

**ORAL HEALTH WORK GROUP
OF THE MEDICAID ADVISORY COMMITTEE**

July 7, 2016
9-11am

Oregon Health Authority-Lincoln Building
421 SW Oak Street, Suite 775, Transformation Center Training Room
Portland, OR 97204

Webinar registration: <https://attendee.gotowebinar.com/register/4641463367606824962>

Call– In number: 888.398.2342; code: 3732275

Time	Item	Presenter
9:00	Opening remarks and introductions	David Simnitt, OHA Co-Chairs
9:10	Oral Health Work Group overview <ul style="list-style-type: none"> • OHA Oral Health Initiatives • Oral Health Work Group Work Plan and Guiding Principles 	David Simnitt, OHA; Alyssa Franzen, Care Oregon; Bob Diprete, Retired health policy professional (MAC Liaisons)
9:25	Barriers to oral health access in the Oregon Health Plan <ul style="list-style-type: none"> • Brainstorm 	Co-Chairs
9:45	Defining access to oral health – model definitions and frameworks <ul style="list-style-type: none"> • Presentation • Q&A 	Amanda Peden, OHA
10:00	OHP oral health access framework and definition <ul style="list-style-type: none"> • Small group activity • Report outs and discussion 	Co-Chairs
10:45	Public Comment	
11:55	Closing comments	Co-Chairs

Materials:

1. Agenda
2. Oral Health Work Group Work Plan
3. Oral Health Work Group Roster
4. Oral Health Work Group Guiding Document
5. OHA Oral Health Initiatives Presentation
6. MAC Oral Health Work Group Work Plan and Guiding Principles Presentation
7. Defining Access to Oral Health – Model Definitions and Frameworks Presentation

8. Dental Care Delivery for Oregon's Medicaid Population
9. Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults (Kaiser Family Foundation)
10. Medicaid Adult Dental Benefits – An Overview (CHCS)
11. Medicaid-CHIP Oral Health Services October 2010 (CMS)

Next Meeting:

August 11th, 2016: 2:00-4:00 p.m.

Oregon State Library bldg. -Room #103

250 Winter St. NE, Salem, OR 97301



Oral Health Access Framework: Overview and Committee Work Plan

The Oregon Health Authority is uniquely positioned to work with CCOs and across divisions (Health Policy and Analytics, Health Systems Delivery, and Public Health) to coordinate activities to improve oral health outcomes for Oregonians. Recently, OHA expanded the capacity of its cross-divisional oral health program, with the hire of its first Dental Director, Dr. Bruce Austin (2015).

During the summer of 2016, OHA will commence an oral health strategic planning process to develop a coordination and alignment roadmap for oral health work across the agency: the OHA Oral Health Strategic Plan (OHA Strategic Plan). The OHA Strategic Plan will incorporate and build on:

- OHA-specific priorities and strategies in existing internal/external oral health plans, including the statewide [Strategic Plan for Oral Health in Oregon: 2014-2020](#) (Oregon Oral Health Coalition/Oregon Health Authority/Oral Health Funders Collaborative) and the [State Health Improvement Plan: 2015-2019](#) (OHA Public Health Division); and
- Emerging oral health priorities and strategies in the context of Oregon's Health System Transformation 2.0 efforts and other broad agency priorities, such as OHA's 10 priority areas, and Oregon's renewal of its 1115 waiver.

Oregon's Medicaid Advisory Committee (MAC) has the opportunity to inform OHA's ongoing strategic planning efforts with regard to oral health. Specifically, OHA has asked MAC to recommend a **framework** for defining and assessing oral health access for OHP members by addressing two foundational questions:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key data could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

The committee will review this issue in May-September of 2016 and will submit its recommendations to OHA by October 1st, 2016. The Committee's recommended framework around access to oral health for OHP enrollees will be incorporated into the OHA Oral Health Strategic Plan, which will be released by the end of 2016.

Date (2016)	Task Description
<p style="text-align: center;">May 25 (MAC Mtg.)</p>	<ul style="list-style-type: none"> • Introduce OHA request to develop the framework for assessing oral health access in OHP and committee work plan; present background on oral health for adults in Medicaid, summary of oral health delivery system in Medicaid, and summary of OHA strategic priorities and initiatives. <i>Committee approved creating an Oral Health Work Group to advise the committee on dental access framework.</i>

Oral Health Access Framework: Overview and Committee Work Plan

June	<ul style="list-style-type: none"> Recruitment for Oral Health Work Group.
June 22 (MAC Mtg.)	<ul style="list-style-type: none"> MAC approve <i>Oral Health Work Group</i> committee roster.
July 7 (Oral Health Work Group)	<ul style="list-style-type: none"> Presentations on national/state model definitions and factors. <i>Work Group</i> consider factors that help/hinder oral health access. Develop a working definition of access.
July 27 (MAC Mtg.)	<ul style="list-style-type: none"> <i>Work Group</i> present list of key factors influencing access for OHP members and working definition of access.
August 11 (Oral Health Work Group)	<ul style="list-style-type: none"> Presentations on model metrics/measures from dental work groups, strategic plans, national sources. <i>Work Group</i> Develop and prioritize list of key data influencing access for OHP members.
August/September	<ul style="list-style-type: none"> <i>Staff</i> draft memo on framework for oral health access in OHP per work group discussions.
September 20 (Oral Health Work Group)	<ul style="list-style-type: none"> <i>Work Group</i> review and discuss draft memo on framework for oral health access in OHP.
September 28 (MAC Mtg.)	<ul style="list-style-type: none"> MAC review and finalize draft committee memo on framework for oral health access in OHP for OHA.

Medicaid Advisory Committee: Oral Health Work Group

Member Name	Title	Organizational Affiliation	City	Race/ Ethnicity	Gender	Category
Christina Coutts	Community Health Worker	ShelterCare Homeless Medical Recuperation Program	Junction City	C	F	Consumer/ Advocate
Susan Filkins	Nutrition Consultant	Oregon Center for Children and Youth with Special Health Care Needs	Portland	C	F	Consumer/ Advocate
Dr. James Tyack	Dentist	Tyack Dental	Clatskanie	C	M	Provider
Kuulei Payne	Dental Hygienist	Winding Waters Medical Clinic	Wallowa	C	F	Provider
Dr. Lisa Bozzetti	Dentist/Dental Director	Virginia Garcia Memorial Health Center	Gresham	C	F	Provider
Heather Simmons	Medicaid Dental Services Director	PacificSource Community Solutions	Bend	C	F	CCO
Laura McKeane	Oral Health Integration Coordinator	AllCare Health	Grants Pass	C	F	CCO
Jim Connelly	VP of Network Development and Contracting	Trillium Community Health Plan	Eugene	C	M	CCO
Laura Bird	Director of Government Affairs/Policy Analyst	Northwest Portland Area Indian Health Board	Portland	NA	F	Tribal
Maria Ahrendt	Dental Manager	NARA Northwest Clinic	Portland	C	F	Tribal
Kelle Adamek-Little	Health Administrator	Coquille Indian Tribe	Coos Bay	C	F	Tribal
Dr. Mike Shirtcliff	President	Advantage Dental	Redmond	C	M	DCO
Matthew Sinnott	Director of Government Affairs and Contracts	Willamette Dental Group	Hillsboro	C	M	DCO
Dr. Jeffrey Sulitzer	Chief Clinical Officer/Dental Director	InterDent/Capitol Dental	Happy Valley		M	DCO
Dr. Eli Schwarz	Dentist, Professor & Chair	OHSU School of Dentistry, Department of Community Dentistry	Portland	C	M	General Public
Tony Finch	Executive Director	Oregon Oral Health Coalition	Happy Valley	C	M	General Public
Alyssa Franzen	Dental Director	Care Oregon	Portland	C	F	MAC Liaison
Bob Diprete	Former MAC Director; retired health policy expert	Retired	Amity	C	M	MAC Liaison

Guiding Document Oral Health Work Group of the Medicaid Advisory Committee

Authority
<p>On behalf of the Oregon Health Authority (OHA), the Medicaid Advisory Committee formed the Oral Health Work Group. The work group is tasked with developing a framework to assess oral health access in the Oregon Health Plan (OHP). The Work Group is directed to develop a framework by answering two key questions:</p> <ol style="list-style-type: none"> 1. What are the <u>key factors</u> that influence access to oral health care for OHP members (i.e. how should Oregon define access)? 2. What <u>key data</u> or <u>information</u> should be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?
Timeline
July – September, 2016
Roles, Responsibilities, and Scope of Work
<p>The purpose of the Oral Health Work Group is to develop a <u>high-level framework</u>, including a shared definition of oral health access in OHP and recommended data OHA can use to assess access to oral health services for members.</p> <p>Criteria for Developing a Definition of Oral Health Access: The Work Group will draw on existing federal and state definitions and frameworks regarding access to oral health and other health services. The definition and framework adopted by the Work Group should be tailored to Oregon’s unique health care delivery system; demographic characteristics, health needs and disparities among populations served by OHP; provider composition, and other Oregon-specific considerations.</p> <p>Key Data to Assess Oral Health Access: The Work Group will review, select, and prioritize measures on oral health access from existing local and federal sources, including local oral health advisory and work groups, existing oral health and oral-health-related strategic plans, and federal oral health access measures and metrics. Measures will be selected and prioritized for the purpose of OHA monitoring and evaluation of oral health access in OHP.</p> <p>The workgroup <u>is not tasked</u> with recommending incentive or accountability metrics for coordinated care organizations (CCOs). <u>The scope of work also does not include developing recommendations related to oral health access improvement strategies or solutions.</u> While critically important, these discussions are outside of the current scope and timeline for the Oral Health Work Group of the Medicaid Advisory Committee.</p>
Deliverables
<p>The Oral Health Work Group will be responsible for developing a memo that recommends a framework for assessing oral health access in the Oregon Health Plan. The memo will be presented for review and discussion at the Medicaid Advisory Committee meeting on September 29, 2016. The Medicaid Advisory Committee will approve and submit the final Oral Health Access Framework to OHA.</p>

Membership

OHA Leadership Sponsors:

David Simnitt, Oregon Health Authority
Dr. Bruce Austin, Oregon Health Authority

OHA Staff:

Oliver Droppers, Health Policy and Analytics (staff to the MAC)
Amanda Peden, Health Policy and Analytics (staff to the MAC)
Margie Fernando, Health Policy and Analytics (staff to the MAC)

MAC Liaisons

Alyssa Franzen, Care Oregon
Bob Diprete, Retired health policy professional

Work Group Members:

By MAC designation, the Oral Health Work Group is comprised of representatives from Coordinated Care Organizations (CCOs), Dental Care Organizations (DCOs), providers, consumer/consumer advocates, tribal, and members of the general public

Kelle Adamek-Little, Coquille Indian Tribe
Maria Ahrendt, NARA NW Clinic
Laura Bird, Northwest Portland Area Indian Health Board
Dr. Lisa Bozzetti, Virginia Garcia Memorial Health Center
Jim Connelly, Trillium Community Health Plan
Christina Coutts, ShelterCare Homeless Medical Recuperation Program
Susan Filkins, Oregon Center for Children and Youth with Special Health Care Needs
Tony Finch, Oregon Oral Health Coalition
Laura McKeane, AllCare Health
Kuulei Payne, Winding Waters Medical Clinic
Dr. Eli Schwarz, OHSU School of Dentistry, Department of Community Dentistry
Dr. Mike Shirtcliff, Advantage Dental
Heather Simmons, PacificSource Community Solutions
Matthew Sinnott, Willamette Dental Group (Co-Chair)
Dr. Jeffrey Sulitzer, InterDent/Capitol Dental
Dr. James Tyack, Tyack Dental (Co-Chair)

Meeting Schedule

Oral Health Work Group Meeting #1

Thursday, July 7, 9-11am
Lincoln Building, Suite 775, Transformation Center Training Room
421 SW Oak Street
Portland

Oral Health Work Group Meeting #2

Thursday, August 11, 3-5pm (please hold 2-5pm)
Oregon State Library, Room 103
250 Winter St., NE
Salem

Oral Health Work Group Meeting #3

Tuesday, September 20, 9-11am (please hold 9am-noon)

Wilsonville Training Center, Room 111/112

29353 SW Town Center Loop

Wilsonville

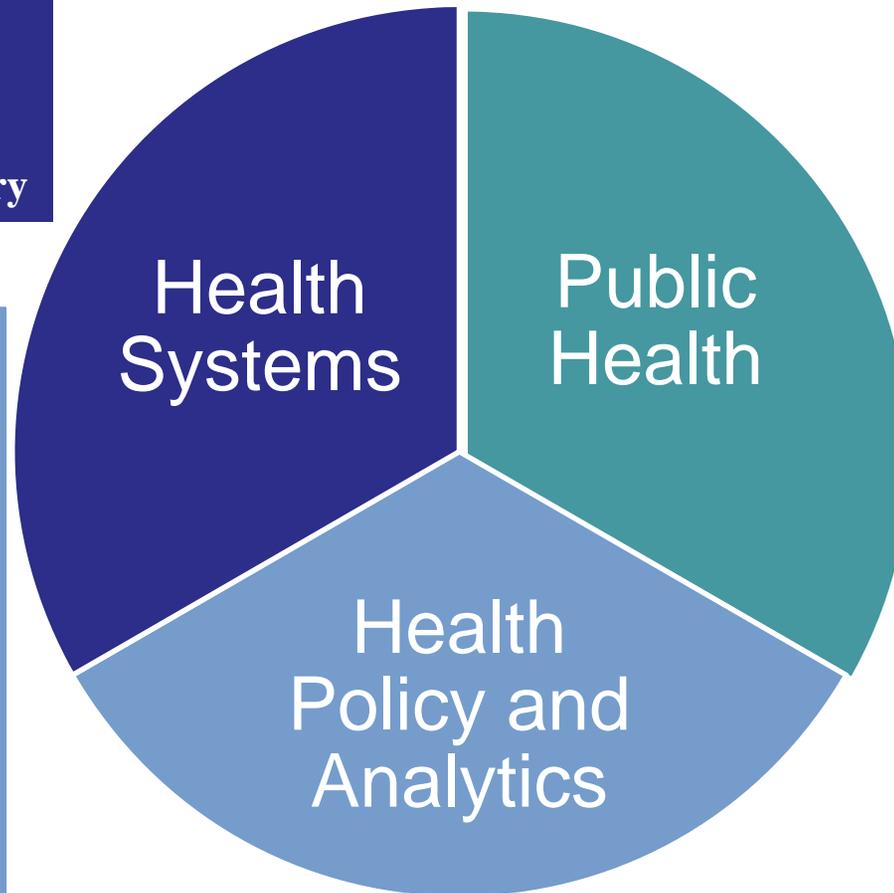
OHA Oral Health Initiatives

David Simnitt, Director of Health Policy
Oregon Health Authority
Office of Health Policy and Analytics

Oral Health in OHA

- Medicaid policy analysis, rules and policy implementation
- OHP oral health benefits and delivery

- State Dental Director (works across agency)
- Dental data hub and dental metrics
- Oral health policy development/health system transformation policy
- Strategic planning/coordination of oral health team
- Transformation Center TA, QA, support



- Oral health surveillance
- School-based programs (e.g. dental sealant and fluoride) and dental sealant certification
- Dental pilot projects
- HRSA Oral Health Workforce Grant
- Public health interventions local & statewide (e.g. Title V)
- Health education (e.g. tooth brushing, benefits of fluoridation)

Oral health in a changing landscape

2013

Medicaid expansion

Affordable Care Act Insurance Marketplaces launch

- Pediatric dental of one 10 Essential Health Benefits



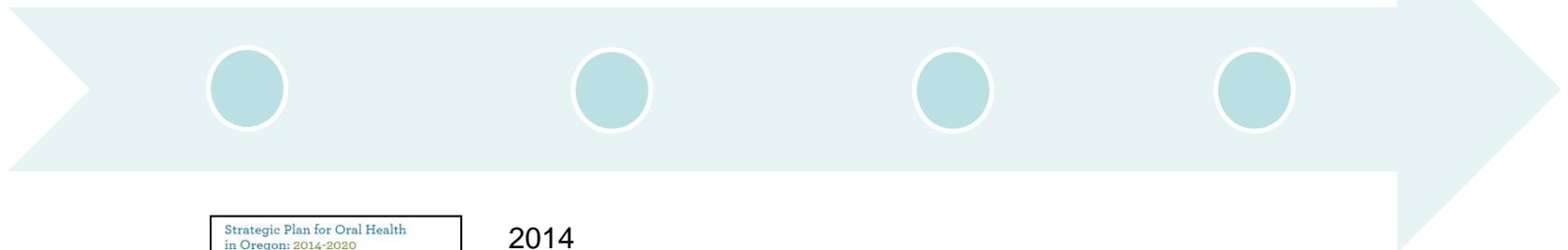
2015

State Health Improvement Plan (2015-2019)

- OHA Public Health Division created plan for statewide use
- Oral health one of 7 priorities

OHA Dental Director hired

Dental sealant metric adopted as of 2016



2014

Strategic Plan for Oral Health in Oregon (2014-2020)

- Statewide multi-stakeholder plan for oral health improvement

Dental integrated into CCO model (July)

2016

Oral Health in Oregon: OHA Dental Director report to the legislature (March)

Restored certain dental benefits

Develop OHA Oral Health alignment and coordination strategic plan and road map

The case for considering oral health access in Oregon

- Historically, OHP members show lower utilization rates than the general population
 - In 2014, 23% of OHP adults had dental visit in 2014¹; while 67% of all adults reported having a dental visit²
- Recent developments call for agency exploration of oral health access
 1. **Influx of new enrollees:** over 440,000 Oregonians newly enrolled in OHP since Medicaid expansion
 2. **Oral health integration:** Integration of oral health into CCO model occurred in July 2014.
 3. **State responsibility re: network adequacy:** Recent CMS rules require network adequacy standards for pediatric dental providers

1. OHA administrative data
2. 2014 Behavioral Risk Factor Surveillance System (BRFSS) data from the Oregon Oral Health Surveillance System
<https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/surveillance.aspx>

MAC Oral Health Work Group Ask and Guiding Principles

Alyssa Franzen, Care Oregon
Bob Diprete, Retired health policy professional
Medicaid Advisory Committee Liaisons

MAC Ask to Oral Health Work Group: Oral Health Access Framework

Develop a framework for defining and assessing access to oral health for OHP members.

- Deliverable: Memo recommending framework to be presented to Medicaid Advisory Committee, September 29, 2016

Guiding Questions

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should we define access)?
2. What key data and information could OHA use to assess access to oral health services for OHP members (i.e. how should we monitor and identify access problems)?

Scope of Work

- **Define oral health access:**
 - Draw on existing federal and state definitions and frameworks regarding access to oral health and other health services
 - Tailor to Oregon’s unique health care delivery system; demographic characteristics; health needs and disparities among populations served by OHP; provider composition; other Oregon-specific considerations.
- **Recommend key data to assess access (i.e. access measures):**
 - Identify, select, and prioritize key access measures from existing local/federal sources
 - Purpose is for OHA monitoring/assessing access; not recommending incentive or accountability metrics for coordinated care organizations (CCOs).

*The scope of work does not include developing recommendations related to oral health access improvement strategies or solutions.

Oral Health Access Framework – Work Plan

Date (2016)	Task Description
May 25 (MAC Mtg.)	MAC commits to developing a framework for oral health access and directs OHA to form the Oral Health Work Group to develop recommendations and a proposed framework.
June 2016	Oral Health Work Group recruitment and appointment (see Oral Health Work Group Roster)
June 22 (MAC Mtg.)	MAC approves Oral Health Work Group roster and revised work plan.
July 7 (OHWG Mtg #1)	<ul style="list-style-type: none"> • Introduction to the Work Group purpose and objectives • Presentation on national model access definitions and frameworks • <i>Work Group</i> identify barriers to oral health care access in the Oregon Health Plan and develop shared definition of oral health access
July 27 (MAC Mtg.)	<i>Work Group</i> present list of key factors influencing access for OHP members and working definition of access.
August 11 (OHWG Mtg #2)	<ul style="list-style-type: none"> • Presentation and review of model metrics/measures of access from dental work groups, strategic plans, national sources • <i>Work Group</i> develop and prioritize list of key data to assess access for OHP members
August/September	<i>Staff</i> draft memo on framework for oral health access in OHP per Work Group and MAC discussions
September 20 (OHWG Mtg #3)	<i>Work Group</i> review and discuss draft memo on framework for oral health access in OHP. Recommend revisions for memo to present to MAC.
September 28 (MAC Mtg.)	MAC review and finalize draft committee memo on framework for oral health access in OHP for OHA

Defining Access to Oral Health: Model Definitions and Frameworks

Amanda Peden, Policy Analyst
Oregon Health Authority
Office of Health Policy and Analytics

Potential Barriers to Health Care Access¹

1. Structural barriers related to the supply of care (e.g. providers, organization and delivery of care, and transport to care);
2. Financial barriers related to insurance coverage and continuity, provider payments, and benefits/cost sharing;
3. Personal barriers related to patient characteristics such as culture, language, attitudes, education, and income, which may influence acceptability of care.

MACPAC Access Framework



Medicaid and CHIP Payment and Access Commission (MACPAC). (2011). Report to the Congress on Medicaid and CHIP, Chapter 4: Examining Access to Care in Medicaid and CHIP. Available at: https://www.macpac.gov/wp-content/uploads/2015/01/Examining_Access_to_Care_in_Medicaid_and_CHIP.pdf

Enrollees

Medicaid and CHIP enrollees differ from the general population in terms of their demographic characteristics, health needs, and how they qualify for coverage.

- lower incomes and assets;
- discontinuous eligibility;
- geographic location;
- complex health care needs;
- cultural diversity;
- level of health literacy; and
- state variation in composition of enrollees.

Availability

Availability of providers represents “potential access.” Provider availability includes the characteristics of local health care markets, and state policies and provider responses to those policies (e.g. payment rates, participation rates, willingness to accept Medicaid, scope of practice).

- Provider supply (including provider characteristics, e.g. languages spoken)
- Provider participation
- Influenced by:
 - Health care delivery system
 - Distribution of providers
 - State policies and provider response (e.g. provider payment, participation rates, willingness to accept Medicaid, workforce issues [e.g. scope of practice])

Utilization/Use of Health Care Services

Utilization is “realized access,” or how services are actually used by individuals, and reflects availability, affordability, and acceptability of services:

- What services are used
- Affordability to enrollee
- How easily enrollees can navigate the health system (e.g. wait times, transportation)
- Enrollee experience/satisfaction with care
- Whether care is considered necessary/appropriate

IOM-NRC Committee on Oral Health Access to Services

- The National Research Council (NRC) and the Institute of Medicine (IOM) formed the Committee on Oral Health Access to Services to assess the current oral health care system with a focus on the delivery of oral health care to vulnerable and underserved populations (2009)
- Guiding Principles:
 1. Oral health is an integral part of overall health and, therefore, oral health care is an essential component of comprehensive health care.
 2. Oral health promotion and disease prevention are essential to any strategies aimed at improving access to care.

IOM-NRC Vision for Oral Health Care in the US

Everyone has access to quality oral health care across the life cycle.

To be successful with underserved and vulnerable populations, an evidence-based oral health system will

1. Eliminate barriers that contribute to oral health disparities;
2. Prioritize disease prevention and health promotion;
3. Provide oral health services in a variety of settings;
4. Rely on a diverse and expanded array of providers competent, compensated, and authorized to provide evidence-based care;
5. Include collaborative and multidisciplinary teams working across the health care system; and
6. Foster continuous improvement and innovation.

IOM-NRC endorsed broad definition of oral health access for vulnerable and underserved¹

- Timely use of personal health services to achieve the best possible health outcomes (earlier NRC-IOM committee definition)²
- Incorporate health care disparities:
 - Individual's ability to gain entry into the health care system (e.g. cost barriers) & appropriate sites of care to receive needed services.³
 - Providers who meet the needs of individual patients
- Additional considerations:
 - Access to oral health preventive services at regular intervals and treatment services when needed
 - Access to *quality* care – care that is safe, effective, timely, efficient, equitable, patient-centered

1. <http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx>

2. Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993.

3. AHRQ 2011 www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap9.html

Proposed definition of oral health access based on IOM-NRC considerations

Oral health access is the availability, affordability and timely use of quality oral health services at appropriate sites of care and from providers who meet the needs of individual patients, including oral disease preventive services at regular intervals and treatment services when needed, to achieve the best possible health outcomes.

Dental Care Delivery for Oregon's Medicaid Population

Oregon's Coordinated Care Model



Coordinated Care Organizations (CCOs)

A CCO is a network of all types of health care providers (physical health care, addictions and mental health care, and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

- 16 CCOs serve approximately 90% of Oregon Health Plan members.
- Mental, physical, dental care held to one per capita budget.
- Responsible for health outcomes and receive monetary incentives for quality care.
- Required to develop Transformation Plans with strategies to improve health outcomes, increase member satisfaction, and reduce overall costs.

Dental Care Integration

Prior to Oregon's health system transformation, Dental Care Organizations (DCOs) served the majority of the Medicaid population.

As of July 1, 2014, CCOs began managing the dental benefit, primarily by contracting directly with DCOs.

- Nine DCOs work with 16 CCOs and community partners to improve oral health for adults and children.
- CCOs contract with all DCOs available in their region (in some cases, all nine).
- CCOs connect members with DCOs.

Eight CCOs have specific oral health strategies in their 2015-2017 Transformation Plans, including:

- Eliminate/minimize barriers to dental care for all members
- Primary care integration, including implementing First Tooth early childhood prevention training, referral mechanisms, dental screenings for co-morbid severe and persistence mental illness (SPMI)/diabetes populations
- Value-based payments for dental
- Dental/medical integration

A small percentage of Oregon Health Plan members receive dental care outside of a CCO dental care arrangement, either in dental-only managed care or through the fee-for-service delivery system.

Health System Transformation : Dental Care

Developing Dental Quality Metrics

In 2013, OHA convened the Dental Quality Metrics Workgroup, including dental and CCO stakeholders.

Workgroup purpose: Recommend to the Metrics and Scoring Committee objective outcome and quality measures and benchmarks for oral health services provided by the CCOs.

Parameters: Metrics should align with national measures, be measurable, and focus on outcomes where possible.

Outcome: Metrics and Scoring Committee adopted two incentive pool quality metrics as of 2015.

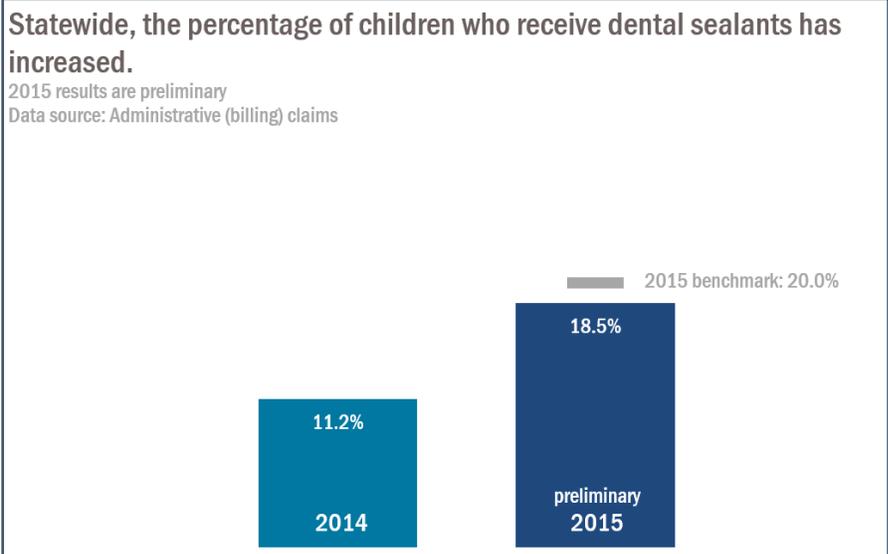
1. Mental, physical and dental* health assessments within 60 days for children in Department of Human Services (DHS) custody (e.g. foster care). (**measure amended in 2015 to include dental along with mental/physical health assessment*)
2. Dental sealants on permanent molars for children (ages 6-14)

Quality Metric: Dental Sealants on Permanent Molars for Children

Dental sealants are a widely recognized, evidence-based tool used to prevent tooth decay. Childhood tooth decay causes needless pain and infection, and can affect a child's nutrition and academic performance.

Description: Percentage of children ages 6-14 who received a dental sealant during the measurement year.

- Preliminary 2015 data indicates improvement by all 16 CCOs
- Statewide change since 2014: +65%
- All racial and ethnic groups experienced improvement



March 2016 | Issue Brief

Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults

Elizabeth Hinton and Julia Paradise

Introduction

Oral health is a critical but often overlooked component of overall health and well-being.¹ Although good oral health can be achieved through preventive care, regular self-care, and the early detection, treatment, and management of problems, many people suffer from poor oral health, which often has additional adverse effects on their general health and quality of life.² The prevalence of dental disease and tooth loss is disproportionately high among people with low income, reflecting lack of access to dental coverage and care. Racial and ethnic disparities in these measures are also pronounced.

Medicaid, the major health coverage program for low-income Americans, provides a uniquely comprehensive mandatory benefit package for children that includes oral health screening, diagnosis, and treatment services. In the last decade, with federal and state leadership, Medicaid and the Children's Health Insurance Program (CHIP) have made important progress in addressing gaps in low-income children's access to dental care, boosting children's use of preventive and primary dental services. However, even with a robust benefit package, securing access to dental providers and services has remained a key challenge. The situation for low-income adults in Medicaid is more complex than that for children. Dental benefits for Medicaid adults are not required by federal law, but are offered at state option, and most states provide only limited coverage – in many cases, restricted to extractions or emergency services. Further, when states have faced budget pressures, adult dental services in Medicaid have typically been among their first cutbacks.³ It is noteworthy, too, that the Medicare program, which covers elderly adults and nonelderly adults with disabilities, provides no dental benefits.

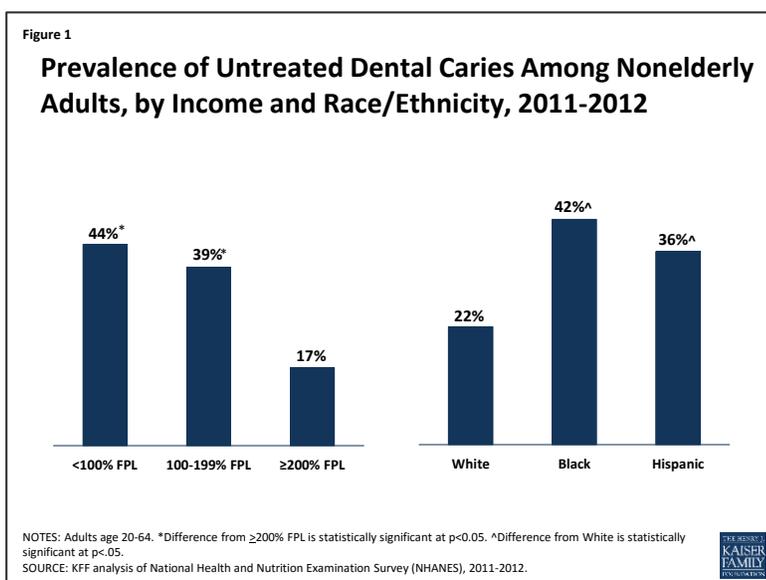
Comprehensive coverage of dental care for children in Medicaid and CHIP, as well as the designation of pediatric dental care as one of the ten essential health benefits (EHB) under the Affordable Care Act (ACA), indicate recognition among policymakers of the importance of oral health. New opportunities now exist to establish similarly robust oral health benefits for low-income adults. Broad state flexibility to define Medicaid benefits for adults, the ACA expansion of Medicaid to nonelderly adults up to 138% of the federal poverty level (FPL), and Medicaid payment and delivery system reform are key policy levers. To help inform federal and state action concerning adult access to oral health care, this brief examines the oral health status of low-income adults, the dental benefits covered by state Medicaid programs, and low-income adults' access to dental care today.

Why adult oral health is important

Untreated oral disease can have serious adverse impacts. Untreated oral health problems can affect appetite and the ability to eat, or lead to tooth loss, all of which can lead, in turn, to nutrition problems.⁴ Untreated problems can also cause chronic pain that can affect daily activities such as speech or sleep.⁵ Research has also identified associations between chronic oral infections and diabetes, heart and lung disease, stroke, and poor birth outcomes.⁶ Oral health problems can also interfere with work; employed adults are estimated to lose more than 164 million hours of work each year due to oral health problems or dental visits.⁷ Adults who work in lower-paying industries, such as customer service, lose two to four times more work hours due to oral health-related issues than adults who have professional positions.⁸ Visibly damaged teeth or tooth loss can also harm job prospects for adults seeking work.

Dental disease prevalence in nonelderly adults

Nationally, 27% of all adults age 20-64 have untreated dental caries, but the burden of disease is not distributed evenly in the population.⁹ The rate of untreated dental caries is highest (44%) among adults with income below 100% FPL (\$11,880 per year for an individual in 2016) – more than twice the rate (17%) among adults with income at or above 200% FPL (Figure 1). Racial and ethnic minorities were also disproportionately affected by oral health problems. Both Black and Hispanic adults had significantly higher rates of untreated caries than Whites, largely a reflection of their higher rates of poverty.



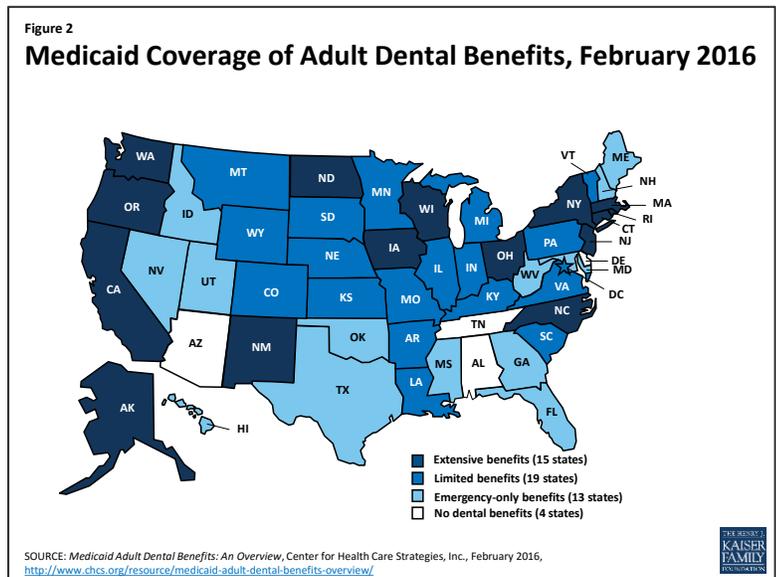
Medicaid's role in covering low-income adults

In 2014, Medicaid covered nearly 28 million low-income nonelderly adults. The program covers 4 in every 10 nonelderly adults under the poverty level.¹⁰ As of February 2016, 31 states and DC had adopted the Affordable Care Act's (ACA) Medicaid expansion, which provides Medicaid eligibility to nearly all adults with income at or below 138% FPL (\$16,394 per year for an individual in 2016); 19 states have not adopted the Medicaid expansion. The uninsured rate among low-income adults remains high, especially in non-expansion states.¹¹ Across non-expansion states, the median Medicaid income eligibility for parents is 44% FPL, and adults without dependent children, except pregnant women and people with disabilities, are excluded from Medicaid no matter how poor they are. An estimated 2.9 million adults with income below 100% FPL fall into the "coverage gap" across non-expansion states – without access to Medicaid coverage and unable to qualify for subsidies in the Marketplace.¹²

Medicaid dental benefits for adults

States have considerable discretion in defining Medicaid adult dental benefits because these services are optional, not mandatory, under federal Medicaid law. Adult dental benefits are a state option across the board – for adults who qualify for Medicaid under pre-ACA law and also for adults newly eligible for Medicaid under the ACA expansion. States must provide Alternative Benefit Plans (ABPs) for Medicaid expansion adults, modeled on one of four "benchmark" options specified in the law, including an option for coverage approved by the HHS Secretary. All ABPs must include the ten essential health benefits (EHBs) established by the ACA.¹³ Notably, the EHBs include pediatric dental benefits, but not adult dental benefits.¹⁴ Many states have used the Secretary-approved coverage option to conform the benefits they provide for expansion adults with their benefits for adults in traditional Medicaid, modifying them as necessary to comply with the EHB requirements. Of the 31 states and DC that have adopted the Medicaid expansion, all but two states provide the same dental benefits for expansion adults that they do for the traditional adult Medicaid population. The two exceptions are Montana and North Dakota. Montana provides limited dental benefits for its traditional Medicaid adult population, but none for Medicaid expansion adults; North Dakota provides extensive dental benefits for traditional Medicaid adults, but none for expansion adults.

Almost all states (46) and DC currently provide some dental benefits for adults in Medicaid (Figure 2 and Appendix). However, just as commercial dental plans typically do, many state Medicaid programs set a maximum on their per-person spending for adult dental benefits or impose caps on the number of certain services they will cover. The scope of Medicaid adult dental benefits varies widely by state. As of February 2016, 15 states provided extensive adult dental benefits, defined as a comprehensive mix of services including more than 100 diagnostic, preventive, and minor and major restorative procedures, with a per-person annual expenditure cap of at least \$1,000. Nineteen states provided limited dental benefits, defined as fewer than 100 such procedures, with a per-person annual expenditure cap of \$1,000 or less. The remaining 13 states with any adult dental benefits covered only dental care for pain relief or emergency care for injuries, trauma, or extractions. Four states provided no dental benefits at all.¹⁵ Even in states that provide some dental benefits, adult Medicaid beneficiaries may face high out-of-pocket costs for dental care, making it difficult or impossible to afford.



As optional Medicaid services, adult dental benefits are also subject to being cut. Many states change their benefits from one year to the next. In particular, when states are under budget pressures, adult dental benefits in Medicaid have been cut back and, when their economies improve, states often move to restore them. For example, in 2009, California eliminated coverage of non-emergency dental services for adults. In 2014, the state restored many of the benefits, including preventive and restorative care, periodontal services, and dentures. Similarly, Illinois eliminated coverage of non-emergency dental services for adults in 2012, but

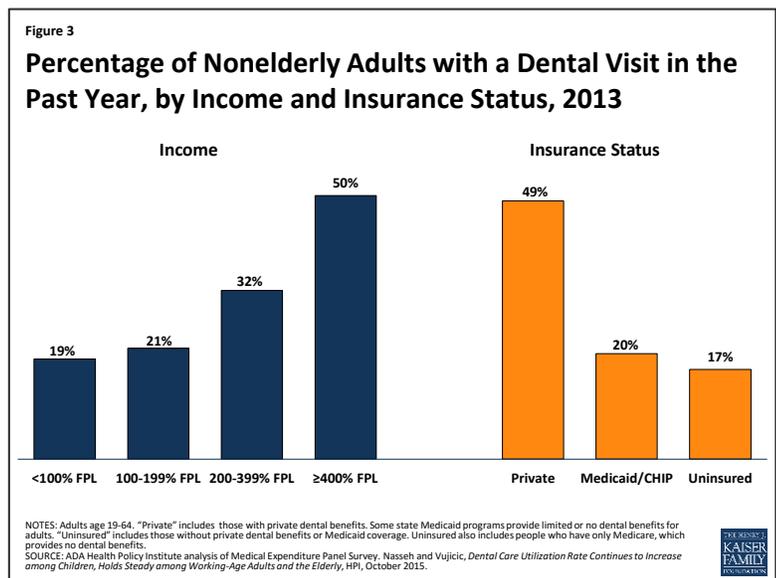
expanded services again in 2014 to include limited fillings, root canals, dentures, and oral surgery services.¹⁶ Research has shown that when states reduce or eliminate adult dental benefits, unmet dental care needs increase, preventive dental service use decreases, and emergency department use for dental problems increases.^{17 18 19}

Adult access to dental care

Access to and use of dental care among low-income adults depends on a number of variables. Medicaid eligibility for low-income adults, Medicaid coverage of dental benefits, the availability of dental providers, and beneficiary and provider awareness of the importance of preventive dental care all bear on whether low-income adults obtain dental services. Particularly in the absence of dental benefits, cost is the main barrier to access to dental care for low-income adults.²⁰ Paying for services out-of-pocket is difficult, if not impossible, on their strained budgets. Over time, persistent lack of access to dental care or connection with dental providers may result in low expectations for oral health among low-income adults, reinforcing existing disparities. And if consumers are unaware of the need for regular checkups or cannot afford them, they may wait until they experience oral pain to seek care.

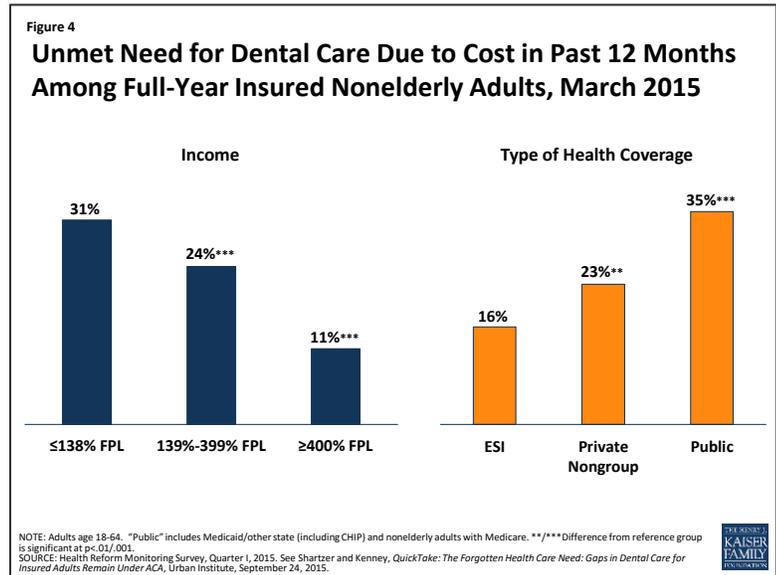
DENTAL CARE UTILIZATION AND UNMET NEED

Regular dental care is important to maintaining good oral health. Low-income adults are less likely to have seen a dental provider within the last year than higher-income adults. In 2013, only about 1 in 5 adults with income below 200% FPL had a dental visit in the past year, compared to 1 in 3 of those with income of 200-399% FPL, and 1 in 2 adults with income above 400% FPL (Figure 3). Similarly, adults with private dental coverage were more than twice as likely as adults with Medicaid/CHIP or uninsured adults to have seen a dental provider within the last year. (Note: “Uninsured” includes adults without private dental benefits or Medicaid and nonelderly Medicare-only adults who do not have private supplemental dental benefits.) In 2013, 49% of adults with private coverage had a dental visit in the last year, compared to 20% of adults with Medicaid/CHIP and 17% of uninsured adults. Children in Medicaid/CHIP, for whom dental benefits are mandatory, were much more likely than adults in Medicaid to have had a dental visit (42%).²¹ The low visit rate for adults with Medicaid/CHIP coverage, compared to both children with Medicaid/CHIP and adults with private insurance, reflects, in part, the limited adult dental benefits covered in many state Medicaid programs.



In recent research, dental care emerged as the service for which insured adults were most likely to report unmet need due to cost. This was especially true for low-income insured adults²² (Figure 4). Nearly one-third (31%) of full-year-insured nonelderly adults with income at or below 138% FPL and one-quarter (24%) of those

between 139% and 399% FPL reported an unmet need for dental care due to cost, compared to 11% of full-year-insured adults with income at or above 400% FPL. Also, nonelderly adults with public insurance, including those with Medicaid/other state coverage and those with Medicare, were more than twice as likely to report an unmet need for dental care due to cost as adults with employer-sponsored insurance (35% vs. 16%) – again, likely reflecting limited Medicaid adult dental benefits in many states.



PROVIDER AVAILABILITY AND THE ROLE OF HEALTH CENTERS

As of January 1, 2016, there were nearly 49 million people living in over 5,000 dental health professional shortage areas (HPSAs) across the country. HPSAs are defined primarily in terms of the number of dental health professionals relative to the population.²³ Although there is some debate about whether a national shortage of dentists exists, most experts agree that there is a geographic maldistribution of dentists and a shortage of office-based dentists available to treat low-income and special needs populations, including people in nursing homes and other residential institutions. In addition, dentist participation in Medicaid is limited, as a large percentage of dentists accept no insurance and many dentists who do accept private insurance do not accept Medicaid.²⁴ Medicaid beneficiaries often have difficulty finding a dental provider. The reasons dentists generally cite for not participating in Medicaid are low reimbursement rates, administrative burden, and high no-show rates among Medicaid patients.

Medicaid dental services may be delivered and paid for on a fee-for-service basis or by comprehensive or dental-only managed care plans that contract with the state. Of the 39 states with comprehensive Medicaid managed care in 2015, 29 states reported that they cover adult dental benefits. Of these states, 10 states reported carving-out adult dental benefits to Medicaid fee-for-service or prepaid health plans.²⁵

Although most dental care is provided in solo or small office-based dental practices, community health centers are an important source of dental care for Medicaid beneficiaries and others in low-income, medically underserved communities. In 2014, health centers across the country served 22.5 million patients, a large majority of them Medicaid beneficiaries (46%) and uninsured patients (28%).²⁶ The ACA made a major investment in health center growth, establishing a five-year \$11 billion Health Center Trust Fund (which has since been extended through 2017), and providing \$1.5 billion in new funding for the National Health Service Corps, which supplies many of the medical and dental providers who staff health centers. Health centers can also contract with private dental practices to provide oral health services to health center patients. Between the ACA trust fund dollars and increased patient revenues generated by expanded coverage for low-income people under the ACA, health centers in all states have been able to expand their service capacity; a recent survey of health centers found that those in Medicaid expansion states were significantly more likely than those in non-expansion states to have expanded their dental and mental services capacity since the start of 2014.²⁷ In 2014,

over three-quarters of health centers provided dental care, and about 15% of all health center patient visits were for dental services.²⁸

One strategy with potential to increase access to dental care in low-income communities is to develop a more diverse oral health workforce, because minority providers are more likely to work in minority communities and to provide care to the underserved.²⁹ Programs like the National Dental Pipeline Program have increased enrollment of under-represented minority students at participating dental schools. In addition, dental school accreditation standards have been revised to improve diversity among dental school faculty and students.³⁰

EXPANDING THE SUPPLY OF DENTAL CARE: SCOPE-OF-PRACTICE & NEW PROVIDER TYPES

In addition to dentists, dental hygienists, who specialize in preventive care and oral hygiene, are an integral part of the dental workforce. Dental hygienists work in a variety of settings (e.g., private offices, schools, nursing homes) in accordance with varying state requirements for dentist supervision, based on each state's practice acts or regulations. To expand access to dental care, some states have amended their scope-of-practice rules to allow dental hygienists to furnish services without the presence or direct supervision of a dentist. Accompanying changes may be needed in some states' Medicaid reimbursement policies and systems to permit dental hygienists to bill the program directly for services provided to Medicaid beneficiaries.

Some states have broadened the dental workforce further by introducing new midlevel dental provider types. Conceptually, midlevel dental providers play a role similar to that of nurse practitioners and physician assistants in the medical care context.³¹ They are part of the dental professional team and perform routine preventive and restorative services in a variety of settings.³² Three states – Alaska, Minnesota, and Maine – have recognized and licensed a new type of midlevel provider known as a dental therapist, to help improve access to care, especially for underserved populations. Education requirements, roles, and supervision requirements for midlevel dental providers vary across states. For example, Minnesota requires that at least 50% of the caseload of dental therapists and advanced dental therapists be Medicaid beneficiaries or underserved populations.³³ Emerging research on midlevel dental providers indicates that they provide high-quality, cost-effective care.³⁴

Other strategies for optimizing current dental care capacity are also developing. Effective January 1, 2015, California began requiring the Medicaid program to reimburse for services delivered by dental hygienists in consultation with remote dentists, a practice known as “teledentistry.”³⁵ This law was passed years after the state began the Virtual Dental Home Demonstration Project, a pilot program designed to test the “virtual dental home” model to expand access to care in dental shortage areas. In this model, telehealth technology is used to link allied dental professionals working in the community – registered dental hygienists in alternative practice, registered dental hygienists, and registered dental assistants – with dentists located in dental offices or clinics. The community-based providers collect patient information, including medical histories and x-ray images, and this information is then sent to the collaborating dentist. A treatment plan is developed, and the community-based provider furnishes the services they are authorized to provide in the community, and patients requiring more complex services are referred to a local dentist.³⁶

DENTAL DELIVERY SYSTEM

Important changes in two key realms are poised to affect the delivery of dental care in the coming years. The first relates to the organization of service delivery. Movement toward more integrated, “whole-person” care and more accountable systems of care (e.g., Accountable Care Organizations) is leading to arrangements in which providers who have not traditionally done so are now sharing patient information and collaborating in care planning. Currently, states and delivery systems (e.g., managed care plans) are focused primarily on integrating behavioral health care with general medical care, but some systems are taking steps to integrate dental care as well.³⁷ Interestingly, early research indicates that ACOs that provide dental services are more likely to include a health center and are much more likely to have contracts with Medicaid.³⁸

The second realm of change is clinical care itself. A different paradigm for oral health care is emerging that departs from the traditional fee-for-service, procedure-driven model that prevails today, and instead involves care planning based on individual patient characteristics and risk factors, and payment tied to quality and outcomes, not volume.³⁹ This approach is essentially a model of prevention and chronic care management, in which patient risk is assessed, and preventive care, early intervention, close monitoring, and care management are targeted to individuals with or at high risk for disease. The aim is to improve oral health outcomes by providing services based on individual patient risk and need. Rethinking systems of care and broad health system accountability may improve access to and utilization of dental care as well as the impact of Medicaid spending for dental services.

Looking ahead

Improving the oral health of low-income adults involves efforts to expand coverage, strengthen benefits, promote oral health, and improve access and care delivery. State Medicaid programs can play a major role in this area and have important levers for making advances. States that have not yet expanded Medicaid under the ACA have an opportunity to cover millions of poor adults who lack other affordable health coverage options. Independent of the Medicaid expansion, improving state economies may enhance the prospects for expansion of adult dental benefits in Medicaid programs. The progress that states have made in increasing children’s access to and use of dental care, by building stronger provider networks, leveraging accountability through contracts, and investing in care coordination efforts, provides a foundation for similar action for adults in Medicaid.⁴⁰ States are also expanding the dental workforce by removing scope-of-practice barriers and through targeted efforts among dental schools to increase diversity among dental students, as under-represented minority students are more likely to provide care to the underserved. Finally, state Medicaid programs are implementing a host of payment and delivery reforms in pursuit of higher-quality care, better patient outcomes, and reduced costs. A central emphasis of these new approaches is more integrated care, sometimes encompassing an expanded range of health and social services and supports, as well as innovative workforce and other strategies for expanding access. With growing recognition that oral health is essential to overall health and well-being, these new models of care present potential for increasing access to dental care and improving dental care and outcomes for both children and adults in Medicaid.

Appendix

Table 1: Oral Health Access in the States – Selected Measures

State	Medicaid Income Eligibility Limits for Adults (as % of FPL): ¹		Percent of Adults** ≤138% FPL Reporting “Poor” Condition of Mouth/Teeth, 2015 ²	Scope of Medicaid Adult Dental Benefits ³	Percent of Medicaid Children who received preventive dental visit in 2013 ⁴
	Parents (in a family of three)	Childless Adults			
Medicaid Expansion States:					
Alaska	143%	138%	14%	Extensive	42%
Arizona	138%	138%	25%	None	46%
Arkansas	138%	138%	32%	Limited	50%
California	138%	138%	20%	Extensive	37%
Colorado	138%	138%	10%	Limited	51%
Connecticut	155%	138%	14%	Extensive	60%
Delaware	138%	138%	19%	None	46%
DC	221%	215%	6%	Limited	50%
Hawaii	138%	138%	12%	Emergency-Only	44%
Illinois	138%	138%	20%	Limited	52%
Indiana	139%	139%	20%	Limited	38%
Iowa	138%	138%	9%	Extensive	50%
Kentucky	138%	138%	21%	Limited	43%
Louisiana*	138%	138%	27%	Limited	48%
Maryland	138%	138%	18%	Emergency-Only	53%
Massachusetts	138%	138%	15%	Extensive	54%
Michigan	138%	138%	20%	Limited	40%
Minnesota	138%	138%	17%	Limited	38%
Montana	138%	138%	21%	Limited	48%
Nevada	138%	138%	13%	Emergency-Only	45%
New Hampshire	138%	138%	17%	Emergency-Only	56%
New Jersey	138%	138%	15%	Extensive	47%
New Mexico	138%	138%	17%	Extensive	51%
New York	138%	138%	12%	Extensive	41%
North Dakota	138%	138%	14%	Extensive	29%
Ohio	138%	138%	9%	Extensive	21%
Oregon	138%	138%	20%	Extensive	40%
Pennsylvania	138%	138%	20%	Limited	40%
Rhode Island	138%	138%	15%	Extensive	41%
Vermont	138%	138%	19%	Limited	59%
Washington	138%	138%	18%	Extensive	55%
West Virginia	138%	138%	27%	Emergency-Only	46%
Non-Expansion States					
Alabama	18%	0%	19%	None	52%
Florida	34%	0%	26%	Emergency-Only	NR
Georgia	37%	0%	24%	Emergency-Only	50%
Idaho	26%	0%	14%	Emergency-Only	56%
Kansas	38%	0%	21%	Limited	46%
Maine	105%	0%	21%	Emergency-Only	40%
Mississippi	27%	0%	20%	Emergency-Only	48%
Missouri	22%	0%	25%	Limited	NR
Nebraska	63%	0%	13%	Limited	52%
North Carolina	44%	0%	15%	Extensive	49%
Oklahoma	44%	0%	18%	Emergency-Only	47%
South Carolina	67%	0%	21%	Limited	51%
South Dakota	52%	0%	18%	Limited	41%

Table 1: Oral Health Access in the States – Selected Measures

State	Medicaid Income Eligibility Limits for Adults (as % of FPL): ¹		Percent of Adults** ≤138% FPL Reporting “Poor” Condition of Mouth/Teeth, 2015 ²	Scope of Medicaid Adult Dental Benefits ³	Percent of Medicaid Children who received preventive dental visit in 2013 ⁴
	Parents (in a family of three)	Childless Adults			
Tennessee	101%	0%	16%	None	49%
Texas	18%	0%	24%	Emergency-Only	53%
Utah	45%	0%	13%	Emergency-Only	52%
Virginia	39%	0%	28%	Limited	48%
Wisconsin	100%	100%	21%	Extensive	25%
Wyoming	57%	0%	20%	Limited	41%
US	138% (median)	138% (median)	19%	NA	48% (median)

NOTES:

NR- Not Reported

* LA’s Governor signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. For purposes of this analysis, LA is considered an expansion state.

**Adults age 18 and older

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- ³⁷ Taressa Frazee et al., *Research Brief: Early Insights on Dental Care Services in Accountable Care Organizations*, (Chicago, IL: American Dental Association, Health Policy Institute, April 2015), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_1.ashx.
- ³⁸ Ibid.
- ³⁹ Michelle Hurlbutt, *CAMBRA: Best Practices in Dental Caries Management*, (Chesterland, OH: Academy of Dental Therapeutics and Stomatology, Aug. 2011), <http://www.rdhmag.com/etc/medialib/new-lib/rdh/site-images/volume-31/issue-10/1110RDH095-109.pdf>.
- ⁴⁰ Andrew Snyder and Keerti Kanchinadam, *Adult Dental Benefits in Medicaid: Recent Experiences from Seven States* (Washington, DC: National Academy for State Health Policy, July 2015), <http://www.nashp.org/wp-content/uploads/2015/07/Adult-Dental-Benefits-in-Medicaid-Recent-Experiences-from-Seven-States.pdf>.

Medicaid Adult Dental Benefits: An Overview

Access to oral health care for low-income adults is a persistent challenge in the United States. As many states expand Medicaid coverage for adults through the Affordable Care Act (ACA), there are new opportunities to expand much-needed dental coverage and avoid the dangerous and costly consequences of untreated dental disease.

Scope of the Problem

Low-income adults suffer a disproportionate share of dental disease, and are 40 percent less likely to have a dental visit in the past 12 months, compared to those with higher-incomes.ⁱ Forty-two percent of low-income adults ages 20 to 64 have untreated tooth decay, and more than one-third of those 65 or older have lost all of their teeth.ⁱⁱ Adults who are disabled, homebound, or institutionalized have an even greater risk of dental disease.ⁱⁱⁱ

Poor oral health can elevate risks for chronic conditions such as diabetes and heart disease, as well as for lost workdays and reduced employability.^{iv} It can also lead to the preventable use of costly acute care. A recent study identified \$2.7 billion in dental-related hospital emergency department visits in the U.S. over a three-year period. Thirty percent of these visits were by Medicaid-enrolled adults, and over 40 percent were by individuals who were uninsured.^v

Challenges to Oral Health Care Access and Utilization for Low-Income Adults

Inadequate Dental Coverage: While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental benefits for Medicaid-eligible adults are optional. States have considerable flexibility in determining the scope of dental services covered. As a result, Medicaid adult dental coverage varies tremendously across states, and is limited in some cases to emergency services such as tooth extractions, or to specific populations such as pregnant women.^{vi} In response to fiscal challenges, many states reduced or eliminated Medicaid dental coverage over the past decade,^{vii} with a concurrent 10 percent decline in oral health care utilization among low-income adults.^{viii}

Insufficient Provider Availability: Medicaid enrollees often have difficulty finding Medicaid-contracted dental providers. Only 20 percent of dentists nationwide accept Medicaid, citing burdensome administrative requirements, missed appointments, lengthy payment wait times, and low reimbursement rates as barriers to participation.^{ix,x}

Individual Barriers: Disparities in dental access and utilization for low-income adults are often exacerbated by challenges in making work or child care arrangements and/or obtaining transportation to appointments as well as covering the cost of required copayments. Additional issues that may pose barriers include: (1) a lack of awareness of dental benefits; (2) gaps in oral health literacy; (3) the perception that oral health is secondary to general health; and (4) primary care providers who may not encourage oral health care.^{xi,xii}

Medicaid Coverage of Adult Dental Benefits: Medicaid Base and Expansion Populations

The ACA provides new opportunities for states to leverage federal dollars and extend dental access to low-income adults through Medicaid expansion. A state can offer a dental benefits package to its expansion population that is either the same or different than what is provided to its base Medicaid population.^{xiii} Dental benefits covered by state Medicaid programs typically fall into three general categories:^{xiv}

- **Emergency Only:** Relief of pain under defined emergency situations.
- **Limited:** Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure for care is \$1,000 or less.
- **Extensive:** 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.

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Nearly all states (46) and the District of Columbia offer some dental benefit to their base adult Medicaid population. Thirty-three states cover services beyond defined emergency situations (e.g., uncontrolled bleeding, traumatic injury), and among those, 15 offer extensive services. The majority of states currently expanding Medicaid – 29 out of 31 – plan to offer the same dental benefits package to both their base and expansion populations.^{xv}

EXHIBIT 1: State Medicaid Coverage of Adult Dental Benefits by Type of Beneficiary Population (Base or Expansion)^{xvi}

Dental Benefits Category	Offered to Medicaid Base Population	Offered to Medicaid Expansion Population
No dental benefits	4 states: AL, AZ , DE , TN	4 states: AZ, DE, MT, ND
Emergency-Only	14 states: FL, GA, HI , ID, ME, MD , MS, MO, NV , NH , OK, TX, UT, WV	5 states: HI, MD, NV, NH, WV
Limited	18 states: AR , CO , DC , IL , IN , KS, KY, LA, MI , MN , MT , NE, PA , SC, SD, VT, VA, WY	10 states: AR, CO, DC, IL, IN, KY, MI, MN, PA, VT
Extensive	15 states: AK , CA , CT , IA , MA , NJ , NM , NY , NC, ND , OH , OR , RI , WA , WI	12 states: AK, CA, CT, IA, MA, NJ, NM, NY, OH, OR, RI, WA

Notes: Bolded states have decided to expand Medicaid eligibility under the ACA. DC is included as a state. Montana and North Dakota offer different categories of benefits to their Medicaid base vs. expansion populations. Idaho offers limited Medicaid dental benefits beyond emergency care to pregnant woman and adults with disabilities and/or other special health care needs. Maryland’s contracted managed care organizations provide a limited dental benefit to adult Medicaid beneficiaries who are enrolled in managed care.

State Strategies to Increase Dental Coverage and Access for Adults

States are engaging in a variety of strategies to promote adult coverage and access to oral health care. These include tailoring oral health literacy campaigns to educate eligible adults about coverage options; developing coalitions of likeminded partners to build political support; and expanding the dental workforce to include mid-level providers such as dental therapists, who can be trained and licensed to perform preventive care and routine restorative procedures.^{xvii}

ⁱⁱ 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>.

ⁱⁱⁱ 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>.

^{iv} The Institute of Medicine (2011). “Improving Access to Oral Health Care for Vulnerable and Underserved Populations.” Available at: <http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf>.

^v National Academy for State Health Policy (2008). “Medicaid Coverage of Adult Dental Services.” Available at <http://www.nashp.org/sites/default/files/AdultDentalMonitor.pdf>.

^{vi} V. Allareddy, S. Rampa, M. Lee, V. Allareddy, and R. Nalliah. “Hospital-based Emergency Department Visits Involving Dental Conditions: Profile and Predictors of Poor Outcomes and Resource Utilization.” *Journal of the American Dental Association*, 145, no.4 (2014): 331-337.

^{vii} Health Policy Institute, American Dental Association (2014). “More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion.” Available at http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_1.ashx.

^{viii} National Conference of State Legislatures (2014). “Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators.” Available at: <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>.

^{ix} Note: This decline was from 2002-2010. Health Policy Institute, American Dental Association (2013). “Dental Care Utilization Declined among Low-income Adults, Increased among Low-Income Children in Most States from 2000 to 2010.” Available at http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0213_3.ashx.

^x Subcommittee on Primary Health and Aging (2012) “Dental Crisis in America: The Need to Expand Access.” U.S. Senate Committee on Health, Education Labor and Pensions. Available at: <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

^{xi} National Conference of State Legislatures, op cit

^{xii} The Kaiser Commission on Medicaid and the Uninsured (2012), op cit.

^{xiii} Ibid.

^{xiv} S. Chazin, V. Guerra, and S. McMahon. *Strategies to Improve Dental Benefits for the Medicaid Expansion Population*. Center for Health Care Strategies. February 2014. Available at http://www.chcs.org/media/CHCS-Revised-Adult-Dental-Benefits-Brief_021214.pdf.

^{xv} Ibid.

^{xvi} Ibid.

^{xvii} Ibid.

^{xviii} Ibid.

Despite considerable progress in pediatric oral health care achieved in recent years, tooth decay remains one of the most preventable common chronic diseases of childhood. Tooth decay causes significant pain, loss of school days and may lead to infections and even death. CMS has been working with State and Federal partners as well the dental provider community, children's advocates and others to improve access to pediatric dental care for children eligible under Medicaid and the Children's Health Insurance Program (CHIP).

Use of Dental Services by Children

According to data collected for CMS's Early Periodic and Screening, Diagnostic and Treatment (EPSDT) benefit, approximately 38 percent of Medicaid eligible children received a dental service in 2008 (see Table 1). While this is an improvement over the 27 percent of children who received a dental service in 2000, it remains below the Healthy People 2010 goal of 56 percent of children having a dental visit within a year. Importantly, however, 17 States had dental service utilization rates above the average rate in Medicaid. Likewise, the use of preventive dental services also varied by States, with 10 States having at least 40 percent of children receiving a preventive dental visit in 2008. These findings are an indication that some States have identified ways of overcoming the barriers they face in improving access to oral health services.

Data from the Medical Expenditure Panel Survey (MEPS) show Medicaid performance on access to dental services in a broader context.¹ One study found that a larger percent of children with public coverage had at least one dental visit in a year than children without any coverage. While promising, these rates are still below those of privately insured children. This study also was useful in identifying children who may have greater problems accessing dental services than other children. For example, younger children (ages 2-5) and children in households where English is not the primary language, were less likely to have a dental visit in a year than their respective counterparts.

Challenges & Opportunities

The challenges to ensuring that Medicaid/CHIP eligible children receive the oral health services they are entitled to are varied. States note that enrolling sufficient dental providers and creating a dental home are continuing challenges. Administrative issues and low reimbursement rates are noted by providers as being a barrier to their participation in these programs.

To better understand how States are addressing these challenges, CMS reviewed eight States that were identified as having innovative practices and/or higher than average utilization rates.² From these reviews, we confirmed what we suspected: there is no "one size fits all" solution to improving access to dental services. In fact, it appears that States that use multiple activities-- including collaboration, reducing administrative barriers, and an increase in fees, have been able to improve access.

In addition to the barriers mentioned above by providers, children in Medicaid/CHIP may not have a dentist in their neighborhoods or lack transportation. They may face language barriers that make it difficult to access or receive services. Some families may not understand the importance of taking their children to a dentist for a check-up or of obtaining preventive care when there are no apparent problems. Moreover, some parents may not be aware that their children are eligible to receive dental services.

Despite the many challenges, opportunities do exist to improve access to oral health services for children. Some States are collaborating with State provider organizations, dental schools, health departments and others as a way of increasing access. Collaborations can be effective in educating dentists about Medicaid and CHIP programs, assisting them in enrolling as a provider in the program and helping the provider's staff navigate the unique Medicaid and CHIP administrative requirements such as confirming eligibility and filing claims. A number of States have increased provider rates as part of their strategies to increase children's oral health access, although fiscal conditions are an obstacle to many States increasing rates. In addition, working together to educate beneficiaries about the importance of oral health and reinforcing that message through multiple channels (e.g., Head Start programs) can provide States with opportunities to reach families and provide consistent information.

¹ "Findings on Children's Health Care Quality and Disparities." June 2009. Agency for Healthcare Research and Quality (AHRQ). <<http://www.ahrq.gov/qual/nhqrd09/nhqrdchild09.pdf>> 28 September 2010.

² Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports (October 2010) <http://www.cms.gov/MedicaidDentalCoverage/>