

SAMPLE PURCHASING SPECIFICATIONS FOR FOR MEDICAID PEDIATRIC DENTAL AND ORAL HEALTH SERVICES

March 10, 2000

This document sets forth illustrative language for the purchase of pediatric dental and oral health services for Medicaid beneficiaries enrolled in managed care organizations (MCOs). The specifications are intended for use in health care service purchasing agreements with managed care organizations (MCOs) that either for a preset fee (i.e., a premium) or under an administrative services agreement (ASO) arrange for the delivery of comprehensive health care, including pediatric dental and oral health services, through a network of participating providers. In the case that pediatric dental and oral health services are excluded from comprehensive managed care service agreements, the specifications may be used in purchasing pediatric dental and oral health services under separate purchasing agreements with MCOs that specialize in these services.

The specifications have been developed for use by state agencies purchasing health care services for Medicaid-eligible and other low-income children, who are at significantly higher risk of untreated dental caries than children in higher-income families.¹

The specifications were drafted by the Center for Health Services Research and Policy (CHSRP, formerly Center for Health Policy Research) of the George Washington University Medical Center, School of Public Health and Health Services under the direction of experts in the field of pediatric dental and oral health services. The Centers for Disease Control and Prevention (CDC) provided guidance on clinical and policy issues addressed in the sample specifications and financial support for their development. The specifications were reviewed in draft form by representatives of the Health Care Financing Administration, the Health Resources and Services Administration, state Medicaid agencies, consumers, health care providers, and managed care organizations.

*As a publication of CHSRP, the specifications do not represent agency policy, guidance or other official act by any public agency. **The contents of this document are optional for state policymakers.***

These sample specifications are illustrative. They are designed to function as one of many tools that Purchasers employ to develop and oversee managed dental and oral health care services for Medicaid beneficiaries who are children and adolescents. The specifications may be used in their entirety or on an item-by-item basis, depending on the range of issues that a Purchaser wishes to address. Individual specifications may be added to appropriate sections in a purchasing agreement or a package of specifications

¹ **Commentary:** Vargas CM, Crall JJ, Schneider DA. Sociodemographic distribution of pediatric dental caries: NHANES III, 1998-1994. JADA 1998;129:1229-36.

may be added to an agreement as a dental and oral health services appendix or attachment.

Because of variations in Purchasers' financing options, policy preferences and legal duties, there is no single correct method for covering and delivering pediatric dental and oral health services. An important variable in purchasers' decisions would be the risk of pediatric dental caries in the Medicaid population(s) to be enrolled by a managed care Contractor, taking into consideration the fluoride level(s) of the water supply(ies) where the population(s) live and the higher risk of dental caries in all low-income children and youth.² Given these variables, it is nevertheless possible to identify the critical decision points that purchasers may face and to suggest approaches to each. The specifications offer illustrative options for purchasing including key issues in coverage, access, delivery and quality of care. The specifications have been drafted to be consistent with federal legal requirements pertaining to dental and oral health services for children and adolescents enrolled in Medicaid. Drafters may wish also to incorporate a state's medical assistance (Medicaid) plan, which includes, for example, the state's periodicity schedules for dental and oral health assessments ("screens") under the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. For purchasers who wish to use this drafting strategy, the document includes suggestions for incorporating the state's medical assistance plan by inserting citations to it.

A Purchaser may elect to remain silent with respect to a particular matter for which illustrative language has been prepared. In such a case, rules of contract construction would mean that the purchaser would effectively elect to defer resolution of the particular issue to contractor discretion.

*The specifications are accompanied by **Commentaries**(shown as endnotes) to aid in reading and interpretation. All specifications will be hyperlinked to numerous related government and private agency website addresses. The specifications are part of a series of sample purchasing specifications that, beginning in 1998, are being posted at CHSRP's website address.³*

² **Commentary:** Information on the risk of caries and on fluoride levels in community water supplies may be available from state or county public health agencies.

³ **Commentary:** The Center website address is: <http://www.gwu.edu/~chsrp>. At the time this draft was prepared, specifications had been posted for vaccine preventable diseases, childhood lead poisoning and pediatric (adolescent and child) Medicaid specifications. In addition to the pediatric MEDICAID specifications cross-referenced in this document, other CHSRP specifications projects were: access to health care; care for children in the child welfare system; child development services and services for children with special health care needs; cultural competence; data and information collection and reporting; HIV/AIDS; information and reporting; memoranda of understanding between managed care organizations and state and local health and other agencies; mental illness and addiction disorders services for children and adults; pharmacy services; services for homeless individuals; sexually transmitted disease services; and tuberculosis services. In addition to CDC, support for these specifications projects comes from the Health Resources and Services Administration (HRSA); the Substance Abuse and Mental Health Services Administration (SAMHSA); the National Committee on Vital and Health Statistics; the David and Lucille

*The specifications are designed to be used in conjunction with other specialized CHSRP sample specifications, which relate to comprehensive health care services for children and adolescents enrolled in Medicaid and in state Child Health Insurance Programs (CHIP) that extend Medicaid coverage to CHIP-eligible children and adolescents. The current version of the comprehensive document includes general provisions relating to dental and oral health services; the document also includes a section reserved for insertion of these more detailed pediatric dental and oral health services specifications. The comprehensive specifications are identified in Commentaries by references to **MEDICAIDSPECS**, which refers to Sample Medicaid Pediatric Purchasing Specifications: A Technical Assistance Document.⁴*

The dental and oral health services and other sample purchasing specifications in the series may be obtained in diskette form from:

*Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center
2021 K Street N.W. #800
Washington D.C. 20006*

Packard Foundation, Center on the Future of Children; The Commonwealth Fund; and Glaxo Wellcome Inc.

⁴ **Commentary:** The Center website address is: <http://www.gwu.edu/~chsrp>.

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Note on symbols that appear alongside sample purchasing specifications: In order to provide additional guidance to Medicaid purchasers, these sample purchasing specifications contain applicable symbols that are designed to identify the basis (or bases) for the sample specification. The meaning of each symbol is as follows:⁵

L: The provision is based in whole or in part on federal Medicaid law, as articulated in the Medicaid statute, a federal regulation, or other written HCFA policy such as an Action Transmittal, State Medicaid Directors Letter, Regional Office Memorandum, or other formal HCFA transmittal. Just because an item is marked “L” does not mean that the service or activity is mandatory either for state agencies or for managed care contractors. Where the legal basis in question identifies a required service or activity, a footnote will so indicate. Law-related provisions that relate to optional services and activities also will be identified in a footnote.

G: The provision is based on whole or in part on formal guidelines issued by, or under the auspices of, a government agency (e.g., Health Resources and Services Administration (HRSA)), a professional society (e.g., the American Academy of Pediatric Dentistry), or a formally convened, impartial deliberative body.

K: The provision is based in whole or in part on the best judgment and opinions of persons knowledgeable in a particular area of oral health and dental care practice, service delivery, or service organization and management. This symbol is used to signify sample specifications that do not reflect a formal legal policy or that are not part of a formal practice guideline but that are recommended for consideration because they reflect good practice in the opinion of experts.

⁵ **Commentary:** Definitions of certain terms used in these sample specifications are at §109.

PART 1. PEDIATRIC DENTAL AND ORAL HEALTH SERVICES BENEFITS

§101. In General

(a) **Contractor Duties** -- Contractor shall, for each enrollee who is under age 21, cover and furnish, or arrange for the furnishing of, dental and oral health services enumerated in this Part in accordance with:

- (1) guidelines and recommendations relating to dental and oral health preventive, treatment and restorative services that are enumerated in §107 (and any subsequent editions of such guidelines and recommendations);
- (2) accepted standards of practice by dentists and other dental and health care professionals acting within the scope of state law; and
- (2) coverage determination standards and procedures described in §108.

§102. Scope of Benefit

(a) **Pediatric Dental and Oral Health Services** -- Pediatric dental and oral health services are:⁶

⁶ **Commentary:** Under federal Medicaid law, a state's Medicaid plan must include "dental services" as one element of the mandatory Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Medicaid beneficiaries under age 21. The EPSDT dental benefit consists of dental "screening services," at "intervals that meet reasonable standards of...dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care." (42 U.S.C. §1396d(r)(1)(A),(3)(A)(i)), and also "at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." In addition to the screenings, the EPSDT dental benefit also includes dental services "which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health." (42 U.S.C. §1396(r)(3)(A)(ii),(B)) Health Care Financing Administration (HCFA) guidance further described covered EPSDT dental services as "emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures." Health Care Financing Administration (HCFA) State Medicaid Manual, §5124B.2.b.) The EPSDT benefit also specifically includes "health education (including anticipatory guidance)," which must be provided in the context of dental as well as medical assessments ("screens") and which must be provided both to parents (or guardians) and children. (42 U.S.C. §1396d(r)(1),(B),(v), Health Care Financing Administration (HCFA) State Medicaid Manual, §5124B.2.b.)

As with the EPSDT benefit generally, any "mandatory" or "optional" Medicaid service must be covered for an individual child if the dental screen or another provider encounter ("interperiodic screen") indicates that the service is "necessary...to correct or ameliorate a defect or condition" discovered during the screen or other encounter. (42 U.S.C. §1396d(r)(5)). A "mandatory" Medicaid service is one that a state Medicaid plan must include, at least for categorically eligible individuals. Mandatory Medicaid services that might be needed include certain types of services and providers that may provide preventive, diagnostic and or treatment services for routine or complex dental and oral health care. Such benefits include inpatient and outpatient hospital services, laboratory and X-ray services; rural health clinic services, Federally-qualified

- (1) preventive dental and oral health services enumerated in **§103**;
- (2) treatment and restorative dental and oral health services enumerated in **§104**;
- (3) radiographic, laboratory and other diagnostic services enumerated in **§105**;
and
- (4) prescription drugs enumerated in **§106**.

§103. Preventive Services

L.G (a) **In General** -- Preventive oral and dental health services are the following items and services delivered in accordance with subsection (b) of this Section:

- (1) education on measures to promote an enrollee’s dental and oral health and prevent dental and oral disease;⁷
- (2) dental and oral health assessments;⁸
- (3) referrals to dentists;⁹
- (4) examinations of the teeth and oral cavity;¹⁰
- (5) fluoride therapies which shall include:¹¹

health center services, physician services and “medical and surgical services furnished by a dentist... to the extent that such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine...;” and clinic services. (42 U.S.C. §1396d(a)(1), (2)(A)-(C), (3), (5)(B), and (9). An “optional” Medicaid service is one that a state need not include in its state plan; however, it would be considered mandatory under EPSDT for an individual child or adolescent, if found to be “necessary” as described above. Optional Medicaid services include prescribed drugs. (42 U.S.C. §1396d(a)(12)) Regulations implementing dental and oral health care as an EPSDT service are found at 42 C.F.R. §§ 440.40(b), 440.50 et seq.; and 441.56(b)(vi). In addition, detailed guidance is provided at §§5110, 5122.C, 5123.2, 5240 and 5310 of the Health Care Financing Administration’s State Medicaid Manual.

⁷ **Commentary:** Health education is a required element of EPSDT screens, including dental screens. For applicable law, see preceding **Commentary**.

⁸ **Commentary:** HCFA guidance anticipates both an oral health screening as part of a child’s physical examination by a primary care provider and also a professional dental examination by a dentist (“an oral screening may be part of a physical examination [but] it does not substitute for examination through direct referral to a dentist.” HCFA State Medicaid Manual, §5124G.

⁹ **Commentary:** See preceding **Commentary**.

¹⁰ **Commentary:** See **Commentary 8**.

¹¹ **Commentary:** The fluoride therapies described in this paragraph are considered to be important adjuncts to daily use of fluoridated toothpaste and a fluoridated water supply, taking into account risk of caries in a population. For applicable guidelines, See **107(g)**.

- (A) application of topical fluoride; and
- (B) dietary fluoride supplements enumerated in **§106**;
- (6) application of dental sealants;
- (7) dental prophylactic services;¹² and
- (8) space maintainers.

^L (b) **Delivery of preventive services.** In delivering the preventive services described in subsection (a) of this Section, Contractor shall ensure that:

^{L,G} (1) the education services described in paragraph (a)(1):

^G (A) are provided to an enrollee and to the enrollee’s family or care giver as part of:¹³

- (1) dental and oral health assessments described in paragraph (a)(2);
- (2) examinations of the teeth and oral cavity described in paragraph (a)(4); or
- (3) treatment and restorative services described in **§104**; and

^G (B) address use of fluoride toothpaste, sealants, tooth cleaning, fluoride supplementation, and other topics appropriate for the age of the enrollee.¹⁴

^L (2) dental and oral health assessments described in paragraph (a)(2) are furnished by an enrollee’s primary care provider as part of EPSDT initial and periodic well-child screens;

¹² **Commentary:** Prophylactic services include tooth scaling and, for young children (generally less than 10 years of age) with minimal formation of calculus, toothbrush prophylaxis as an educational tool. For applicable guideline, see **§107(a)**.

¹³ **Commentary:** See **Commentary 7**.

¹⁴ **Commentary:** Experts in dental and oral health recommend that children’s teeth be cleaned daily from the time that they erupt in the mouth; that parents and guardians consult with a dentist or other health care provider before using a fluoridated toothpaste with a child under age two; and that parental supervision of toothbrushing and other measures to minimize the amount of fluoridated toothpaste swallowed be followed for children under age six. Topics for age-appropriate education of pediatric (including adolescent) and anticipatory guidance of parents or guardians of a child are described in the guidelines at **§107**

^L (3) referrals to dentists described in paragraph (a)(3) are provided;¹⁵

(A) in accordance with the schedule for periodic EPSDT dental and oral health screens as set out in *[drafter insert citation to state medical assistance plan]*; and

(ii) at other times as indicated by one or more dental or oral health risk factors identified by a primary care provider;

^{L,G} (4) examinations of the teeth and oral cavity described in paragraph (a)(4) are:

^L (A) performed by dentists;

^G (B) include a medical and dental history to determine the presence of oral and dental health risk factors;

^L (C) furnished in accordance with the schedule for periodic EPSDT dental and oral health screens as set out in *[drafter insert citation to state medical assistance plan]*;

^L (D) at other times as indicated one or more risk factors identified by the treating dentist;

^G (5) application of topical fluoride described in subparagraph (a)(5)(A) is provided:¹⁶

¹⁵ **Commentary:** Under HCFA guidance, “[a] direct dental referral is required for every child in accordance with a state’s periodicity schedule and at other intervals as medically necessary.” The state’s periodicity schedule “must be established after consultation with recognized dental organizations involved in child health care.” The guidance distinguishes the dental periodicity schedule from that for physical health and observes that “where any screening, even as early as a neonatal examination, indicates that dental services are needed at an earlier age, states must provide dental services.” *HCFA State Medicaid Manual* §5123.1.G.

¹⁶ **Commentary:** Indications for fluoride therapy will vary with a child’s medical and dental history, risk of caries, the fluoride level of the available water supply, frequency of the child’s use of fluoride dentifrice, and other factors. Because of this variability, two alternative schedules for topical fluoride administration are provided. A minimum, annual level of therapy may be indicated for several reasons. First, available data show that low-income children are at higher risk of untreated caries and that a low percentage nationally of Medicaid-eligible children receive any preventive dental service annually. Second, the frequent disruptions in Medicaid eligibility that many low-income families experience heighten the importance of preventive measures during periods when these children have Medicaid coverage for dental and oral health care. Finally, the the marginal cost of fluoride therapy as part of a periodic dental visit is low and there are no current data on the frequency with which low-income children use fluoride dentifrice.

[Alternative A]

(A) annually or more frequently, as indicated in the judgment of the treating dentist, other dental professional, or primary care provider; except

(B) in the case of a child with active caries, semi-annually or more frequently as indicated in the judgment of the treating dentist, other dental professional, or primary care provider; and as recommended by the manufacturer of the fluoride product;

[Alternative B]

(A) semi-annually or more frequently, as indicated in the judgment of the treating dentist, other dental professional, or primary care provider;

G (6) application of dental sealants described in subparagraph (a)(6) is provided for pits and fissures of:¹⁷

(A) an enrollee's first and second permanent molars that are free of restorations and non-incipient caries; and

(B) other teeth, as indicated in the judgment of the treating dentist, other dental professional, or primary care provider

G (7) dental prophylactic services described in subparagraph (a)(7) shall be furnished:¹⁸

(A) *[drafter insert frequency of visits for routine dental prophylactic services]*; or

Alternative A reflects a minimum fluoride therapy level but provides also for more frequent applications of topical fluoride for children with active caries.

The American Academy of Pediatric Dentistry recommends that topical fluoride be furnished at least semi-annually. The CAPIR Council, American Dental Association, has suggested that topical fluoride be furnished at least semi-annually for all children living in areas served by low-fluoride water supplies and for children with active caries living in areas served by fluoridated community water systems. Alternative B reflects this recommendation.

¹⁷ **Commentary:** HCFA guidance provides for coverage of [p]rofessional application of dental sealants when appropriate to prevent pit and fissure caries." HCFA State Medicaid Manual, §4123.2.G. At the time these specifications were drafted, the Task Force on Community Preventive Services was completing its review of the evidence of effectiveness of school-based and school-linked sealant delivery programs in preventing dental caries.

¹⁸ **Commentary:** AAPD recommends that dental prophylactic services be furnished at least semi-annually. For applicable guidelines, see §107(a).

(B) at the frequency that is indicated in the judgment of the treating dentist, other dental professional or primary care provider; and

^G (8) space maintainers described in subparagraph (a)(8) shall be furnished to prevent space closure following an enrollee's premature loss of primary teeth.

§104 Treatment and Restorative Services

^{L,K} (a) **In General** -- Dental and oral health treatment and restorative services are the following items and services delivered in accordance with subsection (b) of this subsection:

- (1) radiographic, laboratory and other diagnostic services enumerated in **§105**;
- (2) restorative services (fillings and prefabricated crowns);
- (3) orthodontic services;
- (4) endodontic services (pulpotomy, root canal therapy and/or apicoectomy and apexification);
- (5) dental and oral surgery;
- (6) periodontic services;
- (7) prosthodontic services;
- (8) oral pathology services;
- (9) anesthesia services;
- (10) prescribed drugs enumerated in **§106**;

^K (11) consultations by treating dentists (including dental and oral health specialists and subspecialists) with the physician(s) who are clinically responsible for enrollees with complex medical conditions, chronic conditions, or disabilities that require specialized dental and oral health care; and

(11) other services that are covered services under Section 1396d(a) of the Social Security Act.¹⁹

L,G (b) **Delivery of Treatment and Restorative Services** -- In providing treatment and restorative services covered under subsection (a) of this Section, Contractor shall ensure that:

L (1) the services enumerated in subsection (a) are provided for relief of pain; resolution of infection; restoration of teeth; and maintenance of dental function and oral health of an enrollee;

G (2) restorative services enumerated in paragraph (a)(2) are provided for restoration of an enrollee's:

(A) permanent teeth; and

(B) primary teeth not nearing exfoliation;

G (3) orthodontic services enumerated in paragraph (a)(3) are provided for:

(A) an enrollee diagnosed with severe, handicapping malocclusion or other congenital or developmental anomaly or injury resulting in malalignment or severe handicapping malocclusion of teeth; or²⁰

(B) following repair of an enrollee's cleft palate;

G,K (4) anesthesia services enumerated in paragraph (a)(8) are provided in the course of treatment and restorative services enumerated in subsection (a):²¹

(A) as local anesthesia; or

¹⁹ **Commentary:** For applicable guidelines, addressing specialized dental and oral health services for children with special health care needs and for hospitalization and use of general anesthesia for pediatric dental services, see **§107(a)**. For applicable Medicaid law, see **Commentary 6**.

²⁰ **Commentary:** Purchasers may wish to consider specifying an objective severity index for use in identifying children without cleft palate for whom orthodontic services are appropriate. See: American Association of Orthodontics. Proceedings of the Orthodontic Indices Consensus Conference, 1993; Parker WS. The HLD (CalMod) index and the index question. American Journal of Orthodontics and Dentofacial Orthopedics, 1998; 114 (2):134-41.

²¹ **Commentary:** For applicable guidelines, addressing specialized dental and oral health services for children with special health care needs and for hospitalization and use of general anesthesia for pediatric dental services, see **§107(b)**.

^K (B) as sedation or general anesthesia, when indicated in the opinion of the treating dentist;

^K (5) consultations enumerated in paragraph (a)(10) are provided for enrollees with complex chronic conditions or disabilities that require specialized dental and oral health care; and

^{G,K} (6) In the case of an enrollee diagnosed with an illness, disability or condition or receiving a medical treatment(s) that constitutes one or more risk factors for dental or oral disease as defined in §109, Contractor shall ensure that:²²

(1) dental and oral health services are provided, as indicated by the enrollee's illness, disability, condition or medical treatment:

(a) as inpatient services and in other appropriate settings; and

(b) under general anesthetic or with other procedures.

§105. Radiographic, Laboratory and Other Diagnostic Services

^L (a) **In General** -- Radiographic, laboratory and other diagnostic services are the following services delivered in accordance with subsection (b) of this Section:

(1) radiographs;

(2) laboratory tests; and

(3) other diagnostic procedures.

^G (b) **Delivery of Radiographic, Laboratory and Other Diagnostic Services** -- In providing radiographic, laboratory and other diagnostic services covered under subsection (a) of this Section, Contractor shall ensure that:

²² **Commentary:** This provision addresses the specialized dental and oral health needs of enrollees under treatment for chronic and acute medical conditions (e.g., HIV infection, cancer) and/or with behavioral disorders, developmental disability or other conditions that require specialized dental and oral health interventions. At least one state Medicaid agency (Connecticut) has recognized the specialized needs by providing in its managed care contract for coverage of oral and dental health services in an enrollee's home and for patient "management" in connection with dental services for enrollees with developmental disability. Rosenbaum et al., *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts* (2nd ed., 1998). For applicable guidelines, addressing specialized dental and oral health services for children with special health care needs and for hospitalization and use of general anesthesia for pediatric dental services, see §107(b).

(1) radiographs are furnished:

(A) when indicated, in the judgment of the enrollee's treating dentist, by the enrollee's history and dental and oral examination; and

(B) in accordance with appropriate clinical guidelines;²³

(2) laboratory tests and other diagnostic procedures are furnished when indicated, in the judgment of the treating dentist, by the enrollee's history and dental and oral examination.

§106. Pharmaceuticals

^{L,G} (a) **In General** -- Pharmaceuticals that are covered under **§103(a)(5)(B)** (relating to preventive services) and **§104** (relating to treatment and restorative services) are the following pharmaceuticals delivered in accordance with subsection (b) of this Section:

(1) dietary fluoride supplements; and

(2) drugs prescribed for prevention or management of an enrollee's dental or oral disease, condition or injury.

^G (b) **Delivery of Pharmaceuticals** -- In providing pharmaceuticals covered under subsection (a) of this Section, Contractor shall ensure that:

^G (1) dietary fluoride supplements are provided when prescribed for enrollees ages six months to sixteen years:

(A) in accordance with applicable guidelines and recommendations²⁴

(B) by the enrollees' primary care practitioner or treating dentist; and

^G (2) drugs for prevention or management of an enrollee's dental or oral disease, condition or injury are prescribed:

(A) in conjunction with treatment and restorative services enumerated in **§104**

²³ **Commentary:** For applicable guidelines, see **§107(i)** and **(j)**.

²⁴ **Commentary:** For applicable guidelines, see **§107(f)**, **(g)**, and **(h)**.

(B) by the enrollee's treating dentist.

§107. Guidelines²⁵

(a) American Academy of Pediatric Dentistry. Journal of the American Academy of Pediatric Dentistry, Special Issue Reference Manual 1998-99. 20(6).

(b) Casamassimo P. Bright Futures in Practice: Oral Health. Arlington, Virginia: National Center for Education in Maternal and Child Health, 1996.

(c) U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Alexandria, Virginia: International Medical Publishing, 1996.

(d) American Dental Association, Council on Access, Prevention and Interprofessional Relations (CAPIR). Caries Diagnosis and Risk Assessment: A Review of Preventive Strategies and Management. J Am Dent Assoc 1995;126:1s-24S.

(e) Workshop on Guidelines for Sealant Use: Recommendations. J Pub Health Dent 1995; 55:263-273.

(f) New fluoride guidelines proposed. J Am Dent Assoc 1994: 125:366.

(g) American Academy of Pediatrics. Fluoride supplementation for children: interim policy recommendations. Pediatrics 1995; 95:777.

(h) U.S. Food and Drug Administration. The selection of patients for X-ray examination: dental radiographic examinations. Rockville, MD.: 1998; HSD Publication Number 88-8273.

(i) American Dental Association, Council on Dental Materials, Instruments and Equipment. Recommendations on radiographic practices: an update, 1988. J Amer Dent Assoc 1989; 118:115-117.

²⁵ **Commentary:** Purchasers may wish to consider the chapter on oral health promotion in the evidence-based *Guide to Community Preventive Services*, for which publication was expected in mid-2001. This publication is a companion volume to the 1996 U.S. Public Health Service publication, *Guide to Clinical Preventive Services*; the forthcoming *Preventive Services* guide is designed to articulate evidence-based public health practices for such defined populations as communities and members of insured (managed care) health coverage plans. Before publication, information on the status and content of the report may be found at <http://www.thecommunityguide.org> and also in the publication: Task Force on Community Preventive Services. Introducing the Guide to Community Preventive Services: Methods, First Recommendations and Expert Commentary. Am J Prev Med 2000;18(1s):1-42. At the time these specifications were drafted, a *Guide* chapter on oral health promotion, addressing the following topics, was under development: school-based sealant delivery programs; community water fluoridation; school-based fluoride delivery programs; provider and public education; oral hygiene education and supervised practice; oral examination for early detection of oro-pharyngeal cancer, and combined approaches.

§108. Coverage Determinations

^{L,K} (a) **Use of Prior Authorization Procedures for Certain Services** -- Contractor shall not impose any requirement for prior authorization or a “medical necessity” coverage determination for:

^K(1) referral by an enrollee’s primary care provider for an enrollee visit to a dental provider or dental specialist provider for services described in **§103** (relating to preventive services) or **§104(a)(1)** and **(2)** (relating to radiographs, laboratory tests and other diagnostic procedures and to restorative services); or

^L (2) services enumerated in **§104** when furnished for symptomatic relief and stabilization of emergency dental conditions.

^K (b) **Determinations of Medical Necessity** -- In making coverage determinations with respect to the medical necessity of services enumerated in **§104(a)(3)-(11)** (relating to treatment or restoration) for purposes of authorizing such services for an enrollee (including the medical necessity of such services which an individual is receiving at the time of enrollment as described in **§202(a)**), Contractor shall:

(1) utilize appropriate clinical guidelines;²⁶

(2) take into account:

(A) the judgment of the treating dentist; and

(B) the condition of the individual enrollee; and

(3) not deny coverage on the grounds that such services are available at a discount or free of charge through a publicly-assisted provider as defined in **§109**.

§109. Definitions

(a) **Dental or oral disease or condition** -- a disease or condition of the oral cavity, including but not limited to: dental caries; gingivitis; periodontitis; oral and pharyngeal cancer; salivary and oral mucosal conditions; malocclusion; congenital anomaly; injury or trauma to oral facial structures; and any other dental or oral disease or condition including manifestation of systemic disease and effect of certain medications and other medical treatments.

²⁶ **Commentary:** For applicable guidelines, see **§107**.

(b) **Emergency dental condition**²⁷ -- a dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

^L (c) **EPSDT** -- the Medicaid Early and Periodic Screening, Diagnostic and Treatment program, which is a specific set of benefits set forth in 42 U.S.C. §§1396d(a)(4)(B), 1396d(r) and implementing regulations and guidelines, to which all Medicaid beneficiaries under age 21 are entitled.

(d) **Low fluoride water supply** -- a water supply with less than 0.7 parts per million (ppm) fluoride as determined by *[drafter insert the name of the state agency with authority to evaluate the quality of a community's water supply, including its fluoride content]*.

(e) **Poor personal oral hygiene** -- oral hygiene practices that offer less than optimal prevention of dental caries or oral disease, as determined by professional standards of practice and the opinion of a health professional competent to assess oral hygiene practices.

(f) **Publicly assisted health care provider** -- a provider that: (1) is a public or private non-profit agency or entity; (2) furnishes services enumerated in §103 either free-of-charge or on the basis of a discounted schedule of charges adjusted for family income; and (3) receives funding under any federal, state or local program or under a privately-sponsored program to furnish free or subsidized health care to low income, medically underserved or other specified populations. Such providers include: local public health agencies; school-based health services; clinics of dental schools and dental and oral surgery residency programs; Ryan White CARE Act grantees; Federally Qualified Health Centers; Rural Health Centers; Health Centers for the Homeless; Migrant Health Centers; and other community-based ambulatory care providers.

²⁷ **Commentary:** This language may be used to supplement the Medicaid definition of “emergency medical condition” (emphasis added) in order to ensure that certain conditions of the mouth and teeth and supporting structures are not excluded from emergency care. The federal statutory definition of emergency medical condition for Medicaid enrollees in managed care, which this language may supplement, is:

“a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) the placement of the child’s health (or with respect to a pregnant adolescent, the health of the adolescent or her unborn child) in serious jeopardy;
- (2) serious impairment of the child’s bodily functions; or
- (3) serious dysfunction of any bodily organ part.” 42 U.S.C. §1396u-2b(2)(C)

(g) **Risk factors for dental or oral disease or condition** -- the presence of one or more of the following: history of dental caries; poor personal or family oral hygiene; use of a low fluoride water supply; absence of regular source of dental care; congenital oral facial anomalies; abnormal tooth morphology; certain medical conditions including diabetes mellitus, HIV infection, pregnancy and xerostomia; use of certain medications and other medical treatments including chemotherapy, radiation of the head or neck, and frequently used sugared medications; physical or mental disability; residence in an institution; use of tobacco; high alcohol intake; or addiction disorder.

(h) **Urgent dental condition**²⁸ -- a dental or oral condition that require services within for relief of symptoms and stabilization of the condition within a reasonable period of time, as determined by the treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care. Such conditions may include minor tooth fracture; an oral tissue lesion that is visible to the enrollee (or enrollee's family or caregiver); and lost restoration.

§110. Compliance Measures

^K (a) **Availability to Purchaser of Certain Documents** -- Upon request, Contractor shall make available to Purchaser the most recent version of each of the following documents:

(1) copies of all manuals, memoranda, and other documents that are distributed to network providers (including dentists and other dental professionals, primary health care providers, providers furnishing pregnancy related care, and adult and pediatric specialists furnishing care for persons with illnesses and conditions which place them at risk for dental or oral diseases) and that describe the benefits provided under this section, the standards used to make coverage determinations, the conditions under which prior authorization for covered services must be obtained, and the evidence that must be submitted to the Contractor with respect to a coverage determination.

(2) copies of all educational materials prepared for families that explain risk factors for dental and oral disease and steps for preventing and ameliorating dental and oral disease and promoting dental and oral health as well as a written explanation of the procedures that contractor uses to distribute such materials and provide education to enrollees and their families or other caregivers; and

²⁸ **Commentary:** Drafter may wish to specify a maximum time within which an enrollee must be seen for an urgent condition. Maximum waiting times for urgent dental care services in Medicaid managed care range from 24 hours to 3 days among 19 states participating in a 1998 survey. Dental Care Medicaid Managed Care: Report from a 19 State Survey. National Academy for State Health Policy (November, 1998).

(3) copies of all coverage manuals and plan descriptions furnished to enrollees that describe services covered under this Part, as well as applicable limitations (including prior authorization and medical necessity requirements).

PART 2. PEDIATRIC DENTAL AND ORAL HEALTH SERVICE DELIVERY AND QUALITY

§201. Enrollee Access to Dental and Oral Health Care Providers²⁹

K,L(a) Time lines for covered services -- Contractor shall provide and arrange for services covered under this agreement in accordance with the following standards:

L (1) Contractor shall ensure immediate access to services for emergency dental and oral conditions or injuries;

(2) Contractor shall ensure access to services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care; and

(3) Contractor shall ensure that visits for non-emergency, non-urgent preventive, treatment and restorative oral and dental health services are scheduled to occur within *[drafter insert the average waiting period for such visits for enrollees in private-sector managed care organizations doing business in Contractor's service area]* of the date on which an enrollee requests an appointment, provided that the scheduling of visits is consistent with:

²⁹ **Commentary:** Medicaid purchasers may also wish to consider general service access standards at **MEDICAIDSPECS Part 6** and a specialized package of access-related specifications currently under development by CHSRP. Amendments to Medicaid law in the 1997 Balanced Budget Act (BBA) create a general requirement that MCOs serving Medicaid beneficiaries to provide "assurances" of "a sufficient number, mix, and geographic distribution of providers" in the MCOs' service areas. (42 U.S.C. §1396u-2(b)(5)(B)). State Medicaid agencies vary in the geographic access standards for primary care and specialty providers included in Medicaid managed care service agreements; distances for access to providers of dental and oral health services are rarely addressed, however. A thirty-minute or thirty-mile travel time in urban areas is frequently used as a standard, as is 45 minutes or miles in rural areas. Purchasers may wish to review other options at: Rosenbaum, S et al, *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts*, Table 3.8. (3rd ed., 1999). For a range of time and geographic standards adopted by state Medicaid managed care programs, see also *Dental Care in Medicaid Managed Care: A Report from a 19 State Survey*. National Academy for State Health Policy (November, 1998).

(A) the state medical assistance plan schedule for referrals to dentists for periodic dental and oral health assessments, as described at §103(b)(3)

(B) the schedule for application for topical fluoride, as described at §103(b)(5);

(C) the schedule for applicant of dental sealants, as described at §103(b)(6); and

(D) the schedule for dental prophylactic services, as described at §103(b)(7).

^K (b) **Geographic access** – Contractor shall ensure that travel time for dental and oral services is no greater than *[drafter insert number of minutes or miles]* from an enrollee’s residence using commonly available public travel arrangements and *[drafter insert number of minutes or miles]* in the case of those portions of the Contractor’s service area designated as rural by a state health agency.

§202. Enrollment and Disenrollment

^K (a) **Enrollment of individuals receiving dental or oral health services at the time of enrollment** – Except as provided in subsection (b), in the case of an individual receiving dental or oral health services at the time of enrollment, Contractor shall provide coverage for items and services in the enrollee’s pre-enrollment plan of care until the enrollee has been evaluated by a provider within Contractor’s network and a decision regarding continuation or modification of such a plan of care has been made and implemented.

^K (b) **Payment arrangements for individuals receiving dental or oral health services at the time of enrollment** – In the case of an individual described in subsection (a) for whom a specified course of orthodontic or prosthodontic treatment was paid in full before the individual’s enrollment with Contractor, Contractor shall arrange for the treatment to be completed by:

(1) the previous provider who was paid for the enrollee’s treatment; or

(2) Contractor, provided that Contractor is able to enter into an agreement under which the previous provider agrees to pay Contractor on a pro rata basis to complete the treatment.

^K (c) **Disenrollment of individuals receiving dental or oral health services at time of disenrollment** – In the case of an individual who is receiving dental or oral

health treatment or restorative services at the time of disenrollment, Contractor shall:
shall:

(1) continue such services until completed or through the last day of the period for which a premium was paid for the enrollee, whichever occurs first, except that in the case of orthodontic or prosthodontic treatment for which the Contractor has been paid in full before the disenrollment, Contractor shall complete the treatment in accordance with enrollee's treatment plan; and

(2) provide, at the written request of the former enrollee, for the transfer of all dental and medical records³⁰ related to such services to the former enrollee's successor medical and dental providers at no cost to the recipients.³¹

§203. Provider Network Requirements

^K (a) **Network requirements** – Contractor's network shall include the following classes of providers in numbers that are sufficient to enable Contractor to furnish services described in this agreement in accordance with the timeline, geographic and other standards described in §201 of this agreement:

(1) dentists, dental hygienists, nurses who are trained in dental care and oral health care and experienced in performing triage for such care; pediatric dentists; orthodontists; periodontists; endodontists; prosthodontists; oral pathologists; and oral and maxillofacial surgeons.

(2) dentists and other health and dental professionals described in paragraph (1) of this subsection with demonstrated experience in the provision of services to children with acute and chronic medical conditions, including cardiovascular conditions; HIV infection; developmental disability; or cancer; and

(3) medical and dental specialists and subspecialists that furnish multidisciplinary treatment of cranio-facial anomalies.

Contractor may meet the network standards for specialized dental and oral health care professionals described in this subsection by arranging for and covering referrals to

³⁰ **Commentary:** A Medicaid enrollee's medical and dental records may be maintained by more than one MCO in a state where the Medicaid agency purchases prepaid comprehensive managed medical and health care separately from specialized managed care services for dental and oral health, behavioral health or children with special health care needs. For this reason, Medicaid agencies may wish to include comparable language addressing records transfer in each type of managed care service agreements.

³¹ **Commentary:** Medicaid law does not directly address charges to beneficiaries for transfer of medical records. Arguably, such charges would not be consistent with the generally applicable requirement that covered "care and services" be "provided in a manner consistent with...the best interests of the recipients [beneficiaries]." (42 U.S.C. §1396a(a)(19).

specialists and subspecialist providers described in this paragraph who do not participate in the provider's network and reimbursing these providers at Medicaid or other, negotiated rates in accordance with the same coverage and payment timeline principles that apply to providers of services within the Contractor's network.

K (b) Use of publicly-assisted providers -- Contractor shall make a reasonable effort to include in its network publicly assisted providers as defined in §109 that offer dental and oral health programs. Contractor shall pay such providers at negotiated rates in accordance with the same coverage and payment timeline principles that apply to other providers of services within Contractor's network.

K (c) Updating provider network information -- Contractor shall provide to all potential enrollees, to individuals at the time of enrollment, and to any enrollee on request, a list that identifies all providers of dental and oral health services. Such list shall include current provider addresses and telephone numbers and shall be updated no less frequently than *[drafter insert frequency of updating]*.³²

§204. Data and Reporting

K (a) Integration of dental and oral health information into medical record³³ -- Contractor shall ensure that dental and oral health screenings and referrals to dentists which are described in §103(a)(2),(3) are noted by the primary care provider delivering these services in the enrollee's medical record.

K (b) Special Rule for Certain Enrollees -- In the case of an enrollee diagnosed with an illness, disability or condition or receiving a medical treatment(s) that constitutes one or more risk factors for dental or oral disease as defined in §109, Contractor shall ensure that the enrollee's medical treatment plan includes the dental and oral health services recommended by the enrollee's treating dentist.³⁴

³² **Commentary:** For general specifications relating to information for potential and newly-enrolled Medicaid children, purchasers may wish to review **MEDICAIDSPECS Part 3**, which addresses enrollee information on covered items and services, excluded services that are covered under the state medical assistance plan; information on providers; emergency services; items and services subject to and excluded from prior authorization; cost-sharing and other matters. These specifications are drafted to be consistent with consumer protection requirements of Medicaid managed care provisions of the 1997 Balanced Budget Amendment (Section 1932 of the Social Security Act, 42 U.S.C. §1396u(j)).

³³ **Commentary:** This specification addresses only medical records of screenings and referrals by a child's primary care provider. It is intended to permit primary care providers' performance of these services to be evaluated. The specification should not be read to require primary care providers' medical records to include the separate records kept by the child's dentist.

³⁴ **Commentary:** This provision addresses the specialized dental and oral health needs of enrollees under treatment for HIV infection, cancer and certain other chronic and acute conditions as well as of enrollees with developmental disability, behavioral disorders and other conditions that require specialized

^K (c) **Dental and oral health services encounter data:** Contractor shall collect encounter data on all dental and oral health services described in **Part 1** that utilize universal codes for all dental and oral health services and that at a minimum, identify the enrollee, the date of service, the service provided including the tooth and tooth surface treated, the treating dentist, other dental professional, or primary care provider and, if available, the diagnosis related to the service provided.

§205. Quality Measurement and Improvement

^K (a) **Practice guidelines** – Contractor shall disseminate to all network providers practice guidelines that conform to the clinical guidelines and recommendations incorporated into this agreement and shall regularly update such practice guidelines in accordance with changes in the guidelines and recommendations.

^K (b) **Quality studies** – Contractor shall conduct periodic quality studies of the timeliness and quality of dental and oral health services described in **Part 1**. Such studies shall at a minimum consider one of the following:

(1) the percentage of all enrollees ages four through twenty-one who are continuously enrolled for a period of at least twelve months (allowing one break in service of up to forty-five days) who had one or more dental visits with a dental provider;³⁵

(2) the percentages of enrollees from birth through age twenty, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who are continuously enrolled for a period of at least twelve months (allowing one break in service of up to forty-five days) who had one or more dental visits with a dental provider;³⁶

interventions. At least one state Medicaid agency (Connecticut) has recognized the specialized needs by providing in its managed care contract for coverage of oral and dental health services in an enrollee's home and for patient "management" in connection with dental services for enrollees with developmental disability. Rosenbaum et al., *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts* (2nd ed., 1998). For applicable guidelines, addressing specialized dental and oral health services for children with special health care needs and for hospitalization and use of general anesthesia for pediatric dental services, see **§107(k)**.

³⁵ **Commentary:** This performance measure is included in: National Committee for Quality Assurance (NCQA), HEDIS 1999 Technical Specifications, Vol. 2 (Washington, D.C.)

³⁶ **Commentary:** This measure is one of several quality measures recommended by an expert advisory panel organized by the National Committee for Quality Assurance (NCQA) under a contract with the Health Care Financing Administration. At the time these sample specifications were drafted, the recommended measures had not been included in the NCQA Technical Specifications; however, anecdotal evidence suggested that certain state Medicaid managed care programs were already collecting data relating to one or more of the measures. Purchasers may wish to review the recommended measures at: NCQA, *The Future of Pediatric Oral Health Performance Measurement: Expert Panel Recommendations*. Deliverable 203,

(3) the percentages of enrollees from birth through age twenty, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who are continuously enrolled for a period of at least twelve months (allowing one break in service of up to forty-five days) who, within the reporting year, received:³⁷

(A) any dental procedure;

(B) any preventive dental procedure;³⁸ and

(C) any dental treatment other than diagnostic and preventive procedures;
and

(4) enrollee experience with pediatric oral and dental health services, as measured with the pediatric oral health survey module of the CAHPS survey instrument prepared by the Agency for Health Care Policy Research (AHCPR).^{39, 40}

HCFA, May 19, 1999; see also Crall JJ, Szlyk CI, Schneider DA. Pediatric Oral Health Measurement: Current Capabilities and Future Directions. *J Public Health Dent* 1999;59(3):136-40.

³⁷ **Commentary:** This measure is one of the several recommended quality measures described in the preceding **Commentary**. This recommended measure incorporates the requirements for state Medicaid agency reporting of EPSDT data relating specifically to dental services for Medicaid-eligible children, under Form HCFA-416 as revised in 1999. The revised HCFA form defines the three categories of services to be reported by service codes as follows: “any dental services...as defined by HCPC codes D0100 - D9999 (ADA codes 00100 - 09999)...preventive dental services as defined by HCPC codes D1000 - D1999 (ADA codes 01 - 01999)...dental treatment services as defined by HCPC codes D2000-D9999 (ADA codes 02000 - 09999).” *HCFA State Medicaid Manual*, §2700.4.

³⁸ **Commentary:** Purchasers may elect to use application of a dental sealant and or application of topical fluoride as the “preventive” service to be measured. Suggested measures for these services are:

The percentages of enrollees from birth through age twenty, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who are continuously enrolled for a period of at least twelve months (allowing one break in service of up to forty-five days) who, within the reporting year, received at least one topical application of fluoride in accordance with **§103(b)(5)**;

The percentages of enrollees from birth through age twenty, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who are continuously enrolled for a period of at least twelve months (allowing one break in service of up to forty-five days) who, within the reporting year, received at least one dental sealant application on a permanent first and a permanent second molar in **§103(b)(6)**.

³⁹ **Commentary:** CAHPS 2.0™ At the time these sample specifications were drafted, the CAHPS survey instrument included questions on whether a child had received dental care in the previous year, the frequency of such care, and the quality of the care (as perceived by the respondent). The expert panel described at **Commentary 31** recommended that additional questions be formulated with regard to: (a) access; (b) regular source of care (availability); (c) satisfaction; (d) timeliness; (e) involvement in decision-making; and (f) assessment of unmet needs.

⁴⁰ **Commentary:** The Purchaser may wish to consider other recommended quality measures described at **Commentary 31**. These include:

(1) Assessment of Disease Status -- Percentage of all child enrollees who have had their periodontal and caries status assessed within the reporting year;

206. Compliance Measures

^K (a) **Availability to Purchaser of Certain Documents** -- Upon request, Contractor shall make available to Purchaser the most recent version of each of the following documents:

- (1) copies of all manuals, memoranda, and other documents that are distributed to participating providers and enrollees that explain coverage requirements for individuals receiving treatment for dental or oral conditions at the time of enrollment and disenrollment;
- (2) a list of all participating providers that furnish dental and oral health services enumerated in **Part 1**, including the addresses and telephone numbers of such providers and the service capacity of each provider.⁴¹
- (3) the list of network providers, with names, locations and telephone numbers, that is furnished to enrollees; and
- (4) all practice guidelines and quality study protocols and results.

(2) New Caries among Caries-active Children -- Percentage of all caries-active child enrollees who receive treatment for caries-related reasons within the reporting year;

(3) New Caries among Caries-inactive Children -- Percentage of all caries-inactive child enrollees who receive treatment for caries-related reasons within the reporting year.

(4) Preventive Treatment for Caries-active Children -- Percentage of all caries-active child enrollees who receive a dental sealant or a fluoride treatment within the reporting year.

⁴¹ **Commentary:** A provider's service capacity would be indicated by whether the provider's practice was open to new Medicaid patients, was limited to a specified number of such patients or was closed to them.