ORAL HEALTH INNOVATION: Opportunity and Risk, Medicaid Waivers and Keys to Good Oral Health
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.
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
Access to oral health care:

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

Oral health is health!
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’s Dental Transformation Initiative (DTI) provides incentive payments to providers

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

Colin Reusch
Director of Policy
The Progress/Stagnation Paradox

Setting the state for innovation
Children’s Coverage: Significant Progress in Recent Years

Source: American Dental Association Health Policy Institute analysis of MEPS data
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.
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
Missed Opportunities for Oral Health

Medicaid-enrolled children 1-2 years of age Receiving Preventive Services 2010-2015

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.”

What are we trying to accomplish through innovation?

- **Adequate AND Affordable Coverage**
  - Benefit structure, cost-sharing, etc.
  - Payment and periodicity policies
  - Flexibility and provider supports

- **Access to AND Accessibility of Care**
  - Outreach & care coordination
  - Medical/Dental/Other provider Integration
  - Alternative care settings

- **Appropriate, Efficient, Patient-Centered Care**
  - Risk assessment & individualized protocols
  - Emphasis on low-cost, high-impact interventions
  - Non-clinical interventions & family supports

- **System Accountability & Improved Quality of Life**
  - Quality & outcomes measures
  - Value-based incentive structures
  - Sufficient HIT systems
Why is this difficult to accomplish?

- Fear of change
- Separation of Dental Care
- Separation of Dental Financing
- Requires testing new approaches
- Oral health not seen as priority health care issue
- Upside-down incentives

Oral health not seen as a priority health care issue, separation of dental care and financing, fear of change, and the need to test new approaches are identified as reasons why this task is difficult to accomplish.
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
Examples of innovation in the field
Oral health/caries risk assessment: Driving accountability

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

- 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
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 pediaricians
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)
Payment incentives to drive access and/or specific interventions

- **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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**Alternative Payment Model Framework – Health Care Payment Learning & Action Network**
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
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
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.
Thank You

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