

May 22, 2018

Tim Hill, Acting Director  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Baltimore, MD 21244-8016

Submitted electronically: <http://www.regulations.gov>

**RE: CMS-2406-P, Comments Proposed Changes to the Medicaid “Access Rule” 42 CFR 447.203(b)**

Dear Mr. Hill:

We, the undersigned, are organizations with a vision of achieving oral health for all. We write to express our concerns regarding proposed changes to the Medicaid “Access Rule” announced by the Centers for Medicare & Medicaid Services (CMS) in the March 23, 2018, edition of the Federal Register.

We applaud CMS for its recent focus on oral health. The Oral Health Initiative, launched in 2011, set national and state-specific goals to increase by ten percentage points the proportion of children on Medicaid/CHIP receiving a preventive dental service. We fully support this goal as it aligns with our goal of eradicating dental disease in children. In addition, many of our organizations are working to persuade more state Medicaid agencies to offer a dental benefit for adults because we firmly believe in the importance of oral health across the lifespan.

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.<sup>1</sup> The efforts of CMS and the states are beginning to pay off: by 2016, 46% of those children were receiving a preventive dental service.<sup>2</sup>

But more improvement is needed. And because dental services are included in the types of services that must be examined under the Access Rule, the Rule can help both CMS and the oral health community achieve our respective oral health improvement goals.

**We are concerned about the following aspects of the proposed changes to the Access Rule:**

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

<sup>2</sup> Form CMS 416 data for FFY 2016, Lines 1b and 12b, available at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

- **The proposed exemption from the Access Rule of dental services delivered in fee-for-service carve outs in states with a high proportion of beneficiaries in managed care (e.g., 85%);**
- **The proposed exemption from the Access Rule of fee-for-service dental care in cases where only a small proportion of a state’s enrollees (e.g., 15% or less) get their dental care in fee-for-service;**
- **The proposed exemption for nominal payment rate changes and the proposed modification of payment rate change state plan amendment submission information, especially as they relate to dental services.**

As we understand it, the intent of the Access Rule is to provide states, CMS and the public with information needed to understand whether a state’s fee-for-service reimbursement rates are “sufficient to enlist enough providers so that care and services are available [in Medicaid] at least to the extent that such care and services are available to the general population in the geographic area.”<sup>3</sup>

Such analysis and transparency are critical in the oral health arena because utilization rates have historically been low and reimbursement rates have been shown to impact utilization rates.

For example, in **Wisconsin**, where Medicaid fee-for-service reimbursement rates for children’s dental services in 2016 were approximately 32% of fees charged by dentists in the state,<sup>4</sup> only 30% of enrolled children received a preventive dental service. This is one of the lowest utilization rates in the nation<sup>5</sup> and 40 points below the proportion of Wisconsin children with commercial dental insurance who visited the dentist.<sup>6</sup> In 2015, only 32% of licensed dentists in Wisconsin participated in the Medicaid program.<sup>7</sup>

**Wisconsin** also offers dental coverage for adults on Medicaid. The state’s fee-for-service reimbursement rates for adult dental services in 2016 were about 31% of fees charged by dentists. However, there is little to no information available in the public domain about

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<sup>3</sup> See 42 U.S.C. section 1903(i)(4).

<sup>4</sup> American Dental Association Health Policy Institute, 2016, *The Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Services for All States*, available at [https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief\\_0417\\_1.pdf](https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf)

<sup>5</sup> Form CMS 416 data for FFY 2016, Lines 1b and 12b, available at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

<sup>6</sup> See American Dental Association Health Policy Institute, *Wisconsin’s Oral Health Care System* graphic, available at <https://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Wisconsin-facts>

<sup>7</sup> See American Dental Association Health Policy Institute, *Dentist Participation in Medicaid or CHIP*, available at [https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic\\_0217\\_1.pdf?la=en](https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0217_1.pdf?la=en)

Medicaid adult dental access and utilization rates. This is all the more reason why it is critical to require states with fee-for-service dental delivery systems to include an analysis of dental access in their Access Monitoring Review Plans. From Wisconsin's 2016 Access Monitoring Review Plan we learned that across the state only 34% of adults enrolled in Medicaid had a dental visit in 2014, and that adult utilization varied regionally from 30% to 40%.<sup>8</sup> These rates compare unfavorably to the 63% dental utilization rate for Wisconsin's commercially insured adults in 2013.<sup>9</sup>

### **Fee-For-Service Dental Carve Outs**

**Under the proposed rule change, there are almost a dozen states<sup>10</sup> that deliver *dental care* to all or most enrolled children through fee-for-service but would be at risk of being exempted from having to address dental care in their Access Monitoring Review Plans simply because a high proportion of their enrollees get their *medical care* through managed care. We hope this was an unintended omission in the proposed rule change. We believe this omission can be remedied simply by spelling out that states with fee-for-service carve outs of any service included in the Access Rule must continue to abide by Access Rule requirements for those services regardless of the proportion of the population enrolled in managed care.**

In all but perhaps one of the aforementioned states there is a significant disparity in dental care utilization between children enrolled in Medicaid and children with commercial dental insurance. This suggests the continued relevance in those states of an analysis of the impact of reimbursement rates on provider enrollment and access to care such as is required by the Access Rule.

For example, in **California** in 2016, only 44% of children enrolled in Medicaid had a dental visit,<sup>11</sup> compared with 67% of the state's commercially insured children.<sup>12</sup> Medicaid fee-for-service dental reimbursement rates in California are about 31% of what the state's

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<sup>8</sup> See Wisconsin's Access Monitoring Review Plan, 2016, available at

<https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/wi-amrp-16.pdf>

<sup>9</sup> See American Dental Association Health Policy Institute, *Wisconsin's Oral Health Care System* graphic, available at

<https://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Wisconsin-facts>

<sup>10</sup> CA, DE, HI, IN, IA, MD, MS, NH, SC, VA, WA

<sup>11</sup> Form CMS 416 data for FFY 2016, Lines 1b and 12a, available at

<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

<sup>12</sup> See American Dental Association Health Policy Institute, *California's Oral Health Care System* graphic, available at

<https://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/California-facts>

dentists charge,<sup>13</sup> and only about 15% of licensed dentists in California participate in Medicaid.<sup>14</sup>

The Access Monitoring Review Plans were intended to bring attention, analysis and oversight to exactly this type of situation. And while **California** would not immediately be impacted by the proposed 85% managed care enrollment exemption – currently about 80% of California’s Medicaid recipients are enrolled in medical managed care – close to 95% of enrollees receive their dental care through the fee-for-service dental carve out known as Denti-Cal. California should continue to be required to monitor access in Denti-Cal through the Access Rule process even if, or when, its managed care enrollment reaches up to the 85% threshold.

**Maryland** is an example of a state that likely would be exempted from examining access to dental services in its Access Monitoring Review Plan because of the 85% managed care enrollment threshold, even though all Maryland Medicaid dental services for children are fee-for-service. While Maryland has made significant improvements over the past decade, there remains a nine percentage point disparity between Medicaid children’s dental care utilization and that of commercially insured children in Maryland,<sup>15</sup> and only 29% of the state’s licensed dentists participate in Medicaid.<sup>16</sup>

**We urge CMS to continue to require states to include in their Access Monitoring Review Plans those services, such as dental care, delivered via fee-for-service carve-outs from managed care. This is necessary in order to achieve the purpose of the Plans: “to document whether Medicaid payments in fee-for-service systems are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with the statute.”<sup>17</sup> Without the process provided for in the Access Rule interested members of the public such as ourselves would not be informed of, or have an opportunity to provide input concerning, decisions**

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<sup>13</sup> American Dental Association Health Policy Institute, 2016, *The Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Services for All States*, available at [https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief\\_0417\\_1.pdf](https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf)

<sup>14</sup> See American Dental Association Health Policy Institute, *Dentist Participation in Medicaid or CHIP*, available at [https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic\\_0217\\_1.pdf?la=en](https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0217_1.pdf?la=en)

<sup>15</sup> See American Dental Association Health Policy Institute, *Maryland’s Oral Health Care System* graphic, available at <https://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Maryland-facts>

<sup>16</sup> See American Dental Association Health Policy Institute, *Dentist Participation in Medicaid or CHIP*, available at [https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic\\_0217\\_1.pdf?la=en](https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0217_1.pdf?la=en)

<sup>17</sup> See 83 FR 12696.

**regarding changes to fee-for-service reimbursement rates and what impact those decisions could have on access to care.**

### **Fee-For-Service Dental Programs Serving a Small Proportion of Enrollees**

We can understand why CMS would decide to remove from the Access Rule health care services that are available through fee-for-service only on a de minimus basis, for example during the period of time new Medicaid enrollees are selecting a managed care plan. However, there are some states that maintain a parallel fee-for-service dental system for a relatively small proportion of enrollees even though the majority of Medicaid enrollees receive dental services within managed care. These states should not be exempted from including dental care in their Access Monitoring Review Plans.

For example, in the **District of Columbia**, children with special health care needs are exempted from mandatory managed care enrollment. These children, for whom regular dental care is especially essential, need a well-functioning fee-for-service dental delivery system to meet their needs. The District of Columbia should not be exempted from complying with Access Rule requirements for its fee-for-service dental services even though only children with special health care needs use that system.

Another example is **Nevada**, where mandatory managed care is in place only in the more urban areas of the state. About 15% of Nevada's Medicaid enrollees, both adults and children, live in areas where managed care is not available. These enrollees receive both medical and dental care through a fee-for-service system. Access to care issues are just as critical to residents of rural areas, perhaps more so, than to residents of urban areas, and should not be exempted from Access Rule requirements because of an arbitrary cut-off of 85% enrollment in managed care.

**We urge CMS to limit the Access Rule exemption to only those states in which fee-for-service dental care is limited to truly de minimus situations, e.g., upon initial enrollment prior to choosing a managed care plan, or for purposes of retroactive eligibility. When whole sub-populations or geographic areas use the fee-for-service delivery system, the state should be required to comply with the Access Rule requirements and processes. Such an approach would ensure adequate transparency for the public and appropriate oversight by CMS.**

In conclusion, we ask that CMS reconsider these proposed changes, and to work collaboratively with us to identify delivery system reforms and other health care quality improvement initiatives that will reduce health care costs and improve efficiency, care, and health outcomes. CMS has an important part to play by providing strong oversight through the Access Rule to ensure Medicaid fee-for-service dental reimbursement rates are sufficient to provide adequate access to quality care. We will continue to also work hard in our own states and communities to improve oral health access, but we will be unable to effectively advocate for improvements and monitor the success of new initiatives without the transparency and opportunity for public input provided by the Access Rule.

Thank you for the opportunity to comment on the proposed changes to the Access 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 Cheryl Parcham, Director of Access Initiatives at Families USA at [CParcham@familiesusa.org](mailto:CParcham@familiesusa.org) or Deborah Vishnevsky, Policy Analyst at the Children's Dental Health Project at [dvishnevsky@cdhp.org](mailto:dvishnevsky@cdhp.org).

Sincerely,

Alaska Dental Society  
American Academy of Pediatric Dentistry  
American Dental Association  
Arcora Foundation  
Asian American Advancing Justice - Los Angeles  
Association of State and Territorial Dental Directors  
California Pan-Ethnic Health Network  
Catalyst Miami  
Children Now  
Children's Dental Health Project  
Delaware State Dental Society  
DentaQuest Foundation  
Detroit Community Solutions  
Families USA  
Georgia Dental Association  
Hawaii Dental Association  
Healthy Smiles of California  
Iowa Dental Association  
Maine Dental Association  
Maryland Dental Action Coalition  
Maryland State Dental Association  
Massachusetts Dental Society

Maternal and Child Health Access  
McDonald Oral And Maxillofacial Surgery  
Michigan Oral Health Coalition  
Minnesota Dental Association  
Mississippi Primary Health Care Association  
Missouri Dental Association  
Medicaid-Medicare-CHIP Dental Services Association  
NYU Rory Meyers College of Nursing  
Oral Health America  
Oral Health Florida  
Orange Grove Center  
PA Coalition for Oral Health  
Pennsylvania Dental Association  
The Children's Partnership  
The Los Angeles Trust for Children's Health  
The North Dakota Dental Association  
Vermont State Dental Society  
Virginia Coalition of Latino Organizations  
Virginia Oral Health Coalition  
Washington State Oral Health Coalition  
West Virginia Dental Association  
Wisconsin Dental Association



# THE PARTNERSHIP FOR MEDICAID

May 22, 2018

Ms. Seema Verma, MPH  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2406-P  
P.O. Box 8016  
Baltimore, MD 21244-8016  
Submitted electronically to <http://www.regulations.gov>

Dear Administrator Verma,

On behalf of the Partnership for Medicaid – a nonpartisan, nationwide coalition of health care providers, safety net health plans, counties and labor – the undersigned organizations appreciate the opportunity to respond to *CMS-2406-P Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*. While we recognize the Centers for Medicare & Medicaid Services (CMS) seeks to ease unnecessary administrative burden for state Medicaid agencies, we are deeply concerned by the proposed changes to the reporting and documentation requirements that states must provide to demonstrate access to care for Medicaid beneficiaries enrolled in fee-for-service (FFS). We urge CMS to fully implement the existing access requirements before proposing changes and to base any changes on strong data and analyses that take into account the range of populations and services remaining in FFS and capture nuances in payment rates across states and services.

Medicaid serves as a lifeline for tens of millions of Americans, and plays an important role in providing access to necessary health services that include maternity care, pediatric services, behavioral health services, primary and dental care, and long-term services and supports. It is critical that beneficiaries access high quality, necessary services when they need them, and this is especially true for those on Medicaid who have a disability or a chronic or complex health condition. Delays in accessing needed treatments and services can lead to poorer outcomes and unnecessary costs to the health care system, and federal oversight is needed to ensure the Medicaid program is serving our nation's most vulnerable.

The Partnership for Medicaid strongly believes that federal and state financing of Medicaid-covered services should be sufficient to ensure that Medicaid enrollees have timely access to high quality, necessary care. This includes ensuring payments to safety net providers and plans are adequate and, where relevant, actuarially sound in order to ensure access to meet the same goal. In addition, any proposals that make changes to Medicaid and program requirements should balance state flexibility and innovation with necessary federal standards to protect patients. This is true regardless of whether Medicaid is delivered through FFS or managed care. We believe the proposed rule weakens enforcement of requirements that ensure access to care and does not strike the right balance between state flexibility and beneficiary protections.

The existing regulatory access monitoring requirements are the only means of meaningful oversight and enforcement of the equal access provision of the Medicaid statute. This provision

requires Medicaid provider payments be “consistent with efficiency, economy, and quality of care...and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”<sup>1</sup> The federal government is responsible for enforcing this provision, and we are concerned the rule proposes exemptions that leave access to care in some states and for particular service categories unchecked and that are not supported by data and information.

The access monitoring requirements enacted under the 2015 rule were a positive first step to ensure beneficiaries can access needed services. States were first required to submit an access monitoring review plan (AMRP) by October 1, 2016, and we are only a year and a half into the rule’s implementation. The initial AMRP’s submitted by states vary in quality and how access is measured. We should build on this first step and improve our understanding of access in the states before loosening up monitoring requirements. Any changes should not take a one size fits all approach and be based on data and analyses.

The rule proposes to exempt states with high levels of managed care enrollment from submitting an AMRP and complying with additional requirements, but the rule does not justify why an 85 percent threshold was selected nor does it take into consideration the populations or services remaining in FFS. While states are increasingly shifting Medicaid delivery to managed care, the populations remaining in FFS are often the most vulnerable beneficiaries, such as individuals with complex health care needs and dual eligibles. States also often carve out certain services from managed care altogether, such as behavioral health and long-term services and supports. The proposed rule does not include any review of the services and populations remaining in FFS in states that would be exempt. We are concerned the exemption threshold is arbitrary and leaves many beneficiaries vulnerable to access challenges.

The rule also proposes to exempt states from demonstrating access and seeking stakeholder input when implementing “nominal” reductions, but the rule does not state why a 4 percent annual or 6 percent reduction over two years was selected as a “nominal” reduction. Such reductions can have different implications depending on the state or service and their current rate levels, and these implications may not be “nominal” depending on the circumstance. The proposed rule does not provide information or analyses on the implications of these thresholds across states or services to demonstrate what can be consistently considered as nominal. We are also concerned that the rule does not provide additional information on the acceptable forms of alternative analyses states may provide. It is critical that CMS monitor rate reductions to ensure high levels of access to quality care, and to ensure that beneficiaries and providers are able to provide input on the implications of rate reductions.

We are also concerned the proposed rule will have implications beyond FFS. States often look to FFS as a benchmark for capitation payments to managed care entities, making FFS rates relevant in determining whether payments to plans are actuarially sound. Insufficient rates under FFS can also undermine access in managed care, and it is important that FFS rates are evaluated to ensure access for all beneficiaries, regardless of how their benefits are delivered.

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<sup>1</sup> 42 U.S.C. § 1396a(a)(30)(A)



We urge CMS to identify opportunities to improve access to care, including promoting payment parity between Medicaid and Medicare when appropriate. Medicaid payment rates for many providers are often far below what Medicare pays for comparable services. Low Medicaid rates can affect provider participation and create barriers to health care access for beneficiaries. It is critical CMS look for ways to ensure strong access to care and promoting payment equity is one step that can be taken to protect beneficiary access.

The federal government must serve as a strong steward of the Medicaid program in order to ensure Medicaid beneficiaries have access to high quality, necessary services, and the existing access review requirements are the primary means of enforcement. We believe the proposed rule suggests changes that are premature and not based on sufficient data and experience. We urge CMS to fully implement the existing access requirements. Additionally, we strongly believe any future changes be based on strong data and analyses that take into account the range of populations and services remaining in FFS and capture nuances in payment rates among unique state Medicaid programs.

We appreciate the opportunity to provide comments on the proposed rule, and we look forward to working with CMS to ensure all Medicaid beneficiaries have access to range of services and providers. If you have any questions, please contact Shannon Lovejoy at the Children's Hospital Association, First Co-Chair of the Partnership for Medicaid, at (202) 753-5385 or [shannon.lovejoy@childrenshospitals.org](mailto:shannon.lovejoy@childrenshospitals.org).

Sincerely,

American Academy of Pediatrics  
American College of Obstetricians and Gynecologists  
American Dental Association  
American Dental Education Association  
American Health Care Association/National Center for Assisted Living  
America's Essential Hospitals  
Catholic Health Association of the United States  
Children's Hospital Association  
Easterseals  
The Jewish Federations of North America  
National Association of Community Health Centers  
National Association of Counties  
National Association of Pediatric Nurse Practitioners  
National Council for Behavioral Health  
National Health Care for the Homeless Council  
National Hispanic Medical Association