



Assessment of Virginia's Disability Services System:

Accessibility of Dental Care



2023 Assessment of the Accessibility of Dental Care

First edition

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The Virginians with Disabilities Act § 51.5-33 directs the Virginia Board for People with Disabilities (the Board), beginning July 1, 2017, to submit an annual report to the Governor, through the Secretary of Health and Human Resources, that provides an in-depth assessment of at least two service areas for people with disabilities in the Commonwealth. The Board, as part of its authority and responsibility as a Developmental Disabilities (DD) Council under the federal Developmental Disabilities and Bill of Rights Act (42 U.S.C. §15021-15029), is also required to complete a similar analysis as it develops and amends its federal State Plan goals and objectives.

The Board selected dental care as a topic area to be assessed. Due to staff vacancies, Board staff were unable to complete and release this assessment in July 2023 as planned. In this Assessment, the Board identifies key dental care barriers that people with developmental disabilities face. The Board then makes recommendations to increase access to dental care and improve dental hygiene for this population.

We appreciate the assistance of the dental professionals, state agencies, organizations, and other stakeholders that provided information and clarification on dental care. The policy recommendations were developed by an ad hoc committee of the Board and approved by the full Board at its December 6, 2023 meeting.

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Statement of Values

"Physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination ...; historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem ..."

— 42 U.S. Code § 12101 – Americans with Disabilities Act – Findings and Purpose

The Virginia Board for People with Disabilities serves as Virginia's Developmental Disability Council. In this capacity, the Board advises the Governor, the Secretary of Health and Human Resources, federal and state legislators, and other constituent groups on issues important to people with disabilities in the Commonwealth. The following assessment of oral health for people with developmental and other disabilities is intended to serve as a guide for policymakers who are interested in ensuring that people with disabilities have access to high-quality oral health care. The Board's work in this area is driven by its vision, values, and the following core beliefs and principles:

Inherent Dignity: All people possess inherent dignity, regardless of gender, race, religion, national origin, sexual orientation, or disability status.

Presumed Capacity: All people should be presumed capable of obtaining a level of independence and making informed decisions about their lives.

Self-determination: People with disabilities and their families are experts in their own needs and desires. They must be included in the decision-making processes that affect their lives.

Integration: People with disabilities have a civil right to receive services and supports in the most integrated setting appropriate to their needs and desires, consistent with the Supreme Court's Olmstead decision.

Diversity: Diversity is a core value. All people, including people with disabilities, should be valued for contributing to the diversity of our neighborhoods and of the Commonwealth.

Freedom from Abuse and Neglect: People with disabilities must be protected from abuse, neglect, and exploitation in all settings where services and supports are provided.

Fiscal Responsibility: Fiscally responsible policies are beneficial for the Commonwealth, and they are beneficial for people with disabilities.

Executive Summary

KEY TAKEAWAY

Dental access for Virginians with developmental disabilities (DD) ranks last among 27 states for which data is available and is far below what is needed to comply with a U.S. Department of Justice settlement agreement. People with DD have difficulty getting dental care because many dental professionals are not able or willing to treat them. A continuum of provider education methods, higher Medicaid reimbursement rates, and improved oversight are needed.

People with developmental disabilities (DD) have a higher risk of poor oral health, which is critical to overall health and wellbeing. Some of the risk is inherent to the disability, which can cause physical, behavioral, or other changes that increase the risk of developing oral health problems. Some of the risk is also due to dental professionals not being able or willing to treat this population.

One reason many dental professionals are not able or willing to treat people with DD is that they haven't been educated enough about them. During interviews and focus groups, dental professionals and other stakeholders talked about not knowing what each developmental disability is, how to manage behavior, how to be accessible, how to administer sedation and anesthesia, and the ethical importance of serving people with DD. Dental school education has improved in recent years, but there are opportunities for further improvement and a need to reach more dental professionals who have already graduated.

The other reason many dental professionals are not able or willing to treat people with DD is that they aren't compensated enough for the extra time, other accommodations, and sedation and anesthesia that people with DD often need. Several dental professionals were concerned about the financial sustainability of serving this population. The Medicaid reimbursement rate for interpreters is not enough to even cover discounted prices available to American Dental Association members and state agencies. The Medicaid reimbursement rates for sedation and anesthesia are only about 50 to 65% of what other large commercial dental insurers reimburse, which is well below the Commonwealth's goal of 82-83%.

Consequently, access to dental care for Virginians with DD substantially lags key benchmarks. Only 56% of Virginians with DD receiving state services had a dental exam in the past year, according to the 2021-22 National Core Indicators. This rate ranked last among 27 states who participated in that data collection effort. This rate was also far below the 86% needed to meet a compliance indicator in Virginia's settlement agreement with the U.S. Department of Justice.

Despite these access issues, there is limited state oversight of how well the Medicaid dental benefit is meeting the needs of people with DD. The Medicaid dental benefits administrator does not have data on the disability status of its members. The adequacy of the dental provider network is not assessed for people with DD. Feedback is only requested from Medicaid members who have had a dental visit.

Oral hygiene is also a critical component of oral health that should not be overlooked. Several factors limit the ability of people with DD to brush their teeth. Over one-third of people with developmental and other disabilities are not brushing twice a day, according to the 2019 Virginia Department of Health Basic Screening Survey. Educational programs can improve their ability to brush at home but Virginia does not have any that target people with DD and their family members.

The Commonwealth needs to make serious changes to meet its policy goals. Several initiatives are underway to improve oral health for people with DD, which are commendable, but additional support from state policymakers is needed. This report offers 18 recommendations to improve oral health for people with disabilities. The recommendations are action steps to implement six overall strategies. A brief version of each recommendation is listed below, by strategy, and the full recommendations are listed in Appendix A.

Invest in initiatives that increase the exposure of dental students to people with DD

- Virginia General Assembly fund a clinic at the Virginia Commonwealth University School of Dentistry that is dedicated to treating people with special health care needs (Recommendation 1, page 10)
- Virginia General Assembly fund a Fellowship program at the Virginia Commonwealth University School of Dentistry that addresses oral health disparities affecting people with developmental disabilities (Recommendation 2, page 10)

Increase access to and utilization of continuing education on oral health for people with DD

- Virginia Department of Medical Assistance Services (DMAS), Virginia Department of Health (VDH), Virginia Department of Behavioral Health and Developmental Services (DBHDS), and other stakeholders expand continuing education offerings for dental professionals on people with developmental disabilities (Recommendation 3, page 11)
- Virginia General Assembly amend Code of Virginia 54.1-2709 to allow dental professionals to receive up to two continuing education credit hours for providing uncompensated care to people with disabilities (Recommendation 4, page 12)
- Virginia General Assembly amend *Code of Virginia* §54.1-2709 and §54.1-2722 to require that a portion of the 15 annual continuing education credit hours for licensed dental professionals pertain to underserved populations including but not limited to people with developmental disabilities (Recommendation 5, page 14)

- DBHDS develop a supplemental module on oral health for inclusion in their mandatory direct support professional orientation materials (Recommendation 17, page 38)
- Virginia Department of Education incorporate oral health into guidance regarding Individualized Education Programs (Recommendation 18, page 38)

Invest in the sustainability of the dental service system for people with DD

- DBHDS and VDH establish a pilot program that provides funding for dental professionals to remove physical, communications, or programmatic accessibility barriers that are identified by an on-site accessibility assessment (Recommendation 7, page 20)
- DMAS seek approval from the Virginia General Assembly to increase reimbursement for certified translation or sign language services (Recommendation 8, page 21)
- DMAS seek approval from the Virginia General Assembly to increase reimbursement for sedation and anesthesia provided in the dental office (Recommendation 9, page 26)
- Virginia General Assembly increase funding for the DBHDS Dental Program so they can expand their capacity to meet demand (Recommendation 14, page 33)

Assess how well the Medicaid dental benefit meets the needs of people with DD

- DMAS review the adequacy of individual reimbursement rates that are key to serving people with developmental disabilities, including how the rates compare to the agency's goal of 82-83% of commercial insurance rates, and report publicly on its findings every three years (Recommendation 6, page 16)
- DMAS collaborate with disability stakeholders to regularly verify self-reported information from dental providers on their physical, communications, and programmatic accessibility using independent site reviews and secret shopper studies (Recommendation 12, page 30)
- DMAS biennially assess network adequacy for people on the Developmental Disabilities waiver (Recommendation 15, page 34)
- DMAS regularly collect feedback from providers and members on disability-specific issues and solicit input from disability stakeholders on Request for Proposals and contracts for the agency's dental benefits administrator (Recommendation 16, page 35)

Conduct outreach to Medicaid members with DD

- DMAS, VDH, and other relevant stakeholders conduct user testing of their dental provider directories to ensure that they are useful for, understandable to, and accessible to people with developmental disabilities (Recommendation 13, page 31)
- DMAS regularly collect feedback from providers and members on disability-specific issues and solicit input from disability stakeholders on Request for Proposals and contracts for the agency's dental benefits administrator (Recommendation 16, page 35)

V

Study additional opportunities for improvement

- Joint Commission on Health Care study innovative ways to address barriers to accessing sedation and anesthesia for dental procedures and innovative ways to reduce the need for sedation and anesthesia (Recommendation 10, page 27)
- DMAS, VDH, DBHDS, and other stakeholders participate in a workgroup on oral health for people with disabilities to continue sharing information and explore opportunities for improvement (Recommendation 11, page 29)

Background

KEY TAKEAWAY

People with DD are at increased risk of poor oral health, which can impact their overall health. Dental professionals are required to provide equal access to people with and without disabilities. People with DD often rely on Medicaid, which has expanded in recent years.

There is growing recognition that oral health is critical to overall health and well-being. Gum disease is associated with other health conditions including diabetes, heart disease, pregnancy outcomes, and dementia, according to the National Institutes of Health. Poor oral health can impact someone's ability to eat and sleep. It can also impact someone's ability to get a job and their social status. These challenges ultimately result in increased medical expenses, unemployment, and sick days from school or work.

People with Disabilities Have Increased Risk of Poor Oral Health

Some developmental disabilities (DD) cause physical, behavioral, or other changes that increase the risk of developing oral health problems. Some people may have too few teeth, too many teeth which can lead to crowding, or differently shaped teeth that make it more difficult to remove plaque. Some people produce too much or too little saliva, which helps break down food, neutralize acid, and fight bacteria. Other people may clench or grind their teeth, choke or gag which increases acidity, or bite inedible items. They may also have to eat a liquid diet which sticks to teeth longer, avoid certain foods which can lead to malnutrition, or take medications that are high in sugar or cause dry mouth.

In addition to the risks inherent to a given disability, people with DD encounter other challenges that can be mitigated. For example, many people with DD have trouble taking care of their teeth at home. They also have trouble visiting the dentist because dentists are not able or willing to treat them. These preventable factors are the focus of this report.

As a result of these increased risk factors, people with disabilities have worse oral health outcomes than people without disabilities. National studies have found that people with developmental and other disabilities have more gum disease, untreated cavities, and missing teeth (NCD 2022, NRC 2011, Obeidat 2022, Waldron et al. 2019, Wilson et al. 2018). Similarly, children with developmental and other disabilities in Virginia were 30 to 60% more likely to have had decayed teeth, teeth in fair or poor condition, or a toothache in the past, as reported by their parents or caregivers on the 2020-21 National Survey of Children's Health. They were more than twice as likely to have had bleeding gums in the past year.

People with Disabilities Have Legal Right to Access Dental Care

Healthcare providers must provide equal services to people with and without disabilities, according to the Americans with Disabilities Act, although there are some limits. For example, private providers are only required to remove architectural barriers in existing facilities when “readily achievable.” Standards for medical equipment accessibility are not mandatory. And private providers are only required to make “reasonable modifications” to policies and practices and provide auxiliary aids and services when necessary, unless it would “fundamentally alter the nature” of the service or result in an “undue burden.”

Section 504 of the Rehabilitation Act of 1973 also established accessibility requirements for facilities and prohibited discrimination against people with disabilities by providers who receive federal financial assistance including Medicaid. A proposed rule, released in September 2023, would update the law to further promote health care access for people with disabilities. The proposed rule, among other things, clarifies what constitutes health care discrimination, establishes accessibility requirements for medical equipment, and clarifies website accessibility requirements. The public comment period closed when this report was being written.

Dental Care System for Virginians with DD Has Changed Rapidly

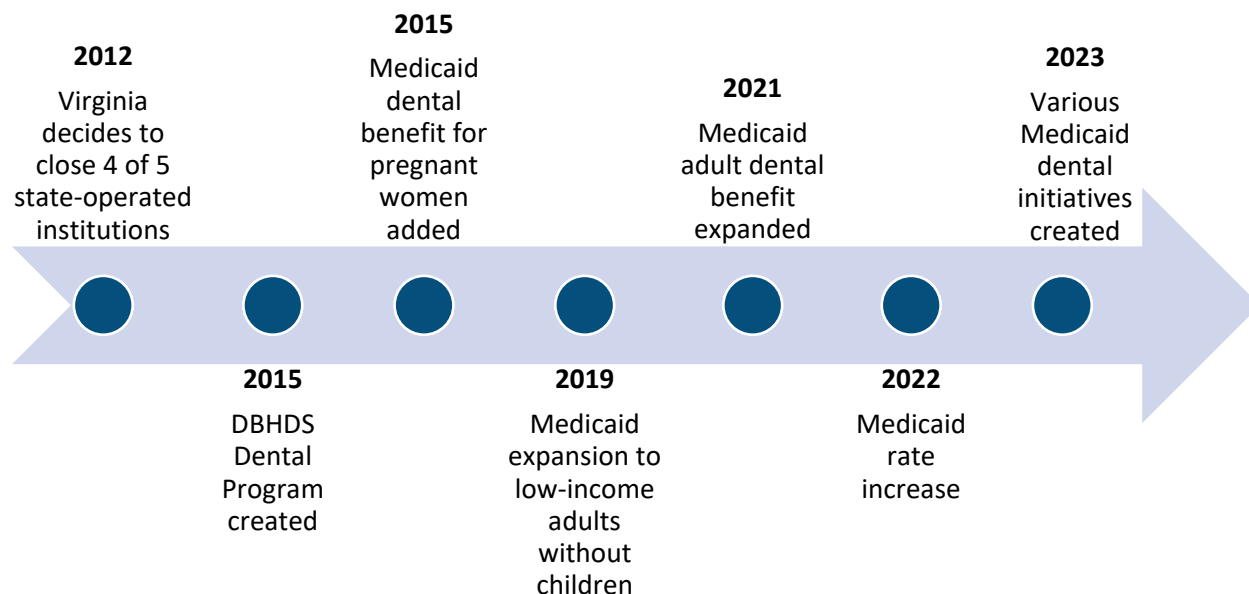
The deinstitutionalization of people with disabilities has altered how they access health care (Milano 2017, Stiefel 2002). Institutions historically provided their dental and other health care services. When people with disabilities began transitioning out of institutions in the 1970s, they had trouble finding health providers in their community. Public health insurance programs provided little to no coverage of dental care for adults. Dental providers in the community typically had little to no experience working with people with DD.

Virginia has made several changes over the past decade to help mitigate these challenges as it accelerated deinstitutionalization (see Figure 1). In 2015, the Department of Behavioral Health and Developmental Services (DBHDS) created a dental program to provide dental care to people with DD who transitioned out of state institutions. This program is now open to anyone with DD. Virginia added comprehensive Medicaid dental benefits for pregnant women in 2015 and other adults in 2021. Virginia also increased Medicaid dental reimbursement rates by 30% in 2022.

The Virginia Department of Medical Assistance Services (DMAS), in partnership with its Dental benefits administrator DentaQuest, has started implementing several new initiatives to support the Medicaid dental benefit. One initiative calls new members to educate them about the dental benefit, identify any special health needs, and help schedule their first appointment. Other initiatives assign each member to a dental home and provide case management and care coordination to certain members. DentaQuest will also call members who miss an appointment.

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Figure 1: Key Changes to Virginia's Dental Care System (Staff analysis)



Additional initiatives are underway that go beyond Virginia's Medicaid program:

- Delta Dental of Virginia implemented a new dental benefit for people with disabilities on July 1, 2023 that includes unlimited dental visits for desensitization.
- Delta Dental and the Virginia Department of Health (VDH) have a Centers for Inclusive Dentistry program that provides comprehensive training and equipment to two safety net clinics this year so they can better serve people with DD. The program has a goal of reaching a safety net clinic in each region within three years.
- Virginia Health Catalyst, Delta Dental of Virginia Foundation, and VDH are partnering with four safety net clinics to expand school-based oral health programs.

These changes are commendable but they will take time to be realized. Most of the data used in this report will not fully capture their effects so additional evaluation will be needed.

Research on Dental Access for People with DD Is Limited

Relatively few research studies have been conducted to understand and address barriers that people with DD have when accessing dental care. Available studies typically rely on a small sample size, focus on a limited geographic area, were conducted over 10 years ago, or were conducted outside of the United States where special needs dentistry is a recognized specialty.

Consequently, this report relies heavily on first-hand research. Staff conducted interviews with 40 key stakeholders in Virginia and focus groups with 18 dental professionals in Virginia. Staff also requested data and information from key stakeholders. See Appendix B for more information on the research methodology.

I. Dental Access for Virginians with DD

KEY TAKEAWAY

Many Virginians with DD aren't visiting the dentist enough. Their dental utilization is much worse than other states and well below what Virginia needs to comply with its settlement agreement. A key barrier is dental provider inability or unwillingness to treat people with DD.

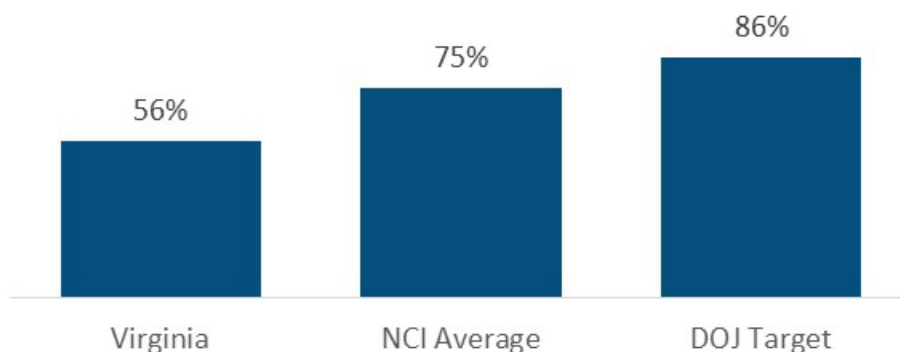
Regular dental visits are important for good oral health. The standard recommendation is to visit a dentist every six months. People with DD may need more frequent visits because of their increased risk of oral health problems.

Dental Utilization by People with DD Is Well Below Benchmarks

Unfortunately, many Virginians with DD are not visiting the dentist often enough. Only 56% of Virginians with DD receiving state services had a dental exam, per the 2021-22 National Core Indicators (NCI). This is well below the recommended two or more visits per year.

People with DD visit the dentist less in Virginia than other states. An average of 75% of people with DD had a dental exam in the past year across 27 states who participated in the 2021-22 NCI (see Figure 2). Virginia ranked last among those 27 states, at just 56%.

Figure 2: Annual Dental Exam Among People with DD (Staff analysis of 2021-22 NCI Data)



Dental visits for Virginians with DD substantially lagged the Commonwealth's goal. In 2022, Virginia was 30 percentage points behind its goal that 86% of people with DD have an annual dental exam (see Figure 2). This goal was developed to measure compliance with Virginia's settlement agreement with the U.S. Department of Justice regarding providing services to people with DD in the most integrated setting appropriate to their needs. Since then, dental access has climbed to 60%, but Virginia is still well behind its goal.

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Inability or Unwillingness to Treat People with DD Is A Key Barrier

Three key barriers limit the availability of dental providers (see Figure 3). The first two key barriers affect everyone, regardless of disability status, and several initiatives are underway to address them. The third barrier is unique to people with DD and has received less attention.

Figure 3: Three Key Barriers Limit Availability of Dental Professionals (Staff analysis)



The first key barrier is the shortage of dental professionals in Virginia. Virginia had 145 designated dental professional shortage areas, as of September 2023, which accounted for over 28% of Virginia's population. This shortage could get worse in the coming years. Over one-quarter of dentists reported that they expected to retire within 10 years and over half expected to retire within 20 years, according to a 2023 Virginia Department of Health Professions report.

The second key barrier is low Medicaid participation among dentists. Only 27% of dentists in Virginia treated a Medicaid or FAMIS member, and Virginia ranked second to last among 41 states that were analyzed, according to a 2022 DMAS report. Low Medicaid participation has been attributed to Virginia's historically low reimbursement rates, missed appointments, and the perception of a high administrative burden, according to the 2022 DMAS report, stakeholder interviews, and provider focus groups. It is not yet clear how the recent reimbursement rate increases and other new initiatives will impact future participation.

The third key barrier is difficulty finding a dental provider who is able and willing to treat people with DD. Nearly two-thirds of focus group participants said they thought less than 25% of dental professionals in Virginia are willing to treat patients with DD. This reluctance may be due to several reasons including insufficient education about this population, additional costs to treat this population, or difficulty providing sedation and anesthesia. As one provider said,

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“It comes down to desire and money. Are you willing to go out of your comfort zone to do something a little different, and can you get paid for it. That’s what’s really holding people back.”

Each of these challenges is explored in the rest of the report. Additional challenges regarding Medicaid oversight, connecting people to providers, and oral hygiene are also explored.

Service System for People with DD Relies on Small Subset of Compassionate Providers

The small subset of providers who serve people with DD do so with intention. These providers understand the level of need and have personal beliefs about how people should be treated. Feedback from dental professionals during interviews and focus groups included the following:

“It comes down to who has a heartbeat. I do hospital dentistry because I feel it’s my mission in life to serve people who wouldn’t otherwise be served.”

“It’s probably more about my spirituality and religious beliefs.... I know it’s going to be very hard for them to get care elsewhere.”

“We’re in it for the selfish reward of serving and that’s why we’re working in community health centers.”

“I believe everyone deserves the best care that they can get. If they’re in my dental chair, then I’m gonna try my best to do what we can with the time...”

“Almost everyone who gets into this field has a personal connection.”

While these providers are commendable, Virginia should not continue to base its service system for people with DD on a small subset of compassionate providers. This approach has left many people with DD behind and overwhelms the providers who are willing to help. Focus group participants raised the need for a bigger network of providers to serve this population:

“Taking patients with developmental disabilities should not fall into the charity part of the world. You know, it should be economically feasible.”

“We’ve got to build the infrastructure in our community to see these folks because our practice won’t be able to do it. We are maxed out pretty much....”

“As providers, we have to be advocates for the patient, advocates for the patient to the caregiver, and advocates to the community. It would be nice if more private practitioners served this population.”

The rest of this report identifies ways to strengthen the provider network.

II. Improving Provider Comfort Level to Treat People with DD

KEY TAKEAWAY

Most dental professionals have received limited education on people with DD. State legislators need to support more exposure of dental professional students to people with DD. State legislators and other stakeholders also need to implement a continuum of continuing education methods to reach existing dental professionals.

Provider comfort level with treating people with DD is one of the biggest challenges in Virginia. Dental professionals are trained in two primary ways, neither of which has historically addressed the unique needs of people with disabilities. First, dental professionals receive training while they are in dental school. Second, they take continuing education courses to meet state licensure requirements.

Many Dental Professionals Feel Unprepared to Treat People with DD

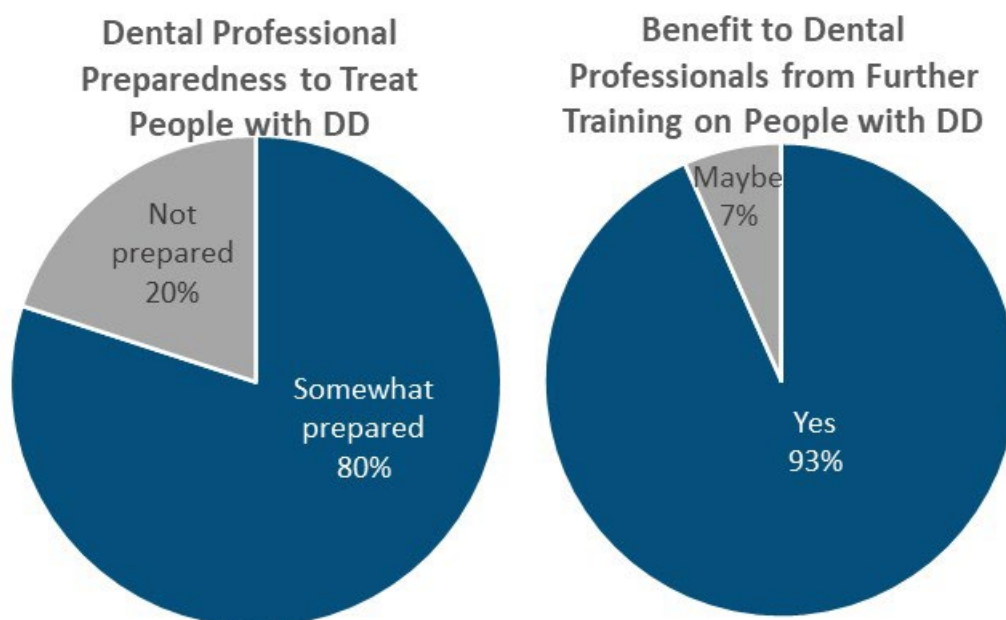
Dental professionals in Virginia and nationwide have consistently reported feeling unprepared to treat people with DD. In nationwide surveys in recent decades, most dental school deans and graduates reported that their curriculum did not prepare them to treat this population (NCD 2017). Similarly, dental professionals in Virginia reported during focus groups that dental professionals are typically only “somewhat prepared” to treat people with DD and that dental professionals could benefit from further training on this population (see Figure 4). Feedback from the focus group participants included the following:

“Probably the biggest barrier is just the comfort of the healthcare team in providing the care.”

“The confidence and the ability to feel comfortable treating this population, I think, is definitely a big aspect so training would be really helpful here as a solution.”

“I think there’s maybe a fear that someone might be practicing below the standard of care. That may affect their willingness to treat. So I think that training and education piece [is important].”

Figure 4: Opinions from Dental Professionals in Virginia on Preparedness to Treat People with DD (Focus group polls)



There are several reasons why dental professionals may not feel comfortable treating people with DD. For example, they need to understand and account for co-occurring medical conditions. Certain medical conditions may require clinical changes to the treatment protocol. Certain disabilities might be associated with a greater difficulty swallowing while lying down, higher risk of bleeding, or higher risk of bacterial infection. Additionally, dental professionals must be able to manage someone's behavior. Many people with DD are scared to go the dentist and have disabilities that cause noise sensitivity, light sensitivity, or involuntary movements. There are a variety of behavior management techniques that providers can use (see Appendix C). Also, dental professionals may not feel prepared to provide sedation and anesthesia when other behavior management techniques fail, as discussed later in this report.

Dental School Education on People with DD Has Been Historically Limited

General dentists have historically received limited education on people with developmental and other disabilities in school, although that is changing. Prior to 2004, accredited predoctoral dental education programs were not required to provide any training on this population. Since 2004, dental school graduates from accredited schools have to be competent in "assessing the treatment needs" of people with special needs. Since 2020, they also have to be competent in "managing the treatment" of people with special needs.

While these changes are positive, they do not fully address the problem for two key reasons. First, the requirements speak to special needs which is broader than DD. Consequently, the schools have discretion regarding how much to focus on people with DD. Second, the new accreditation requirements do not affect people who have already graduated dental school.

One exception to the historically limited training is pediatric dentists. They have mandatory training in caring for patients with disabilities, including behavior management techniques shown in Appendix C. However, most people with disabilities have to seek care from general dentists at some point in their life, either due to the limited number of pediatric dentists or because the pediatric dentist is not able to address their needs as they grow into adulthood.

There was stakeholder consensus that dental students nationwide need more education about, and exposure to, people with DD. They noted that exposure early in dental school is critical to fostering the provider's comfort level and willingness to treat the population. Feedback from dental professionals during interviews and focus groups included the following:

"Everyone starts with the right intentions, and their hearts are in the right place, but something changes in those four years. They are taught that they can't manage this population and should just refer them elsewhere."

"I did not understand what cerebral palsy was coming out of dental school. They had a lecture about the importance of serving people with special disabilities, but that was the end. Another faculty freaked you out about every possible cardiac condition associated with Down's syndrome."

"We learned so much information in a lecture setting. It's different when you actually are doing hands-on applications.... I probably took the course [on special care dentistry at VCU]. Was it enough for me to jump out and be prepared to treat patients? Absolutely not."

"...When I was in school, we didn't really get much exposure to dealing with patients with very special needs. Most of my exposure came in residency.... I think they've increased it a little bit more at VCU, but I don't think enough to where someone NOT doing a residency or one that has that focus. They don't get that experience, and so they're not comfortable. And if they're not comfortable, you're not gonna do it because there are certainly challenges."

"I started out as a dental assistant, and I know that in my assisting program, we didn't even touch on it. And I was then sent for my clinicals to public health, where we had a patient who I had no idea how to handle. None. And I was told... 'It takes 4 of us, and we hold him down.' And I was mortified."

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The VCU Dental School has made several improvements in recent years. They have had a one credit hour required course on special care dentistry for third-year students since at least 2018; a required service-learning course with rotations that include an assisted living facility, group home, and a pediatric clinic; and a senior elective in special care dentistry for a limited number of students. Predoctoral students also have the option to participate in the Missions of Mercy project in collaboration with Special Olympics.

While these developments are positive, there are further opportunities for improvement that require additional funding. The VCU School of Dentistry hopes to develop an accessible dental clinic that is dedicated to treating people with special health care needs within the next year. Predoctoral students could rotate through the clinic with support from students and faculty in advanced programs. The School is also interested in creating a Fellowship program to address oral health disparities that affect people with DD. The program could be modeled after the New York State Academic Dental Centers Fellowship to Address Oral Health Disparities, for which fellows provide direct care to patients with DD and teach dental students about patient needs.

Recommendation 1: The Virginia General Assembly should provide funding for the Virginia Commonwealth University School of Dentistry to establish a clinic dedicated to treating people with special health care needs. Predoctoral dental students and dental hygienists should rotate through the clinic.

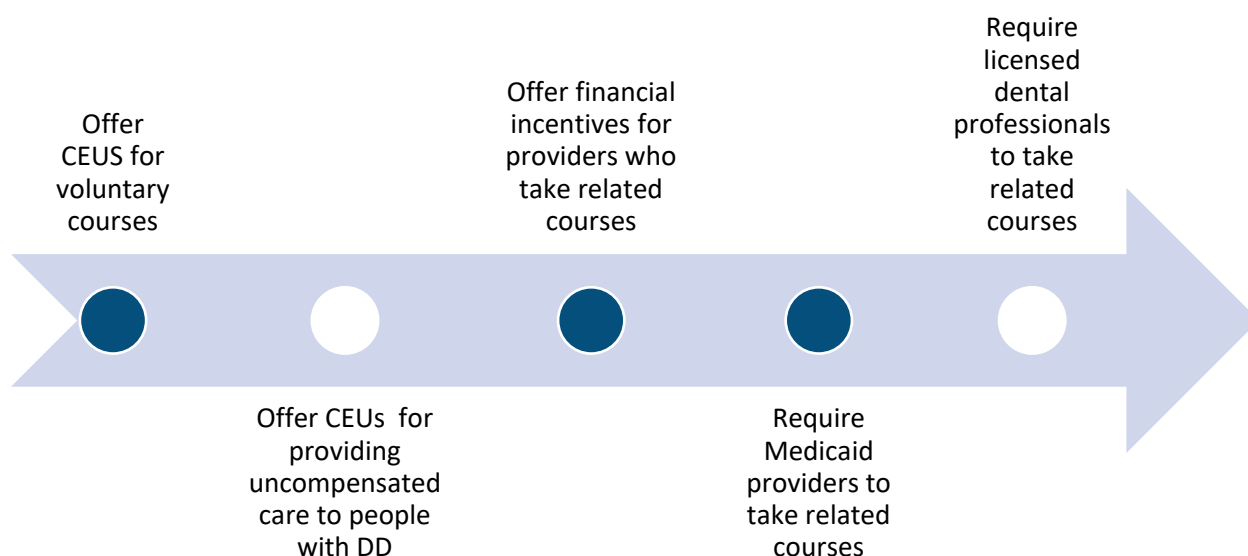
Recommendation 2: The Virginia General Assembly should provide funding to the Virginia Commonwealth University School of Dentistry to establish a Fellowship program that addresses oral health disparities affecting people with developmental disabilities.

Continuing Education on People with DD Has Been Limited

The only way to reach dental professionals who have already graduated from dental school is through continuing education. This is particularly important for dental professionals who graduated before accredited schools were required to prepare them to treat people with DD. It is also important for all dental professionals to stay up to date as best practices for treating people with DD evolve. For example, the American Academy of Pediatric Dentistry stopped recommending the “hand over mouth” technique in 2006. This technique involved dentists placing their hand over a person’s nose and mouth until they perform a requested behavior.

There are several ways to promote continuing education on people with DD to dental professionals (see Figure 5). Virginia uses three of these methods, noted by the dark blue circles. VDH has a free special needs dentistry course for continuing education units (CEUs) that is well-regarded among stakeholders. Delta Dental of Virginia and VDH are offering accessible equipment to safety net clinics that attend immersive training. DentaQuest requires Medicaid providers to take an annual training on cultural competency and non-discrimination. However, there are opportunities to further build off these efforts and implement additional efforts.

Figure 5: Continuum of Methods to Promote Continuing Education to Dental Professionals (Staff analysis of research literature)



There was consensus among stakeholders that there are opportunities to improve the visibility and breadth of optional continuing education courses for dental professionals on people with DD. All focus group participants responded affirmatively to a poll asking if they would like to see the Commonwealth support voluntary continuing education courses about people with DD that offer CEUs. They suggested increasing the visibility of available courses through partnerships with local and state dental associations. They also suggested providing training on additional topics including behavior management, logistical considerations such as scheduling, person-centered practices, trauma-informed care, the rights of people with disabilities to access healthcare, and their social responsibility to serve everyone, including people with DD.

Recommendation 3: The Virginia Department of Medical Assistance Services, Virginia Department of Health, and Virginia Department of Behavioral Health and Developmental Services, in partnership with other stakeholders including but not limited to the dental benefits administrator and the Virginia Dental Association, should expand the available continuing education offerings for dental professionals on people with developmental disabilities.

Several stakeholders liked the idea of offering continuing education hours for providing uncompensated care to people with DD. This approach would build off an existing allowance for providing uncompensated care to people who are low-income (18 VAC 60-21-250; 18 VAC 60-25-190). Fifty-three percent of focus group participants responded affirmatively to a poll asking if they would like to see the Commonwealth allow CEUs for this purpose. A few

stakeholders said the change could encourage additional dental professionals to volunteer at Mission of Mercy events and at free and charitable clinics. However, a few stakeholders expressed uncertainty about how much impact the change would have.

Recommendation 4: The Virginia General Assembly should amend Code of Virginia 54.1-2709 to allow dental professionals to receive up to two continuing education credit hours for providing uncompensated care to people with disabilities, in addition to the “low-income individuals” already specified in the regulation.

Several focus group participants also liked the idea of providing higher Medicaid reimbursement rates when providers treat patients with DD if they have taken related training. For example, the Medicaid managed care organization AmeriHealth Caritas has an Inclusive Dental Plan with separate reimbursement rates for trained providers, according to a 2022 National Council on Disability report. Fifty-three percent of focus group participants responded affirmatively to a poll asking if they would like to see the Commonwealth take this approach. However, few stakeholders felt strongly enough to provide more feedback about this option.

While there was interest among some dental professionals in receiving financial incentives through Medicaid, this approach could have several drawbacks. First, this approach would not reach the vast majority of providers who do not participate in Medicaid. While it might encourage more providers to join Medicaid, higher reimbursement rates for all Medicaid providers would be more effective in that regard. Second, this approach could be seen as a barrier to Medicaid reimbursement. Providers who do not take the additional training would receive lower compensation, and they already report losing money when they treat this population, as discussed later in this report. Third, this approach would pose logistical challenges to determine which advanced training programs qualify, which continuing education courses qualify, how often providers are expected to take related education, and tracking provider compliance. CMS approval would also be required.

Another option is to tie training requirements to student loan repayment programs. VDH’s State Loan Repayment Program offers student loan repayments for dentists and other healthcare professionals who commit to serving two to four years at eligible practice sites, which exclude private for-profit practices, in designated Health Professional Shortage Areas. The Delta Dental Loan Repayment Program is an extension of this program that offers student loan repayment for dentists or dental hygienists in exchange for 12 months of service at a safety-net clinic. These and other repayment programs should consider requiring recipients to take training on underserved populations, including people with DD, when allowable.

There was mixed interest among stakeholders in continuing education requirements for licensed dental professionals. Forty-seven percent of focus group participants responded affirmatively to a poll asking if they would like to see the Commonwealth require that a portion of continuing education hours address underserved populations. Some focus group participants

and other stakeholders felt it would be appropriate to require a short course given the high need for increased dental care for this population and the state's related policy goals, as expressed in comments like the following:

"I think that at a minimum there could be a requirement for all of the licensed health professions in Virginia to obtain 1 CEU on providing care to individuals with DD.... Certainly, given the Commonwealth's investment in a dental benefit [and] the DOJ focus on 86% of individuals with a DD waiver having an annual dental exam...there could or should be a focus on a CEU for certified or licensed dental professionals having a CEU requirement for this education."

"I hate required stuff but you might need to do it for a while. Maybe not forever.... Maybe it's every four years or something.... We're talking about effecting change in the community, not just from the dental school that's going to take years to affect change, but we have all these practicing dentists now who are more capable than they think they are. Requiring part of their CE to be in that area might be a way to help with that."

"I think the idea of requiring something is a good idea, whether you're going to be seeing this population or not because it kind of desensitizes you to that fear of, 'Am I doing enough? Am I doing this right or not?' It doesn't have to be... 10 hours, but having something in there about it... is a good idea."

"So I think that having something mandatory for treating those that aren't always included in the mainstream would be very important to just advancing our profession. ...I think it's easy when doctors are in private practice... and hygienist and other professionals not to be quite as sensitive to some of those issues just because they're kind of in their little bubbles..."

On the other hand, some stakeholders were opposed to requiring continuing education on people with DD. One key stakeholder questioned whether a requirement would translate into increased access, and a few said that more in-depth technical assistance is needed. Focus group participants expressed concerns about restricting a provider's ability to choose what they think is most valuable for their practice, and whether a short course would provide false confidence, as expressed in comments like the following:

"...Is it the chicken or the egg? I mean, I think a requirement is certainly the only way that you're going to put this information in front of some people. You know, I can see too a lot of people, if you make it a requirement, [wondering] 'Why am I watching this if I'm not even going to provide care to these people.' So I think a requirement is a great way to bring this about, but I think there's gonna have to be a lot of change in the front end..."

“I know for me, I would do a course like that. But then I also understand, for those in private practice, they probably won’t focus on a course like that, you know.... Maybe this one wouldn’t be a top priority to them.”

“There are dentists who don’t think that information would be relevant to their practice because they don’t see patients with special needs.... There is a big thing about desire. If you have desire, things can work out really well. If you don’t have desire, they go to the OR [operating room].”

“I would worry about making it a requirement because.... there are others that should not treat these patients.... There are some people that you just need to not be around that population because they don’t have the capacity for it, or the patience. And I worry if making something a requirement – that it’s not going to actually make someone more comfortable. It’s gonna make them think that, “Well, I can do this because I took a 2 hour course.”

Some stakeholders were more in favor of a requirement if it built in choice regarding the underserved population and topic. Stakeholders suggested that training on topics such as the code of ethics and how to access resources for patients that providers aren’t able to treat would be applicable to a wide range of underserved populations. They also suggested training on oral hygiene and the discrepancy in care that high- and low-income patients receive.

Although Virginia has given dental professionals broad discretion over continuing education topics, requiring continuing education on certain topics is not unprecedented in other states. At least eight other states have required dental professionals to take continuing education on underserved populations (see Appendix D). Three additional states have given dental providers a list of topics to choose from, at least one of which related to underserved populations. Related topics include behavior management, cultural competency, and implicit bias.

If the Commonwealth is serious about meeting its policy goal, it needs to implement a continuum of continuing education methods that includes a required course on underserved populations. While one short course may not be sufficient to increase access to care, it may be sufficient to spark provider interest in seeking more information and exposure. The short courses could refer them to more in-depth information sources including the VDH special needs dentistry course and the Centers for Inclusive Dentistry program.

Recommendation 5: The Virginia General Assembly should amend *Code of Virginia* §54.1-2709 and §54.1-2722 to require that a portion of the 15 annual continuing education credit hours for licensed dental professionals pertain to underserved populations including but not limited to people with developmental disabilities.

III. Mitigating the Extra Cost of Treating People with DD

KEY TAKEAWAY

People with DD typically take more time to treat. Time is money for providers who are paid per service. State policymakers should regularly assess Medicaid reimbursement rates to ensure the sustainability of the service system for people with disabilities.

Another challenge is that people with DD typically take more time to treat. More time may be needed to manage behavior. More time may also be needed for other accommodations, such as transfer from their wheelchair or communicating with the doctor, which are discussed more in depth in the next section of the report.

Longer Appointment Times Can Impact Financial Sustainability of Providers

Longer appointment times have financial impacts for providers. Fee-for-service providers could be getting paid to treat somebody else during the additional time that it takes to treat someone with a disability. Although the Americans with Disabilities Act requires the provision of reasonable accommodations including extra appointment time, as discussed later in this report, it is important for health insurers to mitigate the financial impact to promote the sustainability of the service system.

Numerous stakeholders raised concerns about the cost of extra time to treat people with DD. Dental professionals shared the following feedback during the focus groups:

“Sustainability is a concern too. If the care is going to take longer, how do we do it? How do we make it sustainable?”

“When you are in private practice, it is quite money driven.... Time is money at that point. If you are needing to spend over an hour, you know, talking and coaxing a patient... with developmental issues, that costs a lot of time...”

“If you made more money treating this population, we wouldn’t have this issue.... The problem is they’re harder to treat. Some, not all. But I mean, it does take more time.... On the whole, it’s not an economic winner.”

“Across the reimbursement codes, I knew it was going to be a loss for me, but it was my patient so I want to do it. It was always a loss.”

Review of Medicaid Behavior Management Rate Is Needed

Virginia's Medicaid program helps offset the extra cost of treating people with disabilities. The program reimburses \$89 per visit for extra time or staff needed to manage behavior. Providers can only bill for this procedure code five times per adult per year, but that limitation will be removed starting January 1, 2024.

It is not clear if the reimbursement rate is sufficient. Few of the focus group participants had experience with this procedure code. One provider said the rate is sufficient while another provider posited that a variable rate, dependent on how much additional time or staff are needed, might be warranted. At least four other state Medicaid programs appeared to reimburse higher than Virginia for behavior management, based on an April 2023 review of their websites (see Appendix E). The average fee that general dentists charged for behavior management was \$127 nationwide, and ranged as high as \$273, according to the 2020 American Dental Association Survey of Dental Fees.

It is also unclear if Virginia reimburses for behavior management in all relevant situations. Virginia does not reimburse for behavior management that is "solely for the management of dental fear/anxiety," according to the program's Office Reference Manual. This appears to conflict with the purpose of behavior management techniques such as desensitization. Staff were unable to find another state Medicaid program using similar language, although a few required that the procedure code be billed with a payable service (see Appendix E). Another procedure code that Virginia does not reimburse for, "dental case management – patients with special health care needs" (D9997), might be able to cover desensitization visits but additional research is needed.

DMAS recently committed to reviewing all dental reimbursement rates every three years, according to a November 2022 report, but that review is not necessarily intended to identify insufficiencies in individual rates. DMAS should also review individual reimbursement rates that are key to serving people with DD, including but not limited to behavior management (D9920). As part of the review, Virginia can look to lessons learned from Delta Dental of Virginia's new inclusive dental benefit that was introduced in the Background section of this report.

Recommendation 6: As part of the Virginia Department of Medical Assistance Services' review of dental reimbursement rates every three years, it should review individual reimbursement rates that are key to serving people with developmental disabilities and report publicly on its findings. The review should assess whether (1) each rate is equal to or greater than the Department's target of 82-83% of commercial insurance; (2) each rate is sufficient to cover provider costs and mitigate any negative impact; and (3) additional procedure codes need to be covered to adequately serve this population. Rates to review include behavior management (D9920), certified translation or sign language services (D9990), and sedation and anesthesia (D9222-D9248).

IV. Increasing the Accessibility of Dental Services

KEY TAKEAWAY

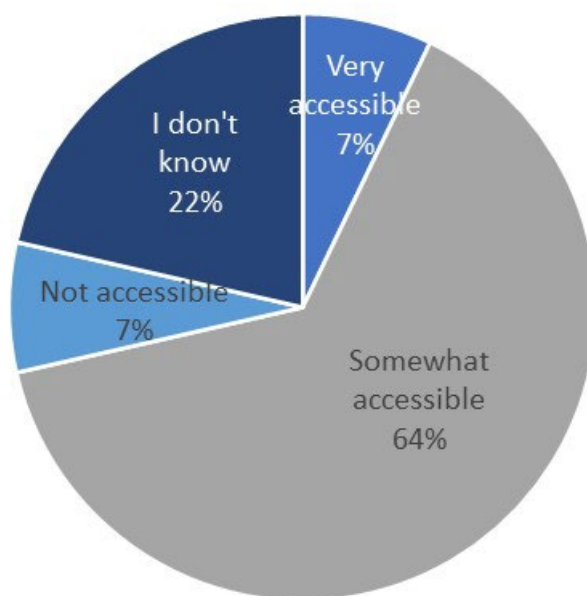
Some dental professionals appear to be violating accessibility laws by failing to provide accommodations and discriminating against people with disabilities. Dental professionals may be more likely to comply if they have additional knowledge and financial resources.

Accessibility is another challenge for people with DD trying to access dental care. Accessibility includes physical access, communications access, and programmatic access. Programmatic access involves office policies and procedures such as patient eligibility and scheduling.

Some Dental Professionals Appear to Be Violating Accessibility Laws

Many dental services are not fully accessible, according to available data. Only 7% of focus group participants reported on a poll that dental offices are “very accessible” when it comes to physical, communications, and programmatic accessibility (see Figure 6). Twelve and 20% of Virginians with developmental and other disabilities cited physical and communications access, respectively, as barriers to dental care on the 2019 VDH Basic Screening Survey. National reports also cite accessibility as an oral health barrier (NCD 2017, NCD 2022, NRC 2011).

Figure 6: Provider Opinions on Accessibility of Dental Offices (Focus group polls)



Some dental professionals appear to be violating the Americans with Disabilities Act by failing to provide reasonable accommodations. For example, some dental professionals are not providing interpreter services or extra appointment time. Feedback from dental professionals and other key stakeholders included the following:

“... We have a lack of translation services. When we’re treating [a patient with a hearing impairment],... we have no way of communicating with her. So we have to kind of rely on writing things down, or just making it work. And we’ve made it work so far, but it’s not ideal in any way, shape, or form.... Because we really don’t have a lot of hearing impaired patients, [an interpreter service] is not something that’s considered a necessity, I guess. We make due.”

“There is also the time that goes into seeing a patient with special needs. It can take nearly a year to build in the extra time as many providers are booking out 12+ months in advance.”

Dental professionals also appear to be violating the Americans with Disabilities when they refuse to conduct an individual needs assessment for someone with a disability. Many dental professionals are reportedly refusing to schedule an appointment for people with disabilities, according to the following feedback from dental professionals during interviews and focus groups:

“We get plenty of people that say that, even over the phone, offices won’t see them.”

“Stigma is one key barrier. Dentists don’t want people with disabilities in their waiting room because they think it can make others uncomfortable.”

“They say they haven’t been trained. That’s how they get around the Americans with Disabilities Act.”

“I feel like we just have to, you know, tell our colleagues look man, you can’t say no [to seeing a patient with a disability].... At least see someone when they call, make an appointment. Yes, and then they come to your office and if you literally can’t take care of them then you know to give us a call...I think there’s a lot of offices that reflexively say no. And they say they aren’t trained. So many of the folks don’t need any special care. They really don’t. So I think they’re technically in violation of the Americans with Disabilities Act....”

This feedback indicates that some provider claims about insufficient training are either misinformed or masking discrimination against people with disabilities. People with the same disability can have very different needs, so an individual assessment is required for the provider

to have an accurate understanding of their treatment needs. If the provider is unable to treat them, they are expected to refer them to another provider who can.

This failure to provide an individual assessment appears to be in violation of the Americans with Disabilities Act. The Act prohibits eligibility criteria that screen out people with disabilities “unless such criteria can be shown to be necessary for the provision of the services... being offered.” It also allows for safety requirements that are “based on actual risks and not on mere speculation, stereotypes, or generalizations about individuals with disabilities.” It seems challenging for providers to demonstrate compliance with these provisions without first assessing the person’s needs.

Additional Resources May Support Compliance

It is important to consider whether there are ways to support provider accessibility rather than blaming them for noncompliance. There are likely some dental professionals who would comply with the law if they were given related supports. Related supports could include educational and financial resources.

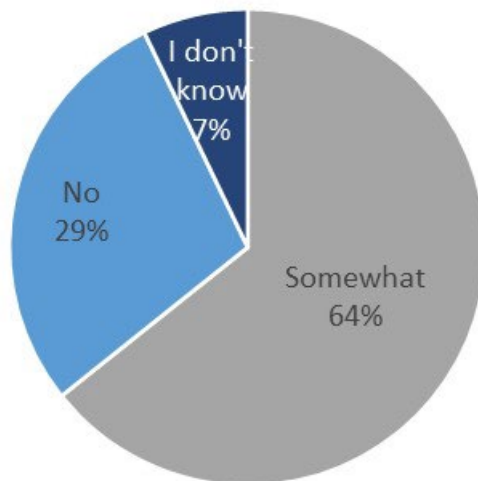
One reason providers may not be complying with accessibility laws is that they don’t fully understand them. None of the focus group participants reported that dental office staff typically understand the accessibility laws and how to comply with them (see Figure 7). About two-thirds felt there was only “somewhat” of an understanding of the accessibility laws, and the remaining one-third felt there was “no” understanding. Some providers spoke to the need for additional training during the focus groups:

“The other thing would be training for dental staff and dental assistants, all the way down to auxiliary staff like the receptionist, to know what kinds of questions to ask e.g., mobility, preparation for the appointment,... behavior management, etc.”

“I guess if I knew that there was some type of [translation] service that I could access just... on a needed basis not on a consistent basis because it’s not something that we need consistently.... So if I had access to something when I needed it, that would be amazing, even if I had to pay per appointment...”

“...A lot of it goes back to the training... There’s a lot of things that we can do, you know, in their [wheel]chair... There’s a lot of misunderstanding and the opportunity for the education of the profession on how to manage that. Make it easier for patients to get care in their neighborhood.... I think it’s important. And then...the Americans with Disabilities Act, I think that’s another opportunity for just education on rights and responsibilities.”

Figure 7: Knowledge of Accessibility Laws Among Dental Office Staff (Focus group polls)



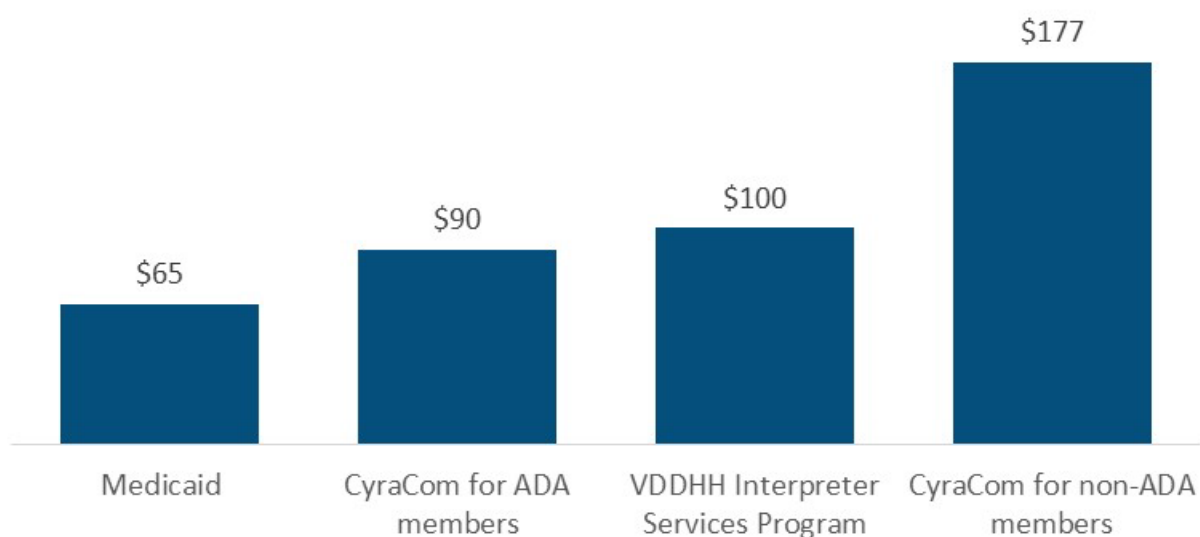
Another reason providers may not be complying with accessibility laws is that they pose additional costs. Dental professionals may have less ability to absorb overhead costs than other healthcare providers due to their small size. Fifty percent of dentists were in solo practice, compared to just 14% of physicians in 2020, according to reports by the American Dental Association’s Health Policy Institute and the American Medical Association. Consequently, some compliance costs may pose an “undue burden” for dental professionals and therefore be exempt from the requirement.

To address these two accessibility barriers, the National Council on Independent Living and Centene Corporation established a Barrier Removal Fund that has operated in 16 states. Providers participating in affiliated health plans can apply for funding to remove accessibility barriers. For example, the funding can be used to install ramps, automate doors, purchase accessible equipment, produce accessible formats of written materials, and buy noise cancelling headphones or weighted blankets. Providers undergo an on-site assessment, and receive related training and technical assistance, to guide the use of the funding. Virginia should consider implementing a similar program.

Recommendation 7: The Virginia Department of Behavioral Health and Developmental Services, in partnership with the Virginia Department of Health, should seek funding from the Virginia General Assembly, the Centers for Disease Control and Prevention’s Disability and Health State Programs, or other sources to establish a pilot program that provides funding for dental professionals to remove physical, communications, or programmatic accessibility barriers. Providers who receive this funding could have the opportunity to undergo an on-site accessibility assessment and receive related technical assistance.

Virginia's Medicaid program reimburses for certified translation and sign language services, but its reimbursement rate of \$16.25 per 15 minutes appears insufficient to cover cost. This rate is less than the cost of one hour of video remote interpretation services through CyraCom, a service endorsed by the American Dental Association (see Figure 8). The reimbursement rate is also less than the rate that government agencies pay through the Interpreter Services Program offered by the Virginia Department for the Deaf and Hard of Hearing. They pay \$50 per hour of on-site services plus \$40 per hour of travel time. When the combined onsite and travel time is two hours or less, they pay a two-hour minimum at the onsite rate for a total of \$100.

Figure 8: Rates for One Hour of American Sign Language Interpretation (Staff analysis of Medicaid fee schedule and user agreements)



This comparison likely represents a best-case scenario. Other interpreter services are likely even more expensive than these discounted options. Additionally, there are circumstances in which video remote interpreting, which tends to cost less than an on-site interpreter, may not be appropriate. For example, video remote interpreting may not be appropriate if a provider lacks a reliable internet connection, if a provider doesn't have the necessary technology, or if the patient would have difficulty seeing the screen while the provider is working on them.

DMAS is currently reviewing the reimbursement rate in response to provider concerns. DMAS should seek to increase the rate so that it is more in line with provider costs. Although the Americans with Disabilities Act requires the provision of interpreter services, health insurers should mitigate the financial impact to promote the sustainability of the service system.

Recommendation 8: The Virginia Department of Medical Assistance Services (DMAS) should seek approval from the Virginia General Assembly to increase the reimbursement rate for certified translation or sign language services (D9990).

V. Increasing Access to Sedation and Anesthesia for People Who Need It

KEY TAKEAWAY

Sedation and anesthesia can help manage behavior. Some providers may default unnecessarily to sedation and anesthesia, however, rather than using a person-centered approach to care. When sedation and anesthesia is needed, limited provider education and compensation can delay access for up to two years or more.

Sedation and anesthesia can help manage behavior so that people with DD can receive dental care. There are varying levels including mild sedation using nitrous oxide, moderate sedation, and general anesthesia. General anesthesia has the biggest health risks and is only recommended in industry guidelines if other behavior management techniques are insufficient (AAPD 2023, ADA 2021, Lyons 2009).

There are two main ways to improve access to sedation and anesthesia for people who need it. One way is to ensure that limited sedation and anesthesia resources are not being used for people who don't need it. The other way is to address provider barriers to accessing sedation and anesthesia.

Some Providers May Recommend Unnecessary Sedation and Anesthesia

There was stakeholder consensus that the need for sedation and anesthesia falls along a continuum and should be considered on a case-by-case basis. Some people can be seen without any sedation or anesthesia, some need sedation or anesthesia for certain procedures, and others need sedation or anesthesia for everything. Someone may start out needing sedation but gradually become comfortable enough to be treated without it. Programs in Virginia and other states have demonstrated that people with DD do not need sedation or anesthesia as often as previously thought (Berens et al. 2022, NCD 2022, DBHDS interview).

Some dental providers in Virginia may be recommending unnecessary sedation or anesthesia, according to available data. Nearly half of dental professionals who responded to a focus group poll said they think there are opportunities to reduce the number of people with DD who need sedation or anesthesia for dental care. Only about 10% of the poll respondents said there aren't opportunities, and the remainder said they didn't know. Additionally, 20% of Virginians with developmental and other disabilities cited their dentist only treating them with sedation as a barrier to care, according to the 2019 VDH Basic Screening Survey.

Several stakeholders talked about how a lack of behavior management training can cause dental professionals to recommend unnecessary sedation and anesthesia. Comments during stakeholder interviews and provider focus groups included the following:

“You have to build trust. Start with [asking] what can you accomplish without sedation, using person-centered techniques. Don’t default to sedation as a preventative measure. Lots of facilities used restraints and anesthesia as prevention of anticipated behavior. Those folks didn’t even need it. I don’t like to say this person does or doesn’t need sedation, versus something in-between.”

“For a long time here, it’s been treating [patients with disabilities] with nothing or take them to the OR. But I think there is a lot of middle ground.”

“For some patients [with disabilities] we can do cleanings, x-rays, etc. in the chair because we’ve worked with them for so long. Many of them need OR for extensive treatment. The average dentist may not have the experience and training to treat people in their office. Many providers assume, for example, that people with autism automatically need the OR.”

“I’m not even sure if a lot of practicing hygienists have ever been exposed to behavior management techniques, to be honest.”

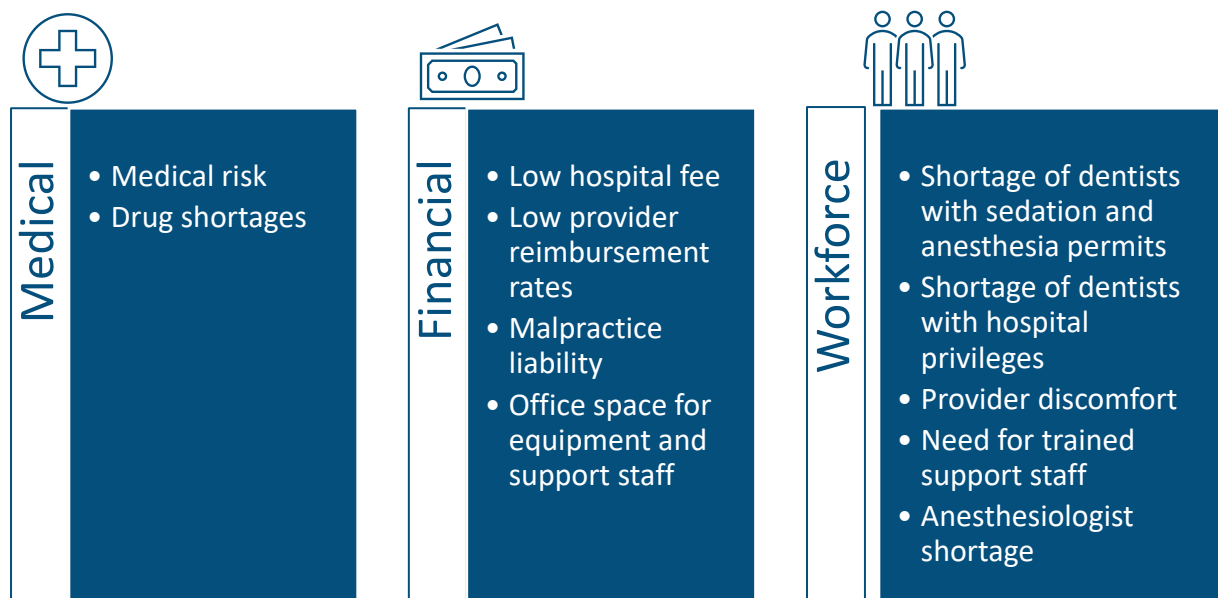
The lack of training could be addressed through recommendations made in an earlier chapter of this report on improving provider comfort levels. The recommendations spoke to the need to support the exposure of dental students at Virginia Commonwealth University to people with DD. The recommendations also spoke to the need for a continuum of continuing education methods to reach existing dental professionals.

Stakeholders also suggested other ways to minimize unnecessary sedation and anesthesia. Silver diamine fluoride can delay the need for general anesthesia to treat cavities in young children by 3 months (Meyer et al. 2023). During that time, the child may develop enough skills to receive treatment without general anesthesia. Additionally, a dental hygienist suggested expanding the settings where remote supervision hygienists can practice so that people have greater access to preventive services. A study of innovative ways to reduce unnecessary sedation and anesthesia, including but not limited to silver diamine fluoride, could be helpful.

Medical, Financial, and Workforce Barriers Limit Access to Sedation and Anesthesia

A variety of barriers limit a dentist's ability to provide sedation and anesthesia, according to stakeholders in Virginia and the national research literature. The barriers can be grouped into three categories, as shown in Figure 9 below.

Figure 9: Various Barriers Limit Dental Provider Access to Sedation and Anesthesia (Staff analysis of stakeholder interviews and focus groups)



Relatively few dental professionals can provide advanced levels of sedation and anesthesia. Dental professionals must have a certain amount of training and experience to get a sedation permit from the Board of Dentistry. Only 6% of dentists who are actively licensed and living in Virginia have a moderate sedation permit and less than 1% have a deep sedation/general anesthesia permit, according to data that the Board of Dentistry shared in October 2023. Additionally, oral maxillofacial surgeons are allowed to provide sedation and anesthesia without a permit.

The low permit rates are primarily due to limited provider education and incentives. Stakeholders talked about the lack of education during dental school and beyond. Stakeholders also spoke about how the Medicaid reimbursement rates for sedation or anesthesia are reportedly not sufficient to cover the cost of an anesthesiology provider, support staff, drugs, equipment, other supplies, and liability insurance. Feedback during stakeholder interviews and focus groups about the limited provider compensation included the following:

“Reimbursement is the biggest problem to highlight... The Medicaid fee schedule does not reimburse enough for anesthesia. My practice takes a hit on the anesthesia.... Part of the reason for the insufficient fees is that the fees haven’t kept up with the price of the drugs.”

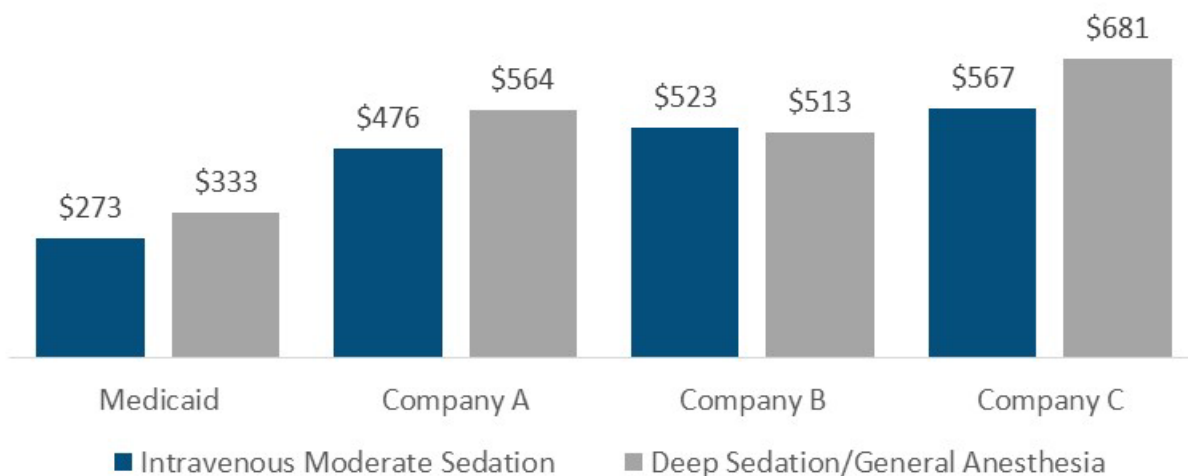
“The biggest barrier is that Medicaid reimbursement for sedation is too low... \$400-450 per hour is reasonable for staff, medication, supplies, etc. The current Medicaid rate is somewhere around \$65 per 15 minutes.”

“The Medicaid reimbursement rate might sound reasonable at first, but it doesn’t cover the time before and after sedation that’s needed. It doesn’t come close to paying the typical salary of a CRNA, especially in the competitive market right now.”

“The real problem is with this... mild sedation, you really have to be ready for moderate.... It’s a continuum. That’s where the experience, not necessarily just training, has to be there.... Because the requirements to get a moderate sedation license when you’re in private practice are prohibitive. I mean, good luck finding a course and spending the money to get that license for what?”

Virginia’s Medicaid program reimburses substantially less than other large commercial insurers for sedation and anesthesia provided in a dental office. Medicaid reimbursement for one hour of moderate and deep sedation ranged from 48 to 57% and 49 to 65%, respectively, of the commercial reimbursement rates provided by three large dental insurers in Virginia (see Figure 10). This data indicates that Virginia is well behind the DMAS goal of reimbursing 82-83% of commercial insurance rates.

Figure 10: Reimbursement for 1 Hour of Sedation by 4 Large Dental Insurers (Billing staff)



Recommendation 9: The Virginia Department of Medical Assistance Services (DMAS) should seek approval from the Virginia General Assembly to increase the reimbursement rates for sedation and anesthesia provided in the dental office (D9222-D9248).

Some people with disabilities need to receive sedation or anesthesia in a hospital setting to ensure their safety, but that poses additional financial costs to dental professionals. Dental professionals have to dedicate a substantial amount of time to hospital cases due to the travel time and the complexity of the case. Providers report that reimbursement rates do not adequately recognize these additional costs. Stakeholder feedback included the following:

“The operating room takes so much more time. [My colleague] has to weigh his time spent over there against time spent in our office and trying to make a living. And you know, we’ve always said that taking patients with developmental disabilities should not fall into the charity part of the world. You know, it should be economically feasible.”

“If we tried to do that in the hospital setting, [with] the way community health centers get paid, we wouldn’t be able to sustain that service.”

Additionally, hospitals are giving dentists limited or no access to the operating room because the hospital fee is substantially lower for dental services than other medical services. Consequently, wait times for dental services in the hospital setting can reportedly range up to two years or more. Stakeholder feedback included the following:

“Dental kinda takes a backseat to most of the other... services... So we have what limited time we have. We just have too many people to plug into it.”

“I don’t understand how that’s even legal, quite frankly. Is the hospital meeting its mission and with the Americans with Disabilities Act? I have some real serious questions about that....It’s pretty disheartening, quite frankly.”

“The hospital administration has to be willing to tolerate losses in certain segments because it’s the right thing to do. And because, as a community hospital that doesn’t pay taxes, it’s part of your community benefit....”

“The three hospitals in Richmond are turning dental care for people with disabilities away. We need a mandate in state-funded hospitals to give OR time to dental cases.”

One alternative to these challenges is partnering with certified registered nurse anesthetists (CRNAs). CRNAs were recently authorized to provide sedation or anesthesia in a dental office even if the dental provider does not have a sedation permit. According to stakeholders, CRNAs receive more training than general dentists on how to safely administer sedation and

anesthesia. CRNAs also enable the dentist to focus solely on the dental procedure, rather than on both the dental procedure and the sedation or anesthesia. They are more cost-effective than other anesthesiology providers.

However, there may be limitations to what role a CRNA should have in a dental office. Several stakeholders were concerned about the appropriateness of providing sedation or anesthesia to patients with higher medical risks in an office setting. Some stakeholders said CRNAs might be appropriate to administer milder sedation to patients with lower medical risk in an office setting. However, they emphasized the importance of having emergency personnel available, noted the difficulty of predicting what level of sedation is needed in advance, and noted that it might not be financially feasible unless a provider has a high enough caseload.

Recommendation 10: The Joint Commission on Health Care should study innovative ways to (1) address barriers to accessing sedation and anesthesia for dental procedures, both in and out of the hospital setting, including limited provider education, limited provider compensation, and limited hospital fees; and (2) reduce the need for sedation and anesthesia through, for example, silver diamine fluoride.

VI. Connecting People with DD to Providers

KEY TAKEAWAY

Virginia has several dental provider directories which may cause confusion, frustration, and inefficiency. Stakeholders should work collaboratively to consolidate and improve them.

Provider directories are an essential resource for connecting people to providers who can meet their needs. However, they are only useful if their information is relevant, accurate, and easy to understand. Virginia has several provider directories, but their usefulness may be limited.

Multiple Provider Directories Exist

There are at least six dental provider directories in Virginia (see Table 1). Each directory has benefits and limitations. They differ in terms of target audience, eligible providers, content, update frequency, reach, and sponsorships.

Table 1: Virginia Dental Provider Directories (Staff analysis of websites & stakeholder feedback)

Host	Population	Method	Benefits	Limitations
Each dental insurer	Providers in the insurance network	Time of credentialing & at least annually thereafter	Providers are aware of it & incentivized to update it	Excludes providers outside the insurance network
disAbility Navigator	All providers	Annual website reviews, provider outreach	Several sponsors	Can't filter results by insurance or disability type
Unite Virginia	Participating providers	N/A – Providers join coordinated care network	Connects providers to each other; Several partners	Only available to providers; Amount of disability info unclear; Cost for private providers
Virginia Dental Association	Association members	N/A - Annual update based on membership	Well-known to providers	No disability info; Only available to providers
Virginia Department of Health	All providers	2008 and 2023 surveys, updated upon provider request	Known to providers who take VDH special needs training	Onus is on providers to proactively update; Consumers may be less aware
211	Large providers	Annual provider outreach	Known to consumers; Several sponsors	Limited disability info

In addition to these provider directories, there are also other efforts to help connect people with disabilities to dental professionals. DBHDS and the VDH Care Connections for Children program have their own provider lists that they use to make referrals. Special Olympics has also been working to develop dental provider directories across the country.

While these efforts are commendable, the multitude of provider directories and lists can pose several problems. First, people may be confused about which directory or list to use and why each one might provide different results. Second, providers may be frustrated about having to update multiple directories. Third, the redundant efforts may be an inefficient use of collective resources across organizations.

There was consensus among stakeholders that there would be value in collectively evaluating existing efforts and identifying any opportunities for improvement. There are no easy solutions given each organization's purpose, funding sources, and requirements. However, there might be opportunities to link the directories to each other, consolidate some of the directories, and/or combine resources to improve directory content.

Recommendation 11: The Virginia Department of Medical Assistance Services, Virginia Department of Health, Virginia Department of Behavioral Health and Developmental Services, and other stakeholders should participate in a workgroup on oral health for people with disabilities to (1) continue sharing information, (2) explore ways to use their combined resources to better connect people with disabilities to dental providers who can meet their needs, and (3) explore ways to use their combined resources to better connect dental providers with other dental providers who can serve people with disabilities.

Directories Have Relied on Self-Reported Information from Providers

Just because a provider claims they serve people with disabilities does not necessarily mean that they serve them in practice. Many healthcare providers may not be willing to admit their inability or unwillingness to serve people with disabilities, while others may not realize that their services are not fully accessible. Stakeholders need to verify provider self-reports to ensure more accurate provider directories and network adequacy analyses. Verification can be done by triangulating information across multiple sources (see Figure 11).

One verification method is secret shopper studies. Secret shoppers can pretend to be a person with a disability, or a caregiver of someone with a disability, who is trying to schedule a dental appointment over the phone. The dentist office's responses either validate or invalidate the accessibility information that the provider reported. Most of the published secret shopper studies have focused on comparing healthcare access across insurance types, but experts like the Urban Institute and the Kaiser Family Foundation have called for secret shopper studies that investigate healthcare access for people with disabilities.

Figure 11: Information Sources for Dental Provider Directories (Staff analysis)



DMAS has not used secret shoppers to assess dental care access for Medicaid members with disabilities, but the agency plans to do so soon in response to this report's findings. DMAS should collaborate with disability stakeholders to develop the secret shopper questions. The questions should address physical, communications, and programmatic accessibility.

A second verification method is on-site assessments, which are used in some other state Medicaid programs (Singer, Dickman, and Rosenfeld 2017). California requires its Medicaid managed care organizations to conduct an on-site survey every three years of primary care providers who serve people who are older or have disabilities. Primary care providers in Colorado's Medicaid program can participate in an on-site assessment using the Disability Competent Care Assessment Tool. And, through the Barrier Removal Fund mentioned earlier, Centene Corporation and the National Council of Independent Living have conducted over 2,500 on-site assessments of providers in participating health plans across the country.

DMAS has not conducted on-site assessments of dental providers. The agency could consider assessing a sample of providers on a rotating basis to minimize the resources needed to conduct them. The findings could be used to update the provider directories, inform network adequacy analyses, identify opportunities for improvement, and track progress over time.

Recommendation 12: The Department of Medical Assistance Services, and its dental benefits administrator, should regularly verify self-reported information from providers on their physical, communications, and programmatic accessibility for people with disabilities by collaborating with disability stakeholders to conduct (1) independent site reviews at the time of credentialing and/or on a rotating sample of providers; and (2) secret shopper studies of dental care providers.

Provider Directories May Benefit from User Testing

People with disabilities should be consulted on the content and design of provider directories. They know what types of information are most useful and understandable to them. They also know what formats are most accessible to them.

Information on the extent to which Virginia’s provider directories conduct user testing is not available, but a review of the directories indicates there may be opportunities for improvement. For example, some provider directories might benefit from using more plain language and defining terminology such as “provider experience,” health plan names, and types of dental professionals. Some directories would also benefit from including more disability-specific information and refining the disability categories.

DMAS and DentaQuest updated the online Medicaid dental provider directory this past summer. The update included adding information on providers who offer sedation to people with disabilities, in response to this report’s findings. The update is commendable, yet there might be additional opportunities for improvement.

Recommendation 13: The Virginia Department of Medical Assistance Services, its dental benefits administrator, the Virginia Department of Health, and other relevant stakeholders should conduct user testing of their dental provider directories to ensure that they are useful for, understandable to, and accessible to people with developmental disabilities. The user testing should be conducted once upfront and each time the directory is updated thereafter.

VII. Meeting Demand for Key Stopgap Program

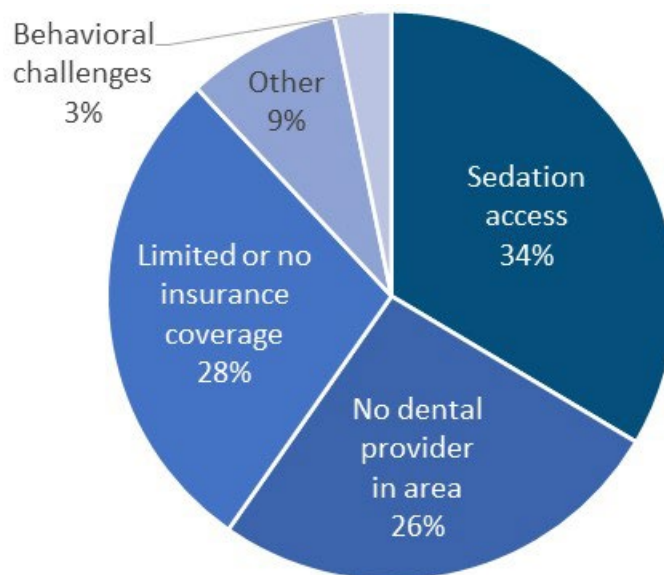
KEY TAKEAWAY

The DBHDS Dental Program is a lifeline for people with DD who cannot find a dental provider. Limited resources prevent the program from providing timely services, outreach, and services to people under 21 years old. Legislators should provide additional funding to meet demand.

The DBHDS Dental Program is a key stopgap program that people with DD rely on. The program educates dental professionals and connects people with DD to Medicaid, community-based, or DBHDS dental professionals to receive services. Services include preventative care, basic dentistry services, and sedation and anesthesia.

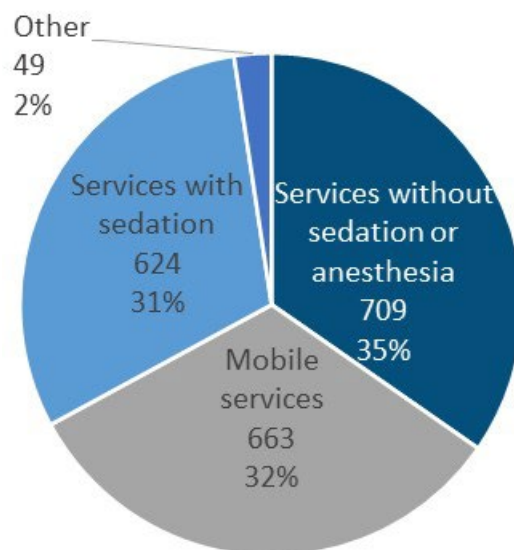
The DBHDS Dental Program is only open to people with DD who were unable to access a dentist in the past year. Of the people who were referred to the program between January 2017 and June 2022, about one-third were referred because they were unable to find a dentist who could provide sedation in the past year (see Figure 12). Twenty-six percent were referred because they could not find a dental provider in their area in the past year.

Figure 12: Primary Barriers for People Referred to DBHDS Dental Program (Program data, Jan. 2017 - June 2022)



The program served over 2,000 unique people with DD between January 2017 and June 2022 (see Figure 13). About one-third of them received services through DBHDS mobile units. The remaining two-thirds received services, with or without sedation, through participating Medicaid providers or DBHDS community-based partners.

Figure 13: DBHDS Dental Program Participants (Program data, Jan. 2017 - June 2022)



The program does not have enough resources to meet demand. DBHDS started a waitlist this year that included 200 referrals waiting to be processed, 285 people waiting for mobile assessments, and 185 people waiting to receive services through mobile units, as of September 2023. The estimated wait time was three to four months for referral processing and another three months for the mobile assessment. The program also continues to serve about 460 patients who receive DBHDS mobile services on an ongoing basis.

Due to limited resources, DBHDS staff have also had to restrict their outreach and eligibility criteria. Their limited outreach means that people with DD who need help may not know about their services. Their limited eligibility criteria mean that people with DD under 21 years old can't receive services.

Virginia should provide additional funding to the DBHDS Dental Program while it continues to strengthen its Medicaid program. Medicaid is the most cost-effective way to provide dental care in the long run because federal funding covers about half of the costs. However, the DBHDS Dental Program is a lifeline until Medicaid can better serve people with DD. The DBHDS Dental Program may also continue to play a valuable, albeit more limited, role in the long run.

Recommendation 14: The Virginia General Assembly should increase funding for the Department of Behavioral Health and Developmental Services Dental Program so they can expand their capacity to (1) screen and refer people with developmental disabilities (DD) to dental providers who can meet their needs; (2) treat people with DD using mobile units while the Commonwealth's Medicaid provider network continues to scale up; (3) conduct outreach so that disability stakeholders know about the program; (4) serve people with DD who are under 21 years old; and (5) provide in-depth technical assistance to dental professionals as needed.

VIII. Strengthening Medicaid Oversight

KEY TAKEAWAY

More oversight is needed to ensure that the Medicaid dental benefit is meeting the needs of people with DD. State policymakers need to regularly assess the dental provider network for people with DD. They also need to conduct more outreach to Medicaid members with DD.

Virginia must ensure that people with disabilities have access to Medicaid services that meet their needs, according to 42 C.F.R. §440.262. One way Virginia can support this requirement is through network adequacy analyses. Stakeholder outreach can also provide important context to supplement data analysis.

Medicaid Doesn't Assess Network Adequacy for People with DD

DentaQuest uses two methods to assess the Medicaid dental provider network. One method assesses patient load. The goal is to have at least one provider for every 1,500 Medicaid members. The second method assesses the time and distance needed to travel to a dental provider. The goal is that a member should not have to travel more than 30 miles or 30 minutes to see a dentist in an urban area, nor more than 60 miles in a rural area.

Neither of these methods are used to assess network adequacy for people with DD, even though only a subset of dental providers reportedly serve this population. DentaQuest does not conduct this analysis because it is not part of their contract and they do not have data on which members have disabilities. Without this type of analysis, it is not clear how the Commonwealth can ensure access to Medicaid dental services for people with DD or track progress over time.

Moving forward, DentaQuest should assess network adequacy for people who are on the DD waiver. DentaQuest should be able to get data from DMAS on DD waiver participants in each region. DentaQuest will also need to explore ways to collect data on which providers serve people with DD to support the analysis. DentaQuest collects data on how many providers report serving people with special needs at the time of credentialing, but this population is much broader than people with DD. DentaQuest could consider using data collected for the provider directory or through the secret shopper studies discussed earlier in this report.

Recommendation 15: The Virginia Department of Medical Assistance Services and its dental benefits administrator should expand their biennial dental network reviews to include an assessment of network adequacy for people on the Developmental Disabilities waiver. To support this analysis, they should explore data sources for providers who serve people with DD.

Outreach to Medicaid Members with DD Has Been Limited

DentaQuest regularly surveys members and providers, but they don't ask for information specific to people with disabilities. The provider survey does not ask about barriers to serving members with disabilities. Similarly, the member survey does not ask whether their disability-related needs were met. DentaQuest is not able to identify which survey responses came from members with disabilities because the survey does not give members the option to disclose their disability and DentaQuest does not have data from DMAS on member disability status.

The DentaQuest member survey only goes to members who have had a dental visit that year. Members who did not go to the dentist that year are not surveyed. DentaQuest attempts to educate these members about their dental benefit and give them an opportunity to make an appointment through postcards, telephonic reminders, and other efforts. However, DentaQuest does not ask them why they haven't used their dental benefit.

Several new DMAS initiatives, introduced in the Background section of this report, will increase member outreach. For example, the new member welcome program will help identify people who have special healthcare needs, the dental home program will assign members to a dentist, and the case management and care coordination program will help members address problems. It is too early to determine the impacts of these new programs, but they do not negate the benefits of soliciting feedback through provider and member surveys.

Additionally, there is a lack of transparency on the dental benefits administrator contract. It is not publicly available, making it difficult for disability stakeholders to provide feedback on the contract requirements and hold DentaQuest accountable to them. Disability stakeholders should have an opportunity to provide feedback on each contract prior to its finalization.

Recommendation 16: The Virginia Department of Medical Assistance Services and its dental benefits administrator should regularly collect feedback from providers and members on disability-specific issues by (1) including questions in the annual provider survey about their barriers to serving people with developmental disabilities; (2) including questions in the annual survey for members who have had a dental experience about whether their disability-related needs were met; (3) administering an annual survey to members who have not had a dental experience to identify related barriers and opportunities, including any issues with accessing dental providers due to their disability; and (4) soliciting input from disability stakeholders on Request for Proposals and contracts for the Department's dental benefits administrator.

IX. Improving Oral Hygiene

KEY TAKEAWAY

Many people with disabilities are not brushing enough. Education can improve their confidence and ability to brush at home, but education efforts in Virginia are limited. State policymakers should expand oral health education for paid and unpaid caregivers as well as people with DD.

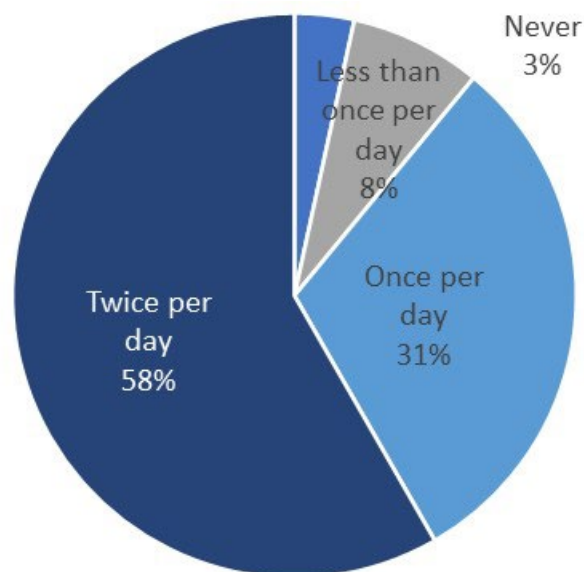
Regular oral hygiene at home is just as important for oral health as visiting the dentist. Dental visits typically only occur a few times per year, but oral hygiene is needed daily. Unfortunately, many people with disabilities have difficulty caring for their teeth at home.

Many People with Disabilities Don't Brush Enough

The American Dental Association recommends people brush their teeth at least twice per day. Brushing removes plaque that develops from leftover food. If plaque is not removed regularly, it can lead to gum disease.

Many people with disabilities aren't brushing enough. Only 58% of Virginians with developmental and other disabilities reported that they or a caregiver brushed their teeth twice per day, per a 2019 VDH Basic Screening Survey (see Figure 14). About one-third brushed once per day, and 11% brushed less often or never. These findings are similar to national research (Campanero, Huebner, and Davis 2014; Kurth and Hall 2019; Minihan et al. 2014).

Figure 14: Brushing by Virginians with Developmental and Other Disabilities (2019 VDH BSS)



Some people with disabilities and their caregivers in Virginia are not confident in their ability to care for their teeth at home. Nearly two-thirds of Virginians with developmental and other disabilities reported that they or their caregiver felt “very confident” in caring for their teeth at home, according to a 2019 VDH Basic Screening Survey. The remaining one-third were only somewhat confident, less than confident, or not sure. A California study had similar findings and found that paid caregivers felt more confident than family caregivers (Minihan et al. 2014).

A variety of factors limit the ability of people with DD to brush their teeth. People with DD may have difficulty remembering to brush, gripping the toothbrush, staying still, swallowing, or not gagging (Waldron et al. 2019). Caregivers may have difficulty helping if the person with a disability refuses to open their mouth or bites them. They may also have difficulty helping them due to lack of time, not having additional people to help, or not having related knowledge or skillsets (Campanero, Huebner, and Davis 2014; Minihan et al. 2014; Wilson et al. 2019).

While these barriers can be substantial, there are ways to mitigate them. Disability resources often recommend using motivational aids, calming aids, reminders, toothbrush adaptations, among other things (see Appendix F). The research literature on these methods is extremely limited, unfortunately. No single approach works for everyone. People with DD and their caregivers need to try different approaches to find what works best for them.

Oral Health Education for People with DD and Their Caregivers Is Limited

One way to improve their confidence and ability to brush at home is through education programs. Experts have called for more education programs on oral hygiene for people with disabilities (NCD 2022, NIH 2021). The research literature has found some positive early outcomes from various educational programs, although more research is needed (Kangutkar 2022, Kurth and Hall 2019, Waldron et al. 2019, Wilson et al. 2019).

Virginia has mandatory training for paid caregivers, but it only includes basic information on oral health (12 VAC 30-122-180). The orientation manual briefly mentions that oral health is important because it can lead to serious medical conditions. It also says that the caregiver may need to help someone with a disability brush their teeth, find a dentist, and/or communicate with a dentist. The knowledge-based test only requires caregivers to know that loose, missing, or decaying teeth present a choking hazard and that regular dental care is essential.

DBHDS should include more oral health information in its mandatory training for paid caregivers. Additional information is needed on how to help someone with a disability brush, including the related supports summarized in Appendix F, and how to help someone with a disability find a dentist. Additional information is also needed on the legal rights of people with disabilities to access health care, as well as general information on oral health and its

relationship to overall health. The training should also share other resources such as the free oral hygiene training, discussed next in this report, and the DBHDS Dental Program.

Recommendation 17: The Virginia Department of Behavioral Health and Developmental Services should develop a supplemental module on oral health for inclusion in their mandatory direct support professional orientation materials.

Paid caregivers aren't the only support network for people with DD. Nearly 80% of people with DD in Virginia lived with a family caregiver in 2019, according to the most recent State of the States in Intellectual and Developmental Disabilities report. It is therefore important to include unpaid caregivers in any education efforts.

However, Virginia does not target any oral health education to unpaid caregivers or people with DD. VDH and DBHDS offer a free two-hour course on oral health, but it primarily targets paid caregivers. Public schools are required to educate students on oral health, but the model curriculum does not address disability-specific issues because it is intended for the entire student body. Virginia Health Catalyst provided oral health education to people with DD and their families, using funding from the Virginia Board for People with Disabilities, but the grant project ended in 2015.

One way to fill this gap is to address oral health through the Individualized Education Programs (IEPs) that schools develop for students with disabilities. The Virginia Department of Education has been developing guidance to help ensure that IEPs address health education, among other things, in response to Code of Virginia § 22.1-214.4. That guidance, or any supplemental guidance, should incorporate oral health.

Recommendation 18: The Virginia Department of Education should incorporate oral health into its draft "Self, Health, and Relationship Education (SHARE)" guidance or any related supplemental guidance.

Another way to fill this gap is to create an oral health education program that targets people with DD and their caregivers. The VCU Partnership for People with Disabilities intends to do so in 2024, in collaboration with the Virginia Board for People with Disabilities and the disAbility Law Center of Virginia, to address this report's findings. The program will need support from other disability stakeholders and oral health experts, including VDH and DBHDS.

Appendix A: Recommendations

Improving Provider Comfort Level to Treat People with DD

Recommendation 1: The Virginia General Assembly should provide funding for the Virginia Commonwealth University School of Dentistry to establish a clinic dedicated to treating people with special health care needs. Predoctoral dental students and dental hygienists should rotate through the clinic.

Recommendation 2: The Virginia General Assembly should provide funding to the Virginia Commonwealth University School of Dentistry to establish a Fellowship program that addresses oral health disparities affecting people with developmental disabilities.

Recommendation 3: The Virginia Department of Medical Assistance Services, Virginia Department of Health, and Virginia Department of Behavioral Health and Developmental Services, in partnership with other stakeholders including but not limited to the dental benefits administrator and the Virginia Dental Association, should expand the available continuing education offerings for dental professionals on people with developmental disabilities.

Recommendation 4: The Virginia General Assembly should amend Code of Virginia 54.1-2709 to allow dental professionals to receive up to two continuing education credit hours for providing uncompensated care to people with disabilities, in addition to the “low-income individuals” already specified in the regulation.

Recommendation 5: The Virginia General Assembly should amend *Code of Virginia* §54.1-2709 and §54.1-2722 to require that a portion of the 15 annual continuing education credit hours for licensed dental professionals pertain to underserved populations including but not limited to people with developmental disabilities.

Mitigating the Extra Cost of Treating People with DD

Recommendation 6: As part of the Virginia Department of Medical Assistance Services’ review of dental reimbursement rates every three years, it should review individual reimbursement rates that are key to serving people with developmental disabilities and report publicly on its findings. The review should assess whether (1) each rate is equal to or greater than the Department’s target of 82-83% of commercial insurance; (2) each rate is sufficient to cover provider costs and mitigate any negative impact; and (3) additional procedure codes need to be covered to adequately serve this population. Rates to review include behavior management (D9920), certified translation or sign language services (D9990), and sedation and anesthesia (D9222-D9248).

Increasing the Accessibility of Dental Services

Recommendation 7: The Virginia Department of Behavioral Health and Developmental Services, in partnership with the Virginia Department of Health, should seek funding from the Virginia General Assembly, the Centers for Disease Control and Prevention’s Disability and Health State Programs, or other sources to establish a pilot program that provides funding for dental professionals to remove physical, communications, or programmatic accessibility barriers. Providers who receive this funding could have the opportunity to undergo an on-site accessibility assessment and receive related technical assistance.

Recommendation 8: The Virginia Department of Medical Assistance Services (DMAS) should seek approval from the Virginia General Assembly to increase the reimbursement rate for certified translation or sign language services (D9990).

Increasing Access to Sedation and Anesthesia for People Who Need It

Recommendation 9: The Virginia Department of Medical Assistance Services (DMAS) should seek approval from the Virginia General Assembly to increase the reimbursement rates for sedation and anesthesia provided in the dental office (D9222-D9248).

Recommendation 10: The Joint Commission on Health Care should study innovative ways to (1) address barriers to accessing sedation and anesthesia for dental procedures, both in and out of the hospital setting, including limited provider education, limited provider compensation, and limited hospital fees; and (2) reduce the need for sedation and anesthesia through, for example, silver diamine fluoride.

Connecting People with DD to Providers

Recommendation 11: The Virginia Department of Medical Assistance Services, Virginia Department of Health, Virginia Department of Behavioral Health and Developmental Services, and other stakeholders should participate in a workgroup on oral health for people with disabilities to (1) continue sharing information, (2) explore ways to use their combined resources to better connect people with disabilities to dental providers who can meet their needs, and (3) explore ways to use their combined resources to better connect dental providers with other dental providers who can serve people with disabilities.

Recommendation 12: The Department of Medical Assistance Services, and its dental benefits administrator, should regularly verify self-reported information from providers on their physical, communications, and programmatic accessibility for people with disabilities by collaborating with disability stakeholders to conduct (1) independent site reviews at the time of credentialing and/or on a rotating sample of providers; and (2) secret shopper studies of dental care providers.

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Recommendation 13: The Virginia Department of Medical Assistance Services, its dental benefits administrator, the Virginia Department of Health, and other relevant stakeholders should conduct user testing of their dental provider directories to ensure that they are useful for, understandable to, and accessible to people with developmental disabilities. The user testing should be conducted once upfront and each time the directory is updated thereafter.

Meeting Demand for Key Stopgap Program

Recommendation 14: The Virginia General Assembly should increase funding for the Department of Behavioral Health and Developmental Services Dental Program so they can expand their capacity to (1) screen and refer people with developmental disabilities (DD) to dental providers who can meet their needs; (2) treat people with DD using mobile units while the Commonwealth’s Medicaid provider network continues to scale up; (3) conduct outreach so that disability stakeholders know about the program; (4) serve people with DD who are under 21 years old; and (5) provide in-depth technical assistance to dental professionals as needed.

Strengthening Medicaid Oversight

Recommendation 15: The Virginia Department of Medical Assistance Services and its dental benefits administrator should expand their biennial dental network reviews to include an assessment of network adequacy for people on the Developmental Disabilities waiver. To support this analysis, they should explore data sources for providers who serve people with DD.

Recommendation 16: The Virginia Department of Medical Assistance Services and its dental benefits administrator should regularly collect feedback from providers and members on disability-specific issues by (1) including questions in the annual provider survey about their barriers to serving people with developmental disabilities; (2) including questions in the annual survey for members who have had a dental experience about whether their disability-related needs were met; (3) administering an annual survey to members who have not had a dental experience to identify related barriers and opportunities, including any issues with accessing dental providers due to their disability; and (4) soliciting input from disability stakeholders on Request for Proposals and contracts for the Department’s dental benefits administrator.

Improving Oral Hygiene

Recommendation 17: The Virginia Department of Behavioral Health and Developmental Services should develop a supplemental module on oral health for inclusion in their mandatory direct support professional orientation materials.

Recommendation 18: The Virginia Department of Education should incorporate oral health into its draft “Self, Health, and Relationship Education (SHARE)” guidance or any related supplemental guidance.

Appendix B: Research Methodology

In addition to a literature review of available research and reports, the Virginia Board for People with Disabilities (VBPD) conducted first-hand research through stakeholder interviews, provider focus groups, and data and document requests. A description of each method is below.

Stakeholder Interviews

VBPD staff held interviews with a total of 40 stakeholders from 18 organizations:

- Carilion Clinic Dental Care (1 staff)
- Delta Dental of Virginia Foundation (1 staff)
- disAbility Law Center of Virginia (1 staff)
- Special Olympics Virginia's Special Smiles Program (1 staff)
- Virginia Association of Free and Charitable Clinics (1 staff)
- Virginia Association of Nurse Anesthetists (4 staff)
- Virginia Board of Dentistry (2 staff)
- Virginia Commonwealth University Partnership for People with Disabilities (2 staff)
- Virginia Commonwealth University School of Dentistry (3 staff)
- Virginia Dental Association (4 staff)
- Virginia Dental Association Foundation (1 staff)
- Virginia Dental Hygienists Association (1 staff)
- Virginia Dental Society of Anesthesiologists (1 staff)
- Virginia Department of Behavioral Health and Developmental Services, including the Integrated Health, Provider Development, and No Wrong Door divisions (6 staff)
- Virginia Department of Education (3 staff)
- Virginia Department of Health (4 staff)
- Virginia Department of Medical Assistance Services and their Dental Benefits Administrator (3 staff)
- Virginia Health Catalyst (1 staff)

The goal of the interviews was to understand what each stakeholder does to support oral health for people with developmental disabilities, identify key barriers to oral health for that population, and explore opportunities for improvement. The interviews were also used to obtain quotes for the report, all of which were approved by the relevant stakeholders for anonymous inclusion. The interviews were conducted primarily via phone and Zoom, although some communication was in person and via email.

Provider Focus Groups

VBPD staff also invited dental professionals in Virginia to provide input through focus groups. VBPD distributed a flyer via social media and the ToothTalk listserv for dental safety net providers. VBPD also shared it with 15 organizations and asked them to distribute it, eight of whom confirmed distribution:

- Carilion Clinic Dental Care shared it with select contacts
- disAbility Law Center shared it on their social media
- Special Olympics Virginia shared it with select contacts
- Virginia Commonwealth University Partnership for People with Disabilities shared it with select contacts
- Virginia Dental Association shared it with select contacts
- Virginia Department of Health shared it with select contacts
- Virginia Health Catalyst shared it on social media and in a monthly newsletter
- Virginia Association of Free and Charitable Clinics shared it with their members

As a result of these recruitment efforts, 18 dental professionals participated in one of three virtual focus groups. The focus groups were held on different days and times, based on provider availability, to maximize attendance. The focus groups consisted of polls and group discussion of the poll results, broken into five topical sections. The poll questions are listed below:

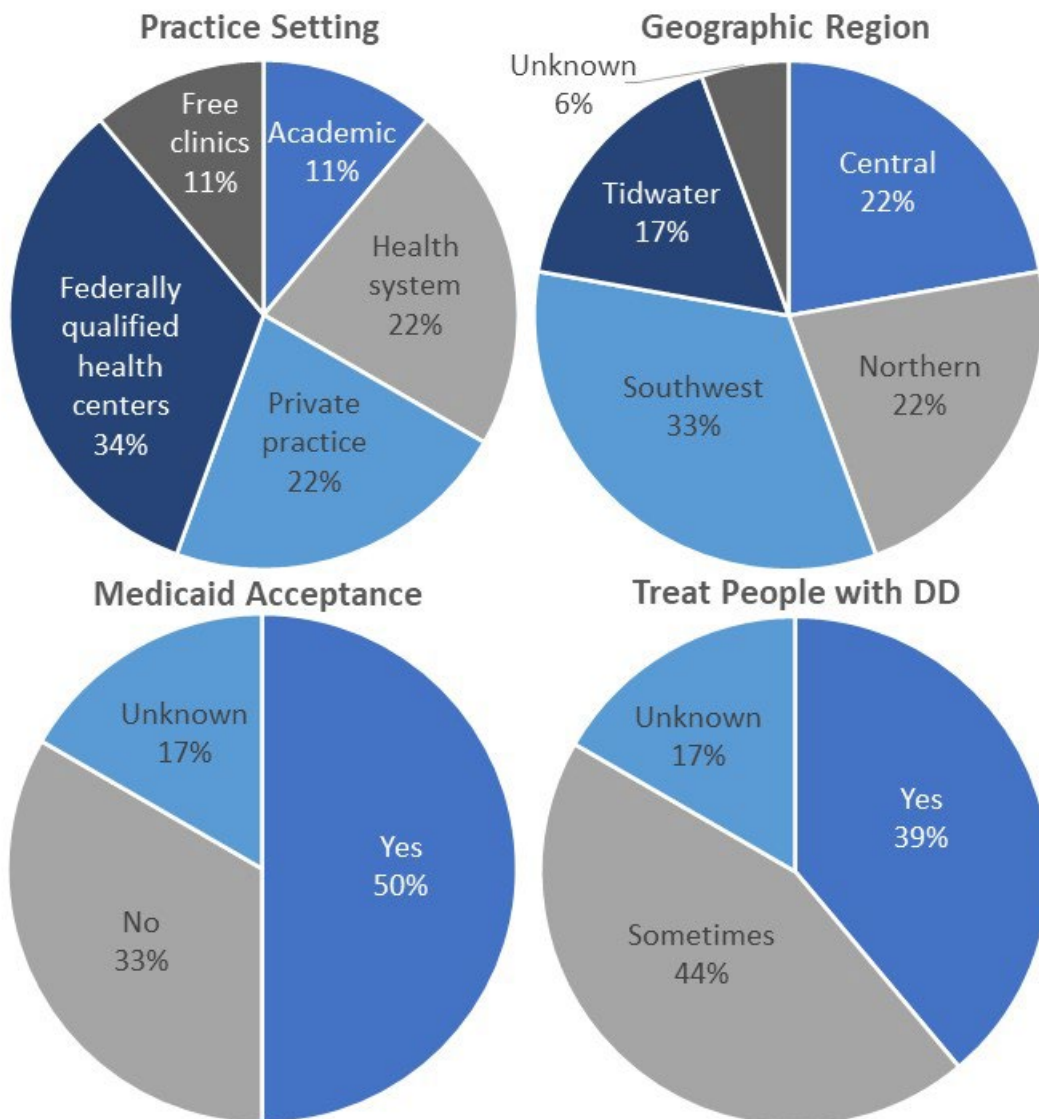
1. Do you treat patients with developmental disabilities? *(No/Sometimes/Yes)*
2. If you had to guess, how many other dental professionals in Virginia are willing to treat patients with developmental disabilities? *(Very few (e.g., fewer than 25%)/Some (e.g., 25% to 75%)/A lot (e.g., more than 75%)/I don't know)*
3. Do you accept Medicaid? *(No/Sometimes/Yes)*
4. What is the highest level of sedation or anesthesia that you or other staff in your dental office provide to people with developmental disabilities? *(No sedation/Minimal sedation/Moderate sedation/Deep sedation or General anesthesia)*
5. Are there barriers that substantially limit your or others' ability to provide sedation or anesthesia to people with developmental disabilities? *(No/Yes/I don't know)*
6. Do you have any concerns about Medicaid coverage for in-office sedation and anesthesia (e.g., procedure codes D9222, D92223, D9230, D9239, D9243, and D9248)? *(No/Yes/I don't know/Not applicable to my practice)*
7. Do you think there are opportunities statewide to reduce the number of people with developmental disabilities who need sedation or anesthesia for dental care? *(No/Yes/I don't know)*
8. Do you have any concerns about Medicaid coverage for behavior management (e.g., procedure code D9920)? *(No/Yes/I don't know/Not applicable to my practice)*

9. How prepared do you feel to treat people with developmental disabilities? (*Not prepared/Somewhat prepared/Very prepared*)
10. How prepared do you think other dental professionals are to treat people with developmental disabilities? (*Not prepared/Somewhat prepared/Very prepared*)
11. Do you feel that you could benefit from further training on people with developmental disabilities? (*No/Maybe/Yes*)
12. Do you feel that other dental professionals could benefit from further training on people with developmental disabilities? (*No/Maybe/Yes*)
13. Which of the following continuing education approaches would you like to see the state support? Please check all that apply. (*Continue supporting voluntary courses that offer CEUs/Allow CEUs for providing uncompensated care to people with disabilities/ Offer a higher Medicaid reimbursement rate when providers treat patients with developmental disabilities if they have taken related training/Require a portion of the annual continuing education hours to address underserved populations/ Other*)
14. How accessible do you think your office is to people with developmental disabilities? Please think about physical, communications, and programmatic accessibility. (*Not accessible/Somewhat accessible/Very accessible/I don't know*)
15. How accessible do you think other dental offices typically are for people with developmental disabilities? Please think about physical, communications, and programmatic accessibility. (*Not accessible/Somewhat accessible/Very accessible/I don't know*)
16. Do you feel like you and other staff in your office understand the legal rights of people with developmental disabilities to access health care and how to comply? (*No/Somewhat/Yes/I don't know*)
17. Do you think staff in other dental offices typically understand the legal rights of people with developmental disabilities to access health care and how to comply? (*No/Somewhat/Yes/I don't know*)
18. Do you have any concerns about Medicaid coverage for certified translation or sign language services (e.g., procedure code D9990)? (*No/Yes/I don't know/Not applicable to my practice*)
19. The professional code of ethics says that providers who can't meet the needs of a patient with developmental disabilities, due to needing additional equipment or expertise, should refer them to another dental professional who can. How often do you think dentists provide appropriate referrals in these cases? (*Rarely/Sometimes/Often*)
20. Do you think dental professionals typically have difficulty identifying others who can treat people with developmental disabilities? (*No/Yes/I don't know*)
21. Are you aware of the following service provider directories? Please check all that apply. (*disAbility Navigator, which lists dental and other providers who serve people with disabilities/Unite Virginia, which uses technology to create a coordinated care network*)

for Virginians/Virginia Department of Health’s directory of dental providers who care for people with special health care needs/211, which provides information and referral for health and other services to Virginians)

The 18 focus group participants were relatively diverse (see Figure 15). Over three-quarters were general dentists, and the remainder were dental hygienists, assistants, and coordinators. About one-third worked in federally qualified health centers, 22% in private practice, 22% in a health system, and 22% in free clinics and academic settings. Each geographic region of Virginia was represented. Most participants served people with DD and half accepted Medicaid.

Figure 15: Characteristics of Focus Group Participants (Staff analysis of provider websites and focus group polls)



Data and Document Requests

VBPD obtained the following data and documents via requests to six organizations:

- Delta Dental of Virginia provided an overview of their new expanded benefit for members with special healthcare needs, information on some of the procedure codes they cover, and an overview of their efforts to educate providers and members
- Virginia Board of Dentistry provided data on the number of dentists with sedation and anesthesia permits
- Virginia Department of Behavioral Health and Developmental Services provided data about progress toward the compliance indicator for Virginia's settlement agreement with the U.S. Department of Justice, data on why people were referred to their dental program, data on people served through their dental program, waitlist data for their dental program, and the result of an informal project to verify Medicaid provider directory information
- Virginia Department of Health shared their training materials for dental professionals and paid caregivers
- Virginia Department of Medical Assistance Services, and its dental benefits administrator, provided denial rates for behavior management, denial rates for sedation and anesthesia, and data on the percentage of Medicaid providers who report during the credentialing process that they serve people with special needs
- Staff at one dental office shared data on their reimbursements for sedation and anesthesia

Stakeholders also shared other information and data as desired to support the stakeholder interviews.

Appendix C: Behavior Management Techniques

Figure 16: Recommended Behavior Guidance Techniques for Pediatric Dentists (Staff summary of 2023 American Academy for Pediatric Dentist Guidelines)

-  **Communication and Communicative Guidance**
Establish trust through questions, active listening, body language observation, & directives
-  **Positive Pre-Visit Imagery**
Show images of dental care before the appointment so they know what to expect
-  **Direct Observation**
Show videos of, or allow them to directly observe, a young person undergoing dental treatment
-  **Tell-Show-Do**
Explain procedures, show aspects of the procedure, and do the procedure
-  **Ask-Tell-Ask**
Ask about patient's feelings, explain procedure, & ask about patient's understanding & feelings
-  **Voice Control**
Alter voice volume, tone, or pace to gain attention and establish adult-child roles
-  **Non-Verbal Communication**
Reinforcement through appropriate contact, posture, facial expression, and body language
-  **Positive Reinforcement and Descriptive Praise**
Reward desired behavior through voice modulation, facial expression, verbal praise, toys, etc.
-  **Distraction**
Divert attention using stories, music, television, and short breaks
-  **Memory Restructuring**
Provide positive associations for dental experiences using visuals, verbal reminders, praise, etc.
-  **Desensitization**
Psychological technique to diminish emotional responses through progressive exposure
-  **Enhancing Control**
Establish a signal like handraising for patient to use when uncomfortable or needing a break
-  **Other Techniques**
Parent presence or absence, sensory-adapted environments, animal-assisted therapy, etc.

Appendix D: Continuing Education Requirements on Underserved Populations in Other States

Table 2: State Continuing Education Requirements Regarding Underserved Populations (Staff analysis of other state laws in April 2023)

State	Topic	Requirement	Frequency	Who	Citation
CT	Cultural competency, Access to care	Two of 10 topics determined by the Health Commissioner, from which dentists must select at least 3	Every 2 years	Dentists	Conn. Gen. Stat. 20-126c; Connecticut Department of Public Health
CT	Cultural competency	Mandatory topic	Every 2 years	Dental hygienists	Conn. Gen. Stat. 20-126l
DC	Cultural competency or specialized clinical training on LGBTQ+ population	Mandatory topic	Every year	Dentists, dental hygienists, dental assistants	D.C. Official Code § 3-1205.10 (b)(5)
ID	Care and treatment of geriatric, medically compromised, or disabled patients and treatment of children	Mandatory topic until July 1, 2021	Every 2 years	Registered dental hygienists with extended access	IDAPA 24.31.01.015
IL	Implicit bias awareness	Mandatory topic	Every 3 years	Dentists, dental hygienists	20 ILCS 2105/2105-15.7
IL	Emergency procedures for medically compromised patients, geriatric dentistry, pediatric dentistry	Mandatory topic	Every 3 years	Public health dental hygienists	225 ILCS 25/13.5

State	Topic	Requirement	Frequency	Who	Citation
MD	Implicit bias	Mandatory topic	Once, by the first license or renewal occurring after April 1, 2022	Dentists, dental hygienists	Md. Code Ann., Health Occ. §1-225
MD	Cultural competency	Optional	Every 2 years	Dentists, dental hygienists	COMAR 10.44.22.04
MI	Pain and symptom management, such as behavior management and behavior modifications	Mandatory topic	Every 3 years	Dentists, dental hygienists, dental assistants	Mich. Admin. Code R. 338.11701 ; Mich. Admin. Code R. 338.11704
MN	Patient communication, such as non-verbal communication, non-English languages, and sign language	One of 6 fundamental areas, from which dental professionals must select at least 2	Every 2 years	Dentists, dental hygienists, licensed dental assistants	MINN. R. 3100.5100 ; Minnesota Board of Dentistry
NV	Patient management skills	One of 8 approved subjects for dentists to choose from	Every 1 or 2 years, depending on license type	Dentists, dental hygienists	NAC 631.175
OR	Cultural competency	Mandatory topic	Every 2 years	Dentists; dental hygienists;	OAR 818-021-0060 ; OAR 818-021-0070

Appendix E: Medicaid Reimbursement for Behavior Management in Other States

Table 3: Medicaid Reimbursement for Adult Behavior Management in State Medicaid Programs (Staff analysis of state fee schedules and references manuals in April 2023)

State	Rate	Definition of Behavior Management	Eligible Populations	Frequency Limits	Prior authorization	Other Service Provision
CA	\$100	Patient requires additional time	Patients who have physical, behavioral, developmental, or other emotional condition that affects their response to treatment	4 visits per year	N/A	Must be billed with procedures that are payable, except for sedation
MA	\$86	Patient management	Patients who are severely and chronically mentally, physically, or developmentally impaired	Once per day	Yes	N/A
MN	\$56	When additional staff time is required	Patients with behavioral challenges	Once per day	Yes	Must be billed with a primary service or procedure that is covered
MT	\$59 per 15 minutes	N/A	N/A	12 15-minute increments per visit & 12 units per year	N/A	N/A

State	Rate	Definition of Behavior Management	Eligible Populations	Frequency Limits	Prior authorization	Other Service Provision
PA	\$125	Visit fee for difficult to manage persons	People with substantial handicap before age 18 that has indefinite duration & is attributable to neuropathy	Once per day and 4 visits per year	N/A	N/A
RI	\$86	Significant modification to care is required	Members with illness or disability	Once per day	N/A	N/A
SD	\$113	N/A	Patients with developmental disabilities	N/A	N/A	N/A
VA	\$89	Cannot be used solely for management of fear or anxiety	Patients with handicapping conditions that prevent treatment	Unlimited	N/A	Can't be billed same day as moderate or deep sedation for children
VT	\$52	N/A	N/A	N/A	N/A	Can't be billed same day as anesthesia
WA	\$50	Using one additional professional staff to manage behavior	Adults with a developmental disability or live in an assisted living facility or nursing facility	N/A	N/A	Can't be billed with anesthesia

Appendix F: Supports for Brushing at Home

Figure 17: Supports for Brushing at Home (Staff analysis of various caregiver fact sheets)



Motivational Aids

- Offer choices e.g., toothbrush style, toothpaste flavor
- Praise
- Reward



Calming Aids

- Social stories
- Tell-show-do approach
- Music
- Favorite object e.g., blanket, stuffed animal, fidget toy



Reminders

- Establish a schedule
- Offer a visual schedule
- Timer



Adaptated Tools

- Enlarged handle e.g., tennis ball, bike grip, sponge
- Strap e.g., velcro, rubber band, hair tie
- Triple-headed toothbrush (e.g., SuperBrush)
- Electric toothbrush
- Floss pick
- Mouth rest



Doing It With Them

- Supervision
- Physical guidance



Doing It for Them

- Try different positions for the person with a disability e.g., floor, wheelchair, bean bag chair, bed
- Start by touching the toothbrush to their hand and gums

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