Comments on NYS Department of Health
1115 Medicaid Demonstration Waiver Amendment Application
May 20, 2022

The Schuyler Center recommends that the 1115 Research and Demonstration Waiver proposed by the NYS Department of Health include specific references to oral health. There must be an explicit expectation that this important component of overall health be a foundational element to the design and execution of HEROs, Social Determinants of Health Networks (SDHNs) and VBP arrangements.

JUSTIFICATION

Good oral health is “not just” the absence of disease, but the full ability to use the mouth for everyday functions such as eating, smiling, speaking, or kissing. While oral health focuses specifically on issues presenting in the mouth—including the teeth, tongue, gums, and the entire oral cavity—oral health is inextricable from physical and mental health.

To a great extent, oral health issues are completely preventable, but eradicating oral health issues requires a focus on public health efforts that reach large numbers of people consistently. The prime example of a successful public health approach is water fluoridation: an inexpensive, unobtrusive, and nearly universal preventive measure that has yielded dramatic improvements in dental health. Other preventive measures, like screenings and dental sealants if made widely available, could improve outcomes further. Also, availability and affordability of healthy food plays an important role in oral health, and they connect nutrition programs and policies to oral health outcomes.

There are many examples of how oral health affects, and is affected by, the health of the whole body. When oral health is compromised, it can lead to increased risk for diseases such as cardiovascular disease or stroke. Oral disease has been linked to complications in pregnancy and childbirth and to respiratory, gastrointestinal, rheumatologic, and immunological issues. The influence goes the other way, too: other health conditions can affect the mouth, as when medication side effects lead to a dry mouth and thereby increase the risk of cavities or gum disease. Furthermore, oral health has unique psychological and social elements. Because the mouth is a prominent part of personal appearance, people with visible signs of oral disease are negatively judged and socially stigmatized, with consequences for their mental health as well as other influences on well-being, such as employment outcomes.

The recently released report by the National Institute of Health, *Oral Health in America*, makes the point that the benefits of good oral health extend beyond the individual to families and communities. When considering oral health from a population perspective, it becomes clear that the burden of oral disease falls most heavily on subgroups that have limited economic resources, low levels of educational attainment, poor access to dental care, and lower levels of social influence or political capital. This leads to recognizable oral health disparities and inequities that are the result of differences in the availability of social and economic health-promoting resources that are largely avoidable and amenable to policy action—including access to affordable, healthy foods, professional dental prevention and treatment services, and dental insurance.1
When oral health is difficult to access, patients are more likely to develop problems that could have been prevented, or defer treatment until the problem becomes severe or acute, then seek emergency treatment. Emergency treatment is more expensive and rarely solves the problem, as it is ill suited to handle chronic health issues, making it likely that emergency care will be sought once again. In the process, the emergency system can become overburdened, lowering the quality of care for all. The cumulative effect is an increase in health care costs, with no commensurate improvement in health outcomes. Many oral health problems are readily preventable through sound public health measures.

Research indicates that the largest burden of disease occurring among children living in poverty, racial and ethnic minorities, frail elderly, with the largest burden of disease occurring among children living in poverty, racial and ethnic minorities, frail elderly, individuals with special health care needs and other socially marginalized groups, such as immigrant populations. Many of those most affected by inequities inherent in systems are subgroups recognized in the waiver document: justice-involved populations, homeless and long-term institutional populations, individuals with mental illness and with substance use disorders.

RECOMMENDATIONS

1. **Oral health must be explicitly referenced throughout the Medicaid waiver, not just assumed to be included in physical health.**

   If the waiver does not specify that oral health is a necessary component of the work being done by HEROs or SDHNs and integrated into VBP arrangements, New York risks building a system that continues to put oral health low on the public policy agenda even in a moment of intense public debate on the structure of the health care system. Currently, the only mention of oral health in the Waiver document is a reference to Community Dental Health Coordinators (CDHCs) (p45).

   The root causes of disparities in oral health outcomes is often structural: the geographic dispersion of oral health care systems, uneven access to linguistically and culturally appropriate oral health care services, and differences in coverage. The cumulative effect is that people who live in marginalized communities have the greatest difficulty accessing oral health care. Multiple policy reforms are needed to reduce disparities, including targeting specific communities with more resources and better oral health care delivery systems. The HEROs could not only be a laboratory for innovation but could tailor approaches to the communities.

2. **The waiver must incentivize oral health approaches that take care to populations and incorporate practitioners and sites outside of traditional dental practices.**

   Improving oral health outcomes will require that many kinds of providers offer oral health services and that effective approaches embed oral health services across community institutions. Benefits accrue from initiatives that provide oral health services in the places where people already gather or go: Head Start programs, schools, pediatricians’ offices, or community health centers. And they point to ways in which the system could be further reimagined to provide care in remote areas or for other hard-to-reach populations. The overarching theme is that oral health can and should be addressed in many places, and in many ways, by a variety of health providers.
SPECIFIC STRATEGIES TO REDUCE THE BURDEN OF ORAL DISEASE IN COMMUNITIES

Below are some examples where oral health should be explicitly considered in the waiver proposal:

Promote Value-Based Oral Health Care — Value-based oral health care should be included in Goal 1: Building a More Resilient, Flexible and Integrated Delivery System.

Oral health lags behind health care in the evolution of value-based models for many system-level factors, but also because of the siloed nature of dentistry. But there are identified opportunities such as more transparency about oral health outcomes versus costs, better integration of oral health services and medical care, provider payments that put emphasis on keeping people in good oral health instead of incentivizing restorative treatment, reorienting oral health prevention more toward public health, and dental service planning to be more responsive to population oral health needs. Ensuring that oral health is considered in VBP models is essential to moving toward integrated care for chronic conditions, such as diabetes; conditions where medications impact oral health, such as mental illness, and toward population health, such as improved access to services.

Develop a Strong, Representative and Well-Trained Workforce — Specific attention to the oral health workforce should be included in Goal #3: Redesign and Strengthen System Capabilities to Improve Quality, Advance Health Equity and Address Workforce Shortages.

New York is experiencing a shortage of dental providers. As with other professions, it is imperative that there be an adequate supply of people skilled in preventive and restorative dental care that is also representative of the populations being served. The workforce initiatives outlined in the waiver (recruitment and retention initiatives, career pathways, training initiatives, expanding community health worker and related workforce and standardize occupations and job training) should explicitly include dental providers.

Recognize and Promote Teledentistry — The ability to expand care and reduce health inequities through teledentistry should be recognized in Goal #4: Creating Statewide Digital Health and Telehealth Infrastructure beyond the use of CDHCs.

New York allowed tele-dentistry prior to COVID and continues to examine what rules and regulations can continue. Teledentistry has the ability to improve access to oral health care, improve the delivery of oral health care, and lower its costs. It also has the potential to reduce disparities in oral health care between rural and urban communities. Teledentistry may turn out to be the cheapest, as well as the fastest, way to bridge the rural-urban health divide. The waiver should explicitly address funding and technical assistance for teledentistry through the Equitable Virtual Care Access Fund. While the waiver calls for 62 Medicaid Community Dental Health Coordinators, there should be an explicit expectation for integration into the health system and not exclusively siloed in dental care settings.

COMMENTS ON FUNDING ALLOCATIONS

The waiver request includes funding allocations that are likely to exacerbate health disparities, not improve them. The investments, as described in the funding allocations, are not allocated based on populations of people in poverty, race and ethnicity, morbidity, or other relevant factors. The State should revise funding allocations on a population (attentive to poverty, race, ethnicity, morbidity) basis rather than a county or regional basis.
CONCLUSION

Former Surgeon General David Satcher called oral disease America’s silent epidemic. People suffer from preventable, treatable disease mostly because of systemic issues that hinder access to prevention and treatment. The health system and dental systems are not connected at all—different providers, different health records, different insurance systems, different care teams. This divide continues even as the connections between poor oral health and poor general health, stunted job prospects, lost education days, and lack of social mobility are being better understood.

This waiver, designed to make the strategic, targeted, evidence-based investments to improve health equity, is a perfect vehicle to improve and connect oral health to the health system. Improving oral health outcomes—and, concomitantly overall health outcomes—requires investments in both evidence-based and innovative initiatives at the community level and the alignment of financial incentives, workforce policies and data systems at the state level.

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