Alaska Department of Health and Social Services

DENTAL SERVICES: MEDICAID COVERAGE AND PAYMENT

Public Comments Received Through March 24, 2021

The following comments are listed in the order in which they were received.

FROM	COMMENTS	DIVISION OF HEALTH CARE SERVICES RESPONSE
Owen Mandanas Conduent State Healthcare	My name is Dr. Owen Mandanas and I do service authorizations through Conduent for Alaska Dental Medicaid. My job is to decide if procedures should get paid that do not have clear guidelines and need a professional dentist's perspective. I have had this position for only 2 years now, but many things I have seen are troubling. Dental Medicaid reimbursement is out of control and how it got that way is a troubling story, As a bit of background, I have a private practice in Anchorage (for 11 years) and worked as a public health dentist in Nome for the Norton Sound Corporation for almost 9 years. I was asked to apply for this job with Conduent, by a colleague, Dr. Dale Burke, who also has performed this same job for over 10 years. According to Dr. Burke, the former dental supervisor (whom I never met) added dental reimbursement codes willy-nilly for 10 years. Dr. Burke would question the addition of certain codes as not being appropriate for a welfare program and she would add them anyway even though she had no dental background. Sadly, this woman passed a few years ago. Interestingly, her solo actions done without proper professional dentists' recommendations or governmental oversight is likely responsible for the influx of dentists into the state and the proliferation of box-type/chain practices during the past 10 + years. Due to her cavalier approach of what should get paid by Dental Medicaid, Alaska became a "gold mine" for out of state dentists and sentiments such as this can be seen in texts and conversations seen in transcripts of the Hoverboard Dentist legal case (that recently resulted in jail time and loss of this provider's dental license). Due to the word spreading of this Alaska Dental Medicaid gold rush, I have seen many cases pass my desk involving dentists' taking advantage of our liberal coding regulations that can best be described as poverty abuse. There are many instances of providers performing unnecessary procedures such as a full mouth of extractions (that radiographs would show to be unnecessary by the majority of dentists) that get paid under emergency services. Since Denali Kid Care gets paid with little oversight, the children in our state are also abused. An actual case is a 16 y.o getting 25 crowns on a single date of service with Medicaid paying $19, 632 and six weeks prior this same child, getting 9 root canals, 25 build ups and 4 extractions on the same date of service at the reimbursement of $11,174. So one child by one provider, for two days had over $30,000 of work done paid by our state and federal funds. We Alaskans are literally paying for other Alaskans to be abused. There are similar cases like this happening all the time. Even if this work was dentally/medically necessary (which much of it is not) this is certainly NOT what Medicaid, a public health welfare program, was intended to pay for.	Thank you for your comments. DHSS proposed dental changes to address known dental program issues. You noted concerns that date back as far as 10 years ago, however DHSS has no record of these concerns being shared with DHSS prior to your public comments. We encourage you to notify the HCS director, through the fiscal agent contract manager, as you identify any areas in which you believe the Medicaid program can be improved. This will allow DHSS to evaluate concerns in a timely manner. Additionally, if you observe Medicaid provider or recipient activity that you believe to be fraudulent, please contact the Alaska Medicaid Fraud Control Unit at 907.269.6279.

	Fortunately, the new dental supervisor for Medicaid, Sheri Larue, has worked with a team of dentists to try and update the regulations. She inherited a very big mess and has done a great job trying to be fair and sensible. Many of the abuses in the example above can easily be stopped if you review and just pass the guidelines she has doggedly worked on for the past two years . She and Dr. Gosselin created a Dental Medicaid Quality Advisory Group made up of a group of volunteer dentists and we have addressed many of these issues in a series of multiple meetings for 1 1/2 years now. The Quality Advisory Group which includes Dr. Dane Lenaker, the dental representative for the Medical Care Advisory Committee for the state, and Miss Larue's supervisory team have all agreed on the regulations she has sent to Juneau. Examples of some of the measures include requiring preauthorization for a porcelain crown for children and preauthorizations for extractions over a certain number of teeth on adults. We were eager to have these regulations passed in July, but this issue and/or documentation appear to be lost somewhere in the bureaucratic void. I am sure Covid has not helped. Rest assured, these guidelines in no way prevent Medicaid recipients from receiving adequate dental care. The primary goal is to prevent state and federally funded physical abuse of the Alaskan welfare population. I am asking for your help for two things only. 1) Please just ensure the new regulations/guidelines sent to the state by Sheri Larue get passed hopefully before or by January 2021. 2) If possible, please follow up on the FBI investigations being conducted on a few dentists over the past 4-6 years. I truly thank you for your time which I understand is precious as the year comes to an end. After 2 years of being privy to this sad information, I feel like I am now part of the problem if I do not help rectify the exploitation of our Medicaid recipients. I am hoping you will be an integral part of the solution.	
Dr. Daniel Kiley Oral Health & Healthcare Strategies	When a patient knows the “painful tooth” cannot be removed today without pre-auth, it increases the period during which pain needs to be managed and increases the demand for opioid like scripts and the dangerous mismanagement of OTC meds.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Samantha Mize	I am a pediatric dentist and I have a few questions about the proposed changes. 1) Do stainless steel crowns have to be authorized? 2) Do extractions of teeth on children <21 years need to be preauthorized?	Thank you for your comments. Proposed regulations for which the public comment period closed 03/24/21 included

	If either of these is this case, this will greatly hinder provider's ability to provide care to children, especially native children who are flown in for treatment as we often do not know if teeth are in need of extraction or not prior to the day of treatment.	prior authorization requirements for all crowns and all extractions, irrespective of age of the Medicaid recipient. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dave Logan, DDS Executive Director, Alaska Dental Society	The Alaska Dental Society, representing 376 Alaskan licensed dentists, offers written comment on the proposed changes to the Medicaid dental system. Most of the prosed changes seem to simply codify policies that have been in place for some time. The change to requiring preauthorization for emergent extractions, codes 7140-7230, represents a substantial change to policy. It is unclear what the division's motivation is for the change given the startling lack of information given to providers at any time beyond the article on periodicity for prophies. The practical effect of requiring preauthorization for emergent extractions will be three fold: • Patients will be required to return for a second visit while the preauthorization is secured unless the office is able to secure preauthorization while the patient waits, a process most offices are unable to complete given the other daily demands on a practice. • If the patient has to return for a second appointment then pain medication will likely be required- if the extraction is under emergent generally the patient will be in severe pain and/or infection -which means prescribing narcotics. The sequela of opioid prescriptions is well known and this will only worsen the situation. • If the dentist extracts the tooth without preauthorization then they take on the financial risk that preauthorization will not be secured post treatment. It seems unlikely under normal circumstances a dentist's professional judgement to remove a tooth will be questioned so it is hard to see the motivation here. If the Division sees this as a cost savings then why the extractions will not be preauthorized needs to be clearly articulated. If the Division believes that most/all pre-authorizations will be granted then the additional burden of preauthorization seems to simply increase the operating expenses for all involved - the Division, the dentist, and Conduet.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

Dr. Dale Burke Conduent State Healthcare	As one of two dental reviewers for the Alaska Dental Medicaid program (under a contract with Conduent), I am not only strongly in favor of the changes, but actually would like to see even more changes and controls in place. I have been doing this since 2008 and the abuse, fraud, and overtreatment that I and Dr Mandanas face weekly is staggering. The only way around this is to either drop a high number of covered services, keeping only the basics necessary for prevention, relief of pain/infection, and basic restorative. There also needs to be more defined policy as to when, and how often procedures are covered. This would be no different than the 49 other states. I urge the passage of these changes and also urge the continual development of rules and controls. It is a long story, but if anyone would like to know more, I am always happy to accept phone calls.	Thank you for your comments. DHSS proposed dental changes to address known dental program issues. You noted concerns that date back as far as 13 years ago, however DHSS has no record of these concerns being shared with DHSS prior to your public comments. We encourage you to notify the HCS director, through the fiscal agent contract manager, as you identify any areas in which you believe the Medicaid program can be improved. This will allow DHSS to evaluate concerns in a timely manner. Additionally, if you observe Medicaid provider or recipient activity that you believe to be fraudulent, please contact the Alaska Medicaid Fraud Control Unit at 907.269.6279.
Dr. Matthew Parisek	Thank you for hearing my concerns. My only concern with these new changes is the provision that "crowns need to be authorized by the department". I am just concerned if this includes stainless steel crowns (SSCs). SSCs are (and should be) considered a restorative procedure as the need for SSCs on a primary (or permanent molar in some cases) is often not known until during tooth preparation. Oftentimes primary teeth with caries need the caries to be excavated first before determining if a resin filling or stainless steel crown are the better restorative option. Adding SSCs as a procedure that needed to be preauthorized would add unneeded stress and work for both the dental offices and the medicaid offices of Alaska. Otherwise, thank you for all you do to help those in need in our communities. Please feel free to reach out to me if you have any questions or concerns.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Jennifer Wilson	To Whom it may concern,	Thank you for your comments. The Division of

	As a pediatric dental specialist, it is one of my jobs to advocate for the dental health of children. The latest updates for the Medicaid coverage for children have two main changes that could hinder dental care for children of Alaska. On page 8; Page 9; Treatment planning is an important element for pediatric dentists. When we see a child in our Anchorage office and provide a treatment plan to the family, we have the ideal situation. We have a dental radiograph, the child present for intraoral exam and can discuss options with parents and re-appoint for their next visit. This scenario is not always the norm in pediatric dentistry, especially in Alaska. If there is a young child with pre-cooperative behavior due to age or dental anxiety, we often cannot obtain diagnostic radiographs that show every surface of dental caries. We may know that there is rampant caries from a simple visual exam and these children will need general anesthesia for full mouth dental rehab. It would be logistically impossible for us to take intraoral radiographs the day of treatment under General anesthesia and then get pre-authorization from Medicaid to then complete their treatment. This is especially true when a child from a remote village is referred for full mouth dental rehabilitation. For example, the referring general dentist may be able to see up to 4 quadrants of rampant decay and know that the child may need 8 stainless steel crowns or extractions, but without current radiographs the day of treatment it is impossible for a practitioner to predict 100% of the time which treatment will be rendered for each tooth. It is very common that we will estimate 8 stainless steel crowns for all the primary molars and when we get the bitewings during surgery, we identify caries on the canines, therefore the child will need 12 SSC's. I urge you not to require preauthorization for dental extractions or stainless steel crowns for Medicaid patients under 21 years of age. To refresh you on why we treatment planning for a stainless steel crown vs a resin composite, there are a few main criteria that the pediatric dentist looks for. I spend a lot of time discussing this criteria with parents, so they can make an educated decision about treatment for their child. I will review some main points with you, as if you are a parent reviewing a child's tx plan. If caries are interproximal (IP; between the teeth) on a primary molar or canine tooth, based on dental literature, an average composite restoration will last on average 2-3 years vs. a stainless steel crown that averages 5 years. This is due to many factors, the width of primary tooth enamel is thinner than adult teeth, the interproximal contact on primary teeth is wider and therefore more likely for a composite to leak and fail and proper isolation with children can be more difficult in placement of composite resins. For these reasons, if a tooth has IP decay or decay on the occlusal surface greater than 1/3 the width or either of these with demineralization or decay on the buccal surface, a stainless-steel crown is recommended. The age of the child should also be considered in treatment planning. For example, if a 2-5 year old is tx planned for SSC's on a primary molar, we expect that tooth's crown to last until that molar exfoliates anywhere from age 9-13. If we were to place a composite restoration, the likelihood of failure of that composite is going to be higher,	Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	therefore increasing the possibility that the child will need further treatment and more dental visits for that tooth. For children, diagnostic dental radiographs can be difficult to obtain. Often is the case that we have a child with obvious rampant dental caries that needs full mouth dental rehabilitation under general anesthesia, but we are unsure of all the surfaces of the tooth involved until with get diagnostic radiographs, once they are asleep. Pre-authorization for such crowns is going to be a waste of resources and time for Medicaid, not to mention not feasible, because we will only know the actual treatment recommended for the tooth on the day of treatment, during the surgery. This is exactly why when we go over pre-op consent with a parent that we give them all the possibilities of what we may find and make sure the parent understand and agree to all of the possible treatments that we may have to complete. It is the same idea for Medicaid. We need for you to understand how pediatric dentistry flows and why pre-authorization is not suited for this type of practice. I completely understand how it applies to a permanent tooth crown. Treatment planning for a permanent crown can have pre authorization as the timing is very different. Permanent teeth crown pre authorization makes total sense, but pre authorization for primary teeth stainless steel crowns does not. Along the same lines. Please do not require pre authorization for primary or permanent extractions. There are some cases when if a permanent tooth cannot be restored during a general anesthesia case, that with the parents consent, a pediatric dentist will try to save a tooth, but cannot due to the extent of decay. This is another reason not to require pre-authorization for primary or permanent teeth. I would be happy to discuss these points further. Please do not requiring pre-authorization for the above procedures.	
Sonia Turner Southcentral Foundation	I work for the Southcentral Foundation Children's Dental Clinic. I do have some concerns with some of the new regulations. When a child is sent to the operating room under general anesthesia the providers come up with their treatment plan in the room after the child is put to sleep. Most children that are sent to the operating room are uncooperative and will not sit for a full comprehensive exam. Most x-rays are done in the operating room to see cavities in between the teeth and then that is when it's decided if a tooth needs to have a stainless steel crown placed.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Geraldine Jones Children's Dental Clinic	I am writing you my comments/concerns on behalf of my Pediatric costumer-case owners of Alaska. The proposal to require preauthorization for dental codes Per tooth is an Extreme measure. I schedule for Pediatric Dental Surgeries and let me tell you, a referral coming in from a provider at one facility, to our providers at our facility might have a different view of how they want to approach care for each patient Dental Code wise. Asking a provider from a different facility of the receiving	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without

	referral end that has not laid eyes on a patient to add dental codes is not the correct way to go about this. I am fully understanding that this approach is probably due to the fact that Medicaid funds are being exhausted, for quite some time now. Maybe there needs to be a change in the approval process for receiving Medicaid services for applicants.	creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Dalton Pigman	I would like to express my opposition to the proposed dental medicaid changes. I am a pediatric dental resident about to enter the world of private practice. Requiring pre-authorizations for SSC would greatly inhibit our ability to provide appropriate care to Alaska children. Many times we cannot tell what treatment is indicated until we surgically prepare an adjacent tooth. We need the flexibility to be able to add treatment while in the chair operating.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Kayla Carver Southcentral Foundation	I have reviewed the proposed changes to procedures requiring preauthorization in the recent documentation that was sent out by the ADS. I have concern for the routine procedures that are completed daily in dental practices in the state. If we, as dentists, must gain preauthorization for procedures like stainless steel crowns and routine extractions, it could place an undue barrier to care for an already underserved population. This will slow our ability to take children out of pain by providing the most basic, AAPD recommended care. If we are unable to fill next available appointments, it could cause issue getting children who are covered by Medicaid insurance into the schedule in a timely manner. I currently am the director for the pediatric dental program at the Alaska Native Medical Center and we also have concern that if the local private practices have difficulty getting these children in, they may have to come back to ANMC for care and we will have a back log of children that now have to wait 8-12 months for care, especially in an OR setting. The local pediatric dentists have worked hard to ensure access to care for children in our community and it would be unfortunate to have a barrier to care placed by the insurance who helps provide the funds for these children to be seen. Please consider advocating for those patients who cannot do so for themselves.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. James Singleton Southcentral Foundation	My name is Dr. James Singleton, I am a Board Certified Pediatric Dentist practicing in Alaska for the past 30 years. I am writing to express my strong feelings against the changes that are being considered to the current Medicaid reimbursements. Medicaid is supposed to provide a safety net for patients that do not have the resources to pay for dental care themselves and do not work for an organization that provides dental insurance. Young Medicaid patients happen to be the ones with the greatest amount of unmet dental needs and have the most severe dental disease. Stainless Steel Crowns and Extractions are two of the most common procedures required by young Medicaid patients. To require pre-authorization for these treatments will delay treatment for those that have already suffered through limited access brought on by the COVID-19 Pandemic. I am afraid that	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-

	because of this delay these children will require more costly emergency treatment and perhaps even hospitalization and General Anesthesia! In reality is will not be a cost saving measure at all! In addition, because these are very common procedures virtually EVERY patient will be affected by this regulation change and the backlog of those waiting for approval will be tremendous. In short, I believe this change will unfairly place the greatest burden on those that need dental care the most. Thank you for your time and consideration.	enrolled providers or Medicaid recipients.
Dr. Thomas Brewer Southcentral Foundation	In my capacity as a pediatric dentist with many years of public health practice experience in the State of Alaska, I would like to register my concerns regarding recently proposed changes to Medicaid dental services coverage for children (under 21 yrs of age, 7 AAC 110.150). I am concerned that some reductionist reasoning, vagueness, or lack of specificity in the rewrite could have a negative impact on the provision of, and access to, dental care for Alaska's children. Specifically I have the following concerns: The estimated annual cost to comply with the proposed action to a private person is $0. I think this is potentially inaccurate. In particular if dentists were required to get pre-authorization from the department for commonly applied treatments such as stainless steel crowns, there could be considerable cost to the provider in time dedicated to completing such paperwork. The proposed regulation changes mention that "crowns must be authorized by the department". I take this to mean prior authorization will be required. This would seem to me to be a reasonable requirement for a lab fabricated crown on a permanent tooth. However, the wording does not indicate that this authorization would be limited to such crowns, or if the requirement would apply to all crowns , including prefabricated stainless steel crowns on primary teeth. Prefabricated stainless steel crowns on primary molars in pediatric dentistry are the equivalent of a class II amalgam or composite in the adult dentistry world. If pediatric dentists will be required to get pre-authorization for every stainless steel crown the burden placed upon them will be huge, not to mention the burden on the department that gets to review all those pre-authorization requests. The same would apply to pre-fabricated porcelain (zirconia) crowns for primary incisors. In addition, there is the logistical concern that many pediatric patients are not cooperative for exam and or radiographs, and so often pediatric dentist find themselves with their patient asleep under general anesthesia on the operating table before they are able to complete a comprehensive examination with good quality radiographs, which often confirms the need for crowns on teeth that up until that point could not have been known to need such treatment; not a good time to be requesting a pre-authorization obviously. I'm certain we don't want to discourage the use of stainless steel crowns for the restoration of interproximal molar caries in high caries risk children, as this has been well documented in the literature and by experience as the most durable and cost-effective restoration in these situations. The proposed changes indicate that pulp capping will not be covered. Again I have concern about specificity here. While there is considerable evidence that direct pulp capping in situations of carious	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	exposure is not a very effective treatment long term, there is excellent evidence to support direct pulp capping (such as Cveck technique) in trauma cases, and indirect pulp capping in cases of suspected carious exposure without symptoms of irreversible pulpitis or pulpal necrosis. In these cases if pulpal vitality can be preserved, then that is the best possible outcome for the patient at a fraction of the cost of full-on endodontic treatment. It would be a shame to see third party payment regulations inadvertently leading to much more aggressive and expensive pulpal therapy than is needed or is in the patient's best interest. In summary: As a taxpayer, I very much appreciate the intent here to reduce fraud and make best use of resources, but I don't think the proposed changes are without cost. I implore those charged with making the decisions here to look at more specific language to protect the use of prefabricated crowns on primary teeth, and the use of direct pulp capping in cases of trauma and indirect pulp capping in cases of suspected carious exposure without signs or symptoms of irreversible pulpitis or necrosis. Or if the intent truly is to require pre-authorization for pre-fab crowns on primary teeth and to not pay for any kind of pulp capping, to reconsider this intent and the negative ramifications that could result.	
Dr. Alex Olson Southcentral Foundation	My name is Alex Olson, and I am a dentist currently in residency at the Alaska Native Health Campus to pursue the specialty of pediatric dentistry. I am writing regarding recent proposals that would implement changes to Alaska Medicaid. For the sake of brevity, I urge you to withhold approval of these proposed changes until further clarification can be outlined and publicly presented. As they currently stand, the proposed changes would do incredible harm to the thousands of children receiving dental care under Alaska Medicaid and would significantly hinder their access to care. From what I understand from these changes, pre-authorization becomes a prevailing factor in the ability to provide treatment. While I acknowledge that this approach is to limit overuse of services and ensure that appropriate treatment is covered, this strategy is shortsighted and will only result in further challenges to these patients who depend on Alaska Medicaid for care. The world of pediatric dentistry frequently--daily--requires the use of prefabricated crowns for treatment, but its indication for use is not clear enough to be able to rely on pre-authorization. I will provide three examples to illustrate the problems with the current proposal changes: 1) Clinical exam and radiographs are helpful but not always definitive in our decision to choose a crown over a typical filling. Often, however, the decision must be made only after the patient has been anesthetized and the caries excavated to determine the type of restoration that would be needed. Pre-authorization would make this decision virtually impossible, which in turn either pushes the dental provider to choose a treatment regimen that is not in the patient's best interest or ultimately leads them to no longer provide services as a Medicaid provider. 2) Many pediatric patients require either sedation or general anesthesia for their dental needs to be addressed. In many cases, radiographs cannot even be acquired until the day of treatment after the patient has either been sedated or put to sleep. In these cases, we may have no idea	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	that multiple posterior teeth require treatment with crowns, but the patient is already sedated and absolutely should be able to receive the treatment deemed necessary at that time. Requiring pre-authorization for coverage of crowns would again create an impossible stumbling block in these frequent cases, resulting in the likelihood that the dental provider will choose to no longer treat these Medicaid-dependent children. 3) When a pediatric patient presents to the dental office with emergent pain, treatment is necessary and should be provided at that time. It is not uncommon for pediatric dentists to perform either pulpotomy or pulpectomy treatments in these cases, which necessitates the protection of a crown in order to preserve the tooth. To require pre-authorization for crowns would affect our ability as providers to treat emergencies properly and ethically at the time of the emergency. This serves as a detriment to the health of the child and is an embarrassment to the strides that Alaska has made regarding healthcare coverage for children. I speak with all the sincerity of my heart and my profession when I say that I am against the proposed Alaska Medicaid changes as they currently stand. To approve them without further consideration or clarification would be extremely detrimental to the children of Alaska by limiting their ability to access and receive the dental care that they need--when they need it. I am confident that you hold these children in high priority in your decision and will do all that you can to protect and advocate for their health and well-being.	
Dr. Mark Birmingham	I am writing to express my disapproval of the rule for preauthorization of extractions for Medicaid patients. I believe that the option to immediately remove a tooth that is causing a patient pain is vitally important to the Medicaid population. Many patients that arrive at our office for emergency extractions are presenting with teeth that, even if the patient did have the resources available, would not be able to be restored. The only thing that the preauthorization rule does, is leave that particular patient in pain for a longer period of time. Patients that are not treated on the same day for pain will be pressuring providers further for more opioid prescriptions, something that the dental community as a whole is trying to do away with. Extractions are the most basic treatment that a dentist can perform to alleviate patient's pain, delaying this treatment makes no sense to me as a dentist.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. David Paape	I am writing to voice my opinion on the proposed change to the preauth needed for dental extractions. I have been a dentist in Alaska accepting Medicaid for 13 years. Of all the changes over the years this one is by far the most detrimental to patient and dentist. This is a terrible proposal. It's actually pretty cruel. Please consider eliminating a preauth need for extractions.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

Dr. William Bergeron	Name is William F. Bergeron, Jr. I am writing this letter to register my opposition to the proposal to require pre-authorization for extraction of teeth in Medicaid patients. I am an oral and maxillofacial surgeon and cover trauma call at the local area hospitals to include Providence Alaska Medical Center, Alaska Regional Hospital and the Alaska Native Medical Center. Occasionally these calls require treating patients with severe head and neck infections of dental origin which require the drainage of intra oral and or extra oral abscessed spaces. If the necrotic teeth which caused these infections are not extracted when the abscesses are drained the patient will not get better and will face an increased length of stay in the hospital and possibly death. I do not understand how in situations like these I am to pre-authorize extraction procedures. If back billing Medicaid for pre-authorization required procedures was seamless and easy I might not object, however this has never been the case. In a different situation if patients who present to an office in acute pain are required to wait for pre-authorization this could cause the patient to develop one of these severe potentially life-threatening head and neck infections. Therefore I would like to register my opposition to adding extractions to the Medicaid list of procedures which will require pre-authorization in the future. Thank you very much for considering my opinion in this matter and I hope your decision will reflect my concerns.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Eldon DeKay	I am writing because I am concerned about the proposed change to medicaid rules. I am an orthodontist who still accepts medicaid patients, despite the low reimbursement rate. We often request extractions for our cases. Orthodontic cases are already pre-approved before treatment begins. This would be one more roadblock and would serve no purpose. I encourage not enacting this rule change.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Kimlea Medlin SSMH Dental Clinic	I strongly believe that any consideration to require an approved prior authorization before a dental extraction for a patient could occur would be detrimental to the patient and negatively impact dentists in being able to offer appropriate emergency dental services within our professions standards of care. If we as professionals were to be waiting an unknown amount of time for approval to perform an extraction the following would occur in many cases: 1) Antibiotic prescriptions to help alleviate pain that would not be indicated if the source of pain and infection could otherwise have been removed => goes against standards for antimicrobial stewardship 2) Pain medication prescriptions more likely to involve scheduled narcotic medications due to failure to remove the source of pain while awaiting authorization => could worsen our opioid misuse concerns	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	3) More likely to have a "non-return" of the patient for definitive care due to the potential that the combo of antibiotic and pain medication may alleviate the urgent need and the patient could go about their life/schedule deferring the treatment until it hurts again. This would lead to an ongoing cycle of deferring care to having payment authorization within the window allowed for the services to occur. 4) Increased costs to both the patients (multiple occasions off work and transit costs) and the dental practices for repeated visits one for the exam and a separate encounter for an extraction when approved that could have remained combined into one encounter (staff time, sundry supplies for treatment room and instrument sanitization/set-up and sterilization, staffs personal protective equipment, etc)… a. In our clinic it with new COVID19 guidance it now costs about $18 dollars each time we have an assistant setup a room with fresh PPE, clean barriers, and supplies for a patient encounter (being a tribal facility we get many supplies on a Federal discount) I imagine it is even more costly to the private providers in the state. b. Each set-up and breakdown of a treatment room also generates garbage (mostly non-recyclable plastics) that clog up our waste stream, landfill, etc 5) Increased challenges in attempts to comply with COVID19 practice guidelines including trying to obtain negative COVID test result prior to dental services. In particular, my main disagreement with this proposal goes back the believe that this would be a "bad" move for patient care and their safety. I was firmly taught nearly 19 years ago in dental school by our Oral Surgery department - "don't let the sun set on pus". What the phrase meant is you see a source of active infection for a patient, maybe they have a swollen face, maybe they are in pain, maybe you just see a pustule next to a tooth… we have a professional obligation to address that concern in that moment. The definitive cure is to remove the source of infection => most often this is an extraction. Delaying that for a prior authorization is not appropriate patient care.	
Dr. Alison Walsh Polar Bear Dental Care	Please reconsider the proposed rule to require prior authorization before extraction appointments. Doing so would be a disservice to those on Alaska Medicaid as well as providers willing to accept Alaska Medicaid. I have had patients who needed to choose between using gas for the day to get their children to school or come to their dental appointment. Many of these families already have barriers to accessing dental care. By requiring prior authorization for extractions this automatically necessitates two appointments which increases their burden to access dental care. The delay in treatment can also cause an increased risk of infection, an increase in pain, and a greater chance of sequelae. Antibiotics, with their systemic implications, would be given more frequently. A better course of treatment is to remove the source of the infection. It is also a poor use of the dental providers time and resources. Frequently an extraction can be performed at the time of the emergency exam. A second visit doubles the ppe cost, increases the risk of covid exposure, and increases the chair time needed to care for the individual.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	Please also reconsider requiring prior authorization for crowns (D2929-D2934) for children on Medicaid. Frequently the best long term treatment for a child's tooth with cavities is a crown. By requiring prior authorization, teeth that may be best treated with a crown may receive only a restoration due to the extra step of obtaining prior authorization and need more treatment in the future. This will be more costly to the Alaska Medicaid program because the tooth will need treatment twice and the child will be asked to go through two procedures. Frequently for children coming into Anchorage from rural villages diagnosis is complete one day prior to their scheduled surgery. There isn't enough time to gain prior authorization. Will this then require two trips to Anchorage, one for diagnosis and a second for treatment? This would be a disservice to the family and an inefficient use of Alaska Medicaid money.	
Dr. Benjamin Hadfield Chena Dental Care	I hope this email finds you well, I just wanted to take a moment and express respectful opposition to the proposed waiting period and pre-authorization requirement for dental extractions in medicaid patients. There are many angles to view this from, but one that lies near to my heart and is often overlooked is that the patient base who is already at risk for narcotics addiction and abuse would have an even greater opportunity to fall into this deadly trap. Relieving pain in a timely manner among low-income and underserved populations is important, and part of treating them with the respect and dignity we all deserve.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Sameer Kapil	Unable to open document; sender notified and invited to resubmit comments. No reply was received.	Thank you for your comments. Unfortunately we could not open the document, and no reply was received when we reached out to request that you resubmit your comments.
Dr. Craig H Mullett	Please do not allow for yet another cumbersome rule to be put in place. When a patient comes to the dental office in pain, needing an extraction-the last thing they need is to be sent away to await preauthorization. A repeat trip puts them at risk for an infection or going to the ER for meds they may not have sought or required. It burdens their lives in other ways too-missing work, finding childcare, can't eat or sleep properly. It will double travel costs and Covid exposure and PPE use. Some will use alcohol or inappropriate substances to try and control . This change would NOT be in our patients best interests, it would --in fact-- be inhumane. Please do all you can to not let this happen !	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

Dr. Robert MacArthur	I am a dentist working in remote/rural Alaska and I am the Only Medicaid dental provider on the entire Island of about 5,000 people (which can increase in numbers to over 10,000 during peak fishing season). My dental team and I fly into Unalaksa-Dutch Harbor every other month to provide dental care to the members of my community. We see all ages and a range of services are provided including extractions. Requiring pre-authorizations before extractions can be very damaging to the oral and overall health of my patients due to extending the length of pain and increasing the likelihood of an infection to spread, especially if I am on island but cannot see my patients for an extraction until the pre-authorization comes back. We only have a remote health clinic on the island so if an infection does spread in a patient we don't have the resources and they have to be flown off island (Med-Evac) into Anchorage which winds up costing way more money in the long run. More importantly, it is dangerous to the overall health, safety and well-being of my patients, my community members, our fellow Alaskans. While waiting for pre-authorization my team and I might be at the end of our trip and leaving the island then forcing the patient to have to wait a month before we are back on island....a month in pain with an infection and taking antibiotics unnecessarily. Alaska is such a unique state with our beautiful geography, cultures, people and ways of life. Requiring pre-authorization before extractions would be deleterious to the overall health and well-being of my beloved patients and community members. I strongly oppose the proposal to require pre-authorization for extractions and thank you for your time and consideration in hearing my viewpoint.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Arne Krough	I wanted to formally express my concerns regarding the new proposed service authorizations for Medicaid simple and surgical extractions. I am a lifelong Alaskan, and a recent dental school graduate of New York University who has returned to my hometown of Anchorage to practice. I am currently in my fifth month of practicing since becoming licensed and am employed by a larger dental office in Anchorage, serving primarily Medicaid patients on a daily basis. One of my desires to become a dentist was the ability to help and provide a tangible service to my community, particularly the less fortunate who have been deprived of dental benefits or adequate dental care. Some of my most gratifying moments in my brief career thus far have been the treating the plethora of emergency patients who visit our practice in pain and/or with an active infection. The ability to diagnose and extract an individual's non-restorable tooth in the same day, knowing you have improved their life in a matter of minutes, is a feeling I can't compare to anything I have ever experienced in my life. It's rewarding to know these individuals will be feeling better instantaneously, possibly halting an infection from expanding to a further life compromising condition, and also	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	preventing an individual from becoming addicted to opioid pain medication. Because of these positive experiences, I see firsthand many of the same patients return for comprehensive care, who have avoided dental care for years and are forever changed by our ability to improve their lives. I strongly believe this provides a tremendous service to our community, while also leaving a positive impression on our field. I firmly believe the proposal of requiring a Medicaid service authorization for simple and surgical extractions will present undesired challenges to our community while also dismissing the welfare of the individuals who may need it most. I urge you to reconsider this proposal and look at other options to reduce or delay benefits rather than potential cause further harm to the people in need.	
Dr. Meghan Foster	Hello, my name is Meghan Foster and I am a pediatric dentist in Anchorage. I have major concerns about the potential for having pre-authorizations required for dental treatment. Very frequently when we are having patients come in they are having dental issues such as pain or infection. Anytime this is the case, we always try to do treatment the same day to relieve the issues whenever passable. I don't see how it is possible to require a pre-authorization for basic dental needs. This should not be a requirement. Also, in case the committees are unaware of how pediatric dentistry gets done for patients that live outside of Anchorage, I will provide a quick explanation. These patients frequently have not had dental exams, show up one day, and have dental surgery the next day. There is no possible way that this can be completed if pre-authorizations occur. We almost always go into the dental surgeries completely blind, and take x-rays once the children are asleep. We spend the next 60 to 90 minutes doing full mouth rehab at one time. There is no room in that to request for pre-authorizations. The entire unique and amazing systems in place for serving the Alaskan dental communities are not conducive to a requirement of pre-authorizations. This will make treatment impossible. I am asking for you guys to please reject the requirement for pre-authorization for dental work.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Joseph Vargas	My name is Dr. Joseph W. Vargas and I am a practicing endodontist in Fairbanks Alaska. I am writing your office to voice my personal and professional opinion about the recent requirement to have preauthorization for extraction for Medicaid patients. I do not see Medicaid patients and I do not perform extractions so I have no financial interest, only a professional one. Why does your office feel the need to impose this restriction? Does your office feel that dentists are abusing the current system and if so please elaborate. Is your office putting up another obstacle for treatment as a cost cutting measure if so please elaborate. Has your office truly considered the consequences of this action? The dental community has and these are just a few of the concerns we have if your policy goes into effect: Obtaining preauthorization, in most cases, will require a second appointment. Declining services at the initial emergency visit will invite an increase in prescriptions for pain or infection. People who are in pain or suffering from a dental infection (left untreated by their dentist if pre-authorization is required) may then go and burden urgent care and ER facilities who are ill equip to handle dental emergencies.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	There is an active pandemic going on. Access to care is already diminished. The challenges of visiting the dentist includes finding a dentist that accepts Medicaid, securing childcare, being excused from work, getting transportation (taxi/bus during covid). Traveling from remote locations in Alaska requiring a second visit will double this. Medicaid covers one day of travel; will they accept the burden of two? I believe requiring preauthorization for dental extractions of Medicaid patients is wrong, a disservice to the patients and disrespectful to the dental profession. I look forward to hearing back from you regarding this matter.	
Dr. Jon McNeil	I am writing to address the proposed changes to service authorizations for extractions. I have been practicing in Alaska for 11 years. During my decade-long tenure our practice has always accepted Medicaid. I have personally treated thousands of patients who rely on the Medicaid program for dental benefits. I am deeply opposed to the proposed regulations that would require service authorizations for dental extractions on Medicaid recipients. When a patient has an infected or abscessed tooth it is critical that the source of the infection be removed as quickly as possible. In dentistry, we really only have two options at that point: doing an extraction or the more costly alternative of a root canal. Currently, root canals require a service authorization that can take 1-3 weeks to receive. Extractions are the only immediate solution for relief for patients who present with pain. Requiring a service authorization for dental extractions will result in patients being placed unnecessarily on antibiotics. Antibiotic use is already a concern and does not fix the problem. It can take 3-4 days for antibiotics to work and even then they do not necessarily relieve the patient from pain. On top of unnecessary antibiotic use, the number of narcotic prescriptions will undoubtedly rise in a demographic of patients who are already at risk for misuse of narcotics. A patient who undergoes a dental extraction can generally get by with little to no narcotics. A typical dose would be 4 tabs of norco 5/325mg. If a patient is required to wait a week for treatment you can expect a prescription of 12-16 norco 5/325mg. An increase of 300-400% of narcotics prescribed. I truly believe that the State of Alaska should be liable for the increase in patients becoming dependent or addicted to narcotics by essentially refusing to allow them to have the proper emergency treatment. Further, the emergency rooms can expect to see a significant number of ER visits for toothaches and abscess teeth. Generally, when providers are confronted by unreasonable and frankly reckless bureaucratic decisions they push back by refusing to see the patients. At the end of the day the patients are the ones who ultimately suffer and the increased costs on the hospital system, drug abuse and addiction resources all get passed on to the State of Alaska. There are plenty of ways to save costs without denying patients the basic right to have definitive emergency services. There are way too many able body, working age people on Medicaid. The State should consider tightening the guidelines and requiring some accountability by the patients. The	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	dental society in the past has offered a number of cost saving cuts to non emergent / elective services including: Not paying for permanent crowns on adult patients, Not paying for partial dentures, not paying for retreatment of root canaled teeth. I am very disappointed that the State of Alaska has even proposed such a reckless change to a system that is already strained by limited participating providers and almost NO speciality support. By refusing emergency care to the patients you can expect to have infections that are so serious and life threatening no general dentist will touch them. Currently, in Anchorage there is 1 oral surgeon who is taking Medicaid. There are probably a half dozen points that I didn't bother addressing. Whoever is responsible for proposing this reckless change should be terminated for being grossly irresponsible and incompetent.	
Dr. Greg Moody Anchor Dental	for Medicaid extractions. 1. This potentially leaves a patient in pain to reschedule. 2. Because they are in pain they may use more opioids which may increase risk of addiction. 3. I have too many staff now to deal just with medicaid requirements and therefore I am considering dropping medicaid because of the burden. 4. Who thought this was a good idea and why? Did anyone even consult a dentist that had worked with Medicaid patients. Especially in Alaska? 5. It is a waste of everyone's time. The doctor, the staff, and the patient. This means we are less capable of seeing more people.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Debra Miller	I have been a practicing dentist in Anchorage for 35 years. When a patient calls in with a toothache & is seen, it's usually an emergency. The best care we can provide is to get the problem tooth taken care of. Often that is extraction. Of all the procedures we do, extraction is one that should NOT require pre-auth. Otherwise, they probably will need antibiotics & pain medication to get them by. As we are facing antibiotic resistance and the opioid epidemic, this is not a good option.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Maggie Arwood	I am a dentist in Alaska. Requiring a second appointment for extractions will leave a person in pain, increase antibiotic and pain med use, and allow infection to fester. Has someone from the medical community been consulted regarding this change?	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-

		enrolled providers or Medicaid recipients.
Dr. Christine Moleski	I am writing in opposition to the proposed changes to the medicaid pre-authorization requirement for extractions and other procedures. As a medicaid provider, it is already frustration to wait for claims to be reviewed and authorized. This, in itself, is a disservice to the patient, especially if a patient is in pain. As time has moved forward in my dental career, the number of "rules" and hoops that we must negotiate causes a decrease in the delivery of care. It is already unattractive enough to be part of the medicaid delivery system and more rules will make it even less so. Making more rules as a reaction to those who abuse the system (I'm talking about providers) is not the solution. Perhaps focusing on those who are unethical (i.e. recommending full mouth extractions and complete dentures when many of the teeth are savable or viable) makes more sense, rather than frustrating ethical care providers. In addition, there is a complete list of other reasons why I oppose the changes. They are as follows: • Requiring a second appt will leave a person in pain • Dental pain can be excruciating, and leave someone unable to eat or sleep. • A local infection can cause great pain and be relieved by an extraction. Delaying care can have systemic effects. • Declining services at the initial visit may invite antibiotic prescriptions that were otherwise not indicated and contribute to antibiotic resistance. • People in pain may go malnourished and have decreased capacity to care for children or elders. [The darkest cases may see people in pain abusing alcohol to escape pain or, far worse, harming others] • Declining services at the initial emergency visit may invite an increase in opioid prescriptions • People in pain (left untreated by their dentist if pre-auth was required) may then go and burden urgent care and ER facilities (during a pandemic) • Access to care will be diminished. The challenges of visiting the dentist may include securing childcare, being excused from work, getting transportation (taxi/bus during covid), traveling from remote locations in AK. Requiring a second visit will double this. [Medicaid covers one day of travel; will they accept the burden of two?] • Requiring a second visit will cause increased opportunities for covid exposure • Requiring a second visit will cause increased burden on ppe supplies • Considering all of the problems that requiring a second visit introduces, such a rule invites sympathetic docs to commit fraud. One could consider themselves taking the moral high ground offering care on the day of the emergency visit, and postdating a claim.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

Dr. Roger Beck Pediatric Dentistry of Alaska	I am writing to you to provide my comments and concerns regarding the proposed changes to the Medicaid re-imbursement requirements for dental services for children. I am a board certified pediatric dentist having practiced in the State of Alaska since 1996. Preceding that, I severed three years in bush Alaska as a commissioned officer with the US Public Health Service from 1991 – 1994. I have over 27 years of experience treating pediatric patients with Medicaid benefit coverage. I hope that you will consider my concerns with regard to the proposed changes. The concerns I have with the changes in requirements are with regard to the requirement of "Service Authorization Required". As I am sure you are aware, dental disease in the lower social economic pediatric population is significant. Additionally, this population is nationally underserved with regard to access for dental care. Although in Alaska, we also have challenges serving the dental needs of this population of children, I am proud to say that it is my understanding that nearly 100% of the private practice pediatric dentists in the State of Alaska are Medicaid providers. This attentiveness to this underserved population with specialty care is extraordinary and is by far not the national norm. In our specialized training as pediatric dentists, we are prevention focused. When the need arises for surgical or restorative dental care, we are trained to provide reliable surgical and restorative care that is definitive and punctually delivered. This includes prioritizing the elimination of pain and infection and the restoration of diseased teeth to function. Our goal is also to minimize the challenges associated with the delivery of dental restorative and surgical care so that positive relationships are developed with our pediatric patients. When diagnosing dental disease of pediatric patients, we rely on our experience and training. We review dental and medical histories and evaluate clinical and radiographic information to make a diagnosis and then formulate a treatment plan. Children have a range of tolerance limitations for diagnostic procedures. These limitations are due to young age, special behavioral afflictions and various special medical needs. Oftentimes, we must obtain our final diagnosis at the time of treatment due to these patient tolerance limitations. I am concerned that the practical and punctual obtainment of service authorization requirements will not be able to be achieved under these circumstances. It is noteworthy that when providing care for pediatric patients, we frequently must finalize our diagnosis during the course of the treatment procedure visit. This is a unique aspect to the practice of dental care for the pediatric population. I am concerned that these procedures are planned for a "Service Authorization Requirement" D2929 Prefabricated Porcelain/Ceramic Crown-Primary Tooth D2930 Prefabricated Stainless Steel Crown-Primary Tooth D2391 Prefabricated Stainless Steel Crown Permanent D2932Prefabricated Resin Crown D7111 Extraction ,Coronal Remnants-Deciduous Tooth D7140 Extraction, Erupted tooth or exposed root (elevation and or forceps removal)	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	D7210 Surgical Removal of Erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. All of these procedures are frequently in need of being provided based on a, diagnosis at the time of treatment, due to intolerance of the patient for pre-treatment diagnostic procedures. With the goal to minimize challenging procedures for our pediatric patients, the appropriate time to provide the newly diagnosed procedures is at the time of diagnosis. For example: A common occurrence is of a young child with significant early childhood caries that is treated under general anesthesia for their extensive dental treatment needs. Pre-operatively, young children are often not able to tolerate diagnostic radiographs and therefore the treatment plan is made for treatment of the clinically (visually) diagnosed cavities. Intra-operatively we take appropriate radiographs once the child is asleep. The diagnosis is finalized and with informed consent of the legal guardian, we proceed to provide the treatment that is most appropriate with respect to the diagnostic findings—often times this involves treatment of cavities in between teeth that are not visually detected. These cavities are often most optimally treated with stainless steel crowns. All of the above listed procedures could also be recommended under similar circumstances. As you can see, in this scenario, I am assuming that service authorization would not be able to be obtained while the child is asleep under general anesthesia. I am concerned as to what our options as providers would be. Certainly, a second anesthetic to address the treatment needs that were not performed due to not having the required authorization would not be in the patient's best interest. There are multiple scenarios of which, at the time of treatment, diagnosis and additions or changes in treatment plan are applicable. These scenarios are not specific to patients that are asleep, but also for standard clinic restorative appointments. A second visit to have the same area anesthetized with local anesthetic also is not in the best interest of the patient. Another concern I have is that of the delay in treatment that these new "Service Authorization Requirements" will have. The Medicaid population has challenges to access for their dental care attributed to their socioeconomically situation. Placing additional authorization requirements will predictably cause significant delay in the delivery of their care as well as an additional appointment necessity. For example, we will often provide same day surgical or restorative services for children at the time of their periodic oral examination appointment or problem focused examination. If we are required to obtain authorization for extractions or stainless steel crown restorations, then a second appointment would be necessary. Transportation reliability, missed school and parent availability to name a few are all considerations for not necessitating a second appointment due to the need to acquire authorization. Delays in treatment can often lead to progression of the dental disease and the development of pain and infection. Although our preventive focused profession works hard to educate the population of the value of routine dental evaluations, often we see our pediatric patients present to their first examination when pain occurs. In these circumstances, there are often	

	multiple diseased teeth. It is important that we have the ability to be efficient and punctual in addressing childhood caries and infections. In summary, I am hopeful that my concerns, based upon my experience in treating Alaska's Medicaid pediatric population will be helpful in your consideration of eliminating the proposed change of requiring service authorization requirements for the procedures I listed. I have enjoyed the privilege to care for this population of deserving children by being a Medicaid provider for more than 27 years. I appreciate the trust given to me and my colleagues with regard to our responsibility as Medicaid providers. I also understand the need for administrative oversight and attention to proper utilization of the allowable services. Regardless of the decisions made with respect to these proposed changes, I will continue to serve this population as a Medicaid provider because I am genuinely concerned with their wellbeing. I sincerely believe that I could serve this population more optimally without these proposed changes in place. I do believe that the changes will create delays in treatment and thus result in progression of disease and potentiate worse outcomes for the Medicaid pediatric population. I have attached three pictures from our national academy of children with dental infections from cavities of baby teeth. These are serious outcomes that we work tirelessly to prevent. When we are presented with situations like these or ones that are headed in this direction—we need the ability to act punctually and effectively. Your trust in us to make appropriate and effective diagnosis and treatment recommendations so that we may provide the dental care these children need is facilitated by the policies and procedures that you allow us to practice under.	
Dr. Robert Pierson	Please keep in mind that I am writing you as a dentist who does not accept Medicaid. Preauthorizations are understandable for some procedures. When infection is present, a preauthorization is a barrier to treatment. It would be a disservice to the patient to require preauthorizations for extractions when they are being done to treat pain and infection.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.
Dr. Kim Conley Mat Su Health Services	I have been a public health dentist in Alaska for almost 25 years. By far the most important service I provide is the relief of pain from a dental abscess with a tooth extraction. These patients often experience a sudden onset of pain that quickly becomes excruciating. Many of the patients have dangerous swelling of the face and are often in tears by the time they present to the dental chair. Imagine, faced with such suffering, having to tell this patient that they will have to wait for treatment until Medicaid approves this procedure. It is inhumane.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	In addition, since as a community health center we are paid by the face-to-face visit, this would actually necessitate a second visit and cost MORE money. I very much hope this plan would be reconsidered.	
Dr. Chad Wintrop Alaska Dental Society	I read that Medicaid is considering new dental regulations. The spirit of many of these changes is one that I agree with; it is clear that some billing practices are abusive. I wish to help those who would consider requiring authorization of dental extractions to understand the unintended consequences of such a policy change. The repercussions can be organized into humanistic, public health, logistical, and ethical concerns. First, and foremost, is the humanistic concern. Dental pain is particularly excruciating. Even with preventative care, acute dental pain can arise - sometimes from conditions not revealed in clinical and radiographic examination. Requiring a second appointment will leave a person in pain. Dental pain frequently leaves people unable to eat or sleep. While waiting for preauthorization, people in pain may go malnourished and have decreased capacity to care for children or elders. Second, there are many public health considerations. Declining emergency extraction services, while authorization is requested, may invite opioid and antibiotic prescriptions that were otherwise not indicated or contribute to addiction and antibiotic resistance, respectively. People in pain may then advocate for themselves by burdening urgent care and ER facilities, which can only refer then to the dentist and likely write prescriptions for antibiotics and opioids. Some people cope poorly with pain and another public health risk, dark yet real, is that a person in pain may abuse alcohol or, worse, abuse others. Add to these public health risks the fact that we are in the midst of a pandemic. Second visits for extractions will double opportunities for exposure and PPE usage. Third, consider the logistical impacts. Access to care will be diminished. The challenges of visiting the dentist may include securing childcare, being excused from work, lost wages, getting transportation (taxi/bus during covid), and traveling from remote locations in Alaska. Requiring a second visit will double these. Medicaid may be additionally burdened by travel expenses for patients requiring a second visit. Delaying care may increase the risk of the dental infection having systemic effects. Such matters come with far greater health care costs. Fourth, one must consider the ethical problems associated with requiring preauthorization. Pretend you are the dentist and a patient seeks your care, crying from pain. They have struggled to reach you because they could not take off from work until today, and they are a recovering substance abuser. However, you have to look them in their eyes and say that you cannot help them today. One could make a strong moral argument to treat them and postdate the service after authorization is returned. Medicaid has provided a proposal that seems aimed at reducing billing fraud, yet would put dentists in a moral dilemma and possibly invite fraud.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	I appreciate you seeking public comment, and considering these examples of unintended consequences. A policy to require authorization for extractions could have a terrible effect on our community.	
Dr. Brant Darby	The proposed medicaid changes related to preauthorization for codes 2930-2934, and 7111-7250 will cause substantial problems if implemented. My concerns are the following: 1. It will cause a substantial increase in "red tape" for dental practices and for the state. It may result in increase costs for everyone. 2. It will cause a significant barrier in the access to care. As a pediatric dental specialist (pedodontist) I see many children from all over the state that have substantial treatment needs. These needs are often urgent or emergent. Many times I see patients that have been referred to me from remote villages. I see them for the first time in the operating room. The treatment plan is completed in the operating room and then the care is delivered there. Requiring preauthorization for the codes 2930-2934 and 7111-7250 will cause barrier to medically necessary care. 3. The preauthorization requirements for these codes may reinforce the the use of other inferior services that do not require preauthorization. I will give you an example. The code 2930 is for the restoration of posterior primary teeth with prefabricated stainless steel crown. The pediatric literature strongly supports the use of stainless steel crowns for the restoration of posterior teeth in pediatric patients with interproximal decay and high risk of recurrent decay. The 2392 code is for a two surface composite restoration on a posterior tooth. The reimbursement for the 2930 and 2392 are similar. The posterior interproximal composite restoration(2932) is inferior to the the prefabricated stainless steel crown for the restoration of posterior pediatric teeth with interproximal decay. This is clearly proven in the pediatric literature. This change may significantly increase the use of posterior composites for the restoration of interproximal decay on posterior primary teeth. This policy may lead to substandard care and increase the state's cost associated with pediatric dental care. 4. The proposed preauthorization requirements will increase the complexity, and cost of managing pediatric dental patients with Alaskan Medicaid coverage. The rates of reimbursement for pediatric patients with Alaskan Medicaid coverage has not been increased in over 10 years. General inflation in Alaska has been about 3 percent per year. As a result the reimbursement we receive for pediatric dental services is 30 percent less than it was 10 years ago. Making these proposed changes for preauthorization of the mentioned pediatric dental codes will cause greater costs and a greater burden on dental providers who provide care for Alaska's children in need. In summary these proposed changes may do more harm than good. They may not decrease the state's medicaid associated costs but they may substantially alter the quality of care our children receive. I have been a licensed pediatric dentist in Alaska for almost 20 years. I am a surgeon on staff at the Alaska Regional Hospital and Providence Alaska Medical Center. I served for many years as the	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	section chief for oral surgery and dental specialties at PAMC. I have also served on the state of Alaska's Medicaid advisory committee. I believe these proposed changes are very problematic. Please consider my well substantiated concerns.	
Dr. Kenley Michaud Northern Lights Dental Anesthesia	Medicaid states multiple goals with these broad changes in statues and regulations. I will be addressing the following goals of the changes proposed by Medicaid: "conform to industry standards", "address overuse or misuse of services", "reorganize child and adult dental to follow a logical and similar flow", and "update fee schedule and materials adopted by reference." Regarding emergency services such as extraction of an infected tooth, it would be contrary to industry standard to require a pre-authorization prior to the removal of the infected tooth. Requiring a pre-authorization will mean patients must take pain medications alone or in conjunction with opioids to tolerate the dental pain until approval has been given from the state to remove the offending tooth. Current industry standards are geared towards decreasing the time that patients are requiring opioids and pain medications. Medicaid recipients should have access to medically necessary care that allows them to swiftly remove infected, abscessed, or painful teeth and thus decreasing the amount of time a Medicaid recipient will be taking pain medications with or without opioids. If the state would like additional documentation regarding the extraction of an infected tooth, it would be more logical to require documentation after the treatment has been rendered in the form of medical justification. An intra-oral photo and an x-ray can be submitted to Medicaid after the procedure has been done. This will still allow patients to promptly receive treatment, decrease the amount of pain medication and opioid used, and provide documentation to Medicaid as to why the treatment was necessary. In an attempt to address overuse and misuse of services, a broad change across all age groups will drastically affect access to care. It makes sense that Medicaid would identify a possible area for abuse and require a service authorization for permanent crowns for children who are aged 13-21. It has been said that in general permanent crowns were not indicated for this age group without special exception. However, this should not include prefabricated crowns (D2929-D2934), which are commonly indicated for patients under the age of 13. Unlike laboratory fabricated permanent crowns, prefabricated crowns are placed in one appointment and should not require a pre-authorization for young children. It should be remembered that children are not just small adults. The goal to reorganize child and adult dental Medicaid to follow similar logic and flow may not address the specific dental needs of childhood. Decay patterns and the speed at which decay progresses is faster in the primary dentition. Children should not be required to wait for a pre-authorization for a prefabricated crown (D2929-D2934). The final goal Medicaid stated was to update the fee schedule and materials adopted by reference. Behavior management and sedation has been a topic of discussion as a code that are possibly abused	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	and over billed. The American Academy of Pediatric dentistry published a document most recently revised in 2020 called "Behavior Guidance for the Pediatric Dental Patient." I will attach this document to these comments and I would recommend that Medicaid adopt this document for reference. Specifically regarding children it states the indications for different types of behavior managements, as well as the indications for different types of sedation and anesthesia. As Medicaid has updated & AAC 110.155 (b) to shorten the list of conditions that permit anesthesia, I would encourage the regulations to be updated to include reference to the guidelines set forth by the AAPD.	
Dr. Mark Keller	Please consider the impact of adding prior authorizations for Medicaid coverage for treatment of young children with primary crowns. Such requirements would hinder kids oral health specifically the very young and the ones with the most critical dental needs. I work as a pediatric dentist in Anchorage, Alaska. Delivering operative dental care to young children is complex; it involves diagnosis of oral caries (cavities/dental infections/other complex dental disease and then deliver that care in a safe and nurturing environment. The goal is to restore oral health so children can "have healthy teeth for life. The kids I see in my practice are varied along many attributes. Some have high dental IQ with treatment only involving minor dental interventions. Then there are other children to no fault of there own manifests complex oral disease. Approaching each kids care is like a puzzle. You diagnose the dental disease and then develop a plan to restore. Once you identify a patients needs for treat it's time to figure out how to get the treatment completed on for the kid. Factors affecting ability to deliver quality care in a humane manner: 1. Patients age 2. Patient anxiety/fear of having treatment 3. The amount of treatment required 4. Geographical barriers to treatment (ie..patient/family live remote 5. Underlining medical To deliver predictable high quality dental care to youngest kids of Alaska care to children is complex. To gain cooperation for treatments treatment with GA is utilized. It's important to be able to diagnose, develop and execute a dental surgery. Most pediatric DDS stress restoring teeth with the method that give the most predictable and long lasting result. In a large number of cases crowns are involved. Requiring Prior authorizing kids dental care makes delivering care to children less effective and overlooks the nature of young children. Remember who we treat: young Children; requiring prior authorization in much of the kids that need complex dental care would separate the physical diagnosis's from the reality of who this kids is and how do we get the treatment done.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	Please let pediatric dentist do what we do best, treat significant dental disease on our challenging young patients. The standard of care would by nature limits the appropriateness of prior authorization in many of the clinical situations. PS. I think if you see who we treat and their restorative and behavior needs you will have a more understanding of this issue.	
Dr. Ken Wynne Dimond Family Dental Center	Called Susan Dunkin, refused to listen after 5 minutes on the phone! Woman is the worst type of state bureaucrat! Seems like an unhappy person, scary she is in a regulatory position of which she knows nothing about dental care.	The following response was sent to Dr. Winne on the date his email was received: *Dr Wynn,* *This morning you called to discuss your concerns about proposed changes to dental regulations that were public noticed on 02/02/2021 (and supplemented on 02/09/2021). Your input is important to the Department of Health and Social Services, and I encouraged you to submit your comments in writing by email or mail as designated in the notice.* *Unfortunately department staff members are unable to comment on proposed regulations during the public comment period. All public comments received during the oral hearing that was held on 03/08/2021, all written comments received during public comment period, and department responses to those comments will be published at Alaska Online Public Notices after public comment period closes.*

		Please let me know if additional information is needed. *Regards,* *susan*
Winn Davis for Andrew Jimmie Alaska Native Health Board	The Alaska Native Health Board (ANHB) is writing to provide comment on the proposed regulatory changes to the Medicaid Dental Services Coverage and Payment. Firstly, as we recommended in the Tribal Consultation comment submitted as part of the State Plan Amendment process, we strongly recommend that the Department withdraw these proposed regulatory changes until Tribal Consultation can be conducted on the proposed changes to Children's Dental and Orthodontic Services Coverage and Reimbursement offered as part of this regulatory package. We also offer the below comments and additional recommendations to reduce the adverse impacts to Alaska Native and American Indian (AN/AI) Medicaid beneficiaries who access dental services. Children's Dental Services Coverage and Reimbursement Concerns We have serious concerns regarding proposed changes to the Children's Dental Services and Orthodontic Services. The regulatory proposals found in the accompanying fee schedules to add prior service authorizations for certain services including for crowns, extractions, and removal of impacted teeth along with the proposed exclusion of space maintainers and pulp capping for children will make the delivery of critical dental care to children in rural and remote Alaska almost prohibitively difficult. This will create additional administrative burdens that ultimately create barriers for children to receive care. Our dental providers often only visit rural locations on a quarterly or biannual basis, often seeing children in school settings. We must be able to deliver the dental care our children need when they are seen without the additional burden of applying for and waiting to receive prior authorization; forcing service authorizations into this process will require scheduling multiple visits and travel which will reduce access to care for our children by placing obstacles to care in their way. In most cases, this will increase the need and incidence of required medical travel for patients and parents, it will also increase the amount of time children may suffer with decayed teeth before getting appropriate care. Finally and most importantly, we know that the number one predictor for caries in the adult dentition is caries in the primary dentition. Thus increasing barriers to effectively treating the primary dentition will mean more young adults presenting with malformations and decayed teeth which ultimately will drive up the costs of adult dental care and other related health care costs associated with poor oral health. We believe that Tribal Consultation is required before the Department decides upon these changes to Children's Dental and Orthodontic Services. As with the Department's proposed use of fee schedules, the Department may not rely on the mandates of EPSDT coverage to	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	avoid Tribal Consultation or CMS scrutiny of proposed material changes to mandatory services for children. We offer the below recommendations and comments regarding these changes at the respective existing or proposed citations. 1. 7 AAC 110.150(a)(7)(A) – Requiring service authorizations for extractions will negatively impact the ability for children in rural and Bush Alaska to receive dental care. The Department should remove the authorization requirement for this procedure. Recommendation: Remove proposed service authorization requirements for extractions. 2. 7 AAC 110.150(a)(11) Office Visits – This exists in the current body of regulations, but would be removed under the proposed language. This service is important to treat children with oral infections and monitor those conditions, including the prescription of antibiotics. Recommendation: We recommend that the Department restore this covered service. 3. 7 AAC 110.153(a)(2) – The Department has included the proposed language, "The department will pay for interceptive orthodontic treatment for recipients under 13 years of age." Recommendation: We recommend that the Department consider the phrasing, "In addition to coverage of Phase 2 interceptive orthodontic treatment for children 13 years of age or older, the Department will also cover Phase 1 interceptive orthodontic treatment for children under 13 years of age." This language would clarify the availability of interceptive orthodontic treatment using common dental practice language. 4. 7 AAC 110.153(a)(3) – The Department proposes raising the Handicapping Labio-lingual Deviation Index (HLDI) eligibility score from 26 to 28 in its proposed changes. This score is used to qualify children for orthodontic treatments to be covered as part of Medicaid dental coverage. This will reduce access to care for hundreds of children who would otherwise require orthodontic intervention. Some Tribal providers would see as high as 77% declines in eligible child patients due to this change, thus having an adverse effect on Tribal providers and their AN/AI beneficiaries. The developer of the HLDI indicated when the index was released that this scoring system produced an adjustable cut-off point to meet the budgetary needs of programs. Recommendation: This proposed change does not have a dental or medical basis, and we recommend the Department maintain the current HLDI eligibility score of 26. 5. 7 AAC 110.153(a)(3)(E) – This section lists "films" instead of "radiographs". Recommendation: We recommend the Department update "films" to "radiographs" to correspond with other proposed language using the term "radiographs" in this regulatory package. 6. 7 AAC 110.153(b) – The proposed language in this subparagraph would decline reimbursement for comprehensive orthodontic treatment if it comes less than 18 months after limited or interceptive orthodontic treatment.	

Recommendation: We recommend that the Department include language allowing for an exception to this in the cases of dental or medical need that requires the amendment of treatment plans and further comprehensive interventions.

7. 7 AAC 110.153(c) and (d) – These two subparagraphs place the costs of on-going treatments onto children and families if they become ineligible for Medicaid during the course of their treatment. Of particular concern in this proposal would be under subparagraph (d), which requires children to be removed from covered treatment plans during the course of treatment for severe orthodontic conditions such as cleft palates, cranio-facial anomalies, and clinically impacting conditions of overbite, crossbite, overjet, or sever traumatic deviations.
   Recommendation: We recommend the Department insert an exception that would allow the completion of approved treatment plans for children whose conditions were qualified by the HLD eligibility index under "automatic qualifying conditions" in recognition of the sometimes complex series of procedures which might be required during a course of treatment for such conditions.

Accompanying Fee Schedules
We recommend that the proposed prior service authorization requirements be removed from the following service codes:

1. D2930 - PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH
2. D2931 - PREFABRICATED STAINLESS STEEL CROWN-PERMANENT
3. D2932 - PREFABRICATED RESIN CROWN
4. D2934 - PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH
5. D7111 - EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH
6. D7140 - EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)
7. D7210 - SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED
8. D7220 - REMOVAL OF IMPACTED TOOTH-SOFT TISSUE
9. D7230 - REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY
10. D7240 - REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY
11. D7241 - REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS
12. D7250 - SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)

Excluded Services
Additionally, we would also like to address some items that are being implemented in both 7 AAC 110.145 Adult Dental Services and 7 AAC 110.150 Children's Dental Services as excluded services:

1. Behavioral Management for Adults – The exclusion of behavioral management for adults in dental services will have an adverse impact on our developmentally disabled adult patients seen in the Alaska Tribal Health System. This coverage is critical for delivery of appropriate dental

	services to disabled adult patients. Without the ability to provide this service and be reimbursed, we believe it will become incredibly difficult to provide the necessary dental care to this small but vulnerable population. Excluding the services would effectively make other covered services inaccessible to disabled adults, and may thus violate the State's obligations under the federal Americans with Disabilities Act (P.L. 101-336) and the Rehabilitation Act (P.L. 93-112). Recommendation: We recommend that the Department remove behavioral health management from the list of excluded services, and to add this to allowable services in the Fee Schedule. 2. Pulp capping – Pulp capping is vital pulp therapy and has a high success rate in immature permanent teeth. This is a technique used for adults in attempt to avoid root canal therapy. Pulp capping is a conservative step that allows dentists the time to develop comprehensive plans or initiate a referral to an endodontist and avoid an extraction if there is a delay in treatment due to rural location of a patient. This coverage is particularly useful in developing treatment plans for young patients. The loss of this service will be particularly felt in rural Alaska where dental providers are often only quarterly or biannual visiting providers, and time between visits can be as long as several months to perform needed dental work. Recommendation: We recommend the Department remove pulp capping from the list of excluded services, and to restore services for the appropriate use of pulp capping. 3. Immediate, interim, and temporary dentures – In rural Alaska, the use of interim and/or temporary dentures is a high priority for adults that suffer traumatic loss of anterior teeth. In addition to aesthetics, failure to maintain space when a tooth has been lost or had to be extracted (due to decay for example) can make future restorable plans challenging or impossible. For those adults that live in rural locations, the fabrication of interim prosthetics while a person waits for a more permanent solution to be planned and created, ultimately represents a cost-avoidance. Recommendation: We recommend the Department remove immediate, interim, and temporary dentures from the list of excluded services, and to restore services for the appropriate use of immediate, interim, and temporary dentures for children and adults. 4. Space maintainers – In rural Alaska, the use of space maintainers is a high priority for saving the adult teeth coming into dentition. If we do not save that space because a tooth has been lost or had to be extracted, we run the risk of malformation or any malocclusion that may occur due to misalignment of the remaining teeth. Space maintainers allow dentists to retain the gap while more permanent solutions are planned and created, this ultimately represents a cost-avoidance because additional orthodontic care can be avoided when this treatment modality is used. Recommendation: We recommend the Department remove space maintainers from the list of excluded services, and to restore services for the appropriate use of space maintainers. General Anesthesia and Sedation The Department also proposes to require prior service authorizations for all general anesthesia and intravenous sedation for dental procedures in 7 AAC 110.155. Similar to other proposed service	

	authorization requirements, we recommend the Department not to change the language at 7 AAC 110.155 and not to impose such service authorization restrictions. Again, this will interfere with the timely and cost-effective treatment of Medicaid beneficiaries in rural and remote Alaska due to the quarterly and biannual visits which dentists often make to these communities off the road system. The result of requiring these types of service authorizations will mean that more patients will need to travel into larger communities for procedures. This ultimately will drive up travel and accommodations costs, require more encounters with patients, and reduce how far their limited Medicaid dental benefits can go. All culminating in a reduction of care to patients, which ultimately drives up other medical costs. We also recommend that the conditions required under subparagraph (b) continue to allow for "failure of local anesthetic to control pain," and "extreme apprehension" as allowable reasons for the provision of these services, when appropriate as determined by a dental provider. Dental Telehealth The Department's proposed regulations are silent on the modality of telehealth for the provisions of certain dental treatments. We recommend the Department review current services and allow for the provision of certain services through dental telehealth (teledentistry), when appropriate. The Department should amend the proposed Fee Schedules to include dental codes D9995 and D9996 for synchronous and asynchronous teledentistry as reimbursable services, respectively. Recognizing that in the COIVD-19 pandemic, many forms of health care have seen an increase in the utilization of telehealth modalities, dental care has been left behind largely due to allowances and reimbursement for such services via telehealth. In fact, many Tribal providers have already stood-up teledentistry capabilities in their clinics, but lack the reimbursement for these services that will be needed to make them sustainable in the long-term. Many types of dental services can be safely and effectively provided via telehealth modalities, and we recommend the Department allow for this in recognition of the increased need for these modalities now and in the post-COVID-19 environment for such delivery methods. The additional benefits of allowing dental telehealth can reduce the need for patient travel for less complex office visits, and could help reduce program costs overall when safely administered. Closing In closing, we would like to address the Legislative Audit findings, which the Department cited as cause for some of the proposals made in this proposed regulatory package, related to the possible overuse of particular services by some providers. Rural and remote Alaska is one of the least served dental regions in the United States. The Alaska Tribal Health System has built a model of care that provides for routine dental care that allows for mid-level providers to be present in our communities closer to patients, but it has not yet solved the shortage of trained and licensed dentists needed to care for our People. Therefore, we are still in need of regularly scheduled quarterly or biannual trips for higher level providers to visit our rural and remote communities across the state to provide higher levels of dental care. Our providers need the flexibility to be able to deliver clinically	

	appropriate dental care during such visits with patients to ensure the on-going health and safety of our patients. Placing prior service authorization requirements as a method to control the number of services rendered by some providers will not solve the possible abuses cited in the Legislative Audit findings, but it will serve the purpose to reduce access to care for beneficiaries, especially our most vulnerable. There are other methods to monitor and control possible abuses that the Department can utilize which will not impact the access to care for beneficiaries. We recommend the Department consider those other options after engaging with stakeholders on these concerns. Again, we strongly recommend that the Department withdraw this proposed regulatory package, engage in Tribal Consultation on Children's Dental and Orthodontic Services, engage with stakeholders on Legislative Audit findings and reasonable solutions, and finally, work with stakeholders to find and develop new proposals for this regulatory package that would better control possible service abuses while preserving services for beneficiaries. We appreciate the opportunity to provide these recommendations on the proposed regulatory package, and should you have any comments or questions regarding our recommendations, please contact ANHB.	
Dr. Crystal Marrs	I am writing in opposition to the proposed changes to the medicaid pre-authorization requirement for extractions and other procedures. As a medicaid provider, it is already frustration to wait for claims to be reviewed and authorized. This, in itself, is a disservice to the patient, especially if a patient is in pain. As time has moved forward in my dental career, the number of "rules" and hoops that we must negotiate causes a decrease in the delivery of care. It is already unattractive enough to be part of the medicaid delivery system and more rules will make it even less so. Making more rules as a reaction to those who abuse the system (I'm talking about providers) is not the solution. Perhaps focusing on those who are unethical (i.e. recommending full mouth extractions and complete dentures when many of the teeth are savable or viable) makes more sense, rather than frustrating ethical care providers. In addition, there is a complete list of other reasons why I oppose the changes. They are as follows: • Requiring a second appt will leave a person in pain • Dental pain can be excruciating, and leave someone unable to eat or sleep.	Thank you for your comments. The Division of Health Care Services is seeking regulatory options that will meet the needs of the program without creating an unnecessary burden for Medicaid-enrolled providers or Medicaid recipients.

	• A local infection can cause great pain and be relieved by an extraction. Delaying care can have systemic effects. • Declining services at the initial visit may invite antibiotic prescriptions that were otherwise not indicated and contribute to antibiotic resistance. • People in pain may go malnourished and have decreased capacity to care for children or elders. [The darkest cases may see people in pain abusing alcohol to escape pain or, far worse, harming others] • Declining services at the initial emergency visit may invite an increase in opioid prescriptions • People in pain (left untreated by their dentist if pre-auth was required) may then go and burden urgent care and ER facilities (during a pandemic) • Access to care will be diminished. The challenges of visiting the dentist may include securing childcare, being excused from work, getting transportation (taxi/bus during covid), traveling from remote locations in AK. Requiring a second visit will double this. [Medicaid covers one day of travel; will they accept the burden of two?] • Requiring a second visit will cause increased opportunities for covid exposure • Requiring a second visit will cause increased burden on ppe supplies • Considering all of the problems that requiring a second visit introduces, such a rule invites sympathetic docs to commit fraud. One could consider themselves taking the moral high ground offering care on the day of the emergency visit, and postdating a claim.	