2015 National Medicaid and CHIP
Oral Health Symposium

Session 1

Creating Integrated Systems of Care:
Priority Conditions for the Oral Health Team

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Washington Marriott Wardman Park
Monday, June 1st, 2015
Disclosure: Dental Benefits for 23M People in 28 States
“Integrated” Has Many Meanings

1. “Integrated” is frequently used to refer to a package of preventive and curative health interventions for a particular population group – often (but not always) this group is distinguished by its stage in the life cycle.

2. “Integrated health service” can refer to multi-purpose service delivery points – a range of services for a catchment population is provided at one location and under one overall manager.

3. “Integrated services” to some means achieving continuity of care over time.

4. Integration can also refer to the vertical integration of different levels of service – for example a regional hospital, health centers and private practice.

5. Integration can also refer to integrated policy-making and management which is organized to bring together decisions and support functions across different parts of the health service.

6. Integration can mean working across sectors.

Key Attributes of Integrated Care

- Centered in primary care - PCMH
- Informed & involved patient
- Comprehensive treatment plan for total health
- Sharing data
- Coordination of care
- Effective communications
Creating **Interoperability** via

Challenge: Information may not be available in **real time**
4 Priority Conditions for Oral Health

1. Prevent the establishment of an acidogenic microflora in the oral cavity of children between birth and 30 months of age

2. Prevent pit and fissure caries on permanent first and second molars

3. Eliminate active infections in cavitated teeth.

4. Effectively manage the inflammation from chronic periodontal disease, especially for patients with comorbidities such as diabetes and heart disease
Restorative Costs - Typical Medicaid Program

Restorative Costs by Age and Tooth Type

- D 2nd Molar
- D 1st Molar
- D Canine
- D Lateral Incisor
- D Central Incisor
- 2nd Molars
- 1st Molars
- 2nd Premolars
- 1st Premolars
- Canines
- Lateral Incisors
- Central Incisors

ECC
Sealant

Age of Beneficiaries
Millions
$0.0
$0.5
$1.0
$1.5
$2.0
$2.5
$3.0
$3.5
$4.0
$4.5
$5.0

1
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25% of children have 80% of disease – low income, minority children Medicaid/CHIP populations

Source: CMS 416 data for 2013
**Percent of 6 and 7 Year Olds Receiving Dental Sealant on First Molars**

- **Count of Ages 5, 6 & 7**
- **Percent 5-7 w/ Seal**

Provider Offices Are on the X Axis
Ecological Plaque Hypothesis

Non-Cariogenic Plaque

- Microflora adapted to low-sugar diet
- Infrequent low-pH episodes
- Non-aciduric/non-acidogenic flora

- Selection against non-aciduric bacteria
- Aciduric bacteria gain competitive advantage
- Growth of aciduric-acidogenic bacteria

Cariogenic Plaque

- Microflora adapted to efficient use of sugar
- Frequent, prolonged low-pH episodes
- Acidogenic, aciduric flora

- Low-pH episodes deeper and more involved

Sugar Acidic drinks

Strep mutans is acquired at an average age of approximately 2 years

Percent of Children Accessing Care

Source: CMS 416 data for 2013
“It focuses on frontline primary care health professionals, specifically nurse practitioners, nurse midwives, physicians and physician assistants. These primary care practitioners are members of the existing delivery system who could incorporate oral health core clinical competencies into their existing scope of practice.”

“HRSA synthesized the following recommendations:

1. **Apply oral health core clinical competencies within primary care practices to increase oral health care access for safety net populations in the United States.**

2. Develop infrastructure that is interoperable, accessible across clinical settings, and enhances adoption of the oral health core clinical competencies. The defined, essential elements of the oral health core clinical competencies should be used to inform decision-making and measure health outcomes.

3. **Modify payment policies to efficiently address costs of implementing oral health competencies and provide incentives to health care systems and practitioners.**

4. Execute programs to develop and evaluate implementation strategies of the oral health core clinical competencies into primary care practice.”
Early Prevention = Lower Costs

• “The age of a child at the first preventive dental visit has a significant effect on dentally related expenditures, with the average dentally related costs being less for children who received earlier preventive care”

1992-1997

North Carolina Well-Child Visits

Number Of Well-Child Visits And Oral Health Medical Visits Per 100 Medicaid-Enrolled Children, By Age Group, 2000–2006


ORAL HEALTH RISK ASSESSMENT

• Every child should begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional

• **Primary prevention** involves optimization of maternal dental flora before and during colonization of the oral flora of the infant (during eruption of the primary dentition). This invaluable mode of prevention provides an opportunity for a reduction in the mother’s constitutionally virulent, aciduric flora and down regulation of virulence genes within the aciduric flora, decreasing the child’s risk of dental decay, and is the basis for first dental visit recommendations at 1 year or earlier made by various medical and dental organizations

American Academy of Pediatrics

- **Secondary prevention** is the continual and ongoing management of subpopulation ratios of benign and aciduric flora within dental plaque.

- **Secondary preventive** strategies are hierarchical and currently consist of dietary counseling, oral hygiene instruction, and judicious administration of fluoride modalities.

- Therefore, although all preventive modalities are important, **modification of diet is most important**, followed by **oral hygiene compliance** and then **administration of fluorides**.

**Risky and Protective Behaviors**

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93

Outcomes of ECC Protocol

Primary Prevention
1. Risk Assessment
2. Oral Evaluation
3. Behavior modification

Secondary Prevention
1. Fluoride varnish

[Bar chart showing outcomes of ECC Protocol for BCH, SJH, and Phase II FQHC with percentages: 65% for BCH, 42% for SJH, and 28% for Phase II FQHC.]
Integrating Oral Health into Primary Care

**Primary Care**
- Birth – 5 Yrs.
  - Risk Assessment
  - Risk Reduction
  - Remineralization
  - Referral
- 6 Yrs. – 14 Yrs.
  - Risk Assessment
  - Check for cavities
  - Check for sealants
  - Referral
- Teens – Adult
  - Risk Assessment
  - Check for cavities
  - Screen for perio disease
  - Refer

**Dental Care**
- Birth – 5 Yrs.
  - Risk Assessment
  - Risk Reduction
  - Remineralization
  - ITR
  - Refer
- 6 Yrs. – 14 Yrs.
  - Risk Assessment
  - Seal 1st & 2nd molars
  - Restore
- Teens – Adult
  - Risk Assessment
  - Remineralization
  - Restore
  - Treat perio inflammation

**IT Communication & Coordination**

**Patient**
Coordinated Integrated Care

**Medical Plan**
- List of diabetics and their physician info

**NGC NQF**
- EB Guidelines & Performance Measures

**Dental Plan**
- List of diabetics
- Dental hx and provider(s) information
- File Claim for D4910 and A1C if indicated

**Oral Health Integrator**
- **Primary Care**
  - PC’s Diabetic List
  - Reports
  - Emails
  - Request for A1C
  - Reinforcing letter from PC if necessary

- **Dental Team**
  - D4910 and A1C
  - Treatment provided
  - Recall reminders to patient

- **Patient**
  - Disease Management Letter
  - Recall reminder

- **Request for A1C**
- • List of diabetics with any requests from PC
  - • Emails

**List of diabetics**
2015 National Medicaid and CHIP Oral Health Symposium

Session 1

Opportunities for Early Childhood, Children, Youth and Teens

Laurie Norris, JD
Centers for Medicare & Medicaid Services

Washington Marriott Wardman Park
Monday, June 1\textsuperscript{st}, 2015
Learning Objective(s)

Participants will gain knowledge in:

- The Medicaid benefit for children and adolescents
- Bright Futures (periodicity and guidelines)
- How two state Medicaid programs have begun to integrate oral health into primary care
- Resources available from CMS
- Several action options for states
Disclosure and Conflict of Interest Declaration

- I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.

- I declare that I have a financial interest/arrangement or affiliation with the corporate organization offering financial support or grant monies for this continuing dental education program, or I do have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
Integrated Care = Whole Child
The Children’s Benefit in Medicaid - EPSDT

EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents

• EPSDT = early and periodic screening, diagnostic and treatment benefit
• Prevention oriented
• Dental benefit
  – at a minimum, relief of pain and infections, restoration of teeth, maintenance of dental health, and medically necessary orthodontic services.
• Periodicity schedule
• Individualized care
  – all medically necessary care

Bright Futures

- Periodicity schedule
- Guidelines for health supervision

https://brightfutures.aap.org/Pages/default.aspx
Bright Futures: Periodicity Schedule

https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
Bright Futures: Guidelines

https://brightfutures.aap.org/Bright%20Futures%20Documents/BF3%20pocket%20guide_final.pdf
Oral health service provided by a non-dentist ages 1-2, FFY 2013

Source: FFY 2013 CMS-416 reports, Line 1b, 12f
Note: Data reflects updates as of 10/22/14.
Oral health service provided by a non-dentist ages 1-5, FFY 2013

Source: FFY 2013 CMS-416 reports, Line 1b, 12f
Note: Data reflects updates as of 10/22/14.
CMS Issue Brief Series

- Reducing Early Childhood Tooth Decay
- Primer: An Overview for State Policymakers
- Leading Steps for State Policy Makers
- Strategies for State Medicaid and CHIP Dental Program Managers

Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
Action Options for States

- Look at your program manuals.
- Develop provider handbooks based on AAP guidelines.
- Make caries risk assessment a required service for children under 6 at their well-child exams, with fluoride varnish as indicated by their risk level.
Action Options for States

• Make sure doctors know how and where to refer a child who is assessed as high-risk or has observable untreated caries.

• Implement oral health Performance Improvement Projects (PIPs).

• Make sure dentists know they can ask for “extra” services for kids.
North Carolina

• Children’s oral health is a joint responsibility between medical and dental providers

• **Medical periodicity schedule**
  – Oral health screening is required at every well-child visit starting at 6 months of age and continuing through 42 months of age
  – Oral health risk assessment is recommended by 6 months of age; includes use of an accepted tool, education on infant oral health, and evaluation and optimization of fluoride exposure
  – Referral to a dental home is recommended by age 1 and required by age 3
  – Fluoride varnish is separately billable

• **Into the Mouths of Babes / Connecting the Docs Toolkit**
North Carolina

- **Oral health periodicity schedule**
  - By 6 months of age
    - Oral evaluation
    - Caries risk assessment
    - Fluoride as indicated
    - Anticipatory guidance, dietary counseling, oral hygiene counseling
    - Refer to PCP as needed
  - Caries risk assessment: repeat at regular intervals
  - Fluoride: individualize type + frequency per child’s needs
  - Can be modified for CSHCNs or if disease contributes to variation from the norm
Oregon

• Oregon Health Transformation – 1115 waiver demonstration program
  – Triple aim: individual, community, most effective pricing

• 16 Community Care Organizations (CCOs), 9 Dental Care Organizations (DCOs)

• Statewide oral health quality measures
  – the number of children between the ages of six and 14 who receive sealants on permanent molars, and
  – the number of patients between the ages of 2 and 21 who receive any type of dental service in a calendar year.
More Dimensions

• Benefit design
• Payment methodologies
• Performance measures
• Service locations
• Workforce flexibility
Children’s Oral Health System: People
Laurie Norris joined the Centers for Medicare & Medicaid Services (CMS) in 2011 as a Senior Policy Advisor. In addition to oral health, her CMS portfolio includes children’s health care generally, or EPSDT. Prior to joining CMS, Laurie was the state campaign manager for the Pew Children’s Dental Campaign. Before that Laurie served for twenty years as an advocate for low-income children and families in both California and Maryland. In 2007, she was introduced to the world of oral health when her client, 12-year-old Deamonte Driver, died from a preventable dental abscess that spread to his brain. Laurie holds a law degree from New York University School of Law.

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