CMS Mission

- CMS aims to be a major force and a trustworthy partner for the improvement of health and health care for all Americans
- CMCS carries this mission forward with a particular emphasis on making Medicaid and CHIP the best programs they can be
- Beneficiaries are our focus
- Partnerships are critical to success
Medicaid 101

• Who?
• How many?
• What responsibilities?

Profile of Children’s Coverage, 2009

Source: HHS ASPE analysis of the 2010 Annual Social and Economic Supplement to the Current Population Survey
Federal/State Partnership

Federal
Statutory and regulatory requirements
Matching funds (50% - 76%)
Approvals of State plans and waivers
Oversight

States
Determine who is eligible
Determine scope of “optional” services
Determine delivery system
Overall administration / claims payment
Set payment rates

Medicaid and CHIP

Scope of Dental Coverage

- MEDICAID – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requires all medically necessary dental care.
  - No “hard” limits allowed; only “soft” limits supported by prior authorization
  - No cost sharing

- CHIP – dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
  - Annual benefit maximums allowed with prior authorization for additional medically necessary care
  - Limited cost sharing allowed
    (new CHIPRA dental regulations are under development)
Changes Under Health Care Reform

ALREADY IN PLACE:
CHIP and Medicaid coverage for children
continues through 2019
The ACA’s "maintenance of effort" provision requires states to maintain eligibility for children enrolled in the Medicaid program in families earning under 133% of the federal poverty level and in the CHIP program until September 30, 2019. If states do not comply, they can be sanctioned and lose all federal Medicaid funding. The ACA also extended funding for CHIP through September 30, 2015.
5 Ways Health Reform Helps Children

ALREADY IN PLACE:
No pre-existing condition exclusion for children under age 19

The ACA prohibits health plans and insurers from denying insurance to children due to pre-existing conditions (a similar provision for adults goes into effect in 2014). Starting in 2014, this provision will apply to plans that were in existence at the ACA’s enactment (known as grandfathered health plans). Further, once a child is enrolled, health plans and insurers cannot deny coverage for services related to a pre-existing condition.

5 Ways Health Reform Helps Children

ALREADY IN PLACE:
Coverage of dependent children up to age 26

Dependent children can remain on their parent’s health insurance until age 26. This only applies to health plans that offer dependent coverage; there is no requirement that all plans must offer it. Since the ACA’s enactment, over 2.5 million dependent children have been able to retain coverage due to this provision.
5 Ways Health Reform Helps Children

COMING SOON:
Services in private health plans that are specifically focused on children

The ACA requires that health plans participating in Exchanges provide “pediatric services including oral and vision care” as part of the mandated Essential Health Benefits. Health plans must also provide, at no additional cost, all screening and services recommended by the USPSTF for children ages 6 to 18, all immunizations recommended by the CDC and all screenings in the Bright Futures guidance developed by the AAP and HRSA (this does not apply to grandfathered plans).

from CDHP

5 Ways Health Reform Helps Children

COMING SOON:
Extended Medicaid coverage of children aging out of foster care

Beginning in 2014, states must expand Medicaid coverage to children who have aged out of foster care from age 21 up to age 26.

from CDHP
Themes: Final Rule on Implementation

A Seamless Path to Affordable Coverage

- Expands access to affordable coverage
- Simplifies Medicaid & CHIP
- Ensures a seamless system of coverage

Seamless, Streamlined System of Eligibility and Enrollment

- Submit single, streamlined application to the Exchange, Medicaid/CHIP
- Eligibility is determined and verified
- Enroll in affordable coverage

- Online plan comparison tool available to inform QHP selection
- Advance payment of the premium tax credit is transferred to the QHP
- Enrollment in Medicaid/CHIP or QHP

- Online
- Phone
- Mail
- In Person
### Minimum Medicaid Eligibility Levels in 2014

<table>
<thead>
<tr>
<th>Population</th>
<th>2014 Minimum Eligibility Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Varies by State Average 241% FPL</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>≥133% (Varies by State)</td>
</tr>
<tr>
<td>Parents</td>
<td>133%</td>
</tr>
<tr>
<td>Disabled Adults</td>
<td>133% (Based on income, not disability)</td>
</tr>
<tr>
<td>Other Adults</td>
<td>133%</td>
</tr>
</tbody>
</table>

### Simplifying Medicaid & CHIP

- Move to MAGI; replaces complex rules in place today
  - TA to States on converting current standards to MAGI
- Following State lead, modernizes eligibility verification rules to rely primarily on electronic data
- The federal government will perform some of the data matches for States, relieving administrative burden
- Renewals every 12 months
  - If eligibility can be renewed based on available data, no return form is needed
Measuring Progress: the CMS-416
(similar measures are in CARTS for separate CHIP programs)

Total number of children (enrolled for at least 90 days) receiving: (each line represents an unduplicated count of children)

- Line 12a – any dental service (by or under the supervision of a dentist)
- Line 12b – a preventive dental service
- Line 12c – a dental treatment service
- Line 12d – a sealant on a permanent molar tooth
- Line 12e – a dental diagnostic service
- Line 12f – an oral health service provided by a non-dentist (and not under the supervision of a dentist)
- Line 12g – any dental or oral health service (12a+12f)

[By CMS definition, “dental” and “oral health” services are different by provider]

Use of Any Dental Services Improved Nationally From 2000-2009

Graph reports average utilization for each quartile of states.

Use of Any Dental Services Improved Even While Enrollment Increased

Variation Among States in Utilization: “Any Dental Service” (2009)
Wide Variation Among States in Rate of Improvement: “Any Dental Service”

Variation Among States in Utilization: “Preventive Dental Services” (2009)

Source: CMS-416 2009 state reports.
Wide Variation Among States in Rate of Improvement: “Preventive Dental Services”

Percent Change, Preventive Dental Services, 2000-2009

% Receiving Any Dental Service 2009

Age (Yrs)
Goal #1 – Increase by 10 percentage points the proportion of Medicaid and CHIP children (enrolled for at least 90 days) who receive a preventive dental service.

Baseline year is FFY 2011. [mini-audit of 2010 data]
Goal year is FFY 2015.

Goal #2 – Increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a dental sealant on a permanent molar tooth.

This goal will be phased in.

States’ Obligations

• Inform families of available benefits
• Facilitate access to care
  – Link medical and dental providers
  – Provide help with referrals and making appointments
  – Assist in providing transportation when needed
  – Follow up to ensure required services were obtained
• Pay adequate reimbursement rates
• Claims reporting to CMS
  – Report claims from all provider settings (managed care, FQHCs, IHS)
  – Report annually into CARTS and on the CMS-416
States’ Obligations

- Increase provider participation
  - Simplify and expedite provider enrollment
  - Rapid confirmation of patient eligibility at point of service
  - Mirror commercial administrative processes to the extent possible
  - Use ADA procedure codes and claim forms
  - Allow electronic filing of claims
  - Prompt payment of clean claims
  - Reduce prior authorization requirements (e.g., no prior auth for sealants)
- Provider hotline
- Dental advisory panel

CMS Oral Health Strategy

- Work with states to develop pediatric oral health action plans
- Provide technical assistance to states & facilitate peer-to-peer learning
- Outreach to providers
- Outreach to beneficiaries
- Partner with other HHS agencies
- The CMS Oral Health Strategy is available at:
State “Action Plans”

- State Medicaid agencies encouraged to develop and submit an “action plan” to accomplish the two goals by FFY 2015.
- Stakeholder participation is critical.
- Consider how to align efforts:
  - State oral health plan
  - Healthy People 2020 goals
  - HRSA MCHB Title V performance indicators

Innovative Practices

- Increase or reconfigure reimbursement rates (AL, MD, NE, NC, TX, VA)
- Reduce administrative barriers (AL, VA, MD)
- Develop and improve collaboration and partnerships with stakeholders (TX, MD, VA, RI, NE)
- Establish performance targets and feedback loops (AZ, RI)
- Change the delivery system (RI, MD, VA)
- Partner with dental schools for loan repayment assistance and public health clinical rotations (AL, NE, TX)
- Authorize dental hygienists to apply sealants without a prior dental exam (NE, MD, AR)
- Develop training and partner with pediatricians to perform oral health risk assessments, fluoride varnish, referrals (NC, MD, AL, RI, TX, AR)
- Track and analyze gaps in access to care & design custom approaches to addressing identified gaps. (NC)
Key to Reaching Our Goals: Assuring that all Partners are at the Table

Resources

- Medicaid dental periodicity schedules, recommended preventive care intervals, for each State: http://www.aapd.org/policycenter/periodicity/periodicitymap.asp
- Medicaid dental resources, in general: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
- Medicaid and CHIP State Dental Association: www.medicaiddental.org
- Association of State and Territorial Dental Directors: www.astdd.org
CMS and Oral Health

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