The impact of managed care on dental clinic administration

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Dental health management organizations (DHMOs) are the fastest growing method of providing dental benefits[1]. This statement from a recent special issue of Compendium and seen often in other articles on managed care is supported by a report of the National Association of Dental Plans. This report states that DHMOs grew 27.3% in 1994 and 132% since 1990 with projected growth of 19.5% in 1995[2]. In 1994, 18.4 million people were enrolled in DHMOs. This appears to be rapid growth, but how much will it grow? It is said that the number of people with dental insurance has leveled at 95 million persons and that most of this is employer based[3]. Will these employers seek to reduce cost by moving to DHMOs? Are dentists lining up to join provider networks? I think it's still too early to tell. The concerns are different for different parts of the country. In southwestern Ohio most dental practitioners think the problem will "just go away if we ignore it."

The problem is viewed differently by our medical colleagues. They are a little deeper in the bog than are the dentists. They've allowed their ranks to swell to the point where they are very susceptible to the forces which are driving the health care industry into managed care. The employer purchasers of health insurance want lower cost and higher quality. The insured employees want lower premiums on the portion they pay. The providers, because their numbers are high in relation to available patients, are willing to join managed care networks at a negotiated price. These market forces are different in different parts of the country. They are also somewhat different for dentistry by virtue of there not being a busyness problem in the offices of most dentists across the country[4]. My sense is that this means it is just a matter of time.

While market penetration in dentistry is variable by locale in the private sector, it is probably less so for those of us affiliated with academic health centers, particularly for hospital based programs. This is even more evident in centers with no dental school. As academic health centers are adopting strategic plans calling for alliances of medical care providers consisting of hospitals and physicians, both in-house and community based, and in some locales (dental schools), we have no option for exclusion. We must follow where these integrated health care delivery systems lead. As someone has said, "We can be part of the solution or be part of the precipitate." Academic health centers are engaged in a serious game of survival. Managed care programs are demanding competitive pricing for patient care while stating that paying for the cost of training future health care providers or for research is a problem not for the managed care organizations (MCOs), but for the educators and researchers to work out. That, friends, is you and me.

To establish a basis for this presentation, permit me to describe the situation at Children's Hospital Medical Center (CHMC) in Cincinnati. The medical center is the pediatric affiliate of the University of Cincinnati Medical Center and operates as the Department of Pediatrics for the College of Medicine. CHMC is a private not-for-profit institution. It is the largest of two pediatric hospitals in the greater Cincinnati area comprised of thirteen counties in southwestern Ohio, northern Kentucky, and southeastern Indiana. There are pediatric beds in a few of the general hospitals in the area, but no large service with in-house staff. CHMC is 335 bed facility which according to the National Association of Children's Hospitals and Related Institutions (NACHRI) ranks third among children's hospitals in number of admissions and first in emergency room visits, outpatient visits and surgical procedures. CHMC is designated as a Level 1 Trauma Center and is the only Level 1 Pediatric Trauma Center in southwestern Ohio, northern Kentucky, and eastern Indiana. The Center also contains a large pediatric research facility, which is expanding based on a feeling by the leadership that funds exist. The CHMC strategic plan focuses on community outreach and establishing a presence throughout the area by means of satellites and partnering with community practices and hospitals. There have been serious on-going discussions regarding a partnering arrangement with the other pediatric facility in the area.

Right now, CHMC has a virtual monopoly in pediatric health care. The plan is obviously to do whatever it takes to retain that situation. That requires being price competitive and ready to negotiate with any sound managed care plan.

Any strategic plan for dentistry should follow the plan

of the institution in which the service exists and should focus on integrating educational goals with health care delivery goals. Over 30 years ago as the newly accredited program at CHMC got under way, patient care emanated from the residency and fellowship training programs and was mostly inpatient and highly selective for patients compared to the present. Today, we are moving, fairly quickly by necessity and somewhat motivated by managed care, toward residency training, and to a lesser degree fellowship training, emanating from ever increasing patient care activity. Much of this patient care is on an outpatient basis and open to all populations. Our strategic plan centers around an expanding effort to increase the patient base by emphasizing patient care as a business. Training programs are now simply a part of this business. The times and the development of different, cost effective methods of health care delivery have brought about this turnaround in concept. How many of us have heard the words "more fiscally responsible" in the last two or three years? We have no time or opportunity to debate the issues. Influences beyond our control are forcing the changes. I would argue that it is possible to adjust to these changes with even better results than with the earlier concept. The challenge is achieving and maintaining balance among the varied elements. Equal attention must now be given to an array of customers: patients, residents, fellows, and various other services of our institutions and we must attempt to be fair to all of them. This requires better leadership and better business sense from the top down. It doesn't hurt to have a few visionaries in the mix - actually vision is a key element of this survival game. Another element is the ability to quickly make wise mid-course corrections, especially today with the uncertainties existing among the policy makers even within institutions! This strategic plan is characterized by a willingness to take and share risks and has its roots in managed care. The plan offers a way to financially support resident training.

In dentistry at CHMC we are developing a full time clinical care staff. The only responsibility of these dentists is to care for patients. These clinical care staff do not have faculty appointments. We are placing satellites in the community in both underserved areas as well as areas where pediatric referrals are potentially high as determined by our marketing people. At present there is no intent to send resident staff to the satellites, but with the concept of preceptoring coming back, this may change. Two of these satellites are operating at full capacity with two more to come on line in September. Our goal is to substantially increase revenue. This requires us to develop positive ways to manage the issue of becoming a competitor in the private sector.

The Department of Human Services in Ohio has begun a process aimed at placing the entire Medicaid program in a capitated system through managed care. The vision was great; the reality is less so. The decision was made to phase the project in on a selected county basis. One county plan was begun several years ago as a pilot. Presently, two counties each containing two large urban areas are in almost full operation and CHMC is in one of them. Another county is scheduled for implementation in July with more to follow.

In addition, the commercial plans have moved into our area in a fairly major way. These market the employer purchased products consisting of both capitated HMOs and indemnity type plans. These plans were purely medical coverage for a short time (a very short time). The purchasers wanted packages that included dental coverage. Some of these health care payers already offered dental plans, others began to develop their own or to subcontract through existing HMOs, PPOs and/or IPAs. Currently, these are all fee for service (no capitation). There still exists two levels of managed care since the discounted fees for Medicaid and those for the commercial plans are not the same. They are approaching each other, but there remains a gap which may not change much in the foreseeable future. To date we have joined eleven MCO dental networks with another eleven in process. Contracts have been negotiated on our behalf and with our input through CHMC's Department of Patient Financial Services. Billing protocols were developed for these contracts. Registration, a very essential element, is being tuned to capture ever changing and program specific information. Authorization mechanisms are being developed to work with the "gatekeepers" of these various organizations. Since we are considered by most, but as yet not all groups, to be both primary care and specialty providers, these "gatekeepers" include general dentists, pediatric dentists, and in some cases physicians. Our record system, our scheduling system, our supervision of the resident and auxiliary staff, indeed our basic thinking is being re-engineered to cope with the requirements of managed care to prevent missed information, repeated handling of paper and lost revenue. Computerization is an ongoing and ever improving facet of our operation. It has to be. CHMC is painfully aware of this as we are behind schedule in networking our facilities. Information Services has become a number one priority at our institution. A Chief Information Officer has recently been recruited to develop and manage this department most crucial to successful participation in managed health care delivery. The accurate collection, rapid disbursement to multiple users and safe storage of information is now, more than ever before, a key element in this business.

Managed care has increased our business and busyness. At the stage at which we find ourselves presently much of it is Medicaid, but the commercial component is growing rapidly. We have had commercially covered patients leave our practice because we were not providers for their particular carrier. That situation is difficult for both parties. To be sure it is a motivating factor to get involved. There is an implication that for some reason we are not acceptable to the patient's carrier if we don't belong to the network. Also, we have had parents assume the expense out-of-pocket realizing that for their children

we were doing predominately prevention and surveillance at a cost they could afford. We recently had a substantial reimbursement increase from Medicaid which makes for a more comfortable payer mix and eases the financial stress of being required to switch to a population based mode of practice.

Referrals are coming at an increased magnitude that creates scheduling problems for routine care, sedation blocks and operating rooms. At the six month period of the fiscal year indications are that we will more than double patient visits for fiscal 96. We are averaging 40 outpatient surgery cases and 150 emergency room visits per month, but this increase in referrals is a nice problem to have. I would suggest that this comes from one of the requirements of managed care which benefits those of us in pediatrics the most. When a practitioner signs a contract with an MCO, a population based obligation to treat the patients assigned to that practitioner is created. The clients of the MCO as well as the employer purchaser expect care to be provided. The quality assurance (QA) mechanisms which are required of MCO's audit regularly check this obligation. For the very young and the difficult to manage child, this could mean a potential end to supervised neglect. The parents we talk to want their young children cared for and actually ask the MCO dentist for referral. It is also easier for this practitioner to refer to the specialists in the provider network of the same organization. An unhappy client could mean the loss of an entire family to another MCO. At a QA audit a provider might be questioned why the patient was not referred.

The case load of our division is presently managed by six pediatric dentists, one orthodontist, one hygienist, and nine residents. The average daily case load for a resident is ten to twelve. We cannot increase this and preserve necessary academic time. Our plan for the next fiscal year includes increasing resident staff by one and the clinical staff by two dentists plus necessary auxiliaries. This strategy keeps the resident program defined as a distinct project of the Dental Service.

The fiscal well-being of the dental service continues to improve. A year ago the medical center administration assigned a business manager to dentistry which has been of considerable benefit and has helped put us in a more positive position. I hope I have demonstrated that we now view ourselves as being in the business of dental service as well as dental education and we are taking it as serious as any large group practice. It appears to be working and we are poised to adjust to the challenges and opportunities of managed care as a part of a developing integrated pediatric health care delivery system.

What worries me right now? The answer is different for different managed care programs. The Medicaid HMOs are working fairly well. At this time 97% of Hamilton County recipients are enrolled. A specific problem exists with one of them having to do with authorizing outpatient anesthesia in the operating room. Interestingly this is one of two who subcontract their dental program through a DHMO or PPO. The medical director countermands the decisions of the dental consultant and requires a very detailed treatment plan and explanation of the reason for the request. The denials are very arbitrary and have obvious cost containment overtones. We have had numerous heated discussions because of his refusal to accept the statement of the American Academy of Pediatric Dentistry on the standard of care regarding this treatment option.

The commercial plans vary considerably on this issue. Some are refusing to authorize hospital charges and general anesthesia while some are not. I do think this situation is improving. An MCO with local or regional administration does provide us with the opportunity to sit down with someone and discuss this important mode of treatment delivery as well as other provider concerns. Some plans are now stating in the policy that they do cover these costs when medically necessary and for the very young.

One commercial plan would not pay for stainless steel crowns underscoring the need for endorsed standards of care. The issue of acceptable standards is still open and controversial in our area. Proper referrals from the primary care person (PCP) can be a problem. We all need to decide how we will manage referrals for treatment only with initial exam and subsequent follow up being performed by the PCP. We have found that these providers need to be educated as to the conduct of your particular practice. Patients will be referred on the same day expecting treatment at that time. They will be sent for sedation or even anesthesia the same day. In time, these problems will disappear, but presently this is a frustration. Parents get angry when expectations are not met. Films exposed need to be transferred because repeat films will not be paid for. I'm sure there are many more examples like these among you. There are billing and payment problems. There are communication problems. There are potential contractual problems. However, there is a high probability that most of this is due to newness of concept, resistance to change, education in all areas of the new systems and rules of the road. Education, standardization, and most of all time, will have a lot to do with implementation of what is without a doubt an inevitable evolution in delivery of all health services. Will this mode be with us forever? Probably not. Most people with whom I have talked in preparing these remarks feel another evolution will occur in time. However, we won't revert to old styles and systems.

The cracks are beginning to show already. Follow the developments closely and think proactively. Gag rules are under fire. Bad outcomes are mounting and being challenged. There is a mounting database developing (note Project Sound Off on the Internet). Since the last draft of these remarks, Choice Care has announced that as of July 96, they will no longer be a Medicaid Provider in Hamilton County. We may yet

come to a single payer system. A very explosive issue is building over the programs for children with special health care needs. Many MCOs don't want these clients under current provisions of Title V. The MCOs want to decide what these kids will receive and from whom. There are some angry parents involved in this debate.

What do I feel good about? I have already mentioned how I think managed care will improve access for children and grow your practice by virtue of the contractual process if you are willing to adapt. Another aspect that I feel will have far reaching implications is the quality assessment and improvement requirement. I was skeptical of this at the outset because I felt it was an issue that would receive much attention to the letter but little to the intent. Having become involved in the process as a QA advisor, I am becoming considerably more sanguine about this issue. Again, the end effect may well depend on which level of managed care is involved. The MCOs involved in Medicaid programs are under mandates and the watchful eye of the State Department of Human Services while the commercial or private vendors are under the surveillance of the State Insurance Commission. Perhaps it won't make any difference at all who has oversight. The organizations with which we are currently engaged are taking it very seriously at this time. Thus, the QA and I programs are very real and would appear to be capable of involving true peer review in the dealings with providers. Many providers will not care too much for this since it will definitely be intrusive. The process as I view its development could be very similar in its final form to a JCAHO review including and probably based on an audit or random review of documents including patient records required to be kept current by the provider. If responsible providers take any opportunity to involve themselves in the development of the QA & I guidelines and the protocols for reviews as they are currently being invited to do this could have a positive outcome. If we avoid this opportunity or responsibility and lose the positive input, the outcome may not be to our liking. There is great opportunity now for state dental associations to become involved with MCOs on our behalf. This may depend greatly on the interest and urging of the membership. I worry about that.

Credentialing of providers is another familiar requirement for MCOs. Current direction is to follow a process similar to credentialing for hospital staff membership. The intent is serious here as well. This is very good and we should support these efforts. For the physician providers cooperative arrangements with hospital staff offices are being worked out. Credentialing for dentists will be different but accomplished in essentially the same manner, perhaps sharing information among MCOs once some standard protocol is designed. Perhaps dental associations can be involved here also. This too could have positive outcomes, but not without involvement and not without detractors. While we as a group are not always known for taking a proactive stance with such issues, we must take advantage of the current mandates being placed on these organizations to deliver a quality service to their customers before the whole system makes its own adjustments due to our indifference. I have long held the opinion that such was the case when the Headstart program came into being.

Let me summarize by enumerating what we'll call the Rules of Engagement.

1. Watch medicine. Follow the lead. Sort out the good.
2. Demonstrate vigorously the value of your service to specific defined populations. Be a fighter!
3. Negotiate to be an added value to any offered benefit package.
4. Share the risk on price break.
5. Develop integrated information systems.
6. Build relationships with other care givers.
7. Teach post-docs how to work in a managed care environment.
8. Use the IOM report as part of a strategic plan.
9. Revere the past — charge the future.

I want to close by thanking those who organized this Directors Symposium and the Academy and its Educational Foundation for their vision in supporting it. I commend you all for the wisdom to be here. The programs need to close ranks and help each other meet the challenge given by the MCOs to "solve our own problems."

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