NOTE: This tool was developed by the Medicaid-CHIP State Dental Association to assist State Medicaid Dental Programs in the development of their State Oral Health Action Plans for CMS.

Oral Health Action Plan Template
For Medicaid and CHIP Programs

STATE: New Hampshire	**STATE CONTACT:** Margaret Snow, DMD
AGENCY: NH Dept of Health and Human Services	**TITLE:** Dental Director
PROGRAM NAME: NH Medicaid	**AGENCY:** NH DHHS
PROGRAM TYPE REFLECTED IN THIS TEMPLATE: ____MEDICAID ____CHIP __X__COMBINED MEDICAID /CHIP	**PROGRAM:** NH Medicaid **TELEPHONE:** (603) 271 9251 **EMAIL:** mmsnow@dhhs.state.nh.us

INSTRUCTIONS

It is best to complete separate templates for each of your State's Medicaid and CHIP dental programs. If your State has a combined Medicaid and CHIP dental program, or if you are implementing common improvements across both Medicaid and CHIP dental programs, you may complete a single template for both programs.

ORAL HEALTH INITIATIVE GOALS

1) To increase the proportion of children ages 1-20 enrolled in Medicaid or CHIP for at least 90 consecutive days who receive a preventive dental service by 10 percentage points over a five-year period. Target year is FY 2015.

2) To increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period. Target year has not yet been determined.

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TYPE OF DENTAL DELIVERY SYSTEM

SERVICE DELIVERY FOR DENTAL	Calendar year implemented	Number of children currently enrolled	If a new dental delivery system was launched since 2005, please explain why the new dental delivery system model was chosen.
Fee For Service	FFS since program inception prior to 1972	CHIP + MA : 1-19yrs = 96,545 0-21yrs = 102,118	No change in dental delivery system in this period
Dental Managed Care	N/A		

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PARTICIPATING" DENTAL PROVIDERS

"Participating"= submitted at least one claim. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR: SFY 2012	NUMBER LICENSED IN STATE	Primary Dental Delivery System Type: Fee For Service (Based on enrolled providers submitting claims. Includes billing providers) # PARTICIPATING	Primary Dental Delivery System Type: Fee For Service (Based on enrolled providers submitting claims. Includes billing providers) # ACTIVE	Secondary Dental Delivery System Type: N/A # PARTICIPATING	Secondary Dental Delivery System Type: N/A # ACTIVE
DENTISTS		947 (With active license, in-state address)	396	52		
DENTAL HYGIENISTS			N/A Dental Hygienists' services are billed under billing providers' enrollment, thus no data about number of hygienists participating or active is available	N/A		

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OTHER DENTAL MID-LEVEL			N/A There are no dental mid-level providers enrolled in NH Medicaid	N/A		
DENTAL SPECIALISTS (enumerated by type)			Included in above. (Medicaid enrollment by "specialty" is not consistent with specialty status as per NH Dental Board's designation. For example, a dental group may enroll as "Pediatric Dentist" if it			

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"Participating"= submitted at least one claim. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR: SFY 2012	NUMBER LICENSED IN STATE	Primary Dental Delivery System Type: Fee For Service (Based on enrolled providers submitting claims. Includes billing providers) **#** PARTICIPATING comprises general dentist(s) willing to treat children.	Primary Dental Delivery System Type: Fee For Service (Based on enrolled providers submitting claims. Includes billing providers) # ACTIVE	Secondary Dental Delivery System Type: N/A # PARTICIPATING	Secondary Dental Delivery System Type: N/A # ACTIVE

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"PARTICIPATING" NON-DENTAL (MEDICAL) PRIMARY CARE PROFESSIONALS PROVIDING ORAL HEALTH CARE SERVICES:

"Participating"= submitted at least one claim for oral health services. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR:	NUMBER LICENSED IN STATE	# PARTICIPATING	# ACTIVE
MDs			N/A*	N/A*
NURSE PRACTITIONERS			N/A*	N/A*
PHYSICIAN ASSISTANTS			N/A*	N/A*
OTHER NON-DENTAL MID-LEVEL PROVIDERS			N/A*	N/A*

*To date, non-dental medical primary care professionals have not been enrolled as dental providers and do not file claims for oral health services using a CDT code or other code. Required oral health services for children 6 months to 3 years of age to be delivered by PCPs are described within the medical managed care contracts to be implemented later in 2013. PCPs are required to be certified by a course approved by the AAP, and to provide age appropriate anticipatory guidance, risk assessment, oral health screening and fluoride varnish if appropriate, along with a referral to a dentist for all Medicaid enrolled children between the ages of 6 months and 3 years. Oral health services are to be integrated with the well child visits every 6 months.

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Describe any specific access challenges in your State, such as rural areas, dental health professional shortage areas, etc.
Between FFY 2003 and the end of FFY 2011 NH Medicaid increased the percentage of children receiving any dental service from nearly 26 % to 60%, those receiving preventive services rose from 20% to 56%, and those receiving dental treatment increased from 11% to nearly 26%. Using HEDIS measures, utilization of dental services for NH Medicaid-eligible children is now very close to that of the insured. These gains have been made by applying the formula that has been shown effective in other states: increase rates significantly for many codes, reduce administrative burden, provide client services to match dentists with client needs and provide support services such as transportation and language support. Nonetheless, despite demonstrated success, children remain without a paid dental claim each year. As utilization increases, the challenges to reaching the remaining children become more complex and more difficult and costly to overcome. Identifying the factors that are amenable to strategic intervention and most cost effective to address is a challenge in itself. Three sets of environmental challenges appear to be the next most important to address: • Shortage of dental professionals with specific skill sets needed by those most difficult to treat in areas of sparse population with broad based socio-economic hardship • Patient understanding of the value of oral health and oral health services • Safety net that is not sufficiently robust to provide both preventive and routine and emergency dental care statewide Two-thirds of NH lies within DHPSAs, most notably the northernmost part of the state. The same area demonstrates the state's highest reports of untreated dental disease among very young and school aged children, the highest percentage of edentulous adults, tobacco use, oral cancer and other oral disease, dietary practices that promote oral disease, and the lowest prevalence of community water fluoridation. Because of the prevalence of oral disease and the demographics in the "North Country", there is a specific shortage of pediatric dental specialists and oral surgeons. The shortage of specialists is in addition to a shortage of general dentists with the broad skill set to manage extensive disease in the very young, the frail elderly, and adults with long standing oral diseases. Factors that discourage provider-participation and otherwise constrain access to dental care in the North Country and other DHPSAs include: lack of understanding of the value of routine and preventive dental care, the role of diet and self-care in oral health, lack of education about the preventability of oral disease, population insufficient to support dental practice, especially specialties such as pediatric dentistry and oral surgery, rugged terrain, harsh climate in mountainous areas, no public transportation, high unemployment rates, marginally employed people who are unable to leave work to attend dental appointments, lack of dental insurance and no adult dental Medicaid benefit. These economic and non-economic factors reduce access not just on the supply side of willing providers, but also on the demand side, especially for routine and preventive dental services. These factors appear to reduce Medicaid utilization of available services statewide, especially within the DHPSAs where existing dental professionals report low utilization despite current availability of dentists willing to treat new Medicaid patients. Effectiveness of preventive and therapeutic services is limited by other patient factors, as well. Medicaid utilization of both preventive and treatment services is significantly reduced by broken appointments. The high rate of broken appointments affects access in three ways: the appointed child cannot receive treatment, the child who was denied the appointment in the time reserved for the absent child is denied treatment, and dentists are discouraged from

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appointing Medicaid patients because of frustration and direct costs related to broken appointments. Data collection by NH Medicaid in 2005-2007 indicated that the rate of no-shows for dental appointments presents a significant challenge to NH Medicaid in providing dental care to more Medicaid-eligible children. The assumption has been that no-shows are driven by many of the factors listed above, including especially: low acceptance of the value of routine and preventive dental treatment, transportation problems, inability to leave work, harsh climate, illness of siblings, etc. NH's safety net does not provide oral health services uniformly statewide. NH has no county-based health departments. Instead there is a state-level health department that provides limited funding but no clinical services; only two cities have health departments providing oral health services. The majority of the oral health safety net in NH is a product of FQHCs, Community Health Centers, school-based and school-linked clinics, community hospitals and private foundations, with limited state funding except for Medicaid reimbursement for services to children and limited funding from the NH Department of Health. An undetermined number of services provided to Medicaid children is not billed because the organizations have determined that the infrastructure of their programs is insufficient to overcome administrative obstacles of enrolling and filing claims, because the services they provide are not billable, or because they do not structure payments from non-Medicaid patients so that Medicaid is not the sole payer. Because NH has no comprehensive adult dental Medicaid benefit, some safety net programs services to adults and uninsured children must be sustained by revenue generated primarily by the children's Medicaid benefit. The dependence for sustainability on children as a single patient sector for revenue puts service delivery at risk for all. NH Medicaid's strategic initiatives are aimed at addressing these challenges by promoting behaviors that reflect value of oral health and demand for services that improve oral health, increasing dental and other providers with specific skills for the underserved, reducing administrative burden and missed appointments, and strengthening the safety net, including FQHCs, school and community-based oral health programs. The specific activities of NH Medicaid's Strategic Plan to Improve Access To Oral Health fall into 5 categories: 1. Policy development and implementation to reduce incidence and prevalence of oral disease and increase access to and utilization of services that improve oral health 2. Outreach and support of Medicaid clients to increase value of oral health and drive utilization of behaviors and services to improve oral health 3. Develop and leverage effective partnerships to increase access to oral health services, especially in underserved areas and populations 4. Reduce administrative burden and other barriers to provider participation 5. Build safety net capacity and sustainability

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Strategic Intent	Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.

Strategic Intent #1: Policy development and implementation to reduce incidence and prevalence of oral disease and increase access to and utilization of services that improve oral health	NH DHHS and NH Medicaid's oral health policies recognize the necessity of oral health for overall health across the lifespan, and support consideration of methods to promote oral health in policies, rules, and programs. The policies directly support preventive approaches in programs and integration of oral health care in the medical care setting as a reflection of integration of oral health with overall health.
	
	Examples of specific initiatives that reflect the oral health policy of the NH DHHS and NH Medicaid:
	
	• Appoint a Medicaid Dental Director with educational and professional experience in public health, business management, health marketing, private dental practice, program development and strategic management
	• Assign the Dental Director critical performance objectives including:
	
	  • Assure access to care in NH Medicaid eligible children
	  • Improve utilization of preventive and comprehensive dental treatment and improve oral health status for NH Medicaid eligible children
	  • Recruit sufficient capacity to sustain access to preventive and comprehensive dental treatment for Medicaid eligible children
	
	• Promote effective prevention of oral disease by adopting and promoting American Academy of Pediatric Dentists (AAPD) periodicity, including regular examinations before age one year
	• Integrate oral health services in primary care through MCO contracts' requirement for PCPs providing oral screening, anticipatory guidance, fluoride varnish where appropriate, and referral to a dentist as part of well child visits every 6 months for children between 6 and 36 months
	• Enroll school and community prevention programs as Medicaid providers in order to

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	sustain delivery of preventive treatment in public health settings • Require examination, sealant placement and treatment of any existing disease, evaluation of ability to maintain oral health prior to orthodontic treatment • Build partnerships to leverage resources and promote broad based community support for activities to improve oral health • Increase access to preventive and treatment services through education, by increasing capacity of the dentist and non-dentist provider network, by providing support to Medicaid clients to reduce barriers • DHHS will develop a single, simple portal from which clients are able to obtain all Medicaid services, from enrollment through assistance in getting dental care • Remove age limits for fluoride application and other preventive services • Continue annual review of rates to find budget- neutral or otherwise sustainable means to reimburse procedures deemed most important to improving oral health • Dental health service delivery is different from other health services in ways that must be recognized in developing administrative systems and policies in order to support dentists' participation and support revenue generation for the safety net
Strategic Intent #2: Outreach and support of Medicaid clients to increase value of oral health and drive utilization of behaviors and services to improve oral health	Support of all Medicaid clients is delivered through a robust Medicaid Client Services Unit (MCSU), with staff specially trained in solving problems related to oral health, from promoting care according to NH providing information about providers who can meet those needs, whether for children with ordinary or special health care needs or those needing emergency dental treatment. MCSU promotes access to care by asking each caller, even those calling about non-dental services, if their children have had dental visits, stressing the importance of routine dental check-ups, preventive and treatment services, and offering to help find a dentist if the children do not already have a dental home. A database populated with information about each enrolled dentist or clinic, updated continually by responses to quarterly surveys of enrolled providers and information provided by dentists by email, is used to provide accurate and appropriate information to each client about dentists who report capability to address the specific needs of

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	the child and able to appoint new patients. MCSU arranges transportation, language support, information about recommended periodicities, and communicates with the Dental Director in cases that require unusual support in order to access routine or emergency treatment. Information about dentists always includes a brief description of the importance of appointment keeping once a dental appointment is made. Outreach to newly enrolled Medicaid clients includes • Written summary of Medicaid dental benefits and periodicity, with number of MCSU if assistance is needed • Brochure written at low reading level in English and Spanish, promoting oral health and providing tips for improving oral health of children and encouraging routine dental visits and preventive strategies • Telephone call to review information about oral health, preventive visits and measures, and need for routine dental check ups Outreach to all Medicaid clients includes • Reminder letter every 6 months of the importance of oral health and need for every child to have a dental check up every 6 months, behaviors that promote oral health and need for sealants and fluoride • Annually, a letter to any parent whose child has not had a paid Medicaid claim for a dental check up in the previous six months with encouragement to call MCSU for help finding a dentist or transportation to dental appointments • Posters and brochures (in Spanish and English) are displayed in Medicaid District Offices to promote oral health, behaviors that promote oral health, and the necessity for regular dental care beginning before the first birthday. The posters and brochures include the telephone number of MCSU. Outreach to clients whose children are reported by dentists as having missed appointments

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	• MCSU staff or, in any case in which the needed dental treatment represents a threat to the child's wellbeing, the Medicaid Dental Director will contact the parent and determine and arrange for any support services required to ensure access to care
Strategic Intent #3: Develop and leverage effective partnerships to increase access to oral health, especially in underserved areas and populations	Intra-agency partnerships that leverage resources and increase access to preventive services and other dental treatment for Children in Medicaid include: Medicaid and the Division of Public Health Services • The Oral Health Program (OHP), in the Bureau of Rural Health, within Maternal and Child Health, works closely with Medicaid to ensure that funding opportunities will be sought and leveraged to improve oral health of populations that include many Medicaid eligible children. Important OHP activities that serve to increase access to sealants and other preventive and dental treatments include: • With support from Medicaid, OHP secured a HRSA grant to support TA from Safety Net Solutions to develop business & operational plans that will sustain 3 new dental centers in rural NH, serve as training sites integrated with teledentistry for dental students from the Univ. of New England College of Dental Medicine, and convene 3 educational sessions for safety net dental providers • On May 10, 2013 the OHP will sponsor the 9th Annual Calibration Clinic for PH Hygienists to train to conduct ASTDD Basic Screening Surveys for the fourth *Healthy Smiles Healthy Growth* Third Grade Survey and the second BSS for Older Adults in NH senior centers; Medicaid relies heavily on the surveillance functions of the SOHP in shaping oral health policy and program development • Over more than 10 years the OHP has used the NH Dental Society (NHDS) as a

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	fiscal agent to support projects for expansion of school-based sealant programs, WIC, Seniors, and Bhutanese refugees.. NHDS administrative support has provided opportunities for the OHP and Medicaid to educate members about high-risk and underserved populations • Education/outreach to pediatricians, family practitioners and state: OHP developed and provided five years of courses for pediatricians and family physicians to adopt oral health risk assessment, screening, fluoride varnish application and referrals to dentists for treatment. Drs. Amos Deinard and Hugh Silk have made many presentations to NH physicians, dental professionals and oral health stakeholders in the last five years. • Coordination with Maternal and Child Health (MCH) Title V programs (Title V is the Federal/State program focused on assuring the health of all mothers and children, and Children with Special Health Care Needs (CSHCN) The OHP annually reports performance measures on MCH populations to the Title V Block Grant on rates of dental sealant application, untreated decay and on population-based community water fluoridation. The OHP has been instrumental in directing federal funds for oral health services to agencies that provide primary care services for MCH populations. In 2011 the OHP facilitated the implementation in WIC sites statewide of knee to knee oral health screenings, fluoride varnish application, and referrals for restorative care for families seeking WIC recertification and nutritional counseling. The key element of each WIC dental visit is parent education on the importance of children's oral health to total health, the first dental visit by age 1, the impact of nutrition on oral health, and goal setting for parents to improve their child's oral health. NH OHP has supported similar activities in Head Start programs statewide since 2004. • Undertaking administrative simplifications in collaboration with Medicaid- The SOHP is collaborating with the Medicaid Dental Director, the State Office of Head Start and the WIC Director, and a local foundation to engage, train and enroll Community Action Programs (CAP) agencies as Medicaid dental providers.

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	The goal is to provide financial support for preventive oral health services delivered by hygienists to children enrolled in WIC and Head Start who receive services through four CAP agencies statewide • Coordination with Federally Qualified Health Centers:With HRSA funding the OHP will purchase equipment for 10 new dental units in 2 rural FQHCs. The OHP currently provides support to two FQHCs with on-site dental centers with associated school-based preventive programs • Expanding available providers of preventive oral health services for Medicaid eligible children: The Medicaid Dental Director and the OHP Manager supported and provided technical assistance to the NH Board of Dental Examiners and the state's Legislature in changes to permit public health supervision of dental hygienists, application of sealants without a dentist's examination, and creation of the new provider, the Public Health Dental Hygienist • Medicaid and the Division of Children, Youth and Families (DCYF) • Collaborate to ensure that policies in each area will support children in foster and adoptive care in obtaining dental preventive and treatment services • Work together to ensure that support services available through DCYF can be employed to ensure access to comprehensive oral health services including preventive dental care, to prevent abuse and address neglect of oral disease External/community partnerships that leverage resources and increase access to preventive services and other dental treatment for Children in Medicaid include: • Medicaid and the New Hampshire Dental Society (NHDS): • This partnership has grown steadily over a decade and provides the following benefits:

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	• NHDS resources are used for communications between NH Medicaid and NHDS member dentists; this includes announcements made via NHDS email and website, articles written by the Medicaid Dental Director for the NHDS newsletter, NHDS convening stakeholder meetings under their auspices and at their meeting facility, facilitating Medicaid presentations to local dental societies for provider recruitment and to deepen cultural affinity between NH Medicaid and dentists' sense of the profession's social contract; identifying and facilitating use of opportunities for Medicaid to capture dentists' allegiance to serving their communities through Medicaid programs such as the Statewide Sealant Program; NHDS leadership and members have shown themselves invaluable counsel in such matters as rate setting, policy change and building acceptance among dentists statewide for Medicaid initiatives in increasing access to sealants and other preventive services for all children enrolled in Medicaid and for programs to increase dental visits for children between 0-3 yrs • The NHDS Trustees and Executive Board created and sustain a standing "Committee on Access", one of only five standing committees, to inform and support policies to address access to care, especially to promote a cultural norm of Medicaid participation by member dentists, active participation in policy and programs to increase access to sealants, preventive and other dental services, to find ways to lower barriers to oral health through Medicaid and other for other underserved people • NHDS, with the Medicaid Dental Director as advisor and having hired a public health dentist as project director, is launching a one year project with the following activities to improve Medicaid eligibles' access to preventive and other dental services

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	• Recruit 25 dentists as active Medicaid providers • Meet at least twice with all school/public health programs and involve more dentists in at least two programs each, and establish protocols for future involvement with school based programs • Establish formal links between physicians and dentists to increase access to preventive oral health services for the 0-3 year old populations in at least two areas of the state • Medicaid and the NH Academy of Pediatric Dentistry Medicaid works closely with the Academy to assure that Medicaid policies assure 100% active participation by NH's pediatric dentists. 25 NH Pediatric dentists provider approximately 40% of the access to comprehensive dental care for NH Medicaid children, and are especially important to ensuring ongoing dental homes not only for very young children, but also for those with extensive disease and/or special health care needs. The Academy provides technical assistance in rate setting, provider communications, and leadership in policy development that is aligned with AAPD recommendations and responsive to the needs of pediatric dental patients. Pediatric dentists also provide leadership to the dental community at large in support of active Medicaid participation and participation by dentists in local preventive and dental home initiatives • Bi-State Primary Care Association, partnership projects as described by Bi-State's Recruitment Project Manager Bi-State Primary Care Association administers the Recruitment Center and works in partnership with New Hampshire Medicaid to increase the number of dentists offering services to uninsured, underinsured, and Medicaid-eligible state residents in designated underserved areas of New Hampshire. Bi-State has successfully operated the Recruitment Center since 1994 and has been working on dentist workforce development and recruitment efforts over the last 8 years.

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	To date the Recruitment Center has had exposure through its national marketing and outreach to hundreds of dentists. Seventy-three dentists have been recruited to NH as a result of communications and guidance from the Bi State Recruitment Center. Presentations to dental schools/residency programs have been the number one source of identifying those who were placed in New Hampshire. Advertisements in JADA/ADA ranked as the second most effective source. The success of the Recruitment Center in attracting and recruiting dentists to the state has been the result of collaboration between key stakeholders such as the NH Dental Society and its member dentists in private practice, NH Medicaid, representatives from safety net dental practices as well as representatives from dental schools and residency programs in the region. The Recruitment Center serves as the lead organization in maintaining a coordinated system for recruitment of dentists for the state especially focused on recruitment to areas of need such as designated underserved areas, the public health sector and rural areas. In addition to promoting the opportunities to practice dentistry in New Hampshire through national marketing and outreach, the Recruitment Center maintains relationships with four dental schools (Tufts, Boston University, University of CT and the new University of New England) and three residency programs (Brigham & Women's Hospital/MA General Hospital Harvard General Practice Residency and Lutheran Medical Center's AEGD) as well as stakeholders including the NH Dental Society and a unique group of 25 NH dentists who serve as "ambassadors" who assist Bi-State with its outreach and recruitment efforts. The Recruitment Center has recently started outreach to pre-dental students who are in college in New Hampshire. Since 2011 the Recruitment Center has met 43 pre-dental students in New Hampshire. Twenty-four of those expressed interest in practicing in New Hampshire after they

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	complete dental school. Twelve of these pre-dental students were interested in meeting NH dentist ambassadors to gain a better understanding of what it is like to practice in NH. How the BiState Recruitment Center Expands Capacity for Access The collaboration among partners has already resulted in opportunities to bring new resources to New Hampshire to increase access to dental care for the underserved. Bi-State worked with the NH DHHS to develop and submit a grant to HRSA for the *"Building Oral Health Capacity in Rural New Hampshire"* project. The goals of this project are: 1. Build capacity within Federally Qualified Health Centers and school based prevention programs to increase the availability and utilization of preventive and restorative care for children and adults on Medicaid and Medicare and low income uninsured children and adults who reside in DHPSAs. 2. Expand capacity of the Molar Express and Health First Family Care Center to provide dental screening, preventive services and oral health education to children and families through an early intervention or school-based sealant program that links them to restorative services and assists in the identification of a dental home. 3. Establish a relationship with the University of New England's College of Dental Medicine to create training opportunities for dental students to develop the experience and expertise needed to treat NH's rural and underserved populations. Establishing dental services in Federally Qualified Health Centers in New Hampshire's North Country brings an important resource to the underserved at a time when we know that more than 50% of the dentist population in the region is planning to retire within 5-10 years. The

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	FQHCs will offer a prevention based model of care where oral health is integrated with primary care. Over time, the FQHCs may prove to be the key to attracting dentists and maintaining dental services in the region. The FQHC model may be of interest to younger dentists who are not ready to set-up on their own. After working with the FQHC for a time some dentists may choose to move into private practice and may be more likely to stay in the region because they have settled and lived there while working at the FQHC. The Recruitment Center systems will support this work. Bi-State also has a grant from the DentaQuest Foundation to work on the goals of: 1. Promoting inter-professional activities among dental and medical programs in Community Health Centers. (Key strategy is using Smiles for Life Curriculum) 2. Elevating the importance of oral health within Bi-State and develop executive leadership at Community Health Centers to promote optimal oral health. 3. Advancing Safety net oral health needs at the state level (key activity is working with stakeholders to promote and support the addition of a dental benefit for pregnant women on Medicaid) 4. Working with Safety Net Solutions to optimize the management of dental programs to provide sustainable and effective oral health care. • Examples of other important external partnerships: • NH Oral Health Coalition: NH Medicaid was one of many stakeholders providing input into the 2003 State NH Oral Health Plan, which continues to drive broad based community support for development of policies and initiatives consistent with NH

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Strategic Intent	Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.
	Medicaid's strategic intent to increase access to sealants, preventive and comprehensive dental care for children • Endowment for Health: A major source of inspiration, wisdom and funding for research and development, pilot programs, and evaluation of oral health programs, including the development of the NH State Oral Health Plan.
Strategic Intent #4: Reduce administrative burden and other barriers to provider participation	Many administrative systems for enrollment, claims submission and payment are designed for large volume providers, and not well suited for business operations in small offices such as private dental practices and small public health programs. Administrative complexity is usually listed second to low rates as a barrier to provider participation in Medicaid. Reducing administrative burden has been essential to the success of NH Medicaid in increasing access to care through participation by dentists and our larger community programs; nonetheless, NH Medicaid needs to continue to reduce administrative burden for these stakeholders and also for school based sealant and other programs that have traditionally sustained operations by grants and are not accustomed or equipped to send claims to Medicaid. To achieve the CMS oral health goals, NH Medicaid needs to maintain the commitment of private dentists to serve Medicaid children and drive increased productivity in public health and community programs as well as capture data by assuring that the programs enroll as Medicaid providers and actually submit claims for all Medicaid eligible children's services. • Important activities by NH Medicaid that have been implemented to reduce administrative burden on dentists and other oral health providers • Simplified the provider application and eliminated requirement to submit certain forms/information • Incorporated warm and appreciative language in routine informing materials and communications with dental offices • The Medicaid Dental Director directly recruits dentists, assists their staffs in

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Strategic Intent	Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.
	enrolling and learning how to file claims, and personally resolves dentists' administrative problems • NH Medicaid's fiscal agent developed a "Dental Boutique", a distinct workgroup to provide personalized customer service to dental providers ▪ Provide assistance with completing enrollment forms and claims ▪ Expedite enrollment ▪ Follow the directive "Make any dental claim work"; Eliminate requirements that all forms must be OCR-ready and on a specific ADA form; accept claims on any rational form; review paper claims manually and work directly with providers to correct claims as received rather than returning or rejecting claims; ▪ Implement a weekly billing cycle to speed payments ▪ Produce an online NH Medicaid Dental Provider Manual, a user friendly guide to Medicaid policy, goals, rules, and processes for submitting prior authorizations ▪ Ensure that the Dental Director's contact information is readily available so that providers have a specific person to go to for resolution of problems • Moving forward • NH Medicaid rolls out its new MMIS system on April 1, 2013 with a new fiscal agent, Xerox • System development includes enhanced electronic interface to reduce administrative burden including streamlined processes for ▪ Enrollment ▪ Prior authorizations ▪ Confirming patient eligibility

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Strategic Intent	Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.
	▪ Claims submission ▪ Reviewing claims payments
Strategic Intent #5: Build safety net capacity and sustainability	Many of the activities above, including the Bi-State Primary Care Recruitment project and the expansion of school based and school linked sealant and dental centers, directly strengthen the safety net. In addition, expanding preventive services in medical settings and expanding capacity in private dental practice, increasing evidence based preventive service delivery by public health hygienists combine to reduce the stress and expand the capacity of the safety net. The "Safety Net" in NH includes 5 FQHCs, two with dental clinics within the health centers, several with school based and school linked preventive programs, a mobile dental facility, "The Molar Express" in the North Country, several hospital-based dental services, and several community and privately funded dental clinics dedicated to serving the underserved. In some communities, dentists in private practice serve the essential function of "safety net provider". NH Medicaid strategy to build safety net capacity and sustainability includes the following initiatives: • Provide funding and collaboration with Bi-State Primary care, as described above, to recruit dentists to provide stable workforce for safety net dental delivery systems • Support financial sustainability of safety net providers by using a fee for service reimbursement system for preventive and other dental services • Collaborate with NH DPHS and others to seek funding opportunities, grants, and technical assistance to support the sustainability of the safety net • Provide outreach, technical assistance in program and policy development to ensure safety net programs' scope of services align with Medicaid goals and reimbursement structure, that they can maximize Medicaid enrollment of eligible patients, and that claims are submitted for all billable services provided to Medicaid eligible patients

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Strategic Intent	Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.
	• Provide technical assistance in financial strategies for safety net dental operations through contracts with organizations such as Safety Net Solutions • With HRSA funding the OHP will purchase equipment for 10 new dental units in 2 rural FQHCs. The OHP currently provides support to two FQHCs with on-site dental centers with associated school-based preventive programs

Other Oral Health Improvement Initiatives	Comment
Has your State undertaken any initiatives within the last 5 years to increase the number of children who receive oral health or dental services? If so, please describe those activities.	In 2003 NH Medicaid developed and began implementing the above described strategic initiatives to improve access to dental care and utilization of preventive and comprehensive dental services.
What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe.	The success of these strategic initiatives can be summarized by the following comparisons, based on CMS 416 reports from FFY 2003 and FFY 2011: 12 a) Percent of children 1-20 with any dental service 2003 = 26% 2011 = 60% 12 b) Percent of children 1-20 with a preventive dental service 2003 = 20% 2011 = 56% 12 c) Percent of children 1-20 receiving dental treatment services 2003 = 11% 2011 = 26% 12 d) Percent of children 6-9 with sealants was not reported in 2003; 11% in 2011. It is noteworthy that more than doubling access to care and utilization of dental services was accomplished by an increase in the number of enrolled providers by only 24%. NH Medicaid has demonstrated ability to capture capacity to increase access to care by increasing the willingness of existing providers to treat children eligible for Medicaid as well as through recruitment of new

Other Oral Health Improvement Initiatives	Comment
	dental providers. In that same period, the number of enrolled dental providers treating more than 100 Medicaid patients more than doubled, and the average number of Medicaid children treated by each of the dentists among the most productive ten-percent of dentists rose from an average of 380 children per dental provider to 1020 children per dental provider. None of the dental services above was provided by non-dental professionals.
	If the activities did not achieve the results that you had expected, please describe the lessons learned. The results approximate the predictions of the original modeling for the project as designed in 2003. NH Medicaid experience has demonstrated. For example: • Marginal costs rise faster than access and can approach a point of diminishing returns • Rates of expenditure for dental treatment services do not decrease with increased utilization of preventive services including prophylaxis, sealants and fluoride application. The NH experience in increasing access to dental care in Medicaid also seems to indicate that some within the population will be able to access dental care if there are more willing providers, or if there is delivery of information about those providers or transportation. Nonetheless, increasing access to care beyond those groups may require different or more precisely targeted approaches in addition to raising rates, reducing administrative burden, providing transportation and other client support and strengthening the safety net. Sustaining increases in access will likely require new strategies such as: • Targeted outreach and education to drive demand for routine and preventive dental services in those not currently utilizing preventive and treatment oral health services • Targeted case management and support services to increase appointment keeping • Education of providers to shift performance from less effective preventive treatment such as prophylaxis to more effective interventions such as sealant and fluoride use • Increase integration of oral health and other health services to provide appropriate oral

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Other Oral Health Improvement Initiatives	Comment
	health services and to promote self-care and professional care seeking consistent with attaining oral health • Affecting individuals' and communities' value of oral health in order to support health behavior change beyond individual care seeking

Dental Data Measurement
Does your State compute or report the National Committee for Quality Assurance's (NCQA) HEDIS dental measure or a modification of it? (Dental care: percentage of members 2 through 21 years of age who had at least one dental visit during the measurement year." Web site: http://www.qualitymeasures.ahrq.gov/browse/by-topic.aspx) If yes, describe how that data compares with the data submitted on line 12.a of the CMS-416 and/or Section III, G.1.a. of the CHIP Annual Report (Total Enrollees Receiving Any Dental Services). Yes, NH Medicaid has calculated the HEDIS measure, most recently in 2011 based on 2010 data. Using HEDIS definitions 69.2% of children 2-21 years received an annual dental visit. By comparison, using calculations based on the FFY 2010 CMS416 report, 57.6% of children 1-20 years had any dental treatment. Using the HEDIS definitions, 66.6% of the 15 to 18 year olds had at least one dental visit as compared to 60.0% using the CMS416 definition.
If the HEDIS measure result differs from the result reported on CMS-416, line 12.a, or the CHIP Annual Report, Section III, G.1.a., please explain why you think there is a difference. As expected, differences in data were noted between the CY 2010 HEDIS and FFY2010 CMS-416 report with regard to line 12.a. The only age group that is identical for HEDIS and CMS 416 is the 15 to 18 year old group. For that age group, 7,677 beneficiaries had at least one dental visit in the HEDIS measure, compared to 9,486 in the CMS416 measure. (Differences between HEDIS and CMS measures for other ages are comparable.) The reason for the difference is that for the eligible population HEDIS uses 12 months of continuous enrollment with a one-month gap as opposed to the 90 days of continuous eligibility on the CMS416. In New Hampshire, many more beneficiaries are eligible continuously for 90 days than for 12 months with a one month gap. This resulted in a denominator of 11,526 for the HEDIS measure of 15 to 18 year olds, as compared to 15,790 using the CMS 416 definition of continuous enrollment. Using the HEDIS definition, 66.6% of the 15 to 18 year olds had at least one dental visit as compared to 60.0% using the CMS416 definition. The use of HEDIS definitions also decreases the impact of error attributable to inclusion of those with retroactive eligibility and increases the percentage of children with at least one dental visit by excluding those under age 2, a group that generally has lower rates of dental service utilization and is included in the CMS416 definitions.
If you use a modification of the HEDIS measure, please describe the modification.

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Dental Data Measurement
NH Medicaid did not use a modification of the HEDIS definition.

Reimbursement Strategies: What are your current reimbursement rates for the following 10 procedures for services provided to children eligible for Medicaid and CHIP? Please describe any increases or decreases in these reimbursement rates that have occurred in the last five years.
In 2003 and 2004, NH Medicaid raised rates for 48 codes. Each procedure was analyzed individually, relative to its role in our strategic intent to drive increased access to comprehensive oral health care, improved oral health outcomes, fiscal sustainability, and its potential for abuse. The percentage of increase ranged from 10% to 20% for the 12 procedures that had been adjusted fairly recently, to more than 250% for codes that had not been adjusted in many years. The specific rate increases per code were guided by utilization and payment data from North East Delta Dental, with certain constraints, and in extensive consultation with the provider community. Following the extensive rate adjustment of 48 codes, NH Medicaid has adjusted certain codes as needed to ensure that children will have access to comprehensive care. These subsequent rate adjustments were in 2007, 2009, 2010 and 2011, and affected payments for root canal therapy, crowns, orthodontic treatment and general anesthesia. Rates and utilization are reviewed annually, and consultations with dentists and other stakeholders are important in assessing the impact of rates on capacity to provide access to dental treatment for NH Medicaid eligible children.

CODES	Current Reimbursement Rates	Current Fees	Plans to Adjust
D0120	Periodic Oral Exam	$30.50	Review annually
D0140	Limited Oral Evaluation, problem focused	$45.00	Review annually
D0150	Comprehensive Oral Exam	$57.00	Review annually
D0210	Complete X-rays with Bitewings	$58.00	Review annually

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CODES	Current Reimbursement Rates	Current Fees	Plans to Adjust
D0272	Bitewing X-rays – 2 films	$26.00	Review annually
D0330	Panoramic X-ray film	$37.50	Review annually
D1120	Prophylaxis (cleaning)	$38.00	Review annually
D1203	Topical Fluoride (excluding cleaning)	$18.00	Review annually
D1206	Topical Fluoride Varnish	$18.00	Review annually
D1351	Dental Sealant	$33.50	Review annually

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Efforts Related to Dental Sealants

Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
Do you encourage or plan to encourage dental providers in your State to provide dental sealants?	Yes _X_ No ____
If yes, how do you communicate that information to providers?	Comment: Through policies such as requiring sealants before orthodontia is approved; through our provider manual, in emails and communications posted on the NHDS website and newsletter, through announcing our policies on paying both dentists and school programs for children whose sealants might unknowingly be duplicated in both settings.
Have you seen an increase in the number of children receiving sealants over the last year or years? If yes, please explain.	Yes _X_ No ____ Comment: According to ad hoc Dental Performance Reports of NH Medicaid Dental Services there were 2304 unduplicated children with paid claims for sealants in SFY2003, 5615 in SFY2007, and 8661 in 2011.
Does your state support school-based or school-linked dental sealant programs?	Yes _X_ About half the funding of school based and school linked programs comes from state funds. In addition, school based and school linked programs, as well as community programs and foundations may enroll as Medicaid dental providers and be reimbursed for sealants
If yes, how many Medicaid or CHIP enrolled children were served by these programs in the past year? Are you continuing to see increases in the number of children served by these programs? YES	An estimated 1000 children received sealants in school based or school linked programs. Number of programs and utilization apparently increasing. Comment: This number is estimated and is likely an understatement of the total number of children receiving sealants. Many sealant programs, especially those with private or foundation funding, are not enrolled as Medicaid providers or do not submit claims. Many schools will not provide Medicaid enrollment information to sealant coordinators, and parents have

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Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
	not been responsive to requests for information. NH Medicaid will research eligibility if asked, but we receive few requests from the school programs for this information. Being an enrolled Medicaid provider is now a requirement for all sealant programs; nonetheless, reports of utilization are greater than claims data indicate.
How many sealants were placed in these programs in the past year?	#728 2nd & 3rd grade students had sealants applied in school-year 2011-2012. 2nd & 3rd grade is the cohort that programs report national performance indicators, and are not required to report performance for other grade levels.
Has funding from the Centers for Disease Control and Prevention (for oral health infrastructure development) contributed to these efforts? Please describe.	Yes _X_ No ____ Comment: NH does not have a cooperative agreement with CDC, but we receive CDC funds through the Preventive HHS Block Grant that support 50% of funding for the school-based DPHS funded programs (11 out of a total of 16 school-based programs). NH SB programs benefit from several tools developed by the ASTDD including the ASTDD Basic Screening Survey as the basis for annual reporting and for the 3 (soon to be 4) BSS Third Grade Surveys that we have done in NH. We use training materials developed by ASTDD for sealant programs, and we use the School-Based Sealant manual as a key reference in planning and evaluation. Our school-based RDHs attend webinars sponsored by ASTDD. NH OHP follows guidelines developed by the ASTDD, have applied the SOHP Competencies to evaluate our program and frequently look to the ASTDD Best Practices. All these benefits represent indirect but important benefits of CDC funding.

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Collaboration with Dental Schools or Dental Hygiene Schools
Do you have a dental school or dental hygiene program in your State? If yes, do you have any arrangement with the dental school or dental hygiene program to treat Medicaid beneficiaries, serve in rural areas, provide educational opportunities, etc.? Please describe. (Described below.) There is no dental school in NH; we have forged relationships with dental schools in Boston (70 miles) and Connecticut (150 miles). The state's dental hygiene program is located at New Hampshire Technical Institute, in Concord, NH. NH Medicaid and NH Oral Health Program (NH OHP), closely aligned and collaborative, leverage respective Medicaid and Public Health missions, requirements, funding, and infrastructure to achieve the goals of each program. Together, NH Medicaid and the NH OHP have worked with the dental hygiene program at New Hampshire Technical Institute to promote development of the public health hygienist to increase delivery of preventive professional services to Medicaid eligible children, especially in school based and school linked settings. NH Medicaid and NH OHP have also been among collaborators including the NH Oral Health Coalition, North East Delta Dental, the NH Dental Society, and the Endowment for Health, to increase the pipeline of public health dentists through development of a new dental school at the University of New England, in Biddeford, ME. Following the AT Still Arizona Dental School, the UNE Dental School will prepare dental professionals for the special demands of our population. NH Medicaid and the Department of Public Health Services have jointly funded a provider recruitment grant to BiState Primary Care Association, in order to recruit and support dentists, especially in the North Country and other DHPSAs. This recruitment project relies in part on arrangements with dental schools at Tufts, Boston University, Harvard (Pediatric Dental Residency Program), and the University of Connecticut.

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Plans to Expand Dental School or Dental Hygiene Program Collaboration
Describe any plans to initiate or expand collaboration with dental school or dental hygiene program? In 2010 The Allied Dental Education Department at NHTI, Concord's Community College, in collaboration with the N.H. Division of Public Health Services Oral Health Program announced a continuing education certificate for dental professionals working in dental public health settings. Completion of prescribed courses ensures that hygienists seeking collaborative agreements with supervising dentists have the latest information vital to their programs. Core courses include Sealant Considerations in Public Health Settings, Evidence-Based Dentistry for Dental Professionals, Infection Control for Alternative Dental Settings, Management of Medical/Dental Records, Medical Emergency Management for the Dental Professional, and Evaluations of Clinical Techniques. Available elective courses are: Managing the Special Needs Patient, and Working with Residents in Long-Term Care Facilities. The curriculum was developed in collaboration with NH DHHS. The Collaborative Practice initiative aligns with the NHTI Mission: "Providing educational and training experiences to dental professionals working in public health settings and school-based programs in the delivery of oral health services by emphasizing: Adherence to the American Dental Hygienists Code of Ethics and the State of New Hampshire Dental Practice Act; use of critical thinking skills and effective problem solving; the value of respectful communication; and ongoing professional development." Certificate courses will provide standardized protocols and quality assurance for public health dental hygienists who deliver preventive services in WIC and Head Start programs; school-based dental sealants and links to restorative care; and oral screenings, education and links to treatment for older adults in senior centers. Funds from DHHS' successful application to HRSA to build oral health capacity in rural NH will purchase equipment for 2 dental operatories in the new University of New England (UNE) School of Dental Medicine scheduled to open in Portland, Maine in Sept 2013. HRSA grant funds will be also be used to purchase equipment for 2 new dental centers to be built in rural FQHCs in Littleton and Bristol, NH. The new rural dental centers, outfitted with state of the art teledentistry equipment linking them to UNE, will serve as training sites for dental students. A desired long-term outcome of our close collaboration with the new dental school will be the recruitment of dental graduates with the experience and expertise to meet the oral health needs of rural and underserved populations in NH.

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Electronic Dental Records
Describe the use of electronic dental records by providers in your State for the Medicaid and CHIP populations. Estimate the percentage of dental providers using electronic dental records. Is the dental record integrated with the medical record? How is the State supporting dental provider efforts to qualify for meaningful use incentive payments? EDR is limited to those in hospital based and FQHC-based practices, in which the electronic records are integrated with the institutions' medical records. By report, the constraining factor for NH dentists in private practice appears to be lack of understanding of any meaningful use beyond the first year for practices outside institutional settings. Many of the hospital and FQHC formats have been customized by end users for the needs of their own physician networks. Non-institutional dental practices do not seem to be aligned with any single institution to warrant adapting their records to share information. In addition, it appears that institutions are not willing, or are perhaps unable, to open or support their records in order to provide access to dental practices outside their own provider networks.

Technical Assistance
Indicate areas of interest or topics about which you would be interested in receiving technical assistance. • Ways to determine factors that constrain demand for preventive and dental treatment services and means to increase the demand • Methods used to identify specific external barriers to accessing dental services for those who are without claims for preventive services and/or dental treatment • Achieving economic efficiency by providing effective outreach and support to the hard to reach, and prevent waste by avoiding over-serving the already-served • Successful approaches to reducing administrative burden to providers • How to identify and change state and federal policies that constrain growth in delivery of preventive and dental treatment services • Explore models of success in moving from various points along the access curve, with emphasis on understanding the challenges that characterize various levels of access • Ways to encourage/enable school based and other programs to submit claims for dental services to improve data collection

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Other Materials or Links to Relevant Websites
If you would like to submit copies of materials or provide links to relevant websites for additional information, please do so as attachments to this template.