

Partnering California's Health Centers with Private Dentists: Why and How?

A Care Delivery Innovation for California FQHCs

A Companion to the FQHC Handbook

Developed with the support of the California HealthCare Foundation

by the Children's Dental Health Project



Federally Qualified Health Centers' contribution to dental care in California

Despite its small size relative to the private dental care delivery system, the dental “safety net” is an essential provider of care to low-income and special needs populations in California^{i iii} and the nation.^{iv} Predominant among safety net sites are Federally Qualified Health Centers (FQHCs)—primary health care clinics that are recognized and partially funded directly by the US Federal Government. By 2009, after considerable growth, California’s network of FQHCs comprised nearly 1000 sites located in 48 of 58 counties.ⁱ While all FQHCs deliver primary medical care, not all have on-site dental care capabilities.^v Many face challenges in ‘providing or arranging for’ dental care as required by federal regulation.

California FQHCs employ 450 full-time-equivalent dentists among the States 26,500 active practitioners^{vi} yet provide a disproportionate volume of dental care to socially vulnerable individuals. They include Medi-Cal beneficiaries and others who are low-income, medically compromised, and disabled. For example, in 2007—before California Medi-Cal eliminated dental benefits for most adults in July 2009—the 2% of FQHC dentists provided nearly one-tenth (9%) of all dental care for Medi-Cal beneficiaries.ⁱⁱⁱ Medi-Cal patients treated that year in FQHC dental programs included over 20,000 seniors; 73,000 adults, 37,000 who have disabilities; and 83,000 children, 5,000 who have disabilities.

Because the private dental sector is far larger, however, the majority of Medi-Cal services are provided in private dental offices. Ninety-one percent of Medi-Cal beneficiaries who received dental care in 2007 (1.8 million) obtained services from the 40% of California’s dentists who were then Medi-Cal providers. Nonetheless, despite the contributions of both the public and private care systems, far greater numbers of Medi-Cal beneficiaries received no dental service at all (6 million comprising 75% of Medi-Cal beneficiaries).ⁱⁱⁱ

Even before the benefit elimination, lack of access from the small dental safety net and paucity of private practitioners active in Denti-Cal (the dental component of Medi-Cal) was associated with poor oral health and lack of dental care for targeted populations. Latino and non-English speakers reported higher levels of not obtaining dental care in the prior year (25% Latino versus 18% non-Latino; 30% non-English speakers versus 19% English speakers). A third (32%) of poor and low income individuals report being “unable to get needed dental care” compared to a tenth (9%) of high income Californians. Twice as many Latinos as non-Latinos (19% versus 10%) and twice as many non-English speakers as English speakers (23% versus 11%) similarly reported being unable to access care. Among those who cannot find care when needed, three times more consider their oral health to be only “fair or poor” rather than “good to excellent” (25% versus 8%).^{vii}

FQHCs are designed to serve these populations. California FQHC’s clients are poor (76%) or low-income (19%), primarily minority (62%) with half preferring languages other than English (49%). More than a third (38%) are enrolled in Medicaid while nearly half (45%) are uninsured and pay for services on an income-based sliding fee schedule.ⁱⁱ Because of their demographics, their pent-up dental needs, and their high prevalence of complex illnesses and disabilities, these patients often present significant clinical challenges.^v The California HealthCare Foundation in August 2008 reported that “compared to patients seen in private practice, those served by public dental clinics have substantially more complex dental treatment needs, are more likely to be medically compromised, and have poorer compliance to recommended self care.”^v

As a result of the dental benefit elimination, today California dentists participate in Medi-Cal at about the same modest rates as do their counterparts across the country. While more than a 735,000 California residents are insured through the program, only 25% of California private dentists now participate in Medi-Cal.ⁱⁱ The loss of coverage and associated loss of participating dentists adds greater pressure on FQHCs and other safety net providers to deliver dental services to socially vulnerable populations.

In seeking to expand FQHC’s contribution to dental care, the California HealthCare Foundation reports that “FQHCs...could potentially take on more patients. However they face numerous obstacles in establishing or expanding dental services.”^v These impediments fall into four categories: (1) high start-up and operating costs; (2) unfavorable payer and patient mix; (3) staff recruitment, retention, and training challenges; and (4) leadership and management deficits. The report provides a number of

recommendations to address these impediments including increasing efficiency, expanding physical capacity, and expanding workforce. One approach not considered in the earlier report is contracting private dentists with FQHCs so that these private dentists can provide services to FQHC patients in their private offices. Such contracting addresses two of the four obstacles: the high costs of providing care on site at the FQHC and attracting sufficient numbers of providers. This brief explains this public/private contracting option.

Public/Private Contracting

Given the physical and personnel limitations of delivering dental care within FQHC sites, the Children's Dental Health Project (CDHP) has worked since 2001 to advance the concept of public/private contracting. Originally with support from the Connecticut Health Foundation and collaboration with the American Dental Association and the National Association of Community Health Centers, CDHP explored this concept with federal officials at the Centers for Medicare and Medicaid Services (CMS, which regulates Medicaid programs) and the Health Resources and Services Administration (HRSA, which regulates FQHCs). Its resulting 2003 publication, *Increasing access to dental care through public/private partnerships: contracting between private dentists and Federally Qualified Health Centers*,^{vii} provides a "how-to" Handbook on public/private contracting. This handbook was updated in 2010 with the support of the California HealthCare Foundation.

The Handbook describes these public/private partnerships as having many advantages to both the dentist and health center:

Dentists can provide services to Medicaid patients without necessarily registering as Medicaid providers; are relieved of most responsibilities to bill FQHC patients or their insurers; can predetermine blocks of time, numbers of patients or numbers of visits they wish to provide for care of the underserved; and can answer the needs of those in their community who have the most need and least access to care. For health centers, contracting allows them to meet their requirement that they provide dental services to their patients, reduce their need for expensive capitalization of dental facilities and equipment reduce their direct staff costs, expand the number of available dental providers, reduce the length of waiting times for patients to receive services and may help make dental service costs more predictable.^{viii}

Under such partnerships, dentists enter into contracts with FQHCs to provide care to FQHC patients in the dentists' private offices and receive payment from the FQHC based—at the option of the dentist and FQHC—on payment for numbers of services, numbers of patients seen, numbers of visits provided, and/or numbers of hours committed to care of the FQHC's patients. Patients remain clients of the FQHC and do not become patients of record of the dentist. Dentists must be credentialed by the FQHC and must provide detailed clinical and administrative information to the FQHC regarding the care they deliver to FQHC clients. Dentists do not need be registered as Medicaid providers in order to care for FQHC patients covered by Denti-Cal seen in their private offices although they may be. A formal contract that details both parties' obligations and responsibilities is required.

The Handbook, which was formally endorsed by both the American Dental Association (ADA) and the National Association of Community Health Centers (NACHC), details the terms and conditions, operations, and arrangements needed to implement these public/private partnerships. It contains an explanatory manual addressing both FQHC leaders and dentists; a model contract; a flow chart of federal requirements; and endorsement letters from the ADA and NACHC.

In California, this approach to expanding access was explored by both the California Dental Association (CDA) representing California's dentists and the California Primary Care Association (CPCA), representing the State's FQHCs. After reviewing the Handbook and exploring the concept with CPCA, CDA's Policy Development Committee recommended that CDA adopt formal supportive policy. CDA's policymaking body, its House of Delegates, in 2006 promulgated a resolution (#46-2006) that encourages liaison between FQHCs and private dentists through their local dental societies ("dental components"), stating:

Expansion of Dental Services in Safety Net Clinics. Resolved, that CDA supports the role safety net clinics have in providing care to underserved populations, and be it further Resolved, that CDA supports expansion of dental services in safety net clinics by initially facilitating communication between clinics and dental components, being an information resource, and providing technical assistance to members or community organizations seeking to expand their local safety net clinics to include services.

A significant issue in understanding the opportunity for public/private contracting is consideration of the “four walls” test. In practice this test has been more of a concept that is open to interpretation by states than a definitive federal standard that must be satisfied. The Handbook, which was reviewed for accuracy by both CMS and HRSA, relates the four walls test to stringent criteria for defining an FQHC patient. Under these criteria, the patient must have a medical record at the FQHC, must use the FQHC as a “medical home,” and must obtain primary care services at the center that meet the patient’s needs.^{viii} A patient who meets these criteria is considered to be a patient of the FQHC and thereby to be served within the four walls of the FQHC.

Implementing public/private contracting in California: The Four Walls issue

CMS’ regulatory comment on the four walls standard, as published in the 1996 Federal Register provides a description of the four walls test that relates more directly to the physical structure of the FQHC:

The “four walls test” requires that the objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic or center be housed in a permanent structure or mobile unit that has fixed, scheduled locations. The requirement that the clinic or center be housed in a permanent structure ensures that the equipment, records, supplies and whatever else is necessary to provide the defined services are in one permanent place.^{ix}

However, it then goes on to address services provided off-site, stating:

The “four walls test” is not a requirement that limits cost-based payment to only those services provided at the clinic or center, and it does not restrict a physician from providing services off-site. A physician, including any specialist under contract to the FQHC, can have an agreement with the FQHC to provide FQHC services off-site. For reasons discussed later in this preamble, we have reconsidered our policy on contracting for professional staff members other than physicians. FQHCs may provide services of physician assistants, nurse practitioners and other professionals under contract.^x



FOUR WALLS TEST

1. Medical record
2. Center as medical home
3. Obtains primary care services
4. Meet patient’s needs

Professionals around the country have reported a wide range of arrangements between FQHCs and private dentists—from formal contracting as described in the Handbook to memoranda of understanding (MOUs) and simple referral arrangements to general and specialist dentists who are Medicaid providers. Experience with contracting is reportedly mixed with significant variation in state Medicaid authorities’ acceptance of this approach to expanding care. Some respondents suggested that such contracting be explored with rural health centers, tribal health centers, migrant health centers, and critical access hospitals as well as with FQHCs and that dental hygienists as well as dentists be considered for contracting. Other respondents were pessimistic that private dentists could or would accommodate FQHC clients in their private offices without, in one respondent’s words, “solid preconditioning and understanding of the mission and purpose of an FQHC.” From these responses, it is clear

that successful contracting requires both supportive state Medicaid policy and meaningful communication among the parties.

To address the four-walls question and the appropriateness of this contracting arrangement, the Children's Dental Health Project led an effort to clarify federal Medicaid policy. As a result, the 2009 Child Health Insurance Program Reauthorization Act (CHIPRA) contains the following provision (Title V, Section 501(c)(1)):

[A state plan for medical assistance must] provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.

As of January 2011, interested parties are awaiting a CMS "State Health Official (SHO) letter" on contracting in which federal regulators are expected to clarify the CHIPRA law with regard to how contracting can be implemented. The SHO letter is anticipated to clarify that states must allow contracting with off-site private dental providers.^x

To reflect this legislation as well as federal policy changes since 2003, the California HealthCare Foundation supported the Children's Dental Health Project in updating the Handbook. The updated Handbook is available from the Children's Dental Health Project at www.cdhp.org/resource/FQHC_Handbook.^{xi} Like its predecessor, it has also been reviewed for accuracy by federal officials and has been endorsed by NACHC and the ADA.

Payment issues

Of particular interest is the position CMS takes on allowable payment arrangements when FQHCs and private dentists partner in expanding care to underserved Medicaid beneficiaries. In addition to their direct Federal funding, California's FQHCs are supported substantially by Medicaid revenues (41% in 2007) and additionally by state and local governments (12% in 2007).ⁱⁱ For the 45% of their patients who are Medi-Cal beneficiaries,ⁱⁱ California FQHCs are reimbursed on an all-inclusive visit rate. This "prospective payment rate (PPR)" is based on the FQHC's overall reasonable costs of providing the full range of services defined in their scope of services. If an FQHC includes dental services in its scope, the costs of delivering these services are comingled with all other costs in determining this rate. If the FQHC does not include dental services in its scope, no funding for dental care is included in this rate.

FQHCs have long been prohibited from passing their Medi-Cal PPR rate on to contracted healthcare providers who serve clients outside of the FQHC. The Handbook reports that "in general, [the federal government] permits health centers to contract for services based on any payment rate or payment mechanism that is reasonable, in accordance with federal cost principles..." It further suggested that "For purposes of federal anti-kickback law, the payment amount should reflect an arm's length negotiated fair market dollar value for services provided under the contract." Under this arrangement, payments are "not...equivalent to the enhanced reimbursement rate that the FQHC receives from the state's Medicaid program...[and are] ... not ... the same as the payment rate that the FQHC receives from other payers, or equivalent to a specified portion of its [federal] grant funds."^{viii}

In short, FQHCs cannot simply pass though their PPR rate (which is based on a range of services in addition to or exclusion of dental care) to contracting dentists. Rather, the rate paid to dentists must be determined in fair-market negotiation between the dentist and the FQHC.

As FQHCs are obligated to care for all who seek their services, an additional substantial portion of California FQHC's patients are uninsured (37% in 2007).ⁱⁱ Uninsured individuals pay FQHCs for services on an income-based sliding fee schedule and would also be included in the public/private contracting arrangement.

Improving Access in the face of Medi-Cal cuts

Dental services for California's low-income and disabled adult populations are currently inadequate to meet demand and need, particularly subsequent to elimination of most adult dental benefits. Elimination of dental services does not net the full value of cost savings anticipated by state Medicaid authorities. For example, after Maryland eliminated adult dental benefits in 1993, dental visits to emergency departments by Medicaid recipients increased by 22% even as overall use of emergency departments by Medicaid recipients was declining for other conditions.^{xii} Investigation of these low-income individuals who experienced a toothache during the prior year found that they dealt with pain through nonprescription medications, other home remedies, and prayer.^{xiii} Most eventually sought professional treatment, often from emergency departments and physicians^{xiv} before ultimately seeking professional dental care, often at high personal financial cost. Thus, savings associated with the benefit elimination were reduced by fruitless emergency department and physician visits paid for by Medicaid.

Federal healthcare reform does much to increase the capacity of FQHCs but does little to address dentally uninsured adults. It does not mandate dental coverage for adults in Medicaid even as that program is being expanded to cover more people. It does not provide access to a dental benefit for adults in the health insurance Exchanges which will sell health insurance to the uninsured (although it does mandate pediatric dental coverage). As the costs of employer-based medical coverage continues to increase, elective dental coverage is anticipated to erode, become optional, or be increasingly costly to employees, thereby further diminishing the quantity and quality of dental coverage for adults. These trends, coupled with demographic drivers leading to increasing proportions of poor and low-income populations, portend ever greater pressure on the dental safety net to provide essential dental services. Even with significant expansion, the contribution of FQHC dental programs will be modest compared to the size and capacity of the private dental care delivery system. Contracting between FQHCs and private dentists will become an ever more valuable tool for assuring that socially vulnerable populations receive the dental care they need for their health and function.

Public/private contracting may be a valuable strategy to better serve those who are already in need of dental services while preparing for the growing numbers who will be seeking dental care from the safety net in the future.

^vSaviano EC, Powers M. California's Safety-Net Clinics: A Primer. California HealthCare Foundation, November 2005.

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^{viii}Edelstein BL. Increasing access to dental care through public/private partnerships: contracting between private dentists and federally qualified health centers – A Handbook. Children's Dental Health Project., September 2003, Washington DC. Developed for the Connecticut Health Foundation.

^{ix}61 FR 14642 (1996-04-03).

^xPersonal communication from Dr. Conan Davis, CMS Dental Officer, 5/12/2010.

^{xi}Children's Dental Health Project. Increasing access to dental care through public private partnerships: contracting between private dentists and federally qualified health centers. A Handbook. May 2010, Washington DC.

^{xii}Cohen LA, Manski RJ, Hooper FJ. Does the elimination of Medicaid reimbursement affect the frequency of emergency department dental visits? J Am Dent Assoc 1996;127:605-09.

^{xiii}Cohen LA, Bonito AJ, Akin DR, Manski RJ, Macek MD, Edwards RR, Cornelius LJ. Toothache pain: behavioral impact and self-care strategies. Spec Care Dentist 2009;29:85-95.

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Download the full FQHC Handbook at www.cdhp.org/resource/FQHC_Handbook. For additional information on FQHC contracting for dental services, please contact the Children's Dental Health Project at 202-833-8288 or info@cdhp.org.