Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract

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Background

This toolkit developed by the American Dental Association (ADA) serves to assist state dental associations in working with state Medicaid program administrators to incorporate key elements into state Medicaid Managed Care Request for Proposals (RFP), contract specifications, or proposed amendments to new and existing contracts between state Medicaid Programs and Managed Care Organizations (MCO), Pre-paid Ambulatory Health Plans (PAHP, typically carved-out dental managed care organizations), Dental Benefit Managers (DBM) or Administrative Services Organizations (ASO) as applicable (noted as "Contractor" within this document). Note that these criteria can be used irrespective of whether the dental benefits are administered by a state-contracted entity directly or when dental benefits are administrated via a subcontract with the medical MCO that contracts with the state. In either instance, the state should retain the right for open communication with the dental benefits administrator to best serve its Medicaid population. Further, the toolkit is applicable to any dental benefit program regardless of whether children and/or adults are covered.

The toolkit was developed through the review of existing publicly available model RFPs and other relevant sources of information.[1] This document serves as a "catch all" for best practice elements of a program contract. This document is designed to assist states in the completion of certain diagnostic elements to determine which elements need to be addressed for improvement.

Dental associations should consider encouraging their state administrators to seek the association's input during the RFP development. It may also be a good idea to ask for a formal Request for Information (RFI) prior to releasing the RFP. That is the crucial time for a state's Medicaid agency to recognize the important role that the dental society can play in contract development.

This toolkit was developed by the ADA's Council on Dental Benefit Programs. The Council appreciates the input provided by all stakeholders and will continue to maintain this document as a relevant and up-to-date resource.

[1] Some state contracts, RFP's and Requests for Information (RFI's) that served to develop this toolkit include documents from Texas, Louisiana, Indiana, Idaho RFI and Kentucky. In addition, staff from several state dental associations and national policy research firms provided input and comment.

Need for a State Medicaid Dental Program Director

Experience from states that have successful Medicaid programs indicates that the presence of a dedicated Medicaid dental program director (assisted by a Dental Advisory Committee) is key to successful implementation and oversight of the program. A dentist licensed in the state provides an opportunity for greater expertise in helping states achieve success.

A state Medicaid dental program director must have the capacity, experience and expertise to request key analytical reports and review the data to effectively manage the administration of the dental program. The section below on "Key Elements of a Dental Program Contract" provides some examples of reports that can be requested from the contractor for review by the dental program director to make policies and ensure that patients covered by Medicaid have access to high quality programs.

The overall goal of the program design should be to improve the oral health for populations served through Medicaid. In order to achieve this, the state Medicaid dental program director can:

- facilitate ensuring a robust contract between the state and the contractor to effectively manage the dental program;
- encourage collaboration between the MCO and the dental administrator (for states that subcontract the dental program);
- facilitate collaboration between contractors and dentist networks;
- establish outreach and education to patients and dentists; and
- achieve health equity and measurable improvements in the access, utilization of services and health status of Medicaid enrollees through routine review and assessment of data using quality measures endorsed by national consensus building entities.

The Contract: Include and Enforce

The contract is the most important tool the state has to manage its Medicaid dental benefit program. **Once the contract is executed it is the responsibility of the state to ensure conformance with all contract clauses.** This list of criteria is not meant to be exhaustive and not every element will be applicable to every state program. Each state can select elements best suited to enhance its program, whether it includes pediatric and/or adult dental benefits.

A great contract without enforcement is meaningless.

Key Elements to Enforce Through a Dental Program Contract

The 14 key elements identified below serve as a checklist to assist state dental association's working with state Medicaid program administrators to incorporate key elements when developing RFPs and contracts. The elements can also serve as a tool to monitor ongoing implementation by identifying key areas of focus for a Medicaid dental program director.

1. Assuring Adequate Access

Assuring an adequate network is key to the success of any Medicaid program. Through its contract the state can assure health equity such that all covered services are as accessible to Medicaid-insured members in terms of timeliness, quantity, duration, and scope as the same services are to commercially covered members in the contractor's region.

Consider encouraging your state to include contract clauses requiring contractors to:

1.1 Allow any willing dentist to participate in the contractors' network especially for programs striving to improve access to care.

1.2 Allow dentists currently enrolled in the Medicaid program to participate in the contractor's network when a state administered program moves to a program administered by a contractor.

1.3 Prohibit any requirement for a dentist to enroll exclusively with one contractor to provide covered services specifically when there are multiple contractors in a given service area.

1.4 Have written policies and procedures regarding selection and retention of dentists that do not discriminate against dentists who serve high-risk populations.

1.5 Meet standards for access for dental benefit plans. At minimum, geographic distribution of dentists, number of dentists accepting new patients and adequate availability of specialists given the number of enrollees and healthcare needs of the population should be considered. Metrics, such as transportation time or appointment waiting time can be used to assure network adequacy, e.g., transportation distance not to exceed (X) miles; appointment waiting times should not exceed (X) weeks for regular appointments and (X) hours for urgent care. Some programs may also determine specific member-dentist ratios to assess network adequacy. More advanced geo-mapping capabilities are also becoming commonplace to assure network adequacy.

1.6 Have a written provider outreach plan and recruitment strategy to maintain a viable network that meets that state's network adequacy standards. States should also perform annual due diligence to ensure that the contractor's provider network is meeting these adequacy standards.

1.7 Allow enrollees to seek care outside the network using the Medicaid benefit in areas where there is an inadequate network, or where an out-of-network dentist has the necessary expertise (e.g., special needs children; adults with comorbidities) to treat the condition.

2. Enrollment and Credentialing

The Medicaid dentist credentialing or enrollment process is often laborious and time consuming. **A state- supported common credentialing entity for use across all contractors is ideal.** Facilitating a transparent and efficient (online) credentialing process is important for attracting more dentists to a Medicaid program and growing an effective network.

Consider encouraging your state to include contract clauses requiring contractors to:

2.1 Adopt standardized criteria and common credentialing entities for credentialing dentists.

2.2 Ensure that all credentialing/re-credentialing or enrollment applications are processed within thirty (30) calendar days of receipt of a completed application.

2.3 Ensure continuity of care when a dentist is going through the credentialing process (especially for those already participating in the program) when the process takes more than a reasonable time (e.g., 30 calendar days).

2.4 Include an appeals process for dentists not credentialed or enrolled upon the initial application.

3. Securing the Dentist-Patient Relationship

Programs should strive to maintain the integrity of the dentist-patient relationship to ultimately achieve high quality care.

Consider encouraging your state to include contract clauses requiring contractors to:

3.1 Ensure enrollees have freedom of choice to change plans and network dental dentists through a simplified process and without limitations.

3.2 Permit enrollees to obtain covered services from any general or pediatric dentist as the primary care dentist in the contractor's network.

4. Continuity of Care

In programs where multiple contractors are utilized to manage care, it is important for the Medicaid program to ensure continuity of care.

Consider encouraging your state to include contract clauses requiring contractors to:

4.1 Support continuation (treatment begun prior to contract start date) of the planned treatment without any form of additional approval from the new contractor (services covered under EPSDT and those approved by previous contractor/plan) and regardless of whether the dentist is within or outside the new contractor's network. *[Note: special consideration may need to be given to patients undergoing orthodontic care]*

4.2 Allow enrollees to be able to go out-of-network when specialty services are required if there are no in-network dentists capable/qualified to perform medically necessary services within a reasonable distance/time of where the patient lives. The Medicaid program should reimburse out-of-network dentists in such instances. This is especially important for any child with special needs.

5. Fee Schedules and Reimbursement

Low reimbursement rates are one of the most significant barriers to dentist participation and beneficiary access. The state should strive to maintain authority in setting the minimum reimbursement rates for covered services.

Consider encouraging your state to include contract clauses requiring contractors to:

5.1 Abide by a loss ratio/benefit distribution requirement (annual report). The state should consider establishing a loss ratio/benefit distribution for contracts to maximize the portion of program expense spent for direct delivery of dental services (i.e., dentist reimbursement). Include clauses in the contract seeking reports of administrative expenses versus expenses spent towards clinical care.

Utilization benchmark assumptions will need to be part of these MLR calculations. For example, if the capitation rate for the plan is set using an assumption on utilization of 40%, then good access should be benchmarked at 40%. If a state wants to improve access, then rates should be set at a higher assumption and at year end the plan should be held to both the MLR and utilization benchmark. State dental associations should actively seek to understand how these processes will function locally.

5.2 Provide dentists at least 60 days written notification prior to any change in fee schedule or processing policies.

6. Claims Processing and Appeals

Slow claims processing and delayed payment serves as a burden to Medicaid dentists. A best practice for states is to choose a benefits company with dental claims processing experience to manage the dental benefit. Experience with state and federal regulations governing the Medicaid program would also be beneficial. The state can use the contracting process to uphold timeliness and accuracy of payment.

Consider encouraging your state to include contract clauses requiring contractors to:

6.1 Abide by metrics for claims processing. The state could consider establishing such metrics within the contract such as requiring the contractor to ensure that 95 percent of claims that can be auto adjudicated are paid within thirty (30) days of receipt of such claims by the contractor/plan administrator.

6.2 Ensure that the remittance advice or other appropriate written notice specifically identifies all information and documentation that is required when a claim is partially or totally denied. Contractors should include details on all errors in the claim submission rather than sending information on only the first noted error.

6.3 Ensure that all prior authorization requests should be handled within 10-14 days for non-emergency and 48 hours for urgent/emergency situations and there should be clearly written policies explaining when such authorization is required.

6.4 Use the services of a health care professional who has appropriate clinical expertise/specialty in treating the enrollee's condition or disease when making decisions regarding prior authorization requests or to authorize a service in an amount, duration, or scope that is less than requested.

6.5 Establish an appeals process to review and resolve dentist appeals. Time limitations should be included in the contract to promote timely resolution of any

appeals. Ideally, appeals should be resolved in 30 days at most.

6.6 Use the most updated dental claim form (2019 version of the ADA paper claim form or the latest version of the 837D electronic dental health care claim).

7. Role of Peers in Resolving Issues

Appointing a dentist as a dedicated resource to manage the clinical aspects of the care provided to a contractor's Medicaid beneficiaries could help ensure the long-term success of the relationship between the contractor and network dentists.

Consider encouraging your state to include contract clauses requiring contractors to:

7.1 Employ a dentist licensed in your state to manage the clinical aspects of the contract such as proper provision of medically necessary covered services for enrollees, monitoring of program integrity, quality, utilization management, utilization review and credentialing processes.

7.2 In states where dental benefits are subcontracted out by a primary medical contractor, require the medical contractor to employ a dentist licensed in your state to serve as the liaison with the dental benefits administrator (i.e., subcontractor).

8. Monitoring Education and Outreach

The onus of improving utilization of Medicaid dental care to improve and maintain oral health through education and outreach lies with both the contractor and the state.

Consider encouraging your state to include contract clauses requiring contractors to:

8.1 Have mechanisms to track missed and (late) cancelled appointments to conduct targeted outreach to members with repeated occurrences. *[Note: One of the administrative burdens for dentists are no-shows and cancellations. In a managed care situation there can be shared responsibility among all parties to manage this.]*

8.2 Engage in broad outreach and education activities including promoting oral health as part of systemic health and engage families on the importance of achieving good oral health.

8.3 Engage in targeted outreach (in addition to the broad outreach mentioned above) such as case management for young children with early childhood caries or case management for those individuals with acute or chronic medical conditions.

8.4 Monitor network use and assist members in finding dentists that accept new patients.

9. Coordination of Care

Evidence indicates that a greater percentage of children are seen in a pediatrician's office than by a dentist especially at younger ages. Additionally, evidence increasingly suggests a correlation between medical and dental conditions for adults. It is important for medical and dental contractors to work together to improve referral and establish dental and medical homes (i.e., health homes).

Consider encouraging your state to include contract clauses requiring contractors to:

9.1 Work with the primary medical contractor on primary care education and initiatives to improve ease of referral between primary physicians and dentists.

9.2 Establish mechanisms to enable medical-dental coordination for Medicaid beneficiaries, particularly for those individuals with co-morbid conditions.

9.3 Assume responsibility for all members seeking dental care in the emergency department or urgent care facilities by establishing an emergency department diversion program, helping to ensure the establishment of a dental home. Contracts could also require contractors to offer case management services to ensure follow up and discourage repeated use of emergency departments in lieu of routine dental care.

10. Contractor Administrative Performance Monitoring

It is important to assure accountability of the contractor to maintain program standards. To that end, the State's use of performance metrics to monitor the administration of the program will help ensure contractor performance. Contractors and subcontractors should have the capacity to generate analytical reports requested by the state enabling the state to make informed decisions regarding contractor activity, costs, and quality. Consider encouraging your state to include contract clauses requiring contractors to:

10.1 Report metrics related to program administration on a quarterly basis which include:

- Network size
- Average time to make payment of claims
- Accuracy of paid claims
- Response time (call wait time) in dentist call center
- Response time (call wait time) in enrollee call center
- Missed calls in each call center
- Accuracy of dentist directory
- Grievance and appeals resolution
- Credentialing times

10.2 Be accredited by a nationally recognized agency. Such accreditation may assure compliance with minimum standards, aiding the state's oversight efforts to ensure proper administration of the dental program.

10.3 Encourage contractors to monitor patient satisfaction with the plan and its network.

10.4 Encourage contractors to monitor dentist satisfaction through annual assessment of the utilization management and quality improvement programs via network surveys. The state should maintain authority for approving the dentist satisfaction survey tool.

State Medicaid agencies should conduct an annual assessment of the managed care organizations who are their current Medicaid contract vendors (including all subcontractors) to determine what percentage state allocated Medicaid dollars are being spent annually for clinical dental services and what is being spent on program administration in order to determine an accurate dental loss ratio. States should strive to establish a benchmark for dental loss ratio to hold the contracted vendors accountable for responsible and transparent stewardship of taxpayer dollars.

11. Utilization and Quality of Care for Enrolled Population

It is important to monitor and improve the oral health of the enrolled population. CMS is requiring states to establish a quality rating system (QRS) for Medicaid and CHIP plans (i.e., a website with quality rating of each MCO/PAHP) and will require information to be publicly available so that beneficiaries can use the information as part of the plan selection. CMS will specify some national standard measures and specific performance improvement initiatives. States can include other measures. Consider encouraging your state to use the contracting process to set forth parameters for measurement and quality improvement. Efforts to measure and improve quality of care should be separate from the traditional utilization management activities of the contractor. States typically use HEDIS and CAHPS to assess quality. However, these tools lack comprehensive dental specific measures. Quality should be measured using nationally recognized measures, especially those developed by the Dental Quality Alliance (DQA) or endorsed by the National Quality Forum (NQF). Measures developed by the DQA for evaluating plan performance are available for use. Quality and performance improvement programs are also best monitored by an external quality reporting organization (EQRO). Integrity of data within the Medicaid Management Information System (MMIS) system is also essential for program administrators to monitor quality at the program level.

Consider encouraging your state to include contract clauses requiring contractors to:

11.1 Monitor utilization using measures developed by the DQA and endorsed by NQF to assess the performance of the contractor, e.g., percentage of enrollees having at least a comprehensive evaluation and preventive service in the year.

11.2 Ensure that measurement data are available to all stakeholders in the dental community in order to allow the Medicaid system (Medicaid office, contractor, dental association, and patient groups) to participate in improving program administration and patient health. Any quality improvement program should include care and services of members with special health care needs; use of preventive services; coordination of dental and physical health needs; monitoring and providing feedback on dentist performance.

11.3 Ensure that measurement data are used to assess healthcare equity and to generate an action plan for robust quality improvement programs in the consecutive year.

11.4 Develop any performance improvement projects (PIPs) with input from the network dentists and the state dental association. CMS is requiring all MCO/PAHP contracts to include PIP's.

11.5 Ensure that the capitation rate setting process for the MCO/PAHP accounts for PIP related expenditures. Improving quality for the Medicaid/CHIP population through a PIP requires significant system supports including adequate funding to be successful.

The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive programs must be improvement in the quality of oral health care, so performance measures in those programs should be valid measures of healthcare quality. The provisions of P4P or other third-party financial incentive programs should not interfere with the patient-doctor relationship by injecting factors unrelated to the patient's needs into treatment decisions. Treatment plans can vary based on a clinician's sound judgment, available evidence and the patient's needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans. The incentives in P4P or other third-party financial incentive programs should reward Both progressive quality improvement as well as attainment of desired quality metrics.

Consider encouraging your state to include contract clauses requiring contractors to:

11.6 Ensure that P4P or other third-party financial incentive programs do not limit access to care for patients requiring extraordinary levels or types of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.

11.7 Ensure that any profiles generated by the contractor will be shared with respective dentists and that dentists will be allowed the opportunity to discuss any such rankings. The contractor should provide opportunities to educate both new and current dentists on how to improve their scores on a regular basis.

11.8 Ensure that profiling activities are not structured so as to provide incentives for the individual dentist or contractor to deny, limit or discontinue medically necessary services to any enrollee.

According to federal regulations, CMS must review and approve all contracts that states enter into with MCOs/PAHP's, including contract provisions that incorporate standards for access to care. (42 CFR § 438.6(a). In addition, each state must submit to CMS its quality strategy, which includes these standards, and must certify that its MCOs have complied with its requirements for availability of services. (42 CFR §§ 438.202 and 438.207(d). Further, each state must submit to CMS regular reports describing the implementation and effectiveness of its quality strategy. (42 CFR § 438.202(e) (2).

12. Value-Based Payments

Movement towards value-based payments within public programs is increasing. The newest models introduced by CMS include models that incentivize primary care providers to reduce hospitalizations and cost of care by rewarding them through performance-based payments.

As Medicaid programs are increasing their efforts to learn from innovative value-based payment models, states that choose to establish Value-Based Payment (VBP) programs, either directly or through their contractors (or subcontractors) should retain oversight over any VBP program that is implemented by one of their contractors (or any of their subcontractors).

Consider encouraging your state to include contract clauses requiring contractors to:

12.1 Ensure that any VBP program begins by incentivizing data reporting as it related to measuring provider performance before any payments for services rendered are tied to any sort of provider-related performance metric.

12.2 Ensure that a VBP program advisory committee that is made up of all stakeholders is established to identify valid metrics to be used to measure provider performance.

12.3 Ensure that there are clear programmatic goals and desired outcome that have been identified and approved of by the state before instituting a VBP program.

12.4 Ensure that any methodologies used to assign patients to a provider for the purposes of a VBP program are transparent and valid.

12.5 Ensure that the primary objective of any VBP program must be improvement in the quality of oral health care. Therefore, the agreed upon and approved performance metrics used in any VBP program should be feasible, attainable, reliable, valid, and evidence based.

12.6 Ensure that any provider participating in VBP programs is given feedback on their performance in the VBP program in a consistent and timely manner; and is allowed to appeal those results as needed.

12.7 Ensure that any VBP programs do not limit access to care for patients requiring extraordinary levels or types of care, nor provide a disincentive for providers to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.

12.8 Ensure that VBP programs performance monitoring activities are not structured so as to provide incentives for the individual dentist or contractor to deny, limit or discontinue medically necessary services to any patient.

13. Utilization Management

Compliance with administrative record maintenance rules, program coverage rules, medical necessity rules, state policies, requirements of EPSDT and clinical criteria in the dentist billing manual are generally monitored through claims audits or random chart reviews. Any issues with compliance relating to claim submissions or contract provisions should be identified in a timely manner to avoid retrospective audits that could jeopardize the network. In addition, payers also evaluate treatment patterns across dentists. Dentists are compared with other Medicaid dentists performing similar procedures based on dentist specialty. Dentists whose treatment utilization patterns deviate significantly (specific standard deviation limit) from their peers are then identified as “under” or “over utilizers”. Managing compliance and overutilization must be conducted in a manner that is transparent and fair.

Consider encouraging your state to include contract clauses requiring contractors to:

13.1 Allow the state Medicaid dental program director to approve all procedures (including edits in the claims system to assure medical necessity) used to monitor compliance and utilization. At minimum, these policies should detail the processes that will be used to determine “outliers” and applicable benchmarks. It is essential that compliance issues be handled separately from any cases of fraud and abuse and the penalties are structured appropriately.

13.2 Ensure that any audits to determine medical necessity and medical appropriateness of services and treatments utilize auditors and reviewers who have a current active license to practice dentistry in both the same specialty (or equivalent education) as dentist being audited and in the state where the audited treatment has been rendered and be able to present their findings as such.

13.3 Have mechanisms to detect underutilization as well as overutilization.

13.4 Provide detailed resources and periodic education and training to dentists and their staffs to inform them about program guidelines and compliance requirements.

13.5 Bring such issues of under or overutilization to the knowledge of the dentist within (X) days and support the dentist to ensure that corrective action is taken.

13.6 Have readily available mechanisms to resolve disputes by using the state dental association’s peer review mechanism, arbitration or another mutually agreeable process as required by federal law.

13.7 Assure that audits are not structured so as to provide incentives for any party to

deny, limit or discontinue medically necessary services to any enrollee.

13.8 Allow dentists to have access to an appeal process. Should a dentist decide to appeal an audit finding, no repayment of potential overpayments is to be made until the appeals process returns a final decision on the findings of the audits.

13.9 Ensure that if fraud is suspected, then the case will be monitored by the state and a clear protocol to handle issues should be in place.

13.10 Document and reference the guidelines of an appropriate dental or specialty organization as the basis for their findings, including the definition of Medical Necessity being used within the review.

13.11 Have a history of treating Medicaid recipients in the state in which the audited dentist practices.

13.12 Have experience treating patients in a similar care delivery setting as the dentist being audited, such as a hospital, surgery center or school-based setting, especially if a significant portion of the audit targets such venues.

In addition, these entities shall be expected to conduct the review and audit in an efficient and expeditious manner, including:

1) Stating a reasonable period of time in which an audit can proceed before dismissal can be sought.

2) Defining the reasonable use of extrapolation in the initial audit request.

14. Member and Dentist Manuals

Administrative burden for dentists increases significantly if processing policies are unclear or constantly changing.

Consider encouraging your state to include contract clauses requiring contractors to:

14.1 Ensure that plans maintain the most up-to-date **member handbook** (i.e., beneficiary handbook), which among other details includes the summary of benefits, patient copay information, service limitations or exclusions from coverage, member rights and responsibilities, rules for missed and cancelled appointments, details on when the dentist may need prior authorizations and beneficiary appeal rights and process.

14.2 Ensure that plans maintain a **dentist manual** that serves as a source of information to dentists regarding covered services and frequency limitations, a clear definition for medical necessity, contractors policies and procedures for reimbursement (e.g., bundling, downcoding, alternative treatment provisions, etc.), dentist credentialing and re-credentialing, grievances and appeals process, claim submission requirements, compliance requirements (including those from state statutes), prior authorization requirements, quality improvement programs and dentist incentive programs.

14.3 Ensure that plans maintain a dentist manual that is thorough and up to date, rather than referring dentists to additional websites for coverage and processing policies.

14.4 Easy online access to the dentist manual should be provided to all network dentists.

14.5 Provide the manual to dentists **before** they are asked to sign the contract.

14.6 Ensure timely dentist notification of any specific policy changes by mail or electronic communication.

14.7 Provide detailed resources and periodic education and training to dentists and their staff to inform them about processing policies such as prior authorizations that can be significantly different between MCO's and increases the administrative burden for a dentist participating in the program.

14.8 Take responsibility for consistency between the member handbook and the dentist handbook in terms of covered services and processing policies.

14.9 Provide copies of the member and dentist handbook to the state for approval and the state should be notified within 30 days when any changes are made. Manuals should be reviewed by a licensed dentist if the state does not have a state Medicaid dental program director.

14.10 Ensure that enrollees have the ability to easily access the network listing that is most up to date. The listing should include information on whether the dentist accepts new patients or not.

Dentist manuals should have clear language regarding the dentists' rights and responsibilities including but not limited to the following:

Dentist's right to:

- Obtain information regarding patients' eligibility and claim status in a timely manner.
- Access to a customer service line with an assurance of minimal wait time to respond to dentist questions.
- Develop treatment plans needed to bring and maintain patients' oral health.
- Receive prompt payments on clean claims.
- Appropriately decline to treat patients who repeatedly miss appointments, are not engaged in maintaining their oral health or are disruptive to other patients in the practice.
- Not be subjected to retroactive decisions based on credential status (e.g., if a dentist is not re-credentialed, any claims already in the system should not be impacted and the dentist should be provided adequate time to refer patients.)

Dentist's responsibility for:

- Maintaining confidentiality of records in line with state and federal laws regarding confidentiality.
- Obtaining consent from the patient before providing non-covered services.
- Engaging in shared decision making with the patient. Educating the patient regarding the need for dental treatment and obtaining buy-in for the treatment plans developed.
- Treating Medicaid patients the same as other patients in the office.
- Providing mechanisms to address emergency situations.
- Continuing to provide emergency treatment and access to services for up to thirty days and offer to transfer records to a new dentist upon the patient's

signed authorization to do so – in situations when a patient is dismissed from the practice.

15. Medical Necessity and Processing Policies

When multiple contractors operate in a state and each administers the dental program differently, the enrollees in the state do not receive the same Medicaid benefit. The state should fully define the list of covered services using the most recent version of the CDT Code rather than simply including "EPSDT services" or "dental services" within RFPs and contracts. An example to consider for benefit pediatric coverage is the American Academy of Pediatric Dentistry's (AAPD) model dental benefit policy accessible at http://www.aapd.org/media/Policies_Guidelines/P_ModelDentalBenefits.pdf

Consider encouraging your state to include contract clauses requiring contractors to:

15.1 Abide by the state's definition of covered services. Allow the state to review and approve the benefit coverage and contractual limitations regarding coverage and service frequency determinations.

15.2 Allow the state to review and approve the contractors' claims processing policies and policies relating to prior authorizations and claims for medical necessity. *[Note: It is important for the state to assure consistency in administration of the dental benefit across multiple contractors within the state.]*

15.3 Have mechanisms in place to check the consistency of application of review criteria by multiple claims reviewers.

Integrity of Subcontracts

When the state contracts with a medical (primary) contractor and expects the primary contractor to subcontract the dental benefit program, the primary contractor should be held accountable for monitoring the subcontractors' performance on an ongoing basis.

- Subcontracting services should always be contingent upon the state approving the subcontractor and the subcontract. *[Note:* The *state should consider ensuring that all clauses identified above are part of the subcontract between the primary contractor and the dental subcontractor.]*
- The state should consider retaining the right to revoke delegation for subcontracting functions if the subcontractor's performance is inadequate.
- The primary contractor should subject the dental benefits subcontractor to the same level of performance as the primary contractor and conduct a formal review at least once a year. Examples of elements of performance of the subcontractor that should be reviewed include:
    - ability to provide services to Medicaid enrollees
    - quality improvement/utilization management function capability
    - ability to provide adequate accessible network
    - technical capacity to process claims
    - ability to process complaints, grievances and appeals
    - systems for enrollee support and outreach
    - systems for dentist network support

Request for Proposals: Readiness Assessment Checklist

States that use the managed care model release an RFP soliciting proposals from third party program administrators to manage the Medicaid program. Ensuring that the RFP is seeking all the information required to make an informed decision is the first step towards success. Many of the key elements of contracts noted in the next section must be included in the RFP in order to ensure that a comprehensive contract is established.

Past performance in terms of program administration including credentialing, network size, outreach, dentist relations, and claims processing *specific to the dental program* should be investigated before the state approves the contract/subcontract. If the dental benefit is subcontracted, the primary contractor should provide the state with enough information to evaluate performance of the subcontractor prior to the award. Subcontracting should not relieve the primary contractor of any responsibility for the performance of the duties pursuant to the contract.

Below are some elements to look for when reviewing proposals in response to RFPs specific to a dental program.

- Does the proposal demonstrate the potential for an adequate network? *[Note: Network adequacy should be addressed in the response to an RFP. Geo-maps can be used after signing the contract to ensure implementation. Location of dentists, location of participants and transportation issues should be considered when addressing network adequacy. Geo-maps should be created based on a complete and accurate dentist directory that also provides information on meaningful participation in Medicaid].*
- Does the proposal include a recruitment strategy to maintain a viable network to assure access?
- Does the proposal have a strategy to assure access for participants with special needs, non-English speaking participants and developmentally disabled participants?
- Does the proposal include a robust strategy for outreach and education to Medicaid participants?
- Does the proposal use metrics to demonstrate an efficient claims processing system to assure prompt dentist payment?
- Does the proposal include a process for addressing a) Participant grievances or complaints? b) Dentist complaints?
- Does the proposal include an efficient and fair process for oversight and management of potential fraud, waste, and abuse?
- Does the contractor have prior experience with quality measurement and improvement?
- Does the contractor have the systems/data analytics capability to provide the State with the required reports on a quarterly basis?
- Will the contractor employ a dentist licensed in the state to become the dental director? *[Note: The dental director at the state can best communicate with the dental director at the MCO].*

Other Related Resources

- Medicaid Contracting Strategies to Improve Children's Oral Health Care Access http://www.chcs.org/resource/medicaid-contracting-strategies-improve-childrens-oral-health-care-access/
- NAIC Plan Management Function: Network Adequacy White Paper
- https://content.naic.org/sites/default/files/inline-files/committees_b_related_wp_network_adequacy_0.pdf

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Medicaid Managed Care: A Guide to Reporting Metrics

Successful management of the Medicaid program requires periodic assessment of critical data to determine if and when policy changes are needed to support improved program administration. States, especially those with Medicaid managed care programs, have found great utility in reviewing critical program data within their Dental Technical Advisory Committees (DTAC).

To assist members of state dental societies who may have an opportunity to review program policies with state officials and those dentists who participate in DTACs, the American Dental Association (ADA) Council on Dental Benefit Programs (CDBP) has developed a list of reporting metrics that may be useful to review at regular meetings. Note that these metrics can be used irrespective of whether the dental benefits are administered by a state-contracted entity directly or when dental benefits are administrated via a subcontract with the medical MCO. Especially for states with multiple managed care organizations (MCOs) or prepaid ambulatory health plans (PAHPs) or dental benefit managers (DBMs), it is important to review the same information from all entities in order to provide meaningful input into state-wide policy discussions.

This guide serves to be a catch-all for all the metrics that can be reported. While a lot of data can be generated, it is important for each state program to prioritize reporting requests such that meaningful/actionable data is generated and reviewed.

This guide does not address program integrity metrics.

The Council appreciates the input provided by all stakeholders and will continue to maintain this document as a relevant and up-to-date resource. Please send input to dentalbenefits@ada.org.

Categories of Metrics

- Enrollment
- Network Adequacy
- Quality of Care
- Beneficiary's Oral Health State
- Financial
- Credentialing
- Provider Satisfaction
- Claims Administration
- Call Center Management

Enrollment

Total number of beneficiaries enrolled	

Network Adequacy

Table 1

	% network meeting state time/ distance standard	% of network accepting new patients	Average wait time for appointment for new patient in relation to state standard	Average wait time for routine appointments for patients of record in relation to a state standard	Average wait time for urgent appointments in relation to a state standard

General Dentist					
Pediatric Dentist					
Oral Surgeon					
Periodontist					
Prosthodontist					
Endodontist					
Orthodontist					

Note 1: It is useful to request a "heat-map"/ geo-maps from the managed care company that plots relative distance between dentists and beneficiaries. Acceptable distance standards may vary between urban/rural settings and transportation availability.

Note 2: States should also develop standards for "active" dentists and use that to populate table for network adequacy. Typically, the characterization of "active" is based on number of beneficiaries treated or claims per year/month. DTAC's should play a role in helping states define these standards at the time of contracting.

Table 2

Total number of beneficiaries enrolled for at least 90 days with a dental visit	

Note 3: Network Adequacy is prospective, and utilization is retrospective. Analyzing both together is important to understand access issues.

Note 4: The Dental Plan CAHPS survey is another tool to gain an understanding of access issues from the beneficiary standpoint.

Provider Participation

% of all licensed, practicing dentists in the state who are enrolled as Medicaid providers	
Distribution of dentists by the number of unique Medicaid beneficiaries treated in the year (such as: 0, 1-9, 10-99, 100+)	
Distribution of dentists by the number of and/or dollar amount of claims	

Quality of Care

Children: % of children receiving a dental evaluation	
Children: % children risk assessed	
Children: % of children at risk for cavities receiving twice yearly fluoride	
Children: % of 10-year-olds who have had their permanent first molar sealed	
Children: % of 15-year-olds who have had their permanent second molar sealed	
Children: # seen in emergency department for preventable dental conditions	
Children: % with a dental visit following an emergency department visit for preventable dental conditions	
Adults: % of adults with periodontal disease receiving oral examination	
Adults: % of adults with periodontal disease receiving periodontal maintenance treatment	

Adults: % of diabetics receiving an oral evaluation	
Adults: % of pregnant women receiving oral evaluation	
Adult: # seen in emergency department for preventable dental conditions	
Adult: % with a dental visit following an emergency department visit for preventable dental conditions	
Total amount that is paid on direct provision of care (reimbursed for clinical services) per member per month for all enrollees	

Use Dental Quality Alliance measure specifications for consistent and comparable reporting when available.

Use Dental Plan CAHPS survey to understand patient experience with care.

Beneficiary Oral Health State

Beneficiary survey: Requires survey sample of beneficiaries. May be accomplished annually.

How would you describe the condition of your mouth and teeth?	[Poor, Fair, Good, Very Good, Don't Know]
How often during the past 12 months have you felt that life in general was less satisfying because of problems with your mouth and teeth?	[Never, Rarely, Occasionally, Very Often, Don't Know]
Have you ever felt that the appearance of your mouth and teeth affected your ability to interview for or maintain a job?	[Yes, No, Don't Know]
How often have you experienced any of the following problems related to your mouth and teeth during the past 12 months? • Difficulty when biting or chewing foods • Difficulty with speech or trouble pronouncing words • Dry mouth • Felt anxiety • Felt embarrassment • Avoided smiling • Took days off work because of pain or discomfort • Difficulty doing usual activities • Reduced participation in social activities • Problems sleeping • Experienced pain	[Never, Rarely, Occasionally, Very Often, Don't Know]
Ask if last dental visit was more than 12 months: Why did you not visit the dentist more frequently? Please select all that apply. • My mouth is healthy, so I do not need to visit the dentist • I do not know where to go to receive dental services • I cannot afford to go to the dentist • It is too hard to find a dentist that accepts my dental plan or Medicaid • I cannot find the time to get to a dentist (e.g., cannot get the time off from work, dentist does not have convenient office hours, etc.) • Many services are not covered by my dental plan or Medicaid, so I end up having to pay with my own money • I cannot travel to a dentist easily (e.g., do not have transportation, located too far away) • I do not have any of my original teeth (e.g., I have no teeth or I have dentures) • I am afraid of going to the dentist • Other • No reason	

[Adapted from Oral health and Well-Being in the United States, Health Policy Institute, American Dental Association]

Financial

Average benefit paid per user (those who have a dental visit)	
Average benefit paid per beneficiary (all enrolled)	
Medical Loss Ratio (Annual)	

Credentialing

Average number of days from application receipt to credentialing application approval	
Initial Applications: Total # Received	
Initial Applications: % Approved	
Initial Applications: % Denied	
Total # of providers credentialed	
Re-credentials: % Approved	
Re-credentials: % Denied	
Terminations: # Voluntary	
Terminations: # Involuntary	

Provider Satisfaction

Network dentist satisfaction survey: Requires survey sample of dentists. May be accomplished semi-annually.

% of network dentists satisfied/very satisfied with:

Billing inquiry assistance	
Appeals/grievance system	
Prompt payment (i.e., claims processed within 30 days)	
Dentist handbook and notification of changes	
EOB communications	

Claims Administration

No. of claims received	
% of claims fully approved	
% of claims partially approved	
% of claims appealed	
% claims processed within 30 days	
% of claims denied	
Payment accuracy	

Call Center Management

Total number of calls	
Average hold time to answer	
Number of calls abandoned	
Caller satisfaction	

ADA HPI Resources: Tools for Policymakers

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