Medicaid Dental fee benchmarking:

Based on advisement from Medicaid dental providers, **the Colorado Dental Association (CDA) strongly recommends utilizing the CIVHC Dental Claims Dashboard as the benchmark for Medicaid Dental**:

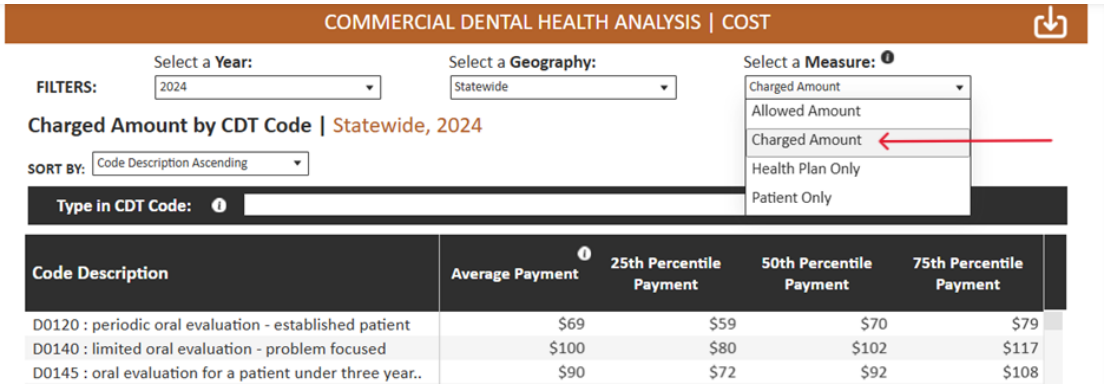
https://civhc.org/get-data/public-data/dental-health-analysis/

The CIVHC dashboard provides a comprehensive view of dental care in Colorado using commercial claims data from 2022 to 2024 from the Colorado All Payer Claims Database.

A benchmark is a reference point to judge what is the typical cost to receive a given dental service in the free market. The benchmark does not determine the Medicaid fee, however it represents how close that Medicaid fee is to the fair market cost.

Colorado's fee-for-service Medicaid Dental program contracts with private practice and DSO dentists. Comparing to private pay rates is appropriate and most informative as a benchmark. As such, the CIVHC claims database is the best benchmark, as it is the most accurate and comprehensive look at dental fees, with the biggest sample size that is directly reflective of fiscal conditions for providing dental care in Colorado.

The most appropriate figures from the CIVHC dashboard for benchmarking are the "Charged Amount" figures:



Code Description	Average Payment	25th Percentile Payment	50th Percentile Payment	75th Percentile Payment
D0120 : periodic oral evaluation - established patient	$69	$59	$70	$79
D0140 : limited oral evaluation - problem focused	$100	$80	$102	$117
D0145 : oral evaluation for a patient under three year..	$90	$72	$92	$108

The "charged amount" figures reflect the dentist fees and are most accurate to the actual clinical work and practice expense required. These figures show the true market value of dental procedures.

There was an assertion during the first dental stakeholder workgroup in September that private fees/commercial rates are primarily profit driven. We would contest that assertion. A dentist sets their fees based on many cost-driven factors – this includes costs for staffing to provide or assist in providing services (which is impacted by staffing shortages, often increasing cost when shortages are higher), cost for physical infrastructure, supplies and

equipment, lab fees, and the time and expertise of the dentists, many of whom are also working to pay down significant student loan debt. Dentist fees are all inclusive of every aspect of cost of care (including what medical otherwise bills as a separate "facility fee"; in dental, every cost that goes to providing care is rolled into one fee for that procedure code).

If we consider how Medicare determines fees for medical services, they look at three components which represent the overall cost and effort associated with a given service - (1) clinician work required to provide the service, (2) practice expenses including staffing and infrastructure costs, and (3) professional liability insurance costs[1]. Dentists set their own fees in a similar way to cover the cost and effort of providing a given service. Because Medicaid often benchmarks to Medicare for other services, but cannot do so for dental, the CIVHC database provides a comprehensive alternative that reflects these same cost and effort components.

HCPF asked stakeholders to suggest other states' Medicaid Dental fee schedules to be considered as benchmarks. We do not believe that using other states' fee schedules is useful or appropriate for benchmarking. We cannot consider using another state as a benchmark without knowing how that state sets their fees and what methodology they use to set fees. Without knowing another state's methodology, we risk using an arbitrary and possibly detrimental benchmark. As pointed out in the September dental review stakeholder meeting, it is very possible other states are benchmarking to each other, including to Colorado, and therefore it is merely an echo chamber of states looking to each other to set fees, rather than setting fees based on actual costs to provide care.

It is also challenging to use other states as a benchmark because of the variation in economic conditions. It is not sufficient to just compare cost of living or similar criteria. States may have different staffing shortage levels, and a state with greater staffing shortages will have higher costs for the dental practice to incentivize and retain staff when shortages are higher. There are so many factors when considering what the actual cost of providing care will be, and comparisons to other states fall short in identifying actual costs in Colorado. The CIVHC dashboard is based on Colorado claims data, and is the most accurate tool for insights into Colorado-specific costs.

[1] https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

DIDD Dental fee benchmarking:

Dental patients with intellectual and developmental disabilities often require a thoughtful and individualized approach, with extra preparation and training on the part of the provider. The complex medical history of many of these patients typically means extensively more time, effort, and collaboration with medical providers to plan for safe treatment.

The MPRRAC has already discussed that the DIDD dental fees should be above Medicaid dental fees, and we strongly agree with that.

Rather than identifying an entirely different methodology for benchmarking these DIDD dental fees, they should be tied to the Medicaid dental fee schedule, in that the DIDD dental fees should be benchmarked at 150% of their Medicaid fee counterpart. This is a recommendation that the MPRRAC discussed in July and August, and we agree with this methodology of benchmarking for DIDD dental code fees.