CareQuest Institute for Oral Health®

RESEARCH REPORT

Unlocking Value in Alternative Payment Models

The Power of Readily Available Information

SUGGESTED CITATION:
McLeod, Caroline, Danielle Apostolon, Paige Martin, Andrea Clark, Renee Clark, Kelly Schroeder, Hannah Cheung, Rebekah Mathews. Unlocking Value in Alternative Payment Models: The Power of Readily Available Information. Boston, MA: July 2024. DOI: 10.35565/CQI.2024.2002

Authors

Caroline McLeod, RDH, MS
Value-Based Solutions Manager, Health Transformation
CareQuest Institute for Oral Health

Danielle Apostolon, BS
Program Manager — Value-Based Care, Health Transformation
CareQuest Institute for Oral Health

Paige Martin, BA
Science Writer, Analytics and Data Insight
CareQuest Institute for Oral Health

Andrea Clark, MS
Director, Health Care Economics, Health Transformation
CareQuest Institute for Oral Health

Renee Clark, BS
Care Coordination and Interoperability Manager,
Health Transformation
CareQuest Institute for Oral Health

Kelly Schroeder, RDH, MS
Program Evaluation Specialist, Analytics and Data Insights
CareQuest Institute for Oral Health

Hannah Cheung, MPH, MS, RDH
Health Sciences Specialist, Analytics and Data Insights
CareQuest Institute for Oral Health

Rebekah Mathews, MPA
Vice President, Health Transformation
CareQuest Institute for Oral Health

Acknowledgments

Bob Russell, DDS, MPA, CPM, FACD, FICD
Consultant
Bob Russell Consulting, LLC

Eric Tranby, PhD
Director, Analytics and Data Insights
CareQuest Institute for Oral Health

Honor Childress, MPH
Strategy and Payer Relations Officer
Michigan Primary Care Association

Lisa Heaton, PhD
Science Writer, Analytics and Data Insights
CareQuest Institute for Oral Health

Kaz Rafia, DDS, MBA, MPH
Chief Health Equity Officer, Executive Vice President
CareQuest Institute for Oral Health

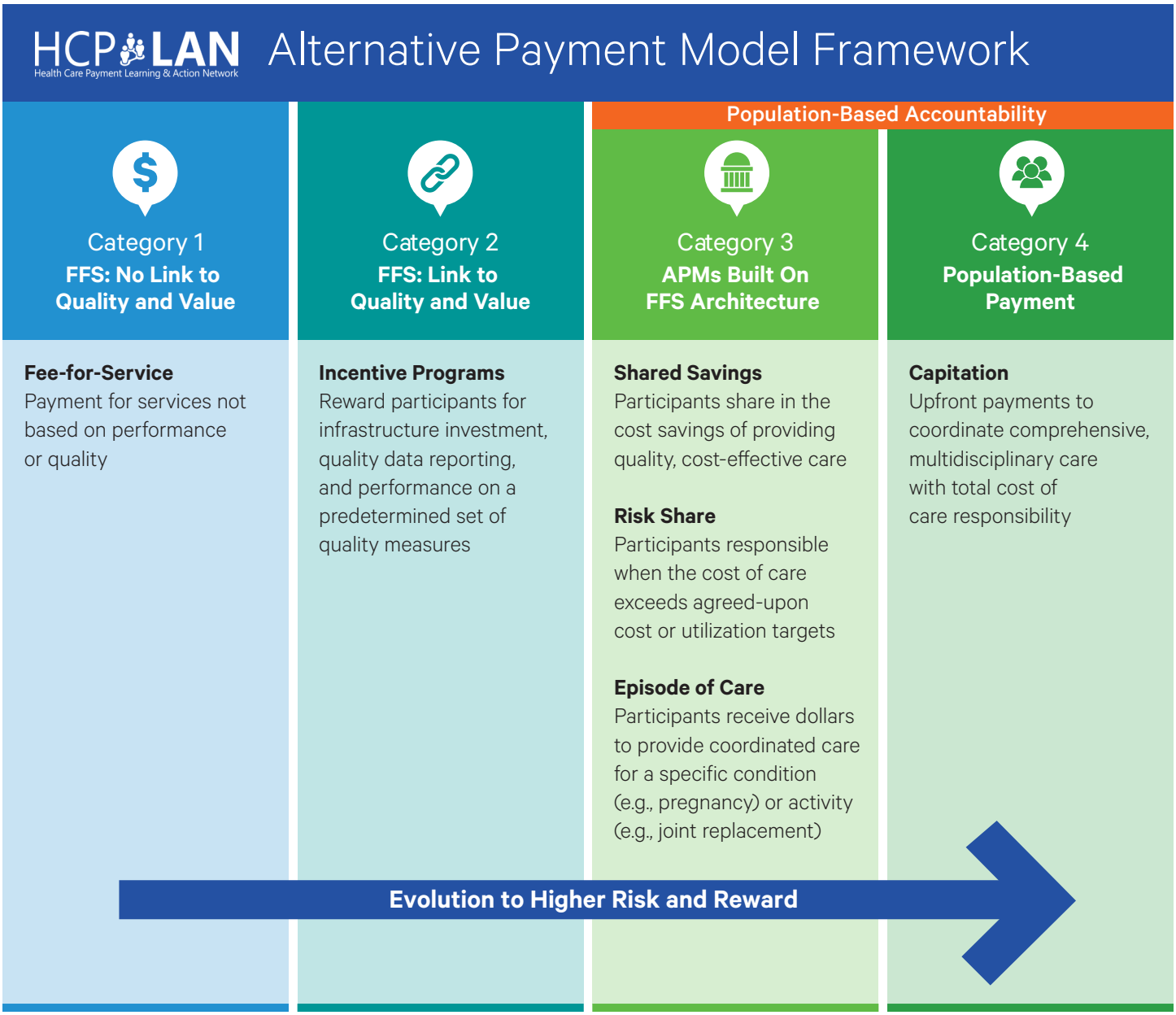
Alternative Payment Models and Oral Health

Over the past decade, health care payment models have shifted from volume-driven, fee-for-service (FFS) payments toward value-based care and payment models that hold potential to improve quality, enhance patients' and providers' care experience, and reduce health care costs. Value-based payment (VBP) is a broad set of performance-based strategies that link financial incentives to a provider's performance based on a set of defined quality measures.[1] VBP models allow for greater flexibility and financial reward for quality improvement, incentivizing providers to deliver surgical, preventive, and coordinated services effectively to achieve the best patient health outcomes.[1,2]

Value-based payment is a broad set of performance-based strategies that link financial incentives to a provider's performance based on a set of defined quality measures.

VBP is largely enabled through policy and regulatory activity and promoted through channels such as the Health Care Payment Learning and Action Network (HCP-LAN). HCP-LAN is a public-private partnership commissioned by the Centers for Medicare and Medicaid Services (CMS) that developed the most commonly used alternative payment model (APM) framework in the US. The HCP-LAN framework, which includes a continuum of model options, establishes core principles for the design of APMs.[2] While VBP is the broader concept of paying for value, APMs are the specific financial arrangements that reward the delivery of high-value care.[3] APMs are designed to move away from fee-for-service payments and toward payments based on quality and value. The HCP-LAN framework is used by CMS, states, and commercial payors to establish terminology and levels of risk required across of APMs. The HCP-LAN framework includes four continuum categories: fee-for-service with no link to quality and value; fee-for-service with a link to quality and value; APMs built on fee-for-service architecture; and population-based payment. The categories contain specific model designs that support quality care delivery in unique ways (Figure 1).[4]

Figure 1: APM framework payment classification system



Public payors, health plans, and providers are increasingly adopting VBP arrangements.[1] Despite the growing adoption of VBP within health care and evidence linking oral health to systemic health, oral health is often not considered in the testing of APMs, and the dental field has been slow to adopt APMs on its own.[1, 5, 6] This divergence is likely due to the fragmented state of the current dental benefits system including, but not limited to, a lack of widespread Medicare dental coverage, the state-by-state variation in Medicaid coverage of adult dental services, the inaccessibility of dental benefits for underserved populations, and the limited provider acceptance of patients with Medicaid and Medicare dental benefits.[7] These factors pose significant challenges to the inclusion of oral health in APMs. With the expectation by CMS and other stakeholders that states will shift from FFS toward APMs, it is critical to ensure oral health care is included and prioritized.[8] This inclusion is not only a recommendation but also a necessity for improving health care. The objective of this report is to review historical and active public-payor APM designs in six leading states, expand the evidence base for APMs in oral health, and support decision-making to advance comprehensive payment transformation that includes quality oral health care.

Methods

CareQuest Institute for Oral Health explored the health care payment landscapes and APMs across six states that are currently implementing and advancing VBP models: California, Maryland, New York, Ohio, Vermont, and Washington. Researchers leveraged publicly available information and existing professional connections to gather information about state health care payment landscapes and APMs between June and November 2023. Inclusion criteria consisted of models previously or currently active through Medicaid or Medicare that include oral health in their plan information or have a systemic link to oral health. The information in this report is presented to the best of our knowledge based on publicly available sources at the time of publication.

The research team aimed to find the following information in each state for each payment model used: model name, state of operation, status (active or not active), operational dates, basic description, model scale (statewide, regional, population specific), operational management (state Medicaid, managed care organization, Medicare), known payors, payment design (inclusive of oral health services in medical APMs), payout time frame, number of covered members, number of network providers included, and quality and cost goals. Researchers searched online resources, including the Centers for Medicare and Medicaid, state Medicaid websites, oral health coalition websites, state reports to the legislature, payor websites, and historic conference materials. Additionally, researchers identified existing professional connections or partnerships with CareQuest Institute in the six states and in some cases asked targeted individuals for additional information.

Information on APMs is Limited

State APM Findings

Researchers found publicly available information describing how health care is paid for in each state, including oral health care. The most common sources for this information were state Medicaid websites and the CMS website. This information included details about demonstration payment models, through which many states test APMs.

While all six states reported testing medical APMs, only two of those states reported testing APMs involving oral health (Figure 2). For instance, several states used models within community health centers that focused on managing chronic disease, improving care coordination, and lowering the total cost of care. While many community health centers have dental departments, information about these medical models did not explicitly indicate oral health care providers as a part of the full, coordinated care team or include oral health care services in care cost or chronic condition management. While all six states' medical-related APMs followed a population-based capitation payment model, only two states' oral health-related APMs followed such a model. Additionally, two states tested bundled payment models and APMs that utilized performance-based incentives focused on oral health. (Figure 2).

Figure 2: States Testing APMs by Model Design

	Performance-Based Incentives	Shared Savings or Shared Risk	Episodes of Care	Bundled Payments	Population-Based Payments
California	☑			☑	☑
Maryland					☒
New York	☑			☑	☑
Ohio					☒
Vermont					☒
Washington					☒

☑ Model(s) included oral health care ☑ A portion of model(s) included oral health care ☒ Model(s) did not include oral health care

Only California and New York provided publicly available information about APMs inclusive of oral health (Figure 2). These models tend toward the utilization of performance-based incentives with few risk-sharing arrangements where providers can share the cost savings of providing quality, cost-effective care (known as shared savings or upside risk) and/or are responsible when the cost of care exceeds agreed-upon cost or utilization targets (known as downside risk). These two states tested 17 total payment models with various designs. Twelve of these models utilized performance-based incentives, rewarding participants for performance on a predetermined set of quality measures. Three models tested a bundled payment design and provided a fixed dollar amount for a set of oral health services. For example, California described testing bundled payment models focused on caries prevention and management for children 6 years old and younger. Participating providers received bundled payments for completion of caries risk assessment and other preventive services like nutritional counseling and motivational interviewing. The designated patient risk level determined by providers also informed the frequency of covered preventive care, where individuals with a higher risk for caries received more frequent coverage for preventive services.

California and New York also tested two capitation-based models. New York's hybrid capitation model assigned prospective payments by membership count, with additional fee-for-service payments made after providers reached the prospective payment ceiling. California took an innovative approach to including oral health in a primary care–focused capitation model within health centers. The model provided per-member per-month (PMPM) payments to cover physical health, behavioral health, obstetrics, and pharmacy services, telehealth, case management, and care coordination. While comprehensive oral health care is not included in covered services, fluoride varnish application by primary care providers is included in the set of model quality measures for pediatric patients.

Model Information Availability

The search for information about APMs inclusive of oral health in these six states generated 17 distinct models. Researchers categorized models by the transparency of publicly available information as "difficult to find," "moderately available," or "readily available." Of the 17 models, information for eight models was categorized by the research team as "difficult to find" while information for two models was categorized as "moderately available." Information for seven models — all of which were from California — was categorized as "readily available."

The most commonly available model information included name, state of operation, HCP-LAN model category, model status (active or not active), operational dates, model scale (statewide, regional, population specific), and a basic description of model purpose and structure. Information less commonly available included known payors, payout time frame, number of members covered, number of network providers involved, and explicit quality and cost goals. While the availability of model outcomes was also assessed, most models did not have a public evaluation.

Publicly available, high quality, easy-to-find information is an essential tool for oral health stakeholders, consumer advocates, policymakers, payors, and others.

Barriers Remain to Fully Understand Scope of APMs Inclusive of Oral Health

Publicly available, high quality, easy-to-find information is an essential tool for oral health stakeholders, consumer advocates, policymakers, payors, and others. This information is critical in payment reform efforts to fully understand the oral health landscape in APMs, to ensure that more APMs include oral health, and to learn from the successes and challenges of existing models.

Findings from this report demonstrate that the public availability of quality information needs to be expanded for audiences interested in payment model changes in both oral and medical health. Sharing progress, barriers, and facilitators of APM adoption can inform future model design and resource allocation for successful payment transformation efforts.

The location of information pertinent to models inclusive of oral health should also be considered. While the CMS website is often utilized to find model information, our research found that additional information is spread across numerous sources including state Medicaid websites, oral health coalition websites, state reports to the legislature, the HCP-LAN website, payor websites, and historical conference materials. This fragmentation of data availability demands additional resources (e.g., staff, time, coordination) to find, consolidate, and interpret model information, and introduces room for misinterpretation. While much of the oral health-related APM information is fragmented and difficult to access, states may learn from other states' APM data-sharing efforts. Vermont provides one example of information transparency and is described in the next section.

Case Application: Vermont

Vermont has made significant progress in transitioning from fee-for-service to population-based payments linked to quality outcomes. While Vermont's existing models do not include oral health currently, the state's transparent and public processes have created a path to help ensure that future models address oral health. Importantly, other states, as well as in-state stakeholders, can learn from Vermont's value-based payment journey because stakeholders publicly share information about their efforts. As Vermont tested payment models over the past 13 years, stakeholders shared information about model design and impact, allowing others to understand model processes and progress (Figure 3) (Appendix).

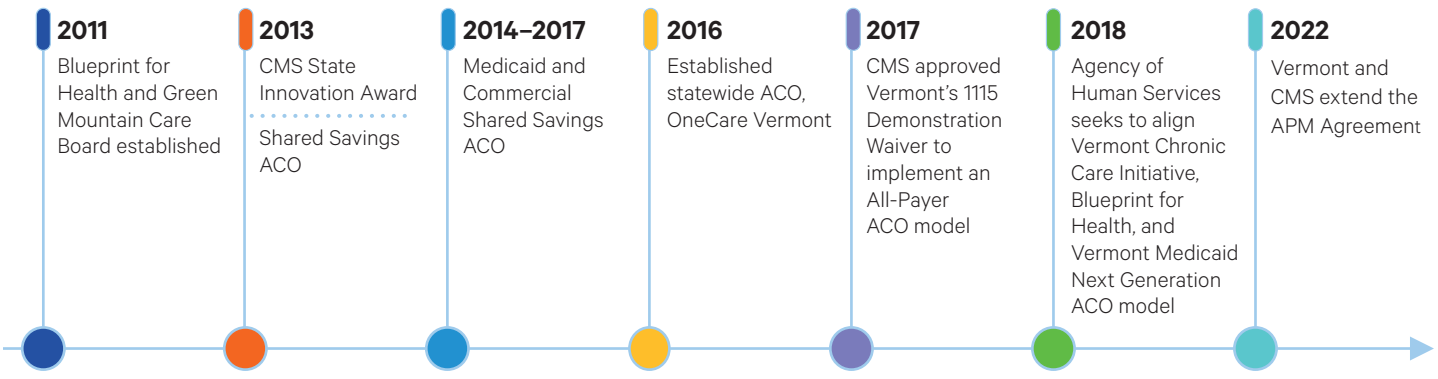
In 2011, the Vermont state legislature established the Green Mountain Care Board (GMCB) to regulate the health care market and improve health care quality, curb spending, and report on cost and quality metrics. The Board developed Blueprint for Health, a strategy that incentivizes quality and population health within primary care using a patient-centered medical home model. Building on that work, Vermont developed a pilot program as part of a grant awarded through the CMS State Innovation Model (SIM) initiative to help states implement delivery systems and payment reforms to improve health system performance. Under the pilot, the state began an Accountable Care Organization (ACO) shared savings model in 2016 called OneCare Vermont (OCV). Universities, hospitals, primary care practices, health centers, skilled nursing facilities, community-based organizations, and payors unified to streamline care coordination and set quality targets to improve health outcomes and reduce spending.[9] In 2022, Vermont and CMS agreed to an extension of the APMs for one year (2023) with an additional transition year (2024) at the state's discretion.

The GMCB established a precedent of information sharing and transparency, serving as the backbone of health care reform in Vermont. The Board monitors and evaluates health care payment and delivery performance, regulates important areas of health care with public interest at the forefront, and shares unbiased information, resulting in the use of data for improvement versus judgment. Information includes a performance dashboard of the All-Payer Model, which displays the status of the financial and quality performance targets related to population, system, and process. Public availability of the All-Payer Model ACO Agreement speaks to the transparency of the information shared by the state. Since the model was implemented in 2018, OCV shares reports on its website each year, bringing together data from health care services, insurance claims, medical records, pharmacies, and hospital visits. These data are analyzed to measure health care cost, quality, and utilization. The data sharing and transparency support providers in their journeys to value-based care and increase the buy-in to participate in APMs across the state.

Vermont worked with CMS to gain funding and technical assistance resources and created a multi-stakeholder coalition to establish a common forum, goal, and strategy to achieve impactful payment reform. It is critical to create space for an open dialogue among payors, providers, states, and community members to share priorities when initiating change. This exercise builds trust, improves collaboration, and creates payment models that engage and benefit everyone.

This collaboration and transparency across the state of Vermont have set the stage for oral health to be included in payment and care transformation efforts. The Department of Vermont Health Access, in consultation with the Board

Figure 3: Vermont's Payment Transformation Timeline



A considerable takeaway from Vermont's experience — common across the health care industry — is that transitioning from fee-for-service to value-based payment will take time.

of Dental Examiners and the Vermont State Dental Society, established a Dental Access and Reimbursement Workgroup of interested stakeholders to submit suggested policy changes to the VT House and Senate that impact access to oral health and reimbursement.[10] Working group participants reached a consensus regarding the importance of oral health being included with physical and mental health for a comprehensive approach to improving the health and well-being of Vermonters. As a result, the working group proposed several recommendations in a report to the Vermont Legislature, including the potential for future integration of dental services within the scope of services provided by accountable care organizations.[11] The state included those actionable activities in its 2022 Vermont Oral Health Plan to generate momentum around implementing activities to improve oral health equity in the state.

A considerable takeaway from Vermont's experience — common across the health care industry — is that transitioning from fee-for-service to value-based payment will take time. It will also take time to ensure all critical components, such as oral health, are integrated into this new way of doing things. However, Vermont also exemplifies the critical nature of information transparency practices, and how transparency helps inform new learnings and improvements that can catalyze forward momentum.

Call to Action

To advance whole-person health, alternative payment models must include oral health. While few in number, APMs inclusive of oral health often have little publicly available information about their design, operation, and evaluation. As APMs including oral health generally remain in their infancy, sharing resources and information on design and operation that demonstrate effectiveness is critical. While CMS recommends that those responsible for the design and testing of APMs (e.g., states, CMS) should share model information to allow others (e.g., other states, payors, ACOs) to apply these insights and lessons learned to their own environments, in reality, this does not always happen.[12] Available information is often scattered in small increments or held as proprietary. More public information is needed to assess the current APM landscape. We encourage state agencies and payors to share information and lessons learned about the payment models they are testing. This could take the form of reports, presentations, or social media posts. Additionally, we encourage the value-based payment advocates (e.g., HCP-LAN) to collect and share information about APMs and oral health in APM-monitoring efforts. This information can be used to inform future payment model designs for oral health and ensure that APMs are leveraged effectively for addressing health equity. As noted by CMS, integrating equitable design practices and evaluating the extent to which models help improve the health of underserved populations and eliminate care disparities will inform future efforts to better address health inequities using payment approaches.[12] These practices will only be possible to assess and, if effective, replicate if we have enough public information to understand how an APM fits the needs of unique communities.

Integrating oral health as a vital piece of overall health into payment transformation efforts will require consideration of various stakeholder perspectives, infrastructure changes, increased transparency, and continued APM testing and evaluation over time. It is essential that health disciplines (medical, behavioral, and oral health) work together to design a cost-effective payment system that addresses a person's oral and overall health to create a health care system that is built to benefit everyone.

It is essential that health disciplines work together to design a cost-effective payment system that addresses a person's oral and overall health to create a health care system that is built to benefit everyone.

Appendix

Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Model Information Value-Based Care

Element	Description
Goal of APM	To shift payments from a fee-for-service system that rewards the delivery of high-volume, high-cost services, to a payment system based on value, high-quality care and good health outcomes at a lower cost
Reimbursement	Commercial and government payors align around per-member-per month capitated payments to ACOs for care of attributed members. Payments from the different payers move through the ACO, which then distributes the payments to providers based on their attributed patients.
Patient Populations/ Conditions of Focus	Mental health and substance abuse disorder treatment
	Chronic illness prevalence and treatment
	Access to primary care
	Population health indicators like reducing deaths from suicide and drug overdose and reducing the prevalence of chronic illness
Quality Measures	21 annual quality measures in the following categories: • Preventive care for both adults and children • Screening and treatment for chronic illness • Treatment for mental health and substance abuse disorder • Self-reported patient and caregiver experience • Hospital utilization
	Measures are developed with Medicaid, Medicare, and MVP health plan; payers contracted with OneCare on behalf of their network[13]
# of Providers in Network	5,000
# of Vermonters Attributed	200,000

References

1. Greg Howe, Madeline Pucciarello, Lauren Moran, and Rob Houston, *Moving Toward Value-Based Payment in Oral Health Care*, Center for Healthcare Strategies, Inc., February 2021, https://www.chcs.org/media/Moving-Toward-VBP-in-Oral-Health-Care_021021.pdf.
2. Caroline McLeod, Madhuli Samtani, Adrianna Sonnek, Rebekah Mathews, and Eric P. Tranby, "Update on Alternative Payment Models in Oral Healthcare," *The Journal of Multidisciplinary Care Decisions in Dentistry*, 8 no. 11 (November 2022): 26–29, https://decisionsindentistry.com/article/update-alternative-payment-models-oral-healthcare/.
3. Washington State Health Care Authority, *Value-Based Payment Basics: Summary of Alternative Payment Models (APMs)*, September 2022, https://www.hca.wa.gov/assets/program/apm-basics-slide-deck.pdf.
4. Health Care Payment Learning & Action Network, *Alternative Payment Model: APM Framework*, The Mitre Corporation, 2017, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.
5. Danielle Apostolon, Caroline McLeod, Eric Tranby, Rebecca Mathews, *Alternative Payment Models in Dentistry: A Provider Perspective*, Boston, MA: CareQuest Institute for Oral Health, December 2020, https://www.carequest.org/system/files/CareQuest-Institute-Alternative-Payment-Models-in-Dentistry-Report.pdf.
6. Lisa J. Heaton, Tamanna Tiwari, and Eric P. Tranby, *Oral-Systemic Interactions and Medical-Dental Integration: A Life Course Approach*, Boston, MA: CareQuest Institute for Oral Health, September 2023, https://www.carequest.org/system/files/CareQuest_Institute_Oral-Systemic-Interactions_11.28.23.pdf.
7. Marko Vujicic and Chelsea Fosse, "Time for Dental Care to be Considered Essential in US Health Care Policy." *AMA Journal of Ethics*, 24 no. 1 (January 2022): 57–63, https://journalofethics.ama-assn.org/article/time-dental-care-be-considered-essential-us-health-care-policy/2022-01.
8. Centers for Medicare and Medicaid Services. "Value-based Care State Medicaid Directors Letter," September 15, 2020, https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter.
9. Change Healthcare, *Value-Based Care in America: State-by-State*, Primary Care Collaborative, 2019, https://thepcc.org/sites/default/files/resources/%7Ba7b8bcb8-0b4c-4c46-b453-2fc58cefb9ba%7D_Change_Healthcare_Value-Based_Care_in_America_State-by-State_Report.pdf.
10. Vermont Department of Health, *Vermont Oral Health Plan 2022*, https://www.healthvermont.gov/sites/default/files/documents/pdf/hpdp-oral%20health-2022%20plan.pdf.
11. James, Nissa, *Dental Access and Reimbursement Working Goup Report* (Vermont Agency of Human Services Department of Vermont Health Access, 2019), https://legislature.vermont.gov/assets/Legislative-Reports/Sec.-E.306.3-Act-72-of-2019-Dental-Access-Reimbursement-1-November-2019_DVHA_FINAL.pdf.
12. Centers for Medicare and Medicaid Services, *Innovation Center Strategy Refresh*, accessed June 24, 2024, https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.
13. OneCare Vermont, *2023 Quality Measures*, https://www.onecarevt.org/wp-content/uploads/2023/02/2023-02-16-Quality-Measures-Chart-OCV-D1.pdf.

CareQuest Institute for Oral Health

CareQuest Institute for Oral Health® is a national nonprofit championing a more equitable future where every person can reach their full potential through excellent health. We do this through our work in grantmaking, research, health improvement programs, policy and advocacy, and education as well as our leadership in dental benefits and innovation advancements. We collaborate with thought leaders, health care providers, patients, and local, state, and federal stakeholders to accelerate oral health care transformation and create a system designed for everyone. To learn more, visit carequest.org.

This report and others are available at carequest.org.