



## **Dental Benefits Collaborative Public Meeting: First Meeting**

August 9, 2013, 1:00 p.m. – 3:00 p.m.

COPIC Building, 7351 E Lowry Blvd, Denver, CO 80230, Mile High Conference Room

### **MEETING NOTES**

<b>Time</b>	<b>Topic/Agenda Item</b>	<b>Responsible</b>
1:00 – 1:15 p.m.	Welcome <ul style="list-style-type: none"><li>• Staff Introductions</li><li>• Ground Rules</li><li>• Who to contact throughout this process</li></ul>	William Heller MaryKathryn Hurd Dawn McGlasson
1:15 – 1:45 p.m.	Benefits Collaborative Overview <ul style="list-style-type: none"><li>• What is it?</li><li>• How does it work?</li></ul>	Kimberley Smith
1:45 – 2:15 p.m.	Adult Dental Timeline <ul style="list-style-type: none"><li>• Legislative Background (Links: <a href="#">SB13-242</a> /<a href="#">fiscal note</a>)</li><li>• Guiding Principles</li><li>• Upcoming Meeting Dates</li></ul>	MaryKathryn Hurd William Heller
2:15 – 2:45 p.m.	Discussion of Service Delivery Model <ul style="list-style-type: none"><li>• Overview of delivery model options and associated pros and cons</li></ul>	William Heller
2:45 – 3:00 p.m.	Roadmap Moving Forward	William Heller

### **Welcome**

Bill Heller, Director of Managed Care and Contracts Division introduced the Department of Health Care Policy & Financing (Department) Dental Policy Team, including Marykathryn Hurd, Legislative Liaison, Dawn McGlasson, Dental Policy Specialist and Kimberley Smith, Benefits Collaborative Coordinator. Bill also thanked Department staff Sarah Tilleman and Pat Connally for their contributions in planning today's meeting.

Bill introduced the ground rules for this and future Dental Benefits Collaborative meetings, they include:

- Hard 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

Participants were invited to add to the list; suggestions for additional ground rules were not provided.

Repeated for those on the phone again when the phone difficulties were discovered and resolved (~10 minutes into the meeting).

Kimberley Smith's contact information ([Kimberley.Smith@state.co.us](mailto:Kimberley.Smith@state.co.us) 303-866-3977) was provided for participants to address their future questions and suggestions.

### **Benefits Collaborative Overview**

Kimberley Smith introduced herself as the Benefits Collaborative Coordinator and reiterated that questions and comments about the content or process of today's meeting and future meetings may be directed to her using the contact information above.

Kimberley then walked participants through both the concept of a Benefits Collaborative and the steps involved in the Benefits Collaborative Process.

#### Overview

The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and ends when final draft is taken to the Medical Services Board (MSB) to be approved for incorporation into Department rules. The Department takes the draft policy to public Stakeholders (SHs), advisory boards, and the public at large (through a public noticing process on the Department Web site) to gather varied types of feedback before seeking MSB approval of a final draft.

#### Purpose

The Department is charged through Federal legislation (42 CFR 440.230) with defining the amount, scope and duration, of the benefits it covers. It does so by drafting a benefit policy, called a Benefit Coverage Standard. The Benefits Collaborative Process is the process by which the Department drafts, revises and finalizes its Benefit Coverage Standards (BCS).

Usually, the Department contracts with an outside, objective subject matter expert(s) to author a first draft of the BCS in question. The contractor reviews medical literature and conducts extensive research into evidence-based best practices at the national and state level. The Department strongly relies on Stakeholder (SH) input to ensure the benefit drafted meets client and provider needs.

Format of a Benefits Coverage Standard – A BSC includes the following:

- Brief Coverage Statement
- Related Services Addressed in Other Coverage Standards
- Eligible Providers
- Eligible Places of Service
- Eligible Clients
- Covered Services and Limitations
- Non-Covered Services and General Limitations
- Requirements
- Billing Guidelines
- Definitions
- References

Kimberley explained that the Covered Services and Limitations section of the BCS is where specific services are listed in detail, including any Medical Necessity criteria a client must meet in order to be eligible to receive a specific service.

SUGGESTION – Colorado Cross-Disability Coalition (CCDC) representative suggested that the collaborative consider Medical Necessity eligibility criteria thoughtfully and be specific yet flexible when detailing this criteria within the BCS, to accommodate situations where a client may not meet a specific criterion the moment they need the service but would meet that criteria were services to be denied.

RESPONSE – Kimberley noted that this is an important observation and that the collaborative should be thinking through eligibility criteria thoughtfully so that nothing is missed and policy gray areas are avoided. She reminded the participants that covered services should:

- Be evidenced based;
- Follow industry best practices;
- Improve health outcomes;
- Be cost effective

Process

Kimberley walked participants through each step of the Benefits Collaborative Process. They include (in order):

- Drafting BCS
- Engaging SH collaboratively in public meetings to improve upon BSC draft
- Submitting revised draft to the [Colorado State Medical Assistance and Services Advisory Council](#) (Night MAC) for feedback and possible revision

- Submitting revised draft to Children’s Advisory Council for further feedback and possible revision
- Scheduling additional SH collaborative meetings, if substantial revisions have been made
- Posting revised draft on the Department Web site for a 45-day open comment period
- Submitting ‘final’ BSC draft to Medicaid Director for approval
- Taking approved BSC before the Colorado Medical Services Board for adoption into Colorado Medicaid Volume 8 rule.

After each step in the process, the internal policy team reviews the feedback received and makes necessary revisions. If more meetings are needed, the team schedules them.

*Important note:* Kimberley explained that all questions that go unanswered in a meeting and all suggestions and comments made within the meeting and sent via email thereafter are logged in the Dental Benefits Collaborative Listening Log, which is posted to the Department [Web site](#) 1- 2 weeks after the meeting. The Department provides responses to the questions asked and feedback given within this listening log. Periodically consulting the listening log is a good way to track how the Department uses the feedback it receives.

QUESTION – Jose Torres-Vega with CCDCC asked who drafts the Benefit Coverage Standards and will that expert be part of future meetings.

ANSWER – In this case, The Department hired an outside objective expert to do research nationally and author first drafts. The Department will bring those drafts to the collaborative in future meetings to gather input and the author, Dr. Randi Tilleman, will co-facilitate future meetings. Kimberley pointed out that it would be hard to create a draft from scratch with everyone in the room and on the phone; pre-drafting standards gives everyone something on which they can comment.

QUESTION – unattributed. 1) Why would the adult dental benefit be taken before the Children’s Advisory Council and 2) Is there dental representation on the Night MAC council?

ANSWER: Bill Heller explained that standards are taken before the Children’s Advisory Council when relevant and there may be aspects of the Adult Benefit that touch on the children’s benefit that may necessitate it go before the CAC. Dennis Lewis, DDS, is part of the Night MAC and his term ends in November. The Department is happy to field recommendations for his replacement via Kimberley’s contact information.

## Adult Dental Timeline

### Legislative Background

Marykathryn Hurd walked the collaborative through the Adult Dental enabling legislation, SB 13-242, and began by thanking those on the phone, in the room and at large who worked to pass the legislation.

The Legislative Declaration on the first and second pages of the bill outlines the various items that the legislature felt necessitated passage of the bill.

Section 2A on the third page states that by April 1<sup>st</sup>, 2014 the State Department shall design and implement a limited Dental Benefit for Adults using a collaborative process. Within this are listed the pieces of the process to be discussed collaboratively; they include:

- components of the benefit
- cost
- best practices
- effect on health outcomes
- client experience
- service delivery model
- maximum efficiencies around the delivery of the benefit

It is also stated here that the Department must determine the most cost effective method for providing the adult dental benefit. Marykathryn underscored the importance of this point and noted that the Department must be good stewards of tax payer dollars. She asked participants keep in mind the limited funding source as we move forward with benefit design.

Section 3A on the bottom of page three specifies the provision that, if the Department chooses to move forward with an Administrative Service Organization (ASO), the ASO is prohibited from requiring dental providers to participate in their public or private programs or to accept any of their insurance products.

COMMENT – Jose Torres-Vega with CCDC commented that, without including some kind of regulation or law that encourages providers to participate in these programs, we are creating a huge lack of providers. He pointed to the difficulties experienced by the Department while implementing the Dually Eligible Demonstration Project. Specifically, he observed that not many providers currently see clients who are dually enrolled in Medicaid and Medicare – they usually see one or the other – which results in a lack of providers to cover every network. He further commented that it is very important for Medicaid to have enough providers and suggested the collaborative brainstorm around creating

incentives for providers to participate. Otherwise, there may be a huge capacity issue.

RESPONSE – Marykathryn stated that provider capacity is an issue that the Department takes seriously and asked for a show of provider hands in the room; several were present. She pointed out that the Joint Budget Committee increased provider reimbursement rates in the state budget last year as an added incentive. She agreed that the collaborative should continue to explore how best to engage the provider community and what else can be done within state rules and regulations to encourage more provider participation within the Medicaid community.

COMMENT – Representative with the Colorado Developmental Disabilities council (CDDC) and parent, noted that her daughter is dually eligible and only recently has had issues accessing assistive technology and physical therapy services, due to the hours she has worked. She would like to hear from the dental providers to mitigate access issues because they are currently paying privately for dental, which is expensive.

RESPONSE – Marykathryn acknowledged the issue and suggested setting aside some time moving forward to discuss it further. She expressed desire for open dialogue and invited suggestions from clients, providers and others as to options for the Department should explore to address.

QUESTION (phone) – Mark Simon asked what percentage of dentists in Colorado are currently enrolled in the Medicaid program as dental providers. He observed that many providers are enrolled to serve children but may not know they can serve adults.

RESPONSE – Marykathryn clarified that the enabling legislation being discussed will allow the Department to enroll dental providers into the Medicaid program to serve adults and that the Department will work to educate providers about the new benefit.

Marykathryn continued through the legislation and highlighted the funding mechanism. No general fund dollars will be used to fund the adult dental benefit.

Marykathryn reminded the collaborative of the need to be good stewards of financial resources. She also informed participants that the Department created estimated adult dental utilization rate, and calculated associated costs, when the bill was drafted. At that time, the fiscal assumption placed a \$1,000 cap on services per person per year – which is not a final figure. Marykathryn pointed out that exact costs will be part of the discussion moving forward within the collaborative as we work to define services.

Marykathryn then clarified that the source of funding for the adult dental benefit is the revenue and interest within the Unclaimed Property Trust Fund, which previously funded Cover Colorado – a program that is now being phased out due to the passage of the federal health care law.

The Department believes that the adult dental benefit will utilize less money than previously utilized by Cover Colorado, which will help to ensure the sustainability of the benefit.

QUESTION – Hollie Stevenson, Dental Lifeline Network, asked if the \$1,000 cap mentioned above is mentioned in the fiscal note (see link in agenda above), because it is not in statute.

ANSWER – Correct, it was an internal fiscal assumption.

QUESTION – Jose Torres-Vega with CCDC stated that those individuals who are currently covered for emergency dental have a \$1,000 cap and that, with the market as it is today, this amount is not sufficient. He then asked, if it is determined through the collaborative process that the cap needs to be higher than \$1,000, could the Department deny services to clients due to budget constraints.

ANSWER – Marykathryn did not believe so and reiterated that this is part of the conversation needed around what an appropriate cap might be. She pointed out that experts, including Dr. Randi Tillman, will be on hand to talk about utilization rates. She also mentioned that there may need to be a separate conversation about utilization of adult dental services by those individuals in Home and Community Based Waivers to identify if there are specific populations that may need something above any cap established.

QUESTION – Jose then asked the Department if it can look at current usage data within the private market for both disabled and non-disabled clients, to determine what people use every 6 months.

ANSWER – Marykathryn pointed out that, while there were no Department budget staff in the room, she believes the Department can provide those numbers.

### Guiding Principles

Bill Heller reminded the group that the purpose of today's meeting is to explain the process and set the stage for meetings to come and to talk a little about the service delivery model. He thanked participants for their input thus far on the benefit and reminded them that

these comments are being logged. He then explained that each Dental Benefits Collaborative meeting moving forward will begin with a short review of the Benefits Collaborative Process and the principles that should guide the collaborative's work. These Guiding Principles are:

- Be good stewards of public resources
- Build a person centered culture of care and coverage
- Embrace Colorado uniqueness
- Streamline/ simplify whenever possible
- Ensure access and continuity of care
  - Urban and Rural
- Improve health outcomes
  - Align quality measurement, outcomes and payment
  - Engage providers in a coordinated fashion
- Strengthen the Public Health - Department of Human Services - Medicaid partnership
- Strengthen stakeholder partnership

Bill ended the conversation around the adult dental timeline by speaking to a few of the questions and concerns raised. He noted that the Department has been working with the Department of Public Health to strengthen its public partnership and with the Department of Human Services to begin discussing some of the Developmental Disability dental issues. The Department has also had meetings with the Colorado Dental Association about access issues and they are excited to work with us. The Department has also started to pull some system data on the names of current Medicaid dental providers and going to start trying to work that list with the CDA's list of providers – an effort that will evolve when a service delivery model is identified.

Bill also reviewed the list of future meeting dates, which can be found here and noted that dates and times are subject to change; we will provide adequate noticing if changes to the schedule are made.

**QUESTION** – David Beal, Delta Dental, asked Bill if he can project forward, after December, to when the Department thinks beneficiaries may begin to receive services.

**ANSWER** – The Department is aiming to have an interim process in place so that beneficiaries can begin to receive dental services on April 1<sup>st</sup>. This process would be separate from procuring a delivery system or vendor (to be discussed below) that may manage administration of the benefit in the future. Bill noted that the state of Colorado has a lengthy procurement process – for good reason – to ensure that the Department is being a good steward of dollars. Because of this, the Department has set an aggressive timeframe of July 1<sup>st</sup> for implementation of any vendor service delivery option chosen, if chosen.

REQUEST – Jose Torres-Vega with CCDC asked that the following be added to the Guiding Principles: A completely non-discriminatory policy that acknowledges the importance of constituent contribution, not only stakeholder (SH) contribution.

RESPONSE – Bill explained that SH is meant to be an all-inclusive term and asked Jose to send Kimberley any additional language he would like added to cover this.

## **Discussion of Delivery System Options**

Bill began by explaining that the Department has not yet made a decision on a delivery system option for the adult dental benefit. He noted that the SB13-242 legislation drives many of the decisions that need to be made and, as constructed, may make certain options more attractive. Bill pointed out that the Department has been working many angles but can't think of them all and is open to other network ownership and delivery system model suggestions.

### Network Ownership

Bill explained that the first part of the ensuing discussion will pertain to the choice of network (in other words, the choice of dentists and providers that will be providing this care) because this discussion informs how we get the care out to the clients via a service delivery model.

Two network options were presented and Bill invited participants to offer others. The two options outlined are:

- State holds the contract with providers
  - Bill explained that the Department currently runs reports through the Medicaid Management Information System (MMIS) to pay fee-for-service claims to health providers in a network that the Department owns.
- Vendor holds the contract with providers
  - Bill further explained the second option by using the example of Health Plan of the Rockies. HPR contracts with providers and owns a provider network and sells insurance to the Department, which benefits from the insurance rate that HPR has negotiated with providers; the Department pays a premium and HPR assumes full risk for the care provided. Alternatively the Department could rent the HPR network.

Bill then read through the advantages and disadvantages of each option as outlined in the handout entitled [Proposed Delivery System Options for the Colorado Medicaid Dental Program](#) (PDSO).

COMMENT – Jose Torres-Vega with CCDC commented on a bullet point listed in the Disadvantages row of the Vendor Held Contract column of the PDSO handout (see link above), which states “Loss of control by state can be somewhat mitigated via vendor negotiation.” Jose observed that this could be a good thing, in that it alleviates state capacity issues, or a bad thing. Jose further explained that, by allowing the vendor to hold the provider contracts there is potential to see a phenomena currently observed in the administration of the Durable Medical Equipment Benefit. Specifically, there is a single provider of DME and, if the state doesn’t exercise enough control over the quality measures that provider must follow, problems arise for constituents.

RESPONSE – Bill asked, as a point of clarification, if Jose was referring to instances where, for example, the vendor may not be able to pull in a particular number of providers in an area and constituents, as a result, don’t have as wide of an access as they might otherwise have.

Jose agreed and added that the Department becomes less able to address the issue.

Bill noted that this is an example of where the enabling legislation forces the Department hand a little bit. Regardless of the model chosen, the legislation states that any vendor chosen cannot require that provider’s contract with their commercial line of business to be a participant in their Medicaid line of business. So, to a certain extent, that concern may be mitigated by that provision in the law. He added that we must keep in mind that the legislation specifies certain parameters and offered, as an example, that the legislation clearly states the state retains ultimate decision/policy making authority over the benefits.

QUESTION – Jennifer Goodrum, Colorado Dental Association, stated that the legislation clearly states the Department retains policy making authority over both benefits and rate setting. She pointed out that, usually, when a contract is between the vendor and the dentist, the vendor sets policy and rates. She suggested as a point of research whether a contract can be written differently and if vendors are willing to accept the Department setting those parameters.

RESPONSE – Bill noted that there were some carriers in the room and he himself used to work in that world and he offered that he would be happy to site any kind of product with the right price. He explained that he could mitigate risk by pricing high enough and concluded that it can be done but the question is “at what point can the Department afford it”.

QUESTION – Quinn Dufurrena , DDS, Colorado Dental Association, pointed to the Description row of the Vendor Held Contract column of the PDSO handout,

where it states “vendor has ultimate contract control” and noted that, per his interpretation of the legislation, a vendor owned network is not an option. He then asked if the state could use the vendor’s network and still maintain control.

RESPONSE – Bill explained that the vendor may have more flexibility to change aspects of their contracts with providers than the Department would, given procedures around rules and regulations. He then clarified that the Department needs to retain power to determine how much those providers are paid and that the Department can’t mandate that the providers in the vendor’s commercial book of business participate in the Medicaid book of business.

Quinn pointed out that the language on within the PDSO handout may need to be tweaked, if possible, to accommodate the observation above.

Bill clarified that the Department wanted to be completely unbiased and present all possible options to the group so that the group could assist in thinking through each option, identify obstacles to choosing a particular option and also have an opportunity to brainstorm solutions to those obstacles before discounting an option. That said, he pointed out that some options presented in the PDSO handout may have practical limitations and that Quinn’s question is a prime example of constraints leading to natural decision points.

### Delivery Service Options

Bill walked the collaborative through the descriptions of the three service delivery options outlined in the PDSO handout. They are:

- Full-Risk
- Administrative Service Organization (ASO)/Third Party Administrator (TPA) – self funded
- Incentive-Based

Bill noted that the full-risk model was the original model developed and that, as participants read through the handout, they will notice that the disadvantages in one model may look like advantages in another model. This is because these models evolved to address shortcomings in one another.

QUESTION – Jose Torres-Vega with CCDC stated that the Full-Risk Model would be ideal but that he suspects the Department is leaning toward the ASO Model. He noted that the ASO looks a lot like the Department manages the CDASS program currently. He offered that, in order for the management of this benefit to work best, a consumer directed board should be established so that the vendor does not have all control. In the CDASS case, the vendor is accountable to

the Department and also the PDPPC committee, made up of constituents. He sees various challenges due to capacity and accountability.

RESPONSE – Bill noted that part of the purpose of the Benefits Collaborative is to include constituents in the benefit design.

Jose pointed out that the Benefits Collaborative is not designed to continuously monitor a program, whereas the PDPPC is designed to monitor program quality ongoing.

Bill asked Jose to outline these concerns in writing so that the Department may fully address them and noted that the Medical Services Board is one important check and balance that is in place.

Jose noted that the MSB is concerned with rules and that there are always issues outside rules that need addressing post-design. He asserted that there must be a body that oversees the quality and outcomes of this benefit.

Bill noted that, while not something the Department is prescribed to do, it is a good point and offered to take the suggestion back to the Department for discussion and consideration. The Department will let the collaborative know if it can accommodate the request and, if not, why.

COMMENT – Katherine Carol with CDDC offered the following for consideration in a future meeting. Katherine is concerned about what capping the dollar amount of the benefit may mean for the quality of care that individuals with, for example, developmental disabilities (DD) can expect to receive. In her experience, if a provider is not adequately trained to provide care to this population, it can create more problems than it solves. She asked that the Department consider offering training and support for the providers to treat the range of clients, including DD clients.

RESPONSE – Bill thanked everyone for their comments on the benefit design and reiterated that the collaborative process around benefit design has just begun. He also noted that the Department has begun conversations with staff that manage the DD waiver on how they go out and get providers and has met with Colorado Dental Association. He further noted that, while the Department may have work to do to better address the concerns Katherine raised, it is open to trying and to continuing the dialogue.

QUESTION/COMMENT – David Beal, Delta Dental, observed that adopting a full risk model would be difficult, on the basis of risk, given the likely difficulty in determining what actuarially sound rates would be for the purposes of writing a contract with a vendor. He pointed to the 27% figure in the fiscal note for the

adult benefit and explained that a one percent deviation from that figure is equal to \$1.8 million. He also noted that Delta Dental has looked at other states and has seen wide variation from that 27%. He concluded that the Department may want to start with an ASO model and move towards full-risk model.

RESPONSE – Bill reminded all participants that the fiscal note contains a series of assumptions that the Department needed to make in order to secure funding, including the 27% figure and the \$1,000 per person per year cap. These are just assumptions. He reiterated that there is a model decision to be made, keeping in mind that the legislation requires certain things.

Bill also likened the choice of model for the adult benefit to the start of the CHP+ health (not dental) program. When CHP+ began, health insurance could not be bought for kids alone, therefore, there was little helpful data for the purposes of estimating utilization and setting rates. The CHP+ program started as an ASO model with a risk-pool that carriers could pull from. Carriers may be a little leery of a full-risk model.

COMMENT – Jennifer Goodrum, Colorado Dental Association, agreed with David and stated that it could be exceedingly difficult to administer a full risk model out of the gate because we don't have utilization history. She asked how the state can manage a full risk contract without severely overpaying or underpaying a vendor during the start-up process.

RESPONSE – Bill noted there are ways to do this, such as setting up a risk pool, but ultimately there is only so much money to set up risk pool and pay premiums. The limited budget should drive part of the process.

Bill then continued to review the PDSO handout with the collaborative, reading through the advantages and disadvantages of each model and, also, which models allow for which types of network ownership (see handout for details).

QUESTIONS – Pat Cook with CQS asked if the Department has an estimate of the different administrative costs between the two models (that would come off the top prior to servicing the claims).

RESPONSE – Bill used the example of CHP+ dental program, noting that it is not an apples-to-apples comparison. In the case of CHP+, the Department pays \$24.22 per member per month (PMPM) for administration of the network, and the premiums paid are roughly \$200 PMPM (\$175 for health care services, \$25 administration).

QUESTION – Quinn Dufurrena with CDA asked what the Department anticipates the length of the initial contact to be. Do you anticipate combining both the

children's and adult dental benefits into one contract for a certain amount of time?

RESPONSE – Bill stated that the Department is not yet sure about contract length because a service delivery model has not yet been picked. Generally, the Department contracts with vendors for one year, with four renewable years.

The Long Bill (separate from SB13-242), includes a line item for management of the children's dental benefit through an ASO structure. As we go through the process of developing a vendor bid, the Department will likely look at the option of combining the two, so that a vendor bids on managing both. However, if the Department does not choose the ASO model for the adult benefit, then they cannot be combined. Bill pointed out that the ASO model for the adult benefit looks to make a lot of sense for this reason, but that the Department is open to other options.

QUESTION – Gene Bloom, DDS, asked a two-pronged question. He pointed to the mention of both “benchmarks” and “oversights” in the model descriptions. Who determines what the “benchmarks” will be? Does “oversight” speak, not only to financial oversight but also to cost/benefit, delivery of care, balance of care, etc.? Who makes those determinations?

RESPONSE – Bill explained that it is the Department has the responsibility of contract oversight to make sure the contracts put in place take into account targeted outcomes, including quality outcomes which the Benefits Collaborative process may help identify. Contract language may include measurements and incentives designed to drive these outcomes.

COMMENT – Jose Torres-Vega with CCDC pointed out that CCDC supported the passage of SB13-242 at the JBC and worked for months to ensure the budget request remained as first drafted. CCDC is happy the adult dental benefit is being implemented. However, Jose wished to echo Katherine Carol's point that putting a cap on services may drive costs, given the fact that what is medically necessary for some is not for others and individuals with disabilities, for example, may have greater need of services.

RESPONSE – Bill repeated that the Department is not presently sure if a \$1,000 cap is appropriate and asked the collaborative to please also keep in mind that the Department does not have unlimited funds allocated to the adult dental benefit. If no cap is placed on a certain population, that means the rest of population would see a lower cap. That may be the right decision, or it may not, but there needs to be an understanding of the process that we

are trying to cover as many people as we can with the resources that we have.

Jose pointed out that we must also keep in mind that, at the beginning, costs should be higher, due to the fact that many individuals will be receiving dental care for the first time in decades but, eventually, costs will go down.

Marykathryn acknowledged that the disability community is interested in further discussion around caps and that the discussion is an important one and will be continued in a future meetings. The Department acknowledges and values that it serves many different types of clients and services and needs and this consideration will need to be part of the consideration when crafting the adult benefit.

As the meeting neared close, Bill summarized his desire to take the collaborative's pulse on the selection of the service delivery model and network option to be chosen so that the Department may begin the next steps for those two components. He stated that these two decision items should not affect the future work of the Benefits Collaborative around benefit design. He stated that, upon first consideration, the Department thought choosing an ASO model would be most appropriate and asked for further and final comment on this option.

**SUGGESTION** – Kate Paul, Delta Dental, suggested that the Department not rule-out-of-hand the risk-based agreement and endorsed a full-risk model that phases in incentives. She offered the example of the CHP+ dental program that has been administered as a risk-based structure for ten years. Kate thinks this structure has served the majority of recipients very well and has reimbursed dentists in a manner consistent and appropriate with a commercial agreement. She suggested a risk agreement with incentives, that caps the money that a vendor can make and minimizes the amount of money that can be lost; which she stated could be done creatively with quarter arrangements. A blend of an incentive model and a risk model may get you where you want to be.

**RESPONSE** – Bill asked Kate to send a conceptual model that the Department can share with people to ensure it addresses what the state has to do in terms of defining the benefits, designing the network and setting the pricing.

Kate agreed to send information to share.

**QUESTION** – unattributed. Some of us are representing larger constituencies, can we come back and discuss further after consulting with those groups? If not, should we email feedback as we receive it?

RESPONSE – Bill noted that the Department is under a tight timeline to move forward on the choice of delivery system and network, given the length of time involved in the state procurement process and the April 1<sup>st</sup> and July 1<sup>st</sup> deadlines already mentioned. He is hoping to make a decision in the next two weeks. He noted that, if the need seems great, the Department will call a special session. He suggested all suggestions and information be emailed to Kimberley.

REQUEST – Pat Cook with CQS requested that the Department post the information and comments it receives as quickly as possible. Pat’s request is informed by her desire, based on experience, to ensure administrative costs are low, the majority of money is put into the people and that a great quality program is created.

Bill stated we would post the information on the Benefits Collaborative web site.

QUESTION – CCDC representative asked for clarification, that a decision must be made in two weeks? Upon confirmation, she asked for a special session because she felt the disability community has not had adequate time to review the information presented.

CCDC colleagues agreed and wants to present, perhaps, another kind of model.

RESPONSE – Bill pointed out that, while the Department is trying to come to consensus a unanimous agreement will not be possible and the Department will ultimately need to make a decision.

COMMENT – Quinn Dufurrena with CDA asked if other entities may post model suggestions as well so that everyone can conduct apples-to-apples comparisons.

RESPONSE – Bill agreed to post to the Department web site all information on model options sent to Kimberley.

SUGGESTION – Katherine Carol with CDDC identified the following suggestion as out-of-the-box thinking for future conversation. She pointed to the income sliding scale participation model that is used in the Section 8 Housing program. She asked if we might be able to create a hybrid model that allows clients to contribute to their dental care (much like a Medicaid buy-in).

## **Roadmap Moving Forward**

Kimberley assured all participants that all questions and comments have been recorded. Reminded the collaborative that unanswered question and suggestions offered will be logged and posted online.

Marykathryn pointed to a [takeaway document](#) at the back of the room (emailed to phone participants following the meeting) summarizing the possible content of an adult dental benefit. She pointed out that the handout is meant to be a thought-provoking for further discussion at the August 23<sup>rd</sup> meeting and noted that additional information for the August 23<sup>rd</sup> meeting will be posted online.

Meeting adjourned 3:10p.m.