# Challenges in Boston EMA and MA

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# HIV Dental Ombudsperson Program (HIV DOP)

- Created in 1990
- Comprehensive oral healthcare access program for Boston EMA under Part A
- Funding from MDPH to expand to entire state

# Disclosures

•Helen Bednarsh has no financial interest or relationships to disclose.

•HRSA Education Committee Disclosures
HRSA Education Committee staff have no financial interest or relationships to disclose.

• CME Staff Disclosures
Professional Education Services Group staff have no financial interest or relationships to disclose.

# Objectives

By the end of this session participants will be able to:

1. To describe HRSA oral health programs

2. To discuss how HRSA oral health programs affect HIV oral health care

3. To identify potential partnership opportunities between HRSA oral health programs and Ryan White funded programs

# Major Activities

- Enrollment
- Referral
- Reimbursement
- Education (consumer and dental professional)
- Client Advocacy

# Goal of HIV DOP

- Reduce/remove barriers to care
  - Financial
  - Stigma
  - Disclosure

  Identify qualified dental providers and ensure they receive annual training and updates

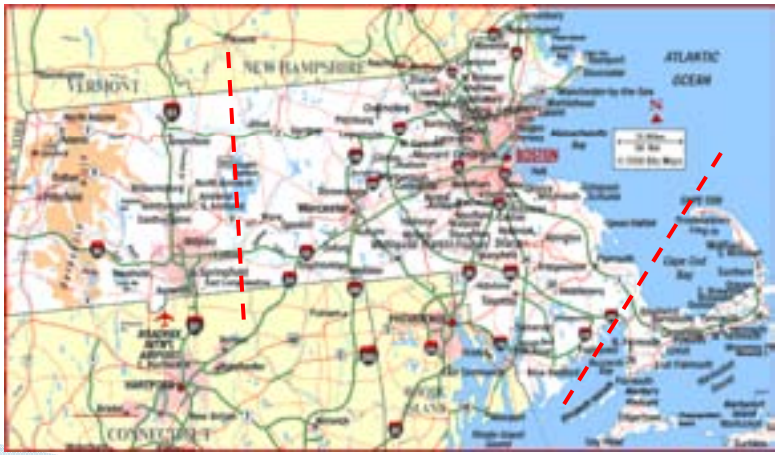
  Provide access to specialty care and consults

# Model

- Public and private network of dental providers
- Individual arrangement with providers on referrals (numbers and method)
- Payor of last resort
- All claims and prior approvals for care are processed in-house
- Case management process for client enrollment, verification of eligibility and referral to a dental provider.

# Program expansion

- Years 1-4 Boston EMA which expanded yearly in the greater Boston Area
- 1994 an inner and outer EMA was established to include 3 counties in Southern NH
- 2000 expanded to include MA counties not within EMA such as Cape Cod and Western MA



# Maximizing Funding

- Payor of last resort after any private or public third party payor
- Maximized use of adult dental Medicaid
  - Established medically necessary dental service coverage under Medicaid
- Challenges of Medicaid
  - 2003 Cuts eliminated adult dental except category designated as special circumstances which included PLHIV/A

# Continued

- Part F funding
- Referral to participating Part F programs
- Established a dental workgroup in 1992 with representation from all dental institutions and affiliated Part F programs, consumers, private providers, advocates, and legal services
- Expanded workgroup to a Part F working group to strive for coordination of care and education of students

# Scope and Fees

- Fees are linked to the State Rate Setting Commission and are similar to adult dental Medicaid as per condition of award
- Scope is based on restoration and maintenance of function
  - Primarily first molar to first molar
  - No cosmetics, implants, or orthodontics
  - Limitations on Endodontics, crowns, dentures and partials to maximize resources
  - Focus on periodontal and preventive services

# Challenges of Medicaid

- 2010 Cuts- adult dental eliminated with exception of preventive, diagnostic, emergency and limited oral surgery
- About 50-60% of clients were eligible for adult dental and cost was deferred to that program
- Scope of services had to be limited due to cuts to maintain program
  - Endodontic and crowns limited to one per patient per year instead of two
  - Some fees were reduced for services no longer covered by adult dental by about 10-20% of an already low fee schedule
  - Eliminated some complex oral surgery procedures

# Approvals of Services

- Routine services do not require a prior approval
- Services requiring a prior approval are noted in provider manual and include:
  - Specialized periodontal services
  - Endodontic services
    - Crowns
    - Removable full and partial dentures
    - Complex oral surgery
    - General Anesthesia

# Provider Network Impact
# The knowns/Unknowns

- No loss of providers to date – but will they stay?
- Can we maintain services to clients – even with new limitations
- Free education to providers as enhancement to continue to participate
- Free consultation on infection control and exposure management offered to providers
- How much care can Part F programs absorb?

# Specialty Sevices

- Very few specialists participate on a routine basis
- Dentists who have referral arrangements with a specialist are able to arrange limited referrals with reimbursement through HIVDOP at our rates and scope of services
- Other specialist referrals are to Part F programs which increase access and maximizes our resources since we do not reimburse Part F programs. However, many Part F have limited their scope and our major Part F referral site closed in June ‘09

# Case Management

- Clients may enroll directly through the HIVDOP and have verifications, consent and signed grievance policy sent or faxed
- CMs enroll clients, fax immediately with verifications and other required forms (this is particularly important with emergencies or language barriers)
- Dental providers also enroll clients when they find out HIV status

# Requirements to Enroll Clients

- Completion of dental intake form
- Completion of Joint Form and outcomes form for Part A
- Signed consent form
- Signed grievance policy
- Financial verification
- HIV verification on physician letterhead

# Eligibility

- Once forms received and complete client is contacted to review:
  - Previous dental history and chief complaint
  - Dentist of record and whether they participate or are willing to enroll
  - Masshealth or other third party payor
  - Convenient location for care
  - Income if at or up to 400% poverty level, care is reimbursed ( 95%). If over then assistance in finding a provider is offered (5%)

# Providers

- In 1991 it was not easy to find providers due to issues of confidentiality, stigma, fear of loss of patients
- Now the more significant limitation is the low fees
- Providers are allowed to designate how many referrals they will accept and other considerations
- Providers sign a participation agreement that includes a statement of patient confidentiality, acceptance of reimbursement without balance billing
- We abide by their policies and procedures, including no shows

# Proactive Steps to Maintain Program

- Track cost of procedures previously covered by adult dental
- Present data to Planning Council and MDPH
- Testify at public hearings (August 2010) to advocate for restoration of adult dental and not make cuts permanent
- Advocate within EMA for increased allocations to oral health
- Continuing to advocate with Masshealth for restoration of medically necessary dental services
- Continue to refer to Part F programs

# Lessons Learned

- MA is the first state to adopt universal healthcare coverage, but oral health was not included
- Impact of previous cuts to adult dental were so significant that services to special groups were incrementally restored.  Has this lesson been lost?
- Most importantly, even when you think you've got it covered and addressed the challenges, the rug could still be pulled out from under so be prepared!