Looking Back, Looking Forward

An Empirical Look at Access to Dental Care in the United States

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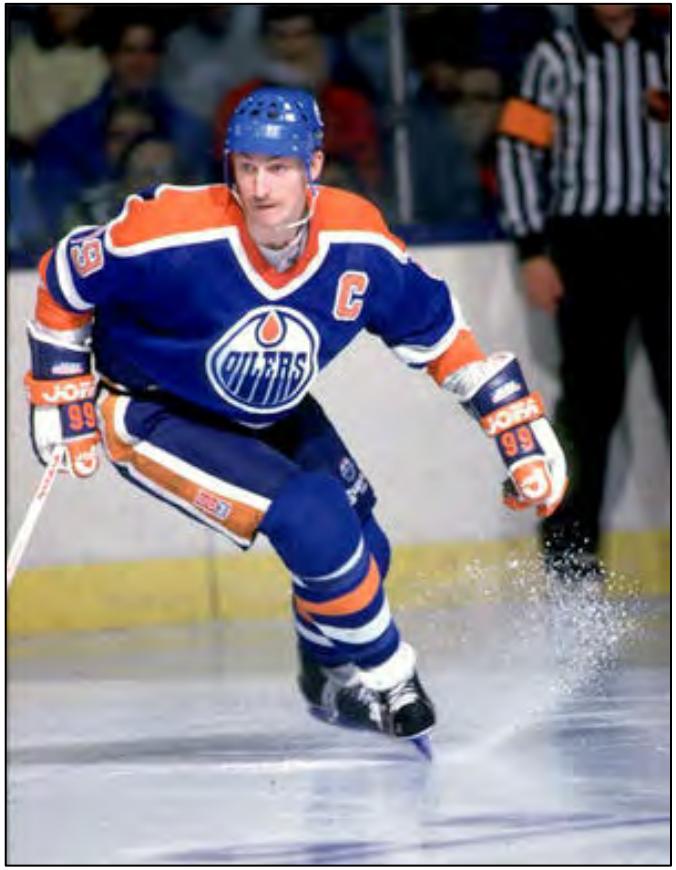
ADA American Dental Association®

Agenda



About Me

ADA American Dental Association®
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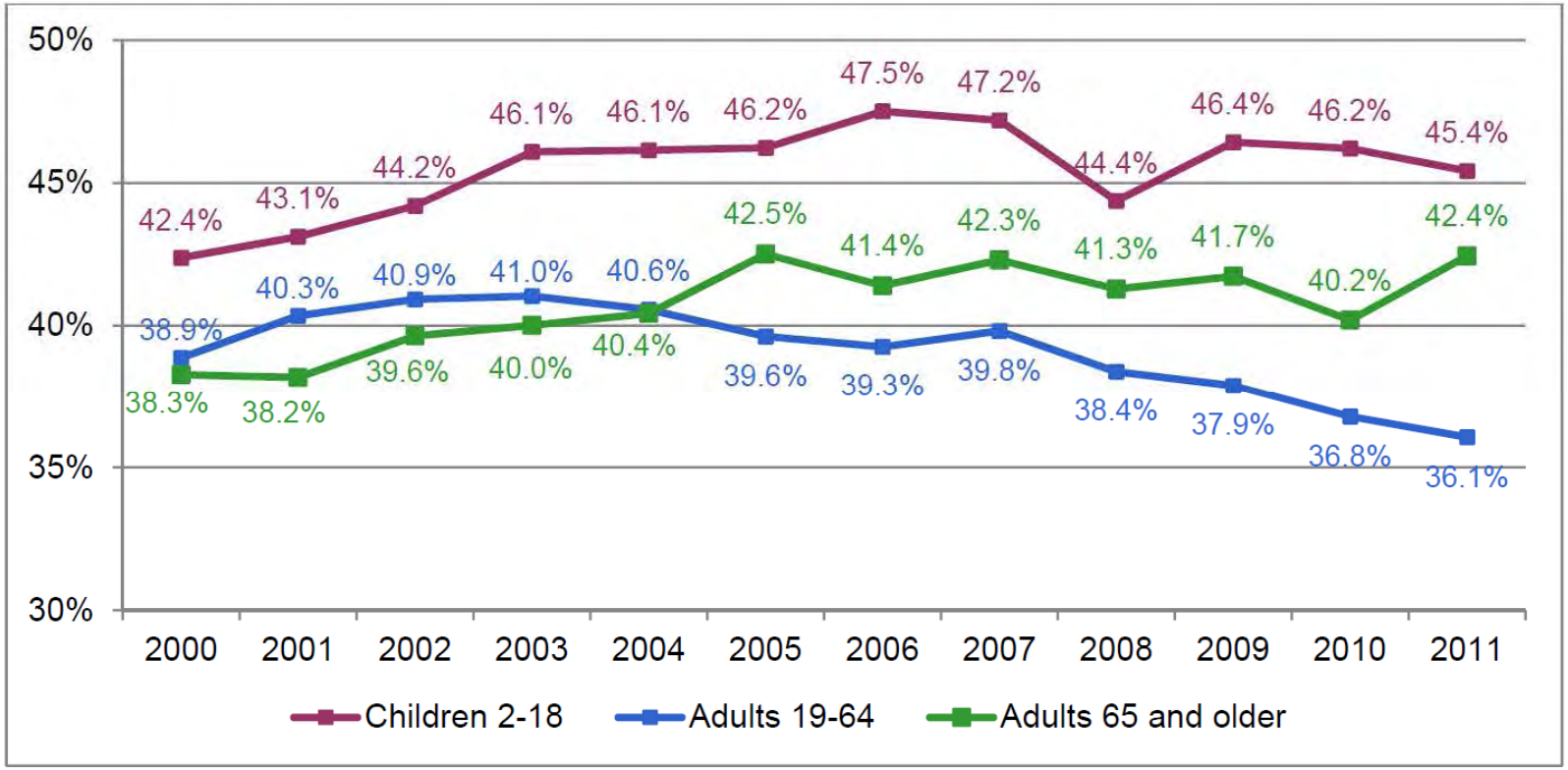
Part 1 – A Look Back…

Dental Care Use

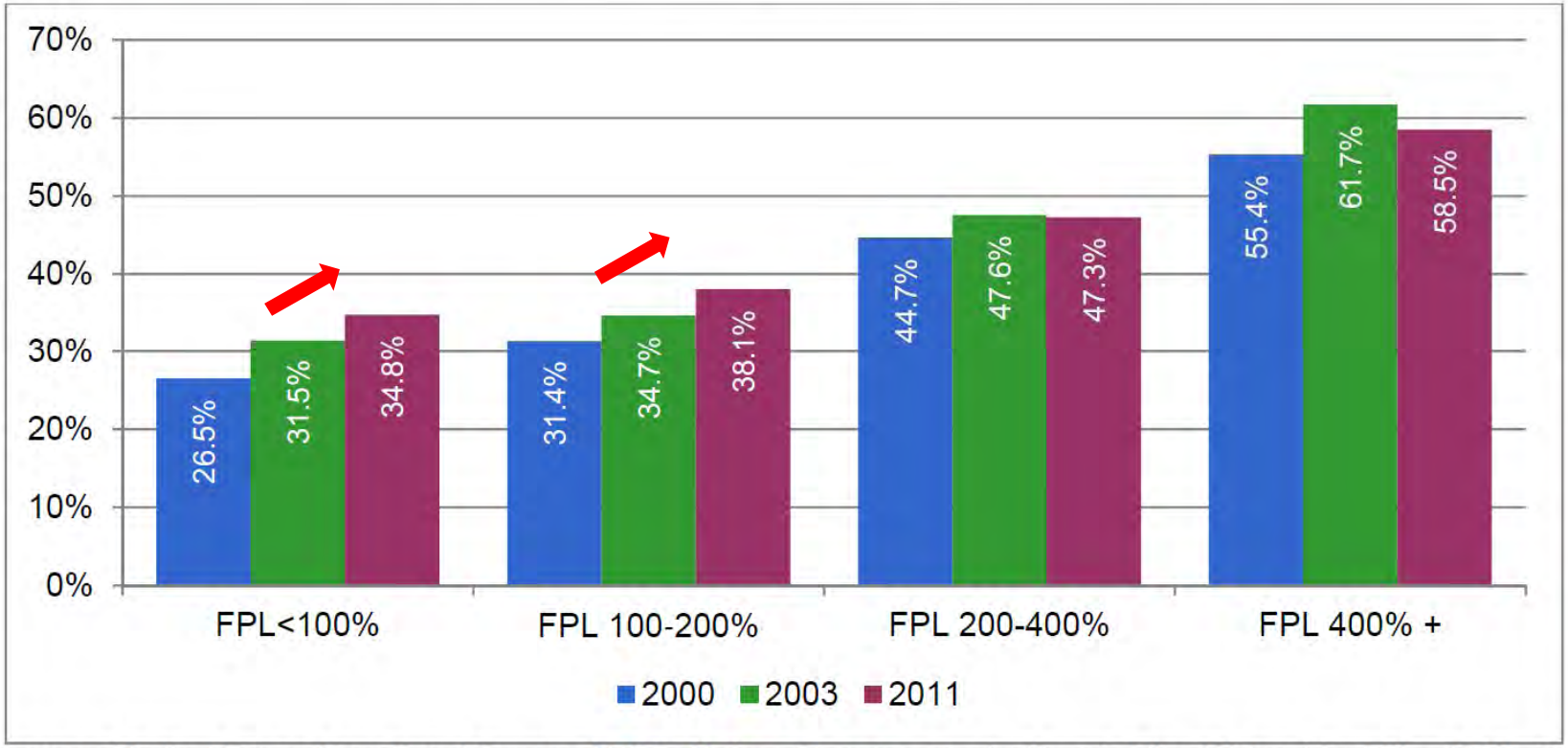
Figure 1: Percentage of the Population with a Dental Visit in the Year, 2000-2011



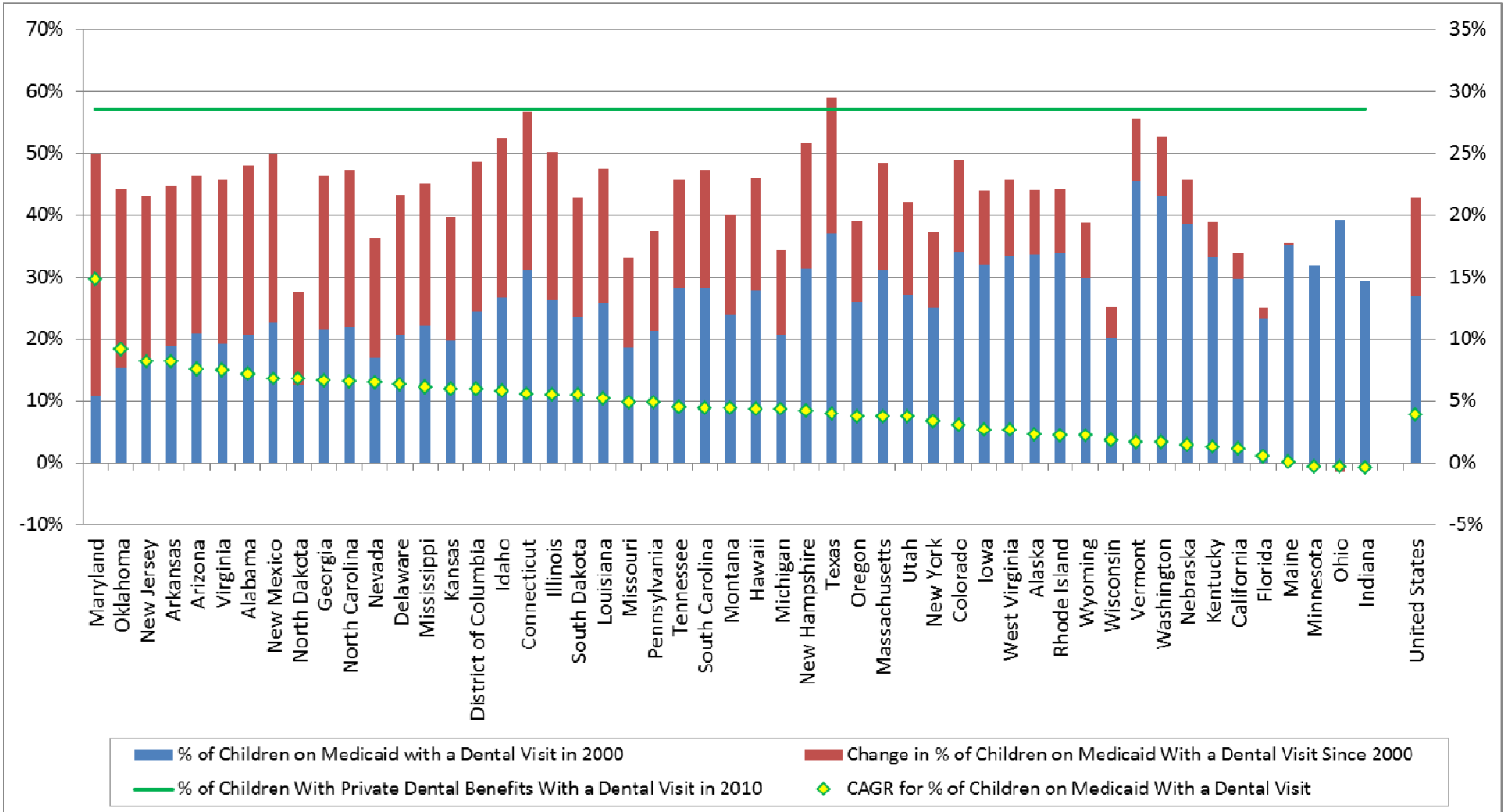
Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes are statistically significant at the 5% level for children ages 2-18 (2000-2011), at the 1% level for adults ages 19-64 (2003-2011), and at the 1% level for adults ages 65 and over (2000-2011).

Dental Care Use

Figure 3: Percentage of Children Ages 2-18 with a Dental Visit in the Year for Select Income Groups, 2000-2011



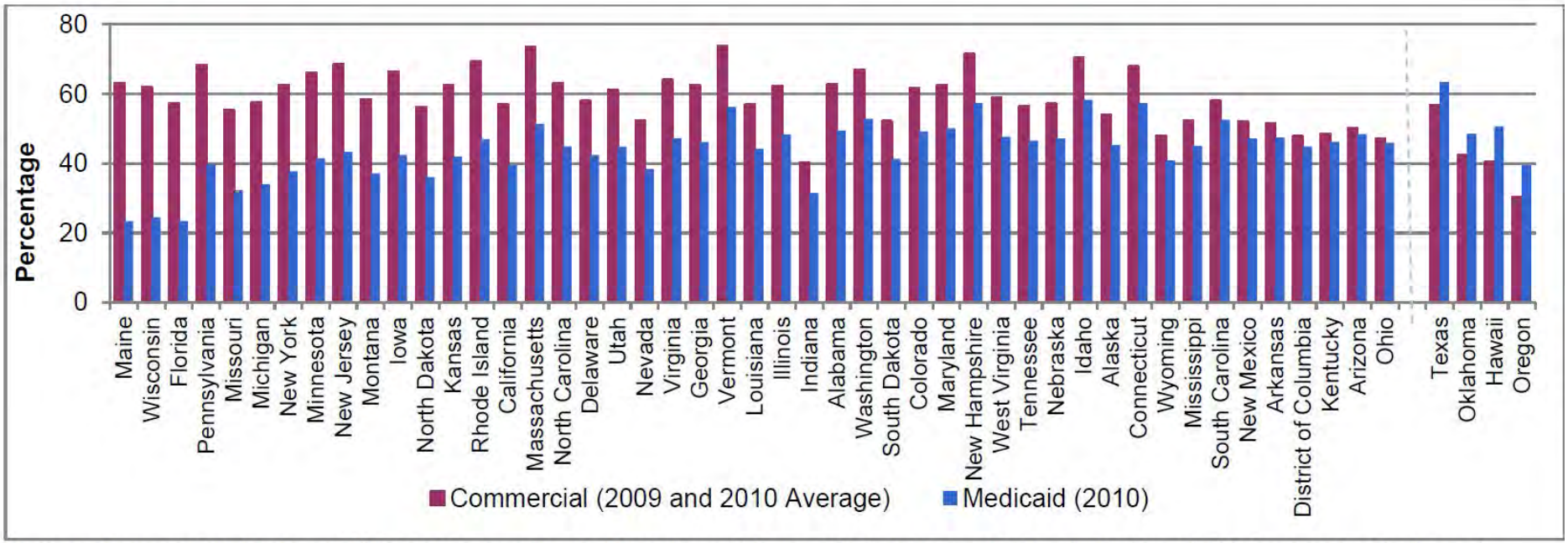
Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes are significant at the 1% level for FPL <100% and at the 5% level for FPL 100-200% (2000-2011).



Note: Data for AR, AZ, CA, CT, MD, OR, SD, TN are through 2011. Data for all other states are through 2012. Data for NE, NM, ME, KY, NY, and CA may not adequately capture dental visits within FQHCs in the calculation of the total number of children on Medicaid with a dental visit. Utilization rate for children with private dental benefits is for the U.S. and is based on most recent data available. CAGR is compound annual growth rate. FPL is federal poverty level.
Source: CMS (Medicaid 416) for state level Medicaid data; MEPS for utilization data for children with private dental benefits.

Dental Care Use

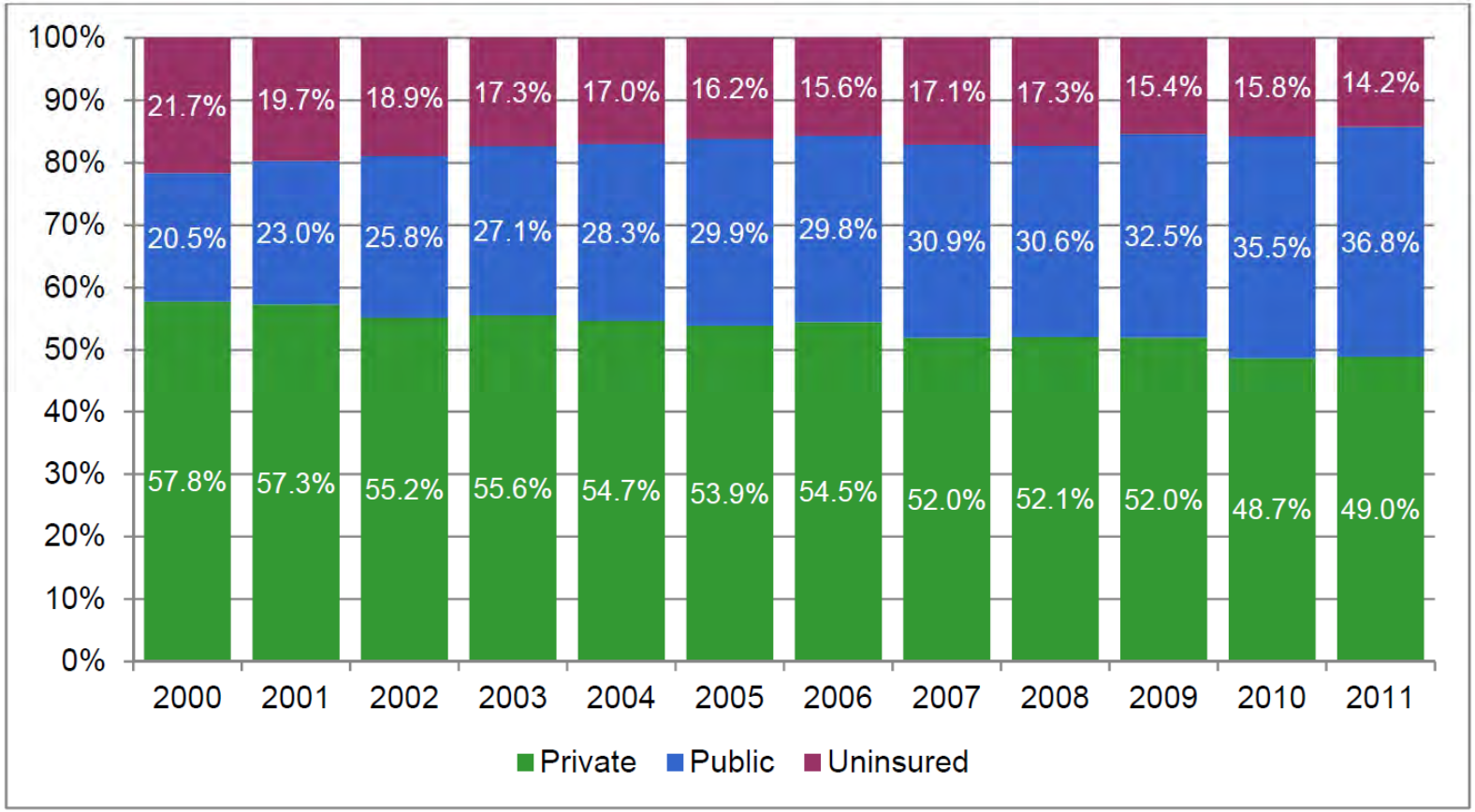
Figure 2: Percent of Children with a Dental Visit in the Past Year, Commercially and Medicaid Insured



Source: Commercial data from 2009-2010 Truven Health MarketScan® Research Databases. Medicaid data from 2010 Centers for Medicare & Medicaid Services (CMS) 416 report. **Note:** States are ordered from left to right according to the relative gap between the commercial and Medicaid populations. Population is based on children ages 0-20 continuously enrolled in a dental plan for 90 days.

Dental Benefits

Figure 1: Source of Dental Benefits, Children Ages 2 to 18



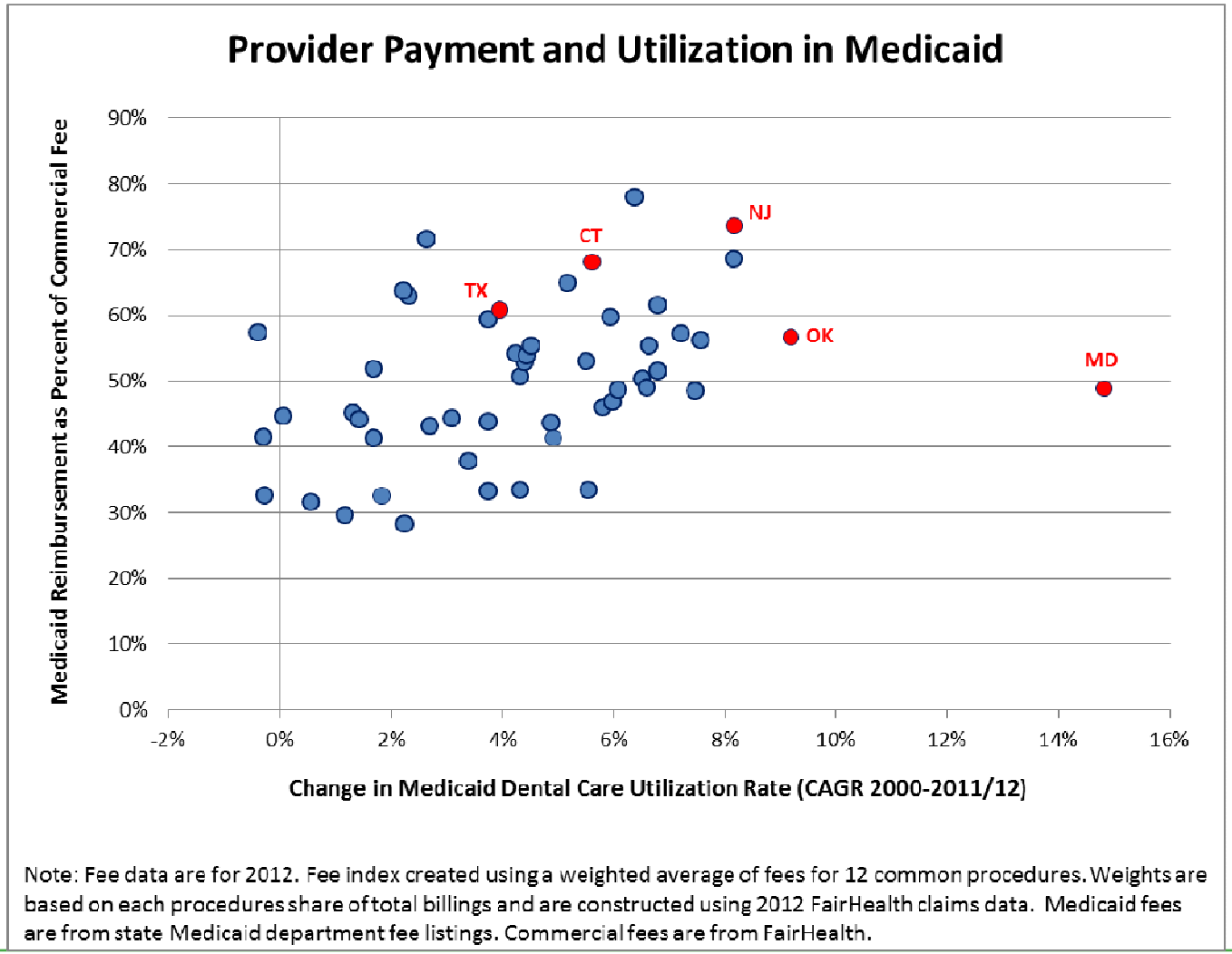
Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** All changes are significant at the 1% level (2000-2011).

‘Enabling Conditions’ in Medicaid

- Texas, Maryland, Connecticut made improvements to their Medicaid program and saw impressive gains in access to care
  - Beazoglou T, J Douglass , H Bailit, V Myne-Joslin. 2013. Impact of increased dental reimbursement rates on husky a-insured children: 2006-2011. Health Issues Connecticut Health Foundation. February 2013.
  - Thuku NM, K Carulli, S Costello S, HS Goodman. 2012. Breaking the cycle in Maryland: oral health policy change in the face of tragedy. J Public Health Dent. Suppl 1:S7-13.

- Adjusting provider incentives and streamlining administrative process has impact
  - Decker SL. 2011. Medicaid payment levels to dentists and access to dental care among children and adolescents. JAMA. 2011;306(2):187-193.
  - Buchmueller T, S Orzol, L Shore-Sheppard. 2013. The effect of Medicaid payment rates on access to dental care among children. NBER Working Paper No. 19218.

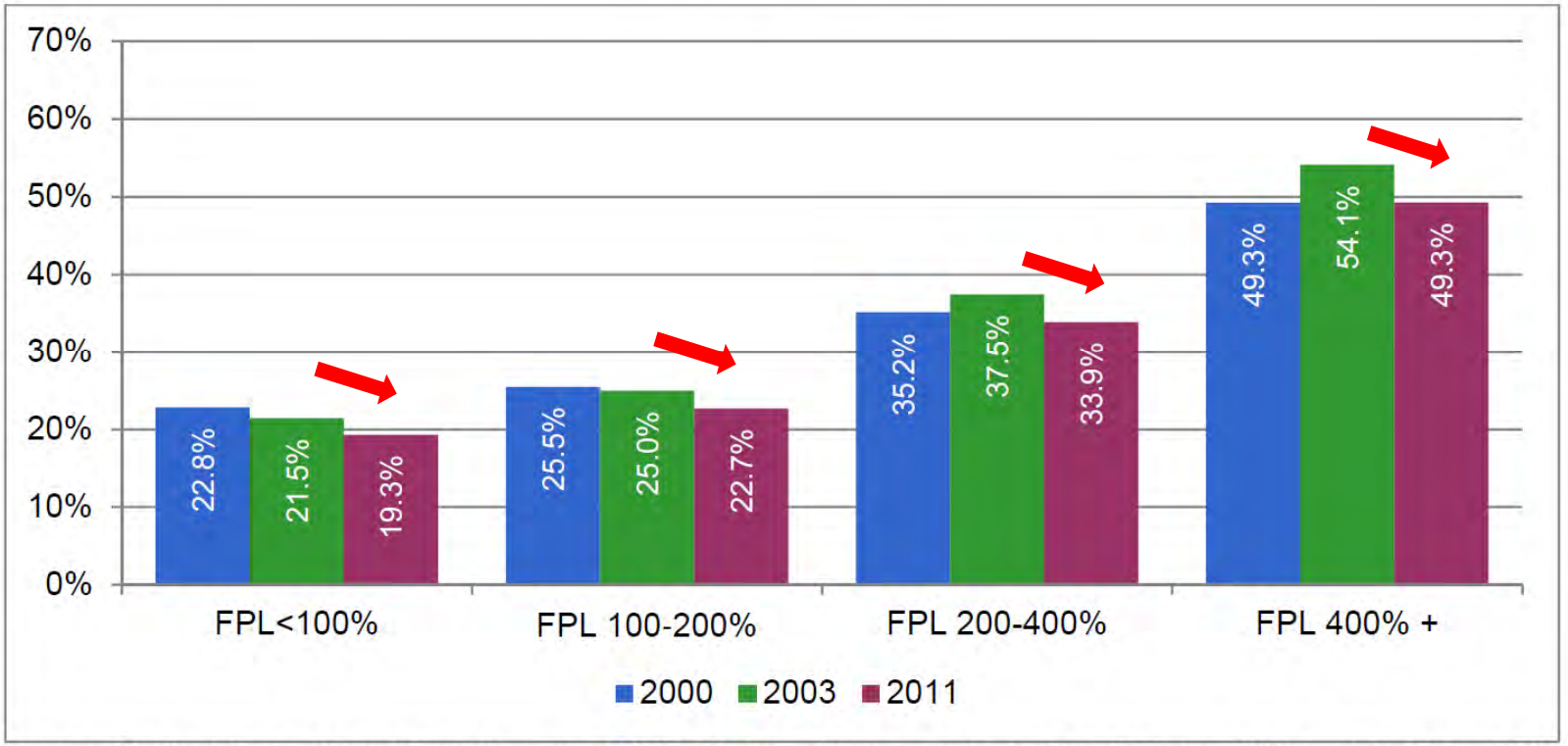
‘Enabling Conditions’ in Medicaid



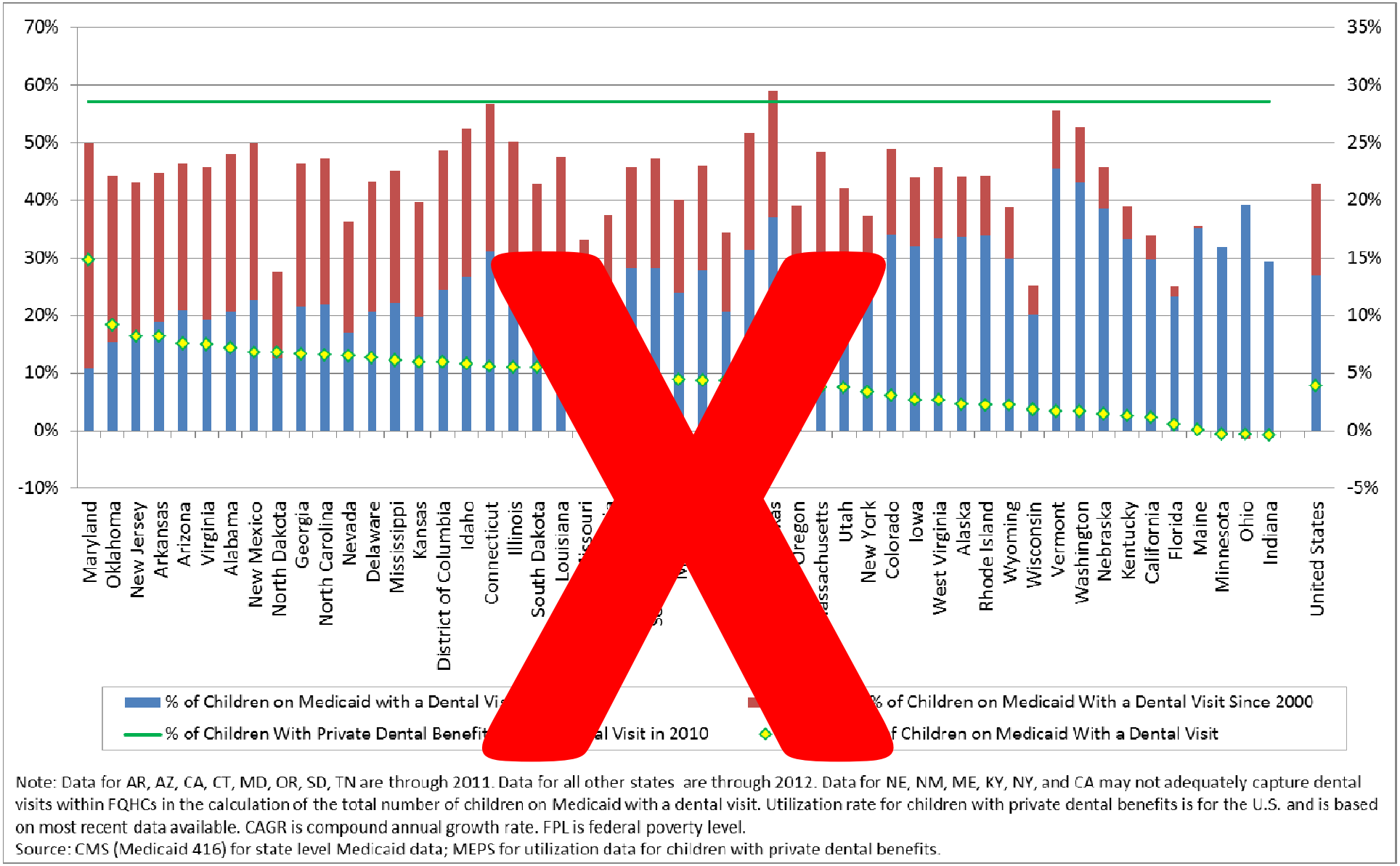
Note: Fee data are for 2012. Fee index created using a weighted average of fees for 12 common procedures. Weights are based on each procedures share of total billings and are constructed using 2012 FairHealth claims data. Medicaid fees are from state Medicaid department fee listings. Commercial fees are from FairHealth.

Dental Care Use

Figure 4: Percentage of Adults Ages19-64 with a Dental Visit in the Year for Select Income Groups, 2000-2011



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes are significant at the 10% level for FPL <100% (2000-2011), at the 5% level for FPL 200-400% (2003-2011), and at the 1% level for FPL 400%+ (2003-2011).



Note: Data for AR, AZ, CA, CT, MD, OR, SD, TN are through 2011. Data for all other states are through 2012. Data for NE, NM, ME, KY, NY, and CA may not adequately capture dental visits within FQHCs in the calculation of the total number of children on Medicaid with a dental visit. Utilization rate for children with private dental benefits is for the U.S. and is based on most recent data available. CAGR is compound annual growth rate. FPL is federal poverty level.
Source: CMS (Medicaid 416) for state level Medicaid data; MEPS for utilization data for children with private dental benefits.

Dental Care Use

ORAL HEALTH

By Kamyar Nasseh and Marko Vujicic

Health Reform In Massachusetts Increased Adult Dental Care Use, Particularly Among The Poor

ABSTRACT States frequently expand or limit dental benefits for adults covered by Medicaid. As part of statewide health reform in 2006, Massachusetts expanded dental benefits to all adults ages 19–64 whose annual income was at or below 100 percent of the federal poverty level. We examined the impact of this reform and found that it led to an increase in dental care use among the Massachusetts adult population, driven by gains among poor adults. Compared to the prereform period, dental care use increased by 2.9 percentage points among all nonelderly adults in Massachusetts, relative to all nonelderly adults in eight control states. For poor Massachusetts adults, the effect was larger—an eleven-percentage-point increase in dental care use above the increase among the state's nonpoor residents. The Massachusetts experience provides evidence that providing dental benefits to poor adults through Medicaid can improve dental care access and use. Our results imply that the lack of expanded dental coverage for low-income adults under the Affordable Care Act is a missed opportunity to improve access to oral care.

The Massachusetts experience is particularly important in the current context of national health reform.

Dental Care Use

A Decade in Dental Care Utilization among Adults and Children (2001–2010)

Marko Vujicic and Kamyar Nasseh

Objective. To decompose the change in pediatric and adult dental care utilization over the last decade.

Data. 2001 through 2010 Medical Expenditure Panel Survey.

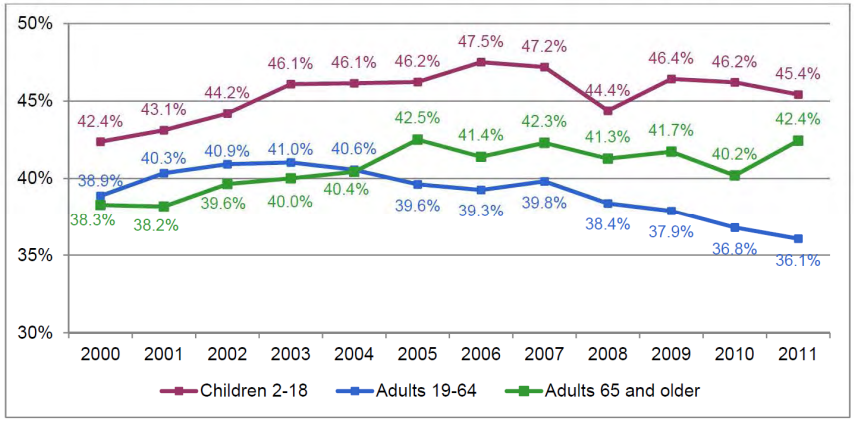
Study Design. The Blinder-Oaxaca decomposition was used to explain the change in dental care utilization among adults and children. Changes in dental care utilization were attributed to changes in explained covariates and changes due to movements in estimated coefficients. Controlling for demographics, overall health status, and dental benefits variables, we estimated year-specific logistic regression models. Outputs from these models were used to compute the Blinder-Oaxaca decomposition.

Principal Findings. Dental care utilization decreased from 40.5 percent in 2001 to 37.0 percent in 2010 for adults and increased from 43.2 percent in 2001 to 46.3 percent in 2010 for children ($p < .05$). Among adults, changes in insurance status, race, and income contributed to a decline in adult dental care utilization (-0.018, $p < .01$). Among children, changes in controlled factors did not substantially change dental care utilization, which instead may be explained by changes in policy, oral health status, or preferences.

Conclusions. Dental care utilization for adults has declined, especially among the poor and uninsured. Without further policy intervention, disadvantaged adults face increasing barriers to dental care.

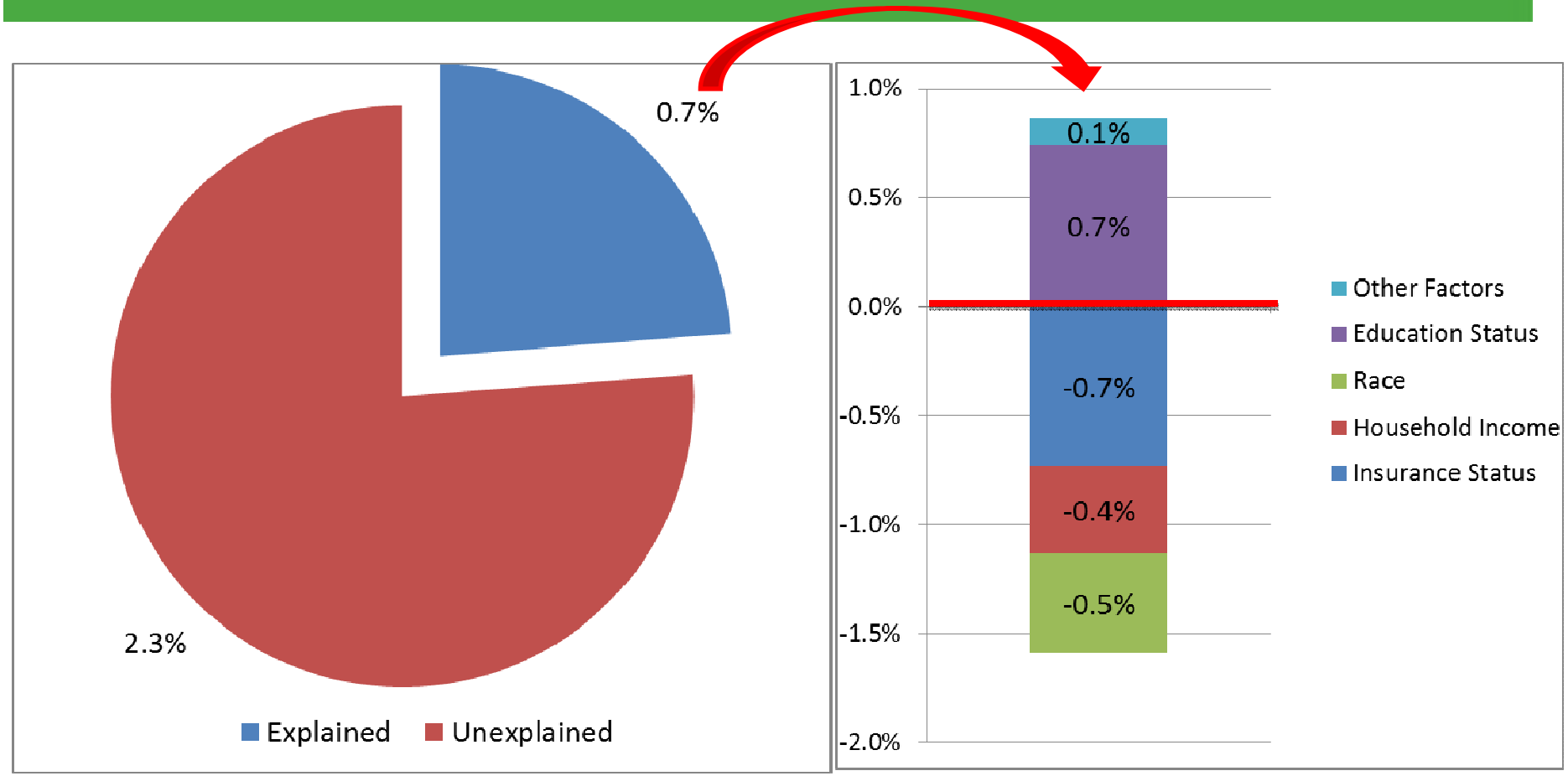
Key Words. Dental care utilization, decomposition, oral health, dental benefits

Figure 1: Percentage of the Population with a Dental Visit in the Year, 2000-2011



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes are statistically significant at the 5% level for children ages 2-18 (2000-2011), at the 1% level for adults ages 19-64 (2003-2011), and at the 1% level for adults ages 65 and over (2000-2011).

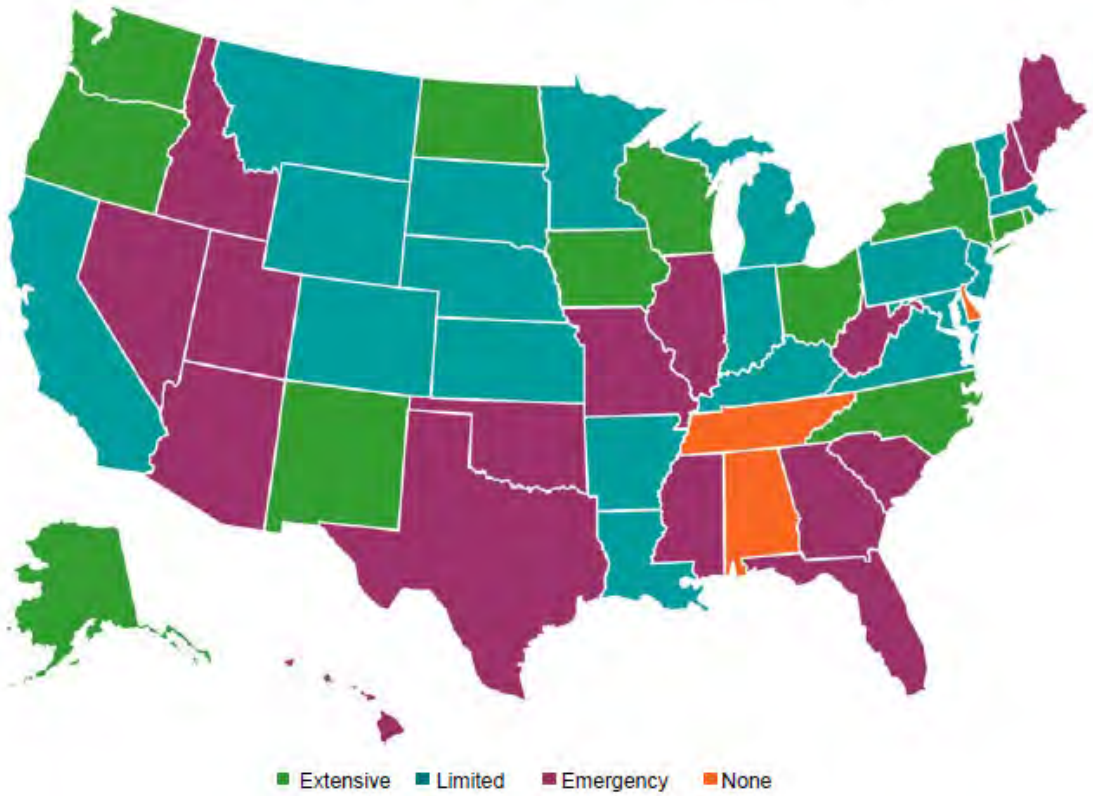
Dental Care Use – The 3% Decline



Source: M. Vujicic, K. Nasseh. "A Decade in Dental Care Utilization among Adults and Children (2001-2010)," *Health Services Research*, early view published December 3, 2013.

Adult Dental Benefits in Medicaid

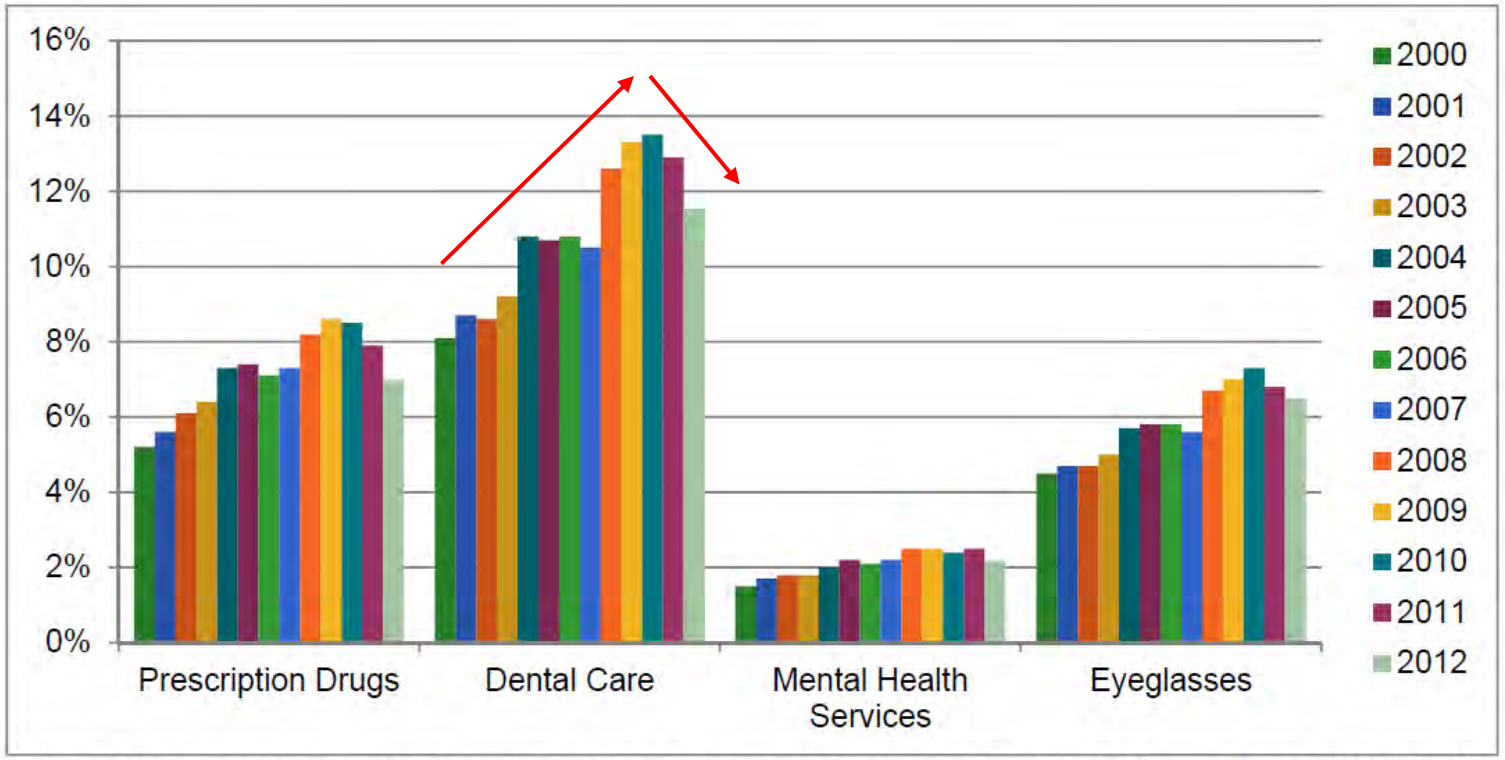
Figure 2: Adult Dental Benefit Provided in State Medicaid Programs



Source: ADA Health Policy Resources Center analysis of state Medicaid policies as of December 6, 2013. **Notes:** Kansas' Medicaid program officially covers emergency dental services, but all of the plans contracted with Kansas' Medicaid program offer two routine dental check-ups (exams and cleanings) per year for adults over 21. Maryland's Medicaid program officially covers emergency dental services, but the majority of Medicaid beneficiaries are enrolled in the Medicaid managed care program which provides limited adult dental benefits.

Financial Barriers to Dental Care

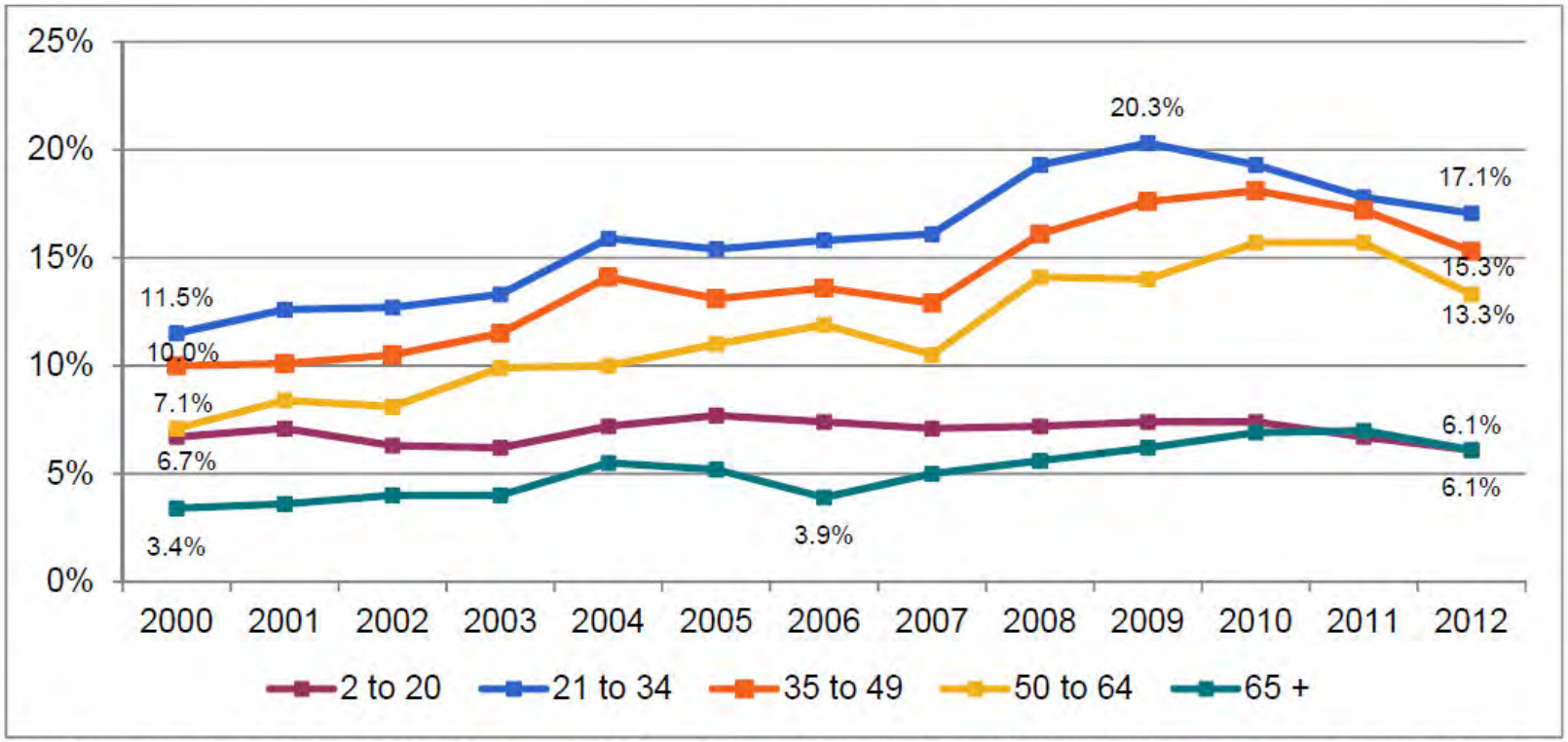
Figure 1: Percentage of the Population Who Needed But Did Not Obtain Select Health Services during the Previous 12 Months Due to Cost as a Barrier



Source: National Health Interview Survey, National Center of Health Statistics. **Notes:** Changes from 2000 to 2010 for Prescription Drugs, Dental Care, Mental Health Services and Eyeglasses are statistically significant at the 1 percent level. Changes from 2010 to 2012 for Prescription Drugs, Dental Care and Eyeglasses are statistically significant at the 1 percent level. Change from 2010 to 2012 for Mental Health Services is significant at the 5% level.

Financial Barriers to Dental Care

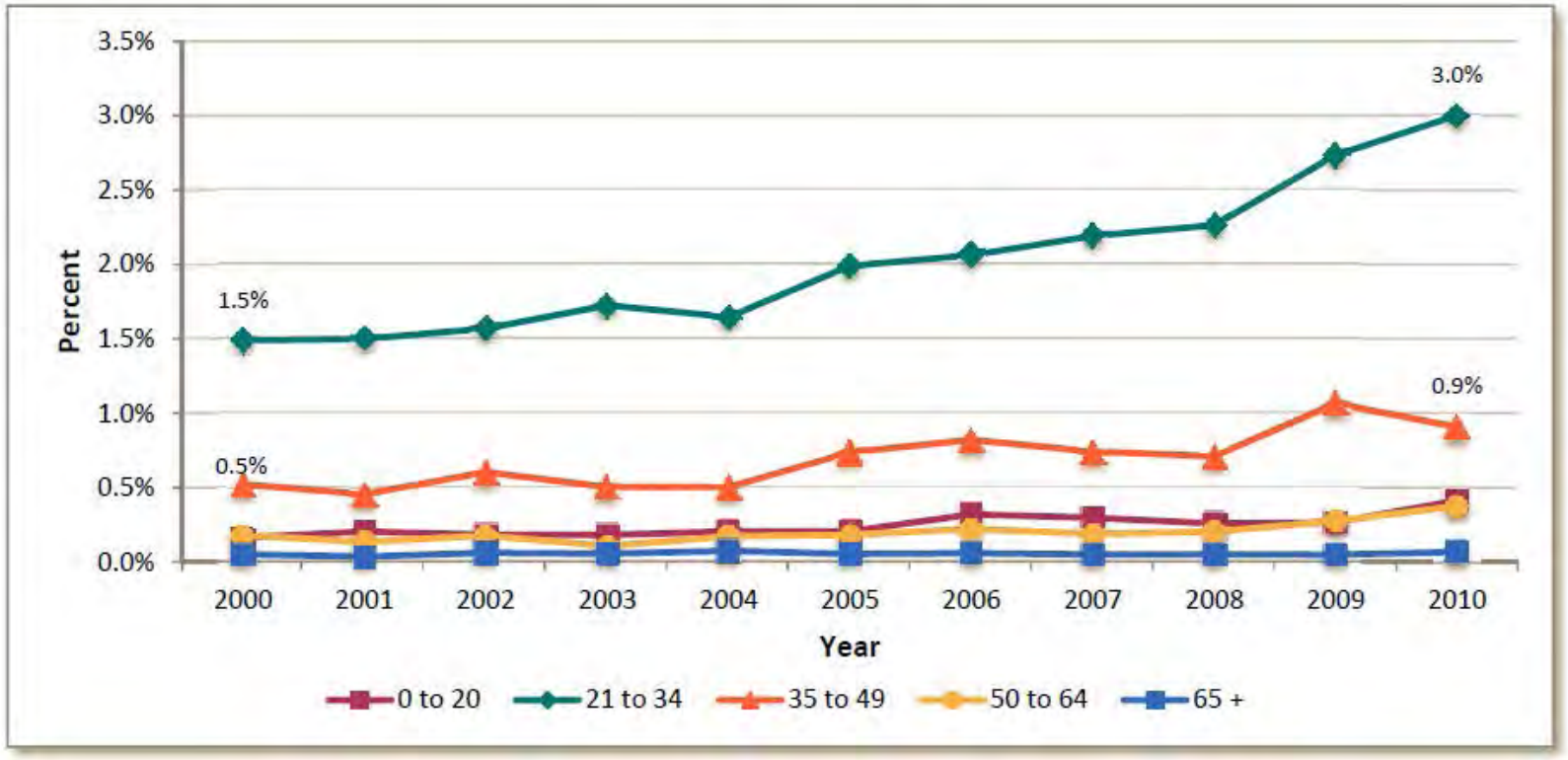
Figure 2: Percentage of the Population Indicating Cost as a Barrier to Receiving Needed Dental Care by Age



Source: National Health Interview Survey, AHRQ. **Notes:** Changes from 2000 to 2010 for age groups 21 to 34, 35 to 49, 50 to 64 and 65 + are statistically significant at the 1 percent level. Changes from 2010 to 2012 for age groups 2 to 20, 21 to 34, 35 to 49 and 50 to 64 are statistically significant at the 1 percent level. Change from 2010 to 2012 for age group 65+ is significant at the 10% level.

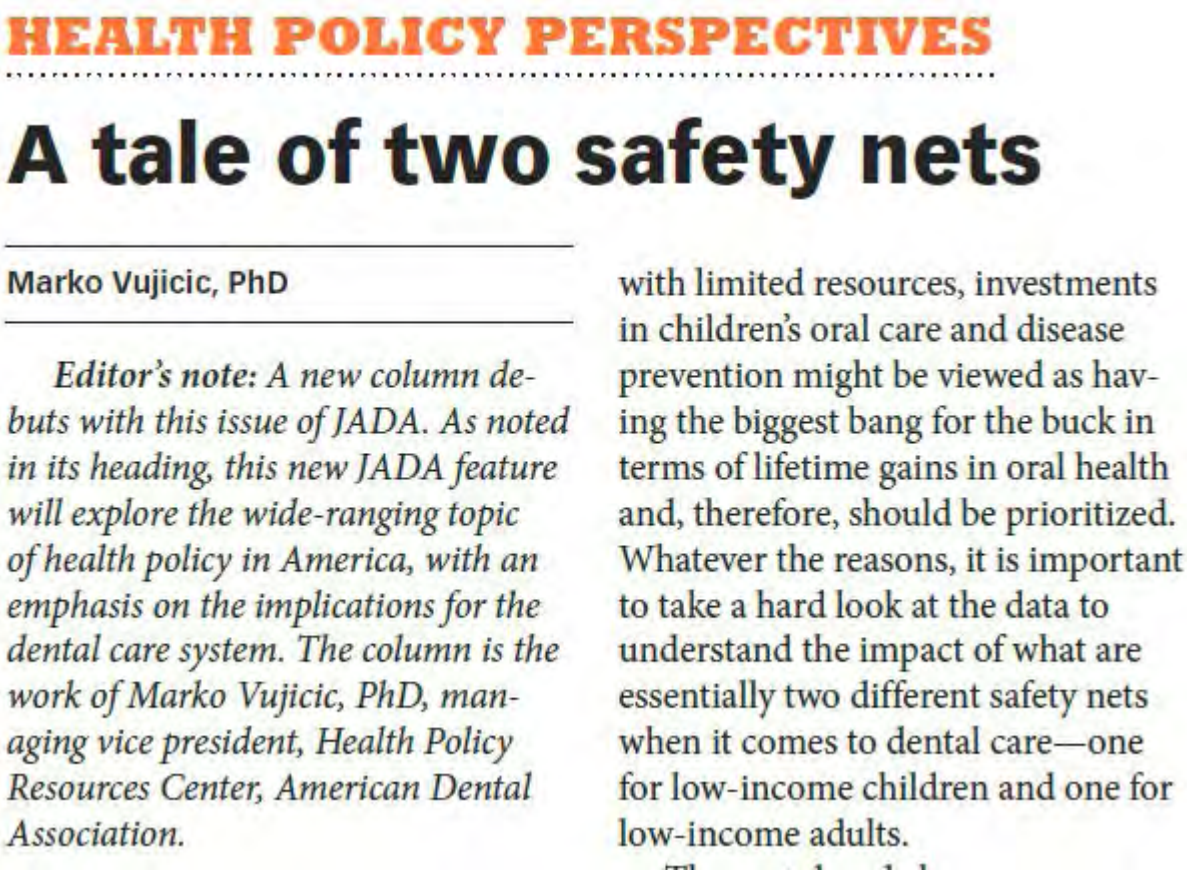
Access to Care

Figure 3: Dental Emergency Department Visits as a Percent of Total Dental Visits by Age in the United States, 2000 to 2010



Sources: National Hospital Ambulatory Medical Care Survey, NCHS; Medical Expenditure Panel Survey, AHRQ.

Access to Dental Care



HEALTH POLICY PERSPECTIVES

A tale of two safety nets

Marko Vujicic, PhD

Editor's note: A new column debuts with this issue of JADA. As noted in its heading, this new JADA feature will explore the wide-ranging topic of health policy in America, with an emphasis on the implications for the dental care system. The column is the work of Marko Vujicic, PhD, managing vice president, Health Policy Resources Center, American Dental Association.

with limited resources, investments in children's oral care and disease prevention might be viewed as having the biggest bang for the buck in terms of lifetime gains in oral health and, therefore, should be prioritized. Whatever the reasons, it is important to take a hard look at the data to understand the impact of what are essentially two different safety nets when it comes to dental care—one for low-income children and one for low-income adults.

Access to Dental Care

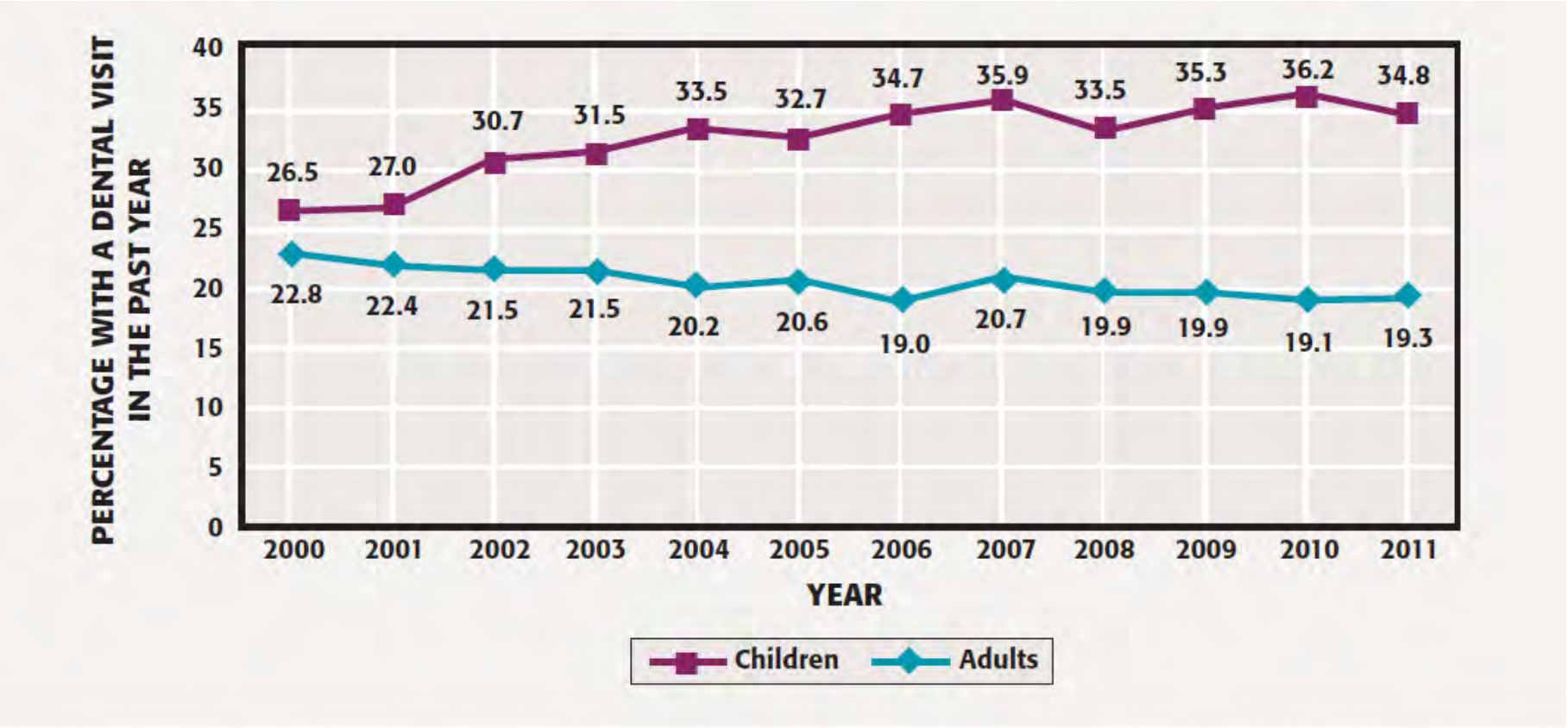


Figure. Percentages of low-income children and adults with a dental visit in the past year. Low income is defined as being at less than 100 percent of the federal poverty guidelines. Children are defined as being aged 2 through 18 years; adults are defined as being aged 19 through 64 years. Changes are significant at the 1 percent level (2000-2011). Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality.[1-12]

Access to Dental Care

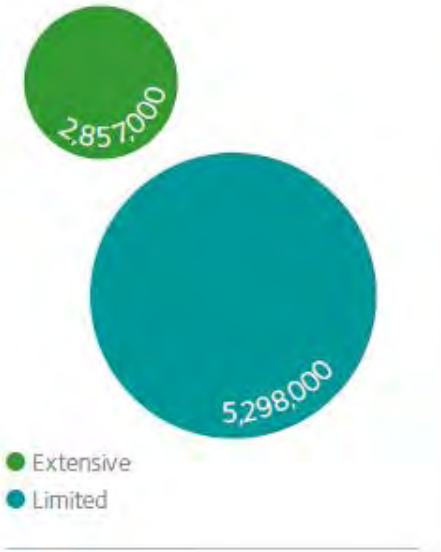
> The central question for the policy community is whether this tale of two safety nets–one for low-income children that has seen a decade of progress, the other for low-income adults that has not–is the right tale for America's oral health.

Part 2 – A Look Forward…

Medicaid Expansion

More Than 8 Million Adults Could Gain Dental Benefits Through Medicaid Expansion

INCREASE IN THE NUMBER OF LOW-INCOME NON-ELDERLY ADULTS WITH DENTAL BENEFITS IN 2014



ADULT DENTAL BENEFITS PROVIDED IN STATE MEDICAID PROGRAMS

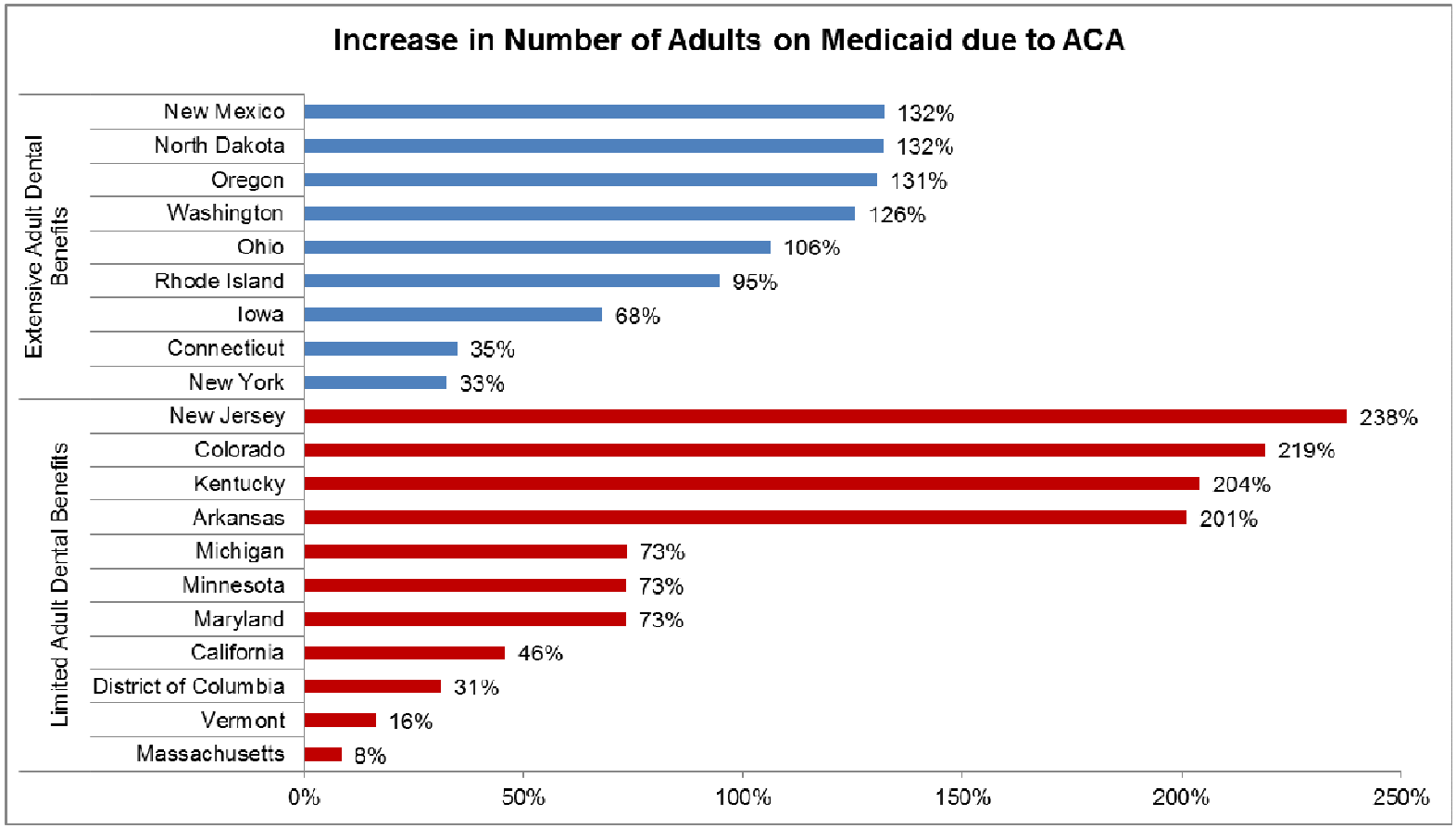
35 PERCENT Estimated reduction due to the ACA in the number of low-income adults who lack dental benefits

15% of general dentists

50% of pediatric dentists

are accepting new Medicaid patients

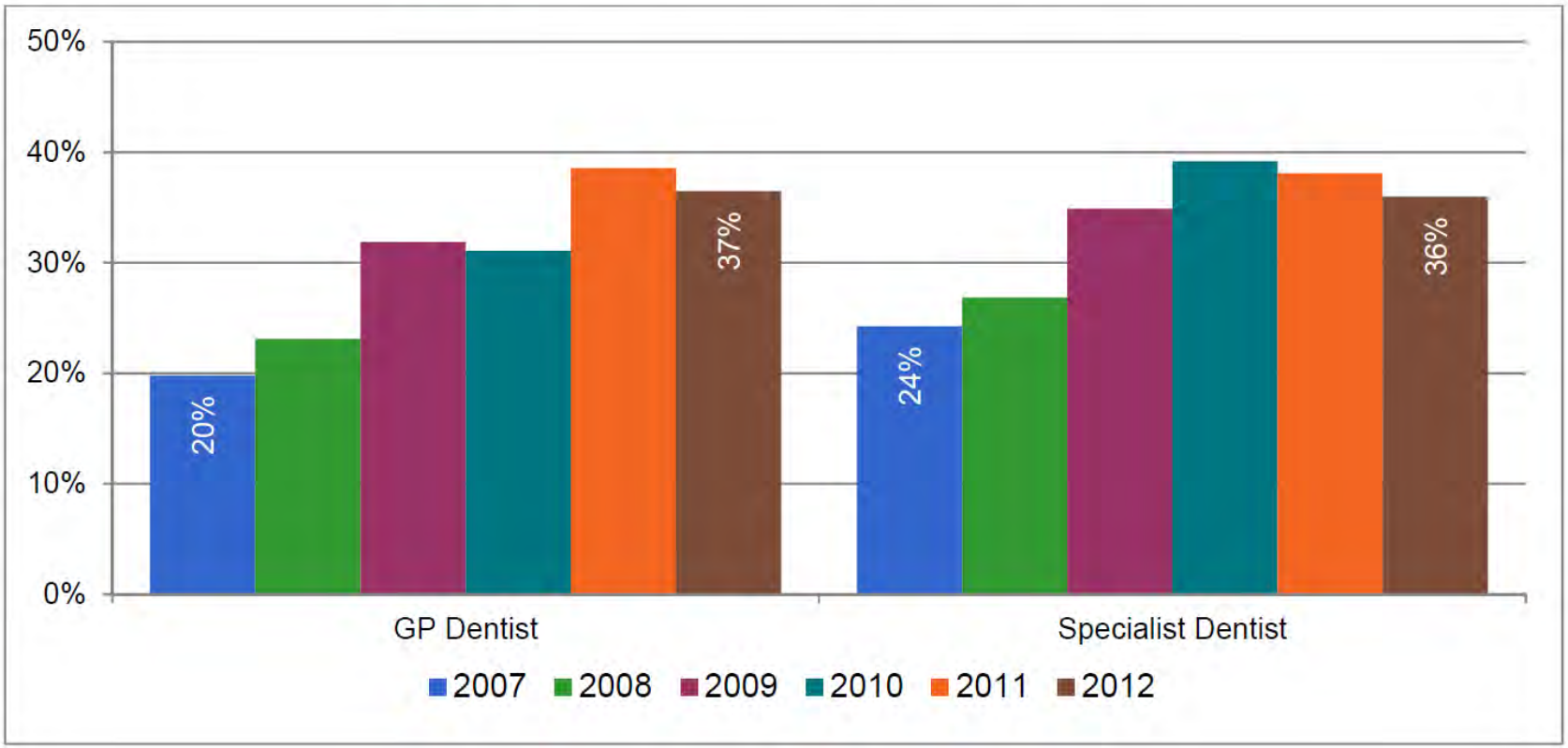
Medicaid Expansion



Source: ADA Health Policy Resources Center analysis of State Medicaid Policies, Kaiser Family Foundation. **Notes**: We examined the Medicaid benefits offered by each state to determine the type of dental benefits provided to enrolled adults. States typically post benefits information on their state Medicaid website, or in a statement of benefits. We classified each state's adult Medicaid dental benefits into one of four categories: extensive dental benefits, limited dental benefits, emergency dental benefits, and no dental benefits. While there is no clearly defined, well-established method for classifying adult Medicaid dental benefits, these categories are consistent with previous methodology developed by the ADA. We calculated the potential percentage change in adults eligible for Medicaid by dividing the number of adults potentially eligible for Medicaid in 2014 as determined by the Kaiser Family Foundation by the number of adults enrolled in Medicaid in 2010, by state.

Capacity in Dental Offices?

Figure 2: Percentage of Dentists "Not Busy Enough"



Source: ADA Health Policy Resources Center annual *Survey of Dental Practice*. **Note:** Indicates the percent of dentists reporting they are 'not busy enough and can see more patients.'

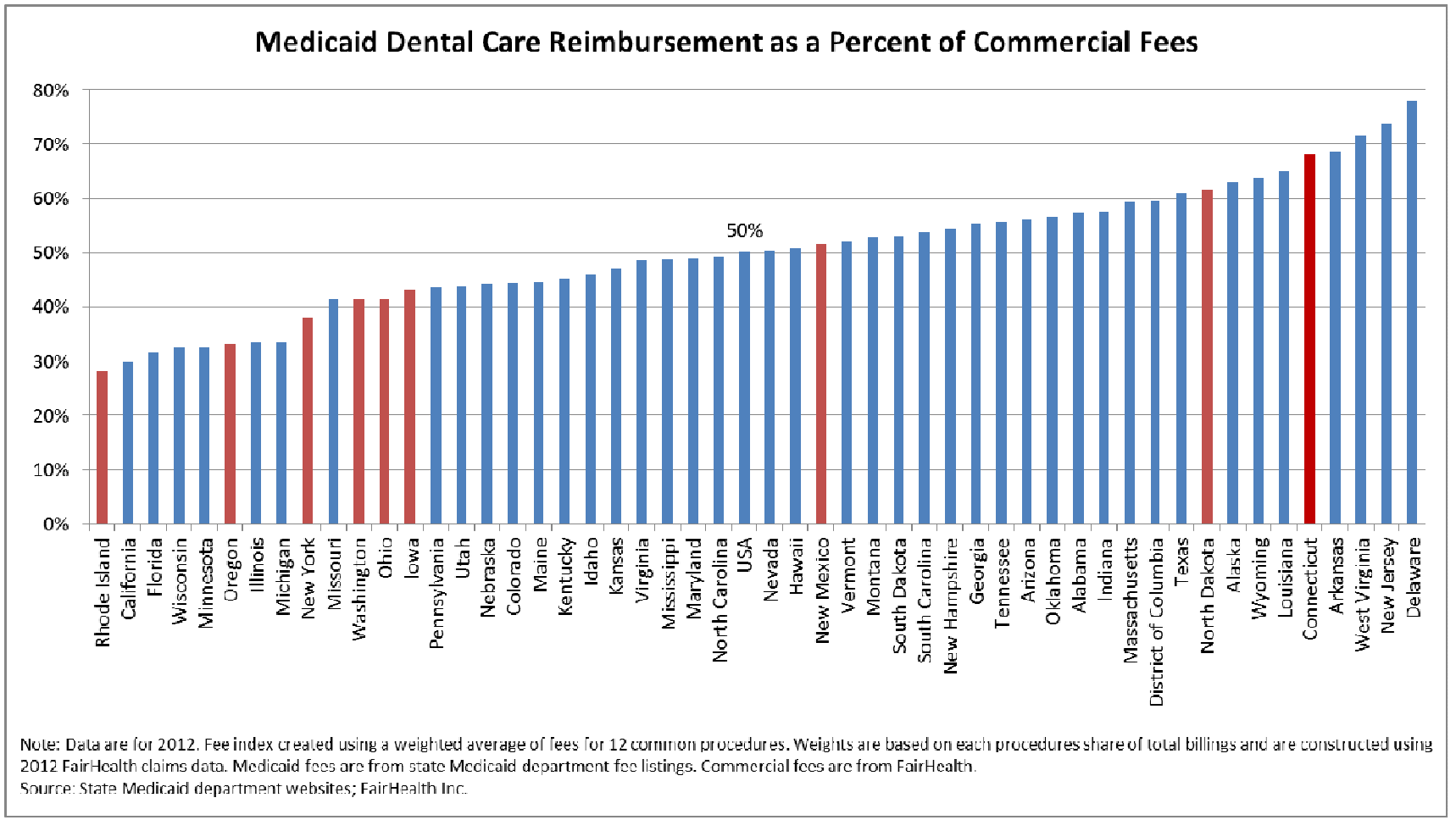
Capacity in Dental Offices?

When states add adult dental benefits to Medicaid…..

- Dentists' participation in Medicaid increases and dentists see more publicly insured patients.
- Dentists make greater use of dental hygienists. As a result, dentists' income increases.
- Wait times increase only modestly, with the largest increases in states with restrictive scope of practice laws governing dental hygienists.
- Enough capacity exists to largely address the increase in demand for dental care that accompanies a large increase in public dental coverage.

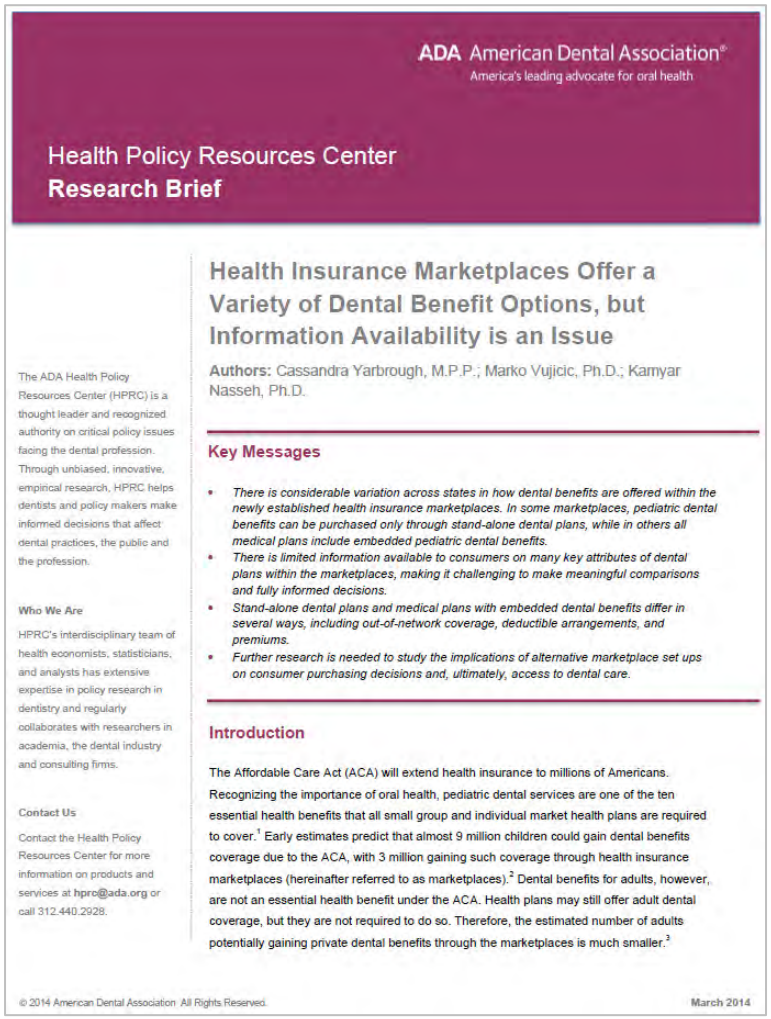
Source: Buchmueller, T., S. Miller, M. Vujicic. *How Do Providers Respond to Public Health Insurance Expansions? Evidence from Adult Medicaid Dental Benefits*. NBER Working Paper #20053, April 2014.

‘Enabling Conditions’ in Medicaid?



Note: Data are for 2012. Fee index created using a weighted average of fees for 12 common procedures. Weights are based on each procedures share of total billings and are constructed using 2012 FairHealth claims data. Medicaid fees are from state Medicaid department fee listings. Commercial fees are from FairHealth.
Source: State Medicaid department websites; FairHealth Inc.

Health Insurance Marketplaces



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Health Policy Resources Center
Research Brief

Health Insurance Marketplaces Offer a Variety of Dental Benefit Options, but Information Availability is an Issue

Authors: Cassandra Yarbrough, M.P.P.; Marko Vujicic, Ph.D.; Kamyar Nasseh, Ph.D.

The ADA Health Policy Resources Center (HPRC) is a thought leader and recognized authority on critical policy issues facing the dental profession. Through unbiased, innovative, empirical research, HPRC helps dentists and policy makers make informed decisions that affect dental practices, the public and the profession.

Who We Are

HPRC's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in policy research in dentistry and regularly collaborates with researchers in academia, the dental industry and consulting firms.

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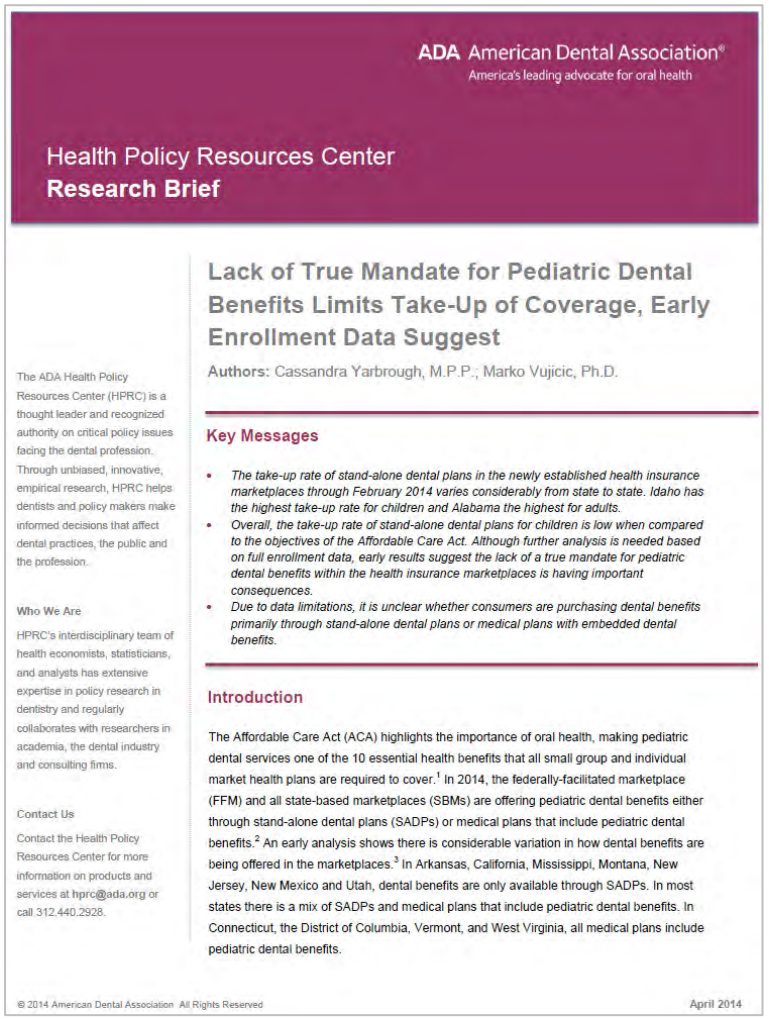
Key Messages

- *There is considerable variation across states in how dental benefits are offered within the newly established health insurance marketplaces. In some marketplaces, pediatric dental benefits can be purchased only through stand-alone dental plans, while in others all medical plans include embedded pediatric dental benefits.*
- *There is limited information available to consumers on many key attributes of dental plans within the marketplaces, making it challenging to make meaningful comparisons and fully informed decisions.*
- *Stand-alone dental plans and medical plans with embedded dental benefits differ in several ways, including out-of-network coverage, deductible arrangements, and premiums.*
- *Further research is needed to study the implications of alternative marketplace set ups on consumer purchasing decisions and, ultimately, access to dental care.*

Introduction

The Affordable Care Act (ACA) will extend health insurance to millions of Americans. Recognizing the importance of oral health, pediatric dental services are one of the ten essential health benefits that all small group and individual market health plans are required to cover.[1] Early estimates predict that almost 9 million children could gain dental benefits coverage due to the ACA, with 3 million gaining such coverage through health insurance marketplaces (hereinafter referred to as marketplaces).[2] Dental benefits for adults, however, are not an essential health benefit under the ACA. Health plans may still offer adult dental coverage, but they are not required to do so. Therefore, the estimated number of adults potentially gaining private dental benefits through the marketplaces is much smaller.[3]

March 2014



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Health Policy Resources Center
Research Brief

Lack of True Mandate for Pediatric Dental Benefits Limits Take-Up of Coverage, Early Enrollment Data Suggest

Authors: Cassandra Yarbrough, M.P.P.; Marko Vujicic, Ph.D.

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Who We Are

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Key Messages

- *The take-up rate of stand-alone dental plans in the newly established health insurance marketplaces through February 2014 varies considerably from state to state. Idaho has the highest take-up rate for children and Alabama the highest for adults.*
- *Overall, the take-up rate of stand-alone dental plans for children is low when compared to the objectives of the Affordable Care Act. Although further analysis is needed based on full enrollment data, early results suggest the lack of a true mandate for pediatric dental benefits within the health insurance marketplaces is having important consequences.*
- *Due to data limitations, it is unclear whether consumers are purchasing dental benefits primarily through stand-alone dental plans or medical plans with embedded dental benefits.*

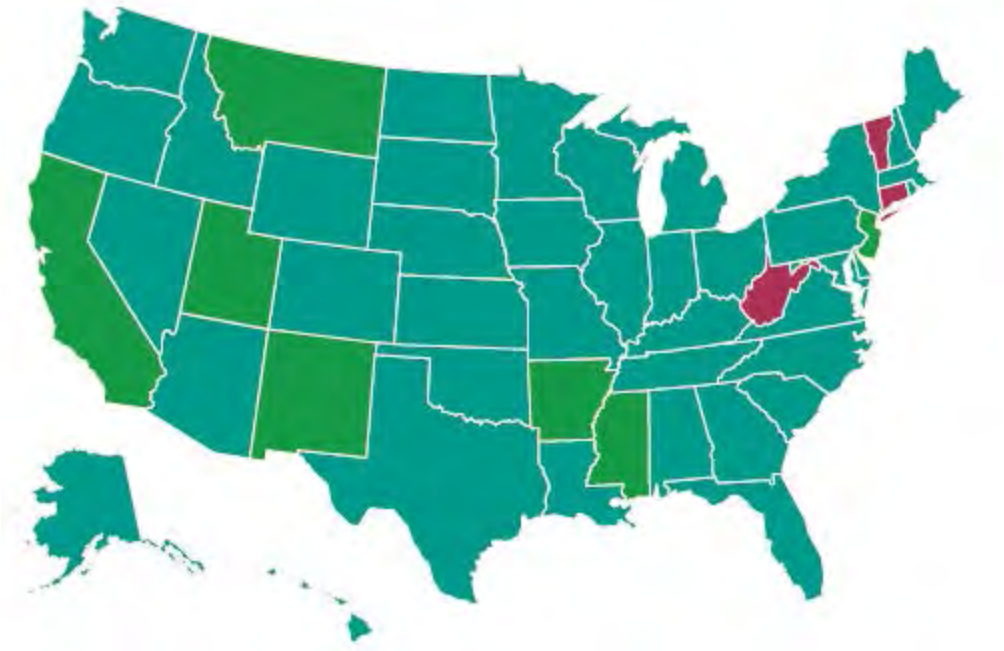
Introduction

The Affordable Care Act (ACA) highlights the importance of oral health, making pediatric dental services one of the 10 essential health benefits that all small group and individual market health plans are required to cover.[1] In 2014, the federally-facilitated marketplace (FFM) and all state-based marketplaces (SBMs) are offering pediatric dental benefits either through stand-alone dental plans (SADPs) or medical plans that include pediatric dental benefits.[2] An early analysis shows there is considerable variation in how dental benefits are being offered in the marketplaces.[3] In Arkansas, California, Mississippi, Montana, New Jersey, New Mexico and Utah, dental benefits are only available through SADPs. In most states there is a mix of SADPs and medical plans that include pediatric dental benefits. In Connecticut, the District of Columbia, Vermont, and West Virginia, all medical plans include pediatric dental benefits.

April 2014

Health Insurance Marketplaces

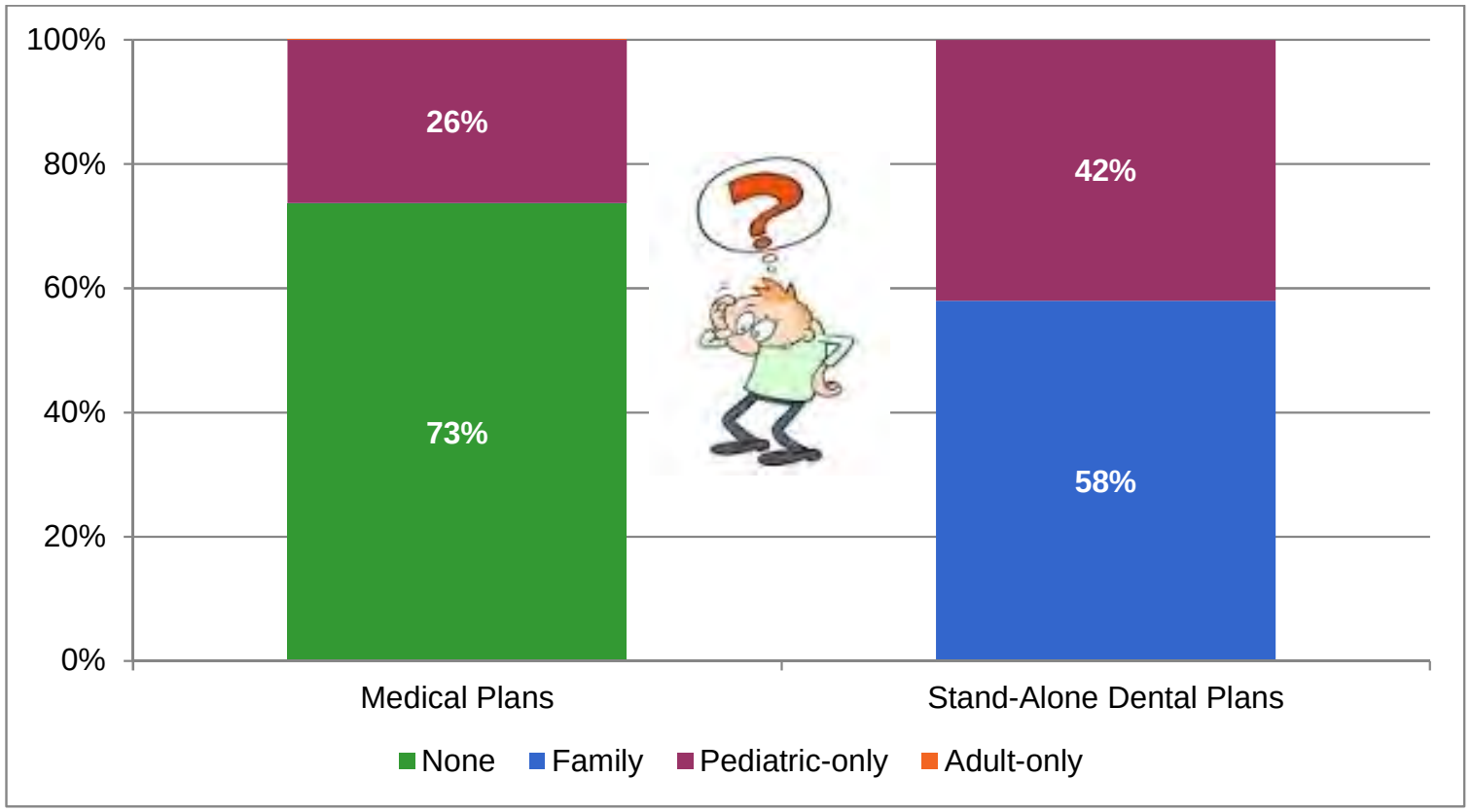
DO MEDICAL PLANS INCLUDE PEDIATRIC DENTAL BENEFITS?



- No medical plans include pediatric dental benefits
- Some medical plans include pediatric dental benefits
- All medical plans include pediatric dental benefits

Health Insurance Marketplaces

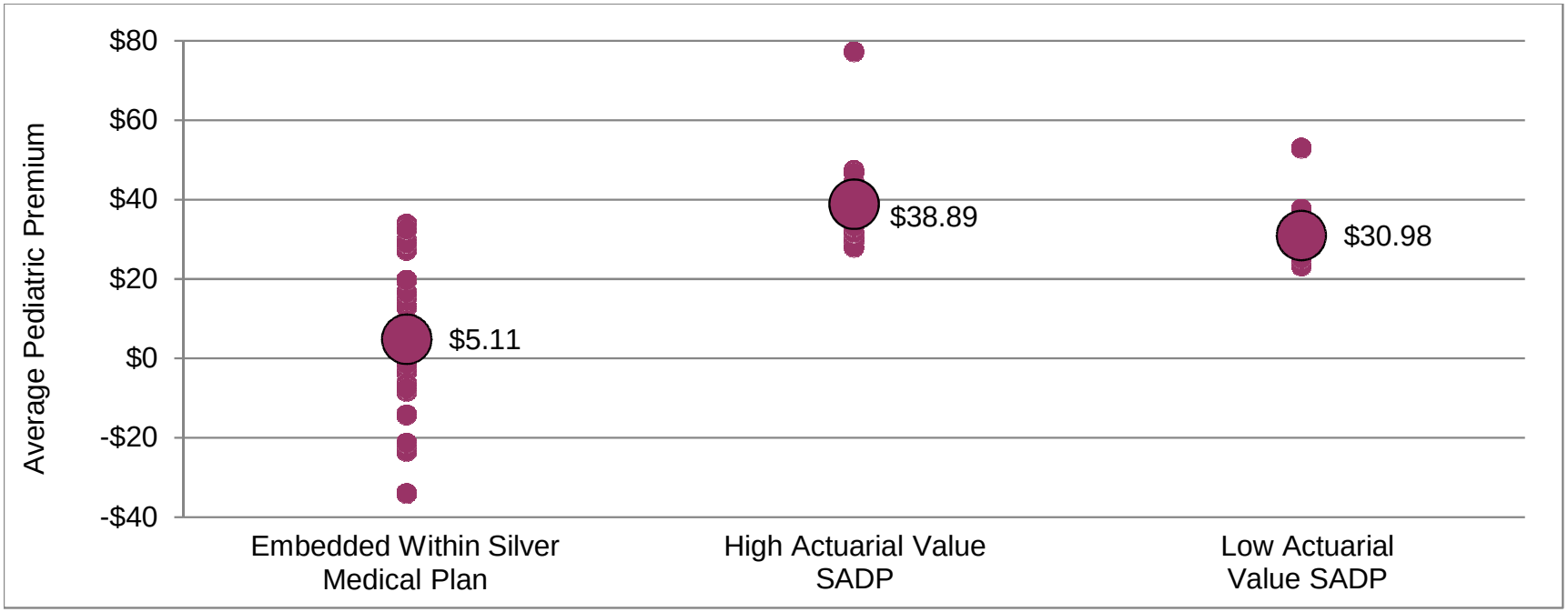
Figure 1: Dental Benefits Available within Medical and Stand-Alone Dental Plans



Source: ADA Health Policy Resources Center analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans and SADPs offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by a unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We then analyzed each unique medical plan and SADP for the type of dental benefits offered. Analysis is based on 3,180 medical plans and 697 SADPs.

Health Insurance Marketplaces

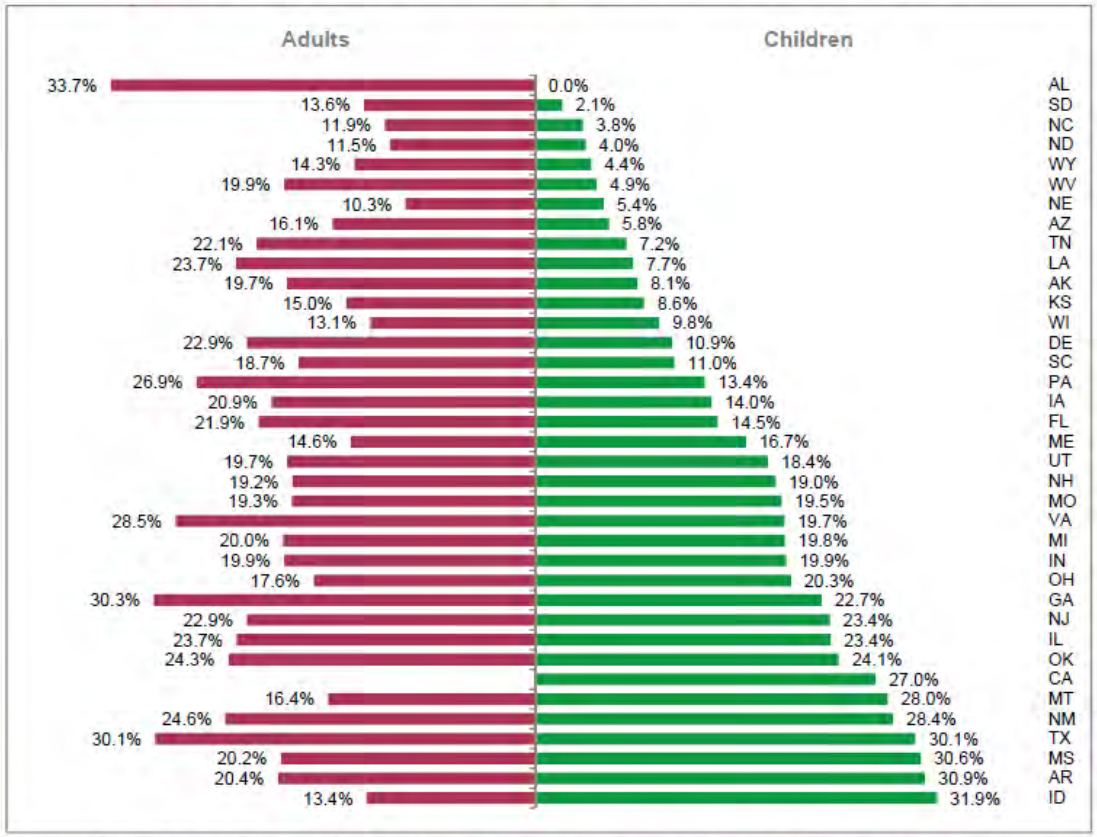
Figure 3: Average Monthly Pediatric Premium for Dental Benefits by Plan Type



Source: ADA Health Policy Resources Center analysis of data from the FFM. **Notes**: Each small data point represents the average premium in a state and each large data point represents the average across all states (unweighted). Premiums were analyzed separately for silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs. States were included in the analysis only if there were silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs available for purchase. This resulted in 25 states being included. States were excluded if all four types of plans were not available for purchase. This resulted in 11 states being excluded. To calculate the premium for pediatric dental benefits when they are embedded within a silver medical plan in a state, we first calculated the average premium for silver medical plans that have embedded pediatric dental benefits in a state. We then subtracted the average premium for silver medical plans that do not have embedded pediatric dental benefits in that state. This is a 'shadow' premium in the sense that it is not observed.

Health Insurance Marketplaces

Figure 1: Take-Up Rate of Stand-Alone Dental Plans in Health Insurance Marketplaces



Source: ADA Health Policy Resources Center analysis of HHS's marketplace enrollment data as of February 1, 2014. **Notes:** We calculated the number of individuals under the age of 18 that selected a medical plan and an SADP through the FFM (children). We also calculated the number of individuals age 18 and older that selected a medical plan and an SADP through the FFM (adults). We assume that all individuals that selected an SADP also selected a medical plan. We calculated the take-up rate of SADPs by dividing the number of individuals that selected an SADP by the number of individuals that selected a medical plan. We also included the percentage of children in California that selected an SADP using Covered California's published data. In California, no adult-only or family SADPs are offered.

Emphasis on Value

"Providers should be required to measure…improvements in quality of life, functioning and longevity.

After a patient has a knee replaced, can she walk normally? When a child has asthma can he play school sports? Unfortunately, the measurements we use today leaves us unable to make many of these vital judgments about the quality of doctors, hospitals or health care organizations."

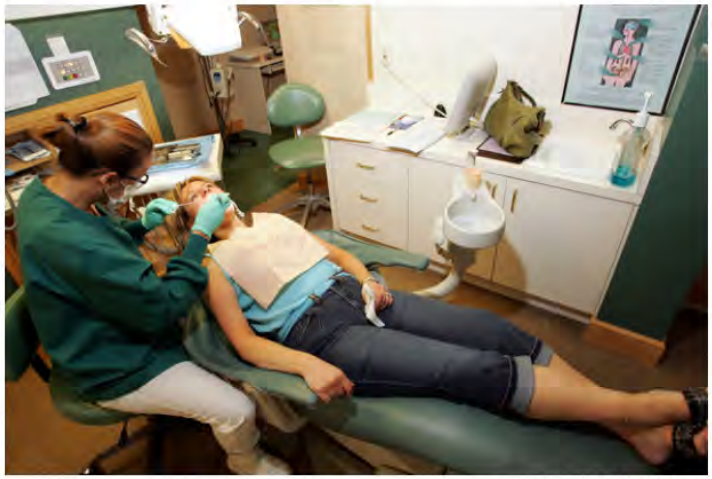
David Lansky, CEO, Pacific Business Group on Health, speaking on behalf of Boeing, Target, Disney, Wal-Mart, Intel, GE, Wells Fargo and the California Public Employees Retirement System.

Emphasis on Value

BODY | JUNE 10, 2013, 11:34 AM | 165 Comments

Rethinking the Twice-Yearly Dentist Visit

By CATHERINE SAINT LOUIS



Aaron Houston for The New York Times

Nancy Schlachter visits Lincroft Village Dental Care in Lincroft, N.J. for a dental cleaning from Nancy Garsick, a dental hygienist.

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For decades, dentists have urged all adults to schedule preventive visits every six months. But a new study finds that annual cleanings may be adequate for adults without certain risk factors for periodontal disease while people with a high risk may need to go more often.

Almost half of adults age 30 and older, about 65 million, have a form of chronic inflammatory gum disease that can ultimately lead to tooth loss. The study, published on Monday in The Journal of Dental Research, suggests that the frequency of dental visits for cleanings and other preventive services should be tailored to each person's risk factors for periodontal disease.

"The findings suggest that for low-risk patients, a yearly

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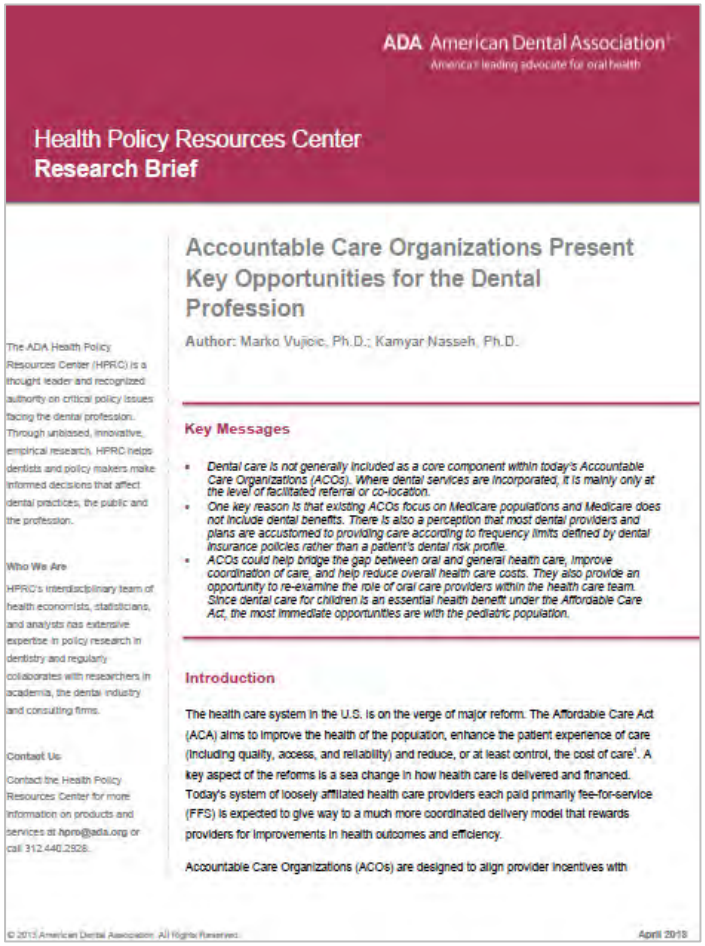
What happened to the research in the early '90s that showed marijuana smokers to have broken or deformed chromosomes? Has this research been discredited? 60

Are high triglycerides an independent risk factor for heart disease? My overall cholesterol is about 150, although the ratio could be better. 33

I recall reading several years ago that taking cholestrol-lowering drugs was shown to have no effect on lowering the risk of heart attack for people who did not already have heart disease. Is there any new data to confirm or refute this? 100
Asked by nicoara from Peoria, IL

Increased Care Coordination



ADA American Dental Association
America's leading advocate for oral health

Health Policy Resources Center
Research Brief

Accountable Care Organizations Present Key Opportunities for the Dental Profession

Author: Marko Vujicic, Ph.D.; Kamyar Nasseh, Ph.D.

The ADA Health Policy Resources Center (HPRC) is a thought leader and recognized authority on critical policy issues facing the dental profession. Through unbiased, innovative, empirical research, HPRC helps dentists and policy makers make informed decisions that affect dental practices, the public and the profession.

Who We Are

HPRC's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in policy research in dentistry and regularly collaborates with researchers in academia, the dental industry and consulting firms.

Contact Us

Contact the Health Policy Resources Center for more information on products and services at hpro@ada.org or call 312.440.2928.

Key Messages

- *Dental care is not generally included as a core component within today's Accountable Care Organizations (ACOs). Where dental services are incorporated, it is mainly only at the level of facilitated referral or co-location.*
- *One key reason is that existing ACOs focus on Medicare populations and Medicare does not include dental benefits. There is also a perception that most dental providers and plans are accustomed to providing care according to frequency limits defined by dental insurance policies rather than a patient's dental risk profile.*
- *ACOs could help bridge the gap between oral and general health care, improve coordination of care, and help reduce overall health care costs. They also provide an opportunity to re-examine the role of oral care providers within the health care team. Since dental care for children is an essential health benefit under the Affordable Care Act, the most immediate opportunities are with the pediatric population.*

Introduction

The health care system in the U.S. is on the verge of major reform. The Affordable Care Act (ACA) aims to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce, or at least control, the cost of care[1]. A key aspect of the reforms is a sea change in how health care is delivered and financed. Today's system of loosely affiliated health care providers each paid primarily fee-for-service (FFS) is expected to give way to a much more coordinated delivery model that rewards providers for improvements in health outcomes and efficiency.

Accountable Care Organizations (ACOs) are designed to align provider incentives with

April 2013

Increased Care Coordination

StarTribune | health

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In a year, Hennepin Health improves care for poor, keeps costs down

Article by: ROCHELLE OLSON , Star Tribune | Updated: May 18, 2013 - 12:04 AM

Innovative program serves poorest of the poor while keeping costs down.

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Like many of Hennepin County's poorest residents, Alfred McClary suffers from multiple chronic health problems that require lots of attention to manage.

"I've got so many medications here," the 60-year-old Minneapolis resident said recently. He takes as many as 10 a day. He's had gout surgery in the past month, and peripheral artery disease causes excruciating pain in his legs. The pain cost him his longtime job in purchasing at a hotel a few years ago, he said.

in case you missed it

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At the dental offices of HCMC,

Part 3 – Some Opportunities…

Fill Key Knowledge Gaps

- Dig deeper into why adults – especially young adults – are less likely to go to the dentist
  - Cost? Lack of insurance?
  - Changing values? Oral health literacy?
  - Improved oral health and reduced need?
- What do Medicaid adult dental benefits cost and what do they save in…
  - Costly dental care downstream
  - Avoided ER visits
  - Reduced unemployment
- What is an appropriate way to assess provider sufficiency?
  - Current HRSA methodology is highly flawed
  - Looming dentist retirements vs. Increased dental school enrolment

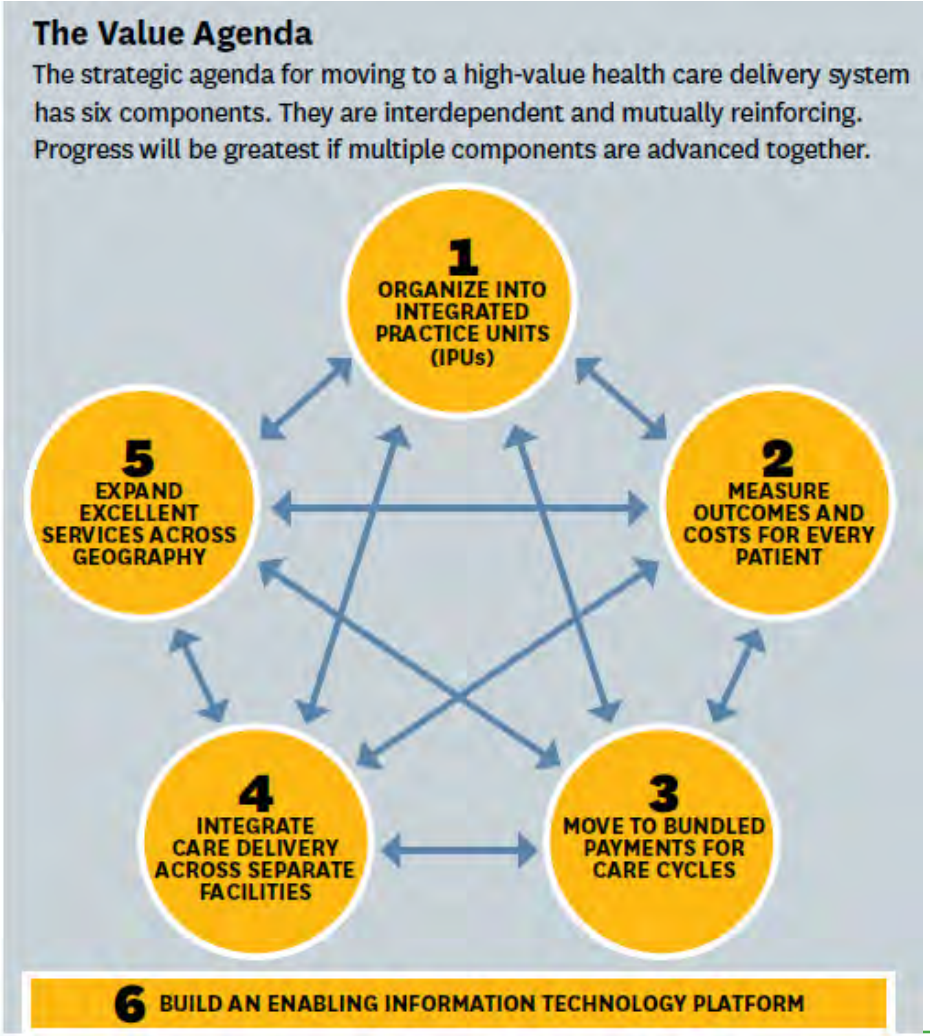
Leverage the Value Agenda

THE BIG IDEA

The Strategy That Will Fix Health Care

Providers must lead the way in making value the overarching goal *by Michael E. Porter and Thomas H. Lee*

Organizations that progress rapidly in adopting the value agenda will reap huge benefits, even if regulatory change is slow.

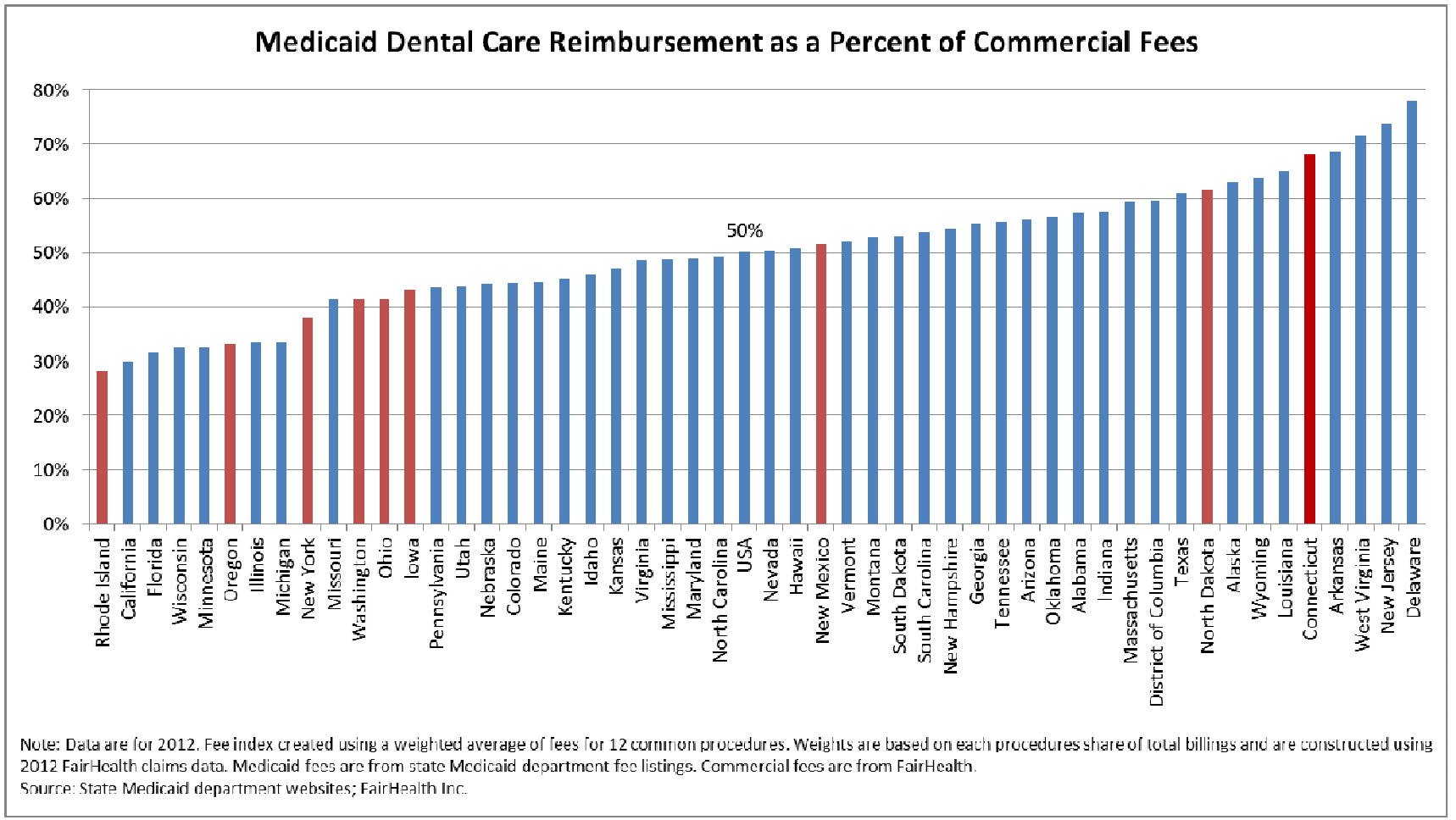


Promote ‘Enabling Conditions’ in Medicaid

- Texas, Maryland, Connecticut made improvements to their Medicaid program and saw impressive gains in access to care
  - Beazoglou T, J Douglass , H Bailit, V Myne-Joslin. 2013. Impact of increased dental reimbursement rates on husky a-insured children: 2006-2011. Health Issues Connecticut Health Foundation. February 2013.
  - Thuku NM, K Carulli, S Costello S, HS Goodman. 2012. Breaking the cycle in Maryland: oral health policy change in the face of tragedy. J Public Health Dent. Suppl 1:S7-13.

- Adjusting provider incentives and streamlining administrative process has impact
  - Decker SL. 2011. Medicaid payment levels to dentists and access to dental care among children and adolescents. JAMA. 2011;306(2):187-193.
  - Buchmueller T, S Orzol, L Shore-Sheppard. 2013. The effect of Medicaid payment rates on access to dental care among children. NBER Working Paper No. 19218.

Promote ‘Enabling Conditions’ in Medicaid



Note: Data are for 2012. Fee index created using a weighted average of fees for 12 common procedures. Weights are based on each procedures share of total billings and are constructed using 2012 FairHealth claims data. Medicaid fees are from state Medicaid department fee listings. Commercial fees are from FairHealth.
Source: State Medicaid department websites; FairHealth Inc.

Rethink the Role of the Dental Practice

Tomorrow's health care environment will provide an opportunity to re-examine the role of oral care providers within the health care system.

GUEST EDITORIAL

A profession in transition

Marko Vujicic, PhD; Hilton Israelson, DDS; James Antoon, DMD; Roger Kiesling, DDS; Thomas Paumier, DDS; Mark Zust, DDS

Dentistry is a profession in transition. Important economic, demographic and political forces are colliding to reshape the practice environment for America's dentists. To better understand the potential changes on the horizon, the American Dental Association (ADA) recently carried out a comprehensive, future-oriented analysis of the dental care sector as part of the 2015-2020 strategic plan development process.[1] This first-of-its-kind analysis drew on research carried out by health care consulting firm Diringer and Associates, various external consultants and the ADA's Health Policy Resources Center. Researchers investigated a wide variety of topics over a period of several months. To help identify the most pressing environmental factors that need to guide the ADA's strategic plan and to assist in a "what does it all mean for dentistry" discussion, a group of external thought leaders with diverse backgrounds and perspectives were asked to share their insights at a two-day conference. The full report, A Profession in Transition,[1] was released in August 2013. This is an executive summary of the key findings.

> One of the most important findings is that utilization of dental care is declining among working-age adults, particularly the young and the poor, and that this trend is unrelated to the recent economic downturn.

LOOKING BACK

Several important structural changes have occurred in the dental care sector in recent years. Structural changes are those that are driven by changes in the underlying behaviors of various groups—including patients, dentists and payers—and are distinct from cyclical changes that are driven simply by economic cycles.

One of the most important findings is that utilization of dental care is

Rethink the Role of the Dental Practice

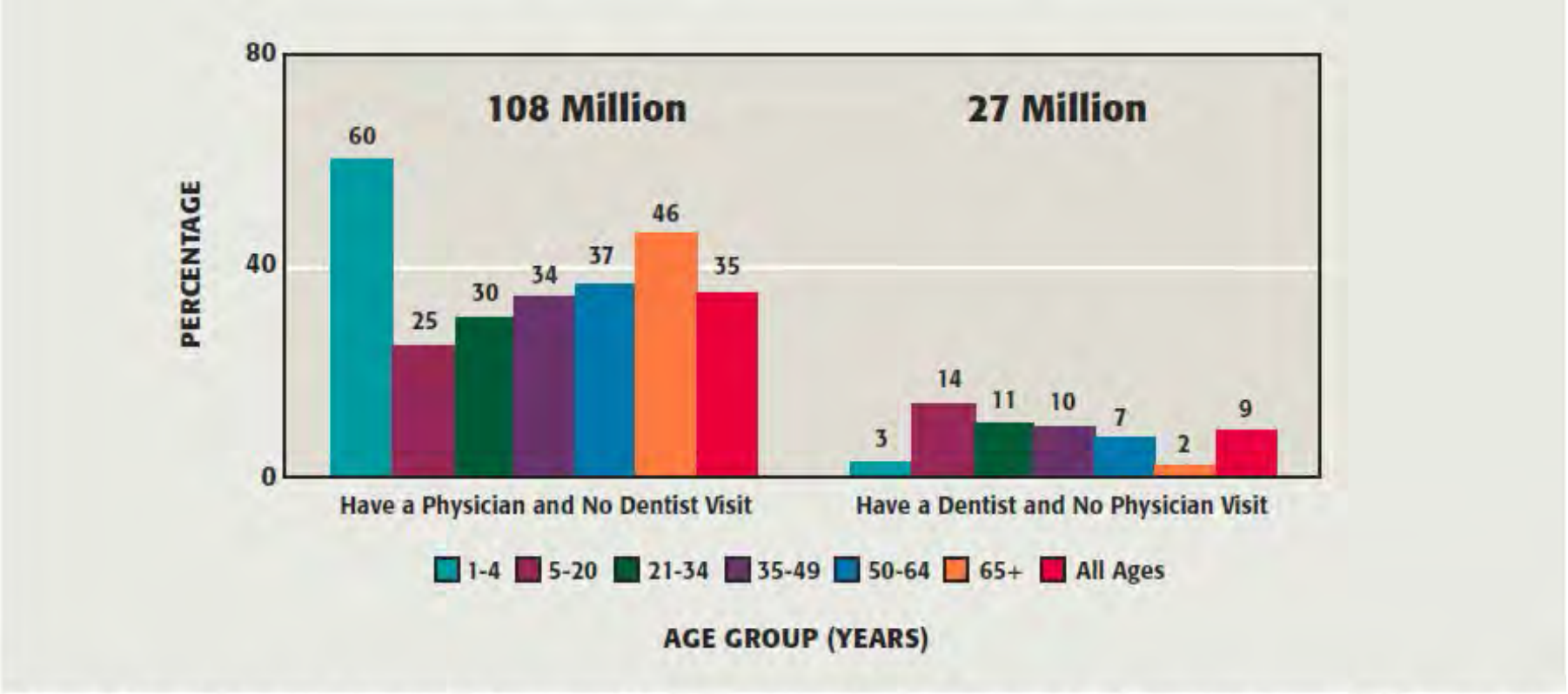


Figure. Visits to dentists and physicians in the course of one year among U.S. patients. Analysis by the American Dental Association Health Policy Resources Center, based on data from 2011 (the most recent year for which data are available) from the Medical Expenditure Panel Survey of the Agency for Healthcare Research and Quality.

Rethink the Role of the Dental Practice

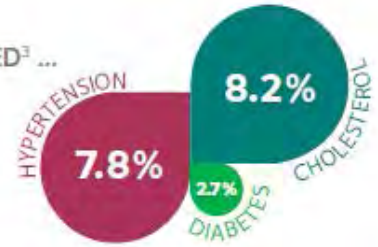
Screening for Chronic Diseases in the Dental Office

$153 BILLION

in lost productivity each year due to chronic disease[1]

27 MILLION PEOPLE visit a dentist and not a physician each year[2]

RATES OF UNDIAGNOSED[3] ...



SCREENING FOR CHRONIC DISEASES IN DENTAL OFFICES COULD REDUCE U.S. HEALTH CARE COSTS BY ...

up to **$102.6 MILLION** per year

OR

up to **$32.72** per person screened[4]

The Effect of Chairside Chronic Disease Screenings by Oral Health Professionals on Health Care Costs

Kamyar Nasseh, PhD, Barbara Greenberg, MSc, PhD, Marko Vujicic, PhD, and Michael Glick, DMD

Objectives. We estimated short-term health care cost savings that would result from oral health professionals performing chronic disease screenings.

Methods. We used population data, estimates of chronic disease prevalence, and rates of medication adherence from the literature to estimate cost savings that would result from screening individuals aged 40 years and older who have seen a dentist but not a physician in the last 12 months. We estimated 1-year savings if patients identified during screening in a dental setting were referred to a physician, completed their referral, and started pharmacological treatment.

Results. We estimated that medical screenings for diabetes, hypertension, and hypercholesterolemia in dental offices could save the health care system from $42.4 million ($13.51 per person screened) to $102.6 million ($32.72 per person screened) over 1 year, dependent on the rate of referral completion from the dental clinic to the physician's office.

Conclusions. Oral health professionals can potentially play a bigger role in detecting chronic disease in the US population. Additional prevention and monitoring activities over the long term could achieve even greater savings and health benefits. (*Am J Public Health*. Published online ahead of print February 13, 2014: e1–e7. doi:10.2105/AJPH.2013.301644)

About 133 million Americans, or almost 1 in 2 adults, have at least 1 chronic illness. Chronic conditions account for more than 75% of health care costs and 70% of deaths each year in the United States.[1] Chronic diseases cost the United States $153 billion annually in lost productivity, and individuals who are overweight, obese, or have other chronic conditions miss an additional 450 million days from work compared with healthy workers.[2] The high prevalence, associated morbidity, and economic impact of chronic diseases, particularly diabetes, hypercholesterolemia (high blood cholesterol), and hypertension, are a serious public health issue in the United States today. According to the Medical Expenditure Panel Survey, about 40% of adults visit the dentist in a given year,[3] 10% to 20% of whom have not seen a physician in the preceding year.[4,5] This presents an opportunity for oral health professionals to be part of an integrated health care team working to combat these chronic diseases.

Screening for undiagnosed medical conditions in the dental office has long been proposed as a potentially valuable public health service.[6–8] Widespread adoption of this practice is dependent on determining the efficacy of screening in the dental setting and acceptance by dental care providers and patients. To examine the effectiveness and acceptance of screening programs, several studies have evaluated screening for diabetes, hypercholesterolemia, and hypertension in the dental setting.[4,9] These conditions were chosen because of (1) their prevalence in today's society, (2) the significant morbidity and mortality associated with these conditions, (3) the ability to lessen their burden through early detection, and (4) the availability of well-validated, safe, and easy-to-use screening tools.[4,9,10] Additional studies have found that a majority of dentists[11] and patients[12] believe that it is important for oral health professionals to perform medical screenings for heart disease, diabetes, and hypertension in the dental office.

A study conducted in Sweden concluded that limiting screening to patients older than 40 years of age would increase the percentage of patients who participated in screening and who had hypertension.[13] Another study came to a similar conclusion, and also found potential benefits for patients who had been previously diagnosed with hypertension but who did not maintain adequate blood pressure control.[14] The utility of screening for diabetes during dental visits has also been evaluated. Among 356 patients with no known history of diabetes who visited an outpatient periodontal clinic in India, diabetes was found in 19.1% of the patients.[15]

In practice, physicians who detect an abnormal test result for the presence of chronic disease are inclined to provide medication to their patients. The thresholds upon which primary care physicians determine mediation treatment, particularly for diabetes and hypertension, have been lowered since the early 1990s, and newer guidelines encourage the treatment of prediabetes and prehypertension.[16] In this analysis, we assumed that people who had undiagnosed diabetes, undiagnosed hypercholesterolemia, or undiagnosed hypertension and were subsequently diagnosed for 1 or more of these conditions by a physician would receive prescription drug treatment per treatment guidelines.

Once patients start medication therapy, it is important that they adhere to the regimen. Medication treatment of cardiovascular disease has been shown to be effective only if patients adhere to their medication.[17] Poor medication adherence has been associated with increased hospitalization, increased use of health care resources, and higher overall health care costs.[18–20] Poor medication adherence has also been associated with failure to reach treatment target goals, (such as blood pressure control), adverse clinical outcomes, and higher rates of mortality.[17,21,22]

No previous studies we know of examined the cost implications to the US health care system stemming from chronic disease screenings in a dental office. In the current environment of fiscal constraint and the focus on cost control in health care reform, potential cost savings are important to consider. In this analysis, we estimated 1 component of the

Thank You!

To access the groundbreaking report *A Profession in Transition* visit:

http://www.ada.org/escan

To access reports and data from the ADA Health Policy Resources Center visit:

http://www.ada.org/1442.aspx

Trends in Student Debt

The NEW ENGLAND JOURNAL of MEDICINE

Are We in a Medical Education Bubble Market?

David A. Asch, M.D., M.B.A., Sean Nicholson, Ph.D., and Marko Vujicic, Ph.D.

Trends in Student Debt

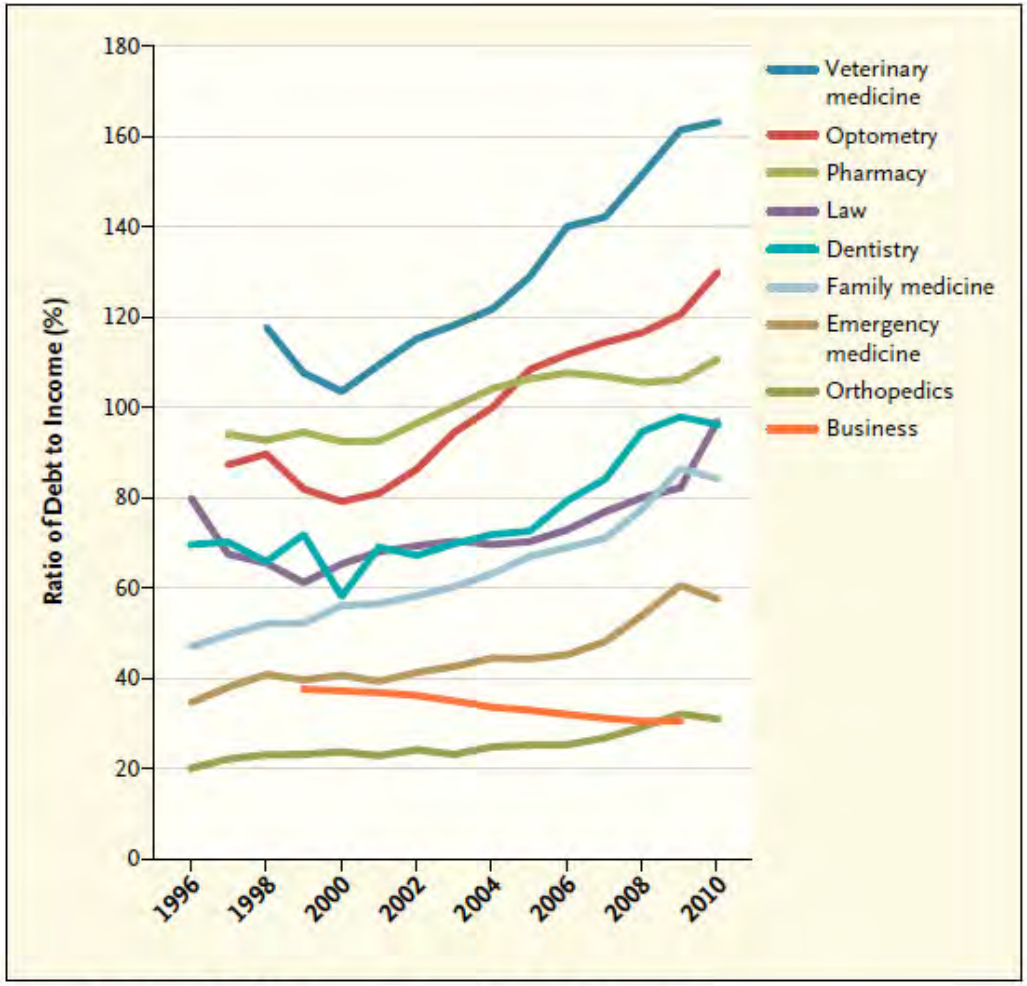


Figure 2. Ratio of Debt to Income, According to Occupation.

Although it seems unlikely that we're in a bubble market for medical education, we may already be in one for veterinary medicine. That bubble will burst when potential students recognize that the costs of training aren't matched by later returns. Then the optometry bubble may burst, followed by the pharmacy and dentistry bubbles. At the extreme, we will march down the debt-to-income-ratio ladder, through psychiatrists to cardiologists to orthopedists . . . until no one is left but the MBAs.

Classification of Dental Group Practices

Category	Definition
Completely Dentist Owned and Operated Group Practice	An aggregation of a variable number and/or type of dentists in a single practice that may be located at a single or multiple sites completely owned and operated by dentists, usually organized as a partnership or professional corporation.
Dental Management Organization Affiliated Group Practice	A group practice that has contracted with a dental management organization to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice. There are several types of dental management organizations and there can be significant variations in the nature of the agreements between the dentist and the dental management organization.
Insurer-Provider Group Practice	A group practice that is part of an organization that both insures the health care of an enrolled population and also provides their health care services.
Not-For-Profit Group Practice	A practice that is operated by a charitable, educational or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals.
Government Agency Group Practice	A practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government employees or contractors and operate according to agency policies.
Hybrid Group Practice	A practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them.

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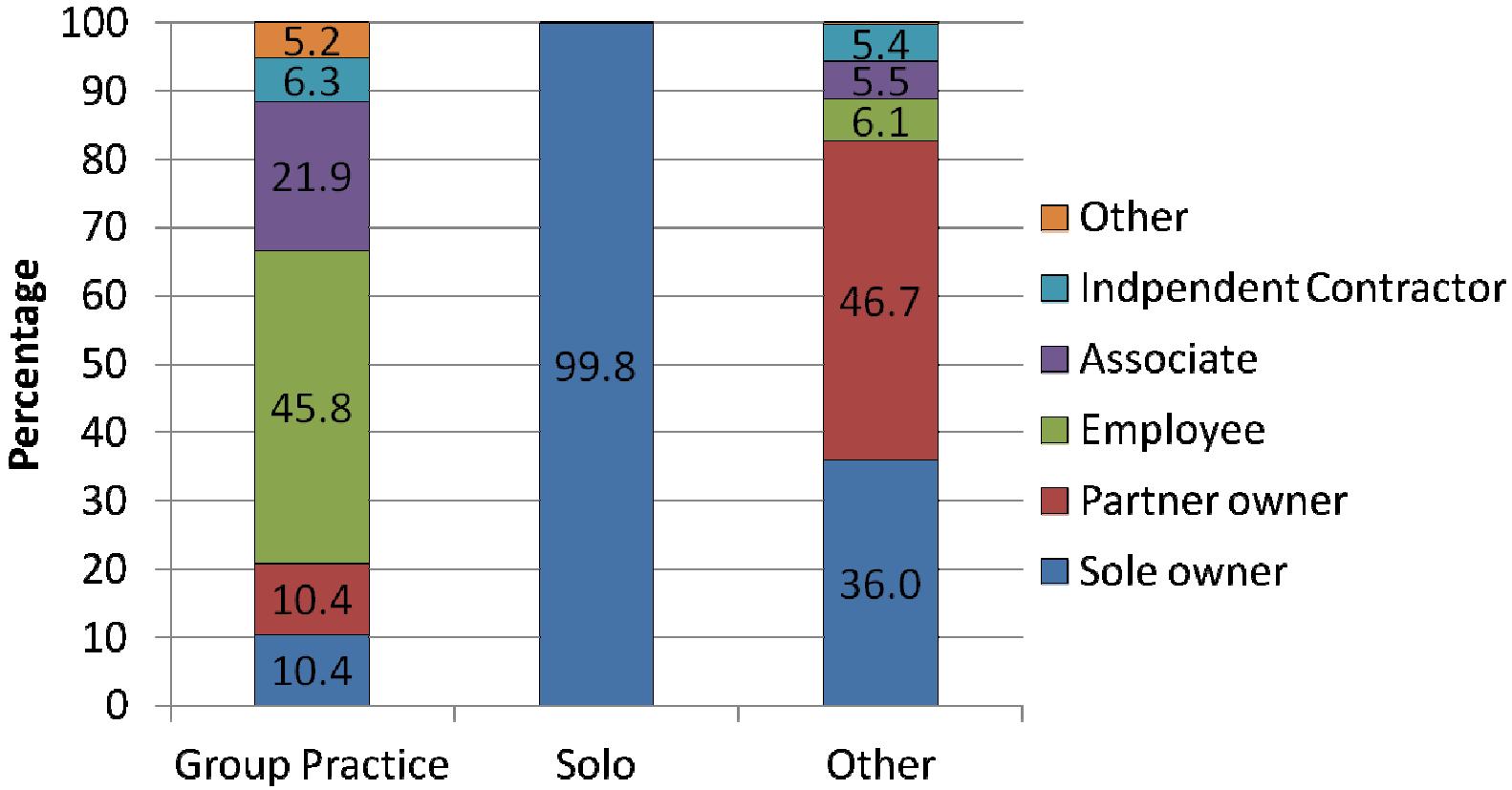
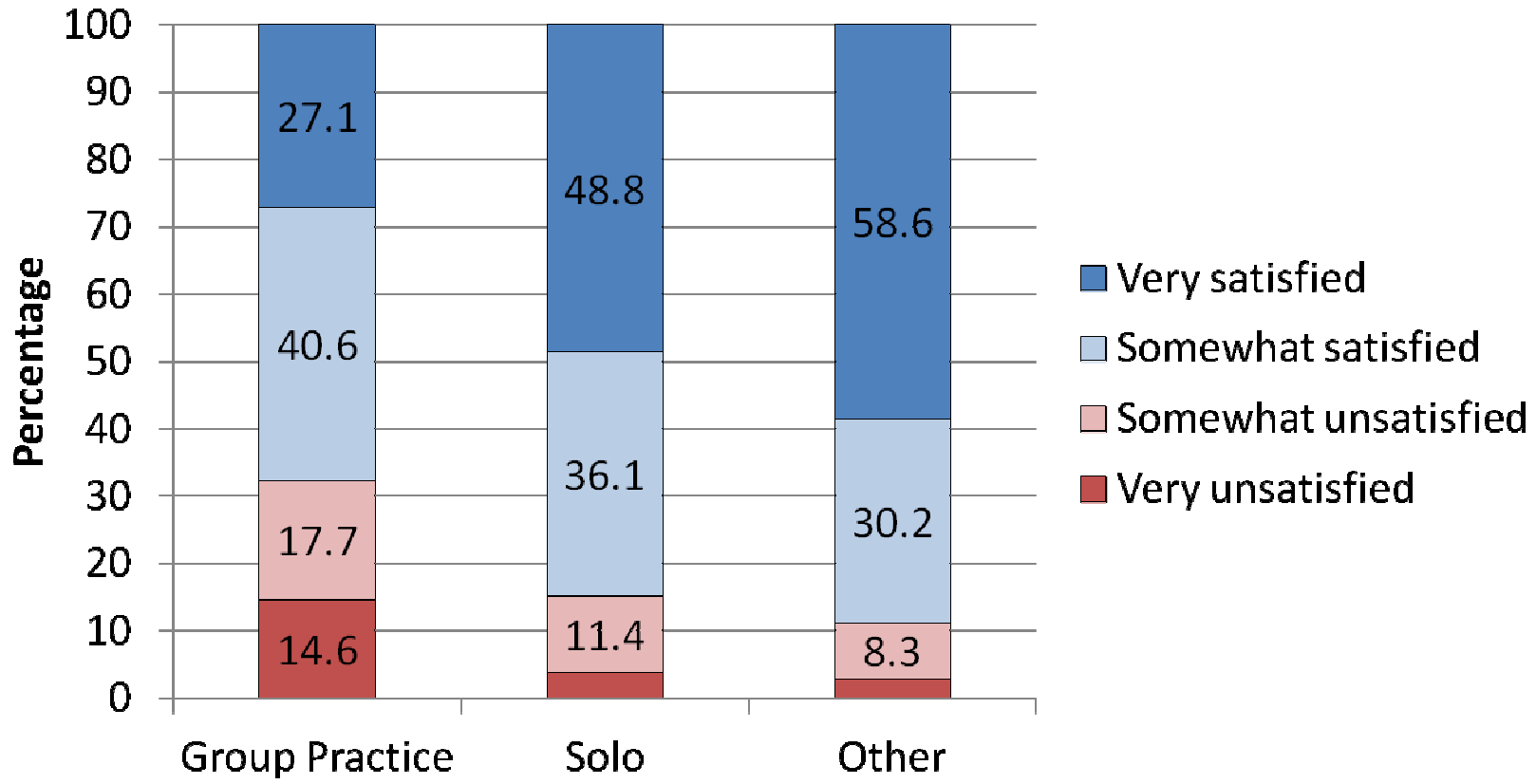
Demographics

	Group Practice	Solo	Other
Age			
Mean age	42.1	54.9	53.5
Gender			
Male	62.5	84.4	78.3
Female	37.5	15.6	21.7
Years at Current Practice			
Less than 1	18.5	0.8	2.7
1 to 2	30.1	2.1	3.0
3 to 5	24.2	4.2	9.3
6 to 10	10.5	10.8	12.5
11 to 20	9.5	18.1	19.7
More than 20	6.3	64.1	52.8
Hours Worked			
Full-time	83.3	89.9	80.3
Part-time	16.7	10.1	19.7

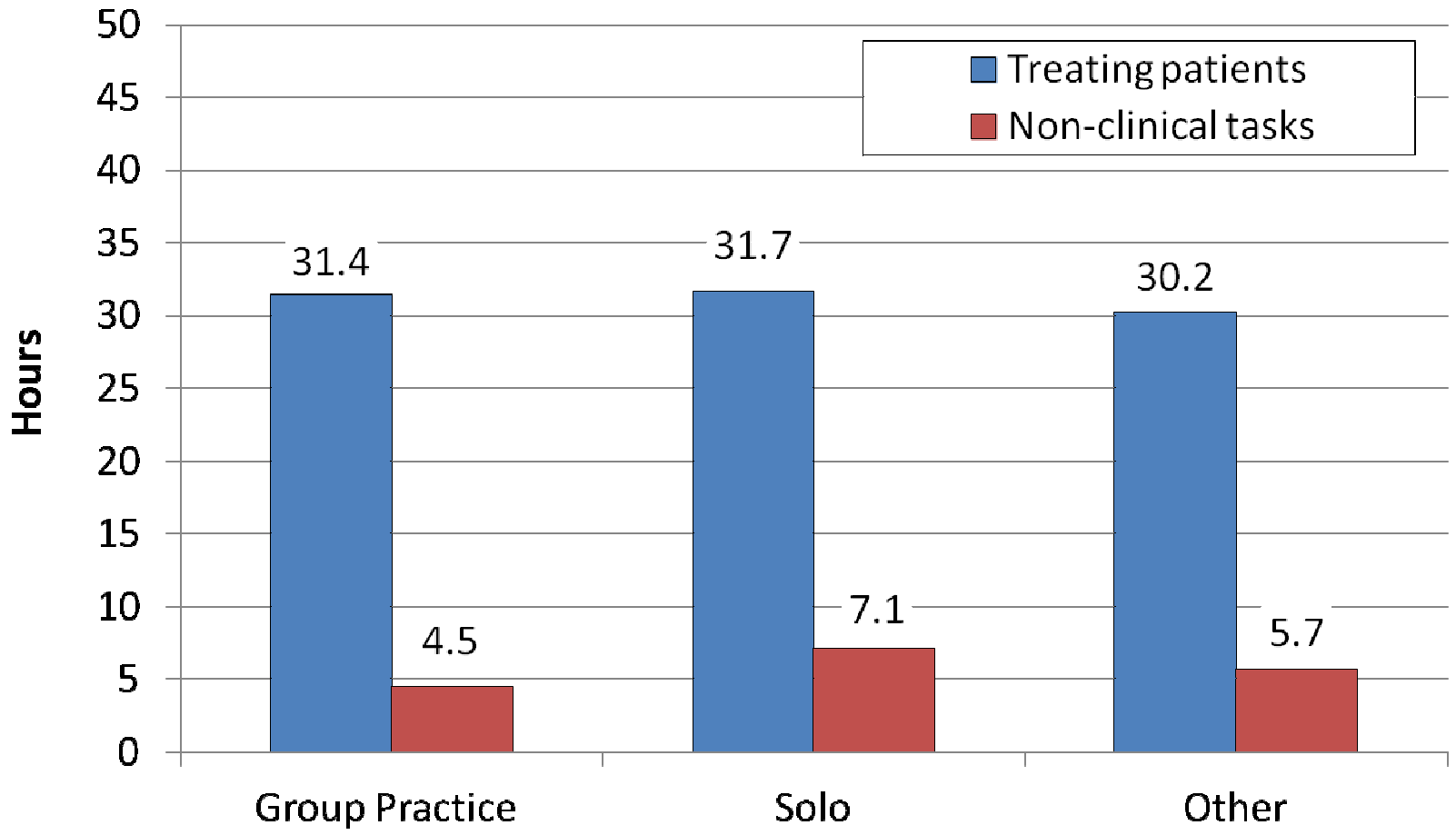
Employment Type



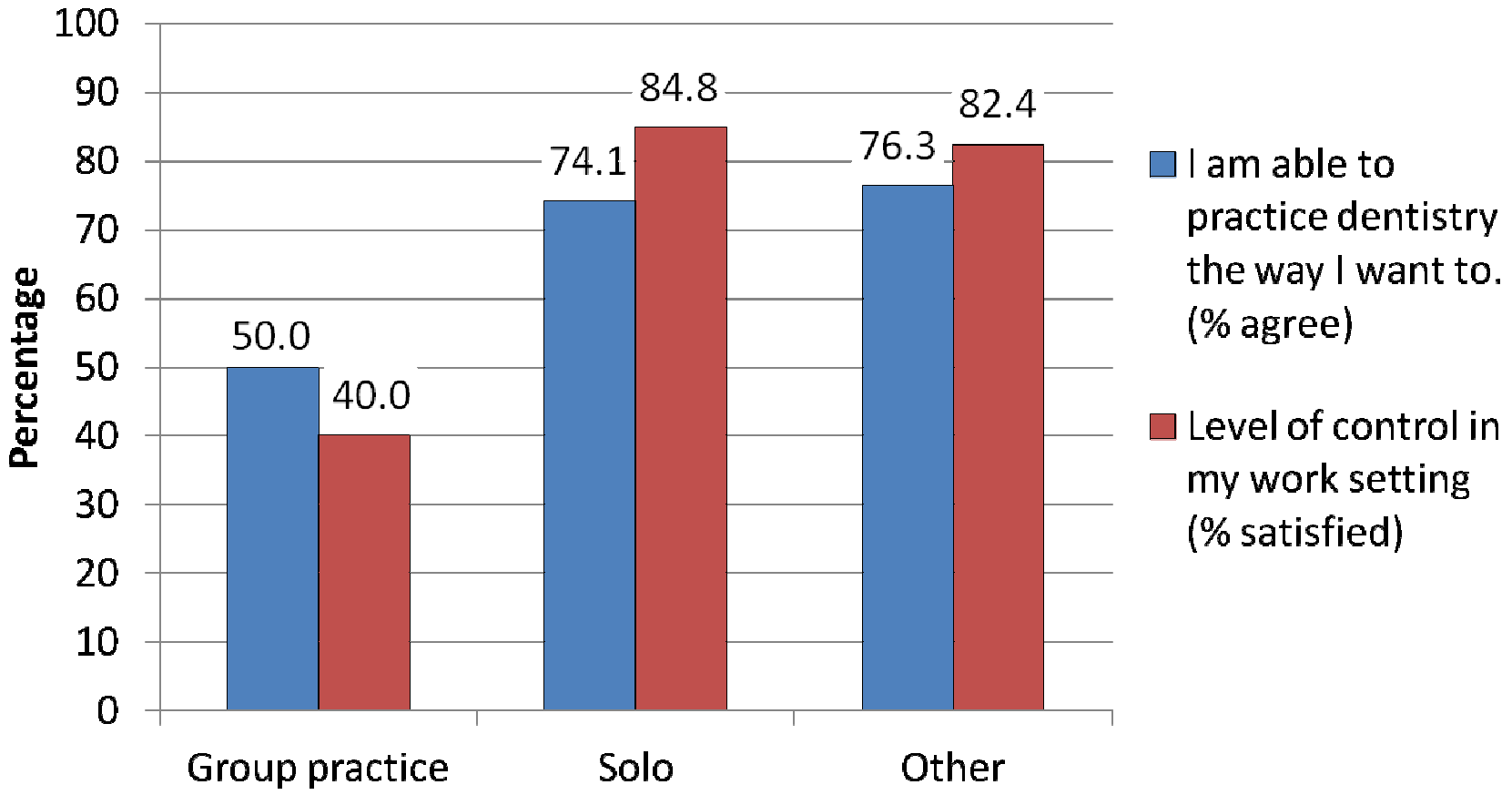
How satisfied are you working in your current primary practice?



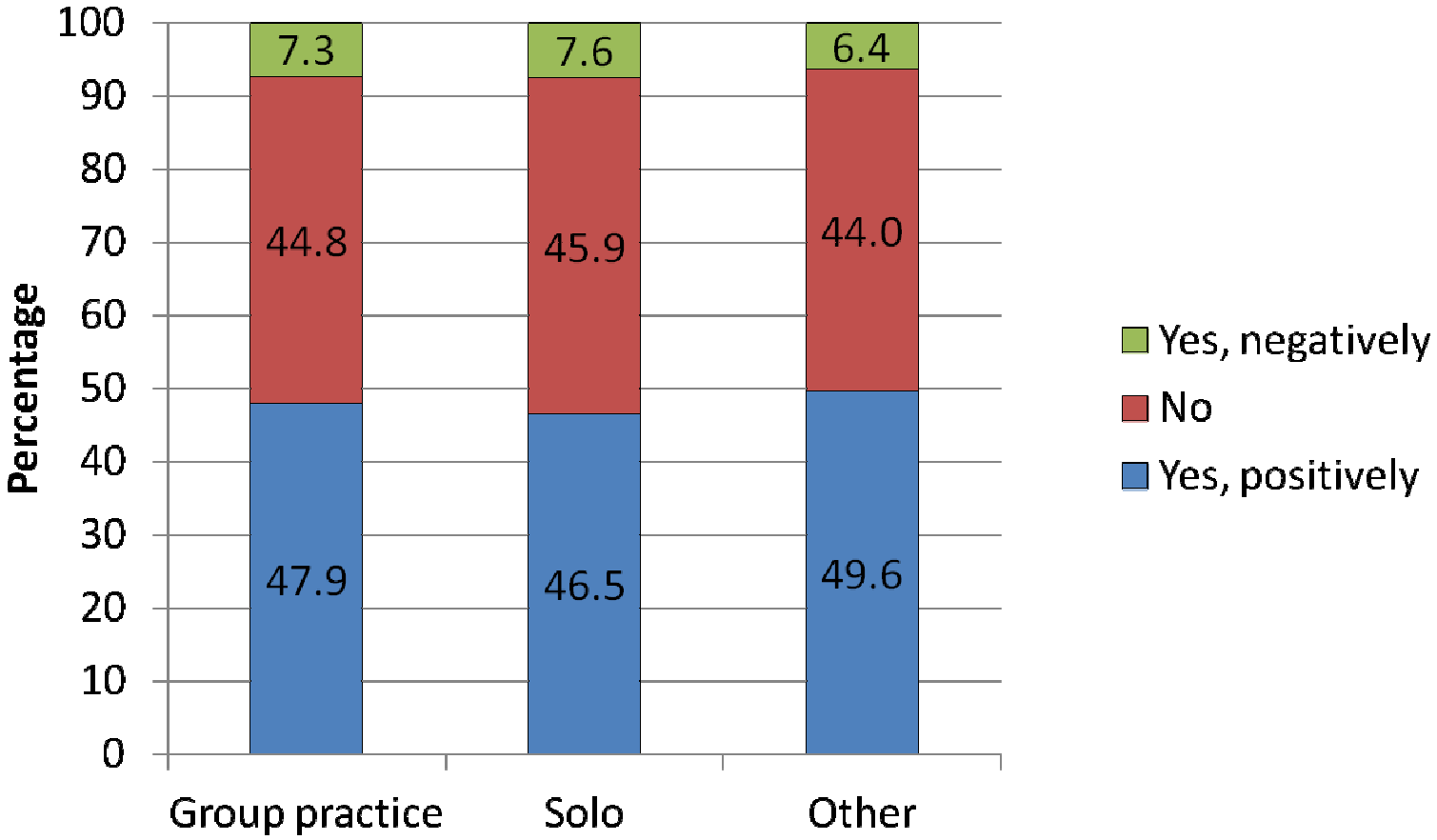
Hours spent on treatment vs. non-clinical tasks



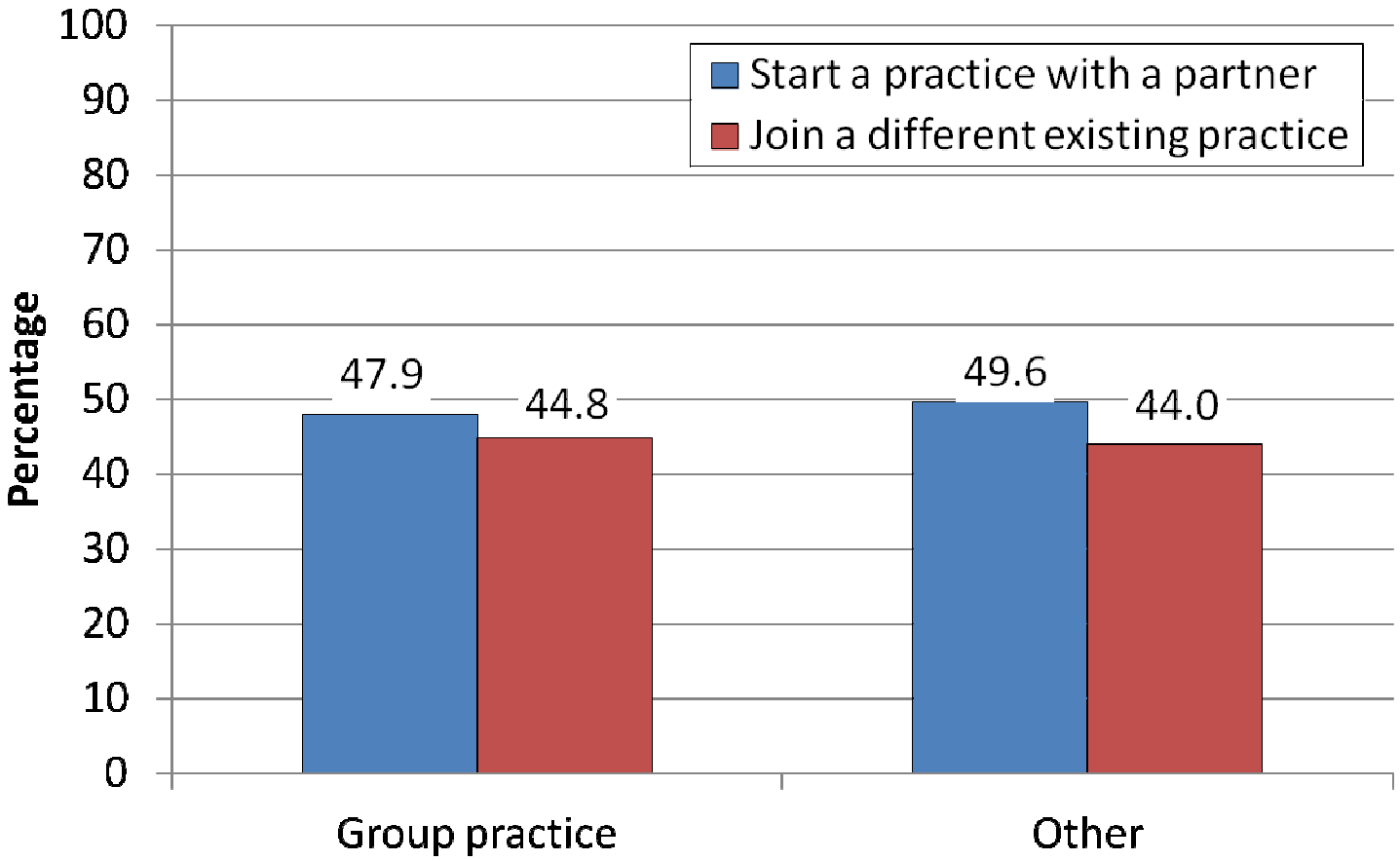
Perceptions of clinical autonomy



Has the experience of working in your current primary practice changed how you make decisions about treatment?



Future plans among employees and associates



Impact of ACA

Table 3: Information Available to Consumers on Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Does the dental plan indicate coverage of preventive services?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, consumers can determine:		
Whether the deductible applies	14%	18%
If there is a copay	14%	14%
Coinsurance level	100%	100%
Does the plan indicate coverage of restorative services?		
Yes	8%	98%
No	0%	0%
Unclear	92%	2%
If yes, consumers can determine:		
Whether the deductible applies	100%	71%
If there is a copay	0%	12%
Coinsurance level	100%	100%
Does the plan indicate coverage of orthodontia services?		
Yes	8%	96%
No	0%	2%
Unclear	92%	2%

Impact of ACA

Table 3: Information Available to Consumers on Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Does the plan indicate that there is a separate dental deductible?		
Yes, and the amount is shown	14%	100%
Yes, but the amount is not shown	6%	0%
No	0%	0%
Unclear	80%	0%
Does the plan provide a list of in-network dental providers?		
Yes, list is accessed from SBC	56%	100%
Yes, but list is not accessed from SBC	20%	0%
No	24%	0%
Does the plan indicate coverage of dental services out-of-network?		
Yes	52%	94%
No	48%	6%
Unclear	0%	0%

Health Insurance Marketplaces

Table 4: Summary of Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Is there a separate dental deductible?		
Yes	42%	100%
Average amount	$34.21	$41.10
No	34%	0%
Average amount	$2,935.29	N/A
Unclear	24%	0%
Are preventive services covered?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, average that plan pays	98%	97%
If preventive services are covered, does the deductible apply?		
Yes, medical deductible is used	12%	0%
Yes, dental deductible is used	2%	26%
No	86%	74%
Unclear	0%	0%