State Medicaid Advocacy Toolkit

A guide for state dental organizations to successfully advocate for an adult Medicaid dental benefit in their state that works for both the program's beneficiaries and providers.

ADA American Dental Association®

State Medicaid Advocacy Toolkit

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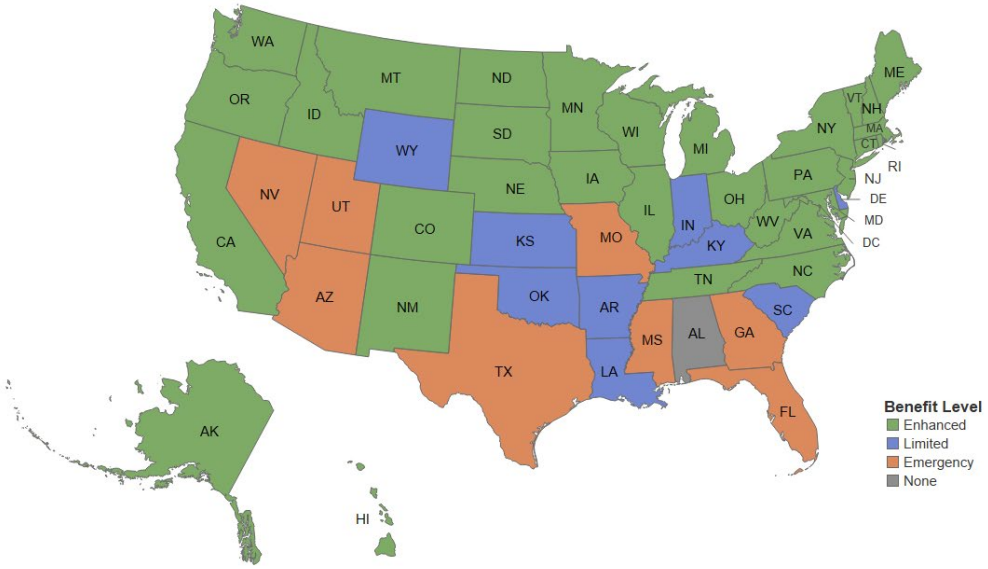
Section I: Introduction

FIGURE 1: Adult Medicaid Dental Benefit Level by State



Source: Health Policy Institute analysis of CareQuest Medicaid Adult Dental Coverage Tracker and state Medicaid websites

This map reflects benefits as of July 2024. Note: None = No coverage. Emergency-only = Coverage for pain relief under defined emergency situations. Limited = Coverage for a subset of diagnostic, preventive, and minor restorative procedures with a per-enrollee annual maximum expenditure of $1,000 or less. Enhanced = Coverage for a more comprehensive mix of services, including most diagnostic, preventive, and restorative procedures, and a per-enrollee annual maximum expenditure of at least $1,000 or no annual maximum.

To enhance dental care access for low-income and vulnerable populations, the American Dental Association (ADA) has developed a toolkit to guide your state dental organization's Medicaid program reforms. The ADA Medicaid Advocacy Toolkit is a centralized hub of research, legislative language and media messaging strategies to successfully advocate for an adult Medicaid dental benefit that works for both the program's beneficiaries and providers.

In this toolkit, the ADA has included the following to assist in your advocacy efforts:

- Research for "Making the Case for Adult Medicaid Dental Benefit with Legislators";
- Medicaid reimbursement rates as a percentage of average dentist charges by state;
- Model legislative language that helps with expanding current coverage, increasing reimbursement rates, and reducing administrative burdens (credentialing and audits);
- Strategies and talking points for "Making the Case for Medicaid Dental Benefit with the Media";
- Draft text to use for advocacy related-publications such as letters to the editor, statewide association newsletters, and grassroots advocacy emails to legislators; and
- Information about MCOs/PAHPs and additional advocacy steps that can be taken.

The ADA encourages state dental organizations to customize the resources contained in this toolkit with state-specific statistics and anecdotes to advocate for changes to their states' Medicaid dental benefit for adults.

Section II: Medicaid Literature Review

MAKING THE CASE FOR ADULT MEDICAID DENTAL BENEFITS WITH LEGISLATORS

What is the impact of dental care access on employability?

- While dental coverage for children is mandatory under the Affordable Care Act, it is optional for adults. Low-income adults and other vulnerable populations who rely on Medicaid for dental care access are more susceptible to the biological, social, and economic risk factors for oral disease. Low-income adults can gain improved employability prospects if they have access to dental care, promoting economic activity in the community.[i, ii, iii, iv]

- Among Medicaid-enrolled adults in states that do not provide dental coverage to adults in their Medicaid program, 60% reported that the appearance of their mouth and teeth affects their ability to interview for a job. For those in states with dental coverage for adults, it was much lower, at 35%.[v]

What is the impact of dental care access on our health care system?

- Dental-related emergency department (ED) visits among Medicaid enrollees and the uninsured made up more than 60% of all ED visits by non-elderly adults.[vi]

- Among states with expanded Medicaid coverage, or a more comprehensive dental benefit for adults, beneficiaries have 11.4 fewer quarterly dental ED visits per 100,000 population compared to states that offered emergency-only or no dental benefits.

- ED visits for non-traumatic dental conditions cost $3.4 billion in 2019. While ED visits are down compared to previous years, the prevalence of ED visits and low dental care utilization rates indicate a lack of a safety net, particularly for working-age adults, racial/ethnic minorities, people in rural communities, and those who are uninsured or are covered by Medicaid.[vii, viii]

What is the impact of dental disease on the U.S. economy?

- Pain and other complications caused by oral disease cause productivity losses among workers and students and cost the U.S. economy $46 billion annually.[ix]

- 34 million school hours and 92 million working hours are lost due to unplanned dental visits for untreated conditions.[ix]

- For low-income individuals, especially working-age adults, dental care presents significant cost barriers. In 2022, the percentage of working-age adults who did not obtain needed dental care due to cost was nearly the same for those who were uninsured and those who were covered by Medicaid.[ix]

How can oral health interventions and preventive care lead to health care cost savings?

- Adults covered by Medicaid are less likely to receive routine preventive dental care compared to adults with private dental benefits. However, routine dental visits are essential to keeping health care costs down, especially among individuals with chronic conditions.[x, xi]

- In the United States, individuals with heart disease who received preventive dental care visits saved $548 to $675 per year.[xii] For individuals diagnosed with diabetes, health care savings range from $900 to $2,840.[xiii] Among pregnant women, improved oral health reduced medical costs by $1,500 to $2,400 per pregnancy.[xiv]

- A dental benefit covering routine dental care for adults in every state Medicaid program would save the U.S. economy an estimated $273 million per year due to cost savings among pregnant women and individuals with diabetes and heart disease. Put another way, for every dollar spent on preventive dental care, $8 to $50 will be saved in restorative and invasive treatments.[xv]

- Medicaid-covered adults who have five continuous years of preventive care had 43% lower dental care costs compared to those who received no preventive dental care at all.[xvi]

Section III: Model Legislation

The following section will outline model legislation for expanding the Adult Medicaid dental benefit, model legislation for an increase in reimbursement, model legislation and current state provisions for credentialing, and model legislation and current state provisions on audits.

Model Legislation – Expanding Coverage

AN ACT ESTABLISHING DENTAL SERVICES FOR ADULTS IN THE MEDICAID PROGRAM
Be it enacted by the General Assembly

PROVIDING DENTAL SERVICES FOR ADULTS IN MEDICAID

SECTION I

The general assembly hereby finds that:

- Untreated oral health conditions negatively affect overall health and have associations with chronic conditions, including diabetes, heart disease, kidney disease, Alzheimer's disease, and even mental illness;
- Regular preventive dental care is the most cost-effective method available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care;
- One in four adults has untreated tooth decay. Early detection and access to preventive and restorative treatments for oral health conditions can be up to ten times less expensive than treating those same conditions in an emergency setting;
- Research has also shown that good oral health improves Medicaid beneficiaries' ability to obtain and keep employment. Employed adults lose more than one hundred and sixty-four million hours of work each year due to dental problems;
- Children are more likely to receive regular dental services if their parents have access to dental services; and
- Therefore, the general assembly declares that in order to improve overall health, promote savings in Medicaid programs, and prevent future health conditions caused by oral health problems, it is in the best interest of the state to establish a permanent oral health benefit for adults in the Medicaid program.

SECTION II:

State Medicaid department requirements:

1) [*Insert pertinent state Medicaid department*] shall design and implement a dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit, including but not limited to the cost, best practices, the effect on health outcomes, patient experience, service delivery models, and maximum efficiencies in the administration of the benefit.
    I. Stakeholders shall include:
        a) A consumer representative who is currently, or has within the past five years been, enrolled in Medicaid;
        b) Appropriate representation of dental benefits companies operating in the state;
        c) A representative of the disability rights community;
        d) A representative of the state dental association or society;
        e) A representative of the state hospital association;
        f) The Governor or his/her designated representative;
        g) The Secretary of Health or his/her designated representative;
        h) The Commissioner of Insurance or his/her designated representative;
        i) Such stakeholders as the [*Insert pertinent state Medicaid department*] may deem necessary and appropriate

2) Benefits shall include services that:
    a) Provide emergency care [as defined elsewhere]
    b) Eliminate active dental decay
    c) Treat periodontal conditions
    d) Provide preventive dental services including examinations, necessary x-rays or other imaging, prophylaxis, topical fluoride, oral hygiene instruction, behavior management and smoking cessation counseling, and other services as determined by the commissioner
    e) Provide restorative treatment to restore tooth form and function
    f) Provide medically necessary oral and maxillofacial care
    g) Provide removable prosthodontics to replace missing teeth subject to medical necessity

3) [*Insert pertinent state Medicaid department*] shall design the dental benefit for adults in compliance with Section 1902(a)(30)(A) of the Social Security Act using a benchmark on which to establish a dental services fee schedule. To establish a reasonable fee schedule, provider payment levels will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in practice expenses of the particular provider category involved to the extent data is available.

4) [*Insert pertinent state Medicaid department*] shall seek all federal authorizations necessary to provide the adult dental benefit.

5) [*Insert pertinent state Medicaid department*] shall include a dentist on a Medicaid Advisory Committee.

FOR STATES ESTABLSHING MANAGED CARE CONTRACTS FOR THE ADULT DENTAL PROGRAM ACCOUNTABILITY MEASURE FOR CONSIDERATION

1) **If State Selects Managed Care Organization(s) (MCO) to Manage Adult Dental Medicaid**

    I. Prohibit MCO(s) from requiring Medicaid participating dentists to join some or all commercial MCO products
    II. MCO(s) must reimburse providers at a level that is at least equal to the rate paid by the state's dental fee-for-service plan
    III. State must retain policy-setting power

2) **Setting Benchmark Measurements for MCO(s)**
    I. Establish a time limit for review (i.e., 4-5 years) to measure utilization; compare utilization to a benchmark (i.e., national average) to measure success or failure of MCO

3) **Corrective Action Plan**
    I. If MCO falls below benchmark by a certain amount (i.e., 10 percentage points), MCO must submit corrective action plan describing how the entity intends to increase dental utilization to meet the performance benchmark

Model Legislation – Reimbursement Increase

AN ACT CONCERNING DENTAL FINANCING
Be it enacted by the General Assembly

SECTION I

The general assembly hereby finds that:

Untreated oral health conditions negatively affect overall health and have associations with chronic disease, including diabetes, heart disease, kidney disease, Alzheimer's disease, and even mental illness;

Regular preventive dental care is the most cost-effective method available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care;

SECTION II

Therefore, the general assembly declares that in order to improve overall health, promote savings in Medicaid programs, and prevent future health conditions caused by oral health problems, it is in the best interest of the state to create an oral health benefit for adults in the Medicaid program.

No funds shall be expended in furtherance of dental provider rates greater than the rate in effect on January 1, 20XX, except increases for rate setting dental services at the 50th percentile of dentists' charges.

OPTION 2

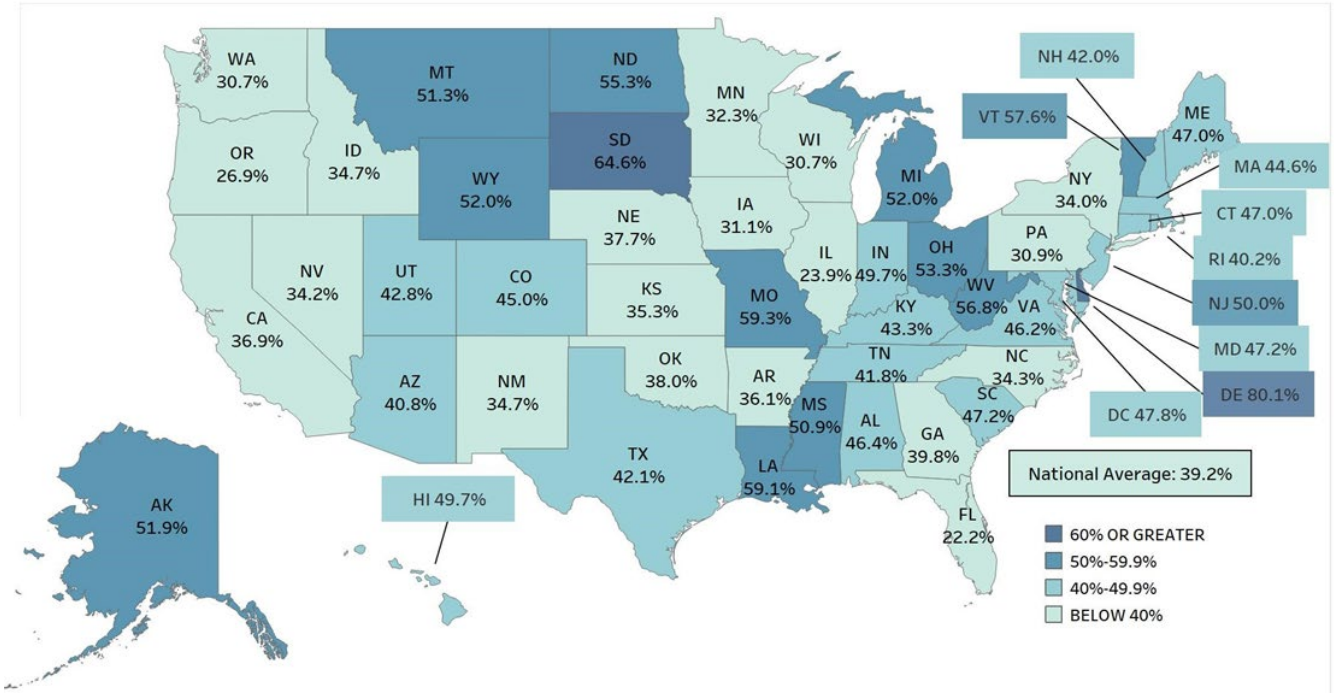
The [STATE MEDICAID AUTHORITY] shall develop a reimbursement structure for dental services in the [STATE] Medicaid program that encourages dentists to provide preventive care.

[STATE MEDICAID AUTHORITY] shall evaluate current Medicaid reimbursement rates to dentists and determine the amount of fiscally responsible increases to the rates for specific services that would be needed in order to attract additional providers to participate in the Medicaid program.

[STATE MEDICAID AUTHORITY] shall investigate the benefits of synchronizing the Medicaid fee schedule with the average commercial reimbursement rates for dental services in this state with a goal of achieving reimbursements for Medicaid dental services that are XX% of average commercial reimbursements for dental services.

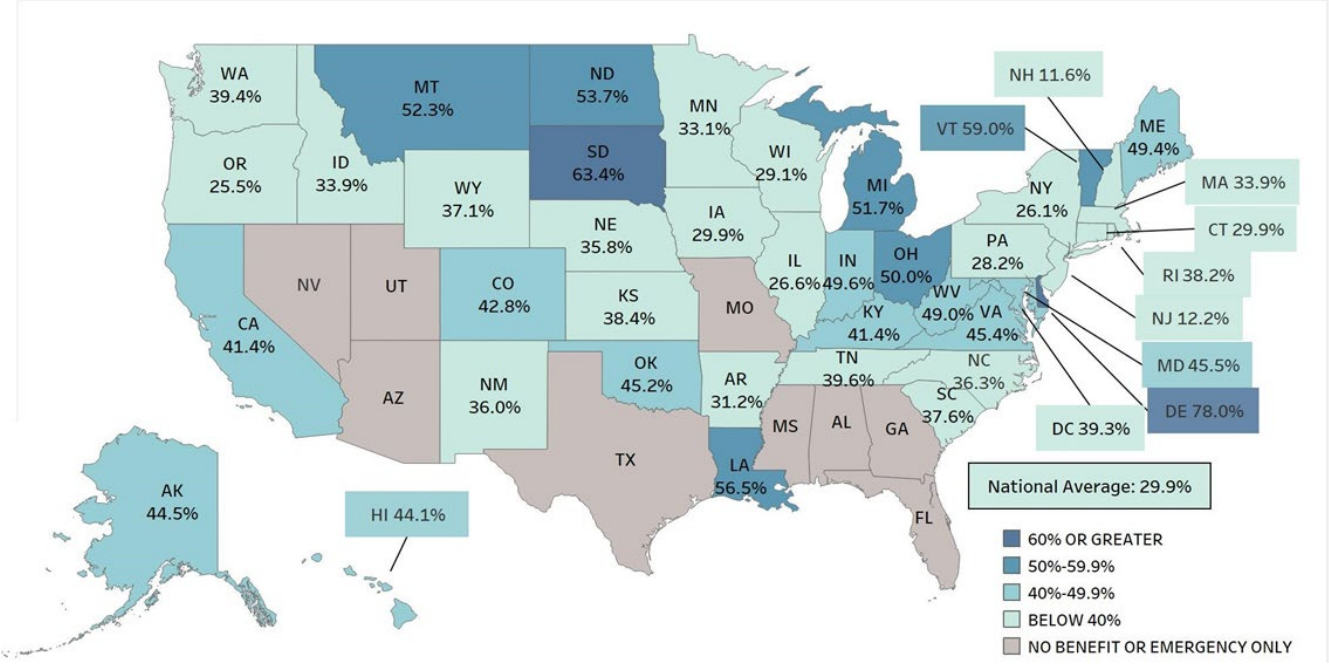
MEDICAID FEE-FOR-SERVICE (FFS) REIMBURSEMENT AS PERCENTAGE OF DENTIST CHARGES FOR CHILD AND ADULT DENTAL SERVICES, 2024

FIGURE 2: Medicaid FFS Reimbursement as a Percent of Average Dentist Charges, Child Dental Services, 2024



Source: American Dental Association, Health Policy Institute (ADA HPI), 2024

FIGURE 3: Medicaid FFS Reimbursement as a Percent of Average Dentist Charges, Adult Dental Services, 2024



Source: American Dental Association, Health Policy Institute (ADA HPI), 2024

This data compares charges submitted by dentists to fee schedules (MCO reimbursements will vary). For additional information, please review the data update from the American Dental Association Health Policy Institute's (ADA HPI). Please note that reimbursements from MCOs/PAHPs may be different than the FFS fee used in comparison for the above figures.

Additional information on basic adult utilization and emergency department utilization can be found on the Dental Quality Alliance (DQA) website. Furthermore, please visit the DQA State Oral Healthcare Quality Dashboard for more information.

Model Legislation – Credentialing

AN ACT CONCERNING DENTAL FINANCING
Be it enacted by the General Assembly

SECTION I

1) Within two working days after receipt of a credentialing application, the [STATE MEDICAID/MCO] shall send a notice of receipt to the practitioner. A [STATE MEDICAID/MCO] shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application.
2) If a [STATE MEDICAID/MCO] determines the application is not a completed application, the [STATE MEDICAID/MCO] shall have ten days from the date the notice of receipt was sent to request any additional information from the practitioner. The application shall be considered a completed application upon receipt of the requested additional information from the practitioner. Within two working days of receipt of the requested additional information, the [STATE MEDICAID/MCO] shall send a notice to the practitioner informing him or her that he or she has submitted a completed application. If the [STATE MEDICAID/MCO] does not request additional information, the application shall be deemed completed as of the date the notice of receipt was sent.
3) A [STATE MEDICAID/MCO] shall assess a health care practitioner's completed credentialing application and make a decision as to whether to approve or deny the practitioner's credentialing application and notify the practitioner of such decision within sixty days of the date of receipt of the completed application. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:
    I. A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
    II. Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;
    III. Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or
    IV. A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.
4) If a practitioner's application is approved, the [STATE MEDICAID/MCO] shall provide payments for covered health services performed by the practitioner during the credentialing period. The practitioner providing services shall submit to the [STATE MEDICAID/MCO] all claims for services provided by such practitioner during the credentialing period within six months after the [STATE MEDICAID/MCO] has approved that practitioner's credentialing application. Claims submitted for reimbursement under this section shall be sent to the [STATE MEDICAID/MCO] by the provider in a single request or as few requests as practical subject to any technical constraints or other issues out of the contracted provider's control. "Credentialing period" shall mean the time between the date the practitioner submits a completed application to the [STATE MEDICAID/MCO] to be credentialed and the date the practitioner's credentialing is approved by the [STATE MEDICAID/MCO].

OPTION 2

SECTION I

The [STATE MEDICAID/MCO] shall adopt by regulation a universal dentist application for participation form for use by carriers which offer or administer dental plans for the purpose of credentialing dentists who seek to participate in a carrier's provider network and for the purpose of credentialing dentists who are seeking to participate in a carrier's Medicaid provider network.

The [STATE MEDICAID/MCO] shall also adopt by regulation a form for renewal of credentialing, which shall be an abbreviated version of the universal application form. The renewal form shall be designed to enable a dentist to indicate changes in the information provided in the application form.

The [STATE MEDICAID/MCO] shall revise the universal application and renewal forms, as necessary, to conform to industry-wide, national standards for credentialing.

Within 180 days of the adoption of the forms by regulation pursuant to this act, a carrier which offers or administers a Medicaid dental plan shall accept the universal dentist application for participation form and renewal form adopted pursuant to this act for the purpose of credentialing dentists who seek to participate in the carrier's Medicaid provider network.

Nothing in this section shall be construed to prevent a carrier from requesting additional information from an applicant that is not provided for in the universal application or renewal form, as applicable, if the requested information does not duplicate any information included in the applicable form.

OPTION 3

SECTION I

All contracted entities shall formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by the [State Medicaid] in accordance with 42 C.F.R., Section 438.214. A contracted entity shall complete credentialing or recredentialing of a provider within sixty (60) calendar days of receipt of a completed application.

MEDICAID CREDENTIALING PROVISIONS

Using the model legislation for Medicaid Credentialing: *An Act Concerning Dental Financing*, above, it is recommended to use the samples to build your state-specific legislation.

To support these efforts, here are the core tenets of the model legislation and a chart of states that have adopted these current tenets in their state laws:

	Time Limits on Process	Complete within Limited Time	Universal application	Universal Renewal	Centralized
California			**X**		
Kentucky		**X**	**X**		
Mississippi			**X**		
New Jersey			**X**		
Ohio			**X**		
Oklahoma	**X**		**X**		
Texas			**X**		

Source: American Dental Association, StateNet Tracking, September 30, 2024

In summary, this table demonstrates the need for increased legislation to improve a streamlined and centralized credentialing process.

Below are the provisions of the Model legislation for Medicaid Credentialing: *An Act Concerning Dental Financing*, which are being referenced above:

Time Limit

1. Requires state to provide notice of receipt of application and website where providers can track status.
2. Time limits on state to request more information on incomplete applications.
3. Requires limited time on notice to provider when additional info received.
4. Specifies that no additional request from state within timeframe means application is complete.
5. Credentialing decision must be done within set number of days unless extenuating/specified factors exist.
6. Payments during credentialing period -- Payments to applicant retroactive to date of application.

Single Form

1. Requires state to adopt universal dentist application/renewal form carriers must use for credentialing.
2. Renewal form must be abbreviated version of the universal application form and be designed to enable a dentist to indicate changes in the information provided in the original application form.
3. Requires carriers administering Medicaid dental plan to accept the universal dentist application for participation and renewal.
4. Preserves carriers' right to request additional information from an applicant not provided for in the universal application or renewal form.

Model Legislation – Audits in Medicaid

MODEL ACT CONCERNING FAIR AND EFFECTIVE DENTAL MEDICAID PROVIDER AUDITING
Be it enacted by the General Assembly

1) Definitions:
    a) Extrapolation Limits: Provides some degree of limitation on use of extrapolation.
    b) File/Records Request: Provides some degree of limitation on sample size or look-back period.
    c) Appeal: Provides avenue for appeal of findings.
    d) Peer: Includes appropriately educated, trained and experienced peer in review process.
    e) No Contingency: Prohibits collection of fees based on amount of funds recovered or repaid.
    f) Reasonable Scheduling: Requires effort to find mutually agreeable time for audit-exempts fraud cases.
    g) Audit Based on History: Includes provision(s) requiring (advanced) review to be based on flagged provider history.
    h) Clerical Errors Exempt: Provides some degree of exemption for errors found to be clerical in nature.
    i) Require Provider Training: Requires provider training to minimize errors.

2) Program integrity contractors may be used to promote the integrity of the medical assistance program, to assist with investigations and audits, or to investigate the occurrence of fraud, waste, or abuse.

3) Entities conducting Medicaid program audits either directly through state Medicaid department or through a contracted entity shall when conducting Medicaid program audits, investigations, or reviews shall:
    a) Review claims within [Select timeframe such as 2 years] from the date of payment;
    b) Send a determination letter concluding an audit within [Select timeframe such as 180 days] after receipt of all requested material from a provider;
    c) In any records request to a provider, furnish information sufficient for the provider to identify the patient, procedure, or location;
    d) Develop and implement a procedure in which an improper payment identified by an audit may be resubmitted as a claims adjustment, including:
        i. The resubmission of claims denied as a result of a reinterpretation of scope of services by the department;
        ii. The resubmission of documentation when the document provided is incomplete, illegible, or unclear; and,
        iii. The resubmission of documentation when clerical errors resulted in a denial of claims for services actually provided. If a service was provided and sufficiently

documented but denied because it was determined by the department or the contractor that a different service should have been provided, the department or the contractor shall disallow the difference between the payment for the service that was provided and the payment for the service that should have been provided;

e) Utilize a licensed health care professional from the specialty area of practice being audited to establish relevant audit methodology consistent with:
    i. State-issued Medicaid provider handbooks; and,
    ii. Established clinical practice guidelines and acceptable standards of care established by professional or specialty organizations responsible for setting such standards of care;
f) Provide a written notification and explanation of an adverse determination that includes:
    i. The reason for the adverse determination;
    ii. The clinically appropriate criteria on which the adverse determination was based;
    iii. An explanation of the provider's appeal rights; and,
    iv. If applicable, the appropriate procedure to submit a claims adjustment in accordance with subdivision (1)(d) of this section; and
g) Schedule any onsite audits with advance notice of not less than [Select timeframe such as ten business days] and make a good faith effort to establish a mutually agreed upon time and date for the onsite audit.

4) The use of contracted entities to perform Medicaid audits of providers shall operate under limitations and requirements as follows:
    a. Contracts with auditing entities entered into to execute Medicaid audits on a contingency fee basis shall provide that contingent fee payments are based upon amounts recovered, not amounts identified;
    b. In any contract between the department and a Medicaid audit contractor, the payment or fee provided for identification of overpayments shall be the same provided for identification of underpayments; and,
    c. Contracts shall include a limit on contingency fees of no more than twelve and one-half percent of amounts recovered.
    d. On an annual basis, the state Medicaid department shall require the entity contracted to execute Medicaid audits to compile and publish on the department's Internet web site metrics related to the performance of each recovery audit contractor. Such metrics shall include:
        i. The number and type of issues reviewed;
        ii. The number of medical records requested;
        iii. The number of overpayments and the aggregate dollar amounts associated with the overpayments identified by the contractor;
        iv. The number of underpayments and the aggregate dollar amounts associated with the identified underpayments;
        v. The duration of audits from initiation to time of completion;
        vi. The number of adverse determinations and the overturn rating of those determinations in the appeal process;

vii. The number of appeals filed by providers and the disposition status of such appeals;
viii. The contractor's compensation structure and dollar amount of compensation; and
ix. A copy of the department's contract with the recovery audit contractor.

Note there are two options (Section 5) for regulating file extrapolation audit processes.

Option 1

5) Audits of Medicaid providers may not use extrapolation to determine a finding of overpayment or underpayment by a provider unless:
   a. There is a determination of sustained or high level of payment error involving the provider;
   b. Documented educational intervention has failed to correct the provider's level of payment error; or,
   c. The value of the claims in aggregate exceeds [select amount such as $150,000] on an annual basis.
      i. "Extrapolation" means the determination of an unknown value by projecting the results of a review of a sample to the universe from which the sample was drawn.

Option 2

5) Extrapolation and statistical sampling prohibited – exceptions.
   a. Except as provided in subsection (b):
      i. In an overpayment audit the department or an auditor may not use statistical sampling extrapolation for automated reviews and may not rely on extrapolation to determine or support the amount of an overpayment determination; and
      ii. An overpayment determination must be based on and supported by evidence of an overpayment for each claim.
   b. In an overpayment audit of a high-risk provider, the department or an auditor may use statistical sampling extrapolation for an automated review or may rely on extrapolation to determine or support the amount of an overpayment determination.
   c. "High-risk provider" means a provider who within the previous [Select timeframe such as 3 years]:
      i. Has either admitted to Medicaid fraud or abuse in a written agreement with a governmental agency or has been determined by a final order of judgment of a governmental agency or court to have committed Medicaid fraud or abuse; or
      ii. Has a documented history of a high Medicaid claim error rate that has been sustained over a substantial period of time and that documented educational interventions have failed to correct.

d. "Extrapolation" means the determination of an unknown value by projecting the results of a review of a sample to the universe from which the sample was drawn.

6) The department shall exclude from the scope of review:
   a. any claims processed or paid through a capitated Medicaid managed care program; and,
   b. any claims that are currently being audited or that have been audited by a contracted Medicaid program audit entity or state Medicaid department.

7) Claims processed or paid through a capitated Medicaid managed care program shall be coordinated between the department, the contractor, and the managed care organization. All such audits shall be coordinated as to scope, method, and timing. The contractor and the department shall avoid duplication or simultaneous audits.

8) No payment shall be recovered in a medical necessity review when the provider has obtained prior authorization for the service and the service was performed as authorized.

9) No overpayments shall be recovered until all appeals have been completed unless there is a credible allegation of fraudulent activity by the provider, the matter has been filed with the Medicaid department for investigation, and an investigation has commenced.

10) All amounts recovered and savings generated as a result of an audit shall be returned to the Medicaid program.

11) Records requests in any [Select timeframe such as 180-day] period shall be limited to the lesser of not more than two hundred records for the specific service being reviewed or 5% of the number of claims filed by the provider for the specific service being reviewed. The auditor shall allow a provider no less than [Select timeframe such as 45 days] to respond to and comply with a records request. If the auditor can demonstrate a significant provider error rate relative to an audit of records, the auditor may, with permission of the state Medicaid department if under a contracted entity arrangements, initiate an additional records request regarding the subject under review for the purpose of further review and validation. The request shall not be made until the time period for the appeals process has expired.

12) The Medicaid audit entity, in conjunction with the department, shall perform educational and training programs for providers that encompass a summary of audit results, a description of common issues, problems, and mistakes identified through audits and reviews, and opportunities for improvement.

13) Providers shall be allowed to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic format deemed appropriate by the department or via facsimile transmission, at the request of the provider.

14) Appeal-Consultation
   a. A provider shall have the right to appeal a determination made under the audit.
   b. The auditing entity shall establish an informal consultation process to be utilized prior to the issuance of a final determination. Within [Select timeframe such as thirty days] after

receipt of notification of a preliminary finding from the entity, the provider may request an informal consultation with the auditing entity to discuss and attempt to resolve the findings or portion of such findings in the preliminary findings letter. The consultation shall occur within [Select timeframe such as thirty days] after the provider's request for informal consultation, unless otherwise agreed to by both parties.

c. Within [Select timeframe such as thirty days] after notification of an adverse determination, a provider may request an administrative appeal of the adverse determination as set forth in the Administrative Procedure Act.

MEDICAID AUDIT PROVISIONS

Using the model legislation for Audits in Medicaid: *An Act Concerning Fair and Effective Dental Medicaid Provider Auditing* above, it is recommended to use the samples to build your state-specific legislation.

To support these efforts, here are the core tenets of the model legislation and a chart of states that have adopted these current tenets in their state laws:

	Extrapolation Prohibited unless need to use is present	Clericals Error/Resubmit	Training of Providers	Contingency Prohibited	Contingency on under and over payments	Contingency percentage Limited	Time Limits for State to Complete	Peer Review Required	Record Request Limits	Total # of Select Provisions in each state
Arkansas				X			X			2
Connecticut	X									1
Florida								X	X	2
Louisiana		X			X		X		X	4
Maine					X					1
Montana	X	X	X					X	X	5
Nebraska	X	X	X		X	X	X	X	X	8
New Mexico	X									1
North Carolina		X								1
Washington	X									1
Utah	X		X	X				X		4

Source: American Dental Association, StateNet Tracking, September 30, 2024

In summary, this table demonstrates the need for increased legislation to improve a streamlined and centralized audit process.

Below are the provisions of the Model legislation for Audits in Medicaid: *An Act Concerning Fair and Effective Dental Medicaid Provider Auditing*, which are being referenced above:

1. Complete review of claims within timeframe & conclude an audit within designated timeframe.
2. Record request must identify the patient, procedure, or location.
3. Resubmitted as a claims adjustment.
4. Peer review – utilize a licensed healthcare professional peer.
5. Provide a written notification and explanation of an adverse determination.
6. Schedule any onsite audits with advance notice.
7. Contracts with auditing entities must be on contingency fee basis upon amounts recovered.
8. Pay same fee to auditors for finding overpayments and underpayments.
9. Limits on contingency fees of no more than 12.5% of amounts recovered.
10. On an annual basis, the state Medicaid department shall require the entity contracted to execute, compile, and publish contractor performance metrics for compliance with requirements in state plan.

11. Limits on extrapolation to determine a finding of overpayment or underpayment.
12. No payment shall be recovered in a medical necessity review when the provider has obtained prior authorization for the service and the service was performed as authorized.
13. Limits number of Records requests in any period.
14. Allow time for a provider to respond to and comply with a records request.
15. If the auditor can demonstrate a significant provider error rate relative to an audit of records, the auditor may initiate an additional records request regarding the subject under review for the purpose of further review and validation. The request shall not be made until the time period for the appeals process has expired.
16. Perform educational and training programs for providers that encompass a summary of audit results, a description of common issues, problems, and mistakes identified through audits and reviews, and opportunities for improvement.
17. Providers shall be allowed to submit records by variable format.
18. No overpayments shall be recovered until all appeals have been completed unless there is fraudulent activity.

Priority issues on audits:

1. Resubmit erroneous claims for adjustment to avoid penalty.
2. Ensure those doing audit/review include professionals educated/trained/licensed on service review.
3. Contingency fee limitations.
4. Limits on extrapolation.
5. Limit number/time of records.
6. Education and training before penalty/prosecution.
7. Appeals.

Section IV: Making the Case for Medicaid Dental Benefits to the Media

Tips for State Dental Societies

- Media interviews about Medicaid ideally should include a provider who participates in the state's Medicaid program.

- If relevant to offer an overview of the challenges within the Medicaid program for both patients and providers, always try to offer legislative solutions that the state dental society is advocating for or how the society is working with members to address access to care challenges.

- Acknowledge current statistics about the state and also point out wins or improvements that the data may not reflect.
    - Example: " ____% of adult Medicaid beneficiaries in the state of _____ have not been able to utilize their dental benefit due to _____ (low reimbursement/provider barriers/lack of coverage). State-based utilization data can be found here."

    - If recent progress has been made on Medicaid and 2021 utilization numbers may not be applicable to your state, then state dental associations are encouraged to discuss anecdotal data (i.e., "Since implementation of an increased reimbursement rate, our association has seen more than 40 dentists begin accepting Medicaid.")

    - Additional information on basic adult utilization and emergency department utilization can be found on the Dental Quality Alliance (DQA) website. Furthermore, please visit the DQA State Oral Healthcare Quality Dashboard for more information.

Key Messages

- Millions of Americans rely on the Medicaid program but are the least likely to access dental care (including basic preventive services). Low-income populations face the biggest cost barriers to dental care and experience persistent disparities in oral health outcomes compared to other income groups.

- Although the Affordable Care Act expanded the number of disadvantaged children with pediatric dental benefits, low-income adults still lack adequate access to dental care due to the non-existent or low level of variable dental benefits offered through state Medicaid programs.

- Medicaid oral health coverage opens the door to regular care in more appropriate and cost-effective settings for our patients. If adults have comprehensive dental Medicaid benefits, fewer would turn to emergency departments to relieve dental pain. This change could save our US health system $2.7 billion annually. The research shows that expanding dental benefits to adults also significantly reduces costly emergency department visits for dental conditions. Adult enrollees who have dental coverage are more likely to make sure their children get dental care too.

- We continue to believe that maintaining an adequate provider base, as well as providing adequate funding for dental services is critical for vulnerable Medicaid insured adults.
    - *Offer what the state dental society is doing on provider enrollment and other programs to fund dental services. i.e., the _____ Dental Association is partnering with _____ to help educate providers about recent changes and assist in provider enrollment challenges.*

- [If applicable to your state] 16 states, including our state, still do not provide enhanced dental coverage to adults in their Medicaid programs. Because of state-by-state differences in oral health coverage for underserved adults, there has been much less progress in the oral health of working-age adults versus that for children.

Administrative & Other Provider Barriers

- While more state Medicaid programs are providing enhanced dental benefits, administrative barriers for dentists who want to participate in the Medicaid program create challenges for patients who are trying to access dental care.

- We support *(insert bill or policy)* to reduce these administrative barriers by making it easier for dentists to become credentialed Medicaid providers.

- Program coordination within the state is critical. We need to manage and exchange information about best practices for safety-net operations to help patients find providers and affordable dental care.

- Due to unpredictable state Medicaid budgets, working low-income adults have more difficulty accessing consistent dental care services when states decide to change benefits or eligibility requirements.

Government Affairs Messages

- The ADA collaborates with Congress and other federal policymakers to implement solutions to address the accessibility and affordability of oral health care in America. The ADA supports numerous bills in Congress that promote access to dental care, including S.570/H.R.1342, the Medicaid Dental Benefit Act of 2023, that would provide comprehensive dental coverage to all adults in the program. The ADA supports H.R. 1422, the Strengthening Medicaid Incentives for Licensees Enrolled in Dental Act, that would reduce administrative barriers by simplifying the credentialing process. In addition, the ADA supports legislation that will strengthen the dental workforce and address distribution of providers.

- In our state, we're working to address *(insert key issues, including provider focus and patient focused topics.)*

- It has been shown that when an adult benefit that is adequately funded and implement, more Medicaid beneficiaries are seen.
    - Example: Missouri saw more than 100 new providers sign up to participate in Medicaid in 2023. This 10% increase took decades of work with many oral health care stakeholders addressing many changes including a reimbursement rate and a Medicaid facilitator at the Missouri Coalition for Oral Health to help new providers join the program.

- If media asks: "What are the other states' fees?" Visit *Medicaid Fee-For-Service Reimbursement for Dental Care Services* from the ADA's Health Policy Institute.

- If media asks: "Which are the best/worst MCOs?" *Offer your talking points about how the state dental society is trying to collaborate or offer improvements to the MCOs.*

- It is important to remember that MCO performance has more to do with the provisions in the contract with the state Medicaid department and enforcement of the contract, state laws and federal rules. (Also, mention using ADA RFP Guide)

- It is important to ensure dental Medicaid MCO accountability by avoiding medical MCO subcontracting to dental Medicaid MCOs. Dental Medicaid MCOs should have a direct contract relationship with the state Medicaid program so that the state, not the medical Medicaid MCO, has authority to enforce corrective actions if/when needed.

Section V: Draft Text for Advocacy Related-Publications

Text for Letter to Editor: Making the case for an adult dental benefit under Medicaid

Dear Editor:

One in five low-income adults in this country say their mouth and teeth are in poor condition. It is time for us to make meaningful improvements to [state] Medicaid program to increase access for low-income adults. Dentists in other states have made significant improvements to their Medicaid programs in recent years, including notable reimbursement rate increases, innovative approaches to state Medicaid funding, centralized credentialing improvements, and other major reforms that will enable dentists to reduce disparities in oral health access and outcomes. According to the American Dental Association's Health Policy Institute, only [_____] % of [state] adults with Medicaid coverage saw a dentist in 2021 compared to [_____] % of privately insured adults and children have a much higher chance of going to the dentist if they have Medicaid coverage thanks to CHIP and mandatory dental coverage requirements. Let's work with our legislators and [Governor'] office to prioritize policies that will offer meaningful coverage for patient care and increase provider recruitment efforts.

Signed,

Dentist in state

E-Blast Text for State Dental Association Newsletters for Federal Medicaid Legislation

Essential Health Care Needs Includes Comprehensive Medicaid Policy

Over the past two decades, we have seen steady improvements among children, particularly the most vulnerable, when dental care was included as an essential benefit under Medicaid and CHIP and, later, under the Affordable Care Act. State-by-state differences in oral health coverage for underserved adults have resulted in less progress among working-age adults. Only 34 of 50 states provide comprehensive dental coverage to adults in their Medicaid programs. We [state dental society] are working hard to establish an adequate provider base in [state], as well as advocating for adequate funding for dental services as critical for vulnerable Medicaid insured adults. The ADA asks Congress to pass _____, to provide comprehensive dental coverage to all adults in the program in our country. For more information on how you can be a part of the implementation of solutions in our state please visit: [state dental association website] or ADA.org/advocacy.

Grassroots Alert Text to State Legislators to Import into State's Advocacy Software

Dear Assemblyman/State Legislator:

One in five low-income adults in this country say their mouth and teeth are in poor condition. I am urging you to support [bill name and number if introduced]. *OR alternative text to support a specific Medicaid policy.*
Many adults who rely on Medicaid benefits find that there is little, if any, coverage for dental care due to a patchwork of dental benefits by state Medicaid programs. We have seen there are competing priorities for [state]; adult dental Medicaid benefits and comprehensive adult dental coverage should be offered to Medicaid enrollees in our state.

This lack of coverage or lack of access is particularly problematic because the millions of adults who rely on Medicaid are the least likely to access dental care (including basic preventive services), face the biggest cost barriers to dental care, and are more likely than their higher income counterparts to experience dental pain, report poor mouth health, and find their lives to be less satisfying due to their poor oral health.

As an active dentist member of the [State Dental Association], American Dental Association and your constituent, I am asking for your support of [bills or issue]. It is time for us to make meaningful improvements to our state's Medicaid system.

Thank you,

Section VI: Information about Managed Care Organizations and Pre-Ambulatory Health Plans

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.

What are pre-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 or sometimes known as a "dental carve-out plan" to deliver the state's Medicaid dental benefits. PAHPs function similarly like commercial insurance or stand-alone dental plans in which providers must go through credentialing, and claims submission, while beneficiaries have in-network providers.

What are important considerations about MCOs/PAHPs in relation to treating Medicaid beneficiaries?

- Many states' Medicaid programs offer a dental benefit that utilizes MCOs or PAHPs 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 or PAHPs.

- Reimbursement rates from MCOs/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 MCOs/PAHPs. While some states have directed the MCOs/PAHPs to reimburse dentists at fee-for-service rates, many states allow MCOs/PAHPs to reimburse below the fee-for-service rate.

- Administrative burden still exists with MCOs/PAHPs, such as delayed decisions on credentialing and handling of multiple payor portals.

What are important advocacy steps I can take in relation to MCOs/PAHPs?

- Find out when your state's MCO/PAHP contract for dental services is up for renewal/bid and the length of the contractual term. If your state's MCO/PAHP contract renewal/effective date is occurring within the next eight months, you can facilitate conversations about the importance of setting up provisions and enforcing them in the areas such as:
  - Reimbursement Transparency;
  - Turn Around Times for Credentialing, Enrollment, and Claims Processing and Appeals;
  - Network Adequacy to Ensure Medicaid Beneficiaries Have Access to Care; and
  - Beneficiary Outreach and Care Coordination to Decrease Missed Appointments

More examples of provisions or areas to include in advocacy in the MCO/PAHP contract can be found by clicking on this Medicaid RFP Toolkit.

- In a recently published federal rule released in April, Centers for Medicare & Medicaid Services (CMS) stated they would require states and MCOs/PAHPs:
  - Choose an area of healthcare, such as dental, for access monitoring;
  - Choose a standard wait time for appointments as a measure of network adequacy for that chosen healthcare area;
  - MCOs must hire an independent monitor to assess network adequacy, which will detect trends deficiencies in network adequacy;
  - If a deficiency is network adequacy is found, MCOs and States would be required to file a 12-month remedial plan on how to improve access within that 12-month period, with priority for MCOs to raise reimbursements or reduce administrative burden; and
  - If activities in the 12-month remedial plan are not completed or deficiencies in network adequacy are not corrected, CMS reserves its right to withhold its federal funds that would pay for MCO/PAHP contract.

  To learn more about this federal rule on MCOs/PAHPs and how you can advocate for enforcement of these rules, you can click on MCOs/PAHPs Advocacy Toolkit.

- In a letter to State Health Officials, CMS recently provided best practices and guidance on implementing the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in partnership with MCOs. While this EPSDT benefit only applies to children on Medicaid/CHIP, CMS outlined how states and MCOs/PAHPs can improve care coordination and help patients overcome transportation barriers. This includes MCOs arranging for patient transportation to appointments, MCOs reminding families when yearly dental check-ups are due, and states utilizing only one MCO for foster children to remove enrollment barriers. Click here to view the letter to State Health Officials that help guide discussions on best practices and possible strategies with your state's Medicaid administrator or MCO/PAHPs.

Section IX: Additional ADA Resources Related to Medicaid and Managed Care Organizations

- The ADA's advocacy efforts are not limited at the state level. The ADA is advocating for two pieces of federal legislation in 2024 that would reshape Medicaid programs across all states. The **Medicaid Dental Benefit Act** would mandate extensive dental coverage for all adult Medicaid beneficiaries; currently, adult dental benefits are optional at the state level, leading to a current patchwork of coverage that varies by state. The **Strengthening Medicaid Incentives for Licensees Enrolled in Dental (SMILED) Act** would simplify credentialing and reduce administrative burdens that often discourage dentists from signing up for or staying in the Medicaid program. This bill encourages states to use an integrated system such as the Council for Affordable Quality Healthcare (CAQH) to minimize paperwork and complete the credentialing process within 90 days. Additionally, the SMILED Act would reduce unfair Medicaid audits by requiring that they be performed by a dentist from the same specialty and be based on clinical practice guidelines from dental organizations.

- The ADA has specific policies related to Medicaid passed by its House of Delegates. To read the ADA's Medicaid policies, **click here.**

- Some states may be renegotiating their MCO contracts for the Medicaid dental benefit. The ADA has developed a 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 the ADA's RFP Toolkit, **click here.**

- To increase provider participation, 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.**

- For State Oral Healthcare Quality reports and the Dental Quality Alliance (DQA) Dashboard, please visit **www.ada.org/DQA**

For more information, please visit **www.ada.org/Medicaid**

Appendix: 1 – References

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