Managed Care Organization Dental FAQ for Providers

A. General information
   a. Why is the state moving from one Managed Care Organization to three?
      i. The Heritage Health Managed Care Organizations offer high quality health and dental plans that integrate primary care and dental care to positively impact patient health and healthcare savings.
   b. Can you explain the names of the managed care plans for the medical and dental side?
      i. Nebraska Total Care is the name of the Managed Care Organization, and their Dental Benefit Manager is Envolve
      ii. United Health Care is the name of the Managed Care Organization, and their Dental Benefit Manager is United Healthcare Dental
      iii. Molina is the Managed Care Organization, and their Dental Benefit Manager is Molina Dental
   c. How long are these companies going to be the Dental Medicaid Contractor?
      i. The current Medicaid contract starts 1/1/2024 and is for five years, with two additional one-year options the state can exercise at their discretion.
   d. I am a new dentist or dental team member. Where can I go to learn about Dental Medicaid and how it all works? How can I reach a provider representative?
      - UHC:
        - Provider Training go to dbp.com > Provider resources and support > UHC-On-Air, or click on the link below:
        - Provider resources and support | UnitedHealthcare Dental Provider Portal (dbp.com)https://www.nebraskatotalcare.com/newsroom/envolve-dental-webinars.html
      - NTC:
        - ProviderRelations@EnvolveHealth.com
        - 1-844-385-2192 (TTY 711) and follow the prompts.
      - Molina:
        - MDVSProviderServices@MolinaHealthcare.com
        - Phone: 844-862-4564 M-F 8am-5pm CST Fax: 855-297-3304 Hearing Impaired: 711
   e. How is network adequacy established and maintained?
      i. The Managed Care Organizations ensure adequacy by contracting to set Network Adequacy thresholds outlined in their contract with MLTC who monitors adherence to the access to care standards for the dental network.
   f. MCNA primarily used licensed Nebraska dentists to serve as claims reviewers and their dental directors. Can we expect the same from the new MCO's?
      i. Yes, each MCO will use licensed Nebraska Dentists
   g. How can a provider initiate change in services offered?

i. Each plan will have a Dental Quality Advisory Improvement Committee made up of NE dentists. The role of the Dental Quality Committee is to provide feedback and identify opportunities that can have a beneficial impact on dentists and patients. Note: some rules and services are determined at a program level and would require a state level change for Medicaid and all Managed Care Organizations.

B. Provider credentialing, choosing a plan, and accepting new patients.
   i. How do I go about getting credentialed? To request to be part of a Managed Care Organization's network please use the following contacts:
      - UHC: Please reach out to 800-822-5353, or email: ce_packetrequest@uhc.com
      - NTC: Please reach out to 727-437-1736, or email: Eileen.Fennelly@EnvolveHealth.com
      - Molina: Please reach out to 855-812-921, or email: credentialing@skygenUSA.com

   b. Can I sign up for one, two, or all three plans?
      i. We encourage providers sign up with all three plans, but you can select the plans you sign up with. However, if you do not sign up with a plan, you would be considered as an Out of Network provider for that plan.
   c. What if I do not have a DEA number?
      i. If you do not have a DEA number, a waiver will need to be completed during the credentialing process.
   d. Are contracts with each Managed Care Organization able to be amended?
      i. You can have contract language negotiations with your MCO contract liaison.
   e. Will contracting with each MCO open our office to more than just Medicaid insured patients?
      i. You can either sign a Medicaid only Dental provider contract with each MCO or a multi-product Dental contract with each MCO. The MCO's contract and own their own dental networks and none of the MCO's lease a dental network.
   f. Am I able to terminate my contract with the Managed Care Organization?
      i. Each MCO contract will include termination language.
   g. We are hidden now in the MCNA directory as we do want to see new patients but continue caring for whom we have. Can we choose this as well with the new plans…. both to not accept new patients and to be removed from directory?
      i. While we would like all providers to see Medicaid patients and be visible you do have the opportunity to identify you as a participating provider with a closed panel, as well as select suppression from the MCO's Find a Provider tool.
   h. Can you be an out of network provider?
      i. Yes, however if you choose to be an out of network provider you will be subject to those provisions of that status, including submission of prior authorization requests for all services for Medicaid members in which you are out of network for. Out of Network providers outside of the Transition of Care period may be subject to lower rates. Note: Providers must be enrolled in Medicaid for the service provided, ordered, referred, or rendered to be coverable.
   i. Credentialing is cumbersome when my practice has multiple providers and works in multiple clinical settings. Do you foresee this being streamlined?

i. Yes, all MCO's are collaborating to select and use a Centralized Credentialing Vendor beginning in 2025. Until then, credentialing is required with each MCO, however we all use CAQH to try to streamline the credentialing process for providers. All MCO's also require a W9 and roster.

j. I am worried if I take new patients I will be inundated with calls. Can I decide whom I will accept (such as patients from my county only)?
   i. You can manage your business as you see fit if you do not discriminate against an individual solely based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition.

k. What if I only want to be a Medicaid provider and do limited treatment? For example, I would be willing to see emergency patients and extract teeth.
   i. All MCO's would rather have you in network and providing services to Medicaid members in some capacity than delivering no Medicaid services.

C. Patient (member) eligibility and sign-up
   a. How do patients sign up for one of the three plans? Can the patient choose their plan?
      i. The patients can select their health plan when they enroll for the first time and during their annual open enrollment period. The state's member enrollment broker is Automated Health Systems and their website for support is: https://www.neheritagehealth.com/
   b. Are there different coverage tiers for patients?
      i. No, all beneficiaries receive the same physical, mental health and dental benefits.
   c. When is the open enrollment period for Medicaid recipients?
      i. Open enrollment for members is November 1st through December 15th annually.
   d. What type of ID number will the patient have?
      i. Members will have a Medicaid ID number and Medicaid ID card as well as an ID Card and ID number from their Managed Care Organization. Please note you do not need to be the Dental Home identified on a member's ID card to provide them dental care and be reimbursed for those services. No referrals are needed.
   e. Will each patient have their own member card?
      i. Yes, each member will have a Medicaid ID card and an ID Card from their Managed Care Organization.
   f. What if the patient does not have their card. Is there another way to verify eligibility?
      i. Yes, you can verify member eligibility through the state Nebraska Medicaid Eligibility System (NMES). https://dhhs.ne.gov/Pages/Medicaid-Provider-Client-Eligibility-Verification.aspx
   g. Do all members of the same family have the same plan?
      i. Often, yes; but not in every situation. Please verify plan eligibility
   h. If a patient already has an assigned medical plan for Medicaid, does it automatically enroll them in the dental plan?
      i. Yes, their Dental Benefit Plan follows their medical health plan.
   i. How often do providers need to check eligibility?
      i. We encourage monthly and certainly prior to each scheduled appointment.

D. Covered services, limits, and access to care.
   a. To confirm, each MCO will issue their own payments?
      i. Yes, each MCO will be the claims payor for services provided to their members.
   b. I was told the adult maximum annual limit of $750 will be eliminated. Is that true?

i. Yes, per Nebraska Medicaid the adult benefit max is being eliminated in 2024 once CMS has approved the State Plan Amendment.

c. It is very inefficient to extract one wisdom tooth at a time when you know the patient will be back to have the others done. Will this change?
   i. Yes, you can now do all of them at once in 2024 when CMS has approved the State Plan Amendment.

d. Will there be access to a list of other specialists in network? What if I cannot find one to take my Medicaid patient?
   i. Yes, we will have specialists available in our Find a Provider tools and if there are issues identifying a provider, members can call Member services to assist with identifying a provider and arranging for transportation.

e. Will you have a provider handbook?
   i. Yes, it will be posted to the MCO's dental provider websites once approved by Nebraska Medicaid

f. Will all plans reimburse public health hygienists?
   i. Plans will reimburse public health hygienists in line with Nebraska Medicaid guidance. Nebraska Medicaid is currently in the process of updating regulatory guidance on public health hygienists and once that is issued all MCO's will align.
   ii. Please verify with the Dental Benefit Manager related to Public Health Hygienist credentialing requirements.

E. Billing

a. Is billing for hospital visits allowed?
   i. Yes

b. What is the filing limit for a claim?
   i. Please consult your provider contract and provider manual for timely filing guidance

c. How soon after a claim is submitted should we expect to get paid?
   i. MCO's work to pay 90% of claims within fifteen business days per contract.

d. Will we be able to submit things electronically?
   i. Yes, authorizations and claims may be able to be submitted electronically either via the provider portal or clearinghouse.

e. If I have a question regarding claims whom should I contact?
   i. Please contact your MCO's Dental Provider relations team:
      - UHC:
        - Karen_Vincent@UHC.Com; Jackie_Ayala-Collins@UHC.com; Mary_Divis@UHC.com
        - Phone: 855-806-5192 M-F 7am-8pm CST (Available 01/01/2024) Hearing Impaired: 711
      - NTC:
        - ProviderRelations@EnvolveHealth.com
        - 1-844-385-2192 (TTY 711) and follow the prompts.
      - Molina:
        - MDVSProviderServices@MolinaHealthcare.com
        - Phone: 844-862-4564 M-F 8am-5pm CST Fax: 855-297-3304 Hearing Impaired: 711

f. Will tribes and FQHC's still bill per encounter as we do now?
    i. Yes, Tribal Providers and FQHC's will bill and be reimbursed at their encounter rates.
g. If we accept Medicaid and Medicare, who is primary?
    i. Medicare is primary and Medicaid is secondary to Medicare.
h. If a patient has private insurance and Medicaid, how does that work?
    i. You would bill the private insurance as primary and Medicaid as secondary. Medicaid is always the payor of last resort.
i. Do you have to provide the Medicaid ID number for each provider?
    i. No, that is not required on the claim.
j. Will there be a different EDI payer?
    i. Each MCO has their own EDI payor ID # that can be accessed in our presentations from our webinars and in our Provider Manuals
k. What if a prior authorization was approved by MCNA?
    i. Per the continuity of care elements of the Managed Care Organizations contract the new dental benefit managers for each Managed Care Organization will receive, process and honor prior authorizations for dental services that were approved by MCNA for dates of service from 1/1/2024 forward.
l. What is the turnaround time for a PA?
    i. 72 hours for urgent requests and 14 days for standard in line with NCQA guidelines
m. How accessible are EOBs?
    i. EOBs are sent directly to providers via electronic transactions or available on the provider portals. If you receive a paper check, you will receive your EOB with the paper check.
n. Many commercial plans make my staff be on hold for a long time. What can we expect from the new plans?
    i. We have contractual service agreements to answer 90% of calls within 30 seconds.
o. The fees are incredibly low. How do the plans evaluate the fees set by MLTC?
    i. The plans utilize the Nebraska Medicaid Fee Schedule as the basis for coverage and rates that must be paid at minimum. Please discuss any fee schedule concerns with your contract liaison directly.

F. Audits
a. Why are audits needed? Should I be worried if I receive an audit request?
b. Medicaid programs are required to ensure claims are processed correctly and that Medicaid dollars are used appropriately. Please refer to: Provider Participation and Audit regulations. How often do you audit?
    i. MCO's audit in line and in coordination with MLTC program integrity to contract requirements and internal Fraud, Waste and Abuse policies.