ADA American Dental Association
America's leading advocate for oral health

July 5, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-2328-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: 42 CFR Part 447, Medicaid Program: Methods for Assuring Access to Covered Medicaid Services.

Dear Doctor Berwick:

On behalf of the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), we are pleased to offer comments in response to the May 6, 2011, Federal Register notice, Medicaid Program: Methods for Assuring Access to Covered Medicaid Services. Medicaid provides an important safety net for many Americans and is a vital part of our nation's healthcare delivery system. We support efforts by the Centers for Medicare and Medicaid Services (CMS) to provide oversight on access to services for the millions of individuals enrolled in Medicaid programs across the country. Furthermore, we support efforts by CMS to assist states in developing programs that improve access through policies that encourage dentists' participation and enrollees' utilization of oral health services.

As many states are adjusting to the new economic reality, state Medicaid programs are struggling to keep up with both the demand for services and budget shortfalls. The result is often increased difficulty in accessing services, which could be exacerbated through widespread fiscal year 2012 cuts to provider payment rates as predicted in a June 2 report by the National Association of State Budget Officers and the National Governors Association. We commend CMS for moving forward to address access through the proposed rule, taking into consideration enrollee needs, the availability of care and the utilization of services. While these changes affect all Medicaid covered services, the ADA and the AAPD are concerned with access to dental services.

State Benefit Reviews
We fully support the new requirement for Medicaid programs to review access concerning specific benefits but suggest these reviews be conducted at more frequent intervals, such as every three years. Utilization of and access to dental services, a federal requirement for children enrolled in the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), continues to be a challenge for many state programs. Network adequacy, geography, oral health literacy and family-related barriers, such as lack of transportation, are a few of the barriers that exist for many Medicaid beneficiaries. Providers also experience their own barriers, which most prominently include administrative burdens such as eligibility verification, woefully inadequate reimbursement rates, and missed appointments. Monitoring access to and utilization of services, and maintaining an open line of communication with both beneficiaries and providers through the public process to involve stakeholders will hopefully allow states to address concerns and implement effective changes.

The ADA and AAPD suggest the inclusion of an additional measurement for state reviews that specifically addresses access for children with special health care needs (CSHCN). While dental services can be

challenging for all beneficiaries, this portion of the pediatric population has traditionally experienced more difficulty accessing services.

We are concerned that a review that demonstrates insufficient access for mandatory services may result in the reduction or elimination of optional services. While dental services for children are mandatory, services for adults, which include pregnant women and people with special health care needs, are optional for state programs.

As noted in the proposed rule, this review requirement does not apply to Medicaid managed care services. Since many beneficiaries receive care through some type of managed care arrangement, we believe the focus on the fee-for-service program will not provide a full picture on access to services. In the August 2010 report, CMS's Oversight of States' Rate Setting Needs Improvement (GAO-10-810), the Government Accountability Office (GAO) addressed the inconsistencies by CMS in its review of Medicaid managed care rates. The report recommended that CMS improve its oversight of rate setting and to be more consistent across the states. In light of this report and the number of Medicaid beneficiaries that receive care through manage care, we urge CMS to move as quickly as feasible to meet its stated goal to promulgate a rule addressing managed care plans.

The ADA and the AAPD support removal of any reference to the term "significant", and request clarification from CMS that any changes in rates, methods and standards require public notice. The meaning of the term "significant" can be hard to quantify since it will mean something different to each affected party. In addition, given the lack of outcome data related to Medicaid changes, it would be difficult to quantify what degree of change would have an impact on access and/or utilization. For example, in dentistry rates in many states hover around the 10th percentile of average private sector dental fees. A modest decrease in fees is likely to cause further deterioration in the provider network; conversely, a modest increase in fees may have little impact in expanding the network because of the significant gap between Medicaid and private sector payment rates. Therefore, we support the proposed requirement that states complete periodic access review of their payment structures regardless of whether they are in the process of revising their rates. In many states adjustments have not been made for many years, allowing the Medicaid dental program to fall further behind the rates paid by other insurers. We also agree with National Health Law Program's request for clarification from CMS regarding state plan amendments (SPAs). To ensure that CMS maintains the oversight of state programs and the SPA process, CMS should amend the regulations to clarify that SPAs that include reimbursement reductions cannot be implemented until the agency has reviewed the SPA.

Analysis of State Data and Reimbursement

While we support the idea of providing states flexibility to address access issues, we are concerned that a lack of uniformity in data sets will make it difficult to compare state programs. MACPAC's recommended framework to demonstrate access provides a good basis for evaluation, but for programs to evaluate these areas, an effective measurement tool needs to be available and uniform across states. Access will be difficult to demonstrate if states are left to their own devices to define access. The impetus for this proposal is due to the states' inability to manage access. We recommend CMS provide some uniform guidance for states in this area.

Our organizations believe that there is a strong correlation between higher, market-based reimbursement rates and provider participation; therefore, we are also very concerned that this proposed regulation provides states an alternative to addressing access outside of reimbursement rates. Access to an ongoing source of dental care is especially important for children at elevated risk for common, chronic dental diseases such as dental caries, e.g., children in low-income families and children with special health care needs, who generally are covered by Medicaid and other public programs. Reimbursement rates (or payments to providers for services rendered) that are sufficient to engage an adequate number of providers having the knowledge and skills to meet the full range of dental care needs of children of all ages is fundamental to ensuring access and sustaining good oral health.

Both of our organizations recognize the need to make changes that do not have large fiscal implications, such as easing provider credentialing, providing an electronic means for eligibility verification and electronic claims filing. However, recognizing the important role reimbursement rates play in provider participation and retention, rates must continue to be a critical part of the access equation. Reimbursement will be even more important as state programs expand under the provisions of the Affordable Care Act (ACA) and work to provide access for current beneficiaries as well as the additional ones that will be enrolled. The compilation of rate change information extrapolated from State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium Update found in the ADA 2008 publication, "Medicaid Financing Improvements and Reported Results," demonstrates the positive effect that significant rate changes can have on provider participation.

The proposed changes to §447.203 (b)(1)(iii)(B) would require the reviews to include an estimate of the fee percentile which Medicaid payment represents of the estimate average customary provider charges and an estimate of the percentile which Medicaid represents of one or more of the listed payment structures. The ADA and the AAPD caution against using Medicare payment rates since the program does not provide a comprehensive dental benefit nor does it focus on pediatric services, such as those available through EPSDT. Further, "customary" usually refers to the fee level determined by dental benefit plans. To have an accurate comparison with the private sector market rate, we recommend a reference to average "usual" provider charges, which are based on what dentists actually charge independent of any third party contractual agreement.

We agree with the proposed use of fee percentiles as 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. For example, the 10th percentile fee level for the most common dental services for Medicaid-eligible patients in a particular area would likely result in roughly 10 percent of dentists participating in Medicaid, since the 10th percentile fee level would represent a payment level that would be viewed as equal to or greater than the fees routinely charged by only 10 percent of dentists in that area. Conversely, if fees were set at the 75th percentile, it would be expected that roughly 75 percent of dentists would participate in Medicaid, since fees would be equal to or greater than those charged by 75 percent of dentists in that area.

As described above, the use of fee percentiles can be very helpful as a basis for estimating the number or proportion of dentists in the state who might participate in Medicaid at selected Medicaid payment levels. States can use this form of analysis to adjust dental payments so that their programs are likely to enlist sufficient dental providers and assure access equal to that experienced by the general public. This approach is consistent with the State Medicaid Directors Letter #01-010, January 18, 2001, where CMS suggested a number of access/rate measures that states could use; including that Medicaid rates for dentists should be set at least at the 75th percentile of fees charged by dentists in the state to assure adequate access. To compare Medicaid reimbursement levels to fee percentiles in a state, one ideally needs to obtain current data sets that describe the percentile distribution of fees routinely charged by the state's dentists. Information on dentist/fee percentile distributions is available from commercial organizations or from other actuarially sound, state-specific sources, such as those which may be available from commercial dental insurers. The ADA's Survey of Dental Fees, which offers regional, rather than state-level fee distribution data, also has proven in the past to be an excellent source of information, if state-specific prevailing data are otherwise not available. Existing Medicaid claims data bases are not a good source for making dental fee comparisons. Access to dental services for Medicaid beneficiaries remains a challenge. Between October 2007 and May 2008, CMS conducted specific dental program reviews in 17 states based on low utilization rates as reported through the CMS-416 report. In 2009, the Government Accountability Office (GAO) released a report, State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain (GAO-09-723, 9/30/2009) and between 2007 and 2009, the House Oversight and Government Reform Committee held three hearings specifically addressing the need to improve dental services in Medicaid. Our organizations know more needs to be done. We believe more oversight, such as measures included in this proposed regulation, from CMS is necessary to help states remain in compliance with the access requirements in

the law. Our organizations remain committed to improving utilization of and access to dental services in Medicaid and working with CMS to achieve these goals.

Thank you for the opportunity to comment. Should there be additional questions please contact Janice Kupiec at the ADA, 202-789-5177 (kupiecj@ada.org) or C. Scott Litch at AAPD, 312-337-2169 ext. 29 (slitch@aapd.org).

Sincerely,

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