

**2005 North Carolina  
Oral Health Summit  
Access to Dental Care**  
Summit Proceedings and Action Plan



**health policy**  
*North Carolina Institute of Medicine*

# 2005 NC Oral Health Summit

## Access to Dental Care

### Summit Proceedings and Action Plan

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Submitted by the North Carolina Institute of Medicine to the NC Oral Health Section of the NC Division of Public Health within the NC Department of Health and Human Services.

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[www.nciom.org](http://www.nciom.org)

and

<http://www.communityhealth.dhhs.state.nc.us/dental/index.htm>

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The Summit extends special recognition to the six authors who wrote background pieces for the Summit. Those articles served as the basis for discussion at the Summit, as well as the foundation for this report. The authors and their background papers included: "Increasing dentist participation in the Medicaid program," by Mahyar Mofidi, DMD, MPH; "Increasing the overall supply of dentist and hygienists in North Carolina: Focus on dental professionals to practice in underserved areas and to treat underserved populations," by John Stamm, DDS, DDPH, MScD; "Increasing the number of pediatric dentist practicing in North Carolina; expanding the provision of preventive dental services to young children," by Michael Roberts, DDS, MScD; "Training dental professionals to treat special needs patients; designing programs to expand access to dental services," by Allen Samuelson, DDS ; "Training dental professionals to treat special needs patients; designing programs to expand access to dental services," by F. Thomas McIver, DDS, MS; and "Educating Medicaid recipients about the importance of ongoing dental care; developing programs to remove non-financial barriers to the use of dental services," by Don Schneider, DDS, MPH. These background papers can be accessed online at [http://www.communityhealth.dhhs.state.nc.us/dental/oral\\_health\\_summit.htm#workgroups](http://www.communityhealth.dhhs.state.nc.us/dental/oral_health_summit.htm#workgroups).

Special thanks are also due to the members of the planning committee for helping to plan the Summit, and arrange for the background papers and resource individuals, facilitators, and recorders: Keshia Bailey, Missy Brayboy, Rebecca King, DDS, MPH, Faye Marley, Rick Mumford, DMD, MPH, Mike Roberts DDS, MScD, Paul Sebo, Marla Smith, Jean Spratt, DDS, MPH, Martha Sexton Taylor, RDH, MBA, MHA, Kristie Weisner Thompson, MA, and Ronald Venezie, DDS, MS. The Summit also appreciates the participation of the facilitators and recorders: Gordon H. DeFriese, PhD, Gary Rozier, DDS, MPH, Monica Teutsch, MPH, William F. Vann, Jr., DMD, PhD, MS, Kristen L. Dubay, MPP, Robert Leddy, DDS, MPH, Adrienne R. Parker, Pam Silberman, JD, DrPH, Jeffrey Simms, MSPH, MDiv, and Martha Sexton Taylor, RDH, MBA, MHA.

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The primary staff direction for the work of the Summit was the responsibility of Rebecca King, DDS, MPH, Jean Spratt, DDS, MPH, and Keshia Bailey of the Oral Health Section of the Division of Public Health, a division of the NC Department of Health and Human Services (DHHS). They were principally responsible for leading the overall work of the Summit. Primary responsibility for compiling research, writing, and editing this report were Kristen L. Dubay, MPP, Gordon H. DeFriese, PhD, Pam Silberman, JD, DrPH, Kristie Weisner Thompson, MA, and Michaela Jones, PhD of the North Carolina Institute of Medicine. Data provided by the Division of Medical Assistance were integral to the development of this report.

Finally, but most importantly, the Oral Health Section extends its appreciation to the 61 participants (listed below) who shared their time and expertise in an effort to continue evaluating the status of access to dental care in North Carolina. Many of the Summit participants are professionals who have dedicated their careers to improving access to dental services for underserved populations, and for this, we applaud them.

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## **2005 NC ORAL HEALTH SUMMIT PROCEEDINGS AND PROPOSED ACTION PLAN**

In 1998, the NC General Assembly asked the NC Department of Health and Human Services (DHHS) to study and recommend strategies to increase access to dental services for Medicaid recipients. The Honorable David H. Bruton, Secretary of the NC DHHS, asked the NC Institute of Medicine (NC IOM) to convene a task force to study this issue. The NC IOM Task Force on Dental Care Access was comprised of 22 members, and was led by the Honorable Dennis Wicker, Lt. Governor (Chair), and Sherwood Smith, Jr., Chairman and CEO of Carolina Power & Light (now Progress Energy) (Co-Chair). The NC IOM Task Force on Dental Care Access released its report to the NC General Assembly and the NC DHHS in April 1999. It consisted of 23 recommendations, which focused on:

- 1) Increasing dental participation in the Medicaid program;
- 2) Increasing the overall supply of dentists and dental hygienists in the state with a particular focus on efforts to recruit dental professionals to practice in underserved areas and to treat underserved populations;
- 3) Increasing the number of pediatric dentists practicing in North Carolina and expanding the provision of preventive dental services to young children;
- 4) Training dental professionals to treat special needs patients and designing programs to expand access to dental services; and
- 5) Educating Medicaid recipients about the importance of ongoing dental care, and developing programs to remove non-financial barriers to the use of dental services.

The NC IOM convened a one-day meeting in 2003 to review progress on these recommendations.<sup>1</sup> In July 2003, the Oral Health Section of the NC Division of Public Health, a division of the NC Department of Health and Human Services, obtained funding from the Association of State and Territorial Dental Directors and the National Governors Association to convene an NC Oral Health Summit. The purpose of the Summit was to review the 1999 NC IOM Task Force report for progress made

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<sup>1</sup> The 2003 Update of the NC IOM Task Force on Dental Care Access is available at: <http://www.nciom.org/pubs/dental.html>.



since 2003.<sup>1</sup> The NC Oral Health Summit was held on April 8, 2005, and included 63 participants. Participants included representatives of the Oral Health Section within the NC Division of Public Health, the NC Dental Society, the NC State Board of Dental Examiners, the NC Academy of Pediatric Dentistry, the NC Dental Hygiene Association, the University of North Carolina at Chapel Hill (UNC-CH) School of Dentistry, East Carolina University, the NC Community Health Care Association, the Division of Medical Assistance, the NC Office of Research, Demonstrations and Rural Health Development, the NC Division of Aging, the NC Partnership for Children, non-profit dental clinics, community health centers, and other interested individuals. Six of the original 22 members of the NC IOM Task Force were among the participants.

The Summit participants reviewed the Task Force's original findings and recommendations to determine if the issues were still relevant, what actions had occurred to implement the Task Force's recommendations, and the barriers to implementation. Summit participants then suggested changes to the original recommendations. The goal of the NC Oral Health Summit was to identify potential strategies to improve dental care access – whether by further implementation of the original 1999 NC IOM Task Force recommendations – or through new strategies to improve access.



The report begins with an overview of the problem as it exists today (2005), followed by sections corresponding to recommendations in the original 1999 report. These sections present updated data (if available) related to the problem, highlight what has been done to implement the recommendations, propose changes to the recommendations (if any), and propose strategies for fulfilling them.

Unlike the original Task Force, which met multiple times over several months, the Summit was a single-day event. Thus, participants did not have the ability to thoroughly analyze or discuss new recommendations. Nonetheless, the Summit provided an opportunity to gather dental care leaders to reflect upon the actions taken and identify further steps needed to improve access to dental services for underserved populations. This document is the genesis for a new *action plan*, which if

implemented, will help ensure access to dental care for more of the underserved North Carolinians across the state.

## **OVERVIEW OF THE PROBLEM IN 2005**

Since the 1999 NC IOM Task Force on Dental Care Access, North Carolina has made significant progress toward improving access to dental care for underserved populations. One of the most positive steps was the increase in Medicaid reimbursement rates for dental services. Following the rate changes in 2002 and 2003, data indicate that between 2002 and 2005, the price Medicaid paid per unit of dental service increased 31% (from \$133 in 2002 to \$174 in 2005), after dropping 8% between state fiscal years (SFY) 2001 and 2002.<sup>2</sup> Total expenditures also increased during this time. Medicaid dental expenditures accounted for \$197 million in 2004, an increase of 89% since 2002. In fact, the dental program constitutes one of the highest growth areas in the North Carolina Medicaid program.<sup>3</sup>

Data indicate that this increase in reimbursement has coincided with an increase in dentist participation in the Medicaid program between state fiscal years (SFY) 2001-2005. Table 1 illustrates the number of private dentists who submitted a Medicaid claim to the Medicaid program during that period. Between SFY 2001 and 2005, 156 additional dentists participated in the Medicaid program, an increase of almost 10%. Of that group, more than 50% began serving Medicaid patients since SFY 2004, and 80% of the growth occurred in the last two years. While the absolute number of dentists who participate in Medicaid has increased, the *percentage* of private practicing dentists who participate in Medicaid remained relatively steady (about 48-49%) between fiscal years 2001 and 2004.<sup>3</sup>

**Table 1. Number and percentage of private dentists participating in the Medicaid program.**

	2001	2002	2003	2004	2005
<b>Number of private dentists who treat Medicaid enrollees<sup>a</sup> (Percent of private dentists who practice in NC)</b>	1,615 (49%)	1,619 (48%)	1,643 (48%)	1,686 (49%)	1,771 (*)
<b>Total number of Medicaid recipients (total unduplicated Medicaid excluding MQB recipients)<sup>b</sup></b>	1,334,062	1,362,567	1,423,229	1,484,608	1,513,727
<b>Dentist to Medicaid ratio</b>	1:826	1:842	1:866	1:881	1:855

<sup>a</sup> Source: Loomis, W. Data provided by the North Carolina Division of Medical Assistance to Mahyar Mofidi. February 9, 2005. Attiah, E. Data provided by the North Carolina Division of Medical Assistance to Kristen Dubay. August 2005.  
<sup>b</sup> Source: Attiah, E. Data provided by the North Carolina Division of Medical Assistance to Kristen Dubay. August 2005.  
\* Fiscal year 2005 data not available at time of publishing.

The 1999 Task Force on Dental Care Access Report defined “active participation” in the Medicaid program as those dentists who received more than \$10,000 in Medicaid reimbursements in a fiscal year.<sup>4</sup> Table 2 illustrates that, during SFY 2001 and 2005, there was a 43% increase in the number of dentists “actively participating” in the Medicaid program. The largest increase in participating providers (20%) occurred between SFY 2003 and 2004 when 143 new dentists began actively participating in the Medicaid program.<sup>3</sup>

**Table 2. Number and percentage of private dentists “actively participating” in the Medicaid program.**

	2001*	2002	2003	2004	2005
<b>Total number of private dentists who practice in NC, Jan-Dec (not including public health dentists)<sup>a</sup></b>	3,280	3,381	3,414	3,426	*
<b>Number (percentage) of private dentists who “actively treat” Medicaid enrollees, July-June<sup>b</sup></b>	644 (20%)	670 (20%)	712 (21%)	855 (25%)	920 (*)

<sup>a</sup> Source: NC Health Professions Data System with data derived from the NC Board of Dental Examiners. Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research, University of North Carolina; 2003.  
<sup>b</sup> Source: Loomis, W. Data provided by NC Division of Medical Assistance. Personal communication with Mahyar Mofidi. February 9, 2005.  
\* Fiscal year 2005 data not available at time of publishing.

The number and percentage of Medicaid patients receiving dental services has also increased since 2001. Table 3 illustrates the annual number and percentage of Medicaid-eligible recipients who had at least one dental visit during the years 2001-2005. The percentage of Medicaid enrollees receiving dental services increased from 25% to 29% during this time period. That increase amounts to a 63% increase in the total

number of Medicaid enrollees receiving dental services compared to a total increase of Medicaid recipients of 38%.<sup>3</sup>

**Table 3. Percent and number of Medicaid recipients who had at least one dental visit.**

	2001	2002	2003	2004	2005 <sup>a</sup>
<b>Total number Medicaid recipients with dental coverage (total unduplicated Medicaid excluding MQB recipients)</b>	1,124,129	1,264,362	1,459,239	1,522,508	1,552,069
<b>Number (percentage) of recipients with a dental visit</b>	276,247 (25%)	327,285 (26%)	370,447 (25%)	417,935 (27%)	450,974 (29%)

Source: Source: Data initially collected by Mahyar Mofidi, from Bill Loomis, NC Division of Medical Assistance, for the 2005 NC Oral Health Summit (February 2005). Updated information provided by Emad Attiah, NC Division of Medical Assistance, to the NCIOM (September 2005).

<sup>a</sup> Data for 2005 are not final. Claims may be submitted up to three months following the end of the state fiscal year, June 30, 2005. Therefore these data may increase.

Sixty-two percent of Medicaid recipients receiving dental care in 2005 were children below the age of 21, while 30% were adults aged 21 or older. Tables 4 and 5 illustrate the number and percent of enrolled children under the age of 21 and the number and percent of enrolled adults, aged 21-64, that received annual dental visits. Table 4 indicates that utilization rates for children below the age of 21 increased from 28% to 32% between 2001 and 2005. Table 5 illustrates that utilization rates for adults aged 21-64 rose to 28% in 2005.

**Table 4. Enrolled children under age 21 years getting a Medicaid dental visit.**

	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005 <sup>c</sup>
<b>Number of Medicaid enrolled children under age 21 years</b>	551,215	651,061	768,442	831,942	881,356
<b>Number (percentage) of unduplicated Medicaid recipients under age 21 years with any dental visit <sup>a</sup></b>	156,478 (28%)	195,926 (30%)	222,094 (29%)	261,017 (31%)	279,643 (32%)
<i>At a private dentist <sup>b</sup></i> <i>(% of total visits)</i>	127,031 (75%)	150,525 (76%)	177,438 (78%)	211,011 (80%)	235,424 (82%)
<i>At a public health facility <sup>b</sup></i> <i>(% of total visits)</i>	43,024 (25%)	47,624 (24%)	51,377 (22%)	52,582 (20%)	51,631 (18%)

Source: Data initially collected by Mahyar Mofidi, from Bill Loomis, NC Division of Medical Assistance, for the 2005 NC Oral Health Summit (February 2005). Updated information provided by Emad Attiah, NC Division of Medical Assistance, to the NCIOM (September 2005).

<sup>a</sup> Dental visit data was provided by the NC Division of Medical Assistance and is based on total dental claims submitted for the population.

<sup>b</sup> The sum of total visits at the private and public health facilities will be greater than the unduplicated number of Medicaid recipients (column 2) because some recipients receive more than one visit, and may visit both a private and public provider.

<sup>c</sup> Data for 2005 are not final. Claims may be submitted up to three months following the end of the state fiscal year, June 30, 2005. Therefore the total number of recipient and visits may increase.

**Table 5. Enrolled adults ages 21-64 with an annual Medicaid dental visit.<sup>2</sup>**

	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005 <sup>c</sup>
<b>Number of Medicaid-enrolled adults ages 21-64 years</b>	371,359	416,199	498,114	503,565	491,687
<b>Number (percentage) of unduplicated Medicaid recipient adults ages 21-64 years with any dental visit <sup>a</sup></b>	88,040 (24%)	99,521 (24%)	114,793 (23%)	124,334 (25%)	135,684 (28%)
<i>At a private dentist <sup>b</sup></i> <i>(% of total visits)</i>	85,040 (93%)	96,969 (93%)	109,094 (94%)	121,698 (94%)	129,238 (94%)
<i>At a public health facility <sup>b</sup></i> <i>(% of total visits)</i>	6,190 (7%)	6,976 (7%)	7,336 (6%)	7,423 (6%)	8,357 (6%)

Source: Data initially collected by Mahyar Mofidi, from Bill Loomis, NC Division of Medical Assistance, for the 2005 NC Oral Health Summit (February 2005). Updated information provided by Emad Attiah, NC Division of Medical Assistance, to the NCIOM (September 2005).  
<sup>a</sup> Dental visit data was provided by the NC Division of Medical Assistance and is based on total dental claims submitted for the population.  
<sup>b</sup> The sum of total visits at the private and public health facilities will be greater than the unduplicated number of Medicaid recipients (column 2) because some recipients receive more than one visit, and may visit both a private and public provider.  
<sup>c</sup> Data for 2005 are not final. Claims may be submitted up to three months following the end of the state fiscal year, June 30, 2005. Therefore the total

Similarly, Table 6 indicates that dental utilization rates for older adults enrolled in Medicaid, aged 65 and over, increased from 16% to 20% between SFY 2001 and 2005. Although dental utilization rates increased, the SFY 2005 rate of 20% continued to trail the averages for the other age groups.

**Table 6. Enrolled adults ages 65 and older getting an annual Medicaid dental visit.**

	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005 <sup>c</sup>
<b>Number of Medicaid-enrolled adults aged 65 years and older</b>	201,555	197,102	192,683	187,001	179,026
<b>Number (percentage) of Medicaid recipient adults aged 65 years and older with any dental visit <sup>a</sup></b>	31,729 (16%)	31,838 (16%)	33,560 (17%)	32,584 (17%)	35,647 (20%)
<i>At a private dentist <sup>b</sup></i> <i>(% of total visits)</i>	31,698 (97%)	31,982 (97%)	32,803 (97%)	33,021 (97%)	34,935 (98%)
<i>At a public health facility <sup>b</sup></i> <i>(% of total visits)</i>	871 (3%)	991 (3%)	924 (3%)	892 (3%)	888 (2%)

Source: Data initially collected by Mahyar Mofidi, from Bill Loomis, NC Division of Medical Assistance, for the 2005 NC Oral Health Summit (February 2005). Updated information provided by Emad Attiah, NC Division of Medical Assistance, to the NCIOM (September 2005).  
<sup>a</sup> Dental visit data was provided by the NC Division of Medical Assistance and is based on total dental claims submitted for the population.  
<sup>b</sup> The sum of total visits at the private and public health facilities will be greater than the unduplicated number of Medicaid recipients (column 2) because some recipients receive more than one visit, and may visit both a private and public provider.  
<sup>c</sup> Data for 2005 are not final. Claims may be submitted up to three months following the end of the state fiscal year, June 30, 2005. Therefore the total

The majority of dental services are provided by private dentists. In SFY 2005, 82% of children under age 21, 94% of non-elderly adults age 21-64 years, and 98% of older adults age 65 years or older receiving annual dental visits were seen by private dentists.<sup>5</sup> Further, services provided by private dentists are increasing more rapidly than those provided by public health dentists. For Medicaid recipients of all ages combined, the number of annual dental visits provided by private dentists increased by 64% during the period SFY 2001-2005, compared to an increase of 4% at public health facilities. A comparison by age shows that dental services at private offices increased most for children under the age of 21: the total number of dental visits provided to children in private offices increased by 85% between SFY 2001-2005, compared to a 20% increase in visits provided to this age group by public health facilities. Utilization rates in private dentists' practices also increased for Medicaid-enrolled adults aged 21-64 by 52% and by 10% for those aged 65 years and older. Visitation rates at public health facilities for those populations increased by 35% and 2%, respectively. These data show that private dentists play a critical role in providing services for the adult population and are increasingly providing their services to children. The increase in children's dental care provided in private dentists' offices may indicate a positive reaction to the increased reimbursement rates, which focused primarily on services to this younger population. On the other hand, dental visits for the adult Medicaid population remain low, which may be a reflection of providers' discouragement with lower reimbursement levels for this population.<sup>3</sup>



## **INCREASING DENTIST PARTICIPATION IN THE MEDICAID PROGRAM**

The original 1999 NC IOM Dental Care Access report found that only 16% of dentists in North Carolina “actively participated” in the Medicaid program, and only 20% of Medicaid recipients visited dentists in 1998. Dentists seemed to have two primary concerns with Medicaid: (1) the low reimbursement levels and (2) the high rate of broken appointments and (3) poor patient adherence among Medicaid recipients. To address these concerns, the 1999 Task Force recommended that the NC General Assembly increase the Medicaid reimbursement rates

to attract more dentists to serve this population, develop an outreach campaign to encourage dentists in private practice to treat low-income patients, and establish a Dental Advisory Committee to work with the Division of Medical Assistance on an ongoing basis.<sup>4</sup> A lot has been done to implement these recommendations; however, the 2005 NC Oral Health Summit found that more work is needed. The group suggested further reimbursement rate increases, ongoing outreach efforts to recruit additional dentists into the Medicaid program, and continued collaboration between the NC Dental Society and the Division of Medical Assistance. The following reflects the work that has been done to implement the recommendations, as well as the additional work that is suggested to further increase dental participation in the Medicaid program.

### **1999 Task Force Recommendation #1**

*Increase the Medicaid reimbursement rates for all dental procedure codes to 80% of usual, customary, and reasonable charges (UCR). UCR was based on the fee schedule of the University of North Carolina (UNC) Dental Faculty Practice.*

### **2005 Proposed Action Plan:**

**Increase the Medicaid reimbursement rates for all dental procedure codes to reflect 75% of market-based fees in North Carolina. The Division of Medical Assistance should continue to work closely with the NC Dental Society to achieve reasonable rates using an agreed upon market-based fee schedule.**

In 1999, the NC IOM Task Force on Dental Care Access found that Medicaid paid North Carolina dentists approximately 62% of the usual, customary, and reasonable charges (UCR) for the 44 most common dental procedures for children, and 42% of UCR for other procedures.<sup>4</sup> Subsequently, these rates were increased, partially in response to actions taken by the NC General Assembly and NC Division of Medical Assistance, and partially in response to a lawsuit that challenged the adequacy of the dental reimbursement rates. In 2000, plaintiffs, representing low-income children, filed a lawsuit against DHHS challenging the adequacy of the dental reimbursement rates. The lawsuit, *Antrican v. Bruton*, was settled in 2003. As a result of the settlement, the Division of Medical Assistance increased the reimbursement rates for a selected list of dental procedures

commonly provided to children to a level of 73% of the UNC Dental Faculty Practice's UCR. The changes in dental reimbursement rates effectively increased rates for 27 dental services that are also available to adult Medicaid recipients. Presumably, these rate changes helped increase the willingness of private dentists to serve the Medicaid population.

*Concerns and Issues.* Although there are clear improvements in dental service utilization for the Medicaid population, and particularly for children, the North Carolina Medicaid population still lags behind the national averages for higher income populations. North Carolina children under the age of 21 in the Medicaid population had 41% utilization rates in SFY 2004, compared to rates of 49.4% and 65.2% for children between 200-400% and greater than 400% of the poverty line, respectively.<sup>6</sup> In addition, some participants of the NC Oral Health Summit believe that the UCR fee schedule does not accurately follow changes in the private sector market. They argued that moving toward a more market-based reimbursement fee schedule would make dentists feel more positively about participating in the Medicaid program and thus increase access to dental care for the Medicaid population.

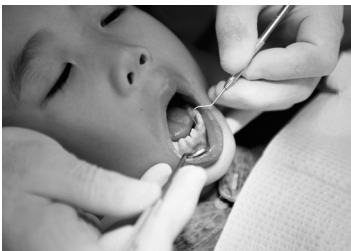
The UNC-CH School of Dentistry fee schedule was initially adopted because it was one generally supported by both dental providers and the Division of Medical Assistance (DMA). This fee schedule became known as the UCR fee schedule. However, more recently both groups have begun to discuss the potential benefits of a market-based fee schedule. One problem with the UCR fee schedule is that there are certain services whose reimbursement rates lag behind the market dramatically, while others are more closely aligned with, or even exceed, the market average. Developing a market-based fee schedule would reduce some of the major variations in payments for different services. Market-based fee schedules have the added benefit of automatically indexing to adjust for inflation so that Medicaid reimbursement would keep pace with the marketplace. Alabama, Michigan, and Tennessee have established competitive Medicaid reimbursement rates, which have significantly improved dental care access for the Medicaid population in those states.<sup>7</sup>



There are challenges in moving to a market-based reimbursement fee schedule. For example, no data are currently collected at the state level about dental fees. The National Dental Advisory Service (NDAS), a national fee survey that is based on average national costs, could be used as a basis for a market-based reimbursement rate. However, the market rates in North Carolina may be lower than the national averages. Tennessee's Medicaid program overcame this problem by reimbursing dentists for services at 75% of the average fees for the East South Central region. As a result of this reimbursement adjustment in Tennessee, dental care utilization of the Medicaid population almost doubled (from 24% to 47%), coming much closer to the private market averages.<sup>8</sup> A similar change to a 75% of market-based fee schedule made in South Carolina in 2000 had an immediate impact on reversing the negative trends in dental care services to children with Medicaid.<sup>9</sup>

In terms of a targeted reimbursement level, Summit participants generally agreed that, as an ultimate goal, Medicaid rates should reflect the 75<sup>th</sup> percentile of market-based fees in North Carolina. This means that dental reimbursement rates would be equal to or greater than the rates charged by 75% of dentists in the state and could encourage many more dentists to participate in the Medicaid program.

Subsequent to the Oral Health Summit, the NC General Assembly appropriated \$2.0 million in each year of the biennium to increase Medicaid dental rates. This actually translates into an approximate increase of \$6.4 million/year after factoring in the federal and county share of Medicaid costs. At the time of publication of these Summit proceedings, it was not yet clear how DMA would implement this rate increase (e.g., across the board rate increases, or increases targeted to certain procedures).



***Application of recommendation to NC Health Choice:***

The 2005 Summit participants also discussed legislation pending in the NC General Assembly to move children birth through age five with family incomes equal to or less than 200% of the federal poverty guidelines into the Medicaid program. This was a recommendation that grew out of another NC IOM Task Force on the NC Health Choice Program (2003).<sup>10</sup> The NC Health Choice program provides health insurance coverage to

children with family incomes that are too high to qualify for Medicaid, but equal to or less than 200% of the federal poverty guidelines. NC Health Choice operates within certain state and federal budgetary constraints. If either the federal or state funds run out, then children can be denied coverage. Because of limited state funding, the program was frozen in 2001 for eight months and, as a result, more than 34,000 eligible children were put on a waiting list for coverage. In contrast, Medicaid is a federal entitlement program, thus, all eligible children are entitled to coverage. To prevent another freeze in the NC Health Choice program, the NC IOM Task Force on the NC Health Choice Program recommended that children birth through age five be moved from NC Health Choice to Medicaid, and that the state pay the county share of this Medicaid expansion. This would guarantee that these children obtain health insurance coverage regardless of budgetary shortfalls, and would also save funds in the NC Health Choice program in order to cover more children.<sup>11</sup>

Participants in the 2005 Dental Summit voiced concerns that access to dental services might be limited if the NC Health Choice dental reimbursement rates were reduced to the Medicaid levels, and recommended that Medicaid dental reimbursement rates be increased in order to encourage the active participation of dentists in both NC Health Choice and Medicaid. Subsequent to the Oral Health Summit, the NC General Assembly enacted legislation to move children birth through age five from NC Health Choice into Medicaid. In addition to this change, the NC General Assembly enacted legislation to reduce all of the NC Health Choice provider payments from the current reimbursement rates to the Medicaid rates by July 1, 2006 for children ages 6-18.<sup>12</sup> This change effectively decreases the dental reimbursement rates for all children who were previously covered by NC Health Choice. It is important to monitor the impact of this change on access to dental services for NC Health Choice participants, who have in the past had much better access to dental services than have children enrolled in Medicaid. This is another reason to increase Medicaid dental reimbursement rates to more accurately reflect market rates.

## **1999 Task Force Recommendation #2**

*The North Carolina Dental Societies should develop an outreach campaign to encourage dentists in private practice to treat low-income patients.*

### **2005 Proposed Action Plan:**

**The North Carolina Dental Society, the Old North State Dental Society, and the Division of Medical Assistance should continue their collaborative efforts to encourage dentists in private practice to serve low-income patients, with a particular emphasis on dentists who are not already providing services to the Medicaid population.**

The 1999 NC IOM Task Force Report noted that another barrier that discouraged dentists from participating in the Medicaid program was the high-cancellation and “no-show” rates among Medicaid recipients. National data from the American Dental Association (ADA) indicate that an average of 30% of Medicaid recipients failed to keep their appointments in 1998.<sup>13</sup> The report also cited that the Division of Medical Assistance made a number of program operation changes to standardize claim forms and procedure codes, automate claim submissions and payments, and eliminate prior approval requirements. However, despite these changes, stigma surrounding the Medicaid program remained. Therefore, it was determined that an outreach campaign to inform dentists of these changes and encourage further participation would be a valuable step in attracting more dentists to participate in the Medicaid program.

In the 2003 NC IOM update to the original report, this recommendation was considered fully implemented. The NC Dental Society created an Access to Care committee that encouraged local dental societies to serve more low-income Medicaid patients. The NC Dental Society also provides outreach to dental school classes to encourage their participation in Medicaid after graduation. The NC Dental Society and the Division of Medical Assistance now meet regularly to develop strategies to increase dental participation.<sup>14</sup> As a result of this collaboration, the Division of Medical Assistance, in consultation with the NC Dental Society, developed a frequently asked questions (FAQ) information sheet about the Medicaid program to overcome negative

impressions of the Medicaid program and to promote positive changes within it. The NC Dental Society distributed the document to all its members and provided information about the FAQ sheet in its newsletter, the *Dental Gazette*. In addition, the NC Dental Society and the Division of Medical Assistance have hosted seminars and workshops to address misconceptions about Medicaid and to publicize the joint work and positive relationship that has developed between the two organizations. Approximately 80% of private dentists in the state belong to the NC Dental Society, thus, these outreach efforts are potentially able to reach a large group of private providers. The Old North State Dental Society, a statewide dental organization comprised largely of African American and other minority dentists, also plays an important role as a model of service to the underserved because almost all of its members treat Medicaid patients.

**Concerns and Issues.** These efforts are helping to achieve the goal set forward in this recommendation. However, participants at the 2005 NC Oral Health Summit felt that these efforts should be viewed as ongoing, rather than fully implemented, as noted in the 2003 Update. In particular, the Summit workgroup on this topic stressed the importance of targeting marketing strategies to dentists who are not currently serving Medicaid patients, as much of the increase in dental utilization since 1999 was provided by dentists who were already serving the Medicaid population. In addition, it was suggested that providing training on cultural diversity and sensitivity and respectful provider-patient interaction for providers serving Medicaid patients could be very valuable. Such training hopefully would teach clinical and office staff to treat Medicaid patients in a non-stigmatizing manner and to better understand the challenges some Medicaid recipients face in accessing dental care.

### **1999 Task Force Recommendation #3**

*The Division of Medical Assistance should work with the NC Dental Society, the Old North State Dental Society, the NC Academy of Pediatric Dentistry, the Oral Health Section of the NC Department of Health and Human Services, the UNC-CH School of Dentistry, and other appropriate groups to establish a dental advisory committee to work with the Division of Medical Assistance*

*on an ongoing basis. The Advisory Committee should also include Medicaid recipients or parents of Medicaid-eligible children.*

### **2005 Proposed Action Plan:**

**The Division of Medical Assistance should work with the NC Dental Society, the Old North State Dental Society, the NC Academy of Pediatric Dentistry, the Dental Health Section of the NC Department of Health and Human Services, the UNC-CH School of Dentistry, and other appropriate groups to continue to promote strong dental representation within the NC Physicians Advisory Group (PAG) and provide ongoing support to the PAG Dental Advisory Committee, and ensure that the Dental Advisory Committee continues to include representation of Medicaid recipients or parents of Medicaid-eligible children.**

In 2003, the Division of Medical Assistance added a dentist to the Board of Directors of the NC Physicians Advisory Group (PAG), which gives guidance to the Division of Medical Assistance (DMA) in setting medical coverage policy, and created an independent Medicaid Dental Advisory Committee. The Dental Advisory Committee reports to the PAG and has been particularly effective in helping to streamline DMA policy.

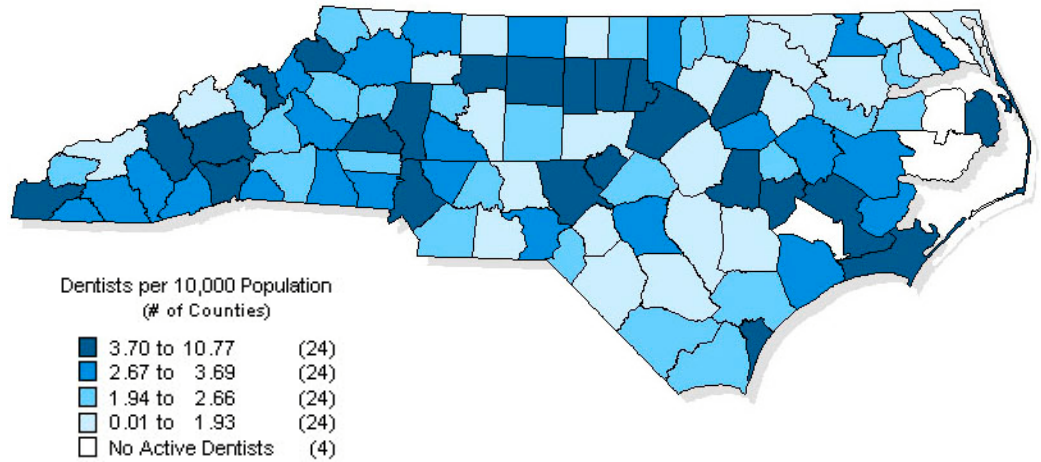
*Concerns and Issues.* The Summit participants noted that the essence of the 1999 recommendation has been implemented, but the actual implementation is not exactly as the recommendation suggested because the NC Physicians Advisory Group is not constituted in a way that would include Medicaid recipient representatives. This population is, however, represented on the Dental Advisory Committee that reports to the PAG, and this participation seems to satisfy the spirit of the 1999 recommendation. Therefore, participants at the 2005 NC Dental Health Summit suggested updating the recommendation to indicate this difference and to clarify that, although this recommendation has been implemented, it should still be considered ongoing.

**INCREASING THE OVERALL SUPPLY OF DENTISTS AND DENTAL HYGIENISTS IN THE STATE WITH A PARTICULAR FOCUS ON EFFORTS TO RECRUIT DENTAL PROFESSIONALS TO SERVE UNDERSERVED AREAS AND TO TREAT UNDERSERVED POPULATIONS**

One of the major concerns addressed in the 1999 NC IOM Dental Care Access Report was the limited supply of dental professionals in North Carolina. In 1999, the dentist-to-population ratio was 4.0 dentists per 10,000 people, and the dental hygienist-to-population ratio was 4.6 per 10,000. In 2004, the supply of dental professionals in North Carolina was still grim, with a dentist-to-population ratio of only 4.1 dentists per 10,000 people. This rate placed North Carolina 47<sup>th</sup> out of the 50 states, well below the national average of 5.8 dentists per 10,000 people.<sup>15</sup> This illustrates the state's continuing need for dentists throughout the state. Even more staggering is the unequal distribution of dentists across counties. Four of North Carolina's 100 counties, all in the eastern part of the state, have no practicing dentists, and only eight counties have a dentist-to-population ratio equal to or greater than the national average (See Map 1). Seventy-nine counties qualify as federally designated dental health professional shortage areas, meaning that they have a full-time-equivalent dentist to population ratio of at least 1:5,000, or between 1:4,000 and 1:5,000 with unusually high needs for dental services or insufficient capacity of existing dental providers.<sup>16</sup> This shortage and the uneven distribution of dental professionals in North Carolina are major barriers to accessing dental care in the state.



**Map 1. Dentists per 10,000 Population, North Carolina, 2003.**



Source: North Carolina Health Professions Data System. Cecil G. Sheps Center for Health Service Research. The University of North Carolina at Chapel Hill. Chapel Hill, 2004.

Dental hygienists also play a vital role in providing dental care services. Fortunately, the number of dental hygienists increased 18% from SFY 1999 to SFY 2003, and the ratio of hygienists-to-population increased 6%, to 4.8 per 10,000 people.<sup>17</sup> As a result, North Carolina experienced a 5% increase in the ratio of dental hygienists-to-dentists over the same period. Nonetheless, this ratio remains very low, particularly considering the number of dental health professional shortage areas in North Carolina.

**2005 Proposed Action Plan:**

**The University of North Carolina System should make it a priority to expand the number of dental students trained in North Carolina. The goal of this initiative should be to increase the number of dentists who practice in underserved areas of the state and who agree to treat Medicaid and other underserved populations.**

The 1999 NC IOM Task Force on Dental Care Access was not specifically charged with estimating the extent of dental workforce shortage in the state. However, these issues arose as the focus of those deliberations was on the lack of available dental services, both in certain geographic areas and among low-income people who could not obtain dental care services, even when covered by Medicaid. The extensive shortages of

dental professionals in recent years is particularly problematic in rural areas.

During discussion of the data on dental health professionals, participants in the Oral Health Summit were informed that East Carolina University (ECU) was actively considering the establishment of a school of dentistry in Greenville. The proposed dental school would be “community-based,” giving emphasis to the special problems of dental care access in eastern and rural regions of the state. Privately practicing dentists in eastern North Carolina would play an active role in the clinical education of dental students trained in such a program. The proposal was for a school of dentistry modeled on the successful Brody School of Medicine, which has one of the highest proportion of minority students and graduates compared to any school of medicine in the nation, as well as one of the highest rates of graduates choosing to practice primary care specialties and locate their practices in smaller communities in this state. Less than 7% of North Carolina dentists are from racial or ethnic minority groups. More than 30% of the current enrolled students in the Brody School of Medicine represent these minority groups.

There was also discussion about the possibility of expanding the UNC School of Dentistry to educate more dental students. Currently, the UNC School of Dentistry admits approximately 80 dental students each academic year. The proposed expansion would accommodate an additional 50 students, for a total enrollment of 130 students per year.

Summit participants supported the goal of increasing the capacity of the University of North Carolina System to train additional dentists, although there was no clear consensus on how this should be accomplished (e.g., through the establishment of a new school at East Carolina University, the expansion of the UNC School of Dentistry, or both). Participants understand that either approach will require new financial resource. Nonetheless, there was strong support for the concept of trying to raise the number of dentists per population closer to the national average. The relative dearth of practicing dentists, particularly among underserved populations and communities, is one of the greatest health resource challenges facing the state.



#### **1999 Task Force Recommendation #4**

*Establish an Oral Health Resource Program within the Office of Research, Demonstrations and Rural Health Development to enhance ongoing efforts to expand the public health safety net for dental care to low-income populations in NC. The state cost of this program would be \$1.0 million for each year for three years.*

#### **2005 Proposed Action Plan:**

**The Office of Research, Demonstrations and Rural Health Development should continue its work to expand the number of dental safety net programs and recruit dental professionals to serve low-income underserved populations and in dental underserved areas of North Carolina. To this end, it should work with the NC DHHS Oral Health Section to secure funding for these efforts.**



Although no funds were specifically allocated by the state for an Oral Health Resource Program, the NC Office of Research, Demonstrations and Rural Health Development (ORDRHD) and the NC DHHS Oral Health Section worked with the Kate B. Reynolds Charitable Trust to expand the number of dental safety net programs. In 1998 there were only 43 dental safety net programs. By 2003, there were 72 programs, and by 2004, there were 115. In addition, since 1999, the NC ORDRHD's dental recruitment program has grown. The program recruited 140 dentists and five dental hygienists to serve in dental underserved areas between state fiscal years 2000 and 2004. The NC ORDRHD also began meeting with dental directors to exchange information and ideas about how to improve access to dental care for low-income, indigent, and Medicaid patients.

**Concerns and Issues:** Despite the NC ORDRHD's success in expanding the number of dental safety net programs and recruiting dental professionals to underserved areas, the data above clearly indicate a serious ongoing need for dental health professionals. Participants at the 2005 NC Oral Health Summit felt that the NC ORDHD and the NC Oral Health Section should continue to solicit financial support to expand these efforts. In addition, one participant mentioned the idea of focusing financial support on safety net clinics that offer non-traditional hours of service. Many of the patients most in need of safety net services do not have employment that allows them

to leave work (with or without pay) for medical or dental appointments. Supporting the development of more safety net providers offering services during non-business hours may alleviate this barrier to access.

### **1999 Task Force Recommendation #5**

*The NC Dental Society should seek private funding from the Kate B. Reynolds Charitable Trust, The Duke Endowment, and other sources to establish a NC Dental Care Foundation for the purpose of assuring access to needed preventive and primary dental care services in underserved communities and populations in our state.*

### **2005 Proposed Action Plan:**

**The NC Dental Society should seek private funding from its members and private philanthropies to support the work of the NC Dental Care Foundation for the purpose of assuring access to needed preventive and primary dental care services in underserved communities and for underserved populations in our state.**

The NC Dental Society established the NC Dental Health Endowment through the NC Community Foundation and began funding it through its own fund-raising activities. As of 2004, \$150,000 had been raised for the Endowment. The first two grants were awarded to support dental care clinics operated by the Buncombe County Health Department and the Alamance County Health Department. The Buncombe County Health Center received \$4,800 to support routine and preventive care for disabled children and adults and help indigent children and adults receive care for untreated dental needs and pain. The Alamance County Health Clinic received \$4,051 to purchase equipment, including a rotary endodontic system, to help treat children whose teeth would otherwise require extraction.<sup>18</sup>

**Concerns and Issues.** The 2005 NC Dental Health Summit participants were pleased with the successful development of the NC Dental Health Endowment and its distribution of grants, but participants understood that the Endowment was not currently at a level to make significant enough grant awards to expand access. Participants expressed a desire to increase attention to and interest in the Endowment to increase its funding so that more grants could be made throughout North

Carolina. Therefore, they recommended ongoing efforts to secure funds for the Endowment.

### **1999 Task Force Recommendation #6**

*Revise the NC Dental Practice Act to permit specially trained public health dental hygienists to perform oral health screenings as well as preventive and educational services outside the public school setting under the direction of a licensed public health dentist.*

### **2005 Proposed Action Plan:**

**The NC DHHS Division of Public Health Oral Health Section should develop a data collection system to determine the extent to which the Dental Practice Act training is increasing the number of oral health preventive clinical services being provided by state and local public health dental hygienists.**

The 1999 recommendation was implemented when the NC General Assembly, in their 1999 session, passed legislation to revise the NC Dental Practice Act to permit specially trained public health dental hygienists to perform preventive clinical services outside the public school setting under the direction of a licensed public health dentist (Sec. 11.65 of HB 168). Under the NC Dental Practice Act, public health dental hygienists must meet four qualifications to work under the direction of a licensed public health dentist. Those requirements include: attaining at least five years or 4,000 hours of clinical dental hygiene experience, fulfilling annual six-hour medical emergency training, annually renewing cardiopulmonary resuscitation (CPR) certification, and completing a NC Oral Health Section four-hour training on public health principles and practices.

As of June 2005, 32 dental hygienists working in local health departments and one working in a safety net special care clinic, had been specially trained to provide the services outlined in the NC Dental Practice Act, under the direction of a public health dentist. The NC Oral Health Section periodically notifies local health directors about the availability of training for additional staff.

In addition, the NC Oral Health Section includes the content of the four-hour dental public health training as part of its

orientation program for all new NC Oral Health Section public health employees. As a result, all of the NC Oral Health Section public health dental hygienists with the adequate years/hours of experience (36 people, or about 65% of state dental hygienists) qualify to provide preventive services under the direction of the state public health dentists. In addition, the NC Oral Health Section sealant program, designed to reduce dental decay among public health's patient population, was modified in SFY 2002-2003 to use the increased capacity of these qualified state public health dental hygienists. In the 2004-2005 school year, the majority of the 6,459 sealants provided to 1,911 children by the NC Oral Health Section were completed by hygienists working under the direction of a public health dentist.

**Concerns and Issues:** Although the NC Oral Health Section has made significant gains in fulfilling this recommendation through training of both state and local public health dental hygienists, there is no accounting mechanism to determine if dental hygienists at local health departments are using this training to increase the level of services to patients at those clinics. As a result, the NC Oral Health Summit participants recommended that the NC Oral Health Section develop a system for collecting data on the level of services local public health dental hygienists are providing prior to and following training on the NC Dental Practice Act.

#### **1999 Task Force Recommendation #7**

*The NC IOM, in conjunction with the NC State Board of Dental Examiners, the NC Dental Society, the Old North State Dental Society, NC Dental Hygiene Association, the NC Primary Health Care Association, the Dental Health Section and the NC Office of Research, Demonstrations and Rural Health Development of the NC Department of Health and Human Services, should explore different methods to expand access to the services of dental hygienists practicing in federally funded community or migrant health centers, state-funded rural health clinics, or not-for-profit clinics that serve predominantly Medicaid, low-income, or uninsured populations. The study should include consideration of general supervision, limited access permits, additional training requirements, and other methods to expand preventive dental services to underserved populations.*

### **2005 Proposed Action Plan:**

**The NC State Board of Dental Examiners is requested to re-consider the feasibility of possible arrangements under which dental hygienists working in migrant health centers, federally qualified health centers, or community health centers could provide preventive dental health services under the general supervision of a dentist employed by those same organizations.**



Under the existing state law and dental regulations, dental hygienists employed by federally funded community or migrant health centers, state-funded rural health clinics, and not-for-profit dental clinics cannot practice under general supervision of a dentist. Dental hygienists working in local/state public health clinics or dental programs may perform preventive dental care procedures if working under the general supervision of a public health dentist. Summit participants representing other safety net organizations expressed a desire to have the same flexibility. Theoretically, contractual arrangements could be developed between a local health department (who would hire and supervise the hygienists), and other non-profit dental safety-net institutions that would give the hygienist the authority to practice under general supervision. However, no such arrangements have been developed as of the spring of 2005. The NC State Board of Dental Examiners should re-examine this issue.

### **1999 Task Force Recommendation #8**

*Existing and any future loan repayment programs established with the purpose of attracting dental professional personnel to work in rural or underserved areas should be accompanied by more stringent requirements to ensure that the dentists serve low-income and Medicaid patients.*

### **2005 Proposed Action Plan:**

**The NC health professional loan repayment program should implement a requirement for individuals who have completed their dental or dental hygiene education and obtained a license to practice to report every six months (during the period of obligated practice) on the place of practice and volume of patients served.**

The 2003 Dental Care Update reported that the NC Office of Research, Demonstrations and Rural Health Development (ORHRD) was not given additional funding to recruit dentists to serve in rural areas of North Carolina, but the Office was granted flexibility in the use of existing funds for educational loan-repayment. Priority for loan forgiveness dollars was shifted from physicians to dentists and hygienists who are willing to work in federally qualified health centers, state-sponsored rural health centers, county health departments, and non-profit clinics. Most of the dental sites qualify for Dental School Loan Repayment and travel reimbursement subsidies for pre-approved interviews. The state loan repayment program, which had a maximum repayment level of \$70,000, was enhanced approximately two years ago to grant \$10,000 more for bilingual providers accepting positions in areas with a high Hispanic/Latino population. In return, the providers receiving these funds through the loan repayment program are required to see patients a minimum of 32 hours per week, allowing a total of eight hours per week for administrative duties. Using loan-repayment funds, the NC ORDRHD has recruited 140 dentists and five hygienists (since October 1999).

Preliminary research at the Sheps Center for Health Services Research supports the theory that dental health professionals who benefit from loan repayment programs and serve underserved populations, continue to do so during professional years following the program at a greater rate than do dental professionals who were licensed at the same time, but are not participating in a loan repayment program.<sup>19</sup> To support this research and quantify the services provided to underserved populations through the loan repayment program, Summit participants recommended requiring those professionals involved in the program to report back biannually on the location of the practice and the volume of patients served.

### **1999 Task Force Recommendation #9**

*The Board of Governors' Scholarship Program and other state tuition assistance programs should carry a requirement of service in underserved areas upon graduation.*

## **2005 Proposed Action Plan:**

**The Board of Governors' should vote to carry a requirement of service in underserved areas upon graduation for individuals in the Scholarship Program. In addition, the Board of Governors' should consider reallocating funds currently used to support special arrangements with Meharry Medical College and Morehouse School of Medicine for the admission of North Carolina minority and dental students and applying those funds to scholarship support at North Carolina's own academic institutions.**

As reported in the 2003 Dental Care Access Update, the NC State Education Foundation Assistance Authority, which manages the Board of Governors' Scholarship programs, created a special task force in 2001 to look at this issue. The Task Force unanimously supported the idea. The pay-back provision that was discussed would allow dental students seven years to pay out their service requirements. However, the proposal needs to be voted on by the Board of Governors before it can be implemented and would be implemented in the 2006-2007 academic year, at the earliest.

The participants at the 2005 NC Oral Health Summit praised the work done so far to implement this recommendation and hoped that the service requirement could be voted upon this year by the Board of Governors, for the earliest possible implementation.

Another suggestion for consideration by the Board of Governors was to potentially cancel special arrangements with both Meharry Medical College and Morehouse School of Medicine for the admission of North Carolina minority dental and medical students and apply those funds to the scholarship support at North Carolina's own academic institutions.

**Concerns and Issues:** Participants at the 2005 NC Oral Health Summit also discussed the idea of requiring all UNC dental students covered at the in-state tuition rate to pay back the education subsidy provided by North Carolina taxpayers through their service to publicly insured patients. The group suggested that in lieu of providing community service in public areas, students could be required, for the first ten years in

private practice, to have 10-20% of their patients covered by public insurance.

### **1999 Task Force Recommendation #10**

*The General Assembly should direct the NC State Board of Dental Examiners to establish a licensure-by-credential procedure that would license out-of-state dentists and dental hygienists who have been practicing in a clinical setting in other states with the intent of increasing the number of qualified dental practitioners in the state.*

In August 2002, Senate Bill 861 was signed into law (SL2002-37) to allow licensure by credentials for dentists and dental hygienists who have practiced in another state for at least five years without any disciplinary actions. The NC State Board of Dental Examiners enacted rules to implement this procedure, effective January 2003. Since that time, 139 dentists and 145 dental hygienists have received a license by credentials. Dental professionals have one year from the time their application is approved to establish a practice in North Carolina.

### **1999 Task Force Recommendation #11**

*The NC State Board of Dental Examiners should be required to evaluate the competencies required by the different regional examinations to determine if these examinations ensure the same level of professional competence required to pass the North Carolina clinical examination. The NC State Board of Dental Examiners shall report its findings to the Governor and the Presiding Officers of the North Carolina General Assembly no later than March 15, 2001. If the Board concludes that participation in one or more regional examinations would not ensure minimum competencies, the Board shall describe why these other examinations do not meet North Carolina's standards and how the quality of care provided in North Carolina could be affected negatively by participating in such examinations. If the Board finds these exams to be comparable, procedures should be developed for accepting these examinations as a basis for North Carolina licensure in the year following this determination.*

As highlighted in the 2003 Dental Care Access Update report, the NC State Board of Dental Examiners examined the other regional examinations and recommended against pursuing this option any further. Since then, the NC State Board of Dental Examiners has entered into discussions with its counterpart boards in other states (and members of the American



Association of Dental Boards) about the feasibility of a national licensing exam for dentists. This matter is still unresolved, but it is thought that North Carolina would likely participate were such an exam to be promulgated.

### **1999 Task Force Recommendation #12**

*The NC State Board of Dental Examiners should consider a change in the wording in the regulations governing Dental Assistants in order to increase access to dental services for underserved populations.*

As highlighted in the 2003 Update of the Dental Care Access Report, this recommendation has been fully implemented. New rules became effective August 1, 2000, with provisions for in-office training for dental assistants.

### **INCREASING THE NUMBER OF PEDIATRIC DENTISTS PRACTICING IN NORTH CAROLINA AND EXPANDING THE PROVISION OF PREVENTIVE DENTAL SERVICES TO YOUNG CHILDREN**

A 2000 Task Force report from the American Academy of Pediatric Dentistry found that between 1990 and 1998, the number of trained pediatric dentists in the United States declined from 3,900 to 3,600. This decline was attributed to a lack of pediatric training programs rather than a lack of interest in pediatric dentistry training.<sup>20</sup> Fortunately, between 1998 and 2004, North Carolina succeeded in reversing the declining workforce trends of pediatric dentists in the state. As of 1998, there were only 47 pediatric dentists practicing in North Carolina, but by 2004, 92 pediatric dentists were active in the state. Most notably, five of these dentists are engaged in community dental health services within health departments or Medicaid clinics. In addition, there are ongoing efforts to establish a new pediatric dental residency program at the Carolinas Medical Center in Charlotte. These successes are extremely important because, according to the American Academy of Pediatric Dentistry, pediatric dentists provide a disproportionately higher amount of oral healthcare for underserved children and children receiving Medicaid.

### **1999 Task Force Recommendation #13**

*Increase the number of positions in the pediatric residency program at the UNC School of Dentistry from two per year to a total of four per year.*

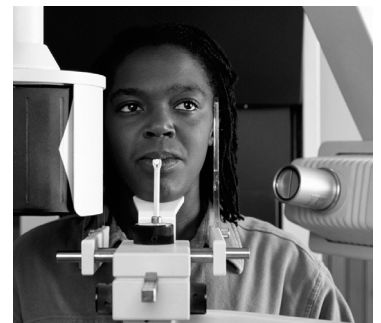
### **2005 Proposed Action Plan:**

- a) **The UNC School of Dentistry should maintain its effort to train additional pediatric dental residents;**
- b) **The Department of Pediatric Dentistry within the UNC School of Dentistry, Area Health Education Centers program, NC Academy of Pediatric Dentistry, NC Dental Society, Cecil G. Sheps Center for Health Services Research, NC Oral Health Section within the NC Division of Public Health, and other interested groups should convene a workgroup to study the supply and distribution of pediatric dentists, including whether the increased supply of pediatric dentists is keeping pace with the growth in the number of young children, and whether the aging and retirement of pediatric dentists is likely to create a shortage of pediatric dentists in the future.**

Following the 1999 Task Force recommendation that UNC Chapel Hill pediatric dentist residency program be expanded from two-to-four, NC Senate introduced a bill in the 1999 session (SB 752) to appropriate \$100,000 per year in sustained state funds for three UNC School of Dentistry (SOD) pediatric dentistry residents (one per year). However, Senate Bill 752 was not enacted.

Despite the fact that SB 752 was not enacted, the Department of Pediatric Dentistry at UNC-CH still hoped to make an effort to address the shortage of pediatric dentists in the state. Through a variety of creative financing mechanisms, the Department has succeeded in training approximately a dozen additional pediatric dentists. A few came as independently funded international students and a couple dentists worked in pediatrics in conjunction with their studies in other PhD programs at UNC.

Additionally, in 2003, the Department obtained a federal grant, "Residency Training in General Dentistry and/or Advanced Education," from the Health Resources and Services Administration (HRSA) to increase the number of pediatric



dentistry residency position by one per year for 2003-2006. This grant provided firm financial support to increase the number of residents from six (two per year) to nine (three per year). However, the grant is intended to be seed money, and if additional funding is not secured, this increase will be lost in June of 2006. It was reported at the 2005 Summit that the Department hopes to continue to accept three residents per year, but secure funding remains elusive.

The 2003-2006 HRSA grant is just one strategy that has been used to increase the number of pediatric dentists in the state. Another strategy that was already in process during the production of the 1999 report was to encourage UNC dental students to complete pediatric residency training outside North Carolina and return to the state to practice.

As a result of all the efforts described, the number of pediatric dentists nearly doubled, from 47 in 1998 to 92 in 2004. Most notably, five of these dentists are engaged in community dental health services within health departments or Medicaid clinics. Considering this progress, it was the belief of participants at the 2005 NC Oral Health Summit that this success was far greater than expected during the 1999 Dental Care Access Task Force. In addition, there are some ongoing efforts (noted in Recommendation #14 below) to establish a new pediatric dental residency program at the Carolinas Medical Center in Charlotte.

**Concerns and Issues:** While the ongoing training of pediatric dentists currently may be sufficient, there was concern about the age of the pediatric workforce and the potential impact on pediatric dental workforce supply in the future. Additionally, pediatric dentists are not available throughout the state; they are largely concentrated in urban areas. Thus, participants recommended further study of the capacity of the current system to produce sufficient pediatric dentists to support the growth in the number of young children, and to examine the availability of pediatric dental services throughout the state.

#### **1999 Task Force Recommendation #14**

*The NC IOM, in conjunction with the NC Academy of Pediatric Dentistry, the UNC-CH School of Dentistry, the NC AHEC program, and the Dental Public Health Program within the UNC-CH School of*

*Public Health, should explore the feasibility of creating additional pediatric dental residency program(s) at ECU, Carolinas Healthcare System, and/or Wake Forest University. A report should be given to the Governor and the Joint Legislative Commission on Governmental Operations no later than March 15, 2000. The report should include the costs of establishing additional pediatric dental residency program(s) and possible sources of funding for pediatric dental residency programs, such as state appropriations or the Health Resources and Services Administration (HRSA), within the U.S. Department of Health and Human Services.*

### **2005 Proposed Action Plan:**

**Participants of the NC Oral Health Summit should support and assist efforts by Carolinas Healthcare System to establish a new pediatric dental residency program in North Carolina.**

Meetings following the release of the 1999 Task Force Report involving dental faculty from East Carolina University, the University of North Carolina at Chapel Hill, Wake Forest University, and Carolinas Healthcare System led to a proposal that Wake Forest University begin a pediatric dental residency program in Winston-Salem (with a plan for two residents per year and total of four when the program was fully enrolled). However, Wake Forest University was not able to recruit a pediatric dentist to establish that program.<sup>21</sup>

Carolinas Healthcare System, which was not initially interested in developing a pediatric dental residency program, was able to recruit an American Board of Pediatric Dentistry (ABPD)-certified dentist with experience in graduate program development and plans to establish a new pediatric dentistry residency program. Carolinas Healthcare System has applied for program approval from the American Dental Association's Commission on Dental Accreditation and is in the process of submitting an application for a federal HRSA grant to support development of the program. However, the Carolinas Healthcare System pediatric dentist who is leading the development of this residency program was planning on moving out of the state in July 2005. As a result, the residency's formation will be dependent upon finding a new program director.

**Concerns and Issues:** The low number of board certified pediatric dentists across the country may make it challenging

for Carolinas Healthcare System to find someone to replace the existing program director. However, the participants at the NC Oral Health Summit supported efforts to create new pediatric dental residency programs and, thus, should work collaboratively to assist Carolinas Healthcare System in finding another ABPD-certified dentist to lead the development of their new pediatric dental residency program.

#### **1999 Task Force Recommendation #15**

*The Division of Medical Assistance should add ADA procedure code 1203 to allow dentists to be reimbursed for the application of dental fluoride varnishes and other professionally applied topical fluorides without the administration of full oral prophylaxis.*

This recommendation has been fully implemented. As noted in the 2003 Dental Care Access Update Report, the Division of Medical Assistance added this procedure code as of April 1, 1999 for Medicaid-eligible children age 0-20 years.

#### **1999 Task Force Recommendation #16**

*Fund the Ten-Year Plan for the Prevention of Oral Disease in Preschool-Aged Children as proposed by the NC Dental Health Section. The goals of this effort would be to reduce tooth decay by 10% in all preschool children statewide in ten years; and reduce tooth decay by 20% in high-risk children statewide in ten years. The Ten-Year Plan would expand the use of public health dental hygienists from school-based settings to community-based settings, such as day care centers, Smart Start programs, Head Start Centers and other community settings where high-risk children are located. The program would provide health education to mothers and caregivers, apply fluoride varnishes to young children, use dental sealants when appropriate, and provide continuing education courses for any professional who has contact with young children.*



#### **2005 Proposed Action Plan:**

**The Oral Health Section within the NC Division of Public Health should work with the NC Partnership for Children, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start, Early Head Start, UNC Department of Pediatric Dentistry within the UNC School of Dentistry, local health departments and community health centers, child care institutions, early intervention programs, Parent Teacher Associations, the Department of Public**

**Instruction, and others to develop an action plan to further reduce tooth decay among preschool and school-aged children.**

This recommendation from the 1999 NC IOM Dental Care Access report intended to provide additional staff to the Oral Health Section (then Dental Health Section) to serve the preschool population. Over the last five years, rather than expanding, the state budget shortfalls have significantly reduced the Oral Health Section resources to serve young children.

Beginning in 1998, a program called Smart Smiles was piloted in western North Carolina. This is the program on which the program Into the Mouths of Babies (IMB) was later modeled and introduced statewide. The IMB program provides dental preventive service packages to health departments and physicians' offices serving Medicaid-eligible children. The packages include targeted oral health education for caregivers, and a dental screening and fluoride varnish application for high-risk children from birth to age three. Medical practitioners attempt to refer children in need of dental care to a source for care. In some areas, the referrals work well, while in other areas it is very difficult to find referral dentists, particularly for very young children with severe dental problems. Collaboration is underway with the Early Head Start program to develop educational materials for use with their clientele, to help them receive dental preventive services from the medical community, and to help them to find a dental home. In March 2005, the Oral Health Section created a permanent position (77% state appropriations, 23% federal financial participation) for the trainer and coordinator of the IMB program so that practitioner training will continue after the development and evaluation grant funding is exhausted.

In 2003-2004, the Oral Health Section and the UNC School of Public Health, with funding from the Centers for Disease Control and Prevention, conducted a statewide oral health survey of children, kindergarten through 12<sup>th</sup> grade, to evaluate the school-based dental prevention programs. The results of this survey will demonstrate the effectiveness of the school-based dental prevention program and it can serve as the baseline for the preschool dental preventive program.

**Concerns and Issues:** Participants at the 2005 NC Oral Health Summit suggested an action plan to continue the work done in this area, including: increasing dental students' comfort levels in working with children and infants (one way to do this would include exposing dental students to children in health department well-baby clinics); strengthening the partnership between dentistry and pediatric medicine; and reviewing current research on mothers' use of Xylitol, a sugar substitute. Potential collaborative partners include the NC Partnership for Children, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Head Start, Early Head Start, UNC Department of Pediatric Dentistry, local health departments and community health centers, schools, Parent Teacher Associations, early intervention programs, and other child care institutions.

### **1999 Task Force Recommendation #17**

*The NC Dental Society, the NC Academy of Pediatric Dentistry, the Old North State Dental Society, the NC Pediatric Society and the NC Academy of Family Physicians should jointly review and promote practice guidelines for routine dental care and prevention of oral disease as well as guidelines for referring children for specific dental care, so as to provide all children with early identification and treatment of oral health problems and to ensure that their care givers are provided the information necessary to keep their children's teeth healthy.*

As discussed above in Recommendation #16, this has been partially implemented by the Into the Mouths of Babes (IMB) program. The IMB steering committee has evaluated the program and is encouraging its expansion through the participation of more physicians. However, additional work is needed to develop a dental periodicity schedule for children.

### **1999 Task Force Recommendation #18**

*The Division of Medical Assistance should develop a new service package and payment method to cover early caries screenings, education, and the administration of fluoride varnishes provided by physicians and physician extenders to children between the ages of nine and 36 months.*

This recommendation was fully implemented as part of the Into the Mouths of Babes program, as noted above in recommendation #16.

## **1999 Task Force Recommendation #19**

*Support the enactment of House Bill 905 or Senate Bill 615 which would expand NC Health Choice to cover sealants, fluoride treatment, simple extractions, stainless steel crowns, and pulpotomies.*

This recommendation was fully implemented. The 2003 Dental Care Access Update noted that NC Health Choice was expanded to cover dental sealants, fluoride treatment, simple extractions, stainless steel crowns, and pulpotomies. This provision was enacted as part of the 1999 Appropriations Act. (Sec. 11.9 of HB 168).

## **TRAINING DENTAL PROFESSIONALS TO TREAT SPECIAL NEEDS PATIENTS AND DESIGNING PROGRAMS TO EXPAND ACCESS TO DENTAL SERVICES**

Dental professionals face a unique challenge when treating special needs patients because each patient is different and, thus, there is no common process by which all special needs patients should be treated. Some patients can be served in a traditional private practice environment, needing no additional time or services, while others must be served at their residence, require specific facility capabilities, and/or take significantly longer to serve than traditional patients.

Historically, many special needs patients received services through residential institutions where they lived. As the number of institutional programs for special needs populations has decreased and those individuals are integrated into communities across the state, accessing healthcare needs, including oral health needs, through existing health resources has become a greater challenge.

Barriers to accessing dental health services arise from a variety of factors within the special needs community. One of the problems is that dental health is often not seen as an important component of overall healthcare for the special needs individual. Special needs children may lack appropriate dental care if oral health is not specifically outlined in the overall health plan for the child. Caregivers may be overwhelmed by



other health and developmental concerns and not realize the importance of oral healthcare prevention techniques until a problem occurs.<sup>22</sup> This is a similar situation for frail adults or other people with poor health living in nursing homes whose caregivers may not understand the importance of oral health to overall health. In fact, studies find that elderly subjects with missing teeth have a lower intake of nutrients than individuals with all of their teeth and oral health can significantly impact nutritional deficiencies. Poor oral health, dry mouth (xerostomia), and inability to chew sufficiently (inadequate masticatory function) are three factors that contribute to nutritional deficiencies among nursing home populations.<sup>23</sup>



The dental health of special needs individuals is also affected by their own ability, or lack thereof, to actively participate in preventive oral care. Problems that prevent some individuals with special health needs from accessing dental services include frequent illnesses, difficulty scheduling appointments, and inadequate transportation.

Those living in nursing homes face other challenges. Many live there because they can no longer complete common activities of daily living on their own. In fact, the National Nursing Home Survey found that 97% of residents need assistance bathing; 87% dressing, 58% toileting, and 40% eating. Therefore, it is not surprising that many nursing home residents would also require assistance performing oral hygiene activities. In these settings, dental care professionals and licensed practical nurses (LPNs) usually develop an oral care plan for residents, and the nurse aides carry out the plan. Nurse aides provide 90% of direct patient care (including oral care). However, many nurse aides lack training in oral health. Further, there may not be an emphasis on oral health within the nursing home or standardization in how to perform oral assessments. Residents also may exhibit physical and behavioral reactions, such as biting toothbrushes and refusing care, which make it difficult to complete proper oral healthcare. In-service training programs try to address these problems by educating nursing home staff about oral health, examinations, and daily care. Nurse aides who receive training are able to perform daily oral care better and refer patients to a dental provider more efficiently. Also, studies indicate that the benefits of oral health training

programs may stay in effect for as long as three years, but periodic updating is recommended.<sup>23</sup>

Many dentists are unwilling to treat patients with special health needs. Some dentists lack training in providing services to this population, some are not comfortable interacting with special needs populations, and some find it disruptive to their conventional dental practices and infeasible financially. Ninety-nine percent of special needs patients are Medicaid recipients. Therefore, low Medicaid reimbursement rates, coupled with the extra time it sometimes takes to treat people with special healthcare needs, deter some dentists from serving this population. In addition, some patients with special healthcare needs have equipment needs that private practices are not able to address. Even dentists that treat special needs patients may refuse to treat severely uncooperative or disruptive patients because they lack the expertise or resources needed for these patients.<sup>23</sup>

#### **1999 Task Force Recommendation #20**

*The UNC-CH School of Dentistry, the NC AHEC system, and the NC Community Colleges that offer educational programs for dentists, dental hygienists, and dental assistants should intensify and strengthen special-care education programs to train professionals on child management skills and how to provide quality oral health services to residents and patients in group homes, long-term care facilities, home health, and hospice settings.*

#### **2005 Proposed Action Plan:**

- a) **The UNC-CH School of Dentistry, the NC AHEC system, and the NC Community Colleges that offer educational programs for dentists, dental hygienists, and dental assistants should intensify and strengthen special-care education programs to train professionals on child management skills and how to provide quality oral health services to residents and patients in group homes, long-term care facilities, home health, and hospice settings.**
- b) **The Division of Medical Assistance should enhance the Medicaid reimbursement for patients with disabilities or behavioral problems that require additional time to treat.**

The 2003 NC IOM Dental Report Update considered this recommendation completed, highlighting a number of programs within the UNC-CH School of Dentistry that provide dental and dental hygiene students with training and skills for working with special needs populations, such as child behavior management and dental care for patients with disabilities. These programs are an important step in preparing dental professionals to work with special needs populations and are critical to implementing the recommendation above. However, participants at the 2005 NC Oral Health Summit expressed concern that it is difficult to determine the impact of this training without collecting data to measure the level of service these new professionals provide to special needs populations. Most of the data that are collected focus on dental care for the pediatric population. In fact, data are not being collected to even determine if these students are serving Medicaid patients when they begin their professional positions. Therefore, the Summit participants suggested developing a system to collect data on students receiving oral health training for special needs patients and their professional services to the Medicaid and special needs populations.

Further, it was suggested that special needs training for dental students and practicing dentists should, in addition to clinical instruction, incorporate techniques for scheduling and integrating patients within a more traditional patient base. Skills such as managing and scheduling time for special needs patients, developing a comfort level in treating special needs patients, and learning to make the office comfortable for traditional patients and special needs patients concurrently are integral to successfully treating special needs patients in a private practice environment. Treating some special needs patients may take longer than traditional appointments and if dentists are unfamiliar with how to schedule appropriately, it could prevent them from treating these patients in their practices. One recommendation for addressing this issue was for dentists to set aside a half-day to serve only patients with special needs. It was also suggested that concentrated special needs clinics could be designed to provide the equipment and facility needs that may be unavailable in most dentists' offices and dentists could be encouraged to provide part-time services in those clinics. This could also eliminate dentists' concerns that

traditional patients may feel uncomfortable around special needs patients in the private practice offices.

**Concerns and Issues:** Reimbursement rates are a serious impediment to expanding the number of dentists willing to serve special needs populations. For many, serving this population would require more time to treat, and would result in a lower reimbursement rate per hour than from a privately insured client. Until this discrepancy in reimbursement is at least partially mitigated, it will be very difficult to attract more dentists to serve the special needs population. One recommendation for addressing this issue is the development of additional Medicaid reimbursement codes for services to disabled/special needs populations. A medical and behavioral code could be tied to the medical diagnosis and time required to serve these special needs patients, but this would need to be monitored to ensure no abuse (e.g., “upcoding”) in the use of this code. Summit participants discussed developing a pilot program to serve as a regional resource for patients with special physical, mental, and medical conditions. The pilot could be cost-based and help the Division of Medical Assistance and the General Assembly identify the true costs of care for these special needs populations.

### **1999 Task Force Recommendation #21**

*Support the development of statewide comprehensive care programs designed to serve North Carolina’s special care and difficult-to-serve populations.*

Since the release of the NC Institute of Medicine’s report on Dental Care Access in April, 1999, there have been a number of agencies that have established programs to provide dental services to institutional and other difficult-to-serve populations (see sidebar for examples). Mobile dental care programs have been helpful in reaching special needs patients who face obstacles that keep them from getting to the dentist’s office; however, these dental vans are not available in all parts of the state. Additional work is needed to ensure that these programs are available statewide.

### **North Carolina Programs Serving Special Needs Patients**

Carolinas Mobile Dentistry:

Provides dental care to 1,500 nursing home residents in the Charlotte area.

Access Dental Care: Serves over 1500 patients in Guilford and Randolph Counties.

Special Care/Geriatric Dental Clinic: This special care/geriatric clinic provides dental services to between 600 and 1,000 patients each year.

Fellowship Program in Geriatric Dentistry: This Duke University program is able to serve between 450 and 500 geriatric patients annually.

UNC Hospitals Dental Clinic: Provides inpatient and outpatient services, mostly for medically compromised, geriatric, ill pediatric patients, and operating room cases.

Private practitioners: A few private practitioners specialize in geriatrics, but their practices are not limited to that population.

Individual hospital-based programs: Moses Cone, Wesley Long Community Hospital, UNC Chapel Hill.

Mission Children's Dental: Provides out-patient services for medically compromised and developmentally disabled pediatric patients.



Currently, the Sheps Center at UNC-Chapel Hill has funding from the NC Council on Developmental Disabilities to conduct a three-year demonstration project aimed at improving the quality of medical care for adults with development disabilities. Although not currently in the scope of this funding, the Sheps Center would like to extend the project's focus to dental care. Care coordination for people with disabilities in the program is provided by care managers through Local Management Entities (LMEs) or through Community Care of North Carolina (CCNC). These staff could help train caregivers on how to improve oral hygiene in the home environment.

**Concerns and Issues:** Participants at the 2005 NC Oral Health Summit thought it would be useful to develop a publication outlining state-run and independent organizations that currently provide dental services to special needs patients. These organizations could then be used as models for initiating new pilot programs. This resource could also provide evidence for which dental services are most in need of increases in reimbursement rates.

The group also felt that more collaboration and information sharing between physicians and dentists could accelerate the treatment process for special needs patients. Medication and health histories would help dentists determine what type of behavior they may expect from a patient, and if it is possible to use anesthesia, if necessary. Additionally, physicians familiar with dental health problems could identify oral health needs and refer patients to a dentist when needed. Similarly, there could be consideration of expanding the role of dental hygienists to provide prevention, education, and screening of special needs patients in a physician's office or nursing home. This could emulate the work being done with children and fluoride varnish (See recommendation 18).

## **EDUCATING MEDICAID RECIPIENTS ABOUT THE IMPORTANCE OF ONGOING DENTAL CARE, AND DEVELOP PROGRAMS TO REMOVE NON-FINANCIAL BARRIERS TO THE USE OF DENTAL SERVICES**

Ongoing dental care can have a significant positive impact on the oral health of patients. Therefore, emphasizing this value to Medicaid patients and encouraging them to access regular, preventive dental services should be a major goal of the NC Division of Medical Assistance (DMA). When Medicaid recipients enroll in the Medicaid program, they receive a handbook with an explanation of the program's benefits. Unfortunately, the handbook is very long and many people do not read it fully. As a result, recipients are not always aware of the dental services available to them under Medicaid.

Lack of information is just one of the non-financial barriers keeping Medicaid patients from accessing care. Other problems include finding a dentist willing to serve Medicaid patients, overcoming transportation challenges, and an inability to leave work during normal work hours to visit a dentist.

### **1999 Task Force Recommendation #22**

*The Division of Medical Assistance, in conjunction with the NC Dental Health Section of the NC Department of Health and Human Services, should develop or modify community education materials to educate Medicaid recipients about the importance of ongoing dental care.*

### **2005 Proposed Action Plan:**

- a) **The NC Oral Health Section, within the NC Division of Public Health, should convene a committee, including representatives of the Division of Medical Assistance, NC Dental Society, Medicaid recipients, local health departments and other interested groups, to identify educational materials and develop an ongoing social marketing campaign to educate Medicaid recipients about the importance of ongoing preventive dental care. The committee should also work to create referral systems that would help Medicaid recipients identify dentists willing to treat them.**
- b) **The Division of Medical Assistance should develop a web-based referral database that is available to the public that**

**identifies dentists who accept Medicaid patients, indicates if they are currently accepting new Medicaid patients, and permits dentists to update data about their practice and their availability to serve these patients online.**

No action was taken to implement the 1999 recommendation. In order to implement this recommendation, the Division of Medical Assistance (DMA) will need to determine which educational materials are most appropriate, the best process for distributing those materials to recipients, and how to provide referral services.

The 2005 NC Oral Health Summit participants recommended evaluating existing educational materials from the National Institutes of Health, National Institute of Dental Research, the National Center for Child and Maternal Health, other states, the NC Dental Society, and the NC Oral Health Section to determine how to best develop materials that are culturally and linguistically appropriate for the Medicaid populations. In addition, participants recommended developing other models of communication with patients, such as CDs and the Internet. Informational videos could be used in the offices of local departments of social services, physicians, Head Start, and WIC programs. Additional written materials about the importance of oral health and good dental care could be provided to mothers at WIC screenings and by the NC Baptists Men's medical-dental buses, which periodically travel to every county to provide medical and dental services to special needs groups in the state. Currently, DMA provides written materials through quarterly and monthly mailings.

In addition, participants in the NC Oral Health Summit recommended that the Division of Medical Assistance develop a referral database that patients could access to find dental providers in their local areas. This system should be both web-based and linked to CARE-LINE, the existing NC DHHS information and referral hotline. In addition, dentists should be encouraged to update their information to indicate if they are accepting new patients. Certain counties, such as Wake County, have developed referral lists of dentists and keep them up-to-date. This local model could be used as an example at the state level.

In order to achieve the goal outlined in this recommendation, participants recommended that the NC Oral Health Section take the lead in developing a committee, including DMA, the NC Dental Society, Medicaid recipients, local health departments, and other interested groups, to identify education materials and referral systems that could be effective in serving the Medicaid populations.

### **1999 Task Force Recommendation #23**

*The NC Division of Medical Assistance should pilot test dental care coordination services to improve patient compliance and enhance the ability of low-income families and people with special healthcare needs to overcome non-financial barriers to dental care. The Division of Medical Assistance should evaluate the program to determine if care coordination increases utilization of dental care services. The evaluation should be reported to the Governor and the NC General Assembly no later than January 15, 2001.*

### **2005 Proposed Action Plan:**

**The Division of Medical Assistance should continue to explore and pilot test dental care coordination services through the use of Health Check coordinators, Community Care of North Carolina (CCNC) case managers, or other models to improve patient compliance and enhance the ability of low-income families and people with special healthcare needs to overcome non-financial barriers to dental care. The Division of Medical Assistance should evaluate the program to determine if care coordination increases utilization of dental care services.**

As reported in the 2003 Update on Dental Care Access, the Division of Medicaid Assistance (DMA) tested dental care coordination through Health Check coordinators in some counties throughout the state.

There are currently insufficient care coordinators (through either Health Check or CCNC) to provide dental care coordination for all Medicaid recipients. Thus, participants in the NC Oral Health Summit suggested that dental care coordination be provided to Medicaid patients who have an enhanced risk for dental caries or for complications from dental disease. Populations with such enhanced needs for dental services include those with a history of dental disease, diabetes, heart disease, pregnant women, low-birth weight babies,



children who have chronic conditions, special needs populations, people using the emergency department for dental disease, and nursing home/institutionalized patients. Medicaid patients should be targeted proactively for case management services based on their risk status, or targeted retroactively, according to whether or not the patient did not follow the dental periodicity schedule, or both.

The participants of the Oral Health Summit thought this model should be tested through pilot programs, before implementing it statewide. One possible model would use Health Check coordinators to identify high-risk children through the fluoride varnish program. They could help schedule appointments with referral dentists and arrange transportation. This model exists in some North Carolina counties, but funding is not available to expand it further. Another model is to add dental service coordination to the medical service functions of CCNC case managers. Case managers could provide referrals and support in finding dental homes for children and adults, much like the medical home model now employed in pediatric medical care. Recommendation #17, which suggested developing a dental periodicity schedule, could also be used to guide Medicaid recipients' use of dental services. Medicaid recipients at highest risk could then be identified for case management services based on diagnostic codes on their medical/dental claims or if they do not follow the periodicity schedule. The dental and medical communities will need to work with the Division of Medical Assistance to be sure that a screening periodicity schedule is kept up-to-date. All efforts in this area will require a wide range of partners, including North Carolina dental health professionals, the NC Pediatric Society, the CCNC networks, Health Check coordinators, school health nurses, and other health providers.

***Concerns and Issues:*** Developing a dental home program for Medicaid recipients will be challenging because there currently are not enough dentists actively participating in the Medicaid program. Unlike physicians, dentists do not receive an administrative per member per month fee to manage all of the patients oral health needs. While participants thought that this idea was worth exploring, it would be difficult to implement given the current level of dentist participation in Medicaid. This recommendation would need to be coupled with a

reimbursement rate increase to encourage more dentists to participate in Medicaid and agree to serve as the recipient's dental home.



## ENDNOTES

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<sup>1</sup> The NC IOM held one-day reviews in 2001 and 2003 to determine what action had occurred on the Task Force's recommendations. These updates can be found at: <http://www.nciom.org/pubs/dental.html>. The NC Oral Health Summit (2005) was a further review of progress made on the original recommendations.

<sup>2</sup> North Carolina Division of Medical Assistance, 2005.

<sup>3</sup> Mofidi, Mahyar. Background Paper for Recommendation Section I: Increasing dentist participation in the Medicaid program. North Carolina Oral Health Summit, April 8, 2005. Chapel Hill, NC. Available at: [http://www.communityhealth.dhhs.state.nc.us/dental/images/summit/Background\\_Mofidi.pdf](http://www.communityhealth.dhhs.state.nc.us/dental/images/summit/Background_Mofidi.pdf). Accessed July 2005.

<sup>4</sup> North Carolina Institute of Medicine Task Force on Dental Care Access: Report to the North Carolina General Assembly and to the Secretary of the NC Department of Health and Human Services. North Carolina Institute of Medicine: Durham, NC. May 1999. Available at: <http://www.nciom.org/projects/dental/dental.html>.

<sup>5</sup> Source: Loomis W. Data provided by North Carolina Division of Medical Assistance. Personal communication between Mahyar Mofidi and William Loomis. February 9, 2005.

<sup>6</sup> American Dental Association. State and community models for improving access to dental care for the underserved-A white paper. Chicago, IL: American Dental Association; 2004.

<sup>7</sup> American Dental Association. State and community models for improving access to dental care for the underserved-A white paper. Chicago, IL: American Dental Association; 2004.

<sup>8</sup> Ibid.

<sup>9</sup> Nietert J, Bradford W, Kaste L. The Impact of an Innovative Reform to the South Carolina Dental Medicaid System. Health Research and Educational Trust. 2005;40(4):1078.

<sup>10</sup> NC Health Choice: 2003 Report of the North Carolina Institute of Medicine Task Force on the NC Health Choice Program. Durham, NC: North Carolina Institute of Medicine, Feb. 2003. Available online at: <http://www.nciom.org/pubs/child.html>. Accessed July 2005.

<sup>11</sup> Studies suggest that children enrolled in Medicaid actually receive better care coordination, through Medicaid care coordinators and Community Care of North Carolina, than those enrolled in NC Health Choice. An independent evaluation of NC Health Choice and Medicaid showed that children under age five who subsequently enrolled in NC Health Choice received fewer well-child check-ups once on NC Health Choice than while on Medicaid. Slifkin RT, et al. Assessing the effects of the North Carolina Health Choice Program on beneficiary access to care. Final Report. Submitted to the NC Division of Medical Assistance. Sept. 25, 2001.

<sup>12</sup> Sec. 10.22 of Chapter 276 of the 2005 Session Laws.

<sup>13</sup> North Carolina Institute of Medicine Task Force on Dental Care Access. Durham, NC: NC Institute of Medicine, 1999. Available at: <http://www.nciom.org/pubs/dental.html>. Accessed July 2005.

<sup>14</sup> Participants in the Oral Health Summit lauded the work of Medicaid Dental Director, Dr. Ronald Venezia, for his collaboration with the NC Dental Society and development of a strong relationship between the two organizations. It was emphasized that this type of positive, collaborative leadership role is integral to the continued promotion and expansion of serving the Medicaid population through private providers.

<sup>15</sup> American Dental Association, Health Policy Resources Center. Telephone inquiry by John Stamm, DDS, DDPH, MScD, January 2005.

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<sup>16</sup> North Carolina Health Professions Data System. Cecil G. Sheps Center for Health Service Research. The University of North Carolina at Chapel Hill. Chapel Hill, 2004.

<sup>17</sup> North Carolina Health Professions Data System. Cecil G. Sheps Center for Health Service Research. The University of North Carolina at Chapel Hill. Chapel Hill, 2004. Available at: <http://www.shepscenter.unc.edu/hp/>. Accessed July 2005.

<sup>18</sup> Foundation News. Spring 2005. North Carolina Community Foundation. Available at: [http://www.nccommunityfoundation.org/publications/05\\_news\\_spring.pdf](http://www.nccommunityfoundation.org/publications/05_news_spring.pdf). Accessed May 2005.

<sup>19</sup> Konrad R. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Telephone inquiry by NC Institute of Medicine, July 2005.

<sup>20</sup> Survey of advanced dental education. American Dental Association Survey Center, 1993, 1999, 2003.

<sup>21</sup> The American Dental Association requires that all program directors be board-certified. There are only 3,783 board-certified pediatric dentists in the nation, and not all of them are practicing.

<sup>22</sup> Eden-Piercy GVS, Blacher JB, Eyman RK. Exploring parents' reaction to their young child with severe handicaps. *Mental Retard* 1986;24:285-291.

<sup>23</sup> Samuelson A. Background Paper for Recommendation Section IV: Training dental professionals to treat special needs patients; designing programs to expand access to dental services. North Carolina Oral Health Summit, April 8, 2005. Chapel Hill, NC. Available at: [http://www.communityhealth.dhhs.state.nc.us/dental/images/summit/Background\\_Samuelson.pdf](http://www.communityhealth.dhhs.state.nc.us/dental/images/summit/Background_Samuelson.pdf). Accessed September 2005.

**NC Institute of Medicine**  
**November 2005**

**ERRATA SHEET**

This document outlines an error found in the 2005 North Carolina Oral Health Summit Access to Dental Care report.

On page 9, the document incorrectly reads, “North Carolina children under the age of 21 in the Medicaid population had 41% utilization rates in SFY 2004, compared to rates of 49.4% and 65.2% for children between 200-400% and greater than 400% of the poverty line, respectively.”

Updated data indicate that state fiscal year 2004 utilization rates (the unduplicated number with a full dental visit) for the Medicaid population under the age of 21 years was 31%. In SFY 2005, the utilization rate of this population, as of September 2005<sup>1</sup>, was 32%.<sup>2</sup>

Therefore, the corrected information should read, “North Carolina children under the age of 21 years in the Medicaid population had 31% utilization rates in SFY 2004, compared to rates of 49.4% and 65.2% for children between 200-400% and greater than 400% of the poverty line, respectively.”

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<sup>1</sup> Data for 2005 were not final as of September 2005. Claims may be submitted up to three months following the end of the state fiscal year, June 30, 2005. Therefore the total number of recipients and visits may increase.

<sup>2</sup> Data initially collected by Mayhar Mofidi, from Bill Loomis, NC Division of Medical Assistance, for the 2005 NC Oral Health Summit (February 2005). Updated information provided by Emad Attiah, NC Division of Medical Assistance to the NC Institute of Medicine (September 2005).