Integrating a Dental Caries Disease Management Model into Medicaid Programs

Presenters
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Webinar #1 - March 26, 2014 1:00 PM (ET)
Acknowledgement

• DentaQuest Institute
• Boston Children’s Hospital
• DentaQuest Foundation
Objectives

Participants will gain knowledge and understanding of:

• The DQI dental caries (Early Childhood Caries ECC) prevention and disease management (DM) clinical protocols;

• Administrative strategies that align Medicaid policies and financing with DM clinical protocols
<table>
<thead>
<tr>
<th><strong>Aims of Quality Improvement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe:</strong> Avoid injuries to patients from the care that is intended to help them.</td>
</tr>
<tr>
<td><strong>Effective:</strong> Match care to science; avoid overuse of ineffective care and underuse of effective care.</td>
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<td><strong>Patient-Centered:</strong> Honor the individual and respect choice.</td>
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<td><strong>Timely:</strong> Reduce waiting for both patients and those who give care.</td>
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<td><strong>Efficient:</strong> Reduce waste.</td>
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<td><strong>Equitable:</strong> Close racial and ethnic gaps in health status.</td>
</tr>
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</table>

*Crossing the Quality Chasm - IOM, 2001*
Quality Improvement

• The combined and unceasing efforts of everyone to make changes that will lead to better patient outcomes (health).
• The systematic, data-guided activities designed to bring about immediate improvements in health care delivery in particular settings.

Batalden PB, Davidoff F. What is “quality improvement” and how can it transform healthcare? Qual Saf Health Care. 2007 Feb
Early Childhood Caries Cost in Medicaid/CHIP

ECC Collaborative

Slide Courtesy of Rob Compton
DQI ECC
Problem Statement

• Dental caries is a preventable disease
• Hospital-based dental clinics care for a disproportionate number of children with ECC
• Surgical treatment takes place in operating room (OR)
• Months-long backlogs for OR care
• High incidence of decay reoccurrence
• High cost associated with use of OR
Other Pediatric Clinical Care Sites
Private Providers; FQHCs; Other Clinics

• ECC remains a problem

• Other clinicians also impact the need for the OR and Medicaid costs associated with the OR
  – Traditional care increases need for OR

• New ECC DM clinical protocols implement risk based care and lower need and costs associated with OR

• New ECC DM clinical protocols may be used in diverse clinical care sites
Medicaid and CHIP

2nd Problem Statement

“Systems of care, community, financing and policy are not aligned.”

• Most Medicaid and CHIP oral health benefits, policies and financing support traditional care

• Per beneficiary/per month (PB/PM) costs associated with TC are higher than DM care

• Increasing enrollment increases demand for care

• Increasing enrollment increases financial burden to states
What is the DQI ECC Disease Management Improvement Project and how is it improving oral health and care for young children?
ECC Disease Management
Quality Improvement Demonstration

Aim Statement
Over an 18 month period, caries will be managed and caries progression will be reduced in all children under 60 months of age who present with high risk for ECC.

Goals
• Reduce the percent of patients with new cavitation
• Reduce the percent of patients who are referred to the OR
• Reduce the percent of patients with pain

Slide Courtesy of Manwai Ng, DMD
Traditional Care Verses Risk-Based Care

• Traditional Care employs a surgical model
• Re-think dental caries as a chronic disease
• New DM model
  – Risk-based
  – Chronic disease management approach
• Systems level paradigm shift
• Fall 2013
• 30+ Provider Practices
• Phase III Aim Statement:
  – To spread the practices and protocols of disease management for early childhood caries including, risk assessment, risk-based recall, fluoride use, self-management goal setting, and restorative treatments we have successfully tested in diverse settings to reduce the percentage of new cavitations and OR treatment.
What is MSDA doing to support the DQI QI Project and ECC Disease Management?
MSDA & DQI Partnership

• Public-private partnership
• Shared Vision
  – Every child achieves optimal oral health, free from oral diseases, and practicing healthy behaviors that will be maintained as the child transitions into adulthood.
• Innovators, spreaders and adopters
Systems Approach
Two QI Arms

Two QI Learning Collaboratives

• Providers:
  – DQI ECC Phase III Learning Collaborative

• Payers/Administrators:
  – MSDA ECC State Teams Learning Collaborative
MSDA ECC DM Learning Collaborative State Medicaid Teams

- Kentucky
- South Dakota
- Virginia
- Texas

Other Ongoing ECC State Medicaid Efforts
- Pennsylvania
- Rhode Island

* State Team Liaison: Full-time staff support for each State Team
2014 MSDA Medicaid & CHIP ECC Learning Collaborative

Purpose:

• Develop and promote evidence-based Medicaid & CHIP best practices & policies through innovative collaboration with stakeholders

• Support CMS, CMCS Dental Team Priority: ECC DM

• Demonstrate systems alignment with DQI’s ECC Project & ECC Learning Collaborative and DM protocols

• Support CMS, CMMI HCIA Round 2 Priority
The Center for Medicare & Medicaid Innovation (CMMI)

- Affordable Care Act created the CMMI
- CMMI supports the development and testing of innovative health care service delivery (DQI) and payment models (MSDA)
- Health Care Innovation Awards (HCIA)
- Two rounds of funding opportunity announcements
HCIA Round 2:
Innovation Categories & Priority Areas for Funding

1. Models that are designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings

2. Models that improve care for populations with specialized needs
   * Priority Area – children at high risk for dental disease

3. Models that test approaches for specific types of providers to transform their financial and clinical models

4. Models that improve the health of populations
HCIA Round 2: Requirements for Payment Model

• Demonstrate payment & service delivery

• Establish detailed and fully developed payment model and a list of payers interested in testing the model
Primary Question

• How are we going to do this?
2014 Medicaid and CHIP Early Childhood Caries Learning Collaborative

- Establish Learning Collaborative for State Medicaid & CHIP Oral Health programs
- Establish State Medicaid Teams and Strategic Working Processes
State Medicaid Team Representatives

• Medicaid/CHIP Program
  – Dental program
  – Managed Care
  – IT managers
  – Project Supported State Liaison

• Contractors
  – MCOS
  – DBAs (dental plan administrators)
  – Others

• Providers and State Dental Association

• Others
Strategic Work Processes:
State and Collaborative Level Activities

• Independent State Team Meetings
• Coordination with MSDA and DQI Project
• Education and Training
  – Virtual Resource Center (DQI & MSDA)
  – Quarterly Distance Learning (webinars)
  – State-Based Team Trainings
• Ongoing Bi-monthly Teleconferences
  – Sharing Information
**MSDA Flow Chart for the Project Implementation, Monitoring & Operation**

**CLINICAL ARM**
DQI ECC Project Phase III Learning Collaborative

**DQI Has Clinical Sites**
*Dental Teams in 15+ States*
- Train up to 40 dental teams (40 clinical sites) in ECC protocol
- Up to 40 dental teams in diverse settings implement ECC service delivery model
- Measure protocol compliance using “balancing measures”
- Use quality improvement strategies to accelerate care delivery changes
- Review quality measures

**Systems Alignment**
*Care System:*
- ECC protocol is implemented
- Data is gathered & shared

*Community System:*
- Quality measurement for risk based disease management
- Community Integration

*Funding System:*
- Pay for performance
- Reimbursement for disease management procedures

*Policy System:*
- Dental coding usage
- Service frequency coverage based on caries risk level

**ADMINISTRATIVE ARM**
MSDA Center for QPF ECC DM Payment Model LC

**Test States**
*State Teams in 4 States*
- Train Medicaid/CHIP dental program staff, state liaison, systems/IT staff & state administration
- Prepare retrospective study, baseline data, predictive cost benefit models & pathways
- Establish/finalize State Team
- Educate/outreach to payers
- Tailor payment model to test state
- Test payment model
- Review quality measures
Take Home Message: “Return on Investment”

• Better oral health among beneficiaries
• Better oral health care
• Lowered Per Beneficiary/Per Month (PB/PM) costs
Driver Diagram Part 1: DQI ECC Service Delivery

Early Childhood Caries Phase III

Outcomes

- Improve Oral Health of Children 1-5
  - O1 Reduce % of pts with new caries
  - O2 Reduce % of pts complaining of pain
  - O3 - Reduce % of pts with OR Tx

Primary Drivers

- P1 - Practice QI infrastructure supports population management
- P2 - Reliable delivery of risk-based preventive & restorative care
- P3 - Engaged patients/families adequately manage their care

Secondary Drivers

- S1 System supports reporting QI measures
- S2 Practice staff has necessary QI skills and culture
- S3 Practice systems support more frequent recalls
- S4 Patients are screened for caries risk
- S5 Standard method for charting caries progression
- S6 Patients are recalled at risk-appropriate intervals
- S7 Treatment is conservative, based on a risk-based treatment plan
- S8 Care is organized around patient self-management goals
- S9 Patients / parents understand caries as a chronic disease

Changes

- Dentrix dummy codes; reports
- Recall visits – alternative scheduling schemes
- Non-office patient contact & coaching

M1 (O1a)
M2 (O1)
M3 (O2)
M4 (O3)
Driver Diagram Part 2: ECC DM Payment Model

Outcomes

- Improve the net-cost savings by 18% over the 3-Year period
- Increase # providers using CDT risk assessment codes to at least 30 by the end of year 1 of the project period
- Increase % providers who receive OR incentive payments
- Decrease the PB/PM cost by 33% over the 3-year project period
- At least 3 states will implement the ECC DM payment model by the end of the 3-year project period

Primary Drivers

- Sufficient program infrastructure and capacity
- Reliable data systems to support program monitoring
- Engaged providers actively monitoring their patient registries and adjusting patient care
- Engaged payers actively monitoring their claims data and adjusting program policies

Secondary Drivers

- System supports reporting QI measures
- Providers and payers have necessary QI skills and culture
- Standard method for payer measurement
- Routine input of standard data by providers
- Routine extract and analysis of data payer systems support risk appropriate services
- Payers are incentivized to improve program quality via shared savings with provider
- Providers are reimbursed for delivering DM services
- Providers are incentivized to deliver DM services via shared savings with payer

Changes

- CDT Risk assessment codes and reports
- IT logic to support DM schedule
- Communication plan between payer and provider
- Program training, TA and coaching in QI
What strategies can Medicaid and CHIP Oral Health Programs implement to support DM?
Strategy #1-DM Protocols

Strategy # 1: Increased preventive services payout

These preventive protocols will increase preventive costs for moderate and high risk children; however, these services will drive cost reductions in dental restorative care as well as costs associated with the outpatient operating room.
### Strategy #1-Additional DM Service and Associated Costs by Risk Status

<table>
<thead>
<tr>
<th>Total # Kids</th>
<th>Service Utilz.</th>
<th>Risk Level</th>
<th>Service</th>
<th>Unit Cost</th>
<th>TS Units of Care per Year</th>
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<th>Total ADD’L Costs By Risk Status</th>
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</table>
What is the potential impact of DM if implemented and supported by Medicaid and CHIP Oral Health Programs?
# Impact of ECC Disease Management on Non-OR Dental

<table>
<thead>
<tr>
<th>Mos.</th>
<th>BGH Cumulative Ppt Charges</th>
<th>Medicaid Pays 45% Percent</th>
<th>Gross Medicaid Paid</th>
<th>Incentive</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>TS</td>
<td>DM</td>
<td>Savings</td>
<td>TS</td>
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<tr>
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<td>$430</td>
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<tr>
<td>12</td>
<td>$2,561</td>
<td>$1,810</td>
<td>$751</td>
<td>$1,153</td>
</tr>
</tbody>
</table>

| Pt Ct: | 123 | 401 | 45% |

Net Savings: $101,661
# Impact of ECC Disease Management on Outpatient - OR

## Table 1. ECC Disease Management Impact on Operating Room Costs BCH
Boston Children’s Hospital (BCH) Operating Room Costs, Historical Control versus ECC DM Protocols

<table>
<thead>
<tr>
<th>Patient Count:</th>
<th>Historical Control</th>
<th>ECC DM Protocol</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to OR</td>
<td>20.90%</td>
<td>10.90%</td>
<td>48%</td>
</tr>
<tr>
<td>Patients</td>
<td>44</td>
<td>84</td>
<td>40</td>
</tr>
<tr>
<td>OR Medicaid Pay</td>
<td>$5,000</td>
<td>$5,000</td>
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<tr>
<td></td>
<td>$219,635</td>
<td>$419,045</td>
<td>$200,500</td>
</tr>
</tbody>
</table>

| Incentive: | 10% | $20,050 | $500 per patient kept out of OR |
| Net savings | $180,450 | $50 per ECC patient |

Fewer patients referred to OR

Reduction in Medicaid payment
How can Disease Management Reduce PB/PM Costs?
# Total Cost of Care Estimates

**Before**

**DM Savings**

PB/PM Medicaid and CHIP

<table>
<thead>
<tr>
<th>Service Categories</th>
<th>Baseline (BCH Outcomes)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital (OR)</td>
<td>$87</td>
<td>$89</td>
<td>$91</td>
<td>$92</td>
</tr>
<tr>
<td>Dental</td>
<td>$96</td>
<td>$98</td>
<td>$99</td>
<td>$101</td>
</tr>
<tr>
<td>Total</td>
<td>$183</td>
<td>$187</td>
<td>$190</td>
<td>$193</td>
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</tbody>
</table>

Based on BCH and DQI DM
**% Reduction** in Total Cost of Care Estimates Due to DM
PB/PM Medicaid and CHIP

<table>
<thead>
<tr>
<th>Service Categories</th>
<th>Baseline</th>
<th>Year 1 BCH Outcomes</th>
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<td>Outpatient Hospital (OR)</td>
<td></td>
<td>48%</td>
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<tr>
<td>Dental</td>
<td></td>
<td>29%</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td>Total % Reduction to Cost</td>
<td></td>
<td>38%</td>
<td>30.8%</td>
<td>32.8%</td>
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</table>

Based on BCH and DQI DM Protocol
## Total Cost of Care

**After DM Savings is Applied**

**PB/PM Medicaid and CHIP**

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<tr>
<td>Outpatient Hospital (OR)</td>
<td>$87</td>
<td>$46</td>
<td>$47</td>
<td>$48</td>
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<tr>
<td>Dental</td>
<td>$96</td>
<td>$70</td>
<td>$84</td>
<td>$82</td>
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<tr>
<td>Total</td>
<td>$183</td>
<td>$116</td>
<td>$131</td>
<td>$130</td>
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DQI and BCH ECC Phase 1
Strategy #2: Provider Performance Incentives ➔ Share the Wealth

• Performance incentives [$$], based solely on a percentage of achieved savings to Medicaid, to dental providers who implement DM clinical protocols and demonstrate quality improvement in dental care service delivery.
## Strategy #1—Additional DM Services and Associated Costs by Risk Status

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BCH and DQI DM Protocol
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<th>Mos.</th>
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<th>DM</th>
<th>Savings</th>
<th>TS</th>
<th>DM</th>
<th>Savings</th>
<th>TS</th>
<th>DM</th>
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<td>$1,810</td>
<td>$751</td>
<td>$1,153</td>
<td>$815</td>
<td>$338</td>
<td>$462,190</td>
<td>$326,642</td>
<td>$135,549</td>
<td>$84.51</td>
<td>$33,887</td>
</tr>
</tbody>
</table>

Net Savings: $101,661

Payment Model **Incentive for Outpatient Dental [Non-OR]**

Courtesy of DQI
### Payment Model Incentive for ECC Disease Management in OR

**Table 1. ECC Disease Management Impact on Operating Room Costs BCH**

Boston Children’s Hospital (BCH) Operating Room Costs, Historical Control versus ECC DM Protocols

<table>
<thead>
<tr>
<th>Patient Count:</th>
<th>129</th>
<th>401</th>
<th>401</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Historical Control</td>
<td>ECC DM Protocol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to OR</td>
<td>20.90%</td>
<td>10.90%</td>
<td>20.90%</td>
<td>48%</td>
</tr>
<tr>
<td>Patients</td>
<td>44</td>
<td>84</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>OR Medicaid Pay</td>
<td>$5,000</td>
<td>$5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$219,635</td>
<td>$419,045</td>
<td>$200,500</td>
<td>Reduction in Medicaid payment</td>
<td></td>
</tr>
<tr>
<td>Incentive:</td>
<td>10%</td>
<td></td>
<td>$20,050</td>
<td>$500 per patient kept out of OR</td>
</tr>
<tr>
<td>Net savings</td>
<td></td>
<td>$180,450</td>
<td>$50 per ECC patient</td>
<td></td>
</tr>
</tbody>
</table>
## Expenditures Before DM Model Savings Applied to Target Population

<table>
<thead>
<tr>
<th>Target Count</th>
<th>401</th>
<th>3,000</th>
<th>6,000</th>
<th>10,000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>4,812</td>
<td>36,000</td>
<td>72,000</td>
<td>120,000</td>
<td></td>
</tr>
<tr>
<td>Total PB/PM</td>
<td>$183</td>
<td>$187</td>
<td>$190</td>
<td>$193</td>
<td></td>
</tr>
<tr>
<td>Target Expenditure to be impacted</td>
<td>$880,596</td>
<td>$6,732,000</td>
<td>$13,680,000</td>
<td>$23,160,000</td>
<td>$43,572,000</td>
</tr>
</tbody>
</table>
Projected Savings **After** DM Model Applied

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>3 Yr. Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total % change</td>
<td>38%</td>
<td>30.8%</td>
<td>32.8%</td>
<td></td>
</tr>
<tr>
<td>Estimated PB/PM</td>
<td>$116</td>
<td>$131</td>
<td>$130</td>
<td></td>
</tr>
<tr>
<td>Estimated Total</td>
<td>$4,170,960</td>
<td>$9,465,840</td>
<td>$15,558,000</td>
<td>$29,294,800</td>
</tr>
</tbody>
</table>
# Total Cost of Care Savings (Project)

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Gross Cost of Care</td>
<td>$2,561,040</td>
<td>$4,214,160</td>
<td>$7,602,000</td>
<td>$14,377,200</td>
</tr>
<tr>
<td>Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aler actual program costs</td>
<td>$838,310</td>
<td>$2,139,915</td>
<td>$4,494,100</td>
<td>$7,472,325</td>
</tr>
<tr>
<td>Aler In-kind</td>
<td>$272,360</td>
<td>$1,573,965</td>
<td>$3,928,150</td>
<td>$5,774,475</td>
</tr>
</tbody>
</table>
QUESTION AND ANSWER

PLEASE USE THE CHAT TEXT BOX AT THE BOTTOM OF YOUR SCREEN TO TYPE IN YOUR QUESTIONS.
FOURTH ANNUAL MSDA SYMPOSIUM

“State Contracting: Improving Program Quality and Value”

Sunday-Tuesday, June 8nd-10th, 2014
Washington Marriott Wardman Park, Washington DC
CONTACT MSDA

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Telephone: 202-248-2315
mfoley@medicaiddental.org

www.medicaiddental.org
PLEASE STAY ON TO COMPLETE THE WEBINAR EVALUATION-

YOU WILL NOW BE REDIRECTED...
Mary E. Foley, RDH, MPH

Ms. Mary E. Foley is the Executive Director of the Medicaid-CHIP State Dental Association (MSDA). She is a licensed dental hygienist in Massachusetts; and holds a Masters Degree in Public Health with a concentration in Epidemiology and Biostatistics from the University of Massachusetts School of Public Health and Health Policy. Since joining the Medicaid-CHIP State Dental Association, Ms. Foley has been instrumental in broadening collaboration, convening a variety of federal, national and state Medicaid and CHIP stakeholders, and advancing state Medicaid and CHIP dental program policy and protocols by incorporating quality driven, program and performance improvement concepts into efforts aimed at building and promoting organizational and state Medicaid/CHIP dental program infrastructure and capacity.
Martha M. Dellapenna, RDH, MEd

Marty Dellapenna is the MSDA Center Director. In this role, Ms. Dellapenna provides oversight to the projects and activities of each the five divisions within the Center. She is the former Project Manager for the Rhode Island Oral Health Access Project. Ms. Dellapenna joined the RI Department of Human Services in the Center for Child and Family Health in 2003 through its project management contractor, Xerox. Ms. Dellapenna’s primary role at that time was to manage the development of RItote Smiles, the state’s first managed care dental program for young children. Ms. Dellapenna is also the current Chair of the Center for Medicare and Medicaid Services (CMS) Oral Health Technical Advisory Group.