children's dental health project

TO: Seema Verma, M.P.H.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

FROM: Children's Dental Health Project

DATE: January 14, 2019

RE: CMS-2408-P: Proposed Regulations regarding Medicaid Program: Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Submitted electronically via regulations.gov

Dear Administrator Verma:

The Children's Dental Health Project (CDHP) appreciates the opportunity to comment on the proposed regulation shared by the Centers for Medicare & Medicaid Services (CMS) regarding efforts to streamline the Medicaid and Children's Health Insurance Plan (CHIP) managed care regulatory framework.

As an independent organization dedicated to advancing innovative policy solutions to eliminate dental disease as a barrier to child and family success, we believe everyone, regardless of socioeconomic status, benefits from strategies that improve child wellbeing. We believe that any coverage for children must ensure access to timely, affordable, high-quality and age-appropriate care, including dental care, that meets children's unique needs. We support a number of ideas in this proposed regulation which would streamline processes, but we are concerned that some of the proposed changes may endanger access to high quality, age-appropriate dental professionals and specialists for children and families.

Oral health is critical to overall health, and impacts school performance,[1] employability,[2] and military readiness.[3] Therefore, timely access to oral health care is of vital importance to children and families. Untreated dental disease can cause pain, missed school or work days,[4] worsening of other health issues,

[1] H. Seirawan et al., "The impact of oral health on the academic performance of disadvantaged children," Amer J of Public Health, Sept. 2012.
[2] Glied, Sherry, and Neidell, Matthew. "The economic value of teeth." J of Human Resources 45.2 (2010): 468-496. AND Hyde S, Satariano WA, Weintraub JA."Welfare dental intervention improves employment & quality of life." J Dent Res. 2006; 85(1):79-84.
[3] Bipartisan Policy Center. 2012. "Lots to lose: How America's health and obesity crisis threatens our Economic Future." AND Simecek JW, Colthirst P, Wojcik BE: "The incidence of dental disease non-battle injuries in deployed U.S. Army personnel." Mil Med 2014; 179(6): 666–73.
[4] Jackson, S. L., Vann, W. F., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of Poor Oral Health on Children's School Attendance and Performance. *American Journal of Public Health*, *101*(10), 1900-1906.

and unnecessary emergency room expenditures.[5] However, dental disease is largely preventable, and consistent access to early interventions and treatment can help children achieve optimum health while minimizing cost throughout the lifespan.[6] Yet access to oral health care has historically been complicated by a variety of issues including cost and geography, with vulnerable populations like rural communities and low-income communities facing particular challenges.[7] Furthermore, treatment of complex dental issues can require multiple visits and access to specialists. Inadequate coverage, lack of coverage, or lack of appropriate provider networks can exacerbate these pre-existing health inequities. However, as a result of benefits offered under Medicaid and the Children's Health Insurance Program (CHIP), the dental uninsured rate among children is at an all-time low. Ninety percent of children have some form of dental coverage[8] and the gap in oral health care use between low-income and high-income children has narrowed.[9]

We are concerned that recent trends relaxing oversight, compounded with this proposed regulation, may negatively impact access to dental care for Medicaid beneficiaries.

Understanding the impact of oral health on overall health and well-being, CMS has made great efforts to improve access to children's oral health care. According to CMS's Oral Health Initiative data, only 42% of Medicaid-enrolled children ages 1-20 across the nation received a preventive dental service in 2011.[10] However, the efforts of CMS and states are beginning to pay off: by 2016, 46% of those children were receiving a preventive dental service.[11]

We are concerned about any regulatory changes which might remove safeguards that ensure access to oral health care for children and families. Just last year we saw such changes proposed to the Medicaid Access Rule. Under the March 2018 proposed regulation, almost a dozen states that deliver dental care to all or most enrolled children through fee-for-service payments would be exempted from having to address dental care in their Access Monitoring Review Plans, because a high proportion of their enrollees get their medical care through managed care. We would caution that some of the efforts in this proposed rule may further remove expectations of state agencies and protections for children. We

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[5] American Dental Association: Health Policy Institute. (February 2018) Emergency Department Visits for Dental Conditions – A Snapshot. Retrieved from:
https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0218_2.pdf?la=en

[6] Beil H, Rozier RG, Preisser JS, Stearns SC, Lee JY. Effect of early preventive dental visits on subsequent dental treatment and expenditures. Med Care. 2012;50(9): 749–756.

[7] MacDougall H. (2016) Dental Disparities among Low-Income American Adults: A Social Work Perspective. Health and Social Work.41(3):208-210. doi:10.1093/hsw/hlw026. Retrieved from:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985883/
Rural Health Information Hub. (February 2017). "Oral Health in Rural Communities." Retrieved from:
https://www.ruralhealthinfo.org/topics/oral-health

[8] American Dental Association Health Policy Institute. (November 2017). Dental Benefits Coverage in the U.S. Retrieved from:
https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1117_3.pdf?la=en

[9] American Dental Association Health Policy Institute. (November 2017) Dental Care Utilization in the U.S. Retrieved from:
https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1117_2.pdf?la=en

[10] Form CMS 416 data for FFY 2011, Lines 1b and 12b, available at
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

[11] Form CMS 416 data for FFY 2016, Lines 1b and 12b, available at
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

fear there is great potential for network adequacy and access to oral health care to suffer in the name of streamlining processes.

Analysis and transparency are critical in the oral health arena because participation and utilization rates have historically been low and have required active interventions. Indeed, a 2000 report by the Government Accountability Office (GAO), showed that an inability to find willing treatment providers was the most commonly cited issue from Medicaid and CHIP beneficiaries, citing that "Some low-income people live in areas where dental providers are generally in short supply, but many others live in areas where dental care for the rest of the population is readily available."[12] By and large, the situation is improving, but similar barriers to care, particularly difficulty finding dental providers, persist. Some patients report waiting months for appointments and others simply cannot find care providers.[13] The American Dental Association encourages their members to participate in Medicaid programs, but they report that only 39% of their members participate in Medicaid.[14] That number varies widely depending on the state and on the subspecialty within dentistry, and is further complicated by how many Medicaid patients said dental professionals take on.

Change is possible; however, it requires creating an environment where a lack of access can be clearly defined and addressed. For example, in California in 2016, only 44% of children enrolled in Medicaid had a dental visit, compared with 67% of the state's commercially insured children, and in 2016 only about 16% of licensed dentists in California participated in Medicaid. These numbers are changing thanks to efforts like the Dental Transformation Initiative which addresses high need issues, including improved reimbursement and decreased administrative load on dental professionals. However, these changes came about because of critical transparency and national and state level oversight.

The Children's Dental Health Project supports state flexibility, but history has also shown us the value of federal standards and supervision.

Our specific concerns in the proposed regulation are as follows:

Information to Plan Enrollees (§438.10)

The proposed regulation would no longer require all taglines be formatted in large fonts in prevalent non-English languages on all print materials. While this would alleviate concerns that such requirements limit the use of smaller and simpler document formats, like postcards and brochures, this does not address the more serious concern contained in the previously specified interpretation of the regulation. This standard is based on guidance from the American Printing House (APH) for the Blind (81 Fed. Reg.

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[12] Government Accountability Office (at the time the Government Accounting Office). (September 2000). Factors Contributing to Low Use of Dental Services by Low-Income Populations. Government Accountability Office. Retrieved from: https://www.gao.gov/assets/240/230602.pdf

[13] Frosh, W. (Spring 2017). Strategies to Enhance Dentists' Participation in Medicaid A Review of Current Practices. Missouri Foundation for Health. Retrieved from: https://mffh.org/wordpress/wp-content/uploads/2017/04/Policy-Strategies-to-Enhance-Dentists-Participation-in-Medicaid.pdf and Bakst, B. (November 28, 2018). Low-income Minnesota families struggle to get dental care. MPR News. Retrieved from: https://www.mprnews.org/story/2018/11/28/low-income-minnesota-families-struggle-to-get-dental-care

[14] American Dental Association Health Policy Institute. (March 14, 2018) Dentist Participation in Medicaid or CHIP. American Dental Association Health Policy Institute. Retrieved from: https://www.ada.org/en/publications/ada-news/2018-archive/march/more-than-a-third-of-all-us-dentists-participate-in-medicaid-or-chip-for-child-dental-services

27724). The APH established standards for print documents, including the minimum of 18 point font for large print, to allow "optimal usability for persons with low vision." The APH developed its standards for large print and other features for print document readability based on "research that originated from the study of the impact of print characteristics on readers."[15]The proposed regulation replaces this language with more vague guidelines like "conspicuously visible." The ultimate purpose of requiring larger type and a variety of languages is supporting beneficiaries and their families. If these documents cannot be easily read by their recipients, this could impede beneficiaries' access to coverage and care.

This proposal would also alter requirements for notifying beneficiaries and their families of of provider termination from a network. Current policy requires beneficiaries or their families receiving regular care from a provider be informed with within 15 days of termination notice. New guidance would require plans to contact beneficiaries by 30 days prior to effective date of final termination of their healthcare provider. We are concerned that this could have a serious impact on beneficiaries hoping to smoothly transition to a new provider. As we mentioned earlier, finding dental professionals accepting new Medicaid patients can be particularly difficult. This challenge only increases for beneficiaries in rural areas or those requiring specialist care. For parents and families, advanced notice is crucial for continuity of care.

This section also seeks to change requirements that managed care plans provide updated, monthly printed provider directories to beneficiaries. Under this proposal, managed care plans could forego this requirement if they instead provide access to a mobile-enabled, electronic directory. The language of the proposed regulation points out that "64 percent of U.S. adults living in households with incomes less than $30,000 a year owned smartphones in 2016." However this still leaves a significant portion of beneficiaries who do not have access to a smart phones or reliable internet access without an accessible and updated provider directory. It is vital that any such change in how beneficiaries access information about their plans and providers is monitored in an intentional way, with considerations for ease-of-use, understanding of any limitations of their devices or internet access, and any other factors that may serve to impede their ability to find providers and ultimately access care.

Overall, this section seems focused on streamlining efforts for state agencies and managed care plans, but does not sufficiently address concerns for beneficiaries. As mentioned, CMS has made great strides to improve access and utilization of oral health care, and we are concerned that changes to communications and information sharing could undercut these recent achievements.

Network Adequacy Standards (§438.68)

We are extremely concerned about the proposed modifications to the required Network Adequacy Standards. As mentioned, finding dental providers is a particular concern for Medicaid recipients. Current regulations require states to develop and post time and distance standards for eight different types of providers, including primary care providers and specialists such as pediatric dental providers. These standards are in turn incorporated into MCO contracts with state Medicaid agencies, and must be reflected in their provider networks. Nevertheless, to allow for the needs and challenges of individual states, there is no specified national benchmark for these standards. This system, provides states with a guideline that acknowledges the potential ease, or challenge, of physical access to providers for beneficiaries. We agree that across states, beneficiaries may face a variety of unique challenges, but

[15] J. Elaine Kitchel, Low Vision Project Leader, APH Guidelines for Print Document Design, American Printing House for the Blind, https://www.aph.org/research/design-guidelines/ (accessed Dec. 23, 2018).

relaxing these standards rather than encouraging states to also acknowledge and address these other barriers could serve to continue the access inequities that we've mentioned.

Under the proposed rule, this time and distance standard would be replaced by a requirement that states simply establish a "quantitative network adequacy standard" and states could use their own definitions of specialists. While this could allow for standards that address state-specific barriers to care, we are concerned that the adequacy of networks could be defined by measures as broad as a simple patient-to-provider ratio. Such oversimplification would not take into account important barriers for providers or patients such as geographic distribution and wait times.

Instead, time and distance standards should be used in conjunction with other measures of network adequacy, such as the number of regional providers billing Medicaid and how many Medicaid patients a given provider sees during the plan year. For example, as research compiled by the Arizona-based Children's Action Alliance demonstrates, looking at one measure may not be sufficient. They showed that while work by the American Dental Association's Health Policy Institute indicated that 90% of pediatric beneficiaries in Arizona had adequate time-distance access to dental providers,[16] other research indicated that the ratio of beneficiaries to practitioners accepting-Medicaid was troublingly high.[17] This demonstrates how a network's adequacy would be insufficiently represented with one measure.

In addition, previous guidance requiring a time and distance standard was complemented by the Medicaid Access Rule's required reporting of measures to improve access to care and engage practitioners. While we believe in state flexibility, we are also concerned that patterns of inequity are still present. Relaxing network adequacy standards, as well as these reporting requirements, would weaken protections for beneficiaries unable to reasonably find practitioners, and could create opportunities for further decline in access. Simply put, we are concerned that in states facing budgetary constraints or a dearth of specialists, agencies and MCOs may choose to look for a more budget-friendly or simpler solution, rather than addressing the complex challenges of underserved children and families.

We would urge that federal guidance continue to include the time and distance standard, and that any proposed changes to these considerations place specific focus on obstacles to access and on the general experience of beneficiaries seeking care. We also urge CMS to include standards for access to dental care for pregnant women. CMS should additionally encourage states to continuously monitor the experiences of these populations so that adjustments to network adequacy standards can be made as necessary. These recommendations should be, whenever possible and practicable, applied to CHIP as well (§457.1218).

Managed Care Quality Rating Systems (§438.334)

Lastly, we are concerned about potential changes to Managed Care Quality Rating Systems (QRS). In the proposed regulation, it is reported that state agencies have found it challenging to provide quality

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[16] American Dental Association-Health Policy Institute. (January 2017). Geographic Access to Dental Care: Arizona. American Dental Association-Health Policy Institute. Retrieved from: https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/AccesstoDentalCare-StateFacts/Arizona-Access-To-Dental-Care.pdf

[17] Children's Action Alliance. (May 2018) State of Play in Arizona (PowerPoint Presentation). Based on research out of Northern Arizona University reviewing 2016 Medicaid claims data.

measures yielding comparable information to enable comparison of plan performance across states. Indeed, Medicaid programs and their managed care plans can look very different depending on the unique obstacles and concerns of states. However, despite these challenges, consumer-facing rating systems are only useful if they are thorough and relatively comparable.

The proposed regulation would alter current guidance to only require that "information yielded be substantially comparable to the extent feasible to enable meaningful comparison across states, taking into account differences in state programs that complicate achieving comparability." This paragraph goes on to describe that CMS will develop a QRS framework of mandatory performance measures that would be used in development of state-specific alternative QRSs. We would urge that the process for developing this framework include beneficiaries, providers, and researchers. Furthermore, we urge CMS to ensure that the framework is as comprehensive as possible in addressing an array of health issues, including oral health, to accurately define challenges within networks and propose measures which represent the beneficiary experience. With regard to oral health quality measures, we encourage CMS to directly engage the Dental Quality Alliance on how best to incorporate plan-level measures that adequately address the oral health care needs of Medicaid and CHIP beneficiaries.

This section also describes eliminating the process of prior approval of state alternative quality rating systems. This would mean that states would not be required to prove the substantial comparability of their QRS with national quality rating standards. Furthermore, states would only have to submit their framework at the request of CMS, including their performance measures and methodologies for ratings. These changes are described as helping states avoid challenges produced by the lag time of approval before switching to another rating system. We are concerned that while this method may streamline state agency processes, a lack of proactive review and guidance could lead to serious gaps in tracking and oversight which could in turn have negative consequences for beneficiaries and create a lack of useful data for state agencies as well as advocates.

Overall we would urge that CMS consider the impact on beneficiaries and their families before enacting any efforts to simplify processes for state agencies and managed care providers. We fear that some of the proposed changes will threaten access to adequate care for the vulnerable children and families who rely on their state Medicaid programs. We ask that CMS reconsider these proposed changes, and instead work collaboratively with advocates and state programs to identify delivery system reforms and other health care quality improvement initiatives that will improve efficiency and better meet the needs of children and families without eliminating essential oversight.

We support state flexibility and efforts to find innovative solutions that meet the unique needs of states. Creating an environment that allows for access to comprehensive medical and oral health care while also providing sufficient oversight, keeps children learning, parents working, families strong, and allows all of us to contribute fully to our communities and our country. Thank you for the opportunity to comment on the proposed changes to the Medicaid Managed Care Rule. We hope we can continue to be aligned in our goals of improving the oral health of all Americans. If we may provide further information or otherwise be of assistance, please contact Debbie Vishnevsky at dvishnevsky@cdhp.org or (202) 417-3602.

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