DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
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Children and Adults Health Programs Group

APR 2 6 2017

Marie Zimmerman
Medicaid Director
Minnesota Department of Human Services
540 Cedar St., P.O. Box 64983
St. Paul, MN 55167

Dear Ms. Zimmerman:

Due to longstanding concerns about access to and utilization of dental services by children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), the Centers for Medicare and Medicaid Services (CMS) launched the Oral Health Initiative (OHI) in 2010 with the goal of increasing by ten percentage points the proportion of children ages 1-20 enrolled in Medicaid or CHIP who receive a preventive dental service. As a result, we have been closely monitoring dental utilization data submitted to us annually via the CMS 416 report, as well as other state-level dental data.

There are indications both that Minnesota children enrolled in Medicaid do not currently have sufficient access to dental services and that not enough dental providers participate in Minnesota Medicaid to ensure access to dental care for the state's child enrollees. Minnesota's Medicaid pediatric dental periodicity schedule calls for enrolled children to receive a first dental examination at the eruption of the first tooth or no later than 12 months of age, and to have a repeat examination every 6 months or as indicated by the child's risk status/susceptibility to disease.

- In Federal Fiscal Year (FFY) 2015, only 41 percent of all Minnesota Medicaid-enrolled children ages 1 to 20 received any dental service, compared to a national average of 50 percent.[1] Similarly, only 37 percent of Minnesota Medicaid-enrolled children ages 1 to 20 received a preventive dental service in FFY 2015, compared to a national average of 46 percent.[2] We note that Minnesota seems to have succeeded in recovering eight percentage points of performance in FFY 2013 on "preventive dental services" that it had lost in FFY 2012. Perhaps there are some lessons there for how to further improve performance now.

- Minnesota itself came to a similar conclusion about low utilization in its Access Monitoring Review Plan (AMRP), submitted to CMS on October 3, 2016. As a proxy for access to dental care, Minnesota used the HEDIS Annual Dental Visit (ADV) measure (children ages 2 to 20 enrolled for at least 11 continuous months who had at least one dental visit during the measure year). Minnesota concluded that, in Calendar Year (CY) 2014, just more than half

[1] Form CMS-416, Lines 1b and 12a, FFY 2015.
[2] Form CMS-416 Lines 1b and 12b, FFY 2015.

(55.31%) of Minnesota children enrolled in Medicaid managed care received a dental visit, and a much lower proportion (38.43%) of children enrolled in Fee-for-Service (FFS) Medicaid had a dental visit (AMRP Table V.B.1).

- A recent study by the American Dental Association's Health Policy Institute, which examined use of dental services by children in both Medicaid and the commercial environment, found that in 2014, 71% of commercially insured children in Minnesota had a dental visit, but just 42% in Medicaid did.

This evidence leads us to conclude that Medicaid-enrolled children in Minnesota are not receiving the dental services called for in the state's dental periodicity schedule. Further:

- Data included in the state's AMRP shows that Minnesota's Medicaid dental reimbursement rates are relatively low compared to other benchmarks. For example, Minnesota's base Medicaid FFS dental reimbursement rates was only 47% of the average State Employee Group Insurance Plan (SEGIP) payment. When Critical Access Dental (CAD) rates were added to the computation, the average Medicaid payment was found to be only 56% of the average SEGIP payment. These percentages are strikingly lower than the results from comparing Medicare rates to the Medicaid rates for other services such as primary care (87%), oncology (91%) and mental health (112%) (AMRP Appendix A).

- Reinforcing this point, another recent study by the American Dental Association's Health Policy Institute found that, in 2013, Minnesota's Medicaid FFS dental reimbursement for services to children, as a percentage of commercial dental charges in the state, was 27% (the lowest in the nation), compared to a national average of 49%, and had decreased by 41.3% between 2003 and 2013.

- Minnesota Medicaid enrollees themselves report the greatest level of difficulty in securing an appointment with a participating dental provider. In the 2015 Health Access Survey, 24.4% of respondents identified some kind of provider supply issue. Dental care was by far the highest provider type cited, with 39.5% of respondents reporting that a dentist did not accept their insurance and 61.7% reporting that the dentist was not accepting new patients (AMRP Figure 29).

CMS staff convened a call with Minnesota Medicaid staff on November 18, 2016, to discuss concerns about children's access to, and utilization of, dental services. CMS staff shared a range of potential approaches to addressing the state's relatively low utilization. Among other possible solutions, we discussed the possibility of increasing Medicaid dental reimbursement rates. We were subsequently pleased to learn that a 54 percent across the board rate increase for dental services has been proposed in the Governor's 2018-19 biennial budget. If implemented, this would bring dental reimbursement rates closer to commercial charges, which is likely to increase provider participation and thus access and utilization for children.

Unless significant improvement in children's access to dental services under Medicaid is achieved, however, CMS is concerned that Minnesota is at risk of non-compliance with sections 1902(a)(43)(B) and 1905(r)(3) of the Social Security Act ("the Act"). Under section 1905(r)(3)

of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes screening services provided in accordance with the State's pediatric dental periodicity schedule. Section 1902(a)(43)(B) of the Act requires states to provide or arrange for all EPSDT screening services, which includes dental services provided in accordance with the State's pediatric dental periodicity schedule. Please submit a plan within ninety (90) days of the date of this letter specifying steps that Minnesota will undertake to make substantive progress within twelve (12) months toward increasing the number of children enrolled in Medicaid in Minnesota who receive dental services.

CMS is committed to supporting Minnesota as it works to improve children's access to, and utilization of, dental services. If you have any questions or would like additional technical assistance please contact me at 410-786-5647.

Sincerely,

Sarah deLone on behalf of Anne Marie Costello

Anne Marie Costello
Director