



# The Funding of Community Health Center Dental Programs in California

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**ABSTRACT** The financing of dental services in community health centers, CHCs, is a mystery to most dentists in private practice, and this lack of knowledge has resulted in misconceptions that hamper mutual support. This review seeks to explain and demystify how CHC dental clinics remain financially viable. The mechanisms of financing dental care in CHCs are described including types of revenues received, financing constraints unique to CHCs and how services to indigent patients are funded.

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Perhaps no aspect of the community health center, CHC, dental practice engenders more questions than financing. There are many myths, assumptions, and opinions about how CHC dental clinics are funded, where their operating income derives from, and how patients are charged for services. There is a common misconception that CHC dental clinics see patients “for free,” that CHCs are “in competition” with private practice dentists, and that the clinics somehow have an unfair advantage because “they are funded by the government.”

## Community Health Center History

To begin to understand CHC dental clinic financing, a brief history is needed. Many of the regulations that govern CHC finances are contained within the federal

legislation that created and continues to fund CHCs.

Community health centers were first developed and funded in the mid-60s as part of President Lyndon Johnson's war on poverty.<sup>1,2</sup> Section 330 of the Public Health Service Act consolidated and defined the characteristics of CHCs.<sup>3</sup> From that point onward, CHCs that receive federal funding have also been known by the short hand of “330s” or “330 CHCs” to differentiate them from other nonprofit clinics that may also exist in a given community.

From an initial group of two demonstration sites, the number of CHCs has grown to 1,067 organizations across the United States and its territories, many with multiple clinic locations, providing medical services to 16 million individuals in 2007.<sup>4</sup> Of 1,067 grantee organiza-

tions, 742 (70 percent) also deliver dental services serving 2.8 million individuals.<sup>4</sup>

The federal government has simplified the terminology so that all programs that have received funding in the past (330 CHCs, migrant health centers, health care for the homeless grantees, health services for the residents of public housing grantees, etc.) will be referred to as “health centers,” although the term CHC will be used in this article.

### Funding Considerations

Two historically codified aspects within the CHC statutes are: 1) A CHC must not deny services to any member of its patient population due to their inability to pay; and 2) the CHC is obligated to offer a sliding fee scale for services to patients with incomes between zero to 200 percent of the federal poverty level, FPL. The 2008 Federal Poverty Level is \$10,400 for a single person, therefore 200 percent of the FPL is \$20,800.<sup>5</sup>

CHCs are nonprofit organizations. However, in the end, the health center as a whole must be financially viable or it would not be able to pay employees or procure supplies to deliver care. As a part of the health center, the dental clinic is under the same constraints. Like a private practice, a dental clinic must be self-sustaining over the long term, or it will not survive.

CHC dental program expenditures are the same as in any private practice, including salaries, supplies, utilities, laboratory costs, and capital equipment. Additionally, the dental program may be assigned its proportionate share of administrative overhead for the entire health center.

### Revenues

There are a few important differences in the types of revenue received by private practices and CHCs. CHC dental clinics receive traditional reim-

bursement sources such as third-party payer revenues from insurance plans and patient fees. Unlike private practice, a CHC dental program can/should be assigned revenue that is a percentage of the total health center 330 grant, usually based on the percentage of total health center operating costs that the dental program utilizes. A dental program can also have additional funding sources such as private grants and donations.

Another key difference is that CHCs are reimbursed for Denti-Cal visits in a different manner than in private practice. In California, the Medicaid program is called Medi-Cal for medical services and

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When CHCs were initially developed, services to Medicaid beneficiaries in CHCs were reimbursed in a fee-for-service manner. This was changed in 1989 when Congress created the Federally Qualified Health Center, FQHC, provision of the Medicaid program. Under this provision, CHCs could be reimbursed their average cost of providing a visit as determined by each state Medicaid program.<sup>6</sup> This was called the “cost-based” reimbursement system.

When this change in reimbursement occurred, each CHC had to apply to be designated as an FQHC and to determine the initial per encounter reimbursement rate for the health center. Variables that influenced the individual FQHC reimbursement rate were the cost of providing services in a rural versus urban community, the total scope of services the health center provides and the local variations in the cost of living. FQHC rates could increase yearly based on the federal cost of living adjustments.

In 2001, newer legislation modified the terminology and methodology for determining the per visit reimbursement, now called the “Prospective Payment System,” with medical and dental services in California CHCs are still reimbursed on a per encounter basis.

### Sliding Scale

Returning to the original purpose of the 330 Public Health Service Act, which was to increase access to health care for individuals with income and/or geographic barriers, what makes health centers unique is that CHCs utilize what in private practice would be considered the “profit,” to subsidize the sliding scale for services offered to indigent patients without resources to pay the full fee.

Health center patients without an existing third-party payer source would be routed to the health center’s eligibility department, to ascertain if the client might be eligible for some type of third-party payer program. Clients will be assisted in applying for benefits. If a client does not qualify for any third-party payer program, then their income level is verified and used to assign their individual/family sliding scale discount. In most health centers, clients can only qualify for a sliding scale discount if their income is between zero and 200

percent of the FPL. Clients above that level pay the regular full fee for services.

The development of the sliding scale fees for dental services is both an art and a science. Although the sliding scale may be described as 100 percent (or full discount), 75 percent, 50 percent and 25 percent based on income, those clients at 100 percent full discount are usually expected to pay a nominal fee that should not impede access but yet contributes to the viability of the dental clinic. Some services such as prosthodontics may never be discounted to a nominal fee even for those at 100 percent sliding scale because these services generate upfront costs for the dental clinic through laboratory charges.

A practical example can illustrate this process. Assume that a private practice and a CHC dental clinic have the same fee schedule and the same 65 percent overhead. If in a private practice the fee for a particular procedure is \$100 with an overhead of 65 percent, then the dentist (if reimbursed fully) will have a \$35 profit. In a CHC dental practice, an individual with a 100 percent sliding scale discount may be charged \$25 for the same procedure. The dental clinic must still subsidize the remaining \$40 from some other revenue stream (330 grant, foundation grant, FQHC reimbursements), in order to remain fiscally viable.

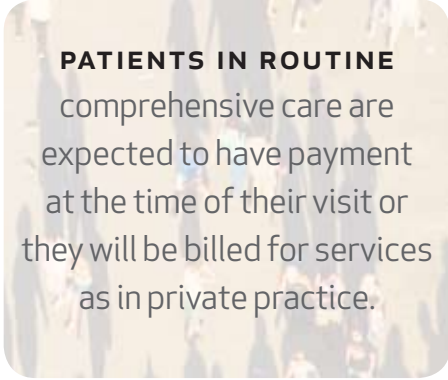
The more “profit” a health center dental clinic generates beyond its operating expenses, the more subsidized dental care can be provided to indigent patients. In this way, health center dental clinics fulfill the mandate of the original 330 legislation to create access to dental care for individuals otherwise unable obtain services.

## Discussion

With this context, the author would like to revisit the myths, assumptions, and opinions mentioned at the start of this article. CHC dental clinics do not

see patients “for free.” They cannot deny emergency services because of an individual’s ability to pay, which means that occasionally, an individual who receives emergency care may eventually not pay their bill, but is this any different than private practice? Patients in routine comprehensive care are expected to have payment at the time of their visit or they will be billed for services as in private practice.

CHC dental clinics may indeed be “in competition” with private practice dentists in some cases. As in real estate, location is everything. In a rural area, the CHC dental clinic may be the only dental provider in the area and there is



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no competition. In other locations, the CHC may be the only dental provider in the area that accepts government-sponsored insurance plans like Denti-Cal, Healthy Families, or Healthy Kids. Again, there is no competition for patients covered by those particular plans.

Certainly, in some areas where private practice providers accept government-sponsored insurance plans, there may be competition between private practices and CHCs. This is rarely the case since CHCs provide less than 2 percent of all Denti-Cal services in California.<sup>7</sup> The vast majority of Denti-Cal visits occur in the dental schools or in private practice.

Besides, is there inherently anything wrong with competition in a marketplace? Let the private practice and the CHC compete for Denti-Cal patients based on traditional criteria such as accessibility, office appearance, staff friendliness, and perceived quality of care.

CHC dental clinics could be in competition with private practice for indigent patients, but this is also highly unlikely. As mentioned previously, 200 percent of the 2008 federal poverty level is \$20,800.<sup>5</sup> Indigent patients making \$20,800 a year or less will most likely not be able to afford full-fee dental care after meeting their basic needs for food and shelter.

Lastly, the idea that clinics somehow have an unfair advantage because “they are funded by the government” is not true. As has been seen, the amount of a health center’s total 330 grant allocated to the dental program is not guaranteed and covers only a portion of total expenses. The vast majority of CHC revenues come from patient and third-party reimbursements.<sup>4</sup>

## Conclusion

There are some differences in the manner in which CHC dental programs are funded compared to private practice, but ultimately both private and public entities must achieve fiscal balance and viability in order to continue to serve patients.

CHCs and their dental clinics are providing needed health care services to millions of Americans who could not otherwise access care. CHCs provide a unique and valuable opportunity for collaboration and partnership between the private practice sector, which makes up the overwhelming majority of dentists in practice today, and the public non-profit sector. Examples of collaboration could include accepting referrals to treat certain CHC patients in your practice at

the sliding scale fee or providing services at a CHC dental clinic as a volunteer or employee a few times a month. Find out where the nearest community health center is located and call the dental clinic to ask how you can assist them.

*“So let us summon a new spirit of patriotism, of responsibility, where each of us resolves to pitch in and work harder and look after not only ourselves but each other.”*

**PRESIDENT-ELECT BARACK OBAMA**

Nov. 4, 2008



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