



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

MEMORANDUM

To: Individuals Who Commented on Regulation 2015-132
Requirements for Payments of Dental Services

From: Cynthia Cartier, JD, LLM, Staff Counsel
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Date: January 23, 2024

Re: Responses to Comments on the Proposed Regulation 2015-132

The Department of Social Services (“Department”) provides the following responses to public comments received concerning the proposed regulation referenced above. The Department published the Notice of Intent for this regulation on the Secretary of State’s website and the Department’s website on October 20, 2017. On December 14, 2017, the Department held a public hearing. A copy of the regulation with revisions based on public comments is attached.

The Department received comments from the following organizations: (1) American Dental Hygienists’ Association, Connecticut (ADHA-CT); (2) Association of State and Territorial Dental Directors (ASTDD); (3) Community Health Center, Inc. (CHC); (4) Community Health Center Association of Connecticut (CHCACT); (5) Connecticut Association of School Based Health Centers (CASBHC); (6) Connecticut Coalition Against Domestic Violence (CCADV); (7) Connecticut Institute for Communities, Inc.; (8) Connecticut Oral Health Initiative (COHI); (9) Connecticut State Dental Association (CSDA); (10) Fones School of Dental Hygiene, University of Bridgeport; (11) Fair Haven Community Health Center (FHCHC); (12) Generations Family Health Center; (13) Greater Hartford Legal Aid (GHLA); (14) Hartford Public Schools Dental Program; (15) Health Equity Solutions; (16) New Haven Legal Assistance Association, Inc.; (17) Southwest Community Health Center, Inc.; (17) Staywell Health Center; and (18) City of Stamford, Department of Health and Social Services.

The following schools that utilize the CHCI mobile dental clinic or have a school based health center run by CHCI commented on the regulation: (1) Branford Public Schools; (2) Chamberlain Elementary School; (3) East Haven Public Schools; (4) East Windsor Public Schools; (5) Isaac Interdistrict School for Arts and Communication; (6) Meriden Public Schools; (7) Meriden YMCA Head Start; (8) Middletown High School; (9) Nathan Hale Arts Magnet School; (10) New Britain High School; (11) Smith Elementary School; (12) Thomas Edison Middle School; (13) Pulaski Middle School; and (14) Woodrow Wilson Middle School.

I. General Comments

Comment: Consider combining document as many items overlap such as most definitions, parts of limitation on coverage and services not covered.

Response: The regulations document is organized in the current structure because it follows the same format as other Department of Social Services Regulations. It is arranged to allow for a person who is not familiar with regulations to more readily locate the categories of services that are covered, the limitations of service categories and the services that are not covered under the Connecticut Medical Assistance Program (CMAP) also known as the HUSKY Health Program.

Comment: Add a section describing the Dental Provider Manual, including the general topics and the process to making changes within it. Review areas that will be, both in the regulations and/or Dental Provider, for a repetition of the definition. Could the repetition be deleted?

Response: Upon adoption by the Legislative Regulation Review Committee (LRRC), the approved regulation will replace the existing regulation in Chapter 7 of the Provider Manual. Thus, there is no need to reference or describe the Provider Manual in the regulation.

Comment: Unlike all other categories of services, these proposed regulations essentially include detailed clinical guidelines for when certain dental services would be covered and when they would not be. To the extent the proposed regulations do not allow for any exceptions to these guidelines, they would directly violate C.G.S. § 17b-259b (b), which prohibits the use of such criteria as the basis for decision of any requests for treatment under Medicaid, including dental services. We include in our comments suggested revisions which make clear that services may not be denied on the basis of lack of medical need except as set out in Section 17b-259b (a), with prior authorization available to request approval for any kind of treatment not listed or for any treatment which is specified as being covered only in narrow circumstances.

Response: The Department has incorporated the suggested revisions to make clear that services may not be denied on the basis of lack of medical necessity except as provided in section 17b-259b of the Connecticut General Statutes.

Comment: We are concerned that the level of prescriptiveness may be counter-productive in that it does not account for changing recommendations as medical and dental bodies evolve in their recommendations based on research and additional clinical insight. Although a service not listed or a service limited to very narrow circumstances can and must be allowed to be overridden via prior authorization, having to go through prior authorization necessarily discourages busy dentists from doing those kinds of procedures. While this may be a desirable result for certain services today, the following year or two it may be determined that it actually is wise and cost-effective to encourage the provision of those very services, and yet the formal, hard to change regulations will specify that they cannot be provided except following an onerous prior authorization procedure. Accordingly, we encourage you to consider reducing the level of prescriptiveness with regard to when particular services are covered without the need to resort to prior authorization, so as to more readily accommodate evolving medical and dental practice. If the Department desires to utilize these guidelines as an easy reference for services not currently requiring prior authorization, they can be included in an on-line sub-regulatory provider manual, as in the past.

Response: The Department respectfully disagrees. Because of the current prior authorization and post procedure review requirements, the program has been able to maintain high quality dental services for the members. Additionally, these requirements have prevented a substantial amount of unnecessary dentistry and poorly performed procedures on members who are deserving of quality care.

Comment: Under the proposed regulations, “Any procedure or service which is not listed on the dental fee schedule is not covered unless authorized for members under the age of twenty-one through EPSDT.” Proposed § 17b-262-1012(k). No such exception is allowed for Medicaid enrollees over 21. This would arbitrarily and categorically deny coverage for non-experimental dental items or services not on this list. Similarly, Proposed Section 17b-262-1012, entitled “Services not covered,” purports to exclude any kind of service not listed or any service sought for a condition not meeting listed criteria.

As the Department has recognized in other contexts, the use of an exclusive list for covered services, or of categorical exclusions, is impermissible for dental care or any other category of Medicaid benefit. There must be a readily accessible procedure for requesting and obtaining approval for a non-experimental service not on a list of covered services or items, if medical need is in fact established. The exclusions in the proposed dental regulation are akin to the exclusive list which was rejected by the Centers for Medicare and Medicaid Services (then the Health Care Financing Administration) in September 1998, after DSS attempted to apply an exclusive list to the Medicaid benefit category of durable medical equipment (DME), resulting in a class action against the Department. See *DeSario v. Thomas*, 139 F.3d 80 (2d Cir.1998), vacated sub nom. by *Slekis v. Thomas*, 525 U.S. 1098 (1999). The result of *DeSario* was a settlement whereby DSS agreed to amend its regulations to provide that its list of DME was non-exclusive, with non-listed items available through prior authorization upon establishment of medical need. Just as the DME list was ruled invalid under federal law by CMS then, the use of an exclusive list or categorical exclusions is also impermissible for dental care now.

Apart from the legal requirement barring any categorical coverage exclusions, a prior authorization exception process in fact is already appropriately included in the proposed dental regulations related to any numerical (“frequency”) limitations. See Proposed Section 17b-262-1014(d). The fact that an exception is nevertheless available where there is a medical need for services in excess of these numerical limitations demonstrates the need for an exception process for particular treatments that are excluded entirely, or for when certain criteria are not met.

Response: The Department revised the regulation accordingly.

II. Section 17b-262-1007 Definitions

Comment: The definitions that are CDT codes and are found in the American Dental Association Glossary of Terms should be explicitly stated for purposes of review, but not in these regulations. We recommend that they be moved to the *Dental Provider Manual*. These definitions change regularly, and the process for amending regulations is lengthy and cumbersome. Moving them to the *Manual* will facilitate amending them. Specifically, we recommend:

1. Removal of the terms defined at <http://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms> to the Dental Provider Manual

2. Inserting the following language after the first sentence in this section: “For definitions currently used in oral health care, refer to the American Dental Association Glossary of Terms or other nationally recognized professional resources which may be found in the CT DSS Dental Provider Manual.”
3. In addition, please correct the spelling of “temporomandibular” and “occlusal” throughout the document.

Response: The Department is not moving definitions to the Provider Manual because following adoption by the LRRC, the approved regulation will replace the existing regulation in Chapter 7 of the Provider Manual.

Comment: CODA - Regarding page 2, Section 13 should be revised to read as follows: “CODA” means the Commission on Dental Accreditation.

Response: The Department revised the regulation accordingly.

Comment: Recommended language for Dental Home: “Provide comprehensive care, including but not limited to preventive, restorative, periodontal, endodontic, prosthetic, oral and maxillofacial surgery, and emergency services”

Response: The Department revised the definition of dental home as suggested.

Comment: A definition for Dental Hygienist should be included because not all Hygienists work in a public health facility or capacity

Response: The Department added a definition for dental hygienist.

Comment: Dental Services - This definition does not recognize that dental hygienists work under general supervision of a dentist, except for local anesthesia which is done under indirect supervision. Also, dental hygienists provide services in public health settings as defined in the DH statute without supervision by a dentist.

Response: The Department revised the regulation to include services provided by dental hygienists.

Comment: The definition of Dental Services does not include services provided by licensed dental hygienists who work under general supervision and unsupervised in public health settings.

Response: The Department revised the regulation to include services provided by dental hygienists.

Comment: “Dental Services” should include services provided by a Registered Dental Hygienist (this section does not include Registered Dental Hygienists but in other sections in the Regulations, it appears to presume that Hygienists are included.)

Response: The Department revised the regulation to include services provided by dental hygienists.

Comment: Dental assistants, including EFDA, work under direct and indirect supervision. The sentence “The licensed dentist assumes the primary responsibility for all dental procedures performed under the direct or indirect supervision” can be deleted, because it is defined in Chapter 379, Sec. 20-123.

Response: The Department revised the regulation accordingly.

Comment: Recommended substitute language for this definition: “Dental services” means any service provided by a licensed dental provider or under the direct or indirect supervision of a licensed dentist as defined in Chapter 379, Sec. 20-123.

If “licensed dental provider” needs to be defined, we recommend: “Licensed dental provider means a person holding a Connecticut dental or dental hygienist license as found in Sections 20-123 and Sec. 20-126l.”

Response: The Department revised the regulation by adding services provided by dental hygienists and adding a definition of “dental hygienist.”

Comment: Emergency – a new definition for emergency should be included. Emergency condition means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate dental attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, causing serious impairment to body functions or causing serious dysfunction of any body organ or part. Recommended inserting a new definition for emergency conditions, as defined in 17b-282c.

Response: The Department revised the regulation accordingly.

Comment: Medical Necessity - “Medical necessity” or “medically necessary.” The definition of medical necessity as defined in Sec. 17b-282-1007 is limited. Recommend defining Medical Necessity with the dental aspect added to 17b-259b. Further definition should be added to Sec.17b-259b to include oral disease, and that the services be (1) Consistent with generally-accepted standards of dental practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed dental literature that is generally recognized by the relevant dental community, (B) recommendations of a dental-specialty society, (C) the views of dentists practicing in relevant clinical areas, or (D) any other relevant factors. The term “medical” is not regularly used to include dental.

Response: The current definition appropriately references the definition in § 17b-259b. It is not necessary to add dental to the statute.

Comment: “Mobile dental clinic” Dental services in mobile clinics offer more than only preventive-based or restorative services. We therefore recommend omitting the clause “preventive-based or restorative dental services.”

Response: The Department revised the definition of “mobile dental clinic” to have the same meaning as provided in § 17b-282f of the Connecticut General Statutes.

Comment: Regarding page 4, Section 50 add the sentence: “A Pediatric dentist can be considered a primary care dentist for infants and children through adolescence” at the end of the paragraph.

Response: The Department revised the regulation accordingly.

Comment: We recommend substituting this ADA Glossary of Terms language: “Prophylaxis” means the removal of calculus, plaque, and stains from the tooth structures. It is intended to

control local irritational factors.” Polishing of the teeth should be deleted as it is no longer considered a best practice because it removes the most fluoridated layer of enamel along with healthy biofilm. Delete “including toothbrush and flossing instructions” because depending on the person’s oral conditions, abilities and other factors, he or she may require other daily hygiene practices. An appropriate replacement would be “oral hygiene instruction based on the individual’s needs and capabilities.”

Response: The Department revised the definition of prophylaxis accordingly. The change from “toothbrush and flossing instructions” will be changed to reflect oral hygiene instruction. The change will be made to “oral hygiene instruction based on the individual’s needs and capabilities” as suggested.

Comment: Polishing of teeth should be removed from the definition of prophylaxis as it is not the standard of care for every patient.

Response: The Department revised the regulation accordingly.

Comment: Post Procedure Review—this should include those procedures which can be done on an emergency or urgent basis and the Regulations allow submission of the prior authorization after the fact (this is in the current practice).

Response: The Department revised the regulation accordingly.

Comment: School-Based Health Center is not defined in the regulation.

Response: The Department revised the regulation by adding a definition of school-based health center.

Comment: “Screening evaluation” is defined in this section as performed by medical professionals and dental providers. We recommend that this section should be redefined into separate lines as the risk assessment conducted by dental hygienists in public health settings, is much different for than the screening in medical practices.

Response: The Department revised the regulation to provide that screening evaluations are performed by different types of health care professionals, including dental hygienists.

Comment: Regarding page 4, Section 60 should be revised to read: “Specialist” means a dentist who has taken and passed the required practicum for dental licensure and received and successfully completed post graduate training program accredited by the Commission on Dental Accreditation. . .

Response: The Department revised the regulation accordingly.

Comment: “Specialist” can be moved to the *Dental Provider Manual*, which would simplify these regulations. Specialists should be defined by the State in Sec. 20-106a. Additionally, Registered Dental Hygienists, though they may specialize in the preventive care portion of dental care, are not considered “Specialists. “Recommended language: “Specialists are those with a specialty license as defined by the State in Sec. 20-106a. Designation of limited practice. No licensed and registered dentist shall designate in any manner that he has limited his practice

to one of the specialty areas of dentistry expressly approved by the American Dental Association unless such dentist has completed two years of advanced or postgraduate education in the area of such specialty and has notified the Dental Commission of such limitation of practice. Nothing contained herein shall prohibit any licensed and registered dentist who has limited his practice prior to May 8, 1975, from continuing to designate such limitation.”

Response: Upon approval by the LRRC, these regulations will replace the current regulations in Chapter 7 of the policy manual. The current definition is consistent with section 20-106a of the Connecticut General Statutes and therefore, no changes are necessary.

Comment: Regarding page 5, Section 61 definitions should be revised to read as follows: “Specialty practice” means a practice that holds itself out as a specialty practice or offers selective dental services concurrent with a dental specialty or an Interest Area in General Dentistry recognized by the American Dental Association. The dentist must have obtained a degree and/or certificate in the specialty or interest area from a CODA accredited training program. The practice will provide the services that are deemed to require advanced knowledge and skills that are essential to maintain or restore oral health. This includes anesthesiology, endodontics, oral surgery, orthodontic, pediatric, periodontic or prosthodontic services.

Response: The Department revised the regulation accordingly.

Comment: Teeth - Repeating “teeth” as a definition of “Teeth” is redundant. Replace the first line with: (62) “Teeth” are described using the Universal/National Numbering System and can be found in the *Dental Provider Manual*. Move the list to the *Dental Provider Manual*.

Response: The Department revised the regulation accordingly. The definition will remain in the regulation. As already noted, upon adoption by the LRRC the regulation will replace the existing regulation in Chapter 7 of the Provider Manual.

Comment: Tooth Surfaces - Repeating “tooth surfaces” as a definition of “Tooth surfaces” is redundant. Replace the first line with: (63) “Tooth surfaces” are described in the American Dental Association Glossary of Terms and can be found in the *Dental Provider Manual*. Move the list to the *Dental Provider Manual*.

Response: The Department revised the regulation accordingly. The definition will remain in the regulation. As already noted, upon adoption by the LRRC, the regulation will replace the existing regulation in Chapter 7 of the Provider Manual.

III. Sec. 17b-262-1008 Provider Participation

Comment: Emergency care- We already have a difficult time getting providers. Emergency call is one thing, but to ask Dentists to physically come in after hours will be detrimental our program. Keeping in mind that this would involve a Dentist/Assistant/Mgr. or front desk to register the patient to be seen.

Response: The definition of a Dental Home includes the availability of a dentist for their patient in the event that an emergency arises; a dentist can at least be available to assess the situation and

decide whether the condition is emergent or urgent and can advise the member on appropriate steps to take until the member can be seen.

Comment: The regulation does not state how to obtain info on a patient's dental home. It states to review the patient's service history. Our hope is there will be some kind of indicator on the CTDHP website to identify the "Dental Home," as we will have to consult with this dentist of record before performing ANY treatment on one of their members. We will have to obtain written consent for any of these services provided "in lieu" care provided at their "dental home." Would this requirement have any negative impact on Medicaid-covered children who live in rural parts of CT?

Response: There has been an indicator on the member's profile page for several years indicating the last place where dental services were obtained; the place of service is included for each dental service paid by the CT Medical Assistance Program (CMAP). The performing provider is the entity that needs to have the consent and access is adequate in rural areas.

A. Requirement for Contracts

Comment: Section 17b-262-1008 (D) (1) provides: Mobile dental clinics and school-based health centers shall: Have or contract with a dental home office of a fixed location where a Connecticut Medicaid enrolled licensed dentist maintains the diagnostic imaging, diagnostic tests and charts of treated patients and accepts and treats patients from the mobile dental clinic or school-based health center as a patient of record.

ASTDD is unsure as to the rationale for requiring mobile dental clinics and school-based health centers to have or contract with a dental home office of a fixed location. A school-based health center with a dentist shouldn't have to have a contract with another dental location. If the mobile or school-based program does not have a dentist on site, why should they be required to have more than the current statute requires, which is a collaborative agreement with a dentist and to have a referral system. The new proposed language is creating a regulation that goes beyond the statute.

Response: The Department removed the requirement for a contract between a SBHC and a fixed location from the regulation. With respect to the requirement for a contract between a mobile clinic and fixed location please see section (a) of section 17b-282f of the Connecticut General Statutes.

Comment: It looks like the regulations may require specialty offices to contract with us, as we would be considered the "dental home." What is the proposed verbiage of said contract, and will they provide guidance on these agreements?

Response: The regulation does not require a contract between the dental home and specialty offices.

B. Coordination of Care

Comment: 17b-262-1008 (D) (5) Review each member's service history before rendering treatment. If the member has a dental home, the mobile clinic or school-based health center shall consult with the dentist of record before performing any treatment to the members;

If a parent or guardian has signed a permission slip authorizing treatment, why should the mobile or school-based health center be required to consult with the dentist of record? It appears this language is intended to protect the interests of the dentist rather than the interests of the client.

Response: The Department respectfully disagrees. If the member has a dental home, the mobile clinic or SBHC shall consult with the dental home before performing treatment.

Comment: Section (d) (4) proposes: "Review each member's service history before rendering treatment. If the member has a dental home, the mobile clinic or school-based health center shall consult with the dentist of record before performing any treatment to members." Information regarding School Based Health Center services, including on-site dental services is distributed annually to all students enrolled in the particular school. Information requesting verification of the presence of a dental medical home is requested via the SBHC Enrollment Form. If a community-based dental provider is noted, the child's parent/guardian is contacted by the SBHC to determine the date of last visit to ensure that services are not duplicated but are a compliment to a dental home.

While a community-based dental provider may be noted on the enrollment form, it is a reality that the majority of children seen in the SBHC has not received dental care at all or minimally and is experiencing severe dental decay which leads them to the SBHC. Barriers including concerns about documentation status, lack of dental coverage, and/or complacency on the part of the parent/guardian regarding the importance of dental care, all impacting access to quality, timely dental care.

Response: The Department respectfully disagrees. If the member has a dental home, the mobile clinic or SBHC shall consult with the dental home before performing treatment.

Comment: Most of our students do not have a dental home. Few may have seen a dentist at some points in their life for an isolated visit, but most do not have a dentist they see routinely. Most have only had preventive care at the school's clinic. Consulting another dentist that may have only seen the patient for emergency treatment would once again block access to care.

Response: The Department respectfully disagrees. If the member has a dental home, the mobile clinic or SBHC shall consult with the dental home before performing treatment.

Comment: Section 17b-262-1008 (d)(4) puts forth the proposed requirement that a provider "Review each member's service history before rendering treatment. If the member has a dental home, the mobile clinic or school-based health center shall consult with the dentist of record before performing any treatment to members."

To the extent possible and practicable, the mobile dental program or school-based health center already confers with the dental home, but it is ultimately the parent's decision where the child receives services. Upon enrollment for services, the mobile dental program or school-based health center obtains the name and phone number of the child's dental home prior to provision of services. Coordination with the dental home, if one exists for the child, ensures that services are not duplicated by are a complement to the dental home. For a significant number of children, a dental home has not been obtained by the parent or guardian, and the mobile program or school-based health center provides information to families to assist the child in obtaining a dental home. The mobile dental program or school-based health center increases access to care and is often the only source of primary care for the child.

Recommended Language: Review each member's service history before rendering treatment, if available. If the member has a dental home, the mobile clinic or school-based health center [shall] may consult with the dentist of record before performing any treatment to members.

Response: The regulation shall remain as written because it is imperative that if the member has a dental home, the mobile clinic or SBHC consult with the dental home before performing treatment.

Comment: Section 17b-262-1008(d)(4): “Review each member’s service history before rendering treatment. If the member has a dental home, the mobile clinic or school based health center shall consult with the dentist of record before performing any treatments to the members.” Unless the mobile dental clinic or the SBHC has a shared dental record with the dental home, then potentially time-consuming efforts to contact the dental home provider will be necessary. This outreach will actually slow down the provision of care, both on the part of the mobile dental clinic or the SBHC and the dental home.

Response: The Department respectfully disagrees. If the member has a dental home, the mobile clinic or SBHC shall consult with the dental home before performing treatment.

C. Permission Slips

Comment: Subsection (d)(5)(A) re permission slips provides: “shall clearly state that services being offered are in lieu of care provided at member’s dental home” – this statement should not be required unless the SBHC is not affiliated with a public health facility like a community health center where the community health center is considered the student’s dental home.

Response: The Department agrees. The Department revised the regulation to state that services are provided in coordination of care with the member’s dental home.

Comment: Part (A) proposes: “All permission slips shall clearly state that the services being offered are in lieu of care provided at the member’s dental home”. The SBHC dental providers may coordinate with a child’s dental home, not to duplicate services, but to compliment care and/or serve as a referral source. The following substitute language is recommended: change “in lieu of care provided” to “in coordination of care with the member’s dental home”.

Response: The Department revised the regulation accordingly.

Comment: Regarding page 7, Section 17b-262-1008 (d) (7) (B) and (C): We encourage further review of requirements of permission slips in regards to these two sections, to ensure that the requirements are not too restrictive for implementation within School Based Health Centers. The language places unnecessary barriers to the operation of mobile and school-based health centers, which are widely viewed as an efficient, cost-effective model to reach children and families, particularly for preventive services targeting schools with a high percentage of children at high risk for dental disease. Based on recommendations and reviews by a panel of experts supporting the Task Force on Community Preventive Services, the Guide to Community Preventive Services (The Community Guide) strongly recommends school-based and school-linked dental sealant delivery programs for preventing or reducing occlusal caries on posterior teeth of children. Regulations for mobile and school-based program services should be based on sound public health approaches and some of the proposed language does not appear to meet that criteria.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Section 17b-262-1008 (D) (5) (C) provides: “The permission slip shall clearly state each procedure that will be performed including tooth number if applicable.” This places a significant barrier to the efficient and effective operation of mobile and school-based programs. For example, a school-based dental sealant program would have to get a signed permission slip to do a screening and then get another signed permission slip that specifies exactly which teeth they intend to seal before they proceed with placing sealants. This means that at the very least the program would have to see a child a minimum of two times, simply to place preventive dental sealants. This also means that if a child has multiple visits for restorative, dental sealants, retention checks, etc. that there would need to be a permission slip signed for each visit. This provides a significant barrier to programs and to families that benefit from the program’s services.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Comment: Sec. 17b-262-1008(d)(5): Changing the school-based model of obtaining a consent form that covers the child for the duration of the school year (or even longer), to one that requires specific permission forms for each service will require intensive staff resources and, ultimately, restrict access to needed dental care. Unfortunately, children often lose permission slips; other times, families simply don’t return them, for a variety of reasons. CHCACT recommends the use of a consent form that covers the scope of services that may be provided for children in the school-based health center, including opt-out provisions for certain types of services and/or specific teeth.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Comment: Part C proposes “The permission slip shall clearly state each procedure that will be performed including tooth number if applicable. Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian.” It would be impossible to list the specific and/or exact services to be provided on the permission form until the provider does a complete oral health assessment, create a paperwork log jam, and likely result in delay scheduling students for dental care services. Once the initial visit is completed, written notification is sent home to the parent/guardian listing the services that were provided, and if restorative services are needed, the parent is notified of the findings with a recommendation that the restorative service should be provided by the dental home or community dentist -- or in cases where the mobile program or school based health center provides restorative services on site -- the parent is notified of the appointment date and time when the restorative service will be performed to the extent possible.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Comment: Section 17b-262-1008(d)(S)(C) states, "The permission slip shall clearly state each procedure that will be performed including tooth number if applicable. Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian."

The permission form can list the services that are typically provided at the first visit, but until the visit is completed, the full extent of services needed is not yet known. The permission forms generally list the services that would be provided at the initial hygiene visit: screening, prophylaxis, radiographs, fluoride treatment if needed, and sealants if needed. Until the initial visit is conducted, and an assessment of needs is made, it would be virtually impossible to ascertain written permission for a specific service that has not yet been provided. Once the initial visit is completed, written notification is sent home to the parent/guardian listing the services that were provided, and if restorative services are needed, the parent is notified of the findings with a recommendation that the restorative service should be provided by the dental home or community dentists- or in cases where the mobile program or school based health center provides restorative services on site- the parent is notified of the appointment date and time when the restorative service will be performed to the extent possible.

Recommended Language: The permission slip, or prior enrollment form, shall clearly state [each procedure that will be performed including tooth number if applicable] the services provided at the initial hygiene visit including screening, prophylaxis, radiographs, fluoride treatment if needed and sealants if needed. [Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian.]

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Comment: The regulations proposing that you must obtain a signed parental permission slip before "every visit", including specific treatment and tooth number, vs permission to treat, severely limits the ability of the DDS on site or public health RDH on site in these dental programs, to provide all preventative services, including sealants that would benefit the child, and necessary restorative care. In school-based settings, obtaining parental permission slips, having the child take the slip home, parent sign the slip, and return the slip is presently challenging at best and once slips are misplaced the child cannot receive timely care. It is hard enough at the present time to get these signed parental permission slips returned to the clinic even if services are at no cost to the child. Requiring multiple permission slips for each "specific tooth" and "treatment visits" would even more so limit the care for the children who need it most. Dental needs that are not treated in a timely manner, increase the cost of care and risk of infection, abscess and pain to the child.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Comment: The requirement that all SBHC dental visits must be preceded by parental consent for the specific procedure (including identification of affected tooth) will bring the SBHC oral health program to a grinding halt. Currently, FHCHC runs a robust school based oral health program in New Haven. We employ a full-time dental hygienist and a full-time dental coordinator/educator dedicated solely to school-based programs. Typically, students are screened on-site, if dental hygiene is warranted it is then provided either via portable or mobile equipment. Students requiring treatment by a dentist then receive this care through our Smiles 2 Go dental van which

is equipped with two full dental operatories. Over the last school year, over 1000 visits were provided to students who otherwise might not have received the needed dental care. Our full-time dental coordinator spends the majority of his time educating parents about the importance of oral health and then obtaining parental permission to provide care over the course of the school year. This is an extremely time-consuming process and if the requirement is changed to a permission for every visit, it will not be possible to comply. The only option will be terminating the program with resultant impairment to care for so many children.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out. The Department also revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Subsections (d)(5)(B) and (C) provide that “the permission slip shall be valid for one date of service which shall be specified on the permission slip; and “the permission slip shall clearly state each procedure that will be performed including the tooth...”

This requirement is not practical for SBHCs because of the goals of SBHCs and it will be cumbersome for the SBHC’s from an administrative standpoint. Southwest provides dental services at six SBHCs and the attractiveness for the parents is that they can complete their enrollment application, which includes a dental consent form, and it covers the preventive and basic restorative work. For invasive procedures, parents must sign an informed consent that is specific to the date, the patient, the procedure, etc. The goal of SBHCs is to increase access to medical and dental services for children who might otherwise not be able to access these services because parents may not be able to afford them, they may not be able to take time off during school hours to take them to providers, or they don’t perceive that the services are important to the overall health of their children. While SBHC’s provide a non-traditional setting for service delivery, the ultimate benefactors are the children. The proposed requirements would place an undue burden on the SBHC staff to have to obtain multiple permission slips from parents who are already busy and over-extended.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out. The Department has also revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Part B proposes “The permission slip shall be valid for one date of service which shall be specified on the permission slip.”

Part C proposes “The permission slip shall clearly state each procedure that will be performed including tooth number if applicable. Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian.” Adopting these proposals will: Create a significant barrier to care for children; Deny students their right to convenient access to care (convenient access to care means eliminating transportation barriers, language barriers, health insurance barriers, inability for parents/caretakers to leave work to take students to outside appointments); Create discrimination against our most underserved and vulnerable populations; Force students to miss precious learning time for outside appointments (if they are able to go to outside appointments); Increase frequency of emergency room visits; Increase chronic absenteeism due to pain/illness resulting from lack of care; Decrease student success outcomes. Student cannot

effectively learn when they are in pain; and Make it impossible to continue to provide school-based dental services in Hartford.

We urge DSS to seriously consider the negative effects these proposals will have. Our children deserve the right to the easily accessible, quality dental care that Hartford Public Schools currently provide.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out. The Department has also revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: In the specific, proposed legislative document, section 17b-262-1008 outlines several proposals that will hinder clinical efficiency with an increase in administrative burden. Namely, this includes proposals to require specific consent at each visit, requirement to provide procedure-specific data, as well as, extending school-based screening allowances from 6-month intervals to annum.

Response: The Department revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out. The Department has also revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Requiring a new permission slip for every visit for every child will break down the current level of continuity of dental care and treatment completion. It is not reasonable or possible to obtain a permission slip for every single visit.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Part (B) proposes: “The permission slip shall be valid for one date of service which shall be specified on the permission slip.” This proposed process will create a paperwork nightmare which will drive staff to spend more time on collecting paperwork than providing actual dental services, ultimately delaying and/or possibly prohibiting access to care. The majority of children receiving dental services in the SBHC setting have severe decay requiring several visits and obtaining parental permission for even one SBHC dental visit can take weeks if not months. Having to get a sign permission form for every single visit will likely result in backlog in scheduling resulting in delayed care or no care. A patient in a community medical practice or dental practice is not required to complete a new permission slip every time they receive services, similarly it should not be required in a mobile or school-based health center dental program.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: If a new permission slip was to be sent for each treatment: There is a time delay in returning permission slips and our providers send out multiple permission forms when one is not returned; Many of our children would not get the care they need; and Sending out multiple permissions would confuse many parents. We in the Hartford Public Schools dental program take the acquisition of dental consent very seriously. The time spent attempting to reach

parents/guardians is well known to all that work in the Hartford Public Schools. It is not an exaggeration to state that requiring a consent form for each dental procedure would immediately prevent our hygienists and dentists from providing ANY care.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: The HPS Dental Program is The Dental Home for the children signed up to receive dental treatment, and only those with a signed permission receive care. It is often difficult to obtain one parental consent let alone a permission form for each procedure, and some of the neediest children are the ones for whom we have the most difficulty in obtaining a permission. To obtain a permission for each individual procedure is unrealistic. In Hartford, as in most other SB programs, the Hygienist is also responsible to send home and process all permission forms in addition to checking and confirming all health histories, parent signatures, and patient eligibility, and rendering care along with the dentists. These new proposed regulations would severely inhibit, if not totally prevent our ability to care for the hundreds of HPS students that we currently provide services for. Because parents are not accompanying their children to appointments as in a Private Practice setting, and there is no front desk person to handle all forms and insurance paperwork as you would have in a private practice, the ability to continually turn around forms that require signatures for each procedure for each patient every day is not possible.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: The potential impact of requiring a new signed permission from parents for every appointment would have a serious detrimental effect on our program, a program that has served thousands of students over the course of its long successful history. The time and effort involved in constantly securing new consent forms would significantly reduce the amount of time we, as dental hygienists, would spend in the clinic delivering the necessary dental care to the students. We no longer have dental clerks to assist us with paperwork as the reduced reimbursements and change of paid procedures from HUSKY resulted in layoffs this past school year. Just this year, a dental hygienist position was also eliminated due to a decrease in school enrollments. Our mobile dental vehicle, the Molar Express, has also been sidelined due to lower school enrollment and budgetary concerns. We work with CTDHP to confirm dental treatment on our children and DCF to ensure the extended care is sought when we are unable to fully complete complicated treatment on some children. These are our students, the children of Hartford, who deserve the quality dental treatment and health care that we have been providing for decades. Please do not penalize these children.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: The proposed DSS regulation that would require permission slips to be signed for each dental visit would make it extremely difficult for our dental clinic to continue servicing students. This would serve as a barrier to families, parents, students, and our dental staff. I am fearful that this proposed regulation, if enacted, could even make it impossible for our dental clinic to continue operating.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Please rethink changing the permission slip validity to every visit. We would be increasing that large barrier and diminishing care for these children who are in desperate need.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: The proposed regulations requiring consent for each service performed would essentially prevent our program from providing service to the hundreds of Hartford Public Schools students that we presently care for, and to whom we provide a dental home.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Requiring a signed parental permission prior to each visit would likely cause the demise of our program. Parents are not good at returning forms and we have many walk-ins with emergencies which could not be treated until a signed form is back. In general children who are referred out are not usually taken for care so if our program collapses this will mean a large population that will likely suffer from neglect of dental treatment. At present if we are to perform procedures beyond simple restorations, we try to call the parents to inform them of our intentions. More often than not we cannot get in touch, so a note is sent home, we never get a written response. I think this proposed approach is unfeasible and will result in many children with untreated dental caries.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: It is not reasonable or possible to obtain a permission slip for every single visit. Every mobile dental program or school-based health center utilizes an enrollment form/written parental permission slip before any child is seen for dental services. In the vast majority of cases, the enrollment form is sent home with the student, completed and signed by the parent or guardian, and brought back to school by the student. In other cases, the form is mailed home to the parent. Once the form is completed and returned, the child may receive services. Obtaining signed permission forms is a very time-consuming task and often requires several phone calls and written reminders. A patient in a community medical practice or dental practice would not be required to complete a new permission slip every time they receive services, similarly it should not be required in a mobile or school-based health center dental program. Doing so would essentially close the program because parents may not be able, or willing, to complete a new form each time their child is to be seen. This proposal is excessive and would essentially create a barrier to accessing care.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Sec. 17b-262-1008(d): Changing the school-based model of obtaining a consent form that covers the child for the duration of the school year will, single handedly, destroy or severely hinder the programs that are currently providing extremely important care to children that otherwise, may not receive any care. It is imperative that these children receive services, and this

proposed single visit consent form will prevent children from accessing care due to the difficulty of obtaining the consent forms. As an administrator in a dental clinic that has a school-based program, I can say that obtaining even the initial consent form from the child's parent or legal guardian is difficult. School based health centers cannot be expected to send and receive consent forms for each date of service. A consent form that covers the scope of services that may be provided for children in the SBHC is efficient and each child receives a detailed take home report for the parents or legal guardian to review what services were completed for that visit.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Our program is severely challenged with obtaining an original signed consent form by parents/guardians solely to provide dental services on a regular basis. Having to receive a signed form for EVERY VISIT within our high-risk population will have detrimental consequences on the school dental program, possibly forcing it out of existence. For most of our school children this is the only dental care they receive.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: If just the proposed regulation of requiring a separate permission form for every dental visit were to pass, we would be forced to shut down immediately, given the enormous efforts it takes to get any permission forms returned in a timely way. On average, it takes 4 targeted attempts to get a returned permission form, if we get them.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Requiring permission slips for each procedure is not workable and will result in the majority of time spent getting permissions rather the providing services. A permission slip that is valid for the entire school year is critical.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Requiring CHCs to have permission for each service that is provided including date and tooth number is difficult.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: To have to get a new permission slip and to have it be good for 1 day the parent would sign and the date would be past by the time it came to school and the hygienist was able to process.

Response: The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit.

Comment: Section 17b-262-1008(d)(5)(A): "All permission slips shall clearly state that the services are being offered in lieu of care provided at the member's dental home."

Section 17b-262-1008(d)(5)(B): “The permission slip shall be valid for one date of service which shall be specified on the permission slip.”

Section 17b-262-1008(d)(5)(C): “The permission slip shall clearly state each procedure that will be performed including tooth number if applicable. Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian.”

The subsections would place new administrative burdens on mobile dental and SBHC clinicians. These requirements differ materially in comparison to any existing requirements for SBHC clinicians who provide pediatric health services. In addition, the requirement for outreach to a child’s parent or guardian on a per-visit basis differs materially from current requirements for consent for pediatric health services in SBHCs. Such outreach would be time-consuming and could result in deferral of care, in the event that the parent or guardian could not be reached.

Response: In subsection (d)(5)(A): The Department changed “in lieu of care provided” to “in coordination of care with the member’s dental home.” The Department revised the regulation to allow for permission slips to be valid for one year rather than require a permission slip for each visit. The Department also revised the regulation to remove the requirement of a permission slip for each procedure. Instead, the revised regulation requires that the permission slip list procedures that may be provided at the clinic and allow for the parents to opt out.

Numerous comments with respect to requiring a permission slip for every visit and the requirement to list each procedure and tooth number were received from the CHCI mobile dental clinics and school-based health centers. Rather than restate each comment from each mobile dental clinic and SBHC, the Department confirms that the comments have been addressed above through the above responses.

D. Patient Records

Comment: Regarding page 7, Section 17b-262-1008 (d) (7) (E) (“All patient records shall be placed in the primary care dentist or dental home office within five business days of providing dental services in the mobile dental clinic.”) in regard to transmission of patient records: we encourage further review of this item to ensure that the requirements are not too restrictive for implementation by School Based Health Centers.

Response: The Department revised the regulation to provide that SBHCs shall provide records to the individual requesting the records within 5 days of the request. Thus, there is no longer a requirement for the SBHC to share the records with the dental home unless requested.

Comment: SBHC dental providers utilize electronic medical/dental record keeping systems to clearly detail and document results of findings and services to be performed as part of the patient’s dental record, for referral purposes and as documentation for billing. This information is available to the child’s parent/guardian upon request. SBHC providers, including those providing dental services, work closely with a child’s parent/guardian to assure an understanding of their child’s condition and treatment regimen to assure compliance to care and complete patient satisfaction. This includes timely communication regarding the specific medical, behavioral or dental condition and specific action to be taken.

Response: The Department revised the regulation to provide that SBHCs shall provide records to the individual requesting the records within 5 days of the request. Thus, there is no longer a requirement for the SBHC to share the records with the dental home unless requested.

Comment: Language is confusing, as mobile programs are often administered by an organization which contracts with dentists to provide treatment in a home office. The dentist does not personally maintain the records. Unless the mobile dental clinic or the SBHC has a shared dental record with the dental home, then potentially time-consuming efforts to contact the dental home provider will be necessary. This outreach will slow down the provision of care, both on the part of the mobile dental clinic or the SBHC and the dental home.

Response: It is essential that the dental home receive information regarding the potential negative findings found in a screening assessment performed by the mobile or school-based health center. The current data shows that the number of dental visits through claims submission has shifted from a restorative modality to a preventive modality. In September 2016, the Connecticut Dental Health Partnership (CTDHP) launched a screening program where members who are screened through a mobile or school-based program are rated by the severity of their dental condition using the D0601, D0602 and D0603 procedure codes. The majority of children's claims are submitted using the D0601 or low risk for decay code.

These results are also demonstrated with the yearly Centers for Medicare and Medicaid Services (CMS) 416 report which shows that children receive more preventive services than restorative services.

(<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>).

Since many of the mobile dental clinics do not provide comprehensive care, the Department believes that the mobile clinic should work to coordinate care with the member's dental home to ensure members with dental disease get evaluated and treated for disease in accordance with the Early, Periodic Diagnoses and Treatment (EPSDT) provisions of the Social Security Act. With the advent of electronic health records, it should not prove to be more cumbersome to provide the dental home with the results of the assessment. Protocols should be in place with any facility providing health care services to ensure that all aspects of the Healthcare Insurance portability and Accountability Act (HIPAA) are maintained. The Department revised the regulation to reflect that the patient records shall be placed in or available electronically to the fixed location not more than five days from the date on which services were provided.

Comment: "All patient records shall be placed in the primary care dentist or dental home office within five business days of providing dental services in the mobile clinic." Recommendation: CHCI uses electronic health records for all patients. When a mobile dental patient is not a patient of record of CHCI, the mobile dental clinic makes every effort to establish a dental home for the patient, either at the fixed dental location or with a community dentist. In order for a mobile dental clinic to provide a community primary care dentist or dental home office with patient records, the patient's parent/guardian must complete a Release of Information for every visit. Due to the difficulty of obtaining this from the parent/guardian, it may not be possible to send patient records to the community primary care dentist or dental home office within five days. In addition, requiring that all patient records be sent to a primary care dentist or dental home office increases the risk of HIPAA violations due to the volume and frequency of information being sent electronically.

Response: Since many of the mobile dental programs do not provide comprehensive care, the Department believes that the mobile dental clinic should work to coordinate care with the

member's dental home to ensure members with dental disease get evaluated and treated for disease in accordance with the Early, Periodic Diagnoses and Treatment (EPSDT) provisions of the Social Security Act. With the advent of electronic health records, it should not prove to be more cumbersome to provide the dental home with the results of the assessment. Protocols should be in place with any facility providing health care services to ensure that all aspects of the Healthcare Insurance portability and Accountability Act (HIPAA) are maintained for all people receiving treatment regardless of whether the patient is a Medicaid beneficiary.

The Department revised the regulation to reflect that the patient records shall be placed in or available electronically to the fixed location not more than five days from the date on which services were provided.

CHCI mobile dental clinics and SBHCs affiliated with CHCI made similar comments to the above.

Comment: Section 17b-262-1008(7)(E): “All patient records shall be placed in the primary care dentist or dental home office within five business days of providing dental services in the mobile dental clinic.” This proposed requirement would require the mobile dental clinic, but not a SBHC provider, to obtain the consent of the parent or guardian prior to the release of any clinical record. The timeframe that has been proposed differs from materially (i.e., is much more compressed in time) from the requirement for release of records as required by 45 CFR Section 164.524 (*Access of information to protected health information*).

Response: Section 17b-282f of the Connecticut General Statutes requires the fixed location that contracts with a mobile clinic to maintain the records; accordingly, the Department revised the regulation to reflect that the patient records shall be placed in or available electronically to the fixed location not more than five days from the date on which services were provided.

Comment: Section 17b-262-1008 (d)(1). Language is misleading, as mobile programs are often administered by an organization which contracts with dentists to provide treatment in a home office. The dentist does not personally maintain the records. Recommend to change the language to reflect current practice.

Response: Section 17b-282f of the Connecticut General Statutes requires the fixed location that contracts with a mobile clinic to maintain the records; accordingly, the Department revised the regulation to reflect that the patient records shall be placed in or available electronically to the fixed location not more than five days from the date on which services were provided.

Comment: The requirement that records be forwarded to a dental home would be an administrative burden and does not acknowledge that for many children the public health setting is the dental home.

Response: For mobile clinics, the regulation has been revised to be consistent with requirement in 17b-282f that the fixed location with which the mobile clinic is associated maintain the records. The Department revised the regulation to state that the records shall be placed in or available electronically to the fixed location not more than five days from the date on which services are provided.

E. Geographical Access

Comment: 17b-262-1008 (D) (3) limits submitting claims for services provided within a geographic area that is no greater than 15 miles of the mobile clinic's fixed dental location or the school-based health center;

This language is extremely concerning. ASTDD is aware of numerous mobile and school-based programs that travel hundreds of miles to serve children and families in rural locations. And even within urban and suburban communities, transportation issues can be a significant barrier to accessing services. There is no rational reason to limit the distance that mobile programs can travel or that school-based programs can serve.

Response: For mobile clinics, the Department revised this section to be consistent with requirements in section 17b-282f (b) of the Connecticut General Statutes. The Department removed the distance requirements for SBHCs.

Comment: Section 17b-262-1008(d)(3) limits mobile dental clinics and school-based health centers to submitting claims for services performed "within a geographic area that is no greater than 15 miles of the mobile clinic's fixed dental location or the school-based health center."

We acknowledge the importance of making sure that mobile dental clinics and school-based health centers have proximity to its fixed location and where all the diagnostic imaging, diagnostic testing and charts of treated patients can be maintained. However, we would recommend that the geographic restriction be expanded from 15 to 20 miles. This expansion would be consistent with the twenty-mile radius required of dental homes to the patient base (see Sec. 17b-262-1008{b)(2)), and ultimately allow for more children to receive dental care.

Recommended Language: (3) Be limited to submitting claims for service provided within a geographic area that is no greater than [15] 20 miles of the mobile clinic's fixed dental location or the school-based health center.

Response: For mobile dental clinics, the Department revised the regulation to be consistent with the distance requirements in section 17b-282f (b) of the Connecticut General Statutes. The Department removed the distance requirements for SBHCs.

Comment: The regulation requires the mobile clinic's fixed location to be within a 20-mile radius. How is "fixed dental location" defined? For Generations, the dental van license is based out of our Willimantic address, but the van shares patients with the Putnam site and circulates in the northeast corner. Does this mean that pts that live 20 miles and further from our said "fixed locations" should be seen at another practice close to their place of residence? If yes, how do we control that?

Response: "Fixed location" is defined in 17b-282f of the Connecticut General Statutes and the regulation references that definition. Per section 17b-282f (b), a mobile clinic located in Windham County may submit claims for services that occurred not more than 50 miles from the fixed dental location.

Comment: The regulation limits providers to submitting claims for services provided within a geographic area that is no greater than 15 miles of the mobile clinic's fixed dental location or the school-based health center.

Response: Per subsection (b) of section 17b-282f of the Connecticut General Statutes, a mobile dental clinic may submit claims for Medicaid reimbursement to the Department of Social Services for dental treatment of Medicaid beneficiaries that occurred not more than thirty miles from the associated dentist's fixed location, except that a mobile dental clinic located in the counties of New London, Litchfield and Windham may submit claims for Medicaid reimbursement to the Department of Social Services for dental treatment of Medicaid beneficiaries that occurred not more than fifty miles from the dentist's fixed location. The Department revised the regulation to be consistent with section 17b-282f (b).

Comment: The regulation provides that the mobile clinic "is close to the patient's home and have regularly scheduled appointment hours available weekly including the summer months" We feel DSS needs to define "close to the patient's home", in our catchment area.

Response: The Department revised the regulation to be consistent with the distance requirements in section 17b-282f (b) of the Connecticut General Statutes. Per 17b-282f (b), a mobile dental clinic may submit claims for Medicaid reimbursement to the Department of Social Services for dental treatment of Medicaid beneficiaries that occurred not more than thirty miles from the associated dentist's fixed location, except that a mobile dental clinic located in the counties of New London, Litchfield and Windham may submit claims for Medicaid reimbursement to the Department of Social Services for dental treatment of Medicaid beneficiaries that occurred not more than fifty miles from the dentist's fixed location. The Department deleted the requirement that the clinic be "close to the patient's home" as the distance requirements in section 17b-282f of the Connecticut General Statutes are sufficient.

Comment: Sec. 17b-262-1008(d)(3): The fifteen-mile limitation on billing for mobile dental services will restrict access to care in those areas of Connecticut in greatest need of mobile services: the rural areas of our state. For example, Generations Family Health Center's mobile van provides services in over 25 locations over a 1,700 square mile area in northeastern Connecticut. The van is registered to Generations' Willimantic facility, but services patients of its Putnam site as well. The value of the mobile van is that there are fewer dental providers in rural Connecticut than in more populated areas of the state. Additionally, transportation is a significant barrier to care in rural Connecticut; with no public transportation system, it is often best to "bring health care to people," instead of bringing people to health care facilities. CHCACT recommends including language that exempts rural areas of the state from the fifteen-mile limitation, to maintain access to services in these underserved areas.

Response: The Department revised the regulation to be consistent with the distance requirements in section 17b-282f (b) of the Connecticut General Statutes.

Comment: Mobile dental clinics and school-based health centers (mobile units) Referrals - We recommend that the contract refer patients to a defined dental home within a certain distance, with full dental services so they can get comprehensive care. When mobile units are far away enough from a fixed dental location or SBHC that does not have a dentist in the fixed location, the patient may not have access to the fixed location for other dental services not provided at the mobile unit.

Response: The Department revised the regulation to be consistent with the distances between mobile dental clinics and fixed locations in section 17b-282f (b) of the Connecticut General Statutes.

Comment: Submitting claims - If they can contract with a local dental home, why the limitation to 15 miles for providing services and receiving payment? We do not want to see a limitation on services, such as those provided by a dental hygienist who may be able to refer to a local dental home that may not be their fixed location.

Response: The Department revised the regulation to be consistent with § 17b-282f (b) of the Connecticut General Statutes.

Comment: Section 17b-262-1008(b) lists requirements for a “dental home”, which would include “... the provision of continuity of services that is within a twenty-mile radius of the patient base, is close to the patient’s home and have regularly scheduled appointment hours available weekly including the summer months.” Would this requirement have any negative impact on Medicaid-covered children who live in rural parts of CT?

Response: The Department does not anticipate that there will be a negative impact on children living in rural areas.

Comment: (d)(3) The City of Stamford covers 52 geographical miles. Sometimes, it is over 15 miles from school mobile clinic sites to the dental home office where a patient will receive restorative treatment. Recommend eliminating mileage limitation for billing procedures.

Response: The Department revised the regulation to be consistent with the distance requirements in section 17b-282f (b) of the Connecticut General Statutes. For Stamford, the distance from the mobile clinic to the fixed location is thirty miles.

IV. Sec. 17b-262-1010 Administrative Services Organization

Comment: We have concerns about who would physically examine the patient, and therefore recommend stating that the exam be completed by a licensed dental provider.

Response: The Department revised the regulation accordingly.

V. Section 17b-262-1011 Services covered and limitations

Comment: Most CHCs have patients that come in several times per year for emergency care. Since problem focused exams are limited to 2 per year, how do we bill for subsequent visits?

Response: Up to four (4) problem focused examinations are allowed per member per year; additional problem focused examinations may be prior authorized or post – procedure reviewed.

Comment: “If patient’s progress to a complete denture within the first two years of placement if the partial denture by the same provider, then the money for the partial denture shall be recouped.” There are times where our patients do not properly take care of themselves and this type of situation DOES happen. It’s not often, but it can happen. In a sense, this could potentially punish the FQHC for a patient’s disregard for their own oral health.

Response: The Department has been following this protocol since 2008. It is understood that sometimes this does happen, and adjustments are made accordingly when appropriate documentation is provided by the dental office.

Comment: Anesthesia - Regarding page 8, Section 17b-262-1011 (a) (1): Should be revised to read “General anesthesia and moderate sedation administered by a dentist or oral and maxillofacial surgeon, who holds a valid General Anesthesia or Moderate Sedation Permit issued pursuant to section 10-123b of the Connecticut General Statutes”.

Response: The Department revised the regulation accordingly.

Comment: Anesthesia – Inhalation Sedation - Regarding page 8, Section 17b-262-1011 (a) (2): Should be revised to read “Inhalation of nitrous oxide sedation for members who are under the age of twelve or members of any age who have a diagnosis of a documented cognitive disorder which supports the need for behavior management related to the dental procedures to be delivered”.

Response: The Department revised the regulation accordingly.

Comment: We did not see anything regarding the cap of \$1,000 for adults. Is this no longer a consideration?

Response: The cap of \$1,000 for adults is in statute; therefore, there is no need to include it in the regulation.

Comment: Add this language after the section title: “Non-exhaustive coverage for dental services and limitations to diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and adjunctive services as set forth in the *Dental Provider Manual* may be subject to the exception process through prior authorization.”

Response: The Department revised the regulation to allow for prior authorization for services that are not covered.

Comment: Detailed descriptions of services covered and limitations are necessary, but would be better if written into the *Dental Provider Manual*. We are concerned that these regulations are too detailed. New services may come available or others proven not effective, and the long and cumbersome process of amending regulations will prevent best practices from being implemented in a timely manner. The list of covered services is a case in point: it is lengthy and changes regularly.

Response: Upon adoption by the LRRC, the regulations will replace the existing regulation in Chapter 7 of the Provider Manual.

Comment: Insert new language titled “Non-exhaustive statement of covered services: Insert introductory sentence reading: “Non-exhaustive coverage for dental services and limitations to such services are set forth in subsections (a) through (i), subject to the exception process through prior authorization set forth in subsections (j) and (k) and Section 17b-262-1014.”

Response: The Department revised the regulation accordingly.

Comment: Insert new subsection reading: “Notwithstanding subsections (a) through (i) above, a type of non-experimental dental service not listed above or limited above to situations not covering an individual member’s particular situation will nevertheless be authorized through the prior authorization process where the member provides required medical documentation establishing his or her medical need for the particular requested treatment in accordance with the definition of medical necessity in C.G.S. § 17b-259b.”

Response: The Department revised the regulation accordingly.

Comment: Insert new subsection reading: “Notwithstanding subsections (a) through (i) above, a numerical or frequency limitation on a type of dental service will not be applied in instances where the member, through the prior authorization process, provides medical documentation establishing his or her medical need for the particular quantity or frequency in accordance with the definition of medical necessity in C.G.S. § 17b-259b.”

Response: The Department revised the regulation accordingly.

Comment: Subsection (k) should be revised to read: “Any non-experimental procedure or service which is not listed on the dental fee schedule is not covered unless the member submits a request for prior authorization pursuant to § 17b-262-1014 and provides required medical documentation establishing his or her medical need for the particular requested service in accordance with the definition of medical necessity set forth in C.G.S. § 17b-259b.”

Response: The Department revised the regulation accordingly.

Comment: List the covered services in the order of the CDT codes as other insurance and programs list them, whether you choose to locate the list in the regulations or the *Dental Provider Manual*. If the list of covered services is moved to the *Dental Provider Manual*, make the appropriate language change this in the regulations and insert the quoted language above in the *Manual*.

Response: The services listed in the regulations are in alphabetical order so that it is easy to locate a specific service. The covered services will not be moved to the provider manual because upon approval by the LRRC, the regulations will replace existing regulations in Chapter 7 of the provider manual.

A. Diagnostic Services:

Comment: Panoramic image - Recommended changing “12” to “9” in the statement because age 12 may be too late for an impacted canine. This statement does not match with the list in “Services not covered” which lists it as under the age of 8.

Response: The Department changed it from age 12 to age 9 as stated in Section 17b-262-1012.

Comment: Screening or Risk Assessment

1. Recommended that all children be assessed for risk and that it becomes part of their record.
2. Recommended that a statement be added as reimbursement is only for dental hygienists in public health settings.
3. Recommended to add a reference as to where the accepted referral form can be found and a description of the proper use and submission for reimbursement.

Response: 1. The codes used for the assessment capture the disease risk (D0601, D0602 and

D0603) remains in the member's member claims history. The screening assessment should be made part of the patient's permanent record because it is required to be performed in conjunction with preventive services.

1. Agree with the suggestion that the code is only reimbursable in the public health settings and the appropriate change will be made to the regulations.
2. There is a description in the Provider Manual regarding the use of the screening form, a reference to the www.CTDHP.com website where an electronic copy of the form can be downloaded. The option to enter the information on the CTDHP website will also be created.

Comment: The elimination of payment for dental screenings by public health hygienists will result in the inability to assess the student population and prioritizing of dental needs.

Response: The Department revised the regulation to allow for two screenings per twelve-month period: A screening examination may be performed by a public health hygienist, two times per member per every twelve-month period.

B. Endodontic Services:

Comment: Apicoectomy - Regarding page 10, Section 17b-262-1011 (c) (2): Delete the phrase "when the quadrant is not missing any teeth". The sentence should instead read: "Apicoectomy therapy for members over the age of twenty-one with the exception of third molars or premolars that have been extracted for orthodontic purposes".

Response: The Department revised the regulation accordingly.

Comment: Pulpotomy - clarify if a pulpotomy is ever indicated for any tooth with any pathology or resorption. If not, then restate the limitation here.

Response: The Department revised the regulation accordingly.

Comment: Section (c) (6) Endodontic Services.... Post procedure review is required for all providers except endodontists – specialists should not be exempt from this standard. It should be applicable to any provider who receives prior authorization to perform an endodontic procedure.

Response: The Department revised the regulation accordingly.

C. Orthodontic Services:

Comment: Severely Handicapping - Regarding page 18, Section 17b-262-1012 (d) (6): We suggest adding a little more of a definition for "severely handicapping". We think that might be more helpful.

Response: The Department revised the regulation accordingly.

D. Periodontal Services:

Comment: Periodontal therapy is covered for members who have undergone chemotherapy, radiation therapy to the head and neck and/or organ transplantation, but we believe this is insufficient. We recommend that periodontal therapy be covered for members who have chronic diseases where periodontal disease beyond gingivitis is proven and for a chronic disease that is affected by infection or inflammation in the mouth, such as diabetes, certain heart and lung disease, etc. This would require prior authorization with evidence of the chronic disease as well as the periodontal disease. We also recommend that periodontal therapy should be covered for members who are pregnant and have periodontal disease beyond gingivitis. This would require prior authorization with evidence of periodontal disease.

Response: The Department revised the regulation to cover periodontal therapy for members who have diabetes, end stage renal disease, who will or have had heart valve procedures or infection of the heart valves.

E. Preventive Services:

Comment: Bisphosphanate - Regarding page 14, Section 17b-262-1011 (g) (4) (C): Delete the word biphosphanate and change to bisphosphanate.

Response: The Department revised the regulation accordingly.

Comment: Section 17b-262-1011(g)(3) states that the preventative service coverage shall apply to "Topical application of fluoride or a professional anti-cariogenic agent for members under the age of twenty-one, one time per every six-month period, in conjunction with dental prophylaxis."

Several reviews of use of fluoride therapies in preventing dental caries have been published since 2000. The Cochrane reviews of topic concluded that fluoride varnishes applied professionally two or more times a year would substantially reduce tooth decay in children, and 2 or more applications is effective in reducing caries prevalence. Related, a recent study suggests that fluoride exposure during childhood has a strong, statistically significant effect on women's earnings.⁴ Frequency of this treatment is also important in high risk cases. Our dental services providers treat many of these high risk patients who benefit from four treatments per year. In other words, we know the clinical efficacy of fluoride varnish treatments.

What we also know is that tying the receipt of fluoride varnishes to an extra treatment -in this case a cleaning -may reduce the frequency of the service. And with respect to cleanings, there is no clinical evidence available that illustrates the necessity of tying it to a fluoride treatment. Moreover, in many states, nurses are permitted within their scope of service to administer fluoride varnishes during medical appointments, but of course do not do a dental cleaning. A dental hygienist should be able to provide these same services, along with the added benefit of being able to educate the child on dental health, do appropriate screening and triaging, and if needed, establish a dental home for the child.

Recommended language: Topical application of fluoride or a professional anti-cariogenic agent for members under the age of twenty-one, one time per every six month period [, in conjunction with dental prophylaxis.], and with prior authorization, up to two times every six month period.

Response: All dental services that are medically necessary may be prior authorized for additional need. Because treatment continues to evolve, the Department will not make the

change and leave the request for additional fluorides – regardless of the form – with the rendering provider.

Comment: The proposal to tie fluoride varnish to cleanings will result in less frequency of this service and deteriorating dental health for poor children. Fluoride treatments are proven to substantially reduce tooth decay in children, and the application of fluoride varnish up to two times a year within a six-month period, with prior authorization should be allowed.

Response: The regulation has been revised to allow for additional fluoride treatments with prior authorization.

Comment: Fluoride varnish - Recommended inserting at the end: “Up to four additional applications for patients with high risk can be submitted by prior authorization” because high risk patients have shown better results when the fluoride varnish is applied 4 – 6 times a year.

Response: All dental services that are medically necessary may be prior authorized for additional need. Because treatment continues to evolve, the Department will not make the change and leave the request for additional fluorides – regardless of the form – with the rendering provider.

Comment: Prophylaxis Recommended removing the definition, as it is already defined in definitions, and seem unnecessary here.

Response: The Department revised the regulation accordingly.

Comment: Oral hygiene Recommend that “including brushing and flossing” be deleted, because the daily oral health practices should be matched to the needs and abilities of the patient.

Response: The Department revised the regulation accordingly.

Comment: Sealants: Recommended to define which teeth. Recommended language (because sealants are now used for early decay, to arrest it as well as to prevent decay): “All teeth that are candidates for sealant placement shall have erupted sufficiently so proper isolation can be achieved for sealant placement and be free of decay or determined by the provider that the sealant will arrest decay. Reimbursement - Recommended stating that reapplication by another provider is reimbursed if sealant is missing, but not for replacement the same provider within 5 years. Age limitations - We are concerned about the ages, as some children do have the teeth erupt earlier than current standard eruption guidelines.

Response: 1. Teeth 2, 3, 14, 15, 18, 19, 30 & 31; other teeth may be prior authorized. Agree with the suggestion and the change will be made. There is currently a mechanism in place to recoup missing sealant restorations and reimburse the provider who is reapplying a sealant.

Comment: Subsection (g)(8) Sealants are covered ...”one time per three-year period per member for non-carious teeth for pits and fissures in permanent dentition.”

(A) All teeth that are candidates for sealant placement shall be “free from decay...”

Placement of sealants on children’s teeth should be allowed in those teeth where sealants can slow the development of caries.

Response: The Department revised the regulation accordingly.

Comment: (C) Sealant placement age limitations ... indicated where there is” high caries susceptibility,”

Prior authorization should not be required for the placement of sealants in pre-molar teeth that have “moderate” caries susceptibility. Further, sealant placement on teeth in children who come from low-income areas should be encouraged because they are a cost-effective way to improve not just dental health outcomes, but overall health outcomes, by reducing the number of school days lost as a result of pain or infection caused by untreated caries.

Response: The Department maintains its policy for coverage for molar teeth. In instances where “high” incidence of caries exist, there is the Caries Assessment Tool and post-procedure review is an option if prior authorization is not feasible to request sealant placement on premolar teeth or primary teeth. The CDC and CMS supports placing sealants on molar teeth.

F. Prosthodontic Services:

Comment: Replacement of Dentures - Regarding page 15, Section 17b-262-1011 (h) (1) (C) (i): Should be revised to read “Replacement dentures shall not be approved if lost within the first year of placement regardless of the reason for loss except for in the case of a catastrophic reason for loss”.

Response: The Department revised the regulation accordingly.

Comment: Section 17b-262-1011(h)(1)(D)(iv) requires that "all hygiene, restorative and oral surgical procedures shall be complete prior to requesting prior authorization and before constructing the partial denture(s)."

By requiring all related procedures to be completed prior to requesting a prior authorization, there may be unnecessary work done on patients (with an avoidable cost to the State), and the potential for delay in services. Additionally, we have seen situations where patients have lost their front teeth and would like to have them placed before other dental work is completed. A delay here can result in a negative impact to the patient's mental health, and possible loss of work.

Response: The Department disagrees. All preventive, restorative and endodontic procedures should be completed before prosthodontic procedures in accordance with the standard of care. Moreover, it is inappropriate to provide dental services without a well-developed treatment plan. In the case of missing anterior teeth, the Department will pay for a temporary flipper until all treatment is completed.

VI. Section 17b-262-1012 Services Not Covered

Comment: The proposed regulations include certain exclusions from periodontal treatment for individuals “with poor hygiene or who have a history of smoking or substance abuse,” and state that “Periodontal therapy shall be discontinued for members who do not comply with hygiene, home care instructions or appointments.” Proposed § 17b-262-1012(e) (5). These restrictions are improper, interfering with the provider-patient relationship in violation of C.G.S. § 17b-259b (a) and potentially the Americans with Disabilities Act (“ADA”).

Categorical exclusions from treatment are not permissible under federal Medicaid law, and any reviews of medical need must be made pursuant to C.G.S. § 17b-259b (a). Accordingly, apart from the lack of clinical basis for the exclusions in proposed subsection (e) (5), any categorical declaration that periodontal therapy may be denied to someone with poor hygiene, or who has a history of smoking or substance abuse, would violate that state statute because it would deprive some Medicaid enrollees of an individualized assessment of their medical need based on what has been submitted by their providers. Denying someone services just because they have a history of some less than ideal behavior is not rational, and is irrelevant to their medical need for services today. In addition, the failure to provide services to an individual because that individual has a history of substance abuse, but is no longer engaging in such use, may indeed be a violation of the Americans with Disabilities Act. Such an individual may in fact be a qualified individual with a disability and under the ADA cannot be denied services on the basis of his or her past history of drug use.

We recognize that it is possible that someone with poor hygiene or a history of non-compliance may be viewed by their dental provider as not a good candidate for certain services, and the provider may withhold treatment in those circumstances, for a limited period of time. But that is for the provider, who knows the patient, to decide on a case-by-case basis, after consulting with his or her patient. The state should have no role in second-guessing providers' careful judgement in these sensitive matters.

Amend Subsection (e) (5), due to an inappropriate interference with the patient—provider relationship. This is for the dentist to decide after consulting with the patient- not for the payer to decide. It also violates the medical necessity statute to declare that individuals who happen to have a history of smoking or substance use are categorically ineligible for periodontal services. The amended section should read, "Periodontal therapy without obtaining prior authorization."

Response: The Department revised the regulation accordingly.

Comment: Sec. 17b-262-1012(e)(5): CHCACT is alarmed at this provision, which restricts payment for services to patients based on their lifestyle (e.g., smoking) or compliance with provider instructions. This section sets a dangerous precedent that, carried over into medical care, could eliminate Medicaid payment for conditions such as lung cancer, diabetes and liver disease. Providers can advise patients; in health centers, case workers or community health workers often provide follow-up assistance. However, providers cannot force patients to adopt healthy lifestyles; nor can they deny care to patients who are noncompliant. CHCACT recommends removing this subsection entirely.

Response: The Department amended the subsection as follows: "Periodontal therapy without obtaining prior authorization."

Comment: Section 17b-262-1012(e)(5) states that services not covered includes "periodontal therapy for members with poor oral hygiene or who have a history of smoking or substance abuse. Periodontal therapy shall be discontinued for members who do not comply with hygiene, home care instructions or appointments." This restriction raises questions to us about how it will be administered. Additionally, because of the broad strokes contemplated by this language, the application may be arbitrary, and ultimately capricious.

Response: The Department amended the subsection as follows: "Periodontal therapy without obtaining prior authorization."

Comment: We oppose the provision in Section 17b-262-1012 subsection (e) (5), which prohibits coverage of “periodontal therapy for members with poor oral hygiene or who have a history of smoking or substance abuse. Periodontal therapy shall be discontinued for members who do not comply with hygiene, home care instructions or appointments.” Not only do we believe the decision course for care provision should be left to the patient and the provider, rather than the payer, we believe this provision in the policy may have a disproportionate adverse impact on those who are racial or ethnic minorities receiving dental benefits through Medicaid. According to the Center for Disease Control (2015), 22% of smokers identify as American Indian/Alaska Natives, 16.7% are Blacks, 10% are Hispanics, and 20% are multiple races, compared to 16.6% who identify as White. In addition, 26% live below the poverty level.

Response: The Department amended the subsection as follows: “Periodontal therapy without obtaining prior authorization.”

Comment: Section 17b-262-1012 (e) seems to imply that periodontal services [Sec. 17b-262-864(3)] are now covered for members if a prior authorization is submitted and approved. This section is unclear and should be removed or simplified for greater clarity. The proposed regulations are also unclear about whether implants [Sec. 17b-262-864(4)] and fixed bridges [Sec. 17b-262-865(1)] are covered. There is a lengthy discussion that seems to imply that these items are covered on a case-by-case basis. It would seem that if they are covered by DSS for some, then they should be available treatment for all so long as they are medically necessary and the procedures go through a prior authorization process.

Response: Periodontal services are covered in certain situations. Please see 17b-262-1011 (g) for further detail.

VII. Section 17b-262-1013 Documentation

Comment: Regarding page 20, Section 17-262-1013 (a) (12): This language should be reviewed to ensure that it is consistent with established Medicaid audit regulations.

Response: During an audit of a dental provider, the auditor will refer to the dental regulations to determine what is required.

VIII. Section 17b-262-1014 Need for Service and Authorization Process Section

Comment: In proposed Section 17b-262-1014(b), it states that “each dental provider shall comply with all prior authorization requirements” and that “The department in its sole discretion determines what information is necessary to approve a prior authorization request.” The problem with this broad language is that it is unmoored from the governing medical necessity standard, that is, it suggests that the department could require submission by a dentist of information which is not necessary to establish medical need under C.G.S. § 17b-259b(a). It also suggests that prior authorization procedures not specified in other regulations, specifically § 17b-262-866, could be required. Neither of these would be proper. We therefore include suggested additional language which qualifies the language in Section 17b-262-1014(b) accordingly.

Referencing Hearing Rights As with denials of Medicaid eligibility, a denial or partial denial of any requested services, or approval of less than the amount requested, must always be accompanied with a formal notice of action advising of the reason for the action, the regulatory basis for the action and the right to appeal. Although other DSS regulations spell this out, the Department usually includes the basic information about the right to appeal in regulations

governing specific kinds of services, as it has for other dental regulations. It would therefore seem appropriate to include this here.

At the end of subsection (b), second sentence, add: “, provided this is consistent with these regulations and subject to the definition of medical necessity set forth in C.G.S. § 17b-259b.” Add new subsection (g) reading: “Any member denied prior authorization, in whole or in part, for any reason shall be provided a written notice explaining the action and advising of the right to appeal such action through requesting an administrative hearing with the Department in accordance with section 17b-60 of the Connecticut General Statutes.”

Response: The Department revised the regulation accordingly.

Comment: Section 17b-262-1014 (c)(4) - To require prior authorizations for EPSDT services is a duplication of services. EPSDT services are a mandate of the federal government for State Medicaid programs.

Response: While hard limits or caps on services are not permissible under EPSDT, soft caps or limits may be placed for purposes of utilization control. For example, states may require prior authorization for certain treatment services (though prior authorization cannot be required for EPSDT screening services).

Comment: Add new subsection (g) reading: “Any member denied prior authorization, in whole or in part, for any reason, shall be provided a written notice explaining the action and advising of the right to appeal such action by requesting an administrative hearing with the Department in accordance with section 17b-60 of the Connecticut General Statutes Please refer to Sec. 17b-262-866 to either insert reference here or if combining Sec. 17b-262-862 to 17b-262-866 into this document.

Response: The Department revised the regulation accordingly.

Comment: We are concerned that patients will need prior authorization for splinting. We hope that the regulation is further clarified to exclude emergency patients that may have avulsed teeth etc., where it would be impossible to get a prior authorization and potentially have a negative impact on the patient successfully keeping their tooth.

Response: For avulsed teeth, prior authorization is not needed to splint teeth back in.

Comment: RE: Prior authorization and Post authorization: Requiring “fully developed” Treatment Plans to be included with these. Do the regulations require the actual Tx plan from the Patient’s record?

Response: For extensive dental work/reconstruction the CTDHP dental consultants have found it necessary to have full treatment plans rather than receiving proposed piecemeal requests from dental providers. In the commercial setting, this is known as pretreatment determination.

IX. Section 17b-262-1016 Billing

Comment: Timely filing is reduced to 120 days. This could become an issue for patients that become retroactive and for any issues relating to prior/post authorizations or coordination of benefits

Response: At the time the dental regulations were written, the Department was moving toward a 120-day timely filing period. Since that time, the Department reevaluated this change and decided to keep the 365-day limitation for timely filing. The regulation has been revised accordingly.

X. Section 17b-262-1017 Marketing Guidelines

Comment: (l) To general public Limiting them at health fairs and other events that may be planned or not notified about them prior to thirty days sounds like a restraint of trade.

Response: The Department revised the regulation to provide that nothing prohibits a CMAP dental provider from engaging in a marketing activity at a community sponsored education event, health fair, outreach activity or other similar community or non-profit event in which the provider participates.

Comment: What is the penalty if a practice does not follow the guidelines, such as “Offering free screenings, examinations or other dental services to potential future patients or soliciting referrals from patients of record?”

Response: This may result in termination from the program if the Department determines that it is a prohibited marketing activity.

Comment: The reference/section on p. 24 (k) (3) related to mass marketing, “any other means by which they establish unsolicited personal contact” is somewhat vague and what could it mean for something like our Facebook Page, web site, portal?

Response: The Department revised the regulation to clearly delineate the difference between prohibited marketing activities and permissible marketing activities.

Comment: Another distance restriction (15 Miles) on where we can market

Response: The revised regulation does not contain a distance restriction in section 17b-262-1017.

Comment: Not only are they having us get approval for the materials...but they are even dictating the size of the font!

Response: The revised regulation does not dictate the font size.

Comment: They do not provide the way in which we would even submit our materials for their approval.

Response: The material may be submitted to the Dental Manager at DSS or the CTDHP.

Comment: We have to notify them 30 days in advance if we intend to do outreach etc.

Response: The revised regulation doesn't require submission of marketing materials within a specific time frame but does provide that the Department shall review the materials and respond to provider's request within 60 days, or it is deemed approved.

Comment: There are often outreach opportunities that present themselves with very short notice.

Response: This is not meant to interfere with outreach opportunities.

Comment: Are they expecting FQHCs to forgo these opportunities?

Response: The marketing guidelines are applicable to all dental providers.

Comment: The use of social media requires quick turn-around time. How would providers receive approval from DSS for each Facebook post or tweet promoting services?

Response: Social media accounts are not included as a social media account does not involve unsolicited personal contact.

Comment: Section 17b-262-1017(k) (3) prohibits the establishment of “unsolicited personal contact with potential members of CMAP.” The goal of any broad public relations campaign – whether through earned “unpaid” media (e.g., radio interviews), billboards, mass mailings, newspaper ads, bus ads, etc – is to promote services to people who may not be aware of them. Why should dental providers be prohibited from advertising their services to potential patients? How will DSS fairly assess and monitor this provision?

Response: The revised regulation provides that marketing that involves the general dissemination of information, including by television, radio, newspaper, or billboard advertisements and does not involve unsolicited personal contact is permissible.

Comment: As for marketing/outreach events, unfortunately, these events are sometimes planned within a short timeframe; 30 days’ notice, as required in 17b-262-1017(l) (2), is not always possible. Health centers and other providers should not be forced to skip worthwhile outreach events, simply because they were planned or noticed only three weeks in advance.

Response: The revised regulation does not require the provider to provide 30 days’ notice. Additionally, submitting the material for review is up to the provider but not required.

Comment: Finally, CHCACT opposes the blanket prohibition of offering gifts/gift certificates to Medicaid enrollees, outlined in 17b-262-1017(m) (4). There are occasions when private foundation grants allow for patients to be paid a nominal sum to participate in focus groups or to share their health care experiences.

CHCACT and health centers participated in advertising approvals, as proposed in this section, for the SNAP program, conducted in partnership with DSS. Those requirements were specific to SNAP-related items only and therefore were trackable; for example, grocery bags advertising SNAP were approved in advance by DSS and paid for with SNAP funds. However, extending that requirement to all marketing conducted by dental providers and their representatives is not practicable. Given the multiple revenue sources at health centers and CHCACT, it would be administratively burdensome – and potentially impossible – to tease out which sources of funding are paying for staff time, for public relations campaigns, for promotional materials and for outreach events that promote health centers.

CHCACT recommends removing this subsection entirely.

Response: The revised regulation does not include a blanket prohibition against gifts or gift certificates.

Comment: Attempting to regulate FQHC marketing material is simply unacceptable. Medicaid is not often the only revenue stream for many FQHCs and dental practices. To dictate marketing, outreach, and attendance at events when funding for these initiatives are not coming from Medicaid is outrageous, and no practice should have to do this.

Response: The marketing guidelines are applicable to all dental providers. The department revised the regulation to clearly delineate between prohibited marketing activities and permissible marketing activities.

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