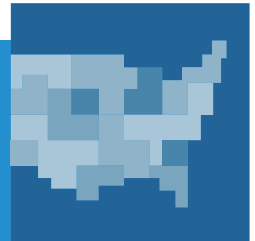


REPORT



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Improving Access to Oral Health Care for Adults in Medicaid: Key Themes from a Policy Roundtable

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Executive Summary

State Medicaid and CHIP programs have made significant strides in improving low-income children's access to and use of dental care, but access to dental care for low-income adults lags far behind. To probe current opportunities, challenges, and strategies related to expanding access to oral health care for adults in Medicaid, the Kaiser Commission on Medicaid and the Uninsured convened a group of experts and stakeholders in Spring 2016 to discuss the issues. Several key themes emerged from the conversation:

- **Oral disease affects overall health and well-being and also bears on other major national concerns.** Poor oral health has adverse impacts on overall health and well-being. The detrimental effects of poor oral health and lack of access to services among low-income adults also ramify to employability, opiate abuse, emergency department use, and health disparities.
- **Good oral health among low-income adults is an achievable goal.** The science of dental caries is understood and dentistry possesses the clinical tools to prevent and manage it. Emphasizing that this capability exists and raising awareness about the burden and impact of oral disease on low-income adults could increase support and political will to expand Medicaid dental coverage for adults.
- **States have levers in Medicaid to improve access to dental care for adults.** States can expand Medicaid to low-income adults, expand dental benefits, ease administrative burdens that dampen dentist participation, improve provider payment, and make strategic use of incentives to improve access to and utilization of dental care.
- **Innovative workforce approaches can help maximize current oral health resources and expand access.** Elimination of scope-of-practice restrictions, new provider types, teledentistry, and health center expansion can increase the supply and availability of oral health care to address the growing demand for care among low-income adults as coverage expands.
- **Experts say that ending the oral health crisis will not be possible without transforming the oral health care system.** Ending the epidemic of poor oral health among poor populations will require an oral health system centered on prevention and evidence-based care, not driven by an invariable set of covered benefits; integration of oral and primary care; and community-based models of care.

Introduction

A little over 15 years ago, *Oral Health in America: A Report of the Surgeon General* documented a “silent epidemic” of dental and oral diseases among poor Americans and people of color. Through concerted efforts by the Centers for Medicare and Medicaid Services (CMS) and the states in recent years, the share of low-income children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) who receive preventive dental care and treatment services has been growing, although continued efforts are needed to further reduce income- and insurance-related disparities in children’s utilization of dental services. Compared to children, access to oral health care for low-income adults has lagged far behind, for two main reasons. First, historically, Medicaid eligibility for non-elderly adults has been very restrictive, leaving many uninsured. Second, while states must provide dental benefits for children in Medicaid and CHIP, adult dental benefits are a state option.

The environment for efforts to increase access to dental care for low-income adults is favorable. Millions of previously uninsured adults have gained coverage under the Affordable Care Act’s (ACA) expansion of Medicaid to non-elderly adults with income up to 138% of the federal poverty level. Growing awareness of the importance of oral health to overall health and well-being, the movement toward more integrated care, and improving state economies have all brought the issue of strengthening adult dental benefits in Medicaid into sharper focus. A major infusion of federal funding has enabled health centers, a key source of dental care in underserved communities, to expand their service capacity. And new workforce and care delivery models designed to increase access to dental care are spreading.

To probe current opportunities, challenges, and strategies associated with improving access to oral health care for adults in Medicaid, the Kaiser Commission on Medicaid and the Uninsured convened a diverse group of experts and stakeholders in Spring 2016 for a roundtable discussion of the issues. Participants included federal and state Medicaid officials, dental providers, a large health center and large Medicaid health plan, leading clinical experts, and policy researchers, who brought a range of expertise and perspectives to the discussion. This report summarizes key themes that emerged from the conversation. A [related brief](#) provides key data and information about low-income adults’ oral health status, their access to dental care, and coverage of adult dental benefits in Medicaid.

Key Themes

GOOD ORAL HEALTH AMONG LOW-INCOME ADULTS IS AN ACHIEVABLE GOAL.

Good oral health is integral to overall health and well-being.

As one roundtable participant put the point: “The mouth is part of the body.” Discussants cited associations between oral infection and chronic diseases prevalent among low-income adults, such as diabetes, and poor birth outcomes. They also stressed the broader impacts of oral health problems on individual well-being, including pain and suffering and potential adverse implications of bad or missing teeth for nutrition, employability, and self-esteem.

The capability to prevent dental disease exists.

It was noted emphatically that dental caries (tooth decay) – in sharp distinction to many other health conditions – is well-understood scientifically, and dentistry possesses the clinical know-how and technology to prevent and manage it. However, federal and state policy decisions have led to limited public spending for oral health coverage and care. Discussants suggested that messaging to policymakers and the public that emphasizes that we have capability to solve this problem, but are under-spending, could build more pressure to increase funding for adult dental coverage and services.

Failure to address the oral health needs of low-income adults affects other national priorities as well; connecting the dots could impel more action.

Roundtable participants underscored that poor access to oral health care among low-income adults stands in the way of national goals to improve population health and health equity. They also pointed out that, in addition to its adverse impact on adult oral health itself, lack of access to dental care is also a factor in both high rates of preventable emergency departments (ED) use and the opioid abuse epidemic. Individuals who lack dental coverage and care often have no alternative but to seek care in a hospital ED when they have oral pain and, since EDs do not generally provide dental services, prescription pain relief medication and a referral slip for dental care is often all they can offer. Discussants also observed that poor teeth can jeopardize job prospects among low-income adults. Interconnections were drawn between oral health problems, drug use, unemployment and economic marginalization, and incarceration, and between these risk factors and persistent social and economic disparities. Attendees suggested that, in framing initiatives to expand Medicaid adult dental coverage, articulating these connections might help broaden the constituency and strengthen the case for federal and state policy action.

A federal initiative to improve access to oral health care for adults would bring focus and resources to the issue and help drive state action.

Reflecting on the CMS Oral Health Initiative focused on children in Medicaid and CHIP, launched in 2010, and the important gains in low-income children's utilization of dental care that have been achieved since then, discussants proposed that a similar federal initiative directed toward adults in Medicaid that sets goals for improvement, provides technical assistance to states, increases reporting, and establishes dental quality metrics, would sharpen states' attention to this issue and increase its traction as a policy and financing priority among state decision-makers. CMS could help guide states that are interested in moving forward by providing a model Medicaid adult dental benefit and tools for estimating the cost of adding dental benefits.

More work is needed to improve oral health literacy.

Discussants highlighted the need for increased outreach and education to improve public awareness regarding the importance of oral health. One official from a state with a robust adult dental benefit in Medicaid reported that only about one-third of adults had used the benefit, and he cited low oral health literacy and patient navigation challenges as key causes of under-utilization. While Medicaid coverage of dental services removes financial barriers to access for low-income adults, overcoming these less obvious barriers, too, is necessary to convert coverage to consumer understanding of the value of dental care and the actual receipt of care. There was also discussion of the need for more education and engagement of primary care providers regarding adult oral health, generally, but also especially in light of the risks poor oral health poses to pregnancy outcomes and the management of diabetes and other chronic conditions prevalent among low-income adults.

ADDRESSING BARRIERS WITHIN MEDICAID COULD IMPROVE LOW-INCOME ADULTS' ACCESS TO ORAL HEALTH CARE.

Because adult dental benefits are a state option in Medicaid, establishing, sustaining, or improving them can be challenging.

In Medicaid expansion states, millions of previously uninsured low-income adults now have health coverage. However, adult dental services are an optional benefit in Medicaid and most states cover limited or emergency-only services.¹ Even in states with extensive benefits, caps on per-enrollee dental spending may constrain access for adults with high needs. State dental officials indicated that, especially in tight budget environments, prioritizing funding for Medicaid adult dental benefits is an uphill battle even when internal support for them is strong. They said that just maintaining benefits year to year can be a struggle because adult dental coverage is often seen as “low-hanging fruit” by policymakers seeking to cut spending. They added that, after new benefits are introduced, states must simultaneously implement them and think about how to keep them. Some state dental officials said that they had been able to identify temporary revenue sources to finance dental benefits, such as an unclaimed property trust fund, but sustainability remains a challenge. Limited and unstable benefits hinder access to dental care for Medicaid adults and deter dentists from seeing Medicaid patients because of uncertainty about whether services will be covered.

Dentists in many states face Medicaid policies that may discourage participation.

The roundtable discussion affirmed that low Medicaid fees and high administrative barriers dampen dentist participation in Medicaid. Managed care organizations (MCOs) often set payment rates for dentists by discounting already low Medicaid fee-for-service (FFS) rates. Onerous provider enrollment processes and prior authorization systems also deter participation, and discussants mentioned that the ACA requirement for revalidation of providers every five years has also led to some loss of dentists from the program. Government audits are often perceived as adversarial. Other barriers were cited, too. Small dental offices lack the expertise and resources to analyze and compare managed care plans' coverage policies and payment rates. They also find it burdensome to file applications with multiple plans to participate in their networks and to deal with plans' different credentialing processes. Medicaid coverage that pays for extractions but limits or does not pay for services that can save patients' teeth (e.g., root canals, crowns) frustrate dentists, as do policies that thwart continuity of care, such as loss of maternal dental benefits following pregnancy in some states. One participant indicated that dental practices that serve primarily low-income patients can find it harder to get bank loans or face higher interest rates to borrow.

- **Dental benefits.** Recognizing the extensive unmet need for oral health care among poor adults, some states are taking steps to expand dental benefits and dentist participation in Medicaid. Participants stated that, with millions of low-income working-age adults entering the Medicaid program, awareness of the urgent need for dental care in this population has sharpened. In recent years, a number of states have restored adult dental benefits that were previously cut, introduced an adult dental benefit, or added new benefits, such as preventive dental services. The point was made that the adult Medicaid population is not monolithic and that there is need to think about subgroups with special oral health needs, including pregnant women, individuals with disabilities, and people with diabetes. Some states with limited adult dental benefits have taken steps to provide more expansive access to services for selected groups. For

example, one state with caps on covered services instituted a “benefit limit exceptions” process to permit additional services, including dentures, crowns, and endodontic and periodontic care, for pregnant women as well as adults with a serious chronic or other condition when certain criteria are met. Other states provide a more robust dental benefit package for pregnant women. It was suggested that, in states where a more meaningful adult dental benefit is not possible, even paying for toothbrushes and toothpaste in Medicaid could improve prevention and self-care among adult enrollees. One participant proposed that a 90% federal match rate, as now applies to family planning services in Medicaid, would go a long way to secure a sound dental benefit for adults.

- **Dental payment rates and participation.** State dental officials mentioned several tacks that states are taking to improve dentist participation in Medicaid. Increased Medicaid payment rates for dentists and/or targeted increases to sustain or boost dentist participation in rural or other underserved areas are one lever states can use; one discussant noted that even small rate increases are important because they are a legislative “foot in the door.” A couple of states have instituted incentives to dental providers to participate. Under a time-limited program in one state at the table, dentists and dental hygienists enrolled in Medicaid receive an incentive payment if they take five additional Medicaid patients (and provide two visits to each), and additional incentive payments for larger increases in their Medicaid patient panels. Along similar lines, under the Dental Transformation Initiative in California’s section 1115 waiver, the state will pilot incentive payments to Medi-Cal FFS dental providers (including safety-net clinics) based on year-on-year continuity in the provider and location of the annual dental exam received by a child.²
- **Medicaid delivery system choices.** State policy choices regarding how dental benefits are delivered can also impact dentist participation in Medicaid and Medicaid enrollees’ access to dental care. One state Medicaid official emphasized that when his state introduced an adult dental benefit in 2014, it decided to administer the benefit itself, using an Administrative Services Only contract rather than contracting with managed care organizations (MCOs) on a capitation basis. This approach kept the state in control of credentialing, network development, and pricing, which addressed the dental community’s apprehension about managed care and reimbursement. Many states see managed care as a better means to deliver the dental benefit and ensure access to care for Medicaid enrollees. Contracts with MCOs give states leverage to establish network adequacy standards and performance requirements and hold plans accountable, and capitation payment provides plans with flexibility and incentives to organize and pay for services in innovative ways. Discussants suggested that administrative barriers to dentist participation in Medicaid could be lowered if plans within a state had uniform credentialing and other processes.

Leadership, stakeholder engagement, and being ready matter.

Roundtable participants cited the critical role of leadership and advocacy by the Governor, legislative champions, state oral health coalitions, and the state dental association in the success of state effort to strengthen Medicaid adult dental benefits. Broad stakeholder engagement and an inclusive, deliberative planning process also emerged as important factors. Discussants identified turnover in state legislatures and term limits as a challenge to gaining policymakers’ attention and commitment and legislative traction. At the same time, there can be a sudden but fleeting opportunity to advance an initiative, so having a well-developed proposal ready to go is strategically important.

INNOVATIVE WORKFORCE AND SERVICE DELIVERY MODELS HAVE POTENTIAL TO EXPAND ACCESS TO ORAL HEALTH CARE, WITHIN AND BEYOND MEDICAID.

We have not maximized the potential of our current health care workforce to supply oral health services.

Roundtable participants observed that, while more dentists and other dental professionals are likely needed to meet increasing demand for services as insurance coverage expands, it is possible to increase the supply of care available with today's workforce. There was wide agreement that enabling dental hygienists to work "at the top of their license" by eliminating state scope-of-practice restrictions would enlarge the supply of care, especially in areas underserved areas, where dental hygienists are more willing to work and dentists are scarce. Primary care providers can also be trained and paid to furnish basic preventive services, and new provider types such as dental therapists can expand existing oral health care capacity and access. Another point discussants raised is that states may have leverage to work with dental schools – most of which are public institutions – to bring more dentists to disadvantaged and underserved communities.

Health centers remain a cornerstone of access to dental care for low-income adults.

Discussants emphasized the crucial role of health centers as a source of dental care for both Medicaid enrollees and other low-income adults, including uninsured individuals as well as QHP enrollees, many of whom lack dental coverage and qualify for health centers' sliding fees. Most health centers have dental clinics onsite, and the large ACA investment in health centers over a 5-year period and further extended by Congress has enabled health centers to expand the oral health services they provide and increase the number of patients they serve.

It is important that strategies to provide integrated, whole-person care incorporate oral health care.

Citing the widespread efforts to integrate behavioral and physical health care in Medicaid, discussants expressed the importance of including oral health in integrated care approaches as well. They explicitly recognized health centers as leaders in the integrated delivery of oral and primary care. Discussants also highlighted the increasing number of states that previously "carved out" dental benefits from their MCO contracts but are now carving them in, holding medical directors responsible for oral health as well. The MCO executive at the table expressed strong support for integration, but observed that oral health care is not a core competency of most MCOs, so, for the near-term, many may need to pass the risk for these services to other entities. Turning to the data needs for truly integrated care, participants identified how integrated patient health records and clinical decision-support tools can improve patient care – for example, prompting dental providers when their patients are due for a cancer screen, or generating oral health messages to physicians for their patients with diabetes. Discussants suggested that other approaches to integrated care at the provider level, such as having dentists screen for hypertension and physicians screen for oral disease, could also improve patient care.

Experts said that it will not be possible to grow our way out of the oral health crisis among low-income adults without reforming the current care delivery paradigm.

Clinical experts at the table stressed that high rates of oral disease among adults in Medicaid are unlikely to change in the years ahead without fundamental reorientation of our oral health care system. The prevailing structure of dental coverage is provider-driven, based on a more or less uniform set of services and periodicity

schedules regardless of individual risk factors, and on FFS payment. Even as states move to risk contracting, the capitation rates they set assume FFS fee levels and utilization experience. Discussants urged the need to move to evidence-based models of coverage and care that emphasize prevention, early intervention, and caries risk management, and to payment models like pay-for-performance, bundled payments, and other approaches that incentivize the provision of preventive care and reward improvement in outcomes rather than simply reimburse for utilization. While stressing that a transformed system that revolves around prevention is imperative if we are to get ahead of the epidemic of oral disease among low-income adults, roundtable participants stated that, for the foreseeable future, capacity for “rescue operations” performed by dentists must also be maintained or even expanded to deal with the current burden of disease and new demand for services as coverage expands.

New models to increase access to oral health care in underserved communities and populations show promise.

A thread running through the discussion was the need to rethink how services are delivered. The vast majority of dental visits take place in dentist offices today, but new models are bringing oral health care to people where they live, go to school, and work. The discussion highlighted the “virtual dental home” demonstration in California. In this technology-facilitated model, specially licensed dental practitioners provide preventive and simple restorative care in community settings including Head Start sites, residential facilities for people with disabilities, and long-term care facilities. These providers are equipped with portable imaging and other equipment and a web-based dental record system, which enables them to exchange patient information with a collaborating dentist. The dentist reviews the information and creates a treatment plan, and the community-based providers furnish the services they can in their setting and refer patients to dentists for more complex care. It was noted that this model involved state legislation both to expand the scope of practice for allied health personnel and to require California’s Medicaid program to pay for teledentistry services. Another model, known as “hub-and-spoke,” connects dentists in their main practice locations (hubs) to settings in nearby communities (spokes) where the dentist or a dental hygienist provides dental care on scheduled days.

DATA NEEDS

Quality measures for adult oral health are needed.

Discussants suggested that prioritizing adult oral health is made more challenging by the absence of commonly accepted adult dental quality measures. Such measures would help convey the scope and scale of the problem, identify key gaps (e.g., by state or poverty level), and provide benchmarks against which performance and improvement can be assessed – data that are needed to guide Medicaid and other health policy. One policy expert noted that the American Dental Association’s Dental Quality Alliance is developing and testing several adult as well as pediatric measures, but added that only pediatric measures had been at all embraced by states, consistent with the CMS Oral Health Initiative’s tight focus on low-income children’s oral health and the much more limited coverage of adults and adult dental services in Medicaid.

Monitoring the impact of adding adult dental coverage in Medicaid may require a phased approach.

One state official emphasized that the impacts of a newly established adult dental benefit emerge over time as implementation is solidified, changes in access to care and utilization occur, and outcomes potentially improve,

and that state monitoring strategies should be structured to take this reality into account. This discussant's state adopted a multi-year monitoring plan when it launched an adult dental benefit in Medicaid. Reflecting expectations about the early impacts of the benefit, state monitoring in Year 1 focused modestly on increases in dentist participation in Medicaid, and monitoring in Year 2 focused on reductions in ED visits for non-emergency dental care. Over time, the state will focus its monitoring on measures tied more closely to long-term goals for improved oral health outcomes.

Determining the return on investment (ROI) from covering dental benefits for adults in Medicaid is challenging.

While being able to demonstrate ROI from adult dental coverage, or provide a cost-benefit analysis, could enhance efforts to stabilize and expand these benefits, the discussion highlighted several issues that present challenges. Fundamentally, costs tend to be easier to quantify than benefits. In addition, benefits often take longer to materialize. Oral health outcomes, in particular, are lagging indicators and measurable gains may not occur in the budget or election or term-limit timeframe relevant to policymakers. Offsets or savings within Medicaid, for example, from reduced ED visits or hospital uncompensated care, can be difficult to attribute directly to expanded adult dental coverage and to quantify. Further, as new low-income adults continually cycle into Medicaid, their oral disease burden can conceal or wash out improvements in utilization, spending, and outcomes in the underlying Medicaid population. Identifying and quantifying returns to adult dental benefits beyond the Medicaid program (e.g., improved diabetes control and lower health spending, ability to work, social integration) is even more difficult analytically.

Technical assistance could help states move forward on Medicaid adult dental coverage.

Participants agreed that the availability of tools to estimate the cost of adding adult dental benefits would help states, advocates, and others begin to formulate proposals and model different alternatives. Other technical assistance from CMS and mechanisms to facilitate sharing of state experience and best practices, such as learning collaboratives, could also provide support to states considering dental benefit expansions and help guide their planning and implementation. In addition, discussants said, demonstration funding for innovative oral health care models and their evaluation could help identify promising delivery and payment system reforms and advance their diffusion.

Conclusion

The roundtable discussion on improving access to oral health care for low-income adults, drawing on the wide-ranging perspectives and expertise of the participants, yielded important themes and observations. Overarching all of them was a collective emphasis on the importance of prioritizing access to oral health care as part of the health care policy agenda. Medicaid's growing role in covering low-income adults, combined with the large infusion of federal dollars for Medicaid expansion and health center growth, provides an opportunity to address the high rates of oral disease and unmet dental need among low-income adults by expanding adult access to dental care in Medicaid. The ramifications of poor oral health among low-income adults, which extend beyond health to employment, drug use and incarceration, social isolation, and wide-ranging disparities, enlarge the context for considering action on this issue. As a

growing number of states are demonstrating with their own initiatives, states have important levers to expand both adult coverage and the availability of dental providers in Medicaid; health plans, health centers, and provider practices are a locus of innovation as well. Federal leadership focused on measuring and improving access to dental care among adults in Medicaid could accelerate progress, and broader efforts to address workforce shortages, oral health literacy, and other factors will also be important. But ultimately, leading experts agree, ending the epidemic of oral disease among poor populations will depend on greater integration of oral and primary care and a transformed oral health system defined by an emphasis on prevention, patient risk assessment and evidence-based care, and community-based models of service delivery.

Endnotes

¹ *Medicaid Adult Dental Benefits: An Overview*, Center for Health Care Strategies, July 2016. Available at: <http://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/>.

² Dental Transformation Initiative (DTI), Medi-Cal 2020 Waiver, California Department of Health Care Services. Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx>.



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