

**Medicaid Innovation Accelerator Program Children’s Oral Health Initiative  
Value-Based Payment Technical Support Opportunity: National Dissemination Webinar #3  
Transcript—Insights and Key Considerations for Implementing  
Value-Based Payment in Children’s Oral Health: Perspectives from Participating States  
August 27, 2019, 2:00 PM–3:15 PM ET**

**Webinar/Webinar Logistics**

OLIVIA REDING: Hello, and welcome to today’s Medicaid Innovation Accelerator Program [IAP] webinar: Insights and Key Considerations for Implementing Value-Based Payment [VBP] in Children’s Oral Health: Perspectives from Participating States. My name is Olivia Reding, and I am a Senior Research Analyst at IBM Watson Health, the prime contractor for the Medicaid IAP contract for VBP in children’s oral health and maternal and infant health. We work alongside our colleagues at the Children’s Dental Health Project, the National Academy for State Health Policy, and Actuarial Resources Corporation to provide targeted technical support to states.

[next slide: reviews logistics for webinar]

Now, I am pleased to now pass the presentation to Bill Olesiuk, Project Director for this Medicaid IAP technical support opportunity.

**Learning Objectives, Agenda, and Today’s Presenters**

WILLIAM OLESIUK: Hello. As Olivia mentioned, my name is Bill Olesiuk, and I am the Project Director for this IAP technical support opportunity. I will also be serving as cofacilitator for today’s call. Our learning objectives for today’s webinar are to highlight at a high level the support that was provided to participants in the technical support opportunity; develop a richer understanding of how the participants used an iterative process to select, design, and test their contracting approach; and, finally, highlight some key considerations for implementing a value-based payment program for children’s oral health services among your served population.

Our agenda includes an overview of the support provided and time to answer any questions related to that support; presentations from each of our participants, where they will share their experiences implementing VBP—those will be the District of Columbia, Michigan, and New Hampshire—and an opportunity to ask questions after all the participants have spoken about their experiences. We will also highlight key takeaways.

As mentioned, my name is William Olesiuk, and I am a Project Director at IBM Watson Health. I will be cofacilitating along with Andrew Snyder, Health Insurance Specialist in the Division of Quality and Health Outcomes within the Children and Adults Health Programs Group for Center for Medicaid and CHIP Services and the Centers for Medicare & Medicaid Services [CMS]. The state presenters on today’s call are:

- Colleen Sonosky, Associate Director in the Division of Children’s Health Services for the District of Columbia Department of Health Care Finance

- Sandhya Swarnavel, a Quality Analyst in the Quality Improvement and Program Development in the Bureau of Medicaid Care Management and Quality Assurance within the Michigan Department of Health and Human Services
- Sarah Finne, Dental Director in the Office of Medicaid Services within the New Hampshire Department of Health and Human Services.

### **Overview of Medicaid IAP and the OHI VBP Technical Support**

We begin our presentation with an overview of the Medicaid IAP and the OHI [Children’s Oral Health Initiative] VBP technical support. The IAP is a commitment by CMS to build state capacity and support ongoing innovation and Medicaid through targeted technical support. The goal of IAP is to increase the number of states moving toward delivery system reform across program priorities. It is not a grant program. It provides targeted technical support.

Each of our participating states has a distinct program goal with [its] VBP initiative within the oral health context. Michigan’s goal was to increase the proportion of Medicaid-enrolled children with preventive oral health care utilization. New Hampshire sought to decrease caries experience among children under 5 years of age treated at two Women, infants, and Children [WIC] sites in the state. The District of Columbia sought to decrease the proportion of children under 6 years of age covered by Medicaid who are at high risk for caries and referred for treatment in the operating room [OR].

The technical support that we provided fell in the process of selecting, designing, and testing a value-based payment approach. So, within selecting a program, we helped states set ambitious achievable aims and develop driver diagrams that underlie the goals and activities they sought to perform, and finally identify and select a VBP approach. In terms of designing a payment program, we helped the states assess the value-based payment approach’s cost impact and identify quality metrics to monitor progress toward goals in designing the value-based payment approach. With testing, we helped with the process of defining cycles for testing and to iterate in the design as the test progressed. We created a plan to sustain and spread the value-based payment approach where appropriate. We also provided individual technical support, including regular virtual discussions and communications, in-person site visits, and shared learning opportunities, including peer-to-peer learning, state and national expert presentations, and resource dissemination through our virtual resource library.

In terms of overarching lessons learned, I will turn it over to my colleague, Andrew Snyder at CMS.

ANDREW SNYDER: On behalf of CMS, it really has been a pleasure and an honor to watch the progress of the three state teams work through all of the steps that Bill describes to really think through what it would take to do value-based payment in the oral health context. Some of the things that we’ve learned from the last 2 years of work [are] that value-based payment implementation is an iterative process that requires consistent evaluation and also looping back to think about your priors in the course of the work, thinking about what your targets and your aims are, and revisiting and revising as necessary.

Second, a well-established data infrastructure really can facilitate both appropriate benchmarking and measurement of the impact of the VBP. We did a lot of work with states to identify data sources, figure out measures that worked for them, and implement those.

Third, engagement across policymakers, payers, and clinicians is critical to VBP success in any realm, but I think particularly in oral health since it is a relatively new thing.

In regard to external-facing products from this technical support opportunity, this is the third in a series of national webinars that we've put on. You can find recordings from the previous two webinars, an October 2017 webinar on Medicaid VBP Approaches for Children's Oral Health and an August 2018 webinar on VBP and Contracting Approaches for Caries Management, posted on the IAP page on Medicaid.gov. Slides and a recording of this webinar will be posted in the next couple of weeks to Medicaid.gov. In addition to that, there are going to be some written materials, a number of which are currently in development, but, on the IAP page on Medicaid.gov, you can find *Children's Oral Health Care Delivery Models and VBP Approaches: Key Findings From an Environmental Scan* that we did to kick off this work. In the not-too-distant future, there will be a couple shorter pieces that are listed here. The first is a tool on ways to determine children's oral health costs at an alternative care delivery site based on some of the work that New Hampshire did, a piece on determining baseline data for VBP in children's oral health, a piece on steps necessary and relationships necessary to facilitate care coordination and data sharing in children's oral health to support VBP, and an overarching state summary document that will describe in some detail the work that each of our states undertook in this technical support opportunity.

### **Poll Question**

Before we get to hearing from the states directly, we do want to take a temperature of the folks that are joining us today and ask all of you: Where are you currently in the design and implementation process of a VBP approach? Think about it in terms of your team or organization or whatever you think the appropriate unit to talk about is. Options are:

1. We are selecting a VBP approach.
2. We are designing a VBP approach.
3. We are testing a VBP approach.
4. We are implementing a VBP approach.
5. We are sustaining a VBP approach.
6. We are not currently considering a VBP approach but are interested.
7. We are not part of an organization involved in implementing a VBP approach.

Check all of these that apply to you. [poll open/closed] It does look like what I said before about value-based payment being a relatively new thing in the oral health space holds up here, as well with the majority of our folks in the "not considering but interested" or "not engaged currently" buckets. But it is a sizable subgroup, I would say 15 percent, that are in the context of designing a VBP approach. That is encouraging to hear, and hopefully what you hear today will give you some insights on experiences a couple states have had of being on that journey as well.

### **State Experience: District of Columbia**

WILLIAM OLESIUK: Thank you, Andy. I don't see that there are any questions or comments that have come in. I would like to turn it over to Colleen Sonosky at the Division of Children's Health Services for the District of Columbia, Department of Health Care Finance. Colleen, would you be able to discuss with us the experience of the District in implementing value-based payment in children's oral health?

COLLEEN SONOSKY: Thanks, Bill. I'll go straight to the project background where, just to give you a little sense of work that we do in DC, nearly all kids have health insurance coverage in the District with Medicaid being a primary insurer. So, the work that we do in the Division of Children's Health Services at the District's Medicaid agency focuses on implementing the pediatric component of the Medicaid program for kids with a lot of work that we do on oral health and dental care. Part of this work came out of us working with one of our largest managed care organizations [MCOs], AmeriHealth Caritas, as well as one of our largest pediatric providers to come together in thinking about what are things that we can do to improve dental health outcomes for Medicaid-enrolled kids.

In working in this project and with CMS and the IBM folks, our main goal was to look at within 5 years, decreasing the number of Medicaid-enrolled kids under 6 who are referred to operating rooms by using appropriate caries risk management services and looking at ways of incentivizing using caries risk management services in order to divert kids or not have them have to go into the operating room. So, a large part of this was working with our largest managed care organization, thinking through how to incentivize a new care delivery model, and working on incentivizing that to prevent operating room treatments.

A lot of the work we looked at with Children's National and with AmeriHealth was developing a pay-for-performance approach that could look at bringing together preventive dental visits, case management, and care coordination services for Medicaid-enrolled children under 6—looking at what those additional procedure codes would need to be to aid service delivery; looking at additional oral health interventions including additional exams, fluoride varnish, and case management codes; and then, putting that together, thinking through how to implement a shared savings model.

In thinking through some of the tangible things that we worked on in this process, one of the biggest things was probably, through work with AmeriHealth and Children's National, the development of a District-specific caries risk assessment tool that could be something that could be developed and shared across MCOs and across other providers; then, also working with Children's National in their use of caries risk assessment procedure codes before they were part of the claims processes submission; and working on that on the front end and then working on the back end with the MCO dental benefit managers to make sure that they were correctly processed and could be uploaded into our MMIS [Medicaid Management Information System] system appropriately.

The other big tangible thing was the creation of a cost savings worksheet for AmeriHealth to use in thinking through what the incentive payment is and trying to look at the cost of care and projected savings in order to get to what are the things that we need to do to develop best practices to make sure that kids are gaining access to care for these services.

From that and looking at what we did and where we want to go, [we wanted to make] sure that we established a data collection infrastructure to support the transitioning to a value-based payment approach because that is definitely something that's new in the District, especially in the oral health world. [We are] also thinking through what is our [required] provider capacity to make sure that this happens, in addition to thinking about who are the other providers in the dental community that would need to be brought on to think through this and how it would be implemented. In addition, [we are] thinking through the documentation of the extreme cost of care that's associated with operating room treatment to help develop the case of getting to what could be saved from not having the OR treatment if the services were

done on the front end. [We are also] developing a framework to assist Children’s National with the additional codes that are needed through managed care reimbursement.

A few other things on what we did through the process [were] thinking through what is the evidence base that we need to bring this to the other Medicaid MCOs in the District as well as decision-making officials at DC Medicaid, moving that to an at-risk incentive payment model, and figuring out how we do this with all the ongoing activities that are already happening with other organizations in the District.

In thinking through what to talk about on the call, states were asked, “What are words of wisdom?” One thing that we think is really important in this world is to not give up because this really wasn’t easy, but keep trying and working through what you want to get at as well as having transparent communication across agencies, across providers, and across MCOs because it’s not really easy to change a paradigm of care and how things are done currently, so working through and not giving up is kind of our best advice for states who are beginning to think through this. That’s all from the District. I can pass it over to Michigan.

### **State Experience: Michigan**

**WILLIAM OLESIUK:** Thank you very much, Colleen. Sandhya Swarnavel, Quality Analyst from the Michigan Department of Health and Human Services, will now present to discuss the experience of Michigan in implementing value-based payment in children’s oral health.

**DR. SANDHYA SWARNAVEL:** Good afternoon, everybody. This is Dr. Swarnavel, Senior Quality Analyst for the Michigan Medicaid Managed Care Division, headed by Kim Hamilton, Bureau Director, Kathy Stiffler, and I work directly for Tom Curtis, the Section Chief for the Quality Improvement and Program Development, with whom I strategize an oral health strategy to oversee the quality of the Healthy Kids Dental (HKD) program covering about one million kids, the Healthy Michigan adult dental benefits covering a half a million kids, and pregnant women’s dental benefits.

In addition to the Michigan Innovation Accelerator Program team, we also have the Plan Management Section Manager, Heather Slawinski; the Contract Manager, Kim Heinecke, who operationalizes the contract; [and] Sharene Johnson, a contract specialist who helps with the contract language to hold the plans accountable. We also partner with Matthew Schneider, who is the Section Manager for the Actuarial Division, and Penny Rutledge, Actuarial Division Manager, who helps us with the data needs so that we can plan the project. We also have on our team Kyle Norman, a policy specialist for oral health care policy, as well as Cindy Linn, Actuarial Health Services Section Manager. Finally, we also partner with our dental health plan vendors—Delta Dental of Michigan and Blue Cross Blue Shield, who subcontracts with DentaQuest. They, in turn, contract with a provider network, and we are working as a team.

The goal of this project is to improve preventive dental care among Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) children in the HKD program between the ages of 0 to 20, who will be the target population.

The selection and design for this project is based on two criteria. The criteria [are] based on the fact that we want to address those who do not use preventive care and those who use the care in the wrong setting by accessing emergency dental providers. So, we target both these subpopulations so that we can

outreach and change the care-seeking behavior. We test the VBP approach by the iterative testing methods, shadow monitoring, measures, and benchmarking.

We follow the methodology of iterative testing, which is equal to the PDSA (Plan, Do, Study, Act), and what we do is we refine the strategy, the planning, analyzing the data, gain insight into what resources are available, what barriers exist, and modify the existing current plan to accommodate all the information we have gained on an ongoing basis. The slide that you see is a driver diagram, which captures those ongoing bases of fact which we come across as we analyze the data, as we plan the data, as we come across barriers, as we come across proposals.

Here in the driver diagram we see on the slide is captured the changes that have been made for the last 2 years. It did not start this way, but we have come to this, and we cannot say that this is going to be the final template on which we are going to be acting, because, again, depending upon what we see in the field, this will change. On the left-hand side you see the aim, which was basically increasing by 5 percent for preventive services points every year for the next 2 years. Again, this has to be reassessed and revisited to see if it is realistic according to the available data and modify it accordingly.

On the right-hand side, you see under “Potential Activities” there are two boxes. The upper box is what the state is going to be doing, and the lower box is what the dental vendors are going to be doing. The state is going to be creating templates; [selecting] measures; facilitating the work group; holding the dental vendors accountable; putting in the contract language, which helps with the capitation withhold; and coming up with an oral health care strategy.

The plan, which is on the lower right-hand side box, where they are going to be given the flexibility to come up with a VBP approach, because every vendor is different, what proposals they have is different, and what kind of network they have and outreach and their models, so, we want to give them flexibility in coming up with an approach which addresses the attribution methodology to come up with a provider incentive program and make sure that the providers are incentivized based on the outcome measures which are desired for the population.

By doing that, what we hope that they will be doing is coordinate with 11 Medicaid health plans that you see on the primary drivers and also work with the PCPs [primary care providers]. So, in Michigan, the Medicaid health plans pay for the PCPs to cover the oral health screening services as well as fluoride placements for 0 to 5 years of age. But the data is not sent to dental plan vendors; they do not have that information. Emergency dental utilization bills are paid by the Medicaid health plans, but the data is not sent to the dental health plan; so, they [dental health plans] do not know who those beneficiaries under HKD have accessed emergency dental utilization. So, by having the coordination, the DUA [data use agreement], the data sharing, the referrals, and working together as a state and aligning the goals which are present under the Medicaid health plans—seven health plans under Medicaid health plans are focusing on emergency dental utilization—and aligning those goals with the dental health plans by incentivizing them with a capitation withhold is what we are planning. by addressing the change of behavior of utilization itself and concentrating on increasing preventive utilization.

What we plan to do is have an identification of the metrics according to the phases of the VBP. So, we plan to do it in three phases. One is going to be the implementation phase, where we are going to be focusing on the operational and process measures, and some examples would be like number of data user

agreements, number of referrals from emergency departments, number of dental homes, specializations or actual assignments by the dental vendors, [and] number of outreach calls.

Phase two will be the outcome measures, and those would be based on CMS 416 measures and timely follow-up within 60 days after ED [emergency department] utilization and preventive visits among nonutilizers and ED utilizers—also overall HKD metrics for preventive and ED utilization.

Phase three will be the shared metrics between the Medicaid health plans and dental health plans. These are the long-term goals. For example, it can be something like PMPM (per member per month) metrics and see the return on costs.

I did want to say that for the challenges, we are planning to see how it goes. We have identified significant data extraction challenges and benchmarking after identification of the encounter. So, we're trying to figure out what will be the timeline and what will be the appropriate metrics within the time frame and setting benchmarks accordingly. That's a big challenge. And having that challenge addressed in shadow monitoring, this is trying to have this implemented without consequences. So, [we are] setting up the measures, trying to establish baseline benchmarks, and seeing if it works. Then, [we are] modifying the benchmarks accordingly. This has been implemented this summer, and we have already started this process, after significant drilling into the benchmarks and trying to figure out which metrics for which phase are going to be possible and feasible in a valid way where everyone agrees to what the data validity is about and setting the goals accordingly. That's what we are doing right now.

The process will be iterative testing, so based on all those data, based on all that information, modifying the process, and inclusion of a capitation withhold based on the next fiscal year contract, which is going to start at 0.5 percent, which comes to roughly about one million dollars, and is going to be increased to 1 percent. This is going to be about two million dollars in the next fiscal year. This is from October 2020 to 2021. So, this fiscal year, which starts October 2019 to September 2020, that would be 0.5 percent.

So, what are key takeaways for the other states? One is drill down your data and take a chance to participate in any quality improvement initiative. Use the publicly available technical support and design the components of your program. We did not stick just with this particular project, but we looked at overall consumer satisfaction surveys, looking at all the different tools which are available out there and the sources which are available nationally.

This is my presentation. I will take your questions at the end of the process.

### **State Experience: New Hampshire**

WILLIAM OLESIUK: Thank you, Dr. Swarnavel, for that great presentation. Our final state presenter is Dr. Sarah Finne, the Dental Director in New Hampshire Department of Health and Human Services, who will speak on the value-based payment in children's oral health program being initiated in New Hampshire.

DR. SARAH FINNE: Thank you very much; it's nice to be with all of you today. I'd like to start with a brief description of our WIC Pay-for-Prevention Project, which actually began back in 2014. It's a beautiful partnership between the dental Medicaid program here in the state and also our Division of Public Health Services oral health program and two WIC locations in the state, one in the center of the state, Concord, and one over in the southwest corner in Keene, that chose to become a part of this project 5 years ago.

The original project was part of the CMS Oral Health Learning Collaborative that began a number of years ago and has now morphed over to having a focus on increased delivery of preventive services to our 0- to 5-year-old WIC participants. One of the basic ideas that we felt was very important here in New Hampshire was the codelivery of services, the WIC services, to those participants and oral health services at the same setting that is convenient and familiar to these families. We placed a certified public health dental hygienist, which is a dental hygienist with expanded functions basically, here in New Hampshire, along with the dental assistant as an oral health team embedded within the WIC staff at the WIC location.

One of the added benefits of having the care delivery in this situation was that the dental hygienist and assistant could meet with the nutritionists who were at the WIC location. [They] developed very good consistent messaging about oral health and diet and [could] really be supportive for these participants from two different places, [which] provided a great reinforcement of a positive message about health.

As you can see, we've offered a number of services there, and not all of those services were available to be reimbursed by Medicaid at this time. So, the idea of a value-based payment method appealed to me because I would be able to change the fee schedule to allow for coverage for services that were actually being performed on a daily basis at those sites.

We began this technical assistance project by creating our goal and deciding who our target population would be. We decided that we wanted to show that we could decrease caries experience by 10 percent among children aged 0 to 5 who were attending two WIC locations in New Hampshire, and at the same time delivering the services in a manner that was financially sustainable for both the WIC agency and also New Hampshire Medicaid over the long term.

The driver diagram development was a large amount of time for our New Hampshire team, and at the time I don't think we realized how important it was that we spent that amount of time, but it truly was critical for us to make sure that our driver diagram did what it needed to do and allowed us to then go on with the steps needed to prove that we were doing what we said we wanted to do. This investment of time is critical and well worth it as you move into the other stages of the project. We went through multiple revisions and, during the process, refined our primary and secondary drivers multiple times, again because, as we had discussions, we wanted to make sure that we were going to be able to answer the questions that we had and we were going to be able to show with our data that we had created the correct drivers and the work that would go on behind that. We had very, very long discussions to develop consensus, and I would say it's also very important to have a diverse group at the table having those discussions because each of us brought a different perspective to the conversation that was very important to achieving our long-term goals.

During the process of choosing our primary and secondary drivers, we needed to decide how we were going to select measures that went along with those. There was discussion of process measures, which would show if the preventive services that we were providing were truly efficient in terms of time and their ability to have a significant level of prevention. Outcome measures made sure that we were achieving our desired results, and a lot of conversation went on around that to decide what those measures would be. It was also very important to have balancing measures because, sometimes, you have unintended consequences that occur during the course of your project and in your deliberations, and that was also another critical piece of our development.



Once we had chosen data elements that would support the measures that we had chosen, and that is another point that I would say is very important—if you are choosing your data elements, you need to make sure that they are easily accessible and are easily used—the iterative testing plan was developed at this point where we had decided the frequency at which we would be doing data pulls. We decided where that data would be coming from, and, in our case, we had to do a combination of sources. We were using some claims information coming out of MMIS as well as clinical information that came from the electronic health record that was used at each location. We then analyzed that data according to the measures that we had chosen, and yes, once again, this is another place in the process where there were ultimately revisions because we realized maybe the data that we had initially thought we would need was not exactly the right thing and so there would be revision at this point as well.

I would say that the most important piece of work for my state in this process was our cost assessment worksheet, which is a time-driven activity-based costing methodology. This worksheet basically took a tremendous amount of information from various sources. We were using supply costs from each of the WIC locations [and] salary costs, and then we also went on to look at how much time was spent per procedure on average. All of this information came together and was fed into a spreadsheet, and that led us to be able to really see what it would cost to deliver all these services in this type of a location, which is much different than your traditional dental delivery site. I would say that if anyone is trying to really get at what the cost of a program could possibly be in alternative locations, this is the type of spreadsheet that can really help you get all of the information gathered in one place to have a realistic look at what your costs will be.

Once again, as we were developing this worksheet, we were gathering data over a long period of time, and you get much more accurate information the longer time span you have with data to put into the worksheet. Again, as we looked at the worksheet as it was developing, there were places that we realized we had to make adjustments. We looked back at, say, our estimates for how long it would take to place sealants versus putting on fluoride varnish. So, once again, this is a stage where there were refinements. I think even at this point in the future as we use this worksheet here in New Hampshire we may find areas that need additional changes.

Basically, why this is so important for me in-state in dealing with the Medicaid team here, both in terms of policy but also in finances, is that we really do need to make sure that this is sustainable for everyone involved. WIC locations have to worry about their funding sources for their own programs, and, as much as they feel that the oral health delivery is very important and they want that to occur at their sites, it can be difficult for them to try to obtain enough funding to cover the total costs of the program. At the same time, I have to look at the Medicaid budget and make sure that changes that we make with a VBP is something that can be handled within our budget here in Medicaid.

One of the things that we did recognize in terms of doing our analysis of this program, the clinics are offered 1 day a week in each location, which is a very regular schedule, which is good. The oral health visits are either on demand or can be scheduled in advance, and each of the locations has a different way they make space available for the program, but this can also impact the cost. In one location, there was enough space available that even though the oral health team was only there for 1 day, they were able to have a room set aside that was theirs, and they could leave the equipment there, we had posters on the walls, and it was a very permanent situation in that room. In the other site, our oral health staff used a

room that had other things going on the rest of the week. Both worked very well, and it really just depends on what is available and what the wishes are of the WIC location.

Some of the overarching challenges that we noticed in our care delivery sites is that there is a need to merge data from multiple systems, which can make things a little more difficult, but once you identify the correct pieces of information that you need from both systems, you can usually work out how to merge them.

Staffing changes can become problematic, and they are out of the control of many of us, as well as patient flow, which some of that is due to factors within the agencies that are hosting the dental team, but we also are here in New England, and the reality is that if you have clinic scheduled on Mondays and Christmas and New Year's fall on Monday, that's going to affect your availability. Snowstorms can affect your availability, and we definitely did find seasonal changes in the program once we had a very long-term look at our data. Those challenges affect how you look at that VBP number that you arrive at at the end of the time-driven activity-based costing calculation.

Here in New Hampshire, we are looking at the possibility of doing a number of different things. We are going to look at the budget impact of moving this VBP out to just patients, 0- to 5-year-olds, which is a small population statewide. Or, will this eventually go across the entire 0- to 21-year-olds in our Medicaid coverage here? The second thing is that we will have to decide if there are going to be Medicaid authorities or state plan amendments that are needed to pilot the VBP approach across the state, and we will have to develop a timeline for this. As many of you out there can appreciate, sometimes legislative things that are happening can have an impact on whether or not you're able to launch a new plan such as this. Right now, we are waiting to have a finalized budget, and so it is a little premature for me to be having conversations about how I'd like to work within the budget that I have.

What I would like to include for my words of wisdom is that it's really important that all the partners involved in the VBP need to be invested in the process, invested in what it is that you're trying to deliver in terms of care for our Medicaid members, and that they share the same vision and goals. I have to say that we've been very, very lucky here with the two sites where we have had the project in operation now for 5 years, that these agencies truly, truly are invested in what we're trying to do. They want to continue to offer oral health services there, and they want to make sure that we can make this work both for the state and for the agency.

It takes a lot of time to reach this consensus and also to get through the process, and I have to say a huge thank you to everyone involved with our technical assistance because I now have multiple items at my fingertips that I can use going forward now that I've learned how to work through this and that will be beneficial to the state for a long time to come.

As I said earlier, the time that is spent at each part of the project, getting your driver diagram really ironed out, is truly critical. Getting agreements on measures so that everyone really feels like they're moving forward in the same direction is very important. I'm looking forward to some good things happening here. Our preliminary results show that children who have had preventive services at WIC locations versus a similar cohort of children the same age that did not have early prevention at the WIC locations do have higher costs in restorative care moving forward. I'm happy to say that, but I also have to keep in mind that we have a very small sample here. We're a very small state, and we are spending some time now really

analyzing our data to make sure that what we're seeing is truly accurate, but I think that we are seeing that we are achieving what we set out to. Thank you.

## **Q&A**

**WILLIAM OLESIUK:** I want to say thank you to our three excellent state presenters. I also want to acknowledge some of the great questions we're receiving. Some of the questions that are coming in fall into broader categories of questions and, in those instances, we'll be aggregating the questions into a broader heading. If you don't see your particular question asked as you asked it, fear not; hopefully the question will be answered in an appropriate fashion under a different form.

To begin, I know a lot of the states, particularly District of Columbia and New Hampshire, have spoken about data collection instruments and the data that they use to make calculations about costs and outcomes achievable through their programs. I want to ask each of the state participants, starting with New Hampshire, how did the availability of data shape your goal and VBP approach?

**DR. SARAH FINNE:** I think that it made us very aware that there is a limit to what you can do with claims data alone, like we all know that. That's why it was so critical for us to find a way to merge some of the clinical data, and it's a large task. That's why I say you have to make sure that you are actually going to be able to get what you need right at the outset when you're choosing your measures because you don't want to get deep into the project and not be able to analyze the correct information.

**WILLIAM OLESIUK:** That's great; that initial stage of developing a data collection plan and really making sure there's a strategy to ensure the data is available before moving forward is something we saw across all the states. The same question for the District of Columbia—Colleen, would you be able to discuss how the availability of data shaped your strategy and maybe even how some of the initial analysis of that data about the feasibility of your approach may have shaped your plans for VBP?

**COLLEEN SONOSKY:** I think for us, it was kind of the issue around not having really good baseline data since we didn't have billing for caries risk assessment codes, and really having to figure out what assumptions we would make with that were some of the areas that we struggled with and tried to figure out how to move forward with.

**WILLIAM OLESIUK:** That's a great point and one we'll touch on a little bit when we talk about in our National Dissemination Strategy in the documents that CMS will be making available online, where we talked about the need for assessing the availability of baseline data. Lastly, Dr. Swarnavel, would you like to talk about how data availability in Michigan helped shape your strategy?

**DR. SANDHYA SWARNAVEL:** Yes; we started with first focusing on foster care children. In Michigan, the data have not been integrated into the Medicaid data warehouse. We do not get the case management data. Due to the nature of this population itself, it's very difficult to get data accuracy and, therefore, attribution is a problem. So, we decided that this is going to take more than the time period we have with the IAP team in this program. Therefore, we expanded our target population to cover the whole program so that this has the subpopulation of foster care children and, therefore, address it as a whole. That's been one of the problems.

The other problem is that we have a new program where we have a new dental vendor with our existing old dental vendor, and, therefore, there is a discrepancy in the population numbers. There is a problem with operationalizing things, like any of the programs, when you start, you are going to have a lot of new issues, so we are working through all those things. Auto-assignment is based on a difference in trying to make sure that there's viability for the new vendor, so there's a difference in that population, where the new vendor is getting substantially children below 5 years of age, so we've got to look at that as well.

All those things are happening as well as the data sharing between the Medicaid health plans who get the emergency department utilization and who PCPs are seeing children under 5 years of age—that is not being communicated to the dental health plans who have the population and who need to know what kind of utilization their beneficiaries are doing. So, trying to progress through all these challenges and trying to make sure that they can also access CC360 [CareConnect 360], which is an information system currently being used only by Medicaid health plans, trying to get them access. We have a deficiency of budget in our state, so the priority of trying to get the IT [information technology] project moving is another big challenge. So, working through all these challenges but still keeping the eye on the ball and trying to move this project with what is available, we are trying to do our best. We thank the IAP team for helping us navigate this process, and we have help from all the different stakeholders, and we are working our way through. Thank you.

WILLIAM OLESIUK: Thank you, Sandy. That's an important concept to realize, too, that as states begin the work of implementing value-based payment, they'll run into challenges that perhaps in their quality programs they haven't yet encountered because when you have to operationalize quality metrics and payment, the need for specificity and accurate data becomes much more of an important issue for discussions. Stakeholders are much more engaged when money is on the line.

Another question that has come in through our chat box is one regarding access to care and ensuring availability of services under a value-based payment context. It really deals with two ideas: one is areas where provider availability is low, such as rural settings, and the other is situations when providers opt out due to low reimbursement rates. I think that the New Hampshire program is actually situated to address these issues, in particular of improving availability both in rural settings and related to having a payment that's sufficient to keep providers engaged with it. Dr. Finne, would you be willing to speak a bit about that?

DR. SARAH FINNE: Yes, I agree. Those were both concerns that we had here. There are large areas of our state that are very rural, and it's very important to be able to get preventive services at the very least out as widely spread as possible. But, at the same time, I recognize the fact that due to our current reimbursement schedule, there are a number of things that providers spend time on with these really young kids and their families that they're not able to bill Medicaid for. So, I felt like this was hopefully the perfect solution to getting the early preventive services with a wider spread across the state that would include the most number of providers. It remains to be seen. I think that it's not just changing the fee schedule and doing the VBP. I think that we also need to do some supportive measures as well and some education of providers so that we get everyone on the same page about when it is we need to see the kids and what is the message that needs to go out. So, I'm hoping that we will be able to address both of those things because they are a piece of the access puzzle.

WILLIAM OLESIUK: Great, thank you. There was a question particularly for Michigan that I'd like to ask now regarding engagement of stakeholders and, really, that process of working in a large state with multiple managed care providers. How did you engage your managed care stakeholders and also providers in development of the approach, if you did, and how do you think that process will shape your implementation going forward?

DR. SANDHYA SWARNAVEL: As a Managed Care Plan Division, we basically attracted dental plan vendors who, in turn, have contracted with their provider network. Therefore, we are hoping that, with this incentive program which they are going to be designing, which we have given them the flexibility to design it as they feel is appropriate, they will be able to make sure that the providers take part in this program and are able to engage. But our main challenge is trying to first get the dental plan vendors on board. In order for that to happen, we initially started up on the patients a year back after having the new bid go through, having the quality strategy, and analyzing our data, and coming up with a template as to what we are going to be doing for this program overall, and what our vision is. After we were clear about where we were going with this program, we had a day-long session where we brainstormed with the dental health plans and the IAP team had a site visit. They were there in person.

So, it was very challenging initially to make sure they understand where we were coming from, but then it was evident that they are the stakeholders and we are not as a state telling them what to do, but we have an incentive to do this because the capitation payment is based on that—so the withhold, basically. Once they saw that we are implementing this in a small way, not going with a high percentage of withhold and going with 0.5 percent and then moving on to a 1 percent withhold, and giving them the flexibility to design the program but with the broad guidelines as to what we would like to see, and knowing the outcome measures upfront, what we are going to be measuring, and having their input as to whether they are working or not, and letting them know that we would have them as a stakeholder and not just that they are a dental health plan and supposed to carry out what we are going to be saying or asking them to do—so, making sure they understand that their input or feedback is going to be taken. So, that's the point at which we are right now. It's too early to tell how this is going to develop, but we are optimistic. We hope to go through this process and see where this takes us and make sure that this is implemented in all regions of the state for the whole entire Healthy Kids population and see if we can emulate the same thing with the Healthy Michigan Plan dental benefits as well and other different benefits programs. Thank you.

WILLIAM OLESIUK: Thank you. A final question that is targeted specifically to DC, but I think it would be interesting for other states to speak to as well. Colleen, would you be willing to discuss the road ahead for DC in terms of what you expect for either the model spread or if you expect the model to spread in the time ahead and any potential challenges or issues related to further expansion of your value-based payment approach?

COLLEEN SONOSKY: I can discuss a little because it's really kind of internal to AmeriHealth right now and discussions there, so there's not much that I can say to that. But it's something that we have the baseline and the background work developed to be able to figure out how to discuss this more broadly District-wide and with the other MCOs, but I don't really have a timeline for that.

WILLIAM OLESIUK: Yes, that makes sense. Similarly, New Hampshire, is there a strategy or next steps you'd be willing to discuss, Dr. Finne?

DR. SARAH FINNE: I think a lot of it has to do with budget right now. There are a lot of things going on in New Hampshire right now. We're in the process of working on an adult benefit and what that will look like. I do have to look at while our EPSDT benefit is separate, I do have to look at the overall picture of what's happening in oral health in New Hampshire. Ideally, I want to move this forward in the short term but, ultimately, the biggest part of this is going to be budgeting. I think that due to all the work that we've done over the last 2 years, and I had a great team both here and in New Hampshire and my coach team, I have the information that I need to make a great presentation within Medicaid and to the Finance Department here. It really is just the timing with the budget that is a little bit unknown right now.

WILLIAM OLESIUK: Yes, that makes sense. There are many financial considerations as these programs develop and the iterative process of monitoring how the rollout happens, whether the measures are improving as expected and taking the opportunity to make adjustments as needed, is an important part of the value-based payment implementation process. Dr. Swarnavel, I know that you answered this question moments ago when you talked about your road ahead in Michigan. With that I will conclude questions or comments for today.

### **Key Takeaways**

WILLIAM OLESIUK: We have the following key takeaways today that we hope help states and other attendees understand what we hope to provide by presenting this information. We hope that we offered an understanding of how your population's oral health needs can be assessed through the data collection and analysis process and why that's useful for value-based payment implementation, especially as you continue to process an implementation and continue to measure those targets in achieving your children's oral health care goals.

We think it's important to promote consistent engagement with key stakeholders, including your payer organizations, who you may find are just as interested in implementing value-based payment as the state Medicaid office is, key policymakers, and also the health care providers who want to do what's best for their payment; so, engagement is essential.

We also think it's important to connect with external entities that offer their support. CMS has a great team of subject matter experts, and your local CMS office may be willing to discuss with you steps. Also available on the CMS website are a number of resources which have been created through this IAP support opportunity—specifically, as mentioned by Andy earlier in the presentation, the two previous national learning webinars, the first on value-based payment approaches for children's oral health and the second on contracting approaches in value-based payment specifically for caries management and what the implications for implementation and state Medicaid programs are, and also, a fact sheet which summarizes findings from an environmental scan that highlights oral health care delivery models and VBP approaches that are in operation in the oral health context.

I want to, again, extend a special thank you to the participating states. Thank you to our speakers: Andrew Snyder, Dr. Finne, Dr. Swarnavel, Colleen Sonosky. I want to thank the other IAP team members, the National Academy for State Health Policy, the Children's Dental Health Project, and Actuarial Resources Corporation for the excellent support they provided over the past 2 years. I want to thank you all for attending today's call. Please take a moment to complete a short feedback survey. Thank you very much for attending today and have a great rest of your afternoon.

[end of tape]