# MORE CARE™ Alternative Payment Model Framework

## The MORE CARE Program

MORE Care is a program developed by CareQuest Institute for Oral Health that aims to develop and strengthen Interprofessional Oral Health Networks (IPOHN) by integrating oral health competencies and capabilities into primary care practices and building referral networks with dental providers using health information technology (HIT). MORE Care acknowledges that systems change cannot occur only through working in clinical settings, but that partnering with community, regional and state stakeholders is crucial to sustained success. State-based partners work with local primary care and dental teams to support the cultivation of referral relationships so that patients receive more coordinated care. Dental and primary care teams work together to establish open lines of communication that promote shared goals and comprehensive care for their patients.

A combination of curriculum instruction, value-based payment, and empowering local patients, providers, and community organizations, MORE Care aims to increase the number of primary care teams providing oral health services and patients receiving preventive care, and equip communities to create and sustain equitable, accessible, and integrated oral health care systems to ultimately reduce population oral disease burden.

## Purpose

The Framework below outlines the basic structure, components, and operation of the Alternative Payment Model (APM) in the MORE Care Ohio program.

## APM Design

To evaluate how integrated care pathways function, how access, prevention, and outcomes can improve, and to maintain provider engagement, the MORE Care curriculum and provider education will be accompanied by a value-based reimbursement design. The intended design is a [fee for service (FFS) + incentive alternative payment model (APM)](https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf). Participating practices will receive normal reimbursement for claims associated with covered procedures rendered to eligible patients within the program while additional allocated dollars from public and commercial payors will cover incentives tied to performance goals of program metrics reported on by practices. Incentive dollars will be rewarded to practices by a fiscal intermediary (Health Path) based on timeliness and quality of reported data ([pay-for-reporting](https://revcycleintelligence.com/news/understanding-the-top-10-terms-of-value-based-purchasing)) and performance of program metrics against set benchmarks ([pay-for-performance](https://revcycleintelligence.com/news/understanding-the-top-10-terms-of-value-based-purchasing)). The APM will serve as a testing ground for how the integrated care model can be supported by value-based payment to reward utilization of preventive, risk-based oral health care within primary care and a referral process between dental and primary care practices.

## Clinical Practice Transformation

Clinical practice transformation will happen through several synchronized pathways:

1. Medical and dental practices will gain experience in value-based payment arrangements.
2. Payors will gain experience in engaging dentistry in a value-based payment arrangement.
3. Participating medical and dental practices will be incentivized to strengthen local interprofessional oral health networks through integration and coordination of oral health within primary care.
4. The combination of practice education and the incentive aims to lower or maintain total cost of care, lower rates of invasive, surgical dental procedures while increasing rate of preventive oral health services.

## APM Rationale

Oral health care, especially preventive care, is [under accessed](https://journalofethics.ama-assn.org/article/health-equity-needs-teeth/2022-01) by many populations, including the pediatric population, for a variety of reasons. Medical and dental care typically operate and are paid for separately, leading to care that is fragmented, inaccessible, and not comprehensive. Additionally, medical providers are generally not trained to assess for signs of oral disease and provide oral health services. The traditional fee-for-service payment system tends to promote continuation of siloed care and rewards the provision of a high volume of invasive over preventive procedures that have little effect on health outcomes. [Value-based payment](https://www.aafp.org/about/policies/all/value-based-payment.html) is becoming increasingly common in medicine, including the [comprehensive primary care program (CPC)](https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care) in Ohio, but lacks inclusion of dentistry and oral health services as a component of quality, holistic care. Success with medical-dental integrated care has been [demonstrated](https://journalofethics.ama-assn.org/article/health-equity-needs-teeth/2022-01), but payment model to sustain this valuable, collaborative care lacks widespread operation. This APM builds on the [evidence](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4803682/) of incentive-based designs in medicine to improve quality of data, access to care, and health outcomes and incentivizes creation and strengthening of local interprofessional oral health networks through integration and coordination of oral health within primary care.

## Proposed Scale

The proposed scale of the APM is presented below:

**Duration:** theAPM willspana period of 25 months; the first 12 months will focus on curriculum and quality improvement, data infrastructure building and practice performance in the APM while the latter 13 months will focus on sustaining changes and improved practice performance in the APM.

**Eligible Practices**: the APM will engage five medical and five dental practices and their associated providers and care teams.

**Patient Population:** individuals age 0-18 who present for a prenatal, well child or annual adolescent assessment medical visit or a routine, diagnostic, or problem focused dental visit at the participating practices.

**Patient Volume**: estimated patient volume is between 5,000 and 10,000 combined medical and dental patients per year of the program.

**Practice Diversity**: recruited practice types will include private practices, group practices, hospitals, health systems, and federally qualified health centers, with an emphasis on dental private practice participation.

**Geographic Diversity**: recruited practice locations will operate in either the Northwestern or Southeastern/Appalachian counties. This target geography was identified by Oral Health Ohio.

**Demographic Diversity**: the variety of practice types and locations should allow for engagement with a diverse patient population in terms of insurance status/type, race, ethnicity, gender, sexual orientation, age as well as other social need demographics; patient demographic characteristics will be measured by the practices under the APM arrangement.

*Note:* The APM seeks to create incentives to enhance prevention-focused, risk-based, integrated and coordinated care to ultimately improve health outcomes for this population. Therefore, the scale of this model, while geographically diverse, is limited in its clinical and demographic diversity.

## Alignment of Stakeholders

The MORE Care APM will bring together multiple stakeholders to fund and operate the incentive necessary for practices to make fundamental changes in their care delivery. Stakeholders and their roles are outlined below:

* **Fiscal intermediary (Health Path):** the parent organization to Oral Health Ohio and experienced fiscal intermediary, Health Path will house a fund line for the incentive pool. Additionally, Health Path will have responsibility for fund disbursement to MORE Care participating practices at set intervals according to the incentive schedule.

## Quality Measurement

The APM sets forth two domains of quality measurement, pay for reporting (P4R) and pay for performance (P4P) in an effort to incentivize practices to report quality data in a timely manner and to assess practice performance of prevention-focused, risk-based, integrated and coordinated care as well as cost of care. Weights of the P4R and P4P measures will change as the program advances – less weight will be put on P4R measures as practices become proficient in data reporting while more weight will be put on P4P measures as practices gain experience with performing the appropriate oral health services. Program quality measures are presented below.

*Pay-for Reporting measures:*

|  |
| --- |
| **Incentivized metrics for *medical and dental practices*** |
| 1. Completeness of reported required data 2. Completeness of reported demographic data 3. Quality of reported data |

*Pay-for Performance measures:*

|  |  |  |
| --- | --- | --- |
| **Incentivized metrics for *medical practices*** | **Incentivized metrics for *dental practices*** | **Non incentivized metrics for *medical and dental practices*** |
| 1. Oral health risk assessment 2. Oral health self-management goals 3. Fluoride varnish application 4. Closed loop referrals to participating MORE Care dental providers | 1. Caries risk assessment 2. Surgical intervention rate 3. Primary and secondary prevention rate 4. Closed loop referrals to participating MORE Care medical providers | *Dental*   1. Annual dental visit 2. Broken appointment rate   *Medical & Dental*   1. Referrals to any medical or dental provider 2. Emergency visits |

## APM Operational Process

***Data Extraction, Performance, and Payout Processes***

Data collection from each practice and subsequent processing and scoring will be done on a monthly basis. See the monthly data cycle below:

Data collection, processing and incentive payout will operate according to a set schedule. Payouts to qualifying practices by the fiscal intermediary will take place every 4th month during the 25-month program beginning in March 2023 based on performance against set benchmarks for quality measures. Each practice will also be given a lump sum payment in month one of the program to incentivize data infrastructure building with CareQuest Institute.

***Practice Earning Potential and Budget***

In addition to normal reimbursement for claims associated with covered procedures, each participating practice has the opportunity to earn $10-15k in additional incentive dollars per year based on reporting and performance against MORE Care metrics.

Participating practices will also receive a lump sum payment of $5,000 at the onset of the program to set up the needed data infrastructure.

## Operational Feasibility

The APM is designed for medical and dental practices that are already working toward or have a desire to practice in an integrated manner. Practices must have personnel capacity to test new workflows, participate in curriculum / learning activities, and extract data in the agreed upon format. Data requirements include an existing electronic health record, the ability to create and pull a report with required data fields, and to receive and track referrals to other medical or dental providers. These requirements create an environment that will allow for successful performance in the APM.