
Creating a Dental Network (Make or Buy?) and Selecting a Dental Vendor

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As more states convert their Medicaid dental programs to managed care, health plans are faced with deciding between adding the development and management of a dental network to their operational capabilities or contracting with a vendor to provide the managed care dental program. At first glance, it seems logical for a health plan to add a dental program to its array of products and capabilities. After all, dental and medical programs require the same support structure: enrolling members, assigning members to providers, processing specialist referrals, handling grievances, recruiting and maintaining a network of providers, processing encounters and claims, and providing quality assurance. However, managing a dental program is quite different from managing a medical program. The purpose of this paper is to summarize the special needs involved in managing a dental program and to contrast medical and dental managed care delivery. Once the differences between medical and dental programs are understood, an enlightened decision can be made concerning whether to “make” or to “buy” the dental program—that is, whether to develop the internal capabilities to operate a dental program, or to contract with a qualified vendor to develop and manage such a program. Important issues in selecting a dental vendor are also discussed.

Part I. The Make-or-Buy Decision

The Challenge

Regardless of whether the health plan makes or buys the dental program, certain strategic goals must be achieved:

- The dental program must complement the medical program

- The dental program should achieve a high degree of patient satisfaction
- The dental program must maintain a high level of quality
- The dental program must be cost-effective
- Patients should have satisfactory access to dental providers
- The need for enrollees to switch providers should be minimized

The dental program should parallel the medical program in terms of appropriate size and distribution of the provider panel, ease and sophistication of plan administration, reputation in the marketplace, and comprehensiveness of benefit design. Patients should be highly satisfied with the dental program and should not need to consider switching medical plans because of dissatisfaction with dental care. The dental program must ensure that its dental services are consistently satisfactory in technical quality, service mix, and quantity of care. The dental program should provide satisfactory access to general dentists and dental specialists. The cost of the dental program must not exceed the monies allocated to the program by the health plan. It is preferable for patients to continue to seek care from their current dental providers within their current health settings, when possible.

Differences Between Medical and Dental Care Delivery

Delivery Systems. There are several significant differences between the medical and dental care delivery systems. First, more than 85 percent of dental services are provided by general dentists, compared with a much higher deployment of specialists in medicine. Most dentists, including

specialists, are not board certified. Although postdoctoral clinical training is mandatory in medicine, such training is optional for most dentists, except for those in dental specialties.¹ The hospital is not a common treatment setting for dental care; generally, it is not necessary for dentists to have hospital privileges, except for some oral surgeons and for pediatric or general dentists treating children with high rates of early childhood caries. This distinction is critical when contemplating the make-or-buy decision, as noted below.

Lack of Formal Care Protocols. Adding to the difficulty of deciding whether to make or to buy the dental program is the recognition that the field of dentistry has few established standards. For instance, medicine has developed protocols for treating various diseases and conditions, and many texts and guides are available on standard medical therapeutics in clinical practice. On the other hand, the dental profession has not developed standardized regimens that have been widely published or adopted.

The same concern exists in the area of plan performance. For many decades, the medical industry has had formal evaluation and accreditation programs such as the American Accreditation Association of Health Care Organizations (AAAHCO), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), formerly known as the Joint Commission for Accreditation of Hospitals (JCAH), and the National Committee for Quality Assurance (NCQA). The dental industry has not developed similar mechanisms for assessing levels of knowledge.

Many individual attempts to formulate standardized quality assurance protocols have been developed, but none of the published efforts has been widely accepted or implemented.

The dental managed care industry unofficially has adopted NCQA credentialing standards (Dentstat and Healthplex are two certified Credentials Verification Organizations specific to dentistry). However, although health maintenance organizations (HMOs) aim to achieve NCQA accreditation, dental plans have no similar accreditation vehicle. Recently, a contract has been awarded by the National Association of Dental Plans (NADP) to begin development of an accreditation standard for dental plans; however, publication and acceptance of a dental accreditation system is at least several years away.

For the health plan desiring to create its own dental program, the question is: What standards and protocols should be implemented? And for those plans likely to contract with a dental vendor, how can they objectively evaluate potential dental care companies?

Managed Care Participation: Dentists vs. Physicians. The New York Times recently reported that over 92 percent of the physicians in the United States participate in one or more managed care plans. The rate of participation by dentists is much lower, although it is difficult to obtain reliable statistics on the degree of dentist participation in managed care. An estimated 33 percent of dentists participate in some form of preferred provider organization (PPO) program (discounted fee-for-service), and an estimated 20 percent of dentists

¹Over time, the lack of emphasis on postdoctoral training may change, as more dental school graduates decide to enter specialty or advanced general dental training.

participate in some form of dental HMO (capitated) plan.²

There are several reasons why the rates of participation in managed care plans are lower in dentistry than in medicine:

- Medical plan payers have adopted managed care as the standard method for providing medical care coverage
- Few patients purchase medical services on a fee-for-service basis
- Managed care in medicine has been in existence since 1929, with the creation of the Ross-Loos Plan
- Dental managed care began to emerge as a significant alternative only with the development of the “busyness” problem (the relative oversupply of dentists) that peaked in the 1980s

Adaptability of Health Plan Capabilities. The typical health plan has a comprehensive set of operational capabilities, all of which could (at least theoretically) be used to develop, support, and deliver a dental program. However, in examining each operational capability carefully, the issue of whether generic health plan skills and functions are easily transferable to a dental program remains questionable.

Table 1 highlights the major operational capabilities of a typical medical health plan and indicates whether a particular capability can be extended to dentistry in a straightforward manner.

Credentialing (discussed earlier) is easily adapted to dentistry. In fact, credentialing dentists is simpler than credentialing physicians

because few dentists have hospital training, hospital privileges, or board certification.

The *member services* function certainly can be extended to support a dental program because both medical and dental programs require the same types of support:

- Enrolling members
- Referring members to providers
- Answering members’ questions about eligibility and plan benefits
- Handling grievances

However, the member services staff would need additional training in dental terminology and in the specialized functions of the various dental specialties.

The remaining operational capabilities of health plans do not appear to be applicable directly to dental program support.

Table 1. Adaptability of Medical Plan Operations to Dental Plans

Operational Capability	Transferable?
Credentialing	Yes
Member Services (additional training required)	Yes
Provider Relations	No
Utilization Review (Referrals)	No
Quality Assurance/Utilization Review	No
Claims/Management Information System (MIS)	No

²Source: National Association of Dental Plans, “Dental HMO/PPO Enrollment Continues Growth Improving Access to Care” [press release], March 25, 1998.

The *provider relations* function is responsible for developing and managing the network of general dentists and dental specialists. While the mechanics of recruiting medical and dental providers are similar-meeting with providers and office staff and executing provider contracts-the “pitch” made to dentists differs from that made to physicians. With the majority of physicians participating in managed care, the primary goal of the provider relations representative is to convince the medical provider that the representative’s HMO is a good choice compared with other plans. On the other hand, as discussed above, managed care has a much lower level of penetration in the dental marketplace than in the medical marketplace. Often, the primary task of the dental provider relations representative is to educate dentists about the benefits of participating in managed care plans and how managed care reimbursement works.

To provide this type of education, provider relations representatives need to understand the dynamics of dental practice, including the specifics of various types of dental treatment such as x-rays, dental exams, fillings, crowns, bridges, dentures, root canal treatment, gum treatment, oral surgery, and other treatments. The representatives must also be familiar with how dentists employ auxiliary professionals, especially hygienists. It is unlikely that a medical network representative can quickly acquire the dental knowledge and practice management insight necessary to “talk dental managed care” to prospective dental providers. Often the representative is faced with a hostile audience. In today’s marketplace, one of the most difficult positions to staff is that of the experienced dental provider relations representative.

Utilization review (controlling specialist referrals) requires a totally different body of knowledge in dentistry than in medicine. The primary dental specialties are

- Endodontics
- Periodontics
- Orthodontics
- Oral surgery
- Pediatric dentistry³

Health-plan utilization review staff (usually nurses) typically would not have a working knowledge of the various dental specialties.

Quality assurance and utilization review (QA/UR) in dentistry employs the same generic tools as in medicine; however, the clinical knowledge base is different. The health plan physicians and nurses responsible for QA/UR generally would not have the clinical knowledge needed to analyze the quality and appropriateness of dental care.

Dental procedure codes known as current dental terminology (or CDT-2) codes are promulgated by the American Dental Association (ADA) and are not related to the current procedure technology (CPT) and International Classification of Diseases (ICD) codes used in medical care. The capitation component of the health plan computer systems would be applicable to paying dentists, but the medical claims systems would be unable to process dental claims. Furthermore, a standard Health Care Financing Administration (HCFA) claim form is used for medical claims, but no such standard claim form is used in dentistry. (This may change in the next few years as a result of the passage of the Health Insurance Portability and Accountability Act

³Pediatric dentists are also recognized as primary care dentists for the child population.

[HIPAA], which mandates the adoption of national standards for electronic transmission of all health care claims transactions.)

The Cost Factor: Dental network management demands the same level and quality of administrative support found in most health plans. However, the funds available for dental plan delivery are often only 5 to 10 percent of the funds usually available for medical care per enrolled member.

In summary, it is probably more cost-effective to “buy” dental plan administration than to “make” a dental program from the operational building blocks available within the health plan. The remainder of this paper will focus on the factors that are important in selecting a dental vendor.

Part II. Critical Success Factors in Vendor Selection

The process of selecting a dental vendor is complex. Five critical factors must be evaluated when selecting a dental vendor:

- Compensation
- Network access
- Quality assurance and utilization review
- Administrative service level
- Reporting and data

In addition, the health plan must ensure that the dental vendor is licensed or otherwise legally enabled to provide or administer the dental managed care program. If its legal department is unfamiliar with certain dental terminology, the health plan should arrange for someone with specialized knowledge of dental contracts to review the dental vendor contract.

The Impact of Compensation

One of the defining characteristics of dental managed care plans is the method of compensating dentists. How the plan compensates primary care dentists will influence the following: utilization rate, amount of care delivered, type of care delivered, data reporting, and cost of the program. Utilization rate may be defined as the percentage of unique patients receiving care during the course of any year. The amount of care delivered will depend on the combination of the number of visits that each patient using the plan will receive during the course of a year, and the number of dental procedures likely to be performed at an average visit. Type of care refers to either (1) comprehensive and preventive care, or (2) episodic and emergency care. Regardless of the compensation mechanism, if the primary care dentists in the plan are “at risk” for specialist care (see explanation of risk, below), very few referrals will be made to specialists.

Compensating Providers Participating in Dental Managed Care. Four basic compensation methods are used in dental managed care (Table 2).

Table 2. Basic Methods of Compensation in Dental Managed Care

Capitation	Full Risk
	Hybrid
Fee-for-Service	Fee Schedule
	Pool Distribution

Under *full risk capitation*, the primary care dentist receives a monthly capitation payment intended to cover all of the care that the patient may require, including any necessary referrals to specialists. Usually the dentist is at complete risk and will not receive any additional funds, even if the dentist experiences adverse selection or abnormally high utilization.

Under *hybrid capitation*, the primary care dentist receives a monthly capitation payment for each subscriber or member assigned to his/her office. In addition, the dentist will receive additional funds based on the amount of care delivered or the types of procedures performed. The dental plan will employ one of two methods: setting aside a risk pool that will be distributed to the dentists according to the aggregate amount of care delivered, or paying dentists a fixed amount of money for certain procedures upon submission of a claim form. The hybrid capitation model is the standard method used in commercial managed care dental plans. In this system, the dentist bears most of the financial risk for care, but the dental plan might share some of the risk if claims are paid for procedures performed.

The distribution of a “risk pool” or “cap pool” to dentists is performed in a similar way by vendors using this method. First, the amount of the pool is set each month by the vendor. At the end of each month, all of the dentists submit encounter forms listing all of the services performed. The procedure counts are usually converted to relative value units (RVUs). The aggregate number of RVUs is divided into the pool, yielding a monetary value per RVU. Each dentist will then receive a check for the value of the RVUs submitted for that month.

Many dental plans employ the traditional *fee-for-service* system, in which a fixed amount of

money is paid for each procedure performed and a fee schedule (often discounted) is then used. This system places all financial risk on the dental vendor.

A variation of the fee-for-service system is the *pool distribution* system, in which the dental vendor takes its administrative fees “off the top,” then places the remaining money into a risk pool. Participating dentists will receive all of the money in the risk pool according to the amount of care delivered. The mechanics of distributing the risk pool are identical to those outlined in the hybrid capitation section.

Compensation Systems: Pros and Cons

Each of the four basic compensation systems has positive and negative implications, as noted below.

Capitation–Full Risk

Pros

- Simple to administer
- Encourages preventive care

Cons

- Encourages underutilization and undertreatment
- Provides little incentive for encounter data reporting
- Discourages referrals to specialists

Capitation is the only method that (theoretically) rewards dentists for bringing their population to health. As the enrolled population achieves maintenance, the patients require less (and less intensive) treatment, and the dentist receives the same amount of money. On the other hand, because the dentist receives a fixed amount of money regardless of treatment rendered, there is a potential financial disincentive to provide care to the patients. Because the dentist will receive a monthly capitation payment regardless of actual

utilization, there is little financial incentive for the dentist to submit completed encounter forms to the plan administrator.

Hybrid Capitation

Pros

- Provides incentive to perform complex treatment
- Reduces financial risk to primary care dentists
- Captures treatment encounter data

Cons

- Risk of uncontrolled claim costs

What happens to the undistributed capitation? Some dental plans retain the capitation for members not assigned to dental providers, or some vendors may begin paying capitation only when a member has selected a dentist, even if that member has been enrolled for a long period of time. The net effect of either of these less-than-desirable practices is that less money is available to compensate dentists for care. To avoid these problems, the health plan can insist that all members who have not voluntarily selected a dentist are assigned to a dental office upon enrollment, or that capitation is paid retroactively to the effective date of eligibility (“back cap to the effective date”).

Often, the money available for dental managed care in the Medicaid setting is likely to be marginally adequate. If the dental vendor retains an excessive portion of the premium, the dentists are likely to exhibit undesirable yet predictable behavior. Dentists probably will decrease utilization, and the quantity of service is likely to suffer if providers (from their perspective) start to view substandard care as commensurate with the low compensation level.

Fee-for-Service (Fee Schedule)

Pros

- Encourages utilization and treatment
- Ensures encounter data reporting

Cons

- Risk of uncontrolled claims costs
- Encourages claims abuse

The method understood by all providers is the traditional fee-for-service system. It is a straightforward system to administer. However, in Medicaid plans or in any plan in which the reimbursement level is likely to be low compared with community fees, there are several risks involved. When fees are much lower than the community average, the dental plan will experience increased “upcoding,” “unbundling,” and fraud. Upcoding involves using a procedure code with a higher compensation than the code for the procedure actually performed (e.g., a periodontal scaling might be claimed for a patient who received a simple cleaning).

Unbundling involves breaking down a procedure into all of its component parts in order to achieve a higher reimbursement (e.g., a dental office might submit 18 single x-rays for reimbursement instead of billing for a comprehensive full series of x-rays). Utilization review computer systems should be designed to identify upcoding and unbundling.

Unfortunately, some dentists will submit falsified claims in order to increase their reimbursement amount. Compared with most medical offices, dental offices have high fixed costs, typically 65 percent of the cost of practice. Reimbursement levels that are too low could have a negative financial impact on a dental office with high fixed costs.

Fee-for-Service (Pool Distribution)

Pros

- Encourages utilization and treatment
- Ensures encounter data reporting

Cons

- “Diminishing returns” effect will discourage utilization and treatment
- Potential for abusive claims

This system resembles fee-for-service in that the pool is distributed according to the treatment reported on the claim or encounter forms. However, unlike traditional fee-for-service, the pool generally has a fixed amount. The irony of the pool distribution system is that the financial return per procedure decreases as more services are delivered—thus having the negative impact of discouraging treatment rather than encouraging care.

Regardless of the compensation system used, insufficient funding will result in rampant underutilization. States should consider carefully “fixing” the reimbursement rates to reflect local conditions. If this does not occur, health plans must be wary of the “low-ball” bid. The costs of running a dental practice are high and largely fixed. It is estimated that managed care plans can achieve a 25 percent discount from average fees in large cities. Appropriate QA/UR programs will further reduce the overall costs of dental care. Excessive reductions in the cost of care necessitated by low-ball bids will occur only at the expense of the patient, in terms of reduced utilization and inappropriate care.

Network Access Factors

In addition to compensation issues, network access is a critical factor in dental managed care. The

network should be of sufficient size to provide

- Adequate access for members
- Sufficient volume per dental office to allow for population management

The distribution of dentists in a network is different from that of the typical health plan. There should be an ample network of primary care dental facilities (e.g., general dentists, pediatric dentists, hospital clinics, community health centers, dental schools) supported by a smaller but well-distributed network of specialists. Health plans typically are quite adept at analyzing access by using geographic mapping tools.

Access to dentists should parallel access to physicians as defined by standard measures. To measure access, the following network characteristics should be examined carefully:

- What is the voluntary turnover rate?
The plan-initiated turnover rate?
- What percentage of offices are accepting new patients?
- What is the ratio of patients to dentists?

Quality Assurance Program

An effective quality assurance program should include the following⁴:

- Formal written policies and procedures
- Credentialing according to National Committee for Quality Assurance standards
- Site visits
- Ongoing utilization and peer review
- Treatment profiling and outlier identification
- Appropriate corrective actions
- Formal grievance system with reporting

⁴A number of dental managed care plans are beginning to consider including performance measures as part of their quality assurance programs, but much work needs to be completed before the adoption of a “report card.”

National Committee for Quality Assurance Credentialing Requirements. The credentialing process, as defined by the National Committee for Quality Assurance in its Standards for Accreditation, includes the following components:

- Current valid license
- Hospital privileges in good standing
- Valid Drug Enforcement Agency/Controlled and Dangerous Substances certificate
- Graduation from dental school
- Completion of specialty training/residency
- Board certification
- Work history
- Malpractice insurance
- Query of the National Practitioner Data Bank
- Application statement regarding physical and mental health, lack of impairment due to chemical dependency and/or substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges
- Applicant's attesting to the correctness of the application

Site Visits–Facility Review. All participating dental offices should receive a site visit evaluation. Site visits should include, at minimum, an evaluation of the following:

- Physical plant
- Appointment availability
- Staffing
- Equipment
- Sterilization and asepsis
- Emergency preparedness
- Recordkeeping system
- Recall system

What Is Done with Utilization Review and Grievance Information? The dental vendor should use all available information to perform the following activities:

- Focused office review and/or record audits triggered by complaints or profile analysis
- Standardized correction action plans with follow-up
- Appropriate disciplinary action, including termination from the network

Health plans should be wary of the dental plan that never disciplines its member offices or accepts all applicants.

Administrative Capabilities

The dental plan vendor should have the capability to conduct the following:

- Electronic transfer of enrollment data
- Responsive member services function
- Formal grievance system
- State-of-the-art management information system (MIS)

The dental vendor should be able to provide quantitative reports describing the vendor's performance in each of the administrative areas, including the member services function.

Data Collection and Reporting

A quality system for gathering and reporting data is critical. Reports should be produced quarterly and accumulate data for rolling 12-month periods. The dental plan vendor should be able to report the following:

- Utilization
- Treatment by ADA code
 - By dentist
 - By patient

Utilization reports should contain the following information:

- Utilization rate (unduplicated) by age
- Number of visits per utilizer
- Percentage of services and number of procedures in the major ADA treatment categories:
 - Preventive
 - Diagnostic
 - Restorative
 - Fixed prosthetics
 - Prosthodontics
 - Endodontics
 - Periodontics
 - Oral surgery
 - Orthodontics, if covered
- Procedural data (by ADA code), classified by
 - Entire group
 - Office
 - Dentist
 - Patient

Unfortunately, accurate reporting is rare in dental managed care. However, without standardized reports it is impossible to accurately assess the performance of the dental plan vendor.

Summary

The movement to managed care in dentistry in the Medicaid sector is presenting health plans with a critical decision: to develop internal dental programs or to contract with external vendors. This paper has presented the key issues that must be considered—regardless of whether the health plan decides to “make” or “buy” the dental program—and has discussed some of the common pitfalls involved. Also described are some of the key factors to consider in selecting a dental vendor.