ADA American Dental Association®

MEDICAID FINANCIAL SUSTAINABILITY TOOLKIT:

An Operational Guide for Dentists Wishing to Treat Medicaid Beneficiaries

October 2025

The ADA is dedicated to making improvement to Medicaid access and prepared this toolkit to support dentists who participate in Medicaid or are considering participation. This document offers policy grounded guidance and operational strategies to help practices delivery high-quality care while maintaining financial viability. It aligns with ADA advocacy priorities to reduce administrative burdens, improve reimbursement rates, and enhance program design so that participation is financially and professionally suitable for all dentists and beneficial for all beneficiaries.

Medicaid Financial Sustainability Toolkit

An operational guide for dentists

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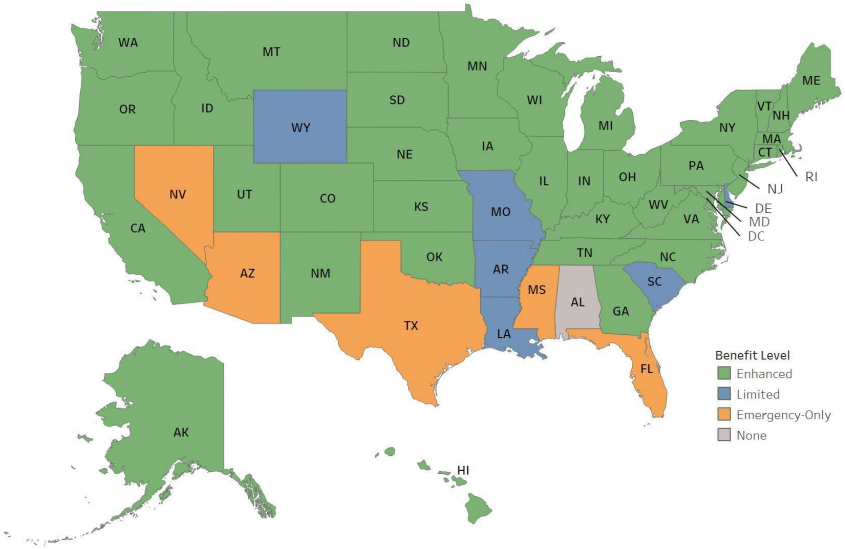
The ADA encourages state dental associations, in partnership with their Medicaid agency, oral health coalition, dental advisory committee(s), and participating dentists, develop state-specific toolkits and checklists. These resources can provide greater detail on enrollment, credentialing, and recredentialing processes, covered services, peer-mentor opportunities, and lessons learned to improve efficiencies and guide advocacy priorities, while reflecting the unique policies and operational requirements of each state's Medicaid program.

Acknowledgement

This toolkit was developed by the American Dental Association (ADA), with input from dentist who participate in Medicaid across the United States. The ADA extends its gratitude to the practicing dentists, dental teams, and state leaders whose experience and insights shaped this resource, ensuring it reflects the realities of having a successful practice that accepts Medicaid and manages the operational complexities of serving Medicaid beneficiaries.

Background

Medicaid is a joint federal-state program established under Title XIX of the Social Security Act of 1965. It provides health coverage to eligible low-income individuals.[1] Medicaid's dental benefit varies across age and enrollment categories and is a vital access point for all people – children, adults, pregnant women, and individuals with intellectual and developmental disabilities. Dental benefits are an essential and mandatory component of Medicaid for children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Currently for adults, however, dental coverage is optional, and states determine whether to include preventive, restorative, or emergency dental services in their benefit packages. As a result, adult dental benefits vary substantially across the country.

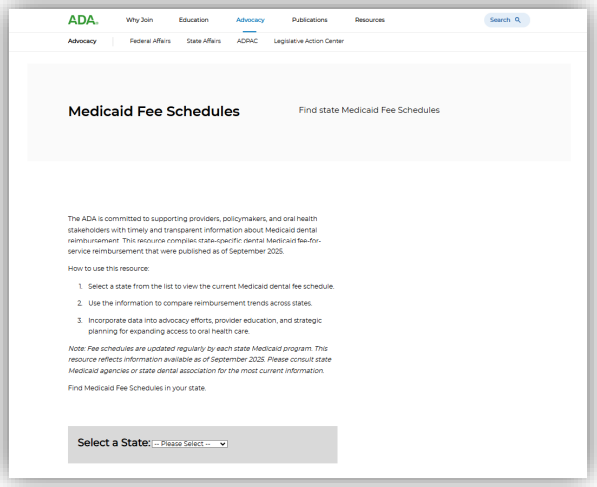


Source: *Health Policy Institute analysis of data from state Medicaid websites and the CareQuest Medicaid Adult Dental Coverage Tracker (2025)*

[1] Title XXI of the Social Security Act established the Children's Health Insurance Program (CHIP) in 1997 to provide health coverage to uninsured children families with incomes too high to qualify for Medicaid but too low to afford private insurance. CHIP programs are administered by states within broad federal guidelines, and each state designs its own structure, benefits, and eligibility standards, often operating as a stand-alone program, a Medicaid expansion, or a combination of both.

Because Medicaid is administered at the state level with federal guidelines, the administration of the program are state specific, meaning provider and administrative processes are state specific. Enrollment and credentialing requirements, reimbursement rates, covered services, and prior authorization protocols differ from one state Medicaid program to another and may also vary across the managed care organizations (MCOs) that administer Medicaid dental benefits in the state. A dentist participating in Medicaid should be familiar with how the program is administered in the state and review the dental provider manual(s) for their state and MCO specific differences. For this reason, dentists should consult their state Medicaid dental program manuals, MCO provider handbook(s), and state dental associations to ensure compliance with current requirements.

Understanding the program administration and operational implications can help dentists identify opportunities for advocacy, program improvement, and feedback to the state during the managed care procurement process. **To understand your state's fee-for-service schedule, you may refer to your state's fee schedule collected by the ADA's Health Policy Institute.**



Source: ***www.ada.org/MedicaidFeeSchedules***

Purpose

Providing dental care to Medicaid beneficiaries can be professionally fulfilling for many dentists. They can help serve their communities, while you keep operating the practice and model that is beneficial for them. A successful practice model is one that balances patient-centered care, provision of high-quality, mission, financial viability and sustainability, and staff and operational efficiencies.

By understanding enrollment and reimbursement policy, patient engagement, and adoption of structured processes and operations, practices can integrate Medicaid participation without compromising standards. **The Medicaid Financial Sustainability Toolkit is designed to support dentists and their practices in delivering care to Medicaid beneficiaries with greater confidence, efficiency, and financial sustainability.** The ADA recognizes that the dentist and their team are making a substantial commitment by treating Medicaid beneficiaries, especially when low reimbursement and administrative burdens are a part of the equation.

Practice Management Strategies for Financial Sustainability

The following sections will outline dentist and practice-level strategies to achieve success while serving Medicaid beneficiaries.

Enrollment and Credentialing: Preventing Avoidable Revenue Loss

Credentialing is not a one-time administrative hurdle–it is recurring and should be carefully monitored. Proper enrollment and credentialing ensure timely reimbursement and minimize administrative burdens. Lapses in licensure documentation, expired malpractice certificates, or missed credentialing windows not only cause payment holds that can persist for months but will not allow the dentist or hygienist to serve Medicaid beneficiaries. *Improper or delayed dentist enrollment and credentialing is one of the biggest causes of denied claims and lost revenue.*

A practice-level "credentialing program" should at least include: a single individual in your office who is selected to help complete the entire process. These steps include assembling and auditing a digital dossier of required documents from all licensed team members, working with the licensed team members to maintain and adhere to a calendar of renewal dates with pre-set reminders, and establishing confirmation protocols with each MCO. When multiple MCOs are involved, it can be important to maintain separate confirmation logs and any plan-specific onboarding or verification steps.

Practical safeguards include verifying effective dates before the first scheduled Medicaid patient, maintaining payer contact channels, establishing a peer-mentor, and documenting all correspondence. While state Medicaid dental programs publish plan-specific checklists or portals, it may be important to link them with your own practice guide or tools for accepting new patients. A single practice team member could be trained to prevent single-point failure. However, despite delegating the collection of submission of documents to a person within your practice, the dentist must still be involved with attesting or certifying their credentialing before submission.

HEAR IT FROM YOUR DENTAL COLLEAGUES … ABOUT NAVIGATING THE PAYER'S ADMINISTRATIVE PROCESSES

"[Find] a practicing mentor that has been accepting Medicaid for a while and can give advice on how to handle."

— Dentists from Arizona, Kansas, and Mississippi.

Here are six key steps to dentist enrollment:

1. **Understand the pathway**: Centers for Medicaid & Medicare Services (CMS) → State Medicaid Agency → Managed Care Organizations (MCOs), if applicable → Board of Dentistry for licensure verification → Dentists

2. **Understanding your credentialing channels:** Find out whether your State's managed care organizations or your state Medicaid agency use CAQH for credentialing so you do can reduce the amount of time spent on credentialing applications.

3. **Maintain a credentialing binder or digital dossier with all essential documents if you don't already use the CAQH system** (i.e., licenses, NPI, DEA, malpractice insurance, IRS W-9, etc.): This should be maintained for all licensed team members, whether it is a dental hygienist or an expanded function dental auxiliary EFDA) professional. The CAQH system provides a free digital lockbox to store up-to-date credentialing information and provides a reminder system, so your profile always remains current. Even when your state or MCO does not automatically use CAQH, often a download of the application form is a suitable to transmit credentials stored in CAQH when it is time to renew.

4. **Create a credentialing calendar to track renewals and recredentialing deadlines.**

5. **Assign responsibility**: a staff member could serve as an official or unofficial Credentialing Coordinator or Medicaid Coordinator and be the lead for all-things credentialing or Medicaid.

6. **Follow-up**: always ensure confirmation is obtained.

By implementing these practical safeguards, practices protect reimbursement reliability, maintain uninterrupted access for Medicaid beneficiaries, and reduce administrative strain that often discourages dentist participation.

Quick Win	Develop a one-page Credentialing Checklist and review it quarterly to prevent lapses.
Patient Impact	Smooth enrollment and timely credentialing ensure faster dentist availability for patients who need access to dental care.

Operational Efficiency: Appointment Design, Roles, and Office Culture = Patient Compliance and Continuity

Financial sustainability in dentistry hinges on the ability to preserve quality and time with the patient, while making considerations for efficiency as it is critical to sustainability. Practices with strong scheduling protocols, optimized staff utilization, and a shared value and office culture are better positioned to provide care without overwhelming financial losses.

Schedules should be designed around predictable administrative steps: eligibility verification, benefit checks for planned procedures, pre-visit prior authorization (if applicable), effective patient communications, and all members of the dental team working at the top of their license or ability. While each practice may develop a different strategy, those who adopt layered reminders (e.g., a call one-week out from the appointment, a reminder text at 48 hours, a call at 24 hours, same day text) reduce no-shows; when coupled with a same-day standby list and a defined rescheduling protocol, overall chair-time utilization improves without compromising care or patient safety. Other scheduling and no-show management strategies include double-booking slots where no-shows are common, maintain a

standby list to fill-last minute cancellations, adopt a clear no-show policy that is consistent for all patients, and offer same day treatment or services when possible. These operational choices are consistent with best-practice recommendations for reducing avoidable cancellations and aligning services to meet patient needs.

Below is a productivity goal that some safety-net clinics have used to ensure they can remain financially sustainable. It helps them understand the necessary pace and how to use the clinic's resources most effectively.

Productivity Based on Practice Assets

# of Chairs/ # of DA's	1 Dental Chair	2 Dental Chairs	3 Dental Chairs
1 Dental Assistant	1.2 patients per hour	1.4 patients per hour	No recommendation
2 Dental Assistants	No recommendation	1.6 patients per hour	2.2 patients per hour

Source: A clinic in Wisconsin

Utilizing all dental team members efficiently and effectively, through expanded utilization of allied personnel, where permitted by state law, preserves dentist time for complex diagnostics and procedures. For example, if a hygienist is trained or certified in your state to inject local anesthetic, you can use a short window of their time to do so while you work on other patients for an additional 15-20 minutes. This can be done under general, direct, indirect, or unsupervised supervision depending on your state.

An emerging trend in some state Medicaid programs is the reimbursement of teledentistry. However, the modalities and rules/regulations around teledentistry vary in every state. 14 states reimburse for D9995 (synchronous) and D9996(asynchronous), which are CDT codes often used in teledentistry encounters. Some states have very unique situations for reimbursement in their Medicaid programs. For example, Georgia's Medicaid program only reimburses for store-and-forward services related to teledentistry in a school-based setting for Medicaid. However, there are states like Oregon that reimburses dental dentists for remote monitoring.

There are multiple modalities for incorporating teledentistry in your practice. A common modality is to the Virtual Dental Home (VDH) model. VDH allows community-based clinical team to upload the patient information through a secure web-based cloud storage system for review by a dentist at a clinic or dental office. The records are not reviewed in real time, but at the convenience of the dentist (i.e. before and after office hours, during openings in the schedule including downtime created by patient cancellations). Some dentists have partnered with hygienists that visit multiple sites such as residential facilities for people with mental illnesses or developmental disabilities, nursing home facilities, and community centers using this model. Another modality, which is dependent on state regulations, is for practices to link with school-based programs that do not have a dentist on site and helping prescribe SDF application, which can then be performed by a hygienist.

Another way to improve efficiency is to implement morning huddles, which provide an opportunity to discuss all patients and not stigmatize Medicaid beneficiaries. Rather, these short 10–15-minute meetings can be used to discuss patient appointment history and whether the appointment is

confirmed, as well as the required items needed prior to the planned services (i.e., prior authorization, documentation, etc.), regardless of insurance type. This discipline shortens cycle time and reduces post-visit documentation gaps or delays that lead to inaccurate clinical documentation or claims denials.

The ADA has created a **Medicaid Provider Resource: Strategies to Reduce Missed Appointments** which outlines more detailed opportunities for a practice to incorporate standardizations. As a reminder, a successful practice engages the patient and creates understanding of time and value, utilizes scheduling best practices, maximized practice staff and expanded workforce models, and demonstrates compassion. *It is important to note that despite the desire to charge a fee for a cancelled or missed appointment, Medicaid beneficiaries are excluded from such charges due to federal statutes and regulations.* Also, the practice must maintain one unified policy for all patients as to the protocol for missed appointments.

Patient compliance is one of the greatest challenges for Medicaid dental practices. Missed appointments, transportation constraints, work and caregiving conflicts, lack of treatment adherence, and limited health literacy create inefficiencies and lost revenue. A sustainable practice addresses these barriers systematically. Transportation and logistics assistance may be something the state Medicaid program or the managed care organization offers. Practices may ask patients coming to their office if they have reliable transportation to the appointment to help facilitate a linkage between the transportation company or MCO. Many practices have found ways to utilize motivational interviewing to help build trust, understanding, and in return improved appointment retention.

MCOs are required to provide translation services at no cost to the beneficiary, including oral interpretation and written translation of important materials, for individual with limited English proficiency or communication needs. Other **interpretation services** can help develop strong communication and trust between your staff and patients. Including regular review of your print and electronic materials will help **make health literacy part of your practice**.

In all efforts, it is essential to reframe attendance to the necessity to have a dental home, and as a shared commitment to oral health. Compassion, patience, and the ability to actively listen will support Medicaid beneficiaries and alleviate practical barriers before they lead to disengagement.

HEAR IT FROM YOUR DENTAL COLLEAGUES…ABOUT EFFICIENCY AND SCHEDULING

“We do what we can to accommodate same day treatment on a patient's exam day. This bumps production significantly. We also have a robust confirmation system. More than any of that, my front office team works hard to get to know the families and treat them as our own extended family. That level of trust helps us to minimize failed appointments which is the biggest killer of production.**”**

— Dentist from Missouri

“Have a strict no-show policy- one no-show or two cancellations within 24hrs of their appointment, and they are "same-day" or "walk-in" only.**”**

— Dentist from Illinois

Here are seven key steps to improving operational scheduling efficiency:

1. **Design efficient schedules**: Build scheduling systems around predictable administrative needs, including eligibility verification, benefit verification, and prior authorization status. Set up scheduling templates that can maximize chair use for your patients. Incorporate layered patient reminders, maintain a standby list, and adopt a consistent no-show policy to maximize chair-time utilizations without compromising patient care. Some dental practice owners or leaders may suggest double or triple booking Medicaid beneficiaries. While some dentists may be comfortable with this workload, many dentists have suggested that this frequently leads to burnout and job dissatisfaction.

2. **Leverage the full dental team**: Ensure all team members work at the top of their license, training, or skill. Expanded utilization of allied personnel, where permitted by law, preserves dentist time for complex procedures and improves overall productivity.

3. **Incorporating teledentistry into your practice:** Check with your state Medicaid program to see if it reimburses for any teledentistry modality. Offer to partner with community-based programs that can help you provide access to care while receiving reimbursement when there is an opening in your schedule.

4. **Frequently review your exact no-show rate:** Practices have as small as 4% in their no-show rates, even among Medicaid beneficiaries, ultimately because they are frequently reviewing their no-show rate and engaging in improvement activities. These activities can include scheduling improvements, more reminders or stringent enforcement of their no-show policies.

5. **Conduct structured morning huddles**: Begin each day with a team review of all patients, confirming appointment status, identifying required documentation or prior authorizations, discussing treatment complexity, outstanding needs or history of diversion, and addressing any risk factors for missed visits. This prevents delays, reduces documentation errors, and promotes shared accountability across the team. Having an individual designated as the Medicaid Coordinator can help improve efficiencies. Incorporating a checklist that includes eligibility and prior authorizations, required forms, and appointment confirmation, with the designated individual signing their initials in your electronic health record can ensure accountability and improve practice operations.

6. **Minimize scheduling whole families into blocks:** While some families may prefer to do multiple's family members' dental visits all in one day, this can be detrimental to a dental practice if a family does not show for the appointment and leads to multiple hour vacancies in your schedule. If transportation is a factor, offer to connect them with the MCO transportation hotline, if available, or the direct number for the non-emergency transportation company that has been approved by Medicaid.

7. **Engage patients with compassion and clarity**: Communicate the value of appointments, use clear and consistent messaging about attendance expectations, and provide alternatives when barriers arise. While Medicaid regulations prohibit charging missed-appointment fees, practices can foster accountability through education, accessibility, consistent follow-up, or limited

appointment options (such as same-day or waiting list) for those who consistently break or cancel appointments.

By implementing these, practices protect their operational efficiencies which will ensure continuity of care, preserve reimbursement reliability, and promote long-term viability of Medicaid participation.

Quick Win	Run a monthly no-show report to understand your practice's exact no-show rate, and work with your front desk to minimize no-shows across all payer types.
Patient Impact	Offering empathy and solutions, patients will feel respected, supported, and valued, rather than judged, which will strengthen trust in their dental home, improve adherence to future visits and treatment completion, and promotes better long-term oral health outcomes.

Patient - Payer Mix and Other Revenue Strategies: Balancing Mission and Margin

Policies and sudden changes of coverage within Medicaid can potentially create losses that are difficult to recoup in the short term. Dentists have reported successfully participating in Medicaid with a mix of anywhere between 2% - 50% of a practice's patient mix having Medicaid, and this will be dependent on your state's fee schedule or MCO reimbursements for dental services. In a survey of 83 dentists in private general or pediatric dental practices, the average share of patients having Medicaid was 24%, and the most commonly cited percentage of Medicaid beneficiaries in the patient mix was 20% (Source: Internal ADA Survey).

Understanding annual limits and non-covered services in Medicaid are important and will be listed in the state Medicaid agency's provider manual or the MCO's dentist manual. As many as 12 states have annual dollars limits for the pediatric dental benefit, and even more states have annual or biannual dollar limit. While most treatments are covered for the pediatric population through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, there are some limitations on orthodontics for children that vary by state. Non-covered services can often be found in a state's adult dental Medicaid benefit and greatly vary by state. For example, many state Medicaid programs do not cover topical application of fluoride for adults, and a few states with an adult dental benefit do not provide coverage for dentures.

A Medicaid-inclusive practice can remain financially stable by also balancing the procedure mix, managing chair-time, and offering the full portfolio of all non-covered services and preventive services offered by the dentists. Federal law prohibits Medicaid beneficiaries being balance billed for covered services, and dentists should expect to write off the difference between the practice's charge and what Medicaid/MCO reimburses. However – Medicaid beneficiaries may have unique circumstances (i.e., a small line of credit or help from a family member) that still allow them to pay full fee for non-covered services.

Service diversification should be evidence-based and transparent for patients. Clear, written estimates for non-covered services and straightforward in-office payment options reduce confusion and help patients make informed decisions. It is also important for the administrative or operations team to ascertain before a patient's appointment if they have visited a dentist within the last year – as many Medicaid programs will not reimburse for cleanings, comprehensive oral exams, or bitewing x-rays within the same year. States also have varying fee schedules that may underpay or incentivize prevention – and it is important to check the rates for these particular services closely.

To reduce wait time and revenue losses, it is best practice to schedule initial visits for patients with dentists instead of dental hygienists. Creating initial visits (in 15–20-minute blocks) as staggered appointments for x-rays and limited/comprehensive oral exam for an hour with a dentist and dental assistant(s) can yield better results and return as opposed to scheduling an initial visit with a dental hygienist. If the patient requires treatment, a dentist can then immediately have them scheduled for their next appointment, develop a treatment plan, and submit prior authorizations. This will allow the patient to be treated by a dentist in a faster time frame and allow individuals to later join the hygiene schedule and schedule dental recall visits. When considering implementing such strategy, practices should ensure it aligns with the dentist's professional philosophy and complies with all applicable state regulations.

Continued oversight of revenue, production, and other key operational performance metrics will drive operational decisions, like addition of a team member, that support a sustainable and financially healthy practice. Balancing commercial insurance and cash-pay patients will also stabilize revenue. For further information, you can download the **ADA's Guidelines for Practice Success: Managing Finances**.

HEAR IT FROM YOUR DENTAL COLLEAGUES … ABOUT FEES, COVERED SERVICES

"Look at the fee schedule first and ensure that it is at least in line with what other PPO plans you take pay, understand non-covered services and how to present them to patients. [Familiarize yourself] with how Medicaid wants you to present non-covered services … Give them their options whether the service is covered or not.**"**

— Dentist from Utah

"Train your team - this is likely a new patient group with different needs than what your team is used to…The more you have your team bought into this change, the better the experience for the patient and the whole team, decide your metrics. Are you only going to take referred patients? Are you going to limit to a certain percentage? Another metric? Like any other business venture, it is important not to over-extend and ruin the experience for yourself, your team, and your patients. The more prepared you are to take on your desired metric, the more likely to succeed, Be open. You will hear and experience life through a different lens from your own. Be curious and not judgmental. The more you show your community you are there for them, the more you will build that trust, especially with a group of folks that are not often used to being treated with value."

— Dentist from Missouri

Here are four key steps to optimize reimbursement:

1. **Understand your patient mix**: Understand the percentages of Medicaid, commercial, and cash-pay patients that may make up your patient mix.

2. **Monitor and adjust patient-payer mix**: Review patient-payer mix monthly with administrative and operations staff and do so when a new dentist joins the team. You can often generate a report or query on this mix through your electronic dental record or practice management software. If the Medicaid volume exceeds sustainable levels, adjust scheduling protocols or market to new patients of a different payor to rebalance schedule templates while maintaining access for vulnerable populations and ensuring your internal protocols do not create further disparities. Contrary to popular belief, you are able to tell your state Medicaid agency or managed care organizations that you are at capacity for accepting new patients from Medicaid. However, you cannot deny access to some Medicaid beneficiaries while selecting some Medicaid beneficiaries to become patients who you believe will acclimate to your practice–this may violate your contract with managed care organizations and federal law.

3. **Diversify services transparently**: Offer all evidence-based services that complement Medicaid-covered care, whether these be preventive or non-covered services. Provide clear written estimates and consent forms outlining the patients' responsibility for non-covered services. Offer several payment options that may help patients make informed decisions. You can use **this fee schedule to negotiate your fees with MCOs** and define production and revenue goals that align with your practices' financial stability.

4. **Check on preventive care rates, then customize initial visits and recall systems**: After understanding rates, build optimal schedules around initial visits and risk-based recall interval.

By implementing these strategies, practices protect their revenue strategy without compromising mission, patient safety, and promote long-term viability of Medicaid participation.

Quick Win	Select your benchmark for how many Medicaid beneficiaries will make up your payer mix and schedule a meeting with your administrative or operations team after the first month or quarter to ensure your team is not exceeding the benchmark.
Patient Impact	Diversified revenue allows practices to continue serving Medicaid beneficiaries without compromising financial viability.

Reimbursement Optimization: Documentation, Claims, and Prior Authorizations

Reimbursement challenges are among the most significant barriers faced by Medicaid dentists. Denied claims not only delay payment but also increase administrative burden and reduce staff morale. Practices that consistently submit clean claims, submit accurate CDT codes and required narratives/documentation, and maintain denial logs recover significantly more revenue.

Medicaid claims can be paid promptly and consistently, just like private insurance, when clinical documentation and submission processes match program expectations. Practices should institute a standard that includes eligibility verification at scheduling and again day-of, coding accuracy aligned to the current **CDT manual**, and mandatory inclusion of narratives and radiographical/clinical evidence for procedures commonly denied without documentation.

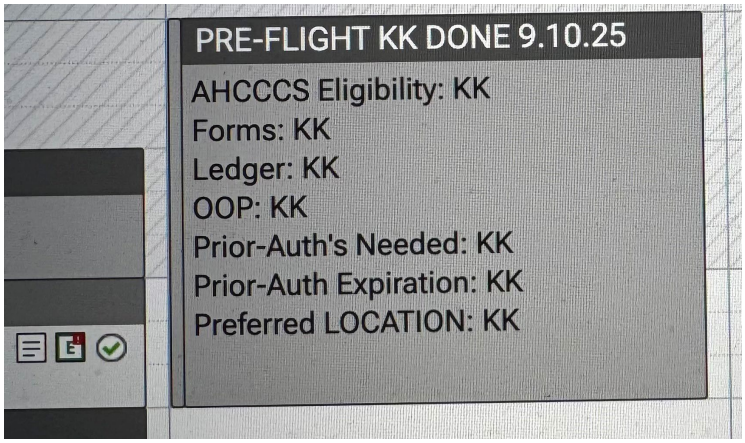
Denial management should be a measured, data-driven function. Practices should maintain a denial log, review trends monthly or quarterly, and update pre-submission requirements when patterns emerge. Commitment by the entire team to improve claims processing through improving identified roadblocks, like labeling tooth numbers on an intraoral camera picture, strengthen results. Developing templates for appeals that cite the clinical notes, additional documentation, and the medical necessity with attached clearly labeled supporting evidence will improve the success rate. Referencing your state Medicaid agency manual and MCO(s) provider handbook will also improve prompt claim payment.

Medical necessity in dentistry refers to the professional determination that a dental service or procedure is essential to prevent, diagnose, or treat a dental disease, injury, or condition that affects a patient's oral or overall health. For Medicaid claims, this means the treatment must be justified as more than cosmetic and must address a functional or health-related need, such as relieving pain, eliminating infection, restoring normal chewing or speech, or preventing significant deterioration of oral structures. Documentation is critical; dentists must provide clear clinical notes, diagnostic findings, and supporting evidence (such as X-rays or periodontal charts) to demonstrate that the service meets Medicaid's criteria for coverage. In many states, this may require the dentist to also document **corresponding ICD-10 codes**.

Checking your provider manual around medical necessity is crucial because some states mandate a medical necessity statement or narrative on every claim beyond preventive care. Others only require it when the procedure is outside standard frequency limits, requires prior authorization, or is typically considered elective/cosmetic. Narratives or statements should not be vague (i.e. "needed for oral health") and should include a concise but specific narrative in the claim explaining why the procedure is medically necessary. Without adequate proof of medical necessity, Medicaid may deny or recoup payment even if the procedure was performed appropriately.

While commercial dental plans may support "predetermination" -- an assessment of benefit availability on the date of such determination with no guarantee of payment, many states Medicaid agencies require "prior authorization" – an assessment of medical necessity with a guarantee of payment. Adhering to prior authorization guidance and participating in modernization will ensure the patient's eligibility for services and subsequent claim payment. As a reminder, a Medicaid beneficiary cannot be charged for a covered service, and in the instance of a non-covered service, a practice standard of having the patient sign a consent form is a best practice. The ADA has created a **Medicaid Provider Resource: Strategies to Reduce Denials and Improve Efficiency** which outlines more detailed opportunities for a practice to incorporate standardizations.

Whether you plan on implementing a morning huddle or not, designating an individual in your practice can improve efficiencies. Incorporating a checklist that includes eligibility and prior authorizations, required forms, and appointment confirmation, with the designated individual signing their initials in your electronic health record can ensure accountability and improve practice operations.



Source: A clinic in Arizona

Note: AHCCS = Arizona Health Care Cost Containment System [AZ's Medicaid Program], OOP = Out of Pocket Payment

While this example above is specific to one practice, you may utilize your dental electronic health record (EHR) to model this checklist to improve pre-appointment planning preparations and efficiencies.

Beyond the strategies discussed in this section, these additional tactics will maximize payment or improve payment timeliness include:

- Train staff on annual CDT updates or changes made by the state Medicaid program (i.e., changes to the state Medicaid provider manual or MCO provider handbook and the required narratives). This will help support standardized protocols for clinical notes and documentation.
- Submit claims electronically with required documentation (i.e., x-rays, intraoral images, clinical notes, medical necessity, etc.) and diagnostic codes, if applicable.
- Use standardized appeal templates that cite payer policy and clinical justification

HEAR IT FROM YOUR DENTAL COLLEAGUES … ABOUT NAVIGATING DOCUMENTATION, PRIOR AUTHORIZATION, AND DENIAL

"Form a relationship with caring champion (or provider representative) inside the Medicaid entity [or MCO] who can give you direction and have a network of resources who understand how to navigate the space."

— Dentist from Massachusetts

Here are six key steps to optimize reimbursement:

1. **Develop clean claim workflow**: Eligibility Verified → Treatment Plan or Preventive Visits Review with Patient → Patient Scheduled → Eligibility Verified → Services Rendered → Accurate Documentation and Clinical Notes Attached → Claim Summitted → Payment/Denial Logged → Appeal (if necessary)

2. **Understand the pathway**: Reimbursement depends on alignment with state Medicaid program rules at every level – CMS established federal requirements, state Medicaid agencies set program-specific guidelines such as non-covered services and potentially included MCO(s) administer day-to-day operations and set their own fees and billing requirements. Dentists should ensure their documentation and billing practices are consistent throughout the pathway.

3. **Maintain a documentation binder**: Just as credentialing requires organized records, reimbursement success requires a central repository for claims-related essentials: CDT coding updates, payer specific requirements, clinic notes and documentation, radiographic or clinical requirements, prior authorization forms, and sample appeal template.

4. **Create a claims/denial tracker**: Tracking prior authorizations, denials, and outstanding claims can decrease delay in payment. In creating a tracker, list the patient, date of service, CDT code(s), claim submission date, denial reason (if applicable), action taken, resolution, resolution date, and additional notes. Analyze trends of frequent claim denials to help develop a centralized solution for similar claims to move forward in the pipeline in the future.

5. **Assign responsibility**: A staff member could serve as the Medicaid Claims or Reimbursement Coordinator to oversee claim submission, denial logging, and appeals. This individual should also serve as the practice's main contact with MCO representatives and stay informed of policy updates.

6. **Follow-up and confirmation**: Always secure of claim receipt (at any level), prior authorization status, and appeal determinations. Documenting payer correspondence protects the practice in case of disputes and prevents unresolved revenue loss.

By implementing these, practices protect reimbursement reliability, maintain uninterrupted access for Medicaid beneficiaries, and reduce administrative strain that often discourages dentist participation.

Quick Win	Assign a "Reimbursement Champion" on staff to monitor claims, oversee denials, lead appeals, and monitor trends to offer changes in practice protocols and standardizations.
Patient Impact	Accurate and timely claims prevent billing disputes which helps ensure patient satisfaction, dentist and staff morale, and financial success.

Risk Management and Quality Assurance

Medicaid participation should be embedded within the practice's overall framework for quality and risk management. This requires standardization of informed consent, post-operative instructions, documentation of medical necessity, and incident report. Clinical protocols must be aligned with evidence-based guidelines, and dentists should be routinely calibrated to reduce variability that leads to denials, retreatment, or inconsistent outcomes. Quarterly chart review of Medicaid cases should be prioritized to confirm that documentation, coding, and narratives meet payer expectations and reflect current clinical standards.

Quality assurance (QA) in dentistry encompasses the systematic processes that ensure care consistently meets professional, regulatory, and payer standards. QA functions on two levels:

- Clinically, it safeguards safety, enforces adherence to evidence-based practice, calibrates dentists, and monitors outcomes.
- Administratively, it secures accurate documentation, ensures compliance with payer requirements, and incorporates regular internal audits of records and workflows.

For Medicaid-inclusive practices, QA is especially critical because reimbursement is directly tied to documentation, accuracy, coding precision, and evidence of medical necessity. Integrating QA into daily operation through chart audits, staff training, continuing education, incident tracking, and policy updates reduces denials, enhances patient safety, and demonstrates accountability to patients and peers.

This extends beyond error prevention. It represents a culture of continuous improvement, compliance, patient-centered care. This culture sustains Medicaid participation, strengthens program integrity, and builds patient trust by ensuring that beneficiaries receive safe, effective, and equitable treatment.

HEAR IT FROM YOUR DENTAL COLLEAGUES … ABOUT MITIGATING RISK AND IMPROVING PATIENT-CENTERED CARE.

"Make sure you document, code for what you do and support it with diagnostic films, treat all patients equally (don't label them by their form of payment)."

— Dentist from Arizona

Here are four key steps to prioritize quality assurance:

1. **Standardize documentation**: Use consistent templates for informed consent, medical necessity, narratives, and post-operative instructions.

2. **Conduct regular audits**: Review a sample of Medicaid charts quarterly to verify coding accuracy, documentation completeness, and alignment with payer requirements.

3. **Calibrate dentists and staff**: Hold periodic case reviews and clinical calibration sessions to reduce variability and ensure consistency across the dental team.

4. **Train and update staff**: Provide ongoing training on payer policies, compliances requirements, and changes in Medicaid guidelines to minimize errors and denials. This could be mentioned at a morning huddle.

By implementing these practices, dental teams strengthen quality assurance systems, safeguard compliance, reduce preventable denials, and promote sustainable Medicaid participation while maintaining patient safety and trust.

Quick Win	Implement a quarterly "Medicaid Quality Check" by auditing five randomly selected charts for documentation and coding accuracy. Share results with the team at a staff meeting to highlight strengths and correct areas of improvement.
Patient Impact	Strong QA practices ensure accurate, safe, and consistent care. Patients benefit from fewer delays, improved trust, and confidence that their treatment is both clinically sound and properly supported for Medicaid coverage.

Advocacy and Policy Engagement: Practice Data to Policy Impact

Medicaid reimbursement, policies, and administrative rules are determined at the state and payer level. Medicaid dentists can help influence change by engaging in targeted advocacy efforts through their state dental association and/or oral health coalition.

Practical advocacy actions for dentists includes:

- Participate in state Dental Advisory Committee(s) to provide input on coverage and administrative barriers.
- Submit practice-level de-identified data (denials, prior authorizations delays, reimbursement companions) to advisory committees and policy makers to support legislative efforts.
- Maintain a one-page summary of Medicaid practice data and why you serve these patients will support both advocacy and payer negotiations. It highlights trends and reinforces the dentist perspective.
- Ask patients (with written and informed consent) if you can share their stories about how the Medicaid dental benefit has improved their lives with state government officials.
- Participate in your state dental association/society's advocacy day.
- Contacting the State Medicaid Agency or MCO if there are continual issues with a patient's non-emergency medical transportation benefit.

HEAR IT FROM YOUR DENTAL COLLEAGUES … ABOUT ADVOCACY.

"Keep a running list of concerns/issues that need change or improvement and get involved with all other dentists in the state [through your dental society] to organize and schedule a conversation with state Medicaid agency to show them that you are a good resource for them to improve and thus gain more providers in broader coverage of the state."

— Dentist from Nebraska

The ADA continues to support efforts to reduce administrative burden and make reimbursement more adequate and predictable. Utilizing the **ADA's State Medicaid Advocacy Toolkit**, submitting dentist or patients' testimonies into the **ADA's StoryBank**, and engaging with the state dental association will only enhance advocacy efforts. More information can be found at **ADA.org/Medicaid** and **ADA.org/MedicaidResources**.

While there are not always quick wins in advocacy – what might be small, meaningful changes can help improve the system at large for both the dentists and patients. For example:

- In 2025, West Virginia lawmakers extended their $1,000 annual limit to $2,000 every two years so that Medicaid beneficiaries would have dentures fully covered.
- In 2025, Wisconsin lawmakers recently passed a funding increase for dental services to individuals with intellectual or developmental disabilities. This means these services will be paid at a significantly higher Medicaid reimbursement rate, which could help broaden access for this population.
- In 2024, Nebraska lawmakers removed their annual monetary limits on dental services in Medicaid while the State Medicaid Agency is moving towards centralized credentialing among multiple MCOs.

This list is not fully inclusive of all recent advocacy victories around Medicaid dental services, but it does demonstrate that creating avenues for small change may have larger buy-in and still make meaningful difference in access and experiences for patients.

Appendix I: Checklist for States' Adoption of State Toolkit

While this toolkit can help provide general strategies, ultimately each practice will need to make decisions and better understand their workflow based on state-specific items that can only be found with a state Medicaid agency or applicable MCOs. While not fully inclusive, here are some items that may be considered when creating a state-specific toolkit.

- State FFS Fee Schedule
- Treatment Coverage for State (List of Qualifying Procedures w/Limitations)
- Provider handbook for Medicaid & MCO(s) provider manual(s) hyperlinked
- Credentialing/Enrollment Webpage and Best Contact (in case they have one or two reliable people to use)
- State Contacts for Non-Emergency Transportation
- Resource list of physicians and other healthcare providers who accept Medicaid to aid in facilitating referrals

Appendix II: Glossary of Terms

CAQH System – *Council for Affordable Quality Healthcare Credentialing System:* a centralized database that gathers essential data like education, work history, and licenses to facilitate credentialing and network management with payers and dentists.

CHIP – *Children's Health Insurance Program*: a joint federal-state program similar to Medicaid that provides low-cost health coverage to children and pregnant women in families that earn too much money to qualify for Medicaid.

CMS – *Centers for Medicaid & Medicare Services*: the federal agency that provides health coverage to more than 160 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

EPSDT – *Early and Periodic Screening, Diagnostic, and Treatment Services:* a comprehensive package of Medicaid services for children and youth under age 21 that provides necessary preventive, diagnostic, and treatment services to identify and correct health conditions early, ensuring children receive the care they need, even for services, such as dental, not covered by a state's standard Medicaid plan.

MCO – *Managed Care Organization*: a healthcare plan that coordinates and delivers healthcare services on behalf of Medicaid beneficiaries by contracting with a network of providers. MCOs are the predominant delivery system for state Medicaid programs, and delivers tiered networks similarly to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).