

WHITE PAPER

# Oral Health Value-Based Care

**The Federally Qualified Health  
Center (FQHC) Story**

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# Contributors

## **Sean Boynes, DMD, MS**

Vice President, Health Improvements  
CareQuest Institute for Oral Health

## **Annaliese Cothron, DHSc, MS, CPH**

Executive Director  
The American Institute of Dental Public Health

## **Jeremy Crandall**

Director, State Affairs  
National Association of Community Health Centers

## **Rebekah Mathews, MPA**

Director, Value-Based Care  
CareQuest Institute for Oral Health

## **Myechia Minter-Jordan, MD MBA**

President and CEO  
CareQuest Institute for Oral Health

## **Jennifer Nolty**

Director, PCA and Network Relations  
National Association of Community Health Centers

## **Jason Patnosh**

Associate VP, Partnership and Resource Development  
National Association of Community Health Centers

## **Da-Nell Pedersen, MPA**

Director, Clinical Programs  
Arizona Alliance for Community Health Centers

## **Bob Russell, DDS, MPH, MPA, CPM**

Senior Consultant CareQuest Institute for Oral Health

## **Eric P. Tranby, PhD**

Data and Impact Manager, Analytics and Evaluation  
CareQuest Institute for Oral Health

## **Donald L. Weaver, MD**

Senior Advisor, Clinical Workforce  
National Association of Community Health Centers



# Executive Summary

Federally Qualified Health Centers (FQHCs) serve as a point of care for over 28 million patients annually (1), many of whom are uninsured, living in poverty and located in rural areas. These social determinants of health create chronic conditions, including a disproportionate burden of oral disease, within a vulnerable patient community. Facilitated by better access to technology infrastructure and coordinated primary care delivery, FQHCs have been at the forefront of providing comprehensive, person-centered health care. Shifting away from fragmented dental care provision and into a coordinated, integrated model of health care primes FQHCs to lead transformation into a value-based system.

A series of analyses were performed using 3 data sources: the IBM Watson MarketScan Multi-State Medicaid Database, the Health Resources and Services Administration Uniform Data System and a survey of participants in a safety net technical assistance program. Data were analyzed to explore health outcomes and service provision in an FQHC population compared to non-FQHC populations.

## COVID-19 Impact

The COVID-19 pandemic has substantially impacted how FQHCs deliver and fund primary care. Decreases in routine patient visits led to the furlough of more than 100,000 health providers with a collective \$34B reduction in revenue. Rural-based health clinics have closed, placing communities with overlapping inequities at even higher risk. Despite these challenges, FQHCs responded to the pandemic with flexibility in workforce modeling, pivoted telehealth care for improved and timely triage and increased testing capacity for underserved populations. The FQHC infrastructure created opportunities for resiliency and capacity that can translate into a value-based system of care.

## How can FQHCs adapt oral health care delivery as a result of COVID-19?

We contend that FQHCs can continue workforce integration and emphasize prevention to increase both quality of and access to oral health care. Continued expansion into telehealth catalyzed by the COVID-19 pandemic can improve chronic disease management in oral health.

# Should FQHCs move toward value-based payments and care during a pandemic?

We suggest that leveraging existing flexibility in financial operations toward a value-based design can position FQHCs to weather the fluctuations and disruptions in care delivery during and after the pandemic. Incorporating minimally invasive care, supported by increased telehealth, is safer for both dental practitioners and patients. FQHCs can engage in alternative payment models (APMs) through enhanced preventive services and minimally invasive care that is utilized only when needed.

Based on the findings of our analysis coupled with reviews of existing data on FQHC capacity, we recommend that FQHCs explore value-based payment models for oral health

to increase integrated care, improve health outcomes, reduce costs and diversify business operations and revenue streams. States should consider expansion of teledentistry beyond COVID-19 to explore its efficacy in reducing emergency department visits and managing chronic disease. The Uniform Data System should expand oral health measurement for improved assessment of oral health outcomes. Lastly, dental programs should review and replicate the successful person-centered care models cultivated in FQHC environments.

FQHC dental systems are positioned to drive change toward value-based solutions within the broader dental community. Improved health outcomes, care innovation, and information technology capabilities all point toward the ability of FQHCs to serve as a conduit for value-based payment transformation.

## Key Findings

- **13% of Medicaid dental visits to FQHCs were acute or emergency** in nature (compared to 9% of all visits in non-FQHC settings)
- **FQHCs are conducting caries risk assessments during Medicaid encounters more regularly than non-FQHC dental programs** (2.15% of adults and 2.72% of children in FQHCs received the assessments in 2017, compared to less than 0.5% of those who had a dental visit outside of the FQHC system)
- **12% of FQHC dental patients have a chronic condition**, with 7% having either complicated or uncomplicated diabetes and 2% having cardiovascular disease, **rates nearly double** that of Medicaid enrollees seen in non-FQHC dental offices

- **For every 1% increase** in patients receiving dental services, the proportion of **diabetes patients with uncontrolled diabetes declined by 0.2%**
- **FQHCs generally have a higher degree of interoperability**, which supports the ability to collect both outcomes and payment information crucial to a value-based model, but inconsistent metrics still present a challenge



# Purpose and Significance

Though considered an important part of overall health, oral health remains a significant issue for Americans. According to a recent report by DentaQuest, approximately half of patients rank oral health as their top health concern, over heart, eye, skin, digestive and mental health. Additionally, 3 in 4 Americans have experienced barriers to accessing dental care. Patients most commonly cite the high costs of dental care and a lack of dental insurance coverage as barriers to accessing dental care (2). For Americans in poverty, these challenges are even greater — 93% percent of individuals living in poverty have unmet dental needs compared to 58% in high-income families (3).

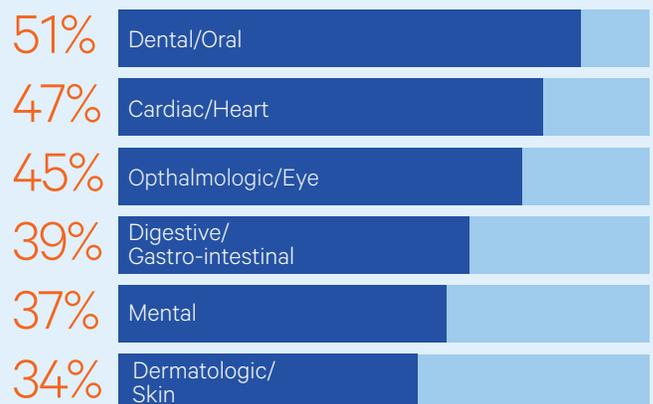
When able to access care, low-income Americans spend 10 times more as a proportion of their annual family income on dental services compared to high-income families (3).

Patients with difficulty accessing care often seek out safety net health systems like hospitals, free clinics or Federally Qualified Health Centers (FQHCs). These profound oral health disparities have only become more pronounced since the pandemic outbreak of the novel corona virus, or COVID-19.

The purpose of this report commentary is to

- provide evidentiary support that positions FQHCs as facilitators of oral health value-based care;
- compare oral health services provided in FQHCs to oral health services provided elsewhere;
- describe the FQHC model of care and its role in the value-based transition; and
- outline opportunities for FQHCs to respond to the COVID-19 outbreak within a value-based framework.

## Patients' Personal Health Concerns



# FQHCs and the Safety Net System

Federally Qualified Health Centers “are nonprofit facilities that provide comprehensive primary medical care — and often dental, vision, and behavioral health services — to low-income patients in medically underserved areas, regardless of a person’s ability to pay” (4). A health center must meet requirements in 21 areas outlined in the [Health Center Program Compliance Manual](#) and uphold this operational approach in order to maintain eligibility for funding as an FQHC (5). In addition to these requirements, FQHCs must be located in medically underserved areas or serve medically underserved populations and include members of the communities they serve on their governing boards. They are also charged with regular reporting and continual quality improvement exercises to ensure quality of care and an approach to care delivery that matches the needs of their communities (6). FQHCs save the healthcare system up to \$24B annually through quality, innovative, whole-person, community-based care (7). Today, there are 1,400 health center organizations nationwide. More than 28 million people receive care from an FQHC.

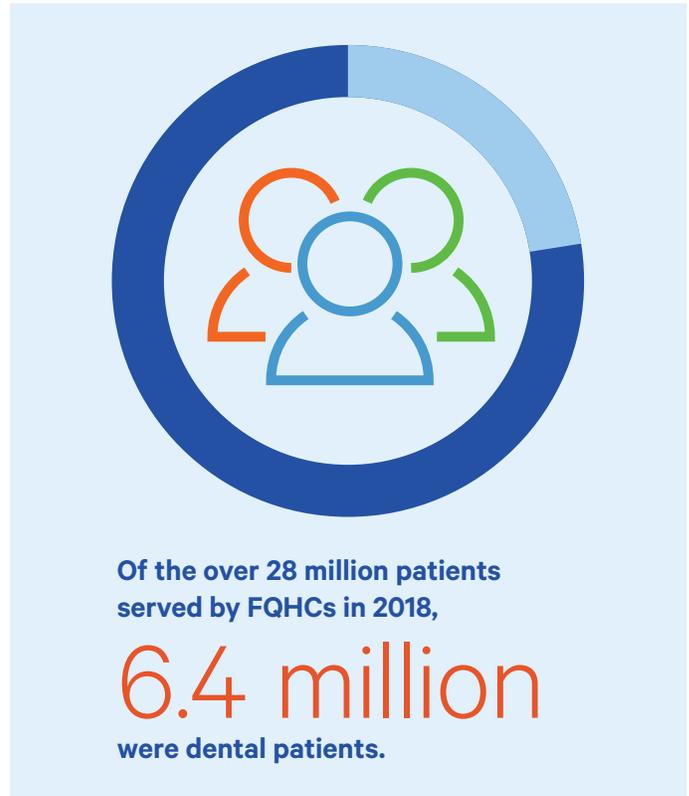
Nationally, 23% of FQHC patients are medically uninsured (1). It is likely that the uninsured rate for patients seeking dental services at FQHCs is even higher given the limited dental coverage for adults through Medicaid. According to the [Centers for Health Care Strategies](#) 19 states offer extensive dental coverage through Medicaid for adults, 16 have limited coverage, 13 offer emergency only and 3 have no coverage at all (8). This disparate coverage results in a high number of uninsured patients seeking care from the safety net provider system, including FQHCs. FQHCs are required to provide emergency and preventive services regardless of ability to pay which can pose a challenge to maintaining financial sustainability. Additionally, 45% of the 1,400 health center organizations across the country are in rural areas (7). As rural populations face complex barriers to accessing care, including limited transportation, lack of insurance and higher rates of poverty, the ability of FQHCs to serve 1 in 5 rural residents is vital (7). Access to dental care in rural areas is especially challenging, with 66% of Dental Health Professional Shortage Areas (HPSAs) designated as rural (9). Since the COVID-19 pandemic is leading to millions of Americans filing for unemployment, uninsured rates and the number of individuals on Medicaid are expected to increase (10). Community-based clinics like FQHCs will likely be the source of healthcare for these individuals and families.



# Care Innovation in FQHCs

Of the over 28 million patients served by FQHCs in 2018, 6.4 million were dental patients (1). 81% of community health centers provided on-site dental services in 2017, a 30% increase since 2010, according to the National Association of Community Health Centers (NACHC) (11). In addition to dental and oral health care, 99% of FQHCs provided enabling services (case managers, translators, transportation staff, social workers, and patient educators), 90% provided behavioral health services and 25% provided vision services. The integrated care model employed by FQHCs has positioned them as leaders in healthcare innovation, with 78% of FQHCs certified as Patient-Centered Medical Homes (PCMH) (1), a model that focuses on reducing fragmentation of care, improving patient experience, achieving better management of chronic conditions, and lowering health-related costs (12). Although oral health has not been a substantial component of the PCMH initiative (13) and other nationally-recognized quality programs, health centers have been trailblazers in implementing innovative integrated care models. According to a [survey conducted by the National Network for Oral Health Access](#), almost 34% of health centers have dental providers embedded in the medical clinic (14). As the overall healthcare system incorporates value-based transformation, the role of oral health in maintaining and improving overall health and the need for medical-dental integration are becoming more apparent. The COVID-19 pandemic has presented an opportunity for the dental team to step out of their silo and come into the fold with the larger healthcare workforce, as dental team members have been diverted to support medical teams with response efforts. This experience has the potential to foster enhanced teamwork within health centers beyond the COVID-19 pandemic.

In addition to integrated care, FQHCs have excelled at utilizing technology to enhance patient engagement and improve the patient experience. In 2018, over 43% of health centers were utilizing telehealth in order to provide remote clinical care (1). The use of telehealth has increased dramatically during the COVID-19 pandemic, and although the impact is yet to be determined, there is a chance that some elements of this temporary shift in care delivery will end up being permanent. FQHC dental programs have an opportunity to leverage these innovations as the dental care delivery landscape continues to evolve.



# FQHCs as a Conduit for Value-Based Payment Transformation

Value-based care is a model designed to align the system of care, the person, the provider and the community to achieve better health outcomes at lower costs (see Figure 1). Successful designs are prevention-focused, minimally invasive, person-centered and risk-based to ensure an equitable distribution of resources. These goals are currently even more important since avoiding unnecessary interaction and reducing aerosols to mitigate disease risk are necessary.

FQHCs receive federal funding under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) (“Federal Section 330”) to carry out their mission of serving our nation’s most vulnerable populations. When treating the Medicaid and Medicare population, many FQHCs are paid based on the Prospective Payment System (PPS), which involves “a single, bundled rate for each qualifying patient visit” that “pays for all covered services and supplies provided during the visit” (15). Through a bipartisan effort, the PPS was established by Congress in 2001 to prevent FQHCs from utilizing their Federal Section 330 grant funds, funds meant to be allocated toward caring for the uninsured and to subsidize care for Medicaid patients (15). In addition to supporting the financial sustainability of the health center program, the PPS also enables state Medicaid programs to use alternative payment models (APMs) in place of the

PPS, setting key protections for use: the payment amount in an APM cannot be less than what the FQHC would receive via the traditional PPS calculation, and the FQHC has the right to consent to use of an APM (16). This requirement ensures dialogue and enables payer-provider collaboration in the establishment of an APM (17).

In a value-based payment environment, providers are paid to care for a population with incentives for demonstrating value by preventing dental disease and keeping patients healthy rather than relying on a payment model that prioritizes volume of services provided. Prospective payments can ensure a steady revenue stream for the patient base even if there are fluctuations in care pathways driven by risk status or by disruptions to practice operations. Value-based care also encourages and rewards interprofessional practice while tracking health outcomes and patient satisfaction. Dental programs were already perceiving pressure to diversify financial models related to dental care delivery. As more health-oriented financial plans enter the market, dental care teams may be required to demonstrate that services provided in each encounter result in improved processes or outcomes of health. FQHCs and their dental programs could benefit from intentional efforts to integrate value-based care as they restore oral health services following the COVID-19 pandemic.

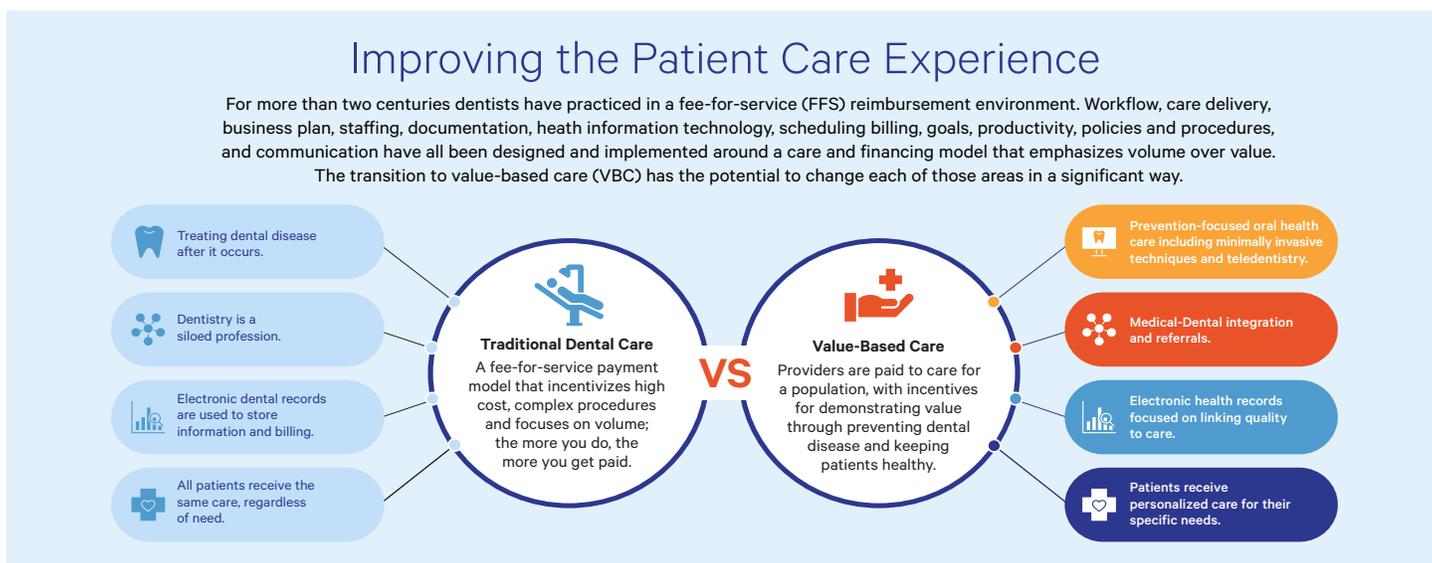


Figure 1: Characteristics of Traditional Dental Care Compared to Oral Health Value-Based Care (OHVBC)

# Methods

Findings presented in this report are drawn from three different data sources. First, the bulk of the analysis presented in this report comes from the [IBM Watson MarketScan Multi-State Medicaid Database, 2013-2017](#). This is a nationally representative sample containing all Medicaid dental, medical, and pharmacy claims from 13 states. The 2017 data includes information on 13.5 million enrollees and 32 million dental claims made by over 4.2 million patients. Of those, 736,919 were dental claims and 125,000 patients received care from an FQHC. This is more than double the 235,392 claims made by and 42,252 patients treated by FQHCs in 2013.

Second, using the Health Resources and Services Administration's (HRSA) 2016 [Uniform Data System \(UDS\)](#), an analysis was performed focusing on 630 health centers nationwide that saw more than the average proportion of adults (> 74% of patients seen were adults 18 or over). The association between the proportion of adults receiving dental services and the proportion of patients with uncontrolled diabetes was assessed in fractional outcome regressions that controlled for the age, race, income and insurance status of the patient population.

Third, clients of Safety Net Solutions (SNS), a non-profit safety net technical assistance program of the DentaQuest Partnership for Oral Health Advancement, were surveyed between June and July 2018 via SurveyMonkey about readiness for value-based designs and quality metrics tracked within their programs. Of the 939 individuals who received the survey, 50 responded, and their responses to key questions are summarized in this report (See Figure 6). The survey was sent to SNS dental providers and administrators from FQHC organizations. The survey questions were developed by the former SNS team at the DentaQuest Partnership for Oral Health Advancement to obtain FQHCs' knowledge of and interest level around value-based care.

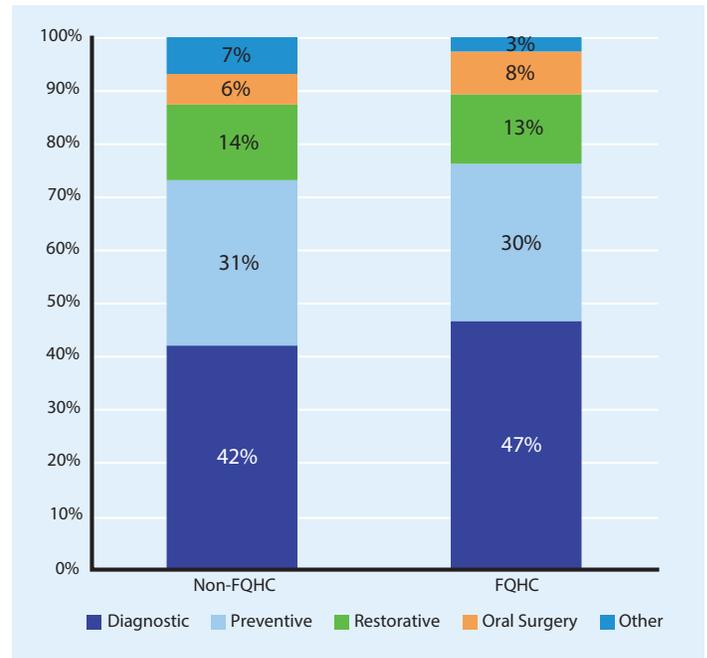
The characteristics of value-based contracted care utilized by a large Medicaid benefits organization (DentaQuest) served as the premise for data analysis. (Figure 1). We further codified risks and benefits of OHVBC as part of the reporting process and directed reporting to address prevention versus treatment, interprofessional practice and measurement capabilities.

# Results of Analysis

## Prevention vs. Treatment

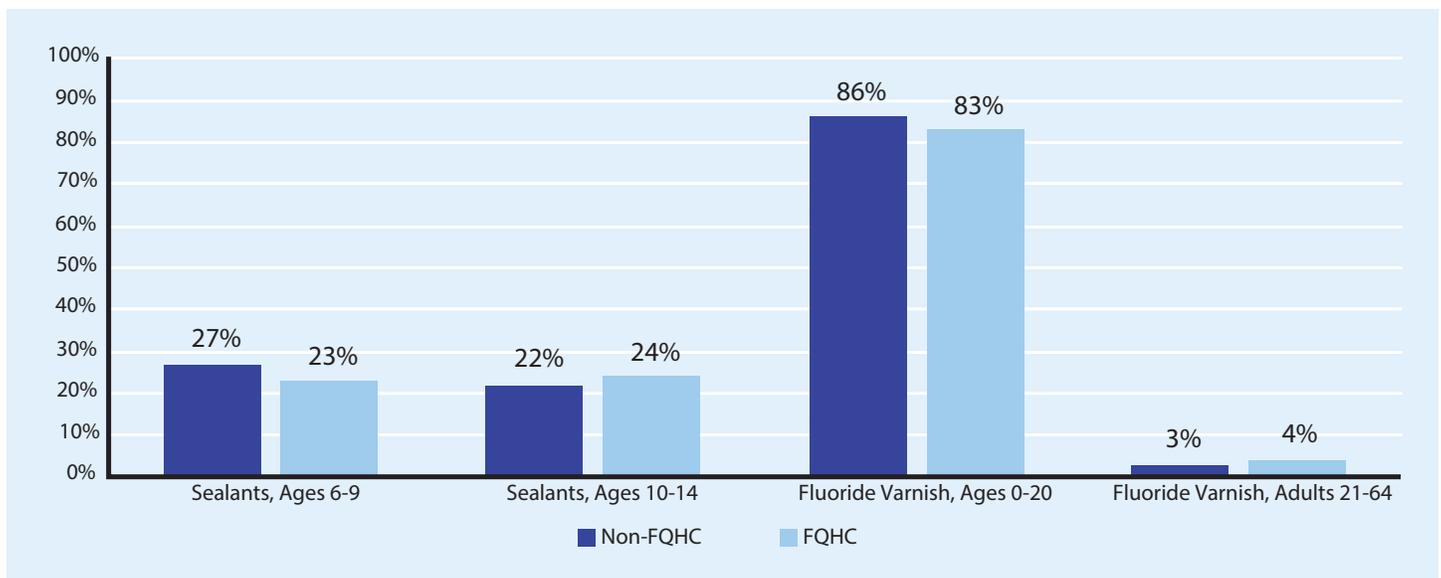
According to our analysis of the IBM Watson MarketScan Multi-State Medicaid data, 30% of services provided in FQHC dental clinics are preventive (see Figure 2), which is consistent with the national average of 31%. FQHCs compare favorably in relation to key preventive services performed, with 23% of children ages 6-9 and 24% of children 10-14 receiving sealants in 2017, and 83% of children and 4% of adult dental patients receiving a fluoride varnish application (Figure 3).

Less than half of patients (48%) who had an FQHC dental encounter in 2017 were seen at an FQHC dental care site in the prior year, compared to the nearly two-thirds of patients seen in non-FQHC dental clinics who had received care in the prior year. It should be noted that many patients seeking care in FQHCs live in poverty, with the financial burden of oral health services resulting in episodic and incomplete care. This inconsistent access to dental care was evident in our analysis as 13% percent of dental visits to FQHCs were acute or emergency in nature<sup>1</sup> (compared to 9% of all visits in non-FQHC settings). Additionally, 47% of dental care in FQHCs is classified as diagnostic and only 13% as restorative. Preventive and diagnostic care combined accounts for 77% of dental services provided by FQHCs (compared to 73% in non-FQHC settings).

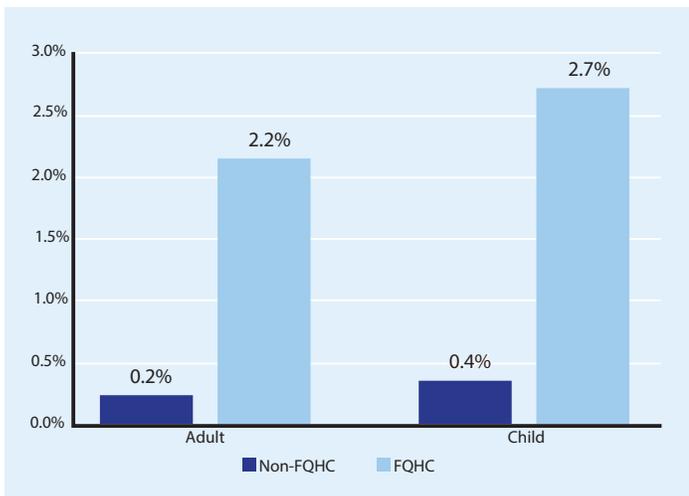


**Figure 2:** Scope of Medicaid Dental Services in Non-FQHC Dental Clinics and FQHC Dental Clinics, 2017

<sup>1</sup> Emergency care involves CDT codes D0140, D9110, or D9711.



**Figure 3:** Medicaid Related Sealant and Fluoride Varnish Applications in Non-FQHC Dental Clinics and FQHC Dental Clinics, 2017



**Figure 4:** Percent of Medicaid Patients Receiving Caries Risk Assessment, Non-FQHC Dental Clinics Compared to FQHC Dental Clinics,

FQHCs that focus on improving dental home status and completing active treatment plans are most likely to see success in prevention efforts.

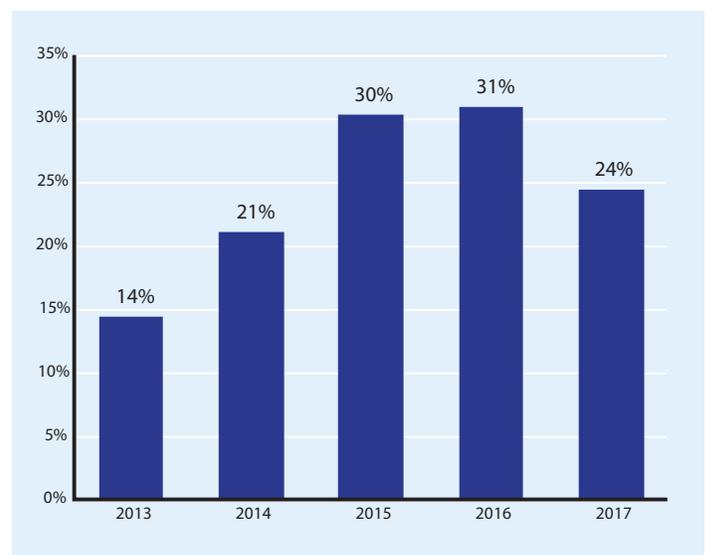
FQHCs that focus on improving dental home status and completing active treatment plans are most likely to see success in prevention efforts. Despite serving a much more challenging population, FQHCs can, overall, effectively create oral health models that positively impact health.

Risk-stratified care in dentistry ensures the appropriate distribution of resources so all patients can receive the care they need at the time it is needed. Unfortunately, risk assessments are rarely documented across the dental profession. Our analysis showed that FQHCs are conducting caries risk assessments more regularly than non-FQHC dental programs (2.15% of adults and 2.72% of children in FQHCs in 2017, compared to less than 0.5% of those who had a dental visit outside of the FQHC system) (See Figure 4). To improve in a value-based structure, FQHCs must continue advancing this practice and utilize risk stratification to foster patient engagement and appropriate care (18). Meaningful use of risk assessments can aid FQHCs in addressing social determinants

of health that often present as barriers to care, including transportation, income, health literacy and access to healthy food (19).

## Medical-Dental Integration

The ability of FQHCs to provide comprehensive, integrated care is by far their greatest asset in responding to the current COVID-19 crisis as well as a main lever for value-based transformation (20). While dentistry has traditionally been a siloed profession with limited interaction across healthcare disciplines, FQHCs provide opportunities for patients to receive both primary medical and dental care in the same healthcare system, often at the same location. As one study noted, FQHCs, along with Accountable Care Organizations, are more likely to have a dependable medical-to-dental referral network (21). According to our analysis, almost a quarter (24%) of patients seen in a FQHC had a medical and dental appointment on the same day in 2017 (see Figure 5). A decline in same-day interprofessional access was noted from 2015-2017. Although these averages are substantially better than those seen within non-FQHC settings, this decrease may warrant additional evaluation. Additionally, 3.5% of all patients seen by FQHCs had a medical health screening conducted during a dental visit, compared to less than 0.5% of patients seen in a non-FQHC setting.

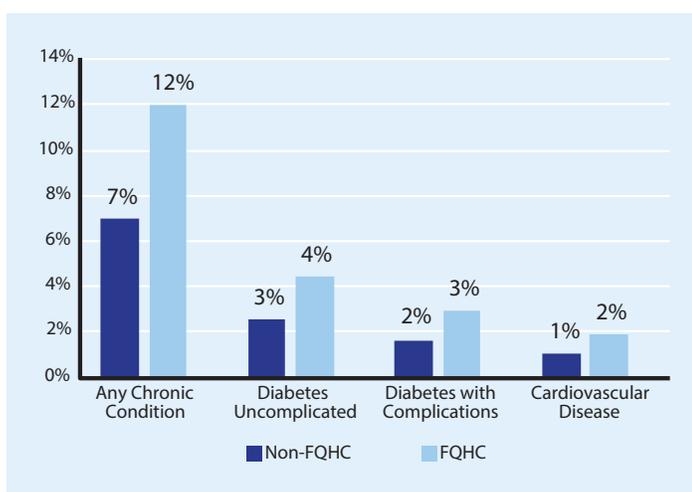


**Figure 5:** Percent of Same Day Medical and Dental Visits, FQHC Dental Clinics, 2013-2017

FQHC patients are significantly more likely than dental patients in other settings to have a chronic condition. Among FQHC dental patients, 12% have a chronic condition, with 7% having either complicated or uncomplicated diabetes and 2% having cardiovascular disease. These rates are nearly double those of Medicaid enrollees seen in non-FQHC dental offices (see Figure 6). This result parallels findings that patients accessing care at FQHCs have higher rates of chronic conditions like diabetes and hypertension, and the majority (68%) are at or below 100% of the federal poverty level (FPL) (7).<sup>2</sup> Despite having a patient population with higher disease burdens and a lower ability to pay for care, FQHCs perform better on ambulatory care quality measures compared to physicians in private practice and are narrowing health disparities (7).

## FQHC patients are significantly more likely than dental patients in other settings to have a chronic condition.

Dental services help FQHCs reduce the burden of chronic diseases. Based on our analysis of the Health Resources and Services Administration’s 2016 Uniform Data System (UDS) information, FQHCs with a higher proportion of adults receiving dental services encountered a lower proportion of adults with uncontrolled diabetes after controlling for age, race, poverty and the insurance status of the FQHC patient population.



**Figure 6:** Percent of Patients with a Chronic Condition, Non-FQHC Dental Clinics Compared to FQHC Dental Clinics, 2017

## For every 1% increase in patients receiving dental services, the proportion of diabetes patients with uncontrolled diabetes declined by 0.2%.

For every 1% increase in patients receiving dental services, the proportion of diabetes patients with uncontrolled diabetes declined by 0.2%. NACHC reports the overall savings FQHCs generate, including their performance on ambulatory care quality measures compared to private physicians, yet the impact of the provision of oral health services isn’t factored into the measurement (7). There is an opportunity for FQHCs to demonstrate how the treatment of oral disease leads to cost savings on medical expenditures, especially among patients with chronic conditions.

## Measurement Capabilities

Access to and the reporting of data is a key driver of success during value-based transformation. Nearly all — 99% — of FQHCs have installed electronic health record systems (1), compared to 46% of dentists in solo practice (22). In a recent stakeholder survey, the National Network for Oral Health Access (NNOHA) found that 39% of health centers reported their medical and dental records are “fully interoperable” (14). Despite these health information technology advancements, interoperability is still a challenge for many FQHCs. In a survey conducted by the DentaQuest Partnership (DQP) for Oral Health Advancement in June/July of 2018 via SurveyMonkey, electronic dental records and the inability to extract data from them was one of the most common barriers to readiness for OHVBC identified by respondents.

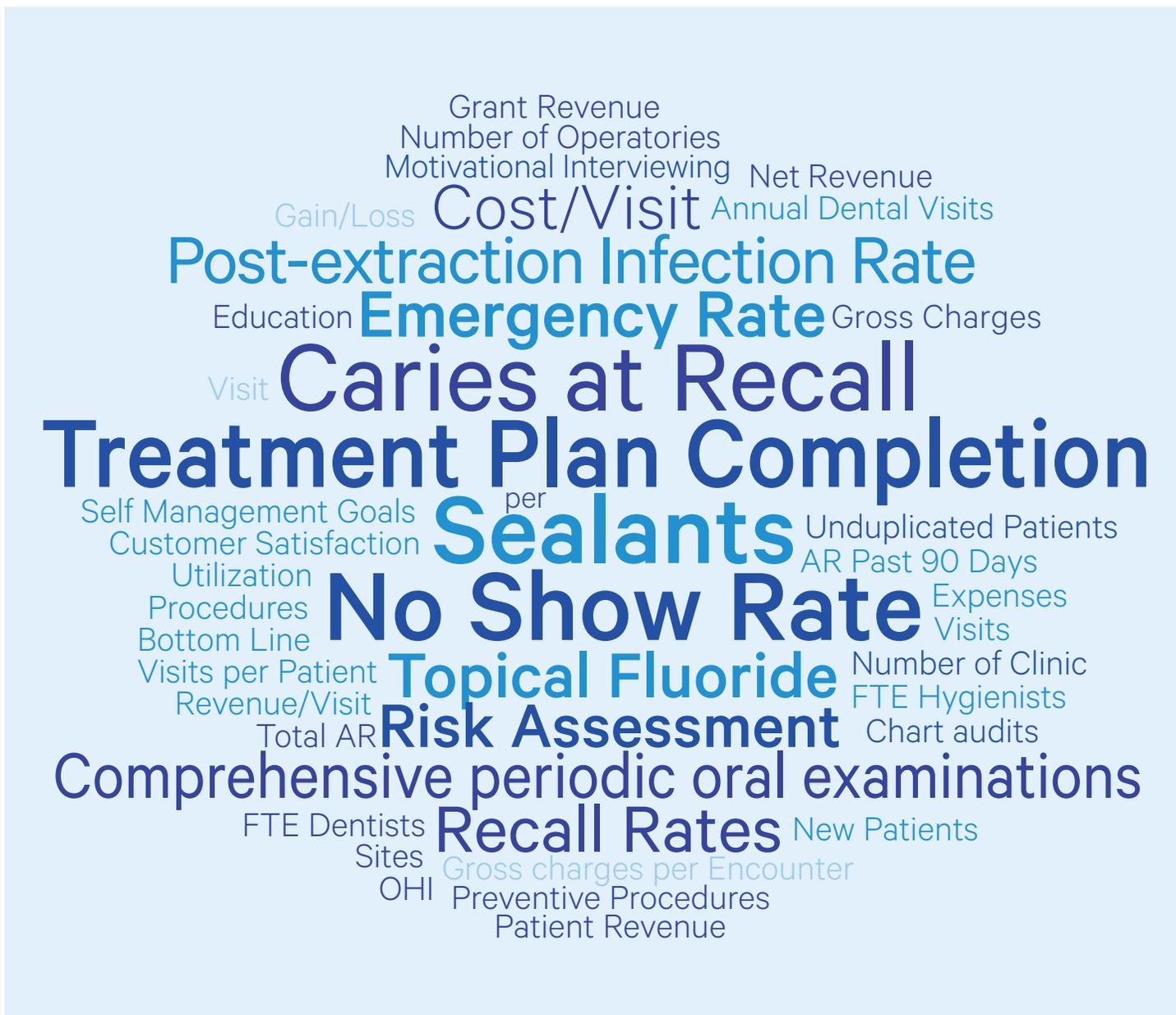
There is a lack of consensus regarding oral health outcome measures, and historically electronic dental record and practice management systems have not been equipped to monitor patient outcomes. Additionally, how FQHC stakeholders, providers and administrators measure for value in care varies widely (see Figure 7). In a DQP survey distributed to safety net subject matter experts, a lack of “black and white criteria to determine value-based thresholds” was presumed as a barrier to OHVBC readiness. The only dental measure currently tracked among FQHCs for UDS reporting is a process measure rather than an outcome measure. According to the Agency for

<sup>2</sup> FPL is the income measurement process used by the U.S. government to determine financial eligibility for certain programs.

<sup>2</sup> Dental HPSA is defined as the shortage of dental providers in a defined geographic location.

Healthcare Research and Quality, outcome measures reflect the impact of the health care service or intervention on the health status of patients, while process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health condition (23). However, FQHC dental programs could leverage the health information technology capabilities of their medical departments to become innovators in measuring the impact

of oral health on overall health. Effective FQHC value-based oral health models co-locate medical and dental services for improved patient access (24,25). Coupled with technology infrastructure and higher utilization of electronic health record management, FQHCs are positioned to change from an encounter-based system toward increased community-based oral health care delivery within a patient-centered medical home.



**Figure. 7:** Most Common Responses to “What quality metrics do you regularly track in dental?” DentaQuest Partnership for Oral Health Advancement Survey, Jun-July 2018

# Impact of the COVID-19 Pandemic on FQHCs

Despite the flexibility facilitated by the FQHC model, health centers have reported significant operational and financial struggles during the COVID-19 pandemic. Over 1,900 health center sites were forced to close temporarily during COVID-19 as visits decreased by over 50% (27). The challenges of the pandemic to the FQHC model proved to be multifactorial, with each having unique implications on operations and the health center business model.

## Financial Impact of COVID-19 Outbreak

While FQHCs have experienced surges in COVID-19-related visits, declines in primary care and preventive treatment have resulted in 34 million fewer visits per week (28). Revenue has declined by a collective \$34B and more than 100,000 jobs have been furloughed. The significant reduction in revenue for FQHCs has created financial uncertainty despite the necessity of these clinical sites, particularly in rural areas where workforce needs are abundant.

Although Congress allocated specific COVID relief funding for health centers through various stimulus packages totaling over \$1.42 billion, health center advocates across the country are concerned it will not be enough to sustain these programs long-term (29). In the second phase of the CARES Act, approved in April 2020, an additional \$225 million has been carved out for rural health centers (RHCs) and rural hospitals to support financial relief efforts (30). Despite these supplements, at least 5 rural hospitals have closed in the past several months due to the coronavirus outbreak, with an additional 25% identified as at high risk for closure (31).

In March 2020, the Surgeon General advised that all non-essential and elective health procedures be postponed in preparation for the COVID-19 infection surge (32). In response, the American Dental Association clarified essential procedures for dental clinicians, including care for life-threatening issues and conditions that require immediate attention due to pain or infection (33). During March, April and May of 2020, more than 65% of private dental practices reported only seeing emergency patients, with an additional 26% reporting that they were closed completely (34).

## Safety Concerns with Dental Procedures

FQHCs have been on the forefront of absorbing a surge in patients, many of whom are low-income with comorbidities, needing testing or treatment for COVID-19. Many health centers are reporting severe shortages of PPE, creating high risk of infection for health providers (27). To date, nearly 2,000 health center workers have tested positive for COVID-19. Dentistry is classified as one of the most susceptible occupations to virulent airborne infections like COVID-19 (35). This places additional importance on protective methods, include identification of infected persons, immunization and engineering of the dental environment to further reduce the potential of transmission. Throughout the pandemic, health centers have experienced significant issues with securing enough PPE. At one point, 25% reported they may run out of within the week (27).

Dental programs have relied on the CDC's Standard Precautions and OSHA's Universal Precautions that urge providers to consider all patients to be potentially infectious given there are no current means of knowing infection status. Such methods of prevention have worked well in the past as FQHC dental programs adjusted to outbreaks like HIV and bloodborne contaminants. The pandemic outbreak of COVID-19 and the uncertain nature of this highly contagious disease places additional stress on dental clinics to assure a safe environment for patients, practitioners and staff. The lack of rapid testing, antibody detection and vaccines are significant barriers for dental clinics seeking normalization of dental care.

## Transition in Care Delivery

As of April 2020, many FQHCs shifted care to support a telehealth model with more than half of reported patient visits occurring virtually (27). Using telehealth capabilities when appropriate and available can triage patient needs avoiding unnecessary visits to the health center. Teledentistry models can help dental clinicians identify urgent cases and provide prophylactic care to reduce the burden of non-essential visits while preserving needed personal protective equipment (PPE). In response to developing care models, the Federal Communications Commission has released \$200 million in

funding to be allocated to telehealth infrastructure support as part of the Coronavirus Aid Relief and Economic Security (CARES) Act (37). As an additional measure, the Health

Resources and Services Administration (HRSA) allocated \$1.3 billion directly to health centers to support ongoing diagnosis and treatment efforts in light of COVID-19 (38).

# Critical Outstanding Question #1: Should FQHCs Move Toward Value-Based Payments and Care during a Pandemic?

## Financial Benefits of Value-Based Payment Systems

As noted, the COVID-19 pandemic's impact on dental practices, including FQHCs, has displaced productivity and cash flow. The addition of large, likely unbudgeted expenses to update and enhance practice environments for increased safety magnifies challenges for the revenue cycle. FQHCs would benefit from improved financial diversification that includes a secure, flexible system capable of adjusting to decreased productivity by providing a margin of capital for upgrades. Such would be the advantage of a value-based prospective payment design.

Recognition of the benefits of a value-based payment design during this period of disruption and demand to the healthcare system is growing. A member study by the Primary Care Collaborative shows that practices paid within a prospective payment design were faring better in the rate of patient visits during April 2020, given the ability for the practice to adapt to nontraditional care modalities without an accompanying reduction in revenue (43).

FQHCs can leverage the extension of teledentistry coverage and reimbursement by payers to offer nontraditional appointment times to patients during evening and weekends. Such a scheduling approach can add control to the timing and deployment of staff resources while adding convenience for the patient. Teledentistry as administrative controls identified by OSHA can also be used in-office to limit the need or frequency of direct contact between patients and providers (44).

## Minimally Invasive Care is Safer for Practitioners and Patients

Among the recommendations emerging during the pandemic by government agencies like the CDC and OSHA, limiting or the elimination of aerosols in dental care is the best method for reducing COVID-19 transmission within the dental practice. Methods exist within dental care that can assure optimal patient treatment that produce minimal aerosols, but the traditional payment systems reward more invasive procedures.

Our results indicated that FQHCs are more likely than private practice counterparts to utilize a risk assessment with dental patients. Risk stratification of the patient panel, or a practitioner's patient base, informs appropriate care pathways for the individual patient, which may include reduced periodicity for lower risk patients and more frequent, focused visits for the higher risk. The variability in individualized patient management based on risk lowers the cookie cutter approach to services and potentially lowers demand on resources and time. Less invasive procedures lower costs in supplies and time expenditures.

## 77% of dental care provided by FQHCs is preventive and diagnostic in nature.

Our findings note that 77% of dental care provided by FQHCs is preventive and diagnostic in nature. FQHCs transitioning toward OHVBC can realize an opportunity to continue focusing on enhanced preventive services and minimally invasive care that is utilized only when needed. Value-based payment (VBP) doesn't reward a particular procedure, but rather rewards treatment outcomes and trackable patient care improvements. Under such a payment system, FQHCs are provided the flexibility to change treatment methods and assure safe environments.

# Critical Outstanding Question #2: How Can FQHCs Adapt Toward Valued Oral Health Care Delivery as a Result of COVID-19?

## Continue Workforce Integration to Ensure Access to Care

FQHCs are positioned to react rapidly to the continually evolving population needs in response to COVID-19. As of May 2020, 90% of health centers can test for COVID-19 with 67% offering drive-through or walk-up testing capabilities (27). The co-located, team-based comprehensive model of care has allowed for greater responsiveness and flexibility with staffing, particularly with dental clinicians. Once the Surgeon General advised all non-essential and elective health procedures be postponed, dental staff were able to pivot to perform triaging, testing, assisting in welfare calls, providing pharmacy support and aiding in contact tracing (39, 40). FQHCs also have the ability to request changes in scope of service to create temporary locations for serving patient needs in response to the COVID-19 emergency (41). These low-cost access points have become more critical as unemployment rates increase in conjunction with increased infection rates.

## Expand Use of Telehealth for Chronic Disease Management in Oral Health

Early on in the pandemic, more than half of the visits taking place in health centers were occurring virtually (27). While medical providers in FQHCs have been able to utilize telehealth for prevention and chronic care management in order to maintain touchpoints with their patients, oral health providers have been limited to utilizing teledentistry to triage dental emergencies. It isn't uncommon for vulnerable populations to seek treatment for dental pain in an emergency room setting, which is costly and ineffective (41). The ability to provide access to a dental provider via telehealth emerging as a result of the pandemic may be worth maintaining long

term. FQHCs are equipped with tools to reduce the number of patients seeking care within emergency departments for dental-related issues. Additionally, oral health providers in FQHCs have an opportunity to learn from their medical counterparts by utilizing telehealth for chronic disease management and e-follow ups. In many states there is no reimbursement mechanism in place that allows dental providers to perform a risk-based oral health assessment, oral hygiene instruction and nutrition counseling via a telehealth platform to help ensure maintenance of good oral health until they are able to have their next preventive dental visit. Some FQHC dental providers have reported providing oral health education to their patients telephonically during the pandemic regardless of reimbursement. The effectiveness of this patient education model will need to be evaluated through patient satisfaction and engagement surveys, decreased caries risk status and other health-oriented measures.

## Continue Emphasis on Prevention and Minimally Invasive Oral Health Care

In addition to broader use of teledentistry, another way oral health care delivery may transform as a result of the pandemic is an increased emphasis on non-aerosolized procedures to treat and prevent dental disease in order to mitigate exposure risk for both dental patients and staff. As discussed earlier, FQHCs already demonstrate a focus on prevention. The public health environment, including FQHCs, has led the way in employing minimally invasive treatment options such as silver diamine fluoride, but reimbursement varies by state posing a challenge for some practices (43). Broader acceptance and increased comfortability of these materials by payers and providers will be needed in order to ensure dental providers are able to sustain the use of such approaches.

# Conclusions

FQHCs provide integrated, comprehensive and person-centered care that emphasizes preventive and community-based approaches. As state Medicaid agencies and the Medicare program and benefit administrators explore value-based payment, FQHCs are well-positioned to lead in value-based transformations.

## The four major conclusions from this paper are:

- **FQHC dental programs are actively prioritizing oral health prevention.** FQHCs are in a good position to implement value-based tools for prevention, like caries risk assessments, and are providing more preventive dental procedures.
- **FQHC dental programs improve overall health.** Adults receiving oral health services at FQHCs are more likely to have better diabetic health status. FQHCs have a more robust, interprofessional referral network with the ability to link patients more effectively to follow up care.
- **FQHCs have the technology to support holistic health care.** Health information technology (HIT) infrastructure within FQHCs is more likely to support interoperability between medical and dental records. Furthermore, increased use of telehealth technology positions FQHCs to coordinate care across health disciplines and curtail unnecessary visits to providers, reducing wasteful spending. While few value-based metrics are currently tracked by the UDS, FQHCs have the necessary HIT support to expand indicators that reinforce positive health outcomes.
- **FQHCs are positioned well to respond to the COVID-19 outbreak.** Co-located care, cross-training, and flexible workforce models have kept health centers responsive to the testing and treatment needs associated with COVID-19. While FQHCs are currently experiencing financial hardships, this paper argues that value-based payment models may improve the financial viability and long-term sustainability of health centers. FQHCs have an existing focus on prevention and minimally invasive treatment that produces fewer aerosols. This focus will provide better financial diversification in operations as well as create a safer environment for the patient.

# Recommendations and Call to Action

1. FQHCs should explore value-based payment models for oral health and leverage the use of integrated care to improve outcomes and reduce costs.
2. FQHCs should expand the use of value-based treatment tools, like caries risk assessments, to support public health best practices.
3. States should consider allowing teledentistry beyond COVID-19 so FQHCs and other oral health providers can explore its effectiveness in improving patient engagement, reducing emergency department visits for dental-related conditions and fostering chronic disease management for oral health.
4. Data collected through the Uniform Data System should expand oral health measurement and advance outcome metrics similar to other health conditions (e.g., diabetes).
5. Dental programs should study and replicate the integrated, person-centered care model fostered in FQHC environments.

**For FQHC dental programs,**  
the following will be crucial to ensure success within  
a value-based care environment:



**Focusing on prevention,  
chronic disease management  
and risk-based care**



**Patient engagement and case man-  
agement to prevent episodic care and  
ensure treatment plans are completed**



**Effective use of the oral health  
workforce to institute primary  
and secondary oral health care**



**A community and policy environ-  
ment that aligns with a proficient  
and efficient care structure to drive**



**Measurement of oral health outcomes  
and the impact oral health services  
have on overall health**



**Interprofessional practice and HIT  
interoperability**

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