VERMONT DENTAL LANDSCAPE

Policy Implications for Oral Health Care Payment Reform

Craig Stevens, MPH
JSI Research and Training Institute, Inc.

Charlie Hofmann
Stone Environmental Inc.

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METHODOLOGY

- Convene local advisory committee
- Literature and secondary source review
  - Evidence base
  - Story Mapping of Vermont data
- Identify priority policy areas
  - Participation and Utilization
  - Workforce
  - Quality
  - Medical/Dental Collaboration
  - Essential Benefits
- Interviews with national experts
- Develop financial impact projections

OVERARCHING ISSUES

- Medicaid Dental Director
- Focus on oral health in GMCB committees and planning
  - Meaningful engagement of VT stakeholders in furthering the results of this study
  - Convening oral health stakeholders to oversee and support pilot studies
- Allocate additional resources to oral health
  - Investments now may reduce the rate of spending growth but do not expect savings
- Policy initiatives are interdependent

FINANCIAL SUMMARY

New Expenditures

- $13,821,600 – reimbursement
- $300,000 – workforce
- $150,000 – Quality
- $270,000 – Med/Dental
- $120,000 – Medicaid Dental Director
- Total = $14,661,600

Potential Savings/Shifts

- WIC/PHDH – $1,200,000
- General Assistance Fund - $1,500,000
- Total = $2,700,000

DENTAL LANDSCAPE

Dental Landscape Web Maps

INCREASE DENTIST PARTICIPATION

- Medicaid participation and resulting utilization is low as compared to private pay
- Dentists cite two major reasons for lower participation:
  - Reimbursement rates
  - Missed appointments (see Workforce section)
- Reimbursement
  - Overhead of cottage industry high
  - State experiences of increasing rates to 75% of commercial show increased participation and resulting utilization
  - Weighting specific procedures, age groups and specialties which promote prevention and address specific access gaps

INCREASE DENTIST PARTICIPATION

Table 1. State Dental Reforms in Medicaid and Their Effects on Service Use and Provider Participation

	PERCENTAGE OF ENROLLED CHILDREN USING SERVICES				ENROLLED PROVIDERS			
STATE	INITIAL YEAR OF REFORM (YEAR)	TWO YEARS AFTER REFORM	FISCAL YEAR 2006	PERCENT INCREASE	PRIOR TO REFORM (YEAR)	TWO YEARS AFTER REFORM	MOST RECENT (YEAR)	PERCENT INCREASE
Alabama	21% (2000)	28%	37%	76%	441 (2000)	586	778 (2007)	76%
Michigan	21% (2000)	29%	30%	43%	769 (2000)	1624	1926 (2005)	150%
South Carolina	28% (2000)	35%	43%	54%	619 (2000)	886	1197 (2006)	93%
Tennessee	26% (2002)	36%	36%	38%	386 (2002)	700	817 (2005)	112%
Virginia	24% (2005)	—	32%	33%	620 (2005)	—	1007 (2007)	62%

While evidence shows increased reimbursement results in increased participation and utilization we cannot predict provider participation.

FINANCIAL IMPACT INCREASED MEDICAID REIMBURSEMENT

- Current Budget
  - $21,264,000/$8,505,600
- Projected budget at 75% of commercial (50% increase)
  - $31,896,000/$12,758,400
- Projected budget:
  - 25% increased utilization
    - $39,870,000/$15,948,000
  - 50% increased utilization
    - $47,844,000/$19,137,600
  - 75% increased utilization
    - $55,818,000/$22,327,200

WORKFORCE

- Increasing demand for oral health services
- 68% of primary care dentists are accepting 5 or more new non-Medicaid patients per month, 29% are accepting 5 or more new Medicaid patients per month
- Significant oral health gaps for special populations e.g. over 65
- Aging dentist population
  - In 2011 49% of primary care dentists were over the age of 55
- Will public health programs be able to reduce demand?
  - CWF, education, etc.
  - CBOE Analysis: 125,000 Medicaid eligibles, 50% utilizing services. Public health programs eliminate 100% of need for those utilizing services, demand is still the same (other 50%), dentist population shrinking. We need to replace those retiring and reducing hours AND increase workforce FTE in order to improve access.

WORKFORCE MODELS

Factors to consider include:

- Education and training requirements and state capacity
- Local need
- Political culture
- Financial viability
- Safety and quality

ALASKA MODEL

Dental Health Aide Therapist

- High school graduate
- 18 month training program
- Primary Role: Expanded Scope of preventive and limited restorative
- Didactic and clinical training
- Design to train from the community, return to the community
- After graduation initial work site is supervised
- Remote supervision
- No educational capacity within VT at this time, none anticipated

ADA MODEL

Community Dental Health Coordinator

- High school graduate
- 18 month education program
- Primary role includes: care coordination, education and prevention
- Limited Clinical Scope
- Significant on-line didactic education available
- Additional clinical training capacity does not exist and not planned in VT

VERMONT MODEL

- Vermont– Licensed Dental Practitioner (VT) – Similar to Minnesota's Advanced Dental Therapist Model
- Education
  - Must be a Registered Dental Hygienist (RDH)
  - One full year (3 semesters; 48 credits) of didactic and clinical education and will earn a Bachelor's degree
- Scope of practice
  - Will work with a collaborative agreement with a licensed dentist
  - All dental hygiene preventive services as well as restorative services
- Vermont Technical College is prepared to gain capacity to offer program

EXISTING WORKFORCE

Utilizing existing workforce to its maximum

- Expanded Function Dental Assistants (EFDAs)
  - Higher scope of practice than Dental Assistant, lower than Dental Hygienist
  - EFDA penetration in the state is relatively limited
- Public Health Dental Hygienists
  - Operate under general supervision vs direct
  - Public Health Dental Hygienists used in two WIC clinics but could be expanded significantly

WORKFORCE REVIEW

- Education and training capacity (or planned)
  - Alaska – no capacity, none planned
  - ADA – online capacity, no clinical planned
  - Vermont/Minnesota – Dental Hygiene exists, expansion planned
- Local need
  - ADA – case management and missed appointments
  - Alaska and Vermont – higher scope of clinical practice for restorative and preventive care
- Political culture – mixed

WORKFORCE REVIEW

- Financial viability – study of 5 state reimbursement structures
  - Alaska – yes
  - ADA – yes
  - Vermont/Minnesota – study reviewed the 6 year Minnesota model which incurs higher educational debt and results in higher salaried profession, needs to be analyzed under Vermont proposal and reimbursement structure.

- Safety and Quality
  - Alaska – confirmed
  - ADA – study in process, results complete in next 6-12 months
  - Vermont/Minnesota – confirmed

WORKFORCE FINANCIAL IMPACT

- No impact for State unless choose to incentivize development of workforce
  - Additional loan repayment and scholarships to Vermont residents
    - $50,000
  - Grants to build capacity and infrastructure within dental practices
    - $200,000
  - Financial analysis under Vermont private and public payment structures
    - $50,000
- Primarily students and education and training institutions carry the burden of financial risk
  - Consider a regional approach

QUALITY AND PAYMENT

- Quality in oral health care is thought of from the perspective of procedural quality vs outcomes
  - One procedure vs 5 procedures = no real differences in outcomes
- Oral health spending is increasing faster (%) than over all health spending yet we don't have expectations for what we purchase in terms of outcomes
- Systems of care and payment are not designed to promote outcomes
- There is not agreement on oral health quality measures on a national level
- Capitation and managed care curb costs but don't change ER utilization in medicine, assume the same for oral health

QUALITY AND PAYMENT

Where to start if Vermont is ahead of the curve?

Small Scale Pilot Project

- Quality and systems improvement project in dentist practices
  - Sealants
  - Engage in conventional QI approach
  - Collect baseline information
  - Engage in PDSA cycle
  - Review change from baseline
  - Convene group to discuss payment reform to promote QI

QUALITY AND PAYMENT FINANCIAL IMPACT

- Estimated cost QI pilot project
- $150,000

MEDICAL/DENTAL COLLABORATION

- Increasing understanding of the relationship between oral health and overall health
  - Pregnancy outcomes, cardiovascular disease, diabetes etc.
- Move towards a whole body approach to disease prevention and disease management
  - Promotion and coordination of medical/dental home
- Consumer participation in medical care is high, provides an entry point and opportunity for providing oral health services and oral health service integration
  - Immunization rates are high
  - Individuals with chronic conditions more likely to use medical health system
- Guidance for medical/dental collaboration exist, however have yet to be operationalized in a payment system

MEDICAL/DENTAL COLLABORATION

Integrate an oral health professional into a Blueprint team.

Two concurrent approaches in terms of change management

- Public Health Dental Hygienist in Blueprint team
  - Focus on research related to diabetes management and oral health
  - Convene committee to oversee integration, discuss quality/outcome measures and strategize regarding payment reform
- Public Health Dental Hygienist in WIC Clinics
  - 3 million in avoidable expenditures among children 0-5
  - 80% are currently seen in WIC
  - Transition from WIC to Blueprint over time

MEDICAL/DENTAL COLLABORATION FINANCIAL IMPACT

- Oral health and diabetes pilot
  - .5 FTE Public Health Dental Hygienist
  - $50,000 annual salary, 100% fringe and overhead = $50,000
  - Clinical provider qualifies for federal match
  - Evaluation $25,000
  - GMCB advisory committee to oversee

- Public Health Dental Hygienists in WIC Clinics
  - One in each of 12 District WIC Clinics
  - $50,000 annual salary, 100% fringe and overhead
  - Clinical provider qualifies for federal match
    - $600,000 in costs annually
    - Expectation – costs in WIC reduced over five years
  - Over time move to Blueprint teams

ESSENTIAL BENEFITS

- Children's benefits defined under ACA
- Adult benefits
  - No national consensus nor opinion on adult benefit
  - California state to watch as they anticipate adding
  - Keep scope of services in Vermont status quo
  - Cost of adult benefits if added to Exchange and remain unfunded:

SUMMARY

- Increase utilization and dentist participation through rate increases
- Adopt all workforce models which have shown to be effective
  - Let dental practices choose the “tools” which best fit their practice needs and style
- Promote the penetration of existing workforce models which are underutilized
- Pilot Quality and System Improvement project in dentist practices
- Pilot oral health and diabetes initiative in Blueprint community
- Implement Public Health Dental Hygienists in WIC clinics, transition over time to Blueprint teams
- Maintain adult dental benefits in Health Exchange as currently defined under Medicaid

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