

Increasing Access to Dental Care Through Public/Private Partnerships:

Contracting Between Private Dentists and Federally Qualified Health Centers

A Handbook



Developed for the Connecticut Health Foundation

By Burton L. Edelstein, D.D.S., M.P.H., of the
Children's Dental Health Project

September 2003



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9/10/03

Leo Canty, Chair Board of Directors
Patricia Baker, President
Connecticut Health Foundation
270 Farmington Avenue, Suite 357
Farmington, Connecticut 06032

Dear Mr. Canty and Ms. Baker:

On behalf of the American Dental Association, I congratulate the Connecticut Health Foundation for recognizing the important role that private contracting between private sector dentists and Community Health Centers can play in ensuring that CHC patients are provided with cost-effective, high quality oral health care services. ADA policy supports increased private contracting and the Handbook developed by the Children's Dental Health Project for the Connecticut Health Foundation is an important step in furthering this policy.

The ADA welcomes the introduction of the Handbook. It will be a valuable tool for both dentists and Community Health Centers to understand how to encourage contracts between private dentists and health centers.

The ADA is mindful of the numerous, state-specific issues which must be addressed in these contracts and that dentists and health centers need to carefully review with their attorneys both their individual needs and state law requirements. Nevertheless, the Handbook highlights some key issues, which will need to be addressed in order to improve access to dental care through increased private contracting between Community Health Centers and private sector dentists.

Again, congratulations and thanks for your efforts.

Sincerely,

A handwritten signature in black ink that reads "T. Howard Jones DMD".

T. Howard Jones, DMD
President

cc: Dr. Burton Edelstein, founding director, Children's Dental Health Project



Mr. Leo Canty, Chair, Board of Directors
Ms. Patricia Baker, President
Connecticut Health Foundation
270 Farmington Avenue, Suite 357
Farmington, CT 06032

September 2003

Dear Leo and Patricia,

On behalf of health centers all across the country and the 12 million Americans who rely on them for health care, I am pleased to offer our strong support for “Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers,” a handbook developed for the Connecticut Health Foundation by the Children’s Dental Project. We very much appreciate the efforts of the Children’s Dental Health Project to involve NACHC and our legal counsel in the development of the Handbook. We hope that the use of this publication will contribute to expanded access to dental health care services for poor, uninsured and underserved individuals across the country.

This publication, including the model contract, 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 strongly support its being made available to every health center across the country.

Once again, thank you for the opportunity to work with your foundation and the Children’s Dental Health Project on this important project.

Sincerely,

Daniel R. Hawkins, Jr.
Vice-President for Federal, State, and Public Affairs

cc: Burton L. Edelstein, D.D.S., M.P.H., Anne De Biasi, MHA, Children’s Dental Health Project



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Introduction

The Connecticut Health Foundation (CHF) vigorously supports the goal of improving equity in access to dental care. As part of a multi-stage strategy to improve access, the Foundation commissioned the Children’s Dental Health Project (CDHP) to investigate strategies to improve access to dental services for underserved populations. One such strategy of wide interest and potential application involves establishing contractual arrangements between Federally Qualified Health Centers (FQHCs) and “FQHC Look Alikes” (both herein referenced as “FQHCs” or “health centers”)¹ and private-practice dentists (“dentists”)² for the purpose of providing dental services to health center patients, either in the dentists’ private offices or in designated areas within health center facilities.



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

There are many advantages to both the dentist and health center when they contract to provide care to FQHC patients. Dentists can provide services to Medicaid patients without necessarily registering as Medicaid providers³; are relieved of most responsibility to bill FQHC patients or their insurers⁴; can predetermine blocks of time, numbers of patients, or numbers of visits they wish to provide for care of the underserved; and can answer the needs of those in their community who have the most need and least access to care. For health centers, contracting allows them to meet their requirement that they provide dental services to their patients, reduce their need for expensive capitalization of dental facilities and equipment, reduce their direct staff costs, expand the number of available dental providers, reduce the length of waiting times for patients to receive services and may help make dental service costs more predictable.

Most FQHCs have experience entering contractual agreements with private providers to increase their capacity to provide specific medical services to health center patients. For example, some contract with obstetricians to increase their capacity for prenatal care. To date, however, this approach has not been widely explored in the area of dental services.

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

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 U.S. Department of Health and Human Services (DHHS) and, in particular, the Bureau of Primary Health Care (BPHC), located within the Health Resources and Services Administration (HRSA)⁵. BPHC is the agency responsible for administering the



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FQHC program and the “Section 330” grant funds that support them. Officials from HRSA and from the Centers for Medicare and Medicaid Services (CMS)⁶ provided invaluable assistance to this project regarding federal requirements on health centers. Every effort was made to create a Handbook that 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. As a result, there is controversy and inconsistency among regional federal offices about this practice. 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 to engage in these opportunities. It also provides dentists and health center administrators with a step-by-step decision 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 ADA’s Council on Governmental Affairs staff, and dentists and health centers that support this practice. We acknowledge legal contributions, guidance, and review from the Connecticut Appleseed Center for Law and Justice, Inc., and NACHC’s attorneys, the firm of Feldesman Tucker Leifer Fidell LLP in Washington, D.C.

These documents are intended as guidance, based on federal law and policy, for those dentists and 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 suited to them and review all legal documents for compliance with all current federal, state, and local laws and regulations.

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



PARTNERSHIPS

Getting Started



**EACH HEALTH CENTER IS
REQUIRED TO ESTABLISH
A FEE SCHEDULE FOR
ITS SERVICES THAT IS
CONSISTENT WITH LOCALLY
PREVAILING RATES.**

1. REQUIREMENTS TO PROVIDE DENTAL SERVICES AND AUTHORITY TO CONTRACT

All FQHCs are required by the Section 330 grant program to provide “primary health services,” which are defined in the statute to include “preventive dental services” [42 U.S.C. §254b(a)(1) and §254 (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:

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

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 be required to provide additional oral health services pursuant to their participation in a federal oral health initiative or receipt of supplemental grant funding to expand the range and type of dental services available (see Section 3 below).

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 ability to pay or payor source.

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 also must establish a schedule of discounts, based on patient income, which are utilized for underinsured and uninsured patients when these patients incur out-of-pocket costs.

An FQHC that does not have sufficient internal capacity to provide directly the required and, as necessary, additional health care 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,

- the FQHC operates as the licensed billing provider of services;
- all patients served by the contracted provider are the FQHC’s patients; and
- 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 individuals’ ability to pay or their payor source. Each of these elements is addressed below.



PARTNERSHIPS

Getting Started

2. OBTAINING AUTHORITY TO PROVIDE DENTAL SERVICES:

SCOPE OF PROJECT

FQHCs define their *Scope of Project* in two ways. First, the FQHC defines its scope as part of its original Section 330 grant application (or its initial application for supplemental expansion funds), by designating whether it intends to provide certain services directly, through contract, or by referral (for which the health center may or may not pay the referral provider). Second, once a health center's scope has been approved by BPHC, it can request a change in its scope to either add or delete specified sites or services in accordance with BPHC Policy Information Notice #2002-07, provided that the health center does not request any additional federal funds to implement the change. This request can be submitted at any time, but must be submitted separate from the health center's continuation grant. If, however, additional federal funds are needed to implement the change, a request for additional grant funds should be submitted as part of a grant application to expand services (see Section 3 below).

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 are available. It also defines the services that must be offered to all health center patients, regardless of whether such services are provided directly or by contract. 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.

SCOPE OF PROJECT
1. INITIAL APPLICATION FOR SUPPLEMENTAL EXPANSION FUNDS
2. REQUEST CHANGE IN SCOPE

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 through competitive applications to HRSA. Receipt of such an award automatically defines or, in the case of expansion grants, revises, that center's *Scope of Project* to reflect the new funding. For example, a competitive grant opportunity may provide supplemental funding to expand various services, including dental care.



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Getting Started



FOUR WALLS TEST

1. MEDICAL RECORD
2. CENTER AS MEDICAL HOME
3. OBTAINS PRIMARY CARE SERVICES
4. MEET PATIENT'S NEEDS

4. DEFINING THE “PATIENT”

In the past, CMS utilized a stringent set of criteria to define a patient. It specified that the FQHC patient have a “medical record” at the center, uses the center as a “medical home,” and “obtains primary care services at the center that meet the patient’s needs” (the so-called “four walls test”). In general, the central office of CMS has now adopted a less stringent HRSA definition. It now defines a health center patient as someone who uses the services of the health center as his or her principal source of primary health care. A patient typically resides in the center’s service area and is able to “reasonably” access primary and preventive care services at the center.

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 regulators, states also have authority to define the term “patient” for purposes of determining whether contracted services qualify as “FQHC services.” It is therefore advisable that health centers check with their respective state Medicaid agencies prior to entering into contracting arrangements for 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. HRSA-supported FQHCs also may use a portion of their Section 330 funds to subsidize the otherwise uncompensated costs of providing services to underinsured 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 through age 21 years under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. 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 and, in some cases, some adults, through the State Children’s Health Insurance Program (SCHIP). As of mid-2003, all states except Delaware and Texas offer some dental coverage through SCHIP but additional states are considering dropping dental benefits in this program.

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 Notice A-122. For example, 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-block of time, or any other basis agreeable to the parties.

For purposes of federal anti-kickback law, the payment amount should reflect an "arm's length," negotiated fair market dollar value for services provided under the contract.

The payment provided by the health center to the contracted dentist should not be equivalent to 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 payors, or equivalent to a specified portion of its Section 330 grant funds. That is, the health center is not permitted to "pass-through" its Medicaid or Medicare reimbursement or a specified portion of its Section 330 grant funds to another provider. Therefore, the health center's Medicaid reimbursement rate cannot directly determine the rate payable to contracting dentists.

To establish their own internal Medicaid enhanced reimbursement rates, health centers provide estimated cost data to their state Medicaid authorities. Medicaid agencies use these estimates to calculate an adjusted visit rate by employing formulas that vary somewhat by state and 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 accepts 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 the reasonableness of the proposed costs, and the agency may limit its payment to the health center accordingly. While the Medicaid agency 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.



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Getting Started

**IT IS ADVISABLE FOR
THE HEALTH CENTER
TO PARTNER EARLY
WITH ITS STATE
MEDICAID AGENCY.**



PARTNERSHIPS

*Policies and
Procedures*



**BOTH PARTIES SHOULD
CAREFULLY REVIEW
ESTABLISHED POLICIES
AND PRACTICES.**

7. SATELLITES VERSUS “OFF-SITE” SERVICE LOCATIONS AND APPLICABLE POLICIES AND PROCEDURES

When private dentists contract with FQHCs to provide services to health center patients within their own dental offices, their offices may be considered by HRSA to be either satellites of the center or off-site locations for contracted services.

It may be preferable to characterize the dental office as an off-site location for services, rather than a satellite location, under terms of the contract. If a dental office is established as a satellite of the health center, rather than simply as an off-site service location, it would need to comply with a range of facility requirements that may be incumbent on health centers, for example, by the Joint Commission on the Accreditation of Healthcare Organizations 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.

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

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 health center patients served at 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 “agent” for the health center, the dentist is required to provide services to health center patients in a manner that is consistent with applicable health center policies and procedures. Both parties should carefully review their established policies and procedures including, but not limited to clinical protocols and guidelines, quality assurance standards and practices, standards of conduct, and productivity standards to ensure or establish common expectations.

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 are required to establish formal patient grievance procedures. FQHC patients served by private dentists may access these procedures to address any grievance they may have. Dentists should become familiar with pertinent health center policies and procedures before contracting with health centers.

Health centers are required to ensure that their in-house and contracted 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.), are appropriately credentialed, and maintain appropriate insurance coverage. Contracting dentists will need to provide health centers with required credentialing information, including evidence of professional insurance coverage, so that the health center can, in turn, meet its regulatory obligations.



8. PAYMENT MECHANISMS AND SCOPE OF CONTRACTED SERVICES

PARTNERSHIPS

Policies and Procedures

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 ability to pay or payor 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 can see the health center's Medicaid patients without becoming obligated to see all patients enrolled in Medicaid (see Section 8 below).

When contracting by service, patient, visit, or session, 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 a specified range of services for a specific number of patients over a designated period of time for a fixed charge per patient. Contracting "by visit" establishes a fixed payment rate for a visit regardless of the services provided or length of visit. 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.

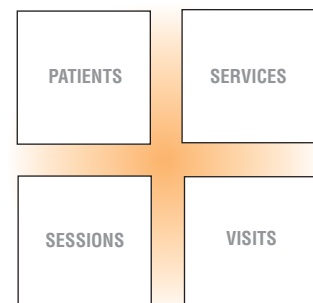
Regardless of approach, both the dentist and health center should seek to determine anticipated costs and income when deciding on a payment methodology in order to limit financial risk to both parties. Ideally, the FQHC will limit its financial risk while still assuring the dentist a predictable income for care of FQHC patients.

Specific services to be provided by the contracted dentist also are 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 *Scopes of Project*, population needs, participation in a supplemental expansion grant or oral health initiative to expand oral health services, and whether they elect to use discretionary and fungible resources for dental care (e.g., foundation or local government support).

Regardless of the range of services negotiated between the dentist and the health center, FQHCs are required to ensure all services defined by their scope 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. Health centers may elect to provide services beyond those required by law or included in their scope. For example, centers that have not expanded their scope to include restorative dental services, may nonetheless elect to provide these services.

It is important to note again that 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.

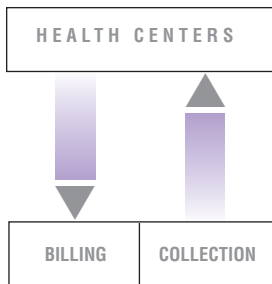
CONTRACTING OPTIONS





PARTNERSHIPS

*Roles, Responsibilities
and Resources*



HEALTH CENTERS ARE RESPONSIBLE
FOR ALL BILLING, COLLECTION,
AND PAYMENT FUNCTIONS.

9. BILLING PATIENTS, MEDICAID, AND OTHER THIRD PARTIES

When dentists contract to health centers to care for FQHC patients, they are freed of any obligation to bill insurers, Medicaid, or patients (beyond collection of payments or co-payments routinely due at the time of service); and they need only provide information on all of their FQHC patient services to the health center. Under this arrangement, health centers are responsible for all billing, collection, and payment functions.

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 do not require FQHCs to re-credential each new provider for purposes of Medicaid, although each new provider will need to be initially 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 based on the agreed-upon payment methodology. 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 billing agent, directly.

10. RISKS

For dentists, contracting with an FQHC does not entail financial risk beyond the possibilities of FQHC insolvency or of incurring higher than anticipated costs in providing services. However, depending on the payment methodology chosen by the parties, health centers may bear significant financial risk if they are 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 services, patients, visits, or sessions to be provided and monitor experience carefully. For example, the dentist and the health center may elect to institute a utilization and cost review during the 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, or due to patient dissatisfaction with the services provided. Therefore contracts should include suitable "hold harmless" and termination clauses 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 other's 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 of all contracted services provided to health center patients. For example, 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 visits, 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. To ensure this, the dentist and the health center can negotiate a fee-for-service equivalent charge when contracting on a per-patient, per-visit, or per-session basis or the dentist can report the value of services provided in terms of customary charges.

Monitoring and oversight duties required of health centers extend to assurances regarding the dentist's professional qualifications. At the outset 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, they typically include evidence needed to support credentialing, assurance that the dentist has not been disqualified as a provider under federal health care programs, such as the Medicaid program or SCHIP, and evidence of sufficient liability insurance.

Both the dentist and health center should reserve the right to determine whether the other party continues to meet all contractual requirements and is performing satisfactorily and, if not, to terminate the contractual arrangement, subject to obligations to complete patient care.

Under typical contracting arrangements, the health center guarantees the dentist timely payment and the dentist agrees to provide health centers with necessary service delivery and financial reports reflecting his or her care of health center patients. Health centers may need to access records maintained by the dentist that pertain to services provided to health center patients in order to meet their performance, quality assurance, and general monitoring and oversight requirements. Since the contract is expected to be typically paid with federal funds, the dentist also may be asked by appropriate governmental funding agencies to provide access to pertinent 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.**



PARTNERSHIPS

Roles, Responsibilities and Resources

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, has primary responsibility for awarding and administering Section 330 grant funds, and the health center program. HRSA maintains ten Field Offices that support its various programs in the states including providing 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 Children’s Health Insurance Program (SCHIP). It, too, currently maintains ten regional offices around the country. These Regional Offices are co-located with the HRSA Field Offices and 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 either in their private offices or in designated areas within the health center facility, FQHCs can hire dentists as full- or part-time staff, or dentists can provide volunteer services within or outside 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 common than contracting with private dentists for patient care, these arrangements are beyond the scope of this Handbook.

14. TECHNICAL ASSISTANCE

HRSA, CMS, ADA, NACHC, and 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, by email at cdhp@cdhp.org, or on the web at www.cdhp.org.

15. MODEL CONTRACT

A companion document, a model “Dental Services Agreement” between private dentists and health centers, is appended for informational purposes. It also is available from the Connecticut Health Foundation at www.cthealth.org and from the Children’s Dental Health Project at www.cdhp.org. This contract, which was developed by the law firm of Jones Day for the Connecticut Appleseed Center for Law and Justice, Inc., was commented on extensively and revised based on input from the Washington, D.C., firm of Feldesman Tucker Leifer Fidell LLP, general counsel for NACHC. This contract also was provided to the ADA for review and comment.

The attached 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 an agreement. Where appropriate, the document provides options for parties to select how they wish to work together.

16. DECISION CHART

As health centers and dentists develop relationships to better serve the oral health needs of underserved individuals in their communities, many key decisions need to be made. The appended Decision Chart for Contracting between Private Dentists and Federally Qualified Health Centers reviews these decisions step-by-step. The Chart is designed to help both parties understand options as well as determine what steps need to be taken to develop an effective, sustainable, and productive relationship.



PARTNERSHIPS

*Roles, Responsibilities
and Resources*



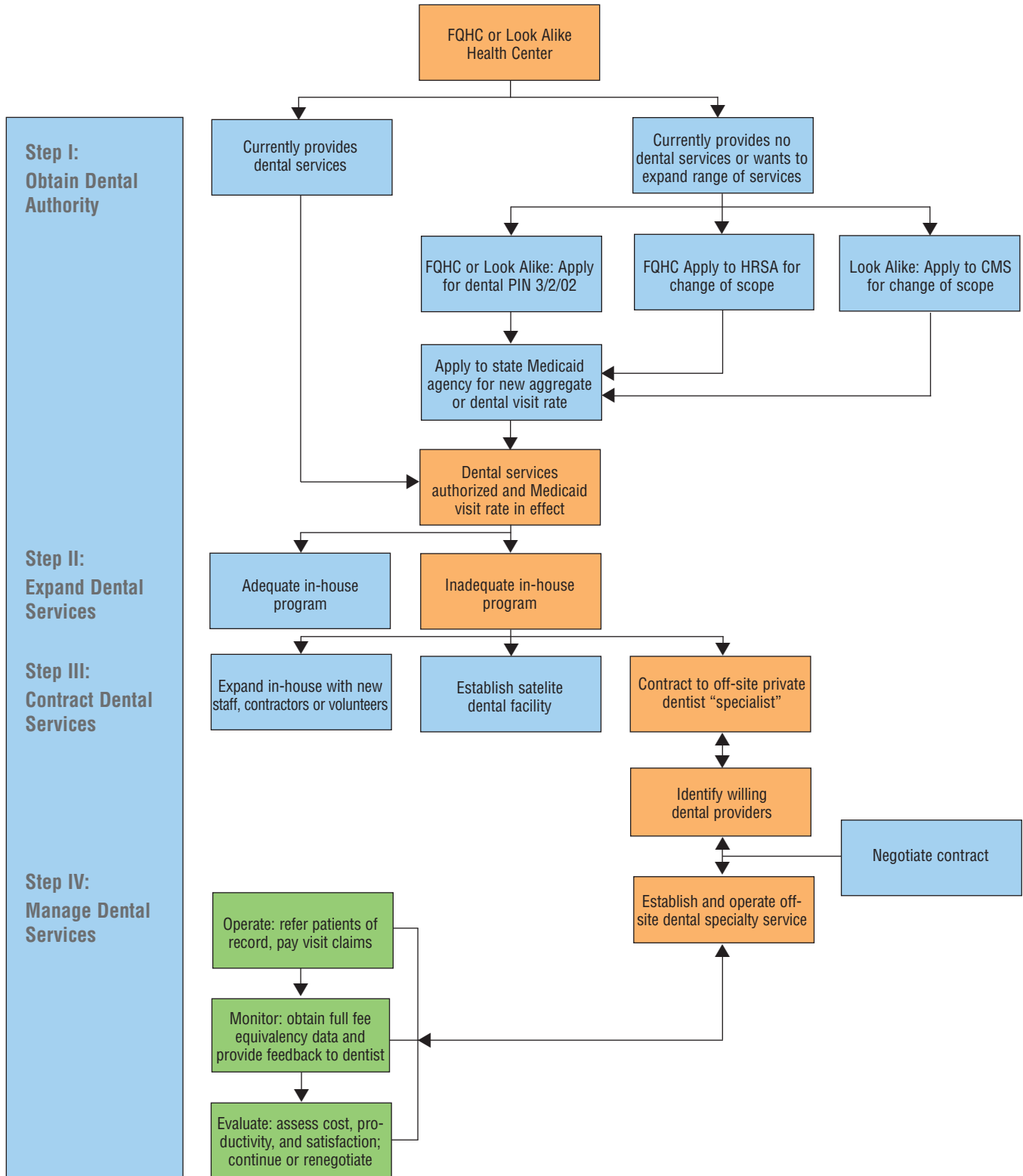
MODEL CONTRACT

IS AVAILABLE AT

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DECISION FLOW CHART OF NECESSARY STEPS TO ESTABLISH OFF-SITE DENTAL SERVICES



ACKNOWLEDGEMENTS

The Connecticut Health Foundation (CHF) and the Children’s Dental Health Project (CDHP) are grateful for the support of many authorities that have contributed information for this challenging project. We particularly appreciate the informal consultation and document review provided by CMS Regional Office and HRSA Field Office staff in Boston, Mass., and by the Bureau of Primary Health Care staff in Bethesda, Md.

At CHF, President & CEO Patricia Baker provided project guidance and direction, and Board Member Peter Libassi provided wide-ranging technical assistance and arranged for contract drafting by attorneys from the firm of Jones Day as part of their work in support of the Connecticut Appleseed Center for Law and Justice, Inc.

At the Connecticut Primary Care Association, Executive Director Evelyn Barnum arranged for meetings with health center CEOs and dental personnel at which the items in this Handbook were discussed in detail.

At the Connecticut State Dental Association (CSDA), Executive Director Noel Bishop and Immediate Past President Michael Egan, D.D.S., provided the opportunity to discuss health center contracting to private dentists at a meeting of its Executive Committee where the perspective of the practicing community was well represented.

Gail Bellamy, Ph.D., Director of Community Studies at the West Virginia Institute for Health Policy Research, facilitated initial review and feedback by local communities of interest.

The National Association of Community Health Centers (NACHC) and the American Dental Association’s Washington, D.C., Office (ADA) provided comments and suggestions, which were incorporated into the document. We thank NACHC for arranging for the services of its general counsel, Feldesman Tucker Leifer Fidell LLP, who reviewed and commented on both this Handbook and the model contract in connection with each document’s compliance with pertinent federal law, regulation, and policy.

CDHP’s Washington, D.C., Director Anne De Biasi worked extensively with both NACHC and the ADA in obtaining their feedback. De Biasi and CDHP’s editor, Joanna Parzakonis, worked together to ensure that the highly technical information provided is both accurate and balanced and is readily understandable to the target audiences of dentists, health center directors, and advocates for equity in health care.

END NOTES

¹ FQHCs are health centers that have met federal requirements for services, programs, and structure and, as a result, have been awarded funding through Section 330 of the Public Health Service Act. These grants support the provision of health care and related enabling services to medically underserved and vulnerable populations residing in their communities, regardless of the individual’s or family’s ability to pay. FQHCs are also eligible for additional benefits, such as, enhanced reimbursement under Medicaid and Medicare, professional malpractice coverage under the Federal Tort Claims Act (FTCA), and discount drug pricing under Section 340B of the Public Health Service Act. 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 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.

² The terms “dentist” and “contracted dentists” refer exclusively to private dentists who provide dental services, on behalf of the health center, to health center patients, either in the dentists’ private offices or in a dedicated space located within the health center facility.

³ To contract with health centers, dentists must be eligible to participate in federal health care programs, including Medicare and Medicaid and cannot be debarred or suspended.

⁴ If the FQHC patient is seen in the dentist’s private office, the health center and the dentist may negotiate terms under which the dentist will collect at the time of service applicable co-pays, including sliding fee payments, and remit those payments to the health center.

⁵ The Health Resources and Services Administration (HRSA) is an operating division of the U.S. Department of Health and Human Services responsible for issues of access, particularly for underserved populations.

⁶ The Centers for Medicare and Medicaid Services (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.

About the Author:

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PARTNERSHIPS

Model Contract

Model Dental Services Agreement

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.

THIS DENTAL SERVICES AGREEMENT (this "Agreement") is entered into this ____ day of _____, 200_, between _____ (the Community Health Center, or "CHC"), a 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 described in Section 501(c)(3) of the Internal Revenue Code (IRC) 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) of the Social Security Act (42 U.S.C. §1396d(l)(2)(B)), 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 preventive 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. PURPOSE

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. (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 whose primary health care needs are served by the 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 access to such records.
- D. Special Services. For dental services needing individual consideration or prior approval from the [insert applicable Federal/State agency], Dentist must provide CHC with documentation necessary to seek 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 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 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. 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). 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 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;
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, 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), 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 Board's policies and procedures, or as otherwise may be necessary to assure appropriate collaboration with other local providers (as required by Section 330 (j)(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. 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 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 of Dentist and CHC under this Agreement will terminate, except as otherwise noted in this Agreement. That 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.

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 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, 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 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.

- 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 Conn. Agencies Regs. § 19a-14-44, 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.
- 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;
 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.
- 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: _____

EXHIBITS

Exhibit A: Payment Schedule (to be inserted)

Exhibit B: Covered Services:

A. Preventive Dental Services Required Under Section 330 of the Public Health Service Act

- 1. Oral hygiene instruction
- 2. Oral Prophylaxis
- 3. Topical application of fluorides
- 4. Prescription of fluorides
- 5. Children's dental screening
- 6. Other

B. Supplemental Dental Services [add additional dental services (1) required by earmarked, expansion grants; (2) required due to participation in a BPHC-funded oral health initiative; or (3) not required, but negotiated between the health center and the dentist, e.g., certain restorative services]

Exhibit C: Services requiring prior approval (to be inserted)

Exhibit D: Description of CHC quality assurance programs (to be inserted)

Exhibit E: Description of CHC grievance procedures (to be inserted)