Removing obstacles to children’s dental care in Medicaid: A renewed push for change

August 29, 2018

Webinar hosted by the Children’s Dental Health Project
About the Children’s Dental Health Project

Colin Reusch, MPA
Director of Policy, Children’s Dental Health Project
In 1997, Children’s Dental Health Project was conceived to advance innovative policy solutions so no child suffers from tooth decay. We advocate for systems that nourish families...
Why this bulletin is a big deal

A vision of what oral health care should be
CDHP and its partners have long emphasized that:

- Every child’s needs are different and there are tools to assess those needs.
- One-size-fits-all approach to oral health care is insufficient and incompatible with Medicaid.
- Medicaid/CHIP programs must incentivize appropriate care.
- State are ultimately responsible for ensuring that each child gets what she needs.
- Greater program efficiency AND better outcomes CAN be achieved together.
Even with many pieces in place, the system falls short if policies aren’t aligned

Every child should get what they need to be healthy

- Evidence-based clinical guidelines
- Risk assessment tools & guidance
- Statistical requirements for individualized care
- Minimally-invasive disease management strategies
- Medical/dental codes available
- Quality improvement requirements
CMS Bulletin encourages states to...

- Align fee schedules, payment policies with periodicity schedules
- Recognize periodicity schedules establish the minimum recommended services (and State policies should not inhibit more frequent care when needed)
- Ensure that the payment policies MCOs/payers are aligned with the periodicity schedule/priorities
- Look to existing clinical guidelines
  - American Academy of Pediatric Dentistry
  - American Academy of Pediatrics
CMS Informational Bulletin: A Tool for Change

Removing Obstacles to Children’s Dental in Medicaid: A Renewed Push for Change
August 29, 2018
Laurie J. Norris, JD
The Medicaid Children’s Dental Benefit

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit
  - Screening Services
  - Vision Services
  - Dental Services
    - At intervals which meet reasonable standards of dental practice
    - At such other intervals as are medically necessary
    - At a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health
  - Hearing Services
  - Other services necessary to correct or ameliorate defects and physical and mental illnesses and conditions

Every state is required to adopt a pediatric dental periodicity schedule “after consultation with recognized dental organizations involved in child health care.”

See Section 1905(r)(3) of the Social Security Act.
Existing Policy: Keep Kids Smiling (2013)

- Dental coverage:
  - Adopt a periodicity schedule for exams and prevention
  - Subject to the same “medical necessity” parameters as other health care for children in Medicaid
  - Allow for interperiodic visits more frequent than outlined in the periodicity schedule, as medically necessary
  - Minimum coverage parameters: relief of pain and infections, restoration of teeth, maintenance of dental health, and medically necessary orthodontic services

Finding: Two of four states in the study failed to align their payment policies with their periodicity schedules.

Recommendation:
- Ensure that States pay for services in accordance with their periodicity schedules.
- Require States to conduct regular reviews of their periodicity schedules and payment policies to ensure that States are paying for services in accordance with their periodicity schedules.

Available at https://oig.hhs.gov/oei/reports/oei-02-14-00490.pdf

“CMS concurs with this recommendation. CMS will work with states to crosswalk their payment policies with their dental periodicity schedules and make any necessary adjustments to their payment policies.”
States should ensure that fee schedules and payment policies are aligned with periodicity schedules.

States with dental managed care should ensure that the managed care plans’ fee schedules and payment policies align with the state’s periodicity schedule.

Payment policies for oral health services provided in primary care should also be examined for alignment with the state’s pediatric periodicity schedules.

Available at: https://www.medicaid.gov/federal-guidance/downloads/cib050418.pdf
The periodicity schedule should be treated as a “floor” for coverage of dental services, not a “ceiling.”

- Additional services should be covered based on each individual child’s risk profile and health needs.
- Allow for individualized care plans
- Cover and reimburse dental care necessary to correct or ameliorate an individual child’s condition
- Even when these services fall outside of the standard scope and even when the frequency of services is greater than specified in the periodicity schedule or coverage policy.
Implement a mechanism through which providers can obtain timely approval of, and payment for, additional or more frequent dental services beyond what is specified in the periodicity schedule or coverage policy.

States delivering dental services to children through managed care or other contracting arrangements should ensure that a similar mechanism is available through their contracted plan(s).
A Role for Advocates

- Is there alignment between your state’s pediatric dental periodicity schedule and the payment policies?
  - Obtain and examine your state’s pediatric dental periodicity schedule, dental fee schedule, dental provider manual, dental provider advisories, etc.
  - Compare them for alignment on ages, frequencies, etc.
  - Talk to providers. Find out what they are experiencing.

- Is there alignment between your state’s primary care (medical) periodicity schedule for oral health services and its payment policies?
  - What is the mechanism in your state to cover (and pay for) medically necessary dental and oral health services that exceed what is specified in the relevant periodicity schedule?
  - How has your state ensured MCO / dental plan compliance with these requirements?
Medicaid Benefits for Children and Adolescents

Kelly Whitener
Children’s Dental Health Project
August 29, 2018
# Medicaid’s Pediatric Benefit

## Building Blocks of EPSDT

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Early</strong></td>
<td>Identify problems early, starting at birth</td>
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<tr>
<td><strong>Periodic</strong></td>
<td>Check children’s health at periodic, age-appropriate intervals and as needed</td>
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<tr>
<td><strong>Screening</strong></td>
<td>Provide pediatrician-recommended screenings of physical, mental and developmental health</td>
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<tr>
<td><strong>Diagnostic</strong></td>
<td>Perform diagnostic tests to follow up when a risk is identified</td>
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<tr>
<td><strong>Treatment</strong></td>
<td>Treat any problems that are found</td>
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</table>
How did we get such a comprehensive pediatric benefit in Medicaid?

‘One Third of a Nation: A Report on Young Men Found Unqualified for Military Service’ demonstrated the need for children and adolescents’ access to preventive medical services starting from an early age.

1964
EPSDT Defined

- States must provide all coverable and medically necessary services
  - Coverable = listed in Medicaid §1905(a)
  - Medically necessary = as defined by the state but see below

- Needed to correct or ameliorate physical and behavioral health conditions
  - Determination must be made on a case-by-case basis, taking into account a particular child’s needs

- Even if such services are not in the Medicaid state plan
  - Includes all mandatory and optional Medicaid services
EPSDT Includes Coverage of ALL Services... whether listed as mandatory or optional

<table>
<thead>
<tr>
<th>Mandatory Services</th>
<th>Optional Services</th>
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<tbody>
<tr>
<td>✓ Family planning services and supplies</td>
<td>✓ Optometry services</td>
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<tr>
<td>✓ Federally Qualified Health Clinics and Rural Health Clinics</td>
<td>✓ Other diagnostic, screening, preventive and rehabilitative services</td>
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<td>✓ Home health services</td>
<td>✓ Other licensed practitioners’ services</td>
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<tr>
<td>✓ Inpatient and outpatient hospital services</td>
<td>✓ Physical therapy services</td>
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<tr>
<td>✓ Laboratory and X-Rays</td>
<td>✓ Prescribed drugs</td>
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<tr>
<td>✓ Medical supplies and durable medical equipment</td>
<td>✓ Primary care case management services</td>
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<td>✓ Non-emergency medical transportation</td>
<td>✓ Private duty nursing services</td>
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<tr>
<td>✓ Nurse-midwife services</td>
<td>✓ Program of All-Inclusive Care for the Elderly (PACE) services</td>
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<tr>
<td>✓ Pediatric and family nurse practitioner services</td>
<td>✓ Prosthetic devices</td>
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<tr>
<td>✓ Physician services</td>
<td>✓ Respiratory care for ventilator dependent individuals</td>
</tr>
<tr>
<td>✓ Pregnancy-related services</td>
<td>✓ Speech, hearing and language disorder services</td>
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<tr>
<td>✓ Tobacco cessation counseling and pharmacotherapy for pregnant women</td>
<td>✓ Targeted case management</td>
</tr>
<tr>
<td></td>
<td>✓ Tuberculosis-related services</td>
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See Social Security Act § 1905(a)
# EPSDT - Limitations

<table>
<thead>
<tr>
<th>Utilization Controls</th>
<th>Permitted</th>
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<tr>
<td>✓ Utilization controls, such as prior authorization for some services</td>
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<table>
<thead>
<tr>
<th>Prohibited</th>
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<tbody>
<tr>
<td>✗ Prior authorization for screenings</td>
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<td>✗ Using utilization controls that delay the provision of necessary treatment</td>
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<td>✗ Service caps (“Hard limits”)</td>
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<tr>
<th>Experimental Treatment</th>
<th>Permitted</th>
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<tr>
<td>✓ While EPSDT does not require coverage of experimental services, a state may do so if it determines that treatment would address a child’s condition</td>
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<tr>
<td>✓ Relying on the latest scientific evidence to inform coverage decisions</td>
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<th>Prohibited</th>
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<tr>
<td>✗ Denying treatment due to cost alone</td>
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<tr>
<th>Cost Effective Alternatives</th>
<th>Permitted</th>
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<tr>
<td>✓ Considering cost when deciding to cover a medically necessary treatment or an alternative</td>
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<td>✓ Covering services in a cost effective way, permitted they are as good as or better than the alternative</td>
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Promoting EPSDT through Partnerships

Marielle Kress
Director, Federal Advocacy
American Academy of Pediatrics
STAY IN THE BOAT
AAP/CCF PROJECT GOALS

Protect and strengthen children’s Medicaid benefits under EPSDT at the federal and state levels by:

- Educating and raising awareness among policymakers and other stakeholders about EPSDT and its critical role for children
- Strengthening the capacity for collaborative initiatives between state child advocates and AAP chapters (including technical assistance with 6 states)
- Identifying and executing state-level strategies to strengthen EPSDT protections for children enrolled in Medicaid
ARIZONA

• Hosted a legislative day in February, using a new EPSDT fact sheet
• Creating a data dashboard focusing on the collection of quality measures
• Updating EPSDT section of health plan manual

Three-Pronged Approach:
• Providers: Editing EPSDT brochure for offices
• Beneficiaries: Adding EPSDT benefits to CHIP program
• Policymakers: Hosted a legislative breakfast and meeting with gubernatorial candidates

IOWA
GEORGIA

- Identifying administrative procedures to help increase coverage (ELE and 12-month continuous)

Hosted health care access roundtable focused on transportation barriers

NORTH CAROLINA

- Exploring idea of folding separate CHIP into Medicaid
- Building relationships with MCOs & influence new MCO contracts
Utah

- Meeting with EPSDT staff and considering push to add EPSDT to CHIP
- “Listening Tour” of providers
- Advocacy day in November

West Virginia

- Tiny Hearts advocacy day in Feb, still using resources to educate providers and lawmakers about EPSDT
NEW AAP STATE EPSDT PROFILES

- **New! AAP State EPSDT Profiles**
EPSDT EDUCATION FOR PROVIDERS AND ADVOCATES

SAVE THE DATE

WEBINAR: MEDICAL NECESSITY AND BEST PRACTICES FOR ENSURING CHILDREN ENROLLED IN MEDICAID CAN ACCESS NEEDED SERVICES

THURSDAY, SEPTEMBER 20TH
1 PM – 2:30 PM EASTERN
Opportunities for progress in your state

Strategies and tools for effective advocacy

Colin Reusch, MPA

Director of Policy, Children’s Dental Health Project
Stakeholders impacted by CMS bulletin

• State Medicaid and CHIP programs
• Payers (Insurers, Managed Care Organizations [MCOs], Dental Contractors, etc.)
• Dental/Health Care Providers
• Families/Caregivers of Children covered by Medicaid and CHIP
Stakeholders may not act independently

- Unaware of the bulletin and its implications
- Focused on specific obstacles to individualized care
- Constrained by existing care models and costs
- May believe they are already sufficiently in compliance
Stakeholders may not act independently

Unaware of

Focused on

Constrained

May believe

So advocacy efforts should begin by investigating stakeholder concerns and efforts
Questions to guide your efforts...
State Medicaid/CHIP Program Administrators

• Review your state policies (Medicaid fee schedule, dental periodicity schedule, provider manual, etc.) for alignment

• **Ask your Medicaid/CHIP Dental Director…**
  
  • How has the CMS bulletin been communicated to providers and plans/contractors?
  
  • Are policies and procedures clearly articulated in state/plan documents (e.g., provider manual)?
  
  • What do contracts with payers require?
  
  • How does state verify children are getting appropriate care (quality strategies, auditing/oversight, etc.)?
  
  • Is risk assessment covered and how does it impact care/payment?
The DC HealthCheck Dental Periodicity Schedule follows the American Academy of Pediatric Dentistry Periodicity Schedule in consultation with the local dental community. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

<table>
<thead>
<tr>
<th>RECOMMENDED PROCEDURES</th>
<th>AGE</th>
<th>6-11 MONTHS</th>
<th>12-23 MONTHS</th>
<th>2-5 YEARS</th>
<th>6-11 YEARS</th>
<th>12 YEARS AND OLDER</th>
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<tr>
<td>Clinical oral examination¹</td>
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<td>Assess oral growth and development²</td>
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<td>Caries-risk assessment³</td>
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<td>Radiographic assessment⁴</td>
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<tr>
<td>Oral Prophylaxis and topical fluoride⁵</td>
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<td>Fluoride supplementation⁶</td>
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<tr>
<td>Anticipatory guidance/counseling⁷</td>
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<tr>
<td>Dietary counseling⁹</td>
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<td>Injury prevention counseling¹⁰</td>
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<tr>
<td>Counseling for nonnutritive habits¹¹</td>
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<td>Counseling for speech/language development</td>
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<td>Substance abuse counseling</td>
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<td>Counseling for intraoral/perioral piercing</td>
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<tr>
<td>Assessment and treatment of developing malocclusion</td>
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<tr>
<td>Assessment for pit and fissure sealants¹²</td>
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<td>Assessment and/or removal of third molars</td>
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<tr>
<td>Transition to adult dental care</td>
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Last Updated on July 30, 2018
NOTES

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination

3 Must be repeated regularly and frequently to maximize effectiveness

4 Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.

5 Must be repeated regularly and frequently to maximize effectiveness. Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.

6 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

7 Appropriate discussion and counseling should be an integral part of each visit of care.

8 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, child only.

9 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

10 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth guards.

11 At first, discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching or bruxism.

12 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.


Last Updated on July 30, 2018
Payers (Insurers, Managed Care Organizations [MCOs], Dental Contractors, etc.)

- “Payers” play a powerful role in sharing information and incentivizing care protocols

- **Ask the MCOs or plans in your state program:**
  - Have plans and contractors reviewed their own policies and procedures for alignment?
  - How might their payment policies clash with principles of EPSDT, especially for high-risk kids?
  - Have they communicated the contents of this bulletin with providers on their panels?
  - How do they evaluate whether appropriate care is being provided to children (i.e. medical necessity & prior authorization policies, internal tracking and auditing measures)?
Providers (and Professional Organizations)

- Providers are where the rubber meets the road and must have a clear understanding of Medicaid/CHIP policies
- **Policy alignment may be aided by working with professional organizations:**
  - How has the CMS bulletin been communicated to participating providers?
  - Have providers in your state encountered barriers to providing appropriate oral health care? Can members identify specific issues, procedures, or policies that require attention?
  - How easy is it for providers to interpret such policies as outlined in provider manuals and other communications? (Does a lack of clarity disincentivize care)?
Families, Caregivers, and Patients

- Assess the knowledge of families covered by Medicaid or CHIP:
  - Do parents know their children are entitled to individualized care to treat oral health issues as well as mitigate any worsening disease?
  - Do they know what to ask for if their child is at high risk for tooth decay?
- What materials and communications are publicly available to families?
  - Do they communicate to families how to access care in different settings (dentists office, pediatrician office, etc.)?
  - Do families know what services can be made available to them (e.g., more frequent follow-up for high-risk patients)?
Children receive care based on their needs without unnecessary delay

**Medicaid/CHIP Agencies**
- Alignment of Periodicity Schedules & Payment Policies
- Oversight of payers & contractors
- Clear contract language
- Quality/performance improvement strategies
- Provider manuals & outreach
- Risk assessment policies

**Payers (MCOs, dental plans, etc.)**
- Aligning payment with state policies
- Clear communication with providers
- Easy-to-navigate prior authorization procedures
- Internal auditing
- Patient outreach

**Providers & Professional Orgs**
- Communications with members
- Understanding of state & payer policies
- Identification of existing barriers
- Patient education

**Patients/Families**
- Communication from Medicaid agencies, payers, and providers
- Understanding of coverage, benefits, limits, etc.
- Understanding of individualized care & risk factors
A few parting thoughts…

- Just because it’s in the periodicity schedule or fee schedule doesn’t mean kids are getting the care they need.
- Service frequency and prior authorization policies may become real barriers to necessary care.
- Incentives for appropriate care don’t always have to be financial.
- State Medicaid/CHIP agencies are ultimately responsible for ensuring contractors & their policies don’t conflict with EPSDT or state CHIP requirements.
Resources

- CDHP Quick Guide on CMS Informational Bulletin
- AAPD Guide to State Periodicity Schedules
- ADA Medicaid Provider Reference Guide
- MSDA National Profile of State Medicaid & CHIP Oral Health Programs
- CMS Briefs on Strategies for Reducing Early Childhood Tooth Decay
- CMS Insure Kids Now (Medicaid/CHIP Benefit Info)
- CDHP Fact Sheet on Oral Health Risk Assessment
Thank you!

For more information:

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Follow us on Facebook or Twitter:
Web: www.cdhp.org
Twitter: @Teeth_Matter
Questions & Answers

Type your question in to the chat box.
Thank you for joining us!

Contacts for further questions:

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