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Turning Coverage Into Care: How Advocates Can Leverage Administrative Services Organization Contracts to Improve Medicaid Oral Health Benefits For Consumers

Often, our collective advocacy for better oral health care focuses on the threshold question of whether people do or do not have coverage for dental care. This is critically important, since health coverage is the foundation for ensuring that all people have access to quality, affordable care.

But that coverage works only if people know they are eligible for oral health care, have sufficient access to providers, and can efficiently and effectively use their benefits. Many state Medicaid programs contract with dental Administrative Service Organizations (ASOs), also called benefits managers, who have responsibilities in those areas. ASOs are often in charge of outreach to enrollees regarding oral health care, recruiting dental providers, and other functions that help people with Medicaid use their dental benefits. Therefore, the contracting process between the state and the ASO that administers Medicaid dental benefits is one important lever for making sure that coverage actually works as intended.

To make services more user-friendly, oral health advocates can make official comments on current and proposed ASO dental contracts. Weighing in on these contracts also pushes the state and an ASO to focus on and address inequities in oral health. These contracts are an important lever to promote policies and data collection that better support racial and ethnic minorities, rural and urban communities, and people in both institutional and community settings.

Advocates in California have been particularly active and engaged in this process. Below, we describe how advocates can get involved in ASO contracting, as well as some common types of contract provisions advocates can push for in the commenting process, using California as a case study.

How States Use ASOs in Medicaid Dental Programs

ASOs play an important role in administering benefits and informing the public about available oral health services.[1] While they do not provide services directly, as managed care plans do, ASOs can fill numerous other roles. States contract with ASOs to carry out tasks like educating Medicaid enrollees about their coverage and the importance of oral health care, helping enrollees find and use dental services, recruiting dental providers, or processing dental claims and approving treatments that require prior authorization. Many states that provide Medicaid dental benefits on a fee-for-service basis use ASOs.[2] Other states that deliver dental care through Medicaid managed care organizations also use ASOs for some administrative functions.

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How Consumer Organizations Can Get Involved in ASO Contracting

Advocacy to improve a contract often starts with raising a concern with the state Medicaid agency. For example, advocates may raise concerns about the need for better outreach to enrollees about their oral health coverage, or to notify the agency about problems that people with limited English proficiency face in getting dental services. In bringing such issues to the agency, advocates may learn that existing contracts do not hold ASOs sufficiently responsible for addressing these problems.

Advocates can always ask their Medicaid agencies, or the dental services chief within the agencies, when an ASO contract will next go out to bid. They can ask to review the provisions of the current contract and comment on provisions they would like to see strengthened, added or changed. In some states, obtaining contracts may require a public records act request, while in other states, contracts may be posted on public websites and readily available. Sometimes, states may issue a "request for information," formally seeking input on what to put into a contract, before they issue the request for proposals itself, which formally invites bidders. It is important for advocates to look out for these Requests for Information (RFIs), as they may be the only formal or informal way to engage (depending on the state).

Even if the state has not formally asked for comments, agency officials may reach out informally, particularly if the state has consumer or Medicaid enrollee advisory committees. Advocates should also feel free to communicate with agency officials, raise issues in advisory committees, and talk with legislative oversight committees about how they would like the duties of an ASO to be strengthened to better serve people needing oral health services.

Spotlight on California: Advocates Provide Example of Effective Engagement

In California, advocates have long raised concerns about continually low utilization rates for adult dental care, noting insufficient outreach to Medicaid enrollees and a lack of oral health providers among the causes. They contended that the ASO should do more to reach people whose primary language was not English and to help people schedule appointments, and that the state should hold the benefits manager accountable for this.[3]

To achieve these goals, advocates were involved in stakeholder meetings with the Dental Services Division of the Medicaid agency, and they were invited to comment on what should be in a new scope of work for an ASO. The organizations involved in this effort included the California Pan-Ethnic Health Network, Children Now, Justice in Aging, Maternal and Child

Health Access, the National Health Law Program, and the Western Center on Law and Poverty. These groups reviewed the existing scope of work and commented as the agency prepared to write a new request for proposals.[4]

Four months later, the agency issued a formal request for information, officially seeking input on some aspects of the forthcoming request for proposals for an ASO. Advocates reiterated their recommendations. As of this writing, California is still in the process of revising its Request for Proposals and upcoming contract for an ASO, but the fact that the state recently issued a Request for Information that reflected some of these concerns indicates that it is taking advocates' input seriously.[5]

Learning from California: Key Provisions to Look for and Comment on in ASO Contracts

There are numerous issues that advocates can raise in the ASO contracting processes. Many of them will depend on the state, the health system, and the dental coverage the state Medicaid program offers.

The provisions that California advocates raised concerning their state's contract are a good starting point for advocates in other states. By analyzing the existing contract and using their own knowledge of patients' problems, California advocates suggested contract improvements that fall in to several high level categories.

Improve enrollee support services, including outreach and communications:

ASOs are responsible for assisting enrollees in securing dental appointments, treatment and care. They do this through activities like furnishing provider directories, conducting broad outreach and making direct contact with enrollees and providers.

For example, ASOs are often responsible for sending a variety of mailings and notices to Medicaid enrollees. In the California ASO contract, advocates sought requirements to improve the readability of those notices or requirements to provide additional communication at key times. To encourage higher use of dental services, ASO contractors could be required to:

- Reach out to new enrollees, reach out to enrollees on their birthdays to remind them to schedule preventive oral health appointments, and reach out to enrollees who miss appointments.
- Send appointment reminders by text in an enrollee's primary language.
- Provide additional materials about dental services available to children that are part of Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements of Medicaid.

States could also determine performance metrics for the ASO to incorporate into the contract, such as the number of contacts per enrollee, the number of contacts that result in a dental visit, or meeting certain utilization targets.

Provide language access:

Given that ASOs are responsible for a wide variety of critical communications, contracts could ensure that enrollees receive information in their primary languages. There is a lot to learn from California advocates on this issue, since more than 44% of residents speak a primary language other than English.[6]

Advocates urged that the contract require the ASO to publish community outreach, educational, and written materials in all "threshold languages" — the languages that a certain number or percentage of Medicaid enrollees in a given service area speak.

They also noted that the ASO should provide telephonic interpretation in even more languages.

They recommended that the contract set standards for language access that could be monitored, including benchmarks for increasing telephone service center calls in languages other than English, standards for training and accreditation of interpreters, and clear lines of responsibility between the ASO and providers for coordinating interpretation services in dental offices.

The ASO might undertake some services directly and could be required to subcontract with a language broker or community-based organizations for other services.

Improve telephonic support services:

Practically all ASOs provide important services to enrollees by phone. California advocates raised a number of concerns related to their ASO's Telephonic Service Center. For example:

- Contract standards should limit hold times and require services in multiple languages. Best practice is to hold contractors accountable to a call abandonment rate (how often callers give up on waiting and hang up) of less than 3%.[7] And performance standards should assure that wait times are reasonable for everyone, including those requiring assistance in other languages or formats.
- States should consider extending hours of call center operation and call-back services during busy times, since many people who need services may be unable to make long calls during the work day.
- States and ASOs might consider adding educational messages when people are on hold about covered benefits and rights to care, second opinions, how to get care coordination services, etc.
- Contracts should also require alternative formats for these services and with assistive communications devices for people with disabilities.
- Contract can also ensure that phone service staff include multilingual personnel and that staff are trained in cultural humility, cultural and linguistic competency, and best practices for use of interpreters.

Enhance provider recruitment, particularly in areas with provider shortages:

California advocates also wanted to ensure that the ASOs would help recruit and train providers and make it easier for them to sign up, submit claims, schedule visits and get reimbursed. They recommended several topics for provider training, including cultural competency, language access, EPSDT, and other accessibility requirements. They also recommended contracts ensure that ASOs help with regular outreach to dental associations and dental schools and facilitate ease of provider relationships with the Medicaid program. And well-designed contracts could incentivize ASOs to target provider recruitment efforts in "dental deserts" – counties that have no or few dental providers. Of course, the state would also need to address Medicaid reimbursement rates to attract and retain providers outside the ASO contracting process.

Require current, accurate information about available providers: ASOs play a crucial role in informing Medicaid enrollees about where and how to find dental providers who will see them. As California advocates suggested in their comments, ASO contracts should require regular updates of provider lists and inclusion of information about provider's specialty areas, such as whether they specialize in pediatric dentistry or in serving people with developmental disabilities. Further, enrollees should be able to easily search for providers that speak their language.

Ensure proper handling of complaints and grievances:

California advocates urged that ASOs be required to clearly communicate to dissatisfied enrollees that they have a right to file grievances and request hearings. Contracts could also hold ASOs accountable by having them use data regarding complaints and grievances filed by enrollees to determine areas for improvement and topics on which ASOs will train providers and their own staff.

Define the ASO's role in billing and reimbursements: ASOs can help resolve problems with billing and reimbursements, and California advocates sought contract improvements to help ensure that they did so. For example, ASOs could be required to resolve problems with the provider, the patient and/or the state Medicaid office through three-way calls that ensure all parties are informed. ASOs could also be required to explain notices to patients and providers if the ASO denied, deferred or modified prior authorization for a treatment. The ASO should explain the denial and how it can be appealed to the patient and the provider.

Expand the ASO's role in care coordination: Advocates also encouraged California to consider how contracts shape the role ASOs might play in helping integrate oral health care with primary and behavioral health care. For example, contracts could require ASOs to provide training and outreach to primary care and behavioral health care providers on how important it is to screen patients for oral health needs and on the process of making referrals to oral health providers. ASOs could even take this one step further by assisting Medicaid enrollees with scheduling and obtaining transportation to oral health providers.

While these recommendations were inspired by California's contracting process, they are likely to come up in many states' ASO contracts. They are a great place to start, but advocates will also want to comment on any specific issues or types of expertise that their state needs additional support with. For example, **Washington state** wanted ASO staff to be trained in standards for culturally and linguistically appropriate health services and in Medicaid rules regarding American Indian and Native American providers.[8] **Colorado** sought input on ways to integrate primary care and dental care and serve high-risk populations. And the Colorado Dental Association requested that a contractor also support dentists with procedures for e-prescribing and translation services that might be unique to public programs.[9] Maryland included payment incentives in its ASO contract that reward the ASO for increasing general and specialty dental provider enrollment in targeted counties.[10] All of these are areas in which advocate input could further strengthen the final contract.

Conclusion

Clearly, ASOs play an important role in improving Medicaid enrollees' access to oral health care. Before a state solicits bids and finalizes a contract with an ASO, advocates should weigh in on provisions that will best help people learn about and use their oral health coverage. Advocates should also recommend provisions that are likely to help with provider recruitment and retention in communities that may be underserved.

California advocates' review of their state's contract is a strong example of some initial areas that advocates can examine and improve. As more advocates engage their states on ASO contracts, there will be additional ways to promote equitable, accessible services—and the need to elevate those best practices for other states. Building on California's example, oral health advocates are well positioned to make meaningful change for people who rely on Medicaid for their health care.

Endnotes

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