OVERVIEW OF VALUE DRIVEN AND VALUE-BASED PAYMENT MODELS IN ORAL HEALTH CARE

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Disclosures

I received a small stipend from the American Academy of Pediatric Dentistry's Pediatric Oral Health Research and Policy Center to author their "Value-Based Care in Pediatric Dentistry" technical brief (https://www.aapd.org/globalassets/media/policy-center/vbcinpd.web.pdf).

I know many of you on this Task Force, so in that way there may be potential personal conflicts of interest.

I do not have professional or financial relationships beyond a clinician-payer relationship with any third-party payer who is exploring potential Value-Based Care models in oral health.

I volunteer on the Steering Committee for the MORE Care Ohio Value-Based Care pilot program, which is sponsored by the CareQuest Institute for Oral Health.

The content of this presentation reflects my assessment of the literature on the topic, as well as my own clinical and professional experience.

About Me

DDS: OSU 2014

Residency: UNC (Pediatric Dentistry) 2017

Graduate School: UNC (MPH; Health Policy and Management) Dec 2016

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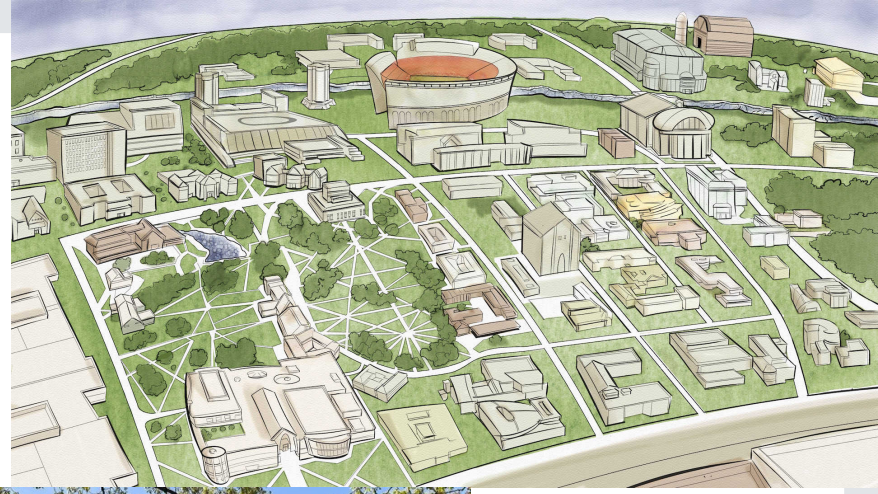


Outline

01

Define value-based care in oral health services delivery

02

Discuss proposed value-based payment models in oral health services delivery

03

Review performance measurement as it relates to value

04

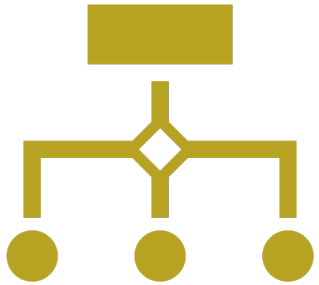
Key takeaways

CMS definition

Value-Based Care:

- Better care for individuals
- Better care for populations
- Lower costs

In principle, I think this is a definition we can all get behind.



How do we operationalize that definition?

Perceptions of VBC

Traditional fee-for-service mechanisms pay providers for specific procedures

- Perception that this mechanism incentivizes volume over value

Traditional full capitation mechanisms pay providers for treating a defined population

- Perception that they incentivize providers to "under-care" for patients—that is, they provide only the bare minimum not necessarily what is needed

Food for thought: How would these perceptions shift if reimbursement was comparable to market rates?

Value-Based Care in Oral Health

- Most iterations attempt to change how care is delivered (and subsequently, received)
  - Preventive rather than restorative health care
- Most iterations include alternative provider reimbursement
  - Shift away from the volume of procedures towards 'value' of procedures related to health

The two (care delivery and care reimbursement) are inextricably linked

- Presenting dilemma: Controlling costs (i.e. lowering) while delivering high quality care that is valued by the patient, provider, payer, health system, population

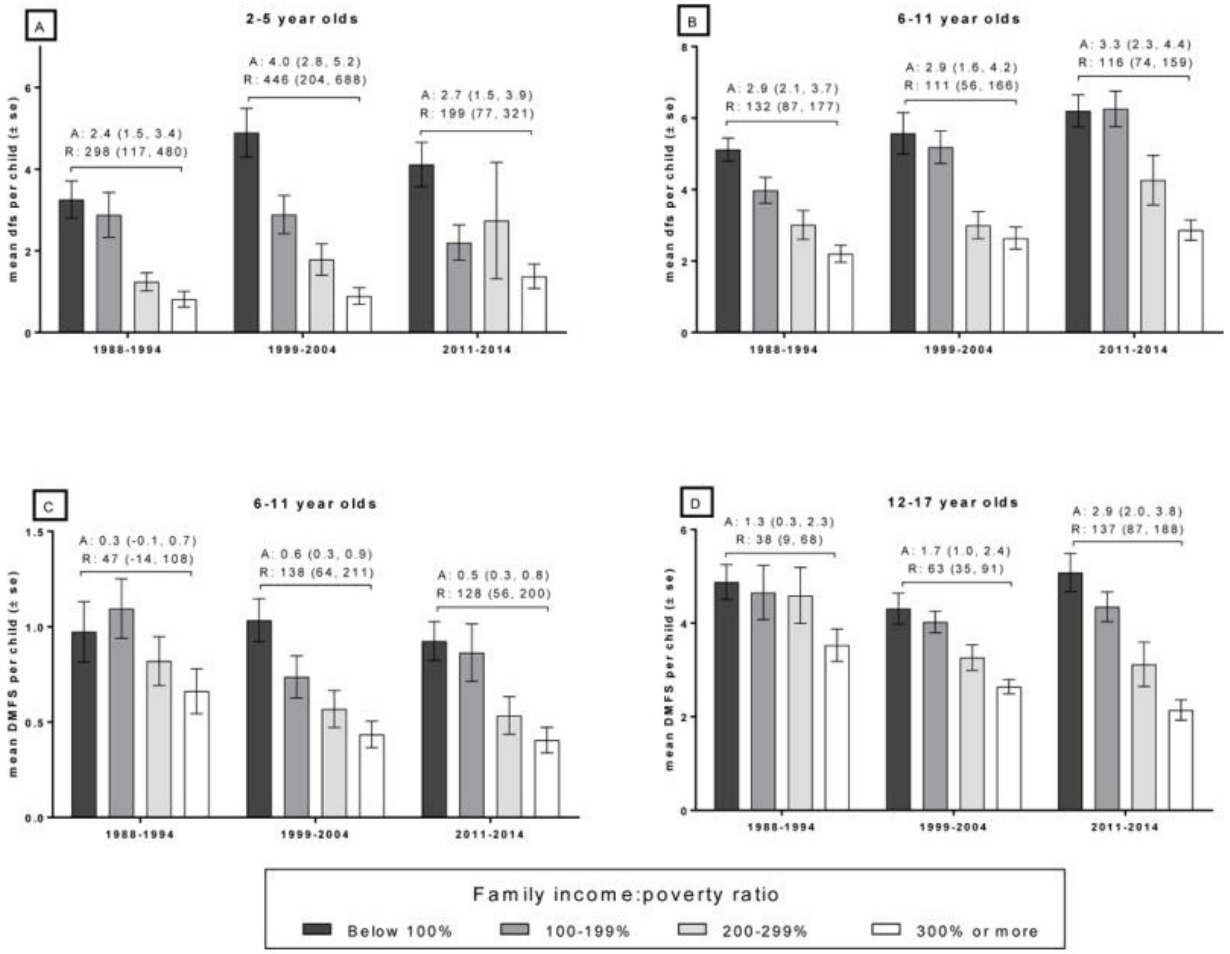
- Solving the problem is asking ***A LOT*** of patients, providers, and decades-old systems

Potential problems VBC purports to address

Problem: Dental caries (VBC Goal: Improve population oral health)

- Dental caries is a decades-old problem with no real change in prevalence (~40% in kids)
- Largely mediated by health behaviors

Slade and Sanders. 2018. JPHD.



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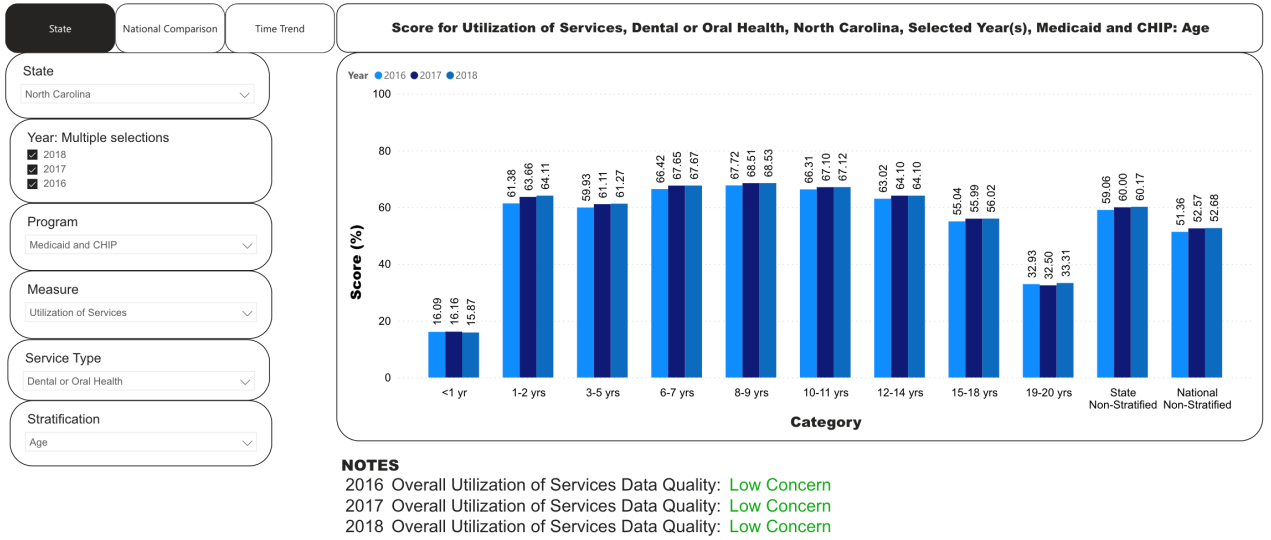
- Largely mediated by health behaviors
- Year-to-year gains in preventive utilization are difficult to track



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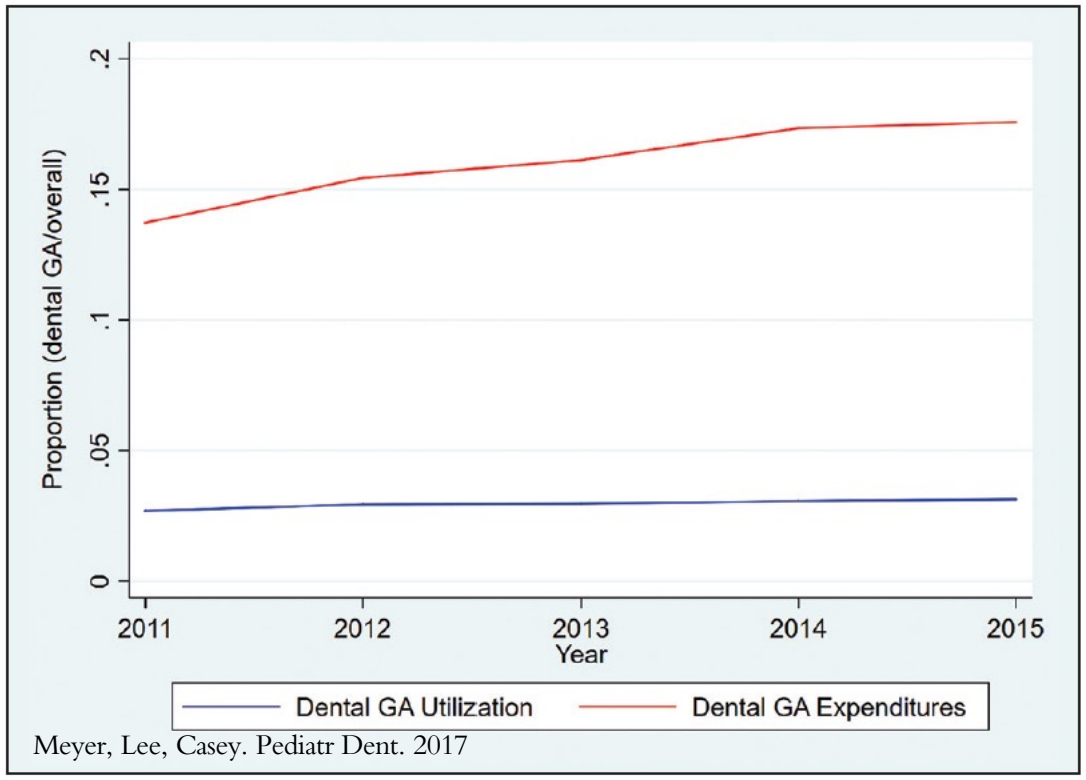

Meyer, Lee, Casey. Pediatr Dent. 2017

Figure 3. Dental general anesthesia proportion of overall utilization (blue) and expenditures (red) for state fiscal years 2011 to 2015 for Medicaid-enrolled zero- to eight-year-old children.

Problem: Most expensive dental treatments for Medicaid programs are those completed in a hospital setting (VBC Goal: Lower costs)

Hospital operating room utilization rates age dependent: 1-3% of dental users in NC

- Context: accessibility of hospital operating rooms, restrictions on sedation permitting, shifts towards office-based anesthesia, sometimes the most compassionate venue for treating children

Potential problems VBC purports to address

"for many children, ***especially those with extensive dental needs, SDF provides minimal long-term benefit in terms of cost-savings*** since this subgroup ultimately went on to receive treatment under GA. The economic benefit may be greatest for very young children (i.e., 3 years old and younger) with limited extent of disease (i.e., dmft=4)." Kopczynski & Meyer. Patient Pref Adher. 2021; Meyer et al. JADA (in revision)

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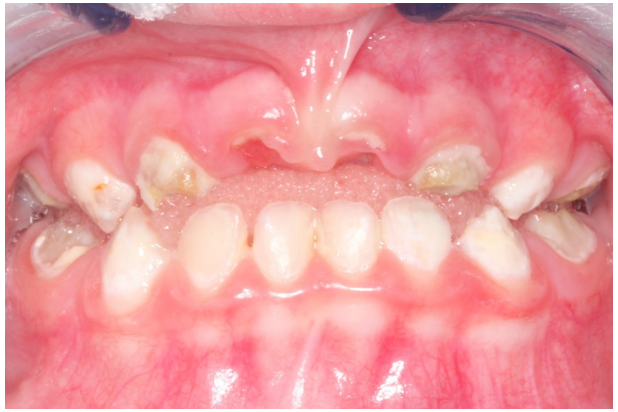
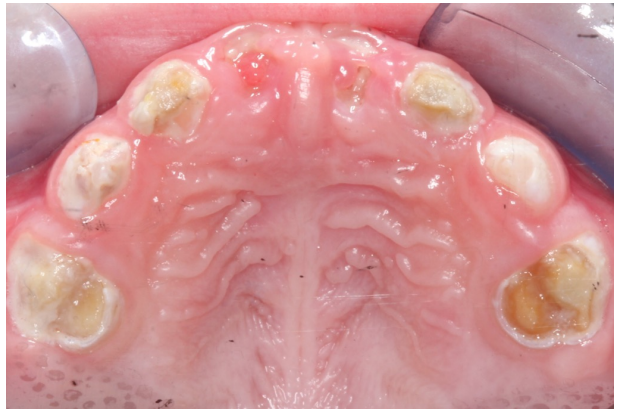
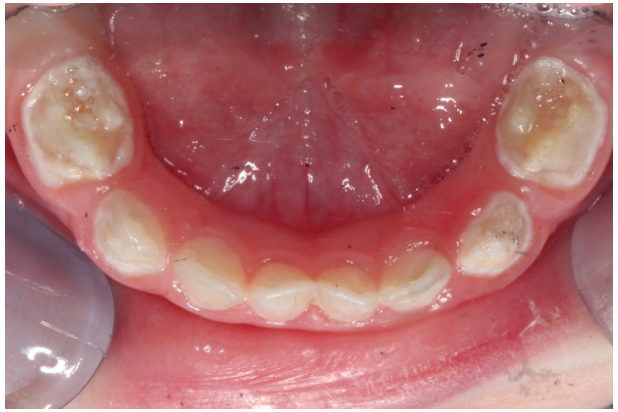
Hospital operating room utilization rates age dependent: 1-3% of dental users in NC

- Context: accessibility of hospital operating rooms, restrictions on sedation permitting, shifts towards office-based anesthesia, sometimes the most compassionate venue for treating children
- SDF might not be doing what we (collectively in public health) expected it to do at population levels: kids ultimately go on to get their teeth restored and often under general anesthesia

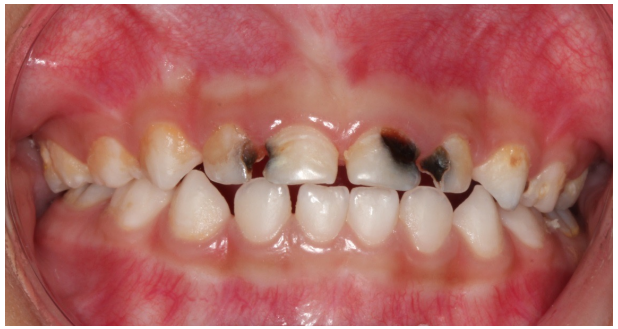
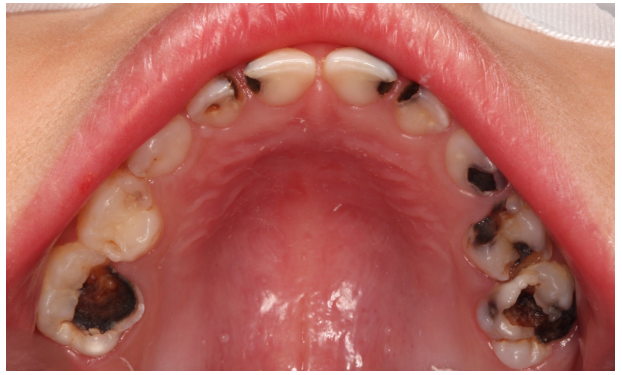
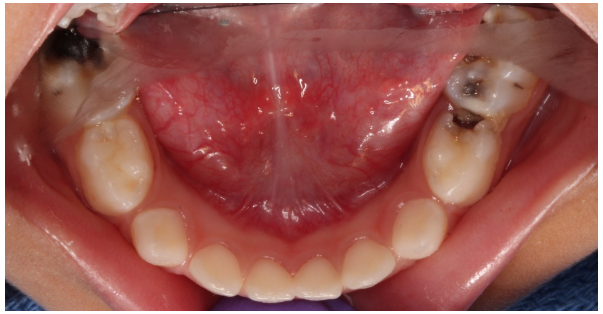
Where can VBC interface to solve these kinds of problems?

What is better care for these individuals?
How does that care improve population health?
What are the strategies to lower costs?

20-month-old female; healthy, 2-hour travel, geographically isolated

4-year-old male; healthy, recent immigrant with Medicaid; language barrier

VALUE-DRIVEN PAYMENT

Table 1. Oral health value-based payment framework.[16]

CATEGORY	PAYMENT FRAMEWORK
1. Fee for Service—No Link to Value	A. Payment for volume
2. Fee for Service—Link to Value	A. Payment for infrastructure and care management B. Payment for reporting C. Payment for performance
3. VBP* Built on Fee-for-Service Architecture	A. VBP with shared savings—upside only B. VBP with shared savings—upside and downside
4. Population-Based Payment	A. Episode of care B. Subcapitation for specific services C. Integrated delivery system and capitation

* VBP: Value-based payment.

PROPOSED MODELS

Good summary of models proposed in recent JADA article (Riley et al. 2019)

Comparing models

FEE-FOR-SERVICE (NO LINK TO VALUE)

Status quo for many payers/clinicians

Payment centers on the specific services provided

FEE-FOR-SERVICE (LINKED TO VALUE)

Builds on traditional FFS model by linking to quality or performance measures

The article mentions:

- Infrastructure (care coordination)
- Reporting (reporting agreed upon measures)
- Performance (achieving certain benchmarks)

Potential exists for disincentivizing (or penalizing) providers for maintaining status quo.

Comparing models

VALUE-BASED PAYMENT ON FFS ARCHITECTURE

Essentially, would be similar to the previous category but the incentives would be pooled based on care provided to specific populations

- Think special needs or children <3yo

Could be agreements where provider shares financial risk for assigned patients.

POPULATION-BASED PAYMENT

Described similar to conventional capitation payments plus the requirement to achieve certain quality metrics to receive an incentive.

Bundled care is listed under this model.

Box. Example of care bundle for a comprehensive examination (new patient).

CARE BUNDLE (CHILD)	CARE BUNDLE (ADULT)
Radiographs as Recommended	Radiographs as Recommended
Dental Examination	Dental Examination
Prophylaxis	Periodontal Examination
Fluoride	Prophylaxis
Treatment Plan	Fluoride Treatment Plan

Some thoughts on incentive structures from the AAPD brief

"Incentives should be ***large enough to alter provider services*** directly related to increased quality of care and decreased cost of care…Without an enticing incentive, improvements in pediatric oral health outcomes may be difficult to achieve in a VBC model."

"…improvements in care delivery and oral health outcomes must drive VBC planning. Across all incentive structures payers and providers should recognize that ***value means more than simply reducing costs***."

Paradoxically, it seems, VBC models are effectively paying providers to lower costs.

HOW DO YOU MEASURE VALUE?

QUALITY MEASURES

Atchison, Weintraub, Rozier.
JADA 2018

Box. Selected examples of dental performance metrics used among the case studies.

Clinical Quality

- Proportion of well-child visits with preventive oral health service
- Percentage of patients aged 2-21 years with at least 1 dental visit with a dental practitioner
- Dental risk assessment followed by individual care plan for caries and periodontal disease
- Application of fluoride varnish in medical offices to children enrolled in Medicaid
- Receipt of any preventive dental service
- Children who received at least 2 fluoride varnish applications per year
- Percentage of pregnant women who received obstetrical examinations, were referred to the dental department, and obtained a treatment plan

Patient Experience

- Percentage of patients who receive information from their medical or dental professional that they could understand
- Plan members who report to the physician that they have a dentist
- Percentage of patients who are encouraged to be part of the decision making regarding their care
- Plan members who were able to see a dentist as soon as they wanted in the case of a dental emergency

Care Coordination

- Proportion of professional oral health services provided in medical and dental offices that are integrated with community programs like Early Head Start
- Percentage of referred pregnant women who seek oral health care as part of prenatal care
- Adult members identified as having diabetes who received at least 1 dental service within the year
- Proportion of children enrolled in Medicaid who are in the targeted age group and received preventive dental care in dental offices
- Percentage of patients with diabetes who are referred to a dentist and who receive periodontal therapy
- Members who were seen in the emergency department for nontraumatic caries-related dental reasons and visited a dentist within 30 days after the emergency department visit
- Identified patients with diabetes receiving referrals from their dental provider to their primary care provider

Who is value measuring? (using the measures from the Atchison box)

PROVIDER/SYSTEM MEASURES

- Proportion of WCV with POHS
- Percentage of 2-21yo with a dental visit
- Dental risk assessment followed by individual care plan
- Application of FV at WCV
- Receipt of preventive dental service
- Children who received at least 2 FV per year
- Percent of pregnant women who received OB exams that were referred to dentist
- Diabetics who received at least 1 dental servicer per year
- Percent of diabetics who receive periodontal therapy per year
- Follow-up after an ED-dental visit

PATIENT MEASURES

- Received information they could understand
- Report to their physician that they have a dentist
- Are part of the decision-making process regarding their care
- Could see a dentist as soon as they needed

Who is driving the value discussion?

Dental Quality Alliance (Pediatric Starter Set)

Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (NQF#2689)

Follow-Up after Emergency Department Visits for Dental Caries in Children (NQF#2695)

Care Continuity*

Caries Risk Documentation*

Oral Evaluation (NQF#2517)

Per Member Per Month Cost of Clinical Services

Preventive Services for Children

Receipt of Sealants on First Permanent Molar

Receipt of Sealants on Second Permanent Molar

Sealants: eMeasure

Topical Fluoride for Children (NQF#2528, 3700, 3701)

Treatment Services

Usual Sources of Care

Utilization of Services (NQF#2511)

These measures help insurance plans measure themselves, effectively measuring the dental system not necessarily oral health outcomes

How do you measure patient or health outcomes?

- Patient satisfaction
  - Balancing satisfaction as a reflection of the patient experience vs. their perception of the provider (e.g. a Yelp review)
- Detailed, accurate, and calibrated clinical data
  - This type of data would certainly be most meaningful
  - Challenging to create and validate—how to handle the second opinions or referrals from a general dentist to a pediatric dentist where there are potential disagreements in a clinical condition
  - Difficult to integrate, especially outside of hospital settings
  - Once accessed, what do payers do with it?
- Detailed, accurate, and calibrated health behavior data

CHALLENGES AND ADDITIONAL CONSIDERATIONS

Planning challenges

"Preventing disease and maintaining health should be primary targets of VBC and incentive strategies."

"Patients or their advocates, providers, payers, and the general public must buy in for VBC to be successful."

"A patient or family's ability to select their own provider is imperative."

"VBC should allow patient-centered care to address an individual's specific needs, while also improving population oral health."

"Currently, dental records lack interoperability with external systems, such as medical records or health information exchanges."

Making sure providers who care for the most vulnerable and disadvantaged are appropriately accounted for in measuring and comparing quality metrics.

Key Takeaways

Value-based care is what we should strive to deliver to our patients and communities.

Need to figure out what value means (and to whom value is being delivered) before designing and/or selecting alternative payment mechanisms.

My cynicism:

- Are we really "transforming" oral health delivery by switching to a different payment model?
  - Or are we just shifting money around and assigning it a definition of "value"?
- What is the real outcome we are hoping to change?

THANK YOU

Please feel free to send questions to meyer.781@osu.edu