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Analysis and Recommendations for Medicaid Network Adequacy Standards and Enforcement

September 2025

This report was commissioned by the American Dental Association (ADA) to support assessment of the Centers for Medicare & Medicaid Services' (CMS) enforcement of network adequacy standards in Medicaid dental programs.

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Analysis of Medicaid Network Adequacy Standards and Enforcement

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Executive Summary

Federal and state governments share statutory and regulatory authority over Medicaid network adequacy, although historically, enforcement has almost exclusively been left to the states. This has resulted in a significant state patchwork approach to both the management and enforcement of Medicaid network adequacy with lack of transparency for dentists, patients and other stakeholders. **The Centers for Medicare and Medicaid Services' regulatory history between differing Administrations shows there is little consensus over what network adequacy means in practice, how to assess it, and how to enforce standards.**

This report reviews the broad federal statutory and regulatory framework for network adequacy for Medicaid Managed Care Organizations (MCOs) and more recent efforts to regulate fee-for-service Medicaid programs and establish far more transparency for providers and patients. It assesses state efforts to comply with loose federal requirements and to set and monitor state-imposed requirements. **In the absence of strong measurable standards, Medicaid network adequacy has largely been dictated by how the managed care organizations (MCOs) have interpreted regulatory terms and responded to federal and state quantitative requirements. This presents a challenge for federal regulators to assess and enforce state compliance and for states to police themselves.**

This report identifies policy recommendations for consideration on ways to enhance and/or enforce Medicaid network adequacy requirements and dental network adequacy, specifically:

- **Ensure Any Willing Dental Provider Can Participate in Medicaid with Reasonable Contract Terms**: Model after Medicare statute and rules that seek to ensure convenient access standard requirements are in place and that payer contract terms for dentists are reasonable, including reasonable reimbursement. Provide data to demonstrate benchmarks for setting reasonable dental payment rates that can help to attract dentist network participation.
- **Encourage Rural Dental Residency and Other Incentive-Focused Programs to Address Dentist Deserts**: Explore whether programs that provide enhanced payments to other providers for serving in rural and underserved communities can serve as a model to enhance dental network adequacy.
- **Adopt Transparent Metrics**: Encourage states to publish annual reports on provider participation and reimbursement rates as some states have begun to do and as 2024 federal rules envisioned. Such information should be reported by states and made available and accessible on the CMS website. Encourage a different standard for comparing FFS dental rates, given the lack of Medicare coverage and payment for dental services.
- **Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance**: Support implementation of final 2024 federal rule requirements that establish remedy plans for MCOs. Encourage state legislation that sets benchmarks for dental network participation and establishes rewards for plans that meet requirements and imposes fines on plans that are not compliant.

Introduction

In the Medicaid program there are federal and state rules that set parameters around network adequacy in an effort to ensure that Medicaid beneficiaries have timely access to services, including dental care. **For many years, federal statute and rules governing the Medicaid Managed Care Program have outlined a "general expectation" of what network adequacy is supposed to mean. However, the authority for overseeing and enforcing the rules around network adequacy has long been left to the states and largely without any federal interference.** New Medicaid rules finalized in 2024 sought to take a much more proactive federal step into the oversight and enforcement of Medicaid network adequacy, with implications for both managed care plans and fee-for-service Medicaid programs, but whether those rules will be rescinded under a new administration remains unclear. This report provides an overview of the historical and current regulatory framework for dental network adequacy within Medicaid MCOs and Medicaid FFS programs and identifies policy reforms and options that can support dentists and dental stakeholders in working toward Medicaid dental network adequacy improvements.

Study Approach

To consider federal and state Medicaid dental network adequacy requirements, the authors first assessed all federal government requirements for network adequacy in Medicaid plans. The authors reviewed federal laws, regulations, and subregulatory guidance as well as federally-required state reports submitted on state Medicaid network adequacy activities. Federal regulatory review focused on regulations and guidance issued by the federal government over the last ten years (2015-2025). Included in the review was an assessment of Centers for Medicare and Medicaid Services-approved Medicaid waivers and amendments and memorandum concerning state correspondence on network adequacy, and dental network adequacy specifically.

A significant research review was conducted for each of the 50 states and the District of Columbia, including an assessment of state Medicaid regulations that address network adequacy requirements, state government agency memos, reports, and any corrective action plans (CAPs) for addressing network adequacy concerns in relation to dental access. Included was a review of the research conducted by the Medicaid and CHIP Payment and Access Commission (MACPAC), National Conference of State Legislatures (NCSL), national think tanks, policy foundations and others on federal and state actions to address Medicaid dental network adequacy requirements. We undertook an effort to outline each state's dental Medicaid arrangement to understand which states administer their Medicaid pediatric dental benefit and any adult dental benefits on a fee-for-service (FFS) basis; through a comprehensive managed care benefit with a managed care organization(s) (MCOs) with carved in or carved out dental benefits; through dental-only Pre-Paid Ambulatory Health Plans (PAHPs); through a combination of FFS-MCO(s), FFS-PAHP(s), MCO-PAHP(s); or any of these options with the support of a Dental Benefit Manager, Dental Administrative Service Officer or a similar dental administrative entity.

Background

I. Overview of the Medicaid Act (42 U.S.C. § 1396a(30)(A))

Network adequacy standards for the provision of services under Medicaid (42 U.S.C. § 1396a(a)(30)(A)) were passed as part of the Medicaid Act[1] in 1965 and require state Medicaid plans to "provide . . . methods and procedures . . . as may be necessary . . . to assure that payments . . . 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."[2] In other words, this section requires state Medicaid plans to have processes in place to evaluate and ensure that there are sufficient available providers under a Medicaid plan in a particular geographic area at least to the extent available to other people. It's important to note that **federal Medicaid regulations do not explicitly require states to directly compare their network adequacy standards to commercial, employer, or exchange plans when assessing compliance with the statutory requirement to ensure care availability comparable to the general population. However, the regulatory framework creates indirect mechanisms that could involve such comparisons through broader access monitoring requirements encouraged or required by the Centers for Medicare and Medicaid Services (CMS) or states themselves.** Under 2016 regulatory requirements, "the State agency must have in effect a monitoring system for all managed care programs (emphasis added). The State's system must address all aspects of the managed care program, including the performance of each MCO, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), and Primary Care Case Management (PCCM) entity (if applicable) in at least the following areas…Availability and accessibility of services, including network adequacy standards." **While not explicitly requiring network adequacy comparisons, this rule could be amended directly or through CMS guidelines to support a framework where states could analyze geographic distribution of providers serving Medicaid in comparison to exchange markets or commercial populations.**

In its current form, the very broad statutory directive for Medicaid network adequacy has led to great flexibility in the ability for the federal government and state governments to define what is meant by network adequacy through regulation. Regulations implementing the statute have shifted considerably over time, with significant differences in approach depending on the Presidential Administration in office, their policy priorities and philosophies regarding federal engagement and oversight over Medicaid.

Is There Any Relationship Between Federal Medicaid Network Adequacy Requirements and Federal Health Professional Shortage Areas?

Federal Medicaid network adequacy standards and federal Health Professional Shortage Area (HPSA) designations represent two distinct but related approaches to addressing healthcare access challenges.

[1] Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30).
[2] 42 U.S.C. § 1396a(a)(30)(A).

Both frameworks aim to identify areas with provider shortages and ensure access to care for vulnerable populations, and both use quantitative measures, such as provider-to-population ratios, though with different methodologies and thresholds. However, there is no clear direct integration between these two regulatory frameworks.

- Network adequacy requirements ensure health plans maintain sufficient provider networks that allow patients to access covered services without unreasonable delay. These requirements typically include quantitative standards such as provider-to-enrollee ratios, time and distance standards, and appointment wait times.

- Health Professional Shortage Areas (HPSAs) are federally designated areas with insufficient healthcare providers to meet the needs of the population. As of March 2025, there are 7,054 dental HPSA designations covering nearly 60 million Americans.[3]

Several factors limit the usefulness of HPSAs as a direct basis for broadly setting or supporting network adequacy standards. Specifically, according to MACPAC, "the pervasive use of [HPSA/Medically Underserved Area-MUA] designations limits the usefulness of MUAs and HPSAs as a tool for targeting high-need areas. The majority of the United States has received some sort of HRSA designation." That said, **as some states seek to identify policy options for improving dental access and meeting network adequacy requirements, they may want to consider model efforts in Medicare:**

- **Medicare pays a 10% quarterly bonus to physicians who provide services in primary care HPSAs and psychiatrists practicing in mental health HPSAs.[4]**

What is the Responsibility of State Medicaid Agencies and CMS for Meeting These Requirements?

The responsibility for carrying out the requirements of 42 U.S.C. § 1396a(30)(A) is primarily delegated to each state in constructing its state plan.[5] As demonstrated throughout the analysis that follows, there has been considerable deference to states to develop and enforce network adequacy standards.

CMS, however, has exerted oversight of Medicaid network adequacy by referencing its authority over other provisions of the Social Security Act, Section 1932(b)(5) and (c)(1)(A)(i) [42 U.S.C. § 1396u-2(b)(5) and (c)(1)(A)(i)] and Section 1902(a)(4) [42 U.S.C. § 1396a(a)(4)].[6]

- Section 1932(b)(5) requires MCOs to "provide the State and the Secretary [of HHS] with adequate assurances," as determined by the Secretary, that the MCO "offers an appropriate range of services and access to preventive and primary care services," and

[3] Bureau of Health Workforce, Health Resources and Services Administration; Designated Health Professional Shortage Areas Statistics. March 31, 2025.
[4] MLN Learning Network, Centers for Medicare and Medicaid Services; Health Professional Shortage Area Physician Bonus Program. February 2021.
[5] *See* 42 U.S.C. § 1396(a)(30)(A).
[6] *See* Proposed Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098, 31144 (June 1, 2015) ("2015 Proposed Rule").

"maintains a sufficient number, mix, and geographic distribution of providers of services."[7]

- Section 1932(c)(1)(A)(i) requires states to develop a "quality assessment and improvement strategy" which provides that "covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity."[8] Such improvement strategy is required to be consistent with standards developed by the Secretary.[9]
- Section 1902(a)(4) requires state Medicaid plans to include "methods of administration... as are found by the Secretary to be necessary for the proper and efficient operation of the plan."[10]

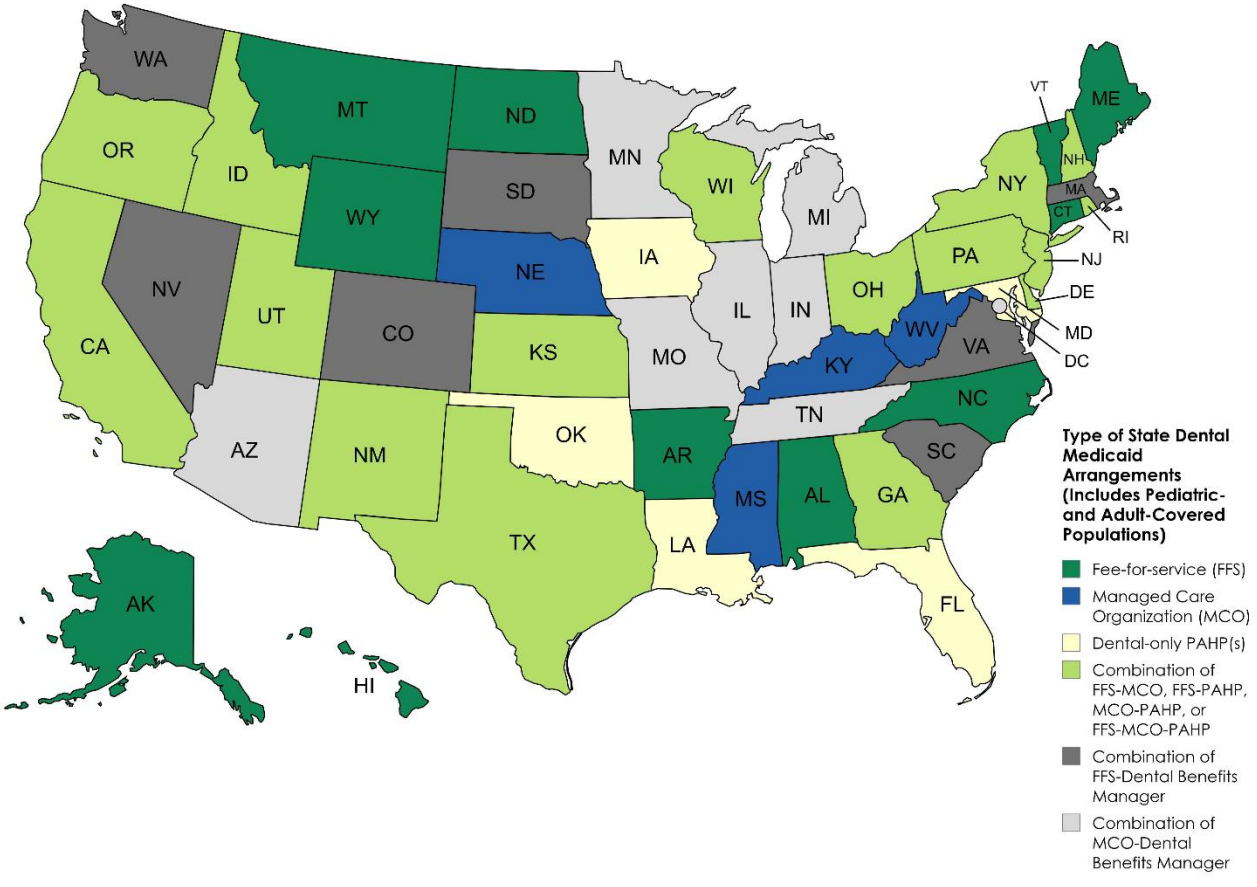
Medicaid Managed Care Versus Fee-for-Service: Disparity in Regulatory Specificity for Network Adequacy

The question of whether federal Medicaid dental network adequacy standards apply to both FFS and managed care delivery systems (of any form) requires a nuanced analysis of regulatory frameworks, historical policy shifts, and rule interpretations over the years. **While managed care plans have been subject to explicit federal network adequacy requirements for years, FFS programs have operated under a distinct set of access assurance mechanisms—a dichotomy that has begun to change course with new regulations finalized in 2024, setting first-time requirements for FFS Medicaid programs.**

Historically, dental Medicaid benefits have been delivered through both FFS and a variety of different MCOs or types of MCOs, with states having flexibility in how they structure their dental benefits, including carve-in, carve-out models.[11] States have considerable flexibility in how they structure their dental benefits, with some states having FFS dental systems within a Medicaid managed care medical delivery system. Some states provide dental services through a dental-only PAHP, a non-comprehensive prepaid limited health plan that provides only certain outpatient services. Other state FFS programs and/or state MCOs will subsequently contract with a Dental Benefits Manager to support the administration and management of the dental Medicaid program.

[7] 42 U.S.C. § 1396u-2(b)(5).
[8] 42 U.S.C. § 1396u-2(c)(1)(A)(i).
[9] 42 U.S.C. § 1396u-2(c)(1)(B).
[10]42 U.S.C. § 1396a(a)(4).
[11] National Conference of State Legislatures, Medicaid Managed Care 101, (Sept. 21 2023), https://www.ncsl.org/health/medicaid-managed-care-101.

Breakdown of State Dental Medicaid Arrangements



Network adequacy requirements under Medicaid managed care are detailed with much more specificity than under FFS Medicaid. Implementing regulations for managed care[12] provide further detail on what is required of states to meet this network adequacy statutory directive. These standards are intended to apply universally to managed care entities that are contracting with states. In contrast, Medicaid FFS programs have historically operated without formal network adequacy requirements, relying only on the broader "equal access" provisions available in statute under 42 U.S.C. § 1396a(a)(30)(A). States are required to ensure payments sufficient to enlist enough providers but faced minimal specificity regarding provider distribution or availability metrics.[13] **Inherent statutory flexibility has permitted significant variability in state network adequacy standards, with some states conducting sporadic access reviews while others relied on compliance-driven oversight.**[14]

It is important to understand that despite the statute requiring that access in Medicaid MCOs be at least as similar to other people's access (presumably as similar as those who are covered under another insurer), 42 U.S.C. § 1396a(a)(30)(A) directs the <u>states</u> to ensure

[12] 42 C.F.R. § 438.68.
[13] Ensuring Access to Medicaid Services—A Guide for States to the Fee-For-Service Provisions of the Final Rule, CMS (2024).
[14] California Health Care Foundation, Network Adequacy Standards in California: How They Work and Why They Matter (Dec. 2021), https://www.chcf.org/wp-content/uploads/2021/12/NetworkAdequacyStandardsHowTheyWorkWhyTheyMatter.pdf.

that network adequacy requirements are met, rather than CMS. CMS exerts discretionary rulemaking authority, but primary authority pertaining to adherence to the statute rests with the states. CMS has discretionarily regulated in this space via its power to approve state plan and state plan amendments, demonstration projects and waivers, and review of state expenditures for compliance with Medicaid law.

What Are the Requirements of 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act as It Relates to Network Adequacy and its Implementing Regulations?

Changing Administrations, Changing Priorities: A Timeline of Key Network Adequacy Developments

2015-2016: Obama Administration Establishes Network Adequacy Regulations

Greater oversight of network adequacy in Medicaid began with the Obama administration with two proposed rules, one related to managed care, released in June of 2015[15] and finalized in May of 2016,[16] and one related to fee-for-service finalized in 2015 and related to proposals first published in 2011.[17]

In the 2016 rule, the administration sought to align requirements governing Medicaid managed care with those governing qualified health plans and Medicare Advantage plans.[18] A major priority of the administration was to determine a state's readiness to implement and sustain managed care programs, which it determined network adequacy was a primary component of. The managed care rulemaking[19] constitutes the primary regulations governing Medicaid managed care network adequacy to this day. The Obama administration stated that these changes were intended to "maintain state flexibility while modernizing the current regulatory framework to reflect the maturity and prevalence of Medicaid managed care delivery systems, promoting processes for ensuring access to care, and aligning, where feasible, with other private and public health care coverage programs."[20] Prior to 2016, Medicaid network adequacy standards were deferred to each state to develop specific standards. CMS relied heavily on attestations and certifications from states about the adequacy of their network.

In the 2015 rule, CMS sought to enable states to transparently "document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A)."[21] This rule implemented standards that were proposed in 2011, but never finalized. In this final rule, CMS emphasized that it aimed to provide "increased state flexibility within a framework to document measures supporting beneficiary

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[15] Proposed Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31098 (June 1, 2015) ("2015 Proposed Rule").
[16] Final Rule, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27498 (May 6, 2016) ("2016 Final Rule").
[17] Final Rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67576 (Nov. 2, 2015) ("2015 Final Rule").
[18] 2016 Final Rule at 27498.
[19] 42 C.F.R. § 438.68.
[20] *Id.*
[21] 2015 Final Rule at 67576.

access to services."[22] **Rather than setting nationwide standards, which the agency stated would be difficult given "limitations on data, local variations in service delivery, beneficiary needs, and provider practice roles," CMS prioritized federal guidelines that would establish a framework for states to document beneficiary access to services.**

Time and Distance Standards

The regulations finalized in 2016 required states to establish "time and distance" standards for Medicaid MCO plans. The regulations do not specify detailed time and distance standards but instead defer to each state to develop specific standards for themselves.[23] In the rule, CMS described "the primary role of states in Medicaid" in articulating its reasoning for this approach. The agency stated that this approach was also consistent with existing requirements for Marketplace plans and qualified health plans.[24] The agency required each state to establish time and distance standards for services including primary care, OB/GYN, behavioral health, specialist, hospital, pharmacy, pediatric dental, and additional discretionary provider types. The agency stated that time and distance standards were "a more accurate measure of the enrollee's ability to have timely access to covered services than provider-to-enrollee ratios."[25] In developing standards, CMS suggested that states look to standards established for the private insurance market, including standards set under the Medicare Advantage program, as well as historical utilization patterns for accessing services.

During the open comment period on the proposed rule, some stakeholders requested that states be required to implement more network adequacy measures in addition to time and distance, such as "enrollee ratios, appointment and office wait times, and beneficiary complaint tracking."[26] However, CMS declined to do so, stating that "states are in the best position to set specific quantitative standards that reflect the scope of their programs, the populations served, and the unique demographics and characteristics of each state."[27] **The agency, at the time, also opined that it would be inappropriate to import Medicare Advantage network adequacy requirements into Medicaid managed care because of the greater level of discretion granted to the states under Medicaid.**

State Monitoring Standards

The 2015 and 2016 rules strengthened state monitoring standards, requiring state Medicaid agencies to create access monitoring review plans[28] that considered beneficiary needs, the availability of care through enrolled providers in each geographic area by provider type and service, changes in utilization in each geographic area, the characteristics of the beneficiary population, and actual or estimated levels of provider payment from other payers.[29] States were required to develop the Access Monitoring Review Plan (AMRP) in consultation with the state's Medical Care Advisory Committee (MCAC), were required to have the plan approved by CMS,

[22] 2015 Final Rule at 67577.
[23] 2016 Final Rule at 27658.
[24] *Id.* at 27658.
[25] *Id.*
[26] *Id.* at 27661.
[27] *Id.* at 27515.
[28] 42 C.F.R. § 438.66.
[29] 2015 Final Rule at 67611.

and had to make the plan available for public review and comment at least 30 days prior to its finalization. Additionally, when access to care issues were identified through AMRPs, states were required to take remediation efforts, the specifics of which were left up to the state. This could include "modifying payment rates; improving outreach to providers; reducing barriers to provider enrollment; and improving care coordination," among other strategies. States are required to review this access information for "primary care services," which CMS specifies includes dental care.

The 2016 rule required states to use data collected from monitoring activities to improve managed care performance, and specified minimum activities that states must implement in conducting monitoring, including: enrollment and disenrollment trends in each MCO, PIHP, or PAHP; provider grievance and appeal logs; and an annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity.[30] State monitoring programs were required to include minimum elements including: provider network management, including provider directory standards; quality improvement; and availability and accessibility of services, including network adequacy standards.

CMS also required states to provide an annual program assessment of managed care plans, including "[m]odifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State," and the "availability and accessibility of covered services . . . including network adequacy standards," in addition to other requirements.[31] The rule also required states to assess the "readiness" of each MCO, PIHP, PAHP, or PCCM it intends to contract with. Some commenters requested that states provide quarterly updates to providers, consumers, and stakeholder groups, however, CMS declined to do so, stating that this was "too prescriptive" and that the annual managed care program assessment was sufficient.[32] Some commenters also requested that CMS require states to establish specific standards for monitoring program elements, including network adequacy standards, but CMS did not adopt this recommendation, emphasizing the importance of state flexibility.[33]

Finally, related to network adequacy in Medicaid managed care, the 2016 final rule established a Medicaid managed care quality rating system (QRS)[34] "to increase transparency[,] . . . increase consumer and stakeholder engagement, and enable beneficiaries to consider quality when choosing a managed care plan."[35]

During this rule making process, CMS also published a Request for Information (RFI) seeking input regarding the future development of access standards in Medicaid.[36] CMS expressed interest in specifically developing "core access to care measures" that could be utilized across both FFS and managed care, setting national access to care thresholds, and creating a process for beneficiaries experiencing access issues to seek resolution.[37] CMS asked specific questions

[30] 2016 Final Rule at 27717.
[31] *Id.* at 27717.
[32] *Id.* at 27718-19.
[33] I*d.* at 27719.
[34] 42 C.F.R. § 438.334
[35] 2015 Final Rule at 27686.
[36] Medicaid Program; Request for Information (RFI)-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program, 80 Fed. Reg. 67377 (Nov. 2, 2015).
[37] *Id.* at 67379.

pertaining to access to care data collection and methodology, processes for access concerns, access to care measures, measures for the availability of care and providers, measures for beneficiary reported access, measures regarding service utilization, and comparison of payments.[38] Of particular note, pertaining to beneficiary access, CMS asked for stakeholder comment on "unmet need for . . . dental . . . due to cost concerns" and pertaining to service utilization, asked for rates of utilization for dental services.[39] No further action was taken on this RFI.

2018-2020: Trump Administration Scales Back Obama-Era Network Adequacy Requirements

In 2018 and 2019, the Trump administration took a considerably different approach to network adequacy than the Obama administration, releasing two proposed rules[40] [41] that would have relaxed requirements pertaining to access monitoring review plans, but these rules were never finalized. The rules would have, among other things, provided a reporting exception for states that had a high managed care enrollment and an exception where the state engages in "nominal" payment rate changes below four percent. It also would have removed the requirement that states submit an analysis where there is a change in payment rates that affects access and instead would require an attestation of sufficient access.[42] CMS reasoned that the current data being collected had "limited usefulness due to many uncertainties inherent to such analyses."[43]

In 2020, the Trump administration issued a new rule intended to allow states maximum discretion in establishing network adequacy requirements. CMS modified the Medicaid managed care network adequacy standards at 42 C.F.R. § 438.68, changing the standard from a "time and distance" requirement to a general "quantitative requirement," as determined by each state. CMS stated that it believed it best not to be overly prescriptive in setting standards after receiving concerns from states that a uniform time and distance standard was not the most effective type of standard for determining network adequacy. Instead, the quantitative standard was intended to be a more flexible requirement.

Quantitative Standards

Examples of quantitative standards that states could use under the 2020 rule (but were not required to use) included: provider-to-enrollee ratios; travel time or distance; percentage of contracted providers accepting new patients; wait times; hours of operation; or a combination of such standards.[44] The agency also removed its discretionary ability to choose other providers that could become subject to network adequacy requirements, noting that "states

[38] *Id.* at 67379.
[39] *Id.* at 67379.
[40] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold, 83 Fed. Reg. 12696 (Mar. 23, 2018).
[41] Proposed Rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold 83 Fed. Reg. 12696 (Mar. 23, 2018).
[42] Id. at 12697.
[43] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, 84 Fed. Reg. 33722 (July 15, 2019).
[44] Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, 85 Fed. Reg. 72754 (Nov. 13, 2020).

have expressed concern that . . . managed care plans may have to assess network adequacy and possibly build network capacity without sufficient time."[45]

Following release of the proposed rule, many stakeholders offered comments strongly encouraging additional guardrails be set for Medicaid network adequacy review, such as a combination of qualitative and quantitative standards; allowing separate standards for urban and rural areas in a given state; setting up routine monitoring requirements; setting restrictions on use of telehealth to satisfy network adequacy requirements; and other factors.[46]

In the published final rule in 2020, the agency declined to establish further standards or guardrails. CMS repeatedly emphasized its deference to states in determining any specifics, reasoning that it "should defer to states and not set Federal standards as prescriptive as the commenters suggest."[47] The agency acknowledged that flexibility could result in widely varied standards being set across states, but it justified such variations given the diversity and complexity of Medicaid managed care programs.[48]

2022-2024: Biden Administration Seeks to Button Up Federal Oversight of Medicaid Network Adequacy; Focuses on Fee-for Service in Addition to MCOs

Beginning in 2022, the Biden administration began efforts to again amend the Medicaid managed care network adequacy provisions, steering standards in an entirely different direction and reversing course from the Trump administration's decision to provide states broad general discretion over these standards.

In February of 2022, the Biden administration first signaled an interest in establishing more stringent federal oversight requirements of Medicaid network adequacy with its release of a RFI concerning *Access to Coverage and Care in Medicaid & CHIP.*[49] The stated goals of the RFI included: reaching people who are eligible under Medicaid and CHIP; providing consistent coverage; ensuring timely, high-quality, and appropriate care; improving access to data to "measure, monitor, and support improvement efforts related to access to services; and providing sufficient payment rates to enlist and retain providers. Questions pertaining to network adequacy in the RFI included:

- What priorities should be focused on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? Should standards be at the national level, state level, or both? How should standards differ by delivery system, value-based payment arrangements, geography, and program eligibility, etc.?
- How could CMS monitor states' performance against any minimum standards?
- In what ways can CMS support states to increase and diversify the pool of available providers for Medicaid and CHIP?
- What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems?

[45] *Id.* at 72802.
[46] *Id.* at 72803.
[47] *Id.* at 72803.
[48] *Id.* at 72803.
[49] Centers for Medicare and Medicaid Services. Request for Information: Access to Coverage and Care in Medicaid & CHIP (Feb. 2022), https://www.medicaid.gov/medicaid/access-care/downloads/access-rfi-2022-questions.pdf.

- What measures of potential access (care availability) should CMS consider as most important to directly monitor and encourage states to monitor (e.g., provider networks, appointment wait times, grievances and appeals, etc.)?

First Expansion of Regulations - Seeking to Modernize Network Adequacy Standards, Oversight and Enforcement

In May 2023, the Biden administration released two proposed rules, the *Ensuring Access to Medicaid Services Rule* ("Access" Rule)[50] and the *Managed Care Access, Finance and Quality Rule* ("Managed Care" Rule), [51] responding to many of the recommendations offered by stakeholders through the RFI issued in 2022. Together, the rules aimed –for the first time– to address access to care in Medicaid across both FFS and MCO delivery systems and authorities. The Access Rule primarily addressed a couple relevant areas of interest to dental Medicaid network adequacy including: documentation of access to care and service payment rates and the establishment of new stakeholder and enrollee advisory committees. The Managed Care Rule primarily addressed many relevant regulatory areas of interest to dental Medicaid managed care: network adequacy; state directed payments; medical loss ratio standards; data and payment transparency; and beneficiary engagement.

Access Rule

<u>New Medicaid Advisory Committee and Beneficiary Advisory Council[52]</u>

Medicaid regulations have long required states to operate "Medical Care Advisory Committees" (MCACs) to allow for stakeholder feedback on Medicaid operations and concerns. The Access Rule fundamentally changed the MCAC structure, renaming the Committee to the "Medicaid Advisory Committee" (MAC) and creating a second entity, the "Beneficiary Advisory Council" (BAC), to allow Medicaid beneficiaries to directly engage state Medicaid agencies, with overlap in membership between the two councils. The MAC membership must include: a consumer advocacy organization, a provider group, a managed care entity, and another relevant state agency (the state agency is in a non-voting role). The rule requires MACs and BACs to meet at least quarterly and the MAC to hold at least one public meeting each year. BACs can choose whether their meetings are public. Assessing Medicaid network adequacy in FFS and MCO plans is expected to be an area of focus for both councils.

Takes Effect: Stood up by July 9, 2025, allowing for membership in the MAC to be built out over three years (2028) to allow for sufficient beneficiary representation on the MAC.

<u>Experience Surveys[53]</u>

Historically, state Medicaid agencies are to consider needed access improvements from agency or MCO surveys, but they have never been required to perform surveys. Under the new rules,

[50] Proposed Rule, Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27960, 27998 (May 3, 2023).
[51] Proposed Rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (May 3, 2023) ("2023 Proposed Rule") ("Managed Care Rule").
[52] 42 C.F.R. § 431.12.
[53] 42 C.F.R. §§ 438.66(b)(4) and (c)(5), 457.1230.

state Medicaid agencies must conduct an annual enrollee experience survey and act on its findings to make any recommended improvements. States can opt to have External Quality Review Organizations (EQROs) conduct these surveys.

The final rules state that survey results must also be included in the required Medicaid and CHIP Annual Program Report (MCPAR) that state Medicaid programs must submit to CMS annually.

Takes Effect: For contract rating periods beginning after July 9. 2027.

Managed Care Rule

Network Adequacy

Provider Directories[54]

Federal law already required MCOs to make provider directories available to enrollees and to update the directories regularly; however, out of concern for "ghost networks," listing providers no longer in network, Congress sought to codify protections,[55] and the final rule implements these protections and expands directory requirements. The final rule provides more explicit terms on what providers must be included, the information that must be in the directory, and the necessity of updating the directory to ensure its accuracy. The directory must provide information for the following types of providers: physicians, hospitals, pharmacies, behavioral health providers, and any additional providers the state has opted to include for its wait time standards (which could include dentists). In addition to the provider's location information, the directories must also include whether the provider will accept new enrollees. Each MCO will be required to make its directory available in searchable electronic form; and indicate whether the provider offers covered services via telehealth. CMS issued a State Health Official Letter[56], explaining provider directory requirements.

Takes Effect: July 1, 2025 and must have provider directories on state websites beginning July 1, 2026.

Wait Time Standards[57]

States are required to develop and enforce appointment wait time standards for four service types: adult and pediatric outpatient mental health and substance use disorder treatment; adult and pediatric primary care; obstetrics and gynecology; and an additional type of service to be determined by the state. While dental was not included in the first categories as a federal requirement, states have the discretion to include dental as the fourth category. CMS stated that the purpose of allowing discretion for the fourth category was to give states the opportunity to use an appointment wait time standard to address an access challenge being faced in their local market.

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[54] 42 C.F.R. § 438.10(h).
[55] Consolidated Appropriations Act of 2023, H.R. 2617, 117th Cong. § 5123 (2023).
[56] Letter to State Health Official from CMS (July 16, 2024), https://www.medicaid.gov/federal-policy-guidance/downloads/sho24003.pdf.
[57] 42 C.F.R. §§ 438.68(e), 457.1218.

As prospective benchmarks for services, the rulemaking established a maximum national wait time of 15 days for routine primary care and OB/GYN care and 10 days for outpatient mental health and substance use disorder treatment.

Takes Effect: Contract rating periods beginning on or after July 9, 2027.

Secret Shopper Surveys[58]

The rule requires a first-time federal requirement for "secret shopper" surveys for the purpose of assessing managed care plan compliance with the rules' wait time requirement and the provider directory requirement. Managed care plans are required to demonstrate a 90 percent minimum compliance rate. States must contract with an independent entity not affiliated with the state Medicaid office or the MCO being surveyed. Surveys must include all areas of the state served by the MCO and must be statistically significant when assessing wait times. Survey results must be reported by the states to CMS and made available through the state Medicaid website 30 days after submission.

Takes Effect: Contract rating periods beginning on or after July 9, 2028.

Remedy Plans[59]

Before this final rule (2024), CMS regulations required that state Medicaid agencies submit Corrective Action Plans (CAPs) to address the network adequacy/access deficiencies they identify in FFS programs, but there was no such corrective action requirement required for Medicaid MCOs. The 2024 rules recognize that to ensure MCO compliance with network adequacy standards, enforcement requirements are necessary. The Managed Care Rule establishes *remedy plans*. If a state Medicaid agency or CMS identifies an area where a MCO can improve access to care and meeting network adequacy requirements, the state Medicaid agency must submit a remedy plan to CMS for approval within 90 days of awareness of the issues of concern, outlining how the issues identified will be addressed within a period of 12 months. The state agency must submit quarterly updates on the progress of implementation to CMS. CMS can require the state to continue the plan for another 12 months, if problems persist.

Takes Effect: Contract rating periods beginning on or after July 9, 2028.

State Directed Payments[60]

State Medicaid agencies are generally prohibited from directing how MCOs, PIHPs, and PAHPs, pay their network providers. However, CMS established a regulatory exception in 2016 to allow states some authority on how managed care plans pay providers. This exception is referred to as "State Directed Payments" (SDPs). Some states have used SDPs to require a minimum or maximum fee schedule, set a uniform payment increase for select providers, or use value-based purchasing, for example. Some states have used SDPs to support access to dental care.[61]

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[58] 42 C.F.R. §§ 438.68(f), 457.1218.
[59] 42 C.F.R. §§ 438.207(f), 457.1230(b).
[60] 42 C.F.R. §§ 438.6, 438.7, 430.3.
[61] MACPAC, Issue Brief: Directed Payments in Medicaid Managed Care (2023), https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf.

Under the final rule, states can require managed care plans to pay providers using Medicare rates. However, the new rule also increases oversight over SDP spending, and as of September 2024, requires states to include Medicare spending data in medical loss ratio (MLR) reporting. It's important to note, however, that this spending data is limited to medical data, as Medicare data does not include dental spending data. States will have to report provider-specific data annually through the Transformed Medicaid Statistical Information System (T-MSIS) and CMS will track which providers are receiving these funds and by what amounts. The rule allows some managed care SDP payments to go as high as the Average Commercial Rate (ACR). Some stakeholders expressed concern that ACR is typically well above Medicaid and Medicare rates, and that this allowance creates misalignment with FFS supplemental payments, which typically are no higher than Medicare payment levels.

Takes Effect: SDP reporting in MLR reports to begin September 9, 2024; SDP payments as high as ACR, contract rating periods beginning on or after July 9, 2024.

Medical Loss Ratio (MLR) Standards[62]

MLR measures how much of a capitation payment to a plan goes toward providing Medicaid services and improving quality instead of plan costs and profit. Medicaid regulations in effect since 2017 require plans to submit annual MLR reports to states, and states must then submit MLR reports to CMS.[63] The new rule clarifies that MLR reports must be provided for each plan under contract with the state. MLR reporting must also be considered in state directed payment (SDP) spending, and provider incentive arrangements and bonus payments must now be considered in the MLR calculation.

Takes Effect: Plan MLR reporting and inclusion of SDPs in MLR reporting began September 9, 2024. Incorporation of provider incentive arrangements and bonus payments in MLR calculations is to begin during contract rating periods after July 9, 2025.

Payment Transparency

The Access and Managed Care Rules make important strides toward significantly improving payment rate transparency to providers/practitioners. States are required to post FFS payment rate schedules, compare Medicaid FFS payment rates to Medicare rates, and report aggregate provider payment rates under managed care compared to what the state would have paid under FFS, among other requirements. These changes, should they go into effect, will most certainly help to inform future payments for dentists and other health care providers.

FFS Rate Transparency[64]

The Access Rule rescinds the state AMRP requirements (from 2015), implementing a new transparent regulatory framework, requiring states to post Medicaid FFS payment rates on a publicly available website, separating out payment rates for adults and children and including

[62] 42 C.F.R. §§ 438.8, 438.3, 457.1203.
[63] *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498 (May 6, 2016).
[64] 42 C.F.R. § 447.203(b)(1).

any geographic payment differences. Medicaid FFS payment rates must be organized and easily understood, allowing the public to determine the amount Medicaid would pay for a service.

Takes Effect: States no longer have to comply with AMRP rules as of July 9, 2024. States must post FFS payment rates by July 1, 2026.

Both the Access Rule and Managed Care Rule were finalized in 2024;[65] [66] taken together, the rules provide more tools than ever previously in place for holding states and Medicaid MCOs accountable for network adequacy and are intended to provide a new level of transparency to dentists and other practitioners on how the states are addressing network adequacy and access to dental and other services. The challenge, however, is that the rules have a lengthy timeline for implementation, with the regulatory requirements in the rules spread out for implementation from 2024 to 2030, making the rules fully vulnerable to the political whims and decisions of the Trump administration and future administrations, as of January 2025. There is a high likelihood that without advocacy efforts by the dental community and broader provider community, many of the rules could be temporarily or fully rescinded, delayed, and/or altered before the effective dates of the individual regulations.

Key Themes in Federal Network Adequacy Actions

Rulemaking Under Different Administrations Speaks to Different Philosophies About Medicaid Network Adequacy, Its Importance, and Its Oversight and Enforcement

The evolution of Medicaid network adequacy requirements across the last three presidential administrations reflects differences in philosophies and policy priorities when it comes to Medicaid network adequacy. The Obama administration prioritized standardization of Medicaid network adequacy, looking to establish requirements similar to Medicare Advantage and marketplace plans, and using those structures to inform new requirements for Medicaid Managed Care plans. While the Obama administration remained mostly deferential to state authority over Medicaid matters, it sought to establish a federal floor that required states to establish time and distance minimums to confirm efforts to meet federal Medicaid network adequacy statutory requirements.

The Trump I administration, consistent with its priorities of deregulation, dismantled the regulations put in place by the Obama administration to establish federal Medicaid minimum network adequacy requirements. The Trump administration's flexible "quantitative" standard allowed for states to implement Medicaid network adequacy standards that could encompass any measure, whether that be time and distance, provider-ratios, or other measures of adequacy.

The Biden administration then worked to return to and expand upon the work started by the Obama administration and go further to standardize measurement of Medicaid network adequacy in an effort to improve access to care. For the first time, the administration sought to equalize FFS and MCO payments and access, applying transparency requirements and addressing payments to providers. The components of the final rules issued by the administration merit

[65] Final Rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002, 41012 (May 10, 2024) ("2024 Final Rule") ("Managed Care Rule").
[66] *Id.*; Final Rule, Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40542, 40685 (May 10, 2024).

close review and consideration for how they can directly support improvements in dental Medicaid network adequacy.

The current Trump administration is expected to put a hold on these Biden rules and alter or eliminate them. The Administration has taken an even more aggressive stance toward deregulation during this Trump term, with an executive action that would require ten regulations to be rescinded for every new regulation.[67] It is likely that parts of the Biden regulations will be altered, delayed or rescinded consistent with the Trump administration's past (and current) state-centric position regarding Medicaid network adequacy.

What is the Responsibility of State Medicaid Agencies, CMS, and Other Entities for Meeting These Requirements?

Network Adequacy Enforcement Mechanisms

There are distinct differences in how Medicaid dental network adequacy is enforced within Medicaid managed care and Medicaid fee-for-service arrangements. Medicaid managed care plan violations of network adequacy requirements are typically contract-based. States often impose contractual penalties for managed care plan network deficiencies, such as financial sanctions through reductions or claw backs in capitation payments, mandatory out-of-network coverage at in-network cost sharing, and enrollment freezes for repeated violations. FFS programs do not typically have visible CAPs.

42 C.F.R. § 438.68: Network Adequacy Standards

42 C.F.R. § 438.68 is the primary regulation governing network adequacy for Medicaid managed care plans. These regulations provide greater clarity on what is required by states rather than by CMS to ensure the network adequacy requirements under section 1396a(a)(30)(A). Specifically, 42 C.F.R. § 438.68(b)(1) requires a state to develop a "quantitative network adequacy standard" for a defined provider list. This provider list includes "pediatric dental" providers.[68] States are required to publish their network adequacy standards on their websites.[69] States are required to comply with the following requirements in developing network adequacy standards:

Geographic Requirements

States are required to have network standards for "all geographic areas covered by the managed care program." However, states have latitude to vary standards between geographic areas for a provider type.

Required Elements

Network adequacy standards must include, at a minimum, the following elements:

(a) Anticipated Medicaid enrollment
(b) Expected utilization of services

[67] Fact Sheet: President Donald J. Trump Launches Massive 10-to-1 Deregulation Initiative, The White House (Jan. 31, 2025), https://www.whitehouse.gov/fact-sheets/2025/01/fact-sheet-president-donald-j-trump-launches-massive-10-to-1-deregulation-initiative.
[68] 42 C.F.R. § 438(b)(1).
[69] 42 C.F.R. § 438(g).

(c) Characteristics and health care needs of specific Medicaid populations covered
(d) Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services
(e) The number of network providers who are not accepting new Medicaid patients
(f) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees
(g) The ability of network providers to communicate with limited English proficient enrollees in their preferred language
(h) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities
(i) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

In developing network adequacy standards, states must also consider elements that would support an enrollee's choice of provider, strategies to ensure the health, welfare, and community integration of enrollees, and other considerations that are in the best interest of enrollees that require long-term services and support.

Wait Time Standards

States are required to establish and enforce wait time standards to ensure enrollees have access to timely care. Regulations specify specific wait time minimums that must be followed for certain "routine appointments" including outpatient mental health and substance use disorder services, primary care services, and obstetrics and gynecological services.[70] Such set minimums are not established for pediatric dental services. However, states have latitude to establish wait time standards for additional services of their choosing, so long as the standards are "chosen in an evidence-based manner."[71] Additionally, CMS also has the authority to establish wait time services for additional services after "consulting with States and other interested parties" and offering opportunity for notice and comment.[72]

Provider Directories

Plans are required to have provider directories for outpatient mental health and substance use disorder, primary care, and obstetrics and gynecology providers.[73] States must also have provider directories for any additional services that they have chosen to specify wait time standards for as described in the paragraph above. Plans are required to ensure that their provider directories are up to date. Plan provider directories must include the provider's active network status with the plan, the provider's street address and telephone number, and whether the provider is accepting new enrollees.[74]

[70] 42 C.F.R. § 438(e)(1).
[71] 42 C.F.R. § 438(e)(1).
[72] 42 C.F.R. § 438(e)(3).
[73] 42 C.F.R. § 438(f)(1).
[74] 42 C.F.R. § 438(f)(1).

Secret Shopper Surveys

To ensure compliance with wait time standards and provider directory requirements, CMS requires states to conduct annual "secret shopper surveys," which must be administered by an entity independent from the state Medicaid agency and its contracted health plans.[75] Survey results are then provided to states to facilitate any needed corrections by the plan. In accordance with CMS's authority to establish wait time standards for additional services, CMS can also require secret shopper surveys to be completed for these additional services.

42 C.F.R. § 438.206: Availability of Services

42 C.F.R. § 438.206 pertains to the general availability of services. It requires states to ensure that "*all services covered under the state plan are available and accessible to all enrollees*" of (MCOs, PIHPs, and PAHPs in a timely manner.[76] Since the requirements of 42 C.F.R. § 438.206 pertain to "all services covered under the state plan," these requirements would apply to pediatric dental services, since pediatric dental services are required to be covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) federally-required benefit under Medicaid. Whether these same requirements apply to the adult population depends on the state's individual coverage policies outside of the mandated EPSDT benefit. 42 C.F.R. § 438.206 requires states to ensure that the plans they contract with:

(a) Maintain and monitor a network of appropriate providers "sufficient to provide adequate access to all services covered under the contract for all enrollees"
(b) Provide female enrollees with access to a women's health specialist
(c) Allow for a second opinion from a network provider
(d) Provide for adequate and timely coverage of out of network services when a provider network is unable to provide them
(e) Ensure that network providers meet credentialing requirements
(f) Ensure that networks have sufficient family planning services

The regulation also requires states to ensure plans have timely access standards that:

(a) Comply with applicable state standards
(b) Provide the same hours of operation as under fee-for-service Medicaid
(c) Make medically necessary services available 24 hours a day, 7 days a week
(d) Ensure providers comply with timeliness requirements, and monitor and take corrective action if necessary to assure compliance

42 C.F.R. § 438.207: Adequate Capacity

42 C.F.R. § 438.207 requires states to ensure that plans have "the capacity to serve the expected enrollment" in the area they serve. To ensure adequate capacity, plans must submit documentation to the state which demonstrates, in part, that the plan:

(a) Offers an appropriate range of preventative, primary care, specialty care, and long-term care services for the number of enrollees

[75] 42 C.F.R. § 438(f).
[76] 42 C.F.R. § 206(a).

(b) Maintains a provider network sufficient in number, mix, and geographic distribution
(c) Provides a payment analysis to the state that demonstrates the amount paid for certain services including primary, obstetrical and gynecological, mental health, and substance use disorder care

"Primary care" is defined to include services provided by an "other licensed practitioner as authorized by the State Medicaid program." [77] Therefore, this regulation would apply to dental care services to the extent that such services are covered under a particular state's Medicaid program. As stated above, at a minimum, this would include pediatric dental services but could include adult dental services if covered by a state plan.

The state is required to review a plan's provided documentation and certify compliance with CMS.[78]

42 C.F.R. § 440.262: Cultural Competency

42 C.F.R. § 440.262 requires states to "promote access and delivery of services in a culturally competent manner to all beneficiaries."[79] The regulation requires the state to have methods to ensure that all beneficiaries have access to services, regardless of English proficiency, background, disability, or sex.

Conclusion: An Evolving Regulatory Landscape

The regulation of Medicaid network adequacy has followed in the footsteps of requirements first established for Medicare Advantage and Marketplace plans. Federal Medicaid network adequacy standards currently apply primarily to managed care plans through explicit quantitative requirements under 42 CFR § 438.68.

While Medicaid fee-for-service network adequacy is subject to less federal oversight, the 2024 final rules have begun to introduce managed care-style oversight to fee-for-service programs through strategies such as access monitoring and payment transparency mandates. This regulatory convergence reflects CMS's "comprehensive access strategy" as of 2024, aiming to create parity across delivery systems while respecting the diversity of fee-for-service state Medicaid programs. While the Biden administration expressed interest in continuing the integration of managed-care requirements into the FFS space, such efforts are likely to stall, or even be rescinded, under the Trump administration. The focus of network adequacy oversight at the regulatory level means requirements can be subject to frequent change to fit a given administration's political priorities, messaging and goals. While the broad statutory directive to ensure that Medicaid beneficiaries are provided the same "care and services" that are available to the general population in a given geographic area, the specifics on how to implement this requirement is expected to continue evolving at both the federal and state levels.

[77] "Primary care" is defined as "all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them." 42 C.F.R. § 438.2.
[78] 42 C.F.R. § 207(d).
[79] 42 C.F.R. § 440.262.

II. A Comprehensive Survey of Medicaid Networks for Dental Services

It is important to understand the differences in states that operate their Medicaid programs primarily through fee-for-service vs. primarily through managed care. **The number of states that have a large portion of their beneficiaries in fee-for-service Medicaid has grown smaller over the years, and today, more than two-thirds of all Medicaid beneficiaries receive care through some kind of managed care arrangements.**[80] States that still rely heavily on fee-for-service for dental include: Alabama, Alaska, Arkansas, Connecticut, Hawaii, Maine, Montana, North Carolina, North Dakota, Vermont, and Wyoming. This represents significant diversity, both geographically and politically. Many states have 90 percent or more of their patients overall (for medical and dental) enrolled in Medicaid managed care. The following states operate dental through managed care arrangements, including PAHPs: Arizona, Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nebraska, Oklahoma, and Tennessee.

Key Divergences in Application: Quantitative vs. Qualitative Standards

While managed care retains explicit numerical (quantitative) requirements that plans must meet, fee-for-service programs tend to adhere to more value-based metrics (qualitative standards). In managed care, plans are held to such standards such as the number of days within which appointments for certain services must be provided; a 90 percent minimum compliance rate for meeting appointment requests; correction of errors identified by secret shopper surveys within three business days; and public posting of results of secret shopper surveys within 30 days of submission to CMS.[81] In FFS, the general statutory requirement states are held to include no such quantifiable minimums. Some states have looked at comparing dental provider participation in Medicaid FFS to that of commercial insurance markets or examining dental access based on secret shopper surveys. Ultimately, in the past absence of federal requirements, state Medicaid FFS programs have had discretion in choosing whether the Medicaid network adequacy standards they establish are qualitative or quantitative.

[80] *Medicaid Managed Care Tracker,* KFF, https://www.kff.org/statedata/collection/medicaid-managed-care-tracker.
[81] 42 C.F.R. § 438.68.

Quantitative Network Adequacy Standards	Descriptors
Time and Distance	Establish an upper limit on how far or for how long enrollees should have to travel to access a provider in their network (measured in miles or average travel time).
Provider-to-Enrollee Ratio	Establishes a minimum ratio for the number of providers available to deliver services to enrollees in a given service area.
Appointment Wait Times	Establish a maximum amount of time an enrollee must be required to wait before accessing care.
Acceptance of New Patients	Establishes a minimum number or percentage of providers willing to accept new patients.

A study by the Medicaid and CHIP Payment and Access Commission (MACPAC) found that most states do not provide specific enforcement mechanisms for failure to meet access standards or report network data.[82]

Some states with documented monitoring approaches include:

- North Carolina: Requires health plans to submit regular access plans and provider network data to demonstrate network adequacy.
- Texas: Analyzes provider network access for each managed care program quarterly, including conducting geospatial analysis annually to monitor distance standards and applying secret shopper methodology to evaluate timely access standards.
- Maryland and Minnesota: Require MCOs to submit provider network data as part of the contracting process or as a prerequisite to operating networks.

How States Monitor Dental Network Adequacy Compliance

State	Broad Consumer or Provider Surveys	Geo-Mapping	Secret Shopper Surveys
AK			
AL			
AR			
AZ	✓		✓
CA	✓	✓	✓
CO			
CT	✓		✓

[82] Network Adequacy in Managed Care. MACPAC; July 2018.

DE			
FL			✓
GA			
HI			
IA			
ID	✓		
IL			✓
IN			
KS			✓
KY			✓
LA			✓
MA			✓
MD			✓
ME			✓
MI	✓		✓
MN			
MO		✓	✓
MS		✓	✓
MT			
NC			✓
ND			✓
NE	✓	✓	
NH			✓
NJ			
NM			✓
NV		✓	
NY			✓
OH		✓	✓
OK			
OR		✓	✓
PA			✓
RI			✓
SC			✓
SD			
TN			
TX			✓
UT			✓
VA			
VT		✓	
WA			
WI	✓	✓	
WV			✓
WY			

Which State Medicaid Fee-for-Service and Managed Care Networks Are Not Meeting the "Distance to Provider" Standards, the "Care and Services"[83] or Any Other Standards for Dental Services?

The latitude states have in establishing quantitative standards for evaluating network adequacy standards is clearly demonstrated when looking across states. Many states, presumably due to the original 2016 regulations, pursue a "distance to provider" approach, varying the requirements based on geography (e.g., longer distance standards for rural communities). While there are no formal "care and services" standards (see footnote description), states have consistently looked toward other standards, including minimum provider to patient ratios; whether there is access to specialists within the provider of focus (including dental specialists); minimum appointment wait times, which can vary by provider type; and consumer survey experience, which tend to be less objective or actionable.

State Dental Network Adequacy Standards

State	Time & Distance Requirements	Minimum Provider to Patient Ratios	Access to Specialists	Minimum Appointment Wait Times	Consumer Experience Surveys
AK					
AL					
AR					
AZ	✓			✓	
CA	✓	✓		✓	✓
CO	✓				
CT	✓	✓		✓	✓
DE					
FL	✓	✓	✓	✓	
GA	✓			✓	
HI					
IA	✓				
ID	✓			✓	
IL	✓	✓			
IN	✓				
KS	✓			✓	
KY	✓				
LA	✓				
MA	✓	✓		✓	
MD	✓		✓	✓	
ME	✓	✓			

[83] *While the 2016 Medicaid Network Adequacy Regulations outline "time and distance (distance to provider) standards," there is no foundational regulation for "care and services" standards. The reference to care and services is included in the broader Medicaid network adequacy statute but was not defined in Medicaid regulations. This report speaks instead to all quantitative standards recommended at the federal level or established at the state level via statute or regulations.*

MI	✓	✓		✓	
MN	✓				
MO	✓			✓	
MS	✓			✓	
MT					
NC					
ND					
NE	✓			✓	
NH	✓	✓		✓	
NJ	✓			✓	
NM	✓			✓	
NV	✓				
NY		✓			
OH	✓	✓		✓	
OK					
OR	✓			✓	
PA	✓	✓			
RI	✓				
SC	✓				
SD					
TN	✓			✓	
TX	✓				
UT	✓			✓	
VA	✓			✓	
VT	✓	✓		✓	
WA	✓	✓			
WI	✓	✓		✓	
WV	✓				
WY					

Which State Medicaid Fee-For-Service or Managed Care Networks Have Pursued Improvements in Dental Network Adequacy or Made Strides Toward Compliance with 42 USC 1396a (30)A of the Medicaid Act?

States strive to increase dentist participation in Medicaid networks by implementing initiatives designed to entice participation, and therefore, improve access to oral health providers and services. Innovative strategies have been attempted by states, largely focused on: establishing financial incentives; directly raising Medicaid reimbursement rates; addressing workforce support needs (e.g., loan repayment programs); establishing tax credits; and other strategies.

Financial Incentives

Nearly all states identify low Medicaid reimbursement for dental services as a key barrier to provider participation in Medicaid dental networks. In the absence of adjusting fee schedule

payments across the board, some states have sought to offer incentive payments tied to specific goals and requirements. The following offers state examples of this approach.

- Between 2015-2021, California received a Section 1115 Medicaid Waiver from CMS to implement their "Dental Transformation Initiative (DTI)" with an aim to improve pediatric dental coverage and prevent dental decay. One of the primary components of this waiver was to implement financial incentives for providers to increase "categories of care:" (1) preventive dental services, (2) Caries Risk Assessment (CRA) and management, and (3) continuity of care.

Category 1 providers were paid on a semi-annual basis if they met or exceeded a predetermined increase in preventive services provided to Medi-Cal beneficiaries. The incentive amounts ranged from 37.5% or 75% above the current schedule for maximum allowances based on if the provider met or exceeded the benchmark for each preventive service for children. Category 2 providers were paid an incentive payment if they followed a CRA that was developed under the waiver. Category 3 providers were provided incentive payments if they continued providing dental examinations to enrolled Medi-Cal members for a continuous period.

Results from the waiver indicated improved pediatric preventive service utilization. As a result, California has continued to implement this program since 2022.[84]

Reimbursement Increases

In response to continued calls for reimbursement increases, several states have passed legislation to increase dental reimbursement. In an effort to incentivize Maryland providers to participate in their Medicaid dental program, Healthy Smiles, Maryland approved a 9.4% reimbursement increase for preventative, diagnostic and restorative treatments.[85] In a similar effort, in 2023 Vermont increased their Medicaid dental provider rates to 75% of the general regional commercial dental rates, an approximate 50% increase in reimbursement to dentists.[86]

Between 2018-2025, 28 states have implemented dentist rate increases at varying levels in Medicaid FFS (excluding MCO data) in an effort to incentivize provider participation in Medicaid: CO, CT, DE, GA, HI, ID, IL, KY, ME, MD, MS, MI, MO, MT, NE, NH, NJ, NY, ND, OK, OR, RI, SD, VT, VA, WA, WY.[87]

Workforce Support - Loan Repayment Programs

Many states incentivize individual participation in Medicaid through state student loan repayment programs. Delaware offers $100,000 in loan forgiveness to qualified dentists who

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[84] California DHCS, California's Med0Cal 2020 Demonstration (11-W-00103/9) (2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dental-transform-initiative-prgrm-final-rprt-01012021-12312021.pdf

[85] Maryland Department of Health, 2023 Report on Dental Provider Participation in Maryland Healthy Smiles Dental Program (2024), https://dlslibrary.state.md.us/publications/Exec/MDH/HB290Ch377(3)(2023).pdf

[86] Summary of Improved Dental Benefits Effective July 1, 2023, Dep't of Vermont Health Access, https://dvha.vermont.gov/providers/dental/summary-improved-dental-benefits-effective-july-1-2023#:~:text=Effective%20July%201%2C%202023%2C%20the,provided%20to%20VT%20Medicaid%20members

[87] States Reporting Provider Rate Increases, KFF (2023), https://www.kff.org/medicaid/state-indicator/states-reporting-provider-rate-increases/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

commit a minimum of two consecutive years of full-time service in a health professional shortage area and agree to support a minimum of 20% of patients eligible for Medicaid or CHIP.[88]

Florida's Reimbursement Assistance for Medical Education program awards a maximum of $250,000 to dentists employed by any eligible public health program that serves Medicaid patients in a dental health professional shortage area or medically underserved community.[89]

Delta Dental of Iowa sponsors a program that offers up to $125,000 over a five-year period for dentists who work in a priority county, and up to $200,000 over a five-year period for dentists who work in a high-priority county. In return, each selected dentist agrees to practice in one of Iowa's designated dental shortage areas and to allocate 35% of patient services to underserved populations, including a minimum of 15% Medicaid-insured patients.[90]

Tax Credits

A few states offer income tax credits or bonuses for dentists agreeing to practice in underserved areas where network participation has been limited. The Louisiana Small Town Health Professional Tax Credit provides a nonrefundable tax credit for up to $3,600 for five years to dentists who establish and maintain a primary office within a federally designated dental area of need that is also in a rural area as defined by the Louisiana Department of Health.[91]

Oregon's Rural Practitioner Tax Credit for Dentists Program grants up to $5,000 in personal income tax credits for dentists working in designated frontier counties with populations less than 5,000 and accept 15% Medicaid patients.[92]

South Dakota's Recruitment Assistance Program offers incentive payments to dentists that provide services in an eligible community serving Medicaid and CHIP patients for at least three consecutive years with a maximum payment of $256,204.[93]

In addition to a loan repayment program, North Carolina awards High Needs Service Bonuses to qualifying dentists without student loans who provide services in eligible facilities serving those with significant oral health care needs. The bonus maximum for a four-year commitment is $100,000 for dentists and $60,000 for dental hygienists.[94]

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[88] Delaware State Loan Repayment Program, Delaware.gov, https://dhss.delaware.gov/dhcc/slrp.html
[89] About FRAME, FRAMEworks Portal, https://www.fdohframe.com/s/
[90] FIND Project: Dental Education Loan Repayment, Delta Dental, https://www.deltadentalia.com/foundation/find/
[91] WELL-AHEAD, Tax Year 2020: Louisiana Small Town Health Professional Tax Credit Application (2020), https://ldh.la.gov/assets/Wellahead/LA_Small_Town_Health_Professional_Tax_Credit_2020_FAQ.pdf
[92] Oregon Rural Practitioner Tax Credit for Dentists, Oregon Office of Rural Health, https://www.ohsu.edu/oregon-office-of-rural-health/oregon-rural-practitioner-tax-credit-dentists
[93] Recruitment Assistance Program (RAP), South Dakota Dep't of Health, https://doh.sd.gov/healthcare-professionals/rural-health/careers-and-recruiting/recruitment-assistance/rap/
[94] Medical, Dental, and Behavioral Health Recruitment and Incentives, NCDHHS, https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs/provider-recruitment-and-placement/medical-dental-and-behavioral-health-recruitment-and-incentives

Other Innovative Programs to Increase Access

Several states have implemented strategies to address dental access needs, focusing on teledentistry, mobile dentistry, and improving provider directories and patient outreach.

Teledentistry

California Medi-Cal implemented Virtual Dental Homes that uses teledentistry to provide dental care in community settings in 2016. Many states including Colorado, Oregon, Idaho, Iowa, Maine, Nevada, Texas, Florida, Minnesota, and New York implemented teledentistry programs, as well.[95]

Provider Directories

Nevada offers an online provider directory and mobile app for Medicaid members to support finding available dentists, and the app includes information on teledentistry options.

Illinois developed an enhanced online provider directory with real-time updates and patient reviews to assist Medicaid members in finding dental care providers.[96]

Appointment Availability Parameters

Several states, including MD, OH and GA now include maximum appointment wait times for dental appointments in their FFS and MCO contracts.

[95] Adam Lampe et al., Improving Oral Health Using Teledentistry and Virtual Dental Homes: Concepts and Progress, OpenSmiles Collaborative (Mar. 20, 2024), https://opensmiles.ucsf.edu/news/improving-oral-health-using-teledentistry-and-virtual-dental-homes-concepts-and-progress; Nevada Medicaid and Nevada Check Up Dental Program Member Handbook (2025), https://www.libertydentalplan.com/Resources/Documents/LDP_NV_Medicaid_Member_Handbook.pdf;https://dental.metrostate.edu/teledentistry/; https://www.chwsny.org/wp-content/uploads/2023/05/Theekshana-Teledentistry_6x3_Web.pdf.

[96] Provider Directory, Il. Dep't of Healthcare and Family Servs., https://ext2.hfs.illinois.gov/hfsindprovdirectory/Main

Examples of State Innovations to Improve Dental Medicaid Network Adequacy

State	Innovations
CO	Increased Reimbursement, allocating $78 million toward Medicaid funding for fiscal year 2024-25 to increase reimbursement rates for dental providers and approving rate adjustments for specific dental codes.
MA	Transportation subsidies provided to support network adequacy.
MD	Telehealth permitted to support network adequacy.
MO	Increased Reimbursement for dental procedures, raising rates to 80% of the 50th percentile. Hired a dental Medicaid facilitator to assist dentists in applying to become providers, answer questions, and provide education about Medicaid.
NE	Increased dental reimbursement rates and removed the $750 annual cap on dental services for adults enrolled in Medicaid to improve dental care access and allow providers to offer more comprehensive treatment.
NH	Mobile dentistry served 15,000 rural beneficiaries. Mobile dental units count toward network adequacy in counties with less than 50 dentists per 100,000 residents. State utilizes tiered reimbursements, with up to a 15% increase for dentists meeting annual visit thresholds.
NJ	Teledentistry coverage to support 12 rural counties.
VT	Reimbursement increases, benefit cap increases.
MO	Reimbursement rate increases, a dedicated dental Medicaid facilitator to support patient access to a dentist, targeted media campaigns on oral health access.

Financial Penalties

In Louisiana, the state issues $40,000 penalties for plan failure to maintain adequate dental provider networks.[97]

Other Corrective Actions

In Georgia, the state works extensively with MCOs to ensure plans are meeting network adequacy regulations and contractual obligations. In addition to CAPs, MCOs are required to contact providers practicing in the area and make a contract offer. The state monitors the process and ensures timely action. The state allows the MCO access to a database with all currently credentialed Medicaid dental providers. If MCO actions do not result in a sufficient network, the state requires the plan to include providers outside the network and arrange transportation and/or telehealth services when necessary.

[97] Louisiana issued sanctions on DentaQuest in 2023 for failure to maintain an adequate provider network.

Examples of State Corrective Action Plans to Address Dental Network Adequacy Requirements

State	Corrective Action Plans
GA	If access falls below the 90% threshold in any county, Care Management Organizations (CMOs) must provide a corrective action plan to address the deficiency. Corrective actions include recruiting additional providers where providers are available, contracting with providers in nearby counties to fills the gaps in access, or coordinating non-emergency transportation services, as necessary, to ensure that members receive care.
NJ	The state mandates quarterly Network Adequacy Reports from MCOs, and reports are reviewed during performance accountability meetings, with deficiencies triggering corrective action plans (CAPs).
MN	If a managed care or county-based purchasing plan has a dental utilization rate that is 10% or more below the performance benchmark, the commissioner requires the MCO to submit a corrective action plan describing how they intend to increase dental utilization.

States that Issued Penalties for Network Adequacy Violations (on any required service):

# of States	Issued Penalties in Past Three Years
10	California, Florida, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Ohio, Oregon, Washington

SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2023 and Powers Research. Penalties between 2019-2022.

III. Analysis of CMS and State Enforcement Activities – Dental Network Adequacy

What Activities Has CMS Undertaken to Ensure Full Compliance of the Standards Outlined in 42 USC 1396a (30)A of the Medicaid Act?

Required State Network Adequacy Plans

CMS requires that states demonstrate to them that the plans they contract with both meet the state's requirements for availability of services and provide an analysis that supports the state's certification of each plan's provider network adequacy. As of October 2022, states are required to use a CMS-required standard reporting template.[98] In its 2024 Final Rule, the Biden administration planned to have CMS make the state Network Adequacy and Access Assurances Reports publicly available on Medicaid.gov.

External Quality Reviews (EQRs)

CMS also requires that states that contract with managed care plans must have a qualified External Quality Review Organization (EQRO) perform an annual quality assessment[99] on each

[98] Centers for Medicare and Medicaid Services, Medicaid and CHIP Managed Care Reporting, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting.
[99] 42 C.F.R. § 438.310.

contracted plan to validate network adequacy, among other performance issues, and provide these reports on their website. In February 2023, CMS released updated EQR protocols,[100] mandating network adequacy validation activity and requiring that states and EQROs begin using the new network adequacy validation protocol by February 2024.

Essentially, EQRO's serve an audit role. The strength of that audit has not been seen or tested at this point, given states have only been using the new protocols established since early 2024, and we have a new administration that has not even begun to assess the reports. **When identifying how to potentially strengthen use of this kind of audit tool, however, one opportunity could be to implement a similar quality review/audit process in FFS states. 42 C.F.R. 447.203 provides that "To remedy an access deficiency, CMS may take a compliance action using the procedures described [in] … this chapter."[101] For example, under the regulations, CMS *may* withhold payment to states for failure to comply with Federal requirements. This could be another avenue to request CMS to take action, although it would be their right to make that decision since the regulations say they "may" use this enforcement authority, which is not a requirement.**

Managed Care Program Annual Report (MCPAR)

Beginning December 2022, CMS required that states submit MCPARs and that these reports be provided for each Medicaid managed care program in the state and no later than 180 days after the end of a state's contract year.[102] As a result of the differing contract year periods, MCPARs will be received by CMS in different tranches. These reports assess MCO-specific data on: grievances and appeals by type of service; state hearings information; evaluation of individual MCO performance on quality measures for primary care access and preventive care, maternal and perinatal health, behavioral health, and other types of services, often including dental; MLRs for each MCO; and any sanctions or corrective action plans imposed on each MCO and the reasons for each intervention. The Biden administration established a page on the Medicaid.gov website for the MCPARs to be publicly available following CMS' review and approval of the reports. The first reports posted were submitted by state Medicaid agencies for performance year 2023.

CMS uses these various methods to ensure that dental networks are adequate and accessible to enrollees across different types of health plans and programs.

There is a dearth of information on whether CMS has initiated enforcement actions against states for failures to address network adequacy for Medicaid dental services provided by MCOs. Our research did not find any record of CMS issuing an enforcement action against a state for failing to meet Medicaid dental network adequacy standards. If current reporting mechanisms continue under the Trump administration and thereafter, given the new transparency of the process, this may result in more direct engagement between CMS and the states on

[100] Ctrs. for Medicare & Medicaid Servs., CMS External Quality Review (EQR) Protocols (2023), https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf.
[101] 42 C.F.R. § 447.203
[102] **Some states contract with MCOs on a January 1 through December 31 basis; others on a July 1 through June 30 basis. Other states start their contracts on April 1, September 1, or October 1.

whether state plans are meeting Medicaid network adequacy requirements, and if they are not, what the consequences may be from the federal government.

Documented Reports on Medicaid Network Adequacy (Including Dental Information)

*Click MCPAR Link for All Reports
*Click Checks for Accessible EQRO and State-Specific Reports

State	MCPAR Report	EQRO Network Adequacy Report	Other State Network Adequacy Reports
AK			
AL			
AR			
AZ	✓	✓	
CA	✓	✓	
CO	✓	✓	✓
CT		✓	
DE			
FL			
GA	✓		✓
HI		✓	
IA	✓		
ID	✓	✓	
IL	✓	✓	
IN	✓	✓	
KS	✓	✓	
KY	✓		✓
LA	✓		✓
MA	✓	✓	
MD			
ME			
MI	✓	✓	
MN	✓		
MO	✓		
MS	✓		✓
MT			
NC		✓	
ND			
NE	✓		✓
NH			
NJ	✓	✓	✓
NM	✓	✓	
NV	✓	✓	
NY		✓	
OH	✓	✓	
OK		✓	

State	MCPAR Report	EQRO Network Adequacy Report	Other State Network Adequacy Reports
OR	✓	✓	✓
PA		✓	
RI	✓	✓	
SC		✓	
SD			
TN	✓	✓	
TX	✓		✓
UT	✓	✓	
VA	✓		
VT		✓	
WA		✓	
WI	✓	✓	
WV	✓		
WY		✓	

*Reports captured from 2020-2025

What Activities Have States Undertaken to Ensure Full Compliance of the Standards Outlined in 42 USC 1396a (30)A of the Medicaid Act?

Several states require dental MCOs to provide their states' Medicaid, Health and Human Services, Insurance, or other similar agencies with network adequacy reports. For example, the District of Columbia requires carriers to submit network adequacy reports and access plans to identify and address any deficiencies in provider networks. Nevada requires quarterly network adequacy reports. Colorado requires contractors to provide an annual network adequacy report which details these and other facets of the network as well as a quarterly network report that details the changes in the makeup of the network over a quarter. Other states with more recently implemented reporting requirements include Idaho (requiring quarterly reports) and Kentucky, which developed a quarterly report to allow it to have a better idea of the existing gaps in its MCO network.

Other enforcement methods, which were not commonly reported among other states, include the following: Nebraska's quarterly sampling of provider availability; Ohio's quarterly review of provider rosters; Wisconsin's annual surveys, site visits, and handbook and contractual terms requirements; California's annual timely access surveys; and Utah's EQRO tableau dashboard.

When MCOs fall below a state's mandatory network adequacy standards, some states will issue CAPs, which lay out how the MCO is to address the gaps in network adequacy. Some states report use of CAPs to address deficiencies including: Georgia, Kentucky, and Texas.

While our research did not come across many states that issue monetary penalties for failures to maintain an adequate provider network, Louisiana is one exception. In Louisiana, a failure to maintain an adequate provider network can result in state issued sanctions of up to $40,000 to a plan.

State Report Card- How States Are Doing in Meeting Medicaid Dental Network Adequacy Requirements

Standards Not Met	State has received penalties or a corrective action plan; CMS has raised concerns; there is low dentist participation in Medicaid networks
Needs Improvement	Struggling to address Medicaid dental network adequacy, but offering improvements
Innovating	Innovating to address Medicaid dental network adequacy

State	
AK	MT
AL	NC
AR	ND
AZ	NE
CA	NH
CO	NJ
CT	NM
DE	NV
FL	NY
GA	OH
HI	OK
IA	OR
ID	PA
IL	RI
IN	SC
KS	SD
KY	TN
LA	TX
MA	UT
MD	VA
ME	VT
MI	WA
MN	WI
MO	WV
MS	WY

Have Any States Been Granted Network Adequacy Exemptions?

Federal Framework for MCO Network Adequacy Exceptions to Be Authorized by States

Over the years, some state Medicaid plans have secured network adequacy exceptions through federal regulatory authorities[103], particularly for rural and other underserved locations facing provider workforce challenges. These exceptions have sought to enable flexibility in meeting quantitative standards, given the regulatory effort to ultimately provide states authority to determine standards that are most measurable and achievable for them.

Under federal regulations guiding network adequacy, states may evaluate and approve exceptions to network adequacy standards if:

1. The exception is specified in the MCO, PIHP, or PAHP contract.

[103] 42 CFR § 438.68.

2. Is based, at a minimum, on the number of providers in a specialty practicing in the MCO, PIHP, or PAHP service area.
3. Include consideration of the payment rates offered by the MCO, PIHP, or PAHP to the provider type or for the service type for which an exception is being requested.

States that grant an exception in accordance with an MCO, PIHP, or PAHP must monitor enrollee access to the provider type or service the exception was sought for on an ongoing basis and include the findings to CMS in the federally-required MCPAR.

Our research shows that while states must develop standards for all geographic areas of the state covered by a managed care program, states may permit plans to meet different standards in different parts of the state. A state could, for example, require plans to provide required services within 10 miles or 15 minutes in urban areas of the state, but within 30 miles or 45 minutes in rural areas.[104]

We did not identify any recent state examples of such exceptions during our research, but view this as an area for further investigative research by reviewing all MCPAR reports submitted by states as states continue to issue these on an annual basis.

Creative Use of State Medicaid Waivers and State Plan Amendments to Improve Access to Care

Medicaid waivers[105] and Medicaid state plan amendments can also both be used to allow states to identify options to incentivize providers to participate in Medicaid networks. The flexibility of waivers allows states to creatively use Medicaid dollars to support Medicaid goals, including improving access and services.

Section 1115 Waivers

Through Section 1115 waivers, CMS can approve experimental, pilot, or demonstration projects aimed at serving the Medicaid populations. Our research shows a few examples of ways states have used 1115 waivers for network adequacy improvements. For example, California used the waiver process to provide incentive payments to practitioners in an effort to expand participation in Medicaid and the accepting of new patients. Some states have also utilized waivers in an effort to increase access to care for Medicaid-eligible individuals over the age of 21 who have disabilities by encouraging more practitioners to accept these patients.

1915(b) Waivers

The 1915(b) waiver is specifically used for managed care, allowing states to waive freedom of choice and require its Medicaid populations to enroll in a MCO. The 1915(b) waiver can also be used by states to offer certain benefits only to managed care enrollees and to limit the providers the state contracts with for these benefits. For example, Utah secured a 1915(b) managed care waiver to require contracted dental plans to ensure the delivery of dental benefits to specific populations, including children with disabilities.[106] The state requires contracted dental plans to

[104] Monitoring Managed Care Access, Medicaid and CHIP Payment and Access Commission, MACPAC, June 2022, https://www.macpac.gov/subtopic/monitoring-managed-care-access.
[105] Waivers available via Social Security Act sections 1915(b); 1915(c); and 1115. 42 U.S.C. §§ 1396n(b), (c), 1395.
[106] Choice of Dental Care Delivery Program (UT-0004), Medicaid.gov, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83371..

ensure direct access to specialists, to ensure that each enrollee has an ongoing source of primary dental care, and the state utilizes independent monitors to analyze demographic data to assess access needs for this population in the state.

Waiver approvals by CMS for state dental programs focused on expanding access can be grouped into two main categories:

1. Extending benefits to individuals in the state who are over age 21; and
2. Transitioning dental services from FFS to a PAHP overseen by a MCO. There are a few exceptions outside of these, which will be discussed further below.

Extending Benefits to Individuals Over the Age of 21

Using Section 1115 waivers, states have identified a number of opportunities to extend the Medicaid dental benefit to individuals over the age of 21. Commonly, requirements for meeting the threshold of coverage included: individuals who had a disability (including one state who specified individuals with diabetes alone for coverage); individuals who met dual eligibility criteria, and individuals who could continue to qualify for benefits through COVID-19 after a Medicaid beneficiary turned 21.

- Examples of States that Extended Dental Coverage Based on Disability

    - Delaware added adult dental benefits to its state plan through the state's managed care delivery system, which is authorized through the state's 1115 demonstration. Beneficiaries include elderly disabled individuals who meet the nursing facility level of care or are at risk for nursing facility care, those with HIV/AIDS, those who receive home and community-based services, disabled children with incomes at or below 250 percent of the SSI, and those in a residential treatment facility for substance use disorder.[107]
    - New Hampshire began covering removable prosthodontics for nursing facility residents, age 21 and over in 2022 through 1115 and 1915(c) Home and Community Based Services amendments.[108]
    - Tennessee began providing dental benefits for adults age 21 and over in Medicaid through an 1115 waiver for those who are medically needy and are aged, blind, or disabled individuals, or caretaker relatives.[109]

- Examples of States that Extended Dental Coverage Due to COVID 19

    - Arizona received an amendment to their Section 1115 Demonstration Waiver in January 2021 under the Public Health Emergency (PHE) to allow them to cover EPSDT dental services authorized prior to a beneficiary turning age 21 for those

[107] Letter from CMS to Stephen M. Groff (Jan. 19, 2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-adult-dental-benefits-amend-appvl-01192021.pdf.
[108] Print Application Selector for 1915(b) Waiver: NH.0002.R00.00, New Hampshire (2023), https://www.medicaid.gov/medicaid/section-1915-demonstrations/downloads/nh-medicaid-care-mgt-dental-services-NH-02.pdf.
[109] Letter from CMS to Stephen Smith (Dec. 27, 2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-adult-dental-care-cms-ack-updated-12272022.pdf.

beneficiaries who turned 21 on or after March 1, 2020, and through 60 days after the termination of the COVID-19 PHE who remained Medicaid eligible.[110]

- Examples of States that Extended Dental Coverage Due to Dual Eligibility (Medicare/Medicaid)
    - Maryland received an 1115 waiver amendment to cover basic dental benefits for dually eligible enrollees.[111]

Transitioning Dental Services from FFS to a PAHP

In an effort to address rising Medicaid costs, states have sought to identify services that can be carved out from Medicaid FFS and provided through limited managed care plans. One option has included shifting service coverage to PAHPs, a non-comprehensive prepaid health plan that only covers limited services (including dental) and does not cover inpatient care. PAHPs are covered through a fixed per patient capitated payment, which allows for limited flexibility should costs change. CMS has approved two state-specific waivers to provide dental services through PAHPs in Louisiana and Utah.[112] [113]

Other State Waivers Affecting Medicaid Dental Access

There are few examples of states requesting waivers for other dental-related services that fall outside of the two most common categories explained above. The best example of this is the California 1115 Waiver for their DTI which ran from 2015-2021. The purpose of the DTI was to improve Medi-Cal dental service coverage and utilization of: (1) preventive dental services, (2) CRA and management, and (3) continuity of care. It also attempted to use Local Dental Pilot Programs to further improve dental service coverage. To improve Medicaid patient coverage of preventive dental service and to prevent caries, the waiver provided for incentive payments to dentists through the California Department of Health Care Services (DHCS) to dental service office locations that met or exceeded utilization benchmarks. Incentive payments for improving preventive dental care totaled $307.5 million between 2015-2021.[114] Due to the access and health improvements noticed through this program, DHCS expanded DTI through the California Advancing and Innovating Medi-Cal (CalAIM) program which began in 2022.

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[110] Letter from CMS to Director Carmen Heredia (Oct. 28, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-st-cms-approved-covid-epsdt-denyal-amndmnt-final-rpt.pdf.
[111] Letter from CMS to Dennis R. Schrader (Apr. 5, 2019), https://health.maryland.gov/mmcp/Documents/MD%20HealthChoice%20Amendment%20Approval%20%28updated%20April%2025,%202019%29.pdf.
[112] Print Application Selector For 1915(b) Waiver: LA.0005.R02.01, Louisiana (Jul. 1, 2022), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/LA_Dental-Benefit-Program_LA-05.pdf.
[113] Print Application Selector For 1915(b) Waiver: UT.0004.R02.00, Utah (Jan. 1, 2024), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/UT-0004.pdf.
[114] California's Medi-Cal 2020 Demonstration (11-W-00103/9), DHCS (2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dental-transform-initiative-prgrm-final-rprt-01012021-12312021.pdf.

State Plan Amendments

State approval of updates to dental coverage in the state can be covered by waivers, or the alternative is a state plan amendment. There are a few notable state plan amendments that impact dental coverage in the state, both of which impact payment and reimbursement rates for dental services.

In 2022, Maryland received state plan amendment approval from CMS Maryland Medical Assistance reimbursement rates for certain dental services, including preventative, diagnostic, emergency and treatment services by 9.4% beginning July 1, 2022. [115]

In 2011, South Carolina submitted a state plan amendment for reducing provider payments by 3%, including dentists. The state plan amendment was not approved for questions about the methodology to determine payment rates and reconciling actual and incurred costs with Medicaid reimbursement. Due to the failure to provide more detailed information about how this would impact beneficiaries the state plan amendment was not approved.[116]

Are There Opportunities for CMS to Engage in State-Level Enforcement and Monitoring Activities in Relation to the 42 USC 1396a (30)A of the Medicaid Act?

CMS State Letters

Another way that CMS can communicate to states that adjustments are needed to support Medicaid access generally, and Medicaid network adequacy specifically, is through state Medicaid director letters. This is less common, as such letters are usually only issued if a direct question is raised to CMS by a state official or Medicaid-providing entity that the agency believes they need to address directly.

Minnesota

There is notably one state letter identified that directly addressed concerns for dental network adequacy, which was sent to the state of Minnesota. In 2017, CMS issued a state director letter indicating that they were concerned that the state did not provide sufficient access to dental services for children enrolled in Medicaid, and that not enough dental providers participate in Minnesota Medicaid.[117] After conducting a review, CMS determined that Minnesota Medicaid beneficiaries were not receiving the dental services called for in the state's dental periodicity schedule.

Following the letter, CMS held a call with Minnesota Medicaid and shared a range of suggestions for addressing the agency's concerns, including increasing Medicaid dental reimbursement rates to improve coverage. The state subsequently voted to increase the reimbursement rates.

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[115] Maryland, State Plan Amendment #22-0020, https://www.medicaid.gov/medicaid/spa/downloads/MD-22-0020.pdf.
[116] Letter from CMS to Anthony E. Keck (June 23, 2011), https://www.scdhhs.gov/internet/pdf/StatePlanApprovals/SC-11-005CompanionLetter.pdf.
[117] Letter from CMS to Marie Zimmerman (Apr. 6, 2017), https://www.mndental.org/files/Letter-from-CMS-Director-Anne-Marie-Costello.pdf.

Outside of the letter to Minnesota, there have been a couple state letters that provide examples of how CMS can investigate concerns, regarding Medicaid coverage; however, our research did not identify any additional CMS letters specific to dental Medicaid network adequacy.

CMS State Director Letter Examples

In 2024, CMS sent separate letters to Missouri and Texas detailing concerns with the significant processing times for Medicaid and CHIP applications.[118] [119] In the letters, CMS proposed to conduct a review of the application date, turn-around time, and proposed staffing updates. CMS proposed using the review to help the state identify mitigation efforts. This CMS strategy, like the one used in the Minnesota letter, can be used to correct state specific concerns about Medicaid not meeting federal requirements to ensure adequate coverage of services.

CMS Guidance to States

In addition to direct state outreach, CMS provides general guidance to states on how they should be implementing required components of Medicaid, including EPSDT and the Oral Health Initiative (OHI). These guidance documents provide suggestions for how states can improve dental coverage and services within the state.

OHI Bulletin

CMS, which launched OHI in 2010, releases guidance for how states can meet the goals of OHI to improve Medicaid enrolled children's use of appropriate dental and oral health services. In the guidance, CMS outlines state examples of best practices. In the 2020-2022 guidance CMS highlighted Pennsylvania's use of managed care contracts top quality improvement incentive program for plans and required plans to develop a pay-for-performance program for dental providers in order to increase access to preventive dental services for new and established patients.[120]

EPSDT Best Practices

Periodically, CMS releases EPSDT best practices guidance. The guidance is intended to support states in ensuring that children on Medicaid and CHIP are receiving the full range of health services, including dental. The guidance provides specific state examples that other states can replicate. In the 2024 EPSDT best practice comprehensive guidance, CMS notes that "a different approach that has yielded an increase in available dental practitioners is to provide training, support, and enhanced payments to general dentists to increase their ability to serve younger children."[121]

[118] *Id.*
[119] Letter from CMS to Todd Richardson (May 22, 2024), https://www.documentcloud.org/documents/24762403-missouri_application_timeliness_review_letter_signed_52224.
[120] Letter from CMS to Calder Lynch (June 25, 2020), https://www.medicaid.gov/federal-policy-guidance/downloads/cib062520.pdf.
[121] Letter from CMS to State Health Official (Sept. 26, 2024), https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

IV. Suggested Remedial or Enforcement Actions to Ensure States are Meeting the Full Compliance Standard as Outlined in 42 USC 1396a (30)A of the Medicaid Act

With so much latitude in the interpretation and enforcement of Medicaid network adequacy laws, network adequacy standards across Medicaid managed care plans are highly variable. Dental plans within varied state Medicaid dental plan and MCO arrangements are permitted to self-regulate and self-report with minimal accountability. When reflecting on federal and state efforts over the last 10 years, it is clear that enforcement of network adequacy is extremely difficult, regardless of the terms of law or requirements outlined in federal and state laws and regulations.

CMS regulations governing Medicaid managed care contain standards for provider networks that can at best be characterized as ineffective. This can largely be attributed to the rollercoaster of Medicaid network requirements and taking away of those requirements between 2016-2020 in the policy arm wrestle between the Obama and Trump administrations. Trump successfully minimized initial federal network adequacy requirements that were put in place. Instead, states were encouraged to adopt any "quantitative standard" of their choosing for pediatric dental care along with other Medicaid required services. **No minimum federal quantitative standard was put in place, and there was no dedicated enforcement or oversight mechanism in place to ensure Medicaid MCOs formalized or complied with whatever "quantitative standards" the states determined should be in place.**

Conclusion

What Are Additional Suggested Remedial or Enforcement Actions that CMS Could Undertake to Strengthen Enforcement of 42 USC 1396a (30)A of the Medicaid Act?

Three specific recommendations can be made in consideration of how dental network adequacy might be improved through remedial actions within dental Medicaid/Medicaid Managed Care networks:

- **Ensure Any Willing Dental Provider Can Participate in Medicaid with Reasonable Contract Terms**: Model after Medicare statute and rules that seek to ensure convenient access standard requirements are in place and that payer contract terms for dentists are reasonable, including reasonable reimbursement. Provide data to demonstrate benchmarks for setting reasonable dental payment rates that can help to attract dentist network participation.
- **Encourage Rural Dental Residency and Other Incentive-Focused Programs to Address Dentist Deserts**: Explore whether programs that provide enhanced payments to other providers for serving in rural and underserved communities can serve as a model to enhance dental network adequacy.
- **Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance**: Support implementation of final 2024 federal rule requirements that establish remedy plans for MCOs. Encourage state legislation that sets

benchmarks for dental network participation and establishes rewards for plans that meet requirements and imposes fines on plans that are not compliant.

- **Adopt Transparent Metrics**: Encourage states to publish annual reports on provider participation and reimbursement rates as some states have begun to do and as 2024 federal rules envisioned. Such information should be reported by states and made available and accessible on the CMS website. Encourage a different standard for comparing FFS dental rates, given the lack of Medicare coverage and payment for dental services.

Any Willing Dental Provider – Reasonable Contract Terms

Quantitative plan measures for assessing dental network adequacy do not typically assess whether reimbursement rates for dental services provided within Medicaid are "reasonable." Unlike terms that exist in other areas of federal law for other federal payors that are intended to ensure that "any willing provider" can participate in a plan network[122] with assurance of reasonable contract terms (including reasonable reimbursement), Medicaid plans are not held to any such standard.

While many states have deliberated on and some have sought to adjust dentist Medicaid payment rates to improve network participation, ultimately contractual obligations required by Medicaid may be necessary to support such participation.

CMS' 2024 final rules in many ways open the door to a new discussion about how to address provider payment rates in contracts, given the planned requirement for states to publicly report provider payment rates.[123] For example, the rules require states to submit *remedy plans* to address any areas where managed care plans need to improve access. Payment adequacy information was not included as a required focus for access improvements that would generate the need for a remedy plan evaluation and plan correction. States could choose to incorporate payment-related factors into their remedy plans.

Recommended Approach: Federal legislation (and/or state legislation) can be pursued to establish any willing dental provider participation requirements that seek to ensure that contractual terms are not prohibitive (e.g., underwater reimbursement; excessive audits, administrative challenges). Federal/state regulations could set the terms for what is considered "reasonable" but setting a standard (not rates) for evaluation of contract rates. Terms can be modeled after Medicare Part D standards seeking to ensure adequate pharmacy network participation in relation to convenient access and reasonable contract terms.

Encourage Rural Dental Residency and Other Incentive-Focused Programs

While federal network adequacy regulations and federal workforce programs meant to address provider shortages are not formally connected in the law or in regulations, many states, and even CMS, has sought to apply workforce program-type solutions to encourage provider participation and address network needs. Dentistry has a long history of advocating for dental workforce

[122] 42 § C.F.R. 423.505(b)(18) ("any willing pharmacy" provision).
[123] 2024 Final Rule, 89 Fed. Reg. 41002, 41012, 41026 (May 10, 2024).

programs, recognizing the challenge of workforce needs in rural and other underserved communities. The profession, therefore, has workforce programs in place that could prove resourceful in addressing Medicaid network needs.

Recommended Approach: Review federal program efforts in Medicare that pay a 10% quarterly bonus to physicians who provide services in primary care HPSAs and psychiatrists practicing in mental health HPSAs.[124] See if the terms for a similar initiative would work for practicing dentists. This could initially be pursued as a regulatory pilot program to address rural shortage concerns in a specific region, for example.

Advocate for the 2016-established Medicaid network adequacy rules to be further amended through CMS rulemaking or guidelines to support a framework for states to analyze geographic distribution of dentists serving Medicaid in comparison to exchange markets and/or commercial populations to better assess and determine dental network challenges.

Enforce Rewards and/or Penalties to Address MCO/PAHP Compliance/Noncompliance

States and their contracted plans should be incentivized to address challenges within their dental networks, and penalized when they do not bother to address these challenges. Federal rules finalized in 2024 envisioned this strategy through the use of "remedy plans." Strategies could be encouraged to address issues impacting dental network adequacy through teledentistry and allowing out-of-network participation by dentists, for example.

Recommended Approach: Establish model state legislation to set benchmarks for state dental network participation with rewards for plans that meet requirements and the imposition of fines on plans that are not compliant, generating revenue to support such a program.

Transparency and Sufficient Access to Care in Medicaid Networks

Providing reliable information to Medicaid beneficiaries about dentists who are accepting new Medicaid/Medicaid Managed Care patients could be instrumental in improving access and addressing network adequacy concerns. Allowing for resources such as real-time provider databases where dentists can directly update their participation status could eliminate state concerns over "ghost networks" and outdated plan directories.

States should also be encouraged to publish annual reports on dentist participation as well as reimbursement rates to dentists as 2024 federal rules envisioned.

Recommended Approach: The federal government must be encouraged to put into place state reporting requirements that are then accessible on the CMS website. Advocacy here will be important to ensure envisioned federal rules go into effect. Guidance from CMS to the states on how to effectively establish a standard for comparing FFS dental rates to plan rates will be necessary, and CMS will need this guidance from the dental community. The current CMS standard of relying on Medicare coverage and payment is not an appropriate benchmark for comparing dental data, given limited coverage and reimbursement for dental benefits under Medicare/Medicare Advantage.

[124] MLN Learning Network, Centers for Medicare and Medicaid Services; Health Professional Shortage Area Physician Bonus Program. February 2021.