florida dental ASSOCIATION SM

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To Whom it May Concern:

The Florida Dental Association (FDA) would like to provide information to the Agency for Health Care Administration (AHCA) that will be beneficial and insightful as the state prepares for its upcoming re-procurement of the statewide Medicaid managed care program.

The FDA represents many dentists who participate as Medicaid providers and agree to treat eligible recipients receiving care through Medicaid managed care. Under Medicaid, states are required to provide dental benefits to children, specifically referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT benefit requires that all services must be provided and funded by the state, if determined necessary. If a condition requires treatment, then the state must provide the necessary services to treat that condition, whether or not those services are included in the state's Medicaid plan[1].

Dental services for adults are optional for states under the Medicaid program. Florida currently covers emergency dental services for adults, and partial and full dentures. Dental managed care plans have the option of offering expanded dental services for adults who are eligible for the Medicaid program; however, the state's budget has never been adequately funded to cover these expanded services for adults. Expecting the dental managed care plans to provide dental care for adults, who may have extensive dental disease, with the same pot of funds to cover comprehensive dental care for children, is an irresponsible way to manage the Medicaid program. This could potentially provide a false sense of security for adults who desperately need dental treatment and are expecting that treatment through the Medicaid program.

Funding for the Medicaid program has increased every year, with a focus on increasing appropriations for medical care. Funding for dental care in the Medicaid program has been overlooked and not prioritized, even though there is an expectation for dental care utilization to increase every year. AHCA needs to request appropriate funding from the Legislature to address this concern and be proactive in making sure there is appropriate resources to provide those services. Just as AHCA requested millions during the 2022 Legislative Session to cover anticipated legal challenges of the re-procurement process, it is imperative that AHCA requests increased funding for dental care.

[1] Medicaid.gov – Dental Care: https://www.medicaid.gov/medicaid/benefits/dental-care/index.html

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AHCA released a request for information (RFI), to solicit concepts from stakeholders on best practices and innovations in business models for the delivery of services through Medicaid managed care. The FDA supports the independence of Florida's dental managed care program and would like to offer assistance in implementing ideas and best practices to increase utilization of oral health services for Medicaid recipients. As such, the FDA submits this response to AHCA for consideration.

Dentists typically do not see children as often as medical providers, especially during the first few years of their life. There needs to be better education on the importance of visiting the dentist during a child's early years of life. There are training programs available for medical providers on oral health screening and fluoride application. Providing these services, in addition to referring the child to a dentist, as well as affirming the importance of oral health care, would increase the overall health of children. The medical plans have patient coordinators who should be trained to educate patients (parents) on the importance of oral health care and visiting the dentist. The dental plans also have patient coordinators. The coordinators from both plans should work together to ensure the child's overall health is addressed.

AHCA could facilitate providing an auto-identifier for patients with special health care needs during patient application to Medicaid that would be used by both the medical and dental plans. Special needs patients who require anesthesia/sedation for any dental service, even exams (due to behavioral issues where the patient may bite, thrash, grab sharp instruments, or are uncooperative or have serious medical conditions), need access to ambulatory surgical centers and hospitals for sedation services. Very few dentists have access to these facilities because they are not granted hospital privileges, the Medicaid reimbursement rates for these procedures are extremely low, and the facility fee for an operating room is considerably lower for dental procedures than for medical procedures. With entities attempting to manage costs, many hospitals have been decreasing or eliminating the time a dentist may work in a hospital or ambulatory surgical center. A recommendation would be for the medical plans who control access to the surgical centers and hospitals to leverage their relationships to get more dentists access for these vulnerable patients.

A second recommendation is to increase the facility reimbursements for dental procedures to a similar amount paid to the medical personnel. In its Fiscal Year 2023 Hospital Outpatient Prospective Payment System (HOPPS) final rule, the Centers for Medicare and Medicaid Services (CMS) took action to address this problem by establishing a new Healthcare Common Procedure Coding System G code (G0330). CMS assigned this code to the Medicare Ambulatory Payment Classification (APC) 5871 (Dental Procedures) with a national average Medicare facility payment rate of $1,722.43 to appropriately cover dental procedures. A third recommendation would be to combine other short medical procedures such as phlebotomy and

gynecology with dental procedures to be able to provide these services under one sedation, thus decreasing costs and improving outcomes for patients. This would include the statutorily required treatment of cleft lip/palate patients. Treatment of these patients involves both medical and dental providers to correct these conditions and medical defects. Barriers to communication between medical and dental plans need to be removed for continuity of care. An auto-identifier for cleft lip/palate patients used by both the medical plans and dental plans would remove administrative barriers in the processing of claims that will help streamline the process for these patients who desperately need care.

In addition, fundamental issues with the current rules and regulations set forth by AHCA for orthodontic treatment and their interpretation by the managed care plans have been noted by orthodontists across the state. These issues create unnecessary hardship and another barrier for these patients of lower socioeconomic status to obtain quality orthodontic treatment from participating providers. The FDA believes that simplifying the reimbursement process can improve the accessibility to and quality of orthodontic care that Medicaid recipients receive. The orthodontic specific sections from the provider reference manuals below for each of these programs are provided as a reference. Overall, the current verbiage for Orthodontic Services in Ref-09633 Florida Medicaid Dental Services Coverage Policy, August 2018, is too vague and allows for the managed care plans to develop individual policies which vary widely between the programs and benefit the plans more than its members. This is negatively impacting both patients and providers.

4.2.1 Orthodontic Services

Florida Medicaid covers orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

- *Up to 24 units within a 36-month period, including the removal of the appliances and retainers at the end of treatment.*
- *One replacement retainer(s) per arch, per lifetime.*

Issues:

- 24 Units of D8670 - Monthly Visits
  - Managed care plans pay per visit billed. The placement of braces on teeth is paid per arch and then 24 periodic orthodontic visits (D8670) are paid per visit billed. To receive full reimbursement for an orthodontic case, this results in a requirement of 26 separate visits as these payments cannot be bundled together.
  - Current biomaterials (i.e. super elastic Nickel Titanium) allow for activations to work over a longer period of time, often up to 10-12 weeks. It is not necessary for a patient to take the time out of their busy life (school, work) monthly to see the orthodontist. This also presents a challenge to orthodontists considering

becoming a provider as having to see patients monthly is cumbersome and not needed.
    - Providers are required to manually submit claims every time a patient comes in, adding another challenge to orthodontic practices in treating patients with these plans and reducing accessibility for patients.
    - Benefits should be paid automatically on a quarterly basis over a 24-month period, or the remaining units should be reimbursed upon treatment completion with records demonstrating full removal of appliances and case completion, regardless of the number of visits.
    - Providers are penalized for providing efficient treatment to members, and members are unfairly being required to come to the office 26 times versus an average of 15 times for other patients with other insurance programs or without insurance. For patients of lower socioeconomic status, having to pay more in fuel or transportation costs and miss more work and school is a major disadvantage.
    - Each managed care plan develops their own rules with their interpretation of this which makes billing very difficult.

- Fixed Appliances (D8220)
    - When an appliance is approved, managed care plans require practitioners to use the appliance up front at the beginning of treatment or not be reimbursed for D8660 if D8080 was performed first.
        - Due to the point system used to qualify patients, many patients that would be approved by managed care plan are likely to need a fixed appliance (D8220) due to complexity. The timing for this appliance should be up to the provider for the best outcome for the patient.
        - Ultimately the plans are dictating members' treatment and timeline of treatment if providers would like to be reimbursed for costly appliances.
        - Some of these appliances include Class II or III bite correcting appliances that cannot be used without the braces being placed first. Some appliances cannot be used upfront prior to leveling and aligning and would be more effective in a different order.
        - Some cases even require more than one appliance (example: Open bite due to habit with a Class II occlusion needing a habit appliance AND a class II corrector). Providers should be allowed the ability to charge for any additional appliances needed throughout treatment if the insurance does not approve it.

- Reimbursement for Consultations (D8660)
    - This varies widely by managed care plan. Some will simply pay D8660 following a consultation while others will only pay if the related D8080 preauthorization was denied. If treatment (D8080) is approved D8660 is not reimbursed to the provider and considered to be part of the reimbursement for D8080.

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  - This is another example of the managed care plans combining reimbursements and CDT codes inappropriately. D8080 and D8660 are very specific codes. D8660 should be reimbursed separately upon completion of the procedure.
  - Regardless of if a member is approved or denied for D8080, the consultation requires providers to render an exam, complete and submit additional paperwork (IAFs and Narratives), obtain all records which include additional records then what is completed at regular consultations (panoramic, lateral ceph, and complete set of photos) with the expectation of being reimbursed for these procedures.
  - Combining codes complicates billing, often results in underpayment, and adds an additional burden on the provider offices. If a member is approved for D8080 but never returns to start treatment or loses coverage from managed care plan, the provider that completed D8660 is never reimbursed for the procedures.

- Phase I benefit
  - The managed care plans usually do not include a Phase I benefit. Many orthodontic problems and complications can be prevented by providing Phase I treatment to patients. Many patients are faced with the issue of allowing problems to worsen until the insurance will pay for their treatment or having to pay out of pocket for treatment. By paying out of pocket, the initial problem is often corrected, and the patient later doesn't qualify for treatment. This is an unfair burden to place on Medicaid recipients.

- Missed appointments
  - The managed care plans currently do not allow providers to charge a fee to patients who miss appointments. As previously discussed above, requiring this high number of appointments is a major challenge for orthodontic providers. This problem is compounded by the inability to provide repercussions to members who miss these appointments and then must reschedule them in a busy practice to accommodate for the appointment that needs to be within a specific time frame.
  - Providers should be allowed to charge members some sort of fee or copay when missing more than a certain number of appointments. This can be logged in the individual managed care plan portals for tracking purposes.

- Review approval process
  - Many necessary treatments are denied and there are extreme inconsistencies between the managed care plans.
  - Certain programs will approve treatment once per lifetime for all patients regardless of the severity of the malocclusion (i.e., approve almost all cases). However, some go based on a point system and automatic qualifiers, while others only approve those with automatic qualifiers. This results in many patients with severe malocclusion and true needs being denied for D8080. This also results in provider offices having to develop 3-4 different workflows for submitting members for approval.

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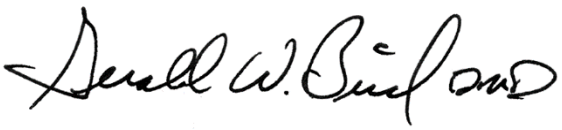
Finally, the FDA has had many productive conversations with Dr. Christopher Cogle, Chief Medical Officer at AHCA, about many of these issues. While we appreciate Dr. Cogle's willingness to assist on dental issues, the FDA strongly recommends AHCA hire a Chief Dental Officer or at minimum work with the DOH and the FDA to oversee and assist with the dental managed care program. A dentist has a unique insight into the management of a dental office and managing the oral health care of patients that a physician, while qualified in his or her own field, just does not have.

The FDA openly invites a continued discussion with AHCA on the dental managed care program and looks forward to working with AHCA on these initiatives. If you have any questions or need additional information, please contact Casey Stoutamire, FDA's Chief Legal Officer at cstoutamire@floridadental.org or 850.350.7202.

Sincerely,



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FDA President

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