Contracting with Private Practice Dentists: Partnerships for Access

January 7, 2014

National Association of Community Health Centers
National Network for Oral Health Access
Reminders

• To receive CE credits, you must fill out the evaluation form at the end of the session.
• The recording of the webinar will be available at http://www.nnoha.org/.
• For any questions, contact Mitsuko Ikeda, NNOHA Project Director, at mitsuko@nnoha.org.
Contracting with Private Practice Dentists

• CDHP’s *FQHC Handbook - Increasing access to dental care through public-private partnerships* (2011)

Models for Healthy Mouths

Contracting Concepts for FQHCS and Private Practitioners
NNOHA  January 2014
Dr. Jane Grover- Director CAPIR
The “Whats, Whos and Whys”

- What does the health center need for dental services?
- Is it within the scope?
- What does the environment tell you?
- Who is telling you what you need?
- Who can help you— and why could they help you?
- The other “W” words: “Win-Win”
The Main Focus- what do the patients need?
Why Contracting Makes Sense

• From the Health Center Dentist perspective:
  • “Horsepower” and Specialty Care = Quality

• From the Health Center perspective:
  • Savings on “bricks and mortar”
  • Supporting local infrastructure
  • Widening base of support
Leverage Other Community Relationships

- Local Non-Profits
- Educational and Faith Based Communities
- Hospitals
- Local Businesses
- Community Groups
- Allied Health Organizations

- All need quality dental care in the community!
Practical Steps

• A good contract spells out how the health center compensates the private practice dentist
• The private practice dental office must comply with QI/QA chart reviews, staff support and cultural competence
• Both must partner on patient record issues
Other details

- Sliding fee patients and Medicaid patients both are shared - Logistics
- After hours coverage, required services
- Agree on methodology: how many patients, grievance procedures, reporting requirements, liability issues, staff liaisons
- Follow up and evaluation of the agreement - both staff and patient satisfaction
- Spell out “more” rather than “less”
One Particular Model: Voucher System

- Montana Health Center: 3 years track record
- Provides vouchers for medical users to access local dental office
- Extraction Service- with follow up in other local programs
- Local Hospital support and Ronald McDonald Foundation
Comprehensive Issues
• What is the “weakest link” in the health center dental menu?
• Local organized dental society provides foundation for relationship building
• What does local hospital ER or school district nurses group tell you?
• Start small- with a great relationship and good contract (done by good legal counsel)
Any Questions?
PUBLIC-PRIVATE PARTNERSHIPS

Jason Roush, DDS
WV State Dental Director
West Virginia Department of Health and Human Resources

[Logos]
Objectives

• Discuss items in Public-Private Partnership Contract
• Discuss successes of Public-Private Partnership
• Discuss challenges of Public-Private Partnership
Public-Private Partnership

- School-based dental prevention program
Elements of Public-Private Contract

- **Clear Project Scope**
  - **Who** receives services? **Who** provides services?
  - **What** types of services will be rendered?
  - **When** will services be provided?
  - **Where** will services be provided?
  - **How** were services provided?

- **Compensation**
  - Rate of pay, hourly rate

- **Term**

- **Liability**
Successes

- Increased access to care
- Increased patient load
- Increased revenue
- Increased professional satisfaction
- Eliminate barriers
  - Child behavior
  - Transportation
Challenges

- Parental consent
- Scheduling
- Follow-up care
- Supplies
- Equipment
Lessons Learned - Contract

• Clear delineation of responsibilities outlined in contract
  • Infection control, sterilization
  • Equipment, maintenance logs
  • Supplies, order frequency
  • HIPAA
  • Reporting to State Oral Health Program
• Collaborative agreement for public health hygienist
• Provider service manual
• Include support staff
• Review sample Dental Service Agreement
Lessons Learned - Project

- Work with State Oral Health Program
- Review CDC Community Guide and ASTDD recommendations for evidence-based service delivery
- Develop understanding of Public entity
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NACHC and NNOHA webinar
January 7th 2013
Contact Information

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Overview

- Background
- Program Development
- Contracts
- Exhibits and supporting documents
- Logistics
- Lessons Learned
Disclaimers

• Our program was a pilot.
• Some parts worked, some didn’t.
• The program is now suspended while we re-evaluate.
• We are sharing our experience as an example, not necessarily as a ‘promising practice’ model.
Why did we contract?

• Limited internal resources.
• Limited access for MA/low income.
• Huge demand for adult services.
• Focus on children in-house.
• Requested by local dentists and politicians.
Our Program Goals

• Increase access to dental services
  – Particular populations, locations, services, etc.
• Strengthen small businesses in our communities
• Improve relationships
• Increase encounters
• Decrease our cost per encounter
• Generate revenue
• Create a replicable model
FQHC Considerations

Pros

• Provide needed services without infrastructure expenses.
• Provide services for areas/populations you can’t accommodate internally.
• Generate more encounters and control payer mix.
• Create/strengthen relationships in community.
• Support local businesses.
• Provide Sliding Fee services for less.
FQHC Considerations

Cons

• Diminished control of quality.
• Other diminished controls.
• Change in Scope required.
• Complicated patient record ownership issues.
Private Dentist Considerations

Pros

• Better reimbursement.
• Stay busy (contribute to fixed costs).
• See more community members (good PR!)
• Offer more services to your patients (through CHC).
• Create/strengthen relationships in community.
Private Dentist Considerations

Cons

• Loss of ‘total independence’.
• Quality requirements.
• Reporting requirements.
• Logistics of dealing with another organization for patient care.
• Complicated patient record ownership issues.
Initial Barriers to Program

• Time/energy to focus on new program
• Lack of a model to copy
• HRSA (control issues)
• Medicaid
• Lack of trust between private dentists and CHCs
Program Development

• Identify your internal program and financial goals.
• Discuss the idea with your HRSA Project Officer.
• Choose providers – Determine your criteria.
• Build relationships.
• Agree upon program goals.
• Agree upon target populations.
  – MA, uninsured/low income, adults, kids, etc.
Program Development

• Agree upon logistics.
  – Volume, schedule/availability, staff liaisons, etc.
• Agree upon allowable services.
• Agree upon a payment methodology.
  – Per procedure, per encounter, capitation, annual limits, etc.
• Agree upon Quality and Reporting requirements.
• Create a contract.
• Complete and submit a Change in Scope.
• Implement!
Contract Obligations-CHC

• Patients of the Program are OUR patients.
• Register and manage program participants.
• Responsible for all permanent charting, prior authorizations with Medicaid, referral services.
• Provide Resource Coordination – Medicaid eligibility/applications, food stamps, heating assistance, transportation, etc.
• Verify eligibility for MA patient and slide status for self-pay patients upon registration.
• Submit claims to MA and pay contractors.
• Manage contract and monitor quality.
Contract Obligations-Dentist

• Serve patients getting other services (Medical, Mental Health) at CHC.
• Submit all claims to CHC each month.
• Check MA eligibility the day of the appointment.
• Carry their own malpractice/ liability insurance
Maintaining WI Medicaid Provider status.
• Participate in CHC Quality Assurance Program, including chart audits and reporting.
• Manage appointments and reminders with enrolled patients.
CONTRACTING – EXHIBITS AND SUPPORTING DOCUMENTS
Exhibit A: Covered Services

• Establish general priorities (for example:)
  – 1. Prevention, 2. All children, 3. Emergency

• But for actual covered services, indicate specific codes, not general principles.

• Add a clause indicating that covered services will be periodically reviewed and are subject to change.
### Exhibit B: Payment Schedule

**By Procedure**

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
<th>PPO Fee</th>
<th>Medicaid Fee</th>
<th>Contract Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic Oral Eval</td>
<td>$31.00</td>
<td>$15.92</td>
<td>Pick % of PPO Fee, greater than MA</td>
</tr>
</tbody>
</table>

**By Encounter**

<table>
<thead>
<tr>
<th>CHC Cost per Encounter</th>
<th>Dental Cost/Dental Encounter</th>
<th>DC/CPE ratio</th>
<th>Contract Fee per Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150</td>
<td>$95</td>
<td>63%</td>
<td>$95 flat fee per encounter OR 63% of total CPE, not to exceed $95</td>
</tr>
</tbody>
</table>
Exhibit C: Non-Covered Services

• List services that will not be paid for under the Agreement.

• List those services that will only be paid for if Prior Authorization is obtained.

• Include provision/procedure for contracted provider to provide services without payment.
Exhibit D: Mission/Values/Goals

• Attach CHC’s mission, vision, values, goals, strategic plan or other documentation that explicitly outlines the Community Health Center model of providing comprehensive, integrated primary care, regardless of a patient’s ability to pay.
Exhibit E: Quality Improvement

• Create and attach a robust QI Plan to the Agreement.
• Include any reporting tools to be used.
• Be explicit about frequency, requirements, roles and responsibilities.
• Be explicit about the consequences of non-compliance.
Exhibit F: Grievance Procedure

• Create a process for patients to submit a complaint about any provider, interaction, etc.
• Train all providers and patient participants to be sure all parties are familiar with the process.
• Be explicit about the consequences of multiple/serious patient complaints.
LOGISTICS
Dental Services Coordinator

- Dedicated staff was critical! Handholding required.
- Handle patient registration and eligibility determination.
- Resource Coordination (basic case management services).
- Assist dental referrals for patients who do not qualify.
- Face-to-face interaction with contracted dental staff.
- Coordinate claims, billing, payment, prior authorizations.
- Patient and contracted dentist liaison—questions, concerns, complaints.
- Coordinate quality program elements.
Program ‘Flow’

- Patients referred to Dental Services Coordinator (DSC)
- DSC reviews program eligibility criteria with patient
- Eligible patients completed normal CHC registration
- Patient referred to contracted dentist for scheduling
- Contracted dentist manages scheduling, treatment planning, reminders, etc.
- Prior authorizations, transportation or other social services needs, etc. sent back to DSC
- Patient is seen by contracted dentist
- Dentist submitted claims to CHC for services rendered
- CHC billed Medicaid/patient
- CHC paid contracted dentist
LESSONS LEARNED
Past...

- Program ran for nine months with 3 dentists
- Discontinued when some contracts began to be denied by Medicaid
- Total of 459 encounters
  - 339 Medicaid (74%)
  - 120 Sliding Fee Scale (26%)
- One provider saw a large majority and practiced very differently from internal providers, resulting in potential financial issues if program continued
- Looking at the numbers
  - Total Charges: $140,000
  - Total Gross Revenue: $95,000
  - Total Paid to Dentists: $90,000
  - Net CHC Revenue: $5,000
Lessons Learned

• Mutual trust is critical to success.
• The Dental Services Coordinator needs to be able to make programmatic and financial decisions.
• Too many people involved causes confusion.
• Contracted providers should be paid by the same (or compatible) payment methodology as CHC.
• Services provided should be limited.
Lessons Learned

• Quality and reporting requirements and protocols should be established together, agreed upon early, implemented immediately and maintained consistently.

• Do not underestimate the awkwardness of quality conversations between providers; or the cost of dealing with issues after the fact!
Present...

• Contracted Dental Program is suspended while we fix several issues.
• We are still referring patients to these dentists through referral contracts without enhanced reimbursement.
• We hope to resume contracts in 2014 that:
  – Provide patient choice
  – Are financially sustainable
  – Increase access to high quality care for adults
  – Are a win-win-win for patients, Medicaid and dentists
Future...

• Keep it limited to 2-3 dentists for new pilot.
• Control payer mix with majority MA and uninsured.
• Consider dollar limit per year on services to uninsured.
• Potentially limit to only 100% FPL and below.
• Payment methodology: per encounter rate based on dental costs/dental encounter only.
• No transportation—local only.
Future...

• Limited list of allowable procedures/services.
• But! Provide enough services to make it quality care: find the sweet spot.
• Non-eligible patients will be referred elsewhere, or seen in-house.
• Do a better job communicating to patients what the program is and is NOT.
• Dental Services Coordinator: re-examine job description and required expertise.
Future...

• Create a robust quality program with contract dentist participation.
• Be very clear about quality monitoring!
• Application process for contracting candidates.
• Name the program so people know what they are enrolling in.
• Define and understand what makes participants “our patients”.
• Perform screening for all needs. Questionnaire? Medical or dental visit?
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Questions?

- Please type your questions in the chat box and specify who your question is for.