

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–2439–P, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

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–2439–P, *“Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality.”*

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. Additionally, oral health is an essential part of overall health, especially for Medicaid beneficiaries, many of whom are disabled and face other serious health conditions. We appreciate the Centers for Medicare and Medicaid Services’ (CMS) efforts to improve access to care, quality, and health outcomes, as well as better address health equity issues for Medicaid and Children's Health Insurance Program (CHIP) managed care enrollees and offer the following comments on how this can best be achieved in dentistry.

Rate Transparency Requirements

The rule proposes that for Medicaid managed care plans, payment rates would not be shared publicly each year, but plans would provide the state with comparisons of their total Medicaid and CHIP payments for these service categories against what Medicare Fee-For-Service (FFS) would have paid. Both the FFS and Managed care analyses would be public and account for rate variations based on provider type, geographical location, site of service, or age of the beneficiary (i.e., adults vs. children). **We support transparency requirements for managed care 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

Acknowledging the role of provider payment in promoting access and not having national data regarding Medicaid provider rates, the rule requires states to undertake rate analysis for OB/GYN, primary care, and mental health services. However, the proposal excludes public comparative rate analysis, such as for federally qualified health center (FQHC) and rural health clinic (RHC) rates, stating that federal rate-setting standards apply to these providers. We would like to see evidence that a wide rate variation does not exist before precluding these centers from a comparative rate analysis. Further, for dental services we are unaware of federal rate setting standards.

The proposed rule would use Medicare rates as the benchmark while acknowledging that a Medicare comparison does not work for all services, such as dental and especially for pediatric services. **We wish to emphasize that comparisons to Medicare FFS are not applicable for dental services. Instead, Medicaid rates should be compared to commercial market rates or FAIR Health data in each geographic area.**

Although the rule requires publication of rates, it does not require states to take corrective action in the case of very low rates especially when they impact network sufficiency and quality of care. **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 above, 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 applaud CMS for noting "that provider payment rates in managed care are inextricably linked with provider network sufficiency and capacity" as there is a 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.¹ The authors of this analysis note that *"the data were collected from Medicaid fee-for-service (FFS) reimbursement rate data from state Medicaid program web pages in December 2020. Many state Medicaid programs contract with managed care organizations to administer dental services and therefore do not pay dental care providers via the publicly available FFS schedule. The lack of transparent, publicly available data on reimbursement rates within managed care programs presented a significant limitation to our analysis, as we were not able to include such data in our analysis. While Medicaid FFS reimbursement rates are intended to be a benchmark or guide for managed care*

¹ 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.

organizations, it is unclear whether this happens in practice.” Thus, rate transparency within managed care is critical to even begin to understand issues around access.

State Directed Payments (SDP)

While CMS seeks to overhaul SDPs by reigning in increasingly large, unjustified payments, we note that currently the number of dental providers receiving payments through SDPs is a relatively low.² **We are supportive of efforts to increase accountability for dollars directed through SDPs. However, we also strongly support the original intent of creating exceptions for circumstances in which a state may make specified payments to health care providers such as funding to ensure certain minimum payments are made to safety net providers (like FQHCs and dental schools, which provide care to a disproportionately high amount of Medicaid beneficiaries) to ensure access to care or funding for quality payments to ensure providers are appropriately rewarded for meeting certain program goals.** The ability for states to influence managed care plans through SDPs when done correctly and justifiably is overall beneficial to states and their beneficiaries by allowing for these payments to providers as no less than the FFS rate approved in the Medicaid state plan or to pay a uniform dollar/percentage increase in payment above negotiated base payment rates.

Federal Standards for Measuring Access

CMS proposes a new national standard to promote access in managed care which would set maximum wait times for getting routine appointments for primary care, obstetrics/gynecology, and outpatient behavioral health services and at least one additional service selected by the state. States could also adopt standards for nonroutine visits, allow exceptions to the wait-time requirements, and/or apply more stringent standards than those proposed. We believe in the importance of ensuring that dental plans offered within Medicaid managed care plans include an adequate provider network that meets beneficiary needs. This network must include pediatric dentists, other specialty dental providers, and general dentists. **Should a state choose to select dental as an additional service, we are supportive of using appointment wait times in addition to time and distance standards as a way to measure access.**

Access Monitoring

Oversight of access to care is important and the proposed rule would require ongoing monitoring. This monitoring could include “secret shopper” surveys through which states could assess appointment wait times for managed care enrollees and verify information in provider directories. If plans fail to perform, states would be required to devise “remedy plans.”

To further the engagement of enrollees and stakeholders and advance equity goals, the proposed regulations would bolster opportunities for public input at the state level. Annual

² [Directed Payments in Medicaid Managed Care](#)

“satisfaction” surveys of managed care enrollees would be required, and the ADA supports this requirement.

CMS notes it proposes approaches that states could consider addressing the access issue, such as “increasing payment rates to providers, improving outreach and problem resolution to providers, reducing barriers to provider credentialing and contracting, providing for improved or expanded use of telehealth, and improving the timeliness and accuracy of processes such as claim payment and prior authorization.” **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 a 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 managed care entity establishes a designated Provider Advocate position to conduct educational sessions for participating providers and provide ongoing technical and navigational support. As CMS seeks to mandate every state establish a uniform credentialing and recredentialing policy that requires each plan to follow those policies, we strongly urge inclusion of dental providers within these policy updates, wherein processes and timelines should be benchmarked against private carriers. All MCO’s and PAHP’s within a state should share a single system for provider data collection and ensure that re-credentialing cycles are aligned to reduce administrative burden.**

We also support CMS in requiring states to have a remedy plan within 12 months if issues are identified, and further by requiring that steps be taken by states to address issues for another 12 months by requiring revisions to the remedy plan if warranted. We agree with CMS that this proposal would improve access and is critical to ensuring that the state’s and managed care plans’ efforts are effective at addressing the identified access issue.

Medical Loss Ratio

While there is no federal requirement pertaining to Medicaid plans as there is for insurers and employer plans under the Affordable Care Act, states have discretion to require remittances under Medicaid plans. **We note that President Biden’s FY 2024 Budget proposed requiring Medicaid managed care plans meet an 85% minimum MLR and would require the states to collect remittances if plans fail to meet the minimum MLR, efforts we support.**

In this rule, CMS assumes that states will determine their actuarial rates consistent with an 85% MLR. To stop plans and states from raising their MLRs and distributing additional funds to certain network providers unrelated to care or quality improvement, CMS proposes to stop inclusion of any payments not tied to permissible MLR activities and instead creates new, detailed, compliance procedures for showing MLR integrity. **We support efforts seeking further transparency in these payments.**

Separately, as we have previously noted, in January 2022, the Medicaid and CHIP Payment and Access Commission (MACPAC) published an issue brief, [Medical Loss Ratios in Medicaid Managed Care](#), in which they detail the implementation of MLR requirements within Medicaid managed care organizations (MCOs) and state that “*MLR requirements went into effect in 2019, and data on plan and state experience with them is expected to be available in 2022.*” In September 2022, the Health and Human Services’ Office of Inspector General (OIG) issued a [report](#) reviewing 495 annual MLR reports that it obtained from states for completeness, to see if these reports contained the seven required data elements: claims costs; non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; calculated MLR; and member months. Close to half (49%) of the MLR reports submitted by MCOs in 28 states were incomplete and missing at least 1 of the 7 required data elements, thus allowing the reporting requirement to become optional.

The OIG report made a number of recommendations that the ADA agrees with, however, it did not identify the MCOs or PAHPs that submitted the incomplete MLR reports or the states that did not address the reporting gaps. **The ADA encourages CMS to publish this information, which could further encourage the MCOs and PAHPs along with states to meet the requirements. Furthermore, the ADA encourages CMS to publish in a timely manner a state-by-state assessment of MCOs and PAHPs with the percentage of allocated Medicaid funding that is being spent on dental services and asks that CMS require each state Medicaid agency to monitor the specific dental loss ratio among their contractors. Because Medicaid is a critical access point for dental care to millions of enrollees, tracking the correct data is important to ensuring Medicaid enrollees are getting the dental care they need going forward. In summary while all dental PAHP’s should report their MLR, any MCO that includes dental services should report the dental component of their MLR separate from the medical services especially in cases where the provision of dental services is subcontracted by the MCO.**

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.**

Mandatory Medicaid and CHIP Core Set Reporting

CMS is seeking to establish intent with this proposed rule to align with the stratification factors required for Core Set measure reporting, believing that it would minimize state and health plan burdens to report stratified measures. To further reduce burdens on states, CMS would permit states to report the same measurement and stratification methodologies and classifications as those proposed in the Mandatory Medicaid and CHIP Core Set Reporting proposed rule and the

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Ensuring Access to Medicaid Services proposed rule. **We fully support aligning the stratification factors for Core Set Reporting along with enrollees having greater access to more detailed quality measures. We also would support dentists having access to those quality measures.**

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.

Sincerely,

George R. Shepley, D.D.S.
President

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

GRS:RAC:dl