



Questions and Answers from the Children's Dental Health Project webinar, "Removing obstacles to children's dental care in Medicaid: A renewed push for change"

Webinar held on August 29, 2018

Background

This CDHP webinar addressed a [pediatric dental informational bulletin](#) released by the U.S. Centers for Medicare and Medicaid Services (CMS) in May 2018. It urges state Medicaid and Children's Health Insurance Program (CHIP) agencies to improve children's access to the full slate of dental services that these programs cover. Webinar panelists reviewed the bulletin's background, purpose, current state work to realize Medicaid's promise, and strategies to act for progress locally in light of the bulletin.

Below, our expert speakers respond to questions raised by attendees during the webinar. Panelists are identified by their initials. The webinar panel included:

- Colin Reusch (CR), Director of Policy at the Children's Dental Health Project
- Laurie Norris (LN), former Senior Policy Advisor for Oral Health at U.S. CMS
- Marielle Kress (MK), Director of Federal Advocacy, American Academy of Pediatrics
- Kelly Whitener (KW), Associate Professor of the Practice, Georgetown University Center for Children and Families

Resources from this webinar are available on CDHP's Toolkit page, www.cdhp.org/toolkit.

Panelist Q&A

- 1. Are states that are ahead in aligning their periodicity and payment seeing an impact in terms of increasing dentists' willingness to take Medicaid and/or increasing the number of Medicaid patients they're willing to take?**

Response/Panelist comments:

LN: As far as I know, no one knows yet which states have better alignment and which states have worse alignment. The OIG only examined 4 states, and they did not reveal which 2 states were misaligned and which 2 were aligned. Further, CMS has not had the resources to look at this issue across all states. My guess is that any such misalignments are experienced by providers as another annoyance and cause of frustration, but perhaps not enough to cause them to disenroll from the program.

CR: I concur with Laurie's assessment and add that while such obstacles probably aren't enough to dissuade providers from participating, they may very well dissuade providers from seeking to provide the full range of services that some patients may need.

- 2. In Louisiana, they have mandated that all children are grouped into only 1 Managed Care dental provider by implementing a CMS MCD waiver that takes away their freedom of choice and groups them in only this one program. They have no option to transfer. By doing this, they then dictate who can be a provider or not. (Any response from panelists?)**

Response/Panelist comments:

LN: Yes, several states have a single statewide dental managed care plan for children in Medicaid, e.g. Tennessee. While enrollees do not have a choice of dental plan (which is also true in states that contract with a single Administrative Services Only (ASO) dental plan), they still have free choice of provider among all those signed up with the plan. My recommendation is for advocates to pay extra attention to holding the state accountable according to 42 CFR sections [438.206](#), [438.207](#) and [438.208](#). [These provisions address equal access to services as well as coordination and continuity of care.] You can also hold the plan accountable with reference to the quality and access provisions in the dental plan contract.

CR: Assigning patients to specific plans/providers isn't in and of itself problematic so long as the Medicaid agency and MCO provide appropriate oversight to ensure that patients actually get the care they need.

- 3. What are the incentives/consequences for states doing poorly on oral health performance measures? If they aren't philosophically supportive, what carrots/sticks can motivate them to improve the two [Core Set measures](#) [of preventive dental service and dental sealants for children at elevated caries risk]?**

Response/Panelist comments:

LN: What I have seen work to some extent, from a CMS perspective, is publicizing which states are poor performers. Nobody wants to be in the bottom five. But this is unlikely to be a motivator for states in the middle of the pack. A well-organized coalition with good relationships at the agency and sway in the state legislature can also be effective. Sometimes the state agency wants to do better but cannot obtain the necessary funds for staffing or other improvements. Advocates can help support such agency efforts.

CR: I concur with Laurie and would add that advocates can also seek to improve upon the existing performance measures which currently do not tell us much about appropriateness of care or improvements in health as a result of services rendered.

- 4. Are there any creative ways to draw on EPSDT benefits or the alignment efforts to help improve benefits for pregnant women? Is there a parallel strategy that could help us increase access to preventive care for pregnant women?**

Response/Panelist comments:

CR: Unfortunately, dental benefits for pregnant women are optional and as such, there's typically little reporting on what care is received but that may be the avenue for seeking improvement: adding reporting requirements and metrics to any contracts or newly established benefits.

- 5. Is there a resource for comparing fee schedules across states?**

Response/Panelist comments:

LN: Three resources I know if can help to compare FFS dental reimbursement rates across states, but it is not the entire fee schedule.

A.) Try this webinar from the ADA's Health Policy Institute (HPI):

Medicaid Participation and Reimbursement for Physicians and Dentists in Every State, May 2017,

<https://www.ada.org/en/science-research/health-policy-institute/publications/webinars/medicaid-participation-and-reimbursement-for-physicians-and-dentists>

B.) And this HPI research brief:

Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016,

https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_04171.pdf

C.) Also look at the Medicaid CHIP State Dental Association (MSDA) state profiles:

<http://www.msdanationalprofile.com/>

If you encounter a log in requirement, just follow the instructions on how to get one; they are freely granted.

MK: The AAP periodically publishes a Medicaid reimbursement report that compares selected CPT codes between Medicare and Medicaid. The last report was done in 2015 and looked at the payment rates for 2014 that included the payment bump for selected services (not sure if dental was included) and 2015 when the payment bump went away:

<https://www.aap.org/en-us/professional-resources/Research/research-resources/Pages/2015-Medicaid-Reimbursement-Reports.aspx>

6. **Our state is proposing amendments to the state plan as a ‘realignment’ of rates to 2016 ADA values, resulting in net decreases to rates for several preventive and critical services for pediatric patients. For example, the state is proposing to slash reimbursement for fluoride varnish by 61.5% and there are several other concerning cuts which will affect providers’ ability to deliver services. Is there any case to be made that unacceptably low reimbursement rates are a violation of EPSDT benefits, since children won’t be able to access these services if providers are unable to serve the Medicaid population?**

Laurie addressed this during the webinar, but her comment prompted a follow-up question:

Can you send something out that explains in more depth what Laurie Norris talked about in response to that question, regarding a case to be made for equivalent access to services? This is an argument we could use.

Response/Panelist comments:

LN: First, I’m not sure what you mean by “2016 ADA values.” Is this referring to the usual and customary rates survey that the ADA does by region? If that is the case, I would be surprised if the state’s Medicaid dental rates exceed the usual and customary rates by very much if at all. What state is this? In most states the Medicaid dental rates fall far short of U+C. If “2016 ADA values” refers to something else I would really like to know what that is.

Look at the language in Section §1902(a)(30)(A) of the Social Security Act: the State Plan must “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section [1903\(i\)\(4\)](#)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the

plan at least to the extent that such care and services are available to the general population in the geographic area.

As part of the state plan approval process, CMS should be looking to the state to show evidence as to how they are going to assure this “sufficiency” even with the rate cut. If advocates have contrary evidence that should be submitted to the state during the public comment period. Advocates can also bring the information directly to the attention of CMS (send it to the state lead in the CMS Regional Office), but also know that the state must include in its communications with CMS a summary of all the public comments they received as well as how they addressed them.

- 7. Any other creative ideas for non-financial incentives for schedule completion? [In his presentation on the webinar,] I think Colin mentioned streamlining processes which would be a good policy change for providers — anything else we could try?**

Response/Panelist comments:

CR: One such non-financial incentive would be to require caries risk documentation to submit claims for relatively routine care (e.g., oral exams, fluoride varnish, etc.). That way, if a provider then seeks reimbursement or authorization for services beyond the periodicity schedule, the payer already has recent information on that child's risk level/score and could potentially fast track those authorizations. In general, I think Medicaid agencies should be seeking to establish Health Information Technology (HIT) “triggers,” whether they be risk assessment or referral for specific treatments; these may both indicate that a child is at high risk and needs additional services to better manage their disease. Ideally, such triggers would automatically authorize additional services for a specified period of time without requiring the provider to submit additional paperwork.

- 8. Is there any link between this issue brief [sic] and the webinar that was presented by CMS last week on innovation in value based purchasing? It feels like there should be an intersection between them, but I can't see whether they are linked somehow.**

Response/Panelist comments:

LN: Yes! Last week, CMS sponsored a webinar through its Innovation Accelerator Program (IAP) focused on advancing value-based payment for children's oral health in Medicaid. The slides and audio should be available by September 7 and are well worth the time.

<https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html>

That webinar made the point that Medicaid programs can design a value-based approach to payment by changing not only how they pay but what they pay for. In the CDHP webinar, Colin discussed the importance of customizing care to the child, basing care on the child's risk profile, and using a chronic disease management approach to care. The CMS Informational Bulletin supports both of these ideas by making clear that the EPSDT benefit covers what is medically necessary for each child, and that states should have mechanisms in place to approve and pay for such care that may not follow the standard prescribed periodicity schedule. The Informational Bulletin does not directly address the idea of moving from a fee-for-service approach to a value approach, but there is nothing in EPSDT that would inhibit rewarding a Medicaid provider for delivering more individualized care using a chronic disease model or for achieving better health outcomes.

CR: Indeed. While not officially linked as part of the same initiative, the bulletin and the Innovation Accelerator Program aim to advance the same ultimate outcome - that Medicaid and CHIP programs achieve more efficient and effective approaches to preventing and managing childhood tooth decay.

9. EPSDT prohibits prior authorization for screenings. Is there any explicit requirement to pay a dental professional (dentist, dental therapist, or dental hygienist, depending on the state's practice act) to do a dental screening or assessment?

Response/Panelist comments:

LN: From over on the dental side, I have always thought it was up to the state to decide whether or not to pay for the CDT screening and assessment codes. If the state pays, then these dental professionals get reimbursed for dental screenings. Otherwise, oral health screening is built into an EPSDT well-child check-up (or is supposed to be according to AAP guidelines) and so those screenings occur regularly on the medical side. I don't know if there is an argument to be made for oral health screenings by a dental professional based on a state's obligation to pay for EPSDT screens without prior authorization. A note of background is that Apple Tree Dental (Deb Jacobi's organization) has been having this argument with Minnesota Medicaid since at least 2010. It came to CMS in 2011 and I thought we had resolved it but perhaps not. I don't recall right now what the resolution was.

CR: This is a great question and highlights what I think is a yet unresolved issue - there's not necessarily an agreed-upon standard for a dental/oral health screening under EPSDT, at least not as an analog to something like a developmental screening. That said, it seems that a caries risk assessment or oral health risk assessment using one of the established risk assessment tools, would make the most sense.

KW: 42 CFR 441.56 requires referral to a dentist beginning at age 3. Before age 3, I think states can rely on other providers to complete the required screenings.

10. Rate cuts are certainly a barrier. I work for a DMO and we often have difficulty finding providers who will accept Medicaid because the rates are so low. This places a heavy burden on us to maintain a provider network as required by the state, as those who are credentialed often will refuse to see our Medicaid patients. (Any response from panelists on this challenge?)

Response/Panelist comments:

LN: Yes, this is a tough situation. Medicaid contracted dental plans often don't have a lot of leverage to get a state to raise provider reimbursement rates other than by refusing to bid on the contract or refusing to agree to a renewal unless the rates are raised. If the dental plan is a PAHP, the plan can design its own payment rates (does not have to use the fee schedule in the state plan), but that approach will only go "so far" because of constrictions imposed by the PMPM amount the dental PAHP is receiving from the state.