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Dental Services for Persons With Disabilities in Pennsylvania

Conducted Pursuant to
Senate Resolution 2013-61

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Summary and Recommendations

Senate Resolution 2013-61 calls on the LB&FC to study the need for and availability of dental care for Pennsylvanians with disabilities, both children and adults, and to make recommendations to preserve and improve such services.

We found:

- ***Comprehensive dental services are generally available to children with disabilities.*** Children (under age 21) who are enrolled in Medical Assistance (MA), Pennsylvania's Medicaid program, are automatically enrolled the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which provides comprehensive health care, including dental care. Due to Pennsylvania's PH-95-Children with Special Needs category (known as the "loophole") almost all children with a serious disability qualify for MA. Children enrolled in the CHIP program also receive dental services.
- ***Adults with disabilities are much less likely to qualify for comprehensive dental services.*** While states are required to provide dental care for children covered under Medicaid and CHIP, dental services for adults is optional for states. Pennsylvania does include some dental services as part of its MA program for adults, but the Department of Public Welfare (DPW) significantly scaled back the level of benefits in 2011. For example, dentures are now limited to one per lifetime and procedures such as crowns are only reimbursed on an exception basis. The scaled-back benefits do not apply to persons in nursing facilities or ICF/MRs, but do apply to other MA-eligible Pennsylvanians with disabilities.
- ***The federal Affordable Care Act requires insurers to offer a dental plan, but does not require consumers to purchase it.*** This should allow broader coverage for persons with disabilities who can afford to purchase a dental plan.
- ***Thirty of Pennsylvania's 67 counties had no dentists in the MA fee-for-service plan that indicated they were willing or able to accept a special needs patient.*** Dentists who are enrolled in a state Medicaid plan indicate on the federal InsureKidsNow website whether they can accommodate special needs patients and if they are accepting new Medicaid patients. Of the 1,819 Pennsylvania dentists enrolled as an MA fee-for-service provider, only 148 (8 percent) indicated they could accommodate special needs patients. Of those 148, 107 (72 percent) indicated they were accepting new patients.

- ***Pennsylvania has many clinics that provide free or low-cost dental services to persons with disabilities.*** Pennsylvania has over 200 Federally Qualified Health Care Centers across the state, 84 of which reported offering dental services. The Pennsylvania Dental Association participates in the Donated Dental Services program that recruits dentists to provide services to the disabled and certain other vulnerable patients. Pennsylvania's three dental schools, two of which are in Philadelphia and one in Pittsburgh, operate clinics that provide services to persons with disabilities, as does the Elwyn Institute. Special Smiles Ltd. is an innovative program that provides comprehensive dental services to persons with disabilities enrolled in several Medicaid Managed Care Organizations (MCOs) in the Philadelphia region.
- ***Pennsylvania's dentists report that providing dental services to persons with disabilities is a multi-faceted problem.*** We surveyed all 8,100 Pennsylvania dentists with an active license through an internet questionnaire and received 684 responses. The responding dentists cited several factors that adversely affect the dental care received by persons with disabilities. The top factors were: low MA reimbursement rates, difficult behavioral issues, and high levels of no-show appointments. Many also cited that the MA program does not cover needed services, burdensome MA rules that discourage provider participation, and lack of training and/or specialized equipment.
- ***About 70 percent of dentists responding to our questionnaire indicated that they would be willing to treat special needs patients.*** A number of dentists commented, however, that it would depend on the level of disability. This contrasts markedly, however, with the information reported on the InsureKidsNow website, in which only 8 percent of Medicaid fee-for-service dentists indicated they could accommodate special needs patients.

Recommendations

We recommend:

- ***The Department of Public Welfare revert to pre-2011 Medicaid dental regulations with regard to the type and frequency of services allowed for adults with disabilities.*** Persons with disabilities have both physical and emotional conditions that would justify them being exempted from the September 2011 restrictions placed on dental services for adults with Medical Assistance. Persons with Down syndrome, for example, are at an increased risk for gum disease and bruxism (teeth grinding), both of which can cause damage to the teeth. Persons with disabilities are also more likely to require behavioral management interventions or require general anesthesia. In these cases, DPW should consider waiving pre-authorization requirements for services (e.g., perio-charting and x-rays prior to

crowns) that could require multiple trips to a dentist office. This would facilitate the ability to combine these procedures into one visit.

- ***Allow dentists to receive Medicaid reimbursement for key preventative services at a greater frequency than for the general Medicaid population.*** Given the inherent differences between the special needs population and the general Medicaid population, consideration should also be given to expanding some services beyond the pre-2011 limits. Examples include allowing cleanings four times a year rather than two, allowing fluoride treatments regardless of age, allowing sealant treatments more than once in a lifetime and for patients older than age 16, and reimbursing for root canals and crowns as a way to avoid extractions. The added costs of these preventative measures, in addition to improving the dental health of patients, should reduce expensive reconstructive work.
- ***Increase the amount of the Medicaid Dental Behavioral Management supplement and the number of visits allowed.*** Under Pennsylvania's Medicaid regulations, dentists can submit for the \$128 Dental Behavioral Management supplement up to four times per year per patient. Persons with disabilities tend to have complex dental problems, and may need to see a dentist more than four times per year. Consideration should also be given to increasing the supplement, which was last increased in 2006. Increasing the Dental Behavioral Management fee by \$50 (to \$178) would increase Medicaid costs by about \$1.6 million annually.
- ***DPW build on the Special Smiles, Ltd. model to help establish specialty dental clinics in other areas of the Commonwealth.*** Special Smiles, Ltd., located in Philadelphia, was the result of a collaborative effort between DPW, Medicaid managed care organizations, and private practice dentists. We recommend DPW take the lead to work with Medicaid MCOs in the five other regions of the state to replicate this successful model for providing services to persons with disabilities.
- ***DPW work with its physical health Medicaid Managed Care Organizations to allow reimbursement to dental facilities treating special needs patients who are living in residential facilities outside their Medicaid MCO's geographic boundaries.*** A special needs client whose official place of residence may be, for example, Erie, would be enrolled in a New West Zone (Northwestern PA) Medicaid managed care organization. If that individual was living in a residential facility in, for example, Southeastern Pennsylvania, the New West Zone MCO will not pay for dental services provided in Southeastern Pennsylvania.
- ***The Pennsylvania Developmental Disabilities Council (PDDC) take the lead in meeting with representatives of Pennsylvania's three dental schools to explore the training needs identified by Pennsylvania dentists.*** Many of the dentists responding to our survey indicated they received little training in dental school on techniques for providing services

to persons with disabilities, particularly conscious sedation. We recommend the PDDC undertake this project in conjunction with the dentists and organizations that participated in the 2006 PDDC-funded report entitled *People with Developmental Disabilities and Oral Health in the Commonwealth of Pennsylvania*.

I. Introduction

Senate Resolution 61 (Appendix A) calls on the Legislative Budget and Finance Committee to conduct a study of “the status of and any disparities found in dental care for Pennsylvanians with disabilities.” The study is to be completed by November 30, 2014.

Study Scope and Objectives

The objectives of this study are:

1. To determine the availability of Pennsylvania dentists, county by county, to provide services to people with disabilities, in both community-based and specialized care settings.
2. To determine the percentage of Pennsylvania dentists that have wheelchair accessible offices and specialized equipment for providing dental services to people with disabilities, including deep sedation and conscious sedation.
3. To determine the percentage of Pennsylvania dentists that accept Medicaid payment.
4. To make recommendations to preserve and improve the quality of dental services to people with disabilities.

Methodology

To determine the availability of Pennsylvania dentists to provide services to people with disabilities, we obtained data from the federal Medicaid InsureKidsNow website (insurekidsnow.gov). This website provides information on Pennsylvania dentists, including the type of insurance they accept, whether they can accommodate special needs patients, and whether they are accepting new patients. We also sent questionnaires (via SurveyMonkey) to all 8,100 dentists in Pennsylvania with active licenses to assess the extent to which they provided services to people with disabilities. We received responses from 684 dentists, an 8.5 percent return rate.

To determine the percentage of Pennsylvania dentists that have wheelchair accessible offices and specialized equipment for providing dental services to people with disabilities, we included a question on the dental questionnaire soliciting this information.

To determine the percentage of Pennsylvania dentists that accept Medicaid payment, we reviewed prior information on Pennsylvania dentist participation in Medicaid and included a question on our dental questionnaire asking whether the dentist participated in Medicaid.

To develop recommendations to preserve and improve the quality of dental services to people with disabilities, we considered comments made by Pennsylvania dentists, recommendations made in previous reports, and our own analysis of the data collected during this study.

Acknowledgements

We thank the Pennsylvania Department of State for the assistance they provided in distributing our questionnaire to Pennsylvania dentists and the Department of Public Welfare's Chief Dental Officer for reviewing and commenting on the questionnaire. Valuable assistance was also provided by ACHIEVA, Dr. Alexandre R. Vieira of the Pittsburgh School of Dentistry, Dr. Joan Gluch of the University of Pennsylvania School of Dental Medicine, and representatives from several dental clinics specializing in services to persons with disabilities.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania, 17105.

II. Dental Services for Persons With Disabilities

In March 2009, ACHIEVA, a Pittsburgh-based advocacy organization and provider of services for persons with disabilities, issued a report entitled *Access to Dental Care for People with Disabilities: Challenges and Solutions*.¹ The report noted significant disparities in dental health services for people with disabilities. Among the key findings of that report were:

- 75 percent of Pennsylvania dentists do not accept Medicaid.
- There are approximately 2,000 Pennsylvania dentists available to treat approximately 2 million people on Medicaid. (1,000 patients to 1 dentist)
- Practices that provide intravenous (IV) sedation and other specialized care are difficult to find.
- Dentists cite low reimbursement rates and lack of training as to why they do not treat people with disabilities.
- The dental workforce is aging, with 43 percent of the Pennsylvania dentists being between the ages of 50 and 64.
- 57 percent of pediatric dentists, those who traditionally have treated people with disabilities, are age 50 and older.
- 75 percent of people with disabilities can be treated in a typical dentist office.

The report recommended:

- Pennsylvania maintain its commitment to Medicaid funding for dental services for adults.
- More incentives be provided in the Medicaid rates for dental services provided to people with disabilities.
- Pennsylvania institute a flexible dental loan repayment program, using existing funds, to treat people with disabilities, especially in Pennsylvania's underserved areas.
- Mandate that private insurance companies provide dental insurance payment for anesthesia for children under the age of five and people with disabilities who need it.
- Support workforce initiatives that expand the duties for dental assistants, thereby allowing dentists to provide more services to all patients.

¹ ACHIEVA, together with many others, also participated in developing a 2006 report entitled *People with Developmental Disabilities and Oral Health in the Commonwealth of Pennsylvania*, funded by a grant from the Pennsylvania Developmental Disabilities Council. Recommendations from that report are shown in Appendix B.

- Ensure that fluoride is added to our public drinking water, noting that one CDC study found that in communities with more than 20,000 residents, every \$1 invested in community water fluoridation yields about \$38 in savings each year from fewer cavities treated.²
- The Legislative Budget and Finance Committee study and issue a report on the disparities in dental care for Pennsylvanians with disabilities.

As a follow-up to the ACHIEVA report, in December 2013, the Pennsylvania Senate passed Senate Resolution 61 directing the Legislative Budget and Finance Committee to study the issue of dental services to persons with disabilities.

A. Existing Dental Services for Persons With Disabilities

According to the U.S. Census Bureau, 18.7 percent of the U.S. population has a severe disability, and another 4.1 percent needs at least some assistance with the tasks of daily living. To provide dental services to this population, we found:

Medicaid and CHIP

Several public and private programs exist to provide dental services to children and adults with disabilities, the most significant of which is Pennsylvania's Medical Assistance (Medicaid) program. Of the approximately 2.2 million Pennsylvania residents in the Medicaid program, about 236,000 are under age 65 and living with a disability.

Medicaid dental services are paid for through both the fee-for-service and Medicaid managed care systems. In FY 2013-14, the Department of Public Welfare (DPW) paid 1.55 million claims for dental services incurred through the fee-for-service program, totaling \$83.9 million (\$45.1 million federal, \$38.9 million state).

In Medicaid managed care organizations, all members have a Primary Care Provider (PCP) who provides a Medical Home for the member and manages their medical care. The PCP makes referrals to specialists for care when medically necessary. Members have access to a wide range of specialists, hospitals, dentists, laboratory sites, therapists, home health providers, pharmacies, and other medical providers. The MCOs negotiate payment arrangements with dental subcontractors, which in turn contract directly with dentists. MCOs also negotiate some payment arrangements directly with dentists.

² The Pennsylvania Department of Health and the Pennsylvania Dental Association have offered \$300,000 in grants to localities with fluoride-deficient water systems to assist them in converting to fluoridated water systems.

Medical Assistance (Medicaid) services for children. A child may qualify for Medical Assistance (MA) if he or she has a disability (see definition below) or special health care needs, regardless of parental income. This eligibility is called “PH-95-Children with Special Needs,” informally referred to as the “Loophole Category.”

To be eligible in the “PH-95-Children with Special Needs” category, the child must meet the Social Security Administration’s definition of disabled and have an income of no more than \$903 per month in his/her name.

The Social Security Administration definition of disability for children is:

- Physical or mental condition(s) that very seriously limit the child’s activities.
- The condition(s) must have lasted, or be expected to last, at least 1 year or result in death.

Examples of a child’s income counted towards MA eligibility include Social Security Disability Income (SSDI), interest or dividends on bank accounts, stocks or bonds in the child’s name, and earnings from a child’s job.

If the child’s monthly income exceeds \$903, monthly medical expenses can be used to meet a deductible (referred to as a “spend down”), which will then allow the child to obtain MA coverage for the rest of the month.

Children (under age 21) who are enrolled in Medicaid are automatically enrolled in the EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program which provides comprehensive free preventive health care, including dental care (see Exhibit 1). However, even with this coverage, the Kaiser Commission on Medicaid and the Uninsured found that on average only 40 percent of Medicaid-enrolled children received any dental care in 2010.

Medicaid dental service for adults. While states are required to provide dental benefits to children covered by Medicaid and CHIP, dental benefits for adults is optional. In Pennsylvania, the scope of dental benefits for which adult MA recipients are eligible differ according to recipients’ categories of assistance. MA covers the following:

- Categorically needy individuals³ 21 years of age or older are eligible for medically necessary dental services. Families with children who

³ Aged, blind, or disabled individuals who meet the financial eligibility requirements for TANF, SSI, or an optional state supplement.

Required EPSDT Dental Services

Screening:

Screening services provided at intervals meeting reasonable dental standards, and at such other intervals to determine illness and which shall, at a minimum, include dental services that are provided at intervals meeting reasonable dental standards and at other intervals as medically necessary to determine the existence of illness, and which shall, at a minimum, include relief of pain and infections; restoration of teeth; and maintenance of dental health. Although an oral screening may be a part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct oral referral is required for every child in accordance with a state's periodicity schedule and at other intervals as medically necessary.

General care:

Dental care, at as early an age as necessary, needed for relief of pain, infections, restoration of teeth, and maintenance of dental health.

Emergency services:

Includes: services necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures; palliative therapy for pericoronitis associated with impacted teeth.

Preventive services:

Includes: instruction in self-care oral hygiene procedures; cleanings; sealants when appropriate to prevent pit and fissure caries.

Therapeutic services:

Includes: pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth with silver amalgam, silicate cement, plastic materials and stainless steel crowns; scalings and curettage; maintenance of space for posterior primary teeth lost permanently; and provision of removable prosthesis when masticatory function is impaired or when existing prosthesis is unserviceable; and orthodontic treatment when medically necessary to correct hand-capping malocclusion.

Source: American Dental Association

are eligible for MA and who meet the financial eligibility requirements for TANF, SSI, or an optional State supplement are also defined as categorically needy.

- Dental services are also provided for medically needy only⁴ adults for palliative treatment (i.e., relieving pain or alleviating a problem without dealing with the underlying cause) or if the condition of the patient requires services be provided in a short procedure unit (SPU), ambulatory surgical center (ASC), or inpatient hospital.

⁴ The medically needy program provides states the option to extend Medicaid eligibility to individuals with high medical expenses whose income exceeds the maximum threshold, but who would otherwise be eligible for Medicaid.

The Department of Public Welfare changed the Medical Assistance dental benefits effective September 30, 2011. These changes do not apply to MA recipients who are under age 21 or who reside in nursing facilities or intermediate care facilities (ICF/MR). The changes do, however, apply to other MA-eligible Pennsylvanians with disabilities.

Under these changes, dental exams and cleanings are limited to one per 180 days, with additional exams and cleanings requiring an approved benefit limit exception (BLE). Dentures are limited to one per lifetime. Dental services that are only reimbursed with a BLE include:

- crowns and adjunctive services;
- endodontic services, including root canals; and
- periodontal services.

The MA physical health Managed Care Organizations have the option to impose the same or lesser limits for these benefits. According to the Pennsylvania Health Law Project, almost all Pennsylvania Medicaid managed care plans have adopted the dental benefit reductions.

MAWD. Persons with disabilities who are able to work part-time can purchase Medical Assistance under the MAWD program (Medical Assistance for Workers with Disabilities). Under the MAWD program, individuals can have much higher income limits than allowed for basic Medical Assistance. MAWD plans vary, but may include dental services. A proposal has been made, however, to eliminate the MAWD program as part of *Healthy PA*, Pennsylvania's proposed approach to the ACA's Medicaid expansion provisions.

CHIP. Dental services for children are also available through CHIP (Children's Health Insurance Program), a state-subsidized free or low-cost health care insurance program for children up to age 19 from families who do not meet the income guidelines for the Medical Assistance or Healthy Beginnings (a Medicaid program for pregnant women and children) programs.

The Affordable Care Act (ACA)

Under the federal ACA, dental coverage is available in two ways:

- Health plans that include dental coverage - Dental coverage is included in some health plans (consumers can see which plans include dental coverage at the Healthcare Marketplace website).

- Separate, stand-alone dental plans - The website notes that consumers may want a stand-alone dental plan if the health coverage they have chosen does not include dental coverage, or if they want different dental coverage.

Under the ACA, dental insurance is treated differently for adults and children 18 and under:

- Dental coverage for children is an essential health benefit. This means if a consumer is getting coverage for someone 18 or younger, dental coverage must be offered, either as part of a health plan or as a stand-alone plan. While it must be available, consumers do not have to buy it.
- Insurers do not have to offer adult dental coverage.

Thus, while under the ACA, most people must have health coverage or pay a penalty, this is not true for dental coverage. Consumers do not need to purchase dental coverage, even for children.

Availability of Dental Services for Persons with Disabilities

We attempted to identify the availability of dental services for people with disabilities at both the individual practitioner level and through public and private clinics.

Private Practice Dentists That Can Accommodate Special Needs Patients.

To access the availability of private practice dentists for persons with disabilities, we reviewed the list of dentists included in the federal InsureKidsNow website. The website is intended as a resource for families enrolled in the Medicaid or CHIP program. Table 1 shows the number of dentists reported as enrolled in the Medicaid fee-for-service plan that indicated they can accommodate special needs patients. The table also shows how many of those dentists indicated they accept new patients (as of July 2014).

Table 1

Dentists Reporting They Can Accommodate Special Needs*

County	Dentists (Medicaid Fee-for- Service) ^a	Accommodate Special Needs?		Of those that Accommodate Special Needs, do they accept new patients?	
		Yes	No	Yes	No
		Adams	3	0	3
Allegheny.....	216	11	205	7	4
Armstrong.....	5	0	5	0	0
Beaver	24	1	23	0	1
Bedford.....	7	0	7	0	0
Berks	32	2	30	2	0
Blair	18	2	16	2	0
Bradford.....	10	2	8	1	1
Bucks.....	103	10	93	8	2
Butler	51	4	47	2	2
Cambria.....	29	0	29	0	0
Cameron.....	0	0	0	0	0
Carbon.....	2	0	2	0	0
Centre.....	12	7	5	6	1
Chester	44	4	40	3	1
Clarion	3	0	3	0	0
Clearfield	13	4	9	3	1
Clinton	6	2	4	1	1
Columbia	10	1	9	0	1
Crawford.....	30	6	24	6	0
Cumberland.....	5	0	5	0	0
Dauphin	22	2	20	1	1
Delaware	51	4	47	3	1
Elk	2	0	2	0	0
Erie	45	1	44	1	0
Fayette	15	0	15	0	0
Forest	1	0	1	0	0
Franklin.....	10	0	10	0	0
Fulton	12	0	12	0	0
Greene	4	0	4	0	0
Huntingdon.....	4	0	4	0	0
Indiana.....	8	3	5	2	1
Jefferson.....	11	1	10	1	0
Juniata.....	1	0	1	0	0
Lackawanna	34	7	27	3	4
Lancaster.....	41	1	40	0	1
Lawrence.....	7	2	5	1	1

Table 1 (Continued)

County	Dentists (Medicaid Fee-for- Service) ^a	Accommodate Special Needs?		Of those that Accommodate Special Needs, do they accept new patients?	
		Yes	No	Yes	No
		Lebanon	1	1	0
Lehigh.....	70	3	67	3	0
Luzerne	64	9	55	6	3
Lycoming	1	0	1	0	0
McKean	6	2	4	2	0
Mercer	10	0	10	0	0
Mifflin	10	1	9	1	0
Monroe	9	3	6	2	1
Montgomery	143	3	140	3	0
Montour	32	0	32	0	0
Northampton.....	19	1	18	1	0
Northumberland .	10	0	10	0	0
Perry.....	0	-	-	0	0
Philadelphia.....	400	25	375	19	6
Pike	1	1	0	1	0
Potter.....	1	0	1	0	0
Schuylkill	9	0	9	0	0
Snyder	2	1	1	1	0
Somerset.....	21	1	20	0	1
Sullivan.....	4	0	4	0	0
Susquehanna	3	1	2	1	0
Tioga	5	1	4	1	0
Union	5	2	3	2	0
Venango	8	0	8	0	0
Warren.....	6	1	5	0	1
Washington	15	0	15	0	0
Wayne	2	0	2	0	0
Westmoreland	45	14	31	9	5
Wyoming	0	-	-	0	0
York	<u>26</u>	<u>1</u>	<u>25</u>	<u>1</u>	<u>0</u>
Total	1,819	148	1,671	107	41

* The Centers for Medicare and Medicaid Services has indicated this field will be refined later to identify the types of special needs that can be addressed.

^a Dentists reporting they are enrolled in Pennsylvania’s Medicaid Fee-for-Service program.

Source: Developed by LB&FC staff using information from InsureKidsNow.gov website.

Due to the way the InsureKidsNow website is designed, Table 1 should be viewed as illustrative, not comprehensive. In particular, users must first select an insurer before identifying which dentists participate in that plan. InsureKidsNow lists 24 different Medicaid and CHIP insurance plans. Because it was not feasible to identify how many dentists in each county participated in each plan, we based Table 1 on the Medicaid fee-for-service plan, which has statewide coverage.

As Table 1 shows, only 8 percent of the dentists enrolled in Pennsylvania's fee-for-service plan indicate they are able to accommodate special needs patients, and only 6 percent indicated they are both able to accommodate special needs patients and are accepting new patients. Thirty of Pennsylvania's 67 counties, had no dentists in the Medicaid fee-for-service plan that indicated they were willing or able to accept a special needs patient.

Our questionnaire to all 8,100 dentists with an active practice in Pennsylvania provides another perspective on the availability of dental services. Of the 686 dentists who responded, 39 percent indicated they accepted Medicaid clients and 94 percent indicated they accepted children with CHIP coverage. Seventy percent indicated that they would be willing to provide dental services patients with special needs, depending on the severity of the disability. Additional information on the questionnaire responses is presented later in this report.

Clinics for Dental Services for Persons With Disabilities

Pennsylvania has various programs and clinics where people with disabilities⁵ can obtain dental care, either through Medicaid or for low or no cost. These include:

Federally Qualified Health Care Centers. Over 200 Federally Qualified Health Care Centers are located across the Commonwealth. These centers often offer both medical and dental care. Services are provided regardless of ability to pay; charges are based on the patient's family size and income. Of the over 200 site locations, 84 reported offering dental services.

The Donated Dental Services (DDS) Program. Pennsylvania's DDS program operates in conjunction with the Pennsylvania Dental Association to recruit dentists who are willing to donate their time to treat vulnerable patients such as the disabled, elderly, and those who have serious medical conditions for whom an oral health problem may be life-threatening. In 2009, Commonwealth funding (\$150,000) for Pennsylvania's DDS program was cut. These funds were restored in FY 2013-14, and by February 2014 the program was fully operational and available

⁵ The Commission on Dental Accreditation defines special-needs patients as patients whose medical, physical, or social situations make it necessary to modify regular dental routines in order to provide dental treatment tailored for the individual.

to assist eligible low-income residents in finding oral health services. People who have dental coverage under the Pennsylvania Medical Assistance program are not eligible for Donated Dental Services.

The Dental Lifeline Network, a non-profit agency based in Colorado, administers DDS programs across the country. Two regional coordinators facilitate the program by determining patient eligibility and coordinating services with volunteer dentists and labs.

Dental Schools. Pennsylvania is home to three dental schools: the University of Pittsburgh School of Dentistry, the University of Pennsylvania School of Dental Medicine, and the Maurice H. Kornberg School of Dentistry at Temple University. All three schools accept and provide services to persons with disabilities.

The University of Pittsburgh's Center for Patients with Special Needs, for example, is devoted to providing dental care to those with special needs. Care is done by experienced students under the close supervision of dentist faculty. Medical Assistance is accepted, as are most dental plans. Penn operates the Penn Dental Medicine clinic, where dental students, under faculty supervision, offer a wide range of dental services at reduced rates. Temple operates several dental clinics in Philadelphia, including the Rosenthal Clinical Center which specializes in providing services to persons with disabilities. These services are provided for free or reduced rates.

Elwyn's Dental Clinic. The Hart M. Dixon Dental Clinic (Media, PA) is a full-service facility serving the residents of Elwyn as well as persons with disabilities in the community. If necessary, patients over 14 can be sedated with IV sedation administered by a Board-certified Anesthesiologist. The clinic is open to people with disabilities aged three and older, people with mental health problems, and the frail elderly. The clinic accepts Medicaid, KIDSChoice (CHIP), and a wide variety of commercial insurance plans.

Special Olympics Special Smiles. Special Olympics Special Smiles, a national nonprofit founded in 1993, provides dental care to their athletes and other people with disabilities. Pennsylvania's Special Olympics program participates in the Special Smiles dental program.

Special Smiles Ltd. Medicaid managed care organizations have flexibility that fee-for-service Medicaid programs often do not, including the ability to negotiate payment arrangements for specialty services. Special Smiles, a Philadelphia-based general dental facility providing comprehensive dentistry to people with emotional, behavioral, physical, cognitive, and other developmental disabilities, is such an example.

The program was a result of collaborative discussions among representatives from Pennsylvania’s Department of Welfare, four Medicaid managed care organizations, advocacy organizations, and the dentists who own the practice. Special Smiles employs two full-time and two part-time general dentists. Each dentist has completed advanced education with a specific focus on special needs patients. The practice contracts with an independent anesthesia group that is able to provide general anesthesia services in an outpatient setting.

B. LB&FC Survey of Pennsylvania Dentists

To assess the dentists’ perspective, in May 2014, we sent a survey to all 8,100 dentists with active licenses with the Pennsylvania dental board living in Pennsylvania;⁶ 684 questionnaires were completed, for an 8.5 percent return rate.⁷ The questions and responses are shown in Appendix C. Illustrative comments are shown in Appendix D. Key points from the survey include:

- 40 percent of dentists said they accepted Medicaid, compared to 95 percent that accepted CHIP.
- 64 percent of dentists said they treated ten or fewer children with disabilities a year.
- 46 percent of dentists said they treated ten or fewer adults with disabilities a year.
- 42 percent of dentists said they had no special training for how to treat persons with disabilities.
- About 70 percent of dentists said they would be willing to treat patients with cognitive impairments, developmental disabilities, physical disabilities, or mental illness. A number commented, however, that it would depend on the level of disability.
- According to the dentists, access to care is most difficult for children and adults without insurance, next most difficult for children and adults with public insurance (e.g., Medicaid), and least difficult for children and adults with private insurance.
- Access to care appears to be most difficult for adults with public insurance (i.e., Medicaid), with 46 percent of dentists reporting access to be a “big”

⁶ We worked with the PA Dental Board to obtain e-mail and postal mail addresses. For those dentists that had an e-mail address (about 3,800) on file, we sent them an e-mail describing the purpose of the study with a link to the survey at Survey Monkey. For those dentists that did not have an e-mail address (about 4,300), we sent a post card describing the purpose of the study and asking them to complete the study either online at Survey Monkey or to go to our website and print out a copy of the questionnaire and return it to us.

⁷ Statistically significant at the .05 level, meaning that there is a 95 percent probability the responses accurately represents the opinions of all Pennsylvania dentists (assuming no response bias). Response bias would occur if, for example, there was a greater tendency for dentists who treat persons with disabilities to respond.

problem for this group. By comparison, only 3 percent of dentists thought access to care was a big problem for adults with private insurance.

- Dentists report the biggest factor impeding access to care for persons with disabilities is low reimbursement levels. Difficult behavioral issues and high levels of no-show appointments are also significant factors.
- The top steps dentists reported the Commonwealth could take to improve access to care are:
 - Increase Medicaid rates (74 percent of dentists indicated this would be “very helpful”)
 - Establish regional centers for specialized care (61 percent of dentists indicated this would be “very helpful”)
 - Liberalize dental loan repayment programs for treating persons with disabilities (46 percent of dentists indicated this would be “very helpful”)

We also asked dentists an open-ended question on what they saw as the barriers that may impede access to care for persons with disabilities and to provide recommendations to improve dental services for such patients. Many dentists took the opportunity to provide such comments (see Appendix D). These comments reinforce what other studies have found, that access to care for persons with disabilities is a multi-faceted problem. The key issues identified by the dentists responding to our survey include:

- *Poor daily oral hygiene practices.* Proper oral hygiene practices are difficult to maintain for almost everyone. For people with cognitive or physical impairments, who often have difficulty with fine motor skills, the challenge is especially difficult. Added to this, certain disabilities make individuals prone to dental problems, in part due to the medications used to manage the disability and in part due to craniofacial anomalies (e.g., individuals with Down’s syndrome are prone to periodontal disease and bruxism).⁸
- *Deferring regular dental check-ups.* Dentists report that people often avoid routine dental checkups, waiting instead until a problem develops. For persons with disabilities, especially if they have difficulty communicating, such problems may not be identified until they reach an even more severe stage.
- *Low Medicaid reimbursement rates.* Low Medicaid reimbursement rates—and hence relatively few participating dentists to see Medicaid patients—was by far the most common reason cited by dentists for difficulty in accessing care. As a result, many dentists noted that the problem is not

⁸ See also *Dental Issues and Down Syndrome*, National Down Syndrome Society and *Practical Oral Care for People with Autism*, National Institute of Dental and Craniofacial Research.

access to care, but rather access to financing. As one dentist noted, “Severely discounted payments for a higher level of services is a way to ensure an access problem. If the reimbursement is worthwhile, you will get more doctors willing to provide these more demanding services.”

- *Needed services not covered.* While Medicaid and CHIP offer comprehensive dental coverage for children, covered services for adults, including adults with disabilities, are much more limited. Root canal therapy, crowns, and several other services are no longer covered for adults on Medicaid, and dentures are limited to one set per lifetime.⁹ (Cleanings, fillings, and extractions continue to be covered.) Others mentioned that Medicaid does not allow reimbursement for outpatient dental anesthesia services for procedures done outside of a hospital.
- *Denials and delays of insurance claims.* Many dentists cited difficulty dealing with insurers (both public and private) and third-party claim administrators as major problems. This problem, however, would appear to apply equally to persons without disabilities.
- *Burdensome Medicaid rules.* In addition to low reimbursement levels, many dentists cited burdensome paperwork and regulatory requirements as reasons they do not participate as Medicaid providers. As one dentist noted, “The paperwork is ridiculous and the appreciation from the state [is] not worth mentioning because there is none.” Again, this issue applies to Medicaid generally, not just providing services to people with disabilities. One dentist suggested that they be allowed to limit participation in the Medicaid program to only those patients with disabilities, which is currently not allowed.
- *Lack of training and specialized equipment.* While many dentists reported that most persons with disabilities can be seen in a regular dentist office, oftentimes, either for behavioral or dental reasons, patients with disabilities need to be sedated or require specialized equipment (e.g., for wheelchair-bound patients).¹⁰ Several dentists also noted that they received little training in dental school on the specialized needs of persons with disabilities and that additional training, particularly in conscious sedation, would be helpful.

⁹ DPW can, however, grant exceptions to these general policies.

¹⁰ The 2009 ACHIEVA report estimated that 75 percent of people with disabilities can be treated in a standard dentist office.

C. Impact of Reimbursement Rates on Dentist Participation in the Medicaid Program

The greatest barrier to care cited by dentists responding to our survey is low Medicaid reimbursement rates, which results in many dentists not participating in the program. This, in turn, places additional burdens on those dentists who do participate.

Studies have shown, however, that increasing Medicaid dental reimbursement rates is generally not an effective way to increase dentist participation for special populations. For example:

- A study issued in July 2013 (*The Effect of Medicaid Payment Rates on Access to Dental Care Among Children*¹¹), found that while higher Medicaid payments had a positive and statistically significant effect (i.e., higher rates resulted in higher participation by dentists in the Medicaid program), the effect was small. The study found that increasing Medicaid reimbursements is not a particularly cost-effective way to increase dentist participation, primarily because 90 percent of the additional spending associated with the increase would be used to pay dentists more for visits that would have occurred anyway under the lower fee schedule.
- A 2008 study (*Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?*¹²) came to much the same conclusion: "...while increases in provider payments were necessary to the success of the states' reform efforts, they were not sufficient to produce substantial gains in either dentist participation or patients' access to care."
- A 2011 study (*Higher Medicaid Rates Mean More Dental Care for U.S. Kids*¹³) was more supportive of a raise in Medicaid rates, noting that "In the states that raised Medicaid reimbursements for dental care—even by a small amount—more children were able to get oral care." But even then, it took a 100 percent increase in prophylaxis payment (from \$10 to \$20) to achieve a 3.92 percentage point increase in the chance that the child would be seen by a dentist.
- Connecticut raised its Medicaid rates for dentists strikingly in 2006; from \$39 per filling in 2006 to \$114 per filling in 2008. Initial dental exams reimbursements were increased from \$24 in 2006 to \$65 in 2008, extractions from \$33 to \$115, and crowns from \$88 to \$230. At the same time, Connecticut made a number of other changes to their Medicaid program,

¹¹ *The Effect of Medicaid Payment Rates on Access to Dental Care Among Children*, Thomas C. Buchmueller, Sean Orzol, and Lara D. Shore-Sheppard, in *The National Bureau of Economic Research*, July 2013.

¹² *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations*, National Academy for State Health Policy, March 2009.

¹³ *Higher Medicaid Rates Mean More Dental Care for U.S. Kids*, *Journal of the American Medical Association*, July 13, 2011, Vol. 306:2, pp. 187-193).

including initiating an outreach effort to sign up more dentists. Connecticut reported the number of participating dentists more than doubled, from 416 to 937, as a result of these steps.

Medicaid's Dental Behavioral Management Fee. To help offset the higher cost that can be incurred by treating persons with disabilities, under Pennsylvania's Medicaid program, dentists are allowed to receive an additional Dental Behavioral Management fee of \$128 "for difficult to manage persons with developmental disabilities."¹⁴ A developmental disability is defined as a substantial handicap having its onset before the age of 18, of indefinite duration, and attributable to neuropathy (a disease of the nervous system). Dentists are to maintain documentation on the need for extra time and any procedures used above and beyond normal expectations.

The Department of Public Welfare reported it increased this fee (from \$78 to \$128) in 2006 "as part of the Department's continuing commitment to support the increased utilization of dental services by persons with disabilities." The behavioral management fee is limited to four visits per patient per calendar year. DPW reported that for the 12-month period April 2013-March 2014, it paid approximately 32,000 dental behavioral management fee claims, amounting to about \$4.1 million for the 12-month period.¹⁵

New Mexico has taken a somewhat different approach to providing extra compensation to dentists serving people with disabilities by building a corps of community dentists who are specially trained to provide the more involved and time-intensive care that people with developmental disabilities need. Its *Special Needs Code* program provides an enhanced payment of \$97 per dental visit to dentists completing a program of on-line study and in-person training with special care dentists. Since the program's inception in 1995, the state reports it has developed a small but dedicated corps of 40 dentists who have completed Special Needs Code training.

Advocates in California have proposed a similar training program that would provide dentists with 20 hours of instruction, followed by ten hours of hands-on experience. After the completion of this training, the dentist would be certified to receive an additional \$85 behavior management fee when treating enrollees with developmental disabilities.

¹⁴ Medicaid managed care organizations may negotiate a different fee. One dentist we spoke with reported that he received a behavioral management fee of only \$37.50 from several Medicaid MCOs.

¹⁵ In addition, about 700 behavioral management fee claims were rejected during this 12-month period.

III. Appendices

APPENDIX A

PRIOR PRINTER'S NO. 752

PRINTER'S NO. 1646

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 61

Session of
2013

INTRODUCED BY MENSCH, SCARNATI, TOMLINSON, GREENLEAF, FONTANA,
SMITH, HUGHES, BREWSTER, STACK, BAKER, ALLOWAY, FERLO,
ERICKSON, HUTCHINSON, VOGEL, BROWNE, COSTA, GORDNER,
TARTAGLIONE, VULAKOVICH, FARNESE AND BOSCOLA, MARCH 20, 2013

SENATOR VANCE, PUBLIC HEALTH AND WELFARE, AS AMENDED,
DECEMBER 10, 2013

A RESOLUTION

Directing the Legislative Budget and Finance Committee to study
and to issue a report on the status of and any disparities
found in dental care for Pennsylvanians with disabilities.

WHEREAS, Dental care is vitally important for each of us,
affecting overall health, employability and social inclusion;
and

WHEREAS, Many individuals, including the unemployed, those of
low income, the uninsured and the elderly, have great difficulty
finding and seeing a dentist and paying for dental care, and
those who have disabilities have greater difficulties still
because of the very nature of dental offices, many of which are
not accessible to people with physical disabilities; and

WHEREAS, Beyond structural inaccessibility, many individuals
with disabilities are insured through Medicaid and there is a
chronic and serious shortage of dentists and dental care
professionals available to Medicaid patients; and

WHEREAS, Dental patients with disabilities may present to the
dental health professional other challenges that the dentist is
unwilling or unskilled to undertake, including positive
behavioral supports, the need for anesthesia and the concomitant
need for specialized anesthesia application; and

WHEREAS, Lack of dental care is a recognized indicator of
greater likelihood of chronic illnesses and poor health
outcomes; and

Appendix A (Continued)

WHEREAS, Dental care and preventive dental health are far less expensive to deliver than is care resulting from the lack of oral health care and the chronic and serious conditions that are left untreated; and

WHEREAS, The breadth and depth of the problem of lack of access to dental care must be fully understood before systemic changes are made in the way health care professionals are recruited and incentivized to serve persons with disabilities and other underserved communities; therefore be it

RESOLVED, That the Senate direct the Legislative Budget and Finance Committee to conduct a study of the disparities that exist in accessing and receiving dental care among persons with disabilities in this Commonwealth and to issue a report; and be it further

RESOLVED, That the Legislative Budget and Finance Committee determine the need for and availability of dental providers for children and adults 21 years of age and older with disabilities, county by county, throughout the State; and be it further

RESOLVED, That the Legislative Budget and Finance Committee examine availability of dental services for children and adults with disabilities in community-based care and specialized care, including the availability of accessible offices and equipment, the opportunity for dentists to perform deep sedation and anesthesia, conscious sedation and nitrous oxide for individuals with disabilities, which services accept Medicaid and which counties need additional dental care and specialty support; and be it further

RESOLVED, That the Legislative Budget and Finance Committee study its findings and make recommendations as to what will preserve the quality dental services already in place and what mechanisms, including the feasibility of increasing Medicaid dental care payments; liberalizing and modifying dental loan repayment programs for service in underserved areas and for this underserved population; ~~requiring private insurers to pay for anesthesia services for dental patients who are persons with disabilities who need such service;~~ and work force initiatives to responsibly expand the scopes of practice of carefully supervised dental ~~public health hygienists~~ PUBLIC HEALTH DENTAL HYGIENE PRACTITIONERS will incentivize more dental practitioners to open their practices to persons with disabilities; and be it further

RESOLVED, That the Legislative Budget and Finance Committee compile a report based on its findings and recommendations and submit the report to the Senate as soon as possible, but not later than November 30, 2014.

APPENDIX B

Recommendations From *People With Developmental Disabilities and Oral Health in the Commonwealth of Pennsylvania, September 2006*^a

Access to Care

- Establish three centers of excellence in special care dentistry in strategic geographical locations throughout Pennsylvania. By building upon already existing infrastructure, establish centers of excellence in special care dentistry in the east, west, and central regions of Pennsylvania. These centers of excellence should provide the most advanced care, including dental services under general anesthesia, for patients with developmental disabilities who cannot be treated in Level II or community dental settings. They hold the potential to be the most efficient source of highly specialized dental care for the population that most needs this level of care. Centers would likely have the ability to hire practitioners on salary so that direct care providers don't have to deal with the challenges and obstacles of MA. These centers of excellence should be established as referral points for dentists who cannot treat complex cases. Having such centers available could also provide an incentive to community practitioners to provide generalized care by knowing they have an available referral source for harder-to handle cases. Centers of excellence should also offer training, education, and reference for dentists and auxiliary staff in the care of patients with developmental disabilities in general. Partnerships with key state organizations are essential to maintain such centers and provide a sustainable treatment environment ensuring a continuum and standard quality of care for their patients. The emphasis that these centers are sanctioned to treat patients with the highest level of need is important to minimize wait times and prevent the inundation of the facilities with patients that may be treated in a community dental office. The right financial arrangements should accompany the levels of care. Moreover, by centralizing the general anesthesia services into these specific facilities, some of the burden of the increased anesthesia licensing requirements is relieved from those dentists in the community.^b Consideration of establishing a network of centers of excellence in special care dentistry could follow in the form of the recommendations of the Florida Developmental Disabilities Council's dental and disabilities report (45). Centers of excellence should be supplemented by regional centers throughout the state that provide support and places of referral for community dental practitioners who have patients that are more difficult to treat. Regional centers should have relationships with dentists specifically trained to treat people with disabilities and with hospitals for

^a *People with Developmental Disabilities and Oral Health in the Commonwealth of Pennsylvania, September 2006*, submitted by Elwyn to the Pennsylvania Developmental Disabilities Council. These are the recommendations of the working group that developed the report. The report also included a series of recommendations derived directly from focus groups and consumer surveys. Many of these recommendations built on or add more specificity to recommendations made by the working group.

^b Report Prepared by Drexel University School of Public Health, August 2006, Page 151.

Appendix B (Continued)

access to sedation and anesthesia services. Together with community practitioners, the centers of excellence and regional centers approach would support the three levels of care outlined in this report. Such a system would hopefully eliminate long travel times and find ways to assure access to dental services within one to two hours of patients' homes.

- Following the recommendation outlined by the Pa DOH document "Status of Oral Health in Pennsylvania," create and maintain on the Pa DOH website an updated map and database of clinics and key providers that specialize in serving the population of people with disabilities (particularly identifying those that take MA clients) and providing the location and contact information for each. Make sure that the various Pa DOH help lines know about this information and can make proper referrals to it. (1). Build on the state's recommendation (3) to maintain an easily accessible database of special facilities designed to serve special populations. This could be tied to another recommendation (3) to develop a state database on the status and location of the dental workforce that could be tied to anesthesia licenses (3).
- Require the state dental office at Pa DOH to create a Task Force on Special Care Dentistry and identify existing local, state, national and international dental resources for use by dentists and individuals who are interested in Special Care Dentistry. These should be made readily available to dentists on the web and through dental societies.
- Continue and expand the Pennsylvania Loan Repayment Program to encourage more dentists and dental hygienists to practice in Pennsylvania and to serve in areas of low dentist supply. The Pa DOH should offer incentives, increased payments and allow part-time employment in underserved areas.
- Increase and expand meaningful and successful outreach efforts by Pa DPW to recruit dental providers into the MA program (see also Policy and Fiscal recommendations.)^c

Education and Training

- Curriculum in dental school should include more education about serving persons with developmental disabilities. A partnership between the relevant state agency of- fices serving people with developmental disabilities (such as the Office on Mental Retardation) and state dental schools should be encouraged. Evidence has shown that those dentists who are trained in Pennsylvania tend to stay here. The state should provide incentives for more dentists and training in the state's three dental schools for treating people with disabilities. Students should receive training on three levels of dental management for individuals with developmental disabilities, such as appropriate anesthesia levels and behavior management.

^c Report Prepared by Drexel University School of Public Health, August 2006, Page 152.

Appendix B (Continued)

- Educate community dentists so that they become more comfortable in providing basic preventive dental services for people with disabilities, thereby reducing the downstream need for more costly treatment at a later date. Dental societies, dental schools, dental companies, managed care companies and others should work together to promote a better understanding among community dental professionals and dental professionals, in general, about how treatable many persons with disabilities can be in community dental offices. This effort should counteract the negative stereotypes that may exist. An objective would be to counteract the possibility that when a dental professional hears the words “special needs” or “disabilities”, they don’t automatically assume providing services to these persons is more difficult, challenging and less cost-effective for their practice.
- Dental societies, Pa DOH, dental schools and others should make dentists and dental students aware of resources, such as Special Care Dentistry (SCD), an organization that dentists can join to enhance and share knowledge available for treating patients with developmental disabilities. Comprised of the American Association of Hospital Dentists (AAHD), the Academy of Dentistry for Persons with Disabilities (ADPD) and the American Society for Geriatric Dentistry (ASGD), SCD provides members access not only their Annual Meeting, but also a bimonthly newsletter, a bi-monthly peer-reviewed journal, and the important opportunity to network and share information with other professionals serving patients with developmental disabilities (52) – the availability of such a network responds to the need echoed by many participating dentists.
- Create more opportunities for dental students to be mentored by dental providers who serve people with disabilities.
- Dental societies should educate dental providers about the plethora of clinical best practices resources that are available in the marketplace about how to provide oral health treatment to persons with disabilities.^d
- Provide greater education of elected officials and state agencies’ staff about the importance of oral health and the dental needs of persons with developmental disabilities.
- Dental providers and consumers should engage in dialogue with insurers and MCOs to educate consumers and assure that proper outreach and oral health referrals are provided to enrollees.

^d Report Prepared by Drexel University School of Public Health, August 2006, Page 153.

Appendix B (Continued)

Policy and Fiscal

- In general, Pa DPW needs to make it more enticing for dental providers to participate in the MA program. This includes raising fees for dental services provided to people with disabilities and engaging in dialogue with providers about how to do so effectively and efficiently. Reimbursement mechanisms should provide oral health providers with fees that take into account the expertise, time and staffing needed to provide care to people with disabilities, particularly in difficult cases.
- Pa DPW should carefully review and discuss/review in-depth with dental providers how they are administering the behavior management fee. Currently, dental providers cannot bill a behavior management fee if the patient is receiving IV sedation or general anesthesia. This is problematic in some cases and needs adequate review and careful study. Patients with disabilities sometimes need behavior management 20-30 minutes before receiving care and anesthesia to assure positive outcomes to treatment. Policies that push for “sameness” across the board do not always work. All issues of funding require that the state agency fully understand how a dental office that serves people with disabilities operates.
- Eliminate prior authorization requirements for crowns, bridge work and dentures and institute retrospective authorization with review of proper documentation required to receive payment. Enhance the motivating forces for dental providers to provide necessary care and treatment in the proper way with the proper documentation and proper financing to support the treatment. Currently prospective review can be problematic because dental providers do not always have all the information related to potential complications of a case. With prospective review, they must submit a treatment plan in advance. Providers face not receiving payment for unexpected challenges incurred. The preliminary “look/see” visit doesn’t always provide all the necessary information for a case, especially if it is difficult to work in the mouth of a patient with disabilities.^e
- Pa DOH should expand the state oral health needs assessment to develop more specifics of what can and should be done to more appropriately serve the oral health needs of people with disabilities. Establish a task force to explore this issue in depth, reaching beyond the most accessible disability consumer population and advocates and develop recommendations that leverage public/private partnerships and information dissemination. This could include working cooperatively with Pa DPW, dental societies and the Pennsylvania Developmental Disabilities Council to convene regional dental summits around the topic of serving people with disabilities. This could also include strengthening the work of the already-established Pennsylvania Dental Summit’s Work Group on Special Needs.

^e Report Prepared by Drexel University School of Public Health, August 2006, Page 154.

Appendix B (Continued)

- Pa DPW should work closely with consumers receiving MA, providers and disability advocates to gather more finely tuned data about serving the population of persons with disabilities eligible for MA. Similar to the recommendation noted above for Pa DOH, Pa DPW must penetrate beyond the most easily accessible disability groups and to learn with more depth about what consumers with disabilities who receive MA need. This is in accordance with the recommendation in the Pa DOH document State of Oral Health in Pennsylvania, the state should “assess and determine the special populations most at risk in the Commonwealth in order to effectively address their needs” (3).
- As noted in the levels of care section of this report (in the chapter “Overview of the State Perspective”) from utilization data and data collected through this grant project, it is clear that a system to determine the levels of care is required. This necessitates matching the need for care at each level to the community resources that could greatly enhance access to care for the disability population. The Pa DPW should consider a review of its resource distribution, keeping in mind the levels of care required by the disability community, and match resources to need. The department should consider a comprehensive process to determine the level of care needed and match funding for the person to that level of care.
- Pa DPW should also allow for greater use of the behavior management fee at all levels of care to ensure that people with disabilities get the care required to promote optimum health. The department should also investigate and address the small percentage of utilization of dental care within the SSI category.
- Require Medicaid MCOs and their contracted primary physicians to recommend oral health care check-ups, explain dental care as a benefit to which the enrollees are entitled, make referrals, and provide educational materials for home-based preventive oral health.
- Pa DPW and/or Pa DOH should survey hospital emergency departments to identify the amount of care dedicated to treating dental emergencies. A subset of this study should focus on emergency oral health care to persons with disabilities.
- Pa DPW should investigate model policies to expand provider participation in Medicaid and invite public input. Model policies might include:
 - Utah’s approach of providing an added 20% reimbursement bonus to urban providers after they see 100 MA patients and continue to see the number of patients required for the bonus. This same reimbursement for rural providers would be for those who see any MA patients.
 - Michigan and Missouri’s tax incentives for providers. Michigan provides a tax credit to dentists of \$5,000 or the amount equal to uncompensated dental treatment of indigent individuals. Missouri created a tax credit for dentists who provide services to Medicaid recipients.

^f Report Prepared by Drexel University School of Public Health, August 2006, Page 155.

Appendix B (Continued)

- Eliminate or reduce prior authorization criteria, simplifying provider contracts, allowing dentists to file claims using forms and billing codes accepted by the American Dental Association.
- Pa DPW should explore the feasibility of adopting a special needs code into Medicaid similar to the one adopted by the State of New Mexico designed to provide patients with developmental disabilities with comprehensive oral health care. Adoption of a state special needs code entails provider training based on a core curriculum, hands-on training and CE certification from the state dental board.

Environmental

- Provide discounts, rebates and financial incentives—some of which could come as financial help from the state—to dentists to purchase and use the newest equipment available for treating people with developmental disabilities and/or to support environmental redesign or restructuring that would allow adequate space and openness to alleviate fears of being closed in.⁹

Clinical and Treatment

Note: This project focused very little on clinical care because there are multitudinous detailed resources already available for the clinical practitioner to access.

- Dental treatment of persons with developmental disabilities should take into account the unique individual oral health needs, dental service needs, sedation level availability and appropriate funding to assure that needed services are received.
- Care coordination and continuity of care should be provided and assured.
- Advocates voiced the request for dental sealant programs to help with preventive care. The state should explore ways to provide and fund dental effective and age-appropriate dental sealant programs.
- Advocates voiced the recommendation that dental waiting rooms have more sensory activities available to make it an enjoyable experience.
- Preventive and primary care services should be incorporated and provided as an integral part of care delivery. This includes a strong and pressing need for appropriate home oral health care, such as working with families and substitute caregivers to demonstrated ways of accessing teeth, providing new types of mouthwashes and home products.

⁹ Report Prepared by Drexel University School of Public Health, August 2006, Page 156.

Appendix B (Continued)

- Expanded availability and use of an x-ray gun for those persons with disabilities in order to allow greater flexibility in performing x-rays of people who are in wheelchairs. This can reduce the need to transfer a person from one chair—or one setting—to another.
- Use an itinerant anesthesiologist for more complex cases requiring higher levels of anesthesia.
- Partner with local hospitals and surgery centers to gain access to operating rooms
- Create a dental home for patients with disabilities with improved communication and care coordination between oral health care and the patient's other health care and medical providers. The dental home can help educate the patient and family members, identify any referral needs, and help coordinate among specialists.
- Assure familiarity with the patient's medical history in order to decrease risk of any medical problems encountered during dental treatment.

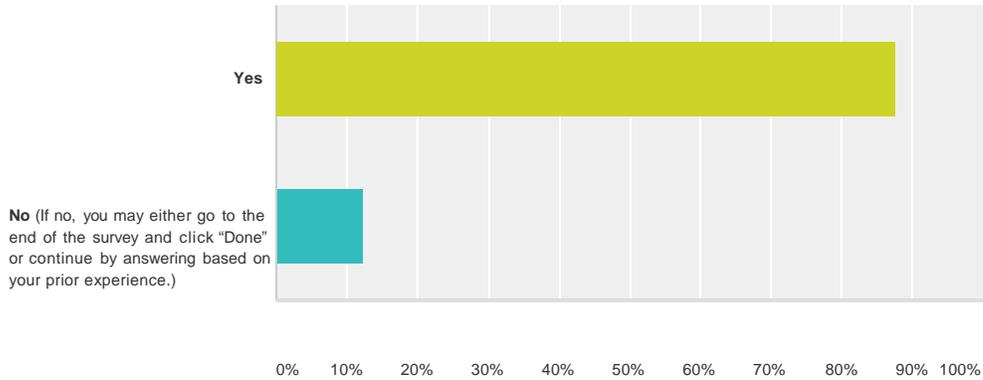
Source: *People with Developmental Disabilities and Oral Health in the Commonwealth of Pennsylvania*, September 2006, submitted by Elwyn to the Pennsylvania Developmental Disabilities Council.

APPENDIX C

Responses to LB&FC Survey of Dentists in Pennsylvania

Do you currently practice dentistry within the Commonwealth of Pennsylvania?

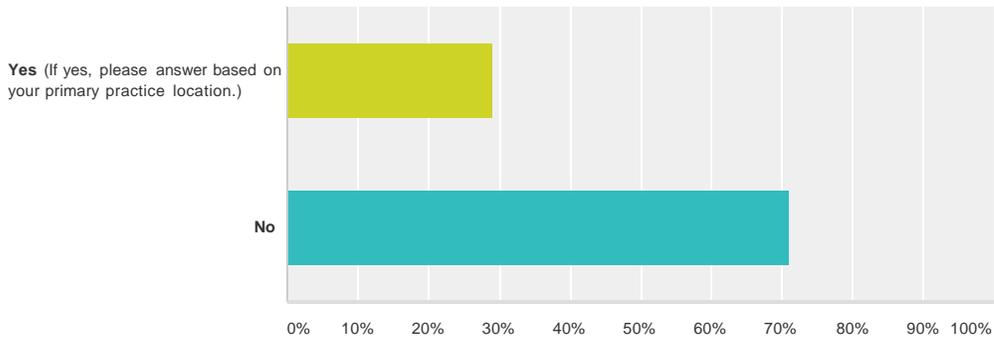
Answered: 684 Skipped: 2



Answer Choices	Responses
Yes	87.72% 600
No (If no, you may either go to the end of the survey and click "Done" or continue by answering based on your prior experience.)	12.28% 84
Total	684

Do you practice/consult at more than one location?

Answered: 613 Skipped: 73

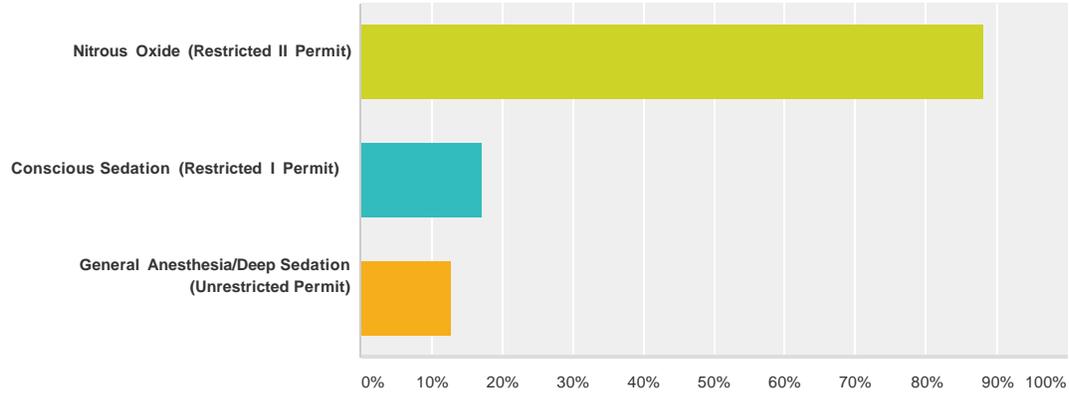


Answer Choices	Responses
Yes (If yes, please answer based on your primary practice location.)	29.04% 178
No	70.96% 435
Total	613

Appendix C (Continued)

Do you have a permit to administer:

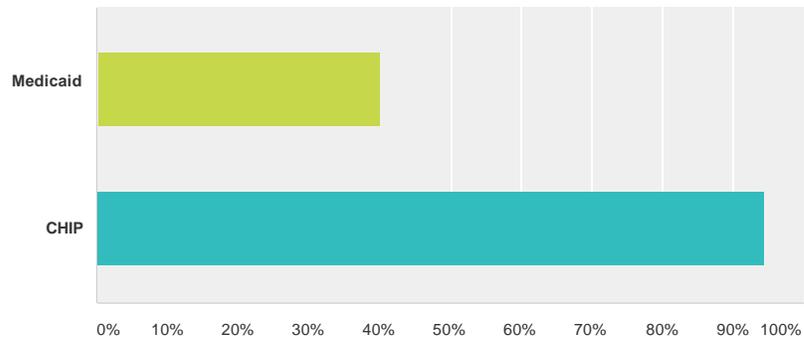
Answered: 252 Skipped: 434



Answer Choices	Responses
Nitrous Oxide (Restricted II Permit)	88.10% 222
Conscious Sedation (Restricted I Permit)	17.06% 43
General Anesthesia/Deep Sedation (Unrestricted Permit)	12.70% 32
Total Respondents: 252	

What types of public insurance payments do you accept?

Answered: 349 Skipped: 337

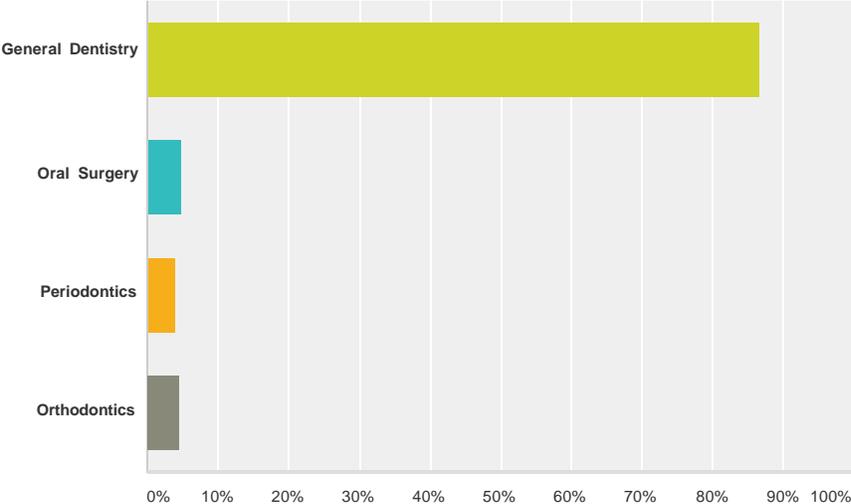


Answer Choices	Responses
Medicaid	40.11% 140
CHIP	94.56% 330
Total Respondents: 349	

Appendix C (Continued)

Please indicate practice or specialty

Answered: 548 Skipped: 138

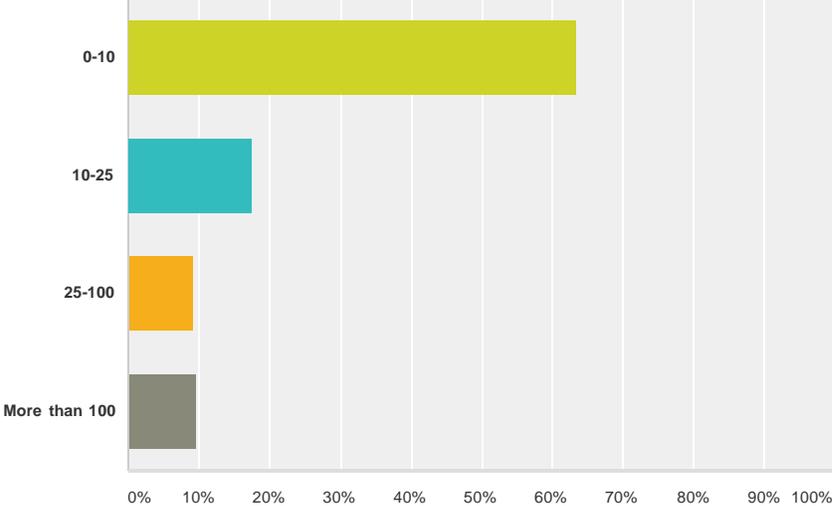


Answer Choices	Responses
General Dentistry	86.68% 475
Oral Surgery	4.74% 26
Periodontics	4.01% 22
Orthodontics	4.56% 25
Total	548

Appendix C (Continued)

How many children (under 21) with disabilities do you treat per year?

Answered: 601 Skipped: 85

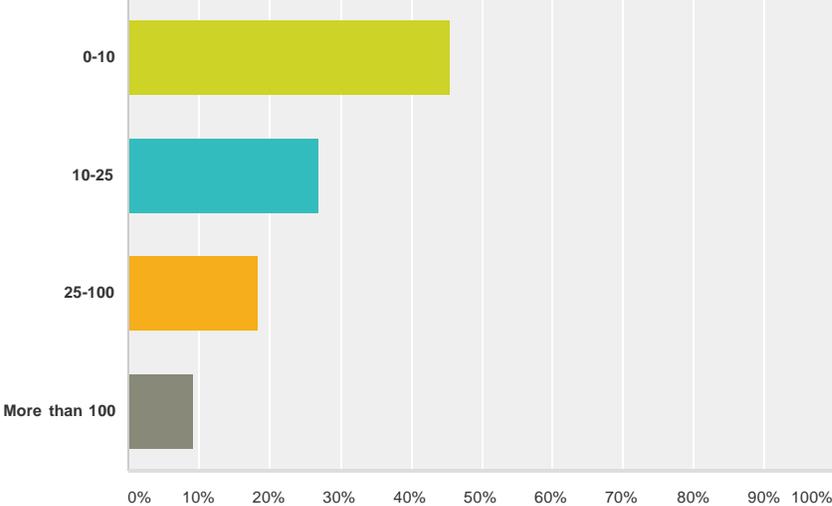


Answer Choices	Responses
0-10	63.56% 382
10-25	17.64% 106
25-100	9.15% 55
More than 100	9.65% 58
Total	601

Appendix C (Continued)

How many adults (21 and over) with disabilities do you treat per year?

Answered: 611 Skipped: 75

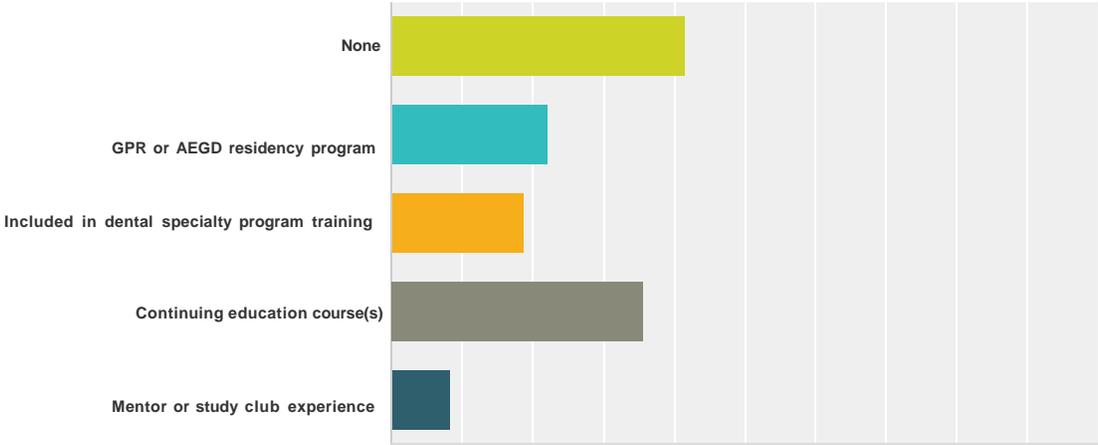


Answer Choices	Responses
0-10	45.50% 278
10-25	27.00% 165
25-100	18.33% 112
More than 100	9.17% 56
Total	611

Appendix C (Continued)

Please indicate any special training you have had for treating persons with disabilities (check all that apply):

Answered: 594 Skipped: 92

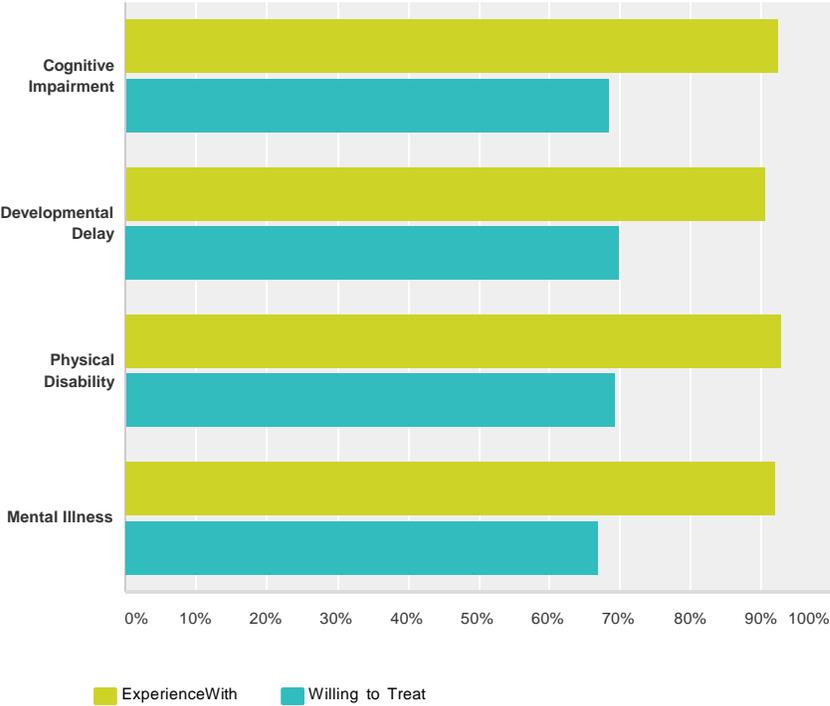


Answer Choices	Responses
None	41.58% 247
GPR or AEGD residency program	22.22% 132
Included in dental specialty program	18.69% 111
Continuing education course(s)	35.69% 212
Mentor or study club experience	8.25% 49
Total Respondents: 594	

Appendix C (Continued)

Please indicate the types of disabilities that you have experience with and the types of disabilities you are willing to accommodate.

Answered: 585 Skipped: 101

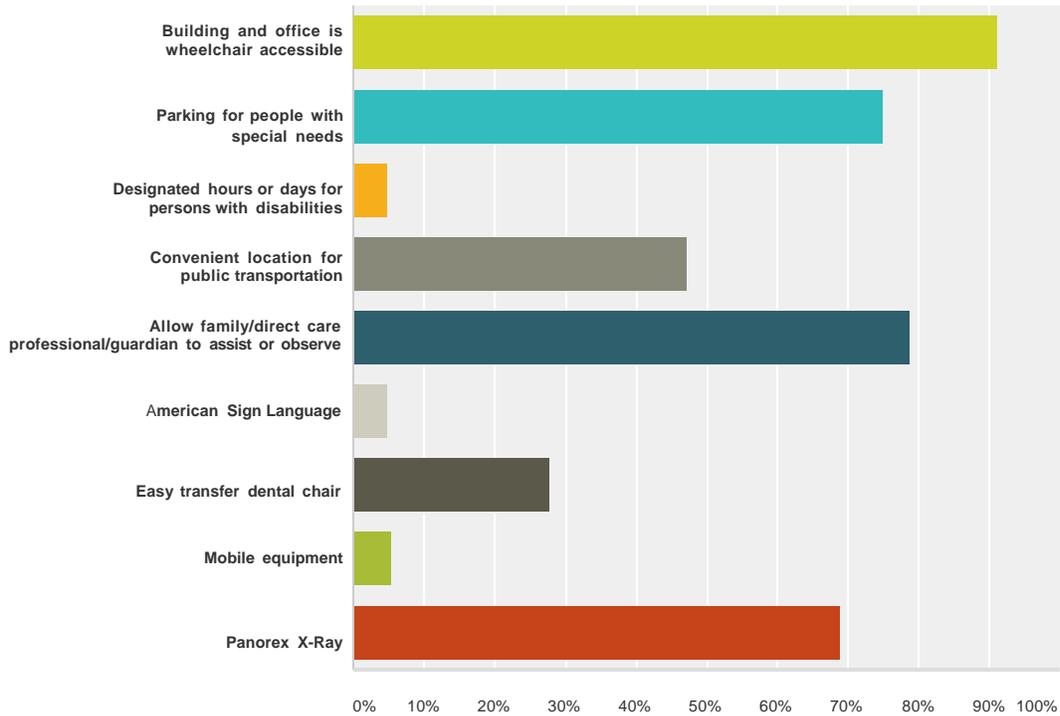


	Experience With	Willing to Treat	Total Respondents
Cognitive Impairment	92.51% 482	68.52% 357	521
Developmental Delay	90.61% 444	70.00% 343	490
Physical Disability	92.98% 530	69.30% 395	570
Mental Illness	92.11% 420	67.11% 306	456

Appendix C (Continued)

Which of the following accessibility features does your practice have to help persons with disabilities? (Select all that apply)

Answered: 594 Skipped: 92

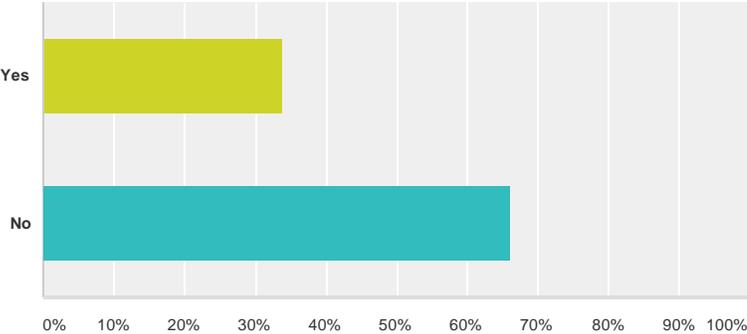


Answer Choices	Responses
Building and office is wheelchair accessible	91.25% 542
Parking for people with special needs	74.92% 445
Designated hours or days for persons with disabilities	4.71% 28
Convenient location for public transportation	47.14% 280
Allow family/direct care professional/guardian to assist or	78.62% 467
American Sign Language	4.88% 29
Easy transfer dental chair	27.78% 165
Mobile equipment	5.39% 32
Panorex X-Ray	68.86% 409
Total Respondents: 594	

Appendix C (Continued)

Do you work with staff (hygienist or assistant) who have had special training and/or experience treating persons with disabilities?

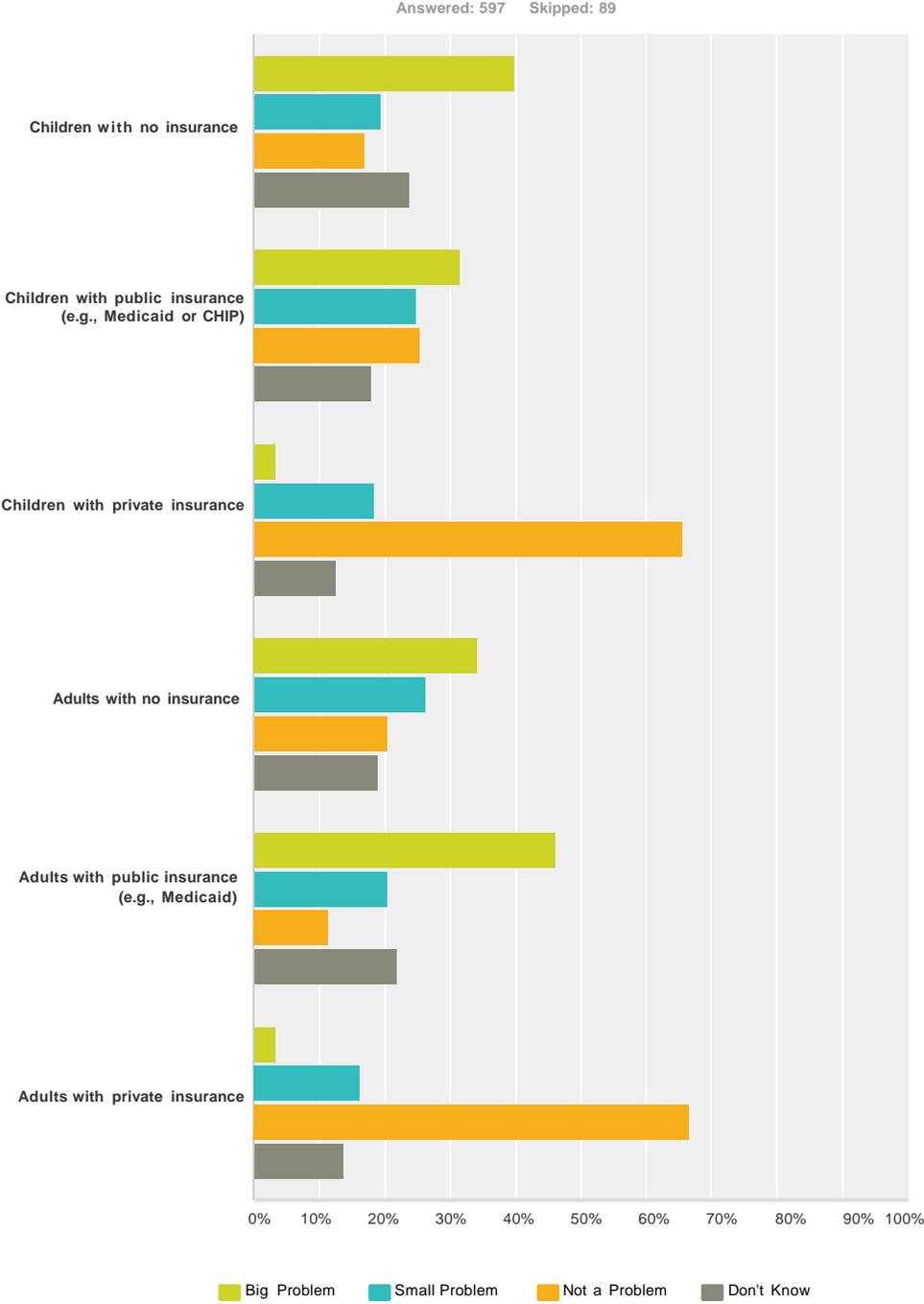
Answered: 604 Skipped: 82



Answer Choices	Responses
Yes	33.77% 204
No	66.23% 400
Total	604

Appendix C (Continued)

How would you rate the ease of access to quality dental care for persons with disabilities living in your area with the following types of insurance:



Appendix C (Continued)

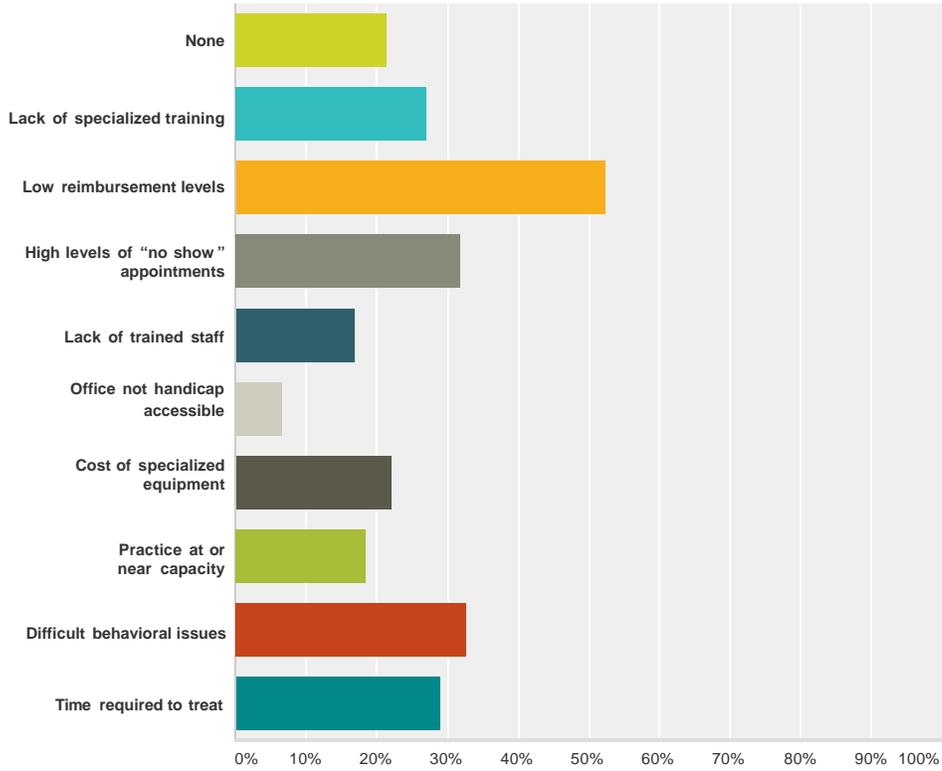
**How would you rate the ease of access to quality dental care for persons with disabilities living in your area with the following types of insurance:
(Continued)**

	Big Problem	Small Problem	Not a Problem	Don't Know	Total
Children with no insurance	39.83% 237	19.33% 115	16.97% 101	23.87% 142	595
Children with public insurance (e.g., Medicaid or CHIP)	31.60% 188	24.87% 148	25.55% 152	17.98% 107	595
Children with private insurance	3.38% 20	18.44% 109	65.65% 388	12.52% 74	591
Adults with no insurance	34.18% 202	26.40% 156	20.47% 121	18.95% 112	591
Adults with public insurance (e.g., Medicaid)	46.22% 275	20.50% 122	11.43% 68	21.85% 130	595
Adults with private insurance	3.38% 20	16.24% 96	66.50% 393	13.87% 82	591

Appendix C (Continued)

What factors impede you from providing or expanding services to persons with disabilities?

Answered: 576 Skipped: 110

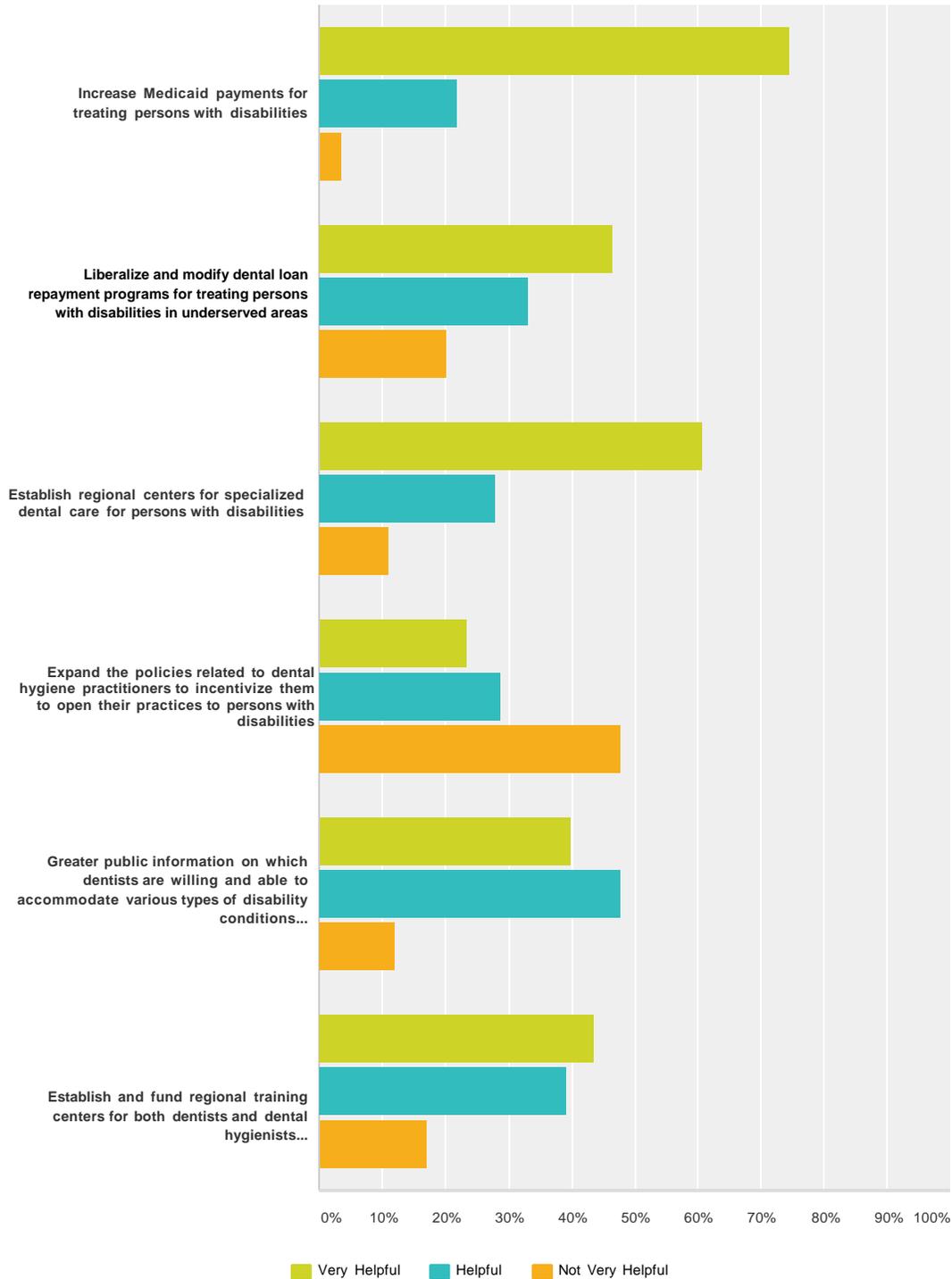


Answer Choices	Responses	
None	21.53%	124
Lack of specialized training	27.08%	156
Low reimbursement levels	52.43%	302
High levels of "no show" appointments	31.94%	184
Lack of trained staff	17.01%	98
Office not handicap accessible	6.60%	38
Cost of specialized equipment	22.05%	127
Practice at or near capacity	18.58%	107
Difficult behavioral issues	32.81%	189
Time required to treat	28.99%	167
Total Respondents: 576		

Appendix C (Continued)

What steps, if any, do you think the Commonwealth could/should take to increase dental services to persons with disabilities? Please also indicate how helpful you think such a step would be.

Answered: 598 Skipped: 88



Appendix C (Continued)

What steps, if any, do you think the Commonwealth could/should take to increase dental services to persons with disabilities? Please also indicate how helpful you think such a step would be.

(Continued)

	Very Helpful	Helpful	Not Very Helpful	Total
Increase Medicaid payments for treating persons with disabilities	74.43% 428	21.91% 126	3.65% 21	575
Liberalize and modify dental loan repayment programs for treating persons with disabilities in underserved areas	45.50% 259	33.21% 185	20.29% 113	557
Establish regional centers for specialized dental care for persons with disabilities	60.82% 354	28.01% 163	11.17% 65	582
Expand the policies related to dental hygiene practitioners to incentivize them to open their practices to persons with disabilities	23.45% 129	28.73% 158	47.82% 263	550
Greater public information on which dentists are willing and able to accommodate various types of disability conditions	39.93% 226	47.88% 271	12.19% 69	566
Establish and fund regional training centers for both dentists and dental hygienists	43.59% 245	39.32% 221	17.08% 96	562

APPENDIX D

Responses to Selected Survey Questions*

How would you rate the ease of access to quality dental care for persons with disabilities living in your area?

- Many of our patients have no insurance and pay personally because they value our services. Lack of insurance is not a reason to forego dental care.
- Public "insurance" does not come close to covering the cost of providing care. Practitioners who don't work in clinics that receive grants, can't afford to give away treatment to more than a few patients each year.
- Do not accept welfare due to previous experience with reimbursement below cost of overhead and welfare patients consistently fail to show up for appointments so I choose to do pro bono on patients referred by family or local churches
- No pediatric specialist in our area if behavioral issues or anesthesia complicate treatment. An FQHC is in our town and offices are access compliant for ADA.
- If the reimbursement rates and paperwork burden were comparable to private insurance, and the threat of major repercussions for honest mistakes were removed, MANY more dentists would accept public assistance.
- The cuts in benefits has made delivery of comprehensive care very difficult. The lack of periodontal coverage is counterproductive. In dental school patients can't even start the restorative phase of treatment until their periodontal health is stable. The BLE's are a complete disaster. This is wasting resources. The extra staff time is extremely costly and it is costing the state time and money to review. For a small percentage of claims that are approved. Most of this work is being done knowing that the claim will be denied. A complete waste.
- Mostly a big problem, insurance is the patients' perceived barrier. When people say "I could not go to the dentist because I did not have insurance." That is not an access problem. When their previous dentist does not take their insurance that is not an access problem. Insurance is not an access problem.
- Access to care may be a problem for some. Unfortunately people tend to ignore minor dental problems that become major problems. Pain is the great motivator and unfortunately minor dental problems do not have a lot of pain with them. When they are ignored, then the potential for pain increases greatly.
- Practice location is at the University of Pennsylvania and assistance is given by orthodontic residents of the graduate program
- It is very difficult to get coverage for disabled adults to get dentistry in clinic or operating room
- Children and adults without ins. have no access problem. It is a problem if they don't want to spend the money to acquire care. There seems to be a mindset that you need insurance to go for dental care.

Appendix D (Continued)

- Closest center for such patients that I know of is special smiles in Philadelphia. General anesthesia and hospital costs deter treatment.
- Patients with no insurance comes down to ability to afford treatment patients with insurance comes to offices who accept it and then are willing to treat special needs and I think that is a bigger problem also, it is more work and takes more time to treat patient w/special needs so it is harder to function as a business in the private sector
- Medicaid's reimbursement is so low, it's not worth accepting their payments, especially with a higher broken appointment rate which is not reimbursable. Our office overhead is so high, there is no way this could be absorbed by a practice especially when no one else participates.
- All children have insurance--including disabled children the key word is quality--we see many patients who have had years of "care" that has been poor and negligent.
- The Harrisburg Area Dental Society offers the SMILES program to serve these patients in Dauphin, Cumberland and York counties.
- Public insurance programs pay so poorly. For some reason, governmental agencies think that is the treating dentist responsibility to absorb some of the true cost of treatment.
- I don't participate with any insurance programs
- Anesthesia coverage seems to be directed toward oral surgical procedures. Carrier focus on the procedure not the requirements of a patient with special needs, i.e., intellectual or developmental delay.
- Most of our Clinic patients have no access to Orthodontic treatment without State support.
- Our office only accepts CHIP with Highmark. Now that there are other CHIP contracts this creates a problem for our patients when they get switched or switch themselves. We have some uninsured adults that are part of larger family relationships that we simple treat at no charge. We did take Medicaid years ago however with the lack of other doctors participating we were getting overwhelmed and I was told I could not limit the access if we participated so we had to make the business decision to stop participating.
- Access to care is not an issue for persons with or without disabilities. There are more dentists in the state than needed to meet current demand for care. Education of the citizens about the need for care would increase demand and utilization of dental care. The issue in meeting the health needs of the citizens dentistry seeks to serve is the citizenry's demand for care and the ability of individuals to cover the unavoidable costs of care. Pennsylvania funding of dental care for the socio-economically disadvantaged is egregiously inadequate to providing even a minimal standard of adequate care, and current reimbursement rates and fee schedules utilized for such purposes effectively exclude those who need help from obtaining care. There is no access to care problem, there is a funding problem.
- The operative word above is "Quality". The remuneration rates for public assistance patients negates any semblance of quality therapy. Its costs my office more to treat a patient at the quality level than the State pays, forgetting about any profit - it's a loss!
- Public assistance/Medicaid does not adequately reimburse providers to care for this population that requires more time and expertise than the healthy dental patient.

Appendix D (Continued)

- I believe our office sees more patients with disabilities than any other private situated office in the 5 county Philadelphia area access issues for many patients are a major issue: including insurance problems and Medicaid not indicating that patient has special health care needs. Many patients cannot find offices "willing to take care of persons with disabilities" within a relatively close distance. We have patients driving from as far as York, PA.
- Depending on the type of care necessary it can be impossible for adult patients on public insurance or adults with no insurance to afford the care needed due to the cuts to spending
- The reimbursement rates for those with Public insurance is terrible. This is even more true for the disabled because their treatment generally involves longer time periods and requires a greater number of staff personnel to ensure safe treatment.
- Insurance companies have sent notification that persons over 18 will no longer be covered in a pediatric dental office. We are no longer providing care for patients over 18 regardless of disability. I do not know where they will have access.
- People with no insurance and the ability to pay should have no problems, with NO ability to pay a big problem and with some ability probably a small problem.
- Not enough pediatric dentists in region.
- Patients without insurance or money have difficulty with access to dental care.
- Hard to find a doctor with in their coverage if it is beyond my level of treatment with Medicaid insurance.
- Huge lack of trained professionals. Little regard for caring for this population.
- More dental offices don't accept insurances because the compensation is so low that it doesn't cover the materials used or staff needed.
- Legislators in Pennsylvania are not sympathetic to the plight of the handicapped and refuse to pay a fair fee for the rather difficult treatment of the handicapped. It takes three times as long to provide treatment and the fee associated with procedures is 60% lower than my actual cost. If fair fees were paid all of the problems would go away as we cannot afford to treat all disabled patients for free. I sincerely doubt this will ever change in PA as legislators and administrators do not care. The amount this survey costs should have been used for treatment of a few patients as it serves no purpose and no change as I have filled it out several times through the years and the problem still exists because of the lack of any governmental response.
- Dental services are expensive. Access is dependent on insurance for most people. The disabilities themselves are not generally a barrier.
- Dental care is available to all people. There are many dental practices, hospital clinics, and dental and hygiene school programs available for all socio-economic groups. We see many patients who wait to receive treatment until the situation is emergent and treatment options are limited and expensive. Regular dental cleanings, exams and x-rays are affordable. More people need to make it a priority and part of their general healthcare.
- Unless the reimbursement rates go up for Welfare I do not see myself or other dentists participating for very much longer.

Appendix D (Continued)

- Few offices can afford to accept Medicaid reimbursement. Payments are too low
- Unfortunately, it's very difficult to efficiently give care to special needs population. And therefore it's more expensive than the general population.
- CHIP basically covers dental procedure but not anesthesia. In rare cases the child with CHIP doesn't need a full mouth restoration procedure under general anesthesia. More often than not the patient can't afford the out of pocket expense and I'm sure if or how these kids get treated.
- Limited dentists accepting public insurance plans. Extremely few specialists in area.
- The most prominent feature for ease of care is perceived need. Many people will not take the time to acclimate the disabled person to the treatment facility. There is no regular care, they are only presented when there is pain. Their ability to handle the situation is lowered and the appointment becomes increasingly stressful for all involved
- The problem we see is that some clinics do not take the time necessary to treat special needs with comfort. The current access structure of "encounters" makes it impossible to treat multiple needs in one setting in any concept other than full fee for service. Special Needs patients require a Special Touch
- A lack of specialists in the area leads to a large problem in completing treatment plans.
- There is plenty of open chair time for patients that can pay for treatment. A clinic needs to set up as a business model to be able to make Medicaid and CHIP participation viable. Reimbursements and hassles of payment from the state are too great to easily integrate into a fee-for-service practice model
- I work in a dental underserved area and local dentists are not accepting welfare. Currently, I have no oral surgeon to refer my Medicaid patients to unless they are under 21 and have 4 impacted third molars b/c I believe that can get billed medically. But I have patients with only 1-2 teeth...where do I send them, Pittsburgh? They'll never get there. I see the future need to buy advanced oral surgery equipment to provide care for these patients b/c they need a solution not a "call your case worker" answer.
- Access is not the problem financing is.
- the "welfare clinic" in my immediate area has a very poor reputation; I am repeatedly told that the staff is extremely rude, the wait times for emergent problems is horrendous (months!!!!) and we have to try to find places for them to call...They perceive the quality there is low and the staff DO NOT CARE.
- Care is available for most people, but ability to afford services I cannot address.
- Access to care is a huge problem. Dental care has become unaffordable for a huge number of people.
- Most people do not value their Dental Health and therefore do not seek preventive care.
- Lancaster County Dental Society has partnered with Saint Joseph Health Ministry and Lancaster General Hospital to form DALCO, a program that places low income adults without dental insurance in a private dental office that becomes their "dental home." All treatment is donated.

What factors impede you from providing or expanding services to persons with disabilities?

- Insurance companies not understanding the extra effort and time it takes to treat individuals with disabilities and not willing to adjust reimbursements to reflect that extra care that needs to be provided.
- The office is not able to provide sedation for patients due to the cost involved with setting it up in our office as well as maintaining it. Our office treats a large number of state funded patients and the reimbursement levels do not allow for extra cost and overhead. Also, we have a very large patient base and finding dentists to work in Erie County, PA is very hard. We are currently looking for 2 full time dentists and have been looking for quite a while.
- It takes a huge amount of resources and time to treat patients in the operating room. Many times the reimbursement for these cases is \$30-40 for the dental care especially since we are no longer being paid for scaling and root planing. These cases take a tremendous amount staff time and take an entire day out of the office to treat. It is becoming cost prohibitive to provide this care. The more and more of the financial burden is being taken on by the dentist. Fees have not increased in years but cost keep going up.
- Disabled patients require on average 50% to 100% more time than and non-disabled, and reimbursement is so low we often can't even break even on costs when treating. Also lack oral surgical care for these patients. May have to travel 60-100 miles for oral surgery appointment.
- Inability to contract with anesthesiologist to provide IV sedation in a Long Term care facility
- Patients may have federally funded HMO insurance but the primary physicians take one kind of HMO which the Penn Dental School do not take.
- It is very difficult to treat these patients. The reimbursement is totally inadequate.
- At my age (59) cannot physically handle operative procedures outside my normal envelope of positioning, strength and endurance.
- Office not equipped to handle uncooperative patients.
- Practice owners do not want to accept public insurance, do not have hospital privileges to see patients who require general anesthesia in a hospital for treatment.
- Not able to do deep sedation. May change soon.
- Lack of public transportation and community services.
- The high no show rate and low reimbursement levels for many of the state funded plans are definitely two major factors that have caused us to decide to not accept those plans. There is a high need for an office that does accept those plans that can see those patients in a timely fashion.
- We are a safety net clinic-we see anyone with PA Medicaid or managed care. If we need to refer, we facilitate referrals and communications. Most family members/care givers are very grateful for care rendered here. My biggest concern is the debate about restraints used with consent and guardian present. As managed care denies more sedation/OR cases, restraints used properly are needed. The state could present a definitive protocol for use of restraints.
- I have NEVER refused to treat a patient because of mental/physical disabilities. I also see a number of patients each year who are unable to pay for my services.

Appendix D (Continued)

- Persons with disabilities do not seem to be seeking care; we get very few inquiries.
- We treat those that call our office and are a candidate for treatment.
- Not equipped or licensed to provide general anesthesia, IV sedation or nitrous oxide sedation.
- Not handicap accessible for large wheel chairs.
- No ability to use conscious sedation or gen anesthesia.
- Paperwork and barriers of the system! It is not a problem with willingness it is a problem with the red tape, the paperwork, the system that requires specialists to treat, the poor reimbursement for the difficulty involved, and the lack of appreciation from the state or the system.
- A lot of patients need to be sedated. Requires specialized training.
- Inability to sedate.
- Routinely patients with specialized needs require considerably longer appointments. There is increased risk of an adverse event relative to transferring the patient to the dental chair and positioning them during a procedure. For certain procedures, infection control protocols advocate minimizing the number of individuals in the dental operatory (i.e. surgical procedures).
- We evaluate all patients with disabilities to see how to best take care of them. We use Surgicenters and Hospital if necessary to provide care under general anesthesia and we do in office sedations
- There should be reimbursement for the additional clinical time required for special needs patients having sedation services. Safely providing these services require additional recovery time, recovery area, and trained monitoring. These costs are deflected to the dentist and are a barrier for providers who would otherwise treat these patients.
- I treat anyone, but some individuals may require sedation greater than Nitrous Oxide. I refer patients to Pitt's dental school, specifically the clinic for Special Needs, I believe this area of the dental school is the best services offered to the community
- Difficult to move patients to and from wheelchairs or to work on them while in a wheelchair. Difficult to work on patients who are retarded or otherwise mentally impaired and cannot follow instructions or communicate well. High cost and risk of liability associated with offering conscious sedation/general anesthesia
- Most of the individuals living in these centers, their motivation and understanding toward the importance of oral hygiene measures (brushing and flossing their teeth) is poor. Some of them are combatively uncooperative which make their basic dental care a great challenge, so we use sedation and physical support on their heads and hands to render our dental care on those individuals.
- A cooperative patient can almost always be treated without significant difficulty. State provided insurance plans tend to have low reimbursements and have limited coverage making a full range of treatment unavailable. Additionally, state plans tend to force providers to "jump through hoops" in order to get claims paid. Claims payments should be similar to current private industry standards.
- Lack of anesthesia services i.e., conscious sedation or general anesthesia in my office

Appendix D (Continued)

- People with disabilities almost always show up. It's the young one with kids who are irresponsible as a group. It'd be nice to get paid better, but the real problem is hours in the day.
- Besides Pitt, our office in Slippery Rock, PA sees a substantial volume of patients with special needs. This is facilitated by having three or more anesthesia providers on site at any point in time.
- My own tolerance level has decreased as my practice has matured. Getting angry with persons that have a diminished capacity to understand is counterproductive. It is best for all involved to refer these more difficult cases to those willing and able to succeed
- Some dental treatment on patients with special needs just cannot be performed without some type of sedation, so I am limited in that respect.
- Treatment of Special kids and adults requires time and passion and carries a bigger labor cost and materials challenge.
- It seems difficult to acquire advanced certifications in the state of Pennsylvania (i.e., the ability to utilize nitrous oxide, etc.). Also, these Nitrous type courses are very expensive and it is difficult to get the time off work.
- It depends on what the disabilities are and what care is needed.
- Have not experienced the need to expand these services.
- Degree of disability may require sedation. Nitrous oxide won't help. IV or inhalation sedation is needed, which we don't do. We would have to bring in an anesthesiologist which would be cost prohibitive to the patient.

What steps do you think the Commonwealth could/should take to increase dental services to persons with disabilities? Please also indicate how helpful you think such a step would be.

- Better reimbursement for sedation and general anesthesia administered in the office.
- Do not contract with entities that will not pay either dentist or patient for services performed upon them. Change claim form.
- Best solution in my opinion is regional centers staffed to care for these patients and with 1-3 mobile vans attached to the center and going at a hospital on regular basis for routine and preventative care.
- Please remove the 3rd party contractors/Medicaid HMO/Medicaid DMO and streamline payment and preauthorization process. Allow or approve General Anesthesia coverage without much complicated process. Let us have an open communication with the Medicaid by appointing a patient and provider advocate.
- I really see the biggest hurdle is that the dentists cannot be adequately compensated for the time that is needed to spend with this patient population. The population is growing and the people willing to help is diminishing.

Appendix D (Continued)

- Perhaps fund a pilot project in collaboration with Temple Dental School with the objective to specifically train dental therapists to work with Special Needs patients. These dental therapists could serve as a productive team member for the dentist and the hygienist.
- Current Medicaid payments do not cover overhead expenses. Most treatment is being done at the expense of the dentist. Even insurance reimbursements have not increased since 2008 to keep up with the overhead cost increases. Dental offices are being squeezed due to high overhead and low reimbursements. Record keeping, legal issues, governmental policy requirements including the reporting of potential "child abuse" in cases where the children have more caries from "baby bottle syndrome" to welfare agencies, all require additional time be spent by the professional and support staff to provide the required reports. This takes away from treatment time available. Legal issues are also a problem for general dentists. We have to refer patients out to specialists, mainly pediatric dentists, when there is a patient with cognitive impairment, developmental or physical disability, or mental illness or disability that we may not have the expertise to treat.
- The best location for this type of oral/dental treatment for patients with severe medical, physical and mental disabilities is in a hospital dental department staffed by experts with special hospital residency training.
- Expand covered services for adults to include endodontic and crown services.
- Anesthesia services are very important for facilitating dental care of many persons with disabilities.
- Sadly, the financial issue comes into play with dentists' rejection of Medicaid reimbursement. This is a governmental budgetary issue, not a dental practice one. If you paid fairly, more dentists would participate. Unfortunately, our government can't afford to pay for expanded care since no one wants to pay more taxes, let alone pay off our current debt. This is a political issue which shouldn't be left for dental practitioners to bear the burden of the cost alone.
- Trying to get authorization to provide emergency treatment of an autistic child with a severe dental infection who is insured by Gateway can take up to a week of phone calls and fax submissions. My staff typically spend more time jumping through all the insurance approval hoops than the time I need to actually treat the patient. This is a major contributor to the soaring costs of health care (I have twice as many administrative staff as surgical staff for this very reason).
- How about some form of tax break, or a program that gives us access to lower overhead (supplies, utilities, etc.).
- Would think it would be easier to have the facility and have dentist come to a centralized location and serve, also have staffing of accessory personnel there.
- Regional centers should be centered toward maximizing patient treatment as opposed to academic centered focused on training.
- Hospital based residencies are best training. Increase funding for hospital based residencies.
- Help fund facilities where patients can be put to sleep for management of difficult patients who have any of the full range of disabilities noted above.
- Loan repayment programs would be a great way to get coverage for patients with disabilities. Maybe a one for one coverage \$1 reimbursement - \$1 of loan forgiveness.

Appendix D (Continued)

- If dentists want to treat patients with disabilities there are CE courses available.
- Most dentists and hygienists are not exposed to these people in dental education, they are kept away from them. That problem needs to be addressed first if we want more practitioners to get involved.
- Pennsylvania already has three dental schools, and many schools of dental hygiene. Fund those. There is no need for new institutions.
- Many special needs patient have HMO dental coverage. The state cannot expect the dentist to pay for the care of HMO patients. Only the government can operate at a financial loss.
- Require CE in the area of Special Health Care Needs Dentistry to include Geriatric Dentistry. Similar to the required CE for Anesthesia permits
- Work with PDA to establish partnerships for volunteer care in local hospitals.
- Training the dental community and making treatment affordable for the provider as well as the patient
- I think the training is there. There needs to be a special reimbursement for this group. The office time they consume is huge, and the reimbursement for the cleaning is \$37. No thanks
- My biggest problem is not the level of reimbursement (although it could be better) but the constant stream of denials and other administrative hassles with trying to get treatment approved. It seems like every pre authorization sent is routinely denied. Approvals are hard to come by without multiple appeals.
- If I were allowed to limit my participation in medical assistance programs to special needs children then I would absolutely participate. I do not wish to open my practice to all children on medical assistance because I am a participant in CHIP. I have not opted to take medical assistance since I cannot limit which patient population I see.
- People are only going to do it if they WANT to and can still make money by seeing these patients. If taxpayers pay for regional training centers, who is going to run it? I feel that the cost of operating and running such a facility would be too much and there would be too much bureaucracy involved. The ADA should and most likely does have CE courses available for those who are interested in performing treatment.
- More flexibility with reimbursement of behavioral techniques and increased time
- Specialized training in treating people with very severe disabilities
- This was the role of the former State Dentist to plan, develop, and implement programs for sub populations of oral health disparities. Currently, we no longer have programming but only entitlement insurance administration. We call this downstream disease management and not prevention due to lack of trained Commonwealth State Dentist from the Dept. of Health.
- I also believe that patients with disabilities should be approved with a BLE form for recommended treatment such as Root Canals, Post's, and Crowns so that the patient can restore masticatory function then to remove the teeth. It is wrong for the insurance representatives to tell the patients that there are other alternatives to the denial of the BLE like pulling the teeth since they are denied for the treatment advised by their dentist.

Appendix D (Continued)

- Opening centers to treat disabled patients would help the patients given them the best care and employ Dentists who need work.
- Dental Hygiene Practitioners cannot diagnose diseases.
- do not tax reimbursements to providers to inc business increase fees to specialists to allow general dentists to refer for better treatment options
- Work with dentist to fund equipment purchase, staff expansion, and practice development for incorporating special needs patients. The real thing is this. These patients take more time to treat, some need sedation but do not get it because of the hassle to get equip, get increased malpractice coverage and then probably not going to get reimbursed for all that effort. Without cbct machines that acquire a lot of info in one scan and reimbursement incentives of some kind it is not a good roi. I buck the trend in that I prefer welfare patients and currently have done root canals for free b/c upmc welfare does not cover root canals on people over 21. But I have single moms that have front tooth abscess and I will not allow an ins co to dictate my responsibility to my patients. I have also done a single implant for free in another similar case. But I know of several others that should receive high tiered treatment like down syn patients with dentures that will not staying b/c of palatal anatomy assoc w/ that syn. I see mini implants being a huge cost effective benefit. The state should offer a program tied to a dental implant co and offer free advanced dental ce in placing implants for only Medicaid and via patients to dentist. A win-win program. Dentist gain hands on training with in the state and patients receive care they need. Things like this is the only way you will motivate a dentist in PA that has ample private pay ins patients to ever take on more of a load for little financial benefit.

Please provide any other comments about any barriers that may prevent your clinic from offering care for persons with disabilities or any policies the Commonwealth could adopt to improve dental services for such patients.

- A facilities fee is necessary for adult special needs patients who require sedation.
- Inadequate reimbursements for services performed.
- Increased compensation for additional time required, special training needed, special equipment needed, etc.
- Assist the dental offices in setting up their practice for nitrous oxide and other sedation and compensate them accordingly for treating these patients. Offer incentives to newly graduated dentists to help pay off their student loans if they contract at an office like ours for a period of time to be determined.
- It is a very rewarding group of patients to treat but it is time intensive. Since there are so few providers willing to work with this population, those providers that do see this group are completely overwhelmed.
- We do not see patients with moderate to severe disabilities due to the nature of orthodontics and the daily cooperation needed for treatment.
- Very complex problem. Societal in nature. Dentist and patient alike. Regional centers for dental training sounds helpful, increase exposures in dental and hygiene and assisting schools.
- Create a course in dental school. I have asked to no avail.

Appendix D (Continued)

- We do not sedate patients here as of yet.
- Use Physical Therapists to train dental personnel on proper transferring techniques.
- Overhead costs for dental practices are creating a big problem for future treatment of any kind. It especially impacts services for those with special needs.
- The reimbursement system is a mess.
- I have spent my career in hospital dental departments and there is a shortage of trained dentists who can care for the oral/dental needs for the growing population of patients with severe medical disorders such as transplant patients, patients receiving cancer chemotherapy, etc. Support for training of dentists and hospital dental departments would go a long way to help these patients.
- I am the end of my career. I do not recruit patients with disabilities but I perform oral surgery for many older patients with significant medical disabilities. Low function Cognitive and severe behavioral disabilities are referred to specialty centers.
- Transportation is available on para transit but is difficult for many people.
- Anesthesia services are very important for facilitating dental care of many persons with disabilities
- The barriers are multidimensional. Help is needed greatly.
- Our office is not fully handicap accessible. We do not have chairs that are easily transferred to, along with small treatment rooms.
- If other dentists participated, I would too, but you should not only be covering our costs of treatment, but we do deserve a salary for our work, let alone minimum wage. In either case, good luck!
- We see a number of patients with both physical and mental disabilities. Limiting the plans that patients are eligible for because of their disabilities is a source of frustration for both myself and the patients that we are willing to treat, but cannot because they can't be covered under an accepted plan, i.e., they are automatically placed on Medicaid/Access just because they are Autistic, instead of having them on the CHIP program like their siblings are.
- Provide a definitive protocol for use of restraints and cover complying facilities/dentists against suits. Investigate the massive denials of sedation/OR procedures by Medicaid managed care.
- We keep hearing how dentists need to do more, but this is a PUBLIC problem; but no one is pressuring dental suppliers or utilities or anyone to lower overhead. It is a difficult population to treat; requiring more time, more training, specialized equipment and supplies that costs more money. There should be a way to share or reduce the burden.
- It is primarily due to the very poor compensation.
- Include funding for outpatient dental anesthesia services for procedures done in facilities or private offices outside of the hospital.
- Dentistry is very dependent on its physical equipment. If there would be a facility that is set up for the additional requirements, it would then allow the dentists to just do the dentistry.

Appendix D (Continued)

- Many of these cases require general anesthesia and hospital admission in a facility prepared and equipped for dental restoration and surgery. I had some experience with this 37 years ago at Waterbury Hospital in Connecticut. It was difficult, time consuming work and it is in my opinion not very compatible with a typical general dental practice. This work needs specialized teams and public funding and must be based in community hospitals.
- Would be willing to donate time to work for low reimbursement once or twice a month at a centralized location. I believe it would be easier to get dentist to do this than to make it a full-time practice or to make the necessary changes to their existing facilities and staff.
- 1. Main stream reimbursement. 2. Reimburse transportation costs for patients & caregivers.
- Improve reimbursement for dentistry in operating room for those severe ill patients who need it.
- I won't be able to continue to work without the Pitt School of dental medicine remaining in operation.
- It seems hard to throw a blanket over the entire population. As always, it comes down to \$ and time from the adults.
- Even though reimbursement is poor, you couldn't reimburse me enough to cover the toll it puts on my body, mind, staff and the extra costs to the physical structures.
- Most if these patients are on Medicaid. I used to see quite a few of these patients while in private practice. There is a code that could be used to get a little extra money from Medicaid that I would use. When they audited my records one time I had to pay the state back because they said it wasn't necessary. They weren't the ones working on these patients. The state thinks you should do the work for free.
- The rate of reimbursement needs to be in line with the amount of time needed to treat the patient. This may not be the same as a regular fee schedule.
- It would take some creative planning, but since Pa can only add limited additional money to this issue, aren't there any other ways to incentivize greater numbers of dentists to participate such as tax reductions or relaxed regulations?
- Too many state bonehead rules.....tough to get paid!!!! State workers get paid every week!!!!
- You need to make the reimbursement level at least cover overhead costs. I do not mind offering my time gratis but your level of reimbursement does not even cover my cost to open the door. It should not be that burdensome. The paperwork is ridiculous and the appreciation from the state are not worth mentioning because there is none.
- Reimbursements rates must be much better to allow it to work for providers.
- I would welcome additional training to provide treatment to persons of all types of disabilities, from older age dementia to younger age developmental issues. Please provide this training. I am worried about future nursing home care for patients with teeth.
- Accessible Dental (a program based out of the Pittsburgh area) was traveling to The Sullivan County Dental Clinic where I volunteer. It lost its certification to see MA patients when the MA program was restructured, thus losing the ability to see special needs patients.

Appendix D (Continued)

- The primary point of service for special needs dentistry are Pediatric Dentists. A dental specialty the state of Pa does not even recognize. The state of Pa must realize it cannot provide service for among the most difficult patients with a reimbursement that is a pittance.
- Time is money. Reimbursement is low and often time required is more than normal. This equates to donated services because of a failure to financially compensate adequately. This limits access to care. There is a limit where you cannot donate more.
- Patient cooperation, responsibility, and attentiveness to high level of plaque removal, oral hygiene on a daily basis is paramount to successful periodontal (my specialty) therapy. This is difficult to achieve with competent, interested, and "I want to keep my teeth" patients.....by far, the most frustrating aspect of 48 years of periodontics.
- Extremely low reimbursement rate allows you to basically operate at cost or a nonprofit organization.
- The biggest problem is reimbursement. These patients take longer to treat - it takes more time to get them into the chair, it takes longer to get a good medical history, it take longer to do the work. Practices that take Medicare are based on doing volume to make up for the low level of reimbursement, and seeing patients with disabilities just slows that down and is not feasible for most providers.
- Adopt the standard ADA form and codes for reporting dental services.
- 1. Identify patients with SHCN on Medicaid insurance forms and pay a higher fee schedule for taking care of them. 2. Require Dental schools in the state to provide courses both didactic and clinical (and have a SHCN Clinic) for all students before graduation - I do not believe that either Temple or Penn has these courses
- The survey touches on a very complex set of topics including what is your definition of disability, fair or profitable level of reimbursement for working on very complex patients, and the increasing burden of regulation interfering with actually trying to do something to help these patients. Streamlining and simplification of the dental medical assistance program would be a start, encouragement of proper training and licensing of safe use of sedation in general practice would be another big step in helping patients get the proper care. Many patients with disabilities can be treated quite adequately and simply in the office but the reality of dental practice is that the young dentists have massive education debts, the equipment materials and supplies, cost of labor, HIPPA, malpractice insurance, and gov't. rules and regulation make it almost impossible to thrive.
- We do not sedate.
- I really wish that more general dentists would outfit their offices and pursue training for the treatment of patients with special healthcare needs. As a pediatric dentist, we open our doors to all patients with special healthcare needs. At some point, however, the needs of the patients are beyond our scope of practice and finding a general dentist to transition them to has been a challenge.
- Primarily, it's the lack of or low reimbursement rates.
- CHOP administration and by laws are a big impediment.
- Expand benefits to include root canal therapy, post and cores, crowns, root planing and scaling, pulpotomies, perio maintenance (these have been removed from reimbursement). Prosthetic appliances should be replaced one time every five years if necessary.

Appendix D (Continued)

- Require training in treating special needs patients for licensure. Enforce the aw/da laws. Centers for disabled care only breed the idea that it requires special expert training. More training will get more doing if paid well enough to cover extra time needed to treat.
- Prescreen for type of disability and match with appropriate practitioner.
- Adequate payment for the additional time required to provide services to these individuals.
- Educate and hire graduate Dental Aide Coordinators being trained at Temple Dental School to help navigate the disabled and poor to dentists capable of treating these patients and finding them transportation and seeing that they show up at their appointments.
- As a pediatric dentist we accept both Medicaid and chip programs and provide high quality dental series to children and children with disabilities/special needs. We are a busy practice but actively accept new patients. For those who cannot tolerate treatment in a traditional environment we utilize local surgery centers or hospital OR's to treat children on a regular basis. Long term adult patients with disabilities and special needs often continue with the practice into adulthood as they at times have difficulty finding a dentist who is comfortable treating them. For children the commonwealth can do a better job by actively encouraging those patients to seek care from a pediatric dentist who is trained and comfortable with their needs. For those children on Medicaid they are often treated by the dental chains (and receive severely substandard care. These chains pray on this vulnerable population for financial gain and do little to promote the health and well-being of the child.
- Allow us to limit participation to patients with special needs.
- I have limited experience treating patients with disabilities. I had a potential patient call the office who was deaf. They told me I was required to provide them with someone who would interpret with sign language. I researched it and determined that I was required to pay for an interpreter for the consultation (which I normally do not charge for) and for any other future appointments. The fee was around \$150-\$200/hr. to hire an interpreter. The patient ended up not coming to the appointment, because we did not participate with their insurance. If they had come and then started orthodontic treatment, I'm not sure I would have been able to cover my costs (in fact I would probably ended up losing money). I also read, if I didn't provide the interpreter, I could be fined. I'm not sure that I can increase my fee to deal with these costs, especially with the many insurance plans that I do participate with (since they determine the maximum allowable charge). It's a catch 22 and I find it quite unfortunate. As a small business owner, the cost of doing business continues to increase.
- Considered not filling out survey because I don't believe anything is going to change.
- Expanded funding for treatment without limitations. People with disabilities frequently have more dental needs as a result of physical limitations regarding oral hygiene. Decay needs to be treated and the office needs to be compensated at an appropriate level
- Reimbursement levels make it almost impossible for a regular practice such as mine to be able to treat these patients. Most have to go to a public or government funded clinic.
- Perhaps having training in conscious sedation would be helpful.
- Not applicable, no barrier here. The cooperation level on some of our patients is poor (combatively uncooperative) which makes their basic dental care a challenge, even with sedation and physical support on their heads and hands.

Appendix D (Continued)

- State should offer free training in conscious sedation techniques to facilitate treating difficult patients. Offer tax credits to doctors who treat patients with disabilities.
- Every little bit helps in providing care for this population.
- Scheduling problems due to not sure how long procedures will take with some disabilities.
- Get [insurers] to pay us to treat these patients instead of continuously denying care.
- Are you serious, if you don't know the barriers yet, you are truly in the dark ages!
- Most offices are more than willing to accommodate the disabled. Patients with the most severe mental/physical disabilities may not be able to receive treatment in standard dental offices and would need specialized facilities staffed with personnel trained to handle those cases. As dental services are expensive insurance coverage can be a barrier for those patients.
- Have PPO dental insurance for persons with disabilities so they can choose the dentist their families use and feel most comfortable with.
- It will be a cold day in hell when I register as a Medicaid provider again. The system is poorly run and should be dismantled.
- Easy to treat patients are becoming difficult with increase costs and lack of proper insurance payments. Patients that take longer, need extra care, and require special equipment cannot be treated regularly at a private dental office unless the dentist is doing free dentistry and can afford to take a loss going to work daily.
- The reimbursement rate for some of the state funded insurances is so low that we have to limit the amount of patients we see with this insurance. We would be out of business or providing such a low quality of service if we had to rely solely on the insurance reimbursement from the state. I view this as community service due to the poor reimbursement rates.
- Specialized equipment.
- I'm rural, and sometimes transportation can be an issue. Allowing Nurse Anesthetics to administer anesthetic in my office.
- Honestly, it's basic economics. My fees would probably need to be TWICE as much as general population given cost of equipment, staff, training, and increase time to do a procedure.
- Treatment of many special needs patients requires treatment in an operating room setting unfortunately the reimbursement often does not even cover the cost to send the doctor to treat.
- Payment for Services Rendered, especially long hospital cases.
- Too much red tape and hassle to schedule difficult, unmanageable patients to be done in the OR.
- Many people with disabilities are unable to be treated in ambulatory settings. Whether that is due to the extensive nature of their dental problems or the ability to sit still for prolonged time periods. It is difficult enough to treat "normal" patients at times. These persons require sedation and full treatment in a controlled environment-- general anesthesia is often the only way to properly treat these people. Yet this is the area that has been curtailed the most due to cost savings or mainstreaming objectives

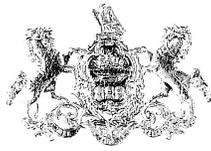
Appendix D (Continued)

- We treat many patients with disabilities at no cost or reduced cost. The "red tape" and lack of autonomy involved with seeking re-imbursement through Medicaid and other public assistance programs is not worth the fees covered by these services. We would rather provide free dentistry to people in need than deal with the obstacles involved in trying to be reimbursed. This limits the number of patients we can see this way. Providing business tax incentives or less complex re-imbursement programs would allow more dental practitioners, many of whom already have the training to treat persons with disabilities to do so.
- Regional centers could be established to treat the truly disabled i.e., physical and/or mental where treatment options are 3 hours away at this time. Options currently exist for patients who do not have insurance. Offices in county extend payment plans, however, most patients do not want this. They want minimal or no cost treatment. If you go to a grocery store, the store doesn't let you walk out without paying, so it is with dental offices. Fair compensation is asked.
- Bureaucracy of dealing with Medicaid and very low reimbursement.
- The access to care issue for disabled involves having offices that can adequately sedate them and adequately reimbursing those offices for these high level services. Severely discounted payments for a higher level of services is a way to ensure an access problem. If the reimbursement is worthwhile you will get more doctors willing to provide these more demanding services.
- Town hall meeting or focus group to discuss Commonwealth improvement for those professionals who are treating a number of disabled individuals.
- Reimbursements need to be appropriate to allow skilled practitioners to train and focus practice on persons with disabilities.
- Eliminate some of the Government regulation. I was a longtime member of Medicaid for years but gave it up due to all the "red tape"
- Specialized training and compensation are the keys to open doors for the disables.
- Mainly financial.
- Practice overhead can be very high and many times in the past it has been difficult to cover overhead.
- Put more money into dental reimbursement.
- Do NOT want more as patients.
- Lack of training and specialized equipment.
- Facility, cost of care.
- In my 60s, practice at capacity. Not enough hours in the day.
- It is difficult to be not only the taxpayer who funds the program but also the provider of the services and then essentially "donate" my services to the Commonwealth because dealing with DPW can be so difficult.

*Does not include all responses.

Source: Responses to Legislative Budget and Finance Committee questionnaire to dentists in Pennsylvania.

APPENDIX E
Response to This Report



RECEIVED NOV 04 2014

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OCT 21 2014

Mr. Philip R. Durgin
Executive Director
Legislative Budget and Finance Committee
P.O. Box 8737
Harrisburg, Pennsylvania 17105-8737

Dear Mr. Durgin:

Thank you for sharing the Legislative Budget and Finance Committee's (LBFC) report titled "Dental Services for Persons with Disabilities," and allowing the Department of Public Welfare (Department) to submit written comments. After careful review of the report, the Department offers the following comments regarding the findings in the LBFC's report:

- **Adults with disabilities are much less likely to qualify for comprehensive dental services.**

The Department implemented limitations on adult dental benefits in 2011 as part of a budgetary cost savings initiative. Many states do not offer dental benefits, which are optional under federal Medicaid regulations. Pennsylvania, however, has maintained the core dental benefit to ensure the health care needs of the Medical Assistance (MA) population are met. Prior to implementing the dental benefit package changes, the Department closely evaluated the utilization of, and payments for, particular dental services to determine which services could be eliminated with minimal impact. The changes had no impact on over 96 percent of the total MA adult population eligible for dental benefits who received services in that fiscal year. To further assist with the goal of minimizing the impact of these changes, the Department implemented a benefit limit exception (BLE) process. The Department grants a BLE to a dental benefit limit when it is determined that the beneficiary has a serious chronic systemic illness or other serious health condition and a denial of the exception will jeopardize the life of or will result in the rapid, serious deterioration of the health of the beneficiary. A BLE is also granted if the exception is a cost-effective alternative for the MA Program or is necessary in order to comply with federal law. Individuals with disabilities or conditions that meet the BLE criteria and are approved by the Department will receive the requested dental services.

All MA eligible children, including those with disabilities, receive medically-necessary dental services. MA eligible adults with disabilities receive core

preventive dental services, which are in line with commercial dental plan benefits. MA eligible adults with disabilities may qualify for additional dental services if the severity and symptomatology of an individual's disability meets the BLE criteria.

- **The federal Affordable Care Act requires insurers to offer a dental plan, but does not require consumers to purchase it.**

The ACA includes dental services for children under 21 years of age as an essential health benefit, but does not require this for adults. The LBFC Survey Report indicates the same on Page 8, "Insurers do not have to offer adult dental coverage."

- **Thirty of Pennsylvania's 67 counties had no dentists in the MA fee-for-service plan that indicated they were willing or able to accept a special needs patient.**

The report is subject to erroneous interpretation of the information contained on the Insure Kids Now (IKN) website. First, the report limits the findings to information supplied for the Fee-for-Service (FFS) delivery system of the MA Program only; Pennsylvania has statewide managed care, most of our covered lives are within a managed care setting.* Exact distribution ratios, between the FFS and HealthChoices managed care delivery systems, for beneficiaries with disabilities are not available (because there is no standard identifier available for all disability categories). However, there are sizable population cohorts of special needs patients in both delivery systems. Ignoring the managed care networks artificially diminishes the geographic distribution of service delivery sites. In addition, the assumption was made in the report that the data on the IKN website is provided by the dentists and indicates their personal responses on capacity/willingness to accept new patients and/or accommodate special needs patients. That is not the case. The Centers for Medicare and Medicaid Services (CMS) requires the Department to submit the data on a quarterly basis to a central repository for uploading to the IKN website. To avoid an extremely expensive and administratively onerous process for both the Department and the participating dentists, the Office of Medical Assistance Programs reviews claim data and populates the corresponding fields for those FFS dentists who have submitted actual claims for either a new patient examination or a behavior management service. This helps to ensure that "false positives" are not published on the website. However, the process does tend to diminish the accounting for dentists who treat persons with disabilities, especially those with less severe disabilities that do not require higher levels of accommodation in time or behavior management.

*LB&FC note: The report notes the limitations of using the fee-for-service numbers and states that the information "...should be viewed as illustrative, not comprehensive."

- **Pennsylvania has many clinics that provide free or low-cost dental services to persons with disabilities.**

Not all clinics offering free or low-cost dental services participate in the MA Program, but Federally Qualified Health Clinics, Elwyn and Special Smiles, Ltd. do. Special Smiles was created in 2001 through a cooperative effort of MA participating dentists and the HealthChoices managed care organizations (MCOs) in the Southeast Zone.

- **Pennsylvania's dentists report that providing dental services to persons with disabilities is a multi-faceted problem.**

The Department agrees with the opinion of the survey's respondent dentists as to the multi-faceted nature of the challenges involved in providing dental services to persons with disabilities. Although the level of compensation is somewhat less than commercial insurance rates or dentist's full fees, it is important to note that the Department raised fees five times in the past nine years for dental services.

- **About 70 percent of dentists responding to our questionnaire indicated they would be willing to treat special needs patients.**

It should be noted that the sample of respondents to the survey contains a disproportionate share of dentists who participate in the MA Program (40 percent, second question/table, Page 32). This would lend some credence to the inference that the dentists responding to the survey were most likely dentists who have some personal experience, interest and commitment to treating special needs patients. It has already been noted that comparison to percentages calculated using the IKN website data is subject to a skewing toward minimization where willingness to treat is concerned. In a special needs survey of MA participating dentists conducted in 2010, 82 percent of respondents (757/927) indicated that their practice included patients with special needs (particularly patients with developmental disabilities). The LBFC report states that 90 percent of responding dentists in the LBFC Survey Report say they have experience treating the four types of conditions/disabilities listed, but in every case the number of dentists who are willing to accommodate patients with the same disabilities falls off by more than 20 percentage points. This may relate to the significant number of comments that willingness would be dependent on the level of disability. Approximately 17 percent of survey respondents skipped that question.

Specific to the recommendations included in the LBFC's report, the Department submits the following comments:

- **The Department of Public Welfare revert to pre-2011 Medicaid dental regulations with regard to the type and frequency of services allowed for adults with disabilities.**

Many states do not offer dental benefits, which are optional under federal Medicaid regulations. Pennsylvania, however, has maintained the core dental benefit to ensure the health care needs of the MA population are met. Prior to implementing the dental benefit package changes, the Department closely evaluated the utilization of, and payments for, particular dental services to determine which services could be eliminated with minimal impact. The changes had no impact on over 96 percent of the total MA adult population eligible for dental benefits who received services in that fiscal year. To further assist with the goal of minimizing the impact of these changes, the Department implemented a BLE process. The Department grants a BLE to a dental benefit limit when it is determined that the beneficiary has a serious chronic systemic illness or other serious health condition and a denial of the exception will jeopardize the life of or will result in the rapid, serious deterioration of the health of the beneficiary. A BLE is also granted if the exception is a cost-effective alternative for the MA Program or is necessary in order to comply with Federal law. Individuals with disabilities or conditions that meet the BLE criteria and are approved by the Department will receive the requested dental services. All MA eligible children, including those with disabilities, receive medically-necessary dental services. MA eligible adults with disabilities receive core preventive dental services, which are in line with commercial dental plan benefits. MA eligible adults with disabilities may qualify for additional dental services if the severity and symptomatology of an individual's disability meets the BLE criteria.

- **Allow dentists to receive Medicaid reimbursement for key preventative services at a greater frequency than for the general Medicaid population.**

There are already mechanisms in place for allowance of case-by-case consideration of such requests. CMS has been very clear in its policy interpretation that Medicaid programs may not be disparate in service coverage based on groupings within a specific population, i.e., the categorically-needy or medically-needy adult populations.

- **Increase the amount of Medicaid Dental Behavioral Management supplement and the number of visits allowed.**

The number of visits for which the Behavior Management supplement may be available can currently be increased by request for a BLE with demonstration that additional appointments are medically necessary to treat any individual with a qualifying disability. There is no evidence in the survey that a \$50 increment will

be sufficient to spur any increase in overall participation by dentists in the MA Program or motivate acceptance of special needs patients into any additional practices already participating.

- **DPW build on the Special Smiles, Ltd. Model to help establish specialty dental clinics in other areas of the Commonwealth.**

The Department is open to such discussions involving committed oral health professionals and our HealthChoices MCO partners.

- **DPW work with its physical health Medicaid Managed Care Organizations to allow reimbursement to dental facilities treating special needs patients who are living in residential facilities outside their Medicaid MCO's geographic boundaries.**

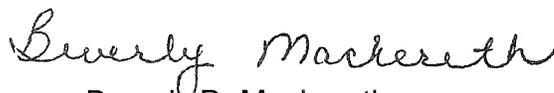
The Department already has a process in place to address this concern. MA beneficiaries already receiving benefits in another county, or the payment name on the case, should have the County Assistance Office initiate an inter-county transfer to the new county of residence so that MA benefits can continue to be received.

- **The Pennsylvania Developmental Disabilities Council (PDDC) takes the lead in meeting with representatives of Pennsylvania's three dental schools to explore the training needs identified by Pennsylvania dentists.**

The Department has and will continue to encourage such overtures and training enhancements. We respectfully request that the Department's comments be submitted to the LBFC for inclusion as an addendum in their final report.

The Department appreciates the opportunity to comment on the LBFC report. If you have any further questions regarding the information provided in the report, please contact Ms. Christine Seitz, Director, Office of Legislative Affairs, at (717) 783-2554.

Sincerely,



Beverly D. Mackereth
Secretary

c: Ms. Christine Seitz