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July 3, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically at Regulations.gov

Re: CMS-2442-P; Medicaid Program; Ensuring Access to Medicaid Services

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Pediatric Dentistry (AAPD)[1] and our nearly 11,000 members, we appreciate the opportunity to comment on the ***Ensuring Access to Medicaid Services*** proposed rule for the Medicaid program (**CMS-2442-P**), relating to 42 CFR Chapter IV. We applaud the Centers for Medicare & Medicaid Services' (CMS) commitment to increasing transparency and accountability, standardizing and streamlining data collection and monitoring, and promoting active beneficiary, provider, and other stakeholder engagement in State Medicaid programs. Our suggestions and requests for consideration follow, and we especially draw your attention to AAPD's concerns regarding the shortcomings of relying exclusively on Medicare payment rates for rates analyses (page 4-5).

42 CFR Part 431: State Organization and General Administration

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG)

- **Establishing the MAC and BAG:** Recognizing that the structure and composition of Medical Care Advisory Committees (MCAC) have not adequately facilitated the open sharing of feedback across all members – particularly beneficiaries – the establishment of a Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG) is a sound suggestion. It is sensible to require at least 25% of the MAC to be individuals with lived beneficiary experience, either currently or in the past. We agree that staffing is necessary for the recruitment, administration, institutional knowledge, and ongoing support for these bodies, and the Federal financial

[1] The AAPD is the recognized authority on children's oral health. As advocates for children's oral health, the AAPD promotes evidence-based policies and clinical guidelines; educates and informs policymakers, parents and guardians, and other health care professionals; fosters research; and provides continuing professional education for pediatric dentists and general dentists who treat children. Founded in 1947, the AAPD is a not-for-profit professional membership association representing the specialty of pediatric dentistry. Our nearly 11,000 members provide primary care and comprehensive dental specialty treatments for infants, children, adolescents and individuals with special health care needs. For further information, please visit the AAPD website at http://www.aapd.org or the AAPD's consumer website at http://www.mychildrensteeth.org.

participation (FFP) will be helpful to States. AAPD supports CMS's proposal to allow one year for states to establish and initiate their MAC and BAG.

- **Scope of Topics:** The scope of topics to be addressed by the MAC and BAG should extend to all service categories included in the State Medicaid program (e.g. pediatric dentistry and adult dental care when applicable), not limited to the service categories explicitly noted in this proposed rule (e.g. primary care, obstetrics and gynecology, and behavioral health). We support the proposal to include topics on health-related social needs (e.g., transportation, care coordination, housing supports, etc.) in the agendas of the MAC and BAG, so beneficiaries and other stakeholders can regularly discuss whether these services are being effectively promoted and administered in their State.

- **Representation of Children:** In line with including "categories of members that can best reflect the needs of a Medicaid program," experiences of children must be represented on the MAC and BAG. As such, AAPD urges CMS to require States to include a parent, guardian, caretaker, or other proxy representative for children in their BAG and MAC membership.

- **Representation of Providers:** While the proposed rule notes that the MAC should have representation from "clinical providers or administrators," we strongly believe that clinicians and administrators have sufficiently distinct experiences and perspectives as related to Medicaid programs. AAPD urges CMS to require representation of clinical providers *in addition to* administrators. Providers representing each covered health service category should be represented on the MAC. While perspectives of providers opting *not* to participate in Medicaid are important to understand, the majority of provider representation should be that of providers with meaningful experience in Medicaid programs (i.e., providers who are enrolled and actively treating Medicaid beneficiaries). We suspect that professional associations (much like AAPD) would be pleased to support States as they identify candidates for participation.

  Additionally, some states have Dental Advisory Committees (DACs) that have worked closely with MCACs in the past. AAPD suggests MACs include representation from existing DACs and continue to share information and coordinate activities.

- **BAG Accessibility:** We commend the proactive approach that CMS has outlined to make participation in the State BAG feasible for those with varying schedules, locations, logistical challenges, and technology capabilities. These accommodations – in addition to making the meetings accessible for people with disabilities – are important for the earnest participation of beneficiaries.

- **State Guidance for Recruitment:** AAPD suggests CMS provide subregulatory guidance to states for recruitment of MAC and BAG members with information on common stakeholder groups and organizations a State may wish to engage in their MAC and/or BAG. Organizations such as Family Voices and state oral health coalitions have vast experience elevating the consumer voice. Additionally, CMS could consider suggesting that States include basic information regarding the BAG in enrolment materials (such as, "[State Medicaid agency] has a Beneficiary Advisory Group to represent you in Medicaid. Interested in getting involved or learning more? Visit …"). For the MAC, subregulatory guidance to states may include a more comprehensive list

of possible recruits for ex officio roles. In addition to representatives from state agencies or offices for foster care, mental health, and public health – as noted in the proposed rule – others might include the developmental disabilities agency, department of education, welfare and social supports, and more.

- **Website Transparency & Information Sharing:** We agree that MAC and BAG information should be readily available to beneficiaries and other stakeholders. AAPD gently suggests that CMS consider publishing an "MAC and BAG hub" on its own website where users can quickly be directed to their States' MAC and BAG information, similar to the easily navigable Medicaid Unwinding State Map web page. As the proposed rule notes, the State pages would house the current roster, selection process, meeting dates, annual reports with state response, and an area for eligible users to indicate interest.

42 CFR Part 441: Services

Home and Community Based Services (HCBS)

- **Dedicated to Serving People with Disabilities:** The profession of pediatric dentistry is deeply committed to serving people with disabilities, oftentimes beyond childhood. We are invested in the long-term health and wellbeing of those served by HCBS. It is noted in the proposed rule that, "the Affordable Care Act requires States to allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving HCBS." AAPD looks forward to fostering relationships with HCBS administrators and service providers to ensure dental needs are addressed in HCBS programs and oral health is included in HCBS person-centered care plan development.

- **HCBS Quality Measure Set:** We support CMS's proposal to move from voluntary to required HCBS reporting. We urge CMS to include an oral health measure in the mandatory HCBS Quality Measure Set. CMS has identified the appropriate measures / measure sets from which to craft the HCBS Quality Measure Set, including the NASDDDS/HSRI NCI-IDD preventive screening measures (including routine dental exams), as well as the CMS Core Sets (including measures on topical fluoride, sealants, and oral evaluation). Further, we understand the movement from burdensome and costly (perhaps especially so with the HCBS population) survey-based measures to those that are yielded from administrative data. The FFP for the design of new data collection and reporting systems at 90%, and operation at 75% should be very helpful to states.

- **Defining Direct Care Workers:** The rule states, "We propose to define direct care workers to include workers who provide nursing services, assist with activities of daily living, or instrumental activities of daily living…" While not directly addressed, we look forward to the ongoing dialogue regarding the eligibility of parents or family members to be considered direct care workers if their primary role is caregiving for children or other family members with disabilities.

- **Website Transparency & Information Sharing:** We agree that HCBS information should be readily available for consumers. AAPD gently suggests that CMS consider publishing an "HCBS

hub" on its own web domain where users can quickly be directed to their States' HCBS program, information on waiting lists, and more, similar to the easily navigable Medicaid Unwinding State Map web page.

42 CFR Part 447: Payments for Services

- **Fair Payment Rates:** AAPD appreciates CMS's detailed review and summary of the literature on the impact of payment rates for providers on access to care for beneficiaries. We wholeheartedly agree that fair, market-based rates are essential to an effective Medicaid program that engages and retains sufficient providers to meet the needs of its beneficiaries in a timely manner. As stated in the rule, "the [Social Security] Act requires that State plans 'assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.'"

- **Payment Rate Transparency:** The proposed rule states, "While there is no current Federal requirement for States to consistently publish their rates in a publicly accessible manner, we are aware that most States already publish at least some of their payments through FFS rate schedules on State agency websites. Currently, rate information may not be easily obtained from each State's website in its current publication form, making it difficult to understand the amounts that States pay providers for items and services furnished to Medicaid beneficiaries and to compare Medicaid payment rates to other health care payer rates or across States. However, through this proposal we seek to ensure all States do so in a format that is publicly accessible and where all Medicaid FFS payment rates can be easily located and understood." This assessment of the challenges of accessing rates aligns with our experience and we enthusiastically support the proposal to require publishing rates in an easily accessible format online. Additionally, AAPD agrees that "the availability of this data could be used to inform State policy changes, to compare payment rates across States, or be used for research on Medicaid payment rates and policies."

- **Comparative Payment Rate Analysis:** We understand that Access Monitoring Review Plans (AMRP) were burdensome for states, ambiguous in direction, not widely used by stakeholders for which they were designed, and had questionable utility in measuring or understanding access to care. We generally support the proposal to replace AMRP with a better defined and targeted payment rate analysis methodology. However, we note some concerns as follows related to the proposed reliance on Medicare payment rates.

- **Concerns with Reliance on Medicare:** The proposed rule states, "We considered, but did not propose, requiring States to use a different point of comparison, other than Medicare, for certain services where Medicare is not a consistent or primary payer, such as pediatric dental services or HCBS" [emphasis added]. We believe strongly that payment rate analysis should be required for all mandatory Medicaid service categories, including pediatric dentistry. While Medicare payment rates may be used reliably for many health services, it is not currently feasible for using as a rate comparison for dental care. The Medicare Physician Fee Schedule does include dental procedural codes (as noted in the proposed rule), however, there are

generally not RVUs assigned for CDT codes. Further, the CDT codes included in the MPFS may not be comprehensive for a pediatric population. Also as noted, private payer payment data is typically considered proprietary and not available to the public.

AAPD would be supportive of utilizing the largest state employee dental plan or FAIR Health data to develop benchmarks for dental service payment rate analysis. It is our understanding that many State Medicaid agencies' analytics teams are familiar with FAIR Health, even if it has not to date been used for dental purposes. States may need support in the form of a higher percentage FFP to incorporate that data source and analytics process into their routines. (Please note that the characterization of the ADA Survey of Dental Fees was not accurately presented in the proposed rule. This survey information is based on dentists' full charges; it is not obtained from private payers. For this reason and others, it may not be suitable for Medicaid benchmarking purposes.)

- **Subpopulations:** The proposed rule indicates, "for States that pay varying Medicaid FFS payment rates by population (pediatric and adult), provider type, and geographical location, as applicable, those States would need to separately identify their Medicaid FFS payment rates in the payment rate transparency publication by each grouping or multiple groupings, when applicable to a State's program." We agree with this approach. Additionally, within the pediatric population, separate Medicaid and CHIP payment rate information should be included where applicable.

- **Medicaid Provider Participation:** AAPD appreciates CMS's recognition of the following (emphasis added): "The ability for providers and beneficiaries to provide ongoing feedback to the State regarding access to care and a beneficiary's ability to access Medicaid services is essential to the Medicaid program in that it provides the primary interested parties the opportunity to communicate with the State and for the State to track and take account of those interactions in a meaningful way."

- **"Consistent Administration" Concerns:** It is understood that "Medicaid FFS payment rates published under the proposed payment rate transparency requirement would only include fee schedule payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through a FFS delivery system." There is not currently a mechanism to obtain comparable payment information from managed care entities, given its proprietary nature. However, we look forward to this ongoing discussion – including as part of the Managed Care Proposed Rule comment period – on how CMS can uphold its obligation to monitor and secure access to services without more payment transparency in a managed care environment.

- **Meaningfully Measuring Realized Access:** From the proposed rule: "We are seeking public comment regarding our decision not to propose States identify the number of unique Medicaid paid claims and the number of unique Medicaid enrolled beneficiaries who received a service within a calendar year." The number of unique Medicaid enrolled beneficiaries who received a service seems to be one of the most meaningful and feasible measures of realized access. It is understood that some individuals and populations fare better in navigating and accessing care in

Medicaid programs. As such, the raw number of claims for a service may not be as powerful an indicator of true, program-wide access to services.

- **Other Administrative Aspects:** While the pediatric dental community typically is not deeply involved in the administrative aspects of the following, we voice our general support for these aspects of the proposal:

    - **Reporting Timeframe:** We agree with the biannual reporting of payment rates. Triennial (AMRP) was too infrequent, annual could be too burdensome.
    - **Initial and Additional State Rate Adjustment Processes:** We support the two-tiered approach.
    - **Interested Parties Advisory Group:** We stress the importance of soliciting feedback from providers, the public, and other interested parties.
    - **Compliance:** In instances of State noncompliance, the proposal to withhold or reduce the FFP (federal share) seems sensible.

Thank you for the opportunity to comment on the proposed rule. AAPD looks forward to continuing to work with CMS to ensure that all Medicaid and CHIP beneficiaries can access high quality dental care. Should you have any questions, please contact Dr. Chelsea Fosse, Director of the AAPD Research & Policy Center, at 773-938-4857 or cfosse@aapd.org.

Sincerely,

Scott W. Cashion, DDS, MS
President