[Submitted electronically]

January 8, 2024

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program (CMS-9895-P).

Dear Secretary Yellen, Secretary Becerra, and Administrator Brooks-LaSure:

The undersigned members of the Consortium for Constituents with Disabilities (CCD) Health Task Force are writing in response to the 2025 Notice of Benefit and Payment Parameters (NBPP) proposed rule.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society, free from racism, ableism, sexism, and xenophobia, as well as LGBTQIA+ based discrimination and religious intolerance.

Provision of EHB (45 CFR § 156.115)

We strongly support the proposal to remove the regulatory provision that prohibits issuers from including routine non-pediatric dental services as an essential health benefit (EHB). CCD agrees with the Departments that § 1302(b)(2) of the Affordable Care Act (ACA), in directing the Secretary of Health and Human Services to define the EHBs as equal in scope to the services provided under a typical employer plan, includes all of the benefits covered by an employer, whether a medical benefit or a dental benefit. Removing the prohibition on issuers including routine non-pediatric dental services as an EHB would give states the option of adding routine adult dental services as an EHB by updating their EHB-benchmark plans without having to defray the costs of that coverage.

Dental coverage and access to dental services are essential to good oral health, as well as overall physical health at all ages. Poor oral health is linked to respiratory, cardiovascular, and endocrine disease.[1] Dental coverage should expand to include robust coverage for adults as well as children. The rate of children with dental coverage increased after passage of the ACA,[2] and CCD believes the same will be true for adults if the Departments' proposal is finalized.

This issue is particularly important to CCD because people with disabilities are less likely to have dental insurance.[3] They often are unable to work or cannot work full-time. Therefore, they lack employer-sponsored insurance and instead rely upon the ACA and Medicaid. Without dental insurance under the ACA and Medicaid, people with disabilities, many of whom are low-income, are less likely to be able to afford dental care. As a result, they have more difficulty receiving dental care and have more dental disease and

[1] R. Rautemaa, et al., *Oral Infections and Systemic Disease – An Emerging Problem in Medicine*, 13 CLINICAL MICROBIOLOGY AND INFECTION 1041 (2007).
[2] Ashley M. Kranz and Andrew W. Dick, *Changes in Pediatric Dental Coverage and Visits Following the Implementation of the Affordable Care Act*, 54 HEALTH SERV. RES. 437 (2019).
[3] CareQuest Inst. for Oral Health, *Family Affair: A Snapshot of Oral Health Disparities and Challenges in Individuals in Households Experiencing Disability* (Oct. 2022), https://www.carequest.org/system/files/CareQuest_Institute_Family-Affair-Visual-Report_FINAL.pdf.

more missing teeth.[4] People with intellectual and developmental disabilities, for example, are more likely than those with no disabilities to not have had their teeth cleaned in the past five years or to never have had their teeth cleaned.[5] These disparities exist across many different types of disabilities. The National Institutes of Health (NIH) found that systemic health changes associated with chronic illnesses can result in poor oral health.[6] The opposite is also true: poor oral health can lead to worsened disabilities in adults. Furthermore, people with disabilities can have poor oral health due to their medications causing dry mouth, issues with cognition, or problems with their physical dexterity that can make flossing and brushing their teeth difficult.[7] People with physical, vision, or hearing disabilities may find that dental offices are not accessible. Dental care can also be difficult for people with neuromuscular disorders that cause them to have difficulty keeping their mouth open for an extended period of time.[8]

In many states, there remains a paucity of dental providers who are trained, willing, and eager to treat individuals with disabilities once they reach adulthood.[9] CCD believes that increased dental coverage will incentivize more dental schools to offer this training and encourage more providers to take the training. This will make it easier for people with disabilities to find providers.

Removing the prohibition on coverage of routine adult dental services is also important to advancing health equity. As described, people with disabilities face disparities in access to oral health care and outcomes. These disparities are compounded for disabled

---

[4] Paul Glassman and Christine Ernst Miller, *Preventing Dental Disease for People with Special Needs: The Need for Practical Preventive Protocols for Use in Community Settings*, 23 SPEC. CARE DENTIST 165 (2003).

[5] Barbara Kornblau, Autistic Self Advocacy Network, *The Case for Designating People with Intellectual Disabilities as a Medically Underserved Population* (April 2014), https://autisticadvocacy.org/wp-content/uploads/2014/04/MUP_ASAN_PolicyBrief_20140329.pdf.

[6] National Insts. of Health, *Oral Health in America: Advances and Challenges*, (2021), https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf.

[7] *Id.*

[8] Am. Inst. of Dental Public Health, *Disabilities and Dental Care: Why More Must Be Done* (June 26, 2023), https://aidph.org/disabilities-and-dental-care-why-more-must-be-done-to-improve-access/.

[9] National Council on Disability. "At NCD's Recommendation, Dental Schools Will Train Students to Manage Treatment of People with Intellectual, Developmental Disabilities." https://beta.ncd.gov/2019/08/14/at-ncds-recommendation-all-u-s-dental-schools-will-train-students-to-manage-treatment-of-people-with-intellectual-developmental-disabilities/ (Last visited Jan. 4, 2024).

people of color. For example, Black and Mexican-American adults are almost twice as likely to have untreated cavities compared to non-Hispanic white adults.[10]

Finally, including adult dental as EHB would also help increase Medicaid coverage of these critical services. Currently, adult dental is an optional Medicaid benefit. As of October 2022, only 26 states provided extensive adult dental benefits.[11] Some states that have expanded Medicaid only cover emergency services for most adult enrollees (e.g., Arizona, Nevada, Utah).[12] Because most states align their adult expansion benefits with the Medicaid state plan benefits, adding adult dental to the EHB will likely benefit adult Medicaid enrollees in these states as well.

The Departments seek comment on whether similar changes should be proposed with regard to the provision of "routine non-pediatric eye exam services and long-term/custodial nursing home care benefits." We support removing the regulatory prohibitions on including these services as EHB. The Affordable Care Act in no way requires prohibiting benefits described in § 156.115(d). Visual impairments are one of the most common types of disability and frequently develop during adulthood. Furthermore, Black communities experience higher rates of vision impairment and blindness resulting from chronic conditions.[13] Long-term services and supports (LTSS) are also extremely important to people with disabilities and need not be explicitly prohibited from EHB coverage, so long as the LTSS coverage is consistent with the Americans with Disabilities Act and other applicable civil rights statutes. Any state wishing to cover long-term institutional LTSS as an EHB, for example, would also have to cover home and community-based services sufficiently so individuals would have the option to receive care in the most integrated setting appropriate for their needs.

Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR § 435.601)

CMS is proposing to allow states to target income and/or resource disregards for discrete subpopulations within the same non-MAGI eligibility groups by eliminating the

---

[10] Centers for Disease Control and Prevention (CDC). "Disparities in Oral Health." https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm (Last visited Jan. 4, 2024).
[11] Nat. Acad. For State Health Policy, *State Medicaid Coverage of Dental Services for General Adult and Pregnant Populations* (Oct. 20, 2022), https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/.
[12] *Id.*
[13] Angela R. Elam et al., *Disparities in Vision Health and Eye Care*, 129 OPHTHALMOLOGY 89 (2022).

regulatory comparability requirement in 42 CFR § 435.601(d)(4). While we support the aim of this proposal, we are concerned about finalizing such a significant change in policy without protections to ensure that states use this flexibility to expand, and not reduce, eligibility. As CMS acknowledges in discussing this proposal, a state could use this flexibility to narrow an existing disregard that applies broadly to an eligibility group. States may find this option attractive when facing budget cuts, which could result in coverage loss for people with disabilities and other populations with high health care needs who are subject to extremely low income and asset limits without these disregards. It is also important to consider that this flexibility, whether used to expand or reduce eligibility, adds complexity to an already complex eligibility system. Complexity leads to inequities in access that particularly harm marginalized communities.

Finally, we are concerned about the timing and placement of this significant Medicaid policy change in the NBPP. Because this rulemaking focuses on Marketplace policy, CMS is likely missing input from important stakeholders who represent people with disabilities and other non-MAGI Medicaid populations directly impacted. Given the short 45-day comment period spanning multiple federal holidays, we are concerned that these stakeholders have not had adequate opportunity to respond to this significant proposal. We strongly urge CMS to solicit additional feedback and consider safeguards to ensure this flexibility is used as CMS intends—to expand eligibility.

Thank you for the opportunity to comment on the NBPP.

Sincerely,

American Academy of Pediatric Dentistry
American Association of People with Disabilities
American Association on Health and Disability
American Physical Therapy Association
Autism Society of America
Autistic Self Advocacy Network
CommunicationFIRST
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation
Justice in Aging
Lakeshore Foundation
Muscular Dystrophy Association
National Association of Councils on Developmental Disabilities

National Disability Rights Network (NDRN)
National Health Law Program
Paralyzed Veterans of America
Special Needs Alliance
The Arc of the United States