CareQuest Institute for Oral Health®

RESEARCH REPORT

An Alternative Payment Model to Support Medical-Dental Integration

A Case Example

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  - Franklin Care Center Pediatrics
  - Navarre Primary Care Center
- Southern Ohio Medical Center (SOMC) Pediatric Associates

Background

The rising costs of health care in the United States (US) despite a lack of improvement in health outcomes can be attributed to a variety of factors including growing prevalence of chronic disease, aging populations, individual lifestyle factors, increasing influence of social drivers of health, technology advancements, and broadening health insurance coverage.

Lowering the cost of health care to consumers and for the nation requires changes in the ways health care is paid for and delivered. Such changes are often tested at scale in the Medicare and Medicaid programs, as coverage engages millions of individuals across the US.

Within the Centers for Medicare and Medicaid Services (CMS) programs, a core driver of the changes to payment for health care is alternative payment models (APMs). APMs are "a payment approach that gives added incentive payments to provide high-quality and cost-efficient care [for] a specific clinical condition, a care episode, or a population." This approach contrasts with the fee-for-service (FFS) system that reimburses providers for the volume of services they provide without regard for coordination with other providers, care quality, or effect on health outcomes. CMS has developed and evaluated many APMs through the Center for Medicare & Medicaid Innovation (CMMI) since the founding of the organization in 2010.

Existing evidence shows APMs can produce cost savings to the health care system, most notably CMS' Medicare Shared Savings program, which has rewarded medical accountable care organizations (ACOs) for delivering cost savings and quality primary care for over a decade. A key driver of the program's success is care integration, including the ability of providers to share health information and coordinate care. In addition to CMS, commercial plans are also increasingly adopting APMs using the Health Care Payment Learning and

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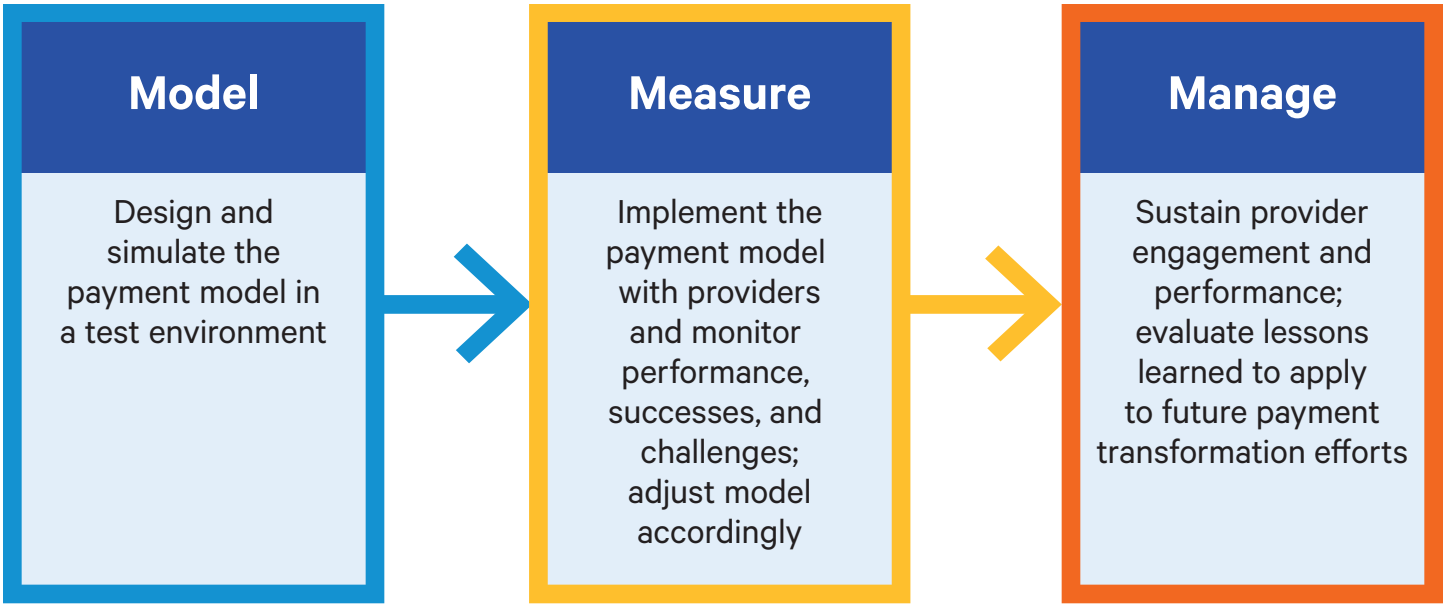
Action Network's (HCPLAN) framework to standardize design and operation of APMs across the industry. The framework includes four categories of models, three of which are uniquely designed to support quality care: fee-for-service with no link to quality and value, fee-for-service with a link to quality and value, APMs built on fee-for-service architecture, and population-based payment.

With the growing adoption of public and commercial APM arrangements that center care integration and coordination to improve health outcomes, there is untapped potential to align oral health with this focus. Growing evidence on the connection of oral health to overall health and the benefits of medical-dental integration can be leveraged in APM designs to further improve patient outcomes and control costs. With the expectation by private industry and public stakeholders that health care will continue to shift from FFS toward a streamlined set of APMs, it is critical to build on limited models that do include oral health and ensure comprehensive, affordable health care.

Testing an Integrated APM

CareQuest Institute for Oral Health addressed this gap of payment models to support medical-dental integration by testing an APM within their state-based initiative known as Medical Oral Expanded (MORE) Care®. This initiative aims to develop and strengthen interprofessional networks by integrating oral health competencies and capabilities into primary care practices and strengthening referral networks with dental providers using health information technology. To evaluate how payment structure could support cost-effective integrated care, improve access to preventive care, and encourage sharing goals between health disciplines, the MORE Care Pilot in Ohio tested an HCPLAN fee-for-service (FFS) + incentive APM model. The pilot focused on the pediatric population (ages 0–18) at four dental and three primary care practices across six Ohio counties with the highest dental caries prevalence. For more on pilot design and participant selection, see the full pilot impact report. The APM ran from November 2022 through November 2024, with design of the model and onboarding of participants preceding November 2022. The model was tested in three phases (see Figure 1).

Figure 1. Testing an Integrated APM



Implementing the APM

Model

September 2021 to September 2022

The design process for the integration-focused APM began with a review of the literature on financial incentive designs that influence health care provider behavior. This review had several applicable key findings:

- Pay-for-reporting models were effective in easing providers into data reporting workflows.
- Pay-for-performance models showed mixed results in changing provider behavior and improving care quality.
- Incentives should be tailored to practice types and individual providers, with adequate infrastructure and regular evaluation to ensure sustainability and alignment with organizational goals.

These insights were used to create a framework for the APM, including incentive duration, patient population, quality measures, performance benchmarks, and incentive payout schedule. This ultimately led to a consensus to test a combination of pay-for-reporting and pay-for-performance models focused on prevention and integration using the quality measures described below (Table 1) to promote shared processes and goals between primary care and dentistry. Incentive dollars were rewarded by performance period, according to a set schedule of six payouts over the course of the program.

The design received support from program stakeholders, including a project oversight committee local to Ohio. Additional preparation was made for implementation, including the development of tools and materials for participant onboarding, data reporting, and quality measure tracking.

Table 1. APM Quality Measures

Pay-for-Reporting Measures
1. Completeness of reported clinical data*
2. Completeness of reported demographic and social data*
3. Quality of reported data**
Pay-for-Performance, Primary Care Practice Measures
1. Percentage of patient encounters with an oral health risk assessment
2. Percentage of patient encounters with oral health self-management goals
3. Percentage of patient encounters with fluoride varnish application
4. Percentage of patients referred to a dental provider participating in MORE Care+
5. Percentage of patients with a dental consultation and treatment plan received from dental provider participating in MORE Care (closed loop referral)
Pay-for-Performance, Dental Practice Measures
1. Percentage of patients with a caries risk assessment (due annually)
2. Percentage of all services that are primary and secondary preventive procedures
3. Percentage of all services that are surgical procedures
4. Percentage of patients referred by a MORE Care participating medical provider with a dental consultation++

* Data completeness refers to the ability to submit all required data fields, avoiding missing fields.

** Data quality refers to the ability to submit each data field in a consistent format for each required submission.

\+ Because dental home status couldn't be tracked, any patient seen by a primary care participant for a well child visit was eligible for referral.

++ This measure includes only patients referred by a MORE Care medical provider to a MORE Care dental provider.

Measure

October 2022 to October 2023

Practices were selected to participate in the program through an application process that assessed their patient volume, payer mix, electronic health record usage, and desire to collaborate with the other health discipline. Onboarding of participants to the APM focused on model design, quality measures, and monthly data reporting processes. Each participating practice received a lump sum payment from CareQuest Institute to support staff time spent on creating initial (baseline) data reports and data infrastructure improvements (e.g., electronic record system upgrades). As the program began, data reporting challenges emerged. Some practices required additional staff to compile reports, and one practice lacked the electronic record capability to extract the required data, necessitating the use of an application programming interface (API) to support data reporting.

After each practice submitted the required data for the 12-month pre-program period and the first four months of the program, practices received incentive payments based on their data completeness and quality (pay-for-reporting) but were not yet assessed on quality measure performance (pay-for-performance). To prepare for pay-for-performance, CareQuest Institute analyzed the previously submitted data from each practice to set quality measure performance benchmarks. The benchmarks were designed to help participants set goals and assess their success or identify gaps in meeting oral health quality measures. The benchmarks were established based on the feasibility of achievement, as indicated by historical performance data. Benchmarks included:

- 10% improvement in well-child medical visits including oral health services (risk assessment, self-management goals, fluoride varnish)
- 5% increase in preventive dental services and caries risk assessment compared to the pre-program period
- 5% decrease in surgical dental services compared to the pre-program period

No standardized benchmark was set for the referral measures because there was no documented historical referral data from the participants.

Along with setting benchmarks, CareQuest Institute used the previously submitted data on patterns of historic service utilization to model future performance for each practice. Understanding possible performance and earnings encouraged participant engagement with the model while also allowing CareQuest Institute to manage model budget.

CareQuest Institute developed interactive digital dashboards for each practice to visually track their own performance and progress. The dashboards included aggregated data for each quality measure, monthly quality measure performance against the set benchmark, and a “scorecard” showing how many incentive dollars the practice earned under the pay-for-reporting and pay-for-performance arrangement. Additionally, the dashboards showcased referral measures jointly, so medical and dental providers could concurrently track referral progress and make collaborative improvements. The following (Figures 2–3) is a deidentified example of a dental and a medical dashboard page showcasing select program quality measures.

As data challenges arose, especially regarding the documentation and coding of oral health services by primary care providers, CareQuest Institute collaborated with practices to resolve these issues through virtual training and technical assistance. CareQuest Institute also monitored entire cohort quality measure performance, budget spending, and total incentives attributed.

Figure 2. Dental Performance Dashboard

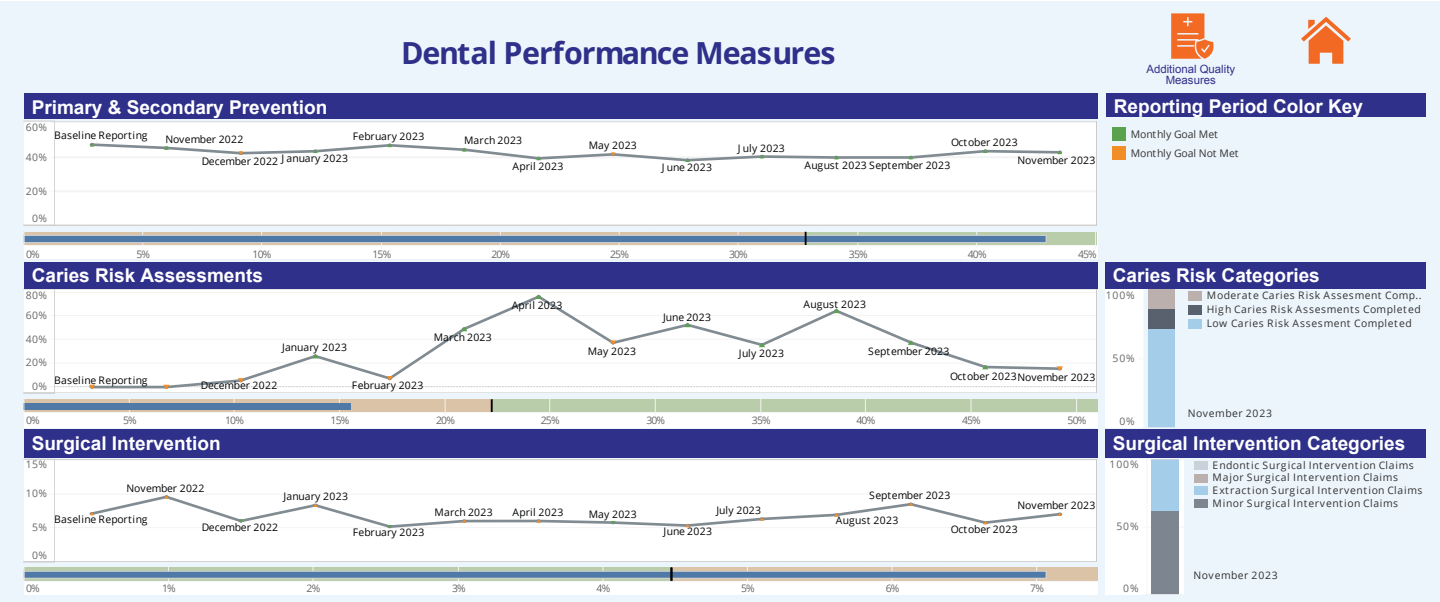
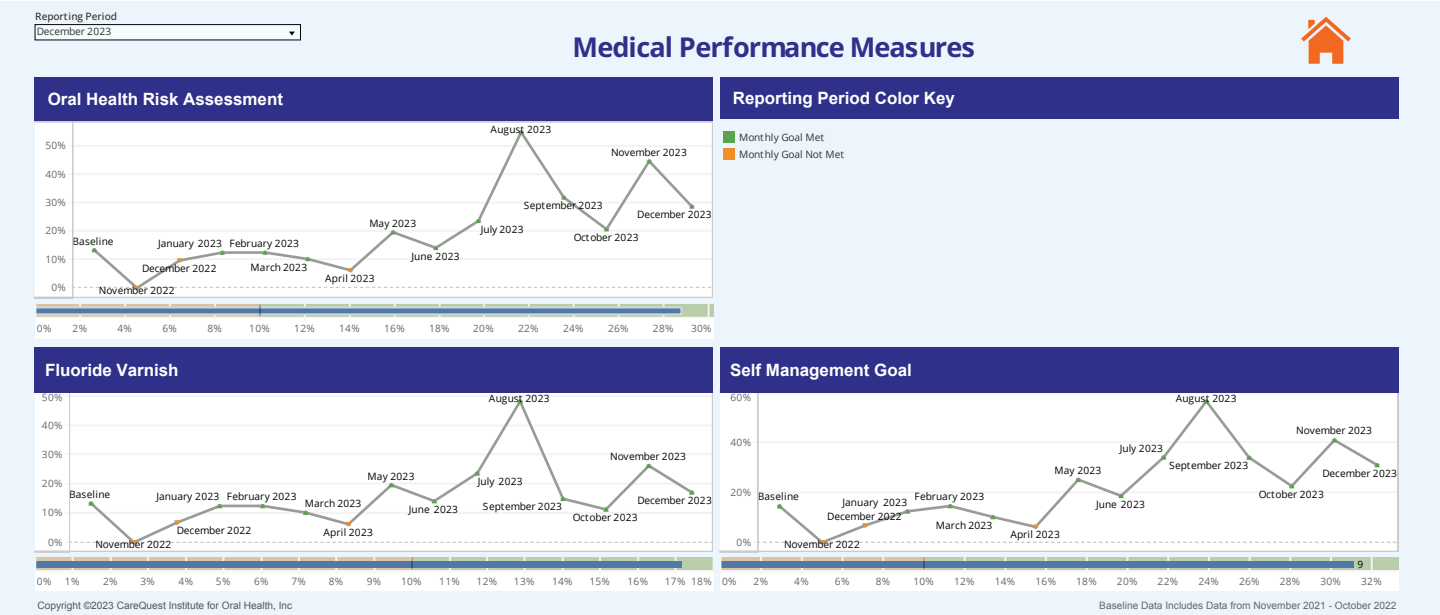


Figure 3. Medical Performance Dashboard



Manage

November 2023 to November 2024

Sustaining Engagement

In November 2023, the MORE Care program received recognition as a health care quality improvement initiative by the Ohio Department of Medicaid at the request of CareSource, a Medicaid managed care plan in Ohio. This designation reflects the success of the program's first year in improving oral health care quality. During the second year of the program, participants focused on building upon the improvements made in the first year, with an emphasis on addressing challenges related to integrated care. Participant data and dashboards were used to track progress and reforecast practice performance on quality measures and budget expenditures for the remainder of the program. Three reforecasts were performed throughout the year to evaluate performance and assess financial needs, ensuring the model stayed on track.

By analyzing their data from the first year of the program, CareQuest Institute identified which quality measure benchmarks were most frequently met and adjusted benchmarks accordingly to promote a continued shift toward prevention-focused, lower-cost care.

CareQuest Institute also updated quality measure benchmarks for the dental practices based on their performance in the previous year. By analyzing their data from the first year of the program, CareQuest Institute identified which quality measure benchmarks were most frequently met and adjusted benchmarks accordingly to promote a continued shift toward prevention-focused, lower-cost care. These updated dental benchmarks, implemented starting in April 2024, aimed to drive further improvement and were incorporated into performance-tracking dashboards. Benchmarks for primary care practices were not updated because they were still making progress toward meeting the initial benchmarks, likely because it took time to implement the new oral health services. As participants continued to deliver services and coordinate care, the updated benchmarks and data monitoring helped assess their progress, with incentive payments linked to performance through November 2024.

Evaluation

Evaluation of the model took place during implementation through previously described forecasting efforts and informed changes made during operation (e.g., benchmark updates). Further evaluation took place after model implementation to grasp overall achievement compared to aims for integrated, coordinated care set out at the beginning of the design process (Table 2).

Table 2. APM Evaluation and Recommendations for Future Models

Question	Evaluation	Recommendation
How did the model perform compared to forecasted predictions?	• Because benchmarks for improvement were based on historical practice performance, they were attainable during the program by all participants, even if they took time to reach. • Percentage-based benchmarks enabled practices with varying patient and service volumes to be evaluated consistently, allowing each to successfully meet performance targets. • Dental practices exceeded predicted performance, and all earned the maximum incentive amount. Primary care practices, however, had mixed results, with only one of three reaching the maximum incentive amount. Differences may be attributed to the time needed to scale new services. • Having a maximum incentive amount that providers could earn supported program budget maintenance and cost containment.	• APM designs should better account for variations in practice size and volume and align quality measures (e.g., referrals, care coordination) between primary care and dental practices to ensure more balanced rewards, motivation, and goals for integrated care. Payers and providers should collaborate on model design to build trust and increase transparency. • Future APM designs for oral health should utilize historical practice-level data to set and monitor performance benchmarks. • Stakeholders designing integration-focused APMs should consider testing the performance benchmarks used in the MORE Care Ohio model.
Did the APM design support increased prevention?	• The APM was designed to reward increased concurrent provision of preventive oral health services by medical and dental providers to support a decreased need for and cost of surgical dental services through oral disease prevention. Due to the presence of multiple program components (APM, educational training, coaching), the sole impact of the financial incentive is not fully clear. However, both dental and primary care providers increased their provision of preventive oral health services. Additionally, surgical dental services decreased by 4% over two years compared to the pre-program period. • Despite challenges with data reporting and infrastructure, performance improvements on all quality measures for the cohort were noted, though variations in outcomes occurred due to differing infrastructures and workflows between practices.	• APMs should be structured to incentivize preventive care and promote coordinated patient health management through shared goals and integrated technology across health disciplines. • APMs must support providers in building proper data, technology, and staffing infrastructure to support a focus on prevention. • Improved approaches for measuring the impact of delivery of preventive services on cost savings and patient health outcomes for oral health (e.g., broader use of diagnostic coding) are needed.
Did the model support improved value of the health care dollar through integrated care pathways?	• The APM rewarded primary care providers for referring over 400 children for dental care, of which 34% (138) were seen by a participating dental provider, expanding use of dental coverage and member access to care. • A key challenge was the lack of technical infrastructure for primary care and dental practices to exchange referral information, requiring manual processes that hindered efficiency and data management.	• Improvements to infrastructure for referral tracking (e.g., software, coding, data exchange standards) would increase provider success in integrated APMs and likely lower administrative costs for integrated care. Initial costs for improving infrastructure may be high but should even out over time with cost savings from more streamlined care.

Lessons Learned and Call to Action

Testing an integration-focused APM generated many successes and lessons learned.

As was evidenced by the pilot, practices involved in the APM approached participation in different stages of readiness for integrated, value-based care. Primary care practices had some experience with quality measurement, care coordination, and even APMs, while dental practices had less experience in those areas. However, these processes had not historically involved coordination with dentistry. It was observed that large health care practices had more robust electronic systems and staff for utilizing data and analytics but sometimes lacked flexibility for rapid-cycle quality improvement and change needed for success with APMs. Smaller health care practices did implement changes more quickly but often lacked technology and staff for administrative work required to make data-driven decisions and participate in APMs. Lack of technical infrastructure for primary care and dental practices to share referral information necessitated manual referral tracking and reporting processes that, at times, lacked efficiency and quality data. Enhancing referral tracking infrastructure (e.g., software, coding, data standards) between primary care and dentistry should be pursued to improve integration.

While the APM was designed to engage distinct provider types while simultaneously promoting shared, standardized goals, it occasionally lacked flexibility to meet the variety of participant infrastructure, operational, and community needs. For example, dental practices that cared for a large volume of patients with high surgical dental needs had a harder time reaching prevention-oriented quality measure benchmarks. For optimal outcomes, payment models should balance standardization and flexibility to ensure quality and support a variety of provider types and practice readiness. One way to do this is to prioritize provider input during model design and allow for changes during model implementation based on provider feedback.

While many APMs have been tested by CMS and commercial plans, they do not often concurrently incentivize the integration of medical and dental practice aimed at more comprehensive care. This model test generated evidence that financial incentives paired with technical assistance support improved preventive dental care provision and medical-dental integration. As CMS has identified oral health as one of 13 cross-cutting initiatives and is prioritizing evidence-based prevention while increasing independent provider participation in value-based payment programs, stakeholders like HCPLAN, state Medicaid agencies, and commercial payers should consider how they engage dentistry and measure oral health as a part of their strategy for disease prevention and total cost of care management. Additionally, as CMS makes progress on its goal for all individuals with Traditional Medicare to be in an accountable care model by 2030, advocates should examine how Medicare pays broadly for dental care as a part of accountable, comprehensive care.

The successful testing of a pay-for-reporting and pay-for-performance design represents a meaningful advancement in the pursuit of value-based care that includes oral health. This foundational APM design served as a strong catalyst for interprofessional practice, promoting shared goals and fostering collaboration between health disciplines. This initiative underscored the importance of accounting for both practice and system-level factors in the development of APMs that support integrated care. While volume-based models have laid important groundwork by strengthening infrastructure and encouraging preventive services, they lack concrete evidence in demonstrating measurable impact on health outcomes and cost of care. As dentistry continues to gain experience with alternative payment models, future designs should prioritize the ability to track and manage both health outcomes and costs. Overall, the tested model proved to be an effective tool for enabling integrated care pathways and advancing more equitable, impactful oral health care.

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CareQuest Institute for Oral Health

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