MCO/PAHP ADVOCACY TOOLKIT

RATE TRANSPARENCY ● NETWORK ADEQUACY ● ACCOUNTABILITY

This toolkit will assist state dental association/society members in understanding and advocating for oral health as it relates to the *Center for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*. The new rule provides opportunities for states and their contracted managed care organizations (MCOs) or prepaid ambulatory health plans (PAHPs) to deliver on the promise of dental care access to Medicaid beneficiaries and reduce administrative and financial barriers for dental providers.

This toolkit includes:

- An informational brief outlining important features of the new MCO/PAHP rule.
- Sample letter/email request to meet with your State Medicaid Agency's Director.
- Sample advocacy "asks" sheet to give to your State Medicaid Agency's Director during a meeting.
- A one-page informational sheet about American Dental Association's Health Policy Institute to provide to your State's Medicaid Agency
- Additional ADA resources related to Medicaid, MCOs, and PAHPs.
- Names, addresses, and email addresses of the Director and Dental Director/Contact of your State's Medicaid Agency as of July 2024.

Further technical assistance on this rule and MCOs/PAHPs can be provided by contacting hedgesi@ada.org.

CMS Rules on Managed Care Organizations and Prepaid Ambulatory Health Plans

Informational Brief (2024)

WHY ARE THESE NEW RULES IMPORTANT FOR MY STATE?

- The *Center for Medicare and Medicaid Services* (*CMS) Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule* ensures that Medicaid MCOs and PAHPs must deliver on the promise of access to Medicaid beneficiaries. From this rule, MCOs and PAHPs must provide transparency in their reimbursement rates, adhere to access standards for their beneficiaries, and hire an independent entity to monitor whether MCOs/PAHPs are meeting these access standards.

- Rules around access and monitoring access will be applicable for primary care, OBGYN, and behavioral health services covered by MCOs and PAHPs. However, CMS stated that States will be able to choose "a fourth health service" for reimbursement rate transparency, setting a wait-time standard, and having an independent entity to monitor the access standards. This fourth health service selected by the state could be dental services. If your state does not choose dental as the fourth health service, then many access, administrative, and reimbursement issues addressed in this regulation will remain unresolved for dental services.

- If larger access issues are detected for any of the four health services by independent entities, the state and MCOs or PAHPs must submit a 12-month remediation plan to CMS. In its publication of the final rule, CMS cited possible remedies to improve network adequacy for the four health services by the MCOs/PAHPs include increasing provider reimbursement and reducing administrative burdens.

What are Managed Care Organizations (MCOs)?

- Medicaid Managed Care Organizations (MCOs) are private insurers that administer a state's Medicaid benefits. MCOs function similarly like commercial insurance in which providers must go through credentialing, and claims submission, while beneficiaries have in-network providers.

- Many states' Medicaid programs offer a dental benefit that utilizes MCOs to deliver this benefit. While states can set fees for dental reimbursement in their own Medicaid fee-for-service reimbursement schedules, reimbursement rates for dental services vary between different MCOs.

- Furthermore, MCOs' reimbursement rates for dental services are not always published or transparent until a provider contracts to be in-network with a particular MCO. This makes it harder for dentists to make fair comparisons between their commercial rates versus the rates reimbursed by the MCOs.

What are prepaid ambulatory health plans (PAHPs)?

- This term is sometimes used interchangeably with MCOs, but is legally structured differently than an MCO. These are typically considered carved-out dental managed care organizations. PAHPs are a non-comprehensive health plan that provides certain outpatient services, including dental services. States may utilize a PAHP to deliver the state's Medicaid dental benefits.

- Similarly to MCOs, states can set fees for dental reimbursement in their own Medicaid fee-for-service reimbursement schedules. Reimbursement rates for dental services vary between different PAHPs. Reimbursement rates from PAHPs are also not always transparent or available to the public, which make it harder for dentists to make fair comparisons between their commercial rates versus the rates reimbursed by the PAHPs.

CMS Rules on Managed Care Organizations and Prepaid Ambulatory Health Plans

Informational Brief (2024)

What is network adequacy?

- Network adequacy refers to a federal or state standard established for MCOs/PAHPs (or other health plans) to guarantee that a plan meets certain criteria, such as sufficient number and type of health care providers. Network adequacy may also ensure Medicaid beneficiaries (or plan members) have adequate access to covered benefits within reasonable distance or through appointment wait times.

How will MCOs/PAHPs provide rate transparency? Why is rate transparency important with this rule?

- *While rate transparency is a part of this rule, ADA is still seeking clarification from CMS as of July 29, 2024 if PAHPs or MCOs will have to report out dental services in their payment analyses and if reimbursement rate comparisons can be tied to something else other than Medicare for dental services.*

- If MCOs/PAHPs must submit their provider reimbursement rates for adults and children in comparison to the average Medicare reimbursement rate to their State Medicaid Office. This rate comparison will then be included in the State's annual quality assurance report sent to CMS annually.

- CMS has stated it believes "*this analysis of payments provides States and CMS with vital information to assess the adequacy of payments to providers in managed care programs, particularly when network deficiencies or quality of care issues are identified, or grievances are filed by enrollees regarding access or quality."*

- This provision will take effect during the first rating period beginning on or after September 9, 2024. MCOs/PAHPs can use rates from the previous rating period for comparison.

What is the access standard that CMS is proposing?

- The CMS rule stipulates that States shall set a proposed wait-time standard for access to each of the four health services in the MCO's/PAHP's network. CMS stated that wait-times should be set for urgent and non-urgent appointments.

- While each state dental association prefers a different wait-time standard, the standard set for non-urgent dental appointments should not be less than 30 days. While 30 days is commonly set as the non-urgent standard for primary care or behavioral health services, current dental workforce constraints would make this standard difficult to meet.

- This standard will need to be set by the State Medicaid Agency after the first rating period after July 9, 2026.

How will States/MCOs enforce or monitor the access standard?

- The new CMS rule mandates that MCOs/PAHPs must hire an independent entity to monitor whether MCOs/PAHPs are meeting the access standards for the four health services selected by the State Medicaid Agency. This monitoring will occur through "secret shopper surveys." The purpose of these secret shopper surveys is to determine if providers are accepting new patients, information such as the number/address are valid in the provider directory, and if the wait time for appointments meet the access standard set by the State Medicaid Agency. These surveys will be used to determine if the MCO's/PAHP's network provided to Medicaid beneficiaries is meeting network adequacy and is not meant to penalize dentists.

- This practice will become a requirement after the first rating period after July 9, 2027.

- Entities like ADA's Health Policy Institute have performed secret shopper surveys on behalf of State Medicaid Agencies in the past. States could stipulate or recommend that MCOs/PAHPs utilize ADA's HPI as an independent entity to monitor for dental network adequacy.

What happens if MCOs/PAHPs are not meeting the access standard or network adequacy?

- If larger access issues are detected through this monitoring, CMS ruled that states or MCOs/PAHPs must file a 12-month remediation plan with CMS. CMS stated that "*one of the first areas that states and MCOs should re-examine in their 12-month remediation plan is increasing provider reimbursement and reducing administrative burden."*

- If the objectives and actions of the 12-month remediation plan are not by the end of the 12-month period, CMS has stated that it will withhold its federal share of payment for the contract of Medicaid MCO/PAHP was found to be in violation.

What can we as a State Dental Association/State Dental Society do?

- Send an email or formal letter to the Director/Administrator of your State Medicaid Agency to request a meeting about the new MCO/PAHP rules. A sample letter/email and names and email addresses for the Directors/Administrators of your State's Medicaid Office are attached to this informational brief.

- In the meeting with the Director/Administrator, ask that dental services be the "additional health service" or "fourth health service" that MCOs/PAHPs must provide access to services based on a state-established wait-time standard and monitoring by an independent entity. It is helpful to include your state's Medicaid beneficiaries' low utilization rates (which can be found at ADA HPI's website) and how current reimbursement rates from MCOs/PAHPs are not sufficient to maintain access to dental services.

- Advocate for States to suggest that MCOs/PAHPs with dental benefits utilize ADA's HPI as an independent entity to monitor dental network adequacy. An informational sheet about ADA HPI and network adequacy is included in this toolkit.

- Depending on your relationship with the State Medicaid Agency, you may send a follow-up letter or email detailing the above requests. It may be helpful to CC this letter or email to other allies you may have in State Government, such as the health policy advisor to the Governor or the Chair of your state's assembly/house/senate health committee. If you feel there is already buy-in to implement dental services as the "fourth health service choice," then this step is unnecessary.

SAMPLE ADVOCACY LETTER – MCO/PAHP RULES

Director
State Medicaid Agency

Dear _____:

On behalf of the _____ Dental Association/State Dental Society, we are formally requesting a meeting to discuss dental care access for Medicaid beneficiaries through the State's contracted managed care organizations (MCOs) or prepaid health plans (PAHPs). This discussion is timely due to the release of the *2025 Center for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule* that was released in April 2024. These rules address rate transparency, network adequacy, and other potential access issues that exist when a Medicaid's dental benefit is delivered by an MCO/PAHP.

While the state's Medicaid dental benefit has improved over the years, low utilization of Medicaid's dental benefit and barriers to provider participation continue to exist. On average, only 18% of adult Medicaid beneficiaries in America utilize their dental benefit[1]. Research has shown that there is an association between access to dental care for low-income individuals and whether dentists participate in Medicaid[2]. In many states, lack of dentist participation in MCOs/PAHPs, due to administrative and financial burdens, have created lower network adequacy for dental benefits that are offered through Medicaid MCOs/PAHPs.

However, our organization believes that this new federal rule can increase dental provider participation in Medicaid and would ultimately increase utilization and access to the State's dental benefit delivered through MCOs/PAHPs. According to the new rule, MCOs/PAHPs must adhere to a state-determined standard for wait times and hire an independent entity to do access monitoring for four health services. These major health services include primary care, behavioral health, and OBGYN services, with the fourth health service to be determined by the State Medicaid Agency. As the state's premier organization advocating for the oral health of the public, we strongly urge you to consider "dental services" as the fourth health service.

We have seen that when the Medicaid's dental benefit is adequately provided in other states, it can drastically improve the quality of life of Medicaid beneficiaries. We believe selecting dental services as the fourth health service for rate transparency and access monitoring during the next rating period for MCOs/PAHPs can ultimately lead to improvement in the employability and health of Medicaid beneficiaries drastically.

During our meeting, we hope to discuss the following and provide opportunities for collaboration:

- If the State selects dental services as the fourth health service, then we ask the State set a wait-time standard for dental appointments that is no less than 45 days for non-urgent appointments and 7 days for urgent appointments. Due to current dental workforce challenges, any standard below these number of days may be challenging to meet.

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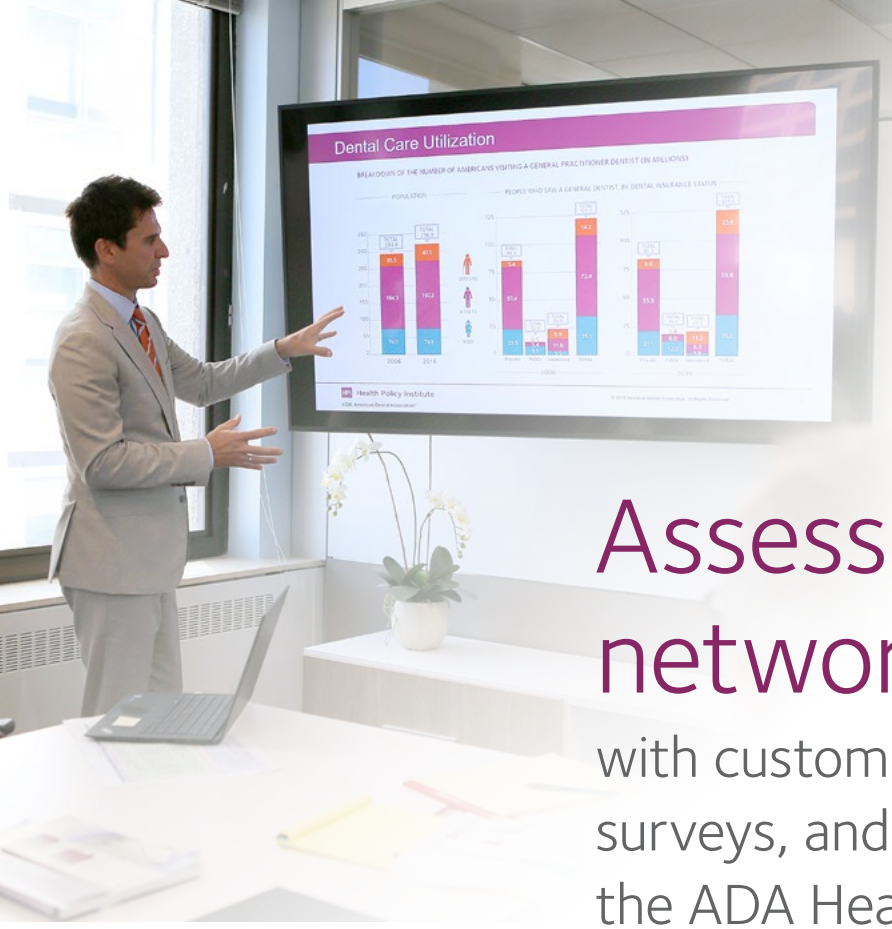
[1] American Dental Association. Dental care utilization among children dashboard. Health Policy Institute. 2023. Available from: https://www.ada.org/resources/research/health-policy-institute/child-dental-care-utilization-dashboard.
[2] Chalmers NI, Compton RD. Children's access to dental care affected by reimbursement rates, dentist density, and dentist participation in Medicaid. Am J Public Health. 2017;107(10):1612-1614.

- If the State selects dental services as the fourth health service, then we ask the State provide guidance to the MCOs/PAHPs on access monitoring for dental services. The State should suggest that the ADA's Health Policy Institute be selected as an entity to perform the secret shopper surveys on behalf of the MCOs/PAHPs. This will ensure that the entity providing the secret shopper surveys understands dental access issues and provides reliable and independent findings to the MCOs/PAHPs.

We would appreciate the opportunity to discuss with you the options for addressing these access to care issues, and look forward to hearing from you regarding a meeting date.

MCO/PAHP RULES "ASKS" FOR STATE MEDICAID AGENCIES

- MCOs/PAHPs must abide by a state-determined access standard for primary care, behavioral health, OBGYN services, along with a fourth health service as chosen by the State Medicaid Agency.
    - Ask:
        - Our organization requests that the State Medicaid Agency choose "dental services" as its fourth health care field for wait time standards and access monitoring.
    - Additional Asks:
        - If State Medicaid Agency sets a wait-time standard for oral health access, then wait-time standard should not be less than 30 days for non-emergency appointments and less than 7 days for emergency appointments.
- MCOs/PAHPs will be required to hire an independent entity to perform access monitoring, which will include secret shopper surveys to determine if MCOs/PAHPs are meeting appropriate network adequacy standards.
    - Ask:
        - If MCOs/PAHPs hire an independent entity to do access monitoring for dental services, the State Medicaid Agency recommends or stipulates that the MCO uses the American Dental Association's Health Policy Institute to perform this access monitoring. A prospectus detailing ADA HPI's experience with access monitoring is included with this informational sheet.



HPI Health Policy Institute

ADA American Dental Association®

Assess your state's network adequacy

with custom data, secret shopper surveys, and expert analysis from the ADA Health Policy Institute

The ADA Health Policy Institute (HPI) offers actionable data and insights at the national and state levels to guide policymakers and other stakeholders on access to oral health care.

The American Dental Association's Health Policy Institute (HPI®) works closely with state Medicaid departments and health organizations to produce in-depth reports on dental care access. Past collaborative projects conducted by HPI include **estimates of the cost of adding an adult dental benefit under Medicaid** for **Virginia**, **Florida**, **Hawaii**, and **Maine** – these projects combined data from HPI and state agencies on Medicaid enrollment, dental spending, emergency department visits, and other key factors concerning dental care access.

HPI has also conducted customized **secret shopper surveys** on behalf of a state health department and can do so for managed care organizations and other agencies.

About HPI

HPI is the trusted source for critical policy knowledge about the U.S. dental care system. HPI is a team of economists, health policy researchers, and data scientists led by Marko Vujicic, Ph.D., HPI's Vice President and ADA's Chief Economist.

Using a variety of in-house, proprietary, and public data sources, HPI's independently led research team focuses on a variety of topics related to the U.S. dental industry, including the supply, distribution, and demographics of the dental workforce; Medicaid fees and reimbursement for dental care services; dentist participation in Medicaid; dental care utilization and expenditures; and more.

For more information, contact **hpi@ada.org** or visit **ADA.org/statefacts**.

ADDITIONAL ADA RESOURCES RELATED TO MCOs/PAHPs

- ADA has specific policies related to Medicaid passed by its House of Delegates

  To read ADA's Medicaid policies, click here.

- ADA Health Policy Institute provides research on the health and economic benefits of expanding the adult dental Medicaid benefit.

  To read ADA HPI's "Making the Case for Dental Coverage for Adults in All State Medicaid Programs", click here.

- Some states may be renegotiating their MCO contracts for the Medicaid dental benefit. The ADA has developed an RFP toolkit that guides state dental associations/societies in what to advocate for in a new MCO contract proposal. This toolkit helps ensure that the dental benefit delivered under MCOs is accessible to beneficiaries and less burdensome to dental providers.

  To utilize ADA's RFP Toolkit, click here.

- To increase provider participation in the Colorado Dental Association took a leadership role with MCOs to begin a program known as "Take 5", which helped incentivize dentists to treat more Medicaid beneficiaries in exchange for an incentive payment.

  To read more about the Colorado Dental Association's "Take 5" program, click here.