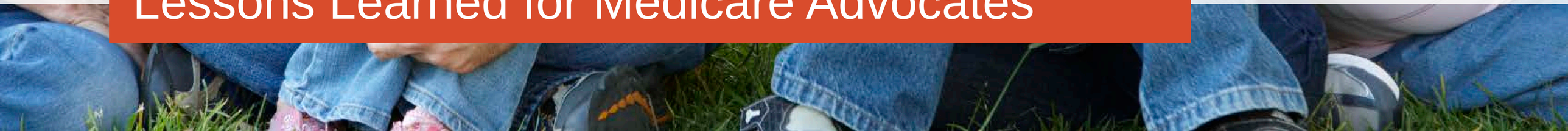
20 Years of Securing and Protecting Medicaid Coverage for Children & Families

children's dental health project

Lessons Learned for Medicare Advocates



Today’s Discussion

Children’s Dental Health Project (CDHP)

- What CDHP set out to do
- What CDHP accomplished (and didn‘t)
- How CDHP accomplished its objectives
- Lessons learned for Medicare policy & advocacy

What CDHP set out to do

Let’s go back to 

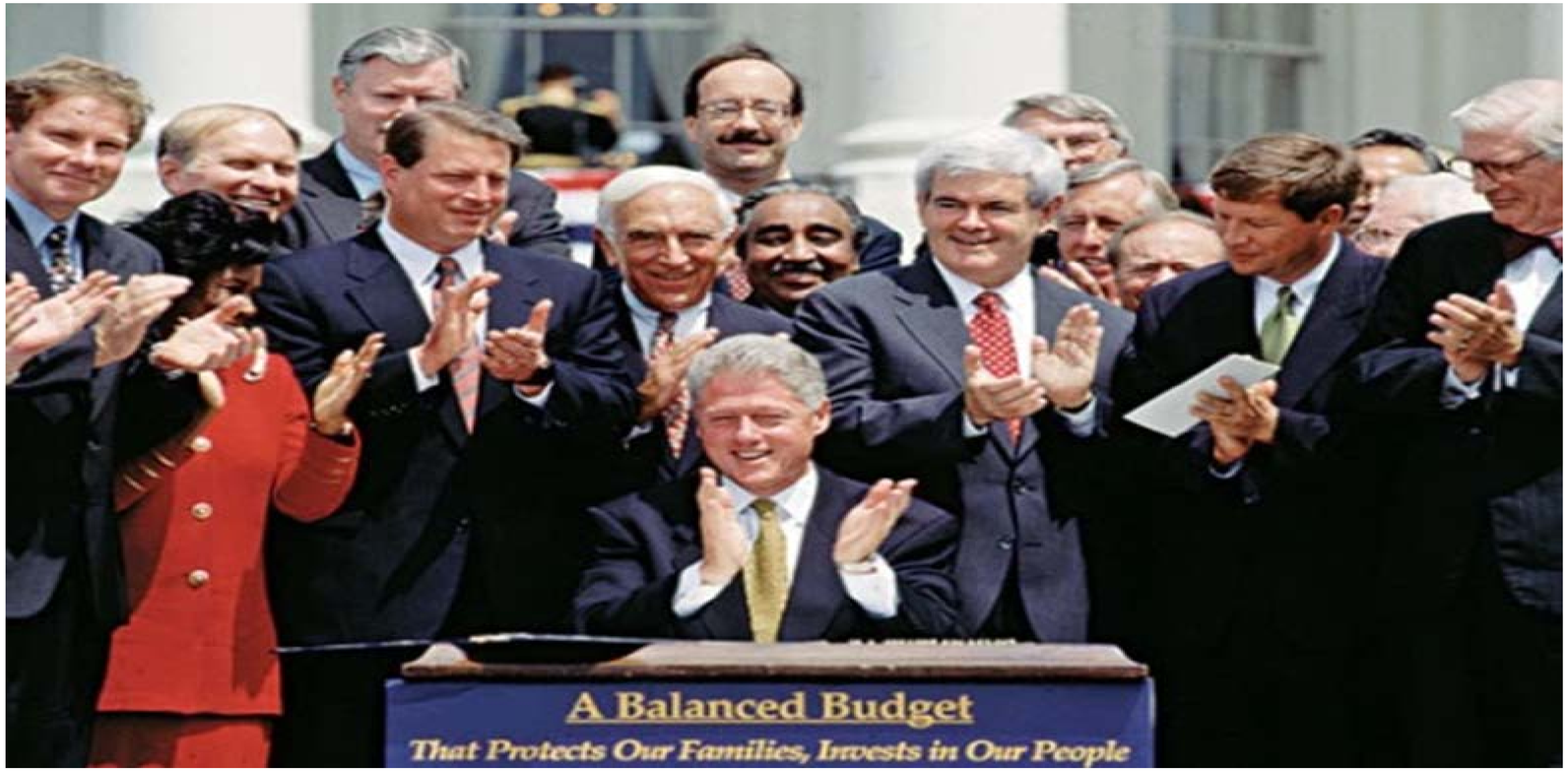
TOP NAMES IN THE NEWS

- Princess Diana (died)
- Tony Blair (elected)
- O J Simpson (lost civil suit)
- Timothy McVeigh (convicted)
- Dolly (cloned)
- Madeleine Albright (appointed)
- Joe Camel (put to rest)

TOP EVENTS IN THE NEWS

- Mars rover landing
- Hong Kong goes back to China
- Titanic top movie
- First Harry Potter book
- Red River flood
- **S-CHIP ENACTED!!**
- **CDHP FOUNDED!!**

CDHP was founded in 1997 in response to S-CHIP enactment because S-CHIP had no dental coverage mandate



S-CHIP was the largest governmental health insurance expansion since Medicaid and Medicare were enacted in 1965

Every policy (and all legislation) begins with a problem

The problem CDHP was founded to address was oral health inequities among U.S. children

The first policy CDHP sought was dental coverage for all children – coverage to assure financial access to care and make dental coverage equal to medical coverage

We sought
a pediatric coverage
mandate
in all public and private
health insurance programs

What CDHP has accomplished
(and hasn’t)

20 Years of coverage policy successes

CDHP worked to

- Retain Medicaid's "EPSDT" robust dental benefit (so far)

  CDHP joined many others to successfully push back on block granting, benefit limits, and eligibility cuts

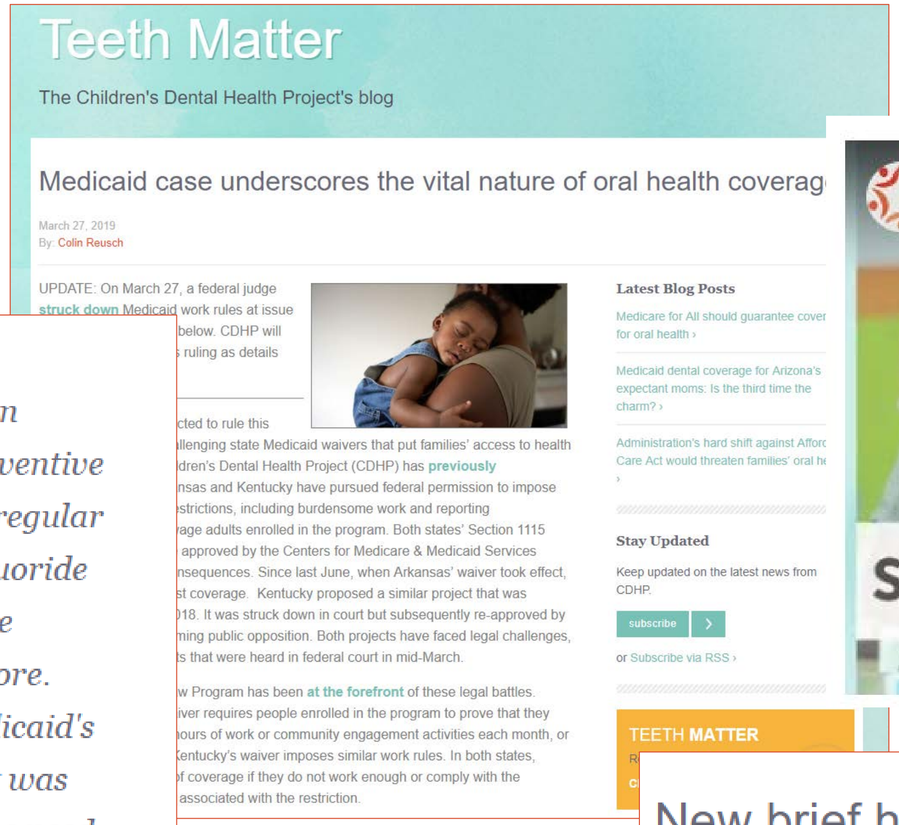
- Address S-CHIP's lack of a dental mandate

  CDHP led successful policy efforts to secure a mandate for pediatric dental coverage in CHIP reauthorization

- Secure dental coverage in private marketplace insurance (ACA)

  CDHP led successful policy efforts to secure a mandate for pediatric dental coverage as an "essential health benefit" (among nearly two dozen other provisions)

CDHP Retains the Medicaid dental benefit



"While all children benefit from preventive dental care like regular cleanings and fluoride treatments, some children need more. Thankfully, Medicaid's pediatric benefit was designed with the need for this flexibility in mind."

New brief helps states improve dental care for kids in Medicaid/CHIP

March 13, 2019
By: Meg Booth

CDHP secured a dental mandate in CHIP

1997

Because of limited advocacy, dental coverage was deemed optional for “standalone S-CHIP programs”

Each state could determine whether to include dental coverage

``(5) Dental benefits.--

``(A) In general.--The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

``(B) Permitting use of dental benchmark plans by certain states.--A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

``(C) Benchmark dental benefit packages.--The benchmark dental benefit packages are as follows:

``(i) FEHBP children's dental coverage.--A dental benefits plan under chapter 89A of title 5, United States Code, that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

``(ii) State employee dependent dental coverage.--A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

``(iii) Coverage offered through commercial dental plan.--A dental benefits plan that has the largest insured commercial, non-Medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.".

(2) Assuring access to care.--Section 2102(a)(7)(B) (42 U.S.C. 1397bb(c)(2)) is amended by inserting ``and services described in section 2103(c)(5)‘ after ``emergency services".

(3) <<NOTE: 42 USC 1397bb note.>> Effective date.--The amendments made by paragraphs (1) and (2) shall apply to coverage of items and services furnished on or after October 1, 2009.

CDHP secured a pediatric dental benefit in ACA

2010

ACA was enacted with over 20 dental provisions including pediatric dental coverage as an “essential health benefit”

Essential health benefits ensure that health plans cover care that patients need

EHB requirements ensure that everyone in the individual and small group health insurance markets has access to comprehensive coverage that actually covers the services they need. These essential health benefits fall into 10 categories:

1. Ambulatory patient services (outpatient services)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

What happened as a result of these coverage successes?

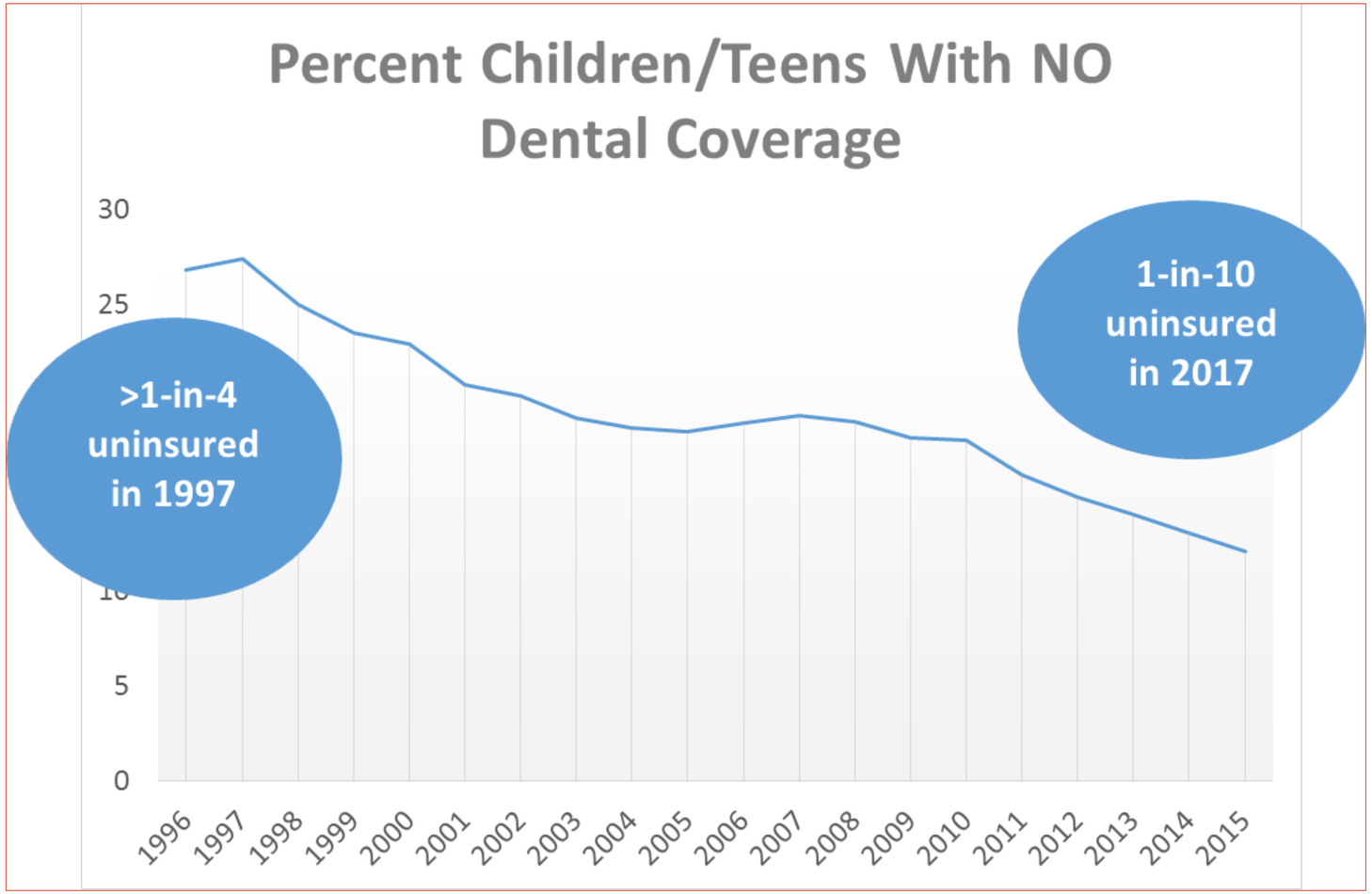
Coverage Gains: The proportion of children lacking dental coverage dropped substantially

1997

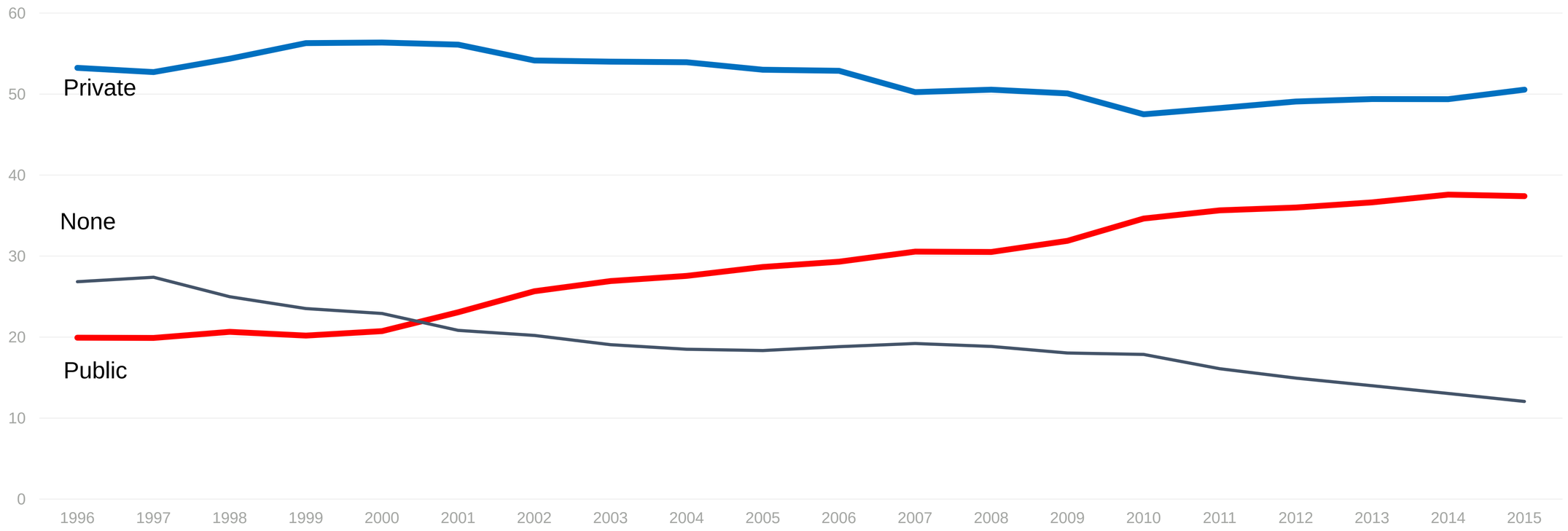
27% of U.S. children dentally uninsured

2017

10% of U.S. children dentally uninsured



Coverage Sources: Gains were mostly from public insurance (Medicaid & CHIP)



Source: AHRQ MEPS

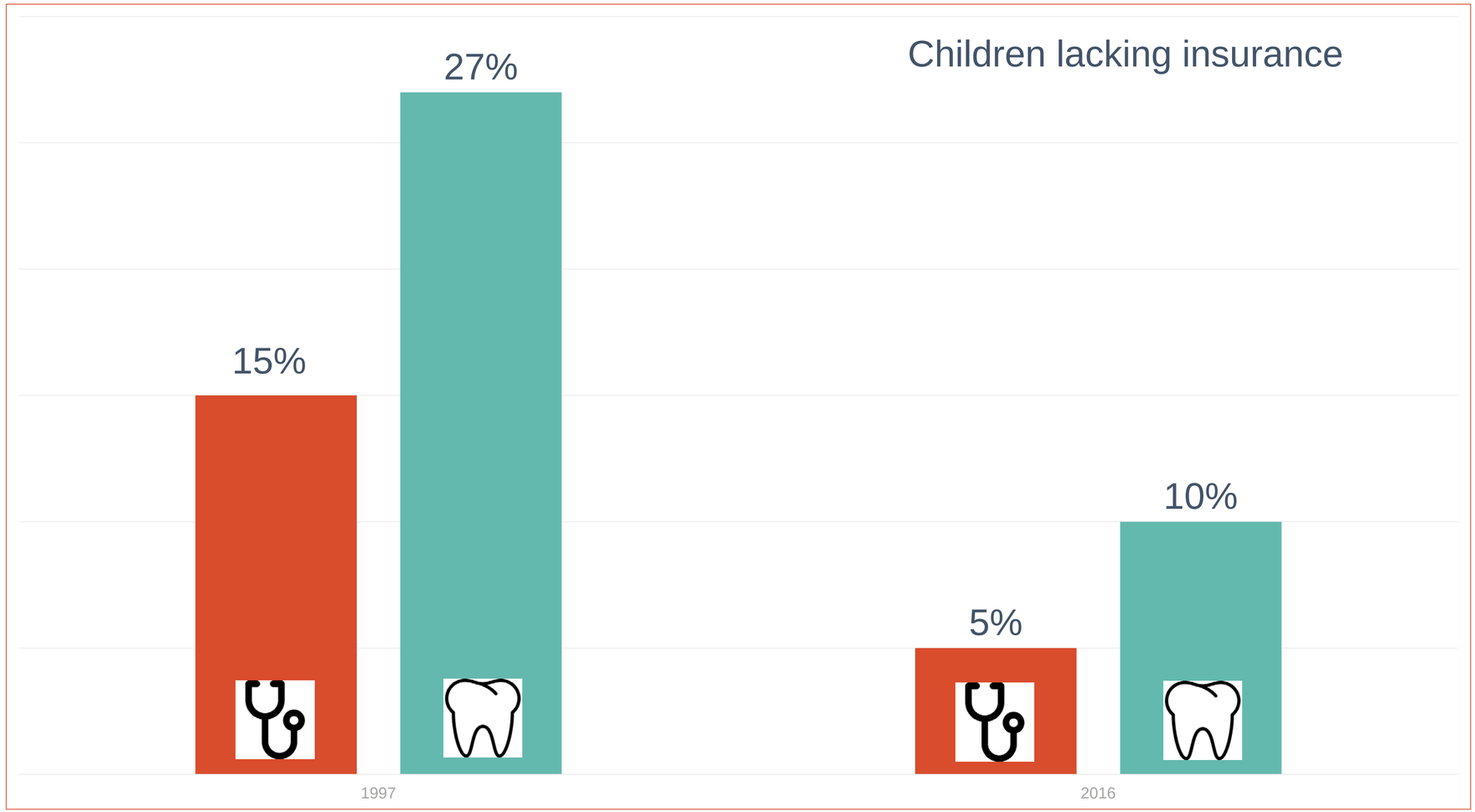
Medical/Dental Coverage: Disparities between medical and dental insurance persisted…but now at low levels

1997

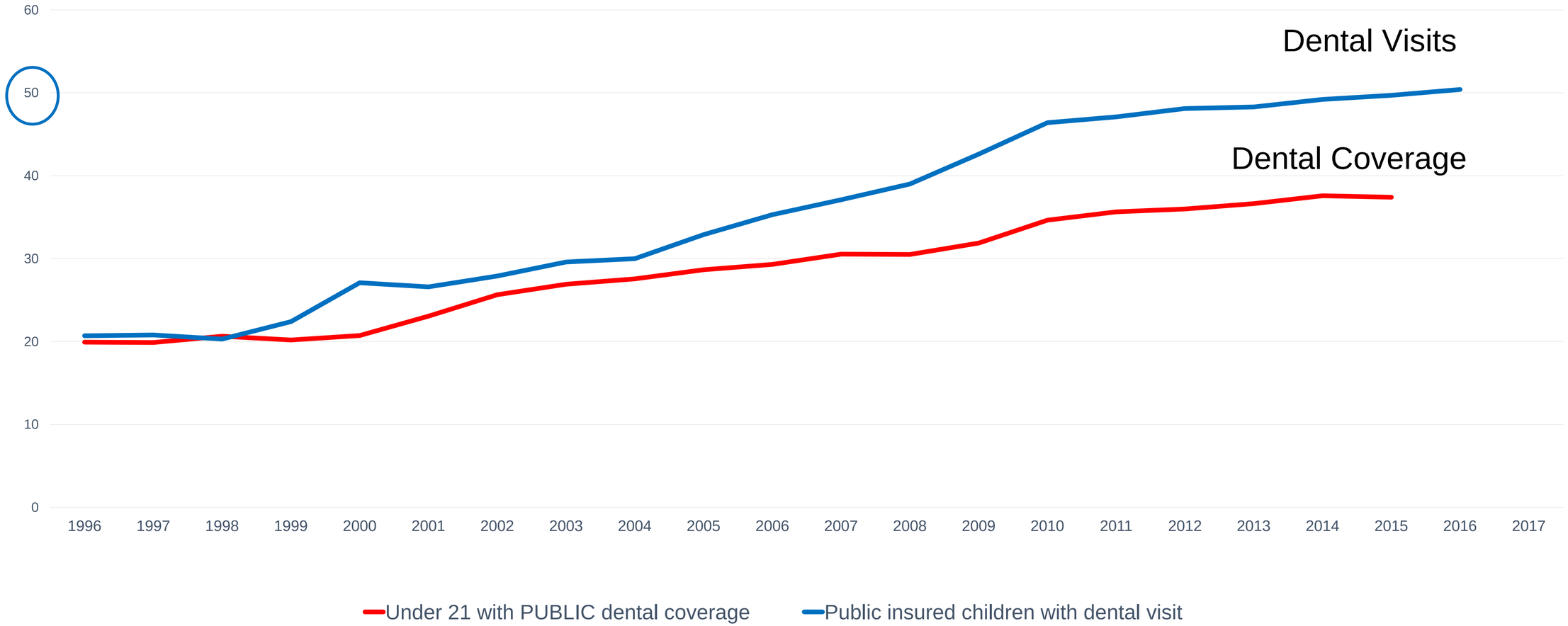
Double # of children lacked dental as medical coverage

2017

Still double # of children lacked dental as medical coverage - But at much lower rates



Medicaid Dental Visits: Public insurance gains increased dental care for poor children



Sources: AHRQ MEPS, CMS 416

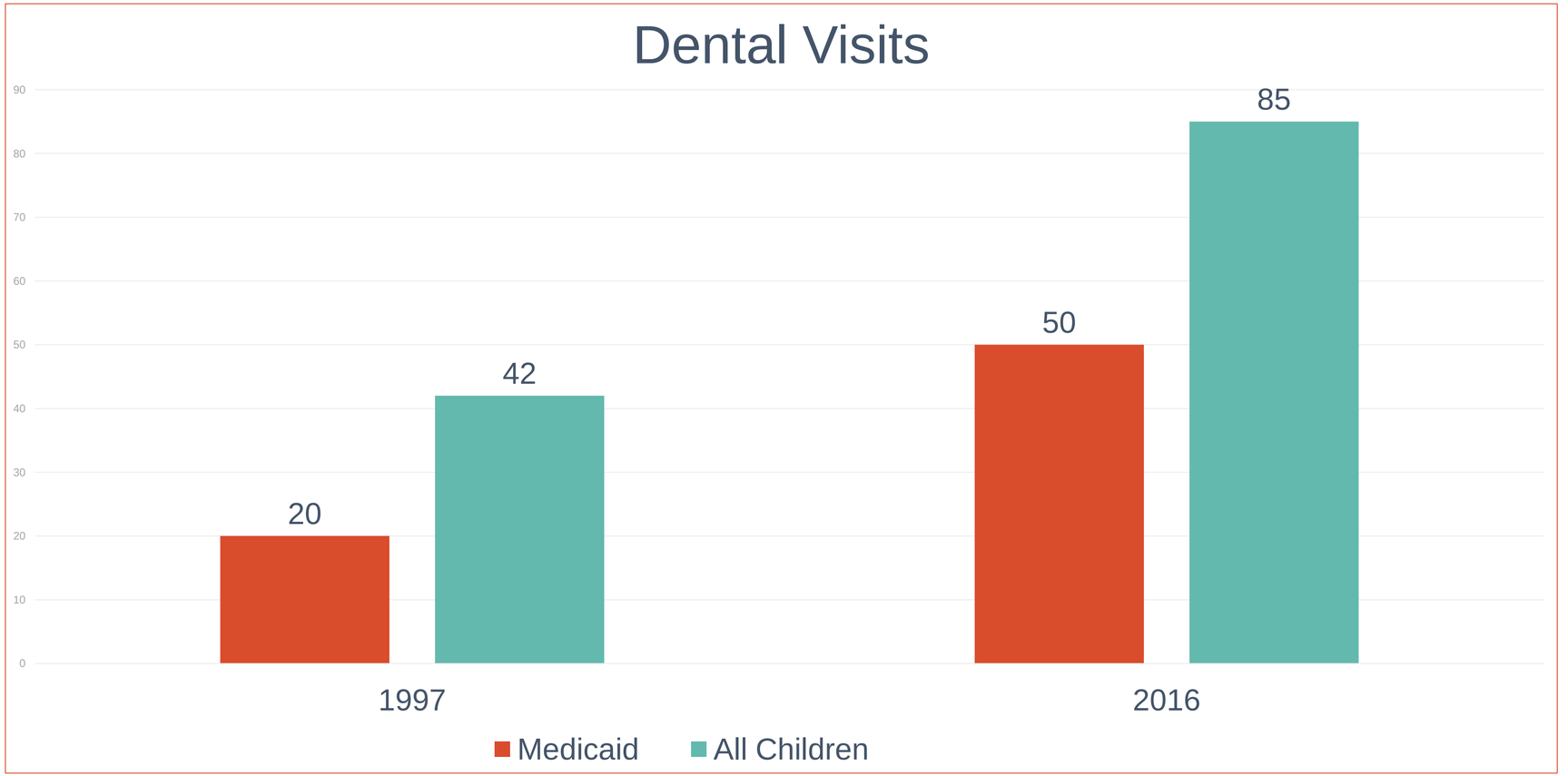
Dental Visits: With new coverage, dental visits for publicly-insured poor children increased… but disparities persisted

1997

Fewer Medicaid children had a dental visit than all children

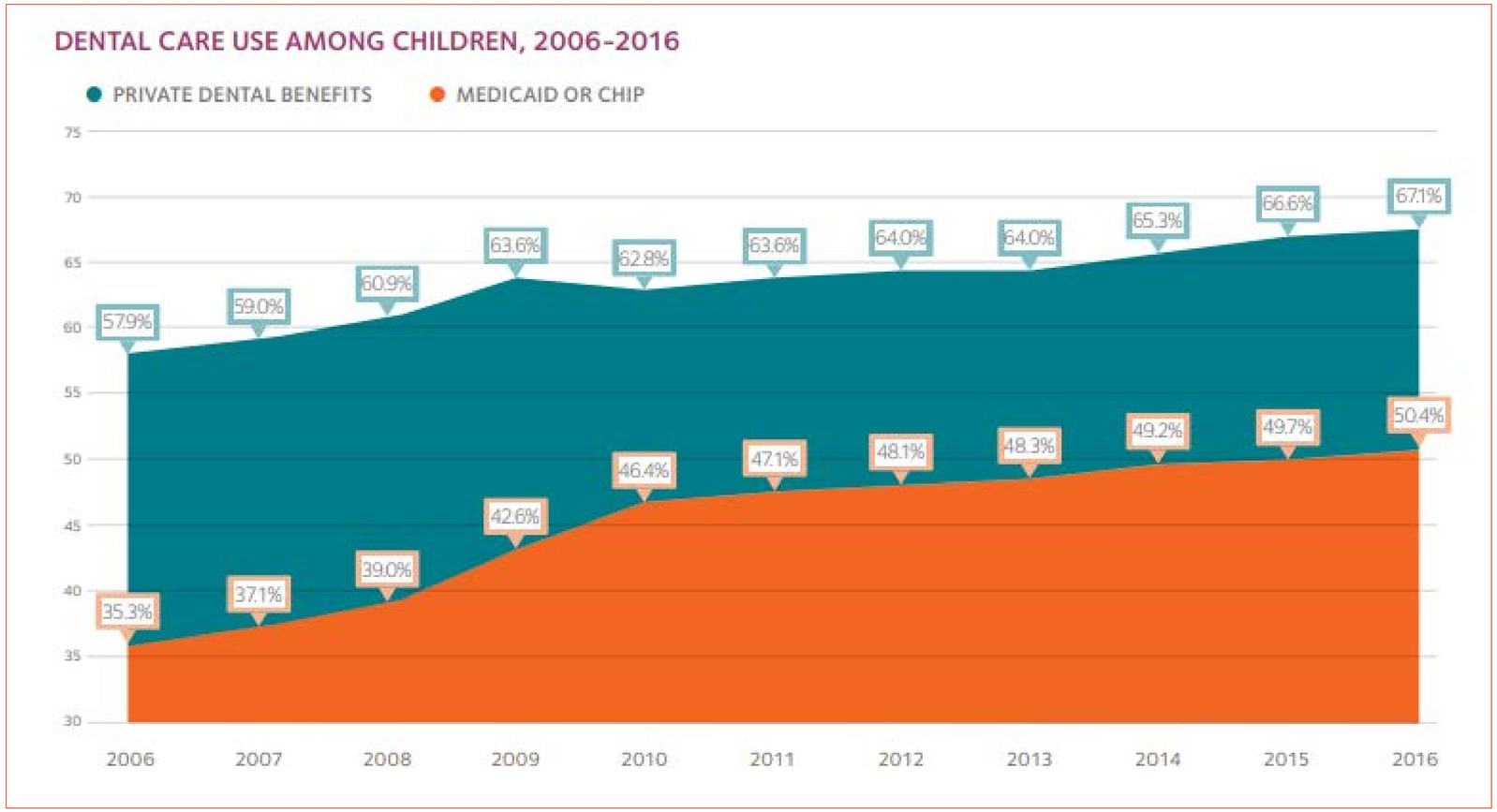
2017

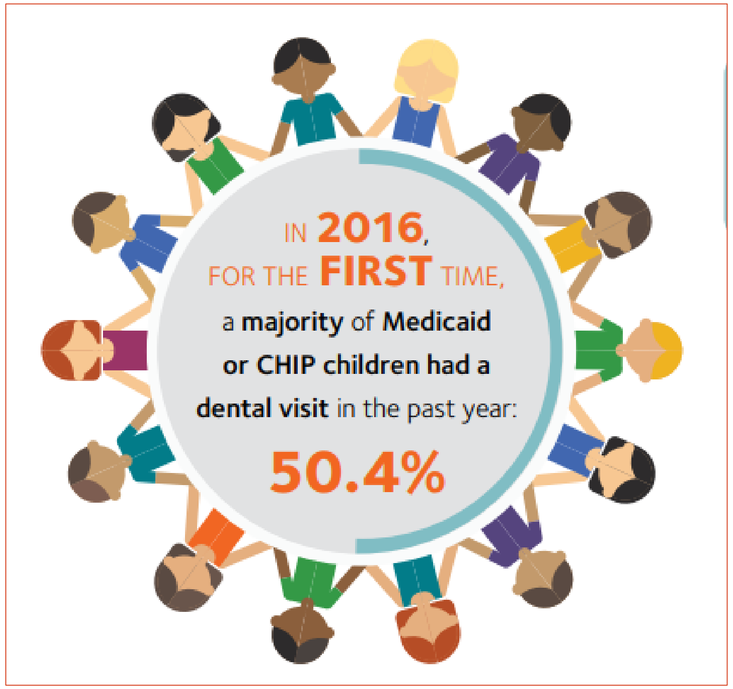
Still Medicaid children lacked dental as medical coverage but dental visits increased for all



Source: AHRQ MEPS

Visits: *Gap* closed in dental care between public- and private-insured children





Source: ADA HPI: Truven & CMS

REMINDER

Every policy (and all legislation) begins with a problem

- The problem CDHP was founded to address was oral health inequities among U.S. children.
- The policy CDHP was founded to secure was dental coverage for all children – coverage that would assure financial access to care

SUMMARY

The POLICY was secured

- More children got covered
- Financial access to care increased
- More dental care was delivered

But was the ORAL HEALTH PROBLEM solved?

“Most US children today have public or private dental health insurance, yet oral health among publicly insured children remains a policy concern.”

Shariff & Edelstein
Health Affairs 2016

By Jaffer A. Shariff and Burton L. Edelstein

Medicaid Meets Its Equal Access Requirement For Dental Care, But Oral Health Disparities Remain

DOI: 10.1377/hlthaff.2016.0583
HEALTH AFFAIRS 35,
NO. 12 (2016): 2259–2267

ABSTRACT **Most US children today have public or private dental health insurance, yet oral health among publicly insured children remains a policy concern. We analyzed data for 2011–12 from the National Survey of Children's Health to compare oral health status and the use of dental care among publicly and privately insured children. After we adjusted for demographic and parent characteristics, we found no differences between the two groups in parent-reported use of dental care or unmet need for dental care. However, compared to parents of privately insured children, parents of publicly insured children were less likely to report that the condition of their child's teeth was excellent or very good and more likely to report that the child had had a dental problem in the past twelve months. Family income differences between the groups accounted for much of this disparity. Our findings suggest that Medicaid is meeting its mandate to ensure that dental care is as available for children in the program as it is for privately insured children, but refinements in Medicaid policy are needed to improve poor children's oral health.**

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Burton L. Edelstein is a senior fellow in public policy at the Children's Dental Health Project, in Washington, D.C., and a professor of dental medicine and health policy and management at the Columbia University Medical Center.

Rates of pediatric dental coverage in the United States have increased, primarily through expansions of publicly funded insurance programs. The rate of dental coverage for all US children increased from 70 percent in 1996,[1] before the establishment of the Children's Health Insurance Program (CHIP), to 88 percent in 2013, with the greatest gains attributable to public insurance through Medicaid and CHIP.[2]

Public dental coverage increased steadily, while private coverage declined modestly: By 2013, 38 percent of children had public coverage, and 50 percent had private coverage.[3] Public coverage for pediatric dental services began as a state option under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program in 1967, became a Medicaid mandate under the Omnibus Budget Reconciliation Act of 1989, expanded as a state option through CHIP under the Balanced Budget Act of 1997, became a mandate under the CHIP Reauthorization Act of 2009, and expanded again under the Affordable Care Act (ACA). The ACA lists pediatric dental services among its essential health benefits but does not create a defined pediatric dental mandate, since consumers who purchase a health plan but no dental coverage are not subject to the financial penalty for being uninsured.

The use of pediatric dental care increased along with these coverage expansions. Use of dental care by children in Medicaid nearly doubled from 2000 to 2012, increasing from 23 percent to 42 percent,[4] and utilization rates of publicly insured children began to approach those of privately insured children. Comparing Medicaid claims data to data from a proprietary private insurance claims database, Marko Vujicic and Kamyar Nasseh found that the gap in utilization rates between privately and publicly insured children closed from 24.3 percentage points in 2005 to 15.7 percentage points in 2013.[4] Similarly,

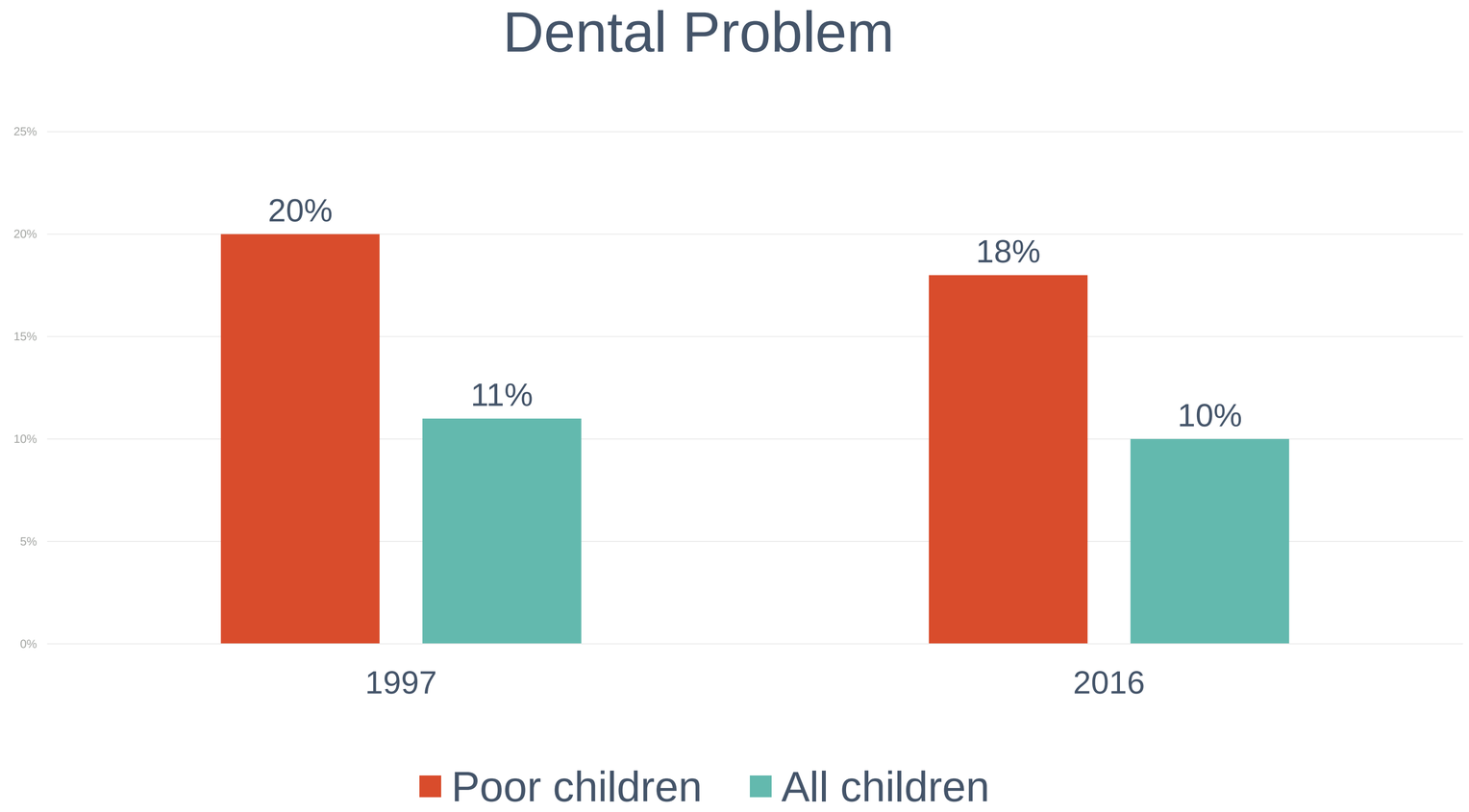
Oral Health Disparities: Profound inequities in pediatric oral health persist: Poor children have more “dental problems”

1997

Poor children were about twice as likely as all children to have a “dental problem”

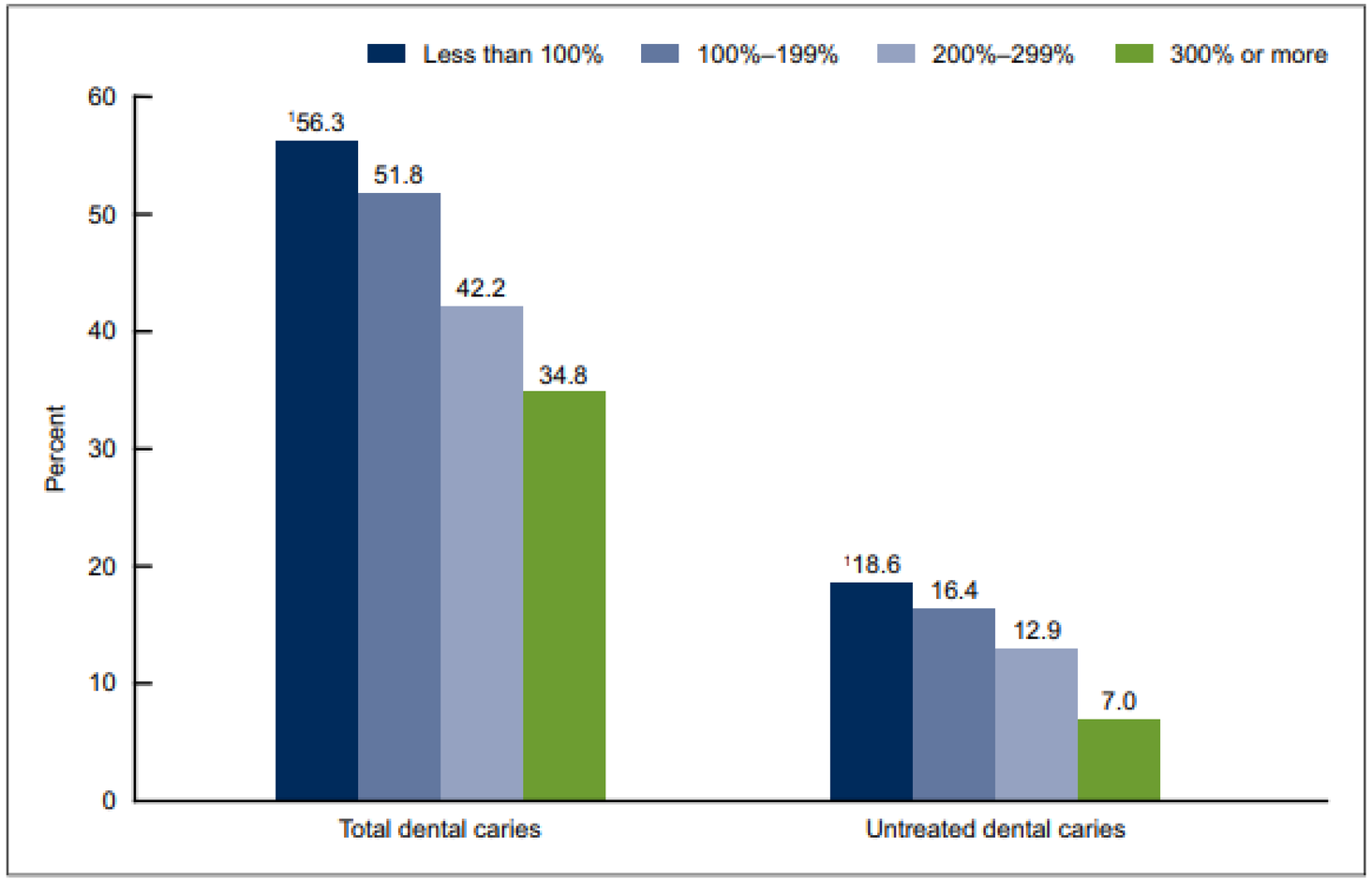
2017

Still poor children are more likely to have a “dental problem”



Source: NHIS and NSCH

Oral Health Disparities: Poor children still have more cavities and more untreated cavities



Source: NHANES

Why does it matter that poor children have poorer oral health?

Consequences of poor oral health in children range from poor appearance to death

COMMENTARY

Dental Sedation Kills 4-Year-Old Who Might Have Been Saved By A Toothbrush

November 10, 2017 | By Paul C. McLean

Covering Health

MONITORING THE PULSE OF HEALTH CARE JOURNALISM

Aftermath of child's death continues to highlight risks of pediatric dental anesthesia

BY MARY OTTO | JANUARY 9, 2019

The problem persists even after securing the coverage fixes. So new policies are needed

Policies that…

1. Maintain hard-won coverage gains
2. Integrate dental and medical coverage and practice
3. Address all oral health determinants – not jut dental care
4. Consider the child within a “Two-Gen” understanding
5. Reward dentists for oral health outcomes rather than procedures

How CDHP accomplishes its objectives

Essential characteristics of CDHP's Work

Start with the "Why"

Opportunity for children and families is not equally distributed.

Mission driven

No family should be held back from their dreams because of dental disease.

Clear Goals

- *Integrate oral health into systems where families live, learn, and work*
- *Race, income & geography are not barriers to good oral health*
- *Better health and quality of life drive systems of care*

CDHP’s Operating Principles

Evidence-based	Start with data to build solutions.
Full cycle of change	Build policy → Advocate → Support Implementation → Evaluate. (Start again, if needed.)
Persistence	Always at the table providing solutions.
Partnerships	Give as much as you take.
Mission First	Mission #1 = issue visibility. Share the wins.

CDHP’s Tactics & Strategies

Framing Family success is the endpoint.

Hooks Show bi-directional relationships between oral health & outcomes for health, education, employment, etc.

Drivers Use payment & delivery systems design to drive change.

Targets Federal & state legislation, regulations, guidance, and contractual arrangements. And cross-sector partnerships.

Visibility Raising the relevance of oral health across electronic platforms and through traditional coalition building & partnership.

Example: Full Cycle of Change

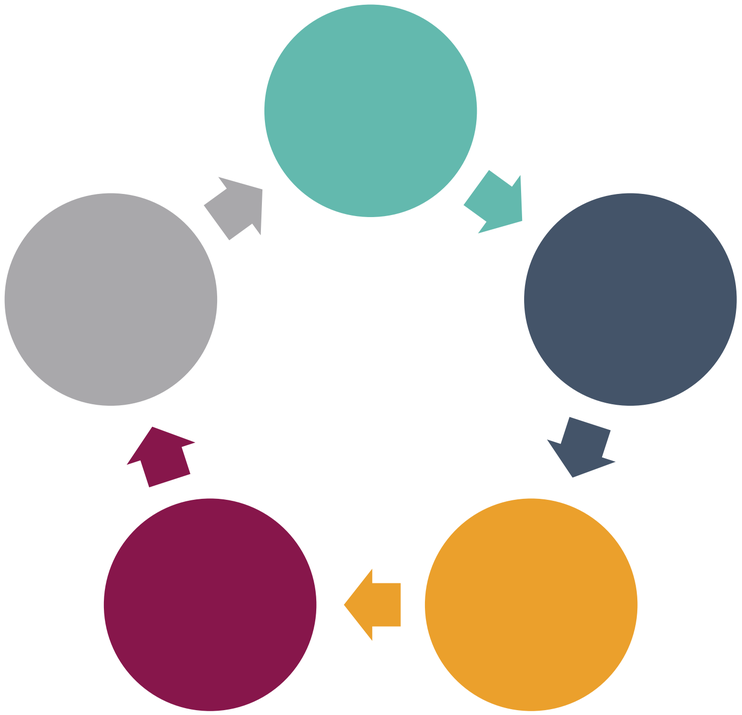
Dental Benefits in ACA

Concept: Expand dental coverage in private markets

Design: Use existing CHIP benchmarks in private marketplaces

Advocacy:

- Dental benefits for all: Compromised pediatric only
- Consumer-focused benefits: Compromised to preserve existing insurance market
- Used existing Sen. Bingaman bill for public health and education programs



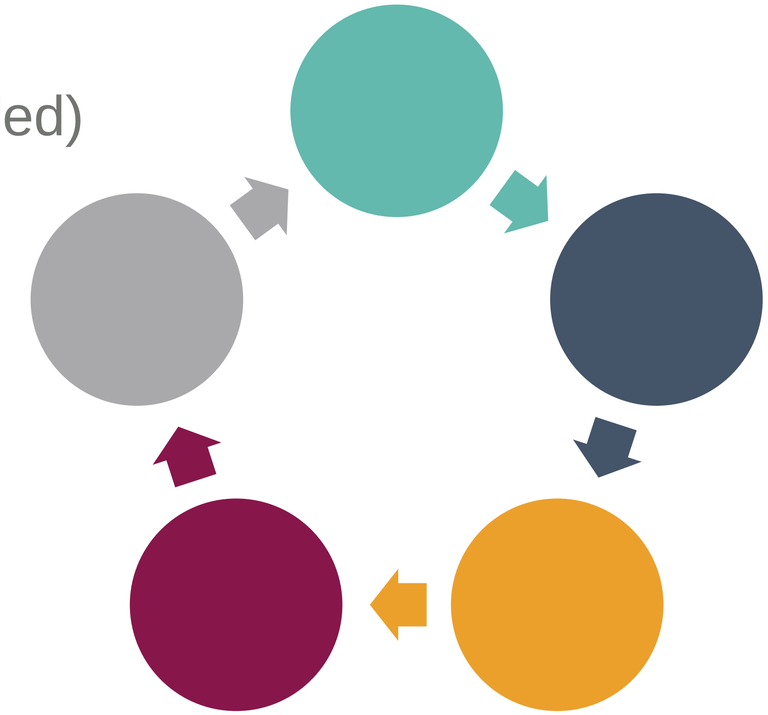
Example: Full Cycle of Change (cont.)

Dental Benefits in ACA

Implementation:
- Regulatory definitions for pediatric dental services (failed)
- Consumer protections & affordability
- Supported state design of marketplace dental benefits
- Educated navigators

Evaluation:
- Monitored enrollment and consumer experience
- Monitored affordability

New Design and Advocacy:
- Need for data collection
- Integration of benefits
- Expansion to adults



Persistence & Partnerships: Maternal Oral Health

2005

Partner with AAPD on professional guidance & educational standards (HRSA)

2009

Draft CIHPRA language supporting education on oral health & pregnancy

2013

Support state launch of maternal oral health initiative & guidance

2014

16 State learning collaborative on improving access to dental care (HRSA)

2015

Launch online Oral Health & Pregnant Women Resource Center

2018

- Release *Oral Health During Pregnancy: Oral Health's Unanswered Questions*
- Target maternal health/mortality bills

2019

- Maternal health coalition on oral health w/ ACOG
- Maternal mortality bills introduced that expand oral health coverage in pregnancy

Take home:

It “takes a village” to make things happen.

But nothing happens without
- commitment
- persistence, and
- leadership.

“The path from dreams to success does exist. May you have the vision to find it, the courage to get on to it, and the perseverance to follow it.”

Kalpana Chawla PhD
Aerospace Engineer
Space Shuttle *Columbia* Crew

Thank You

children's dental health project

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