COMMENTARY

Commentary on "Potential to improve oral health care through evidence, protocols, and payment models"

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Keywords
evidence; protocols; payment models; insurance; dental care.

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Received: 12/29/2011; accepted: 12/29/2011.

doi: 10.1111/j.1752-7325.2012.00317.x

The first half of the paper presents compelling arguments on why we should adopt risk- and evidence-based dental treatment which we agree with. It also identifies real obstacles which need solutions that are universally agreed to. Only the dental profession can create: a single, commonly accepted and validated risk assessment tool for dental caries as well as one for periodontal disease; diagnostic codes to communicate risk status to payers to reduce misuse of benefits (as described for fluoride); scientific studies that demonstrate a correlation between the frequency of dental prophylaxes and a reduction in dental caries – the same for the frequency of examinations; and clinical management pathways tied to risk status. Academic institutions should already be training all dentists in risk- and evidence-based methods so that we do not need special certificates when a dental degree or continuing education credit for license renewal should suffice. The lack of these things, and not dental plan administrators or payers, is the real barrier to creating risk- and evidence-based dental benefits.

It is important to understand that most programs such as the Maryland Healthy Smiles Dental Program are not insurance programs. They are state-funded entitlements that often contract with third parties to provide administrative services such as processing claims which the state pays. The fee schedules, and exclusions and limitations, such as how often topical fluoride will be paid as a benefit, are determined by the state. But even if the state (or insurance company) wanted to make the benefits more evidence-based, the dental profession has not yet created the necessary things identified above. Plan administrators are often caught between the payers of benefits, who are trying to lower their costs, and providers of care, who are trying to increase their revenues. Additionally, the state and national governments are trying to lower Medicaid costs. Any changes to existing reimbursement will have to benefit these parties as well as patients.

While academic papers have value, we believe that successful real-world models are more compelling. We suggest that dentists and payers who believe in this approach sit down together and create a solution. If dentists believe that their protocols for delivering care based on evidence and risk status will allow them to redistribute funds spent on unnecessary care to more beneficial care for the same or lower cost, then they should create that program. We also suggest creating something like an Accountable Care Organization with a form of global payment reimbursement. You could take a population of children, determine what was paid during the prior 12 months, and tie that to the global payment. Such a program could eliminate the unnecessary care and use those funds to provide additional preventive services to higher-risk children. If all parties are really serious about finding a solution, they can make it happen.

Conflict of interest

The author has declared no conflict of interest relevant to the submitted work.

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Keywords
quality measurement; evidence-based; payment aligned with quality.

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Received: 11/28/2011; accepted: 12/2/2011.

doi: 10.1111/j.1752-7325.2012.00319.x

We agree that the implementation of evidence-based clinical guidelines in dental practice and the integration of those guidelines into reimbursement mechanisms can contribute to the improvement of oral health outcomes. America's Health Insurance Plans (AHIP) actively promotes evidence-based care in both medicine and dentistry. In 2007, we created our Evidence-based Dental Coverage Task Force to specifically focus on this important issue. That Task Force published the *Guiding Principles for the Development of Quality Affordable Dental Coverage Based on Evidence* in January 2008. The document cites similar arguments and rationales presented by Dr. Tinanoff as reasons why we need to move toward evidence-based care.

AHIP continues to support the movement toward improving quality of care in dentistry by its membership in the Dental Quality Alliance (DQA) formed at the request of the Centers for Medicare and Medicaid Services and through the leadership of the American Dental Association. The chair of the AHIP Task Force on Evidence-based Dental Coverage serves as one of five people chosen to serve on the DQA's *Committee for the Research and Development of Performance Measure*s. It is important that we begin to develop measures for quality care and measure provider performance against them. Michael Leavitt, Secretary of Health and Human Services during the Bush administration, said when addressing the American Dental Association in 2007,[1] "If you desire to do business with the Federal Government you need to adopt quality standards" and "We intend to begin moving to a system where at least part of the payment structure is a reward for high quality." When Centers for Medicare & Medicaid Services developed its Quality Strategy,[2] it identified among its five key strategies "Evidence-based care and quality management" and "Payment aligned with quality."

Our current reimbursement models do not address the disparity between the *quantity* of care and its *quality*. In many areas of dental practice, dentists do not have a set of diagnostic terms or clinical pathways to attain dental health for their patients based on the best available evidence and accurate risk assessment. Until this obstacle is overcome, dentistry cannot accurately be characterized as evidence-based, and reimbursement mechanisms cannot be structured to encourage treatments that are evidence-based. Changes in the current reimbursement systems to reward the delivery of evidence-based care can provide much-needed incentives, but not until there is further movement by the profession to identify and publish more evidence-based clinical guides, where usage can be tracked and measured. AHIP continues its efforts to advance the movement toward evidence-based care, and we look forward to partnering with the profession toward these goals.

Conflict of interest

The author declares no conflict of interest.

[1] Furlong A. Sec. Leavitt enlists major companies in support of value-driven health care. ADA News. April 2007.

[2] Centers for Medicare & Medicaid Services. Value-based . . . results-driven . . . healthcare: The Medicaid/CHIP Quality Initiative. July 2006.