

Increasing Access to Dental Care through Public Private Partnerships:

Contracting Between Private Dentists
and Federally Qualified Health Centers

An FQHC Handbook

Developed by the Children's Dental Health Project



Table of Contents

| | |
|---|-------|
| Letters of Endorsement | 4-5 |
| Introduction. | 6-7 |
| 1. Requirements to provide dental services and authority to contract | 8 |
| 2. Providing dental services within the health center’s “Scope of Project” | 9 |
| 3. Obtaining new funding from HRSA for dental services. | 9 |
| 4. Defining a “patient”. | 10 |
| 5. Sources of funding for dental care | 10 |
| 6. Rate Setting for the purchase of contracted services | 11 |
| 7. Satellite sites versus “off-site” “other” locations and applicable policies and procedures | 12 |
| 8. Payment mechanisms and scope of contracted services. | 13 |
| 9. Billing patients, Medicaid and other third parties | 14 |
| 10. Risks | 15 |
| 11. Accountability | 15 |
| 12. Roles for Federal and State agencies | 15 |
| 13. Alternative dental arrangements | 16 |
| 14. Technical assistance | 16 |
| 15. Model contract | 16 |
| 16. Decision chart | 16 |
| Decision flow chart | 17 |
| Model Dental Services Agreement | 18-25 |
| Acknowledgements | 26 |
| End Notes | 26 |



Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

DATE: March 25, 2011

FROM: Cindy Mann, JD
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: Recent Developments in Medicaid and CHIP Policy

This CMCS Informational Bulletin is intended to provide a series of operational policy clarifications regarding our work implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Affordable Care Act of 2010. We hope you will find this information helpful as you administer these critical health coverage programs.

Further Clarification on CHIPRA Performance Bonuses

In our CMCS Informational Bulletin dated March 3, 2011, we provided information regarding the criteria needed to meet the program feature --"Liberalization of Asset Tests" -- for purposes of the Fiscal Year 2011 CHIPRA Performance Bonuses. As you know, the purpose of the Performance Bonuses is to encourage States to remove barriers that prevent eligible children from enrolling in and retaining coverage. In our previous Bulletin, we indicated that in order to qualify for this program feature, States would be required to liberalize the asset test for all Medicaid categories for which being a child is a condition of eligibility (including the section 1931 family coverage group under which parents can be eligible as well as children). Although one of the most effective ways to ensure that children are enrolled in coverage is to remove the asset test for the whole family, it was brought to our attention that States may have mechanisms in place where, even if there is an asset test for the 1931 group, children's access to coverage is not impaired.

CMCS has determined that, for purposes of CHIPRA Performance Bonuses, States will not be required to remove the asset test for the 1931 eligibility group as long as the State can demonstrate that all children who are income eligible for Medicaid can be enrolled in one of the State's eligibility categories that does not include an asset test and, therefore, will not be denied eligibility due to an asset test. States may be able to qualify for this program feature if they submit documentation to show that as of April 1, 2011, children in families that do not qualify under section 1931 due to assets are placed into another eligibility category and enrolled without requiring further action on the part of the family.

We have also determined that States will not be required to liberalize the asset test for the medically needy eligibility group for children, the group of “Katie Beckett” children eligible under 1902(e)(3) of the Act, and children eligible under section 1902(a)(10)(A)(ii)(XIX), as created by the Family Opportunity Act.

To recap, for FY2011, the asset test must be eliminated or self-declaration of assets must be accepted without the family’s verification for all children enrolled in CHIP and children enrolled in Medicaid as poverty-related children, Qualified Children, AFDC-related reasonable classifications of children, non-IV-E State subsidized adoption children, optional targeted low-income children, and independent foster care adolescents.

As always, States should submit a State Plan Amendment (SPA) to eliminate the asset test for any eligibility category. These may be in State Plan Attachment 2.2-A, State Plan Attachment 2.6-A, and/or supplements to State Plan Attachment 2.6-A, as appropriate. States that choose to liberalize the asset test by using self-declaration or administrative verification of assets should submit supporting documentation of this change with their FY2011 Performance Bonus Application, but a SPA is not required.

States considering applying for a FY 2011 Performance Bonus are encouraged to contact Dena Greenblum of the Children and Adults Health Programs Group at 410-786-8684 or via email at CHIPRABonusPayments@cms.hhs.gov before April 1, 2011 to ensure that all documentation is in order. We hope this clarification will be helpful.

Coverage of Freestanding Birth Centers

We also wanted to provide States with information regarding section 2301 of the Affordable Care Act, which ensures Medicaid coverage of care provided in freestanding birth centers. Section 2301 requires States that recognize freestanding birth centers to provide coverage and separate payments for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center, to the extent the State licenses or otherwise recognizes such providers under State law. This provision took effect upon enactment of the Affordable Care Act on March 23, 2010, for services furnished on or after that date, unless State legislation is required.

States will need to submit amendments to their Medicaid State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services in order to comply with this provision. Questions regarding this information may be directed to Ms. Linda Peltz, Director of the Division of Benefits and Coverage at 410-786-3399 or via email at Linda.peltz@cms.hhs.gov. As always, CMS Regional Office staff are available to assist States in submitting the appropriate State plan changes.

Dental Services in FQHCs

Section 501(d) of CHIPRA added a new section 1902(a)(72) of the Social Security Act, which provides that a State may not prevent a Federally-Qualified Health Center (FQHC) from entering into contractual relationships with private practice dental providers in the provision of FQHC services. Section 501(d) also amended section 2107(e)(1)(B) of Title XXI by applying this same requirement to CHIP. Following are several questions and answers regarding this provision.

Question 1: How does section 501(d) affect State Medicaid and CHIP programs?

Answer 1: This section removes potential barriers to FQHCs contracting with private dental providers to furnish Medicaid and/or CHIP-covered FQHC services. In the past, some State Medicaid agencies may have required dental providers who contracted with FQHCs to individually enroll in the Medicaid program. This is no longer permissible under the statute. However, States may set standards that are generally applicable to all dental providers and dental services furnished under the Medicaid and CHIP State plan, such as quality standards, but must allow FQHCs to contract with qualified providers who meet such standards.

Question 2: How will this provision be implemented?

Answer 2: Dental services furnished off-site by private dental providers who contract with FQHCs will be covered by Medicaid and CHIP as FQHC services when those dental services are of the type that would be covered if provided on-site at the FQHC. Payment for such services should be made to the FQHC in accordance with the State plan. This CHIPRA requirement will help to ensure dental access for individuals enrolled in CHIP and Medicaid.

Question 3: What is the Health Resources and Services Administration's (HRSA) role and responsibility regarding the FQHC program?

Answer 3: FQHCs are defined in section 1905(l)(2)(B) of the Act. To qualify as an FQHC, an organization must meet one of the following criteria:

- Receive a grant under section 330 of the Public Health Service Act,
- Be designated as meeting the statutory requirements to receive a grant under section 330 (commonly known as a "Look-Alike"); or
- Be an outpatient health program or facility operated by a tribal or urban Indian organization.

HRSA is responsible for administering the FQHC program for those organizations that qualify under the section 330 grant program of the Public Health Service Act and the Look-Alike program. In this role, HRSA is responsible for assuring that section 330 grantees and Look-Alikes meet all the same statutory requirements. HRSA performs its program oversight role in a similar manner for both types of entities.

Questions or concerns regarding HRSA's program requirements, including those regarding FQHC contract arrangements with providers, should be referred directly to oppdgeneral@hrsa.gov or to Ms. Tonya Bowers, Director, Office of Policy and Program Development, Bureau of Primary Health Care, HRSA, who may be reached at (301) 594-4300.

Model Interstate Coordination Process for Medicaid and CHIP

Section 213 of CHIPRA also required that by August 4, 2010, CMS develop a model process designed to coordinate Medicaid and CHIP enrollment, retention and access to care for children who frequently change their State of residence. The Secretary is required to submit a Report to Congress describing additional steps or authority needed to make such further improvements to coordinate the enrollment, retention and coverage under CHIP and Medicaid for such children.

In July 2010, CMCS released a proposed model process for interstate coordination based on consideration of comments received in response to the notice published in the *Federal Register* on December 18, 2009, information included in the 2006 Report to Congress entitled "*Studies Regarding Barriers to Participation of Farm Workers in Health Programs*," and information gathered from States and the CMS Tribal Technical Advisory Group. This process has not been finalized and we are very interested in States' and other stakeholders' feedback on the proposed model.

Proposed Model for Interstate Coordination

Host State Activities

The Host State is the State where a Medicaid or CHIP eligible individual arrives seeking coverage of medical care. Upon such a request, the Host State will confirm eligibility in the Home State, and upon receipt of confirmation, issue a Guest Card to the individual and notify the Home State of the individual's guest status and current address. The Host State will enroll the individual through its Medicaid Management Information Systems (MMIS) with a guest status, including a code that identifies the Home State. The individual will be able to use the Guest Card to access any services covered by the Host State, subject to the Host State's limitations and requirements, from any provider enrolled with the Host State. The Guest will be exempt from enrollment in any managed care plans or benchmark plans.

Home State Activities

The Home State must confirm eligibility for the Host State, and upon notification from the Host State of individual's guest status, change mailing address for the individual on the eligibility file and place the individual in a suspense status. The individual should be disenrolled from any managed care plans or benchmark plans, unless the benchmark plan will provide coverage in the Host State. The Home State remains responsible for eligibility for the individual while out of State, including performing redeterminations at scheduled intervals.

Federal Financial Participation (FFP)

The Host State will be reimbursed at 100 percent for services provided to Guests. CMS will adjust the federal matching payment to the Home State by an amount equal to the Home State's share of services that were provided to its beneficiaries as Guests.

Eligibility Verification

The timely and efficient exchange of eligibility data is fundamental to this model. There are several ways in which eligibility can be verified and data can be exchanged, however, these methods vary widely with respect to their efficiency and reliability. As could be expected, the methods that can be implemented most quickly and inexpensively will most likely prove to be the least efficient, and those that require greater investment of resources will be more efficient and reliable. The Report to Congress will explore a range of potential eligibility verification methods.

As we develop the Report to Congress, CMCS encourages stakeholders to provide feedback regarding the viability of the model coordination process, especially:

- Suggestions for improvement of the proposal;
- Identification of CMS policy decisions that must be made in order to put the process in place, such as:
 - o the length of time allowed for an individual to be a “guest” in another State
 - o whether to require Host States to cover all benefits available under the State plan or just mandatory benefits, and
 - o whether to allow all eligible individuals to be a “guest” in another State or if this policy should only apply to mandatory groups; and
- Identification of implementation issues or major impediments, including statutory, regulatory, and/or systems changes that may be needed both for CMS and the States.

The full proposal is available at

<http://www.cms.gov/CHIPRA/Downloads/InterstateCoordination.pdf>

Please contact Rebecca Bruno of the Division of Eligibility, Enrollment and Outreach at (410) 786-5568 or via email at Rebecca.Bruno@cms.hhs.gov with feedback and suggestions.

\$55 Million Awarded in Grants to Further Children’s Quality Measurement

On March 1, 2011, the Agency for HealthCare Research and Quality (AHRQ) awarded cooperative grants to seven AHRQ-CMS *CHIPRA Centers of Excellence in Pediatric Quality Measures*. These Centers are part of the CHIPRA required Pediatric Quality Measures Program (PQMP) and will: (1) test and refine the initial core set of measures to make them more broadly applicable to Medicaid, CHIP, and other programs; and (2) develop additional quality measures that address dimensions of care where standardized measures do not currently exist. The measures developed by the Pediatric Quality Measures Program will be considered for the improved CHIPRA core measure set which will be made publically available by January 1, 2013.

The *Centers of Excellence* awardees are:

1. Gary Freed - Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium, University of Michigan-Ann Arbor (Ann Arbor, MI)
2. Lawrence Kleinman - Mount Sinai Collaboration for Advancing Pediatric Quality Measures, Mount Sinai School of Medicine (New York, NY)

3. Mark Schuster - Children's Hospital Boston Center of Excellence for Quality Measurement/Harvard Medical School (Boston, MA)
4. Jeffrey Silber - Children's Hospital of Philadelphia Center of Excellence/University of Pennsylvania School of Medicine (Philadelphia, PA)
5. Sarah Hudson Scholle - National Collaborative for Innovation in Quality Measurement – National Committee for Quality Assurance (Washington, D.C.)
6. Rita Mangione-Smith - Center of Excellence on Quality of Care Measures for Children with Complex Needs – Seattle Children's Institute (Seattle, WA)
7. Ramesh Sachdeva – Pediatric Measurement Center of Excellence, Medical College of Wisconsin/National Outcomes Center (Milwaukee, WI)

A total of \$55 million will be awarded to the *Centers of Excellence* over a period of four years. For additional information on the CHIPRA AHRQ-CMS *Centers of Excellence*, visit:

<http://www.ahrq.gov/chipra/pqmpfact.htm>

We hope you will find this information helpful. Thank you for your commitment to these critical health coverage programs.



March, 2010

Meg Booth MPH, Director of Governmental Affairs
Children's Dental Health Project
1020 19th Street NW, Suite 400
Washington DC 20036

Dear Ms. Booth:

On behalf of the National Association of Community Health Centers (NACHC), health centers all across the country, and the 20 million Americans who rely on them for health care today, I am pleased to share in offering you a newly-updated version of "Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers," developed by the Children's Dental Project, with support from the California Health Care Foundation. We very much appreciate the efforts of the Children's Dental Health Project to involve NACHC and our legal counsel in the development of this updated Handbook. We hope that the use of this publication will contribute to expanded access to dental health care services for millions more poor, uninsured and underserved individuals across the country.

This publication, including the model contract it contains, reflects the extensive review and input by our staff and legal counsel; in our view, it thoroughly and accurately conforms to current statutory and regulatory requirements for federally-supported health centers. NACHC believes that the establishment of contractual arrangements for oral health care services represents a viable option for many health centers that wish to establish or expand their oral health service capacity. As such, we believe the Handbook is and will be an indispensable aid to health centers interested in that option and we are pleased to be part of making it available to every health center across the country.

All of us hope that you will find this Handbook useful and informative as you work to improve access to all-important oral and other health care services for those most in need in your community.

Sincerely,

Daniel R. Hawkins, Jr.
Senior Vice-President for Public Policy and Research

June 29, 2010

Dr. Burton Edelstein
President
Children's Dental Health Project
1020 19th Street NW, Suite 400
Washington, D.C. 20036

Dear Doctor Edelstein:

The American Dental Association (ADA) is pleased to endorse the "Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers" handbook developed by the Children's Dental Health Project in recognition of the important role that contracting between private sector dentists and Federally Qualified Health Centers can play in ensuring that FQHC patients are provided cost-effective, high quality oral health care services.

The handbook, intended for use by private practicing dentists, dental societies and FQHCs, is designed to encourage the adoption of contracting as an important approach to increasing oral health care for underserved populations. It provides background on how contracting works, offering step-by-step options for implementation. As a "how to" manual, the handbook contains, for example, useful material addressing the statutory authority to contract, a description of how FQHC grant money can be used, information on how to obtain new funding, rate setting for the purchase of contracted services, and payment mechanisms, as well as scope of contracted services, risks and accountability, and additional tools such a model contract. The handbook also points out the advantages contracting offers to FQHCs and private practitioners.

Sincerely,

A handwritten signature in black ink that reads "R. L. Tankersley DDS". The signature is written in a cursive, flowing style.

Ronald L. Tankersley, D.D.S.
President

RT:TS:nh

Introduction

Partnerships

Contracted dentists... answer the needs of those in their community who have the most need and least access to care.

In 2009, the U.S. Congress determined that Federally supported health centers (FQHCs¹ and “Look Alikes”²) may contract with private dentists³ to provide dental services to health center patients in the dentists’ private offices. This determination resolved controversy over the allowability of this practice, thereby encouraging adoption of contracting as an important approach to increasing dental care for underserved populations.

This updated Handbook reflects changes in Federal law and policy since the first version of the Handbook was published in 2003. It provides background on how contracting works, includes a model contract, and offers step-by-step options for implementation.

There are many advantages to both the dentist and health center when they contract to provide care to FQHC patients. Often, contracted dentists will be able to provide services to Medicaid patients without necessarily registering as Medicaid providers (exceptions may exist based on specific state Medicaid rules). Further, they are relieved of all responsibility to bill FQHC patients or their insurers (although, more than likely, the dentists will be required to provide the health center with information it needs to bill patients and payors); can predetermine the amount of time, number of patients, or number of visits they wish to provide for care for the underserved; and can answer the needs of those in their community who have most need and least access to care. For health centers, contracting for dental services allows them to meet their requirement to provide such services to their patients, reduces their need for expensive capitalization of dental facilities and equipment, reduces their staffing requirements, expands the number of available dental providers in their communities, and may help stabilize their dental service costs.

The number of FQHCs in the country currently contracting with dentists is increasing. These contracts are similar to the health center’s agreements with private providers to increase their capacity to provide specific medical services. For example, some contract with obstetricians to increase their capacity for prenatal care.

Contracting for dental services is an approach that is not only permitted by the Federal regulators, but also endorsed and promoted in concept by national organizations that represent the interests of dentists and health centers—the American Dental Association (ADA) and the National Association of Community Health Centers (NACHC).

As FQHCs are subject to a myriad of Federal laws, regulations, and policies, the primary sources of information in this Handbook are the rules, regulations and policies of the Bureau of Primary Health Care (BPHC), the agency responsible for administering the health center program within the Health Resources and Services Administration (HRSA) at the Federal Department of Health and Human Services (DHHS).⁴

Introduction cont.

Officials from HRSA and from the Centers for Medicare and Medicaid Services (CMS)⁵ provided invaluable assistance to this project regarding Federal requirements on health centers. Nonetheless, every effort was made to create a *Handbook* which well balances the interests of both dentists and health centers.

Currently, there exists little, and sometimes seemingly contradictory regulation and guidance on how FQHCs can contract with private providers (other than the manner by which contracted services can be included within the health centers' Scope of Project, which is discussed herein). In the absence of comprehensive official policy, this document reflects the best available information and answers many essential implementation questions. This *Handbook* explains the contracting opportunities available and the process by which to engage in such opportunities. It also provides dentists and health center administrators with a step-by-step flow chart for establishing and implementing contractual arrangements that meet current Federal rules and policy. A companion document, a model "*Dental Services Agreement*" between private dentists and health centers, is intended to facilitate this process further. This *Handbook* and the model contract reflect information gained from Federal authorities, the American Dental Association (ADA), and dentists and health centers that support this practice. We acknowledge legal contributions, guidance, and review from Appletree legal services in Connecticut, the firm of Feldesman Tucker Leifer Fidell LLP in DC, and ADA staff.

These documents are intended as guidance, based on Federal law and policy, for those dentists and health centers desiring to pursue the opportunities described herein. Prior to entering into any contractual arrangements, both parties should consult with legal counsel to determine the nature of the relationship best for them and to review all legal documents for compliance with all current Federal, State, and local law and regulation.

Partnerships



*... a Handbook
that balances
the interests
of both
dentists and
health centers.*

1. Requirements to provide dental services and authority to contract

All FQHCs are required by the federal Section 330 statute to provide “primary health services,” which are defined in the statute to include “preventive dental services.” (42 U.S.C. §254b(a)(1) and §254b (b)(1)(A)(i)(III) (hh)). “Preventive dental services” are further defined by regulation (42 C.F.R. §51c.102(h)(6)) to include “services provided by a licensed dentist or other qualified personnel, including:

- (i) “oral hygiene instruction;
- (ii) oral prophylaxis, as necessary;
- (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply”.

Partnerships

Getting Started

Further, FQHCs can obtain federal approval to provide “supplemental health services” which can include “dental services other than those provided as primary health services” (42 C.F.R. §51c.102(j)(6)). Centers may also be required to provide additional oral health services pursuant to the health center’s participation in an oral health initiative or its receipt of supplemental grant funding to expand the range and type of dental services available (see Section 3 on page 10).

FQHCs are permitted to provide required and supplemental services either “through staff and supporting resources of the center or through contracts or cooperative arrangements” (42 U.S.C. §254b(a)(1)). On February 4, 2009, Congress enacted the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), which, among other things, improved low-income children’s access to dental services by enhancing the dental coverage and benefits available. Of particular importance to relationships between FQHCs and dental providers, the statute explicitly prohibits States from preventing “a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services” (Section 501(d) of Public Law 111-3, amending Section 1902(a) of the Social Security Act [42 U.S.C. §1396a(a)]). Further, the statute applies this provision to the CHIP program at Section 2107(e)(1) of the Social Security Act (42 U.S.C. §1397(e)(1)).

Once a health center includes certain services as part of its Scope of Project (see Section 2 below) it is obligated to offer such care to all residents of its service area, including those persons who are publicly or privately insured and those who are uninsured, regardless of the patient’s ability to pay for such services or the patient’s payor source. Further, all services included within the health center’s federally-approved scope of project must be equally accessible and available to all patients served by the center as a whole, regardless of whether each service is offered at every site within a health center’s approved scope of project. In other words, if a health center operating multiple sites includes dental services within its approved scope but does not offer such services at every site, the health center must ensure that all of the patients served by the health center organization are able to access the full range of “in-scope” dental services offered, either at one of the health center’s sites or through an established arrangement within the community (see Section 2 below for additional information regarding the types of arrangements that HRSA allows health centers to utilize to provide required in-scope services).

Each health center is required to establish a fee schedule for its services that is consistent with locally prevailing rates and reflects the health center’s reasonable costs of providing services. Centers must also establish a schedule of discounts (or sliding fee scale) for individuals who earn annual incomes equal to or less than 200% of the then current Federal Poverty Guidelines (which are modified annually). These discounts are applied to the schedule of charges for under-insured and uninsured patients when these patients incur out-of-pocket costs.

Thus, an FQHC that does not have sufficient internal capacity to provide directly the required (and, as necessary, additional) healthcare services included within its *Scope of Project* (including preventive dental services) to all patients served by the health center, is expected to contract with community providers to ensure sufficient

service availability for its patients. Under such circumstances:

- (i) the FQHC operates as the licensed billing provider (and provider of record) of the contracted services;
- (ii) all patients served by the contracted provider are the FQHC's patients; and
- (iii) the FQHC assumes full financial risk for the services provided.

Further, the FQHC must ensure that all of its patients have access to the contracted services, regardless of such individual's ability to pay or payor source. Each of these elements is addressed below.

2. Providing dental services within *Scope of Project*

Partnerships
Getting Started

The FQHC's *Scope of Project* defines the approved services, sites, providers, service area and target population for which the health center can utilize its Section 330 grant funds and for which additional program benefits may be available (See Policy Information Notice (PIN) 2008-01). FQHCs define their *Scope of Project* in two ways. First, the FQHC defines its scope as part of its original Section 330 grant application by designating, among other things, which services it intends to provide and the manner by which these services will be provided. All required services (including dental services) must be provided one of three ways: (1) by the FQHC directly; (2) through a formal written contract (under which the FQHC is responsible for the contracted services and provides payment to the contractor who furnishes the services on behalf of the FQHC); or (3) by formal written referral arrangement under which the patient is referred to another provider who is responsible for services. This *Handbook* addresses dental services provided under the second option—services provided through a formal written contract.

SCOPE OF PROJECT

1. Initial application for supplemental expansion funds
2. Request change in scope

Once a health center's scope has been approved by HRSA, it can request prior approval to change its scope (without additional federal funds) to either add or delete specified sites or services, in accordance with the requirements of PIN 2008-01. If the health center needs additional grant funds to implement this change, it cannot utilize the change in scope process. Rather, it must submit an application for new funding (see Section 3 below).

As noted above, the *Scope of Project* defines, among other things, the services for which the health center can utilize its Section 330 grant funds and for which additional program benefits may be available. It also defines the services that must be offered to all health center patients, regardless of ability to pay (whether such services are provided directly, by contract or by formal written referral). Accordingly, if dental services are not included in a health center's existing *Scope of Project*, the center should request and obtain a "change in scope" from BPHC prior to contracting for dental services if the health center intends to use grant funds and access additional benefits in connection with the provision of these services. The health center can request approval of a change in scope at any time, provided that it can satisfy the criteria set forth in PIN 2008-01. While approval permits the health center to use its existing 330 funds and benefits for the new services, without an application for expansion funding (see Section 3 below), approval will not increase the FQHC's Section 330 grant award amount.

3. Obtaining new funding from HRSA for dental services

New FQHCs and those that are expanding their services or establishing new health center sites can seek federal funding to support services by submitting competitive applications to HRSA. Receipt of such an award automatically defines (or, in the case of service and/or site expansion grants, revises) that center's *Scope of Project* to reflect the services/sites supported by such funding. For example, a competitive grant opportunity may provide supplemental funding to expand various services, including dental care. Alternatively, a grant opportunity to add new sites may involve opening a dental site.

4. Defining the “patient”

In the past, CMS utilized a stringent set of criteria to define a patient. These specified that the FQHC patient must have a “medical record” at the center, use the center as a “medical home”, and “obtains primary care services at the center that meet the patient’s needs.” In general, the central office of CMS has now adopted a less stringent HRSA definition, which defines a patient as someone who uses the services of the health center as their customary source of primary health care. A patient must also reside in the center’s service area and be able to “reasonably” receive primary care services at the center.

Partnerships
Getting Started

In addition to being regulated by federal authorities, health centers are regulated by various state agencies. For example, health centers must negotiate with state Medicaid agencies to determine payment rates for Medicaid-enrolled patients. As such, states also have authority to define the term “patient” for purposes of determining whether contracted services qualify as “FQHC services.” It is therefore advised that health centers check with their respective State Medicaid agencies prior to entering into any contracting arrangements for services, including arrangements for dental services.

5. Sources of funding for dental care

Health centers may receive direct payment for dental services from public and private dental insurance, as well as full and sliding fee scale payments directly from patients (as discussed in Section 1 above). HRSA-supported FQHCs may also use a portion of their Section 330 funds to subsidize the otherwise uncompensated costs of providing services to under-insured or uninsured patients. In addition, centers may receive “supplementary” funding, for example from state government, local government, foundations, and other philanthropies.

In particular, many health center patients are beneficiaries of the Medicaid program, which covers certain dental services. Dental coverage in Medicaid is currently comprehensive for children to age 21 years under the EPSDT program (Early and Periodic Screening Diagnostic and Treatment program). State Medicaid programs vary widely, however, in the range of dental services they cover, if any, for adults. As of mid-2003, only 12 states were providing reasonably comprehensive dental services to adults in Medicaid, and further cutbacks were under consideration in many states. As a result, many low-income adults who seek care in FQHCs have neither public insurance nor personal resources to pay for dental care.

States also insure children through the Child Health Insurance Program (CHIP). Since February 2004, all states are required to provide dental services to children in CHIP that either meet a definition of comprehensive dental care or are at least equivalent to one of three common commercial dental plans.



FOUR WALLS TEST

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

6. Rate setting for the purchase of contracted services

Rate setting for the purchase of services provided by contracted providers is perhaps the most complex and indeterminate component of the contracting process. In general, HRSA permits health centers to contract for services based on any payment rate or payment mechanism that is reasonable, in accordance with the Federal cost principles contained in Office of Management and Budget Circular A-122. For example, under HRSA's policies, health centers can contract with dentists to provide services either in the dentists' private offices or in the health center facility. For such care, payments to the dentist may be on a dollar amount per-service, per-patient, per-visit, per-time or any other basis agreeable to the parties, provided that final payment is reasonable.

For purposes of Federal anti-kickback law, the payment amount should reflect a fair market value rate, negotiated at arm's length, for the services provided under the contract.⁶ In particular, the payment provided by the health center to the contracted dentist should not be equivalent to the total or a fixed percentage of the "enhanced reimbursement rate" that the FQHC receives from the state's Medicaid program. Similarly, it should not be the same as the payment rate that the FQHC receives from other payers. That is, the health center is not permitted to "pass-through" its enhanced Medicaid or Medicare reimbursement or its Section 330 grant funds to another provider. Therefore, the health center's Medicaid reimbursement rate cannot directly determine the payment rate payable to contracting dentists.

To establish their own internal cost-based Medicaid enhanced reimbursement rates, health centers provide estimated cost data to their State Medicaid authorities. Medicaid agencies use these estimates to calculate either the health center's Prospective Payment System (PPS) rate or, if the State employs an alternative methodology, an adjusted visit rate by employing formulas that vary somewhat by State and vary within states over time. State Medicaid agencies have considerable discretion to determine reasonable costs and are granted much flexibility in their negotiations with FQHCs by Federal oversight agencies. It is therefore advisable for the health center to partner early with its state Medicaid agency to ensure that the agency is accepting of the service being added and the payment structure that is sought.

The rate setting process between the dentist and the health center may be scrutinized by a Medicaid agency for fairness of the proposed costs, and the agency may limit its payment to the health center accordingly. While the Medicaid agency generally will not disallow a properly structured contractual arrangement between the health center and a dentist, it may disallow certain costs associated with the arrangement, thereby reducing the amount of reimbursement made available to the health center.

Partnerships
Getting Started

*It is advisable
for the health
center to
partner early
with its state
Medicaid
agency.*

7. Satellite sites versus “off-site” “other” locations and applicable policies and procedures

Partnerships Policies and Procedures

*Both parties
should
carefully
review
established
policies and
practices.*

When private dentists contract with FQHCs to provide services to health center patients within their own dental offices, their offices may be approved by HRSA as either satellite sites of the center at which contracted services are provided to health center patients on a regularly schedule basis, or off-site “other” locations at which contracted services are provided to health center patients on an occasional or “as needed” basis.

If HRSA and State law permit, it is preferable to characterize the dental office as an off-site “other” location for services, rather than a satellite location, which will be based on the terms of the contract. If a dental office were established as a satellite of the health center, rather than simply as an off-site “other” location, the dental office would need to comply with a range of facility requirements that are incumbent on health centers by the Joint Commission and others. While most dental offices already offer handicapped access and prohibit smoking on premises, additional facility requirements that may pertain to health centers (e.g. width of hallways) may be onerous or inappropriate for private offices.

Patient protections that are typically afforded by dentists to all patients served in their offices extend to health center patients. Similarly protections afforded by health centers to patients seen in their sites extend to the private dental offices as well. These protections include, by example, non-discrimination policies and practices, proper sterilization techniques, appropriate radiation safety procedures and other quality-assurance standards. Since the contracting private dentist acts as an “agent” for the health center, both parties should carefully review their established clinical protocols and guidelines, quality assurance standards and practices, standards of conduct, and productivity expectations to ensure or establish compatibility.

Patient grievance procedures vary somewhat between private dentistry and FQHC practice. Private dentists typically address patient grievances directly and seek to satisfy patients’ concerns within their offices. A patient who remains unsatisfied may seek additional satisfaction, adjudication, or remedy from the state’s dental licensing board, local dental society’s grievance committee, or through the courts. In contrast, FQHCs may be required to meet specified patient grievance procedures and requirements for “fair hearings.” When FQHC patients are served by private dentists, the patients should be able to access these FQHC procedures to address any grievances they may have. The health center’s responsibility for grievances or professional liability may be lessened by a contract “hold-harmless” provision that assigns grievance and liability responsibility to the contracting dentist. In any case, dentists should become familiar with the health center’s pertinent policies and procedures before contracting.

Both dentists and health centers are, of course, required to provide all services in accordance with applicable Federal, State and local laws, regulations, and policies and generally accepted principles of professional conduct.

Additionally, HRSA/BPHC PIN 2002-22 requires all health centers to ensure that their in-house, contracted and volunteer health care providers meet professional requirements including appropriate state licensure, certifications and registrations (e.g., a particular states’ requirement for radiation training, child abuse identification, specialty licensure, etc.), and insurance. Contracting dentists will need to provide health centers with required credentialing information so that the health center can, in turn, meet its regulatory obligations.

8. Payment mechanisms and scope of contracted services

When contracting to provide services to health center patients, dentists and health centers may elect to contract based on the:

- specific services provided to the FQHC patient using a negotiated fee-schedule;
- number of patients to be seen;
- number of visits available to FQHC patients;
- number of sessions (hours or days) to be committed to FQHC patients; or
- any other mutually-agreeable basis.

In all cases, the dentist and the health center negotiate payment rates for an agreed-upon range of services. Services are provided to individual health center patients without regard to the patient’s underlying ability to pay or payer source. Therefore, a dentist who is not registered or enrolled as a Medicaid provider with the applicable state Medicaid agency or its managed care contractor may be able to treat Medicaid patients without becoming obligated to see all Medicaid patients (see Section 8 below).⁷ However, given that health centers are required to credential all providers treating their patients—whether employed, contracted, or volunteers—the dentists will need to provide the health center with required information and assurances regarding such things as licensure and insurance coverage.

As dentists are most accustomed to charging on a fee-for-service basis, this is likely to be the most common method of payment. When doing so, the parties must establish the range of services to be provided as well as the individual payment for each service.

When contracting by patient, visit, session, or time, the dentist and the health center negotiate a fixed payment for each such contracting unit. For example, contracting “by patient” obligates the dentist to provide specified services for a specific list or number of patients over a designated period of time. Contracting “by visit” establishes a fixed payment rate for a visit regardless of the services provided or length of session. Contracting “by session” obligates the parties to a specified number of clinical sessions which may be defined, for example, as a specified half-day each week or each month with “half-day” defined by agreed-upon hours. Finally, contracting “by time” obligates the parties to a specified period of time in which health center patients will be served, regardless of the number of sessions within the contracted block of time.

Regardless of approach, both the dentist and health center should seek to pre-establish anticipated costs and income in order to limit financial risk to both parties. Ideally, the FQHC will limit its financial risk while still assuring the dentist a predictable income for care of FQHC patients.

Specific services to be provided by the contracted dentist are also negotiable by the parties. As the FQHC “agent,” the dentist is not obligated to provide dental services that are not included in the agreement. Centers vary widely in the range of dental services they provide. This variation reflects differences in their Scope of Project, 330 filing, participation in a supplemental expansion grants or oral health initiatives, and election to use discretionary and fungible resources for dental care (e.g. foundation support).

Regardless of the scope and range of services negotiated between the dentist and the health center, FQHCs are required to ensure that all services provided within their approved Scope of Project must be available to all patients of the health center, regardless of individual patients’ ability to pay and, therefore, the health center’s ability to recoup costs of contracted care. Further, if the contract between the health center and the dentist does not cover all of the health center’s patients, the health center will need to enter into other established arrangement(s) to ensure that all patients are served.

It is important to note that, technically, dentists who contract with FQHCs do not do so under the Medicaid program, even though they may provide services to individuals who are enrolled in Medicaid. Rather, dentists are contracting to provide services on behalf of the FQHC under the terms and conditions of their joint contract. Therefore, Medicaid program dental benefits do not govern the range of services that a dentist and FQHC may agree to provide for an FQHC patient, nor do they determine the payment arrangement between the dentist and health center.

Partnerships

Policies and Procedures

CONTRACTING OPTIONS



9. Billing patients, Medicaid and other third parties

When dentists contract with health centers to provide care to FQHC patients, they are freed of any need to bill patients, insurers, or Medicaid, and need only provide information to the health center on the FQHC patient services provided and the encounters with FQHC patients generated. Under this arrangement, health centers are responsible for all billing, collection, and payment functions.

For purposes of billing patients, FQHCs establish a fee schedule for their services that is consistent with locally prevailing rates and reflects the health center's reasonable costs of providing services, as well as a corresponding schedule of discounts (or sliding fee scale) for individuals who earn annual incomes equal to or less than 200% of the then current Federal Poverty Guidelines (which are modified annually).

For purposes of billing Medicaid, FQHCs typically obtain and maintain Medicaid provider numbers for each of their service departments or for the health center entity, as a whole, rather than for each of their in-house and privately-contracted providers. In this way, turnovers or expansions in professional personnel typically do not require FQHCs to credential each new provider for purposes of serving Medicaid patients⁸ although, as previously described, each provider will need to be credentialed under the health center's professional credentialing policies.

Dentists may elect to become or remain Medicaid providers independent of their contracting arrangement with a health center. Dentists who are Medicaid providers outside of their contracts with FQHCs should not provide their individual or corporate Medicaid identifier number(s) to the FQHC as this number should not be used by the FQHC for billing Medicaid. When providing services to FQHC-contracted patients, the dentist will simply bill the health center. When caring for Medicaid-enrolled patients who access their offices directly (i.e. not through the health center), the dentist will bill Medicaid, or its agent, directly.



10. Risks

For dentists, contracting with an FQHC entails some minimal financial risk such as the possibility of FQHC insolvency or incurring higher than anticipated costs in providing services if the dentist is paid on an all-inclusive rate. For health centers, depending on the payment methodology chosen by the parties, more significant financial risk may result if unable to recoup adequate funding from their various payors to cover the contracted costs. It is therefore essential that dentists and centers carefully project the numbers of sessions, patients, or services to be provided and monitor experience carefully. For example, the dentist and the health center may elect to institute utilization and cost review after an initial contracting term to evaluate the accuracy of their initial projections.

Non-financial risks may arise in relation to failure of either party to meet requirements of the contract or function effectively together. Therefore contracts should offer termination clauses, especially for cause, that can be triggered by either party. Again, it is essential that contract documents well protect the interests and needs of both dentists and FQHCs.

11. Accountability

Good practice requires that both parties remain accountable to each other and address each others' needs in an ongoing way. Accordingly, good communication between the parties is essential to ensure satisfaction and program accountability. Additionally, federal regulation and policy mandate that FQHCs be accountable for oversight over all contracted services provided to patients. Further, health centers must include details regarding such services and the patients served in the reports that the centers submit to the federal government (such as reports based on user and encounter data). Thus, it is important that dentists provide centers with information regarding progress in meeting the contracted goal—whether that be a specified number of patients, availability of care for specified sessions, or numbers and types of services provided. Further, because payments made by health centers to contracted providers must be reasonable as they relate to services provided, it is important that dentists provide a sufficient dollar-value of services to substantiate the contracted payment amount. One way to ensure this is for the dentist and the health center to negotiate a fee-for-service equivalent charge when contracting on a per-patient, per-visit, or per-session basis.

At the onset of contracting, the dentist needs to provide the health center with information validating that he or she has the professional qualifications and authority to provide care. While these requirements will vary somewhat by state, they typically these will include evidence of licensure, assurance that the dentist has not been disqualified or declared ineligible to participate as a provider under the Medicare, Medicaid or SCHIP program (or other federal health care programs), and evidence of sufficient liability insurance.

Further, both the dentist and the health center should reserve the right to determine whether the other party is performing satisfactorily and, if not, to terminate the contractual arrangement.

Under typical contracting arrangements, the health center guarantees the dentist timely payment and the dentist agree to provide health centers with necessary service delivery and financial and programmatic reports reflecting his or her care of health center patients. As health centers may need to access treatment records in order to meet their performance, quality assurance, and general monitoring and oversight requirements, dentists need to provide access to records of patients. Since the contract is paid with Federal funds, the dentist may also be asked by appropriate governmental funding agencies to provide access to office records.

Partnerships

*Roles, Responsibilities
and Resources*

*Good practice
requires that both
parties remain
accountable
to each other
and address each
other's needs in
an ongoing way.*

12. Roles for Federal and State agencies

HRSA: (www.hrsa.gov) HRSA is the federal public health and “access agency” that, through its Bureau of Primary Health Care (BPHC), has primary responsibility for awarding and administering Section 330 grant funds, and the health center program, in general. Although centrally located in Rockville, Maryland, BPHC maintains three divisions—the Eastern Division, the Central/Mid-Atlantic Division and the Western Division—each of which is comprised of three Branch Offices that support the health center program including providing technical assistance to health centers and monitoring their compliance with federal requirements.

CMS: (www.cms.gov) CMS administers publicly financed health insurance programs including the federal Medicaid and Medicare programs and the State Child Health Insurance Program (SCHIP). It currently maintains 10 offices around the country, which it calls “Regional Offices.” These Regional Offices are responsible for designating entities as FQHC look-alikes, upon recommendation of HRSA.

State Medicaid authorities: Because both Medicaid and SCHIP are Federal-State partnership programs, each State's Medicaid authority interacts directly with FQHCs on Medicaid rate setting and other programmatic compliance issues.

13. Alternative dental arrangements

Beyond contracting with independent dentists to provide care for health center patients in their private offices, FQHCs can hire dentists as full- or part-time staff, or dentists can provide volunteer services in the health center facilities. As paid staff, dentists can be remunerated based on salary, patients seen, sessions (time), and/or productivity. Although these arrangements are more straightforward than contracting with dentists for patient care in their private offices, these arrangements are beyond the scope of this *Handbook*.

Partnerships
*Roles, Responsibilities
and Resources*

14. Technical Assistance

HRSA/BPHC, CMS, the American Dental Association, the National Association of Community Health Centers, and the Children's Dental Health Project (CDHP) are all familiar with issues typically involved in contracting between dentists and health centers and all can provide technical assistance. CDHP, which developed this handbook, can be contacted at 202 833 8288 or by email at cdhp@cdhp.org.

*Model contract
is available at
www.cthealth.org
and
www.cdhp.org.*

15. Model Contract

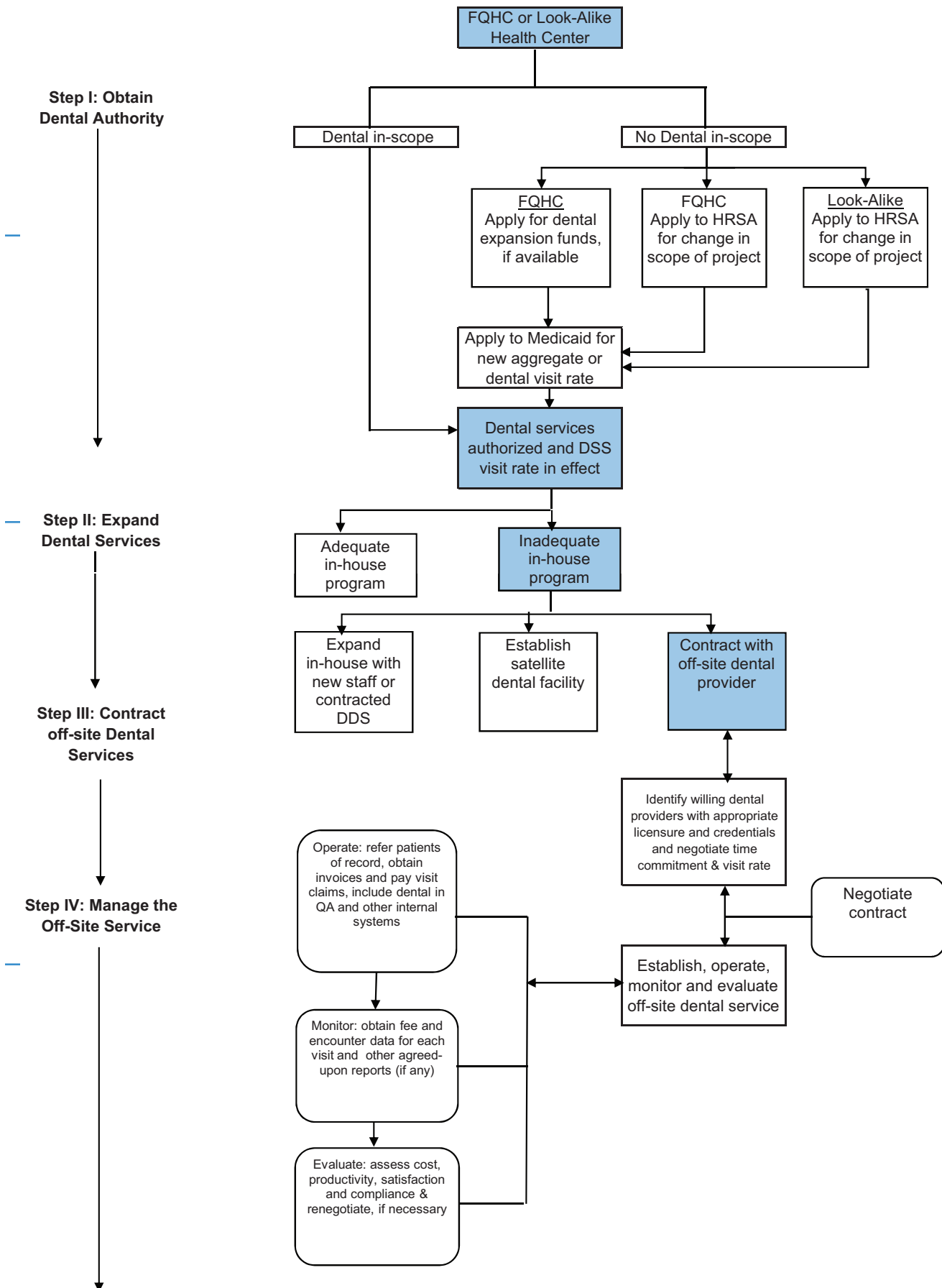
A model "Dental Services Agreement" between private dentists and health centers is appended for informational purposes and is also available from the Children's Dental Health Project at www.cdhp.org/resource/FQHC_contract. This agreement was developed by the law firm of Jones Day for Appletree Legal Services. It reflects input from the firm of Feldesman Tucker Leifer Fidell LLP which serves as general counsel for the National Association of Community Health Centers and was provided to the American Dental Association for review and comment.

The model contract is intended for dentists and FQHCs to use as a starting point in drafting and negotiating a final agreement. It should not be used as the definitive document without first consulting legal counsel as state-specific regulations and other considerations may impact the proper structuring of an agreement. Where appropriate, the document provides options for parties to select how they wish to work together.

16. Decision Chart

There are many key decisions to be made as health centers and dentists develop a relationship to better serve the oral health needs of under-served individuals in their communities. The appended *Decision Chart for Contracting between Private Dentists and Federally Qualified Health Centers* reviews these decisions in a step-by-step way that should be helpful to both parties. The *Chart* is designed to assist both parties in understanding options as well as determining what steps need to be taken to develop an effective, sustainable, and productive relationship.

Decision Flow Chart Of Necessary Steps To Establish Off-Site Specialty Services



Model Dental Services Agreement

Partnerships *Model Contract*

The following model dental services agreement between a private practice dentist and a community health center was developed for the Connecticut Health Foundation through the Connecticut Appleseed Center for Law and Justice, Inc., a nonprofit public interest law center, by Jones Day Attorneys at Law of Washington, D.C. It was provided to the American Dental Association and the National Association of Community Health Centers (NACH).

It was extensively reviewed and modified by Attorney Marcie Zakheim of Feldesman Tucker Leifer Fidell LLP, general counsel to the NACH.

The language provides guidance to dentists and health center executives as they explore a contractual arrangement. In addition to model language, a number of notations are provided to address specific circumstances and/or options available to the contracting parties.

The model contract is intended for dentists and FQHCs to use as a starting point in drafting and negotiating a final agreement. It should not be used as the definitive document without first consulting legal counsel because state-specific regulations and other considerations may impact the proper structuring of a particular agreement.

Model Dental Services Agreement

THIS DENTAL SERVICES AGREEMENT (this “Agreement”) is entered into this ____ day of ____, 200__, between _____ (the Community Health Center, or “CHC”), a [insert applicable State] nonstock corporation, and _____, a licensed Doctor of Dental Surgery, or Doctor of Medical Dentistry, or dental professional corporation (“Dentist”).

I. Parties

“CHC” is an entity exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and that (i) meets the definition of a Community Health Center under [insert applicable State statute]; and (ii) meets the definition of a Federally-Qualified Health Center (“FQHC”) under Section 1905(l)(2)(B) and Section 1861(aa)(4) of the Social Security Act (42 U.S.C. §1396d(l)(2)(B); 42 U.S.C. §1395xx(aa)(4)), and whose scope of services, as approved by the Bureau of Primary Health Care (“BPHC”) within the United States Department of Health and Human Services (“DHHS”), includes the performance of primary dental services.

(NOTE: If the health center is a public entity model, the reference to the IRC should be deleted.)

“Dentist” is an individual licensed to perform dentistry under [insert applicable State statute], meets the applicable provisions thereunder, and is not the subject of any Medicaid/Medicare related actions, suspensions, exclusions or debarments that would disqualify him or her from providing services under this Agreement.

II. Parties

The purpose of this Agreement is to assist CHC in providing access to dental services to all patients of the CHC by entering into agreements with various Dentists to provide dental services for the CHC at an arm’s length negotiated rate reflective of the fair market value for such services, to be furnished at [see NOTE below].

(NOTE: As these services could be provided either off-site or on-site, depending on the specific arrangement negotiated between the individual CHC and the Dentist, insert either: at the Dentists’ practice location [specify] or at the following CHC site [specify].)

III. Provision of Covered Services

- A. PARTICIPATING PATIENTS.** A “Participating Patient” who is eligible to receive dental services under this Agreement is defined as any individual residing in CHC’s federally-approved service area and who is a registered patient of CHC.

(NOTE: To be included in the scope of project, the health center needs to offer these services to all residents of the service area or members of the special population served under grant, e.g., homeless persons, as applicable.)

- B. COVERED SERVICES.** Dentist agrees to provide the dental services described in Exhibit B (Covered Services), as required, to Participating Patients, in accordance with the attached Payment Schedule (Exhibit A). CHC is responsible for contacting Dentist to make initial appointments for Participating Patients. Notwithstanding, CHC is under no obligation to utilize Dentist to provide dental services to any or all Participating Patients who require such services, in accordance with Section V of this Agreement.

- C. DESCRIPTION OF SERVICES.** Consistent with Section XI.C of this Agreement, Dentist agrees to establish and maintain dental records that will contain descriptions of any dental services provided to Participating Patients, as well as proposed follow-up treatment plans for subsequent visits (if any). The descriptions of the services will be made using American Dental Association CDT-3 Standard Claims Codes, and will include the Dentist’s customary charge for each service provided. In the event that such records are housed in a location other than the health center facility, CHC shall have reasonable and timely access to such records.

- D. SPECIAL SERVICES.** For dental services needing individual consideration or prior approval from the [insert applicable Federal/State agency] or from CHC, Dentist must provide CHC with documentation necessary to seek or provide such approval, and may not render such services until CHC notifies Dentist that approval has been obtained. A list of services requiring prior approval is attached (Exhibit C).

- E. AGREEMENT NOT TO CHARGE PATIENTS.** The parties agree that all Participating Patients receiving services from Dentist pursuant to this Agreement shall be considered patients of CHC. Accordingly, CHC shall be responsible for the billing of such patients, as applicable, as well as the billing of Federal, State and private payors, and the collection and retention of any and all payments. Dentist agrees not to bill, charge or collect from Participating Patients or payors any amount for any dental services provided under this Agreement. If Dentist should receive any payment from Participating Patients or payors for services provided hereunder, Dentist agrees to remit such payment to CHC within ten (10) days of receipt.

(NOTE: If the services are provided at an off-site location, e.g., dental office, insert the following provision: Notwithstanding the aforementioned, Dentist recognizes that certain Participating Patients may be charged at the time of service, in accordance

Model Dental Services Agreement *cont.*

with a fee schedule and, as applicable, schedule of sliding fee discounts established by CHC pursuant to 42 C.F.R. §51c.303(f). Dentist shall, on behalf of CHC and consistent with CHC's guidelines, schedules and procedures, make every reasonable effort to collect fees from eligible Participating Patients at the time services are provided to such patients and to remit such payments to CHC within ten (10) days of receipt. CHC shall perform the follow-up activities necessary to collect patient fees not collected by Dentist at the time of service.)

- F. NON-DISCRIMINATION.** Dentist agrees to provide dental services to Participating Patients in the same professional manner and pursuant to the same professional standards as generally provided by Dentist to his or her patients, regardless of an individual's or family's ability to pay for services rendered. This section shall not be read to prevent Dentist from limiting the number of hours and/or days during which Dentist agrees to see Participating Patients (see Section IX.A below), provided that such limitation shall not be based on a Participating Patient's payor source or insurance status. Dentist also agrees not to differentiate or discriminate in the provision of services provided to Participating Patients on the basis of race, color, religious creed, age, marital status, national origin, alienage, sex, blindness, mental or physical disability or sexual orientation pursuant to Title 45 of the Code of Federal Regulations, §§ 80.3–80.4, and [insert applicable State statute].

IV. Oversight and Evaluation of Services by CHC

- A. CHC, through its governing Board of Directors and its Executive Director, shall, consistent with the Board's authorities and CHC's federally-approved scope of project (as approved by BPHC), establish and implement clinical and personnel policies and procedures relevant to the provision of services by Dentist pursuant to this Agreement (e.g., qualifications and credentials, clinical guidelines, standards of conduct, quality assurance standards, productivity standards, patient and provider grievance and complaint procedures). Notwithstanding, nothing herein is intended to interfere with Dentist's professional judgment in connection with the provision of such services.
- B. CHC, through its Executive Director and/or Medical Director, shall retain and exercise ultimate authority and responsibility for the services provided to participating Patients pursuant to this Agreement, consistent with the policies, procedures and standards set forth above. In particular, CHC shall retain ultimate authority over the following:
1. Determination as to whether Dentist meets CHC's qualifications and credentials, consistent with Section X.A of this Agreement;
 2. Interpretation of CHC's health care, personnel and other policies and procedures, clinical guidelines, quality assurance standards, productivity standards, standards of conduct and provider and patient grievance and complaint resolution procedures, and their applicability to Dentist; and
 3. Determination with respect to whether Dentist is performing satisfactorily and consistent with CHC's policies, procedures and standards, in accordance with this Section and Section X below.

If CHC's Executive Director is dissatisfied with the performance of Dentist, or CHC's Executive Director determines that Dentist has failed to satisfy applicable qualifications and credentials or comply with applicable policies, procedures, standards and protocols (consistent with this Section and Section X below), the Executive Director may terminate this Agreement, in accordance with Section VIII below. If Dentist believes CHC's termination has not been made reasonably and in good faith, Dentist may avail him or herself of the dispute resolution provisions set forth in Section XIV of this Agreement.

- C. Dentist shall, as soon as reasonably practicable, notify CHC of any action, event, claim, proceeding, or investigation (including, but not limited to, any report made to the National Practitioner Data Bank) that could result in the revocation, termination, suspension, limitation or restriction of Dentist's licensure, certification, or qualification to provide such services. CHC may suspend this Agreement, until such time as a final determination has been made with respect to the applicable action, event, claim, proceeding, or investigation.

V. No Obligation to Refer and Non-Solicitation of Patients

- A. It is specifically agreed and understood between the parties that nothing in this Agreement is intended to require, nor requires, nor provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party.
- B. Dentist agrees that during the term of this Agreement, he or she shall not, directly or indirectly, solicit or attempt to solicit or treat, for his or her own account or for the account of any other person or entity, any patient of CHC. Dentist further agrees that for a period of two (2) years following termination of this Agreement (however such termination is effected, whether by Dentist or CHC, with or without cause, or the expiration of this Agreement),

Model Dental Services Agreement *cont.*

Dentist shall not, and Dentist shall not cause any entity or individual he or she is employed by or with whom he or she is professionally associated to, directly or indirectly, solicit or attempt to solicit for his or her own account or for the account of any other person or entity, any patient of CHC for whom Dentist provided care during the term of the Agreement. For purposes of this paragraph, a “patient of CHC” shall mean any patient seen or treated by CHC (whether by its employees or independent contractors) during the one (1) year period immediately preceding the termination or expiration of this Agreement, including, but not limited to, those patients treated by Dentist hereunder.

VI. Contracts with Others

CHC retains the authority to contract with other dentists or dental practices, if, and to the extent that, CHC’s Executive Director reasonably determines that such contracts are necessary in order to implement the CHC Board’s policies and procedures, or as otherwise may be necessary to assure appropriate collaboration with other local providers (as required by Section 330 (k)(3) (B)), to enhance patient freedom of choice, and/or to enhance accessibility, availability, quality and comprehensiveness of care.

VII. Compensation

- A. FEE SCHEDULE.** Dentist will be compensated for providing dental services under this Agreement in accordance with the attached Payment Schedule (Exhibit A).

(NOTE: Payment methodology/rate will be based on whether the CHC purchases blocks of the Dentist’s time (i.e. # hours during certain days/times) or a certain number of appointments, and whether the CHC pays the Dentist based on hourly rate, per service, or other methodology. In either circumstance, the actual payment should reflect fair market value for services and should not differentiate based on ultimate payor source.)

- B. TIMING OF PAYMENT.** No later than the tenth day of each month, Dentist will submit to CHC a Request for Payment, which details the specific services provided to Participating Patients during the previous month, the number of hours worked or appointments conducted (as applicable), and other information reasonably required by CHC to verify the provision of services and, as applicable, to submit claims for such services to appropriate Federal, State and/or private payors. CHC agrees to reimburse Dentist (in accordance with rates set forth in Exhibit A) for all Requests for Payment properly submitted by Dentist to CHC within [_____] days of CHC’s receipt of such requests.

VIII. Term and Termination

- A. TERM.** This Agreement begins on [_____] and shall remain in effect until [_____] , unless terminated earlier in accordance with the terms contained herein. This Agreement may be renewed for additional terms, subject to CHC’s determination that Dentist performed satisfactorily and successful re-negotiation by the parties of key terms, as applicable.
- B. TERMINATION WITHOUT CAUSE.** Either Dentist or CHC may terminate this agreement, for any reason, at any time upon thirty (30) days written notice.
- C. TERMINATION FOR CONVENIENCE.** This Agreement may be terminated at any time upon the mutual agreement of the parties.
- D. TERMINATION FOR BREACH.** This Agreement may be terminated by either party upon written notice to the other party of such other party’s material breach of any term of this Agreement, subject to a thirty (30) day opportunity to cure and failure to cure by the end of the thirty (30) day period.
- E. IMMEDIATE TERMINATION.** In addition, CHC may terminate this Agreement immediately upon written notice to Dentist of: (1) Dentist’s violation of, or inability to comply with, his or her obligations set forth in Sections X, XI, or XII(A) herein; or (2) the good faith determination of CHC that the health, welfare and/or safety of Participating Patients receiving care from Dentist is or will be jeopardized by the continuation of this Agreement.
- F. SURVIVAL.** Upon termination, the rights and obligations of Dentist and CHC under this Agreement will terminate, except as otherwise noted in this Agreement. Termination, however, will not release Dentist from his or her obligation to complete any multi-step dental treatment which Dentist began prior to the effective date of the termination, provided that such termination did not result from a determination by CHC that the health, welfare and/or safety of Participating Patients would be jeopardized by continuing this Agreement. Dentist is not obligated to provide any other services. Termination of this Agreement does not release CHC from its obligation to reimburse Dentist for any dental services provided on or before the effective date of the termination.

Model Dental Services Agreement *cont.*

IX. Case Management

- A. AGREEMENT TO PROVIDE DESIGNATED NUMBER OF SERVICES.** Dentist agrees to provide services to the CHC in one or both of the following manners (check one or both as applicable):

_____ # of Participating Patients per [TIME PERIOD]; and/or

_____ hours per week during the following specified times: _____.

The above parameters may be modified by mutual agreement of Dentist and CHC.

- B. VERIFICATION OF PATIENT STATUS.** CHC agrees to verify each Participating Patient's status as a registered CHC patient on the day on which an appointment is made for such patient with Dentist. Dentist agrees to verify information regarding the patient's status as a CHC patient on the date of service, or shall establish an alternative mutually-acceptable method of verifying with CHC the status of patients presenting to Dentist. If it is determined that the Participating Patient is not a CHC patient on the date of service, CHC, in consultation with Dentist, will decide whether or not to authorize Dentist to proceed with treatment. If CHC authorizes Dentist to proceed with treatment, CHC will be responsible for payment for the services provided by Dentist according to the compensation provisions in this Agreement.
- C. ENABLING SERVICES.** To assist Dentist in treating Participating Patients, CHC agrees to provide appropriate interpreter services as reasonably needed, unless CHC and Dentist otherwise agree.
- D. REFUSAL TO PROVIDE SERVICES.** Dentist has the right to refuse services to any Participating Patient who has a history of breaking appointments with Dentist without good cause (as determined by Dentist), or who has behaved in a disruptive or grossly discourteous manner towards Dentist, Dentist's employees or other patients. Dentist must promptly report all such instances to CHC, who will notify the Participating Patient that, unless the Participating Patient corrects such behavior immediately, he or she will no longer be eligible to receive dental services from the Dentist. In such a case, Dentist has no obligation to provide further services for that Participating Patient.

X. Licensure, Quality, Policies and Procedures

- A. LICENSURE, CERTIFICATION AND OTHER QUALIFICATION.** Dentist will provide CHC with evidence of current licensure within the State of [insert applicable State] (as well as any other certification or qualification necessary to provide the services hereunder) prior to entering into this Agreement, and annually upon request of CHC, and will maintain unrestricted licensure and/or certification and qualification as a Medicaid and, as applicable, Medicare participating provider during the term of this Agreement. Dentist agrees to have such additional qualifications and credentials as CHC may reasonably require for Dentist to provide services pursuant to this Agreement and shall maintain such qualifications and credentials during the term of this Agreement.
- B. REFERRAL FOR SPECIALTY SERVICES.** Dentist agrees to provide to Participating Patients all reasonable and necessary dental services, as listed in Exhibit A (Covered Services), that are within the Dentist's knowledge, skill and training. To the extent that Dentist is not able or qualified to provide a necessary dental service to a Participating Patient, Dentist has no obligation to provide such specialized treatment, but must contact the CHC as soon as practical so that alternative arrangements can be made.
- C. COMPLIANCE WITH LAW.** Dentist will practice in accordance with the all Federal, State and local laws, regulations, and generally accepted principles applicable to the practice of dentistry. Failure to comply with this provision is grounds for immediate termination under Section VIII.E of this Agreement.
- D. CHC POLICIES AND PROCEDURES.** Dentist will provide services pursuant to this Agreement in accordance with CHC's Section 330 grant and applicable grant-related expectations and requirements, as well as policies and procedures established by CHC's governing Board of Directors with respect to health care services, clinical guidelines, standards of conduct, productivity standards and provider grievance and complaint resolution, as may be amended from time to time, to the extent that such policies, procedures and standards apply to the services provided. CHC will provide Dentist with such requirements, policies, procedures and standards, upon request. Notwithstanding, nothing herein is intended to interfere with Dentist's professional judgment in connection with the provision of such services.
- E. QUALITY ASSURANCE AND PATIENT GRIEVANCE PROCEDURES.** Dentist agrees to participate in CHC's quality assurance programs, as described in Exhibit D, to the extent required of all providers providing services to CHC. Dentist also agrees to be bound by CHC's patient grievance procedures, as outlined in Exhibit E. CHC may amend these procedures from time to time and will provide Dentist with notice of such amendment. Dentist shall have an opportunity to discuss any proposed amendments to CHC's quality assurance and grievance procedures prior to proposed amendments becoming effective. If Dentist does not agree to CHC's proposed amendments, Dentist may terminate this Agreement pursuant to Section VIII.B above.

XI. Record-keeping and Reporting, and Compliance with Applicable Laws and Regulations

- A. PROGRAMMATIC RECORDS.** Dentist agrees to prepare and maintain programmatic, administrative and other records and information that pertain to the services provided hereunder and that CHC and/or DHHS may reasonably deem appropriate and necessary for the monitoring and auditing of this Agreement, and to provide them to CHC as reasonably requested. In addition, Dentist will maintain such records and provide such information to CHC or to regulatory agencies as may be necessary for CHC to comply with State or Federal laws, regulations or accreditation requirements, as well as CHC's reporting obligations pursuant to its Section 330 grant.
- B. FINANCIAL RECORDS.** Dentist shall prepare and maintain financial records and reports, supporting documents, statistical records, and all other books, documents, papers or other records related and pertinent to this Agreement for a period of four (4) years from the date this Agreement expires or is terminated. If an audit, litigation, or other action involving the records is started before the end of the four (4) year period, Dentist agrees to maintain the records until the end of the four (4) year period or until the audit, litigation, or other action is completed, whichever is later. Dentist shall make available to CHC, DHHS and the Comptroller General of the United States, or any of their duly authorized representatives, upon appropriate notice, such financial systems, records, reports, books, documents, and papers as may be necessary for audit, examination, excerpt, transcription, and copy purposes, for as long as such systems, records, reports, books, documents, and papers are retained. This right also includes timely and reasonable access to Dentist personnel for the purpose of interview and discussion related to such documents. Dentist shall, upon request, transfer identified records to the custody of CHC or DHHS when either CHC or DHHS determine that such records possess long term retention value.
- C. PARTICIPATING PATIENT RECORDS.** Dentist agrees to establish and maintain dental records relating to the diagnosis and treatment of Participating Patients served pursuant to this Agreement. All such records shall be prepared in a mutually agreed upon format that is consistent with the clinical guidelines and standards established by CHC. Dentist and CHC agree to maintain the privacy and confidentiality of such records, in compliance with all applicable Federal, State and local law (including, but not limited to, the Health Insurance Portability and Accountability Act) and consistent with CHC's policies and procedures regarding the privacy and confidentiality of patient records.
- D. RETENTION OF PATIENT RECORDS.** Dentist will retain dental records for seven (7) years beyond the last date of delivery of the services, or, upon the death of the patient, for three (3) years. X-Ray films must be kept for three (3) years. In the event that Dentist retires or discontinues his or her practice, Dentist must comply with the public and private notice provisions set forth in [applicable State law], and must retain medical records for at least sixty (60) days following both the public and private notice to patients. Record retention obligations survive the termination of this Agreement.
- E. OWNERSHIP OF PATIENT RECORDS.** Dentist and CHC agree that CHC shall retain ownership of all dental records established in accordance with Section XI.C of this Agreement, regardless of the physical location in which such records are housed. Dentist and CHC agree that Dentist, upon reasonable notice to CHC and consistent with applicable Federal and State laws and regulations and CHC's policies and procedures regarding the privacy and confidentiality of patient records, shall have timely and reasonable access to patient records to inspect and/or duplicate at Dentist's expense, any individual chart or record produced and/or maintained by Dentist to the extent necessary to: (i) meet responsibilities to patients for whom Dentist provides services pursuant to this Agreement; (ii) respond to any government or payor audits; (iii) assist in the defense of any malpractice or other claims to which such chart or record may be pertinent; and (iv) for any other legitimate business purpose, consistent with patient confidentiality and to the extent permitted by law. In the event that such records are housed in Dentist's practice location or any other location controlled by Dentist, CHC shall have reasonable and timely access to such records.
- F. MISREPRESENTATION.** Dentist acknowledges and agrees that willful misrepresentation of the type, frequency, reasonableness and/or necessity of dental services provided to Participating Patients may constitute a fraudulent act and may be referred by CHC to the applicable Federal or State regulatory agency, and will be cause for immediate termination under Section VIII.E of this Agreement.
- G. COMPLIANCE WITH OTHER LAWS.** In connection with the provision of services pursuant to this Agreement, Dentist agrees to the following requirements, to the extent that such requirements are applicable:
1. To comply with the Civil Rights Act of 1964 and all other Federal, State or local laws, rules and orders prohibiting discrimination, as well as Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented by U.S. Department of Labor regulations at 41 C.F.R. Part 60;
 2. To make positive efforts to utilize small businesses, minority-owned firms and women's business enterprises in connection with the work performed hereunder, whenever possible;

Model Dental Services Agreement *cont.*

3. To comply with all applicable standards, orders, and regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. § 7401 et. seq.) and the Federal Water Pollution Control Act (33 U.S.C. § 1251 et seq.), as amended;
4. To comply with the certification and disclosure requirements of the Byrd Anti-Lobbying Amendment (31 U.S.C. § 1352), and any applicable implementing regulations, as may be applicable; and
5. To certify that neither it, nor any of its principal employees, has been debarred or suspended from participation in federally-funded contracts, in accordance with Executive Order 12549 and Executive Order 12689, entitled “Debarment and Suspension,” and any applicable implementing regulations.

XII. Insurance

- A. **PROOF OF COVERAGE.** Dentist will provide CHC with sufficient evidence of professional liability coverage in the amount of at least [\$ _____] per claim and [\$ _____] in the aggregate, and general liability coverage of at least [\$ _____]. If requested by CHC, Dentist will submit proof of such insurance to CHC on an annual basis, and in all cases will notify CHC immediately of any termination, suspension or material change in coverage.
- B. **INDEMNITY.** Dentist will indemnify and hold harmless CHC against any and all liabilities, claims, causes of action and losses, including attorney fees, arising out of any act or omission of Dentist or his or her employees or agents, including any professional negligent action or professionally negligent failure to act of Dentist or his or her employees or agents. CHC similarly agrees to indemnify and hold harmless Dentist against any and all liabilities, claims, causes of action and losses, including attorney fees, arising out of any action or failure to act of CHC or its employees or agents.

(NOTE: This Section assumes that CHC has appropriate insurance to cover indemnification (FTCA does not cover indemnification of third parties). If that is not the case, the second sentence of Section B should be deleted. If the Dentist will not agree to indemnify CHC without a reciprocal indemnification, it is best to delete the entire Section B.)

XIII. Confidentiality

- A. Except as is necessary in the performance of this Agreement, or as authorized in writing by a party or by law, neither party (nor its directors, officers, employees, agents, and contractors) shall disclose to any person, institution, entity, company, or any other party, any information which is directly or indirectly related to the other party that it (or its directors, officers, employees, agents, and contractors) receives in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) as a result of performing obligations under this Agreement, or of which it is otherwise aware. The parties (and their directors, officers, employees, agents, and contractors) also agree not to disclose, except to each other, any proprietary information, professional secrets or other information obtained in any form (including, but not limited to, written, oral, or contained on video tapes, audio tapes or computer diskettes) during the course of carrying out the responsibilities under this Agreement, unless the disclosing party receives prior written authorization to do so from the other party or as authorized by law.
- B. The parties agree that their obligations and representations regarding confidential and proprietary information (including the continued confidentiality of information transmitted orally), shall be in effect during the term of this Agreement and shall survive the expiration or termination (regardless of the cause of termination) of this Agreement.

XIV. General Provisions

- A. **AMENDMENT/MODIFICATION.** This Agreement may be amended or modified from time to time upon the mutual written agreement of the parties. Any amendment or modification shall not affect the remaining provisions of the Agreement and, except for the specific provision amended or modified, this Agreement shall remain in full force and effect as originally executed.
- B. **ASSIGNMENT.** This Agreement may not be assigned, delegated, or transferred by either party without the express written consent and authorization of the other party, provided prior to such action.
- C. **EFFECT OF WAIVER.** A party to this Agreement may waive the other party’s breach of a provision of this Agreement, but such a waiver does not constitute a waiver of any future breaches.
- D. **EFFECT OF INVALIDITY.** The invalidity or unenforceability of any provision of this Agreement in no way affects the validity or enforceability of any other provision, unless otherwise agreed.
- E. **NOTICE.** Any notice required to be provided under this Agreement must be in writing and delivered in person or sent by registered or certified mail or by next business day delivery service to each party at the address set forth on the signature page.

Model Dental Services Agreement *cont.*

- F. INDEPENDENT CONTRACTOR STATUS.** The relationship of Dentist to CHC at all times will be of an independent contractor. None of the provisions of this Agreement will be interpreted to create a relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Dentist nor CHC, nor their employees or agents, will be construed to be the agent, employer or representative of the other.
- G. DISPUTE RESOLUTION.** Any dispute arising under this Agreement shall first be resolved by informal discussions between the parties, subject to good cause exceptions, including, but not limited to, disputes determined by either party to require immediate relief (i.e., circumstances under which an extended resolution procedure may endanger the health and safety of the Participating Patients). Any dispute that has failed to be resolved by informal discussions between the parties within a reasonable period of time of the commencement of such discussions (not to exceed thirty (30) days), may be resolved through any and all means available.
- H. CHOICE OF LAW.** This Agreement shall be governed in accordance with the laws of the State of [insert applicable State]. Any disputes arising under this Agreement will be settled in accordance with the law of the State of [insert applicable State].
- I. ENTIRE AGREEMENT.** This Agreement represents the complete understanding of the parties with regard to the subject matter herein and, as such, supersedes any and all other agreements or understandings between the parties, whether oral or written, relating to such subject matter. No such other agreements or understandings may be enforced by either party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

ACCEPTED AND AGREED TO THIS ____ DAY OF ____, 20__.

Signatures:

Date: _____

Date: _____

Name of Dentist: _____

Name of CHC: _____

Practice Name: _____

Exec. Dir. _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Facsimile: _____

Facsimile: _____

Contact: _____

Contact: _____

Acknowledgements

Children’s Dental Health Project appreciates support from the California HealthCare Foundation for updating this Handbook. The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, its goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford.

This document was originally created in 2003 with the support of the Connecticut Health Foundation. The Connecticut Health Foundation is Connecticut’s largest independent health philanthropy dedicated to improving lives by changing health systems. Since it was established in July 1999, the foundation has supported innovative grant-making, public health policy research, technical assistance and convening to achieve its mission to improve the health of the people of Connecticut.

The National Association of Community Health Centers (NACHC) and the American Dental Association (ADA) provided helpful comments and suggestions, which were incorporated into the Handbook. NACHC arranged for the services of Attorney Marcie Zakheim of Feldesman Tucker Leifer Fidell LLP, who assured that recommendations comply with pertinent federal law, regulation, and policy.

The Children’s Dental Health Project is a national oral health policy analysis and advocacy organization committed to creating and advancing innovative solutions to achieve oral health for all children.

End Notes

¹ FQHCs are health centers that have met federal requirements for services, programs, and structure and have therefore qualified for funding through Section 330 of the federal Public Health Service Act. These grants support provision of health care and related services to medically underserved and vulnerable populations residing in their communities. FQHCs are also eligible for additional benefits, such as, enhanced reimbursement under Medicaid and Medicare, professional malpractice coverage under the Federal Tort Claims Act, and discount drug pricing.

² FQHC Look Alikes are entities that do not receive Federal grant funds under Section 330, but comply with the same functional characteristics, operate under the same statutory and regulatory requirements and are eligible for some, but not all, of the additional benefits available to grantee health centers. Throughout this Handbook the terms “FQHC” and “health centers” denote both FQHC Look-Alike entities and grantee organizations.

³ The terms “dentist” and “contracted dentists” refer exclusively to private dentists who contract with the health center to provide dental services, on behalf of the health center, to health center patients, either in the dentist’s private offices or, less frequently, in a dedicated space located within the health center facility.

⁴ HRSA is an operating division of the United States Department of Health and Human Services responsible for issues of access, particularly for underserved populations. The FQHC program is managed by HRSA’s Bureau of Primary Health Care.

⁵ CMS is the Federal agency responsible for administering the federal Medicaid, Medicare, and State Child Health Insurance programs and for designating, upon recommendation of HRSA, certain health centers as FQHC “look-alike” entities.

⁶ In 2007, the Office of Inspector General (OIG) promulgated a federal anti-kickback safe harbor specifically for FQHC grantees, under which certain arrangements between grantees and their contracting partners (vendors, suppliers, other providers) will be protected from anti-kickback prosecution when contracting for the provision of no-cost or below market rate goods, items or services which ultimately benefit the FQHC’s patients, provided that the specific arrangement satisfies all requirements and conditions of the safe harbor. However, safe harbor does not apply to violations of the federal physician self-referral law (Stark). In addition, state anti-kickback and Stark laws may also apply.

⁷ Please note that whether the contracted dentist can treat health center Medicaid patients without registering as a Medicaid provider typically varies by state; thus, it is important to contact your state Medicaid agency to ensure compliance with the contracting rules specific to your Medicaid program.

⁸ Please note that whether a specific Medicaid agency requires FQHCs to credential each of its providers—employed or contracted—for purposes of serving Medicaid patients typically varies by state; thus, it is important to contact your state Medicaid agency to ensure compliance with the rules specific to your Medicaid program.



Children's Dental Health Project
1020 19th Street NW, Suite 400
Washington , DC 20036
Phone: 202.833.8288
Fax: 202.331.1432
www.cdhp.org