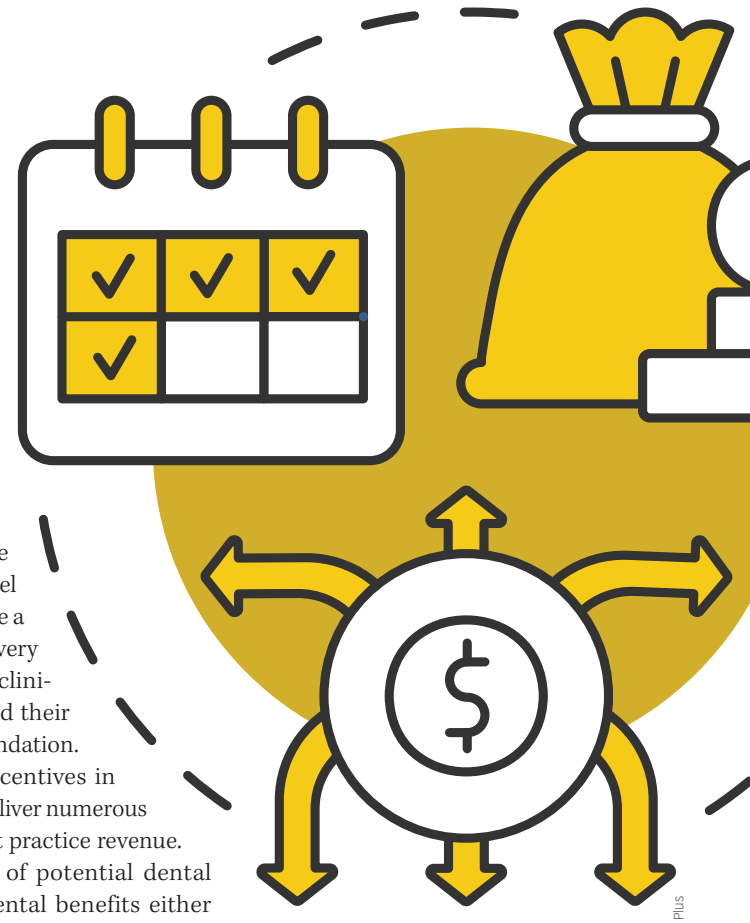
Comparing fee-for-service and capitation revenue models in dental practice: Part 1

Steve Duffin, DDS



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THE TWO PRIMARY REVENUE STREAMS for dental practitioners are fee-for-service and capitation. Given the current controversy around these business models, there now exists an opportunity to explore the terminology, incentives, and operational aspects of both economic models. Another important subject to explore is if these reimbursement methods are exclusive or mutually compatible in the general dental practice setting.

DEFINITIONS OF FEE-FOR-SERVICE AND CAPITATION

Fee-for-service: This business model is based on the concept that when a particular clinical service is rendered to a patient, the dental practice is compensated for that service based on a set fee associated with the procedure. An example is placement of a sealant with a reimbursement of $30.

Many patients have dental insurance that covers part or all the cost. There are also examples where dental insurance pays 80% of the fee and the patient is responsible for the rest. When insurance becomes involved, there may be a maximum allowable fee, which can be less than the clinician's standard fee schedule.

Insurance programs may also require preauthorization prior to committing to payment. The time from claim submission to payment can be a problem for many practices that accept insurance, as delays and multiple requests for x-rays and clinical records can extend the time until payment.

In summary, the fee-for-service model that does not involve a third-party payer is very simple, and many clinicians aspire to build their practice on this foundation.

The financial incentives in this system are to deliver numerous procedures to boost practice revenue. However, millions of potential dental patients receive dental benefits either through employee benefit programs or government plans. Requiring payment of services in full at the time of care delivery will exclude a large population of potential dental patients in most communities.[1]

The dark side of the fee-for-service model is overtreatment to increase practice revenue. Dentistry provides a wide range of services, from simple prevention to complex surgical options. It is common for clinicians to develop several treatment options for a patient to select from. The line between reasonable treatment plans and overtreatment is a gray area; however, honest clinicians should not be influenced by the economic aspects of their proposal.

Capitation: In this reimbursement model, the dental practice agrees to receive a set monthly compensation to deliver a specific set of clinical services to a group of patients, or even to achieve a health objective, such as fewer cavities or improved gingival health. The capitation payment may come from a commercial third-party payer

or directly from a government program, such as Medicaid. The clinician becomes responsible for a cohort of patients and is, in essence, paid in advance for caring for this group. In this model, the incentive is to move patients toward a healthy state and decrease the cost of care over time for this population.

The dark side of the capitation business model is undertreatment. Accepting a new patient who, upon examination, has high dental needs, and learning this after receiving a payment of $15, is unsettling. Being assigned 1,000 patients with high treatment needs can be overwhelming. I'll address new approaches to disease management at the population level later.

BALANCING BUSINESS AND CLINICAL ASPECTS OF CARE

I've sat on both sides of this table, serving as a dental director operating as the payer in both the fee-for-service and capitation models. I've also worked as a provider, receiving compensation from both methods of payment. Acting as an advocate for patient welfare and balancing the business and clinical aspects of patient care is a complex task. Regardless of the practice reimbursement model, the goal should be disease management and excellent oral health for patients. If the business model is broken, then this goal will be a failure.

GIVING EACH MODEL A TRY

Forty years ago, I graduated with dental clinical skills that at the time were considered state-of-the-art. My dental education contained very little business training, which placed me in a challenging situation when I started my practice. I started small with low overhead in a rural area of California. Fee-for-service economics was all I understood at the time, and while I was successful my first year, I could have seen more patients.

After attending a dental practice management seminar, a "dental care" organization proposed a capitation contract, and I was attracted to the idea of receiving a check at the first of the month instead of waiting months for the insurance process. My first experiment with capitation was a disaster. All my assigned patients needed extensive treatment, and my first capitation check was half what was promised because of a "withhold," which was meant to ensure that I did not withhold care.

I had no idea what premium was being paid to the DSO or what percent of those funds was passed on to me as the provider. I felt ethically bound to provide all appropriate dental services based on patient needs, while being totally in the dark about how this system supported me economically. This was a short-lived experiment. What I lacked at the time were tools to manage dental disease. Patients who received restorations came back with new disease. My efforts to explain the causes of caries and periodontal disease, and to encourage healthy behaviors, were less effective than I had hoped.

MEDICAID MAKING A DIFFERENCE

I moved to Oregon in the early '90s and became involved with the efforts of then Governor John Kitzhaber, MD, to reform the federal Medicaid program in the state.[2] Oregon obtained the first federal waiver to reform its state Medicaid program. While many states included dental benefits for children up to age 18, low-income adults were often left without dental benefits.

The final waiver program in Oregon included an adult dental package. Hundreds of thousands of adults with high levels of disease were now eligible for dental benefits. Few existing dental providers embraced this new population. Some participating dental plans set up a reduced fee-for-service reimbursement program to attract providers, with little success. Others, notably Advantage Dental Care, set up a capitation program and revealed the economics of the plan to clinicians, which gave 80% of the federal/state premium directly to the provider.

This allowed dental practices to calculate the available free time in their schedules and determine how many Medicaid patients they could accept in order to fill their schedules. This successful program is largely the result of efforts by R. Mike Shirtcliff, DMD, then president of Advantage Dental Care. Still, existing dental resources were stretched thin by the newly covered population, which led to various dental plans opening new offices throughout the state. Some of these offices were supported by a reduced fee-for-service reimbursement model, while others were set up based on patient assignment and capitation. This was a very interesting time to evaluate the risks and benefits of these two systems.

It's difficult to control disease in a high-risk population. We needed something different. At this juncture, Peter Milgrom, DDS, representing the University of Washington, delivered a lecture to everyone involved with the Oregon Health Plan dental programs. He told us that in Japan there was a medicine called Saforide that stopped tooth decay.[3] My dental treatment philosophy began to shift from surgical restorative approaches to care toward a medical treatment model, which I'll explain in part two. **DE**

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During his 40 years of practice as a general dentist, **Steve Duffin, DDS,** worked in a rural solo practice with one employee, grew a large group practice with more than 20 locations, served as dental director and CEO of a large managed care DSO, and last, served as a primary investigator in large dental public health research programs. He's currently the owner of Shoreview Dental LLC and dental director for the medical device manufacturer NoDK LLC.