ORAL HEATLTH INNOVATION:
Opportunity and Risk, Medicaid Waivers and Keys to Good Oral Health

Dental Access Project Webinar
March 20, 2018

Community Catalyst

Community Catalyst is a national non-profit advocacy organization that works with national, state and local consumer organizations, policymakers and foundations to build consumer and community leadership to improve the health care system.

We support consumer advocacy networks that impact state and federal health care policy, and ensure consumers have a seat at the table as health care decisions are made.

COMMUNITY CATALYST

Presenters

Kasey Wilson is a Policy Analyst with the Dental Access Project at Community Catalyst. Kasey provides policy expertise on state- and national- level oral health policy. She conducts policy analysis, research and provides strategic technical assistance to grassroots health advocacy organizations working to expand access to dental care and improve oral health. Before joining Community Catalyst, Kasey worked for the Boston University School of Public Health conducting research and policy analysis on reducing insurance coverage and financing inequities among children with special health care needs. She holds a Bachelor's degree in Psychology from The College of New Jersey and a Master's degree in Social Work from Rutgers University.

Colin Reusch is the Director of Policy at the Children's Dental Health Project. He is a recognized expert in the Affordable Care Act's pediatric dental benefit and has advised policymakers and advocates throughout the country on implementing the law's dental provisions. In addition to the ACA, Mr. Reusch researches works at both the state and national levels to advance innovative approaches to oral health care delivery in Medicaid, CHIP and other public health initiatives aimed at improving the oral health of children and families. State policymakers and advocates turn to him for technical assistance in identifying and assessing policy options. Prior to joining CDHP, Mr. Reusch worked on government policy issues at the Kentucky League of Cities. He earned his Master's of Public Administration from Eastern Kentucky University.

Eileen Espejo oversees Children Now's media and oral health policy advocacy, education and outreach efforts. She has directed several conferences that convene federal policymakers, agencies and stakeholders to learn about the impact of media on children's health including, Is Food Marketing to Children Getting Any Healthier? and The Future of Children's Media: Advertising in Washington, D.C. Additionally, Eileen leads the organization's efforts to improve oral health care quality and access for children in California. This work has included leading a medical-dental collaboration project in Los Angeles County to increase dental utilization among children under age 6 enrolled in Medi-Cal, and helping the state implement a pediatric oral health action plan as called for by the Centers for Medicare & Medicaid Services. These projects are now being scaled through the Perinatal Infant Oral Health Quality Improvement Project on which Eileen serves as an advisory member, as well as in Sacramento County. Due to these projects and other advocacy Eileen has supported, she is advisory member on the State Office of Oral Health Strategic Plan and serves on several local health departments' oral health plan committees. She is an alumna of the University of California, Davis and the Coro Fellows Program in Public Affairs.

Oral Health Innovation: Opportunity and Risk, Medicaid Waivers and Keys to Good Oral Health

KASEY WILSON, POLICY ANALYST

1115 Waivers: Fostering Innovation, *Not* Limiting Access to Care

- **Medicaid's primary objective:** Provide insurance coverage and access to care to low-income populations

- 1115 "innovation" waivers allow states flexibility to waive some federal Medicaid regulations **as long as the innovative program** proposed is budget neutral and **meets Medicaid's objectives**

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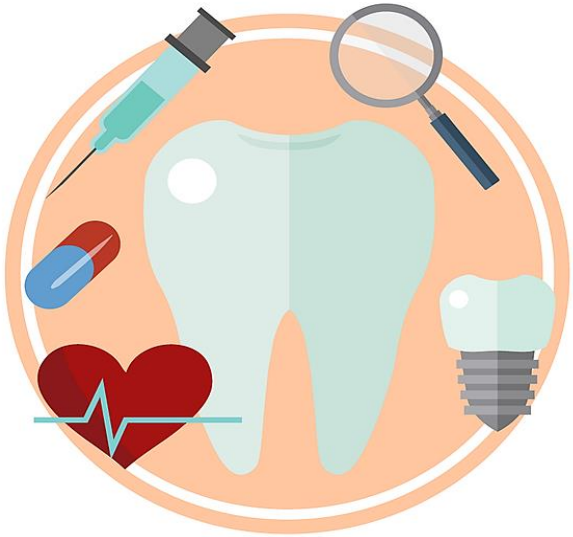
1115 Waivers:
A Pathway to Oral Health Innovation

Oral health is health!

Access to oral health care:

- Reduces need for costly future restorative care
- Reduces adverse general health problems
- Reduces ER use
- Lowers dental care costs



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Oregon: An Innovative Approach to Oral Health Integration

Integration:

- Co-located services
- Shared referral/EHR systems
- Coordinated medical/dental education
- ***Coordinated financing***

Oregon's Coordinated Care Organizations (CCOs):

- Foster inter-professional relationships
- Improve attention to and interest in oral health
- Improve children's oral health

California: Incentivizing Oral Health

California's Dental Transformation Initiative (DTI) provides incentive payments to providers

- Increase preventive services
- Caries risk assessments
- Continuity of care

Work Requirements: Risks to Access and the Intentions of 1115 Waivers

Work requirements = coverage loss
= lack of access to dental care:

- Missed work days
- Fewer interviews
- Fewer job offers

Lessons Learned and Moving Forward

Advancing Oral Health Systems Change through Policy Innovation

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Colin Reusch

Director of Policy

The Progress/Stagnation Paradox

Setting the state for innovation

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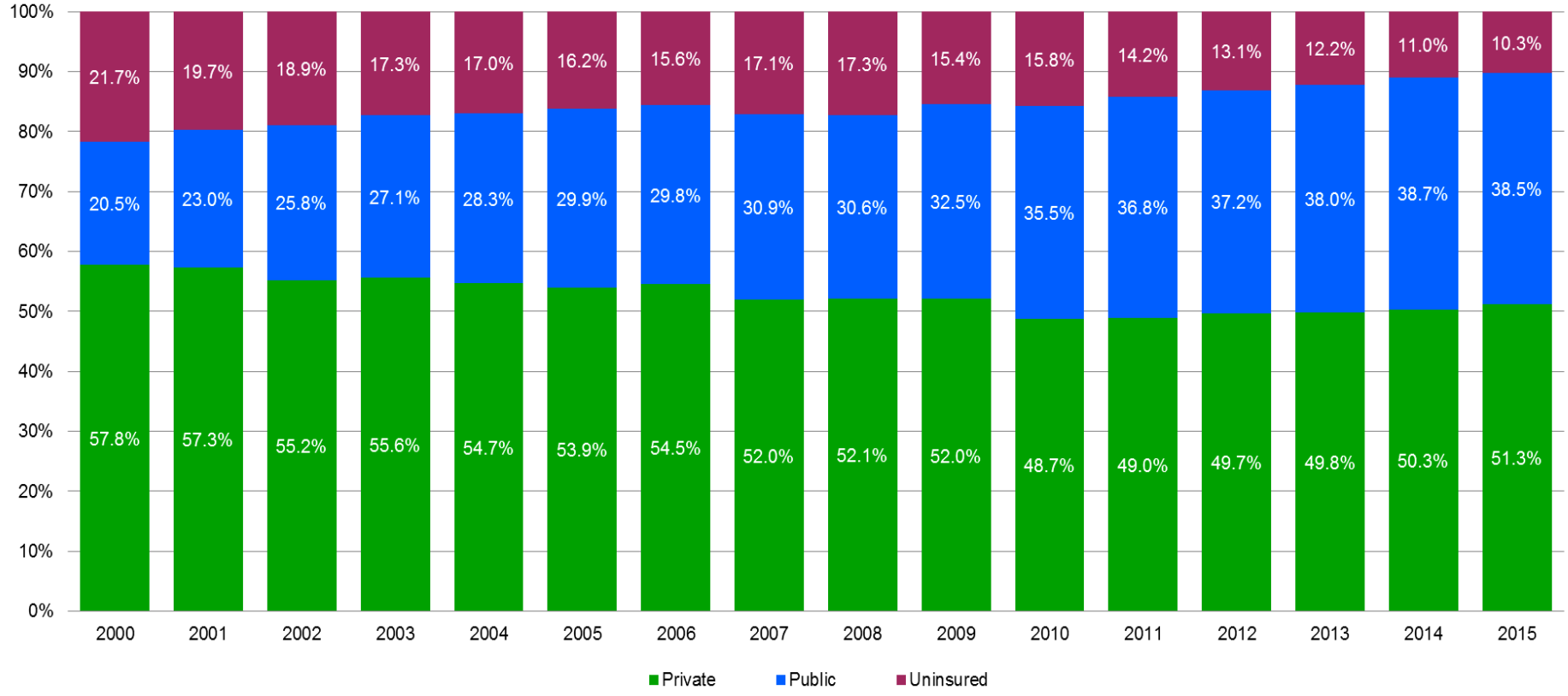
Children's Coverage: Significant Progress in Recent Years



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** All changes from 2000 to 2015 were statistically significant at the 1% level. Changes from 2014 to 2015 were not statistically significant.

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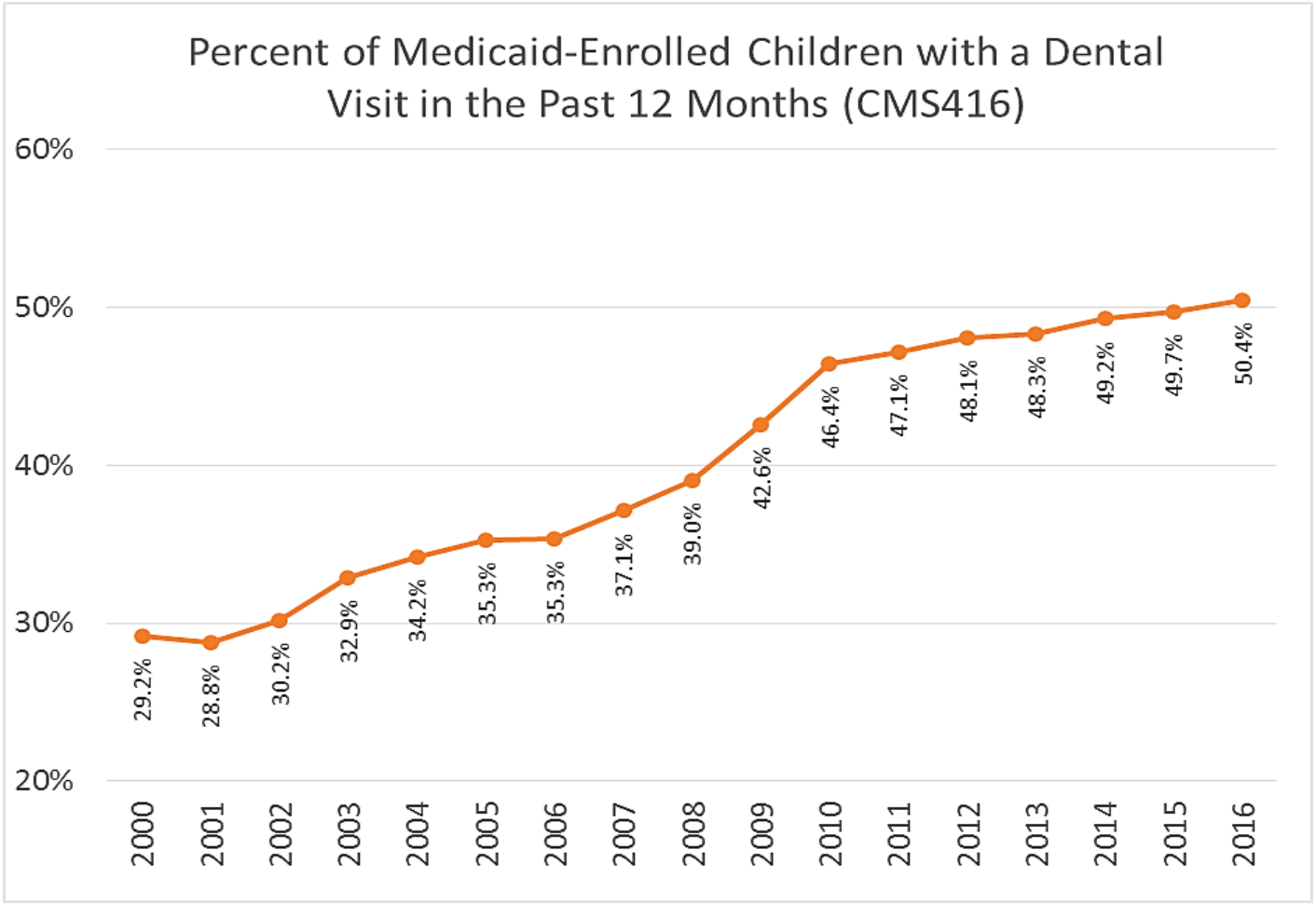
Source: American Dental Association Health Policy Institute analysis of MEPS data

Access: Significant Progress in Recent Years

On the whole, public programs are on par with private coverage when it comes to basic dental access for children.

But basic access is a pretty low bar.



Source: American Dental Association Health Policy Institute analysis of CMS 416 data

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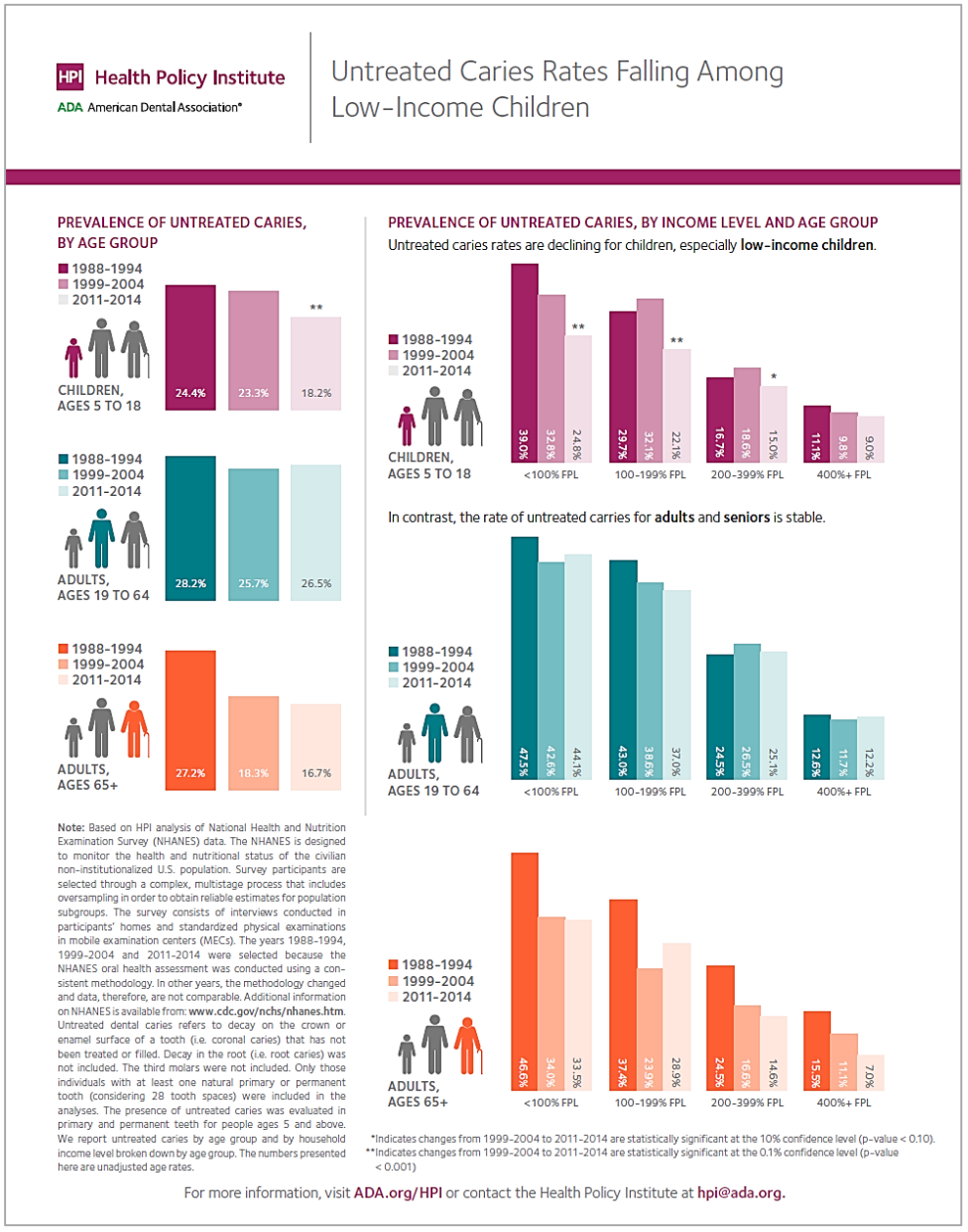
Improving outcomes for kids. Is it enough?

- Racial disparities still persist
- Progression of disease into adolescence remains
- Adults, including parents/caregivers, aren't seeing the same level of improvement
- These trends come at a cost to children, families and the economy



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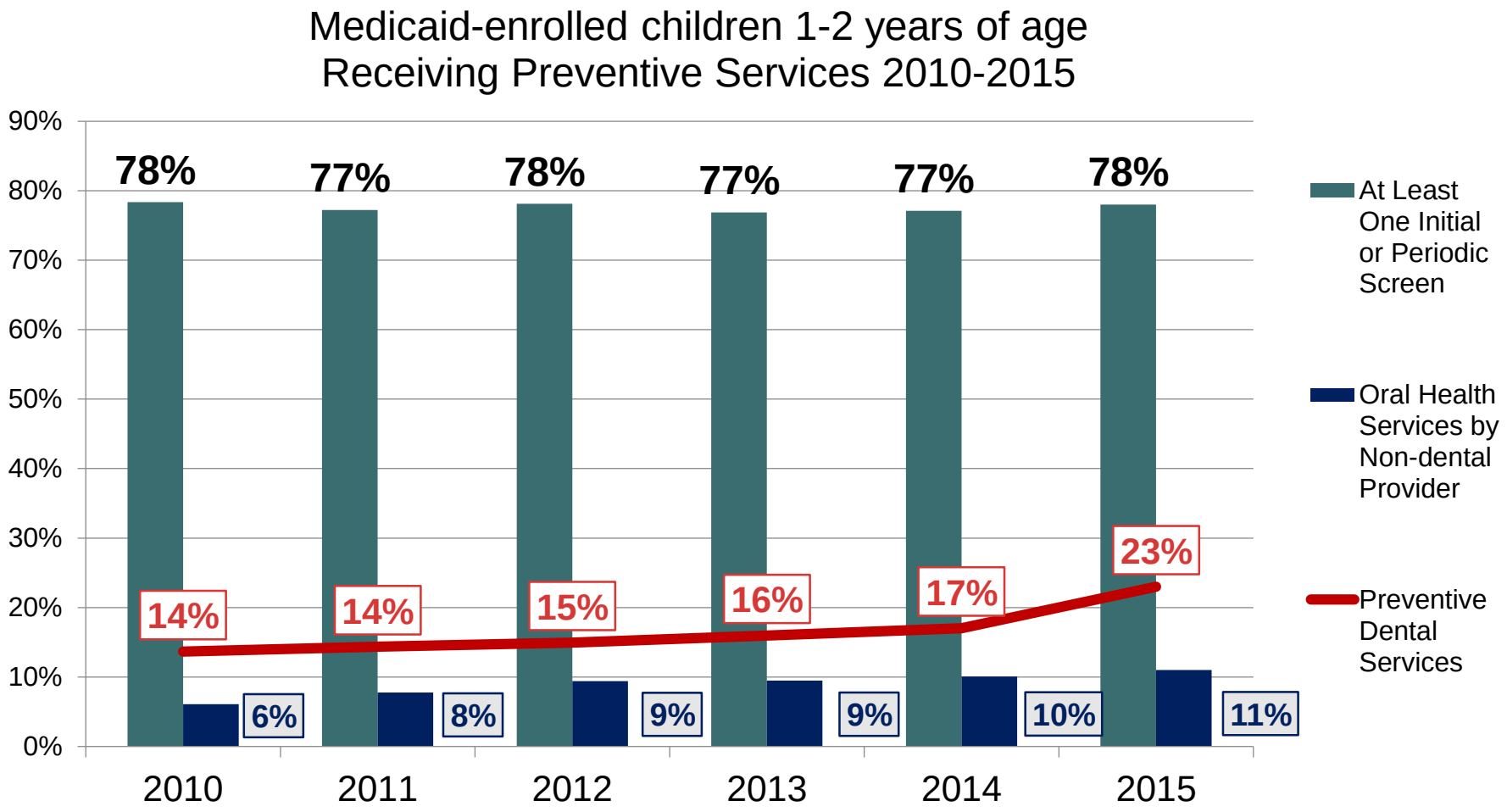
Missed Opportunities for Oral Health



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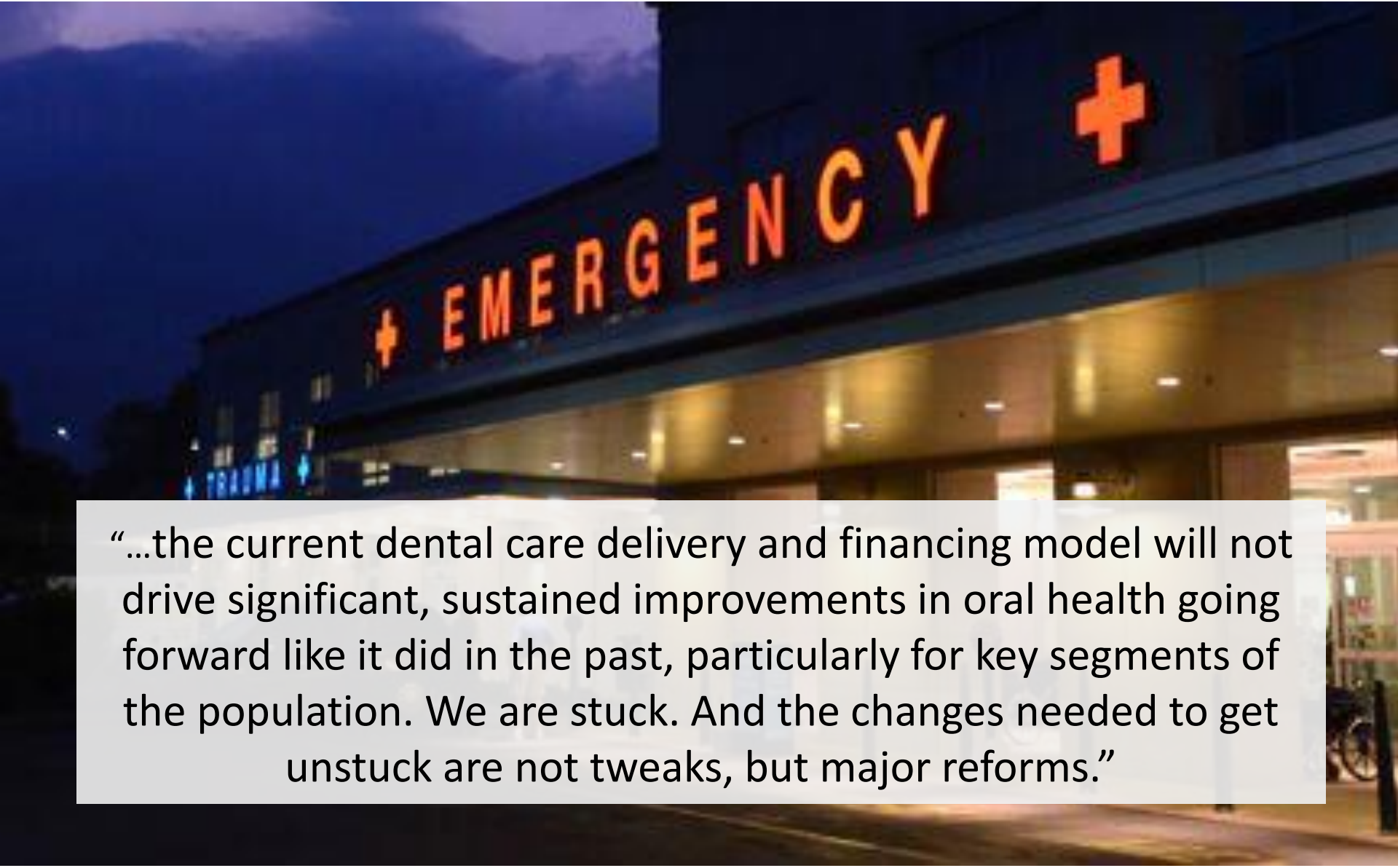
Source: CDHP Analysis of CMS 416 Data



"…the current dental care delivery and financing model will not drive significant, sustained improvements in oral health going forward like it did in the past, particularly for key segments of the population. We are stuck. And the changes needed to get unstuck are not tweaks, but major reforms."

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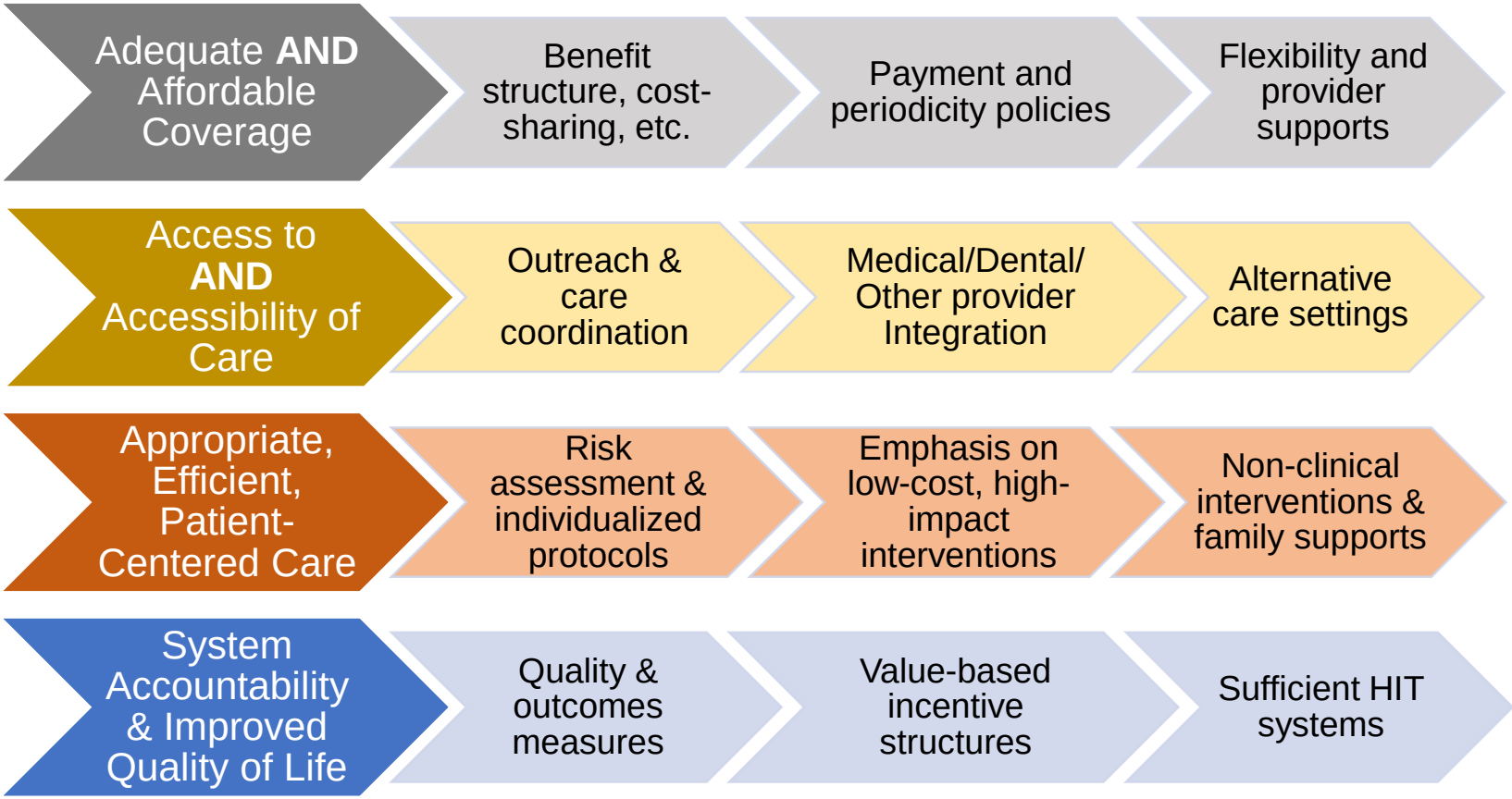
Sources: *Marko Vujicic, American Dental Association Health Policy Institute:*
Our dental care system is stuck. The Journal of the American Dental Association , Volume 149 , Issue 3 , 167 – 169.

What are we trying to accomplish through innovation?



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Why is this difficult to accomplish?

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Examples of Mechanisms for Oral Health Innovation

Care Delivery System Experimentation

- 1115 Waivers for local pilot projects
- CMMI funding to test new care delivery models
- Establishment of Accountable Care Organizations

Program Level Tweaks

- State Plan Amendments to delegate services to new providers
- Alignment of periodicity schedules & payment policies
- Performance metrics for MCOs

Plan/practice level changes

- Provider payments to achieve or avoid certain outcomes
- Value-add benefits for non-covered populations
- Tracking patient disease & outcomes in HER

Innovation beyond the dental clinic

- Inclusion of oral health into home visiting programs
- Oral health interventions for moms via WIC
- Oral health guidelines for OBGYNs

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Examples of innovation in the field

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Oral health/caries risk assessment: Driving accountability

- Well-established in clinical guidelines but not widely implemented
- CDT billing/diagnostic codes available
- Can be performed by medical and dental professionals and shows promise beyond clinicians

Uses include:

- Serving as basic screening tool
- Tracking patient health over time
- Targeting intensive care to highest risk patients
- Tailoring interventions for specific risk factors
- Raising awareness among providers AND patients
- Improving care coordination and referral
- Driving payment incentives

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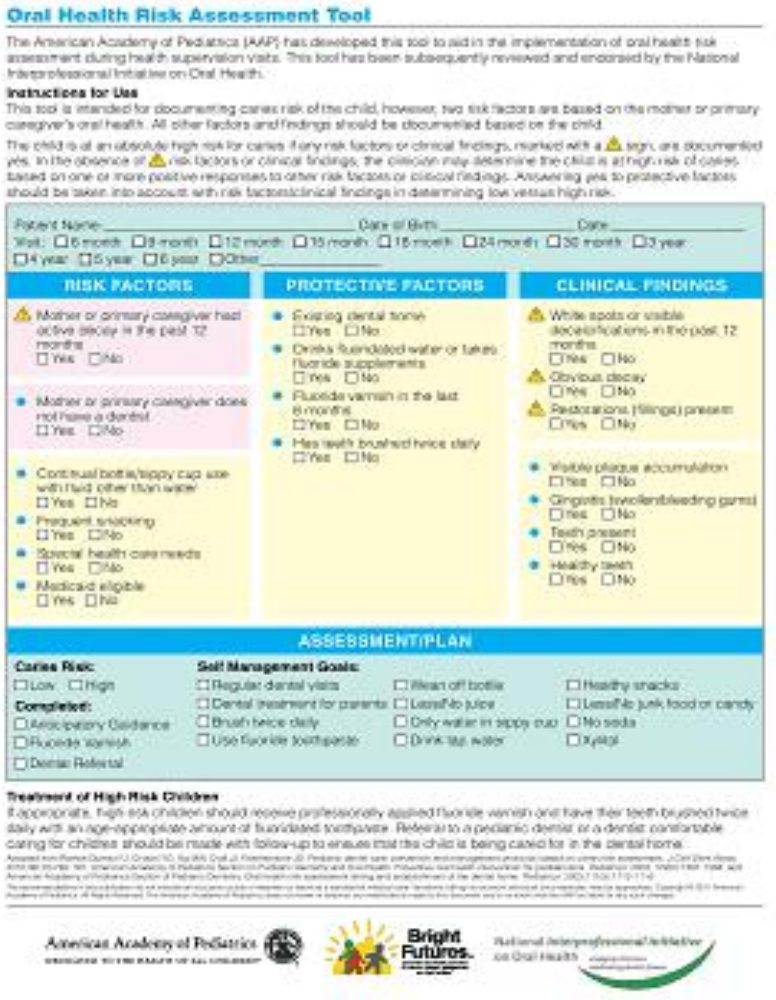
Oral health/caries risk assessment: Driving accountability

- Major component of California Dental Transformation Initiative
- Used for adults as part of Iowa's Dental Wellness Program
- Requirement of Texas First Dental Home initiative
- Delaware tying payment for other oral health services to risk assessment, especially for pediatricians



Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child; however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries, based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐Yes ☐No	• Existing dental home ☐Yes ☐No	⚠ White spots or visible decalcifications in the past 12 months ☐Yes ☐No
• Mother or primary caregiver does not have a dentist ☐Yes ☐No	• Drinks fluoridated water or takes fluoride supplements ☐Yes ☐No	⚠ Obvious decay ☐Yes ☐No
• Frequent bottle/sippy cup use with fluid other than water ☐Yes ☐No	• Fluoride varnish in the last 6 months ☐Yes ☐No	⚠ Restorations (fillings) present ☐Yes ☐No
• Frequent snacking ☐Yes ☐No	• Has teeth brushed twice daily ☐Yes ☐No	• Visible plaque accumulation ☐Yes ☐No
• Special health care needs ☐Yes ☐No		• Gingivitis (swollen/bleeding gums) ☐Yes ☐No
• Medicaid eligible ☐Yes ☐No		• Teeth present ☐Yes ☐No
		• Healthy teeth ☐Yes ☐No

ASSESSMENT/PLAN

Caries Risk: ☐Low ☐High

Completed: ☐Anticipatory Guidance ☐Fluoride Varnish ☐Dental Referral

Self Management Goals: ☐Regular dental visits ☐Dental treatment for parents ☐Brush twice daily ☐Use fluoride toothpaste ☐Wean off bottle ☐Less/No juice ☐Only water in sippy cup ☐Drink tap water ☐Healthy snacks ☐Less/No junk food or candy ☐No soda ☐Xylitol

Treatment of High Risk Children

If appropriate, high risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

American Academy of Pediatrics | Bright Futures | National Interprofessional Initiative on Oral Health

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Payment incentives to drive access and/or specific interventions

- Can be used at either plan or provider level
- Often tied to performance metrics of some sort
- Most often involves upside gains (e.g., bonus payments, shared savings)
- May include downside risk (e.g., relinquishment of savings or % of up-front payment)

May be operationalized through:

- Medicaid waivers (e.g., California, Oregon)
- MCO contracting arrangements (e.g., Pennsylvania)
- Inherent flexibility of managed care arrangements
- Restructuring of fees/reimbursement structure (may require plan amendment)

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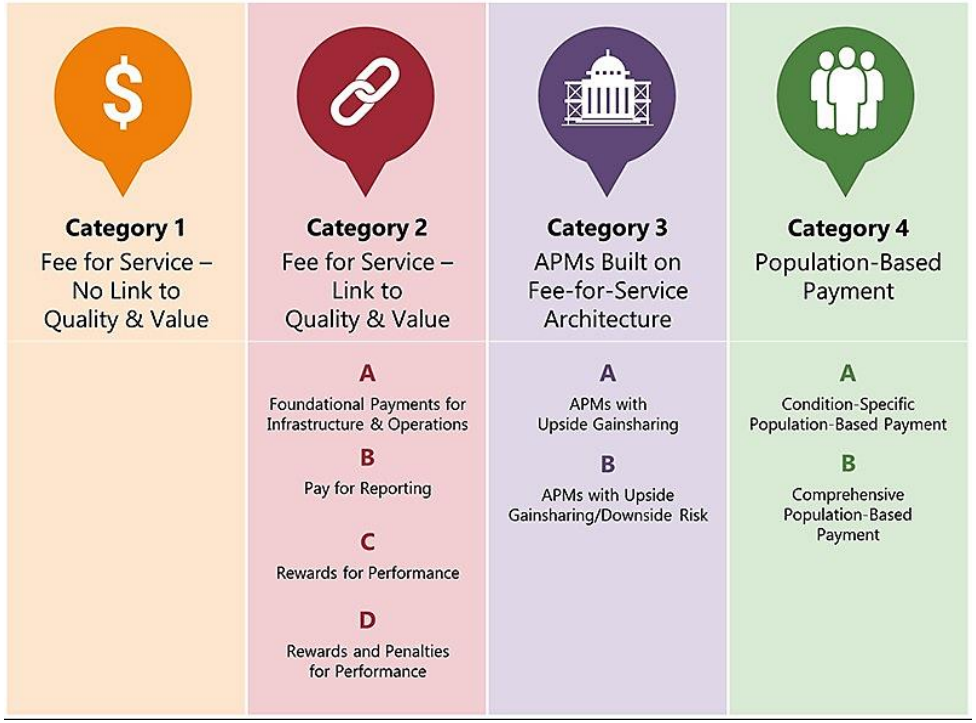
Payment incentives to drive access and/or specific interventions



Alternative Payment Model Framework –
Health Care Payment Learning & Action Network

- **Georgia:** Medicaid dental provider bonus payments for application of silver diamine fluoride AND avoidance of operating room care
- **Texas:** Dental pay for quality program, including at-risk capitation based on Dental Quality Alliance measures
- **Pennsylvania:** Setting targets for MCOs to engage in value-based purchasing and pay for quality, including dental
- **CMS:** Supporting three states (DC, NH, MI) to support innovative care delivery models with alternative payment

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Experimenting with bringing oral health to children and families

- Capitalizing on existing touchpoints and inherent connection between children and parent/caregiver's oral health
- Utilizing allied health professionals, lay health workers, and other non-clinicians to:
  - Address oral health in context of social determinants
  - Connect families to care
  - Promote and support healthy behaviors

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Experimenting with bringing oral health to children and families

- **Columbia/NYU:** CMMI-funded project using community health workers and iPad app (MySmileBuddy) for risk assessment, motivational interviewing, self-management goals, family supports in NYC
- **Kentucky:** Use of care coordinators for “Screening + Brief Intervention + Referral to Treatment (SBIRT)” for Medicaid eligible individuals
- **New Hampshire:** WIC clinics as touchpoint for children and pregnant women - assessment, parent education, sealants, SDF, and interim therapeutic restorations by advance practice hygienists

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Advancing Oral Health Systems Change through Policy Innovation

Eileen Espejo, Children Now, Media and Oral Health Policy Advocacy, Education and Outreach

CA Dental Transformation Initiative: Domain Goals

Domain 1: Increase the statewide utilization of preventive services for children by at least 10 percentage points over five years

Domain 2: Decrease the caries risk assessment (CRA) risk level, use of emergency room visits and use of general anesthesia among CRA utilized children age six and under from the pilot counties by 20 percent compared to the control group (i.e. Medi-Cal beneficiaries in same age group, CRA levels and counties of residency who do not receive CRA treatment)

Domain 3: Increase continuity of care for targeted children under the age of 21 in participating counties through regular examinations with their established dental provider with a goal of at least a five percentage point increase in continuity of care

Domain 4: Local Dental Pilot Projects (LDPP) address one or more of the three domains through alternative programs

Alameda County LDPP

Community Dental Care Coordinators (CDCCs): A linguistically and culturally responsive workforce

Case manage families seeking culturally competent care regardless of service area and based on parent/caregiver preferences (hours, weekend availability, languages spoken).

- 27 CDCCs in 14 agencies recruited and trained as of January 2018
- CDCCs will administer a social determinants of health survey to better understand barriers to care experienced by underserved families
- CDCCs (with participating dental providers) will use a web-based care coordination management system that can be accessed by partners to support provision/coordination, data tracking and sharing and to foster ongoing quality improvement efforts

How Did CA Get Here?!

2010: CMS launches Oral Health Initiative

2012: S-CHIP Dental Program ended. Approximately 860,000+ children transitioned to state Medicaid system. Of the 58 counties, dental care is delivered via FFS service, one is mandatory dental managed care, one is a voluntary managed care/FFS option.

2014: California State Auditor releases report, "Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care"

2013: CA selected to participate in *Medicaid Oral Health Learning Collaborative* to help advance CMS OHI Goals

2015-current: Little Hoover Commission
- "Fixing Denti-Cal" Report
- Hearings that have led to passage of bills
- Accountability

Questions?

Please use the chat box to submit your questions. Thank you.

Community Catalyst

Thank You

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