



**COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING**

**Dental Benefits Collaborative Public Meeting: Final Meeting**

Thursday, February 13, 2014

10:00 a.m. – 12:00 p.m.

COPIC Building, 7351 E Lowry Blvd, Denver, CO 80230

Mile High Conference Room

**Agenda**

<b>Time</b>	<b>Topic/Agenda Item</b>	<b>Responsible</b>
10:00 – 10:05 a.m.	Opening/Introductions <ul style="list-style-type: none"> <li>• Meeting and phone etiquette</li> <li>• Ground rules</li> <li>• Benefit Collaborative process overview</li> <li>• Purpose of Today’s Meeting: To Revisit Items Placed on Dental Meeting Series “Parking Lot List”</li> </ul>	Heller Smith
10:05 – 10:15 a.m.	Item 1 - OAP Dental <ul style="list-style-type: none"> <li>• Update from THE DEPARTMENT Legislative Liaison</li> </ul>	McGlasson
10:15 – 10:30 a.m.	Item 2 - PETI Program <ul style="list-style-type: none"> <li>• Integration of PETI with the new adult dental benefit</li> </ul>	Love McGlasson
10:30 – 10:45 a.m.	Item 3 - Medicaid Provider Recruitment Efforts: 3.1 - Colorado Dental Association’s “Take 5” Campaign	Dufurrena
10:45 – 11:15 a.m.	3.2 - Additional Community Collaborators: <ul style="list-style-type: none"> <li>• Univ. of Colorado School of Dental Medicine</li> <li>• Oral Health Colorado</li> <li>• Cavity Free at Three (CDPHE)</li> </ul>	Brunson Carlson Bonnett
11:15 – 11:30 a.m.	3.3 - Department Efforts around Dental Network Expansion <ul style="list-style-type: none"> <li>• Highlights of initiatives being asked of new vendor</li> <li>• Demo: THE DEPARTMENT Provider Enrollment webinar</li> </ul>	McGlasson
11:30 – 11:40 a.m.	Discussion of Remaining Items on Parking Lot List	Smith
11:40 – 11:55 a.m.	Discussion – Prosthetics Policy Decision Item	Brennan McGlasson
11:55 a.m. – 12:00 p.m.	Meeting Wrap-Up	Heller

**Facilitators:**

- William Heller, Division Director, Managed Care Contracts, Colorado Dept. of Health Care Policy and Financing (THE DEPARTMENT)
- Kimberley Smith, Benefits Collaborative Manager, THE DEPARTMENT
- Dawn McGlasson, RDH, MPH, Dental Policy Specialist, THE DEPARTMENT

**Guest Speakers:**

- Dr. Quinn Dufurrena, Executive Director, Colorado Dental Association
- Diane Brunson, RDH, MPH, Director, Public Health, Univ. of Colorado School of Dental Medicine
- Karen Cody Carlson, Executive Director, Oral Health Colorado
- Marcy Bonnett, Oral Health Workforce Manager, Colorado Dept. of Public Health and Environment (CDPHE)
- Suzanne Love, Rates & Operations Specialist, Long Term Services & Supports Division, THE DEPARTMENT

## **Welcome**

Bill Heller, Director of Managed Care and Contracts Division introduced the Department of Health Care Policy & Financing (Department) Dental Policy Team.

Bill then reviewed the ground rules for this and future Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Kimberley Smith introduced herself as the Benefits Collaborative Coordinator and went over protocol for tele-conferencing and instructions for speaking during the meeting.

## **Benefits Collaborative Overview**

Kimberley then briefly reviewed the purpose of the public collaborative meetings. She explained that the meetings are held to define the amount, scope, and duration of new Adult Dental benefits. The final “parking lot issues” meeting is meant to revisit issues that came up in earlier meetings. These issues merited further discussion, but were not quite on topic at the time. She explained that the purpose of the meeting was NOT to revisit every aspect of the policy.

Kimberley then explained that the Adult Dental benefit coverage standard – referred to as Department policy – is located online. Changes to the policy will be discussed in the meeting and the updated version will be sent to all meeting participants. She also explained other materials available on the website including meeting minutes and stakeholder feedback.

Kimberley outlined the agenda of the meeting and the “parking lot” issues to be discussed, including:

- PETI Program and how it interacts with the adult dental benefit
- Provider recruitment
- Other “parking lot issues”

She briefly explained that the purpose of The Benefits Collaborative process is to create a benefit coverage standard. She also explained that the three guiding principles of the Department in creating these standards are:

1. Standards should be based on clinical research and evidence-based best practices
2. Standards should place reasonable limits on services and should be cost-effective
3. Standards should promote the health and functioning of Medicaid clients

Kimberley explained that policy changes resulting from public input were made due to their adherence to these criteria.

Kimberley provided her contact information [Kimberley.smith@state.co.us](mailto:Kimberley.smith@state.co.us) 303-866-3977, to which participants can address their future questions and suggestions. She also reminded participants that the call is recorded and that the recording and this transcription are both posted to the Benefits Collaborative web site.

Kimberley then introduced the facilitators of the PETI discussion - Dawn McGlasson, dental policy specialist, and Suzanne Love, Rates & Operations Specialist at THE DEPARTMENT.

### **PETI Program**

Dawn began by introducing Susan Love and explaining her role with the Post-Eligibility Treatment of Income (PETI) program. She acknowledged that there are questions as to how the program would interact with the new adult dental benefit as well as the OEP program.

Susan Love explained that PETI is defined as the portion of an individual’s income that must be paid to the nursing facility for cost of care given to that individual after certain deductions have been applied. It has been federally mandated that the income may be used for medically necessary items that are not covered by Medicaid or a third party insurance. Examples include:

- Hearing aids
- Eyeglasses
- Health insurance premiums
- Dental benefits

Susan explained that nursing facilities currently approve dental benefits without Department approval for the first \$400. Once the \$400 threshold has been breached, all requests must be submitted to the PETI program for review and determination. With the implementation of the

new dental benefit, the nursing facilities will no longer be required to submit a PETI approval request for the first \$1000. The dental providers will also be able to bill Medicaid directly without the delay of PETI processing time.

Susan then explained what this means for the clients who are utilizing the PETI program. For current clients that are eligible for PETI, they will continue to have dental benefits as usual. For clients that do not have PETI benefits, they will also have access to dental. As of April 1<sup>st</sup>, 2014 all routine dental services such as exams, cleaning, and x-rays will no longer need PETI approval. They will instead be billed directly to the Department.

As of July 1<sup>st</sup>, 2014, dental services requiring a PAR (i.e. crowns, partials) will be able to be billed to the Department.

Susan then explained this means less wait time for providers in being reimbursed because they no longer have to go through the PETI process. She also explained that this means less PETI paperwork for nursing facilities.

Susan also explained that the message is being conveyed in PETI trainings as well as mass e-mails to all administrators and provider bulletins.

## **Discussion**

QUESTION – unattributed commentator (on phone) asked for clarification on how the health insurance company is billed if the client has third party coverage.

RESPONSE – Susan explained that A PETI request has to be submitted to the Department for any health insurance premiums, and that this has not changed from before. If a person has third party coverage, they can submit a PETI request to the Department for review and approval. Those premiums can then be paid from the PETI.

QUESTION – Same commentator asked whether this is an extension of the \$400 where they would just do a PETI in-house for the \$1000. Are the provider themselves billing?

RESPONSE – Susan explained that the extension of the \$1000 benefit means you no longer have to do a PETI at all. This is only for dental benefits. For all other PETI requests, it has not changed.

QUESTION - Same commentator asked whether a PETI will still be needed for requests over \$1000.

RESPONSE – Susan explained that PETI will still be needed for any benefits over \$1000.

QUESTION – same commentator asked if the PETI benefits would kick in after the health insurance has paid.

RESPONSE – Susan explained that health insurance will pay before Medicaid, and that any Medicaid benefits would be paid after this.

QUESTION – same commentator asked if anything done up until April 1<sup>st</sup> will be added to the \$1000. Does the money spent until April 1<sup>st</sup> count towards the \$1000?

RESPONSE - Susan explained that anything spent before April 1<sup>st</sup> will not be included.

QUESTION – Becky from Rowan Community asked how the facility is going to know that the \$1000 threshold has been reached if the providers are billing the first \$1000.

RESPONSE – Susan explained that an administrative service organization will be entering claims for all dental benefits and will be able to track the \$1000 being spent. This will be available starting July 1<sup>st</sup>, 2014.

QUESTION – Becky then asked how this will be communicated to the facility.

RESPONSE - Susan explained that once the \$1000 threshold has been reached, the dental provider will be denied because the benefit has been maxed just like any other health insurance and the provider will be informed.

QUESTION – Another unattributed commentator asked whether a doctor's order will still be required to take someone to the dentist.

RESPONSE – Susan explained that nursing facility staff would continue to consult with the physician regarding the health needs of a resident, but a medical necessity form required for a PETI request will not be necessary to access routine dental benefits.

COMMENT – Jose Torres with CCDC asked if a person needs dental care his doctor might not know.

RESPONSE – Susan explains that that facility staff will ensure that residents' needs are met. If you are in a community, then you can make your own decisions about how your needs are met. It is different in a nursing facility.

QUESTION – Kristen Bright with the Colorado Community Health Network asked if there is a fact sheet or one-pager available that concisely explains the information presented at the meeting.

RESPONSE – Dawn explained that it is being worked on, and that the information is available on the website as well as the provider bulletin. Dawn also explains that a communications piece will be released eventually detailing this information.

### **Medicaid Provider Recruitment Efforts**

Dawn then introduced Executive Director Dr. Quinn Dufurrena and Policy Specialist Jennifer Goodwin of the Colorado Dental Association to discuss the “Take 5” program. This is an initiative the Colorado Dental Association is working on in conjunction with the Department.

Dr. Dufurrena noted that CDA recognizes the vital importance of having a strong network of dentists ready to help meet the needs of the many Colorado adults that will soon qualify for dental care through Medicaid. This is why the CDA has been proactive in launching the new “Take 5” program to recruit more dentists to see Medicaid patients in their practices. The “Take 5” program asks the CDA’s 3000+ dentists to treat at least five Medicaid patients each week, month, or year, especially in rural or other underserved areas.

He explained that the addition of adults to Medicaid dental programs is a big change, and that past experience of provider participation may not be a good barometer of future outcome. In the past, Medicaid benefits were limited to children, and not all dentists treat children. There are a number of dentists and dental specialists focused primarily on adults, and Medicaid has now become relevant to these practices.

Dr. Dufurrena explained that the CDA welcomes the news that the administration of Medicaid dental benefits will be outsourced to a private vendor. Many dentists who have experienced past administrative frustrations are willing to give it another chance. The CDA has committed to help dentists with administrative issues that can often seem overwhelming to a busy dental practice, including enrollment and billing.

Dr. Dufurrena went on to say that the goal of the “Take 5” program is to make participation in Medicaid as simple, efficient, and successful as possible.

Jennifer Goodwin then explained some of the communications aspects of the campaign. She discussed the efforts to re-educate people on misconceptions about working with the Medicaid program. She talked about the various media being used including flyers and social media. She explained that these communications have been successful in attracting dentists who have either never seen Medicaid patients or who stopped taking Medicaid patients.

Jennifer briefly discussed the timeline of educating the provider community and the education efforts taking place. Jennifer also discussed working with the state to provide some sort of financial incentive to providers to encourage enrollment, but stresses that these incentives are tentative and may still require legislative approval.

Jennifer mentioned additional programs including efforts aimed at helping dentists partner with rural communities to increase access and partnerships between dentists and Emergency Rooms to discourage clients from accessing treatment through the ER and instead see a local dentist. Another program being worked on is having sufficient referral networks at local schools.

Jennifer acknowledged that “Take 5” is a starting point and that if every dentist in the state saw only 5 Medicaid patients it would still not be enough. She expressed CDA’s hope that through its communications outreach effort after dentists get involved with the program they will recognize changes in the Medicaid program and be more willing to participate.

Dr. Dufurrena added that there have been experiences in other states with programs similar to “Take 5” that have affirmed CDA’s hope that doctors are more willing to participate after accepting an initial 5 patients. In some instances, dentists accepted hundreds of patients because they saw how easy the program was and the patients became part of their dental family.

QUESTION – Jose Torres with CCDC, mentioned that one of the challenges associated with provider recruitment is that they do not have experience with Medicaid populations, specifically people with certain disabilities. He explained that this is due to a variety of reasons, including the resources necessary to remain ADA compliant. He mentioned that he has worked hard with other organizations to create accessible protocols with providers that provide services to dual eligibles. He explains that many clients within the disabled population will be dual eligible.

RESPONSE – Jennifer explained that there is opportunity for continued collaboration between the disability population and the ADA. Obviously there needs to be additional provider education in this regard. She explained that this is a conversation that needs to take place and that they are willing to have. She explains that there are training initiatives in place and more in the works and they are happy to work with their partners towards these ends.

QUESTION – Dr. Steven Perry, owner of a healthcare provider network and director of a non-profit that services low income clients, explained that his organization has been a provider for ten to twelve years in the Medicaid program. He explained that he initially found that the program extremely frustrating to work with, and was fraught with issues such as take-backs and audits that made life difficult. He explains that this experience has made the providers in his network hesitant to participate in the “Take 5” program. For this reason, Dr. Perry explained that he would like to see additional incentives rolled

into the program to ameliorate some of their concerns. He went on to explain some of his suggestions for incentives, including:

1. Reducing sales tax for supplies used to treat Medicaid patients. He asked if the state can help with this.
2. Marketing done by the state to identify providers and attract patients, rather than at the expense of providers. For example, interview with providers who have registered as a Medicaid provider placed in articles in newspapers.
3. Fees paid to providers for patients who do not show for appointments, or incentive to continue treating patients who do not show. Several people applauded this comment.

Dr. Perry continued to explain some of the issues that providers have with accepting Medicaid patients. He recommended the governor appoint someone who provides dental care within the Medicaid environment to represent such providers to the Dental Board so that they aren't judged by different standards than non-Medicaid providers. Medicaid providers are faced with different constraints and may therefore treat patients differently.

Lastly, Dr. Perry asked that the state help organize an authorized laboratory where providers can send Medicaid cases at a reduced cost. He explains that there are opportunities where crowns can be made very inexpensively but providers are not given access to such products because they are not labs.

Dawn explained that there is a lot in Dr. Perry's list that is outside the scope of the Department. The Department cannot influence the providers' access to cheap technology for crowns.

Suzanne Brennan then explained that while some of Dr. Perry's do not fit within the mission of the Department, he certainly raises some good points which merit further discussion. She suggested that the Department can look into how taxes are set and see whether or not an exclusion can be provided. She explained that the Governor's office encourages collaboration between state agencies and that they can look into how the tax policies in this regard are set.

Suzanne also explained that there are federal restrictions on co-pays and penalties with regards to fees for failure-to-show. She also explained that the Department is looking into strategies to incentivize greater personal responsibility and consumer engagement. She mentioned that the Department will look into advocating for provider representation on the Dental Board. She also said that she liked the idea about having an authorized lab for Medicaid providers. She reiterated that the Department welcomes new ideas.

Dawn then introduced the community partners, Diane Brunson, Karen Cody Carlson, and Marcy Bonnett.

Diane Brunson started by saying that CU Denver Dental School is surrounded by a community where 31% of the population is below the poverty level and 39 languages are spoken within the community. She explained that this puts the school in a unique position to serve the underserved community, and outlined some of the changes that have increased the capacity to serve this population. This includes an increased class size as well as facility enhancements.

She also explained the ACTS program (Advanced Clinical Training and Service) which sends fourth year dental students into the community to enhance the capacity of the safety net dental providers to serve low-income populations. She explained that the students have had limited exposure to Medicaid patients in the past given the lack of adult benefits, but that they are excited to work with this population now that they have the capacity. She explained that the University clinics are looking into extending hours and a special effort to increase the number of disabled populations that the University is serving.

Karen Cody Carlson, Executive Director of Oral Health Colorado, explained that the organization is focused on advocacy efforts that increase access to care. She outlined the “Smart Mouth, Smart Kids” in-school oral health program and its ability to provide data on the Medicaid population.

She also expressed OHCO’s interest in working with the “Take 5” program in order to ensure clients are receiving the care that they need.

Marcy Bonnett of Colorado Department of Public Health and Environment outlined the “Cavity Free at 3” program. The program’s goal is to prevent cavities among children, especially those most at risk – during the first 3 years of life. She explained that the program is a statewide initiative of CDPHE that trains medical and dental providers in current standards of care and early childhood care’s role in preventing childhood disease.

She explained that the program does not provide any direct patient service, but teaches providers about disease etiology, how to conduct an oral disease risk assessment on an infant or toddler, and how to provide anticipatory guidance to (inaudible) (1:04:29) oral health, and how to bill Medicaid.

Marcy outlined the vision of “Cavity Free at 3,” whose principles include:

- All Colorado children have access to preventable oral care
- All Colorado children have access to a dental home starting at age one
- All pregnant women receive dental care as part of pre-natal care
- Parents understand the importance of early childhood dental care

She explained that the program has trained more than 2,600 healthcare providers and individuals who engage in children’s health. She explains that more work must be done to engage the dental community. She then outlined the strategies being used to achieve the program’s goals, including:

- Training dental provider to care for young children following the program’s protocols
- Increase public awareness about the importance of preventable oral care and pregnancy in early childhood
- Provide education to encourage general dentists to accept Medicaid patients
- Provide THE DEPARTMENT enrollment contact information to facilitate provider participation

Marcy also explained that it is part of the organization’s HRSA grant to build oral health infrastructure in rural communities. The local public health agencies and rural oral health specialists have deliverables on their grant regarding recruiting dentists towards these ends.

COMMENT – Jose commented that he understands Dr. Perry’s concerns about no-shows, but that he would not go so far as to suggest that Medicaid should reimburse doctors for such clients or whether it would be possible. He commented that Medicaid patients are often needy and disabled. He explains that this requires cultural competency on the part of the providers. He commented further that he does not want the providers to lose money, and that there must be a way to address the problem of no-shows while understanding the population’s limitations.

RESPONSE – Suzanne Brennan added a few things with regards to no-shows and clients’ ability to make appointments. She commented that the Department is aware of issues with transportation and that effort is being made to resolve some of these issues with vendors.

She also explained the Accountable Care Collaborative and efforts being made by the RCCO’s to address such problems via care coordination and data analysis to determine why the clients are missing appointments. She mentioned that such a problem could be due to any number of issues including behavioral health issues, family issues, and disabilities.

QUESTION – Erica Herrera with the Department of Health Care Policy and Financing asked Diane whether the lack of participation of providers opens the program up to participation from other counties than Arapahoe.

RESPONSE – Diane responded that the program is statewide, although the majority of the patients come from the areas surrounding the school.

QUESTION – Dr. Stephen Perry mentioned that he had recently been at the CU Denver dental school and met with some of the directors about the ability to participate in cold referrals. He explained that he was told there was a barrier, although unofficial, that prevented the overflow patients from being referred to private practices.

RESPONSE – Diane responded by saying that she wasn’t aware of any such conversation about this and that she would have to do some research and get back to Dr. Perry.

QUESTION – unidentified commentator from the Arc of Aurora asked whether there is an expectation from the clinic to better understand what a timeline for service might look. She mentioned that some of the clients at her service are waitlisted for six months to a year. She asked whether there have been any discussion to clarify this timeline to better ensure that clients receive services when they need it.

RESPONSE – Diane responded that the Department is aware of the problem and that it is one of the problems that the Department is trying to fix. She explained that the Department is engaging outside consulting help to figure out how to solve the problem.

QUESTION – Same commentator raised the issue of consent for people with disabilities in accepting dental care, and that some people have been denied because of this issue. She asked Diane whether something can be done on this issue.

RESPONSE - Diane responded by saying that she would love to have the conversation after the meeting and provide her e-mail address for the caller.

QUESTION – Dennis Lewis with Dental Aid commented that most dentists do not understand the role of a RCCO and most do not even know what a RCCO. He asked what is being done to educate on this issue.

RESPONSE – Dr. Quinn Defurrena with CDA responded by agreeing that most dentist probably don't know what a RCCO is and that the model is moving from procedure based reimbursement to outcomes based reimbursement. He mentioned that this involves a transition and that dentists and providers will need to be educated in this regard.

QUESTION – Bertha from Kids Choice mentions that they are right down the street from the university and that they are more than happy to help with overflow of patients.

Kimberley mentioned that any comments on the phone will be recorded on the listening log and invites anybody whose questions have not been answered to reach out by e-mail after the meeting.

Dawn mentioned Deirdre Callahan and that the organization of school-based health centers is looking to expand and that anybody can e-mail Deirdre directly if they are interested in learning more.

### **Department Efforts around Dental Network Expansion**

Dawn then explained some of the Department's efforts around provider recruitment.

The Department is trying to encourage provider network expansion and the Department is trying to be innovative and creative. She mentioned that the forthcoming RFP will be looking for a new ASO to manage the dental benefit, and that the Department will be asking the ASO to focus on expanding Medicaid enrollment of dentists and hygienists. These innovations will possibly include bonus incentives on multiple tiers. The first year's incentives will focus on enrolling more dentists and hygienists, while the second year's incentives will likely focus on reducing ER utilization. The third year, the ASO will be asked to increase children's preventive dental services. The fourth and fifth years have been left open to mid-course corrections.

We are trying to be responsive to comments, initiatives and suggestions and will continue to be in contact with others to determine what future incentives should be.

Dawn mentioned that the day before this meeting the Department discussed hiring a new position that will be focused on provider outreach and client outreach and education. That position has just been posted to the web site. Dawn encouraged meeting participants to encourage applicants to apply.

COMMENT – Jose Torres with CCDC suggested that the Department look into recruiting experts in community outreach and engagement from organizations like Family Voices and CCDC that have valuable experience. Nobody knows better what the community needs but the community itself and CCDC offered its help in the area of provider recruitment, in addition to other areas.

RESPONSE – Dawn added that the ASO vendor contract also asks the ASO to provide provider education on how to better serve specialty populations, including the elderly and disability population. They were also asked to help with public health interventions, such as efforts to control diabetes and tobacco cessation.

Dawn went on to explain that the Department has developed a provider recruitment webinar that is offered online and available 24/7. This webinar will attempt to explain the dental provider enrollment process.

On the website currently there is a provider enrollment application tutorial and workshop. Visit [colorado.gov/the Department >Provider Services >Enrollment](http://colorado.gov/the Department >Provider Services >Enrollment).

Dawn provided a quick review: April 1<sup>st</sup>, diagnostic, preventive and minor restorative services (such as x-rays, cleanings and fillings) will be available to adults: July 1<sup>st</sup> services that require a prior-authorization will be available.

## **Discussion of Remaining Parking Lot List Items**

Kimberley thanked everyone for their participation in the Collaborative thus far and pointed to how, for example, the feedback received though out the meeting series impacted decisions made outside of the Collaborative – such as adding cultural competency education to the Dental ASO RFP – and decisions made within the Collaborative with regard to the appropriate amount, scope and duration of services.

Kimberley then began to revisit the remaining policy issues that were placed on the Parking Lot List earlier in the Collaborative and Dawn explained each policy decision.

Kimberley noted that, as the team was looking back through the Parking Lot list, it realized that the Department was able to accommodate many of the issues placed therein; others the Department is not able to accommodate at this time. Kimberley reminded the group that the Department is a learning phase right now; it has never implemented an adult dental benefit before. The Department needs to do more research on certain things. Where good evidence is lacking the Department will err on the side of caution because the Department has a responsibility to make sure the program is built on a strong fiscal foundation, so that it continues on into the future. She asked the group to keep this mind.

Item #1 – Who will make prior authorization decisions?

The ASO will be required to employ a Colorado licensed dentist to be their dental director, who will review prior-authorizations for medical necessity. Currently there is a registered dental hygienist as the dental policy manager on the Department side. The Department retains the right to determine all final coverage decisions.

Item #2 – Will individuals with concurrent medical conditions receive the care they need – they haven't always in the past? For example, treatment of TMJ so that someone whose condition would be further complicated were they to grind down their teeth, can avoid this outcome.

The concurrent medical condition part of the current rule will be moot July 1<sup>st</sup> since Medicaid-enrolled adults will have access to services.

The Department will not cover TMJ appliances, night guards and mouth splints. Most state Medicaid programs do not cover these appliances and they are not commonly covered in commercial insurance. Given that the Department is trying to err on the side of caution to insure a solid financial foundation for the program, this has not been included. That said, the Department will be monitoring cost and utilization in the first year and may be open to changing this in the future.

Item #3 – Is it possible to create a separate adult dental policy that addresses individuals with special needs?

Currently, Persons with Developmental Disabilities (HCBS-DD) and the Home and Community Based Services – Supported Living Services (HCBS-SLS) waivers have Preventative and Basic Dental Services at \$2000 per year. Major Services are limited to \$10,000 for the lifetime of the waiver (July 1, 2009 through June 30, 2014). It is mandated that all Medicaid clients must access the State Plan benefit first. After the \$1,000 annual maximum is met for the Medicaid adult dental benefit, then eligible DD waiver clients will be able to utilize their DD waiver benefits. If a service is not covered by the Medicaid adult dental benefit but is allowable in the DD waiver, those DD clients will be able to use their DD dental waiver benefits without exhausting the \$1000 Medicaid state plan benefit first.

For the first time in Colorado’s history, adults will have access to comprehensive dental care. The benefit, as it has been determined, is a great first step. The Department will be monitoring cost, utilization, and service gaps in the first year of the benefit rollout. Once we have a more complete picture of this new program and budget capacity, we will be better equipped to assess potential need.

We are already working with our DDD partners to get the provider lists from the CCBS so we can make sure we target those providers for enrollment into Medicaid (and to make sure they have the resources they need to change billing processes—will begin submitting to ASO in July. We have 7 of 20 CCB lists to date.

Item #4 – What is allowable as “private-pay” if a non-covered Medicaid dental service or if the client needs additional services once they have reached their \$1,000 maximum benefit within the year?

Clients may pay out-of-pocket for non-covered services.

Item #5 – Oral Hygiene Instruction

**Note:** Since this meeting, the Department has decided that oral hygiene instruction will not be a covered benefit as it should be part of routine professional care.

Item #6 – Coverage of code 0190 (pre-diagnostic screening of a client age 3 years and older)

D0190 will be allowed once every 12 months after age 5. This is a code which could be easily abused, in which hundreds of screenings could be charged to the Department in a day. There is a risk of the patient feeling they have had a dental examination and not complying with the annual recommendation for a more comprehensive examination and x-rays. A screening without follow-up dental treatment accomplishes nothing.

Item #7 – Use of nitrous

The use of nitrous oxide for the pediatric population will not require prior-authorization. Routine use of nitrous oxide for **adults** will not be a covered benefit.

This is a limited benefit. We do not want to open codes with known potential in the industry for substantial abuse and we must be conservative. We need to help ensure that clients do not unnecessarily max out their benefit and guard against a scenario where the program runs out of funding prior to the end of the year. As discussed, we will revisit cost and utilization and make adjustments if we find we have been too conservative. Until we have the first year's utilization data available, we must err on the side of caution to protect the program as it gets off the ground. Not every procedure code is able to be a covered benefit. After due consideration of all of these factors, and discussion with community dentists, it was determined that it is best for the program if this procedure is not covered for adults.

#### Item #8 – Coverage parameters for adult anesthesia

General anesthesia and deep sedation will be allowed for qualifying medical conditions. General anesthesia and deep sedation will only be covered when there is sufficient evidence to support medical necessity. General anesthesia and/or deep sedation is not covered when it is for the preference of the patient or the provider, and there are no other medical considerations. All general anesthesia and deep sedation procedures will require prior authorization. General anesthesia and deep sedation will be covered when there is documented evidence of a concomitant medical condition necessitating general anesthesia or deep sedation.

Conditions which qualify as meeting the criteria of medical necessity, include the following:

- Clients with a documented physical, mental or medically compromising condition
- Clients who have a dental need and for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy
- Clients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred.  
*Evidence of the attempt to manage in an outpatient setting must be provided*
- Clients who have sustained extensive orofacial and dental trauma

We expect this will only be a very small subset of patients that have certain medical conditions.

#### Item #9 – Code 2940 policy parameters

This is a limited benefit. We do not want to open codes with known potential in the industry for substantial abuse and we must be conservative. We need to help ensure that clients do not unnecessarily max out their benefit and guard against a scenario where the program runs out of funding prior to the end of the year. As discussed, we will revisit cost and utilization and make adjustments if we find we have been too conservative. Until we have the first year's utilization

data available, we must err on the side of caution to protect the program as it gets off the ground. Not every procedure code is able to be a covered benefit. After due consideration of all of these factors, and discussion with community dentists, it was determined that it is best for the program if this procedure is not covered.

Item #10 – Coverage of code 0191 (pre-diagnostic assessment of a client age 3 years and older)

D0191 is not a covered benefit, and research indicates it not a commonly covered benefit in most states, or private insurance plans. It is an appropriate exclusion, and one that is consistent with policy in most other states. This is a limited benefit, and choices have to be made as to which services are the most important to cover.

### **Suzanne Brennan Discussion of Dentures**

Kimberley then introduced Suzanne Brennan, Medicaid Director, once again and Suzanne provided participants with an update on coverage of full dentures. Some of the points Suzanne touched on are as follows:

- C.R.S. 25.5-5-207 (formerly SB 13-242) establishes the creation of a *limited* benefit
  - o As authorized by legislature, the Dept. retains policy-making authority, including but not limited to policies concerning covered benefits and rate setting.
- Fiscal note attached to legislation assumed:
  - o \$1,000 per client/per year cap on services
  - o Average client using 60% (or \$600) of their available benefit
  - o 27% of all clients utilizing benefit
- The Department does not know:
  - o The actual number of clients who will take advantage of the dental benefit; or
  - o To what extent they will use the full benefit available to them
- Therefore, we must be conservative and manage to the pool of funds available.
- Conflicting estimates priced dentures at between \$30 and \$50 million dollars
  - o We cannot cover this cost in the absence of more utilization data specific to our client population and dental services industry environment in Colorado.
- Over the next year we plan to get consensus around:
  - o the cost of dentures; and
  - o the cost of other procedures involved (surgical, etc.)

- In addition, the ASO will assist us in monitoring:
  - o client utilization; *and*
  - o client needs (via monitoring of PARs, etc.)
  
- We will continually revisit this data; and make adjustments to the benefit  
Changes may include:
  - o opening certain services that we find are most needed and closing others
  
  - o increasing the annual benefit limit for adults – if we find that money is left in the appropriation after year one
  
  - o the Department may need to go back to the legislature to seek additional appropriations - once there is data to prove where the gaps are between the benefit and our clients' needs.

## OAP

Suzanne then went on to speak about the OAP program.

Given that Medicaid has an obligation to stay within budget, coverage of Full Dentures is not currently fundable with available resources. That said, the state appropriates funds to two Old Age Pension programs. These could be targeted for the financing of dentures for eligible seniors. Senator Kefalas has announced interest in exploring how OAP funds might be better utilized around this. Suzanne encouraged participants to provide input by contacting Senator Kefalas directly.

**Note:** Meeting recording ended unexpectedly 20 minutes prior to the time the meeting adjourned.

Stakeholders had additional comments post-recording that are not captured here. For example, several participants expressed great concern over the exclusion of full dentures from the benefit, with some noting that such services are more integral than root canals.