Dental Coverage, Access, and Quality in Medicaid: The Role of Data in Policy Opportunities

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I. Introduction to the Center for Health Care Strategies (CHCS)

II. Oral Health Challenges for Low-Income Populations

III. Opportunities in Medicaid for Oral Health Care Coverage and Access

IV. Seeking and Applying Data in Current Medicaid Oral Health Quality Improvement Efforts

V. Key Takeaways
About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care
CHCS Initiatives To Advance Oral Health in Low-Income Populations

Children

- **State Action for Oral Health Access** initiative (2002-04)
- **New Jersey Smiles: A Medicaid Quality Collaborative to Improve Oral Health in Young Kids** (2007-08)
- **Healthy Smiles – Healthy Families: Improving Oral Health in CA’s Healthy Families Program** (2010-11)
- **Medicaid Oral Health Learning Collaborative** (2012-present)
- Subcontractor on **CMS Oral Health Initiative** (2014-present)
Adults

- Advancing Dental Access, Innovation, and Quality for Medicaid-Enrolled Adults (2014-present)
- Faces of Medicaid Adult Oral Health (2014-present)

All Populations

- DQF Regional Oral Health Connection Team (2014-present)
- National Oral Health Connection Team (2015-present)
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Oral Health in Low-Income Populations

- Low-income adults are 50% less likely to have visited the dentist in the past 12 months than those with higher incomes.
- 42% of non-elderly, low-income adults have untreated tooth decay.
- More than one-third of elderly, low-income adults have lost all their teeth.
- Poor oral health elevates risks for chronic disease such as diabetes and heart disease.
- Poor oral health can lead to lost workdays and reduced employability.
Populations at Even Greater Risk for Oral Health Problems

- Chronically Ill
- People with special health care needs
- Elderly
- Institutional/homebound
- Racial/ethnic minorities
- Residents of rural or underserved areas
- Homeless
- Pregnant women and mothers

Key Barriers to Oral Health among Low-Income Adults

• **Inadequate Coverage**
  - Many states have eliminated or cut Medicaid adult dental benefits
  - Scope and frequency of adult dental benefit coverage varies by state

• **Insufficient Provider Availability**
  - Low dentist participation in Medicaid driven by low reimbursement rates, administrative requirements, patient behaviors

• **Individual Barriers**
  - Inability to make work/childcare arrangements or to obtain transportation
  - Low oral health literacy
  - Perception that oral health is secondary to overall health
  - Knowledge of dental coverage and how to utilize benefits
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### Medicaid’s Purchasing Power

<table>
<thead>
<tr>
<th>Medicaid serves 68 million Americans</th>
<th>41% newborns</th>
<th>Poor health care quality is an issue for all Americans; however, the gap is substantially greater for Medicaid beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>With expansion, may serve up to 79 million</td>
<td>33% children</td>
<td>Many people with chronic illnesses and disabilities</td>
</tr>
<tr>
<td></td>
<td>Many frail elderly</td>
<td>Many frail elderly</td>
</tr>
</tbody>
</table>

**As the largest purchaser of health insurance, Medicaid can leverage its purchasing power to:**

- Access performance data
- Identify and address gaps in quality
Vehicles to Expand Access to Coverage Under the Affordable Care Act

ACA provides three vehicles to expand access to health insurance coverage:

1. Private market reforms
2. Health Insurance Marketplaces
3. Medicaid Expansion
Medicaid Expansion State of Play: States Expanding Coverage to Adults <138% FPL

*Montana’s expansion has been approved by the state legislature but requires federal waiver approval.

Source: Kaiser Family Foundation
http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
## Current Definitions of Medicaid Adult Dental Benefit Categories

<table>
<thead>
<tr>
<th>Medicaid Dental Benefits</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Only</strong></td>
<td>Relief of pain under defined emergency situations (e.g., uncontrolled bleeding, traumatic injury, etc.).</td>
</tr>
<tr>
<td><strong>Limited</strong></td>
<td>Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure cap is $1,000 or less.</td>
</tr>
<tr>
<td><strong>Extensive</strong></td>
<td>A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least $1,000.</td>
</tr>
<tr>
<td>Dental Benefits Category</td>
<td>Base Population</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>No dental benefits</td>
<td><strong>5 states</strong>: AL, AZ, DE, MD, TN</td>
</tr>
<tr>
<td>Emergency-Only</td>
<td><strong>15 states</strong>: FL, GA, HI, ME, MS, MO, MT, NV, NH, OK, SC, TX, UT, WV, ID</td>
</tr>
<tr>
<td>Limited</td>
<td><strong>15 states</strong>: AR, DC, IL, IN, KS, KY, LA, MI, MN, NE, PA, SD, VT, VA, WY</td>
</tr>
<tr>
<td>Extensive</td>
<td><strong>16 states</strong>: AK, CA, CO, CT, IA, MA, NJ, NM, NY, NC, ND, OH, OR, RI, WA, WI</td>
</tr>
</tbody>
</table>
Alignment Between Each State’s Offerings for Base and Expansion Populations

• 28 of the 29 confirmed Medicaid-expansion states offer the same package to their base and expansion populations.
  ▶ Only exception is North Dakota, which offers extensive dental benefits to base, but none to expansion population.

• In Montana, where Medicaid expansion is pending federal waiver approval, dental benefits to be offered to the newly eligible are unknown (current beneficiaries receive emergency-only).
Growing Emphasis on Oral Health in Medicaid

Improve Oral Health Across the Lifespan

- Surgeon General Landmark Report: Oral health is integral to overall health and well-being.
- Adult dental care utilization lags behind children’s.
- Major barriers: coverage, access, personal/financial.

Leverage Momentum From the ACA

- Twenty-eight states plus DC expanded Medicaid eligibility for adults under Affordable Care Act (ACA).
- All states have the opportunity to include or enhance dental benefits for base and expansion beneficiaries.

Effectively Manage Costs

- Increasing use of emergency department (ED) for dental needs.¹
- 70% of dental-related visits to the ED from 2008-2010 were by residents of low-income geographic areas.²

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¹ Health Policy Institute, American Dental Association (2013). “Dental-related emergency department visits on the increase in the United States.” Available at: [http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0513_1.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0513_1.pdf)

Factors Influencing States’ Dental Benefits Decisions for the Expansion Population

- Continuation of the status quo
- Legislation and/or budgets
- Stakeholder process and engagement
- Cost estimates
- Perceived value of oral health
- Desire to create benefits parity with base Medicaid populations
Fiscal Impact is Top-of-Mind

- States considering cost-mitigating policies:
  - Limitations on services
  - Prior authorization requirements
  - Copayments for certain services
  - Care coordination to reduce preventable costs

- Monitoring ongoing service utilization data
State Strategies to Promote Oral Health Access Following Medicaid Expansion

- Outreach targeted to newly eligible and hard-to-reach populations (e.g., homeless).
- Building connections and support through stakeholder engagement and collaboration.
- Financial and non-financial incentives to improve the number of and access to oral health providers.
- Expand the dental workforce through use of alternative practice and mid-level providers.
Major Areas of Opportunities for States

- Evidence base for including adult and child dental benefits
  - **Concretely** quantifying return on investment (ROI) for including comprehensive dental benefits in Medicaid

- Changes to reimbursement structures:
  - Reductions and increases in provider reimbursement rates: pay more for “primary care” and less for “specialist care.”
  - Payment “bumps” to encourage providers to serve areas where access is a challenge.
  - Restructuring codes to incentivize care for certain populations.
  - Increases to individual service rates (e.g., oral surgery).
Questions?
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Where Does Measurement Fit In?

Short Answer: Everywhere!
States Working Toward Two CMS National Oral Health Goals

- Goal #1 – Increase by **10 percentage points** the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who receive a **preventive dental service** between FFY 2011 and 2015.

- Goal #2 – Increase by **10 percentage points** the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a **sealant on a permanent molar** tooth over a five-year period (baseline year TDB).
• CMS tracking annual state submissions of 416 data to identify yearly improvements in specific service utilization, as well as progress since baseline year.

• While important and valuable, 416 data do not tell the full story.
What Else Do We Need the Data to Tell Us?

• Within Medicaid, data should help to identify where the need for services/access are greater (and the greatest), in terms of:
  ► Various age categories;
  ► Regions/counties of a state;
  ► Provider type;
  ► Service delivery setting;
  ► Etc.
CHCS Medicaid Oral Health Learning Collaborative

- Support for seven states working toward CMS’ children’s oral health care access goals
- Quality improvement concepts and tools, peer learning opportunities, and tailored TA to support state quality and access goals
- All-state and individual state TA calls and convenings
- Sharing of expertise, best practices, experiences, and other resources
- Funded by the DentaQuest Foundation
Data Also Critical to Illustrate Achievement of Underlying Objectives and Success of Interventions

- **OHLC** states identified and are pursuing aims that support each of the two goals – each with their own data and measurement needs.

- Applying Plan, Do, Study, Act (PDSA) framework to perform rapid-cycle testing of interventions, producing data to inform quality-improvement.

Note: States participating in the OHLC are Arizona, California, Minnesota, New Hampshire, Texas, Virginia, and Washington.
Focus of State Aims to Support Goal #1

- Percentage of *oral health providers* who deliver a preventive dental service, including targeting those:
  - With service rates below the state; and
  - Who practice in counties/regions with service rates below the state average.

- Percentage of *non-dental providers* who deliver fluoride varnish with a dental referral.
Focus of Aims to Support Goal #1 (cont’d)

- Percentage of all children or those of specific ages who receive a preventive dental service in various settings.
- Percentage of pregnant women ages 19-21 served by WIC who receive a preventive dental service.
- Reducing the age of the first dental visit.
- Percentage of children who have a dental home.
- Increasing use of alternative providers.
- Improving rates, and accuracy of billing and reporting by providers.
- Tracking referrals to dental care.
Focus of Aims to Support Goal #2

- Percentage of *children* ages 6-9 who receive dental services from a dental home.
- Percentage of *providers* who provide sealants to children ages 6-9.
- *Plan encouragement* of sealant application.
- Number of *schools* with sealant programs.
- Percentage/number of children ages 6-9 receiving a sealant in a *particular setting*. 
Example #1: *Percentage of non-dental providers who deliver fluoride varnish with a dental referral.*

<table>
<thead>
<tr>
<th>Data Needed</th>
<th>Possible Data Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of PCPs contracted with Medicaid.</td>
<td>• State Medicaid agency provider files.</td>
</tr>
<tr>
<td>Number of PCPs who apply FV in the year.</td>
<td>• PCP claims for FV application.</td>
</tr>
<tr>
<td>Number of PCPs who provide referrals to dental care.</td>
<td>• Copies of referral forms</td>
</tr>
<tr>
<td></td>
<td>• Medical charts/EHRs</td>
</tr>
<tr>
<td></td>
<td>• PCP or family self-report</td>
</tr>
</tbody>
</table>
## Example #2: Plan Encouragement of Dental Sealant Application

<table>
<thead>
<tr>
<th>Data Needed</th>
<th>Possible Data Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of dental plans sending letters/e-mails or placing calls to dental providers.</td>
<td>Dental plan self-report.</td>
</tr>
<tr>
<td>Total number of dental providers contracted with a Medicaid dental plan.</td>
<td>Dental plan provider databases.</td>
</tr>
<tr>
<td>Number of contracted dental providers successfully reached by dental plans.</td>
<td>Dental plan reports of:</td>
</tr>
<tr>
<td></td>
<td>• E-mail messages sent and not returned undeliverable.</td>
</tr>
<tr>
<td></td>
<td>• Letters mailed and not returned undeliverable.</td>
</tr>
<tr>
<td></td>
<td>• Completed phone calls.</td>
</tr>
<tr>
<td>Number of contracted dental providers who increase their rates of dental sealant application in Medicaid beneficiaries ages 6 to 9 years.</td>
<td>Dental sealant claims data reported by plans.</td>
</tr>
</tbody>
</table>
Questions?
Using Data for Rapid-Cycle Improvement: PDSA

- **Plan** – What is the plan for this phase of your work – **how** will you get it done?
- **Do** - What actually **happened** during this phase of your work?
- **Study** - What did you **learn** from the study of your work to this point – are there areas for **improvement**?
- **Act** - How will you **improve the plan** for the subsequent phase of your work?
“Do” and “Study” Rely Most on Data

• **Do - What actually happened during this phase of your work?** For example:
  - Number of PCPs applying FV
  - Number of dental referrals made
  - Number of letters sent by plans
  - Percentage of phone calls attempted and completed
“Do” and “Study” Rely Most on Data

- **Study** - *What did you learn from the study of your work to this point – are there areas for improvement?*
  
  - Providers appear to have difficulty incorporating FV and referral delivery into practice, suggesting they could use guidance around doing so.
  
  - Providers need an easier system for reporting delivery of referrals.

- An unacceptable percentage of letters from dental plans were returned as undeliverable, suggesting the plans need to update their patient databases.
Challenges Around Data Collection Underscored by OHLC

- Data for some measures (e.g., delivery of dental referrals) are not readily available or fully reliable.
- Plans/practices have variable capacity and approaches to data collecting and reporting.
- Variations in covered population make it difficult to track change, and/or to identify the impact of interventions on utilization/access.
Considering new categories of adult dental benefits classifications.

- More accurately represent state offerings.
- Consider various dimensions of comprehensiveness (e.g., number/type of services covered, limitations around frequency, expenditure caps, etc.).
- More “nuanced” definitions may allow improved tracking of changes in coverage, possibly incentivizing states to enhance their offerings.
Retrospective analysis of Medicaid data to assess dental service utilization and expenditures among nonelderly, adult Medicaid beneficiaries. Study will include specific analyses of:

- Individual and community-level predictors of dental service utilization and costs.
- High-cost, high-need subpopulations.
Technical Assistance for Oral Health Stakeholders

CHCS’ Advancing Dental Access, Innovation and Quality for Medicaid-Enrolled Adults technical assistance series. Topics to include:

- Stakeholder Engagement
- Financing and Contracting Strategies
- Quantifying the ROI of a Comprehensive Medicaid Adult Dental Benefit
- Improving Dental Care Access and Quality for Vulnerable Adult Populations
- Identifying and Disseminating Oral Health Care Innovations
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Observations and Takeaways

• Data are needed throughout the planning, implementation, and assessment phases of oral health quality improvement.

• While some data are readily available, those that reside outside of the Medicaid agency – or nowhere at all – can present important challenges to program effectiveness and evaluation.

• State Medicaid agencies, their contracted plans, and participating providers all play critical roles in data collection, reporting, and analysis. Without commitment from all three, oral health quality improvement efforts cannot be optimally successful.
Questions?
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
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