Digging Deeper: Preparing for a HRSA Operational Site Visit

Our mission is to improve the oral health of all.
Disclosures

All speakers in this session have completed conflict of interest forms and none have any relevant financial relationships to disclose for themselves or any immediate family members.
Today’s Agenda

1:00-1:30 p.m. Part 1, What is an Operational Site Visit?
1:30-2:30 p.m. Part 2, What is Evaluated?
2:30-2:45 p.m. Break
2:45-3:45 p.m. Part 2, What is Evaluated?
3:45-4:45 p.m. Part 3, Fees/Sliding Fee Scale Discounts
4:50-5:00 p.m. Wrap-Up
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Today We Are Going to Discuss:

- The rationale and format of an Operational Site Visit
- The HRSA program guidelines within the new Compliance Manual and how they apply to dental
- The “win-win” of preparing dental for an OSV
- A deeper dive into the Sliding Fee Schedule Discount
Part 1: What is an Operational Site Visit?
When Can You Expect an OSV?

- Generally during the first 10 to 14 months of a newly funded/designated health center’s project/designation period
- At least once per project/designation period or at least once every 3 years
- Typically, OSVs will take place 18 months into a 3-year project/designation period for most health centers
The OSV Purpose

- Evaluate HC performance in meeting program guidelines
- Understand what makes the health center unique
- Learn about the HC’s successes, challenges and future plans
- Assess overall HC financial and operational compliance
- Identify opportunities for improvement and/or technical assistance
- Discover best practices that can be shared with other HCs
- Gather the information necessary to formulate a report to HRSA
Preparing for the OSV

• Typically receive notice of visit 3 months before
• Inform key staff and Board members
• Review the Program Guidelines and accompanying Demonstrating Compliance found in the Health Center Program Compliance Manual
• Review the HRSA Site Visit Guide- Updated Release – August 20, 2018
• Gather/review documents to determine compliance—each reviewer will send the health center a list of required documents
• Contact your Project Officer with any questions related to the site visit
• Participate in the Planning Call—key health center staff, reviewers, Project Officer
The OSV Process

• Takes place over three days
• Entrance conference/presentation—Senior Management/Board
• Tour of the site(s)
• Document review
• Individual Key Staff Interviews
• Board of Directors Meeting
• Pre-Exit Conference with CEO
• Exit conference—Senior Management/Board
• Site visit report to HRSA
• Final report from HRSA to health center
OSV Logistics

- Generally, there are three members on the site visit team, who are members of BPHC’s Expert Roster

- Each member is assigned a particular area of the review (administration/governance, fiscal, or clinical) based on their program expertise

- When possible, the health center’s Project Officer and/or other BPHC staff will attend the site visit

- The health center’s Project Officer typically is on-site, communicates with the consultant site visit team and serves as the health center’s primary point of contact for all questions and areas related to this program
The OSV is an Opportunity, not a Threat

• Survey team members have great depth of experience in running and/or providing services to health centers

• Surveyors are often peers (CEO/CFO/Key Leaders) of other CHCs

• They’ve done other OSVs and can share best practices gathered from other health centers

• Consider this an opportunity to get some free technical assistance

• This is also a wonderful opportunity to tell your story!
The Surveyor’s Perspective

- Have been on the receiving end of several OSVs
- Have been a reviewer on numerous OSVs and FTCA site visits
- In my experience, the focus has primarily been on Medical
- Focus of OSV moving forward - are you meeting requirements and are processes implemented
What Do Reviewers Look At in Dental?

- Credentialing and Privileging
- Peer Review
- Quality Indicators, Now and in the Future
- Minutes from Staff Meetings—”Very Informative”
- Sterilization/Infection Control
- Prescribing Patterns (esp. with Emergency Patients)
What Do Reviewers Look At in Dental?

- Tracking Process for Referrals
- Policies and Procedures- Nitrous Oxide
- MOU/MOA– Community Specialists– Does the oral surgeon offer discounted fees? Do you have a credentialing and privileging process for services included on Form 5A Column II and III?
What Else?

- As a surveyor, I like it when someone takes us around and introduces us to the dental staff.
- Have Chief Dental Officer and Chief Medical Officer give site tour together—talk about integration efforts.
- What is the staffing plan for dental?
- Do people look happy to be there?
- Dental *should* be part of the OSV—"You’re an important part of the health center!”
Other Thoughts

• HRSA is trying to be helpful with OSVs
• The OSV is your time to brag—we want to hear who you are and what you’re doing for your patients and the community
• HRSA Project Officers typically attend OSVs, but sometimes aren’t able to
• Health centers should invite their Primary Care Associations to attend the exit interview
• If the health center’s Board isn’t involved in the OSV, that’s a red flag to surveyors
New Compliance Manual

• **Effective August 28, 2017, updated August 20, 2018**

• **Purpose:**
  – To consolidate many PINs and PALs into one document
  – To provide guidance for understanding of the Program Requirements
  – To describe how you can demonstrate compliance with the Program Requirements
New Compliance Manual Structure

- **Authority**: Lists the applicable statutory and regulatory citations
- **Requirements**: States the statutory and regulatory citations
- **Demonstrating Compliance**: Demonstrates how you will demonstrate to HRSA compliance with the Requirements by satisfying all elements in this section
- **Related Considerations**: Describes areas where you have decision-making discretion or areas that may be worthwhile to consider when implementing a requirement – must be consistent with all applicable statutory, regulatory and policy requirements
Part 2: What is Evaluated?
Opening of the Compliance Manual

• Introduction

• Chapter 1: Health Center Program Eligibility

• Chapter 2: Health Center Program Oversight
Chapter 3: Needs Assessment

Requirements:

• *The health center must define and annually review the boundaries of the catchment area or proposed catchment area to be served...*

• *The health center must assess the unmet need for health services in its catchment area...based on the population served...*
Needs Assessment

• Health center performs periodic needs assessments...at least once every three years...

• Assessments document the needs of the target population in order to inform and improve the delivery of appropriate services...
Needs Assessment

A health center needs assessment typically includes, but is not limited to, data addressing factors related to:

- **Assess to care and healthcare utilization**: geography, transportation, occupation, transience, unemployment, income level, educational attainment

- **Morbidity and mortality**: diabetes, cardiovascular disease, cancer, low birth weight, behavioral health and other health disparities

- **Social determinants of care**: physical environment, cultural and ethnic factors, language needs, housing status, etc.
What does this mean to Dental?

- Identify the target populations to be served (same as medical?)
- What is the rationale for identifying these populations (such as children, pregnant women and the elderly)?
- What is the level of need among your target populations? How was this need determined?
  - Do the zip codes of your dental patients match those of your service unit?
  - Are the majority of your dental patients also users of the health center medical services?
- Use data and cite your sources
Some additional sources for Data!

- American Fact Finder (US. Census Bureau) [http://factfinder.census.gov](http://factfinder.census.gov)

- Centers for Disease Control
  - [http://www.cdc.gov/OralHealth/state_programs](http://www.cdc.gov/OralHealth/state_programs)


- Health Data Tools and Statistics [https://phpartners.org/health_stats.html](https://phpartners.org/health_stats.html)


Chapter 4: Required and Additional Services

Requirements:

• *Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.*

• *Health centers requesting funding to serve homeless individuals and their families must provide substance use disorder services among their required services.*
Required and Additional Services

• Ensures the health center is directly providing or has written arrangements and referrals in place to provide a comprehensive array of required and as necessary, additional primary and preventive services that meet the needs of the populations it serves.

• In scope referral arrangements must be formally documented in a written agreement (MOA, MOU, etc.) that at a minimum describes the manner by which the referral will be made and managed and the process for referring patients back to the health center for appropriate follow-up care.
Required and Additional Services

- HC patients with limited English proficiency have interpretation and translation available. Staff have availability to cultural competency training to bridge linguistic and cultural differences.

**Cultural Competency Program for Oral Health Providers**

- This free online course developed by the Department of Health and Human Services offers six hours of free continuing education credits.
<table>
<thead>
<tr>
<th>5A Service</th>
<th>Service Descriptor</th>
<th>Statute Reference</th>
<th>Regulation Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Dental</td>
<td>Preventive dental services prevent diseases of the oral cavity and related structures. At a minimum, these services include all of the following: • basic dental screenings and recommendations for preventive intervention; • oral hygiene instruction and related oral health education (e.g., prevention of oral trauma and oral cancer); • oral prophylaxis, as necessary; and • topical application of fluorides (e.g., fluoride varnishes) and the prescription of fluorides for systemic use when not available in the water supply. Services may include application of sealants, and diagnostic screening for caries and periodontal disease through the use of dental x-rays.</td>
<td>Section 330(b)(1)(A) “(i) Basic Health Services: ... (III) Preventive Health Services, including...(hh) preventive dental services”</td>
<td>42 CFR, Part 51c.102(h) “Primary Health Services means... (6) Preventive dental services provided by a licensed dentist or other qualified personnel, including (i) oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply.”</td>
</tr>
<tr>
<td>Pharmaceutical Services</td>
<td>Pharmaceutical services provide access to prescribed medications. These services may include a broad spectrum of functions ranging from the dispensing and tracking of medications to pharmacist-delivered patient care services (e.g., disease state management, medication reconciliation, therapeutic monitoring, wellness promotion, and disease prevention).</td>
<td>Section 330(b)(1)(A) “(i) Basic Health Services: ... (V) pharmaceutical services as may be appropriate for particular centers”</td>
<td>42 CFR, Part 51c.102(j) “Supplemental health services means health services which are not included as primary health services and which are: ... (9) Pharmaceutical services, including the provision of prescription drugs;”</td>
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Form 5A—Additional Dental Services

**ADDITIONAL SERVICES**

<table>
<thead>
<tr>
<th>Additional Dental Services</th>
<th>Not described</th>
<th>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</th>
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<tbody>
<tr>
<td>Additional dental services are basic services at a general practice level to diagnose and treat disease, injury, or impairment in teeth and associated structures of the oral cavity and include any diagnostic x-rays or imaging. These services may include: fillings and single unit crowns; non-surgical-endodontics, extractions, periodontal therapies, bridges or dentures. Complex dental services (e.g., oral surgery, surgical endodontics, orthodontics) are considered specialty services.</td>
<td>Not described</td>
<td>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</td>
</tr>
</tbody>
</table>
What Does This Mean to Dental?

- Is your scope of service reasonable, in alignment with the standard of care within your community and timely?

- Where do you refer patients for services that you don’t deliver? Be ready with lists and other documentation.

- What written agreement is in place with these providers? Be able to demonstrate/discuss the fees and discounts your patients can expect to receive from these referral providers.

- How do you track referrals to make sure the patient got the necessary care? Did you get written feedback? Document!
What Does This Mean? (cont.)

• Does the health center provide training on cultural competence to all staff? Is this part of new staff orientation?

• Do you have educational materials and patient information that reflect the primary language(s) your patients speak?

• Be able to describe the interpreter services available for your non-English speaking patients?
Chapter 5: Clinical Staffing

Requirements:

- Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged.

- The health center must [ensure that its] services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.
Staffing Requirements

• Staff composition and numbers must support the health center’s Health Care Plan including required and additional services, either directly or by referral.

• Staffing should be culturally and linguistically appropriate for the population being served and as noted in the health center’s needs assessment.

• The HC has standard procedures for granting and recurring review of staff privileges, as well as regular review of credentials, while maintaining adequate records of such. The same is true for other contracted providers serving at the HC.
What Does This Mean for Dental?

• All provider licensure is on file and up to date—make copies and have a folder ready in case you are asked to show this.

• Are providers credentialed and privileged for the services they are providing? Is there documentation of this? (privileging form). Be able to show your policy and processes related to this area. Updates?

• Do you have up-to-date job descriptions for all dental staff members ready to show?

• Does your staff have copies of their job descriptions?
What Does This Mean? (Cont.)

• Is there a formal dental orientation for new staff? Be prepared to show your policy and checklist.

• Are you fully staffed as to budgeted positions? How are you addressing vacancies? How are you recruiting?

• Do you maintain employee files in the dental area? Are they locked and secure?

• Do you have staff members on contract? If so, do you have copies of their current contracts on file and readily available?

• Are all contracted staff or volunteer providers credentialed and privileged?
Chapter 6: Accessible Locations and Hours of Operation

Requirement:

The required primary health services of the health center must be available and accessible in the service area promptly, as appropriate, and in a manner which assures continuity of service to the residents of the center’s service area.
Accessible Hours of Operation/ Locations

• The **times/hours** that services are provided are **appropriate to ensure access** for the health center’s patient population.

• The **locations** at which services are provided must be **accessible to the patient population**.

• **Appropriate consideration is taken into account in determining site/service locations and hours of operation** for health centers serving special populations. (migrants, homeless or public housing)

• The HC determines how to best obtain patient input on accessibility and how to measure distance/travel time when accessing **impact on patient access**.
What Does This Mean for Dental?

• Are you open at times that assure accessibility and meet the needs of your patients? (evening, early morning or Saturday hours) This means when it is convenient for your patients...not the staff.

• Do you offer services at locations that assure accessibility and meet the needs of your patients?

• Can individuals in your defined service area get to your dental program readily? If not, can you bring portable/mobile services to them?

• Are there other strategies to increase access in play or meet unmet need/demand for care?
Chapter 7: After-Hours Coverage

Requirement:

Health center provides professional coverage for medical emergencies during hours when the center is open and closed.
After Hours Coverage

• There are provisions for promptly responding to patient medical emergencies during regularly scheduled hours.

• After hours coverage includes the provision, through clearly defined arrangements, for access of health center patients to professional coverage for emergencies after the center's regularly scheduled hours.

• Specific arrangements for after hours coverage (such as in a rural area) may vary by community. However, all health centers must have some type of clear arrangement(s) for after hours coverage.
After Hours Coverage

• The coverage system should ensure telephone access to a covering clinician (not necessarily a health center clinician), who can exercise independent professional judgment in assessing a health center patient's need for emergency care and who can refer patients to appropriate locations for such care, including emergency rooms, when warranted.
What Does This Mean for Dental?

How do you address patients who call after hours with dental needs?

- Is there a message about emergency coverage on the dental department phone? Is there reference to dental emergencies on the overall HC after hours message?
- Is the message in the language(s) your patients speak?
- Is there written information on what to do after hours in all relevant languages? When is this shared with the patient?
Chapter 8: Continuity of Care & Hospital Admitting

Requirements:

• The health center must provide the required primary health services of the center promptly and in a manner, which will assure continuity of service to patients within the center’s catchment area.

• The health center must develop an ongoing referral relationship with one or more hospitals.

CONTINUITY OF CARE
not just a catchphrase

safety net
solutions

NNOHA
National Network for Oral Health Access

DentaQuest INSTITUTE
Continuity of Care and Hospital Admitting

• All health centers must either have admitting privileges for their physicians at one or more referral hospitals, or some other arrangements that ensure continuity of care.

• In cases where hospital admitting privileges and membership are not possible, the health center must have firmly established arrangements for patient hospitalization, discharge planning, lab results and tracking.
What Does This Mean for Dental?

• Generally does not apply to dental

• If your health center treats dental patients in a hospital operating room, this requirement very well could apply.
Chapter 9: Sliding Fee Discount Program

Requirements:

• *No patient shall be denied service due to an inability to pay.*

• *The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to covers its reasonable costs of operation and must prepare a corresponding schedule of discounts to be applied to the payment of such fees...by which discounts are adjusted on the basis of the patient’s ability to pay.*
Chapter 9: Sliding Fee Discount Program

Requirements:

• The health center must establish systems for [sliding fee] eligibility determination.

• The health center’s schedule of discounts must provide for:
  ▪ A full discount to individuals and families living at or below 100% of the federal poverty level, except that nominal charges for service may be collected...where imposition of such fees is consistent with project goals
  ▪ No discount to those living above 200% of FPL
KEEP CALM AND WAIT AND SEE

Learn more
Chapter 10: Quality Improvement / Assurance

Requirements:

• **Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.**

• **This ongoing QI/QA system must provide for all of the following:**
  - Organizational arrangements, including a focus of responsibility, to support this program and the provision of high quality patient care;
  - Periodic assessment of the appropriateness of the utilization and quality of services provided or proposed to be provided to HC patients.
Chapter 10: Quality Improvement / Assurance

Requirements continued:

- **Such periodic assessments must:**
  - Be conducted by physicians or other licensed health professionals under the supervision of physicians;
  - Be based on the systematic collection and evaluation of patient records;
  - Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and
  - Identify and document the necessity for change in the HC services and result in the institution of such change, where indicated.
Quality Improvement / Assurance Plan

The QI/QA program must include:

• Board approved policies that establishes the QI/QA program that addresses:
  ▪ Quality and utilization of health center services
  ▪ Patient satisfaction and grievance processes
  ▪ Patient safety, including adverse events

• An individual to oversee this program whose responsibility is to support the quality improvement/assurance program and the provision of high quality patient care.

• Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center.
What Does it Mean for Dental?

• If you still have paper charts in dental, are they secured when staff is not present?

• Is the dental director responsible for QI/QA or is it delegated?

• Do you have a process for periodic chart reviews? If so, who does them and how often? How are the results shared and used?

• Is there a formal process to follow up on deficiencies noted during these reviews? Are formal action plans developed and documented? Is regular re-evaluation part of your overall QI/QA process?

• Why do you still have paper records?
What Does it Mean for Dental? (cont.)

- Do your records have standardized content and organization?
- Is patient information handled in a way that is HIPAA compliant?
- Is there a process within your health center (including dental) to report/track incidents/adverse outcomes? What happens with these reports? How is follow-up documented?
- Is the dental program tracking clinical outcome measures? Where are they reported? How are the results used? Be ready with data!
Chapter 11: Key Management Staff

Requirements:

• Health center must have position descriptions for key management staff that set forth training and experience qualifications necessary to carry out the activities of the health center.

• Health center must maintain such key personnel to carry out the activities of the health center.

• HC must request prior HRSA approval for a change in the key personnel specified in the HC Program award or look-alike designation.
Key Management Staff

Health center demonstrates compliance by fulfilling all of these:

• Determining the makeup of and distribution of functions among key management staff to carry out the HRSA-approved scope of project, and documenting their training and experience qualifications.

• Implementing, as necessary, a process for filling vacant key management staff positions.

• Keeping the HC Board informed of the above issues by the HC project director/CEO.

• If there is a post-award change in the project director/CEO position, the health center requests and receives prior HRSA approval.
What Does it Mean for Dental?

• Is there a dental director? Is this person an active member of the Health Center executive leadership team?

• Does the dental director have regularly scheduled time for administrative duties?

• Does the dental director regularly interact with other department heads...to improve *overall health*?

• Does the dental director have the opportunity to report on oral health directly to the health center board of directors?
Chapter 12: Contracts and Subawards

Requirements: Procurement and Monitoring

- The health center must determine whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.

- The HC must request and receive approval from HRSA to contract for [substantive programmatic] work under its 330 award.

- The health center must have its own documented procurement procedures in place...and paragraphs more...
Chapter 12: Clarification of terms

- The purpose of a subaward is to carry out a portion of the Federal award and create a Federal assistance relationship with the subrecipient, while...

- The purpose of a contract is to obtain goods or services for the health center’s own use and creates a procurement relationship with the contractor.

- In determining whether an agreement between a pass-through entity (HC) and another non-Federal entity casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement...the HC just use judgment in classifying each agreement as a subaward or a procurement contract.
Contracts and Subawards...

- The health center has the appropriate amount of oversight and the ability to maintain its independence and compliance for all contracted services and affiliation agreements.

- All contractual arrangements must comply with Federal procurement standards set forth in 45 CFR Part 75 (including conflict of interest standards).
What Does it Mean for Dental?

• If the dental program utilizes contracts or subawards, they must meet health center requirements.

• Affiliation agreements or contracts must not:
  ▪ Threaten the health center’s integrity
  ▪ Compromise compliance with any other Program Requirements
  ▪ Limit the health center’s autonomy

• Generally, no “handshake” agreements
STRETCH BREAK!!!!
Chapter 13: Conflict of Interest

Requirements:

• The health center must maintain written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award, or administration of contracts that comply with all applicable Federal requirements.

• No employee, officer or agent of the health center may participate in the selection, award, or administration of a contract supported by a Federal award if he or she has a real or apparent conflict of interest.

• Officers, employees, and agents of the HC may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts.
Chapter 13: Conflict of Interest

Requirements:

• The health center’s standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the health center.

• If the health center has a parent, affiliate, or subsidiary organization that is not a State, local government, or Indian tribe, the health center also must maintain written standards of conduct covering organizational conflicts of interest.
Chapter 13: Conflict of Interest

The HC demonstrates compliance by fulfilling all of the following:

• The HC has and implements written standards of conduct that apply, at a minimum, to its procurements paid for in whole or in part by the Federal award....these standards cover organizational conflicts of interest when conducting a procurement action involving a related organization.

• The HC has procedures for informing its employees, officers, board members, and agents of these written standards...

• In cases where a conflict of interest was identified, the health center’s procurement records document adherence to its standards of conduct.
What Does it Mean for Dental?

- Don’t assume someone’s financial interest is not substantial or a gift is an unsolicited item of nominal value and, therefore, could be accepted by employees, officers, board members, and agents of the health center.

- This is not a time to “ask forgiveness, instead of permission” as you could place your Federal award in jeopardy.

- It is fine to be discrete, but bring your questions to someone higher up in the organization. Document their response. CYA
Conflict of Interest
Chapter 14: Collaborative Relationships

Requirements:

• The health center has made and must continue to make every reasonable effort to establish and maintain collaborative relationships, including with other health care providers that provide care within the catchment area [service area], local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments.

• To the extent possible, the health center must coordinate and integrate project activities with the activities of other federally-funded, as well as State and local, health services delivery projects and programs serving the same population.
Chapter 14: Collaborative Relationships

What does this mean for the health center:

• The HC documents its efforts to coordinate and integrate activities with others in the service area, such as adjacent health centers, social service organizations, specialty services, and/or hospitals in order to support:
  ▪ Continuity of care across community providers; and
  ▪ Other health or community services that impact the patient population.

• When the HC seeks to expand its HRSA-approved scope of project, it seeks written evidence of the above coordination and collaboration.

1+1=3
What Does it Mean for Dental?

- Are there any collaborations in place between the dental program and other community organizations, such as hospital ERs, Public Health Departments, private dentists in the community, other health and human service organizations, public schools, WIC, and/or Head Start?

- When do you cross the line between a collaboration agreed to “with a gentle person’s agreement” to the need for a contractual relationship?

- Be prepared to talk about them—show data and storyboards. Make it a win/win for everyone.

- Does your HC mention the importance of oral health in every grant application? If not, why not!
Chapter 15: Financial Management and Accounting Systems

Requirements:

• The health center must maintain effective control over, and accountability for, all funds, property, and other assets in order to adequately safeguard all such assets and ensure that they are used solely for authorized purposes.

• The HC must utilize sound financial management procedures to ensure the fiscal integrity of grant transactions/reports, as well as ongoing compliance with Federal statues, regulations, and terms and conditions of the health center program award or designation.
Chapter 15: Financial Management and Accounting Systems

Requirements:

• The health center’s financial management system must specifically identify in its accounts all Federal awards...

• A health center that expends $750K or more in Federal awards during its fiscal year must have a single or program-specific audit conducted for that year.

• The health center must use any non-grant funds as permitted under section 330, as long as such use is not specifically prohibited under section 330, and furthers the objectives of the health center project.
Financial Management & Control Policies

• The health center has appropriate measures in place to protect its assets and adheres to Federal accounting requirements, including:
  ▪ Accounting and internal control systems that are appropriate to the size and complexity of the organization and reflect Generally Accepted Accounting Principles (GAAP).
  ▪ Policies and processes that safeguard the organization’s assets, including drawing down Federal funds and expending them in a timely manner.

• The health center can determine which accounting software to use; the type, frequency, and format of financial reports; and actions to take in response to negative financial trending.
What Does it Mean for Dental?

• Is there a separate cost center for dental? Is it site specific?
• Does the dental director have input into formulation of the dental budget and receive budget/billing info monthly?
• Does the dental director review and share provider productivity reports?
• Does the dental director receive an aging report for dental broken out by payer source?
• Does the dental director know what the current payer mix is in dental?
What Does it Mean for Dental? (cont.)

- Does the dental program regularly review its financial viability and develop ways to respond to negative variances?
- Does the dental director know the break even number for visits and payer mix?
- Does the dental director know and share the significance of cost savings across the health center due to oral health being integrated into overall health?
- Are gross charges and net revenue tracked and reported by payer type?
- Are your fees reflective of those charged (usual and customary) by private practitioners in the area?
Chapter 16: Billing and Collections

Requirements:

• *The HC must have a fee schedule consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.*

• *The HC must have a sliding fee discount available to assure that no patient is denied care sue to an inability to pay...and establish systems for eligibility determination*

• *The HC must make reasonable efforts to collect reimbursement of its costs associated with Medicaid and CHIP...as well as from patients in accordance with fee schedules and discounts.*
Billing and Collections

• Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement.

• Health centers must bill Medicare, Medicaid, CHIP, and other applicable public or private third party payers in a timely manner.

• Additional billing options are accessible to all patients.

• There are board-approved policies that include the specific circumstances when the HC will waive or reduce fees or payments due to any patient’s inability to pay.

• If a HC elects to limit or deny services based on a patient’s refusal to pay, there are policies that distinguish between refusal and inability to pay...all with proper documentation.
What Does it Mean for Dental?

- Are there written policies for billing, credit and collections?
- Are dental codes updated annually?
- **Who is responsible for dental billing?** How is it done? Through a dental or medical practice management system?
  - If done through medical, how are charges entered? Via HL7 interface or do they have to be entered manually?
  - If entered manually, by whom and when? Who checks to make sure procedures were completely and accurately entered? Who checks to make sure all charges went across the interface?
- Do you know your collection rate? What happens to Accounts Receivable after 90 days?
What Does it Mean for Dental? (cont.)

- How are claims submitted to public and private payers?
- Are patients asked to pay at the time of the visit? What percentage do? Is this tracked and reported anywhere? What is the follow-up with patients who have outstanding balances?
- What is the process for managing denied claims? Are they reviewed in a timely manner? By whom? If inappropriate coding or billing patterns are noted, are procedures adjusted accordingly?
Chapter 17: Budget

Requirements:

• The health center must develop an annual budget that:
  ▪ Identifies projected costs of the HC program project
  ▪ Identifies those costs to be supported by the Federal award
  ▪ Includes all other non-Federal revenue sources that will support the health center, including state, local, and other grant funding, as well as fees and third-party reimbursements

• The health center must submit this budget annually...
What Does it Mean for Dental?

- Is there an annual operating budget for dental?
- Does the dental director provide primary input into the development of the budget and is responsible for it?
- Does the dental director meet regularly with the CFO to discuss and better understand how the dental budget fits into the overall health center budget?

The health center determines how to allocate projected costs between HC program award funds, consistent with Federal requirements, and other projected revenue sources within the annual budget.
Chapter 18: Program Monitoring and Data Reporting Systems

Requirements:

• The health center must establish systems for monitoring program performance to ensure:
  ▪ Oversight of the Federal award
  ▪ Performance expectations are being achieved
  ▪ Areas for improvement in program outcomes and productivity are identified
Chapter 18: Program Monitoring and Data Reporting Systems

Requirements:

• The health center must compile and report data and other info as required by HRSA, relating to:
  ▪ Costs of health center operations
  ▪ Patterns of health center service utilization
  ▪ Availability, accessibility, and acceptability of HC services

• The health center must submit required data and info to HRSA in a timely manner and with HRSA prescribed frequency
Program Data Reporting Systems

• The health center has a Management Information System (MIS) in place that accurately collects and produces data to support health center oversight and direction.

• The health center submits accurate and timely reports, related to the HRSA-approved scope of project as required, including data elements for UDS reporting.

• The health center provides a complete Health Care and Business Plan with its annual application to demonstrate performance improvement.
What Does it Mean for Dental?

• Does dental have an electronic dental record system?
• Is it integrated seamlessly with the EMR...becoming an EHR?
• Does the dental program have specific metrics that will be used to evaluate program success? How were these determined?
• Does dental leadership have ready access to reports that will show performance in meeting/exceeding the dental and overall health center program metrics?
• Does dental leadership use dashboards to track and report success in meeting performance metrics?
What Does it Mean for Dental? (cont.)

• Is there a process for regularly sharing dental program performance with administrative leadership and dental staff?

• Does dental leadership use data to make informed decisions about changes in oral health program operations?
Chapter 19: Board Authority

Requirements:

• *Health center governing board maintains appropriate authority to oversee the operations of the center, with bylaws that specify the responsibilities of the board.*

• *The Board must hold monthly meetings and document attendance, key actions and decisions.*

• *The Board approves the selection and termination/dismissal of the HC chief executive officer.*

• *The Board establishes/adopts health center policies, conducts long-range planning, and adopts a three year fiscal plan.*
Board Authority

The Health Center Board:

• Reviews and approves the services to be provided and the health center’s hours of operation.

• Measures and evaluates the health center’s progress in meeting annual and long term clinical and financial goals.

• Engages in strategic and/or long term planning for the health center.
Board Authority

The Health Center Board:

• Reviews the health center’s mission and bylaws as necessary on a periodic basis.

• Receives appropriate information that enables it to evaluate health center patient satisfaction, organizational assets, and performance.

• Establishes the general policies, which must include, but are not limited to: personnel, health care, fiscal, and quality assurance/improvement policies for the organization.
What Does it Mean for Dental?

• Be prepared to share performance data for dental regularly with the Board *(offer to do this if you’re not already!)*

• Any scope of service changes in dental should be approved by the Board

• Any scope of project changes in dental should be approved by the Board

• All significant dental policies should be reviewed regularly by the Board
Chapter 20: Board Composition

Requirements:

• *The health center governing board must consist of at least 9 and no more than 25 members.*

• *Minimally 51% of the board members must be patients served by the health center.*

• *Non-patient board members must be representative of the community served and be selected for their relevant expertise, such as community affairs, local government, finance, legal, trade unions or social service agencies within the community.*
  ▪ *Of these, no more than 50% may derive more than 10% of their annual income from the health care industry.*
Chapter 20: Board Composition

Requirements:

• A board member may not be a HC employee, or spouse, child, parent, brother or sister by blood or marriage of such an employee.

• The CEO may be a non-voting, ex-officio member of the board.

• The HC bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members.

• If the HC receives migrant, homeless or public housing awards and does not receive an award/designation under section 330(e), the HC may request approval from HRSA for a waiver of the patient majority board composition government requirement.
Board Composition

• A majority (at least 51%) of the board members receive services (i.e., are patients) at the health center.

• As a group, the “patient/consumer” board members must reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and gender.

• In cases where language or literacy may present a barrier to board members’ evaluation of written materials, the HC determines how to ensure meaningful participation.
What Does it Mean for Dental?

• How many Board members access dental care in the HC?
• Can you recommend any dental patients for the Board?
• For the 49% of non-patient Board members, are there any private practice dentists in the community that are (or might be) champions for your oral health program?

Such dentists should offer to serve on board committees, such as finance or clinical, to gain familiarity with the health center and to let the current board get to know them.
Chapter 21: FTCA Deeming Requirements

Requirements:

• Health center has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed.

• Has reviewed and verified the professional credentials, references, claims history, fitness, professional review organizations findings, and license status of its physicians and other licensed or certified healthcare practitioners.

• Has no history of claims, or, if such claims exist, fully cooperates with the Attorney General in defending such claims in the future; and

• Will fully cooperate with the Attorney General and other applicable agencies in providing required information.
FTCA Deeming Requirements

Health center demonstrates compliance by fulfilling all of these:

- **Credentialing and Privileging**
  - *The health center is in compliance with all of the credentialing and privileging requirements of Chapter 5: Clinical Staffing and all requirements within Chapter 10: Quality Improvement/Assurance prior to the deeming determination*
FTCA Deeming Requirements

• **Risk Management**
  – The health center has and currently implements an ongoing health center risk management (RM) program to reduce the risk of adverse outcomes that could result in malpractice or other health-related litigation that requires the following:
    • RM across the full range of health center activities;
    • RM training for all health center staff
    • RM assessments completed quarterly
    • RM report presented to the BOD inclusive of:
      – Completed RM activities
      – Status of established RM goals
      – Proposed RM activities that relate or respond to identified high risk areas within the center
FTCA Deeming Requirements

• Risk Management Continued
  
  – The health center has RM procedures that address the following areas for health center services and operations:

  • Identifying and mitigating areas/activities of highest risk within the center’s approved scope of project, including but not limited to tracking referrals, diagnostics, and hospital admissions ordered by RM across the full range of health center activities;

  • Documenting, analyzing, and addressing clinically-related complaints and “near misses” reported by health center employees, patients and other individuals

  • Setting and tracking progress related to annual RM goals
FTCA Deeming Requirements

• **Risk Management Continued**
  
  • *Developing and implementing* an annual RM training plan for all staff based on identified areas/activities of highest clinical risk—including, but not limited to, obstetrical procedures and infection control and any non-clinical training appropriate for staff such as medical record confidentiality requirements
  
  • *Completing* an annual risk management *report* for BOD and key management staff

  – The health center *provides reports* to the BOD and key management staff on RM activities and progress in meeting goals at least annually, and provides *documentation* to the BOD and key management staff showing that any related *follow-up actions* have been implemented.
FTCA Deeming Requirements

- **Risk Management Continued**
  - The health center has a RM training plan for all staff and documentation showing that such trainings have been completed at least annually
  
  - The health center designates an individual(s)- for example, a risk manager who oversees and coordinates the center’s RM activities and completes RM training annually
FTCA Deeming Requirements

• **Claims Management**
  – The health center has a claims management process for addressing any potential or actual claims, including medical malpractice, that may be eligible for FTCA coverage. RM across the full range of health center activities. In addition, this process ensures:
    • Preservation of all center documentation related to any actual or potential claim or complaint (for example: MR and associated laboratory and x-ray results, billing records, employment records of all involved providers. Clinic operating procedures)
    • Any service-of-process/summons that the center or its providers receives is promptly sent to HHS, Office of General Counsel, Law Division, per the process prescribed by HHS as described in the FTCA Health Center Policy Manual
FTCA Deeming Requirements

- **Claims Management**
  - Designates an individual(s) who is responsible for the management and processing of claims-related activities and serves as the claims point of contact
  
  - Informs patients using plain language that it is a deemed Federal PHS employee via its website, promotional materials and/or visibly posted signs within the center
  
  - Documents it cooperated with the Attorney General, as outlined in the FTCA manual and implemented steps to mitigate the risk of future claims if center has a history of claims
What Does it Mean for Dental?

- Do you review and approve the dental providers credentialing and privileging based on review of their file?
- Do you conduct quarterly provider peer review?
- Do you document action plans and follow-up activities that have been implemented based on these reviews, patient complaints and near-misses? Do you provide the BOD and key management staff with an annual report demonstrating these actions and activities?
- Do you know who your center’s risk management and claims management designated individual is?
What Does it Mean for Dental? (cont.)

- Is there a process within the dental department to assess areas of highest risk within your HRSA approved scope of project? Is this assessment utilized to develop annual dental risk management training?
- Do you determine annual dental RM goals, set, track and provide quarterly progress reports to key staff and BOD?
- Do you have an annual dental risk management plan and documentation showing trainings have been completed?
- Are you aware of the Claims Management process and steps for addressing any claims as outlined in the FTCA Health Center Manual?
What Does it Mean for the Center?

- FTCA Requirements are more clearly defined in the Compliance Manual.
- FTCA and OSV Credentialing and Privileging and Quality Improvement/Quality Assurance requirements are aligned.
- Center will need to address QI/QA and/or C & P non-compliance findings prior to satisfying FTCA redeeming.
Part 3: Taking a Closer Look: Fees and Discounts
Applicability

• Applies to all 330 Program grantees and look-alikes

• Only applies to services/activities within the health center’s federally approved scope of project

• The HRSA Compliance Manual is the only guidance that governs fees, sliding fees and nominal fees at this time: https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html

• HRSA Compliance Manual supersedes PIN 2014-2
General Requirements

• Health center must prepare a schedule of fees or payments for its services consistent with locally prevailing rates or charges and designed to cover reasonable costs of operation

• No patient shall be denied service due to inability to pay

• The sliding fee discount program incorporates the most recent Federal Poverty Guidelines (FPG)
General Requirements

• Eligibility for the sliding fee discount program is based only on family size and income – no other factors

• No specific requirements for how often patients need to be assessed/reassessed for SFDS eligibility (used to be annually)

• Health center must prepare a corresponding schedule of discounts (SFDS) applied to the payment of fees adjusted on the basis of the patient’s ability to pay

• Health center must establish systems for determining patient eligibility for SFDS
General Requirements

• Full discounts to individuals and families with annual incomes at/ below 100% of Federal Poverty Guidelines (FPG) unless the health center elects to have a nominal charge (which must be a flat fee)

• Partial discounts for those with incomes between 101% and 200% of FPG

• No discounts for patients with incomes over 200% of FPG

• At least three discount categories between 101% and 200% of FPG
# Federal Poverty Guidelines

### 2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>Poverty guideline</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
</tr>
<tr>
<td>2</td>
<td>16,240</td>
</tr>
<tr>
<td>3</td>
<td>20,420</td>
</tr>
<tr>
<td>4</td>
<td>24,600</td>
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</tr>
<tr>
<td>7</td>
<td>37,140</td>
</tr>
<tr>
<td>8</td>
<td>41,320</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons add $4,180 for each additional person; different poverty guidelines for Alaska and Hawaii.
Governing Board Oversight

Health center must have Board-approved policies for its sliding fee discount program that applies uniformly to all patients, including:

1. Definitions of income and family
2. Affirmation that eligibility for SFDS will be based only on family size and income
3. Specify methods used to assess eligibility, such as documentation required and how often eligibility will be assessed
4. Define how the SFDS will be structured to ensure compliance with HRSA guidance
5. If a nominal fee is charged to patients at/below 100% FPG (as opposed to full discounts), detailing the methods used to determine that the fee is nominal from the patient’s perspective, such as patient surveys or patient Board member input
Fee Schedule

• The health center must assure that fees are set to cover reasonable costs of operation and are consistent with locally prevailing rates or charges for the service

• The health center’s fee schedule must address all in-scope services (required and additional)

• The health center uses data on locally prevailing rates and health center costs to develop and update its fee schedule (health center has latitude in choosing what data to use)
Fee Schedule

• The health center must assure that fees or payments will be reduced or waived to assure that no patient will be denied such services due to their inability to pay for such services (the circumstances related to waivers should be spelled out in policy format and approved by the Board)

• Can require self-pay patients to pay lab charges out-of-pocket (must inform patients of these charges prior to the time of service)

• Health center has latitude in what/how to charge patients for these lab fees (eg, at cost, discounted)
Determining Eligibility for SFDS

- Health center has latitude in deciding whether to make patients who refuse to provide documentation for sliding fee schedule determination ineligible for discounts.

- Health center *can* take its patient population into consideration when developing processes related to determining eligibility, such as availability of documentation for homeless patients, but does not have to.

- Health center has latitude to decide what measures it will take to inform patients of the availability of SFDS discounts, such as materials in language(s)/literacy level appropriate for patient population, as part of intake process, info on website.
Determining Eligibility for SFDS

• Entire SFDS program should be evaluated at least once every three years (no longer required to do it annually)
  ✓ Evaluate utilization data to determine percentage of patients within each slide category, including 100% FPG
  ✓ Take this and other data, such as results of patient satisfaction surveys or focus groups, or self-pay patient surveys, to ensure SFDS program is not a barrier to care
  ✓ Make changes to the program as needed
Determining Eligibility for SFDS

• An outside grant or subsidy may be applied against the patient’s portion of the sliding fee discount (eg, special grants to help subsidize care to patients above 200% FPG)
Sliding Fee Discount Schedule Structure

• Dental nominal fee can (and probably should) be different than the medical nominal fee

• Health centers can set their own discount schedule, percentage of discounts, nominal fees they charge

• All in-scope services provided via formal written contracts/agreements must follow HRSA SFDS guidelines

• Health centers are responsible for ensuring that fees for services provided via contractual agreements are compliant with SFDS requirements
Sliding Fee Discount Schedule Structure

• Health centers must have a gradation of discounts for income levels between 101% and 200% (discount cannot remain at a constant level across discount categories)

• Not permissible to provide a full discount for patients above 100% FPG
Establishing and Collecting Nominal Charges

• Any health center that chooses to establish a nominal charge must ensure that patients are not impeded in accessing services due to an inability to pay

• A nominal charge **must be a fixed fee** that does not reflect the true value of the service(s) provided and is considered nominal from the perspective of the patient

• The nominal charge must be less than the fee paid by a patient in the first “sliding fee discount pay class” beginning above 100% of the FPG (eg, Slide A is nominal fee, Slide B is patients 101-125% of FPG)
Insured Patients Who Are Also Eligible for SFDS

• Important to know your state laws and various insurance plan policies on the application of sliding fee discounts

• Income and family size make many insured individuals eligible for sliding fee discounts too

• Generally, if allowed, the insurance is billed at their normal rate and the patient’s co-pay portion is discounted based on their sliding fee schedule percentage

• Some insurance plans do not allow this, so be sure to check!
Multiple Sliding Fee Discount Schedules

• Health centers can have different sliding fee schedules for different service categories

• The SFDS must comply with federal rules as to nominal fee, minimal fees, and percentage discounts between 100% and 200% federal poverty levels

• Only one nominal fee within a single SFDS

• The board must determine the nominal fee and assure it does not create a barrier to care for the lowest income populations
Laboratory Charges

• Costs for items done outside the health centers (3rd party lab charges) are exempt from sliding fee discounts and the actual cost can be charged to the patient

• The professional services performed within the health center are subject to all sliding fee discount conditions

• Nominal or minimal fees can be charged to the patient for each visit where lab fees have also been incurred and charged

• Payment options and lab or separate eligible service costs must be discussed up front prior to services and referenced in written documentation
Sample Fee Schedule with Labs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Full Fee</th>
<th>Lab</th>
<th>Slide A-- Patients at/below 100% FPG-- Patient pays $35 per visit</th>
<th>Slide B-- 101-125%, Patient pays 30% of fee</th>
<th>Slide C-- 126-150%, Patient pays 40% of fee</th>
<th>Slide D-- 151-175%, Patient pays 50% of fee</th>
<th>Slide E-- 176-200%, Patient pays 60% of fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis, Adult</td>
<td>$ 130.00</td>
<td>$0</td>
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<td>$ 52.00</td>
<td>$ 65.00</td>
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</tr>
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<td>$0</td>
<td>$ 35.00</td>
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<td>$ 88.00</td>
<td>$110.00</td>
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<td>$420.60</td>
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</tr>
</tbody>
</table>
Sliding Fee Discounts—Are You Ready?

• Is there signage about the availability of discounts for eligible patients? In appropriate languages?

• Are dental fees consistent with locally prevailing rates and designed to cover the reasonable costs of operations? Can you explain how you determined your fees? When were they last updated? Did your Board review and approve them?

• Do patients at or below 100% pay no fees or only a nominal fee? What is your nominal fee? How do you know your nominal fee is not a barrier to care? (tip: look at payer mix to determine the percentage of uninsured patients at/below 100% FPG)

• Do you have a minimum of three discounts for patients between 101% and 200% based on family size and income?
Fees/SFDS—Are You Ready? (Cont.)

- Are patients above 200% of FPL charged full fees?
- Are new patients evaluated during registration to determine their eligibility for the sliding fee scale? Do you require patients to provide proof of income?
- What happens if a patient refuses (or is unable) to provide proof of income?
- Do you have Board-approved policies defining all aspects of the SFDS program?
Sliding Fee Discounts—Are You Ready?

• What discounts do your patients get from outside providers with which you have formal contractual arrangements? Do they comply with HRSA guidelines? Do you have supporting documentation?

• Are you using the most current Federal Poverty Guidelines?
Actions to Consider

• Review all intended or provided dental services, performing a cost analysis on each and making informed decisions about scope, nominal fee, and sliding fees in dental

• Decisions should not be made on guess work, instinct or intuition but should be made using timely, meaningful and accurate data to inform those decisions
Case Study

• An FQHC in Pennsylvania was concerned that it was “losing its shirt” providing molar root canals, crowns and dentures to nominal fee patients

• They were strongly considering dropping all such “high-end” services

• We analyzed the data related to those services for a three-month period
The Results

• Total of 110 patients received specialty services (average of 37 per month)

• Over half of patients had Medicaid, 3% commercial and 45% uninsured

• 39 patients had root canals. Total revenue = $6,995. Average revenue per patient $243

• 52 patients got dentures. Total revenue = $22,995. Average revenue per patient was $460

• 19 patient got crowns. Crown revenue = $5,814. Average revenue per patient was $323.

• Average net revenue per visit for all specialty services = $325.50

• Average cost per patient = $117
The Takeaways

• Shows the importance of using data to make informed decisions!
• Watch the number of specialty services being provided
• Monitor the payer mix for specialty services
• Monitor what’s being collected for each service
• Calculate revenue per visit vs. cost per visit
• THEN decide what to do based on what the data is telling you
Potential Strategies

• Use designated access scheduling to restrict the number of specialty cases that can be started in a given period

• If you do this, create objective criteria to determine who gets these appointments (can’t be only given to insured patients!!!!)

• Can also consider taking specialty services out of scope (requires formal approval from HRSA and the creation of a “firewall” between in-scope and out-of-scope services)
Key Cost-Related Data to Help Determine Scope of Service

- Cost per visit (expenses divided by number of visits)
- Lab, supplies, time and costs for each procedure
- Reports on services provided by ADA code (transaction report)
- Calculation of RVUs for all services divided by expenses (determines the cost for each RVU provided)
Questions/Discussion
Thank You!!!!!!
Please take a few moments before you leave to complete the post-evaluation