



Orthodontia Billing Initiative Frequently Asked Questions

This document summarizes questions asked by stakeholders regarding changes to orthodontia billing policy first presented on 10/14/2016. Below each item, the Department has provided an *interim* response to most questions.

In light of the decision to postpone the implementation of a new payment structure until July of 2017 (see item 5 below), and to conduct further analysis in the interim, the first iteration of this document does not yet include responses to certain procedural questions below. The Department is working diligently to address these important procedural questions and commits to communicating answers within future iterations of this FAQ document.

Important Note: Revisions to orthodontia billing policy are considered draft until changes are made effective in the Office Reference Manual. This FAQ document is a snap-shot of the Department position as of 11/21/2016 and should not be read as a final policy determination.

Item 1

What upcoming changes to orthodontia billing policy did the Department message on 10/14/2016?

- The Department held a meeting on October 14, 2016 to notify the orthodontia provider community of upcoming billing procedure changes, including:
 - Transforming the current orthodontia payment structure for comprehensive treatment by dividing the global fee into payment at banding, four semi-annual visits, and debanding and retention.
 - Presently, upon approval to render orthodontia services, providers are paid a single "upfront" fee, for all comprehensive treatment codes.
 - Averaging the fees currently paid for comprehensive orthodontic treatment across all three treatment codes (D8070/80/90; e.g. paying the same fee regardless of transitional, adolescent or adult dentition), and including payment for exams and records in the new total case rate.
 - Presently, comprehensive orthodontic treatment is paid upfront according to the fee schedule: transitional dentition (D8070) at \$2543.44; adolescent dentition (D8080) at \$2861.37; and adult dentition (D8090) at \$3179.39.



- A new total case rate (\$3135.91) for comprehensive treatment was messaged on 10/14/2016 which would include:
 - Payment of \$1314.18 for codes D8070/80/90 at banding
 - Payment of \$1600 for periodic orthodontia treatment visits (D8670; billed in semi-annual payments of \$400); and
 - Payment of \$221.73 for orthodontic retention (D8680) at debanding.
- Averaging the fees currently paid for interceptive orthodontic treatment across the two treatment codes (D8050/60). Interceptive treatment will continue to be paid upfront.
 - Presently, interceptive orthodontic treatment is paid upfront according to the fee schedule: transitional dentition (D8050) at \$973.85; and transition dentition (D8060) at \$1144.84.
 - A new global fee (\$1084.30) for interceptive treatment was messaged on 10/14/2016.
- Restricting reimbursement for diagnostic casts, x-rays and other preparatory diagnostics associated with the prior authorization process by including certain pre-approval exams and records codes in the total case rate.
 - Presently, orthodontia providers can bill for evaluations, radiographs and diagnostic imaging codes beyond program benefits and limitations.
- Paying a set fee on denied cases, which providers would bill for under the code D8660.

Item 2

Why did the Department propose the changes above?

- In 2011, the Department of Health Care Policy & Financing (the Department) was asked by the Legislature and the Governor to identify potential economies within the Medicaid budget, prior to seeking approval of its annual operating budget.
- On November 1, 2011, the Department submitted its [Fiscal Year \(FY\) 2012-13 Funding Request](#) to the [Governor's Office of State Planning and Budgeting](#). In the funding request, the Department identified reductions to Medicaid expenditure that totaled \$29,699,322 in Total (Federal) Funds and \$30,471,105 in General (State) Funds for FY 2012-13, and also projected savings into future years.
- Among the commitments the Department made to reduce Medicaid expenditure within the Funding Request, were commitments to implement the following changes to the orthodontia program, labeled "Dental Efficiencies" in the Funding Request (p.R-6.11):
 - Clarify rules regarding eligibility for orthodontic services;
 - Transition to a new payment methodology that ends the practice of paying for the entire procedure, in full, upfront; and



- Restrict reimbursement for diagnostic casts, x-rays and other preparatory diagnostics associated with the prior authorization process, when not associated with an approved case.
- The Department initially projected that the orthodontia changes above would amount to \$603,812 Total Fund and \$295,022 General Fund savings in FY 2011-12; \$1,641,594 Total Fund and \$802,081 General Fund savings in FY 2012-13; and \$1,859,598 Total Fund and \$908,597 General Fund savings in FY 2013-14. In total, these projected savings amounted to \$6,110,704 over the first three years.
- After initial conversations with stakeholders in 2012 and 2013, in which the Department messaged that such changes were on the horizon, and as a result of 2013 state legislation ([Senate Bill 13-242](#)), which required the Department to hire an Administrative Services Organization (ASO) to oversee the dental benefit, the Department chose to delay both the implementation of a new payment methodology and the restriction of preparatory diagnostic payment for denied cases, to allow for a smooth provider transition to the ASO model.
- The Department has demonstrated that the per member, per month (PMPM) cost for orthodontia continues to rise and it is time to revisit the promises made to reverse that trend. Refer to Orthodontia PMPM by Fiscal Year graph below.

Orthodontia PMPM by Fiscal Year

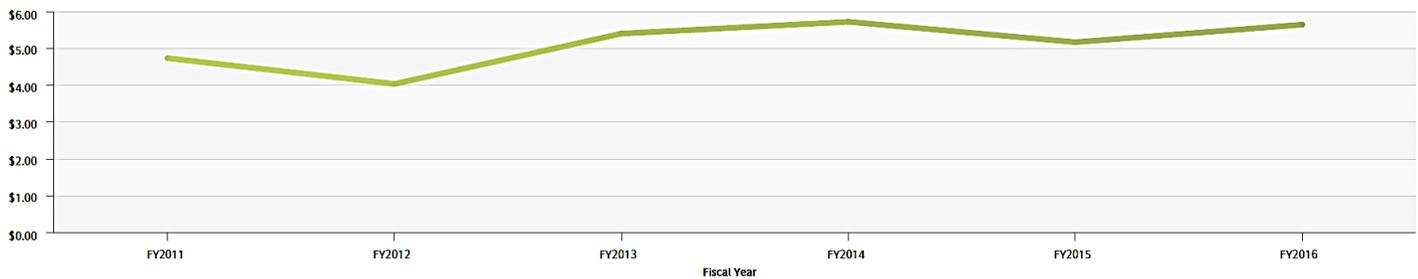


Table 1 - Average dollar amount spent on orthodontia per Health First Colorado member (not per orthodontia recipient), per month between FY2011 and FY2016.



Item 3

Where can I find the presentation the Department gave on 10/14/2016?

- The presentation can be accessed at the following link:
https://www.colorado.gov/pacific/sites/default/files/Ortho%20Billing%20Info%20Meeting%2010-14-16_1.pdf

Item 4

To what extent did the Department engage stakeholders prior to messaging these changes, and why?

When conducting research, how much time was spent visiting with and engaging with providers to get feedback on costs and using financial resources wisely?

- The actions recommended (in Item 2 above) were originally researched and vetted in 2011 through the Department Dental Benefits Manager at the time, with input from other dental directors and orthodontic consultants. Dr. Robert Birdwell, previously dental director of the New Mexico and Arizona Medicaid programs, lent significant expertise.
- This year, as a first step in following these recommended actions, the Department consulted our Administrative Service Organization (ASO), DentaQuest. DentaQuest helps offer solutions for lower cost dental benefits to over 20 million members in state Medicaid and CHIP programs across the country.
- The Department also sought the clinical advice of Galen Miller DDS, MSD with the Orthodontics Department, within the University of Colorado Dental School.

Why didn't the Department convene a meeting to seek public input on these changes prior to messaging them?

- The Department has been directed by our budgeting authority to take specific action as it relates to the Orthodontia payment methodology and orthodontia rates.
- The Department heard valuable stakeholder feedback in the 10/14/16 meeting, is evaluating the changes (outlined in Item 1) in light of the feedback received, and has decided to delay implementation to allow for further analysis and in order to give providers more time to plan for this change (*see Item 5 below*). The Department is circling back with the Centers for Medicare and Medicaid Services (CMS) to investigate whether certain changes may necessitate a State Plan Amendment (SPA).
- If a SPA is required, there will be additional opportunities for stakeholder comment.



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- [42 CFR 447.205](#) requires that the Department issue a public notice for any SPA that proposes a significant change in methods and standards for setting payment rates for services. Public notice will be posted on the Department's website and, in accordance with the [State Administrative Procedure Act](#), published in the Colorado Register.
- [42 CFR 447.203\(b\)\(6\)](#) requires the Department, prior to submitting a SPA that proposes to reduce provider payment rates or restructure provider payments, to make information available so that beneficiaries, providers and other stakeholders may provide input on the impact that the proposed rate change may have, if any, on continued service access. The Department must analyze public input to identify and evaluate access to care concerns. An analysis of the information and feedback must accompany the SPA submission to CMS.
- The Department values the services orthodontia providers render to our members and appreciates the time stakeholders have taken to outline their concerns. We are working to consolidate and consider all questions and feedback received and commit to communicating answers, and any subsequent policy revisions, within this FAQ document.

Why didn't the Department convene a Benefits Collaborative Process to discuss these changes?

- The Benefits Collaborative Process is the Department's formal, public process for developing Medicaid coverage policy (i.e. the amount, scope and duration of the services to be covered within a specific benefit); not billing policy.

Why didn't the Department adhere to the State Administrative Procedure Act, [C.R.S. § 24-4-103\(2\)](#), which requires the Department to solicit input prior to the making of rules?

- The State Administrative Procedure Act (APA) governs the legal and procedural requirements that the Department must follow when promulgating rules. Thus, the requirements of C.R.S. § 24-4-103 are applicable only when the Department proposes making a new rule or amending an existing rule; neither of which is the case here.
- Not all policies require rulemaking in order to be implemented. The Department is not required to promulgate rules to establish or change most Medicaid payment methodologies or rates, and presently does not plan to include the above mentioned changes to orthodontia payment methodology or rates within its rules.
- Should the Department decide, at some point in the future, to add elements of these changes to rule, it will adhere to the rule-making requirements under the [State Administrative Procedure Act](#).



Item 5

Is the Department considering revising aspects of the changes it messaged on 10/14/2016 (*see item 1 above*), based on feedback it received from stakeholders in and after the meeting?

- Yes. As of 11/21/2016 the Department plans to postpone the implementation of the new payment structure messaged on 10/14/16 (*see item 1 above*) until July of 2017, to allow for further analysis and in order to give providers more time to plan for this change. We will: continue to analyze current spending to understand the apparent discrepancies between Department projections and stakeholder reported projections; continue to research state and federal policy to develop answers to the questions we have received; and determine if any of the changes will require a State Plan Amendment.
- The Department plans to publish billing expectations as of January 1, 2017, by December 15, 2016; this document will include clarification of current Department billing expectations with regard to x-rays and exams. Specifically, effective January 1, 2017, the Department will remove the system edit currently in place that temporarily suspended edits, crosschecks and frequency limitations for providers with the primary specialty of orthodontia, while we conduct further analysis on how best to follow the directive outlined in Item 2 (*see item 13 for more information*).
- Please note, there will be no change to the posted fee schedule for any orthodontia treatment code on January 1, 2017.

Item 6

How were the new fees for comprehensive treatment, presented to the public on 10/14/2016 (*see item 1 above*), calculated?

- The American Dental Association's (ADA) Survey Center publishes a consumer price index for dental services. This index is based on a national survey of dentists and provides a mean rate for procedures by Current Dental Terminology (CDT) code. The Department sets rates for CDT codes at 50% of the mean from this index.
- When the Dental Team recently reviewed orthodontia rates as part of the larger effort to implement the new orthodontia payment methodology, we discovered that certain orthodontia rates are out of alignment with this practice. In particular, the rate for comprehensive orthodontic treatment of adult dentition (D8090) is over \$600 greater than 50% of the 2013 ADA mean. The Department will continue to research the circumstance that led to this discrepancy and whether the ADA mean and/or the original fee set by the Department were calculated to include the cost of exams and records. The Department has decided to keep the current fee structure in place until these questions have been fully resolved (*see Item*



5 above).

- In the clinical opinion of the Department's dental ASO, DentaQuest, the current reimbursement structure for comprehensive orthodontia codes D8070/80/90 could incentivize practices to code for D8090, even in cases where it is not clinically appropriate.
 - During the course of evaluation for, and subsequent beginning of, comprehensive treatment, the dentition of the patient may change, making it difficult for a provider to utilize the most appropriate code.
 - Presently, over 75% of all cases are billed to DentaQuest as D8090, even though the age distribution of prior approval requests indicates a mean age of 12 years old.
- To incent appropriate billing practices for comprehensive orthodontia, the Department has been advised to pay the same fee regardless of whether the client has transitional, adolescent or adult dentition.
 - The Department could also follow the practice of other Medicaid programs, by allowing providers to bill for D8080 and eliminating provider ability to code claims as D8070 or D8090, because the clinical criteria overlap (age, teeth, and patient development). In this latter scenario, the D8080 fee would represent the straight average of (50% of the ADA mean) rates currently paid for D8070/80/90.
- The Department has been asked why the new global fee (\$3135.91), messaged on 10/14/16, for comprehensive orthodontia was a straight average of the 2013 ADA mean for all three comprehensive orthodontia codes (D8070/80/90), rather than:
 - a weighted average that gives more weight to code D8090, given provider assertions that the majority of cases present as D8090, which is more expensive to treat; and/or
 - an average of D8080/90, given provider assertions that D8070 is not a valid code/ is clinically subjective.

The Department recognizes the distinctions between these three codes as defined in the CDT 2017 Dental Procedure Codes manual. The Department believes taking a straight average of all three codes is appropriate based on the expertise of our ASO, DentaQuest, and the age distribution of Health First Colorado (Colorado's Medicaid Program) members who utilize services.

Item 7

Did the Department take into account patients coming from outside of Colorado when analyzing termination and continuation of care data?

- Yes. The Department recognizes there are many factors that contribute to termination and continuation of care. It is a challenge to continue care when patients move within and outside of Colorado, and when



the patient's care originated in another state. The Department supports the directive to move beyond upfront payment to a more equitable and efficient billing procedure. Department analysis included data that demonstrates, when both terminating and continuing providers submitted claims, the continuing providers billed at a rate 30% higher than the terminating providers refunded back to the state. The new payment structure, when implemented in July of 2017, will eliminate this discrepancy by keeping the funding with the Health First Colorado member.

Item 8

Can the Department clarify the following clinical questions?

Why does the Department claim that the majority of comprehensive orthodontia cases should not be coded as D8090 (adult dentition), when: patients do not start comprehensive orthodontia until about age 10 or 11 and by age 12 or 13 patients already are at D8090 (i.e. have complete adult dentition); there is a narrow window in which patients may be D8080 (adolescent dentition); and D8070 (transitional dentition) is not considered by many providers to be a valid code?

- Refer to Item 6 above.

Sometimes a provider needs to take a panorex to adequately assess a patient, for example, to determine if a deciduous cuspid needs to be extracted to prevent impaction of a permanent cuspid. Will payment for this procedure be covered?

- Yes. Payment will be covered when the service is deemed medically necessary and/or meets the frequencies and limitations as listed in the DentaQuest Office Reference Manual (ORM). If a provider has an approved prior authorization request on file to treat the patient for appliances, that provider would not be paid for any additional evaluations, radiographs or other diagnostic imaging as they would be considered part of the total case rate.
- If the provider is providing a medically necessary service to a patient that requires a panorex, but that does not require the provision of appliances, the provider may bill for the panorex; payment will be subject to all criteria and benefit limitations as outlined in the ORM.

Item 9

Can the Department speak to the following patient eligibility questions and concerns?

With the move from upfront payment to payment for services rendered, what will happen when a patient loses their eligibility mid-treatment? Can providers charge patients at usual and customary charges?

- Yes. Providers can collect payment for any non-covered service up to their practice's usual and customary charges. The provider must inform the patient prior to treatment of the possibility of



financial responsibility. Providers may use the letter template found in section 4.10 of the [Office Reference Manual](#).

Orthodontia is a commitment to a full course of treatment; providers can't stop providing services to children mid-treatment.

- While the Department is not able to cover the cost of treatment for children once ineligible, in October of 2015, the Department did implement a policy that provides Medicaid and CHP+ eligible children up to 12 months of continuous coverage regardless of changes in the family's circumstances, such as changes to household income or household size, with some exceptions. This [continuous eligibility policy](#) has reduced the number of children who experience periods of ineligibility and has provided an extension of coverage to those who may have lost it abruptly in the past.

Texas and New York do not pay upfront but they do continue to pay for treatment if a patient loses eligibility.

- The Department is aware of the New York and Texas policies.
- The Texas dental program is under managed care and is not directly comparable to the Health First Colorado dental program's fee-for-service model. The state of Texas contracts with two Dental Maintenance Organizations (DMOs) to administer the dental benefit. The state pays each of these DMOs a monthly capitated rate per eligible member. The DMO then pays their network providers directly for the medically necessary services they render. In the case of orthodontics, if the member has 30 continuous days of eligibility the DMO is held responsible for completion of treatment. If the member loses eligibility subsequent to the 30 day qualifying span, the state does not continue to pay the capitation payments to the DMO for that member, however, the DMO is still obligated to pay the provider. The party at financial risk in this arrangement is the DMO. As mentioned, this scenario is not directly comparable to Health First Colorado. The Department believes federal funding match is at risk if we pay for services rendered to a non-covered patient.
- The Department is still researching the policy in New York and a response will be forthcoming.

What will happen to those patients who lose eligibility for Medicaid but who immediately become eligible for CHP+? What will happen in cases where a patient's eligibility constantly switches from one to the other?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure as it relates to this question and will communicate a response in advance of the July 1, 2017 implementation date.

If, upon losing Medicaid eligibility, the patient says they cannot pay for continued treatment out of pocket, are providers expected to remove a patient's braces at that time? Has the Department thought about the clinical implications of removing braces mid-treatment and the legal implications (for the Department and for providers) of patient abandonment?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.



What happens to the surgical case that loses coverage and cannot pay?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

Item 10

Can the Department clarify the following procedural questions related to termination of upfront payment and the new total case rate?

The move away from upfront payment will require Orthodontia offices to check a patient's Medicaid eligibility at each visit; this will be an added administrative burden for providers and perhaps for DentaQuest as well. Will the Department/DentaQuest either create an interface with provider practical management systems so that they may automatically verify eligibility, send providers a monthly list of patients who are about to lose eligibility, or reimburse providers for the additional staff needed to check this every day?

- No. All Health First Colorado providers, including dentists, are required to verify eligibility at each visit, please see section 1.00 of the [Office Reference Manual](#).

Will the Department reimburse providers for the increase in administrative costs that will result from having to submit billing paperwork more than once?

- No, see response above.

With the move away from upfront payment to payment for services rendered, how should providers handle patients who present for treatment at age 20 (one year before they age out of eligibility) and require at least 24 months of care?

- As is the case with other prolonged treatment modalities covered only for children, such as certain therapies, when treatment is begun on patients who are 20 it must end in the month of the patient's 21st birthday. Providers should work with families to understand this fact and plan accordingly, prior to starting treatment. Only 1% of the prior authorization requests received by DentaQuest in 2015-16 fiscal year were for patients ages 20 and over.

With the move away from upfront payment how will providers be compensated if patients disappear in, for example, month nine? How will providers be compensated if patients disappear, for example, after a year of treatment and then return two years later?

- Once treatment is approved, the approval will remain in effect for 1080 days. This represents a change from current policy (which is 180 days). This extension should allow providers to resume treatment of eligible members who return, for example, after two years. DentaQuest is in the process of operationalizing the specifics of this billing procedure and more information will precede implementation.



What if an eligible patient becomes ineligible for six months and pays their provider out-of-pocket during that time period, then subsequently becomes eligible again? Will the provider be able to claim the total case rate of \$3135.91 if/when the patient's eligibility resumes, assuming treatment is still ongoing?

- DentaQuest is in the process of operationalizing the specifics of this billing procedure, which will include the steps providers should take in this instance. More information will precede implementation.

If the case is completed in *less* than 24 months, as may be the case with deep impinging overbite, will providers still get paid the total case rate of \$3135.91?

- Yes. Providers will receive the full case rate and will be able to bill for the remainder at debanding. DentaQuest is in the process of operationalizing the specifics of this billing procedure, which will include the steps providers should take in this instance. More information will precede implementation.

What if treatment takes three years, as is sometimes the case with impacted cuspids? Will providers be reimbursed above the total case rate of \$3135.91 for the third year of treatment?

- No. Providers are expected to complete treatment on whatever timeframe is necessary for best patient care and the total treatment costs billed will not exceed the total case rate. DentaQuest is in the process of operationalizing the specifics of this billing procedure, which will include the steps providers should take in this instance. More information will precede implementation.

Will there be guidelines specifying how to bill periodic orthodontia treatment installments? Should providers bill on every date of service and expect to be paid once every six months? Should providers bill once every six months? If providers should bill once every six months should it always be on the anniversary of banding? For example, if a patient is banded on 10/4, should the provider always use the 4th of the month as the date of service when billing?

- DentaQuest is in the process of operationalizing the specifics of this billing procedure, which will include the steps providers should take in this instance. More information will precede implementation.

Most primary insurances "auto pay" monthly. How will the COB for Ortho work with the 6 month payment? Will providers need to submit each of those 6 monthly EOBs to get paid? Just the month of the date of service claim? Or what will the process be?

- DentaQuest is in the process of operationalizing the specifics of this billing procedure, which will include the steps providers should take in this instance. More information will precede implementation.



Item 11

Can the Department clarify the following procedural questions related to the restriction of payment for diagnostic casts, x-rays and other preparatory diagnostics associated with non-approved cases (i.e. paying a set fee for denied cases)?

How can the Department legally require providers to submit x-rays and photos to make the case for prior authorization of treatment and not pay providers for those x-rays and photos if treatment is denied? Code D8660 is for the initial consult only, not for x-rays and photos. Is the provider expected to absorb the costs of exam and records if treatment is denied?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

Will the current rate paid for D8660 be increased? If so, by how much?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

If a provider knows that a patient does not meet the criteria for approval of orthodontia treatment and will be denied, must that provider still submit a prior authorization request for denial prior to treating the patient and billing them directly? If the patient is ineligible for treatment can the provider bill the patient usual and customary charges? And can the provider bill Medicaid or the patient for preparatory diagnostics, such as x-rays, photos and models in such a case?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

What if the orthodontia office provides digital x-rays with no intention to begin orthodontia treatment? Can the office still bill code D0340?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.



Item 12

Can the Department clarify the following procedural questions related to payment for debanding?

Would the payment for debanding (code D8680), messaged on 10/14/16, at a rate of \$221.73, include retainers? Is this the case for a transfer patient who presents just for removal of braces?

- Yes. When the new payment structure is implemented and code D8680 is available for billing it will include retainers and the policy applies to transfer patients.

Should the provider bill for the final debanding once braces are removed or before?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

Will patients be responsible for the cost of debanding if they are no longer Medicaid eligible?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

Item 13

Can the Department clarify the following general procedural questions?

Can providers bill for missed appointments? These patients need to be held accountable.

- No. Please see the Health First Colorado [Policy Statement: Charging Members for Missed Appointments](#) for more information.

How will records be reimbursed for patients that are not ready for D8060? Maybe they just need a space maintainer, etc.

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.

Will payment for treatment of special needs/DIDD patients under age 21 be the same total case rate? If so, can you create a higher fee? Their treatment is much harder.

- The fee will be the same regardless of the program eligibility of the child.

Can providers treating special needs patients under age 21 bill for sedation (both nitrous and oral conscious sedation) as a separate fee, or would that be inclusive in the total case rate?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.



In the 10/14/16 meeting, Dr. Thommes with DentaQuest clarified existing Department clinical policy, and stated said clarifications would be included shortly in the Office Reference Manual, so that providers can get a better sense, prior to submitting a prior authorization request, if a patient is likely to qualify for treatment. One provider felt these clarifications may constitute new clinical policy and asked what happened to the promise that these types of changes would be made collaboratively? What if the orthodontic community does not agree with these clinical "clarifications"?

- The clarifications included in the meeting do not represent a change to the amount, scope or duration of the benefit. Said criteria is presently, and has traditionally been, used by DentaQuest to evaluate prior authorization requests. The only change is that the criteria will be published in the Office Reference Manual (ORM), for provider reference.

When will the Office Reference Manual be updated with the above clinical clarifications?

- This detail will be included in the ORM by December 15, 2016.

Item 13

Can the Department speak to the following stakeholder concerns?

In prior years providers were told by the Department that orthodontic treatment reimbursement is adequate to compensate orthodontists, however the reimbursement will be going down (i.e. new total case rate) while cost of services (even if only inflation is applied) continues to rise. This is counter-intuitive to the basic economics of any health care business. It appears the Department is creating a reimbursement mechanism that does not adequately cover cost of treatment.

- The Department has decided to postpone updating the orthodontia payment methodology to conduct further research. As mentioned in the response to Item 5, the current fees for orthodontia are not in line with current rate setting methodology. While the costs of health care continue to rise, budget shortfalls are common and procedures out of alignment with current rate setting methodology become areas of concern.

From statements made during the 10/14/16 meeting, it appears the Department did not gather information on provider costs from Health First Colorado providers. It appears you based your analysis on regional reimbursement of other states' Medicaid programs. This appears to be disjointed and unbalanced.

- Refer to response in Item 5.

Has the state accounted for the significant increase in associated dental costs that will be incurred for patients who are left with their braces on because they could not afford the cost to deband after losing coverage?

- Response forthcoming. The Department is reviewing the previously communicated billing procedure relating to this question and will communicate a response in advance of the July 1, 2017 implementation date.



Can we make financial arrangements with patients given the risk that they may have to pay?

- Refer to response in Item 9.

The average overhead of an orthodontia office serving a majority Medicaid population is 60%; if payment will no longer be made, in full, upfront, this means these offices will struggle to be able to cover overhead until full payment is made at the two year mark. How will providers avoid bankruptcy with such a short notice for policy changes? Can a formal request be made at this stage to delay the start of these changes by 3-6 months for offices whose patient base is majority Medicaid? The current fee structure could put those providers out of business without adequate time to prepare.

- The Department has made changes to the timeline first messaged in the 10/14/2016 meeting. Refer to Item 5 for more information.

Has the Department considered other ways to save money? E.g. pay upfront, pay more per case, or make criteria harder and approve fewer cases?

- The Department has specifically been directed to end upfront payment and to bend the orthodontia cost curve per case downward.
- The Department previously attempted to modify, and potentially limit, the clinical criteria, in collaboration with stakeholders. The Department previously drafted a handicapping labio-lingual malocclusion (HLD) index form. It was created in collaboration with stakeholders through Benefits Collaborative Processes in 2011-2013, and has the potential to strengthen existing clinical criteria.
 - This form included a list of clinical questions to which a number of points can be assigned; a total score of X amount would then lead to approval of a prior authorization request.
 - The Department did not implement the HLD index at the time of its creation for several reasons: opinions varied regarding the point allocation for scoring purposes (the points allocation that the Department originally proposed would have likely limited the number of cases approved; this met with provider opposition at that time); and the move to a new Administrative Services Organization (DentaQuest) provided an alternative clinical review form that providers seemed to embrace.

How does this impact access to care?

- Provider count has steadily increased in past years and the Department has reason to believe that the system-at-large can absorb these changes. However, should the utilization, provider count or service penetration rate dip in a statistically significant way post-implementation of these changes the Department will, and must (in accordance with federal [Access to Care regulations](#)), conduct an in-depth access analysis and make changes as necessary to ensure Health First Colorado members have sufficient access to high quality services.

The Department indicated the patient population increased from 2010-2015 by 500,000; has there been an actual decrease in orthodontia services per patient?

- No. The per member, per month (PMPM) cost to the Department increased. This means that, in addition to the rise in total orthodontia expenditure (19% between 2014-15 to 2015-16) the amount spent relative



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to each patient also increased, by 9%. Looking at the PMPM allows the Department to control for changes in the patient population and compare costs from year to year.

- The Department increased provider reimbursement rates across the board by 0.5% in 2015, but that alone does not explain the PMPM cost increase. The Department believes costs have risen, in part, because orthodontists are not subject to certain edits, crosschecks and frequency limitations. This exemption was put in place, in August of 2014, in response to concerns from orthodontists when the Department transitioned to DentaQuest. Effective January 1, 2017, the Department will remove the system edit currently in place that temporarily suspended edits, crosschecks and frequency limitations for providers with the primary specialty of orthodontia, while we conduct further analysis on how best to follow the directive outlined in Item 2.

How did the increase in expenditure over the past five years, depicted in the Department presentation on 10/14/16, compare to the increase in national healthcare costs over the same period?

- The Department uses 50% of the ADA mean as our rate setting methodology. Because the ADA is an index set by provider-reported data; increases in the mean reflect rising health care costs. As mentioned in Item 6, current orthodontic rates are well above this measure. The Department must demonstrate value for the increase in cost and is committed to tackling the challenges of growing costs by ensuring that we are reimbursing for services rendered and ensuring payment policies incent appropriate care.