

August 19, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Massachusetts Section 1115 Demonstration Project Amendment

Dear Mr. Slavitt:

On behalf of the members of the Massachusetts Oral Health Integration Project (OHIP), thank you for the opportunity to offer our comments on Massachusetts' proposed Section 1115 waiver request. The members of OHIP firmly believe that oral health has a critical role in improving overall health and wellbeing and seek to promote the integration of dental care into the rest of the health care system. We are commenting today to request that more definitive support for the integration of oral health into the Massachusetts ACOs be included in CMS' approval of the Commonwealth's 1115 waiver.

Although largely preventable, oral diseases continue to be among the most common chronic diseases in the U.S., resulting in millions of hours of missed school and work days annually.¹ Preventable dental visits to emergency departments (ED) also cost the Commonwealth millions each year,² and almost half of all such ED visits are by MassHealth members.³ Nonetheless, there is mounting evidence to suggest that the provision of oral health care actually lowers overall health care costs.⁴

Aside from the economic toll, poor oral health severely impacts quality of life, particularly for the most vulnerable, including MassHealth enrollees. According to a recent survey by the American Dental Association, the top oral health problem for low income adults in Massachusetts is difficulty

¹ National Center for Chronic Disease Prevention and Health Promotion, (2002). *Fact Sheet: "Preventing Dental Cavities."* Centers for Disease Control and Prevention.

² Division of Health Care Finance and Policy. (2012). *Massachusetts' Emergency Departments and Preventable Adult Oral Health Conditions: Utilization, Impact and Missed Opportunities (2008-2011)*. Boston, MA: Center for Health Information and Analysis.

³ Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

⁴ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions, *American Journal of Preventive Medicine*, 47: 174-182.

biting and chewing, posing challenges to good nutrition; 36% of low income MA adults also report avoiding smiling and 20% reducing participation in social activities due to the condition of their mouth and teeth.⁵ Patients unable to adequately address their oral health needs often turn to opioids to address pain, which is especially concerning in light of the escalating opioid use disorder crisis.

The current MassHealth dental care delivery and payment system does not focus on outcomes and fails a significant part of the population. The existing fee-for-service reimbursement model needs readjustment; it has not kept up with the development of the oral health evidence base, insufficiently prioritizes prevention by rewarding volume, not value, and perpetuates an ineffective surgical approach to infectious disease processes. Additionally, the arbitrary historical separation of dental services from the rest of health care means there is very little incentive for providers to communicate with each other, again posing risks in areas like pain medication management and chronic disease care coordination.

The revised Massachusetts 1115 waiver is a tremendous opportunity to improve the way that oral health care is financed and delivered, and elevate oral health throughout health care more broadly. OHIP applauds the stated intention to include oral health in the MassHealth proposed ACO models as an important first step to oral health integration. All members should have access to patient-centered, integrated, and continuous quality oral health care. Steps taken by MassHealth to integrate oral health into the ACO will support the CMS Oral Health Initiative goals.

We encourage MassHealth to take additional steps beyond incorporating oral health incentives on the primary care side, including requirements for increased ACO accountability for dental services. MassHealth's primary goal of promoting truly integrated, coordinated, and accountable care cannot be achieved without an additional focus on oral health and dental services and sufficient resources allocated for oral health system transformation.

The current waiver does not contain sufficient detail regarding MassHealth's plans for oral health integration. Additional details are needed as well as specific timeframes for the implementation of oral health integration activities within the MassHealth ACOs. The waiver should commit to a stakeholder input process for oral health integration. Understanding that integrating oral health into ACOs is a new field, OHIP encourages MassHealth to include local stakeholders, including dental professionals as well as pediatric and adult primary care providers, and consumer representatives into all planning activities.

OHIP believes that Massachusetts must commit to a specific timeframe within the waiver for oral health integration. We recommend that an oral health integration pilot (which includes dental within the total cost of care) begin within two years. This pilot must be of sufficient duration as to allow for outcomes to be identified and measured. However, elements of oral health integration should be incorporated into the ACO design once they are sufficiently vetted and validated.

Below are the specific recommendations for oral health integration within the MassHealth ACOs, including recommendations previously submitted to MassHealth:

⁵ Health Policy Institute. (2016). *Massachusetts' Oral Health and Well-Being*. Retrieved from <http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Massachusetts-facts>

ACOs must have accountability for oral health and dental services

Oral health care is a vital part of overall health care. As such, ACOs must have accountability for dental services, which can help address unmet population need and help the overall system save money. To start, MassHealth should require ACOs to establish referral relationships and/or partnerships with dental providers and delineate accountable referral processes, with the goal of ultimately moving all dental services to risk-sharing arrangements and value-based reimbursement. This must involve an incremental phasing-in of dental services into ACO total cost of care (TCOC), with safeguards to ensure the population's service needs can be adequately met. We propose MassHealth consider a similar process for oral health integration as is currently proposed in the waiver request for LTSS integration.

Dental providers should be explicitly allowed to join ACOs and/or establish relationships with ACOs and take part in risk-sharing arrangements that align financing with better outcomes. This can occur during the first year of ACO roll-out. In order to facilitate phasing in dental services, MassHealth should incentivize oral health providers to join or partner with ACOs at the start of Year 1. This will also support ACOs to be flexible in meeting the needs of its members while helping providers transition to a new culture of integrated, collaborative care. We ask that MassHealth be more specific about the timeline of implementation of ACO accountability for dental services.

Examples:

- Several states' Medicaid innovation models have already integrated oral health care. Oregon Medicaid's Coordinated Care Organizations (CCOs) have a global budget and are responsible for coordinating all care, including medical, behavioral, and dental. CCOs are specifically required to have formal contractual relationships with dental care organizations in their region.⁶
- A number of health insurance companies have piloted oral health integration, with remarkable results in cost savings and improved outcomes, particularly for those with chronic disease. United Concordia found annual medical cost savings ranging from \$1,090 annually for members with coronary heart disease to \$5,681 annually for stroke patients that underwent periodontal treatment and maintenance. Hospitalizations were also at least 21% lower among patients with chronic disease who underwent dental treatment versus patients with chronic disease without dental intervention.⁷
- Access to full oral health benefits can be a draw for members. For example, Massachusetts One Care members report the availability of dental care is a significant incentive for enrolling in the program, with 48% of voluntary enrollees describing getting better dental benefits as a primary reason for joining One Care.⁸

⁶ Vujicic, M and Nasseh, K. (2013). *Accountable Care Organizations Present Key Opportunities for Dental Profession [research brief]*. American Dental Association and the Health Policy Resources Center. Retrieved from http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0413_2.ashx

⁷ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions. *American Journal of Preventive Medicine*, 47: 174-182.

⁸ Henry, A., Fishman, J., Gettens, J., Goody, M. and Alsentzer, D. (2015). *Findings from One Care Member Experience Survey: The One Care Early Indicators Project*. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/onecare/eip-survey-2-report.pdf>

ACO payment methodologies for dental and oral health services should be value-based and not volume-based

To develop a patient-centered model in dentistry similar to that in medicine, there must be both upfront investments to help dental providers implement the model as well as sustaining reimbursement mechanisms that are aligned with value. Dental providers, like other health care providers, should be held accountable for quality metrics and reporting. This must involve changes to the existing fee-for-service reimbursement system, creating incentives for disease prevention and health maintenance rather than procedure-based care and the treatment of active disease. These modifications should involve the use of shared savings and risk models that reward patient outcomes. There should also be better alignment of payment periodicity with established evidence-based clinical guidelines, encouraging the use of treatment protocols that are based on an individual patient's risk for oral disease rather than third party payer frequency limits.

Additionally, there is an important opportunity to help push dentistry toward using diagnostic coding, which creates greater accountability in treatment by establishing medical necessity for procedures billed. Not only would this more closely align dental services delivery with the rest of health care, but it would also enable better tracking of care quality and patient health outcomes.

Because dental visits are typically longer than medical visits, there is also great potential in dentistry to offer some services and procedures typically done in the primary care setting – for example, certain screenings, vaccinations, and patient education. Adequate risk-sharing in dentistry can support quality care and spur innovations in care delivery. ACOs that incorporate dental services may be better poised to implement such innovative models, provided that appropriate initial investments and sustaining payment models are also applied in areas such as workforce training and infrastructure development, including in health information technology.

There similarly should be sufficient investments and incentives for oral health services to be done in primary care settings, including oral health risk assessments and screening questions, fluoride varnish application, and oral health patient education. Contemplation of value in oral health and dental care must also consider incentives for greater coordination of primary medical and dental care, and special attention should be brought to establishing processes and systems for closed-loop, bi-directional referrals.

Examples:

- Hennepin Health in Minnesota is a county-based Medicaid ACO with advanced integration of dental care, including shared risk and incentives based on performance and outcomes. Recognizing potential cost savings by reducing hospital admissions for dental emergencies, Hennepin Health also created an ED diversion program that connects patients to local dentists.⁹
- Boston Children's Hospital Early Childhood Caries program uses an evidence-based disease management clinical protocol that treats patients based on disease risk. It has been highly effective in reducing caries rates in children, with significant reductions in operating room utilization, new cavities, and pain compared to a historical control group.¹⁰

⁹ Edwards, J.N. (2013). Health Care Payment and Delivery Reform in Minnesota Medicaid. *The Commonwealth Fund*. 12:1667.

¹⁰ Ng, M. W., Ramos-Gomez, F., Lieberman, M., Lee, J. Y., Scoville, R., Hannon, C., & Maramaldi, P. (2014). Disease Management of Early Childhood Caries: ECC Collaborative Project. *International Journal of Dentistry*, 2014, 327801. <http://doi.org/10.1155/2014/327801>

- The total cost of care approach in Oregon Medicaid is currently allowing Advantage Dental to pilot an innovative care delivery system that uses community-based services for prevention and stabilization. The PREDICT program identifies high-risk patients and through case management, facilitates seamless transitions to dental services by removing barriers to accessing in-office care. The program is being evaluated by the University of Washington and early indicators are very positive.¹¹

Use DSRIP funds to transition delivery system to adequately address oral health

State and federal investments in ACO development and infrastructure should consider oral health. Because of the longstanding separation between dental and medical services, thoughtful investments in network development, health information technology, and workforce development and training are particularly critical for successful integration of oral health services and necessary to encourage providers, including oral health providers, to enter into ACOs.

Much like the proposed certifications for Community Partners in Behavioral Health and LTSS integration, MassHealth should establish a similar stream for investments in oral health. Oral health should be one of the ten high priority initiatives in alignment with overall DSRIP goals. Health care workforce development and training programs should include eligibility for dental providers. One out of ten Massachusetts residents lives in a dental health professional shortage area (DHPSA)¹²; meanwhile, a significant number of dentists are approaching retirement, threatening access to dental services. MassHealth has the opportunity to help ameliorate this shortage and maldistribution with DSRIP funds.

Technical assistance offered to providers should include solutions for oral health integration into primary care practice and promote integration models already developed for safety net providers.¹³ According to recent findings from the Health Policy Commission, almost half of all preventable emergency department visits for oral health were paid for by MassHealth.¹⁴ Accordingly, MassHealth should also consider oral health when investing in new care delivery model innovations, especially when examining interventions that may result in the highest return on investment. These innovations must be flexible and meet people where they are; these might include emergency department diversion programs for oral health-related problems and/or teledentistry (notably, Paul Glassman's Virtual Dental Home model), among others. Teledentistry extends dental service access to members who may otherwise have difficulty accessing care and would utilize existing public health dental hygienists and other allied health providers to the full scope of licensure. MassHealth

¹¹ Ludwig, S. (2016). *PREDICT: Delivery System Design & Science to Reduce Oral Health Disparities in Rural Oregon* [Powerpoint slides]. Retrieved from <http://www.nationaloralhealthconference.com/docs/presentations/2016/04-20/Sharify%20Ludwig-Delivery%20and%20Payment%20Systems%20Innovations%20in%20Dentistry-PREDICT-Population-centered%20Risk%20and%20Evidence-based%20Dental%20Interprofessional%20Care%20Team.pdf>

¹² Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

¹³ Hummel, J., Phillips, K.E., Holt, B., Hayes, C. (2015). *Oral Health: An Essential Component of Primary Care*. Seattle, WA: Qualis Health. Retrieved from <http://www.safetynetmedicalhome.org/resources-tools/white-papers>.

¹⁴ Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

should enable reimbursements for off-site screening and service delivery, which would facilitate the use of telemedicine and teledentistry in ACOs.

Investments in health information technology are particularly crucial for oral health integration. Currently, electronic medical and dental health records are largely incompatible; for effective care coordination, particularly for complex and high-risk patients, bidirectional data sharing and structured referrals between primary care and dental care providers is absolutely necessary. ACOs should set standards for health information technologies that enable greater inter-professional communication.

Presently, the vast majority of Massachusetts dentists do not accept MassHealth. Incentives to help transition dental practices to adopt flexible HIT systems may have the added benefit of recruiting more dental providers to serve MassHealth patients. This is particularly opportune considering the impending requirement in state law (Chapter 224 of the Acts of 2012) for all providers, including dental providers, to adopt electronic health records systems by next year.

Additionally, the Safety Net Care Pool redesign must ensure that dental services will continue to be covered.

Oral Health Quality Metrics can help tie oral health into overall health in ACOs

We are pleased to see the inclusion of an oral health quality metric within the ACO prevention and wellness quality measure slate. We encourage MassHealth to establish this measure in accordance with national efforts to develop oral health quality metrics – e.g. the HEDIS dental measure and those from the American Dental Association’s Dental Quality Alliance – and also ensure that the measure adequately captures the incentive for primary care providers to address oral health in a comprehensive manner. For example, the U.S. Preventive Services Task Force recommends that children from birth through age five years receive fluoride varnish application, a reimbursed procedure readily done in the primary care setting and one that is easily measured. Moreover, we see the proposed metrics on avoidable utilization as another important opportunity to evaluate progress in oral health prevention in both primary care and dental settings, and ask that the final metric on potentially preventable admissions captures not only admissions but also preventable ED usage for oral health.

As dental services are phased in to ACOs, we recommend that MassHealth expand oral health quality measures to include metrics evaluating dental provider quality and access to care. These metrics should capture the needed shift toward prevention and risk-based chronic oral disease management in care delivery – which may be facilitated by eventual use of dental diagnostic codes – as well as patient experience and outcomes in dental settings. As an essential part of value-based care, oral health-related measures need to be tied eventually to shared risk and savings.

MassHealth should ensure that oral health metric development involve oral health providers and receives substantial input from the oral health and medical provider communities, including those practicing in diverse settings serving various populations. Measures established should also allow the monitoring and evaluation of care for unique populations, including children, the elderly, and individuals with special needs.

Aside from tying metrics to payment, transparency of data collected is critical for ACO oversight. Just as Massachusetts' Center for Health Information and Analysis (CHIA) publishes annual, public data on the performance of the state's health care system, MassHealth and any bodies responsible for oversight must continuously monitor and evaluate program implementation, including roll-out of dental pilot programs. This will also require publicly setting and reporting on system-wide, measurable goals such as reduced ED utilization and improved health outcomes. Any baseline data collection should be disaggregated and also include oral health data.

Examples:

- In the recently released quality metrics final report for Oregon's CCOs, the sole dental metric – the rate of dental sealants on permanent molars for children – increased by a staggering 65% in one year. This demonstrates the efficacy of tying reimbursement to a dental quality metric. Dental services are included in total cost of care and CCOs are eligible for incentive payments if they meet the benchmark.¹⁵
- New Jersey ACO gainsharing plans submitted to the Department of Human Services will be evaluated in part on whether a gainsharing plan provides funding for improved access to dental services for high-risk individuals likely to inappropriately access an emergency department and general hospital for untreated dental conditions.¹⁶
- The Massachusetts League of Community Health Centers conducted two medical-dental integration pilots programs across multiple community health centers (CHCs). Using a quality improvement approach, CHCs monitored metrics ranging from the percentage of pediatric patients asked about oral health to tracking diabetic patients' referrals to dental care.¹⁷

Oral health should be integrated into all aspects of care coordination

Case managers, community health workers, and other health care workers that coordinate care both within the ACO and with community partners should all consider oral health. These health care workers are key members of the patient care team who can and should have responsibility in supporting members to identify oral health concerns and facilitating connections with oral health providers.

Oral health should be a standard part of any baseline patient assessment or care plan developed by the ACO, MCO, or other provider. Simple screening questions asking about oral health status, oral health self-management, and dental service utilization can identify the need for oral health care. All health care team members must be incentivized to guarantee continuous quality oral health care for each patient. Oral health and dental care providers should also be considered part of the extended patient care team, and adequate, ongoing communications with dental providers must be ensured. This is especially important in light of the ongoing opioid crisis.

These aims will require ACOs to invest not only in oral health training for various team members, but also require providers to establish formal relationships with dental providers. In addition, investments will need to be made to ensure that patient assessments include questions to assess

¹⁵ Office of Health Analytics. (2016). Oregon's Health System Transformation: CCO Metrics 2015 Final Report. *Oregon Health Authority*. Retrieved from http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf

¹⁶ N.J.A.C. 10:79A-1.6(a)(1)(v).

¹⁷ Wells, S. (2016). *The Power of Integrated Care Teams in Improving Oral Health Outcomes: Lessons Learned from Community Health Center Integration Pilots* [Powerpoint presentation]. Massachusetts League of Community Health Centers.

patient oral health, and care plan formats will need to include sections that trigger the inclusion of oral health care needs.

There is also an opportunity to address oral health in community-based settings. ACOs should establish partnerships with community programs and social and support services that address social determinants of health as well as oral health; these partner organizations should include existing community-based oral health services such as school-based oral health programs.

MassHealth should include dental services in the ACO pilot program <??>

MassHealth should directly contract with dental care organizations (DCOs) similar to Oregon's Medicaid model or assist ACOs in launching pioneering dental-focused integration pilots for each proposed ACO model. To promote cost-effectiveness and efficiency, MassHealth should adjust the free choice of provider clause that has appeared in previous 1115 waiver agreements to best allow for optimally-structured dental pilots. All pilots should be introduced in advance of the full inclusion of dental services in ACO total cost of care and should also consider leveraging the expertise of third party dental benefits administrators and their knowledge in working with dental providers to ensure the adequacy of the dental provider network. Additionally, pilot programs need to be implemented and tested with significant and meaningful input from the dental and medical provider communities as well as consumers. This should include benchmarks for each pilot that are consistent across the board, and clearly defined risks that providers are assuming. MassHealth should facilitate the sharing of best practices and data collected through and at the end of the dental pilot phase in order to assist with the next stage of oral health integration roll-out.

A successful pilot that rewards providers for achieving greater patient health may have the added benefit of convincing more providers to accept MassHealth. Piloting should be conducted with diverse practices and in varied geographical settings to demonstrate efficacy of dental integration in ACOs, including with solo-practitioner private practices, and in rural and health professional shortage areas.

ACO governance, quality, and clinical committees should have representation from oral health clinicians

Dental providers, including dental specialty providers and those serving diverse populations, should be represented in ACO governance, quality, and clinical committees. Oral health practitioners, particularly those who serve vulnerable populations, represent an important voice to help ACOs ensure adequate resource allocation to populations commonly left out of the dental care system. Additionally, representation from primary care providers and pediatricians knowledgeable in oral health integration may also be helpful in ensuring sufficient consideration of oral health in ACO decision-making.

Ensure adequate consumer protections through representation and input in ACO governance bodies and advisory councils

We are heartened to see strong consumer protections outlined in the Massachusetts' waiver proposal, particularly around meaningful patient engagement in ACO governance structures. We appreciate the preservation of robust member appeals and grievance procedures as well as the establishment of a new ombudsman role to help MassHealth members who may need assistance.

Member choice of providers, including dental providers, should be protected. If MassHealth rolls in dental services, members should still have access to the full network of MassHealth dental providers.

Risk adjustment methodology should consider oral health and social determinants of health. Due to geographical differences in the availability of dental health professionals, certain populations are at exceptionally high risk. Providers serving high-risk populations, including oral health providers, should not be penalized for serving sicker patients. By the same token, there must be rigorous monitoring and tracking of underutilization where providers may be potentially stinting on care. There should be internal ACO monitoring mechanisms as well as broader MassHealth oversight, particularly for vulnerable and high-risk populations, and all public reporting required of ACOs should also include dental.

We appreciate the chance to offer our thoughts on the Massachusetts 1115 waiver proposal and ask that oral health be more prominently featured in the final version of the proposal. Fully integrated and coordinated care cannot exclude oral health, and MassHealth has the significant opportunity to lead the dental delivery system to be more patient-centered, accountable, and value-driven. We certainly understand that the integration of oral health into the rest of health care is a daunting task – one that will require much thoughtfulness in both planning and implementation. We thank you for your consideration and your leadership and are eager to collaborate with MassHealth to ensure members have access to truly whole-person care. If you have questions or would like more information, please contact Brian Rosman, Policy Director at Health Care For All, at 617-275-2920, or rosman@hcfama.org.

Sincerely,

Hugh Silk, MD MPH, FAAFP, Professor, Department of Family Medicine and Community Health,
University of Massachusetts Medical School

Lisa Simon, DMD, Fellow in Oral Health and Medical Integration, Department of Oral Health
Policy and Epidemiology, Harvard School of Dental Medicine

Michelle Dalal, Chair, Oral Health Committee, Massachusetts Chapter of the American Academy of
Pediatrics

Robyn Olson, Chair, Oral Health Advocacy Taskforce Steering Committee

Samantha Jordan, DMD MPH, Dental Director, Federally-Qualified Health Center

1199SEIU- United Healthcare Workers East

Action for Boston Community Development, Inc.

AIDS Action Committee

Better Oral Health for Massachusetts Coalition

Boston Center for Independent Living

Boston Health Care for the Homeless Program
Boston Public Health Commission
Children's Dental Health Project
Community Health Center of Franklin County
Community Servings
Disability Policy Consortium
Forsyth Institute
Forsyth School of Dental Hygiene
Harbor Health Services, Inc.
Harvard School of Dental Medicine
Health Care For All
Massachusetts Dental Hygiene Association
Massachusetts League of Community Health Centers
MCPHS University
Partners for a Healthier Community, Inc.
Tufts University School of Dental Medicine

CC: Vikki Wachino, Deputy Administrator
Eliot Fishman, Director