

January 16, 2026

The Honorable Gregory F. Murphy, M.D.
Co-Chair, GOP Doctors Caucus
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce, M.D.
Co-Chair, GOP Doctors Caucus
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
Chair, Congressional Doctors Caucus
1110 Longworth House Office Building
Washington, DC 20515

Re: Request for Input for MACRA Modernization Efforts

Dear Representatives Murphy, Joyce, and Schrier:

As the leading authority on oral health in the United States, the American Dental Association (ADA), representing over 159,000 member dentists, appreciates the opportunity to comment on modernizing the requirements put forth by the Medicare Access and CHIP Reauthorization Act (MACRA). Oral health is inseparable from patients' overall health and well-being. Maintaining high-quality care and long-term cost containment in health care is difficult without considerations for patients' oral health and the dentists who treat them.

- 1. What legislative reforms are most needed to ensure future Center for Medicare and Medicaid Innovation (CMMI) models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?**

One major barrier to improving cost and quality in oral health care is the lack of interoperability between medical and dental electronic health records (EHRs). This gap creates significant administrative burden and additional costs for dental practices seeking to serve Medicare and Medicare Advantage beneficiaries. It also limits the development and scaling of innovative care models that integrate medical and dental services, which have the potential to improve quality, enhance care coordination, and reduce overall health care costs.

Currently, many dental electronic health record systems are exempt from Office of the National Coordinator for Health Information Technology (ONC) certification requirements, and there are no meaningful incentives to encourage interoperability in the dental sector. As a result, the dental industry has been largely excluded from the interoperability

advancements driven by the Medicare Access and CHIP Reauthorization Act (MACRA). To close this gap, the **American Dental Association (ADA) urges the federal government to provide targeted technical assistance and financial incentives to support the testing and validation of dental data exchange using established standards such as HL7 Clinical Document Architecture (CDA) and Fast Healthcare Interoperability Resources (FHIR)**. Without this support, dental EHR vendors and participating entities have little incentive to invest in interoperability capabilities necessary to support innovative, integrated care models.

If Congress intends for Center for Medicare and Medicaid Innovation (CMMI) models that integrate medical and dental care to scale, participating plans and providers must have access to standardized, automated dental administrative transactions and data exchange. Today, many Medicare Advantage plans require dental offices to rely on burdensome manual processes, such as proprietary web portals, phone calls, or fax, to verify eligibility, confirm benefits, and receive referrals for patients with supplemental dental coverage. These challenges are exacerbated by substantial variation in coverage and cost-sharing for supplemental dental benefits, even among plans operating within the same geographic area.

According to the 2024 CAQH Index, dental practices could save up to \$580 million nationally each year on eligibility and benefit verification alone by transitioning fully from manual and portal-based processes to standardized electronic transactions.¹ To address these inefficiencies, the **ADA urges lawmakers to pursue legislation requiring Medicare Advantage plans to automate dental administrative transactions in a manner consistent with expectations for medical and pharmacy services**. At a minimum, MA plans should be required to support standardized electronic eligibility and benefit verification and related dental transactions. Doing so would enable dental practices to accept medical referrals electronically, accurately confirm dental benefits in real time, and reduce delays, fragmentation, and administrative complexity that frequently impede timely patient care.

- 2. If the Merit-Based Incentive Payment System (MIPS) program were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes.**

Currently, most dentists do not qualify to participate in the Merit-Based Incentive Payment System (MIPS). Participation is primarily limited to those treating dually eligible individuals – both Medicaid and Medicare – who are also the most vulnerable amongst beneficiaries. While a limited number of oral health–related measures are included in MIPS, these measures have not been sufficiently refined, appropriately specified, or rigorously tested for validity and reliability. As a result, they do not effectively measure quality of care for this population. In addition, the intent and technical specifications of some existing MIPS measures are not consistently aligned with current evidence-based guidelines or clinical practice standards in dentistry.

¹ Council for Affordable Quality Healthcare (CAQH). *The CAQH Index Report*. CAQH. Published 2024. Accessed January 7, 2026. <https://www.caqh.org/insights/caqh-index-report>

If MIPS were to be reformed or replaced, a new physician- and clinician-led quality program should rely on measures that are clinically relevant, evidence-based, and developed through a transparent, consensus-driven process. **For oral health care, the ADA requests that any quality measures used in a reformed program be those developed and tested by the Dental Quality Alliance (DQA).**

The DQA is the only comprehensive, multi-stakeholder organization dedicated to developing dental quality measures using a consensus-based methodology. It includes 36 participating organizations with expertise in oral health care, along with a public member, ensuring broad clinical input, scientific rigor, and patient-centered perspectives. Leveraging DQA-developed measures would help ensure that a reformed quality program meaningfully focuses on clinically-relevant oral health outcomes applicable across diverse practice settings, and would minimize administrative burden by using measures that are validated, operationally feasible, and aligned with existing dental practice workflows.

Thank you for your attention to these issues and for the opportunity to share the ADA's perspective. We would be pleased to serve as a resource for the Caucus as it continues with this bipartisan work, and offer to assist in developing proposals that ultimately contain healthcare costs and improve patient care. If you have any questions, please contact Natalie Hales at halesn@ada.org.

Sincerely,

/s/

Richard Rosato, D.D.S.
President

/s/

Elizabeth Shapiro, D.D.S., J.D.,
Interim Executive Director