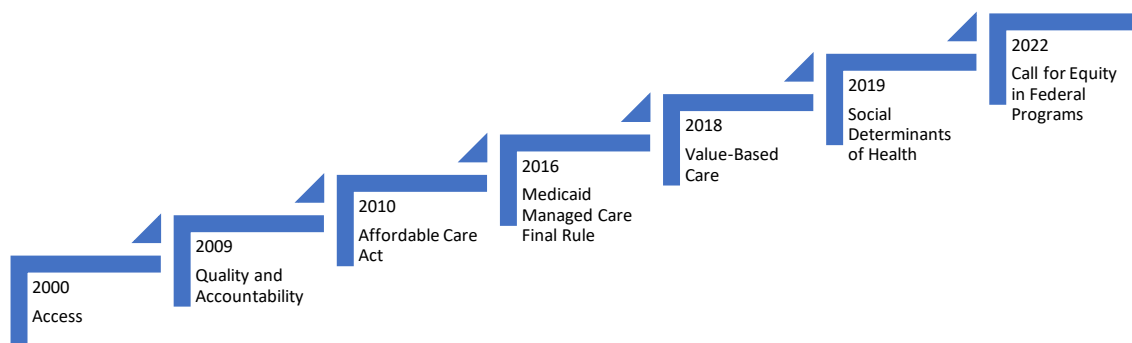


MEDICAID—THE BIG PICTURE IN 2023

Evolution of Healthcare Delivery

Over the last two decades, several legislative changes in Medicare have taken place resulting in improvements in Medicaid policy, program administration and services. These changes allow for more flexibility of services for beneficiaries, alternative payment schedules for providers, and various administrative models for states. Such legislation must be well understood to effectively achieve program goals.

The following narrative lays out key legislation that has evolved Medicaid programs and has the potential to impact and improve design, development and implementation of future Medicaid policy, programs and services affecting Hawaii’s most vulnerable.



Access to Care and Oral Healthcare Disparities—2000

Access to care has been the principal focus or proxy measure of effectiveness of Medicaid programs since its inception. In the early 2000’s access was measured by the number of dental providers in any given network and/or the percentage of licensed dentists in a State that participated in the Medicaid dental program. Access was also measured by the rate of eligible Medicaid enrollees who used *any dental service*. Over time, utilization of *any preventive dental service* was also considered an access measure. Today, access is still considered an important component of healthcare quality, but it is only one of the seven quality domains identified by the Agency for Healthcare Quality and Research. Understanding how to effectively measure access to care for Medicaid adults in Hawaii will be important as Medicaid policy is drafted, and other indicators of quality in the oral healthcare delivery system for this population should be considered.

Quality and Accountability—2009

During the last two decade, the healthcare delivery system has undergone major changes as a direct result of legislative policies beginning in 2009 with the *Reauthorization of the Children’s Health Insurance Program (CHIPRA)*. While the CHIPRA legislation focused on children’s health,

the concept of *quality in healthcare* was re-introduced and defined for use in government programs. All entities doing business in and/or for the federal government would be held to a new standard, the *Triple Aim*, as it was first labeled, to improve healthcare, improve health outcomes, and lower costs. Entities would be held accountable and called to demonstrate achievement of the Triple Aim through the implementation of quality measures.

In the oral healthcare delivery system, development of quality measures was initially slow. The Dental Quality Alliance was charged by CMS to develop them. The measures met resistance from providers and focused primarily on measuring the delivery of preventive services to children enrolled in Medicaid. Receipt of dental sealants and fluorides took center stage. There was little focus on adults and no focus on other vulnerable groups such as adults with Intellectual and Developmental Disabilities (I/DD). Since the inception of quality measures in dentistry, there currently exists six quality measures associated with adult dental services; and 13 associated with pediatric dental care. While there is one quality measure that focuses on the diabetic patient, there are zero measures specifically assessing oral healthcare, oral health outcomes and/or costs associated with oral healthcare service delivery for special populations.

Affordable Care Act—2010

In 2010, the *Patient Protection and Affordable Care Act (ACA)* was passed leading the way for greater innovation in healthcare delivery, healthcare integration, and payment for services. The law expanded eligibility for many underserved adults and was expected to provide an increased opportunity for *oral* healthcare beneficiaries—especially vulnerable individuals whose medical healthcare integration with dental providers is considered critical to achieving improved health outcomes. The *Centers for Medicare and Medicaid Services* expanded to include the *Center for Medicare and Medicaid Innovation (CMMI)*. In 2015, over one billion dollars was made available by CMMI to test innovative models aimed at building quality driven systems of healthcare, for Medicaid and Medicare beneficiaries. To date, fewer than five oral healthcare models have been approved for funding and testing by CMMI despite numerous proposals. Here lies an opportunity for Hawaii to develop and test new models for delivering care to the underserved.

Medicaid Managed Care Rule—2016

In April 2016, CMS released the *Final Rule on Medicaid Managed Care*. This regulation modernizes the Medicaid managed care regulations to reflect changes in the use of managed care delivery systems.¹ The final rule aligns many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery

systems that serve Medicaid and CHIP beneficiaries.ⁱⁱ Since 2016, Medicaid managed care has expanded across all fifty states. Some states include dental coverage in medical managed care contracts (carve-in models), while others, exclude dental coverage from medical managed care contracts but maintain a separate dental benefit (carve-out model) with a separate dental managed care vendor. There are pros and cons for the carve-in and carve-out models, but because of the provisions of the *Final Rule*, both provide an opportunity for increasing access and improving oral healthcare for Medicaid eligible adults.

Changes in Medicaid

The Medicaid and Medicare entitlement programs were first established in 1965 as a means for providing healthcare coverage to our nation’s most vulnerable—the aged, those disabled, and low-income. For over half a century, these programs have survived and expanded with many changes put in place to improve administration and receipt of services by beneficiaries. Today over 80 million Americans are enrolled in Medicaid and nearly 64 million in Medicare.ⁱⁱⁱ Much of the rapid growth of the Medicaid program has been observed in the last decade. This growth is a direct result of the ACA which expanded benefits to childless adults, and the more recent COVID Pandemic which left many unemployed and/or underemployed.

The increase in Medicaid enrollment has significantly impacted state budgets and the availability of State funding specifically for adult dental services. Such benefits are not mandated under Federal law, and as such, there exists tremendous variability across the states in Medicaid dental policy for adults. Traditional Fee-for-Service payment models continue to reign, with most states’ posting Medicaid reimbursement rates far below commercial rates in the same geographic areas. Dental providers often receive payment for the exact same services at two very different payment levels. This irregularity in payment is troublesome to providers, many of whom opt out of the program leaving program beneficiaries with nowhere to turn.

As noted earlier, most states continue to reimburse dental providers using the fee-for-service payment model. Even in states with managed care, the payment structure between the State and vendor may be capitation using a per member/per month payment model, but the provider reimbursement is still fee-for-service. Bundling of services has also been used by dental managed care organizations, but limited data and information exists to determine its efficacy for *spread* to other programs.

Many states also lack the necessary infrastructure and technical expertise needed to administer the dental programs. To address this, many have moved to contracting with dental vendors to administer their programs either through Managed Care Organization (MCO) or Administrative

Services Only (ASO) contracts. While health plan administrators offer knowledge and experience, states are still ultimately responsible to comply with federal law under the Medicaid program.

The use of Medicaid waivers is also expanding. There are several types of Medicaid waivers. All allow for some type of modification of Medicaid law to better accommodate the needs of administrators, providers, and/or beneficiaries. For example, waivers are often used to expand benefits for a subset of the population—i.e. pregnant women or individuals with I/DD. They are also used to enhance fee schedules for services provided to a subset of the population—i.e. pregnant women or individuals with I/DD, and/or to provide incentive payments to providers who demonstrate quality performance in the delivery of services, based on incentive programs with quality measurements to track provider performance.

Value-Based Care

Value-Based Care builds on the initial concepts associated with the *Triple Aim*, where improvements in healthcare, health outcomes, and costs continue to be important, and are associated with quality, measurement, and performance, but now they are also associated with payment. Value-Based Care is a healthcare delivery system framework that moves away from the traditional fee-for-service payments models to one that incentivizes and rewards quality over quantity (value versus volume). For the oral healthcare delivery system, delivery of preventive dental services is a marker of quality in the management of chronic oral diseases. Over the last few years, several states and dental managed care vendors have introduced value-based strategies into their programs. Because the contracts between the states and vendors are proprietary, little is known about each of the different programs, and their true effectiveness in program improvement. CMS has identified and re-confirmed healthcare payment as a key mechanism to improving healthcare. Building a Value-Based Medicaid model for eligible adults will be an essential component to expanding the dental provider network and access to oral healthcare.

Social Determinants of Health

Social risk factors have been determined to be strong indicators of access and use of oral and other healthcare services. For example, when individuals have food and/or housing insecurities, they are highly unlikely to use their Medicaid dental benefits. Medicaid programs have recently been tasked with understanding the social risks of Medicaid enrollees and linking them to social service agencies for support. In considering the Social Determinants of Health for Hawaii's Medicaid adults, policy makers will need to consider each individual's social risks and address them first, as part of a comprehensive oral healthcare benefit and care management plan.

Call for Equity in Healthcare and Health Outcomes

For over twenty years, data has demonstrated that oral health and healthcare disparities exist among low-income, cultural, and ethnic minority groups. While some strategies have been implemented to address these disparities, such as Federal funding to support the expansion of a more diverse dental workforce, little progress has been observed in actual reduction of such disparities. In 2022, an Executive Order was issued for the Federal Government to Advance Racial Equity and Support Underserved Communities. To this end, CMS has defined equity and has made it a pillar in its Strategic Plan. To ensure oral health and oral healthcare equity for individuals with I/DD, it will be imperative to stratify administrative claims and other program data by beneficiary *type or classification, including and not limited to race, ethnicity, disability, sexual orientation, gender identity, socio-economic status, geography, preferred language, and other factors*, to accurately assess access, use of services, health outcomes, and other markers of equity.

Medicaid, Medicare, CHIP Services Dental Association
Center for Policy, Quality, and Financing

ⁱ https://www.medicaidental.org/files/FINAL%20MC%20Rule%20Apr%2025_2016.pdf

ⁱⁱ https://www.medicaidental.org/files/FINAL%20MC%20Rule%20Apr%2025_2016.pdf

ⁱⁱⁱ <https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip>