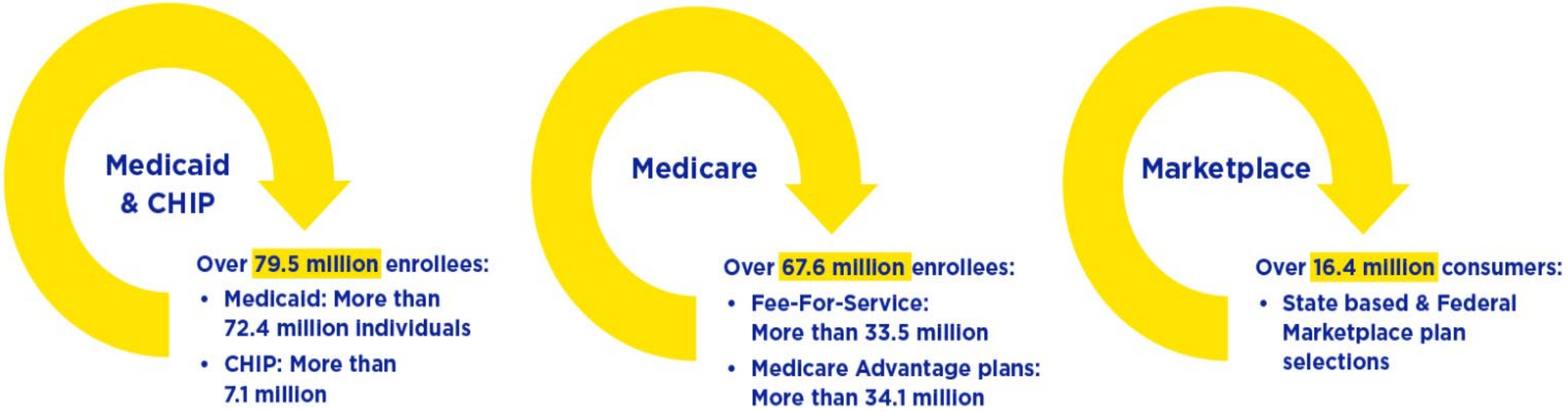
SESSION VII: Improving Oral Health Access and Affordability: Role of Public and Private Payers

Moderator: Hawazin Elani, PhD, MSc, MMSc Planning Committee Member

Speakers:

- **Scott Hinchee,** MPA, Altair ACO
- **Cherag Sarkari, DDS** Liberty Dental Plans
- **Peter Fuentes, DMD** MetLife (virtual)
- **Natalia Chalmers, DDS, MHSc, PhD** Centers for Medicare & Medicaid Services
- **Richard Berman, MBA, MPH** University of South Florida

Every day, CMS ensures that 155.5 million* people in the U.S. have health coverage that works

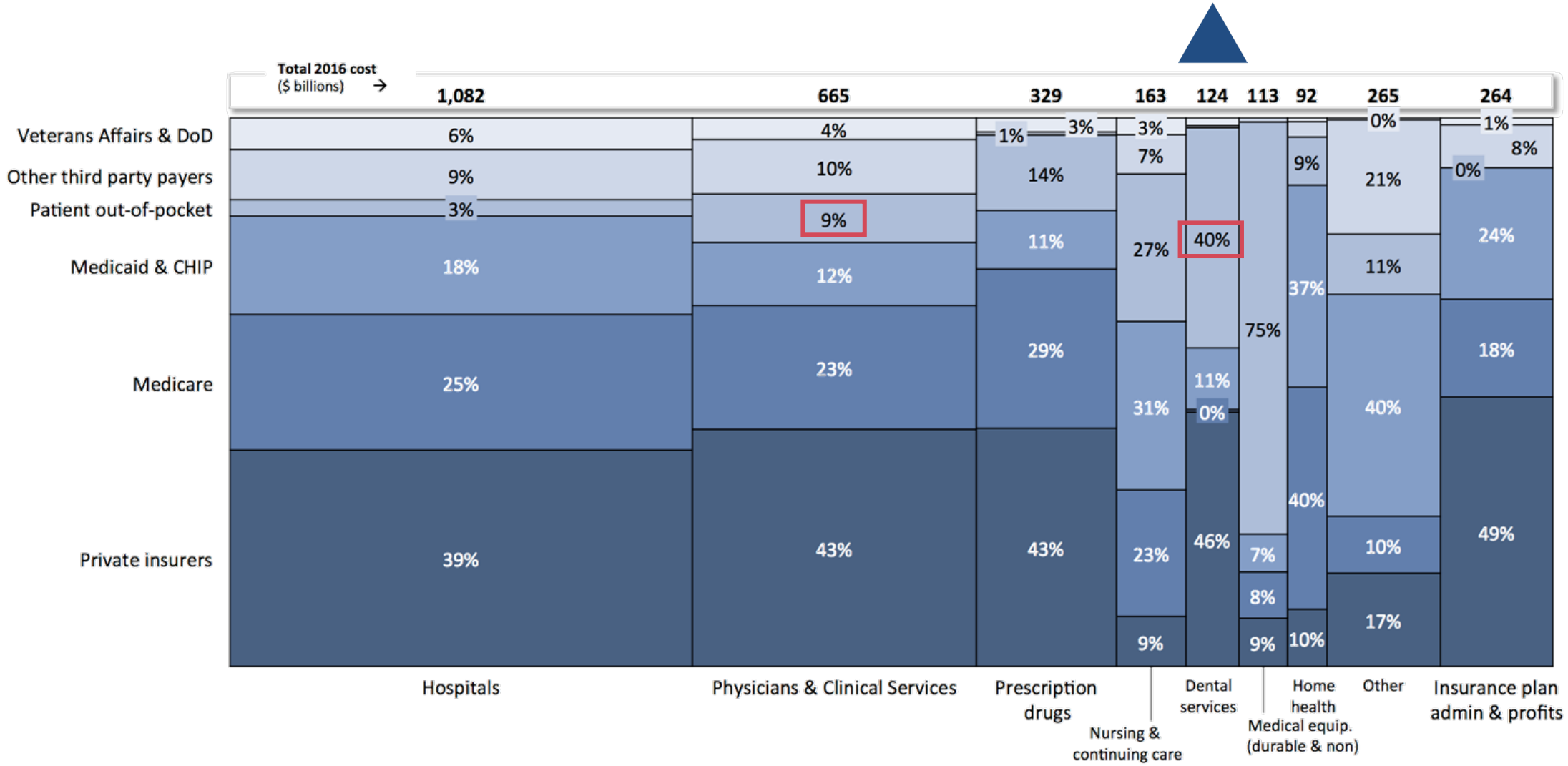


*Subtotal: 163.5 million. Adjust for full-benefit Medicare/Medicaid dual eligibles (-8 million).

Source: https://www.cms.gov/pillar/expand-access as of 10/31/2024

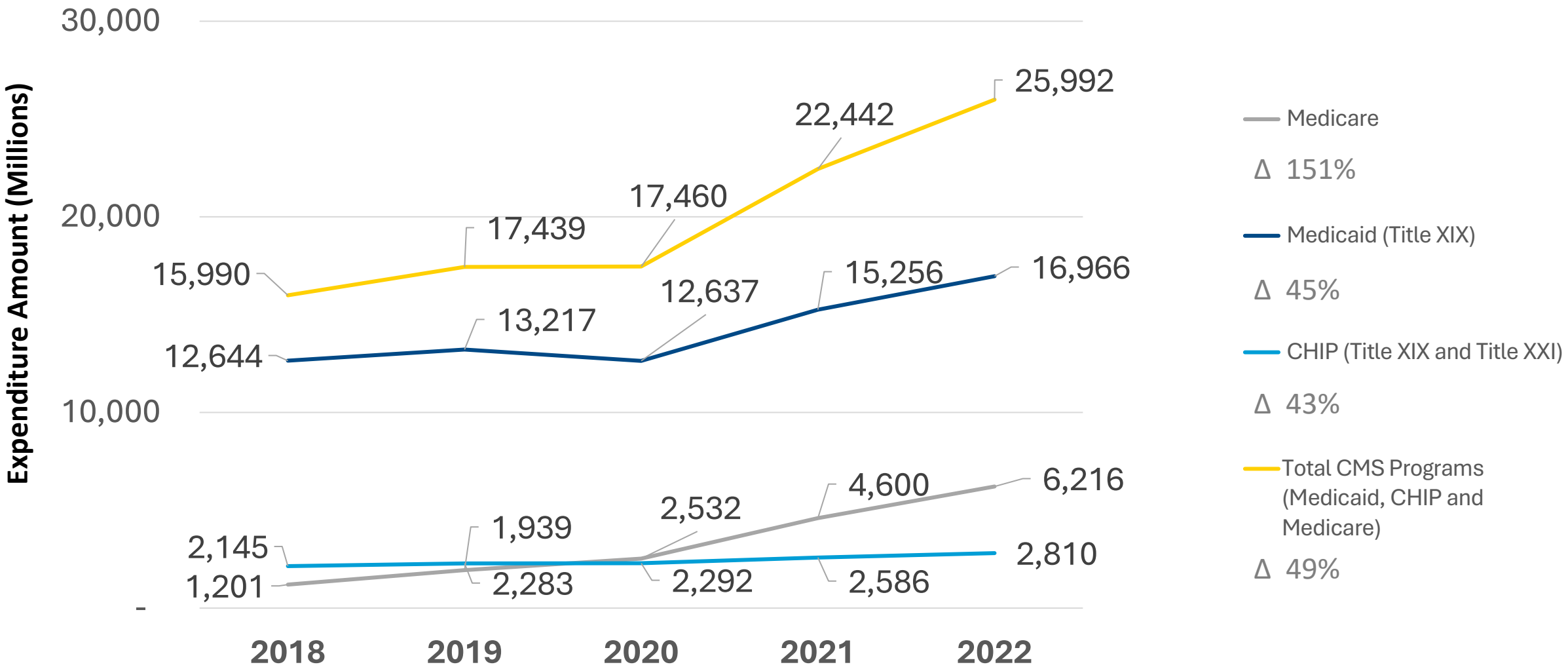
National Health Expenditure

Dental is 4% of all Health Expenditures, $124 Billion



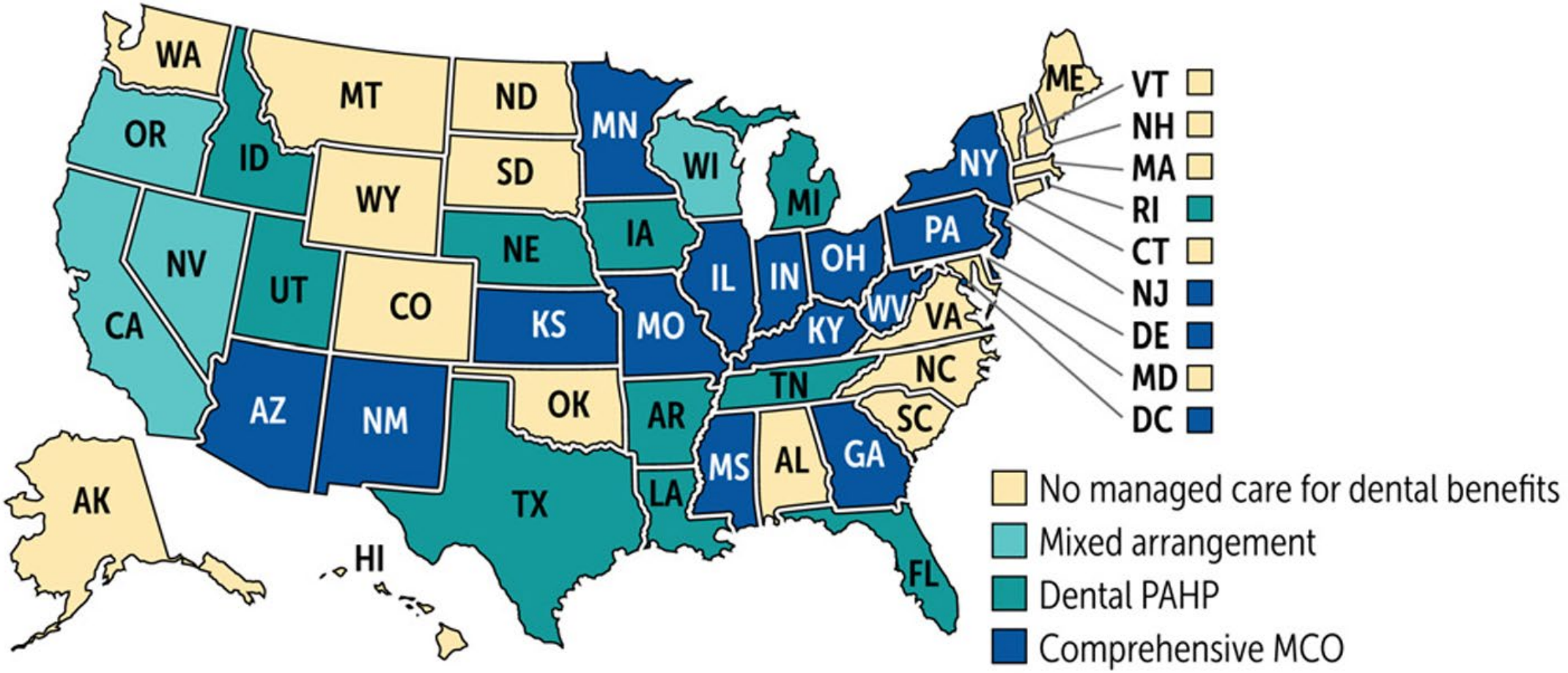
Source: National Health Expenditure, Centers for Medicare and Medicaid Services, 2016

CMS Dental Services Expenditures



Source: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

Medicaid and CHIP Managed Care Arrangements for Dental Benefits, 2021

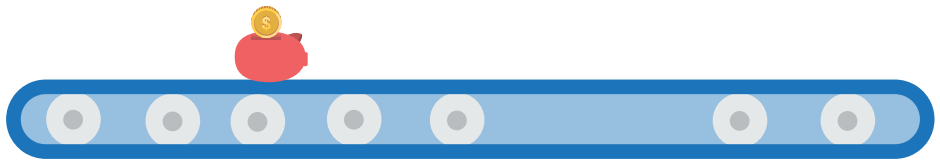


Source: https://www.medicaid.gov/media/176321

What Is the CMS Innovation Center?

- **Incubator** to develop and test new ways to improve the quality of care delivered to people with Medicare and Medicaid and reduce Federal spending.

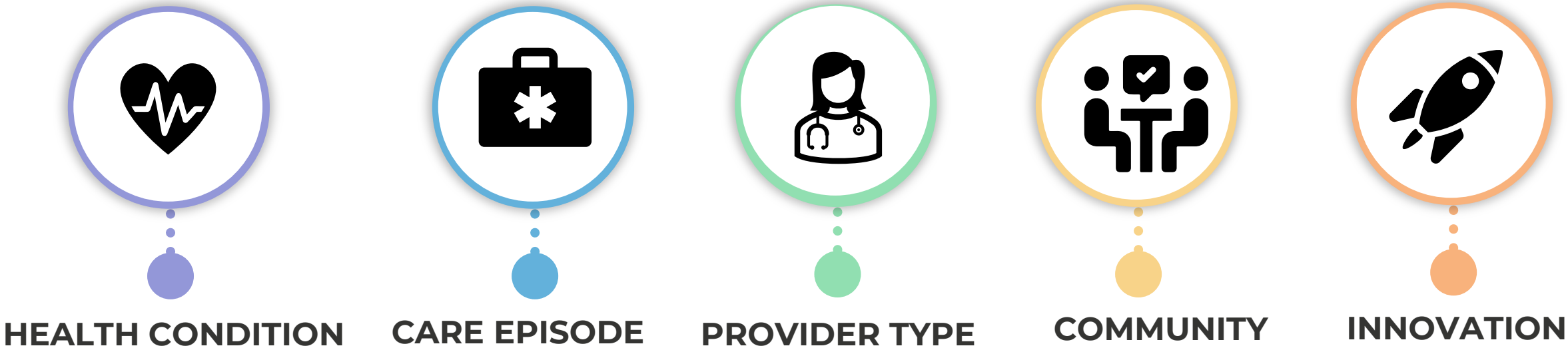
- Ensures new features deliver on expectations before broader adoption.



Innovation in Health Care Payment & Delivery

The CMS Innovation Center tests **alternative payment models (APMs)** which reward health care providers for novel approaches to delivering cost-efficient, high-quality care.

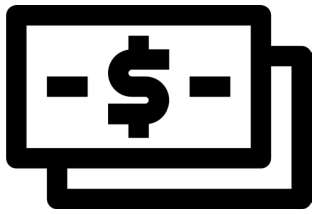
APMs may apply to any of the following:



The CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

There are three scenarios for success under Statute:



Costs are reduced, quality remains neutral

Quality improves, costs remain neutral

Quality improves, costs are reduced

What is Value Based Care?

Value-based care is a term that Medicare, doctors and other health care professionals sometimes use to describe health care that is designed to focus on quality of care, provider performance and the patient experience. The “value” in value-based care refers to **what an individual values most**.

In **value-based care**, doctors and other health care providers ***work together to manage a person’s overall health, while considering an individual’s personal health goals.***

What Value-Based Care Means

For patients:

- ***Better communication and care coordination*** with provider
- Focus on providing ***quality, patient-centered care*** to meet patient's health goals
- ***More holistic care*** to address medical and health-related social needs

For providers:

- ***Reward*** for improving quality of care and better patient outcomes
- ***Support*** to focus on patients that need more attention
- ***Collaboration*** in a care team

More Efficient Care
+
Better Health Care Experiences

Value-Based Care

CMS Innovation Center's Range of Impact

More than 41.5 million beneficiaries reached*

CMS Innovation Center models impact more than 41.5 million beneficiaries **in all 50 states**

More than 314,000 Providers participating*

More than 314,000 health care providers and provider groups[2] **across the nation** are participating in CMS Innovation Center programs

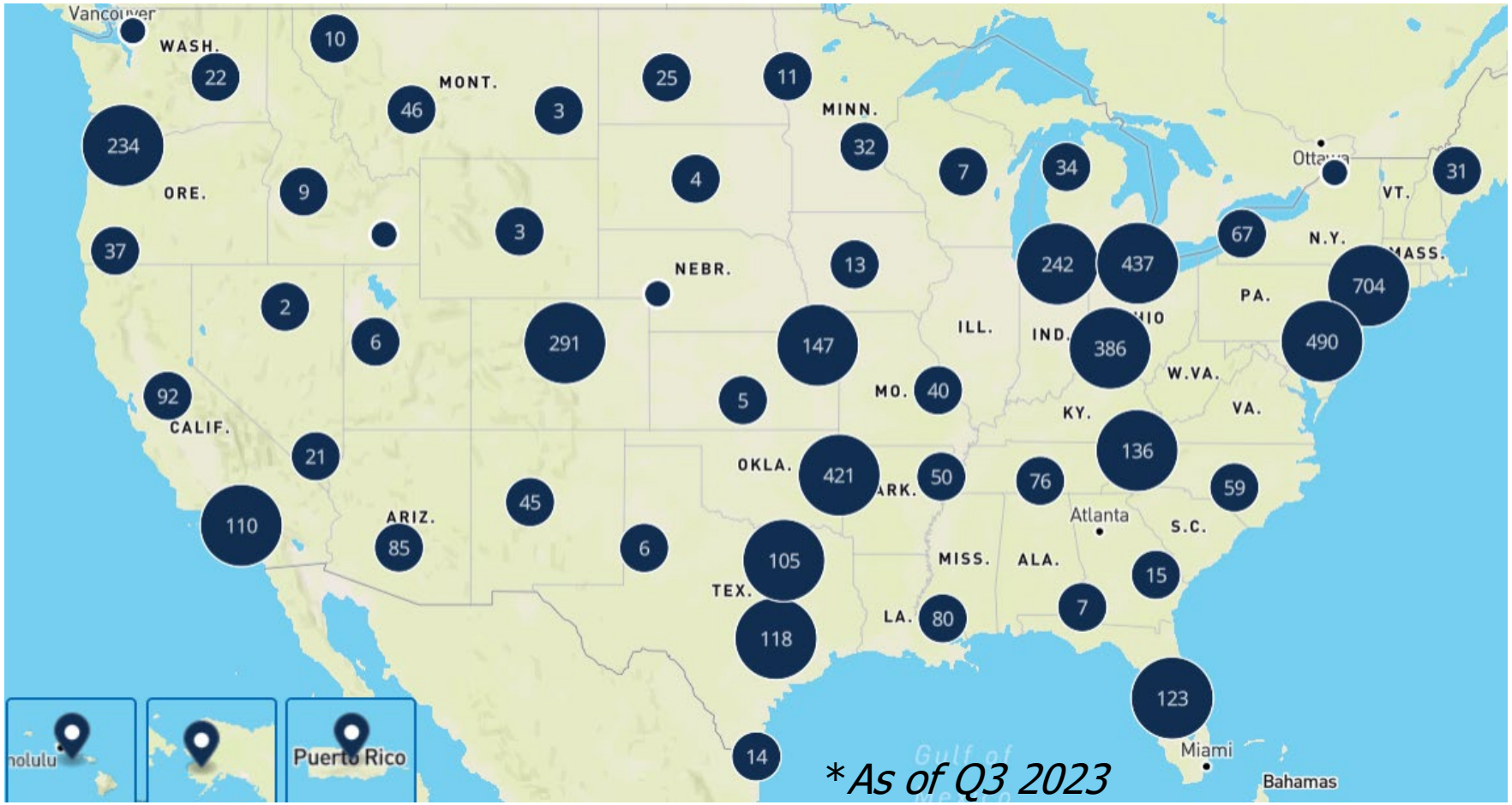
* Source: 2022 **Report to Congress: Center for Medicare and Medicaid Innovation.** Represents two years of data. Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models. The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests.

Models | The Innovation Center Model's Impact

In 2023…

- **Over 116,000 providers** participated in Innovation Center Traditional Medicare models,
- **Over 7.3 million people with Traditional Medicare** received care from providers in these models.
- **Over 1.4 million people with Medicaid** received care from a provider, plan, or organization participating in a model.

Where Innovation is Happening*

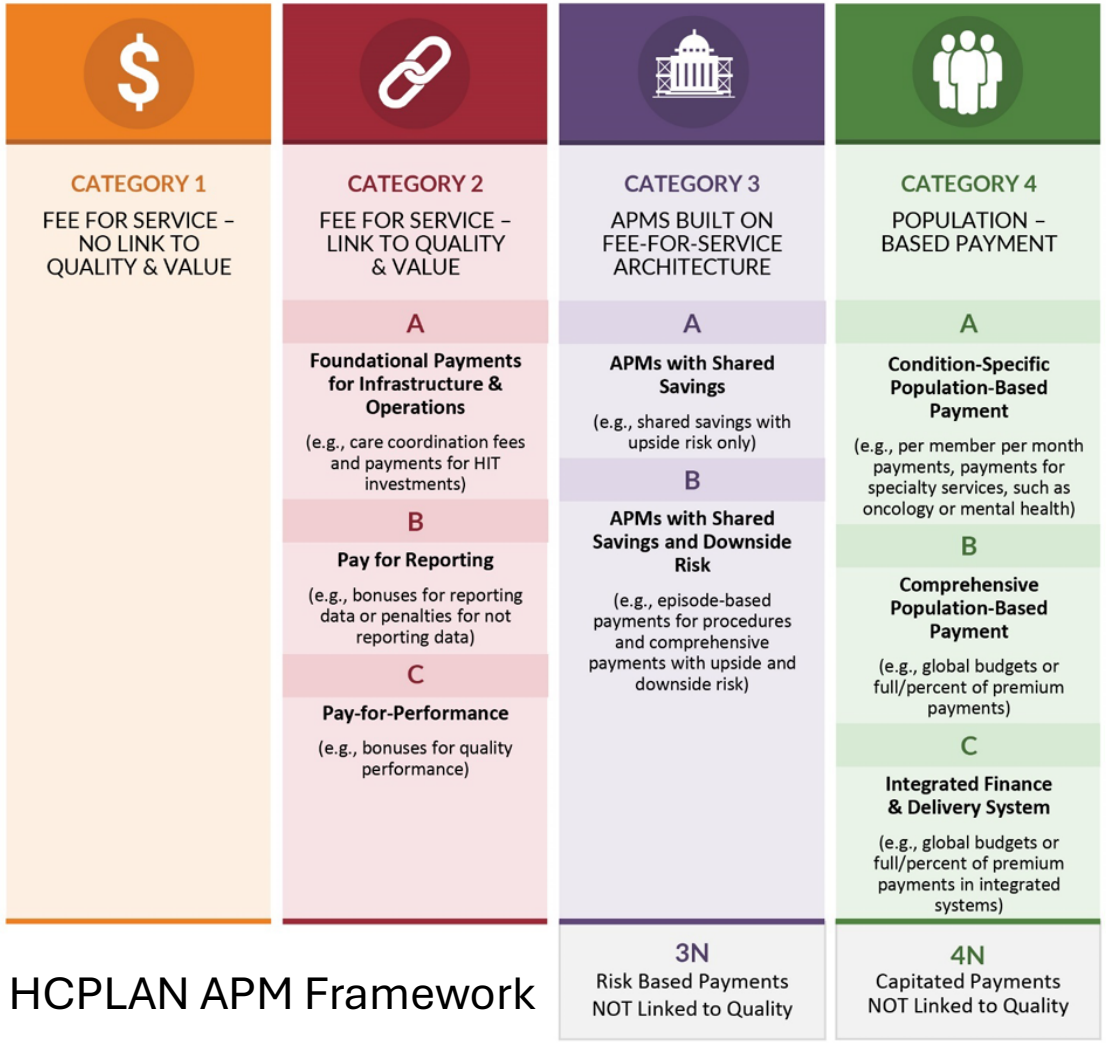


Alternative Payment Models

Health Care Payment Learning & Action Network

HCPLAN GOAL: Accelerate the percentage of U.S. health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models (Categories 3B and 4 of the HCPLAN APM Framework).

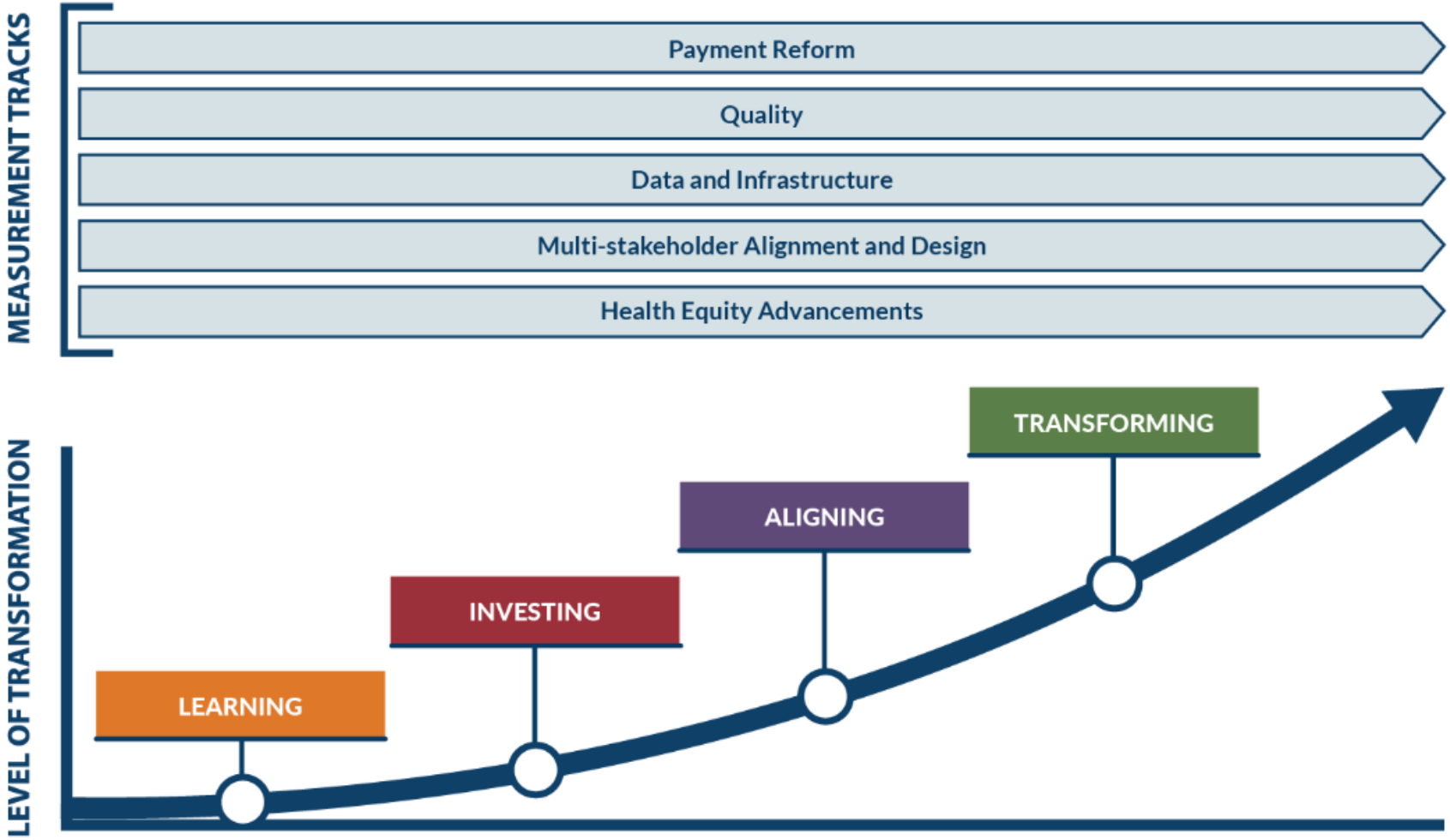
	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%



HCPLAN APM Framework

Source: Health Care Payment Learning & Action Network https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

The Accountable Care Curve



Source: Health Care Payment Learning & Action Network The Accountable Care Curve https://hcp-lan.org/accountable-care-curve

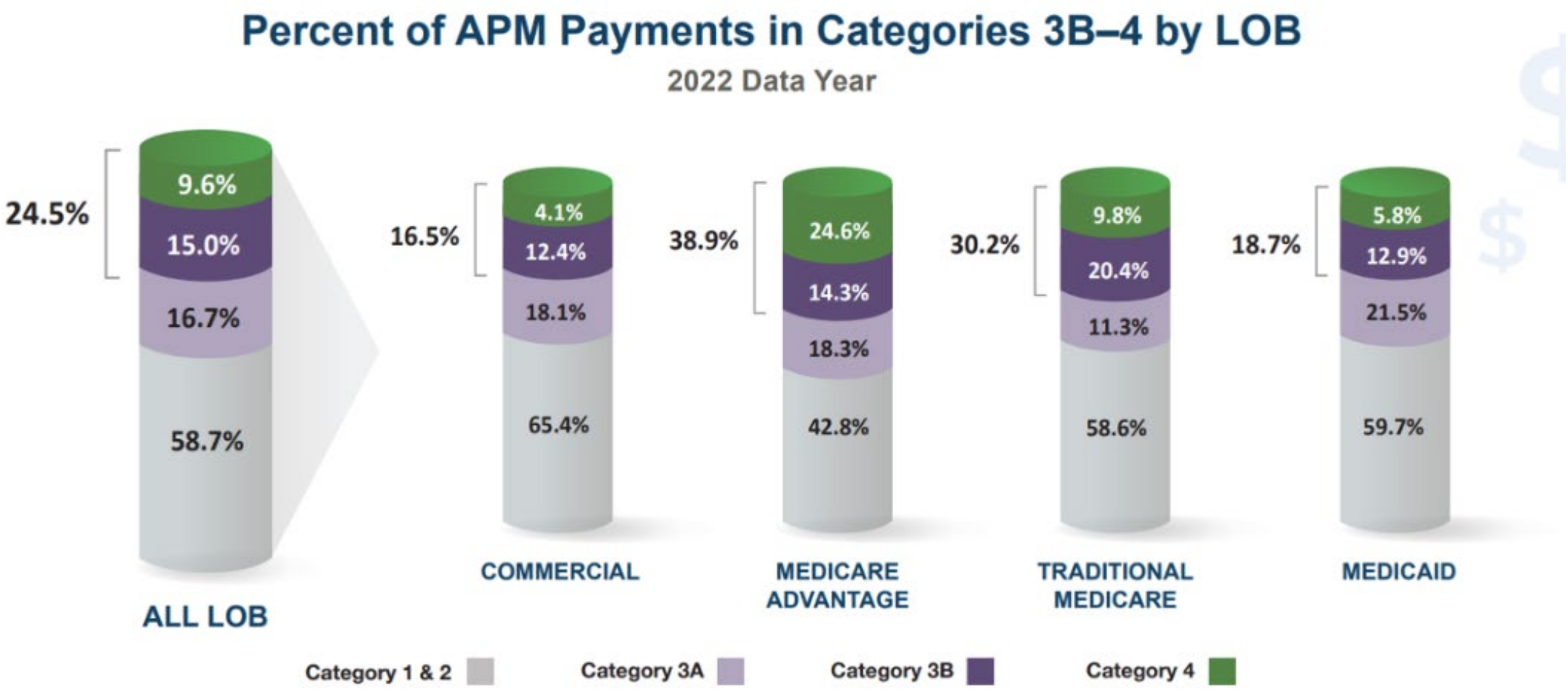
The Accountable Care Curve

Measurement Track	LEARNING	INVESTING	ALIGNING	TRANSFORMING
Payment Reform	• Engages with HCPLAN: - Signed up for the HCPLAN listserv - Attended LAN Summit or other HCPLAN event(s)	• Participates in, administers, or covers shared savings arrangements (Category 3A)	• Grows participation in downside risk arrangements that support accountable care, with links to quality, and well-coordinated specialized care (CMMI model, Category 3B). Begin to see shifts in affordability	• Uses population-based payment or shared savings options that support accountable care with downside risk arrangements (Category 3B or 4) to strengthen primary care, well-coordinated specialized care, and more affordable care for both patients and purchasers
Quality		• Establishes quality goals and supports necessary data collection to measure progress toward goals	• Uses evidence-based care and shared decision-making to achieve better outcomes and person-centered care	• Uses standardized system-wide processes to improve patient experience and drive high-quality, predictable outcomes for all
Data and Infrastructure		• Invests in improved data/infrastructure (e.g., interoperability, advanced EMRs, modernized systems, participation in APM Measurement Effort)	• Significantly invests in data sharing that enables measurable progress on payment reform, quality, affordability, and equity (e.g., participation in HIE) • Relevant members of the care team have access to data for purpose of care coordination	• Implements advanced data sharing infrastructure, activities (interoperable data collection, use, and sharing) to measure progress on payment reform, quality, affordability, and equity
Multi-stakeholder Alignment and Design		• Uses industry best practices and lessons learned to support movement toward accountable care	• Participates in multi-stakeholder efforts to advance accountable care or multi-stakeholder models/arrangements for measurable progress in system-wide regional, state, or national goals	• Initiates, sets priorities, provides the infrastructure for multi-stakeholder efforts to advance accountable care or multi-stakeholder models/arrangements for measurable progress in system-wide regional, state, or national goals
Health Equity Advancements	• Commits to improving equity (e.g., publicly announcing equity goals or commitment, commitment to HEAT guidance)	• Commits to improving equity (e.g., publicly announcing equity goals or commitment, commitment to HEAT guidance) • Develops a plan for health equity	• Significantly invests in equity (e.g., measures or targets initiatives to improve equity, industry equity accreditation or similar, implementation of HEAT recommendations) • Measures and reports outcome disparities and affordability	• Embeds accountability for improving equity in organizational mission, through governance/op model (e.g., payments to support equity) and sustained investments • Measurable reduction in disparities, increased affordability, and improved outcomes across populations

Source: Health Care Payment Learning & Action Network The Accountable Care Curve https://hcp-lan.org/accountable-care-curve

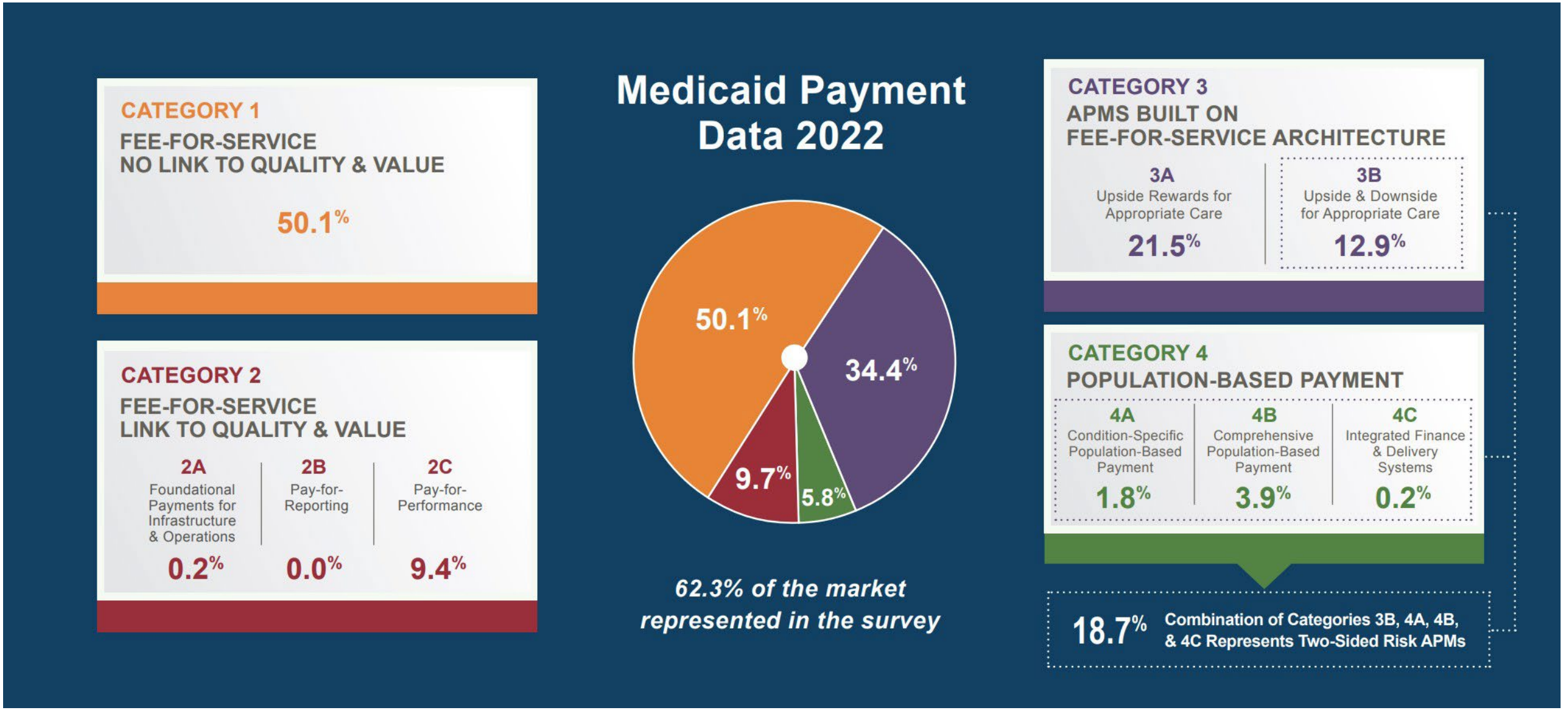
2023 Alternative Payment Models Measurement

In 2022, 24.5% of U.S. health care payments flowed through two-sided financial risk contracts (Categories 3B-4) across all Lines of Business (LOBs).



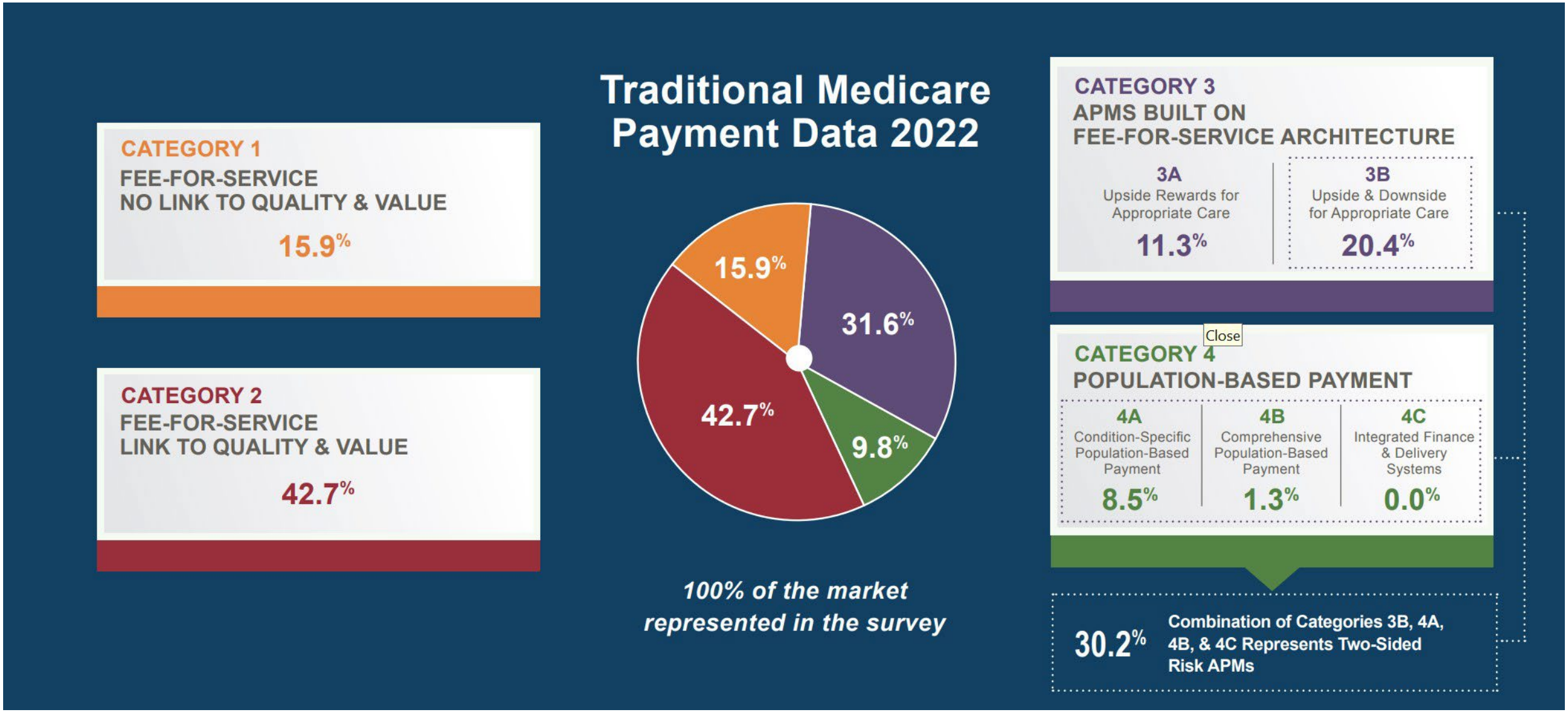
Source: Health Care Payment Learning & Action Network https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/

2023 APM Measurement: Medicaid



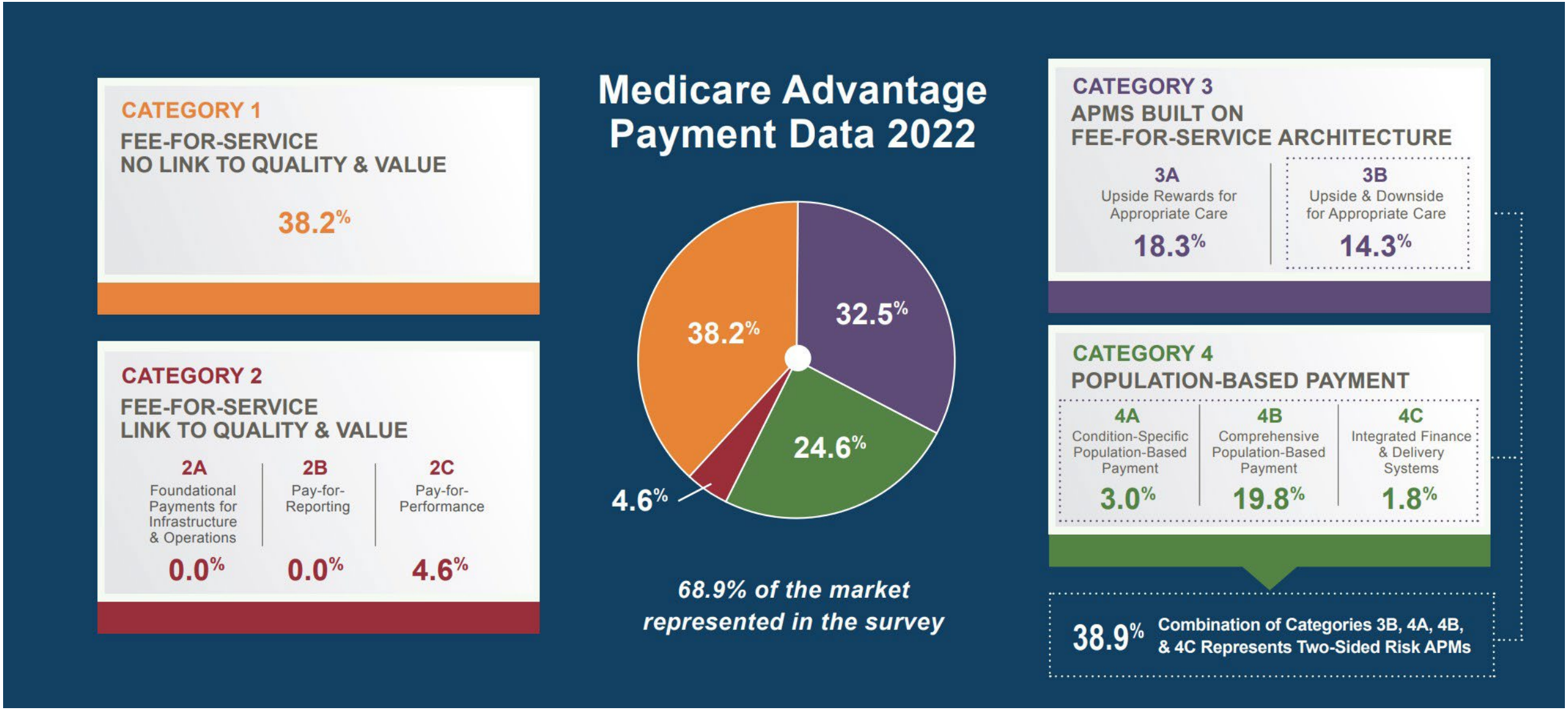
Source: Health Care Payment Learning & Action Network https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/

2023 APM Measurement: Traditional Medicare



Source: Health Care Payment Learning & Action Network https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/

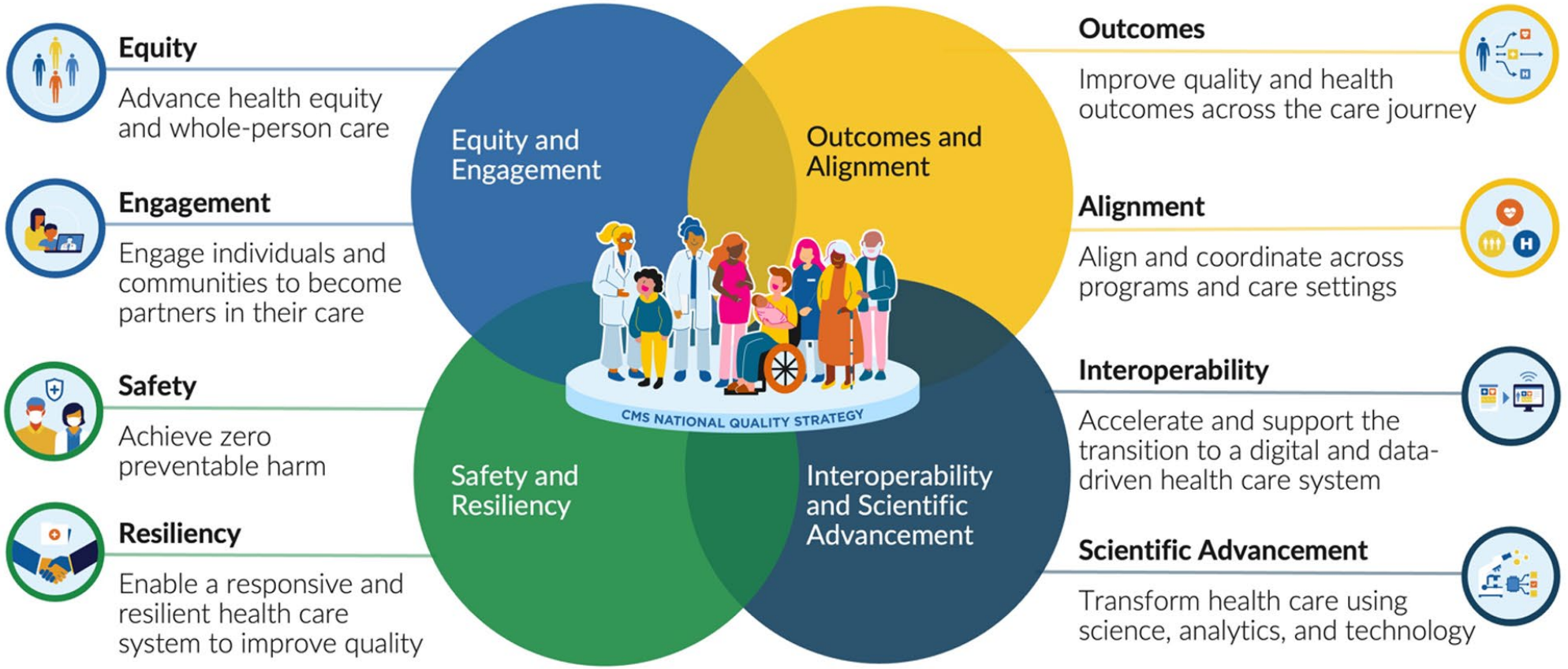
2023 APM Measurement: Medicare Advantage



Source: Health Care Payment Learning & Action Network https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/

CMS National Quality Strategy

Mission: To achieve optimal health and well-being for all individuals.
Vision: CMS, a trusted partner, is shaping a resilient, high-value American healthcare system that delivers high-quality, safe, and equitable care for all.



Source: National Quality Strategy https://www.cms.gov/files/document/cms-national-quality-strategy-fact-sheet.pdf

The “Universal Foundation” of Quality Measures

Selection Criteria for the Universal Foundation:

- The measure is of a high national impact
- The measure can be benchmarked nationally and globally
- The measure is applicable to multiple populations and settings
- The measure is appropriate for stratification to identify disparity gaps
- The measure has scientific acceptability
- The measure is feasible and computable (or capable of becoming digital)
- The measure has no unintended consequences

Source: Universal Foundation https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation

The “Universal Foundation” of Quality Measures

Adult Universal Foundation Measures

Domain	Measure Identification Number and Name
Wellness and prevention	139: Colorectal cancer screening 93: Breast cancer screening 26: Adult immunization status
Chronic conditions	167: Controlling high blood pressure 204: Hemoglobin A1c poor control (>9%)
Behavioral health	672: Screening for depression and follow-up plan 394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)
Equity	Identification number undetermined: Screening for social drivers of health

Pediatric Universal Foundation Measures

Domain	Measure Identification Number and Name
Wellness and prevention	761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits) 124 and 363: Immunization (childhood immunization status; immunizations for adolescents) 760: Weight assessment and counseling for nutrition and physical activity for children and adolescents 897: Oral evaluation, dental services
Chronic conditions	80: Asthma medication ratio (reflects appropriate medication management of asthma)
Behavioral health	672: Screening for depression and follow-up plan 268: Follow-up after hospitalization for mental illness 264: Follow-up after emergency department visit for substance use 743: Use of first-line psychosocial care for children and adolescents on antipsychotics 271: Follow-up care for children prescribed attention deficit-hyperactivity disorder medicine
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)

Source: Universal Foundation https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation

2025 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

- DQA (ADA) **Oral Evaluation, Dental Services** (OEV-CH) Administrative
- DQA (ADA) **Topical Fluoride for Children** (TFL-CH) Administrative
- DQA (ADA) **Sealant Receipt on Permanent First Molars** (SFM-CH) Administrative

Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-child-core-set.pdf

2025 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance

- **New dental measures will be added for voluntary reporting in 2025. CMS expects to add these measures to the Core Sets for mandatory reporting in 2026.**
- DQA (ADA) **Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults** (EDV-AD). Administrative
- DQA (ADA) **Oral Evaluation During Pregnancy: Ages 21 to 44** (OEVP-AD). Administrative
- DQA (ADA) **Oral Evaluation During Pregnancy: Ages 15-20** (OEVP-CH). Administrative

Source: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24001.pdf