January 4, 2021

Seema Verma, M.P.H.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: CMS-9912-IFC; Centers for Medicare and Medicaid Services Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

On behalf of our collective dental organizations, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," hereafter referred to as the IFC. Specifically, our comments focus on Medicaid's optional benefits and mass immunization efforts.

Elimination of Optional Medicaid Benefits Coverage

We are concerned about the impact of the IFC on both Medicaid beneficiaries and their dental providers. The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, includes an option for states to receive enhanced Federal Medical Assistance Percentage (FMAP). In exchange for these additional funds, states must agree to comply with maintenance of effort (MOE) protections. These protections help ensure beneficiaries are able to get and remain covered during the public health emergency (PHE) and receive essential care. The FFCRA includes a requirement to preserve the enrollee's existing benefits, both their enrollment in Medicaid overall and the services for which they have been eligible.

Within the IFC is a new interpretation of Section 6008(b)(3) of the FFCRA which would allow states claiming the 6.2 percentage point FMAP increase to make programmatic changes, such as eliminating optional benefits coverage. Optional benefits like dental care are essential to patient health. Giving states the ability to cut these benefits will harm Medicaid providers, beneficiaries and state budgets.

Past experience shows us that when optional dental benefits are cut during times of fiscal uncertainty in states, the result is an increase in overall associated costs.[1] [2] For example, cuts to optional dental benefits in Massachusetts in 2002 and 2003 and in California in 2009 resulted in both a decline in provider reimbursements as well as increases in associated costs because oral health needs went untreated by providers. This, in turn, led to increased dependence on emergency departments (EDs) for dental problems, which further increased costs for states. We urge a return to previous guidance that kept in place states' benefits packages if accepting an increase in Medicaid funding as this will cost states less over time than making cuts to essential care during a public health emergency.

[1] Health Affairs. Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs. May 2015.
[2] American Journal of Public Health. Effects of Cuts in Medicaid on Dental-Related Visits and Costs at a Safety-Net Hospital. June 2014.

Provider Surge for Mass Immunization
Regarding your request for ideas on how to expand the nation's capacity to immunize the public against COVID-19, we urge the Department of Health and Human Services (HHS), under the Public Readiness and Emergency Preparedness Act (PREP Act), to expand authorization for dentists to order and administer these vaccines. Dentists are essential health care providers who have the knowledge and skills to administer vaccines safely. They are already approved to administer vaccines in Illinois, Minnesota and Oregon. A temporary liability shield at the federal level would extend that authority nationwide during this public health emergency.

Dentists can help increase the nation's medical surge capacity when medical personnel are overwhelmed as they are trained health care providers who can administer critical vaccines to prevent life or health-threatening conditions—and protect the life and health of patients and staff at the point of care. It is worth noting that every year more than 27 million people visit a dentist, but not a physician.[3] Every one of these encounters is an opportunity to vaccinate these individuals for COVID-19.

Expanding the scope of practice, particularly during times of health crisis, is not unprecedented. During the 2009 H1N1 Influenza Pandemic, several states expanded the provider scope of practice to allow dentists to administer the H1N1 vaccine. Dentists administering H1N1 vaccinations had to follow certain state policies, including completing state-defined training and reporting data to the state immunization registry. Certainly, the COVID-19 pandemic justifies continuing this precedent.

As vaccinations begin in the U.S., we implore you to expand the scope of practice for dentists, particularly public health dentists, to administer vaccines in order to aid in outbreak prevention and control. We stand ready to assist with the logistics and practical implementation questions of the expanded scope of practice, including but not limited to, insurance code and reimbursement questions; vaccine acquisition, preservation, and disposal; and immunization reporting requirements.

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We look forward to continuing to work with CMS and we would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. Please contact Mr. David Linn at the ADA at (202) 789-5170 and linnd@ada.org to facilitate further discussion.

Sincerely,

American Dental Association
Academy of General Dentistry
American Academy of Dental Group Practice
American Academy of Oral and Maxillofacial Pathology
American Academy of Oral and Maxillofacial Radiology
American Academy of Pediatric Dentistry
American Academy of Periodontology
American Association of Endodontists
American Association of Oral and Maxillofacial Surgeons
American College of Prosthodontists
American Society of Dentist Anesthesiologists
American Student Dental Association

[3] American Dental Association, Screening for Chronic Diseases in the Dental Office, 2020.