

June 29, 2023

Administrator Chiquita Brooks-LaSure  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: CMS–2442–P, Medicaid Program; Ensuring Access to Medicaid Services**

Dear Administrator Brooks-LaSure:

On behalf of the 159,000 members of the American Dental Association (ADA), we are writing in response to the proposed rule, CMS–2442–P, “*Medicaid Program; Ensuring Access to Medicaid Services.*”

We are dedicated to assisting dentists in advancing the oral health of the public and believe that Medicaid plays an essential role in our nation’s oral health safety net. Oral health is also essential to overall health, especially for Medicaid beneficiaries, many of whom are disabled or face other serious health conditions. We appreciate the Centers for Medicare and Medicaid Services’ (CMS) efforts in improving access to care, ensuring quality and health outcomes, and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), and offer the following comments on how this can best be achieved in dentistry. These proposed improvements seek to increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care.

**Rate Transparency Requirements**

CMS notes the relationship between provider payment rates and access to care by proposing greater transparency on provider rates. This includes using an analysis that compares Medicaid and Children’s Health Insurance Program (CHIP) rates for certain services to Medicare rates for those services. While many states make their FFS rates public this proposed rule would require all states to do so in a simplified and uniform manner. CMS will continue to review states’ payment rates for managed care plans annually when states submit contracts for approval but with the benefit of additional data from the new provider reimbursement analyses and monitoring surveys. Greater federal scrutiny on FFS rates would be triggered if states seek to reduce rates for any service in a manner that could significantly diminish access, such as by bringing rates below 80 percent of comparable Medicare rates, and CMS retains authority to withhold federal payments for noncompliance. **We support transparency requirements for FFS rates but urge CMS to improve transparency further by also requiring more granular**

**data within the dental category, such as utilization numbers, median fees, and service frequency. The tendency towards categorizing dental as a whole, without greater breakdowns in data, does not meet the transparency standards CMS seeks to implement more broadly. Further comparisons to Medicare FFS would be inapplicable for dental services. We urge use of commercial data such as federal or state employee dental plan payment rates or FAIR Health data as benchmarks for such comparisons.**

### **Provider Payment**

As CMS notes many times throughout the proposed rule, states are required by law to ensure that FFS provider payment rates 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.” Along with network adequacy and access standards, sufficient provider payments are critical to ensuring Medicaid recipients have access to an adequate network of providers. Current approaches to ensure provider rates are not sufficient and are administratively burdensome for providers and states. They also vary across states. Medicaid has historically paid very low rates to providers creating situations where, in some states, a very small number of dentists serve a very high proportion of the Medicaid beneficiaries. **Corrective actions should be initiated in payments to maintain network adequacy and at a minimum, incentives should be offered.** We support Medicaid programs establishing policies that incentivize any dentist willing to provide a dental home for children from birth to age 5 and providing opportunities for early-career dentists to engage with state Medicaid programs through loan repayment programs for dentists who are willing to treat a disproportionate number of Medicaid beneficiaries. The ADA also supports additional funding such as enhanced reimbursement to dental schools that treat Medicaid beneficiaries.

In addition to the policies put forth by CMS, we are also supportive of allowing dentists to claim a tax credit for the first \$10,000 of services (based on the most recent Code on Dental Procedures and Nomenclature (CDT) codes) and credited at a rate consistent with the dentists’ full fees for that region or state.

We wish to note the strong correlation between beneficiary access to dental services and payment rates. Establishing an adequate dental provider network and setting a minimum payment level are both elements that ultimately translate into timely access for enrollees and dentist participation. There are sound, reasonable principles related to payment that can be tailored to meet the specific needs of states while being uniformly required by all. Two of these concepts are: regular assessments of fees; and establishing parity in payments across eligibility groups.

### *Fee Assessment*

Many states have not revisited their Medicaid dental payment rates for years. (This is important not only in traditional FFS programs, but also in the state-provided fee guidance that is provided to managed care contractors.) When rates do not adjust for the price of inflation or the CPI year

over year, this can eventually become prohibitory to participation, as the provision of care becomes costlier than the associated reimbursement received for delivering the care.

We believe that a CMS requirement for states to conduct regular assessment of fee policies is prudent. The requirement could be to review on, for example, a tri-annual basis so as not to become too burdensome on the state agencies. The states should be required to make publicly available the results of these fee assessments.

CMS could support states by providing information crucial to their assessment, such as rates of inflation and dental CPI. When data is available, state agencies could compare Medicaid payment rates to private insurance rates.

### *Payment Parity*

In states that administer Medicaid programs separately from CHIP programs, it is not uncommon for the provider payment rates to be substantially higher for services rendered to children covered by CHIP compared to those in the Medicaid program. This is discriminatory and perpetuates oral health disparities, as it disproportionately affects lower income families. Establishing payment parity between Medicaid and CHIP and regardless of age promotes health equity, as it reduces the likelihood of one underserved population accessing care at the expense of another. Payment rates for all CMS programs should be on par with other CMS programs, *and* states should benchmark these rates to private insurance rates using state-level FAIR Health data.

Similarly, reimbursement rates for child dental services are typically higher than for the same service delivered for the adult population in Medicaid. In a recent analysis, ADA's Health Policy Institute found that 2020 Medicaid reimbursement rates were 61.4% of private insurance reimbursement rates for child dental services on average in the U.S., as compared to 53.3% of private reimbursement rates for adult dental services.<sup>1</sup>

### **Enrollee Engagement**

CMS is proposing to replace requirements for states to use a Medicare Care Advisory Committee (MCAC) to advise on health and medical services with more broad stakeholder committees. States would be required to create both a Beneficiary Advisory Group (BAG) and a Medicaid Advisory Committee (MAC). While BAG membership would exclusively include current or former Medicaid beneficiaries, their families, or their caregivers, the MAC membership would include BAG members, advocacy or community-based organizations, managed care plans, and other state agencies. **Though we are supportive of creating a broader stakeholder group, we note the proposed rule only makes recommendations to states on provider inclusion. While dental and oral health providers are recommended, we would suggest mandating**

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<sup>1</sup> American Dental Association. Reimbursement rates for child and adult dental services in Medicaid by state. Health Policy Institute Infographic. October 2021. Available from: [Reimbursement Rates for Child and Adult Dental Services in Medicaid by State](#), Accessed March 31, 2022.

**dental providers be part of such groups. Even if a state does not have an adult Medicaid benefit, the mandated dental coverage of the pediatric population must be taken into account for group participation.**

### **Website Improvements**

The proposed rule would require states to update their websites to simplify navigation and ensure the availability of certain types of information such as provider directories, formularies, enrollee handbooks, and information about payment rates and payment evaluation reports. Improvements would be required as quickly as two years from the date of finalization. **We agree with requiring states to have a more simplified, single website with links to specific program and health plan information, explanations of the availability of assistance, and secret shopper survey results to assist enrollees.**

### **Access Monitoring**

Oversight of access to care is important and the proposed rule questions whether additional access standards for states with a fully FFS delivery system may be appropriate as in the managed care proposed rule. We are supportive of efforts to require fully FFS states to use the same standards in managed care, which could include “secret shopper” surveys through which states could assess appointment wait times for managed care enrollees and verify information in provider directories. To further the engagement of enrollees and stakeholders and advance equity goals, the proposed regulations should bolster opportunities for public input at the state level. **Annual “satisfaction” surveys of managed care enrollees would be required, and the ADA would be supportive.**

CMS notes it proposes approaches that states could consider addressing the access issue, such as “increasing payment rates, improving outreach to providers, reducing barriers to provider enrollment” among others. **We fully support these approaches to improve access. Additionally, we believe that an important part of ensuring access for patients is reducing administrative burdens, especially audits, for dentists so that they enroll and stay in Medicaid. Any necessary audits should be conducted by a dentist who has the similar educational background and credential as the dentist being audited, as well as a license in the state in which the audit is being conducted. The ADA also supports efforts to ensure that each state establish a designated Provider Advocate position to conduct educational sessions for participating providers and provide ongoing technical and navigational support.**

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Thank you again for your commitment to Medicaid and for the opportunity to comment on this important rule. We would welcome the opportunity to meet with you to discuss how the ADA can assist CMS in meeting the challenges outlined here on Medicaid and dentistry. If you have any questions, please contact Mr. David Linn at 202-789-5170 or [linnd@ada.org](mailto:linnd@ada.org).

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Sincerely,

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President

Raymond A. Cohlma, D.D.S.  
Executive Director

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