

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

OVHA

Office of Vermont Health Access

BULLETIN NO.: 05-27F

FROM: Joshua N. Slen, Director
Office of Vermont Health Access

DATE: December 21, 2005

SUBJECT: Reduction in the Medicaid Adult Dental Benefit as Authorized by H.516 §104a (3)

CHANGES ADOPTED EFFECTIVE 2/1/06

INSTRUCTIONS

- Maintain Manual - See instructions below.**
 Proposed Regulation - Retain bulletin
And attachments until you receive
Manual Maintenance Bulletin: _____
 Information or Instructions - Retain
Until _____

MANUAL REFERENCE (S):

M619
M621.4

This bulletin implements a change authorized by the Vermont Legislature in the fiscal year 2006 Appropriations Act, H. 516 §104(a) (June 2005) (An Act Making Appropriations for the Support of Government). The Appropriations Act requires the Office of Vermont Health Access to reduce dental spending by \$243,309 by decreasing dental procedure fees, a reduction to the cap on adult dental services, or utilizing other cost containment strategies. Decreasing fees across the board would have resulted in a reduction in fees for services to children, which was the effect OVHA was directed to minimize. This rule is targeted at adults, as the Appropriations Act instructed, and is estimated to reduce dental spending by \$223,309 of the total required. The remainder of the required savings will be accomplished through procedural changes.

Since the Proposed Filing

Following discussions with the Legislative Committee on Administrative Rules, Federally Qualified Health Centers, the Vermont Dental Society, the Vermont Department of Health Dental Consultant, and advocates for the beneficiary community, the Office did further research and determined that the required savings could be accomplished by changing the cap on adult dental services to \$400 instead of the original proposal of \$375, combined with a reduction in rates for adult services (excluding all specific emergency services) by six percent. Projected savings are \$118,000 from the change in the cap and \$105,000 from the fee reduction. In addition, as a result of the discussions about procedures, four emergency services have been added to the list of medical and surgical services of a dentist. The

Effective date of the bulletin was changed to February 1, 2006 at the request of the Committee.

Specific Changes

Section	Description of change
M619	Adds description of the new procedures that are considered medical and surgical services of a dentist.
M621.4	Reduces the adult dental benefit maximum from \$475.00 per calendar year per beneficiary to \$400.00 per calendar year per beneficiary.

Responses to Public Comment

A public hearing was scheduled for August 29, 2005 at 1:00 p.m., in the Office of Vermont Health Access (OVHA) Conference Room, 312 Hurricane Lane, Suite 201, Williston, Vermont. No commenters appeared.

Written comments were received from five organizations: Poverty Law Project of Vermont Legal Aid, Office of Health Care Ombudsman, Disability Law Project, Bi-State Primary Care Association, and the Community of Vermont Elders. Their comments are summarized below along with OVHA's responses.

Comment: One commenter asked what other strategies OVHA had considered, in light of the legislature's language in Act 71: "Dentists' fees shall be amended, and other strategies, including a reduction to the cap on adult services, may be employed to reduce spending by \$243,309. To the extent possible, the reduction shall be targeted to health services received by adults to minimize the impact on dental services for children." The commenter thought it seems unfair to impose almost the entire reduction in spending on the most medically needy beneficiaries. Another commenter thought this reduction was contrary to legislative intent, because the intent was provider cuts.

Response: As stated above, the Office is will implement a combination of reduced provider fees and a reduction in the adult dental cap.

Comment: The cover sheet states that the remainder of the savings will be accomplished through "procedural changes". Please explain the procedural changes OVHA is implementing and the other strategies OVHA has considered to meet the budgetary figure.

Response: In early March 2005, the Vermont Dental Society proposed a number of suggestions that might save some money in the Medicaid. Among them was a suggestion to make some procedural changes in our orthodontic program to that would reduce spending. This is the one suggestion that we were able to adopt and implement by July 1, 2005. These changes clarified the orthodontia criteria and we have estimated that the changes will save \$20,000 in SFY06.

Comment: One person said she was concerned that \$375 per calendar year will not be an adequate level of dental benefits for many Medicaid beneficiaries. When electing to provide a service through Medicaid, a state must ensure that "... each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42CFR § 440.230(b). Medicaid may place limits on services, but the limits must be based on "...medical necessity or utilization control procedures." 42 CFR §440.230(d). Another commenter stated that this cut would have a higher, disparate effect on people with disabilities. Three commenters requested that OVHA continue to use the prior authorization process in M106 as the process for requesting coverage of dental services above the cap, saying that this was consistent with the position the Department has taken in the past, and should be codified in regulation. A different commenter also stated that this cut was contrary to federal law. Another commenter also proposed a prior authorization process as a way to spread the burden to providers equally. Another commenter suggested finding a way to exempt or lessen the burden on providers seeing a disproportionate share of adult Medicaid beneficiaries, such as community dental clinics.

Response: The commenter seems to suggest that the imposition of a cap (changed to \$400) is illegal because the amount would be insufficient to "... reasonably achieve its purpose". We disagree that the reduced cap will violate federal law regarding amount, duration, and scope. The courts have also upheld the imposition of limits as reasonable in the Medicaid program. In a similar situation, a U.S. Supreme Court case (Alexander, Governor of Tennessee et al. v. Choate et al), the Court ruled that a reduction in the number of covered annual inpatient hospital days from 20 to 14 was neutral, did not discriminate, and did not deny meaningful access. This dental limit reduction is also neutral and is applied to all populations. The commenter goes on to suggest that the OVHA could remedy the shortcoming by creating a formal exception process. This would make the cap meaningless. We do not think this is a practical suggestion to achieve the necessary savings. Regarding the request to find a way to exempt or lessen the burden on providers seeing a disproportionate share of adult Medicaid beneficiaries, we do not see a way to do this.

Comment: Two commenters stated that physician services are mandatory Medicaid services, and that medical and surgical services of a dentist must be covered as physician services if the services are ones that would be considered physician services if furnished by a physician. 42 CFR§ 440.50(b). Vermont Medicaid must cover these services as physician services. This was acknowledged by OVHA in 2001 when the dental benefit was eliminated from VHAP. The commenters ask how OVHA will ensure that these services will continue to be covered.

Response: The commenters expressed concern that mandatory coverage of physician services, even when provided by a dentist, will be violated. This will not occur. As a general rule, physician services are coded using Common Procedure Terminology (CPT) codes while dental services use Common Dental (CDT) codes. They overlap slightly. Dentists can submit claims using those few overlapping CPT codes. When they do, such "physician service" claims are not counted as subject to the dental cap. These services are described at M619.

Comment: Two commenters stated that OVHA intends to implement this cut effective October 8, 2005. The cap on dental services is a calendar year cap. Therefore, the cut cannot be implemented until January 1, 2006. Even if OVHA could implement the cut before the start of a new calendar year, practically speaking it would be extremely difficult. Beneficiaries will be in the middle of courses of treatment, they will have appointments already booked, and it will be difficult, if not impossible to change appointments given such a very short time frame. In 2001 when dental benefits were being eliminated from VHAP there was concern raised at LCAR about the effective date of the cut for these reasons. The Committee expressed concern about lack of notice of implementation of the benefit elimination so that beneficiaries would have time to get dental work done and finish a course of treatment. As a result the benefit elimination was postponed.

Response: The proposed bulletin cover sheet had 11/1/05 as the effective date, but the proposed page was dated 10/8/05. We apologize for the confusion. Our intent initially was to have the cut effective 11/1/05. The commenter requests delay in the implementation of the cap reduction until Jan 1, 2006 because it is a calendar year cap. We disagree that any change in the cap must be made on January 1. However, because adoption of this rule was delayed due to scheduling issues and extended dialogue, we have agreed to modify the start date to February 1, 2006.

Several commenters expressed concern over the social policy aspects of reducing the dental cap on benefits. These ranged from worry that reducing the cap would limit finding for restorative treatment, leading to more serious dental and medical conditions to fear that lowering the Medicaid cap would shift costs to the community health centers. While we acknowledge these concerns, they relate more to the general issues that the legislature must deal with in setting the budget and are not related to the regulation itself. We believe that this methodology is the best alternative to meet legislative intent.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/apa/rules.html> or call Louise Corliss at 828-2863.

For information on upcoming hearings before the Legislative Committee on Administrative Rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedule/schedule2.cfm> or call 828-5760.

Manual Holders: Please maintain manuals assigned to you as follows.

Manual Maintenance

Medicaid Rules

Remove

Insert

M619 (98-11F)
M621 (02-35)

M619 (05-27F)
M621 (05-27F)

2/1/06

Bulletin No. 05-27F

M619

M619 Medical and Surgical Services of a Dentist**M619.1** Definition

Medical and surgical services of a dentist means those services furnished by a doctor of dental medicine or dental surgery if the services are services that: 1) if furnished by a physician, would be considered physician services; and 2) under Vermont law, may be furnished by either a physician or a doctor of dental medicine or surgery. These services are covered as hospital and/or physician services and subject to the applicable limitations found in M500 through M699. This definition was taken from the federal definition found at 42 CFR §440.50.

M619.2 Eligibility for Care

Coverage for medical and surgical services of a dentist is provided to all Medicaid beneficiaries.

M619.3 Covered Services

Services that have been pre-approved for coverage are limited to:

- biopsies;
- repair of lacerations;
- excision of a cyst or tumor;
- reconstructive surgery;
- reduction of a fracture;
- repair of temporomandibular joint dysfunction, including surgical treatment;
- problem-focused limited oral evaluation
- problem-focused limited re-evaluation
- incision and drainage of abscess
- emergency treatment of dental pain – minor procedures

With the exception of services authorized for coverage via M108, other services are not covered.

M619.4 Conditions for Coverage

Tooth repair, replacement or other dental procedures, even if they are a medically necessary part of the surgery, are addressed under the dental benefit and subject to the limitations of M620 or M621 as applicable.

M619.5 Prior Authorization Requirements

Prior authorization is required for all covered services listed above, except for emergency surgery.

M619.7 Qualified Providers

Maxillofacial surgery must be provided by a licensed physician or dentist who is enrolled with Vermont Medicaid.

M619.8 Reimbursement

Reimbursement for maxillofacial surgery is described in the Provider Manual.

M621 Dental Services for Beneficiaries Age 21 and older

M621.1 Definition

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. This definition was taken from the federal definition found at 42 CFR § 440.100.

M621.2 Eligibility for Care

As of January 1, 1989, coverage of dental services was extended to beneficiaries age 21, or older.

M621.3 Covered Services

Services that have been pre-approved for coverage are limited to:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endodontics (root canal therapy);
- restoration of decayed teeth.

M621.4 Conditions for Coverage

Coverage of dental services for adults is limited to a maximum dollar amount per beneficiary per calendar year. The current maximum dollar amount is \$400. Medical and surgical services of a dentist, as described in M619, are not subject to this maximum dollar amount.