

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?