



Center for Medicaid & State Operations, Family & Children's Health Programs Group

March 24, 2008

Dear Quality Improvement Colleagues,

The Division of Quality, Evaluations and Health Outcomes (DQEHO) is excited to announce the next in our series of Medicaid and SCHIP Quality Teleconferences. Our Spring audio-conference is scheduled for April 3, 2008 from 1:30 PM – 3:00 PM Eastern Daylight Time and we invite you to attend. The call-in number will be **1-888-677-5723** and the password is **68110**. You must register to participate as described below.

The audio-conference will provide valuable information on pediatric **oral health** including **innovative State practices to improve provider participation, access and quality improvement performance measures**.

We will start with an update on the State Dental Reviews that are currently being performed throughout the country by CMS and briefly discuss the CMS 416. We will be joined by representatives from several State dental programs who will present their experiences in providing dental services through the Medicaid and SCHIP programs in their States.

We look forward to your participation in this comprehensive program. The formal agenda and handouts will be email to you in the week prior to the teleconference. If you plan to participate, you must RSVP to the DQEHO mailbox at MedicaidQuality@cms.hhs.gov so that you line will be recognized by the operator when you call in. Please include your name, telephone number and email address in the registration response. We will email you handouts several days before the conference.

Sincerely,

/s/

Jean Moody-Williams, RN, MPP
Director Division of Quality, Evaluation and
Health Outcomes

Agenda for National Quality Call
Pediatric Oral Health
April 3, 2008
1:30 pm – 3:00 pm (EDT)

General Updates – Jean Moody-Williams

Statement of Issues (background) - Dr. Conan Davis

Review Findings (general) – Cindy Ruff

416 Discussion – Cindy Ruff

Questions

Topics:

- Innovative Payment Practices
- States Approaches to Increasing Provider Participation & Access to Dental Services
- States Approaches to Dental Performance Quality Improvement Measures

Speakers:

- Jean Moody-Williams, RN, MPP, CMS Director, Division of Quality, Evaluation & Health Outcomes
- Dr. Conan Davis, DMD, MPH, CMS Chief Dental Officer
- Cindy Ruff, CMS EPSDT Coordinator
- Dr. Mark W. Casey, DDS, Dental Director, NC
- Dr. Jim Gillcrist, Medicaid Dental Director, TN
- Christine M. Farrell, MPA, RDH, BSDH, Medicaid & SCHIP, Program Specialist, MI
- Dr. Robert Isman, DDS, MPH, Medicaid, Dental Program Consultant, CA

Questions and Wrap-up

North Carolina Medicaid “Into the Mouth of Babes” Physician Fluoride Varnish Program

State Medicaid Directors
National Quality Call
Pediatric Oral Health
April 3, 2008

Problem: Access to Care for Preschool Medicaid Recipients

- Up to 60% of low-income children enter kindergarten in North Carolina having experienced tooth decay, unfortunately, much of this is untreated decay
 - Early childhood caries (ECC) widely prevalent in disadvantaged children
 - Profound social and economic effects for children and their families
- Preschoolers have significant barriers that prevent them from accessing dental care
 - Behavior management concerns
 - Lack of general dentists trained to treat infants/toddlers
 - Shortage of pediatric dentists in NC
- Low income children (Medicaid) have more difficulty accessing care than other groups

Solution: Policy Initiative

- **Goals of the IMB**
 - Increase access to preventive dental care for low income children 0-3 years of age
 - Reduce the incidence of ECC in low-income children
 - Reduce the burden of treatment needs on a delivery system stretched beyond its capacity to serve young children

Design of IMB

- Utilize more robust NC primary care medical provider (PCP) network to deliver important preventive oral health services to young Medicaid recipients
- Design program services to be administered with successful NC EPSDT/Health Check well child visit program
 - IMB services easily integrated into PCP practice
- To qualify for participation, providers receive enhanced CME training
 - Taught infant/toddler oral exam procedure, caries risk assessment, preventive counseling with the parent/caregiver, application of topical fluoride varnish
 - More than 3000 physicians, PAs, nurse practitioners, nurses, etc. have been trained since statewide inception of the program in 2001; approximately 450 public and private billing providers
 - Training initially provided by NC Academy of Family Physicians and NC Pediatric Society; currently provided by the Division of Public Health – Oral Health Section

Origins of IMB

- Pilot project started in Western NC Appalachian counties in 1998
 - Core group of PCPs and Early Head Start personnel noted significant problems with ECC in their region of the state
- Application to DHHS for statewide implementation developed in 2000 in response to requests “to identify methods of innovative management of oral conditions among young children enrolled in Medicaid and SCHIP that result in oral health improvements and dental care cost savings”
- Funding
 - Partial funding for the development of the initiative by the Appalachian Regional Commission
 - Continued Federal funding first from CMS with later support from HRSA and CDC
 - Funding provided for staff to develop the training curriculum, conduct training, oversee the program and generate the research conducted to support the program

IMB Visit

- Who's eligible for the service? Recipients age 6 months to 3½ years
- Who provides services? PCPs and extenders who have completed the CME training can provide IMB services
- How often can the treatment be done? Every 60 days with a maximum of six (6) IMB visits before age 3½
 - Allows flexibility to provide service at well child visit (WCV), typically every 90 days in first few years of life
 - Allow additional flexibility to provide IMB services at sick child visits and less than every 90 days to play catch-up with many high risk children who have missed WCV visits
 - Extend “grace period” to age 3½ to allow providers to perform IMB services at the 3 year WCV

IMB Visit

- What is an IMB Visit?
 - D0145 -- periodic oral evaluation of a patient under three years of age and counseling with the primary caregiver (Reimbursement = \$38.07)
 - Early caries screening and detection & report of other notable findings like obvious pathology of hard and soft tissues
 - Preventive oral health and dietary counseling with the primary caregiver including development of an age appropriate preventive oral health regimen
 - Prescription of a fluoride supplement if indicated, per the guidelines of the AAP
 - Referral to a dentist, if appropriate

IMB Visit

- What is an IMB Visit (cont'd)?
 - D1206 – topical fluoride varnish; therapeutic application for moderate to high caries risk patients (Reimbursement = \$15.44)
 - Many studies demonstrate that FV is the safest and most effective form of topical fluoride for this age group
 - One important study demonstrated that FV has a dose:response relationship – subjects receiving 3 or 4 FV treatments over a two year period showed a statistically significant decrease in caries in comparison to subjects who received 2 or less FV treatments over the same time frame
- PCPs' offices file claims on the CMS-1500 using CDT codes listed above (D0145 and D1206)
 - Both codes must be reported together on the same claim form to receive reimbursement for both procedures

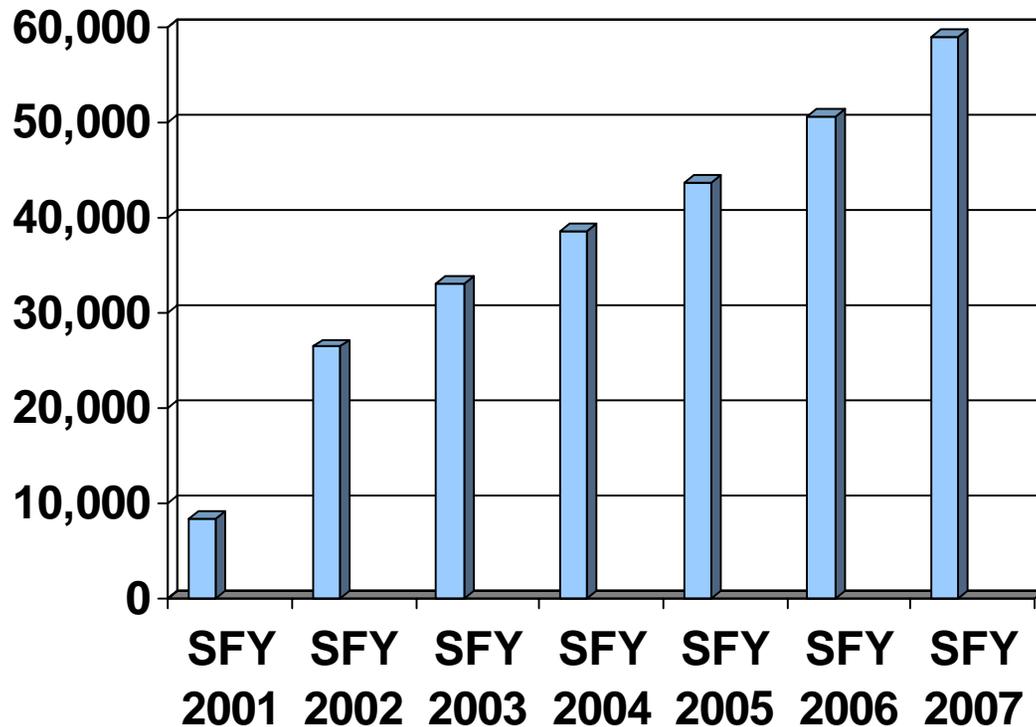
IMB Research Findings

- Increase in access to preventive dental services for infants and toddlers of 30-fold
- By four years of age, children who had received at least four IMB services demonstrated a statistically significant cumulative reduction in the number of restorative treatments needed for anterior teeth of 39%.
- IMB has led to an increase in access to restorative treatment services in the dental office through the effect of referral of children with existing disease at the time of the IMB visit to the dental care system

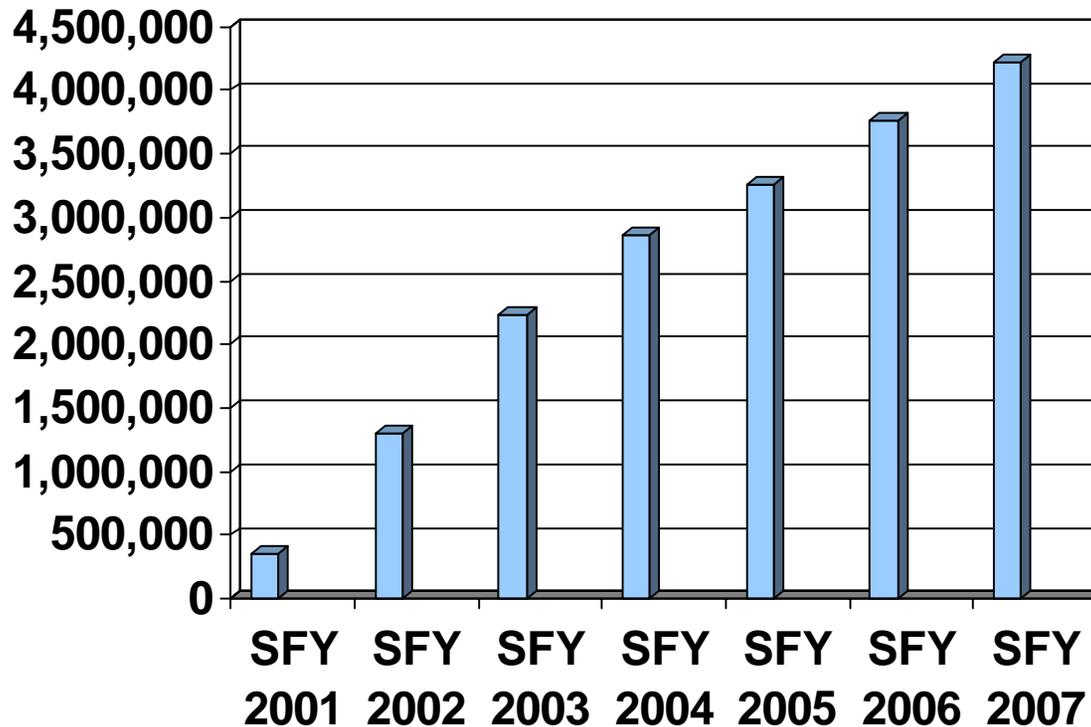
Research Findings

- No reduction in visits to dentists for preventive care for the 0-3 age group; in fact, quite the opposite -- preventive care in the dental office for infants and toddlers under age 3 has increased substantially along with the growth of the IMB
 - No displacement of preventive care from dental offices, rather supplementation – implication is that service is reaching recipients who truly face barriers to seeking care in dental offices

Number of Unduplicated Recipients Ages 0-3 Receiving IMB Services



IMB Services Expenditures



Stainless Steel Crown/Pulpotomy Policy Limitations

- Why?
 - Encourage appropriate utilization patterns that meet established standards of care for in office treatment of pediatric patients
 - Protect welfare and safety of pediatric recipients needing multiple SSCs and pulpotomies
 - Many receive the care in an office setting under local anesthesia (LA) without sedation
 - Distinct possibility that many young children will receive either too little LA (excessive pain) or too much LA (possible toxicity) during lengthy office appointments
 - Many young, uncooperative patients with significant treatment needs are restrained while undergoing lengthy procedures

SSC Policy Limit (Effective 10-1-04)

- NC Medicaid will pay for a maximum of six (6) crowns per recipient for a single date of service.
- This limitation applies to procedure codes D2390, D2930, D2931, D2932, D2933, D2934, and D2970 (SSC codes) or to any combination of these codes delivered on the same date of service.
- This limitation **does not** apply to recipients treated under general anesthesia in a hospital or ambulatory surgery center.
- If a provider believes that medical necessity warrants delivery of more than six (6) crowns for a recipient on a single date of service, the provider must submit a prior approval request along with a letter describing the special circumstances of the case.

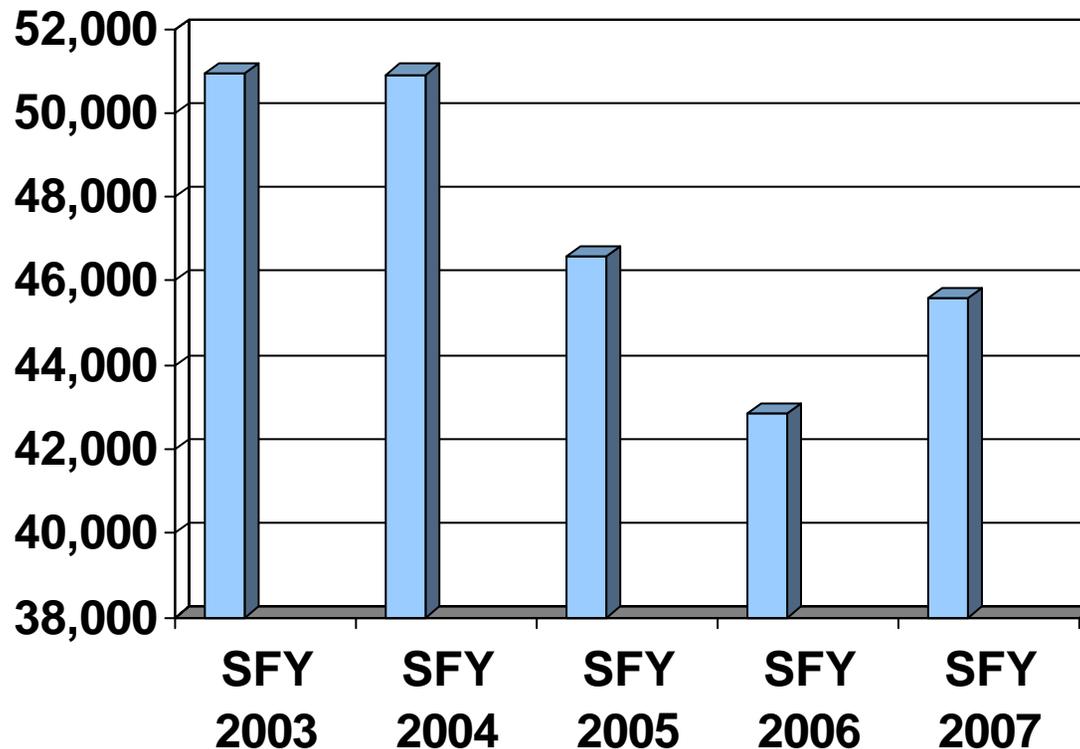
Pulpotomy Policy Limit (Effective 10-1-04)

- NC Medicaid will pay for a maximum of six (6) pulpotomies per recipient for a single date of service.
- This limitation applies to procedure code D3220 – therapeutic pulpotomy.
- This limitation **does not** apply to recipients treated under general anesthesia in a hospital or ambulatory surgical center.
- If a provider believes that medical necessity warrants delivery of more than six (6) pulpotomies for a recipient on a single date of service, the provider must submit a prior approval request along with a letter describing the special circumstances of the case.

D2930 – SSC, Primary Tooth

Number of Units Provided – Office Visits Only

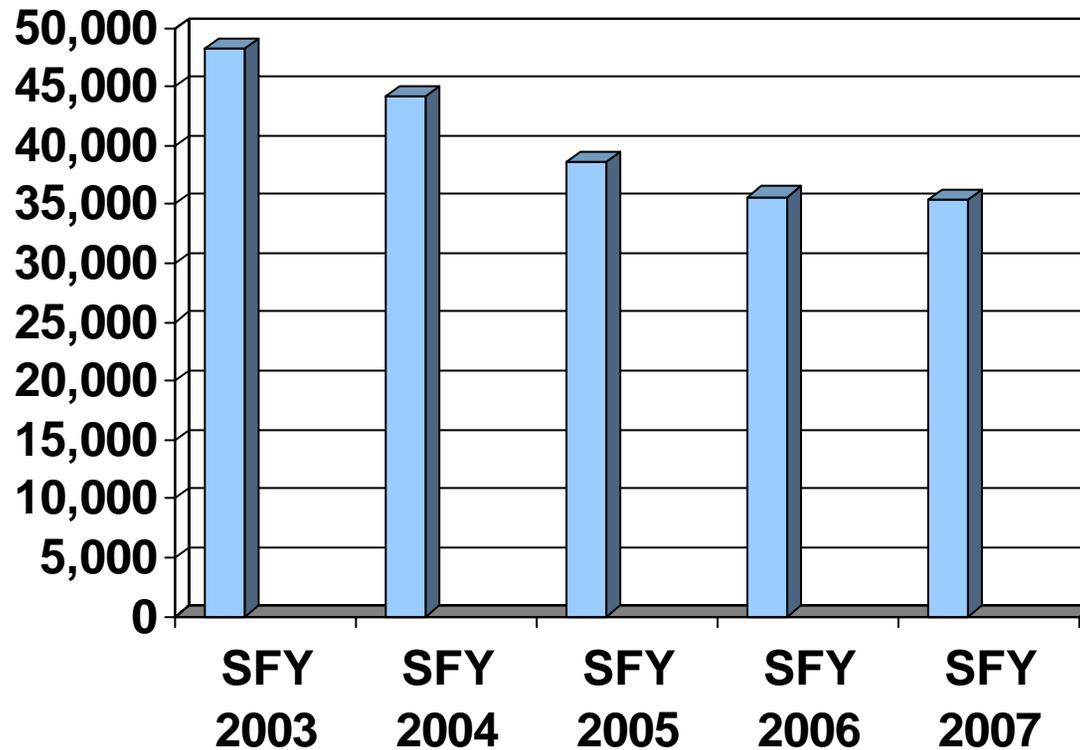
SFY 2003 - 2007



D3220 – Therapeutic Pulpotomy

Number of Units Provided – Office Visits Only

SFY 2003 - 2007



Division of Medical Assistance NC Medicaid Dental Program

www.ncdhhs.gov/dma/dental.htm

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Dental Director

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North Carolina Department of Health and Human Services
Division of Medical Assistance
Dental Program

2501 Mail Service Center • Raleigh, N. C. 27699-2501

Michael F. Easley, Governor
Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director

February 11, 2008

Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Kucinich:

Up to 60 percent of low-income children enter kindergarten in North Carolina having experienced tooth decay. Their oral health and quality of life are further compromised because of extremely difficult challenges in gaining access to dental care. A number of organizations in North Carolina have been involved over the last decade in aggressively and collaboratively trying to help resolve these problems through prevention and treatment programs. Our overall strategy was outlined in a 1999 report to the NC General Assembly by the NC Institute of Medicine [<http://www.nciom.org/projects/dental/dental.html>]. One centerpiece of our strategy is a Medicaid initiative in which children birth to 3 years of age receive preventive dental services in primary care medical offices. The purpose of this letter is to briefly provide the background for this program, its impact on young children and their families and the contributions that Federal funding, including CMS provided to its development.

The Medicaid program, known as Into the Mouths of Babes (IMB), began after a successful demonstration in a few counties in the Appalachian region of the state and pilot studies in an expanded number of medical offices statewide. The program was expanded statewide in 2001. The goals of the IMB program are to: (1) increase access to preventive dental care for low-income children 0 to 3 years of age; (2) reduce the incidence of early childhood caries (ECC) in low-income children; and (3) reduce the burden of treatment needs on a dental care system stretched beyond its capacity to serve young children. Primary care medical providers are reimbursed for screening and risk assessments for oral problems, counseling of parents about oral health and application of fluoride varnish to the teeth of children. Physicians can provide these services in up to six visits before the child is 42 months old. Providers participate in a Continuing Medical Education program, and, to date, more than 3,000 pediatricians, family physicians, nurses and other types of healthcare professionals have been trained. In the third quarter of 2007 alone, the most recent quarter for which information is available, more than 26,000 visits occurred in medical offices in which these oral health services were provided.

Because of its innovation and potentially large impact on the oral health of young children, an extensive evaluation of IMB was undertaken. Some details and current status of the evaluation are provided in the attached Research Brief. To summarize briefly, the program has led to a substantial increase of about 30-fold in access to preventive services for infants and toddlers enrolled in Medicaid. The IMB research team has gathered evidence demonstrating that those children who received preventive services in medical offices need less dental treatment

services than infants and toddlers who have not received IMB services. In addition, IMB has led to an increase in access to treatment services through what we assume to be the effect of referral of children, who already have disease at the time of the physician visit, to the dental care system. Taken together, these findings suggest that the IMB program both prevents early occurrence of dental disease and promotes earlier entry into the dental care system for those in greatest need.

Federal funding played a very important role in the success of the IMB program. Partial funding for the initial developmental work was provided by the Appalachian Regional Commission [ARC Project No. NC-13186-99] for a project entitled "Dental Health Promotion among Preschool Children in North Carolina's Appalachian Region: Smart Smiles Fluoride Varnish Project". The five-year demonstration was initially funded by the Centers for Medicare and Medicaid Services (CMS) and was later supported by funding from the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC) for the project entitled "Development and Evaluation of a Medical Model for Early Childhood Caries" [Grant No. 11-P-91251/4-02]. This application for statewide implementation of the IMB project was developed in response to a request for applications from several agencies in the U.S. Department of Health and Human Services (DHHS) in May 2000. The request (Catalogue of Federal Domestic Assistance Program Number 93.779) sought applications "to identify methods of innovative management of oral conditions among young children enrolled in Medicaid and SCHIP that result in oral health improvements and dental care cost savings." This funding allowed Medicaid and partners in North Carolina to further develop our innovative approach to the prevention of early childhood caries in children enrolled in public insurance programs in North Carolina. In particular, the funding provided for staff to develop the curriculum for training, conduct the training and generally oversee the substantive aspects of the program and generate the science supporting the innovative program.

In our opinion, this one-time funding initiative from CMS and other Federal Agencies provides an excellent model for one strategy that the Federal government could use to stimulate innovative thinking about new approaches for addressing the long-standing problems that children in this country face in gaining reasonable access to dental care. The partners in the IMB collaborative believe that renewal of this funding program, first implemented in 2000 to support innovative demonstration programs, would result in new approaches beyond the medical model developed in North Carolina that would yield oral health benefits to children enrolled in public insurance nationwide.

Please feel free to contact me with additional requests for information that you might have about IMB. I would like to thank you on behalf of all of the partners in the IMB program for bringing well-deserved attention to this important North Carolina dental public health initiative.

Sincerely,

Mark W. Casey, DDS, MPH
Dental Director
NC Division of Medical Assistance

Pediatric Oral Health Conference

Dr. Jim Gillcrist

Handouts provided upon request

james.a.gillcrist@state.tn.us

TennCare's Dental Program

James A. Gillcrist, DDS, MPH
Dental Director, TennCare

Oral Disease versus Medical Disease

- For a condition to be an insurable risk it should be: rare and random, irreversible, with significant financial consequences
- Medical disease is an insurable risk
- Oral disease is not an insurable risk
- Approximately 80% of practicing dentists are general practitioners and the rest are specialists
- Conversely, 80% of physicians are specialists and 20% are generalists
- In dentistry, most care is provided by a single dentist at a single location. In medicine, care is provided by multiple practitioners at different locations.

June 2006 JADA publication by Albert H. Guay, DMD entitled, **“The differences between dental and medical care Implications for dental benefit plan design”**



TENNCARE

Medical managed care model which integrated dental services prior to carve-out

- Dentists frustrated by different administrative requirements associated with multiple MCOs
- Different provider credentialing processes
- Different fee schedules
- Low reimbursement rates
- Different provider pools
- Different enrollee benefit packages offered
- Different provider agreements /contracts
- Different provider manuals
- Different prior-authorization requirements



TENNCARE

Other Problems

- Multiple MCOs with TennCare members enrolled in different plans
- Most dentists contracted with 1 plan only
- Therefore, members did not have access to the entire network of dentists just to those contracted with their individual plan
- Access to dental care affected by medical model



TENNCARE

What is a Carve-Out ?

- A carve-out delivers a single benefit (i.e., dental care) by separating it out from other Medicaid Managed Care services
- Establishes a “dental” budget (dedicated funds allocated)
- Uses a single benefits manager (DBM) to administer dental services.



TENNCARE

"Dental Carve-Out"

- On May 14, 2002, following a competitive bid process, Doral Dental was awarded the original DBM contract with Tennessee.
- Implementation began in the Fall of 2002 following a report of readiness and approval by a EQRO and TennCare.



TENNCARE

Dental Carve Out Achievements

1. Establishment of a TennCare Dental Advisory Committee (TDAC)
2. Support & promotion by organized dentistry
3. Growth of dental provider network
4. Reduction of "Hassle" factor



TENNCARE

Dental Carve Out Achievements

5. Active provider participation
6. Access improvements
7. Utilization improvements
8. Collaboration among key stakeholders
9. Intensive outreach (enrollee & provider)



TENNCARE

TennCare Dental Advisory Committee

- ❖ Comprised of Tennessee dentists, dental specialists and non-dentists
- ❖ Member vs. provider focus
- ❖ Empowered to make recommendations to TennCare
- ❖ Non-binding yet usually adopted



TENNCARE

Promotion of the carve-out by organized dentistry occurred once:

- ❖ A single DBM was awarded the contract,
- ❖ An adequate reimbursement schedule was instituted,
- ❖ TDAC was constituted,
- ❖ ADA contract analysis was completed,
- ❖ Dentists were assured they could participate at a level that accommodated their practice
- ❖ A dentist was hired as the dental program director



TENNCARE

Growth of dental provider network

Between October 1, 2002 and September 30, 2007:

- ❖ Providers statewide grew by 120%
- ❖ Network includes general dentists, and dental specialists



TENNCARE

"Hassle" factor reduction

Streamlined administration by DBM

- One provider credentialing process
- One provider pool
- One provider agreement
- One provider manual
- One maximum allowable fee schedule
- One set of prior authorization requirements
- Electronic claims submission thru DBM



TENNCARE

Post- Dental Carve Out

Dental Participation Ratio/ Utilization Rate

FFY	2002*	2003	2004	2005	2006
DPR	36%	46%	51%	53%	51%

Net 43% increase from 2002-2006

* Year before the carve-out

DPR calculation specific to TN



TENNCARE

Outreach

- ❖ DBM contractual initiatives
- ❖ Dept. of Health contractual initiatives
 - School-Based Dental Preventive Project (SBDPP)
- ❖ Voluntary initiatives with organized dentistry (TDA, Pan-TDA) & Palmolive Colgate
 - “No Child Overlooked”



TENNCARE

DBM Outreach Initiatives

- ❖ Reminder notices
- ❖ Newsletters
- ❖ Collaboration
- ❖ Post Card and Outbound Call Campaign
- ❖ Member Education
- ❖ At - Risk Populations
- ❖ Child Development Centers
- ❖ Prenatal & Coordination
- ❖ Provider Network Expansion
- ❖ Provider Education and Outreach



TENNCARE

Public health dental outreach initiatives

❖ SBDPP

- Using portable equipment, oral disease prevention services are provided to children K-8 in public schools (where $\geq 50\%$ of the children participate in school lunch program)



TENNCARE

Organized dentistry outreach initiatives

“No Child Overlooked”

- Public/private partnership where member dentists volunteer their time to provide free dental screenings for individuals under age 21
- Goal: to increase access to dental services for underserved children



TENNCARE

DBM Utilization Review Process

- Evaluates a provider's treatment practice compared with the norm for peers
- Controls for normal statistical variability/ noise
- Significant deviation from peer norms elicits a thorough analysis and chart review
 - ❖ **Incorporates a professional panel review**
 - ❖ **Requires corrective action intervention by DBM**
 - Behavior Modification
 - Recoupment
 - Termination



TENNCARE

TennCare's Dental Program

- Has a finite budget
- Includes comprehensive dental benefits for over 650,000 enrollees birth through age 20
- Include medically necessary services
- Cosmetic dental services excluded



TENNCARE

TennCare Expenditures for Children 2006

Dental Expenditures as a percentage of all TennCare expenditures for children was 9.3%



TENNCARE

Michigan Medicaid's

***“Healthy Kids Dental”* program**

Christine Farrell, RDH, BSDH, MPA

Medicaid Policy Specialist

Michigan Dept. of Community Health

April 3, 2008

Healthy Kids Dental

In 2000, Michigan initiated the *Healthy Kids Dental (HKD)* program offering dental coverage to Medicaid-enrolled children in **37 of its 83 counties**

History of expansion:

- 22 counties on May 1, 2000
- 15 counties on October 1, 2000
- 22 more counties on May 1, 2006
- Proposed expansion of 2 more counties, July 1, 2008

Healthy Kids Dental Program

- Administered by the Delta Dental Plan of Michigan
- Initially dentists paid usual Delta fees, same as for any other Delta-insured child
- Effective January 1, 2006, established a HKD/MICChild fee schedule
- Beneficiary may use any participating provider
- Program eligibility based on beneficiary county of residence
- Mirrors state Medicaid dental benefits
- Standard claims administration (same as for all other Delta patients)

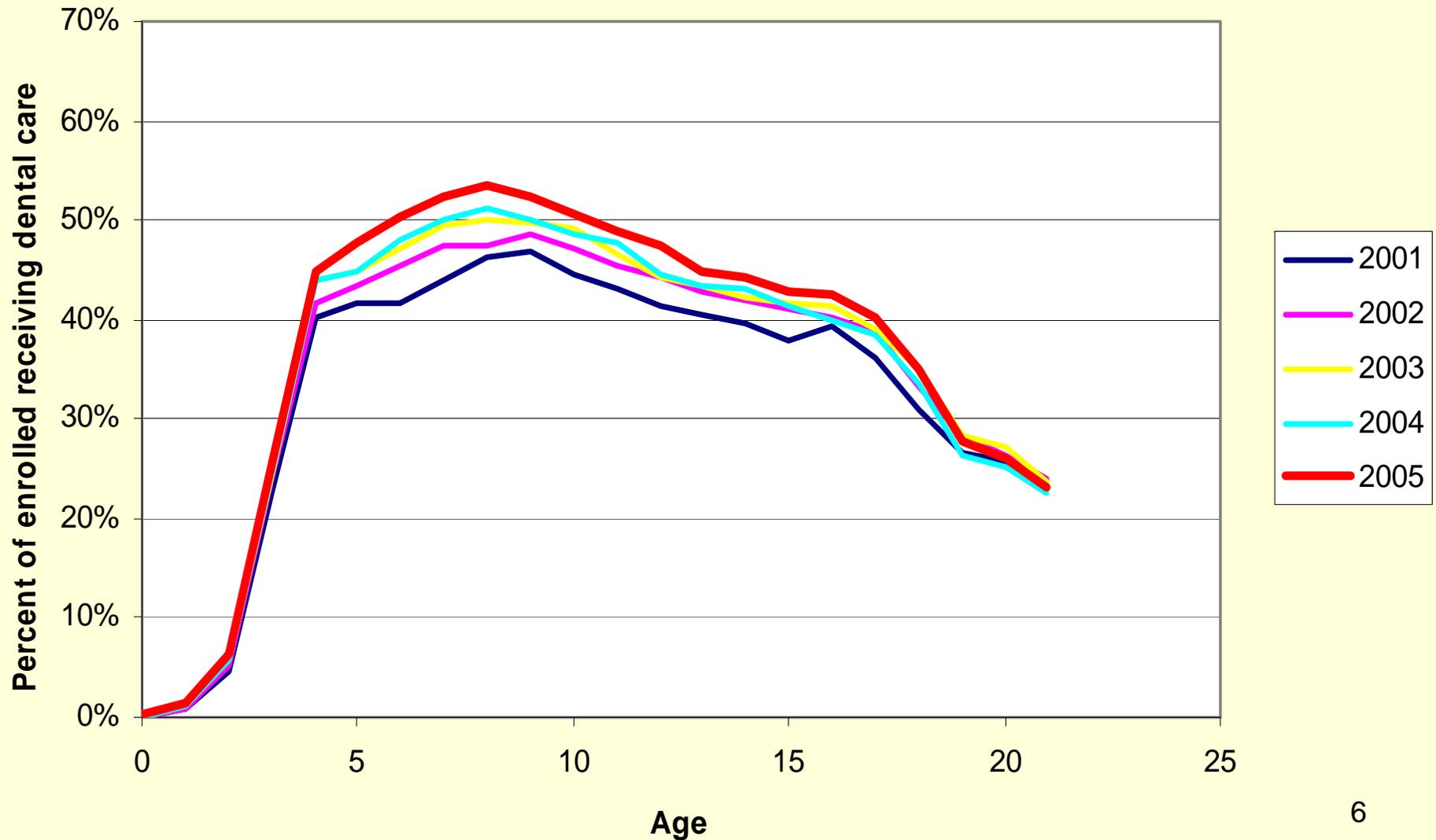
Measures

- **Enrollment Patterns** – Overall and by duration of enrollment (overall, 1-11 months and 12 month enrollment)
- **Access Patterns** – Percent of enrolled children using dental services each year (overall, and by age)
- **Participating Dentists** - Total number and relative proportion of dentists participating in *HKD*
- **Travel Distance** – Average and median travel distance between children and providers was approximated by distance in miles between ZIP code centroids for each visit
- **“Dental Home”** – Proportion of children with two or more dental visits for common preventive procedures (cleanings or topical fluoride treatments) from the same dentist within the same year
- **Utilization and Costs** - Distribution of services delivered and payments per user for select major procedure groupings (diagnostic/preventative, restorative, endodontics, periodontics, prosthodontics, surgical, adjunctive)

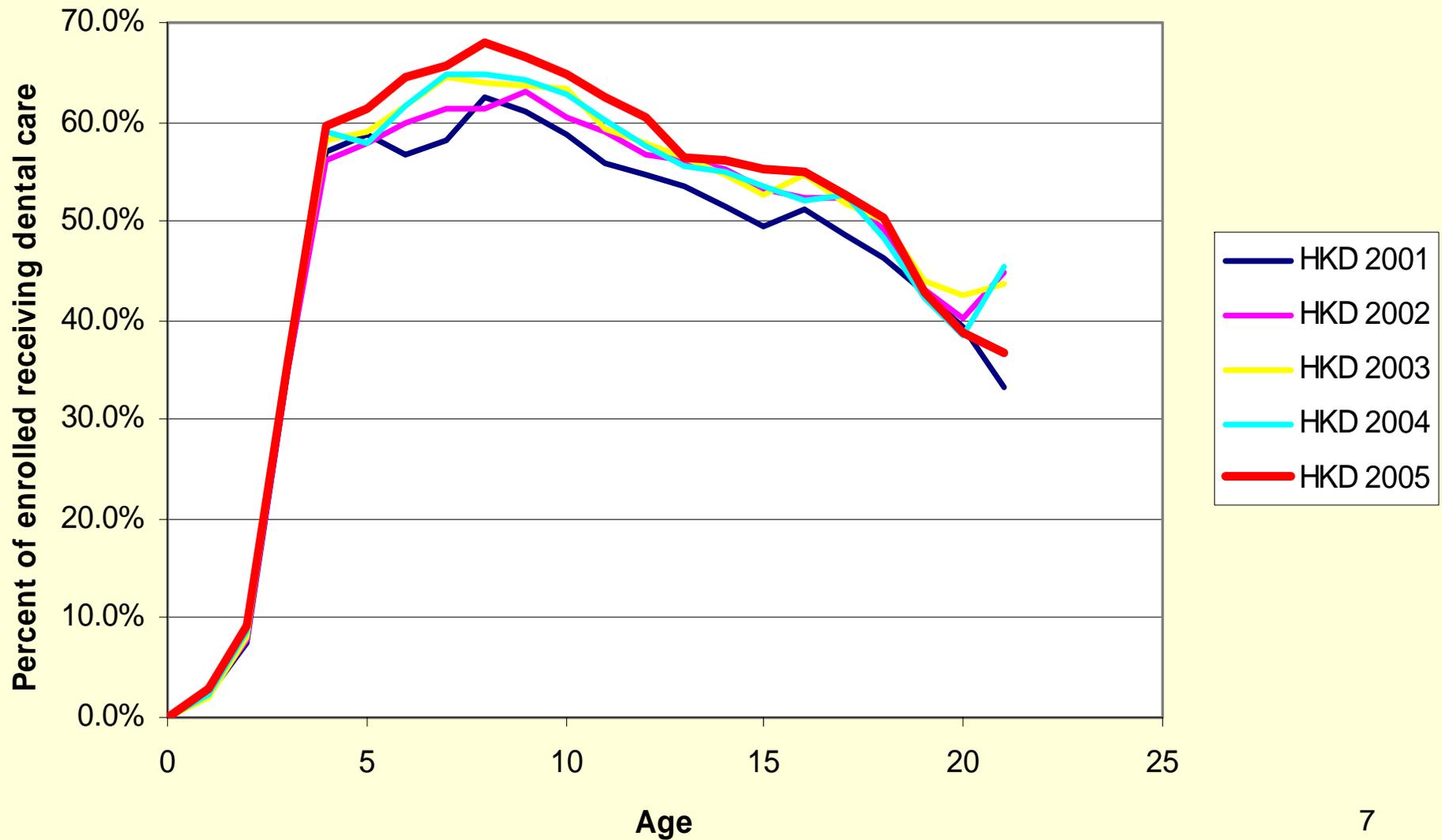
Enrollment and Access

	12 Month Enrolled		1 to 11 Month		Any Enroll- ment	
Year	Enrolled	Users	Enrolled	Users	Enrolled	Users
2001	55,536 (34.1)	27,226 (49.0)	107,142	21,488 (20.0)	162,678	48,714 (29.9)
2002	66,725 (37.4)	33,643 (50.4)	111,794	23,389 (20.9)	178,519	57,032 (31.9)
2003	76,673 (39.9)	39,437 (51.4)	115,654	24,419 (21.1)	192,327	63,856 (33.2)
2004	84,524 (41.3)	43,443 (51.4)	120,140	24,615 (20.5)	204,664	68,058 (33.2)
2005	90,003 (42.2)	47,831 (53.1)	123,474	26,196 (21.2)	213,477	74,027 (34.7)

Michigan Healthy Kids Dental utilization of dental care, any enrollment in calendar year, by age



Michigan Healthy Kids Dental utilization of dental care, 12 month enrollment in calendar year, by age



Participating Dentists

Number of dentists and number of children receiving treatment, by year.

Year	Dentists	Children treated (Children per dentist)	Child-Dentist combinations (Children per dentist)
2001	1544	48,714 (31.6)	56,971 (36.7)
2002	1624	57,032 (35.1)	66,354 (40.9)
2003	1715	63,856 (37.2)	74,307 (43.3)
2004	1773	68,058 (38.4)	79,599 (44.9)
2005	1926	74,027 (38.4)	88,951 (46.2)

Travel Distance

Year	Total HKD providers	Average (and Median) Delta travel distance in miles	Average (and Median) HKD travel distance in miles	29 county Delta gp and pedo providers	29 county HKD gp and pedo providers
2001	1544	13.7 (7.6)	11.0 (7.5)	461	410 (88.9%)
2002	1624	13.5 (7.9)	11.4 (7.6)	471	407 (86.4%)
2003	1715	13.2 (7.9)	11.2 (7.6)	483	416 (86.1%)
2004	1773	13.7 (8.1)	11.3 (7.6)	493	433 (87.8%)
2005	1926	13.3 (8.0)	11.1 (7.6)	493	447 (90.7%)

Dental Home

Year	Number of HKD children with two or more preventive visits per year	Percent of HKD children with two or more preventive visits per year	Percent of Delta children with two or more preventive visits per year	Percent of HKD 12-month enrolled children with two or more visits per year
2001	9,202	19.9	38.4	26.9
2002	12,138	22.8	38.0	29.7
2003	14,729	24.4	38.3	31.3
2004	16,365	25.4	38.7	32.0
2005	17,788	24.8	37.2	30.9

SUMMARY

- Access to dental care has continued to improve as a result of *HKD*
- More children and an increasing proportion of children received dental services each year.
- The number of dentists providing care continues to increase.

SUMMARY - continued

- Children continue to access needed services from local providers close to home.
- Many *HKD* children appear to have a dental home and be entering regular recall patterns.

Contact Information



Michigan Department of Community Health

CHRISTINE M. FARRELL, RDH, BSDH, MPA

Program Specialist

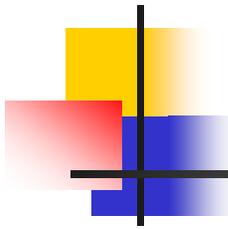
Program Policy Division

Bureau of Medicaid Policy and Actuarial Services

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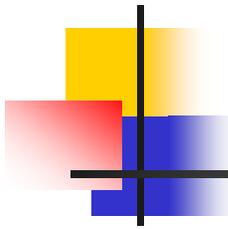
Developing Dental Performance Measures

Robert Isman, DDS, MPH

California Department of Health Care Services
Chair, Medicaid/SCHIP Dental Association

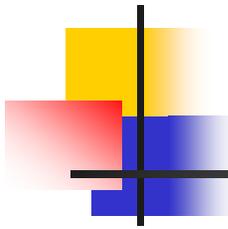
Medicaid & SCHIP Quality Teleconference Series
Pediatric Oral Health

April 3, 2008



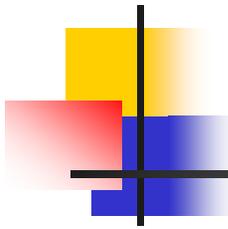
Background

- Separate Medicaid/SCHIP programs
- SCHIP program dissatisfied with previous performance measures
- SCHIP program convened Dental Quality Advisory Committee
 - Dental plan dental directors
 - Public health dentists
 - Pediatric dentist on SCHIP Advisory Panel



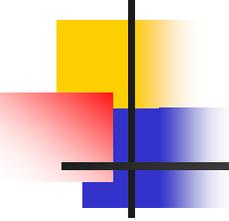
Why these measures?

- Most plans collect administrative data
- Clinical exams/chart audits not required
- Provides some sense of the level and quality of care provided to members
- No nationally-accepted measures or benchmark data (one HEDIS[®] measure)



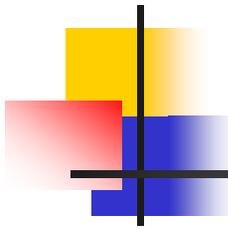
Notes on Access/Utilization Measures

- Many measures and definitions of “access”
- Utilization Rate: proportion of population that uses a service in a specified time period
- Numerator: Unduplicated users
- Denominator: Varies



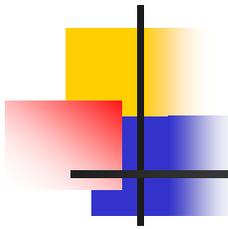
Utilization Rate Denominators

- Unduplicated eligibles
- Average monthly eligibles
- Member-months
- Continuously enrolled eligibles



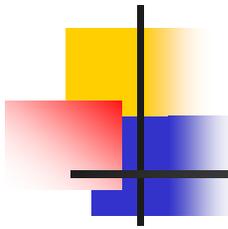
Selected Measures

- **Overall utilization of dental services**
 - Percentage of members continuously enrolled for 1, 2, and 3 years who received any dental service over those periods
- **Annual dental visit (HEDIS[®] measure)**
 - Percentage of enrolled members ages 2-18 with no more than a 45-day gap in eligibility who had at least one dental visit during the year



Selected Measures (Cont'd.)

- **Use of preventive services**
 - Percentage of members enrolled for at least 11 of the past 12 months who received any preventive dental service in past year
- **Use of treatment services**
 - Percentage of members enrolled for at least 11 of the past 12 months who received any dental treatment service in past year



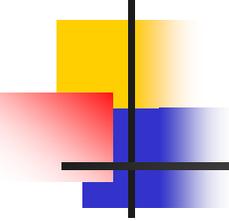
Selected Measures (Cont'd.)

- **Examinations/Oral health evaluations**

- Percentage of members enrolled for at least 11 of the past 12 months who received a comprehensive or periodic oral evaluation (or, for members < 3, who received an oral evaluation and counseling w/primary caregiver) in past year

- **Filling to preventive services ratio**

- Percentage of members enrolled for at least 11 of the past 12 months with 1+ fillings in past year who also received a topical fluoride or sealant application



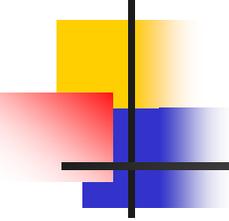
Selected Measures (Cont'd.)

- **Treatment/prevention of caries**

- Percentage of members enrolled for at least 11 of the past 12 months who received a treatment for caries or a caries-preventive procedure

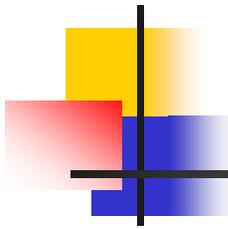
- **Continuity of care**

- Percentage of members continuously enrolled in same plan for 2 years who received a comprehensive oral evaluation or a prophylaxis in the year prior to the measurement, who also received a comprehensive or periodic oral evaluation or a prophylaxis in the measurement year



Selected Measures (Cont'd.)

- **Membership satisfaction surveys**
 - Satisfaction with dentist, dental plan, dental care, office staff (Dental CAHPS[®])



For additional information

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Proposed Dental Performance Measures

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Background

The following dental performance measures were selected because 1) they represent administrative data that most dental plans collect; 2) they do not require clinical examinations or chart audits, which are much more labor-intensive and expensive; and 3) they have the potential to give purchasers of care some sense of the level and quality of care being provided to members. It should be noted that, while a number of these measures are used by different plans, there currently exist no nationally-accepted dental performance standards or benchmark data against which these measures might be evaluated.

A Note About Access/Utilization Measures

There are many definitions of “access” and many ways of measuring it. Probably the easiest to understand and most basic access measure is a simple utilization rate—the proportion of a population that uses a service in a specified time period. The numerator in this equation is typically an unduplicated count of users, i.e., an individual is only counted once regardless of the number of times they are seen or the number of services they receive.

The denominator, however, can be specified in several different ways, each of which tends to influence how the data are interpreted. For example, an annual utilization rate might use an unduplicated count of enrolled members over the course of a year as the denominator. For a stable population, this would be a reasonable measure. However, for a program such as Medi-Cal, where over the course of a year some individuals may be eligible for a month or two while others may be eligible for the entire year, it isn't reasonable to assume that people who have been enrolled for a month have had the same opportunity to avail themselves of dental care as those who have been enrolled for a year. For this reason, Denti-Cal usually uses “average monthly eligibles” as the denominator when reporting utilization rates. This is simply the sum of the numbers of people enrolled each month over the course of a year divided by 12, and is intended to reduce the effect of varying periods of eligibility. However, it also will result in utilization rates that appear higher than those calculated using unduplicated eligibles.

Many health plans use a third method--“member-months”--as the denominator. This is a more accurate way of taking varying periods of enrollment into account. If, for example, 10 members are each enrolled for 3 months and 10 other members are each enrolled for 6 months, the total number of member-months used as the denominator would be $(10 \times 3) + (10 \times 6) = 90$. And finally, some programs only look at the population that has been continuously enrolled for a defined period of time as the denominator. HEDIS uses a variation of this technique—the population that has been continuously enrolled for a year with no

more than a 30-day lapse in enrollment over that period. This is also the method that Healthy Families uses to report utilization rates. The downside of this method is that information on many enrollees—those enrolled for less than 11 months in a year—is not taken into account.

Clearly, there are pros and cons to using each method of calculating utilization rate. It is proposed here that two different denominators be used for the calculation of most rates—unduplicated eligibles, to account in some way for the entire eligible population, and the “continuous enrollment” method used by HEDIS and Healthy Families, to be able to compare with their reported rates.

Note: All of the following measures should be collected by age group: < 1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20.

Note: Measures shaded and marked with an asterisk (*) are those accepted by California’s SCHIP program (Healthy Families) and will be incorporated into contracts with contracting dental plans effective July 1, 2008.

Proposed Measures

1.* *Overall utilization of dental services*

Percentage of members continuously enrolled for 1, 2, and 3 years who received any dental service over those periods

Rationale: The traditional annual utilization rate used by Medi-Cal, Healthy Families and many other plans doesn’t reveal much about the quality of care for the covered population. Even with a stable population, which these tend not to be, an annual utilization rate might count the same users each successive year, i.e., if 50% of the population sees a dentist in Year 1, the same 50% might see a dentist in Year 2, meaning that the remaining 50% had not seen a dentist in two years. Over 2-3 years, we would hope for a high utilization rate, e.g., 90%. This is important because not all children need annual exams or cleanings.

Numerator: Number of members continuously enrolled for 1, 2, and 3 years who received any dental service (D0100-D9999) over those periods.

Denominator: Number of members continuously enrolled for 1, 2, and 3 years.

2.* *HEDIS measure – Annual Dental Visit*

Percentage of enrolled members 2-18 years of age who had at least one dental visit during the measurement year. Members who have had no more than one gap in enrollment of up to 45 days during the measurement year should be included in this measure. [Note: To determine continuous enrollment for a Healthy Families Program beneficiary for whom

enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).]

Rationale: This is the only HEDIS dental measure. Including it allows comparison with other plans using this measure.

Numerator: Number of enrolled members, ages 2 through 18, who were continuously enrolled during the measurement year, with no more than a 30-day gap in eligibility during this period, and who had at least one dental visit during the measurement year. [Note: One way of calculating this is to count the number of members continuously enrolled for the measurement year who received any dental service (D0100-D9999) over that period.

Denominator: Number of members continuously enrolled during the measurement year with no more than a 30-day gap in eligibility during this period.

3. *Use of preventive services*

3a. Percentage of members who received any preventive dental service in past year

Rationale: This is a basic indicator of the extent to which preventive dental services are utilized. In a stable population enrolled in a plan that promotes prevention, it would be expected to increase over time as the population's treatment needs were completed. This is also an indicator that the federal Centers for Medicare & Medicaid Services (CMS) requires states to report for Medicaid enrolled children, so data can be compared with this population.

Numerator: Number of members who received any preventive dental service (D1000-D1999) in past year.

Denominator: Unduplicated number of members eligible at any time during the past year.

3b.* Percentage of members enrolled for at least 11 of the past 12 months who received any preventive dental service in past year

Rationale: Same as 3a with different denominator.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received any preventive dental service (D1000-D1999) in past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

4. *Use of treatment services*

4a. Percentage of members who received any dental treatment in past year

Rationale: This is a basic indicator of the extent to which dental treatment services are utilized. In a stable population enrolled in a plan that promotes prevention, it would be expected to decrease over time as the population's treatment needs were completed. This is also an indicator that CMS requires states to report for Medicaid enrolled children, so data can be compared with this population.

Numerator: Number of members who received any dental treatment (D2000-D9999) in the past year.

Denominator: Unduplicated number of members eligible at any time during the past year.

4b.* Percentage of members enrolled for at least 11 of the past 12 months who received any dental treatment in past year

Rationale: Same as 4a with different denominator.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received any dental treatment (D2000-D9999) in the past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

5.* *Examinations/Oral Health Evaluations*

Percentage of members enrolled for at least 11 of the past 12 months who received a comprehensive or periodic oral evaluation or, for members under three years of age, those who received an oral evaluation and counseling with the primary caregiver in the past year.

Rationale: This is an indicator of the use of more comprehensive services, rather than just the treatment of an emergency condition. This is very similar to one of the measures (comprehensiveness of services) recommended several years ago by an Oral Health Expert Panel organized by the National Committee for Quality Assurance (NCQA). NCQA is responsible for developing the HEDIS measures.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received a comprehensive or periodic exam (D0120 or

D0150) or, for members under three years of age, who received an oral evaluation and counseling with the primary caregiver (D0145) in the past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

6. *Dental Sealant Ratio*

- 6a. Ratio of occlusal surfaces of permanent molars receiving dental sealant to those receiving restoration

Rationale: This ratio provides a way to assess how effectively sealants are being used to prevent further disease/dental caries. It is preferred to the current Healthy Families sealant indicator (dental sealants per 100 children) because the latter measure provides an incentive for overuse or misuse and the potential for erroneous interpretation of the results. This is one of the measures recommended several years ago by an Oral Health Expert Panel organized by NCQA.

Numerator: Number of occlusal surfaces (Surface=Occlusal [depends on how coded]) of permanent molars (Tooth Number=1-3, 9-16, 17-24, 25-32) receiving dental sealant (D1351) in the past year.

Denominator: Number of occlusal surfaces (Surface=Occlusal [depends on how coded]) of permanent molars (Tooth Number=1-3, 9-16, 17-24, 25-32) receiving a restoration (D2000-D2999) in the past year.

- 6b. Ratio of occlusal surfaces of permanent molars receiving dental sealant to those receiving restoration among members enrolled for at least 11 of the past 12 months

Rationale: Same as 6a with different denominator.

Numerator: Number of occlusal surfaces (Surface=Occlusal [depends on how coded]) of permanent molars (Tooth Number=1-3, 9-16, 17-24, 25-32) receiving dental sealant (D1351) among members enrolled for at least 11 of the past 12 months.

Denominator: Number of occlusal surfaces (Surface=Occlusal [depends on how coded]) of permanent molars (Tooth Number=1-3, 9-16, 17-24, 25-32) receiving a restoration (D2000-D2999) among members enrolled for at least 11 of the past 12 months.

7. *Filling to Preventive Services Ratio*

- 7a. Percentage of members with or more fillings in past year who received a topical fluoride or sealant application

Rationale: This ratio is a proxy measure for determining if members who are caries-active (i.e., those who have had at least one filling in the past year) received any caries-preventive procedure. It is preferred to the current Healthy Families sealant indicator (dental sealants per 100 children) and prophylaxis indicator (prophylaxis per 100 children) because the latter measures provide an incentive for overuse or misuse and the potential for erroneous interpretation of the results.

Numerator: Number of members with 1 or more fillings (D2000-D2999) who received a topical fluoride (D1203 or D1204 or D1206) or sealant application (D1351) in past year x 100.

Denominator: Unduplicated number of members eligible at any time during the past year.

7b.* Percentage of members with 1+ fillings in past year who received a topical fluoride or sealant application among members enrolled for at least 11 of the past 12 months

Rationale: Same as 7a with different denominator.

Numerator: Number of members enrolled for at least 11 of the past 12 months with 1 or more fillings (D2000-D2999) who received a topical fluoride (D1203 or D1204 or D1206) or sealant application (D1351) x 100.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

8. *Extraction Rate*

Percentage of members continuously enrolled for past 2 years who received an extraction during reporting year (excluding 3rd molars or premolars extracted for orthodontic reasons)

Rationale: Tooth extractions represent failure to maintain oral health, and to some extent the failure of the oral health care delivery system. For a stable population enrolled for two continuous years, this rate should be low.

Numerator: Number of members continuously enrolled for past 2 years prior to the reporting year who received an extraction (D7111, D7140, D7210-D7250) during reporting year, excluding 3rd molars or premolars extracted for orthodontic reasons (Tooth Number=2-8, 9-15, 18-24, 25-31 and Tooth Number=4, 5, 12, 13, 20, 21, 28, 29 IF there was also any procedure D8000-D8999 provided) x 100.

Denominator: Number of members continuously enrolled for the past 2 years.

9. *Endodontic Treatment to Extraction Ratio*

Ratio of number of teeth receiving root canal treatment to number of teeth extracted

Rationale: This measure is an indicator of alternative therapies among older children and adults. Endodontic (root canal) treatment represents an attempt to preserve a natural tooth, while extractions represent the failure to maintain oral health, and to some extent the failure of the oral health care delivery system.

Numerator: Number of teeth receiving root canal treatment (D3000-D3999) during the past year.

Denominator: Number of teeth extracted (D7111, D7140, D7210-D7250) during the past year.

10. *120-Day Dental Assessment*

120-day dental assessment (percentage of children 1-18 continually enrolled at least 4 months who had initial visit within first 4 months)

Rationale: This is a measure of the ability of the dental plan to provide an oral health assessment within a reasonable time after a member's enrollment. This is a current Healthy Families indicator.

Numerator: Number of children ages 1-18 who were continually enrolled at least 4 months during the past year and who had an initial visit within the first 4 months of enrollment x 100.

Denominator: Number of children ages 1-18 who were continually enrolled at least 4 months during the past year.

11.* *Treatment/Prevention of Caries*

Percentage of members enrolled for at least 11 of the past 12 months who received a treatment for caries or a caries-preventive procedure.

Rationale: As the reason for most children's dental visits is either for the prevention or treatment of caries, this measure provides a sense of the extent to which members are receiving such services.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received a treatment for caries (D2000-D2999) or a caries-preventive procedure (D1203-D1206, D1310, D1330, D1351).

Denominator: Number of members enrolled for at least 11 of the past 12 months.

12.* **Continuity of Care**

Percentage of members continuously enrolled in the same plan for 2 years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in the year prior to the measurement year who also received a comprehensive or periodic oral evaluation or a prophylaxis in the measurement year.

Rationale: When first presenting to a dental office, most children who receive more than emergency treatment receive a prophylaxis. The only procedures that are performed for a large percentage of patients who have already received services are recall examinations and prophylaxes. The number of members receiving these non-emergency treatments in successive years is thus an indicator of continuity.

Numerator: Number of members in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the measurement year.

Denominator: Number of members continuously enrolled in the same plan for 2 years with no gap in coverage who received a comprehensive oral evaluation (D0150) or a prophylaxis (D1110, D1120) in the year prior to the measurement year.

13.* **Member Satisfaction Surveys**

Satisfaction with dentist, dental plan, dental care, office staff (Dental CAHPS®)

Rationale: Member satisfaction surveys represent a well-accepted method for assessing the quality of care provided by health plans. Healthy Families uses a dental version of the widely-used Consumer Assessment of Health Plans (CAHPS®).