REQUEST FOR Information (RFI)

AHCA RFI# 014-22/23

Procurement of the Statewide Medicaid Prepaid Dental Program

May 30, 2023

WELCOME TO PREVENTISTRY®

DentaQuest®

a. The Respondent's name, place of business address(s), contact information, including representative name and alternative, if available, telephone number(s), and e-mail address(s);

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b. A description of how the Respondent's approach will offer advantages or improvements ensuring continued improvement in overall Medicaid program quality with regards to the provision of dental services and will further the Agency's goal to reduce potentially preventable dental inpatient and outpatient hospital events, and unnecessary use of ancillary services. The description should also identify known or potential concerns with the approach.

DentaQuest is proud to have directly served the Florida Agency for Healthcare Administration (AHCA) Statewide Medicaid Managed Care (SMMC) program since 2018 and to have worked extensively with the state administering dental benefits prior to the present SMMC model. During our long and collaborative history with AHCA and the state, we have consistently worked hard to establish ourselves as a dental benefits innovator that has contributed to the oral and overall health of Florida residents.

We are continually looking to build on our past successes by delivering the kind of service that truly makes DentaQuest stand out as a top-tier administrator. Over the past several years, we have endeavored to think "outside of the box" to provide AHCA and its enrollees with the best care possible and to continue to earn our distinction as a collaborative partner that uses innovation to deliver true results.

Commitment to Administrative Excellence

DentaQuest understands that functional areas such as claims processing, utilization management, utilization review, network management, and quality are all fundamental to an effective program and must be continually upgraded to ensure ongoing excellence.

For example, our ability to detect, prevent and remediate instances of fraud, waste and abuse (FWA) are unrivaled in the industry. Our analytic reports are meticulously designed to uncover outlier activities at the earliest possible interval, and we have an established record of building strong FWA referrals to our government partners. Our Special Investigation Unit is headed by a nationally recognized former health care fraud prosecutor who co-chairs the National Health Care Anti-Fraud Association's Dental Fraud Interest Group, which keeps us apprised of cutting-edge best practices in preventing fraud, waste and abuse. The end result is that, through referrals and ongoing monitoring, Florida public resources are spent in a way that ensures overall programmatic integrity.

Reducing Barriers to Care

Plans should consistently be looking at new ways to reduce barriers to care for enrollees, particularly in areas that have traditionally seen access challenges. For example, DentaQuest, through its affiliated retail dental care organization Advantage Dental, has developed four new

oral health center office locations in Pensacola, Ft. Walton Beach, Crestview, and Milton. These new locations have been a true value-add for AHCA, as they have fostered viable and sustainable oral health care opportunities for enrollees in the underserved areas of the Florida Panhandle. Importantly, they have also promoted new opportunities for **nearby preventive care services for populations that have historically faced barriers to care and challenges accessing dental services**. Our goal is to leverage these preventive services to control costs by avoiding the longer-term need for more expensive restorative procedures.

Potential Concerns

Many states - including Florida - have seen a reduction in capacity. Dentists are forgoing participating in Medicaid, and those that stay as participating providers are reducing appointment availability for Medicaid members. Some states like Vermont, for example, are addressing this issue through additional funding to alleviate the problem.

It is concerning that not enough high-quality Florida dental providers register to become Medicaid providers. It is likewise concerning that many of the network providers that have been credentialed for the SMMC program see very few enrollees, which runs counter to the effort to get the ***right providers in the network to provide the right kind of care***. While our network goal should not be to expand the network simply for the sake of size, options that enhance the quality of our network providers must be vigorously pursued. Meaningful steps should be taken to allay the concerns that many high-quality providers have over real or perceived bureaucracy in the SMMC program.

To broaden the depth, breadth, and quality of the Medicaid network – and to offer more choices to enrollees – the state should explore the option of permitting any non-excluded dentist with a valid Florida license to see a Medicaid patient. This may require having specific elements that are federally required for Medicaid participation – such as fingerprinting and a compliant background check – to be incorporated as part of the overall state licensure process. However, doing so would potentially permit thousands of more Florida providers to see Medicaid enrollees without going through the Medicaid credentialing process. It would not be reasonable to assume that all of these dentists would participate fulsomely in the Medicaid program, but it would increase available options and have a positive effect on access.

A Strategically Deployed Network

One of the primary goals of any successful state Medicaid program should be the development of **a right-sized, strategically deployed network**, and DentaQuest seeks to work with AHCA to achieve that goal. Concerns might arise – for both dental vendors and AHCA – if the efforts to optimize the network are compromised by an effort to mandate an excessively large network that emphasizes quantity over quality.

Such mandates run the risk of bringing in additional inactive providers, or worse, creating a need to recruit providers who are not familiar with serving the dynamic needs of Medicaid enrollees. It may also bring into the network providers who are not rendering high-quality care. A requirement for a larger provider pool “checks the box” in terms of numbers, but it can ignore the larger picture of what DentaQuest and AHCA strive to deliver in terms of quality, accessibility, and cost savings.

A larger network does not directly translate into a higher-quality network, particularly when an administrator is contracting with providers in a non-strategic capacity simply to meet a goal related to network size. In fact, contracting in such a way runs the risk of diluting dental vendors' efforts to identify and contract with providers who offer high-quality preventive care and to channel enrollees to them. Ultimately, the goal for the Florida Medicaid dental program should be to use a vendor's skills to deploy the best providers in a right-sized network in close coordination with AHCA and its stated goals.

Utilize value-based payment (VBP) designs to simultaneously increase quality and reduce costs.

We agree that leveraging value-based payment (VBP) models should be incorporated into the new contract, as long as the expectations on their impact are reasonable. Given that dental value-based care and its associated Alternative Payment Models (APM) are relatively new, there is insufficient data to prove how they reduce costs. Additionally, to truly be impactful, sufficient funds are necessary to provide adequate incentives and bonuses.

It is possible to infer the timeline to savings for dental VBP models based on numerous studies using APMs in medicine. However, it is important to also keep in mind that any recent literature examining cost savings in medical APMs has been preceded by decades of experience with VBP and APMS. No such foundation presently exists in oral health, which further compounds the complexity of understanding how costs may be impacted. With that caveat in mind, the following articles demonstrate that while APMs can produce favorable impacts on costs, that impact requires years to be seen:

- In a July 2019 article, The New England Journal of Medicine published a paper showing that an Alternative Quality Contract (AQC) cohort of Blue Cross Blue Shield of Massachusetts took three years to show savings[1].
- A conclusion in a Rand Research report published in 2016 stated: "However, it is reasonable to assume that any substantial reductions in costs cannot be observed in the short time period of the studies, especially for physician- or physician-group-based evaluations, which often focused on chronic diseases, for which the cost implications of better disease management could take years to observe." Since oral disease is a chronic condition, it is expected that any changes will follow a similar timeline[2].
- A summary to the Rand report also observed that "CMS is establishing the cost benchmark for each agreement period for each ACO using three-years-prior expenditure data."[3]

With such a limited dataset, and the confounding of that dataset by the COVID-19 pandemic, there are challenges in assessing the impact of VBC on costs. Using cost impacts of VBC programs in medicine as a surrogate for estimating cost impacts in dentistry has several limitations (e.g., medical practices are distinctly different than dental practices and medical VBC programs have been in place for many years). With those limitations in mind, the experience

[1] Health Care Spending, Utilization, and Quality 8 Years into Global payments https://www.nejm.org/doi/full/10.1056/NEJMsa1813621

[2] Measuring Success in Health Care Value-Based Purchasing Programs https://aspe.hhs.gov/reports/measuring-success-health-care-value-based-purchasing-programs

[3] Measuring Success in Health Care Value-Based Purchasing Programs. Summary and Recommendations. https://aspe.hhs.gov/reports/measuring-success-health-care-value-based-purchasing-programs-summary-recommendations

with medical VBC indicates that while quality improves, under ideal circumstances, no costs savings will be seen for three or more years. The inference is that seeing cost impacts in dentistry will take longer to be seen and subsequently quantify.

Improve integration of dental and primary care services for iBudget enrollees.

Medical-dental integration efforts for iBudget enrollees can be promoted and advanced through better care coordination, and specifically, through the use of Care Coordinators. Care Coordinators are trained professional staff that better connect individuals with Intellectual and Developmental Disabilities (IDD) to the health care services that they most need.

Given the unique needs of the iBudget population, one point we would emphasize is that the state must have a system in place to more accurately identify these members on enrollment files. By clearly establishing iBudget enrollees on the file that is conveyed to DentaQuest and/or other vendors, Care Coordinators would be better equipped to quickly identify these enrollees and help direct them to – and effectively manage – the most appropriate care possible.

Care Coordinators can work closely with dental office staff to coordinate the iBudget enrollee's visit, identify specialized interventions that may be necessary to complete the appointment, and coordinate integrated access to other medical services, such as prescribed drugs or prophylactic antibiotics arranged with the enrollee's MCO or PCP. When needed, Care Coordinators can consult with Dental Directors to determine optimal clinical approaches or to arrange a consultation between the dental provider and Dental Director to discuss specific medical or dental interventions. These interventions could include alternative forms of anesthesia or alternatives to sedation, or any need for multiple sessions for enrollees who cannot tolerate a procedure being completed in a single visit.

Any plan to which the State awards the SMMC contract should have a robust care coordination program and an adequate number of staff in order to establish bi-directional relationships with MCOs, dental and medical providers, and State Agencies supporting at-risk enrollees.

Improve understanding of the unique oral health needs for individuals with intellectual and developmental disabilities

In order to improve access for indviduals with Intellectual and Developmental Disabilities, the state should require providers to have part of their liscensure/re-licensure Continuing Education requirements include courses on understanding and treating IDD patients. By incorporating such lessons into the standard regimen of learning that providers are already required to take, an increased understanding can be fostered among dentists on how to optimally treat IDD populations.

The state should also require dental plans to work with dental schools and other stakeholders to develop IDD and other specialized trainings for the SMMC program's new and existing dental providers. This effort could include elements such as web-based programs, seminars, or even a specialty care clinic where students and licensed dentists can rotate in to learn how to provide such specialized care.

Additionally, the state needs to create a specific rate cell for IDD members that reflects the challenges and dynamics of treating this population. A reasonable adjustment to the per

member/per month rate reimbursable to the plans would help them recruit providers who specialze in the care of IDD patients and increase accessibility and options for IDD populations.

By educating more providers and by providing rates that allow plans to more effectively recruit such providers, the state can reduce the number of IDD members who need sedation, Ambulatory Surgical Centers (ASCs), or hospital based-care. This would not only enhance the care experiece and reduce the risk of care, but it would also mitigate the cost of care for these members.

Identify different options for integrating sedation dentistry into dental services for individuals with intellectual and developmental disabilities, including iBudget enrollees.

Access to sedation for oral health care services is primarily an issue for profoundly disabled adults or children. Challenges related to sedation for this population are not unique to Florida; they are a national problem. Some considerations to bear in mind when developing solutions to this issue include:

- In order to provide sedation services in Florida, a provider must have specialized training. The majority of dental providers with such training are oral surgeons (who do not provide comprehensive care), pediatric dentists (who primarily treat children), and some general dentists. Additionally, there are presently no programs in Florida that provide such training (the closest program is in Georgia). Thus, providers have little incentive to get this training.
- Most general dentists with dental sedation credentials provide self-proclaimed, high-end “sleep” dentistry to individuals who do not need sedation but are more comfortable when they elect it. Dental plans often actively try to recruit such providers, but the majority of them will not accept Medicaid rates or do not want to participate in the Medicaid system due to the bureaucracy. To try to remedy this issue, some dental plans have offered rates that approach the provider’s UCR, even though the state does not pay the dental plans for these higher fees. The state should strongly consider a separate rate cell with an adequate PMPM to help plans recruit these providers.
- Adult IDD members that have MedWaiver receive some dental services through Medicaid and other services (Root Canals and crowns) through the APD and the MedWaiver. This fragmented system causes billing problems for providers and causes many providers who can provide sedation to not want to see this population. If the population was carved out in a higher-paying rate group (like on the health plan side with certain populations), it would be an easier and more effective way to manage them.
- There are predominantly two models of delivering sedation service – single operator and a team approach. The single operator model is one where the dentist provides both the dentistry services and sedation (administration and monitoring) services. For uncompromised patients, this model is arguably acceptable, and providers with credentials can deliver sedation services in their own office. However, for medically compromised patients and very young children, the single operator model can make less sense, as the dentist may have challenges performing two services (dentistry and monitoring anesthesia) at the same time.
- When dental providers should not utilize the single operator model, they need access to Ambulatory Surgery Centers (ASCs), hospitals, and anesthesiologists. Restrictive Board of Dentistry rules limit which dental providers can not only administer sedation, but which

can utilize mobile anesthesiologists. Additionally, coordination with the MCOs is paramount in order for dentists to gain access to these needed facilities.

- Elective use of sedation services reduces access for those who truly need sedation. More dental providers trained in the care of patients with IDD can reduce the need for sedation services.

We recommend a comprehensive review of these and other dynamics that may inadvertently be compromising options for sedation dentistry for the populations that need it the most. DentaQuest would look forward to lending its thinking and recommendations to such a process.

Identify certification(s) and accreditation(s) appropriate for dental health insurance plans which allow the safe and high-quality provision of dental care, including individuals with intellectual and developmental disabilities.

We would recommend that the DBA selected for the SMMC program have both National Committee for Quality Assurance (NCQA) certification for credentialing and re-credentialing and accreditation by the Utilization Review Accreditation Committee (URAC). Both of these distinctions are earned after an extensive independent review, and while they don't speak specifically to the provision of dental care to individuals with intellectual and developmental disabilities, they represent independent validation of overall procedural quality for all populations served.

Identify certification(s) and accreditation(s) appropriate for dental providers, including dentists, dental assistants, and dental hygienists, which allow for the safe and high-quality provision of dental care, including individuals with intellectual and developmental disabilities.

In order to improve access for indviduals with Intellectual and Developmental Disabilities, the state should require providers to have part of their licensure/re-licensure Continuing Education requirements include courses on understanding and treating IDD patients. Such requirements can also be promulgated for certification/accreditation of dental assistants and dental hygieniests. In fact, regimens of CE lessons can be tailored specifically to these positons and roles in delivering care, particularly when it comes to IDD populations.

A more centralized credentialing process should be considered as part of the SMMC program. Presently, there are three separate DBAs that administer the program, each with unique credentialing processes. By working with the state, these administrators could collaboratively identify a process through which providers can be subject to a more streamlined credentialing procedure. This would go a long way toward mitigating frustration in the provider community over the three different processes they must undertake for full program participation.

Further, the state should explore the option of permitting any non-excluded dentist with a valid Florida license to see a Medicaid patient. This may require having specific elements that are federally required for Medicaid participation – such as fingerprinting and a compliant background check – to be incorporated as part of the overall state licensure process. However, it would potentially permit thousands of more Florida providers to see Medicaid enrollees without going through the Medicaid credentialing process. It would not be reasonable to assume that all of these dentists would participate fulsomely in the Medicaid program, but it would increase available options and have a positive effect on access.

Educate future dentists in an academic setting about providing dental services for individuals with intellectual and developmental disabilities.

The state should require dental plans to work with dental schools to develop training programs for the SMMC program's new and existing dental providers, such as web-based programs, seminars, or even a specialty care clinic where students and licensed dentists can rotate in to learn how to provide IDD and other specialized care. These educational opportunites, which could be coordinated with dental learning centers, such as the University of Florida College of Dentistry, the Nova School of Dentistry, and the Lecom School of Dental Medicine, can focus on how optimally to treat IDD and other vulnerable populations. Importantly, these forums could also provide an important "touchpoint" and outreach opportunity to encourage upcoming future dentists to participate in Medicaid programs, particularly in areas where we have identified network or specialty shortages or population treatment challenges.

This outreach can be coupled with Continuing Education requirements related to licensure/re-licensure that reinforce best practice techniques in treating IDD and other vulnerable populations.

Provide enhanced orthodontia services.

Continuum of Orthodontic Care

Enhanced orthodontia services could be promoted through new ways of thinking about both unique cases and provider reimbursement. For example, we recommend that the state adjust the once-per-lifetime orthodontia benefit to account for cases such as cleft palate or craniofacial deformities, which may require more than one comprehensive orthodontic treatment. In such cases, a "continuum" of orthodontic care or longitudinal care throughout childhood is required due to problems associated with improper bone growth for these conditions.

Modernizing the Benefit to Reflect Advancements in Care

Innovations in the provision of orthodontic benefits should relate closely to the reimbursement of providers. The state's traditional reimbursement for orthodontic services has typically commenced on the date of banding and has involved 24 subsequent monthly payment installments, each tied to a physical monthly office visit with the provider.

New development in orthodontia related to materials and techniques have made monthly appointments unnecessary in many cases. Clinical evidence suggests that it is now more appropriate to have the orthodontist conduct an in-person appointment with the average patient every three to four months. Based on this change in approach, orthodontia reimbursement schedules should be adjusted accordingly. Providers should be reimbursed a "case rate" rather than feel compelled to meet with the patient monthly simply to adhere to outdated rules of the prevailing fee schedule. Such an approach would:

- Reduce frustration among providers who may feel compelled to schedule superfluous and unneeded appointments to satisfy outdated reimbursement requirements
- Allow providers to better customize orthodontia treatment on a case-by-case basis depending on the unique needs of the enrollee
- Ensure that the provision of orthodontia services is more aligned with current clinical best practices

Improve integration of dental and sedation services for children, adolescents, pregnant women, and the elderly.

Case Managers play an important role in the integration of sedation services into dental care, irrespective of the population served (e.g., children, adolescents, pregnant women, elderly, etc.). They work closely with at-risk and vulnerable populations to help effectuate clinical decisions with qualified oral health professionals on when sedation services are situationally appropriate.

DBAs can use the Case Management intake and assessment process to inform and draft Plans of Care (POC) to integrate dental care with enrollees' medical and behavioral health providers. Dental POC goals typically align to those provided by the MCO and can often bridge care across different delivery systems for complex conditions, such as cleft palates and oral surgery, or other services requiring anesthesia or sedation.

The state must ensure that any plan awarded the SMMC contract has a robust Case Management Program in place with an adequate numbers of care coordinators to provide important and needed services.

Leverage community partnership innovations to improve access to dental services and outcomes for Medicaid recipients.

Community partnerships not only leverage existing and trusted relationships between the enrollee and a community member/organization, but they also can be impactful through the frequent "touches" that these organizations have with the enrollee in an ongoing capacity in their everyday lives. The state should require that any plan that it chooses to administer Medicaid dental benefits has longstanding relationships with community organizations in the state.

For example, "Cultural Ambassadors" can be identified, appointed, and trained and then used as community partners to advance the mission of the SMMC program across the state. These Ambassadors, often drawn from health and social service organizations, can serve as the program's representatives in communities that have historically experienced barriers to care and/or have limited English proficiency. Such a "train-the-trainer" program is designed to respect and honor the different ways diverse populations prefer to receive information and referrals for healthcare services.

The ultimate goal of Cultural Ambassador programs is to increase the likelihood of enrollees using the system and accessing the kind of preventive care that promotes wellness and reduces overall spend. Through Cultural Ambassador programs, community partners can be educated on several topics, including:

- The importance of early oral health intervention
- How enrollees can obtain medically necessary covered dental services
- The importance of establishing a dental home
- How to refer enrollees in need of care to DentaQuest
- Where to access oral health education resources

Determine the value of our current quality measures and verify other quality measures that might be utilized.

DentaQuest recommends leveraging nationally recognized standards, such as those developed, tested, and monitored by the Dental Quality Alliance (DQA). Once a quality measure is approved by a steward agency like the DQA, it is reviewed annually to ascertain if it is still relevant and accurate. Related systems change is a long process, particularly if an endorsement is withdrawn. Any measure's continued use should be scrutinized at a regular frequency.

The TDENT metric is a good example of how measures evolve over time. What initially may have seemed like a good measure can lose relevancy as more data is collected on its use. TDENT was introduced as a measure in 2010, but in 2014, the National Quality Forum removed its endorsement, stating: "CMS and other stakeholders described that the measure is not an effective tool for quality improvement because it is unclear if an increase or decrease in the rate is desirable. Essentially, any dental visit, regardless of its quality or appropriateness, would count in the measure. A higher number of Medicaid enrollees receiving dental treatment could indicate the positive outcome of improved access to care or the negative outcome of more individuals needing treatment for caries or other poor oral health outcomes. Therefore, the information collected is not actionable by states or CMS. The measure is not NQF-endorsed."

In a similar manner, CMS recently announced they will be removing PDENT as a measure in its child core set in 2023, noting that the percentage of eligibles who received Preventive Dental Services (PDENT-CH) "does not focus on evidence-based interventions to prevent tooth decay as it captures information on services that go beyond the two evidence-based preventive dental services for children, which are fluoride and sealants."

Moreover, quality targets must be reasonable. For example, requiring ever-increasing target rates for TDENT is antithetical to the concept of prevention. If the push is to prevent disease, then treatment needs should go down. Subsequently, requiring an ever-increasing TDENT rate makes no sense in that context. Quite the opposite; TDENT rates should decrease if prevention is increasing.

Implement robust Healthy Behaviors incentive programs.

In order to develop robust Healthy Behaviors incentive programs, we would urge the state to loosen and/or clarify requirements around marketing, incentives, and how plans can contact members. The ability to text enrollees would go a long way to develop and support these programs.

We understand that, particularly when it comes to government programs, privacy is paramount. We also understand that concerns have been raised in the past over the use of text messaging to enrollees without a clear "opt-in" approach; we appreciate this concern.

However, as more and more people are getting their information and lifestyle reminders through non-traditional channels, we think it would be an appropriate time to explore new options that would better inform enrollees and help them lead healthier lives.

Describe innovative delivery methods for the dental care model, including care bundling, that empower recipients in making more informed health care decisions.

Two significant ways to enhance the delivery of care and empower enrollees to make more involved health care decisions involve new holistic strategies related to remote care and teledentistry. DBAs can partner with established teledentistry platforms that give providers an easy-to-use online tool to help them manage remote appointments, store patient records, and optimize their ability to provide care for their patients via the internet. However, the state needs to offer more clarity and official guidance regarding rules around telehealth and how the technology is to be used in the SMMC program.

The potential benefits of such guidance are substantial. Online flexibility for providers can be coupled with a 24/7 network availability through teledentistry to address emergency situations or to better meet the needs of busy parents or guardians during non-traditional hours and weekends. Further, the state needs to loosen and/or further define rules to allow for expansion of mobile care capabilities. Mobile care delivers highly effective remote care to targeted locations such as schools, rural populations, Head Start programs, or health fair events.

To promote awareness of remote and telehealth alternatives, enrollee materials, targeted mailings, and educational emails can include information about alternative service delivery methods. This could include a 24/7 Dental Clinical Support value enhancement, teledentistry options available through a contracted network of providers, and a toll-free Call Center available to assist enrollees.

Describe assessment and needs for rural regions and counties. What relationships can be leveraged to serve the needs of rural populations?

One of the greatest needs for rural populations is having access to a dentist in their area. Many rural counties in Florida have no or limited numbers of providers, and even in rural areas where there are providers it may be that few of them accept Medicaid.

Examples of ways to stimulate access in these areas have been discussed above (e.g., Medicaid registration as part of licensure, teledentistry, and mobile dental programs). However, some other ideas or examples include proactively coordinating with the state Department of Education and individual school administrators to remove barriers and expand school and community-based programs; expanding community water fluoridation through the Department of Health's Public Health Dental Program (which is a proven means of reducing dental disease in vulnerable populations and a cost saver for the Medicaid program); and finding ways to "recruit" more dental providers to practice in rural settings through support and education. One such recruitment tool involves a recently passed amendment that permits DBAs to use a portion of their "claims" funding as incentives to pay for residencies and externships for new dentists who agree to practice in rural areas.

A good example of a dental plan addressing access issues in rural areas involves DentaQuest, through its affiliated retail dental care organization Advantage Dental, investing in and developing four new oral health center dental office locations in Pensacola, Ft. Walton Beach, Crestview, and Milton.

Improve providers' experience with the SMMC Dental Program.

The state should require that any dental plan it awards the SMMC contract have sufficient Florida-based Provider Engagement Representatives to work closely with providers in their designated area. Too few Provider Representatives means that providers have limited resources to address their problems and concerns. Adequate numbers of Provider Representatives in a state as large and geographically diverse as Florida ensures that regular outreach is conducted to provider offices, training and program updates are made available, data obtained from Provider Surveys is thoughfully and properly reviewed and sythesized, and that GeoAccess Reports are thoroughly reviewed to make certain that the network is appropriately deployed.

We would also empasize the importance of plans having Dental Advisory Committees (DACs) to solicit and act on provider feedback on all aspects of the Medcaid program. Any vendor selected by AHCA for the SMMC program should have a strong track record working with and supporting the efforts of these important informational forum. Feedback from the DAC should be coupled with an additional requirement that the plans have periodic regional meetings throughout the state with providers that include not only the plans, but also AHCA representatives. Such meetings are invaluable for giving providers a voice in improving the program among decision-makers and key stakeholders.

Improve recipients' experience with the SMMC Dental Program.

The enrollee experience is paramount to an effective dental program. Some measures to improve that experience could include:

- Enrollees need to be assigned to the right provider at the right time to receive the right care. Adequate networks with a variety of specialists are essential to connecting enrollees to timely and appropriate services. This requires a seasoned administrator that has extensive experience not only in building compliant networks, but one that is also able to effectively maintain those networks to ensure that they remain compliant, particularly in hard-to-reach access areas.
- To broaden the depth and breadth of the Medicaid network – and to offer more choices to enrollees – the state may wish to explore the option of permitting any dentist with a valid Florida license to see a Medicaid patient. This may require having specific elements that are federally required for Medicaid participation – such as fingerprinting and a compliant background check – to be incorporated as part of the overall state licensure process. However, it would potentially permit thousands of more Florida providers to see Medicaid enrollees without going through the Medicaid credentialing process. It would not be reasonable to assume that all of these dentists would participate fulsomely in the Medicaid program, but it would increase available options and have a positive effect on access.
- Data about the health condition of the enrollee must be accurately collected, maintained, and used to assign timely care with the right provider. The more that is known about the member, the easier it is to assign them to the proper provider. Any selected DBA should have the experience and capabilities to collect and constructively use such data.
- DBAs should have robust case management teams and capabilities to ensure that the needs of vulnerable populations are met.
- Measures should be in place to reduce administrative burdens that might serve as a barrier to care for the enrollee (i.e., reducing prior authorizations for certain services or

for providers who have demonstrated a strong record of continually assigning appropriate care to enrollees).

- Better coordination with health plans and their Ambulatory Surgery Centers (ASCs) to provide services and facilities for special needs members in an environment that truly understands behavioral management techniques or provides sedation services. This may involve a discussion on provider rates for this relatively small population and/or medical-dental integration initiatives with health plans to leverage access to ASCs.
- Easy-to-use and intuitive member portals and Find-a-Dentist tools.
- Access to – and availability of – teledentistry services.

Achieve cost savings throughout the SMMC Dental Program.

It has been estimated that approximately 80% of dental disease exists in 20% of the population. This troubling statistic points to the true need to focus on vulnerable populations, a disproportionate amount of whom are on Medicaid plans. To address this imbalance in oral health, steps to prioritize and promote preventive health practices are critical. Efforts to improve preventive practices, and by extension to reduce overall costs, could include:

- Cost-saving preventive practices could be enhanced through better enrollee education and a higher degree of understanding on the importance of routine care and preventive care. Further, this kind of education can be expanded more broadly to communities and local governments on the importance of access to quality foods and nutrition and to community water fluoridation. Any selected DBA should have a proven record and strategies to conduct such outreach to enrollees and other stakeholders.
- The importance of the intersection of oral health and overall health cannot be understated when it comes to controlling costs. Steps to promote a healthy mouth through preventive measure have a significant impact on health conditions such as pregnancy and birth outcomes, diabetes, obesity, and heart disease. The state can consider covering periodontal treatments and simple restorative as a benefit to reduce costs on the medical side around these conditions. At minimum, we believe that the state should cover a periodontal benefit for adults. Many chronic health-related conditions among adults are linked to periodontal disease, and covering such services would result in cost savings for the Medicaid program overall.
- To reduce the immediate and long-term costs of Emergency Department (ED) use for non-urgent dental care, the state should ensure that its DBA has comprehensive and proven programs in place to prevent this costly practice and to direct enrollees to care in an appropriate dental setting.
- The state should consider providing the dental plans with access to pharmacy data so those plans can put in place programs to manage and educate dental providers in the use (or misuse) of opioids.
- The state should ensure that any dental plan has a robust Fraud, Waste and Abuse program, along with a team that is familiar with – and has established working relations with – appropriate Florida agencies and departments in order to curtail improper use of Medicaid funds. Plans should have the capacity to use both established and new technology, such as Artificial Intelligence (AI) to seek out fraudulent behavior.
- Plans should have a constructive working relationship with the Florida Dental Association (FDA). Without communication and support from the FDA, dental plans will have difficulties building networks and operating in and throughout the state.