Three States' Efforts to Use Accountable Care to Improve Oral Health Services in Medicaid

By Neva Kaye

Recognizing that improving oral health significantly affects overall health, Medicaid agencies in Colorado, Maine, and Oregon have begun to leverage their primary care-based accountable care programs to improve the delivery of oral health care to adults and children.

For almost a decade, state Medicaid agencies and the federal government have worked to reform the health care system to produce better quality health care at a lower cost by implementing accountable care programs. States recognize that Medicaid enrollees often have difficulty accessing oral health services, even in states whose Medicaid programs cover dental services for adults. There has also been a growing consensus that integration of primary care and oral health services would help improve oral health.

What's an accountable care program?

In an accountable care program, groups of providers (called accountable care organizations or ACOs) share responsibility for the quality of care, health outcomes, and cost for a defined population. These programs emphasize primary care, care coordination and integration, and value-based payment. Payment to an ACO and its affiliated providers depends, at least partially, on the ACO's performance on defined metrics.

The Medicaid programs in Colorado, Maine, and Oregon cover dental services provided to both adults and children. Although results are not yet available in Maine, Colorado and Oregon's accountable care programs have generated promising results.

- Oregon's program produced increases in the number of children receiving dental sealants on permanent molars and the number who received an oral health assessment upon entering foster care.
- Colorado's program produced an increase in the percent of Medicaid members who had at least one dental visit.
- The accountable care programs in Colorado, Oregon, and Maine have also all produced savings. It is, however, not known how much of the savings was due to including dental services in the model.

Policymakers seeking to improve the delivery of oral health services will benefit from an understanding of these states approaches and outcomes. In addition, as states face significant COVID-19 pandemic-related revenue declines, most will need to find ways to contain costs. As an optional Medicaid benefit, adult dental services could be targeted for cost cutting. As

policymakers face difficult choices, the experience of these three states can inform those deliberations.

Each of these states established policies that address oral health in the areas of ACO payment and performance. Beyond this shared, high-level approach, the states have little in common. There is a some overlap in the measures the states chose to assess ACO performance. Both Colorado and Oregon assess ACO performance by measuring the percent of enrollees receiving preventive dental visits and factor that metric into ACO payments. Also, both Maine and Oregon assess ACOs' performance in their rate of topical fluoride applications, but only Maine chose to factor that performance into its ACO payment. The following explains the policies developed by each state.

Colorado's Regional Accountable Entities

Colorado:
- Considers oral health in three performance areas;
- Factors performance on one oral health measure into ACO payment; and
- Increased the percent of Medicaid enrollees with at least one dental visits.

In Colorado, most Medicaid services are delivered to program enrollees through seven regional accountable entities (RAEs). RAEs support a local network of primary care medical providers (PCMPs) that deliver behavioral health services, coordinate members' care across systems, and are accountable for the cost and quality of care delivered to Medicaid members. RAEs are paid through a combination of per member per month (PMPM) payments, capitation (for behavioral health services), and incentive payments. PCMPs receive fee-for-service payments from the Medicaid agency and administrative and incentive payments from the RAEs.) The total administrative PMPM available to the RAEs is $15.50. RAEs receive $11.50 of the administrative PMPM as a monthly payment and Colorado Medicaid withholds the remaining $4 to fund Key Performance Indicator (KPI) payments. There are seven KPI metrics, including one oral health measure. The Medicaid agency assigns each KPI a specific PMPM amount and, if a RAE produces sufficient improvement in the measure, it receives a payment based on the PMPM amount assigned to the measure. KPI payments are calculated and distributed each quarter. Unearned incentive payments are used to fund a challenge pool that is also distributed to the RAEs based on performance.

Although dental health services in Colorado are delivered under a separate contract and not through the RAEs, Colorado's RAE contract requires RAEs to consider oral health services in several areas of operation. Examples include:

- **Care coordination**: RAEs must establish a relationship and communications with the Medicaid agency's dental contractor to foster the RAEs' members' access to oral health services.
- **ACO payment**: One of the seven KPI measures is an oral health measure called "dental visit," which is defined as the "percent of members who received professional dental services." This measure is worth up to $0.571 PMPM.

- **Provider payment**: Each RAE is required to share incentive payments with providers that are in its "health neighborhood," which consists of the providers (including dentists) and facilities that work with an enrollee's PCMP to meet all of the person's health needs.

During the RAEs' first year of operation, they increased the percent of Medicaid enrollees who had at least one dental visit from 33.83 percent during the baseline period (from July 1, 2017 to June 30, 2018) to 37.63 percent for the 12-month period from July 1, 2018 to June 30, 2019.

Oregon's Coordinated Care Organizations

In Oregon, almost all Medicaid services are delivered through regional coordinated care organizations (CCOs). Oregon's CCOs are community-governed organizations that bring together physical, behavioral, and oral health providers to deliver coordinated physical, behavioral, and oral health care for their members. CCOs are funded through a global budget. CCOs also earn retroactive quality pool payments based on their performance on selected "incentive metrics" during the contract year. In 2018, the quality pool was $188 million, which represented 4.25 percent of the total amount all CCOs were paid in 2018. The slate of quality measures, which are selected by the Metrics and Scoring Committee, changes each year. In 2019, there were 19 incentive measures and in 2020 there are 13. CCOs must pay for all Medicaid-covered services (including dental services) provided to CCO members. CCOs may also use their funding to test new models of care and to provide services in addition to those covered by Medicaid. Finally, Oregon encourages CCOs to distribute quality pool payments to network providers, including oral health providers. Oregon's CCO contract requires CCOs to consider oral health services in several areas of operation. Examples include:

Oregon:
- Considers oral health in six performance areas;
- Factors performance on four oral health measures into its ACO payments;
- Increased the percent of children receiving dental sealants; and
- Increased the percent of children entering foster care system who received an oral health assessment.

- **Network and covered services:** CCOs must contract with sufficient dental providers to deliver oral health services to their Medicaid enrollees, including those who may have difficulty accessing dental care, such as children in foster care or adults in nursing facilities.
- **Care coordination**: CCOs must coordinate physical and dental providers to ensure that enrollees who need to receive dental care in an outpatient hospital or ambulatory surgical center can do so.
- **Quality**: Each CCO must develop a transformation and quality strategy (TQS) that addresses oral health integration as one strategy for improving quality. CCOs must regularly report progress on implementing the TQS.

- **Population health:** Each CCO must develop a community health improvement plan that addresses oral health needs, among others. CCOs may also invest in health-related services, which are cost-effective, evidence-based non-covered services or community benefit initiatives that improve "care delivery and overall member and community health and well-being." One CCO invested in a community-based dental program which, among other things, delivered oral health supplies to participants' homes.
- **ACO payment**: Four of the incentive measures used in either 2019 or 2020 measured oral health performance:
    - Assessments for children entering foster care including oral health assessment;
    - Dental sealants on permanent molars for children;
    - Oral evaluation for adults with diabetes; and
    - Preventive dental visits for children ages 1-5 and 6-14. (Oregon also measured the number of children and adults who had access to dental services and received any dental service and topical fluoride varnish use, but does not include these measures in its pay-for-performance program.)
- **Provider payment**: CCOs must have value-based payment (VBP) for oral health in place by 2024. The state has committed to helping both CCOs and oral health providers develop and implement the VBP models.

Since Oregon began incentivizing performance on these measures, CCOs have increased the percent of children receiving dental sealants on permanent molars from 18.5 in 2015 to 24.8 in 2018. The increase was greatest for younger children — that number increased from 20.7 to 27.8 percent for children ages 6 to 9. The CCOs also increased the percent of children who received an oral health assessment (along with physical and behavioral health assessments) upon entering foster care from 27.9 in 2014 to 86.7 in 2018. (The other measures of oral health performance described above had not been in place long enough to produce documented trends.) An evaluation of Oregon's program found that CCOs were more likely to produce improvements in measures that were part of the incentive program than those that were not—emphasizing the importance of tying ACO payment to performance.

Maine's Accountable Community Partnerships

Maine:
- Considers oral health in two performance areas, and
- At ACO's option, will factor performance on one oral health measure into ACO payments.
- No performance data has published to date.

In Maine, primary care practices can voluntarily form networks, identify a lead entity to administer the network, and contract with the Medicaid agency to become Medicaid ACOs, called Accountable Community Partnerships (ACs). Between Aug. 1, 2018 and July 31, 2019, the four ACs that were participating in the program included 90 practices that served 59,443 patients. Primary care providers that participate in an AC receive fee-for-service payment for the services they provide and those that qualify as a health home or behavioral health home receive PMPM care management fees.

ACs are paid through one of two payment models.

- Model 1 is open to ACs that serve at least 1,000 patients and features shared savings but not losses.
- Model 2 is only open to ACs that serve more than 2,000 members, and it features both shared savings and losses.

Model 2 pays ACs a greater share of the savings they produce than does Model 1. Savings and losses are calculated by comparing the total cost of care (TCOC) for providing a defined package of services to the members assigned to the AC with their projected TCOC absent the AC. Each AC decides whether it will include dental services in the defined package of services. If actual TCOC is less than projected, the difference is savings – if actual TCOC is more than projected, the difference is a loss. In order to receive any portion of the savings it produces, an AC must achieve a specified level of performance on a set of quality measures (fifteen core measures, four elective measures, and one monitoring-only measure). Then, the exact portion of the savings an AC receives depends on its performance on these same measures. Maine's AC contract requires ACs that choose to include dental services in their TCOC calculations to consider oral health services in two areas of operation:

- **Network and covered services**: ACs that are responsible for oral health services must contract with a sufficient number of dentists to serve their assigned population.
- **ACO payment**: The cost of dental services is factored into shared savings and loss calculation of those ACs that choose to be responsible for dental services. Also, effective August 2018, Maine began allowing ACs to choose to factor an oral health measure into the calculation of their shared savings/losses calculation: "primary caries prevention intervention as offered by primary care providers, Including dentists." This measure is defined as, "Percentage of members ages 1-20, who receive a fluoride varnish application during the measurement period."

Although no AC has yet chosen to factor the cost of dental services into its TCOC calculations, one did choose to use the oral health measure in the 2018-2019 performance year.

Conclusion

Although accountable care programs focus on primary care, Colorado, Maine, and Oregon are all leveraging these programs to improve the delivery of dental care. Although it is still too early to assess Maine's results, Colorado's RAEs and Oregon's CCOs have shown improved performance on measures of oral health care performance. It is important to note that even states such as Colorado that do not deliver dental services through Medicaid ACOs can still use the ACO structure to improve oral health care. Colorado, for example, incorporated a measure of oral health access (the percent of members who received oral health services) to reinforce the contract requirement that the ACOs foster connections between primary care and oral health providers. Importantly, however, the measure was also one that the RAEs' contracted

primary care providers could impact. States that seek to improve oral health services through Medicaid ACOs should consider taking the following steps.

- **Measure and publicly report ACO performance on oral health measures** that an ACO can impact. Even if the performance is not factored into ACO payment, knowing that its performance will become public could cause the ACO to devote resources to improve performance in that area.
- **Articulate oral health requirements in contractor performance standards** to establish clear expectations for ACO performance in the area. Some of these performance standards will be chosen based on program structure. Others are likely to be chosen because they are areas the state would like to see improvements in and believes the ACO can produce.
- **Factor the cost of oral health services into ACO payments**. Factoring oral health services into TCOC calculations and/or incentive payments is the most direct way to incent an ACO to change its delivery of oral health services. In addition, Oregon found that its CCOs were more likely to improve performance on incentivized measures. However, factoring oral health into payment is best done in conjunction with performance measurements and performance standards to ensure that the changes result in the desired improvements.

Acknowledgements*: The author thanks state officials in Colorado, Maine, and Oregon who graciously reviewed a draft of this publication. Trish Riley, Carrie Hanlon, and Ariella Levisohn of the National Academy for State Health Policy provided helpful guidance or assistance. Finally, we thank the Health Resources and Services Administration (HRSA) officials who provided thoughtful input. This project is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number UD3OA22891, National Organizations of State and Local Officials. This information, content, or conclusions are those of the author's and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US government.*