THE STATE OF MEDICAID AND CHIP DENTAL SERVICES IN NORTH CAROLINA

Task Force on Children's Preventive Oral Health Services

North Carolina Institute of Medicine

December 14, 2012

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
www.ncdhhs.gov

Governor Beverly Eaves Perdue
Albert A. Delia, Acting DHHS Secretary
Michael Watson, Acting DMA Director

A Word From My Sponsor……

- Customer-focused
- Anticipatory
- Collaborative
- Transparent
- Results Oriented

Objectives of Presentation

- Introduction to the NC Medicaid and Health Choice Programs
- Who are the beneficiaries?—outline demographics for Medicaid and Health Choice Children
- What are the covered dental services for NC Medicaid and NC Health Choice eligible children
- Discuss NC Medicaid and NC Health Choice dental program budgets
- Recent honors/accolades

Objectives of Presentation

- Discuss performance measures for Medicaid/CHIP dental programs
  - Provider participation
  - Utilization measures
  - Measures specific to the CMS OH Strategy
- Utilization of preventive dental services on a county level (see handouts)
- Next steps—potential strategies for improvi access and utilization

NC Medicaid Beneficiaries

- SFY 2010 served approximately one out of every five North Carolinians
- Approx. 1.8 million beneficiaries annually – medically indigent children, pregnant women, aged, blind and/or disabled individuals
- Average of 1.3 million beneficiaries eligible each month during CY 2011
- 60% female, 40% male and 39% white, 44% black, 27% other race or ethnic background
- CY 2010--age breakdown: 0 to 5 (26%); 6 to 11 (16%); 12 to 20 (17%); 21+ non-ABD (19%) and 21+ ABD (22%)
- Of approximately 1.2 million enrolled Medicaid/CHIP children, about 40% are in the 0-5 age range

NC Medicaid Budget

- In SFY 2010, the Medicaid budget was roughly $10 billion
  - The federal government matches state approps roughly two federal dollars to every one state dollar
- Second only in overall NC state budget to primary and secondary education budget – accounts for over 15% of the General Fund operating budget

What is Health Choice?

- Children's Health Insurance Program (CHIP)
- Child health assistance to uninsured, low-income children from families with income from 150-200% FPL
- Serves children ages 6 through 18 (until the last day of the month in which they turn 19)
- Not an entitlement program—once federal funding runs out—enrollment can be closed

NC Health Choice

- Health care coverage to 150,000 children ages 6-18
- Budget of $226 million ($167 million in federal funds and $59 million state appropriations)
- Originally administered by NC Blue Cross/Blue Shield and State Employee's Health Plan in partnership with NC Medicaid (Division of Medical Assistance)
- DMA took over direct administration of the program on July 1, 2010
- Hewlett Packard Enterprise Services became fiscal agent for CHIP on October 1, 2011
- Effective October 1, 2011, NCHC became a Medicaid lookalike—same dental coverage as Medicaid children with some notable exceptions

NC Medicaid and NC Health Choice—Comparative Demographics

From 2007-09 CHAMPS survey—comparing publicly insured children ages 6-17

Characteristics	% Medicaid	% NCHC
Racial Background		
White	39.4	48.5
African American	40.9	33.5
Other Racial Background	19.6	18.0
Ethnicity--Hispanic	15.9	13.6
Parental Education		
Less Than High School Education	17.0	13.9
High School Degree	37.4	30.1
Some College Education	29.5	34.0
College Degree	16.1	22.0

NC Medicaid and NC Health Choice—Comparative Demographics

Health Care	**% Medicaid**	**% NCHC**
● Insurance Coverage Consistency		
Lack Consistent Coverage in Past Year	13.6	14.5
● Usual Source of Care		
Most Often Visit a Doctor's Office	81.9	81.9
Most Often Visit a Public Health Center	11.3	8.8
Most Often Visit a Hospital (Outpatient, ED, Urgent Care)	5.9	9.1
● Personal Doctor		
Professional Knows the Child and Heath Hx Well	79.4	81.3
● Preventive Health Care		
Preventive Medical Visit in the Past Year	82.2	76.0

Dental Coverage for Medicaid/CHIP Children

- Diagnostic—oral evaluations/check-ups every 6 calendar months; radiographs with time limits—bitewing images every 12 calendar months, panoramic and full mouth series images every 5 years
- Preventive—cleanings and fluoride treatments every 6 calendar months; sealants for primary (under age 8) and permanent (under age 16) molars once per lifetime per tooth; space maintainers
- Restorative—fillings and acrylic and stainless steel crowns
- Endodontic—root canals for all permanent teeth except wisdom teeth; pulpotomies for primary teeth and other procedures with limits

Dental Coverage for Medicaid/CHIP Children

- Periodontal—”deep cleanings” or scaling and root planing—some surgical procedures with limits based on underlying medical conditions—e.g.—gingivectomy; many of these services require prior approval
- Acrylic partial dentures and dentures—requires prior approval
- Extractions (including impacted teeth) and many other oral surgery services (biopsies, tumor excisions, fracture repairs, orthognathic procedures) some of which require prior approval
- Orthodontics restricted to children with functionally impairing malocclusions which meet strict policy prior approval criteria
- Adjunctive services like general anesthesia/deep sedation; IV sedation; nitrous oxide; hospital call; palliative care

Top Ten Procedures
Ranked by Program Expenditures-SFY 2011

Procedure	Actual NC Medicaid Rate 2011	NDAS Median 2011 (fee benchmark)	Current % of 2011 NDAS 50% Median	Total Expenditures SFY 2011
Two surface composite filling – posterior tooth	$118.63	$210.00	56%	$31,170,633
One surface composite filling – posterior tooth	$80.00	$161.00	50%	$24,619,094
Surgical extraction – erupted tooth	$109.23	$253.00	43%	$15,255,383
Periodic oral evaluation	$25.79	$42.00	61%	$14,515,1393
Extraction erupted tooth	$63.54	$155.00	41%	$13,466,886
Three surface composite filling – posterior	$144.28	$262.00	55%	$13,461,318
Periodic orthodontic maintenance visit	$96.24	$226.00	43%	$13,337,996
Comprehensive oral evaluation – new patient	$44.61	$79.00	56%	$12,828,651
Prophylaxis -- child	$27.21	$62.00	44%	$12,634,342
Sealant per tooth	$28.58	$49.00	58%	$11,189,476

Top Ten Procedures
Ranked by Total Units Provided-SFY 2011

Procedure (CDT code)	Units SFY 2011	Total Expenditures SFY 2011
Periodic oral evaluation (D0120)	569,537	$14,515,394
Prophylaxis – Child – under age 13 (D1120)	467,033	$12,634,342
Sealant – per tooth	393,073	$11,189,476
Topical application of fluoride (D1203)	358,646	$5,722,174
Intraoral periapical – first film (D0220)	337,865	$4,799,298
Intraoral periapical – each additional (D0230)	311,364	$3,606,368
One surface composite filling – posterior tooth (D2391)	311,059	$24,619,094
Comprehensive oral evaluation (D0150)	290,778	$12,828,651
Two surface composite filling – posterior tooth (D2392)	264,994	$31,170,633
Prophylaxis – adult (D1110)	255,151	$9,594,398

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

A Federal Medicaid requirement that requires the state Medicaid agency to cover services, products, and procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician).

Dental Coverage for Medicaid/CHIP Children--Summary

- For Medicaid--no copays or coinsurance even for major surgeries and orthodontics;
- For NCHC children, $5 per visit from families with income above 150% FPL—copays apply to all visits except diagnostic and preventive
- No caps on maximum paid per year for Medicaid or NCHC
- For Medicaid children—”EPSDT requests”--policy limits do not apply if a provider can demonstrate that a requested service, be it covered or non-covered, is medically necessary to correct or ameliorate a health condition
  - Examples of non-covered treatment approved under “EPSDT”: 1) laboratory fabricated crown for a root canal treated tooth; 2) non-IV sedation for a preschool beneficiary with moderate restorative or surgical needs; 3) early or interceptive orthodontic treatment to prevent a developing malocclusion
- EPSDT does not apply to Health Choice

NC Health Choice

- Effective October 1, 2011, NC Health Choice became a Medicaid lookalike—same coverage as Medicaid children with some notable exceptions
  - Makes sense from the administrative perspective; IT cost savings can be achieved
  - Same benefits and policy limits will be less confusing to families and providers

NCHC Mirrors Medicaid Policy with a Few Exceptions

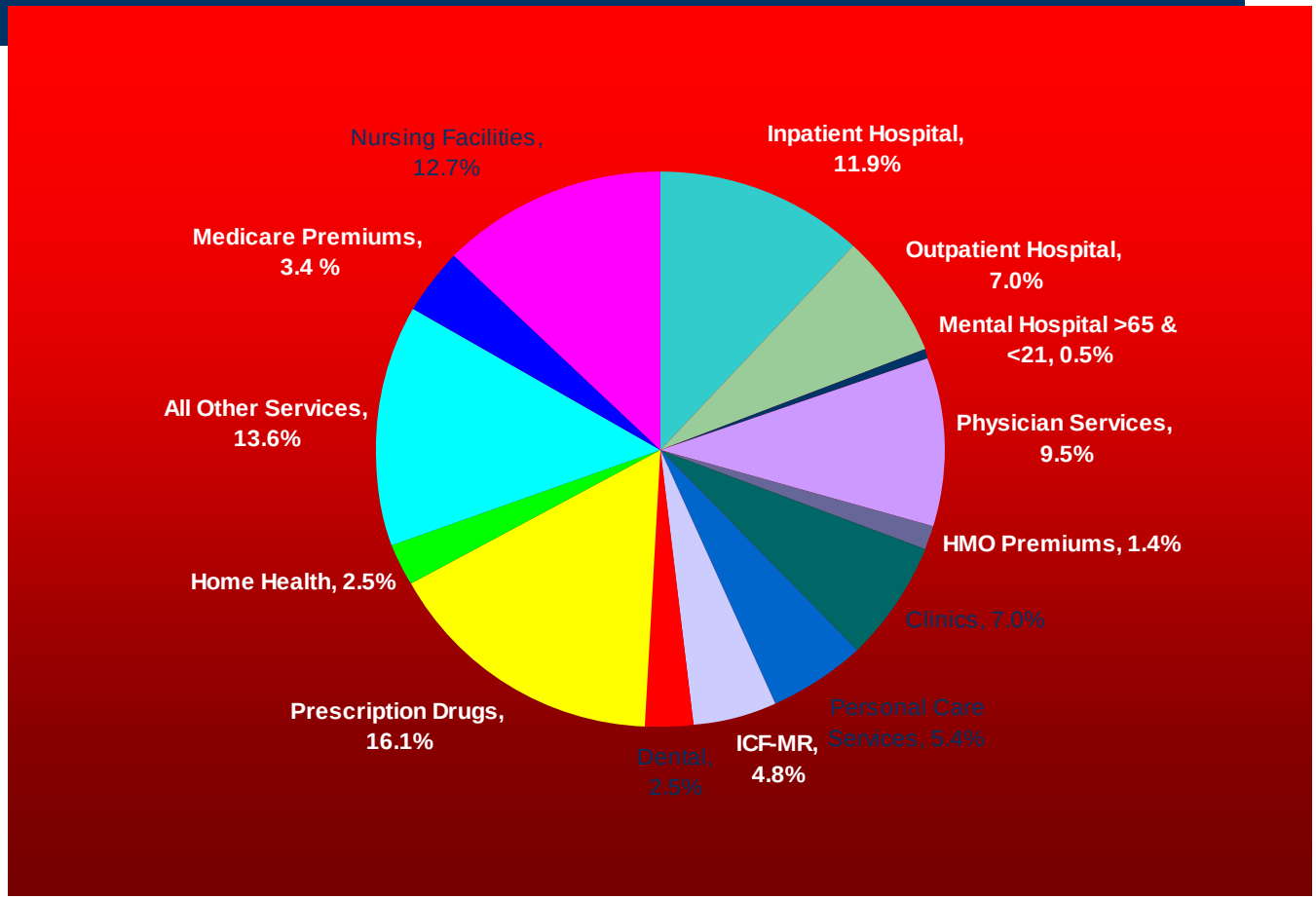
- Prior approval is required for the extraction of impacted teeth–e.g.–symptomatic third molars (wisdom teeth)
- Orthodontic coverage is allowed for severe malocclusions caused by craniofacial anomalies like cleft lip and palate and other syndromic conditions
- No coverage for pre-prosthetic surgeries (alveoloplasty, tori removal, exostoses removal, and vestibuloplasty)
- EPSDT does not apply


34

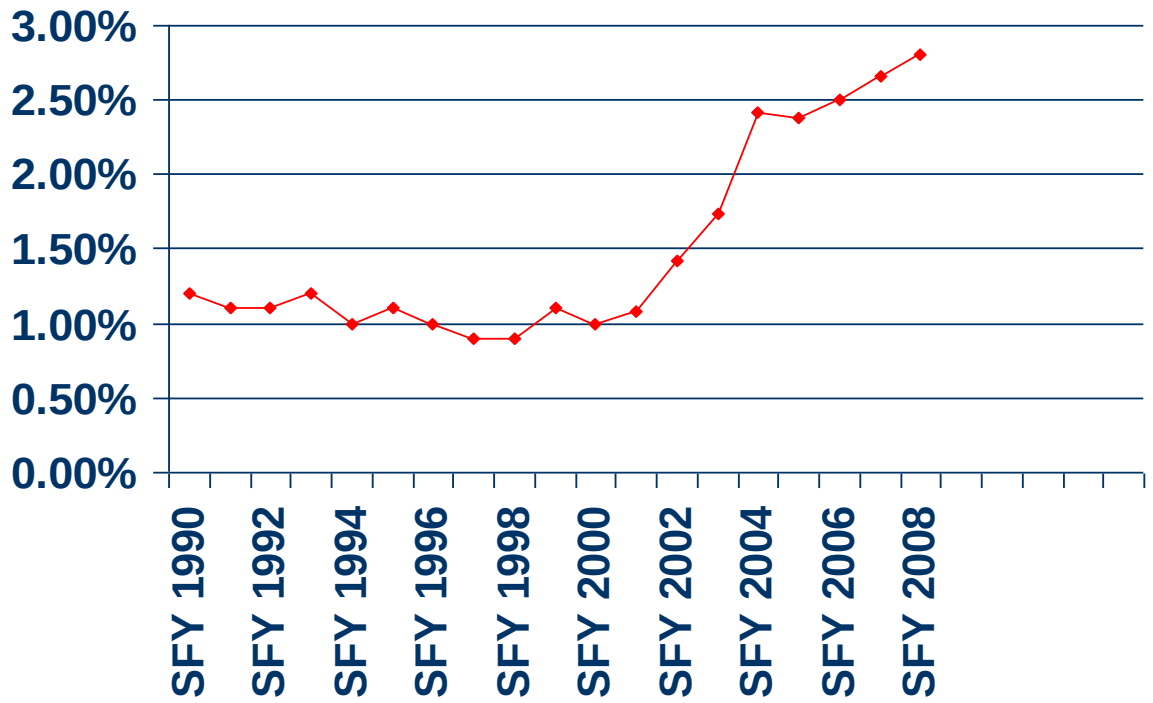
NC Medicaid Dental Program Budget Update

- Dental expenditures in SFY 2012 totaled approximately $356 million dollars. $220 million was spent on children's dental services and $136 million on adult dental services
- Dental Program expenditures were over 3% of the overall SFY 2010 NC Medicaid Budget—continues to grow at a faster rate than most other programs ($356 million out of a $10 billion budget)
- DMA Budget reported in October 2012 that over the course of SFY 2012 the number of Medicaid beneficiaries receiving dental services grew by 10% per 1000 enrolled compared to SFY 2011
- While utilization improved, average cost per recipient for dental services declined by 17% when compared with SFY 2011 results (effect of budget cost-cutting changes)

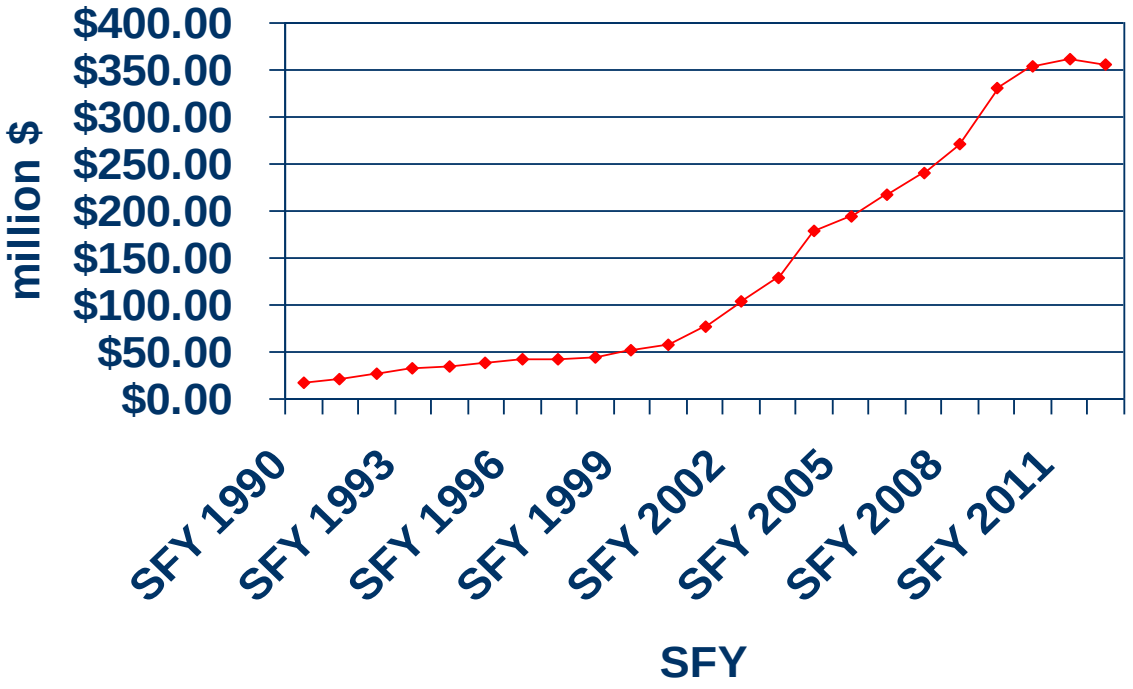
MEDICAID SERVICES EXPENDITURES SFY 2006



Growth in Dental Program from SFY 1990-2008 (% of Total Medicaid Services Expenditures)



Total Dental Expenditures SFY 1990 – SFY 2012



NC Health Choice Dental Program Budget Update

- SFY 2012 dental expenditures totaled approx. $34 million or about 10% of the Medicaid dental budget
- NCHC dental expenditures were lower than the expected fiscal impact of the expansion to the Medicaid lookalike
- The federal match for CHIP is higher—approx. 75/25 in NC—less State approps required for NCHC

Recent Honors/Accolades

- The Pew Children's Dental Campaign 2010 Report Card reported that North Carolina "has outperformed the national average on both rates of reimbursement for dentists and of children who receive dental services"
  - In 2011, Pew reported that NC did not receive a passing grade for the reimbursement rate benchmark

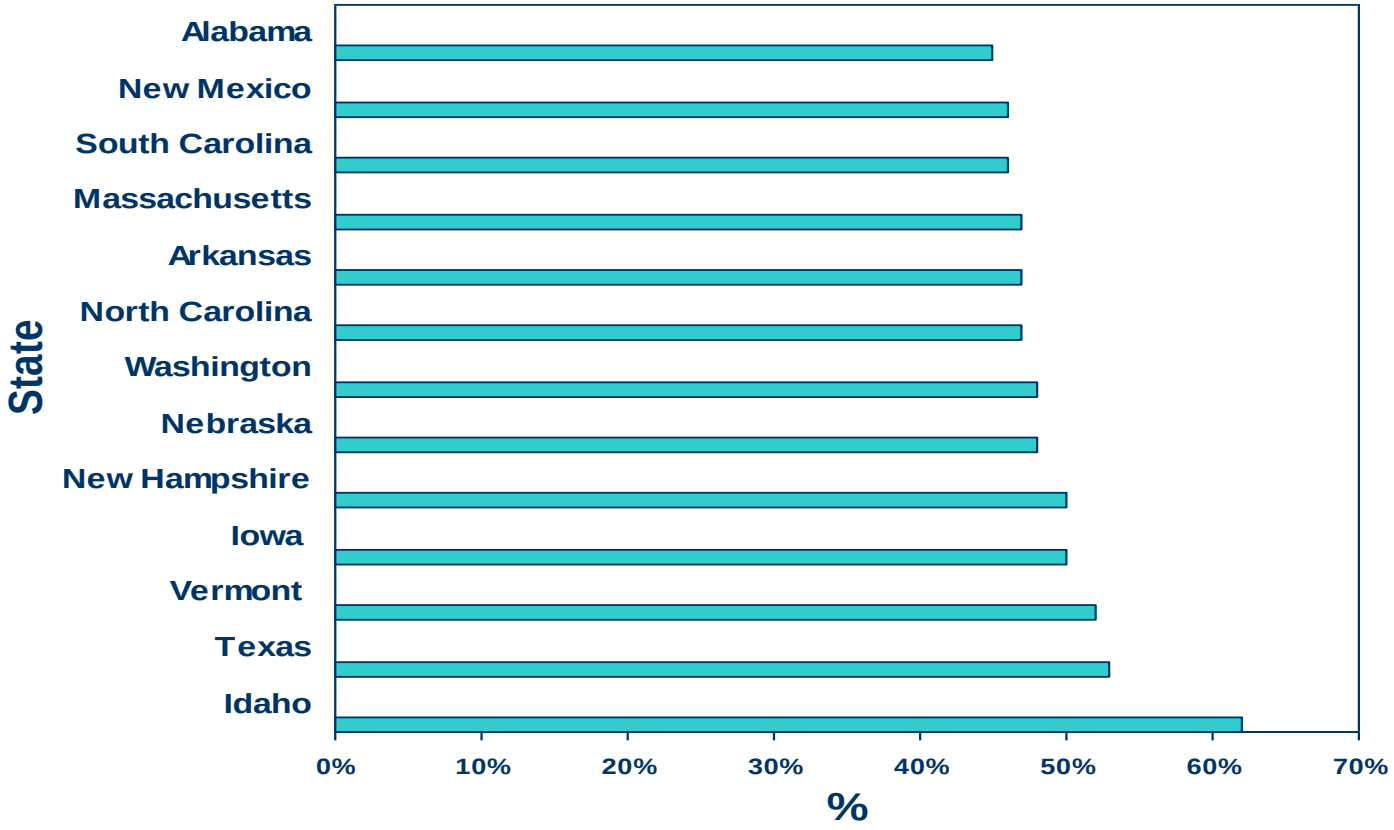
- The "Into the Mouths of Babes" (Physician Fluoride Varnish Services) program was specifically cited as "a model for other states" to improve delivery of preventive OH services to young preschool beneficiaries.

Recent Honors/Accolades

- In January 2011, NC Medicaid was recognized by the Centers for Medicare and Medicaid Services (CMS) as one of eight states with high utilization of pediatric oral health services and/or innovative methods of delivering oral health services to Medicaid children (IMB)
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/8statedentalreview.pdf

- In June 2012, CMS reported that the NC Medicaid Dental Program tied for #7 in the US in terms of utilization of any dental service for children ages 0-20 using CMS 416 data from FFY 2009

States Utilization: “Any Dental Service” FFY 2009 (CMS-June 2012)



Medicaid Dental Program Performance Measures

- How do we measure success in Medicaid dental programs?
  - Provider Participation
    - # of providers with at least one paid claim per year
    - # significant providers with paid claims >= $10,000 per year
    - # of providers treating > 100 recipients

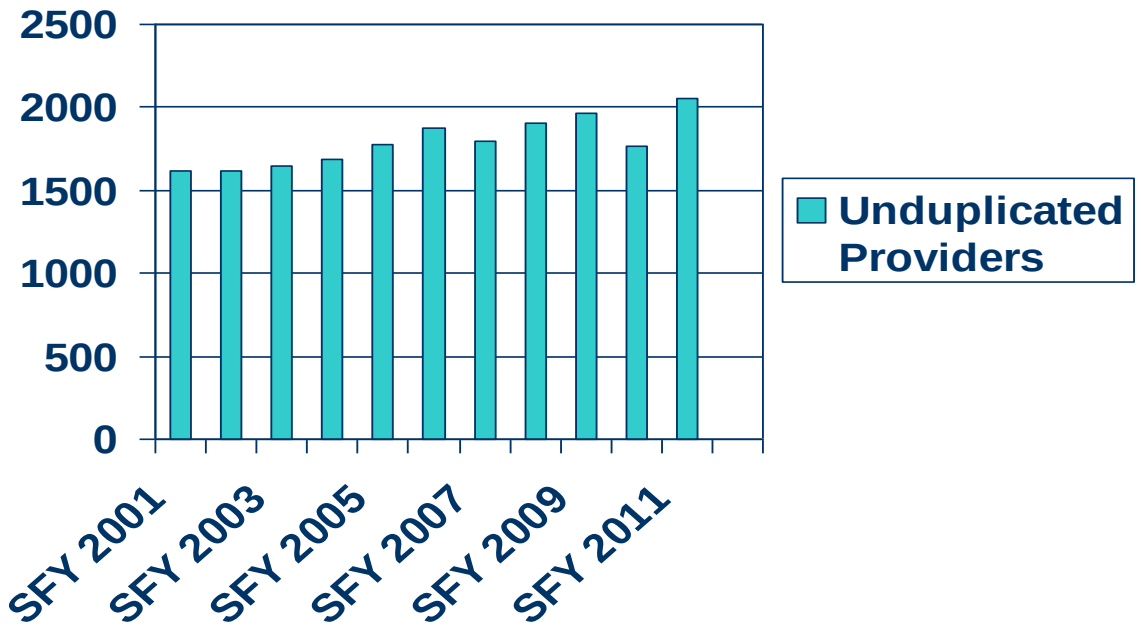
Provider Participation

- From SFY 2009 to SFY 2011 the number of actively participating billing providers has remained relatively constant
- The number of participating attending providers (dentists rendering services) is estimated to be approximately 2200-2300
  - Unable to come up with accurate figures due to MMIS limitations
- It is estimated that a bit less than 50% of the active licensed dentists in NC (around 4600 total) are rendering providers on at least one Medicaid paid claim each year

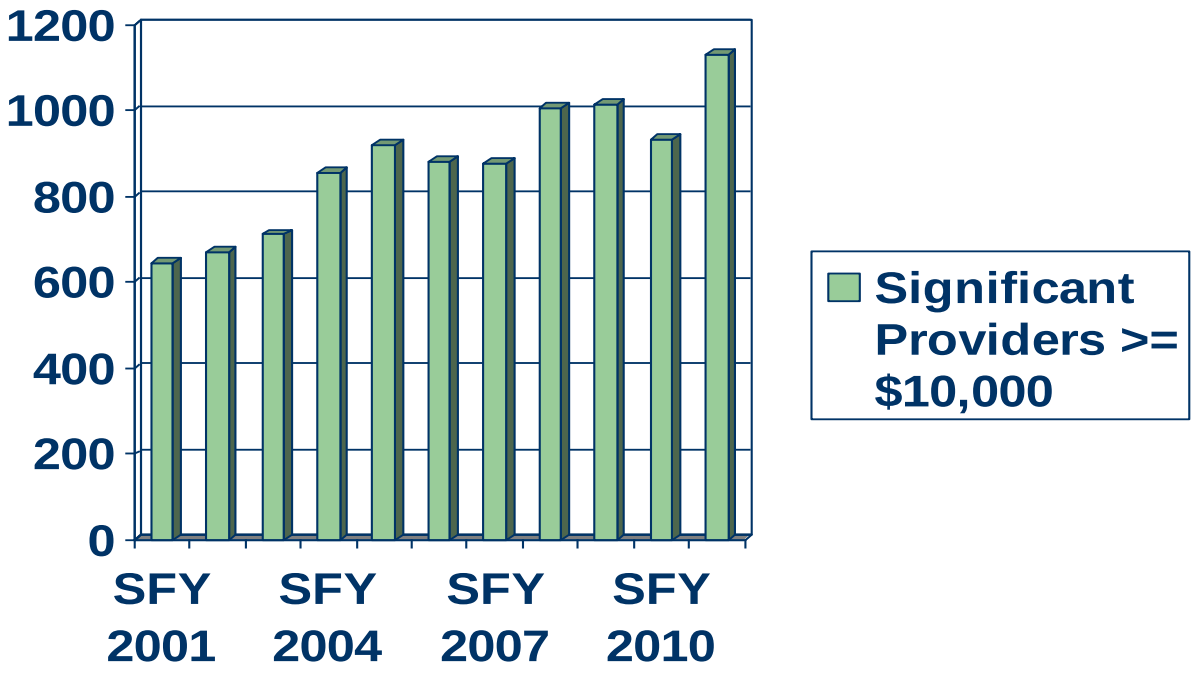
Provider Participation

- Why do we continue to keep providers in the fold even after two across the board rate cuts in 2009 and 2011?
  - In a distressed economy, providers turn to payers that are reliable sources of income
  - Specialists like oral surgeons and orthodontists are participating more than before—still have some areas of the State that are a challenge—NE and western NC
    - Prior approval submissions for Medicaid orthodontics have gone from 1200/month to 2000/month in two years
  - Private pay patient discretionary spending is down—affects specialists more than general and pediatric dentists

Trends in Number of Billing Providers



Trends in Number of Billing Providers



Medicaid/CHIP Dental Program Performance Measures

- Beneficiary Utilization Measures
  - # of unduplicated eligibles receiving services over SFY (any service, preventive, diagnostic and/or treatment services) -- see CMS 416 EPSDT Participation Report: http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp
  - Rates -- # of unduplicated eligibles receiving oral health care services divided by total number of unduplicated eligibles
    - Healthcare Effectiveness Data Information Set Annual Dental Visit (HEDIS ADV) metric—beneficiaries ages 2-21 who are eligible for 11 out of 12 months included In denominator

Utilization Measures

- As reported on the CMS-416 Report in FFY 2011:
  - 49% of NC Medicaid children (ages 1-20) eligible for 90 days or more received any dental service during the reporting period
  - 45% received at least one preventive dental service (BASELINE FOR CMS OH Strategy)
  - 55% received at least one OH service from a dentist or non-dentist
    - Demonstrates the importance of IMB

- Questionable validity-not every child included in the calculation of this measure has an equal opportunity to receive oral health care services
    - Many children who are eligible for short lengths of time (3 - 6 months) during the reporting period are included in the denominator
    - Denominator includes a large number of children < age 2 who have little opportunity to access care with Medicaid enrolled providers (many more general dentists than pediatric dentists)

Utilization Measures

- Dramatic improvement has been made for children in the 1-5 age group
  - 58% of all Medicaid children ages 1-5, who were eligible for dental benefits for six months or more, received at least one oral health care service in SFY 2011 versus SFY 2006 when 47% of these preschool children received services (Source: NCIOM /Action For Children 2012 NC Child Health Report Card)
  - In FFY 2009, NC Medicaid led the nation in utilization of preventive oral health care services by children ages 1-5 and was third in the nation in utilization of any dental service by children in the same age group

Utilization/Access Measures

- In CY 2010, *when a continuous enrollment requirement of 11 out of 12 months is used* to calculate access rates, (HEDIS ADV-like), utilization improves for Medicaid children ages 2-21 to approximately 60% including children seen by physicians in fluoride varnish program
- The HEDIS ADV utilization rate is 56% when reporting the % of children ages 2-21 treated by dentists
- These utilization rates approach or exceed those reported by private dental insurance plans – 58% according to both the Pew Children's Dental Health Campaign and CMS
- Clearly, the longer a child remains eligible for Medicaid benefits, the greater the opportunity he or she has to receive important oral health care services

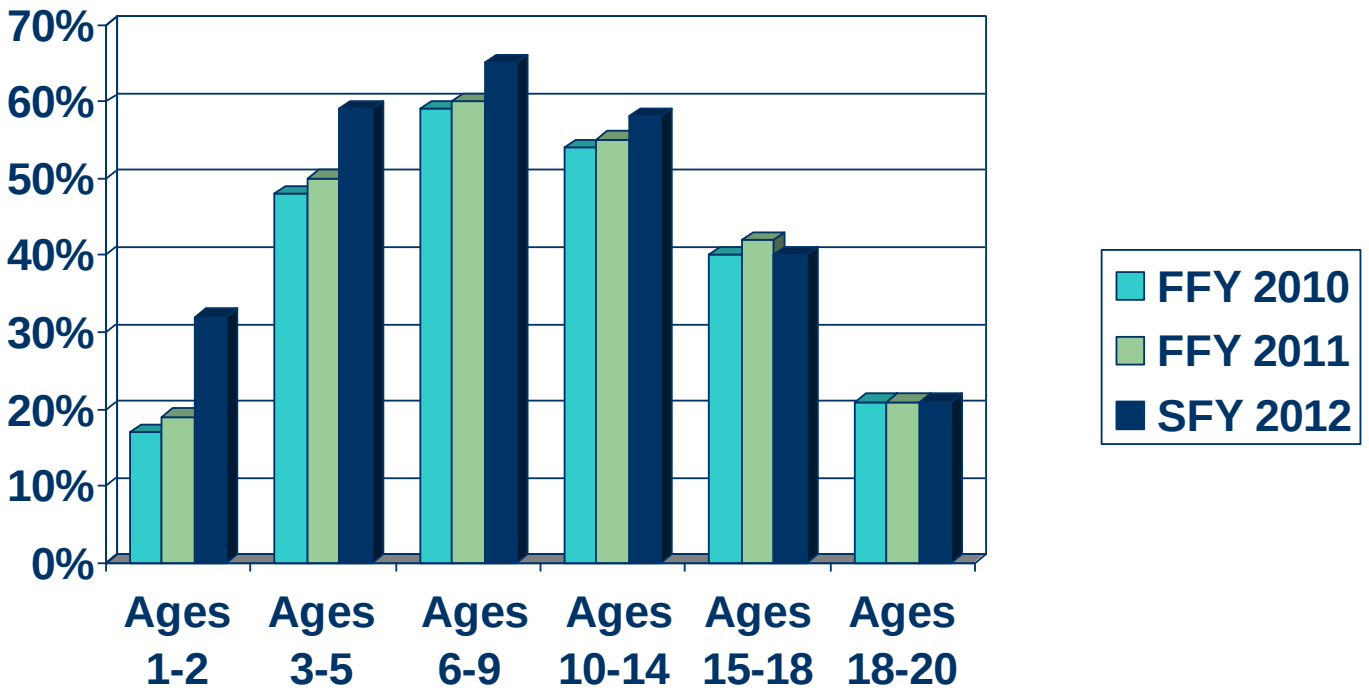
Program Utilization Measures

- It is fair to say that the DMA Dental Program has come a long way from State Fiscal Year 2000 when only 22% of eligible children received at least one oral health care service (using the CMS-416 methodology to calculate utilization rates)
- Credit goes to the many active licensed dentists in the state who remain committed to treating disadvantaged children

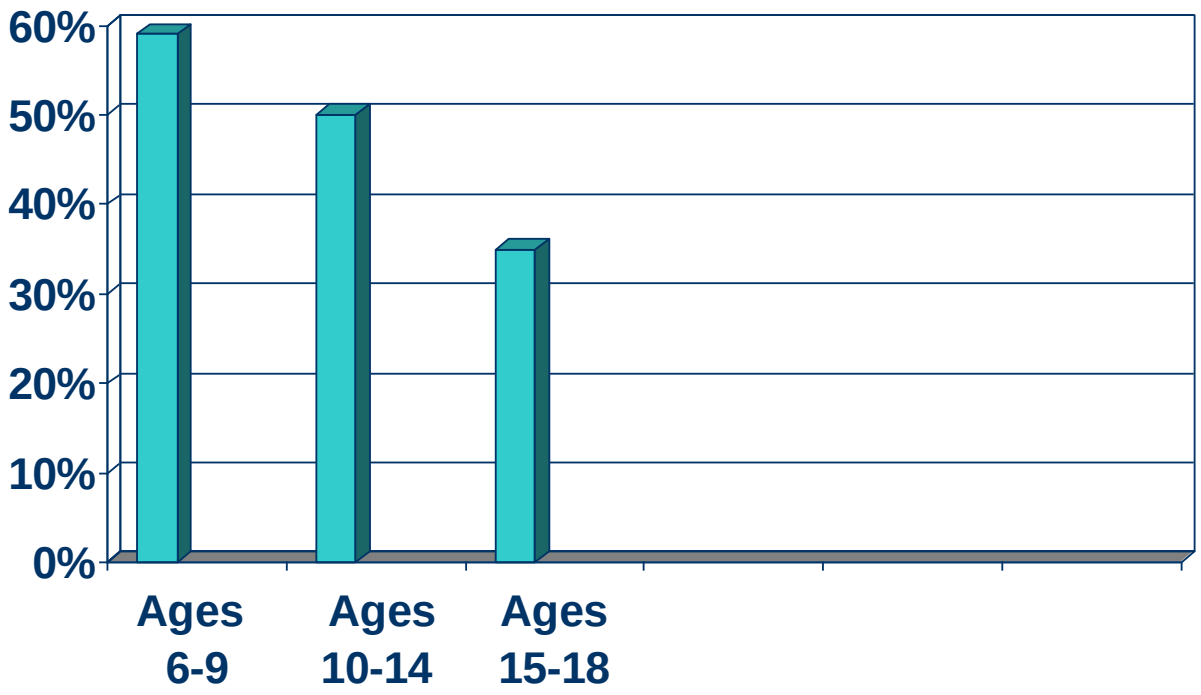
CMS Oral Health Strategy Goals

- To increase the rate of children ages 1-20 enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over a 5-year period
- FFY 2011 data used as baseline—so over five years the target is 55% of all Medicaid and XX% of CHIP children receiving preventive dental services
- Optimistic?

% Medicaid Children Receiving Preventive Services 2010 - 2012



% NC Health Choice Children Receiving Preventive Services SFY 2012



CMS Oral Health Strategy Goals

- To increase the rate of children ages 6-9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a 5-year period
- FFY 2012 or 2013 data will be used as baseline

% NC Medicaid and Health Choice Children Receiving Sealants—2010-11

- 17% of eligible Medicaid children ages 6-9 (continuously enrolled for 90 days or more) received a sealant in FFY 2011 and XX% in FFY 2010

- XX% of eligible NC Health Choice ages 6-9 received a sealant in FFY 2011

Utilization Measurements
County Specific Snapshots

- DMA Quality, Evaluation, and Health Outcomes (QEHO) team has calculated dental access measurements for children < 21 and adults >=21 for each NC county
- Using CMS methodology Statewide measures–
  - 49% of children eligible for dental services from 1-12 months during SFY 2010 received at least one dental service
  - 32% of adults eligible for dental services from 1-12 months during SFY 2009 received at least one dental service
- Please see this data along with other interesting demographic and health care data for each county at : http://www.ncdhhs.gov/dma/countyreports/index.htm
- Why? – to enable policymakers and other stakeholders a chance to examine and better understand Medicaid data on the local level

Access Measurements SFY 2009 -- County Specific Snapshots Trends

- Data is based on recipient county of residence, not on where care is obtained
- Access for adults poorer than for children
- Some NE and SW rural and remote counties have access measures well below state average for both age groups
- Some urban counties with large numbers of active licensed dentists, enrolled Medicaid providers and Medicaid recips are a little below the state average for children. The ratio of actively participating dentists to Medicaid recips is low – Mecklenburg
- Some urban counties with the same elements are significantly above the state average for children – Buncombe, Durham, Forsyth, Guilford

Utilization Measurements for Preventive Services County Specific Trends/Analysis (see handouts)

- Most of the counties with utilization well above the state average for preventive are not urban – Alamance, Alexander, Polk, Wilkes, etc.
- Most of the counties that lag the state averages are in the NE and western part of the state—no surprises from Camden, Chowan, Clay, Currituck, Pasquotank, Perquimans, Swain et al
- Many urban counties—Guilford, Durham, Orange et al are doing relatively well in delivering services to the young preschool beneficiaries and better than average in delivering services to all children
- One urban county with a very large beneficiary population—Mecklenburg—could benefit from more active participation

Utilization Measurements for Preventive Services County Specific Trends/Analysis (see handouts)

- Analysis – What does it all mean?
  - Not entirely accurate to state that urban access is better than rural when referring strictly to Medicaid and CHIP recipients
    - Is it maldistribution of providers or lack of significant participation in some underserved areas? Or, really both?
  - Still need to address access issues in remote NE and SW counties
  - Key ingredients to success – not entirely clear and more detailed analysis is necessary
    - Hypothesis: takes good teamwork between active public and private providers to achieve success – only limited success without both sides pulling their weight—e.g.—Wilkes, Gaston and other counties
    - Mobile dental providers seem to be providing increased access to preventive services in some schools in rural counties
      - Questions unanswered about their ability to establish dental homes and follow-up care for children who need treatment beyond diagnostic and preventive services

MY OTHER SPONSOR--
GO DUKE!!!

Next Steps

- What strategies can be employed to improve access to and utilization of preventive services for the three age groups that are not optimally utilizing services
  - 1-2,15-18 and 19-20 year olds
- A 10 percentage point increase in placement of sealants on 6-9 year olds may face a significant barrier because of dentists' understanding of the ADA guidelines for pit and fissure sealants and their own clinical practice experience with sealants
  - Is this an "old school" vs. "new school" issue?

Next Steps

- No doubt that DMA needs to do more to address OH literacy issues with parents/caregivers with assistance from their partners in dental and medical professional membership organizations as well as UNC SoD and ECU SoDM and a host of other partners

- PCPs are the gatekeepers for many children who face health care issues—can dental professionals work with PCPs to accept referrals of very young children with active disease and increased risk for early childhood caries?
  - Use of a risk assessment tool like PORRT (Priority OH Risk and Referral Tool) used in CHIPRA Connect
  - Establishing a dental home early in life is crucial to improved OH status throughout childhood and into the adult years

Next Steps

- No doubt that DMA needs to do more to address OH literacy issues with parents/caregivers with assistance from their partners in dental and medical professional membership organizations as well as UNC SoD, SPH and ECU SoDM and a host of other partners

- PCPs are the gatekeepers for many children who face health care issues—can dental professionals work with PCPs to accept referrals of very young children with active disease and increased risk for early childhood caries?
  - Use of a risk assessment tool like PORRT (Priority OH Risk and Referral Tool) used in CHIPRA Connect
  - Establishing a dental home early in life is crucial to improved OH status throughout childhood and into the adult years

- Let the brainstorming begin!

Questions/Comments/Criticism?

Division of Medical Assistance
NC Medicaid Dental Program

http://www.ncdhhs.gov/dma/services/dental.htm

Mark W. Casey, DDS, MPH
Dental Director
Mark.Casey@dhhs.nc.gov

919-855-4280