CMS Request for Information (2022)

Access to Coverage and Care in Medicaid & CHIP

<mark>*(Note for reviewers: Additional information about the RFI is available at*</mark>
<mark>*https://www.medicaid.gov/medicaid/access-care/index.html.)*</mark>

https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk

Respondent Information

Tell us about yourself! I am an organization.

Organization Type: Non-profit

Organization Name: American Dental Association

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Respondents are not required to supply personal information, other than that necessary for self-identification. We may or may not choose to contact individual respondents. Such communications would be for the sole purpose of clarifying statements in the respondents' written responses.

Objective 1 <mark>*(Note for reviewers: The ADA will not be responding to Objective 1.)*</mark>

Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

1. What are the specific ways that CMS can **support states in achieving timely eligibility determination and timely enrollment** for both modified adjusted gross income (MAGI) and non-MAGI based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan when applicable.

2. What **additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes**, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

3. In what ways can CMS **support states in addressing barriers to enrollment and retention of eligible individuals among different groups,** which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

4. What **key indicators of enrollment in coverage** should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?

Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income SSI/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. How should states monitor **eligibility redeterminations**, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

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2. How should CMS consider setting standards for how states communicate with **beneficiaries at-risk of disenrollment** and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

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3. What actions could CMS take to promote continuity of coverage for **beneficiaries transitioning** between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

The Agency for Healthcare Research and Quality stated in a 2021 report, "access to dental care and oral healthcare services remains low and has not substantially improved, particularly for people with low income or who live in rural areas."[1] Dental care has the highest level of financial barrier compared to any other health care service, including mental health care and prescription drugs.[2] Cost barriers are the most common barrier to dental care regardless of age, income, or source of dental benefits, yet the data are clear that low-income adults are the most adversely affected. Among adult Medicaid beneficiaries, the second most common barrier is trouble finding a dentist.[3] Adults living in states with extensive dental benefits in the Medicaid program are more likely to access dental care and utilize services.[4] A recent study demonstrated a decline in racial and ethnic disparities in dental utilization in states with extensive adult dental benefits that expanded Medicaid.[5]

CHILDREN TRANSITIONING TO ADULTHOOD

Cost barriers to dental care for children have been reduced in recent years, and the racial disparities in cost barriers to dental care for children have narrowed.[6] This is due in part to EPSDT, which has served a critically important purpose of aligning – to some degree – services and supports for children in Medicaid

and CHIP across state lines. CMS has developed and promoted resources – such as *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*[7] – that have helped state agencies ensure compliance with EPSDT while designing programs that meet the unique set of needs of both beneficiaries and health care providers. EPSDT provided a blueprint for states on designing programs that effectuate comprehensive dental care.

As children transition into adulthood, they experience considerable changes in their Medicaid benefits packages as their eligibility status changes from one categorically needy group to another. In some states, the availability of dental benefits through Medicaid is abruptly curtailed or removed entirely upon reaching the age of 21.[8] These beneficiaries no longer have the security of comprehensive dental care coverage provided by the EPSDT benefit and they become subject to the patchwork of policies on adult dental coverage in state Medicaid programs.[9] Even in states that have "extensive" dental benefits for adults in Medicaid, utilization of these services is much lower than in the privately insured population.

To date, federal policy has suggested that the importance of oral health expires upon reaching adulthood. Dental services are an optional benefit for adults under the Medicaid program.[10] There is no EPSDT-comparable "minimum standard" – let alone a guidebook for what constitutes comprehensive care – for dental care for low-income adults.

It is well understood that making dental benefits mandatory in state Medicaid programs will require the passage of federal legislation. The Medicaid Dental Benefits Act of 2021 (S. 3166)[11,12] was introduced in November 2021. If and when this or a similar bill becomes law, we look forward to partnering with CMS and state Medicaid agencies on the implementation of adequately funded, efficiently-run, outcomes-oriented comprehensive adult dental care in Medicaid programs across the nation.

MINIMUM SET OF SERVICES FOR ADULT DENTAL CARE FOLLOWING EPSDT MODEL

Until that time comes, we suggest that CMS educate state Medicaid agencies on the drastic variation of their programs related to the optional service categories, such as dental care. Researchers have developed classification systems (classifying adult dental benefits as "extensive, "limited," "emergency-only," and "none") to study and track policy changes over time.[13] Oral health policy experts have collaborated to develop tools – like the CareQuest Institute for Oral Health Medicaid Scoring Rubric – that can be used by state policymakers in designing benefits packages that meet the needs of beneficiaries, and define what constitutes a minimum set of dental services for adults in Medicaid. We believe that a dental benefit for adults in Medicaid is essential and the design of adult dental benefits in Medicaid should follow an EPSDT-like model.

COMMUNICATING COVERAGE CHANGES TO BENEFICIARIES

Additionally, given the drastic variation in dental coverage across state lines and the nearly ubiquitous experience that there is at least some alteration in covered services upon reaching adulthood, we recommend that CMS require state agencies to notify beneficiaries of: 1) the upcoming change in their eligibility group at least 120 days in advance; 2) the services (categories and specific) for which they will no longer have coverage and the new service categories for which they will be newly covered; and 3) where and how to access information on finding health care providers in the networks for which they are eligible.

ORAL HEALTH ACCESS FOR FORMER FOSTER YOUTH

There are other critical periods of transition when individuals are particularly susceptible to being unaware of the loss of coverage for some health care services, including dental care. The ADA recently supported a Congressional bill that would expand dental care for former foster youth to age 26 via Medicaid.[14] Such a benefit would give former foster youth the same access to dental benefits as young adults who, under the Affordable Care Act, are able to stay on their parents' insurance until the age of 26. Support in the form of health care coverage would offer security to these young adults as they gain independence, pursue education, and establish their careers.

ORAL HEALTH ACCESS FOR POSTPARTUM PEOPLE

The ADA strongly supports the Oral Health for Moms Act (S.560),[15] which would require dental services for pregnant and postpartum women enrolled in Medicaid and CHIP.[16] Pregnant and postpartum women should be notified in advance of their transition into the largest group of categorically needy adults – which may or may not have adult dental benefits, depending on the state – or out of the program entirely. As noted in our support of this act, "Untreated decay in new moms can translate to their newborn infants acquiring bacteria that puts them at higher risk for severe forms of tooth decay," Furthermore, periodontal disease in pregnancy has been linked to premature labor and low birth weight. This investment in mothers supports the health and development of the youngest Americans.

OPERATING ROOM ACCESS FOR DENTAL CARE FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AND YOUNG CHILDREN WITH EARLY CHILDHOOD CARIES

Individuals with intellectual and developmental disabilities (IDD) – the vast majority of which rely on Medicaid waiver programs for medical and dental care – and their caregivers should be regularly educated on services for which they are eligible via Medicaid and in partnership with the state intellectual and developmental disability (IDD) agency.[17] There is a subset of individuals within the IDD population who rely exclusively on dental care to be delivered under sedation or general anesthesia in operating room settings given the complexity of their medical condition, extensive dental needs, and/or behavioral challenges.

Additionally, young children who have extensive dental needs (such as early childhood caries) also need access to dental care in operating room settings. Pediatric dentists work closely with parents and families on case selection; opting to treat under general anesthesia only when necessary due to the patient's age, ability or inability to cooperate for treatment, and the extensiveness of the therapeutic and restorative need.

In partnership with the American Academy of Pediatric Dentistry (AAPD) and American Association of Oral and Maxillofacial Surgeons (AAOMS), the ADA issued a statement noting that[18] there has been a major decrease in operating room access for dental procedures, with wait times often being six months or more. This is largely due to the lack of a sustainable billing mechanism for dental surgical services in Medicaid and Medicare, as the facility fees do not account for the anesthesia, equipment, additional staffing, medication, recovery services, medical emergency expertise, and infection control that is required in operating rooms.

As such, we urge CMS to establish a new viable facility billing code (HCPCS Level II) for dental rehabilitation surgery. This change in Medicare policy would positively impact the Medicaid programs serving children and adults with disabilities.

For each of these populations, we echo the prior recommendation that CMS require state agencies to notify beneficiaries of: 1) the upcoming change in their eligibility group at least 120 days in advance; 2) the services (categories and specific) for which they will no longer have coverage and the new service categories for which they will be newly covered; and 3) where and how to access information on finding health care providers in the networks for which they are eligible.

IN SUMMARY, WE RECOMMEND THE FOLLOWING TO CMS:
1) In anticipation of a potential mandated adult dental benefit in Medicaid, be prepared to define what constitutes a minimum set of dental services for adults in the Medicaid program, using EPSDT as a model.
2) Establish a new viable facility billing code (HCPCS Level II) for dental rehabilitation surgery in Medicare, as this would increase access to dental care in operating room settings for Medicaid populations with significant needs, such as children with early childhood caries and adults with disabilities with extensive dental needs.

3) Require state agencies to notify beneficiaries of: 1) upcoming changes in their eligibility group at least 120 days in advance; 2) the services (categories and specific) for which they will no longer have coverage and the new service categories for which they will be newly covered; and 3) where and how to access information on finding health care providers in the networks for which they are eligible.
4) Support efforts to educate pregnant women and new moms on the importance of oral health by encouraging and incentivizing state-level Medicaid and WIC agency collaborations. Assist states that offer a dental benefit to pregnant women to measure utilization of dental services among pregnant women.

4. What are the specific ways that CMS can support states that need to enhance their **eligibility and enrollment system capabilities**? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to **eligibility and enrollment system performance** can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

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Objective 3

Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

Comprehensive measurement of access to health care services requires both prospective measures (such as network adequacy and geographic mapping of beneficiaries and providers) and retrospective measures (such as utilization).

Here we describe two measures that are the most basic and most important for measuring access to care: 1) geographic and time/distance access (a measure of potential access), and 2) utilization of services (a measure of realized access). (Please see Objective 4, Question 2, where we note other recommended measures of access.)

Benchmarks should be established using the privately insured population in the state. Minimum standards should be established for each measure that are state-specific and responsive to the population distribution, accounting for variations based on geography, such as rural areas. Rate setting should be risk-adjusted based on the demographics of the covered population of each contracted organization.

Managed care organizations should use commercial utilization rates as the assumption in calculations for rate setting. It should be established in MCO contracts that they are responsible for attaining these benchmarks. When they fail to meet those access benchmarks, the MCO should be subject to a negative incentive. Additionally, a dental loss ratio (DLR) modeled after the ACA's MLR should be instituted for all MCOs. Several states – including Arizona and Massachusetts – have considered legislation on DLR reporting.[19] We see this as a reasonable first step, in the form of information gathering, to assess whether the MLR threshold adopted via the ACA is appropriate for dental care.

GEOGRAPHIC/TIME ACCESS: The ADA has been in regular communication with HRSA regarding the need to refine the definition and designation processes for health professional shortage areas (HPSAs).[20] In its current design, it has many shortcomings, and our concerns previously expressed to HRSA have a direct impact on access to dental care services for low-income populations. Most prominent among those concerns: the provider-to-population ratio currently used by HRSA is not sufficient for measuring potential access or establishing minimum standards. The score designations have been a source of confusion for health centers and dentists alike.

The ADA Health Policy Institute (HPI) developed an alternative approach for measuring geographic access to care that is empirically-driven and beneficiary-centric.[21] For each state, HPI mapped the share of the population who were Medicaid beneficiaries, the dental locations that were participating in Medicaid, and the travel time to a Medicaid-participating dental office. We suggest a similar geo-mapping methodology be employed to evaluate access to care for the Medicaid population. We would be pleased to support HRSA and CMS in this effort.

Given that improved access to health care services is an important goal in the pursuit of improved oral health, which will require that current non-utilizers are connected to care, it is also imperative to assess the availability and willingness of Medicaid-participating dentists to accept *new* Medicaid patients.

A refined HPSA program could create clarity for health centers (that often feel limited based upon their designated HPSA score) and providers (who may worry about changes in scores that would force their relocation as part of loan repayment programs). A more straightforward scoring system may assist with geographic distribution of dentists.

UTILIZATION: The percentage of Medicaid beneficiaries (enrolled for at least 180 days) who received at least one dental service within the year should be measured annually. This measure developed by the Dental Quality Alliance for the pediatric population has been endorsed by the National Quality Forum.[22] It could be similarly applied to the adult population.

Past research showed that dental utilization – the percentage who visited a dentist with a year – among the privately insured adult population was roughly 50%, yet it was only 20% among adult Medicaid beneficiaries.[23] More recently, researchers from the ADA Health Policy Institute used T-MSIS data to compare utilization rates among adults by extensiveness of adult dental benefits in states and found that there was a higher share of Medicaid beneficiaries who were accessing dental care in states with more robust benefits packages. The average utilization among adults in states with extensive Medicaid benefits was about 28% compared to 9% in states with emergency-only dental benefits.[24] The average utilization among children is about 52% from a DQA analysis of 29 states.[25]

The subpopulation of Medicaid beneficiaries who are *not* utilizing dental services – i.e., not accessing dental care – needs to be studied on a regular basis. This population should be characterized based on demographic and social information (i.e., age, gender, race and ethnicity, income level, family size or structure, employment status, education level, availability to secure time away from work and/or childcare, etc.). Other area factors impacting access to care should also be studied (e.g., distance from Medicaid providers accepting new patients, transportation options in the area, extensiveness of the state's adult dental benefit and scope of services, etc.).

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1) Revise measures of geographic access to care. Work with HRSA to deploy a revised health professional shortage area (HPSA) algorithm similar to that used by the ADA Health Policy Institute that uses geomapping to locate beneficiaries, providers (with a particular focus on those accepting new patients), and travel options and times to care.
2) Adopt a utilization measure as established by the Dental Quality Alliance and endorsed by the National Quality Forum: the percentage of Medicaid beneficiaries enrolled for at least 180 days who received at least one dental service within the year. Use this for both children and adults.
3) Benchmark access measures against the privately insured population. Encourage states to adopt a rate setting process within managed care that is sensitive to the desired utilization level for various sub-populations with negative incentive if benchmarks are not met. Encourage states to adopt a loss ratio requirement within the dental contracts.
4) Incentivize states to study and target outreach and programmatic efforts toward populations that are *not* accessing dental care and are not utilizing dental services. These populations should be characterized based on demographic and social information, and relevant area information (e.g. transportation options, adult dental benefit level, etc.) should be included in these studies.

2. How could CMS **monitor states' performance against those minimum standards**? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

BENCHMARKING

In the initial development of benchmarks, the ADA recommends that CMS reference historical trends in the privately insured population in the state. Measures should be produced at the state level, and within each state by age group, gender, race and ethnicity, geography, insurer, and plan. Additionally, benchmarks need to be evaluated for each re-measurement period (i.e. annually or quarterly; assessed at a uniform interval for consistency; determined by needs and capacity of the state) to avoid undermining strides in quality improvements.

ACTIVE MONITORING, COMMUNICATION, AND SUPPORT OF STATE MEDICAID AGENCIES

In 2017, CMS issued a notice to the Minnesota Department of Human Services citing serious concerns related to insufficient access to dental services for children and poor provider participation among dentists.[26] CMS alerted the state agency to potential noncompliance with the Social Security Act and EPSDT and stated that the agency was at risk of losing federal support for their program.

While this was an unfortunate situation, we applaud CMS's oversight and encourage CMS to continue to monitor state programs in this way, actively identifying which states need support and working alongside the state agencies as they make improvements. As CMS suggested, Minnesota raised fees and the provider community has been working closely with the Medicaid agency to improve provider participation and therefore access to care.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1) Work with states to establish benchmarks, initially using historical trends in the privately insured population in the state. Produce measures at the state level, and within each state by age group, gender, race and ethnicity, geography, insurer, and plan. Re-measure on a quarterly or annual basis, based on the needs and capacity of the state.
2) Continue to monitor state performance in terms of beneficiary access to care, proactively communicate with states regarding shortcomings and concerns, and support states in their remediation.

3. How could CMS consider the **concepts of whole person care[5] or care coordination** across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?
[5] Under a "whole-person" philosophy, individuals with chronic physical and/or behavioral health conditions are provided linkages to long-term community care services and supports, social services, and family services, as needed. State Medicaid Director Letter #10-024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd10024.pdf

INTERPROFESSIONAL COLLABORATION FOR WHOLE PERSON CARE

In 2018, there were 112 million people in the U.S. who had a medical visit but not a dental visit, and 28 million who had a dental visit but not a medical visit.[27] There is significant room for improvement in medical-dental integration and interprofessional partnerships that promote whole person care. Medicaid agencies should be promoting, supporting, and rewarding providers for referrals made to other service areas for which the beneficiary needs care.

CARE COORDINATION FOR WHOLE PERSON CARE

Additionally, many managed care organizations now employ care coordinators to help address access barriers and health-related social needs among certain beneficiary populations, such as those with intellectual and developmental disabilities. To our knowledge, there is limited evaluation data on the

effectiveness of these programs. It could be a worthwhile endeavor for state agencies to pilot a similar sort of program where the state agency or its contractors hire and train care coordinators – or dental navigators, community dental health coordinators[28] – to connect beneficiaries to dental care.

Establishing a dental home for Medicaid beneficiaries may reduce the use of costly hospital emergency departments. Since 2014, Medicaid has been the most common payer of emergency department visits for dental conditions, and the average cost of each visit exceeds $1200.[29] Each year, there are more than 2 million dental-related emergency department visits.[30] Rates of ED use for dental needs vary by age and state.[31]

RECOGNIZING AND PAYING FOR CASE MANAGEMENT SERVICES

Reimbursement for dental case managers who have training and experience in addressing social determinants of health should be considered. This is administratively possible today in the dental coding system by using case management CDT codes (CDT D9991-4, D9997). However, very few Medicaid agencies recognize nor pay for these services. These dental "navigators" can connect beneficiaries to care with culturally competent strategies which reduce anxiety and improve compliance.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1) Provide guidance to states on incentivizing interprofessional referrals to promote whole person care.
2) Provide guidance to states on opportunities to use care coordinators, dental navigators, or community dental health coordinators to connect beneficiaries to dental care. These programs could be deployed in traditional FFS programs or as a component of contracts with MCOs. The use of and payment for CDT case management codes should be embedded in this guidance.

4. In addition to existing legal obligations, how should CMS address **cultural competency and language preferences** in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

CULTURAL COMPETENCY PROGRAM FOR ORAL HEALTH PROFESSIONALS

A substantial share of the current dentist workforce has likely not had education and training specific to cultural competency. The Commission on Dental Accreditation (CODA) first implemented a predoctoral educational standard on cultural competency in 2013.[32] The DHHS Office of Minority Health developed a free, publicly available Cultural Competency Program for Oral Health Professionals that "provides oral health professionals with basic knowledge and skills related to cultural and linguistic competency."[33] The Oregon Health Authority has a cultural competency requirement for health care professionals, and this course meets the criteria set forth in their policy. States could be incentivized to have the providers in their network successfully complete the course, including the posttest assessment. If states were to perform poorly on access measures specific to certain diverse subpopulations, the OMH course could serve as one component of a remediation program, by requiring a designated share of the provider network – such as 70-80% -- to complete the course.

COMMUNITY DENTAL HEALTH COORDINATORS

Specifically trained Community Dental Health Coordinators (CDHCs) can also support providers and sites of care in offering more culturally competent care and bridging language gaps between patients and providers. CDHCs are trained to provide oral health education in plain language to children and adults, and have been successful in improving the rates of completed dental appointments in community-based settings. [34, 35]

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1) Incentivize states to have dentists in network successfully complete the Cultural Competency Program for Oral Health Professionals.

2) Provide guidance to states on opportunities to use care coordinators, dental navigators, or community dental health coordinators to connect beneficiaries to dental care, and to support providers and sites of care in offering more culturally competent care and bridging language gaps between patients and providers.

5. What are specific ways that CMS can support states to **increase and diversify the pool of available providers** for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

RACIAL AND ETHNIC DIVERSITY OF THE DENTIST WORKFORCE: The racial and ethnic profile of the dentist workforce does not reflect the U.S. population. Black and Hispanic dentists are significantly underrepresented while Asian dentists are significantly overrepresented.[36] Research indicates that some practice patterns and career choices are associated with race. For example, Black dentists are more likely to participate in Medicaid than White dentists. As noted by other researchers, "workforce diversity is an essential component of any strategy to address oral health care disparities."[37] The ADA is eager to work with others on programs that can expose young people to the opportunities offered by a career in dentistry, perhaps via amplifying pipeline programs like the Summer Health Professions Education Program (SHPEP). We suggest CMS consider setting targets for state agencies' Medicaid provider networks to progress toward reflecting each states' racial and ethnic profile.

TELEDENTISTRY: Teledentistry has the capability of expanding the reach of a dental home to provide needed dental care to populations experiencing distance barriers. These encounters typically involve a dental hygienist who is on site with the patient, expanding the reach of dental professionals and increasing access to care. Having teledentistry-capable dental teams can reduce wait times for initial visits, expedite treatment planning and treatment delivery, and triage cases based on needs of the population being served. The virtual dental home model of California has been very successful in bringing care to where people are – their schools, residential facilities, etc.[38] The concept is being replicated in states across the country, such as in Colorado where a pilot project used a "hub and spoke" model to create virtual dental homes throughout the state.[39]

In an ADA Health Policy Institute (HPI) survey in April of 2020,[40] 25% of dentists indicated they were using virtual technology/telecommunications for remote, problem-focused evaluations to expand access to care while the vast majority of dental offices were closed due to the COVID-19 public health emergency. A few months later in July 2020,[41] the share of dentists using virtual technology/telecommunications for problem-focused evaluations dropped in half to 12%. HPI polled dentists on their use of virtual technology and telecommunications more generally in February 2021,[42] and found that 37% were using virtual technology in practice for a variety of purposes. Twenty-five percent of respondents were using it for triaging emergencies; 21% said they were using it for postop and follow-up care; 18% reported using it for consults; 12% reported using it for patient education; and 4% said they used it for orthodontic checkups.

While the use of teledentistry has not "stuck" to the degree that many expected it would in the spring of 2020, some dentists clearly are using these tools to expand their reach and better serve their patients. The care provided is equivalent to in-person care, and as such, insurer reimbursement of services (including in Medicaid and CHIP) must be made at the same rate that it would be for the services when provided in-person. This should include reimbursement for the teledentistry CDT codes as appropriate. Federal and state policy will continue to shape the utility and feasibility of these technologies in dental care delivery.

LICENSURE PORTABILITY: The ADA has been working with other partners via the Coalition for Modernizing Licensure[43] to support professional mobility and promote license portability in an effort to increase access to care. The mission of the Coalition is to ensure patient safety, increase access to care, and promote professional mobility by modernizing the dental licensure process. The member

organizations – representing a wide range of local, state, and national interests, all committed uniquely to improved access to dental care – include: dental associations, schools, and specialty societies; national and state dental hygienist associations; community colleges with dental assisting programs; as well as the HRSA-funded Center for Health Workforce Studies. Licensure reform could reduce credentialing burdens for providers, lowering the amount of effort and time required of providers to serve Medicaid and CHIP patients in other (typically neighboring or nearby) states. Medicaid agencies are usually very supportive of policies that promote licensure portability that can assist with network adequacy, but they lack the support and expertise in working with their state boards to bring this to fruition. CMS should provide tools to state agencies to help them engage with state professional boards and to implement policies that promote licensure portability.

EPSDT

As previously noted, we believe EPSDT has been hugely successful in reducing oral health disparities among children. It has also provided a guidebook for states in terms of the design of their benefits program for children covered by Medicaid and CHIP. We believe the lessons from EPSDT – namely, the power of providing a consistent, yet flexible minimum standard for the design of benefits programs across states – should be adapted to improve Medicaid dental programs for low-income adults.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1) In an effort to diversity the health professional workforce, consider setting targets for state agencies' Medicaid provider networks to progress toward reflecting their state's racial and ethnic profile.
2) Support payment parity for services delivered via teledentistry. Provide guidance to states on the importance of recognizing and paying for teledentistry CDT codes, D9996-7.
3) Develop subject matter expertise within the agency that can assist state agencies with their discussions and negotiations with state licensing and professional boards to promote licensure portability.
4) Use EPSDT as a model in the development of consistent, yet flexible minimum standards for adult dental benefits in Medicaid programs.

Objective 4

CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. What should CMS consider when developing an **access monitoring approach that is as similar as possible** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide **technical or other types of assistance to support states in standardized monitoring and reporting** across delivery systems in areas related to access?

A recent MACPAC brief on access to health care services provided national statistics on the use of various health care services, emergency room utilization, having unmet health care needs; and needing to delay care due to access barriers. There were breakdowns by age and by race and ethnicity.[44] These are important measures to track. This analysis used data from the National Health Interview Survey (NHIS). NHIS and other national datasets – such as the Medical Expenditure Panel Survey (MEPS) – have been useful for measuring the population's ability to get needed care without delay. However, few of these datasets are representative at the state level and therefore have limited utility when comparing and establishing best practices for state Medicaid programs. It is incumbent upon CMS to lead the way in developing a uniform approach for states to monitor access to care.

We are aware of efforts to identify oral health measures for use within the Medicaid and Children's Health Insurance Program (CHIP) Scorecard, Quality Reporting System for Medicaid Managed Care, Marketplace Quality Reporting System (QRS), and Core Set of Health Care Quality Measures for Adults and Children apart from MIPS. The alignment of measures used across programs must remain a top priority. The ADA strongly encourages CMS to adopt standards as established by the Dental Quality Alliance (DQA) to implement uniform measurement and reporting requirements.

Through the DQA, the ADA has been committed to pursuing coordinated, meaningful, standardized, and parsimonious measurement. DQA was initially convened by the ADA at the request of CMS. DQA is the only comprehensive multi-stakeholder organization in dentistry that develops dental quality measures through a consensus-based process. Thirty-eight national organizations with oral health experience participate in the DQA along with a member of the public. DQA has developed valid, reliable, and feasible claims-based population-focused measures for oral health[45] that have been endorsed by the National Quality Forum (NQF). Further, through access to T-MSIS data, DQA has been developing state-level infographics on oral healthcare quality for pediatric Medicaid beneficiaries.[46] These first-of-their-kind infographics are our initial attempt to understand oral health care quality. As the CMS access monitoring program is established, we urge the agency to embed the measures into T-MSIS reporting mechanisms for ongoing study and evaluation. The DQA is in the process of releasing a measurement dashboard based on our research applying the DQA measures to the TMSIS data. The findings are anticipated to be released in Q2, 2022. This effort could further inform the quality reporting systems under development.

Furthermore, we urge CMS to work with the DQA in the identification and endorsement of other standardized tools for measuring the beneficiary experience, such as the CAHPS Dental Plan Survey (measuring beneficiary satisfaction with service delivery among those who successfully access services)[47] and the Oral Health Impact Profile (OHIP-5, a validated instrument for assessing oral health-related quality of life).[48]

Additionally, it is important that access to care is monitored across all delivery systems, contractors, and plans within each state for any inconsistencies that could be targeted. For instance, there is emerging research on the short-term impact of transitioning from fee for service to managed care for dental programs. Our findings indicate that dental care utilization and share of beneficiaries with a dental claim both declined following adoption of dental managed care, especially in the first few quarters after implementation. This suggests there needs to be better transition planning and that best practices should be established as more and more states move more beneficiaries into managed care. Too many beneficiaries fall through the cracks during these transition periods and are disconnected from their usual sources of care, at least temporarily.[49] Regardless of any contractual relationships, the ultimate responsibility for beneficiaries' access to care rests with state Medicaid agencies.[50] State Medicaid agencies must perform readiness assessments when considering these significant changes to their program operations.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1. Quality Reporting Systems are being established for the Marketplaces, Medicaid and CHIP and Manage Care programs independently. CMS must support alignment of measures across all its programs.
2. As CMS prepares to lead the way in developing a uniform approach for states to monitor access to care, we encourage adopting the standards established by the DQA. These measures are valid, reliable, feasible, claims-based, population-focused measures of oral health that have been endorsed by the NQG.
3. Identify and endorse standardized tools that states can use to measure beneficiary access and experience with dental care and oral health, such as CAHPS and OHIP-5.
4. Embed all measures into T-MSIS reporting mechanisms for evaluation.
5. Evaluate managed care contract proposals for proactive measures to ensure beneficiaries do not get disconnected from care in any transition process.

2. What **measures of potential access**, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the **robustness of provider networks across delivery systems** (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

As previously mentioned, cost is the top reason for not having a dental visit regardless of income, age, or source of dental benefits. Among Medicaid beneficiaries, trouble finding a dentist is a close second.[51]

An ADA developed resource has identified several important aspects of provider networks and network adequacy, which should be considered at the profession and at the specialty level.[52]

NETWORK ADEQUACY:
- % of network meeting state time/distance standard, broken down by specialty type (e.g., general dentists, pediatric dentists, oral surgeons, etc.) (See Objective 3, Item 1 on geomapping. Example standards may be "15 minutes travel time to a general dentist.")
- % of network accepting new patients
- Average wait time for an appointment for new patients in relation to a state standard
- Average wait time for routine appointments for patients of record in relation to a state standard (e.g. 10-14 days)
- Average wait time for urgent appointments in relation to a state standard (e.g. 48 hours)

PROVIDER PARTICIPATION: A recent analysis by HPI measured provider engagement with Medicaid using the distribution of dentists by the number of unique Medicaid beneficiaries served and found significant variation across states.[53] Other researchers have studied provider engagement using the distribution of dentists by the dollar amount of Medicaid claims. As such, we recommend the following.

- % of all licensed, practicing dentists in the state who are enrolled as Medicaid providers
- Distribution of dentists by the number of unique Medicaid beneficiaries treated in the year (such as: 0, 1-9, 10-99, 100+)
- Distribution of dentists by the number of and/or dollar amount of claims

IN SUMMARY, WE RECOMMEND:
1. Adopt the aforementioned specific measures pertaining to network adequacy and provider participation as the standard for state reporting.

3. In what ways can CMS promote a more standardized effort to **monitor access in long-term services and supports (LTSS), including HCBS programs**? For example, how could CMS leverage the draft HCBS measure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?

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4. How should CMS consider requiring states to report standardized data on **Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes** that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?
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5. How can CMS best leverage **T-MSIS data to monitor access** broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to better assess access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?

T-MSIS

The availability of the T-MSIS data system has been a game-changer in health services research as we strive to better understand the health care experiences of Medicaid beneficiaries. Our research teams at the ADA – particularly in the Dental Quality Alliance (DQA) and Health Policy Institute (HPI) – look forward to ongoing study as more years of data are released, and as the data quality improves over time, as has been demonstrated by the DQ Atlas. The DQA is in the process of releasing a measurement dashboard based on our research applying the DQA measures to the TMSIS data. The findings are anticipated to be released in Q2, 2022.

MANAGED CARE FEE DATA

With the rising cost of health care, many research endeavors have attempted to assess the value of delivered care. We too have done research that requires studying fee data. It has been extremely challenging to do so, given that so much of the Medicaid population is now covered in managed care and the associated fee data is largely proprietary and not available via T-MSIS. There should be no proprietary data in Medicaid. In order to assess the cost effectiveness of services, plans, and delivery system, there must be some element of transparency built in for managed care fee arrangements. We believe this to be a reasonable request given that these contracts are publicly funded, and we appreciate

that this will require the input and collaboration of many parties as we work toward greater transparency in these public-private arrangements.

DATA COLLECTION AND REPORTING

Additionally, as we continue to study disparities in health care, particularly among Medicaid beneficiaries, it is exceedingly important that CMS continues to work with state Medicaid programs to improve data collection, reporting, and availability, particularly in these areas:

1. Diagnostic coding. Until dentistry adopts the practice of diagnostic coding, it will be impossible to study clinical outcomes. This will require a directive from large payer organizations, such as Medicaid. We suggest that a requirement for diagnostic coding tied to payment of claims be implemented over a series of 3-5 years, with financial incentives from the federal level to support the state, plan, and provider levels for more rapid implementation. The federal portion should be provided up-front, on an annual basis, to state agencies to help cover the cost of these changes. Doing this will require revisiting ICD-10 and ICD-11 for the level of specificity required by dental providers. We would be pleased to work with CMS, the CDC, and WHO in this review and revision process for future iterations of the ICD codebook.
2. Demographics, including race and ethnicity, gender identity, primary language, and more. (For the most recent years of data, more than half of the states have more than half of the observations with missing race and ethnicity. This makes it extremely challenging to study issues pertaining to health equity.)
3. Health-related social needs and SDOH to enable better assessments to promote health equity is important.
4. Provider taxonomy (We are currently severely limited in our ability to assess the services rendered by different provider types.)
5. Linkage of enrollment data to dental managed care organization (This currently inhibits beneficiary attribution to the appropriate managed care organization.)
6. Detailed, procedure-level claims submissions. For instance, it has been challenging in some cases to study care delivered in settings like FQHC/CHCs that have encounter-based billing policies. It is not uncommon for these claims to lack specific procedures completed. Some state Medicaid agencies have worked with their primary care associations to incentivize detailed data reporting on claims forms by FQHC/CHCs; these health care settings are capable of doing so, but they need to be incentivized.

IN SUMMARY, WE SUGGEST THE FOLLOWING:

1. Incentivize dental providers, plans, contractors, and state agencies to report diagnosis using standardized coding systems such as ICD on claims.
2. Require states to report demographic data for beneficiaries.
3. Deploy some method of tabulating health related social needs in the Medicaid population.
4. Improve existing T-MSIS data availability and quality for provider taxonomy and beneficiary linkage to managed care organization.
5. Engage states and managed care organizations in discussions regarding the need for publicly accessible information on fees as charged by MCOs.
6. Encourage and incentivize FQHC/CHCs to submit detailed claims with procedure-level information, even when the center is paid in an encounter model.
7. Continue to improve upon the data quality (completeness, accuracy, etc.) in T-MSIS.

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.

1. What are the opportunities for CMS to **align approaches and set minimum standards for payment regulation and compliance** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

The ADA believes strongly that public programs must be sufficiently funded and efficiently administered to ensure access to care. 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.

Dentist participation in Medicaid programs pales in comparison to physician participation nationally,[54] and it varies drastically by state.[55] T-MSIS data has allowed us to study provider engagement more granularly than was possible in the past. Evidence shows that some states have a "wide but shallow" pool of Medicaid providers where many dentists enrolled, but the average number of Medicaid patients per provider is low. Other states have a "narrow and deep" pool of providers where there are fewer dentists enrolled, but there is a greater average number of Medicaid patients per participating provider.

One reason for poor provider participation that has been widely reported is low fees. In Michigan, the Healthy Kids Dental program set Medicaid fees to be on par with PPO plans. In the years that followed, dentist participation increased drastically, as did enrollee utilization of services.

Reasonable reimbursement rates are a necessary, but not alone sufficient aspect of Medicaid programs for increasing provider participation and engagement. Addressing the following could also be effective in bolstering dentist participation in Medicaid programs.

FEE ASSESSMENT: Many states have not revisited their Medicaid dental payment rates for years. (This is important not only in traditional fee for service 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 more costly 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, HPI 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.[56]

STATE SUPPORT NECESSARY: State Medicaid agencies will need programmatic and financial support to implement these measures. It is likely that any significant rate increases for any eligibility group or the program as a whole will need to be scaled up over time.

CMS could consider incentivizing and rewarding states that raise fees, potentially in the form of a temporarily enhanced FMAP with a step-down schedule for a few years following implementation. For example, for any procedure that undergoes a fee increase, the federal share could be raised to 90% for that health care services, phasing down to the states' standard FMAP over a course of 2-3 years.

An enhanced FMAP (that is phased down to the regular level over a predetermined period of years) could provide the fiscal support necessary for implementation and incentivize states to take this action, as was successful for the vast majority of states with Medicaid expansion as a part of the ACA. The federal match is a crucial component of incentivizing states to make these important changes to improve access to care.

Taking these measures would promote the sustainability of these programs, making them more attractive and feasible for provider participation. A program must be adequately funded to meet these needs of beneficiaries. An important intermediary in this "transaction" is the provider, who must receive fair compensation to feasibly be able to care for those with lower incomes in their communities.

BASIC FINANCIAL MEASURES (PMPM): CMS should require states to produce two basic financial metrics on an annual basis for time trend study: the average benefit paid per user (among enrollees who had a dental visit) and the average benefit paid per beneficiary (among all enrollees).

DENTAL LOSS RATIO: We believe CMS should require states to report dental loss ratio (DLR) for managed care dental programs, modeled after the ACA's MLR. Several states – including Arizona and Massachusetts – are considering legislation on DLR reporting.[57] Other states have already been reporting these metrics; California found that the average DLR in 2014-15 was 61%. The dental association in Washington supports a 94% DLR in an effort to ensure a greater share of dollars are spent on care delivery. We see the reporting of DLR as a reasonable first step, a form of information gathering to assess the threshold for DLR to tie to plan/carrier risk and reward in the future.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1. Require states to conduct a regular – such as annual or tri-annual – assessment of their fee policies and make this data publicly accessible.
2. Phase out the discriminatory practice of paying different rates for the same services for different populations or eligibility groups. Payment rates for all CMS programs should be on par with otter CMS programs (e.g. Medicaid and CHIP) and should be benchmarked to state-level private insurance rates (using FAIR Health data, ideally).

3. Incentivize states that raise fees, potentially by using a temporarily enhanced FMAP.
4. Require states to report the dental loss ratio (DLR) for managed care dental programs, modeled after the ACA MLR.
5. Require states to report the average benefit paid per user and the average benefit paid for beneficiary.

2. How can CMS **assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access** and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

The ADA developed a toolkit to support state-level stakeholders in their contracting arrangements with third-party administrators or managed care plans. This resource is meant to guide agencies as they design programs that are not overly burdensome on providers in an effort to promote participation, expand the provider network, and increase access to dentists. *Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract* is publicly available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid-rfp-dental-contract.pdf. While primarily designed to assist Medicaid dental programs with their managed care RFP and contracting processes, many of the metrics suggested in the toolkit for measuring performance can and should be applied to traditional fee-for-service Medicaid programs, as well. The ADA would be pleased to discuss this in greater detail with CMS to see how we can improve the content and/or dissemination of this resource.

In addition, we would like to briefly highlight a few state activities and policies that we believe have been very innovating and promising for expanding access to cares.

CALIFORNIA'S DENTAL TRANSFORMATION INITIATIVE:[58] The Denti-Cal program is paying for risk assessment.[59] When dentists perform and document risk assessments, they are paid a higher fee. This could be considered a step in the right direction toward diagnostic coding and even value-based payment policies.[60] They have established risk-based frequency specifications, where children with high caries risk are eligible for preventive services more frequently, and supplemental payments for services like nutritional counseling are available. This is consistent with the advisory issued by CMS in 2018 on the alignment of periodicity schedules and fee policies.[61][62] The roll-out of this program was targeted in high need areas. The California Dental Association (CDA) has worked very collaboratively with Denti-Cal in the planning and implementation of this, particularly in terms of provider education and awareness. We applaud their efforts and look forward to more states implementing similar policies.

MICHIGAN'S HEALTHY KIDS DENTAL:[63] Healthy Kids Dental of Michigan has been an extraordinary private-public partnership. The program began in 2000 in the 22 most rural counties of MI and expanded to eventually reach all 83 counties in 2016. Delta Dental – led by a dentist who knew the ins-and-outs of the state program – worked collaboratively with Medicaid to design a program that could effectively increase dentist participation and beneficiary access and utilization. Fees were on par with PPO plans. The stigma associated with Medicaid was reduced, as enrollees had insurance card information that could not be distinguished from those with private insurance. Dentist participation increased drastically, as did utilization of services.

LOUISIANA DENTAL FULL MEDICAID PRICING PROGRAM:[64] The Louisiana Dental Association worked with other stakeholders in the state, including LSU School of Dentistry, to incorporate performance goal-based supplemental payments into their managed care program. The goals were designed to address historical shortcomings of the program and have specific target metrics: an increase in the utilization of preventive care (target: 4% annual increase beginning in year 2); increase in services provided to children (target: 10% annual increase); and expanded dental access in underserved rural areas. We applaud their use of need-based goals; not focused on the volume of service delivery and how many procedures are "produced," rather they are targeting expanding care to new populations that have not been connected to dental care in the past.

DENTAL ADVISORY COMMITTEES: In each of these states, dentists have been involved in the design and implementation of these programs, working hand-in-hand with state Medicaid agencies, getting buy-in from all parties involved, and ensuring success and sustainability for the Medicaid programs. This supports the need for a Medicaid Dental Advisory Committee in every state, where dentists, carriers, and consumer representatives convene on a quarterly basis to promote an open line of communication to improve the program and assist the State Medicaid Dental Program Director in the successful administration of the program.

PAYMENT POLICIES COMMENSURATE WITH TIME, EFFORT, and CARE INTENSITY FOR HIGH NEED POPULATIONS: One of the first signals of dentistry's appetite for diagnostic coding lies in the caries risk assessment codes (CDT D0601-D0603). California, as mentioned above, is one of the states that has recognized the value in paying for this service. Doing so encourages dentists to consider risk-adjusted, individualized care plans that promote the delivery of less invasive and less costly care.[65]

Providers should also be compensated for the time and resources needed to care for higher need populations. There is a mechanism for doing this using CDT codes. Reimbursing providers for behavior management (D9920) for and case management (D9991, D9992, D9993, D9994, and D9997) will make it more feasible for dental offices to serve populations with greater health and social needs. These codes support care teams that: need extra time, expertise, or adaptive equipment when caring for people with special needs, as well as those that are working to: address appointment compliance barriers, coordinate care with other providers, offer motivational interviewing for healthy behavior change, and educate to improve oral health literacy.

IMPROVED TOOLS FOR STATE AGENCIES: When states implement innovations like those described above, this often requires a State Plan Amendment, demonstration project, or wavier. It is excellent that CMS had made the SPA[66] and Section 1115 Waiver[67] directories publicly available. We propose the following additions to these directories, in the form of filters:

- Service line categories (e.g. behavioral health, dental care, etc.)
- Populations addressed (such as children, older adults, people with IDD, or pregnant people)

This would help states as they gather information from other states with similar goals; trying to improve certain services for certain populations. The directories would have enhanced functionality and utility to spread innovative programs and lessons learned from state to state.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1. Issue guidance to states on innovative payment models and pilot projects. Some of these innovations include paying for risk assessment and implementing performance-based supplemental payments to managed care plans.
2. Require states to benchmark their Medicaid fees to private fee rates, using the 50th percentile of FAIR Health in the state.
3. Require each Medicaid agency to establish a Dental Advisory Committee.
4. Encourage and incentivize states to pay for services that are commonly needed among high need populations, such as case management codes.
5. Improve search functionality and utility of CMS online tools to promote the transfer of ideas.

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to **assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?**

BENCHMARKING FEES

The ADA Health Policy Institute has analyzed Medicaid fees as a percentage of the private reimbursement rates in each state. In 2020, HPI found that 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.[68]

We recommend employing a similar methodology and using private insurance reimbursement rates – specifically, the 50th percentile of dentist charges in the state as tabulated by FAIR Health – as an appropriate benchmark.

PROBLEMATIC MEDICARE PAYMENT RATES REDUCING ACCESS TO DENTAL SERVICES IN OPERATING ROOMS

There are certain traditionally underserved populations that often rely on dental care delivered in operating room settings due to the complexity of their medical condition, extensive dental needs, and/or behavioral challenges. These include young children with severe early childhood caries, children with special health care needs, and adults with intellectual and developmental needs. There has been a major decrease in operating room access for dental procedures,[69] with wait times often being six months or more. This is largely due to the lack of a sustainable billing mechanism for dental surgical services in Medicaid and Medicare, as the facility fees do not account for the anesthesia, equipment, additional staffing, medication, recovery services, medical emergency expertise, and infection control that is required in operating rooms. As such, we urge CMS to establish a new viable facility billing code (HCPCS Level II) for dental rehabilitation surgery. This change in Medicare policy would positively impact the Medicaid programs serving children and adults with disabilities.

IN SUMMARY, WE RECOMMEND:
1. Require states to use private insurance reimbursement rates – specifically, the 50th percentile of dentist charges in the state as tabulated by FAIR Health – as an appropriate benchmark for fees.
2. Establish a new viable facility billing code (HCPCS Level II) for dental rehabilitation surgery in Medicare, as this would increase access to dental care in operating room settings for Medicaid populations with significant needs, such as children with early childhood caries and adults with disabilities with extensive dental needs.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[6] What actions could CMS take to encourage states to **reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP** while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

[6] Dunn, B, et al. "A denial a day keeps the doctor away." National Bureau of Economic Research. Available at https://www.nber.org/papers/w29010

Dentists who are reluctant to enroll in Medicaid or treat Medicaid patients have cited many concerns with the programs that dissuade their participation: low reimbursement rates; administrative burdens (credentialing processes, verifying eligibility, submission of prior authorization); compliance concerns; no-show rates; lack of clarity regarding benefits packages; unclear or infrequent communication from Medicaid or contractor about policy changes; fear of auditing; transportation barriers faced by patients; and language and cultural barriers.

Many of these burdens are perceived as – or actually are – hurdles that interfere with and time that delays the patient's access to and receipt of care.

To help address some of the common administrative concerns, the ADA developed a template for state Medicaid agencies that are working with third-party administrators and/or managed care plans to design dental programs that are not overly burdensome on the provider. This resource – *Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract* – is publicly

available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid-rfp-dental-contract.pdf. The ADA has also developed "best practices" to support states in creating a Medicaid managed care program environment that is provider-friendly.

As publicly-funded programs, state Medicaid agencies should have the capability of assessing and publicly reporting basic metrics related to the administration of their programs. We recommend that CMS require state Medicaid agencies to measure the following. These should be part of required reporting and ideally built into T-MSIS. Initial years of measurement will serve as the state's benchmark for future years, when incentives and rewards could be built into programs. CMS should support states with clear guidance on administrative reporting. CMS could develop a Data Sharing Toolkit – as was recently done for Child Welfare Agencies[70] – that describes the data elements necessary and requirements for reporting.

CREDENTIALING
- Average number of days from application receipt to credentialing application approval
- Total providers credentialed
- Initial applications: total # received, % approved, % denied
- Re-credentials: # approved, # denied
- Terminations: # voluntary, # involuntary

CLAIMS ADMINISTRATION
- # of claims received
- % of claims: fully approved, partially approved, appealed, denied
- % of claims processed within 30 days
- Payment accuracy

PROVIDER SATISFACTION: Semi-annual survey of network dentists.
% of network dentists satisfied/very satisfied with:
- Billing inquiry assistance
- Appeals/grievance system
- Prompt payment (i.e., claims processed within 30 days)
- Dentist handbook and notification of changes
- EOB communications

Further, we believe CMS should recommend the following to states:

PROFESSIONAL EXPERTISE, INPUT, AND BUY-IN FROM INCEPTION TO EVALUATION:
- Establish a Medicaid Dental Advisory Committee. Every state Medicaid agency should appoint and use an advisory committee that brings together the dentists, carriers, and consumer representatives. There should be quarterly meetings, at minimum, to promote an open line of communication to improve the program.
- Issue a request for information (RFI) prior to any new or renewed contract opportunity to gather input from all stakeholders in the state, including patient/consumer organizations and providers/dentists. (The RFI should serve as a "needs assessment," informing state agencies on the elements that are necessary for a successful program.)
- Licensed dentists should lead administrative teams on utilization review and similar activities.
- Licensed dentists, as a third-party, should be consulted and involved in auditing processes. Auditors should undergo standardized training to reduce variability and unpredictability in the evaluation of providers against program integrity principles. This would promote the objective review of providers in auditing practices. Punitive auditing practices have resulted in amplified fears of participating in Medicaid, exacerbating low provider participation. When the diagnosis, treatment, and billing are within reasonable limits of the Medicaid policies and clinically sound, dentists should not face financial penalties. Auditing practices must be fair and reasonable.

CREDENTIALING

- A state-supported common credentialing entity (e.g. CAQH ProView) that provides a uniform credentialing application that meets all state-specific needs to be used across all contractors should be considered.
  (Note: OTAG invited staff from the ADA and TennCare, the Tennessee Medicaid program, to a November 2021 meeting to discuss how the relationship with CAQH, an endorsed partner that offers online centralized credentialing repository that streamlines processes across carriers and plans, including Medicaid MCOs and contractors. We highly encourage CMS to incentivize state agencies to pursue CAQH ProView as the universal credentialing tool for all Medicaid provider types, not just dentists. TennCare has had great success doing this, resulting in significant improvements in their Medicaid credentialing processes.)
- Process applications within 30 days of receipt of completed application
- When contracting arrangements are initiated (i.e. FFS to MC transition) or undergo a change (e.g. new MCOs established), streamline the re-credentialing with the new contractor – allow those providers previously enrolled to simply opt into the new program/plan
- Allow – but do not require – the participation of providers in as many plans as they are eligible; do not limit their participation to one plan/insurer.
- Additionally, we encourage CMS to work with NCQA to establish guidelines for provisional credentialing. Health care providers who want to serve the Medicaid population in their communities should not delayed in doing so due to administrative checkboxes. A 90-day provisional credentialed status should be issued following a cursory review (i.e. certification that a license has never been suspended or revoked). It should be a reasonable standard for credentialing bodies to process applications within 30 days, and penalties should be instated when a review process exceeds 90 days.

COMMUNICATION:
- Proactive notification of any changes to the programs/plans must be communicated to network providers and beneficiaries at least 60 days in advance. This includes information related to fee schedules, covered service, claims processing, and other terms of the relationship.
- The provider manuals and dentist handbook should be readily available online from the Medicaid agency and/or contracted companies.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:
1. Require state Medicaid agencies to report the aforementioned measures that reflect provider experience with the program in these topics (specifics above): credentialing, claims administration, provider satisfaction.
2. Develop a Data Sharing Toolkit that clearly describes the data reporting requirements and all necessary components to assist states in implementing these new reporting requirements.
3. Require each Medicaid agency to establish a Dental Advisory Committee. This committee should offer input prior to the release of any new contracting opportunity. The Committee should also be involved in setting auditing policies and practices for the state.
4. Promote the use of a uniform credentialing application, such as CAQH ProView.
5. Require that states proactively communicate with their provider networks in advance of any programmatic, administrative, or fees changes.

Other Feedback

Using **this text box**, please provide any additional feedback you have for this Request for Information that does not apply to one of the previous questions.

Answering the captcha is required to proceed.

The ADA is eager to partner with CMS to improve access to dental care for Medicaid beneficiaries. We have subject matter expertise in many of these topics, represented in the ADA Council on Dental Benefits Programs, Council on Advocacy for Access and Prevention, Council on Government Affairs, Council on Dental Practice, and the ADA Health Policy Institute.

As previously mentioned, the ADA developed a Medicaid managed care contracting toolkit. Its contents cover many of the aspects of program design and implementation of interest in this RFI, especially as they relate to "potential access," provider availability and accessibility as an element of access to health care services. This resource – *Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract* – is publicly available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid-rfp-dental-contract.pdf.The ADA would be pleased to work with CMS to review and refine some of these recommendations and considerations, and perhaps repackage under CMS title for greater use across states and greater reach to dentists. The ADA Health Policy Institute would also gladly offer any data or analysis to be repurposed or repackaged for CMS's purposes.

We applaud CMS for the thorough and proactive approach to reviewing current shortcomings in access to healthcare services for Medicaid beneficiaries. We thank you for the opportunity to provide feedback from the dental provider community and look forward to partnering with CMS to address these challenges to improve access to dental care and advance the oral health of the nation.

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