

Medicaid Value-Based Payment Approaches in Children's Oral Health National Learning Webinar October 19, 2017

Introduction

Mark Smith: You've joined a webinar sponsored by the Medicaid Innovation Accelerator Program (IAP) and it comes to you through the Children's Oral Health Initiative Value-Based Payment (VBP) Project.

We have three objectives today:

- We will summarize the importance of payment reform to children's oral health;
- We will describe Medicaid VBP approaches that states can use to improve children's oral health outcomes;
- We will provide some examples of Medicaid VBP approaches being used in the field of children's oral health.

(next slide) In our agenda, we will start with an overview of the Medicaid IAP and VBP webinar series. We will then move on to the importance of payment reform to children's oral health. Then, we will talk about specific Medicaid VBP approaches in children's oral health, including perspectives from the states of Oregon and Texas, and at the end we will have a list of resources.

(next slide) We have quite a few presenters today from IBM Watson Health, from CMS (Centers for Medicare & Medicaid Services), and from Oregon and Texas. Three of the speakers from Texas will be from MCNA Dental and DentaQuest.

(next slide) Now, Katherine Griffith of CMS.

Overview of Medicaid IAP and VBP Webinar Series

Katherine Griffith: I'm a senior advisor for the Medicaid IAP here at CMS. A quick background: on the next slide about the Medicaid IAP, many of you probably know we are a CMMI model that's based in CMCS, and we work very closely with CMMI to provide technical assistance to state Medicaid programs around delivery system reform. We're really focused on providing both one-on-one as well as national dissemination webinars such as this with topics around delivery system reform that range from things like substance use disorders, but also VBP and data analytics. We're not a grant program. We are purely focused on technical assistance.

(next slide) This is a series the IAP is putting on around VBP. Our first webinar was a few weeks ago on considerations of Medicaid VBP. Those will be posted on the Medicaid.gov IAP website and this webinar also. In the next few weeks, look out for the webinars on substance use disorders and maternal and infant health.

Importance of Payment Reform in Children's Oral Health

Mark Smith: We're going to start with a poll. *How familiar are you with VBP?* Options:

- I'm well-versed in VBP approaches;
- I'm aware of them but don't consider myself an expert;
- I'm new to VBP;
- I have only participated in the introductory webinar on October 5th called Medicaid IAP VBP Approaches and Key Design Considerations.

You can select more than one option. Just over half of the people are aware of it but not an expert, and about one-third say they're new to it. That represents 90% of the people who responded.

(next slide) What is tooth decay in children? We're thinking both of dental caries, the illness that causes cavities, and the cavities themselves. They are extremely common, unfortunately, five times more common than asthma. It comes from preventable causes like poor diet and lack of access to preventive care. Tooth repair, of course, is valuable because it relieves symptoms and restores function, but it itself does not stop dental caries.

(next slide) We find significant disparities by race, ethnicity, and income in the prevalence of untreated tooth decay in children. On the left side, we see figures by race and ethnicity. Among white children aged 5-9, 15% had untreated tooth decay in 2011-2012, but it was 24-25% for black and Hispanic children. Among younger children ages 2-5 in 2014, there was a 41% rate of untreated tooth decay among American Indian and Alaskan Native children. We see fairly similar statistics on the right by household income. Among children ages 5-9 and under 100% of the federal poverty level, 25% had untreated tooth decay in 2011-2012. The figure was a little lower for those up to 200% of the poverty level, and then in the 200-400% level, you see a substantial drop down to 15%.

(next slide) This graphic illustrates the famous Triple Aim, but as it is applied to children's oral health. The three elements are population health, cost, and patient experience. These are closely related. For example, for children not getting adequate care, you have a higher incidence of dental caries and maybe more significant dental work. That's poorer population health on the top. Moving down to the lower right, that's going to cost more, and probably, moving over to the left, they're going to have a worse experience because they need to have more visits, spend more time, and may experience pain if they have major work done. That's just one example of how these fit together.

(next slide) If you think about how dental care is reimbursed in this country, most of it is based on a fee-for-service (FFS) reimbursement system. You might delineate four levels of treatment. On the far left, we have the least expensive thing: preventive care, such as cleanings, topical fluoride, and sealants. Also relatively inexpensive are diagnostic procedures, like x-rays and intraoral occlusal films. Moving to the right, basic reparative care, like fillings and extractions, are somewhat more expensive. The most expensive are major procedures like crowns, bridges, and root canals. Naturally, if we're going to reduce the inflation in spending, that is, reduce the rate of growth in spending on dental care, we need to move as much care as we can to the left side of this.

Medicaid VBP Approaches in Children's Oral Health

We'll talk about some VBP approaches that are possible in children's oral health under the Medicaid program.

(next slide) This alternative payment model (APM) framework illustrates four categories of the relationship between payment, value, and quality. On the far left, Category 1, we have traditional FFS, where there's no link of quality to payment. In Category 2, we have the beginning elements of linking them, so you may have pay-for-reporting or pay-for-performance (P4P). In many areas of medicine, these have been going on for 10-20 years or more. In Category 3, you're getting to APMs that are built on a FFS architecture. So, for example, under subcategory B, you see upside and downside risk. An example of this would be a program in which there's a threshold for a certain group of patients. It's a dollar threshold for all their care for the year. If the provider on average stays below that threshold by a certain amount, the provider gets some shared savings. Conversely, if the provider's average is too far above that threshold, then there's a loss, a penalty. In Category 4, you get full population-based or capitated payments. What

you also find in Category 4 is integration; not only are dental care providers integrated with one another in networks, but they are also integrated with nondental providers.

(next slide) Here are some key elements one should think about when designing a VBP program:

- Which group of patients will it focus on;
- If it's an approach limited to certain services, like a bundled payment or episode-based payment, you must decide which services are include;
- How you are going to measure payment, such as financial performance, and quality;
- What measures will you use and what benchmarks will you start with to use as thresholds for judging against future events;
- How to attribute patients to providers, given that many patients see multiple providers in the same year;
- As I mentioned in the last slide, there's risk adjustment when you get into certain kinds of models so that providers are not averse to treating patients with the highest morbidity;
- Behind all this, there's typically a lot of data sharing decisions that must be made, such as that individual providers can share data with a centralized group.

(next slide) We can think about those in the context of this crystal ball graphic from the American Dental Association. In the lower left, thinking through the APM slide from two slides ago, you have the solo practice. Along the X axis, you have the size of the practice and along the Y axis, the level of integration. So, the lower portion is like APM Category 1: traditional FFS (solo practices, mostly surgical focus), so a focus on fixing things. What you want to do is move up towards the blue arrow to the right. As you move up, you get to dental practices, rather than solo practices, with a prevention focus. If you keep moving up, you get to dental ACOs [accountable care organizations]. Often, these are carve-out arrangements in insurance. Those have regional dental networks typically. Because it's a carve-out, typically there is financial risk, both upside and downside, so these are APMs. Finally, as you move further up to the right, you get full integration of dental providers with one another and with nondental providers, and global payment.

(next slide) This slide presents the same kind of information in a tabular form. As you go from Tier 1 to Tier 4, it's like going up and to the right on the crystal ball slide along that blue arrow. Level 1 is FFS with a surgical focus, no integration. Level 2 is FFS with a prevention focus and larger groups. You might have patient-centered dental homes and at least some amount of integration, such as facilitated referrals from non-oral care providers. When you get down to Tier 3, you're into APMs, so you may have a dental health carve-out. Typically, there are large regional networks of dentists and some amount of shared financing. But still, there is a separate delivery system from non-oral healthcare. Finally, Tier 4 is like the upper right in the crystal ball slide. You have shared financing, full integration with a non-oral healthcare system and healthcare ACOs, large, fully integrated dental delivery organizations.

(next slide) What are some steps you can take to move yourself either down the Tiers (1-4) or up to the right along that blue arrow?

- Engaging providers is tremendously important. It's been found time and time again in all sorts of areas of healthcare. Engage both clinical champions and frontline providers;
- You need to develop coordinated payment and care delivery systems;
- You need to choose quality measures;
- Use appropriate data architecture and elements. More generally, you need to take account of your IT system and what it's capable of doing. You might decide in the long-run to get a different

one that is more capable. As you're choosing quality measures and implementing this, you need to think about what is really feasible in terms of data and IT;

- Improving coordination between oral and medical health.

(next slide) Another poll question: *What challenges do you face with your current dental payment model?* You can give more than one answer.

1. Lack of access to oral health and/or dental providers;
2. Suboptimal use of services, such as too much reliance on emergency care versus preventive care;
3. A lack of implementation of evidence-based care;
4. A lack of integration and coordination between dental and medical providers;
5. Other.

About 90 have responded. Integration is clearly number one. Two-thirds of respondents chose integration or coordination or really the lack thereof. Almost half chose lack of access to oral healthcare or dental providers, and almost half chose suboptimal use of services. Three-eighths chose evidence-based practices or lack of implementation of this.

Questions or Comments?

Now you can ask questions. You can use the chat box as a way to talk about other things. About 14% of respondents chose “Other” as the answer and you can talk about that here. We have no questions so let’s continue.

State Perspectives: Oregon

We’re going to hear state perspectives from Oregon, then Texas.

(next slide) Our speakers from Oregon will be Amanda Peden and Sara Kleinschmit.

Amanda Peden: I'm from the Oregon Health Authority and am a policy analyst with Oregon. I'd like to give an overview of Oregon’s coordinated care model, which forms the basis for our performance incentive program, which Sara will speak about in more detail.

(next slide) Oregon’s Medicaid program, the Oregon Health Plan, primarily uses a network of managed care health plans, which we call coordinated care organizations, or CCOs. These provide integrated coordinated care to members. CCOs are networks of all types of healthcare providers—physical health providers, addiction and mental health, and dental care providers—who work together to serve Oregon Health Plan, our Medicaid program members, through implementing this coordinated care model. This slide shows a graphic of the key components of that coordinated care model.

The essential components include:

- Best practices, or otherwise evidence-based practices to manage and coordinate care;
- Transparency in price and quality, which helps to ensure accountability of a system and helps patients understand their plan and make choices about their care;
- Shared responsibility for health: the idea that providers, payers, and consumers need to work together to improve health;
- Performance measurement, including the importance of aligning under common measurement strategies and common goals to ease provider burden;
- Sustainable rate of growth or bending the cost curve, which is a vital component of this coordinated care model and one that strengthens all the other principles. For example, in Oregon’s Medicaid program, we aim to keep our cost increases at or below 3.4%;

- Pay for outcomes and health, or VBP, which is the most relevant for today's conversation. This element of the model is illustrated in a global budget for our CCOs and in a set of performance incentive metrics designed to improve quality.

(next slide) A coordinated care model can apply to any type of payer. The primary way that Oregon has implemented the coordinated care model so far is through our CCOs. This slide provides a high-level overview of the CCOs. Currently, we have 16 CCOs and they function similarly to ACOs. CCOs are responsible for physical, mental, and dental care, and are all managed under one global budget. Oregon health policymakers see the integration of oral, behavioral, and physical healthcare as central to the goal of providing whole person coordinated care and promoting health equity. Oral health was incorporated somewhat later than behavioral health into the model, but has been in the global budget since 2014. CCOs hold broad responsibility for the oral health needs of members of all ages in Oregon, so Oregon is one of about 15 states that offers comprehensive dental benefits to children and adults, including members of the Medicaid expansion population. That's part of the reason why it's so important to incorporate dental into CCOs.

A significant goal for Oregon under the coordinated care model has been to move away from FFS payment models. The CCOs operate under a global budget, which provides them additional flexibility in meeting member needs. Additionally, CCOs can earn extra quality incentive payments when they meet certain metrics, which is something we wanted to focus on particularly today. Finally, CCOs are encouraged to use APMs when reimbursing providers directly.

While the CCOs all work under the coordinated care model and work toward common goals, they are also designed as community-based entities with flexibility to serve the needs of their communities. They identify these needs primarily through community health assessments and community advisory councils, which include both Medicaid members and other community partners.

Oregon also assists with innovation and quality improvement for the CCOs through a state office at the Oregon Health Authority called the Transformation Center, and through regular quality meetings with the CCOs. One of the major tools to drive quality is a P4P program called the Performance Incentive Metrics Program. Sara will detail this program.

Sara Kleinschmit: I work at the Oregon Health Authority's Performance Incentive Metrics Program. I want to give a bit more detail about it. A portion of our CCO global budget—4.25% to be exact—is set up as P4P. CCOs can receive bonus payments from this quality pool to improve quality on a set of metrics, and currently there are 17 metrics. CCOs qualify by reaching or achieving progress toward the set of targets on each metric. In terms of the dollars on the line, and to put this in perspective, in 2016, this 4.25% equated to just under \$179 million, and that was spread across our 16 CCOs; that's a lot of money on the line.

Two of the 17 metrics included in the program are focused on oral health. The first looks at children between ages 6 and 14 who receive a sealant on a permanent molar. The second looks at whether children in foster care have received physical, mental, and dental health assessments. Why did we choose these two oral health-based metrics? For the sealant measure, it was a very well-vetted and tested metric by the Dental Quality Alliance (DQA). We also had a really robust program of dental sealants in schools in our state and wanted to expand that to our CCOs. In terms of the foster care metric, this metric was already in existence looking at physical and mental health assessments, so we really thought this would be a great way to build on that metric to incentivize integration of oral health.

(next slide) I'll get into performance now. This slide talks about how we perform on the dental sealants metric. We use standardized national metrics where possible but we do make changes as needed. For

example, this metric is based on the DQA metric, but the DQA focuses specifically on children with elevated caries risk. Risk coding in our state is not as extensive and it's not used uniformly. If we did that, we would have been eliminating a lot of children in our Medicaid program, so we don't make that exclusion. We look at all children between these ages in the state. So, just thinking about our incentive program and how we choose the metrics, sometimes we do have to change them from national standards.

In terms of performance, though, the proportion of children between 6 and 14 who received a dental sealant on a permanent molar in half a year has increased from 2014. Statewide performance surpassed our aspirational targeted benchmark in 2016. You can see in the slide on the right-hand side in darker blue, where it says 2016, that gray line shows the benchmark of 20%, and statewide performance got up to 21.5%; we have since increased that benchmark.

(next slide) This metric, Assessment of Children in DHHS Custody or Children in Foster Care, is really a success story for us. You can see here that performance has really, really increased across these two years. The other thing I will note on this is that it addresses different aspects of oral health; the first metric looks at dental sealants, and this metric looks at dental health assessments. Those are our two oral health metrics included in our quality incentive program.

Next slide. This is our contact information for additional questions.

State Perspectives: Texas

Mark Smith: Now, Texas Medicaid and CHIP efforts. We have Matthew Ferrara, the Texas Health and Human Services Commission, Shannon Turner, MCNA Dental, and Rebekah Mathews and James Burns from DentaQuest.

Matthew Ferrara: I want to talk about two programs we have in Medicaid/CHIP related to advancing quality and VBP. First is our dental P4P program. This is a program where we have a certain percentage of each DMO's (dental maintenance organization) capitation at risk from 1.5%. We're focused on four measures:

- DQA oral evaluation;
- DQA topical fluoride;
- DQA sealants for 6- to 9-year-olds;
- DQA sealants for 10- to 14-year-olds.

We're looking at those measures comprising our P4P program. Again, we have 1.5% of the capitation at risk. We're looking at focusing on improvement on those measures. Basically, this program is a redistributive model; a DMO could lose up to 1.5% of its capitation based on whether it's worsening in performance across these measures. We're looking at our first period of measurement for this program to be calendar year 2018. Calendar year 2016 will be our baseline period which we'll reference. If a DMO should worsen in performance—we look at performance for each metric (a certain percentage of capitation is attached to each metric) across the Medicaid and CHIP programs—and if there's a net loss in capitation across all those metrics across the programs, those dollars are available for the other DMO to claim if it should have a net positive across the measures across the programs. We're really looking at trying to drive improvement through a competitive model that redistributes dollars from one DMO to another.

If both DMOs improve in performance, then there's no dollars to be redistributed; if they both decline in performance, there's no dollars to be redistributed. You must have one that does better or has a net positive to avail themselves of the recoup dollars.

The second program we have is in our contract. We're trying to stimulate more value-based contracting both with our MCOs (managed care organizations) and our standalone DMOs. We've put some performance targets in our contract for the percentage of dollars paid to providers that should be governed by a VBP construct. For the DMOs we've established an overall target of 25% of provider payments to be governed by a VBP construct. Of that 25%, we have a subset of that being 2% of the dollars in that risk model. We're trying to push this forward. We're using the LAN framework referenced earlier in the slide deck as our framework for both our MCOs and DMOs. We're looking at trying to advance that over a period of four years to a 50% overall VBP target and a 10% at-risk purchasing target. Those are lofty goals; we'll see how we do. 2018 will be our first year of establishing the targets so we'll have to see what shakes out here. We do have an exception for meeting that target; if a DMO should not experience any recoupments under the P4P program—that program where the capitation is at risk—and it misses its target, we will waive any penalties associated with not fulfilling the target. So, those are the two programs we have in place for 2018 to try to stimulate this kind of activity.

Shannon Turner: I'm with MCNA Dental. I want to talk about our program we have had going for several years now. It's the Steller Treatment and Recognition Rewards Program.

Next slide. Our program is a VBP approach really based on a P4P model. It utilizes a FFS payment with a bonus amount based on performance. Qualifying main dental homes and primary care providers receive a bonus for providing timely preventive care. Texas has a very robust main dental home program, where not only are members assigned to a dental home provider, but payment is only available to that dental home provider. This is very different than the other dental home programs you see in Medicaid programs in other states. In those states, even though you're assigned and encouraged to see one provider, if you were to go to another provider, that provider would be compensated. In Texas, only the primary care provider that is your assigned main dental home is compensated through the structure that they've outlined. This has really lent itself to a robust P4P model.

We look at five main areas for awarding points to participating main dental home providers:

1. Exams and recall visits;
2. Fluoride;
3. Sealants;
4. First dental home visit;
5. Prophies.

On sealants, we also do a modified version of the DQA measure in that we exclude children who don't have any teeth eligible to be sealed, based on the periodicity associated with sealant, from the denominator. If you had sealant last year, obviously you're not eligible for them this year and you would be removed from the denominator.

First dental home visit is a construct also unique to Texas. It's billed as D0145 CDT code and includes examinations for children under 3 years of age. In Texas, that's already actually a bundled payment, which lends itself very well to VBP. It's a bundled payment that includes fluoride application, prophylaxis exam, oral hygiene instructions, and anticipatory guidance to the caregiver. It's really a great program in terms of getting kids off to a great start.

(next slide) Providers have to treat at least 150 MCNA members in their practice during the measurement year to qualify. That's how we utilize the program to encourage open panels, by having a qualifying number of members treated. The services we selected are key preventive services; by making sure that your assigned members get in for the five services we measure, we're really focused on making sure prevention is the focus. Unlike other bonus programs, we score in a tiered fashion based on the number

of assigned patients receiving the targeted services. So, it's not just an add-on payment (for example, if someone gets a sealant). It really is a tiered program where we look at all the members assigned to you and the rate of success you have with getting your entire book of assigned members in for the targeted preventive care services. Bonuses are not based purely on service volume, but on their member panel compliance with recommended services and periodicity protocols.

We believe that looking at this holistically rather than patient by patient is very useful because we want to ensure that patients all receiving their care in accordance with the AAPD (American Academy of Pediatric Dentistry) periodicity schedule.

(next slide) This is just one of the measures to show preventive dental visit growth in terms of outcomes data. These are the initial program years (in calendar years). These are the validated results by the state's EQRO (external quality review organization). We started in 2013 and saw very limited movement in 2014 after the first year of the program. We saw more of an uptick in 2015. So, what we've seen are more people getting that preventive dental visit. Overall rates have been very high for Medicaid programs; as you can see in our 2015 results, about 75% of all members assigned to MCNA (roughly 1.5 million), had a preventive dental visit, and 74% in the CHIP population had a preventive dental visit.

James Burns: Next slide. When we started with the P4P program with Texas Medicaid and CHIP in 2013, we've seen considerable increases in our quality metrics performance. We attribute this to primarily closely aligning the provider incentive to these P4P measures, having quarterly payments to them for this incentive, and communicating to them about their performance in a scorecard. Currently, the VBP arrangement, as Shannon and Matt had said, with Texas is a FFS preventative focus with incentives, with a dental home for each member.

(next slide) Further, we're seeing a smaller year-over-year increase in restorative services three years into the P4P program compared to considerably larger increases in preventative and diagnostic services. In the long-term, we believe we are turning this into a trend. This will help us achieve the oral health Triple Aim.

Rebekah Mathews: As DentaQuest has worked in assessing our approach to VBP, we quickly adopted the LAN APM framework and use its quantitative assessment specifications to define and measure our status. We see that within the P4P programs and other reimbursement arrangements in place within the state, we have healthy experience already in Categories 2 and 3 within the dental program. The P4P program is within Category 2, with FFS reimbursement going by that linkage to quality.

As Shannon mentioned, within the state, the payment approach for the first dental home initiative combines payment for a visit or series of services to be completed for a new patient evaluation within the CDT code for an early childhood oral evaluation. That makes a bundled payment arrangement that then qualifies within Category 3 of the framework.

(next slide) Looking ahead, and Matt alluded to this as well, HHSC has adopted specific goals to promote value and quality within its programs. Its specific focus on VBP is to increase focus on APMs and introduce risk-based population models for the dental program next year. As shown in my previous slide, DentaQuest will be introducing a capitation program within our program in Texas in 2018. The goals of this program are:

- To align with HHSC's overall focus on APM growth;
- To leverage the success in focusing on quality within the current P4P incentive program;
- To allow our provider partners to serve as care managers for their assigned members;
- To support the importance of prevention and individualized care as key components of a value-based approach.

In closing, P4P has been an important step in Texas's evolution to a value-based system by allowing all partners to focus on shared goals and improved access and prevention, and to give providers recognition for their successful efforts through incentive payments.

(next slide) This is the contact information for the Texas presenters.

Interviewer Questions and Next Steps

Mark Smith: Thank you. I'll ask a few questions and then the audience can ask questions. For both states, what are some challenges that you faced in implementing your model that you think might be instructive for other states that are considering a similar model? Oregon?

Sara Kleinschmit: I'll talk specifically about the incentive program. One challenge we've encountered is that the dental quality measurement field is emergent, so there are limited national measures of clear benchmarks for states to adopt. We crafted the two measures we showed you, and had to work to identify those benchmarks ourselves. So, having some national standard would be exceedingly helpful. We looked to the DQA for measures, but in some cases, we are looking to adopt our own specifically for Oregon. The foster care assessment metric is an example where we have done that.

Benchmarking is a challenge. In terms of the incentive measures program, those are two of the things we have found difficult in terms of trying to integrate oral health measures there.

Amanda Peden: In terms of integration overall of oral health into our CCO model, something that I think has been a challenge and a sign of progress for us over the years is figuring out how to work constructively to move from what was formerly a managed care system with a physical health MCO, a mental health MCO, and a dental health MCO into this integrated model. With dental, we have a very robust system of managed care dental care organizations we really wanted to integrate with CCOs. Because it's such a strong system already that has been operating for many years, we needed to figure out how to bring those stakeholders together, and do a lot of education. I think this has been happening and continues to happen both at the state level and on the ground to really integrate oral health into the CCOs; there is a lot of expertise in the physical health model. We continue to work towards that full integration and something that some of the measures, such as the oral health assessments for foster care that Sara mentioned, really help us to do in terms of a quality improvement strategy.

Mark Smith: Matthew?

Matthew Ferrara: When we talk about the P4P program where we have the dental MCOs and the percentage of capitation at risk, we have two contracted DMOs. That presents a challenge when you have a model that's designed for contractors to compete for performance and for others' capitation dollars. When you have two, it limits you to some degree, so that presents a challenge. At the next level where we have in the contract these contractual targets for value-based contracting, I think we're trying to stimulate activity in the risk-based contracting between DMOs and dental practices, but given that there are standalone DMOs, that does present somewhat of a challenge in terms of how they're going to enter into contracts (perhaps a capitation with a dental practice). It remains to be seen how much of a challenge that is, but having them as standalone DMOs presents a little bit of a challenge in that front.

Audience Questions or Comments?

Mark Smith: I'm going to follow up with an audience question. *Do the Texas MCOs have contracts with their own DMOs, and if so, are they required to include the at-risk contract arrangement?*

Matthew Ferrara: Under our contract, we have 20 medical MCOs. Dental is managed by the two contracted DMOs, not a separate contract from the medical MCOs.

Mark Smith: A question for either state: *Why provide a bonus for prophylaxis where there's no evidence of effectiveness for children?* Maybe the question is, *do you feel there's evidence of prophylaxis in young children?*

Shannon Turner: I do believe there is evidence of effectiveness, and it's one of the measures that the dentists who helped create the program feel very strongly about. Again, when we're looking at that and looking at it being coupled with anticipatory guidance for the caregiver, it has shown in Texas and in the First Dental Home initiative that it's been very effective. The University of Texas at San Antonio College of Dentistry has evidence showing that prior to the program being implemented, there were more hospital cases and more issues with very young children. Once the anticipatory guidance and fluoride were all tied into those exams for very young children, they saw a difference in siblings in the same family; prior to the program, an older sibling may have had to have a full mouth rehab in a hospital setting, while after implementation of the program, you weren't seeing that with the additional children in the family. It's also encouraged by the AAPD and is one of the key aspects of the periodicity schedule.

Mark Smith: One person asked: *How is risk assessment being used to drive appropriateness of care or increased frequency of targeted services for higher risk patients?* Another question gets to the financial aspects but also includes risk: *do you weight the member panel for each provider?* I'll go back to Oregon to address how risk assessment methods relate to appropriateness of care.

Amanda Peden: In terms of the measures we're using that I tried to address earlier, the DQA measure does include risk assessments, but it's an area in our state risk assessments that are not used either formally or extensively throughout the state. From the measurement perspective, it would have been very limiting for us to include that in the measures.

(In response to the second question) For us that would be different because our measures are at the CCO level, which you could think of more as the plan level.

Mark Smith: Back to Texas: *how would you characterize the distribution of dental practices along that tiered spectrum from 1-4, or the blue arrow from the lower left to the upper right?*

Rebekah Mathews: I think we still need a heavy volume that are FFS and a lot of experience due to HHSC's P4P program in the second category, but there's a mix in terms of the provider practice approach between individual practices and larger organizations that have numerous service locations. I think we're still at the lower end of the trajectory, but to me it's looking at how the model of care and the financing mechanisms move ahead to inform and to also complement how practice patterns are emerging as well.

Mark Smith: A question for Oregon: *how were foster care children identified, and does that include all of them, just those in foster care, others in child welfare, and so on, for the sake of setting measures in performance expectations?*

Sara Kleinschmit: The Oregon Health Authority works very closely with the Department of Human Services, which manages child welfare, and they have a reporting system. We work with them very closely to be able to identify the children who are in foster care. Then we use those reports to calculate our denominator.

Mark Smith: The measure that pertained to that, was it state-specific or a national measure that Oregon adopted?

Sara Kleinschmit: It is state-specific.

Amanda Peden: Oregon has a state requirement that in foster care, you get these oral health, physical health, and mental health assessments, so it's specific to our state that we're trying to incentivize that and make sure it's happening among the CCOs.

Mark Smith: Last question, for Texas: *by linking payment to a dental home, how do you address families who are constantly moving or homeless?*

Shannon Turner: When Texas structured the program, it looked at families that are constantly moving and homeless in that it's very simple for you to change your dental home. As a member, you're not locked into a dental home at any point in time, but you do have to affirmatively change it. You can do that by contacting customer service. Your provider is aware of the need for a dental home and he or she can help you facilitate that switch. We have seen a great deal of success with that. Members move; they're able to switch their dental home. The utilization you see in Texas on both the DQA and CMS 416 measures really show the benefits of the program as Texas, I believe, has been one of the top two plans for several years running since implementation of the main dental home program.

Mark Smith: Thank you.

Summary, Resources, and Conclusion

Here's a brief summary. As we've seen, implementing payment reform in state Medicaid agencies can influence health outcomes in terms of oral health. State Medicaid agencies like Oregon, Texas, and others have begun to successfully implement VBP approaches. It does require a significant amount of engagement and coordination efforts, as we've heard, but VBP really stands to improve population oral health and patient experience and reduce costs.

(next slide) These are some resources. We will be sending out materials from the webinar.

(next slide) We hope to see you at the following Medicaid IAP VBP webinars on October 26th and November 2nd. Please complete a short feedback survey. Thank you.

[end of recording]