New York State
Dental Association

SPECIAL COMMITTEE ON DENTAL MEDICAID
October 20, 2015

OFFICIAL MINUTES

Filanova, Vincent, Chair (3)	Blonda-Gil, Nora (9)
Cooperman, Kenneth (NY)	Milord, Fabiola (N)
Backer, Steven (2)	Mota Martinez, Mercedes (Q)
Sandu, Diana (4)	Hanlon, Patricia (S)
Wilson, Michael (6)	Jacobo, Amarilis (B)

The NYSDA Special Committee on Dental Medicaid met via conference call on October 20, 2015. All members participated. Dr. Mark Feldman, NYSDA executive director, Dr. Judith Shub, assistant executive director, and Ms. Jacquie Donnelly, NYSDA staff, participated as well.

Dr. Filanova called the meeting to order at 1:05 p.m. He asked the members to introduce themselves and to provide their background. He repeated the charge to the committee and its position as a part of the Council on Dental Benefit Programs. He pointed out that the committee is charged with providing input on the problems encountered by Medicaid providers and make recommendations to the Council. He then reviewed the suggestions submitted and asked the committee to prioritize the items on the agenda. He enumerated the key items on the agenda:

1. DOH Policy
2. Fee Concerns
3. Managed Care Issues
4. Electronic Health Record Incentive Program
5. Audit Issues

In turn, each committee member described the problems they are experiencing as Medicaid providers. Dr. Hanlon began the discussion with a complaint that there is a problem getting patient's treatment histories. Access to a universal patient data base is critical given that the managed care companies will not reimburse doctors for treatment already provided to a patient within defined program time limits. This would enable doctors to determine the treatment services a patient is eligible to receive at the time of treatment. It would help cut costs and reduce duplicated services. Dr. Backer explained that fee-for-service Medicaid does not have the capability to provide patient's treatment histories. However, approvals are "doctor-specific", rather than patient specific. Thus, a doctor is entitled to reimbursement for services already

provided to a patient by another dentist. Managed care companies, however, have the ability to limit reimbursement for services provided to an individual patient.

Dr. Milord discussed problems she is experiencing when submitting paper prior authorization requests to managed care plans. Dr. Backer pointed out that dental prior approvals require attachments and the electronic systems cannot accept these attachments, resulting in the need for hard-copy submissions.

Dr. Cooperman pointed out that the EHR incentive program does not really benefit orthodontists who use specialized electronic patient software. Currently, there is only one "ortho-specific" EHR program available that meets the state and federal requirements. He added that it would be costly to convert to the only compliant "ortho-specific" software and to continue adding program upgrades to qualify for the EHR incentive payments.

Dr. Milord complained that the fees she receives from HealthPlex are inadequate as her claims for multi-surface restorations are all down-coded to one surface, regardless of the restoration submitted on her claims. Dr. Backer responded pointing out the disparities in the fees for procedures and a lack of oversight by any dentists with the Department of Health over claim adjudication by the managed care companies (MCOs). He stated that the managed care companies are combining surfaces for payment and down-coding restorative claims. Dr. Shub asked Dr. Milord to provide copies of EOBs with down-coded restorative determinations for appeal. She also suggested that contracted doctors appeal these claim determinations and request the criteria for approval from the MCOs in writing.

Dr. Backer raised the issue of New York's "85/15" regulations that essentially require MCOs to spend no more than 15% of the money received from New York on administration and overhead costs, leaving 85% for patient care. He recommended requiring that the State separate payments to the MCOs for medical and dental services. This would also enable the State to evaluate whether the MCOs are spending 85% of the funding budgeted for dental treatment on dental treatment.

Dr. Blonda-Gil raised an issue affecting the Federally Qualified Health Centers (FQHCs). Medicaid requires that prophylaxis be provided at the same visit as the patient's examination and x-rays. Medicaid does not reimburse for cleanings performed at a visit subsequent to one where the patient was seen for an examinations and x-rays. This is a long-standing issue, based in the "fee-per-visit" reimbursement model. It requires claims for prophylaxis submitted at subsequent visits be appealed with documentation justifying why the procedure was not performed at the initial visit in conjunction with the examination and x-rays. Dr. Shub pointed out that this is one of the issues that the FQHC administration should address in their contract negotiations with each MCO.

Dr. Moto-Martinez questioned the CMS Medicaid re-certification process for Medicaid practitioners that requires a fee. She was advised that the fee is <u>not</u> required for private practitioners.

Dr. Backer complained about the 2% reduction in Medicaid fees in 2012. Dr. Shub pointed out that the 2% across the board fee reduction in 2012 applied only to medical fees, not dental. He and Dr. Wilson stated that there were reductions to the reimbursement they are receiving and urged NYSDA to advocate to have the Medicaid fees restored to the "2002 level".

Dr. Blonda-Gil complained about the length of time it takes for the MCOs to credential providers.

Dr. Filanova summarized the issues discussed and asked the members to prioritize the issues raised:

1. Need for a uniform patient treatment data-base accessible to all practitioners
2. Approved dental electronic health record (EHR) software programs to enable dentists to qualify for the Medicaid EHR incentive program
3. Uniform predetermination protocols
4. End MCO practice of bundling surfaces for restorative benefits (down coding)
5. Separate dental and medical budgets to enable the Health Department to verify that at least 85% of funding for dental benefit is used by MCO for dental services
6. Require MCOs to utilize earlier DOH Medicaid treatment protocols
7. Inequitable assignment of patients to office capitation panels
8. Expedite the MCOs' credentialing processes
9. Have DOH create a dental advisory group to review claims submitted to the MCOs

There being no further discussion, the chairman adjourned the meeting at 2:15 p.m.

Respectfully submitted,

Vincent Filanova, DDS
Chair