



# Enhancing Oral Health Access Through Safety Net Partnerships: A Primer and Resource Guide for Medicaid Agencies

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## Executive Summary

The safety net provides crucial access points for vulnerable and low-income populations in need of dental services, including Medicaid and Children's Health Insurance Program (CHIP) enrollees; however, large unmet need for dental services persists among these populations. Not only would increased access to dental services benefit patients, but also the opportunity to provide more preventive dental services could aid in lowering overall healthcare costs by reducing unnecessary related emergency department utilization. Faced with limited resources and many competing demands, states are challenged to expand dental coverage; this presents a ripe opportunity for Medicaid agencies and safety net providers to work collaboratively to find alternative ways to improve access to dental services for these populations.

Through a cooperative agreement with the Health Resources and Services Administration (HRSA), the National Academy for State Health Policy (NASHP) has developed this resource as a primer for Medicaid directors and other Medicaid leadership on the role HRSA-supported safety net providers play in providing oral health care to Medicaid enrollees and other low-income and vulnerable populations. This primer describes the types of services provided and the funding mechanisms that support three types of safety net providers:

- Health centers;
- School-based health centers; and
- Ryan White HIV/AIDS Program grantees.



Additionally, NASHP has identified opportunities for synergies between Medicaid and safety net providers to improve access to dental care:

- **Augmenting the oral health workforce** through expanded scope of practice for dental hygienists and new scope of practice and licensure for other oral health providers, such as dental therapists;
- **Building physical and virtual infrastructure** to deliver oral health services; and
- **Integrating oral health and primary care** through appropriate training programs, reimbursement models, and infrastructure development for practices participating in broader delivery system and payment reforms, such as patient-centered medical homes (PCMH) and accountable care organizations (ACO).

As states take up these opportunities, Medicaid agencies may be leaders or may play complementary roles in adapting their programs to support oral health access initiatives.

## Introduction

There is a large unmet need for dental services by low-income and vulnerable populations, including Medicaid and Children’s Health Insurance Program (CHIP) enrollees. Nearly 18 percent of children ages 5-19 and nearly 28 percent of adults ages 20-44 experienced untreated dental caries in 2012.<sup>1</sup> Utilization of dental services by low-income adults remains low, and even fell between 2002 and 2010, from 54 percent to 48 percent.<sup>2</sup> While the percentage of children in Medicaid receiving any dental services has been increasing,<sup>3</sup> only 46 percent of children enrolled in Medicaid or CHIP received preventive dental services and an average of 24.5 percent received dental treatment services in 2013.<sup>4</sup> Under the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, states are required to provide medically necessary dental services for children under age 21 according to a state-specific periodicity schedule.<sup>5</sup>

Not only does increasing access to dental services benefit patients, but because many oral health conditions are preventable, it may also contribute to reducing unnecessary emergency department utilization and avoiding future acute dental treatment costs.<sup>6</sup> Between federal fiscal years (FY) 2000 and 2010, the number of emergency department visits for an oral health issue increased from 1.1 million to 2.1 million.<sup>7</sup> One study suggests in 2010 alone treatment of oral health conditions in hospital emergency departments could amount to between \$867 million and \$2.1 billion.<sup>8</sup>

Since the safety net<sup>9</sup> provides crucial access points for vulnerable and low-income populations in need of dental services, Medicaid agencies and safety net providers may want to work together to improve access to dental services for these populations.<sup>10</sup> Through a cooperative agreement with the Health Resources and Services Administration (HRSA), the National Academy for State Health Policy (NASHP) has developed this resource as a primer for Medicaid directors and other state Medicaid leaders on the role HRSA-supported safety net providers play in providing oral health care to Medicaid enrollees and low-income and vulnerable populations.

Within this resource, NASHP has identified three opportunities that states can leverage to improve access to and the delivery of dental services:

- Augmenting the dental workforce;
- Building physical and virtual infrastructure to deliver oral health services; and
- Integrating oral health and primary care.

## What Roles Do HRSA-Supported Safety Net Providers Play in Providing Oral Health Care?

HRSA-supported safety net providers—including health centers, school-based health centers (SBHCs), and Ryan White HIV/AIDS Program (RWHAP) grantees—play important roles in providing oral health care to children and adults. The following section is intended to serve as a primer, describing the types of dental services that each safety net program provides, and how each is reimbursed for these services. For an overview of the information contained in this section, please see Table 2.

In this primer, unless otherwise specified, the term “health center” refers to Health Center Program Grantees that are also Federally Qualified Health Centers. Health Center Program Grantees are organizations supported by HRSA through the Health Center Program, as authorized under Section 330 of the Public Health Service Act. Federally Qualified Health Centers (FQHCs) are organizations that have been approved to receive reimbursement under Medicaid and Medicare using FQHC-specific payment methodologies. This primer does not discuss FQHC look-alikes or other similar organizations that do not receive financial support from HRSA.<sup>11</sup>

## Health Centers

### Services

Health centers provide comprehensive, patient-centered, and culturally competent primary health care services, regardless of a patient’s ability to pay. All health centers are required to provide primary, preventive, and enabling health services and, as appropriate and necessary, additional health services, either directly or through contracts or formal written referral arrangements.<sup>12</sup> In addition, they must pro-

vide pediatric dental screenings to determine the need for dental care, and preventive dental services to children and adults.<sup>13</sup> These required services may be provided either by health center staff or through a contract with other providers. Health centers continue to gain momentum as essential sites for oral health care; since 2010, the number of dental patient visits to health centers has increased by 31 percent, reaching approximately 11 million visits per year.<sup>14</sup>

### **Reimbursement**

Health centers receive financial support from HRSA. This support comprises approximately 20 percent of their operating revenues. Remaining financial support comes from reimbursement by Medicaid, Medicare, private insurance, patient fees, and other resources.<sup>15</sup>

Medicaid and CHIP reimbursement methods for dental services delivered at health centers vary. Health centers, in contrast to other Medicaid-enrolled providers, are typically reimbursed through an enhanced prospective payment system (PPS) rate for care to Medicaid- and CHIP-enrolled children and Medicaid-enrolled adults in states that cover adult dental services. PPS rates vary by state.<sup>16</sup> The types of dental providers who may be reimbursed by Medicaid programs also vary based on state laws and regulations.

As of 2011, 17 states allowed PPS reimbursement for encounters with independently practicing dental hygienists, while 18 states explicitly limited Medicaid PPS reimbursement to encounters with dentists.<sup>17</sup>

As an alternative to PPS, state Medicaid and CHIP agencies can establish alternative payment methodologies (APM) for health centers. About half the states use an APM for at least some of their total Medicaid payments to health centers.<sup>18</sup> If a state uses an APM, two criteria must be met: (1) the payment must be at least equal to the state's PPS rate and (2) each health center must agree to that APM.<sup>19</sup>

In states where Medicaid or CHIP enrollees receive dental benefits through managed care, health centers that treat those enrollees may also receive 'wrap-around' payments from the state Medicaid or CHIP program to equalize the rates paid by managed care plans and PPS reimbursement.<sup>20</sup>

In addition to or in lieu of offering dental services themselves, health centers are permitted to establish contracts or other formal written referral arrangements for dental services. Additionally, a provision in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows health centers the option to contract with private dentists to provide dental services to children.<sup>21</sup>

Regardless of whether dental services are provided directly or through referrals, health centers remain accountable for ensuring patients have access to and receive required services. In a contractual arrangement with referral providers, health centers have two options for delivery and payment:

1. The health center bills the appropriate payer source(s) for the encounter directly. As a result, the health center is not restricted as to how it negotiates contracts with referral providers and reimburses the referral providers in accordance with the negotiated terms of the contract.<sup>22</sup>
2. The health center establishes written arrangements (e.g., memorandums of understanding (MOU) or agreement (MOA) with referral providers (or provider entities). The MOU or MOA allows the referral provider to deliver and bill the appropriate payer source(s) for services directly.<sup>23</sup>

Medicaid reimbursement also varies by state when health center staff members deliver dental services off-site, for example, at schools, daycare centers, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program offices, and Head Start programs.

While Medicaid and CHIP are mandated to provide dental benefits to children, dental treatment remains an optional benefit for adults enrolled in Medicaid. Currently, 15 states provide emergency-only dental services, and 15 states offer a comprehensive adult dental benefit (11 of these states extend comprehensive dental coverage to their Medicaid expansion populations).<sup>24</sup> It is important to note in states without a comprehensive

### “Free Care” rule clarification

On December 15, 2014, the Centers for Medicare and Medicaid Services (CMS) released updated guidance on the provision of “free care.” CMS clarified that Medicaid reimbursement is available for any covered services delivered to a Medicaid-eligible child by a Medicaid provider. This is true even when the same service is offered without charge to uninsured children.

This guidance has positive implications for SBHCs wishing to operate no-cost population health-based programs, such as dental sealant programs. Under the previous interpretation of CMS guidance, SBHCs could not bill Medicaid for services provided to Medicaid-eligible children if those services were provided at no cost to other children. The cost implications—near-term expenditures and potential downstream costs or savings—for state Medicaid agencies will unfold as this guidance is implemented.

CMS Letter to Medicaid Directors: <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

Medicaid adult dental benefit, health centers do not receive PPS payments for providing dental care to this population.<sup>25</sup> Health centers are required to offer dental services to all patients on a sliding fee scale based on an assessment of income and family size. They often rely on grant funds from the Health Center Program to defray the costs of providing these services.<sup>26</sup>

## School-Based Health Centers

School-based health centers (SBHCs) operate in approximately two percent of public schools nationwide.<sup>27</sup> While SBHCs vary in structure, many provide a comprehensive range of clinical services through a multidisciplinary team of providers and staff.<sup>28</sup> SBHCs are often operated as partnerships between a school and a sponsoring:

- Health center;
- Hospital;
- Local health department; or
- Advocacy organization.<sup>29</sup>

### Services

The health services available at SBHCs vary according to both the local needs of the community and the capabilities of the sponsoring organization providing care. The vast majority of SBHCs provide primary care, and some also provide oral health services. One report of SBHCs between 2010 and 2011 found, of the nearly 1,400 SBHCs analyzed, 15.9 percent had on-site oral health providers.<sup>30</sup> Dental services offered at SBHCs range from oral health education to preventive dental care and specialty care. The majority of SBHCs provide oral health education (83.6 percent) and dental screenings (72.5 percent) either on-site or through a SBHC-operated mobile clinic, and approximately 38 percent provide on-site dental examinations.<sup>31</sup> It may be advantageous to children to have oral health care readily available within the school setting. A study in 2008 concluded that children with poor oral health status were nearly three times more likely to have absences from school as a result of dental pain.<sup>32</sup> Since many SBHCs operate every day school is in session, they have the potential to become a vital provider of dental services for children in the safety net.

### Reimbursement

SBHCs can be reimbursed for providing care to Medicaid and CHIP enrollees. Additionally, section 4101(a) of the Affordable Care Act (ACA) appropriated \$50 million a year from FY 2010 to FY 2013 in competitive grant funds to assist in financing the construction and implementation of SBHCs. Many states also finance SBHCs through other sources, such as Title V Maternal and Child Health Block Grants or through revenue from tobacco taxes.<sup>33</sup>

A number of states have implemented health policies that

### RWHAP funding can support patient navigators to improve oral health access

Ten community health centers participate in Montefiore Medical Center's program to increase access for 1,000 individuals 18 years and older living with HIV/AIDS. The program utilizes patient navigators to assist patients with appointments, referral management, education, and supportive services within the primary care setting. Montefiore also hired a dental hygienist as a patient navigator specifically to assist patients with access to and education about oral health. Montefiore has leveraged RWHAP Part C and Part F funding to support this oral health navigator program.

Source: Interview with Dr. Julie Kazimiroff and Paul Meissner, April 8, 2015.

affect the way SBHCs can be reimbursed by Medicaid. Seven states specifically designate SBHCs as a "provider type," making them eligible to directly bill Medicaid; four states waive preauthorization for specific SBHC health services and four additional states waive preauthorization for SBHCs entirely; three states require all managed care organizations to reimburse SBHCs; and four states require billing for uninsured patients through a sliding fee scale.<sup>34</sup>

## Ryan White HIV/AIDS Program

### Services

The Ryan White HIV/AIDS Program (RWHAP), administered by HRSA, provides health care services to an estimated 536,000 people living with HIV/AIDS each year.<sup>35</sup> This federal program, which is divided into five parts, works with states and localities to provide financial support for health care services delivered to people living with HIV/AIDS that are not covered or only partially covered by Medicaid and other payers.<sup>36</sup> HRSA estimated that in 2010, 30 percent of people served by RWHAP were uninsured, while 70 percent were underinsured,<sup>37</sup> making RWHAP a critical safety net for this population.

The five parts of the RWHAP are summarized in Table 1. Since dental care is one of the core medical services under RWHAP, dental services may be provided and paid for through all the RWHAP parts.<sup>38</sup> In 2010, almost \$80 million was spent across all parts of RWHAP on dental services.<sup>39</sup>

The Dental Reimbursement Program and the Community-Based Dental Partnership Program were created to address gaps in oral health care for people living with HIV/AIDS. The Dental Reimbursement Program primarily supports accredited dental education institutions by covering some of the unreimbursed costs related to the provision of dental services for people living with HIV/AIDS, while also supporting the education and training of dental providers to care for and treat people living with HIV/AIDS.

Similarly, the Community-Based Dental Partnership Program provides funding to dental schools and universities that educate and clinically train dental providers in addressing the specific dental care needs of people living with HIV/AIDS and increasing access to culturally competent care. The Dental Reimbursement Program and Community-Based Dental Partnership Program support the provision of comprehensive dental services by its grantees, including diagnostic, restorative, periodontal, and prosthodontic services.<sup>40</sup> In FY 2011, Community-Based Partnership Program grantees trained almost 3,000 dentists and dental hy-

gienists, serving more than 5,000 people living with HIV/AIDS. The same year the Dental Reimbursement Program grantees provided education to almost 12,000 dentists and dental hygienists.<sup>41</sup> In FY 2013, Dental Reimbursement Program grantee providers served 41,464 people living with HIV/AIDS.<sup>42</sup>

**Reimbursement**

The Dental Reimbursement Program directs funding to grantees to support the provision of dental services; however, this funding does not cover the entirety of grantees’ unreimbursed costs for treating people living with HIV/AIDS. In 2013, Dental Reimbursement Program grantees reported that the program defrays only 26 percent of all unreimbursed costs for services provided to this population.<sup>43</sup>

## Opportunities for Improving Dental Services for Medicaid Enrollees

NASHP conducted interviews with state Medicaid leaders, national experts, and safety net providers to identify opportunities for states to improve access to dental services. Several interviewees noted that adding or enhancing Medicaid coverage for adult dental services would be beneficial to adult Medicaid enrollees by removing financial barriers to accessing care and might provide some safety net dental providers with a more predictable revenue stream. However, since adding Medicaid adult dental benefits may not be financially feasible for some states, NASHP’s inter-

views identified potential additional opportunities that could help to improve access to oral health care:

- Augmenting the dental workforce;
- Building infrastructure; and
- Integrating oral health and primary care.

As states take up these opportunities, Medicaid agencies may be leaders or may play complementary roles in adapting their Medicaid programs to support oral health initiatives.

### Opportunity 1: Augmenting the Dental Workforce

HRSA has designated over 4,000 dental health professional shortage areas (HPSA), which together are home to approximately 10 percent of the U.S. population.<sup>44</sup> HPSAs can be designated for geographic areas, population groups, or facilities where the provider to population ratio is less than 1:5000.<sup>45</sup> Augmenting the dental workforce available to serve vulnerable populations can be one means of increasing access to needed dental care. States have undertaken a variety of efforts to expand access, including expanding or creating new roles for dental professionals and leveraging loan repayment programs. Many states are also considering recognizing new types of dental providers who can support dentists by performing a more limited scope of services.

Medicaid agencies may want to consider potential opportunities and challenges when expanding the dental workforce. Medicaid rules regarding

**Table 1.**  
**Summary of RWHAP Parts**

RWHAP Part	Eligible Grant Recipients	Example
A	Cities “most severely affected by the HIV/AIDS epidemic”	Local health department
B	States	State health department
C	Primary care settings that serve people living with HIV/AIDS	Nonprofit private entities providing comprehensive primary care to populations at risk of HIV/AIDS that apply for RWHAP funding
D	Entities that serve women, infants, children and youth living with HIV/AIDS	Faith-based or community based organizations that apply for RWHAP funding
F	Dental schools and oral health training programs	Universities; Schools of Dentistry

credentialing and billing may need to be updated to keep pace with expanded scopes of practice for dental hygienists or to accommodate new members of the dental team, such as community dental health coordinators and dental therapists. For example, a state’s practice acts may allow hygienists to provide dental sealants to children in schools; however, regulations may not allow hygienists to independently bill Medicaid or Medicaid managed care plans or a state’s PPS may not permit PPS encounters to be triggered by specific types of health center providers.<sup>46</sup> Medicaid agencies may also wish to consider how to incorporate dental professionals into delivery system models such as medical homes or accountable care entities.

**Dental Hygienists**

States can leverage their role in the credentialing and licensing of health professionals to support

dental professionals in working to the top of their licenses. Practice acts in each state specify allowable types of care and any supervisory requirements for the scope of practice of each dental professional. The levels specified in these acts vary across states, particularly for dental hygienists.<sup>47</sup> According to Bureau of Labor Statistics, in 2014, almost 200,000 dental hygienists were employed in the United States,<sup>48</sup> the majority in private practice.

Some states have explored expanding the roles of dental hygienists on the dental care team.<sup>49</sup> For example, in Colorado and Maine, dental hygienists can practice independently within the scope of their license, without the supervision of a dentist. In Colorado, hygienist-owned practices can provide routine preventive care, such as prophylaxis and sealant application for children.<sup>50</sup>

**Table 2.**  
**Summary of HRSA-Supported Safety Net Providers Offering Oral Health Services**

Safety net provider type	Population primarily served	Oral health services provided	Reimbursement
Health Centers	Low-income, underserved and/or uninsured and underinsured individuals	<ul style="list-style-type: none"> <li>• Required to provide preventive pediatric dental services</li> <li>• May provide adult dental services</li> <li>• Approximately 11 million dental patient visits in 2010</li> </ul>	<ul style="list-style-type: none"> <li>• Prospective payment system (PPS) (encounter-based) rate, variable by state, when dental is a covered benefit in Medicaid and Children’s Health Insurance Program (CHIP)</li> <li>• State Medicaid agency can establish an alternative payment methodology (APM) in lieu of PPS</li> <li>• Sliding fee scale for eligible patients</li> </ul>
School-Based Health Centers	Children, families	<ul style="list-style-type: none"> <li>• Services vary; range from oral health education and preventive dental care to routine dental care and specialty care.</li> <li>• 83.6% provide oral health education; 72.5% provide dental screenings</li> </ul>	<ul style="list-style-type: none"> <li>• Reimbursed through Medicaid and CHIP for covered services</li> <li>• Multiple other potential financing streams (e.g., Title V Block Grants)</li> </ul>
Ryan White HIV/AIDS Program (RWHAP)	People living with HIV/AIDS	<ul style="list-style-type: none"> <li>• Services vary based on grantee; grantees offer comprehensive dental services, including diagnostic, restorative, periodontal, and prosthodontic services</li> </ul>	<ul style="list-style-type: none"> <li>• All RWHAP parts (organized into Parts A-D and F) can support the provision of oral health services through grantees</li> <li>• RWHAP Part F allocates grant funds to the Dental Reimbursement Program and Community-Based Dental Partnership Program, which train oral health professionals and provide oral health services</li> </ul>

In Massachusetts, public health dental hygienists operate independently within local or state government agencies, such as health departments, or when practicing in a mobile prevention program.<sup>51</sup> As state practice acts evolve, Medicaid agencies may need to evolve their reimbursement policies to align with licensing regulations in order to ensure that dental professionals can be reimbursed for all work performed within their scopes of practice.<sup>52</sup> Although increasing the number of providers that can bill Medicaid for dental services might initially cause Medicaid expenditures to rise, increasing access to preventive dental services may also reduce expensive dental-related emergency department visits.

### **Community Dental Health Coordinators**

States can also support the development and reimbursement of emerging dental team members such as the community dental health coordinator (CDHC) and the dental therapist. Similar to a community health worker, CDHCs serve low-income and vulnerable populations in their communities. CDHCs provide oral health education and some basic preventive services such as screenings and fluoride treatments. They can also serve as patient navigators for individuals who need assistance accessing care.<sup>53</sup> In 2012, New Mexico became the first state to pass legislation defining the CDHC scope of practice and educational requirements.<sup>54</sup>

### **Dental Therapists**

Currently, two states as well as Native tribes in Alaska have embraced dental therapists. Despite the common title of dental therapist, the exact roles, supervision necessary, and education requirements to become a dental therapist vary across these states.

While some initiatives related to dental therapy have been controversial, particularly among organized dentistry, supporting the development of the dental team may be a way for states to increase patients' access to more routine, preventive care and some restorative treatments. It also allows dentists to focus on more high-risk, high-need patients. Economic analysis from Community Catalyst found that in Alaska and Minnesota, dental therapists cost employers 27 and 29 percent, respectively, of the revenue they generate.<sup>60</sup> The report also found that these dental

therapists serve primarily low-income adults and children. Minnesota, for example, requires that 50 percent of dental therapists' and advanced dental therapists' caseloads be Medicaid-enrolled or underserved populations.<sup>61</sup> A report to the Minnesota Legislature found that as of February 2014, 17 of the 32 licensed dental therapists in the state were practicing in community-based clinics or FQHCs.<sup>62</sup>

### **Recruitment of Dental Professionals to Serve the Safety Net**

HRSA supports students who wish to become health care providers through the National Health Service Corps scholarship and loan repayment programs.<sup>63</sup> Similarly states may wish to implement loan repayment programs to help increase access to dentists by incentivizing these providers to serve safety net populations. For example, Maryland's Dent-Care Loan Assistance Repayment Program is a legislatively authorized loan repayment program for dentists who serve the state's Medicaid population. At a minimum, these dentists' patient panels must be 30 percent Medicaid.<sup>64</sup> A state currently operating its own loan repayment program may want to consider coordinating its program with the federal National Health Service Corps to streamline requirements and maximize the incentives available to encourage dental providers to practice in rural or underserved areas.

As another means to augment dental professionals serving the safety net, the Children's Health Insurance Program Reauthorization Act (CHIP-RA) contains a provision that allows FQHCs to contract with private dentists to provide dental services to Medicaid- and CHIP-enrolled children. FQHCs negotiate contractual rates with private dentists for providing services to their patients. The option of contracting directly with FQHCs may appeal to private practice dentists by mitigating the administrative requirements of participating in and billing Medicaid.<sup>65</sup> However, despite some outreach efforts, implementation, to date, has been slow. States and FQHCs may want to work together to identify how to support and facilitate private contracting in order to increase access to dental services for low-income and vulnerable populations.<sup>66</sup>

## Opportunity 2: Building Physical and Virtual Infrastructure to Deliver Dental Services

HRSA has identified enhancing dental capacity as a key priority area in recent health center grant opportunities,<sup>67</sup> highlighting the importance of safety net infrastructure and the financial and staff capacity needed to support vulnerable and low-income populations in need of oral health services. Fiscal year 2014 Expanded Services supplemental funding has been estimated to have supported health centers in providing services to 1.5 million new patients, including 137,000 dental patients.<sup>68</sup> States

have the opportunity to support the growth of facilities and programs that establish or broaden dental service delivery sites in dental HPSAs. This can be through the establishment or expansion of community-based dental facilities, freestanding dental clinics, school-linked dental facilities, mobile or portable dental clinics, and teledentistry programs.

States may want to consider aligning Medicaid reimbursement with mobile and community-based dentistry initiatives in order to reach populations who otherwise may not have access to services, such as children. The Massachusetts Seal,

**Table 3.**  
Summary of Current Dental Therapist Initiatives

State	Title	Practicing Since	Education	Services Provided
Alaska (Native tribes)	Dental Health Aide Therapist (DHAT)	2006	2 years of related education in an accredited program post high school. <sup>55</sup>	Preventive services, some restorative services such as fillings and simple extractions, and educational services under standing orders and remote supervision by a dentist through telemedicine systems. <sup>56</sup> Sixty percent of services DHATs perform are preventive. <sup>57</sup>
Minnesota	Dental Therapist; Advanced Dental Therapist	2011	<u>Dental Therapist</u> : Bachelor's degree; <u>Advanced Dental Therapist</u> : Master's degree	<u>Dental therapists</u> can provide preventive services and some restorative services, such as fillings and extraction of primary teeth. Supervision of a dentist is required for certain procedures.  <u>Advanced dental therapists</u> can also develop treatment plans, perform oral evaluations, and extract permanent teeth. Some procedures require the advanced dental therapist to have a collaborative management agreement with a dentist. <sup>58</sup>
Maine	Dental Hygiene Therapist	2014	Bachelor's degree in dental hygiene; accredited dental hygiene therapy program	Perform, among other procedures, preventive services, oral health assessments, simple extractions, prepare and place crowns, provide referrals, and administer local anesthesia and nitrous oxide analgesia under the direct supervision of a dentist. Medicaid reimburses dental hygiene therapists for services that are identified within their scope of practice. <sup>59</sup>

Educate, Advocate for Learning (SEAL) Program is a community-based initiative that provides Medicaid and CHIP-enrolled children, as well as other vulnerable children, with dental assessments, sealants, and fluoride treatments in schools.

The program is administered by the Massachusetts Department of Public Health with funding from HRSA and the state. In order to ensure a sustainable funding source, the state's Office of Oral Health within the Department of Public Health became a Medicaid dental provider during the 2011-2012 school year. As a recognized Medicaid provider, the Department of Public Health can bill Medicaid and CHIP for services provided to Medicaid-enrolled students.<sup>69</sup> Medicaid agencies may want to work with their public health departments to identify opportunities to align reimbursement with public health dental programs that provide preventive services.

Given that the potentially large infrastructural investments necessary for brick and mortar clinics or community-based mobile programs may be cost prohibitive for safety net organizations and states, some states are turning to telehealth as a potential means of increasing access for rural and underserved populations. Teledentistry is a means of providing dental care, provider-to-provider and patient-to-provider consultation, and education remotely using telecommunication technologies.<sup>70</sup>

California's Virtual Dental Home (see text box) is one example of the potential reach of teledentistry to serve Medicaid enrollees and other vulnerable populations in collaboration with health centers. The Virtual Dental Home demonstration project, developed at the University of the Pacific, has been tested in 13 communities across the state. The Virtual Dental Home program anticipates that health centers will be prominent host sites for the collaborating dentists who supervise the registered dental hygienists in advanced practice to deliver services in the community. Health centers generally have a high volume of patients that need care; they have experience working with underserved and vulnerable populations; and they can serve as referral sites for patients in need of more intensive services, especially in HPSAs. By having dental hygienists in advanced practice provide care in community settings, such as schools, WIC clinics, and long-term care facilities, health centers can remove some of the financial and logistical barriers that these populations may face in accessing diagnostic, preventive, and early intervention dental care. Additionally, providing these services in the community allows health centers to see more patients at a lower cost while also allowing dentists to increase access to patients in need of more intensive services in its on-site dental clinics.<sup>71</sup>

### Opportunities under the Indian Health Care Improvement Act Reauthorization

**Dental Health Aide Therapists (DHAT) provide care to Alaska's Native tribes under the authority of the community health aide program, authorized under the Indian Health Care Improvement Act. As part of the reauthorization of this act under the ACA, the DHAT program can be expanded to serve tribal organizations in states that enact dental therapist legislation. There may be opportunities for states considering dental therapist legislation to work in conjunction with tribal organizations to leverage Indian Health Service funding to support expanded access to dental care for tribal populations.**

Source: Elayne Heisler, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline* (Washington, DC: Congressional Research Service, 2011). <http://www.ncsl.org/documents/health/IndHlthCareReauth.pdf>; and National Indian Health Board, *Summary of the Indian Health Care Improvement Act and Indian Specific Provisions in the Patient Protection and Affordable Care Act* (Washington, DC: National Indian Health Board, 2010).

### Opportunity 3: Oral Health and Primary Care Integration

In 2014, HRSA released the report, *Integration of Oral Health and Primary Care Practice*, which identified the agency's strategic priorities on oral health integration and offered recommendations for supporting integrated practice settings. Evidence suggests that oral health has an impact on a person's overall health, especially as dental conditions, such as tooth decay, may be associated with various chronic diseases. Thus, the integration of oral health care across systems is imperative in order to begin to address patients' needs for access to whole-person, comprehensive, and coordinated care. The coordination of prevention activities and management of chronic conditions between primary care and dental providers may also reduce health care costs. As states engage in payment and delivery system reform initiatives designed to integrate care, they may want to consider fostering initiatives that include integrating oral health and primary care. The integration of oral health and primary care is a complex process that requires significant investments of time and resources on the part of health care practices. States can support practice transformation through initiatives that

promote cultural acceptance of cross-system care, develop reimbursement mechanisms that support integrated care, and help build infrastructure necessary for integration.

#### ***Cultural Acceptance and Training:***

Integrating two systems of care—physical health and oral health—that have historically not worked closely together presents unique challenges. Systems need to be put in place to facilitate cross-system collaboration and referrals among health professionals. For example, a National Network for Oral Health Access (NNOHA) pilot project (see text box) found that having integrated electronic medical and dental records improved scheduling and data reporting. Additionally, training is necessary for both dental and primary care providers to ensure they are proficient and comfortable with providing basic medical and oral health assessment and services, respectively.

Training programs, such as the Smiles for Life online curriculum and HRSA's oral health integration training module, provide interdisciplinary educational resources for providers on providing cross systems care. Smiles for Life specifically includes

#### California's Virtual Dental Home Demonstration

**This model places registered dental hygienists in alternative practice, registered dental hygienists, and dental assistants in community settings to provide a range of dental care, including education, preventive services, and case management. The community-based provider collects information from the patient, such as medical history and x-ray images, and uses technology to send that information to a collaborating dentist at a health center. The dentist creates a treatment plan, which is then carried out by the community-based provider. If more complex services are needed than can be provided in the community, the patient is referred to a local dentist. The model has demonstrated that approximately two-thirds of high-risk populations can be kept healthy at community sites with only about one-third needing to see a dentist in person.**

California Assembly Bill 1174, effective January 2015, is paving the way for the Virtual Dental Home to spread by removing reimbursement barriers. First, the new legislation requires reimbursement for dental services regardless of whether they are provided in-person or remotely. This facilitates reimbursement for many services provided by FQHC staff working in community settings who use technology to consult with off-site dentists. Additionally, the legislation increases the services that a registered dental hygienist in alternative practice can perform without the on-site oversight of a collaborating dentist. The California Department of Health Care Services and other state agencies are developing regulations and guidance to implement this model of care in 2015.

Source: Interview with Paul Glassman, February 26, 2015 and [http://www.dhcs.ca.gov/services/rural/Documents/IHPANNUPD\\_MCDENTAL\\_3\\_3\\_15.pdf](http://www.dhcs.ca.gov/services/rural/Documents/IHPANNUPD_MCDENTAL_3_3_15.pdf).

### Additional Resources for oral health and primary care integration

In 2013, HRSA funded a pilot through the National Network for Oral Health Access (NNOHA) that supported three health centers to develop and implement policies that align with HRSA's recommended interprofessional oral health clinical competencies. NNOHA published a "user's guide" to supporting oral health integration into primary care based on the experiences of these three pilot health centers.

The user's guide makes recommendations in five areas:

- Planning/development;
- Training;
- Addressing health information technology needs;
- Modifying clinical care systems; and
- Evaluation processes.

For more information:

[http://www.nnoha.org/nnoha-content/uploads/2015/01/IPOHCCC-Users-Guide-Final\\_01-23-2015.pdf](http://www.nnoha.org/nnoha-content/uploads/2015/01/IPOHCCC-Users-Guide-Final_01-23-2015.pdf).

resources for primary care providers on oral health integration and provision of dental services. States may also wish to consider subsidizing or supporting training programs for existing providers. In addition, states can work through their universities and professional schools to incorporate trainings that prepare future medical and dental providers to practice in an integrated physical health and oral health delivery landscape.

#### ***Reimbursement that Supports Integration:***

Developing a payment methodology that supports integration is imperative to creating a viable and sustainable integrated primary care-oral health program. States have made progress in developing reimbursement structures that support integration. For example, almost all states' Medicaid programs reimburse medical providers for the application of fluoride varnish. And, as of 2014, 36 states allow FQHCs to bill for both a medical and dental encounter in the same day. Medicaid agencies may want to work with their state's primary care association to ensure FQHCs understand these policies.

More flexible reimbursement structures could support additional integration. As it stands, FQHC providers who receive set encounter-based payments may be reluctant to add dental services to an already crowded primary care visit. Longer appointments that accommodate oral health in addition to physical health services could mean fewer appointments each day and thus decreased revenue. States may wish to consider implementing an APM for providers that promotes value over volume of care. Oregon has initiated an APM demonstration project in which Medicaid pays participating health centers monthly population-based payments. Instead of incentivizing individual encounters, the PMPM payment assists these health centers in developing initiatives and infrastructure improvements, such as remote consultations or health information technology that support comprehensive care. While Oregon acknowledges that it has not yet reached a value-based payment model, it is a first step on the path.

States may also wish to consider engaging safety net providers in payment reform initiatives, such as those that incorporate risk and performance-based incentives, to support oral health and primary care integration. In 2010, the Minnesota legislature authorized the formation of Hennepin Health, a safety net accountable care organization in Minnesota. Hennepin Health consists of four partner organizations, together responsible for controlling costs and improving quality for all of their patients. One of these partner organizations, NorthPoint Health and Wellness Center, is a FQHC. Hennepin Health operates

under a global budget, which affords the organization greater flexibility in allocating its monetary resources to initiatives that best meet the needs of its patients. Hennepin has focused some of its efforts, for example, on mitigating inappropriate emergency department utilization for tooth pain. When patients come to the emergency department with tooth pain, they are connected to a dental provider and given same day access to care.

***Infrastructure that Supports Integration:***

Practices can integrate primary care and oral health services to varying degrees, ranging from coordinated referrals to colocation to full clinic integration. Practices at all stages of integration need to ensure they have the necessary workflows and infrastructure, such as health information technology, in place to support providers' work. The patient-centered medical home (PCMH) model has been embraced by many states as a means to enhance integration through a focus on comprehensive and coordinated care. The majority of PCMH initiatives provide per member per month

payments to practices to support practice transformation costs, such as electronic medical records, additional staff, and training. As of March 2015, 47 states have medical home activity and 30 of those states are making payments to practices. States may wish to consider leveraging their PCMH work to encourage cross-system integration of oral health in order to improve access to dental services and ultimately improve health.

Denver Health, a network of FQHCs, provides integrated oral health and primary care services within its PCMH model. When Denver Health first began its medical-oral health integration, it added dental hygienists at six of its primary care sites. These hygienists provide preventive services, as well as some case management. Denver Health also trains primary care providers to provide some preventive oral health services, such as fluoride varnish, during well child visits for children up to age five. Additionally, providers utilize a common EMR to support care coordination and care management.

## Conclusion

Safety net providers play a critical role in delivering dental services to low-income and vulnerable populations, including Medicaid enrollees; however, there is still a substantial need for improved access to these services. Through interviews with state Medicaid leaders, national experts, and safety net providers, NASHP has identified opportunities for synergies between Medicaid and safety net providers to improve access to dental care:

- Augmenting the oral health workforce through expanded scope of practice for dental hygienists and new scope of practice and licensure for other oral health providers, such as dental therapists;
- Building oral health services delivery infrastructure through community-based programs and teledentistry; and
- Integrating oral health and primary care through appropriate training programs, reimbursement models, and infrastructure development for practices participating in broader delivery system and payment reforms, such as PCMH and ACOs.

As states take up these opportunities, Medicaid agencies may be leaders or may play complementary roles in adapting their Medicaid programs to support oral health initiatives.

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