Access to Medicaid Dental Services for Elderly and Special Care Recipients

Study Commission on Aging

October 23, 2008

The Problem: Needless Oral Pain and Infection, Systemic Effects and Loss of Self-esteem

- People with disabilities and the institutionalized aged often have:
  - More dental disease
  - More missing teeth
  - More difficulty obtaining dental care than other segments of the population
- Persons with developmental disabilities residing in community settings have significant unmet health care needs – including oral health needs
- The situation is even worse for the aged and disabled living in rural and remote areas

Effect of Oral Problems on Daily Living

- Mastication
- Nutrition
- Behaviors
- Socialization
- Employment
- Education

Associations Between Poor Oral Health and Systemic Complications

- Diabetes Mellitus
- Adverse Birth Outcomes – low birth weights
- Failure to thrive
- Stroke
- Brain Abscess
- Bacterial Endocarditis
- Respiratory Diseases

Trends that Affect Access

- Deinstitutionalization/more focus on health care delivered in community settings
- “Graying of America” – increased numbers of persons age 65 or older – projected to reach 80 million by 2050
  - Medical advances lead to the aged & special care patients living longer, more productive lives
- Increased numbers of persons being diagnosed with special needs diagnoses
  - Example – autism, dementia, etc.
- More older and special needs adults are retaining their teeth longer in life

Trends that Affect Access – Provider Workforce Characteristics

- Dentists do not receive adequate training to care for people with:
  - Complex medical problems
  - Physical disabilities
  - Behavior challenges
- Dental school accreditation standards don't require special care training in pre-doctoral education
  - "Graduates must be competent in assessing the treatment needs of patients with special needs"
- Declining dental workforce – the number of active dentists per 100,000 US population has been decreasing since 1994 (Source: ADA Dental Workforce Model 2001-2005)

Problem: Access to Care

- Surgeon General's Report in 2000: "Oral Health in America"
  - Noted that "although there have been gains in oral health status for the population as a whole, they have not been evenly distributed across subpopulations
  - Profound disparities exist including:
    - Racial and ethnic minorities
    - Individuals with disabilities
    - Elderly persons
    - Individuals with complicated medical and social conditions
- Access problem exists and due to trends noted before it's growing

Financing Oral Health Care for People with Complex Health Needs

- High correlation between:
  - Disabilities and low income
  - Low income and poor oral health
- Oral health care for people with complex health needs takes considerably more time and expertise
- Medicaid dental benefits for adults are often limited in most states – optional service under Social Security Act
  - NC one of a minority of states that offers fairly comprehensive dental benefits for adults
- Dental providers have a choice

Barriers to Access

- Problems unique to Medicaid
  - Poor reimbursement
  - Administrative burdens – enrollment, claims/billing, prior approval, etc.
  - Limited provider networks
- Dental education & training
- Lack of evidence-based practice guidelines for persons with complex health care needs
- Dental reimbursement codes (CDT) are developed for the provision of care to healthy individuals
- ADA Claim Form does not allow the use of modifiers or diagnostic codes (unlike medical claim forms)
  - No way to identify a patient as having complex health care needs or to justify the use of more time and resources needed to care for that individual

Limiting Factors that Affect Access from Provider Perspective

- Increased legal duties/risks – greater need for consent for all procedures
- Need additional staff for treatment
- Complicated medical, pharmaceutical and behavioral histories
  - ⅔rds of general dentists cite behavioral difficulties as number one reason for not treating special care patients
  - Premedication needs and risks/requirements associated

Strategy: Development of Special Needs Code (SNC)

- Mission:
  - Create access to comprehensive care – overcome the twin evils of pretend care and supervised neglect
  - Reduce the amount of more costly hospital OR care
  - Offer training and limit the use of code to trained providers
  - Seek to provide care utilizing the least amount of restrictive techniques to ensure safe treatment of patients with special needs
  - Create statewide network and safety net backup
  - Develop multidisciplinary consultative resources/integrative oral health care provider community (dental and non-dental providers)

Strategy: Development of Special Needs Code(SNC)

- What is It?
  - CDT code D9920 – behavior management, by report
- Who is eligible to provide the service?
  - Credentialing of dental providers–
    - By education – graduates of pediatric dentistry residency, hospital-based general practice residency, geriatric or special care fellowships
    - By training – AHEC or UNC sponsored CE courses
      - Possible competency exam – NM has didactic and clinical component – must demonstrate clinical competency
    - By documented work experience – required number of hours treating the elderly and/or special care patients

Strategy: Development of Special Needs Code

- Who can receive the service?
  - Special care patients of all ages with specific medical diagnoses – autism, cerebral palsy, Alzheimer's, muscular dystrophy, etc.
  - Behavior management for uncooperative patients with less complex health needs?
- Where is it currently being employed for Medicaid recipients?
  - New Mexico, Arizona, South Carolina have implemented
  - Utah, California and South Dakota have proposed adoption

Special Needs Code: New Mexico Medicaid

- Centralized training collaborative – University of NM and Department of Health
- Implemented in 1995 – currently have 40 trained providers (77 have started program – 57 dentists and 20 hygienists) – 26 actively treating special care
- SNC can be used for children and adults with DD diagnoses – some limits – no stroke or brain injuries
- Recipient travel is often required – NM is a large state with fewer urban areas than East Coast states
  - Two institutional clinics act as consultation source and/or referral source for patients with excessive needs or difficult behavioral challenges

Special Needs Code: New Mexico Medicaid

- From SFY 1995-2006 estimated patient visits = 37,000
- Approximately 3000 patients served each year
- In SFY 2008, about 4400 patient visits with total expenditures for D9920 at roughly $400,000
- D9920 reimbursed at about $90.00 per visit (90% of the NDAS national market-based median)

Special Needs Code: Challenges for NC Medicaid

- Much larger recipient population than NM
  - Adoption of D9920 most likely will require more state funds in NC
- Much larger provider network in NC – good and bad
  - Challenges in providing training
  - Challenges in verifying proper utilization of SNC (Arizona has had difficulty with overutilization of SNC)
- NM has limited to DD diagnoses
  - What about strokes, Alzheimer's, brain injuries, etc?
- Where is our SNC?
  - Pediatric dentists will want to use the code for preschool recipients with behavior management problems
  - Other provider types – PCPs, surgeons, others – argue that enhanced reimbursement needs to be global, not just dentistry

Special Needs Code: Challenges for NC Medicaid

- Information system limitations
  - No way to enter medical diagnosis on dental claim
  - No way to link patient's medical diagnosis from medical claim to dental claim
  - Would have to rely on "honor system" with providers – practice diligent post-payment review to verify diagnoses and eligibility for use of SNC – NM has same problem and requires provider documentation in the record
- Budgetary climate
  - Expansion of services in a time of fiscal restraint?
  - Adult dental services are often viewed as expendable since they are optional services
- Threats of audits from regulatory agencies
  - Reimbursement for code without a service?

Keys to Success

- Advocacy – all stakeholders
  - Special thanks to Access Dental and Carolinas Mobile Dentistry
- UNC and ECU SOD buy-in for training and treatment
- Provider recruitment
  - What if we build it and no one comes?
- Creating a collaborative – from policy development through continued treatment
  - Identify network providers who will treat special care patients
  - Integrative/team approach will ensure that each recipient will receive treatment in a clinical setting appropriate for their needs
- Learn from the approaches of other states – don't throw $ at the problem – need a well-designed initiative to succeed
- State government support for policy change and FUNDING!

Division of Medical Assistance
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www.ncdhhs.gov/dma/dental.htm

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