



ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY
for STATE HEALTH POLICY

North Carolina Medicaid “Into the Mouth of Babes” Physician Fluoride Varnish Program

National Academy for State Health Policy
Annual Conference
Long Beach, CA
“Increasing Access to Dental Care for Children”
October 6, 2009



Governor Beverly Eaves Perdue
Lanier M. Cansler, DHHS Secretary
Dr. Craigan L. Gray, DMA Director

Presentation Objectives

- Define the problem and identify NC's solution
- Discuss the design and origins of IMB
- Explain what constitutes an IMB visit
- Summarize IMB research findings
- Barriers to adoption/obstacles to growth/ongoing challenges/opportunities
- Sams and Rozier survey on medical model

Problem: Access to Care for Preschool Medicaid Recipients

- Up to 60% of low-income children enter kindergarten in North Carolina having experienced tooth decay, much of this is untreated decay
 - ECC widely prevalent
 - Profound social and economic effects for children and their families
- Preschoolers have significant barriers that prevent them from accessing dental care
 - Behavior management concerns
 - Lack of general dentists trained to treat infants/toddlers
 - Shortage of pediatric dentists in NC
- Low income children (Medicaid) have more difficulty accessing care than other groups

Solution: Policy Initiative

- **Goals of the IMB**
 - Increase access to preventive dental care for low income children 0-3 years of age
 - Reduce the incidence of ECC in low-income children
 - Reduce the burden of treatment needs on a delivery system stretched beyond its capacity to serve young children

Design of IMB

- Utilize more robust NC primary care medical provider (PCP) network to deliver important preventive oral health services
- Design program services to be administered with successful NC EPSDT well child visit program (Health Check)—services needed to be easily integrated into PCP practice
- To qualify for participation, providers receive enhanced CME training—face-to-face
 - Taught infant/toddler oral exam procedure, caries risk assessment, preventive counseling with the parent/caregiver, application of topical fluoride varnish
 - Training initially provided by NCAFP and NC Peds Society; currently provided by the Division of Public Health—Oral Health Section

Origins of IMB

- Pilot project started in Western NC Appalachian counties in 1998—core group of PCPs and Early Head Start personnel noted significant problems with ECC
- Application to DHHS for statewide implementation developed in 2000
- Funding
 - Partial funding by ARC
 - Continued Federal funding first from CMS, later from HRSA/MCHB and CDC
 - \$ used for staff to develop the training curriculum, conduct training, oversee the program and generate the research conducted to support the program

IMB Visit

- Who's eligible for the service?
 - Recipients age 6 months to 3½ years
- Who provides services?
 - PCPs and extenders who have completed the CME training can provide IMB services
- How often can the treatment be done?
 - Every 60 days with a maximum of six (6) IMB visits before age 3½

IMB Visit

- What is an IMB Visit?
 - D0145—periodic oral evaluation of a patient under three years of age and counseling with the primary caregiver (current reimbursement = \$38.07)
 - Early caries screening and detection & report of other notable findings like obvious pathology of hard and soft tissues
 - Preventive oral health and dietary counseling with the primary caregiver including development of an age appropriate preventive oral health regimen
 - Prescription of a fluoride supplement if indicated, per the guidelines of the AAP
 - Referral to a dentist, if appropriate

IMB Visit

- What is an IMB Visit (cont'd)?
 - D1206—topical fluoride varnish; therapeutic application for moderate to high caries risk patients (Reimbursement = \$16.80)
 - Many studies demonstrate that FV is the safest and most effective form of topical fluoride for this age group
 - FV dose:response relationship (Weintraub et al., J Dent Research, 2006)
- Claims filed on CMS-1500 using CDT codes listed above (D0145 and D1206)—must be reported together on the same claim form to receive reimbursement
- Render at WCV, sick child or separate visit
- Well accepted in busy PCP practice by staff and parents—physicians want to provide a valuable service for children at risk

IMB Research Findings

- Increase in access to preventive dental services for infants and toddlers of 30-fold
- By four years of age, children who had received at least four IMB services demonstrated a statistically significant cumulative reduction in the number of restorative treatments needed for anterior teeth of 39%.
- IMB has led to an increase in access to restorative treatment services in the dental office through the effect of referral of children with existing disease at the time of the IMB visit to the dental care system

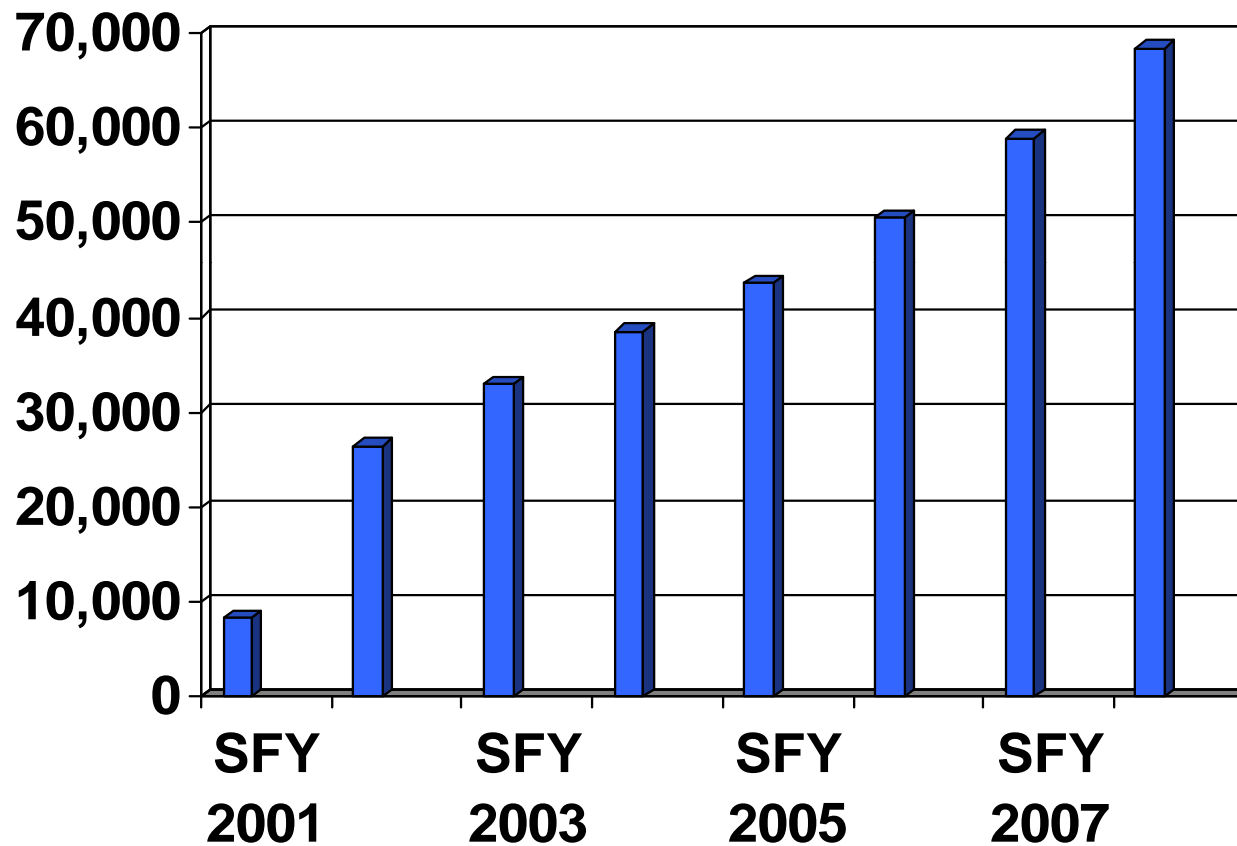
IMB Research Findings (cont'd)

- No reduction in visits to dentists for preventive care for the 0-3 age group
- Opposite effect—preventive care in the dental office for infants and toddlers under age 3 has increased substantially as IMB has grown
 - Not displacement of preventive care from dental offices, but rather supplementation
 - Implication--service is reaching recipients who truly face barriers to seeking care in dental offices
- Cost effectiveness?—the truth is still out there
 - Need larger sample size to follow children as they age out of IMB

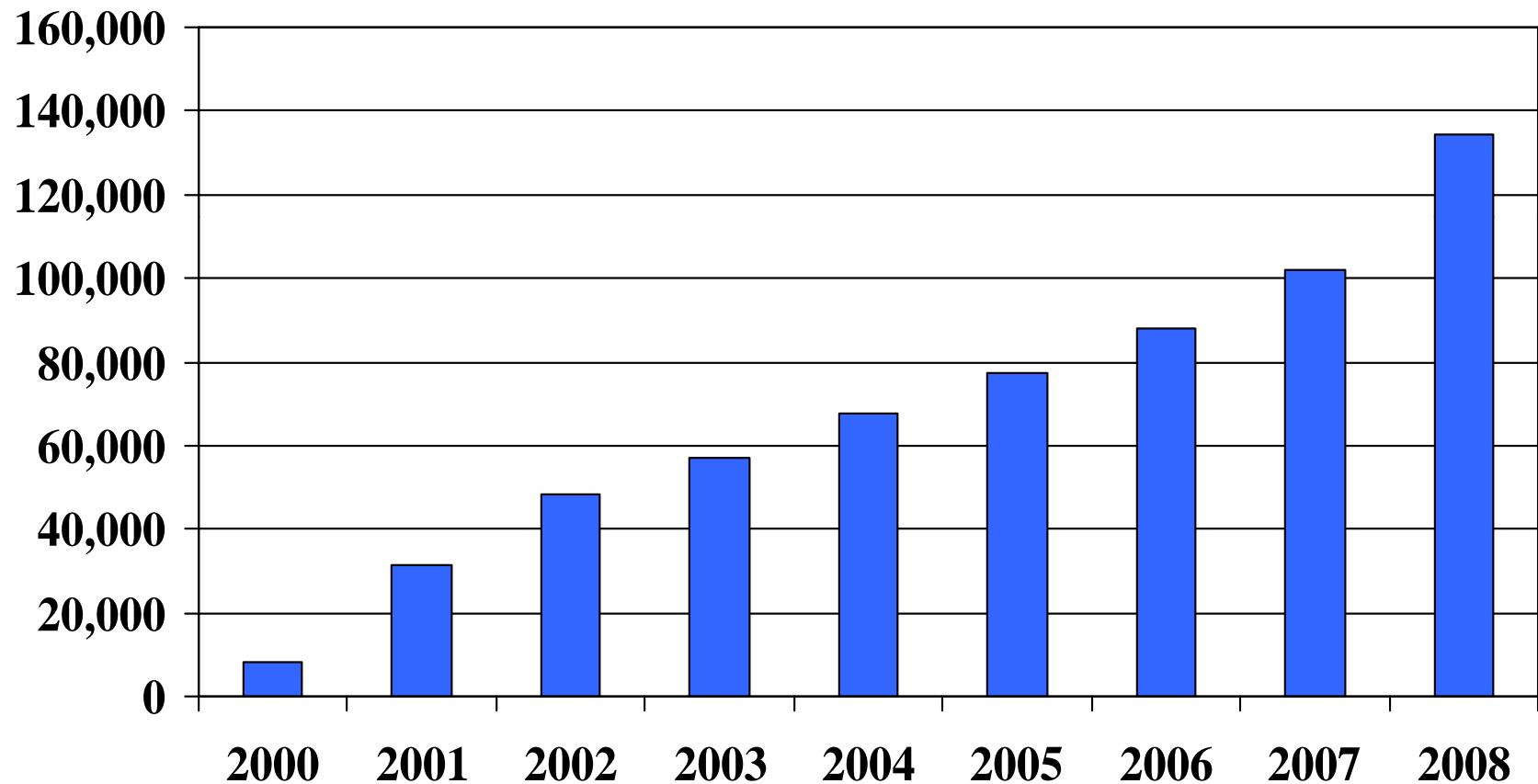
IMB Facts and Figures

- More than 3000 physicians, PAs, nurse practitioners, nurses, office staff et al. have been trained since statewide inception of the program in 2001
- Approximately 450 public and private billing providers
- Children from every county have received services; in about one-third of the state's counties, no Medicaid child in this age group received any preventive care in dental offices before IMB

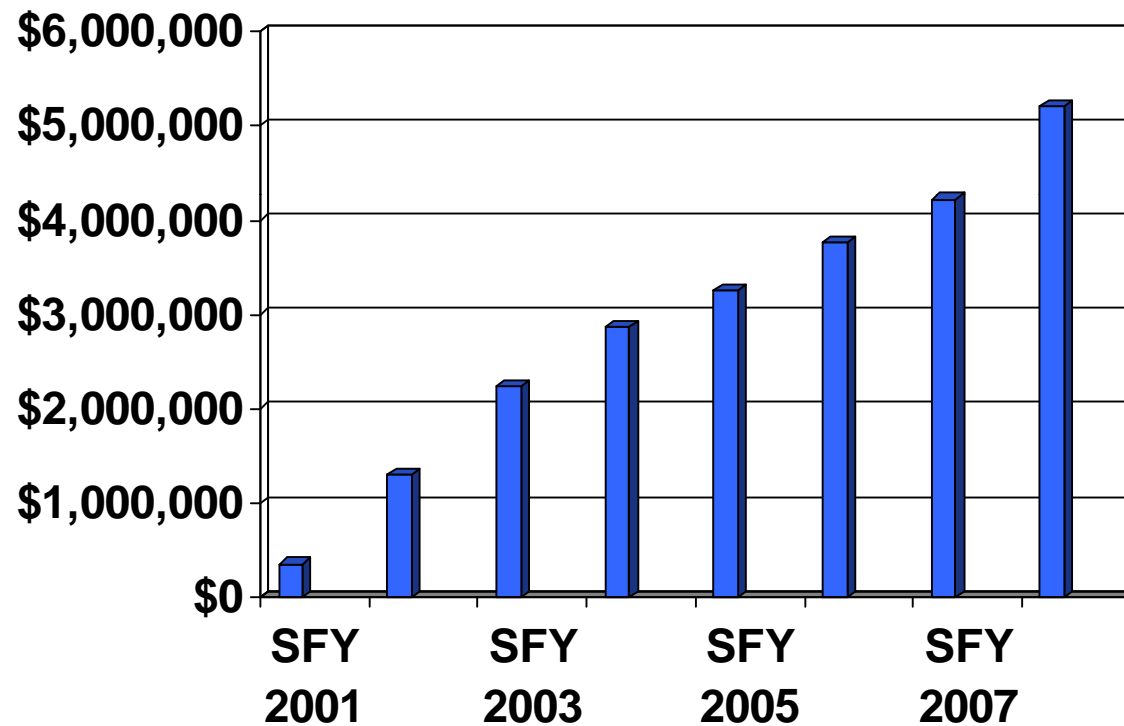
Number of Unduplicated Recipients Ages 0-3 Receiving IMB Services



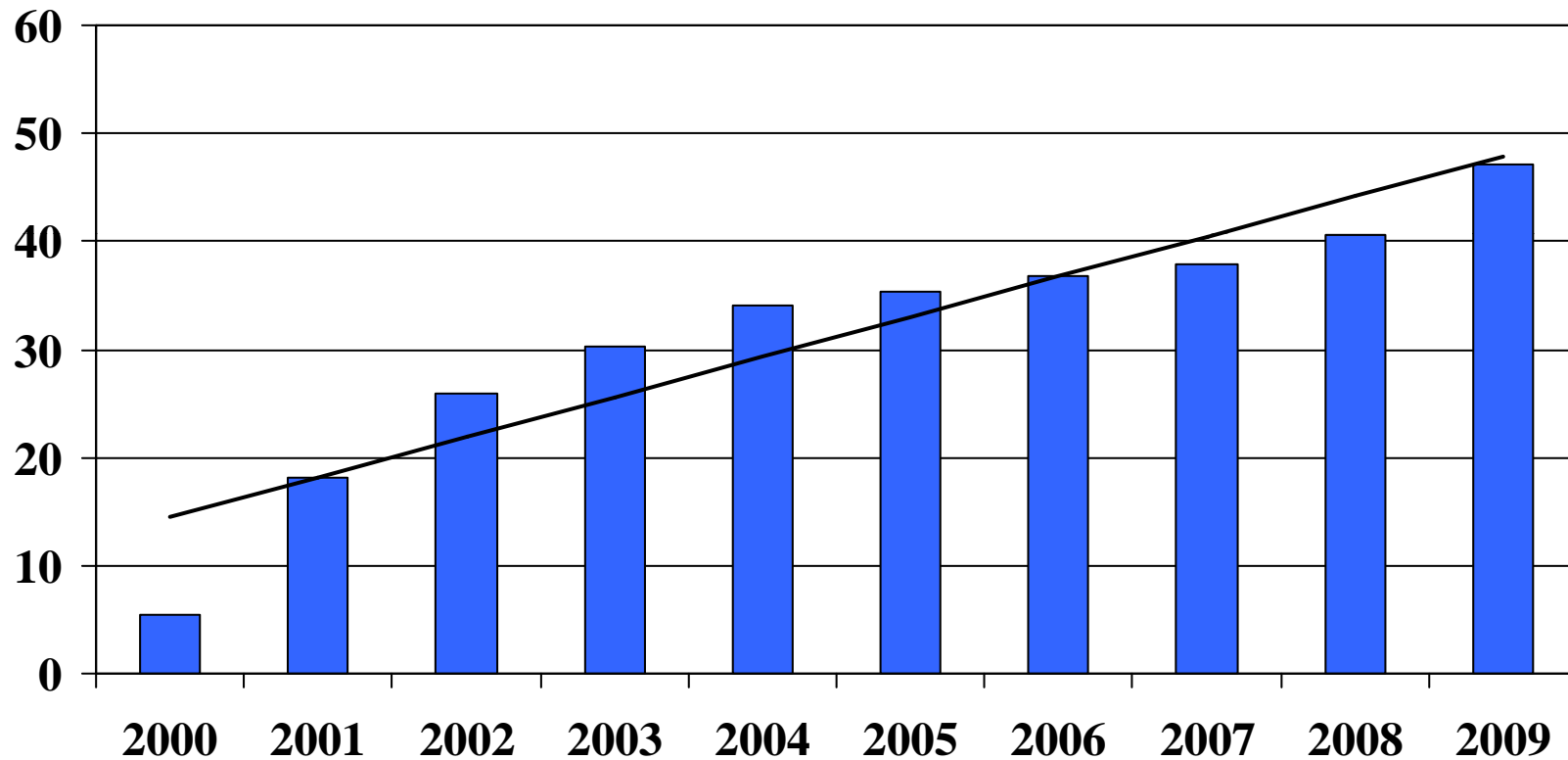
Annual Preventive Dental Visits in NC Medical Offices, 2000-2008



IMB Services Expenditures



Percent of Annual Health Check Screenings Receiving IMB Services *



•For years 2000-2007 includes 1-2 yr olds only, for 2008 on includes 1-3 year olds.

2008 represented by 1st and 2nd quarter data only.

Barriers to Adoption of IMB

- Funding
- Some opposition from provider community
 - Although, NCDS and NCAPD have been supportive
 - Organized medicine including the NCAPD and NC Peds Society have been extremely supportive
- Staffing concerns
- Coding and claim form issues

Obstacles to Growth and Effectiveness

- Licensing boards
- Number of eligible children in practice
- Evaluation
- Dental referrals
- Physician knowledge of oral conditions, confidence in diagnostic abilities
- Reluctance to refer high risk children without disease

Ongoing Challenges for IMB

- Opposition to medical providers rendering oral health care
 - Question effectiveness
 - Medicolegal issues
 - Off label use of FV
- Reimbursement issues
 - Exam covered under EPSDT well child visit?
 - Prior to May 2008, PCPs were paid more than dentists for oral evaluation and fluoride varnish
- Making the connection from medical home to dental home—particularly for children at high risk for ECC
- Funding and staffing in a difficult economic climate

Opportunities

- Increase collaborations
- Enhance health promotion and health literacy
- Develop infrastructure that meets the oral health needs of all Americans
- Decrease need for restorative care
- Integrate oral health into overall health

Lessons Learned in NC

- Necessity is the mother of invention (and, often times, innovation)
- All stakeholders have to be at the table -- organized medicine and dentistry, health care policy makers, academicians from UNC SoD and SPH, EHS, etc.
- Reimbursement and equity issues are important
- **TEAMWORK!**—Need a dedicated core of individuals willing to sacrifice time and money

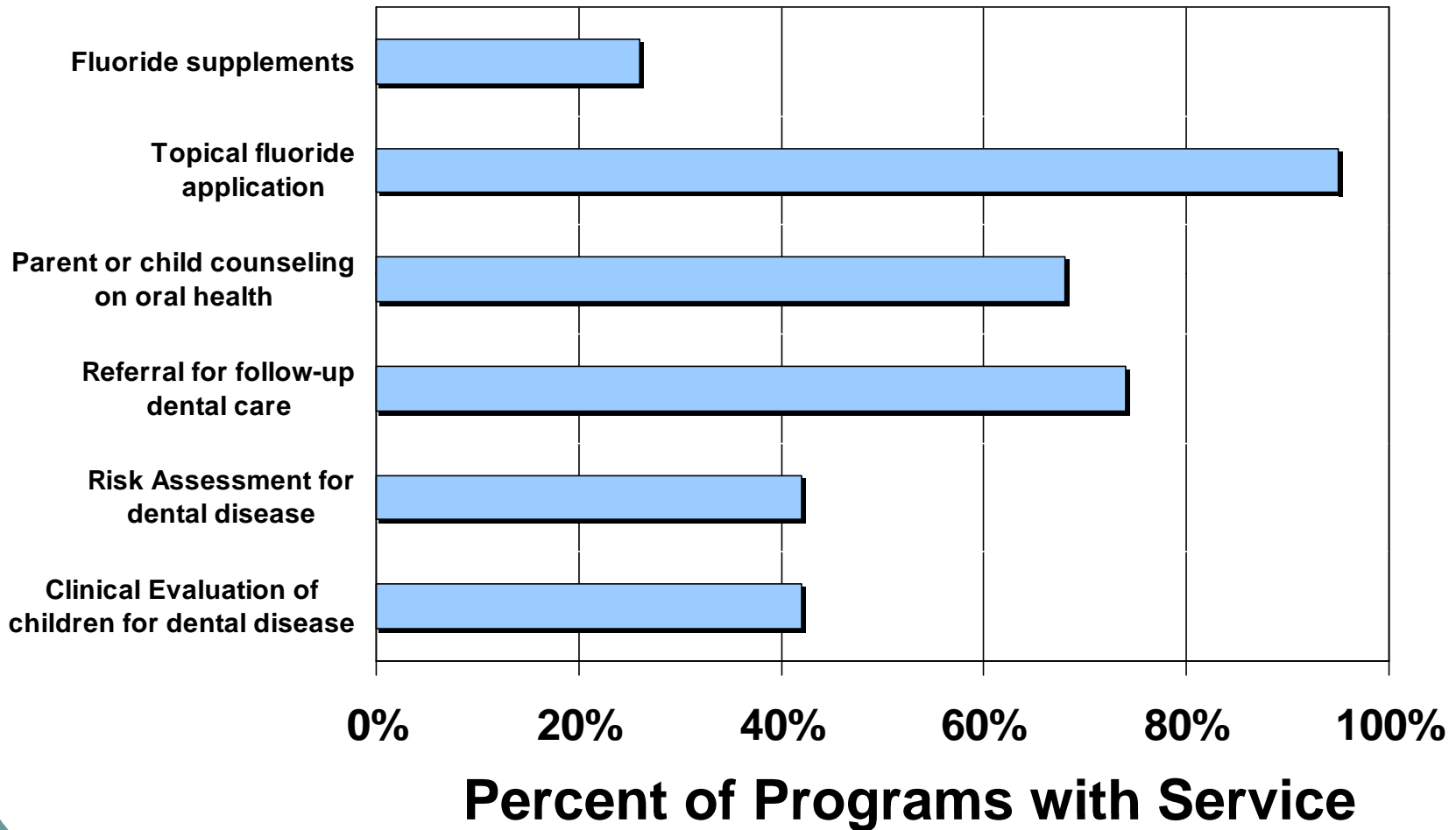
Respondents Identification of Barriers to Adopting

1. Limited budget to add new benefits	(n=36) 79%
2. Concerns about reimbursement codes (CDT or CPT)	(n=34) 74%
3. Concerns about type of claim form to use (CMS-1500 or ADA)	(n=35) 68%
4. Low reimbursement rates for preventive dental procedures	(n=32) 65%
5. Lack of sufficient personnel to implement or oversee program	(n=35) 65%

Respondents Identification of Barriers to Adopting (cont'd)

6. Lack of interest from physicians	(n=33) 60%
7. Opposition from organized dentistry (e.g., dental or dental hygiene associations)	(n=36) 53%
8. Lack of access to information about starting a program	(n=33) 51%
9. Required changes in Medicaid administrative rules or State Plan	(n=35) 49%
10. Need to update computer systems to accommodate preventive dental program	(n=35) 42%

Characteristics of Medicaid Medical Preventive Oral Health Programs



Conclusions from Survey

- Adoption of medical preventive oral health initiatives by state Medicaid programs is becoming widespread in the U.S. (27 States and D.C. have an initiative).
- Innovation is in its early stages (25% exist for <12 months).
- One-half of Medicaid programs require that providers be trained to receive reimbursement and 78% have training available.
- Topical fluoride application (96%) is the most frequent type of service included in the innovation, followed by referral for follow-up dental care (70%) and parental/child counseling on oral health (61%).

Conclusions from Survey (cont'd)

- The most common barriers to program implementation are: concerns about budget (78%), personnel (63%), coding (76%) or claims forms (66%); lack of information about starting a program (52%); and lack of interest by physicians (51%).
- Medicaid programs are improving access to preventive dental care in the U.S. through innovation in the delivery of preventive dental services.

Division of Medical Assistance NC Medicaid Dental Program

www.ncdhhs.gov/dma/dental.htm

Mark W. Casey, DDS, MPH

Dental Director

Mark.Casey@dhhs.nc.gov

919-855-4280





ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY
for STATE HEALTH POLICY