ALASKA MEDICAL CARE ADVISORY COMMITTEE (MCAC) DENTAL CARE SUB-COMMITTEE MEETING
Friday November 18, 2022
5:00 to 6:30

MINUTES November 18, 2022

INTRODUCTIONS:

Members Present are Matthew Hirschfeld (Sub-Committee Chair) Renee Gayhart, Jamie Walker, Julius Goslin, Sheri LaRue.
Guests present include various members of the public

Matthew Hirschfeld Introduction of members and a brief overview of how the meeting will proceed and a brief overview of the MCAC Process and new Dental regulations.

Renee Gayhart Presentation of Power Point slides related to the new dental regulations and the process involved in bringing the regulation change to this point. Key Points of the slides are that because of shortcomings discovered during a legislative audit conducted in 2019 the new regulations were proposed and developed through a public process including public meetings and a scoping process between 2019 and the present and will be implemented on December 1, 2022. These regulations while new to the dental Community are not new to the rest of the medical community where prior authorization for many procedures has been required in the past.

Mathew Hirschfeld Moderates questions and answers from the public and various members.

- Perspective offered by other Dentists involved and comments and questions from the public concerning the regulations and their potential impact on Dentists and patients.

Heidi Ostby: The first question is just, If there's no longer going to be any service authorizations for all of those other adult enhanced codes, what happens if another legislative audit comes along and says, Okay, well, why did you Do ten fillings on this patient, even though you today, under the eleven fifty cap, if there's no longer going to be any kind of medical necessity or service authorization, how do you justify treatment? The second comment was, I know you guys were putting up there on the sides that this wasn't a new thing, and I know it’s not a new thing. I've been working with you guys for the past two years trying to redraft these regulations, and you know we kept coming back with our comments, saying, you know you really should differentiate between primary and permanent

crowns, primary and permanent extraction. And so, my question is, why were our suggestions not listened to? And we also suggested, instead of having a service authorization for prefabricated stainless-steel crowns on primary teeth or primary tooth extractions and why we can't just submit medical necessity after the fact. I've discussed this multiple times but in case there's other people on the Zoom, that haven't been hearing it, you know our GA. Cases are impossible. The majority of them are impossible to treatment plan. What happens if the treatment plan changes mid-treatment? That happens every single day in GA. So, you don't know if a tooth is restorable, or you have to pull it until you see what's left over. So, you guys have told us we can do retroactive submissions, and that's fine. But why even have a prior authorization? Why not just do a medical justification after the fact? Or why not just have a submit chart notes and X-rays. Those are my two comments.

Krystal Nichols - DHCS: I will take a stab at this; I think I can get all your key points. So, first of all, the codes that are being removed, We are doing that strictly for administrative purposes. We were only monitoring those specific codes to stay under that cap and now we have a way to systematically do that through the MMS. Without having to do an authorization for those. I'm not sure if you're aware of all the enhanced adult dental pertains to, but it's primarily preventive services, not everything, but most of it. We were having to authorize fluoride treatments, for example. I can imagine that most of you would agree that those are services that probably don't need to be authorized for medical necessity. On the same note how are we monitoring these things? We are still going to do post-payment audits and we do that every year with every provider type, dental and otherwise. So those are still things that are still going to occur as far as things that are not necessarily service authorized going forward. But we're still going to make sure that they're not being abused, and we do look for claim trends. For example, if somebody has an extremely high percentage of a certain code or service we're going to look for those and we're going to ask for records. We're going to make sure that everything's on the up and up. As far as what if treatment changes mid-treatment that is not uncommon. Think about other surgical types of services, you know you start a surgery, something happens, and you have to do something different. Those are the types of things that we do allow a retro change to the authorization or an explanation through claims processing with medical justification.

I'm not saying that's common, and it should not be done every time, but we do understand that things happen that you can't plan for and on the same note, you should be able to reasonably plan for excessive volumes. I do hear you, Dr. Ostby, about Well, what about our inputs before? With primary teeth versus permanent teeth, seamless steel crowns versus porcelain, et cetera. If you look at the audit report that we have referenced several times in the last couple of weeks. Those were some of the specific concerns that they had uh primary teeth, stainless steel crowns uh, so we can't make exceptions for those we have to put authorization requirements on them to satisfy the compliance issues that they were seeing on their end. And we will work with the dental community to make sure that the authorization uh requirements that we do put in place have minimal impact on the providers and the recipients that are

receiving those services, and I think I captured all of it, but there was an awful lot. So, if I missed something, please let me know.

Matthew Hirschfeld: Thank you, Crystal. Thank you, Dr. Ostby next on the list is Dr. Michaud.

Kenley Michaud: How do you? So, we mentioned that you guys have been allowing so for the authorization to be done. We've tried to service authorization most of this, so we've called Conduit to speak with them to try and do actual service authorization, so we could be prepared for December first and been told multiple times that they don't have criteria from the State to approve or deny a service authorization for general. So, we're wondering what are they doing differently than we are, or when that changed and how do we go about sending service authorizations? Because we've been told multiple times that we can't, or we've been told we can, but that they don't have criteria to process them yet, so they will just sit there.

Krystal Nichols - DHCS: We have had lengthy discussions with the fiscal agent this week. Yesterday was a quite a long discussion about criteria, and how to approve some of these. We are still working on some of the criteria, but we did start moving most of the authorizations that we had in our queue yesterday, and today, and we've approved several, I believe.

Kenley Michaud: Are those criteria something that are going to be shared with us or are we going to have to kind of back and forth by process of elimination, figure out what they are? For example, are you guys going to be requiring X-rays, or what sort of documentation you will be requiring for certain procedures?

Krystal Nichols - DHCS: We are working on a draft right now, and we will have those published but at the same time, we're hoping to use this specific meeting to get some of your input. Do we think every single authorization request needs X-rays? Absolutely not.
Do we think every single general anesthesia request needs x-rays? Absolutely not. So, if you have ideas that we can incorporate into the drafts that we already have we want to hear those things.

Kenley Michaud: Okay, Thank you.

Matthew Hirschfeld: Thank you, Dr. Michaud. Thanks, Crystal. Next is Dr. Blanco.

Dr Jessy Blanco: Hi, Thank you. I read through the legislative audit, and it, you know There's a large assumption that there was fraud, and I understand that you're trying to prevent that with these new regulations. But it's just it's not clear that, I don't know It just seems like a huge stretch to then try to put regulations on children and requiring all these obstacles for children because of a nineteen-year-old receiving a porcelain crown. So, we're the specialists for children and we're trying to provide care for the kids that are coming to us for these extensive needs and we're just having all these obstacles for kids. I don't know, I

just, I see a huge issue that's going to come from this, and you're removing the obstacles for the adults but then putting them on kids.

Krystal Nichols - DHCS: And I don't mean to interrupt you. Dr. but I would like to clarify that the authorization requirements for crowns, extractions, and sedation will be the same across the board, regardless of age. This is not just a pediatric requirement. I do want to make that very clear.

Dr Jessy Blanco: I mean with kids we don't have the ability sometimes to do comprehensive exams to know exactly what we're doing, and I feel like most of the kids that require general anesthesia will need most of the time, and a lot of my colleagues are on the line here, and they could say that they will require more than two crowns. So, I just I worry about preventing care or prolonging care for these kids. For sedation, I don't see anxiety listed as a justification or medical justification and I think that's a huge issue. How is this truly going to stay because we have kids that are anxious, that that require sedation,

Krystal Nichols - DHCS: so, I will say every circumstance is treated individually but we have absolutely approved an authorization just yesterday for one such scenario, so we will take that into consideration. And it again depends on the circumstance.

Dr Jessy Blanco: Okay, nitrous only if local anesthesia is not sufficient for pain. Have you tried doing local anesthesia on a two-year-old on a three-year-old? We're trying to preserve the psyche of these children. I mean, I'm sure if we were able to get the local anesthesia on these kids that would be adequate for pain for the procedure. But how do we get to do it? We are the experts on children and providing care for children. Why aren't you guys listening to us?

Renee Gayhart: Okay, Thank you. I think one of the things that we wanted to do with this was to find out ideas on the service authorization process and the criteria. We're not saying that they're going to get denied. What we're saying is they will require the service authorization ahead of time So if you look at that form when you go online, you prefile it and send it in like Krystal said. There are criteria for X-rays for certain things and other medical justification. It's not an outright denial upfront. I guess I'm trying to remind folks that the rates will go in place December first, and some of you, several of you have already sent these in, and have been working through the process. And like Krystal said, we did spend that time with Conduent today, so it it's not a denial, and I think I just want to remind folks that we're not saying you can't do it. We're saying we need to know ahead of time and authorize it. I think last time and this time we keep hearing about how it's Inhumane, and really, the services can continue. It just requires that service authorization ahead of time. But we won't always know ahead of time and then there's Retro.

Dr Jessy Blanco: So, will that change for these young kids? How it's written so that we know how to request the pre-authorization? Because the reasons that are currently stated do not work in the scenarios that I just mentioned.

Krystal Nichols - DHCS: I will say that I'm positive the nitrous oxide does not require authorization, that one is medical justification. If we go back to the regulations, we did clarify that it should just be General anesthesia and IV Sedation.

Dr Jessy Blanco: Just so we on the same page. Okay, thank you,

Matthew Hirschfeld: Dr. Blanco, I'm going to move on. Just so other people have a chance to comment. Thank you very much for your comments. I'm going to read the next one because it came off an iPhone and I don't have a name for it. So, "what happens if treatment changes during the general anesthesia appointment?" I think we talked about that as it would be a retroactive authorization, I believe. Renee. Connect me if I'm wrong.

Renee Gayhart: correct.

Matthew Hirschfeld: Next person is the Foster, the Foster. You would like to comment.

The Foster: Sorry I don't know why it says that I can't figure out how to change it. My name is Cluster, and I'm a pediatric dentist up here. I just have a couple of things. First, with the example you guys gave from the legislative audit, I have read the whole thing and that is a very standard case and I just want to make sure that the powers to be kind of understand what a lot of us are talking about, and where a lot of these questions and concerns come from. So, let's take a run of the mill general anesthesia case. We're getting a referral from wherever they live and basically all the referrals are the same urgent abscess toothache. They come in, we do a quick needs assessment and they're screaming they're kicking we peek in there, say, Yep, probably kind of roundhouse crowns and extractions. Well, from them landing to the treatment being completed, it's like less than twenty-four hours that this is happening. Everybody's saying, Hey! This treatment changes. Of course, it changes. We don't have X-rays. We don't know the kid. We've barely taken a peek at what's going on in there. So, a standard village case, or a lot of the kids, whether they are from a village or in town, is eight to twelve, stainless steel crowns, and four extractions. That's just a run of the mill case that we're all treating so for that to pop up on the legislative audit as something exceptional, it really isn't that standard for a lot of the cases that we're dealing with. I just wanted to make sure that was out there and then the offices that are doing a lot of this surgery when you guys are saying, oh, you just got to put the authorization in, or you just change the authorization afterwards. Okay? Well, that's like five to twenty cases a week. And so, I think the way that these pre-authorizations, or how we're picturing these payoffs going that adds a huge administrative burden on offices that are already understaffed and maybe you guys are going to expedite the process. So, it's like a minute or two per kid that we're doing, and it's not going to wind up being We've got a higher extra staff to get all of this completed. I think that's just something I really wanted to put out there as a clarifier to make sure that we are on the same page and that example isn't a crazy example of what's happening. And then I'm there right there with Jesse saying we really need to make sure that anxiety is something

that approves general anesthesia, because even on an older kid, if we're talking about like a nine-year-old, who's not letting us get x-rays, and they're sobbing in the corner hiding under the chair. Well, just because they're nine, they are really nervous, but we do still need to get that treatment done.

I think I know you guys are being open minded to feedback. I just wanted to make sure that everyone was on the same page of what's going on. And then I guess, while I have this opportunity to have a question,

The question that I would love answered that I know that we all want answered is, when these kids are getting referred in from the village, and they're here, we don't have time to get the pre-authorization. We have no idea what it's going to be. Is the burden of the pre-authorization going to be able to be taken care of before the kids get here because we're not going to have time to get it before treatments done and their return to the village. So then saying, oh, well, we can approve it after the fact. I think the fear becomes okay. So, we're going to do all these cases, and then everything's going to get denied. And then are we just doing it for the benefit of the kid, and then we aren't going to actually get paid for the treatment that was completed. Those are the concerns that I would just like to have discussed.

Renee Gayhart: So yes, we are aware of those concerns so often when someone's traveling. That service authorization is going to be tied to, or this travel, if it's for that situation, that service authorization goes hand in hand with the travel, so there should be an opportunity there. We do hear you about things being common but as far as a paperwork process, I kind of want to take a step back there, because I think I mentioned last time, and I know this is new to some of the pediatric dentists, for certain prior authorizations. But when we really look at the numbers, you know, we're talking about if you're doing the authorizations, and you guys know this, a couple of weeks ahead of time. You're probably doing one or two or three a day, working out into the future. And then, if you do have to do a modification or an adjustment to that prior authorization, it is a one-page form, and you know you add the justification. In their rarely. Are you not going to get paid for something If you have to go through the retro prior authorization process, we do that often with metadata. So, a need is a need so that's what those forms provide. let's see. I don't know if I missed anything. It's late in the day. Did I miss anything with your comment? And if so, I appreciate that answer. Thank you very much. Thank you very much for your comments.

Matthew Hirschfeld: Next comment is from Dr. Kersha.

Kristiana Krisha: I am not a provider. I work in Dr. Linds and Myers pediatric office In Ketchikan. I appreciate the opportunity to comment and I am kind of going to echo what Dr. Blanco and Dr. Osby have been saying, coming at this from a perspective of after reading the material, I'm just kind of concerned that the pediatric specialist perspective is not being taken into account with certain sections of this like what we were saying earlier, with eight to twelve stainless steel crowns being standard and

just not being able to predict what was going to happen in a general anesthesia case. That is typical and when Krystal was responding earlier, saying, you know things happen, however, you should be able to predict what happens in a case that's just not necessarily true when we take these referrals like we were talking about earlier with the village kids. it's just that we don't know, and so we get in there, and we're talking about doing all these crowns. I feel like the way that this is all laid out right now, it's preventing specialists from caring for their patients the way that the AAP guidelines would suggest and in the end it's kind of forcing people into doing more unnecessary travel or more unnecessary sedation. So, I'm just kind of wondering how you plan to account for that when there are things like up to two crowns in a single day, must be accompanied by medical justification, or with the oral surgery, saying up to two extractions in a single day, must be accompanied by a medical justification and the limit of four or more extractions in a in a twelve-month period. Where does that fit with things like molar replacement or wisdom tooth extractions in addition to maybe an ortho referral? So, things like that that in pediatrics you see frequently. I'm just kind of wondering why there's such a limitation put on specialists where that is their whole practice between these kids that come in from rural areas that need multiple crowns. And then in things like multiple extractions the way it is now with the whole twelve-month piece, or we just had a case where it could have been two general anesthesia cases instead of one. We could have done a few extractions this year, and then we do extraction twelve months from now, because of the way that these guidelines are right now. So, I'm just kind of wondering about that. I'd also like to hear a little bit more about the nitrous piece, as Dr. Blanco was saying, with A three-year-old, and having to try local anesthesia first. We are trying to preserve their peace of mind and not create a traumatic experience for them.

Krystal Nichols - DHCS: So, I will make a couple of clarifications. clarification number one, the medical justification simply means that you do not need a prior authorization. You just need to submit chart notes with your claim and that that's it. Clarification number two, I had previously mentioned that nitrous oxide is not a service that requires prior authorization. It is general anesthesia and IV sedation that does. And again, we will say that we completely understand the concerns about specialists and how this may impact you. But this is coming from an audit of the Medicaid program. We are required to respond to it and do something. Alaska regulations to show that we truly want to make a change to be in compliance and that's what we have done here. The specific targets of the audits were excessive stainless-steel crowns, porcelain crowns and extractions.

Kristiana Krisha: So, I understand that. But I guess my question a couple of questions one as far as Nitrous goes, I'm Seeing that the dental provider justifies in writing that local anesthesia is inadequate to control pain. That's the quote that I'm looking at, the Department will pay for nitrous if that so that's why I'm wondering about it just because when you say inadequate to control pain? We might not have tried the local, so I just wanted to make sure that we covered that and I just kind of want to know what is excessive with the steel crowns, what do you guys define as excessive?

Krystal Nichols - DHCS: So, the Legislative Audit Committee found that in a single year the Alaska Medicaid pediatric population received over fourteen thousand stainless steel crowns. They found that excessive.

Matthew Hirschfeld: I think we better move on. We've got a lot of people making comments. So, there are some uh emails addresses at the end of the at the end of the talk. You're welcome to send your emails to them. I appreciate the comments, though. Thank you very much.

Bridget DeYoung: Actually, I'm kind of looking at a different perspective, because I treat a geriatric population. And so, we run into the problem where we always must pre-authorize our dentures, and sometimes the medical justification has been sent in and the pre-authorization comes through, and we're approved we do the dentures, but then the payment gets denied. And now we have to foot the bill, you know.

Renee Gayhart: I think we we'd probably have to take a look at. I mean, we're not really able to look into specific claim issues right now. We could look at that. You can send it to us, Sherry and uh Krystal and Jamie and I constantly look at claims. But I can't really fix that one right now.

Bridget DeYoung: I guess what we're saying is, is there a different way? Because based on what you're, saying, with the enhanced dental services with the medical justifications, when we would have to send those in to get pre-approval for dentures. Are you saying now that we just have to send in the chart and that it doesn't have to be pre-authorized anymore?

Krystal Nichols - DHCS: Dentures are required to go to a dentist for a clinical review. So those are a little bit different than the crowns and extractions which will not be going to a dentist for every single procedure.

Bridget DeYoung: Okay. And I have one more question regarding the number of extractions in a year, because a lot of the people we're seeing are actually getting full mouth extractions, and they're not, perhaps may not even be able to live as long to wait every four teeth for every year, so we usually have to do it in one sitting, especially if it's going to be under general anesthesia. So are there exceptions to that role that we're able to somehow put when we do the medical justifications or somewhere specific on the form.

Krystal Nichols - DHCS: You're saying, what would you do in the case of a full mouth extraction? And that would be if it's on a same day sitting it would be single authorization request.

Bridget DeYoung: Okay. And there's no limit? Because wasn't there a limit with four per year.

Krystal Nichols - DHCS: No, that's with the four per year limit for not requiring authorizations.

Bridget DeYoung: Thank you.

Matthew Hirschfeld: Thanks Dr. DeYoung. We appreciate your comments

Matthew Hirschfeld: uh Dr. Cummings. You're next

Zazell Staheli Cummings: Good evening. Can you hear me? I wanted to echo some of the things that were already said. There is a long, turnaround time for service authorizations as well as change requests. I've never seen anything come back within three business days of being submitted. Another question I had was, we've been getting some sent back requiring medical justification however, we've contacted Conduit, and they've told us they don't know the mailing address. Is a fax going to be sufficient?

And then to echo what some of the specialists are saying, our early childhood caries rate is extremely high, and treatment plans will change quite a bit. Looking at the legislative audit it was on average, I think, eight stainless steel crowns per child. Our early childhood caries rate is through the roof, so want to support them in that. While I appreciate these open comment periods, I feel like everybody puts time and effort to write things and become, you know, come to these meetings and be eloquent in their delivery but it seems like it's falling on deaf ears, and it's nice, and we appreciate these periods. But it doesn't seem to be considered.

Matthew Hirschfeld: Thanks, Dr. Cummings.

Renee Gayhart: You know I guess my response, if you take a look at even that one slide where we talked about the duration from the start to the finish of Regs projects and the department, and this division in particular, with all the Regs projects we have across providers, we do the best we can to really get out there and do that scoping, meeting. Review those regs, and rarely do we pull them back, rewrite them, and put them out for a second round of public comment. So, we definitely did here in that first round things that needed to change. We change those and put it back out. And then we've had many meetings with this particular group on the prior authorization component and explaining the Reg. So, there's a process, there's a public process for all Regs processes. We also have training from conduit, and with our operation staff. That's another avenue. Behind the scenes every single day we probably deal with fifty to one hundred different providers discussions on billing, on claims, on prior authorizations, a little bit of everything. We do appreciate the input and when we see comments that can make the project better, those regs better. We do take the time to redo those and do that second round of public comment. So, it's definitely not falling on deaf ears from our side. We've probably gotten staff online right now. We do a lot of prep for these meetings, and we work with the MCAC and the advisory group. There's many, many hours that went into just even getting ready for this meeting, so I just wanted to throw that out there that it's not on deaf ears.

Zazell Staheli Cummings: For sure. And so, you know, I'm trying to be very respectful and be thankful for this opportunity but at the same time all of these changes were also happening. You know you put your timeline started in February 2020 so not only are all of your oral health care providers in the in the State and the nation and in the world trying to figure out how to safely provide care during Covid and then and then to have this on top of that, but You also know It's just a lot. And you know, having the boots on the ground, we're here to help, we want to help people, that's why we do what we do but it's making it harder and harder to accept Medicaid and see those patients which is unfortunate. Thank you.

Matthew Hirschfeld: Thanks for coming. Dr. Imler?

Dr. Toby Imler: Thank you. I'm the dental director at the Tanana Chiefs Conference here in Fairbanks, Alaska, and I want to echo some of the concerns that I've heard from others, especially as it relates to our patients traveling to and from the village. It sounds simple to do these prior authorizations but sometimes we're getting these referrals from health aids or from dental health aid therapists and the information is incredibly limited. We're challenged in our flight availability from the villages and the costs associated with that. We don't have hotels here for people to stay at so people are sleeping in their cars because there's no place for them to stay, and so to get them into town for a visit is a significant challenge so when we get the patient we want to get everything done that we can, which means taking them to the operating room and getting them taken care of, and a lot of the things that have been put in place here regarding the numbers of things that can be done at a visit or the requirement for prior authorizations and being able to travel, it just really puts a lot of barriers up for our patients and I just want to make sure that that's understood out here in the hinterlands.

Matthew Hirschfeld: Thanks, Dr. Imler. there's a There's quite a few comments in the chat that are similar to that. So, I'm paging through to get to new comments. we appreciate you summarizing for all the folks that said that Dr. Imler.

Krystal Nichols - DHCS: So, you know we've heard a lot of comments about processing issues. I've seen a couple of comments about fax issues and a couple of other concerns along those lines. I don't know if all of the providers on the meeting are aware that we are changing fiscal agents, and that we are actually in the process of doing that now.

It'll transition from Conduent to our new vendor, which will be HMS. And that transition will be finalized on April the first actually and so some of these comments that you're discussing now with being able to process authorizations easier, better, smoother, getting, a hold of somebody if you have questions, those are all things that we're actively tackling across the board with a new vendor to make sure that the processes are smooth. To make sure that you can get a hold of people when you need to. You can get through fax lines and whatnot. So, I just want to make sure that everybody on the line is aware of that. As far as travel concerns that has been brought up many times in the last couple of weeks. we do hear you and understand that there can be travel concerns, and we do also know that some of the prior assessments before traveling can be limited

because of limited training. With dental health aids, and what not. So, we are also looking at a separate process for same day surgeries just to streamline that get it completely out of the mainstream queue and try to work through some of that as quickly as we can, so that doesn't impact travel. Those are all things that we're trying to do. To scramble to put together quickly because we are listening to you all and we have considered that we didn't realize how much of a challenge some of these things really have been, and we do want to make this as smooth as possible, and still meet the auditors' concerns. So, any ideas you guys have we are open and willing to take those.

Toby Imler: I appreciate those comments. This has been a real challenge for us with Raven closing down up here. It is really our ability to get patients in for care and to add another burden where you've got to be seen and seen again is just tough so anything you guys can do to streamline that process would be greatly appreciated.

Renee Gayhart: Yeah, we've been seeing that quite a bit across all disciplines with Medicaid. I don't know if folks know this, but we probably do about one thousand five hundred travels a week. We are trying to come up with these streamlining's and efficiencies, like Krystal was saying, we spend a lot of time trying to figure that out. If there's repeat visits necessary, is there a way to put that in the system for the travel. We definitely hear you, and we deal with that as well, especially knowing about the reduction of flights per community. So, some of that must be worked out ahead of time, just to have a seat on the aircraft to get out. So, thank you for those comments.

Matthew Hirschfeld: Thank you. Dr. Andler?

Matthew Hirschfeld: Dr. Ambika Srivastava?

Ambika Srivastava: Good evening, everyone. I would like to echo what everyone else has been saying. specifically. I want to talk about how this is going to affect special needs over twenty-one. I'm a general dentist here and I know they're treated as pediatric, but when they have more needs, and there's a cap, how would that be handled? And again, I want to echo having criteria for guidelines for pre-authorizations. There are processing delays, as everyone has mentioned and then recently, I did see a few people talk about how it is possible for us to delay this until April to make sure that when the new system starts, we can start this as well for proper response.

Renee Gayhart: Okay, I'll take that one. The regulations go into place December first, and it requires a service authorization that is within that regulatory package. We can't do a delay once the regs are implemented. But, like we said in the one slide, we are definitely looking at those that we're involved in with the Dental Advisory subgroup setting up another round for folks to take a look at future efficiencies.

Matthew Hirschfeld: Excuse me, Okay, I'll keep moving.
I notice that we're right at five fifty-nine. I'm going to take one more comment if That's okay and then, we'll break for the night. There's a

woman named Devon Banks, from D.C. And there were a couple of comments along your lines, Ms. Banks.

DeVon Banks: Yes, my name is Devon Banks I'm representing D-Tech billing and Claims. Actually, I just wanted to provide some perspective to you guys at the Medicaid program. I think I have a little bit of a unique perspective, because we do process Medicaid claims and pre-authorizations for clients all over the country. When we took this client on, I was really perplexed to see that the processes were just kind of antiquated. I've discussed this on previous meetings before. I really just would like to see if that could be made at least a part of the focus forum going forward with new changes in this day and age, and just such paper-driven processes are creating a bottleneck for your providers who are out there in the field doing thankless jobs trying to provide quality oral health care to a forgotten population, especially out in the villages. So, I feel like, you know, there's so many other challenges they have to deal with, if we could just reduce the paperwork, it would be a help because it's not something that's necessary. We should try to make use of technology to help improve some of these workflows.
I think that would be greatly appreciated and would kind of make the rest of the stuff they have to deal with not quite so bad, you know. But this is possible because I'm seeing it all over the country with other Medicaid programs. I think it's just a matter of making it a priority, so that you are not going to lose providers due to paperwork issues, because that's just not necessary. It's something that you can avoid. At one point I had recommended that my client drop this program because he's had to actually hire two people just to keep up with the paperwork and tracking, and you know what they didn't receive that back, we're still waiting on it, and it's definitely not a three-day turnaround. So, I just wanted to again provide some perspective from an administrative side of what we're seeing. So, it technically creates a situation where you have to hire just to manage.

Matthew Hirschfeld: Okay, we certainly appreciate everybody joining us on late on a Friday afternoon and again, the slides will be available, and there are some email addresses at the end of the slides to ask questions, and certainly if you have any suggestions on how to make the prior authorizations work better, and the regulations work better. We're certainly happy to listen. From my standpoint on the MCAC we are starting the dental subgroup again. And so, we will be at that. That's another great way to provide comment as well. So, thanks to all the Dentists thanks for all you're doing for the kids and adults in in Alaska. I we sure appreciate that. So, thanks for joining everyone.

Renee Gayhart: Thanks for your time. Everybody

Matthew Hirschfeld: Meeting Adjourned

Matthew Hirschfeld
Chair, MCAC Dental Subcommittee