



Integrating Oral Health into Oregon Medicaid's Coordinated Care Model: Lessons for State Policymakers

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Introduction

State health policymakers are increasingly recognizing that oral health is inextricably linked to physical health. From the person with diabetes and periodontal disease who has difficulty chewing nutritious food, to the new mother who inadvertently spreads bacteria that causes tooth decay to her child, the importance of oral health to overall health cannot be ignored. Lack of oral health care has also been linked to costly emergency department visits, where prescription pain medication may be the only treatment available.¹

In Oregon, policymakers are working to integrate oral health into physical health care for Medicaid beneficiaries. This brief highlights the lessons learned from a case study of Oregon's efforts to integrate oral, physical, and behavioral health care in Medicaid. Specifically, this report describes the genesis and goals of Oregon's model, as well as its implementation successes and challenges. It examines the model's payment and financing structures, and traces the flow of funds from the state to Coordinated Care Organizations (CCOs) and providers of oral health services (POHS).

This report:

- Documents the development and implementation of Oregon's oral health incentive measures;
- Explores key partnerships critical to the initiative's success, and future directions for oral health integration in Oregon;
- And explores how other states can use Oregon's model to integrate oral health into their Medicaid programs.

To capture the evolution of Oregon's oral health model, the National Academy for State Health Policy (NASHP), supported by the DentaQuest Foundation, reviewed public documents, including state laws, policies, and publicly available studies detailing Oregon's oral and behavioral health integration, and conducted key interviews with state and local stakeholders.

While Oregon's efforts continue to evolve, the state's experience is mature enough to provide valuable lessons for other state policymakers seeking to integrate oral health into Medicaid accountable care structures, even those without a robust adult dental Medicaid benefit. State policymakers interested in whole-person care, those exploring global budgeting and value-based payment structures, and those grappling with quality and outcomes measurement will glean valuable insights from Oregon's ongoing oral health integration efforts.

Key Policy Considerations When Integrating Oral and Physical Health in Medicaid

State Policy Levers

- Consider using financial incentives to drive change. Many stakeholders in Oregon identified the financial incentive measures as their key motivation to address oral health.
- Explore use of statutory levers to move integration forward, while considering the possible implications of compelling participation. Mandating integration in statute, as Oregon did, clears a path for new payment structures. At the same time, there were drawbacks to compulsory partnerships.
- Balance local flexibility and state control. Enabling community priorities to guide local implementation within state parameters facilitates buy-in because the improvement strategies can be tailored to local needs.
- Use value-based payments and other alternative payment models to encourage oral health integration.
- Acknowledge that integration is difficult without a robust adult Medicaid dental benefit. This is especially important in light of proposed federal legislation that would have cut Medicaid spending an estimated 26 percent by 2026, and 35 percent by 2036.² In the absence of an adult benefit, states could consider adding pediatric oral health assessments or other components to existing physical health measures to help foster integration, particularly for children.

Partnerships

- Work with stakeholders to achieve a shared definition of oral health integration. This is a key first step for state policymakers interested in integration. State leaders can use their capacity as conveners and consensus-builders to bring partners to the table early in the process.
- Identify potential cross-agency and multi-sectoral partnerships—including private and non-profit sector partnerships—to achieve integrated, whole-person care. These partnerships may be even more critical in the long term with federal changes to Medicaid.

Data Sharing

- Prioritize data sharing among providers, accountable care entities, dental plans, and state agencies to support alternative payment models such as value-based payment structures that depend on a transparent flow of reliable data through regular reporting. It may be necessary to overcome technical barriers, such as incompatible electronic health record systems used by dentists and primary care providers.
- Leverage data stratified by race/ethnicity, rural/urban, and other socioeconomic factors to help identify and address health disparities.

Special Populations

- Consider prioritizing oral health integration to address the opioid crisis and meet the needs of persons with serious and persistent mental illness. Physical, oral, and behavioral health providers can cooperate on strategies to respond to beneficiaries complaining of tooth pain, and can schedule dental treatments for individuals with mental illness when they are under sedation or anesthesia for medical reasons, for example.
- Consider adapting successful integration models and processes from behavioral health or other areas to guide oral health integration into primary care. Are there lessons from other initiatives, populations, or sectors that could be brought to bear on oral health transformation?

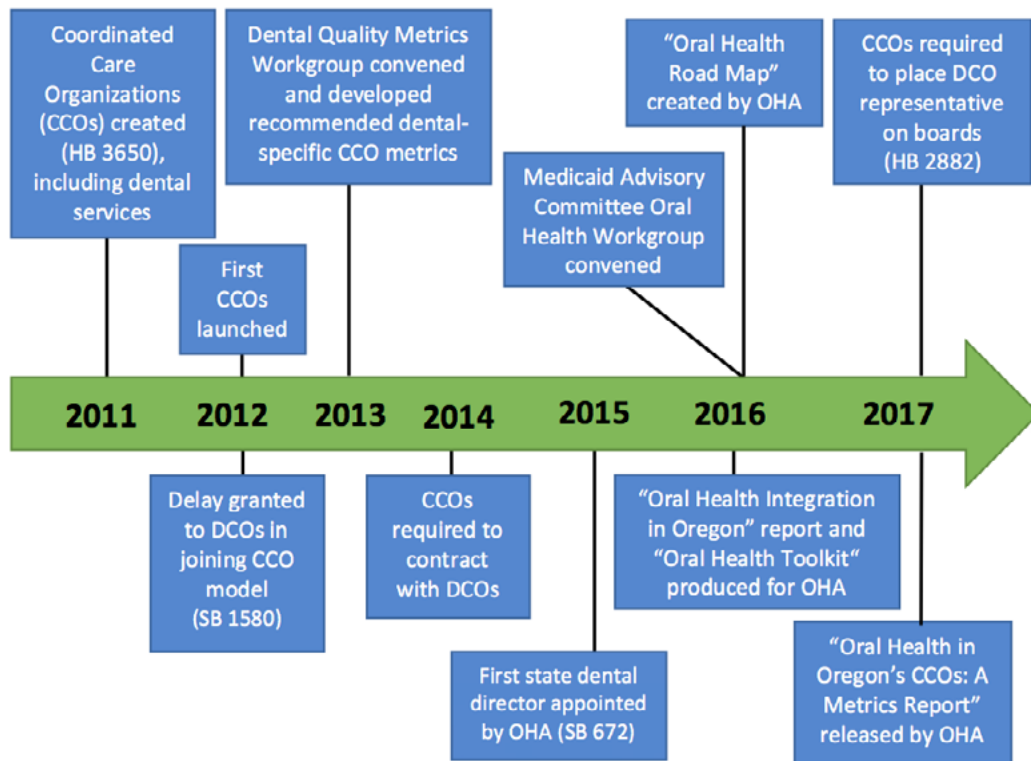
Background

Oregon has worked in recent years to transform its health care delivery system from payment for volume to payment for value. The state launched Medicaid accountable care structures known as Coordinated Care Organizations (CCOs) in 2012, pursuant to state legislation and 1115 demonstration authority. CCOs, like Accountable Care Organizations (ACOs), bring together different types of health care providers and community organizations to share financial responsibility for providing coordinated care that meets quality targets. Oregon's CCOs emphasize whole-person care for the Medicaid beneficiaries they serve, including physical, oral, and mental health care, including alcohol and substance abuse services. As part of this transformation process, more than 40 separate managed care organizations were brought together under the umbrella of 13 (now 16)³ CCOs. The 16 CCOs that work with the state's Medicaid program, known as the Oregon Health Plan, operate in defined geographic service areas, although some CCOs overlap in parts of the state.⁴ In 2014, CCOs became accountable for integrating oral health into physical health care. To ensure the continuity of care, state law initially required CCOs to contract with any Dental Care Organizations (DCOs) in their service areas.⁵ DCOs, which predate CCOs, are organizations that employ or contract with dental care providers to provide dental services to Medicaid beneficiaries.

Prior to 2014, DCOs contracted directly with the state through a single contract. For DCOs, the transition to CCO integration meant moving from contracting directly with the state to contracting with their regional CCOs, although some DCOs continue to also contract directly with the state to provide dental services to the non-managed-care population. For DCOs with a large geographic reach, this was burdensome. One DCO representative reported that they contracted with multiple "bosses," instead of only contracting with the state.

A recent opinion from the Oregon Department of Justice (DOJ) released CCOs from the requirement to contract with DCOs, provided that CCOs maintain their dental coverage network through other means.⁶ As a result, at least one CCO was contracting directly with providers of oral health services. As a result of the DOJ opinion, this report uses the phrase "providers of oral health services" (POHS) instead of "DCOs."⁷ According to OHA, POHS are organizations that contract with CCOs to provide oral health services to the CCOs' members.⁸

Currently, the state pays each CCO a prospective per-member-per month (PMPM) global budget payment for its covered populations that grows at a fixed rate. The CCOs then contract with POHS, or with organizations such as Federally Qualified Health Centers (FQHCs), to provide dental services in exchange for a PMPM payment for most providers. Oregon's coordinated care model is supported by the Oregon Health Authority's (OHA) Transformation Center, which shares innovations and best practices with plans, providers, communities, and other stakeholders, and supports initiatives aimed at advancing coordinated care. It also supports oral health integration by providing technical assistance, such as a statewide learning collaborative for CCOs focused on reporting physical, behavioral, and oral health metrics.⁹

Figure 1. Timeline of Oregon's Oral Health Integration Efforts

Why Integrate Physical and Oral Health?

Oregon health policymakers see the integration of oral, behavioral, and physical health care as central to their goal of providing whole-person, coordinated care and promoting health equity.¹⁰ According to a report from Oregon Health Sciences University (OHSU), oral health integration can refer to the provision of some dental services, such as fluoride varnish, by physical health care providers. It can also refer to payment models that combine payments for physical and oral health services, as well as initiatives that improve communication between medical and dental providers.¹¹ In Oregon, the 16 regional CCOs are explicitly directed in statute to provide integrated oral, behavioral, and physical health services. Oregon is not alone in its efforts to align physical and oral health—a number of other states address oral health in their Medicaid system transformations. Oregon's model stands out for its breadth and its holistic approach.

Both Medicaid and public health policymakers in Oregon acknowledge the importance of oral health to achieving health and well-being. OHA's Public Health Division named oral health improvement as one of seven priority areas in its state health improvement plan.¹² The plan identifies the integration of oral health into medical settings as one way to improve the oral health of children and adults. It also recommends including, "oral health in chronic disease prevention and management models," and noted the association between oral infections and some chronic diseases such as diabetes and cardiovascular disease.¹³

Oregon also recently undertook a strategic planning process to determine the next steps needed to accelerate oral health integration. Comments from stakeholders interviewed for this case study often aligned with those in documents resulting from that planning process, including *Oral Health Integration*

in Oregon: *Environmental Scan & Recommendations*, and *Oral Health Toolkit: Resources for Supporting Oral Health Integration in Oregon* by Health Management Associates, *The Impact of Dental Integration in Oregon's Medicaid Program*, by the OHSU Center for Health System Effectiveness, and the *Strategic Plan for Oral Health in Oregon: Progress Report*, by the Oregon Oral Health Coalition, Oregon Health Authority, and the Oral Health Funders Collaborative.¹⁴

What Other States Are Doing to Integrate Oral Health into Medicaid Transformation

A number of states are working to integrate oral health into their Medicaid health system transformations and promote whole-person care for beneficiaries. While several noteworthy state initiatives aim to integrate oral and physical health for children by encouraging primary care providers to administer fluoride varnish, adult initiatives are less common. By developing oral health measures for accountable care structures, integrating oral health into primary care settings, or incentivizing oral health, the following states may hold helpful lessons for policymakers interested in integrating oral health in Medicaid.

- **California's** Medi-Cal 2020 Dental Transformation Initiative for children provides incentives for dental offices that increase the rate of children receiving preventive dental care, pursuant to the state's Section 1115 Demonstration.¹⁵ Dental office locations with larger increases receive greater incentives. The state pays incentive payments directly to office locations, and the incentive payments are not considered direct reimbursement for dental services under the State Plan. The 1115 Demonstration also permits local dental pilot projects that can include incentive payments.
- The Dental Wellness Plan for the **Iowa** Medicaid expansion population incentivizes members to receive dental care by giving them more benefits the more preventive services they utilize.¹⁶ A March 2017 evaluation of the first two years of the program found that very few participants reached Tier 2 or 3 status; evaluators concluded this could be due to beneficiary confusion about the benefit structure, low rates of routine dental visits, and the high rate of churn.¹⁷
- Pursuant to its Section 1115 Demonstration, **Massachusetts** is pursuing an ACO initiative that includes an oral health quality metric.¹⁸ The proposed measure would use claims data to gauge the percentage of ACO enrollees under age 21 who receive an oral evaluation.¹⁹ ACOs would be rewarded for reporting on the measures in the first year of the program, which is scheduled to start in late 2017. In subsequent years, ACOs would be paid for performance on the quality measures.²⁰
- **Tennessee** contracts with DentaQuest to administer Medicaid dental benefits through a partial risk-sharing contract. DentaQuest created a TennCare dental provider network based on quality and efficiency criteria as well as geographic access requirements.²¹
- The **Texas** First Dental Home initiative targets children between the ages of 6 and 35 months and pays a bundled payment for a First Dental Home dentist visit. Such visits include a review of the patient's health history, caries risk assessments, fluoride varnish, and other services.²²
- Improving access to oral health services, particularly for adults, is one of three optional projects under the Prevention and Health Promotion domain of the Healthier **Washington** Accountable Communities of Health (ACH) Medicaid Transformation Demonstration. Each ACH that chooses the oral health project may focus on integrating oral health screenings and referrals into primary care settings or using mobile clinics and equipment to improve access, or both. Regardless of the chosen approach, each ACH is expected to establish a pay-for-performance model to reward improvement.²³

Statutory and Other Partnerships

By law, CCOs are required to be comprised of various partnerships, thereby holding the CCO accountable in delivering health care services, meeting consumer and community needs, and maintaining optimal clinical practice. CCOs are governed by members of the community and local government, with the requirement that consumers fill at least 50 percent of seats on their Community Advisory Councils (CACs).²⁴ State statute also requires that CCO governing boards be composed mostly of people who share in the financial risk of the organization.²⁵ Further, according to state law,²⁶ CCOs are required to place a DCO representative on their governing structures in order to support oral health integration, although this wording may be revised through the rulemaking process to reflect the new terminology—POHS—preferred by OHA.²⁷ CACs work on their CCO's Community Health Improvement Plan (CHIP) to ensure that CCOs are responsive to community needs. Another state law requires future CHIPs to include a plan and a strategy for integrating physical, behavioral, and oral health.²⁸ As of 2016, oral health was an element of the CHIP for nine of the 16 CCOs, which reflects the importance of oral health to those communities.²⁹

The Oregon Health Authority houses many services and programs that are important in facilitating oral health integration. In 2015, the state hired a dental director whose role is to integrate oral health into larger health care system transformation. The dental director reports to the agency's Chief Medical Officer on the integrated clinical leadership team, and oversees both Medicaid and public health oral health services and programs, with an eye toward ensuring connections between oral health and population health. Similarly, OHA's Transformation Center provides training on effective ways to recruit and engage CAC members.

Non-state agency partners are also important to fostering a systems-based approach to integration, and in producing resources to state policymakers. For example:

- The **Oregon Oral Health Coalition** is an important partner in promoting overall health for Oregonians. It supports the state's oral health integration through its curriculum for primary care practices on integrating oral health and primary care, and its advocacy of an oral health integration framework that supports primary care providers' incorporation of oral health assessment, prevention, referral and care coordination.³⁰ Local oral health coalitions, established under the Oregon Oral Health Coalition, also help coordinate regional oral health integration and engage populations in rural areas.
- Interviewees cited **CCO Oregon** and **Dental 3** (described on page 9-10) as important integration partners. These convening entities for CCOs and POHS, respectively, aim to align their members' activities and represent their interests with the state. CCO Oregon has also been instrumental in developing a quality measures set that aims to align metrics in CCO dental sub-contracts, and in developing a six-phase framework for oral health integration.³¹
- **Federally Qualified Health Centers** provide integrated care by delivering physical, oral, and behavioral health services in a single setting. FQHCs also help address the social determinants of health and gaps in care for Oregonians ineligible for Medicaid. The **Oregon Primary Care Association**³² received funding to launch an oral health integration curriculum with FQHCs. The pilot program provides technical assistance to clinic care teams to integrate oral health into their workflows, establish information technology, and apply fluoride varnish and other supports.
- **The Oral Health Funders Collaborative** partnered with the Oregon Oral Health Coalition and OHA to produce the *Strategic Plan for Oral Health in Oregon: 2014-2020*.³³ The collaborative helps grantmakers align their investments in promoting oral health in Oregon.³⁴ Aligning oral health investments for maximum effectiveness and efficiency may be especially important for states should federal legislation cut funding to Medicaid.

Delayed Implementation of Oral Health Integration

Despite widespread recognition of the importance of oral health to overall well-being, Oregon slowly phased in implementation of dental services within its coordinated care model. When the Oregon Health Plan began its transition to CCOs, oral health providers expressed concerns about the impact of integrating into the CCO model on their longstanding infrastructure and business models. As a result, DCOs asked the state for—and were granted—more time to transition. State legislation³⁵ allowed dental organizations to remain outside the CCO global payment model until 2014, while behavioral health integration began in 2012. Although some dental providers reportedly hoped the delay would become a permanent carve-out,³⁶ dental providers by and large looked for ways to make the best of the new system once it became clear that legislation required DCOs to work with CCOs.

While the delay gave dental providers more time to prepare for changes, it meant they were largely absent during early discussions about integration with CCOs and community stakeholders. By the time CCOs integrated dental care in 2014, some of the initial stakeholder momentum had dissipated, and “it was almost like integration fatigue,” explained one former state official.

Changing Budgets Lead to Changing Medicaid Dental Benefits

Fourteen states, including Oregon, provide extensive dental benefits to their expansion and non-expansion populations.³⁷ Despite support from Medicaid and public health policymakers, adult Medicaid dental benefits have fluctuated in Oregon in response to budgetary constraints. In 2010, adult dental benefits for crowns and dentures were eliminated and reduced for some members of Oregon Medicaid, but were subsequently reinstated.³⁸ The 2014 integration of DCOs coincided with Oregon's expansion of Medicaid under the Affordable Care Act, which added roughly 400,000 members to the OHP in 2014.³⁹ The OHP offered comprehensive dental benefits to the expansion population in 2014, and at the same time brought all currently enrolled members up to that same comprehensive standard.⁴⁰ Oral health benefits were augmented in 2016 to provide more generous coverage for dentures, stainless steel crowns, and some periodontal services.⁴¹

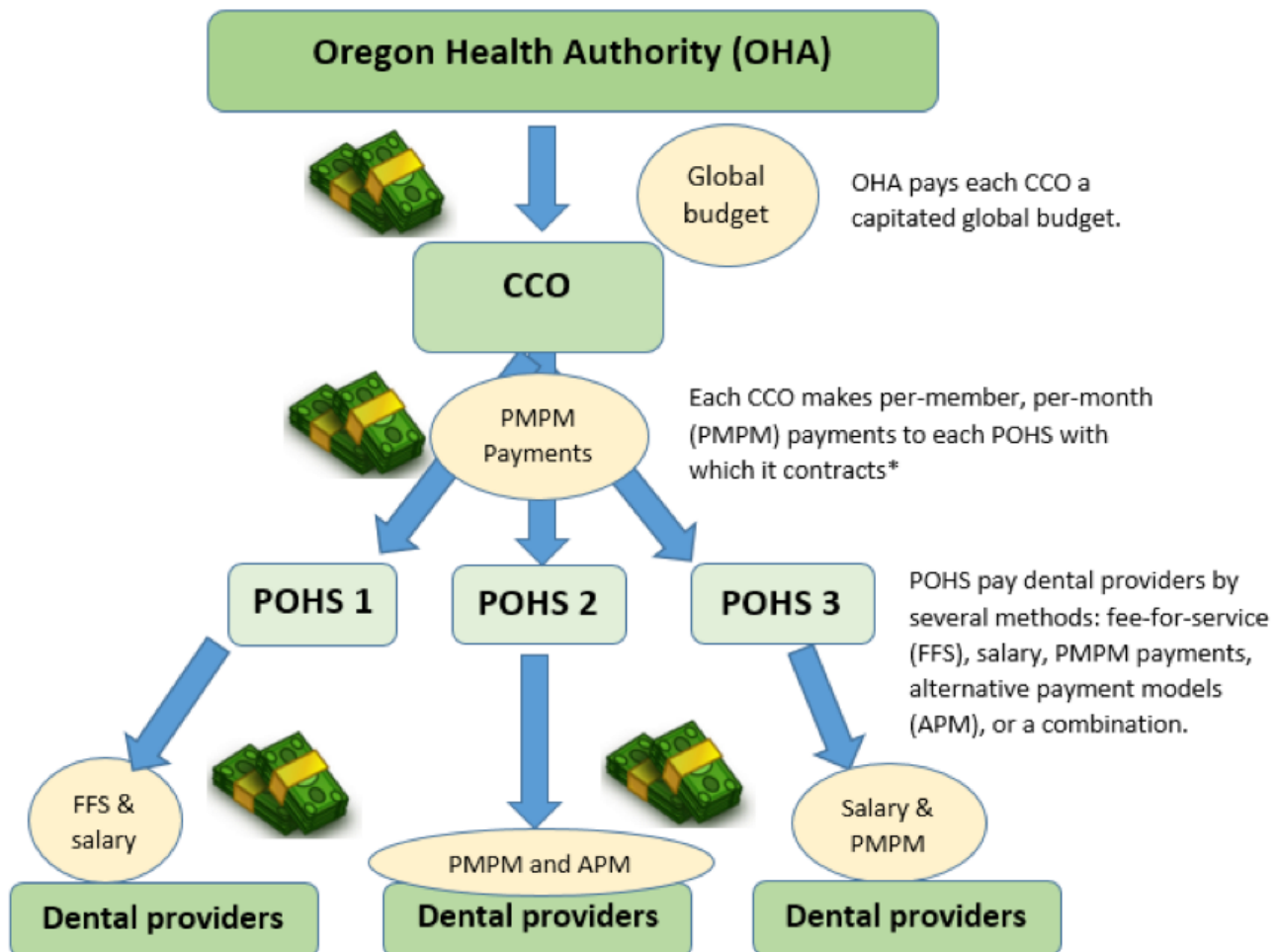
So much change contributed to confusion among some OHP members about their dental benefits, which was a barrier to seeking care for some. “The pendulum swing of people having benefits and no longer having benefits poses challenges and impacts access,” said a stakeholder. Such a shifting environment reportedly made it difficult to collect consistent data on the impact of policies advancing adult oral health care. A fluctuating adult dental benefit may also make primary care practices hesitant to invest in workflow changes and other changes needed for oral health integration.

Oregon's Payment and Financing Model

State leaders are using payment and financing levers to encourage the integration of oral health into physical health care. In 2012, OHA adopted a global budget for CCOs designed to steer the health system toward integrated, accountable care, pursuant to the state's 1115 Demonstration waiver.⁴² Each CCO uses its global budget for physical, oral, and behavioral health care for its members.⁴³ A portion of the budget goes to a quality incentive pool that CCOs can earn based on their performance on incentive measures.⁴⁴ Two of the measures relate to oral health: one requires dental sealants for children and the other requires oral, physical, and behavioral health assessments for children in Department of Human Services (DHS) custody.

Once a CCO receives its global budget payment, it pays any POHS it contracts with a PMPM rate. Some CCOs also share a portion of their incentive pool payments, if any, with their partnering POHS. The POHSs have flexibility in determining how to pay their providers, so a single POHS might use multiple different payment methods with different providers. Under a staff model, the POHS pays the providers as employees who receive a salary or hourly wage for their services. If, instead of relying on staff providers, a POHS pays a panel of contracted providers on a fee-for-service (FFS) basis, the POHS does not have an employer-employee relationship with the providers, but must ensure that the rates it pays are high enough to entice the providers to participate. At least one POHS contracts with panel providers to reserve a certain number of appointments for its members. It also uses a blended model of staff-affiliated clinics and community panel providers. Alternatively, at least one other POHS uses a global capitated model that requires the providers to bear some financial risk for outcomes.

Figure 2. Flow of Funds from OHA to CCOs and Providers of Oral Health Services (POHS)



Alternative Payment Models

CCOs entered into their current sub-capitated arrangements with POHS in order to comply with the legislative requirement to initially contract with DCOs in 2014. Some POHS still contract directly with the state for services they provide to OHP members who are not enrolled in managed care.⁴⁵ Some state officials question whether these subcontracting relationships necessarily lead to true integration of physical and oral health care. However, some alternative payment models point to a willingness by some CCOs and POHS to use payment as a lever to improve oral health integration and quality.

For example, AllCare CCO's alternative payment model awards bonuses, drawn from the CCO's shared savings, to POHS according to their performance on a set of metrics. The metrics, developed with the CCO's dental partners, include a measure of "citizenship," or the level of engagement with the CCO, as evidenced by participation in outreach events, meetings about the payment model, or similar activities. Other measures include results of surveys of provider and access satisfaction, dental visits for diabetic patients, and an increased percentage of diagnostic and preventive services.

Under AllCare CCO's alternative payment model, dental providers are awarded points based on their performance toward the goals set for each measure. The number of points earned determines which of three payment tiers the provider falls into. Providers in the highest tier receive 100 percent of the possible bonus payment. Providers in the middle tier receive 80 percent, and those in the lowest tier receive 65 percent. The lower the number of points, the smaller the percentage of the possible payment the provider receives.

It can be challenging for a CCO with limited or no experience providing dental care to design and implement an oral health alternative payment model. Developing payment models and performance metrics jointly with providers could help CCOs gain the knowledge and perspective needed to influence care delivery through payment. To that end, CCO Oregon (an association of CCOs, POHS, and other stakeholders) convened a workgroup to discuss contracting options for CCOs and POHS.

Challenges and Lessons Learned about Payment and Financing

- Oregon's commitment to local decision-making allows CCOs and POHS to tailor payment models to meet their needs, without seeking approval from state officials. "The state doesn't get in the middle of CCO contracting [with POHS]," explained one state official. However, according to other officials, **some CCOs struggle to determine how much they should pay POHS**, and instead tend to refer to the fee-for-service rates OHA pays for certain beneficiaries who are not enrolled in CCOs.
 - One stakeholder suggested the dental community would benefit if the state required CCOs to use standardized contract language for reporting and auditing requirements, which would minimize the burden on POHS to comply with different contractual requirements for each CCO.
- Another lesson learned from contracting with oral health service providers is that **stakeholders themselves can successfully take the lead** to improve their contracting experiences within the parameters set by the state.

- One example involves the non-profit organization Dental 3 (D3) formed in 2014 to help address the contracting challenges experienced by DCOs in the Portland Tri-County area.⁴⁶ D3 acts as a single contracting body for the seven POHS. In return, the member POHS pay D3 a portion of their monthly capitation payments. D3 also provides oral health services itself and through subcontractors to children in schools and other community settings. In addition to the monthly capitation payments, POHS pay D3 on a fee-for-service basis for services provided to children enrolled with POHS. D3 provides sealants and fluoride varnish in Head Start, WIC programs, and schools with high proportions of students eligible for free and reduced lunches.
- Local flexibility can make it challenging for the state to determine how CCOs pay POHS, and how those providers spend that money. For example, Oregon does not systematically track the POHS's payment methods. Without knowing how much POHS or providers are paid, or what their overhead costs or expenses are, it is difficult to determine whether payments are appropriate and adequate. The **lack of payment transparency also presents challenges** should the state want to implement a statewide value-based payment program.
- The range of contracting options used by POHS highlights the fact that **value-based payments and other alternative payment models could be used more widely** in the future to incentivize integration. The state's Section 1115 Demonstration renewal requires Oregon to ensure that CCOs use value-based payment arrangements with their network providers to encourage quality and rein in costs.⁴⁷ Oral health will be included in CCOs' plans to implement value-based payment, and may depend on partnerships between CCOs and POHS to determine appropriate payment measures. The state's Transformation Center expects to support CCOs and POHS during the shift to value-based payment.
 - One challenge with implementing value-based payment systems is that they require a reliable flow of complete and transparent data. Oregon, like many states, still grapples with data-sharing across systems.

Data and Measurement

Oregon has tracked the performance of CCOs since their inception in 2012.⁴⁸ Since 2012, the OHA Office of Health Analytics has convened a Metrics and Scoring Committee responsible for identifying the quality and outcomes measures used to reward high performers, pursuant to state legislation.⁴⁹ The metrics used to gauge CCOs' progress—including their performance on oral health—are publicly reported twice per year.⁵⁰

As mentioned, CCOs' incentive pool payments are calculated based on their performance on the incentive measures established by the Metrics and Scoring Committee, including two oral health incentive measures:

- Mental, physical and dental health assessments within 60 days for children in DHS custody. This measure was modified to include dental with mental and physical assessments.
- Dental sealants on permanent molars for children (ages 6-14), as recommended by the Dental Quality Metrics Workgroup.

Stakeholders agree the use of incentives focused attention on these two measures. At the time of publication, the rate of sealants for children ages 6 to 14 statewide had increased from a baseline of 11.2 percent in 2014 to 21.5 percent in 2016. The December 2016 rate represents an improvement of 3 percentage points over the 2015 rate of 18.5 percent, exceeding the benchmark established for 2016 by 1.5 percentage points.⁵¹

One state official noted that the rate of dental sealant improvement for children was due not only to the incentive attached, but also to the publicity the measure generated, noting, “People know we’re focused on it, [which] created additional activity.” Others pointed out that the 2016 benchmark was set relatively low (20 percent), while others expressed difficulty identifying children in need of sealants. For additional discussion about the implications of this metric, see School-Based Dental Sealant Programs (page 16).

Figure 3. Dental Sealants for Oregon Children Ages 6-14

Dental sealants for children ages 6-14, statewide.

Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus

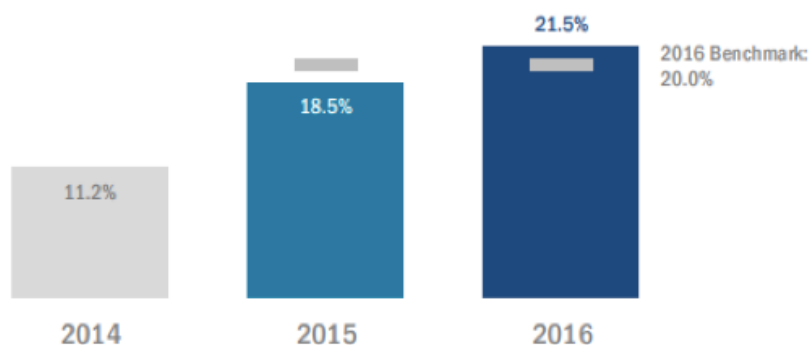


Image from Oregon Health Authority. Source: <http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf>

The rate of dental assessments for children in DHS custody has also steadily improved, from a baseline of 27.9 percent in 2014, to 58.4 percent in 2015, and reaching 74.4 percent in 2016.⁵² A state official noted that one benefit from measuring dental assessments for children in foster care was that it enabled CCOs to develop close relationships with DHS and child welfare programs around the state. CCOs have also forged partnerships with POHS, FQHCs, and other organizations in order to meet their benchmarks.

Figure 4. Percentage of Oregon Children in DHS Custody Who Received Health Assessments

Percentage of children in DHS custody who received health assessments, statewide.

Data source: Administrative (billing) claims + ORKids

Benchmark source: Metrics and Scoring Committee consensus

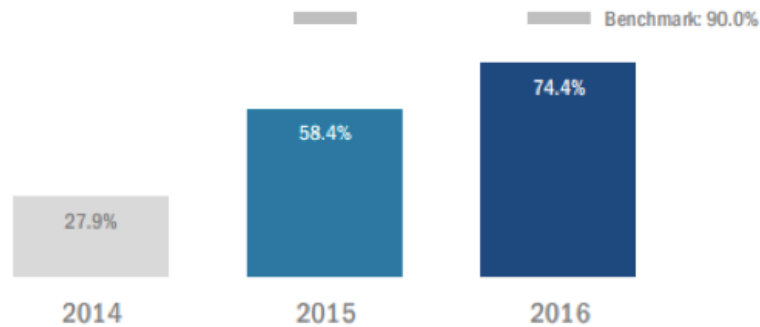


Image from Oregon Health Authority. Source: <http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf>

Additional Performance Measures Collected

It is important to note that CCOs and POHS are also working to improve oral health care quality beyond the areas targeted by the CCO incentive measures. Some CCOs and POHS—such as Advantage Dental and Capitol Dental—use additional oral health measures, such as:

- Emergency department and hospital use for dental issues, including hospital use among children
- Pregnant women and new mothers with a dental visit
- Reductions in untreated dental caries
- Diagnostic services for children
- Patients who have received tobacco cessation counseling
- Dental visits among people with diabetes
- Dental utilization overall
- Number of visits to homebound mothers
- The use of silver diamine fluoride
- Risk assessments performed by oral health providers

CCOs and POHS are also developing or implementing other quality improvement strategies related to oral health, such as electronic information-sharing and case management to support coordinated care, and outreach to members with diabetes to encourage them to receive regular screenings and preventive care. One POHS tracks measures related to tobacco use and oral health visits by people with diabetes because those issues are important to care coordination. Another uses data to reach out to groups not adequately utilizing dental services.

Integrating Measures and Measuring Integration

A number of stakeholders say the DHS measure was effective and should be replicated by other states because it folds dental assessments into an existing physical and behavioral health measure. Some advocate integrating oral health into existing measures as a way to more fully assess oral health integration without causing “measure fatigue,” or increasing the burden associated with a new measure.⁵³ However, one stakeholder who is also a foster parent noted that the measure highlights needed improvement in the coordination and communication between DHS, CCOs, POHS, and foster parents. She noted that one oral health service provider hired a full-time case manager to notify foster parents of the dental assessment requirement and to track foster children’s care. This can be seen as an example of the integrated metric spurring greater attention to integrated care.

A number of stakeholders expressed interest in being able to measure integration. A March 2017 OHA publication, “Oral Health in Oregon’s CCOs: A Metrics Report,” made strides in this direction by reporting for the first time on two measures that gauge oral health integration. The report used administrative claims data to compile the following two integration measures:

- The percentage of oral health assessments of children up to age 6 performed by a primary care practitioner (PCP).
 - The percentage of oral health assessments performed by a PCP in mid-2016 varied widely by CCO:
 - PCPs performed at least 10 percent of oral health assessments in four CCOs.
 - In one CCO, PCPs performed over half (59.9 percent) the oral health assessments.⁵⁴
 - And in eight CCOs, PCPs did not perform any assessments.
- The percentage of adult CCO members with diabetes who received at least one dental service in a year.⁵⁵
 - The measure showed that the percentage of adult CCO members with diabetes who received at least one dental service—approximately 24 percent—stayed nearly the same in 2016 as in 2015.

In interviews, some stakeholders expressed interest in adding an oral health component to an incentive measure of diabetes care quality to encourage integration. They identified diabetes care as a specific area of interest because of the relationship between gum disease and blood sugar regulation.⁵⁶ Some stakeholders also advocated for greater emphasis on outcomes measures, such as the percentage of children without any tooth decay, and others also would like to see greater measurement of adults’ oral health status.

Measures are Evolving

A number of stakeholders are discussing how to measure progress on oral health beyond the existing measures. In 2017, the Oregon Health Policy Board (OHPB)⁵⁷ began overseeing a new, governor-appointed Health Plan Quality Metrics Committee to align and coordinate measures across CCOs, private plans on Oregon’s health insurance exchange, and carriers under public employee and educator health plans.⁵⁸ The Metrics and Scoring Committee⁵⁹ and its Dental Quality Metrics Workgroup report to the new committee. In 2016, the Medicaid Advisory Committee convened an Oral Health Work Group tasked with developing a framework to define and assess oral health access in Medicaid.⁶⁰ It recommended an Oral Health Access Monitoring Measures Dashboard that included care coordination, oral health integration, utilization, and the availability of care.⁶¹ In addition to the state committees and workgroups, private partners have played key roles. For example, CCO Oregon’s Dental Workgroup developed a CCO-DCO Quality Measure Core Set,⁶² presented it to the Metrics and Scoring Committee, and submitted public comments at a later meeting.⁶³

Health Equity and Oral Health Integration

The OHA's March 2017 *Oral Health in Oregon's CCOs: A Metrics Report* provides an important backdrop for discussions of future oral health metrics. It currently reports on 13 oral health measures and stratifies most of them statewide by race and ethnicity, as well as by CCO. It found that among CCO participants, adults receive services at lower rates than children, and that beneficiaries identifying as Hawaiian/Pacific Islander consistently receive services at lower rates than other members.⁶⁴

The stratification of oral health data by race/ethnicity is important to the state's goal of increasing health equity—one of the four strategic focus areas identified in the OHA's 2016 *Oral Health Road Map*.⁶⁵ One state official observed, "Breaking down data by race/ethnicity helps to focus on more specific areas for quality improvement. When you break it up by subgroups, you can find populations that aren't doing well." The roadmap was designed to align with the state's public health State Health Improvement Plan, as well as other OHA priorities. The roadmap identified strategies to address oral health equity, including providing sealants in schools, enhancing the oral health services provided by community clinics, bolstering oral health workforce capacity, and reducing emergency department visits for dental conditions.

Policymakers have taken steps to address the shortage of oral healthcare workers in some rural areas, which results in some rural residents experiencing difficulty accessing oral health care. Pursuant to a state Senate bill developed through mediation with the oral health community, some dental pilot programs are expanding the practice of dental hygienists, and working with tribal organizations to develop a new category of dental staff: dental health aide therapists.⁶⁶

While stratification of measures by race/ethnicity helps policymakers identify disparities, little effort is underway at this time to address those disparities in oral health, and health equity goals within oral health are challenging to implement. A number of state officials point to the school sealant program as a primary channel through which oral health integration addresses equity, by targeting schools with large numbers of students receiving free or reduced-price lunches. The Transformation Center has also included health equity as a topic in its CCO Learning Collaborative, although it was not specific to oral health.⁶⁷ State officials also noted that identifying gaps in oral health care access or outcomes by race/ethnicity can be challenging due to the limited sample sizes arising from limited diversity in the state. A number of stakeholders expressed interest in addressing equity going forward, and one state official reported that a new health equity committee is being created that will report to the OHPB.

Aligning School-Based Dental Sealant Programs

The Maternal and Child Health Section within OHA's Public Health Division supports oral health integration through its involvement in the OHA Statewide School Dental Sealant Program. A school in Oregon is eligible for the program if 40 percent of students receive free or reduced-cost lunches, but all children in the school are eligible to participate. CCOs and POHS are also involved in implementing the school-based sealant program.

Before CCOs became responsible for oral health services, the state public health agency had responsibility for all school-based sealant programs. It still provides some sealants in schools, and remains responsible for certifying the quality of sealant programs. However, in the context of Oregon's required sealant measure, individual POHS now contact schools to establish sealant programs.

Partnerships can help overcome funding challenges associated with providing sealants to all children. One POHS reports that it now partners with community organizations. Such entities can apply for grants, such as one that supports dental services to adults with special needs twice a month at a Health and Human Services building where they receive physical health care, as well as tele-dentistry services.

Lessons and Challenges from the School-Based Sealant Program

- Measures with financial incentives attached can foster partnerships and inspire creative ways to advance oral health integration. For example, the dental sealant incentive metric motivated stakeholders to coordinate to better integrate oral and physical health.
- Several stakeholders speculated that CCOs' and oral health providers' investment in school-based sealant programs might wane if the corresponding incentive measure were changed or removed. Should that occur, it would likely fall to the state public health agency to resume providing school-based sealants to the extent its capacity allowed. However, one stakeholder said that at least one POHS provided sealants in schools before the advent of the incentive measure.

Challenges and Lessons about Integrating Data and Measurement

- **Financial incentives drive change.** Many stakeholders identified CCOs' financial motivation to address oral health—driven by the two oral health incentive measures—as a catalyst driving them to work more closely with partners to address oral health as part of whole-person care. As one state official said, “The incentive program is key. Putting incentive dollars on the table makes a big difference.”
- **Increased attention to oral health brings opportunities to improve communication and collaboration.** Some primary care practitioners provide preventive pediatric oral health services (e.g., oral health assessments, fluoride varnish), and integrate the *Smiles for Life*⁶⁸ curriculum into their practice. Many schools provide dental sealants for children. This increased attention to oral health among providers in various settings brings opportunities for information-sharing and coordination to integrate physical and oral health care for children.
- **Barriers to data** sharing persist, such as the inability of dentists and primary care providers to share data because of incompatible electronic health record systems.
 - This challenge is present in FQHCs as well, where providers may rely on manual data collection and sharing for some purposes.
 - At least one POHS uses an electronic platform that displays patient encounters, claims, and other health information in a format accessible to both dental and primary care providers. Such a tool helps facilitate oral health integration into physical health, and benefits patients and providers.
 - One state official said that public health does not bill Medicaid for school-based sealants because public health-provided sealants are funded by the state general fund. It can be unclear who should receive the incentive metric payment for delivering such services.

Overall Challenges and Lessons Learned

What remains a challenge in Oregon remains a challenge across the country—helping stakeholders determine **what oral health integration looks like** and **why it is important**, and then managing the change that accompanies integration efforts. Progress is difficult to achieve when there is no clear consensus about what oral health integration means (i.e., is it co-location of services, or including oral health services into primary care practices, or something else?) or **who is responsible** for making it happen (i.e., dentists, primary care providers, others?). Ultimately, it is clear from Oregon's experience with the coordinated care model that oral health integration has to occur at multiple levels and include primary care and dental providers, measurement and data collection, incentive payments, workforce innovation, and state legislation.

Some states can also use lessons from their own past integration experiences to guide their oral health work. In Oregon, that means **applying lessons learned from behavioral health to oral health integration**, such as the importance of having all key stakeholders involved in decision-making.

Another lesson from Oregon's model of integrated physical and oral health is **the value of localized implementation guided by community priorities**. Local and regional partnerships are integral to the CCO model, as evidenced by the requirement that CCOs have community advisory councils that provide regular input. This local implementation does not have to—and should not—contravene the values and goals for integration established by the state, according to one state policymaker. Although CCOs were established as community-driven entities, DCOs were not. Some POHS operate nearly statewide, through contracts with most or all of the CCOs. At least one CCO acknowledged this tension between the community-oriented focus of CCOs and the statewide focus of some larger POHSs, and predicted that over time, CCOs would work more closely with the POHS who are aligned with their missions.

A **state can use its leverage as a convener** and consensus-builder to bring partners to the table. It can also support and staff the resulting committees and workgroups. States may also heed a lesson shared by a state policymaker to avoid stakeholder burnout: “Don't have groups that last forever.” The state's Oral Health Workgroup, for example, was formed explicitly as a group with limited duration and convened from July through October 2016.⁶⁹

A **relentless champion** also helps facilitate integration. Stakeholders see support from executive leadership, state legislators, and health policymakers, as well as the appointment of a dental director, as instrumental in making strides toward oral health integration and whole-person care.

Finally, states can use their **statutory levers** to move integration forward. Mandating integration in a statute can clear a path for new payment structures and ensure the participation of key stakeholders. Statutes also codify a state's priorities. For example, the state Legislature passed a bill in 2015 requiring the OHA to appoint a dental director for the first time, which many stakeholders and advocates regarded as emblematic of oral health's importance to the state.⁷⁰

Future Opportunities and Implications for Other States

Despite the challenges to oral health integration, most Oregon stakeholders believe that significant progress has been made. They also acknowledge that complicated systems take years to fix, and Oregon still has work to do on integration.

- **Incorporating oral health into primary care workflows.** As mentioned, many stakeholders would like to see a broader implementation of integration, wherein more primary care providers incorporate oral health into their workflows, and routinely apply fluoride varnish in primary care settings.
- **Co-locating oral, physical, and behavioral health.** One promising vision for this sort of integration comes from the work of a local public health agency, which is also an FQHC. The FQHC, which contracts with a CCO, established a dental clinic within the FQHC so that physical, behavioral, and oral health could all be delivered in the same location. **The fact that incentives for all three types of care flow through the CCOs enables the state to encourage coordinated, co-located care.** One state official said, “We couldn’t have done incentives without CCOs, so we could easily pass patients from one agency to another agency.”

Looking Ahead

One area of interest to a number of stakeholders is **improving oral health access and outcomes among populations with severe and persistent mental illness.** Stakeholders recognize the potential to coordinate oral health services with physical health services for that population; for example, to perform a dental procedure while a patient is under anesthesia for a physical health procedure.

State policymakers are looking at innovative **workforce initiatives**, such as reliance on expanded practice dental hygienists and telehealth, to enhance network adequacy, especially in rural areas. One state lawmaker said that Oregon is actively recruiting expanded practice dental hygienists to serve rural areas, following the Alaska model of employing dental therapists in remote areas. These efforts were supported by Senate Bill 738, passed in 2011, which allows people to practice dentistry or dental hygiene without a license as part of a pilot project under the general supervision of a dentist.⁷¹

The **opioid crisis** might also galvanize efforts to integrate oral, physical, and behavioral health. According to some stakeholders, adults with tooth pain who visit an emergency department are often given pain medication in the emergency department instead of the dental care needed to resolve their problem. Conversely, there have been unconfirmed anecdotal reports of patients with substance use disorders claiming to have tooth pain in order to obtain pain medication in the emergency department. To help providers grapple with these situations, the state public health division convened a task force in 2016—with representation from the dental community⁷²—to develop opioid prescribing guidelines for dentists⁷³ and other providers.⁷⁴ The state dental director and a Medicaid staffer are also leading a year-long project to educate dentists on their roles in the opioid crisis, promote responsible and compassionate opioid prescribing, and encourage dentists to use the Oregon Prescription Drug Monitoring Program.⁷⁵

This situation is ripe for ongoing cooperation between physical, oral, and behavioral health providers on **protocols for patients complaining of tooth pain**, and on treating patients with concurrent tooth pain and substance use disorders. For example, Yamhill CCO worked with dental partners to conduct continuing medical education classes for emergency room doctors treating people presenting with tooth pain. Opportunities exist for similar work statewide.

Developing oral health **value-based payment** strategies is another area of opportunity. Oregon’s Section 1115 Demonstration waiver renewal, which runs through 2022, prioritizes the development of value-based payments while calling for continued integration of oral, behavioral, and physical health.⁷⁶ Federal policymakers are likewise investing in oral health value-based payment in the newly-launched Children’s Oral Health Initiative Value-Based Payment opportunity of the Centers for Medicare & Medicaid Services’ Innovation Accelerator Program.⁷⁷ Participating states’ lessons may prove useful to Oregon and others seeking synergy between value-based payment and oral health integration.

Budgetary Implications of Federal Changes

Oregon is moving forward with its integration of oral, physical, and behavioral health despite changes to the national healthcare landscape. Nationwide, adults covered by the Affordable Care Act (ACA) Medicaid expansion in 29 states could lose access to dental benefits if Congress rolls it back.⁷⁸ Pediatric dental is currently an essential health benefit (EHB) under ACA for the Medicaid expansion population, although recently proposed legislation in Congress would no longer require Medicaid to cover pediatric dental or other EHBs for those covered under the ACA expansion.⁷⁹ EPSDT, the children's health component of Medicaid, and CHIP currently mandate some dental coverage for children. However, EPSDT coverage could be reduced pursuant to proposed federal cuts to Medicaid, and funding for CHIP is due to expire in September 2017, unless Congress extends it.⁸⁰ Further, proposed federal legislation would have cut Medicaid spending by 26 percent by 2026, and 35 percent by 2036, which would have forced states to make difficult choices about how to spend the reduced funding.⁸¹ A June 2017 report from the OHA and the Oregon Department of Consumer and Business Services estimates that passage of the Better Care Reconciliation Act would have increased Oregon's Medicaid costs by \$6.2 billion from 2020 through 2026 by reducing the federal share of funding for the program.⁸²

Oregon would need to find a way to pay those additional costs in order to maintain its robust benefit, or else reduce benefits or coverage, should Congress pass an ACA repeal or replacement bill similar to BCRA. Given the oral health benefit's fluctuation over the years, oral health stakeholders are concerned that the adult dental benefit may be rolled back should these federal cuts come to pass. "When times get tough, dental tends to go," said one stakeholder.

Cuts to the adult dental benefit may slow integration's momentum, but the heightened attention to oral health as a key component of physical health would remain, according to stakeholders. Lessons learned about the importance of oral health for pregnant women, children, and people with chronic conditions could inform other state programs even in the absence of a robust dental benefit across the board.

Also, oral health is not solely under the purview of Medicaid: the state public health agency remains committed to school sealant programs and oral health for special populations. Cuts to Medicaid and public health may heighten the need for multi-sectoral partnerships to achieve integrated, whole-person care. These lessons may likewise be applicable to states without comprehensive adult dental benefits that nonetheless are interested in integration.

Oral Health Integration in Oregon: A Work in Progress

Oregon's recent strategic planning process identified concrete areas in which work remains to be done to integrate oral health.⁸³ One finding from the November 2016 report by Health Management Associates was the lack of a clear consensus among all stakeholders about what integration does and should mean.⁸⁴ For example, there was not universal agreement about whether integration is best implemented by:

- Co-locating dental chairs in physical health clinics;
- Training primary care providers to incorporate dental assessments and fluoride varnish applications into their workflows;
- Encouraging communication and data-sharing between physical and oral health providers;
- Or through some other model or combination of models.

Similarly, some integration models may vary regionally, in response to the needs and capacities of local providers, health systems, and community members. While variation may be appropriate, sustained state policy leadership and consensus-building can help clarify the overarching vision for oral health integration.

A number of policymakers noted that despite the work still needed, a significant amount has been accomplished over the last few years. One state policymaker said, “We are young in doing this,” and another noted that the goal was to, “grow the garden they had planted.” With the renewal of its 1115 Demonstration, Oregon is building on its accomplishments and moving forward with oral health integration. Its lessons learned—and its response to federal changes on the horizon—holds value for states interested in forging a similar path toward integrated, whole-person care.

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