2015 National Medicaid and CHIP Oral Health Symposium

Session Four

Opportunities for the Dual-Eligibles: Medicaid and Medicare Adults

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Washington Marriott Wardman Park
Monday, June 1st, 2015
Learning Objective

Participants will gain knowledge in:

The barriers and opportunities at the federal and state levels regarding dual-eligibles and Medicare beneficiaries.
Disclosure and Conflict of Interest Declaration

✓ I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.

☐ I declare that I have a financial interest/arrangement or affiliation with the corporate organization offering financial support or grant monies for this continuing dental education program, or I do have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
A Brief History Lesson

• Stomatologists
• Baltimore College of Dental Surgery
• The ADA in 1965 and beyond
A Medicare Primer

• Part A, hospital insurance
• Part B, medical insurance.
• Part C, Medicare Advantage (MA) (first known as Medicare +Choice) - added 1997
• Part D, Prescription Drug Benefit - added 2006

• Medicare was expanded in 1973 to include:
  – Individuals who are under age 65 with certain disabilities; and
  – Individuals with End-Stage Renal Disease
  – Now includes ALS
Dual - Eligibles

• Approximately 9 million beneficiaries
• 20 percent of Medicare’s enrollees but accounts for 36 percent of its costs (KFF, 2010)
• Dual-eligibles may choose a dual-eligible special needs plan (D-SNP), which is designed to target the needs of this population. Generally enrolled in their state’s Medicaid or Medicaid managed care plan
Dual - Eligibles

- Beneficiaries include individuals who receive full Medicaid benefits as well as those who only receive assistance with Medicare premiums or cost sharing. They must meet certain income and resource requirements and be entitled to Medicare Part A and/or Part B and one of the following Medicaid Programs:
  - Full Medicaid; or
  - Medicare Savings Programs, which include the following four programs:
    - Qualified Medicare Beneficiary (QMB) Program;
    - Specified Low-Income Medicare Beneficiary (SLMB) Program;
    - Qualifying Individual (QI) Program; and
    - Qualified Disabled Working Individual (QDWI) Program.

- Medicare-covered services are paid first by Medicare because Medicaid is always the payer of last resort.
The chart below provides additional information on dual eligible Medicaid programs.

### Dual Eligible Medicaid Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Criteria</th>
<th>Resources Criteria</th>
<th>Medicare Part A and Part B Entitlement</th>
<th>Other Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Medicaid</td>
<td>Determined by State</td>
<td>Determined by State</td>
<td>Part A and Part B</td>
<td>Income and resource criteria are lower than QMB criteria</td>
<td>Full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home- and community-based waivers; and Medicaid pays for Part A (if any) and Part B premiums and cost sharing for Medicare services furnished by Medicare providers to the extent consistent with Medicaid State Plan.</td>
</tr>
<tr>
<td>QMB Only</td>
<td>≤100% of Federal Poverty Line (FPL)</td>
<td>≤3 times Supplemental Security Income (SSI) resource limit, adjusted annually in accordance with increases in Consumer Price Index (CPI)</td>
<td>Part A</td>
<td>Not applicable (N/A)</td>
<td>Medicaid pays for Part A (if any) and Part B premiums, deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with Medicaid State Plan.</td>
</tr>
<tr>
<td>QMB Plus*</td>
<td>≤100% of FPL</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI</td>
<td>Part A</td>
<td>Meets financial criteria for full Medicaid benefits</td>
<td>Medicaid pays for Part A (if any) and Part B premiums, deductibles, coinsurance, and copayments; and Full Medicaid coverage to the extent consistent with State Plan.</td>
</tr>
</tbody>
</table>
## Dual Eligible Medicaid Programs (cont.)

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Criteria</th>
<th>Resources Criteria</th>
<th>Medicare Part A and Part B Entitlement</th>
<th>Other Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLMB Only</td>
<td>&gt;100% of FPL but &lt;120% of FPL</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI</td>
<td>Part A</td>
<td>N/A</td>
<td>• Medicaid pays for Part B premiums.</td>
</tr>
<tr>
<td>SLMB Plus*</td>
<td>&gt;100% of FPL but &lt;120% of FPL</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI</td>
<td>Part A</td>
<td>Meets financial criteria for full Medicaid benefits</td>
<td>• Medicaid pays for Part B premiums; and Full Medicaid coverage to the extent consistent with State Plan.</td>
</tr>
<tr>
<td>QI**</td>
<td>≥120% of FPL but &lt;135% of FPL</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI</td>
<td>Part A</td>
<td>N/A</td>
<td>• Medicaid pays for Part B premiums.</td>
</tr>
<tr>
<td>QDWI</td>
<td>≤200% of FPL</td>
<td>≤2 times SSI resource limit</td>
<td>Lost Part A benefits due to their return to work; eligible to enroll in and purchase Part A coverage</td>
<td>N/A</td>
<td>• Medicaid pays for Part A premiums.</td>
</tr>
</tbody>
</table>

* Beneficiaries under this program often qualify for full Medicaid benefits by meeting Medically Needy standards or spending down excess income to the Medically Needy level.

** Beneficiaries under this program are not otherwise eligible for full Medicaid coverage through the State.
Barriers

- Medicare exclusion - Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth †

- Medicaid - Adult dental coverage in Medicaid continues to be an optional benefit.

- “Payment signals support and indicates priority.”

† ... except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.”
Opportunities

• Graying of America ("10,000!")
• Longer lives with more teeth
• Greater understanding that health doesn’t end at the hyoid bone
• 2015 White House Conference on Aging
• payment reform typically lags behind delivery system innovations.
Advocates and Partners

AAPHD, ADA, AARP, ASTDD, Educators, Foundations, HDA, Insurers/payers, NACHC, NCOA, NDA, Oral Health America, Other Federal agencies

Medicaid-Medicare-CHIP Services

Dental Association

Blessed with true advocates vs. “they’re just teeth, doc.”
References

• Kenneth E. Thorpe, "Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles." America's Health Insurance Plans, September 2011


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AARP HEALTH CARE POLICY AND ADVOCACY

MSDA Symposium
Ariel Gonzalez, Esq
Director
Federal Health and Family
Government Affairs
AARP
AARP Health Care Policy Priorities

• Increase access to health care for 50+ population
• Make health care more affordable for 50+ population
• Reduce waste, fraud, and abuse
• Reform the Medicare reimbursement system
• Improve care, quality, and outcomes in the health system
• Help people live independently in their homes and communities as they age
Increase Access

ACA greatly improved access for older Americans not yet eligible for Medicare

• Limited age rating to 3:1
• Prohibits denial for pre-existing conditions
• Expands Medicaid eligibility
Improve Affordability

Ensure people who need health care can afford it

• Improve programs for low-income Medicare beneficiaries, such as QI program and Medicare savings program

• Reduce prescription drug costs

• Prevent additional cost-sharing and income-relating

• Reduce use of “observation status”
Waste, Fraud, and Abuse

Improve program integrity in Medicare, Medicaid, and throughout the health system

• Better funding and coordination between state and federal oversight offices

• Better education of consumers to identify improper billing or identity theft

• Better Health Information Technology
Quality Improvement

To get best value for our health care dollars, we need to evaluate what we are purchasing

- More resources for quality measure development
- Consensus-based measure development process
- Streamline reporting systems
- Reward providers for improved outcomes, not just adherence to requirements
- Expand data availability through Qualified Entity (QE) program
- Establish system to publicly report quality that is understandable to consumers
Living Independently

- Protect access to Medicaid funded long-term services and supports (LTSS) including home and community-based services
- Support family caregivers
- Reauthorize the Older Americans Act, especially existing core services
- Improve and expand LTSS financing options
The Case for Dental Benefits

• As Boomers and others continue to age, a growing need for dental care is increasingly evident

• AARP aims to promote oral health for seniors via integration into primary care – hopefully through the coverage of dental services in the Medicare program

• Increasing demographic with lack of dental services
AARP and Dental Benefits

• Medicare coverage should include vision (including eyeglasses), hearing (including hearing aids), dental, and long-term services and supports (LTSS) and guarantee coverage across the continuum of care

• The federal and state governments should: ensure adequate provider participation- including by dental providers and providers of LTSS- in Medicaid
What Can You Do

• Develop relationships with local Areas on Aging so information can be provided on information and referral assistance programs on oral health

• If you are a dental professional, provide data and studies demonstrating the link between oral health care and overall health for Older Americans – particularly those over 65

• Support the coverage of dental care for Medicare beneficiaries via communications with your Member of Congress
QUESTIONS FOR ARIEL?
A Community Integrated Approach to Oral Health

Cora Plass, MSW
Center for Healthy Aging
National Council on Aging

Washington Marriott Wardman Park
June 1st, 2015
National Council on Aging (NCOA)

Who We Are:
NCOA is the nation’s leading nonprofit service and advocacy organization representing older adults and the community organizations that serve them.

Our Mission:
To improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged.
Center for Healthy Aging

• Primary Goal
  – Improve the quality of life for older adults

• Two National Resource Centers
  – Chronic Disease Self-Management Education (CDSME)
  – Falls Prevention

• Other Key Areas of Focus
  – Behavioral Health
  – Oral Health
  – Physical Activity
A Few Facts...

- Oral health is important for overall health and well-being
- Poor oral health is far too common among older adults
- Many older adults have not seen a dentist in the past year because they don’t have insurance or money to pay for the care
- 70% of adults 65 years and older have periodontal disease, and 23% have a severe periodontal disease
- About 25 percent of adults 60 years of age and older have no natural teeth

Source: CDC
Oral Health Disparities

• Racial and ethnic minorities
• Individuals without insurance
  – Most elderly dental expenses are paid out-of-pocket
• Rural residents
• The economically disadvantaged
• Individuals who are disabled, homebound or institutionalized
An Inadequate System of Care

• Poor outcomes and the growing number and proportion of older adults in the U.S.
• Medicare doesn’t cover oral health care
• The majority of state Medicaid plans do not cover oral health
• Focus on episode of care, rather than prevention
• Fragmented dental care
  – Oral health not routinely a part of primary care visit
  – Lack of communication between dentists and other health care providers
  – Lack of access to care by vulnerable and underserved populations
  – Lack of collaboration between dental providers and the community
IHI Framework Offers Potential for Improving Oral Health

Triple Aim

Better health

Better care

Lower cost
HHS Sets Clear Goals and Timeline for Shifting Medicare reimbursements from Volume to Value

• Better, Smarter, Healthier
• Creation of a Health Care Payment Learning and Action Network to expand alternate payment models; first meeting March 2015
• HHS has already seen promising results on cost savings with innovative models
• This new framework also offers potential for improving oral health outcomes
  – Integrating oral health with primary care visits
  – Strengthening community linkages
  – Identifying and testing new service delivery and payment models that support improved oral health outcomes and lower costs
Oral Health Is Influenced by a Variety of Factors

- Health literacy
- Personal hygiene/self-care behaviors
- Financial resources
- Access to dental care
- Dental health coverage
- Social and cultural factors
A Few More Facts...

- Most Oral Health Care Happens Outside the Dentist Office.
- The best predictor of oral health is routine practice of good oral hygiene habits at home.
- There are a number of barriers that prevent older adults from seeing a dentist.
- The people with the most dental disease are the least likely to go to a dentist.

*Therefore...*

A focus on improving self-care behaviors offers great potential for improving oral health outcomes

Community Partnerships Are Needed

- Community organizations are known, trusted, and respected.
- The most effective messages are those delivered by trusted members of one’s own community.
- Community organizations see and interact with older adults regularly.
- They understand social and cultural issues particular to the community and the individual.
- They are skilled in delivering messages at the appropriate literacy level.
- They are in a position to provide and repeat messages or offer coaching toward behavior change.

The Aging Network – An Untapped Resource

Department of Health and Human Services
Administration for Community Living/Administration on Aging

Tribal Organizations

State Units on Aging

Area Agencies on Aging

Local Service Providers

Consumers

Legal Assistance
In-Home Services
Access Services
Institutional Services

Governors and State Legislatures
Local Government

Senior Centers
Transportation
Nutrition Services
Community-based Services
Aging Network – Reaching People in their Communities

• In partnership with public health, provide culturally and linguistically appropriate information and education
• Provide coaching and support related to self-care and the importance of dental visits
• Assess oral health habits and disease risk
• Provide screenings at senior centers, integrated with the provision of other services
• Serve as a delivery site for mobile health services or virtual dental care
• Assess and provide transportation needs related to oral health care
• Provide information about dental health coverage and available resources
Community Integrated Oral Health Care for Older Adults: It Takes a Village…

- Aging and Public Health working collaboratively at national, state, and local level
- Dentists/Dental Associations
- Retired Dentists
- Hygienists/Hygienist Associations
- Allied health professionals
- Dental Schools
- Health Centers/PCMHs/health care providers
- State Medicaid Agencies
- Health Plans
- Faith-based organizations
- Social service agencies and other community organizations
- Tribal organizations
Community-Integrated Approaches That Show Promise

- Formation of state and local coalitions
- Community engagement and partnerships
- Incentive programs to increase access in underserved areas
- Mobile dental services
- Virtual dental home
- Integration of oral health care with primary care
- Use of allied health care professionals, health coaches, and community health workers as part of the health team
- Targeted outreach in hard-to-reach areas

Next Steps...

• New payment models that recognize and reward community-integrated approaches to oral health

• Funding to support new demonstration projects that focus on community engagement and partnerships; aging and public health are key

• Funding to support replication and adaptation of promising practices identified from HRSA 330 A grants

• More research and evaluation of new approaches to learn what works and to compare the results of different models

• Workforce development for community-based organizations to address oral health
Questions/Discussion

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571-527-3922
Dental Coverage through DSNPs for Low Income Elderly & Disabled Populations:
Opportunities and Integrated Contracting Considerations

Elizabeth A. Wood, MPAP
Director, Dual Integration
New Jersey Department of Human Services
Division of Medical Assistance & Health Services

June 1, 2015
Dental Care in Dual Eligible Context

• Demographic Characteristics of dual eligibles
  – Medically & socially complex
    • Medically frail,
    • Multiple chronic conditions,
    • Behavioral health diagnosis comorbidity
    • Culturally & linguistically diverse,
    • Developmental disability,
    • Elderly,
    • Diabetic,
    • Dentally underserved by safety net,
    • Limited education (8th grade to High School may be highest level)
Unintegrated Care for Dual Eligibles – A Cavity in the Safety Net

• A Nationally Observed Need
  – Medicare does not cover preventive, diagnostic, or other “routine” dental care
  – Dental care is an optional Medicaid benefit and many states limit services and populations covered under Medicaid
  – Medicaid beneficiaries may face access problems and out-of-pocket expenses and avoid seeking care
  – Oral health is an unmet need for many Medicaid adults yet:
    • A critical component of sustaining overall, long-term good health
    • Oral health affects more than just the gateway to the digestive system
## Variability in State Medicaid Dental Coverage for Adults

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Medicaid Adult Benefits</th>
<th>Medicaid Benefits for Pregnant Women</th>
<th>CHIP Adult Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>7</td>
<td>14</td>
<td>38</td>
</tr>
<tr>
<td>Emergency Only</td>
<td>15</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Limited</td>
<td>15</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>13</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Not Reported</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

NOTE: Includes all states and the District of Columbia
Source: Association of State and Territorial Dental Directors Synopses of State Dental Public Health Programs, June 2011

http://www.ada.org/~/media/ADA/Public%20Programs/Files/barriers-paper_repairing-tattered-safety-net.ashx
Dual Eligibles – Medicare-Medicaid Enrollees in an Unintegrated System

- Fragmented system
- Beneficiary must coordinate own care across payers and providers
- Gaps in care coexist with duplicative care; underutilization with overutilization
Dual Eligibles in a Fully Integrated System Offering Dental Care

Includes:
- Interdisciplinary Care Team
- Individualized Health Care Plan
- Individualized Care Management

Medicare
A, B & D, and Supplemental “Extras” in Medicare Advantage

Fully Integrated Dual Eligible Special Needs Plans, Some Financial Alignment Demonstrations (e.g., CA), Alternative Demonstrations & PACE

Medicaid & State Level Services

Includes:
- Interdisciplinary Care Team
- Individualized Health Care Plan
- Individualized Care Management
## Integrated Enrollment Options by Type, Enrollment & Availability

<table>
<thead>
<tr>
<th>Type</th>
<th>Enrollment Option</th>
<th>Enrollment Estimate – January 2015</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed FFS or MCO</td>
<td>Traditional / Unintegrated Medicare &amp; Medicaid (May include Medicaid dental FFS)</td>
<td>6+ million</td>
<td>50</td>
</tr>
</tbody>
</table>
|                       | Financial Alignment Demonstrations & Medicare-Medicaid Plans (MMPs)  
(May include dental depending on state Medicaid package) | 1.5 million                        | 12     |
|                       | Fully Integrated Dual Eligible Special Needs Plans (DSNPs)  
(May include dental depending on state Medicaid package & Medicare supplemental bid) | 107,837                            | 7*     |
|                       | Dual Eligible Special Needs Plans  
(May include dental depending on state Medicaid package & Medicare supplemental bid) | 1.5 million                        | 38     |
| PACE                  | Program of All Inclusive Care for the Elderly  
(Includes dentistry) | 34,413                             | 32     |
CMS Has Approved 13 Financial and/or Administrative Alignment Demonstrations in 12 States, in which Nearly 1.5 Million Dual Eligible Beneficiaries Will Be Eligible to Enroll, as of July 2014

Total= 1,499,265 beneficiaries

NOTES: *Enrollment in Los Angeles County is capped at 200,000 beneficiaries. Unlike the other states' demonstrations, Minnesota's demonstration will integrate administrative processes but will not align financing.

DSNPs – What are they?

- Dual Eligible Special Needs Plans (DSNPs) were created by Congress to meet the unique needs of low income elderly and individuals with disabilities enrolled in both Medicare and Medicaid
- Medicare Managed Care Organizations must have two parallel contracts to operate a DSNP:
  - Medicare Advantage Plan – CMS Medicare
  - Medicare Advantage Plan – State Medicaid Agency (“wrap” or “MIPPA” contract)

- Key Authorities and Requirements
  - MIPPA - Medicare Improvements for Patients and Providers Act of 2008
  - Medicare Managed Care Manual 100-10, Chapter 16B
  - State Plan
  - MIPPA Contract
Why Expand Dental Through a DSNP?

What are the opportunities for Medicaid payers

– Medicare Advantage Supplemental Benefit Options include “Comprehensive Dental Services”:
  • Routine services, diagnostic services, restorative, endodontic/periodontal/extractive, prosthodontics, other oral/maxillofacial surgery, other services
– State Medicaid Programs can negotiate with DSNPs to file for the supplemental dental benefit under Medicare
  – Expand dental coverage without needing a State Plan Amendment
  – Expand dental coverage without increasing Medicaid expenditures or expanding coverage when fiscally or politically infeasible
– Improve health outcomes for low income seniors and individuals with disabilities
– Create provisions for Primary Care Dentists and/or Dental Homes
– Prevent known costly and painful long-term complications associated with a lack of oral health care (e.g., cardiovascular disease, chronic kidney disease and progression to end-stage renal disease)
Conceptual Opportunities of Integrated Dental Care for Medicare-Medicaid Providers

What are the opportunities for Medicaid and CHIP medical and dental providers?

- Participation in an integrated health “ecosystem” that better supports patient health and wellbeing
- Gain greater visibility within the total care team surrounding each patient
- Gain greater insight and input into the overall care plan constructed for each patient – create better Medical-Dental Integration
- One insurer relationship to manage and unified claims processing
- Rates set through negotiation with DSNP, not Medicaid
Implementation Lessons

• Integrating care strains systems designed to coordinate care

• State oversight of MIPPA contracts and benefit administration is essential to appropriate delivery; DSNPs are *not* just Medicare
  – Benefit build
  – Appeals & grievances
  – Marketing and member communications
  – Dental vendor oversight
  – CAHPS
  – External Quality Review
Implementation Lessons

• Unintended Consequences
• Provider Resistance
  – Managed care
  – Billing codes
  – Hassle factor of Medicare and Medicaid
• Provider education in eligibility verification, authorizations, claims processing, balance billing
• But..
  – Improved beneficiary satisfaction
Challenges to Expanding Enrollment in Existing Integrated Options

What are the barriers and challenges?

• There are many factors influencing Dual Eligible enrollment decisions:
  – Advice of primary care providers and specialists
  – Cost sharing, if any
  – Supplemental benefit package composition
    » Over-the-counter drug store cards
    » Dental benefits
  – Cultural competence of providers and health plan
  – Intangible brand qualities and market presence
    » Elderly gravitate toward large, big-name health plans
    » Younger duals gravitate toward smaller health plans and those with deeper community connections, the ones that understand disability
  – Perceived ease of use, “hassle factor”
  – Customer service interactions
Questions?
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http://www.state.nj.us/humanservices/dmahs/clients/d_sn.html