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VIA EMAIL: mfoley@medicaiddental.org

February 12, 2026

Mary E. Foley, RDH, MPH
Executive Director
Medicaid Medicare Chip Services Dental Association
2 Grove Street
Sandwich, MA 02563

Dear Ms. Foley:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS) and our 9,500 fellows and members, we appreciate the ongoing work your organization has undertaken to evaluate and strengthen Medicaid dental programs. As a Medicaid provider, to both children and adults, since I began practicing, this topic is of utmost importance to me and the patients I serve. We share your commitment to ensuring that beneficiaries receive the highest standard of care, and we value the intent behind the recently published white paper, *Exploring Policy Solutions that Support the Delivery of General Anesthesia Supplemental Services Associated with Dental Care.*

After careful review of the white paper, we have several concerns, but none as great as regarding the following recommendations, stated on pages 25 and 26:

> *State Medicaid programs should require a dual-provider model for the administration of deep sedation and GA in all dental settings, ensuring that a dedicated, qualified anesthesia provider—such as a MAs, DAs [sic]—is continuously present and not simultaneously performing dental or surgical procedures. This separation of clinical roles upholds patient safety, enables immediate airway management, and aligns with national standards for safe anesthesia delivery.*
>
> *To strengthen patient safety and uphold consistent standards of care, Medicaid policy should require dual providers—that all deep sedation and GA services be administered by a dedicated, qualified anesthesia professional, distinct from the operating dentist.*

While we fully support discussions that meaningfully advance patient safety, the conclusions presented in the paper are not supported by the breadth or depth of evidence necessary to justify such a substantial change in care delivery. More importantly, the document does not fully examine the serious consequences such a policy could have on access to care for Medicaid beneficiaries—particularly those in underserved and rural communities.

I. Concerns Regarding Accuracy and Interpretation of Clinical Practice

The white paper contains factual inaccuracies and oversimplifications concerning how anesthesia is delivered in dental and oral surgery practices. It treats office-based anesthesia as a uniform model,

without distinguishing between provider types, training pathways, or practice structures. This lack of differentiation leads to conclusions that do not reflect clinical and regulatory realities.

Oral and maxillofacial surgeons (OMSs) complete rigorous, accredited residency training programs that include extensive anesthesia education, hospital-based anesthesia rotations, and proficiency requirements comparable to those of many anesthesia professionals in outpatient settings. OMSs' extensive anesthesia training does not end with these anesthesia rotations and continues throughout the entire four- to six-year residency program through the administration of deep sedation and general anesthesia in the OMS clinic. Upon entering practice, OMSs continue to meet strict credentialing and regulatory requirements and undergo regular office evaluations to ensure adherence to established safety standards. By omitting these distinctions, the white paper misrepresents the qualifications of OMSs who safely provide anesthesia within integrated surgical–anesthesia care models, in contrast to other dental providers who may not receive comparable anesthesia training.

The white paper also references the potential involvement of certified anesthesiologist assistants. However, these professionals must practice under the supervision of a physician anesthesiologist and are generally restricted by state law to hospitals and ambulatory surgery centers. These limitations make their use in dental offices impractical, and including them in this discussion is inappropriate. Similarly, the paper does not accurately portray the reality of CRNA practice, particularly the nuanced differences between treatment in a hospital setting versus a dental office. These mischaracterizations risk misleading policymakers unfamiliar with the established and well-regulated nature of office-based dental anesthesia care.

II. Absence of Supporting Evidence for Separate-Provider Anesthesia Models

Critically, the white paper does not present scientifically validated data demonstrating that the involvement of a separate anesthesia provider improves patient safety outcomes in dental or oral surgery settings. The recommendation is not supported by peer-reviewed studies, comparative outcomes research, closed-claims analyses, or claims-based evaluations that measure morbidity, mortality, or anesthesia-related adverse events.

Without objective data showing that separate-provider anesthesia improves patient outcomes, it is difficult to understand how this recommendation advances patient safety. Reorganizing care delivery without supporting evidence risks introducing new inefficiencies, additional care-team communication complexities, and logistical challenges that may not increase safety and could compromise continuity of care.

Further, the paper indicates that "States that require a dedicated anesthesia professional for all [general anesthesia] cases demonstrate fewer critical incidents and improved patient recovery times (pg. 22)." No states currently require such a model, and no data supporting this claim exists. In fact, to the contrary, data found via statewide adverse event reviews in California[1] and Texas[2] found no such correlation exists and the use of a dedicated anesthesia provider does not further patient safety outcomes.

[1] Dental Board of California Pediatric Anesthesia Study. 2016. https://www.dbc.ca.gov/formspubs/anesthesia_study.pdf

[2] Texas Blue Ribbon Panel on Dental Anesthesia/Sedation Safety. 2017. https://www.sunset.texas.gov/public/uploads/files/reports/Blue%20Ribbon%20Panel%20Final%20Report_January%202017_0.pdf

III. Consequences for Medicaid Patient Access to Care

The proposed recommendation does not adequately consider the effect such a policy may have on Medicaid patient access. A review of claims data show that OMSs are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia and IV sedation services in the U.S. to patients, with OMSs delivering 77 percent[3] of private dental setting services and 70 percent[4] of all Medicaid setting services. Because OMSs provide the majority of dental office-based anesthetic care in the country, we are uniquely qualified to offer informed opinion on this topic. This data shows we are a vital keystone in patient treatment models and any limitation on our ability to practice would negatively impact timely access to care.

Many communities – especially rural and underserved areas – already face shortages of both oral surgeons and anesthesia professionals. Requiring or strongly encouraging the use of a second anesthesia provider introduces additional scheduling, staffing and reimbursement challenges that many practices simply cannot absorb. For Medicaid patients, who already navigate limited provider availability and long wait times, these barriers may translate into:

- Longer delays before receiving needed surgical care
- Increased travel distances for essential oral surgery services
- Reduced participation by OMS providers in Medicaid programs
- *De facto* elimination of office-based sedation or anesthesia options in some communities

These concerns are far from hypothetical. Medicaid reimbursement rates for dental and surgical services frequently fall below the cost of delivering care, and adding another provider without adjusting reimbursement structures would impose an unfunded mandate on practices that are already operating on narrow margins. Without addressing these financial realities, the recommendation could unintentionally widen existing disparities rather than improve safety.

IV. A Request for Balanced, Evidence-Based Policy Development

Any Medicaid policy recommendation must be evaluated holistically, with a comprehensive view of patient safety, clinical accuracy, access to care and system-wide impact. Policies that increase cost, reduce access, impose additional administrative burdens or require staffing models that are not feasible –without clear evidence of any safety benefit – will ultimately harm the very populations Medicaid is intended to serve.

AAOMS remains strongly committed to evidence-based policymaking and patient safety and welcomes ongoing dialogue. We are eager to participate in constructive, data-supported discussions about how best to promote patient safety while ensuring equitable access to essential OMS surgical care. We respectfully request that any future policy recommendations incorporate robust clinical evidence, accurate characterization of provider training and careful analysis of both intended and unintended consequences.

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[3] Total sedations reported using CDT® codes D9222 and D9239 as reported to FAIR Health 2018-24. Calculations are based on dental claims data compiled and maintained by FAIR Health, Inc. AAOMS is solely responsible for the research and conclusions reflected in this document. FAIR Health is not responsible for the conduct of the research or any of the opinions expressed in this document. CDT is a registered trademark of the American Dental Association.

[4] Total sedations reported using CDT® codes D9222 and D9239 as reported to national administrators. CDT is a registered trademark of the American Dental Association.

Thank you for your consideration of these concerns and for your continued dedication to improving the quality of care for Medicaid beneficiaries. We look forward to the opportunity to collaborate in strengthening patient safety and maintain access to care for our patients, in ways that are both scientifically sound and operationally practical for the communities we all serve. To continue this conversation, I invite you to contact Karin K. Wittich, Executive Director of AAOMS, at 800-822-6637 or karinw@aaoms.org.

Sincerely,

Robert S. Clark, DMD
President