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America's leading advocate for oral health

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

January 4, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

*Submitted electronically*

Re: CMS-2328-FC
Medicaid Programs; Methods for Assuring Access to Covered Medicaid Services; Final Rule

Dear Mr. Slavitt:

On behalf of the American Dental Association and its 158,000 members and the American Academy of Pediatric Dentistry and its 9,500 members we appreciate the opportunity to comment in response to the November 2, 2015, Federal Register notice, Medicaid Programs; Methods for Assuring Access to Covered Medicaid Services; Final Rule (CMS-2328-FC).

Access Review Requirements
Our organizations appreciate the focus CMS has on monitoring access to services provided by state Medicaid programs. The final rule outlines the following service categories for inclusion in an access monitoring review: primary care services; physician specialist services; behavioral health services (including mental health and substance abuse disorder treatment); pre- and post-natal obstetric services including labor and delivery; and home health services; services where either payment rates have been reduced or restructured; and services for which a higher than usual volume of beneficiaries, providers, or stakeholders have raised access to care issues. The ADA and AAPD believe a further adjustment is warranted and dental services should also be included in this list of services. As we stated in our July 5, 2011, [1] comments, access to dental services continues to be a challenge for many state programs, in both fee-for-service and Medicaid managed care.

Access Review Data Requirements
The ADA and AAPD urge CMS to utilize the comprehensive set of pediatric dental measures as developed by the Dental Quality Alliance[2] and endorsed by the National Quality Forum (NQF) to monitor access to dental services in Medicaid. A detailed response on the measure set is included in our response to the corresponding Request for Information (RFI) – Data Metrics and Alternative Processes

[1] ADA/AAPD comments in response to Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, July 5, 2011.
[2] Dental Quality Alliance, established upon request by CMS to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process. http://www.ada.org/5105/aspx.

for Access to Care in the Medicaid Program. We believe that the measurement burden should be reduced through better alignment of measures between fee-for-service and Medicaid managed care and further between public and private sectors. Our organizations believe that a national core set of access to care measures specific to services supported by Medicaid is essential to truly monitor access and quality.

Beneficiary Information
We urge further exploration of requiring state level formal hearings where access to care concerns can be independently heard. While we appreciate and understand the flexibility granted to states in designing their Medicaid programs, we believe an additional level of oversight by CMS should be considered for concerns focused on access to services. The ADA and AAPD believe there is a direct correlation between payment rates to providers participating in Medicaid and access to dental services. In light of the *Armstrong v. Exceptional Child Care Center*, *Inc*. ruling by the Supreme Court of the United States last year, beneficiaries and providers will rely heavily on CMS to provide oversight on state programs, including ensuring sufficient access to dental services provided under the Early Periodic, Screening, Diagnosis and Treatment Program.

Mechanisms for Ongoing Input
We appreciate the acknowledgement by CMS that ongoing provider feedback is important. Our organizations support collaboration with Medicaid programs and believe ongoing communication, from both programs and providers, is essential to achieving change that ultimately benefits enrollees. We believe this should be a required element rather than a consideration for state programs.

We appreciate the opportunity to provide comment on the final rule and look forward to working with CMS and state Medicaid programs going forward to improve access to dental services. Should there be any questions please contact Janice E. Kupiec with the ADA, kupiecj@ada.org/202-789-5177, or C. Scott Litch with the AAPD, slitch@aapd.org/312-337-2169.

Sincerely,

Carol Gomez Summerhays D.D.S.
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Re: CMS-2328-NC; Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program

Dear Mr. Slavitt:

On behalf of the American Dental Association and its 158,000 members and the American Academy of Pediatric Dentistry and its 9,500 members we appreciate the opportunity to provide comment in response to the November 2, 2015, Request for Information – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program.

Our organizations believe the scope of the access monitoring review plans should also include dental services as one of the service categories. We are disappointed that the final rule, Methods for Assuring Access to Covered Medicaid Services (November 2, 2015), has limited the scope of the review plans. Access to dental services for Medicaid beneficiaries receiving services through the Early Periodic, Screening, Diagnosis and Treatment Program continues to experience challenges in both fee-for-service and Medicaid managed care. As stated in our comments on January 4, 2016,[1] to the Centers for Medicare and Medicaid Services (CMS), we urge CMS to include dental services within the definition.

The following comments are in response to the RFI specific to concerns over monitoring and measuring access to dental services in state Medicaid programs.

**A. Access to Care Data Collection and Methodology**

Our organizations strongly believe that any measurement should be one that triggers an improvement in outcomes. We do not believe there is a disadvantage to measurement but that measurement should have a calculated purpose. We believe a core set of measures, applied

[1] ADA/AAPD comments to CMS in response to Medicaid Programs; Methods for Assuring Access to Covered Medicaid Services; Final Rule (*Federal Register*, Vol.80, No. 211, November 2, 2015).

across all delivery systems is the most useful. The ADA and AAPD support standardized measurement in dentistry that would apply across state Medicaid programs, across all delivery systems, fee-for-service and managed care, and to both the Medicaid and commercial marketplace. The data should be collected and analyzed by states and CMS should make the data available. We do not believe a core set of measures applied across all services (e.g. dental, medical, vision, etc.) will be an effective way to determine access within the specified service categories.

**B. Access to Care Thresholds/Goals**

The ADA and AAPD believe that measures should be set at the national level. Given the variation across state programs, metrics and thresholds should be set at the state level to account for this variation. We believe that the commercial marketplace should serve as a threshold to measure access to dental services. The thresholds that are set at a national level should be used as benchmarks for improvement at the state level.

**C. Alternative Processes for Access Concerns**

The RFI states that CMS is considering requiring standard access to care complaint driven processes to better ensure access and are interested in how data gathered and analyzed through a core set of measures might aid in resolving complaints. While we do not have specific suggestions for CMS, we request that all efforts should ensure that the beneficiary remains the focus of any and all processes that are implemented to address access to care.

**D. Access to Care Measures**

Our organizations would like to highlight the work that the Dental Quality Alliance (DQA)[2] has done as it relates to measures for access to oral health services. The DQA has developed a comprehensive set of pediatric measures and obtained endorsement from the National Quality Forum (NQF). The measures have been tested for validity, reliability, feasibility and usability for use in state Medicaid programs and rely on standard data elements in administrative claims data. This includes patient ID, patient birthdate, enrollment information, ICD diagnosis codes, date of service, place of service codes, revenue codes, dental procedures codes and provider type. These data are readily available and can be easily retrieved because they are routinely used for billing and reporting purposes. Below is a short description of each NQF endorsed DQA measure. The full set of measures can be accessed at www.ada.org/dqa.

General Utilization Measure

1. Utilization of Services: This measure is a measure for utilization of oral healthcare services that captures whether a child received any dental services during the year and, therefore, also measures one aspect of access to oral health care – the "critical and necessary first step to improving oral health outcomes and reducing disparities" (IOM 2011b). This measure also includes important stratifications by the children's age.

Measures Assessing Access to Preventive Care

2. Oral Evaluation: This measure is a process measure that captures whether children receive a comprehensive or periodic oral evaluation during the reporting year. Oral Evaluation allows plans and programs to assess whether children are receiving at least

[2] The Dental Quality Alliance (DQA), established at the request of CMS, advances performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process. The DQA is the largest multi-stakeholder organization focused on oral healthcare quality measurement. http://www.ada.org/5105.aspx

one oral evaluation during the reporting year as recommended by evidence-based guidelines.

3. Prevention: Sealant 6-9 Year Old Children at Elevated Caries Risk: This measure is a process measure that captures whether children at moderate or high caries risk received a sealant on a permanent first molar tooth soon after tooth eruption. Dental sealants have been shown to reduce the incidence of dental caries.

4. Prevention: Sealant 10-14 Year Old Children at Elevated Caries Risk: This measure is a process measure that captures whether children at moderate or high caries risk received a sealant on a permanent second molar soon after tooth eruption. Dental sealants have been shown to reduce the incidence of dental caries.

5. Topical Fluoride for Children at Elevated Caries Risk: This measure is a process measure that captures whether children at moderate or high caries risk received at least two topical fluoride applications. Application of topical fluoride at the recommended frequencies has shown to reduce the incidence of dental caries.

6. Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children: This measure assesses access by measuring the failure of the health system (patient, provider, payers and policymakers) to prevent and proactively treat/manage dental caries in children through the use of the ambulatory healthcare system.

7. Follow-Up after Emergency Department Visit by Children for Dental Caries: This is a system-level measure that specifically focuses on dental caries-related reasons because: (1) dental caries (tooth decay) plays a central role in dental disease among children and (2) definitive care for dental-caries related conditions is most effectively delivered in outpatient dental settings.

Comparison of Payments

The ADA and AAPD believe there is a strong correlation between higher, market-based reimbursement rates and provider participation and that access to oral health care services are especially important for children at an elevated risk for dental caries. We do not believe Medicare fees should be used as a benchmark for Medicaid fee schedules. Medicare does not provide a comprehensive dental benefit and it does not focus on pediatric services.

The RFI seeks comment on the comparisons or measures that would inform managed care rate adequacy. Due to a lack of transparency and availability of fee data, we are unaware of what managed care organizations pay dental providers. Before suggesting that comparisons are made between fee-for-service and managed care fees, we urge CMS to make the fee data more transparent. We believe that state programs must set a floor for dental fees as opposed to using an existing fee-for-service fee schedule as a guide or starting point. This information is crucial in order to make any determination of adequacy as it applies to fee schedules.

We believe that CMS should review the rates that are paid by state programs to managed care organizations and apply a medical loss ratio requirement. We provided a more in depth response on the application of a MLR requirement for managed care plans in our July 27, 2015, comments to CMS in response to the proposed rule entitled Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed

Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.

Additionally, we believe that the use of fee percentiles is an effective way of representing the distribution of fees charged by dentists in a particular area and are viewed as a useful basis for comparing state-specific Medicaid fees for selected procedures with fees that prevail in various markets for dental services.

We appreciate the opportunity to provide comment on the RFI. We strongly believe dental services should be included in any access monitoring review plans. We believe that the measurement burden should be reduced through better alignment of measures between fee-for-service and managed care plans in Medicaid and further aligned between public and private sectors. Having a national core set of access to care measures specific to services supported by Medicaid is essential to truly monitor access and quality. Should there be any additional questions please contact Janice E. Kupiec with the ADA, kupiecj@ada.org/202-789-5177, or C. Scott Litch with the AAPD, slitch@aapd.org/312-337-2169.

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