

# Oral Health Integration in Statewide Delivery System and Payment Reform

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## IN BRIEF

As state Medicaid programs move toward value-based payment, states interested in improving adult oral health care access and outcomes are testing creative strategies to integrate dental care into primary care delivery. Through State Innovation Model (SIM) grants from the federal Center for Medicare and Medicaid Innovation, for example, participating states can include oral health integration in statewide delivery system and payment reform efforts. States without SIM grants are also identifying ways to incorporate dental services into primary care models. This brief explores a robust range of approaches to oral health integration that states are considering, including: (1) Medicaid benefit design and expansion; (2) practice-level oral health reforms; and (3) statewide delivery reform models.

While all state Medicaid programs are required to cover comprehensive oral health care for children, dental coverage for Medicaid-enrolled adults is optional. In fact, only 15 states offer an extensive benefit, and the range of benefits varies widely. As a result, low-income adults — who typically have no other options to pay for oral health care — face inadequate and uneven access to services.<sup>1</sup> For children, although oral health benefits are mandated under Medicaid, many still do not have adequate access to required services, with fewer than half receiving a preventive dental service in a given year.<sup>2</sup> Innovative payment and care delivery models that allow state Medicaid agencies to integrate oral health care into broader delivery system reform efforts are increasingly being considered to address these gaps.

With its goal of improving health care quality and reducing costs, the Center for Medicare and Medicaid Innovation's State Innovation Model (SIM) initiative has provided an impetus for states to consider how to integrate oral health care into primary care delivery and payment reform models. SIM is funding innovative health delivery models in 38 states, aimed at aligning value-based payment methods with care delivery across Medicare, Medicaid, CHIP, and commercial payers. A handful of SIM states — such as Connecticut, Oregon, and Virginia — are addressing the integration of oral health in benefit design, payment, and care delivery. Additionally, many states that are not part of the SIM program are also interested in improving oral health access and outcomes given the significant connection between an individual's oral and overall health and the associated costs. Including oral health as part of quality improvement efforts is an opportunity to increase dental care access, utilization, and quality for Medicaid-enrolled adults, particularly in states without an extensive Medicaid adult dental benefit.

This brief, supported by the Washington Dental Service Foundation, explores opportunities presented by state SIM projects and other state innovation efforts to include oral health in payment and delivery system reform. It draws from discussions with SIM project leaders, federal officials, and

state-level oral health care experts to outline promising opportunities in three areas: (1) Medicaid benefit design and expansion; (2) practice-level oral health reforms; and (3) statewide delivery reform models.

## 1. Medicaid Benefit Design and Expansion

Expanding dental benefits is a first step toward improving oral health access, yet even within states that offer an extensive benefit, there are still barriers to access, leading to increased rates of advanced and untreated dental disease. For example:

- Beneficiaries often do not know they have dental coverage and are not familiar with how to access services.
- Likewise, in most states there is a shortage of providers who are contracted with state Medicaid programs or their contracted plans and willing to serve a sufficient number of Medicaid beneficiaries.
- There are few incentives for payers and providers to adopt integrated approaches — primary care providers (PCPs) do not often focus on oral health, especially because of low Medicaid payment rates for fluoride varnish application and dental interventions.
- Even with reimbursement, PCPs typically do not prioritize oral health in their practices due to a lack of time, resources, knowledge of the connection between oral and overall health, or even awareness that the services are covered by health plans.

### ORAL HEALTH INTEGRATION STRATEGIES: Medicaid Benefit Design and Expansion

- Integrate oral health into value-based insurance designs and behavior incentives
- Stratify risk and enhance or shift payment rates
- Offer payment for care coordination and referral delivery
- Leverage the Medicaid children’s dental benefit to optimize children’s oral health
- Collect and analyze an expanded set of data

State Medicaid programs and other oral health stakeholders can address these challenges through benefits design in a number of ways, some of which are already being pursued in selected states.

### Integrate oral health into value-based insurance designs and behavior incentives

Medicaid enrollees in **Iowa**’s adult Medicaid-expansion program have access to a tiered dental benefit called the Dental Wellness Plan. All members are eligible for a series of core dental benefits. When members complete a follow-up exam within six to 12 months of their initial dental visit, members become eligible for “enhanced” restorative services;<sup>3</sup> those who complete a second follow-up visit six to 12 months after the first become eligible for an even greater set of “enhanced plus” services.<sup>4</sup> Since its launch in May 2014, approximately half of eligible beneficiaries have advanced to higher benefit tiers, suggesting the effectiveness of the model in driving timely and appropriate use of services.

Incentive approaches that have worked in the commercial sector may be adapted to Medicaid. Examples include rewarding members with reductions in premium costs if they complete a minimum number of preventive dental service visits, or giving gift cards to beneficiaries who follow a care plan for chronic illness. The gift card approach might be applied to early childhood caries (i.e., cavities) — the most common chronic disease in children — by rewarding families for compliance with follow-up visits and the subsequent absence of dental caries.

## Stratify risk and enhance or shift payment rates

This approach could entail examining which beneficiaries have the highest risk of developing oral disease, visiting the emergency department for dental needs, or incurring high oral health care costs, then shifting resources to improve their access and utilization. This approach can help to demonstrate the feasibility and positive impact of an expanded scope of benefits, producing data to help build the case for a statewide benefit. It can also suggest areas for improvement to address before taking it to scale.

**Virginia**, which has an emergency-only benefit for Medicaid-enrolled adults, implemented an extensive benefit for pregnant women in March 2015 and reached more than 6,000 pregnant women with dental services in its first year.<sup>5</sup> Subsequent data on emergency department utilization and long-term oral health costs for this population may be used to bolster the case for statewide expansion of the benefit. Similarly, there is interest in **Washington** to develop an enhanced, value-based dental benefit for pregnant women and individuals with diabetes, two high-risk categories for dental disease. Under the CHIPRA Quality Demonstration Grant, **Maine** adopted new Medicaid policies that allow providers to bill Medicaid for oral health evaluations in PCP offices, resulting in a three-fold increase (from 11 percent to 49 percent) in the documentation of oral health risk assessments for children under age four reported through electronic medical records.<sup>6</sup>

Under the payment rate umbrella, states and plans might also change the reimbursement structure to create incentives for the delivery of preventive services. They could increase reimbursement rates for high-value services, or include oral health in a capitated arrangement or global budget, rather than paying FFS for each service. Another approach is to incorporate oral health into bundled payments, which reimburse for an episode of care delivered during discrete periods of time for particular conditions (e.g., early childhood caries).

## Offer payment for care coordination and referral delivery

States can consider going beyond reimbursement for service delivery to give PCPs incentives for patients' subsequent dental office visits. The **New Jersey** Medicaid agency offers a "care management" incentive payment to PCPs for making a pediatric dental referral. Payment is based on how quickly the visit occurs (maximum payment for a visit within 30 days, reduced payment for a visit within 60 days, and no payment for a visit after 60 days). The state is also pursuing increased reimbursement for oral health care providers' delivery of diagnostic and preventive services for children under age three, with additional quality incentives awarded for reductions in emergency department and operating room utilization related to oral health. **Connecticut** reimburses PCPs for fluoride varnish application in children under age three when done in conjunction with an oral health assessment and a referral to a dental home.<sup>7</sup>

## Leverage the Medicaid children's dental benefit to optimize children's oral health

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment benefit outlines required services to meet children's care and treatment needs, which includes payment for more frequent service utilization, as needed, beyond a given state's standard periodicity schedule. States can seek opportunities to use existing benefits more effectively, particularly for those at high risk for dental disease (e.g., children with developmental disabilities) and associated long-term costs of care.

## Collect and analyze an expanded set of data

Creative use of data offers a valuable tool for demonstrating the cost-effectiveness of benefits and specific services to the state, contracted managed care organizations (MCOs), and/or providers. **Hawaii**, for example, is looking to collect population oral health-related data through the creation of an all-payer claims database and smaller-scale data collection efforts to demonstrate the cost-effectiveness of the Medicaid adult dental benefit and sealant programs. Such data can help build the case for further expanding or maintaining the benefit.

## 2. Practice-Level Oral Health Reforms

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Oral health integration at the practice level — that is, including oral health care guidance or services in primary (and sometimes specialty) medical care — can be an important stepping stone to state- and system-wide integration. Oral health and primary care practice settings can test ways to work together to advance beneficiaries’ overall health in clinically sound and cost-effective ways.

Partnerships and integration between medical and dental practices are not likely to happen organically, so states and health plans can help spur relationships. Many states and health plans are seeing initial promise in incorporating oral health into provider- or practice-level reforms under the SIM initiative and other programs. These efforts include:

- Integrating oral health and primary care through multidisciplinary care teams and new workflow models;
- Training PCPs to educate patients about oral health issues or administer basic preventive oral health care services;
- Creating programs that easily refer patients from a primary care setting to an oral health provider (and vice versa); and
- Establishing new workforce regulations to allow mid-level dental providers to have expanded scopes of practice.

However, many PCPs find that oral health competes with other aspects of their work, and report that they do not have the time, capacity, or financial incentives necessary to address oral health during already-short patient visits. PCPs who want to deliver oral health services may be uncertain about how to incorporate those services into practice workflow, and they may feel a sense of “burn out” from the plethora of asks to add further services into already-dense visits.<sup>8</sup>

Following are examples from across the country to help address these challenges and advance oral health through practice-level reforms:

### Determine ways to improve referrals to dental care

Continually improving the referral process is necessary to encourage primary care referrals to dental care. The Marshfield Family Health Center, a community health center with multiple locations in **Wisconsin**, uses “referral monitors” to flag declines in the rates of oral health referrals from specific PCPs. The monitors inform those PCPs when specific referrals do not result in completed dental visits so that providers can issue referrals at subsequent visits with those patients. In **Virginia**, Medicaid data are being used to identify PCPs with high referral completion rates among patients to encourage PCPs to apply fluoride varnish and make dental referrals. The Virginia Oral Health

#### ORAL HEALTH INTEGRATION STRATEGIES: Practice-Level Oral Health Reforms

- Determine ways to improve referrals to dental care
- Educate and engage providers
- Optimize use of mid-level dental providers
- Leverage opportunities presented by federal legislation and funding

Coalition, working with the state and pediatric PCP partners, is facilitating interviews with these PCPs to uncover keys to their success and share promising approaches with other practices. **Washington's** Access to Baby and Child Dentistry program engages PCPs to deliver preventive oral health services during well-child visits and facilitates referrals to dental care from community-based organizations.

### Educate and engage providers

Efforts can be undertaken to educate PCPs about best practices for integrating oral health and primary care. Those providing this outreach, however, should be sensitive to provider overload, and thoughtful when engaging PCP office staff to advance team-based oral health care. **Virginia**, for example, is promoting the integration of oral health and primary care, with specific strategies to address: pediatrics; maternal health; diabetes; emergency department diversion; and individuals with serious mental illness. The Virginia Oral Health Coalition, which was instrumental in developing these models, subsequently produced an implementation toolkit that offers a “one-stop shop” for clinics and health providers interested in pursuing them.<sup>9</sup>

The “Oral Health Delivery Framework,” developed by an interdisciplinary team of clinical, professional, and advocacy leaders and endorsed by the National Interprofessional Initiative on Oral Health, offers a field-tested practical framework for delivering oral health preventive care as a component of routine medical care. With a focus on prevention, screening, and early intervention, the framework includes five action categories — *ask, look, decide, act, and document and follow up* — that can be integrated into the workflow of diverse primary care practice settings.<sup>10</sup>

Conversely, states and plans can develop new models of care that enable oral health providers to incorporate aspects of a physical health exam, such as monitoring diabetic patients' blood sugar levels, into their work. If oral health providers have access to a patient's electronic health record, for example, and can flag medical issues for which the patient's PCP is accountable, PCPs may better value a two-way partnership to support better patient care. Another provider type ripe for engagement is pharmacists, who can deliver oral health education to consumers filling prescriptions — including those for conditions with elevated risk for oral health issues.

### Optimize use of mid-level dental providers

**Minnesota**, for example, is incorporating dental therapists (DTs) and advanced dental therapists (ADTs) into its oral health care workforce. The state is providing grants to dental practices to fund DTs' salaries and creating a toolkit to help potential employers understand how to integrate DTs and ADTs into dental practices. **South Carolina's** Rural Oral Health Advancement and Delivery Systems is hiring dental assistants to help establish referral processes and care partnerships between rural PCPs and community dentists.

### Leverage opportunities presented by federal legislation and funding

The Affordable Care Act (ACA) established the Community Health Center Fund to provide \$11 billion over five years for the operation, expansion, and construction of health centers. Subsequently, the Health Resources and Services Administration (HRSA) announced an offer of funding for oral health service inclusion in new or existing health centers, leading more than 300 HRSA health center grantees to expand oral health services in FY 2014.<sup>11</sup> Additional funding continues to be available, through HRSA 2016 Oral Health Service Expansion grants of approximately \$100 million to help 285 existing Health Center Program grantees increase access to oral health services and improve oral

health outcomes.<sup>12</sup> In states such as **Wisconsin**, which has an extensive Medicaid adult dental benefit, such expansion has led to a significant increase in oral health care access for adult beneficiaries through the state’s 17 community health centers.

### 3. Statewide Delivery Reform Models

Building on innovations in Medicaid benefit design and practice-level reform, oral health integration in statewide health care delivery reform models offers tremendous potential for improving access, outcomes, and costs. As states and other oral health stakeholders consider opportunities to promote oral health integration, there are a few challenges at the state level. For instance, continued reliance on fee-for-service (FFS) payments to physical and oral health care providers incentivizes treating diseases, rather than preventive measures that keep patients healthy. FFS models pay for the volume of treatment services and do not reimburse for consultations or referrals. Illustrative of this challenge is the payment system for Federally Qualified Health Centers (FQHCs) — a key part of the nation’s health (and potentially oral health) safety net — which are required to provide “primary health services” that include preventive dental. FQHCs are paid by encounter rather than service, giving them an incentive to offer dental services at separate visits, rather than incorporate them into well visits, where the likelihood of utilization would be greater. This suggests a strong need for a change in provider mindset — and payment structures — toward value-based, rather than volume-based, care.

#### ORAL HEALTH INTEGRATION STRATEGIES: Statewide Delivery Reform Models

- Explore options for accountable care entities
- Integrate oral health requirements and metrics into physical health delivery models
- Pursue a population health model
- Support provider networks to advance their integration competencies

Coordination between oral and physical health care entities in a value-based payment model can be challenging in terms of: sharing data, creating new payment structures, and developing performance metrics. They each typically have their own infrastructure, priorities, and objectives. Further, health information technology systems may not support integrated reporting and data-sharing. In response to the need to facilitate value-based payment approaches, the 38 SIM Model Design and Test awardees have been pursuing alternative delivery models supporting the transition away from paying for volume and toward paying for value. While many of these models do not yet incorporate oral health, states — both with and without SIM grants — are beginning to think about ways to broaden the scope to oral health and other areas beyond physical health. Key opportunities, described below, offer strong potential.

#### Explore options for accountable care entities

Accountable care entities provide opportunities for states to promote prevention through new programs and payment incentives. Accountable care organizations (ACOs), for example, allow groups of providers to work together and share financial responsibility for health care costs and outcomes. **Washington’s** Accountable Community of Health, Better Health Together, operates the Dental Emergencies Needing Treatment (DENT) Project. DENT recruits providers to see low-income adults with oral health conditions to reduce unnecessary emergency department use for dental care.

**Oregon’s** 16 regional Medicaid ACOs, called Coordinated Care Organizations (CCOs), receive a global budget to cover Medicaid beneficiaries’ physical, behavioral, and oral health care. Each CCO contracts with local dental care organizations (DCOs) to provide beneficiaries’ oral health services, passing a portion of their global budgets to the DCOs in a per-member, per-month payment. CCOs

have three percent of their total funding withheld and placed in an incentive pool; their performance on 17 metrics (including children’s utilization of dental sealants) determines what they can earn back.

## **Integrate oral health requirements and metrics into physical health delivery models**

States may also consider incorporating oral health program design requirements in alternative delivery models. Some options include: incorporating oral health services in payment calculations for ACOs; requiring these models’ governing bodies to include oral health representation; and/or offering enhanced practice transformation support to patient-centered medical homes (PCMHs), a primary care delivery approach that supports improved patient communication and care coordination. Likewise, states can include oral health metrics in quality measure sets for PCMHs, ACOs, and accountable health communities (AHCs), an alignment of health care and community-based organizations to address the social determinants of health.

## **Pursue a population health model**

Population health models, which address a range of factors regarding health for a fixed population, include both broad public health interventions and the overall health care delivery system. In the oral health arena, such models could materialize through providers and public health officials working together to develop or expand a school-based dental sealant program within an entire county or school district.

## **Support provider networks to advance their integration competencies**

**Connecticut’s** Community Clinical Integration Program, which provides practice transformation support to provider networks, identified oral health integration with primary care as a core capability to support better community and clinical integration. The state contracts with a “transformation vendor” to offer technical assistance to provider networks that elect to focus on oral health integration. The state’s SIM-initiated Advanced Medical Home program is also including oral health as an optional standard.

## **Looking Ahead**

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There is growing consensus among researchers, providers, policymakers, and funders that Medicaid beneficiaries are best served when health care delivery systems can efficiently coordinate or integrate oral and physical health services. States are just beginning to incorporate oral health components into statewide payment and delivery system reforms like PCMHs, ACOs, and AHCs, while continuing to advance oral health integration efforts at the practice level and through Medicaid benefit and reimbursement changes.

Ample opportunities exist to incorporate oral health into state-level health transformation efforts, especially as states pursue more sophisticated benefit designs, practice site models, and value-based payment strategies. As state and federal agencies and other oral health stakeholder organizations consider how to improve oral health access, they will find many promising paths for integrating oral health into broader delivery system reforms. Oral health champions at the state and federal levels can consider the opportunities outlined in this brief to achieve the health and cost benefits of increasing Medicaid beneficiaries’ access to oral health care.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).

## ENDNOTES

- <sup>1</sup> For more information about barriers to access, see: The Kaiser Commission on Medicaid and the Uninsured (2012). “Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access.” Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7798-02.pdf>; National Center for Health Statistics, Centers for Disease Control and Prevention (2011). “Selected Oral Health Indicators in the United States, 2005-2008.” Available at: <http://www.cdc.gov/nchs/data/databriefs/db96.htm>; and Centers for Medicare & Medicaid Services (February 2016). “Dental and Oral Health Services in Medicaid and CHIP.” Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/dental-care.html>.
- <sup>2</sup> Centers for Medicare & Medicaid Services (February 2016). “Dental and Oral Health Services in Medicaid and CHIP.” Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/dental-care.html>.
- <sup>3</sup> Enhanced restorative services include root canals and other endodontic care, non-surgical gum treatment, denture adjustments and repairs, certain oral surgery services, and other designated adjunctive services.
- <sup>4</sup> Enhanced plus services are all core and enhanced benefits plus crowns, tooth replacements and gum surgery, all subject to prior authorization. Note that Dental provider reimbursement rates for the DWP are approximately 60 percent higher than in fee-for-service (FFS) Medicaid. Dental providers are also eligible for a “bonus pool” based on the number of exams they perform for DWP members.
- <sup>5</sup> The Virginia Oral Health Coalition estimates that at any given time, there are approximately 15,000 pregnant women in Virginia who are eligible for the benefit.
- <sup>6</sup> University of Maine, Muskie School of Public Service (May 2015). *First Steps Phase III Initiative: Improving Oral Health and Healthy Weight in Children – Final Evaluation Report*. Available at: [http://www.maine.gov/dhhs/oms/pdfs\\_doc/ihoc/First%20STEPS\\_Phase%20III%20report%20final.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/ihoc/First%20STEPS_Phase%20III%20report%20final.pdf).
- <sup>7</sup> Reimbursement is \$25 for the oral health evaluation (Code D0145) and \$20 for the fluoride varnish application (Code D1206, though they have started covering 99188).
- <sup>8</sup> Shanafelt et al. “Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014,” *Mayo Clinic Proceedings*: Dec 2015;90 (12):1600-1613.
- <sup>9</sup> Virginia Oral Health Coalition (April 2016). *Integration Toolkit*. Available at: <http://www.vaoralhealth.org/WHATWEDO/EducateProviders/OralHealthIntegration/IntegrationToolkit.aspx>.
- <sup>10</sup> Qualis Health (June 2015). *Oral Health: An Essential Component of Primary Care*. Available at: <http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf>. Note: Following the completion of field testing of the framework, a complete oral health integration guide for primary care practices will be published in 2016. Once it becomes available, CHCS will provide a link to the guide on its website, [www.chcs.org](http://www.chcs.org).
- <sup>11</sup> Health Resources and Services Administration (November 2015). “HRSA Oral health: Across the Agency.” Available at: <http://www.hrsa.gov/publichealth/clinical/oralhealth/oralhealthfactsheet.pdf>.
- <sup>12</sup> HRSA Health Center Program. “FY 2016 Oral Health Service Expansion Supplement (HRSA-16-076) Funding Opportunity Announcement Technical Assistance.” Available at: <http://bphc.hrsa.gov/programopportunities/fundingopportunities/oralhealth/index.html>.