

## **Topic 1: Accessing Healthcare and Related Challenges**

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, or utilizing healthcare services (including medication therapies) across CMS programs.

The American Dental Association (ADA) agrees with CMS that individuals should be able to efficiently navigate the healthcare system and access comprehensive healthcare, including oral healthcare. Individuals, especially those enrolled in the Medicaid program, are often not aware of the full coverage of benefits provided to them especially when adult dental benefits in Medicaid are optional for states to provide. This disparity in coverage discourages oral healthcare and hinders overall healthcare. For example, Medicaid already provides comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services, however, when those children age out of comprehensive benefits as they become young adults, many of them are cut off from that comprehensive healthcare. Furthermore, as an optional Medicaid benefit, states can often decide to cut dental benefits when fiscal constraints seem overly burdensome and states can change their benefits from one year to the next leaving the adult population not always aware when they have a dental benefit. The ADA Health Policy Institute (HPI) partnered with the CareQuest Institute for Oral Health in the development of the Medicaid Adult Dental Coverage Checker (<https://www.carequest.org/Medicaid-Adult-Dental-Coverage-Checker>). Released in 2022, the Coverage Checker is an interactive tool that identifies where each state's Medicaid adult dental benefits package falls on a continuum from "no dental benefits" to "extensive benefits." The currently available data reflect 2020 coverage levels. Additional data will be released to track trends over time.

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

### CHILDREN TRANSITIONING TO ADULTHOOD

Cost barriers to dental care for children have been reduced in recent years, and the racial disparities in cost barriers to dental care for children have narrowed.<sup>[vi]</sup> This is due in part to EPSDT, which has served a critically important purpose of aligning – to some degree – services and supports for children in Medicaid and CHIP across state lines. CMS has developed and promoted resources – such as *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*<sup>[vii]</sup> – that have helped state agencies ensure compliance with EPSDT while designing programs that meet the unique set of needs of both beneficiaries and health care providers. EPSDT provided a blueprint for states on designing programs that effectuate comprehensive dental care.

As children transition into adulthood, they experience considerable changes in their Medicaid benefits packages as their eligibility status changes from one categorically needy group to another. In some states, the availability of dental benefits through Medicaid is abruptly curtailed or removed entirely upon reaching the age of 21.<sup>[viii]</sup> These beneficiaries no longer have the security of comprehensive dental care coverage provided by the EPSDT benefit and they become subject to the patchwork of policies on adult dental coverage in state Medicaid programs.<sup>[ix]</sup> Even in states that have “extensive” dental benefits for adults in

Medicaid, utilization of these services is much lower than in the privately insured population.

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

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

#### MINIMUM SET OF SERVICES FOR ADULT DENTAL CARE FOLLOWING EPSDT MODEL

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

#### COMMUNICATING COVERAGE CHANGES TO BENEFICIARIES

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

#### LIMITS ON DENTAL CARE

The ADA urges CMS to remove annual limits in Medicaid dental care. These low dollar amounts impede access to care for patients who need extensive and ongoing dental work. Additionally, CMS should eliminate rules that only allow dentists to treat a certain number of teeth per year. If dental care is necessary, the dentist must be able to provide that care as needed and not be forced to treat some areas of the mouth and not others.

#### ORAL HEALTH ACCESS FOR FORMER FOSTER YOUTH

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

#### DENTAL HPSAs

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

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

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

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

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[i] Agency for Healthcare Research and Quality. 2021 national healthcare quality and disparities report. December 2021. AHRQ Pub. No. 21(22)-0054-EF. Available from: <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/2021qdr.pdf>. Accessed March 31, 2022.

[ii] Vujicic M, Buchmueller T, Klein R. Dental care presents the highest level of financial barriers, compared to other types of health care services. *Health Aff (Millwood)*. 2016;1;35(12): 2176-2182.

[iii] American Dental Association. Oral health and well-being in the United States. Health Policy Institute Infographic. 2015. Available from: <https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf>. Accessed March 31, 2022.

[iv] Vujicic M, Fosse C, Reusch C, Burroughs M. Making the case for adults in all state Medicaid programs. Health Policy Institute White Paper. American Dental Association in partnership with Community Catalyst and Families USA. July 2021. Available from [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper\\_0721.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf). Accessed March 31, 2022.

[v] Wehby GL, Lyu W, Shane D. Racial and ethnic disparities in dental services use declined after Medicaid adult dental coverage expansions. *Health Aff (Millwood)*. 2022;41(1):44-52.

[vi] American Dental Association. Cost barriers to dental care among the U.S. population, by race and ethnicity. Health Policy Institute Infographic. April 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic\\_0421\\_3.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0421_3.pdf). Accessed March 31, 2022.

[vii] Centers for Medicare & Medicaid Services. EPSDT – a guide for states: coverage in the Medicaid benefit for children and adolescents. U.S. Department of Health and Human Services. June 2014. Available from: [https://www.medicare.gov/sites/default/files/2019-12/epsdt\\_coverage\\_guide.pdf](https://www.medicare.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf). Accessed March 31, 2022.

[viii] Vujicic M, Fosse C, Reusch C, Burroughs M. Making the case for adults in all state Medicaid programs. Health Policy Institute White Paper. American Dental Association in partnership with Community Catalyst and Families USA. July 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper\\_0721.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf). Accessed March 31, 2022.

[ix] National Academy for State Health Policy. State Medicaid coverage of dental services for general adult and pregnant populations. October 2021. Available from: <https://www.nashp.org/state-medicare-coverage-of-dental-services-for-general-adult-and-pregnant-populations/>. Accessed March 31, 2022.

[x] Medicaid.gov. Mandatory & optional Medicaid benefits. Centers for Medicare & Medicaid Services. U.S. Department of Health and Human Services. Available from: <https://www.medicare.gov/medicaid/benefits/mandatory-optional-medicare-benefits/index.html>. Accessed March 31, 2022.

[xi] Congress.gov. S.3166 – Medicaid Dental Benefit Act of 2021. 117<sup>th</sup> Congress (2021-2022). Available from: <https://www.congress.gov/bill/117th-congress/senate-bill/3166?>. Accessed March 31, 2022.

[xii] American Dental Association. Letter from the ADA to Senator Ben Cardin. November 22, 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/211122\\_ada\\_cardinthankyouletter\\_medicaiddental\\_nosigs.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/211122_ada_cardinthankyouletter_medicaiddental_nosigs.pdf). Accessed March 31, 2022.

[xiii] National Academy for State Health Policy. State Medicaid coverage of dental services for general adult and pregnant populations. October 2021. Available from: <https://www.nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/>. Accessed March 31, 2022.

[xiv] Garvin J. ADA supports legislation expanding Medicaid oral health coverage for former foster youth. *ADA News*. May 2021. Available from: <https://www.ada.org/publications/ada-news/2021/may/ada-supports-legislation-expanding-medicaid-oral-health-coverage-for-former-foster-youth>. Accessed March 31, 2022.

[xvii] Garvin J. Health Resources and Services Administration urged to improve methods for determining shortage areas. *ADA News*. September 2020. Available from: <https://www.ada.org/publications/ada-news/2020/september/health-resources-and-services-administration-urged-to-improve-methods-for-determining-shortage-area>. Accessed March 31, 2022.

[xviii] American Dental Association. Geographic access to dental care. Health Policy Institute. Available from: <https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes/geographic-access-to-dental-care>. Accessed March 31, 2022.

- Recommendations for how CMS can address these challenges through our policies and programs.

1) In anticipation of a potential mandated adult dental benefit in Medicaid, be prepared to define what constitutes a minimum set of dental services for adults in the Medicaid program, using EPSDT as a model.

3) Require state agencies to notify beneficiaries of:

- a) upcoming changes in their eligibility group at least 120 days in advance;
- b) the services (categories and specific) for which they will no longer have coverage and the new service categories for which they will be newly covered; and
- c) where and how to access information on finding health care providers in the networks for which they are eligible.

4) Support efforts to educate pregnant women and new moms on the importance of oral health by encouraging and incentivizing state-level Medicaid and WIC agency collaborations. Assist states that offer a dental benefit to pregnant women to measure utilization of dental services among pregnant women.

5) Revise measures of geographic access to care. Work with HRSA to deploy a revised health professional shortage area (HPSA) algorithm similar to that used by the ADA Health Policy Institute that uses geomapping to locate beneficiaries, providers (with a particular focus on those accepting new patients), and travel options and times to care.

## **Topic 2: Understanding Provider Experiences**

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, operations, or communications on provider well-being and retention.

Example responses may include, but are not limited to:

The ADA believes strongly that public programs must be sufficiently funded and efficiently administered to ensure access to care and providers' willingness to serve those in public programs. There are sound, reasonable principles related to payment that can be tailored to meet the specific needs of states while being uniformly required by all. Two of these concepts are: regular assessments of fees; and establishing parity in payments across eligibility groups.

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

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

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

### **FEE ASSESSMENT**

Many states have not revisited their Medicaid dental payment rates for years. (This is important not only in traditional fee for service programs, but also in the state-provided fee guidance that is provided to managed care contractors.) When rates do not adjust for the price of inflation or the CPI year over year, this can eventually become prohibitory to participation, as the provision of care becomes costlier than the associated reimbursement received for delivering the care.

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

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

### **PAYMENT PARITY**

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

Similarly, reimbursement rates for child dental services are typically higher than for the same service delivered for the adult population in Medicaid. In a recent analysis, HPI found that 2020 Medicaid reimbursement rates were 61.4% of private insurance reimbursement rates for child dental services on



average in the U.S., as compared to 53.3% of private reimbursement rates for adult dental services.[iii]

## STATE SUPPORT NECESSARY

State Medicaid agencies will need programmatic and financial support to implement these measures. It is likely that any significant rate increases for any eligibility group or the program as a whole will need to be scaled up over time. The ADA urges CMS to support a 90/10 federal-state match for dental care.

## BASIC FINANCIAL MEASURES (PMPM)

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

## DENTAL LOSS RATIO

We believe CMS should require states to report dental loss ratio (DLR) for managed care dental programs, modeled after the ACA's MLR. CMS should publish a state by state assessment of managed care organizations with the percentage of allotted Medicaid funding that is being spent on dental services.

## LICENSURE PORTABILITY

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

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

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

To help address some of the common administrative concerns, the ADA developed a template for state Medicaid agencies that are working with third-party administrators and/or managed care plans to design dental programs that are not overly burdensome on the provider. This resource – *Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract* – is publicly available at <https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid-rfp-dental-contract.pdf>. The ADA has also developed “best practices” to support states in creating a Medicaid managed care program environment that is provider-friendly.

We believe CMS should recommend the following to states:

## PROFESSIONAL EXPERTISE, INPUT, AND BUY-IN FROM INCEPTION TO EVALUATION

- Establish a Medicaid Dental Advisory Committee. Every state Medicaid agency should appoint and use an advisory committee that brings together the dentists, carriers, and consumer representatives. There should be quarterly meetings, at minimum, to promote an open line of communication to improve the

program.

- Issue a request for information (RFI) prior to any new or renewed contract opportunity to gather input from all stakeholders in the state, including patient/consumer organizations and providers/dentists. (The RFI should serve as a “needs assessment,” informing state agencies on the elements that are necessary for a successful program.)
- Licensed dentists should lead administrative teams on utilization review and similar activities.
- Licensed dentists, as a third-party, should be consulted and involved in auditing processes. Auditors should undergo standardized training to reduce variability and unpredictability in the evaluation of providers against program integrity principles. This would promote the objective review of providers in auditing practices. Punitive auditing practices have resulted in amplified fears of participating in Medicaid, exacerbating low provider participation. When the diagnosis, treatment, and billing are within reasonable limits of the Medicaid policies and clinically sound, dentists should not face financial penalties. Auditing practices must be fair and reasonable.

## CREDENTIALING

- A state-supported common credentialing entity (e.g. CAQH ProView) that provides a uniform credentialing application that meets all state-specific needs to be used across all contractors should be considered.

(Note: OTAG invited staff from the ADA and TennCare, the Tennessee Medicaid program, to a November 2021 meeting to discuss the relationship with CAQH, an endorsed partner that offers online centralized credentialing repository that streamlines processes across carriers and plans, including Medicaid MCOs and contractors. We highly encourage CMS to incentivize state agencies to pursue CAQH ProView as the universal credentialing tool for all Medicaid provider types, not just dentists. TennCare has had great success doing this, resulting in significant improvements in their Medicaid credentialing processes.)

- Process applications within 30 days of receipt of completed application
- When contracting arrangements are initiated (i.e. FFS to MC transition) or undergo a change (e.g. new MCOs established), streamline the re-credentialing with the new contractor – allow those providers previously enrolled to simply opt into the new program/plan
- Allow – but do not require – the participation of providers in as many plans as they are eligible; do not limit their participation to one plan/insurer.
- Additionally, we encourage CMS to work with NCQA to establish guidelines for provisional credentialing. Health care providers who want to serve the Medicaid population in their communities should not be delayed in doing so due to administrative checkboxes. A 90-day provisional credentialed status should be issued following a cursory review (i.e. certification that a license has never been suspended or revoked). It should be a reasonable standard for credentialing bodies to process applications within 30 days, and penalties should be instated when a review process exceeds 90 days.

## COMMUNICATION

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

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[i] American Dental Association. Medicaid fee-for-service (FFS) reimbursement and provider participation for dentists and physicians in every State. Health Policy Institute Infographic. April 2017. Available from:

[https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic\\_0417\\_1](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0417_1). Accessed March 31, 2022.

[ii] Vujicic M, Nasseh K, Fosse C. Dentist participation in Medicaid: how should it be measured? Does it matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief\\_1021\\_1.pdf?](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf?). Accessed March 31, 2022.

[iii] American Dental Association. Reimbursement rates for child and adult dental services in Medicaid by state. Health Policy Institute Infographic. October 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic\\_1021\\_1.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_1021_1.pdf). Accessed March 31, 2022.

[iv] American Dental Association. Dental insurance reform: state legislation 2021. 2021. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-insurance/ada\\_dental\\_insurance\\_reform\\_state\\_legislation\\_2021.pdf](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-insurance/ada_dental_insurance_reform_state_legislation_2021.pdf). Accessed March 31, 2022.

[v] Coalition for Modernizing Dental Licensure. Available from: <https://www.dentalicensure.org/en>. Accessed March 31, 2022.

- Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

IN SUMMARY, WE RECOMMEND THE FOLLOWING:

1. Require states to conduct a regular – such as annual or tri-annual – assessment of their fee policies and make this data publicly accessible.
2. Phase out the discriminatory practice of paying different rates for the same services for different populations or eligibility groups. Payment rates for all CMS programs should be on par with other CMS programs (e.g. Medicaid and CHIP) and should be benchmarked to state-level private insurance rates (using FAIR Health data, ideally).
3. Incentivize states that raise fees.
4. Require states to report the dental loss ratio (DLR) for managed care dental programs, modeled after the ACA MLR.
5. Require states to report the average benefit paid per user and the average benefit paid for beneficiary.
6. Develop subject matter expertise within the agency that can assist state agencies with their discussions and negotiations with state licensing and professional boards to promote licensure portability.
7. Require each Medicaid agency to establish a Dental Advisory Committee. This committee should offer input prior to the release of any new contracting opportunity. The Committee should also be involved in setting auditing policies and practices for the state.
8. Promote the use of a uniform credentialing application, such as CAQH ProView.
9. Require that states proactively communicate with their provider networks in advance of any programmatic, administrative, or fees changes.

### **Topic 3: Advancing Health Equity**

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual



and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

- Identifying CMS policies that can be used to advance health equity:

Significant disparities exist with regard to affordable, culturally competent, geographically convenient and appropriate oral health services in the U.S. For example, an analysis of 2017-18 data from the Medical Expenditure Panel Survey (MEPS) by the American Dental Association's Health Policy Institute showed that among children, 55.5% of non-Hispanic white children accessed dental services in the past year, compared to 42.6% of non-Hispanic black children and 46.9% of Hispanic children. Among adults, 47.8% of non-Hispanic whites accessed dental services in the past year, compared to just 28.6% of non-Hispanic black adults and 27.8% of Hispanic adults.[i] The ADA strongly believes in the importance of oral health equity, and urges CMS to adopt policies that promote it.

As described in the ADA's response to the previous question, one key way to achieve oral health equity would be to mandate comprehensive adult dental Medicaid benefits in all states, not just some. We also believe that it is critically important to support the Medicaid dental programs in the U.S. territories, whose residents (many of whom are people of color) need and deserve equity with the residents of the states.

Oral health equity also requires a dental health workforce that is culturally competent and diverse. CMS should ask states to incentivize Medicaid dentists to undertake cultural competency training. CMS should also encourage the use of Community Dental Health Coordinators (CHDCs) and allow for their services to be reimbursed under Medicaid. CHDCs are Community Health Workers with a dental skill set. Because they often come from the same communities as their patients, they are better able to relate to these patients and connect them to oral health care.

Oral health equity is also greatly needed for people with disabilities. CMS should help to increase the number of dentists who can see these patients by supporting the dentists' training and continuing education, as well as providing funding for the renovations and equipment needed to see these patients. The ADA would also like to express its strong support for CMS' recent proposal to reclassify the CPT code generally used to report dental procedures performed in hospital outpatient settings (CPT 41899) into the Ambulatory Payment Classification (APC) that includes other dental procedures (proposed reclassification of CPT 41899 from APC 5161 to 5871). The resulting increase in Medicare payment for dental procedures that require general anesthesia has the potential to mitigate the current reimbursement obstacles to OR access for people with disabilities. However, there are still many patients with disabilities that need access to operating rooms for dental surgeries that cannot be accommodated in a hospital, or who live too far from a hospital. These patients need access to dental surgeries in ambulatory surgical centers (ASCs), and CMS should facilitate that through the use of a single CDT code on the ASC list that would be used to report covered dental procedures in ASC settings.

The ADA is a strong supporter of the MOBILE Health Care Act that was recently signed into law (P.L. 117-204), and believes that this legislation can increase access to care in underserved communities through the use of mobile vans. The ADA urges CMS to work with HRSA to ensure that mobile dental, as well as medical, vans are included in the MOBILE Act grant programs. This will help increase oral health equity for underserved areas and populations.

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[i] American Dental Association. Dental Care Utilization Among the U.S. Population, by Race and Ethnicity. Health Policy Institute Infographic. Available from: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic\\_0421\\_4.pdf?rev=0ffe420839ed4c69aa8c9ca37eaaff92&hash=3101021432490F3385B835C4C0FF06E2](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0421_4.pdf?rev=0ffe420839ed4c69aa8c9ca37eaaff92&hash=3101021432490F3385B835C4C0FF06E2). Accessed October 28, 2022.

#### **Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities**

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health

disparities that may have been exacerbated by the PHE. Example responses may include, but are not limited to:

- Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on health care providers, suppliers, patients, and other stakeholders.

In terms of maintaining or exacerbating equitable access to dental care, at least three waivers/flexibilities qualify as best practices or lessons learned from the COVID-19 pandemic.

- **Best practice: Waiver authority to administer COVID-19 vaccines.** One of the Biden administration's early priorities was to expand the pool of clinicians who were able to vaccinate the public against COVID-19. Dentists were able to participate in this effort nationwide when the Assistant Secretary for Health authorized dentists to administer the COVID-19 vaccines under the PREP Act.<sup>1</sup> At the time, at least 19 states<sup>2</sup> had already authorized dentists to administer the approved COVID-19 vaccines, and nine others<sup>3</sup> and the District of Columbia were discussing similar measures.

Consider also that almost two-thirds of dental patients scheduled for a routine dental visit (65 percent) reported being willing to get a COVID-19 vaccine from their dentist.<sup>4</sup> That made every dental encounter an opportunity to educate and vaccinate—and a chance to shorten the line at other vaccination locations.

- **Best practice: Eligibility for Tier 1 vaccine access.** The Centers for Disease Control and Prevention recommended that dental personnel be placed in Tier 1 of critical workers who should be given immediate access to the initial limited supply of the COVID-19 vaccines.<sup>5</sup> Not only did early vaccination enable dentists to volunteer as COVID-19 vaccinators, but it also enabled dental offices to remain open and continue providing care for those with dental benefits.
- **Lesson learned: Waiver authority to administer COVID-19 tests.** Early in the pandemic, the Assistant Secretary for Health granted temporary authority for pharmacists to order and administer FDA-approved COVID-19 tests.<sup>6</sup> Despite considerable effort on our part, however, federal officials never granted dentists the authority to do the same. It was a missed opportunity to test the more than 27 million people who visit a dentist every year, but not a physician.<sup>7</sup>

We note that at least 24 states<sup>8</sup> and the District of Columbia eventually (or already had) approved dentists conduct COVID-19 point of care testing. However, many dentists were not familiar with the requirement to obtain (or the process for obtaining) a Certificate of Waiver from CMS, as required by Clinical Laboratory Improvement Act<sup>9</sup>.

We do not believe HHS intended to exclude any qualified providers from being able to administer COVID-19 point-of-care tests. It is simply our experience that including dentists in pre-pandemic planning can prevent these missed opportunities from happening.

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[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Seventh Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 86 Fed. Reg. 14462 (March 16, 2021).

[2] As of Feb. 8, 2021, Alabama, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Rhode Island, and Washington have authorized dentists to administer FDA-approved COVID-19 vaccines.

[3] As of Feb. 8, 2021, Indiana, Iowa, Minnesota, Mississippi, Missouri, Nebraska, Nevada, Utah, West Virginia, Wisconsin, and the District of Columbia are considering measures that would allow dentists to

administer FDA-approved COVID-19 vaccines.

[4] ADA Health Policy Institute. COVID-19: Economic Impact on Dental Practices. Week of January 18, 2021 Results.

[5] Centers for Disease Control and Prevention, COVID-19 Vaccination Playbook for Jurisdictional Operations (January 2021, Version 1.0) and Centers for Disease Control and Prevention, Categories of Essential Workers: COVID-19 Vaccination (January 11, 2021).

[6] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Guidance for Licensed Pharmacists, COVID-19 Testing, and Immunity under the PREP Act (April 8, 2020).

[7] American Dental Association, Screening for Chronic Diseases in the Dental Office (2020).

[8] As of Feb. 8, 2021, Arizona, California, Connecticut, Florida, Georgia, Idaho, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wisconsin, and the District of Columbia have allowed dentists to order and/or administer FDA-approved COVID-19 tests.

[9] 42 U.S.C. 263a. Certification of laboratories.