2007 Innovations Awards Program
APPLICATION

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ID # (assigned by CSG): 07-S-28VASMILES

Please provide the following information, adding space as necessary:

State: Virginia

Assign Program Category (applicant): *Health and Human Services* – Health Services

1. Program Name
   Smiles for Children

2. Administering Agency
   Virginia Department of Medical Assistance Services

3. Contact Person (Name and Title)
   Patrick Finnerty, Agency Director

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9. **Please provide a two-sentence description of the program.**

   Smiles for Children is Virginia's new dental program developed in close collaboration with Virginia's dental community and advocacy groups to serve more than 400,000 Medicaid and SCHIP children. The ***Smiles for Children*** program involves a completely new paradigm for delivering dental services including extensive member outreach and placement services, consolidated enrollment of all children into one dental benefit program, and many service enhancements for dental providers such as a dedicated call center, flexible claims filing options and streamlined authorization and credentialing requirements.

10. **How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on April 2, 2007, to be considered.**

    Smiles for Children was launched on July 1, 2005. It has been operational for 21 months.

11. **Why was the program created? What problem[s] or issue[s] was it designed to address?**

    Smiles for Children was developed and implemented to improve access to quality dental services for Medicaid and SCHIP children across Virginia. Prior to July 1, 2005, the pediatric dental program was characterized by poor access to services, low utilization of dental services, and dwindling provider enrollment.

    Low reimbursement rates, cumbersome administrative requirements, and a fragmented service delivery model all contributed to low provider enrollment. Only 620 of 4,786 licensed dentists in Virginia participated in the Medicaid dental program. Minimal provider participation, in turn, resulted in low utilization of dental services by children. During 2003, only 23 percent of Medicaid children ages 0-20 and 29 percent of children ages 3-20 obtained dental services. While these problems are not unique to Virginia, several individuals and organized groups decided it was time to make a concerted effort to improve access to dental services for low-income children in Virginia.

    DMAS initiated a partnership with the dental community to design and implement an efficient and effective dental program to address these growing problems. The new dental program looked to resolve these problems by (i) consolidating all administrative and operational aspects of the former dental program under one dental benefits administrator; (ii) increasing dental reimbursement by 30 percent; (iii) implementing a commercial model dental program with streamlined administrative requirements for providers and vastly improved customer service for Medicaid and SCHIP children.

12. Describe the specific activities and operations of the program in chronological order.

2002

- DMAS initiated a comprehensive evaluation of its existing Medicaid and SCHIP dental program for children.
- Collaborative discussions were initiated between DMAS, dental provider associations, advocacy groups, and other State agencies about how to improve access to dental services for children.

2003

- From the discussions with stakeholders, a consensus emerged about the problems associated with the previous dental program and the need to develop an entirely new dental program to address these problems.
- DMAS reconfigured its Dental Advisory Commitee (DAC) to include members with a much wider geographic and demographic representation.

2004

- DMAS obtained legislative authority to implement a new dental program through the 2004 Appropriations Act. Funds were appropriated for related administrative costs.
- DMAS formed an internal team with representatives from various divisions to guide the program's implementation.
- A committee of major stakeholders (dentists, MCO representatives, advocates, DMAS staff, and other interested parties) was formed to help with the planning and the transition to the new program.
- Major decisions were reached with stakeholders about the overall direction of the new dental program including the decision to contract with a dental program administrator.
- The DMAS Director traveled extensively throughout the state with representatives of the two statewide dental provider associations to promote the new dental program to local dental societies and to solicit their support and participation.
- A Request for Proposals to procure services of the dental program administrator was published.

2005

- A broad coalition of stakeholders lobbied the General Assembly successfully for a significant increase in provider reimbursement. The 2005 Appropriations Act authorized an unprecedented 30 percent increase in dental reimbursement rates.
- DMAS conducted a comprehensive provider survey to ensure that a broad range of providers had input into the development of the new program.
- The program administrator contract was awarded to Doral Dental USA in April.

- A Dental Unit was established within DMAS with a new manager to oversee the dental vendor contract and new program.
- The DMAS Director continued making presentations to dental organizations to update them on the latest program developments and to solicit their support.
- All dental networks from the managed care and fee-for-service (FFS) plans were merged into one dental network.
- The new program was named ***Smiles for Children*** with a new logo and registered service mark.
- A marketing campaign was launched and ***Smiles for Children*** materials were sent to recipients and providers.
- Over 400,000 Medicaid and SCHIP children were successfully transitioned to the new ***Smiles for Children*** dental program on July 1, 2005.

13. Why is the program a new and creative approach or method?

The ***Smiles for Children*** dental program for Medicaid and SCHIP children represents a completely new paradigm for designing and delivering dental services. It is the culmination of the efforts and collaboration of many individuals and groups which have overcome a litany of problems to create a comprehensive new dental program with proven results.

The historically poor access to dental care for low-income children in Virginia had been well-documented by legislative commissions, advocacy groups and provider organizations. Specific problems had been identified and partial solutions proposed, but these had received little traction. However, in 2002, a confluence of events and circumstances changed all of that. The new DMAS Director made the improvement of pediatric dental services one of his main priorities, and with the new Executive Director of the Virginia Dental Association, he was able to work with the larger dental community to start addressing the issues. This new leadership and energy encouraged providers, advocates and stakeholders to realize that long-term improvements could be achieved and this produced the momentum needed to affect major changes. Once the overall goals and objectives were identified, it was a matter of reaching consensus on the operational means of achieving them.

The most significant reason this program represents a new and creative approach to state government is the partnership with Virginia's dental provider community. Prior to the development of ***Smiles for Children***, the provider community had become disillusioned with Virginia's Medicaid/SCHIP dental program. There was a steady stream of providers leaving the program, and those remaining were becoming overwhelmed with the ever-increasing patient load they were handling. It was clear that any attempt to resurrect the program would require a close partnership and strong working relationship with the provider community. From the very beginning of the program design throughout the implementation and operation of the new program, Virginia's dental providers played a pivotal role. Examples of the provider community's involvement in the program include: (i) developing overall program goals and design; (ii) participating on the DMAS panel that reviewed and selected the

administrator of the new program; (iii) determining how the 30% increase in reimbursement would be allocated among the various dental billing codes; (iv) participating on DMAS' Dental Advisory Committee which advises the agency on critical program design and administrative issues; and (v) vigorously recruiting dentists to participate in the new program.

The partnership with the dental provider community created a sense of "ownership" among dentists and a strong incentive to make the program successful. It has been so exciting to hear the leaders of the dental community say to their membership "***our*** Medicaid/SCHIP dental program is one of the best in the country….***we*** need to support it by participating and treating these children." That story has been told countless times across Virginia by the two statewide dental associations, the Virginia Dental Association and the Old Dominion Dental Society. This is the innovation…this is the creativity….this is the success.

The collaboration and consensus with the dental community resulted in the creation of a new approach (exemplified by the motto "**A New Day in Dental**") and a totally revamped dental program for children which went beyond the sum of its parts: an unprecedented dental rate increase, a single administrative entity, a separate DMAS dental unit, administrative streamlining for providers, and improved customer service for beneficiaries and providers. DMAS believes that this collaboration transformed a somewhat neglected service within Virginia Medicaid into an exciting new program modeled after successful commercial programs. This new identity included a new name, a new logo, and a new private sector partner to administer the program. It was also accompanied by an extensive promotional campaign to introduce the ***Smiles for Children*** program to the Medicaid and SCHIP populations.

Changes to the pediatric dental program were not cosmetic. Over 400,000 children were successfully and seamlessly transitioned into a totally new program on July 1, 2005. The teamwork that produced the new program is also responsible for a very positive increase in children's dental utilization and an increase in provider enrollment. The program is becoming a nationally recognized model for State Medicaid dental programs. The program offers a prime example of how multiple stakeholders such as providers, patient advocates, and government officials can join forces to design a model program to improve access to health care services.

14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

Several existing staff members spent part of their time managing the prior dental program. Early on, a decision was made to have a separate dental unit which could dedicate its full attention to the new ***Smiles for Children*** program. A full-time dental manager was recruited and hired. At the same time, DMAS kept its dental consultant, a licensed Virginia dentist, to provide continuity with existing participating dentists and program stakeholders. Given that existing staff working on the previous dental program were able to reallocate their time to other programs, the additional cost of establishing a separate dental unit was minimal.

The cost of providing services through the new program was paid by transferring the funding that previously was paid to the MCOs to provide dental services to the new single program administrator (Doral). Additionally, costs incurred by Doral for start-up were included in the contract agreement as explained below. (See Q. 15)

Other start-up costs involved the marketing and promotional activities for the new dental program such as travel for provider outreach/recruitment, pens, decals for provider offices, magnets, toothbrushes, post-it notes, stickers, and informational flyers. These costs were approximately $25,000.

15. What are the program's annual operational costs?

Approximately 70 percent of Medicaid and SCHIP children are enrolled with a contracted Managed Care Organization (MCO) which provides most of their medical services. Previously, dental services were included as a part of the benefits administered under DMAS' MCO contracts. As noted above, the funds for dental services were redirected from the MCO benefit packages and contracts to one single dental vendor (Doral Dental USA) who operates under an Administrative Services Only (ASO) contract. The vendor receives a per member per month (PMPM) administrative fee which totals approximately $4.3 million per year. For fiscal year 2006, approximately $70 million were paid in dental claims for direct services.

16. How is the program funded?

The program is funded through the Medicaid and SCHIP programs which include legislative appropriation of state general funds as well as federal funding.

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

The legislature authorized DMAS to carve dental services out of the managed care program. This language is found in the 2004 Acts of Assembly, Special Session I, Chapter 4, Item 322H.

18. What equipment, technology and software are used to operate and administer this program?

The dental vendor uses a computer processing system capable of fully interfacing with DMAS' main-frame information system to exchange eligibility, encounter data and other information with DMAS through a dedicated line employing TCP/IP protocol. The dental vendor also uses a proprietary claims processing system for the administration/payment of claims. In addition, an electronic data processing system is available to providers to import claims data via numerous electronic data interchange options. The dental vendor has a call center staff to handle incoming calls from Medicaid/SCHIP enrollees and dental providers.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.

The ***Smiles for Children*** program originated in Virginia as a result of the collaboration between DMAS, the dentists in Virginia represented by the Virginia Dental Association and the Old Dominion Dental Society, and many patient advocates. But the two team leaders who had the standing and the respect of all the different dental program stakeholders needed to achieve these results were DMAS Director, Patrick Finnerty and Virginia Dental Association Executive Director, Dr. Terry Dickinson. Improving the children's dental program and increasing access to dental services for Virginia's Medicaid and SCHIP children have been among Mr. Finnerty's and Dr. Dickinson's highest priorities. Without their vision, energy, and dedication, this program would not have come to fruition.

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20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

Other states have dental vendors which manage their dental programs (e.g., Tennessee, Illinois), but Virginia's program is unique in that the dental provider community and other stakeholders played a critical role in the design of the entire program.

Virginia started with a comprehensive, objective evaluation of the dental program as it existed. Several committees were formed or reorganized to look at various aspects of the dental program. Dentists were surveyed to determine their opinions and solicit their suggestions for ways the program could be improved. DMAS worked closely with its MCO partners making sure they understood all options that were being considered and this helped to ease the transition greatly. This concerted effort culminated in the new ***Smiles for Children*** dental program with a new DMAS dental unit, an external vendor to administer the provision of services, a significant fee increase for dentists, and an increased administrative flexibility that would not have been possible without the full participation and cooperation of all the stakeholders.

However, as previously noted, the involvement of the dental provider community in every aspect of the program's design and implementation and their sense of ownership of the program is what sets Virginia apart from other states.

21. Has the program been fully implemented? If NO, what actions remain to be taken?

Smiles for Children was launched on July 1, 2005 and has been fully implemented. Stakeholders continue to be regularly engaged with DMAS to further develop and promote the program.

22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

The ***Smiles for Children*** program was created to increase access to dental services for Medicaid and SCHIP children in Virginia. After the first year of operation, there are tangible signs that ***Smiles for Children*** is making a significant difference in improving dental care for children across Virginia.

First and foremost, as a result of the new program and the provider/member outreach efforts, there has been a significant increase in utilization of dental services by Medicaid and SCHIP children. The percentage of children ages 0-20 receiving dental services has increased from 24% in Fiscal Year (FY) 2005 to 32% in FY 2006 (a 33% increase). Similarly, for children ages 3-20, utilization of dental services has increased from 30% in FY 2005 to 39% in FY 2006 (a 30% increase). Utilization continues to increase in both age groups.

Second, there has been a dramatic increase in the number of providers enrolled in the dental program. From the start of the program in July 2005 through February 2007, 319 new dentists have been enrolled in the new ***Smiles for Children*** program. At the start of the program, there were 620 dental providers; there are now 939 individual providers in the network--a 51 percent increase. Additional providers continue to enroll in the program, further enhancing the availability of services. The goal for 2007 is to have 1000 dental providers in the ***Smiles for Children*** network.

Third, DMAS has received very positive responses from dental stakeholders in Virginia. Providers have written to provide encouraging feedback to DMAS. For example,

- **From Central Virginia** - "Doral and DMAS are there for us and are doing everything that they can to make this a very positive and efficient procedure for all of us… In my opinion, there is no bureaucratic reason not to be a participant in this Medicaid program now."

- **From Shenandoah Valley** - "I have had less trouble with the ***Smiles for Children*** Program than traditional insurance programs."

- **From Northern Virginia** – "I am very excited and pleased at the changes that have occurred in Medicaid."

- **From Southwest Virginia** - "We are very satisfied with the new program. The key is having the entire Medicaid program under one vendor."

- **From the President of the Virginia Society of Oral/Maxillofacial Surgeons – "**I can tell you from experience that we appreciate the new program and can vouch for the many progressive changes put into place to make it more a look alike to traditional insurance type programs".

Provider and beneficiary surveys continue to reflect satisfaction with the new program. The Virginia Dental Association and the Old Dominion Dental Society continue to issue communications to their members touting the improvements in the Medicaid and SCHIP dental program, and strongly encouraging their members to participate in the program.

Fourth, ***Smiles for Children*** is becoming a nationally recognized model for state Medicaid dental programs. Virginia was selected to present at the 2005 Center for Health Care Strategies Purchasing Institute Best Practices for Oral Health Access conference. DMAS also has a staff member who was elected to the governing body of the National Medicaid/SCHIP Dental Association. DMAS has been invited to speak at the 2007 National Oral Health Conference and the 2007 National Medicaid Managed Care Congress. The DMAS Director made a presentation on the new program and participated on a discussion panel at the National Association of Dental Plans in September 2006. At the invitation of the American Dental Association (ADA), the DMAS Director spoke about the new program at a national meeting of the ADA in December 2006.

23. How has the program grown and/or changed since its inception?

While the major initiatives were implemented at the inception of the program, the Commonwealth is always looking for ways to improve the program. Currently, DMAS is working very hard to recruit additional general dentists and specialists. DMAS is conducting a comprehensive gap analysis to identify any remaining underserved areas and to target recruitment of dentists in those areas. DMAS worked with dentists to target an additional fee increase towards specialty services as an incentive to attract specialists. Finally, an intensive pilot project is underway to decrease the number of patients who do not keep their appointments with dentists as broken appointments are a barrier to provider participation.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

The biggest challenge is to bring all the different stakeholders together in the very initial stages of planning any similar program to ensure that all have an opportunity for input, and to maximize the level of agreement and cooperation as changes are considered and implemented. As with many Medicaid programs, recruitment of providers is one of the biggest challenges. Involving the dental community early in the development of program goals, including them in key decisions, and forging a strong partnership and sense of ownership in the program is critical to achieving success.