MEMORANDUM

DATE: December 6, 2018

TO: Representative Richard Raymond, Chair House Human Services

FROM: Mr Jess Calvert and Ms Diane Rhodes

SUBJECT: Dental Services: Medicaid and Children's Health Insurance Program
Dental Education Loan Repayment Pilot Program

Creating workable value-based purchasing/alternative payment models for dentists.

Background: The Texas Dental Association (TDA) recognizes that the national trend is to move away from fee-for-service payment models that are seen as incentivizing volume and instead compensate health care providers for the "value" of the health-care services they deliver—an alternative payment model (APM) also known as value-based purchasing (VBP).

Since 2014, Texas' contract with the dental managed care organizations (DMOs) included a VBP/APM requirement. The goal being to focus on quality dental services, and not volume.

DMOs previously met the requirement by implementing provider incentive plans and not changing payment structures for dentists. VBP is designed to encourage achievement of quality outcomes and reduce inappropriate utilization of services.

As of 2018, Texas now holds the DMOs to a 25% threshold for any kind of VBP (eg, dentist incentive plans) and a 2% threshold for VBP that has a degree of financial risk for dentist providers. For the 25% threshold, this equates to 25% of the DMOs' payments to dentists having some linkage between the overall payment and a measure of quality/efficiency or both (ie, value). So, to meet this target, a DMO could initiate incentive-only VBP models, with really no changes needed to the contracted fee schedules, and Medicaid dentists can get extra incentives if they met whatever target is agreed upon by the DMO and the dentist. For the 2% threshold, this is undoubtedly more challenging because there is a financial risk to dentist providers.

Comments:

- VBP/APM in dentistry should be designed to improve oral health outcomes for members, empower members and improve experience of care, lower healthcare cost trends, and incentivize dentist providers.

- VBP/APM should not interfere with the patient-dentist relationship by injecting factors unrelated to the patient's needs into treatment decisions. Treatment plans can vary based on a clinician's sound judgment, available evidence, and the patient's needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans.

- VBP/APM must not discourage dentists from treating complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases. VBP/APM cannot be utilized by the DMOs to incentivize patient neglect.

- TDA asks the state to recognize the traditionally low Medicaid reimbursement rates paid to dentists and prevent VBP/APM from further eroding payments to dentists.

- Dentistry is quite different from medicine and this must be taken in account when designing and implementing VBP/APM. For example, the number of solo general dental practitioners is higher and the revenue sources are very different than those in medicine. One of the factors that encouraged VBP utilization in medicine was its origin in structured systems of care, such as large physician provider groups. These structures are not prevalent in dentistry.

- When designing VBP/APM, the state must recognize that dental billing is driven by individual procedure codes corresponding to the specific procedure(s) performed (ie, Code on Dental Procedures and Nomenclature). This is different than medical billing. Medical carriers not only require procedure code(s) but also the reason why the procedure(s) were performed or the patient's diagnosis. That is not currently the case for dentistry.

- The state and DMOs must reference evidence-based clinical quality measures created by the Dental Quality Alliance when designing VBP/APM. Measures must be clinical benchmarks rather than administrative performance standards.

- Successful VBP/APM in dentistry must include clear objectives, definable units of assessment, valid performance indicators, analysis and interpretation of performance data, performance standards and financial rewards. HHSC and DMOs must take into account that VBP/APM participation will likely be higher if the measures are designed in close collaboration with dentists, the reimbursement structure considers cost of service increases for dentists; and program evaluation is easy.

- VBP/APM financial incentives/penalties must align with the clinical areas perceived as important and the professional and ethical values of dentists. TDA asks that the state require DMOs to share data and performance reports on a regular basis and work with the Association to design VBP/APM that are workable for dentists.

- TDA asks that HHSC maintain its position that quality measurement in risk-based VBP is highly customizable and dentists can negotiate quality measures with DMOs that fit best for them.

- TDA asks that HHSC maintain its position that dentists cannot be driven by the DMOs into risk-based VBP payments, nor can they be mandated by the DMOs to accept a one-size-fits-all VBP/APM model. Dentists must have choice as to how they are reimbursed and accepting risk-based VBP payments may not be right for a particular dentist's practice (eg, specialty practices).

- TDA asks HHSC and DMOs to review the following from page 2 of the "Health Care Payment Learning and Action Network APM Framework" as the framework for defining APMs. See, (http://hcp-lan.org/workproducts/apm-framework-refresh-draft.pdf): "Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage."

- The state must require DMOs to dedicate sufficient resources for dentist outreach and negotiation, assistance with data and/or report interpretation, and other collaborative activities to support payment reform and provider improvement

Texas Dental Education Loan Repayment Program (DELRP)
The Texas Dental Education Loan Repayment Program (or DELRP) is a statutorily authorized program administered by the Texas Higher Education Coordinating Board. The program provides an incentive to dentists in return for their practice in select underserved areas of the state. Participating dentists must accept Medicaid the Children's Health Insurance Program.

The goal of the program is simple: to place dentists in areas of need so that Texans have access to dental care. According to the 2019-2020 "Update to the Texas State Health Plan" published by the Statewide Health Coordinating Council, although the number of dentists in Texas continues to grow overall and relative to the state's population, the distribution of dentists is not even across the state. The Texas Health Institute's report—"Oral Health in Texas"—notes that no state has added more dentists since 2013 than Texas. However, the dental workforce is disproportionately concentrated in urban areas: while 15% of Texas' population resides in rural areas, just 7% of dentists practice outside of the state's urban centers.

As of September 2018, the Bureau of Health Workforce Health Resources and Services Administration (HRSA) US Department of Health & Human Services, reported that Texas needs only 300 existing dentists practicing in underserved areas in order to meet 100% of the need.

The TDA is requesting a total of $800,000 per biennium to fund 10 dentists for the program. Participating dentists will receive $40,000 per year for four years in loan payment assistance. Based on TDA's analysis, there are currently four areas of the state with the greatest need. These areas will be targeted for the program: Clarendon, Coleman, Ft Stockton, and Victoria.

TDA strongly supports the DELRP and its goal which is to place dentists in areas of greatest need to provide care to needy Texans.