



MSDA
MEDICAID / SCHIP
DENTAL ASSOCIATION

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July 9, 2009

Ms. Nancy Goetschius
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
7500 Security Blvd.,
Baltimore, MD 21244

RE: FR June 23, 2009 Notice Emergency Clearance: Public Information
Collection Requirements Submitted to the Office of Management and Budget/
Collection Request: New Collection: *State Collection and Reporting of Dental
Provider and Benefit Package Information Form # CMS-10291(OMB#: 0938-
NEW)*

Dear Ms. Goetschius:

The Medicaid/SCHIP Dental Association (MSDA) is an association of state officials who manage Medicaid and CHIP dental programs. Established in 2004, its mission is to contribute to the optimal oral health of Medicaid and CHIP beneficiaries by developing, promoting, and promulgating evidence-based practices in state oral health policy. MSDA has several comments and concerns regarding the proposed new collection request.

The necessity and utility of the proposed information collection for the proper performance of the agency's functions

CHIPRA specifically requires: 1) a current and accurate list of "all dentists and providers" within each State that provide dental services to children enrolled in Medicaid or CHIP, and that the list is updated at least quarterly; and 2) a description of the dental services provided under Medicaid and CHIP, and that this list is updated at least annually. In attempting to implement these provisions, CMS has interpreted the first provision to necessitate fairly detailed information about providers and their practices. Although it is possible to question the utility of a few of the proposed required data elements (see comments on #3, below), we think that the proposed information to be collected on name, type of practice,

location and specialty is necessary and useful information for Medicaid and CHIP beneficiaries to have to help enable them to select a provider. Having said that, we agree with some of the comments that have been made in previous discussions, including: 1) requiring such a Web-based list may cause providers to drop out of the program; 2) many providers treat only a few patients; 3) providers' ability/desire to accept new patients is fluid and is subject to change.

With respect to the second provision (description of dental benefits):

- There is only space provided for one State Contact. As the dental benefits may be different in Medicaid and CHIP programs in a state, the State Contact information should be separately required for each.
- On Attachment A there is no place to provide a detailed description of dental benefits for Medicaid programs. Rather, it appears to only be required for states with standalone CHIP programs. This seems to be based on the assumption that dental benefits are all-inclusive for EPSDT beneficiaries, because the Medicaid option states that, "Under the Medicaid State Plan dental benefits are provided to eligible individuals under the age of 21 in compliance with the requirements of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services." This assumption appears to be based on the federal EPSDT provision that requires that services for children under age 21 not be limited to services included in the State's Medicaid Plan. Because states may still place limitations on EPSDT services based on medical necessity, and because the intent of CHIPRA was clearly to inform beneficiaries about the benefits to which they are entitled, Attachment A should also collect the same detailed listing of dental benefits and limitations for Medicaid as it does for CHIP.
- Under "Fluoride treatments," in some states these may be provided by other practitioners besides dentists, physicians and hygienists.
- Under "Sealants," many states have limitations based on tooth type (e.g., permanent first and second molars only), rather than on age.
- Under "Oral hygiene instruction," in most states this would be considered part of an exam and would not be a separately reimbursable service. Some states cover counseling (anticipatory guidance) by medical professionals.
- Under "Dental Screens and Other Services by Hygienists," some states allow dental screenings by medical personnel.
- "Retainers" and "Braces" should be subcategories under Orthodontics.
- Under "Cancer treatment" subheading under "Oral Surgery," this may convey a false impression of the nature of the dental benefit available.
- Under "Emergency Room Services," it is not clear what services this refers to, as the dental benefits available should not be limited by setting, and payment for use of the emergency room is typically a medical, not a dental, benefit.

- Under “Special anesthesia,” it is not clear what this term means. It would be clearer to refer to subcategories of anesthesia, e.g., general anesthesia, intravenous conscious sedation, and non-intravenous conscious sedation.

The accuracy of the estimated burden.

The estimate of Total Annual Hours required for submission of the required information from state, tribal and local governments is 9,180 hours for 255 entities, which works out to 36 hours per entity. For many states, this appears to be a gross underestimate of the time that will be required to implement systems modifications and collect and compile the required data.

Ways to enhance the quality, utility, and clarity of the information to be collected.

- CHIPRA requires a current and accurate list of “all dentists *and providers*.” This language suggests that providers other than dentists are also to be included. CMS has been asked if this includes dental hygienists and medical professionals, who can provide some dental services in some states (including California), but has not yet issued an opinion. The instructions for submitting files on oral health providers say, on the one hand, “Please submit one record for each physical site location where the dentist provides service,” and follow that with, “The elements which will be collected for each dental provider on the IKN website follow:” However, the list of dental benefits on Attachment A includes some places to check where hygienists provide the service. Also, CMS is in the process of revising the CMS-416 form to require states to provide data on the number of children receiving dental services from non-dentist providers. CMS needs to clarify whether states need to provide information on non-dentist providers in their submissions of provider data. A CMS determination that states must provide data on non-dentist providers would create a significant burden for a number of states. MSDA believes that such a burden could be ameliorated if the reporting requirements were more reasonable, e.g., a link to a state website containing name of practice, address, city, county and phone number.
- Under the “Provider Affiliation” data element, the current options are not mutually exclusive. For example, some health departments operate community health centers. Also, the example of a Provider Data File in the Insure Kids Now draft (Attachment B, page 2, Figure 1) uses “FQHC” as the Provider Affiliation, but FQHC is not one of the available options.
- Under the “Active Status” data element, there is no definition of what “active” means. As states may define this term differently, there will be no way to compare states on this measure without a common definition.
- Under the Provider Specialty data element, not all specialties are listed. There are nine dental specialties. Of these, Oral and Maxillofacial Pathology,

Oral and Maxillofacial Radiology, Prosthodontics and Dental Public Health are not listed. As some states offer prosthodontic benefits and some offices may employ public health dentists, at least these two additional specialties should be added.

- The “Can Accommodate Special Needs” data element is unlikely to provide the type of information that will be useful to beneficiaries, unless it is very carefully defined, because it is subject to widely differing interpretations. There are many examples of surveys of dental offices in which dentists said they could accommodate wheelchair-bound patients and yet the office was not wheelchair accessible, or the dentist said they could accommodate patients with disabilities but interpreted that to mean ambulatory patients who appeared “normal.”
- The “Affiliation with Managed Care Plans” data element is listed as optional. We believe this should be a required element, as beneficiaries in managed care plans are entitled to know the same information about providers as those in fee-for-service plans.
- Some state websites list available providers by county, rather than by city. As long as address and city information is still available, it may be helpful to beneficiaries to add a county data element.
- Because many providers will not accept very young children in their practices, and because there is increasing national interest in serving the dental needs of the 0-5 population, it may be of benefit to add a data element to identify the youngest age patient the provider will accept. One possible way to collect the data would be to examine paid claims data for providers treating this age group. If there were such a requirement, it would make sense to use some sort of threshold of paid claims activity to avoid including providers who do not treat many children in this age group, and who thus would be understandably reluctant to having their names included on a list of providers willing to see preschool-age beneficiaries. Also, some providers (non-pediatric dentists) may be willing to treat older, more cooperative preschoolers (ages 3-5) but not younger (ages 0-2) ones. Alternatively, states could survey providers to obtain this information, but this could lead to incomplete or inaccurate information. Having said this, MSDA recognizes that such a requirement would place a significant additional burden on many states, so the benefits would need to be weighed against the burden. In the event that CMS is supportive of any of the additional data elements suggested here, we would hope that they could be developed over a substantially longer time period than the very short one dictated by the provisions of CHIPRA.
- Because many providers limit the number of Medicaid/CHIP beneficiaries they will accept in their practices, and because some specialists only accept referrals from other dentists rather than directly accepting beneficiaries, it may be desirable to offer providers the option of excluding their name from the list available by phone and the website. If CMS takes the position that all active

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providers must be on a publicly-accessible list, these providers are likely to either leave the program or refuse to see many beneficiaries, in which case the intent of listing them in the first place will have been undermined.

Thank you for the opportunity to comment on this proposed new collection.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Birdwell".

Robert Birdwell, DDS, Chairperson
Medicaid/SCHIP Dental Association

cc: Ann Kohler, NASMD
Catherine Hess, NASHP