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Comments on OHA's Application for Renewal and Amendment of 1115 Waiver
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https://mslc.qualtrics.com/ife/form/SV_7O1XVYN2bJqvd8G

It is time to address the orthodontia inequity in Oregon's Medicaid program. Oregon's current 1115 Medicaid waiver waives the federal requirements under the Early and Periodic Screening, Diagnostic and Testing (EPSDT) benefit for services listed below line 471 on the prioritized list of health services. Oregon's draft Application for Renewal and Amendment of the 1115 Waiver, dated 12-1-2021, proposes to continue to *"Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one."* (See pages 42, 147, and 156.)

As treatment of handicapping malocclusion is listed at line 618 of the current prioritized list, well below the line 471 cut off, the Oregon Health Plan (OHP) is proposing to continue to severely restrict children's access to medically necessary orthodontia services. Currently these services are covered by the OHP only when related to the treatment of cleft lip, cleft palate, or another craniofacial anomaly. Oregon is unique in the country in this respect. As required by EPSDT, all other state Medicaid programs cover children's orthodontia when necessary to correct or ameliorate medical conditions such as severe malocclusion. This coverage is required under federal law (unless waived) and enumerated in the Centers for Medicare & Medicaid Services' EPSDT Guidelines. It is time for Oregon to join every other state in offering this coverage.

In this 1115 renewal, the Oregon Health Authority (OHA) should cease waiving EPSDT coverage for non-prioritized services. As noted above, the waiver renewal application includes a request to continue the waiver of EPSDT requirements such that treatment needs identified during an EPSDT screening that are not consistent with the prioritized list of health services for children over age one would not be covered. We believe that continuing this waiver is unnecessary for OHA to meet its stated goals. Federal Medicaid law already provides all the tools a state needs to ensure that services are covered only when medically necessary. This gives states the necessary discretion to design an individualized benefit that also meets State fiscal goals. Forty-nine states and the District of Columbia have demonstrated that it is possible to craft coverage guidelines for children's orthodontia, along with individual medical necessity determination protocols, that ensure provision of the service only to children who need it. We stand ready to help Oregon do the same.

Providing medically necessary orthodontia services to children covered through the Oregon Health Plan will advance health equity. Severe malocclusion is a life-altering condition. It interferes with eating, speaking, sleeping, smiling, and normal social relating. It can affect both the physical and the social/emotional development of children. Its impacts can be felt over a lifetime in the loss of achievements in education, possibilities in employment, and a reduction in overall health and wellness, including mental health. The remedy for severe malocclusion – orthodontia – is well-established but only readily available to middle- and upper-income children. It is not currently available to low-income children in Oregon except through the very limited resources of A Smile for Kids (ASK), a charity that is able to serve fewer than 100 children each year. A failure to address severe malocclusion can combine with other social determinants of health to interfere with a child's ability to access a healthy and successful life trajectory, leading to greater dependency and higher health care costs over a lifetime. Addressing this coverage gap is an essential part of Oregon's aim, in this renewal package, to create more equity in health care and in health outcomes.

Example:

Oscar (name changed) entered the ASK orthodontic program when he was 13 years old in seventh grade. He suffered from a handicapping malocclusion, which led to teasing and bullying by peers. Oscar had a hard time with eating, speaking and drinking, and endured pain in his mouth due to the malocclusion. All of these challenges were exacerbated by the relentless teasing. He grew up in a family of eight with an annual household income of \$28,000. Both parents were undocumented immigrants, so work and income options were limited for them.

Under current OHP coverage and the limitations in the proposed renewal of the Medicaid Waiver, the State of Oregon is telling kids like Oliver that his need for braces is not important enough and that he'll simply have to get used to it and somehow make it through despite this massive barrier. Before and after photos below:



Although the direct correlation is difficult to prove scientifically, Oscar went on to complete the orthodontic treatment funded by ASK, improved his grades in school, graduated high school and is now sophomore at private university in Oregon with a full four-year academic scholarship, majoring in political science. Oscar wants to be an attorney.

When asked to identify obstacles when growing up, Oscar provided the following answer: *"My teeth were definitely one of 2 obstacles. The other obstacle being limited financial resources. Having braces gave me the confidence to take my education and its opportunities to the next level. I don't think I would be where I am now if I had not had the braces."*

To successfully meet its purpose, a new orthodontia benefit will need to be adequately funded and pay reasonable rates to providers. Because orthodontia for children would be a new benefit in the OHP, when computing the base rate in the global budget OHA will need to go beyond the proposed 5-year look back at utilization and spending. OHA will need to estimate what amount it will pay for a course of orthodontic treatment and how many children will be approved for the service in the first year, and then incorporate those figures into the global budget computation. Further, when computing the projected future trend of the base rate, OHA would need to incorporate an assumption of gradually increasing utilization of the benefit. This approach will ensure that Coordinated Care Organizations (CCOs) are not caught short financially as the new orthodontia coverage eventually reaches more eligible children in Oregon.

Lastly, OHA will need to design and implement a meaningful reporting and accountability structure to ensure that all affected children, including those in Tribal communities, can equitably access high quality orthodontic care in locations convenient to where they live. This will help guard against inappropriate underutilization of the orthodontia benefit and outright denials of medically necessary care by CCOs. CCOs should, at the very least, be actively monitored to see that they are effectively implementing the new benefit. Ideally, they could be incentivized to ensure that affected children are being screened, referred, diagnosed, and served appropriately. Both member and provider satisfaction should regularly be assessed and reported. CCOs should be required to report data on utilization of, and satisfaction with, the orthodontic benefit, stratified by subpopulation so any gaps can be identified and addressed.

Specific impacts and measures that are affected by orthodontic treatment include an increase in middle- and high-school grades after orthodontic treatment, increased self-esteem as self-reported and as reported by third party professionals, higher community involvement, higher graduation rates, increased social interactions with peers, improved oral health/hygiene, and assignment of dental home for the child and rest of family.

In conclusion, we urge OHA to include in its Application for Renewal and Amendment of the 1115 Waiver:

- **An explicit withdrawal of the request to limit EPSDT treatment services to those on the prioritized list of health care services;**
- **A statement that OHA will begin to provide coverage for treatment for medically necessary orthodontia in children, i.e., fixed, and removable appliances and associated surgical procedures for handicapping malocclusion;**
- **An indication that OHA will incorporate in the global budget base rate, and in the projected future trending of the base rate, a reasonable provider rate and an expectation of a gradually increasing number of orthodontia cases over the five (5) year duration of the waiver; and**
- **An indication that the CCO accountability structure will include the necessary data collection and reporting requirements, stratified by subpopulation, to ensure that all affected children are being equitably served by the orthodontia benefit.**

Respectfully submitted,

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