Mathematica Policy Research
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Hello, everyone, and thank you for attending today's webinar, How to Improve Your State's Reporting of Medicaid Dental Data on the Form CMS-416 Using New Online Learning Modules.

Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget, as well as your slide area, by clicking on the Maximize Icon at the top right of your widget or by dragging the bottom right corner of the widget panel or slide area.

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Now I'd like to introduce Kimberly Perault, Social Science Research Analyst for the Division of Quality and Health Outcomes at CMS.

Kimberly, you now have the floor.

Thank you, Brice.

First, I would like to thank you for joining us on our webinar today. We have some great material and speakers prepared to discuss CMS's new web-based training modules on the form 416 Dental Data Report.

The intent in creating this series of modules was to help states improve the quality of the dental data reported on their form CMS-416. And as Brice stated, I'm Kimberly Perault. I work in the Division of Quality and Health Outcomes here at CMS. I will start by highlighting our objectives for today and framing today's discussion with a brief overview of the form CMS-416.

We will then hear from Laurie Norris, Senior Policy Advisor and Coordinator of the CMS Oral Health Initiative, who will discuss dental data in the context of the Oral Health Initiative. And Megan Thomas, Technical Director, will share some of the challenges and commonly reported inconsistencies seen in the dental data that impact data quality. Both are also from the Division of Quality and Health Outcomes at CMS.

Miriam Drapkin from Mathematica Policy Research will demonstrate online learning modules. And we will hear lastly from Cordelia Clay, Program Manager with the Department of Health & Hospitals in Louisiana, who served as an early tester of the modules.

In today's webinar, as I said, we will focus primarily on the dental data line items, 12a through 12g of the form CMS-416, which you may also hear referred to as the form 416 or the annual EPSDT report. We would like to provide you with an understanding of how CMS uses data reported on the form, the process of reviewing your form CMS-416 for inaccuracy, and for data errors. We will demonstrate how the online learning modules will help you improve the quality of your form CMS-416 submissions and your feedback. We hope this information is helpful, and we look forward to answering any questions you may have later in the presentation.

Next slide.

Now that you have an idea of the objectives for today's webinar, I think the best place to start is to begin with what is the form CMS-416. States use the form 416 to report benefits under EPSDT, which stands for Early Periodic Screening Diagnostic and Treatment through CMS. EPSDT covers regular screening services for children and adolescents, emphasizing preventive and comprehensive cases. The form 416 was designed to provide basic information on participation in Medicaid and to assess the effectiveness of EPSDT.

Using the form 416, states must provide data on the number of children receiving training services, the number of children referred for corrective treatment, and the number of children receiving dental services. The data gathered from the form serves several different purposes. It's used to track improvement in serving children and adolescents. It's used in targeting of guidance and technical assistance for states. And it's used to review compliance of statutory requirements.

Lastly, the form is available on the www.Medicaid.gov website, as well as the instructions, which were revised in 2014.

Next slide.

Now that the purpose of the form 416 has been explained, I would like to address how and when the form is submitted to CMS. CMS requires states to submit the form 416 each federal fiscal year by April 1 of the following year. On this slide, you can see that there is a dedicated mailbox, the EPSDT Technical Assistance mailbox, which is EPSDT@CMS.hhs.gov, which is where a state sends its completed reports.

This resource is also a place to send your form 416 questions to the team here at CMS. When the form is received by CMS, it will undergo a review process. During this process, the team reviews the submission for any errors or potential data inconsistencies. CMS publishes reports that pass the review on the www.Medicaid.gov website. If a report does not pass the review process, an email is sent to the state from the EPSDT mailbox that explains the errors encountered. The state must then review and resubmit the report.

Later in the presentation, you will hear about the quality checks and the data errors commonly found on the form 416.

While we recognize that there may be some challenges as you report, we would like to be made aware of any significant data limitations that you may encounter. If a state has a data limitation or has made program changes during a reporting period that significantly impact data results, states may include a note accompanying their CMS-416 report.

In addition to posting the EPSDT report of all the CMS-416 forms submitted during the fiscal year, those narratives are posted as a separate footnote report. Additionally, requests for 508-compliant versions of the form can be submitted through the EPSDT mailbox.

Next slide.

Now that I've shared an overview about the form, Laurie Norris is going to delve into a discussion about the dental data lines on the form.

Thank you, Kimberly.

As Kimberly said, I'm going to take a moment to introduce you to the dental lines on the form 416. And then I will share with you some of the ways that CMS and others actually use the dental data to understand utilization patterns and to drive improvement.

Next slide.

First, the dental lines -- There are seven dental lines on the form 416. We break the dental data down into these seven categories. 12a is any dental service. This is really a roll-up of all the dental service types. And then we break dental services down into preventive services, treatment services, sealants and diagnostic services.

In addition to that, we have line 12f, which collects oral health services provided not by a dentist or under the supervision of a dentist; and that is most frequently a medical provider. And then our last line is 12g, which rolls up all the dental services and all the oral health services together into one bucket.

There are a number of nuances here, such as which children are included; which provider types are included; which procedure codes are included. I won't get into those right now. You'll hear more about that later. But I do want to make two points about the technical specifications for reporting the dental services.

One is that we report only for children who have been enrolled for at least 90 continuous days during the reporting period. And the second is that each of these lines is an unduplicated count of children that received a service on that line. So no child appears twice in any one of these lines.

Next slide.

Now let's talk a moment about how CMS uses this data. We have long tracked states' performance on children's use of dental services in Medicaid. For example, in 2008, we performed reviews of Medicaid dental service delivery in the 16 states that at that time had dental utilization below 30% of children. And we provided suggestions for improvement in those programs.

In 2010, we did another round of reviews, this time of the eight states that excelled in delivering services to children in Medicaid. We were working to understand what practices they were using to be successful and to disseminate those practices to other states.

We also, in 2010, announced our Oral Health Initiative, recognizing that there was still a lot of room for improvement in our service to our kids with dental needs. And the graph on this slide shows our improvement goal for increasing the proportion of children who receive a preventive service.

On a national level, in 2011, we were serving 42% of children ages 1 to 20 with a preventive dental service. And our improvement goal by fiscal year 2015 was to reach 52%, a 10-percentage-point improvement goal.

Next slide.

This is another view of our goals in the Oral Health initiative, the first one, again, being preventive dental services, with our national baseline of 42%, our national goal of 52%. And so far, as of fiscal year 2014, we have reached an improvement of 45%. We were hoping at this point to be at 50%. So our improvement rate has been slower than what we had hoped.

Our second goal was looking at sealants on permanent molars. We were never able to set the baseline for this goal, but we wanted to emphasize that sealants are included in the preventive services measure.

And so we really hope states have been focusing on improving the rate at which their enrolled children receive sealants.

Next slide.

Just to show you in a graphic format that we have been achieving steady progress, this slide shows you what's been happening since 2000 all the way up to 2014. And here we have three lines from the 416 represented. The blue line at the top represents line 12a, which is any dental service. The red line in the middle is line 12b, which is preventive dental services. And the green line in the middle is dental treatment services, line 12c. All of those, except for the dental treatment service, seem to have leveled off. We don't know if that's because children are getting healthier or it's because less of the need is getting served.

Next slide.

We also take a look at how individual states are doing. This slide shows as of 2014 for line 12b, our preventive dental services line, what percentage of children, ages 1 to 20, are getting a preventive dental service in every single state. Our top performers are over on the left. Our top two performers are Vermont, with 62% of children getting a preventive service, and Connecticut, with 60% of children getting a preventive service.

Our bottom performers are over on the right. Wisconsin brings up the rear, with only 25% of children getting a preventive service; and then Florida, with 27% of children getting a preventive service. So you can see, there's quite a range across all the states. The red line in the middle is our national average at 45%.

One other thing to notice about this slide is that we have a few standouts on the left who were really high performers and a few really low performers on the right. But a lot of the states are bunched in the middle.

Next slide.

As I mentioned, we've been tracking progress on the preventive dental services goal, or line 12b, since 2011. And we're now four years into our Oral Health Initiative. We would have liked states to have achieved 8 percentage points of their 10-percentage-point improvement goal by now. But as we can see on this slide, only a few states have kept pace with that goal. We have Iowa and Florida and Maine, who have reached or exceeded their interim improvement goals. Everybody else – we've fallen short. Including nationally, we've only achieved three percentage points of improvement.

The states that you see over on the right with lines below 0%, we do actually have some states who have seen a decreasing proportion of their children receiving preventive dental service during the Oral Health Initiative.

Next slide.

This is one state's 416 data trended from 2011 to 2014. And so you can see that the top line is 12a, any dental service. And then we have the red line, preventive dental service; the turquoise line, dental diagnostic services – those are all bunched up at the top. At the bottom, we have the green line for treatment and the purple line for sealants.

And then in the middle there, we have the orange line, which looks a little funny. That one probably caught your eye, and it might make you wonder what was going on there. That is line 12f in this state, the oral health services. And I'm showing you this slide because I'm hoping to make the point that one thing you can do in your state before you submit your data to us is trend your own data and see if there is anything that looks strange, like this, so you can look into what might be going on with your data.

What was going on in this state is that they discovered that they had been reporting all the dental services provided by their dental hygienist in community settings on line 12f, even though those hygienists were supervised by a dentist. And they realized they should be presenting them on line 12b. So they moved those up into line 12b as of 2013. And so what we have in 2013 and 2014 in this state is a true picture of the pretty non-participation of medical providers in that state of providing oral health services.

Next slide.

I'll just take a real quick look here at some of the ways in which we publish this data. We, every year, take a look at the preventive dental services. And up until this year, we've been also looking at the treatment dental services as part of our child core set and publishing the results across all 50 states in our annual report to the Secretary.

In the child core set, we just recently took the treatment dental services measure out and have replaced that with a measure on sealants. We are really looking forward to getting our first reporting of that sealant data from states at the end of this year/beginning of 2016. And we're having a webinar on November 12, 2015, to begin to train states on how to do that reporting.

So this will be a new reporting for states. It's separate from your reporting on the 416. It's an important measure; and so we hope you'll join us on November 12, 2015, to learn about that new measure. Watch for the registration information in your inboxes.

Next slide.

Just real quickly, just wanted to let you know that other researchers use this data. This is a report from George Washington University that looked at trends from 2000 to 2010 in this data.

Next slide.

And the American Dental Association Health Policy Institute has used this data to compare with what's happening with privately-insured kids, kids who have dental insurance commercially -- so just take a look at which kids are getting more care, whether they are getting more care in Medicaid or in private insurance.

My whole point here is that this data matters. CMS uses the data; researchers use the data. We hope you in the states are using the data too. We rely on what you submit to us. We rely on that being accurate and complete.

So that's the framework for this work we're going to be talking about the rest of the afternoon. And I'd like to turn the mic over to Megan Thomas now so that she can help describe how you can ensure that your data is accurate and complete.

Megan?

Thanks so much, Laurie.

As Laurie said, I'm going to talk just a little bit about some of the common challenges supporting high-quality dental data on the form 416. Some of these challenges are raised in the conversations with states, and some of the common errors we may see with the CMS review process of the 416 or what we term our "mini audit" process. But all the challenges that we're going to note here are ones that the new online learning modules can really help states to address.

Next slide, please.

At a high level, the items on this slide are just a few of the major challenges involved in reporting high-quality dental data on the 416. These include completeness of data, the ability to distinguish dental

versus oral health services, and also ensuring that the appropriate codes are being included in the data polls for the report for the appropriate lines.

While we note these as challenges to reporting high-quality dental data, we definitely understand that these challenges may not be unique to dental data specifically and may also be challenges that exist across reporting programs.

First, we honed in on the completeness of data. By this, we're referring to the inclusion, or the ability to include, data reflecting services received across delivery systems or payment arrangements, including managed care encounter data when dental care is provided through dental NCOs. We're also talking about here under this bullet when dental services may be provided in other types of settings or facilities, including school-based settings or federally-qualified health centers.

We know that CMS and states have worked really hard in recent years to both understand and improve data completeness issues in this context. And it may not be an issue that's easy to address, but it's one that states and other stakeholders who have input on the 416 should be mindful of when completing their reports.

Another challenge is the ability to report dental versus oral health data. So counseling services that are provided on this based on the type of dental provider, so that's care provided by a dentist or under the supervision of a dentist versus care provided by another type of provider, including dental professionals not under the supervision of a dentist, or non-dental providers, such as pediatricians. We refer to this also as the provider taxonomy data.

As we understand it, these taxonomy fields may not be required for filing a claim. And also, it may be necessary to collect data about non-dental providers, or physicians, by looking at medical claims versus dental claims in some states in some cases.

Along with this, another challenge is ensuring that all of the appropriate procedure codes that are specified in the 416 instructions or given dental lines are being included in the report. What will happen is that not all the appropriate codes or applicable codes are included, this will affect completeness and accuracy of the data reported, potentially leading to undercounts of children receiving services on the form.

Next slide, please.

One of the common errors we see on the form, which is often one of the underlying reasons for other errors we see on the form, is incorrect reporting of children by age. As you know and as you saw on Kimberly's slide at the beginning of the presentation, data on the form are to be reported by age in seven age groups: under 1; 1 to 2; 3 to 5; 6 to 9; 10 to 14; 15 to 18; and 19 to 20.

Our instructions ask that a child's age be reported based upon their age at the end of the federal fiscal year. And also that screening and service data should be reported in the age group reflecting the child's age as of the end of the fiscal year, even if that child receives services in two age groups or they cross age categories throughout a reporting year. In other words, what we're looking for is a child's data, be it their eligibility data or their service data, should only be counted in one age group across the entire form.

And why is this important? Well, here's why. We know that there are different age groups for which the delivery of certain services is appropriate. On the form, for example, sealants are to be reported for kids ages 6 to 9 and 10 to 14. We also know that if we stratify our data – and age is just one stratification that can be used – this can help identify disparities in access to care. For example, there may be a particular issue around access to care for adolescent populations.

It's also important to ensure that if we're calculating any measures based upon the data in the report, Laurie talked about the PDENT and TDENT measures in her slide, that the same children who fall into

the state's numerator also are in the state's denominator so as not to inadvertently yield inaccurate results.

Next slide, please.

So though the form is often discussed in terms of individual lines, the form is incredibly interconnected, with very, very strong relationships between different lines of the form. It's because of these relationships we have been able to detect some mathematical impossibilities that you shouldn't be on the completed form based upon the instructions that we provide. So these mathematical impossibilities really form the basis of our CMS review process or our mini audits which we rolled out with our review of the 2010 reports that states submitted.

Specific to the dental data, it's important to note that all of the data for the dental lines that Laurie provided an overview of earlier – that's lines 12a through 12g – are to be drawn from kids reported in line 1a. These are kids who are eligible for EPSDT services for at least 90 continuous days in the federal fiscal year. We've included a brief snippet of the instructions for line 12a here on the slide. And you can see that we've highlighted the text from line 1b.

In addition, as Laurie explained, each dental line should reflect an unduplicated number of children, meaning that if the child received more than one dental service in the fiscal year, they should only be included once on the line, you can see once on line 12a. So you can similarly see here that we've highlighted the word "unduplicated" here in this snippet. So it's because of this that no single dental line should include counts greater than the counts on line 1b. In other words, no one dental line should be greater than line 1b. So while we note this, we also note that while a child can be reported on more than one line, a child should only be counted once on a single line during the fiscal year.

Tying this error together with the errors we saw on the previous slide, because we ask states to report children by age on the form, if children are not consistently reported in the same age groups across the form, this is one way that the relationship that I've described here can be violated and consequently one way to get flagged for an error on the report.

Let me just give you one very, very basic example to help hopefully solidify this relationship I'm describing here. If you report that there 100 children ages 3 to 5 eligible to receive EPSDT services in your state on line 1b, but you told me that 150 kids received any dental service on line 12a – and again, these are both unduplicated counts – I'll know that something is amiss. This is one example of one of the errors that is reviewed or one of the flags that checked for on the 416 reviews. And I'll present two additional examples of these relationships between the lines on the form specific to dental data in the next few slides.

Next slide, please.

Here is another example of a relationship between the dental lines on the report. We know that line 12a – again, that's the any dental service line – encompasses children receiving preventive dental services; we know it encompasses dental treatment services; and we know it encompasses diagnostic dental services. Laurie described this at the outset.

We know this not just because I'm telling you that, but we know it if you look at the codes for the lines in these instructions, you'll see this to be correct as far as instructions and the codes that are included there. Because we now know that each line -- 12b, 12c or 12e -- is a subset of line 12a, the count on one of these lines should not exceed the count reported on line 12a. And this will hold true as long as states are remembering that each line should reflect unduplicated counts.

Next slide, please.

Here is one last example on this slide of the relationship between the dental lines. And this is pretty much as complicated as it's going to get, so I hope you can hang in there with me. Line 12g we know is the

count of eligible kids who received a dental or oral health service in the fiscal year. This is where we're being able to distinguish between provider types becomes important.

We just talked about how dental services were captured in line 12a on the previous line. And line 12f, as Laurie explained earlier, is where states are to report the number of children who received an oral health service. So we can really think of line 12g as the unduplicated sum of eligible children who received a dental service, on 12a, or oral health service in the fiscal year, and that's line 12f.

If a child received both a dental and oral health service in the fiscal year, you must make sure to only count that child once in reporting on line 12g. Using me for an example, if I'm an eligible child in your state and I received five dental services and two oral health services in the fiscal year, I get counted once on line 12a, once on line 12f, and only once on line 12g as well. And then also depending on what type of dental service I received, I could also show up in the lines 12b, 12c, 12d or 12e as well.

Before moving to the next slide, where I provide just one state example, there is one important note I want to report about 12d; and that's the eligibles receiving a sealant on a permanent molar. This is a line that I've not yet mentioned to this point in which you kind of can see this image here kind of hovering at the top of this graphic.

Children can be reported on this line whether they received a sealant while under the supervision of a dentist or whether they received it not under the supervision of a dentist, so by an oral health provider. When you're thinking further about the relationships of the lines and what is a subset of what, it's important to keep in mind this line may include a mix of kids who received "dental sealants" and "oral health sealants." If the sealant is provided by or under the supervision of a dentist, the sealant is also considered a preventive dental service, for which the unduplicated child is reported on 12b. And you can see here on this graphic, there's a dotted line pointing from 12d to 12b; and that's signifying the dental seal that was provided or under the supervision of a dentist.

If the sealant was not provided under the supervision of a dentist, this is considered an oral service, for which the child gets reported on line 12f. And you can similarly see the dotted line pointing from 12g to 12f in the graphic.

Next slide, please.

When we talk about the mini audits, the term "mini audits," which I referred to, is very much deliberate. As important as the audit process is for identifying errors and helping states think through some of the errors that are found in the report, the checks that are conducted through this audit really only capture the mathematical impossibilities which I've been speaking of; but they do not catch everything. What they won't catch are things that are potentially unlikely; so for example, if there is large or small variation in year-to-year rates. They really only catch things that are impossible.

So I say this to denote there is still an upward review that should be given to the report outside of the formal process, and Laurie spoke about this during her slides as well. Let's just look at this using one state's example here on this slide. It's one state's experience reporting its FY2014 dental data on the form 416. It will help to illustrate how critical it is to review the information to ensure high-quality dental data in the report.

In the state's initial submission, while the state did technically pass our mini audit, upon closer review and doing some computation, CMS found that all the dental percentages looked surprisingly and unexpectedly low. You can see on this slide, if you're looking at the middle column labeled "FY2014 Before," the report on this state showed rates of 90% of children receiving a dental service, for example, or 3% of children receiving a dental treatment service in the fiscal year. We called this to the attention of the state, and they got to work looking for the problems in their reporting methodology.

Next slide, please.

The state dug into their reporting and identified a number of problems with their reporting. And as you can see, their corrective efforts really did make a significant difference in their report and their performance on their rates if we look at the column labeled "FY2014 After."

One thing to note that the state did as part of this review process, which we also encourage other states to do as well, is to review the report instructions and methodologies with both the dental policy staff and the data analysis staff, where possible and where it's applicable. We understand the data policy and data analysis staff may work in separate offices or divisions; but really, in working together, they may together be able to most effectively understand where there may be data gaps and how to resolve those problems as well.

So the state did this; and after revisiting the report with both of those teams involved, they found several issues that impacted their dental data, not including all types of claims that could be counted on the report. They were including paid claims, but also denied claims or pending claims, which is one of the changes we made to the instructions back in November.

They were also not including all of the codes that should be included on each line of the report on their data polls. We say this to encourage you all to double-check your data before you submit, keeping in mind the major buckets of common challenges we've summed up in the reporting challenges I mentioned in the previous slides. It also includes multiple teams of individuals as part of this review process as necessary and applicable.

You want to check that the numbers make sense. Are they in line with their expectations, given your previous year's numbers? Did you include data for all unduplicated, denied and pending claims? Did the data include children eligible for EPSDT benefits? Did they include all health or dental plans, delivery systems or payment methodologies? Did they include all locations, such as FQHCs? Are you sure that you deduplicated each line so the child only appears once in reporting?

These new online learning modules will help states be mindful of these things to consider as part of the reviews. They do that and more. You'll hear about this more in a minute from Miriam Drapkin. But let's pause here for a moment, and I'll turn it back to Kimberly to see if there are any questions about the content you've heard thus far.

Kimberly?

Thank you, Megan.

At this time, if there are any questions you would like to ask, please feel free to submit them. We'll try to address a few before we move on to Miriam.

[Pause for responses]

We have one question. It's in regard to whether or not the Dental Quality Alliance's proposed measures with 180-day continuous enrollment will match with CMS's continuous enrollment.

Laurie, would you be able to answer this question?

Sure, as we've been discussing on the CMS-416, our continuous enrollment methodology is 90 continuous days. And that is what we plan to stick with on the 416. However, we talked about the S-E-A-L, the seal measure that we've just adopted into the child core set of measures, which looks at sealants on permanent molars for children ages 6 to 9. And that is the Dental Quality Alliance measure. We use the same specifications for that measure that the Dental Quality Alliance developed. So for that reporting, we are asking for the 180 days of continuous enrollment.

So we're sort of straddling in a sense there. On the 416, we're using 90 days of continuous enrollment. And on this sealant measure in the child core set, we're using 180 days.

Are there any additional questions?

[Pause for responses]

We've received a question: "Can states receive a list of specific taxonomies to be used for a dental provider versus a non-dental provider?"

Megan, would you be able to answer this question?

Probably not to the liking of the person who asked it. But I think it's something that I need to look into. We did work with a team of folks to look into this issue awhile back, and we can look to see what we can dig up from what they provided and what the reviews are. So I think it's something we're going to have to follow back up with after the call.

Megan, I think there may be another question that you might be able to assist with. It's in reference to qualifying visits: Do they have to happen after 90 days of eligibility? And what if there are gaps when some of the services were provided?

If a child was enrolled for at least 90 continuous days, the services that happened within the fiscal year can be counted on the form. If there are gaps in when the services were provided, as long as the child was eligible for 90 continuous days, any service that happened within that fiscal year can be included on the form.

Great, thank you, Megan.

At this time, I think we'll resume; and Miriam can pick up with demonstrating the learning modules.

Thank you so much, Kimberly.

Next slide.

This is where we get to talk about how some of the tools that CMS has developed will address some of the challenges that we've talked about so far. I know that it can feel a little bit daunting to think about all of the things that need to be just perfect in the form 416 data, but there are tools to help, and here's where we get to start to talk about them.

I'm going to talk a little bit about how and why we've designed these training modules and why we've structured them the way that they did. We adopted a couple of principles in the development of the training modules.

First, we wanted to keep them brief. We didn't want to throw a 300-slide anything at someone. We know that folks are always busy and might want to just look into the 12d line or the 12a line and not look through everything. So we decided to develop six brief modules instead of one large one.

We also decided to take a no-wrong-door approach to accessing the models. And what that meant to us is that we don't necessarily want someone to have to start at the beginning and then progress all the way through. Again, we know that you're all busy. So if you just want to, say, share information on enrollment data and data quality checks with a stakeholder, you could forward them one and know that they don't have to have seen all of the previews in order to understand what's going on.

We also wanted to keep the modules engaging. And so we tried to include a number of interactive features and exercises. And you'll see me demonstrate some of these in a few minutes; but just off the top of my head, there are hover-over graphics, there are pop quizzes, there are data quality checks, and there are other tools that you can use. And hopefully, that keeps it from feeling too much like you're reading a textbook.

And then we also wanted to develop accompanying resources, so if there are just different ways of engaging with the content that might be more convenient. If you want to print out a glossary to just have as a reference on your desk or if you want just access to different resources that are included in the modules, we also tried to make them accessible outside of the modules.

I'll talk a minute about the audience that this was intended for. We kind of have two levels of audiences. At the very top of the list were state Medicaid and CHIP staff. This is a module that's designed to improve form CMS-416 data submissions, and we know that state Medicaid and CHIP staff are primarily responsible for that. So that's really the target audience.

However, we know that there are others who are invested in this process. And so we wanted to make sure that some of the content is relatable to potentially the managed care contractors or data warehouse contractors that states work with. If there are other partners in dental data reporting, we know that lots of states, Medicaid agencies partner with their public health agencies on aspects of EPSDT. And then other oral health stakeholders – individuals or organizations that might be interested in what's going on with the Oral Health Initiative and what's behind some of the numbers that they might read in the annual reports.

And then the objectives are pretty much exactly what you've heard before. We're looking to use these modules to help states improve the quality of their dental data. We also wanted to introduce some data quality concepts in a non-technical way, knowing that the folks who are on the policy side don't necessarily dig deep all the time into the technical side. So we wanted to give you a little bit of vocabulary there to maybe better bridge that gap between the technical sides of the house.

We also wanted to demonstrate the business case. I think we heard both Megan and Laurie speak to this very persuasively before that these data do matter, and they're used in ways that matter. So we wanted to make sure that we were able to communicate that in these modules.

Here are the six brief modules that I was describing before. Some of these are more technical than others. We have one that just gives an overview of the EPSDT benefits, one that digs a little bit deeper into the form 416 itself. And then we get into the technical line-by-line specifications, and we broke these up into three. Lines 1a and 1b, which we call our denominator lines -- these are our eligibles and eligibles with continuous enrollment. Then there is 12a through 12e, which are roughly the dental lines. And 12f and 12g are our oral health lines.

And then at the end, we have something called Using Form CMS-416 Dental Data. And this is where we tried to show how different states have been using data and how they use it in quality improvement. So it's not just something that ends up in an annual report, but it is something that is used to monitor progress and drive improvement.

Here is just a highlight of some of the features that you're about to see in more detail. But like I mentioned, we employed some interactive graphics, some quizzes, data quality checks, and then a glossary. So if individuals are going through and they're trying to remember what that acronym stands for, we like to provide a little link. And the definitions aren't just spelling out what the acronym is, but also what the acronym means in the context of form 416 reporting.

And finally, here are two of the additional resources I wanted to highlight. We developed a workbook, which is kind of a one-stop-shop for all of the interactive exercises that we included in the Web-based modules. That includes the pop quizzes; it includes some of the data quality checks. And if it's the type of thing that you just want to practice on your own without going through all of the related content, it's a nice little packet of information.

We also compiled the Glossary into a Common Terms and Definitions worksheet. Again, we hope that you can use that as a reference. And then you'll also see a number of related resources that we compiled, links; and you'll see this on the Landing page that I'll show you in just a minute. But it's links to the TA mailbox, the workbook and Glossary.

We also link over to the form 416 Instructions and form 416 Frequently Asked Questions. There is also as a useful reference, but not a definitive guide, a crosswalk of CPT/CDT codes that can be used to identify different preventive and treatment versus diagnostic services in dental and oral health and the Bright Futures Guidelines that can be used to take a look at the periodicity schedule for when children or eligibles should be accessing different services.

With that, I am going to jump right into our live demonstration.

This is the landing page for the training modules. We have a lot of the information that you should need to access the modules and all of the associated resources. If you're directing a stakeholder to it, there is the nice little paragraph that describes what these modules are, the context of the Oral Health Initiative, and also a link back to the EPSDT web page if they want further resources.

There's also a description and links to all of the training modules if you want to just click through and access them. And we also provided the resources that I went over briefly on the page that we just saw – the TA mailbox -- where you can direct all of your questions about the form 416, the workbook. And I'm actually going to click on this so you can see a little bit of what that looks like.

As you can see, the pop quiz is one of our more popular areas. And this is a way that you can kind of engage with those interactive features, the data quality checks as well, and just keep that in one nice place. Especially for the data quality checks, I recommend this.

The Glossary or the Common Terms and Definitions worksheet is another one. And like I was describing before, this includes just a handy reference to some of the common terms and definitions that come up as you're working on your form 416 data.

And just to round it off is the link to the form 416 Instructions, the Frequently Asked Questions, the CPT/CDT crosswalk and, again, the Bright Futures Guidelines.

Moving right along, we'll jump into what the first page of each module itself looks like. On the first page, you'll see a couple of things very standard. You'll always see the title of the module, what it's describing. We also provide a link that will take you back to the landing page, so if you decided you actually wanted to do Module 2. And then we also provide links back to www.medicaid.gov and of course to the EPSDT mailbox if you have questions.

In this left-hand column, you'll see our Navigation pane, which you should think of as a Table of Contents. Consistent with the no-wrong-door approach, we'd like for you to be able to jump around to different content within the module; so not always having to click Next if you're just very interested in the Oral Health Initiative in context, for example.

Another thing just to orient yourself to is the second page of every module, which we call the Overview page. In each module Overview page, you can see the learning objectives. So for Module 1, the learning objectives are to help the user understand the history, goals, and basic requirements of the EPSDT benefit and also to become familiar with the form 416 and the Oral Health Initiative.

We also like to give a brief overview of the content -- so the history and goals of the EPSDT program, the components of the benefit, state requirements, the overview of the form 416 reporting and a brief introduction to the Oral Health Initiative.

Another feature that you might notice is the Print button. As you're progressing through the slides, if you see one that just is particularly useful or helpful, we encourage you to go ahead and print that. And you'll have access to exactly what it sounds like.

Moving on, I'm going to show you one of the interactive features that we have. We tried to make use of Hover Over a lot as a way to really pull the user in and essentially make them work for the information.

We think it will help keep this material engaging. The idea of this one is that we have a timeline that shows how the EPSDT program has grown over time, starting in 1965 when Medicaid was born, just about 50 years ago, and then the expansion over time, so when the benefit was added. And then when SSI became incorporated as well, and then over time as coverage was expanded to children and more children and then culminating in the CHIP program as well. So this is just one illustration as to how we use interactive graphics in these webinars.

Another thing you might notice is on this left-hand side is these little checkmarks start to appear in the Navigation pane. This is tracking your progress as you move through the webinar, so you can pick up where you left off if you're jumping around. However, if you're ever at a point where you just want to clear that history, you can just use this little Eraser bar down here; that will just clear the status flag, and you can start fresh.

I'm just going to briefly show you one other interactive tool that we use. And this is one about magnifying. There are a couple of places where we like to show a lot of information but know that people's screens can't always take it. So here we have the option to look at the overall form 416 and then click and move the mouse over to magnify it. This is just one small way that we tried to make a lot of data little bit more engaging than it might otherwise be.

The other thing that you'll see here is that we tried not to overload the user with a lot of spelling things out. So if you forget what EPSDT stands for, we've put that text in bold as a signal that you can hover over it to get the full definition. You can always access it through the Glossary as well, which is just in that upper right-hand button to toggle either On or Off. But that's one program we used.

Now I'm going to move on to one of the things that Megan was talking about earlier and the trick of age ranges and knowing that this can sometimes be a challenge to make sure that you're reporting eligibles in the correct age category. We know that this can sometimes be a little bit tricky in that a child can receive services in one age category but be counted in line "b" in a different one, so we like to throw in these little quizzes.

Here's an example that says when a child would have received an oral health service and what that child's birthday would be. The pop quiz: Niccole's birthday is on August 4, 2012. At her 30-month well child visit, which took place on February 4, 2015, her primary care physician applied fluoride varnish to her teeth and billed for it using CDC D1206. Which age category should Niccole be included in for reporting on line 12f of the FFY2014 form CMS-416?

There are a couple of things that you'll see that are common to the different pop quizzes. If you get a wrong answer, you'll get a little guidance to try again. The Hint button is also there to give a little bit of help. Here, the Hint button says: Remember, the right age for Niccole is where she falls as of September 30th of the reporting year, which is not necessarily the age she was on the date of service. What is Niccole's age on September 30, 2015?

Well, we know that she turned three on August 4 of 2015; so therefore, we know that she falls into the category (b), 3 to 5. So this is just there to give a little bit of help along the way as you work through some of these more confusing or sometimes issues that will slip us up.

With that, it's your turn. I'm going to introduce another one of the similar questions to. Talique's birthday is on September 17, 2004; and he received a preventive dental service on April 12, 2014. Which age category should he be included in for line 12b in federal fiscal year 2014 in form 416 reporting? The hint is: Remember that the right age group is where he falls on September 30th of the reporting year.

I'm going to push out this poll to you, to the audience. And take a minute to decide what the correct answer is. Talique's birthday is on September 17, 2004; and he received his service on April 12, 2014. Indicate whether he should be counted in line 6 to 9 or 10 to 14, both, or neither age group in submitting his form 416 data.

[Pause for responses]

It looks like nearly everyone has gotten it right. The correct answer is (b), 10 to 14. He turned 10 years old on September 17, 2014. So for reporting in the FY14 data, he should be considered in the 10 to 14 age group.

I will move quickly through the rest of the demonstration.

Here is where we start to get involved in some of the more involved data quality checks. The way that we describe it is there are four general components of data quality that we try to make folks aware of. There is data completeness; there is data documentation; there is accuracy; and then there is consistency. And you can see here just some general guidelines as to what all of those are. But in each of these modules, we start to go a little bit deeper for each of the little groups of lines.

For completeness, we tried to ask very specific questions: Do your data include unduplicated paid, pending and denied claims? Megan talked about this when she talked about the change. For example, if you said, "No," then you would get a little instruction that says: Remember that this is a new requirement as of 2014, and we encourage folks to reference the instructions and Frequently Asked Questions.

We also ask if you've checked your data for duplicates to make sure that you're not double counting individuals in the same line. And again, we tried to provide a little bit of guidance as to how you could potentially deduplicate this pool if, for example, you're not sure as to whether or not you're double counting individuals.

And then we also tried to illustrate: Does this represent your full eligible population? Were you able to account for all of the different providers, plans, services and potentially alternative payment methods?

And so just along each step of the way, we like to give a little bit of guidance as to how you can determine that your data will be as complete as possible. As you might be able to guess, we offer parallel data quality checks for each of the other elements: consistency, accuracy and documentation. These are all available in detail for the three modules that describe the lines.

And finally, at the end of each module, you'll see a summary. We like to just provide a little overview about what was covered. So in Module 4, it would be the Dental Services and Oral Health Services. We need to identify these appropriate services and the relationships of these lines to the OHI. And also, of course, how to determine the age group in which to report a child's data based on their date of birth.

And then the final page of every module is a little note just saying this is completed. And it shows you how to access the other training modules, either the next one or other resources. There's a link that will take you back to the web-based Landing page. And capping it off, again, is a link that will take you back to Medicaid.gov or to the EPSDT mailbox.

With that, we'll just pretend we go back to the beginning. And I'll thank you so much.

Now I'd like to introduce Cordelia Clay, who is a Program Manager at the Department of Health and Hospitals from Louisiana, to talk a little bit about her state's experience in piloting these modules.

Thank you, Miriam.

Let me begin by saying that feedback is an essential part of education and training and very important to the ongoing development of the learning audience. For that reason, I commend CMS and Mathematica for including this step in their planning phase for the form CMS-416 training modules and allowing Louisiana to share our experience in reviewing the prototype.

Overall, the review was a straightforward process that provided an abundance of information. I've been working with the Louisiana Medicaid Dental program for almost eight years; and after reviewing the entire module, I realized there were factors used in obtaining the data of which I was unaware.

All six modules were equally informative with some repetition. In reviewing the modules sequentially, the information became redundant; but after completing the training as a whole, it was evident that the repetitive topics, such as data quality and the determination of age ranges, were essential.

Upon completion of my review, I used the modules for quick refreshers prior to and during internal discussions regarding Louisiana's form 416 data. It was convenient to choose individual modules and have access to relevant information needed to provide clarity to that specific topic.

Each module was educational; however, I appreciated the interactiveness of the process, such as the ability to hover over acronyms, words and phrases for clarity and the active lines within the slide that offered access to detailed information to help in understanding of the configuration of the form 416, as opposed to listing resources on the last page of the presentation or the insertion of footnotes at the bottom of the slides. It is beneficial to have resources at your fingertips to provide additional material for unknown topics and/or words immediately to allow for a better understanding of the information reviewed.

Our review process began with an orientation call to discuss the stages of evaluation, the process of review, and an introduction of each participating state. The states included Arizona, California, North Carolina, Oklahoma, Florida and Louisiana.

We were first given the outline of the curriculum to review and provide feedback. Mathematica provided questions to help guide us in the review, questions like: What data quality checks or procedures does your state currently have in place that aren't reflected, and what additional guidance do you think states would find helpful?

Next, we reviewed the actual modules with additional questions to assist us in the review. Questions such as whether any of the graphics or figures were unclear, if the functionalities were clunky or confusing, content progression and so on. Mathematica encouraged and welcomed any and all types of feedback. And in providing questions for guidance during our review, it caused us to examine the materials from various angles and not just from our personal perspective.

After a review of the modules, there was a discussion concerning everything reviewed thus far; and it was interesting to hear the candid feedback from the participating states. As a result of completing the training module, I feel even more confident in my understanding of the data quality checks and can now confidently discuss how benefit administration and policy changes constantly impact the form CMS-416 data.

Louisiana has a combination of Medicaid service delivery systems with multiple reimbursement structures, which causes our dental data to consist of both claims and encounters. In Louisiana's most recent form 416 report, I noticed the amount in 12f, oral health services provided by a non-dentist, dropped considerably from the previous year. Applying the information acquired from the training modules, I was able to communicate with various sections within our agency to ensure all applicable factors were considering data. The correction of this error caused line 12f to increase significantly.

Louisiana's form 416 data is collected by our fiscal intermediary, with directions from the form CMS-416 subject matter experts, who in turn received input from various program staff. With physician turnover and continuous policy changes, it's very important to perform annual data quality checks to ensure that information reported reflects the actual experience of the state.

In addition to sharing these modules with those responsible for gathering and/or reviewing this data, moving forward I will make it a point to relate changes in dental benefit administration and/or reimbursements to ensure all applicable information is available and incorporated.

Even though the training modules introduced today pertain to the dental lines of the form CMS-416, consider sharing Modules 1 through 3 among all partners, contractors, and program staff with any responsibility in obtaining or reviewing data. With everyone on the same page, it will surely assist in an accurate reflection of your state's data.

Again, I would like to thank CMS and Mathematica for this opportunity. And thank you all for listening. Now I would like to turn it back over to Kimberly.

Thank you, Cordelia, for sharing your experience.

At this time, we'd like to address any additional questions about the modules or maybe about Cordelia's experience, if anyone has any.

[Pause for responses]

I just want to remind you if you have any questions, please feel free to type your questions into the Q&A area.

[Pause for responses]

It looks like we have a question about when the modules will be available. The modules are available on our www.Medicaid.gov website. And you can feel free to go and begin to learn from them.

Well, if there are not any more questions, I would just like to conclude by saying thank you for attending our webinar. I'd also like to remind you that the modules are available. And as you can see on the resource slide, we have provided you with the link on our www.Medicaid.gov website.

I'd also like to say please be on the lookout for our survey about the modules. We would love to hear your feedback on ways we can improve the modules and make them better. If you have any questions or want any more information, please feel free to email the EPSDT mailbox; again, that's EPSDT@CMS.hhs.gov.

Also, I hope that you will register to join our Dental Sealant webinar on November 12, 2015. Please be sure to be on the lookout for more information about that as well.

And with that, Brice, I would like to turn it back over to you.

This concludes the webcast for today. Please submit feedback to the presentation team using the survey in your Browser window when the event concludes. If you are unable to provide your feedback at this time, you can view the On Demand recording of the event and access the survey widget there. The on-demand recording will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

You can also share any feedback or questions with the team using the EPSDT@CMS.hhs.gov mailbox. Thank you and have a great day.