DEPARTMENT OF HUMAN SERVICES

Legislative Report

Dental Home Demonstration Project and Dental Rate Rebasing Recommendations

Purchasing and Service Delivery

February 1, 2022

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Contents

I. Background context

Challenges facing Medicaid dental program

Access to dental care has historically been a major problem in Minnesota for individuals enrolled in public programs. Individuals in public health care programs experience tooth decay at a greater rate than others. Oral health is correlated with greater risk for other major health conditions including heart disease, diabetes, stroke, and breast cancer. While Minnesotans served by public health care programs have dental coverage, that coverage has not always translated into access to care, as 60 percent of children in the Medical Assistance program did not see a dentist in 2019.

Finding a dentist who accepts public program patients is a known challenge for enrollees. Studies performed by DHS in 2014 and 2015 showed that due to administrative complexity, overall low reimbursement rates, and complex rate structures, many dentists, and particularly small clinics in Greater Minnesota, are discouraged from serving public program enrollees.

Additionally, several other factors impact individuals' ability to access dental care including but not limited to:

- variable access in different regions of the state,
- shortages in dental providers,
- special needs of some participants,
- complexity of the oral health needs of underserved populations, and
- a lack of coordination between oral health and other health services.

Many Medicaid recipients in Minnesota are chronically underserved or not served at all. Without access to needed dental care, individuals seek care in emergency rooms and are often prescribed drugs to manage pain without resolution of the dental issue. Dental providers, educators, and advocates are motivated by a deep concern for patients, whose lives are severely compromised because they have limited or no access to dental care.

While many dedicated providers work to serve Medicaid patients, the need is much greater than current availability. Increasing access to dental care requires supporting the sustainability of existing providers while reaching new providers and experimenting with innovative practice, staffing, and workforce models. In addition, the lack of access experienced by Medicaid patients requires new approaches to patient-centered dental care and advanced treatment capabilities. Dental homes have the potential to provide a framework for high-quality, comprehensive, and coordinated oral health services across clinical and community-based settings.

II. Legislative mandate

The 2021 Minnesota Legislature mandated that the Dental Services Advisory Committee (DSAC) design a dental home demonstration project and present recommendations to the legislature and the commissioner of the Minnesota Department of Human Services (DHS). The legislature identified categories of stakeholders to be engaged as part of the process and specified goals of dental homes, including creating incentives for qualified providers that deliver high-quality, patient-centered, comprehensive, and coordinated oral health services.

In addition, the legislature directed DHS to present recommendations on dental rate rebasing consistent with the proposed design of the dental home demonstration project.

This report addresses both legislative mandates. The text of the authorizing legislation is below:

Dental Home Demonstration Project[1]

a. The Dental Services Advisory Committee, in collaboration with stakeholders, shall design a dental home demonstration project and present recommendations by February 1, 2022, to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy.
b. The Dental Services Advisory Committee, at a minimum, shall engage with the following stakeholders: the Minnesota Department of Health, the Minnesota Dental Association, the Minnesota Dental Hygienists' Association, the University of Minnesota School of Dentistry, dental programs operated by the Minnesota State Colleges and Universities system, and representatives of each of the following dental provider types serving medical assistance and MinnesotaCare enrollees:
    1. private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;
    2. private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise 25 percent or less of the clinic's patient load;
    3. nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;
    4. nonprofit dental clinics with a primary focus on providing eldercare;
    5. nonprofit dental clinics with a primary focus on serving children;
    6. nonprofit dental clinics providing services within the seven-county metropolitan area;
    7. nonprofit dental clinics providing services outside of the seven-county metropolitan area; and
    8. multispecialty hospital-based dental clinics.
c. The dental home demonstration project shall give incentives for qualified providers that provide high-quality, patient-centered, comprehensive, and coordinated oral health services. The demonstration project shall seek to increase the number of new dental providers serving medical assistance and

[1] Laws of Minnesota 2021, 1st Spec. Sess. chapter 13, article 1, section 33.

MinnesotaCare enrollees and increase the capacity of existing providers. The demonstration project must test payment methods that establish value-based incentives to:

1. increase the extent to which current dental providers serve medical assistance and MinnesotaCare enrollees across their lifespan;
2. develop service models that create equity and reduce disparities in access to dental services for high-risk and medically and socially complex enrollees;
3. advance alternative delivery models of care within community settings using evidence-based approaches and innovative workforce teams; and
4. improve the quality of dental care by meeting dental home goals.

Dental Rate Rebasing[2]

The commissioner of human services shall present recommendations on dental rate rebasing to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by February 1, 2022. The recommendations must be consistent with the proposed design of the dental home demonstration project and must address the frequency of rebasing, whether rebasing should incorporate an inflation factor, and other factors relevant to ensuring patient access to dental providers and the delivery of high quality dental care.

[2] Laws of Minnesota 2021, 1st Spec. Sess. chapter 13, article 1, section 38.

III. Committee process

Dental Services Advisory Committee

Dental Services Advisory Committee (DSAC) is a subcommittee of DHS's Health Services Advisory Council.[3] DSAC is composed 13 members, including dental providers, representatives from health plans and public health, health researchers, dental education programs, and a Minnesota Health Care Programs (MHCP) health care consumer. The committee provides clinical guidance on the dental care benefits and coverage policies for MHCP.

Dental Home Advisory Committee

DSAC identified providers and researchers to serve on the Dental Home Advisory Committee (DHAC), a subcommittee of DSAC, based on categories identified in session law. The list of these organizations and each named designee is below.

DHAC held public meetings via Zoom. State agency and community subject matter experts were identified and engaged to participate in the meetings. These subject matter experts brought a wide range of perspectives and experiences.

DHAC members and affiliations

Stakeholder Category	Committee Member	Affiliation
Minnesota Department of Health	Prasida Khanal	Minnesota Department of Health
Minnesota Dental Association	James Nickman	Minnesota Dental Association
Minnesota Dental Hygienists' Association	Clare Larkin	Minnesota Dental Hygienists' Association
University of Minnesota School of Dentistry	Sheila Riggs	University of Minnesota School of Dentistry

[3] Minnesota Statutes 2021, section 256B.0625, subdivision 3c

Stakeholder Category	Committee Member	Affiliation
Dental programs operated by the Minnesota State Colleges and Universities system	Colleen Brickle	Minnesota State System Dental Education Programs
Private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;	Kate Tonjum	Southern Heights Dental
Private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise 25 percent or less of the clinic's patient load	Amber Cziok	Sibley Dental Suite
Nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;	Karen Flanagan Kleinhans	Community Dental Care
Nonprofit dental clinics with a primary focus on providing eldercare;	Mike Helgeson	Apple Tree Dental
Nonprofit dental clinics with a primary focus on serving children	Sarah Wovcha	Children's Dental Services
Nonprofit dental clinics providing services within the seven-county metropolitan area	Nenick Vu	Minnesota Association of Community Health Centers
Nonprofit dental clinics providing services outside of the seven-county metropolitan area	Jeanne Edevold Larson	Northern Dental Access Center
Multispecialty hospital-based dental clinics	Mary Seieroe	Hennepin Healthcare

In addition to DHAC subcommittee members, members of the broader DSAC were also invited to DHAC meetings.

Meeting structure

The meetings were facilitated by consultants from Minnesota Management and Budget's Management Analysis and Development (MAD). All meetings were hosted on a virtual platform that accommodated breakout rooms and had adaptive features for participants with disabilities.

MAD consultants worked with DHS to design a meeting arc and overall topics:

- September 23, 2021: Introductions, review timeline and legislative mandate, identify core components of a dental home.
- October 7, 2021: Refine core components of a dental home, identify how success will be measured, and develop measures for patient access and experience.
- October 21, 2021: Refine measures for patient access and experience and develop measures for oral health clinical outcomes.
- November 18, 2021: Finalize measures for patient access and experience and refine measures for oral health clinical outcomes.
- December 2, 2021: Finalize measures for oral health clinical outcomes, identify parameters for the demonstration project, discuss what to consider when evaluating a potential measure, and provide feedback on the rebasing proposal.
- December 16, 2021: Review measure rating data and assess whether chosen measures meet demonstration project needs.

In December 2021 and January 2022, MAD compiled and edited the draft report and shared drafts of the report with committee members, members of the public who had attended DHAC meetings, and DHS staff. Feedback from these groups was incorporated into a final report DSAC met to formally approve on January 31, 2022.

Role of the public

The MAD consultants developed parallel meeting processes at every meeting for the advisory committee and the public. Virtual meeting rooms were set up for both DHAC members and the public to identify features of a dental home, develop baseline and performance measures, and determine parameters for selection into the demonstration project. In addition, advance work was collected from committee members and the public and presented at DHAC meetings, and both committee members and the public were able to submit written feedback and rank potential measures for inclusion in the report. The public also had access to DHS project leaders and MAD consultants throughout the process. Members of the public had access to the meeting notes and worksheets as the meetings progressed.

IV. Committee recommendations

Recommendation development

The committee identified core components of a dental home, discussed how progress towards achieving these components could be measured, and developed dozens of potential measures associated with dental home core components.

The committee then worked in breakout groups to narrow the list down to:

- 21 candidate *baseline requirements* that would describe the minimum expectations all dental homes need to have in place to be participants in the demonstration project
- 13 candidate *performance measures* that would describe ways to determine whether providers and the system are effective

Eighteen DHAC and DSAC members and 10 members of the public then ranked the above measures, and the committee determined the following:

- Six baseline requirements and six performance measures that received 11 or more votes would be recommended for the demonstration project
- The remaining measures would be included in Appendix B (additional potential baseline requirements) and Appendix C (additional potential performance measures)

Finally, the committee discussed the design of the demonstration project—what the committee also referred to as a "pilot" project—and developed recommended approaches for the pilot's financing and reimbursement model, provider selection parameters, and additional dental home pilot design considerations.

Core components of a dental home

The committee's aspiration for the dental home demonstration project (also referred to as the "pilot") is to enable providers to improve access to care and the patient experience, improve oral health clinical outcomes, and do so in a way that also increases the sustainability of the provider ecosystem. Dental homes would provide high-quality, patient-centered, comprehensive, and coordinated oral health services across clinical settings, community-based settings, and virtual oral health care.

The committee identified core components of a dental home, which were grouped together into the following themes. For a full list of underlying components, see Appendix A.

Access and patient experience

- **Diversity, equity, and inclusion**, including a focus on health equity and an ability to provide care to diverse populations including non-English speakers, young children, and older adults.

- **Patient-centeredness**, including community outreach and assistance in entering the system.
- **Access**, including geographic access, physical space accessibility, appointment availability, and minimizing barriers to dental appointments.

Oral health clinical outcomes

- **Quality, comprehensive clinical care**, including evidence-based high-quality clinical care and a route toward creating more evidence.
- **Coordinated, integrated medical-dental care**, including innovation to utilize the entire dental workforce, care coordination to encourage medical-dental referrals, and utilize social workers and community health workers for system navigation.
- **Anticipatory care and education,** including work on oral health literacy, education, prevention, and assessment, with goal of lessening the amount of restorative care needed.

Sustainable provider ecosystem

- **Effective and efficient operations**, including providers that are fluent in rules, regulations, and processes, and a system that is not administratively burdensome on providers.
- **Staffing and workforce innovation**, including utilizing the entire dental workforce to the top of license and creativity in the utilization of allied dental professionals to reduce barriers to care.
- **Provider fiscal sustainability**, including adequate and fair reimbursement, incentives for providers, and transparency and accountability for payers.
- **Controlling costs**, including improving care while controlling costs.

Because the committee's goals for a sustainable provider ecosystem reflect broad system-level goals rather than goals for individual patients or providers, baseline requirements and performance measures were not identified for this category. Instead, the committee identified potential informational data (see Appendix D) and recommended that providers be asked to describe how they plan to utilize the dental home demonstration project to enhance their practices in each of the core components of dental homes, including a sustainable provider ecosystem (see Additional considerations).

Final recommended baseline requirements

The committee recommended the following six baseline requirements as minimum expectations of all dental homes:

Access and patient experience

- Demonstrate capacity to offer preventative, screening, restorative continuity.
- Require procedures in place to provide urgent dental care services for members with swelling or severe pain.
- Demonstrate capacity to offer risk assessment and individualized care.

Oral health clinical outcomes

- Demonstrate capacity to deliver range of treatment needed, directly or through referral.
- Demonstrate ability to provide continuity and follow up.
- Require assessment of periodontal (gum) disease risk and caries (cavity) risk.

For a full list of potential baseline requirements, see Appendix B.

Final recommended performance measures

The committee recommended the following performance measures as ways to assess whether providers and the system are effective:

Access and patient experience

- Compare whether service utilization rates are equitable among patient demographic groups.
- Measure patient satisfaction via surveys.
- Measure reduced risk on recall and stabilization (no new disease).

Oral health clinical outcomes

- Compare diagnosis data with treatment data using claims to determine if follow-up treatment occurred.
- Compare periodontal (gum) disease and caries (cavity) risk assessment claims with total patient population served.
- Compare preventative services claims (for example, fluoride varnish, sealants) with total patient population served.

For a full list of potential performance measures, see Appendix C. In addition, for a list of potential additional measures to collect as informational data, see Appendix D.

Recommended demonstration project design

Financing and reimbursement model

The committee recommended the following demonstration project financing and reimbursement model:

- Initial pilot testing and analyzing the data collection of baseline requirements and performance measures, to evaluate whether measures themselves are appropriate (for example, whether they are feasible, scalable, valid, and reliable). This phase of the pilot would be designed as a grant program to both individual providers and networks of providers with supplementary funding on top of all existing payments.

- Later pilot phase testing and analyzing value-based payments to providers, to evaluate whether varying payments based on dental home performance measures is appropriate and effective. This phase of the pilot would be the first to vary provider payment levels based on their performance.

Selection parameters

The committee recommended that DHS consider the following parameters when selecting providers, in order to ensure a range of providers are included in the pilot demonstration project:

- Geographic distribution (rural/urban, Twin Cities Metro/Greater Minnesota)
- Provider size (small/large practices)
- Provider type (range of practice models, including innovative workforce models)
- Provider location (clinical as well as community settings, such as schools)
- Serving different priority populations; health equity data
- Provider accessibility for patients with varying levels and types of disability

Additional considerations

As part of the pilot, the committee recommended that providers be asked to describe how they plan to utilize the dental home demonstration project to enhance their practices in each of the core components of dental homes:

- Access and patient experience (for example, practices to increase access for patients with disabilities and diversity, equity, and inclusion strategies)
- Oral health clinical outcomes (for example, medical-dental care coordination and anticipatory care and education)
- Sustainable provider ecosystem (for example, innovative workforce practices and alternative delivery models)

The committee also recommended that DHS consider the following additional topics when designing the pilot demonstration project:

- How long will it take to launch pilot projects and how long should they last?
- Will providers need to test all measures, or will there be a menu of things that could be tested with providers allowed to choose? Will measures use universal measurement tools or will there be flexibility for practice-specific measurement tools?
- What will the cost be, and what will the roles be? How will data collection would work between providers, DHS, and MCOs?
- How do we ensure that a range of clinical settings and practice models are included in the pilot?
- How and when would a value-based payment model be linked to performance measures?
- What will funding look like for evaluation? How can we gather qualitative feedback from providers at the end, as well as at the beginning (for non-participating providers)?

- What is the role of partners, such as dental professional organizations, dental educational institutions, K-12 schools, the Minnesota Department of Health State Oral Health Program, the Minnesota Department of Human Services, and Managed Care Organizations?
- How can we support providers during the pilot? How do we build on what has already been learned, and how do providers continue to learn from one another?

Based on feedback received in the review of the report draft, an additional meeting was held on February 10, 2022. Notes from that meeting with additional recommendations on the implementation of the pilot program can be found in appendix E of this report.

V. Dental rate rebasing recommendations

Background

The 2021 Minnesota Legislature directed DHS to present recommendations on dental rate rebasing consistent with the proposed design of the dental home demonstration project addressing the frequency of rebasing, whether rebasing should incorporate an inflation factor, and other factors relevant to ensuring patient access to dental providers and the delivery of high-quality dental care.[4]

This section of the report was developed by DHS staff and presented to DHAC as part of the December 2, 2021 meeting.

Purpose and intent

Why rebasing is important:

- Rebasing ensures that rates paid for the delivery of dental services more closely reflect the needed resources (equipment/supplies and personnel) to deliver each procedure
- Current dental rates are based on 1989 charges and therefore reflect the distribution of cost to deliver dental services in 1989

Potential Rebasing Proposal:

- Budget Neutral Rebasing effective January 1, 2023
    - This would align dental payments, per procedure, more appropriately with the costs of delivering dental care today
- Ongoing Rebasing every three years
    - This would help ensure that dental rates continue to reflect ongoing changes in costs of delivery of care
- Inflationary factor in ongoing rebasing
    - This would ensure dental rates do not deteriorate again avoiding recreating the dental rates issues of the past.

[4] Laws of Minnesota 2021, 1st Spec. Sess. chapter 13, article 1, section 38.

Legislative language (256B.76)

Effective for services provided on or after January 1, 2023, payment for dental services shall be the lower of submitted charges, or the XX percentile of 2018 submitted charges from claims paid by the commissioner. The total aggregate expenditures shall not exceed the total spend as outlined in paragraphs XX through XX of this section. This section does not apply to federally qualified health centers, rural health centers, state operated dental clinics or Indian health centers.

Beginning January 1, 2026, and every three years thereafter, the Commissioner shall rebase payment rates for dental services to the XXX percentile of submitted charges for the applicable base year using charge data from paid claims submitted by providers. The total aggregate expenditures shall not exceed the total spend as outlined in paragraphs (?) through (?) of this section plus the change in the Medical Economic Index (MEI). In 2026, the change in MEI shall be measured from midyear of 2023 and 2025. For each subsequent rebasing, the change in MEI shall be measured between the years that are one year after the rebasing years. The base year used for each rebasing shall be the calendar year that is two years prior to the effective date of the rebasing. This section does not apply to federally qualified health centers, rural health centers, state operated dental clinics or Indian health centers.

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VII. Appendices

Appendix A: Core components of a dental home

In its first meeting on September 23, the Dental Home Advisory Committee (DHAC) worked in small groups to identify up to 10 core components of a dental home. Facilitators from Management Analysis and Development (MAD) grouped these components into themes. Components are listed below, with underlying ideas from different small groups included underneath the component they were grouped into.

Access and patient experience

Diversity, equity, and inclusion

- Cultural competence
- Broad array of services in a culturally competent manner
- Ideally in the community in which they live
- Cultural competency, humility, and agility
- Focusing on health equity, allocating resources with health equity
- Efforts to target the uninsured or underinsured
- Ability to provide care to diverse populations (e.g., non-English-speaking members, young children, elderly adults)

Patient-centeredness

- Family- and patient-centered care
- Patient education—assistance in accessing the system
- Look at community outreach to establish the dental home
- Dedicated to and passionate about serving Medical Assistance members

Access

- Access including but not limited to geographic access, open appointments, and physical space
- Ability to see new patients and those with acute dental needs
- Continuous ongoing accessible comprehensive care
- Serves the members' non-dental needs to minimize barriers to a dental appointment, for example, scheduling transportation and interpretation services as necessary
- Technology, including systems and equipment, to allow for the use of teledentistry
- Prevention work in schools and nursing homes
- Free care and sliding fee care
- Reasonable waiting period to get access
- Reducing overall barriers to care

- Accessibility (geography, availability of appointments, space)

Oral health clinical outcomes

Quality, comprehensive clinical care

- Evidence-based high-quality clinical care
- Evidence-based and a route toward creating more evidence
- Comprehensive clinical assessment in care

Coordinated, integrated medical-dental care

- Collaborative with specialists
- Creativity in the utilization of allied dental professionals to reduce barriers to care
- Innovation to utilize the entire dental workforce
- Care coordination to encourage networking and referral that is medical and dental
- Hub and spoke model
- Services for people with disabilities
- Wrap-around services and referrals
- Comprehensive and coordinated services
- Interdisciplinary care
- Social workers and community health workers for navigation, social determinants of health and coordination
- Expanded and integrated care team—medical and dental integration

Anticipatory care and education

- Education, prevention, and assessment focus in order to lessen the amount of restorative care needed
- Addressing oral health literacy

Sustainable provider ecosystem

Effective and efficient operations

- Fluent in Minnesota Medicaid rules, regulations, and processes
- Not be administratively burdensome

Staffing and workforce

- Entire dental workforce working to top of license
- Staffing—non-dental staffing; hard to recruit dental assistants
- Innovation, utilizing the entire dental workforce
- Creativity in the utilization of allied dental professionals to reduce barriers to care

- Providers—types of providers

Provider fiscal sustainability

- Adequate and fair reimbursement
- Fixes a broken non-system toward a financially sustainable model
- Incentives for providers in a "value-based care lite" manner
- Sustainable practice models
- Transparency and accountability for payers

Controlling costs

- Moves us toward the triple aim
- Improving care and controlling costs

Appendix B: Additional potential baseline requirements

Access and patient experience

- Demonstrate capacity to accept new patients.
- Require collection of patient demographics in intake data (race, ethnicity, language, special health care needs).
- Require process for patients to provide feedback.
- Demonstrate availability of interpretation services and transportation services.
- Provide teledentistry option.
- Demonstrate capacity to minimize wait times for appointments or to be seen.
- Require a continuing education class that focuses on cultural competency (annual attestation form).
- Demonstrate capacity to offer disease mitigation.

Oral health clinical outcomes

- Require utilization of Oral Health Impact Profile (OHIP) measures to assess patient perception of disease.
- Require routine oral cancer exams, blood pressure screenings.
- Demonstrate capacity to provide preventive education.
- Require routine fluoride varnish and sealants.
- Require peer review and provider clinical coaching.
- Demonstrate capability to manage medical emergencies.
- Require utilization of the Prescription Monitoring Program (PMP).

Appendix C: Additional potential performance measures

Access and patient experience

- Distance driven to receive care (system performance measure).
- Measure utilization of workforce to top of license using claims data.
- Compare whether patient demographics reflect site-specific Medicaid demographics.
- Measure interpreter and transportation services using claims data.

Oral health clinical outcomes

- Compare referral data with third party claims data to determine if treatment occurred.
- Measure fluoride application for high-risk patients.
- Measure percent of patients returning.

Appendix D: Potential informational data

Oral health clinical outcomes

- Number of services being conducted by type
- Extent minimally invasive care being provided
- Retrospectively evaluate if care provided was effective
- ER data analysis—how many ER visits are for dental concerns
- Cross-training of medical professionals with dental professionals
- Processes in place to appropriately handle referrals from medical providers
- Clinical outcomes measured by race/ethnicity and language

Access and patient experience

- DHS should map:
    - Where the non-users are
    - Who visits an ER
    - With improved place of service field, distance to place of service
- Workforce diversity
- Free and reduced-price lunch data and dental visits
- Percentage of patients using Medicaid
- Percentage of uninsured patients
- Percentage of patients served using sliding fee scales
- Geographic access
- Access for undocumented patients
- Waiting time for next appointment
- Waiting time to be seen (from scheduling to visit)

- Timeliness of urgent care when needed

Sustainable provider ecosystem

- Claims for services provided by collaborative practice providers
- Provider fiscal sustainability
- Cost control

Appendix E: Dental Home February Follow Up Meeting

Dental Home Advisory Committee

February 10, 2022

Follow Up Meeting Notes

While compiling feedback for the legislative report on a Dental Home Demonstration Project, the Dental Home Advisory Committee (DHAC) identified four topics for additional discussion:

- Ensuring a range of clinical settings and practice models are included in the pilot
- Whether measures will use universal measurement tools or whether there will be flexibility for practice-specific measurement tools
- How data collection will work between providers, DHS, and MCOs
- Pilot design and operations, including timeline and stages

The following summarizes the key points by topic that the DHAC members emphasized in this discussion.

Ensuring a range of clinical settings and practice models are included in the pilot

Throughout the meeting process, DHAC members expressed the importance of ensuring that a wide range of providers can participate in the dental home pilot so that the dental home model can ultimately scale across a range of practice settings. In the legislative report, the committee defined selection parameters to encourage a wide range of providers in the pilot:

- Geographic distribution (rural/urban, Twin Cities Metro/Greater Minnesota)
- Provider size (small/large practices)
- Provider type (range of practice models, including innovative workforce models)
- Provider location (clinical as well as community settings, such as schools)
- Serving different priority populations (health equity data)
- Provider accessibility for patients with varying levels and types of disability

In addition, the committee intentionally kept the number of recommended baseline requirements and performance measures manageable in order to minimize the complexity of the pilot for participating providers.

In support of ensuring a range of providers in the pilot, DHAC participants suggested the following during the February 10 meeting:

- Parameters for selection should be explicit in the RFP and signal DHS's intention to test the dental home model across the oral health delivery system.
- The application process should be accessible and not overly burdensome.

- The number of providers included in the pilot will impact the ability to include a range of different providers.
- Maximize geographic distribution of pilots across the state while keeping in mind providers within the Twin Cities Metro may be serving different priority populations.
- The legislature could provide pilot providers with flexibility in areas such as collaborative practice dental hygienists, enabling providers to engage in emerging practices relevant to the dental home model.

Whether measures will use universal measurement tools or whether there will be flexibility for practice-specific measurement tools

In previous meetings, DHAC noted that the pilot allows providers the opportunity for learning and exploration. In support of experimentation, DHAC suggested providers have a "menu" of measures they could test as part of the pilot.

In the February 10 meeting, the group reiterated that the pilot needs to have a broad "general framework" within which providers design their dental home with creativity and flexibility. A goal of the pilot will be to provide providers with flexibility within a standard framework that enables the state to develop measures which are validated and comparable.

The group arrived at consensus on the following points:

- All pilot providers will be required to report out on baseline requirements as spelled out in the legislative report. In addition, pilot providers will also be required to select from a "menu" of performance measures to test as part of the pilot.
- It is preferable to have the same instruments when measuring baseline requirements and performance measures. If this is not possible in all cases, an instrument that has the capability to be cross-walked for ease in comparability will be accepted.
- It is hoped that the pilot will gather informational data on access, care provided, and other core outcomes beyond baseline requirements and performance measures for data comparability.

The following comments were also made by participants on this subject:

- If we want to keep comparability with Institute of Medicine and federal agencies, would keep the target framework comparable and connected to those frameworks. Not a problem to add more measures — just a question of feasibility. "Menu" approach works, but some items should be mandatory to keep comparability to other results in other settings.
- Iowa has a substantial list of measures that may be helpful for reference and comparison.
- Want to also provide comparability for other states back to Minnesota.
- Access is a core measurement that we need to consider. However, unsure we can increase access without more staff or resources.
- Comparability is complex: For access, there is a difference between merely seeing 20 patients for a dental visit and actually providing them with advanced restorative services.

- A lot of focus is on access. Access per se from a research perspective is nothing without an improvement in outcomes. We provide access in order to do something; we want to demonstrate that access did something to the patient. NIH tool for example looks at oral health outcomes.
- We don't have consistent, reliable tools right now. The pilot might be an opportunity to develop the right tools to measure things like access and oral health outcomes.
- The pilot will need to assess the validity of measures, including for different patient populations.

How data collection will work between providers, DHS, and MCOs

In previous meetings, DHAC discussed that the dental home pilot will need to develop deeper partnership across providers, DHS, and MCOs to support data collection. Some existing data are readily available, such as claims data—yet these data also have clear limitations.

In the February 10 meeting, the group arrived at consensus regarding use of the pilot to incentivize providers, DHS, and MCOs to participate in convening activities and share data.

The following comments were also made by participants on this subject:

- DHS may need additional appropriation to do more data sharing and analytics.
- MCOs should be encouraged via DHS contracting to engage in projects and share data and information.
- In other arenas, DHS, MCOs, health care homes all come together and work through some of these things. Learning from these other settings, create a similar structures and incentives for collaboration as part of the dental home pilot.
- The desire to look to other clinical settings to find a 'usability questionnaire' or other tool that could be applied in a dental home setting.

Pilot design and operations, including timeline and stages

In previous meetings, DHAC discussed that the dental home pilot will likely occur in multiple stages. Early stages will be structured as a grant and focus on data collection to develop and validate measures. Potential later stages could be structured to focus on value-based incentives based on the measures developed in earlier stages.

On February 10, the group arrived at consensus on the following points:

- Timeline
    - There will need to be an initial period for feedback and input in fall 2022
    - Contracting will likely begin in early 2023, followed by time to work out details of measurement with participating providers
    - Patient-facing aspects of the pilot could begin in July 2023, and last for around 3 years for the initial measurement period. This timing may vary by provider as some pilots might move towards later-stage evaluation of value-based payments earlier than others.

- There will need to be concurrent measurement and evaluation work during the pilot as well as post-pilot follow up evaluation work.
- There is no clear answer on the number or size of pilot grants should be. This should be considered as part of the fall 2022 feedback and input process.

The following comments were also made by participants on this subject:

- California discovered they need 5 years for the initial measurement period. We would need a minimum of 3 years of actually doing the pilot. It will also take time for DHS to gear up as well as the providers. Time will also be needed afterwards for evaluation.
- Request for Information (RFI) or Request for Proposals (RFP) is the first step in the process of the pilot, then later on there is the process of starting the measurement. We need considerable front-end work in execution of the contracts to determine what people are measuring and how. Contracting could start before measurement.
- If you have an intervention, the minimal timeline is when the patient experiences the intervention. For most dental interventions, it takes 2 years to have an impact on the patient. Also, there will need to be time for recruitment. We probably don't need 5 years as some impacts could show up earlier.
- Because patients may not come frequently, interventions take time to show impact. In reaching new patients, we'll also need to consider existing capacity constraints.
- Consider large number of providers (10+) to ensure we have a variety of providers across different dimensions.
- Consider evaluability—if you don't have capacity to measure something meaningfully, it isn't effective to measure it.
- Include a meeting midway into the pilot timeline to look at interim outcomes and progress.
- Initial RFP submissions from providers could include a theory or proposal of how value-based payments could be linked to scaling up this effort in the future. The pilot would not move towards value-based payments until comfortable with data and measurement, however.
- Pilots could take multiple paths, including a path for less sophisticated practices to participate. Would potentially be easier for a provider to follow and test what has been successful elsewhere than to design and test entirely new items.
- We could have different types of pilots (for example, smaller grants focusing just on baseline measures) that could attract more providers, and also have larger grants for others doing more ambitious pilots.