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

August 29, 2018

children's dental health project

Webinar hosted by the Children's Dental Health Project

About the Children's Dental Health Project

children's dental health project

Colin Reusch, MPA

Director of Policy, Children's Dental Health Project

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…

- Remove oral health as barrier to success
- Configure communities to support families manage their health
- Support those trusted in communities
- Champion solutions to end inequities

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Why this bulletin is a big deal

A vision of what oral health care should be

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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

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

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CMS Informational Bulletin: A Tool for Change

Removing Obstacles to Children's Dental in Medicaid: A Renewed Push for Change

August 29, 2018

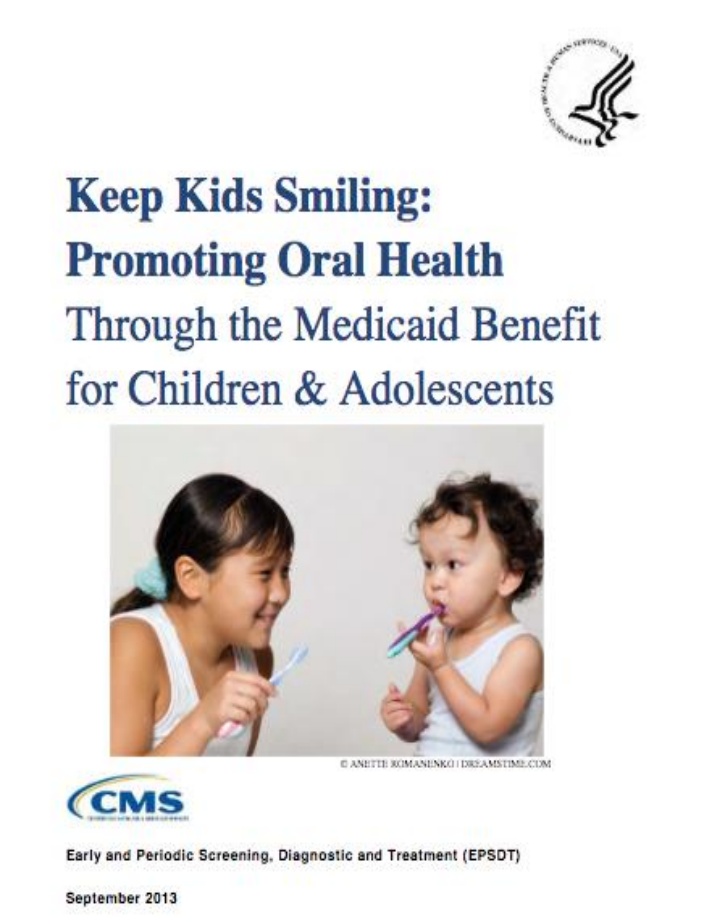
Laurie J. Norris, JD

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."

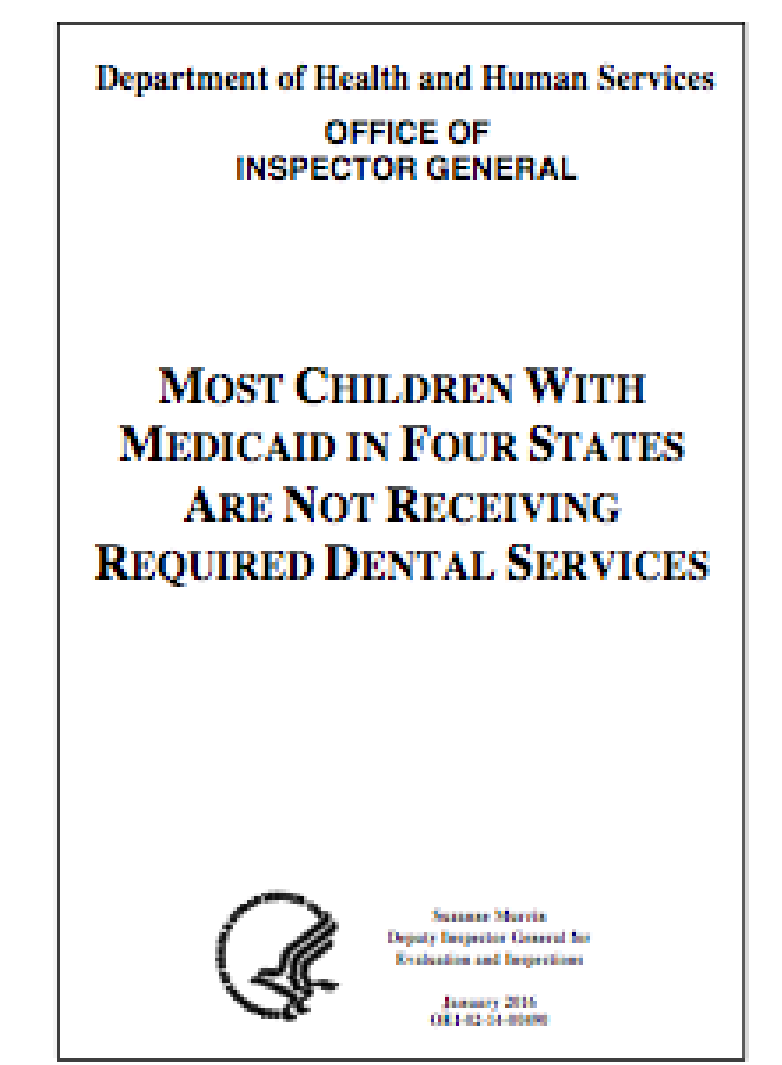
See Section 1905(r)(3) of the Social Security Act.

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
- Available at https://www.medicaid.gov/medicaid/benefits/downloads/keep-kids-smiling.pdf

OIG Report (2014)


Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MOST CHILDREN WITH MEDICAID IN FOUR STATES ARE NOT RECEIVING REQUIRED DENTAL SERVICES

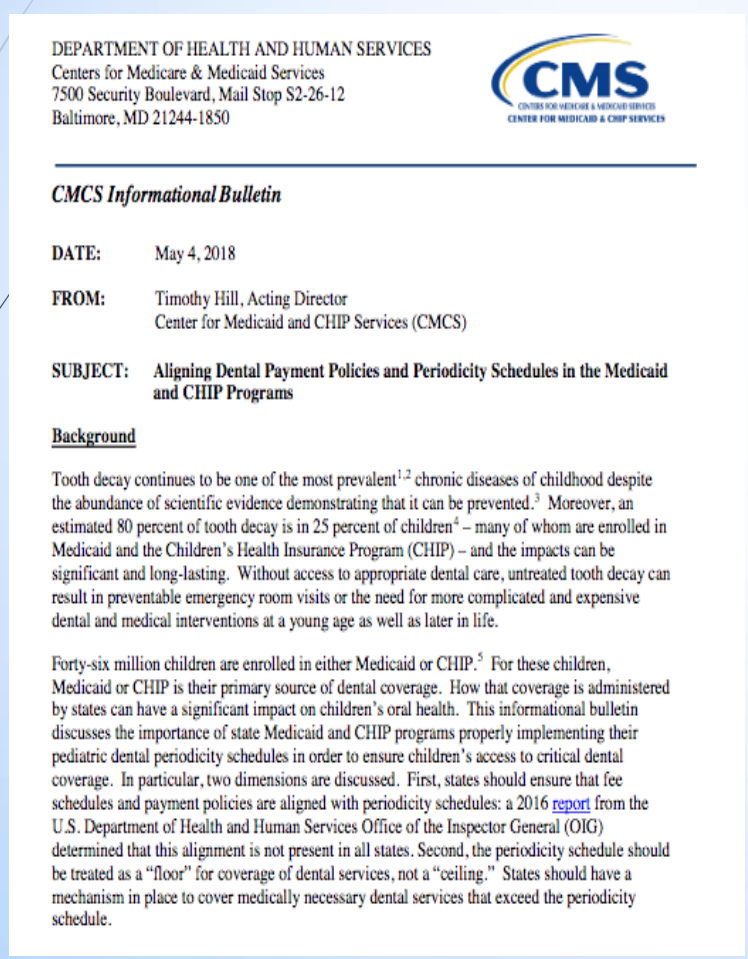
- **Finding:** Two of four states in the study failed to align their payment policies with their periodicity schedules
- **Recommendation:**
  - Ensure that States pay for services in accordance with their periodicity schedules
  - Require States to conduct regular reviews of their periodicity schedules 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 Response to OIG Report (2015)

"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."

CMS Informational Bulletin (2018)

Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: May 4, 2018

FROM: Timothy Hill, Acting Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: **Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs**

Background

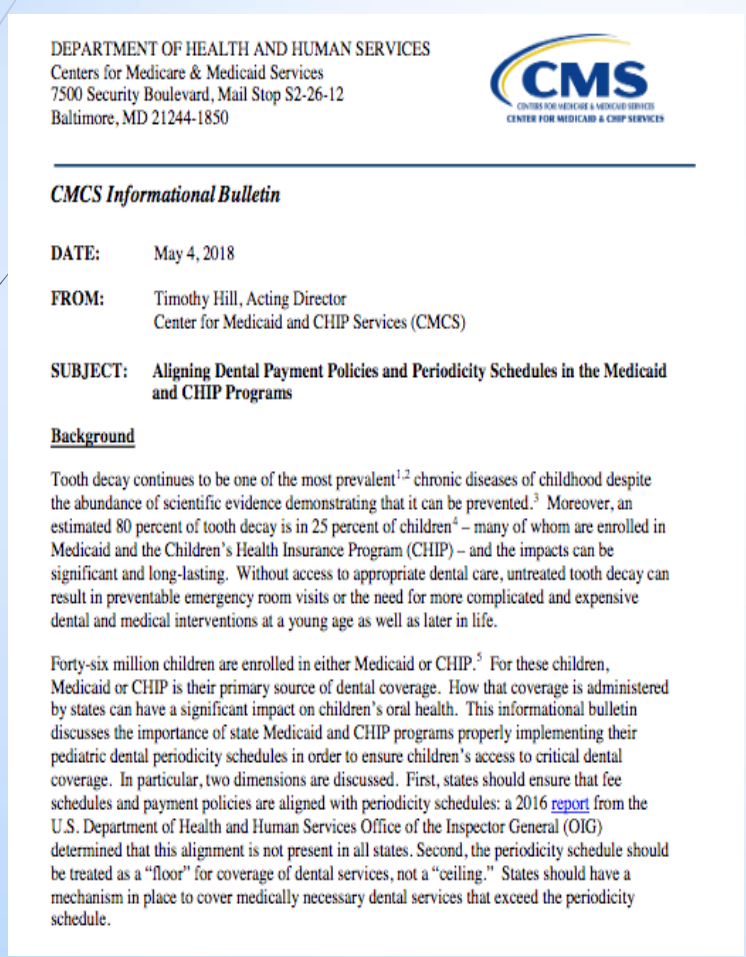
Tooth decay continues to be one of the most prevalent[1,2] chronic diseases of childhood despite the abundance of scientific evidence demonstrating that it can be prevented.[3] Moreover, an estimated 80 percent of tooth decay is in 25 percent of children[4] – many of whom are enrolled in Medicaid and the Children's Health Insurance Program (CHIP) – and the impacts can be significant and long-lasting. Without access to appropriate dental care, untreated tooth decay can result in preventable emergency room visits or the need for more complicated and expensive dental and medical interventions at a young age as well as later in life.

Forty-six million children are enrolled in either Medicaid or CHIP.[5] For these children, Medicaid or CHIP is their primary source of dental coverage. How that coverage is administered by states can have a significant impact on children's oral health. This informational bulletin discusses the importance of state Medicaid and CHIP programs properly implementing their pediatric dental periodicity schedules in order to ensure children's access to critical dental coverage. In particular, two dimensions are discussed. First, states should ensure that fee schedules and payment policies are aligned with periodicity schedules: a 2016 report from the U.S. Department of Health and Human Services Office of the Inspector General (OIG) determined that this alignment is not present in all states. Second, the periodicity schedule should be treated as a "floor" for coverage of dental services, not a "ceiling." States should have a mechanism in place to cover medically necessary dental services that exceed the periodicity schedule.

- **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 polices 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-policy-guidance/downloads/cib050418.pdf

CMS Informational Bulletin (2018)

Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs



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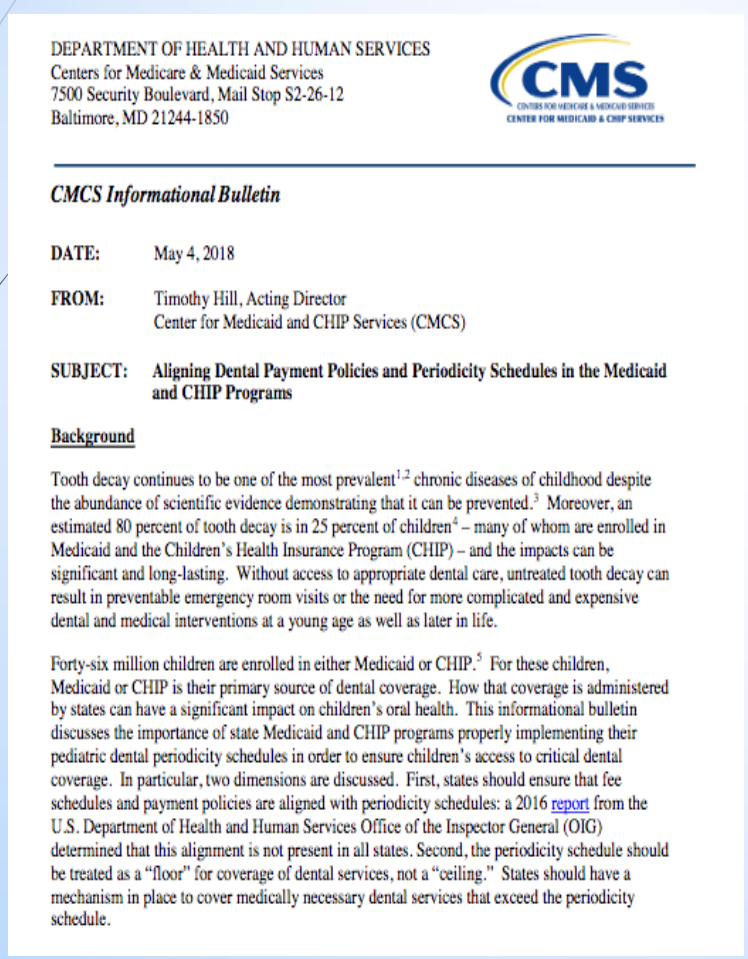
- **The periodicity schedule should be treated as a "floor" for coverage of dental services, not a "ceiling."**
  - Additional services should be covered based on each individual child's risk profile and health needs.
  - Allow for individualized care plans
  - Cover and reimburse dental care necessary 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.

CMS Informational Bulletin (2018)

Aligning Dental Payment Policies and Periodicity Schedules in the Medicaid and CHIP Programs



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- **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?

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Benefits for Children and Adolescents

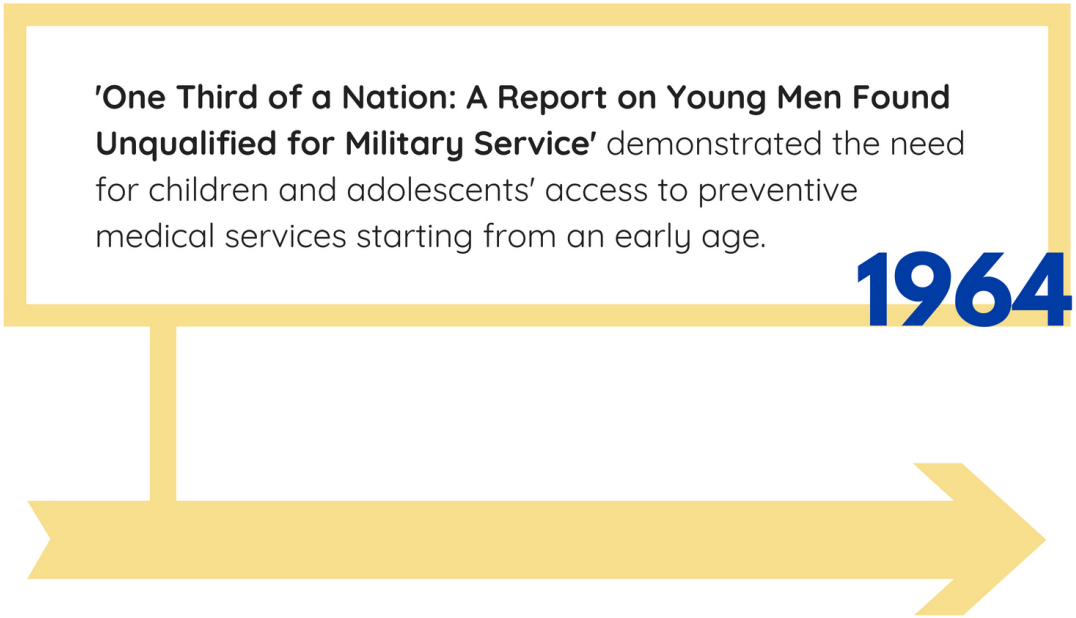
Kelly Whitener
Children's Dental Health Project

August 29, 2018

Medicaid's Pediatric Benefit

Building Blocks of EPSDT	
Early	Identify problems early, starting at birth
Periodic	Check children's health at periodic, age-appropriate intervals and as needed
Screening	Provide pediatrician-recommended screenings of physical, mental and developmental health
Diagnostic	Perform diagnostic tests to follow up when a risk is identified
Treatment	Treat any problems that are found

How did we get such a comprehensive pediatric benefit in Medicaid?



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

Mandatory Services

- ✓ Family planning services and supplies
- ✓ Federally Qualified Health Clinics and Rural Health Clinics
- ✓ Home health services
- ✓ Inpatient and outpatient hospital services
- ✓ Laboratory and X-Rays
- ✓ Medical supplies and durable medical equipment
- ✓ Non-emergency medical transportation
- ✓ Nurse-midwife services
- ✓ Pediatric and family nurse practitioner services
- ✓ Physician services
- ✓ Pregnancy-related services
- ✓ Tobacco cessation counseling and pharmacotherapy for pregnant women

Optional Services

- ✓ Community supported living arrangements
- ✓ Chiropractic services
- ✓ Clinic services
- ✓ Critical access hospital services
- ✓ Dental services
- ✓ Dentures
- ✓ Emergency hospital services (in a hospital not meeting certain federal requirements)
- ✓ Eyeglasses
- ✓ State Plan Home and Community Based Services
- ✓ Inpatient psychiatric services for individuals under age 21
- ✓ Intermediate care facility services for individuals with intellectual disabilities
- ✓ Optometry services
- ✓ Other diagnostic, screening, preventive and rehabilitative services
- ✓ Other licensed practitioners' services
- ✓ Physical therapy services
- ✓ Prescribed drugs
- ✓ Primary care case management services
- ✓ Private duty nursing services
- ✓ Program of All-Inclusive Care for the Elderly (PACE) services
- ✓ Prosthetic devices
- ✓ Respiratory care for ventilator dependent individuals
- ✓ Speech, hearing and language disorder services
- ✓ Targeted case management
- ✓ Tuberculosis-related services

See Social Security Act § 1905(a)

EPSDT - Limitations

	Permitted	Prohibited
Utilization Controls	✓ Utilization controls, such as prior authorization for some services	× Prior authorization for screenings × Using utilization controls that delay the provision of necessary treatment × Service caps ("Hard limits")
Experimental Treatment	✓ 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 ✓ Relying on the latest scientific evidence to inform coverage decisions	
Cost Effective Alternatives	✓ Considering cost when deciding to cover a medically necessary treatment or an alternative ✓ Covering services in a cost effective way, permitted they are as good as or better than the alternative	× Denying treatment due to cost alone

Promoting EPSDT through Partnerships

Marielle Kress
Director, Federal Advocacy
American Academy of Pediatrics

American Academy of Pediatrics
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Stay in the Boat

AAP/CCF PROJECT GOALS

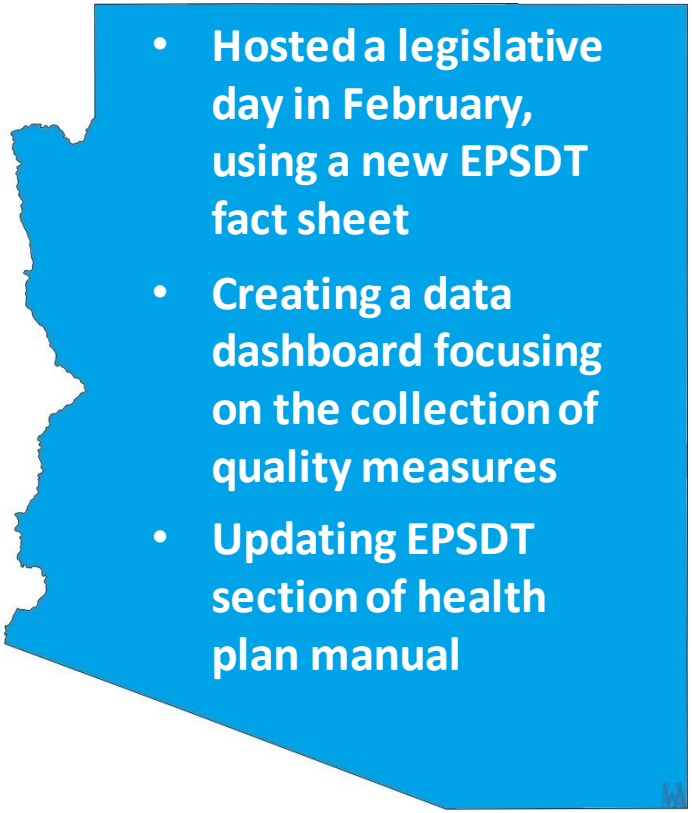
Protect and strengthen children's Medicaid benefits under EPSDT at the federal and state levels by:

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



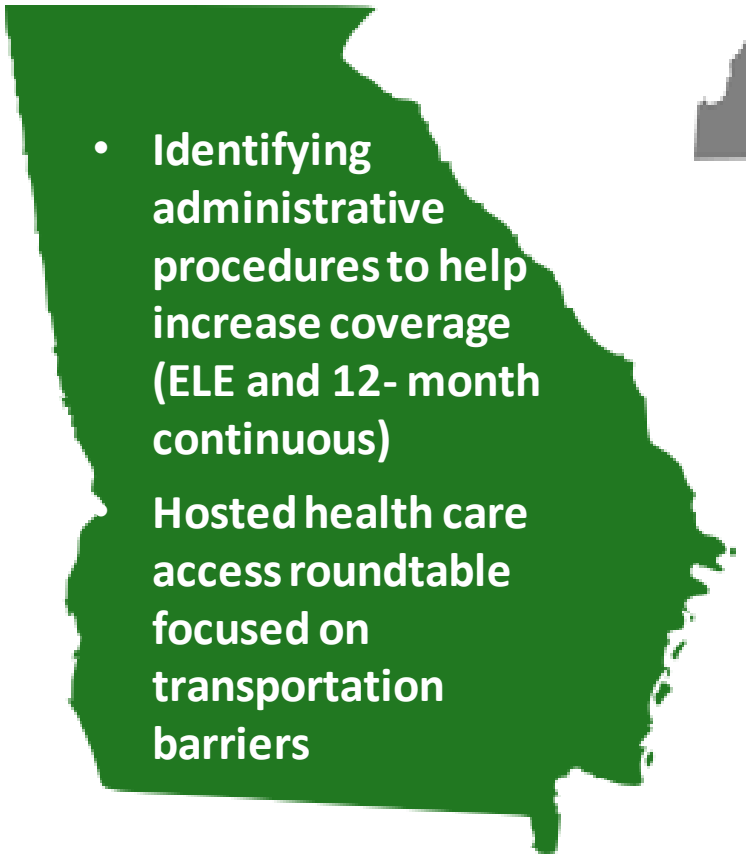
- Hosted a legislative day in February, using a new EPSDT fact sheet
- Creating a data dashboard focusing on the collection of quality measures
- Updating EPSDT section of health plan manual

IOWA

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

GEORGIA



- Identifying administrative procedures to help increase coverage (ELE and 12- month continuous)
- Hosted health care access roundtable focused on transportation barriers

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

NORTH CAROLINA

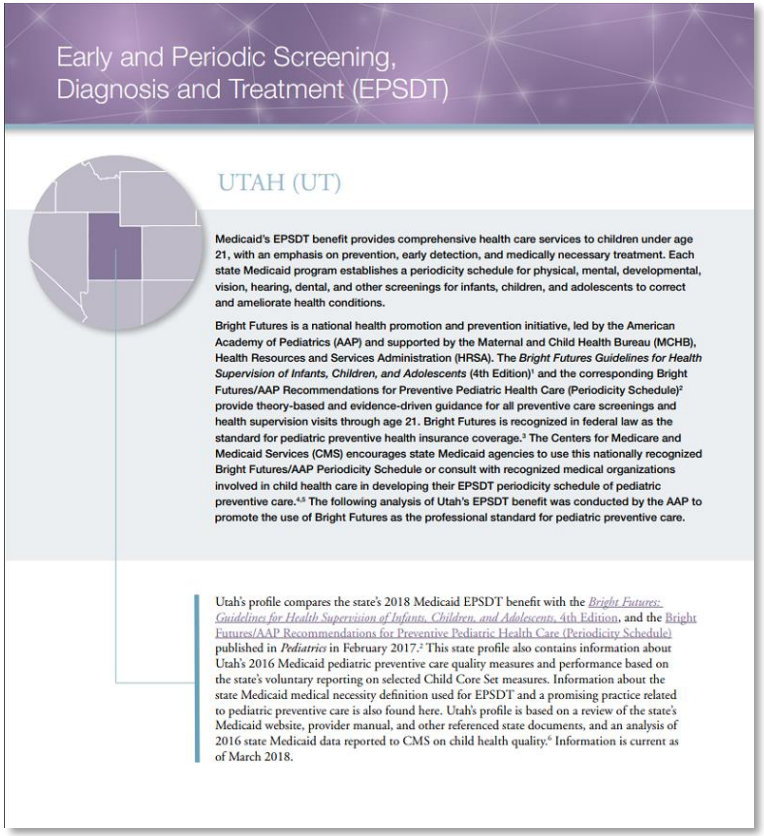
UTAH

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

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

WEST VIRGINIA

NEW AAP STATE EPSDT PROFILES



Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

UTAH (UT)

Medicaid's EPSDT benefit provides comprehensive health care services to children under age 21, with an emphasis on prevention, early detection, and medically necessary treatment. Each state Medicaid program establishes a periodicity schedule for physical, mental, developmental, vision, hearing, dental, and other screenings for infants, children, and adolescents to correct and ameliorate health conditions.

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA). The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th Edition)[1] and the corresponding Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)[2] provide theory-based and evidence-driven guidance for all preventive care screenings and health supervision visits through age 21. Bright Futures is recognized in federal law as the standard for pediatric preventive health insurance coverage.[3] The Centers for Medicare and Medicaid Services (CMS) encourages state Medicaid agencies to use this nationally recognized Bright Futures/AAP Periodicity Schedule or consult with recognized medical organizations involved in child health care in developing their EPSDT periodicity schedule of pediatric preventive care.[4,5] The following analysis of Utah's EPSDT benefit was conducted by the AAP to promote the use of Bright Futures as the professional standard for pediatric preventive care.

Utah's profile compares the state's 2018 Medicaid EPSDT benefit with the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition, and the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) published in *Pediatrics* in February 2017.[2] This state profile also contains information about Utah's 2016 Medicaid pediatric preventive care quality measures and performance based on the state's voluntary reporting on selected Child Core Set measures. Information about the state Medicaid medical necessity definition used for EPSDT and a promising practice related to pediatric preventive care is also found here. Utah's profile is based on a review of the state's Medicaid website, provider manual, and other referenced state documents, and an analysis of 2016 state Medicaid data reported to CMS on child health quality.[6] Information is current as of March 2018.

- **New! AAP State EPSDT Profiles**
- **https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Childrens-Health-Care-Coverage-Fact-Sheets.aspx**

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Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

EPSDT EDUCATION FOR PROVIDERS AND ADVOCATES

HTTPS://CCF.GEORGETOWN.EDU/2018/07/20/EPSDT-EDUCATION-FOR-PROVIDERS-AND-ADVOCATES/

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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

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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

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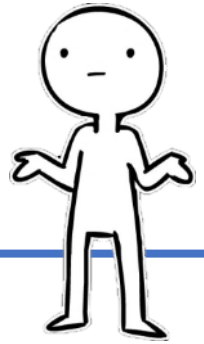
Stakeholders may not act independently



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

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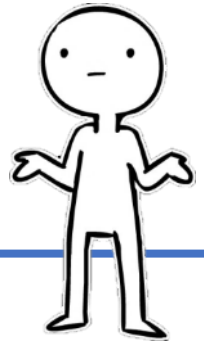
Stakeholders may not act independently



Unaware of

Focused on

Constrained

May believe

So advocacy efforts should begin by investigating stakeholder concerns and efforts

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Questions to guide your efforts…

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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?

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DC Medicaid HealthCheck Dental Periodicity Schedule

Based on recommendations from the American Academy of Pediatric Dentistry

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.

RECOMMENDED PROCEDURES	AGE				
	6-11 MONTHS	12-23 MONTHS	2-5 YEARS	6-11 YEARS	12 YEARS AND OLDER
Clinical oral examination[1]	•	•	•	•	•
Assess oral growth and development[2]	•	•	•	•	•
Caries-risk assessment[3]	•	•	•	•	•
Radiographic assessment[4]	•	•	•	•	•
Oral Prophylaxis and topical fluoride[5]	•	•	•	•	•
Fluoride supplementation[6]	•	•	•	•	•
Anticipatory guidance/counseling[7]	•	•	•	•	•
Oral hygiene counseling[8]	Parent/guardian/ caregiver	Parent/guardian/ caregiver	Patient/parent/guardian/ caregiver	Patient/parent/guardian/ caregiver	Patient
Dietary counseling[9]	•	•	•	•	•
Injury prevention counseling[10]	•	•	•	•	•
Counseling for nonnutritive habits[11]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants[12]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

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.

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)?

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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)?

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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)?

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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

Children receive care based on their needs without unnecessary delay

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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

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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

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Thank you!

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Questions & Answers

Type your question in to the chat box.

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Thank you for joining us!

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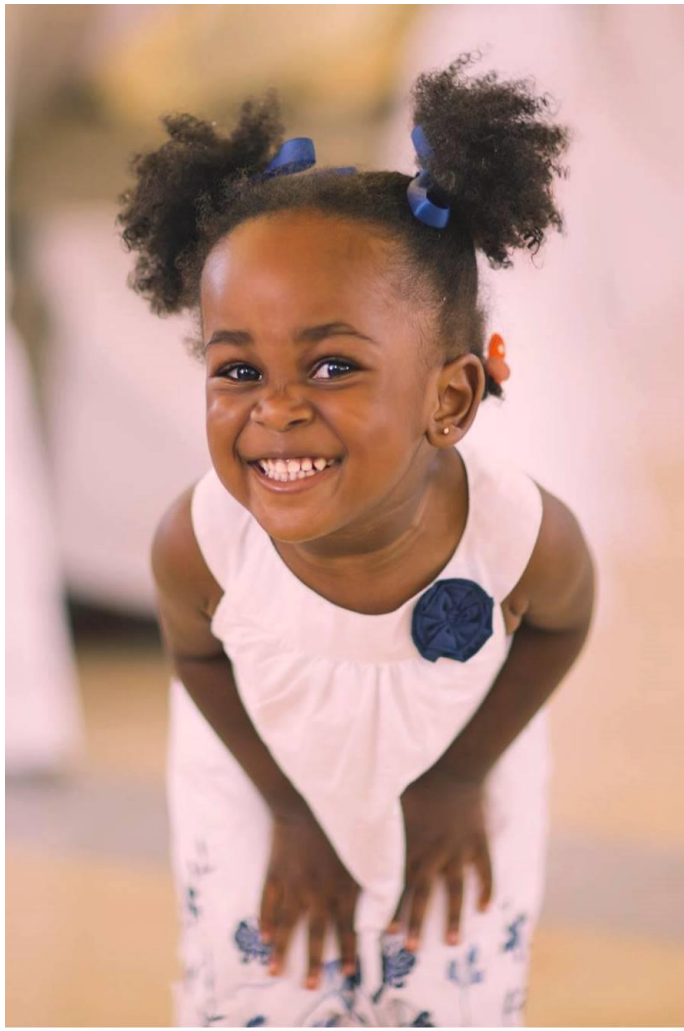

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