SUMMARY OF THE 2019 SANTA FE GROUP SALON

Comprehensive Health Without Oral Health: The Medicare Paradox

The Santa Fe Group Salons: An Oral Health History

In 1996, a group of five dental educators and scientists began to meet regularly to discuss the future of healthcare with special reference to oral health, public education, and research in the United States. Well positioned as educators, researchers, policy advocates, and corporate leaders, these founders began to address some of the challenges, as well as to seize key opportunities, in the interest of improved health through the integration of oral and general health strategies. Eight years later, several new thought leaders joined the five original founders in Santa Fe, New Mexico, to establish the non-profit Santa Fe Group (SFG). This organization continues to serve as a neutral convener of various thought leaders and stakeholders to focus on the key evolving issues of the day, often in an invitation-only small meeting conducted in the French tradition of a salon.

The SFG focuses on critical, actionable issues in health policy, science, education, and practice—one of which is the inclusion of a dental benefit for medically necessary dental care within Medicare. The first SFG Salon on this issue, *Expanding Oral Healthcare for America's Seniors*, was held in 2016 in Arlington, Virgina, and helped to energize scores of diverse organizations to prioritize oral health as a valuable benefit for total health.

The Arlington salon was exceptional in the sheer number and range of interested parties participating, most of whom were already on board to "Put teeth into Medicare," as one enthusiast put it. Over 150 representatives of academia, government agencies, public health and advocacy organizations, foundations, health insurers, and dental, nursing, and other health professional groups attended the 3-day meeting.[1]

The influential group of attendees reviewed evidence about the need for dental coverage for seniors and discussed how the Medicare benefits package could be designed. The rationale, costs, and benefits of improved oral healthcare access for seniors presented at this meeting made a compelling case for expanding Medicare to include dental benefits.

Subsequently, 130 prestigious organizations have signed on in support of a dental benefit for medically necessary dental care within Medicare. These organizations include: consumer advocates, such as the American Association of Retired Persons (AARP) and Families USA; health professional groups, such as the American Nurses Association and the American College of Physicians; specific disease, research, and service entities, including the American Diabetes Association, the National Kidney Foundation, and The Gerontological Society of America; and of course, a broad spectrum of dental organizations. This *Community Statement on Medicare Coverage for Medically Necessary Oral and Dental Health Therapies* acknowledges that "it is well established that chronic diseases disproportionately impact Medicare beneficiaries and impose a substantial cost on the federal government. It is also well established that untreated oral microbial infections are closely linked to a wide range of costly chronic conditions, including diabetes, heart disease, dementia, and stroke. In addition, oral diseases have been documented by researchers and medical specialty societies as precluding, delaying, and even jeopardizing medical treatments such as organ and stem cell transplantation, heart valve repair or replacement, cancer chemotherapies, placement of orthopedic prostheses, and management of autoimmune diseases."[2] The statement concludes that "the Medicare program and all its beneficiaries should not be without the vital clinical and fiscal benefits of coverage for medically necessary oral/dental health therapies. Given the significant potential to improve health outcomes and reduce program costs, we urge the Congress and administration to explore options, including utilization of existing authority, for extending such evidence-based coverage for all Medicare beneficiaries."[2]

2019 Salon - Comprehensive Health Without Oral Health: The Medicare Paradox

Building on these initiatives, the SFG hosted another salon in May 2019, at which more than 25 leading educators, researchers, policy makers, consumer advocates, and business leaders presented to over 200 leading healthcare change agents. Ambitious but tightly focused, this interactive program explored numerous aspects supporting the critical need for Medicare to include oral health benefits. These 2 days of discussion ranged from research, to strategies, to perspectives, building momentum as the evidence was affirmed. As Dr. Michael C. Alfano, president of the SFG, stated, "Simple dental care can keep you out of the hospital. The American people should know this, and the Centers for Medicare & Medicaid Services (CMS) should act on it."

This article summarizes key concepts from the Salon. For further information, the full presentations are available online at: SantaFeGroup.org/salon.

The Evidence

Integrating Dental to Improve Healthcare Value: Private Insurance Data

Dr. Robert Lewando, executive dental director of Blue Cross Blue Shield of Massachusetts, introduced data from their Total Health program, examining medical cost differences and the impact of oral health on life expectancy. The organization usually reviews medical and dental claims data to see differences in medical costs related to whether or not the individuals were having some type of dental services. In addition, he explained that there is an actuarial way of using medical claims data to look at longevity, based on whether they have a medical diagnosis of a serious dental or periodontal condition. The conclusion from the first analysis would be to say that differences in medical costs are a proxy for member or population health. The conclusion from the second would be the potential change of life expectancy resulting from poor oral health.

As an example of the analysis, Lewando presented statistics on the "Impact of Dental Care on Total Medical Costs for Members with Coronary Artery Disease (CAD) and Diabetes: Depending on if they were getting dental care." For CAD, the total difference was $26,907 (total healthcare costs for those who did not receive dental care), versus $20,754 for those who did. For diabetes, it was $16,398 (no dental) versus $13,952. For seniors, the data was particularly compelling: $33,542 versus $21,622 for CAD; and $19,993 versus $16,343 for diabetes.

When reviewing "Medical and Co-Morbidity Costs: All Members," the table detailed the increase in medical costs based on various comorbidities. For CAD, the increase in medical costs for those who did not receive dental care ranged from 17% to 32%; for diabetes, it ranged from 9% to 37%.

Finally, in the analysis of life expectancy, Lewando explained that there are over 200 conditions identified by medical claims data that are assigned a mortality and disability index, which can be used to estimate an individual's overall life expectancy by actuarial and disability tables. It is highly important for patients to understand that a serious dental or periodontal condition may lead to a loss of 1.7 years of healthy life.

"If we can convert our patients to understand these things, then convert our legislators to understand, we are on the track to dental benefits being added to Medicare," Lewando concluded.

Impact of Dental Care on Health Care Events and Costs: New York State Medicaid Data

Although studies have shown reduced healthcare costs and improved outcomes among those who received preventive oral care and treatment of periodontal disease, to date, research has primarily looked at private payer populations. For the first time, this Salon featured data from a public payer population.

Dr. Ira B. Lamster, dean emeritus, Columbia University College of Dental Medicine, and Kevin P. Malloy, public health professional and researcher at the New York State Department of Health, offered their preliminary findings from their research with the New York State Medicaid population. The study period spanned 3 years, 2012 to 2015, and included adults aged 40 to 64 who were not eligible for Medicare and were continuously enrolled in New York State Medicaid for the 36-month study period. The final cohort size was 535,038.

By focusing on a public insurance database, the level of systemic and oral disease could be expected to be higher, given the lower socioeconomic status. Accordingly, the investigation focused on the relationship between utilization of dental care, healthcare events, and costs in a high need public payer population to see what the measurable effects were. Another unique aspect of this research was consideration of the effect of both preventive care (hypothesized to have beneficial effects) and the need for dental extractions and endodontic therapy (as a surrogate for oral infection) on health outcomes.

The preliminary data included "Cross-sectional: Event Rates by Dental Care Utilization," "Cross-sectional: Costs by Dental Care Utilization," and "Longitudinal: Year 3 Event Rates by Dental Utilization in Years 1 and 2." Additionally, one compelling graph illustrated the "Impact of Frequency of Preventive Care," demonstrating that emergency department visits fell from 85.3 per 100 people (for no dental visits), to 5.15 per 100 for four dental visits in the previous 2 years. For hospitalizations, the number declined from 23.2 down to 11.9.

To date, this research shows that provision of preventive dental services is associated with:

- Reduced emergency department and hospitalization rates
- Reduced emergency department, hospitalization, and prescription costs
- Reduced total healthcare costs for those with noncommunicable diseases

The preliminary data analysis indicated effects for the entire cohort as well as for those with specific chronic diseases (ie, cardiovascular diseases, diabetes mellitus, respiratory diseases, cognitive impairment). This analysis is continuing to define determinants of these associations for this population.

Dental Health Is Integral to Overall Health: Dental Insurance Data

Released in 2014, the United Concordia Dental whitepaper, *The Mouth: The Missing Piece to Overall Wellness and Lower Medical Costs* was an important milestone in the effort to prioritize oral health.[3] The study, published in a peer-reviewed medical journal, was conducted on a comprehensive, 5-year data set in collaboration with Highmark Health, Inc. and evaluated the impact of periodontal treatment on medical costs and hospitalizations for members with certain chronic medical conditions and women who were pregnant. Overall, this study showed that annual medical costs and hospitalizations were considerably lower for members who completed their periodontal treatment and maintenance.

Dr. Paul Manos, dental director for United Concordia Dental, joined the Salon to discuss the organization's latest white paper, *The Value of Going to the Dentist.* Published in 2017, the core study population included more than 489,000 United Concordia and Highmark Inc. members with both medical and dental

coverage who were between the ages of 4 and 64 during the 2010 to 2013 study period.[4]

In contrast to the previous research, this study reviewed the entire covered population (not only people with specific diseases). Its desired outcome was stated as "Broaden the value proposition for a dental benefit plan." Its new hypothesis: "Are medical savings possible simply by visiting a dentist regularly for routine checkups and cleanings, regardless of an underlying medical condition?"

Findings from *The Value of Going to the Dentist* included the following:

- All ages, across 3 years, medical savings = $68/person yearly compared to the non-dental users.
- All ages, 3 years = $157/ person yearly compared to intermittent dental users.
- Adults, 3 years = $81/person yearly compared to non-dental users.
- Pediatric members had $134 annual savings over three years, with large savings every year.

As Manos explained, the data is retrospective, not prospective. In addition, providing a dental benefit is not enough. Stakeholders need to provide avenues for patients to become knowledgeable and act upon those changes.

Dental Care for Older Americans: Data Update from the Health Policy Institute, American Dental Association

What's going on in America? Dr. Marko Vujicic, chief economist and vice president of the Health Policy Institute at the American Dental Association (ADA), weighed in with detailed updates on the changing dental practice environment. Critically, the senior population is growing, and a higher share of these older people are visiting dentists, driven by the upper income group. For dental practices, older patients are making up a larger share of dental patients—it's the only demographic whose dental visits are increasing. However, there is a perceived affordability issue with dental care versus other care (such as vision).

In addition, these data demonstrate that there are widening disparities among seniors in dental care utilization. Lower income seniors are not seeing the same improvement in oral health as high-income seniors.

As Vujicic detailed the statistics behind dental care use, dental care financing, and barriers to dental care, he explained that advocates should be prepared with the right analysis, and the right research, at the right time—and to be prepared for questions.

Senior's Oral Health: A Comprehensive Approach

The Salon was not only about healthcare data; it was also about creating demand and determining strategy. Alison Corcoran, president of the DentaQuest Partnership for Oral Health Advancement and chief marketing officer of DentaQuest, and Peter Mitchell, chairman and chief creative officer for Marketing for Change™, presented data demonstrating momentum for adding a dental benefit to Medicare. Their report analyzed events such as bills filed, letters of support, articles written, and mentions of "Medicare dental" in press to support this reasoning. However, the challenge, as they stated, is turning soft support into hard action. For example, an online survey showed that three-quarters of Americans 55+ favor Medicare dental, but two-thirds are unengaged or inactive on the issue.

How does need convert into demand? Dr. Chester W. Douglass shared insights on "The Need for Dental Care by the Medicare Population." Analyzing data from the National Health and Nutrition Examination Survey, Bureau of Census Population Estimates and Projections, and the National Institute on Aging New England Elders Dental Study, Douglass and his co-authors affirm:

- Unmet dental treatment needs are substantial and increasing in the Medicare population
- Periodontal treatment needs are significant and may be related to several systemic conditions.

Significantly, elders are retaining more teeth and, therefore, have more periodontal disease and dental caries experience. If rates stay the same, but the number of people and teeth exposed increase, the number of cases increases.

If oral health is key to overall health, then key to this endeavor is integrating other healthcare workers. Anita Duhl Glicken, MSW, executive director, National Interprofessional Initiative on Oral Health, joined the Salon to discuss "A Systems Change Initiative Advancing Interprofessional Education and Integrated Oral Health Care." This consortium brings together health professionals and national organizations to eradicate dental disease by engaging the primary care team. Its focus is on integrating oral health into primary care education and practice.

Dr. Rita Jablonski, School of Nursing, University of Alabama at Birmingham, presented on "Improving the Oral Health of Older Adults with Cognitive Impairments Via Interprofessional Approaches: Nurse Practitioners as Key Interprofessional Team Members." As the largest health profession, nurses are everywhere in the system, and it is essential for them to be educated on the relationship between oral and systemic health.

Similarly, physician assistants have much to contribute to oral healthcare. Anthony A. Miller, distinguished professor and director, Division of Physician Assistant Studies at Shenandoah University, focused on how "PAs are Contributing to Oral Health in Older Adults." Among his conclusions were:

- PAs working in team-based practices are impacting oral health and its consequences for older adults
- Patient trust and confidence in PAs positions them to have positive impact on preventive care outcomes for older adults
- PAs continue to develop referral networks with dentists and other dental care providers
- PAs have demonstrated they are able to rapidly respond to new markets and research

Finally, Dr. Hugh Silk, a physician from the University of Massachusetts Medical School Department of Family Medicine and Community Health, presented the work of the Center for Integration of Primary Care and Oral Health. His presentation, "Medicare without Oral Health Coverage: Stories from the Front Lines," reviewed the efforts to integrate oral health into primary care to meet the needs of communities.

Coalitions and Strategies

Another aspect that drives support is the multitude of stakeholders, evidenced by the diversity of both presenters and attendees at the Salon and their sharing of insights. Meg Booth, executive director of the Children's Dental Health Project (CDHP), and Dr. Burton Edelstein, professor of Dental Medicine and Health Policy at Columbia University, covered "20 Years of Securing and Protecting Medicaid Coverage for Children & Families: Lessons Learned for Medicare Advocates." They detailed what CDHP set out to do, what CDHP accomplished (and didn't), how CDHP accomplished its objectives, and finally, the lessons learned for Medicare policy and advocacy.

Patrick Willard, senior director of state and national strategic partnerships for Families USA, took it further with his discussion, "Coalition Building: The Usual Suspects, Strange Bedfellows and Game Changers," exploring how advocacy groups are working to

impact healthcare policy. In addition, Dr. Patrick Courneya, executive vice president and chief medical officer of the Kaiser Foundation Health Plan and Hospital, discussed "Medical-Dental Integration," for a holistic approach to healthcare, through which dental providers extend primary care and share responsibility for members' total health.

Regarding the ADA policies related to Medicare and the perspectives of dental professionals, Dr. Lindsey A. Robinson offered "Medicare Dental Benefits and Organized Dentistry... A Policy Conundrum." She explained how:

- Coalitions amplify the voice of oral health to policy makers and regulators
- Collaborative practice model (IPE) is taught in dental school and fits the millennial team orientation
- Increasingly more new dentists will seek opportunities to practice in collaborative groups

Dr. Robinson concluded, "Dentistry can (is poised to!) become an integral component of primary care through improved health outcomes, reduced cost, and better patient/provider satisfaction."

Advocating for Change

Even though there's extraordinary consensus on the need for senior dental care, policy advances require successful advocacy strategies: "making *our* priority, *their* priority," explained Eric S. Berger, who serves as a principal at Liberty Partners Group where he specializes in the development and execution of comprehensive federal and state advocacy campaigns. In his discussion of "Better Care, Lower Cost: Medically Necessary Oral Healthcare Offers a Proven Way to Achieve Both," he offered these keys for action:

- Science: Extraordinary and growing body of evidence
- Savings: Billions of dollars in potential cost reduction
- Strength: Large and expanding community of supporters
- Surround: Media, Hill support, grassroots, and an all-out push

Dr. William Scanlon, a consultant to the West Health Institute, represented the inside perspective of the US Government Accountability Office (GAO) in his address: "Medicare Dental Benefits, Medically Necessary Services and Beyond: The Payer's Perspective." Before this benefit can be implemented, CMS administrators will need to determine: what exact services to cover, how to design payment policy, what is the definition of medically necessary dental care—and more. Private insurers have more capacity to direct the services that they pay for, however, Medicare does not have the resources to limit the services to those groups that will really benefit. In this environment, advocates need to have the evidence that demonstrates the level of need and the health benefits to overcome these financial and administrative concerns.

Fortunately, in 2020, there will be another authoritative resource available: a new Surgeon General's Report on Oral Health in America. As explained by Dr. Bruce A. Dye, director of health informatics-dental public health at the National Institutes of Health/National Institute of Dental and Craniofacial Research, the report will include emerging technologies and promising science to transform oral health, outline a vision for future directions, and educate, encourage, and call upon all Americans to take action.

Vision for the Future

The 2019 Salon's call to action was powerfully reinforced by the plenary address and the two keynote speakers. Dr. George J. Isham, senior fellow at the HealthPartners Institute, shared his vision of why this is so important: healthier, productive Medicare beneficiaries lead to lower heath care costs; more vibrant, multigenerational communities; social and political stability; and the opportunity for creating of additional social and economic value.

Representing a major stakeholder organization—AARP—Catherine Alicia Georges, national volunteer president, described their work on oral health as proceeding with "two mutually reinforcing elements: What individuals should do and what government policy should be. In fact, the heightened attention to oral health that would result from the creation of a new Medicare benefit could go hand-in-hand with new, coordinated efforts to help people become educated about why our dental habits have such profound consequences, and what they should be doing to help themselves."

Georges emphasized that the fact that two-thirds or more of the people in Medicare have no dental coverage does not make sense medically—and should not make sense politically. "Next time an elected official tells you that he or she is committed to dealing with these [health] disparities, ask the official's position on putting a dental benefit in traditional Medicare," she advised.

Providing a unique firsthand perspective, Congresswoman Donna E. Shalala, a former US Secretary of Health and Human Services (HHS) during the development of the first Surgeon General's Report on Oral Health (2000), discussed the necessity of building consensus within complex politics. As she explained, public policy isn't made in a systematic way: sometimes it's the result of evidence and an idea that grows out of that evidence for how to improve public health.

One example is how attitudes toward smoking were transformed after the first report. Since then, tobacco usage has declined. The forthcoming 2020 report—which will extensively cover the science and build on the previous report—will provide a compelling science component to support the dental benefit in Medicare. In Shalala's opinion, this report can be leveraged to make the case to Congress, insurance companies, and the American people. "We can take giant steps in social policy when there's consensus about the problem—and when there's consensus about the solution."

In closing, Dr. Ron Inge, SFG member and chair of the Salon stated, "The 2019 Santa Fe Group Salon created a critical opportunity to convene multiple key stakeholders with a common mission: Putting Teeth in Medicare. The speakers made a powerful case for more integrated total healthcare, for improved healthcare literacy, for expanded collaboration, and for continued study of the emerging consensus that simple dental care can reduce total healthcare costs, reduce the need for hospitalization, and maximize total health benefits in insured populations."

Summary compiled by The Santa Fe Group and Catherine Paulhamus.

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