Dental Payment Innovation: Best Practices of Health Center Dental Clinics in Three States

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Objectives

• Understand the environment driving payer innovation in the public and private health care sectors

• Describe best practices for adapting clinical care in health center dental clinics to provide the most effective care under different payment innovation incentives scenarios
2016 U.S. Spending on Health Care

On average, other wealthy countries spend about half as much per person on health than the U.S. spends

<table>
<thead>
<tr>
<th>Total health expenditures per capita, U.S. dollars, PPP adjusted, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>Switzerland</td>
</tr>
<tr>
<td>Germany</td>
</tr>
<tr>
<td>Netherlands</td>
</tr>
<tr>
<td>Austria</td>
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<tr>
<td>Comparable Country Average</td>
</tr>
<tr>
<td>Belgium</td>
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<tr>
<td>Canada</td>
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<tr>
<td>Australia</td>
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<tr>
<td>France</td>
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<tr>
<td>Japan</td>
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<tr>
<td>United Kingdom</td>
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</tbody>
</table>

The US value was obtained from the 2016 National Health Expenditure data

Health Care % of GDP

National Health Expenditures as a Share of Gross Domestic Product, 1987-2016

The share of GDP devoted to health was 17.9% in 2016

2010 Accountable Care Organizations

• A group of health care providers, who voluntarily come together to provide coordinated high-quality care to populations of patients
• 923 ACOs in 2017
• Commercial, Medicare and/or Medicaid ACO contracts [Link](https://www.healthaffairs.org/do/10.1377/hblog20170628.060719/full/)
• There are all-FQHC Medicaid ACOs
Dental Expenditures Increase - ADA HPI

Figure 2: National Dental Expenditures per Capita (in constant 2015 dollars)

Dental Expenditures: ADA HPI

Figure 5: Distribution of Dental Expenditures by Source of Financing

Source: Centers for Medicare and Medicaid Services. Note: CMS includes Medicare, Medicaid and CHIP.
National Landscape: CMS Medicaid 1115 Waivers

- State flexibility to design Medicaid program
- Demonstrate and evaluate state-specific policy approaches
- 36 states have waivers

https://www.medicaid.gov/medicaid/section-1115-demo/index.html
Figure 1

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, March 5, 2018

Notes: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. "MLTSS" = Managed long-term services and supports.
2017-18 State Medicaid Initiatives

<table>
<thead>
<tr>
<th>Strategy</th>
<th># of States</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment incentives or value-based purchasing arrangements</td>
<td>8</td>
<td>CA, DC, MN, OH, OR, TX, WA, WI</td>
</tr>
<tr>
<td>Reimbursement rate increases (sometimes targeted)</td>
<td>5</td>
<td>CA, MN, OR, PA, WI</td>
</tr>
<tr>
<td>New or planned contracts with Dental Benefit Managers (DBMs)</td>
<td>4</td>
<td>AR, FL, NE, NV</td>
</tr>
<tr>
<td>Dental performance measures or Performance Improvement Projects (PIPs)</td>
<td>4</td>
<td>FL, MI, MO, OR</td>
</tr>
<tr>
<td>within managed care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer outreach/education campaigns</td>
<td>2</td>
<td>FL, MN</td>
</tr>
</tbody>
</table>

Medicaid ACOs

- States with active Medicaid ACO programs
- States pursuing/exploring Medicaid ACO programs
Dental in Medicaid ACOs

• 25% of state Medicaid ACOs cover dental care
The National Safety Net Advancement Center (SNAC) aims to transform the ability of U.S. safety net organizations to respond to payment and care delivery reform efforts in health care's fast evolving financial and delivery environment. SNAC is supported by the Robert Wood Johnson Foundation. This will be accomplished by leveraging new and existing knowledge into actionable tools for safety net organizations.
Resources

• Payment Reform for Federally Qualified Health Centers-PPP
  http://safetynet.asu.edu/resources/payment-reform-for-fqhcs/

• Dental Care in Accountable Care Organizations: Insights from 5 Case Studies
  https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0615_1.pdf?la=en

• ADA-HPI Early Insights on Dental Care Services in Accountable Care Organizations
  http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_1.ashx
Dental Payment Innovation: Best Practices of Health Center Dental Clinics in Three States

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Monday, July 16, 2018
Learning Objectives

1. Describe dental payment innovation structures in 3 states
2. Discuss the impact of each payment innovation on clinical dental practice in safety net settings
3. Discuss best practices in adapting health center dental clinic operations in response to dental payment innovation
Background

- Medicaid expansion
- Managed/Accountable/Coordinated Care Organizations
- Value/Outcome-based reimbursement
Approach

- 30 Interviews across 3 states
  - Iowa
  - Oregon
  - California

- Inquiry on best practices
  - Knowledge of payment innovation
  - Adapting clinical care to payment innovation
  - Reflecting on implications of payment innovation on clinical practice
Framework for Responses

- Dental Payment Innovation Structure
  - Describing framework of management/incentives
- Implementation
  - Learning about the change, workflow changes, education of staff/patients, TA from payer/PCA
- Implications for Clinical Practice
  - Shifts in focus/priority (population, workflow), outcomes measures, impact on population health and paradigm of care delivery
Dental Transformation Initiative (DTI), a California’s dental Medicaid Expansion

- Domain 1: statewide increase in proportion of children ages 1-20 enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period
- Domain 2: county-specific (11) increase in diagnosis of early childhood caries using Caries Risk Assessments to treat it as a chronic disease and introduce a model that prevents and mitigates oral disease
- Domain 3: county-specific (17) increase in continuity of care for beneficiaries under age 20
- Domain 4: county-specific (15) pilot program grantees that use one or more of the 3 domains to implement an alternative strategy focused on rural areas (case management, educational partnerships, tele-dentistry)
Implementation

- Webinars on website for CRA, sealants review, program essentials
- Must register to as a provider to participate in incentive program
- New coding system for tracking eligible codes
  - Diagnostic codes to MediCal for encounter rate and CDT codes to DentiCal for incentive claims
Implications for Clinical Practice

- DTI emphasizes care to children
  - Some HCs already prioritize children (but may not bill through school-based programs)
  - Others don’t have ready access to eligible children (reaching out to medical sites in HC networks)
- Pent-up adult DentiCal need is stretching capacity in many HCs
- Care coordination is needed/helpful (community health workers or in-clinic staff)
- Redundant or novel EHR protocols (CRA and filing claims may still be net negative productivity)
- Baseline to benchmark improvement not possible (providing preventive care to a population that is not transient)
Iowa

- Dental Wellness Plan, Iowa’s dental Medicaid Expansion
  - Administered by Delta Dental
  - Tiered “Earned” benefits model
  - Prospective Payment System (encounter rate) reimbursement for FQHCs with FFS claims to track incentive metrics
  - Incentive (benchmark %)
    - 2014: CRA (25%+)
    - 2015: CRA, preventive exam (50%+)
    - 2016: CRA, preventive exam (70%+)
    - 2017: 80% may be the plateau
- **Implementation**
  - Calls/meetings/mailings with providers and members
  - Engaging outreach coordinators from public health agencies (I-Smile, VNS, in-office)
  - Member pay change (being able to pay out of pocket for service not covered by tier)
**Implications for Clinical Practice**

- Highest no-show is comprehensive care appointment (catastrophic coverage)
- Longer comprehensive care appointment (CRA and patient education)
- Stabilization vs comprehensive disease treatment (quadrant dentistry x2)
- Fluctuation between Medicaid, FFS/private, and DWP coverage
- Population transiency affects tier advancement ability (Marshalltown vs. Des Moines)
CareOregon, a Coordinated Care Organization dental plan

- CareOR receives a global budget from the CCO
- CareOR contracts with dental offices (mainly FQHCs) to assign their members to dental homes
- Per member per month rate is paid to dental providers along with encounter rates
- Incentive metrics (can receive bonus for each metric that is reached and thus prioritize)
  - Sealants for children ages 6-13
  - Assigned vs. seen
  - Prevention bundle (prophy, OHI, dietary counseling, fluoride)
- Implementation
  - Monthly collaborative meetings with dental directors of participation sites
  - New member handbook/welcome packet
  - State-wide measures used to set incentive metrics
Implications for Clinical Practice

- Bundling comprehensive exam (to include preventive services, especially sealants)
- Hiring care coordinators with incentive funding
- Internal metric-tracking improved
- Paradigm shift from FFS between provider and patient to value/outcomes in community
Overarching Themes and Best Practices

- Influence of payment structures on clinical care
  - “We prioritize what we are paid to do”
- Care coordination as a facilitator
- Paradigm shift to caring for an assigned population
- Emphasis on preventive services
- Value-based care and tracking outcomes
- Proactivity versus reactivity
- Importance of engaging partners
Conclusions

- Dental Payment Innovation has direct impacts on clinical workflow, care coordination, and assessment protocols.

- 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.
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
Thank you!

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NOVEMBER 11-14, 2018
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