

Nuts and Bolts of Dental Medicaid Managed Care

James W. Couch, Heather Slawinski

North Carolina has adopted managed care for administration of its Medicaid program for management of *medical* benefits. The NC Medicaid *dental* program, however, continues to be administered through a traditional fee-for-service model. This article addresses what a managed care model for Medicaid dental could look like in North Carolina.

Introduction

In 2021, North Carolina transitioned administration of its Medicaid program for management of *medical* benefits to a managed care model. Today, approximately 2.1 million North Carolina Medicaid beneficiaries receive their medical care through one of five managed care organizations (MCOs) contracted for the Medicaid Standard Plan [1]. As of 2021, 41 states use some model of managed care to operate their *dental* Medicaid programs, but North Carolina is not one of them. Early high-level questions have been posed in North Carolina about the possibility of moving to a managed care model for the Medicaid dental program [2]. What might adoption of Medicaid managed care for the dental program look like in North Carolina?

This article addresses general topics regarding dental Medicaid managed care, including: What is Medicaid managed care? What types of dental services are covered by Medicaid? Why do state Medicaid agencies choose managed care to operate their dental programs? What are the different models commonly used by state Medicaid agencies adopting managed care? How are managed care companies selected by state decision-makers? How are dentists usually paid for services provided to Medicaid beneficiaries?

The Centers for Medicare & Medicaid Services (CMS), the federal government entity that regulates Medicaid, defines Medicaid managed care as a “delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations [MCOs] that accept a set per member per month [capitation] payment for these services” [3]. CMS requires states to provide eligible children under age 21 coverage for certain dental services as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit covers a broad scope of health-related services, including screening, dental, vision, and hearing. In

2021, 58% of children in North Carolina eligible for Medicaid or CHIP (low-cost health coverage for children in families that earn too much to qualify for Medicaid) used a dental benefit. This is among the highest rates of eligible children receiving a dental service in the country [4, 5].

Medicaid coverage for dental services for eligible adults (up to age 65) is optional for states. Many states, including North Carolina, cover an extensive range of dental services for adult Medicaid beneficiaries, though utilization by adults is low. In 2021, only 28% of the adult Medicaid beneficiaries in North Carolina used any dental benefit; while this percentage is low, North Carolina is actually tied for sixth in terms of utilization among all adult Medicaid programs in the country [5].

State Medicaid agencies typically choose a managed care model for administering a Medicaid program to achieve one or more of the following goals:

Budget predictability. Cost of health care services incurred by Medicaid beneficiaries can vary month to month and year to year. In a non-managed care model, the state Medicaid agency must manage through these fluctuations in cost. But in a managed care model, there is a set per-member per-month payment that is paid by the state to the MCO(s). The MCO is then responsible for managing care and necessary resources to serve all of the MCO's Medicaid beneficiaries within that set payment amount.

Reduced administrative burdens on the state. The state Medicaid agency contracts with MCOs to handle significant administrative requirements of running a Medicaid program for which the state is otherwise responsible.

Improved utilization outcomes. Managed care programs have federal statutory and regulatory requirements, such as standards for Medicaid beneficiary access, program improvement projects, and being subject to periodic external performance review. These mandates, along with an MCO's ability to carry out care coordination and having resources to

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Address correspondence to Jim Couch, Delta Dental of North Carolina, 3737 Glenwood Ave, Ste 320, Raleigh, NC 27612 (jcouch1@deltadentalnc.com).

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conduct unique outreach methods, should lead to improved utilization outcomes [6].

Medicaid Managed Care Delivery Models

The goals a state Medicaid agency has for its dental Medicaid program should influence the delivery model chosen by the state. The traditional non-managed care model of administering a Medicaid program is referred to as fee-for-service (FFS). FFS is the model currently used for the North Carolina dental Medicaid program. In this model, the state not only bears the risk of claims costs in the program, but generally also uses internal staff and other resources to carry out most of the day-to-day processes necessary to run the dental program, such as claims processing, beneficiary and dentist communications, dentist contracting, and program development [7].

Another model available to state Medicaid programs is the administrative services only (ASO) model. In an ASO model the state contracts with an MCO for partial or full administrative functions, such as claims processing and customer service, but the state retains the risk for the cost of dental services provided to Medicaid beneficiaries. In the ASO model, the MCO is usually paid an administrative fee for services provided [7].

There are two dental managed care models most often used by state Medicaid programs: 1) the “Carve-In” model in which the state contracts with an MCO that is responsible for providing both medical and dental benefits to Medicaid members; the MCO takes the risk for the cost of all health care services provided to Medicaid beneficiaries; and 2) the “Carve-Out” model through which the state separates dental benefits from other Medicaid covered health care services and contracts directly with a dental-focused MCO that takes the risk for the cost of dental services provided to the Medicaid members. In both the Carve-In and Carve-Out models, the MCO is typically paid a per-member per-month fee (commonly referred to as a “capitation” fee) to cover its administrative services as well as the cost for dental services provided to the MCO’s Medicaid members [7].

MCO Selection

CMS governs Medicaid managed care programs pursuant to federal rule 42 CFR 438, which sets minimum standards that state Medicaid agencies and MCOs must meet. However, state Medicaid programs have flexibility to implement additional initiatives and requirements above the “floor” set by CMS to address unique challenges faced by that state in its Medicaid program [8]. A state Medicaid program usually chooses the MCO(s) with which it contracts through a request for proposal (RFP) process. A state may require interested MCOs to propose innovative initiatives on improving oral health of Medicaid beneficiaries while managing the dental program. This could include addressing social determinants of health, reducing health disparities, and care coordination. An MCO interested in contracting

with the state submits a proposal addressing how it plans to administer the Medicaid program, particularly addressing the specific requirements set out by the state. CMS requires that, absent it granting a Medicaid agency’s request for a waiver, Medicaid beneficiaries in “Carve-In” and “Carve-Out” models must be given a choice of the MCO in which they are enrolled. For this reason, unless a state Medicaid agency seeks a waiver from CMS, it will contract with two or more MCOs submitting proposals. Medicaid beneficiaries are given an opportunity to choose from among the contracted MCOs in which to be enrolled using processes developed by the state [9].

In most states, regardless of the model implemented by a state for administering its Medicaid dental managed care program, dentists providing services to Medicaid beneficiaries continue to be reimbursed on a fee-for-service basis. That is, the dentist is generally paid for each service provided based on a fee schedule set by the MCO subject to any state requirements, e.g., a minimum rate. Common challenges across the country faced by dental offices participating in Medicaid programs include inadequate reimbursement for services provided to beneficiaries, administrative requirements (e.g., prior authorization of services), accuracy of beneficiary eligibility data, and missed appointments by beneficiaries. North Carolina dentists not participating in the Medicaid program or otherwise limiting their participation often cite these issues as being key reasons they do not participate. In North Carolina, only between 32% and 36% of licensed dentists in the state currently provide services to Medicaid beneficiaries [10]. Dentists’ lack of or limited participation can significantly impact Medicaid beneficiary access to care, especially in rural parts of a state.

CMS places many requirements on states establishing and managing dental Medicaid programs aimed at creating positive outcomes for stakeholders. But in the experience of the authors of this article, real success in operating a Medicaid managed care program lies in the collaborative working relationships among the state Medicaid agency, participating MCOs, dentists, lawmakers, and other stakeholders. Through such collaboration, issues and concerns can be appropriately addressed, creative program solutions are born, and delivery of oral health care focused on equitable access and improved health outcomes can be realized. NCMJ

James W. Couch, JD Vice President, General Counsel, Delta Dental of North Carolina, Raleigh, North Carolina.

Heather Slawinski Manager, Medicaid Markets – Analysis & Planning, Delta Dental of Michigan, Okemos, Michigan.

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