



Oral Health Innovation: Opportunity and Risk, Medicaid Waivers and the Keys to Good Oral Health

Despite [improvements in oral health access and outcomes](#) over the past decade, many measures fall short of desired results and [oral health disparities persist](#). [This](#) highlights the need for innovative solutions that create a system of care that delivers oral health services in creative and equitable ways. Although the current political moment has shaped a policy environment that could lock many doors to good health and that has posed challenges for health advocates, there are still opportunities for innovative improvements to the health care delivery system and achieving oral health equity.

Oregon and California have used Medicaid waivers to craft innovative policies for improving access to oral health services in their communities. These examples highlight not only the progress made, but also the possibilities for oral health advocates in other states to use Medicaid's 1115 waiver process to create innovative, community-centered oral health care systems that improve access to care and move toward oral health equity. This policy brief is designed to offer ideas for consumer-friendly approaches to oral health innovation. It highlights 1115 waivers as one promising option, provides caution on the potential for certain waivers to lock doors to access, and presents an overview of other ideas for oral health innovation outside the Medicaid waiver process.

Systemic barriers lock the doors to good oral health for many children and adults

[Systemic barriers](#) to oral health, such as living in a [dental professional shortage area](#), [discrimination in dental offices](#) and other medical settings, uninsurance or insurance that doesn't cover dental care or low rates of providers accepting Medicaid, show the current oral health payment and delivery system is not meeting many peoples' needs. These barriers are like locked doors, blocking people from achieving their best oral health and deepening racial and economic disparities.

As a result of systemic barriers, [tooth decay is one of the most common chronic diseases](#) in the US: Almost 20 percent of children have untreated cavities –five times as common as asthma – and rates are significantly higher among children of color and those in low-income families. Meanwhile, nearly 30 percent of adults have untreated tooth decay and about 75 percent of low-income, Black and Latino adults have an [unmet need for dental care](#).

Largely preventable, high levels of untreated dental disease among children and adults point to the need for innovative, cost-effective solutions.

Oral health innovations are often cost effective

As [health care spending continues to rise](#), many innovations in oral health have the potential to help "[bend the cost curve](#)." Medicaid coverage for comprehensive oral health services and innovations, including Medicaid waivers that make it financially and logistically easier for people to access dental care ensure that people have access to the preventive care they need to keep them healthy and restorative care needs are met in a timely fashion. When people have [access to preventive oral health care](#), they:

- Are less likely to need more costly restorative dental care in the future;

- Are less likely to experience adverse general health problems that are associated with poor oral health and are expensive to treat;
- Are less likely to seek expensive and incomplete care in an emergency department (ED);
- Have lower dental care costs, in general.

In addition to prevention, Medicaid coverage and access to providers for restorative care is integral in addressing existing dental disease and minimizing the costs associated with it. Access to disease management services and necessary restorative care as early as possible can keep dental disease from progressing and causing broader systemic health problems, both of which are more costly to treat than addressing the initial required restorative care.

Given growing health care costs, high unmet oral health care needs and the ability of innovative solutions to bend the cost curve, several states have used creative strategies to unlock the doors to dental care and oral health equity.

In California and Oregon, Medicaid waivers are key to oral health innovation

Medicaid [1115 waivers](#) allow states to get federal approval to try out new ways of administering their Medicaid programs outside of the federal guidelines they typically have to follow. Waivers may be used to provide coverage for services or to populations not typically covered under Medicaid. 1115 waivers are sometimes called “innovation waivers” because they allow states to be creative in how they provide services to people covered by Medicaid. The long-standing intent of these waivers is to provide opportunities for states to experiment with ways to further the Medicaid program’s objectives of improving coverage, access and health for low-income populations.

Oral health integration is one innovative approach to improving oral health access that 1115 waivers can foster. [Oral health integration](#) works to incorporate the delivery of oral health with other physical and behavioral health services, and can take many forms, including co-located services, integrated referral or health records systems or coordinated financing structures, which have been used in Oregon. Oregon used an 1115 waiver to create [Coordinated Care Organizations](#) (CCOs) - regional entities that use a single budget to deliver physical, behavioral and oral health services to Oregonians with Medicaid coverage. CCOs receive incentive payments along a number of quality care measures, including two specific to dental care. Early results of an [evaluation of Oregon’s CCOs](#) show that the model has:

- Fostered strong working relationships among medical and dental stakeholders: CCOs have fostered relationships with the Oregon Department of Human Services (DHS), federally qualified health centers (FQHCs) and others;
- Created attention to and interest in oral health and improving the quality of dental care within the broader health care community;
- Improved oral health outcomes for children. The rate of sealants for children six through 14 years old increased substantially between 2014, when oral health was integrated into the CCO model, and 2016. Over that same time, the rate of children in DHS custody receiving oral health assessments also improved considerably. Improvements in access to care for this often hard to reach population highlight the potential this model has for improving oral health, more generally.

Although still early in the implementation process, the dental integration component of Oregon’s CCO model has opened the door for future policy progress on oral health innovation. Future priorities for improving the model include improved data sharing compatibility between dental and primary care electronic health record systems, continued commitment to local and regional partnerships, co-location

of physical, behavioral and oral health services, and investments in workforce solutions to improve oral health equity.

Like Oregon, California is using the Medicaid waiver mechanism to incentivize providers to unlock the doors to oral health for Californians with Medicaid coverage. California's Medi-Cal 2020 waiver includes the [Dental Transformation Initiative](#) (DTI), which provides incentive payments to dental providers who increase by two percent the number of children with Medicaid to whom they provide preventive services. The DTI also includes two pilot programs for dental providers in a limited number of counties. Providers in selected counties can receive incentive payments for performing [caries risk assessments](#) (CRA) and corresponding treatment for children six and under and for maintaining continuity of care for children under 21. These pilots may be expanded statewide if they are successful.

Still in its first year, the DTI is undergoing an [evaluation](#) that will provide data on whether incentive payments increase provider participation in Medicaid, increase children's use of preventive dental services and other dental care, decrease ER services for non-traumatic dental emergencies and promote continuity of care.

Iowa and Pennsylvania offer caution for waivers that may harm access to care

Recently, there has been an unsettling trend towards waivers that do not protect consumers or that otherwise make it financially or logistically difficult for people to access care. These waivers lock the doors to good oral health and are not in line with how 1115 waivers are intended to be used: to promote innovation and protect the interests of the Medicaid program to provide health care for low-income populations. Waivers to look out for include those with oral health-specific provisions and those that apply to all Medicaid services and put coverage and access to care at risk, more broadly.

One type of waiver to look out for that has been gaining traction in several states would take Medicaid coverage, including dental benefits, away from people who do not participate in state-approved work programs. Earlier this year, the Pennsylvania legislature passed a bill ([HB 59](#)) that would have required the state to use an 1115 waiver to impose work requirements on many adults covered by Medicaid. Having Medicaid coverage makes it easier for people to look for work and stay employed, so instituting work requirements may actually have the opposite effect as intended if people lose their Medicaid coverage and physical, behavioral or oral health issues negatively impact their ability to work. Additionally, [80 percent of people with Medicaid coverage already live in a family with at least one worker](#). Work requirements have little impact on actual employment and actually discourage enrollment in social programs that maintain peoples' oral and physical health. Pennsylvania halted the implementation of this waiver when the governor vetoed HB 59. Nevertheless, several states have approved work requirements and at least 11 others have [similar waivers pending](#). Waivers that include work requirements pose broad risks to coverage and access to care for the comprehensive services Medicaid provides, including dental care.

In addition to work requirements, HB 59 would have required Pennsylvania to eliminate adult dental benefits (which are optional for state Medicaid programs) completely. Cutting adult dental benefits for people covered by Medicaid often causes people [to go without needed care](#) until dental infections cause significant pain, driving patients to seek care in an emergency department (ED). Emergency care is much more [expensive for state Medicaid programs](#) than accessing preventive care in a dental office, and EDs cannot adequately address underlying oral health needs. Cutting Medicaid adult dental benefits causes unnecessary pain and suffering and does not typically save states money in the long run, as costs shift to EDs as well as FQHCs and community health centers, who treat people without insurance.

While Pennsylvania’s waiver never went into effect, since 2013, Iowa has administered the Dental Wellness Program (DWP), as part of a larger 1115 waiver, to provide adult dental benefits to its Medicaid population. The DWP provides full dental benefits with no premiums for the first year of enrollment, but individuals can only keep these benefits in subsequent years if they complete an oral health assessment and receive a preventative dental service. Those who do not complete these behaviors are required to pay a premium and may lose access to full dental benefits.

Including dental services with overall Medicaid benefits is important given the [strong relationship between oral health and overall health](#). However, [evidence shows](#) that within healthy behavior incentive programs, consumer knowledge is low and effectiveness is spotty. Healthy behavior incentives also place an inappropriate burden on consumers to be responsible for outcomes within a system that is very complex and often does not meet their needs. The healthy behavior incentives in the DWP are particularly troubling because they put the burden of improving access to care onto some of the consumers most likely to be negatively impacted by this program – those who are low-income and who may experience additional barriers that prevent them from completing required behaviors. Finally, the DWP is nested within a broader 1115 waiver that creates additional barriers to care: In addition to healthy behavior incentives for dental care, Iowa’s 1115 waiver includes additional behavior incentives for medical services and imposes premiums, which can [cause people to lose coverage and are not cost-effective](#) for state Medicaid programs to administer.

Studies show that the greatest barriers to accessing dental care include lack of convenient office hours, childcare and transportation. A more patient-centered innovation would focus on removing these barriers instead of locking doors with increased work, behavioral and other administrative requirements or by using [waivers to avoid providing non-emergency medical transportation](#) to medical and dental appointments. Waivers and other coverage innovations should follow the trends in Oregon and California by prioritizing that dentists, other providers and the health care system in general be accountable for achieving health systems goals.

Unlocking doors to good oral health: Other consumer-friendly approaches to innovation

In addition to the Medicaid 1115 waiver process, there are [many examples](#) of other strategies that work to improve access to care and outcomes, reduce costs and center health equity in consumer-friendly and community-driven ways. In addition to waivers, like those used in California and Oregon – which incentivize oral health integration and do not create additional and unnecessary barriers for consumers, like work requirements, behavior incentives or premiums – other consumer-friendly approaches to oral health innovation include:

- [Integration and coordination](#) among medical and dental providers and services: Oral health is integral to overall health and wellbeing, but dental and broader medical delivery systems remain mostly separate. Integrating systems, services and providers helps prioritize consumers’ holistic health and wellbeing, which includes oral health. For example, a [pediatric clinic in Washington](#) that primarily serves children with Medicaid coverage provides oral health education, screening and oral exams, fluoride varnish and referrals to dentists during primary care visits. As a result, the clinic has seen a reduction in surgical interventions for dental issues;
- Removing practical barriers to accessing dental care: Some of the biggest [barriers to accessing dental services](#), particularly for people living in rural or other areas that lack an adequate supply of dental providers, include lack of convenient office hours, childcare and transportation. Attention to, and flexible funding for, these and other [social determinants of oral health](#) are needed to support access to oral health care for all. For example, many states use [mobile dental](#)

[clinics](#) to bring services to schools and other community settings to reduce barriers related to transportation and getting to appointments in a dental office;

- Workforce solutions that expand the reach of the dental delivery system: More than 51 million people in the US live in areas that [lack an adequate supply of dentists](#) and the current dentist workforce meets less than 40 percent of the need for care. Many states have started to fill these gaps by expanding the scope of existing oral health providers like [dental assistants](#) and [hygienists](#), which has shown to improve oral health. Several states have also authorized [dental therapists](#), highly trained members of the dental team who provide preventive and restorative care and who have shown to [improve access to safe, culturally competent oral health services](#);
- Models of care that bring services to people where they live, work and play: Dental therapists, expanded-scope hygienists and dental assistants often work outside traditional dental offices to bring care into the community. Re-envisioning sites of care delivery can bring dental care to more people and address barriers related to lack of transportation and living in areas without an [adequate supply of dentists](#). Innovative models include school-based [sealant programs](#) and [dental clinics](#) and providing [dental care in nursing homes](#) and [primary care settings](#). Additionally, [community health workers can play a key care coordination role](#), reaching people where they are to provide education, support and services to help connect them to dental care.

The keys to good oral health rest with innovative delivery system reforms

Innovative solutions are key to transformation given the high and increasing cost of health care in the US, the illogical but persistent divide between dental and general health service delivery systems, and continued oral health disparities.

State advocates should continue to push for consumer-friendly innovations that challenge the current structure and performance of the health system. We need to move toward a system of care that prioritizes the value of oral health, sees patients as whole people,, and centers the needs of people of color, low-income populations and other communities who are disproportionately impacted by discrimination and other structural barriers to accessing oral health services.