Perspectives on evolving dental care payment and delivery models

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ABSTRACT

Background. Health care reform is well under way in the United States as reflected in evolving delivery, financing, and payment approaches that are affecting medicine ahead of dentistry.

Methods. The authors explored health systems changes under way, distinguished historical and organizational differences between medicine and dentistry, and developed alternative models to characterize the relationships between these professions. The authors explored a range of medical payment approaches, including those tied to objective performance metrics, and their potential application to dentistry.

Results. Advances in understanding the essential role of oral health in general health have pulled dentistry into the broader discussion of care integration and payment reform. Dentistry's fit with primary and specialty medical care may take a variety of forms. Common provider payment approaches in dentistry—fee-for-service, capitation, and salary—are tied insufficiently to performance when measured as either health processes or health outcomes.

Conclusions. Dentistry can anticipate potential payment reforms by observing changes already under way in medicine and by understanding alternative payment approaches that are tied to performance metrics, such as those now in development by the Dental Quality Alliance and others.

Practical Implications. Novel forms of dental practice may be expected to evolve continuously as medical-dental integration and payment reforms that promote accountability evolve.

Key Words. Financing; delivery of health care; health systems design; health policy.

JADA 2016:147(1):50-56

http://dx.doi.org/10.1016/j.adaj.2015.08.010

US health care—widely acknowledged internationally for its high cost relative to the health outcomes it produces[1]—is undergoing dramatic payment innovation intended to enhance its value proposition.[2] At its core is the effort to shift from paying for volume to paying for value. Federal and private efforts are under way across health care disciplines, including dentistry, to promote health care quality, safety, efficiency, and accountability while seeking the best individual and population health outcomes at the lowest appropriate cost.[3] Innovative payment efforts aimed at value-based purchasing have been accelerated by many of the Affordable Care Act's provisions, by nongovernmental organizations, and by demands of large public and private purchasers and providers.

Among major federal facilitators of such reform are the Centers for Medicare & Medicaid Services' State Innovation Models Initiative; its Health Care Innovation Awards; its Accountable Care Organizations demonstration projects and Medicare Shared Savings Program; and its Delivery System Reform Incentive Payment program. Quasigovernmental reform drivers include grants from the Patient-Centered Outcomes Research Institute and, in collaboration with the National Governors Association, support for the Medicaid Innovation Accelerator Program. Private insurers, which have become predominant payers for both general and oral health care, similarly are advancing value-based purchasing, patient-centered care, quality initiatives, and

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incentive programs. The Patient Centered Medical Home movement is being promoted by the federal Agency for Healthcare Research and Quality and by private foundations, insurers, and medical systems.

Across the United States, regional consortia of health care providers, payers, and the public are considering local reforms that similarly seek to improve a range of health care services. The iron triangle concept—that higher cost is associated with better health outcomes and greater access to care[4]—has been replaced by the triple aim concept—that better health outcomes are possible at lower cost with enhanced patient and population experience through efficiencies, coordination, and accountability.[5] The mantra has become "work smarter, not harder" in the pursuit of evidence-based holistic care that focuses as much on health promotion as on remediation of health conditions and involves both helping and healing professions in addressing health determinants.

Where dentistry fits within such health care reform, especially relative to medical care reform, and whether it is viewed as primary care, specialty care, or some combination of the 2, has direct implications for the future delivery and financing of dental care. Dentistry's place in health care has been shaped by its origins, with medicine and dentistry emerging from separate physician and surgeon traditions. The separation of the medical and dental fields from their inception gave rise to separate and distinct training programs and their accrediting bodies, licensure, workforces (physician assistants, nurse practitioners, registered nurses, and medical assistants versus registered dental hygienists, dental assistants, and newly emerging dental therapists), financing (health insurance versus dental benefit plans), models of care delivery, and cultures. As a result, dentistry historically has been siloed as an independent health care profession, operating alongside, but separate from, medicine and its components.

There are mounting pressures for integration or, at a minimum, improved alignment of medicine and dentistry. Converging from many directions, these forces include the shift away from a disease-centric approach and toward a holistic, patient-centered approach to health, including oral health; the Affordable Care Act–driven movement toward accountable, value-based care assessed by means of health outcomes; the rise of interprofessional education and practice; the development of diagnostic technologies such as salivary diagnostics; and increased emphasis on primary care, creating potential roles for dentists in general health screening and monitoring.[6]

Dentistry's position relative to medicine will influence its future financing. We can anticipate the effects of reform on dentistry by considering alternative conceptualizations of medical-dental care delivery integration and by observing, monitoring, and learning from delivery and financing changes already under way in the larger health care environment. Already, payment reform in medicine is affecting the primary care fields of internal medicine, pediatrics, and family medicine and is beginning to play out in behavioral health and, to a lesser degree, in long-term care, leaving specialty care for later integration in comprehensive care payment approaches. Whether dentistry is regarded as analogous to primary care and behavioral health or analogous to medical specialty and subspecialty care influences the likelihood that value-based purchasing soon will extend to oral health services.

When we consider the anticipated effect of health care system reform on dentistry, notable differences between medicine and dentistry that retard public and private payers' attention to dental care organization and financing are evident:

- dentistry generally does not use diagnostic codes, which are essential for assessing value through classic health services research methodologies;
- dentistry has had little engagement in interoperable and accountable electronic health record systems that meet federal criteria for meaningful use[7];
- dentistry substantially depends on fee-for-service and out-of-pocket financing—a condition that decreases the leverage of third-party payers;
- the penetration of public insurance is modest in dentistry because Medicare excludes most dental services and adult Medicaid dental coverage varies by state;
- dentistry's acceptance of validated outcomes measures is nascent compared with outcome measures adopted by medicine that typically include morbidity and mortality metrics.

Nonetheless, the historical increase in third-party payment in dentistry has brought scrutiny by payers seeking measurable health improvements for dollars expended—measurable improvements that individual patients would not be able to assess. There has been a steady decrease over time in the proportion of total dental services expenditure that is paid out of pocket—from 96% in 1960 to 42% in 2013, with a concomitant steep increase in the proportions of dental care spending paid by private health insurance (from 2% in 1960, peaking at 52% in 1996, before settling at 47% in 2013) and public insurance (from 1% in 1966 to 9% in 2013).[8]

MODELS OF MEDICAL-DENTAL INTEGRATION

The interface between medical and dental delivery and financing systems may be conceptualized in various ways, and each such conceptualization results in different implications of health systems reform for dentistry. We offer 3 models of medical-dental integration to assist in framing the extrapolation of medical care delivery and payment approaches to dentistry.

ABBREVIATION KEY. DQA: Dental Quality Alliance. **PCCM:** Primary Care Case Management.

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