

Delta Dental's New Plan — Bringing Risk to Plan Design

By Christopher J. Smiley, DDS

In what many considered a significant change in how dental benefit plans are designed, beginning Jan. 1, 2014, employees of the parent company for Delta Dental Plan of Michigan are covered by a new benefit plan design that utilizes a “risk-based” prevention model. What has been changed from the traditional benefit package for employees and dependents over the age of 18 is that only one dental cleaning will be covered annually. The significant change is that those patients who show they are at risk for developing periodontal disease may be able to regain their lost benefit or become eligible to receive additional cleanings.

Participants in the Delta employee benefit plan continue to be eligible for two oral exams each year. Patients who are pregnant or have a history of diabetes, stroke or heart attack, renal failure/dialysis, immune system suppression or radiation treatments of the head/neck due to cancer will be eligible for an additional cleaning per factor, up to a maximum of four total cleanings per year. Additionally, plan participants with a history of periodontal disease may receive three additional cleanings or maintenance visits annually.

In general, the incorporation of risk assessment into benefit plan design holds great potential for improving overall oral health. Plans that provide enhanced benefits for services that have proven outcomes for patients at risk should be championed by the entire dental community. These efforts hold the potential for increasing access to additional services for those who need them most. This can result in improved health and long-term cost savings by preventing further deterioration of the patient's health status and the need for future complex care. From an administrative perspective, individualized risk-based care can reduce a plan's cost exposure by limiting coverage for additional care only to those who need it most, rather than providing universal coverage for these services.

Incorporating patient disease risk status in making treatment decisions has long been an accepted practice with preventive procedures, including dental sealants and application of topical fluorides. The ADA developed clinical guidelines based on the prevailing evidence for expected outcomes in advising the use of these

services for patients at risk. The use of caries risk assessment tools clinically identifies those patients who would benefit from this care. Unfortunately, caries risk assessment, which is also applicable for adults in need of preventive services, is not addressed in the new Delta plan, nor does Delta recognize a patient's elevated risk for decay as a trigger for additional dental cleanings.

A speed-bump to implementing risk-based benefits for periodontal care is that there is no universally recognized tool for assessing a patient's risk for developing periodontitis, and those clinical periodontal risk assessment tools that do exist are often found to be cumbersome to perform. This brings forward a controversial facet of the new Delta plan. As noted above, the plan lists patient health conditions that will open the door to additional benefits. To assess patient risk, Delta asks plan participants to take an online Periodontitis

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An analysis of Delta Dental Plan's new “risk-based” prevention model — its possibilities, potential concerns, and what its widespread adoption could mean for the future.

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Risk Assessment Survey found on its consumer Dental Office Toolkit website, and to take a genetic cheek-swab test to show the presence of an interleukin gene. Each test is voluntary.

It's understandable why Delta would desire a simple way to systemize risk assessment, such as online surveys and lab tests, to allow for automated claims adjudication. What is controversial is that outcomes of each are sent directly to the plan. Although the clinician receives a copy, the determination of a patient's risk status from these can be made by the benefit administrator, circumventing the provider's role in risk determination.

An additional issue is that Delta has determined the need for this test to be administered for its plan participants, unlike other diagnostic services, which are performed when they are determined by the clinician to be necessary or beneficial. The motivation for performing the genetic test appears to be driven by other factors. Time will tell if practitioners see value in this test beyond the incentives available for patients participating in plans that promote its use.

The science of using genetic markers to predict disease is still evolving. The potential of a genetic test to determine risk for developing periodontitis is clinically attractive, however its application to determine eligibility for specific benefits may be less suitable than clinical assessment and may actually deny coverage for some individuals in need. Furthermore, it is unclear how knowledge of the patient's genetic makeup should actually impact treatment decisions. Prevailing evidence is weak for expected outcomes from any therapeutic intervention provided to a patient who simply tests positive for the genetic marker yet shows no clinical signs of disease. Clinical assessment remains essential in evaluating a patient's periodontal status and determination of need for any treatment intervention.

As with any change, it's important to build trust among all parties. It's unfortunate that Delta's initial efforts in risk-based plan design begins by reducing access to preventive services such as cleanings, as this will be controversial for some. However it's not surprising that Delta has elected to curtail the core coverage for dental cleanings within its new plan to one a year. The value of the blanket application of twice yearly dental cleanings has long been questioned in the literature. Its practice may be less grounded in science than it is from toothpaste marketing campaigns in the 1950s, yet both patients and care providers have found value in these recommendations for more than a half a century. Frankly, there is little evidence either way to show that one annual cleaning is as effective as two, three, or four. Most stud-

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ies conclude that recall frequency should be based on the needs of the individual patient. The value of a dental cleaning may include other oral health outcomes beyond periodontal health, such as the management of dental caries, yet this Delta plan has focused the value of dental cleanings squarely on factors associated with periodontal disease.

A University of Michigan study cited by Delta in a letter to its providers announcing this new plan noted that smoking is one of the strongest predictors for the development of disease, yet Delta has chosen to exclude it in its risk-assessment process, stating that it does not want to "reward bad behaviors." This has created additional controversy over the plan's design as Delta appears to be dis-

criminating against specific risk factors it will recognize in triggering additional cleaning benefits. The American Academy of Periodontology (AAP) provides a list of known periodontal disease risk factors that include age, smoking/tobacco use, genetics, stress, medication, clenching/grinding, systemic conditions, poor nutrition and obesity as risk factors for periodontal disease. Excluding smokers or any patient with one of these recognized risk factors from needed benefits until they develop disease is counter-intuitive to a goal of "reducing suffering caused by periodontitis," which Delta stated in announcing this plan.

Preventive services such as dental cleanings are among the most frequently billed services to a dental plan. Reducing the frequency of benefit from two annual covered services to one will result in significant reduction in benefit payments by the plan. Even with the provision of enhanced benefits for at-risk patients and the additional costs for genetic testing, the University of Michigan study projects plan savings from risk-based models to be \$37 per patient/year. Delta's exclusion of at-risk smokers likely will result in even greater reduction in benefit payments by its plan.

Benefiting select risk factors while excluding others will play into practitioners' fears that payers are applying risk assessment and evidence-based design simply to control costs. It is important for payer, provider and patient trust that these changes are motivated from a shared goal to improve the overall oral health for every member of the plan. Dentists must recognize payers' concerns that benefit coverage drives treatment decisions, and be mindful to design treatment recommendations based on patient need and to not let benefit coverage dictate the care they provide or how they code for the services they deliver.

If a patient's needs call for care that is not benefited as a result of his or her assigned risk status, it should be addressed like any other non-covered service. In such cases it is recommended that the practitioner file an appeal with the plan, providing documentation and stating the clini-

cal reasoning why such care is indicated. Often the plan will deny coverage based on contractual allowances, but advocating for patients based on their clinical needs not only opens opportunities for discussion, it helps build goodwill between the dentist and the patient.

Currently, this new benefit offering will impact a little more than 400 Delta plan participants in Michigan, Indiana and Ohio. With the promise of lower plan costs Delta will likely market this concept to other purchasers. There are things that practitioners can do to best position their practice to provide individualized risk-based care, and doing so could help improve the care provided to patients. Implementation of risk assessment tools should be considered for every patient. This will provide documentation and build understanding across the dental team and with patients. It would also be wise to evaluate existing ADA-EBD clinical guidelines to review how risk status can impact care decisions. Current office systems should also be evaluated to

ensure “best practices” are provided for diagnostic services, documentation and treatment planning.

If properly implemented, individualized risk benefit plans have tremendous potential to improve overall patient health and result in fair and equitable distribution of limited resources. It’s evident that there are concerns with the design of Delta’s plan, and it is to be hoped that such offerings will continue to evolve and improve. The potential of a genetic test to determine risk for developing periodontal disease holds potential, but it should be used in conjunction with clinical assessment in assigning risk and determining care recommendations. Circumventing providers’ clinical assessment for risk assignment may actually be harmful by denying coverage for some individuals in need. ♦

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