Impact and Opportunities for Integrated Medical and Dental Care Management under the Affordable Care Act

A Federal Perspective

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Objective of this presentation:

- To share the Federal government’s perspective on dental under the new environment, as well as the opportunities present and future with integration of medical and dental care management
WHAT THE ACA SAYS IT IS FOR DENTAL

• President Obama signed into law the first major reform of the nation’s health care system since the enactment of Medicare in the mid-1960s. *The Patient Protection and Affordable Care Act* expands coverage to 32 million Americans and includes several provisions related to oral health.

• Despite popular beliefs by some, implementation of the law has already begun with the passage of the law.

• Some of the provisions require funding ... and some don’t to get started.

• Some issues are clearly stated ... and some are not.
Key Federal Provisions

Among the oral health provisions that either require no separate appropriation or were already funded by the ACA, key initiatives include:

- insurance benefits for children
- cost-sharing restrictions
- public health grants that may include oral health initiatives
- requirement to review dental provider reimbursement rates.
The impact on integration is that oral health and systemic health is that with so many children covered, primary care may be addressed from the standpoint of nutrition, healthy habits and coordinated care between the medical and dental providers.

Requires that all insurance plans that are made available through state Exchanges to the uninsured and to small groups include oral care for children.

Effective 1/1/14, ACA requires plans in the state health insurance exchanges to provide coverage for children’s oral health services as an essential health benefit.
Pedo – Only; Exchanges

- ACA allows for stand-alone dental plans that offer pediatric dental benefits to participate in state health insurance exchanges. Purchasers will have the option of buying pediatric dental coverage directly from standalone dental plans or through medical plans.

- If a stand-alone dental plan is offered in the exchange, then other insurance plans with limited dental benefits still can participate in a state exchange. These dental plans are exempt from offering the essential benefits package and cost sharing protections.

- Dental-only plans should be available when the state health insurance exchanges are implemented in 2014.

- Adults will not be covered under this program, but oral health education may encourage parents to prevent dental risks for their children.

- Medicare Advantage Plans - Requires Medicare Advantage Plans to use rebates to pay for dental coverage, and other services.
PREVENTION

• A national strategy to coordinate and promote disease prevention, wellness and public health programs is included in the law. This message needs to be integrated between medical and dental.

• The law prohibits insurance plans from imposing copayments or coinsurance for certain preventive services for new plans or policies

• Regarding oral healthcare, covered services with no out-of-pocket costs are:
  • oral health risk assessments for children
  • fluoride supplements for children whose water source does not contain fluoride
More prevention

• The law calls for the development of a five year, evidence-based public education campaign focused on early childhood caries, the value of prevention and the oral health of pregnant women and at-risk populations.

• There are many other provisions in the legislation that address oral health including $11 billion to expand community health centers, a national media campaign to promote early intervention and new efforts to report on the status of oral health nationwide.

• Prevention and Public Health Fund invests $15 billion over 10 years, and $2 billion each year thereafter to initiate public health and prevention efforts in states and communities.

• Although oral health is not specifically mentioned in the act, states may use funds to improve surveillance and community and clinical prevention.
OVERSITE AND REVIEW

- Medicaid and CHIP Payment Access Commission (MACPAC).
- MACPAC reviews state and federal Medicaid and CHIP access and payment policies and makes recommendations to states, Congress and the HHS secretary.
- Requires a review of provider reimbursement rates, including those for dental professionals;
- It provides funding to carry out the work.
Authorized but Currently Unfunded Provisions

- Various additional oral health initiatives within the ACA are authorized, but funding currently is not appropriated. These provisions fall into three categories: oral health infrastructure, prevention and treatment, and workforce.
  
  **Oral Health Infrastructure.**
  - The Centers for Disease Control and Prevention (CDC) currently provides funding to 19 states for cooperative agreements to improve their oral health infrastructure. The ACA requires the CDC to extend this funding opportunity to all states, territories and tribes.
  - National Oral Health Surveillance System to measure early childhood caries (ECC) and authorizes funding to all 50 states to help perform this activity.
  - a. Requires that the Secretary update and improve national oral health surveillance by:
  - i. requiring the inclusion of oral health reporting on pregnant women through PRAMS (Note: currently the oral health component of PRAMS is optional);
• ii. retaining the current NHANES “tooth-level” surveillance (Note: This reverses plans to drop tooth-level analysis in NHANES and replace it with “person-level” analysis and allows ongoing longitudinal analysis of American’s oral health status);

• iii. requiring the MEPS survey findings be validated through a “look back” procedure (Note: currently MEPS conducts this validation for medical expenditures but not for dental expenditures);

• iv. requiring all states to participate in the CDC’s National Oral Health Surveillance System. (Note: currently only 16 states are required to participate.)
• Oral health components should be included in the Pregnancy Risk Assessment and Monitoring System.

• National Health and Nutrition Examination Survey should include oral health components. Data may be established to determine the prevalence of periodontal disease among diabetics, for instance.
**Prevention and Treatment**

- grant programs and an education campaigns are *required but still unfunded*:
- Requires the Secretary (directing to CDC) to establish a 5-year, evidence based public education campaign to promote oral health, including a focus on early childhood caries, prevention, oral health of pregnant women, and oral health of at-risk populations. subject to the availability of appropriations.
- • Authorizes a program providing grants to states to carry out research-based dental caries disease management programs and demonstrate program effectiveness.
- • Extends grants for school-based dental sealant programs to all states, territories and tribes. (Note: Currently only 16 states benefit from these grants.)
- • Requires distribution of operations grants to schoolbased health centers; services include oral health referrals follow-up.
- Dental Medical Diagnostic Equipment – Establishes standards for accessibility of medical and dental diagnostic equipment for persons with disabilities
Workforce

• Some unfunded directives in the ACA address the oral health care workforce, including:
  • Physicians should have mandatory CE requirements for information on oral health disease states
  • The ACA established the National Health Care Workforce Commission, which identifies dental workforce issues among the commission’s priorities. Among other things, the commission will evaluate health professionals’ education and training in the context of demand for services and encourage workforce innovations.
  • A demonstration project for alternative dental health providers for 15 sites over five years was authorized for up to $60 million but not funded. This provision is aimed at training and employing alternative dental providers, such as, but not limited to, community dental health coordinators (Temple’s CDHC pilot), advance practice dental hygienists and dental therapists.
  • Delineation and expansion of the Title VII dental workforce training programs include training of dental students, practicing dentists and residents. These are intended to be grants to support dental training and loan repayment programs.
  • The ACA establishes, through the surgeon general of the U.S. Public Health Service, a public health services track that includes funding for scholarships for dental students and grants to dental schools. The track obligates trainees to serve for a period of time in the Public Health Service Commissioned Corps.
State Roles in Implementation

• Most operational oral health provisions do not require specific state action, but it allows for closer dialog and consideration of state policy collaboration including:

  • Oversee and regulate dental coverage provisions within the insurance exchanges.
  • Address dental provider shortages as more children receive oral health coverage and explore policies to expand the oral health workforce and attract more providers to underserved areas.
  • Explore the use of public health trust fund grants to state and local entities to address oral health.
  • Maintain awareness about authorized programs as funding becomes available.
Major Opportunities for Integrated Oral Healthcare Management

• From review of the documents and conversations with some federal officials charged with the responsibility of managing this initiative, the focus is to use oral healthcare to prevent caries in children, however they have not yet understood the powerful effect of oral health integration to serve as a methodology to help stem health risks and reduce the trends of disease in America.

• In my review of the new law and its current implementation, it appears the provisions of the ACA lay a framework for the oral health industry to make great strides in advancing the agenda to reduce chronic caries as a disease state and push efforts to prove the credibility in its value to significantly improve systemic risk management.
Measuring Success

- BETTER HEALTH
  Improved overall health outcomes
- BETTER HEALTH CARE
- LOWER COSTS THROUGH IMPROVED QUALITY
  Reduced total cost of care for Medicare, Medicaid and CHIP beneficiaries
2: Improve care for populations with specialized needs

Priority Areas

- Pediatric populations requiring high-cost services
- Persons with Alzheimer’s disease
- Persons living with HIV/AIDS
- Children at high risk for dental disease
- Children in foster care
- Adolescents in crisis
- Persons requiring long-term services and supports
- Persons with serious behavioral health needs

*CMS will consider submissions that improve care for other populations with specialized needs*
Pediatric populations requiring high-cost services

Description of Population
• Includes children with multiple medical conditions, behavioral health issues, congenital disease, chronic respiratory disease, and complex social issues
• Medicaid and CHIP pay for half of all pediatric ambulatory care visits and inpatient care for children ¹

Examples of Cost Drivers
• Lack of integration of care across settings, social determinants of health
• Inappropriate use of specialists to provide primary care services
• Fragmentation of services provided by physical and occupational therapists, developmental psychologists

Examples of Opportunities
• Includes improving early screening, assessment and diagnosis; increasing compliance to care plans; coordination of community settings; slowing progression of chronic illness; and reducing avoidable services including hospitalizations and readmissions

¹ http://hcupnet.ahrq.gov/
Children at high risk for dental disease

**Description of Population**
- Medicaid and CHIP beneficiaries identified as high risk through risk assessment tools

**Examples of Cost Drivers**
- Emergency department visits, surgery in operating room, over-utilized restorative services

**Examples of Opportunities**
- Risk-based intensive prevention and chronic disease management approach to childhood caries that leads to less oral disease, fewer surgical interventions, and lower per capita costs
Are you ready to be a part of change?

- Opportunities for Integration Programs with payors
- Opportunities for integration Programs with ACOs
- Opportunities for Integration Programs with other providers