VALUE-BASED PAYMENT AND ORAL HEALTH

Cracking the Code

Mark Doherty
Executive Director
DentaQuest Partnership for Oral Health Advancement's Value Based Care Program
• 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

Fee-For-Service  Value-Based Care
Value Equation is a Paradox

Value = Quality/Cost

Volume-driven health care

Value-driven health care
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

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

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

**Three Eras Of Health And Health Care—Three Operating Systems**

<table>
<thead>
<tr>
<th>First era—1.0: medical care and public health services (1850s to 1960s)</th>
<th>Second era—2.0: health care system (1950s to present day)</th>
<th>Third era—3.0: health system (2000 going forward)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of health</strong></td>
<td>Absence of acute disease</td>
<td>Reduction of chronic disease</td>
</tr>
<tr>
<td><strong>Goal of health system</strong></td>
<td>Improve life expectancy</td>
<td>Reduce disability</td>
</tr>
<tr>
<td><strong>Model of health and disease causation</strong></td>
<td>Biomedical</td>
<td>Biopsychosocial</td>
</tr>
<tr>
<td><strong>Primary focus of services</strong></td>
<td>Diagnose and treat acute conditions</td>
<td>Prevent and manage chronic disease</td>
</tr>
<tr>
<td><strong>Organizational operational model</strong></td>
<td>Clinics and offices linked to hospitals</td>
<td>Accountable care organizations and medical homes</td>
</tr>
<tr>
<td><strong>Dominant payment mechanisms</strong></td>
<td>Indemnity insurance; fee-for-service</td>
<td>Prepaid health benefits, capitation</td>
</tr>
<tr>
<td><strong>Role of health and health care provider/organization</strong></td>
<td>To protect from harm, cure the sick, and heal the ill</td>
<td>To prevent and control risk, manage chronic disease, and improve quality of care</td>
</tr>
<tr>
<td><strong>Role of individual and community</strong></td>
<td>Inexperienced patient</td>
<td>Activated partner in care</td>
</tr>
</tbody>
</table>


[http://www.ihi.org/resources/Pages/Publications/Era-Three-for-Medicine-Health-Care.aspx](http://www.ihi.org/resources/Pages/Publications/Era-Three-for-Medicine-Health-Care.aspx)
Effective Communication

What is the matter with you?

What matters to you?
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.
<table>
<thead>
<tr>
<th>Fee-For-Service</th>
<th>What Works</th>
<th>What Does not Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Providers are only paid when they provide a service</td>
<td>• Care is not linked to quality or results</td>
</tr>
<tr>
<td></td>
<td>• Pays for more care when patients need it (volume)</td>
<td>• Care provided is not predictable</td>
</tr>
<tr>
<td></td>
<td>• Payment does not depend upon variables the provider can’t control</td>
<td>• Cost of care can exceed the payment for care</td>
</tr>
<tr>
<td></td>
<td>• Predictable payment, Providers know what they will be paid before they provide a service</td>
<td>• No fees for many needed services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Costs for care are not predictable or comparable</td>
</tr>
</tbody>
</table>

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
OHVBC 101

What You Need to Know
Creating the Win-Win-Win-Win-Win!!

Payers-Contractors-Providers-Patients
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
<table>
<thead>
<tr>
<th>Value Based Purchasing: What do providers want?</th>
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</thead>
<tbody>
<tr>
<td>Person Centeredness</td>
</tr>
<tr>
<td>Standardized</td>
</tr>
<tr>
<td>Evidence-based</td>
</tr>
<tr>
<td>Financially rewarding</td>
</tr>
<tr>
<td>Measurable</td>
</tr>
<tr>
<td>Ethical</td>
</tr>
<tr>
<td>Care expectations clearly delineated</td>
</tr>
<tr>
<td>Input on assignation of patients</td>
</tr>
<tr>
<td>Contact with assigned patients</td>
</tr>
</tbody>
</table>

DentaQuest
OHVBC CONTRACT 101

What You Need to Know
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

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

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

<table>
<thead>
<tr>
<th>Quality Metric</th>
<th>Description</th>
<th>Medicaid Age</th>
</tr>
</thead>
</table>
| **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
**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**

- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance

### Category 2

**Fee for Service – Link to Quality & Value**

- **A** APMs Built on Fee-for-Service Architecture
- **B** APMs with Upside Gainsharing
- **C** APMs with Upside Gainsharing/Downside Risk

### Category 3

**Population-Based Payment**

- **A** APMs with Upside Gainsharing/Downside Risk
- **B** Comprehensive Population-Based Payment

### Category 4

**Population-Based Accountability**

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*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

**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 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

**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.

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
OHVBC: Capitation in Disguise?

Design
Creating the Win-Win-Win-Win-Win!!

Payers-Contractors-Providers-Patients
What makes people healthy?
Independent dental practice?
Thank you!

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