May 30, 2023

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Imagine Orthodontic Studio
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Re: Response to AHCA Request for Information (RFI) 014-22/23

Dear AHCA / Trey Collins, Chief, Purchasing and Contract Administration:

We thank you for the opportunity to provide direct feedback and input regarding Florida's Medicaid Prepaid Dental Program – specifically as it relates to our area of expertise, the delivery of orthodontic services.

As a specialty practice accepting Florida Medicaid plans, and having provided orthodontic services for a significant segment of eligible Medicaid patients around our existing offices in Lakeland, Tampa, St. Petersburg, and Largo since our establishment in late 2020, we believe we can provide valuable knowledge and insight into best practices and improvements in the business model and service delivery for orthodontic services.

Included on the next page is a concise listing of suggested opportunities for evaluation, of which we would be happy to expand upon in a future discussion, as well as provide additional evidence or information based on our specific practice metrics / statistics to validate initial suggestions.

Should you have any questions or would like to further discuss any suggestions provided, please do not hesitate to contact me directly at the signature below.

Sincerely,

Sam Patel, Founder / Owner
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IMAGINE
ORTHODONTIC STUDIO

1. **Operational Strategies:**
    a. Improved Reimbursement Basis for More Complex Orthodontic Cases
        - At current rates, the reimbursement basis for complex orthodontic cases makes it extremely difficult for providers to provide comprehensive and high quality care for a demographic that typically has severe orthodontic conditions.
        - The limitation, or exceedingly high requirements for comprehensive Phase 1 and 2 treatments, puts orthodontic providers in an ethical dilemma of having to either start treatment (Phase 1) under the notion that the comprehensive (the following Phase 2) treatment would not be reimbursed due to reimbursement maximum limits, or delay treatment potentially exacerbating the existing conditions until Phase 2 timing is appropriate.
        - A more comprehensive viewpoint of orthodontic treatment and its required timeline, that is clearly outlined in an updated policy, would allow providers to more accurately and effectively treat Medicaid patients without a predisposition of concern on affordability.

    b. Re-inclusion of Impactions as a Criteria for Medicaid Orthodontic Treatment
        - Canine impactions account for a majority of the children's conditions that severely affect their self-esteem and ability to smile with confidence
        - Spaces caused by impactions can lead to some speech issues, future decay of permanent teeth, possible gum infections and may severely affect a child's quality of life

2. **Performance Metrics:**
    a. Enhanced Visibility into the Accessibility and Utilization of Orthodontic Services
        - As a Medicaid service provider, the sharing and utilization of de-identified patient information regarding underserved pockets of Medicaid eligible patients and their utilization of orthodontic services would bring greater awareness and understanding into how to better serve this population.
        - Current data and analytics are not readily available, and in turn does not allow providers to accurately establish open access to care where the greatest need exists.
        - Additionally, the sharing of such data would allow two-way communication and feedback with AHCA, plans, and providers to explore additional opportunities to broaden access to care, better serve populations acute needs, and trend geographic areas of gaps in coverage.

3. **Provider Network Requirements:**
    a. Greater Coordination and Facilitation of Transfers between Plan Providers

- A greater coordination in the facilitation of transfer patients between existing Medicaid plan providers would significantly unburden the administrative difficulties experienced by the provider.
- Due to a lack of clear process and policy requirements, plan transfer patients experience uncertainty in payment and coordination of care, ultimately relying on the provider to facilitate much of the process and resubmit in-process treatment of reimbursement by the new plan.
- In doing so, the patient and provider is then left without assurances that the original approval and contract will be honored by the new plan, and uncertainty in if treatment can continue or must be terminated due to denial by the new plan.

4. Best Practices for Maximizing Communication and Resources:

a. <u>Re-evaluation of the Required Appointment Frequency / Cadence</u>

- With the rapid advancement of technology, and the improved techniques to treat orthodontic conditions, comes a need to re-evaluate the traditional approach to patient monitoring and frequency of visits.
- The improvement in bracket and wire technology now allows orthodontists to confidently treat patients without the need for the current 21-28 day or monthly cadence of visits.
- A more accurate timeframe, as already practiced and proven on non-Medicaid patients with similar conditions, is a 6-8 week cadence of routine visits.
- This change would allow greater compliance and commitment by Medicaid patients to prioritize regular visits, by minimizing the increased need to take time off work, or pull their children out of school, to make more frequent, but not necessary, in-person visits.
- Providers should still be required to accommodate Medicaid patients on an emergency appointment basis; however, the decreased frequency of regular visits would alleviate the unnecessary burden of time, travel, and management on the patient and patient's parents to meet outdated policy requirements.

b. <u>Greater Flexibility in Timing of Provider Reimbursement</u>

- A common difficulty experienced in the treatment of Medicaid patients is the reimbursement schedule set by the Medicaid plan providers – which is portioned based on 3-week cadence of in-person visits within a 21-28 day time frame monthly.
- Due to this structure, providers experience significant difficulty receiving reimbursement due to lack of patient compliance on attending office visits.

- This structure also places undue hardship on the patients and their parents when they are attempting to keep all of their necessary appointments and simultaneously managing their work schedule and other family commitments
- The re-evaluation of the reimbursement schedule, with greater payments in a less frequent cadence, would create greater flexibility by providers to accommodate Medicaid patients in contrast to the continual filing and follow-up with plans, creating significant administrative burden, for reimbursement when patients do not show to their scheduled appointments.
- A proposed suggestion would be to follow the private insurance reimbursement schedule of paying in equal installments over 24-36 months in either monthly or quarterly payments, so long as the patient is still active in treatment

c. <u>Enhanced Linkage and Coordination Between Oral Surgery and Orthodontics</u>
   - For the existing Medicaid criteria, some of the more complex cases require oral surgery in conjunction with orthodontics for appropriate treatment. However, the direction for the patient is unclear in terms of finding providers and facilitation for each step in the process.
   - A greater importance, coordination, and facilitation between oral surgery providers and orthodontic providers through the AHCA and Medicaid plans would ensure greater accountability and treatment success for patients with those conditions.

d. <u>Improvement of Communication between the Trio of Managed Care Plans, Patients, and the Provider</u>
   - Denial explanations are not standardized, consistent, or clear for providers from Medicaid plans due to the ambiguity that exists in current policy
   - The bundling of orthodontic treatment is cited as the primary reason for denials; however, no clear guidelines or approved treatment outline has been created to guide providers in justifying the need for treatment based on the patient's specific conditions.
   - Patients are usually told the fault lies with the Provider, when their child’s treatment is denied (usually due to lack of evidence submitted)