The Search for Successful Strategies to Improve Oral Health

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National Conference of State Legislatures

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CHCS Center for Health Care Strategies, Inc.

Rationale for Renewed Focus on Oral Health

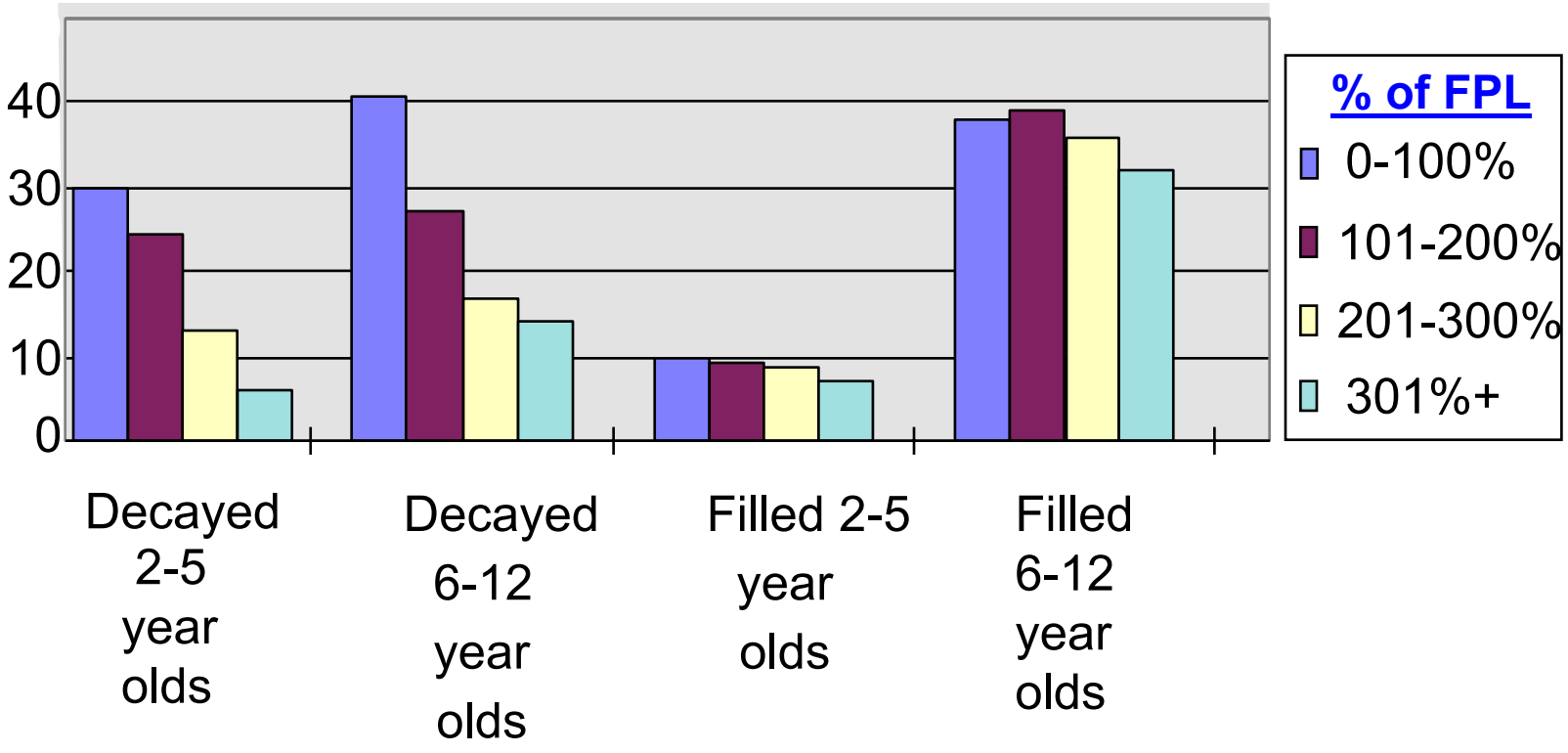
- Surgeon General's Report "Oral Health in America" (2000) and "Call to Action" (2002)
  - Importance of oral health--general health relationships across the lifespan
  - Significant oral health disparities
  - Need to change perception of oral health and dental care
    - It's about more than 'just teeth' & cosmetics
    - Concept of medically necessary dental services
  - Establish partnerships & networks
  - Build programs based on current science base

Major Issues

- Program Administration / Finance
  - Under–financing / low reimbursement rates
  - ‘Silos’ between public health & public benefits programs and between public and private sectors
  - Lack of consumer awareness of significance of oral health and disparities
- Workforce
  - **Supply and distribution of dentists**
  - **Scope of practice and supervision issues**
  - **Coordination among medical and dental providers**
  - **Increase overall workforce diversity, capacity and flexibility**

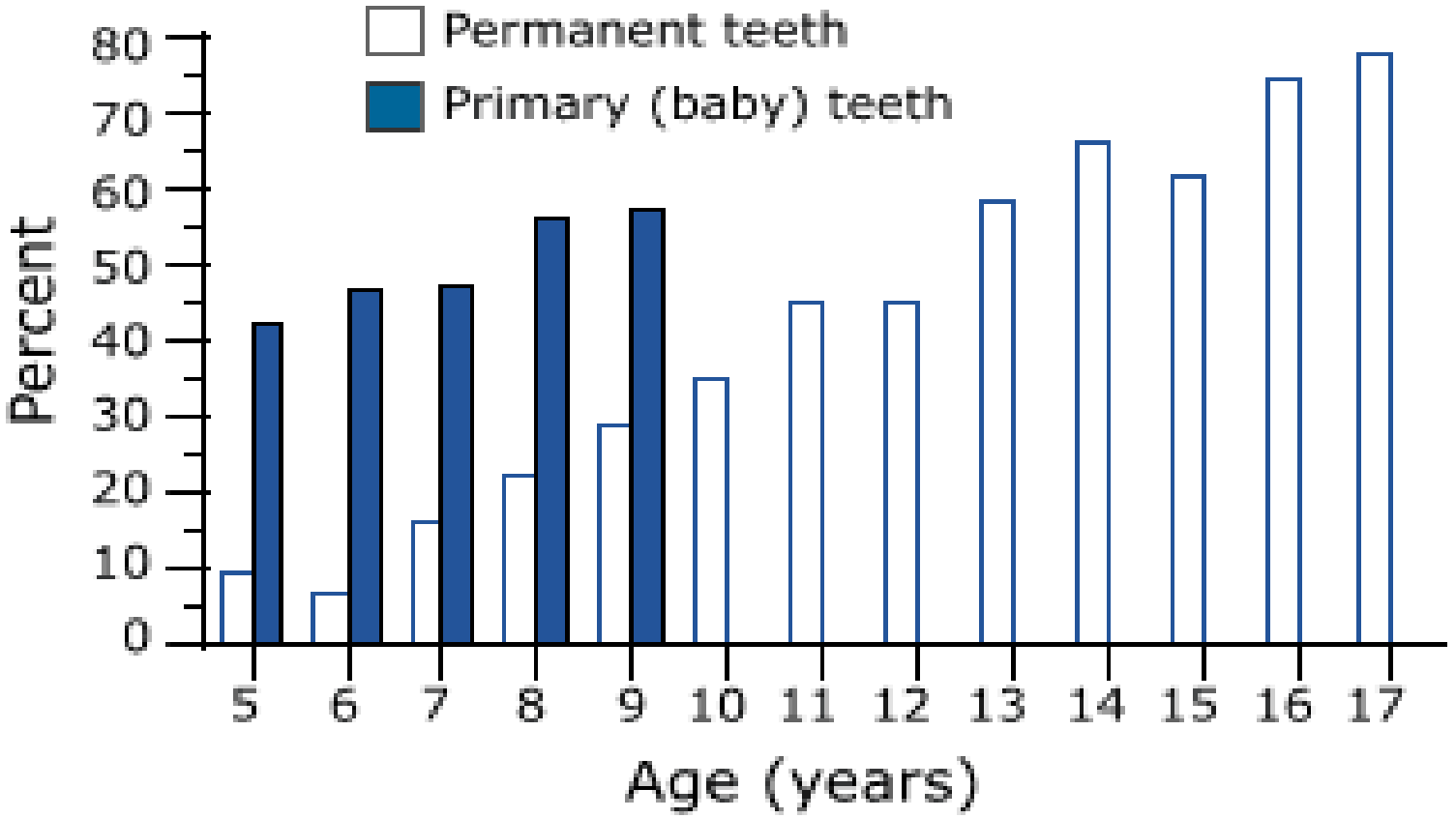
- 75%-80% of dental caries in ~25% of US kids
- Disease levels higher in Medicaid/SCHIP kids

% of Children with Decayed & Filled Primary Teeth by Income (% of FPL)



Vargas, Crall, Schneider. Analysis of NHANES III data. JADA, 1998.

Childhood Tooth Decay: A Complex, Chronic, Progressive Disease



Source: National Center for Health Statistics, CDC. Third National Health and Nutrition Examination Survey, 1988-1994

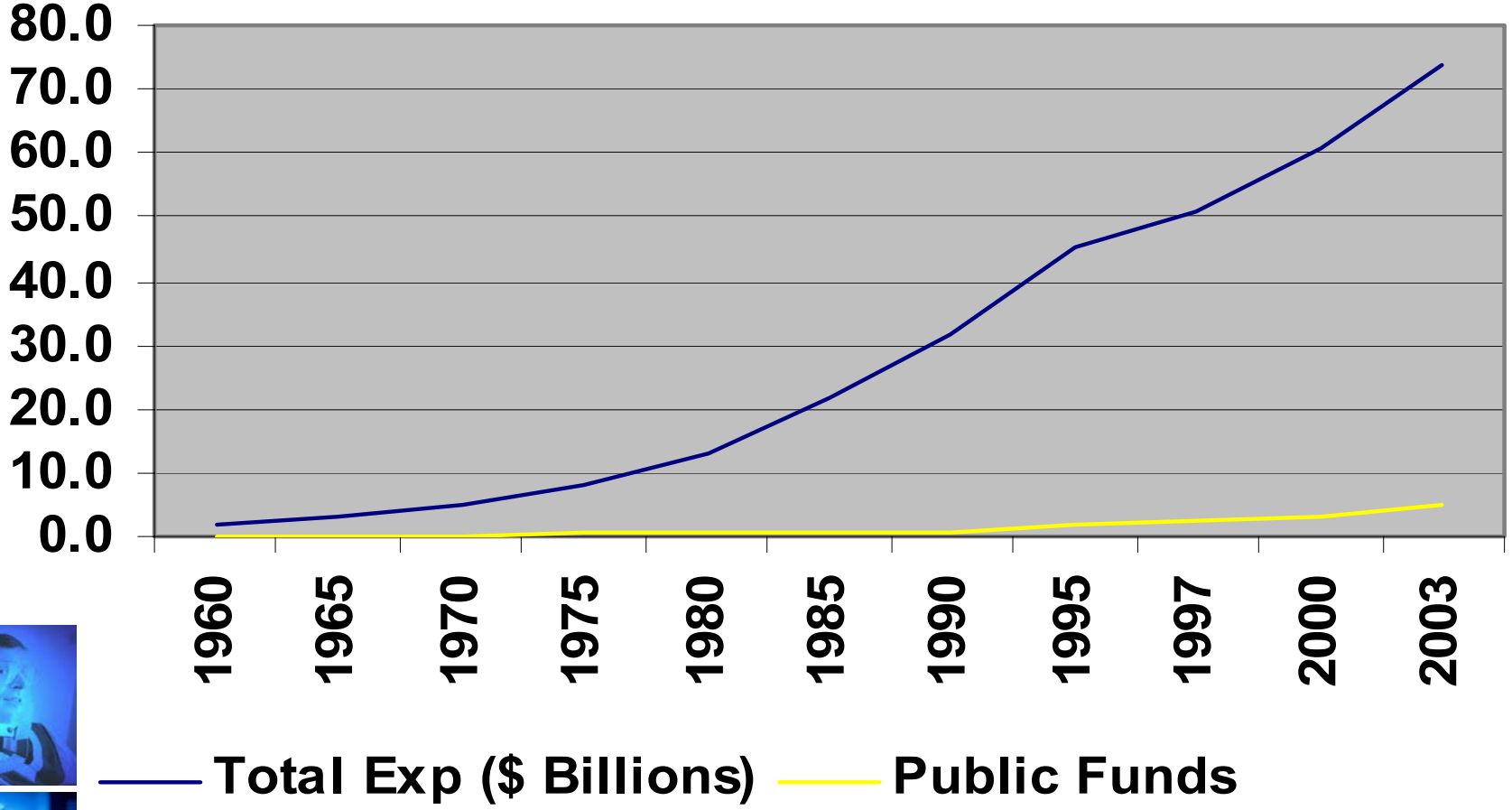
Medicaid Dental Programs

- Federal-State programs
  - Program administration and financing decisions largely made at the state level
- ~ 24 million children covered by Medicaid
  - Roughly 1/3 of all U.S. children
  - EPSDT benefit for children includes relatively comprehensive coverage for dental services

- (Generally fewer) adult benefits vary by state

- Program administration → Purchaser

U.S. Dental Care Financing Trends: Total and Public Funding ($ Billions)



Medicaid Fee Comparisons

Procedure Code	Procedure Description	UX 2004 Medicaid Rates	UX Dentists 50th %-ile Fees (2003)	UX Dentists 75th %-ile Fees (2003)	UX Medicaid Rates %-iles
Diagnostic					
D0120	Periodic Oral Exam	$ 12.08	$ 25.00	$ 28.00	<1st
D0150	Initial/Comprehensive Oral Exam	$ 18.33	$ 36.00	$ 40.00	<1st
D0210	Complete X-rays, with Bitewings	$ 40.83	$ 65.00	$ 81.00	26th
D0272	Bitewing X-rays – 2 Films	$ 12.08	$ 25.00	$ 26.00	<1st
D0330	Panoramic X-ray Film	$ 33.33	$ 60.00	$ 65.00	<1st
Preventive					
D1120	Prophylaxis (cleaning)-Child	$ 20.83	$ 36.00	$ 39.00	<1st
D1203	Topical Fluoride (excluding prophylaxis).	$ 0.00	$ 18.00	$ 21.00	<1st
D1351	Dental Sealant	$ 13.33	$ 25.00	$ 29.00	<1st
Restorative					
D2150	Amalgam, 2 surfaces, permanent tooth	$ 37.50	$ 76.00	$ 84.00	<1st
D2331	Resin , 2 surfaces, anterior tooth	$ 36.67	$ 95.00	$ 105.00	<1st
D2751	Crown, porcelain fused to base metal	$ 200.00	$		<1st*
D2930	Prefabricated Steel Crown, primary tooth	$ 64.17	$ 140.00	$ 160.00	<1st
Endodontics					
D3220	Removal of tooth pulp	$ 20.00	$ 85.00	$ 104.00	<1st
D3310	Anterior Endodontic Therapy	$ 116.67	$ 375.00	$ 398.00	<1st
Oral Surgery					
D7110	Extraction, single tooth	$ 37.50	$ 69.00	$ 82.00	1st

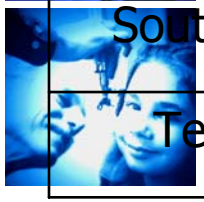
Financing Considerations: Bottom Line

- Most states' Medicaid payment rates are substantially below market rates
- Results of 3 actuarial analyses:
  - $14-$20 PMPM for services
  - $17-$25 PMPM for premiums

- Programs that don't start with adequate funding cannot succeed in meeting program requirements or the needs of children

Recent Medicaid Financing Innovations

STATE	Adjustments Made to Medicaid Rates (Market-based Benchmarks)	Changes in Dentists' Participation in Medicaid Following Rate Increases	Intervals (mos.) Between Rate Increases and Changes in Provider Participation
Alabama	100% of Blue Cross rates	+39%	24
Delaware	85% of each dentist's submitted charges	**1 pvt. dentist to 108** (of 302 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% (to 1,674 of 4,000)	27
Indiana	75th percentile of dentists' fees	+58%	54
Michigan (Healthy Kids Dental Program)	100% of Delta Dental Premier rates	+300%	12
South Carolina	75th percentile of dentists' fees	+73%	36
Tennessee	75th percentile of dentists' fees	+60%	4



MI Healthy Kids Dental Program Increase in Access: 1st 12 mos.

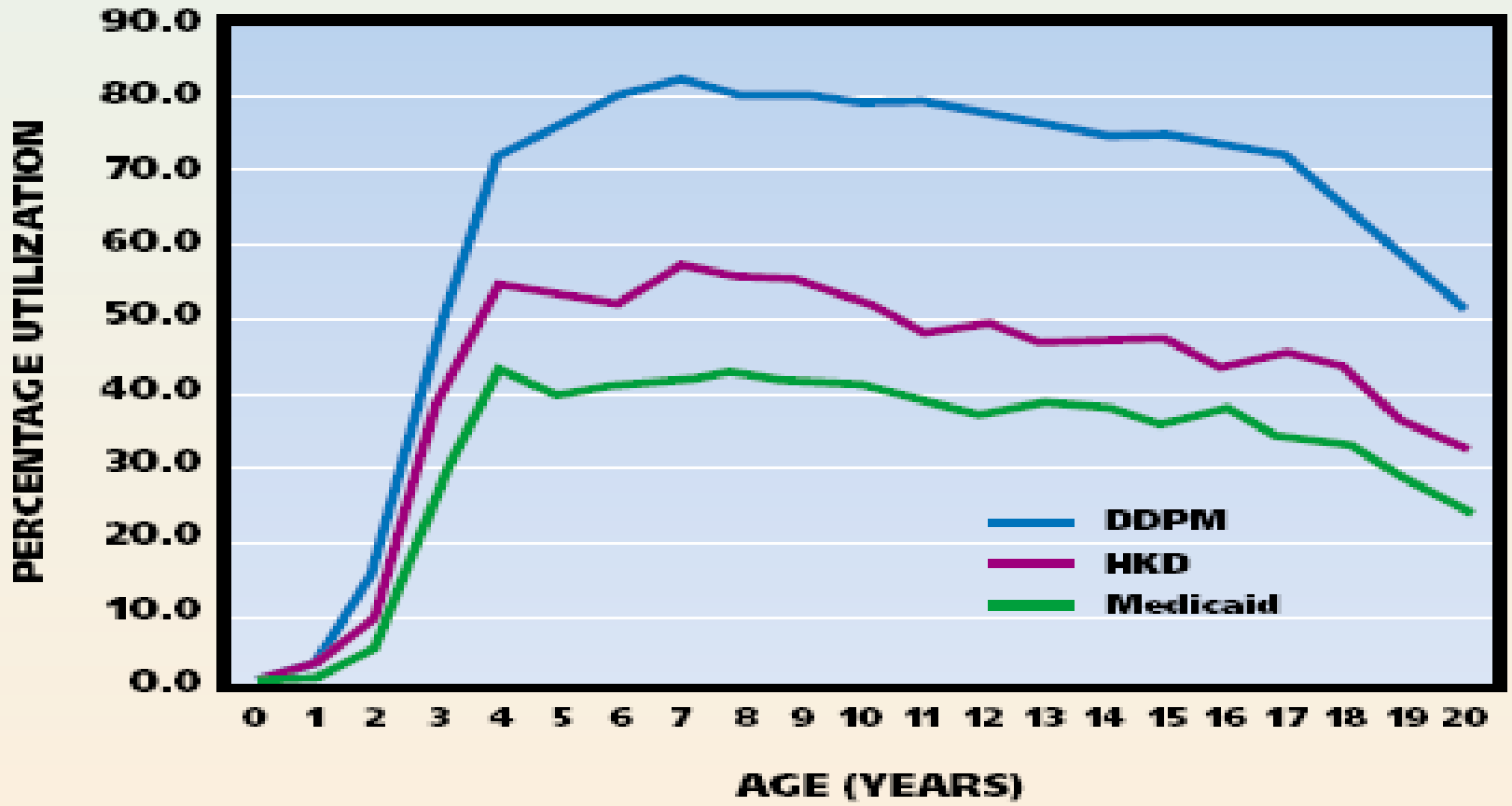


Figure. Utilization in 12 months by continuously enrolled children in 22 Michigan counties. DDPM: Delta Dental Plan of Michigan. HKD: Healthy Kids Dental demonstration program of Michigan Medicaid.

Eklund et al., JADA 2003:134:1509-1515.

Too much of a good thing???
Switch to PPO rates: "66%-89% higher than traditional Medicaid"

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

MICHIGAN DENTAL ASSOCIATION

DELTA DENTAL

November 01, 2005

Name
Address 1
Address 2
City State Zip

Dear Doctor:

More than 174,000 Michigan children are currently enrolled in the Healthy Kids Dental (HKD) and MIChild programs administered by Delta Dental. Because of the success of these programs, which includes the American Dental Association's selection of Healthy Kids Dental as a national model, the Michigan Department of Community Health (MDCH), Delta Dental, and the Michigan Dental Association (MDA) are committed to continuing these programs.

Enrollment in HKD has increased from 95,000 children in 2000 to over 150,000 today, and the percentage of beneficiaries who use their coverage has also increased. HKD and MIChild are enabling an underserved population to receive high-quality dental care; however, the enrollment and utilization increases are resulting in continually rising costs. These increases necessitate the following changes that will be effective January 1, 2006:

- **HKD AND MICHILD:** Reimbursement to all participating dentists for services rendered to enrollees of the HKD and MIChild programs will be based on Delta Dental's DeltaPreferred Option (DPO) fee schedule. Counties will no longer be designated as DeltaPremier-only or DeltaPreferred Option-only. Eligible enrollees will be able to receive treatment from any DeltaPremier dentist who agrees to accept the lesser of the dentist's submitted fee or the amount in the attached fee schedule. The dentist will not be able to balance bill the enrollee for the difference between the charges and the attached fee schedule. This schedule is, on average, 66 percent to 89 percent higher than traditional Medicaid reimbursement.
- **HKD ONLY:** The Healthy Kids Dental program is designed to deliver medically necessary treatment; consequently, the removal of asymptomatic third molars will no longer be a covered benefit.

DeltaPremier dentists may elect to opt out of **only** the Healthy Kids Dental and MIChild programs and continue to participate with all other DeltaPremier groups. To opt out, mail or fax a statement to Delta Dental declaring nonparticipation with only these two programs. Please include the doctor's name, tax identification number, license number, and office address. For all statements received after January 1, 2006, nonparticipating status for HKD and MIChild will be effective 30 days from the date Delta Dental receives the statement. Address your request to Provider Records, Delta Dental, P.O. Box 30416, Lansing, MI 48909-7916, or fax to (517) 706-3618. If you opt out of the programs, please inform the Healthy Kids Dental and MIChild enrollees who are in your practice that they will need to find a new dental provider.

Enclosed is an addendum to your current DeltaPremier contract allowing this special reimbursement for Healthy Kids Dental and MIChild enrollees and a fee schedule for covered services.

If you have questions, please contact Delta Dental's Customer Service department at (800) 462-7283.

Sincerely,

Paul Reinhart
Director, Medical Services Administration
Michigan Department of Community Health

Josef Kolling, D.D.S., M.S.
President
Michigan Dental Association

Thomas J. Fleszar, D.D.S., M.S.
President and CEO
Delta Dental Plan of Michigan

- Switch from Delta Premier to Delta PPO effective Jan., 2006
- Fee schedule 66%-89% higher than traditional Medicaid
- Providers can disenroll from Medicaid and still remain Delta Premier providers (for private beneficiaries)

RWJ Foundation Support

Robert Wood Johnson Foundation State Action for Oral Health Access (SAOHA) Program

Development and testing of innovative systematic approaches for improving access to oral health services for low-income, minority and disabled populations.

STATE ACTION FOR ORAL HEALTH ACCESS

State Applicants and Awarded Grants

Funded by The Robert Wood Johnson Foundation (RWJF):
December 1, 2002 to November 30, 2005

36 **States applied**

6 **States funded, each receiving up to $1 Million:**

- **Arizona**
- **Oregon**
- **Pennsylvania**
- **Rhode Island**
- **South Carolina**
- **Vermont**

Overall Goal and State Strategies

- **Overall Goal – Improve access to oral health services for low-income, minority and disabled populations**

PROPOSED STRATEGIES	AZ	OR	PA	RI	SC	VT
Developing state financing and purchasing strategies				X		X
Broadening provider networks	X	X	X	X	X	X
Expanding the dental safety net	X		X	X	X	X
Enhancing consumer and provider education	X	X			X	X

SAOHA State Strategies

- Arizona:
  - Train general dentists to treat individuals with special needs
  - Affiliated practice arrangements among dentists and hygienists
  - Align MCO dental contracts with state public health goals
- Oregon:
  - Focus on Early Childhood Caries
  - Develop community-based system to provide dental homes for pregnant women and children (Klamath County model)
  - Goal of cavity-free 2-year olds

- Pennsylvania:
  - Expand special needs services to rural location;
  - Special needs Hot line for location of dentists
  - Increase training for expand duty dental assistants

SAOHA State Strategies

- Rhode Island:
  - Performance–based Dental Benefit Manager for new program targeted to providing dental homes for young children
  - Partnership with community foundations for expansions of safety–net and pediatric dentistry residency training programs
  - Welfare to work dental assistant training program
- South Carolina:
  - Develop medical practice linkages to dentists;
  - Faith-based partnerships for consumer education
  - Dental school partnership for dental and medical provider education

- Vermont:
  - Partners with dentists to define economic modeling to increase MA capacity;
  - School-based dental hygienists assess children with referral linkages to community dentists

Outcomes

- At a time when a report[1] from the Centers for Disease Control and Prevention (CDCP) revealed a sharp increase in dental decay among the nation's poorest children:
  - All 6 States made progress;
  - 4 States significantly reduced the percent of children with teeth extracted before their 6th birthday;
  - 5 states significantly increased the percent of Medicaid and SCHIP children receiving dental care.

- [1] Beltrán-Aguilar ED, et al. Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis --United States, 1988--1994 and 1999—2002. National Center for Chronic Disease Prevention and Health Promotion. August 2005

Earlier Interventions → Lower Costs???
Savage MF, et al. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs.
Pediatrics October, 2004.


Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs

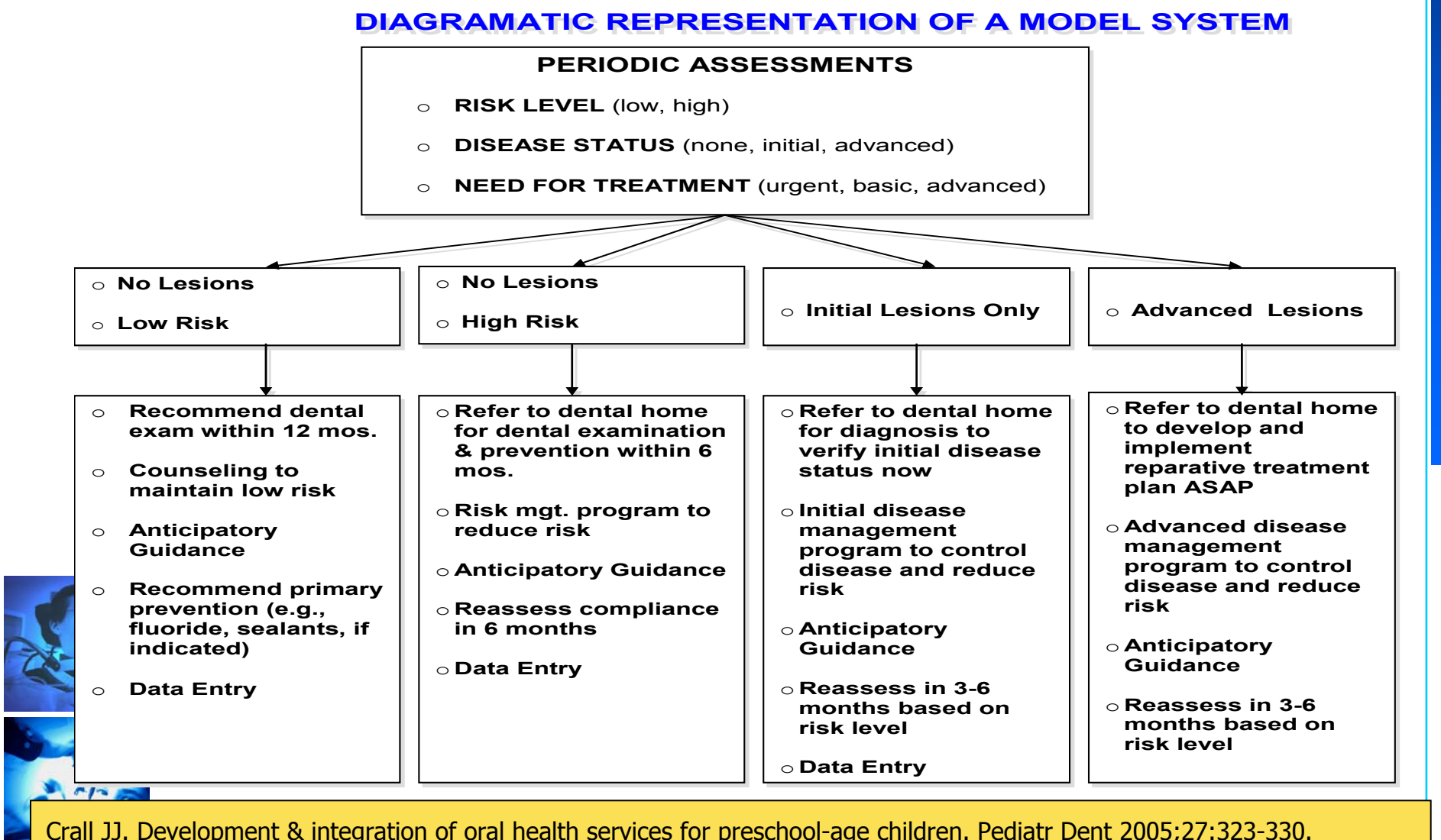
Matthew F. Savage, DDS, MS*; Jessica Y. Lee, DDS, MPH, PhD‡§; Jonathan B. Kotch, MD, MPH‖; and William F. Vann, Jr, DMD, PhD‡

PEDIATRICS Vol. 114 No. 4 October 2004

- "The age at the first preventive dental visit had a significant positive effect on dentally related expenditures."
- **1st dental visit / Total cost:**

1st dental visit	Total cost
– Before age 1	$262
– Age 1-2	$339
– Age 2-3	$449
– Age 3-4	$492
– Age 4-5	$546

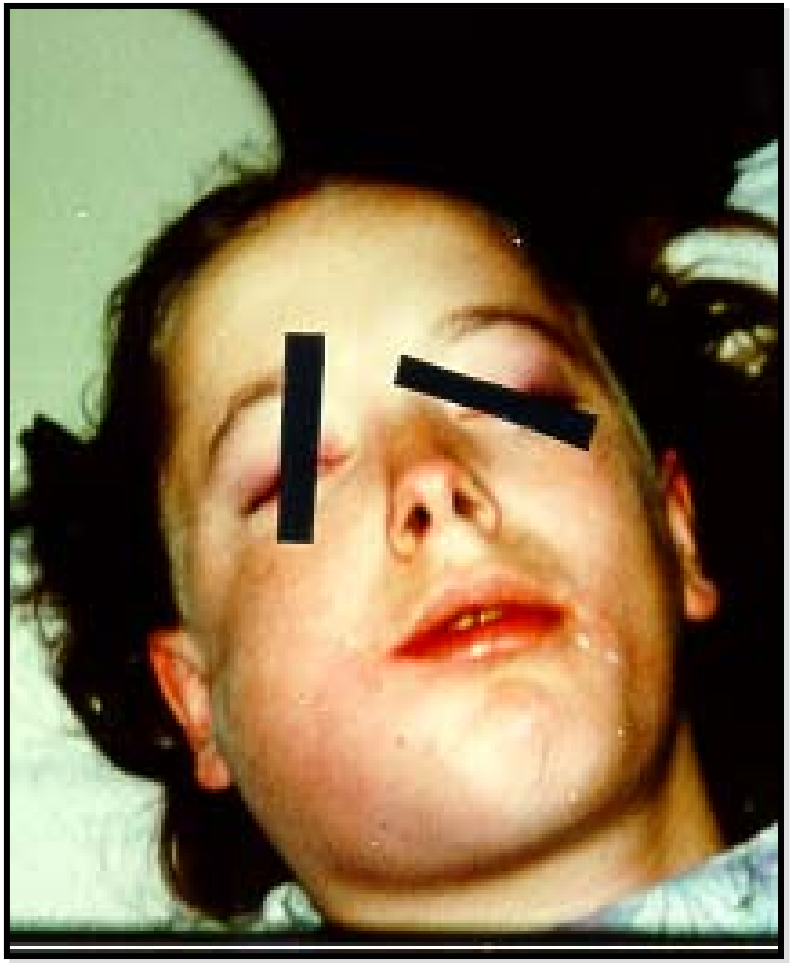
Responding to Changing Paradigms:
Risk-based Interventions for a Chronic Disease



Crall JJ. Development & integration of oral health services for preschool-age children. Pediatr Dent 2005;27:323-330.

'Spill Over' Into Medical Sector Costs: The effects of a dental infection are wide-ranging and long-lasting….

A week or more of pain and sleeplessness, her parents' lost work days and productivity, her own missed schooling, a futile and expensive use of a hospital emergency room, and a life-long external scar are among the ripple effects of this preventable infection.



Consequences of Limited Oral Health Access

For want of a dentist

Maryland boy, 12, dies after bacteria from tooth spread to his brain

Linda Davidson / The Washington Post

Deamonte Driver, aged 12, is shown with his mother, Alyce, at Children's Hospital in Washington, D.C., after emergency brain surgery.

NBC VIDEO

A deadly toothache?
Feb. 28: A 12-year-old Maryland boy is dead after a dental infection spread to his brain. NBC's John Yang reports.

Nightly News

By Mary Otto

washingtonpost.com

Updated: 2:20 p.m. ET Feb. 28, 2007

WASHINGTON - Twelve-year-old Deamonte Driver died of a toothache Sunday.

Consequences of Dental Infections

March 2, 2007

6-year-old boy dies from abscess

The Associated Press

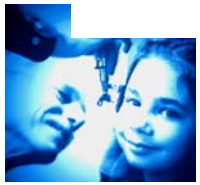
GULFPORT — A 6-year-old boy who collapsed on a Harrison County school bus Thursday died from an abscess where two teeth had been removed from his lower jaw, county coroner Gary Hargrove said.

Alexander "Alex" Callender, a kindergartner at Lizana Elementary, went into shock from the infection and his body shut down, Hargrove said after Friday's autopsy.

Callender collapsed on the bus after leaving school Thursday.

Callender lived in a rural area near Pass Christian.

Grief counselors were available to speak with students at Lizana Elementary today.



Summary

- Medicaid/SCHIP children have 3-5x more disease [*NHANES*]
- Access to dental services for children covered by Medicaid has been a chronic problem [*OIG, 1996; GAO, 2000*]
  -- funding is not the only issue, but it IS a major issue
- Adult Medicaid benefits meager, but potentially important because of oral health-general health relationships
- Dental decay is highly preventable, but not simply or uniformly preventable [*SGROH, 2000*]
- EPSDT requires prevention AND (not instead of) treatment [*Federal statutes, regulations and guidelines*]
- Dental workforce is busy and declining relative to the population, but the population is increasing, especially groups at higher risk for dental disease [HRSA *& Census Data*]