LUNCH TIME!

- Please help yourself to the buffet!
- Then, please find a seat!
- We will start the session at 11:45am
- Legislators and legislative staff are encouraged to find seating at the rounds up front.
STATE ORAL HEALTH EFFORTS – EXTRACTING VALUE AND IMPROVING ACCESS
Welcome, Introductions and Overview

Presentations on Value and Access
- Marko Vujicic, Ph.D., Health Policy Institute, The American Dental Association
- Marcia Brand, Ph.D., DentaQuest Partnership for Oral Health Advancement
- Legislative Respondents: Maryland & Utah
- Q&A
The ‘Value’ of Enhanced Access to Dental Care

Marko Vujicic, PhD
Chief Economist & Vice President
Health Policy Institute
When Addiction Starts at the Dentist

BY TERAESA CARR  WEDNESDAY, OCTOBER 17, 2018  NOVA NEXT

The main reason people avoid the dentist isn't fear

Medicare Doesn’t Equal Dental Care. That Can Be a Big Problem.

Chew on this: Dental coverage gives protection within limits

Why Some Millennials Aren’t Smiling: Bad Teeth Hinder 28% In Job Search
Dental benefit proposed for Medicaid recipients

A bill introduced in the Maine Legislature would give access to preventive, diagnostic and restorative care for more than 100,000 Mainers.

PRESS RELEASE: Governor Larry Hogan Announces Fiscal Year 2020 Budget

- The FY 2020 budget includes nearly $11.5 billion for Maryland's Medicaid program, which provides basic health coverage to nearly 1.4 million Marylanders, including more than 153,000 children through the Maryland Children's Health Program.

- The governor's budget for Medicaid includes an additional $77 million in total funds for Community First Choice services to keep elderly and disabled adults out of nursing homes, $29.3 million to expand treatment access for those with Hepatitis C virus, nearly $6 million in new funding for a pilot program to reduce the incidence of diabetes, and an additional $4.2 million to provide a limited dental benefit to adults under the age of 65 who are dual eligible for Medicare and Medicaid.
23% of low income adults reduce participation in social activities due to the condition of their mouth and teeth.

35% of low income adults feel embarrassment due to the condition of their mouth and teeth.

Appearance of Mouth and Teeth Affects Ability to Interview for a Job

- 82% of all respondents
- 71% of low-income respondents
- 84% of middle-income respondents
- 85% of high-income respondents
- 72% of 18-34 age group
- 80% of 35-49 age group
- 84% of 50-64 age group
- 92% of 65+ age group

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Dental Care and Health Care Costs

EMERGENCY DEPARTMENT VISITS FOR DENTAL CONDITIONS AMONG ADULTS BY PAYER

<table>
<thead>
<tr>
<th>Year</th>
<th>SELF-PAY</th>
<th>MEDICAID</th>
<th>PRIVATE</th>
<th>MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
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<tr>
<td>2011</td>
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<td>2012</td>
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<td>2013</td>
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<td>2014</td>
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<tr>
<td>2015</td>
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</table>

How often, on average, someone visits a hospital emergency department for dental conditions in the United States.

$2 BILLION
Amount spent on hospital emergency department visits for dental conditions in the United States in 2015.
Dental Care Use

PERCENTAGE OF POPULATION WITH A GENERAL DENTAL VISIT IN THE YEAR

CHILDREN (AGES 18 AND UNDER)

ADULTS (AGES 19-64)

SENIORS (AGES 65+)

HIGH-INCOME | LOW-INCOME

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Learning from State Experiences

Percent of Children With a Dental Visit in the Past 12 Months, 2017

- **Private Dental Insurance**
- **Medicaid**

States are ranked from high to low percentage of children with dental visits, with private dental insurance and Medicaid as the indicators.
Financial Barriers to Dental Care

EXHIBIT 1

Percentages of National Health Interview Survey respondents who did not get selected health care services they needed in the past 12 months because of cost, by age group, 2014

- Dental care
- Medical care
- Prescription drugs
- Eyeglasses
- Mental health care

2-18
19-64
65 and older

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Under the ACA, expanded dental coverage led to a 3-6 percentage point increase in dental care use among low-income adults.
Medicaid Dental Coverage for Adults

AN ESTIMATED
9.8
million adults

GAINED DENTAL BENEFITS
through Medicaid expansion
or Medicaid policy changes
following passage of the
Affordable Care Act through
2017.

PERCENTAGE CHANGE IN THE NUMBER OF ADULTS WITH MEDICAID DUE TO THE AFFORDABLE CARE ACT

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My Thoughts on Long-Term Reform

Commentary

Guest Editorial

Our dental care system is stuck
And here is what to do about it

Marko Vujicic, PhD

We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms.

<table>
<thead>
<tr>
<th>Box. Reforms needed to drive major expansions in dental care use and meaningful, sustained improvements in oral health.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address the Dental Coverage Gap</strong></td>
</tr>
<tr>
<td>Consider dental care an essential health benefit for all age groups. Provide comprehensive dental coverage in public health insurance programs and as a core benefit in private health insurance coverage.</td>
</tr>
<tr>
<td><strong>Define and Systematically Measure Oral Health</strong></td>
</tr>
<tr>
<td>Define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers, but mostly for patients. Measure what is done for patients, not just what is done to patients.</td>
</tr>
<tr>
<td><strong>Tie Reimbursement, Partly, to Outcomes</strong></td>
</tr>
<tr>
<td>Make some small portion of provider compensation dependent on oral health outcomes or, at a minimum, on some intermediate measures that influence outcomes and are more within the direct control of providers.</td>
</tr>
<tr>
<td><strong>Reform the Care Delivery Model</strong></td>
</tr>
<tr>
<td>Get dentistry out of its care delivery silo. Engage the rest of the health care system to nudge people into dental care. Rise above scope of practice turf wars fueled by fee-for-service payment.</td>
</tr>
</tbody>
</table>
Tools for States - Projecting Future Supply

Projected Supply of Dentists for Select States

The ADA Health Policy Institute (HPI) has predicted that, despite fears of a looming dentist supply cliff, the dentist workforce in the United States will actually increase through 2035 due to an influx of younger and more diverse dentists. But how will this play out at the state level? Will some states experience a greater dental supply increase than others?

HPI offers projections for nine select states, particularly those with some of the highest population concentrations.

Select the desired state below to access its PDF report of dental workforce projections, calculated using HPI’s unique workforce projection model.

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Tools for States - Measuring Geographic Access
Tools for States - Modeling Fiscal Impact

Table 3: Estimated Increase in State Medicaid Expenditure from Implementing an
Extensive Medicaid Adult Dental Benefit

<table>
<thead>
<tr>
<th>State</th>
<th>Current Total Medicaid Expenditure ($M)</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>An Percentage of Total Medicaid Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$1,578,486,945.64</td>
<td>$1,396,399.31</td>
<td>$1,337,476.25</td>
<td>$205,399.27</td>
<td>0.7%</td>
</tr>
<tr>
<td>Arizona</td>
<td>$2,753,485,639.83</td>
<td>$1,394,314.61</td>
<td>$1,379,476.25</td>
<td>$89,934,517.42</td>
<td>1.1%</td>
</tr>
<tr>
<td>Delaware</td>
<td>$871,289,819.32</td>
<td>$1,165,349.00</td>
<td>$1,149,476.49</td>
<td>$304,039.92</td>
<td>1.4%</td>
</tr>
<tr>
<td>Florida</td>
<td>$87,799,259,369.47</td>
<td>$102,766,689.96</td>
<td>$107,467,692.05</td>
<td>$141,421,687.15</td>
<td>1.1%</td>
</tr>
<tr>
<td>Georgia</td>
<td>$1,065,500,963.94</td>
<td>$1,037,789.47</td>
<td>$1,029,891.62</td>
<td>$89,936,626.13</td>
<td>1.7%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>$772,628,237.14</td>
<td>$1,138,939.33</td>
<td>$1,136,972.09</td>
<td>$1,035,678.96</td>
<td>1.4%</td>
</tr>
<tr>
<td>Idaho</td>
<td>$482,493,214.18</td>
<td>$4,524,450.00</td>
<td>$4,502,256.65</td>
<td>$8,383,304.13</td>
<td>0.7%</td>
</tr>
<tr>
<td>Kansas</td>
<td>$11,198,327,682.27</td>
<td>$12,861,541.63</td>
<td>$11,178,969.61</td>
<td>$2,617,125.17</td>
<td>0.5%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$2,412,589,466.35</td>
<td>$2,474,798.92</td>
<td>$2,434,496.74</td>
<td>$3,517,049.49</td>
<td>0.9%</td>
</tr>
<tr>
<td>Maine</td>
<td>$1,065,287,267.61</td>
<td>$1,078,223.22</td>
<td>$1,060,442.80</td>
<td>$1,093,016.15</td>
<td>1.0%</td>
</tr>
<tr>
<td>Maryland</td>
<td>$3,047,827,672.80</td>
<td>$4,037,892.00</td>
<td>$3,981,802.04</td>
<td>$80,940,132.34</td>
<td>1.1%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$1,245,256,879.52</td>
<td>$1,678,403.63</td>
<td>$1,345,073.77</td>
<td>$2,507,041.12</td>
<td>1.4%</td>
</tr>
<tr>
<td>Missouri</td>
<td>$3,411,856,625.35</td>
<td>$2,383,654.10</td>
<td>$1,793,042.60</td>
<td>$3,713,278.65</td>
<td>0.7%</td>
</tr>
<tr>
<td>Montana</td>
<td>$3,038,582,562.25</td>
<td>$4,501,191.80</td>
<td>$4,345,021.82</td>
<td>$9,690,461.82</td>
<td>1.5%</td>
</tr>
<tr>
<td>Nevada</td>
<td>$725,456,958.91</td>
<td>$1,169,250.16</td>
<td>$1,146,426.52</td>
<td>$2,383,255.22</td>
<td>1.0%</td>
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<tr>
<td>New Hampshire</td>
<td>$504,451,858.62</td>
<td>$6,702,758.06</td>
<td>$4,345,204.48</td>
<td>$11,891,438.72</td>
<td>0.2%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$1,506,854,523.79</td>
<td>$1,267,855.71</td>
<td>$1,278,436.84</td>
<td>$3,220,899.53</td>
<td>1.1%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$2,028,854,665.16</td>
<td>$2,051,429.70</td>
<td>$2,043,191.73</td>
<td>$4,080,169.75</td>
<td>1.7%</td>
</tr>
<tr>
<td>Texas</td>
<td>$11,332,562,781.62</td>
<td>$10,995,351.91</td>
<td>$10,825,742.86</td>
<td>$10,964,170.10</td>
<td>0.8%</td>
</tr>
<tr>
<td>Utah</td>
<td>$642,939,137.92</td>
<td>$4,557,017.38</td>
<td>$3,650,308.35</td>
<td>$7,855,225.03</td>
<td>0.7%</td>
</tr>
<tr>
<td>Virginia</td>
<td>$3,026,875,463.83</td>
<td>$2,383,643.70</td>
<td>$80,756,402.95</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>$3,026,875,463.83</td>
<td>$1,703,072.38</td>
<td>$1,739,662.65</td>
<td>$3,429,932.63</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Source: ADA HPI analysis of CMS Medicaid enrollment, spending and dental care utilization data, MEPS spending data, state Medicaid program adult dental benefit and reimbursement rate data, and Tumblr private dental benefits utilization data. Notes: We substituted 2012 Tumblr utilization data for Montana as the sample year in 2013 was not sufficient.
Thank You

@ADAHPI

ADA.org/HPI

hpi@ada.org
Measuring Geographic Access

Dental Offices
- Office Does Not Participate in Medicaid
- Office Participates in Medicaid

Percentage of Children with Public Insurance
- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%

15 Minute Travel Time to Medicaid Office
Percentage of Children with Public Insurance
- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%
Measuring Geographic Access

Publicly Insured Children Per Medicaid Dentist Within a 15-Minute Boundary

- **No Medicaid Office**
- **<500:1**
- **500:1-2000:1**
- **>2000:1**

- **3%** of publicly insured children do not have a Medicaid or CHIP dentist within a 15 minute travel time.
- **72%** of publicly insured children live in areas with more than one Medicaid or CHIP dentist within a 15 minute travel time for every 500 publicly insured children.
- **24%** of publicly insured children live in areas with one Medicaid or CHIP dentist within a 15 minute travel time for every 500 to 2,000 publicly insured children.
- **2%** of publicly insured children live in areas with less than one Medicaid or CHIP dentist within a 15 minute travel time for every 2,000 publicly insured children.
STATE ORAL HEALTH EFFORTS
EXTRACTING VALUE & IMPROVING ACCESS

National Conference of State Legislatures
State Legislators and Opportunities for Oral Health Innovation

Marcia K. Brand, Ph.D.
Senior Advisor,
DentaQuest Partnership for Oral Health Advancement
Traditional State Oral Health Policy Levers: 
*What States are Already Doing*

**Medicaid/CHIP**

- Providing extensive dental benefits to children in all states through Medicaid/CHIP
- Working to increase the level of Medicaid adult dental coverage
  - 19 states have extensive adult coverage; 17 provide limited adult coverage; 12 offer “emergency only” coverage and 3 provide no adult dental coverage (DE is expected to add dental coverage on April 1, 2020)
  - 37 states (including DC) have expanded Medicaid under the ACA increasing the number of adults with dental benefits
- Working to offer adequate provider reimbursement
- Streamlining administrative processes to encourage provider participation
Traditional State Oral Health Policy Levers: 
What States are Already Doing

Dental workforce
- Creating new provider types – e.g., dental therapists (AZ, CT, ME, MI, MN, NV, NM, VT; tribal lands AK, ID, MT, OR and WA)
- Expanding scope of practice and practice settings for existing oral health providers – e.g., schools, nursing homes; 42 states allow dental hygienists to initiate patient care outside of a private dental office without the presence of a dentist
- Encouraging dental/dental hygiene graduates to practice in underserved areas through selection and loan/reimbursement programs

Dental public health infrastructure
- Support for State Dental Officer, state oral health plans

Maternal and child health programs
- Screening, school enrollment requirements
- Sealants
- Fluoride varnish, sealant programs
- Oral health education
Examples of State Oral Health Innovations: South Carolina, Pennsylvania, Colorado, Oregon, Virginia, Florida

MORE Care (Medical Oral Expanded Care)

- Uses a unique learning collaborative process to integrate oral health for children and adults through an interprofessional team
- Provides primary and secondary preventive oral health services in primary care medical offices to underserved populations
- Tests optimal patient-centered, dependable referral systems between primary care and dental care teams
- Improves ease of HIT and data sharing
- Connects to community support systems
- Partners with State Offices of Rural Health
Examples of State Oral Health Innovations: Oregon

Advantage Dental – State Medicaid provider

• Pushing for centralization of patient health information so the entire health history is available to all providers; better information = better care

• Value-based Care in Oral Health – providers are rewarded for quality health outcomes rather than the quantity of care delivered, focus on better care for individuals and improved population health at lower cost

• Focusing on pioneering new prevention and treatment methods – “Preventistry”

• Bottom line – between 2011 and 2016, median per patient per year – children’s health costs decreased by 10% and adult costs decreased by 6%; compared to a national Medicaid sample where costs between 2013 and 2015 increased
Examples of State Oral Health Innovations: Texas

Texas Oral Health Surveillance System (TOHSS)

- Public health surveillance as “ongoing systematic collection, analysis and interpretation of health data for the purposes of improving health”

- TOHSS allows Texas to collect and review oral health data from available standardized reporting formats and compare the oral health of Texas residents to that of national standards

- By analyzing trends over time, essential oral health information is available for stakeholders and policymakers to evaluate current systems and identify potential resources needed to improve the oral health of all Texans in the future
Examples of State Oral Health Innovations: California

The Virtual Dental Home (VDH): Teledentistry

- Community-based oral health delivery system in which people receive diagnostic and preventive services in community settings
- Uses telehealth technology to link dental hygienists and assistants in the community with dentists in dental offices and clinics
- Portable imaging, internet based dental record system
- Dentist reviews record and creates treatment plan
- Hygienist performs preventive and early intervention procedures, refers patients to dental offices for other procedures
- Lessons learned:
  - Can improve health and lower costs
  - Requires careful planning
Examples of State Oral Health Innovations: California

Assessing Oral Disease Burden

California legislature set forth a vision to assess and improve oral health in the State and charged the California Department of Public Health (CDPH) to prepare an assessment of the burden of disease in the state and develop an oral health plan.

CDPH convened an advisory committee of state and local governmental agencies, professionals and advocacy organizations, foundations, academic institutions, the statewide oral health coalition, and others to develop the California Oral Health Plan 2018 – 2028.

The statewide oral health coalition reorganized to be led by a community based organization (CBO). The strong representation of county level and local CBOs brought a broad consensus and local ownership to the plan.
Examples of State Oral Health Innovations: Washington

Washington

• Oral health stakeholders developed and strengthened their relationship with tribal communities in WA to address oral health and access.

• The relationship supported the ability of sovereign tribal nations to exercise their right to make decisions about their healthcare resources.

• With support from stakeholders, the legislature passed the “Act Relating to Dental Health Services in Tribal Settings” law, authorizing federally certified or tribally licensed dental therapists to practice in Indian Country in Washington State and to be reimbursed by Medicaid.

• Their work was also supported by the W.K. Kellogg Foundation.

DHAT Provider in Swinomish Co, WA
Examples of State Oral Health Innovations: West Virginia My Home State!

- West Virginia Cavity Free by Three: Fluoride Varnish Training Program
  - Uses Smiles for Life training for Medicaid/CHIP primary care providers and their staff - on caries risk assessment, fluoride varnish application and facilitation of the age 1 and well child check ups
  - Free training – qualifies for reimbursement 2X/year for FL varnish

- WV State Dental Screening law – one of 14 states and D.C. (as of January/2019) that requires oral health screening for K-12.
  - In WV - effective 2015-2016 school year – Pre-K or Kindergarten, grades 2, 7, 12

As Legislators, Who Are the Potential Oral Health Partners in Your State?

**Within State Government**
- State public health infrastructure (dental officer)
- State Primary Care Office
- State Medicaid/CHIP Programs
- State Maternal and Child Health Program
- State Office of Rural Health

**Statewide Health Associations**
- State Dental, Dental Hygiene Associations
- State Oral Health Coalition
- State Primary Care Association
- State Rural Health Association
What Can You, As A State Legislator Do?

- **Serve as a Convener**
  - In the State Capitol – provide opportunities for Members to learn about best practices for improving oral health, access
  - In Your District/State – convene public and oral health leaders in local communities, include community health centers, school based health clinics
    - Many solutions to address oral health challenges emerge from within communities

- **Establish an “Oral Health” Caucus within the legislature**

- **Arrange a State Capitol Oral Health Hill Day**

- **Become an Oral Health Champion!**
LEGISLATIVE RESPONDENTS

- Senator Clarence Lam, Maryland
- Representative Steve Eliason, Utah
THANK YOU!

- Erik Skinner, Policy Associate, NCSL Health Program
  - erik.skinner@ncsl.org
  - 303-856-1461