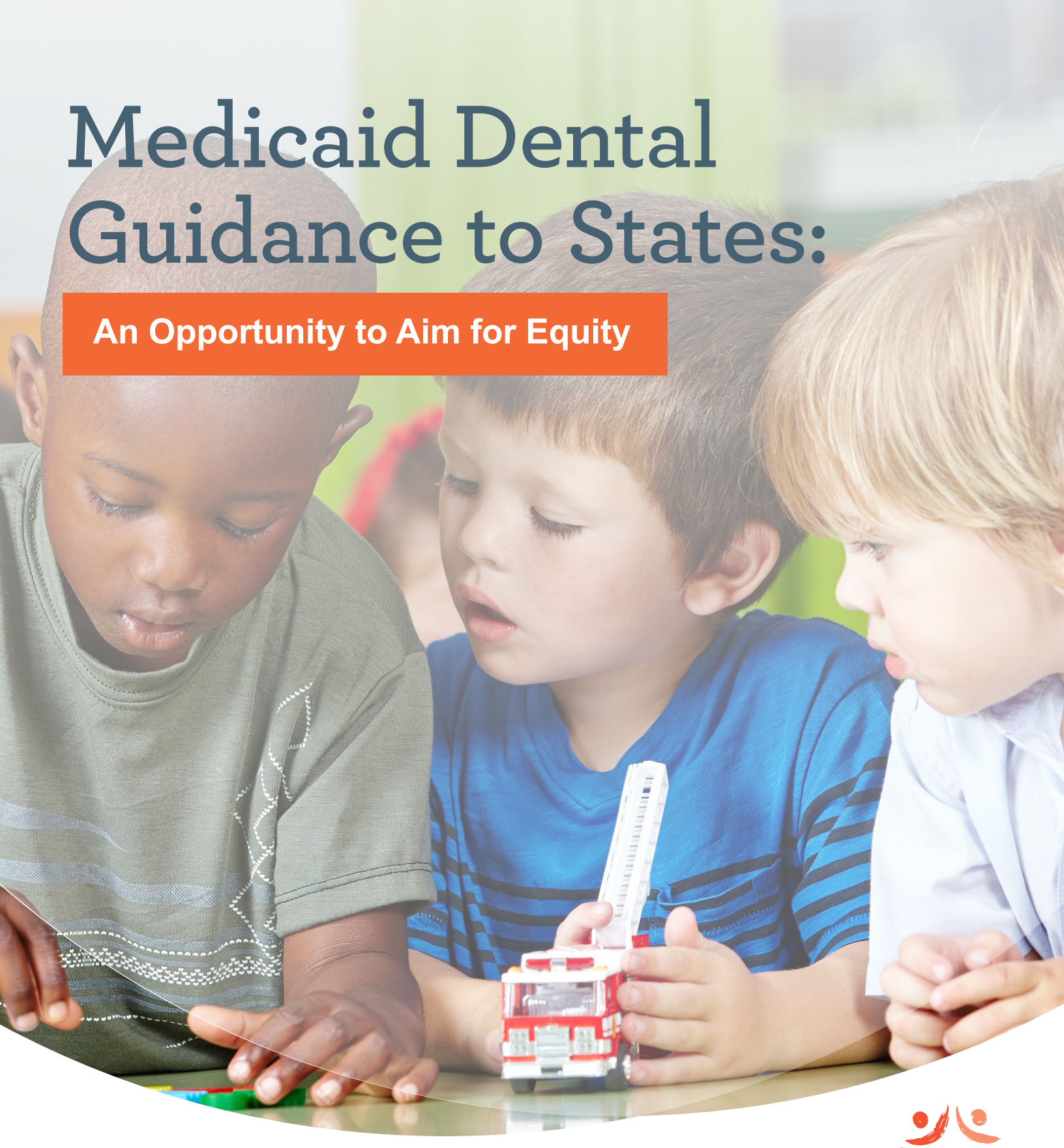
# Medicaid Dental Guidance to States:

## An Opportunity to Aim for Equity



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A report by the Children's Dental Health Project

children's dental health project

Income, race, and geography should not determine whether children grow up healthy. For more than 50 years, Medicaid has offered low-wage families a path to better health. Yet coverage alone is not enough. Fulfilling Medicaid's promise means recognizing that kids need medical and dental care that is personalized to be healthy and active.

The Children's Dental Health Project,a Washington D.C.-based policy organization, produced this report to help state-level advocates seize the opportunity provided by a federal Medicaid bulletin that clarifies the intent of the law.

# Background

In May 2018, the Centers for Medicare & Medicaid Services (CMS) issued an informational bulletin (IB) called *Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs.* It clarifies current policy and encourages state Medicaid and Children's Health Insurance Program (CHIP) agencies to ensure their coverage and payment policies do not unnecessarily impede children's ability to receive appropriate dental services.

For years, the Children's Dental Health Project (CDHP) has called for aligning Medicaid/CHIP periodicity and payment policies with existing clinical guidelines. Doing so is an important step to shift toward an oral health system that recognizes and addresses children's individual risks for dental disease.

While the IB does not establish any new federal policy, state advocates and policymakers should recognize how CMS' recommendations could be the catalyst for strategies that better prevent and manage tooth decay for vulnerable children. The agency's guidance could make state Medicaid and CHIP programs more responsive and accountable—advancing the goal of oral health equity.

## WHY THIS MATTERS

Dental caries, the disease that causes tooth decay, is a chronic condition. It is shaped by a range of factors like diet, family history, social determinants of health, and exposure to fluoride.[1] Consequently, children's oral health care should be tailored to each child's individual needs. Both Medicaid and CHIP are designed with this flexibility in mind.

In 2017, over 46 million children — or six in 10 kids nationwide — were enrolled in Medicaid and CHIP.[2,3] Children in low-wage families count on these programs as their primary source of coverage for medical and dental care.[4] Since their inception, Medicaid and CHIP were intended to provide children with all the care needed to treat acute conditions and prevent worsening disease. As the IB points out, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is "designed to assure that enrolled children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible." It further affirms that "EPSDT is important to the prevention and effective management of dental disease in children."[5] Similarly, states that provide CHIP coverage through a program separately from Medicaid are required by law to offer benefits that

> *"include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."*[6,7]

The IB was prompted by a 2016 report that found some state Medicaid agencies were falling short of meeting these federal standards. Released by the U.S. Department of Health and Human Services' Office of the Inspector General (OIG), the report examined four state programs. It "found that three out of four children did not receive all required dental services" outlined in the state's dental periodicity schedule. Periodicity schedules are baseline timetables of screenings, assessments, and preventive treatments recommended from infancy through adolescence that each state is required to establish.

Additionally, the OIG report found that state Medicaid dental periodicity schedules were often in conflict with what the coverage program or its managed care plans would actually pay for.[8] These findings underscore the need to align policies so that they facilitate — rather than inhibit — access to individualized oral health care.

The IB makes clear that the burden is on states to review their Medicaid and CHIP programs and update policies appropriately. In this regard, advocates have a crucial role to play. They can identify gaps in their Medicaid programs and use the IB to push state agencies and other stakeholders to better address the specific needs of all children.

*A report found that state Medicaid dental periodicity schedules often conflict with what the program actually pays for.*

# Opportunities

## MAJOR GOALS FOR POLICY CHANGE

The IB presents opportunities for state policy change at many points, including: Medicaid and CHIP administrators; insurers such as Managed Care Organizations (MCOs) and contracted dental plans; and information that is communicated to providers and patients. Advocates should seek to:

- Align periodicity schedules and payment policies
- Clarify and streamline provider-level policies and procedures for care that go beyond the periodicity schedule
- Ensure that states' and contractors' "medical necessity" and prior authorization policies do not obstruct individualized care
- Organize payments, contracts, and guidelines across state agencies, insurers, and providers to simplify the process of providing all necessary care for children appropriate to their individual risk-profile

## INDIVIDUALIZED CARE

Individualized care, or risk-based care, is a model that relies on a caries risk assessment to prevent or manage a child's dental disease by addressing underlying risk factors that may hasten the decay process. Professional guidelines from the American Academy of Pediatric Dentistry (AAPD), the American Dental Association (ADA), and the American Academy of Pediatrics (AAP) support shifting care paradigms to fit a child and their family's "risk profile".[9,10,11]

As with any chronic condition, individualized care in oral health means that each patient is assessed for their risk and a care plan is established to address their conditions and risk factors. A variety of determinants influence a child's oral health, such as nutrition, access to fluoridated water, and health behaviors. By using tools that assess these factors, a health practitioner can help patients prevent and manage dental disease with a care plan tailored to their challenges.[12] A plan might recommend more frequent visits to counsel families on oral health habits, and to apply fluoride varnish, other preventive therapies, or non-invasive caries treatments. Children with greater disease risk may obtain treatment plans that go further, such as receiving referrals to help families tackle challenges associated with social determinants, including housing, family trauma, or food insecurity.[13,14]

This shift in approach requires recognition that some children need more care than others. According to the IB, Medicaid and CHIP dental periodicity schedules "should be implemented as the 'floor' of coverage available for exams and preventive dental services, with additional services being covered based on each individual child's risk profile and health needs."[15] This statement echoes support for updating treatment guidelines but also indicates that current systems remain largely stuck in a one-size-fits-all paradigm for oral health care delivery.

## MEDICAL NECESSITY AND PRIOR AUTHORIZATION

### *Medical Necessity*

In addition to highlighting the disconnect between periodicity and payment schedules, the IB affirms that a periodicity schedule should be a baseline for a child's treatment. It points out that "while initial limits may be placed on coverage of a dental or oral health service, services must be covered if determined to be necessary to correct or ameliorate an individual child's condition." For example, providers are often required to get prior authorization for certain services or justify

### California's approach

*California's Dental Transformation Initiative is one example of how states can implement the IB's standard, demonstrating that periodicity schedules are the floor. The Denti-Cal program is now heavily influenced by an individualized approach to care, with many major projects that center on prevention strategies.*

*One pilot program is testing individualized prevention and disease management approaches to control early childhood caries in high-need counties. Another Denti-Cal project is advancing reimbursement for using silver diamine fluoride treatment to stop caries—the disease that causes cavities.*

*In addition, the program funds efforts that increase the use of preventive dental services and strengthen continuity of care for children.*[16]

that a specific protocol is "medically necessary," which can delay individualized care. Navigating such policies can vary significantly from state to state.

To determine the necessity of services on a case-by-case basis, states may develop their own definitions of "medical necessity" for Medicaid and CHIP programs, so long as they do not contradict federal mandates.[17] Regardless of the program, the Congressional intent of Medicaid and CHIP is to ensure that children receive all the oral health care necessary to prevent oral disease, avoid pain, and treat decay.[18] As public coverage has evolved, however, we have seen more discussion and concern over what is determined to be "medically necessary" and who may make that decision.[19]

Some Medicaid agencies and contractors interpret the medical necessity standard narrowly, making it tougher for dental or medical providers to get prior authorization for various services. This poses a key hurdle to achieving individualized care, especially preventive efforts for high-risk children. Although a girl with the early signs of tooth decay may not need a filling, she (or her family) may benefit from more visits with a provider, as well as other services—all of which could help to halt the disease process, but which may appear to extend beyond what is outlined in the state's periodicity schedule. Advocates should be aware of how the medical necessity standard can be interpreted in ways that obstruct or facilitate individualized care.

EPSDT is the child health benefit of Medicaid. This benefit, inserted and clarified through a series of amendments to the Social Security Act, creates national standards for screening Medicaid-enrolled children for various health issues. Emphasizing prevention, EPSDT includes its own medical necessity definition, requiring coverage of diagnosis and treatment of *any* conditions that may limit a child's growth and development.[20,21] By contrast to this nationwide benefit, CHIP programs vary from state to state. In states that combine Medicaid and CHIP programs, EPSDT standards apply to CHIP-covered children. However, these standards are not applicable in states that operate separate CHIP programs. In these states, benefits are modeled on private insurance

## DIFFERENT ROLES TO ENSURE THAT EACH MEDICAID-ENROLLED CHILD IS FREE OF DENTAL DISEASE

The May 2018 bulletin issued by the Centers for Medicare & Medicaid Services (CMS) encourages states to address children's oral health needs by aligning payment and care. Medicaid and CHIP periodicity schedules, which outline how frequently basic care should be provided, are meant to be the floor — not the ceiling.

***What roles can the following stakeholders play to advance this goal?***

**MEDICAID AGENCIES:** Set statewide policies, develop contracts with managed care organizations and ensure that all children receive medically-necessary, individualized care in accordance with federal policy

**MANAGED CARE ORGANIZATIONS AND OTHER PAYERS:** Incentivize providers to deliver individualized care, conduct outreach to patients, and adhere to state and federal policy

**PROVIDERS:** Utilize tools like risk assessment to determine individualized care plans, engage in care coordination and patient education

**FAMILY ADVOCATES:** Help parents/caregivers understand what care their children are able to get, especially if they are at higher risk for tooth decay

plans and may feature stricter limits on services such as orthodontics.[22] In these programs, states "may set the amount, duration, and scope limitations under their benchmark-equivalent plans and define the standard of medical necessity used to determine the extent of coverage."[23] The standards for separate CHIP programs are often less generous and less explicit than Medicaid's EPSDT definitions.

### *Prior Authorization*

States must clearly define Medicaid and CHIP benefits and set expectations for how contracted insurers administer those benefits, while upholding the programs' goals.[24,25] Minimum standards of care are outlined in periodicity schedules, and covered benefits are outlined in fee schedules. For services that go beyond the frequency or types of services outlined in those schedules, state programs require medical and dental providers to submit justification for prior authorization.

Yet the process for requesting prior authorization is not straightforward. Standards vary from state to state, and between public coverage programs. It can be complicated depending on how states communicate and enforce definitions of medical necessity and related burdens of proof. Insurers add further complexity to the process, as they make reimbursement decisions and disseminate branded materials to communicate state rules to providers in their networks.

Additionally, no national standard for medical necessity exists for dental care under these programs. As a result, provider manuals and other official documents sometimes lack clarity, posing a potential barrier to care. Examples from West Virginia and Connecticut illustrate the problem (*see box below*).

These differences are much more than semantics. By providing details and guidance, state agency definitions help providers decide on appropriate care. With this clarity, payers can determine and provide timely approval and payment.

To address the issues named in the IB, advocates may need to look at the methods by which dental procedures are classified as medically necessary, including documentation requirements. It may also be critical to examine protocols that determine prior authorization and reimbursement for services outside the periodicity schedule. Ultimately, there must be clarity across systems to ensure that children receive the care their dental and medical providers deem essential for their health.

The **West Virginia Medicaid Provider Manual** notes that prior authorization is based on a medical necessity review, but standards for such reviews aren't clearly articulated. The absence of specific guidelines may leave providers wondering whether seeking approval is worth the effort:

*"Medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry, the American Academy of Pediatrics (AAP), the American Dental Association (ADA), research based, nationally accredited medical appropriateness criteria OR other appropriate criteria approved by BMS. .... Prior authorization does not guarantee approval or payment."*[26]

By contrast, the **Connecticut Medicaid Dental Provider Manual** provides a detailed definition and clear expectations for prior authorizations:

*..."medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.*[27]

# Partners, Levers, and Conversations

## Confusion in Maine

Maine offers one example of how discrepancies between periodicity schedules and fee schedules (and inconsistencies within each set of guidelines) can cause confusion.

**Need for alignment:** Maine's "Recommendations for Preventive Pediatric Oral Health Care" mentions that regular caries risk assessments should be performed for children of all ages and "must be repeated regularly and frequently to maximize effectiveness."[32] Yet there is no mention of caries risk assessments in the most recent Dental Services Provider fee schedule, creating a lack of clarity for providers as well as payers.[33]

**Discrepancies within guidance:** The state Medicaid program seems to value caries risk assessments and their potential for improving preventive services. In fact, the program developed a code for reimbursing *medical* professionals who perform caries risk assessments for young children and who do an associated fluoride varnish application during a follow-up visit.[34] But gaps lie even within this fee schedule: it lacks similar codes to perform oral health risk assessments on children over age 3, and it excludes a code for dental professionals to provide this service.

## I. MEDICAID/CHIP PROGRAMS AND ADMINISTRATORS

State Medicaid and CHIP programs have the greatest leverage in implementing change in response to the IB. State agencies:

- determine periodicity schedules and set payment policies
- oversee how those standards are communicated to insurers, providers, and families
- develop contracting agreements and audit the performance of insurers and providers

Reform should begin with assessing whether state periodicity schedules and provider fee schedules are aligned. Equally important, advocates should conduct a review of schedules and policies to uncover any potential barriers to providing individualized care to higher-risk children. The periodicity schedule, fee schedule and provider manual should be consistent regarding covered services, their minimum frequency, and reimbursement levels. This review should also consider changes necessary to accurately update online materials or other publicly available documents. For example, New Jersey's periodicity schedule explicitly includes periodic caries risk assessments[28] as expected with any child's oral evaluation by a dental professional. These assessments are listed in documents for parents and providers, but are not in the associated fee schedule.[29]

To complement these policy updates, advocates should urge state agencies to prioritize alignment, individualized care, and prevention when agencies manage contracts, conduct audits with MCOs or other payers, and perform provider oversight. For example, state contracts should reward practices that address individualized care and management of oral disease over the more expensive, invasive treatment of decay, such as care in a hospital operating room. States are required to develop mechanisms to identify and investigate insurers, managed care organizations, and subcontractors for potential fraud or abuse.[30] As with contracts, audit expectations should support prevention-focused efforts, rather than punishing well-intentioned dental providers for delivering more care to children with higher risk of disease.[31]

Medicaid and CHIP programs should have procedures to communicate periodicity and payment policy updates or clarifications in a timely manner to payers and providers. States should also have clear expectations for payers to update their internal protocols in compliance with new state directives. Moreover, states should set guidelines and enforcement policies for this payer-to-provider communication, such as requiring:

- a communications plan from payers
- confirmation that providers have received information on policy changes
- updates to be automatically included in reporting and payment systems
- the incorporation of policy updates in state contract and audit expectations

Importantly, state administrators oversee the process by which providers receive prior authorization from payers for care exceeding the state periodicity schedule. A lack of clarity or overly complicated processes may create a disincentive for dental practitioners to provide children with such care. Maine's guidance is one example of this problem (*see the sidebar*). Since definitions of medical necessity may vary by state, state agencies should be the source of direction and surveillance of these policies.

## The role of MCOs and other contractors

Nearly two-thirds of Medicaid beneficiaries are covered through a Managed Care Organization (MCO). Similarly, as of April 2017, 30 states provided coverage in separate CHIP programs through managed care models.[37] MCOs are organizations which take on responsibility for the comprehensive care needs of a patient; in exchange, MCOs receive a monthly payment by the state per patient. Most MCOs include coverage of pediatric dental services.[38] States may also contract with similar organizations, like prepaid ambulatory health plans, in which a plan receives payments for specific types of care, like behavioral health or dental care.[39]

Even in states with MCOs, they may exempt certain patients or categories of services (such as dental) from managed care arrangements.

Further complicating this scenario, all these types of care organizations can contract services out to other insurers. In a national survey, the vast majority of plans (93 percent) reported making fee-for-service payments to at least some providers.[40]

Medicaid and CHIP administrators also negotiate payers' contract requirements. Through such agreements, state agencies can set expectations of dental service providers. Unless contracts explicitly set standards for individualized care, payers and providers may be incentivized to cut costs by focusing on highly rigid, generic care protocols, rather than delivering more robust care to children with greater needs. This oversight should include reviewing provider manuals, instituting targeted audits, and establishing performance measures. Dental professional groups like the ADA even recommend that states craft contractual requirements that clarify provider policies, including medical necessity definitions and maintaining easily-understood provider manuals. In addition, when establishing measures of utilization and quality, the ADA encourages the development of contracts that consider children with greater dental needs.[35]

These efforts need not occur in a vacuum. Nor do they require a sudden influx of unique resources. States can incorporate the work of addressing alignment and access challenges in other Medicaid reform efforts. Using federal Quality Assessment and Performance Improvement regulations for this task serves as one example. Under such rules, states are required to develop strategies that not only improve the quality of managed care services but also address health care access and outcomes. In 2013, CMS began providing guidance for states to expand these efforts beyond MCOs and across state Medicaid programs.[36] States can also translate the IB's messages into federally mandated Performance Improvement Projects (PIPs), new state Requests for Proposals (RFPs), quality reviews, and other activities.

## II. MEDICAID AND CHIP CONTRACTED PAYERS

States may choose to offer Medicaid/CHIP dental coverage through a variety of arrangements. Regardless of the contracting arrangement under which dental benefits are administered, payers and states both have a vested interest in achieving the most efficient approaches to care delivery. Additionally, both have a responsibility to ensure that each child receives appropriate care. The IB should prompt payers to review their policies for periodicity and payment alignment, while focusing resources on prevention and effective management of dental disease.

Payers send direct and indirect messages to providers about how to "appropriately" provide care. Payer-branded provider manuals and other instructional materials for contracted providers communicate how services can and should be delivered if providers want prompt reimbursement. These materials should be clear when it comes to medical necessity, prior authorization, and payment. Without clarity, providers might be disincentivized from delivering necessary care.
Medicaid/CHIP contractors should also communicate the contents of the IB directly with providers on their panels. These messages should highlight any associated policy and/or payment changes, such as new protocols for providing care beyond the periodicity schedule or incentives for preventive procedures that should be repeated for higher-risk children.

To compliment these efforts, payers should seek ways to streamline or even automate prior authorization and payment systems for children with higher needs. For example, Northeast Delta Dental, in partnership with Previser (developers of an electronic risk assessment tool), has implemented a computerized approval mechanism allowing providers to easily submit risk assessments and other clinical findings electronically in order to receive same-day approval of medically necessary services.[41] These efforts reduce provider burden and eliminate unnecessary delays in care.

Payers can also incorporate provider-level policy changes into their required quality improvement activities. Federal regulation dictates that states include a requirement to conduct Performance Improvement Projects (PIPs) in their contracts with MCOs and prepaid inpatient health plans. PIPs are experimental projects aimed at clinical and non-clinical aspects of care "to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction."[42] States have the option to extend PIP requirements to other types of contracted plans. These plans include dental maintenance organizations or prepaid ambulatory health plans that provide carved-out or limited services, such as those providing only dental services.[43] Such activities may serve as an opportunity for payers to customize their approach to these directives while still updating their provider protocols for individualized care.

## III. PROVIDERS AND PROFESSIONAL ORGANIZATIONS

Providers themselves play one of the most important roles in achieving the objectives of the Medicaid and CHIP programs. They would most directly benefit from alignment of state payment and periodicity policies.

Organized dentistry has voiced concerns that Medicaid and CHIP programs discourage them from providing the most appropriate care to children with the greatest oral health challenges. When policies are misaligned or unclear, providers face significant hurdles to addressing their needs, which may be complex. Providers' concerns often center on an increased administrative burden and the risk that care they provide may not be reimbursed. Offering "too much" follow-up care, providers worry, could open them up to extra audits.[44]

The IB explicitly calls for the provision of programmatic supports to follow through on care plans prescribed by dental professionals:

> *While the periodicity schedule is a generalized recommendation, it can be beneficial to develop individualized care plans for children since the risk of developing dental caries and the severity of the disease can vary across children. These plans may involve caries risk assessments, exams, and preventive dental services such as fluoride treatments at more frequent intervals than what is specified in the coverage policy or the periodicity schedule. While initial limits may be placed on coverage of a dental or oral health service, services must be covered if determined to be necessary to correct or ameliorate an individual child's condition.*[45]

Being that their day-to-day practice would be so directly impacted, dental professional organizations should join state-level conversations. They could advocate for reimbursement and tracking of caries risk assessments, the development of streamlined protocols for providers to submit reimbursement, and for clarifications to provider manuals. California's Dental Transformation Initiative shows the potential of such advocacy. The California Dental Association played an integral role in designing and implementing the

*When policies are unclear, providers' concerns often center on administrative burdens and the risk that care they provide may not be reimbursed.*

initiative. Both children and dental professionals have benefited, thanks to:

- increased reimbursement rates for risk assessments and evidence-based care models
- automatic enrollment of dental practices into the program
- new care protocols that are informed by science, like increased frequency of follow-up for higher-risk children, and
- targeted funding for alternative programs in high-need populations and areas [46,47]

Advocates should engage Medicaid/CHIP-participating medical and dental providers to identify their perceived barriers to delivering individualized oral health care. Beyond providers' frustration with the misalignment of payment and periodicity policies, a number of other factors may need to be addressed to facilitate individualized care at the provider level, including:

- scrutiny of treatment recommendations that go beyond the periodicity schedule
- confusion about guidance in provider manuals or other communications
- uncertainty about interpretations of state or federal guidance

Seeking to understand the full scope of their concerns will engage professional organizations as partners, an asset in change-making. Further, such an effort will inform gaps in the landscape of current state programs to help guide continued advocacy to improve care.

## IV. BENEFICIARY FAMILIES AND CHILDREN

Families are a valuable stakeholder in efforts to improve children's oral health. State programs, payers, and providers should all be communicating to parents and children, in plain language and a timely manner, about what care they may need and are entitled to.

Engaging families will directly impact the care and health of individual children and could also identify other obstacles to be addressed. Parents should feel empowered to follow up with their medical and dental providers about what care is necessary for their children to get better and stay healthy — and to make sure they're receiving services without delays.

**DON'T MISS:**

A Checklist for Advocates:

**IMPROVING CHILDREN'S ORAL HEALTH CARE IN MEDICAID/CHIP**

**ON P. 12.**

# Conclusion

Nearly all state Medicaid programs pose obstacles to individualized care. For too long, the oral health care system has used a one-size-fits-all approach to care. This ignores the reality that some children need more frequent and more intensive care than their peers. To support the most effective and efficient management of dental disease, Medicaid and CHIP programs must align care delivery and payment with existing clinical guidelines in ways that facilitate an individualized approach to care. Indeed, this not only reflects policymakers' continued focus on increasing the value and impact of health care programs—it is what Congress intended when it created child-specific benefits.

In order to achieve this vision, advocates will need to examine state health care programs and regulations, as well as understand the unique concerns of all stakeholders. This work will likely include clarifying contracts and guidance language, altering reimbursement models to incentivize more appropriate care, and setting explicit expectations for all stakeholders.

On their face, many of these changes may seem small. However, in issuing this IB, CMS has communicated that longstanding federal policy requires that nearly all state agencies significantly shift how they carry out their responsibility under the law. By making this shift, state Medicaid and CHIP programs can achieve crucial progress in addressing the oral health needs of millions of children.

# A Checklist for Advocates:

## IMPROVING CHILDREN'S ORAL HEALTH CARE IN MEDICAID/CHIP

**BACKGROUND:** This checklist helps state-level advocates identify and address barriers to individualized oral health care by citing the May 2018 CMS Informational Bulletin. This bulletin encourages state Medicaid and Children's Health Insurance Program (CHIP) programs to align their dental periodicity and payment policies.

### TOOLS NEEDED:

- ☐ Your state's Medicaid and CHIP periodicity schedule(s)
- ☐ Your state's Medicaid and CHIP fee schedule(s)
- ☐ Your state's Medicaid and CHIP provider manuals, as well as any separate policies related to prior authorization and medical necessity
- ☐ An understanding of the payers and plans that administer Medicaid and CHIP benefits for residents in your state
- ☐ The willingness to build or strengthen your relationship with state Medicaid and CHIP officials (example: EPSDT coordinator)
- ☐ The willingness to build or strengthen your relationship with health provider organizations (example: state dental association)

### KEY STEPS TO TAKE:

1. **Review your Medicaid and CHIP periodicity schedules and payment policies for misalignment.**
   - ☐ Are the services outlined in the periodicity schedule (example: oral health risk assessment) included in the fee schedule and provider manuals?
   - ☐ Is the minimum frequency of these services (outlined in the periodicity schedule) reimbursable according to the fee schedule and provider manuals?
   - ☐ Are there additional limitations in the fee schedule or provider manuals that are in conflict with the periodicity schedule?
2. **Examine Medicaid and CHIP-contracted plans for payment policies that align with your state's periodicity schedules.**
   - ☐ Are the periodicity, fee schedules, and provider manuals for contractors such as managed care plans (MCOs) and dental plans available? If not, you may need to file a request for information with your Medicaid agency.
   - ☐ Is the minimum frequency of these services (outlined in the state periodicity schedule) reimbursable according to the contractors' policies?
   - ☐ Are there additional limitations in the contractors' policies that are in conflict with the state periodicity schedule (example: how frequently can a service like fluoride varnish be provided)?
3. **Assess whether state and contractor policies facilitate individualized care, especially for EPSDT coverage.**
   - ☐ Are medical necessity and prior authorization policies readily available and included in provider manuals?
   - ☐ Do medical necessity and prior authorization policies at both the state and contractor level clearly articulate guidelines for when providers are permitted to go above and beyond the periodicity schedule?
   - ☐ Do medical necessity and prior authorization policies conflict with or pose a significant burden for providers seeking to deliver care beyond what is outlined in the periodicity schedule?
4. **Ensure that communications to providers and beneficiary families clearly articulate the *minimum* frequency at which oral health services can be offered under your state's periodicity schedule—and that communications outline a process for approving more frequent care for high-risk children.**
   - ☐ Are both providers and families aware of what services children are entitled to? If so, are these communications provided in clear language?
   - ☐ Does your state or its contractors directly communicate information on service frequency, medical necessity, or prior authorization to providers and families beyond existing policy documents?
   - ☐ Does your state or its contractors provide any patient navigation services?

## ENDNOTES


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