Resources for Integrated Care
Supporting Dental Health Care Coordination for Individuals Dually Eligible for Medicare and Medicaid
July 15, 2024

Leslie Bishop (Moderator)

Welcome everyone. My name is Leslie Bishop, and I am with The Lewin Group. I'm honored to serve as your event facilitator today.

Before we begin, we would like to orient you to the platform. Audio should automatically stream through your computer speakers. Please make sure that your computer is connected to reliable Internet and that the speakers are turned up.

If you are experiencing any difficulties with your connections, please turn off your VPN for the duration of this event. There is no phone dial in option. As always, a recording will be available after the event. Next slide.

In the center of your screen, you will see the slides for today's presentation. Below the slide presentation are resources you may download, including a PDF of today's slides along with a question window where you can enter questions for our presenters or chat with the webinar team. If you need support, our team will also send helpful messages via this window.

Closed captions are available. You can move the windows around to fit your screen. If you minimize a box and want to bring it back, you can click on the associated icon on the bottom of your screen. Next slide.

Welcome to the webinar *Supporting Dental Health Care Coordination for Individuals Dually Eligible for Medicare and Medicaid*. We are grateful for taking the time out of your busy schedules to join us today. We are looking forward to exploring the dental care needs of dually eligible individuals and learning about promising practices for health plans and providers to meet those needs. Next slide.

Today's session will include four presentations from our speakers and a moderated conversation with panelists, including the opportunity to address questions from the audience. The recording and a copy of today's slides will be available at https://www.resourcesforintegratedcare.com. Next slide.

This webinar is supported through the Medicare Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar, MMCO strives to deliver technical assistance to providers from providers. The intended audience for this webinar is a wide range of healthcare providers working with dually eligible enrollees inclusive of health plan staff.

To learn more about current efforts and resources, please visit our website or follow us on X, formerly Twitter. Our handle there is @Integrate_Care. You can also find us on LinkedIn. Next slide.

The roadmap for our time today is as follows. We will start by collecting attendee information via two polls, followed by introductions, and learning objectives. Then, we will hear from our esteemed presenters.

The first presentation is *Advancing Oral Health: An Evidence and Data Driven Approach to Achieve Better Health Equity and Fiscal Responsibility* by Dr. Natalia Chalmers, followed by our first health plan presentation *Addressing the Dental Health Care Needs of Dually Eligible Enrollees Through Benefits and Services Coordination* by the Health Plan of San Mateo. Next, we will hear about *Promoting Health Equity, Advancing Dental Health Care Quality Among Dually Eligible Enrollees Through a Quality Improvement Project* from the Upper Peninsula Health Plan and our final speaker presentation will be on *Applying a Community Collaborative Practice Model to Meet Dually Eligible Individuals Where They Are* by Apple Tree Dental. After the speaker's presentation, we will transition to a moderated conversation and dive into audience Q&A.

If you have questions, please type them into the "Question" window as we go along, and we will answer as many as we can. We will close by sharing additional resources and requesting your feedback on the information shared today. Next slide.

As noted earlier, we are pausing for two brief polls before we launch into today's presentation. The goal of these questions is to get a better sense of our audience members today. To ensure all participants are able to participate in this poll, I will read each response option aloud. To participate, you can chat in your response or click the button corresponding to your response.

You should see a pop up on your screen asking, "In what care setting do you work?" Response options include health plan, ambulatory care setting, dental practice, long-term care facility, home care agency, community-based organization, consumer organization, academic or research, or other. I'll give some time for folks to answer the question. Okay, our top two answers for "In what care setting do you work?" are "health plan," and "ambulatory care setting."

Next slide. Our second poll asks, "Which of the following best describes your professional area?" The options you may select from health plan case manager or care coordinator, health plan customer service, health plan administration or management, medicine, nursing, physician assistant, or other provider, dental health services, pharmacy, social work, advocacy, or other.

Again, I'll give just a moment so that we can see the top responses come in here. Okay, for "Which of the following best describes your professional area are health plan?" it looks like it's a "health plan case manager or care coordinator," and "health plan customer service." Thank you everyone for participating with us. Next slide.

At this time, I'd like to introduce our esteemed presenters. Dr. Natalia Chalmers is the chief dental officer for the Centers for Medicare and Medicaid Services (CMS) and Rear Admiral

(RDML) Michael Windsor Johnson is the chief dental officer for the U.S. Public Health Service. Next slide.

Dr. Carolyn Brown is the Dental Director at the Health Plan of San Mateo. Marissa Cardarelli is the Dental Benefits Manager at the Health Plan of San Mateo. Jessica Serman is the Assistant Director of Clinical Services at the Upper Peninsula Health Plan, and Dr. Michael Helgeson is the Chief Executive Officer at Apple Tree Dental. These folks have been doing incredible work to advance health equity in the dental care space, which we will hear more about soon. Next slide.

This event will accomplish the following learning objectives: understand the dental health care landscape for dually eligible individuals, including dental health care benefit structures, gaps in oral health care and services, and the effect of dental care on an individual's overall health; summarize successful dental health care benefits and services management and care coordination strategies that plans can implement to meet the unique oral health needs of the dually eligible population; articulate why and how providers and plans apply a person-centered care approach to meet the oral health care needs of dually eligible individuals; and describe dental health care equity challenges that disproportionately affect dually eligible enrollees, as well as strategies to improve oral healthcare equity. Next slide.

Now, I am looking forward to an engaging presentation on *Advancing Oral Health: An Evidence and Data Driven Approach to Achieve Better Health Equity and Fiscal Responsibility*. So, without further ado, Dr. Chalmers, I will turn the presentation over to you.

Dr. Natalia Chalmers (Speaker)

Thank you, Leslie, and welcome to all of you to our webinar. Next slide, please.

It is my pleasure to welcome you to a topic that's near and dear to my heart and I think the best place to start is to review the programs that we have and how many of them impact 156 million people. You can see on the little bubble on the very left in Medicaid and CHIP (Children’s Health Insurance Plan) we have close to 85 million enrollees, in Medicare around 66.8 million and in the marketplace 16 million. And of course, we're here to talk about the overlap between those who are dually eligible both for Medicaid and Medicare. Next slide, please.

The CMS vision is that we serve the public as a trusted partner and steward dedicated to advancing health equity, expanding coverage, and improving outcomes. You can see all of our strategic pillars listed as we move the work forward, including in oral health. Next slide, please.

CMS has launched multiple cross-cutting initiatives that are multiyear cross-center initiatives that focus on different topics such as maternity care, behavioral health, rural health, and last year we launched the *Oral Health* cross-cutting initiative where we will consider all opportunities to expand access to oral health coverage using our existing authorities and health plan flexibilities. As we know, access to oral health service is an important piece of whole-person care. Next slide, please.

Let's start by asking a really important question, “How many people in a given state, children and adults together, are enrolled in Medicaid?” You can see from this map that there is a huge geographic variation in the number of children and adults enrolled in Medicaid that can range from 13 percent, all the way to 40 percent. Next slide, please.

First, you will see that that looks very different if you only ask the question, “How many of the children are enrolled in Medicaid?” You can appreciate that in some states that could be up to 80 percent of the children, and in some states in the yellow can be as low as 25 or 50 percent of the children. In the next slide, we will see what that percentage looks for adults. Thank you.

Here for adults, you see huge geographic variation of the proportion of the population enrolled in Medicaid. In some states this could be six to 12 percent and in other states as high as 34 percent of the state population. It's important to remember that those who are dually eligible for Medicaid and Medicare also represent a different proportion of the Medicaid population in the state. Next slide, please.

This map portrays the geographic variation of the percent of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid. You can see that that varies dramatically from states; in one state it can be four percent and in others up to 18 percent of all who enrolled in Medicare and Medicaid. Next slide, please.

When we talk about access to oral health and services, it is important to consider where people present with oral health needs. If you look at the diagram on your left, where we represent the dental delivery system, we have many patients who go on a regular basis, have established dental homes and have ongoing care. We also have those who occasionally seek care when there is an emergency. But when people don't have access to the dental delivery system, they can present for dental needs in the broader healthcare system, for example, in the emergency department, again an ongoing basis, on the bottom with the returning circles only a single time.

Sometimes they need to be seen for addressing their oral health needs in an ambulatory surgery center or urgent care. I have put here the schools and arenas because that's also a point of care where we understand the oral health needs of the beneficiaries. I want to highlight that these two systems, the dental delivery system and the broader healthcare system, there is a huge health information and technology divide that makes the integration and coordination very challenging.

In the next couple of slides, we'll look at the expenditure for oral health services nationally, and more specifically to the programs administered by CMS. Next slide, please.

You will see that dental spending in 2016, represented with the little triangle. It accounts for about four percent of the expenditure that year. While the overall numbers have changed, dental still remains about 3.94 percent of the national healthcare expenditure. It's really important to put that in the context of other expenditures, such as hospitals or physician services or prescription drugs.

I've highlighted with the red box the out-of-pocket spending, and we will talk at the end of the session about out-of-pocket spending for dually eligible. But, just to highlight that right

from the get-go for physician and clinical clinician services, the out-of-pocket spending is usually below 10 percent and for dental, around 40 percent.

In the next slide, you will see the summary of the healthcare spending across the systems. In total between the programs at CMS in 2021, we had $22.5 billion in expenditure. The dotted lines are private health insurance spending and out-of-pocket, corresponding to the y-axis on the right, and the solid lines correspond to the y-axis on the left. Of note, we all felt the impact of the COVID pandemic in 2020, so that's the dip. But, all the public and private spending has increased in 2021. Next slide, please.

Of course, debt spending by healthcare condition varies dramatically in terms of the top priority conditions based on public insurance, private insurance, and out-of-pocket expenditure. If you notice, the top five priority conditions by spending in the public insurance space include diabetes, hypertension, back pain, and you can see that some of them overlap with those in the private insurance. For example, diabetes is still in the top five, but if you focus on where the yellow arrows point, that's the spending for oral health, well care, and also treatment. You will see that in the public space that spending is in 34th and 47th categories.

So, they had to shrink the scale in order for it to fit. Where, in the private insurance spending, it's about eleven and twelve and it's number one and two in the out-of-pocket spending. This is just to highlight that there's differences in access to care that translates in differences in utilization of dental services.

We know that the patients with diabetes don't only have diabetes. In the next slide, I will show you that if we ask that question for Medicare beneficiaries living in the community. We can appreciate in the red rectangle that only three percent in blue of Medicare beneficiaries fee-for-service who live in the community have only diabetes. The remaining 97 percent have diabetes and something else, and 41 percent have five or more other chronic conditions. That reflects the complexity around coordination of care, et cetera.

The next slide reflects the progress we have made in access to dental services. If you look at the bar on the left for children, we have made great progress in closing the gaps between children living below the federal poverty guidelines and those living above 400 percent of the federal poverty guidelines. In the middle, you see that there basically has been no change for adults and for seniors 65 and older, there is an increase in the gap. Next slide, please.

But the reason why we're here is to recognize that for seniors who have had a dental visit in the previous year, there are significant racial disparities that exist based on race and ethnicity in access to dental services.

We've looked at this more closely in the next slide, and you will see that these racial disparities are also reflected in the first set of yellow bars where we compare access to dental services for Medicare beneficiary by race and ethnicity. The second set of yellow bars compares that by income. So, lower income, less access, higher, more access.

The next graph chart is a little complicated, but I want you to have it as a point of reference if we talk about the challenges with access for the dually eligible. So, read on the very top.

These are the people in Medicare who have private coverage. They could be non-dually eligible and have Medicare Advantage. They could be dually eligible and have Medicare Advantage. They could be dually eligible and have dental through Medicaid, or they could be dually eligible and don't have dental through Medicaid. If you read the top row, you will see that those that have private coverage have the highest access and the dually eligible through Medicare Advantage or through Medicaid, about 20 percent, 19 and 21 percent. There are huge racial disparities even in those that have private coverage.

As I mentioned to you, and you'll see that in the next slide, there are significant challenges with the out-of-pocket spending, and this is for all Medicare beneficiaries. If we ask, "What is the proportion of out-of-pocket spending for dental services or other services?" You see, for example, that in a given year a Medicare beneficiary spends around $4,000 for prescription drugs, and out of that they pay about $554 out-of-pocket. If you do that comparison, dental comes in as the second most expensive out-of-pocket expenditure, close to 66 percent. Hearing is the first at 80 percent. So, that's a known barrier to access to dental services. Next slide, please.

Look at the middle bar, and that is the dually eligible. And we're asking how many of the beneficiaries have trouble eating solid food, have lost all of their teeth, or have chronic tooth pain. And in the left, you will see the overall distribution, noting that the dually eligible have the highest proportion of those who have trouble eating, the highest proportion of those who have lost their natural teeth, or have pain. And on the right, you have that breakdown by age, where on the top is under 65 and in the bottom is the beneficiaries that are 65 and older. Just noting the big differences between those that are dually eligible in the middle bar versus those that are not dually eligible. Next slide, please.

We've also asked how many of the beneficiaries in the Medicare current beneficiary survey, a great resource managed by OEDA (Office of Enterprise Data and Analytics). Here in our centers in OEDA, we have asked, "How many of them have difficulties, how many of the beneficiaries have difficulties eating solid foods?" And, you can appreciate that there are significant racial disparities in addition to disability. If they have more, one or two more conditions, that they have harder time eating solid foods, or on the right, 32 percent of Medicare beneficiaries with income less than $25,000 actually have lost all of their natural teeth. And that has huge implications on how they manage their chronic conditions and overall health.

On the next slide, I will show you association with known conditions and overall health, and you have this as a resource. You can dive deep into the data, but just to appreciate that those who have lost all their natural teeth or have difficulty eating or have chronic tooth pain usually tend to have poor overall health. And then they also, in terms of the number of chronic conditions that are managing, that also impacts these oral health outcomes. The next slide shows association between these three and known chronic conditions. And again, this is an association, not a causation. Just to highlight how challenging it could be for many of the dually eligible to manage their underlying chronic conditions. Next slide, please.

We've also recently asked of what type of services they have, and here the coverage is reflected in the first column where again you have private coverage, non-dually eligible through Medicare Advantage, dually eligible for Medicare Advantage, dually eligible for

Medicaid, and no dental coverage, and we ask in the last year, "Did you have a dental exam?" "Did you have a cleaning?" "Did you have an x-ray, filling, or extraction?" And you would know that those with private coverage have had the most dental exams. With cleaning, the colors reflect the intensity, so the higher the darker the color. And those that are dually eligible with dental access through Medicaid or Medicare Advantageous has low access to preventive services, cleaning, and x-rays. Next slide, please.

I've also mentioned that the out-of-pocket spending is really different across groups based on their coverage. And here you see in the very light green, those that have had no out-of-pocket expenditure. In the darker green, those that have spent $1,000 or less, and in the darkest grain, those that have spent over $1,000. And, if we focus on the category of dually eligible either through Medicare Advantage or through Medicaid, you will note notable differences compared to the total distribution of out-of-pocket spending or those without coverage and those with private coverage on the non-normally eligible accessing dental services for Medicare Advantage where dental is a supplemental benefit. In the next few slides, I will review the current changes in the physician fee schedule in cycle 2024 that relate to dental and oral health services. Next slide, please.

In the law, under section 1862(a)(12) of the Social Security Act, there is a provision that prohibits the payment for dental services for expenses such as services in the connection with the care, treatment, filling, removal, or replacement of teeth, with a minor exception when this is in the case of an inpatient hospital service and the underlying medical condition is impacted. Next slide.

In the physician fee schedule 2023, we clarified and codified all aspects of previous Medicare fee-for-service payment for dental services. We also codified payment for dental services that are inextricably linked to other covered medical services, such as a dental exam and the necessary treatment prior to organ transplant, including stem cell and bone marrow transplant, cardiac valve replacement, and valvuloplasty procedures. A very important step forward is that we establish a process to review and consider public submissions for potentially analogous clinical scenarios under which Medicare payment could be made for dental services. And we said in 2024 we will consider payment for dental exams and treatments prior to head and neck cancer. Next slide, please.

In calendar year 2024, we were building on our efforts and clarified that when it comes to head and neck cancer, we mean both primary and metastatic. We also included a clarification that when it comes to head and neck cancer, we're considering access to dental services prior to, contemporaneously, with or after the head and neck radiation.

And we also propose to permit payment for dental services inextricably linked to chemotherapy services, CAR-T (chimeric antigen receptor thymocyte cell) therapy, and the use of high-dose bone modifying agents. Next slide, please.

We work very closely with our sister agency, AHRQ (Agency for Healthcare Research and Quality) to review the evidence, and these are all reflected in the rule where there is evidence to support the inextricable linkage. We were able to expand coverage and in areas where there wasn't, for example, with the implantable cardiovascular devices on the right, we were not able to do so.

The next slide highlights the fact that for the first time in the history of the Medicare program, all dental specialties now can enroll to become Medicare recognized providers.

Thank you very much for your attention and I look forward to what promises to be a fantastic webinar. Leslie, back to you.

Leslie Bishop (Moderator)

Thank you for sharing these valuable insights, Dr. Chalmers. I'd like to remind our audience that questions for our panelists can be entered into the question window. We'll now be hearing from our presenters from the Health Plan of San Mateo, Dr. Carolyn Brown and Marissa Cardarelli, please take it away.

Marissa Cardarelli (Speaker)

Good afternoon, everyone, my name is Marissa Cardarelli and I will start going through the first half of the slides. You can go to the next slide, please.

Okay, so a little bit of background on Health Plan of San Mateo, which I will refer to as HPSM. We are a community-based health plan serving more than 160,000 Medi-Cal, that is Medicaid, eligible individuals in San Mateo County, California. This number includes one in five county residents and nearly 9,000 individuals who are dually eligible for Medicare and Medi-Cal. HPSM provides enrollees with tailored care and comprehensive support services to meet each individual’s specific and diverse needs. And at HPSM, we do strive to foster self-sufficiency and improve the overall quality of life for our enrollees. Next slide, please.

Care Advantage is HPSM's dual eligible special needs plan, or what we refer to as D-SNP, and we contract with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. It helps individuals manage their care by covering the cost of health care services and prescription medications; offering access to an extensive provider network including providers, primary care providers, dentists, specialists, clinics, pharmacies and hospitals; assisting members to identify additional healthcare services that, based on the unique circumstances they need and have coverage to obtain, such as behavioral health and long-term services and support; and providing care coordination services enabling stronger collaboration to achieve their health goals. Next slide.

A little bit of our policy history and our dental landscape for dually eligible enrollees in 2018, the state established a dental integration program in San Mateo County. It sought to understand how funding coordinated dental services through Medi-Cal affects oral care access, quality, utilization, and medical costs.

California then transitioned its Medi-Cal-funded dental services from fee-for-service program, or what's known now as Medi-Cal dental, to a managed care delivery system in 2022. HPSM Dental is San Mateo County's dental plan for Medi-Cal enrollees, integrating care benefits and prioritizing both oral and overall health. With this, we are leveraging best practices to improve enrollees’ overall health. HPSM Dental includes dentists, doctors, and specialists in the same network to enhance providers ability to make referrals and coordinate care, and annual dental visit rates for HPSM dually eligible enrollees increased from 28.8 percent in 2022 to 33 percent in 2023. Next slide, please.

Now, regarding our dental benefits structure for services through HPSM Dental, Medi-Cal enrollees can obtain all covered medically necessary dental services without restrictions and dental access coordination services like care coordination, referral management, transportation, and integrated case management to assess how current medical conditions and medications affect oral health.

For example, diabetes might increase risk of gum disease, and blood thinners might cause excessive bleeding during dental procedures. Regarding fees, HPSM modified service costs based on national reviews of similar dental plans, aligning fees to other Medicaid programs. For authorization requirements. HSM applies a streamlined approach to review authorizations, efficiently reducing administrative burden. Next slide, please.

A little bit more about our benefit structure. In 2023, we rolled out our first benefit update and with this we allowed for more scans for restorative treatment planning, like CBCT (cone-beam computed tomography) scans. We allowed for additional prophylactic treatment up to two times per year for adults aged 21 and older. With Medi-Cal dental this is only allowed every twelve months for a profi [prophylactic treatment]. We also allowed for greater preventative procedures and frequency and more generous allowance for denture or partial denture replacement. For crown buildup, HSM permits for providers to bill separately for this service. Full mouth debridement, which was only allowed in skilled nursing facilities, is now allowed with all dental providers and enrollees residing in nursing facilities or intermediate care facilities are eligible for additional services. Next slide, please.

And then a little bit about our dental pilot [program] scope and key goals one of our key goals is to improve provider supply. Many HPSM enrollees had inadequate preventative dental care through Medi-Cal dental or with the Denti-Cal due to insufficient networks of nearby dentists and long wait times for appointments. The solution is to expand access by growing our local provider networks, specifically for specialists like oral surgeons and endodontists.

We do plan to enhance integration. HPSM's pilot [program] fully integrated dental services with medical and behavioral health care benefits, improving access to care and clinical outcomes. [HPSM's pilot program] applies a person-centered approach by, coordinating care across medical and behavioral health providers, prioritizing services to enrollees with the greatest needs like those needing medically necessary restorative care, and redesigning the administrative workflow by partnering with credentialed dental specialists through a referral matching system to assist enrollees that need advanced dental care and streamlining the authorization and claims processes to reduce burden on providers and administrative staff. Next slide, please.

Here this is a timeline of our of HPSM's start from the legislative to where we are now. HPSM medical-dental services transitioned from fee-for-service to managed care beginning January 1, 2022. HPSM and Department of Healthcare Services, or DHCS, work closely together to detail the following components over implementation of dental services within our managed care delivery system. These components include improving member services supports, expanding dental provider network contracting and relationships, develop referral coordination, streamline claims reimbursement, and integrate with primary healthcare benefits and support care coordination. We are currently in the last phase in July of 2024,

where we are planning our benefit updates to go live in September of this year. I will go to the next slide and pass it to Dr. Brown.

Dr. Carolyn Brown (Speaker)

Great. Thank you, Marisa.

Since Health Plan of San Mateo has been planning our launch, which again started in January of 2022, a person-centered approach has been first and foremost within our internal operations and in working with our enrollees and providers externally. One of the things that we really believe is that person-centered care will be improved and will improve integration. We've seen from the past that when dental is separated from medical and behavioral health, providers have a difficult time helping enrollees connect with all of their needed care, and enrollees themselves oftentimes come to dead ends.

By taking an integrated approach between dental, medical and behavioral health, we think that we can better coordinate and communicate. And we know that we're referring enrollees across a broad range of services. You'll see in a few slides how we've built infrastructure to be sure we're doing so.

It also creates a community support system that is essential, particularly in San Mateo County, California. We improve our care coordination through our staff that connects our enrollees themselves or their authorized representatives, also our dental providers and our primary care providers, to ensure that our enrollees obtain the appropriate and necessary care. As we enhance access to and improve the quality of care, we know we'll see improved health outcomes. Next slide, please.

Benefits of the person-centered approach include leveraging community engagement, and this voice of the community has been essential to us as we've taken a co-design approach of our Health Plan of San Mateo dental oral care benefits from the inception. We focus on member engagement and customer services by curating a provider network to meet the needs of all of our dually enrolled enrollees as part of San Mateo County's Oral Health Coalition.

The Health Plan of San Mateo's dental enrollees offer the coalition direct feedback about their experiences, including access barriers, and we hear from a wide range of our community, both through our member services and also through participation in our oral health coalition. And in turn, our network of dental providers offer feedback directly to the Health Plan of San Mateo by participating in our Dental Advisory Group. Based on our enrollee feedback, we've added dental specialists to our provider network to expand access to oral surgeons and endodontists in particular, and we also help with referral coordination to these providers since we have intimate knowledge of their hours of operations, their areas of specialty within these specialties, and have knowledge of transportation to and from these offices.

Our enrollees' contracts prompted HPSM to contract with clinicians who can provide services who are homebound, who reside in skilled nursing facilities, or who are in a wide variety of other contractual relationships. HPSM also plans to incorporate enrollee education

about services included in their dental benefit packages, how to access dental care consistently, and how to manage oral care at home. Next.

HPSM's dental provider pilot [program] really has looked at provider access expansion. We've increased enrollee dental benefits and service utilization by providing access to a comprehensive provider network across the Bay Area, concentrated in San Mateo County that includes a full range of general dental practitioners and specialists. HPSM also supports provider access expansion by using alternative models of care such as tele-dentistry. This enables convenient access to dental visits via the phone or video, expands healthcare accessibility for members and their families unable to attend in-person visits, and it also increases our providers ability to offer advice and consultation remotely, which might reduce the risk of contagious illness. Next, please.

Lastly, the HPSM dental referral matching system. This is our internal system that we've launched, and it helps to integrate comprehensive coverage across a diverse network of primary dental and behavioral health providers to meet enrollees needs.

For instance, for referrals to primary care or behavioral health providers, our enrollees contact a single system to connect with the care they need. Our staff are available to answer questions throughout the processes and use our referral network system to be able to log and track our referrals for our dually eligible care advantage enrollees HPSM incorporates dental service referrals into the care coordination program. This integration allows our case managers to optimize our enrollees benefit utilization and make sure that they're receiving timely and appropriate care.

If a dentist must refer an individual to a specialist, the dentist contacts HPSM's care coordination line for assistance in locating a provider, and HPSM makes the referral. If the member has a primary medical condition with implications for their dental health, HPSM case managers and referral coordinators help to collaborate to secure the referrals necessary. Enrollees that need to visit an HPSM general dentist or a specialist, or who are struggling to access care can contact our team and we will help reroute them to an appropriate provider. Next.

HPSM is looking forward to continuing our dental pilot. We have several ongoing opportunities to serve our enrollees. We provide access to dental services for our enrollees with special needs. In particular, we have built systems and brought on providers who can provide services to the homebound, to individuals with intellectual and developmental disabilities, and individuals who are in a broad spectrum of short-term or long-term care facility. Our population health needs assessment helps identify additional ways to improve services for our enrollees. HPSM Dental improves access by providing transportation services as well as other ancillary services to and from healthcare visits.

We recognize the need to address additional clinical needs of the dually eligible enrollees and continue to look at both short-term and long-term dental health outcomes. I'm passing it along to Jessica.

Leslie Bishop (Moderator)

Yes, thank you so much for sharing those promising practices Dr. Brown and Marissa, we will now hear from our presenter from the Upper Peninsula Health Plan. Jessica, please go ahead.

Jessica Serman (Speaker)

Good afternoon and thank you. Next slide.

Just a little background on Upper Peninsula Health Plan. We're based in Marquette, Michigan (MI), in the Upper Peninsula. Upper Peninsula Health Plan is a managed care and provider services organization serving all 15 counties spanning about 16,000 square miles of Michigan's Upper Peninsula. UPHP supports this community by partnering with providers, employers and community groups that share a passion for building a healthier Upper Peninsula.

Our network includes 4,040 providers and 280 facilities, such as hospitals and home health and hospice agencies. We serve just over 55,000 enrollees, approximately 4,800 of whom are dually eligible. Through Michigan's Medicare and Medicaid Financial Alignment Initiative (FAI) demonstration project, MI (Michigan) Health Link, UPHP partners with a dental benefits organization to provide in-network benefits to all dually eligible individuals across the service area.

UPHP also leverages these partnerships to offer dental services to our 17,000 other members through the Healthy Michigan Plan, which is part of Michigan's expanded state Medicaid plan. Next slide, please.

In April of 2023, the Michigan Department of Health and Human Services also expanded its state-level adult Medicaid benefit dental benefits to health plans, which impacted our network. In 2022, the MDHHS tasked the state's MI HealthLink plans to identify health equity measures and strategies to improve measure performance for dually eligible enrollees through four-year quality improvement projects (QIPs).

UPHP selected dental health disparity reduction as the focus of its QIP. UPHPS QIP Workgroup is led by UPHP Clinical Services Manager for Quality Management, the Clinical Services Assistant Director, the Quality Information Coordinator, and the HEDIS (Healthcare Effectiveness Data and Information Set) Program Senior Lead. Next slide, please.

In the first step for selecting our quality improvement measure, we worked to consider the following criteria. Our topic needed to align with validated, reliable, and standardized quality reporting systems, and we needed to select data on a topic measure that could demonstrate statistically significant disparities with a large enough sample size to identify meaningful differences. To examine disparities between eligible American Indian and Alaska Native (AI/AN) and White enrollees, UPHP analyzed claims data to assess utilization differences within the annual dental visit measure. UPHP's goal in this QIP was to ensure accessibility inclusivity of dental care across dually eligible enrollees. Next slide, please.

In the next step, we defined our QIP aim questions, which was, "Do targeted interventions eliminate existing *Annual Dental Visit* disparities between American Indian and Alaska Native and White MI HealthLink enrollees?" And if yes, "Is the disparity reduction statistically

significant and attributed to improvements among the American Indian and Alaska Native group, ensuring that we did not reduce annual dental visits among the White comparison group?" For inclusion criteria, we identified enrollees who were American Indian, Alaska Native, or White and were continuously enrolled during the measurement period. The only members excluded were enrollees receiving hospice care. Next slide.

For our performance indicators, we selected the elimination of statistically significant differences between indicator one and indicator two for annual dental care. Indicator one was *Annual Dental Visit* for UPHP American Indian and Alaska Native MI HealthLink enrollees between January 1 and December 1 of the measurement year and indicator two, *Annual Dental Visit* for UPHP White MI HealthLink enrollees between January 1 and December 1 of the measurement year.

For step five, ensuring we had valid and reliable data collection, we ensured that the data and measures were valid and reliable. We selected the FAI demonstration-specific measure, annual dental visit, to do just that, the project used claims and encounter data and the new PHP estimated that the administrative data set was 99.4 percent complete. And for step six, our indicator results in 2022, we used 2021 as our baseline measurement period, and in 2022 we did note that there was a statistically significant difference between the rates.

Moving into our improvement strategies in year one, which was 2022, UPHP leveraged a survey that was done in 2019 for our dually eligible enrollees and developed an updated enrolling survey to ascertain intervention effects. We completed outreach to all of our American Indian and Alaska Native dually eligible enrollees with new surveys to collect population specific data on barriers to care and implementation of improvement strategies. Barrier analysis found some key barriers to care. Twenty-eight percent of our respondents reported having dentures or lack of teeth and indicated that they didn't understand the benefit of dental care for personal dentures. Twenty-six percent had no interest in receiving dental care from a dentist. Fifteen percent noted inadequate geographic access to providers.

Based on this analysis, UPHP developed its 2023 strategy to address enhancing culturally sensitive educational materials, denture care, transportation support and exploring opportunities to leverage the network which turned out to be for us identifying co-located medical and dental facilities. We initiated work group meetings with our dental PO (program office) representatives, including an American Indian dental outreach specialist, and we convened ongoing meetings to collect feedback from indigenous dentists serving American Indian communities to validate the scope of the work. Next slide, please.

Moving into year two, which was 2023, UPHP initiated partnership outreach by identifying tribal medical centers with co-located dental clinics. We engaged the dental clinics in enrollee outreach. We were able to share lists of enrollees who had not received dental care from the dental clinics. UPHP and the dental clinics then called all enrollees to schedule appointments. We developed tailored, culturally appropriate communication campaigns. We analyzed new provider-identified barriers which found that there was long wait times for dental visits.

Some offices reported enrollee wait list numbering in the hundreds, shortage of dental care providers, and some offices stated that they had unique criteria for scheduling dental care

visits, such as dedicating only an hour a day a week for scheduling appointments. As we moved into year three, 2024, we continue to provide continued provider partnerships and outreach to enrollees, we're engaging clinics and alternative payment models to financially support additional dental treatment space for American Indian and Alaska Native MI HealthLink enrollees, and we're performing outreach with the goal of engaging members in dental care and assessing for any new barriers. Next slide, please.

Our MI HealthLink quality improvement project is ongoing. Some initial observations indicate success. We're forging new partnerships with local tribal facilities, which we hadn't done in the past. We're seeing our provider offices actively engaging with the plan as a result of the outreach efforts. We've created culturally targeted communications and entering and reaching our enrollees. And, enrollees are engaging with the MI HealthLink quality improvement project by completing social determinants of health and health screening. Next slide, please.

Some enrollee engagement improvements we've seen: UPHP and dental clinic telephone outreach has successfully engaged 45 percent of the enrollees we've contacted, our interventions resulted in a 50 percent increase in enrollee engagement and of the enrollees that we reached, 24 percent are engaging in dental network benefits and education.

In 2024. The quality improvement project is focusing on both providing enrollees with timely access to dental care and measuring the impact for provider offices. In 2023, we noted long wait times for scheduling that impacted our initiative, but the practices in 2024 are now reporting that a majority of the members that are on the care lists that we have supplied have been seen or scheduled to be seen in 2024. I will turn it over to the next presenter.

Leslie Bishop (Moderator)

Thank you for telling us about the plan's impactful work, Jessica. I'd like to remind our audience once again that questions for our panelists can be entered into the question window. We will now hear from Dr. Helgeson from Apple Tree Dental. Dr. Helgeson, the floor is yours.

Dr. Michael J. Helgeson (Speaker)

Thank you. Thank you so much. I'm really excited to talk about *Applying a Community Collaborative Practice Model to Meet Dually Eligible Individuals Where They Are*. Next slide, please.

I'd like to begin with a little background on Apple Tree Dental (Apple Tree), which is a nonprofit organization that provides preventive oral health care and treatment to diverse clients of all ages, abilities, and socioeconomic status. Our mission and vision are to overcome barriers to oral health and services by fostering partnerships that create healthy communities. We achieve this by applying a patient centered model of care, using specially trained dentists and multilingual staff, delivering education as well as preventive and restorative dental services to underserved populations, and providing leadership and innovation to help transform the healthcare system.

Apple Tree has been nationally recognized for its mobile dental care delivery model, including delivering on site dental care to individuals with limited access to care, such as older adults in assisted living or long-term care facilities, and adults with disabilities and group homes. Next slide, please.

Apple Tree is committed to justice, equity, diversity, and inclusion, which is essential to its mission. Apple Tree operates nine centers for dental health in Minnesota, which you can see enumerated in the map, including five that are located in rural areas with fewer than 3,000 residents. Each year, we provide services to more than 40,000 individuals, including about 6,500 of whom are dually eligible. Next slide, please.

Our model is called *Community Collaborative Practice*, which is collaborating to deliver oral health services where people live, go to school, or receive other help and social services. It's fundamentally interprofessional, so it's actively engaging with local health education and social services professionals to design programs with individuals and stakeholder input. It integrates dental care delivery with behavioral and medical care to create healthcare homes. It leverages local community expertise and financial resources to launch and sustain programs in local communities. It's also engaged with health professional education, and we offer a wide variety of interprofessional clinical rotations for students in the health professions.

Over the years, with Apple Tree's guidance, we've worked with several organizations in different states, including educational institutions, other nonprofits, community health centers to replicate aspects of our program in North Carolina, Louisiana, Texas and California. Next slide, please.

Community partners are really key. Today, we collaborate with about 200 organizations, including assisted living centers and nursing facilities, to serve dually eligible older adults. We engage with community leaders to help design, fund, and sustain local programs. These are just a couple examples. Working with the Mayo Clinic and its foundation to develop a mobile elder care program, the first in Rochester and then a center with a mobile program in Fairmont, Minnesota, where we have a center co located with the Mayo Clinic in that rural community. Another example is a health plan that we partnered with to create a brand-new center for dental health located in Little Falls, Minnesota, in collaboration with a Catholic hospital. We've worked at various cities to raise funds, including tax-exempt bonds issued for building new critical access dental clinics. We've worked with various county public health agencies, state agencies and others to raise funds for staff recruitment and other expansion expenses.

Another key is our interprofessional board of directors, which is the governing organization for Apple Tree. It reflects that same cross-sector expertise to foster partnerships and create healthy communities. We've had experts in nonprofit governance, clinical medicine, public health, epidemiology, dental education, long-term care, et cetera, as you can see on the list. With that kind of expertise, we're able to form partnerships and build new programs. Next slide, please.

So interprofessional teamwork from the board on down is really a key to Apple Tree's model. And we have six innovation teams that work internally to analyze and improve our clinical

programs and services, and externally with all of our community partners to redesign the where, how, what, and who of oral health service delivery occurs to meet diverse needs across the lifespan.

Just a couple of more details. We have eleven board members and we have a paid staff of about 290 individuals, and they have expertise in geriatrics, which is sort of the subject of today, but also pediatrics, dental therapy, public health, and more, as you can see in the list. As I mentioned earlier, we're actively involved in collaborations with dental education and other educational partners on interprofessional rotations where they can learn how to work with others across dental, medical, behavioral health, and so on. And we're also involved in public policy, leadership, and advocacy. Next slide, please.

Building person-centered dental care systems is integral to our philosophy of care. We want to meet people literally where they are both physically, but also in terms of their expectations and their needs, and then provide care in trusted environments, whether they're through our mobile programs or in our clinics and Centers for Dental Health.

We currently deliver on site care to older adults who live in approximately 100 assisted living, long-term care, and skilled nursing facilities across Minnesota. Bringing the care directly to patients overcomes physical and transportation barriers. It facilitates direct, on site interprofessional care in a trusted environment with the entire senior caregiving team. It allows individuals to receive in our model the full spectrum of care, all the way from checkups, cleanings, and fillings to more complex procedures like root canals, extractions, new dentures, and more, without the cost and all the other barriers to traveling to a dental office. We also extensively use tele-dentistry to develop treatment plans with individuals and caregivers remotely, and to help optimize all the planning when in-person visits, either mobile or to our clinics, are needed. Next slide, please.

We have 39 years of experience delivering mobile and on-site care in these various settings and leveraging all the skills of our team members. We've developed some unique oral health workforce models, including deploying hygienists remotely in these various settings where they can do admission screenings, they can complete the oral and nutritional sections of the minimum data set for nursing home and swing bed providers, and they can prepare individualized daily mouth care plans for the nursing team.

We also have dentists and dental therapists, and for those of you that aren't familiar with dental therapists, they are the “nurse practitioner,” of the oral health world. They've been in Minnesota for over a decade, they have master's degrees, and they have training equivalent to a nurse practitioner. They work directly with their supervising dentist and the rest of their team, and they can provide the core of dental primary care. They can work with physicians and nurses, physical and occupational therapists, and other staff in these various settings.

We also are recognized for our expertise in the field of Special Care Dentistry, which is defined there in the footnote. And we work with behavioral health professionals providing on site care in group homes. We have a program where we're integrated on a mental health campus where we provide dental homes and structured work sites for people with disabilities.

And then we have specially trained teams that work in our clinics, which are called Centers for Dental Health. We use collaborative behavioral techniques to help make routine dental evaluations possible, often avoiding the need for sedation or hospital-based care. But when those more advanced services are needed, then we have teams and specialists that are able to provide that level of care, including outpatient anesthesia services, which cost a fraction of providing those services in hospital settings. We also have collaborations with several hospitals where we provide hospital-based care when that's needed. Next slide, please.

One of the themes we've heard throughout the day is integrating dental care with medical primary care and all the benefits that accrue when primary care includes oral health care, frankly. And so, we're excited to be part of the Primary Care Collaborative's publication, and the link is available there, with a vision for how to better coordinate integrate care. And this is especially beneficial for people that are dually eligible. Three of Apple Tree's nine centers for dental health are actually located within rural hospitals and primary care campuses. In those settings, community dwelling older adults in those rural communities can come in and receive coordinated care, really across more than just primary care, but also emergency, urgent care, and primary care. Next slide, please.

One of the unique things about Minnesota is that we've had managed care organizations involved with our Medicare and Medicaid program for more than 30 years. Dually eligibility, older adults in Minnesota have been enrolled in these managed care organizations that manage medical, dental and other health services, including transportation to healthcare visits for both community dwelling and institutionalized enrollees. They provide a host of care coordination services, as we've heard in the other examples, to help individuals and providers navigate enrollees' healthcare needs. Because managed care organizations (MCOs) don't have separate medical and dental funding silos, they do have the opportunity to move towards value-based care that rewards savings in total healthcare spending. We've heard, again, some great examples of that before this presentation.

Apple Tree is designated as a critical access dental provider by the Department of Human Services, and we have that designation for all of Minnesota's MCOs, and we provide care to their older adult enrollees. MCOs have also directly funded various special care dentistry programs and services designed to meet the diverse needs of dually eligible older adults. Next slide, please.

One example of that is a pilot project that we've launched, and Minnesota's program for dually eligible [enrollees] is called Minnesota Senior Health Options. It's a set of benefits within a single MCO-managed program. And Apple Tree has launched a pilot in that program with an integrated D-SNP to improve oral health outcomes by increasing dental service use. Under this pilot, Apple Tree engages older adults upon enrollment who are not currently utilizing dental services.

From the point they get enrolled, we add a set of services. It begins with asking five simple questions in a survey called the Oral Health Impact Profile Five (OHIP-5). OHIP-5 is what it's called, five simple questions that provide a validated research tool that gauges the unmet need for oral health services and helps prioritize which patients need more immediate help getting into a dental office. We combine that with the use of tele-dentistry, as was discussed a little earlier, where we can connect for their first connection, right where they live without

the need to travel, and then we can do matchmaking to connect individuals to dental clinics and/or mobile programs for the follow up care that they need. We're just in the middle of this project and I looked forward to talking about it more in the future.

Thanks so much for the opportunity to be part of the presentation today, and I look forward to the Q&A and the discussion.

Leslie Bishop (Moderator)

Thank you for that engaging, informative presentation, Dr. Helgeson. We will now move into our panel conversation focusing on *Tackling Dental Health Care Challenges* and address audience questions. I'd like to remind our audience once again that if you have a question to please enter it into the webinar question window and our team will include it in the queue of questions. Should we receive many audience questions, we want to welcome you to stay on beyond 4:00 P.M. eastern, but not to exceed 4:15 P.M., if your schedule permits.

As a reminder, a recording of the webinar will be available on the RIC website. I would like to welcome RDML Johnson to facilitate the panel discussion and audience question and answer session. We are thrilled to have him joining us today. Rear Admiral Johnson, would you like to say a few words before we get started?

RDML Michael Windsor Johnson (Session Facilitator)

Yes. Welcome, again, to the 2024 webinar *Supporting Dental Health Care Coordination for Individuals Dually Eligible for Medicare And Medicaid*. Primary care is a central component of a high functioning and equitable health system. However, there is a shortage of primary care clinicians and the time required to complete all recommended prevention services and counseling for a typical primary panel is prohibitive. One solution is to implement high quality primary care, which emphasizes the adoption of interprofessional teams and the use of non-traditional care settings to improve the quality and breadth of primary care in the United States. Today's webinar will aid in understanding the dental health care landscape for dually eligible individuals.

RDML Michael Windsor Johnson (Session Facilitator)

This question is for Apple Tree Dental can you share an example of how dental health care supports broader health conditions that are common among dually eligible individuals?

Dr. Michael J. Helgeson (Panelist)

I was going to give the example of periodontal disease, which is a set of infections around the teeth, into the gums, into the bone, so you can have the direct spread of infection and also triggering of inflammatory responses. Dr. Chalmers provided a number of slides with detailed evidence linking periodontal disease to other conditions, including things like heart disease and stroke, dementia. There's increasing study related to that. If you think about periodontal disease as an open wound, if you were to imagine opening the sockets around the root of a tooth and having just an open infection, maybe on your arm somewhere, that's what periodontal disease is like, it’s a chronic infection like that, and can contribute to all sorts of complications of other major medical conditions. So, that's one example.

RDML Michael Windsor Johnson (Session Facilitator)

Thank you. Almost universally, dental care is provided in a fee-for-service model that emphasizes procedural productivity. This makes the incorporation of lower cost, high value preventive services difficult to justify financially.

This question is for all three panelists. Can you talk more about how a health plan of health systems construct dental health care benefits and services to address dually eligible individuals' dental health care need? That feeds into a broader quality value-based care delivery, as well as what thoughts you can share about strategies to track metrics around value-based care.

Jessica Serman (Panelist)

Hi, this is Jessica Sirman, and I'll go first. The UPHP quality improvement project focuses on patient centered medical homes that include dental facilities and work with our American Indian and Alaska Native enrollees, some of whom are only comfortable seeing providers within their own tribes. By focusing on medical homes with dental facilities, we're working in environments where our enrollees have established relationships and therefore have an existing level of trust.

Federally Qualified Health Centers in our network also incorporate primary medical and dental facilities in a single location. With this onsite integration, we can leverage an existing relationship with a trusted provider to encourage individuals to obtain dental care. We find this to be much more effective than having us as a health plan reach out directly to our enrollees. We think health plans could structure value-based payments to facilities that integrate both primary medical and dental health care.

Strategies we have found helpful include creating provider scorecards that track annual well visits and dental visits. This allows providers to receive payment for getting their attributed enrollees into the office to obtain dental care in addition to medical care.

Dr. Carolyn Brown (Panelist)

Sure, I'll jump in next this is Carolyn Brown from the Health Plan of San Mateo. I think important to us is that Health Plan of San Mateo is an integrated medical and dental managed Medicaid plan. We are locally organized and we really understand and meet the needs specific to our county. We have a deep understanding of our geographic area and understand the barriers that face our enrollees, their caregivers, and our providers. So, that's a really important point to be able to address value-based care organically and holistically.

We are a managed care organization, though we do pay our dental providers specifically in an enhanced fee-for-service contracting. We have flexibility in the dental contracting and we have several initiatives related to incentives. As we were designing our healthcare benefits, we've used this knowledge to really create a flexible plan that invests in alternative models of care and invests in backfilling the gaps that we might see in a state Medicaid program.

For instance, we work with a really great mobile dental care company that takes a full-scope approach to delivering dental care. They offer monthly follow ups for prevention and not

only to address acute issues. And it really helps align with our whole person healthcare model.

From some discussions we had with our community and in response to complex patient needs, we've incorporated a dental provider group that operates in standalone clinics and has several hospital access points. Previously, prior to the Health Plan of San Mateo, there were very long waiting lists. But if we now have an individual with complex healthcare needs and they require general anesthesia, we can get them in for general or specialty dental care within days.

We are really committed to this whole person healthcare approach and we're incorporating a value-based care model with incentives for prevention by paying for completed treatment plans. This is a new initiative that we're just launching and it incentivizes prevention and treatment plan completion for our enrollees. Our enrollee in our patient experience is very important to us as well as the experience that our providers have in working with our health plan.

Dr. Michael J. Helgeson (Panelist)

Hi, this is Dr. Helgeson. I'll just add a couple of additional comments. First of all, as part of the enrollment and initial health assessment into a health plan, they can use this five-question survey, again called OHIP-5. That is a validated tool that's used in research and all sorts of settings and just takes a couple of minutes to do. That asks five simple questions that measure the impact of dental issues on quality of life. The questions can help determine if a person has difficulty chewing foods, they're having mouth pain, if the appearance of their teeth or mouth makes them feel uncomfortable or embarrassed to smile, if they have problems tasting or chewing food, or if their oral health conditions are affecting sleep or other critical functions.

The higher the score, the greater the oral health problems and the greater the need for care. Enrollees with high scores right at the beginning, then, can be triaged, as we've heard about from the other health plan models, so that they can receive priority for services and referrals, which can be especially helpful in a system with limited appointment slots. And as was reported earlier, some of the patients have full dentures, some of the patients maybe aren't seeking dental care, et cetera.

This tool helps you sort out exactly who to prioritize, and it again can be completed during easily during intake. It can also encourage bidirectional medical and dental referrals, which could uncover possible comorbidities for people with high scores. For example, if someone has high use of diabetes [services] and having complications, and so forth, the OHIP-5 could reveal some unresolved oral health infections that are contributing to the complications. Thanks.

RDML Michael Windsor Johnson (Session Facilitator)

Although hurdles exist to incorporating primary care services into dental visits, hundreds of thousands of United States dentists are a substantial resource to address primary care needs, improve care coordination, referral systems, and reimbursement mechanisms could enable the dental office to become a valued part of patients’ primary care.

Again, this question is for all three panelists. Can you talk about the importance of coordinating dental care alongside primary health care for dually eligible individuals and how primary care providers could consider oral health when discussing a person's primary health needs?

Jessica Serman (Panelist)

This is Jessica Serman from UPHP, again. Oral health plays such an important role in our overall health, and our primary care providers play a key role in connecting an individual's condition. For example, one gap UPHP identified as part of our QIP process was enrollees with dentures or no teeth often do not visit the dentist. These individuals could be at risk of malnourishment if they do not have healthy teeth or gums or well-fitting dentures during primary care visits. PCPs (primary care providers) can encourage regular dental visits so that dental health care providers can help enrollees understand how to maintain healthy gums and the importance of preventing infections and conducting screenings for serious conditions like oral cancers.

Relatedly, we found that co-locating primary and dental care is one way to ensure a communication pathway across providers. We found it helpful for PCPs or care managers to complete social determinants of health screenings in their offices so that PCPs can connect individuals with necessary and targeted services that may take precedence over medical and dental care.

Marisa Cardarelli (Panelist)

Hi, this is Marissa Cardarelli with Health Plan of San Mateo. To answer this question, for our dually eligible enrollees, it's really important that we understand each individual's primary healthcare needs to help develop an oral healthcare plan for them. At HPSM, we have four dental access and referral coordinators who act like a bridge to help coordinate care. Knowing that some of our members it's been 10 or 20 years since they've been to a dentist and they've had really bad experiences in the past. We really try to understand each enrollee's needs and overcome barriers to care, educating individuals on the process for visiting a provider, including what they should expect when they see a dentist or a dental specialist. For example, we work to help enrollees understand the impact of their medications that they have on their oral health, like those that can cause dry mouth, or how certain behavioral conditions can impact dental care options such as anxiety or more severe combative behavioral conditions. We have providers who are specifically trained to deliver care to individuals with special needs, even at enrollees’ homes, and who understand the importance of having an enrollees authorized representative or caretaker involved in decision making. We also know that PCPs play a critical role in communicating the importance of preventative oral health care, and we hope that our PCPs help remind enrollees about oral healthcare and can help recommend dental providers or just remind them to contact HPSM where we can help them find a provider for their needs.

Looking forward to year three of our integrated care model, we really want to focus on helping dental providers encourage enrollees to follow up with their PCPs as well, especially when they go to the dentist and they find specific health concerns like high blood pressure or diabetes that they notice during their dental visit.

Dr. Michael J. Helgeson (Panelist)

Yeah, and this is Dr. Helgeson just wanting to echo all of the great comments before me that again, health plans that have coordinators who work directly with care teams and individuals and primary care providers can incorporate those simple questions I mentioned about oral health into their standard care practices, and that gives them an opportunity to initiate a conversation about oral health and facilitate connection to a care coordinator.

Keep in mind, primary care providers are often the only clinicians who can make these type of connections for enrollees, particularly if they haven't been to the dentist for a long time and really don't even know where to go or who to talk to. Another key thing I want to highlight is the importance of health information and data exchange, which is really an important tool to help link primary and dental healthcare providers. And we're working with various partners to support this critical communication pathway.

For instance, through our work in long-term care facilities, we may see dually eligible individuals who are not able to communicate, maybe due to a stroke, or who have significant cognitive impairments. And they're acting out in various ways, and it's because they're in pain or they're having oral infections that really haven't been picked up or detected by any of the other primary care team providers. If a dental professional can evaluate a non-communicative person's mouth, they may be able to uncover the underlying problem causing pain or behavior issues. Including oral health discussions with regular primary healthcare encounters is really critical, I think, for the dual eligible population.

RDML Michael Windsor Johnson (Session Facilitator)

Continuing our questions for the three panelists, what are effective ways to design person-centered dental care? And how do partnerships with primary healthcare providers address dually eligible individuals' holistic health needs?

Dr. Carolyn Brown (Panelist)

Hi, this is Dr. Brown from the Health Plan of San Mateo. I think this is really where health plans can not only leverage all of the tools that they've been using for decades, talking with members, having member advisory boards, having provider relation teams—but this is where health plans can leverage technology and data to really help inform not only themselves, but network providers and really create these person-centered services in a way that's reflective of the year 2024. For example, our data collection can capture an enrollee's language preference or needs, which then helps us as a plan to design services that are specific to those language needs. We also really work to meet enrollees where they live, work, and play by leveraging virtual care options, as we said, such as offering mobile and tele dental provider options.

Part of the question was around, "How do we really try to partner with the providers in designing and sustaining some of these types of person-centered programs?" At the Health Plan of San Mateo, in the piece where we're really looking to add value-based care incentives around prevention and treatment plan completion, we're hosting a dental learning collaborative which really allows us to hear and co-design those incentives with our providers. We also have provider entities that are designed specifically to work with dually

eligible enrollees, and our team understands the needs and provides a bridge to those specific provider groups when necessary.

If an individual requires acute dental care but has high blood pressure, for example, our care coordinator can act as a conduit to the dental office to contact the PCP or to inquire about the hospital's condition and sometimes have relationships that we can lever to be able to do that.

Jessica Serman (Panelist)

This is Jessica Serman. To address oral care needs using our person-centered approach, it's important to understand the specific barriers facing each individual enrollee. We found in our program, which focuses on the American Indian and Alaska Native individuals, that these employees may be more comfortable sharing personal challenges with their PCPs or care managers than with the health plan. While it makes it challenging for the health plan to provide resources or strategies to overcome the barriers, it helps shine a light on the role that PCPs can play. So, by integrating primary care and dental care, PCPs can work with the individual directly to address any specific access barriers or concerns about seeking dental care. Health plans, in turn, can leverage relationships with providers who have established trust within the community they serve.

Dr. Michael J. Helgeson (Panelist)

Great. And this is Dr. Helgeson. I'll just add a couple more comments here to wrap up this particular question, but providing person-centered care for older adults with multiple health conditions is really always a team effort, as we've heard, you know, from all the speakers. Each provider in that team should consider the full scope of healthcare conditions that an individual is facing and really collaborate with them, their caregivers, to set realistic goals with practical implementation plans that complement rather than conflict with the plans around other health and behavioral needs. So, really figuring out ways to do that as a team effort is key.

Dually eligible adults often have really significant service needs. They may have multiple family members involved in their care, often from far away. Some individuals that Apple Tree cares for may be unable to communicate about their health needs, and in instances involving vulnerable adults like this, or with people living in long-term care facility with reduced cognitive ability, it's really critical to identify decision makers within the family support unit and ensure that individuals provide consent and there's open communication about all the treatment decisions.

These can be delicate conversations and involve the entire care team in planning, including dental and primary care providers, especially when things like oral surgery are involved. Understanding and tailoring oral health plans to meet individual needs in the context of the other care and services that they're receiving is really important. I think that understanding an individual's health-related social needs, which was mentioned a little bit early, including their financial constraints, you know, we heard about the huge out-of-pocket costs that can sometimes face patients that have significant needs—that's really critical component to providing person-centered care. And again, dental care needs among older adults are often

greater than their covered benefits and may exceed their out-of-pocket costs. Individuals will need much more than just an annual preventive cleaning and require services for things like cracked or missing teeth, or old fillings that are broken down and so on.

Because health plans are still working within state level benefits to cover dental services and other important strategy involves finding providers and connecting with them, and charitable organizations and nonprofits, folks that offer sliding fee scales, et cetera. Again, working as an entire team, the health plan and the providers and all the other community resources can address these unmet dental care needs.

RDML Michael Windsor Johnson (Session Facilitator)

Okay. One key concern is to ensure that providing primary care and dental settings does not worsen inequality because low income and other structurally disadvantaged populations are less likely to afford or have access to dental care. The integration of primary care services into dental office could perpetuate health inequities.

For health plans seeking to close the gaps in dental health equity or address disparities what recommendations do you have for setting goals and tracking progress?

Jessica Serman (Panelist)

This is Jessica from UPHP. Creating a barrier and gap analysis is really the first step in understanding why the disparities exist. Once a health plan has a gap analysis process, it can work to create initiatives and set goals and timelines that are realistic. Understanding the barriers in setting achievable year-over-year goals is critical. UPHP uses the SMART model when setting goals, ensuring goals are specific, measurable, achievable, relevant, and time bound.

We then measure progress through the PDCA cycle, which is Plan, Do, Check, Act, which allows us to pivot our strategy if we're not seeing a measurable impact. For example, based on our prior surveys, we started out targeting enrollment education, thinking there was a knowledge gap. However, through continued outreach and newer, updated surveys, we were able to better understand that the knowledge gaps are more specific to dental health for individuals with dentures and updated our plan accordingly.

Marisa Cardarelli (Panelist)

Hi, this is Marissa Cardarelli with Health Plan of San Mateo. So, as part of HPSM's work to maintain the National Committee for Quality Assurance, or NCQA, Health Equity Accreditation, we are working on incorporating new equity related policies and procedures as well as goal-setting activities. Specifically, we are reviewing how we collaborate with community organizations where enrollees may access services.

Care coordination that incorporates dental care can be overlooked or outsourced. As a local health plan, we want to leverage our knowledge of local resources in our geographic area to help coordinate with partners and reduce disparities. We also leverage software to address disparities. For instance, just at the end of last year, in December of 2023, HPSM built our own referral management system, or what we refer to as RMS. This helps us to link enrollee

demographic data. The goal of the RMS is really to leverage claims data to understand how student enrollee, who was then referred to a provider, actually received follow up care.

We can also use this data based on when that provider submits a claim. The RMS system also tracks if a referral is flagged as urgent, so we can prioritize those referrals and contact the individual within 24 hours, allowing us to triage and coordinate with a provider that can see the individual quickly. This can help us to avoid having that individual go to the emergency department for care and get the care they need as soon as possible.

Dr. Michael J. Helgeson (Panelist)

Yeah, I'll just add a few more thoughts. This is Dr. Helgeson from Apple Tree. One bit of advice is just to partner with one or more dental organizations that can help establish dental homes and will prioritize patients that have those higher OHIP-5 scores. Again, those are the ones that have scientifically validated higher needs for oral health, and it specifically identifies the kinds of impact that they're having from oral health problems. You can measure things like the number of dental visits completed and the changes in OHIP-5 scores after receiving treatment.

Equity is about getting to an OHIP score of zero, meaning oral health problems are not impacting your quality of life. So, if you start with those individuals with the high scores and then measure impact over time, that will measure not only did they see somebody, but actually whether seeing somebody improved their oral health. I think it's important that the annual dental visits, while that's a long-established measure, it's just the very first measure, because all its saying is they've interacted with the dental health care system. It's not saying that they actually had an improvement in their oral health outcome. Again, I would highlight the need to measure things that really matter and that are validated and so on to measure whether you're making an impact in their oral health outcomes. Thank you.

Leslie Bishop (Moderator)

Rear Admiral Johnson, would you like to go ahead onto an audience question?

RDML Michael Windsor Johnson (Session Facilitator)

Yes, please.

Leslie Bishop (Moderator)

Sure, I will go ahead. And I see one here in our chat. Dr. Brown, could you say more about helpful strategies or best practices you identified to engage dental care providers and specialists in your network?

Dr. Carolyn Brown (Panelist)

Certainly. Thank you for the question. Marisa and her team of dental referral clerks and others in our provider liaison group, you know, do a great job of engaging our current providers and providers that we're talking to about joining Health Plan of San Mateo.

We also, you know, have a very active relationship with our local component dental society and have been bridge-building and building projects together with our local dental society around specialty and general dental care. That has really been a very worthwhile investment on our part, and I hope that they would say the same. Also, our wide swath of community collaboration is really bearing some fruit as well because we have engaged—all different parts of our county, all different types of care groups, the schools, the unions, other dental schools in the area, other facilities providing any type of health care or touching dually eligible enrollees.

For years, even before we launched our dental benefit, we had multiple stakeholder meetings that were very widely attended. Getting the word out and continuing to keep a close ear on what's working with our dental providers, and for those who choose not to join at that time, "What were the reasons that they did not join?" As I said, lastly, we're launching a dental collaborative that we're really looking to organically work with dental providers around value-based care type of incentives.

RDML Michael Windsor Johnson (Session Facilitator)

Okay. Another question for Health Plan of San Mateo or the Upper Peninsula Health Plan is, do you maintain and update provider information, including which providers are accepting new patients. If so, how do you do that?

Marisa Cardarelli (Panelist)

This is Marissa Cardarelli with the Health Plan of San Mateo. Like Dr. Brown mentioned, with our providers, they know who they're talking with. When they call the health plan, it's either most likely myself or a network liaison. So, we really build really close relationships with the providers.

Sometimes I check in weekly or monthly with these providers and we know what their availability is, or we call and ask if we have something urgent. We know where to send a member if it is urgent versus if they can wait a week or two.

And when it's something urgent, like a tooth needs to be extracted due to infection, we kind of see which provider can see them as soon as and help them coordinate the care. Really just ongoing communication with providers and we update it internally for our staff that are directly referring members to dental providers.

Jessica Serman (Panelist)

This is Jessica from UPHP. Our online provider directory search indicates if the provider is accepting new patients or not. But what we did find through our project and initiative is that just because a provider is accepting new patients, that maybe doesn't mean their capacity can be to accept, you know, 50 or 75 new patients. So, when we did our quality improvement project, we really did the legwork in clinical aside from provider relations to see what capacity looked like so that we weren't over-referring members to our tribal dental clinics if they didn't have capacity and ensuring we understood their staffing needs and their wait times as well.

RDML Michael Windsor Johnson (Session Facilitator)

How can collaboration of partnerships among health plans, dental health care providers and other community-based organizations (CBOs) contribute to addressing dental health care disparities for dually eligible individuals? Also, can you identify one practical step that plans can take to foster such collaboration?

Jessica Serman (Panelist)

This is Jessica from UPHP, and I really just kind of touched on this, so I'll go first. Really ensuring that you're doing your provider outreach and engagement. Understanding office capacity is essential to any of these types of projects. We did this by making sure that just because they said they were accepting new patients that they could take the volume of patients that we were looking to refer over.

Dr. Carolyn Brown (Panelist)

Hi, and this is Carolyn from the Health Plan of San Mateo. I think I just touched on some of this too, but I do think that, you know, collaboration and data sharing amongst health plans and dental care providers and CBOs can really mitigate some of these healthcare disparities for dually eligible individuals.

I think these types of partnerships sometimes take some time to set up because each entity has their own guardrails around data sharing, but I think it's really crucial to overcome the fragmented care landscape for this vulnerable population. One practical step may be to really initiate regular collaborative meetings or advisory groups, focus specifically on dually eligible providers, and may include the enrollees themselves. As I said, we had launched prior to launching our benefits, very large stakeholder community meetings and we had a lot of non-traditional dental stakeholders such as skilled nursing facilities and patient advocates and people from all over the county, representative legislators, as well as members themselves.

And these really early conversations really helps us to think outside of the gap and to reduce barriers to this population. Our dental advisory group continues in that same vein, has a wide variety of types of providers and entities that we need with monthly. As I said, I think our provider relations team enlarges group does a great job of trying to reach out and find other voices as well.

RDML Michael Windsor Johnson (Session Facilitator)

Can you share how Upper Peninsula Health Plan delivers effective, culturally competent messaging to boost awareness of the importance of dental health among indigenous communities?

Jessica Serman (Panelist)

Sure. So, for our project, UPHP enlisted the help of an outreach specialist with knowledge of UPHP's American Indian and Alaska Native community to help create an approved dental care messaging campaigns that are specific to our American Indian and Alaska Native

enrollees. We understand that leveraging communication strategies informed by experts in community norms are incredibly important to ensure that messaging is both effective and culturally appropriate. We serve several tribes in the region and want to ensure messaging is appropriate for all tribal members without assuming that they speak the same native language or will respond to the same campaign images. To this, we ensure the campaign walks the line between being targeted toward our enrollees' identities while not excluding any local indigenous members or communities.

RDML Michael Windsor Johnson (Session Facilitator)

This question is for Dr. Helgeson and anyone else who can comment. How have you been able to maintain an oral health workforce and prepare them for this interdisciplinary type of community-based health care provision?

Dr. Michael J. Helgeson (Panelist)

That's a great question. We partner, as I mentioned, with educational institutions, everything from dental assisting schools to dental hygiene schools to our dental school residency programs that are located in the VA (Veterans Administration) and tertiary care hospital. A policy thing in Minnesota that I'm really proud of is we have grants from the Minnesota Department of Health that are called Clinical Dental Education Innovation Grants. They fund partnerships between dental organizations out in the community serving diverse population groups and all the different kinds of educational organizations, including schools of nursing, training for PCAs (dental implants) and things like that. They fund all kinds of experiences where folks can learn about older adults with special needs, for example, long-term care, working with all of the players in those various settings. Those educational experiences are what help create a workforce with special needs training.

We find that in every dental school class, every hygiene school class, whatever, there are individuals that really love to provide this kind of care. By creating an organization that is supported by each local community that we're in, and also at the county and state level and even federal level, with some federal resources that support our work, that we're able to create a sustainable organization that has scaled and grown for 39 plus years. It's a combination of everybody working together, learning together, sharing resources together, and you've heard that theme over and over again, I think, from everybody on the panel today.

RDML Michael Windsor Johnson (Session Facilitator)

Okay. And continuing with the theme, how do you see the use of health-related social needs screening within primary care impacting dental practices and their approach to providing person-centered dental services? This for Apple Tree Dental.

Dr. Michael J. Helgeson (Panelist)

I think a social needs screening is really essential, and it helps you understand the context in which an individual is living, gives everyone insight into, and the ability to form a trusting relationship between the individual and the healthcare provider. It enables the provider and the individual to plan a viable course of action together.

With results of social needs screenings, providers can identify individuals with the greatest need for care, including non-oral healthcare, as I said, that bidirectional thing, and then connect them with either the right dental providers, if they need various specialty care or maybe complex services and so on. And at Apple Tree, we're considered a critical access dental provider, and that's a group that was formed by the state of Minnesota, and that creates a lot of that networking opportunity that was referred to earlier, where the folks that are in those niches learn from one another and can serve Medicaid patients and so forth, and coordinate our services and form established relationships with the health plans. But even with those relationships and partnerships, we find it important to ask about an individual's situation at home, their food security, mobility—other sensitive questions, because if we're out of touch with all that, we're not going to be able to have a meeting of the mind and be able to navigate the individual to the right care and to really to improve their oral health, which is the most important goal.

RDML Michael Windsor Johnson (Session Facilitator)

Leslie, do we have time for one more question?

Leslie Bishop (Moderator)

Yeah, we've got such great feedback from the audience, but I think we want to wrap-up really quickly here. So, thank you so much, Rear Admiral Johnson, for facilitating this session and to our panelists for providing such insights. At this time, if you have any additional questions or comments, please email RIC@Lewin.com.

We thank you for extending your time with us this afternoon. In the following slides, we include links to provide feedback on this event, followed by additional resources and references. Thank you again to our speakers for sharing your engaging and informative presentations. Thank you to our audience members for your participation. And this concludes today's webinar. Have a wonderful rest of your day.