CHCS Center for Health Care Strategies, Inc.

Moving Toward Value-Based Payment in Oral Health Care

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Contents

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IN BRIEF

The health care system is increasingly moving away from volume-driven fee-for-service (FFS) payments and toward value-based payment (VBP) arrangements to improve quality, enhance both the patient and providers' experience of care, and reduce costs. VBP models have primarily been implemented in physical health care and have been slower to emerge in oral health care. This brief, produced with support from the DentaQuest Partnership for Oral Health Advancement, summarizes VBP models, examines challenges and opportunities for VBP in the oral health environment, and provides considerations for the expansion of VBP focused on oral health. To inform this brief, CHCS conducted interviews with oral health stakeholders across the country, representing oral health care providers; Medicaid agencies; professional and consumer organizations; and health plans. The brief also highlights insights from these conversations — presenting opportunities for advancing VBP in oral health care, as well as unique considerations that may need to be addressed for VBP to spread in the oral health care field.

Introduction

Value-based payment (VBP) is a broad set of performance-based strategies that link financial incentives to a provider's performance on a broad set of defined quality measures.[1] Payments made to providers under VBP are linked to quality or demonstrate value in some way, such as improving health outcomes, adhering to evidence-based clinical guidelines, or improving patient experience. These arrangements give providers greater flexibility and financial rewards for quality improvement, thus encouraging providers to coordinate care more effectively and achieve better health outcomes for patients. In more advanced models, VBP ties payment to reductions in the cost of care.

VBP models move away from the traditional fee-for-service (FFS) payment system, where providers are paid based on a defined set of services and are financially compensated for the volume of services they provide. FFS often provides financial incentives to deliver higher cost services, rather than preventive services to help manage chronic disease or address health-related social needs (HRSNs), which may be more beneficial to patients and reduce health care costs.

VBP aims to compensate providers more directly for activities that reflect high-quality, cost-effective care, like care coordination, engaging members of a broader health care team, using data to track clinical outcomes, and addressing HRSNs. VBP models can be designed to give providers resources and flexibility to deliver the best care for their patients. These models can help foster connections between patients and care coordinators who help patients manage their health, follow-up after hospital and specialty care visits, and connect them with community-based social services organizations that can support their care needs. VBP can also reward providers for working together as a team, both within a practice and with external partners. Information

technology (IT) systems, which are critical to successful VBP arrangements, support providers in delivering evidence-based care and allow providers to monitor patient needs and outcomes.

Public payers, health plans, and providers are increasingly adopting VBP arrangements. The U.S. Department of Health and Human Services (HHS) has been actively moving from FFS payments to value-based arrangements in the Medicare program and supporting state efforts to advance VBP in Medicaid programs.[2] HHS has also implemented innovative multi-payer payment models[3] that seek to improve quality and reduce costs by aligning goals and incentives among Medicare, Medicaid, and commercial payers. In the commercial market, health plans have likewise adopted new VBP methodologies engaging providers to build capacity to deliver better care. These efforts have helped expand VBP nationwide. In a survey of Medicare, Medicaid, and commercial payers — covering 226 million people in the U.S. — nearly 60 percent of health care payments made in 2018 were in arrangements linked to quality.[4]

Perhaps the deepest challenge in implementing VBP in oral health care is related to how electronic data are used at both the practice and system level, including gaps in coding, data collection, exchange, and analysis.

While the number and types of VBP arrangements are growing in physical health care, VBP is only beginning to emerge in oral health care, and is influenced by multiple factors. While oral health care providers face challenges common to all health care providers who embark on new payment arrangements, some of these challenges are more pronounced or unique to oral health care. Perhaps the deepest challenge is related to how electronic data are used at both the practice and system level, including gaps in coding, data collection, exchange, and analysis. These challenges limit oral health care providers' efforts to deliver coordinated care and monitor outcomes, which are central to success under VBP arrangements.[5] Uptake of oral health care VBP is also limited by the lack of evidence-based guidelines and a standardized quality measurement set for oral health. Further, oral health care providers have historically practiced independently, separate from physical health care, in smaller practices, and with more autonomy due to a larger percentage of income from self-pay patients rather than public or commercial payers.[6] All of these factors present challenges for launching successful VBP programs.

With support from the DentaQuest Partnership for Oral Health Advancement, this brief explores two key questions on the potential for VBP to improve care and lower costs within oral health care: (1) can VBP models be successful in oral health care?; and, if so, (2) how can VBP models be implemented successfully?

This brief summarizes VBP models, examines the challenges and opportunities for VBP in the current oral health care environment, and provides considerations for the expansion of VBP focused on oral health care. To inform this brief, CHCS conducted interviews with 12 oral health stakeholders across the country, representing oral health care providers; Medicaid agencies; professional and consumer organizations; and health plans. This brief highlights insights from these conversations, presenting opportunities for advancing VBP in oral health care, as well as unique considerations that may need to be addressed for VBP to spread in the oral health field.

Overview of Value-Based Payment

Why VBP?

VBP arrangements offer the potential to remedy the misalignment of payment incentives found in the traditional FFS system. VBP models focused on improving patient care can give providers flexibility to deliver care that patients need and want and avoid volume-driven and often unnecessary care. VBP can also provide financial resources to support critical infrastructure improvements in provider practices, such as electronic health records (EHRs), decision supports, and care management tools. By linking payment to evidence-based care that is supported by quality measures, VBP can help improve patient outcomes. For the larger health care system, VBP can also improve accountability by rewarding providers for improving quality of care and controlling costs.

VBP can provide financial resources to support critical infrastructure improvements in provider practices, such as electronic health records, decision supports, and care management tools.

While VBP is a fairly new concept, many VBP initiatives have shown positive results. Over an eight-year period, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract, which includes provider financial incentives and penalties, demonstrated increased quality and reduced spending for participating patients than a control population.[7] The Centers for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program — which includes 561 accountable care organizations (ACOs) serving 10.5 million beneficiaries — generated savings to the Medicare program and its participating providers, and improved quality for patients.[8] Providers who joined CMS' Next Generation ACO model in 2016 reduced Medicare Parts A and B spending for their patients by more than $100 million.[9] Results from other VBP initiatives, including CMS' Medicare Pioneer ACO Model,[10] Minnesota's Integrated Health Partnership program,[11] and Tennessee's Medicaid Episodes of Care program,[12] have also been positive.

The Health Care Payment Learning and Action Network Framework

The most commonly used VBP framework — the Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework — was created by HHS in collaboration with partners in the public, private, and nonprofit sectors, including state Medicaid agencies. The LAN Framework is used as a tool by CMS, states, and commercial payers, to establish consistent terminology and define the levels of risk in, or sophistication required for, types of VBP models. The LAN Framework can also provide a useful structure for approaching VBP in oral health care.[13,14] Exhibit 1 *(next page)* includes a description of the LAN categories.

Exhibit 1. Health Care Payment Learning and Action Network Alternative Payment Model Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE-FOR-SERVICE – NO LINK TO QUALITY AND VALUE	**FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE**	**APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**	**POPULATION-BASED PAYMENT**
	A	**A**	**A**
	Foundational Payments for Infrastructure and Operations (e.g., care coordination fees and payments for HIT investments)	**APMs with Shared Savings** (e.g., shared savings with upside risk only)	**Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay-for-Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**APMs with Shared Savings and Downside Risk** (e.g., episode-based payment for procedures and comprehensive payment with upside and downside risk)	**Comprehensive Populations-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-Performance (e.g., bonuses for quality performance)		**Integrated Finance and Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk-Based Payment NOT Linked to Quality	**4N** Capitated Payments NOT linked to Quality

Source: Health Care Payment Learning and Action Network (HCP-LAN). *Alternative Payment Model (APM) Framework: Refresh for 2017*. The MITRE Corporation. 2017. Available at: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

VBP Models

VBP is defined as a broad set of performance-based strategies that link financial incentives to a provider's performance on a broad set of defined quality measures. VBP arrangements are typically made between: (1) a federal or state government payer and a health plan; (2) a federal and state government payer and a provider or provider organization, like a dental service organization; or (3) a health plan and a provider or provider organization. This brief focuses on VBP arrangements between payers (government or health plan) and providers. In the broader health care environment, providers can be any kind of clinician or group of clinicians such as nurses, primary care physicians, specialists, hospitals, community health centers, multi-specialty practices, behavioral health practitioners, ancillary practitioners, dentists, hygienists, and oral health specialists, among others. While VBP models encourage cost savings, to prevent cutting corners on care, all arrangements in Category 2C or above must be linked to quality performance to ensure that cost savings do not come at the expense of quality. It is important to note that adoption of VBP models does not need to start with Category 2 and move linearly to Category 4, and payment models may advance within categories.

The most common models for providers engaged in VBP include: (1) pay-for-performance; (2) bundled payments; (3) shared savings; and (4) global or capitated payments. Each of these models is described below:

While VBP models encourage cost savings, to prevent cutting corners on care, all arrangements in Category 2C or above must be linked to quality performance to ensure that cost savings do not come at the expense of quality.

- ***Pay-for-Performance***. In pay-for-performance (P4P) programs (Category 2B of the LAN Framework), providers or provider organizations are financially rewarded or penalized based on certain pre-defined quality measure performance benchmarks (e.g., as opposed to prior performance, peers, or national/regional/state standard). Such measures are typically related to patient satisfaction, use of evidence-based processes, resource use, or health outcomes. P4P arrangements that reward providers in the form of a bonus payment without any financial risk are widespread and often made in combination with other payment arrangements.
- ***Shared Savings***. Shared savings programs provide an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care by offering providers a percentage of any realized net savings for a predetermined population of patients. "Savings" are measured in the aggregate as the difference between an expected cost benchmark for a defined set of services and actual cost incurred during a specific time period for the population. The set of services could be an episode of care, or a total cost of care (TCOC) benchmark, which typically reflects average spending for care both inside and outside a practice site. Services included in TCOC may include laboratory, radiology, pharmaceuticals, behavioral health services, and oral health services.[15] Shared savings arrangements are most used in conjunction with ACO or episode of care delivery system reform models.

  Programs can be structured to include upside-only risk (Category 3A of the LAN Framework) or upside and downside risk (Category 3B of the LAN Framework). For programs with upside-only risk, if actual spending falls within an agreed-upon range below the benchmark amount,

participating providers can earn a percentage of savings achieved. In programs with downside risk, upside savings are also possible, but if actual spending exceeds the target amount, participating providers will also be responsible for a percentage of the losses incurred. Payment adjustments are made to the savings and losses based on measured quality performance. For example, a provider that performs well on their quality metrics will receive a larger percentage of savings than if their performance on some quality metrics was poorer.

This model incentivizes activities like care coordination and effective care management across all services to lower the TCOC. Shared savings models require a sufficient patient population, sufficient and accurate patient attribution (typically at least 5,000 patients), and accurate cost projections. Because payments are received retrospectively, providers typically do not receive upfront resources to invest in staff or IT systems to coordinate care and manage costs. However, the federal Comprehensive Primary Care initiative and some ACO models provide upfront payments.

- ***Bundled Payments***. This model (Category 4A of the LAN Framework) provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a clinically defined episode of care with a defined start and end point. These episodes generally fall under a specific procedure (such as complete joint replacement), a time-limited condition (e.g., maternal/perinatal health), or management of care specific to a condition (e.g., diabetes). The bundled payment, which can be paid prospectively or retrospectively, is the expected cost of the entire episode of care. If the cost of care for the patient during the episode exceeds the cost of the episode, the providers will not receive additional payment. However, if the providers deliver services valued less than the cost of the episode, they can keep the remaining amount in the bundled payment. Payment adjustments are made based on quality performance measures, which can lead to additional bonuses or repayments depending on the design of the bundled payment.
- ***Global or Capitated Payments***. Under global or capitated models (Category 4B or 4C of the LAN Framework), providers receive a prospective per-member, per-month payment to cover a range of services, with payment contractually linked to quality metrics. If actual spending exceeds the payment, the provider or provider organization is financially responsible for the portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payments are based on measured quality performance against a quality benchmark (e.g., as opposed to prior performance, peers, or national/regional/state standard), and typically involve a "withhold" where a percentage of capitation payment is withheld and paid later if the provider meets or exceeds the performance benchmarks. This model typically applies to large provider organizations with patient panels substantial enough to bear the downside financial risk.

Provider Capabilities for Successful VBP Program Implementation

Provider and payer experiences in VBP have shown that successful implementation of VBP models requires several common ingredients. This section highlights the capabilities that may be necessary at the practice level to have success in VBP arrangements.

For providers implementing VBP models, the following capabilities are essential:

- ***Practice transformation to support VBP goals***. To improve on quality and cost metrics, clinical best practices must be incorporated into the practice workflow, if not already implemented. Roles and processes must be defined and clear to providers and staff to ensure coordination and team-based care.
- ***A robust IT infrastructure and data analytics capacity***. Practices need to have an EHR that allows providers to capture and exchange data, support care coordination inside and outside the practice, and monitor and generate reports on targeted metrics. Providers and staff need to have access to training to populate the EHRs, use correct coding, and fully utilize EHR functionality. Practices need to be able to analyze the data to determine if they are impacting quality and cost. Successful practices may also have the infrastructure in place to share data with health plans, state agencies, and external providers.
- ***Leadership and provider buy-in***. In larger practices, leadership must understand VBP, be able to articulate a vision for the practice, and support providers and staff in the transition to VBP. Staff may need to be trained to implement new quality-based payment models and understand how they are being held accountable. Practices that are successful in VBP efforts often engage patients and seek feedback on patients' experience.

For more advanced VBP models that hold providers accountable for TCOC, there are additional ingredients for success, including:

- ***Designing the model to account for complexity***. More advanced models that involve the provider taking on risk require a sufficient patient population, accurate patient attribution, and attention to risk adjustment. In shared savings models, for example, a sufficient patient population reduces random variation and contributes to more accurate accounting for costs and savings. Also, for shared savings models, there needs to be a clearly defined savings distribution methodology for participating providers. VBP arrangements that include multiple provider organizations, such as ACOs, may also require a governance structure to oversee how components are established and ensure buy-in from payers and providers.
- ***Incorporating robust care coordination efforts***. While care coordination can be delivered telephonically, having a care manager who is embedded on-site in the practice increases connections with patients and providers who are involved in their care. Practices need to have the resources to hire and train staff for these roles. Practices also need to be able to manage care transitions and make linkages between external providers, e.g., specialists, hospitals, and community organizations.
- ***Expanding the capabilities of the data infrastructure***. Being able to share and act on data in real-time and across a wider range of providers is critical for effective care coordination, and often requires more sophisticated IT capacity and data analytic tools, as well as staff who are trained in these areas. Having the capability to conduct predictive modeling can also help manage cost and quality.

Opportunities for Implementing VBP Programs in Oral Health Care

Based on findings from interviews noted above, combined with experience in designing VBP models to date, CHCS has identified the following promising opportunities for oral health care.

Category 2. Pay-for-Performance

VBP models in Category 2 likely offer the most promising approach for oral health care and are a common first step to ease into VBP. P4P can be added to existing FFS or capitation payment arrangements, particularly with salaried providers. Health plans and practices can partner on choosing a narrow set of measures and build incrementally as they gain experience with VBP. For example, incentives could be used for conducting risk assessments, delivering preventive care, or moving patients from high- to low-risk for additional care.

To participate in such models, practices would need to ensure that their EHRs can capture relevant data, embed clinical guidelines, and train staff to meet program goals. However, P4P programs are typically more manageable than other VBP models because they can limit their focus to care delivered at the practice site, which does not require as much data sharing with external partners, sophisticated care management programs, nor extensive partnerships with external providers as other VBP approaches.

Category 3. Shared Savings

Shared savings models in Category 3 may be appealing for oral health care practices that are already integrated with physical health care, such as federally qualified health centers (FQHCs) and some multi-specialty group practices, which are more likely to have an infrastructure that lends itself to this model. Working with these larger and more integrated practices could benefit oral health care providers, as such practices often have established care coordination programs between physical and oral health care and supports to address HRSNs. These practices are more likely to have the staff and resources to design successful shared savings models, which require attention to risk adjustment, accurate patient attribution, and a clearly defined savings distribution methodology. Shared savings models also require a sufficient attributed patient population, generally a minimum of 5,000 patients, which may be challenging to achieve for oral health care providers.

Successful shared savings models built around reducing TCOC, for oral health, physical health, and potentially other forms of care require leadership and staff that have the time to identify, build, and maintain relationships with primary care providers, specialists, and community organizations.

Because savings are realized retrospectively, providers may need to allocate upfront resources to invest in staff or IT systems to coordinate care and manage costs. While there are significant challenges to implementing this model, if shared savings are achieved, oral health care practices could benefit from financial resources to invest in quality improvement, managing chronic conditions, and addressing HRSNs.

Category 4. Bundled Payments and Capitation

Two types of Category 4 models are promising for oral health care: bundled payments and capitation. Payers could work with oral health care providers to define a bundled payment for a specific episode of care, such as for either preventive or urgent care. For a preventive bundle, providers could use an individualized risk assessment to define clinical care that could include, for example, nutrition counseling and/or fluoride and remineralization therapies delivered by one oral health care provider.

As another example, a more advanced bundled payment could be designed around treatment and restoration for a damaged tooth and periodontium that involves a root canal, crown placement, and periodontal treatment. The care-plan for the bundle could involve multiple providers including a general dentist, endodontist, and periodontist. Such episodes may be easier to implement than TCOC-based models as they would generally be geared toward improving care and cost for discrete activities that are already being performed rather than creating new processes and workflows. However, such models may be challenging from a financial perspective, as not all practices may have the ability to absorb the financial risk associated with these models, and may require entering into new business relationships with external providers.

Meanwhile, population-based payments, or capitation, provide greater flexibility to care for patients holistically, while tying those models to quality metrics to ensure value. However, most oral health care providers are unfamiliar with managing a population of patients over time, given the prevalence of FFS in oral health care. These models also require providers to have a robust IT infrastructure to share data and manage costs. That said, for those providers who can manage these challenges, prospective payment arrangements do offer greater flexibility for delivering care as well as a predictable funding stream.

Summary of Opportunities and Challenges by HCP LAN Category

Exhibit 2 *(next page)* summarizes the opportunities and challenges of implementing VBP models in oral health care, and provides examples of models. It details issues for providers in general, as well as issues specific to oral health care providers.

Exhibit 2. Opportunities, Challenges, and Examples of VBP Models by HCP LAN Category

Opportunities	Challenges	Examples
Category 2 A, B, and C		
▪ Because there is no risk to the providers, pay-for-reporting and P4P models are a common first step to ease into VBP. ▪ P4P works well to incentivize salaried providers. ▪ New programs can begin with a narrow set of measures. ▪ Incentives could be used for conducting risk assessments, delivering preventive care, or moving patients from high-risk to low-risk. ▪ More advanced goals could be related to managing chronic conditions or addressing HRSNs.	▪ IT infrastructure varies by practice and will impact how and what data can be measured and collected. This is especially true in oral health care practices. ▪ Providers and staff may need training in coding and using EHRs. ▪ Providers need tools and resources to change care delivery, integrate clinical guidelines, and incorporate changes in workflow.	▪ Examples of provider P4P initiatives include: (a) payer incentives for providers who deliver a set of preventive services; and (b) incentives for conducting risk screenings and moving patients from high- to low-risk over time.
Category 3 A and B		
▪ Systems that are already integrated with physical health care, such as FQHCs and some multi-specialty group practices, are more likely to have an infrastructure that lends itself to care coordination between physical and oral health care, and addressing HRSNs, as resources and knowledge may be more easily available. ▪ If shared savings are achieved, providers have additional financial resources to invest in improving quality, managing chronic conditions, and addressing HRSNs.	▪ To the extent shared savings are tied to TCOC beyond oral health care, oral health care practices must identify and build relationships with primary care providers, specialists, and community organizations. ▪ May be challenging to access data from external entities for referrals, care transitions, and community linkages. ▪ Requires sufficient patient population (generally a minimum of 5,000 patients), accurate patient attribution, and attention to risk adjustment. ▪ Savings are realized retrospectively, meaning providers must be able to allocate upfront resources to invest in staff or IT to coordinate care and manage costs. ▪ Savings distribution methodology to individual providers must be clearly defined.	▪ Examples in oral health care are currently rare. Yet, a potential model could be one where providers in a dental practice are eligible to receive shared savings from a health plan if they meet predefined targets tied to managing the TCOC and improving quality for a set of patients as part of a multi-disciplinary team/network of providers.
Category 4 A, B, and C		
▪ Providers may be interested in models that offer prospective payment. ▪ Through the capitation rate, provides flexibility for managing chronic conditions, and addressing HRSNs. ▪ For Category 4A: Payers could work with oral health care providers to define a bundled payment for a specific episode of care.	▪ Most oral health care providers are unfamiliar with managing a population of patients. ▪ Requires linkages between external providers, e.g., specialists, hospitals, primary care providers to manage TCOC. ▪ Advanced data infrastructure is important to share data and manage costs. ▪ For Category 4A: Must clearly define episodes and bundles.	▪ Examples of condition-specific payments in oral health care are currently rare. Yet, a potential model could be one where providers in a dental practice receive a payment from a health plan for a specific episode of care, which could be related to preventive or restorative care. ▪ Oral health is included in some Category 4 arrangements that include physical health. In these models, oral health services are included in the TCOC and sometimes quality metrics related to oral health are present. Examples include Oregon's Coordinated Care Organizations and Hennepin Health in Minnesota.

Challenges for Implementing VBP in the Oral Health Care Environment

Implementing successful VBP programs in oral health care requires building the capabilities described above, as well as addressing unique challenges in the oral health care environment. It should be noted that providers and health plans faced a number of these same challenges when VBP began gaining traction in physical health care, many of which have been addressed through private and federal government investment and providers' experience with these arrangements and refinement over time.[16] Those investments have helped spur the widespread adoption of EHRs and IT infrastructure, the development of robust quality measures, and an increase of care coordination programs and practice transformation efforts. Importantly, these challenges do not preclude the establishment of VBP arrangements, but may impact the speed and ease of implementation and the adoption of more advanced models.

The following challenges to implementing VBP in oral health care were identified through interviews with stakeholders in the field, as well as CHCS' experience in designing VBP models to date.

Providers and health plans faced a number of these same challenges when VBP began gaining traction in physical health care, many of which have been addressed through private and federal government investment and providers' experience over time.

- ***Lack of data***. Effectively collecting and sharing data is the cornerstone of successful VBP arrangements. At the practice level, patient data are critical to: (1) managing patient care in real time and over time; (2) coordinating care with external providers and community organizations; and (3) tracking and monitoring patient outcomes and costs. Oral health care providers face the following data-related challenges:
  - ***Electronic health records.*** Many oral health care providers lack EHRs, limiting their ability to easily monitor clinical outcomes, coordinate care, and track costs. EHR adoption rates in dental clinics are lower than those in office-based physical health provider practices in part due to the number of smaller practices in oral health care.[17]
  - ***Data collection and storage and analytic capability.*** Practices that use EHRs may not have the IT infrastructure, relationships with other provider offices, data use agreements, and staff to share data effectively with providers within their own practices, with external providers, or to participate in state, regional, or national health information exchanges. Even when oral health care providers have IT systems in place, they are typically not linked to physical health care providers, making it difficult to coordinate care for patients with chronic health needs or manage and track a TCOC arrangement. Oral health care practices may also not have sufficient analytic capacity, such as tools, software, and staff to use data optimally. The effectiveness of EHRs and data analysis tools are also limited by the quality of the data entered into the system. Such limitations could be from incorrect coding and data input, or incomplete data about patient encounters with providers, diagnostic tests, pharmacy utilization, and other services outside an oral health care provider office.

- » ***Diagnostic codes***. For providers who collect patient data through EHRs, there is not a standard set of diagnostic codes for oral health, which helps practices monitor performance in VBP arrangements. The American Dental Association (ADA) Code on Dental Procedures and Nomenclature was developed to accurately document dental treatment and provide for the efficient processing of dental claims.[18] While these codes could be used to populate EHRs, they are typically used for paying claims and not captured by current coding practices. While International Classification of Disease codes and Systematized Nomenclature of Dentistry diagnostic codes are available for documenting dental disease and clinical oral health data, interviewees indicated that the two code sets are used by some providers and payers for billing and diagnostic purposes and the lack of widespread use to-date has not prompted robust modification to standardize or optimize the sets.

  At a systems level, data supported by standardized diagnostic codes are also important for predictive modeling (for advanced VBP arrangements), understanding outcomes and cost trends, developing quality and cost measures, and building evidence-based guidelines. In some cases, claims data are available and useful for understanding costs in advanced VBP models, but claims data lack clinical elements that provide important detail to better understand patient health conditions.

- ***Limited evidence base***. Process and outcomes metrics in VBP programs are tied to evidence-based guidelines and agreement on standard treatments. Changes in care delivery at the practice level that lead to improved quality are based on evidence. Interviewees noted that organizations that work to advance health care quality, like the Agency for Healthcare Research and Quality — the lead federal agency charged with improving the safety and quality of the nation's health care system — have limited evidence-based resources in oral health care. The relative lack of evidence-based oral health guidelines, at least compared to physical health, and limited training for oral health care providers, may prevent implementation of standardized approaches necessary to drive quality improvement at the practice level.
- ***Absence of a common quality measure set***. Efforts to develop standardized quality health care measures and a common measure set have largely focused on physical health. Having agreed upon and readily available quality measures is critical to the development, credibility, and acceptance of VBP programs. To begin filling this gap, the ADA's Dental Quality Alliance developed claims-based administrative measures for both pediatric and adult populations.[19] While this is a positive step, these measures do not yet cover the full range of oral health quality improvement goals that could apply to a potential VBP program. Plus, oral health care providers may not be aware of these measures.
- ***Oral health care is mostly delivered by individual practitioners or in small practices***. Many dental providers have a high-level of autonomy. More than half of the dentists in the United States work as solo practitioners.[20] Larger practices may have an advantage in risk-based VBP models due to factors described earlier, while smaller practices may be limited to HCP LAN Category 2 models. This includes the ability to spread risk over a larger patient population, coordinate care within the practice and with external providers and organizations, develop a team-based delivery system, and capture and analyze data. Larger organizations also have the resources to spread technology and staff investments across many providers.

- ***Payment in the oral health care system is largely fee-for-service***. Interviewees noted that providers are familiar and have grown comfortable over time with the volume-driven nature of FFS payments. Most oral health care providers lack experience managing a population of patients. According to a recent survey, 51 percent of responding providers have never heard of APMs in dentistry, while 35 percent had only heard of APMs or knew little about them.[21] Providers may be averse to participating in a capitated arrangement that requires changes to the way care is delivered as well as new financial considerations. This was largely the case in physical health care before the Affordable Care Act, and the transition to VBP in physical health care was also met by significant provider reluctance.
- ***Separation from physical health care systems***. The relationship between oral health and the health of other parts of the body are well known.[22] While dentistry includes preventive services, it functions more like a specialist field in terms of how it is perceived and how care is billed and reimbursed. VBP models for physical health often center on primary care providers, who deliver preventive services, care coordination and care transitions, referrals to specialty care, and linkages to community health resources. As a result, success in VBP models often depends on effective connections among primary and specialty care providers, hospitals, health systems, and community organizations. Oral health care providers who see themselves akin to primary care providers or specialists that are part of a larger health care team — where their roles extend beyond delivering clinical treatment to include activities that improve health, like prevention and screening and coordinating care — are more likely to be successful in VBP arrangements.
- ***What should total cost of care include?*** In more advanced VBP models, such as shared savings or capitation, oral health care could either be part of a larger TCOC arrangement that includes a scope of services of physical health care, behavioral health care, pharmaceutical costs, or other areas. Conversely, it could just include oral health care costs. If a larger scope of services, there would be more incentive to coordinate care across settings, leading to improved quality metrics and opportunity for oral health care providers to reduce costs that their care could affect, leading to greater savings or margin. However, a narrow TCOC limited to oral health care providers could offer more autonomy and control.
- ***Lack of insurance coverage for oral health care.*** Insurance coverage for oral health care, through both commercial and public payers, is less prevalent than in physical health care. Almost one-quarter (23 percent) of the U.S. population has no dental coverage, or more than double the percentage that lacks medical insurance.[23] A vast majority of payment for dental services is out of pocket, due to the lack of dental coverage and limits on what is covered in those plans. According to the National Association of Dental Plans, just under half of dental preferred provider organizations, the predominant dental product in the market, have a maximum annual benefit above $1,500 — half are less than $1,500 — and deductibles for these products are usually between $50 and $100.[24] These factors may make it difficult for VBP to be implemented in oral health care, because if many transactions are simply between the patient and oral health care practice, there is no party other than the patient to hold the provider accountable.

In Medicaid, coverage for adults varies by state and is limited to certain populations and services. In addition, access to care is limited because of the number of providers that accept Medicaid beneficiaries (20 percent nationally) and the lack of services in both urban and rural settings.[25] While Medicaid and CHIP cover dental services for all child enrollees as part of Early and Periodic Screening, Diagnostic and Treatment, state Medicaid programs are not required to cover adult beneficiaries. As of 2019, nearly all states (47 and D.C.) offer some dental benefit to their base adult Medicaid population, excluding adults eligible through Medicaid expansions under the Affordable Care Act. Thirty-four states and D.C. cover services beyond defined emergency situations (e.g., uncontrolled bleeding, traumatic injury), and among those, 19 and D.C. cover extensive services.[26] In states where the adult benefit is nonexistent or is limited to emergency care, designing VBP programs would prove impossible or very difficult.

- ***Lack of supports to help providers address HRSNs***: Oral health care providers who are interested in implementing VBP are often also motivated to address their patients' HRSNs to improve the overall health of their patients. Addressing HRSNs has been shown to improve health outcomes and reduce costs.[27] Despite interest, many oral health care providers, like other health care providers, lack the support to effectively identify, assess, and coordinate the necessary linkages to respond to, patients' HRSNs.

Looking Ahead

Oral health stakeholders interviewed for this brief expressed an interest in new payment methodologies and acknowledged VBP as a viable approach to improving quality and reducing costs in oral health care. Despite the significant challenges in implementing VBP models in oral health care, interviewees noted that VBP shifts the incentives for providers and rewards them for providing high-quality, cost-effective care. VBP also allows providers greater flexibility to care for their patients holistically and presents opportunities to better coordinate care and address physical health conditions and HRSNs. Stakeholders also noted that VBP may serve as a pathway to advance the field of oral health itself — particularly as new lessons emerge from the COVID-19 pandemic — through greater integration with physical health, a renewed focus on prevention rather than restoration, attention to clinical and cost data collection and analysis, and further development and dissemination of robust evidence-based guidelines.

While VBP is a promising opportunity for these reasons, oral health care providers may not be interested in pursuing VBP arrangements. For example, as noted earlier in this brief, implementing VBP is more challenging for providers practicing individually, particularly in advanced VBP models that require taking on financial risk. For providers and health plans that are interested in exploring VBP arrangements, there are opportunities for moving forward:

VBP may serve as a pathway to advance the field of oral health — through greater integration with physical health, a renewed focus on prevention rather than restoration, attention to clinical and cost data collection and analysis, and further development and dissemination of robust evidence-based guidelines.

1. **Start slowly, move forward incrementally, and make adjustments.** This is one of the key lessons from the physical health field's experience with VBP. Many initial VBP programs begin with pay-for-reporting, then move to P4P arrangements, and gradually, to more advanced models. Providers need time to build IT and staff capacity, implement new workflows, and capture and report data. A narrow set of performance measures would also help providers adapt to new programs.
2. **Explore pilots to advance oral health care and VBP goals.** Providers and health plans could develop a pilot program to test the feasibility of a VBP model. Pilots could be time-limited, focus on targeted providers and select populations, and address specific goals. Pilots also target investments to allow providers to build capacity and move toward more advanced VBP models.
3. **Build capacity in dental practices to participate in VBP models.** There are various training and technical support activities underway across the country that support the readiness and capacity of oral health care providers to succeed in VBP models.[28] Capacities not directly related to FFS payment, such as care management systems, information systems, and financial accounting, must be developed to achieve success in new payment models. Participating in patient-centered dental home models,[29] which are designed to foster integrated, quality-driven care, would help build capacity for care coordination and team-based care.

4. **Engage external partners and stakeholders.** When considering VBP models, oral health care providers should determine if they want to focus solely on oral health or join with a broader provider community. Providers who want to participate in broader VBP arrangements should look for opportunities to build relationships with primary care providers and hospitals operating as part of ACOs and align their mutual goals of prevention, treating chronic conditions, and holistically meeting patient needs. Areas of collaboration could also include sharing data and building partnerships with community organizations to address HRSNs. Co-location of services would make receiving care more convenient and promote referrals and care transitions. Affiliation with physical health provider organizations, multi-specialty group practices, FQHCs, or hospital systems, particularly those with a high level of integration, may allow for greater likelihood for success.
5. **Create a glide path for prospective payments.** Capitated models provide greater flexibility to care for patients holistically and tying those models to quality metrics is key to ensuring value. Amid COVID-19, one primary reason for financial challenges confronting many providers is the FFS payment model. In today's environment, oral health care providers may start to see the value of prospective payment arrangements, which offer a predictable funding stream. Providers receive these payments whether they perform services for the patient or not. Prospective payments are intended to: (1) incentivize the provider to keep patients well; (2) promote high-value services that support the overall health of patients; and (3) give providers greater flexibility to deliver services in a variety of ways.[30]
6. **Incorporate VBP models into dental and dental hygiene program curricula.** Greater understanding of payment approaches that improve quality and reduce costs will help newly trained providers be more comfortable participating in innovative models.

While oral health care providers and health plans face challenges in adopting VBP — due to both the novelty of these arrangements and the unique characteristics of the oral health care environment — the opportunities described in this brief offer entry points for effective VBP approaches in the oral health care field. For many oral health care providers, VBP offers the potential to modernize and advance their practices, improve quality of care, and reduce health care costs.

ENDNOTES

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