CPEHN
California Pan-Ethnic Health Network

Advancing Health Equity through Systems Transformation and Payment Reform

February 2020

Integrating Oral and Physical Health

Recommendation: Medi-Cal Managed Care Plans (MCP) can advance health equity by integrating physical and oral health coverage and services, with provider incentives tied to care coordination, patient care management, referral and navigation services.

Background: In the United States and in California the two systems of medical and dental care remain largely siloed in spite of innovative programs designed to bridge this gap. The separation of insurance coverage, payment, and service delivery systems, and the lack of coordination between the two systems is detrimental to achieving whole person care, and disproportionately burdens vulnerable populations. More needs to be done to align the two systems given the interconnectedness of oral and physical health.[i]

Through the Medi-Cal Healthier California for All initiative, the California Department of Healthcare Services (DHCS) proposes to expand incentive payments to providers for dental services, including the Caries Risk Assessment bundle for children aged 0-6 and preventative services for adults. The expansion of incentive payments for dental services alone is a good first start, but not enough to ensure that Medi-Cal enrollees can access oral health care.

People who live in low income and/or rural communities, people who are limited English proficient,[ii] and people living with disabilities and/or who are mobility impaired,[iii] have a more challenging time navigating the divide between the two systems of care. In addition, factors such as access to transportation, proximity to dental offices, limited availability of culturally and linguistically concordant dental providers, have also been found to prohibit access to dental services, especially among Medi-Cal beneficiaries.[iv] The inconsistent funding of adult dental care has also perpetuated disparities in accessing oral health services, especially preventative services. Communities of color bear the brunt of these structural and social disparities which can lead to poorer outcomes. In California, people of color make fewer visits to the dentist or dental clinic and more older adults of color have lost teeth to decay and gum disease, when compared with White adults.[v] More can be done to close these gaps, especially now that the State has restored adult dental benefits for Medi-Cal beneficiaries.

Medi-Cal Healthier California for All also proposes to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted managed care entity. The California Department of Health Care Services (DHCS) can reduce these disparities by making health equity a priority of full integration pilots. Setting clear, transparent and measurable steps towards achieving equitable physical and oral health care informed by, and coordinated with health care providers, community based organizations and consumers is necessary to address multiple determinants of health.

Community Evidence

Community based experiences are an integral part of improving the health system and advancing health equity. In 2019, CPEHN collaborated with six (6) community based organizations throughout the State to listen to the health care access experiences of diverse community groups. Participants reported the following barriers to accessing oral health care:

- High out-of-pocket costs for dental care
- Outdated and inaccurate provider directories
- Desire for more integrated care that is culturally and linguistically appropriate

"I went to the dentist and after this experience I never go to the dentist. My molar was hurting, he recommended they take it out, they took it out very roughly. They made a follow-up to finish the appointment. When I went into the office he gave me a paper about my coverage and what I needed to pay and it ended up being very expensive. I was told that everything was out of pocket. They asked for $200 down payment and the total was $1,500."

- Focus group participant, Fresno

"I have Medi-Cal also, so they just told me to pick a dentist. I had this booklet. I went through and picked one and I didn't like her at all...because of her attitude and she told me I was disrespectful because I wasn't trusting her abilities, so I got another dentist."

- Focus group participant, Los Angeles

"I like that my dentist and medical provider and mental health therapist are all connected in the same place. This makes it great because they all communicate with each other regarding my mental health and other health statuses to give me proper treatment."

- Focus group participant, Sacramento

"In an ideal world there would be health care for everyone that encompasses all health, whether it is your oral health, mental health, reproductive health. Ideally it will be nice if when we are supposed to go to see the provider that is the time we will be seen for everything."

- Focus group participant, Los Angeles

Considerations

DHCS has paved the way for better integration of primary care with oral health care by investing in initiatives that strengthen oral health outreach, education and the service delivery infrastructure for children and adults. These include: the launch of Smile, California- a public communications campaign to promote oral health education and raise awareness of available benefits, the allocation of Proposition 56 funding for additional incentive payments and billing codes, and a loan repayment program for dental providers interested in serving the Medi-Cal population, amongst others.

DHCS has also proposed to eliminate dental managed care in Los Angeles and Sacramento, with the goal of increasing utilization among Medi-Cal beneficiaries in fee-for-service dental. However, in the year after California fully restored adult dental coverage in its Medicaid program, utilization of the benefit remains low. Utilization data shows that less than one quarter (23.92%) of eligible adults had a dental visit last year.[vi] Other problems persist in fee-for-service dental: In 2018, only 12% of calls to the TSC were conducted in languages other than English despite the fact that nearly 40% of Medi-Cal beneficiaries speak a language other than English.[vii] More can be done to improve access to care by beneficiaries, especially people of color and people who are LEP.

Previous Medicaid waivers have spurred the transformation of primary care and the development of health homes for select beneficiaries - emphasizing value-based care in primary care settings and a focus on prevention. Dental health is intricately linked with physical and behavioral health[viii] and opportunities should be found to integrate all three, including the addition of oral health into the current Whole Person Care (WPC) pilot while it continues to develop its infrastructure and care coordination process. An interim assessment of the State's WPC pilots has shown that effective care

coordination is possible across health sectors that have traditionally worked apart from each other.[ix]

Recommendation: Physical and oral health are two essential components of a whole person care approach, which is designed to provide a better system and continuum of care by breaking down existing silos.[x] Integrating primary and oral health care while addressing social needs can reduce disparities, lead to better population health, and improve chronic disease management.[xi] To advance health equity and improve patient-centered care through the integration of physical and oral health care, DHCS should:

Strengthen oral health integration:

- Encourage MCPs to apply to become full integration pilots as envisioned under the state's Medi-Cal Healthier California for All proposal. Full integration is not just consolidating payments through MCPs but working to create a seamless system of care, minimizing treatment disruptions, gaps in care, and cost inefficiencies, especially for patients with complex health needs. While working towards full integration, MCP contracts should encourage and incentivize collaboration, co-location of, and warm handoffs between physical and oral health providers.
- Require MCPs to provide case management and care coordination benefits for all beneficiaries (not only special populations), especially for those with known comorbidities and for diseases that disproportionately impact communities of color. Alternatively, DHCS could establish incentive payments for MCPs and providers to incorporate case management and care coordination benefits into their practice based on quality, care improvement and cross-delivery of care. Require MCPs to develop a transparent process to share the incentive dollars with providers to drive change and accountability on the provider level. DHCS' Medi-Cal Healthier California for All proposals are a good first start.[xii]
- Incorporate oral health as part of the new Enhanced Care Management benefit package proposed under Medi-Cal Healthier California for All. MCPs could leverage the Whole Person Care and Health Homes Programs which presently coordinates complex physical and behavioral health needs of eligible beneficiaries, including case management, care coordination, health promotion, referrals, individual and family support, and comprehensive transitional care to provide these services.
- Encourage MCPs to train and pay for the integration of community health workers (CHWs) in physical and oral health systems especially for co-education (for example, teaching oral health care techniques during health appointments), coordination of oral and physical health care access and navigation services.

Improve Accountability:

- Require MCPs to produce more granular population data collection and analysis on race, ethnicity, language, functional disability, sex, sexual orientation and gender identity and develop plans to address identified disparities.
- Hold MCPs accountable for providing and reporting on language assistance services in all non-English languages by strengthening contractual language that clearly details the responsibilities and roles of the plans and its providers, as well as accurate data collection and reporting requirements such as data on the frequency of interpreter utilization disaggregated by type (in-person, telephone, or video) and language.
- Require MCPs to assist with the identification and referral of language concordant oral health providers, as well as the scheduling of the first appointment, when requested by beneficiaries and/or health providers. MCPs must ensure that providers receive

continuing education for cultural humility, implicit bias and interpreter utilization strategies.

Continue to Invest in Oral Health:

- Extend the Dental Transformation Initiative (DTI), which has successfully established 4 domains to increase preventive services, caries risk assessment and disease management, continuity of care, and the provider and community engaged Local Dental Pilot Projects (LDPP). Continue funding the DTIs and expand the initiative to include preventive and restorative services for adults. Incentivize oral health providers to provide restorative services and continuity of care with new payment codes. Leverage the progress made by (LDPPs) to support outreach and education of children and adults in community-based settings, many who remain unaware of the interconnectedness of their physical and oral health, and of their oral health benefits.

Sources:

[i]. Huong Le, Sherry Hirota, Julia Liou, Tiffany Sitlin, Curtis Le, and Thu Quach, 2017. Oral health disparities and inequities in Asian Americans and Pacific Islanders. American Journal of Public Health 107, S34_S35, https://doi.org/10.2105/AJPH.2017.303838

ii. Georgetown University, Health Policy Institute. Oral health care: Can access to services be improved? https://hpi.georgetown.edu/oralhealth/

iii. California Legislative Analyst Office. Improving access to dental services for individuals with developmental disabilities. https://lao.ca.gov/Publications/Report/3884

iv. Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany, March 2019. Consumer Survey of Barriers to and Facilitators of Access to Oral Health Services. http://www.oralhealthworkforce.org/wp-content/uploads/2019/04/OHWRC_Consumer_Access_Survey_Oral_Health_Services_2019.pdf

v. Centers for Disease Control and Prevention, Oral Health Data, by State and Race https://nccd.cdc.gov/oralhealthdata/rdPage.aspx?rdReport=DOH_DATA.ExploreByLocation&rdProcessAction=&SaveFileGenerated=1&islLocation=06&rdICL-iclTopic=ADT&iclTopic_rdExpandedCollapsedHistory=&iclTopic=ADT&islYear=2016&hidLocation=06&hidTopic=ADT&hidYear=2016&irbShowFootnotes=Show&rdICL-iclIndicators=ADT1_1%2cADT1_3%2cADT1_4&iclIndicators_rdExpandedCollapsedHistory=&iclIndicators=ADT1_1%2cADT1_3%2cADT1_4&hidPreviouslySelectedIndicators=&DashboardColumnCount=2&rdShowElementHistory=&rdScrollX=0&rdScrollY=0&rdRnd=5618

vi. Dental Data Reports: "Dental Fee for Service Performance Measures Report April 2018-March 2019," California Department of Health Care Services, https://www.dhcs.ca.gov/services/Pages/FFSPerformanceMeasures.aspx

vii. Provider Bulletin Special Bulletin Volume 35, Number 12: https://cpehn.org/sites/default/files/la_stakeholder_fact_sheet_2-20- 19_final_6.pdf

viii. https://www.integration.samhsa.gov/about-us/esolutions-newsletter/e-solutions-jan-2015ix. https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1918

x. https://caph.org/wp-content/uploads/2016/09/caph-sni-issue-brief-wpc.pdf

xi. https://www.scielosp.org/article/bwho/2005.v83n9/644-644/

xii. DHCS Medi-Cal Healthier California for All Dental Proposals, https://www.dhcs.ca.gov/Documents/MDSD/Stakeholder%20Docs/CalAIMDental-Proposals.pdf