The Landscape is Changing: Be Prepared
High Points in the History of Dental Care

- Stomatology
- Baltimore College of Dental Surgery
- Cottage Industry
- Flexnor Report
  1965!
- The “Busyness” Problem
- Doc in a Box
- 29 CFR 1910
- Shortage or Maldistribution
- Medical-Dental / Dental-Medical Collaboration
- The Patient Protection and Affordable Care Act
- Program Integrity
- C. U. B. A
- ACOs
Centers for Medicare & Medicaid Services
CMS

- Center for Medicare
- Center for Clinical Standards and Quality
- Center for Medicare and Medicaid Innovation
- Center for Medicaid and CHIP Services
- Center for Program Integrity
- Center for Consumer Information and Insurance Oversight
CMS Mission

- CMS aims to be a major force and a trustworthy partner for the improvement of health and health care for all Americans
- The Center for Medicaid and CHIP Services (CMCS) carries this mission forward with a particular emphasis on making Medicaid and CHIP the best programs they can be
- Beneficiaries are our focus
- Partnerships are critical to success
The Three Goals (aka the Triple Aim)

Better Care, Better Health, Lower Costs
The Three Goals (aka the Triple Aim)

Dentists – and all health care providers – have but one Aim: Doing the best for their patients

But we must all think about the big picture
“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”
Medicaid: A Federal/State Partnership

Federal
- Statutory and regulatory requirements
- Matching funds (50% - 76%)
- Approvals of State plans and waivers
- Oversight

State
- Determine who is eligible
- Determine scope of “optional” services
- Determine delivery system
- Overall administration / claims payment
- Set payment rates

Medicaid and CHIP
Scope of Dental Coverage

- **MEDICAID** – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requires all medically necessary dental care.
  - No “hard” limits allowed; only “soft” limits supported by prior authorization
  - No cost sharing

- **CHIP** – dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
  - Annual benefit maximums allowed with prior authorization for additional medically necessary care
  - Limited cost sharing allowed
  (new CHIPRA dental regulations are under development)
Our First Look at the ACA

MEDICAID

• Expansion (at least in some states)
  • Funding
  • “Essential health benefits”
The Future of CHIP

Current Authorization ends 2017
CMS Oral Health Strategy

- State oral health action plans
- Learning collaboratives
- Outreach to providers
- Outreach to beneficiaries
- Partner with other HHS agencies

The CMS Oral Health Strategy is available at:
- [http://www.cms.gov/MedicaidDentalCoverage/Downloads/5_CMSDentalStrategy04112011.pdf](http://www.cms.gov/MedicaidDentalCoverage/Downloads/5_CMSDentalStrategy04112011.pdf)
Measuring Progress: the CMS-416
(similar measures are in CARTS for separate CHIP programs)

Total number of children (enrolled for at least 90 days) receiving:
(each line represents an unduplicated count of children)

- Line 12a – any dental service (by or under the supervision of a dentist)
- Line 12b – a preventive dental service
- Line 12c – a dental treatment service
- Line 12d – a sealant on a permanent molar tooth
- Line 12e – a dental diagnostic service
- Line 12f – an oral health service provided by a non-dentist (and not under the supervision of a dentist)
- Line 12g – any dental or oral health service (12a+12f)

[By CMS definition, “dental” and “oral health” services are different by provider]
CMS Oral Health Initiative - Goals

- 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 sealant on a permanent molar tooth.

The initial CMS Oral Health Initiative formally ended yesterday, but CMS continues to work with states on improving access.
Use of Any Dental Services Improved Even While Enrollment Increased

- **2000:** 27% of 23 million
- **2009:** 40% of 34 million

Total Eligibles Receiving Any Dental Services (Line 12a): Green
Total Eligibles Not Receiving Any Dental Service: Red

Percentage of children, age 1-20, enrolled in Medicaid for at least 90 days who received any preventive dental service, FFY 2013 (12b)

Source: FFY 2013 CMS-416 reports, Line 1b, 12b
Note: Data reflects updates as of 10/22/14.
Percentage of children, age 6-9, enrolled in Medicaid for at least 90 days who received a sealant on a permanent molar, FFY 2013 (12d)

Source: FFY 2013 CMS-416 reports, Line 1b, 12d
Note: Data reflects updates as of 10/22/14.
Percentage of children, age 1-20, enrolled in Medicaid for at least 90 days who received oral health services by a non-dentist provider, FFY 2013 (12f)

Source: FFY 2013 CMS-416 reports, Line 1b, 12f
Note: Data reflects updates as of 10/22/14.
Top 10 States with a 10 Percentage Point or Greater Increase in Preventive Dental Services
Percentage of Medicaid-enrolled children, age 1-20, who received a preventive dental service FY 2007-FY 2011

Source: FY 2000-2011 CMS-416 reports, Line 1, Line 1b, 12b. Note: FY 2011 data for Idaho, Kentucky and Ohio are not yet available. Estimates for these states are included in the National figure for FY 2011, but they are otherwise excluded from this analysis.
State Oral Health Action Plans (SOHAPs)

Not “State Plans”

i.e. those from dental public health

Action Plans can identify activities States will undertake in order to achieve the dental goals

26 State Oral Health Action Plans, as of 9/1/15

OHI Contract Assistance / MSDA Assistance
Workforce

• CMS is NOT a barrier to an expanded workforce
• CDT “pre-diagnostic services” (effective January 1, 2013)
  – D0190 – “screening of a patient”
    • to determine an individual’s need to be seen by a dentist for diagnosis
  – D0191 – “assessment of a patient:
    • to identify possible signs of oral or systemic disease, malformation or injury, and the potential need for referral for diagnosis and treatment
The CDT

Starting 1/1/2014

• D0601 = Risk assessment – high risk
• D0602 = Risk assessment – moderate risk
• D0603 = Risk assessment – low risk

“Case Management”

• To be proposed again in 2016
Quality Improvement
CMS Learning Labs – “Increasing Oral Health Through Access”

- “Developing State Oral Health Action Plans Using State Data”
- “Successful Beneficiary Outreach Strategies”
- “Quality Improvement Processes”
- “Access to Baby & Child Dentistry”
- “Dental Sealants: An Effective State Strategy to Prevent Dental Caries in Children”
- Sustainable Oral Health Care Delivery Models in Schools and Community-Based Settings
- Building a Partnership Between Medicaid and Head Start
- Program Integrity at the Federal, State and Provider levels
CMS Learning Labs – “Increasing Oral Health Through Access”

• Recordings and transcripts can be accessed on Medicaid.gov: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html.

• To be added to the invitation list for the CMS Learning Lab webinars, send an email to MACQualityTA@cms.hhs.gov.
The Dental Quality Alliance
Lack of standardized, validated dental quality measures

“Oral health lags significantly behind the remainder of the health care system in developing quality measures, and as a result, little is known about the quality of oral health care.”

IOM Report: Advancing Oral Health In America, Key Findings and Conclusions

“Many complex and interrelated factors contribute to poor oral health and lack of access to oral health care, including . . . a lack of quality measures by which to evaluate and improve oral health care.”

In 2008, the Centers for Medicare & Medicaid Services (CMS) conducted 16 State dental reviews to obtain information on dental services provided to Medicaid beneficiaries to further enhance national initiatives to improve oral health care in the United States.
CMS is interested in forming a Dental Quality Alliance (DQA) and is currently in discussion with the American Dental Association (ADA) to begin this process. The DQA would bring together parties from many aspects of oral health fields including national dental organizations, Federal and State partners, payers and consumers to begin working together on measurements that could be used by State for purposes of improving the delivery of oral health services and the development of quality measures. These measures could ultimately be used to enhance reporting on the CMS form 416 or through state-based value based purchasing initiatives. While children eligible for Medicaid will be the primary area of concern, the DQA will also address dental services for the adult population.


http://www.hhs.gov/asl/testify/2008/09/t20080923b.html
Dental Quality Alliance Timeline

2008
- DQA Proposed by CMS

2009
- Formation of Steering Committee

2010
- 1st DQA Meeting

2013
- 1st Fully Tested Comprehensive Measure Set

2014
- DQA measures endorsed by the NQF
- Additional Measure Development in both Adult and Pediatric Populations
**DQA Mission**
Advance the field of performance measurement to improve oral health, patient care, and safety through a consensus building process.
DQA Measures

- Use of Services
- Oral Evaluation
- Topical Fluoride for Children at Elevated Caries Risk
- Sealant use in 6-9 years
- Sealant use in 10-14 years
- Ambulatory Care (ED visit for caries-related reason)
- Follow-Up After ED Visit
CMS is encouraging 25+ states to use the SEAL measure by 2017

TDENT is history
Diagnosis Codes?!?
Media Scrutiny on Quality in Dentistry

The New York Times
Program Integrity
Program Integrity: more from the ACA

RACs

• Why do we have them?
• How do they work?
• Is more than audits!
• Should be important to all dentists
• Is already important to all payers
• The other players
Fraud, Waste and Abuse
“Plans are seen to concentrate on extraction of revenue”

“Every system is gamed.”

CMS Grand Rounds
September 1, 2015
The seven elements of a compliance program can be summarized as:

1. Written policies
2. Designation of compliance officer/contact(s)
3. Training
4. Communication
5. Monitoring
6. Enforcing disciplinary standards
7. Responding promptly
Small Smiles owner excluded from Medicare, Medicaid programs
By Donna Domino, Features Editor

March 12, 2014 — CSHM, which owns 53 Small Smiles dental clinics in 19 states and the District of Columbia, has been excluded from participation in the Medicaid and Medicare programs for a minimum of five years by the U.S. Department of Health and Human Services (HHS).

The exclusion follows a recommendation by a U.S. Senate committee that the Small Smiles chain should be excluded from the Medicaid program for encouraging dentists to perform unnecessary treatments to boost profits.

The March 7 exclusion letter sent from the HHS’ Office of Inspector General (OIG) and signed by Robert DeConti, the assistant inspector general for legal affairs, cited CSHM for failing to cure several breaches of the Corporate Integrity Agreement (CIA) between CSHM and the OIG. The letter was addressed to CSHM’s chief compliance officer.

CSHM officials did not return calls for comment.

The violations in the exclusion letter include the following:

- Failure to file quality of care reportable events at an Oklahoma Smiles Dental Center in Tulsa, OK, and a Small Smiles center in Mattapan, MA.
- Failure to maintain disclosure logs at Oklahoma Smiles that were supposed to include a patient’s quality of care reportable event, also failure include the chief dental officer’s October 22, 2013, disclosure to the chief compliance officer about the incident.
- Failure to implement policies to inform patients, parents, and guardians when a substantiated incident of patient harm occurs.
- Failure to have the chief dental officer, regional dentist, or chief compliance officer participate in compliance review visits at CSHM facilities.
- Failure to perform annual general training in the third reporting period.
- Failure to comply with compliance officer certification: On March, 14, 2013, CSHM submitted a false certification by the chief compliance officer with its third annual report to the OIG, the exclusion letter stated.
Office of Inspector General (DHHS)

“Questionable Billing for Medicaid Pediatric Dental Services…”
(NY, IN, LA, CA)

“Required Dental Services”
Where is all this going?
“Dental care is important to the overall patient-centered, quality care”

“Medical and dental care providers will still be able to practice high quality care for their patients utilizing alternative payment models.”

“While CMS didn’t specifically carve dentist in or out of new service models, dentists still play an important role in today’s changing health systems.”

“Dental care is important to quality of life for all beneficiaries.”

Patrick Conway, M.D., M.Sc.
CMS Acting Principal Deputy Administrator and
CMS Chief Medical Officer
Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information.

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
In Many Ways …

Medicare often drives the conversation
Medicare Medical Needs vs. Dental Needs

• 50 / 5

• 30 / 1

• Compared to 80 / 25
Medicare

• 10,000 / day
• Parts A, B, C, D
• Dual-eligibles
• Will there ever be a dental benefit?
  – Section 1862
  – Funding
  – Workforce
  – Need vs. demand
During January 2015, HHS announced goals for value-based payments within the Medicare FFS system.

**Medicare Fee-for-Service**

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.

**NEXT STEPS:**
Testing of new models and expansion of existing models will be critical to reaching incentive goals.

Creation of a Health Care Payment Learning and Action Network to align incentives for payers.

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

Set internal goals for HHS
Invite private sector payers to match or exceed HHS goals
CMS has adopted a framework that categorizes payment to providers

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Value</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare examples</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality and/or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
</tr>
<tr>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Accountable care organization</td>
<td>Eligible Pioneer accountable care organizations in years 3-5</td>
<td></td>
</tr>
<tr>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value-Based Modifier</td>
<td>Medical homes</td>
<td>Maryland hospitals</td>
<td></td>
</tr>
<tr>
<td>Readmissions / Hospital Acquired Conditions Reduction Program</td>
<td>Bundled payments</td>
<td>Comprehensive primary Care initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive ESRD</td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- 424 ACOs
- 7.8 million assigned beneficiaries

Source: JAMA. Published online May 04, 2015. doi:10.1001/jama.2015.4930; D. Nyweide, L. Woolton, T. Cuerdon, H. Pham; M. Cox; R. Rajkumar; P. Conway; Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience
Back to Medicaid – How CMS helps states
CMS offers a variety of supports to states to help them achieve their Oral Health Initiative goals.

- Featuring four overarching approaches and more than a dozen strategies with concrete state examples to demonstrate how improvement can be achieved. [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf)
CMS offers a variety of supports to states to help them achieve their Oral Health Initiative goals.

CMS has created “Think Teeth!” a set of free oral health education materials, targeted to parents, caregivers and pregnant women, available for bulk order. Find out more on the Insure Kids Now website:

CMS offers a variety of supports to states to help them achieve their Oral Health Initiative goals - 3

• The Oral Health Technical Advisory Group (OTAG) -- an opportunity for states to advise CMS on oral health policy questions, to hear about updates from CMS, to discuss emerging issues with their peers in other states, and to learn about new developments in oral health policy and financing generally.

CMS offers a variety of supports to states to help them achieve their Oral Health Initiative goals - 4

• The dental provider locator tool available on the Insure Kids Now (IKN) website

• The CHCS Oral Health Learning Collaborative - helping states achieve the CMS Oral Health Initiative goals.
  http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1261481
More Help

Some State Medicaid manuals are REALLY old

CMS can help review and offer suggestions to update manuals
Early Childhood Caries

- The presence of one or more decayed, missing (due to caries), or filled tooth surfaces in any primary tooth in a child under the age of six
- 80% of the disease is in 25% of the children
- Children < age 6 in low-income families are 2.5 times more likely to have untreated caries
Early Childhood Caries

• Barriers to success:
  – Low utilization rates
  – Inflexible implementation of dental periodicity schedules
  – Paying for volume rather than value
Low Utilization Rates

• In FY 2014, only
  – 43.3% of Medicaid-enrolled children ages 1-5 received at least one preventive dental service from a dental provider
  – 3.0% of Medicaid-enrolled children ages 1-5 received a preventive oral health service from a medical provider
Dental Periodicity Schedules

• AAPD pediatric dental periodicity schedule

• EPSDT (the Medicaid benefit for children)
  – Prevention-oriented
  – Individualized care
  – All medically necessary care
Paying for Value

- Changing what we pay for and how we pay for it
- Linking payment to quality improvement and health outcomes
Reducing Early Childhood Tooth Decay

• Reducing Early Childhood Tooth Decay
• Primer: An Overview for State Policymakers
• Leading Steps for State Policy Makers
• Strategies for State Medicaid and CHIP Dental Program Managers

Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
Performance Improvement Projects

- PIP Toolkit
- PIP Learning Collaborative
Contracting Toolkit

Late 2015
The CMS Vision for Quality and Accountability

• Dental care for children should meet high levels of professional quality and accountability regardless of the setting in which care is obtained.

• Develop standardized metrics for use across all delivery sources that ensure appropriate, comprehensive, and effective dental care while identifying and eliminating waste, fraud, and abuse.

• Every child has ready access to evidence-based prevention and disease management strategies, and if those fail can get the right treatment at the right time in the right place.
Final Thoughts on Opportunities for Payers

- Graying of America (“10,000!”)
- Longer lives with more teeth
- Greater understanding that health doesn’t end at the hyoid bone
- 2015 White House Conference on Aging

“Payment reform typically lags behind delivery system innovations.”
QUESTIONS
Centers for Medicare & Medicaid Services (CMS)

For More Information

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