Framing a Value-Based Medicaid Dental Program: Dental Case Management

Session 2

Samuel Zwetchkenbaum, DDS, MPH

Dental Director, RI EOHHS
Learning Objective(s)

Participants will gain knowledge in:

• Potential increased value for Medicaid Dental Programs through Case Management
• Training needs around Case Management
• Anticipated documentation around Case Management: needs and challenges
Disclosure and Conflict of Interest Declaration

✓ I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
Rhode Island Challenges

Insufficient number of participating dental providers in Adult Medicaid Dental Program

• 19% of RI general dentists enrolled

• Dental provider concerns:
  • Inadequate reimbursement
  • Missed appointments
  • Patient non-compliance

• RI Medicaid Program concerns:
  • Continued high costs
  • Continued high use of ER for dental diagnoses
Changing **Demographics** in RI

Estimated population growth of seniors ages 65+

- 16.5% in 2016 → 23.1% in 2030
- More chronic illnesses
- Less oral health literacy

Diversity in language

- Increased need for interpreters and translation services

Aging transportation resources

- Public transit can be difficult for families
- Challenges of hub and spoke system
Need: Increase Program Value

• Increase value of Medicaid Dental Program to *dental providers*
• Increase value of Medicaid Dental Program to *adult beneficiaries*
• Improve the *provider-patient relationship*
• Create a mechanism to enhance the *provider-patient relationship*
• Outcomes of interest:
  • Increased provider participation
  • Increase use of services by adult beneficiaries
  • Reduce overall costs
Strategy: Dental Case Management

- Design, develop and pilot Dental Case Management Program
- Target: Adult Medicaid beneficiaries
- Targeted Providers:
  - General Dentists in RI
  - FQHCs
- Model:
  - Framed using new CDT Case Management Codes
What is Case Management?

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Reference: Case Management Society of America
What is Case Management in Dentistry?

The American Academy of Pediatric Dentistry (AAPD’s) Definition:

Case management is not only the customization of available resources to specific patient and provider needs, but the communication of, and explanation and support for, good oral health practices.
Training: Dental Case Management

Objectives

• Recognize the new opportunities for dentistry in delivering patient-centered oral healthcare across the population;

• Understand key components of case management services and how each effects the patient experience;

• Describe the role that state agencies, MCOs, and community supports play in effective communication and care coordination;

• Identify the role and benefits of dental office case management;

• Learn how to document case management services delivered in the dental office setting to help monitor care
Effective **Case Management Strategies** for Dental Teams

In dentistry, the following strategies are useful components of case management:

1. Motivational interviewing
2. Health literacy activities
3. Care coordination
4. Community outreach and education
5. Appointment reminder systems
Who Might Provide DCM?

- Individual dental practices
- Dental managed care organizations
- Medical managed care organizations
- Family and child social workers in the public and private sectors
- Community Health Workers
  - Volunteer members of the community (promotores)
  - Paid frontline public health workers (Community Dental Health Coordinators)

Dental Case Managers have the same responsibilities as other types of case managers -- increasing access to care by the removal of barriers to care delivery.

_Dental Staff may be:_

1) full-time case managers; or
2) dental case management may be part of their job designation.
DCM CDT Codes: *What and Where?*

**Separate codes** that reflect the four activities that define Dental Case Management –

- **D9991** - addressing appointment compliance barriers
- **D9992** - care coordination
- **D9993** - motivational interviewing
- **D9994** - patient education to improve oral health literacy

**All in Adjunctive Category of Service**
Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers.
Dental Case Management

CDT Codes

D9992

Dental Case Management – Care Coordination

Assisting in a patient’s decisions regarding the coordination of oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. This is the additional time and resources expended to provide experience or expertise beyond that possessed by the patient.
Dental Case Management

CDT Codes

D9993

Dental Case Management – Motivational Interviewing

Patient-centered, personalized counseling using methods such as Motivational Interviewing (MI) to identify and modify behaviors interfering with positive oral health outcomes. This is a separate service from traditional nutritional or tobacco counseling.
Dental Case Management

CDT Codes

D9994

Dental Case Management – *patient motivation to improve oral health literacy*

Individualized, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences and adopting information and services to these differences, which requires the expenditure of time and resources beyond that of an oral evaluation or case presentation.
RI Dental Case Management **Pilot**

- Goal: Increase Utilization
- Target: 10 Offices – FQHCs and Private Practices
- Incentive: Provider Compensation for a 6 month period
  - $22 per claim
  - Frequency limitations
- In the end, program was not funded
- Two offices participated
- One private practice dropped out after a month
- FQHC participated for a few months but found paperwork burdensome
# RI Medicaid Dental Case Management Pilot-Data Collection Form

The RI Executive Office of Health and Human Services is piloting four new dental case management service codes to determine the potential effectiveness in advancing use of services among Medicaid beneficiaries. Under the pilot, EOHHS will require dental professionals enrolled in Medicaid to complete the online RI Medicaid Dental Case Management Training modules to become certified/authorized to deliver and bill for dental case management service. The four new dental case management codes below were established by the Code Committee of the American Dental Association, and published in the 2017 Current Dental Terminology (CDT) update.

Below is a series of questions to help identify the Case Management service being addressed and to provide a means to document the nature of the service provided by the dental professional. This form must be completed for each patient visit when case management services are provided and a copy submitted to RI Medicaid along with their dental claim. While the personal identifier data will not be used for measurement purposes, as part of the RI EOHHS Case Management Coding Pilot, the information related to the types of codes being billed and patient progress will be tracked.

Please note that the form below is for both billing purposes and as a patient summary. This form does not substitute the need for a patient needs assessment and/or use of an oral health literacy tool. Supplemental case management documentation should be filed in the patient’s record and may be subject to EOHHS review.

<table>
<thead>
<tr>
<th>Dental Provider’s Name</th>
<th>NPI Number</th>
<th>Date of Service</th>
<th>Code Name</th>
<th>Description</th>
<th>Record Patient’s Need</th>
<th>Provider Intervention</th>
<th>Desired Outcome</th>
<th>Metric (Scoring Guide)</th>
<th>Criteria</th>
<th>Baseline Score</th>
<th>Date</th>
<th>Score</th>
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</tr>
</thead>
<tbody>
<tr>
<td>09991 Dental Case Management—Addressing Appointment Compliance Barriers</td>
<td>Efforts to assist a patient in adhering to scheduled appointment(s) by solving transportation challenges or other barriers</td>
<td>Patient reported for dental appointment in a timely manner</td>
<td>Patient reported for dental appointment in a timely manner</td>
<td>Degree to which patient complies with appointment schedule:</td>
<td>&gt; Serious non-compliance; &gt; Compliance Non Met; &gt; Compliance Met; &gt; Exceeds compliance; &gt; Substantially Exceeds compliance</td>
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<tr>
<td>09992 Dental Case Management—Care Coordination</td>
<td>Assisting a patient’s decisions regarding the coordination of oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. This is the additional time and resources expended to provide experience or expertise beyond that possessed by the patient</td>
<td>Patient received specialty or other care as a result of case coordination initiated by the dental provider</td>
<td>Patient received specialty or other care as a result of case coordination initiated by the dental provider</td>
<td>Degree to which patient complies with efforts to coordinate care with other health care providers:</td>
<td>&gt; Serious non-compliance; &gt; Compliance Non Met; &gt; Compliance Met; &gt; Exceeds compliance; &gt; Substantially Exceeds compliance</td>
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<tr>
<td>09993 Dental Case Management—Motivational Interviewing</td>
<td>Patient-centered, personalized counseling using methods such as Motivational Interviewing (MI) to identify and modify behaviors interfering with positive oral health outcomes. This is a separate service from traditional nutritional or tobacco counseling</td>
<td>Improved Behavior</td>
<td>Improved Behavior</td>
<td>Degree to which desired behavior is achieved/demonstrated:</td>
<td>&gt; No behavior change; &gt; Slight (+) behavior change; &gt; Moderate (++) behavior change</td>
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<tr>
<td>09994 Dental Case Management—Patient Motivation to Improve Oral Health Literacy</td>
<td>Individualized, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences and adopting information and services to these differences, which require the expenditure of time and resources beyond that of an oral health literacy evaluation or case presentation</td>
<td>Improved Health Literacy</td>
<td>Improved Health Literacy</td>
<td>Degree to which oral health literacy is improved:</td>
<td>&gt; No change; &gt; Slight Improvement; &gt; Moderate Improvement; &gt; Significant Improvement</td>
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</tbody>
</table>

We understand and agree to work on the above measures as discussed at today’s appointment.

Patient Signature ____________________________ Dental Provider Signature ____________________________
Forms

- Code
- Description
- Patient’s Need
- Intervention
- Desired outcome, e.g. “Joe arrives on time”
- Metric (0-4)
- Baseline and follow up scores by date
### Fiscal Agent Control Number (FACN)

Policy change: Pilot Introduction of Case Management codes D9991-D9994

**Procedure Code:** D9991  
ADA Description: Dental case management-addressing appointment compliance barriers  
Usage guidelines for each code: Allowed once per date of service, once every three months  
Age Limitations: over 18  
PA required? no  
PA require >20? no  
Units per day: one  
Pricing/Payment: $22  
Effective Date: 7/1/17  
End Date (if any): 6/30/18  
Included providers: List doctors who have taken course

**Procedure Code:** D9992  
ADA Description: Dental case management-care coordination  
Usage guidelines for each code  
Age Limitations: over 18  
PA required? no  
PA require >20? no  
Units per day: two  
Pricing/Payment: $22  
Effective Date: 7/1/17  
End Date (if any): 6/30/18  
Included providers: List doctors who have taken course
Lessons Learned/Questions

• Compensation necessary for participation
• How to set up for FQHCs
• Time limitation
• How will we judge success for a pilot?
• What kind of documentation is effective but not burdensome?
Next Steps

• Budget submitted and considered negligible
• To be submitted in 1115 Waiver Extension Request
• Additional information to be shared with RI providers through Webinar and online training modules
• Once approved, finalize FACN
• Collect data based on increased number of providers, utilization, ratio of preventive services
Questions
Samuel Zwetchkenbaum, DDS

Samuel Zwetchkenbaum, DDS, MPH is a graduate of Brown University and University of North Carolina School of Dentistry. He served as staff dentist at Capitol Hill Health Center in Providence following his general practice residency. Sam was on faculty at the University of Michigan from 1995-2012, providing clinical care and directing the GPR program, and at the same time, he obtained his Masters in Public Health at U of M.

Sam completed a Fellowship in Geriatric Dentistry at Rutgers School of Dental Medicine in New Jersey and subsequently taught Geriatric Dentistry there and provided care to older adults in skilled nursing facilities using portable equipment. He has served as Dental Director in the Oral Health Program in the Rhode Island Department of Health and the Medicaid program in the Office of Health and Human Services since 2016. Sam is currently President of the Special Care Dentistry Association and Chair of the Healthy Aging Committee of the Association of State and Territorial Dental Directors.
Contact Information

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Framing a Value-Based Medicaid Dental Program:  
**Iowa’s Dental Wellness**  
*Lessons Learned Moving from 1.0 - 2.0*

**Session 2**

Heather K. Miller, RDH

Iowa Dental Program Manager
Disclosure and Conflict of Interest Declaration

✓ I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
Dental Wellness Plan

• Iowa agreed to Medicaid Expansion
• New managed care model would start through Iowa’s primary carrier – Delta Dental of Iowa
• Access to care was a concern for members if kept in FFS delivery model
Evaluating Medicaid Participation

Dentist participation in Medicaid has decreased significantly over the last 20 years (Table 7). The 1992 and 1995 surveys were conducted by researchers at the University of Iowa Public Policy Center using similar methods and questions to gather information on Medicaid participation. In 1992, 62% of dentists reported accepting all new Medicaid patients. By 1995 this had decreased to 42%, and as reported, in 2013 it was 16%.

<table>
<thead>
<tr>
<th>Level of Medicaid participation</th>
<th>1992 (N=343)</th>
<th>1995 (N=943)</th>
<th>2013 (N=768)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All new Medicaid patients</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>214</td>
<td>393</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>62%</td>
<td>42%</td>
<td>16%</td>
</tr>
<tr>
<td>Some new Medicaid patients</td>
<td>45</td>
<td>208</td>
<td>325</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>22%</td>
<td>42%</td>
</tr>
<tr>
<td>No new Medicaid patients</td>
<td>73</td>
<td>342</td>
<td>321</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>36%</td>
<td>42%</td>
</tr>
</tbody>
</table>
DWP 1.0 Plan Design

• Target: Medicaid Expansion Population
• Tiered Benefit Design
  • Promoted Preventive Care
  • Goal was to change Member (beneficiary) Behavior
• Use of a risk assessment tool *by providers*
• Provider reimbursement substantially
DWP 1.0 Major Results

• Dental providers supported new managed care design with the preventive focus
• Members appreciated increased access to dental services
• Increased use of services demonstrated by members
• Administrative challenges:
  • Churn of members back and forth between enrollment in FFS and DWP (due to eligibility status)
  • Difficult to manage for both state administrators and providers
  • Coordination with providers complex
  • Difficult for members to move through the benefit tiers
## Dental Wellness Plan

### Benefit Tiers

<table>
<thead>
<tr>
<th>FY 2017</th>
<th>Core</th>
<th>Enhanced</th>
<th>Enhanced Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>85.97%</td>
<td>9.33%</td>
<td>4.69%</td>
</tr>
<tr>
<td>Q2</td>
<td>85.77%</td>
<td>5.71%</td>
<td>8.52%</td>
</tr>
<tr>
<td>Q3</td>
<td>84.89%</td>
<td>5.96%</td>
<td>9.15%</td>
</tr>
<tr>
<td>Q4</td>
<td>80.90%</td>
<td>7.36%</td>
<td>11.74%</td>
</tr>
</tbody>
</table>
Request for Information

RFI Released (December, 2016)

• Sought information from vendors, public and experts in the field
• Input was gained from dentists, other dental plans, and other key stakeholders

Outcome: DWP 1.0 Program Improvement Needed

• DWP 1.0 not working for members, providers, or the state
• Administration was becoming too cumbersome
• Not getting outcome benefit we were looking for
DWP 2.0 Plan Design

Combined Medicaid Expansion and Adult Medicaid Population into one Plan = DWP 2.0

• Seamless experience for members and providers
• Reduced eligibility challenges – members going on and off

Eliminated Tiered Benefits

• Replaced with Healthy Behaviors
• Focus on Preventive Dental Services
• Changed Risk Assessment Model to: *Self Assessment by Members*
DWP 2.0 Plan Design
(Continued)

Reimbursement Model Changed Back to FFS

• Reduced to slightly above the original FFS rates
  o Match allowed higher rates when Expansion population only

• State was unable to sustain the original DWP higher reimbursement when bringing in non-Expansion adults at the lower-federal match
Iowa Medicaid Member Counts
DWP 2.0 Results

**Improved Access to Care**
- Provider network remains stable
- DWP 2.0 has provided dental coverage for a large number of low-income adults

**Comprehensive Services**
- Available first year of enrollment

**Outreach and Education Needed**
- Promote healthy behaviors
- Premium penalty
DWP 2.0 Benefit Changes

July 1, 2018

• Introduction of a $1,000 Annual Benefit Maximum per member per State FY
  • Excluded from this cap: diagnostic, preventive, emergent, anesthesia, and fabrication of dentures
  • Five year limit to replacement of dentures when lost, stolen or broken beyond repair
Questions
Ms. Heather Miller

Heather Miller is a Registered Dental Hygienist in Iowa. In late 2017, she became the Iowa Medicaid Dental Program Manager. Previously, she served as the Outreach Coordinator for the Dental Wellness Program (DWP) administered through Delta Dental of Iowa.

Prior to becoming the Outreach Coordinator for the DWP Program, Ms. Miller worked as a Claims Review Specialist within Provider Services at Delta Dental. She also worked for the Iowa Department of Public Health as an Oral Health Consultant for nine years.

Ms. Miller graduated from the Dental Hygiene Program at Hawkeye Community College and later completed the Certified Public Manager Program at Drake University. She has vast clinical experience working in both private and public health dentistry and strives to use her knowledge and experience to advance the oral health of all Iowa residents.
Contact Information

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hmiller@dhs.state.ia.us
Framing a Value-Based Medicaid Dental Program:

Dental Transformation Initiative

Session 2

Alani Jackson, MPA

Chief, Medi-Cal Dental Services Division
California Department of Health Care Services

Session Sponsored By
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California’s Medi-Cal Dental Services Program Snapshot

- Total Medi-Cal population – Approximately 13.5 million beneficiaries
- Total dental program budget – Approximately $2 billion based on the current State budget
- Two delivery systems: fee-for-service (FFS) (all 58 counties); dental managed care (DMC) (Sacramento – 80% DMC/20% FFS and Los Angeles Counties – 14% DMC/86% FFS)
What would it take to increase value of services?

- **Providers** – $$$ + administrative simplification
  - Proposition 56
  - Dental Transformation Initiative (DTI)
  - Streamlined Dental Provider Enrollment Application
  - Provider Web Application
  - Remote and Onsite Support
  - Legislative Impact on Program Policy
  - Care Coordination
What would it take to increase value of services?

• **Beneficiaries** – access to reliable information
  • Beneficiary Microsite
  • Beneficiary focused materials
  • Support system
  • Care Coordination
  • Multiple touch points reiterating importance of oral health
What does value mean to me?

• *Administrator* – Innovation!
  • SMART Goals
  • Evaluation of Outcomes (Ongoing)
  • Reliable Data and Data Systems
What does value mean to me?

**Customer Service**

- Outreach and Education Plans
- Quality not Quantity
  - Network Adequacy and Access to Care
  - Provider relationships and collaboration across delivery systems
- Meeting or exceeding document processing timelines

**Impact**

- Utilizing provider types to the peak of their licensure
Medi-Cal 2020 Overview

CMS approval for renewal on December 30, 2015

Effective January 1, 2016 through December 31, 2020

$6.2 billion total initial federal funding over 5 years
Program Period & Funding Overview

DTI
01/01/16 – 12/31/20
$740M
Dental Transformation Initiative: Domain Areas

Domain 1: Increase Preventive Services Utilization for Children

Domain 2: Caries Risk Assessment and Disease Management

Domain 3: Increase Continuity of Care

Domain 4: Local Dental Pilot Programs (LDPPs)
Domain 1: Increase Preventive Services Utilization for Children

Domain Goal:

- Increase **statewide** 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.
Dental Transformation Initiative

Domain 2: Caries Risk Assessment and Disease Management

Domain Goals:

• Diagnose Early Childhood Caries (ECC) via Caries Risk Assessments (CRA) and implement chronic disease management;

• Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventive services in lieu of more invasive and costly procedures (restorative services).
Dental Transformation Initiative

Domain 3: Increase Continuity of Care

Domain Goal:

• Increase continuity of care for beneficiaries ages 20 and under for 2, 3, 4, 5, and 6 year continuous periods.

• Assess claims data to determine number of beneficiaries who received an examination each year from the same service office location for two (2), three (3), four (4), five (5) and six (6) year continuous periods.
Dental Transformation Initiative

Domain 4: Local Dental Pilot Programs (LDPPs)

Domain Goal:

- Local Dental Pilot Program (LDPP) will address one or more of the three domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships.

Status:

- DHCS solicited proposals
- 14 LDPPs were approved (13 have executed contracts)
- Evaluation of their success will occur in the third year.
How did we convince policy makers this was important?

• Prior to 2016, policymakers were evaluating ways to improve provider participation, and the impact on access to care and utilization of dental services.

• DTI offered incentives for dental providers new to the Medi-Cal system, and for existing Medi-Cal dental providers for increasing the number of Medi-Cal members they treat.

• DTI represented a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

• An independent evaluator will provide a multivariate analysis that employs appropriate comparisons and integrates administrative, survey, and qualitative data to assess the impact of DTI interventions on provider participation, service use, expenditures, continuity of care, and related outcomes.
Who was involved in the planning and design?

- Primarily DHCS staff in collaboration with CMS staff.
- Convening of multiple stakeholder discussions.
- Establishment of DTI Small Stakeholder Workgroup comprised of legislative staff, children’s health advocates, dental associations, dental clinicians (across delivery systems and academia), dental managed care plans, local agencies (First 5) and clinics.
Did we need to seek waiver approval?

• Yes, DTI is one of the programs under California’s Section 1115(a) Waiver, titled “Medi-Cal 2020 Demonstration.”

• CMS approved the current 1115 waiver on December 31, 2015 and it continues through December 31, 2020.

• AB 1568 (Chapter 42, Statutes of 2016) and SB 815 (Chapter 111, Statutes of 2016) also authorized DHCS to implement the objectives and programs of the current 1115 waiver, consistent with the Special Terms and Conditions approved by CMS.
Where did the funds come from to support the program?

• DTI is funded by Designated State Health Care Program (DSHP) funds.
• The non-federal share (NFS) is funded with the General Fund savings from the DSHP program. The NFS derives from the State’s General Fund appropriated by the State’s Legislature to the State’s Medicaid program.
• The total potential expenditures for DTI payments is $150 million annually ($75 million NFS, $75 million federal funds). Actual expenditures is based on actual DTI achievements. [Total of $740 million in total funds over a 5-year period with additional $10 million in total funds contingent on achieving statewide metrics]
Dental Transformation Initiative

• For information on the project or to submit questions/concerns regarding DTI, send email to:
  DTI@dhcs.ca.gov

• DHCS Webpage dedicated to DTI publications and public information:
  http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx
Questions
Alani Jackson, MPA

Alani Jackson is the Chief of the Medi-Cal Dental Services Division within the Department of Health Care Services (DHCS). She has full management responsibility for administering the Medi-Cal Dental Services Program (Denti-Cal and Dental Managed Care), which provides dental services to nearly 14 million Medi-Cal beneficiaries.

Prior to joining DHCS, Ms. Jackson had over eight years of administrative and managerial experience with the California Department of Corrections and Rehabilitation, California Correctional Health Care Services. She has extensive experience and knowledge working in health care policy planning, development, and implementation, as well as interacting with high-level executives amongst various state departments. She has over 10-years of experience serving Californians as a public servant and additional years of experience working in the legislature and children’s advocacy.

Ms. Jackson has a Master’s in Public Administration from the University of Southern California, and two Bachelor’s in Community and Regional Development and Political Science from the University of California, Davis.
Contact Information

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(916) 464-3888

Medi-Cal Dental Services Division: dental@dhcs.ca.gov
Framing a Value-Based Medicaid Dental Program
Navigating Dental Quality Measures

Session #2

Donna C. Jones, DMD, MPH
Dental Director MassHealth
Massachusetts Medicaid Program

Session Sponsored By
Learning Objective(s)

Participants will gain knowledge in:

• MassHealth ACO Value to Volume Transition
• How to Choose a Dental Quality Measure with FFS Metrics
• Challenges with Designing a Dental Quality Measure as a Siloed ACO
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MassHealth ACO

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Accountable Care Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Provider-Led (17 ACO Contracts)</td>
</tr>
<tr>
<td>Scope of Service</td>
<td>Physical Health</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health (community partners (CP))</td>
</tr>
<tr>
<td></td>
<td>Long-Term services/supports (LTSS) by year 3 with CP</td>
</tr>
<tr>
<td>Payment Model</td>
<td>Three-models:</td>
</tr>
<tr>
<td></td>
<td>1) Model A: Full risk capitation</td>
</tr>
<tr>
<td></td>
<td>2) Model B: Shared savings and loses with MH</td>
</tr>
<tr>
<td></td>
<td>3) Model C: Shared savings and/or loss contracts with MH MCOs</td>
</tr>
<tr>
<td>Quality Measurement</td>
<td>Proposed measures TBD tied to payment in second through year five</td>
</tr>
<tr>
<td></td>
<td>First year, reporting only.</td>
</tr>
</tbody>
</table>
1115 Waiver Authority

• Payment and delivery system reform that promote integrated, coordinated care and hold providers accountable for the quality and total cost of care.
• Improve/integrate physical, behavioral, and long-term services.
• Maintain near-universal coverage, access and sustainably support safety net providers.
• Expand access for Opioid addiction crisis to a broad spectrum of recovery-oriented substance use disorder services.
Dental Program

• Members enrolled in ACOs dental services remain FFS with associated costs not counted against the ACO total cost of care budget.

• ACOs have broad accountability to integrate care across service categories and measurement domains.

• Comprehensive combined Medicaid/CHIP program with a population health management focus.

• Contracted Third Party Administrator (currently DentaQuest). MassHealth pays the claims.
ACO- Full Risk Capitation

- Emergency related dental services medically necessary to treat medical condition and oral surgery performed in ambulatory surgery/outpatient hospital care.

- EPSDT Services – population under 21 years old.

- Fluoride Varnish (FV CPT code 99188) – Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses)
  
  - May apply FV to eligible members under age 21 during a pediatric preventive care visit (members up to age 3)
  
  - Children up to age 21 allowed in instances where the member does not have access to a dentist and the service is medically necessary as determined by a Caries Assessment Tool (CAT).
Non-ACO Covered Services

“The Contractor need not provide, but shall coordinate, for each enrollee the delivery of all MassHealth services which such enrollee is eligible but which are not currently ACO Covered Services”.

- Adult Dentures – full and partial dentures, and repairs to said dentures, for adults ages 21 and over.

- Preventive and Basic services for the prevention and control of dental diseases and the maintenance of oral health for children and adults as described in 130 CMR 420.000
CONFUSION IS THE FIRST STEP TOWARD CLARITY
Getting Started

• Choosing the Right Domain
• Dental Population Impact and ACO Goals
• Steward DQA- Measure Name
• Benchmark
• Critical Data Elements (Claims)
• EOHSS does not capture SNOMED in claims, encounter data processes, excluded in denominator/numerator logic.
<table>
<thead>
<tr>
<th>Measure Domains</th>
<th>ACO Population Health Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal, Child, and Family Health Promotion</td>
<td>Ensure positive early childhood development; Improve Birth Outcomes; Reduce morbidity related to preventable disease</td>
</tr>
<tr>
<td>Healthy Living and Chronic Disease Prevention and Control</td>
<td>Better prevention and management of chronic illness; support tobacco free living</td>
</tr>
<tr>
<td>Reducing ED and Hospital Utilization</td>
<td>Prevent hospital readmissions; reduced visits and acute care hospitalizations</td>
</tr>
<tr>
<td>Promote Mental health and Reduce Addiction by Prevention, Treatment, and Care integration</td>
<td>Timely access to person-centered; evidence-based care; Integrate behavioral health &amp; addiction treatment</td>
</tr>
<tr>
<td>Person centered long term services and supports</td>
<td>Promote person-centered care planning; enhance integration of LTSS and primary medical services</td>
</tr>
</tbody>
</table>
# ACO Quality Dashboard

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>Population Goal</th>
<th>Proposed Quality Measure</th>
<th>Data Source</th>
<th>Domain Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and Wellness</td>
<td>Reduce morbidity related to preventable disease</td>
<td>Oral Health Evaluation-Dental Services DQF #2517</td>
<td>Claims</td>
<td>Year 1: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Years 2-5:10%</td>
</tr>
</tbody>
</table>

Steward: Dental Quality Alliance (DQA)
2018 Benchmark: Reporting Only
ACO Risk Adjustment: None
ACO Population Goals

Dental caries is the most common chronic disease in children in the United States. Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions.

• Ensure positive early childhood development
• Reduce morbidity related to preventable disease
• Improve birth outcomes
Population Health Impact

Each day, millions of children suffer from this silent epidemic

unable to eat, sleep, or concentrate in school
Measure Summary

Description: The percentage of ACO attributed members under age 21 who received a comprehensive or periodic oral evaluation as a dental service in the measurement year.

Numerator: ACO attributed members 0-20 years of age who received a comprehensive or periodic evaluation.

Denominator: Eligible ACO attributed members 0-20 years of age as of December 31 of the measurement year
Eligible Population

- **Age:** ACO attributed members 0-20 years as of December 31 of the measurement year.
- **Continuous Enrollment:** At least 180 continuous days during the measurement year.
- **Allowable Gap:** None during continuous enrollment period.
- **Anchor Date:** December 31 of the measurement year.
- **Event Diagnosis:** None.
- **Exclusions:** Members in Hospice (Hospice Value Set).
Administration Specification

**Denominator:** Eligible Population.

**Numerator:**
1. A comprehensive or periodic evaluation.
2. CDT Codes: D0120 or D0120 or D0145) billed as a dental service.
3. Rendering provider taxonomy code (NUCC).

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1223P0221X</td>
<td>124Q000000X*</td>
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<tr>
<td>1223PO106X</td>
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</tbody>
</table>

Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services. Services provided by independently practicing dental hygienists should be classified as “oral health” services and are not applicable for this measure.
Additional Information

NCQA HEDIS Measure ID: N/A

Disclaimer: Licenses

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• National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy codes ©2018 American Medical Association. All rights reserved.

Summary of Modifications: Defined as MassHealth members in the ACO
HEDIS Value Set Exclusion Criteria: Hospice Value Set (2018 version)
Transforming Care

• Expand ACO dental measure around outcomes vs process and access.
• Years 2 through 5 add additional codes to capture more evaluations to expand prevention and wellness measure.
• Capture data for all populations EPSDT, DDS and Adults.
• Expand rendering providers, PCP’s, Dental Therapist, and Public Health Dental hygienists providers.
The Past

University of Pennsylvania Dental Clinic 1915
Questions

Thank you


• Colla, C., et al., Dental Care within Accountable Care Organizations: Challenges and Opportunities. March 2016, American Dental Association in partnership with the Dartmouth Institute for Health Policy & Clinical Practice: Chicago, Il.

Dr. Jones currently serves as Dental Director for MassHealth, the Commonwealth of Massachusetts combined Medicaid/CHIP program. She is a Consultant with UMASS Medical school Commonwealth Medicine’s Center for Health Policy and Research, Office of Clinical Affairs unit. She is responsible for expert leadership, clinical guidance, policy, regulatory and technical support to Massachusetts Executive Office of Health and Human Service (EOHHS).

She received her dental degree from the University of Pennsylvania School of Dental Medicine in 1982, and holds a master’s degree in Community Public Health and Health Policy from Temple University. Her unique oral health perspective is a culmination of 36 years of work in private practice, serving as dental director for four large FQHC systems; rural central Alabama; the Mexican border town of Brownsville Texas; Urban Chester Pennsylvania and the farm belt of Southern New Jersey and four Insurance Plans; United Concordia, MetLife, United Healthcare Community Plans/AmeriChoice and now MassHealth.

Dr. Jones is an Assistant Professor at the University of Massachusetts Medical School in the Family Medicine and Community Health Dept. where she lectures medical and nurse practitioner students on Interprofessional oral and physical health linkages. She is an active member in many dental organizations, including MSDA where serves on the Board, philanthropies and global outreach programs.
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AWARD LUNCHEON and EXHIBITS

Luncheon Sponsored By avēsis
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