Contracting for Dental Services: Increase Access to Care

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Objectives

- List scenarios in which health centers contract for dental services
- Describe some of the ways that contracting dental providers are reimbursed by health centers
- Recognize the requirements for quality assurance & credentialing for contracting dentists
- Compare planning for dental specialist care contracting vs. full scope general dental care contracting
Background

- Primary care has long contracted
  - Behavioral health services
  - OB-Gyn, etc

- Dental new

- Previous Barrier: “four-walls” principle
  - To bill Medicaid covered dental benefits Federally Qualified Health Center (FQHCs) had to provide the services within the four-walls of the health center’s HRSA and state approved service sites
2009 CHIPRA

- Addressed “four-walls’ issues
- A State could not prevent FQHCs from entering into contractual relationships with private practice dental providers in the provision of Federally Qualified Health Center services.
- 2011- further clarified State Medicaid agencies could no longer require dental providers who contracted with FQHCs to individually enroll in the state Medicaid program.
Contracting Scenarios - No Dental Program

- Emergencies only
- Preventive services
- Limited (state Medicaid) scope
- Comprehensive scope

- 22.4% of HRSA health center grantees do not have on-site dental programs
Contracting Scenarios - Existing Dental Program

- Insufficient capacity - 25% of primary care population
  - Long wait times for appointments
  - Inability to complete treatment plans in a timely manner
  - High rates of drop-in emergency visits and multiple return visits for the same issue
  - High rates of appointment non-compliance
  - Limitations on scope of service for specific patient populations
  - Dissatisfaction by health center patients and staff with the dental program
Contracting Scenarios- Existing Dental Program

- Specialty services
  - Pediatric dentistry
  - Oral surgery
Scope of Contracted Services

- May contract for any service in the health centers current scope of service
- Specialty care must be added to scope if not already included
- Contracted services must be available to all clients regardless of payer source.
Factors to Consider

- Need for dental services in the service area population
- Access to community dental providers for both Medicaid beneficiaries AND sliding scale clients
- Cost of providing dental services directly vs. contracting
- Organizational confidence level to provide dental services sustainably
- Interest by community dental providers to contract with the health center
Identifying Dental Providers

- Dentists that already accept Medicaid
- Health center staff and board may have relationships with dentists who could be potential contractors
- The local component dental society
- Dental Management Service Organizations (DMSOs)
- Dental schools
- Other dental non-profits, including other HRSA health center grantees.
Contractor Reimbursement- Encounter-based

- NOT permitted to “pass through” the health centers FQHC PPS rate for clients that are Medicaid beneficiaries
- Rate determined in consideration of:
  - Cost of providing care
  - Health center’s administrative costs
  - Sustainability of contracting for both the health center’s Medicaid and sliding scale clients
  - Acceptability of the flat fee to the contracting provider
Contractor Reimbursement- Fee-for-Service

- Fee schedule commensurate with the prevailing community level that is acceptable to the contracting provider, for example:
  - State Medicaid fee schedule
  - State Medicaid fee schedule plus an additional percentage, i.e. 5-10% more
  - Other variations if agreeable to both parties in the negotiation
Checks & Balances

- Deter excess billing under the fee-for-service or insufficient treatment performed under encounter-based reimbursement

- Examples of systems:
  - Detailed explanation of the procedures that will be permitted under contracting
  - Pre-approval of individual treatment plans
  - Maximum/minimum charge limits per visit
Systems to be Developed

- Process map for clients that will receive contracted dental care
  - How clients to be referred for contracted dental services will be identified, and by whom
  - What staff is responsible for documenting and tracking the referral
  - How initial appointment at contracting office will be made
  - Transmission of HIPAA protected information
  - Patient’s rights and responsibilities to contracting office, as an extension of the health center
Systems to be Developed

- Process map for billing for contracted dental services
  - Mutually agreeable for the contracting office how to bill health center
  - Frequency of billing by contracting provider and frequency of payment by the health center
  - Health center must develop system to bill Medicaid for covered FQHC dental visits
  - How to bill collection of sliding scale client co-payment for clients receiving dental services at the contracting dental office
Contract Length

- Established contracts generally 12 months, rolling contracts
- When piloting/starting recommend shorter contract period to give health center contracting dentist opportunity to modify aspects of the contract as both sides adapt and learn from contracting experience.
FTCA

- Contractors not covered in their own offices
- Must have their own malpractice insurance coverage
Credentialing

- Contracting dental offices are extensions of the health center
- Patients receiving dental services under contracting are clients of health center, not the contracting office
- Many of the same regulations that affect providers in health center operated clinics, also apply to contracted providers
- Contracted providers must go through the same credentialing process as all health center providers as stated in HRSA Policy Information Notice (PIN) 2002-22.
Quality Assurance

- Charts of health center clients receiving contracted dental care must be made available to the health center when requested, including for quality assurance and peer review activities
UDS Reporting

- Contracting dental offices, if they see children ages 6-9, must report data for the HRSA UDS sealants measure
Resources

- 2011 Children's Dental Health Project
- *Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers- An FQHC Handbook*
- TBA NNOHA publication
Contracting for Specialty Dental Services

Errin Pfeifer, D.M.D.
Chief Dental Officer
Access Community Health Centers
Madison, WI
Access Community Health Centers

• 4 fixed dental locations serving 5 counties
  1 rural location
  3 urban/suburban
• Comprehensive school based program in 29 schools
• 17 FTE dentists
• 10.5 FTE hygienists
Access Community Health Centers

• 2014
  14,221 individual dental patients
  40,439 visits

• 2015
  14,878 individual patients
  42,583 visits
Why Contract?

• Patients need the services

• Hiring
  Expensive/difficulty recruiting
  No specialist peers on staff
  Smaller community
  Maintain relations with local dental community
Overview of Contracting

• Pediatric dental contracts- 7 years
  For all locations
  252 referrals in 2015

• Oral Surgery contract-new this fall
  For our rural clinic location
  Goal is not to exceed 10 referrals a month
Overview of Contracting

• Pediatric contracts
  Pediatric practices in our service area
  Two groups with four locations and ten dentists

• Oral Surgery contract
  Closest oral surgery practice
  Had accepted Badgercare patients previously
  One group with two locations and six dentists
Referral Process

• Dentist identifies referral need
• Communicates with referral point person
  Coordinates/schedules appointments
  Tracks referrals, no shows, reschedules
  Coordinates with billing department for reimbursement to specialists and billing to insurance/patients

Secure electronic communication with referral offices
Insured Patient Process

• All specialists are credentialed and privileged with us
• Pediatric dentist invoice us (copy of chart notes and claim form sent)
• Access bills the patients insurance using information on claims form
• Reimburse specialist based on data on claims form
Uninsured Patient Process

• Patient set up on our sliding fee discount program
• Patient is billed based on claims form from specialist at their discount level
• Specialist is reimbursed at the agreed upon rate
Uninsured Patient Process

• Exceptions:
  For pediatric OR cases anesthesiology and OR time are the responsibility of the patient
  Community Care program is available to help with the cost of these
  Access’ Community Resource Specialists can assist the patients with accessing this program
Referral Follow Up

• After all specialist care/referred care is completed, the patient returns to Access as their dental home
• Pediatric offices usually complete a 6 month follow up (is reimbursable to specialist)
• Can re-refer if necessary
Reimbursement

• Agreed upon codes for reimbursement are an addendum to the contract
• Pediatric contracts are paid as a percentage of our full fee schedule
• Oral surgery contracts are paid as a percentage of their full fee schedule
Contracts

• Contracts are on a rolling basis
• Revisit the pediatric contracts every two to three years to update as necessary
• Visit with contracting specialists on a yearly basis
Payor Mix

- Pediatric referrals for 2015
  96% insured
  4% uninsured

- Oral surgery- budgeted for
  85% insured
  15% uninsured
Quality Assurance

• All specialists are credentialed and privileged with Access
• Specialty services are within our HRSA scope
• Chart notes are reviewed for each case by the referring provider
• Chart notes are scanned into our EDR as part of the record
Quality Assurance

• Specialist referrals are included in our biannual peer chart review process
• Get sent to providers to review with a note to only review the specialty care for the particular case
Implementation Challenges

• Timeline to set up contracting
• Private practitioners understanding of FQHC rules and regulations/why we do things the way we do
• Finding a point person with adequate time to manage the process
Future Challenges

• Wisconsin is converting to PPS
• Ability to replicate the oral surgery contract for our more urban locations
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FQHC/Private Practice Contracts for Dental Services

Tina Sopiwnik, DMD
Ashland, WI
Why did we contract?

• CHC mandate to respond to community needs.
  – Limited resources, we can’t do it all!
  – Few private dentists in our service area were accepting new Medicaid patients.
  – Other FQHCs often too far away for our patients.

• Our local state senator requested that we work with private dentists that had been talking with him about challenges with seeing Medicaid patients due to low reimbursement.
Change in Scope

• We added as a self-update because there is no schedule at the contracted clinics.

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Frequency of Activity</th>
<th>Description of Activity</th>
<th>Type of Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portable Clinical Care</td>
<td>As Needed</td>
<td>When our patients are unable to access dental care at our facility, we refer them to dentists within our service area with whom we have contracts.</td>
<td>Dental Clinics</td>
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</tbody>
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• Not sure if this option is still possible!!
Your Program Development...

- Identify your internal program and financial goals (keeping in mind your State’s programs).
- 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.
Our Program Development

Goals

• Increase access to dental services.
• Strengthen small businesses in our community.
• Improve WDA/FQHC relationships.
• Provide a sustainable way to increase access for our patients and increase our own encounters (needed to break even financially).
• Maintain current (or decrease!) Medicaid spending on dental services.
• Create a replicable model.
Our Program Development

• Choosing providers
  – All were taking new Medicaid patients
  – *Excited* about partnership
  – Supportive of/interested in additional CHC services for their patients

• Building relationships
  – Trust
  – Transparency
  – Communication
  – Shared commitment to leading change!
Contract Obligations

• Patients of the Program are OUR patients.
• We are responsible for all permanent charting, prior authorizations with Medicaid necessary for treatment, and referral services for patients.
• We provide Resource Coordination for patients – assisting patients with Medicaid eligibility and applications, food stamps, heating assistance, transportation, etc.
• Contracted dentists are responsible for submitting all claims to us each month.
Contract Obligations

• Contracted dentists serve patients getting other services (Medical, Mental Health, etc.) at CHC.
• The contract includes a list of covered and non-covered services
  – Non-covered services require prior approval
  – Very similar to MA covered/non-covered services.
• Contracted dentists are responsible for verifying eligibility for Medicaid patients upon registration, and checking eligibility the day of the appointment.
• We are responsible for patient sliding discount program eligibility. Contracted dentists collect patient fee based on the sliding fee schedule.
Contract Obligations

- Contracted dentists carry their own malpractice/ liability insurance.
- Contracted dentists responsible for maintaining WI Medicaid Provider status.
- Contracted dentist responsible for participating in the NorthLakes Quality Assurance Program, including chart audits and reporting.
Dental Services Coordinator (DSC)

- Key to success! The program requires TLC.
- Handles patient registration and eligibility determination
- Resource Coordination (basic case management services)
- Assists dental referrals for patients who do not qualify
- Face-to-face interaction with contracted dental staff
- Coordinates claims, billing, payment, prior authorizations
- Patient and contracted dentist liaison– questions, concerns, complaints
- Manage quality program adherence
Logistics – Patient Flow

• Patient registration with Dental Services Coordinator
  – Referred to program by CHC staff or contracted provider
  – Patient completes standard new patient paperwork, household assessment, dental health history paperwork and the application for sliding fee scale
• DSC refers patient to contracted dental office
• Contracted dental office contacts patient to arrange appointment, reminder calls, etc.
Logistics – Patient Flow

- Patient continues to work directly with contracted dentist to make appointments – DSC assists with transportation, etc. if necessary.
- Contracted dental submits claims as if CHC is insurance/payer.
  - CHC verifies claim and requests corrections, etc.
  - CHC processes claims and bills insurance/patients.
- CHC pays out claims to contracted dentist.
Initial Barriers to Program

- **HRSA**
  - Control!
  - “Four Walls” issues
  - Change in Scope process

- **Medicaid**
  - Payment equity
  - Limiting access

- **Lack of trust between private dentists and CHCs**
Barrier Busting!

- **HRSA**
  - Anything “in scope” is within 4 walls
  - Adding Dental Services in Column II
- **Medicaid**
  - CHIPRA memo from CMS:
    - “a State may not prevent a Federally-Qualified Health Center (FQHC) from entering into contractual relationships with private practice dental providers in the provision of FQHC services”
- Remove distrust with candid discussion about goals, finances and requirements.
Reflections-Programmatic

• What Works:
  – Lots of communication with contracted providers
  – Dedicated program staff member
  – Transportation assistance (MTM, etc.)
  – NLCC staff orienting patients to program
  – Ensure internal staff understands program and how to refer patients to it
Reflections-Programmatic

• Some Challenges:
  – Quality Assurance – very difficult to manage quality with outside partners
  – Partners lack of understanding re: billing requirements for Medicaid (prior auths, etc.)
  – Getting entire team of contracted dentist on board with program
  – Getting patients connected to FQHC for ‘Non-covered’ services under the contract
  – Communication challenges-reaching patients, etc.
Reflections-Financial

• What works:
  – Managing registration to ensure appropriate referrals.
  – Contracted dentist collecting co-pays.
  – NLCC staff submitting prior authorizations.
  – Claims going directly to our dental billing staff.
  – Improving contract dentists’ reimbursement while not increasing Medicaid costs.
  – Flat fee per visit for a prescribed list of services.
Lessons Learned

• Mutual trust is critical to success. Shared mission to increase access.
• The Program staff member needs to be able to make programmatic and financial decisions. Too many people involved causes confusion.
• 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!
• Contracted providers should be paid by encounter (same payment methodology as CHC).
• Services provided should be clearly defined in the contract.
• Some training will be required for FQHC staff and contracted dentists’ staff.
Good Luck!

- Feel free to call us with specific questions.
- We are happy to share our contracts and other supporting documents.
- This is a great program that increases access for patients.

Go for it!
Contact Information

For Program Questions:
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Questions?

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