CMS Learning Lab: Improving Oral Health Through Access

“Developing a State Action Plan Using State Data”

June 19, 2012
The Oral Health Action Plan and the Template

CMS Learning Lab: Improving Oral Health Through Access
Developing a State Action Plan Using State Data

June 19, 2012

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Goal #1 – Increase by 10 percentage points the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who receive a preventive dental service.

Goal #2 – Increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a dental sealant on a permanent molar.

Baseline year is FFY 2011. Goal year is FFY 2015.

CMS expects to set State-specific baselines by October 2012.
The Dental Action Plan

The purpose of this Action Plan: (1) to identify what activities States intend to undertake in order to achieve these dental goals, and (2) serve to assist States in their efforts to document their current activities and collaborations to improve access.

States are asked to:

- provide baseline information on existing programs
- identify access issues and barriers to care that they are currently facing

Improving Oral Health Through Access
Examine data. Is it accurate and complete?

Identify gaps or under-reporting

Examine data by demographics, geography, delivery system, provider mix, etc. for variations

Examine for potential causes of variation
Mining Data for Program Improvement

Use data to:
  Identify strategies for quality improvement
  Reduce administration barriers
  Target beneficiary education and outreach
  Nurture partnerships and collaborations
  Target reimbursement strategies

Implement strategies to improve use of services = Policies

Evaluation, follow-up, needed changes or improvements
The Dental Action Plan

Data specifics in the template

- Reimbursement rates – especially for preventive and diagnostic services
- Provider rates – dental and non-dental
- Comparison of 416 data vs. other datasets (e.g. HEDIS)
The Dental Action Plan

Lessons Learned

• What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe.

• If the activities did not achieve the results that you had expected, please describe the lessons learned.

Improving Oral Health Through Access
Technical Assistance from CMS
Maryland Healthy Smiles Dental Program

CMS Learning Lab: Improving Oral Health Through Access
Developing a State Action Plan Using State Data

June 19, 2012

Maryland Department of Health and Mental Hygiene

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Office of Planning

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Maryland Dental Program History

• Until 2007, seven Managed Care Organizations (MCOs) provided dental coverage

• Dental Action Committee (DAC) convened in June 2007 by former Maryland Health Secretary, with encouragement from Maryland Governor’s Office, providers, and community stakeholders
  • Committee requested several data measures to assess dental program
  • Committee issued seven recommendations in September 2007, based on assessments
Data Measures
Population Assessment

- Baseline: the population participating in HealthChoice, Maryland Medicaid’s managed care program
  - Children ages 0-20, divided into intervals
  - Pregnant women
  - Any time of enrollment and enrollment for at least 320 days of the year
- From the baseline, we determined:
  - % of HealthChoice recipients who saw a dentist at least once that year
  - % who received a preventive visit
  - % who received a restorative visit
  - % who visited the ER with a dental diagnosis
- Resulting data then classified by MCO, by region, by county, and by procedure code/dollars
Data Measures
Network Adequacy and Payment Rates

• Baseline: # of active and licensed dentists in Maryland in study year, divided by region and MCO
  • % of general dentists vs. pediatric dentists
  • % of dentists serving the HealthChoice population
  • % of HealthChoice dentists billing more than $10K per year

• Rates: How competitive were MD rates with other states?
  • Selected targeted procedure codes and compared rates with EPSDT Best Practices States
  • Compared rates with ADA recommended rates for the South Atlantic region, along with rates of other states
Program Administration

• Dentists had to be credentialed with each HealthChoice MCO to practice
• Dentists were surveyed about pros and cons of working with HealthChoice patients (missed appointments, MCO customer service, etc.)
Data Was Used to Make Program Changes

• Increased rates for 12 targeted dental procedure codes by about 94% on average in July 2008
• Implemented statewide dental ASO DentaQuest in July 2009 that streamlined credentialing, revamped customer service, and created a provider portal and missed appointment tracker
• Created a public health dental hygienist position in July 2009 to broaden access to routine procedures for HealthChoice recipients
• Developed a fluoride varnish program for children ages 0-3 using EPSDT well child care providers in July 2009
• Created new safety-net provider sites throughout the state over a three-year period (in partnership with dental schools and clinics)
• Unveiled a unified oral health educational program targeted to parents, providers, and policy makers in February 2012, located at http://healthyteethhealthykids.org
Maryland Children Receiving Dental Services

Ages 4-20, Enrolled for at Least 320 Days in Medicaid

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>% Receiving Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>43.9</td>
</tr>
<tr>
<td>2006</td>
<td>44</td>
</tr>
<tr>
<td>2007</td>
<td>49.3</td>
</tr>
<tr>
<td>2008</td>
<td>53.8</td>
</tr>
<tr>
<td>2009</td>
<td>60.5</td>
</tr>
<tr>
<td>2010</td>
<td>63.9</td>
</tr>
</tbody>
</table>

Source: The Hilltop Institute
Preventive/Diagnostic Visits Followed by Restorative Visits by Children Ages 0-20, Enrolled for Any Period

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Recipients</th>
<th>Preventive / Diagnostic Visit</th>
<th>Preventive / Diagnostic Visit followed by Restorative Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2005</td>
<td>483,304</td>
<td>136,183 (28.2%)</td>
<td>36,001 (26.4%)</td>
</tr>
<tr>
<td>CY 2006</td>
<td>491,646</td>
<td>137,826 (28.0%)</td>
<td>36,675 (26.6%)</td>
</tr>
<tr>
<td>CY 2007</td>
<td>493,375</td>
<td>155,939 (31.6%)</td>
<td>44,491 (28.5%)</td>
</tr>
<tr>
<td>CY 2008</td>
<td>505,339</td>
<td>179,268 (35.5%)</td>
<td>53,294 (29.7%)</td>
</tr>
<tr>
<td>CY 2009</td>
<td>540,173</td>
<td>230,442 (42.7%)</td>
<td>76,608 (33.2%)</td>
</tr>
<tr>
<td>CY 2010*</td>
<td>602,761</td>
<td>276,178 (45.8%)</td>
<td>94,517 (34.2%)</td>
</tr>
</tbody>
</table>

* CY 2010 measures children enrolled in managed care and FFS programs (full DentaQuest population); previous calendar years focus on managed care enrollment only

Source: The Hilltop Institute
## Dentists Participating in DentaQuest

<table>
<thead>
<tr>
<th>Regions</th>
<th>HealthChoice</th>
<th>DentaQuest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>July 2008</td>
<td>August 2009</td>
</tr>
<tr>
<td>Baltimore Metro</td>
<td>401</td>
<td>242</td>
</tr>
<tr>
<td>Montgomery / PG Counties</td>
<td>278</td>
<td>208</td>
</tr>
<tr>
<td>Southern Maryland</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Western Maryland</td>
<td>43</td>
<td>65</td>
</tr>
<tr>
<td>Eastern Shore</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>MD Bordering States</td>
<td>n/a</td>
<td>62</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>743</strong></td>
<td><strong>649</strong></td>
</tr>
</tbody>
</table>

Source: The Hilltop Institute
Maryland’s Next Steps

- **Program Evaluation**
  - Annual report to DAC and Legislature includes member participation and provider participation measurements, as well as updates on implementing the Maryland Oral Health Plan through 2015
  - Comparison of our data to other CMS Best Practices States, CMS-416 data, and national HEDIS averages
  - Maintaining partnerships with local health departments, dentist professional organizations, local universities, and community & advocacy groups

- **Maryland Dental Home Program**
  - Mission of Program
    - Increase use of preventive services
    - Improve continuity of care
    - Establish and improve relationships between members and providers
  - Goal is to institute dental homes statewide by the end of CY 2012
Lessons Learned

• Making reforms all at once is a challenge; but comprehensive approach attracts dentists

• Increasing reimbursement is important; but so are cutting bureaucratic burdens, educating the public about the importance of regular dental care, and rebranding the Medicaid program for providers and recipients

• State Medicaid agencies need champions to make headway in getting resources to carry out comprehensive dental improvement plans (In Maryland, our champion is the Dental Action Committee)

• Lessons will continue as Maryland implements its Oral Health Plan through 2015 and continues program evaluation
How Data Impacted Rhode Island Medicaid’s Dental Program Changes

June 19, 2012

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Director, Center for Medicaid and CHIP Oral Health Program Quality, Policy and Financing
Medicaid-CHIP State Dental Association
Rhode Island’s Impetus for Program Change

- Data analytics determined that children enrolled in RI Medicaid needed dental care access improvements
- Parent focus groups – determined dental care was number one unmet need for their children
- Robert Wood Johnson’s State Action for Oral Health Access (SAOHA) grant - funded numerous activities that led to systems change
- Challenge - to implement a new dental delivery system for young children in a budget neutral environment
The Development of RIte Smiles

- RIte Smiles is the State’s first Medicaid Dental Managed Care Delivery Model
- Currently enrolls approximately 59,000 children
- AUTHORITY= 1115 Demonstration Compact Global Services Waiver
- Program was implemented in 2006 for children born on or after May 1, 2000
- Single Risk-Based Program Administrator (Contractor) statewide
- Remainder of population born before May 1, 2000 remains enrolled in a traditional FFS delivery system
Data’s Role in Program Development Decisions

- MMIS dental utilization data informed initial development decisions for Rite Smiles
- Analyzed dental utilization data for all categories of care and trended over time
- Preventive care particularly low for children under age 6
- Began with youngest Medicaid enrollees from birth through age 5 and planned to “age in” to Rite Smiles one age cohort per year
Financial Forecasts

- Forecasts and projections were completed by both internal program and data analytics staff and external consultants
- Findings - children over age 6 had a higher utilization trend
- Program design and implementation decisions were made
- Actuarial assessment determines annual impact of children’s utilization as they age into the program
Reports - Rlte Smiles Program Data Highlights

- Managed care claims are linked with fee-for-service claims
- Both the total Medicaid population and the full time equivalent (FTE) managed care eligibles have been used as denominators for rate determinations
- Encounter rates for FQHCs are integrated into analyses
- Developed methods to identify ‘wrap-around’ payments to FQHCs in fee-for-service Medicaid to add dollars to managed care claims but not double-count the service
- Some reports use age groups: <2, 3-5, 6-8 and 9-10, while others group children into ages <4 and 4-6, etc.
- Dental service types are broadly categorized as preventive and treatment but are more specifically defined on reports generated more frequently
Rlite Smiles – Access Gains

• Between 2002 and 2010 in Rhode Island, there were gains in access to dental care among children under age 10 with Medicaid coverage, with the largest increases occurring since 2006, when Rlite Smiles began.

• 13 percent of children ages 2 and younger with Medicaid coverage received any dental care in 2010, marking a 597 percent improvement since 2002 and the first time that over 10 percent of this age cohort received dental care.

• Rlite Smiles marked the beginning of an upward trend in preventive dental services among children with Medicaid coverage, including a 33 percent increase in preventive visits between 2005 and 2007.

• From SFY07 to SFY08, the first and second year Rite Smiles began enrollment, there was a 35 percent increase in the percentage of children age 6 who received at least one dental sealant.

• Between 2002 and 2010, there was an 84 percent increase in the percentage of children ages 6 to 9 with Medicaid coverage who had at least one dental sealant, increasing from 1,905 children in 2002 to 3,504 children in 2010.
Conclusions Drawn Through Analysis

• Goals of improving access to care for children, increasing preventive service utilization and decreasing high cost restorative care have been met

• Participation rates have increased concurrent with RIte Smiles Program in all age groups

• Notable increases in magnitude among children ages 2 and under

• Participation rates among children ages 9-10 have reached 70 percent, which is comparable to commercial insurance rates

• Sharp increases in both Prevention and Treatment rates among all children ages 10 and under

• Dental Provider Participation improved significantly - from 27 actively participating dentists to 202 dentists as of 7/1/11, with the largest proportion in private practices
Program Analysis Using Data

- RIte Stats report will focus on treatment services and site of care
- Broader evaluation including distribution of providers, impact of pediatricians on access to dental care and cost
- Outcomes evaluation assessing long term results of adequate care


McQuade, W., et al. (2011). Assessing the impact of RI's managed oral health program (RIte Smiles) on access and utilization of dental care among Medicaid children ages 10 years and younger. Health by Numbers, 94(8), 247-249.