VALUE-BASED PAYMENT AND ORAL HEALTH

Cracking the Code

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Value Based Care Program

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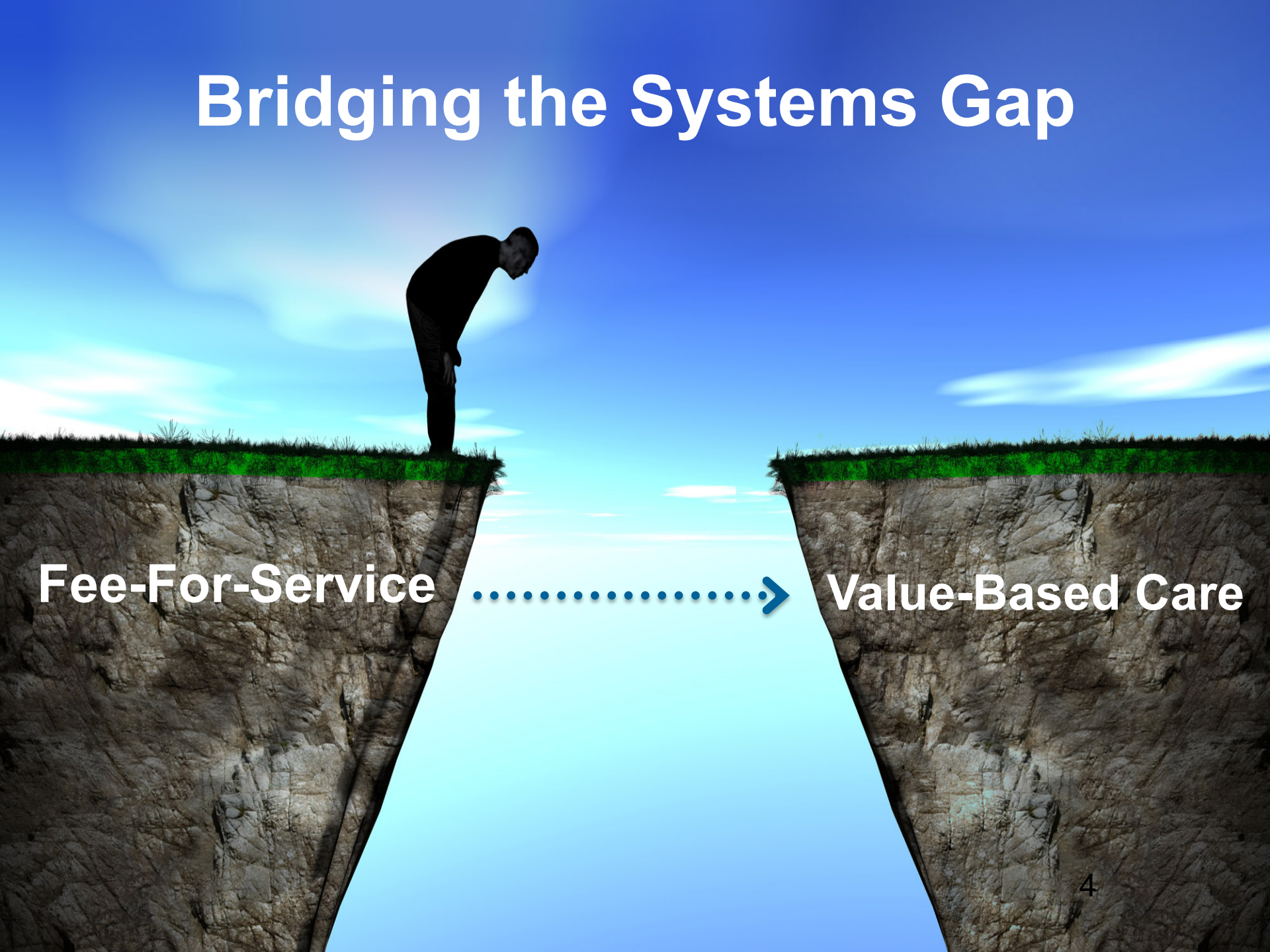
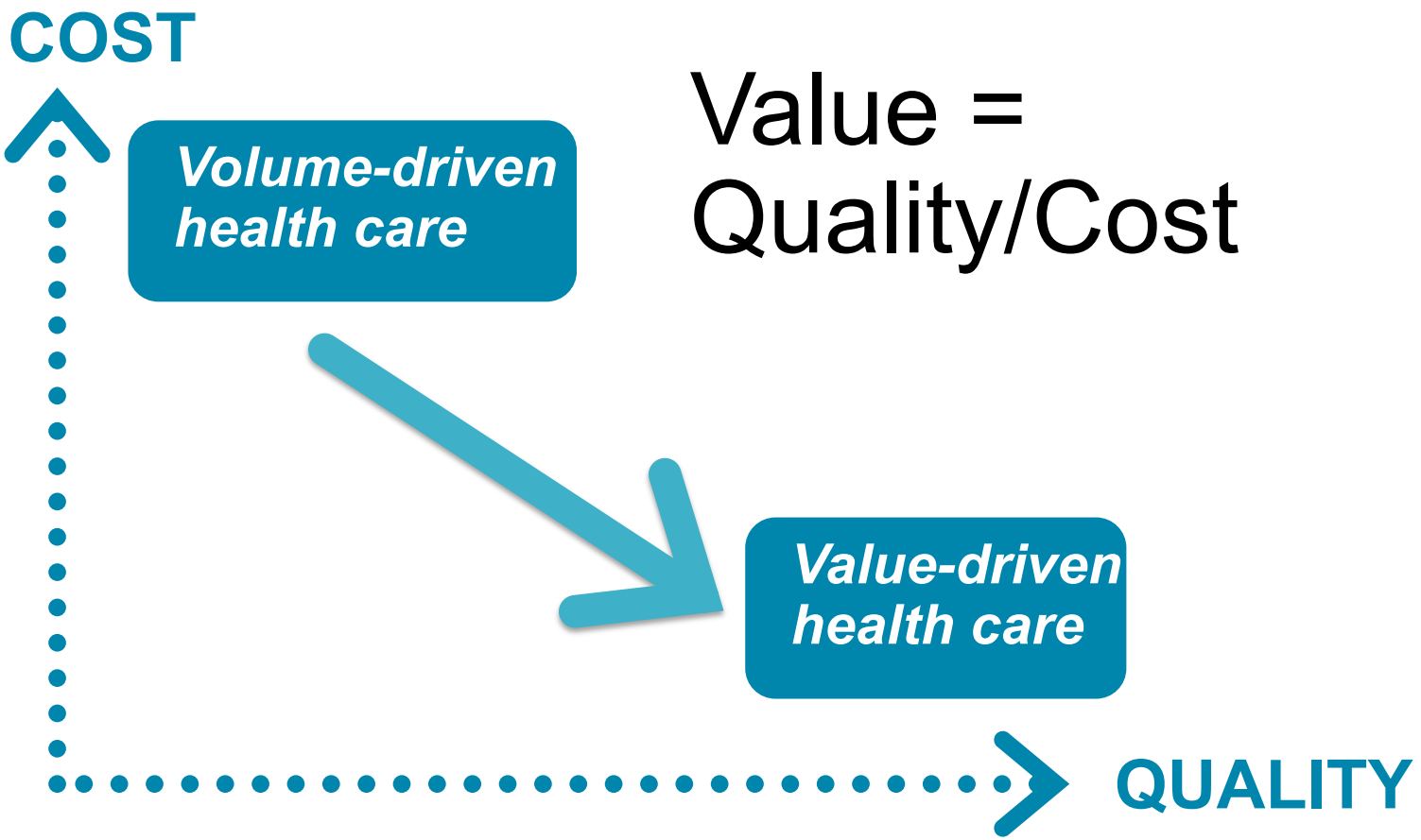
- There is no one model of OHVBC
- Paradox: More for less
- Is…. better……better ?

Value-based healthcare is a healthcare delivery model in which providers are paid based upon making patients healthier while reducing costs of care.

Bridging the Systems Gap



Value Equation is a Paradox



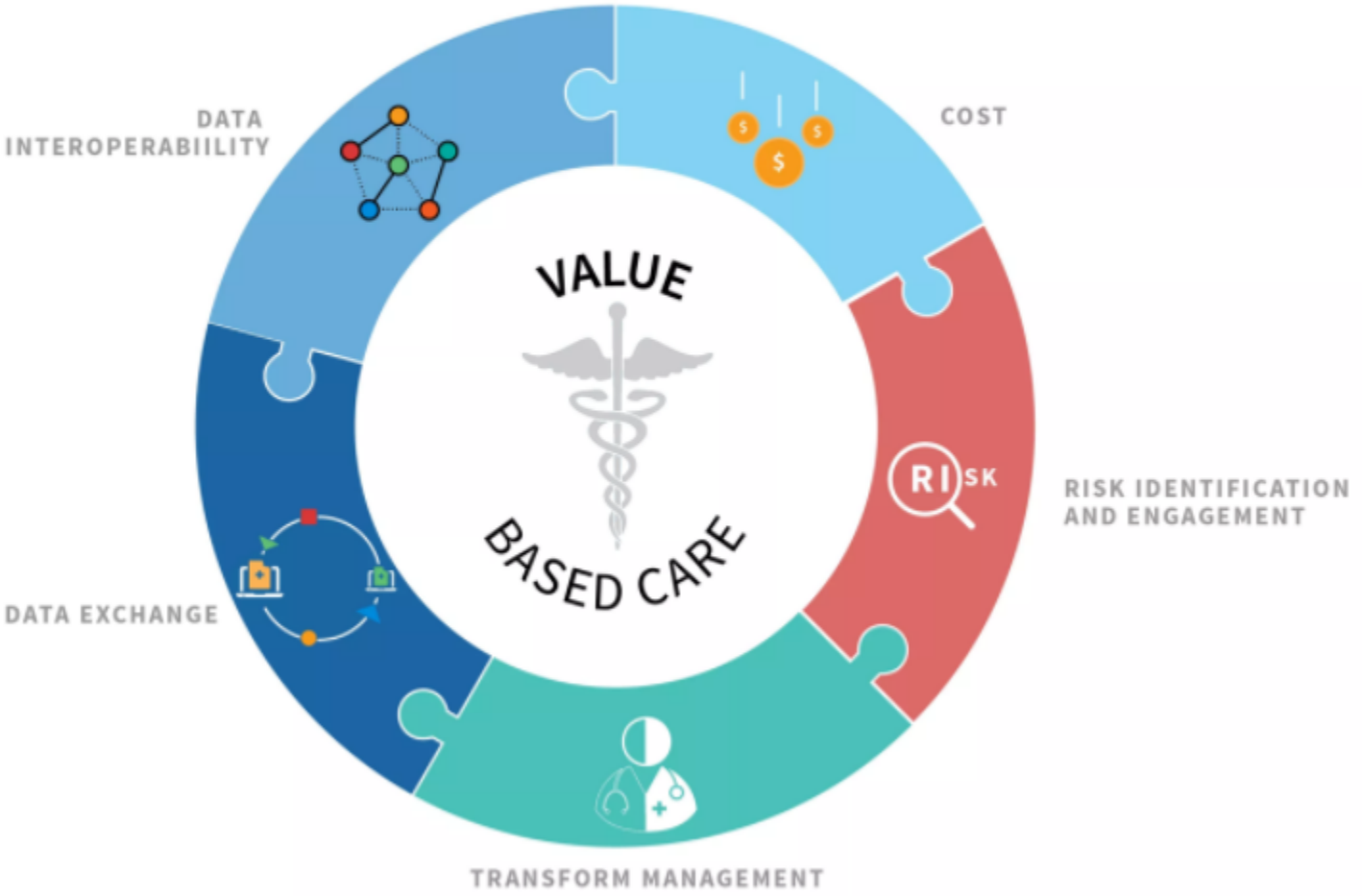
Fee for Service pays us for what we do.

Value Based Care pays us for what we do not do!!!

Fee for Service pays us for what we do.

Value Based Care pays us for the outcomes of our care

VBC Created for Medicine



https://www.omicsonline.org/open-access/what-is-an-integrated-health-care-financing-and-delivery-system-idsand-what-must-wouldbe-ids-accomplish-to-become-competitive-with-heor-1000115.php?aid=73212

Why Health Care Payment Reform?

30%
of health care expenditures is waste

88%
of health care dollars are spent on access

50%
of Medicare dollars spent on 6% of the population during last 6 months of life

Spend $3.3 trillion:> $10,000/person per year

Houston we have a problem!
Something has to change

Source: Institute of Medicine Report – The Healthcare Imperative

Physician/Medicine vs. Dentist/Oral Health Demographics

900,000 physicians	170,000 dentists
4 million nurses	205,000 hygienists
100,000 NPs/PAs	< 100 DTs
130 specialties	9 specialties
$3.3 trillion budget	$128 billion budget(3.96% of Health)
5,535 hospital systems	
900,000 hospital beds	
35 million hospital admissions/year	
Cost of $1 trillion hosp. admits	
561 ACOs/ 10.5 million beneficiaries	
50% physicians are employed	15% dentists are employed
<25% physicians belong to the AMA	>65% dentists belong to the ADA
Medicare and Medicaid	Medicaid

U.S. is ranked 37th by the WHO for health outcomes

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OHVBC is Not:

- Simple
- One size fits all
- Guaranteed to work
- Going away
- Instant

Domains of VBC

Leadership, Vision and Will

Structure, Systems and Operations

Care Pathways and Provider Buy-In

Data/ Analytics Technology and Personnel

Financial Strength

Transition vs. Transformation

Health Systems Change Framework

Treating Symptoms

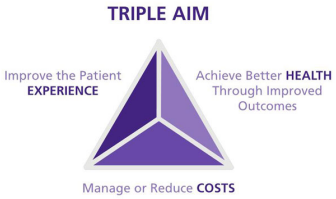

EXHIBIT 1

Three Eras Of Health And Health Care—Three Operating Systems

	First era—1.0: medical care and public health services (1850s to 1960s)	Second era—2.0: health care system (1950s to present day)	Third era—3.0: health system (2000 going forward)
Definition of *health*	Absence of acute disease	Reduction of chronic disease	Creating capacities to achieve goals, satisfy needs, fortify reserves
Goal of health system	Improve life expectancy	Reduce disability	Optimize health
Model of health and disease causation	Biomedical	Biopsychosocial	Life-course health development
Primary focus of services	Diagnose and treat acute conditions	Prevent and manage chronic disease	Promote and optimize health of individuals and populations
Organizational operational model	Clinics and offices linked to hospitals	Accountable care organizations and medical homes	Community-accountable health development systems
Dominant payment mechanisms	Indemnity insurance; fee-for-service	Prepaid health benefits, capitation	Health trusts and management of balanced portfolio of financing vehicles
Role of health and health care provider/organization	To protect from harm, cure the sick, and heal the ill	To prevent and control risk, manage chronic disease, and improve quality of care	To optimize health and well-being
Role of individual and community	Inexperienced patient	Activated partner in care	Co-designers of health

http://www.dosseydossey.com/barbara/pdf/Dossey-Integral_Nursing_HN_6th_ed.pdf

http://www.ihi.org/resources/Pages/Publications/Era-Three-for-Medicine-Health-Care.aspx

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Effective Communication

OHVBP: An Opportunity

Opportunity to be at the Table and not on the Menu

The fact that an alternative payment model is different from fee-for-service does not necessarily mean it is better.

DESIGN

Fee-For-Service

What Works

- Providers are only paid when they provide a service
- Pays for more care when patients need it (volume)
- Payment does not depend upon variables the provider can't control
- Predictable payment, Providers know what they will be paid before they provide a service

What Does not Work

- Care is not linked to quality or results
- Care provided is not predictable
- Cost of care can exceed the payment for care
- No fees for many needed services
- Costs for care are not predictable or comparable

www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

Pay For Performance
What Does not Work

- P4P services provided may not be the ones that a particular patient needs
- Payments may not be enough to cover the costs of care
- There may be needed services that are not covered by the P4P plan
- Costs for care are not predictable or comparable
- Providers still have to deliver services to be paid. P4P is just an adjustment to FFS provided
- Providers could get paid less for treating patients with greater needs
- Providers could get paid less for things they can't control

www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

OHVBC 101

What You Need to Know

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Creating the Win-Win-Win-Win!!

Payers-Contractors-Providers-Patients

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Value Based Purchasing: What do states/payors want?

Improved processes and healthcare services

Improved health outcomes

Lower costs→ Decreased PM/PM

Broader provider network

Broader benefit package

Increased capacity→ Increased access→ Increased use of services

Value Based Purchasing: What do states/payors want?

Decreased disparities

Increased preventive services

Model which couples performance and cost measures→ value based program

Measures that demonstrate improvement across all quality domains

A program model that is cost-effective

Value Based Purchasing: What do contractors want?

- Realistic and achievable goals
- Potential profit
- Normal contract provisions
- RFP includes contract performance requirements, program goals and terms and conditions that are clear, meaningful, doable and measureable

Value Based Purchasing: What do contractors want?

- Ability to communicate with both providers and patients
- Clarity related to expectations
- Pre-procurement communication lines open
- Ability to continue communication during implementation
- Actuarial precision
- Ability to assign patients based on history and capacity

Value Based Purchasing: What do contractors want?

Ongoing partnership in program improvement

Outreach to members

Value Based Purchasing: What do patients want?

Convenient, accessible

Quality

Equitable

Person-centered

Satisfying

Timely

Input

Safe

Value Based Purchasing: What do providers want?

Person Centeredness

Standardized

Evidence-based

Financially rewarding

Measurable

Ethical

Care expectations clearly delineated

Input on assignation of patients

Contact with assigned patients

OHVBC CONTRACT 101

What You Need to Know

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What is Defined in the Contract?

1. Membership Assignment
2. Compensation
3. Minimum Operational Metrics
4. Quality-Based Metrics and Incentives
5. Provision of Services; Specialty Services
6. Submission of Encounter/Claims
7. Monitoring

Health Care Finance Terminology

Prospective Payment System (PPS)

Alternative Payment Methodology (APM)

Fee-for-Service (FFS)

Encounter or Cost-Based

Per Member Per Month (PMPM)

Value-Based Payment(VBP) or Care (VBC)

Pay 4 Performance (P4P)

Bundles

Episodes of Care

Evidence Based Care (EBC)

Global Payment

http://info.pyapc.com/hubfs/White-Papers/Glossary-Reference-Guide-PYA.pdf

Membership Assignment

Assigned Member- Medicaid member who has been selected or assigned to a Provider Service Location as his or her Dental Home.

Members are assigned based on:

- ❑ Member preference
- ❑ Member prior association
- ❑ Member family or household association
- ❑ Geographic convenience
- ❑ Provider specialty

Compensation

- Provider will be paid a monthly per member per month (PMPM) rate for assigned patients
- Mix of FFS ?

Sample Guidelines Related to Minimum Operational Metrics

- Providers assigned patients must meet the minimum operational measures (Goals)
- Performance will be monitored and reported
- Failing to meet any one or more of the Operational Measure Minimums during a set period will have consequences such as:
    - Reduced PMPM rate
    - Assigned member reduction
    - Termination of agreement
    - Termination of VBP program and reversion to a fee-for-service payment

Sample Minimum Operational Measures

Minimum Operational Metric	Description
Monthly Access Rate	Monthly Access Rate= % of all Assigned Members who had a dental visit within the reporting period
Risk Status Assessment	% of enrolled patients whose risk status was formally assessed and recorded within the reporting year
Percentage of Preventive Services	Percentage of all Services provided that were preventive indicated by CDT codes
Percentage of Diagnostic Services	Percentage of all Services provided that were diagnostic indicated by CDT codes
Percentage of Treatment Services	Percentage of all Services provided that were treatment indicated by CDT codes

Operational Measures are examples extracted from DQA and SNS

Sample Guidelines Related to Quality-Based Incentives

- In addition to PMPM Payments, provider is eligible to receive additional incentive compensation
- Providers who exceed the minimum target measurement on one or more of the Quality Measures during the measurement period may qualify for additional incentive compensation

Sample Quality-Based Incentive Measures

Quality Metric	Description	Medicaid Age
DQA Oral Evaluation, Dental Services	Percentage of eligible Assigned Members 0-20 years of ages who: • Received a comprehensive or periodic oral evaluation within the measurement period	0-20 years
DQA Topical Fluoride for children at Elevated Caries Risk, Dental Services	Percentage of eligible Assigned Members 0-20 years of ages and at "elevated" risk for cavities (i.e, "moderate or "high") who: • Received at least 2 topical fluoride applications within the measurement period	0-20 years
DQA Dental Sealant for 6-9 Year old Children at Elevated Risk, Dental Services	Percentage of eligible Assigned Members 6-9 years of age and at "elevated" risk for cavities (i.e, "moderate or "high") who: • Received a sealant on a permanent tooth within the measurement period	6-9 years
DQA Dental Sealant for 10-14 Year old Children at Elevated Risk, Dental Services	Percentage of eligible Assigned Members 10-14 years of age and at "elevated" risk for cavities (i.e, "moderate or "high") who: • Received a sealant on a permanent second molar within the measurement period	10-14 years
DQA Adult Metric for 18+ Year olds at Elevated Risk, Dental Services	% of enrolled adults 18+ at elevated risk (moderate or high risk) who received at least two topical fluoride applications within the reporting year	18 + years

Contract

- Assigned members
- Compensation
- Operational measures
- Quality based incentive measures

HCP LAN
Health Care Payment Learning & Action Network

APM Framework

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

A

Foundational Payments for Infrastructure & Operations

B

Pay for Reporting

C

Rewards for Performance

D

Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

A

APMs with Upside Gainsharing

B

APMs with Upside Gainsharing/ Downside Risk

Category 4

Population-Based Payment

A

Condition-Specific Population-Based Payment

B

Comprehensive Population-Based Payment

Source: HCPLAN

LAN as a Menu for a Blended OHVBC Plan

- FFS
- **Reduced FFS**
- Specialty FFS
- **Bonus** for infrastructure
- **Bonus** for reporting
- **P4P**
- **Care bundles**
- **Episodes of care**
- Care coordination
- **Capitated care tied to specific procedures for assigned patients**
- Capitated care for condition specific populations or for specific populations
- **Global payment for comprehensive care of a population**

Examples of OHVBC Models

Category 2C: Pay-for-Performance

Category 2
Fee for Service
–
Link to
Quality & Value

Payment Model: FFS and PMPM payment linked to achieving quality metric goals

Payment Mechanism: Fee-for-service (at 75% of old FFS fees) with performance bonuses paid quarterly and annually for achieving agreed upon clinical goals (listed) (This is how you make up the 25% reduction in FFS)

Category 2
Fee for Service
–
Link to
Quality & Value

Category 2C: Pay-for-Performance Methodology

Dental practice is paid incentives for achieving pre-selected operational and quality measures.

Goals:

- % attributed/assigned patients seen (PMPM for 90%,80%,70%....) (Operational measure)
- % children needing sealants receiving sealants
- % assigned/attributed patients receiving a CRA
- % Patients with elevated (high-mod) risk status lowered
- % children 0-13 moderate/high risk having 2 Fluoride varnish applications in 12 months.

Category 4B: Comprehensive Population-Based Payment

Category 4
Population-Based Payment

Payment Model: PMPM capitated for all contract specified care provided for entire group of attributed patients

Payment Mechanism: PMPM for the population assigned

Patient Population: All institutionalized children assigned to the practice

Methodology: PMPM with timely accurate reporting on numbers of children served and upon agreed upon services provided as goals (exams, CRAs, cleanings, sealants, fluoride, interim and permanent treatments.....)

Category 4C: Integrated Delivery System (IDS)

Payment Model: A global payment PMPM for the total health of all attributed patients

Patient Population: Adults and children in the network

Methodology: An integrated health care delivery system is one in which all the providers whose services affect a patient work together in a coordinated fashion, sharing relevant medical information, sharing aims or goals (often measurable and measured), sharing responsibility for patient outcomes, and for resource use. The focus of their efforts will be the triple aim and decisions are made with the total results, i.e. patient outcomes and total resource use in mind. Patients are the shared responsibility of the team. Patients perceive that the providers caring for them communicate with each other and share information fully.

https://www.omicsonline.org/open-access/what-is-an-integrated-health-care-financing-and-delivery-system-idsand-what-must-wouldbe-ids-accomplish-to-become-competitive-with-heor-1000115.php?aid=73212

Category 2A: Foundational Payments for Infrastructure and Operations

Payment Model: FFS and PMPM with bonus for achieving infrastructure and reporting goals (Called upside APM)

Example: Software purchase for real time reporting

Methodology: distribute PMPM payment to primary care dentists who have achieved pre set goals of acquiring infrastructure and for timely reporting

Category 4A: Condition-Specific Population-Based Payment

Payment Model: A fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.

Category 4A: Condition-Specific Population-Based Payment

Payment Model: PMPM/Mo for specified patients

Patient Population: Institutionalized patients with disabilities in a state

Methodology: Each month a PMPM is paid for numbers of attributed patients treated and for the treatments provided per agreed upon scope and goals specified in the contract

Major Challenges?

OHVBC: Capitation in Disguise?

Design

Creating the Win-Win-Win-Win!!

Payers-Contractors-Providers-Patients

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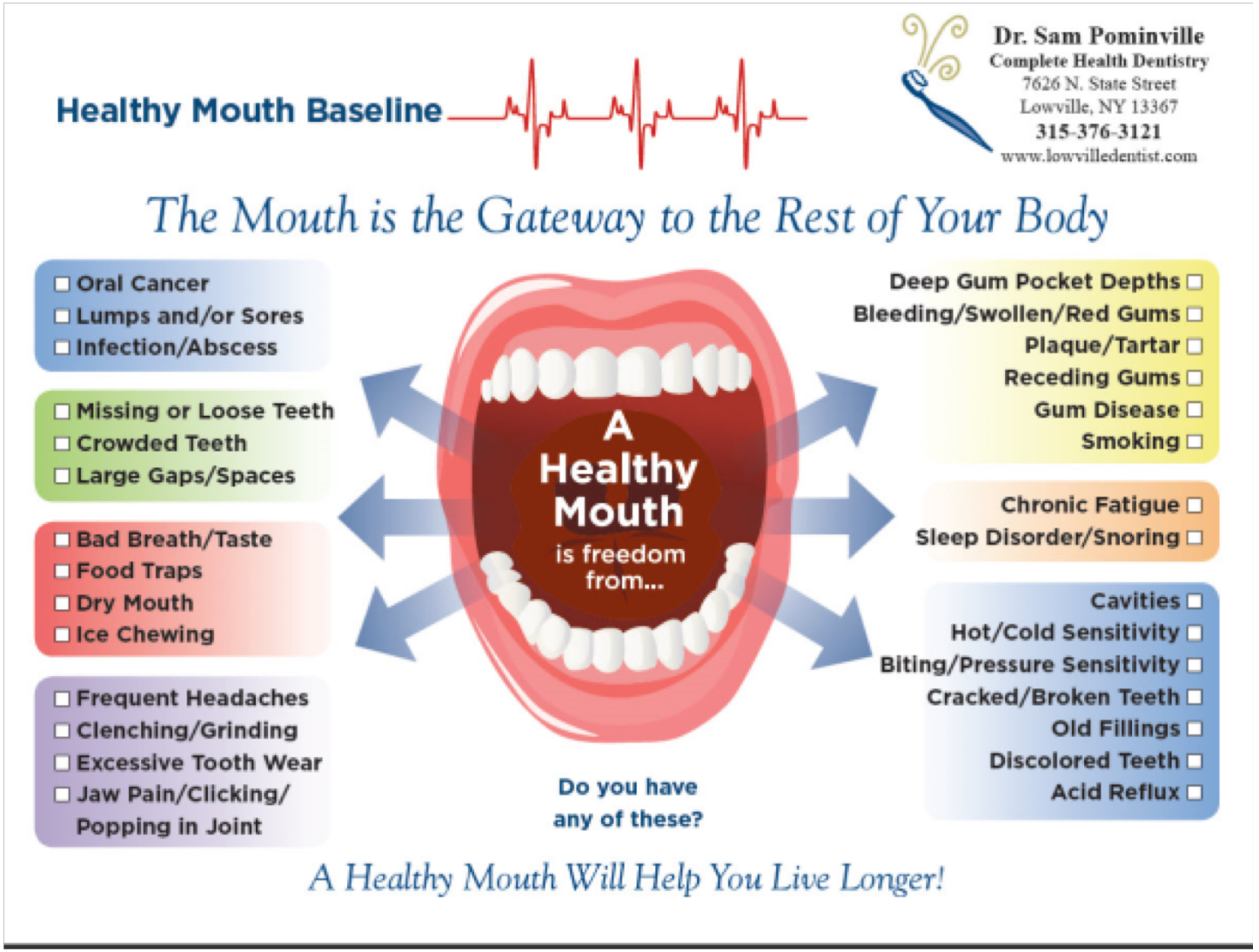
What makes people healthy?



Independent dental practice?

Thank you!

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