# State of Texas
# Health and Human Services Commission

# Capitated Managed Care Model of Dental Services Final Report

As Required By General Appropriations Act for the 2012-13 Biennium
House Bill No. 1, Article II
Health and Human Services Commission, Rider 54
Eighty-second Texas Legislature, Regular Session, 2011

As prepared by Public Consulting Group, Inc. (PCG)

February 15, 2013

**Table of Contents**

**Executive Summary**

Under the provisions of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, effective March 1, 2012, the Health and Human Service Commission (HHSC) changed the service delivery model for Medicaid dental services from a fee-for-service (FFS) model to a capitated managed care model. This report, the Capitated Managed Care Model of Dental Services Report, is thereby required by HHSC Rider 54 of General Appropriations Act for the 2012-13 Biennium, 82nd Legislature, Regular Session, 2011. Rider 54 requires that the impact of providing dental services through a capitated managed care model be evaluated based on access, quality and cost outcomes.

HHSC was required to evaluate issues including but not limited to:

- utilization trends,
- penetration rates,
- provider to client ratios,
- retention of dental providers,
- services provided, and
- premium insurance revenue and managed care premium cost growth.

Public Consulting Group, Inc. (PCG) was hired by HHSC to complete the required analysis and issue a comprehensive report that addresses the requirements of Rider 54. The following report provides an overview of each of the components outlined above that PCG analyzed to address the objectives of Rider 54. PCG evaluated dental services provided before and after the transition to a managed care delivery system, specifically from March to September 2011 and from March to September 2012, respectively. Each section of the report provides a detailed overview of the steps and processes PCG completed in order to address the requirements of Rider 54. PCG ends the report with the findings of the analysis.

***Populations included in this report***

In Texas, over 2.4 million Medicaid beneficiaries eligible for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT, known in Texas as Texas Health Steps) benefits are enrolled in dental managed care organizations (DMOs). Within the first six months of the transition to DMOs, it is important to review the percent of enrolled Medicaid recipients with dental coverage, since it shows that HHSC and the DMOs worked extensively to enroll eligible recipients into the dental plan of their choice, and ensure the system transition was administratively seamless from the viewpoint of recipients. These beneficiaries covered by DMOs represent the majority of all enrolled Medicaid beneficiaries under Texas Health Steps (THSteps) and are further examined in *Section III. b. Penetration Rates*. The average monthly Medicaid enrollment of clients under 21 years of age increased from 2.5 million recipients in the sampled 2011 time period to 2.6 million recipients in the analogous 2012 time period, ninety-five (95) percent of which mandatorily transitioned to the dental managed care system in March of 2012.
It is important to note that the following Medicaid recipients are excluded from the managed care dental program and continue to receive dental services through the FFS service delivery model[1]:

- Certain Medicaid recipients age 21 and over;

[1] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 8.

- All Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICF/IID); and
- Recipients in the STAR Health Program, which is a managed health-care program for children in foster care and other forms of state care.

Also, due to the business rules associated with managed care and eligibility determination, every month a small percentage of managed care eligible members remain in FFS until they have the opportunity to select a dental plan and enroll. This can often mean that for a time period of up to 45 days, the member is accessing dental services through the FFS system.

Please note that Children's Health Insurance Program (CHIP) recipients were not evaluated within this report since the transition to a capitated managed care model did not affect dental services for CHIP recipients. Unless otherwise noted, Medicaid recipients under 21 years of age who mandatorily transitioned to the dental managed care system in March of 2012 are included in this analysis.

***Limitations of this report***

Movement from a FFS delivery system to a managed care system for children's Medicaid dental services in Texas occurred statewide on March of 2012, and the naivety of the program coupled with numerous year one changes limits comprehensive conclusions to be drawn from this analysis. In order to allow ample time to complete this report, PCG was provided with six months of data to analyze and incorporate into discussion on the topics raised in Rider 54. This limited data does not allow for exhaustive analysis of all topics raised in this report. For example, the first month of implementation of a new service delivery model is often atypical as providers and clients adapt to the changes. Also, there are seasonal aspects to access to dental care (i.e. school vacations, etc.) that cannot be trended with less than (at minimum) a full year of data. An in-depth analysis on the true impact of the effects of this transition would likely require data from 12-18 months post transition to show trends and the impact of the change.

***Coverage of Services Findings & Observations***

DMOs must provide the same exact medically necessary covered dental services to members as FFS dental coverage[2], with the exception of a few differences in how the benefit is accessed. The only actual difference in dental services covered in managed care is the value-added services that DMOs provide for their enrolled clients at no additional cost to HHSC and is further reviewed in *Section III. e. Services Provided (covered services in FFS and managed care)*.

Select dental services require prior authorization before the service is performed and deemed payable. All dental FFS prior authorizations granted before March of 2012 were required to be honored by the DMOs. Thus, *Section III. f. Medicaid Dental Services Requiring Prior Authorization* also highlights the 500,915 units of service granted FFS prior authorization between March and August 2011, most of which were for orthodontia services. Many of these authorizations were still open on March 1, 2012, and thus became the responsibility of the gaining DMO. Since the implementation of managed care, 91,522 new units of service have been granted pre-authorization by the DMOs between March and August 2012. There has

[2] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5, 4.3.1.1 Medically Necessary Covered Dental Services." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 48.

been a significant decrease in the number of brand new requests for orthodontic prior authorization requests and approvals. On average, 70 percent of new requests submitted to DMOs for prior authorization between March and August 2012 were for orthodontia related services and 62 percent of submitted orthodontia service requests were approved by the DMOs. On March 1, 2012, the DMOs gained the ability to require (or not require) a prior authorization to determine medical necessity before rendering a specific service on a code-by-code basis. With this recent transition, it can be expected that utilization and the prior authorization process within the managed care delivery system will be in flux until providers and clients acclimate to the managed care delivery model. It is recommended that HHSC continues to monitor utilization and prior authorization trends and then re-assess utilization after sufficient time has passed to ensure the findings are truly reflective of the new delivery model.

***Network of Enrolled Dental Providers Findings & Observations***

The DMOs made efforts to ensure clients received continued care from their initial dental providers as described in *Section III. d. Retention of Dental Providers*. The DMOs' current network of 5,555 providers includes 57 percent of providers that HHSC defined as significant traditional providers (STPs) (3,820 providers) who contracted with HHSC in August 2010 to provide CHIP dental or Medicaid dental services. The current network of providers under the managed care system is less than the 6,682 total STPs contracted with HHSC in August 2010. *Section III. c. Provider to Client Ratios* evaluates the size of the overall DMOs' network of enrolled dental providers to the count of Medicaid recipients under 21 years of age who received paid dental services. For every thousand recipients receiving paid FFS dental services in the 2011 sampled six months, there were 15 FFS enrolled dental providers. In the 2012 equivalent time, there were 12 dental providers enrolled with the DMOs for every thousand Medicaid recipients under 21 years of age who received paid managed care dental services. Quarterly, HHSC requires the DMOs to report statistics on their provider network. If a network deficiency is identified, HHSC can require the DMO to provide ad-hoc reporting on efforts to enhance the provider network.

***Utilization Trends & Penetration Rate Findings & Observations***

Units of services between March and August 2011 decreased by 30 percent in the corresponding six months in 2012, yet the sampled count of recipients enrolled for the THSteps dental benefit in 2011 is relatively constant to the count of dental plan enrollees in 2012 and is further assessed in *Section III. b. Penetration Rates*. Table I below compares the average monthly penetration rate of the Medicaid dental program in the studied time periods. Please note these numbers are the monthly averages and are not reflective of the entire program annually. Again, please note that Table I, II, and III do not include data on the populations excluded from managed care that may or may not have accessed a dental service through the FFS system in the 2012 time period.

Table I: Average Monthly Penetration Rate of Dental Program, March to August 2011 and March to August 2012

| Time Period | Description of Statistic | |
|---|---|---|
| **Average, March to August 2011** | Average Monthly Count of Medicaid Clients under 21 years old Received Paid FFS Dental Service | 450,076 |
| | Average Monthly Count of Enrolled Medicaid Clients under 21 years old | 2,501,659 |
| | *Percentage of Average Monthly Enrolled Medicaid Clients under 21 years old who Received Paid FFS Dental Service* | *18%* |

| | | |
|---|---|---|
| **Average, March to August 2012** | Average Monthly Count of Medicaid Clients under 21 years old Received Paid Managed Care Dental Service | 328,381 |
| | Average Monthly Count of Medicaid Clients under 21 years old Enrolled with DMOs | 2,466,244 |
| | *Percentage of Average Monthly Enrolled Medicaid Clients under 21 years old who Received Paid Managed Care Dental Service* | *13%* |

The decrease in orthodontia services is the driving force behind the decrease in overall total paid units of service in the sampled six months in 2012. Orthodontia services have decreased units by 72 percent and in correlation, the payments to providers for orthodontia services have decreased by 81 percent in the two studied time periods. When utilization trends are examined by category of services as seen in *Section III. a. Utilization Trends*, preventive and diagnostic services are the least impacted.

Table II: Summary and Variances of Utilization and Payments by Service Category, March to August 2011 and March to August 2012

| Category of Dental Services | 2011 Utilization (Paid FFS Units of Service) | 2011 FFS Payments to Providers | 2012 Utilization (Paid Units of Service Reported by DMOs) | 2012 Payments to Providers Reported by DMOs | Utilization Variance | Payment Variance |
|---|---|---|---|---|---|---|
| All Other | 3,631,029 | $353,638,377 | 2,353,350 | $224,868,634 | -35% | -36% |
| Diagnostic | 4,351,407 | $149,137,426 | 3,655,625 | $127,931,719 | -16% | -14% |
| Orthodontics | 1,436,902 | $130,202,259 | 401,362 | $25,068,122 | -72% | -81% |
| Preventive | 4,783,464 | $137,318,468 | 3,570,485 | $100,775,354 | -25% | -27% |
| **Total** | **14,202,802** | **$770,296,529** | **9,980,822** | **$478,643,829** | **-30%** | **-38%** |

Within the first six months after the change to dental managed care in 2012, the Average Cost per Client decreased as compared to the corresponding six months in 2011 as seen in the Table III below. Additionally, the table indicates the Average Cost per Unit of Service decreased and the Average Count of Paid Service Units per Client decreased. These are straight-lined averages calculated only for the purpose of this report and are not weighted for varying reimbursement rates by unit nor adjusted for acuity. Please note these numbers are only for the six month studied time periods in 2011 and 2012 and are not reflective of the entire program annually.

Table III: Summary Statistics of Payments, Units of Services and Enrollment, March to August 2011 and March to August 2012

| Time Period | Service Delivery Model | Total Payments to Providers | Total Paid Units of service | Avg. Monthly Enrolled Clients Age <21 | Avg. Cost per Unit | Avg. Cost per Client | Avg. Count of Units per Client |
|---|---|---|---|---|---|---|---|
| March-August 2011 | FFS | $770,296,529 | 14,202,802 | 2,501,659 | $54.24 | $307.91 | 5.7 |
| March-August 2012 | Managed Care | $478,643,829 | 9,980,822 | 2,466,244 | $47.96 | $194.08 | 4.0 |

***Monthly Capitation Payments & Premium Tax Revenue Observations & Findings***

Accordingly, capitation payments from HHSC to DMOs account for 93 percent or $707 million of total Medicaid spending on dental services between March and August 2012 (exclusive of premium tax revenue or performance payment adjustment). The DMOs have been able to control costs in the first six months of implementation. The total FFS payments to providers between March and August 2011 were $770.2 million, whereas in 2012 corresponding time period the capitation payments from HHSC to DMOs ($707 million) plus the FFS payments to providers ($56.8 million) are $763.8 million in expenditures, which is a savings to HHSC of over $6 million. In addition to that savings, the premium tax revenue for the 2012 corresponding time period is $12 million. Furthermore, within the first six months of implementation, the DMOs are actively enrolling Medicaid recipients into dental plans; the number of covered recipients is not yet stable. As the enrolled members increase for DMOs, the monthly capitation payments from HHSC are also increasing. HHSC can offset some of the monthly capitation payments with the tax revenue from the DMOs, yet at this early stage, the monthly capitation payments and tax revenue are estimated and may change.

***Final Conclusions***

While the data suggests that the first six months of the program have decreased over-utilization and reduced costs to the Medicaid program, final conclusions on penetration rates, utilization, and provider to client ratios will require further review as more program data becomes available. The biggest decrease in utilization has been to orthodontia services, which seems appropriate given the concerns of over-utilization of these services. The DMOs are honoring orthodontia approved prior to March 2012 to ensure the continuum of care to clients. Between March and August 2011 alone, half a million units of service were authorized by Texas Medicaid and Healthcare Partnership (TMHP), the claims administrator under the Medicaid FFS model, and are still honored by the DMOs in 2012. For any new service not previously authorized by TMHP, the DMOs clearly implemented additional controls to the system of care by requiring prior authorization for an increased number of services to assess medical necessity and reduce over-utilization.

Furthermore, access to providers has slightly decreased compared to the FFS model. The number of enrolled providers decreased to 5,555 providers under the managed care model. For every thousand Medicaid recipients under the age of 21 years who received a FFS paid dental service, there were 15.1 enrolled dental providers between March and August 2011; however, there are 12.3 enrolled dental providers for every thousand DMO enrollees who received a managed care paid dental service in the 2012 studied time period.

Premium levels have remained constant and HHSC has achieved cost savings related to the implementation of a DMO service delivery model. In addition to the cost savings, the State of Texas has realized increased revenues due to the premium tax revenue collected from DMOs for the 2012 corresponding time period. The tax revenues received and cost savings achieved have made the rollout of the DMO system a success.

While this report was commissioned by HHSC, the landscape of the Texas dental program changed considerably. Within the first year of dental managed care, HHSC terminated Delta Dental as a DMO vendor and Delta members were transitioned to either MCNA or DentaQuest. By removing Delta Dental, the most costly DMO from premium payments, the actual premiums expenditures for the State is difficult to measure. With the change to the delivery system, it is highly recommended to continue to assess and

monitor the managed care delivery system as vendors and networks stabilize their roles in the Medicaid dental program.

## I. Introduction

To partner with a contractor to write this report, HHSC issued a Request for Quote (RFQ) and Task Order Memorandum as an addendum to the Multiple Award Consultant Service Agreement, and Public Consulting Group, Inc. (PCG) was selected through a competitive procurement process to complete the objectives set by Rider 54. PCG implemented a methodology for completing the evaluation in a timely manner and addressing each of the key issues, using a project work plan that outlined tasks and timelines for completion which can be found in Appendix A. HHSC Medicaid/CHIP Division leadership and PCG participated in a project kick-off meeting to determine the project goals and tasks, and to identify available data sources. Following the consensus of the meeting, PCG used the following methods of data gathering:

- Initial meetings with HHSC Medicaid/CHIP Division;
- Meetings with internal stakeholders including Managed Care Operations, Dental Director, Health Plan Management, *Frew* Coordination, and Office of Inspector General; and
- Collection and analysis of available dental data and reports.

### *a. Background*

Prior to managed care, HHSC provided Medicaid dental services in Texas for THSteps recipients under age 21 through a FFS delivery system. Under this system, the single state agency is solely responsible for directly contracting with, managing and reimbursing individual dental providers for each service they supply to recipients, as well as overseeing medical care policies, payment methods, and rates specific to the multiple types of providers participating in Medicaid statewide. Since 2006, CHIP recipients have received dental services through a capitated managed care model through a single, state-wide managed care dental plan. On March 1, 2012, children's Medicaid dental services (including orthodontic services) were transitioned into a capitated managed care delivery system as well. This is the first time Medicaid dental services would be managed and delivered by DMOs. The selected vendors would provide dental services to both CHIP and Medicaid managed care clients through licensed dental providers.

With the FFS delivery system, HHSC bore the majority of the financial risk of providing dental services, while risk for the providers was negligible, since they were paid on the basis of services provided. As Medicaid patient volume increased and/or as the intensity of service increased, the reimbursement payments provided by HHSC also increased. An essential difference between FFS and managed care is HHSC's ability to hold accountable an entire network of dental providers.

With the capitated dental managed care delivery system, the financial risk and oversight responsibility are shared among HHSC, DMOs, and dental providers. Direct oversight of contracted DMOs and payment rates are established by HHSC regardless of the volume of services or intensity of services rendered. The DMOs enact standards as dictated by HHSC for medical care and referral policies, while determining payment methods and rates for participating dental providers. For example, HHSC required DMOs to submit their prior authorization policies for review with the goal of ensuring medically necessary orthodontic service delivery[3]. Yet HHSC does not dictate to the DMOs any reimbursement rates paid to participating dental providers. With capitated dental managed care, the DMOs carry out administrative

[3] Texas Health & Human Services Commission Chief Deputy Commissioner and Inspector General. "Presentation to House Public Health Committee on Delivery of Dental Services in Medicaid." 15 October 2012. *http://www.hhsc.state.tx.us/news/presentations/2012/101512-dental-svcs.pdf.* Page 9.

activities such as client grievances and provider appeals; however, they remain subject to HHSC as final authority for the program.

The DMOs accept risk-based contracts from HHSC and assume full financial risks for delivered dental services. HHSC defines the terms and conditions for accountability, quality improvement, and utilization review in the contracts with the DMOs regarding access and quality of care. HHSC pays each DMO a monthly capitation premium payment for each eligible and enrolled Medicaid member to provide the defined set of Medicaid-covered dental services through its network of licensed, contracted dentists. The fixed monthly premium rate consists of the following components[4]:

1) an amount for the dental services performed during the month;
2) an amount for administering the program, and
3) an amount for the dental contractor's risk margin.

With respect to managed care, states are required by federal statute to pay risk contractors on an "actuarially sound" basis. Even though premium rates may vary by DMO for each program, HHSC performs actuarial data analysis and calculates the premium rates for each period[5].

HHSC applies a variety of financial and non-financial incentives and disincentives to DMOs' performance. HHSC places each DMO at risk for five percent of the premium payments for the Medicaid and CHIP Programs. HHSC pays each DMO its full monthly premium payments, before evaluating if the DMO fully met the performance expectations for which it is at risk. If the DMO falls short on its performance expectations, HHSC can deduct future premium payments to the DMO by an appropriate portion of the aggregate at-risk amount[6]. HHSC focuses on a series of performance measures that identify crucial aspects of performance to ensure the DMOs' accountability and assembles them into its Performance Indicator Dashboard.

After the first year, HHSC will collaborate with the DMOs to create an annual series of highly specified and measurable Performance Improvement Projects that present significant opportunities for performance and quality improvement. These projects will support HHSC's goals with the Dental Program, and show how HHSC and the DMOs are continuously examining, monitoring, and revising processes and systems to improve administrative and clinical functions. These projects will be incorporated into each DMOs contract[7] as part of its annual plan for Quality Assurance and Performance Improvement (QAPI) Program once finalized and approved by HHSC.

As another mechanism for performance measurement and utilization review, HHSC is required to contract with an External Quality Review Organization (EQRO) for an impartial review of medical

[4] Texas Health & Human Services Commission Office of General Counsel. "Attachment A – HHSC Medicaid/CHIP Dental Services Terms & Conditions." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 29.
[5] Texas Health & Human Services Commission Office of General Counsel. "Attachment A – HHSC Medicaid/CHIP Dental Services Terms & Conditions." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 29.
[6] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 6-5.
[7] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 11.

decisions for Medicaid managed care dental programs. HHSC's EQRO evaluates each DMO's QAPI annual plan in accordance with the relevant Centers for Medicaid and Medicare Services (CMS) protocol.[8] This provides an additional measure to ensure that quality care delivery is not compromised in an at-risk contractual arrangement. In addition to state-mandated efforts, some DMOs also conduct provider profiling to identify unusual service delivery trends and have special investigative units that track, trend, and report possible fraud, waste, and abuse[9].

HHSC released a Request for Proposal to obtain services of at least two statewide DMOs to provide Medicaid and CHIP dental services. Three vendors were awarded the contract and began operations effective March 1, 2012:

- Delta Dental
- MCNA Dental
- DentaQuest

Please note that HHSC has since terminated Delta Dental's contract for Medicaid and CHIP managed care dental services. On December 1, 2012, HHSC transferred all of Delta Dental's clients to either DentaQuest or MCNA Dental. However, the termination of Delta Dental's contract occurred after the studied time period and is not evaluated within this report.

### *b. Frew, et al. v. Janek, et al.*

Filed in 1993, *Frew et al. v. Janek, et al.* (formerly *Frew, et al. v. Hawkins, et al*. and commonly referred to as *Frew*) was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for the EPSDT benefit. The class action lawsuit alleged the Texas EPSDT program did not meet the requirements of the federal Medicaid Act. Primary allegations were related to access and knowledge of available services. The parties resolved the litigation by entering into an agreed consent decree, which the court approved in 1996.

In September 2007, the court presiding over *Frew, et al. v. Janek, et al.* approved 11 agreed corrective action orders to address Defendants' violations of the 1996 *Frew* Consent Decree. In 2007, in anticipation of the Courts approval of the corrective action orders, the 80th Legislature appropriated an estimated $1.8 billion in all funds, including $706.7 million in general revenue funds, for the 2008-09 biennium. The purpose of this funding was to implement required activities to comply with the consent decree and corrective action orders, to increase provider payments for certain services, and to finance strategic medical and dental initiatives.

The Corrective Action Order, "*Adequate Supply of Health Care Providers,*" required an increase in reimbursement rates for dental providers and required funds be applied to strategic initiatives to improve access to services. According to a report from the U.S. Committee on Oversight and Government Reform, "[Texas] raised payment rates for dental services, and as a result, the number of dentists

[8] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 67.
[9] Texas Health & Human Services Commission Chief Deputy Commissioner and Inspector General. "Presentation to House Public Health Committee on Delivery of Dental Services in Medicaid." 15 October 2012. *http://www.hhsc.state.tx.us/news/presentations/2012/101512-dental-svcs.pdf.* Page 9.

participating in the program increased from 45.4 percent in fiscal year 2007 to 63.4 percent in fiscal year 2010."[10]

The First Dental Home (FDH) program began in 2008 as a *Frew* strategic initiative and, as a covered Medicaid service, continues to provide routine parental education and preventive dental care services to children ages 6 to 35 months.[11] Through this initiative, dentists receive Medicaid reimbursement for providing parental education and preventive dental services to Medicaid-enrolled children ages 6 to 35 months. Below is a chart showing the number of children who received FDH services since State Fiscal Year 2008 and the related cost to the State.

Table I-b-1: Number of Children receiving First Dental Home services and Payments for First Dental Home services for State Fiscal Years 2008, 2009, 2010, 2011 and 2012

| | State Fiscal Year 2008 | State Fiscal Year 2009 | State Fiscal Year 2010 | State Fiscal Year 2011 | State Fiscal Year 2012* |
|---|---|---|---|---|---|
| Unduplicated count of Clients | 15,707 | 142,387 | 279,729 | 344,932 | 138,945 |
| Average number of visits per client | 1.0 | 1.3 | 1.4 | 1.6 | 1.0 |
| Service payment for all visits | $2,333,804 | $26,000,619 | $58,254,361 | $77,298,136 | $19,988,756 |

Source: Texas Health & Human Service Commission *Frew* Coordination. November 20, 2012.
* Paid services as of November 2011 and extracted from TMHP as of February 1, 2012.

Below in Table I-b-2, the number of unique dentists participating in the FDH program across Texas in State Fiscal Year 2012 is displayed based on paid claims and encounters as of September 2012. A count was made of unduplicated National Provider Identifier (NPI) number assigned to individual providers, aggregated from FFS and Managed Care Organizations (MCOs)'s records.

Table I-b-2: Number of Dentists who Billed Dental Procedure Code D0145 Service Under the First Dental Home Program for Dates of Services from September 1, 2011 through August 31, 2012

| | General Dentists | Pediatric Dentists |
|---|---|---|
| Unduplicated count of Dentists | 3,124 | 612 |

Source: Texas Health & Human Service Commission *Frew* Coordination. November 20, 2012.

One of the Corrective Action Orders, "*Health Outcome Measures and Dental Assessment*," requires the State to "conduct a valid dental study that assesses *Frew* class members' dental health ... and mandates a corrective action plan following the assessment." Class members consist of children from birth through 20 years old enrolled, the Medicaid and eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (THSteps). The first amended assessment of *Frew* class members' dental health was published in April 2010 by Texas Department of State Health Services (DSHS) indicating that the oral health of children enrolled in Medicaid is better than the oral health of children who are not enrolled in Medicaid[12]. HHSC and DSHS were required to propose a corrective action plan that was agreed upon by all parties in February 2012. The Dental Corrective Action Plan included continuation of

[10] E-mail from Billy Millwee, State Medicaid Director, State of Texas, to U.S. House of Representatives Committee on Oversight and Government Reform staff (March 30, 2012).
[11] The United States District Court for the Eastern District of Texas, Sherman Division, Civil Action No. 3:93CA65 – *Frew et al. v. Janek, et al.*, Defendants' Dental Corrective Action Plan, February 26, 2012. Page 1.
[12] Texas Department of State Health Services, Division of Family and Community Health, Office of Program Decision Support. "First Amended Assessment of Child Dental Health Status As Required by *Frew et al. v. Janek, et al*." April 2010. Report Document. 20 November 2012.

available dental services, outreach for clients, and training for providers. The plan also referenced the transition to dental managed care. A second dental assessment will be completed in the spring of 2014.

The transition from FFS service delivery to managed care still allows HHSC to continue monitoring its objectives. DMOs must report the number of performing dental providers by volume, and the DMOs must also report check-up visits as part of the dental service reporting dashboard available to HHSC. The State continues to hold quarterly meetings with dental stakeholders, including dental care providers, as required under the *Frew* consent decree[13].

### *c. Orthodontia*

Texas exercises the option to cover orthodontic services through its Medicaid dental program only if those services are determined as medically necessary[14]. In order to receive reimbursement for orthodontic services, dental providers must submit documentation to support the child's medical case and receive pre-approval from the State's agent. Under the FFS service delivery model, HHSC contracted with TMHP to provide expert dental consultants who granted pre- authorizations and conducted determination of medical necessity for the Texas Medicaid dental program. Under the managed care model, however, each DMO is responsible for these duties, though providers and clients may appeal to HHSC for secondary and final review.

In 2011, as a result of public concern about the orthodontics program, HHSC initiated a series of reforms, including hiring a new dental director, several orthodontists and 10 additional staff members. Dental providers also face more stringent requirements to gain the State's prior authorization for orthodontic services, such as submitting full-cast dental molds, along with the X-rays, photos and supporting dental documentation. The Medicaid Provider Integrity (MPI) for HHSC is conducting several active orthodontia investigations of Medicaid dental and orthodontic services which began prior to May 2011. MPI provided a statement of their efforts conducting several investigations of dental and orthodontia services newly opened in calendar year 2011 and 2012, which can be found in the Appendix. Below is a brief excerpt regarding orthodontia cases as well as cases opened prior to and post December 31, 2011.

> "MPI identified the top 50 dental providers of orthodontia benefits and added subsequent orthodontia providers who came to the attention of OIG through complaints or referrals. There are at least 61 total cases identified for full scale investigations that amount to more than $425 million in expenditures. Thirty-six (36) of these cases are now complete and have established an error rate pattern averaging 88 percent, representing a potential overpayment amount of $303 million dollars. Additional cases (amounting to expenditures in excess of $75 million) are nearly complete, awaiting final orthodontic consultant reviews."

Preceding the transition to DMOs, prior authorizations for most orthodontic services were suspended by HHSC from January 1, 2012, to February 29, 2012. After March 1, 2012 for clients transitioning to dental managed care, prior authorization requests for orthodontic services are now submitted to and granted by the Medicaid client's dental plan instead of TMHP. Orthodontia authorizations that TMHP approved prior

[13] CMS DHHS Approval letter dated December 12, 2011 to State Medicaid Director Texas Health and Human Services Commission "Texas Healthcare Transformation and Quality Improvement Program, Demonstration Approval Period: Date of approval letter through September 30, 2016".

[14] Texas Health & Human Services Commission Chief Deputy Commissioner and Inspector General. "Presentation to House Public Health Committee on Delivery of Dental Services in Medicaid." 15 October 2012. *http://www.hhsc.state.tx.us/news/presentations/2012/101512-dental-svcs.pdf.* Page 9.

to March 1, 2012 are the financial responsibility of the DMOs' effective March 1, 2012. For clients accessing services within the FFS service delivery system, prior authorization requests for orthodontic services continued to be reviewed by TMHP as HHSC's fiscal agent.

### *d. Historical Penetration Rates and Utilization*

A historical comparison between the number of those eligible for EPSDT and those who actually received dental services in Texas is helpful for understanding the penetration rate of Texas' dental program. Comparing the percentage of eligible individuals who received any dental service across states helps to put Texas' dental program in national perspective. Below are charts and graphs which analyze these topics.

The tables below illustrate that both in Texas and nationally, on average, the percentage of eligible young individuals who received a dental service increased during the last four years, and is based upon the Form CMS-416 used by CMS to collect basic information on State Medicaid and CHIP programs. Form CMS-416 is the primary tool used by CMS for overseeing the provision of dental services to children in state Medicaid programs. The "Total Individuals Eligible for EPSDT" is reported on Line 1a of Form CMS-416 and is defined as the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a CHIP Medicaid expansion program determined to be eligible for EPSDT services, distributed by age (based on age as of September 30) and by basis of eligibility. It includes all individuals regardless of whether the services are provided under FFS arrangements or managed care arrangements. Texas does not have a CHIP Medicaid expansion program to report. The "Total Eligible Individuals Receiving Any Dental Service" is reported on Line 12a of the form and is the unduplicated number of children receiving at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (CDT codes D0100 - D9999). Between 2008 and 2011 Texas had increased the number of EPSDT eligible individuals who received dental services by twelve percent. In comparison, the national average had only increased by six percent.

Table I-d-1: Comparison of Texas to National Averages - Total Individuals Eligible for EPSDT and Total Receiving Any Dental Services: 2008-2011, Under 21 years old

| Federal Fiscal Year | Description of Statistic | Texas | National |
|---|---|---|---|
| 2008 | Total Eligible Individuals Receiving Any Dental Service | 1,428,376 | 11,656,763 |
| | Total Individuals Eligible for EPSDT | 2,943,128 | 32,245,149 |
| | *Percentage of Eligible Individuals Receiving Any Dental Service* | *49%* | *36%* |
| 2009 | Total Eligible Individuals Receiving Any Dental Service | 1,674,912 | 13,402,543 |
| | Total Individuals Eligible for EPSDT | 3,111,775 | 33,826,914 |
| | *Percentage of Eligible Individuals Receiving Any Dental Service* | *54%* | *40%* |
| 2010 | Total Eligible Individuals Receiving Any Dental Service | 1,955,475 | 14,325,989 |
| | Total Individuals Eligible for EPSDT | 3,347,025 | 35,602,313 |
| | *Percentage of Eligible Individuals Receiving Any Dental Service* | *58%* | *40%* |
| 2011 | Total Eligible Individuals Receiving Any Dental Service | 2,159,539 | 14,256,580 |
| | Total Individuals Eligible for EPSDT | 3,545,534 | 33,998,559 |
| | *Percentage of Eligible Individuals Receiving Any Dental Service* | *61%* | *42%* |

Source: "Early and Periodic Screening, Diagnostic, and Treatment." Medicaid.gov. CMS, n.d. Web. 21 Dec. 2012.

A comparison of several states similar to Texas helps illuminate just how different Texas' dental program has been historically. Texas is compared to California, New York, and Florida because, according to the 2010 United States Census, these states have the four largest overall populations in the country. As the chart and graph below illustrate, Texas has been significantly outperforming these other states in penetration rate.

Table I-d-2: Percentage of Eligibles Under 21 years old Receiving Dental Services in Several States, 2011

| Description | Texas | National | California | New York | Florida |
|---|---|---|---|---|---|
| Total Eligible Individuals Receiving Any Dental Services | 2,159,539 | 14,256,580 | 1,700,745 | 816,174 | 447,579 |
| Total Individuals Eligible for EPSDT | 3,545,534 | 33,998,559 | 4,631,723 | 2,195,999 | 2,151,566 |
| ***Percentage Receiving Dental Services*** | ***61%*** | ***42%*** | ***37%*** | ***37%*** | ***21%*** |

Source: "Early and Periodic Screening, Diagnostic, and Treatment." Medicaid.gov. CMS, n.d. Web. 21 Dec. 2012.

***Historical Utilization***

Data collected from March 2007 through February 2012, illustrates a steady increase in utilization and cost statistics, with the exception of the average cost per claim. Table I-d-3 provides a five- year summary of the total FFS payments made by Medicaid and total number of enrolled clients under 21 years of age. In addition, the table calculates the straight-line average cost per client by dividing the Paid Amount by the Number of Clients.

Table I-d-3: Five Year Dental Summary, March 2007 to February 2012

| Year | Paid Amounts | Number of Clients | Average Cost per Client |
|---|---|---|---|
| Mar 2007 - Feb 2008 | $ 569,802,172 | 1,366,709 | $ 416.92 |
| Mar 2008 - Feb 2009 | $ 827,399,556 | 1,471,614 | $ 562.24 |
| Mar 2009 - Feb 2010 | $ 1,094,334,474 | 1,773,855 | $ 616.92 |
| Mar 2010 - Feb 2011 | $ 1,339,654,306 | 2,068,724 | $ 647.58 |
| Mar 2011 - Feb 2012 | $ 1,444,745,585 | 2,214,853 | $ 652.30 |

Source: "12_Five Year Dental Summary by Region_Mar07_Feb12.xlsx"; Clients with dental claims: AHQP Claims Universes, TMHP; Data Quality and Dissemination, SDS, HHSC, November 2012 (gs)

The Average Cost per Client steadily increased during the five years preceding Texas' change to dental managed care. The total number of clients significantly increased over five years from approximately 1.4 million clients to 2.2 million clients. Overall, the data on record paints a picture of a rapidly-growing dental program. The penetration rate and average cost per client are both increasing, causing a two-fold dip into Texas' Medicaid resources. The reason for the increase and whether or not the increase was a reflection of preemptive or reactive implementation of policy are matters for further investigation.

## II. Legislative Direction

When the service delivery model for dental services was changed from a FFS model to a capitated managed care model, Rider 54 required HHSC to evaluate the impact of providing dental services through a capitated managed care model on access, quality and cost outcomes.

As of December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved the new Medicaid section 1115(a) Demonstration waiver, entitled "Texas Healthcare Transformation and Quality Improvement Program," through September 30, 2016. Texas' new section 1115 Demonstration has a two-fold purpose: to expand the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and to establish two funding pools that will assist providers with uncompensated care costs and promote health system transformation.

In addition to these two main purposes, Medicaid beneficiaries under the age of 21 statewide receive coverage for a full array of primary and preventive dental services through contracting pre-paid dental plans via the Children's Dental Program. Contracting DMOs developed networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program is informed by the improved dental outcomes evidenced under the "First Dental Home Initiative"[15].

In order to evaluate the transition to a new service delivery model, HHSC and PCG agreed to review dental payments and service utilization for two comparative time periods before and after the transition. At the time of commissioning this report, encounter data and paid claims were only available from the first six months of the DMOs' implementation, from March to August 2012. Based on input from HHSC, comparable time periods were selected between March 1, 2011 and August 31, 2011 and between March 1, 2012 and August 31, 2012, respectively. To complete the review, HHSC provided PCG claim summaries of Medicaid Fee for Service (FFS) payments and service utilization, and encounter summaries of Medicaid dental managed care payments and services utilization. Please note that the 2012 numbers are not final due to limitations regarding the encounter data for 2012. Providers have 95 days to submit claims and 30 days from the adjudication of the claim to submit the encounter. Also, as a reminder, the 2012 utilization numbers are not inclusive of the previously mentioned populations that accessed services through the FFS model.

[15] CMS DHHS Approval letter dated December 12, 2011 to State Medicaid Director Texas Health and Human Services Commission "Texas Healthcare Transformation and Quality Improvement Program, Demonstration Approval Period: Date of approval letter through September 30, 2016".

## III. Impacts

### *a. Utilization Trends*

To assess the utilization trends of Medicaid dental services following the transition from FFS to managed care effective March 1, 2012, this report compares paid Medicaid FFS dental units of service between March and August 2011 to the paid Medicaid dental units of service as reported by the DMOs' encounters for the analogous six months in 2012. The report displays all components independently by month for the studied time periods in 2011 and 2012. Within the studied 2011 time period, Medicaid enrolled recipients under 21 years old who received dental services under the FFS delivery system, including recipients under 21 years old residing in Medicaid-paid facilities, are included in the following analysis for the 2011 time period. Recipients under 21 years old that accessed dental services through the FFS system are excluded from the following analysis for the studied 2012 time period. Provided below are the key observations to note:

- Between the 2011 and 2012 time periods, total units of services decreased by 30 percent from 14.2 million to 9.98 million. In correlation, payments to providers decreased by 38 percent from $770 million under FFS delivery system to $478 million under the dental managed care system.
- Among the four service categories, orthodontic services have decreased the most between 2011 and 2012 by 1.35 million units of service or 72 percent fewer units, and by $105 million payments to providers or 81 percent less in payments.
- Approximately 65 percent of units of service between the March and August 2011 time period are diagnostic or preventive in nature, and 73 percent of units of service are diagnostic or preventive dental services in the equivalent six months in 2012.
- Among the four service categories, diagnostic services are the least impacted during the recent transition to a managed care delivery system. Diagnostic services decreased by 695 thousand units of service or 16 percent less units, and by $21 million payments to providers or 14 percent less in payments.
- Preventive services have decreased by 1.2 million units of service or 25 percent fewer units of service, and by $36.5 million payments to providers or 27 percent less in payments.

Please note that the service categories are grouped by ADA® CDT dental procedure codes as shown in the following crosswalk:

Table III-a-1: CDT dental procedure codes grouped into four Service Categories

| Service Category | Included CDT Dental Codes |
|---|---|
| All Other | D2000-D7999, D9000-D999 |
| Diagnostic | D0100-D0999 |
| Orthodontics | D8000-D8999 |
| Preventive | D1000-D1999 |

Table III-a-2 below is a chart comparing utilization by service category between March and August 2011 (labeled as 2011) and between March and August 2012 (labeled as 2012). The table defines utilization as Medicaid FFS paid units of service for the March through August 2011 time period and Medicaid paid units of services reported by the DMOs for the March through August 2012 period.

***The majority of Medicaid dental services are diagnostic or preventive, accounting for approximately 65 percent of service units in the 2011 time period and 73 percent in the 2012 time period.*** Although all utilization decreased between the 2012 and 2011 time periods, ***diagnostic and preventive services were the least impacted during the recent transition to a managed care delivery system***. Orthodontic services accounted for ten percent of service units between March and August 2011, but ***orthodontia utilization has greatly decreased*** since, and accounted for only four percent of service units in the comparative 2012 time frame.

Table III-a-2: Utilization by Service Category

| Category of Dental Services | 2011 Utilization (Paid FFS Units of Service)* | 2011 Percent of Total Utilization | 2012 DMO Utilization (Paid Units of Service Reported in DMOs' Encounters)** | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|
| All Other | 3,631,029 | 26% | 2,353,350 | 24% | -35% |
| Diagnostic | 4,351,407 | 31% | 3,655,625 | 37% | -16% |
| Orthodontics | 1,436,902 | 10% | 401,362 | 4% | -72% |
| Preventive | 4,783,464 | 34% | 3,570,485 | 36% | -25% |
| **Total** | **14,202,802** | | **9,980,822** | | **-30%** |

Sources: **1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table III-a-3 below is paid amounts by service category between March and August 2011 (labeled as 2011) and between March and August 2012 (labeled as 2012). Paid amounts for the 2011 time period are actual payments made by HHSC to dental providers under the FFS model, whereas in the 2012 time period, the source of payments to provider is the DMOs' encounters. Under the managed care delivery system, DMOs are responsible for rate setting and making actual payments to dental providers. HHSC does not dictate the reimbursement rates set by the DMOs for its dental providers. The paid amounts reported by the DMOs in the following tables are calculated only for the purpose of this report and may not represent actual audited payments received by dental providers from the DMOs.

Payments for diagnostic and preventive Medicaid dental services account for approximately 37 percent of dental payments in the 2011 time period, and 48 percent in the 2012 time period. In correlation with the decreased utilization between the 2012 and 2011 time periods, ***total payments to providers decreased, and payments for diagnostic and preventive services were the least impacted during the recent transition to a managed care delivery system. Payments for orthodontic services decreased the most among all service categories***, from $130 million between March and August 2011 to $25 million in the comparative 2012 time frame.

Table III-a-3: Paid Amounts by Service Category

| | 2011 FFS Paid Amounts* | 2011 Percent of Total FFS Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Percent of Total DMOs Reported Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|
| All Other | $353,638,377 | 46% | $224,868,634 | 47% | -36% |
| Diagnostic | $149,137,426 | 19% | $127,931,719 | 27% | -14% |
| Orthodontics | $130,202,259 | 17% | $25,068,122 | 5% | -81% |
| Preventive | $137,318,468 | 18% | $100,775,354 | 21% | -27% |
| **Total** | **$770,296,529** | | **$478,643,829** | | **-38%** |

Sources: **1_FFS Dental Claims _Mar11_Aug11.xlsx*, HHS Forecasting System, Received November 2012
***1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

### *b. Penetration Rates*

To evaluate the penetration rate of Medicaid dental services following the transition from FFS to a managed care service delivery system effective March 1, 2012, this report section first compares coverage of dental plan enrollment to the total Medicaid enrolled clients eligible for the EPSDT benefit. Evaluating coverage during the first six months of implementation shows that HHSC and the DMOs worked extensively to enroll eligible recipients into dental plans, and ensure the system transition was administratively seamless from the viewpoint of recipients. The DMOs have taken responsibility for the dental services previously approved before March 2012, and made efforts to ensure clients received continued care from their initial dental providers as described in *Section III. c. Provider to Client Ratios*. Primarily, this section of the report evaluates the penetration rate of Medicaid dental program by comparing the count of enrolled Medicaid recipients eligible for the EPSDT benefit to those who actually received a paid dental service between March and August in 2011 and 2012. This report first displays all components by month for 2011 and 2012 separately, and then compares each individual component by month between 2011 and 2012. Provided below are the key observations to note:

- Total Medicaid enrollment for all ages is less in 2012 than in 2011 by six percent (although the 2012 numbers are not final due to retroactive eligibility).
- There are four percent more clients under 21 years old enrolled with Medicaid in 2012 (2.60 million) than 2011 (2.50 million).
- Dental plans' enrollment in 2012 (2.46 million) is slightly less than the comparable enrolled Medicaid clients eligible for the EPSDT benefit in 2011 (2.50 million).
- The count of Medicaid clients under 21 years old who received a dental service in the sampled six months is less in 2012 than in 2011 by 26.9 percent on average.
- The average monthly penetration rate decreased from 18 percent in the sampled six months in 2011 to 13 percent in the corresponding six months in 2012.

Table III-b-1 shows between March and August 2011 the total Medicaid enrollment for all ages, count of enrolled Medicaid clients under 21 years of age, and count of Medicaid clients under 21 years of age who received a paid FFS dental service. ***During the sampled six months in 2011, the penetration rate for an average month was 18 percent***, which represented the percent of recipients who received a FFS paid dental service compared to the enrolled Medicaid clients under 21 eligible for the EPSDT benefit.

Table III-b-1: Chart of Medicaid Enrollment and Recipients between March and August 2011

| Month | Total Medicaid Enrollment (All Ages)* | Enrolled Medicaid Clients Age <21** | Medicaid Clients Age <21 with Paid FFS Dental Claims** | Penetration Rate |
|---|---|---|---|---|
| Mar-11 | 3,539,419 | 2,473,199 | 478,167 | 19% |
| Apr-11 | 3,551,604 | 2,464,602 | 415,038 | 17% |
| May-11 | 3,570,543 | 2,480,573 | 419,780 | 17% |
| Jun-11 | 3,593,507 | 2,537,183 | 446,831 | 18% |
| Jul-11 | 3,609,516 | 2,528,701 | 435,694 | 17% |
| Aug-11 | 3,653,205 | 2,525,698 | 504,947 | 20% |
| ***Monthly Average*** | ***3,586,299*** | ***2,501,659*** | ***450,076*** | ***18%*** |

Sources: *"Table 1. Total Medicaid Enrollment." *Final Count — Medicaid Enrollment by Month*. Texas Health and Human Services Commission, n.d. Web. Nov. 2012. <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME-Monthly.asp>.
**Data Quality and Dissemination. SDS. HHSC. Nov. 2012.

Note: Penetration Rate is defined as Medicaid Clients Age <21 with FFS Paid Dental Claims divided by Enrolled Medicaid Clients Age <21.

The following table III-b-2 shows the same information by month between March and August 2012: the total Medicaid enrollment for all ages, count of enrolled Medicaid clients under 21 years of age, total dental plans enrollment, and count of total Medicaid clients under 21 years old who received a managed care paid dental service. ***During the sampled six months in 2012, the average monthly penetration rate of enrolled recipients who received a dental service is 13 percent.***

Table III-b-2: Chart of Medicaid Enrollment and Recipients between March and August 2012

| Month | Total Medicaid Enrollment (All Ages)* | Enrolled Medicaid Clients Age <21** | Dental Plans Enrollment** | Medicaid Clients Age <21 with Paid Managed Care Dental Claims*** | Dental Managed Care Penetration Rate |
|---|---|---|---|---|---|
| Mar-12 | 3,301,062 | 2,568,489 | 2,335,364 | 308,064 | 13% |
| Apr-12 | 3,350,443 | 2,612,226 | 2,461,266 | 311,658 | 13% |
| May-12 | 3,352,508 | 2,609,140 | 2,460,173 | 311,320 | 13% |
| Jun-12 | 3,353,653 | 2,608,853 | 2,503,904 | 327,654 | 13% |
| Jul-12 | 3,368,331 | 2,617,016 | 2,529,129 | 341,082 | 13% |
| Aug-12 | 3,340,890 | 2,593,955 | 2,507,626 | 370,509 | 15% |
| ***Monthly Average*** | ***3,344,481*** | ***2,601,613*** | ***2,466,244*** | ***328,381*** | ***13%*** |

Sources: *"Table 1. Total Medicaid Enrollment." *Point in Time Count — Medicaid Enrollment by Month*. Texas Health and Human Services Commission, n.d. Web. Nov. 2012. <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/PIT-Monthly.asp>.
**Data Quality and Dissemination. SDS. HHSC. Dec. 2012.

***Data Quality and Dissemination. SDS. HHSC. Jan. 2013.

Notes: The early "point in time" count released by HHSC offer a preliminary look at enrollment for any given month. The numbers are not final because Medicaid offers up to three months of retroactive coverage for eligible individuals.

Managed Care Dental Penetration Rate is defined as Medicaid Clients Age <21 with Paid Managed Care Dental Claims, divided by Dental Plans Enrollment.

Table III-b-3 aggregates by month the count of enrolled Medicaid clients under 21 years of age from March through August in 2011 and in 2012 as well as the dental plans' enrollment for the period from March through August 2012. Further columns compare this data in percentage terms. Overall, ***the monthly average count of enrolled Medicaid clients under 21 years of age is greater in 2012 than in 2011 by four percent, and the dental plans in 2012 are progressively enrolling recipients throughout the first months of the transition.*** Between March and August 2012, the dental plans increased their enrollment by 172,262 more recipients or seven percent. Please note that some Medicaid subpopulations under 21 years of age continue to receive dental services through FFS, and are excluded from transition to a managed care dental program[16]. Also, note that there is a lag period of up to 45 days between the time that a client becomes eligible for Medicaid and they are enrolled into a DMO. During this time period, the client's dental services are accessed through FFS.

Table III-b-3: Chart of Enrolled Medicaid Clients under 21 years old
March to August 2011 and March to August 2012

| Month | 2011 Enrolled Medicaid Clients Age <21* | 2012 Enrolled Medicaid Clients Age <21** | 2012 Dental Plans Enrollment** | % Difference in Medicaid Clients Enrolled Age <21 from 2011 to 2012 | % Difference in 2011 Medicaid Clients Enrolled Age <21 to 2012 Dental Plans Enrollment |
|---|---|---|---|---|---|
| March | 2,473,199 | 2,568,489 | 2,335,364 | 3.9% | -5.6% |
| April | 2,464,602 | 2,612,226 | 2,461,266 | 6.0% | -0.1% |
| May | 2,480,573 | 2,609,140 | 2,460,173 | 5.2% | -0.8% |
| June | 2,537,183 | 2,608,853 | 2,503,904 | 2.8% | -1.3% |
| July | 2,528,701 | 2,617,016 | 2,529,129 | 3.5% | 0.0% |
| August | 2,525,698 | 2,593,955 | 2,507,626 | 2.7% | -0.7% |
| ***Monthly Average*** | ***2,501,659*** | ***2,601,613*** | ***2,466,244*** | ***4.0%*** | ***-1.4%*** |

Sources: *Data Quality and Dissemination. SDS. HHSC. Nov. 2012.
**Data Quality and Dissemination. SDS. HHSC. Dec. 2012.

Table III-b-4 aggregates by month the count of Medicaid clients under 21 years of age who received a FFS paid dental service between March to August 2011, as compared to the count of Medicaid clients

[16] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 8.

under 21 years of age who received a managed care paid dental service between March to August 2012. Further columns compare this data in percentage terms. ***In an average month, 26.9 percent or approximately 121,000 fewer Medicaid clients under 21 years of age received a dental service in 2012 than in 2011.***

Table III-b-4: Chart of Medicaid Clients under 21 years old who Received Paid Dental Service March to August 2011 and March to August 2012

| Month | 2011 Monthly Average of Medicaid Clients Age <21 Receiving Paid FFS Dental Service* | 2012 Monthly Average of Medicaid Clients Age <21 Receiving Paid Managed Care Dental Service** | Percent Difference from 2011 to 2012 |
|---|---|---|---|
| March | 478,167 | 308,064 | -35.6% |
| April | 415,038 | 311,658 | -24.9% |
| May | 419,780 | 311,320 | -25.8% |
| June | 446,831 | 327,654 | -26.7% |
| July | 435,694 | 341,082 | -21.7% |
| August | 504,947 | 370,509 | -26.6% |
| ***Monthly Average*** | ***450,076*** | ***328,381*** | **-26.9%** |

Sources: **1_FFS Dental Claims _Mar11_Aug11.xlsx*. Provided by Data Quality and Dissemination. SDS. HHSC. Nov. 2012.
***Item3_FFS_MCO_Dental Clients_Mar12_Aug12_Jan13.xlsx*. Provided by Data Quality and Dissemination. SDS. HHSC. Jan. 2013.

***c. Provider to Client Ratios***

To analyze provider to client ratios for Medicaid dental services following the transition from FFS to dental managed care effective March 1, 2012, this section compares total enrolled dental providers to the average monthly count of Medicaid clients under 21 years of age who received a paid dental service. Provided below are the key observations to note:

- From August 2011 to November 2012, the total enrolled providers decreased by 1,243 providers or 18 percent.
- For every thousand Medicaid recipients under 21 years old who received paid dental services, the number of enrolled dental providers decreased between the two studied time period under FFS and DMOs. In the 2011 sampled six months, there were 15.1 enrolled dental providers for every thousand Medicaid recipients under 21 years old who received paid dental services, whereas the ratio is 12.3 in the same sampled six months in 2012.

Table III-c-1 shows the ratio of enrolled dental providers compared to Medicaid recipients under 21 years of age who received any paid dental service from March to August 2011 and from March to August 2012. Enrolled providers and enrolled recipients have decreased between the studied time periods. As of August 2011, there were 6,798 dental provider enrolled with HHSC to provide FFS dental services. In November 2012, the count of dental providers enrolled with the DMOs is 5,555 which is less by 1,243 providers or 18 percent. Moreover, as a monthly average, 121,695 fewer Medicaid recipients under 21 years old received a paid dental service between the sampled six months in 2011 and 2012. As a result, for every thousand Medicaid recipients under 21 years old who received paid dental services in the 2011 sampled six months, there were 15 enrolled dental providers. Whereas, in the 2012 equivalent time, there were 12 dental providers enrolled with the DMOs for every thousand Medicaid recipients under 21 years of age who received paid managed care dental services. ***The ratio of dental providers has decreased in the 2012 studied time period for every thousand recipients receiving paid dental services***.

Table III-c-1: Chart of Enrolled Dental Providers Compared to Average Monthly Medicaid Clients Under 21 years old Receiving Paid Dental Service

| Time Period | Service Delivery Model | Total Count of Enrolled Dental Providers | Average Monthly Count of Medicaid Clients Age <21 Receiving Paid Dental Service | Ratio of Enrolled Providers to Medicaid Clients Age <21 Receiving Paid Dental Service |
|---|---|---|---|---|
| March - August 2011 | Fee-for-Service | 6,798** | 450,076* | 15.1 : 1000 |
| March - August 2012 | Dental Managed Care | 5,555**** | 328,381*** | 12.3 : 1000 |
| **Variance from 2011 to 2012** | | **-1,243** | **-121,695** | **-2.8** |
| **Variance as a Percentage from 2011 to 2012** | | **-18.3%** | **-27.0%** | **-18.3%** |

Source: *Data Quality and Dissemination. SDS. HHSC. Nov. 2012.

** Total Enrolled Providers as of August 2011, provided by Data Quality and Dissemination. SDS. HHSC. Nov. 2012.
*** Data Quality and Dissemination. SDS. HHSC. Jan. 2013.
**** DMO Enrolled Providers as of November 2012, provided by Delta Dental. DentaQuest. MCNA. Nov. 2012.

Note: Provider counts are unduplicated.

### *d. Retention of Dental Providers*

To evaluate the retention of dental providers following the transition from FFS to dental managed care effective March 1, 2012, this report section compares the count of significant traditional providers (STPs) as of August 2010, enrolled dental providers as of August 2011, and dental providers contracted with the DMOs as of November 2012. This report first displays the total count of dental providers for each category, and then compares the count of STPs to DMO providers. STPs were defined as "dental providers who are currently contracted to provide CHIP dental services or are enrolled as a Medicaid dental provider[17]" as of August 2010. Provided below are the key observations to note:

- The count of dental providers contracted with the DMOs as of November 2012 is 1,127 less providers than 6,682 total STPs as of August 2010 and also is 1,243 fewer providers than the total 6,798 enrolled dental providers as of August 2011.
- The DMOs' current network of 5,555 providers includes a majority of former STPs (3,820 providers) and includes a number of providers who were not STPs (1,735 providers).

Table III-d-1 below shows the total count of STPs as of August 2010, enrolled dental providers as of August 2011, and dental providers contracted with the DMOs as of November 2012. The count of dental providers contracted with the DMOs as of November 2012 is less than the count of STPs as of August 2010 and the enrolled dental providers as of August 2011.

Table III-d-1: Chart of Change in Dental Providers Count

| Provider Category and Date | Count of Dental Providers |
|---|---|
| STP Providers, August 2010* | 6,682 |
| Total Enrolled Providers, August 2011** | 6,798 |
| DMO Providers, November 2012*** | 5,555 |

Sources: *"STP Dental Providers - Statewide." *HHSC Medicaid and CHIP Managed Care Services RFP# 529-12-0002*. Texas Health and Human Services Commission, n.d. Nov. 2012. <http://www.hhsc.state.tx.us/contract/529120002/ProcLib.shtml>.
** Data Quality and Dissemination. Strategic Decision Support (SDS). HHSC. Nov. 2012.
*** Delta Dental. DentaQuest. MCNA. Nov. 2012.

Note: Provider count is based on unduplicated count of NPI numbers.

The DMOs were given three years following the operational start date to enroll STPs, as identified by HHSC, in their Provider Network. However, to be enrolled in the Provider Network, the STP providers must:

1. Agree to accept the Dental Contractor's reimbursement rates; and

[17] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Section 8 – Operations Phase Requirements." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 8 – 17.

2. Meet the Dental Contractor's standard credentialing requirements, provided that lack of board certification or board eligibility is not the sole grounds for exclusion from the Provider Network.

Table III-d-2 below, therefore, has the count of dental providers that were former STPs and are now enrolled DMO providers, enrolled DMO providers that were not former STPs, and STPs that are not currently enrolled DMO providers. Overall, the majority of the former STPs are enrolled currently with the DMOs Provider Network (approximately 57 percent); whereas the remaining 2,862 former STPs or 43 percent have not yet enrolled with the DMOs. ***Within the DMOs' network of 5,555 total enrolled providers, the vast majority are former STPs (approximately 69 percent or 3,820 providers)***. The remaining 31 percent (representing 1,735 providers) of the Provider Networks is made up of non-STP providers.

Table III-d-2: Chart Comparing STP and DMO Providers

| Provider Category | Count of Dental Providers | Percent of STPs to Total STPs |
|---|---|---|
| STPs Enrolled with DMO(s) | 3,820 | 57% |
| Non-STP Providers Enrolled with DMO(s) | 1,735 | N/A |
| STPs Not Enrolled with any DMO | 2,862 | 43% |

Note: Provider count is based on unduplicated count of NPI numbers.

***e. Services Provided (covered services in FFS and managed care)***

DMOs must provide the same exact medically necessary covered dental services to members as FFS dental coverage[18]. The only difference in services provided between FFS and managed care are the value-added benefits/services offered by each DMO at no additional cost to HHSC.

***Value-Added Services Offered by DMOs***

Each DMO may offer value-added services to its clients at no additional cost to HHSC. The charts below compile the value-added services offered by the three DMOs. Overall, all three of the DMOs offer a toothbrush, Delta Dental and DentaQuest offer a mouth guard, and DentaQuest and MCNA offer toothpaste and educational materials. Delta Dental is the only DMO to offer a timer, DentaQuest is the only DMO to offer a backpack and water bottle, and MCNA is the only DMO to offer floss, a toll-free 24-hour hotline, and Wal-Mart gift card for $10.00 of dental care products.

[18] Texas Health & Human Services Commission Office of General Counsel. "Attachment B-1 – HHSC Medicaid/CHIP Dental Services RFP, Sections 1-5, 4.3.1.1 Medically Necessary Covered Dental Services." 1 September 2012. *http://www.hhsc.state.tx.us/medicaid/Dental-Services-Contract-0312.pdf*. Contractual Document, Version 1.2. Page 48.

Table III-e-1: Chart of Delta Dental Value-Added Services

| Delta Dental Value-added Services | | |
|---|---|---|
| **Value-added Service** | **Description of Value-added Services and Members Eligible to Receive the Services** | **Limitations or Restrictions** |
| Dental Care Kit | Delta Dental will offer each new member a dental care kit to promote oral hygiene and prevention of tooth decay and periodontal disease.<br>• Infant Kit: (age 0-1 yr.) infant finger brush, brushing instructions, and an adult tooth brush for the caregiver.<br>• Toddler Kit: (2-4 yrs.) toddler tooth brush, and a two-minute timer to encourage brushing.<br>• Child Kit: (age 4-12 yrs.) child tooth brush, a two-minute timer and dental floss.<br>• Adult Kit: (age 12-18 yrs.) Adult toothbrush, a two-minute timer, and dental floss. | Limited to one kit per member. There are no other limitations or restrictions on eligible members for this service |
| Mouth Guard | Delta Dental will offer a mouth guard to each new member age 6 to 18 to help prevent dental injuries while participating in sports (such as football, soccer, basketball, etc). | Limited to one mouth guard per member. There are no other limitations or restrictions on eligible members for this service. |

Source: "Dental Value-Added Services Template." *HHSC Uniform Managed Care Manual*. Version 2.0. 1 Sept. 2011. Nov. 2012.

Table III-e-2: Chart of DentaQuest Value-Added Services

| DentaQuest Value-added Services | | |
|---|---|---|
| **Value-added Service** | **Description of Value-added Services and Members Eligible to Receive the Services** | **Limitations or Restrictions** |
| Healthy Beginnings Toddler Pack | Texas Medicaid enrollees ages 12-35 months who receive a diagnostic dental service from their First Dental Home provider will receive a Healthy Beginnings Toddler Pack. It includes:<br>• Reusable carrying bag<br>• Infant toothbrush<br>• Finger brush (for cleaning baby's gums)<br>• Teething ring<br>• Educational brochure on oral health topics such as caring for a baby's teeth and gums or how to prevent baby bottle tooth decay | This value-added service is limited to members ages 12-35 months who have a diagnostic dental service.<br><br>One pack per member per lifetime. |
| Big Kid Backpack | Texas Medicaid enrollees ages 36 months - five years who receive a fluoride treatment will receive a Big Kid Backpack. It includes:<br>• Backpack<br>• Toothbrush<br>• Toothpaste<br>• Brushing chart<br>• Stickers for brushing chart | Members 36 months – five years old who have a fluoride treatment.<br><br>One pack per member, per lifetime. |

| | | |
|---|---|---|
| Sports Backpack | Texas Medicaid enrollees ages six-14 who receive a sealant will receive a Sports Backpack. The backpack includes the following items to promote oral health and encourage physical activity:<br>• Sport's mouth guard or water bottle<br>• Toothbrush<br>• Toothpaste<br>Informational sheet promoting healthy lifestyles for adolescents such as healthy eating habits, good dental habits and regular physical activity | Members six-14 years old who receive sealants.<br><br>One pack per member, per lifetime. |
| Sports Backpack | Texas Medicaid enrollees ages 15-20 who receive two cleanings per year will receive a Sports Backpack. The backpack includes the following items to promote oral health and encourage physical activity:<br>• Sport's mouth guard or water bottle<br>• Toothbrush<br>• Toothpaste<br>Informational sheet promoting healthy lifestyles for adolescents such as healthy eating habits, good dental habits and regular physical activity | Members 15-20 years old who receive two cleanings per year.<br><br>One pack per member, per lifetime. |

Source: "Attachment B-2.1 – Medicaid Value-Added Service." *HHSC Medicaid/Medicaid Dental Services RFP.* RFP No. 529-12-0003. Operational Start Date – 31 August 2013. Nov. 2012.

Table III-e-3: Chart of MCNA Value-Added Services

| MCNA Value-added Services | | |
|---|---|---|
| **Value-added Service** | **Description of Value-added Services and Members Eligible to Receive the Services** | **Limitations or Restrictions** |
| Bright Beginnings | Free Dental Kit including, toothbrush, toothpaste, floss, and oral health education materials for special needs members receiving case management services from MCNA Dental, and pregnant MCNA Dental Members. | MCNA Dental Members eligible for special needs case management services from MCNA Dental or prenatal health care services. |
| Toll Free 24 Hour Dental Hygienist Advise Hotline | An MCNA Dental Hygienist will be available through our 24 hour toll-free hotline to answer questions or concerns about oral health issues, treatment modalities and emergency care issues. The Hotline will have the following toll-free number: 855-688-MCNA (6262). | After normal business hours, our Dental Hygienist will respond to voice or email messages within one hour. |
| Wal-Mart Gift Card per Member household for $10.00 worth of Dental Care Products from Wal-Mart. | Upon enrollment, each household of MCNA Dental Members will receive a Ten ($10.00) dollar Wal-Mart Gift Card redeemable at any Wal-Mart store for the purchase of dental hygiene products such as Toothpaste, Toothbrushes, Mouthwash and Dental Floss. | Limited to one $10.00 Wal-Mart Gift Card per MCNA Dental Member household regardless of the number of Medicaid enrollees therein; and to the purchase of dental hygiene products such as toothbrushes, toothpaste, mouthwash and dental floss. To redeem the Wal-Mart Gift Card, at least one Member from each household must present an MCNA Medicaid Membership ID Card along with the Wal-Mart Gift Card at the point of sale checkout counter located in the Wal-Mart store. Wal-Mart Gift Card cannot be combined with other gift or discount cards, assigned, or transferred. Ten ($10.00) dollar maximum benefit per Wal-Mart Gift Card per active household. Wal-Mart Gift Card expires March 1, 2013. |

Source: "Dental Value-Added Services Template." *HHSC Uniform Managed Care Manual*. Version 2.0. 1 Sept. 2011. Nov. 2012.

### *f. Medicaid Dental Services Requiring Prior Authorization*

Select Medicaid dental services require prior authorization before the service is rendered as a provision for reimbursement. As general information provided in TMHP's Medicaid Provider Procedures Manual, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. Each DMO provides an office reference manual that outlines specific information needed when prior authorizations are submitted, including pictures, x-rays, and/or a narrative explaining the medical necessity of the procedure. It is important to note that any services granted prior authorization approval before March 2012 by TMHP are honored by the DMOs after March 2012. To note, even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service or the claim is incomplete.

An analysis of services requiring prior authorization is provided in the following section. First, from the viewpoint of coverage, the data examined includes a count of unique payable dental procedure codes that require prior authorization approvals by each Medicaid payer. The report then focuses on the units of services submitted for prior authorization to the FFS program between March and August 2011 and service requests submitted to the DMOs between March and August 2012. The information provided by the FFS program is based upon unit of services, whereas the information provided by the DMOs is based upon count of unique requests submitted by providers, and each request to pre-authorize services for a Medicaid client may represent multiple units of service. Therefore, rather than comparing units of services to requests, the focus of this section is on the percent of units or requests approved. Comparisons by month in 2011 and 2012, and then by category of service type are also made. Also, please note this analysis section is limited to the dental procedures that explicitly required prior authorization under FFS in 2011 as defined in the Texas Medicaid Provider Procedures Manual as of January 2011as well as under the purview of the DMOs in the 2012 time period. Provided below are the key observations to note:

- Of the three DMOs in 2012, MCNA and DentaQuest require more unique dental procedure codes to receive prior authorization than the FFS model in 2011. MCNA has the largest count of procedure codes requiring prior authorization approval (299 procedure codes), while Delta Dental has the least (99 procedure codes).
- Ninety-two (92) procedure codes which required prior authorization under FFS continue to have the same restrictions under the DMOs. There are six procedure codes that previously required authorization under FFS that no longer do so.
- On average, in the sampled six months in 2011, 93 percent of units submitted for prior authorization were approved. In the corresponding six months in 2012, on average 62 percent of submitted requests for authorization were approved by the DMOs.
- Ninety-nine (99) percent of units submitted for prior authorization between March and August 2011 are orthodontia related, while 93 percent of these units were approved. In the corresponding six months in 2012, 69.9 percent of requests are orthodontia related, while 62 percent of these requests were approved by the DMOs. The pre-authorization requests for "All Other" dental services have noticeably increased between 2011 and 2012.

***Covered Medicaid Dental Services Requiring Prior Authorization***

Table III-f-1 shows the count of unique dental procedures requiring prior authorization for FFS, MCNA, DentaQuest, and Delta Dental. MCNA requires prior authorization for the largest amount of unique procedure codes, while Delta Dental requires prior authorization for the least amount of procedure codes.

Table III-f-1: Chart of Count of Unique Dental Procedures Requiring Prior Authorization Approval by Payer

| Payer | Count of Unique Dental Procedures Requiring Prior Authorization by Payer |
|---|---|
| Fee-for-Service* | 121 |
| MCNA** | 299 |
| DentaQuest*** | 224 |
| Delta Dental**** | 99 |

Sources: *"4. TEXAS HEALTH STEPS (THSTEPS) DENTAL." *Texas Medicaid Provider Procedures Manual*. Volume 2. TMHP, Jan. 2011. Web. Nov. 2012. <http://www.tmhp.com/tmppm/2011/Vol2_Children%27s_Services_Handbook.pdf>.
***Covered Services, Fee Schedules, and Guidelines for Texas Medicaid and CHIP Members*. Version 1.0.21. MCNA Dental, 5 July 2012. Web. Nov. 2012. <docs.mcna.net/download.php?type=manuals&alias=texascs>.
****DentaQuest Provider Office Reference Manual*. DentaQuest, 1 March 2012. Web. Nov. 2012. <http://dentaquestnetwork.com/texas/wp-content/uploads/2011/10/Task-22-Final-Draft-TX-HHSC-Front-end-Provider-ORM-20111012.pdf>.
*****Delta Dental Confidential Schedule of Maximum Allowances (SMA)*. Delta Dental, 1 March 2012. Web. Nov. 2012. <http://www.deltadentalins.com/dentists/lib/tx-medicaid-fees-2012.pdf>.

Notes: Count of pre-authorizations required for Delta Dental includes all CDT codes with "YES" of "YES *" for "Prior Auth Required." Count of pre-authorizations required for DentaQuest includes all CDT codes with "Yes" for "Review Required." Count of pre-authorizations required for MCNA includes all CDT codes with the description "Requires Pre-Authorization." Count of pre-authorizations required for Fee-for-Service includes all CDT codes with the description "prior authorization is required," "require prior authorization," or "prior authorization," including orthodontia, implants, fixed prosthetic services, anesthesia, combination of inlays/onlays or permanent crowns, and cone beam imaging, unless stated otherwise.

Below in Table III-f-2 is the count of unique dental procedures requiring prior authorization broken out between FFS, MCNA, DentaQuest, and Delta Dental. Overall, FFS required prior authorizations for six procedure codes that are not so limited by MCNA, DentaQuest, or Delta Dental, whereas there are 92 procedure codes that explicitly required and currently still require prior authorizations by all Medicaid payers.

Table III-f-2: Count of Unique Dental Procedures Requiring Prior Authorization Across Payers

| Payers | Count of Unique Dental Procedures Requiring Prior Authorization by Payer |
|---|---|
| Required Across Delta Dental, MCNA, DentaQuest, and Fee-for-Service | 92 |
| Required Across Delta Dental, MCNA, and DentaQuest Only | 4 |
| Fee-for-Service Only | 8 |
| DentaQuest Only | 6 |
| MCNA Only | 73 |

Notes: Count of pre-authorizations required for Delta Dental includes all CDT codes with "YES" of "YES *" for "Prior Auth Required." Count of pre-authorizations required for DentaQuest includes all CDT codes with "Yes" for "Review Required." Count of pre-authorizations required for MCNA includes all CDT codes with the description "Requires Pre-Authorization." Count of pre-authorizations required for Fee-for-Service includes all CDT codes with the description "prior authorization is required," "require prior authorization," or "prior authorization," including orthodontia, implants, fixed prosthetic services, anesthesia, combination of inlays/onlays or permanent crowns, and cone beam imaging, unless stated otherwise.

***Units/Requests Submitted for Prior Authorization Approval***

The dental procedure codes (CDT codes) can be grouped into categories of services, as defined in Table III-a-1 of this report. These categories of service include Diagnostic, Orthodontics, Preventive, and All Other dental services. All analyses in this sub-section of the report are limited to the CDT codes that explicitly required prior authorization under FFS in 2011 as defined in the Texas Medicaid Provider Procedures Manual as of January 2011as well as under the purview of the DMOs in the 2012 time period. The following analysis does not include prior authorizations for Preventive services, as the CDT codes in this category of service did not require a prior authorization in 2011. Also, this limitation excludes procedure codes that newly require prior authorization in 2012 by the DMOs only.

When looking at service units submitted for FFS prior authorization from March 2011 to August 2011 by category of service, as seen below in Table III-f-3, orthodontia services represent the greatest portion (more than 99 percent) of units of service submitted, approved, and denied for prior authorization. Moreover, of the 533,464 orthodontia service units submitted for FFS prior authorization in the sampled six months in 2011, approximately 93 percent were approved.

Table III-f-3: Total Units of Services Submitted for FFS Prior Authorization by Category of Service, March to August 2011

| Category of Service | 2011 Units of Service Submitted for Prior Authorization | 2011 Units of Service Approved for Prior Authorization | 2011 Units of Service Denied for Prior Authorization | Percentage of Service Units Approved for Prior Authorization |
|---|---|---|---|---|
| All Other | 1,161 | 1,086 | 75 | 94% |
| Diagnostic | 3,058 | 2,823 | 235 | 92% |
| Orthodontics | 533,464 | 497,006 | 36,458 | 93% |
| **Total** | **537,683** | **500,915** | **36,768** | **93%** |

Source: *TMHP_Dental_Auths_Mar2011-Aug2011.xlsx*. Provided by TMHP. Dec. 20

A closer inspection of orthodontia service units submitted for FFS prior authorization within the 2011 time period reveals, as seen in Table III-f-4 below, that the average percentage for approved orthodontic services was 93 percent, and an average of 82,834 orthodontia units of service were approved monthly during this six month time period.

Table III-f-4: Orthodontia Units of Service Submitted for FFS Prior Authorization by Month, March to August 2011

| Month | 2011 Units of Orthodontia Service Submitted for Prior Authorization | 2011 Units of Orthodontia Service Approved for Prior Authorization | 2011 Units of Orthodontia Service Denied for Prior Authorization | Percentage of Orthodontia Service Units Approved for Prior Authorization |
|---|---|---|---|---|
| March | 91,812 | 89,666 | 2,146 | 98% |
| April | 90,817 | 87,902 | 2,915 | 97% |
| May | 83,068 | 80,101 | 2,967 | 96% |
| June | 87,256 | 80,718 | 6,538 | 93% |
| July | 83,946 | 73,687 | 10,259 | 88% |
| August | 96,565 | 84,932 | 11,633 | 88% |
| ***Monthly Average*** | ***88,911*** | ***82,834*** | ***6,076*** | ***93%*** |

Source: *TMHP_Dental_Auths_Mar2011-Aug2011.xlsx*. Provided by TMHP. Dec. 2012.

After reviewing service units submitted for FFS prior authorization between March and August 2011, this following section of the report will now focus on service requests submitted for prior authorization by the DMOs between March and August 2012. It should be noted, however, that the data provided by the DMOs for this report are reported based upon each request for service prior authorization, which could include multiple units of service on each request. This limits the ability to compare the units of service submitted for FFS prior authorization to the service requests submitted for DMOs' prior authorization. Therefore, in order to compare services with prior authorization from 2011 to 2012, this section of the report will focus on approval percentages. Please also note that since DMOs are obligated to honor service units granted prior authorization before March 2012, there are services provided by the DMOs after March 1, 2012 for prior authorizations approved before March 1, 2012 that are not included in this analysis.

The chart below in Table III-f-5 shows service requests submitted for prior authorization by DMOs between March and August 2012 by category of service. Orthodontia service requests represent a smaller portion (between 68 and 70 percent) of service requests submitted for prior authorization by the DMOs in 2012 than under FFS in 2011. The percentage of orthodontia service requests approved for DMO prior authorization was approximately 62 percent. Considering orthodontia service requests still represent the largest portion of prior authorization requests, albeit a decreasing portion from 2011 to 2012, the decrease in the approval percentage may indicate that prior authorization process for orthodontic services is becoming more stringent following March 2012.

Table III-f-5: Total Service Requests Submitted to DMOs for Prior Authorization by Category of Service, March to August 2012

| Category of Service | 2012 Service Requests Submitted for Prior Authorization | 2012 Service Requests Approved for Prior Authorization | 2012 Service Requests Denied for Prior Authorization | Percentage of Service Requests Approved for Prior Authorization | 2012 Total Units of Service Approved for Prior Authorization |
|---|---|---|---|---|---|
| All Other | 24,397 | 14,934 | 9,932 | 61% | 19,798 |
| Diagnostic | 507 | 207 | 300 | 41% | 208 |
| Orthodontics | 57,896 | 36,144 | 22,089 | 62% | 71,516 |
| **Total** | **82,800** | **51,285** | **32,321** | **62%** | **91,522** |

Sources: *TMC_NOAs_Authed_Denied_PCGRpt2.xlsx*. Provided by Delta Dental. Nov. 2012.
*303980_1_0_DentaQuest.Prior_Auth_Count.xlsx*. Provided by DentaQuest. Nov. 2012.
*PCG_DentalRequest110812_IL.xls*. Provided by MCNA. Nov. 2012.

Notes: Sum of Total Submitted Requests was provided by DMOs. Requests sometimes contain individual services which are approved and others which are denied, therefore requests may be double counted and the "Total Submitted Requests" are less than the "Approved" and "Denied." There are also some requests which are still pending, therefore the "Total" is greater than the sum of "Approved" and "Denied."

A closer look at orthodontia service requests submitted to the DMOs for prior authorization in Table III-f-6 shows that the approval percentage for orthodontics service requests started at a low of 30 percent in March 2012, rose to a high of 81 percent in June 2012, and then ended at 57 percent in August 2012. These fluctuations in the approval percentage for orthodontia services in a new service delivery model lend to a recommendation to reevaluate orthodontia approval percentages by the DMOs once the situation becomes more stable.

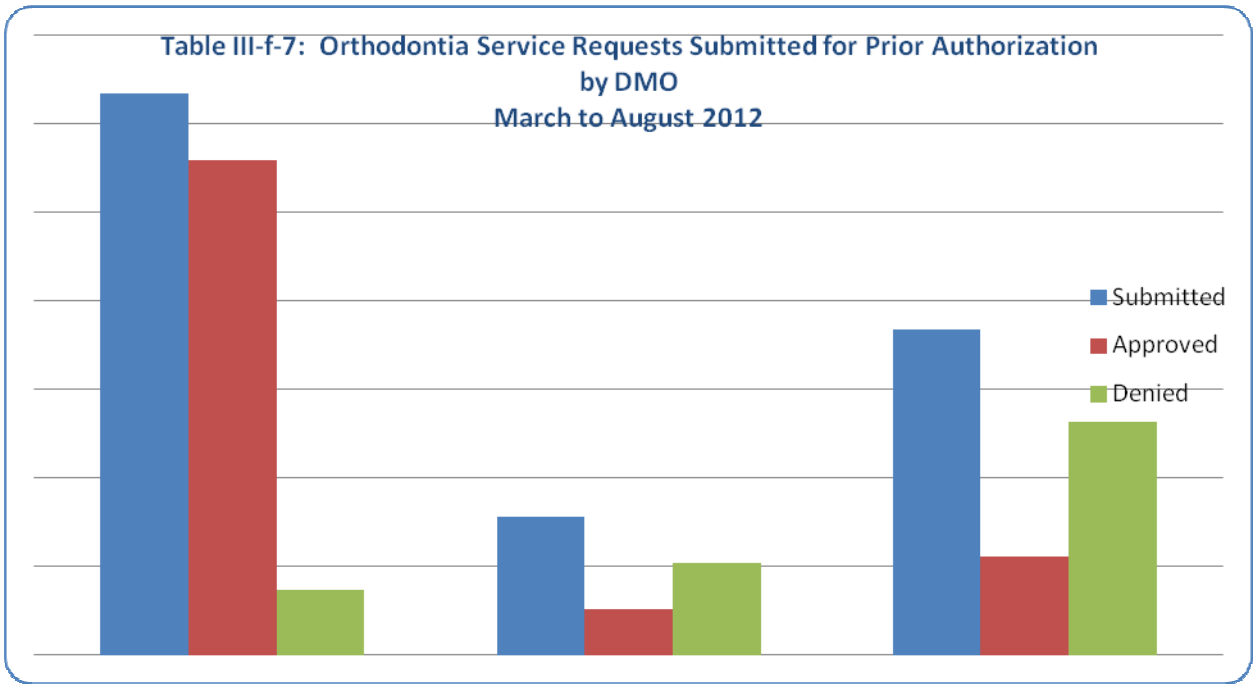
Table III-f-6: Orthodontia Service Requests Submitted to DMOs for Prior Authorization by Month, March to August 2012

| Month | 2012 Orthodontia Service Requests Submitted for Prior Authorization | 2012 Orthodontia Service Requests Approved for Prior Authorization | 2012 Orthodontia Service Requests Denied for Prior Authorization | Percentage of Orthodontia Service Requests Approved for Prior Authorization | 2012 Units of Orthodontia Service Approved for Prior Authorization |
|---|---|---|---|---|---|
| March | 3,260 | 975 | 2,953 | 30% | 4,242 |
| April | 9,851 | 5,547 | 4,214 | 56% | 8,884 |
| May | 11,489 | 7,433 | 3,014 | 65% | 9,371 |
| June | 16,707 | 13,454 | 3,070 | 81% | 18,031 |
| July | 7,845 | 3,783 | 4,211 | 48% | 12,631 |
| August | 8,744 | 4,952 | 4,627 | 57% | 18,357 |
| ***Monthly Average*** | ***9,649*** | ***6,024*** | ***3,682*** | ***62%*** | ***11,919*** |

Sources: *TMC_NOAs_Authed_Denied_PCGRpt2.xlsx*. Provided by Delta Dental. Nov. 2012.
*303980_1_0_DentaQuest.Prior_Auth_Count.xlsx*. Provided by DentaQuest. Nov. 2012.
*PCG_DentalRequest110812_IL.xls*. Provided by MCNA. Nov. 2012.

Notes: Sum of Total Submitted Requests was provided by DMOs. Requests sometimes contain individual services which are approved and others which are denied, therefore requests may be double counted and the "Total Submitted Requests" are less than the "Approved" and "Denied." There are also some requests which are still pending, therefore the "Total" is greater than the sum of "Approved" and "Denied."

The graph below in Table III-f-7 displays the count of orthodontic service requests submitted to each DMO between March and August 2012. Delta Dental represents the greatest proportion of orthodontia service requests approved for prior authorization as compared to those denied, while MCNA and DentaQuest both denied more orthodontia service requests for prior authorization than they approved. As previously mentioned in the Executive Summary of this report, HHSC and Delta Dental agreed to end Delta Dental's contract for managed care dental services effective December 1, 2012.



***g. Managed Care Premium Growth Trends***

To evaluate managed care premium growth trends for Medicaid dental services following the transition from FFS to dental managed care effective March 1, 2012, this report section compares the count of members enrolled with the dental plans, monthly capitation payments from HHSC, average monthly capitation payment per member, and premium tax revenue between March and August 2012. This section first displays all components by month for each DMO and in total, and then compares each individual component between DMOs and in total by month.

For the purpose of this reporting section, the following tables calculate the straight-lined average monthly capitation payment per member. These calculations are not reflective of the actual risk-based monthly premium rates paid by HHSC to DMOs that are adjusted for risk within each DMO's specific managed care population. Please also note that the monthly capitation payments and count of members enrolled with DMOs for April to August 2012 are estimated and are not considered final by HHSC. Additional, the premium tax revenues are estimated for all months in 2012 and are not considered final yet by HHSC. These figures are presented for the purpose of this reporting section only.

Provided below are the key observations to note:

- Of the three DMOs, DentaQuest represents the greatest portion of enrolled members, Delta Dental represents the greatest portion of monthly capitation payments from HHSC, and MCNA represents the smallest portion of both categories.
- The enrolled members and average monthly capitation payments for both DentaQuest and MCNA are increasing across months, while the enrolled members and monthly capitation payments for Delta Dental is decreasing.
- Based on the relative trends in enrolled members and monthly capitation payments, Delta Dental has the greatest straight-lined average capitation payment per member, while DentaQuest has the smallest average capitation payment per member; however, the average capitation payment per member for both DentaQuest and Delta Dental is increasing across months, while the average capitation payment per member for MCNA is decreasing across months, and the overall average capitation payment per member across DMOs has been relatively constant.

The first three tables below are charts with the enrolled members, average monthly capitation payments from HHSC, average monthly capitation payment per member, and premium tax revenue incurred by month from March through August 2012 for Delta Dental, MCNA, and DentaQuest. The fourth table summarizes the total enrolled members, total capitation payments from HHSC, overall average monthly capitation payment per member, and premium tax revenue by month from March through August 2012 across all three DMOs.

Table III-g-1: Chart of Delta Dental Enrolled Members, Monthly Capitation Payment from HHSC and Premium Tax Revenue between March and August 2012

| Month in 2012 | Delta Dental Enrolled Members | Delta Dental Monthly Capitation Payment from HHSC | Delta Dental Average Cost Per Member | Delta Dental Premium Tax Revenue |
|---|---|---|---|---|
| March | 914,162 | $45,785,926 | $50.09 | $801,254 |
| April | 937,413 | $46,754,917 | $49.88 | $818,211 |
| May | 910,330 | $45,586,265 | $50.08 | $797,760 |
| June | 884,927 | $44,512,949 | $50.30 | $778,977 |
| July | 860,265 | $43,480,179 | $50.54 | $760,903 |
| August | 845,827 | $42,798,562 | $50.60 | $748,975 |
| ***Monthly Average*** | ***892,154*** | ***$44,819,799*** | ***$50.25*** | ***$784,346*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payment from HHSC and Enrolled Members for March 2012 are considered final, whereas other months are estimated. Premium tax revenues are estimated for all months.

Note: This table calculates the Average Cost Per Member by dividing the Monthly Capitation Payment from HHSC by the count of Enrolled Members. This straight-line average calculation is not the actual Per Member Per Month (PMPM) rate paid by HHSC, which are risk based rates.

Table III-g-2: Chart of MCNA Enrolled Members, Monthly Capitation Payment from HHSC and Premium Tax Revenue between March and August 2012

| Month in 2012 | MCNA Enrolled Members | MCNA Monthly Capitation Payment from HHSC | MCNA Average Cost Per Member | MCNA Premium Tax Revenue |
|---|---|---|---|---|
| March | 594,557 | $29,103,760 | $48.95 | $509,316 |
| April | 616,051 | $30,232,505 | $49.07 | $529,069 |
| May | 628,824 | $30,663,008 | $48.76 | $536,603 |
| June | 658,563 | $31,790,674 | $48.27 | $556,337 |
| July | 681,043 | $32,672,502 | $47.97 | $571,769 |
| August | 679,531 | $32,542,092 | $47.89 | $569,487 |
| ***Monthly Average*** | ***643,095*** | ***$31,167,423*** | ***$48.49*** | ***$545,430*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payment from HHSC and Enrolled Members for March are considered final, whereas other months are estimated. Premium tax revenues are estimated for all months.

Table III-g-3: Chart of DentaQuest Enrolled Members, Monthly Capitation Payment from HHSC and Premium Tax Revenue between March and August 2012

| Month in 2012 | DentaQuest Enrolled Members | DentaQuest Monthly Capitation Payment from HHSC | DentaQuest Average Cost Per Member | DentaQuest Premium Tax Revenue |
|---|---|---|---|---|
| March | 826,851 | $36,786,031 | $44.49 | $643,756 |
| April | 909,849 | $40,514,386 | $44.53 | $709,002 |
| May | 924,533 | $41,267,381 | $44.64 | $722,179 |
| June | 965,123 | $43,203,547 | $44.76 | $756,062 |
| July | 993,168 | $44,640,854 | $44.95 | $781,215 |
| August | 987,560 | $44,675,637 | $45.24 | $781,824 |
| ***Monthly Average*** | ***934,514*** | ***$41,847,973*** | ***$44.77*** | ***$732,340*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payment from HHSC and Enrolled Members for March are considered final, whereas other months are estimated. Premium tax revenues are estimated for all months.

Table III-g-4: Chart of Total DMO Enrolled Members, Monthly Capitation Payment from HHSC and Premium Tax Revenue between March and August 2012

| Month in 2012 | Total Enrolled Members | Total Monthly Capitation Payments from HHSC | Average Cost per Member | Total Premium Tax Revenue |
|---|---|---|---|---|
| March | 2,335,570 | $111,675,717 | $47.82 | $1,954,325 |
| April | 2,463,310 | $117,501,695 | $47.70 | $2,056,282 |
| May | 2,463,680 | $117,516,320 | $47.70 | $2,056,541 |
| June | 2,508,597 | $119,506,390 | $47.64 | $2,091,375 |
| July | 2,534,452 | $120,792,372 | $47.66 | $2,113,887 |
| August | 2,512,893 | $120,015,181 | $47.76 | $2,100,285 |
| ***Monthly Average*** | ***2,469,750*** | ***$117,834,612*** | ***$47.71*** | ***$2,062,116*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payment from HHSC and Enrolled Members for March are considered final, whereas other months are estimated. Premium tax revenues are estimated for all months.

Table III-g-5 is a chart of the enrolled members by month from March through August 2012 for Delta Dental, MCNA, and DentaQuest, as well as the total enrolled members across all three DMOs, and the percentage of the total enrolled members represented by each DMO. This table is accompanied by two graphs. The first graph compares by month the enrolled members from March through August 2012 for Delta Dental, MCNA, and DentaQuest. The second graph compares the average percentage of the total enrolled members represented by each DMO. ***Overall, DentaQuest represents the greatest portion of total enrolled members (38 percent) and MCNA represents the smallest portion (26 percent), while the enrolled members for both DentaQuest and MCNA are increasing across months and the enrolled members for Delta Dental is decreasing***.

Table III-g-5: Chart of Enrolled members Across DMOs between March and August 2012

| Month in 2012 | Delta Dental Enrolled Members | MCNA Enrolled Members | DentaQuest Enrolled Members | Total Enrolled Members | Delta Dental % of Total Enrolled Members | MCNA % of Total Enrolled Members | DentaQuest % of Total Enrolled Members |
|---|---|---|---|---|---|---|---|
| March | 914,162 | 594,557 | 826,851 | 2,335,570 | 39.1% | 25.5% | 35.4% |
| April | 937,413 | 616,051 | 909,849 | 2,463,310 | 38.1% | 25.0% | 36.9% |
| May | 910,330 | 628,824 | 924,533 | 2,463,680 | 37.0% | 25.5% | 37.5% |
| June | 884,927 | 658,563 | 965,123 | 2,508,597 | 35.3% | 26.3% | 38.5% |
| July | 860,265 | 681,043 | 993,168 | 2,534,452 | 33.9% | 26.9% | 39.2% |
| August | 845,827 | 679,531 | 987,560 | 2,512,893 | 33.7% | 27.0% | 39.3% |
| ***Monthly Average*** | ***892,154*** | ***643,095*** | ***934,514*** | ***2,469,750*** | ***36.2%*** | ***26.0%*** | ***37.8%*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Enrolled members for March are considered final, whereas other months are estimated.

Table III-g-6 are the monthly capitation payments from HHSC by month from March through August 2012 for Delta Dental, MCNA, and DentaQuest, as well as the total monthly capitation payments across all three DMOs, and the percentage of the total capitation payments represented by each DMO. ***Overall, Delta Dental represents the greatest portion of monthly capitation payments ($268 million, or 38 percent) and MCNA represents the smallest portion ($187 million, or 26 percent), while the monthly capitation payments for both DentaQuest and MCNA are increasing across months and the monthly capitation payments for Delta Dental is decreasing.***

Table III-g-6: Chart of Monthly Capitation Payment from HHSC Across DMOs between March and August 2012

| Month in 2012 | Delta Dental Monthly Capitation Payment | Delta Dental % of Total | MCNA Monthly Capitation Payment | MCNA % of Total | DentaQuest Monthly Capitation Payment | DentaQuest % of Total | Total Monthly Capitation Payments from HHSC |
|---|---|---|---|---|---|---|---|
| March | $45,785,926 | 41.0% | $29,103,760 | 26.1% | $36,786,031 | 32.9% | $111,675,717 |
| April | $46,754,917 | 39.8% | $30,232,505 | 25.7% | $40,514,386 | 34.5% | $117,501,695 |
| May | $45,586,265 | 38.8% | $30,663,008 | 26.1% | $41,267,381 | 35.1% | $117,516,320 |
| June | $44,512,949 | 37.2% | $31,790,674 | 26.6% | $43,203,547 | 36.2% | $119,506,390 |
| July | $43,480,179 | 36.0% | $32,672,502 | 27.0% | $44,640,854 | 37.0% | $120,792,372 |
| August | $42,798,562 | 35.7% | $32,542,092 | 27.1% | $44,675,637 | 37.2% | $120,015,181 |
| **Total** | **$268,918,798** | **38.0%** | **$187,004,541** | **26.5%** | **$251,087,836** | **35.5%** | **$707,007,675** |
| ***Monthly Average*** | ***$44,819,799*** | ***38.1%*** | ***$31,167,423*** | ***26.4%*** | ***$41,847,973*** | ***35.5%*** | ***$117,834,612*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payments from HHSC for March are considered final, whereas other months are estimated.

Table III-g-7 are the monthly capitation payment per enrolled member by month from March through August 2012 calculated for Delta Dental, MCNA, and DentaQuest, as well as the average cost per member across all three DMOs. ***Overall, Delta Dental has the greatest overall average cost per member ($50.25) and DentaQuest has the smallest ($44.77)***; however, based on the relative trends in enrolled members and monthly capitation payments from HHSC, the average cost per member for both DentaQuest and Delta Dental is increasing across months, while the average cost per member for MCNA is decreasing across months, and the ***total cost per member across DMOs has been relatively constant around $47.71***. Please note these calculations are not reflective of the actual risk-based monthly premium rates paid by HHSC to DMOs that are adjusted for risk within each DMO's specific managed care population.

Table III-g-7: Chart of Average Monthly Capitation Payment per Enrolled Member Across DMOs between March and August 2012

| Month in 2012 | Delta Dental Monthly Capitation Payment per Enrolled Member | MCNA Monthly Capitation Payment per Enrolled Member | DentaQuest Monthly Capitation Payment per Enrolled Member | Average Monthly Capitation Payment per Enrolled Member |
|---|---|---|---|---|
| March | $50.09 | $48.95 | $44.49 | $47.82 |
| April | $49.88 | $49.07 | $44.53 | $47.70 |
| May | $50.08 | $48.76 | $44.64 | $47.70 |
| June | $50.30 | $48.27 | $44.76 | $47.64 |
| July | $50.54 | $47.97 | $44.95 | $47.66 |
| August | $50.60 | $47.89 | $45.24 | $47.76 |
| ***Monthly Average*** | ***$50.25*** | ***$48.49*** | ***$44.77*** | ***$47.71*** |

Source: HHS System Forecasting. Nov. 2012.

Note: Monthly Capitation Payments from HHSC and enrolled members for March are considered final, whereas other months are estimated.

### *h. Premium (Tax) Insurance Revenue*

To evaluate premium (tax) insurance revenue for Medicaid dental services following the transition from FFS to dental managed care effective March 1, 2012, this report section compares the premium tax revenue incurred by each DMO and in total from March through August 2012. Please note that the premium tax revenues are estimated for all months in 2012 and are not considered final yet by HHSC. These figures are presented for the purpose of this reporting section only. Provided below are the key observations to note:

- Of the three DMOs, Delta Dental represents the greatest portion of premium tax revenue to HHSC, while MCNA represents the smallest portion.
- The percentage of total premium tax revenue represented by DentaQuest and MCNA is increasing across months, while the percentage of total premium tax revenue represented by Delta Dental is decreasing across months.

Table III-h-1 below is a chart of the premium tax revenue by month from March through August 2012 for Delta Dental, MCNA, and DentaQuest, as well as the total premium tax revenue across all three DMOs, and the percentage of the total premium tax revenue represented by each DMO. Also included is a graph comparing by month the premium tax revenue from March through August 2012 for Delta Dental, MCNA, and DentaQuest. A second graph compares the average percentage of the total premium tax revenue represented by each DMO.

***Overall, Delta Dental represents the greatest portion of premium tax revenue ($4.7 million, or 38 percent) and MCNA represents the smallest portion ($3.3 million, or 26 percent)***, but the percentage of total premium tax revenue represented by DentaQuest and MCNA is increasing across months, while the percentage of total premium tax revenue represented by Delta Dental is decreasing across months.

Table III-h-1: Chart of Premium Tax Revenue Across DMOs between March and August 2012

| Month in 2012 | Delta Dental Premium Tax Revenue | Delta Dental % of Total Tax Revenue | MCNA Premium Tax Revenue | MCNA % of Total Premium Tax Revenue | DentaQuest Premium Tax Revenue | DentaQuest % of Total Premium Tax Revenue | Total Premium Tax Revenue |
|---|---|---|---|---|---|---|---|
| March | $801,254 | 41.0% | $509,316 | 26.1% | $643,756 | 32.9% | $1,954,325 |
| April | $818,211 | 39.8% | $529,069 | 25.7% | $709,002 | 34.5% | $2,056,282 |
| May | $797,760 | 38.8% | $536,603 | 26.1% | $722,179 | 35.1% | $2,056,541 |
| June | $778,977 | 37.2% | $556,337 | 26.6% | $756,062 | 36.2% | $2,091,375 |
| July | $760,903 | 36.0% | $571,769 | 27.0% | $781,215 | 37.0% | $2,113,887 |
| August | $748,975 | 35.7% | $569,487 | 27.1% | $781,824 | 37.2% | $2,100,285 |
| **Total** | **$4,706,080** | **38.0%** | **$3,272,581** | **26.5%** | **$4,394,038** | **35.5%** | **$12,372,695** |
| ***Monthly Average*** | ***$784,346*** | ***38.1%*** | ***$545,430*** | ***26.4%*** | ***$732,340*** | ***35.5%*** | ***$2,062,116*** |

Source: HHS Systems Forecasting. Nov. 2012.

Note: Premium tax revenues are estimated for all months.

## IV. Summary Conclusions

Provided below are the key observations from each section of the report.

### *a. Utilization Trends*

- Between the 2011 and 2012 time periods, total units of services decreased by 30 percent from 14.2 million to 9.98 million. In correlation, payments to providers decreased by 38 percent from $770 million under FFS delivery system to $478 million under the dental managed care system.
- Among the four service categories, orthodontic services have decreased the most between 2011 and 2012 by 1.35 million units of service or 72 percent fewer units, and by $105 million payments to providers or 81 percent less in payments.
- Approximately 65 percent of units of service between March and August 2011 time period are diagnostic or preventive in nature, and 73 percent of units of service are diagnostic or preventive dental services in the equivalent six months in 2012.
- Among the four service categories, diagnostic services are the least impacted during the recent transition to a managed care delivery system. Diagnostic services decreased by 695 thousand units of service or 16 percent less units, and by $21 million payments to providers or 14 percent less in payments.
- Preventive services have decreased by 1.2 million units of service or 25 percent fewer units of service, and by $36.5 million payments to providers or 27 percent less in payments.

### *b. Penetration Rates*

- Total Medicaid enrollment for all ages is less in 2012 than in 2011 by six percent (although the 2012 numbers are not final due to retroactive eligibility).
- There are four percent more clients under 21 years old enrolled with Medicaid in 2012 (2.60 million) than 2011 (2.50 million).
- Dental plans' enrollment in 2012 (2.46 million) is slightly less than the comparable enrolled Medicaid clients eligible for the EPSDT benefit in 2011 (2.50 million).
- The count of Medicaid clients under 21 years old who received a dental service is less in 2012 than in 2011 by 26.9 percent on average.
- The average monthly penetration rate decreased from 18 percent in the sampled six months in 2011 to 13 percent in the corresponding six months in 2012.

### *c. Provider to Client Ratio*

- From August 2011 to November 2012, the total enrolled providers decreased by 1,243 providers or 18 percent.
- For every thousand Medicaid recipients under 21 years old who received paid dental services, the number of enrolled dental providers decreased between the two studied time period under FFS and DMOs. In the 2011 sampled six months, there were 15.1 enrolled dental providers for every thousand Medicaid recipients under 21 years old who received paid dental services, whereas the ratio is 12.3 in the same sampled six months in 2012.

***d. Retention of Dental Providers***

- The count of dental providers contracted with the DMOs as of November 2012 is 1,127 less providers than 6,682 total STPs as of August 2010 and also is 1,243 fewer providers than the total 6,798 enrolled dental providers as of August 2011.
- The DMOs' current network of 5,555 providers includes a majority of former STPs (3,820 providers) and includes a number of providers who were not STPs (1,735 providers).

***e. Services Provided (covered services in FFS and managed care)***

- Examining value-added services, all three of the DMOs offer a toothbrush; Delta Dental and DentaQuest offer a mouth guard, and DentaQuest and MCNA offer toothpaste and educational materials. Delta Dental is the only DMO to offer a timer, DentaQuest is the only DMO to offer a backpack and water bottle, and MCNA is the only DMO to offer floss, a toll-free 24-hour dental hygienist hotline, and gift card for dental care products.

***f. Medicaid Dental Services Requiring Prior Authorization***

- Any service granted FFS prior authorization before March 2012 by TMHP is still honored by the DMOs after March 2012.
    - On average, in the sampled six months in 2011, 93 percent of service units submitted for FFS prior authorization were approved.
    - Ninety-nine (99) percent of units submitted for prior authorization between March and August 2011 are orthodontia related, while 93 percent of these units were approved.
- For any new service performed after March 1, 2012 and not already previously authorized by FFS, the DMOs have implemented different reimbursement conditions.
    - In the corresponding six months in 2012, on average 70 percent of requests are orthodontia related, while 62 percent of these requests were approved by the DMOs. The prior authorization requests for "All Other" dental services have noticeably increased between 2011 and 2012.

***g. Managed Care Premium Growth Trends***

- Of the three DMOs, DentaQuest represents the greatest portion of enrolled members, Delta Dental represents the greatest portion of monthly capitation payments from HHSC, and MCNA represents the smallest portion of both categories.
- The enrolled members and average monthly capitation payments for both DentaQuest and MCNA are increasing across months, while the enrolled members and monthly capitation payments for Delta Dental is decreasing.
- Based on the relative trends in enrolled members and monthly capitation payments, Delta Dental has the greatest straight-lined average capitation payment per member, while DentaQuest has the smallest average capitation payment per member; however, the average capitation payment per member for both DentaQuest and Delta Dental is increasing across months, while the average capitation payment per member for MCNA is decreasing across months, and the overall average capitation payment per member across DMOs has been relatively constant.

***h. Premium (Tax) Insurance Revenue***

- Of the three DMOs, Delta Dental represents the greatest portion of premium tax revenue to HHSC, while MCNA represents the smallest portion.
- The percentage of total premium tax revenue represented by DentaQuest and MCNA is increasing across months, while the percentage of total premium tax revenue represented by Delta Dental is decreasing across months.

PUBLIC CONSULTING GROUP

# State of Texas
# The Health and Human Services Commission

# Capitated Managed Care Model of Dental Services Report Appendix

As Required By General Appropriations Act for the 2012-13 Biennium
House Bill No. 1, Article II
Health and Human Services Commission, Rider 54
Eighty-second Texas Legislature, Regular Session, 2011

As Prepared by Public Consulting Group, Inc. (PCG)

February 15, 2013

# *Appendices*

**Table of Contents**

## V. Appendices:

### A. Project Work Plan

Provided on the following page is the work plan used by Public Consulting Group, Inc. (PCG) and the Texas Health and Human Services Commission (HHSC) to track and monitor the progress of this report.

Capitated Managed Care Model of Dental Services
The Health and Human Serivces Commission (HHSC)
PCG Project Work Plan

| ID | % Complete | Task Name | Duration | Start | Finish | Resource Names |
|---|---|---|---|---|---|---|
| 1 | 100% | **Project kick-off meetings** | **6 days** | **Wed 10/31/12** | **Wed 11/7/12** | **PCG & HHSC** |
| 2 | 100% | Verify project goals and objectives | 2 days | Wed 10/31/12 | Thu 11/1/12 | PCG & HHSC |
| 3 | 100% | Develop and confirm project timeline | 1 day | Wed 10/31/12 | Thu 11/1/12 | PCG & HHSC |
| 4 | 100% | Complete analysis and identify data needs | 2 days | Wed 10/31/12 | Thu 11/1/12 | PCG & HHSC |
| 5 | 100% | Develop and submit data request to HHSC | 5 days | Thu 11/1/12 | Wed 11/7/12 | PCG |
| 6 | 100% | **Conduct interviews with relevant program staff and compile data** | **48 days** | **Wed 11/7/12** | **Mon 1/14/13** | **PCG & HHSC** |
| 7 | 100% | HHSC Managed Care Operations | 17 days | Wed 11/7/12 | Fri 11/30/12 | PCG & HHSC |
| 8 | 100% | DSHS | 17 days | Wed 11/7/12 | Fri 11/30/12 | PCG & HHSC |
| 9 | 100% | Office of the Medical Director | 17 days | Wed 11/7/12 | Fri 11/30/12 | PCG & HHSC |
| 10 | 100% | Financial Services | 17 days | Wed 11/7/12 | Fri 11/30/12 | PCG & HHSC |
| 11 | 100% | Systems Forecasting | 17 days | Wed 11/7/12 | Fri 11/30/12 | PCG & HHSC |
| 12 | 100% | Submit data to PCG (timelines dependant on receipt of data) | 48 days | Wed 11/7/12 | Mon 1/14/13 | HHSC |
| 13 | 100% | **Perform data analysis** | **49 days** | **Wed 11/7/12** | **Mon 1/14/13** | **PCG** |
| 14 | 100% | Calculate penetration rates | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 15 | 100% | Analyze and determine utilization trends | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 16 | 100% | Evaluate retention of dental providers | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 17 | 100% | Determine client/provider ratios | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 18 | 100% | Outline services provided and offered | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 19 | 100% | Examine premium insurance trends | 49 days | Wed 11/7/12 | Mon 1/14/13 | PCG |
| 20 | 100% | **Develop and submit draft report** | **9 days** | **Tue 1/15/13** | **Fri 1/25/13** | **PCG** |
| 21 | 100% | **Revise and submit final report** | **23 days** | **Mon 1/28/13** | **Wed 2/27/13** | **PCG** |
| 22 | 100% | Review and revise report based on feedback | 23 days | Mon 1/28/13 | Wed 2/27/13 | PCG & HHSC |
| 23 | 100% | **Submit report to communications** | **1 day** | **Thu 2/28/13** | **Thu 2/28/13** | **HHSC** |

## B. Medicaid Provider Integrity (MPI) efforts in Calendar Year 2011 and 2012

The efforts conducting several audit investigations of Medicaid dental and orthodontia services in calendar year 2011 and 2012 are summarized below in statements provided by the Office of the Inspector General (OIG) for Health and Human Services Commission (HHSC). Please note that several audit investigations were opened prior to 2011 but this summary is limited to only investigations opened in 2011 and 2012.

***Calendar Year 2011***

"In calendar year 2011, Medicaid Provider Integrity (MPI) opened a total of 209 cases on dental providers. These cases consist of dentists who are enrolled as individual providers or group practices and primarily practice in the area of general dentistry, pediatric dentistry or orthodontia. The vast majority of dental cases are opened based on referrals received through our 1-800 Hotline or through our on-line fraud, waste and abuse reporting system (available through the HHSC website). The primary sources for these complaints are Medicaid recipients (or their parents/guardians), providers, other state agencies and members of the general public. MPI does self-general cases when information comes to our attention from other sources such as on-going investigations, data mining, referrals from other OIG department, etc.

The 209 cases opened in calendar year 2011 are currently in various stages of the investigative process.

- 39 cases are in a preliminary investigative status – this status is used when MPI is still gathering the necessary information to determine next steps. Preliminary investigations will normally result in one or more of the follow dispositions:
    - Elevated to Full Scale Investigation
    - Referral to the Attorney General's Medicaid Fraud Control Unit (AGMFCU)
    - Provider Education (in which case the investigation is normally closed following the education)
    - Closed with no additional action
- 48 cases are in a full scale investigation status – this status means MPI is collecting records and gathering other documentary and testimonial evidence to determine whether program violations occurred. If the investigations show evidence of program violations, a potential overpayment amount will be assigned to the case and upon completion, the case will be sent to our Sanctions unit for administrative enforcement (e.g., recovery of overpayments, assessment of penalties and other similar enforcement actions)
- 14 cases are assigned to our Sanctions unit pending various administrative enforcement remedies.
- 75 cases are closed which means one or more of the following occurred:
    - The complaint did not have merit or not enough information was provided so it was closed with no further action.
    - Provider education was conducted and the case was subsequently closed.
    - An existing full scale investigation was in progress and the new preliminary investigation on the same provider/same provider number (opened base a new complaint/referral) was closed to transfer the information to the current full scale investigation.
    - The issues were related to a matter that would be best handled by the Texas State Board of Dental Examiners, so the case was referred and closed.

- 29 cases are in a D1 status which is used to show related cases that are part of the primary case. e.g., MPI has an existing full scale case on ABC Medicaid Clinic and we subsequently receive a complaint on XYZ Medicaid Clinic. Research and investigation shows a common ownership link between the two clinics even though they have separate Medicaid provider numbers. Instead of working multiple independent cases, all of the case information (for both cases) is captured under one primary case. The D1 status allows us to cross-reference these situations in our case management system.
- 4 cases are in a referred status to the AGMFCU and OIG has pended investigative efforts at MFCU's request.

**Dental Cases with Potential Identified Overpayments – Opened in Calendar Year 2011**

- 14 cases opened in calendar year 2011 on orthodontia related services are pending administrative enforcement action. These cases have a cumulative identified potential overpayment of 97 million dollars.
- 1 case opened in calendar year 2011 for general dentistry related services was recently completed and will be transferred to our Sanctions unit for administrative enforcement action. This case has a potential identified overpayment of 3.1 million dollars.

Please note that other dental investigations (with case open dates prior to 2011) have also been completed with potential identified overpayments. These cases are also pending administrative enforcement action or set to be transferred to Sanctions soon. … "

***Calendar Year 2012***

"In calendar year 2012 (as of December 3, 2012), Medicaid Provider Integrity (MPI) opened a total of 229 cases on dental providers. 151 of the 229 were opened after February 29, 2012 (Managed Care Expansion). These cases consist of dentists who are enrolled as individual providers or group practices and primarily practice in the area of general dentistry, pediatric dentistry or orthodontia. The vast majority of dental cases are opened based on referrals received through our 1-800 Hotline or through our on-line fraud, waste and abuse reporting system (available through the HHSC website). The primary sources for these complaints are Medicaid recipients (or their parents/guardians), providers, other state agencies, members of the general public and Dental Maintenance Organizations (DMO's). MPI does self-general cases when information comes to our attention from other sources such as on-going investigations, data mining, referrals from other OIG departments, etc.

The 229 cases opened in calendar year 2012 are currently in various stages of the investigative process.

- 87 cases are in a preliminary investigative status – this status is used when MPI is still gathering the necessary information to determine next steps. Preliminary investigations will normally result in one or more of the follow dispositions:
  - Elevated to Full Scale Investigation
  - Referral to the Attorney General's Medicaid Fraud Control Unit (AGMFCU)
  - Provider Education (in which case the investigation is normally closed following the education)
  - Closed with no additional action
- 51 cases are in a full scale investigation status – this status means MPI is collecting records and gathering other documentary and testimonial evidence to determine whether program violations

occurred. If the investigations show evidence of program violations, a potential overpayment amount will be assigned to the case and upon completion, the case will be sent to our Sanctions unit for administrative enforcement (e.g., recovery of overpayments, assessment of penalties and other similar enforcement actions)

- 4 cases are assigned to our Sanctions unit pending various administrative enforcement remedies.
- 70 cases are closed which means one or more of the following occurred:
    - The complaint did not have merit or not enough information was provided so it was closed with no further action.
    - Provider education was conducted and the case was subsequently closed.
    - An existing full scale investigation was in progress and the new preliminary investigation (opened base a new complaint/referral) was closed to transfer the information to the current full scale investigation.
    - The issues were related to a matter that would be best handled by the Texas State Board of Dental Examiners so the case is referred and closed.
- 17 cases are in a D1 status which is used to show related cases that are part of the primary case. e.g., MPI has an existing full scale case on ABC Medicaid Clinic and we subsequently receive a complaint on XYZ Medicaid Clinic. Research and investigation shows a common ownership link between the two clinics even though they have separate Medicaid provider numbers. Instead of working multiple independent cases, all of the case information (for both cases) is captured under one primary case number. The D1 status allows us to cross-reference these situations in our case management system.

**Dental Cases with Potential Identified Overpayments – Opened in Calendar Year 2012**

- 3 cases opened in calendar year 2012 on orthodontia related services are pending administrative enforcement action. These cases have a cumulative identified potential overpayment of $9.9 million dollars.
- 1 case opened in calendar year 2012 on general dentistry related services is pending administrative enforcement action. This case has a potential identified overpayment of $19.3 million dollars
- 3 cases opened in calendar year 2012 for orthodontia related services were recently completed and will be transferred to our Sanctions unit for administrative enforcement action. These cases have a cumulative potential identified overpayment of $7.4 million dollars.
- 1 case opened in calendar year 2012 for general dentistry related services was recently completed and will be transferred to our Sanctions unit for administrative enforcement action. This case has a potential identified overpayment of $16.2 million dollars.

Please note that other dental investigations (with case open dates prior to 2012) have also been completed with potential identified overpayments. These cases are also pending administrative enforcement action or set to be transferred to Sanctions soon. The request from PCG was specific to investigations opened in 2011 and 2012, so I have limited the response to those cases.

**Additional Information on Orthodontic Investigations**

The following information is supplemental and would include orthodontia cases discussed above as well as cases opened prior to and post December 31, 2011.

MPI had several active orthodontia investigations prior to the WFAA news stories that came out in May 2011. MPI identified the top 50 dental providers of orthodontia benefits and added subsequent orthodontia providers who came to the attention of OIG through complaints or referrals. There are at least 61 total cases identified for full scale investigations that amount to more than $425 million in expenditures. Thirty-six (36) of these cases are now complete and have established an error rate pattern averaging 88 percent, representing a potential overpayment amount of $303 million dollars. Additional cases (amounting to expenditures in excess of $75 million) are nearly complete, awaiting final orthodontic consultant reviews."

## C. Paid Units of Service and Payments made to Providers by Dental Service Category

Tables V-1 through V-8 are graphs comparing the total paid units of service or payments made to providers by service category for March through August 2011 (2011) and March through August 2012 (2012). The service categories are determined by ADA® CDT dental procedure codes and include: Diagnostic, Orthodontics, Preventive, and All Other dental services.

The data for 2011 represents Medicaid Fee-for-Service (FFS) paid units of service and payments made to providers, whereas the data presented below for 2012 represents exclusively managed care paid units of service and payments made to providers as reported by Dental Maintenance Organizations' (DMOs) encounters. Within the studied 2011 time period, Medicaid enrolled recipients under 21 years old who received dental services under the FFS delivery system, including recipients under 21 years old residing in Medicaid-paid facilities, are included in the following analysis for the 2011 time period. The 2012 time period presented below is exclusive dental managed care service units and payments. Recipients under 21 years old residing in Medicaid-paid facilities are not covered by the transition to a managed care dental program and are excluded from the following analysis for the studied 2012 time period.

Table V-1 is a graph comparing the paid units of service for the All Other service category between FFS in 2011 and DMOs in 2012:

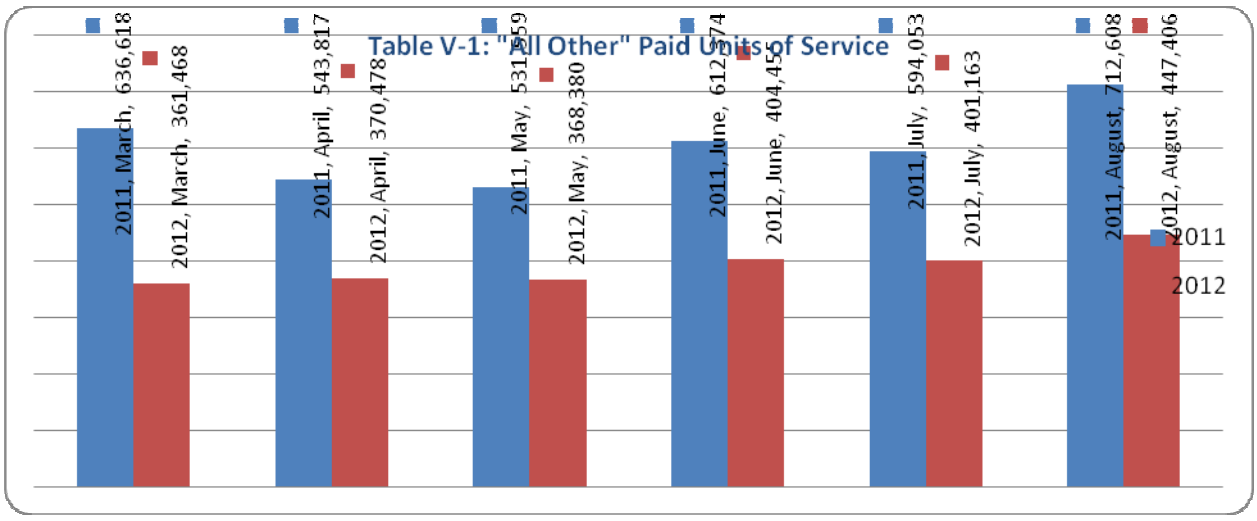


Table V-2 is a graph comparing the payments made to providers for the All Other service category between FFS in 2011 and DMOs in 2012:

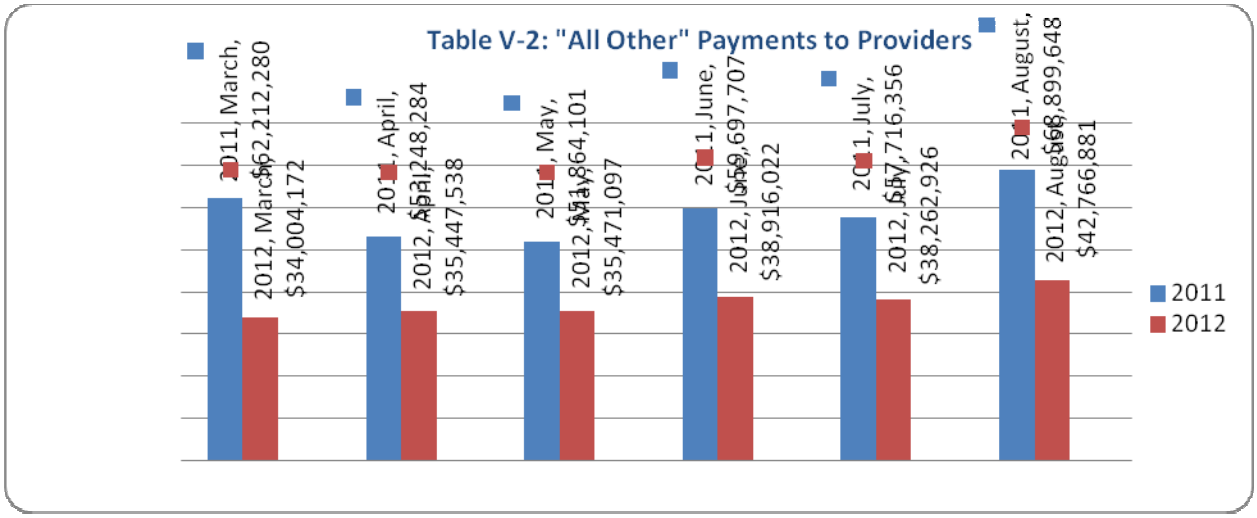



Table V-3 is a graph comparing the paid units of service for the Diagnostic service category between FFS in 2011 and DMOs in 2012:

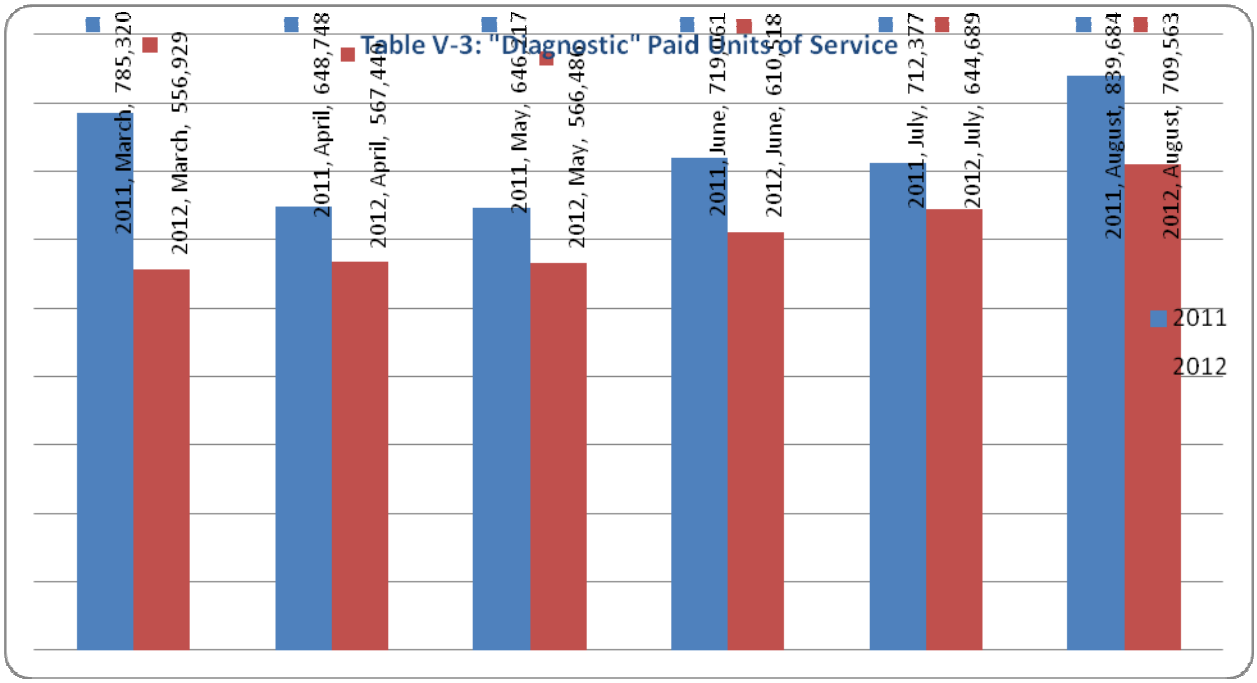


Table V-4 is a graph comparing the payments made to providers for the Diagnostic service category between FFS in 2011 and DMOs in 2012:

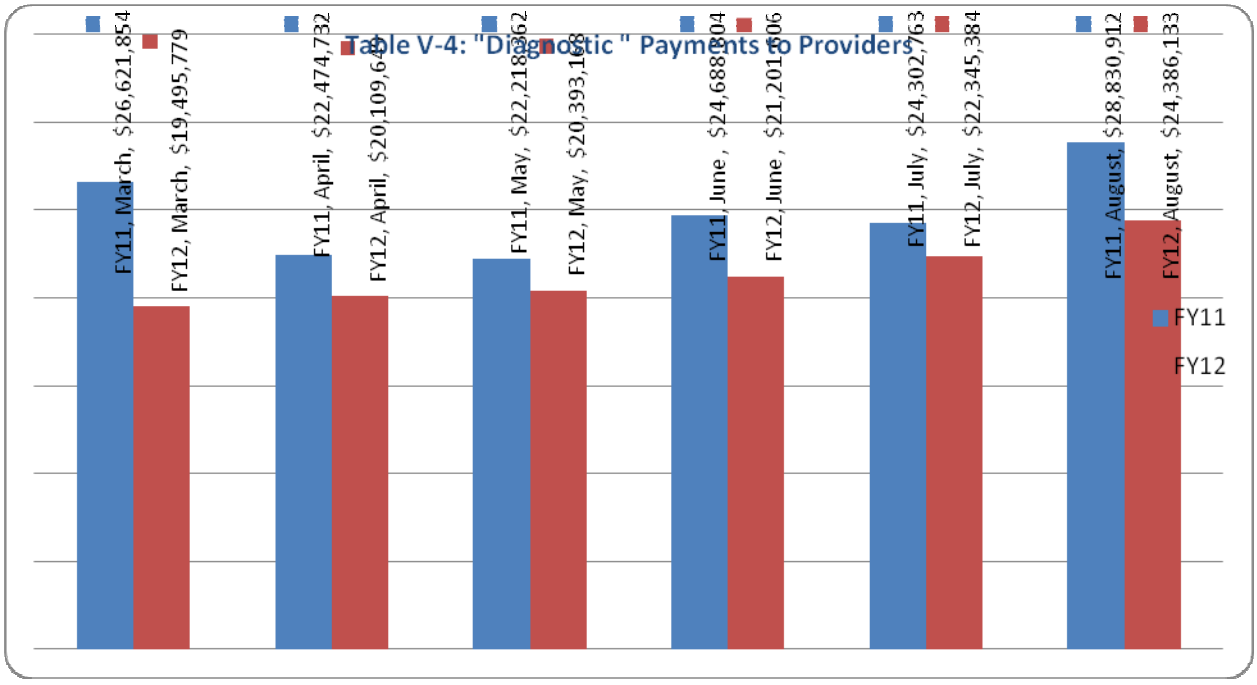



Table V-5 is a graph comparing the paid units of service for the Orthodontics service category between FFS in 2011 and DMOs in 2012:

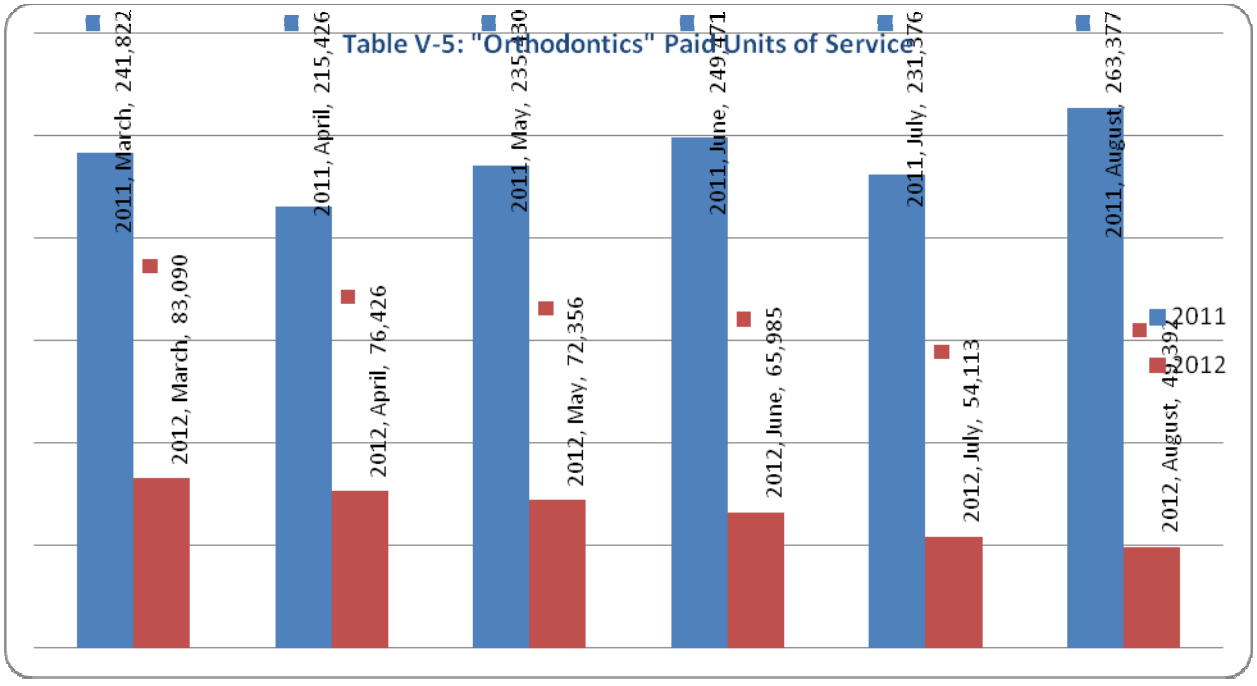


Table V-6 is a graph comparing the payments made to providers for the Orthodontics service category between FFS in 2011 and DMOs in 2012:

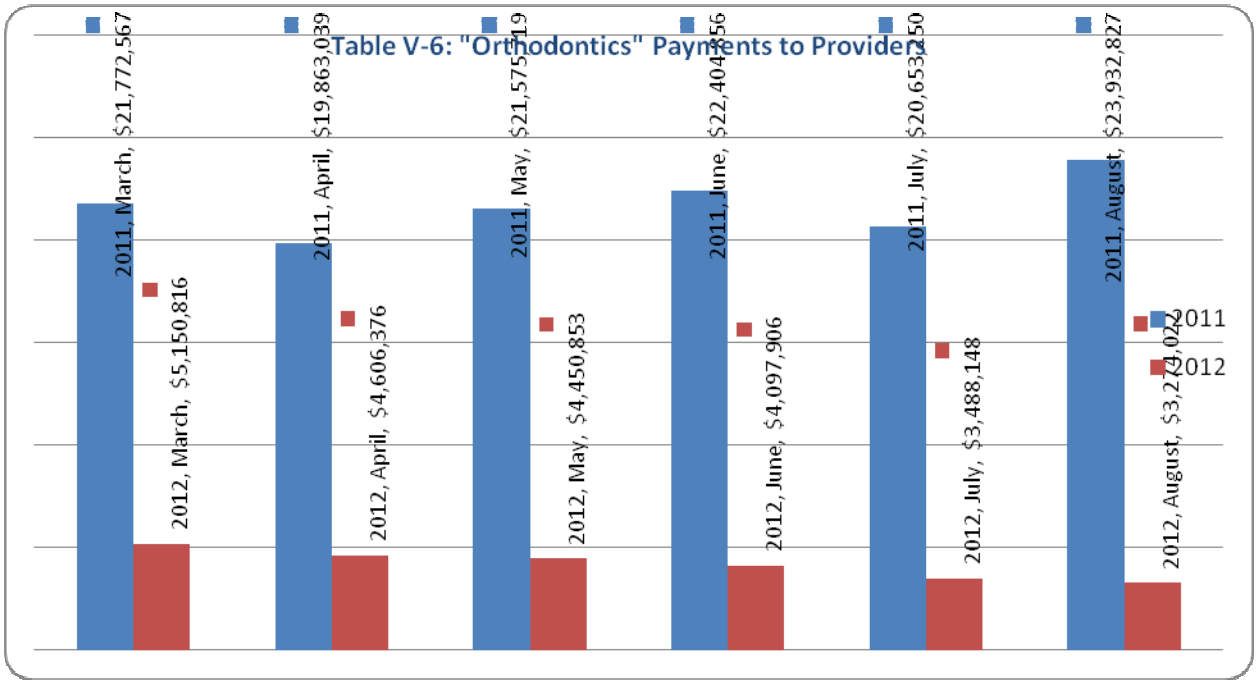



Table V-7 is a graph comparing the paid units of service for the Preventive service category between FFS in 2011 and DMOs in 2012:

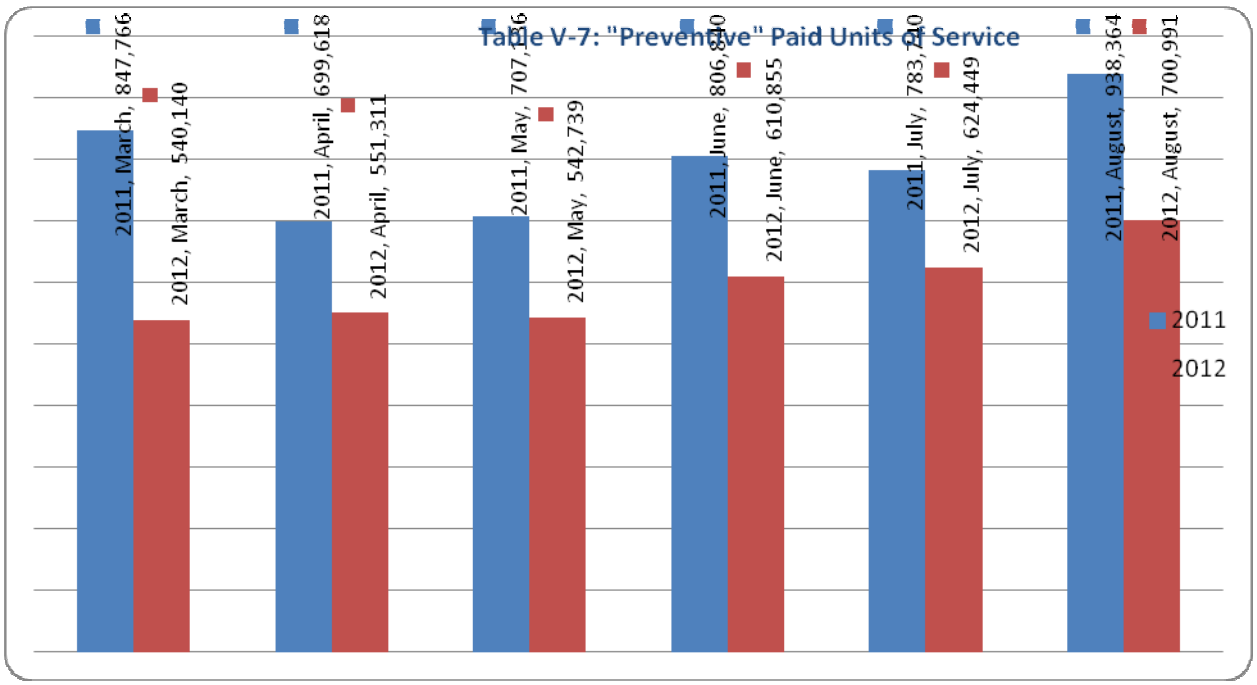
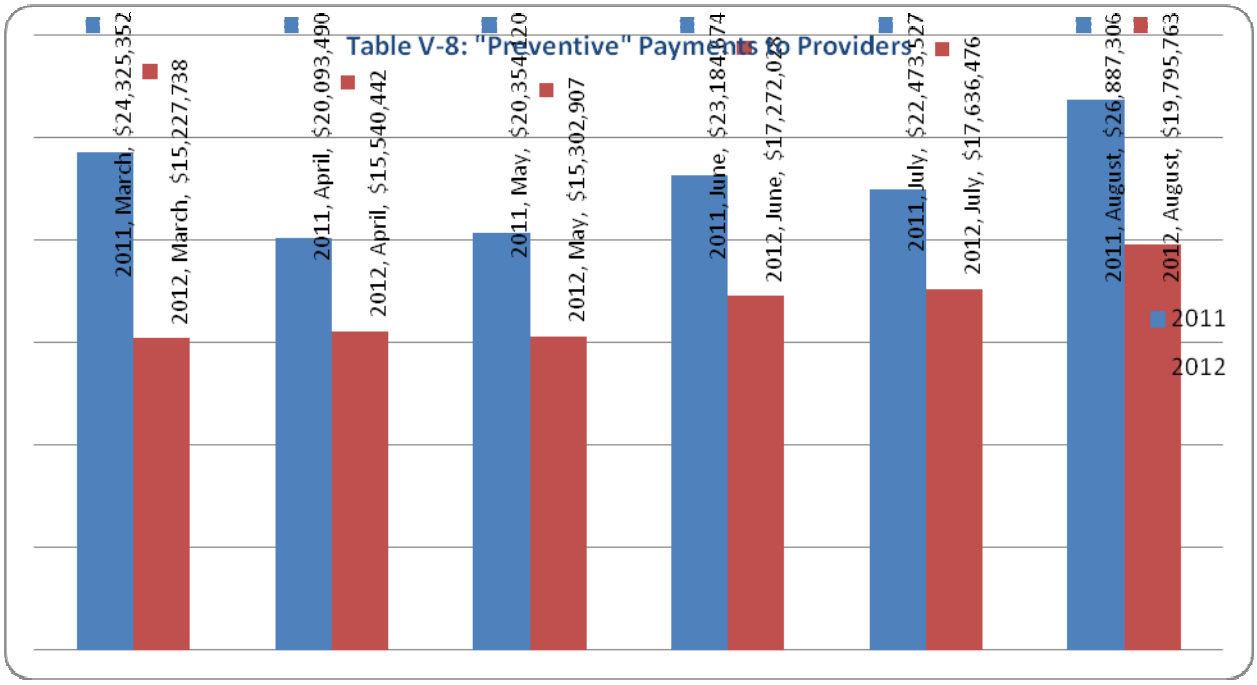


Table V-8 is a graph comparing the payments made to providers for the Preventive service category between FFS in 2011 and DMOs in 2012:



## D. Top 5 CDT Codes by Dental Service Category based on Paid Units of Service and Payments made to Providers

Tables V-9 through V-16 are charts with a list of the top 5 dental procedure codes (CDT codes) by services category. The top 5 CDT codes are determined by the proportion of paid units of service or payments made to providers for each CDT code, as it relates total paid units of service or total payments made to providers from March 2011 to August 2011.

Table V-9 is a chart comparing the top 5 CDT codes based on paid units of service for the All Other service category:

Table V-9: Top 5 CDT Codes for "All Other" Services by Paid Units of Service

| CDT Code | Description | 2011 Utilization (Paid Units of Service)* | 2011 Rank | 2011 Percent of Total Utilization | 2012 DMO Utilization (Encounter Units of Service)** | 2012 Rank | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|---|---|---|
| D2391 | POST 1 SRFC RESINBASED CMPST | 1,217,198 | 1 | 33.52% | 623,924 | 2 | 23.89% | -49% |
| D2392 | POST 2 SRFC RESINBASED CMPST | 459,750 | 2 | 12.66% | 633,542 | 1 | 24.26% | 38% |
| D2930 | PREFAB STNLSS STEEL CRWN PRI | 354,651 | 3 | 9.77% | 271,670 | 3 | 10.40% | -23% |
| D9230 | ANALGESIA | 306,052 | 4 | 8.43% | 267,946 | 4 | 10.26% | -12% |
| D7140 | EXTRACTION ERUPTED TOOTH/EXR | 251,801 | 5 | 6.93% | 173,193 | 5 | 6.63% | -31% |
| | **Total** | **2,589,452** | | **71.31%** | **1,970,275** | | **75.45%** | **-24%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-10 compares the top 5 CDT codes based on payments made to providers for the All Other service category:

Table V-10: Top 5 CDT Codes for "All Other" Services by Payments to Providers

| CDT Code | Description | 2011 Paid Amounts* | 2011 Rank | 2011 Percent of Total Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Rank | 2012 Percent of Total Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|---|---|---|
| D2391 | POST 1 SRFC RESINBASED CMPST | $97,310,357 | 1 | 27.52% | $50,150,886 | 2 | 20.08% | -48% |
| D2930 | PREFAB STNLSS STEEL CRWN PRI | $54,047,746 | 2 | 15.28% | $41,329,864 | 3 | 16.55% | -24% |
| D2392 | POST 2 SRFC RESINBASED CMPST | $47,182,245 | 3 | 13.34% | $65,045,839 | 1 | 26.05% | 38% |
| D7240 | IMPACT TOOTH REMOV COMP BONY | $20,941,064 | 4 | 5.92% | $6,562,719 | 8 | 2.63% | -69% |
| D1740 | EXTRACTION ERUPTED TOOTH/EXR | $16,610,234 | 5 | 4.70% | $11,276,749 | 5 | 4.52% | -32% |
| | **Total** | | | **66.76%** | **$174,366,057** | | **69.83%** | **-26%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-11 is a chart comparing the top 5 CDT codes based on paid units of service for the Diagnostic service category:

Table V-11: Top 5 CDT Codes for "Diagnostic" Services by Paid Units of Service

| CDT Code | Description | 2011 Utilization (Paid Units of Service)* | 2011 Rank | 2011 Percent of Total Utilization | 2012 DMO Utilization (Encounter Units of Services)** | 2012 Rank | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|---|---|---|
| D0120 | PERIODIC ORAL EVALUATION | 876,750 | 1 | 20.15% | 816,168 | 1 | 20.78% | -7% |
| D0230 | INTRAORAL PERIAPICAL EA ADD | 676,369 | 2 | 15.54% | 629,803 | 2 | 16.03% | -7% |

| CDT Code | Description | 2011 Utilization (Paid Units of Service)* | 2011 Rank | 2011 Percent of Total Utilization | 2012 DMO Utilization (Encounter Units of Services)** | 2012 Rank | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|---|---|---|
| D0220 | INTRAORAL PERIAPICAL FIRST F | 643.913 | 3 | 14.80% | 559,897 | 3 | 14.26% | -13% |
| D0272 | DENTAL BITEWINGS TWO FILMS | 581,291 | 4 | 13.36% | 490,162 | 4 | 12.48% | -16% |
| D0150 | COMPREHENSVE ORAL EVALUATION | 444,964 | 5 | 10.23% | 389,911 | 5 | 9.93% | -12% |
| | **Total:** | **3,223,287** | | **74.07%** | **2,885,941** | | **73.48%** | **-10%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-12 compares the top 5 CDT codes based on payments made to providers for the Diagnostic service category:

Table V-12: Top 5 CDT Codes for "Diagnostic" Services by Payments to Providers

| CDT Code | Description | 2011 Paid Amounts* | 2011 Rank | 2011 Percent of Total Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Rank | 2012 Percent of Total Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|---|---|---|
| D0145 | ORAL EVALUATION, PT < 3YRS | $41,659,740 | 1 | 27.93% | $41,647,440 | 1 | 30.04% | 0% |
| D0120 | PERIODIC ORAL EVALUATION | $27,270,948 | 2 | 18.29% | $23,424,332 | 2 | 17.10% | -14% |
| D0150 | COMPREHENSVE ORAL EVALUATION | $16,513,293 | 3 | 11.07% | $13,723,190 | 4 | 10.02% | -17% |
| D0272 | DENTAL BITEWINGS TWO FILMS | $13,329,238 | 4 | 8.94% | $11,360,732 | 5 | 8.29% | -15% |
| D0274 | DENTAL BITEWINGS FOUR FILMS | $10,975,699 | 5 | 7.36% | $10,158,110 | 6 | 7.41% | -7% |
| | **Total:** | **$109,748,918** | | **73.59%** | **$100,313,805** | | **73.21%** | **-9%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-13 compares the top 5 CDT codes based on paid units of service for the Orthodontics service category:

Table V-13: Top 5 CDT Codes for "Orthodontics" Services by Paid Units of Service

| CDT Code | Description | 2011 Utilization (Paid Units of Service)* | 2011 Rank | 2011 Percent of Total Utilization | 2012 DMO Utilization (Encounter Units of Service)** | 2012 Rank | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|---|---|---|
| D8670 | PERIODIC ORTHODONTC TX VISIT | 790,620 | 1 | 55.02% | 455,228 | 1 | 74.04% | -42% |
| D8690 | ORTHODONTIC TREATMENT | 294,645 | 2 | 20.51% | 105,025 | 2 | 17.08% | -64% |
| D8080 | COMPRE DENTAL TX ADOLESCENT | 148,583 | 3 | 10.34% | 1,420 | 7 | 0.23% | -99% |
| D8220 | APPLIANCE FOR HORIZONTAL PROJECTIONS | 68,053 | 4 | 4.74% | 4,388 | 5 | 0.71% | -94% |
| D8210 | BITE PLATE/ BITE PLANE | 58,353 | 5 | 4.07% | 8,596 | 4 | 1.40% | -85% |
| | **Total** | **1,360,436** | | **94.68%** | **574,657** | | **93.47%** | **-58%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-14 is a chart comparing payments made to providers for the top 5 CDT codes within the Orthodontics service category:

Table V-14: Top 5 CDT Codes for "Orthodontics" Services by Payments to Providers

| CDT Code | Description | 2011 Paid Amounts* | 2011 Rank | 2011 Percent of Total Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Rank | 2012 Percent of Total Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|---|---|---|
| D8670 | PERIODIC ORTHODONTC TX VISIT | $52,940,459 | 1 | 40.66% | $30,314,044 | 1 | 78.14% | -43% |
| D8080 | COMPRE DENTAL TX ADOLESCENT | $37,203,777 | 2 | 28.57% | $538,080 | 6 | 1.39% | -99% |

| CDT Code | Description | 2011 Paid Amounts* | 2011 Rank | 2011 Percent of Total Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Rank | 2012 Percent of Total Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|---|---|---|
| D8220 | APPLIANCE FOR HORIZONTAL PROJECTIONS | $18,797,173 | 3 | 14.44% | $1,010,425 | 5 | 2.60% | -95% |
| D8210 | BITE PLATE/ BITE PLANE | $10,297,282 | 4 | 7.91% | $1,146,884 | 4 | 2.96% | -89% |
| D8690 | ORTHODONTIC TREATMENT | $5,844,667 | 5 | 4.49% | $1,921,357 | 3 | 4.95% | -67% |
| | **Total** | **$125,083,358** | | **96.07%** | **$34,930,789** | | **90.04%** | -72% |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Table V-15 compares paid units of service for the top 5 CDT codes within the Preventive service category:

Table V-15: Top 5 CDT Codes for "Preventive" Services by Paid Units of Service

| CDT Code | Description | 2011 Utilization (Paid Units of Service)* | 2011 Rank | 2011 Percent of Total Utilization | 2012 DMO Utilization (Encounter Units of Service)** | 2012 Rank | 2012 Percent of Total Utilization | Utilization Variance |
|---|---|---|---|---|---|---|---|---|
| D1351 | DENTAL SEALANT PER TOOTH | 2,309,420 | 1 | 48.28% | 1,654,253 | 1 | 42.53% | -28% |
| D1120 | DENTAL PROPHYLAXIS CHILD | 963,467 | 2 | 20.14% | 865,388 | 2 | 22.25% | -10% |
| D1203 | TOPICAL APP FLUORIDE CHILD | 893,416 | 3 | 18.68% | 794,810 | 3 | 20.43% | -11% |
| D1110 | DENTAL PROPHYLAXIS ADULT | 246,441 | 4 | 5.15% | 246,775 | 4 | 6.34% | 0% |
| D1204 | TOPICAL APP FLUORIDE ADULT | 227,954 | 5 | 4.77% | 224,545 | 5 | 5.77% | -1% |
| | **Total** | **4,640,698** | | **97.02%** | **3,785,771** | | **97.32%** | **-18%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

Lastly, Table V-16 compares the top 5 CDT codes based on payments made to providers for the Preventive service category:

Table V-16: Top 5 CDT Codes for "Preventive" Services by Payments to Providers

| CDT Code | Description | 2011 Paid Amounts* | 2011 Rank | 2011 Percent of Total Paid Amounts | 2012 DMOs Reported Paid Amounts** | 2012 Rank | 2012 Percent of Total Paid Amounts | Paid Amounts Variance between 2012 and 2011 |
|---|---|---|---|---|---|---|---|---|
| D1351 | DENTAL SEALANT PER TOOTH | $66,040,259 | 1 | 48.09% | $46,463,014 | 1 | 42.26% | -30% |
| D1120 | DENTAL PROPHYLAXIS CHILD | $36,077,261 | 2 | 26.27% | $31,611,699 | 2 | 28.75% | -12% |
| D1110 | DENTAL PROPHYLAXIS ADULT | $13,765,745 | 3 | 10.02% | $13,418,918 | 3 | 12.21% | -3% |
| D1203 | TOPICAL APP FLUORIDE CHILD | $13,217,507 | 4 | 9.63% | $11,629,853 | 4 | 10.58% | -12% |
| D1204 | TOPICAL APP FLUORIDE ADULT | $3,367,340 | 5 | 2.45% | $3,285,859 | 5 | 2.99% | -2% |
| | **Total** | **$132,468,113** | | **96.47%** | **$106,409,342** | | **96.79%** | **-20%** |

Source*: *1_FFS Dental Claims _Mar11_Aug11.xlsx,* HHS Forecasting System, Received November 2012
Source**: *1_ENC Dental Claims _Mar12_Aug12_revised.xlsx*, HHS Forecasting System, Received December 2012

## E. Dental Procedure Codes Requiring a Prior Authorization by Delta Dental, MCNA, DentaQuest, and Fee-for-Service

Table V-17 is a list of the unique payable dental procedure codes (ADACDT codes) that require a prior authorization under Fee-for-Service in 2011 and require a prior authorization by Delta Dental, MCNA, and DentaQuest in 2012:

Table V-17: CDT Codes Requiring a Prior Authorization across Delta Dental, MCNA, DentaQuest, and Fee-for-Service

| CDT Code | Service Description |
|---|---|
| D0360 | Cone beam CT |
| D0362 | Cone beam, two dimensional |
| D0363 | Cone beam, three dimensional |
| D2510 | Inlay - metallic - one surface |
| D2520 | Inlay - metallic - two surfaces |
| D2530 | Inlay - metallic - three or more surfaces |
| D2542 | Onlay - metallic - two surfaces |
| D2543 | Onlay - metallic - three surfaces |
| D2544 | Onlay - metallic - four or more surfaces |
| D2610 | Inlay - porcelain/ceramic - one surface |
| D2620 | Inlay - porcelain/ceramic - two surfaces |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces |
| D2642 | Onlay - porcelain/ceramic - two surfaces |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces |
| D2650 | Inlay - resin-based composite - one surface |
| D2651 | Inlay - resin-based composite - two surfaces |
| D2652 | Inlay - resin-based composite - three surfaces |
| D2662 | Onlay - resin-based composite - two surfaces |
| D2663 | Onlay - resin-based composite - three surfaces |
| D2664 | Onlay - resin-based composite - four or more surfaces |
| D2710 | Crown - resin-based composite (indirect) |
| D2720 | Crown - resin with high noble metal |
| D2721 | Crown - resin with predominantly base metal |
| D2722 | Crown - resin with noble metal |
| D2740 | Crown - porcelain/ceramic substrate |
| D2750 | Crown - porcelain fused to high noble metal |
| D2751 | Crown - porcelain fused to predominantly base metal |
| D2752 | Crown - porcelain fused to noble metal |
| D2780 | Crown - 3/4 cast high noble |
| D2781 | Crown - 3/4 cast predominantly base metal |
| D2782 | Crown - 3/4 cast noble metal |
| D2783 | Crown - 3/4 porcelain/ceramic |
| D2790 | Crown - full cast high noble metal |

| CDT Code | Service Description |
|---|---|
| D2791 | Crown - full cast predominantly base metal |
| D2792 | Crown - full cast noble metal |
| D2794 | Crown - titanium |
| D3460 | Endodontic endosseous implant |
| D4276 | Combined connective tissue and double pedicle graft, per tooth |
| D5951 | Feeding aid |
| D5952 | Speech aid prosthesis, pediatric |
| D5953 | Speech aid prosthesis, adult |
| D5954 | Palatal augmentation prosthesis |
| D5955 | Palatal lift prosthesis, definitive |
| D5958 | Palatal lift prosthesis, interim |
| D5959 | Palatal lift prosthesis, modification |
| D5960 | Speech aid prosthesis, modification |
| D6010 | Surgical placement of implant body - endosteal implant |
| D6040 | Surgical placement - eposteal implant |
| D6050 | Surgical placement - transosteal implant |
| D6055 | Connecting bar - dental implant supported or abutment supported |
| D6080 | Implant maintenance procedures including removal of prosthesis, cleansing of prosthesis and abutment and reinsertion of prosthesis |
| D6090 | Repair implant supported prosthesis, by report |
| D6095 | Repair implant abutment, by report |
| D6100 | Implant removal, by report |
| D6199 | Unspecified implant procedure, by report |
| D6210 | Pontic - cast high noble metal |
| D6211 | Pontic - cast predominantly base metal |
| D6212 | Pontic - cast noble metal |
| D6240 | Pontic - procelain fused to high noble metal |
| D6241 | Pontic - porcelain fused to predominantly base metal |
| D6242 | Pontic - porcelain/fused to noble metal |
| D6245 | Pontic - porcelain/ceramic |
| D6250 | Pontic - resin with high noble metal |
| D6251 | Pontic - resin with predominantly base metal |
| D6252 | Pontic - resin with noble metal |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis |
| D6720 | Crown - resin with high noble metal |
| D6721 | Crown - resin with predominantly base metal |
| D6722 | Crown - resin with noble metal |
| D6740 | Crown - porcelain/ceramic |
| D6750 | Crown - porcelain fused to high noble metal |
| D6751 | Crown - porcelain fused to predominantly base metal |
| D6752 | Crown - porcelain fused to noble metal |

| CDT Code | Service Description |
|---|---|
| D6780 | Crown - 3/4 cast high noble metal |
| D6781 | Crown - 3/4 cast predominantly base metal |
| D6782 | Crown - 3/4 cast noble metal |
| D6783 | Crown - 3/4 porcelain/ceramic |
| D6790 | Crown - full cast high noble metal |
| D6791 | Crown - full cast predominantly base metal |
| D6792 | Crown - full cast noble metal |
| D7260 | Oroantral fistula closure |
| D7272 | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) |
| D7472 | Removal of torus palatinus |
| D7997 | Appliance removal (not by dentist who placed appliance) includes removal of archbar |
| D8050 | Interceptive orthodontic treatment primary dentition |
| D8060 | Interceptive orthodontic treatment transition dentition |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition (1 of D8070, D8080, D8090 per lifetime) |
| D8210 | Orthodontic REM appliance treatment |
| D8220 | Fixed appliance therapy habit |
| D8670 | Periodic orthodontic treatment visit -the number of monthly adjustments will vary based on which level was approved |
| D8693 | Rebonding or recementing; and/or repair, as required, of fixed retainers -Documentation of medical necessity needed. |

## F. Dental Procedure Codes Requiring a Prior Authorization by the DMOs Only

Table V-18 is a list of the unique dental procedure codes (CDT codes) that require a prior authorization by Delta Dental, MCNA, and DentaQuest in 2012, but do not explicitly require a prior authorization under Fee-for-Service in 2011.

Table V-18: CDT Codes Prior Authorizations Required Across Delta Dental, MCNA, and DentaQuest Only

| CDT Code | Service Description |
|---|---|
| D8070 | Comprehensive orthodontic treatment of the transitional dentition (1 of D8070, D8080, D8090 per lifetime) |
| D8090 | Comprehensive orthodontic treatment of the adult dentition (1 of D8070, D8080 or D8090 per lifetime) |
| D8691 | Repair of orthodontic appliance - 1 per arch per lifetime |
| D8692 | Replacement of lost or broken retainer - 1 per arch per lifetime |

## G. Dental Procedure Codes Requiring a Prior Authorization by Individual Payers

Tables V-19 through V-21 are charts with a list of the unique dental procedure codes (CDT codes) that require a prior authorization by individual payers only.

Table V-19 is a list of the unique CDT codes that only require a prior authorization under Fee-for-Service in 2011, but do not explicitly require a prior authorization by Delta Dental, MCNA, and DentaQuest in 2012:

Table V-19: CDT Codes Requiring a Prior Authorization by Fee-for-Service Only

| CDT Code | Service Description |
|---|---|
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures |
| D9211 | Regional block anesthesia |
| D9212 | Trigeminal division block anesthesia |
| D9215 | Local anesthesia |
| D9220 | Deep sedation/general anesthesia - first 30 minutes |
| D9230 | Analgesia, anxiolysis, inhalation of nitrous oxide |
| D9248 | Non-intravenous conscious sedation |
| D8999 | Orthodontic procedure |

Table V-20 is a list of the unique CDT codes that only require a prior authorization by DentaQuest in 2012, but do not explicitly require a prior authorization by Delta Dental or MCNA in 2012, nor do they explicitly require a prior authorization under Fee-for-Service in 2011:

Table V-20: CDT Codes Requiring a Prior Authorization by DentaQuest Only

| CDT Code | Service Description |
|---|---|
| D7261 | Primary closure sinus perforation |
| D9610 | Dental therapeutic drug injection |
| D9612 | Therapeutic PAR drugs 2 or more admin |
| D9630 | Other drug/medicaments |
| D9920 | Behavior management |
| D9940 | Occlusal guard, by report |

Table V-21 is a list of the unique CDT codes that only require a prior authorization by MCNA in 2012, but do not explicitly require a prior authorization by Delta Dental or DentaQuest in 2012, nor do they explicitly require a prior authorization under Fee-for-Service in 2011:

Table V-21: Codes Requiring a Prior Authorization by MCNA Only

| CDT Code | Service Description |
|---|---|
| D0470 | Diagnostic casts |
| D2950 | Core buildup, including any pins |
| D2980 | Crown repair, by report |

| CDT Code | Service Description |
|---|---|
| D3351 | Apexification/recalification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) |
| D3352 | Apexification/recalification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc) |
| D3353 | Apexification/recalification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.) |
| D3430 | Retrograde filling - per root |
| D3450 | Root amputation - per root |
| D3470 | Intentional reimplantation (including necessary splinting) |
| D3910 | Surgical procedure for isolation of tooth with rubber dam |
| D3920 | Hemisection (including any root removal), not including root canal therapy |
| D3950 | Canal preparation and fitting of preformed dowel or post |
| D4920 | Unscheduled dressing change (by someone other than treating dentist) |
| D5410 | Adjust complete denture - maxillary |
| D5411 | Adjust complete denture - mandibular |
| D5421 | Adjust partial denture - maxillary |
| D5422 | Adjust partial denture - mandibular |
| D5510 | Repair broken complete denture base |
| D5610 | Repair resin denture base |
| D5620 | Repair cast framework |
| D5630 | Repair or replace broken clasp |
| D5640 | Replace broken teeth - per tooth |
| D5650 | Add tooth to existing partial denture |
| D5660 | Add clasp to existing partial denture |
| D5670 | Replace all teeth and acrylic on cast meta framework (maxillary) |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) |
| D5710 | Rebase complete maxillary denture |
| D5711 | Rebase complete mandibular denture |
| D5720 | Rebase maxillary partial denture |
| D5721 | Rebase mandibular partial denture |
| D5730 | Reline complete maxillary denture (chairside) |
| D5731 | Reline complete mandibular denture (chairside) |
| D5740 | Reline maxillary partial denture (chairside) |
| D5741 | Reline mandibular partial denture (chairside) |
| D5750 | Reline complete maxillary denture (laboratory) |
| D5751 | Reline complete mandibular denture (laboratory) |
| D5760 | Reline maxillary partial denture (laboratory) |
| D5761 | Reline mandibular partial denture (laboratory) |

| CDT Code | Service Description |
|---|---|
| D5850 | Tissue conditioning - maxillary |
| D5851 | Tissue conditioning - mandibular |
| D5862 | Precision attachment, by report |
| D6092 | Recement implant/abutment supported crown |
| D6093 | Recement implant/abutment supported fixed partial denture |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption |
| D7285 | Biopsy of oral tissue - hard (bone, tooth) |
| D7286 | Biopsy of oral tissue - soft |
| D7290 | Surgical repositioning of teeth |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report |
| D7410 | Excision of benign lesion - up to 1.25 cm |
| D7411 | Excision of benign lesion - greater than 1.25 cm |
| D7440 | Excision of malignant tumor - lesion diameter up to 1.25 cm |
| D7441 | Excision of malignant tumor - lesion diameter greater than 1.25 cm |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue |
| D7540 | Removal of reaction producing foreign bodies, musculoskeletal system |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body |
| D7670 | Alveolus closed reduction may include stabilization of teeth |
| D7820 | Closed reduction of dislocation (TMP manipulation) |
| D7910 | Suture of recent small wounds - up to 5 cm |
| D7971 | Excision of periocoronal gingiva |
| D7972 | Surgical reduction of fibrous tuberosity |
| D7980 | Sialolithotomy |
| D7983 | Closure of salivary fistula |
| D9952 | Occlusal adjustment - complete |
| D9970 | Enamel microabrasion |
| D9974 | Internal bleaching - per tooth |
| D9999 | Unspecified adjunctive procedure, by report |

## H. Dental Procedure Codes Payable by Delta Dental, MCNA, DentaQuest, and Fee-for-Service

Table V-22 is a list of the unique dental procedure codes (CDT codes) that were payable by Fee-for-Service in 2011 and are payable by Delta Dental, MCNA, and DentaQuest in 2012:

Table V-22: Dental Procedure Codes Payable by Delta Dental, MCNA, DentaQuest, and Fee-for-Service

| CDT Code | Service Description |
|---|---|
| D0120 | Periodic oral evaluation |
| D0140 | Limited oral evaluation - problem focused |
| D0145 | Oral evaluation for patients under 3 years and counseling with primary caregiver |
| D0150 | Comprehensive oral evaluation (initial) |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report |
| D0170 | Re-evaluation - limited, problem focused (established patient, not post-operative visit) |
| D0180 | Comprehensive periodontal evaluation - new or established patient |
| D0210 | Intraoral - complete series (including bitewings) (Limited to one per 36 months) |
| D0220 | Intraoral - periapical first film |
| D0230 | Intraoral - periapical each additional film |
| D0240 | Intraoral - occlusal film |
| D0250 | Extraoral - first film |
| D0260 | Extraoral - each additional film |
| D0270 | Bitewing - single film |
| D0272 | Bitewings - two films |
| D0273 | Bitewings - three films |
| D0274 | Bitewings - four films |
| D0277 | Vertical bitewings - 7 to 8 films |
| D0290 | Posterior - anterior or lateral skull and facial bone survey film |
| D0310 | Sailography |
| D0320 | Temporomandibular joint arthrogram, including injection |
| D0321 | Other temporomandibular joint films, by report |
| D0322 | Tomographic survey |
| D0330 | Panoramic film |
| D0340 | Cephalometric film |
| D0350 | Oral/facial photographic images |
| D0360 | Cone beam CT |
| D0362 | Cone beam, two dimensional |
| D0363 | Cone beam, three dimensional |
| D0415 | Collection of microorganisms for culture and sensitivity |
| D0460 | Pulp vitality tests |
| D0470 | Diagnostic casts |

| CDT Code | Service Description |
|---|---|
| D0502 | Other oral pathology procedures, by report |
| D0999 | Unspecified diagnostic procedure |
| D1110 | Prophylaxis (cleaning) - age 13 and above |
| D1120 | Prophylaxis (cleaning) - age six-months through 12 |
| D1203 | Topical application of fluoride - child |
| D1204 | Topical application of fluoride - adult |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients |
| D1330 | Oral hygiene instruction |
| D1351 | Sealant - per tooth (limited to one per tooth, limited to every three years ) |
| D1510 | Space maintainer - fixed, unilateral |
| D1515 | Space maintainer - fixed bilateral |
| D1520 | Space maintainer - removable unilateral |
| D1525 | Space maintainer - removable bilateral |
| D1550 | Recementation of space maintainer |
| D1555 | Removal of space maintainer (not by dentist who placed appliance) |
| D2140 | Amalgam - one surface, permanent |
| D2150 | Amalgam - two surfaces, permanent |
| D2160 | Amalgam - three surfaces, permanent |
| D2161 | Amalgam - four or more surfaces, permanent |
| D2330 | Resin-based composite - one surface, anterior |
| D2331 | Resin-based composite - two surfaces, anterior |
| D2332 | Resin-based composite - three surfaces, anterior |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle |
| D2390 | Resin-based composite - crown, anterior - permanent |
| D2391 | Resin-based composite - one surface, posterior permanent |
| D2392 | Resin-based composite - two surfaces, posterior permanent |
| D2393 | Resin-based composite - three or more surfaces, posterior permanent |
| D2394 | Resin-based composite - four or more surfaces, posterior permanent |
| D2410 | Gold foil - one surface |
| D2420 | Gold foil - two surfaces |
| D2430 | Gold foil - three surfaces |
| D2510 | Inlay - metallic - one surface |
| D2520 | Inlay - metallic - two surfaces |
| D2530 | Inlay - metallic - three or more surfaces |
| D2542 | Onlay - metallic - two surfaces |
| D2543 | Onlay - metallic - three surfaces |
| D2544 | Onlay - metallic - four or more surfaces |

| CDT Code | Service Description |
|---|---|
| D2610 | Inlay - porcelain/ceramic - one surface |
| D2620 | Inlay - porcelain/ceramic - two surfaces |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces |
| D2642 | Onlay - porcelain/ceramic - two surfaces |
| D2643 | Onlay - porcelain/ceramic - three surfaces |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces |
| D2650 | Inlay - resin-based composite - one surface |
| D2651 | Inlay - resin-based composite - two surfaces |
| D2652 | Inlay - resin-based composite - three surfaces |
| D2662 | Onlay - resin-based composite - two surfaces |
| D2663 | Onlay - resin-based composite - three surfaces |
| D2664 | Onlay - resin-based composite - four or more surfaces |
| D2710 | Crown - resin-based composite (indirect) |
| D2720 | Crown - resin with high noble metal |
| D2721 | Crown - resin with predominantly base metal |
| D2722 | Crown - resin with noble metal |
| D2740 | Crown - porcelain/ceramic substrate |
| D2750 | Crown - porcelain fused to high noble metal |
| D2751 | Crown - porcelain fused to predominantly base metal |
| D2752 | Crown - porcelain fused to noble metal |
| D2780 | Crown - 3/4 cast high noble |
| D2781 | Crown - 3/4 cast predominantly base metal |
| D2782 | Crown - 3/4 cast noble metal |
| D2783 | Crown - 3/4 porcelain/ceramic |
| D2790 | Crown - full cast high noble metal |
| D2791 | Crown - full cast predominantly base metal |
| D2792 | Crown - full cast noble metal |
| D2794 | Crown - titanium |
| D2910 | Recement inlay, onlay, or partial coverage restoration |
| D2915 | Recement indirectly fabricated or prefabricated post and core |
| D2920 | Recement crown |
| D2930 | Prefabricated stainless steel crown - primary tooth (birth through age twenty) |
| D2931 | Prefabricated stainless steel crown - permanent tooth (age one through twenty) |
| D2932 | Prefabricated resin crown |
| D2933 | Prefabricated stainless steel crown with resin window |
| D2934 | Prefabricated esthetic coated stainless steel crown - primary tooth |
| D2940 | Protective restoration (sedative filling) |
| D2950 | Core buildup, including any pins |

| CDT Code | Service Description |
|---|---|
| D2951 | Pin retention - per tooth, in addition to restoration |
| D2952 | Post and core in addition to crown - indirectly fabricated |
| D2953 | Each additional indirectly fabricated post - same tooth |
| D2954 | Prefabricated post and core in addition to crown |
| D2955 | Post removal (not in conjunction with endodontic therapy) |
| D2957 | Each additional indirectly fabricated post - same tooth |
| D2960 | Labial veneer (resin laminate) - chairside |
| D2961 | Labial veneer (resin laminate) - laboratory |
| D2962 | Labial veneer (porcelain laminate) - laboratory |
| D2970 | Temporary crown (fractured tooth) |
| D2971 | Additional procedures to construct new crown under existing partial denture framework |
| D2980 | Crown repair, by report |
| D2999 | Unspecified restorative procedure, by report |
| D3110 | Pulp cap - direct (excluding final restoration) |
| D3120 | Pulp cap - indirect (excluding final restoration) |
| D3220 | Therapeutic pulpotomy (excluding final restoration) |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) |
| D3240 | Pulpal therapy (resorbable filling) - (excluding final restoration, posterior first and second molars ) |
| D3310 | Endodontic therapy - anterior tooth (excluding final restoration) |
| D3320 | Endodontic therapy - bicuspid tooth (excluding final restoration) |
| D3330 | Endodontic therapy - molar (excluding final restoration) |
| D3346 | Retreatment of previous root canal therapy - anterior |
| D3347 | Retreatment of previous root canal therapy - bicuspid |
| D3348 | Retreatment of previous root canal treatment - molar |
| D3351 | Apexification/recalification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) |
| D3352 | Apexification/recalification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc) |
| D3353 | Apexification/recalification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.) |
| D3410 | Apicoectomy/periradicular surgery - anterior |
| D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) |
| D3425 | Apicoectomy/periradicular surgery - molar (first root) |
| D3426 | Apicoectomy/periradicular surgery - (each additional root) |
| D3430 | Retrograde filling - per root |
| D3450 | Root amputation - per root |

| CDT Code | Service Description |
|---|---|
| D3460 | Endodontic endosseous implant |
| D3470 | Intentional reimplantation (including necessary splinting) |
| D3910 | Surgical procedure for isolation of tooth with rubber dam |
| D3920 | Hemisection (including any root removal), not including root canal therapy |
| D3950 | Canal preparation and fitting of preformed dowel or post |
| D3999 | Unspecified endodontic procedure, by report |
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4230 | Anatomical crown exposure - four or more contiguous teeth per quadrant |
| D4231 | Anatomical crown exposure - one to three contiguous teeth per quadrant |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4245 | Apically positioned flap |
| D4249 | Clinical crown lengthening - hard tissue |
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4266 | Guided tissue regeneration - resorbable barrier, per site |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) |
| D4270 | Pedicle soft tissue graft procedure |
| D4271 | Free soft tissue graft procedure (including donor site surgery) |
| D4273 | Subepithelial connective tissue graft procedures, per tooth |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) |
| D4275 | Soft tissue allograft |
| D4276 | Combined connective tissue and double pedicle graft, per tooth |
| D4320 | Provisional splinting - intracoronal |
| D4321 | Provisional splinting - extracoronal |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis |

| CDT Code | Service Description |
|---|---|
| D4381 | Localized delivery of antimicrobial agent via a controlled release vehicle into diseased crevicular tissue, per tooth, by report |
| D4910 | Periodontal maintenance |
| D4920 | Unscheduled dressing change (by someone other than treating dentist) |
| D4999 | Unspecified periodontal procedure, by report |
| D5110 | Complete denture - maxillary (upper) |
| D5120 | Complete denture - mandibular (lower) |
| D5130 | Immediate denture - maxillary |
| D5140 | Immediate denture - mandibular |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) |
| D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) |
| D5410 | Adjust complete denture - maxillary |
| D5411 | Adjust complete denture - mandibular |
| D5421 | Adjust partial denture - maxillary |
| D5422 | Adjust partial denture - mandibular |
| D5510 | Repair broken complete denture base |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) |
| D5610 | Repair resin denture base |
| D5620 | Repair cast framework |
| D5630 | Repair or replace broken clasp |
| D5640 | Replace broken teeth - per tooth |
| D5650 | Add tooth to existing partial denture |
| D5660 | Add clasp to existing partial denture |
| D5670 | Replace all teeth and acrylic on cast meta framework (maxillary) |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) |
| D5710 | Rebase complete maxillary denture |
| D5711 | Rebase complete mandibular denture |
| D5720 | Rebase maxillary partial denture |
| D5721 | Rebase mandibular partial denture |
| D5730 | Reline complete maxillary denture (chairside) |
| D5731 | Reline complete mandibular denture (chairside) |

| CDT Code | Service Description |
|---|---|
| D5740 | Reline maxillary partial denture (chairside) |
| D5741 | Reline mandibular partial denture (chairside) |
| D5750 | Reline complete maxillary denture (laboratory) |
| D5751 | Reline complete mandibular denture (laboratory) |
| D5760 | Reline maxillary partial denture (laboratory) |
| D5761 | Reline mandibular partial denture (laboratory) |
| D5810 | Interim complete denture - maxillary |
| D5811 | Interim complete denture - mandibular |
| D5820 | Interim partial denture - maxillary |
| D5821 | Interim partial denture - mandibular |
| D5850 | Tissue conditioning - maxillary |
| D5851 | Tissue conditioning - mandibular |
| D5860 | Overdenture - complete, by report |
| D5861 | Overdenture - partial, by report |
| D5862 | Precision attachment, by report |
| D5899 | Unspecified removable prosthodontic procedure, by report |
| D5911 | Facial moulage (sectional) |
| D5912 | Facial moulage (complete) |
| D5913 | Nasal prosthesis |
| D5914 | Auricular prosthesis |
| D5915 | Orbital prosthesis |
| D5916 | Ocular prosthesis |
| D5919 | Facial prosthesis |
| D5922 | Nasal septal prosthesis |
| D5923 | Ocular prosthesis, interim |
| D5924 | Cranial prosthesis |
| D5925 | Facial augmentation implant prosthesis |
| D5926 | Nasal prosthesis, replacement |
| D5927 | Auricular prosthesis, replacement |
| D5928 | Orbital prosthesis, replacement |
| D5929 | Facial prosthesis, replacement |
| D5931 | Obturator prosthesis, surgical |
| D5932 | Obturator prosthesis, definitive |
| D5933 | Obturator prosthesis, modification |
| D5934 | Mandibular resection prosthesis with guide flange |
| D5935 | Mandibular resection prosthesis without guide flange |
| D5936 | Obutator prosthesis, interim |
| D5937 | Trismus appliance (not for TMD treatment) |

| CDT Code | Service Description |
|---|---|
| D5951 | Feeding aid |
| D5952 | Speech aid prosthesis, pediatric |
| D5953 | Speech aid prosthesis, adult |
| D5954 | Palatal augmentation prosthesis |
| D5955 | Palatal lift prosthesis, definitive |
| D5958 | Palatal lift prosthesis, interim |
| D5959 | Palatal lift prosthesis, modification |
| D5960 | Speech aid prosthesis, modification |
| D5982 | Surgical stent |
| D5983 | Radiation carrier |
| D5984 | Radiation shield |
| D5985 | Radiation cone locator |
| D5986 | Fluoride gel carrier |
| D5987 | Commissure splint |
| D5988 | Surgical splint |
| D5999 | Unspecified maxillofacial prosthesis, by report |
| D6010 | Surgical placement of implant body - endosteal implant |
| D6040 | Surgical placement - eposteal implant |
| D6050 | Surgical placement - transosteal implant |
| D6055 | Connecting bar - dental implant supported or abutment supported |
| D6056 | Prefabricated abutment - includes placement |
| D6057 | Custom abutment - includes placement |
| D6080 | Implant maintenance procedures including removal of prosthesis, cleansing of prosthesis and abutment and reinsertion of prosthesis |
| D6090 | Repair implant supported prosthesis, by report |
| D6092 | Recement implant/abutment supported crown |
| D6093 | Recement implant/abutment supported fixed partial denture |
| D6095 | Repair implant abutment, by report |
| D6100 | Implant removal, by report |
| D6199 | Unspecified implant procedure, by report |
| D6210 | Pontic - cast high noble metal |
| D6211 | Pontic - cast predominantly base metal |
| D6212 | Pontic - cast noble metal |
| D6240 | Pontic - procelain fused to high noble metal |
| D6241 | Pontic - porcelain fused to predominantly base metal |
| D6242 | Pontic - porcelain/fused to noble metal |
| D6245 | Pontic - porcelain/ceramic |
| D6250 | Pontic - resin with high noble metal |

| CDT Code | Service Description |
|---|---|
| D6251 | Pontic - resin with predominantly base metal |
| D6252 | Pontic - resin with noble metal |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis |
| D6720 | Crown - resin with high noble metal |
| D6721 | Crown - resin with predominantly base metal |
| D6722 | Crown - resin with noble metal |
| D6740 | Crown - porcelain/ceramic |
| D6750 | Crown - porcelain fused to high noble metal |
| D6751 | Crown - porcelain fused to predominantly base metal |
| D6752 | Crown - porcelain fused to noble metal |
| D6780 | Crown - 3/4 cast high noble metal |
| D6781 | Crown - 3/4 cast predominantly base metal |
| D6782 | Crown - 3/4 cast noble metal |
| D6783 | Crown - 3/4 porcelain/ceramic |
| D6790 | Crown - full cast high noble metal |
| D6791 | Crown - full cast predominantly base metal |
| D6792 | Crown - full cast noble metal |
| D6920 | Connector bar |
| D6930 | Recement fixed partial denture |
| D6940 | Stress breaker |
| D6950 | Precision attachment |
| D6970 | Cast post and core in addition to fixed partial denture retainer |
| D6972 | Prefabricated post and core in addition to fixed partial denture retainer |
| D6973 | Core build up for retainer, including any pins |
| D6975 | Coping - metal |
| D6976 | Each additional indirectly fabricated post - same tooth |
| D6977 | Each additional fabricated post - same tooth |
| D6980 | Fixed partial denture repair, by report |
| D6999 | Unspecified fixed prosthodontic procedure, by report |
| D7111 | Extraction, cornonal remnants - deciduous tooth |
| D7140 | Extraction - erupted tooth or exposed root (elevation and/or forceps removal) |
| D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated |
| D7220 | Removal of impacted tooth - soft tissue |
| D7230 | Removal of impacted tooth - partially bony |
| D7240 | Removal of impacted tooth - completely bony |
| D7241 | Removal of impacted tooth - completely bony with unusual surgical complications |

| CDT Code | Service Description |
|---|---|
| D7250 | Surgical removal of residual tooth roots (cutting procedure) |
| D7260 | Oroantral fistula closure |
| D7261 | Primary closure sinus perforation |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth |
| D7272 | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) |
| D7280 | Surgical access of an unerupted tooth |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption |
| D7283 | Placement of device to facilitate eruption of impacted tooth |
| D7285 | Biopsy of oral tissue - hard (bone, tooth) |
| D7286 | Biopsy of oral tissue - soft |
| D7290 | Surgical repositioning of teeth |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report |
| D7310 | Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces per quadrant |
| D7320 | Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant |
| D7340 | Vestibuloplasty - ridge extension (secondary epithelialization) |
| D7350 | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) |
| D7410 | Excision of benign lesion - up to 1.25 cm |
| D7411 | Excision of benign lesion - greater than 1.25 cm |
| D7413 | Excision of malignant lesion -up to 1.25 cm |
| D7414 | Excision of malignant lesion - greater than 1.25 cm |
| D7440 | Excision of malignant tumor - lesion diameter up to 1.25 cm |
| D7441 | Excision of malignant tumor - lesion diameter greater than 1.25 cm |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report |
| D7472 | Removal of torus palatinus |
| D7510 | Incision and drainage of abscess - intraoral soft tissue |
| D7520 | Incision and drainage of abscess - extraoral soft tissue |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue |
| D7540 | Removal of reaction producing foreign bodies, musculoskeletal system |

| CDT Code | Service Description |
|---|---|
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body |
| D7670 | Alveolus closed reduction may include stabilization of teeth |
| D7820 | Closed reduction of dislocation (TMP manipulation) |
| D7880 | Occlusal orthodontic appliance |
| D7899 | Unspecified TMJ therapy |
| D7910 | Suture of recent small wounds - up to 5 cm |
| D7911 | Complicated suture - up to 5 cm |
| D7912 | Complicated suture - greater than 5 cm |
| D7955 | Repair maxillofacial defects |
| D7960 | Frenulectomy (frenectomy or frenotomy) - separate procedure |
| D7970 | Excision of hyperplastic tissue - per arch |
| D7971 | Excision of periocoronal gingiva |
| D7972 | Surgical reduction of fibrous tuberosity |
| D7980 | Sialolithotomy |
| D7983 | Closure of salivary fistula |
| D7997 | Appliance removal (not by dentist who placed appliance) includes removal of archbar |
| D7999 | Unspecified oral surgery procedure, by report |
| D8050 | Interceptive orthodontic treatment primary dentition |
| D8060 | Interceptive orthodontic treatment transition dentition |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition (1 of D8070, D8080, D8090 per lifetime) |
| D8210 | Orthodontic REM appliance treatment |
| D8220 | Fixed appliance therapy habit |
| D8670 | Periodic orthodontic treatment visit -the number of monthly adjustments will vary based on which level was approved |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainers) |
| D8693 | Rebonding or recementing; and/or repair, as required, of fixed retainers - Documentation of medical necessity needed. |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure |
| D9120 | Fixed partial denture sectioning |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures |
| D9211 | Regional block anesthesia |
| D9212 | Trigeminal division block anesthesia |
| D9215 | Local anesthesia |
| D9220 | Deep sedation/general anesthesia - first 30 minutes |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes |
| D9230 | Analgesia, anxiolysis, inhalation of nitrous oxide |

| CDT Code | Service Description |
|---|---|
| D9241 | Intravenous conscious sedation/analgesia - first 30 minutes |
| D9242 | Intravenous conscious sedation/analgesia - each addition 30 minutes |
| D9248 | Non-intravenous conscious sedation |
| D9310 | Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician) |
| D9410 | Dental house/extended care facility call |
| D9420 | Hospital call |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed |
| D9440 | Office visit - after regularly scheduled hours |
| D9610 | Dental therapeutic drug injection |
| D9612 | Therapeutic PAR drugs 2 or more admin |
| D9630 | Other drug/medicaments |
| D9910 | Dental app desensitizing medicament |
| D9920 | Behavior management |
| D9940 | Occlusal guard, by report |
| D9950 | Occlusion analysis - mounted case |
| D9951 | Occlusal adjustment - limited |
| D9952 | Occlusal adjustment - complete |
| D9970 | Enamel microabrasion |
| D9974 | Internal bleaching - per tooth |
| D9999 | Unspecified adjunctive procedure, by report |

## I. Dental Procedure Codes Payable by Fee-for-Service Only

Table V-23 is a list of the unique dental procedure codes (CDT codes) that were only payable by Fee-for-Service:

Table V-23: Dental Procedure Codes Payable by Fee-for-Service Only

| CDT Code | Service Description |
|---|---|
| D1352 | Preventive resin restoration |
| D3354 | Pulpal regeneration |
| D5992 | Adjust maxillofacial prosthetic appliance |
| D5993 | Maintenance and cleaning of maxillofacial prosthesis |
| D8660 | Reorthodontic TX visit |
| D8999 | Orthodontic procedure |

## J. Dental Procedure Codes Payable by the DMOs Only

Table V-24 is a list of the unique dental procedure codes (CDT codes) that are only payable by Delta Dental, MCNA, and DentaQuest:

Table V-24: Dental Procedure Codes Payable by Delta Dental, MCNA, and DentaQuest Only

| CDT Code | Service Description |
|---|---|
| D8070 | Comprehensive orthodontic treatment of the transitional dentition (1 of D8070, D8080, D8090 per lifetime) |
| D8090 | Comprehensive orthodontic treatment of the adult dentition (1 of D8070, D8080 or D8090 per lifetime) |
| D8691 | Repair of orthodontic appliance - 1 per arch per lifetime |
| D8692 | Replacement of lost or broken retainer - 1 per arch per lifetime |

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