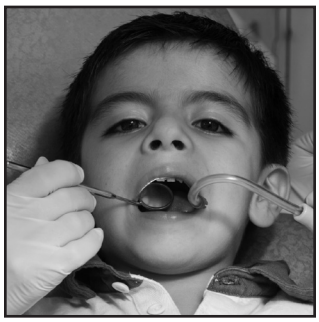

The Centers for Medicare and Medicaid Services (CMS) has challenged state Medicaid programs to increase the use of preventive dental services across the nation.[1] North Carolina ranked among the top 10 states in 2009 for the percentage of children receiving any preventive dental service.[2] Yet access to dental services and utilization of available services continue to remain too low. In North Carolina, approximately 1 million children and young adults ages 1-20[a] were covered by Medicaid in SFY 2012, and almost 200,000 children, ages 6-18 were covered through NC Health Choice.[3] While all of these children had dental coverage, only 49% of children enrolled in Medicaid and NC Health Choice received at least one preventive service from a dentist in FFY 2012.[3,4] (See Appendix C for more information).

While only about half of all children receive preventive dental services in a given year, this proportion varies substantially by age. Both the very young (ages 1-2), and young adults (ages 19-20) are less likely than children or adolescents of other ages to have received a preventive dental service.[b] (Table 3.1)

Table 3.1
Utilization of Any Preventive Dental Services by a Dental Professional by Age (FFY 2012)

	Ages 1-2 years	Ages 3-5 years	Ages 6-9 years	Ages 10-14 years	Ages 15-18 years	Ages 19-20 years
Medicaid	29.0%	55.5%	61.5%	55.8%	40.6%	19.0%
NC Health Choice[1]			59.4%	50.4%	34.6%	

Source: Division of Medical Assistance. Form- CMS 416: Annual EPSDT Participation Report FFY2012. North Carolina Department of Health and Human Services. Division of Medical Assistance. DR2113Health_Choice Preventive_by County SFY 2012. North Carolina Department of Health and Human Services.
[1]NC Health Choice does not provide coverage for children under age 6 or young adults age 19-20.

Untreated tooth decay is more than twice as prevalent among low-income children.[5] As discussed in Chapter 2, children who have untreated dental disease are more likely to miss school, have trouble eating or speaking, and have poorer overall health.[5] Preventive care, which includes cleanings, fluoride treatments, sealants, and space maintainers, is a critical first step to ensuring that children do not develop dental disease or that dental disease is identified early and treated.

Current Efforts to Increase Preventive Dental Services Among Children

The North Carolina Division of Medical Assistance (DMA) engages in a number of activities to promote utilization of preventive dental services. Every six months, the parents of children enrolled in Medicaid and NC Health Choice receive a newsletter with information on why oral health is important, when

a In this report, we will use the term children to refer to the population ages 1-20 unless otherwise noted.
b Preventive dental service refers to a service delivered by a dental health professional. Oral health service refers to service delivered by a medical or dental health professional.

visits should begin, how frequent they should be, and how to find a provider serving Medicaid/Health Choice kids.[c] DMA also sends primary care providers periodic notices about the billing guide, which includes the dental periodicity schedule, to try to encourage primary care professionals to refer patients to dentists and to talk to their patients about when they should take their children to a dentist.[c] North Carolina's Medicaid and Health Choice programs also utilize care managers and care coordinators. (See Chapter 5 for more information.) DMA educates these care managers and care coordinators about the importance of oral health and their role in encouraging families to utilize their preventive dental benefits.[c]

Preventive care is a critical first step to ensuring that children do not develop dental disease or that dental disease is identified early and treated.

DMA also works to increase dentists' participation in Medicaid and NC Health Choice. The Dental Director of DMA and other staff attend the North Carolina Dental Society's annual meeting where they operate a booth to disseminate new dental information and recruit dentists to participate.[3] They also encourage participating dentists to increase utilization of preventive dental screenings and to place sealants on permanent molars.[c] DMA has provider training workshops every two years for dentists. At these workshops they discuss utilization, billing problems, how to submit claims so they will not be rejected, the dental periodicity schedule, and try to answer other questions dentists may have about participating in Medicaid and NC Health Choice.[c] DMA also provides an afternoon session for the staff of any dental providers during annual Basic Medicaid provider training.[c]

Increasing Preventive Dental Services among Children

CMS identified increasing the proportion of children enrolled in Medicaid or CHIP who received preventive dental services by 10 percentage points over 5 years as the first goal in their oral health initiative.[1] The Task Force set the following as goal 1 for North Carolina: increasing the proportion of children ages 1-20 enrolled in Medicaid or NC Health Choice (enrolled for at least 90 days) who received any preventive dental services from dental providers by 10 percentage points, from 45% to 55% for children enrolled in Medicaid and 42% to 52% for children enrolled in NC Health Choice, over a five-year period from FFY 2011-FFY 2015. The Task Force on Children's Preventive Oral Health Services identified existing access barriers and the root causes of these barriers as the first step to identify strategies the state could undertake to achieve the CMS goal. The Task Force focused on families, dental providers, and Medicaid policy.[d]

c Casey, Mark. Dental Director, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication. May 21, 2013.

d The Task Force also looked at what primary care providers can do to increase preventive oral health care utilization. These recommendations are covered in Chapter 5.

Families

- Parents do not bring their children in to the dentist. There is a lack of understanding and appreciation of the importance of preventive dental services (especially for very young children) among some families.[1]
- Low-income families may have scheduling barriers which make it difficult to take their children to the dentist (including problems taking time off work or children out of school, difficulties finding dentists willing to take Medicaid or NC Health Choice, and/or office hours limited to the typical work day).[1]
- Some families may be unaware of Medicaid or NC Health Choice coverage for dental services and what their out-of-pocket cost would be.[1]
- Some low-income families have low health literacy, which makes it difficult for them to navigate the health system.[1]
- Many low-income families have transportation problems.[1]

Dentists

- There are not enough dentists willing to treat very young children.[1]
- There is a maldistribution of existing dentists. In 2011, North Carolina had 4.3 dentists per 10,000 population compared to a national average of 5.8 dentists per population.[6] In seven counties in North Carolina there is one or no dentist in the county.
- Current dental hygiene licensure laws require a dentist to provide on-site supervision to dental hygienists, which limits the ability of dental hygienists to provide preventive oral health services when a dentist is not physically present in the same location.
- Some dentists may choose not to treat Medicaid and/or NC Health Choice children because of discomfort serving low-income populations and/or difficulty serving children with language or cultural barriers.[1]

Medicaid and NC Health Choice Policy

- Dentists are discouraged from actively participating in Medicaid or NC Health Choice because of low reimbursement rates and administrative barriers to enrolling as a Medicaid provider.[1]
- Dentists are also discouraged from actively participating in Medicaid or NC Health Choice because of high no-show rates. The task force also expressed concern that cultural differences may present a challenge to some dentists serving children with Medicaid and NC Health Choice.[1]

The Task Force set the following as goal 1 for North Carolina: increasing the proportion of children ages 1-20 enrolled in Medicaid or NC Health Choice (enrolled for at least 90 days) who received any preventive dental services from dental providers by 10 percentage points from FFY 2011-FFY 2015.

The Task Force developed recommendations to address these barriers. The Task Force prioritized the initial list of potential recommendations based on their potential impact and whether they are actionable and achievable (both politically and financially). Based on this process, the Task Force made four recommendations to increase the proportion of children enrolled in Medicaid and NC Health Choice who receive a preventive dental service each year:

Recommendation 3.1: Increase outreach and education to families of young children about the importance of oral health services

Recommendation 3.2: Support dental care coordination by North Carolina Community Care Networks

Recommendation 3.3: Increase the participation of dentists in Medicaid and NC Health Choice

Recommendation 3.4: Reduce administrative barriers to participation in Medicaid and NC Health Choice

The Task Force made four recommendations to increase the proportion of children enrolled in Medicaid and NC Health Choice who receive a preventive dental service each year.

Increase Outreach and Education Efforts among Young Children and Their Families

The American Dental Association and the American Academy of Pediatric Dentistry (AAPD) recommend that children see a dental provider "at the time of the eruption of the first tooth and no later than 12 months of age.[7]" The AAPD has developed the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children guidelines, which outlines the type of dental care children should receive by age.[7] A modified version of these guidelines is used in the North Carolina Oral Health Periodicity Schedule for children enrolled in Medicaid and NC Health Choice.[8]

As noted previously, very young children are less likely to receive preventive dental services from a dentist than most other children. This is due, in part, to the fact that parents do not always understand the importance of bringing their children to a dentist at a very young age. Parents may also have difficulties finding dentists willing to treat young children (which is discussed more fully in Recommendation 3.3). In order to encourage more parents to bring their young children to a dentist, the Task Force recommended that the state increase efforts to educate families about the importance of early childhood oral health. Not only will this help increase the proportion of young children who receive preventive dental services, but it can help create an understanding of the importance of receiving these preventive dental services throughout the child's life.

By age 5, 36% of young children have had at least one primary tooth treated for tooth decay, and 14% have untreated caries.[e] There are many reasons that preventable oral diseases are widespread among children. Many families do not realize that the bacteria that cause dental caries can be transmitted from parent to child (See Chapter 2). They may not understand that letting an infant suck on a baby bottle for extended periods of time (e.g., when falling asleep) can cause "baby bottle" caries. Further, many families do not understand the importance of taking their young child to the dentist before the child has permanent teeth. Parents may not know how to locate a dentist serving very young children and may be unaware of Medicaid and NC Health Choice dental coverage. Some families and some communities may place less value on caring for and keeping teeth. In order to support better oral health practices, and encourage more people to seek dental care for their very young children, more efforts are needed to increase outreach and education to parents of young children, including pregnant women.[1]

The Task Force recommended that the state increase efforts to educate families about the importance of early childhood oral health.

Many organizations and health care professionals provide services to pregnant women and the families of young children. For example, health care professionals including obstetrician/gynecologists, certified nurse midwives, pediatricians, family physicians, nurse practitioners, and physician assistants provide health care services to pregnant women and young children. Social services, public health, Women's, Infants, and Children (WIC) nutrition agencies, and other community organizations also provide health, nutrition, and social services information to these families. The Task Force recommended that DMA and the Oral Health Section (OHS) of the Division of Public Health work with existing agencies and organizations where families already seek services, to encourage them to educate pregnant women and families about the importance of oral hygiene, and early oral health services. Pregnant women should receive information on how to maintain oral health and the importance of early dental care for their babies at some point during their prenatal care and through birth or parenting classes. Primary care professionals can help educate families with young children about how to maintain proper oral health and can help link young children—particularly those at higher-risk—to dental professionals. Similarly, social service agencies, public health, and other organizations can help educate families about the importance of early oral health services. Far more could be done to get information on the importance of early dental care to pregnant women and families of young children, therefore, the Task Force recommends:

e King, Rebecca. Section Chief, Oral Health Section, Division of Public Health, North Carolina Department of Health and Human Services. Written communication May 31, 2013.

Recommendation 3.1: Increase Outreach and Education to Families of Young Children about the Importance of Oral Health Services

The Division of Medical Assistance (DMA) and the Oral Health Section of the Division of Public Health should:

a) Educate agencies and organizations that interact with pregnant women and young children and their families about how to maintain good oral health for infants and young children, the importance of seeking dental services for children beginning at age 1, and to help link young children, particularly those at high-risk, to dental homes. Outreach efforts should include the following agencies and organizations:

1) Programs serving young children and their parents including local Departments of Social Services, Community Care of North Carolina, local health departments, early care and education providers, Head Start, SmartStart, the North Carolina PTA, the faith community, and others.

2) Programs serving pregnant women and their partners, including WIC and prenatal/birth education classes, offered through health departments, hospitals, local Departments of Social Services, and others.

3) Health care professionals serving pregnant women and their partners and young children, including OB-GYNs, family physicians, pediatricians, certified nurse midwives, physician assistants, and nurse practitioners.

b) DMA should develop a one page document that summarizes the major Medicaid and NC Health Choice dental benefits and information on how young children can receive oral care. DMA should partner with other organizations and agencies to distribute this information to families. Partnering organizations should include those listed above as well as schools, community based organizations, and others.

Expanding Care Coordination to Further Promote Dental Services

Most individuals with Medicaid and NC Health Choice receive care through Community Care of North Carolina (CCNC) a non-profit, practitioner-led, patient-centered medical home model that links more than one million Medicaid recipients (80% of all North Carolina Medicaid recipients), and others

in the state, to primary care practices. There are 14 non-profit regional CCNC network entities across North Carolina covering all 100 counties. North Carolina Community Care Network, Inc. (NCCCN) serves as the umbrella coordinating organization for the 14 networks. The CCNC model was developed recognizing that many factors affect the health of low-income populations, including, but not limited to, access to health care services. As a result, each network includes a broad array of health care providers including primary care providers, federally qualified health centers, local health departments, hospitals, local management entities/managed care organizations, as well as social services agencies, and other community organizations that work together to provide high quality care and care coordination for the enrolled population.

Primary care providers under contract with CCNC receive a per member per month (pmpm) payment from the state to help manage the care provided to their enrolled patients. In addition, the network receives an additional pmpm payment to help pay for care management, disease management, and quality improvement activities; an informatics system that undergirds the quality improvement initiatives; and other resources needed to improve the care provided to the enrollees. As part of this work, CCNC uses a Case Management Information System (CMIS) which provides an electronic record of demographic and claims data for Medicaid enrollees and care management activities.[9] The CMIS system produces "care alerts" which trigger based on claims history and gaps in recommended schedules.[f] There are three alerts that are particularly relevant for children's dental care.[g] The first is a trigger for a missed well child visit. Very young children ages 0-3.5 often receive oral health services during their well child visits. (See Chapter 5.) The second is for children ages 6 months-3.5 years and is to "consider dental fluoride varnishing." (See Chapter 5 for more information on North Carolina's dental fluoride varnishing program.) The third is to "consider recommending annual dental visit) for children ages 2- 21 with no record of a dental visit within the past year. CCNC care managers and care coordinators are supposed to follow up on care alerts for patients.

There are 60 Health Check Coordinators (HCC) located in the 14 NCCCN networks as part of cooperative agreement between DMA, CCNC and the Women and Children's Health Section of the Division of Public Health (DPH). The job of the HCCs is to "assist families [with children enrolled in Medicaid or NC Health Choice] in obtaining medical services and other community services and supports needed by their children.[10]" Their primary responsibility is to follow up by phone when an individual is delinquent on, or has missed, a preventive care visit. Networks get a "care alert" report that HCCs review. They then provide follow up with families whose children have

f Sexton, Carolyn. Care Coordination for Children Project Manager, North Carolina Community Care Network. Written (email) communication. May 20, 2013.

g Sexton, Carolyn. Care Coordination for Children Project Manager, North Carolina Community Care Network. Written (email) communication. May 20, 2013.

care alerts. Through this type of outreach to families, HCCs can help link children to dental homes in their communities. HCCs also provide outreach to new members and to hospitals to work on reducing overutilization by children enrolled in Medicaid and NC Health Choice.

Children ages 0-5 who have certain risk factors[h] may be eligible for care coordination through Care Coordination for Children (CC4C), which is administered jointly by CCNC, DPH, and DMA. The goal of CC4C is to improve young children's health outcomes while reducing their medical costs. CC4C care managers help families connect with needed services and supports (e.g. medical care, child care, and transportation). CC4C care coordinators follow up on care alerts for high-needs children that they are already working with or for whom they are opening a file.

Additionally, North Carolina's CCNC networks are engaging in a number of initiatives to improve children's oral health care. (See Chapter 5 for more information) Each CCNC Network has a pediatric quality improvement specialist (QIS) responsible for working with providers to improve the quality of care provided.(See Chapter 5 for more information) The QISs have begun working with practices to encourage the use of the North Carolina Priority Risk Assessment and Referral Tool (PORRT), which includes a risk screening and referral to a dental home, to increase dental varnishing rates, and to improve the use of electronic health records, which include documentation of the child's dental home. (See Chapter 5 for more information.)

The 60 HCCs across the state provide critical outreach to the approximately 1.2 million children enrolled in Medicaid and NC Health Choice. Average case loads are quite high, which may limit outreach and education efforts. Thus, the Task Force recommends:

Recommendation 3.2: Support Dental Care Coordination by North Carolina Community Care Networks

The Division of Medical Assistance and the North Carolina Community Care Networks should examine whether an additional per member per month payment (pmpm) is needed to expand the capacity of Health Check Coordinators to help families with children enrolled in Medicaid or NC Health Choice understand the importance of oral health and connection to a dental home. The pmpm payment should be increased accordingly if additional resources are warranted.

h Children with special health care needs (chronic physical, developmental, behavioral, or emotional conditions) who require health and related services of a type and amount beyond children generally, those exposed to severe stress during childhood, foster children not linked to a medical home, and other at-risk children may be referred for CC4C services. (Community Care of North Carolina. Care Coordination for Children (CC4C). http://www.communitycarenc.com/emerging-initiatives/care-coordination-children-cc4c/. Accessed June 4, 2013.)

Increasing Dentists Participation in Medicaid and NC Health Choice

Of the approximately 4,600 dentists in North Carolina, less than half of the dentists, or approximately 2,200 dentists provide services to at least one patient enrolled in Medicaid each year and approximately 1,900 dentist provide services to at least one patient enrolled in NC Health Choice each year.[11] Although approximately half of all dentists submitted at least one Medicaid claim last in 2011, the actual number of dentists who actively participate—defined as having at least $10,000 in Medicaid claims throughout the year—is actually much lower. In SFY 2012, of the 1,762 billing providers, 1,240 actively participated in Medicaid; of the 1,499 NC Health Choice billing providers, only 488 actively participated.[11] In SFY 2012, there were four counties in North Carolina that did not have any Medicaid or NC Health Choice dental providers (Camden, Currituck, Hyde, and Tyrrell).[11]

In addition to low numbers of dentists providing services for children enrolled in Medicaid and NC Health Choice, these dentists are not evenly distributed across the state. (See Appendix D.) In many rural areas of the state the number of dentists serving children, particularly very young children, is quite limited. Likewise, in some urban areas, a lack of participation by dentists in Medicaid and NC Health Choice limits access to dental care for children enrolled in these programs. It is critical to enroll as many dentists as possible as Medicaid and NC Health Choice providers and to encourage and support active participation in these programs to improve children's access to preventive dental services. As discussed earlier in the chapter, DMA engages in outreach efforts to increase dentists' participation in Medicaid and NC Health Choice.

Parents of young children may face additional difficulties finding dentists who are willing to treat their children. While there has been an increase in the number of pediatric dentists over the last ten years, the overall number is still limited. There are only 160 pediatric dentists practicing in the state, and in many counties there are no pediatric dentists.[12] While general dentists are more available throughout the state, some general dentists may not feel skilled in treating young children. This is due to limited training in the behavioral, developmental, and dental needs of young children. Although there have been preventive dental care guidelines for young children stating the need for early dental visits for over 30 years, it was not until the early 2000s that the American Academy of Pediatric Dentistry, the American Dental Association, the American Academy of Pediatrics, and others all began recommending the establishment of a dental home by age one.[13] Given the differing views on when dental visits should begin, many dentists may have had limited training in this part of practice. In addition, children with extensive dental caries may need to be treated in a hospital under sedation—which may be beyond the training of general dentists.

One of the primary reasons for low dental participation is the low Medicaid and NC Health Choice reimbursement rates. The Medicaid and NC Health Choice payments for preventive dental services ($27.21/visit) is only 44% of the National Dental Advisory Service (NDAS) median fee; and the current payment of $28.58 per sealed tooth is only 58% of the NDAS median fee.[2] On average, overhead (including rent, clerical and clinical staff wages, and clerical and clinical supplies,) accounts for 62% of the revenues in a general dentistry practice and 57% of the revenues in a pediatric dentistry practice.[14] Although historical experience demonstrates that increasing rates of reimbursement is an effective strategy to increase active dental participation in Medicaid and NC Health Choice, the Task Force felt that, given current financial challenges of the state as a whole, and the Medicaid program in particular, increasing reimbursement rates would not be possible in the near future.

It is critical to enroll as many dentists as possible as Medicaid and NC Health Choice providers and to encourage and support active participation in these programs to improve children's access to preventive dental services.

The North Carolina Dental Society (NCDS) has approximately 3,500 dentist members.(cite http://www.ncdental.org/ncds/Mission_Statement.asp) While some members may be retired, approximately 75% of active dentists in North Carolina are members in the dental society, making the NCDS an excellent purveyor of information to active dentists across the state.[i] Part of the NCDS mission is to "encourage the improvement of the oral health of the public," therefore, advocating for increased dentist participation in Medicaid and NC Health Choice fits within the organization's mission.[15] The NCDS also works with local dental societies on community outreach and legislative advocacy.[j] Through these activities they reach even more dentists in North Carolina. Therefore, the Task Force recommends:

i Parker, Alec. Executive Director, North Carolina Dental Society. Written (email) communication, June 11, 2013.

j Parker, Alec. Executive Director, North Carolina Dental Society. Written (email) communication, June 11, 2013.

Recommendation 3.3: Increase the Participation of Dentists in Medicaid and NC Health Choice

The North Carolina Dental Society (NCDS) should:

a) Partner with the Division of Medical Assistance (DMA) to encourage more dentists to participate in Medicaid and NC Health Choice by:

1) Providing information in the NCDS Gazette about the importance of treating patients enrolled in Medicaid and NC Health Choice.

2) Highlighting dental champions that actively participate in Medicaid and NC Health Choice who can make the business case for participation.

3) Identifying NCDS leaders who can encourage other dentists to participate in Medicaid and NC Health Choice.

b) Partner with DMA to increase the willingness of general dentists to treat young patients. The NCDS can help by:

1) Conducting focus groups or otherwise seeking information from dentists about barriers to treating young children enrolled in Medicaid and NC Health Choice.

2) Identifying local dental champions that can encourage other general dentists in their area to treat young children.

3) Creating a referral system of pediatric dentists willing to take referrals of children with more complex dental needs and/or more difficult behavioral problems.

4) Encouraging dentists to reach out to pediatricians and family physicians in their community to encourage them to use the Priority Risk Assessment and Referral Tool, and to create referral networks into dental homes.

See also recommendation 4.3: Increase private sector efforts to encourage dentists to provide sealants for participants in Medicaid and NC Health Choice.

Removing Barriers to Participating in Medicaid and NC Health Choice

In addition to the low reimbursement rates, some dentists are deterred from enrolling as Medicaid and NC Health Choice providers because of perceived administrative barriers to enrollment. DMA tries to address these concerns at their dental provider training workshops every two years. At these workshops they discuss utilization, billing problems, the dental periodicity schedule, how to submit claims so they will not be rejected, and try to answer other questions dentists may have about participating in Medicaid and NC Health Choice.[3] DMA also provides an afternoon session for the staff of any dental providers during annual Basic Medicaid provider training.[3]

In addition to the low reimbursement rates, some dentists are deterred from enrolling as Medicaid and NC Health Choice providers because of perceived administrative barriers to enrollment.

In order to be paid for services provided to children enrolled in Medicaid and NC Health Choice, all providers, dental or otherwise, must enroll as Medicaid and NC Health Choice providers. The enrollment process includes credentialing, endorsement, and licensure verification. Providers are required to provide information on the counties they serve, their hours of operation, if they have interpretation services, if they serve special needs patients, and the ages and genders of patients they are willing to serve. Dentists must list all staff they supervise in their office, ownership information, and sign the Provider Administrative Participation Agreement, Medicaid Letter of Attestation, Medicaid Provider Certification for Signature on File, and Electronic Claims Submission Agreement.[16] Applications are reviewed and approved or denied by Computer Sciences Corporation (CSC), the fiscal intermediary for Medicaid and NC Health Choice, on behalf of DMA. Additionally, as required under Sections6401(a), 10603 and Section 1866(j) of the Affordable Care Act (ACA), providers must undergo additional screenings and trainings including training on the Basic Medicaid/Health Choice Billing Guide, audit procedures, how to identify and report fraud, and Medicaid recipient due process and appeal rights.[17] Once approval is granted, providers are assigned a Medicaid Provider Number with an effective date and are notified by mail.[18] At the time of enrollment, providers are charged a $100 enrollment fee.

Medicaid and NC Health Choice providers must be re-credentialed a minimum of every three years by CSC. Providers receive a notice and instructions from CSC when it is time to be re-credentialed. When it is time to be re-credentialed providers must verify the information on file and furnish additional information on ownership. CSC also conducts a criminal background check and queries the Federal and State practitioner databases, as required by federal and state regulations.[17, 18] Providers are charged a $100 fee every time they are re-credentialed.

Two changes made by DMA, as part of the implementation of the Affordable Care Act, impact dentists who want to enroll or be re-credentialed as Medicaid and NC Health Choice providers. Beginning in October 2012, DMA implemented federal regulations 42 CFR 455.410 and 455.450, which require all providers

to be screened according to their categorical risk. In 2011, the North Carolina General Assembly passed Session Law 2011-399, which details which types of providers fall into each of the three categorical risk levels for Medicaid and NC Health Choice providers. Under Session Law 2011-399 dentists were classified as "moderate" categorical risk providers. As moderate categorical risk providers, dentists must undergo additional screening and an on-site visit as required by federal law.[k] The Affordable Care Act also required that DMA begin collecting a federal application fee, required under Section 1866(j)(2)(C)(i)(l), from certain Medicaid and NC Health Choice providers to cover the cost of screening and other program integrity efforts. CMS sets the application fee, which is $532 for 2013, and collects the fee for each site location prior to enrolling or re-enrolling a provider.[19] DMA has determined that in North Carolina the fee does not apply to individual dentists, but does apply to solo incorporated and group dental practices.[l] However, federal policy guidance from CMS to the states providing information on how to interpret the requirements of the Affordable Care Act states, "this requirement does not apply to individual physicians or non-physician practitioners.[m]" The chief dental officer for the Centers for Medicaire and Medicaid further clarified that the federal application fee required under Section 1866(j)(2)(C)(i)(l) is meant to apply to large group physician practices and hospitals, not to non-physician practitioners such as dentists.[n]

Many dentists are unaware of the new fees or the classification of dentists as moderate categorical risk providers in North Carolina Session Law 2011-399. Dentists interested in enrolling and those who must re-enroll are often surprised by the new on-site visits and other additional requirements for credentialing. The Task Force is concerned that these new requirements may deter dentists from participating as Medicaid and NC Health Choice providers.

In addition, at the time this report was being written, there has been discussion about whether to change the structure of the North Carolina Medicaid program from one that is largely fee-for-service, administered through the Division of Medical Assistance, to one where the state contracts with Comprehensive Care Entities—essentially managed care organizations—that would take responsibility for managing all of the Medicaid recipients health care needs, including medical, dental, and behavioral health. Some of the task force members were concerned that this move could result in lower dentist participation in Medicaid. Unlike at least 19 other states that had managed dental ambulatory health plans (as of 2011), the North Carolina Medicaid program has never contracted with dental managed care organizations.[20] Further, dentists in North Carolina have not had

k 42 CFR Section 455.432

l Casey, M. Dental Director, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication. June 6, 2013.

m Mann, Cindy. Director, Center for Medicaid, CHIP and Survey and Certification. CMCS Informational Bulletin December 23, 2011. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf

n Mouden, Lynn. Chief Dental Officer, Centers for Medicare and Medicaid Services. Oral communication. June 21, 2013.

much experience with managed oral health programs in the commercial market. In 2011 (the latest data available), there were only 3 dental HMOs operating in North Carolina (Table 3.2). Together, they covered approximately 50,000 people across the state. The companies, had—at most—contracted general dentists in 13 counties. Given the relative inexperience of the North Carolina dental community with managed dental health plans, the Task Force was concerned that any move to capitation for oral health services could create barriers to dentist participation in Medicaid.

Table 3.2
North Carolina Dentists Participating in Single-Service Dental Managed Care Plan (2011)

	Enrollees (2011)	NC General Dentists (NC counties)	NC Oral Surgeons (NC counties)	NC Orthodontists (NC counties)	NC Other dental specialists (NC counties)
Aetna Dental	26,022	151 (13)	4 (3)	20 (7)	12 (2)
American Dental	2,704	15 (6)	4 (2)	2 (2)	4 (3)
Cigna Dental	22,775	119 (13)	4 (3)	23 (8)	25 (15)

Source: North Carolina Department of Insurance. Managed Care Annual Filings. HMO Single Service, 2011. http://www.ncdoi.com/MR/MR_MC_Annual.aspx. Accessed June 7, 2013.

To reduce barriers to dental health professionals participating in Medicaid or NC Health Choice, the Task Force recommends:

Recommendation 3.4: Reduce Barriers to Participating in Medicaid and NC Health Choice

a) The Division of Medical Assistance (DMA) should encourage more dentists to participate in Medicaid by reducing administrative barriers, including conducting outreach to dentists to help them understand the enrollment, certification, and other administrative processes involved with Medicaid.

b) The North Carolina General Assembly should modify Session Law 2011-399 to change the classification of dentists from moderate to low categorical risk providers.

c) DMA should revise their policies so that solo incorporated dentists and group dental practices are not charged the federal application fee.

d) DMA should study the likely impact on dental participation, before making any changes to the Medicaid and NC Health Choice payment structure for dentists, including, but not limited to, moving from fee-for-service to capitation. DMA should not take any steps that would adversely impact on participation.

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2. Casey MW. The state of medicaid and CHIP dental services in North Carolina. Presented to: Task Force on Children's Preventive Oral Health Services; December 14, 2012; Morrisville, NC. http://www.nciom.org/wp-content/uploads/2012/11/OH_Casey_12-14-12.pdf. Accessed June 3, 2013.

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