STATE HEALTH POLICY

Briefing

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

This *State Health Policy Briefing* provides an overview of state efforts to increase access to dental care for children through the use of primary care medical providers.

The results from a new NASHP survey provide an overview of state programs, which vary in their scope, implementation, and reimbursement policies.

Several highlights from the survey can be found below:

- 34 states reimburse primary care medical providers for preventive oral health services. This is an increase of 9 states since NASHP's last survey in 2008. Of these states:
- 33 states separately reimburse providers for the application of fluoride varnish
- 10 states separately reimburse for an oral exam or screening
- 7 states separately reimburse for anticipatory guidance
- 6 states separately reimburse for an oral health risk assessment

NATIONAL ACADEMY for STATE HEALTH POLICY

Engaging Primary Care Medical Providers in Children's Oral Health

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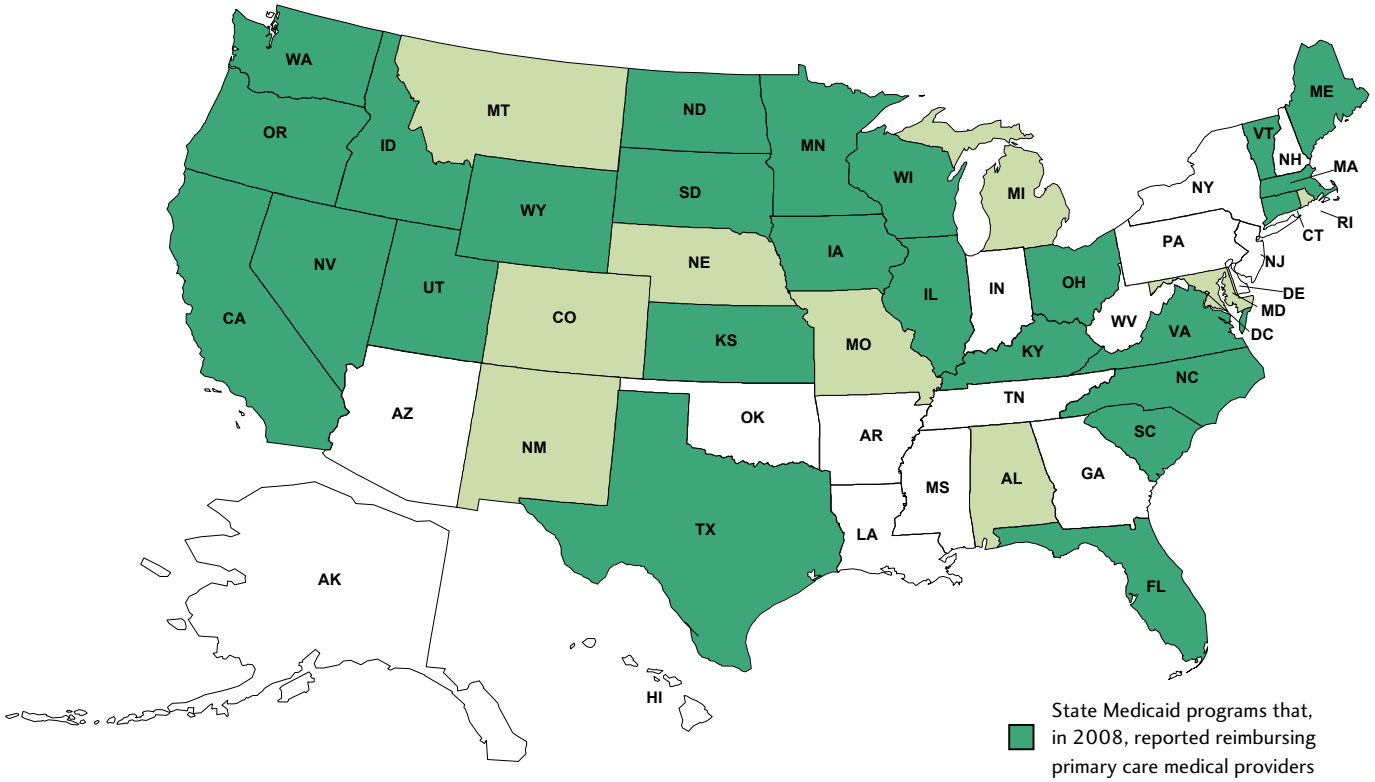
Obtaining access to dental care in the U.S. is a severe problem for young children, underscored by the fact that only a quarter of all children under six had a dental visit in 2004.[1] Despite a tough economic climate, states are developing new and innovative strategies to increase access to dental services for their young and vulnerable populations. One such strategy is the use of primary care medical providers to deliver early preventive dental services as part of well-child care and to encourage the development of proper oral health and eating habits within a family.

A new NASHP survey provides an update to the 2008 State Health Policy Monitor, *The Role of Physicians in Children's Oral Health*, which highlighted state efforts to increase access to preventive dental care through the use of medical providers.[2] Currently, 34 state Medicaid programs reimburse primary care providers for performing preventive oral health care services on children. These preventive oral health care services include the application of fluoride varnish, anticipatory guidance/caregiver education, risk assessment, and an oral examination/screening.[3] As shown in FIGURE 1, this is an increase of nine states over those reported in 2008, indicating that this particular method of increasing access has spread to a broader range of states. By providing incentives

Figure 1: Thirty-Four State Medicaid Programs Reimburse Primary Care Providers for Preventive Oral Health Services



This summary reflects results obtained from a survey of the 50 States and DC performed by Amos Deinard, MD, MPH on behalf of the Oral Health Initiative, American Academy of Pediatrics, Medicaid/SCHIP Dental Association and Chris Cantrell, Jason Buxbaum, et al. of the National Academy for State Health Policy.

for the medical community to get involved in children's oral health, states hope to increase early intervention and reduce the tremendous access problems that low-income children currently experience when trying to obtain oral health care services.

Current Status of Children's Dental Care

The 2007 death of Deamonte Driver, a twelve-year-old from Maryland who died of a brain abscess as a result of untreated tooth decay, brought to the forefront the extent to which our nation's oral health care delivery system has failed to meet the needs of low-income children. Although tragic, Deamonte's story is not unique in that millions of children struggle each year to access basic dental care. The urgency of this problem is made greater by the fact that dental caries has rapidly spread throughout young and infant populations, becoming the most common chronic childhood disease in America, five times more common than asthma.[4] The prevalence of dental disease in children ages 2 to 5 increased from 24 percent to 28 percent from 1988-1994 to 1999-2004.[5] Each year, around 4.5 million children develop early childhood caries.[6] Low-income and minority children are especially vulnerable to this disease, and are five times more likely to develop it than children from families with higher incomes.[7]

A landmark 2000 report of the U.S. Surgeon General stated that oral health is a key determining factor in the condition of a child's overall health.[8] While early childhood caries is on the

whole a preventable disease, many children still go untreated and often experience unnecessary and grim consequences. Dental disease has the potential to cause serious infections, pain, and dietary problems, leading to missed school days and an overall lower quality of life. (According to the Surgeon General's report, in 1999, children missed 51 million hours of school time due to dental conditions.) Since the first years of life are a time of substantial growth and development, children who do not receive proper preventive oral health care at an early stage experience a higher risk of needing more complex and expensive restorative care later on in life.

Due to the high costs of complex restorative care and oral surgery, state budgets also suffer when children do not have adequate access to preventive measures. When children require complex restorative dental procedures in a hospital ambulatory surgery suite under general anesthesia, not only is there the slight but real risk of an anesthetic death, but there is significant cost (hospital's charge, anesthesiologist's charge, and dentist's charge). When looking broadly across the country, total costs for these procedures can range from $10,000 to $15,000 per admission.[9] These costs add up over time as more children are admitted to the hospital for oral health-related complications. Through preventive care, states have an opportunity to better serve young and infant populations, and work toward a goal of reducing state expenditures on costly restorative care.

Dental Coverage Does Not Mean Dental Care

Covering children through insurance is an important policy goal, but achieving it does not necessarily mean that those children will be able to obtain care. According to the Medical Expenditure Panel Survey, while an estimated 26 percent of all children in the U.S. had some form of public dental coverage in 2004, of those only 34 percent had actually visited a dentist.[10] In contrast, nearly 58 percent of privately insured children had a dental visit in 2004. Despite the fact that many children do indeed have dental insurance, these numbers expose the gap between coverage and access that exists among low-income populations.

The American Academies of Pediatrics and Pediatric Dentistry recommend that a child have an established dental home[11] by age one.[12] While some general dentists serve infants and toddlers, those children with severe or complex dental issues may need care by a pediatric dentist. Yet, only 3 percent of all practicing dentists are pediatric dentists.[13]

In addition to the increasing decay rates among young children and limited pediatric dentist capacity, there is low dentist participation in state Medicaid programs. There are several issues that have contributed to the low participation rates among dentists in public programs. Low reimbursement rates and administrative burdens have discouraged provider participation in Medicaid and CHIP. Relative to the medical community, many dentists are unfamiliar with the populations that these programs serve, such as very young children and the developmentally disabled. Until relatively recently, dental schools have not traditionally focused on delivering care to infants and toddlers. Since most dental schools do not require residencies for general dentists, many dentists are not exposed to or trained to care for these special populations. In addition, the tendency of practicing dentists not to locate in rural and low-income areas has created a maldistribution of providers, further exacerbating the difficulties that many families experience when trying to access care. Even with the comprehensive set of dental benefits in Medicaid and CHIP, all of these elements make it extremely difficult for many publicly insured children to access the care they need.

Early Intervention Using Primary Care Providers

Given the access problems that publicly-insured children experience, many states are working to engage the medical community in sharing the responsibility for maintaining children's oral health. Children tend to see primary care providers far more frequently than dentists, a fact reflected in the recommendation of the American Academy of Pediatrics that a child see a primary care provider 11 times for a check-up by age two.[14] The early and frequent access that primary care providers have to young children presents a valuable opportunity to assess a child's oral health status before problems develop, provide preventive oral health services, and educate caregivers on proper oral health practices.

The use of primary care providers as a first line of defense in children's oral health is an innovative approach that provides an opportunity to facilitate a more cohesive working relationship between the dental and medical communities. Since medical providers typically have higher rates of participation in Medicaid than dentists, they can provide preventive oral health services to low-income children as part of well-child care while referring them to dentists for more complex restorative care.[15] Currently, states are reimbursing primary care providers for three separate services.

Methods for Intervention in Primary Care Settings

Oral Examination/Screening/Risk Assessment

It is important that medical providers consider the mouth as part of a routine well-child check-up. An examination of a child's mouth at a young age along with a risk assessment allows the medical provider to detect problems early on, before they develop into more serious conditions. Providers can then refer the child to a dentist for follow-up care. This has been shown to be an effective role for primary care providers. For example, one study found that physicians who were trained to identify the signs of dental disease were 95 percent accurate in identifying it in young children and referring them to a dentist for further care.[16]

Anticipatory Guidance/Caregiver Education

Studies have found that prior experience with dental decay and the education of the primary caregiver are the greatest predictors of future caries in young children.[17] Since children lack the ability to establish effective oral health habits by themselves, it is important that parents or caregivers learn age-appropriate methods of promoting their child's oral health. Oral health messages can be easily discussed during well-child visits in conjunction with broader messages about nutrition and obesity prevention. The objective of educating caregivers is to establish good dental habits at a young age, thus reducing the need for costly restorative care later in life. Primary care providers can serve as oral health advocates and educators along with dental providers.

Application of Fluoride Varnish

The application of fluoride varnish has been proven to be an effective method of reducing early childhood caries by protecting teeth, re-mineralizing weakened tooth enamel and slowing or halting the progression of early decay.[18] The varnish can be safely applied to children as early as the eruption of the first tooth. Since applying fluoride varnish is a quick and easy procedure, it can be easily integrated into well-child visits and delegated to auxiliary staff. Thirty-three states have adopted this approach to caries prevention. For instance, a study of Wisconsin's Medicaid program found that allowing medical providers to be reimbursed for fluoride varnish resulted in a significant increase in fluoride varnish applications in children ages one and two.[19]

Spotlight: Washington State

In 1998, the Washington State Medicaid program became one of the first in the country to reimburse medical providers for the application of fluoride varnish.[20] While fluoride varnish is an important tool in disease prevention, it is also critical that providers screen for early disease, assess risk and equip caregivers with helpful tips and information on oral hygiene and good nutrition. To encourage medical providers to deliver oral screening and oral health education, in 2008 Medicaid reimbursement was expanded to cover those services.[21] The state found that reimbursing the three services resulted in a significant uptick in provider participation. At the time of the program expansion, medical providers had delivered 145 fluoride varnish applications that year to children enrolled in Medicaid. By 2008, that number had increased to nearly 13,000 applications annually.[22]

The Washington Dental Service Foundation, funded by Washington Dental Service/Delta Dental of Washington (WDS), has worked to encourage participation by primary care providers. The WDS Foundation also developed a hands-on training program that has trained more than 2,200 primary care providers and clinical staff since 2001.[23] The required training program is designed to educate providers on performing the three services and billing for them. Currently, the state's program reimburses for fluoride varnish up to three times annually for children up to age five plus twice annually for oral assessments and oral health education. In an effort to expand the delivery of oral health prevention services, WDS also reimburses physicians for delivering oral assessments and fluoride varnish to children with WDS dental benefits. This represents progress toward the vision of establishing a standard of well-child care that includes oral health for all children.

State Policies to Integrate Preventive Oral Health Care into Primary Care Settings

A new NASHP survey provides an overview of the current status of states' efforts to increase access to dental care for children. Despite the current economic climate, many states have expanded on their efforts or started new programs, with many of them varying substantially in their scope, implementation, and reimbursement policies. Since last year's study, nine more states have begun reimbursing primary care providers for providing preventive oral health care to children, bringing the total to 34 states (see FIGURE 1). The services offered by these state programs are shown in TABLE 1, along with an overview of certain restrictions, and reimbursement rates. A quick summary of the data can be found below:

- Of the 34 states that reimburse primary care providers for preventive oral health services, 33 reimburse providers for applying fluoride varnish.
- Ten states separately reimburse for an oral exam or screening, seven separately reimburse for anticipatory guidance, and six separately reimburse for an oral health risk assessment.
- The amount at which states reimburse primary care providers for the application of fluoride varnish ranges from $9 in Michigan and Nebraska to $53.30 in Nevada. Reimbursement rates may vary depending on whether the state administers its dental program through managed care or through fee-for-service.
- Although most reimbursement rates remained unchanged since NASHP's 2008 study, four states actually increased their reimbursement rates: Idaho, Maine, Oregon, and South Dakota.

In order for care providers to be reimbursed for the application of fluoride varnish, some states require that other services be performed in conjunction during the same visit. For instance, North Carolina requires that fluoride varnish be applied along with performing a limited oral exam and providing anticipatory guidance. It is only after all three components have been performed that providers can be reimbursed at the rate of $54.87. Other states have used similar models by bundling services into a package to promote provider participation in the program and encourage them to perform all three services during a single visit. For those states that only reimburse for varnish application, the assumption is that the oral examination, risk assessment, and anticipatory guidance are covered by the reimbursement rate for the EPSDT examination.[24]

Most states impose age restrictions and yearly limits on this benefit. Some states target the benefit specifically to young children up to age 3, while others do not set an age limit at all; however this limit can vary if the program falls under managed care. States also restrict how many applications of fluoride varnish children may receive in a year. Most states limit the number of applications to three or four annually, however some states allow for fluoride varnish to be applied at each well-child visit.[25] Studies have shown that fluoride varnish is effective at preventing tooth decay when applied three to four times during the first two years of a child's life.[26]

Before a primary care provider can be reimbursed for these services, some states require that they undergo training programs designed to educate them on children's oral health and on how to perform preventive services. Currently, 25 states require that providers receive training before beginning to provide these oral care health services, while another three recommend it. The type of training program varies by state, though they are typically in-person or available online.[27] Not only does this training provide medical professionals with the appropriate knowledge they will need to effectively serve young children, it also allows them the opportunity to become more comfortable with sharing the responsibility for maintaining a child's oral health.

Conclusion

Many states are using innovative methods to increase access to preventive dental care for young children. States have found that encouraging primary care medical providers to share responsibility for children's oral health is an important step in improving the condition of a child's mouth and overall health. These programs also have the potential to forge a more cohesive working relationship between the medical and dental communities.

A forthcoming NASHP issue brief will further examine several state programs through in-depth case studies. The issue brief will cover program development and administration, and analyze key policy decisions that have resulted in variation in state programs.

TABLE 1: Reimbursement for Oral Health Services by Primary Care Medical Providers

State	Fluoride Varnish	Oral Exam/Screening	Anticipatory Guidance	Oral Health Risk Assessment	Reimbursement Rates for Fluoride Varnish Application	Fluoride Varnish Application Age Limit	Maximum # of Fluoride Varnish Applications Annually (applied by medical providers)	Is Training Required?
Alabama	✓	✓	✓	✓	$15.00	35 months	3	Yes
California[1]	✓				$18.00 (MCO: 0 - $27)	< 6 years	3	No
Colorado	✓	✓	✓		$15.37	5 years	4	Yes
Connecticut	✓	✓	✓	✓	$20.00	3 years	At each well-child visit	Yes
Florida	✓	✓	✓	✓	$27.00	6 to 42 months	4	No
Idaho	✓				$14.26 (MD) & $12.12 (midlevels)	21 years	2	Yes
Illinois	✓				$26.00	3 years	3	Yes
Iowa	✓				$14.55	3 years	3	Yes
Kansas	✓				$17.00	No age limit	3	No
Kentucky	✓				$15.00	1 to 5 years	2	Yes
Maine	✓	✓			$12.00	21 years	3	No
Maryland	✓				$24.92	9 mos to 3 yrs	4	Yes
Massachusetts	✓				$26.00	21 years	No limit	Yes
Michigan	✓				$9.00	3 years	4	Yes
Minnesota	✓				$14.00 (MCO: 14 - $20)	No age limit	No limit	Yes
Missouri	✓				$13.56	6 years	2	Yes
Montana	✓	✓			$19.65	20 years	6	No
Nebraska	✓				$10.00	≤ 12 years	3	No
Nevada	✓				$42.64 - $53.30	21 years	2	Yes
New Mexico	✓				$15.00	3 years	6 total until age 3	No
North Carolina[2]	✓	✓			$16.80	41 months	6	Yes
North Dakota	✓				$20.60	21 years	2	Yes
Ohio	✓				$15.00	3 years	2	Yes
Oregon	✓				$13.65	≤ 6 years	4	No
Rhode Island	✓				13 - $30.00	Varies by MCO	Varies by MCO	Yes
South Carolina	✓				$16.90	3 years	2	Yes
South Dakota	✓				$18.00	5 years	3	No
Texas[3]	✓	✓	✓		$34.16	6 to 35 months	6 over age range	Yes
Utah	✓			✓	$15.00	4 years	At each well-child visit	Yes
Vermont[4]		✓	✓	✓	TBD	2 years	TBD	Yes
Virginia	✓				$20.79	3 years	2	Yes
Washington	✓	✓	✓		$13.25	20 years	3	Yes
Wisconsin	✓				$12.76	≤ 12 years	------	Yes
Wyoming	✓			✓	$35.00	3 years	3	Yes
Total	**33**	**10**	**7**	**6**				

Notes

FFS: Fee for service, MCO: Managed Care Organization, MD: Medical Doctor

[1]Some Managed care organizations do not reimburse separately for fluoride varnish application.

[2]North Carolina Medicaid currently pays $38.07 for an oral exam/screening and $16.80 for the application of fluoride varnish for a total reimbursement of $54.87.

[3]Texas pays $34.16 for the combination of a limited oral exam, fluoride varnish application, and dental anticipatory guidance.

[4]Fluoride varnish program pending.

Unchecked services may be reimbursed as part of a well-child visit

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Endnotes

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22 Washington State Medicaid Enrolled Children Birth through Five Years Fluoride Varnish Applications by Primary Care Medical Providers 2000-2008, Chart.

23 Russell Maier, "Physicians Can Help Prevent Children's Dental Disease," *Washington Family Physician* volume 25, issue 2 (2008): 14-15; Washington Dental Service Foundation program statistics, August 2009.

24 EPSDT: Early Periodic Screening, Diagnosis, and Treatment

25 These states are Connecticut, Minnesota, and Utah.

26 J.A. Weintraub et al., "Fluoride Varnish Efficacy in Preventing Early Childhood Caries," 172-176.

27 For example, information on Massachusetts's training program can be found at: http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&L4=Information+for+MassHealth+Providers&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_fluoride_varnish_training&csid=Eeohhs2

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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