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Pediatric Dentistry Under Capitation Programs

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Capitation programs constitute a significant challenge to pediatric dental specialty practice as we know it today. Under capitation programs, dental care is funded by third-party payers on the basis of fixed monthly per-patient allotments to participating dentists. The dentists are obligated to provide a constellation of covered services either at no charge to patients or at a contractually determined copayment charge to patients. The characteristics of capitation programs, as well as observed trends in their promotion and implementation, threaten both the current structure of specialty practice as well as the continued recognition of pediatric dentistry as an age-defined specialty.

Pediatric dentistry has been regarded as a special case by capitation carriers because of its age-defined rather than procedure-defined nature. Most programs exclude pediatric dentists' participation for a variety of reasons:

1. Capitated plans function best with few, large, dental facilities wherein large numbers of covered patients of all ages can be seen. Most pediatric offices cannot accommodate adults.

2. Carriers have recognized that the majority of pediatric care is provided by generalists to the apparent satisfaction of their enrollees. The additional administrative and marketing effort necessary to enroll pediatric specialists is not cost effective to the promoters.

3. Pediatric treatment does not generally include procedures which carry a high fee relative to actual cost. Since capitation plans deflate artificially high financial returns on such procedures, they tend to make the delivery of dental care more economically rational. Pediatric dentists, already practicing economically rational dentistry, cannot be offered the same potential level of financial benefit as can generalists.

4. Pediatric dentistry is already efficient, prevention-oriented, and committed to maintenance care. Since capitation programs reward dentists for restructuring from traditionally inefficient treatment-oriented care to more efficient prevention-oriented care, these programs cannot offer such incentives to pediatric dentists.

5. Capitation rates as they are currently structured are frequently underpriced for children. Most capitation rates for children are less than the traditional fee for two semiannual prevention visits. Unless utilization is very low it is unlikely that the pediatric dentist will realize the same level of income under capitation as under traditional fee for service. A child rate which is low relative to an adult rate, even after adjustment for differences in treatment needs, may be acceptable to the generalist but not to the pediatric dentist who may set a higher, more comprehensive standard of care for children.

6. Capitation cannot offer "internal marketing" to pediatric dentists. One of the enticements to capitation participation is the capturing of patients who may then elect uncovered services at the dentist's usual fee. Pediatric dentists, however, provide few non-covered services and therefore cannot benefit from potential "internal marketing".

While many capitation programs make no reference to the pediatric dentist, promotional literature from a variety of carriers reflects common themes. These policies and procedures collectively reflect either an ignorance of the pediatric dentistry body of knowledge or a disregard for that knowledge. The following excerpts are taken from promotional literature and from personal communications.

1. Cigna Dental Health (Provider Manual): "Pedodontia. Routine dental care of patients assigned to CDH provider facilities includes dependents (children). Approval for pedodontic specialty care will not be authorized for children over six for management problems. It is the responsibility of the parent to guide and modify the behavior of their children (in this age group). If the parents are unable to assert control, CDH will not be responsible for the fees for treatment. Handicapped children may be exceptions to this policy (on an individual basis)."

2. DELTA (Northeast DELTACare Manual): "Pedodontists. Payment from subscriber for all services ren-

dered." "Treating very young children is extremely difficult, and often, next to impossible. The Primary Care Dentist should attempt to treat the child initially. If he is unable to treat the child because the child is uncooperative or unmanageable, then the following procedure should be implemented: A. Another appointment is scheduled and, if after seeing the child a second time, treatment is still impossible, the Primary Care Dentist should do the following: 1. The Primary Care Dentist gives the parent/subscriber a letter explaining the need to refer the child to a pedodontist. Delta must receive a copy of this letter. 2. The parent/subscriber will also need to be informed that they will be financially responsible for the pedodontist's charges."

3. Prudential DMO (personal communication with the Northeast Regional Director): "Pedodontists are barred from participation, even as generalists, unless they work for a Personal Dentist (generalist)." Neither the DMO "General Description" nor "List of Dental Services" recognize pediatric dentistry as a specialty. Specialty services are limited to endodontics, oral surgery, periodontics, and orthodontics.

4. Blue Cross through its national management company Dental Network of America, Inc. (personal communication with the Director of Professional Relations and reference to the DNoA Schedule of Services): "Pedodontic practices are not allowed to apply as Dental Centers unless they provide capacity and facilities to treat at least 1,200 new patients including adults. DNoA has no inherent objection to pediatric dentists treating adults or having pediatric dentists hire generalists to treat adults within their offices but does require that facilities be made appropriate for adult care. All treatment performed within hospitals is specifically excluded from coverage."

5. AETNA Prevent Program (personal communication with the Director of Alternative Dental Programs, Employee Benefits Division): Pediatric Dentists are specifically excluded from participation under the Prevent program. This mixed indemnity/capitation program utilizes a reconciliation formula to protect participating dentists from unfavorable utilization. Under the terms of the reconciliation formula, AETNA's cost to deliver pediatric care through specialists would exceed the cost to deliver care through generalists. To avoid this excess cost exposure AETNA has elected to exclude pediatric dentists from the program.

The potential impact of a particular capitation program on an individual pediatric practice depends upon a number of factors unique to the plan and the practice. Operative factors would include the degree of practice dependence on the enrolled group, the number of employees who elect to enroll, the carrier's willingness to accept participation of the pediatric dentist, the capitation rate, the range of covered services, and the contracted copayment limits.

The potential impact of capitation programs on pediatric dentistry as a specialty depends upon their ultimate prevalence as well as economic and organizational characteristics of the specialty. Capitation plans as developed to date have a particular inducement for undertreatment of children because of low annual allotments and generally high utilization rates for children. No level of enhanced efficiency, organization, or intensified prevention orientation can make it possible for pediatric dentists to function comfortably at current common levels of capitated remuneration. Furthermore, capitation plans as currently structured require pediatric dentists to provide adult care, thereby challenging the very definition of our specialty.

Baby bottle tooth decay studied

Prevention of the most serious dental problem facing infants and toddlers, baby bottle tooth decay, will be the goal of pediatric dentists and researchers at Case Western Reserve University in Cleveland.

The dental school will work with the Ohio Department of Health to develop a preventive education program that will serve as a model for other states. The program has been funded by the U.S. Department of Health and Human Services with an initial three-year grant of $267,000.

The project team will develop an educational model to be used at 12 demonstration sites throughout Ohio. The model will help determine the prevalence of baby bottle tooth decay and will help identify children at risk for the disease.

Previous studies with Head Start children have shown that 15% to 20% already have baby bottle tooth decay.