



Adult Dental Benefits in Medicaid: Recent Experiences from Seven States

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The National Academy for State Health Policy (NASHP) conducted interviews with state administrative and legislative branch officials as well as dental stakeholders in California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington, all of which have recently taken action to add, reinstate, or enhance their Medicaid adult dental benefit.

This brief summarizes policy lessons and themes about why states decided to take up this coverage option and how they are implementing it. Accompanying case studies provide a more in-depth look at each state's adult dental benefit.

Key Findings

- There is growing recognition of the importance of oral health as it relates to overall health—including pregnancy, avoidable emergency room utilization, and chronic conditions such as diabetes and heart disease—as well as employability. These data points, as well as personal experiences with individuals who cannot access routine dental care, resonated with key state decision-makers.
- Policymakers generally support providing adult dental benefits to Medicaid enrollees, but prioritizing spending on the benefit can be challenging, given the need of states to balance limited resources with many competing priorities.
- Engagement by high-level state policymakers, including legislative leaders, governors' staff, and Medicaid agency leadership, along with active legislative outreach by dental associations and oral health coalitions is important to raise the profile of the issue.
- In many states, enhancements are progressing incrementally. In some states the benefit is being extended only to certain groups of enrollees such as pregnant women or the Medicaid expansion population. In other states the benefit is capped with a dollar limit.
- Many states expanding their adult dental benefit have done so by building on improvements made to their children's dental coverage programs over the last decade. This includes leveraging existing contractual relationships, provider networks, and care coordination efforts.
- States' decisions on adult dental coverage were affected by their broader work on implementing health reform. Enhanced federal funding through the Affordable Care Act's (ACA) Medicaid expansion motivated action in several states. Some states are also beginning to consider how dental services may fit into payment and delivery system reform efforts such as the State Innovation Models Initiative.

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Introduction

Oral health is an important but often neglected part of overall health, particularly for adults. For children, states are required to cover dental services in Medicaid and the Children's Health Insurance Program (CHIP), also the ACA extended dental benefits to more children through health insurance exchanges and Medicaid expansion. While implementation issues remain, Medicaid-enrolled children have seen significant gains in access to dental coverage and care over the last 10 years.¹

In contrast, adult dental coverage is an optional benefit in Medicaid and the ACA does not address dental benefits for adults. As a result, Medicaid adult dental benefits vary significantly across states. In 2015, only 15 offered extensive adult dental benefits, 17 states offered a more limited package, 15 states offered emergency-only dental benefits, and 4 states offered no adult dental benefit.²

A 2012 survey found that 91 percent of adults aged 20-64 had dental caries and 27 percent had untreated tooth decay.³ Poor and near-poor adults ages 35-44 are more than twice as likely to experience gum disease and untreated tooth decay than non-poor adults, and almost twice as likely to have lost a tooth due to those conditions. Poor seniors are more than twice as likely to have lost all of their natural teeth than non-poor seniors.⁴

Historically, states have cut back Medicaid adult dental benefits due to state fiscal challenges, including in the wake of the 2007-2009 recession. In the past two years, however, a number of states have decided to enhance the dental benefits provided to adult Medicaid enrollees.

NASHP examined recent experiences in seven states that acted to add, reinstate, or introduce adult dental benefits in the last two years: California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington. These states took a range of approaches to adult dental benefits in regard to benefits, program administration, and the legislative or administrative vehicles for advancing the policy change. Across these states, however, some common themes emerged around:

- Key policymakers and advocates who were engaged in the decision, and the key data points that were important in making the case;
- States' adoption of incremental improvements in order to balance dental benefits with other competing budgetary priorities;

Case Studies

For more on the actions taken on Adult Dental Benefits in the states listed in Table 1, see the Case Studies starting on page 13.

- Application of lessons learned from improvements to states' pediatric dental benefits to adult populations; and
- Desire among states to explore how dental benefits might fit within their broader work on payment and delivery system reform in future.

These findings were informed by interviews with a range of experts in each state including state officials—Medicaid leaders, legislators, and governors' health policy advisors—and state dental associations, oral health coalitions, and other key stakeholders conducted between February and May 2015. This brief summarizes the high-level themes that emerged from our interviews. More detailed descriptions of the approaches taken in each of the seven states are provided in case studies in Appendix II. Below is a chart that summarizes the actions taken in each of the seven states, the legislative or administrative vehicle used, date of implementation, and the benefits offered.

Table 1.
Actions Taken on Adult Dental Benefits in Seven States

State	Legislative or Administrative Vehicle	Date Implemented	Benefits and Populations Covered
California	State budget, AB 82 (2013)	May 2014	Reinstated most benefits for all Medicaid-enrolled adults, with \$1,800 annual “soft cap” that can be exceeded when medical necessity is proven. Additional services covered for pregnant women.
Colorado	SB 242 (2013)	April 2014	Introduced benefits for all Medicaid-enrolled adults, with \$1,000 annual cap. Dentures are exempt from the cap.
Illinois	State budget, SB 741 (2014)	July 2014	Reinstated benefits for all Medicaid-enrolled adults. Additional preventive services covered for pregnant women. (Gov. Rauner’s proposed FY2015 budget would cut the rates paid for adult dental services.)
Iowa	Section 1115 Medicaid waiver	May 2014	Introduced “earned benefit” to Medicaid expansion population; individuals who establish a regular source of care qualify for more expansive benefits.
Massachusetts	Annual state budgets	January 2013 March 2014 May 2015	Reinstated services for all adults incrementally – first fillings for front teeth, then all fillings, then dentures. Additional services covered for persons determined eligible through the Department of Developmental Services.
Virginia	Governor’s Healthy Virginia plan (2014)	March 2015	Introduced dental benefit for adult pregnant women over age 21.
Washington	FY 2013–2015 biennial operating budget	January 2014	Reinstated extensive benefits for all Medicaid-enrolled adults.

Key Themes Among States

Partnerships and Gathering Support

Leadership

Involvement by legislative and administrative branch champions was critical in each state that NASHP interviewed. The champions in several states were people with particularly high authority—including Frank Chopp, Washington State Speaker of the House, Darrell Steinberg, California Senate President pro tempore, and Virginia Gov. Terry McAuliffe. Interviewees noted that the addition of adult dental benefits did not usually face organized opposition, but the involvement of high-level champions was important to make and keep adult dental benefits a priority in the midst of many other state concerns.

Oral health coalition members, stakeholders, and provider groups across states focused primarily on the message that oral health is part of overall health—and that there are linkages between oral health and health conditions such as diabetes, heart disease, and potentially, adverse birth outcomes.⁵

Data on use of hospital emergency departments (EDs) for preventable dental conditions, and increases in such visits in states following elimination of adult dental benefits was also noted as important. However, interviewees identified that it was particularly compelling for policymakers to personally meet individuals experiencing pain and tooth loss from untreated dental conditions. Attendance at dental association sponsored events in California and Virginia, where free dental care was provided to underserved communities, was noted as a key factor in policymakers' engagement in the issue.

Relationship building

In all states, efforts to advocate for, implement, and operationalize a new benefit program required the collaboration of many different partners. The most frequently cited partners were oral health stakeholder groups such as state dental associations, dental hygiene associations, oral health coalitions, and oral health-focused philanthropies. The ability of these groups to lobby legislators was noted as an important factor in several states. Oral health stakeholders noted the importance of engaging a broader group of voices from outside of the dental community, like community health centers, anti-poverty groups, and advocates for seniors and individuals with disabilities.

In most states, strong partnership with the state's dental association was an important factor. Several state dental associations indicated that they decided to advocate for the addition of



benefits, even if the policy didn't fully address the concerns of their membership with program administration and provider reimbursement rates, as a way to demonstrate their support for improving oral health and access to care for Medicaid-enrolled individuals.

Good relations between dental associations, oral health coalitions, and Medicaid agencies within a state helped keep dental benefits in front of key decision-makers, so that action could be taken on adult benefits when a window of opportunity opened. All states NASHP spoke with said that the new benefit came about as a result of years of effort and taking advantage of a ripe opportunity, for example opportunities presented by enhanced federal funding for Medicaid expansion under the ACA.

Approach and Implementation

Financing strategies

Most states financed their adult dental benefit through state general funds, and the benefit was often introduced in the context of a state's biennial budget process. One exception was Colorado, which redirected a portion of a trust fund that funded the state's high-risk pool, made obsolete through the ACA, to serve as the state share of funding for its new adult dental benefit.

Interviewees across all seven states shared that an adult dental benefit, particularly one limited to certain services or populations, is a relatively minor budget item in the context of state Medicaid budgets. In 2013, the National Health Expenditure Accounts estimated that total state and local spending on dental services for children and adults in Medicaid was about \$3.2 billion, equaling less than two percent of total state and local spending on Medicaid.⁶ Washington's restoration of a dental benefit for 874,000 Medicaid-enrolled adults required \$23 million in state funding; Virginia's benefit for 45,000 pregnant women is projected to cost approximately \$3 million in the first two years.

Officials in several states reported that the ACA presented a unique opportunity to expand den-

tal coverage to many new enrollees at a reduced cost to the state. In particular, states that opted to expand Medicaid eligibility to individuals up to 133 percent were able to leverage the 100 percent federal match made available through the ACA to help mitigate the cost of a new adult dental benefit. The availability of new federal funding through Medicaid expansion was particularly important in Washington's consideration of an adult benefit. Although the state could have opted to only cover dental services for the expansion population, state officials felt it was important to offer coverage to all adults to ensure continuity and equity of coverage for all enrollees.⁷

Research on links between improvements in oral health and potential reductions in overall health care spending, while compelling to state officials, generally didn't factor into states' budgeting for adult dental benefits. Interviewees in several states noted that demonstrating and booking short-term cost savings is challenging for states that are tied to short annual or biennial budgets and often lack proper systems to coordinate savings that cross medical and dental spheres—for example, reductions in ED usage from improved access to routine dental care. However there was general support for the idea that dental coverage could save money in the long-term, particularly as states move towards efforts to integrate dental and medical services within larger payment and delivery system reforms.

All seven states voiced concern about the perpetual vulnerability of the benefit; because it is categorized as "optional," it can be cut or scaled back during times of fiscal stress. Most states felt confident that the benefits they introduced are going to be fiscally sustainable for the foreseeable future, though Illinois is already considering a potential cutback in adult benefits as part of its 2015 budget negotiations.

Incremental Approaches

Most interviewees expressed a desire to extend full dental benefits to all adults in Medicaid, allowing enrollees to obtain medically necessary care for tooth decay and gum disease. However, many

states pursued an incremental expansion of benefits—by limiting the benefit to certain populations, specific covered services, or placing a dollar limit on the benefit package. For example, Virginia extended comprehensive dental benefits only to women enrolled in Medicaid during pregnancy and 60 days postpartum; non-pregnant adults in Medicaid are covered only for emergency dental services. Over the last three years Massachusetts has gradually added services including fillings, initially for front teeth only, later for all teeth, and dentures back into its adult benefit package. In Colorado, the new dental benefit is comprehensive and available to all adults enrolled in Medicaid, however the benefit is capped at \$1,000 per enrollee per year. Dentures are exempt from the benefit cap.

In most cases, the state chose an incremental expansion because of fiscal concerns. There was wide acknowledgement among interviewees that an incremental benefit is better than no benefit, and there was also a desire among states to limit benefits within what their budget would bear, to reduce the possibility of future cutbacks. Multiple interviewees noted that a “pendulum swing” of repeated expansions and contractions had created challenges and confusion for enrollees, providers, and Medicaid agencies alike. During periods of reduced benefits, enrollees frequently forego care due to inability to pay. Providers—both dentists and safety net providers like community health centers—reported feeling strain from multiple changes to states’ benefit packages, in regard to their ability to develop treatment plans for Medicaid-enrolled patients who may no longer have coverage for necessary services. State officials must manage the administrative challenge of stopping and restarting benefits, and face pent-up demand when benefits are restored—particularly for expensive services like dentures, which might have been avoided with routine dental care.

Building on Existing Programs

States across the country have made great progress in improving Medicaid-enrolled children’s access to dental care over the last decade.⁸



Several states built on these successes in the policies they adopted for their adult dental Medicaid benefit. In particular, states focused on administrative simplification, including the use of specialized dental administrative vendors, and development of supports to help connect enrollees to dental care.

- **Iowa’s** unique Dental Wellness Plan incorporates a tiered “earned” benefit approach for the newly eligible Medicaid expansion population that conditions certain benefits on patients establishing a relationship with a dentist whom they see regularly. To help ensure that adults can build those relationships, Iowa is building on the network of Title V-funded county-based dental care coordinators that it has built over the last 10 years through its I-Smile children’s dental program. Iowa also used the tiered structure to increase the capitation rate for the Dental Wellness Plan, enabling it to address some longstanding concerns about provider reimbursement rates.
- **Virginia** used its successful Smiles for Children program as the basis for its benefit for pregnant women. Smiles for Children has built up strong dentist participation since its introduction in 2005 due to simpler administration and higher reimbursement rates.
- **Colorado** used its CHIP benefit—which uses

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a specialized dental vendor—as a model for its transition to a new Administrative Services Organization (ASO).

Other states NASHP interviewed reinstated the same benefits, administrative processes, and reimbursement rates that had been cut in previous years. Many of these states saw that as a first step, and expressed a desire to continue improving program administration and provider participation in future years.

Outreach and Education

States indicated that outreach and education to both newly eligible enrollees and providers will be crucial to the ongoing success of the new benefit including ensuring that enrollees connect to regular and ongoing care. In addition to initiatives like Iowa's use of dental care coordinators, states are also working in partnership with stakeholders in the dental and medical communities to ensure that outreach and education efforts are successful. In Virginia, the state has partnered with OBGYNs and pediatricians to help communicate the availability of dental benefits for pregnant women, and to spread information to patients and providers that receiving dental care during pregnancy is safe and appropriate. Colorado is working closely with its state dental association to recruit dentists to serve Medicaid-enrolled clients. Despite progress, provider recruitment and network adequacy remain a concern in many states.

Evaluating Success

NASHP spoke with state officials and stakeholders about how they would gauge whether they had achieved their policy goals from introduction or reinstatement of adult dental benefits. States are primarily looking to traditional measures to gauge their success, including utilization rates among enrollees, provider participation rates, and calls to customer service hotlines from enrollees seeking care.

NASHP spoke to many of these states very soon after their adult dental benefits were implemented, so few were able to provide detailed findings. Some states, however, are reporting early successes in improving access to care and provider engagement.

- **In Iowa**, Delta Dental (the administrator of the Dental Wellness Program) reported that, as of February 2015, 36,500 of the program's 115,000 enrollees had received a dental service since the program began in May 2014.⁹
- **In Washington State**, more than 204,000 Medicaid-enrolled adults received a dental service in CY 2014, an increase from the roughly 136,000 adults who received services in CY 2010—the year before services were cut back. Howev-

er, this happened in the context of a doubling of the number of enrollees (from 410,000 to 874,000) due to Medicaid expansion, so the rate at which enrollees used services fell from 33 percent to 23 percent.¹⁰

- **Colorado** reported some success from their provider recruitment efforts, conducted in collaboration with the Colorado Dental Association (CDA). The CDA reported that the number of Medicaid-participating dentists had grown 17 percent between 2012 and 2014.¹¹

Additionally, several states are setting concrete expectations around linkages between dental benefits and overall health spending. Colorado has set yearly performance standards for its administrative services contractor. In year two, the state is focusing on decreased utilization of the emergency room for non-emergency dental care. In Iowa, because the Dental Wellness Plan is being implemented through a section 1115 demonstration waiver, the state, in partnership with the University of Iowa Public Policy Center, has developed a detailed evaluation plan that will attempt to track whether enrollment in the Dental Wellness Plan results in reduced ED utilization, and also measure whether enrollees receiving dental services experience better outcomes related to chronic conditions like diabetes.¹²

Looking Forward

Officials and advocates in many states saw the addition or restoration of adult dental benefits as the first step in addressing oral health for Medicaid-enrolled adults, with more action being necessary to ensure that enrollees can effectively access care. In Colorado, the state legislature has followed up the initial introduction of a dental benefit with subsequent action to provide coverage for dentures (outside of the \$1,000 annual cap) and to provide reimbursement rate increases for targeted services. State officials in Iowa are considering how the Dental Wellness Plan might fit into the state's shift toward managed care for all Medicaid-enrolled populations. In Washington, oral health stakeholders are working to partner with the Washington Health Care Authority to research the possibility of developing a targeted, enhanced benefit for pregnant women and people

with diabetes, modeled after the state's successful Access to Baby and Child Dentistry program. Other states like Illinois, however, are already facing the possibility of cutbacks to benefits in the context of a changing state budget picture.

States are also looking for ways to expand their ability to provide dental services beyond the traditional dental office. California recently enacted legislation to permit Medicaid reimbursement to dentists who provide dental care via telehealth.¹³ This supports programs such as the Virtual Dental Home, a model where dental hygienists and assistants provide preventive and limited restorative services in community settings like nursing homes, schools, and Head Start sites, with connection via telehealth to a supervising dentist. Colorado will soon begin a pilot project to replicate the Virtual Dental Home model, funded by the Caring for Colorado Foundation.¹⁴

Lastly, officials and advocates in several states are looking closely at ways to weave oral health into broader payment and delivery system reforms, to reflect oral health's connection to overall health. Stakeholders from the Virginia Oral Health Coalition will be leading a workgroup through Virginia's State Innovation Model (SIM) design planning process. They will make recommendations on strategies that Accountable Communities for Health (ACH), regional multi-sector collaboratives that make decisions about allocation of health care resources, can use to address the oral health of their communities. In Washington, although oral health was not addressed in detail in the state's SIM Innovation Plan, state officials indicated that they expected several ACHs to identify oral health as a priority area for improvement. Colorado is considering ways to facilitate collaboration between its dental ASO and its Regional Care Coordination Organizations (the state's Medicaid-focused accountable care entities). Colorado is also examining ways to develop better linkages between dental claims data and its all-payer claims database.

Conclusion

Adult dental coverage's status as an optional Medicaid benefit means that it is an area where states have some latitude to make cutbacks, so benefits tend to contract during difficult budget circumstances—such as the 2007-2009 recession—and expand as fiscal pressures ease. States that NASHP examined took a variety of approaches to adding, reinstating, or introducing adult dental benefits, but they have attempted to do so in a way that is fiscally sustainable, and also provides meaningful access for program enrollees. Many have also built on lessons learned from improvements to their Medicaid dental programs for children.

The idea of providing adult dental benefits to Medicaid enrollees is generally supported by policymakers—who frequently cited the importance of oral health, high levels of unmet need among low-income populations, and links between oral health and overall health. However, prioritizing spending on the benefit can be challenging, given states' need to balance limited resources and many competing priorities. Important factors in these seven states included funding opportunities through the ACA, personal engagement by high-level state policymakers, and strong partnerships with dental associations and oral health coalitions to raise the profile of the issue and assist in implementation of the benefit.

These seven states' experiences may be instructive for other states considering addressing adult dental coverage. The case studies in Appendix II of this brief provide much more detail on the strategies that each state pursued.

Endnotes

1. Andrew Snyder, Keerti Kanchinadam, et. al. Improving Integration of Dental Health Benefits in Health Insurance Marketplaces (Washington, DC: National Academy for State Health Policy, 2014).
2. The American Dental Association classifies Medicaid adult dental benefits into the following categories: Extensive benefits: A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the American Dental Association (ADA); per-person annual expenditure cap is at least \$1,000. Limited: Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the ADA; per-person annual expenditure for care is \$1,000 or less. Emergency Only: Relief of pain under defined emergency situations. (Center for Health Care Strategies, "Medicaid Adult Dental Benefits: An Overview." Retrieved May 21, 2015. http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_21915.pdf.)
3. Bruce Dye, et. al. Dental Caries and Tooth Loss in Adults in the United States, 2011-2012. NHCS Data Brief no. 197 (Hyattsville, MD: National Center for Health Statistics, May 2015).
4. Bruce Dye and Gina Thornton-Evans, "Trends in oral health by poverty status as measured by Healthy People 2010 objectives," Public Health Reports 125: no. 6, 817-830 (May-June 2010). Poor is defined as income less than or equal to 100 percent of the Federal Poverty Level (FPL). Near-poor is defined as income between 100 and 199 percent FPL, and non-poor as income greater than or equal to 200 percent FPL.
5. Andrew Snyder, Oral Health And The Triple Aim: Evidence And Strategies To Improve Care And Reduce Costs (Washington, DC: National Academy for State Health Policy, 2015).
6. Centers for Medicare and Medicaid Services, "National Health Expenditures by type of service and source of funds, CY 1960-2013." Retrieved May 26, 2015. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.
7. Interview with MaryAnne Lindeblad, Nathan Johnson, and Gail Krieger, Washington Health Care Authority, April 8, 2015.
8. Centers for Medicare and Medicaid Services, CMS Oral Health Initiative and Other Dental-Related Items (Baltimore, MD: U.S. Department of Health and Human Services, April 2013), CIB-04-18-13.
9. Interview with Beth Jones and Gretchen Hageman, Delta Dental of Iowa, February 25, 2015.

10. Personal communication with Nathan Johnson, Chief Policy Officer, Washington State Health Care Authority, April 8, 2015.
11. Interview with Colorado Dental Association, March 26, 2015.
12. Iowa Medicaid Enterprise and University of Iowa Public Policy Center, "Iowa Dental Wellness Plan Evaluation." (September 2014). Retrieved May 26, 2015. http://dhs.iowa.gov/sites/default/files/DentalWellnessPlanEvaluationDesign_Sept2014.pdf.
13. California Assembly Bill 1174. Approved by Governor September 27, 2014.
14. Caring for Colorado Foundation, "Caring for Colorado Announces New, Major Investments," news release, January 26, 2015, <http://www.caringforcolorado.org/post/newsroom/caring-colorado-announces-new-major-investments>.

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Appendix I: Interviewee List

CALIFORNIA

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Nicette Short
Director of Public Policy
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Darrell Steinberg
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Former Senate President pro Tempore, California State Senate

Chris Wordlaw
Section Chief, Provider and Beneficiary Services
California Department of Health Care Services

COLORADO

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President
Colorado Dental Hygienist Association

Deborah Foote
Executive Director
Oral Health Colorado

Bill Heller
Provider Relations and Dental Program Division Director
Department of Health Care Policy & Financing

Greg Hill
Executive Director
Colorado Dental Association

Jeff Kahl
Co-Chair of Council on Governmental Relations
Colorado Dental Association

Brett Kessler
President
Colorado Dental Association

Jennifer Miles
President, Miles Consulting, Inc.

Carol Morrow
Second Vice President and Secretary
Colorado Dental Association

Jeanne Nicholson
Former Senator
Colorado Senate

IOWA

Lawrence Carl
Executive Director
Iowa Dental Association

Peter Damiano
Director, Public Policy Center
Professor, Preventive and Community Dentistry, University of Iowa

Sabrina Johnson
Policy Specialist
Iowa Medicaid Enterprise

Beth Jones
Public Benefit Manager
Delta Dental of Iowa

Gretchen Hageman
Dental Wellness Plan Director
Delta Dental of Iowa

Sally Nadolsky
EPSDT Manager
Iowa Medicaid Enterprise

Bob Russell
Public Health Dental Director
Iowa Department of Public Health

Robert Schlueter
Bureau Chief of Adult & Children's Medical Programs
Iowa Medicaid Enterprise

Andria Seip
Affordable Care Act Project Manager
Iowa Medicaid Enterprise

Jennifer Vermeer
Assistant Vice President for Health Policy and Population Health
University of Iowa Health Care

ILLINOIS

Mona Van Kanegan
Co-founder and Co-director of Oral Health Forum
Heartland Alliance

Dave Marsh
Director of Government Relations
Illinois State Dental Society

Gina Swehla
Acting Bureau Chief
Illinois Department of Healthcare and Family Services

MASSACHUSETTS

Patricia Edraos
Health Resources/Policy Director
Mass League of Community Health Centers

Stacia Castro
Specialty Provider Network Manager
MassHealth

Ellen Factor
Director of Dental Practice
Massachusetts Dental Society

Brian Rosman
Research Director
Health Care for All

John Scibak
Representative
Massachusetts House of Representatives

Shannon Wells
Oral Health Affairs Manager
Mass League of Community Health Centers

Jane Willen
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VIRGINIA

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Executive Director
Virginia Dental Association

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Office of the Secretary of Health and Human Resources

Sarah Holland
Executive Director
Virginia Oral Health Coalition

Anna Healy James
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Cheryl Roberts
Deputy Director of Programs
Department of Medical Assistance
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Bryan Tomlinson
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WASHINGTON

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Chief Dental Officer
Neighborcare Health

Walt Bowen
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Appendix II : State Case Studies

Medicaid Adult Dental Benefits: California Case Study



In 2014, California restored most dental benefits to Medicaid-enrolled adults, following a cutback in the midst of a deep budget deficit in 2009. The state's implementation of the Affordable Care Act's (ACA) Medicaid expansion factored into the decision to restore dental benefits. There are continuing concerns around access to care for the now 12 million state Medicaid enrollees with dental benefits.

History

In 2009, in the midst of a \$42 billion budget deficit stemming from the financial crisis and recession, California cut back longstanding dental coverage for adults age 21 and older enrolled in Medi-Cal, the state's Medicaid program. Only very limited benefits remained, covering emergency services, extractions, and some oral surgery services for all adults. Pregnant women and individuals in skilled nursing facilities or intermediate care facilities for individuals with developmental disabilities were not subject to the reduced benefits. As the state's fiscal picture improved, adult benefits were partially restored through the 2013 state budget, Assembly Bill 82.¹ State officials estimate that the restored benefits, which went into effect in May 2014, cost approximately \$70 million.

This partial restoration of adult benefits happened in the context of the ACA's Medicaid expansion, which increased total Medi-Cal enrollment to approximately 12 million individuals. State officials noted that their goal around Medicaid expansion was to offer all adults the same benefit package. They also noted that the availability of enhanced federal funding for the Medicaid expansion population was a positive factor with respect to the

financial viability of bringing back adult dental benefits.

Approach and Implementation

The Medi-Cal dental program includes two delivery systems: dental managed care, and the Denti-Cal fee-for-service program. Dental managed care is available only in Sacramento County, where enrollment is mandatory, and Los Angeles County, where it is voluntary. Denti-Cal fee-for-service is available in all other counties of the state.²

The benefits that were restored include exams, x-rays, fillings, root canals on front teeth, and full dentures.³ Coverage for root canals on back teeth and treatment for gum disease were not returned. There is a yearly "soft cap" of \$1,800 in benefits, although this limit can be exceeded if medical necessity can be proven.⁴

Though final figures on utilization of dental services by Denti-Cal-enrolled adults since the restoration of benefits will not be ready until later in 2015, state officials report that utilization has picked up, with some evidence of pent-up demand among adults for restorative and denture services

that had been eliminated. *Health Affairs* recently published an article noting an increase of 1,800 visits per year to hospital emergency departments for dental conditions following the cutback.⁵

Given the restored benefits and enrollment expansion, state officials noted the need to closely monitor provider capacity and enrollees' access to dental care. Provider participation and program administration were noted by Denti-Cal as issues in a recent state auditor's report on children's access to dental care. Provider payments were reduced by 10 percent in September 2013⁶ (for 10 common procedures, the auditor estimated that California's rates were 35 percent of the national average). The report also voiced concerns about whether adults that were newly eligible for dental services might crowd out children seeking care.⁷ In response to the audit findings, state officials must develop a corrective action plan to address recommendations. The state has met with stakeholder groups to establish additional measures of beneficiary utilization and provider participation in the fee-for-service program. The state is also working on an active procurement of an administrative services contractor and fiscal intermediary contractor for the Medi-Cal dental program.⁸

Key Leadership and Partnerships

Senator Darrell Steinberg, former president pro tempore of the California Senate, was a key legislative champion keep restoration of adult benefits a priority in the state budget. Sen. Steinberg became engaged in the issue after attending CDA Cares, a charity event organized by the California Dental Association (CDA), and being deeply affected by the event. He recalled seeing the health effects and human cost of unmet dental needs, including seeing the large number of people needing tooth extractions. After a state tax measure passed, there were sufficient state revenues to prioritize increased spending on a limited number of issues, and the senator advanced adult dental coverage with the support of his caucus. He noted that the measure wasn't controversial among his colleagues, but that high-level leadership was necessary to raise the profile of adult dental cov-

erage and make it a priority.⁹

The CDA was a major supporter of the effort to restore benefits, and worked with legislative staff on developing several options for the benefit. Interviewees also noted the participation and support of the state oral health coalition, the state primary care association, and advocacy groups including The Children's Partnership, which has had longstanding involvement in oral health policy issues.

Looking Forward

Interviewees all indicated, while adult dental benefits are always vulnerable due to their optional status, they were confident that since the state was in a more sustainable fiscal situation they did not see future cuts on the horizon. State officials remain focused on ensuring access to dental care for Medi-Cal beneficiaries. Budget discussions at the legislature have included a proposal to restore the remaining adult dental benefits.¹⁰

Following our interviews, stakeholders including the CDA successfully advocated for a reversal of the 2013 rate cut, effective July 1, 2015.¹¹ Stakeholders are continuing to consider strategies to enhance feeds for targeted services. Making adult coverage more available through Covered California, the state's health insurance marketplace, is also a priority for oral health stakeholders.

California is also examining ways to bring dental care closer to individuals who need it. The state recently enacted legislation to permit Medicaid reimbursement to dentists who provide dental care via telehealth.¹² This legislation supports programs such as the Virtual Dental Home, a model where dental hygienists and assistants provide preventive and limited restorative services in community settings like nursing homes, schools, and Head Start sites, with connection via telehealth to a supervising dentist. The Children's Partnership and CDA are partnering in support of legislation for \$4 million in grants to support start-up costs of Virtual Dental Home projects in 20 communities for equipment, training, learning collaboratives, and technical assistance.¹³

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Medicaid Adult Dental Benefits: Colorado Case Study



In 2013, Colorado introduced a new law providing extensive dental benefits for all Medicaid-enrolled adults for the first time. The benefit is supported with funds that were freed up when the Affordable Care Act (ACA) eliminated the need for the state's high-risk pool. State officials and key stakeholders are continuing to work to bolster provider participation and address reimbursement rates.

History

Prior to 2013, Colorado only covered emergency dental services for adult enrollees in Medicaid. In 2011, upon taking office, Gov. Hickenlooper identified 10 “winnable battles”—public health priorities with known and effective strategies to address them. Improving oral health was among those chosen. While the original focus was on children's oral health, it paved the way to address oral health issues for pregnant women, mothers, and the larger adult population.

In 2012, Colorado saw its first major push towards expanding adult dental benefits. Senate Bill 12-108 proposed dental services for pregnant women under the state's Medicaid program. Advocacy organizations and the bill sponsor, Sen. Jeanne Nicholson, majority caucus chair and a public health nurse by training, spent years educating members of the state House and Senate on the importance of oral health benefits for an adult's ability to maintain employment and their overall health. Interviewees credit these efforts for the success SB 12-108 initially saw. The bill passed the Senate but did not make it on the House's calendar for voting. Despite the initial bill being pulled back, it paved the way for a more compre-

hensive bill in the following year. With the Governor's leadership, Senate Bill 13-242 extended dental services to all adults over age 21 in the state's Medicaid program. This bill was signed in May 2013 with dental benefits beginning in April 2014.

Approach and Implementation

Funding

Funding for the new adult dental benefit came from a unique source. In 1990, the state established CoverColorado, a state-run high-risk pool to help individuals with pre-existing conditions enroll in coverage. Following the ACA's elimination of denials for pre-existing conditions and the establishment of health insurance exchanges, CoverColorado was made unnecessary. The state's Unclaimed Property Trust Fund (UPTF), which funded CoverColorado, was identified as a possible source of funding for the adult dental benefit. Due to Colorado's Taxpayer's Bill of Rights amendment—which requires that excess state revenue be refunded to taxpayers—there was a very limited window of availability for the freed UPTF funds. It was imperative that the state move quickly to redirect the funds. As a result, the Department of Health Care Policy and Financing

(DHCPF) had to implement the new benefit program on a very compressed timeline of less than a year.

Benefit Design

The new adult dental benefit provides a fairly comprehensive set of benefits for adults over age 21 in Medicaid. The main limitation on the benefit is a \$1,000 annual cap. The initial 2013 benefit also did not include dentures, but in 2014, lawmakers from both parties voted to add this coverage. Notably, this addition gained more support from Republican legislators than the initial 2013 legislation.

Benefits offered to adults in Colorado's Medicaid program include: basic preventive dental exams, diagnostic and restorative dental services, extractions, root canals, crowns, partial and complete dentures (not subject to the \$1,000 cap), and periodontal scaling and root planing. Other procedures requiring prior authorization are available.¹

Since July 2014, the benefit has been administered by DentaQuest, a dental administrative services organization (ASO). Because of the short timeframe for implementation, DHCPF directly administered a more limited benefit from April to July 2014. Colorado used its Children's Health Insurance Program (CHIP) benefit—which uses a specialized dental vendor—as a model to develop the new ASO. Though the multiple changes created some disruptions for providers, state officials suggested that using a successful program such as CHIP as a model was beneficial.

Reimbursement Rates and Provider Incentives

The Colorado General Assembly has continued to support Medicaid dental benefits through appropriations. The Joint Budget Committee approved a 4.5 percent increase in dental provider rates in FY 2013-2014² and a two percent across-the-board provider rate increase in FY 2014-2015.³ Additional targeted rate increases for specific dental services are included in the Joint Budget Committee's budget for FY 2015-2016 as well,

but have not been finalized as of this writing.⁴

The Legislature also approved \$2.5 million in state funding (with a \$2.5 million federal match) to provide financial incentives for dentists who treat Medicaid enrollees.⁵ The state contribution comes from reinvesting a portion of the savings from the change in federal match rate for Medicaid and CHP+, Colorado's CHIP program. As of March 2015, DHCPF was awaiting federal approval of a State Plan Amendment to operationalize the provider incentive program. Provider and stakeholder groups are concerned that the delay in implementing the incentives has taken some momentum out of provider recruitment efforts.

Key Leadership and Partnerships

Key policymakers in Colorado championed the issue of improved access to oral health for adults, ensuring that it was a legislative priority in the state. Engagement by Senator Nicholson, Governor Hickenlooper's office, and the leadership of DHCPF were especially important.

From the stakeholder perspective, the Colorado Dental Association (CDA) and Oral Health Colorado (OHCO) led advocacy and lobbying efforts. OHCO convened a wide array of stakeholders, including community and safety net partners, to provide continued feedback on the development and implementation of the new benefit. The CDA was a strong supporter of the new benefit and has been engaged in helping to communicate providers' concerns and administrative challenges with the new benefit. The CDA has shown commitment to increasing provider participation, particularly through a "Take 5" campaign to encourage dentists to begin seeing at least five Medicaid patients. Colorado reported some success from their provider recruitment efforts, conducted in collaboration with the CDA. The CDA reported that the number of Medicaid-participating dentists had grown 17 percent between 2012 and 2014.⁶

Looking Forward

A major concern for the long-term sustainability of the new adult dental benefit is provider participation. Historically, perceived low reimbursement

rates and administrative barriers have made many dental providers reluctant to participate in the Medicaid program. DHCPF and DentaQuest are holding regular town hall meetings to gather provider and stakeholder feedback to address administrative issues. Also, the General Assembly has appropriated additional funds for reimbursement rate increases, though there is some concern that, without raising the \$1,000 cap, enrollees may more quickly exhaust their annual benefit.

Although it is too early for Colorado to report utilization figures for the first year of the benefit, DHCPF has laid out several benchmarks for evaluating their ASO vendor's performance. In year one, they looked to increase provider enrollment. In year two, they are focusing on decreased utilization of the emergency room for non-emergen-

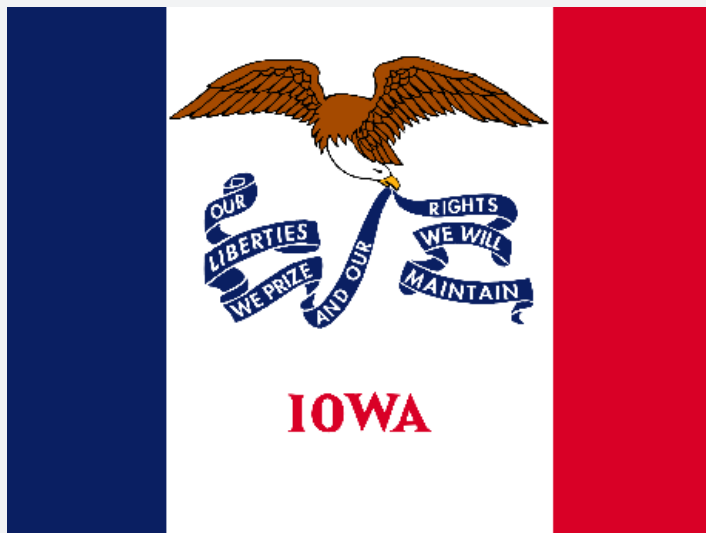
cy dental care. Finally, the goal for year three will focus on better health outcomes, particularly by thinking of ways to coordinate their ASO with the state's Regional Care Collaborative Organizations.

Colorado is also exploring ways to expand their capacity to provide dental services beyond the traditional dental system. Colorado will soon pilot a 5-year, \$1.65 million Virtual Dental Home initiative, funded by the Caring for Colorado Foundation, replicating legislation recently enacted in California. The Virtual Dental Home will allow licensed independent practice dental hygienists to provide preventive dental care and access to a dentist via telehealth technology.⁷ In addition, Colorado is examining ways to develop better linkages between dental claims data and its all-payer claims database.

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Medicaid Adult Dental Benefits: Iowa Case Study



In 2014, Iowa began offering a completely redesigned dental benefit to adults in the Medicaid expansion population. The Dental Wellness Plan is an “earned benefit” model, where individuals who establish a regular source of care qualify for more benefits. Enhanced reimbursement rates, streamlined administration, and care coordinators, modeled after a successful Iowa program for children, support the benefit.

History

The Iowa Medicaid Enterprise (IME) has administered a fee-for-service dental benefit for Medicaid-enrolled adults for many years without interruption. Advocates and stakeholders, however, report longstanding issues with inadequate access to care for enrollees and limited provider participation, driven in part by low provider reimbursement rates. IowaCare, a separate health coverage program for individuals under 200 percent of the Federal Poverty Level (FPL) who were not enrolled in Medicaid, included very limited dental services (mainly extractions).

The IowaCare program ended in December 2013, after the introduction of the Iowa Health and Wellness Plan, an alternative approach to the Affordable Care Act’s (ACA) Medicaid expansion. The new program consists of two parts: the Iowa Wellness Plan, a program similar to traditional Medicaid, for adults ages 19-64 under 100 percent of the FPL, and the Iowa Marketplace Choice Plan, which helps individuals with income between 100 and 133 percent of the FPL purchase coverage on the ACA’s health insurance marketplace.

The Iowa legislature included a dental benefit in

the legislation enabling the Health and Wellness Plan (Senate File 446, signed into law by Gov. Branstad in June 2013). IME implemented the Health and Wellness Plan through a section 1115 demonstration waiver, which received federal approval in December 2013.¹

A 2013 evaluation of IowaCare found that dental services were the most frequently-cited unmet chronic health need among program enrollees, with 39 percent reporting dental, tooth, or mouth problems, and 47 percent reporting that they were unable to obtain needed dental care.² These evaluation findings were important contributors to the approach to dental services in the Health and Wellness Plan. State officials wanted to address the high level of need among enrollees, and also take the opportunity presented by the waiver process to develop a program that addressed multiple barriers to dental access in the traditional Medicaid benefit—program administration, reimbursement rates, and patient engagement—all at the same time. The availability of 100 percent federal funding for the ACA Medicaid expansion was also important in making the new program financially sustainable.

Enrollment in the Dental Wellness Plan (DWP) started in May 2014, a few months following the January 2014 launch of the Iowa Wellness Plan. DWP is open to adults in both the Iowa Wellness Plan and the Iowa Marketplace Choice Plan.

Approach and Implementation

Benefit Design

The DWP incorporates a tiered “earned” benefit approach for the newly eligible Medicaid expansion population. It conditions certain benefits on patients establishing a relationship with a dentist whom they see regularly. Nineteen- and 20-year olds enrolled in DWP can receive additional medically necessary dental services under the Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

There are three levels of benefit under the DWP:

- All enrollees are eligible for “Core” services upon enrollment, including exams, preventive services, x-rays, emergency services, and “stabilization” services intended to maintain basic functioning, including restorations for large cavities, crowns, dentures, and root canals and treatment for gum disease (periodontal disease) in limited circumstances.
- Enrollees who receive a second dental exam in 6-12 months become eligible for “Enhanced” services, including routine fillings, and expanded coverage for root canals and periodontal services.
- After a third recall exam, enrollees become eligible for “Enhanced Plus” services, including expanded coverage for crowns, bridges, dentures, and gum surgery.³

Enrollees must continue to make recall visits in order to keep these higher-level benefits. This approach is in keeping with the Iowa Wellness Plan’s emphasis on personal responsibility, for example, premiums are waived for Wellness Plan enrollees who complete certain healthy behaviors.

To help ensure that adults can build those relationships, Iowa is building on the network of Title V-funded, county-based dental care coordinators that it has established over the last decade in its

I-Smile children’s dental program. Delta Dental, which administers the DWP, contracted with 19 regional coordinators, including many of the same agencies that provide I-Smile care coordination services, to connect DWP enrollees with dental providers. An eventual goal is for these coordinators to build relationships with hospital emergency rooms in order to divert patients seeking urgent care for oral conditions to a regular source of dental care. These contracts started in February 2015 and will be ramping up through June 2017.

Implementation of the benefit has not been without challenges. Dentists cited confusion about which program their Medicaid-enrolled patients are in, what their current level of coverage is, and concern that the tiered benefit design interferes with dentists’ ability to provide appropriate care to their patients. Some issues were also reported with patients’ ability to complete treatment plans that were begun prior to enrollment in the DWP. The state has tried to strike a balance between meeting enrollees’ health needs and maintaining the earned benefit structure. In response to stakeholder feedback, the state added additional stabilization and emergent services to the “Core” benefit, and has also allowed patients and providers to make arrangements for self-pay for services that go beyond a patient’s current benefit level.

Reimbursement Rates and Provider Incentives

An advantage of the tiered benefit structure is that it has allowed the state to increase the capitation payment to Delta Dental to \$22.66 per member per month. This translates into provider reimbursement rates that are approximately 60 percent higher than in fee-for-service Medicaid (though still below Delta’s commercial fee schedule).

Delta also makes incentive payments to providers who complete annual oral health risk assessments for patients. Comprehensive risk assessments can form the basis of a treatment plan, help to measure changes in individuals’ oral health status, and help the state to understand the oral

health status of the DWP population. The first provider incentive payments were scheduled for April 2015. The state initially considered a tiered benefit structure based on risk assessment, but shifted over time to its current focus on establishing a regular source of care.

Key Leadership and Partnerships

Multiple interviewees cited personal engagement by former Medicaid director Jennifer Vermeer in the design and development of the DWP as critical to the plan's success. Delta Dental (who had a history of administering the dental benefit in hawk-i, the state's CHIP program) was also deeply engaged in the development of the plan. Several stakeholders, including Iowa's state dental director, Dr. Bob Russell, and representatives from the University of Iowa College of Dentistry were engaged in reviewing and adapting the plan.

Looking Forward

Delta Dental reports that 36,500 of the program's 115,000 enrollees had received a dental service between the start of the program and February 2015.⁴ About half of those receiving services also received a risk assessment. Provider recruitment

for the DWP has been robust; as of February, 721 dentists were participating in the program, exceeding Delta's goal of 500 providers.

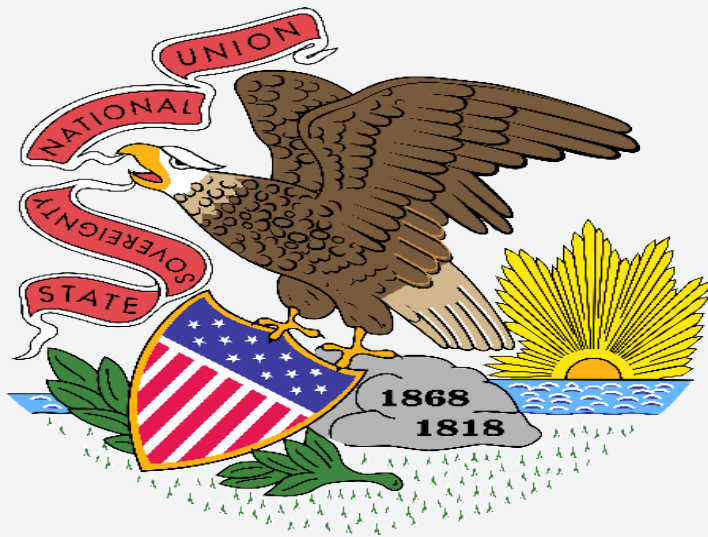
Because the Dental Wellness Plan is being implemented through a section 1115 demonstration waiver, the state in partnership with the University of Iowa Public Policy Center has developed a detailed evaluation plan that will attempt to track over the next three years whether enrollment in the DWP results in reduced emergency department utilization, and also measure whether enrollees receiving dental services experience better outcomes related to chronic conditions like diabetes.⁵ The state is also interested in measuring the program's success in actually improving the oral health of its target population—not just whether access improves, but whether the mix of services enrollees receive shifts away from fillings and extractions and toward preventive services.

State officials are also considering how the DWP might fit into the state's shift toward managed care for all Medicaid-enrolled populations, and whether the approach might be adapted for other Medicaid-enrolled populations.

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Medicaid Adult Dental Benefits: Illinois Case Study



In July 2014, Illinois passed legislation reinstating a dental benefit to Medicaid-enrolled adults. Just two years before, the benefit had been scaled back to emergency dental services only for adults. The Governor's 2015 budget proposes to cut the benefit yet again, leaving the future of the benefit uncertain at this time.

History

Adult dental benefits in Illinois' Medicaid program have had a turbulent history. The benefit was cut and then quickly restored in the mid-1990's. Most recently, in 2012 Gov. Quinn passed the Save Medicaid Access and Resources Together (SMART) Act, which included \$1.6 billion in spending reductions and cuts. Many optional services including most adult dental services were eliminated as a result. Coverage was retained for emergency extractions and for limited services for individuals receiving organ transplants or cancer treatment; later, limited coverage was restored for pregnant women.¹ In the years following the cut, lawmakers and advocates heard many complaints and stories from a variety of constituents regarding lack of access to dental care, particularly preventive care. In 2014, Gov. Quinn signed SB 741—omnibus legislation that included restoration of adult dental benefits.² In March 2015, NASHP spoke with stakeholders and state officials in Illinois to learn more about the 2014 restoration. However, at the time of our conversations, new Gov. Bruce Rauner had proposed \$1.47 billion in Medicaid cuts including the reduction or elimination of adult dental coverage.³ At the time of this writing, the Illinois General Assembly had not yet

passed the final budget.

Approach and Implementation

On July 1, 2014, adults in Illinois began receiving services through the new benefit. Illinois reinstated the same benefit package and provider reimbursement rates that existed in 2011, prior to the elimination.⁴ Covered services include diagnostic services, crowns, root canals, partial and complete dentures, and oral surgical procedures.⁵ Pregnant women are eligible for additional preventive dental services.

Illinois saw a spike in utilization of dental services immediately after the benefit was restored. There was a lot of media and publicity around the new benefit, which interviewees believe contributed to the high demand. The state also sent out notices informing clients of the new benefits. However, after the initial spike in July and August, the state saw significant decrease in utilization.

At the same time, as the state was implementing the new adult dental benefit, it was starting the resource-intensive undertaking of transitioning 1.5 million Medicaid recipients into managed care programs, including multiple subcontractors for

dental services. Interviewees suggested that the lower utilization in subsequent months of the benefit might have been a result of challenges during the transition period.

Key Leadership and Partnerships

The Illinois State Dental Society was a strong supporter of restoration of the adult dental benefit and has consistently met with state officials and lawmakers to discuss the benefit's future. Other advocates engaged in the policy discussion include the state primary care association, community health centers, the Illinois maternal and child health coalition EverThrive, and the Heartland Alliance, an anti-poverty organization. The state Medicaid agency also works with IFLOSS (the state oral health coalition) to get feedback on policy changes.

Stakeholders noted the importance of building and retaining strong dental advocates at the state level. In particular, interviewees noted that the ab-

sence of a state Dental Director since 2007 had made it more challenging to keep oral health as a policy priority.

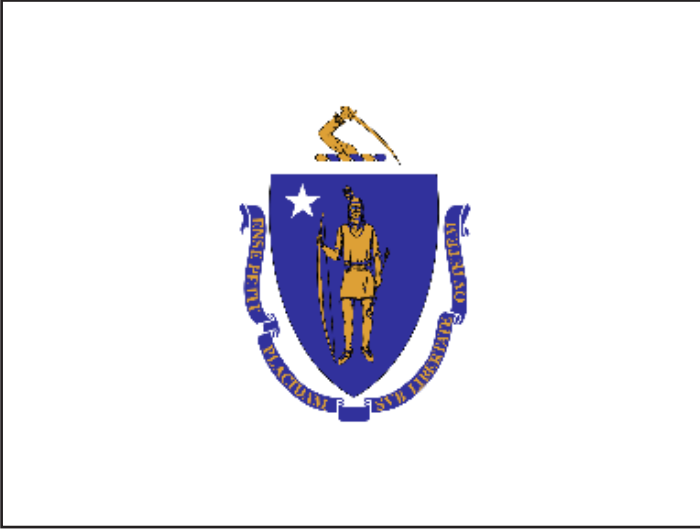
Looking Forward

At the time of this writing, the immediate future of adult dental benefits in Illinois is uncertain. Interviewees in the state feared that the benefit, by virtue of it being an optional benefit, would always be vulnerable to cuts. To help illustrate the need for adult dental benefits, researchers are working to show the impact of poor dental care on emergency room costs. In particular, researchers are collaborating with the American Dental Association and the Illinois Department of Public Health to collect and analyze data on emergency room utilization. Advocates hope that strong data demonstrating the impact of poor oral health on overall healthcare costs could help convince lawmakers in the future.

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Medicaid Adult Dental Benefits: Massachusetts Case Study



Massachusetts has cut and restored Medicaid adult dental benefits multiple times over the last 13 years. In recent years, the state has adopted an incremental approach of restoring individual services like fillings and dentures. During periods of cutback, the state's Health Safety Net allows community health centers to continue providing restorative care.

History

Medicaid adult dental benefits in Massachusetts have experienced what one advocate refers to as a “pendulum swing” of cuts and restorations for more than a decade. The state provided comprehensive dental benefits to all adults enrolled in MassHealth, the state's Medicaid program, until 2002, when benefits were cut back for most adults except for those in “special circumstances,” including adults with developmental disabilities. These individuals were eligible for benefits covering emergency services, x-rays, extractions, and a few other limited services. A supplemental cut to denture coverage happened in 2003. Benefits were restored in 2006, first for pregnant women and mothers of children under age 3, then later for all adults as a result of the state's comprehensive health reform effort. Benefits were cut again in 2010 and were limited to cleanings, extractions, and oral surgery. Benefits were preserved for adults determined eligible through the Department of Developmental Services (DDS).

Since the 2010 cuts, the state has gradually added back coverage on a service-by-service basis through the state budget process. MassHealth has frequently put forward full restoration of the

benefit in its annual budget request, and oral health stakeholders and legislative champions, like those engaged in the state's Legislative Oral Health Caucus, have worked within the state's budget constraints to prioritize certain services. In January 2013, coverage was added for fillings on front teeth, which are important for employability. In March 2014, coverage for all fillings was restored. And in May 2015, coverage for dentures was restored.

During the periods of cutback, community health centers and hospital licensed health centers continued to provide services that were not covered by MassHealth, such as fillings and dentures for adults. Funding for these services came from the state's Health Safety Net, formerly the Uncompensated Care Pool, which is funded through assessments on hospitals and ambulatory surgery centers. The Massachusetts League of Community Health Centers reports that the benefit cuts resulted in increased demand at health center clinics from adult patients, and a more intensive case mix of individuals needing restorative and emergency care.¹

Approach and Implementation

Benefit Design

Massachusetts administers a fee-for-service dental benefit through DentaQuest, a specialized dental administrative vendor. MassHealth currently provides coverage for the following services for adult enrollees: exams, x-rays, cleanings, fillings, extractions, anesthesia, emergency care, certain oral surgeries, and, as of May 2015, full dentures.² Adults that are determined eligible for services through the DDS receive more extensive coverage for root canals, crowns, and treatment for gum disease.

Approach and Implementation

Massachusetts has taken a very incremental approach to restoring adult dental benefits over the past several years. Interviewees noted that their strategies included developing various options for legislators to consider for restoration of services, and working with the Ways and Means Committee to develop a target budget amount, then determining which services would fit inside that budget figure. For example, MassHealth requested \$8 million for the restoration of denture services in FY 2015, but \$2 million was appropriated, which resulted in the benefit starting in mid-May, close to the end of the state's fiscal year.

Interviewees noted that an incremental approach allowed the state to bring back some benefits in a fiscally sustainable way. They also noted some challenges, particularly confusion among providers and enrollees about which dental services are covered at any given time, and a continuing sense that the benefit might be vulnerable to cut-backs in the future. While the state is currently experiencing a budget deficit, interviewees indicated that adult dental benefits are not currently under consideration for cuts.

Key Leadership and Partnerships

Health Care for All Massachusetts (HCFA) was a key stakeholder in efforts to expand MassHealth adult dental benefits. HCFA founded the Oral Health Advocacy Taskforce, a broad coalition of approximately 40 community and provider groups. The coalition communicates with the budget-writing Ways and Means Committee and other policymakers. They formed a Legislative Oral Health Caucus to organize legislative support for Medicaid dental benefits. In years past, HCFA also ran the “Watch Your Mouth” public education campaign, which helped to raise the profile of oral health and its connection to overall health.

Rep. John Scibak, who chairs the Oral Health Caucus, introduced several of the measures to restore dental services. Rep. Scibak noted that his interest in the issue stemmed from his experiences as a clinical psychologist working with persons with developmental disabilities who needed dental care, as well as from legislative hearings where constituents talked about pain and infection, as well as barriers to employment caused by untreated oral health problems.³

Interviewees also noted the Mass League of Community Health Centers and Massachusetts Dental Society as important voices in the conversation.

Looking Forward

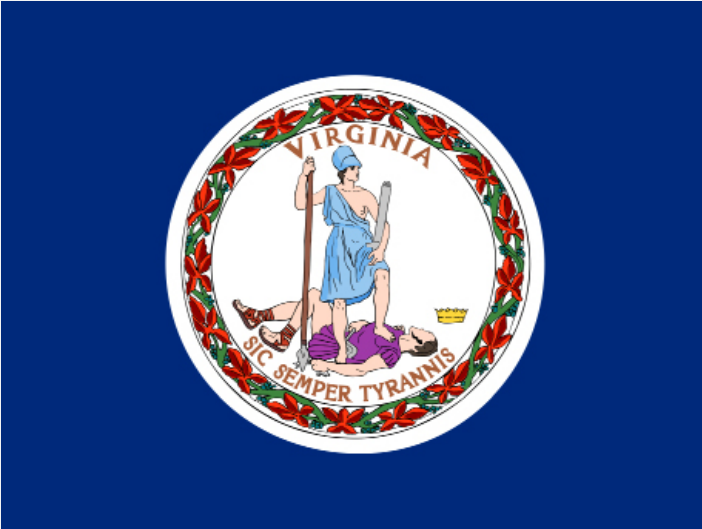
As the new benefits are implemented, MassHealth will monitor utilization rates as well as process measures for quality improvement. The state is also in the process of hiring a new dental director who will help set oral health priorities in the state.

Interviewees indicated that they may continue to pursue their incremental strategy to obtain coverage for additional services like treatment for gum disease. They also indicated interest in exploring opportunities for better integration between dental and medical providers and delivery systems.

Footnotes

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Medicaid Adult Dental Benefits: Virginia Case Study



In March 2015, Virginia began offering full dental benefits to Medicaid-enrolled pregnant women for the first time. The benefit was included in the governor's 10-point plan to expand access to care. It built on improvements to provider participation and program administration that the state made in its successful Smiles for Children program.

History

Prior to 2015, Virginia only offered emergency dental services to adults enrolled in Medicaid, although many actors in the state had been considering ways to expand coverage for years. The Virginia Department of Medical Assistance Services (DMAS), for example, had frequently included adult dental benefits in its agency budget requests.

In 2013, the Virginia Joint Commission on Health Care was directed to study the fiscal impact of untreated dental disease, focusing on adult care. As a result of this study, the Commission voted to provide funding for preventive dental care for pregnant women.¹ A measure was introduced in the next legislative session to extend dental benefits not only to pregnant women but to all adults in Medicaid. This effort was ultimately unsuccessful because of declining 2013 state revenue estimates. In September 2014, in the wake of the legislature's decision not to adopt Medicaid expansion, Gov. McAuliffe introduced, by executive order, the Healthy Virginia Plan, a 10-point plan to expand access to care.² One of the provisions of the plan was a dental benefit for pregnant women, which went into effect on March 1, 2015.

Approach and Implementation

The Healthy Virginia Plan extends comprehensive dental benefits to approximately 45,000 pregnant women over age 21 enrolled in Medicaid and FAMIS MOMS, the state's Children's Health Insurance Program (CHIP). Targeting the benefit to pregnant women was attractive in part because it limited the resources required—approximately \$3 million of state general funds in the first two years. Overall, interviewees agreed that the investment was worthwhile due to the positive effect on mothers' health and potential savings from avoided emergency room and medical costs.

DMAS enlisted a long-standing Dental Advisory Committee—comprised of members from the Virginia Dental Association, Virginia Primary Care Association, Virginia Commonwealth University School of Dentistry, and the Virginia Department of Health—to help design the new benefit. The new benefit builds on a successful dental program for children in CHIP and Medicaid called Smiles for Children. Smiles for Children is a fee-for-service benefit administered by DentaQuest, a specialized dental administrative services vendor. The program has been successful since its 2005 introduction, generating buy-in from both patients and dental providers.³

Services for pregnant women over age 21 are generally the same as those provided in Smiles for Children—a full range of dental services including diagnostic and preventive services, fillings, root canals, treatment for gum disease, and oral surgery. (Orthodontia and denture services are not covered.) Pregnant women above age 21 are eligible for benefits until the end of the month following their 60th day postpartum.⁴

DMAS worked closely with partner organizations including the Virginia Oral Health Coalition, the Virginia Dental Association, VA Health Care Foundation, sister state agencies, and DentaQuest to ensure smooth rollout of the benefit. With input from the Dental Advisory Committee, DentaQuest developed materials to promote the new program and has led provider education efforts.

Key Leadership and Partnerships

In 2010, the Virginia Oral Health Coalition (VaOHC) was formed as an organization focused on improving access to oral health services for all Virginians. VaOHC was built off of an existing all-volunteer committee—Virginians for Increased Access to Dental Care—and had representation from the Virginia Dental Association, the Virginia Department of Health and DMAS, as well as other stakeholders. Since 2010, VaOHC has led the way in the lobbying effort as well as educating other stakeholders on the importance of adult dental coverage.

The Virginia Dental Association has been a strong partner in the Smiles for Children program, and has organized several annual “Missions of Mercy” events to deliver free dental care across the state. Gov. McAuliffe’s attendance at one of these events was noted as an important factor in his engagement in the issue.

Stakeholders including VaOHC worked to engage physicians, pediatricians, community health cen-

ters and OBGYNs to help disseminate messages regarding the link between oral health and high blood pressure, preeclampsia, preterm birth, and other conditions. In addition, after the benefit was established, they partnered with the Virginia Commonwealth University’s School of Dentistry to develop continuing education to build dental providers’ confidence in treating women during pregnancy.

Looking Forward

Though it is too soon to evaluate success of the policy change, DMAS is closely monitoring provider and patient inquiries, and capturing data on utilization and provider participation.

Advocates in the state are also looking at options to expand dental benefits to additional adult populations, either to targeted populations like elders or individuals with developmental disabilities, or to all Medicaid-enrolled adults. All interviewees agreed that in order to successfully expand to a full adult population, the state will likely need to address provider reimbursement rates, which have not been adjusted since the introduction of Smiles for Children in 2005, to ensure continued provider participation.

Finally, there are efforts ongoing in the state to integrate dental health care into larger health reform efforts. In particular, Virginia is considering creating Accountable Care Communities (ACCs) under a new State Innovation Model design grant. The ACCs will engage public and private stakeholders to work collectively to transform care delivery in their region. The state has engaged workgroups to develop strategies for ACCs on behavioral health, chronic care management, and other topics, including oral health. Two leaders from the VaOHC are chairing the Oral Health Workgroup to develop models on oral health integration for ACCs.⁵

Footnotes

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Medicaid Adult Dental Benefits: Washington Case Study



In 2013, Washington's legislature restored funding for full adult dental benefits in Medicaid, following a cutback in 2010 due to the recession. The state's adoption of the Affordable Care Act's (ACA) Medicaid expansion—and the subsequent enhanced federal funding for newly-eligible individuals—was instrumental in the state's decision to bring back dental benefits for all adults. The restored benefit has supported safety net providers' efforts to ramp up dental services, but concerns remain about participation among private dental providers.

History

During times of fiscal pressure, Medicaid adult dental benefits in Washington have periodically been cut back—either cut entirely, or limited to certain populations. Most recently, in 2010, services for all adults were limited to emergency services like tooth extractions. In July 2011, benefits for pregnant women, individuals with developmental disabilities, and individuals in long-term care were restored. Finally, in 2013, the Washington State Legislature's biennial operating budget included approximately \$23 million in state funds (matched by federal funds) to restore full dental benefits to all adults in Medicaid. The state's decision to expand Medicaid eligibility under the ACA was a strong motivating factor for the reinstatement of adult dental benefits. Under the ACA, the state receives 100 percent federal financing for individuals newly eligible for Medicaid under the expansion (gradually declining to 90 percent by 2020). Enhancing the Medicaid benefit to include dental services for all adults at the same time as Medicaid expansion under the ACA meant that the state could leverage newly available federal funds to make a large impact on access to coverage. Although the state could have opted to only cover dental services for the expansion population, state officials felt it was important to offer cover-

age to all adults to ensure continuity and equity of coverage for all enrollees.

Approach and Implementation

Adults in Washington began receiving services through the new benefit on January 1, 2014. The state reinstated the same benefit package, program administration (a fee-for-service benefit directly administered by the Washington Health Care Authority), and provider reimbursement rates that existed prior to the elimination of the benefit. Covered services include diagnostic and preventive services, fillings, root canals on front teeth, treatment for gum disease, full and partial dentures, and oral surgery. Crowns, bridges, and root canals on back teeth are not covered.¹

More than 204,000 Medicaid-enrolled adults received a dental service in CY 2014, an increase from the roughly 136,000 adults who received services in CY 2010. However, this happened in the context of rising Medicaid enrollment, so the rate at which enrollees used services fell from 33 percent to 23 percent.²

Community Health Centers (CHC) are a particularly important source of care for adult enrollees in Washington. Neighborcare Health, a Seattle CHC

that provides medical and dental care, reports that prior to the 2010 cut, adult patients were about 70 percent of its dental caseload. During the time when benefits were eliminated, Neighborcare refocused on providing children's services and treatment for adults with dental emergencies, obstetric patients, and patients with diabetes. Now, the clinic is reintroducing adults into routine dental services, as well as dealing with four years of pent-up demand for services like dentures.³ CHCs have been able to take on this caseload because adult dental services are again eligible to be reimbursed at the clinic's Medicaid encounter rate. During the period when benefits were eliminated, adult dental patients were charged on the clinic's sliding fee scale, which many could not afford. Officials with the Health Care Authority noted that, while CHCs are a welcome point of access, payment at the clinic's cost-based encounter rate can be higher than fee-for-service reimbursement rates, and often result in increased costs to the Medicaid program.

Interviewees acknowledged a need to attract dentists in private practice to treat Medicaid-enrolled adults. Reimbursement rates and program administration were noted as major barriers to participation. More than 1,530 dentists participated in the program in 2014, slightly fewer than the 1,608 who participated in 2010.⁴ This is about 30 percent of Washington's 5,000 active licensed dentists.⁵

Services are reimbursed at the same rate that they were in 2007, and the Washington State Dental Association estimates that Medicaid reimbursements are approximately 25 percent of the prevailing rates charged by dentists.⁶ Stakeholders noted that their initial focus was on bringing the benefit back, but that they intend to continue advocating for further improvements in rates, outreach, and administration of the benefit in future years.

Key Leadership and Partnerships

The Washington Dental Service Foundation (WDSF), a foundation funded by Delta Dental of Washington, organized and primarily led efforts to reinstate the adult dental benefit. The Foundation

credits the success of advocacy efforts to three main factors:

1. **Data and messaging:** WDSF worked with partners such as the Washington State Hospital Association to conduct studies looking at the economic impact of dental benefits, including \$36 million in charges from 54,000 visits to Washington emergency departments for preventable dental conditions.⁷ Advocates were also able to leverage national data, such as a study by United Concordia that found that individuals with type 2 diabetes who received regular periodontal treatment had medical costs that averaged \$2,840 less per year as a result of avoided hospitalizations and reduced utilization of medical services.⁸
2. **Relationship building:** WDSF was a leading partner in several coalitions, including the Coalition to Fund Dental Access, a group consisting mainly of dental stakeholders and led by an anti-poverty advocate and Oral Health Watch, a broader coalition of healthcare, business, and children's and seniors' advocacy groups. Coalition members met regularly with legislators. They created materials and worked persistently on sharing data and information with lawmakers, particularly highlighting the impact of oral health on overall health and its impact on health care costs. In addition, WDSF developed grassroots and social media outreach, and engaged media outlets through news coverage and letters to the editor.
3. **Important champions:** Washington State Speaker of the House, Frank Chopp, was a key champion for oral health. Multiple interviewees noted the Speaker's longtime engagement in the issue through his work with Seattle advocates for low-income individuals, and his work to ensure that oral health was a legislative priority for his caucus.

Looking Forward

Interviewees agreed that they had accomplished a major first step—bringing the benefit back—and now must focus on ensuring that the benefit is meaningful and well utilized. State officials hope to show positive changes in emergency room

utilization and reduced medical costs for individuals with diabetes in coming years stemming from improved access to routine dental care, though they have not factored such savings into their budget projections. State officials are also considering options to bid out administration of the dental benefit, but noted that low dental fee-for-service reimbursement rates translate into per member per month capitation rates that might be too low to attract managed care bidders.

In the near term, stakeholders including WDSF are working to partner with the Health Care Authority to research the possibility of developing a targeted, enhanced benefit for pregnant women and people with diabetes, modeled after the state's successful Access to Baby and Child Dentistry program.

Interviewees agreed that as long as adult dental is optional in Medicaid, the benefit is always

vulnerable to cuts. However, all interviewees felt that the latest dental reinstatement was relatively secure because it was made in the context of the state's broader decision to take up Medicaid expansion, thereby insulating it from being singled out for cuts.

There are a number of other care delivery reform opportunities to further integrate oral health into overall health care. For instance, Washington is undertaking broad-scale delivery system reform through its State Innovation Model grant. While the state's Innovation Plan does not explicitly address dental, it creates Accountable Communities for Health (ACH). ACHs are regionally based entities that will conduct community needs assessments and direct health care resources. Multiple interviewees said they anticipate that the community needs assessments would show a high need for dental services and are preparing to help ACHs meet that need.

Footnotes

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