OHIO DENTAL ASSOCIATION

Informing – Representing – Serving

March 3, 2020

Maureen M. Corcoran, Medicaid Director
Ohio Department of Medicaid
Office of Contracts and Procurement
Ohio Medicaid Managed Care Program RFI #2 (ODMR20210019)
PO Box 182709
Columbus, Ohio 43218-2709

Dear Director Corcoran:

Thank you for providing the opportunity for the public to submit comments concerning the Ohio Department of Medicaid's managed care procurement process.

The Ohio Dental Association is committed to improving access to care and the quality of the Ohio Medicaid program. Outside of Medicaid itself, there are few, if any, individuals, organizations or companies that have more experience in providing oral health care services to Ohio's citizens who are covered by Ohio Medicaid than the ODA and our member dentists.

We are pleased to present the following best practice ideas as ways to improving patient and provider experiences, service quality and system accountability.

10. Dental Services — Stakeholders throughout the State identified the importance of dental services to ensuring improved health outcomes. Describe successful approaches, from Ohio and other states, for increasing access to dental services, including access to specialty dental services, particularly where there are network gaps, such as rural areas.

While not the only inhibiting factor, low reimbursement rates are the single most significant barrier to dentist participation and beneficiary access. The 2018 ODA Membership Survey reported 77 percent of ODA member dentists who do not participate in the Medicaid program do not do so because of Medicaid's low reimbursement rates. This is higher than all of the other reasons combined (patients not showing for appointments – 12%; too much paperwork and too much unspecified hassle – 10% each; no need/practice is busy – 5%; provide other types of charity work, restricts proper/quality care and unappreciative patients – 4% each; bad experience/track record and not cost effective – 1% each; and other – 3%).

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The state should strive to maintain authority in setting the minimum reimbursement rates for covered services and include contract clauses requiring contractors to:

- Abide by a loss ratio/benefit distribution requirement (annual report). The state should establish a loss ratio/benefit distribution in the 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.

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

Data from other states have demonstrated the fastest most effective way to improve access to dental and dental specialty services is to increase reimbursement levels.

The following case studies demonstrate programs that have been shown to increase access to dental services:

- Connecticut – Private Dentist Participation Doubles: Connecticut's low-income families struggled with access to dental health services for a variety of reasons including low private dentist participation. Three strategies led to their success:
  1) Increase reimbursement rates to the 55th percentile of private insurance fees (2008);
  2) Simplify Medicaid dental program administration; and
  3) Recruit dentists through the state dental association. After these strategies were implemented:
     - Nearly 70% of children continuously enrolled in Medicaid had at least one dental visit per year, a rate higher than privately insured children.
     - More than half of all pediatric and general dentists provided care in the Medicaid dental program.
     - Adult dental care utilization also increased.

- Alabama – Finding Dental Homes for At-risk Children: Developed by the Alabama Medicaid Agency in partnership with the state's pediatric dentists and pediatrician's, the 1st Look Program was designed to reduce early childhood caries by encouraging involvement of primary care physicians in a child's oral health, including referral to a dental home by age one. 1st Look improves awareness and detection of early child-hood caries by pediatricians, provides oral health education to families, and enlarges the dental provider referral base.

- California – Legislators ease access for Denti-Cal patients: California adopted a process to expedite Medicaid credentialing for dentists to less than 60 days. The Ohio Dental Association has received many reports from Ohio dentists that it has taken them as long as six months to get credentialed by the state's Medicaid HMOs. Making it easier and quicker for dentists to get credentialed in Ohio makes it easier and quicker for Denti-Cal patients to receive care.

- Maryland – Three Times More Kids Getting Dental Care: Comprehensive Medicaid improvements in Maryland tripled utilization of dental care among Medicaid and CHIP-eligible children. Again, simplified administration, increased reimbursement rates, statewide oral health education of parents and caregivers, and public/private collaborations were the keys to success.

- 48% of Medicaid children in Maryland had a dental visit, 8% more than the U.S. average.
- Despite an increase in funding, the overall investment was less than 1% of total Medicaid spending.

4. *Fiscal Intermediary — Accurate, timely and actionable data are fundamental to the effective operation of a Medicaid program. Currently, ODM has to conduct special analyses and make additional efforts to collect data from several managed care plans. At the same time, providers report that the inconsistency in business processes across managed care organizations requires additional resources and time that could be better spent on patient care.*

   ODM plans to contract with a fiscal intermediary to conduct intake and pre-process claims for both fee-for-service Medicaid and managed care. All claims, either submitted via portal or electronic data interchange (EDI), will come into that single fiscal intermediary. If a claim is for an individual enrolled in an MCO, the fiscal intermediary will edit the claim to specific Strategic National Implementation Process (SNIP) level edits and then send the claim to the correct MCO. The MCO will adjudicate the claim, pay the provider and send a response back to the fiscal intermediary, who will send the response to the provider. The MCO will be required to provide status updates to the fiscal intermediary to report to the provider before adjudication. The MCO will provide data back to the fiscal intermediary for the 835 Electronic Remittance Advice and a "paper" Remittance Advice for the Provider Portal. All these interactions will take place through ODM's System Integrator, not directly between the fiscal intermediary and the MCO.

   Similarly, ODM intends that all prior authorization requests will come into the fiscal intermediary. If the request is for an individual enrolled in an MCO, the fiscal intermediary will forward the prior authorization request to the MCO for determination and response back to the fiscal intermediary.

   The administrative burden for dentists significantly increases if processing policies are unclear or constantly changing. Whether there is an single dental administrator, which would increase administrative efficiency and create clarity in the policies and rules, or a group of administrators for the dental benefit, which would create competition in the marketplace and ensure that companies would have to engage in strategies to attract dental providers Ohio Medicaid should include contract clauses requiring contractors, including the fiscal intermediary, to:

   - 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 and details on when the dentist may need prior authorizations.

   - 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 (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.

- 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.

- Provide easy online access to the dentist manual for all network dentists.

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

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

- 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 managed care plans and increases the administrative burden for a dentist participating in the program.

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

- Provide copies of the member and dentist handbook to the Ohio Medicaid Department for approval and require that the Department be notified within 30 days when any changes are made. Manuals should be reviewed by an Ohio licensed dentist if the state does not install state Medicaid dental program director.

- 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 has a 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 is responsible 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 patients covered by Medicaid in the same manner as other patients in the office.
- Providing mechanisms to address emergency situations.
- Continuing to provide emergency treatment and access to services for up to 30 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.

When multiple contractors operate in the state and each administers the dental program differently, the enrollees in the state do not receive the same Medicaid benefit. Ohio Medicaid should continue to list covered services using the most recent version of the CDT Code and not simply include "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. The state should include contract clauses requiring contractors to:

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

- Allow the state to review and approve the contractors' claims processing policies and policies relating to prior authorizations and claims for medical necessity. This will allow Ohio Medicaid to assure consistency in administration of the dental benefit across multiple contractors within the state.

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

If Ohio Medicaid contracts with a medical (primary) contractor and allows 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 Ohio Medicaid approving the subcontractor and the subcontract. The state should ensure that all clauses identified above are part of the subcontract between the primary contractor and the dental subcontractor.

- The state should retain 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. Elements of subcontractor performance 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 enrollees support and outreach.
- Systems for dentist network support.

Compliance with administrative record maintenance rules, program coverage rules, medical necessity rules, state policies, requirements of EPSDT and clinical criteria in the dentist 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. Ohio Medicaid should include contract clauses requiring contractors to:

- 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.

- Ensure that any audits to determine medical necessity and medical appropriateness of services and treatments are made in consultation with an Ohio licensed dentist, who has appropriate clinical expertise/specialty training (same specialty as the treating dentist) in treating the enrollee's condition or disease.

- Have mechanisms to detect underutilization as well as overutilization.

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

- Bring such issues of under or overutilization to the knowledge of the dentist within 30 days and support the dentist to ensure that corrective action is taken.

- Have readily available mechanisms to resolve disputes by using arbitration or another mutually agreeable process as required by federal law.

- 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.

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

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

a. *Please identify any potential barriers to implementing this model from the MCO and/or provider perspective and proposed solutions.*

We are concerned that many dentists may view the fiscal intermediary as an additional layer of bureaucracy which may slow the process and divert resources away from providing care to Medicaid covered patients and instead to program. To work properly the fiscal intermediary must be well staffed with well-trained individuals. If done properly, the fiscal intermediary will help standardize processes across the MCOs and relieve dentists of certain administrative burdens and that would be welcome.

b. *One key goal of this model is to provide a consistent experience for providers across MCOs and fee-for-service. Please describe the advantages and disadvantages of requiring the MCOs to comply with/apply fee-for-service claims processing edits and rules. Please identify the types of edits/rules that should be determined by the MCO, including the rationale.*

An advantage is that equal treatment across all plans will make it easier for dentists to know what treatments they will be allowed to provide and therefore make it easier to provide care to patients covered by Ohio Medicaid.

5. *Enrollment — ODM intends to redistribute individuals who do not affirmatively select an MCO across all MCOs using an automatic assignment algorithm.*

Care must be taken during the redistribution process that established patient-dentist relationships are not broken or compromised.

a. *Some states place an enrollment cap or maximum size for any individual MCO. Please share your thoughts on managing or limiting the enrollment size of MCOs.*

The numbers of subscribers allowable should be proportionate to the number of providers and administrative support available in each MCO in order to assure MCO can provide services offered in a reasonable time frame.

b. *What steps should ODM take to manage care transitions to ensure the continuity of care for individuals who may be assigned to a new MCO as a result of redistributing members?*

ODM should ensure all MCOs provide the same service levels and have proportionate levels of providers, staff and regional distribution as provider from which subscriber is to be transitioned.

6. *Health and Wellness — To improve health outcomes and support individual wellness, ODM will use a state-driven population health strategy designed to reduce infant mortality and preterm births, increase healthy behaviors, promote tobacco cessation, and address healthcare inequities. ODM envisions a robust community-based organization and MCO partnership infrastructure to accomplish this goal.*

a. *Describe ways in which MCOs serving the same region can collaborate to create and implement strategies that have a collective impact on the population within*

the region with specific attention to the issues identified above (i.e., reducing infant mortality and preterm births, increasing healthy behaviors, promoting tobacco cessation, and addressing healthcare inequities).

Each MCO should have an Ohio licensed dentist serving as a consultant to or employee of their organization who can then work internally and with other MCO dental consultants on the development and deployment of oral health programs to the MCOs' subscribers.

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 oral health and overall health for adults. It is important for medical and dental contractors to work together to improve referral and establish dental and medical homes (health homes). Ohio Medicaid should include contract clauses requiring contractors to:

- Work with the primary medical contractor on primary care education and initiatives to improve ease of referral between primary physicians and dentists.
- Establish mechanisms to enable medical-dental coordination for Medicaid beneficiaries, particularly for those individuals with co-morbidities.
- Assume responsibility for all members seeking care in the emergency department by establishing an emergency department diversion program, helping to ensure the establishment of a dental home. Contracts should also require contractors to offer case management services to ensure follow up and discourage repeated use of emergency departments.

7. *Performance Incentives/Reimbursement Strategies — ODM is interested in aligning incentives and reimbursement strategies to create a health care system that improves wellness and health outcomes, while better managing financial resources.*

   a. *Are there specific strategies that ODM should consider to support movement along the continuum of value based care/payment models and align incentives with MCOs and provider partners to achieve greater levels of integration and improved health care outcomes? What should the MCO's role be in supporting providers in value-based payment models? Are there specific alternative payment models that ODM should consider or promote?*

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. Ohio Medicaid should include contract clauses requiring contractors to:

- 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.

- 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.

- 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.

It is important to monitor and improve the oral health of the enrolled population. To that end, Ohio Medicaid should 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 organizations (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. The state should include contract clauses requiring contractors to:

- 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.

- 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 metrics related to care for patients with special health care needs; use of preventive services; coordination of dental and physical health needs; monitoring and providing feedback on dentist performance.

- 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.

- Develop any performance improvement projects (PIPs) with input from the network dentists and the Ohio Dental Association.

ODM should consider offering Facility Grants for high achieving programs. Budget surpluses resulting from lower cost to ODM due to improved outcomes could be passed back to most successful clinics in forms of bonuses to providers or facilitiy improvement.

17. *Centralized credentialing — ODM intends to centralize provider credentialing and re-credentialing. MCOs will accept provider credentialing information from ODM and will not request any additional credentialing information from a provider. MCOs will potentially participate in the ODM-led credentialing committee. MCO responsibilities will include providing credentialing files prior to the start of operation, negotiating and executing provider contracts, notifying ODM of denied provider applications, loading providers into their claim system, and reporting provider information (e.g., member complaints, quality of care issues, changes in provider information, and any provider terminations) to ODM. MCOs will terminate their contracts with providers whose credentials are terminated by ODM.*

    The dentist credentialing process is often laborious and time consuming. Many dentists have reported it takes six months or more for some of Ohio's current Medicaid HMOs to credential and enroll them or their associates into their networks. These reports come from dentists who have never been disciplined by either the Ohio State Dental Board or Ohio Medicaid itself. 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. The state should include contract clauses requiring contractors to:

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

    - Ensure that all credentialing/re-credentialing applications are processed within 30 calendar days of receipt of a completed application.

    - 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).

    - Include an appeals process for dentists not credentialed upon the initial application.

18. *Standardizing Provider Requirements — Stakeholders have strongly advocated to reduce the administrative burden on providers, which detracts from provider focus on delivering quality care, by standardizing administrative requirements for providers. To address underlying concerns, ODM is considering adding the requirements below:*
    - *MCO use of only state developed standardized prior authorization and concurrent review forms and processes, without additional MCO-specific forms or required information.*
    - *Standardized provider dispute resolution process across all MCOs.*
    - *MCO use of American Society of Addiction Medicine criteria for review of substance use disorder service requests.*
    - *MCO use of state developed medical necessity guidelines, where they exist, to conduct prior authorization and concurrent review.*
    - *Prior review and acceptance of MCO policies as they relate to implementing state developed medical necessity guidelines.*
    - *Prohibition of MCO application of prior authorization for certain services as determined by ODM.*

b. *ODM also plans to establish appointment availability standards. Describe best practices for monitoring appointment availability that minimize provider burden.*

Assuring an adequate network is key to the success of Ohio's Medicaid program. The state can use its contract with managed care plans and/or dental administrators to assure health equity such that all covered services are as accessible to Medicaid-insured members in terms of timeliness, quantity, duration and scope as they are for commercially-covered members in the contractor's region. The state should require that contractors:

- Provide easily accessible, accurate and up-to-date provider listings to assist patients in finding participating dentists and reducing confusion and problems for covered patients and dentists.

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

- 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.

- 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.

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

- Meet specific standards for access to 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.

- 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.

The state should establish a process for Ohio Medicaid to actively monitor, validate and report on network adequacy for dental care at least quarterly and in all regions. As part of this, the state should establish enforceable penalties and fines for failure to meet network adequacy requirements. If Ohio Medicaid finds that a network of a managed care plan or a dental plan administrator is inadequate under the contractual standards the Ohio Medicaid should refer the

managed care plan or a dental plan administrator to the Ohio Department of Insurance for a market conduct study and possible disciplinary action.

21. *Data and Information —*

a. *Describe best practices for exchange of care management information (e.g., assessment, plan of care, notes, referrals, alerts) between the MCO and contracted and non-contracted care management entities (e.g., ODM, partner state agencies, local administrative agencies, state vendors).*

The state could establish one statewide patient file system that is mandated for use across all agencies and providers, medical, behavioral, dental, social and allows ODM 24/7 access to all metrics.

22. *General feedback — What other information should ODM consider as we take the next steps to achieve the goals for Ohio's Medicaid managed care program?*

Medicaid covered beneficiaries and dentists currently have the ability to file complaints with the Medicaid Department against Ohio's Medicaid HMOs. This complaint data and information should be reviewed and analyzed to determine and then address common areas of complaints.

Slow processing and delayed payment serves as a burden to dentists who provide care to patients covered by Medicaid. A best practice for Ohio 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. Ohio Medicaid should include contract clauses requiring contractors to:

- 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 30 days of receipt of such claims by the contractor/plan administrator.

- 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.

- Ensure that all prior authorization requests are 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.

- Use the services of an Ohio licensed dentist 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.

- 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.

- Use the most updated dental claim form (2012 version of the ADA paper claim form or the latest version of the 837D electronic dental health care claim).

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, subcontractors and network dentists. Ohio Medicaid should include contract clauses requiring contractors and subcontractors to:

- Employ an Ohio licensed dentist 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.

- If the dental benefit component of the program is subcontracted out by a primary medical contractor, then require the medical contractor to employ an Ohio dentist licensed to serve as the liaison with the dental benefits administrator (subcontractor).

If multiple contractors are to be utilized to manage care, it is important for Ohio Medicaid to ensure continuity of care. The state should include contract clauses requiring contractors to:

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

- Allow enrollees 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.

Install a state Medicaid dental program director to oversee the dental program. 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. An Ohio licensed dentist provides an opportunity for greater expertise to help the state 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 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(s) to effectively manage the dental program;

- Encourage collaboration between the state and managed care plans and/or dental administrators

- Facilitate collaboration between contractors and dentist networks;

- Establish outreach and education for patients and dentists; and

- Achieve health equity and measurable improvements in access to care, utilization of services and the health status of Medicaid enrollees through routine review and assessment of data using quality measures endorsed by national consensus building entities.

Since the contract is the most important tool the state has to manage its Medicaid dental benefit program, the state must ensure conformance with the provisions contained in the contracts. A great contract without enforcement is meaningless.

Thank you for soliciting input as Ohio Medicaid moves through the managed care procurement process. Please contact the ODA if you have any questions concerning our recommendations or we may provide assistance to the Department as it moves through the procurement process.

Sincerely,

David Owsiany, JD
Executive Director
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