Oral Health: An Evidence and Data-Driven Approach to Achieve Better Health, Equity, and Fiscal Responsibility

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Centers For Medicare & Medicaid Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

“You’re Not Healthy Without Good Oral Health.”
– Surgeon General C. Everett Koop

Oral Health, Equity, Fiscal Responsibility and Inflammation (Clinical Outcomes)

Equity

Fiscal Responsibility

Inflammation (Clinical Outcomes)

CMS Vision Statement and Strategic Pillars

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

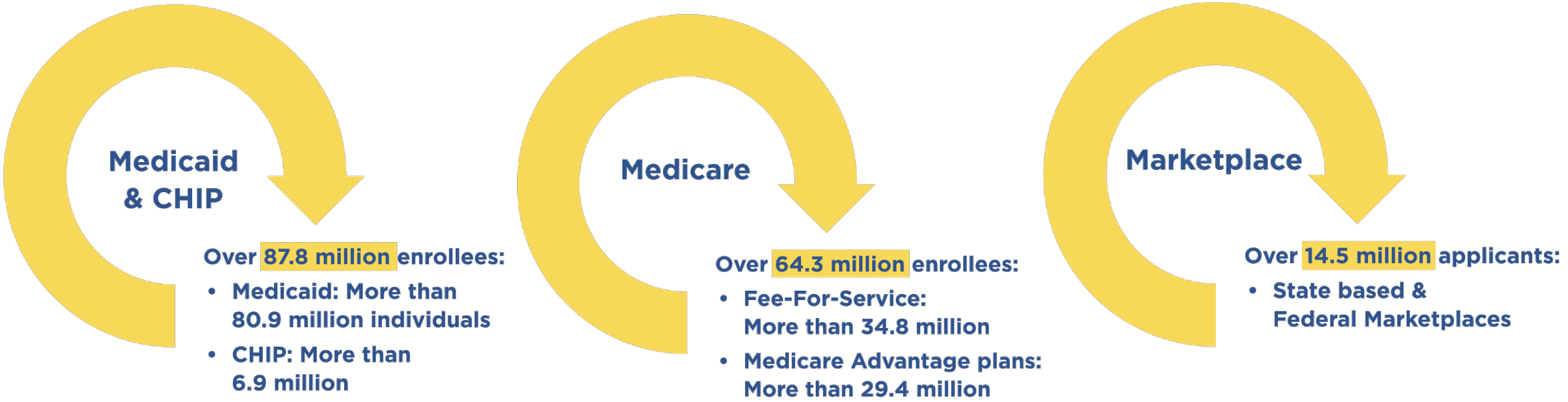
Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

Source: https://www.cms.gov/cms-strategic-plan

Every day, CMS ensures that 154.7 million* people in the U.S. have health coverage that works.



*Subtotal: 166.6 million. Adjust for Medicare/Medicaid dual eligibles (-11.9 million).

Source: https://www.cms.gov/pillar/expand-access

2022 STRATEGY

PILLAR: HEALTH EQUITY

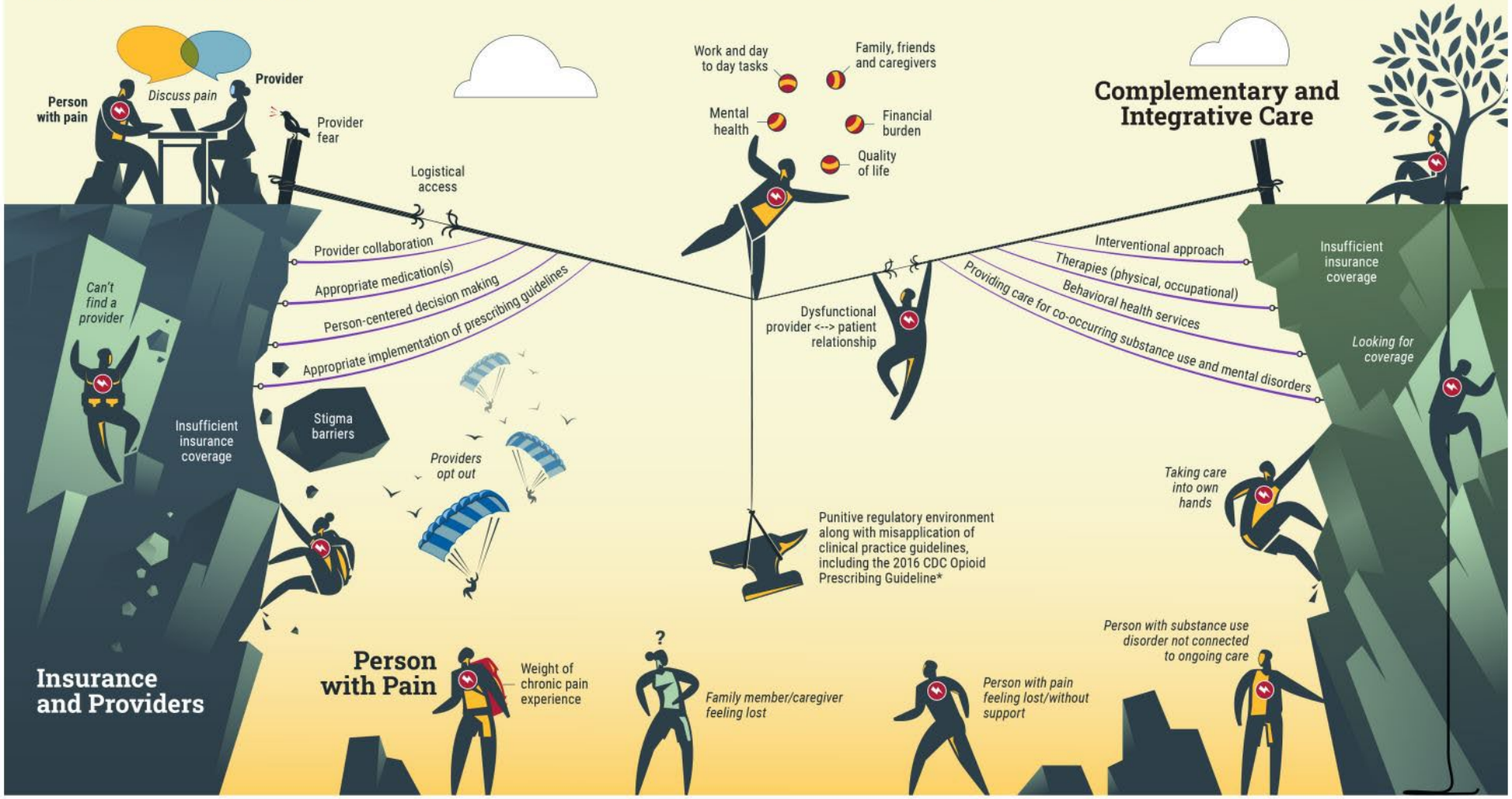
CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

Source: https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

Chronic Pain Experience

Understand access to covered treatment and services for people with chronic pain.

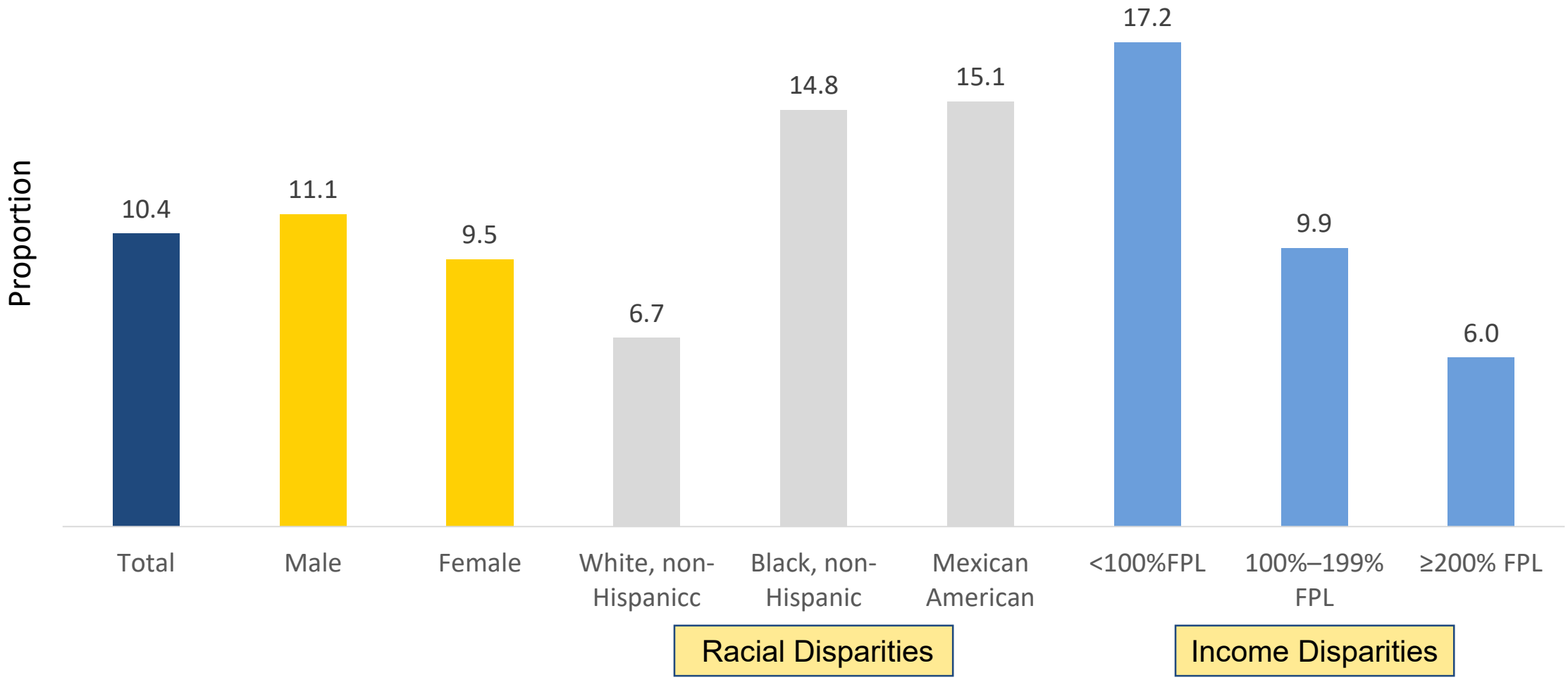
This visual is derived from stakeholder interviews focusing on the experiences of those living with and treating chronic pain. Its intent is to highlight the most prominent barriers experienced by people accessing care and the influencers acting on providers, ultimately affecting the person with chronic pain, their quality of care, and their quality of life. These sentiments were derived from requests for information (RFIs) conducted by CMS and CDC, including as part of CDC's efforts to understand and integrate the lived experiences of patients and providers into their update to the 2016 opioid prescribing guideline.



* CDC is in the process of updating the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. The goal of the revised clinical practice guideline is to help advance effective, individualized, patient-centered care. The revision was designed with a focus on ensuring appropriate use as a clinical tool and to avoid misapplication of the guideline itself.

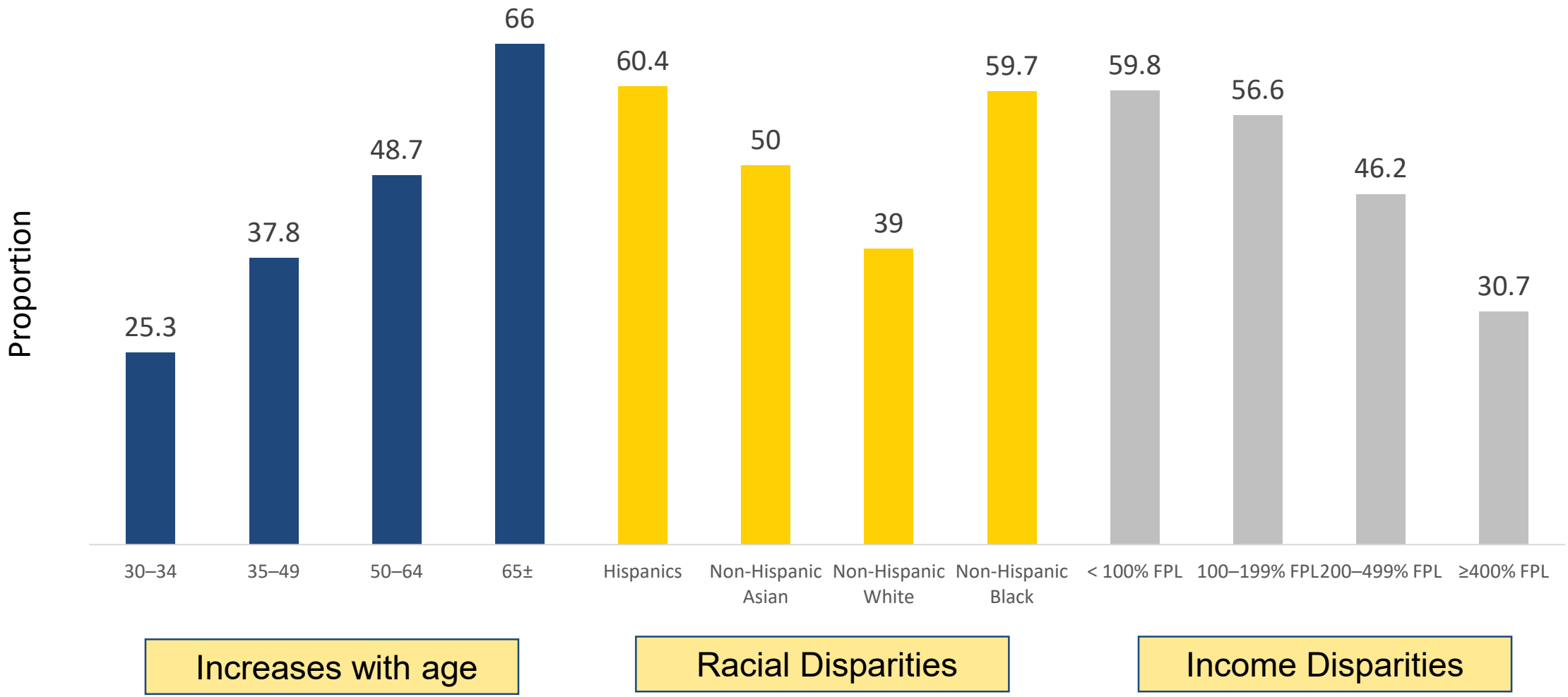
Source: https://www.cms.gov/files/document/cms-chronic-pain-journey-map.pdf

Prevalence of Untreated Tooth Decay In Primary Teeth Among Children Aged 2–5 Years



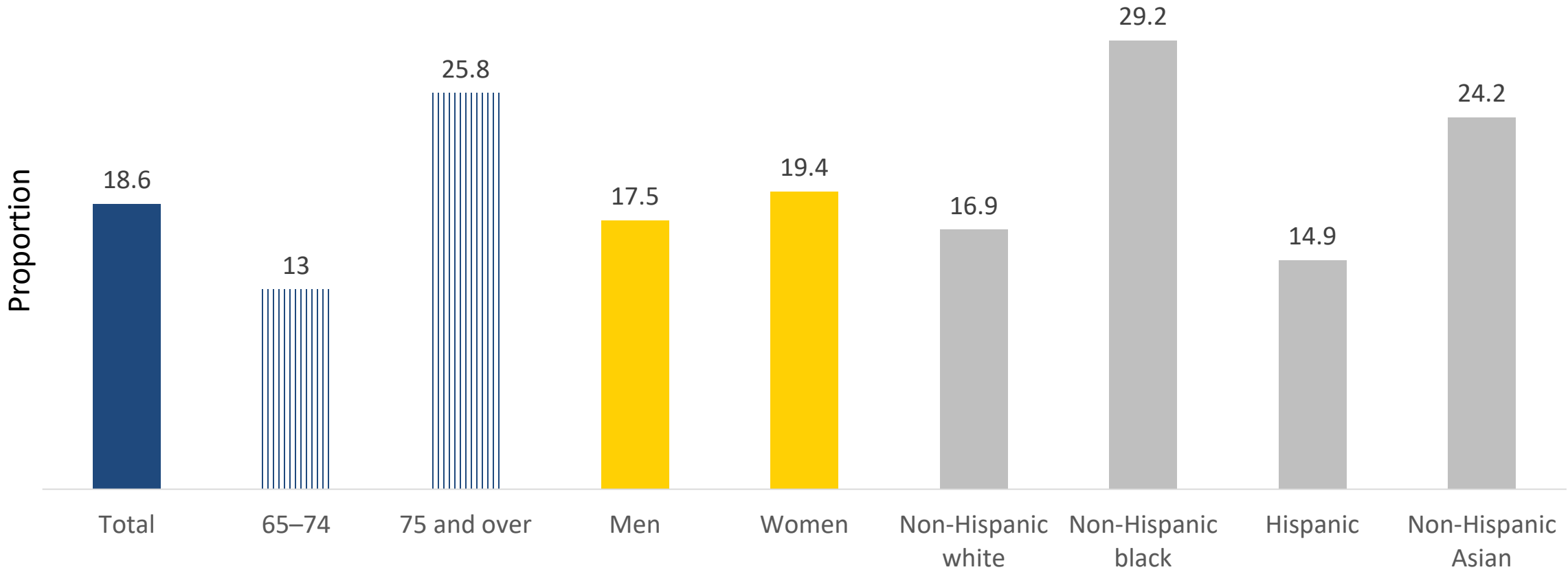
Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2011–2016

Prevalence of Periodontitis in Adults



Source: Eke *et al.* Prevalence of Periodontitis in Adults in the United States: NHANES 2009 to 2012. *J Periodontol*. 2015

Prevalence of Complete Tooth Loss (Edentulism) among Adults Aged 65 and Over



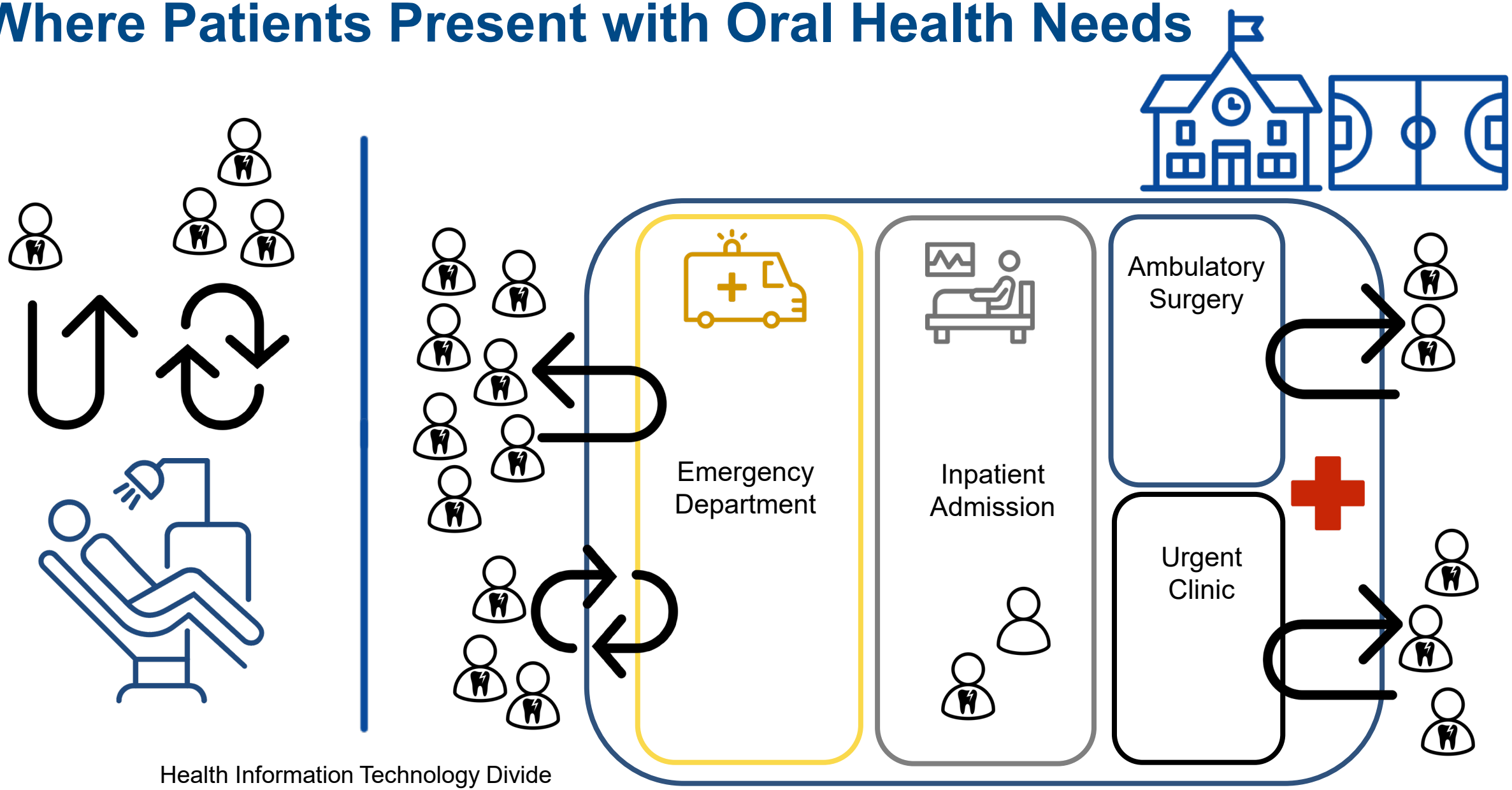
Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2011–2012.

Where People Manage Oral Health

8758 h ← 8760 hours in a year → 2 h

People spend more hours managing their oral health at home than in a clinical setting.

Where Patients Present with Oral Health Needs



Health Information Technology Divide
Diagnostic Coding
Integration and Coordination of Care

Charity and Oral Health

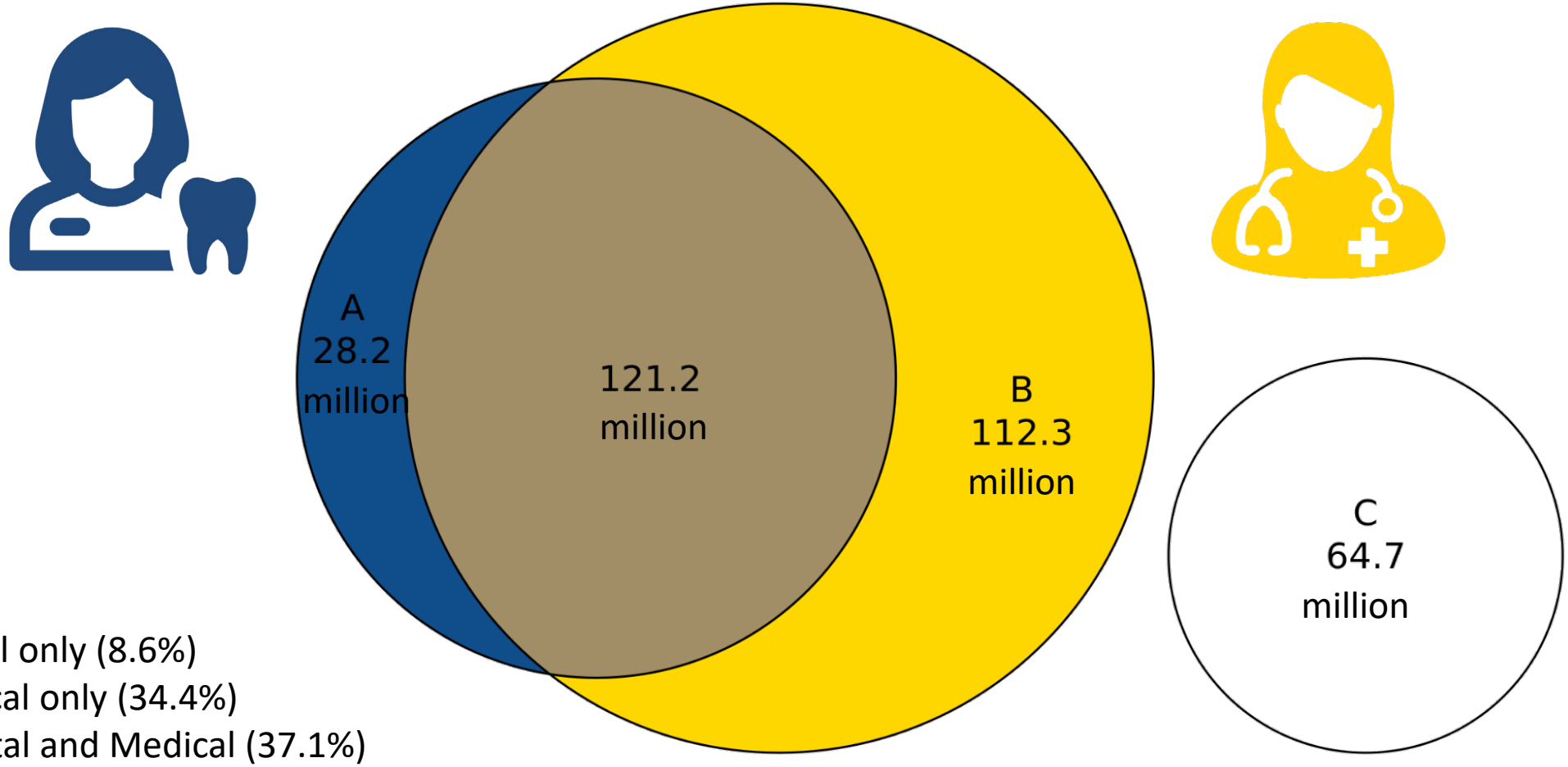
Virginia Remote Area Medical

Oklahoma Mission of Mercy

New Mexico Mission of Mercy

Maryland Mission of Mercy

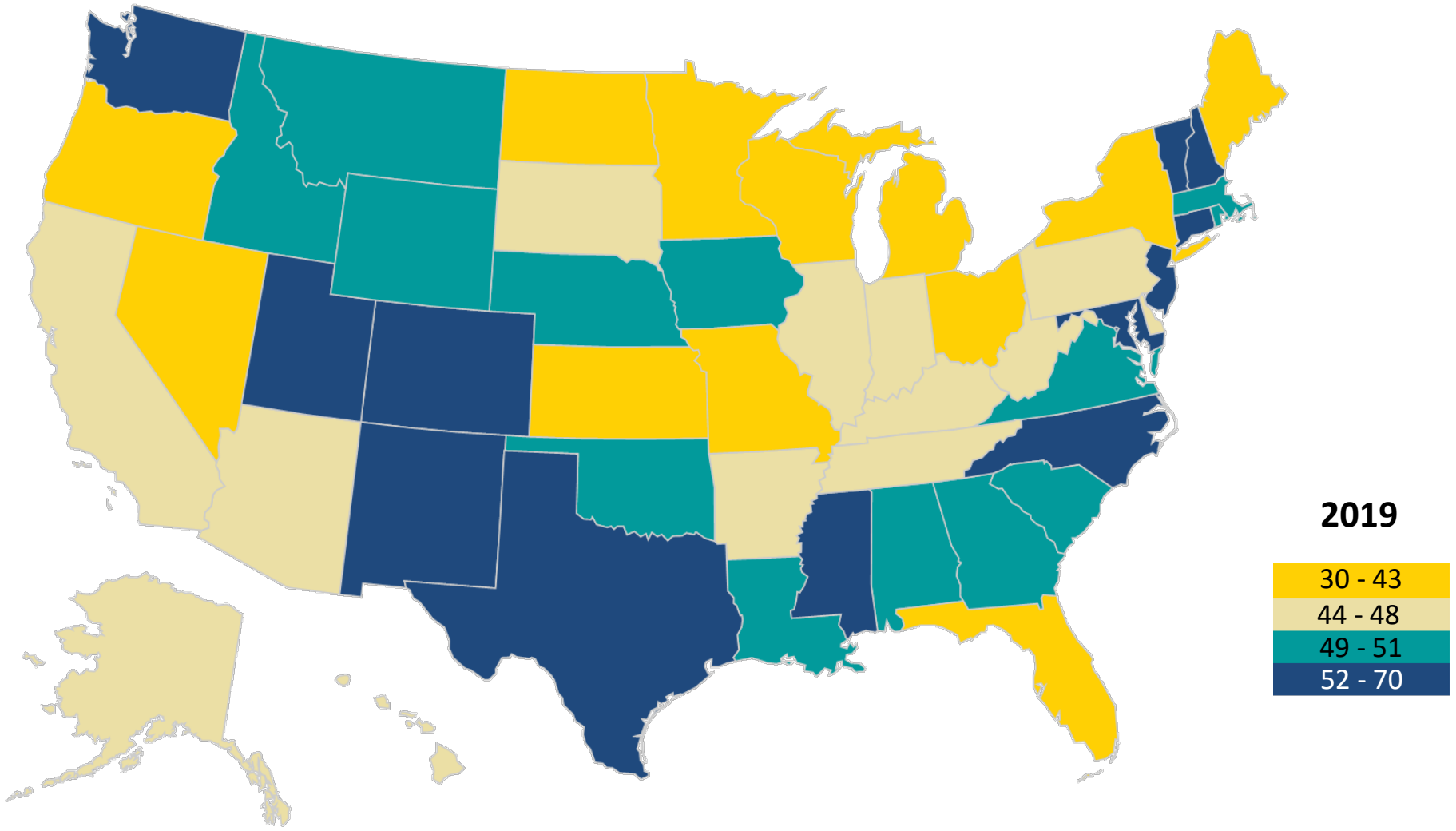
Population with Any Dental and Medical Visits



A: Dental only (8.6%)
B: Medical only (34.4%)
AB: Dental and Medical (37.1%)
C: Neither dental nor medical (19.8%)

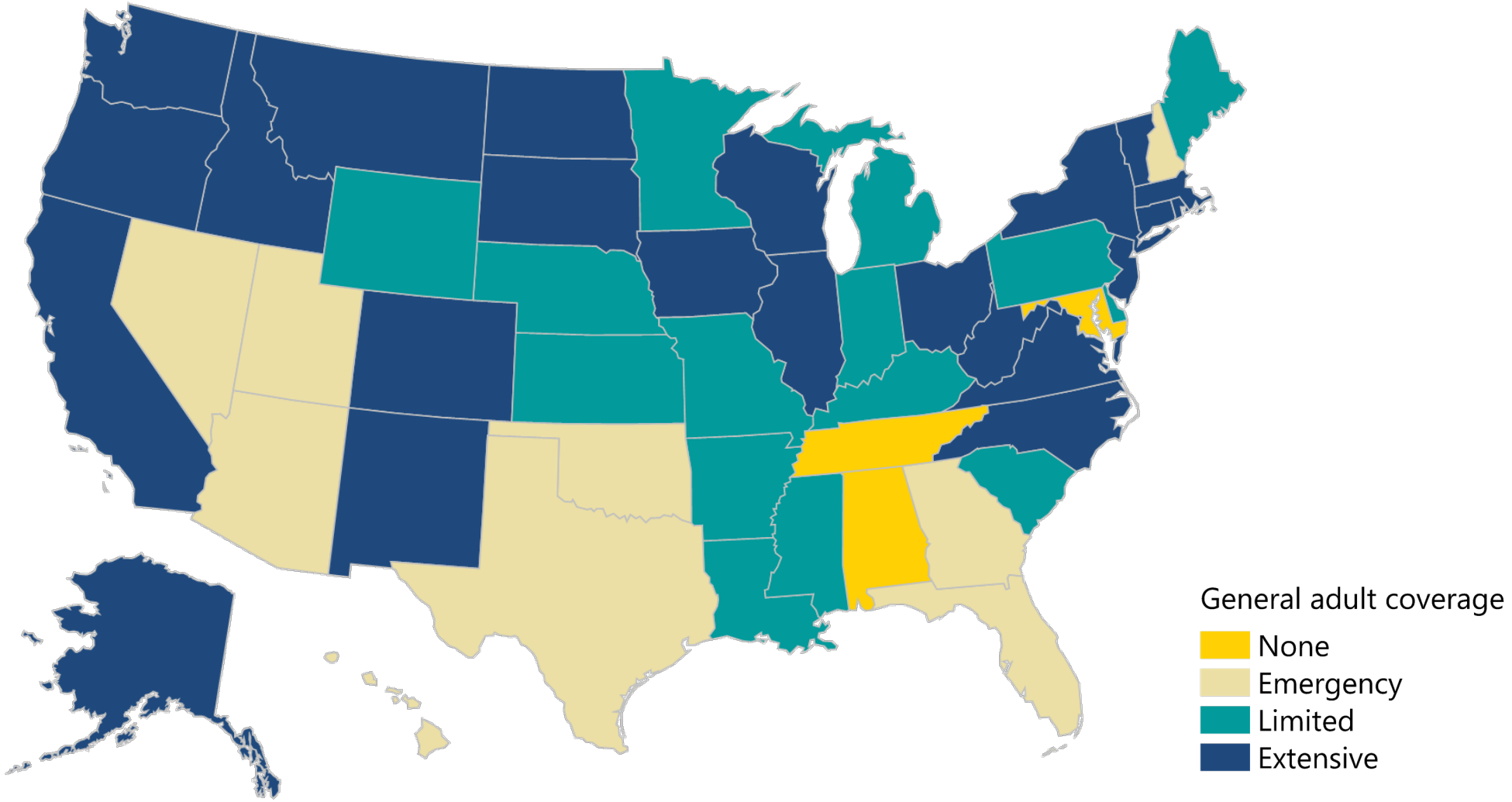
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, Medical Expenditure Panel Survey, Household Component, 2018.

Percentage of Medicaid Eligibles Ages 1 to 20 Who Received Preventive Dental Services



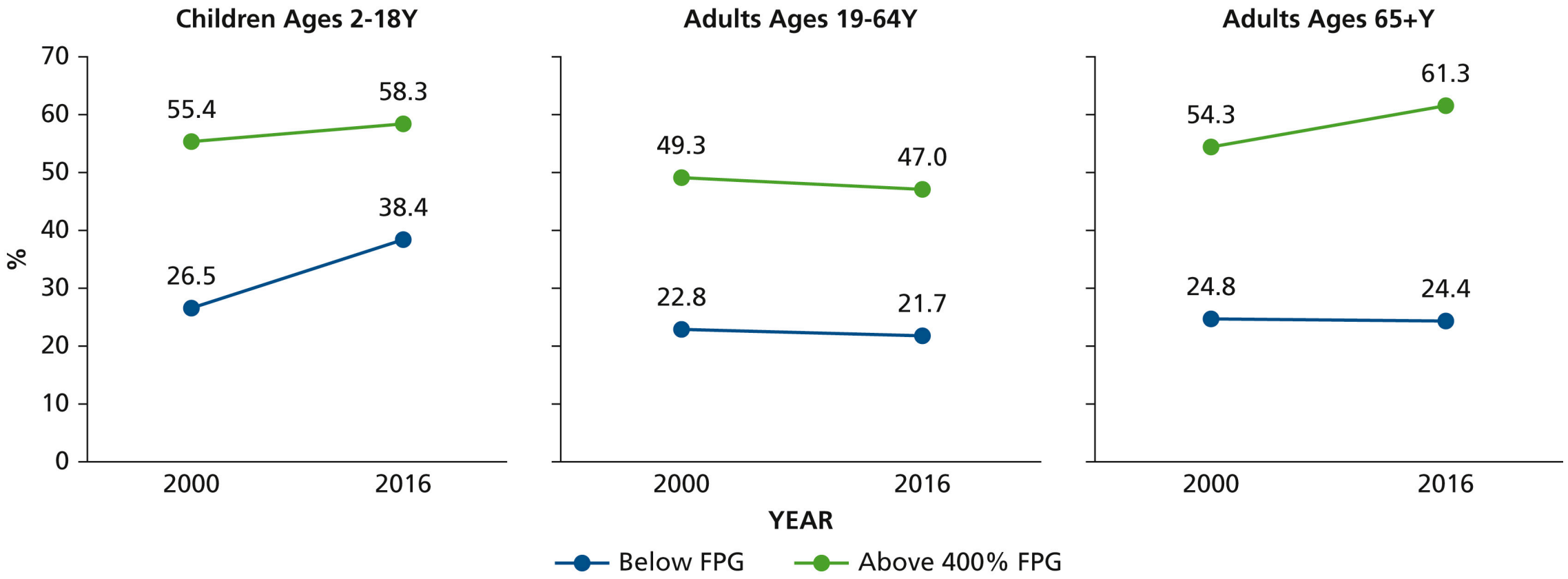
Source: medicaid.gov Children's Health Care Quality Measures

State Medicaid Coverage of Adult Dental Services



Source: The National Academy for State Health Policy, 2021

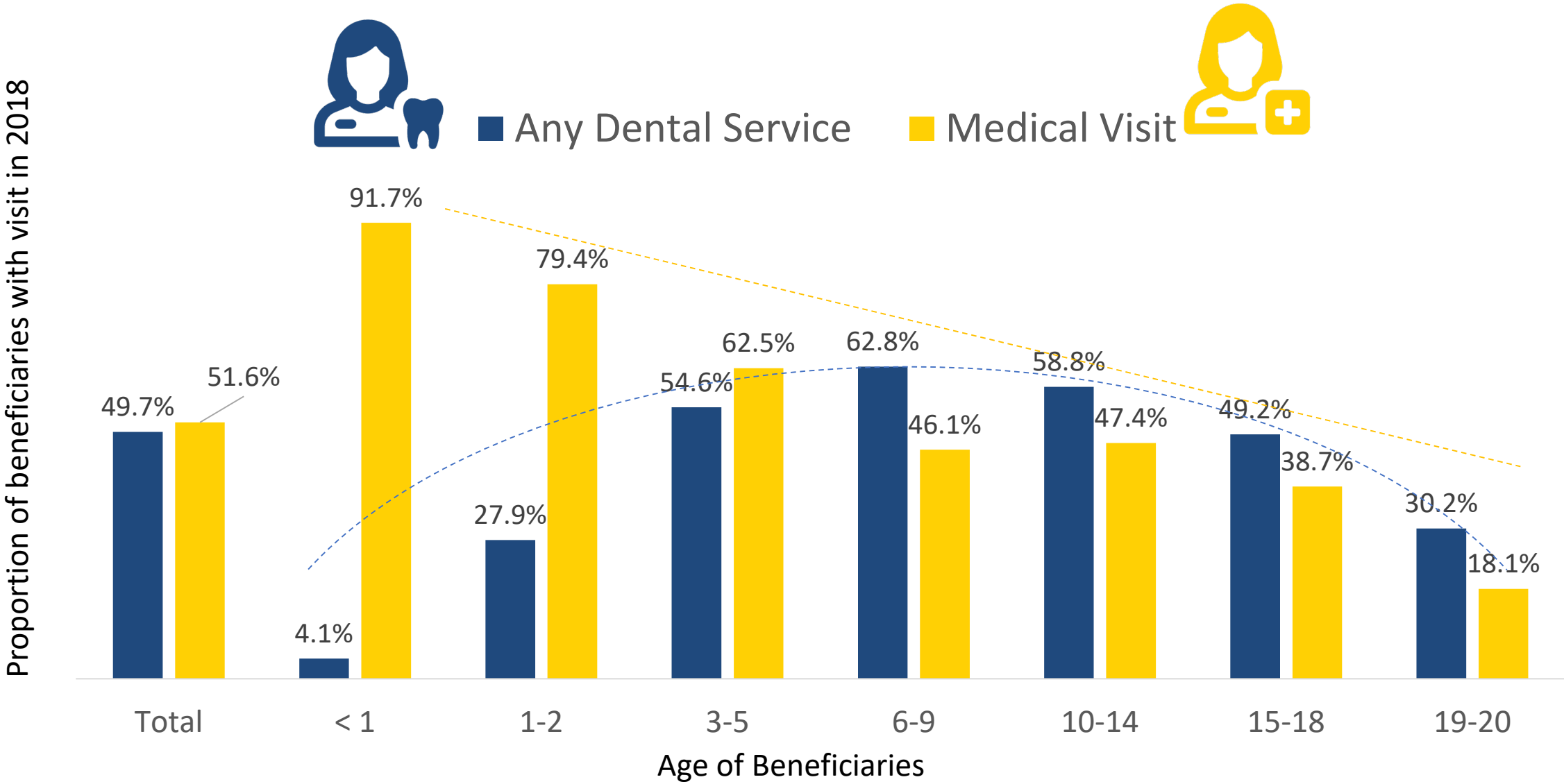
Dental Visit in the Past Year By Poverty



Income Disparities

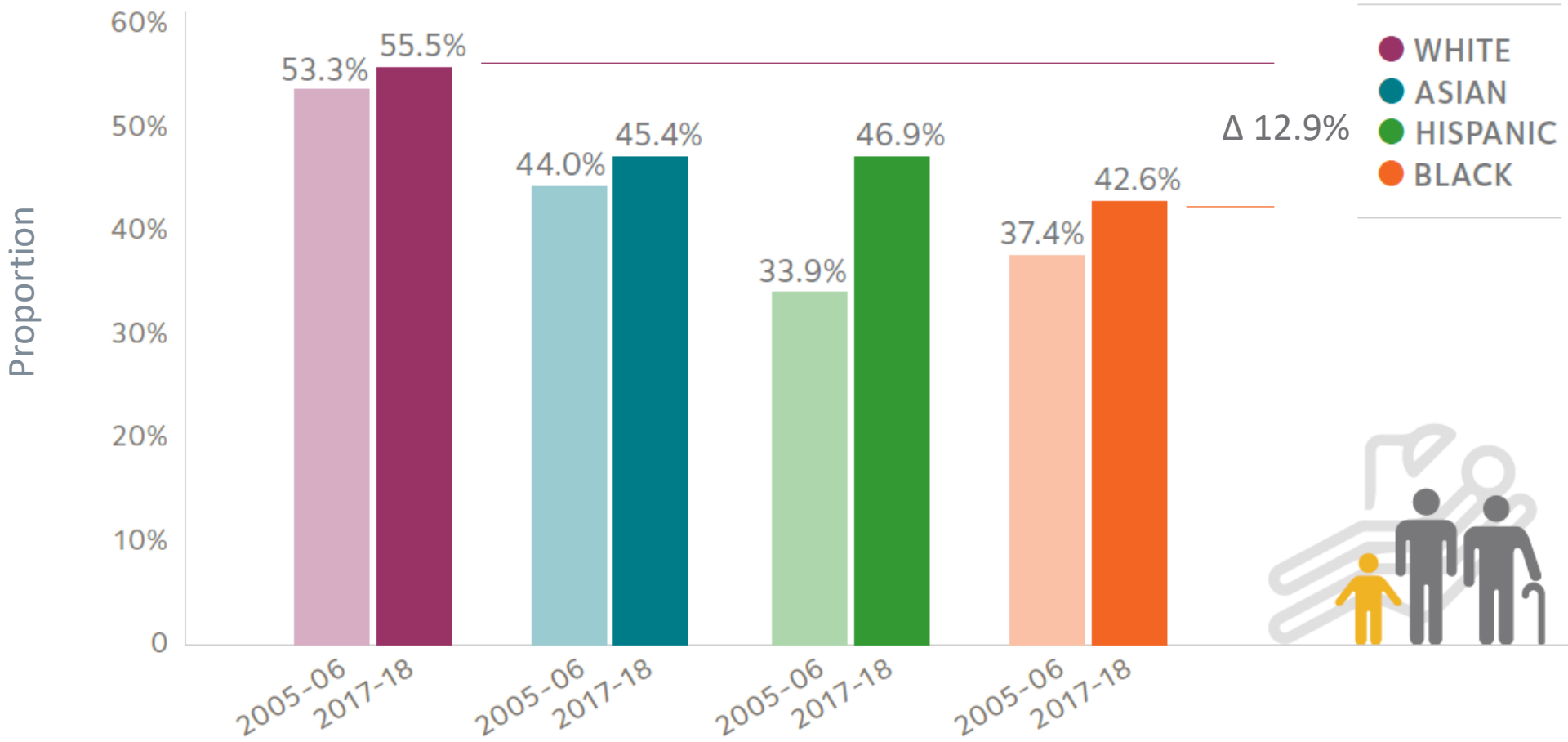
Source: Yarbrough and Vujicic Oral health trends for older Americans JADA 2019

Annual Dental or Medical Visits



Source: 2018 Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT), National

Children With A Dental Visit In The Past Year

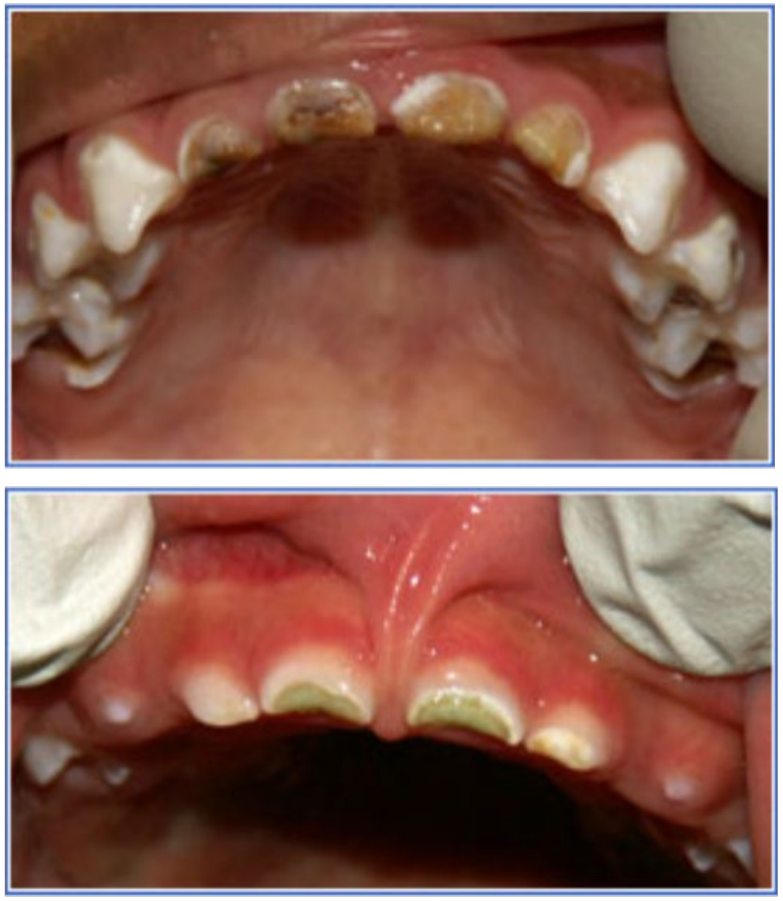


Racial Disparities

Source: ADA Health Policy Institute analysis of data from the Medical Expenditure Panel Survey

The Effect of Poor Dental Health on Children

Severe Early Childhood Caries

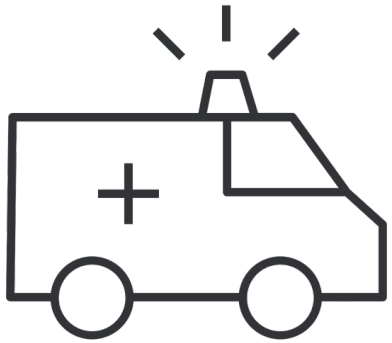


Joanna Douglass, BDS, DDS

Source: smilesforlifeoralhealth.org

Poor academic performance

School attendance, i.e. student absenteeism

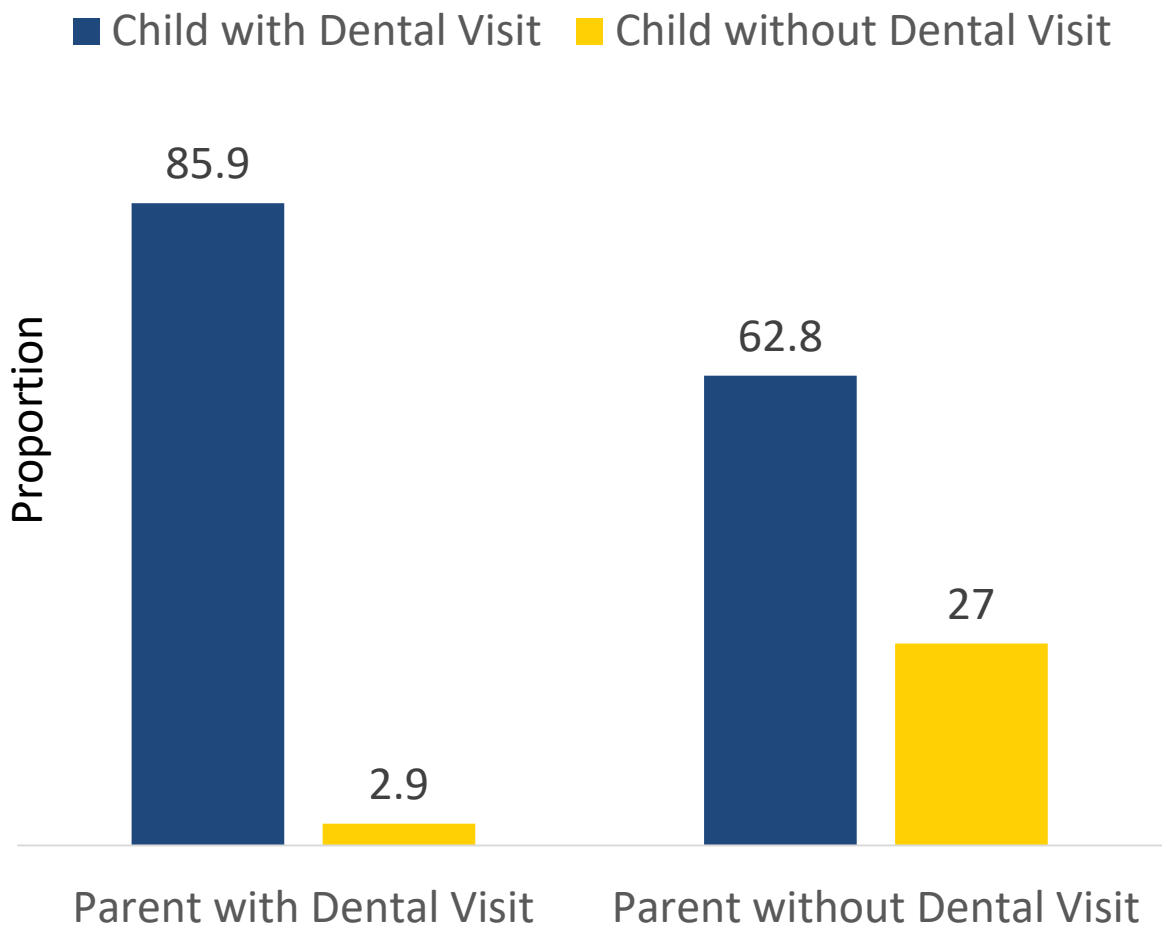


Emergency Department Use

Pain and Infection

Source: Ruff *et al*. Journal of the American Dental Association 2019

Parents Dental Care Experience is Key to Coverage and Access



ORAL HEALTH

By Brandy J. Lipton, Tracy L. Finlayson, Sandra L. Decker, Richard J. Manski, and Mingan Yang

The Association Between Medicaid Adult Dental Coverage And Children's Oral Health

DOI: 10.1377/hlthaff.2021.01135
HEALTH AFFAIRS 40,
NO. 11 (2021): 1731–1739

ABSTRACT **Although all state Medicaid programs cover children's dental care, Medicaid-eligible children are more likely to experience tooth decay than children in higher-income families. Using data from the 1999–2016 National Health and Nutrition Examination Survey and the 2003, 2007, and 2011–12 waves of the National Survey of Children's Health, we examined the association between Medicaid adult dental coverage (an optional benefit) and children's oral health. Adult dental coverage was associated with a statistically significant 5-percentage-point reduction in the prevalence of untreated caries among children after Medicaid-enrolled adults had access to coverage for at least one year. These policies were also associated with a reduction in parent-reported fair or poor child oral health with a two-year lag between the onset of the policy and the effect. Effects were concentrated among children younger than age twelve. We estimated declines in poor oral health among all racial and ethnic subgroups, although there was some evidence that non-Hispanic Black children experienced larger and more persistent effects than non-Hispanic White children. Future assessments of the costs and benefits of offering adult dental coverage may consider potential effects on the children of adult Medicaid enrollees.**

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Sandra L. Decker is a health economist in the Division of Research and Modeling, Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality, in Rockville, Maryland.

Richard J. Manski is a professor in and chair of the Department of Dental Public Health at the University of Maryland School of Dentistry, in Baltimore, Maryland.

Mingan Yang is an associate professor in the School of Public Health, San Diego State University.

Despite considerable progress, tooth decay remains the most common childhood chronic disease.[1] Medicaid-eligible children are more likely to experience tooth decay compared with children in higher-income families but are less likely to visit the dentist annually (29 percent versus 55 percent).[2] All state Medicaid programs cover a comprehensive set of preventive and restorative dental services for children under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Although financial barriers are frequently reported as the reason for not receiving needed dental care among both adults and children,[3] noncost barriers may also play an important role in explaining income-based disparities in children's dental care use.

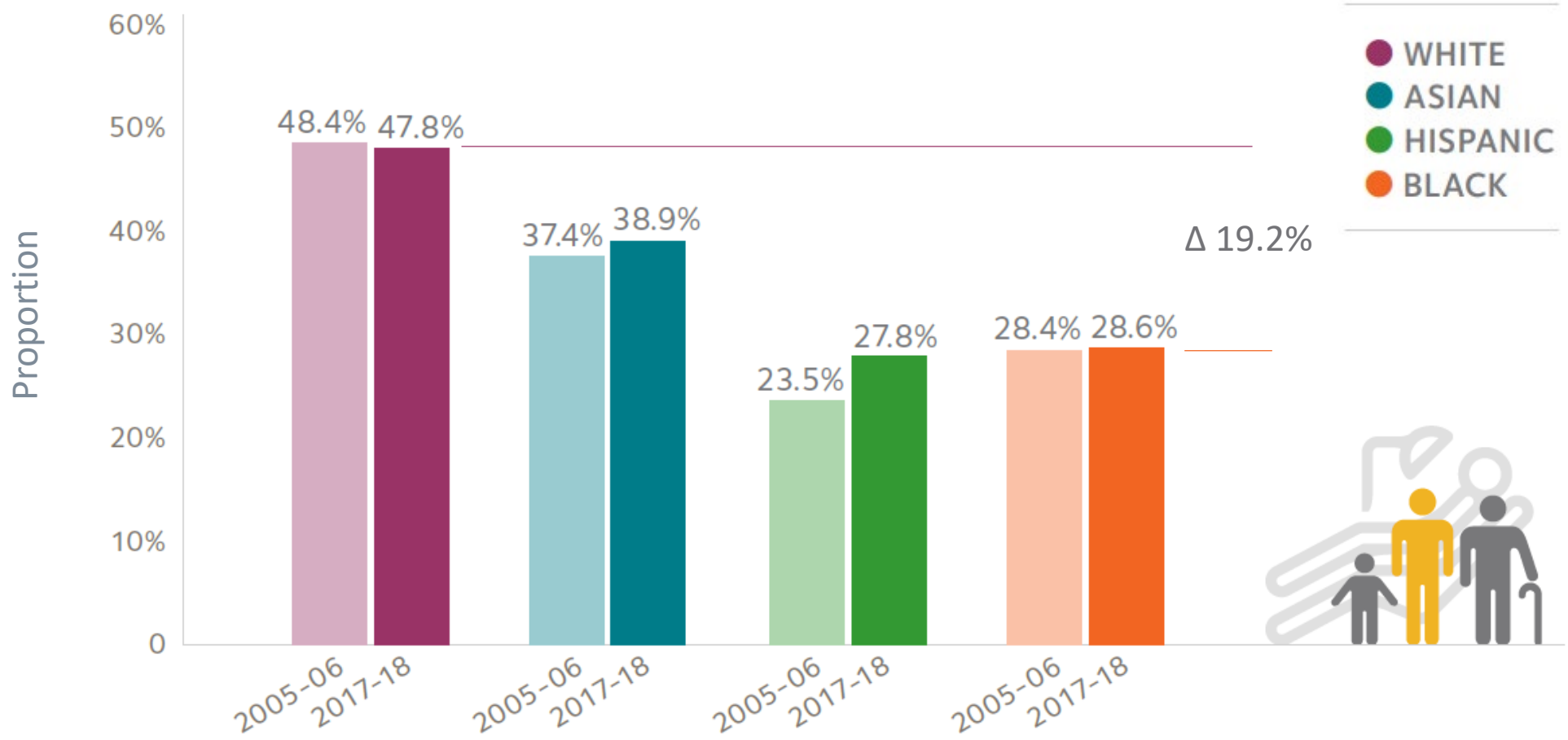
Children are more likely to have regular dental visits when their parents have dental coverage or a recent dental visit.[4–6] Parental dental coverage may facilitate children's dental care use in several ways. For example, providers may relay information about recommended dental care or dental benefits available to publicly insured children when a parent has a dental visit. As many general dentists treat both adults and children,[7] families may cluster their appointments when both parents and children have dental coverage, reducing transportation barriers and requiring less time off work. Parent dental coverage may also reduce out-of-pocket health care spending,[8] which could increase available resources for children's health care needs.

In contrast to the requirements for children, states are not required to provide any level of

Source: Isong *et al.* Pediatrics 2010

Source: Lipton *et al. Health Affairs* 2021

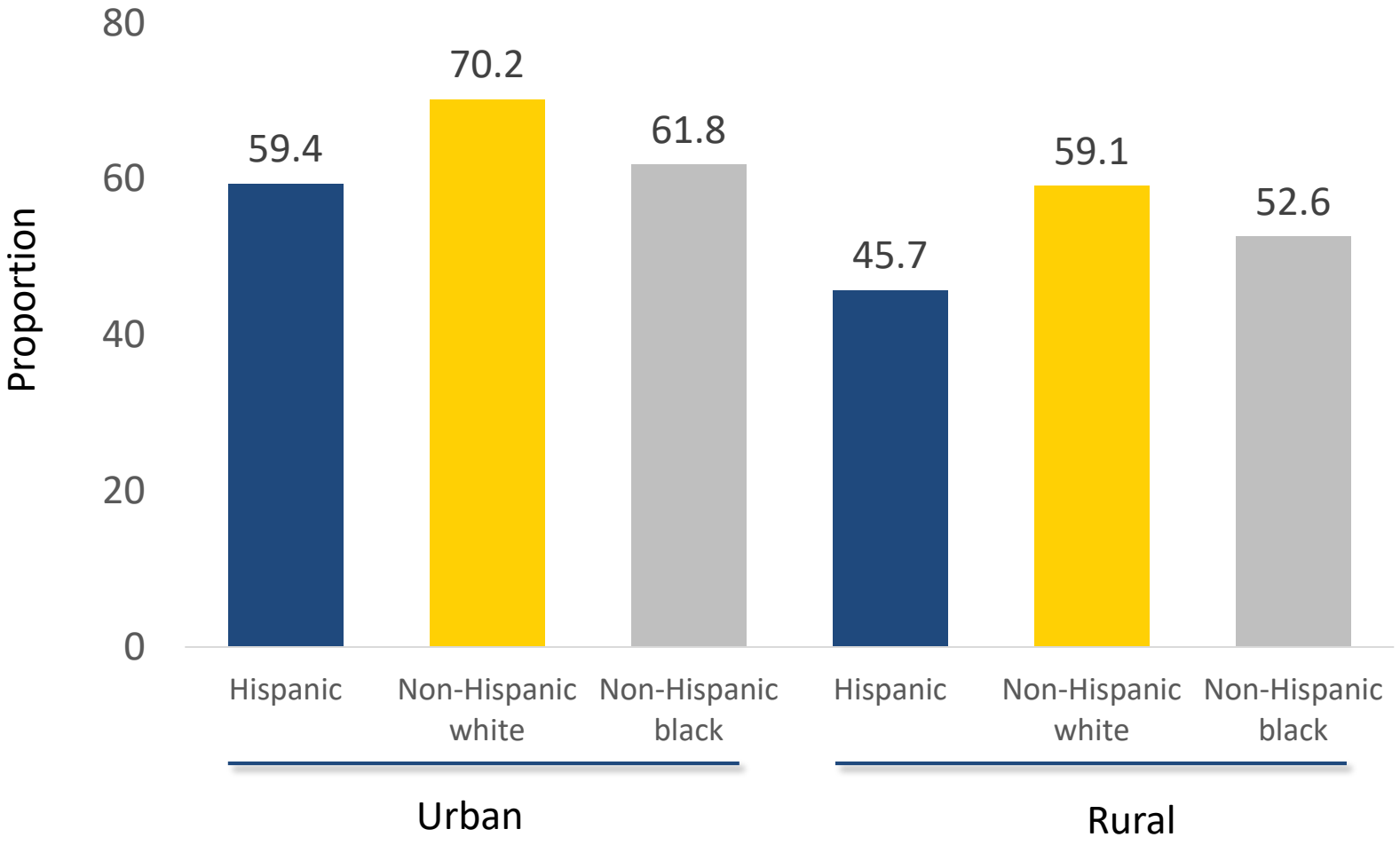
Adults With A Dental Visit In The Past Year

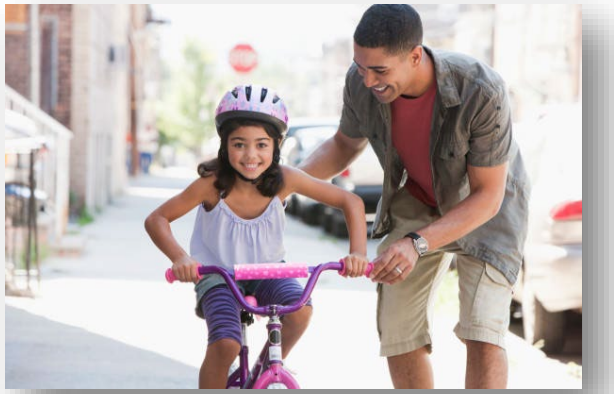


Racial Disparities

Source: ADA Health Policy Institute analysis of data from the Medical Expenditure Panel Survey

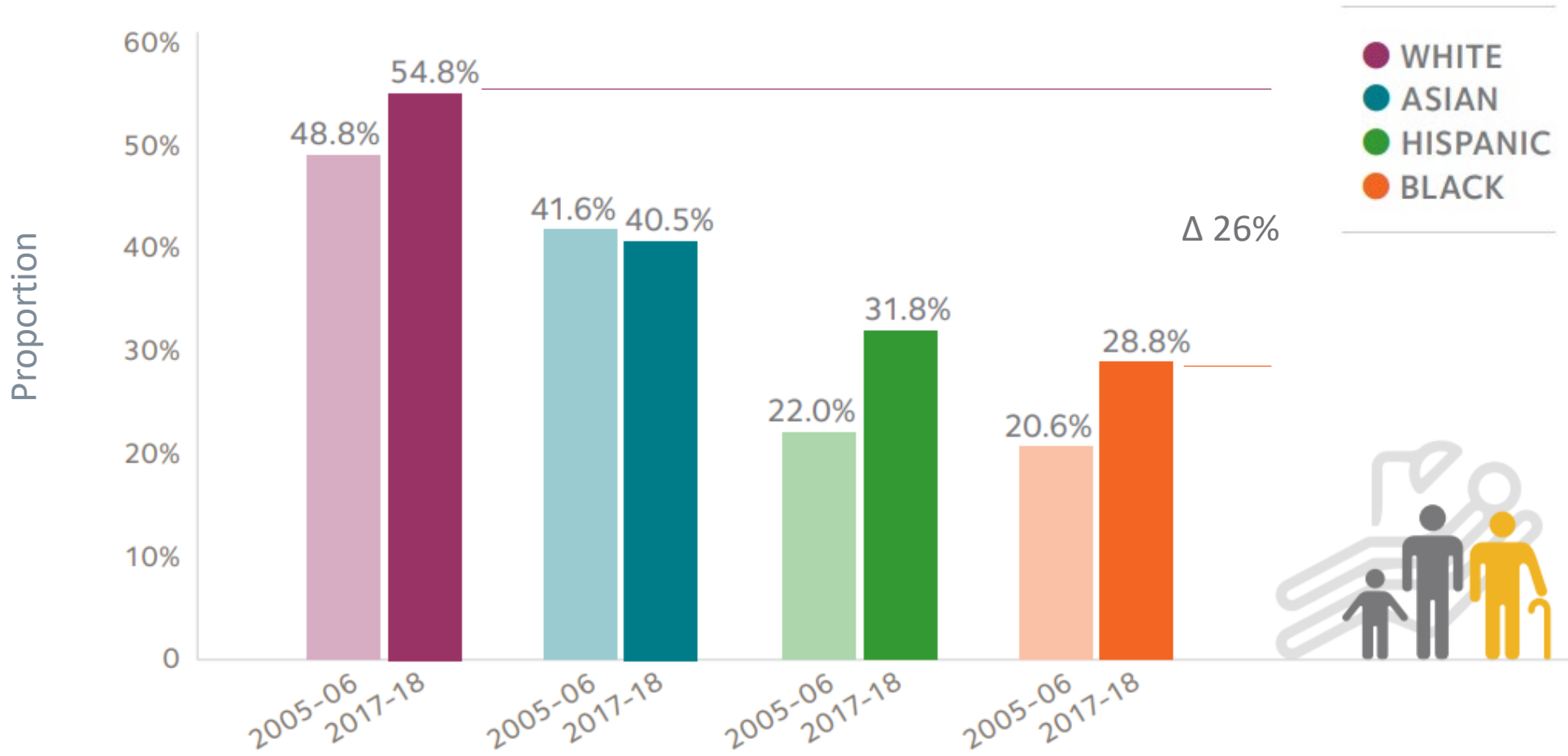
Urban-Rural Differences in Dental Care Use Among Adults Aged 18–64





Source: National Center for Health Statistics, National Health Interview Survey, 2019.

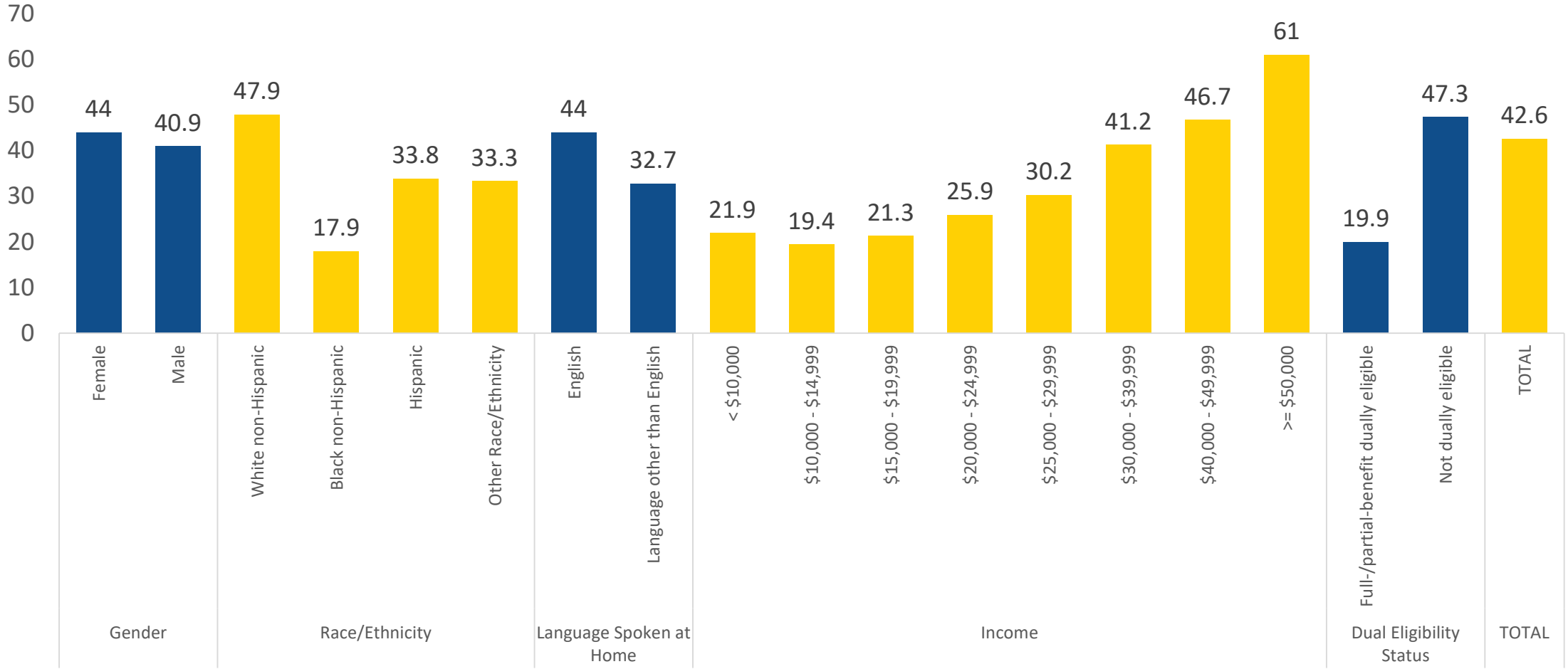
Seniors With A Dental Visit In The Past Year



Racial Disparities

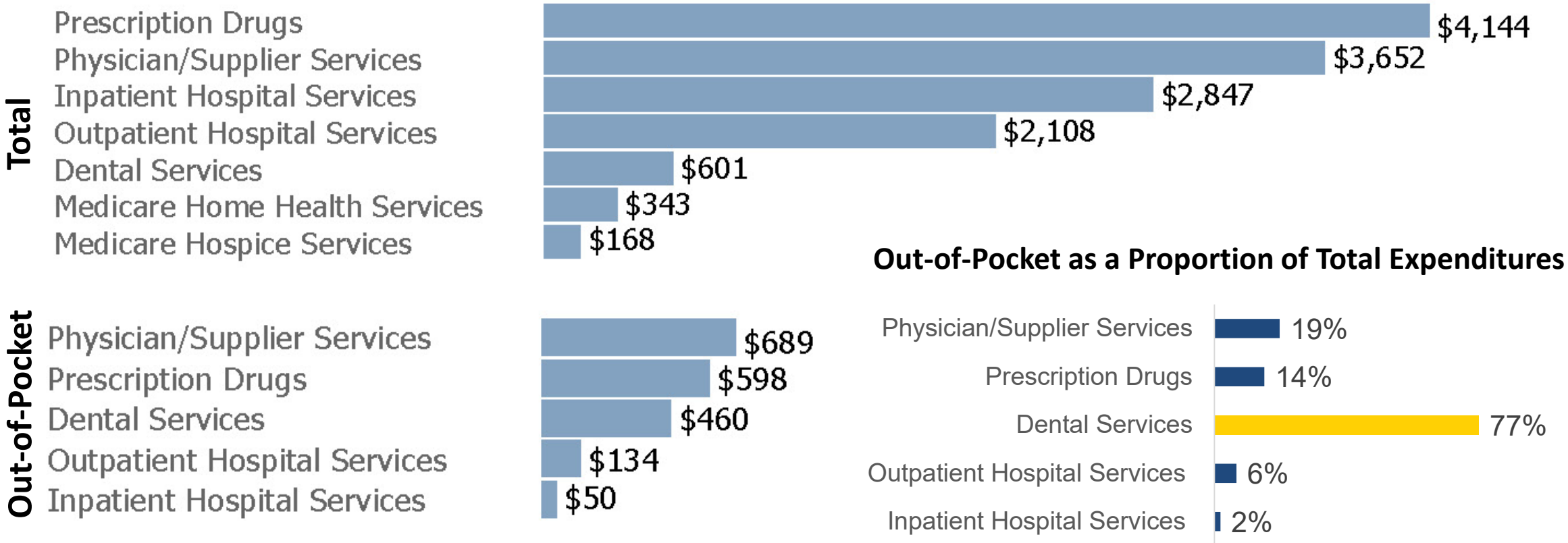
Source: ADA Health Policy Institute analysis of data from the Medical Expenditure Panel Survey

Percentage of Medicare Beneficiaries Living Only in the Community Who Had at Least One Dental Exam in 2019



Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File and Cost Supplement File, 2019
https://www.cms.gov/files/document/mcbs-data-highlight-utilization-dental-vision-and-hearing-care-services-2019.pdf

Health Care Service Expenditures per Capita for Selected Service Types Among Medicare Beneficiaries Living Only in the Community, in Dollars, 2018

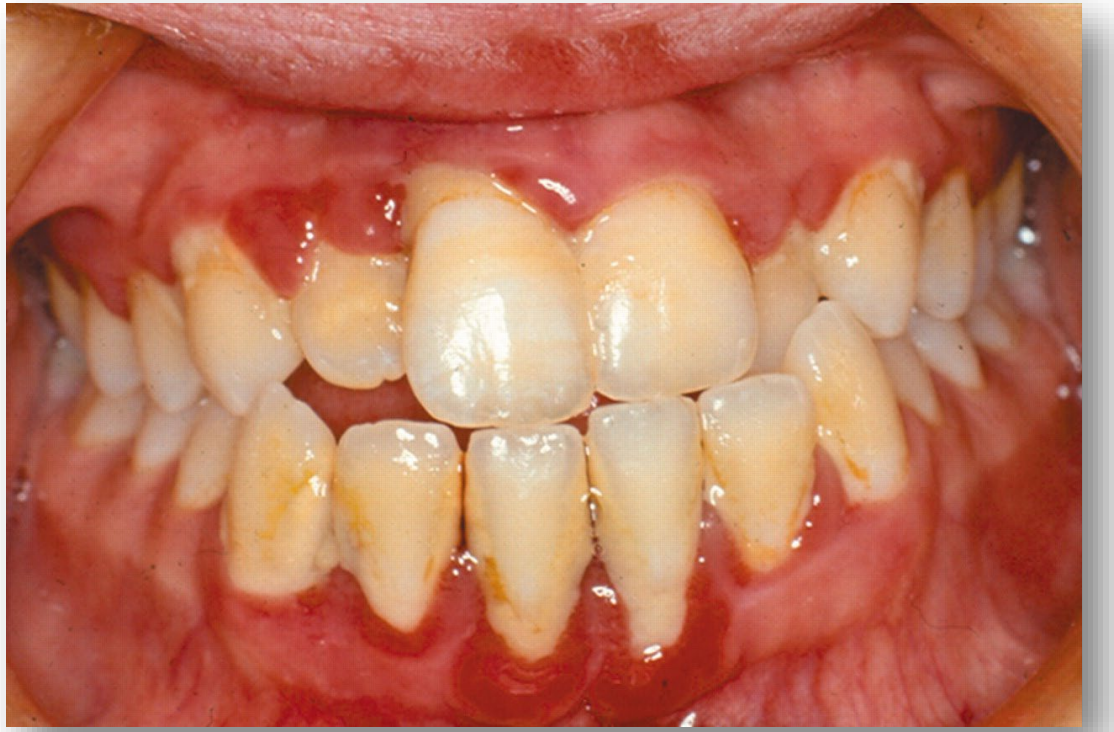


Dental services have the highest out-of-pocket proportion.

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File, 2018 and Cost Supplement File, 2018

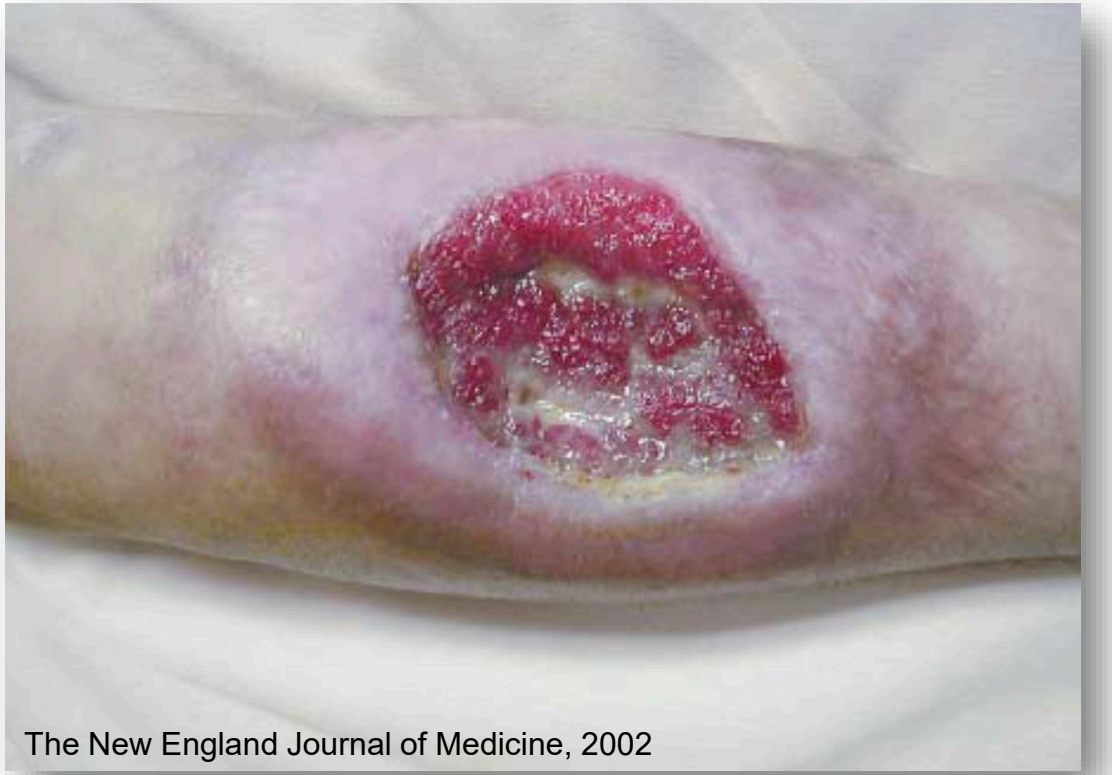
Poor Oral Health, Infection and Inflammation

Total inflammation surfaces are approximately the same.



Fitzgerald Arch Dis Child 2005

Chronic periodontal disease



The New England Journal of Medicine, 2002

Nonhealing Ulcer over the Ulnar Aspect of the Left Forearm

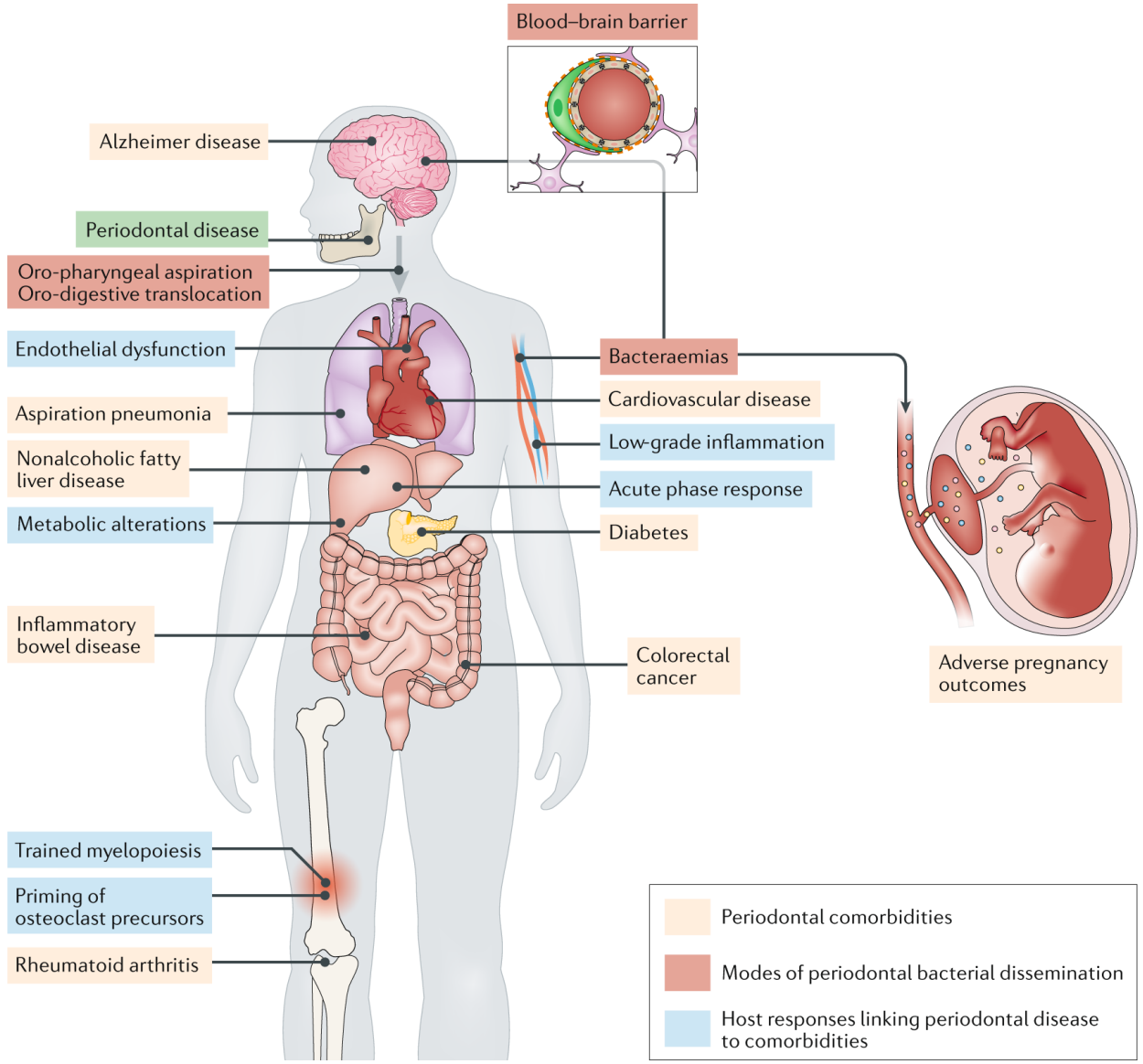
Periodontal Disease and Associated Inflammatory Comorbidities

Periodontitis Inflammatory Comorbidities

- Cardiovascular disease
- Type 2 diabetes mellitus
- Rheumatoid arthritis
- Inflammatory bowel disease
- Alzheimer disease
- Nonalcoholic fatty liver disease
- Cancers

Dissemination

- Bacteremia, hematogenous
- Oro-pharyngeal dissemination
- Oro-digestive dissemination



Source: Hajishengallis and Chavakis Nat Rev Immunol 2021

Association Between Maternal Periodontal Disease and Adverse Pregnancy Outcomes

Maternal periodontal disease increases the odds of low birthweight by

10%

Maternal periodontal disease increases the odds of preterm birth by

15%

Maternal periodontal disease increases the odds of spontaneous abortion by

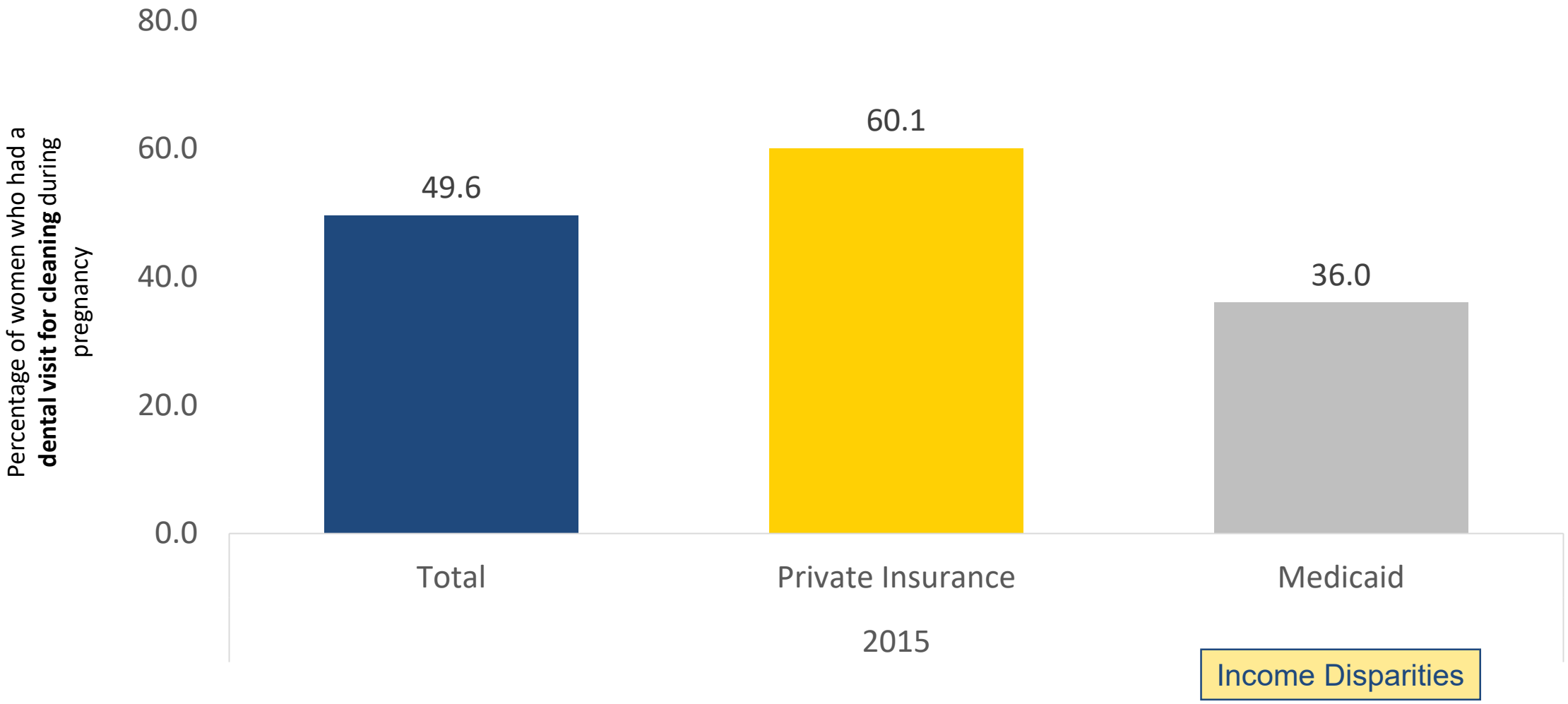
34%

Maternal periodontitis increases the odds of any maternal complications by

19%

Source: Choi *et al*. Family Practice, 2021

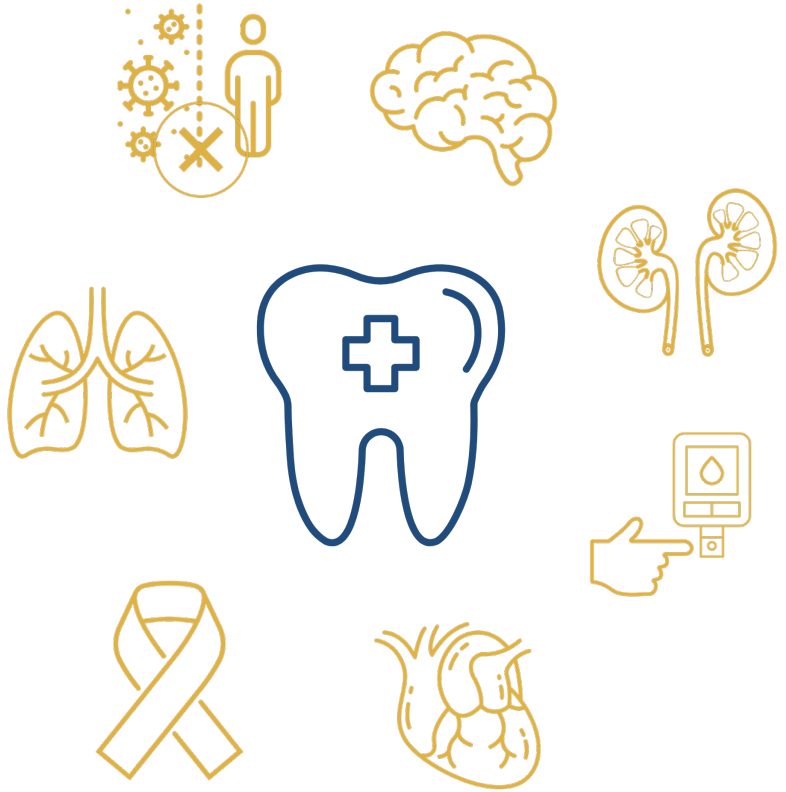
Dental Visit During Pregnancy



Source: Lee *et al.* JDR Clinical & Translational Research 2021

The Science of Oral-systemic Interrelationship

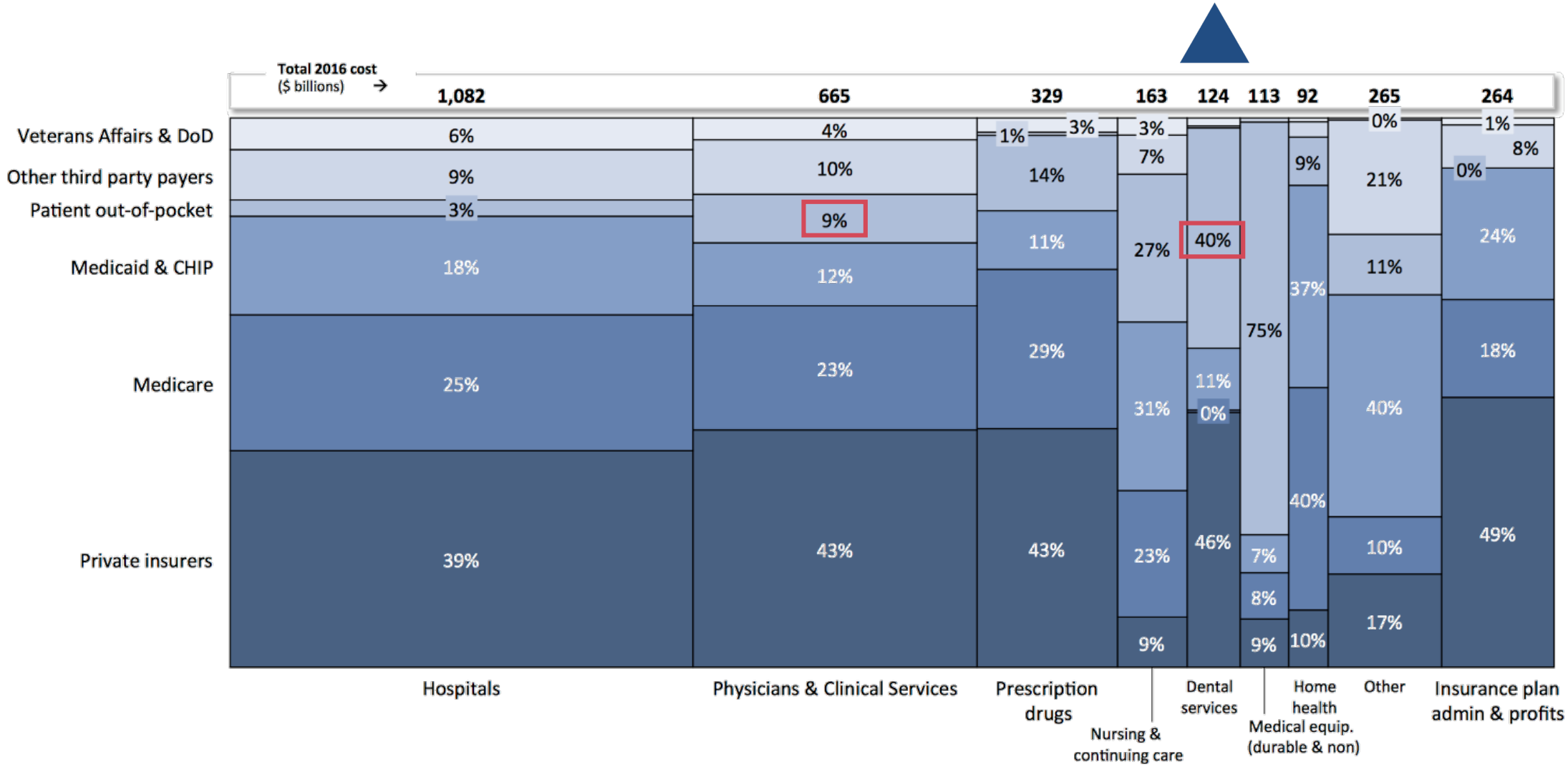
Increased Risk to Oral Health Caused by the Medical Condition or its Treatment.



Increased Risk to Systemic Health Related to Poor Oral Health.

National Health Expenditure

Dental is 4% of all Health Expenditures, $124 Billion



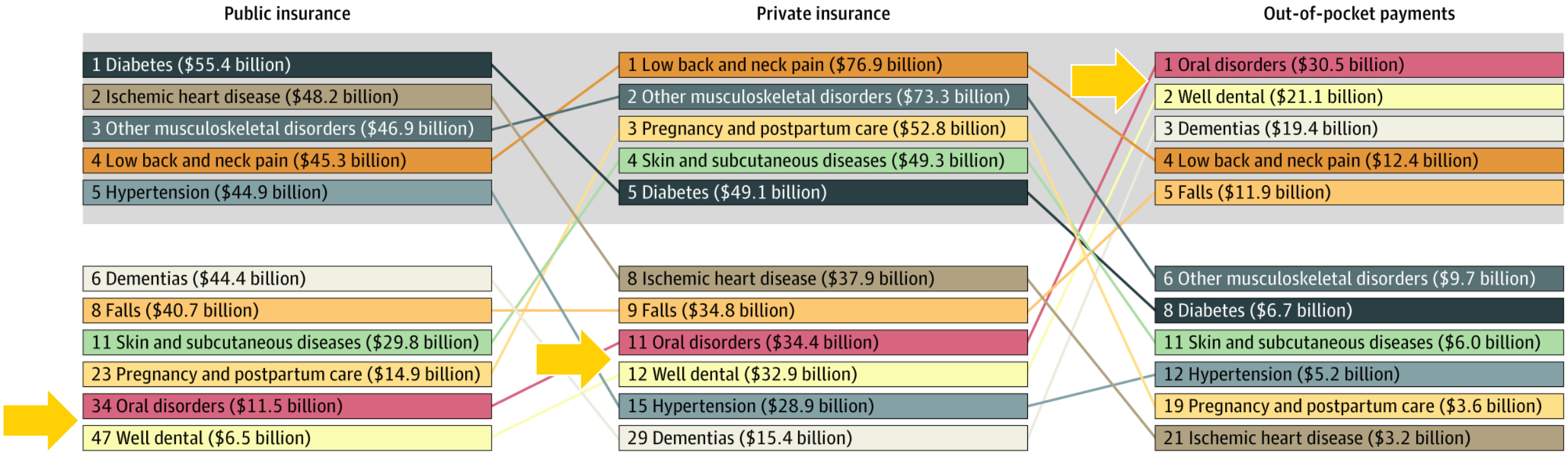
 Source: National Health Expenditure, Centers for Medicare and Medicaid Services

Medicaid and Medicare Dental Spending

- In 2019, **$15.5 billion** was spent on dental services by **Medicaid and CHIP**, representing 2.1% of Medicaid and CHIP expenditures for all services.
- In 2019, **$1.9 billion** was spent on dental services by **Medicare**, representing 0.2% of Medicare expenditures for all services.
- U.S. Health Care Spending Reach **$4.1 Trillion In 2020, 19.7%** Gross Domestic Product (GDP)

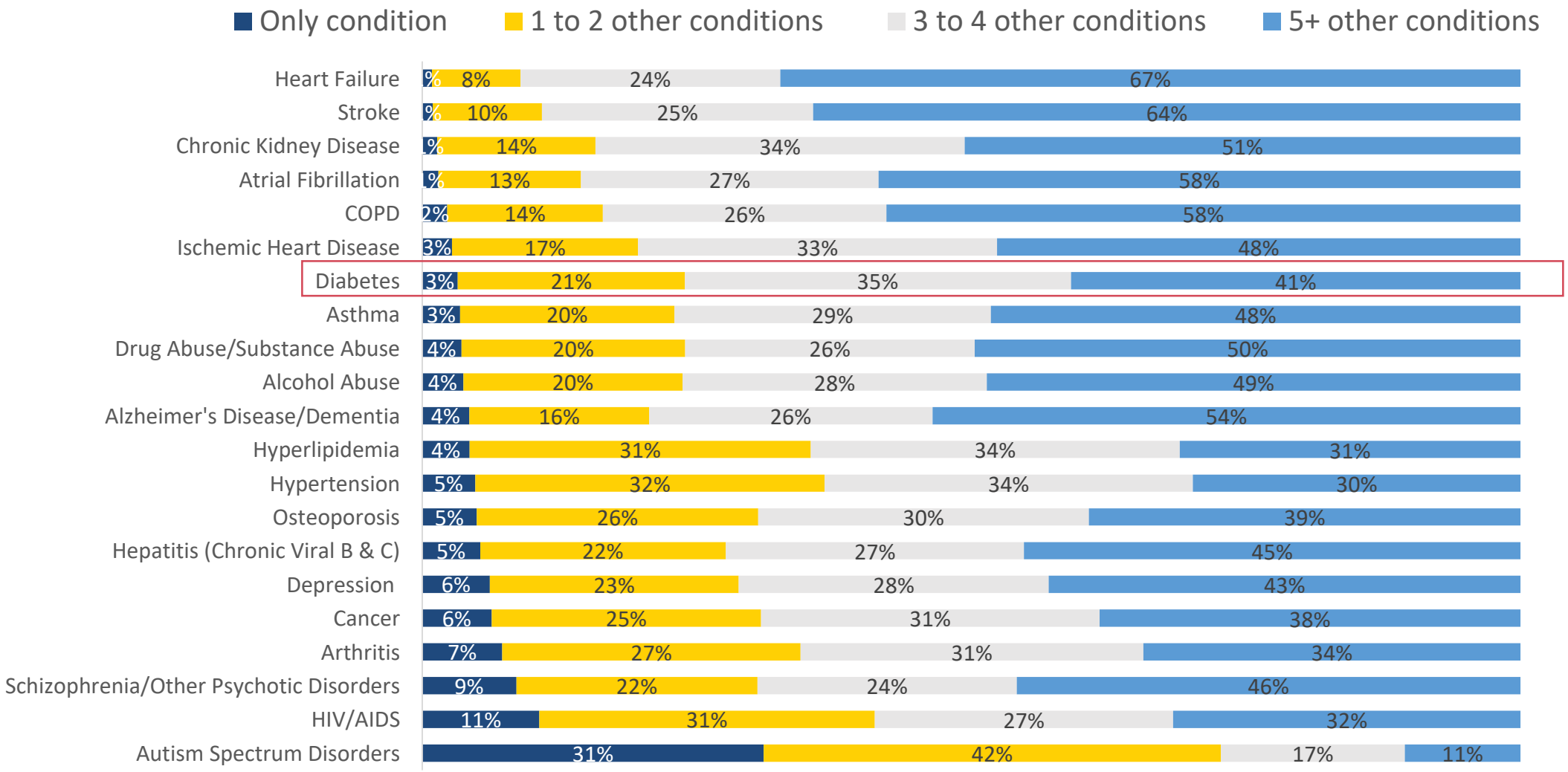
 Source: National Health Expenditure, Centers for Medicare and Medicaid Services

2016 Health Care Spending



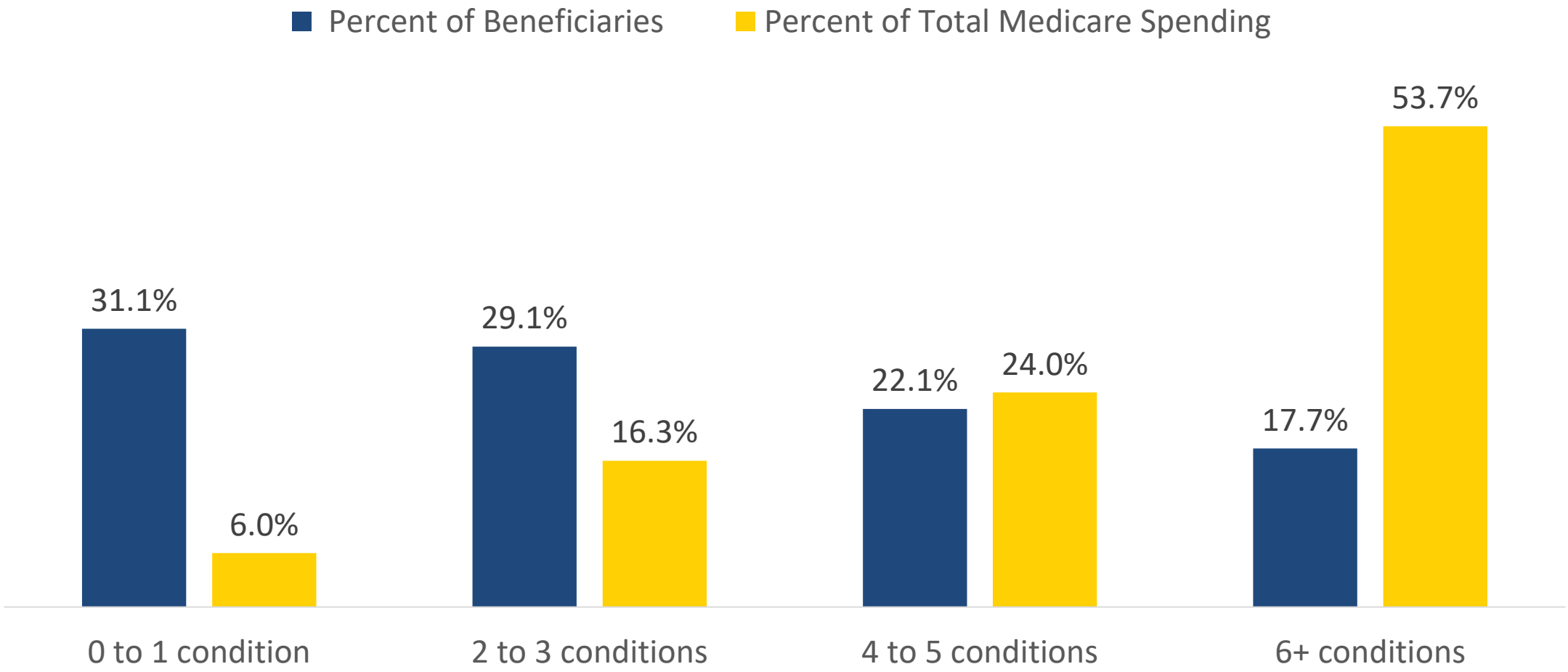
 Source: Dieleman *et al.* JAMA 2020 US Health Care Spending by Payer and Health Condition, 1996-2016

Percentage of Medicare FFS Beneficiaries with the 21 Selected Chronic Conditions: 2018



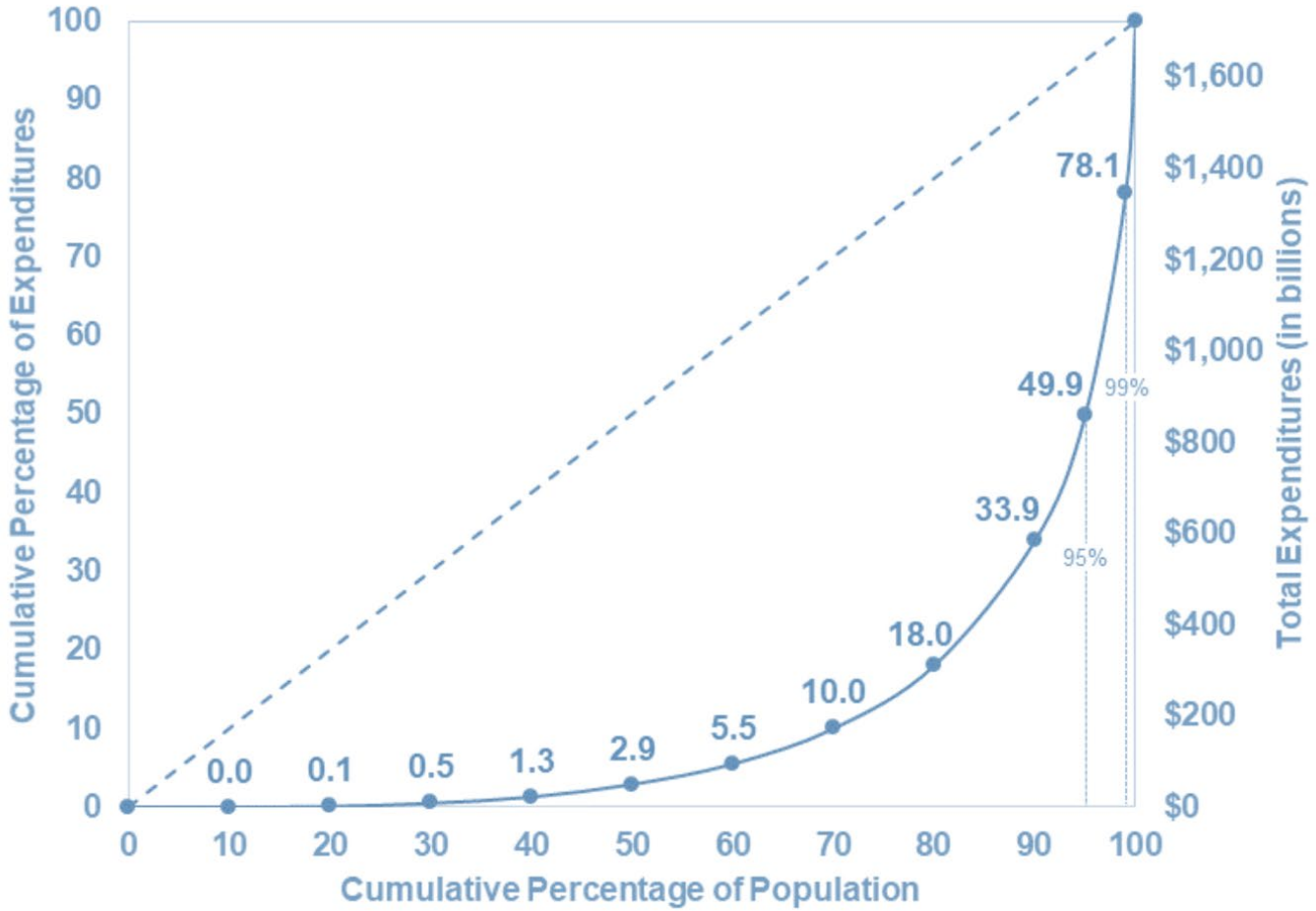
Source: CMS Chronic Conditions Chartbook 2018

Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Spending: 2018



Source: CMS Chronic Conditions Chartbook 2018

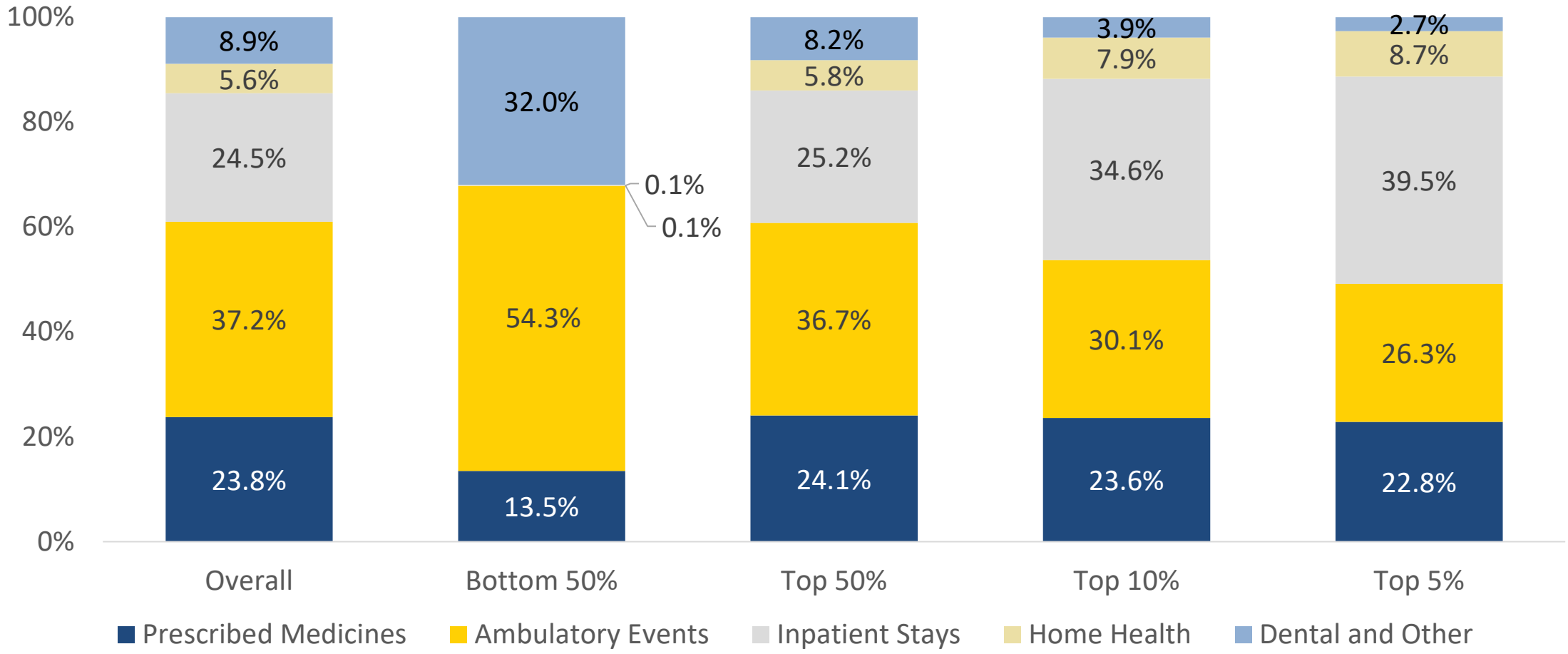
Concentration Curve of Health Care Expenditures, U.S. Civilian Noninstitutionalized Population, 2017



100 people	Total | Medicaid | Medicare $100		
50	$3	$3	$5
5	$50	$55	$40
1	$22	$26	$15

Source: Mitchell | Concentration of Healthcare Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2017. AHRQ Statistical Brief #528. February 2020

Percentage of Persons by Type of Service and Percentile of Spending, 2017, All Payers



Source: Mitchell | Concentration of Healthcare Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2017. AHRQ Statistical Brief #528. February 2020

Poor Oral Health Has Impacts Beyond Healthcare

Poor oral health is linked to all-cause mortality.

Poor oral health is an obstacle to employment.

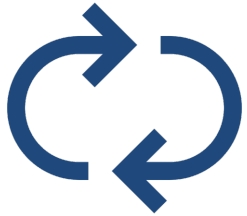
Poor oral health is linked to substance use disorders.

Poor oral health impacts children's school attendance and performance.

EMERGENCY DEPARTMENT VISITS FOR DENTAL CONDITIONS

Equity

Fiscal Responsibility



Readmissions

Mortality

Opioids

Antibiotics

Poor Oral Health in Top 10 First-listed Diagnoses Among Treat-and-release ED visits, 2018

First-listed diagnosis	Medicare		Private insurance		Medicaid		Self-pay/ No charge*	
	Number	Rank	Number	Rank	Number	Rank	Number	Rank
Total treat-and-release ED visits	**24,073,000**	-	**35,544,500**	-	**42,701,500**	-	**16,168,800**	-
Nonspecific chest pain	1,371,900	1	1,841,700	2	1,228,200	6	622,500	5
Abdominal pain, diarrhea, and other digestive symptoms	1,081,700	2	2,137,400	1	2,219,700	2	823,300	1
Superficial injury; contusion	1,026,600	3	1,433,900	4	1,601,800	3	629,800	4
Musculoskeletal pain, not low back pain	1,025,800	4	1,158,300	6	1,334,200	4	590,600	6
Urinary tract infections	858,100	5	794,600	9	1,025,700	9	463,300	8
Respiratory signs and symptoms	717,100	6	683,200	10				
Sprains and strains	546,900	7	1,637,900	3	1,318,800	5	671,700	3
Skin and subcutaneous tissue infections	458,100	8			1,014,100	10	522,800	7
Open wounds to limbs	447,800	9	901,900	8			426,000	10
Chronic obstructive pulmonary disease and bronchiectasis	442,100	10						
Acute upper respiratory infection and other upper respiratory infections†			1,398,900	5	3,286,000	1	737,600	2
Pregnancy-related nausea, vomiting, and other pregnancy complications‡					1,158,200	7		
Otitis media					1,062,700	8		
Headache; including migraine			1,034,900	7				
Disorders of teeth and gingiva							433,200	9

Source: Weiss AJ (IBM Watson Health), Jiang HJ (AHRQ). Most Frequent Reasons for Emergency Department Visits, 2018. HCUP Statistical Brief #286. December 2021. Agency for Healthcare Research and Quality, Rockville, MD

At home all day - not well. Still indisposed with an aching tooth and swelled and inflamed gum.

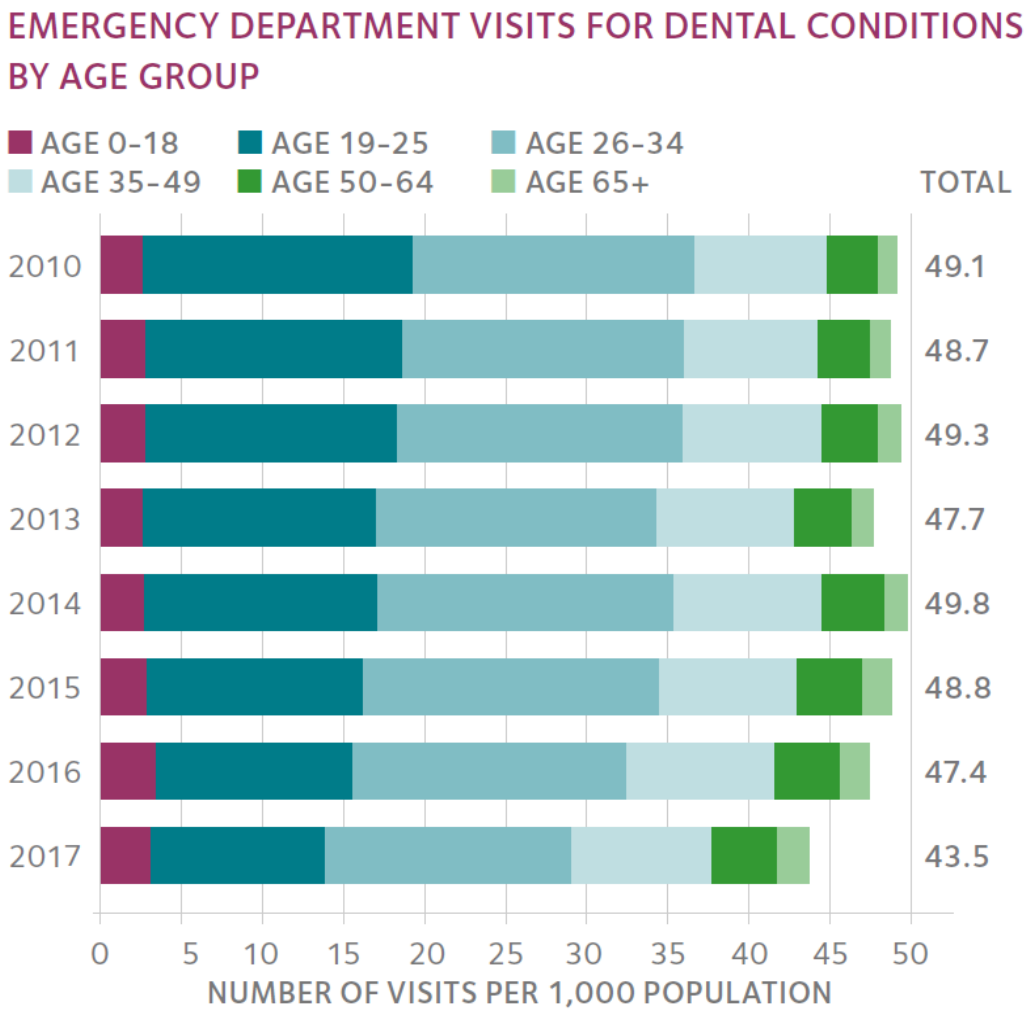
- George Washington

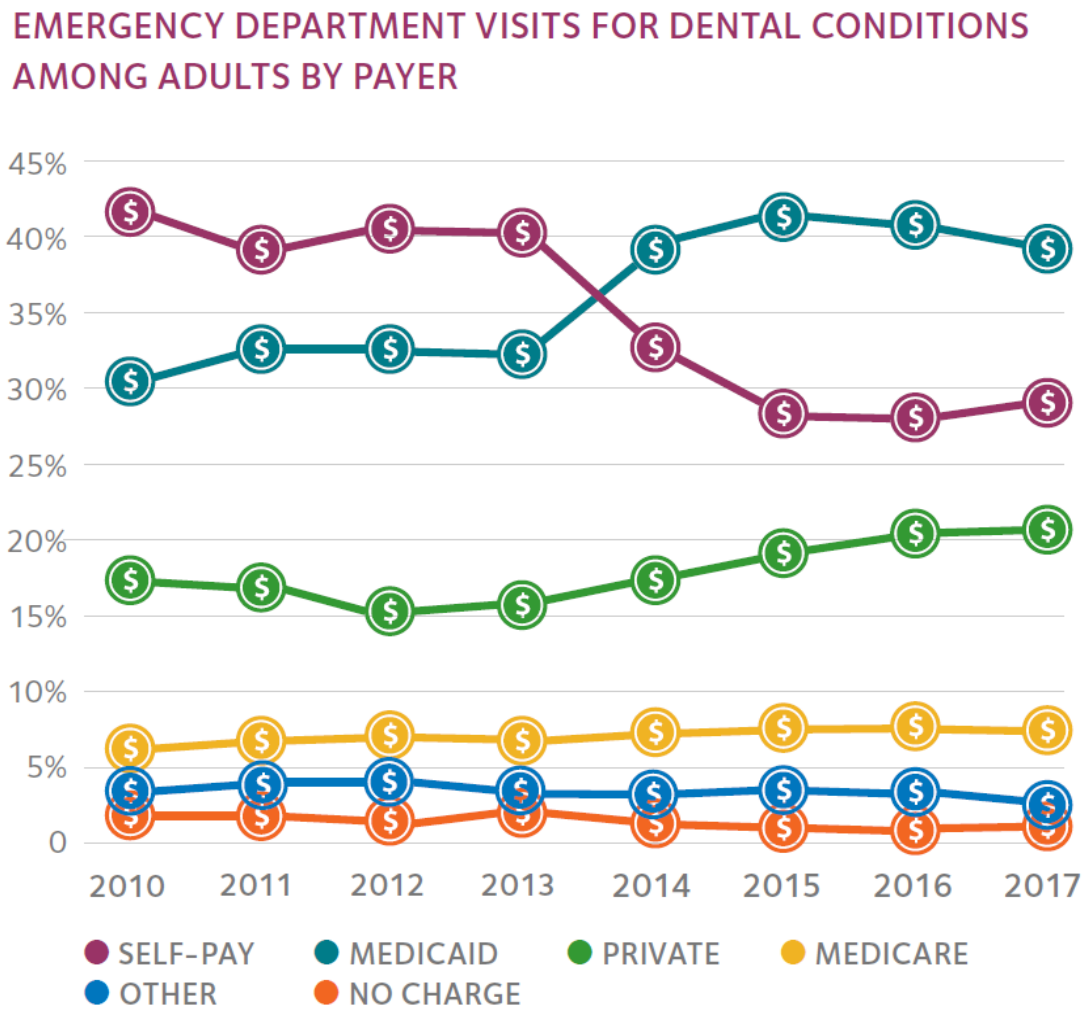
Having some teeth which are very troublesome to me at times and of which I wish to be eased … by a man of skill.

- George Washington
in a letter inquiring about a prospective dentist 1783

Charles Willson Peale, George Washington 1776
The scar on Washington's left check was a result of an abscessed tooth

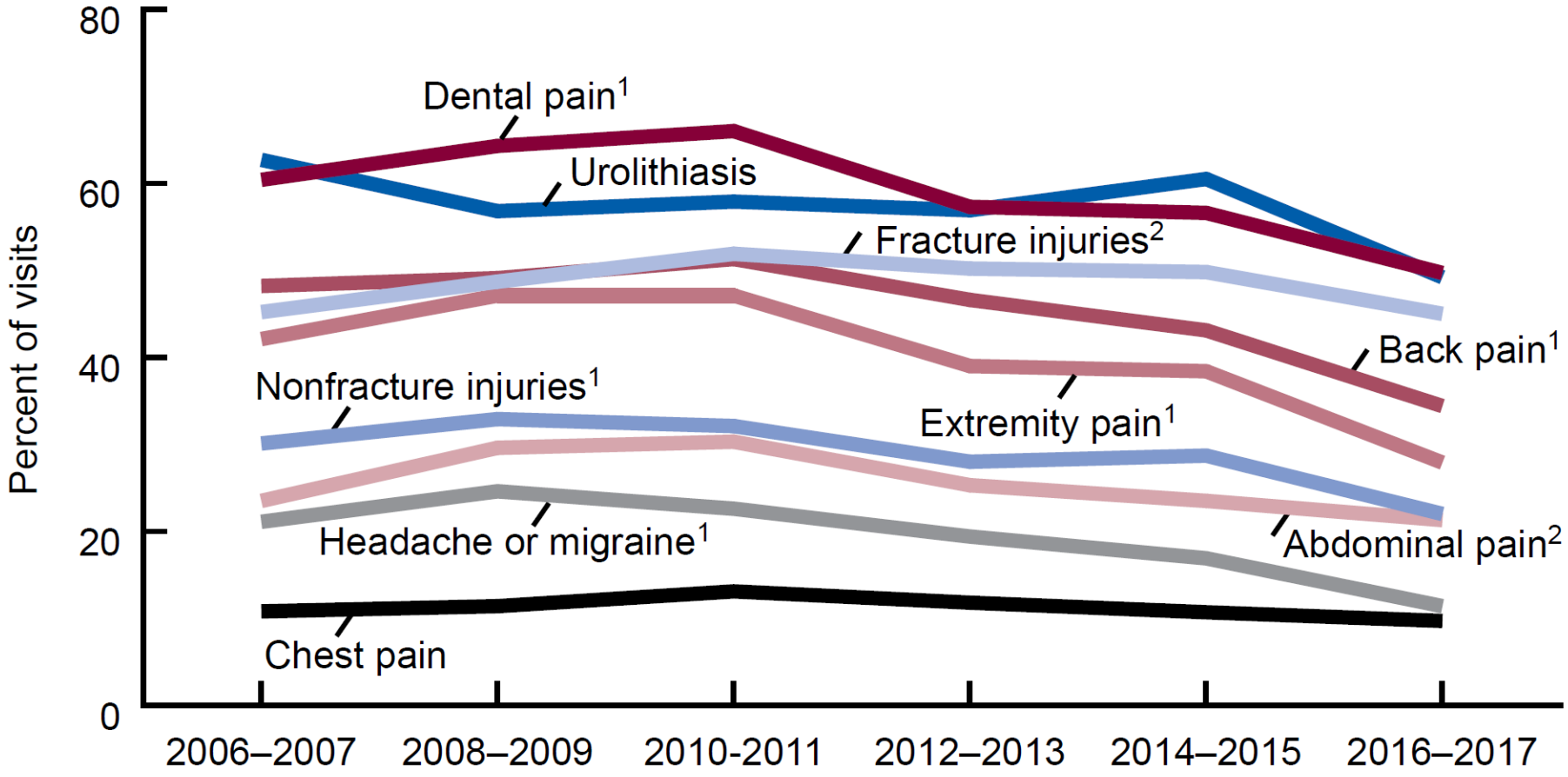
Emergency Department Visits for Dental Conditions





Source: ADA Health Policy Institute

Percentage of Emergency Department Visits by Adults at which Opioids were Prescribed



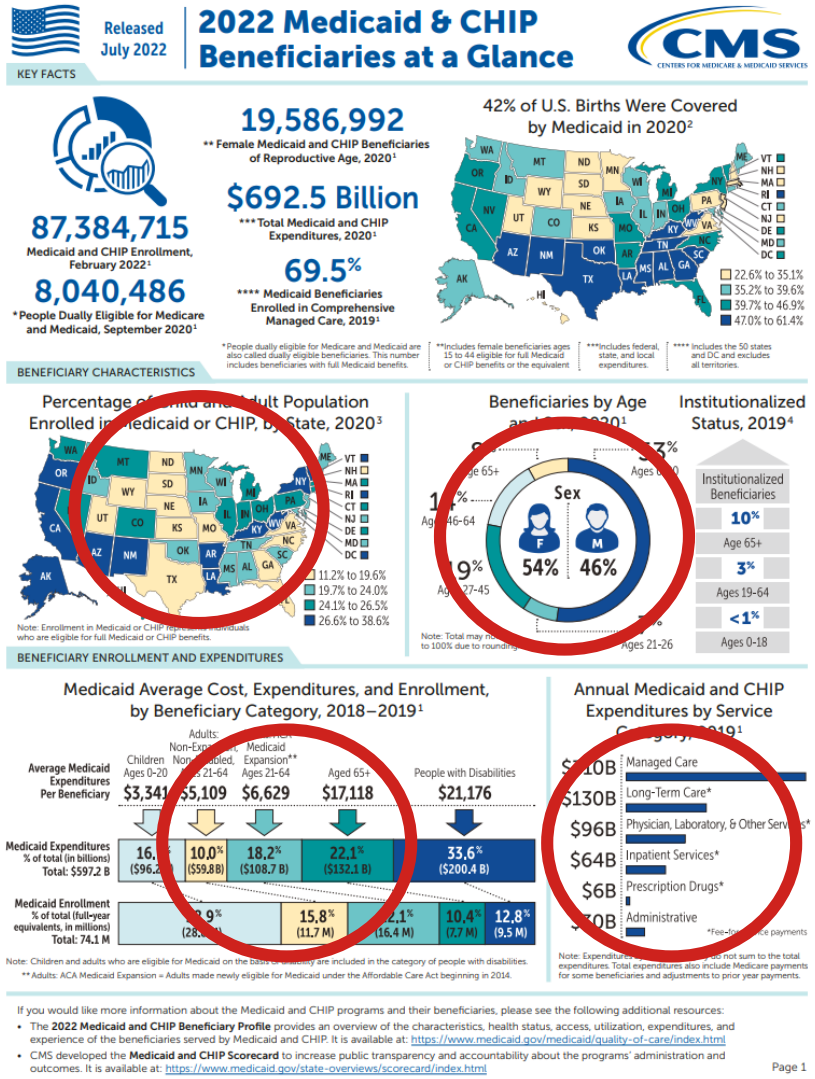
Source: National Center for Health Statistics Report 135, 2020

Medicaid Adult Beneficiaries Emergency Department Visits for Non-Traumatic Dental Conditions

https://www.medicaid.gov/medicaid/benefits/downloads/adult-non-trauma-dental-ed-visits.pdf

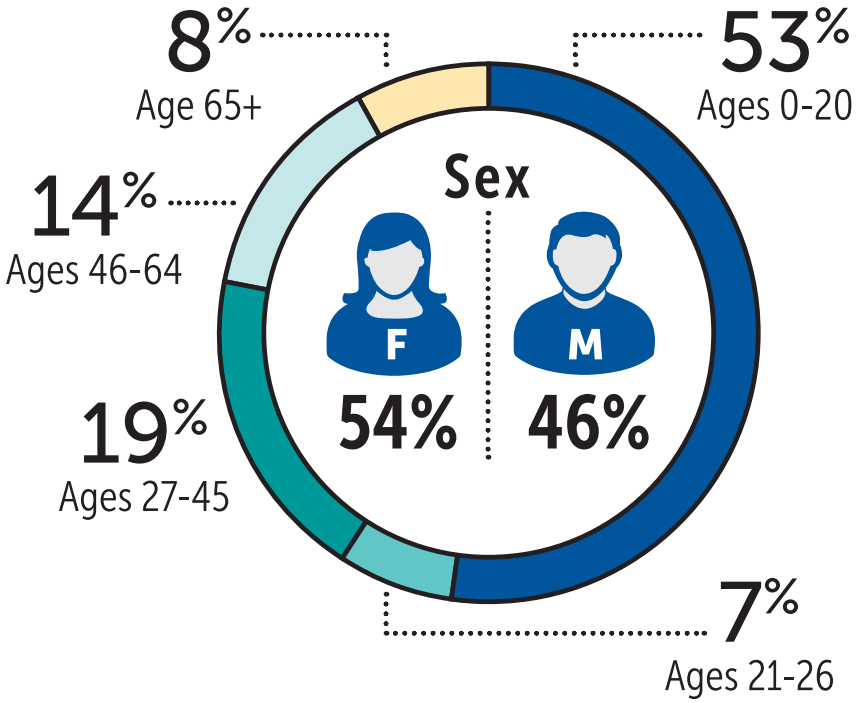
Center for Medicaid and CHIP Services

2022 Medicaid and CHIP Beneficiaries at a Glance

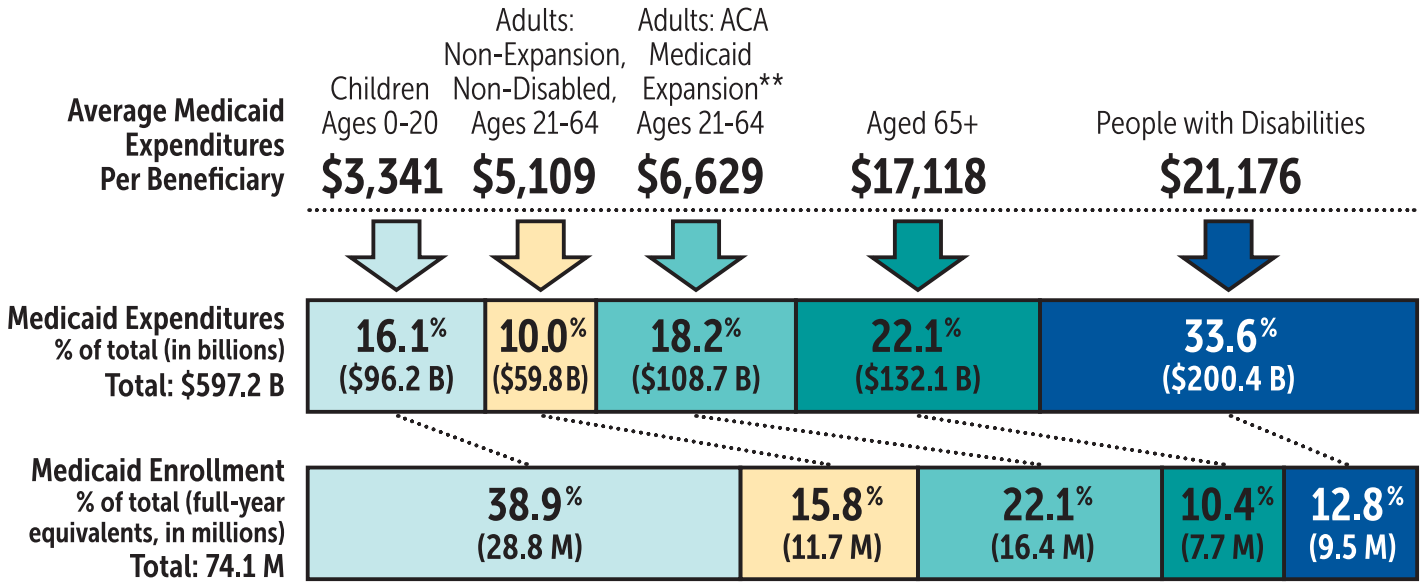


Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Beneficiaries by Age and Sex, 2020



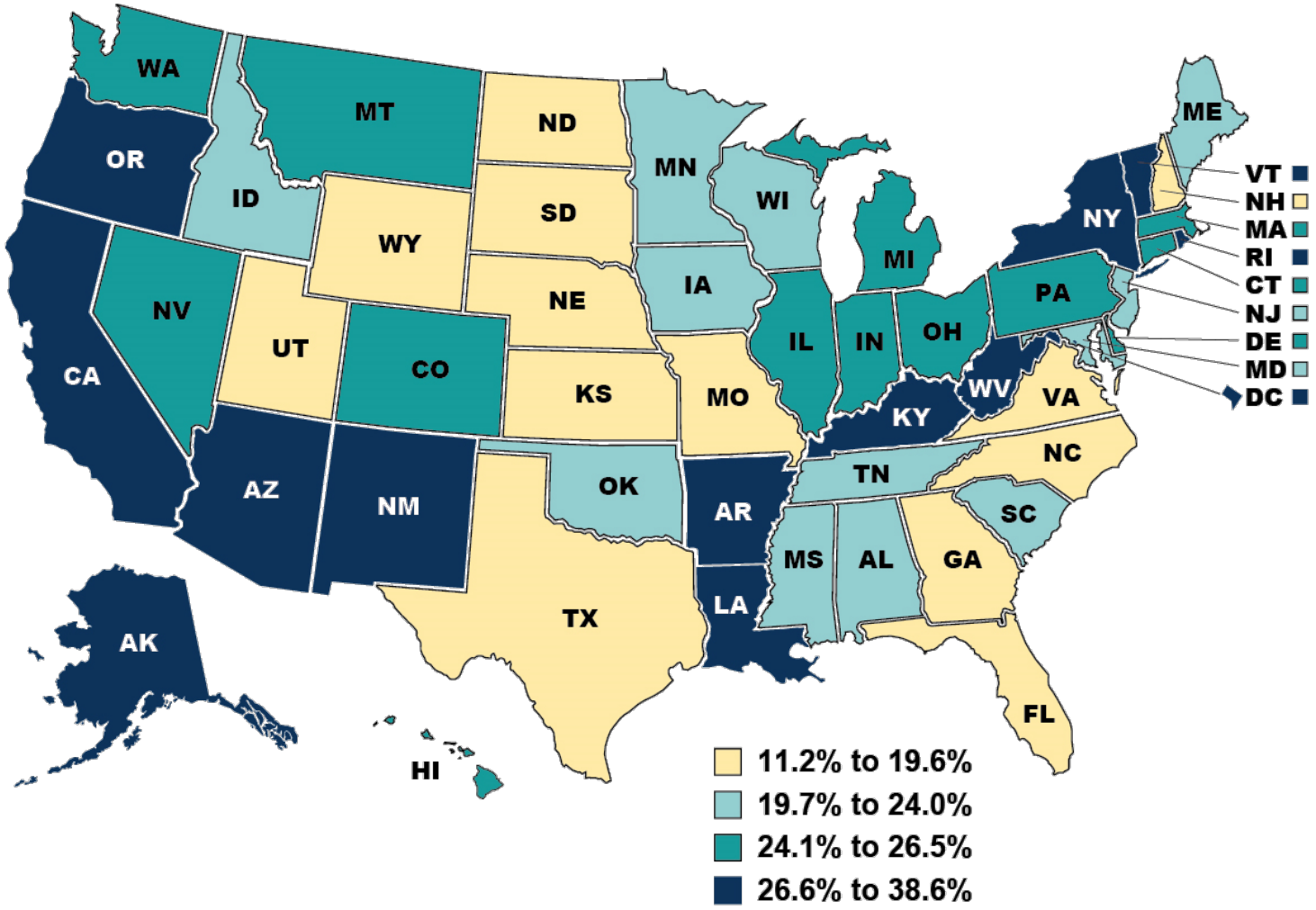
Medicaid Average Cost, Expenditures, and Enrollment, by Beneficiary Category, 2018–2019



Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Percentage of Child and Adult Population Enrolled in Medicaid or CHIP, by State, December 2020

Population: Beneficiaries of all ages with full Medicaid or CHIP benefits



Notes:
Enrollment in Medicaid or CHIP represents individuals who are eligible for full Medicaid or CHIP benefits and excludes individuals who are eligible only for restricted benefits, such as Medicare cost-sharing, family planning only benefits, and emergency services due to alien status. The percentage of each state's population enrolled in Medicaid or CHIP was calculated by dividing administrative, monthly point-in-time counts of Medicaid and CHIP enrollment by annual estimates of each state's resident population. Results were rounded to one decimal place, and then states were assigned to quartiles.

Sources:
CMS. Updated December 2020 Applications, Eligibility, and Enrollment Data (as of November 10, 2021).
Available at:
https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html

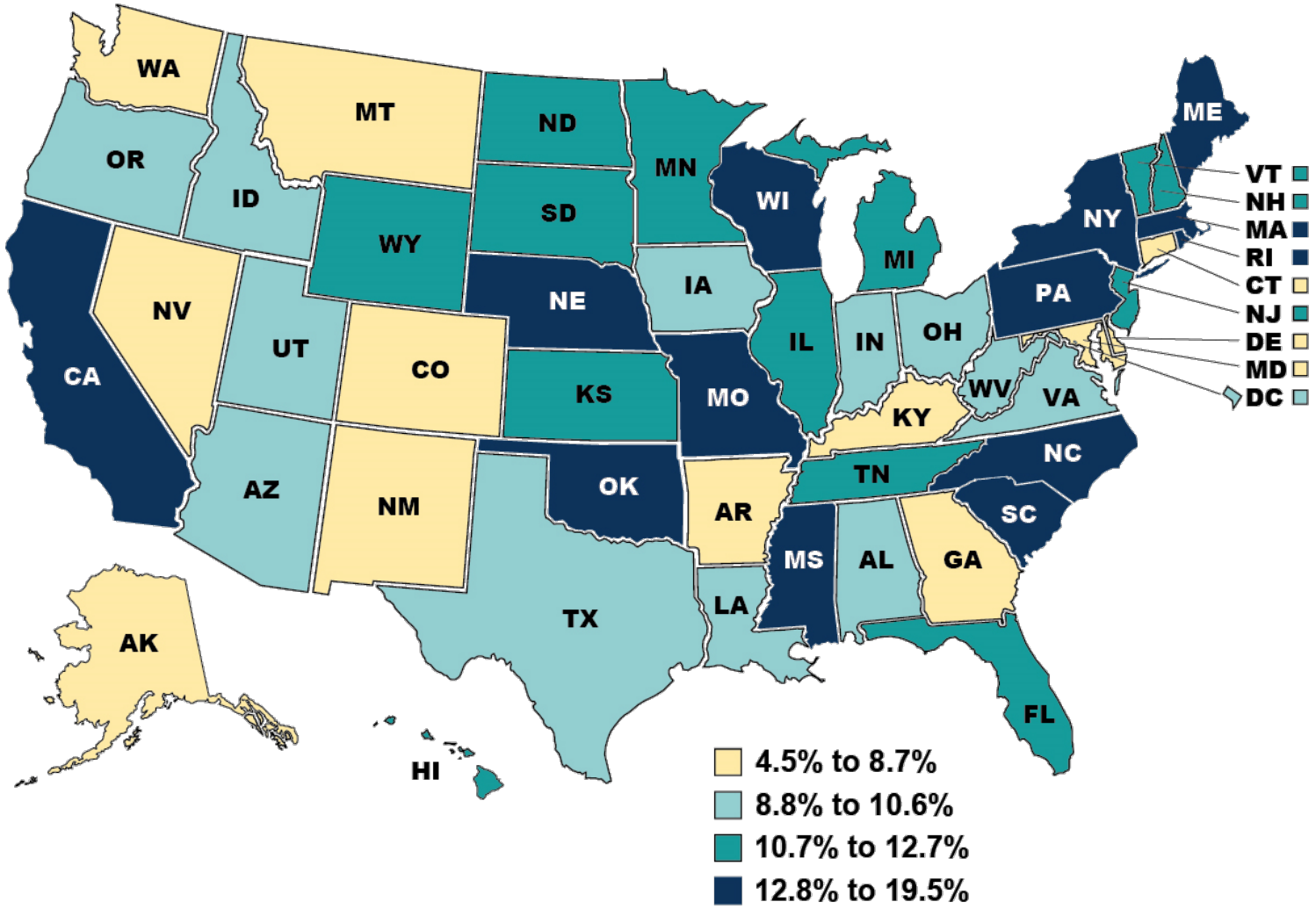
U.S. Census Bureau. 2020 Census Redistricting Data (Public Law 94-171). Table P1.
Available at:
https://data.census.gov/cedsci/all?q=&y=2020&d=DEC%20Redistricting%20Data%20%28PL%2094-171%29

See Appendix for more information on each data source.

 Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Percentage of Medicaid Beneficiaries Who Were Dually Eligible for Medicare and Medicaid, 2020

Population: Institutionalized and community-based beneficiaries with full Medicaid benefits



Nationally, 11.3% of Medicaid beneficiaries (8 million people) are dually eligible for Medicare and receive full Medicaid benefits.

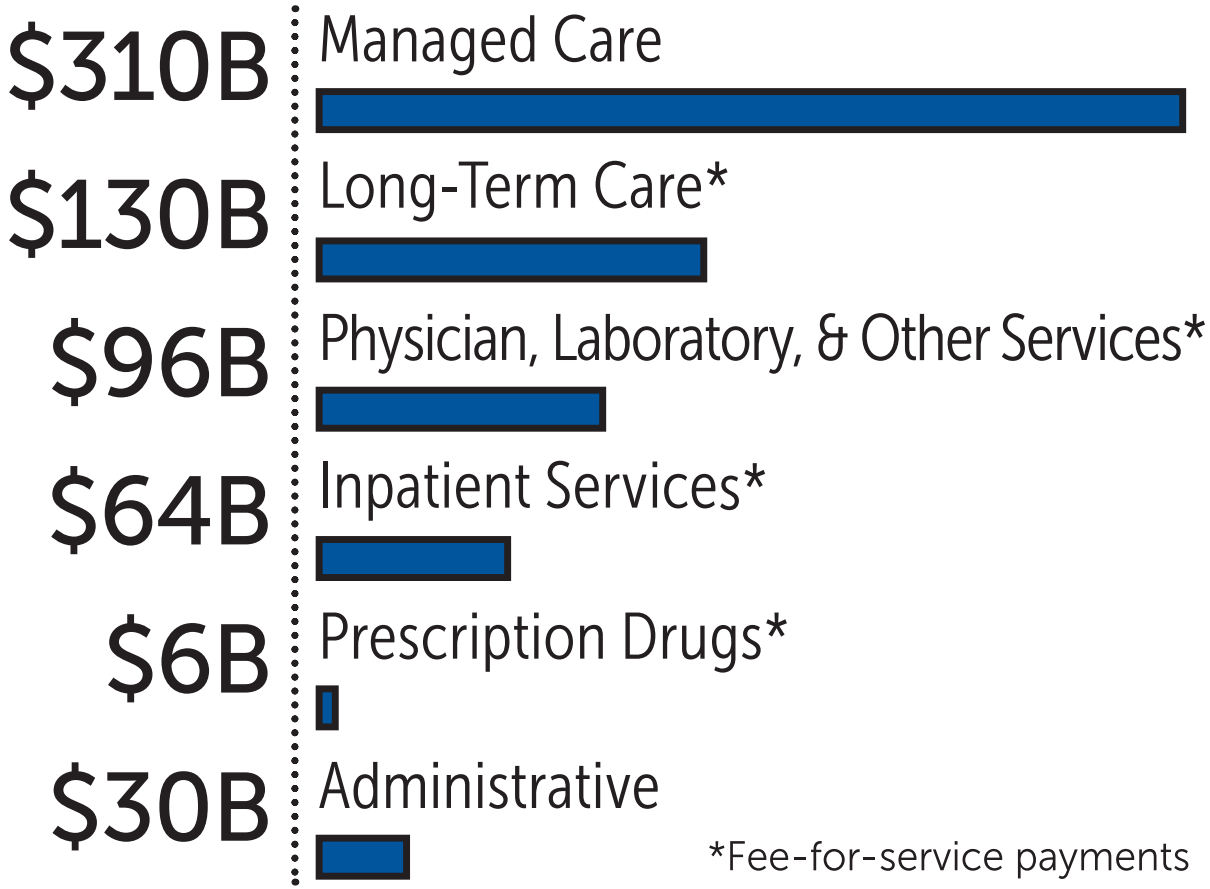
Notes:
The percentage of the Medicaid population that is dually eligible by state was calculated by dividing total, full-benefit, dual-eligible enrollment by total Medicaid enrollment. Results were rounded to one decimal place, and then states were assigned to quartiles. The national percentage was calculated by dividing the sum of the state totals.

Sources:
CMS Medicare-Medicaid Coordination Office Quarterly Enrollment Snapshot (September 2020 data, as of July 15, 2021).
Available at:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

CMS. Updated September 2020 Applications, Eligibility Determinations, and Enrollment Data (as of December 21, 2021).
Available at:
https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html

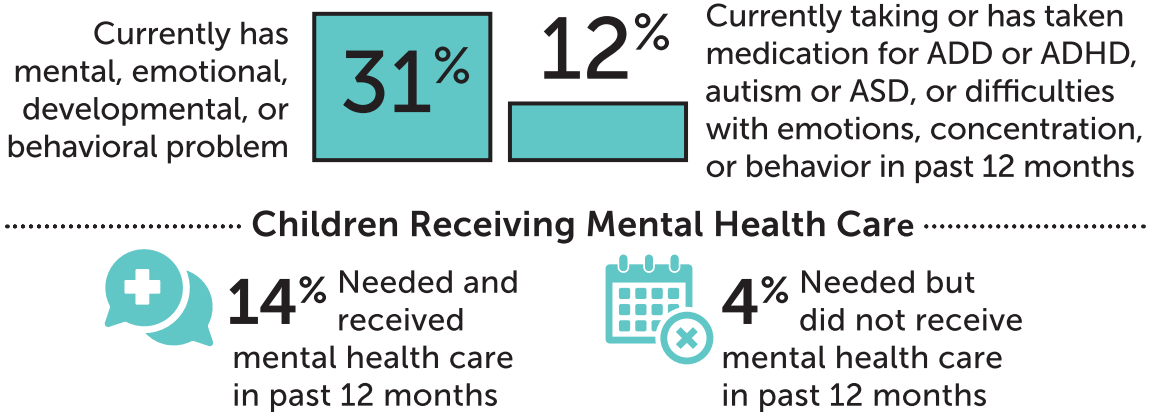
Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Annual Medicaid and CHIP Expenditures by Service Category, 2019

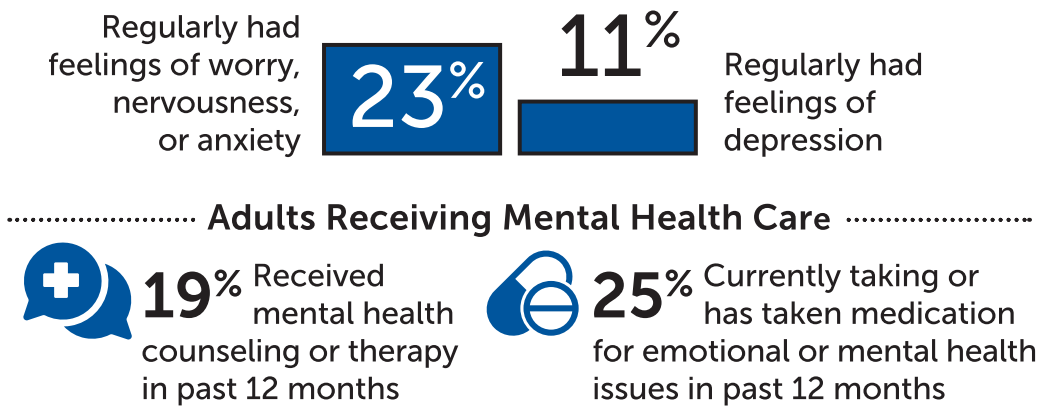


Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Parent-Reported Mental Health Status of Children (Ages 3-17), 2020



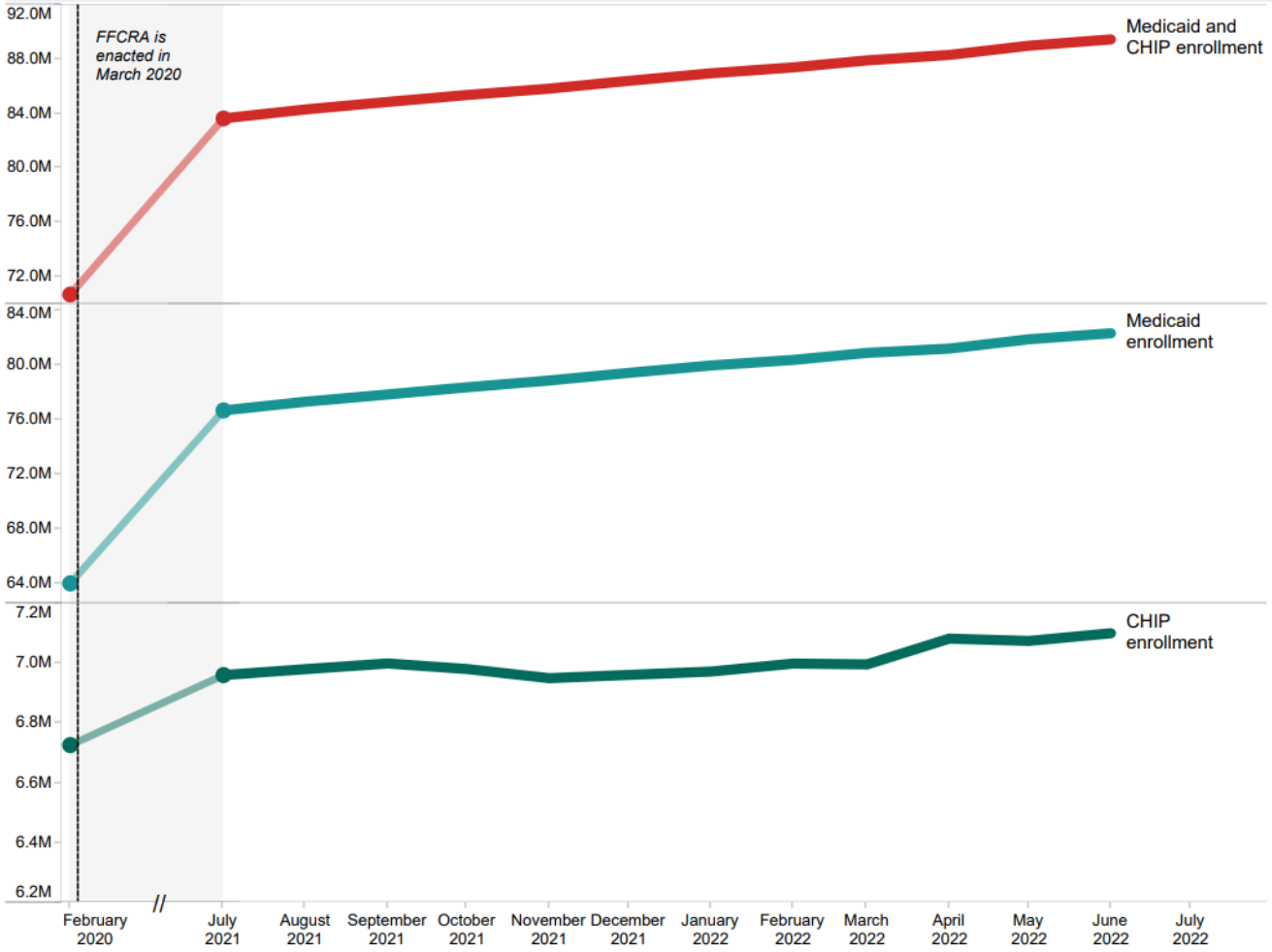
Self-Reported Mental Health Status of Adults (Ages 18-64), 2020



Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-ataglance-2022.pdf

Medicaid and CHIP Enrollment Trends Snapshot

Figure 1. National Medicaid and CHIP enrollment, February 2020 to June 2022, CMS Performance Indicator Data



Date	Medicaid and CHIP enrollment	Medicaid enrollment	CHIP enrollment
June 2022	89,444,160	82,344,149	7,100,011
May 2022	88,978,791	81,904,569	7,074,222
April 2022	88,301,080	81,219,006	7,082,074
March 2022	87,899,695	80,903,679	6,996,016
February 2022	87,384,856	80,386,222	6,998,634
January 2022	86,949,736	79,977,801	6,971,935
December 2021	86,396,073	79,435,247	6,960,826
November 2021	85,823,859	78,874,024	6,949,835
October 2021	85,356,887	78,376,470	6,980,417
September 2021	84,847,309	77,848,253	6,999,056
August 2021	84,296,159	77,316,046	6,980,113
July 2021	83,634,666	76,674,473	6,960,193
February 2020	70,691,258	63,964,955	6,726,303

Annual trend, July 2021 to June 2022

From July 2021 to June 2022, national Medicaid and CHIP enrollment increased by 5,809,494 individuals (6.9%).

Monthly trend, May 2022 to June 2022

Total enrollment	Medicaid enrollment	CHIP enrollment
Increased by 465,369 (+0.5%)	Increased by 439,580	Increased by 25,789 (+0.4%)

Cumulative change, February 2020 to June 2022*

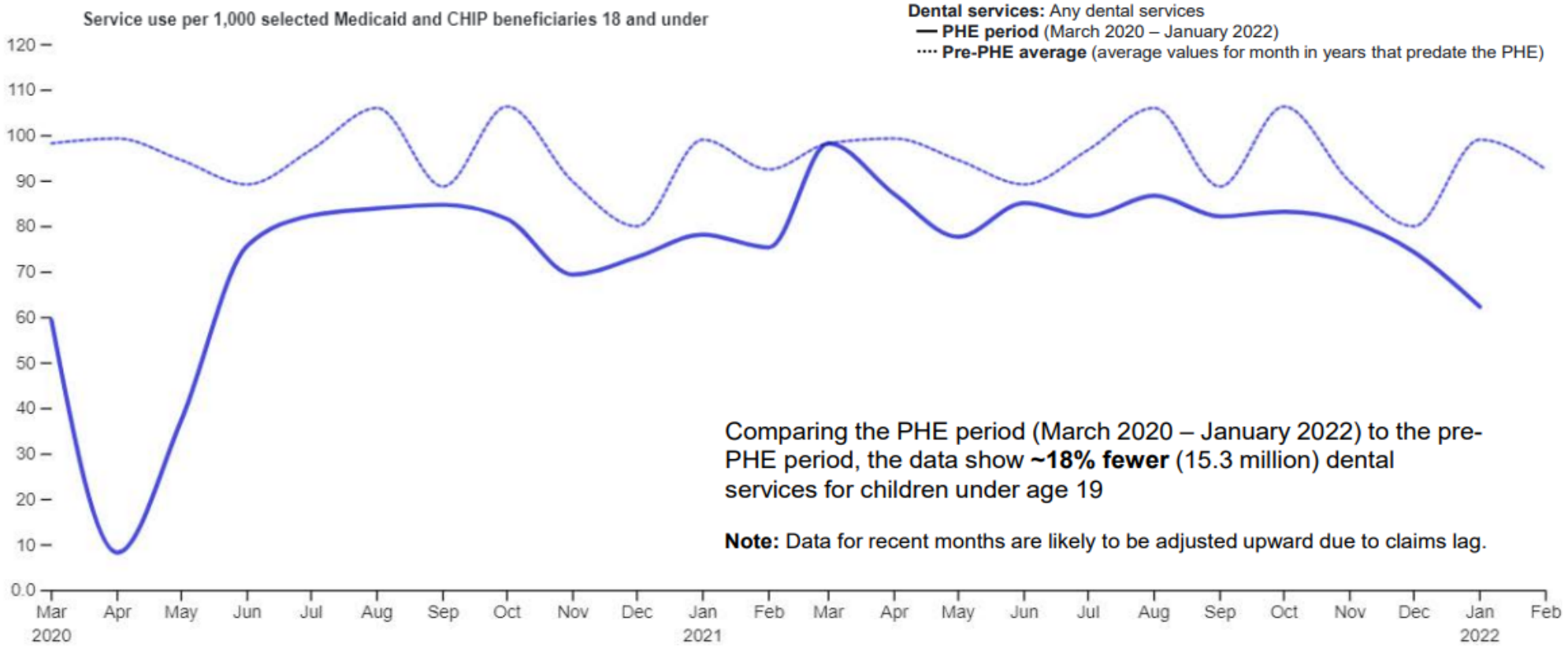
Total enrollment	Medicaid enrollment	CHIP enrollment
Increased by 18,752,902 (+26.5%)	Increased by 18,379,194 (+28.7%)	Increased by 373,708 (+5.6%)

Source: Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data as of August 22, 2022.
Note: This analysis includes preliminary enrollment data from 50 states and the District of Columbia. "FFCRA" refers to the Families First Coronavirus Response Act. Section 6008 of FFCRA includes a continuous enrollment condition, which makes available a temporary 6.2 percentage point increase to each state or territory's federal medical assistance percentage (FMAP) during the national public health emergency. As a condition of receiving the FMAP increase, states must meet several requirements pertaining to eligibility and maintenance of enrollment.
*The cumulative change compares the most recent enrollment data to February 2020, which serves as a baseline of enrollment prior to the impacts of the COVID-19 pandemic and FFCRA's continuous enrollment condition. For additional information on Medicaid and CHIP enrollment from December 2019 to June 2022, please see Appendix A.

https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/june-2022-medicaid-chip-enrollment-trend-snapshot.pdf

Rate of Dental Services for Children During the PHE

After an initial steep decline, remained slightly below pre-PHE levels



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

24

Source: https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-01312022.pdf

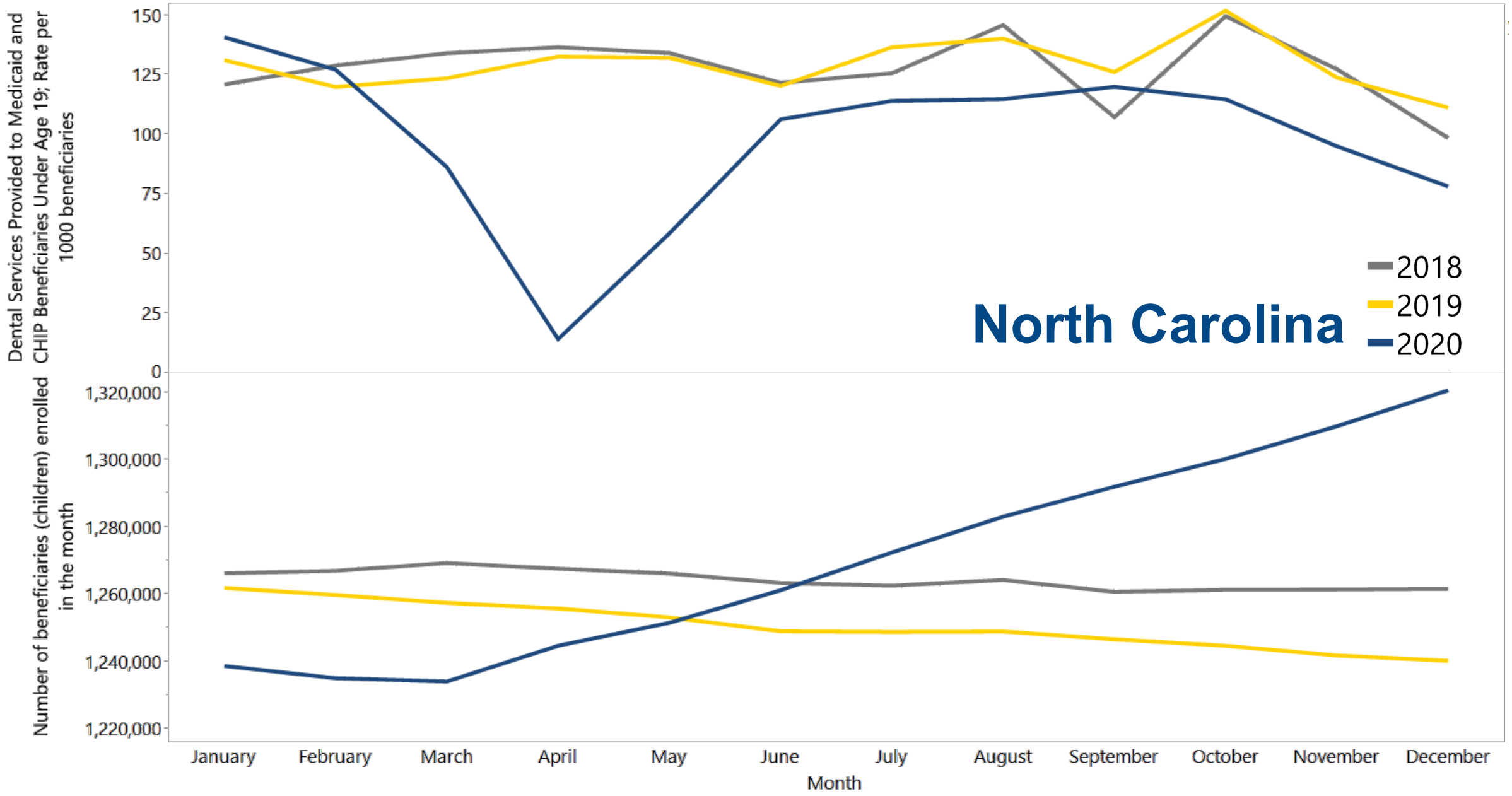
Public Enrollment and Service Use Data

The Centers for Medicare & Medicaid Services (CMS) released the Medicaid and Children's Health Program (CHIP) Enrollment and Service Use Data Tables for the first time to the public.

The first set of data tables includes monthly and annual counts of Medicaid and CHIP beneficiaries by the following enrollment characteristics: (1) program type, (2) scope of benefits, (3) dual eligibility status, **(4) eligibility groups**, and (5) managed care plan participation.

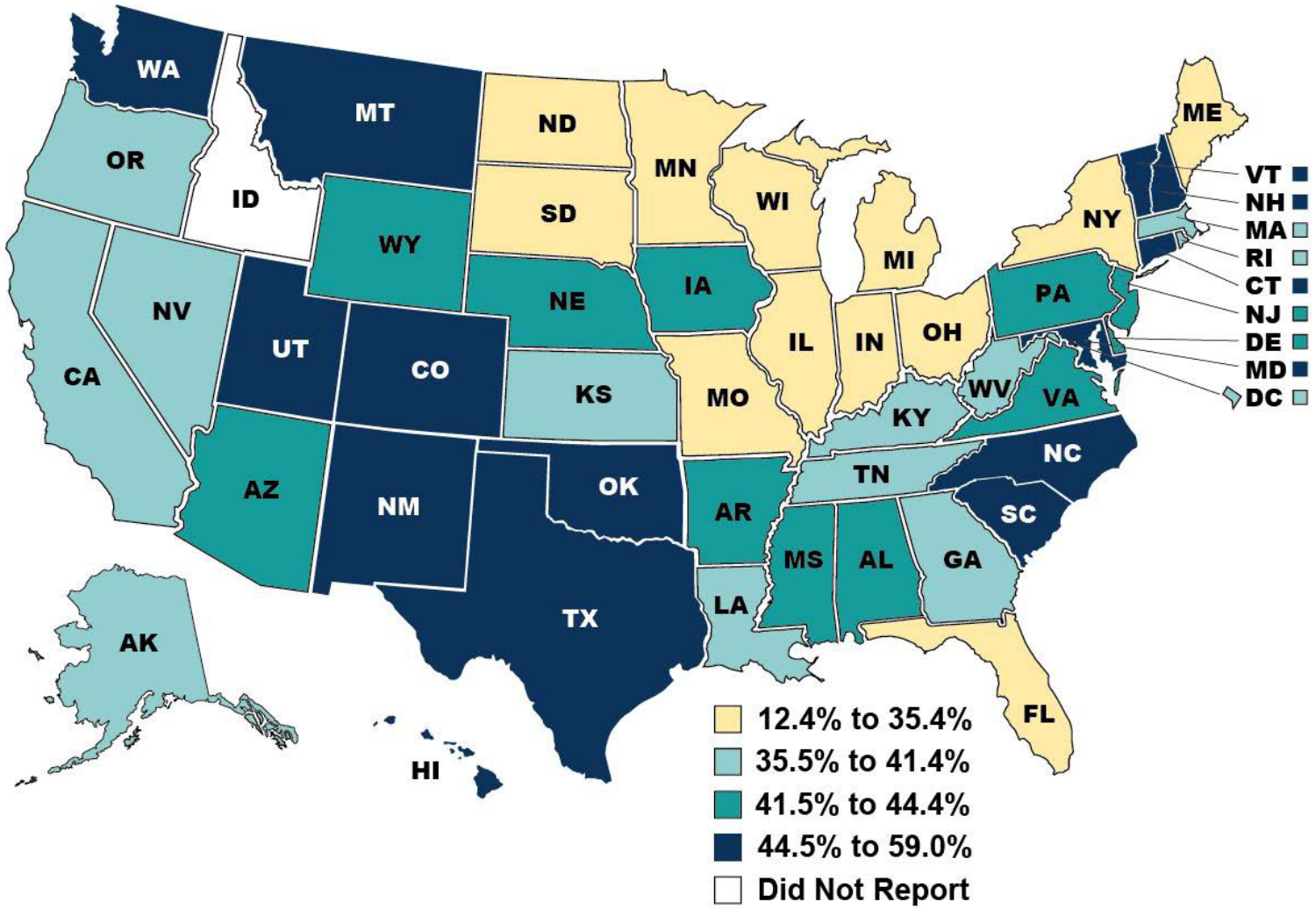
The second set of data tables include monthly counts and rates of services use in the following categories: (1) acute care, (2) behavioral health, (3) blood lead screening, (4) child screening, (5) services for COVID-related conditions, (6) contraceptive care, (7) COVID-19 testing, **(8) dental care**, (9) perinatal care, (10) pregnancy outcomes, (11) provision of services via telehealth, and (12) vaccinations. These files include information for the 50 states, Washington, DC, Puerto Rico, and the US Virgin Islands.

Source: https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html



Source: https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html

Percentage of Medicaid Beneficiaries Ages 1 to 20 Who Received Preventive Dental Services, FFY 2020



Population: Beneficiaries ages 1 to 20 enrolled in Medicaid or Medicaid expansion CHIP programs for at least 90 continuous days and eligible for EPSDT services

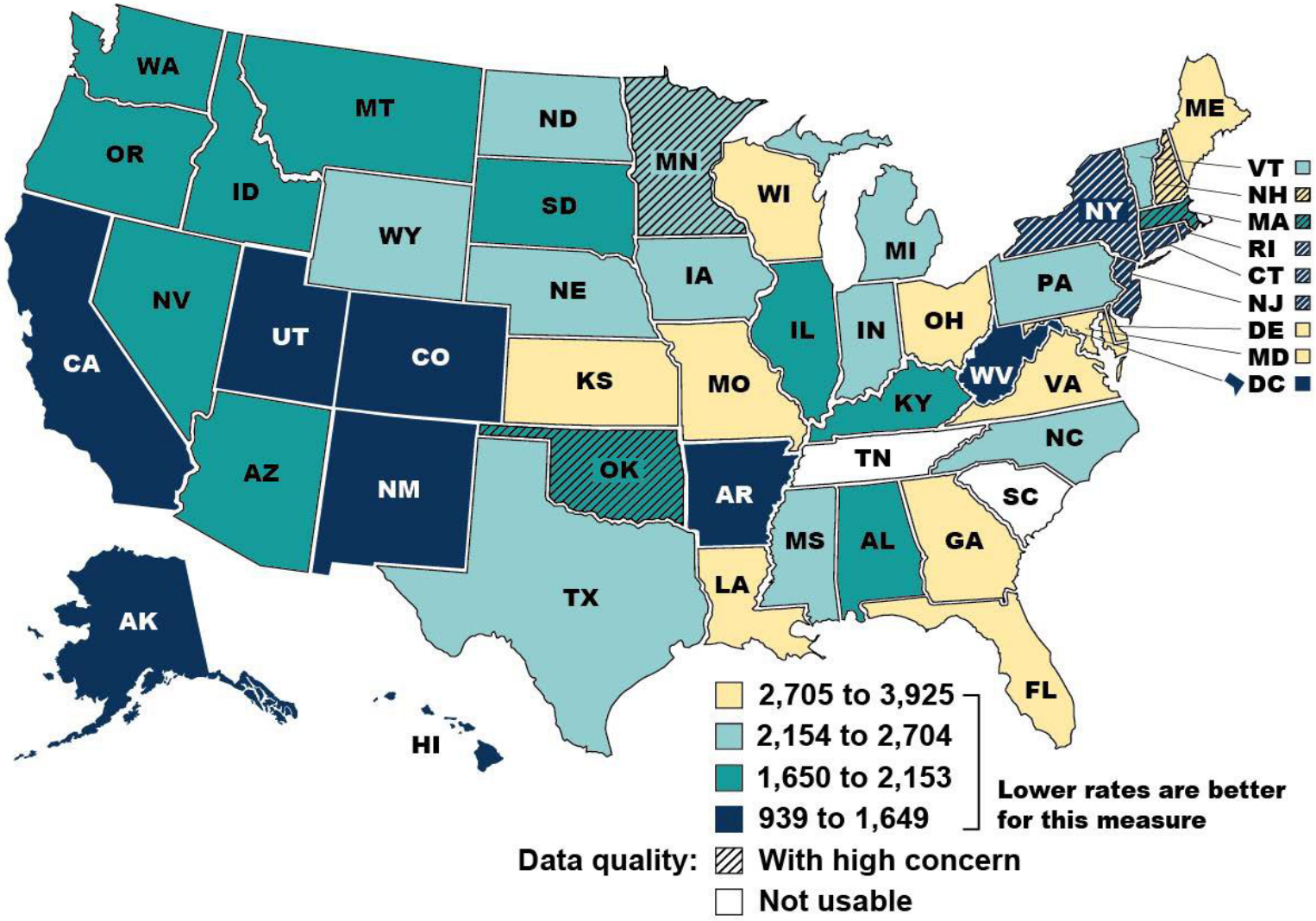
Notes:
This measure shows the percentage of children ages 1 to 20 who are enrolled in Medicaid or Medicaid expansion CHIP programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the measurement period (October 2019 to September 2020).

Source:
Mathematica analysis of Form CMS- 416 reports (annual EPSDT report), Lines 1b and 12b, for the FFY 2020 reporting cycle as of July 2, 2021.
Starting with FFY 2020, some states calculated and submitted their Form CMS-416 reports, while others chose to have CMS produce their Form CMS- 416 reports using Transformed Medicaid Statistical Information System (T-MSIS) data. The FFY 2020 reporting cycle includes services provided between October 2019 and September 2020.

Additional information available at:
https://www.medicaid.gov/medicaid/qua lity-of-care/downloads/performance- measurement/2021-child-chart-pack.pdf

 Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2022.pdf

Emergency Department Visits for Non-Traumatic Dental Conditions per 100,000 Adult Beneficiaries, by State, 2019



Population: Medicaid and CHIP beneficiaries ages 21 to 64 with full Medicaid or CHIP benefits and not dually eligible for Medicare

Notes:

Non-traumatic dental conditions (NTDCs) are dental conditions such as cavities or dental abscesses that might have been prevented with regular dental care. Emergency Department (ED) visits for NTDCs may indicate a lack of access to more appropriate sources of medical and dental care. CMS assessed state-level data quality in the 2019 TAF file using the following metrics: total enrollment, inpatient (IP) and other services (OT) claims volume; completeness of diagnosis code (IP file); completeness of procedure code (OT and IP files); and expected type of bill code (IP file). States with an unusable data quality assessment (TN, SC) are shown in white.

Results for remaining states were rounded to whole numbers, and then states were assigned to quartiles. States with a high concern data quality assessment are shown with a hatched overlay. For additional information regarding state variability in data quality, please refer to the Medicaid DQ Atlas, available at: https://www.medicaid.gov/dq-atlas/welcome.

Source:

CMS analysis of calendar year 2019 T-MSIS Analytic Files, v 5.0.

Additional information available at:

https://www.medicaid.gov/medicaid/benefits/downloads/adult-non-trauma-dental-ed-visits.pdf and https://www.medicaid.gov/medicaid/benefits/ dental-care/index.html

Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2022.pdf

Nursing Homes

THE WHITE HOUSE

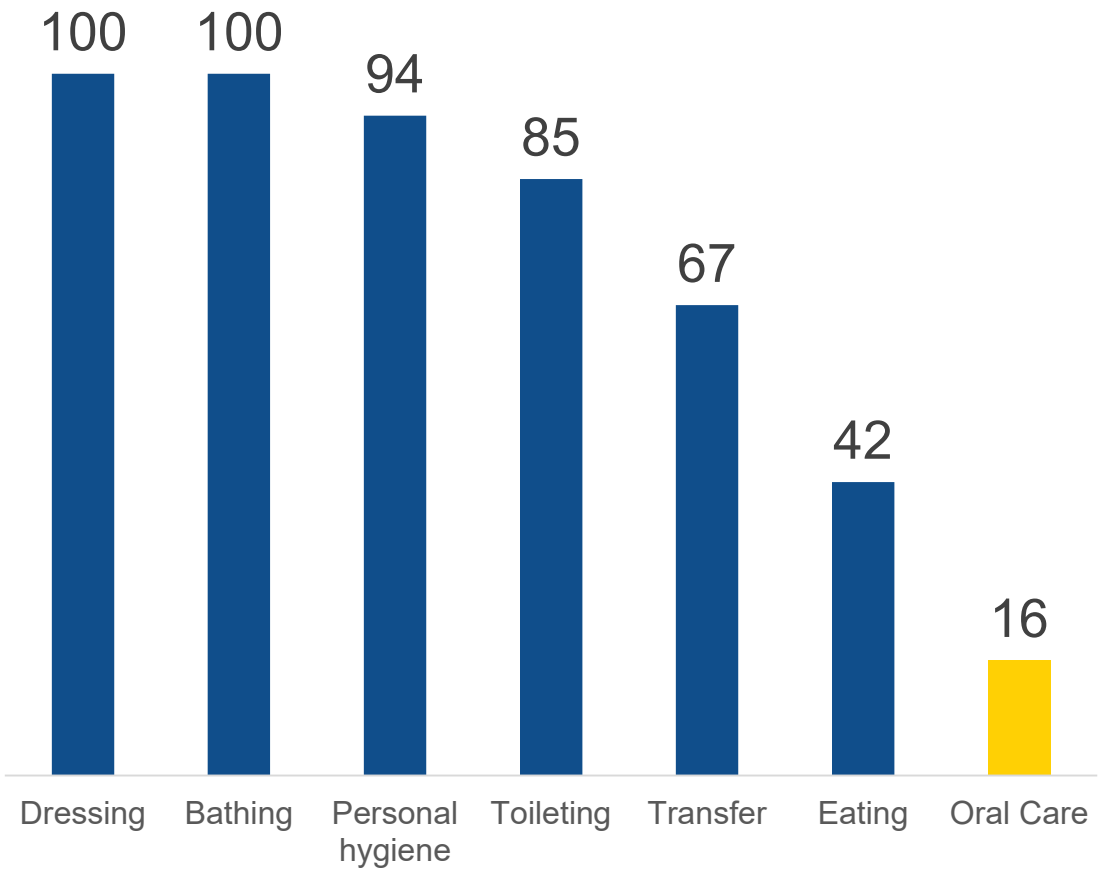
BRIEFING ROOM

FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes

FEBRUARY 28, 2022 • STATEMENTS AND RELEASES

All people deserve to be treated with dignity and respect and to have access to quality medical care. The President is committed to ensuring that all Americans, including older Americans and people with disabilities, live in a society that is accessible, inclusive, and equitable. To accomplish that goal, the Administration continues to be committed to home- and community-based services and ensuring that in no case should a health care facility be causing a patient harm. The President believes we must improve the quality of our nursing homes so that seniors, people with disabilities, and others living in nursing homes get the reliable, high-quality care they deserve. That's why he is announcing a set of reforms—developed by and implemented through the Department of Health and Human Services (HHS)—that will improve the safety and quality of nursing home care, hold nursing homes accountable for the care they provide, and make

Oral Care in Nursing Homes



Oral Care Provided During Direct Observation*	Care %
Teeth were brushed with a toothbrush and toothpaste.	16.4
Teeth were brushed a minimum of 2 minutes.	0.0
Mouth was rinsed with water.	16.4
Mouth was rinsed with mouthwash.	0.0
Tongue was brushed with a moistened toothbrush.	1.5
Teeth were flossed.	0.0
Mouth problems/concerns were assessed.	0.0
Clean gloves were worn while providing oral care.	0.0

Source: Coleman and Watson J Am Geriatr Soc 2006

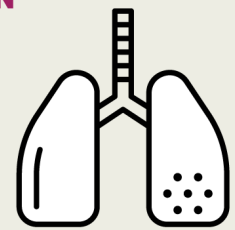
Oral Care in Nursing Homes

JAMA Network | Open

RCT Effectiveness of a Mouth Care Program Provided by Nursing Home Staff on Reducing Pneumonia Incidence

POPULATION

871 Men
1281 Women



All residents of nursing homes with proportionately high rehospitalization rates for pneumonia

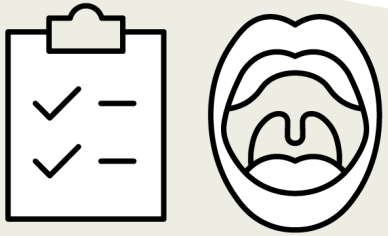
Mean (SD) age, 79.4 (12.4) y

SETTINGS/LOCATIONS

14 nursing homes in North Carolina

INTERVENTION

14 Nursing homes randomized



7 Mouth Care Without a Battle

Nursing homes with 1219 residents received 3 trainings with monthly support visits for 2 years

7 Control

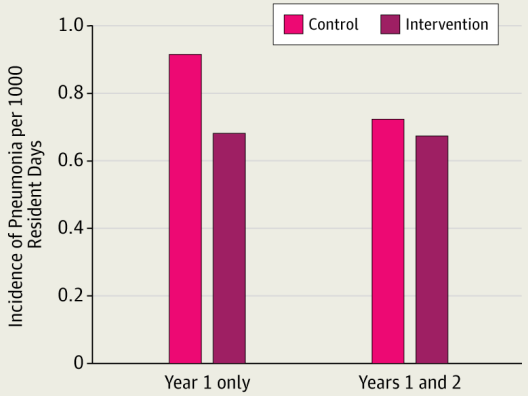
Nursing homes with 933 residents performed standard mouth care

PRIMARY OUTCOME

Incidence rate ratio (IRR) of pneumonia at 2 years based on diagnosis of pneumonia recorded in nurse or provider note

FINDINGS

Compared with standard care, a mouth care program did not reduce pneumonia incidence at 2 years, but a significant reduction was seen in the first year

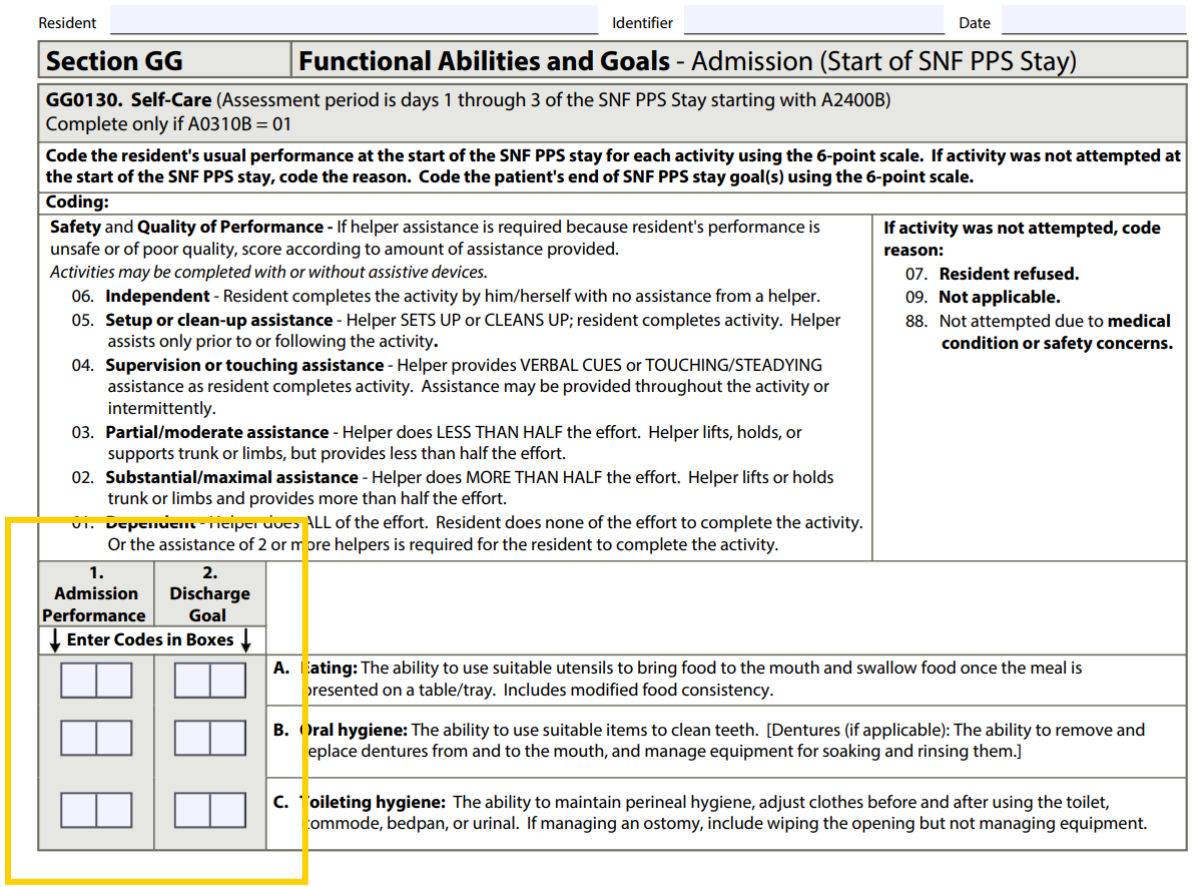


Year 1 only: adjusted IRR, 0.74; upper bound of 1-sided 95% CI, 0.99; *P*=.03

Years 1 and 2: adjusted IRR, 0.92; upper bound of 1-sided 95% CI, 1.27; *P*=.30

Zimmerman S, Sloane PD, Ward K, et al. Effectiveness of a mouth care program provided by nursing home staff vs standard care on reducing pneumonia incidence: a cluster randomized trial. *JAMA Netw Open*. 2020;3(6):e204321. doi:10.1001/jamanetworkopen.2020.4321

Resident Assessment and Care Screening Minimum Data Set



Resident | Identifier | Date

Section GG | **Functional Abilities and Goals** - Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

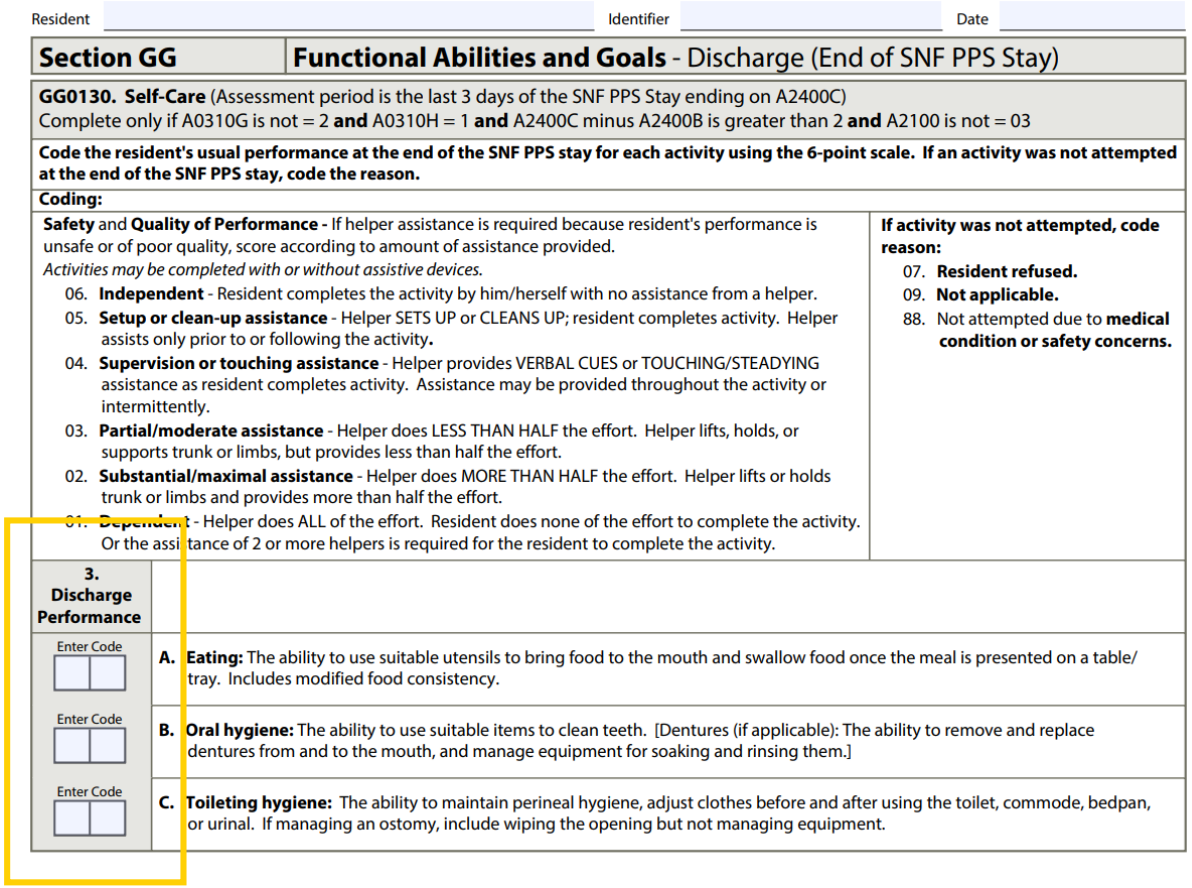
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
		B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
		C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.



Resident | Identifier | Date

Section GG | **Functional Abilities and Goals** - Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

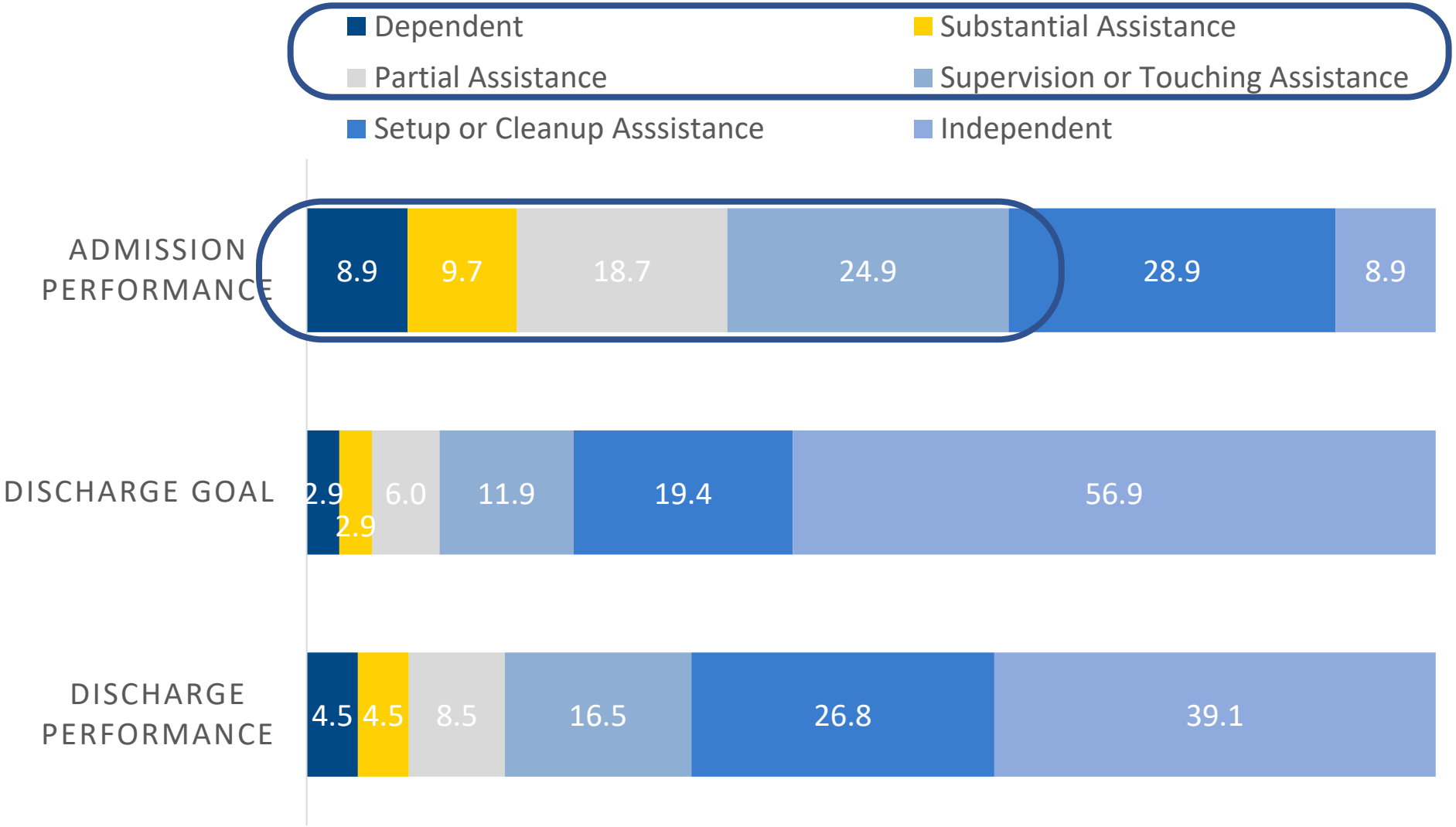
07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Code	A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
Enter Code	B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
Enter Code	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Archive-Draft-of-the-MDS-30-Nursing-Home-Comprehensive-NC-Version-1140.pdf

Oral Health in Nursing Homes, Malnutrition and Patient Safety

60% of nursing home residents need assistance with oral health upon admission.

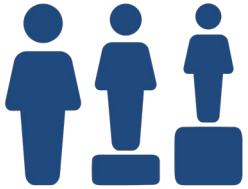


Source: 2020 Minimum Dataset (MDS) 3.0; **Preliminary analysis, not for distribution or publication**

CMS Oral Health Vision

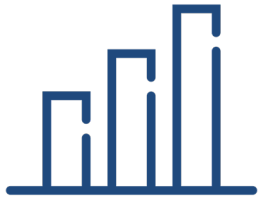
Improve beneficiaries' health by **integrating oral health** and transforming the health care system to advance health equity, expand coverage and improve health outcomes.

Oral Health Strategy Fundamental Principles

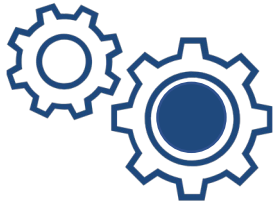


Equity Focused

Evidence Empowered



Data Driven



Integration Centered

Stakeholder Engagement

Innovation Focused

CMS Commitment to Enhance the Oral Health for All Beneficiaries Reflected in Proposed Rules and RFIs

CMCS RFI on Access to Care and Coverage

Biden-Harris Administration Announces Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP

Feb 17, 2022 Medicaid & CHIP

Share

As part of the Biden-Harris Administration's work to advance health equity and reduce health disparities, the Centers for Medicare & Medicaid Services (CMS) is seeking feedback on topics related to health care access, such as enrolling in and maintaining coverage, accessing health care services and supports, and ensuring adequate provider payment rates to encourage provider availability and quality. This Request for Information (RFI) is one of many actions CMS is taking to develop a more comprehensive access

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. *Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, economy, and quality of care and are 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." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner…." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.*

The comment period closed on February 17, 2022

CMMI ACO REACH Model

Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model

Feb 24, 2022 | Innovation models, Medicare Parts A & B

Share

Overview

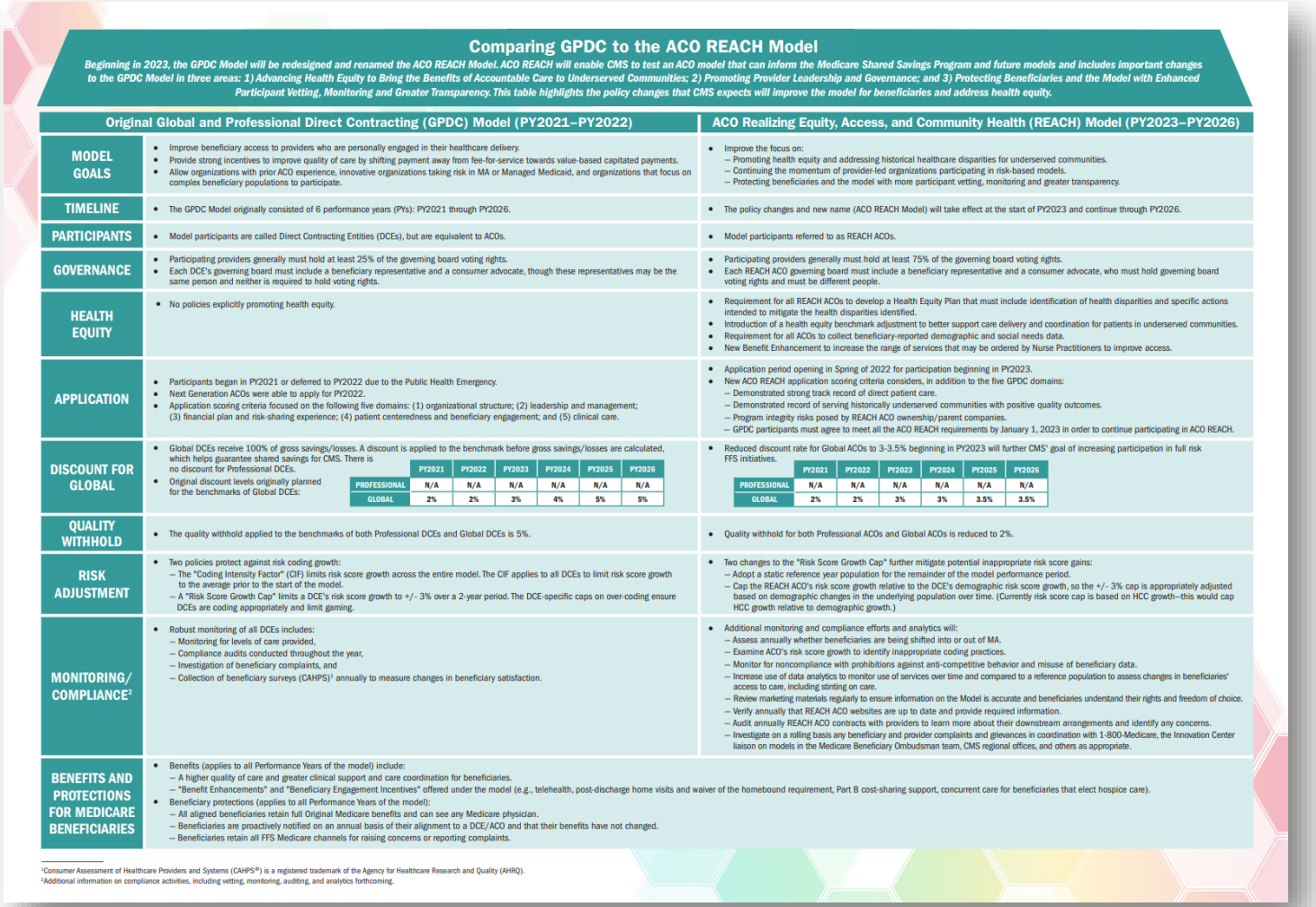
The Centers for Medicare & Medicaid Services (CMS) has redesigned the Global and Professional Direct Contracting Model (GPDC) Model to advance Administration priorities, including our commitment to advancing health equity, and in response to stakeholder feedback and participant experience. The Center for Medicare and Medicaid Innovation (Innovation Center) is releasing a Request for Applications (RFA) to solicit a cohort of participants for the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. The GPDC model will be renamed the ACO REACH model to better align the model's name with its purpose: to encourage health care providers to coordinate care to improve the care offered to people with Medicare – especially those from underserved communities, a priority of the Biden-Harris Administration.

Additional examples of in-kind incentives that ACOs could consider offering might include but are not limited to:

- **Vouchers for dental care services**, for example, prior to jaw surgery to reduce the risk of infection.

Source: https://innovation.cms.gov/media/document/aco-reach-rfa

Comparing GPDC to the ACO REACH Model



Comparing GPDC to the ACO REACH Model

Beginning in 2023, the GPDC Model will be redesigned and renamed the ACO REACH Model. ACO REACH will enable CMS to test an ACO model that can inform the Medicare Shared Savings Program and future models and includes important changes to the GPDC Model in three areas: 1) Advancing Health Equity to Bring the Benefits of Accountable Care to Underserved Communities; 2) Promoting Provider Leadership and Governance; and 3) Protecting Beneficiaries and the Model with Enhanced Participant Vetting, Monitoring and Greater Transparency. This table highlights the policy changes that CMS expects will improve the model for beneficiaries and address health equity.

	Original Global and Professional Direct Contracting (GPDC) Model (PY2021–PY2022)	ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023–PY2026)
MODEL GOALS	• Improve beneficiary access to providers who are personally engaged in their healthcare delivery. • Provide strong incentives to improve quality of care by shifting payment away from fee-for-service towards value-based capitated payments. • Allow organizations with prior ACO experience, innovative organizations taking risk in MA or Managed Medicaid, and organizations that focus on complex beneficiary populations to participate.	• Improve the focus on: – Promoting health equity and addressing historical healthcare disparities for underserved communities. – Continuing the momentum of provider-led organizations participating in risk-based models. – Protecting beneficiaries and the model with more participant vetting, monitoring and greater transparency.
TIMELINE	• The GPDC Model originally consisted of 6 performance years (PYs): PY2021 through PY2026.	• The policy changes and new name (ACO REACH Model) will take effect at the start of PY2023 and continue through PY2026.
PARTICIPANTS	• Model participants are called Direct Contracting Entities (DCEs), but are equivalent to ACOs.	• Model participants referred to as REACH ACOs.
GOVERNANCE	• Participating providers generally must hold at least 25% of the governing board voting rights. • Each DCE's governing board must include a beneficiary representative and a consumer advocate, though these representatives may be the same person and neither is required to hold voting rights.	• Participating providers generally must hold at least 75% of the governing board voting rights. • Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, who must hold governing board voting rights and must be different people.
HEALTH EQUITY	• No policies explicitly promoting health equity.	• Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified. • Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities. • Requirement for all ACOs to collect beneficiary-reported demographic and social needs data. • New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access.
APPLICATION	• Participants began in PY2021 or deferred to PY2022 due to the Public Health Emergency. • Next Generation ACOs were able to apply for PY2022. • Application scoring criteria focused on the following five domains: (1) organizational structure; (2) leadership and management; (3) financial plan and risk-sharing experience; (4) patient centeredness and beneficiary engagement; and (5) clinical care.	• Application period opening in Spring of 2022 for participation beginning in PY2023. • New ACO REACH application scoring criteria considers, in addition to the five GPDC domains: – Demonstrated strong track record of direct patient care. – Demonstrated record of serving historically underserved communities with positive quality outcomes. – Program integrity risks posed by REACH ACO ownership/parent companies. – GPDC participants must agree to meet all the ACO REACH requirements by January 1, 2023 in order to continue participating in ACO REACH.
DISCOUNT FOR GLOBAL	• Global DCEs receive 100% of gross savings/losses. A discount is applied to the benchmark before gross savings/losses are calculated, which helps guarantee shared savings for CMS. There is no discount for Professional DCEs. • Original discount levels originally planned for the benchmarks of Global DCEs:	• Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS' goal of increasing participation in full risk FFS initiatives.
QUALITY WITHHOLD	• The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%.	• Quality withhold for both Professional ACOs and Global ACOs is reduced to 2%.
RISK ADJUSTMENT	• Two policies protect against risk coding growth: – The "Coding Intensity Factor" (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model. – A "Risk Score Growth Cap" limits a DCE's risk score growth to +/- 3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming.	• Two changes to the "Risk Score Growth Cap" further mitigate potential inappropriate risk score gains: – Adopt a static reference year population for the remainder of the model performance period. – Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- 3% cap is appropriately adjusted based on demographic changes in the underlying population over time. (Currently risk score cap is based on HCC growth—this would cap HCC growth relative to demographic growth.)
MONITORING/ COMPLIANCE[2]	• Robust monitoring of all DCEs includes: – Monitoring for levels of care provided, – Compliance audits conducted throughout the year, – Investigation of beneficiary complaints, and – Collection of beneficiary surveys (CAHPS)[1] annually to measure changes in beneficiary satisfaction.	• Additional monitoring and compliance efforts and analytics will: – Assess annually whether beneficiaries are being shifted into or out of MA. – Examine ACO's risk score growth to identify inappropriate coding practices. – Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data. – Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care. – Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice. – Verify annually that REACH ACO websites are up to date and provide required information. – Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns. – Investigate on a rolling basis any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate.
BENEFITS AND PROTECTIONS FOR MEDICARE BENEFICIARIES	• Benefits (applies to all Performance Years of the model) include: – A higher quality of care and greater clinical support and care coordination for beneficiaries. – "Benefit Enhancements" and "Beneficiary Engagement Incentives" offered under the model (e.g., telehealth, post-discharge home visits and waiver of the homebound requirement, Part B cost-sharing support, concurrent care for beneficiaries that elect hospice care). • Beneficiary protections (applies to all Performance Years of the model): – All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician. – Beneficiaries are proactively notified on an annual basis of their alignment to a DCE/ACO and that their benefits have not changed. – Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints.	

PY2021	PY2022	PY2023	PY2024	PY2025	PY2026
PROFESSIONAL	N/A	N/A	N/A	N/A	N/A	N/A
GLOBAL	2%	2%	3%	4%	5%	5%

PY2021	PY2022	PY2023	PY2024	PY2025	PY2026
PROFESSIONAL	N/A	N/A	N/A	N/A	N/A	N/A
GLOBAL	2%	2%	3%	3%	3.5%	3.5%

[1]Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2]Additional information on compliance activities, including vetting, monitoring, auditing, and analytics forthcoming.

HEALTH EQUITY

GPDC

- No policies explicitly promoting health equity.

ACO REACH

- Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified.
- Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities.
- Requirement for all ACOs to collect beneficiary-reported demographic and social needs data.
- New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access

Source: https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

Medicare Advantage RFI

CMS Seeks Public Feedback to Improve Medicare Advantage

Jul 28, 2022 Medicare Part D

Share

Today, the Centers for Medicare & Medicaid Services (CMS) released a Request for Information seeking public comment on the Medicare Advantage program. CMS is asking for input on ways to achieve the agency's vision so that all parts of Medicare are working towards a future where people with Medicare receive more equitable, high quality, and person-centered care that is affordable and sustainable.

In the Medicare Advantage program – also known as Medicare Part C – Medicare contracts with private insurers that must offer all Traditional Medicare services to people with Medicare and may offer added supplemental benefits, such as vision or dental benefits. Most Medicare Advantage Plans also include prescription drug coverage (Part D).

The comment period closed on August 31, 2022

2023 Medicare Physician Fee Schedule Proposed Rule

CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

Jul 07, 2022 Medicare Parts A & B

Share

The Centers for Medicare & Medicaid Services (CMS) today issued the Calendar Year 2023 Physician Fee Schedule (PFS) proposed rule, which would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care — particularly in rural and underserved areas. These proposed changes play a key role in the Biden-Harris Administration's Unity Agenda — especially its priorities to tackle our nation's mental health crisis, beat the overdose and opioid epidemic, and end cancer as we know it through the Cancer Moonshot — and ensure CMS continues to deliver on its goals of advancing health equity, driving high-quality, whole-person care, and ensuring the sustainability of the Medicare program for future generations.

2023 Medicare Physician Fee Schedule Proposed Rule: **Dental services that are inextricably linked to, substantially related to, and integral to the clinical success of covered medical.**

The comment period closed on September 6, 2022

2023 Medicare OPPS Proposed Rule

Fact sheet

CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS 1772-P)

Jul 15, 2022 | Ambulatory surgical centers, Hospitals

Share

On July 15, 2022, the Centers for Medicare & Medicaid Services (CMS) proposed Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services. The calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Proposed Rule is published annually and will have a 60-day comment period, which will end on September 13, 2022. The final rule will be issued in early November.

The comment period closed on September 13, 2022

In calendar year (CY) 2022, CPT code 41899 was assigned to APC 5161 (Level 1 ENT Procedures) with a payment rate of **$216.07**. In the proposed rule, CMS proposed to reassign CPT code 41899 to clinical APC 5871 (Dental Procedures). This proposed change, if finalized, would increase the payment rate for dental procedures described by CPT 41899 to more closely align with the cost of the dental procedures described by this code than with its current APC assignment. The proposed CY 2023 payment rate for CPT 41899 is **$1,956.32.**

HHS Announces Proposed Rule to Strengthen Nondiscrimination in Health Care

FOR IMMEDIATE RELEASE
July 25, 2022

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Announces Proposed Rule to Strengthen Nondiscrimination in Health Care

The proposed rule affirms protections consistent with President Biden's executive orders on nondiscrimination based on sexual orientation and gender identity, and on protecting access to reproductive health care.

Today, the U.S. Department of Health and Human Services (HHS) announced a proposed rule implementing Section 1557 of the Affordable Care Act (ACA)(Section 1557) that prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities. This proposed rule restores and strengthens civil rights protections for patients and consumers in certain federally funded health programs and HHS programs after the 2020 version of the rule limited its scope and power to cover fewer programs and services.

The proposed rule affirms protections against discrimination on the basis of sex, including sexual orientation and gender identity consistent with the U.S. Supreme Court's holding in *Bostock v. Clayton County*,and reiterates protections from discrimination for seeking reproductive health care services. Strengthening this rule is part of the Biden-Harris Administration's commitment to advancing gender and health equity and civil rights, as laid out in President Biden's executive orders on Preventing and Combatting Discrimination on the Basis of Gender Identity or Sexual Orientation, Protecting Access to Reproductive Healthcare Services, and Advancing Racial Equity and Support for Underserved Communities.

- … Compared to individuals without disabilities, people with disabilities are more likely to have unmet medical, **dental**, and prescription medication needs—especially women with disabilities and individuals with disabilities who have lower incomes. Individuals with disabilities are also less likely to receive preventive health care services, such as routine teeth cleanings and cancer screenings. …
- … The third category of health care staff that the Department assumes will receive training comprises non-degreed medical assistants (Occupation code 31– 0000), and includes psychiatric and home health aides, orderlies, **dental assistants**, and phlebotomists. …

The comment period closes on October 3, 2022

OBRHI Make your Voice Heard RFI

Make Your Voice Heard Request for Information Seeks Public Comment to Promote Efficiency, Reduce Burden, and Advance Equity within CMS Programs

Sep 06, 2022 Initiatives, Partnerships, Quality

Share

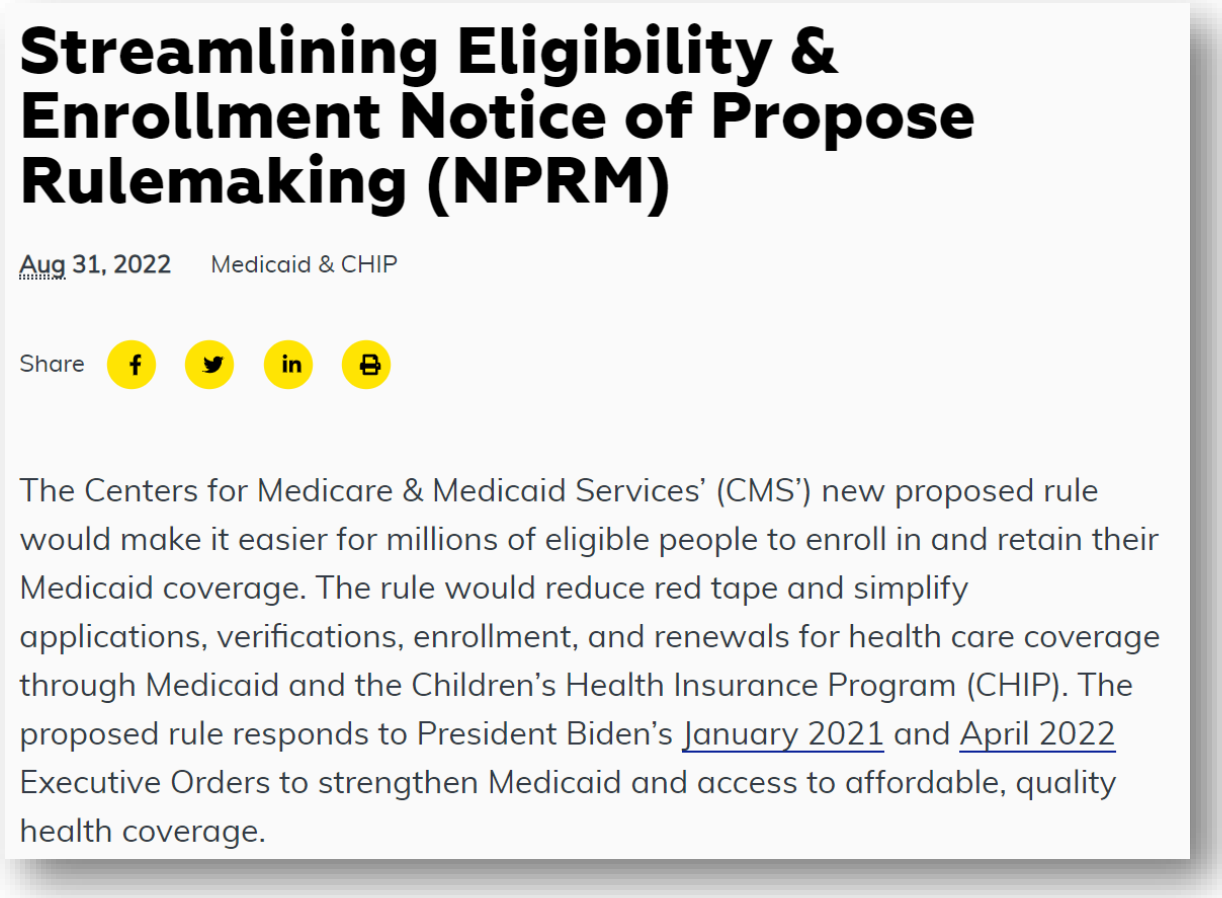
Today, the Centers for Medicare & Medicaid Services (CMS) released a Request For Information (RFI) seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency.

Example responses may include, but are not limited to:

- Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services;
- Challenges in accessing care in underserved areas, including rural areas;
- Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences);
- Challenges with health plan enrollment;
- Challenges of accessing reproductive health services;
- Challenges of accessing maternal health services;
- Challenges of accessing oral health services and the impact on overall health;
- Understanding coverage options, and/or technology to support access to coverage; and,
- Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.

The comment period closes on November 4, 2022

CMCS Streamlining Eligibility & Enrollment



Streamlining Eligibility & Enrollment Notice of Propose Rulemaking (NPRM)

Aug 31, 2022 Medicaid & CHIP

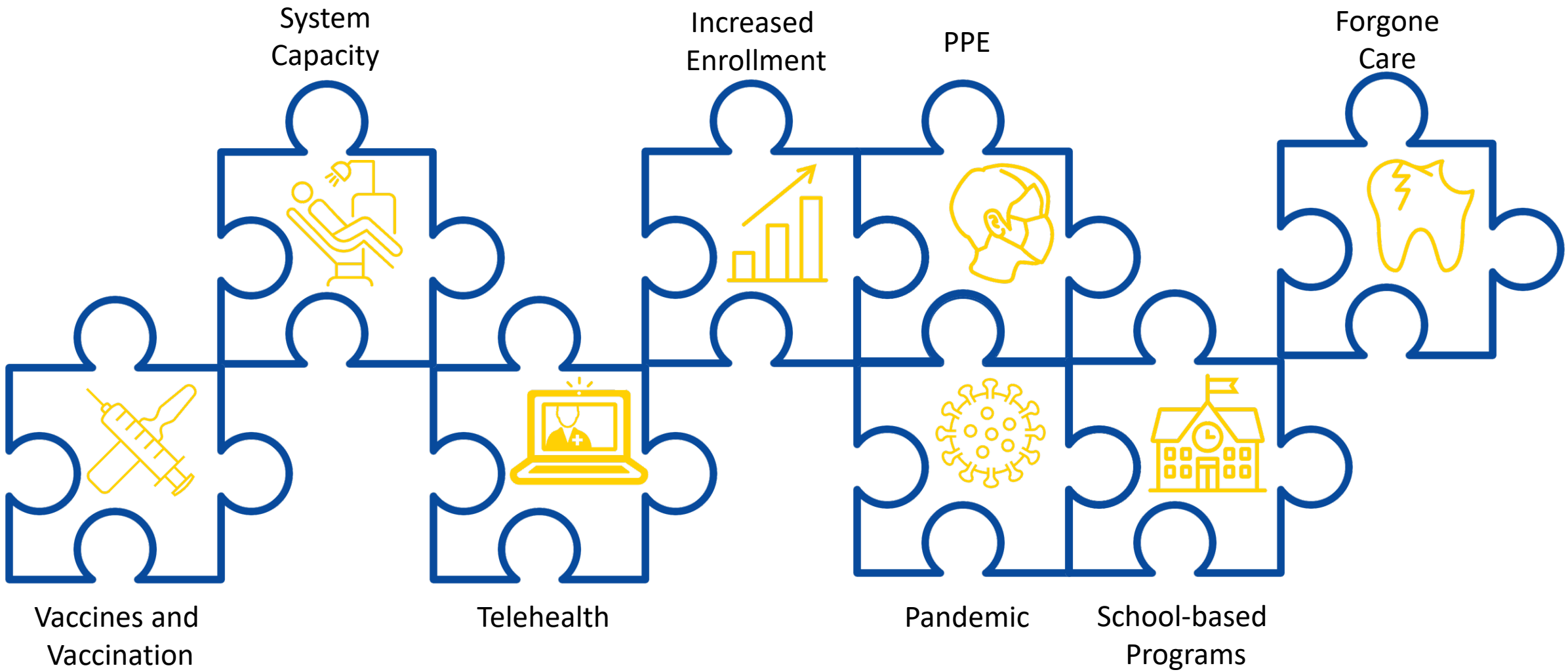
Share

The Centers for Medicare & Medicaid Services' (CMS') new proposed rule would make it easier for millions of eligible people to enroll in and retain their Medicaid coverage. The rule would reduce red tape and simplify applications, verifications, enrollment, and renewals for health care coverage through Medicaid and the Children's Health Insurance Program (CHIP). The proposed rule responds to President Biden's January 2021 and April 2022 Executive Orders to strengthen Medicaid and access to affordable, quality health coverage.

The CMCS Proposed Rule: We propose to redesignate current paragraphs (a) and (b) of § 457.480, as paragraphs (b) and (c) respectively, and to add a new paragraph (a) to **prohibit annual and lifetime dollar limits in the provision of all CHIP medical and dental benefits**.

The comment period closes on November 7, 2022

Oral Health: Challenges and Opportunities

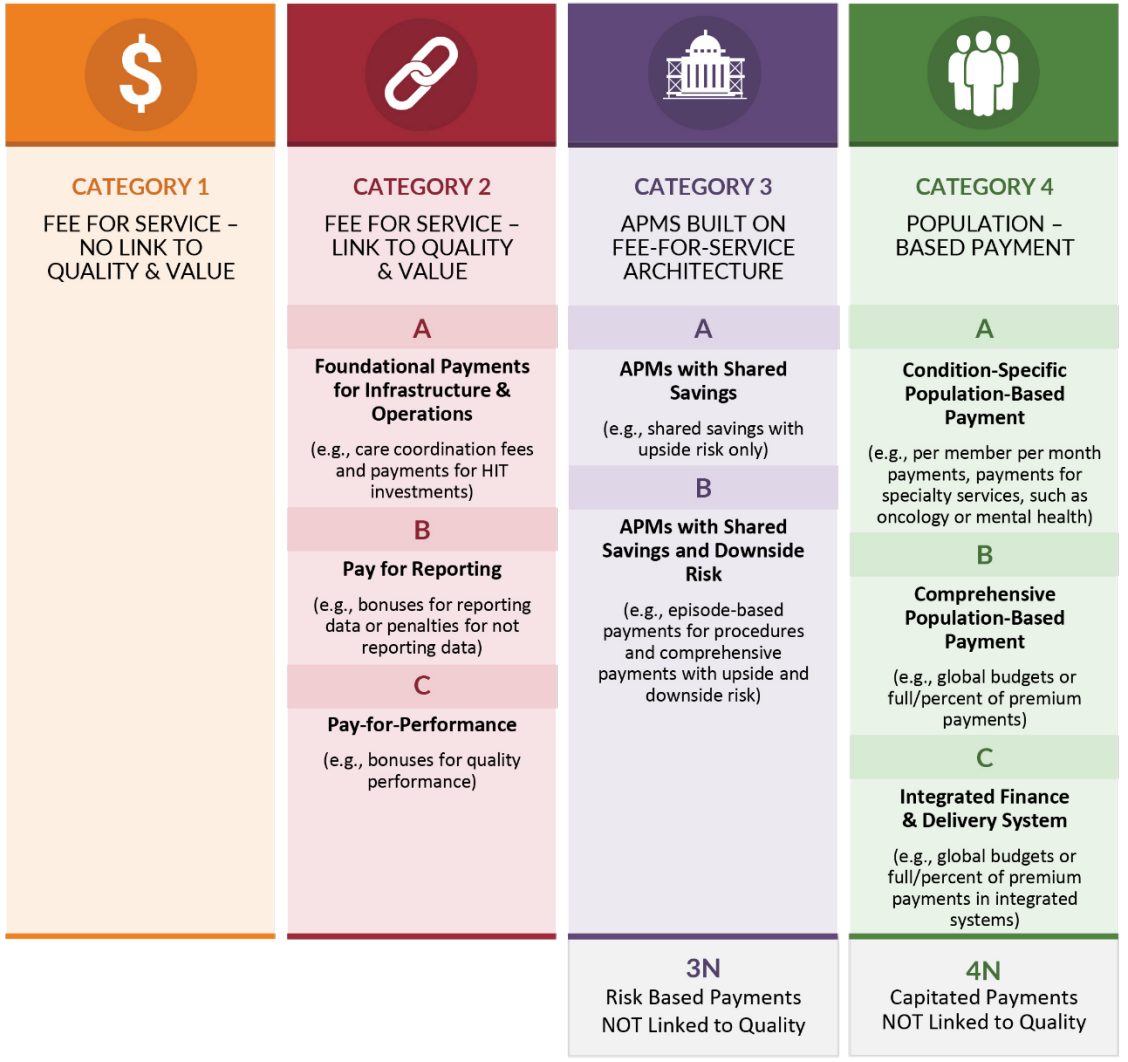


Appendix

LAN APM Framework

The Health Care Payment Learning & Action Network (HCPLAN or LAN)

- First published in 2016 and then refreshed in 2017, the APM Framework established a common vocabulary and pathway for measuring and sharing successful payment models
- 4 Categories & 8 Subcategories
- Has become the foundation for implementing APMs



Source: https://hcp-lan.org/lan-spring-event/

Accountable Care Definition

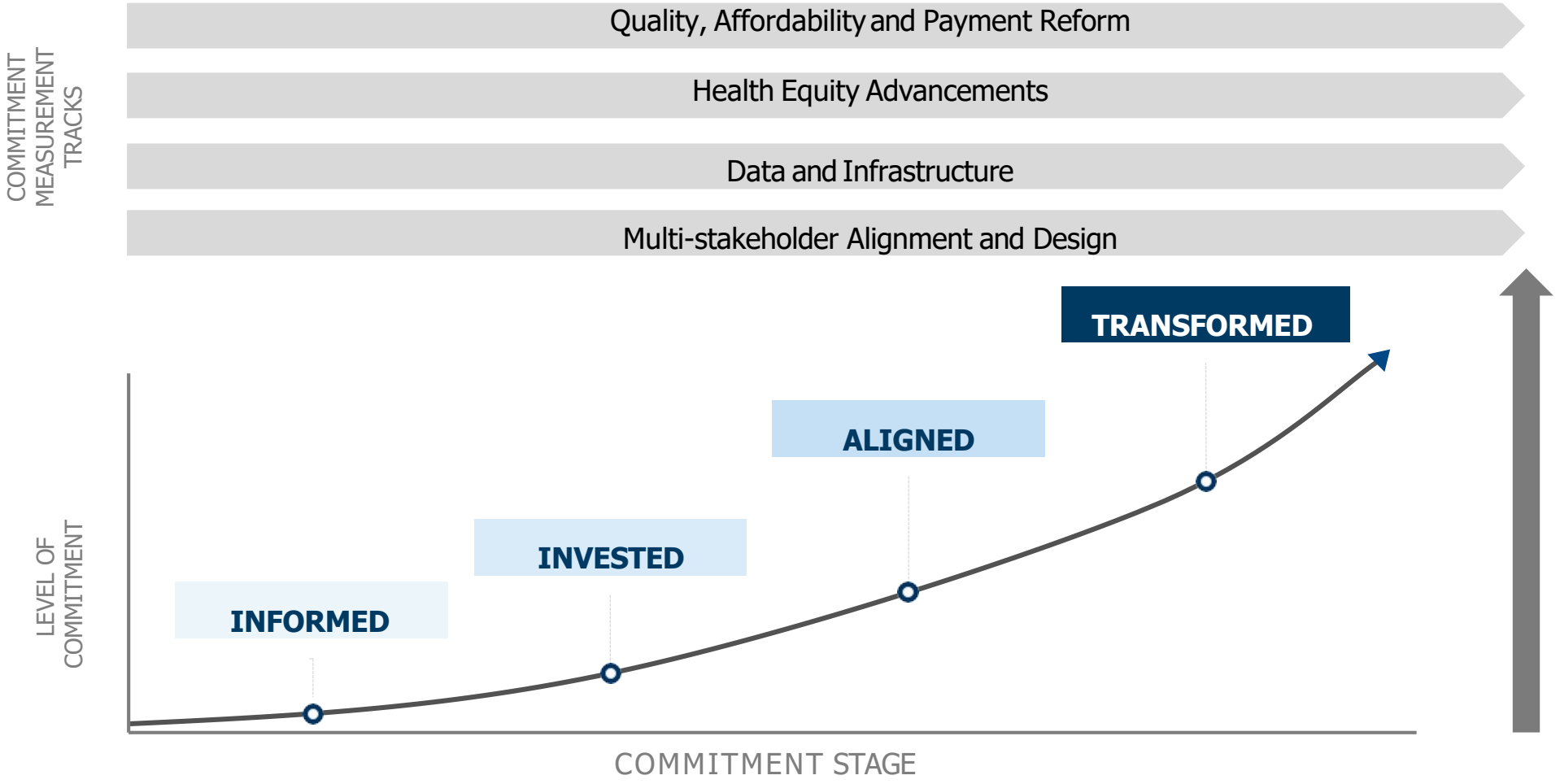
Accountable Care

"Accountable care" aligns care teams to help realize the best achievable health outcomes for all through comprehensive, high-value, affordable, longitudinal, person-centered care.

Source: https://hcp-lan.org/lan-spring-event/

Encouraging Greater Commitment

The Accountable Care Commitment Curve will inform a tailored approach to enhance stakeholder capabilities to drive accountable care.



*The LAN will pursue **targeted tactics to leverage stakeholder progress along the curve.** By understanding key priorities for each stakeholder and opportunities to help them accelerate overall progress, the LAN **can tailor its engagement activities** to have the greatest impact.*

Source: https://hcp-lan.org/lan-spring-event/

Moving Along the Commitment Curve – Implementing Person-Centered Care*

COMMITMENT TRACKS	INFORMED	INVESTED	ALIGNED	TRANSFORMED

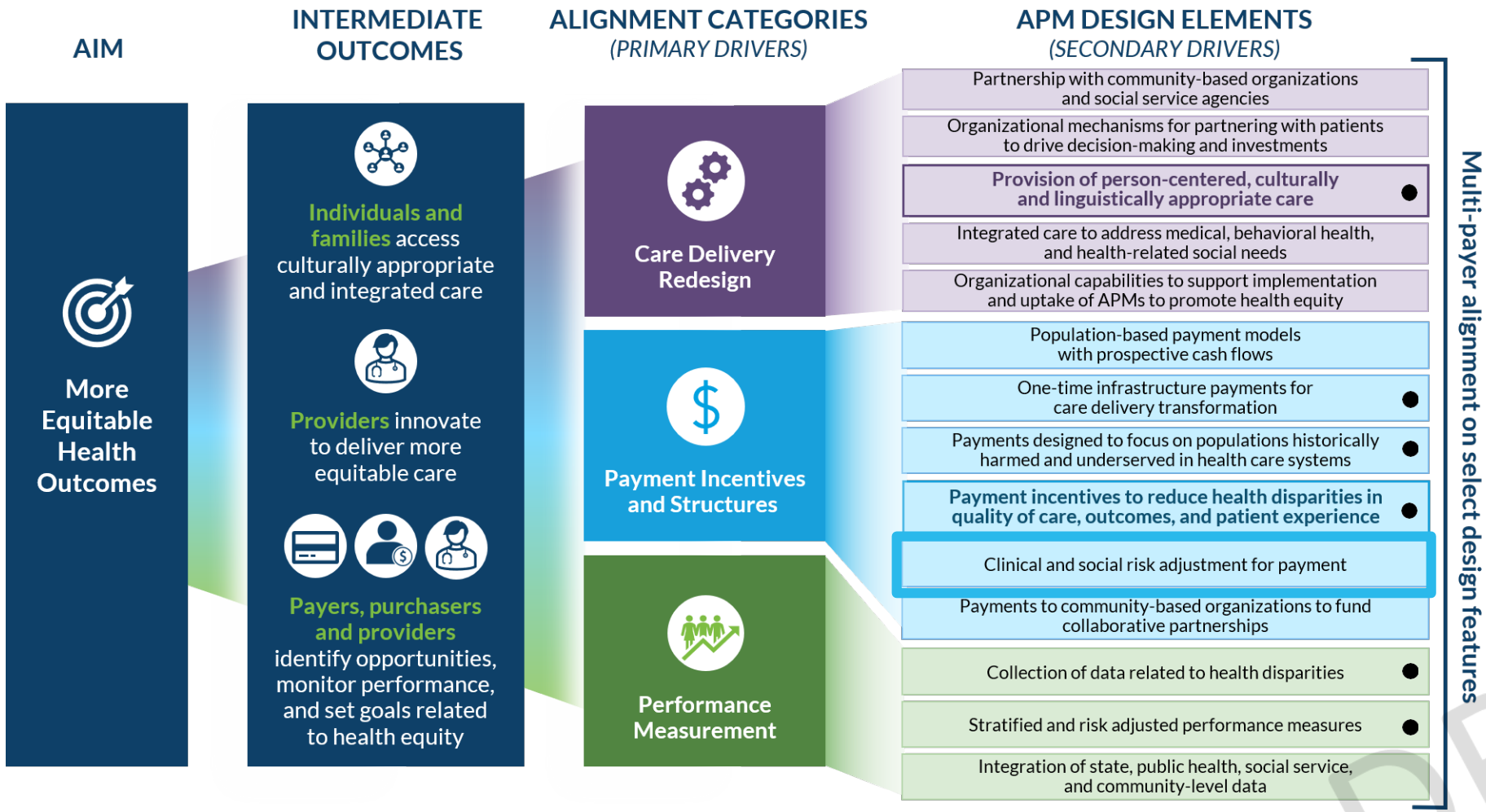
Payment Reform and Care Quality & Affordability	• Engages with LAN:
	  ○ Signed up for the LAN listserv
	  ○ Attended LAN Summit or other LAN event(s)
		• Participates in, administers, or covers shared savings arrangements (Category 3A) ★	• Grows participation in downside risk arrangement(s) that support accountable care, with links to quality, affordability, and well-coordinated specialized care (CMMI model, Category 3B) ★	• Population-based payment or shared savings options that support accountable care with downside risk arrangements (Category 3B or 4), to strengthen primary care and well-coordinated specialized care ★

Health Equity Advancements		• Commits to improving equity (e.g., publicly announcing equity goals or commitment, commitment to HEAT guidance) • Develops a plan for health equity	• Significantly invests in equity (e.g., measures or targets initiatives to improve equity, industry equity accreditation or similar, implementation of HEAT recommendations) • Measures and reports outcomes disparities	• Embeds accountability for improving equity in organizational mission, through governance/op model (e.g., payments to support equity) and sustained investments • Measurable reduction in disparities, improved outcomes across populations ★
Data and Infrastructure		• Invests in improved data/infrastructure (e.g., interoperability, advanced EMRs, modernized systems, participation in APM Measurement Effort)	• Significantly invests in data sharing that enables measurable progress on payment reform, quality, affordability, and equity (e.g., participation in HIE)	• Implements advanced data sharing infrastructure, activities (interoperable data collection, use, and sharing) to measure progress on payment reform, quality, affordability, and equity
Multi-stakeholder Alignment and Design			• Participates in multi-stakeholder efforts to advance accountable care or multi-stakeholder models/arrangements for measurable progress in system-wide regional, state, or national goals	• Leads multi-stakeholder efforts to advance accountable care or multi-stakeholder models/arrangements for measurable progress in system-wide regional, state, or national goals

★ = criteria is required for stakeholder to move to Commitment Curve stage that star is located in

Source: https://hcp-lan.org/lan-spring-event/

Dependencies/Relationship Between Social Risk Adjustment and Other APM Design Elements



Source: https://hcp-lan.org/lan-spring-event/

HCPLAN
Health Care Payment Learning & Action Network