, factors that put one at risk for gum disease include smoking and diabetes.[8] As you know, Kentucky ranks 50th in smoking[9] and 38th in diabetes[10], both of which increase the risk for developing gum disease which can lead to other dental problems and tooth loss. Patients in Kentucky have a great need to visit their dentists more frequently and allowing for reimbursement for two cleanings per year would remove one barrier to access. This would increase the opportunities that dentists have to provide dental education to patients, and would provide for more accountability on the part of the patient. If a patient knows they are scheduled to see their dentist in six months rather than a year, they may be more likely to implement the dentist's recommendations from the previous visit. As with the other KDA recommendations, we would need to fund these additional services.

KDA Recommendation Three: **Remove the one-visit per month per adult patient limit for non-emergency dental care.**

According to a nationwide study by the American Dental Association (ADA), Medicaid patients fail to keep their dental appointments 30% of the time. This leads to patients are not receiving the care that they need, and frustrates providers because it causes them to lose profits. Providers often cite this as a reason for lack of willingness to accept Medicaid patients. Many reasons can contribute to lack of dental compliance, including transportation, bouts of homelessness, gaps in Medicaid coverage and lack of awareness of the importance of oral health.[11] While it would require a comprehensive analysis of all of these issues to determine how to best solve the problem, it can at least be reduced by allowing patients to come in for more than one visit per month. A patient's situation is less likely to change from week to week versus from one month to the next. Allowing a patient to see a dentist for more than one visit per month for non-emergency care may increase the likelihood that they will keep their appointments, thus contributing to their overall dental health. This is especially possible in situations where one may be eligible for Medicaid one month and through an income fluctuation, ineligible the next. Additional funding is required.

KDA Recommendation Four: **Shift from a surgical care model to a disease prevention paradigm to improve oral health and reduce long-term costs associated with dental caries.**

A recent project supported by the DentaQuest Institute called the Early Child Caries (ECC) Collaborative focused on a paradigm shift toward chronic disease management of dental caries. The project used an evidence-based disease management approach to manage and reduce caries progress in children

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[7] United Health Foundation, *America's Health Rankings: United States Overview,2013* http://www.americashealthrankings.org/ALL/dental/2013 (accessed January 15, 2014).
[8] Giannobile, W.V., Braun, T.M. Caplis, A.K., Doucette-Stamm, D., Duff, G.W., Kornman, K.S. (2013). Patient Stratification for Preventive Care in Denistry. *JDR, 92*(8): pp.694-701, http://jdr.sagepub.com/content/92/8/694.full.pdf+html.
[9] United Health Foundation, *America's Health Rankings: Smoking,2013* http://www.americashealthrankings.org/ALL/Smoking/2013 (accessed January 15, 2014).
[10] United Health Foundation, *America's Health Rankings: Diabetes,2013* http://www.americashealthrankings.org/ALL/Diabetes/2013 (accessed January 15, 2014).
[11] Missouri Foundation or Health, *State Strategies to Improve Compliance in Missouri's Medicaid Population, 2008,* http://www.mfh.org/mm/files/DentalComplianceMFH.pdf, (accessed January 16, 2014).

younger than 60 months of age who presented with early childhood caries. The methods employed were performing a caries risk assessment at each visit, explaining the process to caregivers in lay terms, introducing self-management goals to the caregiver, and applying fluoride at each visit. The study found significant reductions in patients being treated in the operating room, in cavity recurrence in patients treated at the hospital and in the percentage of patients complaining of pain.[12] The authors suggest that reimbursement is necessary for caries risk assessment, diagnosis, non-surgical management of caries, more frequent disease-management visits for some appropriate patients, education and counseling in order to successfully shift to a risk-based disease prevention model. DMS should consider incentivizing providers to utilize a disease-management model through allowing for this type of treatment to be reimbursed. This would require additional funding.

Dentists have an opportunity to provide education to their child patients and to their adults at each visit. However, they have limited time to spend with each patient and often have been practicing a treatment approach to dental care rather than a disease management approach. Education regarding healthy dental practices should be provided at every point of contact that a patient has with a healthcare provider. Dental providers should be well-versed on anticipatory guidance and counseling, which is the process for providing practical, developmentally-appropriate information about children's health to inform parents about oral hygiene, healthy food habits, and injury prevention.[13] State agencies are another point of contact where dental information could be disseminated to populations using those services, especially since they are often cross-utilizers of these and Medicaid services. Additionally, Medicaid should partner with oral health coalitions and advocates to conduct training for dental providers and state agency employees to teach them to best methods for reaching and educating parents and children. To encourage providers to enroll in trainings, Medicaid could create incentives, such offering CLE credits through a partnership with a credentialing organization. CMS has been developing educational messages and materials regarding healthy eating and home-based oral health practices. Kentucky Medicaid should collaborate with CMS to ensure that their messaging is being communicated to Kentucky's Medicaid population. Additional funding is required to create incentives.

The Managed Care Organizations could be implementing much of Medicaid's efforts to improve oral health in Kentucky. MCOs should be involved to create and publish information materials to be distributed among each of their network providers as well as to be used at other state agencies. Kentucky's Department of Medicaid Services should work with case management staff at the MCOs to help improve patient utilization by relying on them to more proactively educate their members about finding dental care, making arrangements to get to treatments and following up after any missed appointments. It is crucial that dental care in Kentucky shift to a disease management model. Studies have shown that children in high-income families are more likely to receive dental care than children who fall below 200% of the Federal Poverty Level.[14] Every child deserves to receive dental care,

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[12] Ng, M.W., Torresyap, G. White, A., Melvin, P., Graham, D., Kane, D., Scoville, R., Ohiomoba, H. (2012). Disease Management of Early Childhood Caries: Results of a Pilot Quality Improvement Project *J. of Health Care for the Poor and Underserved, 23*(3 Suppl): pp.193-209.

[13] American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents, 2013,* http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf, (accessed January 16, 2014).

[14] Kenney GM, McFeelers JR, Yee JY. Preventive dental care and unmet dental needs among low-income children. The American *Journal of Public Health. 2005;95(8):*1360–1366, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449367/

regardless of income. Because Medicaid and KCHIP are major conduits for Kentuckians at this income level to receive healthcare, there is no entity better suited to lead the way. Further, managed care companies are contracted to do just that, manage care. They have contact with each and every Medicaid recipient, and as such are uniquely situated to provide education to patients about dental care habits that they can do at home.

KDA Recommendation Five: **Encourage partnerships with non-profit dental clinics providing high-volume low-cost care to Medicaid recipients.**

According to the Deloitte Healthcare Workforce Capacity Report (2013), Kentucky has 36% of the dentist supply needed to meet current need. In order to improve overall dental health, Kentuckians must have greater access to dental care providers. Delivery models which focus on marketing and community outreach to improve service delivery and increase the program's reach are starting to be implemented throughout the country. One example is the Sarrell Dental Center in Alabama. ICF International recently released a report on the Sarrell Dental Center, noting its successes. The report focused on the business approach, extensive community and marketing outreach efforts and service delivery. They offer free screenings that are usually part of preventive care, partner with local community-based agencies and accept Medicaid reimbursements.[15] They work with Head Start, attend health fairs and school PTO meetings to educate parents, case workers and children.[16] They have the potential to be more far-reaching and sustainable than local providers. Kentucky should establish partnerships with such programs and encourage them to build their models in parts of the state which are most in need of dental providers.

Medicaid Summary

The Department for Medicaid Services is supportive of improving our dental outcomes. We are **not** supportive of carving out the dental services from our current Medicaid MCO contracts and believe this would be detrimental to our members and negatively impact our state budget. The data contained in the Executive Brief that was presented to your office was an incomplete picture of the dental claims, lacking both 2013 data and a number of codes that missing from the initial data request.

We believe we have rounded out the view of our Medicaid dental coverage in Kentucky. We have provided you a more robust picture of the coverage, benefits and limitations of our current program. We have researched surrounding states and determined we are better than most with our current benefit offering, but reimburse on the lower end of the scale on a per service basis. However, **all of the KDA recommendations would require additional funding.** And, there is no guarantee that pumping more money into the current system would increase the quality.

We are supportive of the creation of "pilot projects" that take different and new approaches to reducing costs and improving quality. Dental success is sequential in that early prevention saves teeth and

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[15] ICF International, *Systematic Screening and Assessment of Workforce Innovations in the Provision of Preventive Oral Health Services: Evaluability Assessment Site Visit Summary Report, Sarrell Dental Program, Anniston, Alabama, March 2013,* http://www.sarrelldental.org/wp-content/uploads/2013/05/Sarrell-Dental-EA-Summary-Report.pdf, (accessed January 15, 2014).
[16] Jeffrey Parker, "Sarrell Dental: Beyond the Operatory." KDA Today. (Kentucky Dental Association, August 21, 2012).

improves long term dental health. Once the teeth are gone, the opportunity to improve s person's overall dental health is severely limited. Since we are 45th in adult missing teeth, the best value may be spent on our youth and providing more extensive early intervention. Pilot projects would allow us to experiment with different approaches without making huge investments.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services