Cracking the Code: Achieving Value-Based Transformation in Oral Health

Presented by:

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Moderated by: Mark Doherty, DMD, MPH, CCHP, Executive Director, Safety Net Solutions, DentaQuest Institute
CRACKING THE CODE

Value-Based Transformation in Oral Health

Laying the Groundwork
mhpa Tenets

• High-quality and cost-effective care
• Actuarially sound
• Budget predictability
• Person-centered approach to care
“Every system is perfectly designed to get the results it gets.”

—W. Edwards Demming*

* Attribution disputed, see source link: Source: quotes.deming.org/10141
Transition vs. Transformation
Transition vs. Transformation
Bridging the Systems Gap

Fee For Service  Value Based Care
OHVBC is Not:

• Simple
• One size fits all
• Guaranteed to work
• Going away
• Instant
Cost of Healthcare

2017 U.S. Healthcare Costs:
3.5 Trillion/
22% of GDP

U.S. spends
6-11% more
on health
than other countries

The U.S. is ranked
37th in health
outcomes
by the WHO
### 30% of Health Care Resources are Wasted

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210 Billion</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 Billion</td>
</tr>
<tr>
<td>Excessive Administrative Costs</td>
<td>$190 Billion</td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130 Billion</td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105 Billion</td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>$55 Billion</td>
</tr>
</tbody>
</table>

Source: Institute of Medicine Report – The Healthcare Imperative
Oral Health Care Dollars Wasted

2016 Dental Expenditures = $124B

30% = $37.2B
that could have been spent on care

2016 Medicaid Dental Costs = $14.9B

30% = $4.47B
that could have been spent on care
Health Status: Determinants of Health and Health Care Expenditures

**Influence on Health**

- Access to Care: 10%
- Environment: 20%
- Genetics: 20%
- Health Behaviors: 50%

**National Health Expenditures**

- Access to Care: 88%
- Other: 8%
- Health Behaviors: 4%

National Health Expenditures: $3.5 Trillion

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 $3.5 trillion: $10,000/person per year

Houston we have a problem! Something has to change
**Value Equation**

\[ \text{Value} = \frac{\text{Quality}}{\text{Cost}} \]

Volume-driven health care

Value-driven health care

COST

QUALITY

Value = Quality/Cost
Fee-For-Service

What Works

• Paid for services
• More services when needed
• Not responsible for variables
• Predictable payment

What Does not Work

• Care not linked to quality
• Care is not predictable
• Cost can exceed payment for care
• No fees for many needed services
• Costs for care are not predictable

Pay-For-Performance

What Does not Work

- P4P services does not fill all patients needs
- Payments does not always equal costs of care
- Some needed services are not covered
- Costs for care is not predictable
- Providers have to provide services to be paid.
- Paid less for patients with greater needs
- Paid less for things dentist can’t control

Creating the Win-Win
What Does Success Look Like for Medicaid Managed Care Organizations?
Success Look Like…

- Realistic and achievable goals
- Efficient program management yields profit
- General contract provisions are normal
- RFP includes contract performance requirements, program goals and terms and conditions that are clear, meaningful, doable and measurable
- Ability to communicate with both providers and patients
Success Looks Like...

• 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
• Ongoing partnership in program improvement
• Outreach to members
For the Patient, Success Look Like...

• Affordable
• Effective quality care
• Equitable
• Person-centered

• Satisfying
• Timely
• Safe
For the Provider, Success Look Like...

- Quality Person-Centered Care
- Standardized
- Evidence-based
- Financially rewarding
- Measurable
- Ethical
- Care expectations clearly delineated
10 Key Questions to Consider

When assessing an oral health value-based payment system, the following are key questions to ask:

1. Are the operational metrics reasonable, measureable and achievable?

2. Are the quality metrics meaningful, achievable, measureable, appropriate for the patients attributed, and do they ultimately add value to the care of the patients?

3. Is the contract a win–win for the purchaser and the vendor?

4. Are providers accountable for quality, outcomes and cost?

5. Do payment rates match the cost of delivering quality care?
10 Key Questions to Consider

6. Do providers have flexibility to deliver the highest value services?
7. Are patients and purchasers able to determine the total amount they will pay?
8. Are providers only paid when patients receive services and will they know how much they will be paid in advance of delivering services?
9. Will patients with greater needs be able to receive more services?
10. Are providers only held accountable for things they can control?
Thank you!

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Protecting and Improving the Health of Iowans
Value Based Purchasing: *What States Need and Want*

Mary E. Foley, MPH
Executive Director
Medicaid|Medicare|CHIP Services Dental Association

October 23rd, 2018
Medicaid|Medicare|CHIP Services Dental Association
National Organization

- **State Administrators and Policy Makers**—Directors, managers, and staff of State Medicaid and CHIP Dental Programs

- **State Medicaid Vendors**—Corporations that contract with Medicaid programs to administer and deliver health care services to Medicaid and CHIP beneficiaries

- **Individuals and Groups**—Providers, educators, researchers, and others who have an interest in Medicaid, Medicare, and CHIP Dental Programs and their beneficiaries.
MISSION: To improve Medicaid, Medicare, and CHIP oral health programs by collaborating with key stakeholders, sharing resources and disseminating innovative strategies.

• Provide leadership in the development of sound Medicaid, Medicare, and CHIP oral health/dental policy;

• Support oral health for Medicaid, Medicare, and CHIP program beneficiaries;

• Stimulate discussion, innovation and collaboration among Federal, State and national Medicaid, Medicare, and CHIP oral health/dental stakeholders;

• Promote integration of oral health and primary care for Medicaid, Medicare, and CHIP programs; and

• Promote the triple aim of improved health; healthcare, and lowered costs for Medicaid, Medicare and CHIP programs.
WHAT WE DO

COLLECT AND ANALYZE PROGRAM DATA

IDENTIFY AND STUDY INNOVATIVE MODELS

PROVIDE EDUCATION AND TECHNICAL ASSISTANCE

PROMOTE EVIDENCE BASED POLICIES

FORM LINKAGES

MAINTAIN ONLINE NATIONAL PROFILE OF STATE MEDICAID & CHIP DENTAL PROGRAMS
Value Based Purchasing: What do states need and 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
  - 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

- Metrics and measures that demonstrate that the program model works!
NQMC Domain Framework: Health Care Delivery Measures

Used to assess the performance of individual clinicians, clinical delivery teams, **delivery organizations**, or **health insurance plans** in the provision of care to their patients or enrollees.

States Need…

- Increase preventive services
- Reduce disease incidence
- Reduce treatment costs
- Mechanism: Improve utilization of preventive services in children ages 0-3 and measure using quality indicators as a result.

For the next 8 slides:
- Are these organized in a specific way?
- For example is each slide a category of needs vs wants? If not, is there a way to organize them in that way? Right now, the information is overwhelming with no obvious way for a viewer to orient themselves in the discussion.
## Value Based Purchasing: What States Need and Want

<table>
<thead>
<tr>
<th>States Need to...</th>
<th>States Want...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sustain the utilization of preventive dental services by children ages 0-21</td>
<td>• Innovative strategies to incentivize use of preventive services by enrollees</td>
</tr>
<tr>
<td>• Increase the delivery of preventive dental sealants by all general and pediatric network dental providers</td>
<td>• Reliable, feasible, and valid metrics and measures that adequately demonstrate:</td>
</tr>
<tr>
<td></td>
<td>o Increase in # providers delivering sealants</td>
</tr>
<tr>
<td></td>
<td>o Increase in beneficiary receipt of services</td>
</tr>
<tr>
<td>States Need to...</td>
<td>States Want...</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Deliver adult dental benefits to an expanding population</td>
<td>Innovative and reformed adult dental program that addresses critical need and reduced costs</td>
</tr>
</tbody>
</table>
Value Based Purchasing: What States Need and Want

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<tr>
<td>• Increase # adults receiving preventive services</td>
<td>• Value-added preventive strategies that target adults such as annual prophylaxis, exams, and x-rays</td>
<td></td>
</tr>
<tr>
<td>• Decrease dental disease incidence in adults</td>
<td>• Value-added treatment services, such as use of Silver Diamine Fluoride to arrest disease and need for ER services</td>
<td></td>
</tr>
<tr>
<td>• Decrease non-traumatic Emergency Room dental care</td>
<td>• Valid, reliable and feasible metrics and measures that promote and demonstrate improved performance and results</td>
<td></td>
</tr>
<tr>
<td>• Decrease costs associated with adult non-traumatic dental treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States Need to...</td>
<td>States Want...</td>
<td></td>
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<tr>
<td>------------------</td>
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<td></td>
</tr>
<tr>
<td>Improve beneficiary outreach</td>
<td>Value-added innovative strategies that address:</td>
<td></td>
</tr>
<tr>
<td>Improve dental service utilization</td>
<td>- Social determinants of health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Barriers to care</td>
<td></td>
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<tr>
<td></td>
<td>- Oral health literacy</td>
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</table>
Value Based Purchasing: What States Need and Want

**States Need**
- Implement value based payment models that focus on quality, not quantity.
- Systems integration that braids medical and dental service delivery

**States Want...**
- Alternative reimbursement models for providers
- Strategies with cost-incentives that focus on quality and prevention
- Electronic dental/health records that communicate
- Mechanism to link medical and dental records
- Valid metrics and measures that demonstrate process; outcome; and impact improvements
**States Need**  
- Better manage high-cost dental services  

**States Want...**  
- Value added programs that focus on:  
  - Incentivizing delivery of preventive services;  
  - Incentivizing few specialty referrals  
  - Reduced use of ER  
  - Use of Silver Diamine Fluoride  
  - Risk-based care  
  - Disease management  
  - Population management  
  - Case management  
- Increased adoption of strategies by provider network
## Value Based Purchasing: What States Need and Want

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<th>States Want...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced fraud, waste and abuse</td>
<td>Vendors that will assure program integrity</td>
</tr>
<tr>
<td></td>
<td>Enhanced Program Integrity capacity and functionalities</td>
</tr>
<tr>
<td></td>
<td>Early identification of problems</td>
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<tr>
<td></td>
<td>Assurance that problems have been resolved</td>
</tr>
</tbody>
</table>
Contact Information

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VALUE-BASED TRANSFORMATION IN ORAL HEALTH

Models, Essentials and Priorities
The fact that an alternative payment model is different from fee-for-service does not necessarily mean it is better.
Priorities for OHVBC Design Success

1. Actuarial precision
2. Clear contract goals
3. Understanding the beneficiaries/patients
4. Reasonable assignment of beneficiaries/patients
5. Quality and operational goals that are achievable, meaningful and measureable
6. Start simple---evaluate---grow
7. Involve providers from the start
8. Choose the right APM for all involved (payor, MCO, patients, providers)
9. Make it a partnership not a contract
10. Perfectly design the system you need to get the results you want
Health Care Finance Terminology

**Fee-for-Service (FFS)**

**Alternative Payment Methodology (APM)**

**Prospective Payment System (PPS)**

**Per Member Per Month (PMPM)**

**Encounter or Cost-Based Payments**

**Bundled Payments**

**Episodes of Care**

**Global Payments**

**Capitation**

**Value-Based Purchasing (VBP) or Pricing (VBP)**

**Pay-for-Performance (P4P)**

**Vertically Integrated Health Care System**

**Horizontally Integrated Health Care System**

**Evidence-Based Care:**

Evidence-based medicine that is best practice/integrates best research evidence with clinical expertise and patient value.
APM Framework

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

Population-Based Accountability

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
Metrics are Vital

• We have many to consider

• Determining which metrics to include in reporting requirements is a field of intense debate.

• Know your patients and choose achievable, meaningful and measurable metrics

Start simple and evolve successfully
Examples of OHVBC Models

- Payment Model
- Payment Mechanism
- Provider Type
- Patient Population
- Methodology
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)

• **Provider Type:** Dental team

• **Patient Population:** Adults and children
Category 2C: Pay-for-Performance Methodology

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

• Goals:
  o % attributed/assigned patients seen (PMPM for 90%, 80%, 70%....)
  o % children needing sealants receiving sealants
  o % assigned/attributed patients receiving a CRA
  o % Patients with high-mod risk status lowered
  o % 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
- **Provider Type:** Dental team
- **Patient Population:** All patients in state run facilities for children
- **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 4A: Condition-Specific Population-Based Payment

- **Payment Model**: Capitation for specified patients; PMPM/Mo
- **Payment Mechanism**: PMPM for attributed patients with a specified scope of service
- **Provider Type**: Dental team
- **Patient Population**: Institutionalized patients with disabilities in Massachusetts
- **Methodology**: Each month a PMPM is paid for numbers of attributed patients treated and for the treatments provided per agreed upon scope and goals (exams, CRAs, cleanings per risk, sealants, Fluoride per risk, interim and permanent treatments…..)
Criteria associated with VBC Success

- Budget predictable
- The right HIT/personnel
- Contract ownership
- Proactive evaluation
- Strategic Plan in place
- Will
- Self assessed/redesigned
- Success defined
- Financially strong
- Partnered in design

- Simple
- Predictable outcomes
- Tested/proven
- Appropriate metrics
- Standardized
- Actuarially precise
- Scientific assignment of patients
- Capacity
- Person-Centered
Oral Health and OHVBC

- What Should OH VBC success look like for YOU?
- What will our P4P or quality measures be?
- Who should we be watching and learning from?

- Which areas of “waste” should we be focusing on?
- Who will train us?
- What changes do we need in the other systems involved to enable us to change the health care system?
- How can we work with all health benefit stakeholders?
Will we be on the VB menu or at the table?
Thank you!

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Category 4C: Integrated Finance and Delivery System (IDS)

- **Payment Model:** A global payment PMPM for the total health of all attributed patients
- **Payment Mechanism:** Monthly reports on cost and care
- **Provider Type:** Medical and dental teams
- **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.
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 measurable aims or goals, sharing responsibility for patient outcomes, and for resource use. The focus of their efforts will be the quadruple 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.