

# Tomorrow's dental practice today: To join or not to join?



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Since there is so much confusion today about managed dental care, I chose to write this article with Dr. Keller because of his knowledge about managed care and his depth and breadth of experience with it. I also chose him because he and I share the belief that managed care is inevitable, and it is the way we incorporate it into our practice that will determine our success in the future.

One thing I have discovered as a teacher and manager is that there are two parts to any effective decision about managed care: (1) attitude toward fees and income as a right or privilege; and (2) use of objective information to make your decision.

Most dentists in America are graduates of dental schools that still have no practice management course in their curriculum. American dental schools have been primarily biotechnical in orientation, rather than dental-practice oriented. Students graduate with little knowledge about the realities of dental practice.

This may have fostered the attitude that they have a right to fees that have been traditional within fee-for-service dentistry. This fight is evolving into a privilege as dentists respond to the real issues of managed care. It is my hope that the examples in this article will provide you with information necessary to make the most qualified decision about incorporating managed care into your practice.

Let's assume that all dental schools have active practice management courses. The graduate would then see himself/herself as the manager of a health care delivery organization (called the dental practice) and be able to make competent and objective decisions based on fact. Currently, the health care delivery system (dental practice) is one of the few businesses in America in which the owner/manager view anything less than the

full retail fee as "losing money"; however, this perception does not recognize the actual profit being made from a reduced fee. Here's an example:

Airline X fixed the fare for the flight from Washington to Los Angeles at \$600 round trip (similar to a crown fee). If the plane leaves half-empty, the opportunity has been lost to fill it. If it is not being filled with full fare seats, the CEO of the airline can change the pricing on the remaining seats to make them more attractive to more people. All the CEO needs to do is increase net profit is cover the variable cost of \$30 per seat for the meals and drinks, disposables and fuel for added weight. If the airline can sell the remaining tickets for \$300 (similar to a crown fee in a managed care setting), there will be \$270 in additional profit per seat.

As a dentist, if you have open chair time and fill it by providing a managed care patient with a crown for \$300, did you lose \$300 (discount on full fee) or did you gain a \$200 net profit over lab expense?

By the way, the passengers, whether they paid \$600 or \$300, were all treated with identical courtesy and service and referred friends and relatives to the airline. Those who paid \$300 were not made to feel like second class passengers. Quality remained the same for all passengers; there was no "two-tier" service provided.

It seems to us that dentists must look carefully and ethically at the subtle yet pervasive attitude in the profession that the fee determines how competently we treat our patients or how much caring we deliver with the clinical treatment we provide. This, in itself, seems to be an undeserved indictment rather unbecoming to the profession. Perhaps as a result of the influence of managed care on dentistry, we may be required to

develop a new and more realistic professional ethic. Maybe it's time we understand that we are already perceived by the public as providers of excellent care and that all our patients deserve our expertise and compassion.

Everything in dentistry is changing. Dental practice will not be the same ten years from now, and patients will not come from the same sources. We often hear dentists saying, "I don't like managed care even though I participate. I wish things were the way they used to be." The good old days are exactly that; they'll never return. It's time to decide where the future of dentistry is and to shape your own role in the future of dental practice.

Perhaps it is time for the American Dental Association and managed care to work together in a positive way. Currently, about 17,000 general dentists, 15% of those active in private practice, participate in capitation programs. An additional 15%-20% of general dentists participate in at least one preferred provider organization (PPO). Almost 35% of specialists in private practice participate in managed care. According to a recent survey cited in the Washington Post, 71% of all medical care was provided by a health maintenance organization (HMO) or (PPO) in 1995. We think dentistry will probably follow the same trend set by medicine. From 1990 through 1995, enrollment in dental HMOs grew from approximately 7.8 million to 21.9 million people, and this growth continues. With these statistics, it is difficult to justify making snap decisions about managed care. Trends in the profession and objective information about your decision to join or not to join are the basic issue.

Before you join a managed care plan or re-evaluate your decision to remain a member, there are questions you must ask yourself and each plan. The questions should be the same for each plan you evaluate, even though the responses may be different. Each managed care plan has its own distinct qualities. You must recognize them and match them with the goals and objectives you have for your own practice. If the shoe fits, buy it. If the shoe does not fit, try another until you find the size and style that is most comfortable for you.

**Key factor number one** in evaluating a managed care plan is the patient/dentist assignment. Patients should select their dentist when they initially enroll, rather than waiting until they need dental care. The dentist is then paid immediately, regardless of when, or if, a patient's first appointment is made. This is a critical issue and one that should be given close attention in your decision.

**Key factor number two** is the number of patients covered by the plan. Ask how many patients you can expect initially and over time. Also, ask if you have the right to limit or freeze the number of patients you receive from the plan.

**Key factor number three** includes ethical consideration. Patient welfare must always come first; patients must all be treated equally. Any policies or procedures you think will compromise your professional standards must be discussed fully with the insurer so you don't ultimately feel "forced" into practices you consider unethical.

**Key factor number four** addresses the considerations to be negotiated to create a fair agreement, including the length of time the contract covers, rules governing the plan's termination of the provider's participation, withdrawal provisions, and a provider's participation with other programs and plans.

**Key factor number five** involves the group contracts. Is it a long term or short-term contract? The ideal contract is two to three years rather than one year, since it takes approximately one year or more to stabilize the group of patients you will receive. You should discuss the retention ratio of groups of people you will be receiving into your practice and the benefits of groups or individuals coming into your practice.

**Key factor number six** is the issue of competition. What is your proximity to other covered providers? What is the geographic distribution of providers? Can you get an exclusivity clause in your agreement? Are you comfortable with other participating providers and how does that comfort level affect your participation in the plan?

**Key factor number seven** is specialty care. Among the sub-factors requiring consideration in this matter is access, including the number and distribution of specialists in the area. In addition, ask questions about the necessity for pre-authorization, whether referrals to specialists are encouraged or discouraged, and whether general practitioners are penalized for referring.

Finally, **key factor number eight** focuses on the quality of care you are expected to deliver. Plans require that your office receives an initial credentialing and that all office personnel be familiar with the provisions of the agreement between the practice and the plan. There will be a review of your office by the insurer, as well as periodic and spontaneous chart audits. Although this may seem intrusive, it is a regulated requirement intended for the protection of covered patients.

These eight factors should be discussed openly and be part of the objective information you use to make your decision to join or not to join.

The future of dentistry is intertwined with the future of each dental practice. Each practice is being required to make choices about how it will continue to survive and prosper. The best decisions will be made by practitioners fully informed about managed dental care, willing to seek plans most compatible with their own practice philosophies, and capable of a more efficient delivery of the high quality dental care to which the profession has always expressed its commitment. Now is the time to become actively involved in the future of your own practice and the care of the public to whom we are equally committed – and licensed – to treat.

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