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

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Background

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

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

Dental associations should consider encouraging their state administrators to seek the association's input during the RFP development. That is the crucial time for a state's Medicaid agency to recognize the important role that the dental society can play in contract development.

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

Need for a State Medicaid Dental Program Director

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

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

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

dental program director to make policies and ensure that patients covered by Medicaid have access to high quality programs.

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

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

The Contract: Include and Enforce

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

A great contract without enforcement is meaningless.

Key Elements to Enforce Through a Dental Program Contract

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

1. Assuring an Adequate Network

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

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

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

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

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

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

1.5 Meet standards for network adequacy for dental benefit plans. At minimum, geographic distribution of providers, number of providers 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-provider ratios to assess network adequacy. More advanced geo-mapping capabilities are also becoming commonplace to assure network adequacy.

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

2. Enrollment and Credentialing

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

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

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

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

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

2.4 Include an appeals process for providers not credentialed upon the initial application.

3. Securing the Dentist-patient Relationship

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

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

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

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

4. Continuity of Care

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

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

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

4.2 Allow enrollees to be able to go out-of-network when specialty services are required if there are no in-network providers 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 providers in such instances. This is especially important for any child with special needs.

5. Fee Schedules and Reimbursement

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

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

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

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

6. Claims Processing and Appeals

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

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

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

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

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

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

6.5 Establish an appeals process to review and resolve provider appeals. Time limitations should be included in the contract to promote timely resolution of any appeals. Ideally, appeals should be resolved in 30 days at most.

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

7. Role of Peers in Resolving Issues

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

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

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

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

8. Monitoring Education and Outreach

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

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

8.1 Have mechanisms to track missed and ([late) cancelled appointments in order to conduct targeted outreach to members with repeated occurrences. *[Note: One of the administrative burdens for providers is cancellation. In a managed care situation there can be shared responsibility among all parties to manage this.]*

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

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

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

9. Coordination of Care

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

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

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

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

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

10. Contractor Administrative Performance Monitoring

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

10.1 Report metrics related to program administration on a quarterly basis which includes.

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

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

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

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

11. Utilization and Quality of Care for Enrolled Population

It is important to monitor and improve the oral health of the enrolled population. To that end, consider encouraging your state to use the contracting process to set forth parameters for measurement and quality improvement. Efforts to measure and improve quality of care should be separate from the traditional utilization management activities of the contractor. States typically use HEDIS and CAHPS to assess quality. However these tools lack comprehensive dental specific measures. Quality should be measured using nationally recognized measures, especially those developed by the Dental Quality Alliance (DQA) or endorsed by the National Quality Forum (NQF). Measures developed by the DQA for evaluating plan performance are available for use. Quality and performance improvement programs are also best monitored by an external quality reporting 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.

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

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

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

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

11.4 Develop any performance improvement projects (PIPs) with input from the network providers and the state dental association.

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

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

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

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

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

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

12. Utilization Management

Compliance with administrative record maintenance rules, program coverage rules, medical necessity rules, state policies, requirements of EPSDT and clinical criteria in the provider 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 providers. Providers are compared with other Medicaid providers performing similar procedures based on provider specialty. Providers whose treatment utilization patterns deviate significantly (specific standard deviation limit) from their peers are then identified as “under” or “over utilizers”. Managing compliance and overutilization must be conducted in a manner that is transparent and fair.

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

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

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

12.3 Have mechanisms to detect underutilization as well as overutilization.

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

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

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

12.7 Assure that audits are not structured so as to provide incentives for any party to deny, limit or discontinue medically necessary services to any enrollee.

12.8 Allow providers to have access to an appeal process. Should a provider decide to appeal an audit finding, no repayment of potential overpayments are to be made until the appeals process returns a final decision on the findings of the audits.

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

13. Member and Provider Manuals

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

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

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

13.2 Ensure that plans maintain a **provider manual** that serves as a source of information to providers regarding covered services and frequency limitations, a clear definition for medical necessity, contractors policies and procedures for reimbursement (bundling, downcoding, alternative treatment provisions, etc.), provider 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 provider incentive programs.

13.3 Ensure that plans maintain a provider manual that is thorough and up-to-date, rather than referring providers to additional websites for coverage and processing policies.

13.4 Easy online access to the provider manual should be provided to all network dentists.

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

13.6 Ensure timely provider notification of any specific policy changes by mail or electronic communication.

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

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

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

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

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

Dentist's right to:

- Obtain information regarding patients' eligibility and claim status in a timely manner.
- Access to a customer service line with an assurance of minimal wait time to respond to provider 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 provider is not re-credentialed, any claims already in the system should not be impacted and the provider should be provided adequate time to refer patients.)

Dentist's responsibility for:

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

14. Medical Necessity and Processing Policies

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

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

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

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

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

Integrity of Subcontracts

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

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

Request for Proposals: Readiness Assessment Checklist

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

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

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

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

Other Related Resources

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

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