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 could be reimbursed by health centers
- Learn factors health centers should consider when deciding whether to contract
- Understand how one health center implemented contracting for dental services
Background

- 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 cannot prevent FQHCs from entering into contractual relationships with private practice dental providers for services.
- 2011- State Medicaid agencies can no longer require dental providers who contract with FQHCs to enroll in Medicaid program.
Contracting Scenarios- No Dental Program

- Required services
- Additional services

- 22.4% of HRSA health center grantees do not have on-site dental programs

- Contracted services must be available to all clients regardless of payer source
Contracting Scenarios - Existing Dental Program

- Insufficient capacity
  - Long wait times for appointments
  - Inability to complete treatment plans in a timely manner
  - High rates of drop-in emergency visits
  - High rates of appointment non-compliance
  - Dissatisfaction by patients and staff
Contracting Scenarios - Existing Dental Program

- General Dentistry

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

- May contract for any service in the health centers current scope of project

- If adding new services must add to scope of project

- Specialty care must be added to scope of project if not already included
Factors to Consider

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

- Dentists that accept Medicaid
- Local dental society
- Dental Management Service Organizations
- 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 Medicaid and sliding fee clients
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 agreeable to both parties in the negotiation
Checks & Balances

- Deter excess billing under the fee-for-service or insufficient treatment 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 receiving contracted dental care
  - Referral client identification
  - Documentation and tracking
  - Initial appointment making
  - 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
  - How contracting office bills health center
  - Frequency of billing by contracting provider and frequency of payment by health center
  - Collection of fees from clients
Contract Length

- Established contracts generally 12 months, rolling contracts
- When piloting recommend shorter contract period to give health center and contractor opportunity to evaluate and modify contract
- Contract = agreement, understanding
FTCA

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

- Contracting dental offices extensions of the health center
- Patients are clients of health center, not the contracting office

- 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
- Visits to contracting offices are reported in the UDS
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
    https://www.cdhp.org/resources/243-fqhc-handbook-increasing-access-to-dental-care-through-public-private-partnerships

- NNOHA publications
  - Contracting Checklist
  - Implementation Strategies for Contracting
ONE HEALTH CENTER’S CONTRACT FOR “ADDITIONAL DENTAL” SERVICES

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UPPER PENINSULA OF MICHIGAN
NEEDS ASSESSMENT

• COMPLETED A REVIEW OF COMMUNITY NEEDS ASSESSMENT AND EMR DATA TO UNDERSTAND THE SERVICE AREA HEALTH DISPARITIES

• COMPLETED A REVIEW OF AVAILABLE SERVICES ACROSS THE AREA FOR THE LARGEST NUMBER OF PATIENTS SERVED BY HC – WHO TAKES MEDICAID? WHO OFFERS SLIDING FEE?

• SELECTED AREAS WHERE THE HC COULD HAVE THE LARGEST IMPACT (PENETRATION RATE AND POPULATION) TO IMPLEMENT SERVICES AND COULD IN ALL LIKELIHOOD BE SUSTAINED.

• ENGAGED DENTAQUEST TO COMPLETE AN ENVIRONMENTAL SCAN AND BUSINESS PLAN FOR DEVELOPMENT OF A DENTAL CLINIC IN THOSE COMMUNITIES

• ENGAGED IN DISCUSSIONS WITH LOCAL DENTAL COMMUNITY REGARDING THE POTENTIAL OF CONTRACTING FOR SERVICES TO FILL SHORT TERM GOALS FOR THE PROVISION OF SERVICES.
CONSIDERATIONS

• CONSIDER THE DELIVERY AND SERVICE MODEL OF THE HC. WHAT IS YOUR HC’S ‘MISSION’

• WHAT ARE THE HC’S GOALS IN CONSIDERING DENTAL SERVICES?
  • IMPROVING ACCESS?
  • MOVE TO AN INTEGRATED MODEL?
  • INCREASING VALUE AND OUTCOMES FOR PATIENTS AND PAYERS?

• WILL CONTRACTING FOR DENTAL SERVICES MEET THE MISSION OF THE HC – SHORT TERM, LONG TERM OR BOTH?

• BE AWARE OF THE “CONFLICT” BETWEEN A FOR-PROFIT PRIVATE PRACTICE MODEL AND A HC / PUBLIC HEALTH MODEL

• REVIEW THE ROI ON A CONTRACTED SERVICE – VS- A HEALTH CENTER OWNED SERVICE – BOTH CLINICAL AND FINANCIAL AS IT RELATES TO YOUR MISSION
THE CONTRACT

- UGLFHC CEO CONSULTED WITH ANOTHER FQHC IN MICHIGAN THAT CONTRACTED FOR DENTAL SERVICES, THIS MODEL INCLUDED FULL MANAGEMENT OF THE CLINIC IN AN OFFSITE LOCATION.

- UGLFHC REVIEWED THE 2011 “CHILDREN’S DENTAL HEALTH PROJECT” RESOURCE / FQHC HANDBOOK.

- UGLFHC EXTRACTED THE “TEMPLATE CONTRACT” FROM THAT RESOURCE GUIDE AS A BEGINNING POINT.

- CONTRACT WAS DEVELOPED FOR BASIC RESTORATIVE SERVICES.
THE CONTRACT

• INCLUDED CDT CODES ELIGIBLE FOR PAYMENT
• IN GENERAL WE PAID 20% HIGHER RATE THAN THE CURRENT EXPANDED MEDICAID RATE
• REQUIRED PROVIDERS BE CREDENTIALED AND PARTICIPATE IN PEER REVIEW
• REQUIRED THAT THE PRIVATE OFFICE DISPLAY AND PROMOTE OUR SERVICES INCLUDING POSTING SLIDING FEE NOTICE
• INCLUDED PAYMENT TO PRIVATE PRACTICE TO SUBMIT CLAIMS UNDER OUR TIN.
• REQUIRED DENTAL RECORDS BE MADE AVAILABLE AND SUMMARY BE UPLOADED TO OUR EMR
IMPLEMENTATION

• REQUIRED ALL STAFF AT PRIVATE OFFICE BE ORIENTED TO HC’S POLICIES AND PROCEDURES

• SIGN CODE OF CONDUCT, PRIVACY AND CONFLICT OF INTEREST ATTESTATIONS

• HC PROVIDED AN EMR LICENSE TO DENTAL PRACTICE FOR BILLING AND ACCESS RECORDS FOR DOCUMENTATION

• REFERRAL AND DENTAL WORK APPROVAL PROCESS DEFINED IN THE CONTRACT AND ONLY THOSE PATIENTS REFERRED OR APPROVED BY HC WERE QUALIFIED FOR SERVICE.

• MONTHLY INVOICE FROM DENTAL OFFICE BY CDT CODE SUBMITTED FOR PAYMENT
OUTCOMES/FUTURE

• CURRENTLY STILL CONTRACTING IN REMOTE AREAS WHERE POSSIBLE
• HAVE ALSO OPENED UP NEW BRICK & MORTAR DENTAL CLINIC SITES
• KEEP IN MIND THE DIFFERENCES BETWEEN PRIVATE AND PUBLIC HEALTH BUSINESS MODELS
• ALWAYS SEEKING DENTAL PARTNERS WITH SIMILAR PRACTICE PHILOSOPHIES TO EXPAND ACCESS TO CARE
• ELIMINATE ORAL HEALTH DISPARITIES IN OUR COMMUNITIES
Questions?

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