Dental Health Care Program for Low-Income Seniors

Awarded Grantees FY2022-23

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Grantee Website - https://hcpf.colorado.gov/colorado-dental-health-care-program-low-income-seniors-0

Senior Dental Program

- Important Dates
- Eligibility
- Medicare Savings Programs
- Billing
- Annual Report
- Audits
- Questions

Important Dates

- FY2022-23 grant start date is July 1, 2022
  - No procedures from FY2021-22 may be billed past the June 2021 invoice with one exception

    - If a client's procedure was billed to Medicare and the grantee did not receive the statement back in time for the June invoice to bill the remaining amount to the Department.

    - If this should happen, the DOS should be used on the FY2022-23 invoice and all paperwork should be uploaded into SharePoint with the invoice. This includes the paperwork showing when Medicare was billed and what Medicare paid.

Important Dates Continued

- Invoices are due by the 15th of the following month, unless the 15th falls on a weekend or if the Department is closed, and it is then due the first prior workday.

- FY2022-23 annual report is due to the Department BY September 1, 2023
  - The Department's annual report is due to the General Assembly by November 1, 2023

Eligibility

- Must be 60 years of age or over
  - Can maintain a picture ID in the client's file showing proof of their age
  - If the client is 60 through 64 and they fall within the 138% Federal Poverty Guidelines (FPG), they must have a denial letter from Health First Colorado showing they don't qualify.

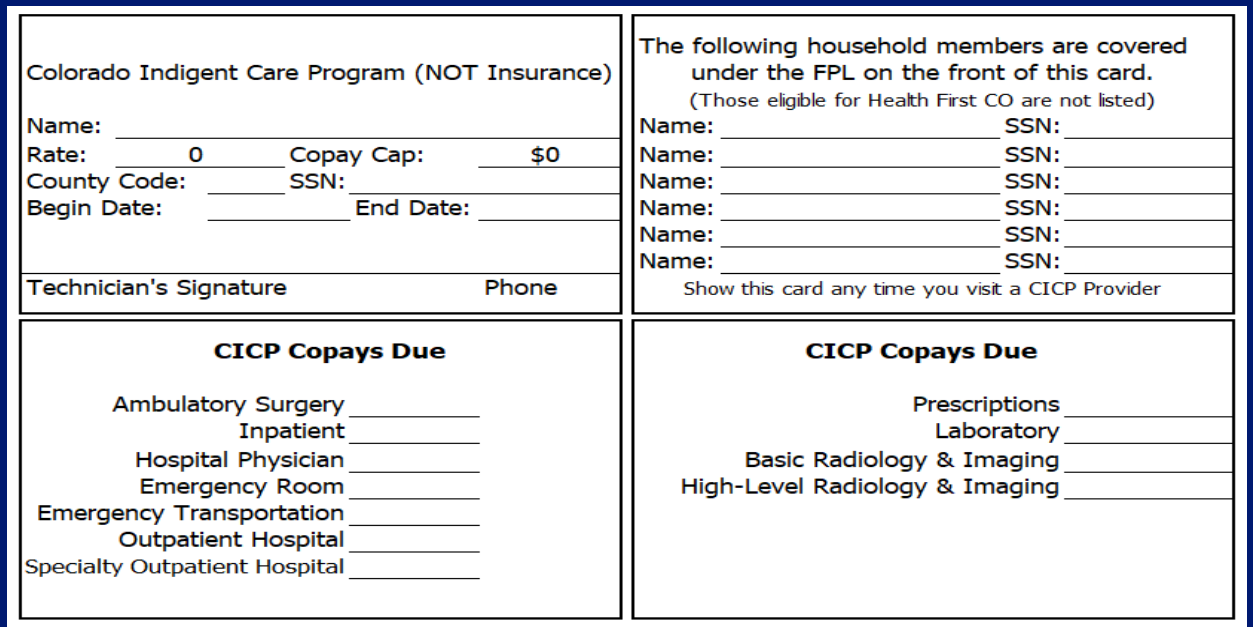
  - The following reasons can't be used for the denial:
    - Did not apply for medical assistance;
    - Does not want medical assistance any longer; or
    - Did not submit requested documents

Eligibility Continued

- Income must be at or below 250% of the current (FPG)
- Client must not qualify or currently have Health First Colorado or Old Age Pension Medical
  - The web portal MUST be checked on all clients
  - It is suggested that you do a print screen of what the web portal shows and put in the client's file
  - It is suggested that the web portal is checked for each visit.

Eligibility Continued

- If a client has an UNEXPIRED Colorado Indigent Care Program (CICP) card, the client automatically qualifies for the Senior Dental Program as long as they are 60 or over
- Ensure a copy of the *unexpired* CICP card is in the client's file for auditing purposes.



Colorado Indigent Care Program (NOT Insurance)

Name:
Rate: 0 Copay Cap: $0
County Code: SSN:
Begin Date: End Date:

Technician's Signature Phone

The following household members are covered under the FPL on the front of this card.
(Those eligible for Health First CO are not listed)

Name: SSN:
Name: SSN:
Name: SSN:
Name: SSN:
Name: SSN:
Name: SSN:

Show this card any time you visit a CICP Provider

CICP Copays Due

Ambulatory Surgery
Inpatient
Hospital Physician
Emergency Room
Emergency Transportation
Outpatient Hospital
Specialty Outpatient Hospital

CICP Copays Due

Prescriptions
Laboratory
Basic Radiology & Imaging
High-Level Radiology & Imaging

Lawful Presence

- Lawfully Present
  - SB 21-199 removed the requirement of individuals to prove lawful presence in the US to be eligible for state programs effective July 1, 2022.
  - Seniors must still be a resident of Colorado to be eligible for the Senior Dental Program

Other Health Programs That Qualify for the SDP

Medicare Savings Programs (MSP)	Description of Programs	FPG	Eligible for the SDP
Specified Low-Income Medicare Beneficiary Program (SLMB)	State pays percentage of premium of Part B.	120%	Yes
Qualified Individual Program (QI1)	Does not qualify for any Medicaid program: state pays Part B premium.	120%-135%	Yes
Qualified Medicare Beneficiary Program (QMB)	State pays for Part A and B premiums and Medicare deductibles, coinsurance, and copays	100%	Yes
Qualified Disabled and Working Individual (QDWI)	State pays for Medicare Part A premium.	$2,285 Individual income & $3,072 Married	No
***Medicare/Medicaid – QMB (Dual Eligible)**	65 years or older, or disabled, status under Social Security or Railroad Retirement assistance with Medicare premiums and out of pocket Medicaid expenses.	100%	No

Medicare Advantage Plans Programs (MAPs)

- If the client has a MAP, a copy of their NAP card should be put into the client's file.
- If the dental insurance is through the client's MAP they still qualify for the SDP.
- If the client has *extra* dental insurance purchased through a supplemental they do not qualify for the SDP.

MAPs Continued

- If the grantee can bill the current MAP insurance they must do so
  - The insurance company must be billed prior to billing the SDP

- If the grantee does not have a current contract with that specific insurance company they do not have to bill and can bill the SDP.

MAPs Continue

- If the grantee “farms” out the dental work and the provider is able to bill the current MAP insurance company they must do so before the SDP is billed

- If the provider is not able to bill the current MAP insurance company they do not need to bill and can bill the SDP.

Reasonable Screening for Income

- The client's income must be at or below 250% of the most current FPG
- Grantees can us their current income screening forms
- Ensure copies of the stubs you use for proof of income are in the client's file

Self Declaring Income

- Clients may self-declare their income
  - CAUTION – some clients use this as a way to get on the program when they don't qualify
  - Have the client sign a statement indicating what they make and are aware that any false information is considered fraud and is subject to full repayment of services if found they don't qualify for the program

Questions?

BILLING

- Invoices are due by the 15th of the following month, unless it falls on a weekend or holiday and it is then due the previous workday
- The SDP will pay no more than Max Program Payment
- It is up to the Grantee if a co-payment will be charged
- Covered procedures must be provided before billing the SDP
- It is up to the Grantee if they will bill the 7% administrative fee

Billing crossing in Fiscal Years

- If you forgot to put a procedure on a June invoice and realize it in the next fiscal year, you CANNOT bill for that procedure unless it is part of a MAP

- It is important that every Grantee gets all procedures on the June invoice to receive payment in that fiscal year

Billing MAPs

- All Grantees must bill the insurance of the MAP if they have the ability to do so PRIOR to billing the SDP

- If the Grantee sends the clients to other providers, and those providers have the ability to bill the insurance of the MAP, they must do so PRIOR to the Grantee billing the SDP

MAP Billing Crossing Fiscal Years

- If a Grantee bills an insurance in June and finds out in the next fiscal year that it didn't pay the full procedure amount, the Grantee may bill the SDP.
  - When the procedure is billed on the invoice for a previous FY procedure, the Grantee must also upload the billing to the insurance showing when it was billed and showing the response from the insurance company

Excel Workbook

- The SDP will only accept the billing on the Excel worksheet and it must be uploaded through SharePoint

- If a new employee starts the Grantee must contact Tracy at tracy.gonzales@state.co.us to obtain access

- If there is an employee that has left, the grantee can also let Tracy know of the access that needs to be removed

Monthly Invoices

- If the following is found, the procedures will be removed from the invoice and the Grantee will be notified and the new invoice amount will be given
  - Requested client information not filled in
  - Procedures and any monetary amount is not filled in
  - Review of invoice shows duplicate services that were already billed

Immediate Dentures

- All clients that receive immediate dentures must be given the Informed Consent for Immediate Denture Form

- It must be signed by both the client and the dentist and be kept in the client's file

Questions?

SDP Annual Report

- A SDP Annual Report must be submitted every fiscal year by September 1st
- The report must be in the format specified by the Department and will include information for the July 1st through June 30th grant period
- A large amount of information needed for the report will be retrieved from the monthly invoices submitted by the Grantees
- The Department will contact Grantees to let them know what other information will be required for the annual report

Questions?

Audits

- Audits will be performed at random times throughout the year. Items the Department looks for include, but are not limited to:
  - Duplicate billing
  - Submitting invoices prior to the procedures being completed
  - Charging the clients more than what their co-pay should be
  - Clients and dentists signed Immediate Dentures form, if applicable

Audits Con't

- The Department will randomly select client files for each Grantee
- Clients that receive immediate dentures are automatically added to the audit list
- All files selected will be reviewed to ensure they were not part of Health First Colorado during the time of service

Audits Con't

- All files will be checked for the age requirement
- If Grantees have findings a letter will be completed showing what all findings were. The Grantee will be required to submit the following:
  - A Corrective Action Plan (CAP) on all findings
  - A check will need to be submitted back to the Department repaying all incorrect billed procedures, if applicable

Audits Con't

- Even though Lawful Presence will not be required effective July 1, 2022, audits for this fiscal year will check for lawful presence as it is currently required for FY2021-22.

Questions?

Contact Info

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Thank you!