The Search for Successful Strategies to Improve Oral Health

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National Conference of State Legislatures
April 20, 2007
Rationale for Renewed Focus on Oral Health

  - 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)

Childhood Tooth Decay: A Complex, Chronic, Progressive Disease

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
## Medicaid Fee Comparisons

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

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

### Too much of a good thing???

Switch to PPO rates: “66%-89% higher than traditional Medicaid”

| • 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) |

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**Switch to PPO rates: “66%-89% higher than traditional Medicaid”**

| Too much of a good thing???
| --- |
| 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 Healthy Kids Dental Association's initiative 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 97,000 children in 2003 to over 156,000 today, and the percentage of beneficiaries who lose 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 communities running out. These formulas 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 Delta Premier Option (DPO) fee schedule. Counties with no DPO designated will be designated Delta Premier-only or DPO/Selected Option-only. Eligible enrollees will be able to receive treatment from any Delta Premier dentist who agrees to accept the limits of the dentist’s submitted fee or the amount in the assigned fee schedule. The dentist will not be able to balance bill the enrollee for the difference between the charges and the assigned 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 fluid cavity will no longer be a covered benefit.

Delta Premier dentists may elect to opt out of only the Healthy Kids Dental and MiChild programs and continue to participate with all other Delta Premier programs. To opt out, send a statement to Delta Dental declaring nonparticipation with only these two programs. Please include the dentist’s name, ten identification number, license number, and office address. For all statements received after January 1, 2006, nonparticipating states the HKD and MiChild will be effective October 1 of the date Delta Dental receives the statement. Address your request to Provider Relations, Delta Dental, P.O. Box 10416, Lansing, MI 48906-7416, or fax it to (517) 765-8618. If you opt out of these programs, please inform the Healthy Kids Dental and MiChild enrollees who are in your practice that they will need to find a new Delta provider.

Effective in addition to your current Delta Premier 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) 482-7283.

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**Paul Schmidt**  
Director, Dental Services Administration  
Michigan Department of Community Health

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**Josef Kelling, D.D.S., M.S.**  
President  
Michigan Dental Association

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**James J. Fekkes, D.D.S., M.S.**  
President and CEO  
Delta Dental Plan of Michigan
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 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

<table>
<thead>
<tr>
<th>Proposed Strategies</th>
<th>AZ</th>
<th>OR</th>
<th>PA</th>
<th>RI</th>
<th>SC</th>
<th>VT</th>
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<tbody>
<tr>
<td><strong>Developing state financing and purchasing strategies</strong></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td><strong>Broadening provider networks</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Expanding the dental safety net</strong></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td><strong>Enhancing consumer and provider education</strong></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
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.

Earlier Interventions → Lower Costs???

- "The age at the first preventive dental visit had a significant positive effect on dentally related expenditures."

- **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

**Diagrammatic Representation of a Model System**

**Periodic Assessments**
- **Risk Level** (low, high)
- **Disease Status** (none, initial, advanced)
- **Need for Treatment** (urgent, basic, advanced)

- **No Lesions**
  - **Low Risk**
    - Recommend dental exam within 12 mos.
    - Counseling to maintain low risk
    - Anticipatory Guidance
    - Recommend primary prevention (e.g., fluoride, sealants, if indicated)
    - Data Entry
  - **High Risk**
    - Refer to dental home for dental examination & prevention within 6 mos.
    - Risk mgt. program to reduce risk
    - Anticipatory Guidance
    - Reassess compliance in 6 months
    - Data Entry

- **Initial Lesions Only**
  - Refer to dental home for diagnosis to verify initial disease status now
  - Initial disease management program to control disease and reduce risk
  - Anticipatory Guidance
  - Reassess in 3-6 months based on risk level
  - Data Entry

- **Advanced Lesions**
  - Refer to dental home to develop and implement reparative treatment plan ASAP
  - Advanced disease management program to control disease and reduce risk
  - Anticipatory Guidance
  - Reassess in 3-6 months based on risk level
  - Data Entry

‘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.

By Mary Otto

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]