New York State
Dental Association

COUNCIL ON DENTAL BENEFIT PROGRAMS
September 14, 2020

OFFICIAL MINUTES

Buchalter, Alyson, Chair (2)
Cooperman, Kenneth (NY)
Goldstein, Gary (3)
Down, William (4)
Bozek, Walter (5)
Lacey, Frederick (6)
Keating, Michael (7)
Craddock, Joseph (8)
Sorrentino, John (9)
Dolin, James (N)
Krishnan, Prabha (Q)
Hanlon, Patricia (S)
Danilow, Anthony (B)
Kim, Mina (New Dentist Representative)
Mauleon, Jr., Luis (BOT Liaison)

The Council on Dental Benefit Programs met via Zoom on Monday, September 14, 2020. All members were present with the exception of Drs. Bozek and Lacey. Dr. Eugene Porcelli, Second District Trustee representative to the ADA Council on Dental Benefit Programs; Dr. Mark Feldman, NYSDA Executive Director; Ms. Betsy Bray, Director and Ms. Jacquie Donnelly, Manager, Health Affairs, were also in attendance.

Dr. Buchalter called the meeting to order at 9:33 a.m. She stated that she may change the order of the agenda and encouraged the members to express their ideas and ask questions. The Council adopted the minutes from its meeting on April 17, 2020, as written, by unanimous consent. Dr. Buchalter welcomed the members and asked them to introduce themselves.

Chairperson' Report

Dr. Buchalter discussed Dr. Ratner's suggestions that NYSDA councils collaborate to share similar interests and ideas, and to address items of importance throughout the year rather than waiting until a scheduled spring or fall meeting.

ADA Council on Dental Benefit Programs' Report

Dr. Porcelli reported on the ADA Council on Dental Benefit Programs' meetings held on August 6, and September 2 and 9. A copy of his report is appended to these minutes.

One of the items discussed by Dr. Porcelli was ADA Resolution 71: Financing Oral Health Care for Adults Age 65 and Over, submitted by the Eldercare Workgroup. The CDBP is opposed to this resolution as worded and has proposed a substitute resolution, which is attached to these minutes.

Dr. Porcelli also highlighted several additional resolutions being submitted to this year's HOD meeting. The CDBP decided not to move Resolution 10 (from the 2019 HOD meeting) forward to this year's meeting as issues raised by the reference committee could not be satisfactorily addressed. The Council also discussed Bento, the Clinical Data Registry and the increase in the use of Artificial Intelligence (AI) by insurers to detect fraud and identify treatment patterns.

Dr. Porcelli reminded the members that they may email him at drporcelli@aol.com if they have additional questions.

Special Committee on Dental Medicaid

Dr. Patricia Hanlon, chair of the Special Committee on Dental Medicaid, reported on the Committee's meeting held on August 31. She stated that Dr. Michele Griguts from the Department of Health, attended the meeting. The Committee discussed the inclusion of coverage for silver diamine fluoride; reimbursement for fluoride varnish to providers other than dentists; expanded counseling for smoking cessation; and the expansion of telehealth services and reimbursement models.

The Committee members spoke about the problems they are expereiencing with some of the Medicaid managed care organizations in relation to down coding, referrals to oral surgeons, and difficulties when contacting insurers by telephone.

Component Reports

The members reported on related activity and concerns in their respective components. Dr. Cooperman reported that Senator Carolyn Maloney has proposed legislation to create a program for business interruption insurance in the event of a pandemic. He also asked about advocating for COVID-19 point-of-care (POC) testing in the dental office. Ms. Bray and Dr. Buchalter updated the members about the Governor's recent Executive Order which lists dentistry as one of the professions that are able to perform POC testing. Ms. Bray explained that the test must be a CLIA waived test and dentists must receive certification by obtaining a CLIA waiver from the NYS Department of Health in order to perform a POC test.

Dr. Buchalter expressed concern about an increase in the number of virtual credit cards being offered by insurers as a way for providers to receive payment. She stated that in order to decline payment in this manner, providers are required to "opt out". She asked if NYSDA would be able to intervene to waive this requirement. Dr. Feldman stated that the ADA has been communicating with insurers about various problems/issues and that this should be addressed.

Dr. Goldstein, who currently serves as Emblem's clinical dental director, offered to bring the member's concerns to Emblem so they can better understand the issues that are important to providers. Dr. Feldman expressed his agreement. Ms. Bray and Dr. Goldstein will speak at a later date.

Dr. Down informed the Council that he is a member of the Dental Medicaid Stakeholders' Group. One of the topics being discussed is access to oral surgeons, especially in the upstate region, as well as access to pediatric dentists. He asked whether the Medicaid Committee could address this issue with the Department of Health to require that the Medicaid Managed Care plans recruit more oral surgeons and other specialists for their networks. Dr. Hanlon stated that the Medicaid Committee had discussed DentaQuest's lack of network specialists with Dr. Griguts in 2019. Dr. Feldman reminded the Council that due to New York State's fiscal crisis, it is doubtful that there will be any increases in the Medicaid program. He cautioned that pressing the issue of network adequacy may prompt the State to cut adult Medicaid entirely. Dr. Goldstein said that if members have problems with DentaQuest or Emblem, they may contact him directly at ggoldstein@emblemhealth.com.

Other issues discussed included reimbursement for PPE expenses and not being able to charge patients if you are in-network; denied coverage for teledentistry services; contract "leasing"; access to care and individual problems with Liberty, Principal, and Excellus.

Old Business

Ms. Donnelly provided an update on S.7812, which was discussed at the Council's April meeting. She also informed the Council that, due to the pandemic, there has been no follow-up since NYSDA's meeting in January with the Department of Financial Services regarding dental plan transparency. Ms. Donnelly and Ms. Bray will follow up at a future date.

PPE Reimbursement Advocacy

Dr. Feldman discussed the circular letter sent by the Department of Financial Services (DFS) to dental insurance companies. He pointed out that the letter was restating current law and reminding providers that they must uphold the contracts they have with their insureds. In most cases, these contracts state that a patient cannot be responsible for additional fees that are outside of their financial responsibility for covered services. Dr. Feldman reminded the Council that when signing a participating provider agreement with an insurer, you agree to accept a defined fee schedule and cannot charge patients above those fees. Providers who are not in-network with an insurer are able to charge their patients for PPE if they so choose.

Dr. Feldman also stated that he has met with the Governor's office to discuss the possibility of insurers sharing dentists' PPE costs. Although discussions are ongoing, he stated that, in his opinion, the Governor will not mandate that insurers reimburse for PPE.

Ms. Bray spoke about an EOB from Aetna that she received from a member. The dentist had asked for NYSDA's help in clarifying the language on the EOB. He is a par provider with Aetna. The EOB stated that Aetna would not cover the cost the dentist submitted for PPE expenses but

that the dentist was free to charge the patient for that fee. After contacting the ADA, it was discovered that the Aetna plan originated in Connecticut, therefore they were not subject to DFS's circular letter and the dentist was allowed to charge his patient for PPE. Ms. Bray pointed out that this is something dentists will need to be aware of.

Teledentistry

Ms. Bray has been asked to participate in the Medicaid Redesign Team II's Teledentistry Workgroup. The Workgroup is discussing how to continue to use teledentistry beyond the pandemic.

Dental Demonstration Project

Ms. Bray gave an update on the Dental Demonstration Project (DDP) and explained that it has now been moved under the purview of NYSDA's Health Affairs department. The DDP is currently in its sixth year and has been partnering with FQHC's. The Project has been modified due to the restraints of COVID-19 and has developed a new workforce model utilizing a community dental health coordinator (CDHC). DDP is currently partnering with the Finger Lakes Health Center and Bassett Healthcare Network.

NYSDA Policy Review

The Council was directed to review the Dental Benefit Programs' section of the NYSDA Policy Manual from the past fifteen years. After review, Dr. Keating made a motion, seconded by Dr. Danilow, to remove the following resolutions from the NYSDA Policy Manual because they have either already been carried out and are now moot, or they reside in another NYSDA governance document. The motion was adopted by unanimous consent.

> RESOLVED: That the following resolutions be deleted from the NYSDA Policy Manual: 4-J-05; 4-N-05; 13-J-06; 24-J-07; 30-J-07; 4-N-07; 14-J-08; 4-N-08; 5-N-08; 6-N-08; 2-EC-09; 27-N-09; 34-N-09; 35-N-09; 36-N-09; 38-N-09; 31H-2010; 33H-2010; 15H-2012; 11H-2015; 16H-2017; 17H-2017; 10B-2018; 1B-2019 and 13B-2019.

New Business

Dr. Buchalter asked for NYSDA staff to develop a list of contacts at insurance companies and state agencies who would be able to address problems members may be having. Ms. Bray is in the process of developing resources for this purpose.

Ms. Donnelly informed the Council that she and Ms. Bray plan to update the Dental Benefit information included on the NYSDA website. She asked the members to provide ideas for FAQs or articles that could be added.

Adjournment

There being no further business before the Council, the meeting was adjourned at 11:15 p.m., following a motion by Dr. Cooperman.

Respectfully submitted,

Alyson Buchalter, DMD
Chair

ADA Council on Dental Benefits Programs Report

September 2020

At the 2019 ADA HOD Resolution 10, "Patient's Rights to Receive a Benefit for Dental Procedures From Their Medical Plan" was referred back to the Council for further study, indicating a need for greater specificity in the proposed policy. At the April 30-May 1, 2020 Council meeting could not satisfactorily address the issues raised by the reference committee. Accordingly, the Council decided not to move Resolution 10 at the 2020 ADA HOD.

Also discussed was a 7.5% increase in dental expenditures overall. 80% of the U.S. population have a dental benefit (up 2%), 87% of those plans were a PPO, also a 2% increase. The market had 52% with fully insured plans versus 48% with self-funded plans. Of the dentists who participate in PPO networks, on average they belong to 26 networks. 49% of plans have an annual maximum of $1,500 to $2,499 for patients, 43% allowed $1,000 to $1,499.

The dental carrier industry is seeing increased interest in using Artificial Intelligence to detect fraud as well as identify inappropriate treatment patterns.

There are several resolutions being put forward at the 2020 ADA HOD by other councils that are of interest to the Council on Dental Benefits Program. These include Resolution 7, "Waiver of Patient Copayment/Overbilling and Resolution 14 on Antitrust Reform, both by the Council on Government Affairs. From the Council on Dental Practice there is Resolution 15 "ADA Statement on Silver Diamine Fluoride (SDF) to Arrest Carious Lesions" as well as Resolution 16, "Amendment of the Comprehensive ADA Policy Statement on Teledentistry" All these resolutions can be read in detail at ADA.org.

The ADA Council on Dental Benefits Programs had three special virtual meeting. One on August 6, 2020, one on September 2, 2020 and the third on Sept 9, 2020.

The first meeting was to discuss the nomination of Arthur Jee, DMD of Laurel Maryland as the ADA representative to the Joint Commission Board of Commissioners. The members of this Board set goals and identify strategic issues to undertake in support of the Joint Commission's mission to continuously improve healthcare. The council's nominee was passed along to the ADA President, Dr. Gehani. However, in the end he chose another candidate. In addition, there was an update on Bento (bento.net) and the efforts being made to educate dental offices on using them to set up their in office dental plan as well as them being a disruptor to the third party benefit arena. Also, the Clinical Data Registry is moving forward nicely.

The second and third meetings were to discuss the set of thirteen resolutions put forward by the ad hoc Elder Care Committee (see the full report at the Council's ADA Connect site) as part of their report to the 2020 ADA HOD of a Comprehensive Strategic Elder Care policy. The council, specifically, had strong opposition to Resolution 71 concerning the financing of oral healthcare for adults aged 65 and older. To that effect a substitute resolution was developed that simplifies the recommendation and incorporates some of the objectives of the Councils work on this topic two years ago. Once this substitute resolution is posted on ADA Connect (hopefully by 9/10/20 or 9/11/20) it can be disseminated and discussed by our NYSDA caucus and NYSDA Council.

Respectfully Submitted,

Gene Porcelli

PROPOSED TESTIMONY FROM COUNCIL ON DENTAL BENEFIT PROGRAMS (CDBP) REGARDING RESOLUTION 71: FINANCING ORAL HEALTH CARE FOR ADULTS AGE 65 AND OLDER
September 10, 2020

The Council on Dental Benefit Programs appreciates the work of the Eldercare Workgroup supplementing the work submitted by the Council in 2018.

Eligibility based on means-testing. The Council fully agrees with the Workgroup's intent to support a means-tested program. Limited public funding should be used towards supporting our most vulnerable seniors with high quality, affordable and sustainable care. At 400% FPL, around 60% of U.S. seniors over age 65 will be eligible for a benefit (approximately 30 million seniors with incomes of $51,040 for individuals or $68,960 for a 2-person household).[1]

Leveraging existing public programs. CDBP believes that the four-program (Medicaid, CHIP, Medicare Advantage and Private model) with four levels of benefits (Level I, II, III, IV) proposed in Resolution 71 is a significantly complex policy proposal. Understanding and implementing such a system of care will in itself be a barrier to implementation and is not a viable solution. A less complex proposal that lays out clear principles that the ADA believes are essential for success is necessary.

With regards to Medicaid, the ADA has argued for years that the Medicaid program is underfunded and must be fixed. Medicaid is often dependent on state budgets and has thus far not supported meaningful coverage for low-income working-age adults. These considerations do not support placing our most vulnerable seniors into the existing Medicaid system.

The Council supports the intent of the workgroup to consider a *single federal* CHIP-like[2] program as a viable policy option as long as the fee schedules are sufficient to support access to care.

Medicare Advantage is a program structured to deliver Part A and Part B covered services through private insurers. It is unclear to us how additional benefits such as dental, not covered within one of these parts, can be offered as a standard benefit to all Medicare Advantage enrollees (1/3 of individuals over age 65) with no path to offer a similar benefit to those enrolled in Original Medicare (2/3 of individuals over age 65).

The Council takes this opportunity to reiterate that Medicaid, Medicare or any other public program is not the panacea. In fact, a program like Medicare has enormous market power and is known to influence and shape the rest of the private sector. However, the Council is cognizant of consumer advocacy groups and certain congressional legislators who may be fixated on Medicare as the program of choice under which a dental benefit should be pursued.

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[1] How Many Seniors Live in Poverty? Kaiser Family Foundation Issue Brief. Juliette Cubanski, Wyatt Koma, Anthony Damico, and Tricia Neuman. Published: Nov 19, 2018. Accessed September 10, 2020.

[2] Child Health Insurance Program (CHIP) is a state-based program jointly funded by the state and federal government. Federal funding for CHIP, has pre-set limits (i.e., it is a capped program). Each state is given an allotment every year. Some states use the money to support combined Medicaid/CHIP programs. Others have separate CHIP programs. States with a separate CHIP program may either provide a Secretary-approved package of dental benefits that meets the CHIP dental requirements, or a benchmark dental benefit package. The benchmark dental package must be substantially equal to either (1) the most popular federal employee dental plan for dependents or (2) the most popular plan selected for dependents in the state's employee dental plan or (3) dental coverage offered through the most popular commercial insurer in the state. More at: https://www.medicaid.gov/chip/financing/index.html and https://www.medicaid.gov/chip/benefits/index.html

Given these considerations, a policy that is less specific but offers guidance on funding and structure may provide a stronger basis for advocacy efforts. Our goal is to achieve common ground in the form of a model that is both sustainable for practices and affordable for our seniors.

Program funding. We must acknowledge the perception that cost is a barrier to oral health care. We must also acknowledge that fair fee schedules that satisfactorily sustain a dental practice are necessary to support access to care. In balance, this Council believes that advocating for an adequately funded program that is not dependent on state budgets is essential to success.

"Levels of care". Dentistry is essential. Achieving and maintaining optimal oral health should be the goal and the patient's dental needs must dictate treatment plans. Therefore, the Council believes that an arbitrary categorization of service types (e.g., excluding surgical periodontal care as a basic covered service) into "levels of care" cannot be justified. Instead, the Council proposes "comprehensive" services to be covered for this population. The benchmark for such coverage may be services currently covered by commercial dental plans or a definition that applies to seniors similar to "EPSDT" for children in Medicaid.

Comprehensive services through an appropriately funded means-tested program is, to us, the best step forward if legislation is introduced to support a dental benefit for seniors.

PROPOSED SUBSTITUTE TO RESOLUTION 71

Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further,

Resolved, that **IF** potential legislation is being developed to include dental benefits for adults age 65 and over in public programs, then the ADA shall support a program administered either at the state or federal level that:

- Covers individuals under 400% FPL
- Covers comprehensive services necessary to achieve and maintain oral health
- Is funded by the federal government and not dependent upon state budgets
- Is adequately funded to support a reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
- Includes minimal and reasonable administrative requirements
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit