VIA EMAIL: RFPQuestions@hcpf.state.co.us

July 12, 2018

Ryan Yarrow
Colorado Department of Healthcare Policy and Financing (HCPF)
Purchasing and Contracting Services Section
1570 Grant Street
Denver, CO 80203-1818

RE: Dental Services RFI 2018000058 Input

Dear Mr. Yarrow:

On behalf of the dental profession, the Colorado Dental Association (CDA) wishes to offer a few comments and suggestions concerning the Dental Services RFI #2018000058. Specific comments on the RFI are outlined below.

RFI RESPONSE 1. Provide a brief overview of your company including number of years in business, number of employees, nature of business, and description of clients.
The Colorado Dental Association is a professional organization of dentists that has worked for the last 125 years to advance oral health in Colorado. We represent a diverse membership of over 3,000 Colorado dentists, nearly 75% of dentists in the state. The CDA's eight staff and hundreds of volunteer dentists are dedicated to improving the quality, availability, affordability and utilization of oral healthcare services. The CDA advocates both for policies that improve oral health across all populations in our state, as well as policies that increase the efficiency in operations of dental practices. In this spirit, the CDA was a key leader in the legislative coalition that advocated for the addition of an adult dental benefit in Medicaid in 2013, and has advocated for a number of program and funding improvements in the last five years. We believe that the state's Medicaid dental benefits have been critical in addressing some key gaps in dental coverage in our state and have resulted in some notable health and cost containment improvements. We are encouraged that the philosophy reflected in this RFI seems to align closely with the CDA's recent policy vision of delivering high quality dental care to Coloradans who have often fallen into gaps for oral health coverage and access. We are seeking ways to break the dental disease cycle to attain the affiliated individual and systemic benefits. The CDA continues to look for innovative ways to deliver top tier dental care, and especially preventive services, to all Coloradans, regardless of race, creed, age, geographic location, or socio-economic status. We are submitting comments on this RFI as a stakeholder interested in seeing continued improvements in oral health outcomes as well as program efficiency. We look forward to working together to this end.

RFI RESPONSE 2. Upon review of the current Contracts for dental services, what areas can be changed to provide additional cost savings? What are common areas of waste in dental services contracts that can be avoided? Have you ever implemented any of these or other cost-saving ideas relative to dental contracts? If yes, what are they? If no, why not?

In coming years, the CDA would like to see preventive services further incentivized and we believe the dental administrative services organization's (ASO) capacity to partner in implementation of these kinds of efforts should be assessed. The private dental plan market offers several innovative approaches to incentivize prevention that might be considered, such as:

- There are a number of plans (Cigna, LifeMap) that offer a structure known as progressive maximum plans. Under these plans, if a patient receives certain preventive services, their plan's annual maximum is increased in either the current or future benefit years (for example, from a $1,000 max gradually increase to $1,500).
- Another private market model (Delta Dental) exempts diagnostic and preventive dental services from being counted toward the patient's annual maximum benefit limitation.

Using a structure like this for the adult dental benefit seems well aligned with program goals of increasing utilization and patient connections with dental homes. Greater utilization of preventive care in dental benefits would help provide additional cost savings in deterring avoidable cost on restorative care over time. This structure could also benefit patients in the short term with providing an increased annual maximum to access needed care. This benefits design change may first require some additional authorizations on the policy side. The CDA is prepared to advocate for those changes and has considered how these objectives may be accomplished even within current dental program allocation. With prerequisite policy changes in mind, the CDA is not necessarily asking that this type of structure be immediately implemented (though immediate implementation would be welcome if feasible). Our primary interest at this juncture would be to ensure that vendors' capacity to deliver innovative preventive models be assessed in the RFP. We would ask that the Department ask a question in the RFP about whether vendors have capacity to implement these types of innovative annual maximum structures to incentivize preventive care and prioritize affirmative answers in evaluating responses.

Another innovative approach to streamline services, reduce waste and increase program efficiency would be to provide each participating Medicaid dentist with a certain number of credits each year to award after prior authorization to patients whose need exceeds the benefit's annual maximum. This type of approach could allow dentists to provide more efficient and timely care to patients who need extensive services. Current practices of splitting needed services over multiple benefit years can result in unnecessary duplicative care given the need for additional anesthetic, supplies, etc. when the case is reopened that could otherwise be avoided. This approach is also not usually in the patient's medical best interest. Allowing limited allowances to exceed the annual maximum in patients' benefit plans could greatly streamline delivery of care and accelerate progress toward better overall health outcomes for the highest need patients. For example, a dentist could award a credit to a patient who needed full mouth extractions to qualify for a denture. The credit to exceed the annual maximum could allow all extractions to be provided in a single benefit as opposed to over multiple visits in multiple benefit years. This type of credit system could either be implemented by awarding a dentist a fixed amount of dollar credit (for example, up to $5,000 of services that exceed a patient's annual maximum could be requested through prior authorization) and the dentist would be allowed discretion to choose how to allocate that allowance to patients in need (could go all to a single patient or be split among multiple). Another option could be to award a fixed number of limited dollar allowances (such as 3 or 5 patient cases per dentist where the annual program max could be exceeded by $1,000 with prior authorization). Again, the CDA is not necessarily asking that this type of structure be immediately implemented. Our primary interest at this juncture would be to ensure that vendors' capacity to deliver innovative models like this be assessed in the RFP. We would ask that the Department ask a question in the RFP about whether vendors have capacity to implement these types of models and prioritize affirmative answers in evaluating responses.

Finally, the CDA would like to see the Department better utilize available vendor program integrity services, particularly to avoid need for contingency audits in the dental program. Kansas' Medicaid program received an exemption from federal contingency audit requirements as a privatized Medicaid program that makes robust use of the administrative service organization's program integrity functions. The CDA would ask that the RFP assess vendors' program integrity functions and capacity for educational and productive provider audits as needed. We would encourage the Medicaid dental program to identify program integrity functions and procedures that would provide sufficient comfort in delegating some, if not all, of these functions to the ASO vendor and to evaluate these capacities as part of the RFP process.

RFI RESPONSE 3. Could you work with a flat fee PMPM as currently utilized in the Medicaid dental program while working with a Full or Shared Risk model as is currently used in the CHP+ Dental Program?

The CDA cannot speak directly to whether the proposed payment or risk methodologies would be feasible for vendors. However, we are committed to maintaining certain statutory and regulatory parameters around the benefit and third-party vendor, including that:

- the state contract with a single third party ASO and not multiple vendors for a single dental program,
- the state retain the policymaking authority around covered benefits and provider reimbursement rates, and
- the vendor be prohibited from requiring provides to participate in their private market plans to participate as Medicaid or CHP+ providers.

So long as these parameters are maintained, the CDA is open to innovation in payment and risk-sharing methodologies.

RFI RESPONSE 4. Do you have any special programs, or have you worked with special programs that could drive the risk for higher rated members to lower fees?

The CDA would encourage the Department to consider vendors that could offer enhanced services and outreach for the senior adult (dual-eligible) population.

Today's senior adults are keeping more teeth for longer, making dental coverage essential. Routine dental care is especially important for higher-risk populations like senior adults, as oral health complications can result in very high medical costs. Seniors often present with concurrent health conditions that can be greatly exacerbated by the lack of utilization of dental services. Dental disease is linked to many chronic and serious health conditions like strokes, stomach ulcers, lung disease, pneumonia, heart attacks, heart disease, hypertension and diabetes. Chronic conditions, which have increased prevalence among senior populations, are often treated by medications that adversely impact mouth health. Because of these direct links between dental and overall health, poor dental health inevitably increases other healthcare costs, both individually and systemically. Poor dental health has adverse implications for nutrition, quality of life, social engagement and well-being. Routine dental care can help seniors stay ahead of the many overall health impacts of dental disease and provide a tremendous opportunity for cost savings.

The CDA would recommend that the dental RFP include an assessment of the vendor's outreach and care coordination capacities for the eligible senior population. It would also be interesting to assess the vendor's potential capacity to provide administration of additional senior dental benefit programs (such

as the Old Age Pension dental benefit or a Medicaid dental buy-in program for senior adults) if contemplated by the legislature in the future. Again, the CDA is not asking for immediate implementation of administration for senior dental benefits, just that a vendor's capacity to incorporate additional programs of this nature be assessed through the RFP.

RFI RESPONSE 5. What are your ideas for a Shared Risk/Shared Savings benefit in an ASO model?
Again, the CDA cannot speak directly to whether the proposed payment or risk methodologies would be feasible for vendors. However, we are committed to maintaining certain statutory and regulatory parameters around the benefit and third-party vendor, including that:

- the state contract with a single third party ASO and not multiple vendors for a single dental program,
- the state retain the policymaking authority around covered benefits and provider reimbursement rates, and
- the vendor be prohibited from requiring provides to participate in their private market plans to participate as Medicaid or CHP+ providers.

So long as these parameters are maintained, the CDA is open to innovation in payment and risk-sharing methodologies.

RFI RESPONSE 6. What data sharing/collaboration ideas do you have to share to enhance the effectiveness of the dental program? Do you have other programs in other commercial markets or states that the Colorado Medicaid or CHP+ could benefit from?
Data sharing capacity was requested as part of the current ASO contract and has been in process, but has not been delivered at this point to our knowledge. The ability to share certain records (e.g. radiographs, intraoral photographs, etc.) among Medicaid providers would be very helpful and could eliminate potential waste incurred in unnecessarily retaking records that cannot be easily shared between providers at this time.

We are also interested in vendors' willingness to provide supports and services to help providers with compliance with Medicaid program rules. For example, the current CHP+ vendor also offers a free translation service that satisfies the language translation requirements of Section 1557 of the Affordable Care Act to all participating CHP+ providers. These kinds of regulatory requirements can deter providers from participating in public programs, and support services can eliminate barriers to provider participation. We would encourage the continuation and potential expansion (e.g., perhaps the provision of free opioid e-prescribing tools for ease of compliance with anticipated Department policies aimed at more responsible opioid prescribing practices) of these kinds of compliance support tools from the selected program vendor.

RFI RESPONSE 7. What opportunities do you see to improve oral health and overall health (primary care) integration? What is your long-term vision?
The mouth is connected to the body. Prevention and whole health integration are vital to containing costs and improving outcomes in the Medicaid program. Because of the direct links between dental and overall health, poor dental health inevitably increases other healthcare costs, both individually and systemically. We think it is vital to incentivize prevention as a means to minimize program costs in the long term (as well as have a healthy population with good oral and physical health outcomes). Incentives could be built for patients through progressive program maximums, as discussed in RFI Response 2, or through other innovative models. We look forward to learning more through the RFP process about innovative programs being implemented by vendors, especially in regard to incentivizing prevention.

The Department has also been in the process of revising the high-risk caries criteria, which allows for additional preventive services to be provided to children and adults for the purpose of avoiding costly future restorative care. If any vendors have expertise in developing successful models for delivering preventive services to high-risk populations in a cost-effective manner that improves long-term outcomes, it would be helpful to note and assess that expertise.

It's also vital that we continue to innovate to deliver patient centered care. Significant strides have been made in this area in the last five years, including the implementation of telehealth dental models like the virtual dental home and medical-dental integration pilots. Anecdotal early data has shown some positive trends in terms of both oral health and physical health outcomes. We would support efforts to expand these pilots to more locations, particularly in rural and underserved areas. Incentive programs might be considered to encourage more widespread roll out. It's also important that we continue to develop common sense and timely reimbursement policies for these models (e.g., creating real-time billing policy for dental hygienists to deliver silver diamine fluoride treatments as authorized in House Bill 18-1045).

Another area of overlap with primary care is for pregnant moms covered by CHP+. Dental coverage is not currently extended to pregnant mothers and there is a documented correlation between good dental health and good pregnancy outcomes. Untreated periodontal infection has been associated with low weight babies and premature births, which have substantial systemic health costs. In addition, the mother's oral health status is the best predictor of a child's oral health status. Treating mom's dental needs during pregnancy can help delay transmission of dental disease, giving the child a healthy foundation and reducing the high expense of early childhood dental care. The CDA believes that dental coverage for pregnant moms under CHP is a key (and low cost) policy intervention that could have a significant return on investment. We will be continuing to pursue this policy change in coming legislative sessions. It may be wise to assess the ability of a vendor to incorporate benefits processing for pregnant moms in CHP+ within the RFP process.

Opioid prescribing policy is another potential area for primary care collaboration and integration, as opioid addiction has widespread physical, mental and even oral health impacts. It drives high systemic health costs and has devastating personal impacts. Dentists are currently among the top three prescribers of opioids, alongside primary care physicians and emergency room physicians. Efforts are underway to improve prescribing protocols for opioid naïve patients, as well as address treatment needs for addicted patients. ePrescribing protocols are being considered as part of these policy discussions, and there has been some discussion of a pilot program to study the impacts of ePrescribing in an integrated system of physical, mental and oral health – like Medicaid. With a smaller provider population, dentistry has been discussed as a potential prescriber group for implementation of such a pilot program. With this in mind, it would be interesting to assess the interest and capacity of applicant ASO vendors to participate in rollout of a pilot program of this nature. The vendor's role could cover a broad range – from very limited (e.g., provider education or contracting for provision of software for e-prescribing) to comprehensive (e.g., design of the program, data evaluation, etc.). This is another area where to Department may be wise to simply evaluate a vendor's capacity to incorporate additional programs of this nature within the dental contract.

RFI RESPONSE 8. Are there any primary care initiatives that you are rolling out to your oral health networks? Please provide examples.

The CDA is currently working on the legislative policy side to explore the potential for mandatory public school dental screenings, which could improve early detection of dental decay in high-risk children. Colorado already conducts several primary care health screenings in schools, including vision and hearing. Oral health is a key primary care service that should also be integrated into screening protocols. Early detection and management of children's dental conditions can improve oral health, overall health and well-being and school readiness. Timely interventions could lead to substantial cost savings, individually and for the many state-funded programs that provide dental coverage to children. With Medicaid and CHP+ offering coverage to approximately 33% of Colorado's children, the savings from increased screenings and prevention could be notable. The CDA may be interested in assessing with the Department potential reimbursement mechanisms to support this type of program, which could ultimately save cost. If any RFP applicants have experience in implementing and paying for school screening programs in other states, this could be a helpful competency.

RFI RESPONSE 9. What type of creative innovations are currently happening in the dental world? How do they fit within the benefit?

In the past, the CDA has pursued some provider recruitment incentive models, particularly the Take 5 Pay for Performance program that rewarded providers for enrolling in the benefit and seeing 5, 55 or 105 new Medicaid patients. This program, implemented at the onset of the adult dental benefit, was very effective in quickly growing the dental provider network. The CDA has explored replicating this program on a smaller scale – particularly for underserved geographic areas and specialties. We would be interested to learn vendors' experience in implementing these types of programs or similar effective models for provider recruitment (e.g., differentiated fee schedules for underserved provider segments, etc.).

Improving administrative efficiency is another area that is vitally important for provider recruitment and retention. Assessing RFP vendors' experience in improving administrative efficiencies in Medicaid benefits, or even asking for input on their top ideas for improving administrative efficiency in the Colorado benefit, would be helpful.

RFI RESPONSE 10. What measures or practices could be implemented to ensure that the awardee maintains a Person-Centered Approach?

Much of the feedback already shared on this RFI speaks to maintaining a person-centered approach. Providing support for patient-centered care models like the virtual dental home, providing additional support services for dual-eligible seniors, delivering school dental screenings, improving the program annual maximum or offering provider credits to exceed the annual maximum are all patient-centered interventions. Patient and provider satisfaction with the vendor in prior markets should likely be considered as part of the RFP assessment. Metrics for patient and provider satisfaction could be built into the current award and contract.

The CDA appreciates the Departments proactive approach in working to ensure appropriate and effective parameters for the vendor selected to administer the adult and children's Medicaid dental program, as well as the CHP+ children's dental benefit. We hope that our comments are productive and beneficial and will help the further improve the program. We appreciate your consideration of these comments. Please contact us if we can provide further clarification on any of the comments or suggestions offered in this document.

Sincerely,

Greg Hill, JD
Executive Director, Colorado Dental Association