

Managed care vs. fee-for-service: Is there a difference?



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The growth of managed care and dental management service organizations has led to much debate over the quality of dental care delivered to patients. Quality of care is certainly an overused expression. The problem is that there is a lack of consensus on what defines quality dentistry. Recent research appears to be limited to a few outcome studies to determine the most effective treatment protocols. This article will present an uncommon perspective on whether or not there exists a difference in the quality of dentistry delivered to managed care patients versus fee-for-service patients.

Many dental managed care plans should be commended for their contributions toward improving the care provided by their participating dentists to all of their patients. These plans have been credited with the establishment of dental practice protocols and credentialing guidelines. Dental plan peer review committees oversee on-site facility assessments and clinical evaluations of participating offices which are used in the initial and ongoing credentialing of participating dentists. They serve to assess the following criteria: federal safety guidelines (OSHA) are in place; adequate medical histories are taken; properly recorded, procedures are followed; a sufficient number of radiographs are taken to make proper diagnosis; periodontal assessments are made; treatment plans are in place; and evidence of adverse outcomes does not exist.

Reports of these findings, along with the recommended changes required to meet a plan's standards, are sent to the dentist. Because dentistry still tends to be a cottage industry (the majority of dentists are still in solo practices) many dentists have never had a formal review of their practice methods. Most appear to appreciate the feedback and are willing to make the recommended changes. This approach has served to improve the care

delivered to all of their patients; not just those in the managed care plan. Conducting on-site visits, which are routinely performed by many DHMOs, but generally not by PPOs, is an expensive process. However, it is an invaluable tool for those plans interested in improving the overall care patients receive for dentists. The dental managed care plans that commit their resources to improving the quality of care provided by dentists, one dentist at a time, must be applauded.

There are dentists who resent this intrusion by a third party and are unwilling to make the recommended changes in their practice protocols and procedures. These dentists are usually denied acceptance and/or continued participation in the managed care plan as a result. However, these same dentists are free to continue participation in the fee-for-service environment despite the fact that they are unwilling to meet standards required by many managed care plans. These same dentists now never have to worry about passing an on-site inspection of their office or meeting charting or documentation standards in order to continue to practice in their respective communities.

Authors of anti-managed care articles allege that managed care plans cause dentists to provide inferior dental care. They often state that dentists cannot afford to perform quality treatment at managed care fees. Another assumption is that if a dentist is willing to participate in managed care plans, then he/she cannot be a very good dentist. I do not think that these authors of anti-managed care articles realize that they are denigrating and indicting the entire profession with their statements. If someone is a good dentist today and then joins a dental managed care plan, does that make them a bad dentist tomorrow? Capitation is a payment mechanism and as such, should have no

relationship to quality. Quality dentists perform quality dentistry, regardless of fees or the reimbursement mechanism of their patients' dental benefits. Lousy dentists with lousy attitudes perform lousy dentistry whether they are providing treatment at their full fees or at a reduced fee. A dentist's ethics and skills determine how patients are treated, not their participation in managed care.

The 1998 Dental HMO/PPO Industry Profile conducted by InterStudy and published by the National Association of Dental Plans (NADP) details the participation of general dentists and specialists in DHMOs and PPOs. Overall, 22% of dentists in this country participated in DHMO networks and 42% of dentists participated in PPO networks. Does this mean that 62,584 dentists in the United States are providing inferior care? I certainly do not think that this is the case.

The true question to be raised is: are dentists ethical and respected professionals who can be trusted to do what is best for patients? Or are dentists unethical and money hungry and cannot or should not be trusted to provide proper treatment unless they receive full fees? Those anti-managed care authors seem to make a case for the latter.

The vast majority of dentists who participate with managed care plans also treat patients on a fee-for-service basis. Very few practices limit their patients to those in managed care plans. Do the authors of these anti-managed care articles believe that those 62,584 dentists who participate with managed care plans are so unethical that they decide, on the basis of the patients dental benefit coverage, whether all decay is removed before restoring a tooth, or whether they should place an ill-fitting crown or not? Again, I do not think that this is the case. I believe that dentists are professionals who can be trusted to do the right thing. I resent the implication that dentists who participate in dental managed care plans are less skilled and less ethical. In fact, because only dentists who participate with managed care plans appear to have their practice protocols and patient charts subject to ongoing review, just the opposite may be true.

A concern among dentists is that the growth of managed care is having a negative impact on the income of dentists. Dentists may feel that they are unable to accept managed care patients into their practices because they are not sufficiently compensated. However, the facts indicate that although managed dental care exploded from about 5 to 10 million beneficiaries in 1986 through 1995, dentist net income still increased by 30.7%. During that same period, the national per capita income only increased 10.1%. This represents a significant increase in the real income of dentists. I believe that managed care had a direct impact on the increased income to dentists by making dentistry more affordable and more accessible, thereby encouraging more people to visit the dentist more often. This translates into busier dental practices, higher revenues, and increased incomes for dentists.

The negative press regarding inferior treatment provided to patients in managed care is fast becoming a double-edged sword. The practice guidelines established by managed care plans could easily become the benchmark for determining quality in the near future and could be applied to those dentists who are not involved in managed care.

If the American Dental Association, individual state licensing boards, or dental societies were truly interested in quality – as they purport to be – then they would establish committees to review treatment protocols and inspect all dental offices. They have elected not to make this commitment. Isn't it ironic that managed care plans, which are often bashed with claims of poor quality, have already instituted many of these procedures?

External pressures on managed care plans by legislators and employers have created a demand for industry wide standards of accreditation. The National Association of Dental Plans Foundation, a non-profit organization, has recently published Dental Plan Accreditation Standard. In addition to the guidelines on credentialing and member rights, a major focus is on the establishment of protocols which details the elements required in a patient's dental record. These elements include, but are not limited to: initial medical

history; the ability to update the history without the loss of previous information; periodontal charting and diagnosis; documentation of oral cancer and soft tissue examination; a sufficient number of radiographs to assess and diagnose a patient's condition; diagnosis of the patient's dental condition; and a signed treatment plan. It will no longer be sufficient to only state in the dental record, as so many dentists currently do.

There are a few studies evaluating the differences of dental services delivered and the level of dental health achieved by payment mechanism. One study conducted by Drs. Hastreiter and Ruff in 1996 stated, "Preliminary findings indicate that these capitation and indemnity patients are provided comparable dental care, irrespective of the dental health financing method used." A second study completed in 1996 by Boffia, Brouder, Colton and Kassler, conducted by the Massachusetts Public Employees Fund and Boston University team, found "no difference between the participants who were enrolled in the Open Dental Plan and the participants who were enrolled in the Closed Dental Plan." These results appear to support the fact that quality dentistry has little to do with the payment mechanism.

Dental managed care plans should be proud of their role and the investment of their resources to help ensure the quality of care provided to its members. In addition, dental plans have played an important role in bringing affordable care to millions of people. A study published in the journal of the American Dental Association in April of 1998 conducted that, "A total of 5.5% of people participated in HMO or IPA plans having unmet dental care wants, which is significantly less than the estimated national average of 8.5%." This is a significant achievement accomplished by dental plans. So when we look at HMOs, PPOs, and fee-for-service dentistry, realize that the quality of dentistry may be no different. Dentistry is performed by dentists. The payment mechanism itself cannot dictate the quality of care. Only a dentist can provide quality or inferior care.

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