

Research Brief

Accountable Care Organizations Present Key Opportunities for the Dental Profession

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Key Messages

- Dental care is not generally included as a core component within today's Accountable Care Organizations (ACOs). Where dental services are incorporated, it is mainly only at the level of facilitated referral or co-location.
- One key reason is that existing ACOs focus on Medicare populations and Medicare does not include dental benefits. There is also a perception that most dental providers and plans are accustomed to providing care according to frequency limits defined by dental insurance policies rather than a patient's dental risk profile.
- ACOs could help bridge the gap between oral and general health care, improve
 coordination of care, and help reduce overall health care costs. They also provide an
 opportunity to re-examine the role of oral care providers within the health care team.
 Since dental care for children is an essential health benefit under the Affordable Care
 Act, the most immediate opportunities are with the pediatric population.

Introduction

The health care system in the U.S. is on the verge of major reform. The Affordable Care Act (ACA) aims to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce, or at least control, the cost of care¹. A key aspect of the reforms is a sea change in how health care is delivered and financed. Today's system of loosely affiliated health care providers each paid primarily fee-for-service (FFS) is expected to give way to a much more coordinated delivery model that rewards providers for improvements in health outcomes and efficiency.

Accountable Care Organizations (ACOs) are designed to align provider incentives with provision of quality, coordinated care rather than volume of services, and to improve the infrastructure underlying care delivery. In the ACA, ACOs are highlighted as a key means to



improve the quality of care, while reducing cost, particularly for the Medicare population^{2 3}. An ACO consists of physicians, physician groups, hospitals, and other providers partnering in various financial and governance arrangements as allowed by the Secretary of the Department of Health and Human Services⁴. Each ACO is assumed to consist of at least primary care clinicians, specialists, and one or more hospitals. The two essential features of ACOs are (1) designated accountable provider entities which share responsibility for treating a group of patients, and (2) performance measurement and new reimbursement mechanisms. New payment approaches could include supplementing each provider's fee-for-service reimbursement based on the performance of the ACO as a whole, or moving toward global budgets or capitation⁵. For these and other reasons, ACOs are very different than the managed care initiative of the 1990s⁶.

Dental expenditure is financed primarily through out-of-pocket spending and stand-alone dental benefit plans⁷. Dentists provide care primarily in small, independent, provider-owned practices. This is changing, however, with the recent robust growth of large group practices⁸. At the same time, there is growing evidence of the link between oral health and general health⁹ as well as the impact of oral health on economic outcomes¹⁰.

A critical policy issue is how the dental care delivery and financing system could potentially change with the growth and expansion of ACOs. In this research brief, we hope to take a first step in answering this question. Specifically, we have three objectives. First, we review a useful framework for explaining the various ways dental care delivery and financing can be managed within an ACO. Second, we examine the way dental care is currently being handled within a sample of ACOs. Third, we summarize key informant views on the possible future direction for dental care within ACOs.

Data & Methods

We summarized key findings from a larger study of the ACA that the American Dental Association commissioned from Milliman, Inc., a consulting firm. Part of the study examined dental care delivery and financing within four types of ACOs.

Shared Savings Program (SSP) ACOs are designed to improve care coordination and quality while reducing cost for the Medicare fee-for-service (FFS) population. They must accept responsibility for 5,000 or more Medicare beneficiaries for a minimum of 3 years and must utilize evidence-based medicine, collect and report on quality measures and performance, invest in its workforce as needed to ensure coordinated care, and actively engage its beneficiary population in the care process. As of April 2012, 27 organizations had been selected to participate in the SSP, spanning 18 states and serving roughly 375,000 Medicare beneficiaries. Clinicians in SSP ACOs are paid on a fee-for-service basis but each ACO is eligible to receive a portion of any savings generated by the ACO relative to a benchmark cost level for their population, as calculated by the Center for Medicaid and Medicare Services (CMS). There are two SSP models from which an organization can choose. The first allows the ACO to share only in savings, but not in risk, for the first two years; in the third year the ACO would share in any savings or losses versus the benchmark cost level. The second model requires the ACO to share savings as well as losses from the first year onward, in exchange for a higher share of any savings generated.

Pioneer Program ACOs involve a more aggressive risk-sharing alternative to the SSP for mature ACOs with existing care coordination infrastructure. Thirty-two organizations are participating in this program. Qualifying ACOs must serve a minimum of 15,000 Medicare beneficiaries (5,000 for rural areas). For the first two years of the program, ACOs participate in a



shared savings and risk program similar to the SSP but with higher levels of risk and reward. In the third year, those with savings during the initial period will convert to a population-based model, in which providers are paid a per-beneficiary per-month amount to replace some or all of the ACO's FFS payments. Further, Pioneer ACOs must move toward similar risk-based contracting arrangements with other payers such that by the end of the second performance year, over 50% of their revenues come from risk-based contracts. By participating in the Pioneer program, these ACOs are showing a true commitment to the accountable coordinated care model and to risk-based contracting.

Patient Centered Medical Home (PCMH) is a practice model guided by a primary care clinician in which a team of health care providers delivers coordinated care to patients, with a focus on evidence-based medicine, enhanced patient involvement and communication, quality, and information technology. The National Committee for Quality Assurance (NCQA) designed accreditation standards for practices to be certified as a PCMH; to be recognized by NCQA, medical homes must meet specific criteria in six categories: enhancing access and continuity, using data to identify and manage patient populations, planning and managing care using evidence based guidelines, tracking and coordinating care, and measuring and improving performance. As of 2011, NCQA had certified over 1500 PCMHs. Unlike ACOs, PCMHs need not move toward bearing financial risk for their patient population. However, PCMHs can become part of ACOs or develop into ACOs; over time we may see that PCMHs provide coordination within an ACO framework with ACO incentives.

The Milliman, Inc. team conducted a comprehensive literature and website review for all of the Pioneer ACOs and SSP ACOs established as of July 2012. Select publicly available literature on other ACOs and PCMHs was reviewed. The consulting team also held

interviews with six key informants. These were Milliman, Inc. senior consultants who had worked with several ACOs, ACO payer groups, ACO collaboratives and one Milliman, Inc. client involved with multiple ACOs.

Results

There are several means by which dental providers might be incorporated into ACOs¹¹. These are summarized in Table 1.

Out of the thirty-two Pioneer ACOs, only two mention dental services or plans on their website. The Atrius Health Pioneer ACO in Massachusetts offers a full range of pediatric and adult dental care services including general dentistry as well as orthodontics, periodontics, and endodontics. The North Texas ACO in Texas indicates that it participates with dental insurers, but it does not appear that dental services are available through the ACO. The other thirty do not mention dental care at all.

Out of the twenty-seven SSP ACOs, none mention dental services on any of the organizations' sites. An additional search of 89 SSP ACOs announced in July 2012 found that only a few mentioned dental care. For example, Mount Sinai Care in New York has a dental department whose providers service the full range of dental procedures for children and adults. Mount Sinai is unique in that it has a department of dentistry within its general hospital setting, one of the first institutions in the country to integrate dental providers in this manner. Another newly-announced ACO, University Hospitals Coordinated Care in Ohio, has a pediatric dental center in its children's hospital.

In Oregon, Coordinated Care Organizations (CCOs) have a global Medicaid budget with capitated and non-capitated components, and are responsible for allocating the budget as they see fit. CCOs must coordinate physical, mental, behavioral, and dental

Research Brief



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health care for people eligible for Medicaid or dually eligible for Medicare and Medicaid¹². CCOs will be responsible for the health outcomes of the population and will be required to publicly report on quality metrics, including dental metrics. CCOs are specifically required to have a formal contractual relationship with dental care organization that serve members. Dental care services are capitated under the current Medicaid managed care program and are part of a CCO's global budget¹³.

Even with Oregon's CCO initiative, dental care organizations are concerned that they may not have as much of an opportunity to influence medical-dental integration as they would like. Dental care organizations are not required to become a part of the CCOs until 2014 and can simply contract with a CCO to provide dental services in the meantime. Some dental provider groups fear that becoming part of the CCO later in the process will reduce their ability to impact the planning process to ensure that dental is a core part of the value proposition. In addition, newlyforming coordinated care organization governance boards are not required to include dental providers, and dental groups who have attempted to join these boards have had mixed results.¹⁴

ACOs in Minnesota and New Jersey are also among the most advanced when it comes to integrating dental care into the core basket of services. Hennepin Health in Hennepin County, MN is an ACO that focuses on childless adult high health care users. Payment methods include shared risk and incentives based on performance and outcomes. It will be responsible for providing comprehensive care, including dental care, mental health and substance abuse services, and public health and human services. A Medicaid ACO demonstration program in New Jersey is intended to

increase access to primary care, behavioral health care, and dental care¹⁵.

Several PCMHs include dental care as part of their services. Organizations serving a population for which dental services are part of the benefit package, such as Medicaid, are more likely to include dental. PCMHs created by non-profit community health centers, seem more likely to include dental services. This is likely due to the Medicaid-heavy population served by these health centers, as well as the mission of these organizations to improve overall access and outcomes for underserved community members regardless of ability to pay. Co-locating dental and medical providers can help these patients obtain care more easily. For example, the Community Health and Dental Care PCMH in Pennsylvania includes both medical and dental providers in a co-located setting, providing a full range of dental services to both children and adults. This clinic was founded with the mission of ensuring access for all, regardless of ability to pay, and its formation was funded by a local foundation and local businesses. The clinic works with most insurance companies and charges uninsured patients on a sliding scale. At International Community Health Services, a certified PCMH in Seattle, patients can receive care from medical as well as dental providers including dentists and dental assistants. This non-profit community health center was founded to better serve needy Asian, Native Hawaiian, and Pacific Islander communities in a culturally and linguistically appropriate manner, as well as other underserved communities in the Seattle area. A broad health team including pharmacy staff, interpreters, referral coordinators, and others coordinate to address all of a patient's health care needs. The center's two sites each house co-located medical and dental professionals¹⁶.

Table 1: Methods of Integrating Dental Care into ACOs

Facilitated referral	Enabling referrals, referral tracking, and follow-ups between medical and dental providers will help to ensure optimal care by both providers.
Co-location	By simply working out of the same location, medical and dental providers may find it easier to refer patients, to communicate with other providers, and to obtain multiple services during one visit.
Virtual integration	Using electronic medical record technology to allow medical and dental providers to access and edit a single set of records for a given patient will help to avoid duplication of services while giving each provider a full understanding of a patient's history.
Shared financing	In this arrangement, medical and dental providers would share in the financial risk and opportunity associated with providing coordinated care. This would include reimbursing primary care providers for applying fluoride varnish to children's teeth, as part of a process of engaging patients in better dental care and referring patients. It could also include more direct arrangements such as including dental services into a global capitation arrangement.
Full integration	In this arrangement, medical and dental providers would share in the financial risk and opportunity associated with providing coordinated care. This would include reimbursing primary care providers for applying fluoride varnish to children's teeth, as part of a process of engaging patients in better dental care and referring patients. It could also include more direct arrangements such as including dental services into a global capitation arrangement.

Source: Adapted from "Patient Centered Medical-Dental Home Initiatives: A Survey of Current and Future Strategies to Coordinate Care in Rhode Island." Oral Health Commission Safety Net Workgroup. September 2011.

Discussion

Dental care is not generally included as a core component within today's ACOs. Where dental services are incorporated, it is mainly only at the level of facilitated referral or co-location. There are rare examples, such as CCOs in Oregon, where integration is much more extensive.

Key informant interviews suggest the low level of integration of dental care within ACOs is due to several factors. Existing ACOs tend to be focused on Medicare-covered populations and Medicare does not have significant coverage for dental services¹⁷. ACOs

are focused on integrating their core medical services, particularly high-cost, high-risk procedures that have potential cost savings. Dental care is usually not viewed as a core service. There may be a perception that dental providers are outside the mainstream of medicine and that they have no need for health plan or ACO arrangements to stay financially stable. Dental providers and dental benefit plans today do not mesh with an ACO's evidence-based care approach. Most dental providers and plans are accustomed to providing care according to frequency limits defined by

Research Brief



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dental insurance policies rather than a patient's dental risk profile.

Looking forward, as ACOs mature it is uncertain how rapidly dental care will be integrated, if at all. Several factors are likely to affect this. Pediatric dental care is part of the essential benefits package, but not adult dental care. As a result, ACOs could focus their attention on the essential health benefits that must be provided (and therefore, must be reimbursed). Adult dental care would not fall into this category. However, for states where Medicaid provides dental benefits to adults, there may be interest in integrating dental providers into the ACO structure to better serve the Medicaid and particularly the Medicare-Medicaid dualeligible population. The analysis confirms that indeed, where dental care is included, it is within ACOs that serve these populations. Medicaid-focused ACOs may be interested in integrating dental providers into the ACO structure for children and adults, where adult dental benefits are provided by Medicaid.

More broadly, as the ACA moves into the implementation phase in 2014, there will be

opportunities for policy makers to re-examine the role of dental care within the broader health care delivery system. Although adult dental benefits are not considered essential within the ACA, routine dental care has benefits to both lifetime dental care costs and overall health care costs¹⁸. On the operational side, it could be more cost-effective for providers to pool services to get the best patient outcomes. ACOs could help bridge the gap between oral and general health care, improve coordination of care, and help reduce overall health care costs. They also provide an opportunity to expand the role of the dentist within the health care team. For example, some studies have examined the feasibility of screening for noncommunicable diseases in dental offices 19 20 21 22 23. Overall, ACOs present a clear opportunity to help millions of Americans better enjoy the benefits of improved oral health.

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