

CONTRIBUTORS

University of North Carolina Gillings School of Global Public Health, student cohort:

Beryl Bortey, Laura Buddenbaum, Caroline Le, Ella Taggart

PROJECT ADVISORS

Dr. Zachary Brian, DMD, MHA

Vice President, Impact, Strategy, & Programs, Foundation for Health Leadership & Innovation

Director, North Carolina Oral Health Collaborative

Kaylan Szafranski, MSW

Health Programs Director, NC Child

ACADEMIC ADVISORS

Dr. Karl Umble, PhD, MPH

Associate Professor, Department of Health Policy and Management

Ashley Cram

MPH Candidate, Department of Health Policy and Management

EXECUTIVE SUMMARY

In July 2021, the North Carolina Medicaid program transitioned to managed care — a health care delivery system organized to manage cost, utilization, and quality — for physical and behavioral health care services. Oral health care was not included in the transition to managed care, but state policymakers have signaled that oral health care’s eventual transformation is possible. This report takes inventory of other states’ approaches to incorporate oral health care into their managed care systems, or otherwise support system transformation.

OBJECTIVES & ACTIVITIES

Current Medicaid transformation models for oral health care services across the United States were researched and analyzed, and these findings were then presented in a literature review.

In addition, key informants were interviewed to learn about varying models of oral health care delivery through Medicaid system transformation. Following this, findings were displayed in matrix form representing the following key areas of interest: communication strategies, social determinants of health, quality measures, care coordination, and case management. Lastly, and based on this research, concrete recommendations regarding how North Carolina could effectively integrate oral health care into NC Medicaid transformation efforts in the future were provided.

METHODS

The literature review focused on Georgia, Ohio, Oregon, Virginia, and South Carolina. The gaps in publicly available information guided the creation of key informant interview questions.

Two to three (2-3) key informants were interviewed per state (Georgia, Ohio, Oregon, and Virginia). Key informants included providers, patient advocacy groups, representatives from managed care organizations (MCOs), and state Medicaid agency officials. Interview questions focused on the provision of oral health benefits, strengths, areas for improvement, and lessons learned.

For qualitative data analysis, transcripts and notes taken during each key informant interview were compiled. These transcripts and notes were then analyzed to identify common themes. Emergent themes were identified across the following topic areas: communication strategies,

social determinants of health, quality measures, and care coordination/case management. These themes then informed the development of a final report matrix and recommendations.

FINDINGS

Findings revolve around the four states that were selected for interviews.

GEORGIA

Georgia provides children with comprehensive oral health care benefits while adults can receive emergency dental care. Care management organizations (CMOs) subcontract these dental benefits to dental management organizations (DMOs).

The oral health care delivery system operates on a “dental home” model. Under this scheme, oral health care is coordinated by a primary dental provider. Despite this streamlined care process for members, Georgia’s oral health care Medicaid transformation arrangement could be strengthened by reducing the administrative burden for providers and enhancing transparency requirements for the DMOs.

OHIO

All Medicaid beneficiaries in Ohio are eligible for oral health care coverage from an MCO. Ohio’s Medicaid managed care system includes five MCOs, each of which contracts with a third-party dental administrator (DA) that oversees the provision of benefits. Comprehensive oral health care benefits are offered, although the associated frequency and cost of each service depends on the specific MCO.

A major strength of Ohio’s system is Medicaid expansion, which broadens eligibility for oral health care coverage. Additionally, the state offers a robust list of oral health care benefits. Areas for improvement include better communication by the Medicaid department, MCOs, and DAs with providers and patients. Additionally, MCOs could assess quality measures related to patient health, as opposed to purely administrative metrics.

OREGON

Oregon’s managed care model is called the Coordinated Care Model. Medicaid beneficiaries enroll in Coordinated Care Organizations (CCOs) to receive their physical, behavioral, and oral health care coverage. To receive oral health care benefits from a CCO, a beneficiary must choose from one of the Dental Care Organizations (DCOs) with which their CCO is contracted. All Oregon Medicaid beneficiaries have access to comprehensive oral health care benefits. Oregon’s Coordinated Care Model is strong in that it features lower costs, care coordination, integration, and financial incentives to encourage CCOs to meet oral health care quality

measures. The model can improve in areas such as communication, prioritization of oral health, and the availability of dental professionals who accept Medicaid.

VIRGINIA

All Virginia Medicaid beneficiaries are eligible to receive comprehensive dental benefits through the Smiles for Children (SFC) program, which is managed by one care administrator, DentaQuest. There are no costs or co-payments associated with receiving dental care services in the SFC program, however beneficiaries are responsible for finding a participating SFC dentist. Additionally, transportation services are available to Virginia Medicaid beneficiaries to attend their dentist appointments.

Virginia's Smiles for Children program has strong communications with providers and streamlined administrative responsibilities because there is just one dental benefits administrator (DBA). On the other hand, having only one DBA results in a lack of competition to improve the dental benefit over time. Currently, DentaQuest does not assess the provision of oral health care using quality measures nor does it facilitate care coordination. Moreover, access to transportation assistance is limited, and Virginia's Medicaid oral health care system does little to address the barriers that many beneficiaries face to receive oral health care.

RECOMMENDATIONS

Our research-informed recommendations are organized by the following overarching themes.

- Care coordination
- Increase access
- Comprehensive dental services
- Quality dental care
- Communication between MCOs and NC Medicaid
- Contract necessities

PROJECT SIGNIFICANCE

Our project will provide key insights and recommendations regarding how North Carolina could most effectively implement Medicaid oral health care transformation in the future.

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GLOSSARY

Managed Care Organization (**MCO**): a private health insurance company, contracted by the state Medicaid agency, to oversee and administer health plans for beneficiaries

- Care Management Organization (**CMO**): Georgia's MCO equivalent
- Coordinated Care Organization (**CCO**): Oregon's MCO equivalent

Prepaid Health Plan (**PHP**): in the state of North Carolina, a term used to describe the health plans for physical and behavioral health care services, administered by managed care organizations for NC Medicaid beneficiaries

- Managed Care Plan (**MCP**): equivalent to a PHP

Dental Benefit Manager (**DBM**): vendors that managed care organizations subcontract with to administer dental benefits

- Dental Management Organization (**DMO**): Georgia's DBM equivalent
- Dental Administrator (**DA**): Ohio's DBM equivalent
- Dental Care Organization (**DCO**): Oregon's DBM equivalent
- Dental Benefit Administrator (**DBA**): Virginia's DBM equivalent

INTRODUCTION

In July 2021, North Carolina Medicaid transitioned to managed care for physical and behavioral health care services (NCOHC, 2020). Oral health care was not included in the original managed care launch, but many state policymakers have signaled an intention to incorporate oral health care in the future (NCOHC, 2020). This project aims to take inventory of other states' approaches to oral health care Medicaid transformation.

The scope of Medicaid oral health care models and coverage varies by state. All state Medicaid programs are required to cover dental care for children under the age of 21, but there's a patchwork of dental benefits for adults (Levisohn et al., 2020). States that cover some form of adult dental care have adopted different approaches for administering these benefits. For example, states with “carve-in” models include oral health care in Medicaid transformation. Under this arrangement, managed care organizations (MCOs) or other subcontracted vendors, called dental benefit managers (DBMs), administer the oral health care benefits. The state Medicaid agency pays a per member per month (capitated) rate to the MCOs to oversee these benefits. Subsequently, the MCOs reimburse providers for services. In contrast, states with “carve-out” models (like North Carolina) provide “fee-for-service” reimbursements directly to dental providers. Other states have hybrid systems that split members between fee-for-service and managed care models.

The oral health care delivery model has major implications for beneficiaries' overall health and well-being in North Carolina and across the country. Significant geographical, cultural, and financial barriers contribute to inequitable access to oral health care. Consequently, there's a disproportionate burden of oral health-related disease on racial and ethnic minority groups, older adults, children, and low-income families (US DHHS, 2000). Furthermore, North Carolinians in rural areas face challenges obtaining oral health care because of the supply and maldistribution of dental providers (US HSRA, n.d).

Based on these challenges, the North Carolina Oral Health Collaborative (NCOHC), a program of the Foundation for Health Leadership and Innovation (FHLI), will establish a task force in collaboration with the North Carolina Institute of Medicine (NCIOM) to evaluate potential Medicaid system transformation in oral health care. The proposed task force, which will begin work in July 2022, will convene key stakeholders in the collective design, development, and messaging of oral health transformation opportunities.

The primary objectives for Phase 1 of the NC Medicaid Transformation Initiative are to research and evaluate oral health care Medicaid transformation models via a literature review

and key informant interviews. These deliverables may shape the task force’s design, structure, and final products.

METHODS

Literature Review

Information was synthesized regarding oral health care Medicaid transformation across five states: Georgia, Ohio, Oregon, Virginia, and South Carolina. These states represent a broad spectrum of demographic compositions, political orientations, and Medicaid structures. This variety helped to ground the array of opportunities for oral health within a managed care or otherwise transformed system.

Each state’s beneficiary profiles, overall Medicaid structure, MCOs, DBMs, and oral health benefits were analyzed. Standardizing these topic areas allowed for comparing other states’ systems to North Carolina’s. These findings highlighted gaps in publicly available information and supported the development of a key informant interview guide.

Interviews

Key informants in four of the five states from an initial literature review (Georgia, Ohio, Oregon, and Virginia) were interviewed. Due to the project time frame and scope, South Carolina was excluded from the interview process, but preliminary findings for South Carolina were supplemented by informally connecting with an expert regarding the state’s strengths and areas for improvement.

An intentional effort was made to connect with prospective interviewees representing diverse positions and perspectives.

Key informants comprised representatives from state Medicaid programs, MCOs, the provider community, and policy advocacy groups.

The stakeholder interviews followed an interview guide (see Appendix) that included general questions and state-specific questions. These questions were generated based on gaps in the preliminary literature review research. The questions address dental coverage, oral health care delivery models, key features of each state’s system, including strengths and areas for

improvement. The interview guide was reviewed by key experts in the field prior to implementation.

A total of nine key informants were interviewed via Zoom telecommunications, and one key informant via email communication. Two student cohort team members attended each interview and assumed the roles of facilitator and scribe.

Prior to each interview, it was reiterated to key informants that their identity would be kept anonymous in the final report. Additionally, consent was obtained to record the Zoom interview for qualitative analysis purposes, and all interviewees agreed to this request.

Qualitative Analysis

The notes and transcripts from each interview were used to perform a qualitative analysis, and recommended practices from the North Carolina Translational and Clinical Sciences Institute were utilized throughout the process. The transcripts were used to identify common themes across the interviews. Common themes identified throughout the qualitative analysis included communication strategies, supporting social determinants of health, centering quality measures, and utilization of care coordination and/or case management. These findings were then organized for each state into a cross-state matrix (included).

The transcripts were also used to pinpoint notable quotes or interest. These quotes captured an idea that could not be found in the literature or highlighted a unique insight from an interviewee. Quotations were anonymized by interviewee and by state and quotes organized by themes (see Table 1. Key Interview Quotations).

The final literature review includes information from both preliminary research and conducted interviews. These two work products were then coalesced into one final report because of their mutually reinforcing information.

FINDINGS

Literature Review

Georgia

Statistics

The oral health care landscape in Georgia is largely colored by differential access in urban versus rural areas. In 40% of Georgia's census tracts, children with public insurance travel at least 20 more miles than their counterparts with higher family incomes or private insurance (Cao et al., 2017). This dimension is apparent in Georgia's ranking 46th in the country for access to dental providers, with just 44.7 providers per 100,000 individuals ("Dental Visit," n.d.).

Out of the state's 159 counties, 21 do not have practicing dentists ("2019 Dentist Workforce," 2020). Lower dental utilization rates are the byproduct of these access disparities. Approximately 61% of Georgia adults reported a dentist or dental clinic visit within the past year ("Dental Visit," n.d.). Only 41.1% of eligible children received preventive dental services in 2020, but this figure could have been distorted by the effects of the COVID-19 pandemic ("Children's Health," n.d.).

While access barriers are a common denominator for multiple priority populations, publicly insured children are asymmetrically impacted because only 27.9% of dentists in Georgia accept their insurance benefit (Cao et al., 2017). Nearly 38% of children in the state are covered by Medicaid or PeachCare for Kids, Georgia's equivalent of the Children's Health Insurance Program, or CHIP ("Health Insurance," 2019). Nearly 89% of eligible children participate in these programs (Haley et al., 2019). Approximately 165,000 children are enrolled in PeachCare for Kids, and over 2.2 million individuals are on Medicaid ("2021 Annual Report," 2022). Eligibility requirements for both programs operate on an income and family size gradient. For example, a family of four has an annual income cap of \$68,543 for PeachCare for Kids eligibility. With respect to Medicaid, the threshold for pregnant people and their infants is 225% of the federal poverty level (FPL) (Haberlen, 2017). Low-income parents must have a family income below 37% of the FPL (Haberlen, 2017).

Dental Care Administration

Georgia's Medicaid design is bifurcated into fee-for-service (FFS) and managed care (Griffin & McGuire, 2021). The FFS delivery model caters to aging populations, individuals with blindness or other disability, people in nursing homes or long-term care facilities, and waiver recipients (Griffin & McGuire, 2021; Georgia Interview #3). In contrast, the managed care arrangement is more extensive. Georgia's current managed care generation (Georgia Families) was introduced in 2006 and accounts for a majority of Medicaid and PeachCare for Kids members ("Managed Care in Georgia," n.d.). Prior to January 2020, the care management organizations (CMOs, analogous to MCOs) were Amerigroup Community Care, CareSource, Peach State Health Plan, and WellCare (Dahmer et al., n.d.). Centene, Peach State Health Plan's parent company, acquired WellCare (Dahmer et al., n.d.). During the transition phase, WellCare members could select another CMO; if the member did not select a CMO, their default assignment was Peach State Health Plan (Dahmer et al., n.d.). As of April 2021, WellCare was officially terminated, and Georgia Families now includes 3 CMOs (Grapevine & Miller, 2021; Dahmer et al., n.d.).

In regard to oral health care, the CMOs subcontract to Envolve Dental, Skygen, and DentaQuest — dental management organizations (DMOs) (Georgia Interview #3). The DMOs are accountable for network adequacy for oral health care delivery (Georgia Interview #3).

Provision of Oral Health Care

Georgia offers comprehensive dental services for children under the age of 21. This includes oral exams every six months, simple tooth removal, teeth cleaning every six months, and bitewing X-rays once a year. In contrast, adults are eligible for emergency dental services such as pain mitigation procedures including extractions, but restorative or preventive services are not covered (Georgia Interview #1; Griffin & McGuire, 2021). Pregnant people are the exception to the narrow adult benefit package, and have access to a range of dental services during their pregnancy term (Georgia Interview #1).

To streamline oral health care services, the Georgia Department of Community Health (DCH) and CMOs have developed dental homes. In this context, a dental home is defined as "a primary dental provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the State Plan" ("Contract," 2019, p. 18). Members are encouraged to select their own dentists or continue visiting their dentists if they participate in the CMO's network ("Contract," 2019). In the event that a member does not

choose a dentist, the contractor can auto-assign them to a dental home (“Contract,” 2019). For members in urban areas, the dental home must be within 30 minutes or 30 miles of their home address (“Contract,” 2019). These parameters are extended to 45 minutes or 45 miles for members in rural areas (“Contract,” 2019).

The dental home model buoys the CMOs’ care coordination and case management requirements. Specifically, the CMOs stratify members according to medical conditions such as asthma, diabetes, and other chronic illnesses (Georgia Interview #3). While care coordination and case management are tracked by DCH, the patient experience in oral health care is not independently evaluated (Georgia Interview #3). The best proxy is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but this does not capture how members rate dental services (Georgia Interview #3). Despite limited patient experience data, DCH appraises two quality measures for oral health. One of the metrics is the percentage of eligible beneficiaries that receive dental care (Georgia Interview #3). Moreover, the state has adopted the American Dental Association’s measure of sealant application to premolars (Georgia Interview #3).

Strengths

- Dental home model
- Monitors if members have their annual appointment
- Oral health care benefits are available to pregnant people
- Leverages the contractual relationship with the CMOs to assess network adequacy

Areas for Improvement

- Communicating the extent of dental benefits to adult members
- Network capacity with respect to specialized dental services
- Quantity and distribution of pediatric dentists
- Administrative burdens for oral health care providers
- Limited transparency requirements
 - Restricted oversight of DMOs who claim their information is proprietary
- No stipulations that CMOs have to report medical loss ratios

Ohio

Statistics

Ohio performs above the national average for several oral health care indicators (OHO, 2022). In 2020, seven in ten adults (ages 18-64) and seven in ten older adults (ages 65+) reported that they visited a dentist within the last year (OHO, 2022). From 2019 to 2020, eight in ten children (ages 6-17) and five in ten younger children (ages 1-5) had one or more preventive dental visits in the past year (OHO, 2022). Additionally, in 2018, nine in ten adults in Ohio had received optimally fluoridated water (OHO, 2022).

However, oral health disparities remain prevalent in Ohio, particularly for older adults and young children (OHO, 2022). In 2020, two in ten older adults had reportedly lost all of their natural teeth. In 2018, four in ten adults had lost six or more of their teeth due to gum disease and tooth decay (OHO, 2022). For young children in Ohio (ages 3-5), almost two in ten already had untreated dental disease, and three in ten had a history of dental disease, specifically tooth decay (2016-2017) (OHO, 2022). Additionally, data from 2020 further highlights oral health disparities in Ohio. Visiting a dentist is more common for those with an annual income greater than \$50,000, individuals with a college degree, and non-Hispanic white individuals (CDC, 2020). As of 2021, and according to data from the Health Resources and Services Administration (HRSA), there were 156 dental care health professional shortage areas in the state, (KFF, 2021). Ohio has only 22.19% of its need for dental providers met, ranking it 37th in the country (KFF, 2021).

Approximately 3.1 million individuals, or one in four, are covered by Medicaid and CHIP in Ohio (OHA, 2020). Medicaid enrollments during the COVID-19 pandemic have increased by roughly 330,000 individuals, a jump to 27% of the state's population (ODH, 2021). Ohio Medicaid eligibility includes pregnant people, infants, children, individuals with disabilities, the aging population, and the "expansion population" (individuals at or below 138% of the federal poverty level), (OHA, 2020). Data from 2018 demonstrates that approximately 30% of all licensed dentists in Ohio are Medicaid providers; however, only 14% of licensed dentists submitted claims for 250 or more Medicaid consumers (Ohio Interview #1). Thus, an insufficient number of dental providers in Ohio is meeting the needs of the Medicaid population.

Dental Care Administration

Ohio's Medicaid managed care system includes five different managed care organizations (MCOs) (Ohio Medicaid Managed Care, n.d.). Medicaid beneficiaries are automatically approved for managed care coverage and have the option to select their managed care plan (MCP) (Ohio Medicaid Managed Care, n.d.). The MCOs offer a range of services from physical, behavioral, and oral health care services (Ohio Medicaid Managed Care, n.d.). Starting in July 2022, Ohio will transition to its next generation of managed care which will include seven managed care organizations (Ohio Medicaid Managed Care, n.d.).

Oral health care coverage by MCOs is overseen by subcontracts with Dental Administrators (DAs), such as DentaQuest (Ohio Interview #3). The Ohio Department of Medicaid (ODM) has no contractual relationship with DAs (Ohio Interview #3). Each MCO and DA establish provider networks and can choose to offer services beyond the minimum standards set by ODM (Ohio interview #1). The oral health Medicaid transformation system in Ohio remains a fee-for-service model (Ohio Interview #2).

Provision of Oral Health Care

All Medicaid beneficiaries in Ohio are eligible for extensive oral health care coverage (NASHP, 2021). The minimum services required by the ODM include routine examinations and preventive appointments, fillings, extractions and crowns, medical and surgical services, root canals, and dentures for adults and children younger than 21 years of age, and orthodontics (braces) for individuals younger than 21 years old (ODM, n.d.). Ohio's oral health care Medicaid transformation system does not currently have any assigned dental homes for beneficiaries, case management specifications, or requirements to address the social determinants of health (Ohio Interview #1).

Public information from MCOs and DAs regarding the provision and quality of oral health care coverage is very limited in Ohio. The quality measures required by contracts with ODM are primarily administrative, such as utilization and dentist participation, and are highly limited in terms of specificity and frequency (Ohio Interview #3). These measures are not related to care quality, patient health outcomes, or take into account the patient experience (Ohio Interview #3). While ODM does enforce fines for failures to meet set standards, these fines are minimal. Consequently, MCOs are easily able to stay within contractual limits (Ohio Interview #3).

Strengths

- Robust adult dental benefits that are above the minimum Medicaid requirements
- More patients are covered due to state Medicaid expansion efforts

- Streamlined Medicaid operation for claim processing and the adjudication of complaints/denials
- Fiscal stability of the Ohio Department of Medicaid

Areas for Improvement

- The state has no oversight of DAs.
- Prior authorizations and denials by MCOs and DAs can reduce service delivery
- No quality measures for health indicators
- No requirements for ensuring a dental home, or care coordination and / or case management services
- Communication challenges remain a burden between providers and beneficiaries

Oregon

Statistics

Approximately 23% of Oregonians (about 1.05 million people) are covered by CHIP or Medicaid (KFF, 2019). Oregon is one of 13 states to offer comprehensive oral health care benefits to adults and children (Oregon Health Authority, 2017). Specific services vary by provider network and plan, but beneficiaries have access to a broad range of preventive and treatment services for oral health (Oregon Health Authority, 2017). Despite this extensive coverage of oral health care services, issues related to health equity, access, and utilization remain. In an analysis of Oregon’s oral health care integration, the state observed that many people do not elect to receive preventive oral health services. Additionally, utilization was higher among children than adults (Oregon Health Authority, 2017). As of September 2021, Oregon was ranked 35th in the country for percent of dental needs met at just 27.82% (KFF, 2021). From the provider perspective, low reimbursement rates for dentists who accept Medicaid patients create workforce shortages (Oregon Interview #2). 58.5% of providers in the state report that they do not see any Medicaid patients (Oregon Health Authority, 2017).

Dental Care Administration

Oregon underwent health system transformation in 2012 and launched Coordinated Care Organizations (CCOs) to provide physical and behavioral health care coverage to Oregon Medicaid beneficiaries (Clary et al., 2017). CCOs, similar to MCOs in other states, focus on “prevention and helping people manage chronic conditions [to] reduce unnecessary emergency room visits and give people support to be healthy” (“Coordinated,” n.d.).

Approximately 92% of beneficiaries are enrolled in one of the 15 CCOs available in the state ("Coordinated," n.d.).

Prior to 2014, the Oregon Health Authority (OHA) provided oral health care services through Dental Care Organizations (DCOs) that were contracted directly with the state for over 20 years (Health Management Associates, 2016). In 2014, Oregon expanded Medicaid, and the CCOs were legislatively mandated to contract with DCOs to integrate the provision of oral health care with physical health (Clary et al., 2017). The state supervises the CCOs while the CCOs oversee their contracted DCOs (Oregon Interview #1) Since integration, beneficiaries choose from or are assigned to one of five DCOs based on their CCO's contractual arrangements ("CCO," n.d.). Those not enrolled in a CCO choose from five DCOs that the state is contracted with to receive their oral health care coverage ("OHP," n.d.).

Provision of Oral Health Care

Various aspects of the integrated managed care system in Oregon enable improved quality of care and access to care for beneficiaries. Both CCOs and the state have highlighted the importance of financial incentives to meet oral health-related quality metrics. The state implemented an incentive metrics program where the state holds a small percent of the CCOs' budget unless they meet certain quality metrics like preventive service delivery metrics or an integration dental metric (Oregon Interview #2). Some CCOs further incentivize their DCOs to meet those quality metrics by sharing a portion of the money with them (Oregon Interview #1).

The coordinated care model has improved access to benefits and supported whole-person health through the integration of oral, physical, and behavioral health care. (Oregon Interview #1). The model also restructured payment methodology, which has lowered costs for the state (Oregon Interview #2).

Strengths

- Lower costs due to the CCO model
- Care coordination via health integration efforts support access to benefits
- Financial motivation to meet oral health care quality measures through incentive metrics and alternative payment methodology
- CCO choice in which and how many DCOs are contracted
- Oral health oversight manager as a role within the CCOs

Areas for Improvement

- Overlapping auditing of the DCOs from the state and the CCOs
- Shortage of oral health care providers who accept Medicaid
- Low Medicaid reimbursement rates
- Lack of communication at the time of transition to managed care
- Oral health was the last to be integrated into the CCO model and appears to be prioritized less than physical and behavioral health

South Carolina

Statistics

South Carolina's Public Oral Health Division works to improve oral health in the state (Ayers, Martin, Gravelle, et al., 2013). In 2016, a Statewide Oral Health Plan was developed to set state priorities for dental public health infrastructure, access to oral health services for vulnerable populations, education, prevention, and policy outreach (SCDHEC, 2020).

South Carolina's population faces considerable barriers to adequate oral health. In particular, minority, low-income, and rural children experience tooth decay, half of which goes untreated (Ayers, Martin, Gravelle, et al., 2013). Additionally, oral health carries through the lifetime, with a substantial portion of adults in South Carolina experiencing untreated oral health problems (Ayers, Martin, Gravelle, et al., 2013). Minorities, males, and individuals with lower levels of education are priority populations for oral health care transformation efforts (Ayers, Martin, Gravelle, et al., 2013).

Data from the Center for Disease Control's Behavioral Risk Factor Surveillance System revealed that in 2020, the age-adjusted prevalence for South Carolina adults (ages 18+) who visited a dentist in the past year was 68% (CDC, n.d.). The 2020 prevalence was lowest for Hispanic (60.5%) and Black populations (64.3%) (CDC, n.d.). Prevalence had a household attainment gradient, with households making less than \$15,000 a year at a 46.1% prevalence. Households with incomes between \$15,000 and \$24,999 obtained a 53.2% prevalence, and households making between \$25,000 to \$34,999 reached a prevalence of 56.5% (CDC, n.d.).

Dental Care Administration

South Carolina Medicaid contracts with five MCOs. Each MCO has their own managed care plan (SCDHHS, n.d.). The five plans are Absolute Total Care, First Choice by Select Health of South Carolina, Healthy Blue by BlueChoice of SC, Humana Healthy Horizon in South Carolina, and Molina Healthcare of SC (South Carolina Choices, n.d.). Most beneficiaries are required to receive their benefits through an MCO plan rather than through the state's fee-for-service model (SCDHHS, n.d.). To provide oral health care benefits to their beneficiaries, each MCO subcontracts with a Dental Benefits Manager (DBM), DentaQuest, which is responsible for providing oral health care coverage to all beneficiaries (Healthy Blue, n.d.). DentaQuest also oversees the oral health care coverage for beneficiaries enrolled in Medicaid directly from the state (SCDHHS, n.d.).

Provision of Oral Health Care

Children can receive oral health care benefits from birth through the month of their 21st birthday (SCDHHS, n.d.). These services include preventive services, X-rays, in-office fluoride treatments (every six months), sealants, restorations, extractions, dentures, partials, and oral surgery procedures (SCDHHS, n.d.). The dental services for adults (≥ 21 years old) are more limited in scope. Healthy Connections covers up to \$1,500 per fiscal year in preventive dental services such as annual cleanings, oral exams, X-rays, extractions, and fillings. Additionally, adult members are responsible for a \$3.40 copayment for preventive care.

Strengths

- Increased their maximum annual cap per recipient over time
- Has a streamlined claims system
- Communicating the transition process to providers was effective

Areas for Improvement

- Closing referral loops
- Assessments for the patient experience
- Broadening same-day preventive services
- Identifying and reporting quality measures
- Incentivize payments for reaching established preventive benchmarks

Virginia

Statistics

As of November 2021, 1,926,548 Virginians have health insurance coverage from Medicaid/CHIP (Norris, 2021). Adults aged 19 to 64 with incomes up to 133% of the federal poverty line are eligible for Medicaid (Cover Virginia, n.d.). Children and pregnant people with incomes up to 143% of the federal poverty line are eligible for Medicaid (Cover Virginia, n.d.).

Since the adoption of comprehensive adult dental benefits in July 2021, more than 900,000 adult Medicaid members have obtained access to oral health care services (Virginia Medicaid, n.d.).

Dental Care Administration

All Virginia Medicaid beneficiaries may receive comprehensive oral health care benefits through the Smiles for Children (SFC) program (Virginia Interview #1). There are no costs or co-payments for receiving oral health care services in the SFC program (Virginia Medicaid, n.d.). Additionally, Medicaid beneficiaries do not have any dental-related dollar limits or service caps for oral health care. Transportation services are available to Virginia Medicaid beneficiaries to attend their dental appointments (Virginia Medicaid, n.d.).

Virginia's oral health care benefit is entirely managed by one care administrator ("Dental Benefits Manager"), DentaQuest (Optima Health, 2021). As a result, oral health care benefits are directly overseen by DentaQuest, simplifying communications with dentists.

Currently, DentaQuest does not assess the provision of oral health care using quality measures. Instead, DentaQuest reports service utilization rates (Virginia Interview #2).

Provision of Oral Health Care

Virginia Medicare beneficiaries have access to the following oral health care services (Virginia Medicaid, n.d.):

- *Children:* regular dental examinations, X-rays, cleaning and fluoride, sealants, space maintainers, orthodontics (braces), anesthesia, extractions, root canal treatment, and crowns
- *Pregnant people:* X-rays, exams, cleanings, fillings, root canals, gum-related treatment, crowns, partials and dentures, extractions, and other oral surgery services
- *Adults:* X-rays, exams, cleanings, fillings, root canals, gum-related treatment, dentures, extractions, and other oral surgery services

Beneficiaries are responsible for finding a participating SFC dentist. DentaQuest has a mobile device app and online support to aid beneficiaries in this process (Virginia Interview #2).

Strengths

- Dental providers are satisfied with how dental care is carved out from the rest of Medicaid services
- Having only one dental benefit administrator (DBA) is simpler
- Medicaid beneficiaries are eligible for a universal list of dental services across the state

Areas for Improvement

- Since Virginia only has one DBA, there is a lack of competition and subsequently less pressure to add new service benefits
- Carving oral health care out means that it is siloed from other Medicaid services, which creates challenges for care coordination
- Virginia stakeholders realized what they needed from a contract with a DBA after the contract was finalized. Requirements for care coordination and quality measures were not originally written into the contract, so the oral health care benefits are lacking in these areas.
- Inadequate number of dental providers in the network
- Virginia's transportation benefit is unreliable and does not adequately address the transportation barriers that beneficiaries face when seeking oral health care services
- Has not increased the reimbursement payment rate for dentists since 2005

Best Practices and Lessons Learned In Dental Benefits

Management

Conversations with Dental Benefits Managers (DBM) overseeing programs in the Southern and Eastern regions of the country provided the following insights on optimal practices, necessary support, as well as ongoing challenges across multiple domains including provider networks, quality, and integration across health care delivery systems. It is imperative to note, and has been acknowledged by the reporting DBMs, that beneficiary voice is missing from current practices. NCOHC and NCIOM should be explicit about embedding patient perspectives throughout the exploration process, and provide opportunities to understand the community experience in our current oral health care system, as well as any future modeling of a transformed system. Moving forward, NCIOM should consider focusing on the below content

“buckets,” as well as beneficiaries’ lived experiences, to help frame discussions and create the opportunity to dive deeper into each content area with specific task force members.

Provider Networks

Lessons learned from Dental Benefit Managers (DBMs) can support utilization of best practices to cultivate and sustain networks that meet the unique needs of both rural and urban populations. For example, several states’ DBMs reported using a “triple aim” approach to center quality, access, and reliability through oral health care provider incentives such as enhanced reimbursement rates. They reported this to be a successful, albeit new, approach to creating robust networks under oral health care Medicaid transformation. States using the triple aim model tend to “stair-step” innovation, often beginning with reimbursement incentives that increase access. Additional enhancements include strengthening quality by developing and reporting specific measures that align with both the provider and state’s priorities. DBMs reported that provider incentives work best when underpinned by cultivating strong and ongoing relationships between the provider and managing entity.

Another key element for a strong provider network is ongoing provider outreach and education. Managing entities noted the need to support providers on a wide range of training and professional development spanning from standard topics like billing, to quality-centered training such as trauma-informed care, and culturally competent practices. Furthermore, establishing touchpoints to help providers demystify transformation and state Medicaid processes was found to be extremely valuable for providers, and allowed for additional collaboration with the managing entity.

Both DBMs and providers noted success in developing formal feedback loops by establishing Dental Advisory Committees (DACs) in which a diverse group of providers (e.g., dentists, hygienists, practice reps, etc.) meets with the DBM at least quarterly to bring forth and directly address grievances, as well as collaborate on quality enhancements. DACs also provide an opportunity to strengthen relationships between the managing entity and providers and practices. It should be noted that both DACs and provider grievance and appeals process should be explicitly outlined in any contract between the provider and managing entity.

According to DBMs, billing and reimbursement are reported to be the most onerous part of transformation from the provider perspective. This is particularly true for independent and rural practices, which often lack the in-house support to bill effectively, making it difficult for them to remain in network. Managing entities acknowledged the need for direct support to ensure large and small practices alike are able to appropriately file claims and collect reimbursements by conducting direct site visits, ongoing training, and DBM-supported claims process alignment to ensure practices have the infrastructure to appropriately bill, regardless of size.

Finally, DBMs reported provider challenges with increased oversight and reporting requirements tied to quality improvement. Under the traditional fee-for-service model, providers faced significantly fewer reporting requirements, and were rarely subjected to benchmarking through quality measures and incentivized reimbursement. Incentives like pay-for-performance measures (P4P) have become increasingly important levers to ensure quality and drive positive health outcomes under Medicaid transformation models. Managing entities note that all efforts to increase quality are best developed in collaboration with providers and require direct support similar to billing and reimbursement.

Quality and Outcomes:

Oral health care often relies on quality measures that prioritize providers and procedures. However, increasing trends in whole person health are moving states to prioritize outcomes and preventative health -focused measures by exploring alternative and value-based payment models. States and managing entities can, and should, select targeted quality measures to accomplish broader goals when developing standard reporting requirements. There is also flexibility to leverage measures to address needs and achieve the goals of individual providers and practices. Indeed, managing entities reported a great deal of success in collaborating with providers to determine measures tied to enhanced payments. Benchmarking providers against others in the network to create a competitive environment that moves the needle in areas of practice that could benefit from increased quality was also viewed favorably.

Furthermore, DBMs noted positive responses to posting quality benchmarks across their state networks at regular intervals. This practice allows providers to see their performance in the context of their peers, and provides a high-level understanding of how the network is performing in total. Additionally, DBMs reported that larger practices have found success benchmarking their own providers, using weekly results to identify opportunities for growth, collaboration, and even innovation. Regardless of how benchmarks are utilized, they seem only as useful as the incentives tied to each measure. Managing entities and providers are able to negotiate enhancements and incentives within their contracts to ensure they are increasing quality in meaningful and sustainable ways.

Quality is only as strong as reporting requirements, which serve as a critical accountability mechanism for both providers and the managing entity. States should work with both managing entities and providers to establish initial reporting requirements and reconvene every few years to reevaluate and revise to ensure reporting is driving quality forward in meaningful ways. DBMs noted the need to align reporting requirements with the state's existing processes to streamline and alleviate administrative burdens for providers. Additionally, DBMs noted any quality efforts should include robust outreach and education on reporting, measures, and benchmarks, and provide direct and ongoing support as needed. Incentives, including P4Ps, reporting requirements, and benchmarking should be explicitly outlined in provider contracts.

Data Share and Integration:

To date, no state has achieved full, seamless integration between dental, medical, and mental health care. However, states are advancing practices that bring these systems of care together in more intentional ways. For example, MCOs in Virginia conduct direct outreach to primary care providers (PCP) and link them to dental providers through a customized directory, including referral support through a PCP-facing customer service line. Ohio uses DACs to establish linkages between dental and medical health providers, as well as conduct MCO-developed PCP-focused training to help better integrate oral health into care plans. Many other states have supported integration through increased funding for Federally Qualified Health Centers (FQHCs) door-to-door services that co-locate medical and dental care.

Managing entities highlight that relationship-building has served as the strongest support in system integration efforts. Relationships between medical and dental providers have been fostered under oral health care Medicaid transformation by incentivizing dental as part of care management teams, as well as exploring value-based payment structures that use a shared risk / shared reward model to ensure oral health care services are provided under care plans. Other opportunities to explore include establishing formal referral feedback loops between PCPs and dental providers, embedding dental provider directories in electronic medical record systems (EMRs), and establishing cross-system collaborative tables that explore whole person health outcomes through innovative payment models.

Matrix

	Communication Strategies	Social Determinants of Health	Quality Measures	Care Coordination / Case Management
Georgia	<p>Beneficiaries:</p> <ul style="list-style-type: none"> -The enrollment broker sends out letters with comparison charts that detail the value-added benefits associated with each CMO. -Welcome packets contain a membership/ID card, member handbook, and other information about the CMO. -The membership card references the dental home the beneficiary has been assigned to. -Healthy Mothers, Healthy Babies Coalition of Georgia publicizes dental services in pediatricians' offices and SNAP offices. -CMOs hold health fairs with sign-up forms for Medicaid. <p>Providers:</p> <ul style="list-style-type: none"> -Banner messages through GAMMIS (the state's Medicaid Management Information System (MMIS) portal) 	<ul style="list-style-type: none"> -CMOs connect members to community resources. 	<ul style="list-style-type: none"> -Percentage of eligible beneficiaries that receive services -Sealant application to premolars -Benchmark measure involves the member seeing the dentist at least once per year 	<ul style="list-style-type: none"> -Stratify members into various categories based upon medical conditions like chronic illnesses, diabetes, and asthma -Crossover with TMJ, sleep apnea, and CPAP machines
Ohio	<p>Beneficiaries:</p> <ul style="list-style-type: none"> - Limited communication, often not aware of their benefits - Advertising on TV and billboards about what MCOs exist - Given large member handbooks that they might not read - Could look online at ODM or MCO website, but unlikely <p>Providers:</p> <ul style="list-style-type: none"> - Standard medical information letters (MILs) from Department of Medicaid director or designee, related to newly authorized codes/services or clarifications - MCOs issue directives to providers about procedures - Immediacy and fidelity of communication is marginal and often lacks immediate human contact - Not always kept in the loop, such as when CareSource contracted with DentaQuest but that was not communicated well - Providers are recruited by MCOs and DAs, not by the Department of Medicaid 	<ul style="list-style-type: none"> - No requirement to address SDOH - Social services like transportation are offered in general to Medicaid, but nothing specific to oral health - No apparent overt attempts to address SDOH by the MCOs 	<ul style="list-style-type: none"> - Few quality measures exist, but those that do are administrative (e.g., utilization and dentist participation) - Measurement is limited in specificity and frequency - No quality measures related to care quality or patient health - Medicaid Department will fine for failure to meet standards, but MCOs are well aware of the "red-line" and use that to maximize profits while staying within contract 	<ul style="list-style-type: none"> - No requirement for case management - No dental homes - Limited or no incentives for PCPs to make a referral

<p>Oregon</p>	<p>Beneficiaries:</p> <ul style="list-style-type: none"> - Beneficiaries largely not aware of new benefits - CCOs need state assistance for communication with beneficiaries - Communication includes social media posts, dental benefits brochure, and a package of materials for CCOs and DCOs from the state. <p>Providers:</p> <ul style="list-style-type: none"> - Providers often not aware benefits had been expanded - DCOs lead this communication given contractual relationship - Regular meetings held with state, CCOs, DCOs, and providers - State sends out memos through established communication channels 	<ul style="list-style-type: none"> - Recent increase in emphasis on SDOH related to oral health and overall health - Transportation benefits required - CCO team has an SDOH director - Integration of care enables elimination of some SDOH-related barriers to care 	<ul style="list-style-type: none"> - CCOs focus on oral health due to an incentive metric program with two oral health-focused measures (one preventive dental metric and one integration metric) to create financial motivation for CCOs to focus on oral health. - State holds a percent of the CCO's budget and gives it to the CCOs if the measures are met; the CCOs share this funding with the DCOs as an incentive. 	<ul style="list-style-type: none"> - Coordinated care model helps oral, physical, and behavioral health due to integration.. - Integration is hard to set up but important because it allows for more people to see providers (e.g., having a dental hygienist at a physical health clinic) - DCOs contractually required to get to a place where they have case management
<p>Virginia</p>	<p>Beneficiaries:</p> <ul style="list-style-type: none"> -Virginia Medicaid reached out to pregnant people to notify them of their eligibility for dental care. -Social support organizations (such as FQHCs and other community institutions) have direct communication with beneficiaries, assisted with messaging. <p>Providers:</p> <ul style="list-style-type: none"> -Initial communication with providers came from DentaQuest to notify them of what services beneficiaries would be entitled to -Virginia Medicaid created a "FAQs" document to address provider questions. -Partnered with CareQuest to put together a spreadsheet tool for providers to estimate their revenues as a participating provider. 	<ul style="list-style-type: none"> -Virginia provides a transportation benefit. -The transportation is poor. -Beneficiaries wait long periods of time to receive a ride to and from their appointment or a driver does not appear at all. 	<ul style="list-style-type: none"> -No reports on quality measures -DentaQuest only reports on service utilization and the size of the provider and beneficiary network. 	<ul style="list-style-type: none"> -No requirement for DentaQuest to follow any care coordination or case management requirements.

RECOMMENDATIONS

Care Coordination

1. The contracts should require each MCO / their contracted DBM to assign the beneficiaries to a dental home.
2. There should be incentives for PCPs to make dental referrals. Additionally, there must be incentives for “closed loop” referral networks. PCPs will refer to a dentist, but the dentist often does not update the PCP on what services were provided.
3. The contract between NC Medicaid and the DCO should explicitly ask dental providers to share medical records with patients’ primary care providers.

Increase Access

4. Leverage the MCOs’ funding and resources to incentivize dental providers to practice in rural areas.
5. In order to address transportation barriers, the state should offer a transportation benefit to beneficiaries. If this benefit is adopted, it must be reliable, accessible, and user-friendly.
6. DCOs should provide translation services for beneficiaries with limited English proficiency. In addition, they should be paired with a provider who speaks their language, where feasible.

Comprehensive Dental Services

7. Network adequacy for oral health care should factor in specialized dental services, especially for neurodivergent individuals or children with developmental disabilities.
8. Same-day authorization should be prioritized for certain dental services.

Quality Dental Care

9. Contracts between the state and the DBMs should include financial incentives for the DBMs to meet oral health-related quality measures.
10. There should be a centralized credentialing process for providers to aid in expedited credentialing and onboarding
11. MCOs and DBMs should use their claims data for targeted outreach. For example, if the MCO knows how many of their beneficiaries are third graders and which ones are actually receiving sealants, they can use this data to conduct targeted outreach. In the same vein, the MCO knows how many beneficiaries are pregnant and can use claims data for preventive service education.

Communication Between MCO, Dental Benefits Manager(s) and NC Medicaid

12. Dental Benefits Manager(s) should be required to report information to the managed care organizations and NC Medicaid.
13. The MCOs or Dental Benefits Manager(s) should track members' dental visits and flag cases where the member has not met the annual appointment threshold. Following this, the MCOs or Dental Benefits Manager(s) should connect with that beneficiary to create a care plan for a future dental visit.
14. The state and Dental Benefits Manager(s) should include oral health representatives on advisory committees, within governance structures, and in other decision-making bodies to prevent oral health from being overshadowed by physical and behavioral health.
15. The state must not lose its role in advocating for patients. Shifting risk and reducing the administrative burden often reduces the number of employees, compromises infrastructure, and impacts budgetary cuts that can distract from the state's purpose.
16. MCOs should hire an oral health manager or representative to manage the oral health benefits for their beneficiaries. This individual would be a conduit between the MCO, the Dental Benefits Manager, and the beneficiary.
17. Penalties for mismanagement and abuse by MCOs and/or Dental Benefits Managers need to be clearly delineated and meaningful.
18. The state Medicaid agency should employ a full-time dentist with investigative and data-generating capability. Reliance on MCO-employed dentists presents a conflict of interest.

Contract Necessities

19. Define terms like oral health integration, network adequacy, and medical necessity in contracts to ensure uniform measurement and understanding.
20. Infrastructure must be set up for data monitoring and control. A central data repository from all the MCOs and the Dental Benefits Manager(s) would reduce data variability.
21. Parameters for reporting medical loss ratios should be addressed in the contract requirements.
22. Contractual language must specify the roles and limits of MCOs in applying discipline to providers, ranging from fiscal penalties to dismissal from the provider network. In addition, an auditing and program integrity investigation process is needed for fairness, timeliness, and due process.
23. Increases for reimbursements rates should be included in the contracts, and this should not be approached legislatively.

24. Create explicit strategies to improve the patient experience and outline these requirements in the contracts.
25. Quality measures should be clearly defined.
26. The association of ICD codes with disease states and procedures would (in theory) reduce prior authorization, denials, administrative effort required by providers and plans, and oversight required by the state for those administrative issues.
27. The system needs a binding, impartial, and independent arbitration system that engages all stakeholders with parity in decision-making.

CONCLUSION

This report's recommendations, strengths, and areas for improvement can serve as a guide regarding how North Carolina can most effectively integrate oral health into Medicaid transformation. The NCIOM Task Force should use this work as a launching point for who to consult, what to prioritize, and how to structure North Carolina's oral health care delivery system for Medicaid beneficiaries.

APPENDIX

Interview Guide

General Questions for States

1. How is dental care delivered to adult Medicaid patients in [STATE NAME]?
2. What communication strategies have been implemented to effectively inform beneficiaries about their oral health benefits?
3. Likewise, what specific communications strategies were implemented when communicating Medicaid transformation to oral health and other health providers?
4. What are the strengths of the Medicaid managed care system, or otherwise transformed Medicaid system with respect to oral health care?
5. What challenges have stakeholders (state Medicaid program, beneficiaries, providers, etc.) faced due to the integration of oral health care in Medicaid managed care, or other form of Medicaid transformation?
6. Does the Medicaid managed care organization or Dental Benefits Manager address the social determinants of oral health? If so, how?
7. What were the key challenges your state encountered when implementing Medicaid Managed Care in oral health, or other forms of Medicaid system transformation, and what advice would you provide a state looking to implement this type of transformation?
8. In the development of our policy recommendation and research for North Carolina, we are considering factors such as quality measures, coordinated care and case management, closed loop referrals to “dental homes,” integration of oral health care and primary care to achieve whole-person health, and factors to improve the patient experience. How have ideas similar to these been incorporated into how [STATE NAME] delivers oral health care to Medicaid beneficiaries?
9. What, if any, quality measures for oral health are assessed in the state’s Medicaid oral health delivery system?
10. Do the MCOs or Dental Benefits Managers have care coordination or case management requirements? What about measures supporting whole-person health such as coordinated referral networks?
11. What has worked well in your state's Medicaid transformation efforts in oral health care, and what has not worked well?

State-Specific Questions

Georgia

- What strategies has the state implemented to increase dentists’ participation in Medicaid?
- What are the challenges associated with having multiple managed care organizations providing dental services?

Ohio

- Can you outline the difference and similarities in care coverage between regular Medicaid, the MyCare Ohio program, and the OhioRISE program?
- What changes are being made with the upcoming next generation of Medicaid managed care, in regards to oral health care?
- How is oral health included in care coordination requirements of MCOs or CCEs?
- How is oral health included in Ohio's managed care report cards? What specific measures do you believe have been most important for your state to track?

Oregon

- Why did Oregon choose dental provider networks for each CCO? Was that the choice of the CCOs, the state, provider influence, or a combination thereof?
- What oversight does the state have regarding dental provider networks, or does the oversight fall to the CCOs? What accountability and reporting standards have been set?

Virginia

- Why did Virginia Medicaid choose to isolate the delivery of dental services from other health services and create Smiles For Children (SFC)?
- What is the difference between the Virginia Medicaid Card and the Managed Care Health Plan Card?
- By partnering with DentaQuest as the state's Dental Benefits Manager, what additional administrative responsibilities did Virginia Medicaid have to adopt?

Key Quotations

Table 1: Key Interview Quotations

Major Themes	Quotations
Benefits of CCO Model	<ul style="list-style-type: none"> • “I think having the coordinated care model has enabled more people to access their benefits. The coordinated model helps not only dental, but physical and behavioral health.” • “The state is not going to have a fee-for-service contract anymore, which I think is a really good thing because I am not confident the state has been able to do the oversight that we are able to do.” • “Dentists don’t have to deal with 6, 7, or 8 different plans. They have one plan administrator. Here’s one office reference manual. There’s one set of credentials and criteria, so it makes it easier for the dentists to participate.”
Provider Concerns	<ul style="list-style-type: none"> • “I have a lot of dentists who would rather just do a free day of dentistry one day a month and give services away than try to navigate the system. It costs me more to pay a person dedicated to understanding how to navigate this.” • “With the DMOs, it’s kind of like, ‘this is the fee schedule, you can take it or leave it.’ It’s kind of adversarial. It doesn’t give the provider a whole lot of negotiation room.” • “The MCOs and DAs have minions whose job is (ostensibly) to deal with providers and patients, but clearly outnumber and overwhelm individual providers with administrative burdens, (real or perpetuated) to save/make a profit.” • “One of the things that we’ve struggled with over the last several years is that, since the [reimbursement] increase in 2005, there hasn’t been an increase in 17 years.”
Overpowerful Dental Benefit Administrators	<ul style="list-style-type: none"> • “There are transparency requirements with the CMOs, but that does not apply to the DMOs, unfortunately. A lot of what goes on in the dental Medicaid sphere is largely unknown because of that.” • “The lack of transparency doesn’t benefit anyone except for the DMOs. They claim that all of their information is proprietary, and they don’t have to share any of that information.” • “We’ve tried to pass transparency laws that require them to say how much they’re spending on administrative costs, kind of like a value-based plan. You have to say you need to meet this goal,

	<p>this number of people served, and this number of services provided in order to continue to be a provider. Those have not been successful because they do have a kind of unfettered ability to regulate (or not) themselves. Those insurance organizations are so large and so powerful.”</p> <ul style="list-style-type: none"> ● “Fines can be levied for failure to meet standards, but these are tokens — in my opinion — and I suspect the MCOs and DAs are very well aware of the “red line” and use that knowledge to maximize profits and stay within contractual limits on adherence to expectations.” ● “Rein in the power of the DMOs”
<p>Inadequate Accountability between Dental MCO and Medicaid</p>	<ul style="list-style-type: none"> ● “It’s just visibility as to what’s going on between the MCO and the DMO. How are reimbursement rates paid? How is the MCO managing the DMO? Are they providing adequate oversight over the DMO? The biggest challenge is making sure that the MCO is providing adequate monitoring and oversight over the DMO.” ● “Any attempt to deal with problems arising from the DAs’ actions involves a ‘telephone game’ set of interactions between ODM, the MCO, and DA. That is a real concern because it is cumbersome and allows either or both the MCO or DA to shunt responsibility to the other and delays resolution.” ● “The road to resolution is very complicated, and the MCOs and DAs are very adept and overwhelmingly staffed to drag resolution out to the detriment of the provider and patient. In some cases, the state oversight staff may not even comprehend the problem and then when it is made known, need to get approval to pursue solutions.” ● “CCOs have not a clue of how to manage dental.”
<p>Inadequate Contract</p>	<ul style="list-style-type: none"> ● “The contractual language agreed to by the state and MCO ensures limited scrutiny and protection for the MCO to maximize profit and for the state, to limit risk.” ● “There has to be some type of incentive metric or quality metric around oral health because it’ll get lost. If you’re doing managed care for everything, oral health will get to the bottom of the pile, so you need to figure out how to raise it to the level where they’re engaged and interested. It has worked for us having that financial incentive tied to it.”
<p>Communication of Dental Benefits</p>	<ul style="list-style-type: none"> ● “We realized that lots of adults didn’t realize they had dental benefits and a lot of dentists were under the impression that there was only so much they could do for adults.”

	<ul style="list-style-type: none"> • “There was a dental consultant that worked with Medicaid, and he hosted many webinars — must have done hundreds of them. This was during the pandemic, so you couldn’t go out and meet with people in-person, so it was entirely online communication and mailing.”
<p>Advice for States Pursuing Dental MCO Model</p>	<ul style="list-style-type: none"> • “It is important to have champions of oral health throughout the decision-making bodies.” • “I would get contracts from other states — most states put them on their websites or they can be found on CMS — and look at the oral health provisions and requirements for care coordination. You can learn about access standards, like time and distance, and what they are doing with social determinants of health. You can learn so much from other states.” • “See what other states are doing in their contract because the contract is going to be the leverage the state has to get these plans to perform.”

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[>>Additional references and key resources can be found linked here.](#)