



Financial Incentives Improve Dental Sealant Rates for Oregon Children

Through accountable care organizations, state sees increase in school-based prevention programs

In 2016, The Pew Charitable Trusts' dental campaign set out to explore the policy and regulatory barriers that may be impeding the growth of school-based sealant programs. Pew identified two challenges: barriers to Medicaid managed care inclusion, and laws or rules that restrict the ability of hygienists to provide care in schools. This is the first of two briefs addressing factors that limit the ability of dental hygienists to deliver preventive sealants to children in perhaps the most convenient location—their schools.

Overview

Highly effective, low-cost clinical prevention strategies rarely exist for the public's health ills. That is what dental sealants are for the problem of tooth decay. A [\\$53 sealant](#) provided to a child at the right time can [reduce decay](#) in permanent molars by [80 percent in the first two years](#) and continue to be effective for nearly five years.

Yet most children, especially low-income children, do not receive sealants. This situation is particularly concerning because low-income kids are [twice as likely to have untreated tooth decay](#) and [less likely to see a dentist than their peers from higher-income households](#). So the Centers for Disease Control and Prevention and a number of other public health organizations have endorsed placing sealant programs in low-income schools to reach the children who are less apt to visit a dentist. Still, a Pew 2015 report found that such programs are in less than half of high-need schools in 39 states.

This brief describes barriers to Medicaid managed care inclusion, which thereby blocks access to a major funding stream for these programs. It also explores a promising strategy used by Oregon's Medicaid program that is promoting the widespread inclusion of school-based sealant programs in managed care networks.

Barriers to Medicaid managed care inclusion

[Medicaid is an important funding source](#) for school-based sealant programs. Increasingly, state Medicaid agencies are contracting with managed care plans to assemble provider networks and deliver dental care in exchange for a capped per-member payment. In 2015, 21 of 38 states including the District of Columbia that contracted with [Medicaid managed care plans](#) to serve children included dental services in these contracts. So for nearly half of states, the extent to which Medicaid managed care plans contract with school-based providers, and make it feasible to do so, makes a big difference in the ability of school-based sealant programs to thrive.

A series of interviews of Medicaid managed care dental contractors conducted in 2016 by the National Association of Dental Plans and Pew researchers revealed the following challenges:

- A dental plan that contracts with Medicaid agencies in two states reported that providing school-based sealants works at cross-purposes with bonuses the plan offers its participating dentists for meeting sealant quotas. These providers are frustrated when Medicaid children come in for services having already had their teeth sealed at school.
- One dental plan in New Jersey that contracts with the state Medicaid office cited a state agency rule that any contracting provider needs to be able to treat dental emergencies at any time of the day, which disqualifies many school-based sealant providers.
- A number of Medicaid managed care dental plan representatives said they hesitate to contract with school-based sealant providers because there is no protocol to refer children with more complex needs to a dental home.
- Some state Medicaid agencies and contracting managed care plans place restrictions on the number of preventive visits a child can have. This creates competition between participating plan dentists and school-based sealant providers who have to “share” this limited number of billable visits.

This list of obstacles is by no means exhaustive, yet it illustrates the policy problems that can interfere with the smooth inclusion of school-based sealant providers in a managed care system. And, while not insurmountable, these challenges illustrate the difficulties that both sealant providers and managed care organizations (MCOs) face in a system where there are no meaningful rewards (or penalties) for plans to include school-based providers.

Medicaid’s new paradigm: Value-based purchasing

Oregon is one example where the state Medicaid agency has created incentives for managed care organizations to work with school-based sealant providers, and the efforts seem to be working. In 2011, the state enacted H.B. 3650, which changed the financing and delivery structure of its Medicaid program after waiver approval from the federal government. The Oregon Health Authority (OHA), the state’s Medicaid program, placed nearly all Medicaid beneficiaries into coordinated care organizations (CCOs), which are groups of regional providers that deliver physical, behavioral, and, most recently, oral health services under a single budget. CCOs are required to meet certain access and health outcomes benchmarks for the beneficiaries they are assigned. Oregon’s goal was to eliminate a fee-for-service payment system that rewarded volume of care regardless of health outcomes, a paradigm change coined as a system move “from volume to value.” Each of the state’s 16 CCOs operates under a capped budget based on numbers of assigned Medicaid enrollees. Every year, the state holds a certain percentage of each CCO’s budget in an “incentive” pool for those that meet at least 12 of 18 health outcomes and care access metrics. (In 2015, this was 4 percent of each CCO’s 2014 allotment.) The average percentage of [6- to 14-year-olds receiving sealants](#) is one of these metrics.

Before the CCOs, dental care organizations (DCOs) contracted directly with the state's Medicaid agency. While the state included certain accountability standards in the contracts, there were no penalties or rewards based on performance, except in circumstances of gross negligence.

Nine dental plans that contract with the two CCOs serving the Portland area—the state's most populated region—have come together and jointly funded Dental3 (D3), a brokering organization that is contracting with school-based sealant providers to deliver care in schools where at least 40 percent of the students qualify for the student lunch program. Without this coordination, it would have been “an administrative mess” for dental plans, said Susan Kirchoff, founding executive director of D3.

Kirchoff noted that as of February 2017, D3 was sending providers to 156 of the 165 schools that meet this criterion in the three counties served (Multnomah, Washington, and Clackamas). Without this coordination, each dental plan interested in offering school-based services would have had to identify which schools its beneficiaries attended, establish the required school relationship, and serve only those students in each school who are enrolled in that particular plan. “You can't do population health work individually,” said Kirchoff. “If we could go in together as one thing, all boats would rise. [The nine dental plans] are not paying much more [to D3] than what they'd pay if they did this themselves.”

OHA is the government agency that houses both public health programs and Medicaid. “From existing OHA statistics, it was known that dental sealants were infrequently provided” by Medicaid contractors, said Dr. Eli Schwarz, OHA adviser and chair of the community dentistry department at Oregon Health & Science University. Baseline data from the two CCOs serving the Portland area bear this out. In 2014, when the sealant metric was introduced, FamilyCare CCO providers had provided sealants to 12 percent of eligible children; Health Share CCO providers had provided 15 percent. The movement from fee-for-service to value-based purchasing “prompted serious discussion on how the DCOs (dental care organizations) could contribute to system improvements and improve oral health outcomes,” said Kevin Boie, chief financial officer at Dental Service LLC. The decision to develop the brokering organization resulted from these discussions, he added.

Dental sealant use increases with financial incentives

The two CCOs serving the Portland area are using bonuses differently to improve the sealant rate. Health Share, which received a \$2 million bonus from Medicaid in 2015 for its performance on sealants, passes the bonus to its participating DCOs. FamilyCare keeps its sealant bonus.¹

The results have been notable. Between 2014 and 2015, sealant placement for both Health Share and FamilyCare has increased. For Health Share, the percentage of eligible children sealed rose from 15 percent to 21 percent. For FamilyCare, placement increased from 12 percent to 18 percent. This progress allowed both plans to have their sealant accomplishment count toward the overall performance needed for them to [earn incentive payments](#). In 2015, FamilyCare received a \$19 million performance bonus; Health Share received more than \$42 million.²

Progress on the sealant metric continued for the two CCOs for the first half of 2016, according to the most recent performance report. FamilyCare increased its sealant rate by an additional percentage point; Health Share was up by half a point.³ “Right now, it is my impression that the sealant metric drives a lot of the business-level motivation for the D3 model,” said Tabitha Jensen, current D3 executive director.

Oregon is one of a number of states that allow dental hygienists to initiate treatment without a dentist's permission and to treat patients without a dentist on-site. D3 contracts with four independent hygienists and three federally qualified health centers to serve the schools. Providers serve all students within a school whose parents have signed consent forms for care—those on Medicaid, with private insurance, or the uninsured. Services provided include screening, fluoride varnish, and sealants. DCOs are able to write off uncompensated care as a community benefit and allow the free care to count toward their required medical loss ratio (the portion of premium dollars spent on care compared with plan administration). Hygienists seal an average of three teeth per visit, according to Kirchoff. If hygienists detect problems that require a dentist's care, D3 refers them to dentists who participate in the CCO in which the child is enrolled. The selling point for the dentists is that "you're going to get all these referrals of kids that you might not have seen otherwise," said Kirchoff.

"Our sealant placement rate in the past had been low," according to Sharity Ludwig, director of community dental programs at Advantage Dental, one of the nine dental plans participating in D3. One reason for this lagging performance: Plan dentists were skeptical of the value of sealants. Also, before CCOs, Advantage was providing community-based screenings and referring patients for any needed care—preventive or restorative—to its network of office-based dentists, and patients did not always follow through. "When you shift the focus of what we're being held accountable for, then plans align with those metrics," said Ludwig, referring to Advantage's more aggressive school- and office-based efforts to place sealants.

Transition from state-run school-based sealant program

Like many states, [Oregon has a state-run school-based sealant program](#) operated by the health department and paid for with general funds. The program had traditionally targeted schools where at least 50 percent of the students are eligible for the National School Lunch Program. But penetration into these schools has been limited by funding. Compared with D3's presence in 156 schools in three counties, the state program, at its height, served about the same number of schools (150) but across 36 counties, according to Laurie Johnson, school oral health programs coordinator with OHA's public health division.

With CCO prevention activity in the schools, OHA adviser Schwarz says the state sealant program has been retreating from direct care provision and instead offering dental plans training for hygienists working in schools, evaluating school-based efforts, and helping school-based providers achieve the certification required by a new state law. S.B. 660, dental sealant legislation passed in 2015, provided for the transition from direct care to an oversight role. According to Schwarz, because the sealant provision is built into CCO budgets, the transition eliminates redundancy in state funding for this preventive service. At the same time, OHA created a uniform data collection system for sealant placement at the CCO level; the state sealant program had no mechanism for feeding the Medicaid agency information on children sealed through its program.

Johnson serves on D3's quality committee and has been providing technical assistance to the organization on how to work in schools. Because D3 is contracting with a number of school-based providers that used to work for the state program, Johnson said that schools faced minimal disruption when DCOs began to take over direct service provision from the state sealant program.

Public health officials say that D3 is successfully coordinating DCO sealant activities in the schools and delivering quality care. "I've seen great success here," said state Dental Director Bruce Austin. The sealant measure "has changed behavior right down to the clinic level." But Austin and Johnson remain wary about the future. "We're always a bit concerned that if the [sealant] metric changes or goes away, DCOs and CCOs may not be that interested in serving kids in the schools," Johnson said.

Conclusion

Still in its early stages of having CCOs manage Medicaid dental benefits, Oregon is attracting interest among policymakers nationwide. Its experiment is testing how access to preventive care for the Medicaid population may improve under a payment system that provides meaningful financial rewards for delivering prevention. If successful in the long term, the state's approach of incentivizing a private delivery system and using public health agents to monitor quality and train providers on how best to work in schools may be a model for the nation.

Methodology

The Pew Charitable Trusts' dental campaign undertook an investigation to understand the universe of policy barriers that inhibit the effectiveness of school-based sealant programs. Pew conducted a literature search of peer-reviewed and gray literature that identified over 50 relevant publications discussing oral health programs and policies related to school-based sealant programs. Pew also conducted 35 targeted interviews with subject matter experts representing Medicaid officials, state dental directors, federally qualified health center directors, school sealant program coordinators, dental plans, elementary school principals, and academic researchers. Pew then worked with the Association for State and Territorial Dental Directors, the National Association of Elementary School Principals, and the National Network for Oral Health Access to survey and collect information from their respective membership. Informed by this process, Pew is releasing a series of issue briefs highlighting policy barriers and recommended changes for reducing or eliminating them.

Endnotes

- 1 Susan Kirchoff, interview with The Pew Charitable Trusts, Jan. 1, 2017.
- 2 Oregon Health Authority, "Oregon's Health System Transformation: CCO Metrics 2015 Final Report" (June 2016), 6, http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf.
- 3 Ibid.

Correction note: This brief was revised on Nov. 2, 2017, to clarify FamilyCare's arrangement concerning sealant bonuses.

For further information, please visit:

pewtrusts.org

Contact: Jennifer Stapleton, communications manager

Email: jstapleton@pewtrusts.org

Project website: pewtrusts.org

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