TASK FORCE ON CHILDREN'S PREVENTIVE ORAL HEALTH SERVICES
February 22, 2013
North Carolina Institute of Medicine, Morrisville
10:00-3:00 pm

Attendees
Members: Mark Casey (co-chair), Frank Courts (co-chair), Sam Bowman Fuhrmann, Rob Doherty, Nicole Dozier, Susan Shumaker, Cameron Graham, Brian Harris, Linwood Hollowell, Rebecca King, Thomas Koinis, Jasper Lewis, Linda Moore, Connie Parker, Rafael Rivera, Gary Rozier, Michael Scholtz, Tom Vitaglione

Steering Committee and NCIOM Staff: Krutika Amin, Pam Silberman, Berkeley Yorkery, Adam Zolotor

Interested Persons: Greg Abrams, Marty Delapena, Lynn Mouden, Regina Rutlidge, Darryl Smith, Lisa Ward

WELCOME AND INTRODUCTIONS
Mark Casey, DDS, MPH
Dental Director
Division of Medical Assistance
North Carolina Department of Health and Human Services

Frank Courts, DDS
Chair
Physicians Advisory Group Dental Committee

Marian Earls, MD
Lead Pediatric Consultant
Community Care of North Carolina

The co-chairs welcomed everyone to the meeting of the task force.

CMS ORAL HEALTH STRATEGY AND THE ROLE OF THE STATE ACTION PLAN
Lynn Mouden, DDS, MPH
Chief Dental Officer
Centers for Medicare and Medicaid Services

Dr. Mouden outlined the Centers for Medicare and Medicaid Services (CMS) oral health strategy and states' progress. Dr. Mouden discussed the progress measure forms CMS-416 and CARTS (CHIP program) for oral health service measures. This data is not currently accessible for Managed Care, federally qualified health centers (FQHCs), school based health centers (SBHCs), and Indian Health Services (IHS). Dr. Mouden discussed improvement in dental health

service utilization in all 50 states, and highlighted North Carolina. North Carolina is better than most other states in overall dental services utilization, but is in the middle range in preventive oral health services utilization. Dr. Mouden also discussed state Action Plan requirements. Lastly, Dr. Mouden shared examples of quality improvement through the "Learning Labs" initiative.

A copy of Dr. Mouden's presentation is available here: CMS Oral Health Initiative.

Selected Questions and Comments:

- Q: Are migrant worker health benefit data captured? A: Migrant health centers (FQHCs) may be reporting visit level data but not necessarily service level data.
- Q: Are Learning Labs successful beneficiary outreach strategies; are these archived somewhere? A: Yes. They are archived on Medicare.gov.
- Q: Are there states improving in quality just through reporting ie false reporting? A: At the North Carolina level data has been reported accurately; but it is an issue. North Carolina has set up coordination with FQHCs to ensure proper reporting.
- Q: General dentists are not sold on the efficacy of sealants. Have you run into this in many other states? A: American Dental Association (ADA) and Centers for Disease Control and Prevention (CDC) has put together informative reviews on efficacy of sealants.
- Q: How much are states and federal agencies working together to reduce fraud and abuse? A: CMS Center for Program Integrity and then states have their own agencies; He is not sure how closely the states and federal government work together on this
- Q: Fraud and abuse is pretty wide spread; how concerned are the federal agents in changing this? A: Dr. Mouden thinks the cases are small in fraud and abuse cases even though may seem large from the press releases.
- Q: How well does quality get measured? A: CMS does not have any dental quality indicators that are regularly used. CCNC has dental access indicators in their system however they are not quality indicators.

STRATEGIES STATES ARE USING IN THEIR STATE ACTION PLANS
Marty Dellapenna, RDH, MEd
Director
Medicaid-CHIP State Dental Association

Ms. Marty Dellapenna discussed examples of how states administer dental health programs in regards to various payment models and delivery models. The state of Michigan has set up a program in selected counties through a private insurer to provide dentists commercial reimbursement rates and therefore increasing access for Medicaid patients. The Rhode Island Medicaid oral health program, RIte Smiles, is also a contract program with a managed care organization (MCO) covering children ages 0-6. The Rhode Island program does not require dentists to be Medicaid providers in order to participate in RIte Smiles, educates staff through "mini-residency" programs, provides higher reimbursement rate to providers, and showed earlier

dental visits and reduction in emergency room visits related to dental care. Ms. Dellapenna also briefly discussed school-based dental services, dental services provided by non-dental providers, beneficiary outreach and education programs, and policy and program changes.

A copy of Ms. Dellapenna's presentation is available here: Strategies & Solutions in States.

Selected Questions and Comments:

- Q: Why is Michigan used as a best practice when one of the worst states according to the CMS 416? A: The data may not reflect all the utilization.
- Q: Is Michigan paying at the commercial rates? If so, is the state struggling with the expenses? A: The cost of the Michigan dental program is 2.5 times that of the Medicaid. This program is difficult to expand out of the pilot counties; they have not expanded to the metropolitan Detroit region due to the expenses.
- Q: What is Michigan's plan to take care of the sickest kids who cost the most? A: Michigan's strategy was to limit the program to some counties because of the cost of the MCO program. The state spent money through school based checks and non-MCO Medicaid. Also in MCO model the incentives aren't aligned and there are incentives for adverse selection.
- Q: Was the state of Michigan not worried about providers or patients banding together to ask for the MCO model across the state? A: Michigan had started the program as a pilot that needed to prove cost efficacy before they could expand to statewide. Michigan had to get waivers on state-wideness and state comparability. Michigan wanted to show success first in order to expand.
- Q: How many children are enrolled in the RItes Smiles program? A: Started at 30% of Medicaid children in RItes program and now upto 62% of Medicaid children in the RItes program.
- Q: What type of programs included in the statistic about 40 states have school-based programs? A: School based health centers, school linked health centers.
- In North Carolina what dental services by non-dental providers reimbursed? A: Oral assessments and fluoride varnishes are reimbursed in North Carolina.
- C: Expenditure per recipient needs to be correlated to outcomes and utilization of preventive services.
- Q: Are there states paying for risk assessment for dental providers or physical providers? A: About 11 states paying for dental risk assessment for physical providers. (Not many states providing risk assessment for dental providers)

DISCUSSION OF POTENTIAL RECOMMENDATIONS

The Task Force reviewed the barriers and root causes of oral health in North Carolina. The Task Force then brainstormed recommendations to address barriers and root causes related to families including:

- Parents do not bring their children in to the dentist.
- Scheduling barriers.
- Lack of awareness on Medicaid coverage of dental services.

- Low health literacy.
- Transportation.

An outline of the discussion topics is available here: Task Force Update.

NEXT STEPS

The Task Force will brainstorm recommendations related to dental providers and Medicaid/ policy issues related to sealants in March. In April, the Task Force will brainstorm recommendations related to primary care providers and workforce development in April. Future meetings of the Task Force will be held at the NCIOM and are scheduled as follows:

- Friday, March 22nd, 10am-3pm
- Friday, April 26th, 10am-3pm
- Friday, May 31st, 10am-3pm