

## Alternative Payment Mechanisms in Value-Based Care: A National Survey's Results

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## INTRODUCTION

The federal government is the biggest payer of healthcare in the United States (U.S.). The Medicaid program provided health coverage to 83 million Americans, including 39 million children in 2021. Out of the \$142 billion spent on dental care, \$59.7 billion were paid by private insurance, \$53.2 billion out-of-pocket, \$19 billion are services from public insurance, and \$10.5 billion from other government relief programs. In 2020, about 70% of the Medicaid beneficiaries in the U.S. were enrolled in a managed care plan, with the purpose of better managing costs and services utilization. One model capable of doing so is the valuebased care (VBC) model (value-based payment) which reimburses providers based on performance linked to quality measures, evidence-based clinical guidelines, improved health outcomes, and patient experience. One of the features of VBC is the incorporation of Alternative Payment Methods (APMs), which reimburses providers based upon value and quality of care provided. The categories include risk-share, partial and full capitation. According to a survey conducted by DentaQuest in 2019, most dentists (73%), physicians (82%), and 87% of employers agreed that dental insurance should emphasize healthy outcomes over volume, with more than half of employers surveyed (benefit decision-makers) interested in implementing VBC strategies. Providers' knowledge and attitudes towards VBC and APMs may delay the adoption of these models. This study aims to provide a baseline of the current knowledge and attitudes among dental providers.

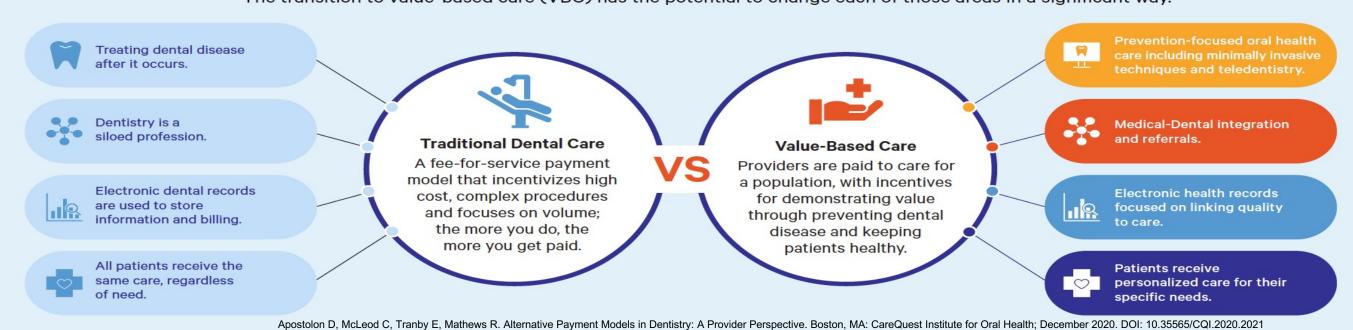
## **METHODS**

This study was approved by the Western Institutional Review Board and the Nicklaus Children's Hospital Research Institute, 45 CFR §46.104. Questions related to VBC and APM from a survey of DentaQuest-enrolled providers conducted between March to April of 2021 were analyzed. Inclusion criteria included age (18+), having a high degree of familiarity with their dental office's patient volume, staffing, dental insurance carriers, treatment protocols, and the office's pre-and post-COVID finances. This study accomplished to encompass a wide variety of providers from different sociodemographic backgrounds, consistently representing the actual dental provider network in the US. Up to four reminders were sent to these providers to promote completion. Three types of APMs were considered: a risk-shared model in which the provider shares with the payer the losses and surpluses, a partial capitation model, and a full capitation model. Answers for each question were stratified by provider's age, race, practice location (rural, suburban, or urban), practice type (private practice, public health setting, or group practice), and specialty type (general dentists, pediatric dentist, or any other specialty). The data was analyzed using Stata 16.0, with a P-value <.05 to be statistically significant. Descriptive and inferential analyses were performed, including Pearson's Chi-Square Test, and Fischer's Exact Test.

## Improving the Patient Care Experience

For more than two centuries dentists have practiced in a fee-for-service (FFS) reimbursement environment. Workflow, care delivery, business plan, staffing, documentation, heath information technology, scheduling billing, goals, productivity, policies and procedures, and communication have all been designed and implemented around a care and financing model that emphasizes volume over value.

The transition to value-based care (VBC) has the potential to change each of those areas in a significant way.



HCP LAN ALTERNATIVE PAYMENT MODEL FRAMEWORK  Health Care Payment Learning & Action Network									
	Population-Based Accountability								
Category 1 FFS – No Link To Quality and Value	Category 2 FFS – Link To Quality and Value	Category 3  APMs Built On  FFS Architecture	Category 4 Population-Based Payment						
	Evolution to Higher	Risk and Reward							
	Incentive Programs	Shared Savings Risk Share Episode of Care Bundled Payments	Capitation						

## **RESULTS**

N=378		
Age categories	n	%
18 to 34	33	9%
35 to 44	97	26%
45 to 54	115	31%
55 to 64	92	24%
65 and older	40	11%
Race categories		
White	205	54%
Black	30	8%
Hispanic	43	11%
Other	100	26%
Practice type		
Private Practice Setting	321	87%
Public Health Setting	47	13%
Practice location		
Rural	61	17%
Suburban	155	43%
Urban	143	40%
Speciality type		
General Dentist	166	44%
Pediatric Dentist	41	11%
Other	170	45%

Risk Share						Partial C	apitation		Full Capitation			
	Extremely/ moderately interested	Slightly	Not interested at all	p-values	Extremely/ moderately interested	Slightly	Not interested at all	p-values	Extremely/ moderately interested	Slightly	Not interested at all	p-values
Age categories												
18 to 34	33.3%	40.0%	26.7%	0.049	40.0%	33.3%	26.7%	0.13	46.7%	40.0%	13.3%	0.16
35 to 44	30.4%	45.7%	23.9%		41.3%	30.4%	28.3%		43.5%	32.6%	23.9%	
45 to 54	25.9%	40.7%	33.3%		27.8%	44.4%	27.8%		31.5%	35.2%	33.3%	
55 to 64	30.4%	17.4%	52.2%		36.1%	19.2%	44.7%		45.8%	16.7%	37.5%	
65 and older	13.0%	43.5%	43.5%		20.8%	50.0%	29.2%		21.7%	43.5%	34.8%	
Race categories												
White	20.2%	42.4%	37.4%	0.199	28.7%	36.6%	34.7%	0.457	32.0%	34.0%	34.0%	0.171
Black	28.6%	21.4%	50.0%		35.7%	21.4%	42.9%		46.7%	13.3%	40.0%	
Hispanic	42.9%	23.8%	33.3%		47.6%	38.1%	14.3%		57.1%	33.3%	9.5%	
Other	34.8%	32.6%	32.6%		34.8%	32.6%	32.6%		39.1%	28.3%	32.6%	
Practice type												
Private Practice Setting	25.7%	34.2%	40.1%	0.063	31.2%	34.4%	34.4%	0.318	37.0%	30.5%	32.5%	0.674
Public Health Setting	34.5%	48.3%	17.2%		41.4%	37.9%	20.7%		41.4%	34.5%	24.1%	
Practice location												
Rural	23.1%	42.3%	34.6%	0.077	26.9%	30.8%	42.3%	0.001	34.6%	30.8%	34.6%	0.014
Suburban	17.6%	35.1%	47.3%		19.7%	35.5%	44.7%		27.6%	29.0%	43.4%	
Urban	35.1%	36.4%	28.6%		46.8%	36.4%	16.9%		48.1%	33.8%	18.2%	
Speciality type												
General Dentist	27.7%	34.0%	38.3%	0.196	29.8%	36.2%	34.0%	0.091	39.0%	31.0%	30.0%	0.149
Pediatric Dentist	6.3%	37.5%	56.3%		11.1%	50.0%	38.9%		12.0%	53.0%	35.0%	
Other	31.1%	39.2%	29.7%		43.2%	28.4%	28.4%		42.7%	26.7%	30.6%	

•	No	Yes	p-value			
Age categories						
18 to 34	58.3%	41.7%				
35 to 44	65.9%	34.2%				
45 to 54	75.0%	25.0%	0.102			
55 to 64	72.2%	27.8%				
65 and older	86.1%	13.9%				
Race categories		22				
White	74.6%	25.4%				
Black	73.9%	26.1%	0.035			
Hispanic	48.4%	51.6%	0.025			
Other	74.4%	25.6%				
Practice type						
Private Practice Setting	74.2%	25.8%	0.015			
Public Health Setting	55.3%	44.7%	0.015			
Practice location						
Rural	75.0%	25.0%				
Suburban	73.9%	26.2%	0.77			
Urban	70.4%	29.6%				
Speciality type						
General Dentist	75.5%	24.5%	25.75.00.52.70			
Pediatric Dentist	77.8%	22.2%	0.186			
Other	66.7%	33.3%	0.100			

-	Have never heard of	Have only heard of	to fee-for-service reimbursement i Know them well but may or	p-values	What factors do yo	Increase in risk sharing		Policy and		
	APMs	APMs/Know a little- moderate amount			Appropriate provider compensation and incentive	models like accountable care organizations	Medical dental Integration	regulation changes	Other	p-valu
Age categories										
18 to 34	51.9%	44.4%	3.7%	0.766	65.2%	0.0%	4.4%	13.0%	17.4%	0.736
35 to 44	44.1%	52.4%	3.6%		57.1%	6.5%	10.4%	10.4%	15.6%	
45 to 54	38.6%	54.5%	6.9%		60.8%	3.1%	12.4%	9.3%	14.4%	
55 to 64	32.9%	59.5%	7.6%		66.2%	2.7%	10.8%	8.1%	12.2%	
65 and older	43.2%	51.4%	5.4%		62.2%	0.0%	2.7%	18.9%	16.2%	
Race categories					0.0000					
White	36.8%	57.1%	6.1%	0.647	65.3%	1.2%	9.3%	9.8%	14.5%	0.240
Black	48.0%	52.0%	0.0%		65.2%	0.0%	13.0%	4.4%	17.4%	
Hispanic	46.9%	50.0%	3.1%		56.7%	10.0%	13.3%	10.0%	10.0%	
Other	41.5%	50.0%	8.5%		55.3%	6.6%	7.9%	15.8%	14.5%	
Practice type										
Private Practice Setting	43.4%	50.9%	5.7%	0.003	62.8%	3.8%	8.3%	10.5%	14.7%	0.237
Public Health Setting	17.1%	75.6%	7.3%		52.6%	0.0%	18.4%	13.2%	15.8%	
Practice location										
Rural	39.3%	55.4%	5.4%	0.992	58.8%	2.0%	9.8%	11.8%	17.7%	0.193
Suburban	38.7%	55.5%	5.8%		61.1%	2.3%	6.1%	13.7%	16.8%	
Urban	40.5%	52.9%	6.6%		65.5%	5.2%	12.9%	6.9%	9.5%	
Speciality type		2000000								
General Dentist	41.2%	54.7%	4.1%	0.695	61.1%	4.2%	11.8%	11.8%	11.1%	0.673
Pediatric Dentist	44.7%	50.0%	5.3%		57.9%	2.6%	7.9%	7.9%	23.7%	
Other	38.0%	54.2%	7.8%		63.5%	2.4%	7.9%	10.3%	15.9%	

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#### DISCUSSION

- With the continuous increase in number of dental services organizations (DSOs), a shift to a VBC delivery system utilizing APMs could be financially advantageous for these organizations.
- From the NHANES 2015-2016 report, Hispanics when compared to other racial groups in the US, also carry the highest burden in unmet oral health needs. Hispanic dentists, when compared to other groups, were more likely to think VBC will increase equitable outcomes.
- Public health practitioners are significantly more likely to have positive attitudes than private practitioners, as the former group is likely to treat more patients affected by poor outcomes from the negative effects of SDOHs (social determinants of health); similar results from a survey by CareQuest in 2020.
- Most providers were interested in full capitation, compared with partial or risk-sharing models of APMs. Nonetheless, an increase in the use of risk-sharing models was not supported as a factor that could accelerate the adoption of APMs to support VBC, while the appropriate provider compensation and incentive factor was perceived as the most significant.
- This study demonstrated that there is a lack of education among provider responses regarding APMs and VBC, showing there is a need for education regarding these payment methods to increase their acceptance and adoption.
- Behavioral public health interventions, utilizing the socioecological model, are likely to be advantageous towards this change. Multiple interventions targeted at the different levels of this framework are most effective when targeted simultaneously, resulting in stronger public health promotion.
- While the use of APMs and VBC in the US is increasing and being slowly adopted by healthcare payers, such as CMS (Centers for Medicare and Medicaid Services), the change towards VBC in dentistry will involve incremental approaches
- Implementing VBC and APMs in dentistry will completely change the way dental care is currently delivered and how practice finances are managed under the FFS model.
- Our findings support the need for further research in the topic, educational opportunities for dental providers, and the use of public health strategies that follow the socioecological model of health behavior changes, to promote changes towards acceptance of APMs and VBC in dentistry.

### CONCLUSIONS

While providers in public health settings and in urban areas understand and currently utilize APMs, most of the dental workforce - those in private practice - and in rural areas in the United States have a lack of knowledge regarding both VBC and APMs. Since access to care in the US is mainly provided by private practitioners, it is imperative to create educational interventions to increase positive attitudes and perceptions, among this group, and those in rural areas.