RICHARD J. DURBIN
ILLINOIS
MAJORITY WHIP

United States Senate
WASHINGTON, DC 20510-1304

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY
COMMITTEE ON APPROPRIATIONS
COMMITTEE ON THE JUDICIARY

November 15, 2023

Steve Pollock
President
DentaQuest
96 Worcester Street
Wellesley Hills, MA 02481

Dear Mr. Pollock:

I write today regarding significant challenges that oral health providers are facing in their engagements with Medicaid managed care organizations (MCOs) in Illinois, which is hampering patient access to this essential health care. In particular, my office has been made aware of certain practices that appear troubling and result in arbitrary or unnecessary barriers for oral health care providers in Illinois, particularly those treating children, people with disabilities, and low-income patients.

First, my office has been made aware of extensive delays that oral health providers face in obtaining credentialing with MCOs. After obtaining state licensure, dentists in Illinois who want to treat Medicaid patients must enroll with the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) program run by the Illinois Department of Healthcare and Family Services (HFS), which can take months on its own. But upon completion of that IMPACT step, prospective Medicaid providers are then forced to wait several *additional* months—compared to the timeline with PPO plans—before becoming fully enrolled and credentialed Medicaid providers. For newly graduated dentists facing significant student loan burdens, there is an economic need to begin seeing patients immediately, yet they are facing senseless added delays —even beyond licensure and state Medicaid enrollment. Long wait times to begin seeing Medicaid patients that are aggravated by MCO policies could discourage these providers from working in a federally qualified health center or other population health setting. Further, for dentists who have not accepted Medicaid within their private practices, such long wait times discourage their enrollment.

Second, oral health providers have shared instances of arbitrary restrictions on the time of care that MCOs would reimburse for their services. For example, anesthesia services for complex pediatric cases often require several specialized staff and implicate patients with special needs or behavioral challenges, and require multiple services and surgical intervention. These services often require two and a half hours (10 increments of 15-minutes) of anesthesia or more, yet data from more than 100 cases at a single provider indicate that MCOs in Illinois are capping reimbursement at significantly shorter increments of anesthesia. Oral health care providers across the state have told me that their waitlists to receive this treatment can be more than 12 months. An apparent practice of MCOs not reimbursing for the full amount of medically necessary services rendered jeopardizes access to care for this vulnerable population.

Third, and this is not unique to oral health benefits, providers have reported extensive delays in obtaining reimbursement and arbitrary rejections of qualified, legitimate claims—necessitating extensive staff time for appeal. Several studies have shown that these administrative burdens contribute to lost revenues, discourage providers form accepting Medicaid, and pull them away from their primary focus: providing essential treatment to low-income Americans.

These challenges and dynamics exacerbate the access to care and workforce problems that stem from the low Illinois Medicaid reimbursement rates for oral health services. In Illinois, only 37 percent of children covered by Medicaid actually have a dental visit in a given year. And one recent study found that privately insured children in Illinois had six times greater odds of obtaining an appointment than children in Illinois who are enrolled in Medicaid. That is unacceptable, and worsens health outcomes.

If oral health providers—already facing challenging reimbursement rates—are forced to jump through burdensome, unjustified bureaucratic hurdles to furnish care and obtain timely reimbursement, patients suffer.

Given the shared federal-state responsibility for the Medicaid program, I request data and responses to the following questions from you by December 8, 2023.

1. How many general dentists and dental specialists (e.g., endodontists, oral surgeons, orthodontists, pediatric dentists, and periodontists) in Illinois are enrolled as providers with your company?
2. How many of those dentists submit more than 50 claims to your company in a given year?
3. What steps must a state-licensed, and IMPACT-enrolled, dentist go through with your company to be credentialed to begin billing?
4. Why do these steps take significantly longer than dentists report it takes with other commercial insurers?
5. Why are these lengthy steps required if your company can already verify a dentist's licensure and Medicaid qualifications?
6. How will your company reduce these barriers to enrollment for dentists?
7. What is your average timeline between a claim being submitted by a dental provider in Illinois and the remittance of an approved payment?
8. What is the average timeline between a claim being submitted by a dental provider in Illinois and the denial of a payment?
9. What is your average denial rate for claims submitted by a dental provider in Illinois?
10. How does your company decide which procedures will be subject to prior authorization?
11. Does your company have a policy of imposing prior authorization on anesthesia care for pediatric patients and patients with special needs during oral health procedures?
12. Does your company have a policy of restricting or limiting the number of anesthesia-related increments covered or reimbursed for dental surgery-related procedures? If so, please provide the medical review team's justification for such policy.

13. How does your company process and reimburse dental procedures that cannot be foreseen, or treatment planned in real-time situations, such as during complex surgery?
14. What is your company's procedure when referring patients to a PPO or out-of-network provider when necessary for case management of a complex condition?
15. Please provide the claims data for each claim submitted to your company for anesthesia increments related to dental procedures for pediatric patients and patients with special needs between 2018-2022, broken down by year and provider/institution (which can be anonymized). For each claim provided, please include the number of increments billed for, and the number ultimately reimbursed for, along with any additional explanatory materials.
16. What is the time limitation for your company to receive claim submissions?
17. Please explain in detail your appeals process for claim denials. In the case of a claim for service furnished by a specialist, is the appeal reviewed by a provider with the same specialty and degree of expertise?
18. What data and reports are provided to Illinois HFS from your company? What is the frequency of such report transmittals, and are they sent automatically or only upon request from HFS?

Thank you for your attention to this important matter. I look forward to reviewing your responses.

Sincerely,

Richard J. Durbin
United States Senator