Improving Children's Oral Health Using Fluoride Varnish in Non-Dental Settings

Recorded September 18, 2020

Stephanie Kelly:

Before we begin, let's learn a little bit about who you, our webinar participants are. You will see a poll open on the right-hand side of your screen. You will have 30 seconds to respond.

For our first question, please tell us which type of organization you represent. Please select all that apply. The polls are now open.

State Medicaid or CHIP agency, health or dental plan or health system administrators, dental providers, other health care providers, community or advocacy organizations, other state or local agencies, federal agencies, and other. And just want to note, after you make your selection, please be sure to hit the submit button in the lower right-hand corner.

Thanks, everybody. So, the poll indicates that we are joined largely by our state Medicaid or CHIP agency partners, followed by other state or local agencies. We have a couple of health and dental planner health system administrators and some providers, so thanks everyone for joining us today. Next slide, please.

For our next poll question, please tell us whether your organization has engaged in any oral health quality improvement efforts, indicating whether that quality improvement effort was specific to fluoride varnish services. The poll should now be open. Your answers are, yes, specific to fluoride varnish; yes, but not specifically related to fluoride varnish; no; or I do not know. And please click the submit button in the lower right-hand corner of your screen once you're done voting.

Thanks everyone. So, it looks like, indicated by our poll results, that about half of you have participated in QI initiatives specific to fluoride varnish, and nearly 20 percent have participated in other quality improvement initiatives, so that's really great to hear. And I would like to now turn it over to my colleague, Andy Snyder from CMCS to kick us off.

Andy Snyder:

Great. Thanks so much, Stephanie. Let's go ahead to the next slide. So, my job here today is to welcome you all to this call, and I do want to welcome you and thank you for making time on a Friday afternoon to join us to hear about some great activities that are going on in states, related to making sure that kids can get the preventive oral health care that they need and working to provide that care in primary care medical settings.

I lead the Center for Medicaid and CHIP Services Oral Health Initiative work. I've worked in dental policy for about 15 years, and we, at CMS have been working to improve kids' access to preventive dental care and preventive oral health services, and we look at fluoride varnish as a very promising pathway to do that, both for delivery of an effective preventive service, and also for the connection that families can make in the primary care setting to ongoing dental care.

So, I very much want to thank our state partners for being with us here on the call today. You will hear a little bit from both Maine and North Carolina, who are states that really have some great well-developed programs that I'm excited for you all to hear about. Let me just do speaker bios right now.

You will hear, first, from our team from Maine. You will hear from Dr. Amy Belisle, who is the chief child health officer for the Maine Department of Health and Human Services. Prior to this position, she worked for eight years as a senior medical director and director of Child Health Quality Improvement at Maine Quality Counts/Qualidigm. With her will be Cassie Grantham, who is the director for Child Health at MaineHealth. In this role, she oversees a variety of programs related to children's health, including From the First Tooth Initiatives.

And then we will hear from a team from North Carolina, including Dr. Rhonda Stephens who serves as a public health dentist for the Oral Health section of the North Carolina Division of Public Health. In this role, she's responsible for grant administration, development and implementation of statewide strategies for oral disease prevention, and she oversees the dental Public Health Residency Program, and she is joined by Dr. Mark Casey, who is the dental officer for the North Carolina Medicaid Program, a position he's held since September 2006. Prior to this position, he worked for nearly 20 years as a clinical dentist in various public health settings. So, let's go ahead to the next slide.

Just to tell you a little bit about where this webinar fits in our quality improvement offering, so this is the second webinar that we've had in the series. We've had one previous one about silver diamine fluoride. And still to come are two more webinars, including an informational session that is an opportunity for a Q&A discussion on the Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Affinity Group. That's going to be held Thursday, October 15, from 3:00 to 4:00 p.m. Registration for that is using the same pathway you used for this webinar. And we also, before the close of the expression of interest period for the Affinity Group we're offering for states, we're going to have one more kind of lead-up webinar, that's specifically going to look at some state practices around medical and dental care coordination. We don't have the date for that one entirely pinned down yet, but it will be in October or November.

So, the expression of interest form for state teams, including state Medicaid agencies that want to participate in our learning collaborative and Affinity Group offering is available now posted on our Medicaid.gov website, and the EOI period is open through November 18th. After the close of the period, we will do a review of the applications that we get, and notify applicants of their acceptance to the Affinity Group by December, and then with the start, the Affinity Group to be in January of 2021.

If you've got any questions about what this technical support offering looks like, or if you want to talk through an idea with us, we certainly welcome any contact from states, and you can reach us by e-mailing the TA mailbox that's on your screen right now at MACQualityimprovement@mathematica-mpr.com. Next slide.

So, a little bit more about what this Affinity Group and technical support offering is. So, our goal here is to support state Medicaid oral health teams over two years to improve the use of fluoride treatments. Particularly, we're interested in fluoride varnish that we're talking here today about, because pretty much every state covers it, but utilization of that service in the primary care setting isn't really where we would like it to be yet, so that identifies it to us as a ripe target for quality improvement efforts.

Participating state teams also have the opportunity to expand their knowledge of oral health policies, programs, and practices, and also develop, implement, and assess a data-driven quality improvement

project using the stable quality improvement coaches that, and also connections we can help make to, you know, important resources in the field. We'll give you a chance to network with your peers and to advance your knowledge and skills in quality improvement methodologies, which we know is something that states are interested in, but you may be starting from a place where you don't feel like you have great fluency in QI. That's okay. We can help you gain that.

Just a note here, there is no funding attached to the Affinity Group but there are technical assistance resources. That is what we can provide. And, again, reach out to us with any questions. We are happy to talk.

Right now, I am going to turn to my colleague, Dr. Natalia Chalmers, who is the brand new, within the last three weeks, dental officer in CMS, just to provide a couple of welcoming remarks. Natalia.

Natalia Chalmers:

Hi everyone and welcome to the webinar. My name is Dr. Natalia Chalmers. I'm a board-certified pediatric dentist, and before joining CMS, I served as dental officer for the Food and Drug Administration. First, I would like to take a moment and thank all the health care providers on this call. You make incredible difference for our beneficiaries every day. Thank you. I know the Covid pandemic has made things a little more challenging, and yet it's inspirational to hear how you are providing the best care in the safest possible way.

I'm honored to serve as the only dental officer at CMS, and I am committed more than ever to help the children, adults, and seniors and do anything I can to bring equity and awareness to the importance of oral health. With one word, I'm here to support you. And thank you again for joining us. You are, indeed, here for a treat and hear two fantastic stories from our states. Andy, back to you.

Andy Snyder:

Great. Thank you so much, Natalia. Now if we go on to the next slide, I would like to hand things over to our team from Maine from the First Tooth Initiative. Dr. Belisle, you have the floor.

Amy Belisle:

Thank you very much, and I'm here with Cassie Grantham, who represents From the First Tooth. I kind of have two roles, as they touched on before. First, I was working with a quality improvement organization when this project that we'll talk about, and then second, now I with Maine DHHS, and we'll talk about some of the Medicaid policies of the state. Go to the next slide. Go to the next slide.

So, I just we want to show you how our state has really tried to improve preventive oral health services for children in primary care settings, provide an overview of some of the work that's happened in Maine, and that was really kickstarted from the From the First Tooth organization. And then when you're really approaching your quality improvement and your work in your state, there's a lot of things that need to come together to make it successful, including getting reimbursement for oral health services, making sure that you've engaged and trained your primary care providers, and that they also have workflows that they can incorporate this into their workflows and their office so that they're able to really see a lot of patients and do the fluoride varnish, as well as the risk assessments.

And then it's also very important to work on how do you manage referrals out to dentists and do that care coordination between primary care and the dental offices to make it easy for families to get their oral health care issues addressed. Next slide.

So, before we had federal funding, a CHIPRA grant in the state, From the First Tooth had actually been working with practices for over ten years on improving children's oral health in the state, both around policy and payment and training. So, Maine was the recipient, with Vermont, on a federal CHIPRA grant between February 2010 and 2016. And looking back on this time, this is really significant for the state. It allowed us to have funding in the state to really build quality improvement infrastructure in the state, and address preventive health services. We also had funding to do evaluation data on the projects that were happening, and this really allowed us to take a lot of projects that were locally developed or done by health systems and build them out into a statewide focused improvement of services.

At the time, Maine Quality Counts was a subcontractor on the grants that went through the Maine Medicaid program, and we did four learning collaboratives on preventive services that included work on improving our immunization rates, developmental screening, healthy weight and oral health. And we targeted practices that enrolled a high volume of children enrolled in our MaineCare program, and this actually allowed us to shift some of our population-based methods and outcome metrics by doing that. Go to the next slide.

So, as part of the CHIPRA grant, the state had already been paying for fluoride varnish, and an oral health risk assessment was developed based on national models. MaineCare opened up the D0145 billing code for an oral health risk assessment so that providers could do both things in a visit. Practices were trained on both the oral health risk assessment as part of a learning collaborative, and those learning collaboratives were about 8 to 12 months long, and we did kind of a standardized IHI model, where we had in-person sessions and webinars, and we did monthly data collection and tracked their progress.

The other piece is sustainability. It's that the oral health risk assessment was built into the electronic medical record in many of the practices, and many of them were able to automate their billing back to the Medicaid office. When our CHIPRA funding did end, From the First Tooth continued to work with practices, and Cassie's going to talk about all the work that's been happening. And in the state, we started to build more infrastructure around oral health, and the Partnership for Children's Oral Health has been developed over the last couple years, which is funded by a local foundation. Go the next slide.

In terms of the roles of the Medicaid agency, when we were doing the CHIPRA grant, actually, the states were the main convener of the work. They were the recipients of the CHIPRA grant. It was really important for the state to lead on this and bring a lot of different sectors together to do work to improve preventive services to children.

The other thing is that we're able -- the Medicaid agency was able to get a lot of buy-in from other groups in the state working on children's health issues like the CDC and the maternal/child block grant and other organizations, especially working with the dentists and medical providers that they had on different advisory groups. And the state role was helping to lead the effort and helping to develop policy, but also as a payer with the Medicaid and opening up billing codes to provide reimbursement. We heard from a lot of practices that without the additional reimbursement, it would be hard for them to sustain the quality improvement work.

The other thing we found with the CHIPRA grant is that many of the private payers in the state were happy to have the Medicaid agency trial and pilot this and to get it to work with primary care practices,

and then eventually many of them came on to cover the codes, the payment codes. So, that was important, kind of as, you know, they were kind of out front for the state and the payers.

The other thing that happened during this time, as you know, is the Affordable Care Act was passed, and so the CHIPRA grant, the Affordable Care Act, and a lot of the work that's happening around quality improvement really aligned together to improve children's health quality in our state. Go to the next slide.

Currently, so I switched to a different role. I'm the child health officer for Maine DHHS now for the past year. We have seen, with the Covid pandemic, that the number of preventive health services and primary care visits did decline between the time of March and June in our Medicaid data, so one of the things that our Department of Health and Human Services and Medicaid agency is doing is providing $3.7 million in incentive payments to primary care offices and dentists to improve preventive services.

So, we're offering additional $31 per member per month for primary care providers who are doing well visits and immunizations to try to encourage catch-up childhood vaccines, the flu vaccine, and then for those who are providing dental services, including oral health assessment, including fluoride varnish with a visit, they would get a $37 per member per month. A primary care office that is doing both well visits, vaccines, and oral health together can qualify for both. So, we're really trying to support primary care so they can reach out to families, provide comprehensive services to cover some of the cost of PPE that's required during Covid.

The other thing that Medicaid is doing is providing this incentive payment to those who are taking care of children who are under the age of 21 at the start of the pandemic to try to get kids caught up, even though they might have aged out of MaineCare by now. So, I'm going to turn this over to Cassie Grantham, who helped lead this From the First Tooth program at Maine Health. You can go to the next slide. And they were our strong partners throughout this group, and they have really helped to sustain the quality improvement work in the state after the CHIPRA grant was done. Cassie says she's not unmuted.

Cassie Grantham:

There we go. Can everyone hear me now?

Yes.

Thank you. Okay, fantastic. Sorry about that technical difficulty, folks. So, I am here to talk a little bit more specifically about the From the First Tooth initiative and our timeline, our implementation and lessons learned. As Amy said previously, you know, the goal of this program is to improve the oral health of Maine's children by increasing access to preventive oral health services.

In the State of Maine, it can be really challenging to find dental homes for children with Medicaid because fewer dentists than needed accepts Medicaid in Maine. We have one county that has no dental providers accepting Medicaid. So, this initiative really does fill a major gap in care, although we, of course, want children to have dental homes.

We integrate early oral health as a standard of care for all children from birth through age five, at well-child visits. And we have four components to the program, an oral health risk assessment, application of fluoride varnish, parent/caregiver education, and referral to a dental home. We work on educating the medical team on how to provide anticipatory guidance to parents and primary caregivers, both on behavioral risk factors and preventive measures that can impact the prevalence of early childhood caries,

and we're hoping that this approach ensures that Maine's children will have access to preventive oral health services within their family centers and comprehensive primary care medical homes.

On this slide you see the phases of the implementation, and, really, those are more about who was funding our initiative at the time, and just to show you that this has been going on for quite some time. Next slide, please.

So, we provided our key driver diagram because we wanted folks to be able to see what our aim and drivers were. It's giving you a good indication of what our work plan looks like and how activities worked in concert to achieve the specific aim. We're always trying to use a QI methodology to drive program implementation and improvement, and you see this is similar but slightly different than a logic model. This is just for your reference in case you're looking at this kind of program in your own state. Next slide, please.

The process for bringing folks into the program, we do recruit. We do ask practices to participate with us. Sometimes they're clamoring for that opportunity and other times it's more of a push/pull. We do provide a lot of support and technical assistance. We work with practices to assess their readiness and conduct some process mapping around where this program will sit within the workflow of the practice. Then we have several training opportunities.

And one thing I wanted to mention, since we are still in the middle of our Covid pandemic, is that a lot of these options, obviously, have now had to move virtually, and we have a Maine-specific virtual training that is focused on our program, and then we've also developed a toolkit to provide practices, so we can actually walk them through a lot of this work virtually now, whereas before, implementation and pilot week you see below, we were hands on for much of the pilot week, literally in the practices assisting folks, so that has changed significantly. Next slide, please.

This is just to show you that, you know although we think we have a great program, sometimes it is challenging to initiate work with some of our practices. You can see here who we've trained, who's been hardwired, which is the process by which we ask folks to help us get this information into their EHR system, and we also ask for all of the folks to be trained, to be hardwired.

Before the First Tooth, I'm not going to get into today, but I just wanted to let you know we did have even earlier perinatal program. It was funded by a HRSA grant, and that has, unfortunately, finished. The work can still go on, but it is a little more limited. Next slide, please.

Just wanted to share with you what our oral health risk assessment looks like, and we did use this as the basis for integration into different EMRs. Next slide, please.

Resources and education materials, just to give you a sense of the suite of materials that we do provide, as Amy was talking about, billing and coding is one of the most frequently requested pieces of information we get, just because this is obviously being incorporated into primary care, and it can be a little challenging for folks to figure out how to drop those codes appropriately. But now we have a CPT code, which makes things a lot's easier in primary care. Next slide, please.

Amy is just briefly going to talk about the reimbursement for oral health. I think we're going to be pretty quick here just because we know we're running out of time.

Amy Belisle:

Just to say that MaineCare does cover the D1206 code and the 99188 CPT code for fluoride varnish. That's been added in the past year-and-a-half. We found that a lot of groups were billing that code to the private insurers, so it needed to be added to the main MaineCare list. And MaineCare also covers the D0145 code up to age 3 for the oral health risk assessment.

Cassie Grantham:

Great. Thank you. Next slide, please. We just wanted to show what our typical workflow looks like for providing the program in a practice. Obviously, we looked to have everyone within the practice work to the fullest extent of their capability and their licensure, so we do ask for medical assistants or clinical support staff to take quite a big role in this initiative, and it works really well in concert with our health care providers in the medical homes. Next slide, please.

Just sharing a couple of our measures that we utilized over time to track our success, and we have worked with an independent evaluator to assist us with making sure we can pull these measures for Medicaid, as well as for those with private insurance. Next slide, please.

Just a couple of quality improvement strategies since we are working on a quality improvement webinar today. We did work with our MaineHealth accountable care organization to incorporate oral health into the pediatric dashboard that we utilize with practices, and that was very effective at, you know, raising awareness around the program and what it can offer, as well as trying to get folks to compete against each other to raise those rates, so just an example of one of our data reports. Next slide, please.

So, our key takeaways, we hope that we've shared with you a little bit about how we collaborate with primary care practices, the workflows that are utilized, and how to improve them. We really encourage leveraging data to track and support this work obviously. It helps to be able to see where you are and where you need to go. We still have a long way to go. We think our program is fantastic, but we definitely need to engage more with pediatric primary care and dental providers to get this program further into the state.

Facilitating payment for oral health risk assessments in pediatric primary care settings was a big win, and I think, you know, making sure that you are incorporating how to meet population health goals around oral health into your program will set you up for success long-term, and enable you to track things over time for to report on successes and progress. I think that's our last slide, so I will turn it back over to our leader.

We have some appendices I should mention. Sorry. Yes, our appendices are in there, but we won't be going through them. You can use them as reference.

Andy Snyder:

Great. Thank you so much. And the slides and the recording of this webinar will be made available on the Medicaid.gov quality improvement webpage for this project, which we will make sure that all of our attendees get the link to a few days after this webinar concludes. So, with that, I want to thank our main keynote of the presentation. I think all of the thought and work you put into both having a quality improvement process, and also working with practices through the steps of actually incorporating the sort of new activity into your workflow is very important and a key thing for states to think about.

But now we are going to turn to North Carolina for a presentation about Into the Mouths of Babes. Dental has so many terrible puns. I think this is a fantastic pun, and I am going to turn to Dr. Rhonda Stephens with North Carolina to take it from here. Dr. Stephens.

Rhonda Stephens:

Thank you and good afternoon all. Again, my name is Rhonda Stephens, and I'm with the North Carolina Oral Health Section, where our primary care fluoride varnish program Into the Mouths of Babes, or IMB, is housed. Next slide, please.

Before I get into the details of IMB, here is a general overview of Medicaid in North Carolina. Over 10.5 million residents, approximately 20 percent are Medicaid or Health Choice beneficiaries. Health Choice is our CHIP program for children ages 6 to 18. Approximately 17 percent of beneficiaries are age zero to five, which is the population of interest when we're talking about physician fluoride varnish initiatives.

We started rollout of Medicaid managed care early last fiscal year. But due to a state budget impact, and now the pandemic, the process has been delayed. However, we are slated to resume implementation in July of 2021. Under such, dental services by dental professionals are completely carved out. They will remain fee for service. Preventive oral health services in primary care will continue under managed care; however, the services will be reimbursed fee for service rather than being rolled into a capitated rate. And lastly, just for a bit of context, we are a state that offers comprehensive adult dental benefits. Next slide, please.

So, what was the driving force behind our IMB program? So not unlike many other states, access to dental care for young children was, and to some degree, continues to be a challenge. For many years, early childhood caries was widely prevalent in the state, with some of our counties having nearly 60 percent of children entering kindergarten with either treated or untreated tooth decay. Young children also face unique challenges to accessing care related to behavioral management issues, lack of general dentist trained to treat infants and toddlers, and/or too few pediatric dentists in the state. And accessing care is especially difficult for low-income children such as Medicaid beneficiaries. Next slide, please.

So, the IMB model actually originated in the mid to late 1990s in western North Carolina. A group of organizations and individuals who were interested in children's health issues conducted a needs assessment of that region, and dental was identified as a top priority for action. So, a group of primary care providers, North Carolina Partnership for Children, UNC School of Dentistry, and our office worked to develop the model, secure grant funding, and pilot it in a nine-county cluster in North Carolina.

And so, in 1999, the North Carolina Institute of Medicine and UNC's Department of Pediatric Dentistry urged Medicaid to develop a new service delivery package and payment reimbursement method. And so, a bundled package of three services was recommended to include screenings, varnish, and counseling, to be provided by medical personnel. The initiative was to impact us with reimbursement, rebranded into the Mouth of Babes and a new pilot was launched. And so, after evaluation of that pilot in 2001, IMB was launched statewide, in partnership with the organizations you see listed here, all of whom continue to be very strong advocates and partners, particularly the Academy of Family Physicians and Pediatric Society. Next slide, please.

So, how does the program work? Children up to age 42 months or three-and-a-half years are eligible for services, and providers must be trained in order to receive reimbursement for services. The required training is primarily provided through face-to-face training from oral health section staff; however,

funding in 2019 allowed for the creation of an online self-guided training, which is available through one of our area health education centers.

So, in the current environment, we have adjusted the training to be able to deliver it through virtual meeting platforms or by telephone only, or still in person, following, obviously, social distancing and face covering guidelines of the state. We still are encouraging providers to continue rendering the services if they have the appropriate PPE. Recently, the American Academy of Pediatrics released their own PPE guidance for ambulatory care, such as well-child visits, and they also include mention of fluoride varnish surfaces particularly. Because it's not an aerosol-generating procedure and in alignment with the AAP, as well as the CDC's PPE recommendations, we have provided a minimum recommendation for PPE to North Carolina providers, which falls just above the recommended PPE for basic well-child visits.

Next, the services must include oral evaluation and parent counseling, which is billed as D0145, and fluoride varnish application, billed as D1206. Evaluation of risk assessment can only be completed by a physician, physician assistant, or nurse practitioner. Except in public health settings, RNs and LPNs can do these under standing orders from a physician. The parent counseling and actual varnish application may be delegated to any other training staff member in the practice.

Claims are then filed on the CMS 1500 form. Both codes must be filed together and in a specific order to avoid denial. Services are allowed once every 60 days, but limited to six times before age three-and-a half, and a commonly asked question or concern, IMB services are reimbursed independently of services provided by dentists, and varnish application provided by a dental office within the last 60 days does not affect a physician's ability to provide the services again. And there is no risk of harm to the child. Next slide, please.

So, as with all things new or non-traditional, there were definitely barriers to the designs, the launch, and ongoing implementation of the program, and just in the interest of time, I have highlighted some of the more notable challenges, both past and ongoing. And so, as you can imagine, there was early opposition to medical providers rendering oral health services, stemming mostly from the dental community, questioning its effectiveness and off-label use of fluoride varnish.

Having early support, however, from the North Carolina Academy of Pediatric Dentistry helped the program gradually gain favor from the dental community. But it was more so the overwhelmingly positive findings from IMB research and evaluation that just couldn't be denied. For instance, infant and toddler access to preventive dental care had increased 30 fold, and one-third of counties, no Medicaid beneficiary aged zero to three had ever received preventive dental care prior to IMB, and there was no reduction in visits to the dentist for preventive care for this age group, and so, essentially, the program was supplementing and not displacing preventive care received in dental offices.

Next, as you can imagine, cost was an initial concern for providers, which was resolved by working with Medicaid to reimburse physicians for services; however, there were then reimbursement issues because primary care providers were being paid more than dentists for the exact same services, and that was resolved in 2008, and reimbursement fees have since been equaled between both provider types.

The coding as changed over the years, from three codes to now just two codes, but the codes, as I mentioned before, must be reported together on the claim form and in the specific order or the claim will be denied. This is the current policy and something providers and/or their billing staff just have to be mindful of. Some practices or public health clinics may not have enough staff to implement IMB in addition to their usual services, whether they lack a physician or a PA or nurse practitioner to complete

the oral evaluation or risk assessment, or they may lack the other staff to be able to delegate varnish application, and parent counseling too.

Some practices simply may not have many children in their practice under age four, or children who are actually eligible for the service. Some providers are reluctant to adopt the program due to lack of knowledge and competence in oral health-related issues, and this is where our in-person trainings have become most helpful, because health providers can ask questions of dental health professionals.

Last but not least, making the connection to a dental home is an inconsistent practice. Some medical providers are simply not aware of dentists in their community to whom they can refer, or they find it difficult to find one who will see young children. Others may not refer because parents and caregivers are likely to fail the appointment, and some may find it difficult to motivate parents to take a high-risk child who does not have obvious disease to the dentist. And so, care coordination would certainly help address many of these issues around dental referrals, but that definitely requires dedicated resources or financial, human, and just time. And so, our staff helps this by making sure that IMB-trained practices have a dental referral resource list that's specific to their community; however, convincing physicians to consistently refer irrespective of broken appointments or perceived broken appointments, and educating parents to keep appointments is still an ongoing challenge. Next slide, please.

Despite the past and ongoing barriers, the program has certainly been a success, and due to these four primary factors: obtaining buy-in from your key stakeholders early on can do nothing but pave the way for success. Providers can be altruistic, but they prefer being compensated for their work, so securing reimbursement for services is critical to program adoption. Based on studies of the program, providing children with four or more IMB visits is when you start seeing a real reduction in early childhood caries. And then, lastly, while there is a training requirement, we try not to make that a barrier, and so anyone in a practice that has already been trained by us can train new staff in the practice. They are still welcome to request training directly from us if they prefer, but they are not required to. Training through us simply confers continuing medical education. Next slide, please.

So, here are key measures that help us monitor the program. The process measures all come from North Carolina Medicaid claims data, and the outcomes measures come from oral health surveillance data collected by the oral health section. So, annually, we used to look it the number of primary care providers rendering IMB services, but found that it may not have been accurately reflecting actual rendering providers. My understanding is that this issue was tied to an old legacy billing system that Medicaid used to use, North Carolina Medicaid used to use and may no longer be a problem. So, we may potentially consider looking at this as a measure again in the future.

Quarterly, we look at both the number of IMB visits completed and the number of beneficiaries receiving IMB services, which are usually near equal in any given quarter. For the oral health outcomes, annually we look at the percent of all North Carolina kindergartners who have treated or untreated tooth decay, and every five years, we do the same for pre-K children. And the pre-K surveillance is new, as of the 2018/2019 school year. Next slide, please.

So, with 20 years of IMB and the scholarly expertise of UNC School of Public Health and Dentistry, there are close to 50 evaluation and outcome studies published in scientific journals, such as the American Journal of Public Health, Pediatrics, Journal of Public Health Dentistry, and Health Affairs. And here are just four with more important outcomes of the program, but in the interest of time, I won't actually read through them. Next slide, please.

So, if we can sum up 20 years of experience and share any words of wisdom with you, it would be this: necessity is the mother of invention, and so we have physicians and others who recognize an oral health need in their region, and they recognize that it wasn't or it couldn't be met by the traditional dental delivery system and so they found an innovative solution. Again, as I mentioned earlier, all stakeholders need to be at the table early on to gain input and buy-in. Reimbursement in general is important, but making sure that you're reimbursing your medical and dental providers the same fees is even more important. And, of course, with any new, innovative, or non-traditional, you absolutely need to have a dedicated core group of individuals who are willing to commit resources to this to see the initiative through to success. Next slide, please.

So, the last bit of information, I'll leave you with is our online IMB toolkit, which can be found on our website here. This is what already-trained providers can use to refresh their knowledge, or they can use it to train others in their practice. It provides a step-by-step training guide with forms, videos, frequently asked questions, including billing, safety, a variety of different topics, and it is a great resource for any state who is considering any fluoride varnish program. Next slide, please.

That wraps it up. So that is pretty much a high-level overview of our program. I'm definitely happy to take any questions you may have today. If there are questions after the webinar, feel free to contact our new Early Childhood Oral Health Coordinator, Miss Emily Horney. So, thank you; that's all.

Andy Snyder:

Great. Thank you so much, Dr. Stephens. I really appreciate the overview of Into the Mouth of Babes. And, yes, a 20-year track record of research and evaluation on that program is unique in the country and it's just so much important information for other states. So, I know we also have Dr. Mark Casey on for our Q&A and discussion section, so if we go ahead to the next slide, we can move to that. And I'm going to invite another member of our QI team to the floor now to help get us through the discussion and Q&A, and that's Stacey Chazin with the Mathematica team. So, Stacy, you are on.

Stacey Chazin:

Great. Thanks so much, Andy. We want to thank everyone who included some questions with their registration when they signed up for this webinar, and we'd like to start by covering a few of those. In the meantime, we want to encourage you to enter any questions that you have electronically here, and we'll try to get to as many of those a possible today.

So, Andy, one of the first questions we received in advance from one of the state Medicaid agencies was about payment, and the question is, how is this service paid for in FQHC settings? Is it included in the PPFS?

Andy Snyder:

It's a good question. It also is going to be state dependent, of course, since it has pretty broad latitude to set FQHC policy, so things that are paid for in the Medicaid encounter rate or a dental encounter rate or through another method is going to be kind of developed by the state Medicaid agency in conjunction with its FQHC partners. I don't know if either of our Maine or North Carolina teams have any other specific insight to offer there on how it's treated in their state.

Mark Casey:

This is Mark Casey, I can tell you that in North Carolina, the FQHCs are paid off our fee schedule and we go through cost settlement. So, there is a calculation of the encounter rate, but it's used at the cost settlement process.

Andy Snyder:

Great. And I think that probably might be fairly common.

Stacey Chazin:

Great. Thanks, Dr. Casey. So, another question we received in advance from a state Medicaid registrant was asking whether CMS will commit to promoting PCP fluoride varnish programs by including children receiving this important preventive dental service in future metrics evaluating state, Medicaid, or CHIP oral health programs? I think that's a question for you, Andy.

Andy Snyder:

Yeah, that is a fair question. So, CMS issued an informational bulletin that was kind of an update on our Oral Health Initiative on June 25th. You can get that from Medicaid.gov, and it talked a little bit about what our contemplated future steps on oral health measurement are. The Oral Health Initiative has used, for a number of years, a count of and a ratio of preventive services that are provided by or at the direction of a dentist. We have, for the fiscal 2020 reporting, through that reporting pathway, the CMS 4-16, we changed one of the lines to give us a better unduplicated count of preventive services that are provided either in oral health or dental settings, and we're in the middle of consideration of for what our measurement strategy might look like in future years. But I encourage everybody to go look at that June 25th informational bulletin.

Stacey Chazin:

Great. Thank you. And Cassie responded, the service is included in the that PMPM for FQHCs in Maine as well. Thank you for that extra information.

So, we've gotten a couple questions for the state speakers specifically in our Q&A box, and the first one that we're going to highlight is for the folks in Maine. We have a participant who asked, I'm curious if there is evidence that incorporating the CPT 99188 in billable codes has improved billing success for MaineCare providers. It's been a challenge in my state to ask providers to bill D codes when private payers only reimburse 99188.

Amy Belisle:

This is Amy. I'm not sure yet on this, because this change was made about a year-and-a-half ago, and there is some claims lag to see whether or not we're going to see a bump up in the numbers. And it's something that we are looking at, though, to see if allowing that to roll will increase number of claims for fluoride varnish. I know a couple of years ago, we looked at this, and we looked to see who was submitting claims into Medicaid. And there were some large groups that were using that code, and they were not getting reimbursed by Medicaid, and that's why one of the reasons they had added it. So, I think it will make a difference. But we haven't actually seen a bump up in the data yet.

Stacey Chazin:

Thank you. We have a question for the folks in North Carolina. I'm curious, in North Carolina, how you arranged for RNs and LPNs to apply fluoride varnish under standing orders. Was this a policy, rule, or statute to clarify that this is allowable?

Rhonda Stephens:

This is Rhonda. I will take a stab at that; however, it may have preceded my tenure with the program. A lot of it -- I know there are questions about just the ability of nurses and other provider types to do that, and that all relates to our state practice. In terms of public health settings, in our state, we're typically able to make rule changes to our practice acts that allow certain types of providers in public health settings to do things differently than one would do in a private setting, and so my initial assumption -- and Dr. Casey, you can clarify if you have more information than do. My initial assumption is that a rule change may have been implemented into the practice act for those particular provider types to allow those in public health settings to do things under standing orders in private practice.

Mark Casey:

To tell you the truth, Dr. Stephens, that predates my time in Medicaid, so I'm not able to give you a good answer to that question.

Rhonda Stephens:

I'll research it more and I'll share it with the organizers if it's different than what I've stated.

Stacey Chazin:

Great. Thank you for that. Another technical question for any of our speakers, is an ICD-10 code needed on claims?

Mark Casey:

That's a good question. In North Carolina, I believe that it is, and they used the same ICD-10 code each time for oral health preventive services. But I don't know the code offhand.

Stacey Chazin:

Okay. If none of our speakers knows that offhand, we can follow up on that and provide that in follow-up material to confirm that; no problem. So, another question we've gotten, and this is also for any of our speakers, speakers from other states, what are the biggest challenges that practices are seeing in providing preventive dental services in the primary care setting, and what strategies would you point to as being most successful in addressing those? So, I wonder if each state -- and I know you touched on this in your formal presentations, but I wonder if a speaker from each of the states might want to highlight one in particular.

Rhonda Stephens:

This is Rhonda. I can start off. I think, again, back to the biggest issue being connecting children to a dental home, and so even after the implementation of Into the Mouths of Babes, there was some pilot

work to try to make that connection more consistent. And what was found is that there's either not enough dentists in an area to make a referral or, again, a physician not feeling comfortable that the patient will actually follow through with the appointment. So, we tried to give a little bit of grace, even though we, ideally, want every child to be referred for dental home by age one.

Recognizing the limitations of our provider pool, we try to give and take so when our staff go out and train in a given a region, if there is sufficient dental providers there to accept young children, then we urge those practices to refer every child, whether they're high-risk or not. In a county where we know that there are a shortage, the recommendation that we have our staff give during a training is to refer those children who are high risk, and anyone else who is not high risk, the children can stay within the primary care office, and that's just sort of, I guess, the happy medium that we've come to now. It's not ideal but it's practical.

Stacey Chazin:

Great. Thank you. Dr. Belisle or Cassie, is there anything you want to offer in response to this question?

Amy Belisle:

In terms of the referral piece, there was a fair amount of work during the quality improvement projects to try to build relationships between the dentists and the primary care providers in the community to convene multiple different "Dining with the Dentist" events that Cassie's group convened to try to get people to know each other and figure out where referral might take place. I think, Cassie, I don't know if you want to step in, but I know you have also worked on the prenatal side to find referrals for moms. But I think continues to be an issue, is finding those who will take children, take young children, take Medicaid payment, and then have this kind of streamlined referral between primary care and the dentist so that it's easy for families to get seen.

Cassie Grantham:

Yeah. I completely agree. It's still a challenge for us. And with Before the First Tooth Program, we saw that very -- it was highlighted for us, because, of course, we were working with a smaller subset of providers, and that was a big source of frustration for them, is how to get those referrals to dentists, how to have a conversation with dentists about the referral. And a lot of folks now, within our primary care medical homes, obviously, are used to doing referrals through an electronic means. And, of course, not all of those records interact with each other very well. So, it can be a little bit more challenging, and I think we're still really working through it.

Stacey Chazin:

Thank you. I know we have several more questions we've gotten in, and, unfortunately, do not have time to get to all of them. I am going to turn it back over to Stephanie Kelly, and she'll go over how you can submit any questions that were not answered today, or any other questions that arise from you as you think about the content any more, and also think about the upcoming Affinity Group opportunity.

So, thank you to our speakers for your in-depth handling of those questions, and for all of our participants for submitting your thoughtful queries. Stephanie?

Stephanie Kelly:

Thanks, Stacey, next slide, please. And next slide. So, coming back to the slide that we saw earlier in the deck that Andy reviewed, we just wanted to remind everyone of our upcoming learning collaborative events. We hope that you'll join us for our information session for the Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Affinity Group on Thursday, October 15, at 3:00 p.m. Eastern. And please stay tuned for a date for our next webinar on Medical and Dental Care Coordination to be held this fall. We also included a couple of other important dates to follow below, related to the upcoming Affinity Group, including the deadline for the expression of interest form, which is November 18th. Next slide, please.

This slide provides a few additional resources related to today's presentation that we wanted to share with you all. As Andy mentioned previously, this slide and these links will be available to you when webinar materials are posted on Medicaid.gov following the event. Next slide, please.

As Stacey mentioned, please do reach out to the technical assistance mailbox with any questions about today's event or anything else, or feedback related to the oral health learning collaborative. You'll see the TA mailbox address here, and, again, this will be available with the materials that are posted following the webinar. Next slide, please.

Thanks again to everyone for attending today's event, and to our panelists for their wonderful presentations. Your feedback is really important to us, so please complete the evaluation that will pop up as you exit the webinar. And we look forward to seeing you at our next event on October 15th. Thanks everyone.