Center for Health Care Strategies

Advancing Oral Health Equity for Medicaid Populations

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TAKEAWAYS

- Medicaid — given its size and diversity of enrollees — offers critical opportunities to dismantle systemic inequities related to oral health access, reduce long-standing disparities, and advance oral health equity. There is limited information, however, about state efforts to improve oral health equity among Medicaid-enrolled populations.
- This brief describes common barriers for addressing oral health equity and outlines recommendations for overcoming these issues within four key areas: (1) coverage and access; (2) workforce capacity building; (3) partnerships; and (4) payment.
- In particular, the brief highlights specific opportunities to partner with community-based stakeholders (e.g., community-based organizations, individuals with Medicaid) as part of efforts to reduce oral health disparities and advance oral health equity for individuals enrolled in Medicaid.

Oral health-related disparities exist across the U.S. based on race, ethnicity, geography, income, and insurance status, among others.[1] Adults with low incomes spend 10 times more of their annual family income on dental services compared to those in families with high incomes.[2] People of color and those who have lower incomes bear a disproportionate burden of oral disease and disproportionately lack access to needed care.[3] The COVID-19 pandemic intensified already existing inequities increasing the imperative to treat unaddressed oral health needs.[4] About six million adults lost dental coverage during the pandemic because of job loss, and 28 million adults delayed getting dental care due to cost, coverage, and/or fear of COVID-19 exposure.[5] For the Medicaid-enrolled population, the pandemic most likely exacerbated longstanding disparities in oral health, including disproportionate oral health care access and poorer health outcomes.[6]

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Medicaid — given its size and diversity of enrollees — offers critical opportunities to dismantle systemic inequities related to oral health access, reduce long-standing disparities, and advance oral health equity. There is limited information, however, about state efforts to improve oral health equity among Medicaid-enrolled populations. Across states, implementation and coverage of adult dental benefits vary significantly as even basic coverage for adults is an optional benefit for state Medicaid programs under federal law.[7] In some states, adult dental coverage is limited to emergency services such as tooth extractions, or to specific populations such as pregnant women. Regardless of the comprehensiveness of a state's benefit, adult Medicaid beneficiaries often experience barriers to accessing regular oral health care.[8] Many Medicaid-enrolled adults also lack awareness of what dental services are available in their state, as the benefit may change frequently based on the economic and political climate. For instance, between 2009 and 2013, when many states faced budget shortfalls, 27 states made cuts to dental benefits.[9]

With support from the CareQuest Institute for Oral Health (CareQuest Institute), the Center for Health Care Strategies (CHCS) developed this brief to help Medicaid stakeholders, including state agencies, plans, providers, advocates, and individuals enrolled in Medicaid, understand the key challenges, policy levers, and opportunities for advancing oral health equity within Medicaid. To inform the brief, CHCS conducted a literature scan and interviewed relevant stakeholders (n=10), including individuals from Medicaid programs, health plans, providers, community organizations, and advocates between December 2021 and March 2022. This brief describes common barriers for addressing oral health equity and outlines recommendations for overcoming these issues within four key areas:

1. **Coverage and access**;
2. **Workforce capacity building**;
3. **Partnerships**; and
4. **Payment**.

In particular, the brief highlights specific opportunities to partner with community-based stakeholders (e.g., community-based organizations, individuals with Medicaid) as part of efforts to reduce oral health disparities and advance oral health equity for individuals with Medicaid.

Engaging Medicaid Enrollee and Community Perspectives to Accelerate Oral Health Equity

Considerations for advancing oral health equity would not be complete without the perspective of impacted communities to address health priorities and co-develop solutions. In partnership with CareQuest Institute, CHCS sought to integrate the voices of people enrolled in Medicaid throughout the findings in this brief. Community stakeholders — including individuals enrolled in Medicaid and representatives from the community-based organizations that serve them — comprised over half of the interviews conducted for the brief. Questions sought to inform priorities for advancing oral health equity and addressing disparities in a meaningful way for community members. Questions probed on the impact of structural racism on oral health equity as well as the importance of taking a person- and community-centered approach to decrease disparities. Sample questions include:

- ***Are you currently partnering/communicating across agencies or with other stakeholders to advance oral health equity?***
- ***How, if at all, have you explored accountability on these efforts within your organization? Have there been any unintended consequences with these efforts?***
- ***We want to ensure that community voices are more fully included in the way that oral health programs are designed and studied. How would you like to be involved in that process?***

Common Barriers Impeding Oral Health Equity in Medicaid

The literature scan and key informant interviews conducted by CHCS highlighted the individual and systemic barriers that prevent people covered by Medicaid from an equitable oral health care experience. Following are the four common barriers identified, which may vary from state to state depending on coverage, community partnerships, and oral health provider availability.

1. Oral Health is Not a State-Level Health Equity Priority

Many states across the nation are taking meaningful steps to address long-lasting, historic inequities in the delivery of Medicaid services. These efforts, however, generally exclude oral health. Most interviewees from the Medicaid, health system, and community perspectives reported that equitable access to affordable and quality oral health care is not viewed as a priority at the state and national level. Disparities around oral health have not been adequately addressed, and greater efforts are needed to tackle the social drivers that create and perpetuate systemic inequities in oral health access.[10]

Community-based organizations (CBOs) reported facing repeated difficulties in getting Medicaid leadership buy-in to invest in oral health for the adult Medicaid population – despite evidence that adult dental coverage can reduce overall medical costs in Medicaid.[11] Medicaid and health system-based interviewees noted that Medicaid oral health coverage and benefits were often on the chopping block in efforts to trim budgets. Interviewees cited multiple reasons for limited dental benefits in many states, including a lack of understanding on the return on investment given the "costly" nature of prevention that usually needs a longer time horizon to prove savings, which does not align with Medicaid budget cycles and reelection timelines.

2. Systemic Barriers Prevent Access to Quality Care

While many populations are able to access oral health care routinely, a disproportionate number of individuals covered by Medicaid face persistent barriers to accessing care. These challenges can largely be attributed to: (1) cost; (2) coverage; (3) provider capacity; and (4) data collection.

Cost

As noted by many interviewees, cost is a significant barrier to receiving oral health care. One interviewee shared, "Across any age group and income group, cost is the number one barrier. I think it's important to keep that at the forefront of our minds as we like to think about what strategies may or may not work from a policy perspective."

Coverage

The high cost of oral health care can also lead to challenges in accessing and receiving quality care. Comprehensive dental benefits for adults enrolled in Medicaid are necessary to achieve and maintain their oral health, but access is limited given differences in state coverage of based and comprehensive benefits across the country. Even basic coverage for adults, however, is an optional benefit for Medicaid programs under federal law.[13] Basic coverage typically focuses on preventive services and less so, if at all, on services to restore tooth structure, such as the use of bridges, dentures, and implants. Medicaid programs with some form of adult dental coverage experience greater utilization of dental services than states without a benefit.

Overview of Medicaid Dental Service Utilization

The mean utilization of dental services per year for adults enrolled in Medicaid for states with:

- No adult dental benefit is 0.9 percent;
- An emergency-only adult dental benefit is 9.2 percent;
- With a limited adult dental benefit is 21.8 percent; and
- With a comprehensive is 28.4 percent.[12]

Historically, the adult dental benefit is one of the first optional benefits that is eliminated in Medicaid budgets during economic downturns.[14] Without robust Medicaid coverage, the cost of dental care is unaffordable for many adults, and they may seek care elsewhere, if at all, including the emergency department (ED).

When calculated per visit on an annual basis, emergency care is much more expensive for Medicaid programs than accessing care in a dental office and cannot adequately address underlying oral health needs.[15] Without regular care, oral health problems can develop and worsen, leading to overall health and social issues that can harm individuals. This "patchwork" of Medicaid dental coverage also results in confusion and adverse downstream effects for individuals with Medicaid. As noted by a health system interviewee, in some cases individuals with Medicaid will try to make an appointment to receive oral health care but are told they only have emergency-only adult Medicaid dental coverage that does not cover routine care. Individuals then believe they have emergency-only Medicaid benefits across the board. This "confusion" can have a negative impact on other aspects of health care delivery and outcomes.

Provider Capacity

In addition to coverage, there are other systemic barriers to equitable access for high-quality and affordable oral health care. Interviewees noted that the lack of provider capacity and data infrastructure can limit state ability to advance oral health equity. Medicaid programs are faced with a limited pool of participating dental providers and challenges recruiting new ones. While 38 percent of licensed dentists in the United States accept Medicaid, the level of engagement and volume of patients for these licensed providers is difficult to measure.[16] Providers often cite Medicaid's low reimbursement rate and high administrative requirements as reasons for not accepting Medicaid patients. Addressing these issues is necessary but may not be sufficient to substantially increase the number of participating providers.[17]

Data Collection

The ability to identify, collect, analyze, and report stratified patient data is essential to improving care delivery and advancing health equity. A lack of comprehensive and stratified oral health patient data hinders Medicaid's ability to make any changes to advance oral health equity. The systems to collect and monitor oral health data by demographics such as race, ethnicity, immigration status, language, gender identity, age, and sexual orientation is severely lacking. In advocating to increase their state's reimbursement rates, one dental director shared, "we bring up issues of equity, including oral health disparities, and try to pull off data showing differences and utilization, but that's hard because Medicaid programs have been notoriously poor at getting data on race and ethnicity." Providers may not have information technology infrastructure to collect, report, and analyze data. Without quality data that can be stratified by factors such as race, ethnicity, and language, policymakers, community

leaders, and other key stakeholders lack the information needed to adequately identify and address inequities and measure progress.[18] Policymakers are making strides in delivery system reform (e.g., value-based payment), but many interviewees emphasized the need for larger practice capacity, both clinical and non-clinical support, to meaningfully collect, analyze, and use data. Practices with electronic health records (EHR) can analyze the data to determine if they are impacting quality and cost. Successful practices may also have the infrastructure in place to share data with health plans, state agencies, and external providers. Even when oral health care providers have IT systems in place, they are typically not linked to physical health care providers, making it difficult to coordinate care for patients with chronic health needs.[19] As noted by one of our interviewees, "Most health centers have a medical side, a dental side, and behavioral side, and the twain don't meet – they don't integrate. How do we get them to work together?"

Oral health care practices may also not have sufficient analytic capacity, such as tools, software, and staff to use data optimally.[20] Half of dentists operate within solo practices and therefore exercise a high degree of autonomy.[21] Where data is lacking, CBOs can play a role in supplementing missing information. For example, one CBO conducted a consumer survey to gain clarity on what barriers individuals with Medicaid in their state face when accessing and using oral health care.

3. Community-Oral Health Partnerships are Challenged by a Lack of Time, Trust, and Transparency

As health care entities prioritize the need to advance health equity, they can benefit by directly engaging patients and their families to inform program and policy design decisions. It can be challenging, however, for Medicaid programs and health systems to engage in and sustain meaningful relationships with patients and community members. Health systems, in particular, face a number of challenges when engaging with individuals and communities, including: (1) structural racism that has led to systemic power imbalances between health systems and the communities they serve; (2) lack of trust; (3) uncertainty of how to solicit and include the feedback provided; (4) cultural differences and limited cultural competency; and (5) the absence of infrastructure to support these relationships.[22] Similarly, community-based interviewees shared that they are interested in building a trusting relationship with Medicaid but are disheartened due to previous negative experiences that parallel the above listed barriers.

Despite these challenges, Medicaid and health system interviewees wanted to include community stakeholders in policy and operational workgroups or discussions, and desired thoughtful partnerships that promoted "bidirectional conversation." Participation from community stakeholders may be facilitated by existing mechanisms within Medicaid, such as community advisory boards. This type of engagement can foster a sense of "collective impact" as noted by one interviewee. For example, Oregon's

Coordinated Care Organization (CCO) model requires each CCO to create at least one community advisory council (CAC), an advisory body made up of members enrolled in Oregon's Medicaid program, Oregon Health Plan, as well as community representatives. CACs are responsible for designing and administering a community health assessment and developing a community health improvement plan.[23] Additionally, CCO governing boards are required to have at least two CAC members, at least one of whom is an Oregon Health Plan member.[24] Stakeholders are still challenged by if and how local partnerships could be brought to scale. As noted by one interviewer, "what is the…effective way to do it, how do we get to economy of scale? How do we bring the right CBOs, community partners, and local public health agencies under the tent?"

4. Medicaid Oral Health Consumers are Challenged by a History of System Mistrust and Gaps in Culturally Competent Care

Dental providers who accept Medicaid are generally not representative of the population they serve. Of more than 201,000 working dentists in 2020 across the United States, roughly 70 percent were white, 18 percent were Asian, six percent were Hispanic, and fewer than four percent were Black.[25] Approximately 43 percent of these dentists participate in Medicaid or the Children's Health Insurance Program (CHIP) for child dental services; of note, more than half of Black (63 percent) and Hispanic (51 percent) dentists accept Medicaid or CHIP coverage, compared to white dentists (39 percent).[26] There is also a significant lack of diversity in the dental workforce, including in support staff such as hygienists, technicians, and dental nurses.[27] This can further stress access to care barriers with limited dental providers. According to one CBO interviewee, the largest barrier to oral health care in their community is often the distance required to travel to find a dental provider who speaks their own language.

A key ingredient raised by CBO interviewees to establishing an equitable oral health care system is strengthening trust between patients and the health care system. One way to start building this foundation is to create a culturally competent experience for individuals from all backgrounds. Culturally competent health care incorporates strategies to tailor care delivery to the beliefs, values, and social environment of diverse communities and individuals.[28]

Recommendations

Drawing from barriers identified by interviewees, following are recommendations to address individual and systemic barriers that prevent people covered by Medicaid from an equitable oral health care experience. Opportunities fall within four broad areas: (1) **coverage and access**; (2) **workforce capacity building**; (3) **partnerships**; and (4) **payment**.

1. Coverage and Access

- ***Continue to expand access to meaningful coverage.*** States have flexibility in the dental coverage they provide to their Medicaid beneficiaries. For states that do not provide an adult dental benefit, adding this benefit would greatly enhance the oral health of this population and significantly reduce disparities in care. States that offer an adult benefit should review the level of coverage they provide to ensure that the benefit covers the evidence-based care, including comprehensive restorative care, that patients need to adequately address oral health needs.[29]

- ***Pursue opportunities to integrate oral health care.*** While states have devoted considerable attention and resources to integrating physical and behavioral health care for Medicaid beneficiaries, oral health care often remains separate.[30] Co-location of dental services with other health care providers, such as in a federally qualified health center, increases access to and coordination of care.[31] Integration can also facilitate the collection and sharing of patient data that is key to addressing an individual's full care needs. States can encourage and incentivize Medicaid managed care plans to coordinate care with dental providers. States with advanced primary care initiatives can work with practices to implement programs to coordinate care with dental providers.

2. Workforce Capacity Building

- ***Deploy workforce initiatives to deliver culturally appropriate care.*** Expanding the oral health workforce and providing opportunities to build provider cultural competence can increase oral health equity. State can prioritize the following opportunities:

  - **Using community health workers (CHWs) to support patients with oral health needs.** CHWs can develop trusted relationships with families and help families navigate systems and address health and social needs in a culturally appropriate manner. CHWs come from the communities they serve, usually sharing identities, geography, or experiences with their clients. Many states are seeking federal approval to allow CHWs to be paid through the Medicaid program.[32] In addition to paying for CHWs, states can promote opportunities in Medicaid for CHWs to build skills to help patients address oral health needs. Oral health curricula can be woven into CHW training or as a separate certification. In Rhode Island, for example, CHWs have the option to participate in a training program on oral health basics through a state partnership with the state's CHW association.[33]
  - **Licensing dental therapists**. States are increasingly licensing dental therapists (DTs) to expand access to dental care. Dentists can supervise DTs without being physically present, which offers maximum flexibility when employing dental therapists, whether in the dental office to expand operating hours or in community-based settings. At

present, dental therapists can practice in 13 states and several Tribal nations.[34] Several community-based interviewees were engaged in advancing dental therapy-focused bills in their states, including in Colorado and Washington.

- **Offering diversity, equity, and inclusion (DEI) training and education for dental providers**. Medicaid programs can work with managed care plans, providers, and other partners to encourage dental schools to increase DEI training and explore ways to incorporate DEI training in continuing education programs.
- **Supporting efforts to develop career ladders for oral health staff.** Dental schools, dental plans, and larger practices can design pathways for CHWs, dental assistants, dental hygienists, and dental therapists to expand their education and training to become dentists. Medicaid can play a role in encouraging these entities to develop sustainable careers for nontraditional and mid-level workers, particularly from communities of color, that can lead to a larger and more diverse dental workforce.
- **Promoting opportunities to use telehealth to expand access to care.** As demonstrated by the COVID-19 pandemic, telehealth has been an effective way to increase access to health care, although special attention must be made to reach those without internet access.[35] As states consider the continuation and even expansion of telehealth authorities, they should include oral health care in policymaking. States can also work with oral health providers to identify creative ways to use telehealth to deliver more and better oral health care. For example, meeting with a patient with an intellectual disability through a telehealth visit prior to an in-person visit may help the patient and provider better prepare for a visit.

- ***Support providers to meet patient needs.*** Medicaid agencies engage their physical and behavioral health care providers in various ways to drive them to provide quality care and effectively meet the needs of their patients. States can build on these efforts by supporting oral health providers in the following ways:
  - **Supporting providers to meet patient's unique needs.** Patients in all settings, including oral health, have unique needs. For example, patients with limited English proficiency who need translation services, and patients with physical and intellectual disabilities who may need additional time and supports to receive quality care. Medicaid agencies can partner with dental associations, plans, large practices, and providers to offer tools and resources to help identify and meet these needs.
  - **Providing financial resources to help practices build infrastructure.** Practices need resources to build accessible sites for patients with disabilities, implement data systems to coordinate care, track patients with special needs, and analyze the care they are delivering. Practices also need resources to train staff at all levels and incorporate best practices into their workflows.
  - **Building provider capacity to identify and address health-related social needs.** Medicaid agencies are devoting resources to addressing health-related social needs in their physical and behavioral health programs. States can expand on these efforts to support their oral health programs.

3. Partnerships

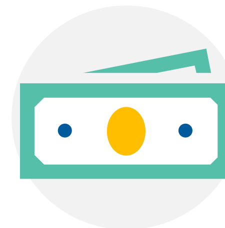
- ***Partner with community organizations and individuals enrolled in Medicaid to build trust and inform policy decisions.*** In every state, multiple community-based organizations are focused on the oral health care needs of Medicaid beneficiaries. States can seek opportunities to partner with these organizations to advance oral health equity by soliciting input on consumer needs and policy solutions. Meaningful and trusting partnerships with community members require substantial time, effort, and a genuine commitment for long-term engagement and change. Health care organizations, such as health systems and Medicaid agencies, can consider leveraging the influence of trusted community figures, such as leaders of community-based organizations, religious leaders, community organizers, or community volunteers, to serve as a launching point for understanding community needs. These leaders may be able to broker relationships with the community more broadly. Health care organizations can hire and meaningfully compensate community liaisons to act as go-betweens, translators, or engagement champions to participate in partnership activities.[36] States should build partnerships that include regular opportunities for direct and meaningful engagement with consumers. For example, Medicaid agencies could leverage existing means of engagement (e.g., Medicaid advisory committees) to solicit input on oral health policy and facilitate connections to other state agencies that impact beneficiaries. Participating individuals can be compensated for their contributions in various ways, including hourly wages, honoraria, gift cards, as well as providing meals and/or childcare during meetings.[37] Community organizations could provide forums and other connection points in the community for Medicaid officials to learn from the people they serve. Additionally, Medicaid could explore program levers to strengthen community-based organizations, including direct funding and incentives for providers and plans to actively engage with CBOs. For example, Medicaid programs can encourage, incentivize, or require health plans to contract with CBOs for the purpose of: (1) care coordination; (2) community needs assessments; and (3) addressing health-related social needs, and more.[38]

- ***Work with providers to engage the communities they serve.*** Partnerships with consumer organizations can be a valuable way to foster connections between providers and the community. For example, Penn Dental Medicine and Nationalities Service Center (NSC) partner to respond to any identified needs for immigrant and refugee clients going through settlement processes. In January 2022, the partnership conducted a pop-up clinic for more than 60 Afghan refugees awaiting permanent placement in the Philadelphia metropolitan area.[39] NSC additionally refers patients who require dental assistance to Penn Dental Medicine's Vulnerable

Populations Clinic.[40] States can also explore mechanisms to encourage oral health providers to better understand community needs, learn how to address community needs, and build trust with their patients.

- ***Collect data to drive equitable care and reduce health disparities.*** Oral health providers would benefit from collecting patient-reported race, ethnicity, language, and disability (RELD) data to measure and track health disparities and share that data with the state. At the practice level, patient data are critical for: (1) managing patient needs care in real time and over time; (2) coordinating care with external providers and community organizations; and (3) tracking and monitoring patient outcomes and costs.[41] At the state level, this enhanced oral health data could be connected to sociodemographic information from other Medicaid providers and state agencies to help inform access needs and address inequities across the state and delivery systems. Community partnership is also vital to the collection of actionable data in all health areas. For example, a community-based interviewee pointed to an "opportunity for the oral health community to come together and decide the right metrics" but emphasized the need to "make sure that communities are involved in the process as well so that we're measuring the right things that are ultimately going to get us to the policy goals we know communities want."

4. Payment



- ***Develop equity-focused value-based payment (VBP) models that encourage the delivery of equitable, patient-focused care and quality outcomes in oral health and embed equity into quality improvement initiatives.*** VBP is a broad set of performance-based strategies that link financial incentives to a provider's performance on a broad set of defined quality measures.[42] Many states are already using VBP models to improve health outcomes and support more efficient care by linking provider payments to quality or value in some way, such as improving health outcomes, adhering to evidence-based clinical guidelines, or improving patient experience.[43] States have opportunities to use equity-focused VBP models to support care delivery changes to advance health equity and eliminate disparities in oral health.[44] To further drive equitable outcomes, these models can include provisions that hold providers and health plans accountable for implementing quality improvement initiatives, coordinating care, delivering prevention services, and collecting RELD data and producing more equitable outcomes. However, implementation of equity-focused VBP models should also incorporate flexibility in payment to providers to support its success and uptake.

Conclusion

There is much work to be done to increase equity in oral health for Medicaid populations. Because of variations in dental coverage and access to dental providers, there are disparities in oral health care for Medicaid beneficiaries across states and compared to people who are covered by commercial insurance or can afford to pay for their care. State Medicaid agencies have various levers to drive more equitable oral health care through policymaking, partnerships, and payment. The recommendations described in this brief can help states move toward greater oral health equity for their beneficiaries, whether states are just beginning to advance an oral health equity agenda or if they are further along in pursuing oral health equity. State-level efforts to advance oral health equity must involve partnerships with the individuals and communities most affected by oral health inequities. Without the expertise of these community partners in identifying oral health inequities and the root causes that drive them, solutions to address identified inequities may have less impact or even potentially exacerbate disparities.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

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