INTRODUCTION

Changes in the healthcare marketplace in the past decade have encouraged payment innovation within state level Medicaid insurance marketplaces to achieve the aim of improving quality while controlling costs. In addition to expansion of the influence of managed, accountable, or coordinated care organizations, broad-level innovations in healthcare payment and individual enhanced benefits, such as a dental benefit, have also provided opportunity for innovation through various methods. Health centers and other safety net dental providers operate and strive to remain solvent and even thrive in this changing fiscal environment.

The National Network for Oral Health Access (NNOHA) aims to provide a glimpse of how health center dental programs are adapting to state-level innovation in payment systems. NNOHA interviewed providers and administrators from health center dental programs, Primary Care Association staff, and dental payer representatives from three states regarding the nature of dental payment innovation in their respective states. The interviews specifically sought to identify how health center dental programs are adapting clinical care systems to provide care most effectively under different payment innovation incentives and protocols that have been implemented in the three states.

As dental care reimbursement follows the trends of healthcare overall towards value-based reimbursement, lessons from pioneers in dental payment innovation will inform effective health center strategies that will both strengthen the dental safety network and improve the oral health of the communities they serve.
California has implemented a five-year (2016-2020) Medicaid waiver program that includes an oral health component, the Dental Transformation Initiative (DTI). The DTI is composed of four Domains focused on: 1) increasing preventive services to children age 1-20 years, 2) implementing Caries Risk Assessment for the diagnosis and management of early childhood caries in children aged 6 years and under, 3) achieving continuity of care within a dental home for children ages 20 years and under, and 4) 15 local pilot programs that integrate components of the first three Domains in addition to other innovation such as care coordination, educational partnerships, or tele-health programs. While registered Medicaid providers are eligible for Domain 1 incentives across the state, the latter Domains are county-specific. The goal of Domain 1 is to increase the statewide utilization of preventive services by at least ten percentage points over the five years. Incentive payments will be paid twice a year to dental office locations that meet or exceed a predetermined percentage increase in preventive services to additional Medi-Cal beneficiaries. A state-managed website contains educational information and registration for the implementation of the DTI.

http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx

Implementation:

Providers are required to complete training webinars depending on the Domain in which they are eligible to participate, for example reviewing caries risk assessment protocols in order to receive Domain 2 incentives. Providers who are registered as Medicaid providers are provided with technical assistance, including ensuring proper tracking of eligible incentive metrics. For health centers, this has meant creating a separate portal for filing CDT (Current Dental Terminology) billing codes to Denti-Cal (California’s Medicaid programs are named Medi-Cal and Denti-Cal) to track incentive metrics in addition to submitting diagnostic codes to Medi-Cal for encounter-rate reimbursement.

Clinical Practice Implications:

The DTI provides incentives for registered providers to prioritize preventive care for
children, as well as caries risk assessment as continuity of care in Domains 2 and 3. Some health centers have historically served a greater proportion of children, particularly during times when optional adult Medicaid benefits were not offered. Current adult Medicaid dental coverage has challenged the capacity of health centers to treat the comprehensive and extensive needs of adult dental patients while also reaching the child beneficiaries of their community to work towards reaching DTI metric targets. Some health centers that have not historically treated a large proportion of children are collaborating with medical clinics within their health center network or community for more robust referral systems. Many health centers view coordination and community outreach as crucial to maximizing the intent of the DTI. Some health center providers raise concerns about the additional visit time required to administer caries risk assessments and the additional administrative time required to file CDT codes using a second service reporting mechanism to track incentive metrics that may still result in net negative productivity even with incentive funding. Several health centers who already provide large proportions of their beneficiaries with preventive services or care for a stable, non-transient populations do not expect to reach the level of improvement that the state has established as a benchmark to qualify for an incentive because they are already within robust levels.

After 18 months (January 2016-July 2017) California health centers are in various stages of implementation of the various DTI Domains. For example, in Domain 1, some health centers have received their first incentive checks for increases in utilization achieved during 2016, while others are still developing the systems to track the incentive metrics.

One of Iowa’s Medicaid oral health programs for underinsured adults is called the Dental Wellness Plan (DWP). It offers a tiered earned benefits model consisting of three levels of service coverage: 1) Core Benefits, 2) Enhanced Benefits, and 3) Enhanced Plus Benefits. The three levels range from preventive/diagnostic/urgent
treatment, to comprehensive disease control, to reconstructive services. Members of the DWP may advance through each tier by adhering to a 6-12 month recall visit; for example, after an initial comprehensive oral exam, only Core Benefits services would be covered by insurance until a 6-month periodic oral evaluation qualifies the patient for coverage of Enhanced Benefits services and Enhanced Plus Benefits services after a 6-month periodic oral evaluation, thereafter. Health centers receive a prospective payment system (PPS) encounter rate but also submit CDT claims to track incentive metrics. Each year, benchmarks are set for caries risk assessment and preventive exam rates to determine qualification for incentive bonuses. 

http://www.dwpiowa.com/ddpahi/index.jsp?DView=Home

**Implementation:**

The dental benefits administrator of the Iowa Medicaid oral health program communicates directly through calls, webinars, meetings, and mailings to both providers and members of the DWP to describe the program at its inception and any evolving changes. The DWP has engaged existing outreach coordinators from public health agencies to assist in enrolling members, care coordination into dental homes, and encouraging continuity of care as members move through the tiered plan levels. Recent adjustments to the program protocol have allowed members to pay out of pocket for dental service above the tier of service in which they currently reside.

**Clinical Practice Implications:**

The population that gained coverage through the DWP was not previously eligible for the state Medicaid dental plan and may have accrued a burden of oral needs that would be met primarily in a hospital emergency department or urgent care setting when pain or infection was present. Health center providers theorize that some of the members of the DWP may be utilizing their new dental coverage as urgent care coverage because the highest missed appointment rate is a comprehensive exam appointment, which usually follows an urgent care visit. Health centers have lengthened comprehensive exam appointments to make room for caries risk assessment and explanation of the tiered benefits system. Health center dentists
have had to adjust to the tiered service coverage model; particularly diagnosing caries for stabilization treatment (lesions more than half-way through the dentin to the pulp chamber and/or symptomatic lesions) versus comprehensive care treatment (all other carious lesions, including those less than halfway through the dentine, and periodontal therapy). Frequent fluctuation between the DWP with Medicaid dental or private dental plans has also added complexity to the trajectory of treatment plans depending on service eligibility of each plan. Health center dental directors observed that transient populations in urban areas were less likely to advance to the top tier of services than their rural community counterparts.

Since July 2017, the DWP has collapsed the tiered earned benefits structure so that beneficiaries have access to full benefits if they accomplish healthy behaviors in the first year of enrollment, including an oral health self-assessment and utilization of a preventive service. If these healthy behaviors are not accomplished, the beneficiary accrues a monthly premium to access full benefits; if beneficiaries do not pay the monthly premium, only emergency dental services will be covered by their plan. This revision to the DWP retains an element of shared provider-patient responsibility in the payment structure but has simplified the incentive structure.

Individuals who receive healthcare coverage under the Medicaid program in Oregon are assigned to a Coordinated Care Organization (CCO), which is a network of healthcare providers who are responsible for providing comprehensive care to these individuals. Many CCOs offer dental care as part of their benefits package. A global Medicaid payment is granted to each CCO that then decides how to apply the funds to ensure proper healthcare provision to the members of their healthcare plan. One such CCO dental plan assigns all members to a dental home; and also collects data on three metrics including members assigned vs. seen, sealant rates for children ages 6-13 years, and whether plan members received at least three preventive services (prophylaxis, sealant, oral hygiene instructions, dietary counseling, or fluoride varnish treatment). In
addition to encounter-based reimbursement, financial incentives are granted for meeting the described metrics at a given level. County-level baseline measures were used to set benchmarks and improvement targets for each consecutive year [http://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx](http://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx)

**Implementation:**

The CCO dental plan engages the dental directors of each participating provider site through monthly collaborative meetings to inform them about metric progress and changes, as well as to listen for challenges that arise with new benchmarks or protocols. The dental plan also communicates with member clients, sending new members a handbook and welcome packet as well as site-specific information from their assigned dental home. Implementation of this program has introduced a paradigm shift in the way providers understand participation with a dental plan; that is, provider sites must understand what it means to manage an assigned population in a way that actively engages each member of the dental plan within their dental home.

**Clinical Practice Implications:**

Educating health center dental staff and patients regarding the structure and rationale of the dental plan incentives has resulted in a shift towards prioritizing preventive service-provision. Whereas providers had previously performed a comprehensive exam in one visit and rescheduled a patient for other services, they are now more likely to render prophylaxis, fluoride varnish treatment, and sealants as part of a comprehensive exam bundle of services. Some provider sites have utilized incentive funds to hire additional staff for intentional care coordination and community-based outreach to improve dental plan member engagement with their site as a dental home. Health center dental directors have adjusted workflow to track additional metrics and appreciate the internal evaluations these data allow. Providers have come to appreciate the emphasis of the dental plan on proactively caring for a beneficiary community.
These findings from health centers in three states that are early adopters of payment innovation for Medicaid funded dental services may not be generalizable to other states. Nevertheless, there are certain key themes that have emerged and may continue to resonate as more states test and implement payment innovation methodologies for Medicaid funded dental services.

**The influence of payment structures on clinical care:** Health center dental clinics are very cognizant of their responsibility to provide much-needed oral health services to the community in fiscally responsible ways. Often operating on tight budgets, dental payment innovation that incentivizes certain priorities or activities are thus potent motivators for adapted clinical workflow, service-provision, and even sub-population targeting.

**Care coordination as a facilitator:** An emphasis on prevention and continuity of care requires active engagement with members of dental plans outside of the walls of a dental clinic. Outreach coordinators and community health workers suitably fill this niche.

**Paradigm shift to caring for a community, providing value care, and tracking outcomes:** Contributing interviewees from various stakeholder groups, health center dental program providers and administrators, Primary Care Association staff, and dental payer representatives, all agree that buy-in and understanding from dental providers and clinic staff is important to the success of dental payment innovation. Specifically, many suggested a necessary shift from providing a single service to a single patient in the dental clinic operatory to understanding one’s professional and clinical obligation to a community of beneficiaries with an emphasis on prevention, continuity of care, and monitoring for improved outcomes.

**The importance of engaging partners:** Health center programs that were most effectively implementing and reaping the benefits of dental payment innovation benefited from active collaboration and open communication with dental payers and Primary Care Association representatives to receive training and education.
NNOHA would like to thank the following individuals for their contribution to the development of this fact sheet.

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