INTRODUCTION

NNOHA has conducted interviews with health centers that are sustainably contracting for dental services. We have gathered promising practices from these organizations to assist health centers, both with and without on-site dental clinics, to implement contracting for dental services to increase access to dental care.

IDENTIFYING DENTAL PROVIDERS TO CONTRACT

Methods to identify dental providers to contract with will vary by community. In many communities, health center staff and board may have relationships with dentists who could be potential contractors. County health departments and other health care safety net providers frequently have lists of dentists that accept Medicaid who could be approached to determine interest in contracting. The local component dental society may be another source of possible contractors. Health centers are not limited to contracting with private dental offices. Contracts may be arranged with Dental Management Service Organizations (DMSOs), dental schools and other types of dental non-profits, including contracting with other HRSA health center grantees.
There are several methodologies for reimbursing contracted providers. Examples would include paying a pre-determined flat fee per encounter or being reimbursed fee-for-service by procedure performed.

If a flat fee is selected as the reimbursement method, it is not permitted to “pass through” the health centers Federally Qualified Health Center PPS rate for clients that are Medicaid beneficiaries. The flat fee should be determined in consideration of the cost of providing care, the health center’s administrative costs, and the sustainability of contracting for both the health center’s Medicaid and sliding scale clients and acceptability of the flat fee to the contracting provider.

If a flat fee is selected as the reimbursement method, in negotiating the amount of the fee, remember that a contract is an agreement in which both parties are in accord. Both parties in the negotiation must determine if the amount being proposed fulfills the financial criteria that each party, in this case the health center and the contracting dental office, has determined is important.

If a fee-for-service approach is selected, a fee schedule should be developed that is commensurate with the prevailing community level and that is acceptable to the contracting provider. In some communities that may be the state Medicaid fee schedule. In other communities the Medicaid fee schedule is only a starting point for negotiation, and the eventually agreed upon fees may be the state Medicaid fee schedule plus an additional percentage, for example an additional 5-10% more, if that amount is agreeable to both parties in the negotiation.

It may be prudent for a health center to incorporate a check and balance system to deter excess billing under the fee-for-service arrangement or insufficient treatment performed under the flat-fee approach by the contracting dental office. Examples of these systems could include detailed explanation of the procedures that will be permitted under contracting, pre-approval of individual treatment plans or maximum/minimum charge limits per visit.
All contracted dental procedures must be within the health center’s scope of project. Some health centers, for example those without existing on-site dental programs, may elect to contract for a limited scope of service, such as emergency or preventive dental care. Other health centers without dental programs may contract for comprehensive care or the scope of dental care covered by the state Medicaid program.

Health centers without existing on-site dental programs should keep in mind that all health center clients should have access to the scope of project dental services available by contracting regardless of their payer source and sliding scale category. There are logical exceptions, for example, services provided by a pediatric dentist may only be available to children or individuals with Special Health Care Needs.

Health centers with on-site dental programs may contract for the same scope of services as offered in their brick and mortar dental clinics or for procedures not currently performed in the dental clinics; this may include specialty care as long as procedures are in the health center’s scope of project. Not all patients need to be able to access contracted services if the services are also being provided directly, that is, some patients may access services through the health center dental clinics and others may access the same services through the contracting dental office.

The protocol for moving clients from the health center to the contracting dental office must be developed. This process includes determining how and by whom clients to be referred for contracted dental services will be identified. The staff responsible for documenting and tracking referrals should be identified. Systems for making the initial appointment at the contracting dental office and for secure transmission of HIPAA protected information must be developed. Procedures to communicate critical information to health center patients, such as the scope of care covered by the health center at the contracting dental office and the patient’s rights and responsibilities to the contracting office, as an extension of the health center, should be reviewed.
A system that is mutually agreeable to the contracted dental provider and the health center should be developed for the contracting office to bill the health center for services provided. The frequency of billing by the contracting provider and the frequency of payment by the health center should be specified.

Concurrently the health center must develop a system to bill Medicaid for covered FQHC dental visits as well as how to handle collection of the sliding scale client co-pay or the nominal fee for clients receiving dental services at the contracting dental office.

There are at least two methods for billing patients receiving contracted dental care if fees are incurred. The most commonly used method is for the health center to bill the client after the dental visit with the contracting provider. In this system the contracting office is removed from collecting fees from the client. The responsibility of the contracting office is to bill the health center for the visit or procedures performed and the health center then bills the client for the sliding fee or nominal fee.

An alternative system, is one in which the contracting office collects fees from the patient. In this case, the contract between the health center and the dental office should clearly describe the roles of the dental office and the health center in collecting money and outlines the process flow of money collected by the contracting office back to the health center.

Most established contracts for dental services are 12 months in length but health centers new to contracting may elect shorter time frames to give themselves and the contracting dentist the opportunity to modify aspects of the contract as both sides adapt and learn from the contracting experience.
When selecting contracting providers health centers should insure they are in compliance with the Procurement Standards section of Title 45 CFR 75 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards). Helpful sections of this resource include requirements for avoidance of conflict-of-interest, criteria for non-competitive proposals and determining contract cost and price. [http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sg45.1.75_1324_675_1325.sg2](http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sg45.1.75_1324_675_1325.sg2)

Contracting dental offices should be considered extensions of the health center. Patients receiving dental services under contracting are clients of the health center, not of the contracting office. Therefore, 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. [https://bphc.hrsa.gov/programrequirements/pdf/pin200222.pdf](https://bphc.hrsa.gov/programrequirements/pdf/pin200222.pdf)

The charts of health center clients receiving contracted dental care must be made available to the health center when requested. This information will be helpful to measure (or determine) quality assurance and for peer review activities.

Contracting dental offices that see children ages 6-9, must report data for the HRSA UDS sealants measure. Health centers providing dental services through paid referral (Form 5A Column 2) under contract must report dental patients age 6 through 9 with elevated risk for caries in the universe count for the dental sealant measure. The health center will have to discuss with the contracting providers how the office will collect data to report on the measure, whether through the contracting office EDR or through random chart sampling.

Contracted dental providers are not covered through FTCA for dental treatment provided to health center patients in their own dental offices. Providers must have their own dental malpractice insurance. An exception to this would be a dental contractor that is working full time at the health center (an average of 32.5 hours per week for the contract period) providing services in the scope of project.
RESOURCES ON CONTRACTING FOR DENTAL SERVICES

The Children’s Dental Health Project, with support from the California HealthCare Foundation, developed a publication in 2011, *Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers: An FQHC Handbook*. The handbook provides information on contracting, includes a sample contract, and contains step-by-step options for implementation. This handbook is a comprehensive publication on the subject of contracting for dental services by FQHCs.

https://www.cdhp.org/resources/243-fqhc-handbook-increasing-access-to-dental-care-through-public-private-partnerships


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