

Medicaid Fee-for-Service: Access Monitoring Plans Review Checklist

In March 2016, CMS finalized new regulations creating a process for CMS to understand the extent to which access to health care is adequate in state fee-for-service Medicaid programs. The process involves states performing an access review that demonstrates how the program meets certain criteria (Access Monitoring Review Plan), states submitting a report of this review to CMS, and CMS reviewing and evaluating those reports.

States are required to submit their first Access Monitoring Review Plan to CMS by October 1, 2016 and every three years thereafter. States that deliver dental care through a fee-for-service delivery system (including ASO plans) must include dental care in their reviews.

If the state Medicaid programs receive comments that offer recommendations to improve the access monitoring review plans and could feasibly be incorporated by the state, CMS expects the state to modify the review plans accordingly. Similarly, to the extent the comments raise concerns about the access monitoring review plans, CMS expects states to explain how it will address the concerns through the access reviews. One intention of the review is to understand whether fee-for-service reimbursement rates are adequate to create sufficient access to care. **This is an opportunity for state-dental associations to meaningfully participate in this process and determine if the state Medicaid program has ensured access to care for its beneficiaries.**

Contact your state Medicaid agency to find out where the plan has been posted for public comment. Review the plan and submit your written comments to the state by the deadline as instructed in their public posting.

To assist members of state dental associations in their review of the access monitoring plans, the American Dental Association (ADA) Council on Dental Benefit Programs (CDBP) has developed a preliminary checklist that appears below.

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.

*Note: Data for all parameters noted below should be reported separately for children and adults within the access monitoring plan by the state Medicaid program.

Enrollment

- ✓ Does the plan specify the TOTAL BENEFICIARIES ENROLLED in the state's fee-for-service program? [Note: This number should be specific to dental enrollment.]
- ✓ Does the plan specify ENROLLMENT BY POPULATION TYPE (i.e. number of tribal children/adults; number of disabled children/adults; number of special needs children/adults)?

Network Adequacy: Access

- ✓ Does the state have a definition for "active" dentist for the purpose of defining network adequacy? If yes, is it reasonable? If not, this is an opportunity for you to suggest such a definition.
- ✓ Does the access monitoring plan provide the number of active dentists (separately for children and adults) by county?
- ✓ Does the state have specific time/distance standards for assessing network adequacy?
 - (1) by urban/rural geographical variations
 - (2) by specialty [Note: The access regulations from CMS include dental care within primary care and thus states are not required to have specific access standards for dental sub-specialties. Nonetheless, the state's plan should address the extent to which children have access to dental care, including to pediatric dentists. States' plans should also reflect an understanding of the extent to which the general dentists in their networks actually see young children. For example, a state could verify this by evaluating prior claims experience. General dentists whose practices do not provide pediatric care should not be included within network adequacy requirements. Within the access monitoring plan look for information on how the state identified the "number of active dentists treating children"]

- ✓ Does the plan provide data on specific measures of network adequacy including but not limited to the following?
 - % of enrollees within state specified time/distance standards noted above
 - Average wait time for appointment for a new patient
 - Number of dentists accepting new patients
- ✓ Does the monitoring plan include “heat-maps” or “geo-maps” that plot distance standards between each beneficiary and closest dentist?

Utilization

- ✓ Does the plan include data for EACH POPULATION TYPE on appropriate utilization measures including: [Note: “enrollees” refer to dental enrollees for all measures. In some states the number of beneficiaries enrolled in the dental FFS program differs from the medical FFS program].
 - CMS 416 Measure - Total number of beneficiaries enrolled for **at least 90 days** with a dental visit [Note: Many plans typically include a measure that looks for a dental visit among those enrolled for 11 out of 12 months. This approach leaves out many enrollees. Request that the state include data on all enrolled for at least 90 days. Measuring all enrollees, no matter how long they’ve been enrolled, would be fine as well.]
 - Dental Quality Alliance Measure - Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.
 - The [Dental Plan CAHPS](#) survey is another tool to gain an understanding of access issues from the beneficiary standpoint.
- ✓ Does the state benchmark its utilization against commercial utilization in the state?

Provider Reimbursement Rates

- ✓ Does the access monitoring plan identify, at minimum, at least the top 20 codes billed to the Medicaid program based on claim frequency?
- ✓ Does the plan specify the fees for each of these top 20 codes?
- ✓ Does the plan compare the Medicaid fee to the typical COMMERCIAL rate IN YOUR STATE for each code? [Note: The CMS regulations require states to benchmark against the commercial rate in their state. Comparison to fees of Medicaid programs in other states is not helpful.]

ADA HPI Resources: [Tools for Policymakers](#)

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