



Keys to Success - Released in May 2018

Value-Based Care

by Danielle Apostolon, Senior SNS Project Manager

What is Value-Based Care?

Value-based care (VBC) is a person/patient centered approach to health care delivery designed to improve health outcomes and lower the cost of care. Value-based payers reimburse providers based on the quality of care instead of the volume of care. The expectation is that payers will eventually move away from a fee-for-service (FFS) reimbursement model towards alternative value-based payment models, such as capitation or global payment; bonus and incentive payments; and shared savings models with or without shared risk. VBC models have been adopted and utilized more in health than in oral health and have proven to be very complex operationally. VBC models also have various financial implications, especially in the short term. Evidence shows that health care costs in the United States are out of control and that health outcomes are declining. VBC has been identified as a solution to reducing costs, improving the patient experience of care, and to also making patients healthier, but there are many cost and care delivery factors to consider that impact results.

What Would Value-Based Care Look Like in Oral Health?

The Department of Health and Human Services (HHS) launched the Health Care Payment Learning Action Network (LAN) to help advance the work being done across sectors to increase the adoption of value-based payments and alternative payment models (APMs). LAN developed a framework for categorizing 4 different payment models as illustrated below.

<p>Category 1</p> <p>Fee-for-Service – No Link to Quality & Value</p>	<p>Category 2</p> <p>Fee-for-Service – Link to Quality & Value</p>	<p>Category 3</p> <p>APMs Built on Fee-for-Service Architecture</p>	<p>Category 4</p> <p>Population-Based Payments</p>
------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	------------------------------------------------------------------------------------	---------------------------------------------------------------

Category 1, which is FFS, is the current payment model and in fact the model that has been used for the past 150 years in both health and oral health. FFS has no link to value or quality resulting in a higher volume of services. Category 2 is FFS as a base architecture that usually involves lower fees with the addition of a link to quality and value. For example, providers are paid fee-for-service with the potential to earn a bonus for meeting a defined set of performance measures. The performance measures can be simple in the beginning of a value-based contract, such as providers investing in technology that can capture and report value-based care data. It

can also support and pay a bonus for infrastructure investments to improve clinical services and enable providers to report quality data, and/or providers' performance on cost and quality metrics. Payments would be adjusted if providers do not meet the performance measure(s), or providers would receive a bonus payment for meeting and/or exceeding the measure(s). This allows the provider or practice to keep the FFS predictability with the added benefit of a payment system that is designed to create value for the services performed instead of a system solely based on volume.

Category 3 begins to move away from the FFS architecture towards an APM that is linked to quality and value. For example, providers are reimbursed under a FFS base model, but if a provider can reduce expenses while providing care to a defined group or number of patients below an established and agreed upon benchmark set by the payer, then the provider and payer would split the amount of savings produced. This model is referred to as shared savings. Providers under shared savings programs can retain a predetermined proportion of the savings. There can also be shared savings and shared risk arrangements, which require providers that fail to fulfill their agreed upon savings benchmark to repay the payer for a portion of the financial loss. In Category 4, payments are based upon the care or conditions of populations. In this model, which is capitated, providers are paid a fixed dollar amount to provide care to patients that might have a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under FFS or other payment method. An example of a condition for a specific population could be patients in a state or in a system with disabilities. Payment models classified as Category 4 can also involve population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined or overall population. An example of a population could be all children institutionalized in state run facilities. The bottom line here is that there are many payment and care models and one size does not fit all. A few of the very important keys are to know the needs and numbers of the population to be served and to agree upon what evidence based quality metrics will be used to make and keep that population healthy. Unlike the FFS system, which pays for services provided to patients, a VBC system pays for the services not provided to patients by keeping them healthy. The goal is to design a system to minimize care through the attainment of health outcomes.

How Do We Prepare for a Value-Based Care System?

The first step in getting ready for implementing a VBC system is to actually understand all of its tenets by studying both FFS and VBC. To help ensure readiness you must understand how each model is defined and what cost and quality outcomes they are designed to produce. It is important to recognize when VBC works and when it fails, and to also see and understand why it fails or succeeds. Preparation then begins with administrative and clinical leadership who have the willingness to shift the focus of care from volume to value and performance. Leadership needs to define their organization's vision for VBC and then develop a strategic plan and timeline that ensures healthy outcomes and financial sustainability during the implementation of a VBC model. Internal and external buy-in will also be necessary from all stakeholders involved including Boards of Directors, public health departments, internal and external staff involved in referral partnerships, state based health organizations and of course the payers.

We don't know when the transition from FFS to VBC will occur. We do have a good idea of what the VBC models in oral health might look like in different states and in different organizations. We also are aware that those who make decisions about cost and efficiency of care are committed to trying the VBC model to control costs and achieve better outcomes. Thus, we must be prepared for a value-based environment and start figuring out how to reduce costs, improve the quality of care, increase access for all people and have the ability to track and report the data needed to evaluate costs and health outcomes.

In our work to date we have been involved in several initiatives related to modeling and determining readiness for VBC in oral health, including the creation of a readiness assessment for programs, providers and payers to

help them assess their readiness to transition to a VBC system of finance and care. This work involved establishing competencies that we believe are essential to success in a VBC environment. With this tool programs have the ability to accurately assess their readiness and determine areas in need of improvement prior to the implementation of VBC. Below is a list of some of the competencies and elements included in the readiness assessment.

- Understand value-based care and spread awareness throughout the organization
- Secure buy-in from all other practice or other health center departments to contribute to the value-based care initiative (e.g., creating two-way referral systems, fluoride varnish application in medical, and the utilization of care coordinators that ensure patients receive a comprehensive set of services (medical, oral health and behavioral health))
- Health IT infrastructure that supports the care transformation initiative, including considerations for interoperability, security/privacy, and change management that supports the payment model(s) and financial risk
- Ability to generate timely and accurate reports that can be shared with all members of the care transformation team (financial data, clinical data, demographic data)
- Ability to track meaningful payment for performance (P4P) outcomes (e.g., reliable EDR/EMR, adequately trained staff, defined outcomes and processes)
- Defined process for sharing related data with administrative, medical and dental leadership, staff and other key stakeholders
- Willingness and ability to expand dental outside the walls of the dental clinic (e.g., embedding hygienists in medical; strengthening outreach; dental case management)
- Presence of a scheduling system that supports the provision of meaningful care in each visit (e.g., appointments that are not too short; warm handoffs; same day appointments)
- Effective system for minimizing broken appointments; goal of or history of a broken appointment rate in dental that is less than 20%
- Sufficient resources to maximize potential capacity of the dental clinic staff (dentists, hygienists, assistants, care coordinator) and structure (number of operatories and days and hours of operation)
- Favorable patient/payer mix (e.g., patients with Medicaid eligibility)
- Infrastructure and process for determining patient eligibility and providing assistance with the enrollment of Medicaid eligible patients who are presently not covered
- Presence of an accounting system that can track revenue and expenses specifically for dental program components or sites as individual cost centers in a timely manner
- Highly functional billing infrastructure with proven success in collecting payments for services provided
- Ability to define billing workflow for value-based care
- Ability to ensure consistency in coding for services provided across all members of the transformative care team; ability and willingness to implement Diagnostic Codes (ICD-10) at the specified time
- Documented control of dental supply and overhead costs
- A leadership team at the clinic level that understands work flow and practice nuances that can impact implementation/success of value-based care (clinical work flow redesign will be needed to support value-based care)
- Ability to incorporate caries risk assessments into medical and dental visits
- In the process of creating and/or implementing (or at least considering) well-defined and consistently applied risk-based and evidence-based clinical protocols (e.g., prevention, treatment, education and patient self-management goals)
- Demonstration of consistent and standardized documentation and accurate coding
- Process for elevating the oral health literacy of patients and success in engaging patients in self-care
- A quality management system for dental that is defined in policy format and followed in accordance with departmental policies
- A formal process for measuring patient satisfaction

- A formal process for performance improvement