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National Association  
of Dental Plans

December 17, 2020

The Honorable Seema Verma  
Administrator  
Center for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC)

Dear Administrator Verma,

The National Association of Dental Plans offers the following comments on the interim final rule “Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” published in the Federal Register on November 6, 2020. The IFR ends the maintenance of effort (MOE) requirements on supplemental benefits for state Medicaid programs receiving increased Federal Medical Assistance Percentages (FMAP) dollars through the Families First Coronavirus Response Act (FFCRA). This would allow states to cut Medicaid adult oral health benefits during the public health emergency and still receive the enhanced FMAP. NADP is concerned that this policy reversal will jeopardize the oral health of Medicaid recipients and incentivize states to cut dental benefits while still receiving the enhanced FMAP.

- **Recommendation:** NADP strongly urges CMS to strike the language of §433.400 and revert to previous guidance issued on April 13, 2020, preserving Medicaid benefits for the duration of the public health emergency for states to receive the enhanced FMAP. The loss of adult dental coverage for Medicaid recipients will increase hospitalizations for oral health conditions and damage public health at a time when preserving hospital capacity and health resources is critical.

**Background**

The Families First Coronavirus Response Act, signed into law by President Trump on March 16, 2020 provides a 6.2% increase in the FMAP, giving states a needed boost in funding for Medicaid programs early in the pandemic. In April 2020, Medicaid enrollment nationwide had increased 2.8%, with individual state increases reaching

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6.5%. As a result, this initial FMAP bump was critical in sustaining the fiscal health of state Medicaid programs, particularly as Medicaid enrollment and unemployment continued to rise.<sup>1</sup>

On April 13, CMS released guidance to states on determining eligibility for the FMAP increase, clarifying the Agency's reading of the FFCRA.<sup>2</sup> The guidance stated that alongside requirements to preserve enrollment, states must also ensure that benefits for enrollees are not cut:

“Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP.”<sup>3</sup>

This language prevented cuts to dental benefits in several states including California, Colorado, and Ohio which anticipated cuts to benefits but preserved them as a result of the CMS guidance.<sup>4</sup> Without the April guidance, over 9 million Americans in those states could have lost dental coverage.<sup>5</sup>

### Interim Final Rule

The IFR reverses CMS' policy from April 13 and undermines adult dental benefits in Medicaid programs, naming dental as an example of benefits that are eligible to be removed under the new “enrollment interpretation” method. CMS now reinterprets the FFCRA to focus requirements on only maintaining coverage for all validly enrolled individuals for minimum essential coverage (MEC), a definition of benefits that does not include adult dental benefits.<sup>6</sup>

The preamble of the rule directs the attention of readers to the possibility that the IFR would allow states to eliminate adult dental benefits and notes the potential negative impact on dental care providers:

“While the enrollment interpretation of section 6008(b)(3) of the FFCRA may be the preferred option for states, we recognize that it could negatively impact certain provider types. Under the enrollment interpretation, states could eliminate optional benefits. For example, a state could cut its optional dental benefit, and dentists in that state would lose Medicaid reimbursement.” (p.80)

“As described at § 433.400(c)(3), states may generally make changes to benefits offered under the state plan (as allowed under relevant provisions of the Act) or a section 1115

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<sup>1</sup> Corallo B, Rudowitz R. (2020, November 5). Analysis of Recent National Trends in Medicaid and CHIP Enrollment. *KFF*.

<https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>

<sup>2</sup> FFCRA § 6008(b)(3)

<sup>3</sup> CMS. (2020, March 26; Updated 2020, April 13). Families First Coronavirus Response Act - Increased FMAP FAQs. *Center for Medicare and Medicaid Services*. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

<sup>4</sup> Park E. (2020, May 7). State Budget Cuts to Medicaid Means Reduced Federal Funding, Larger Total Cuts. *Georgetown Center for Children and Families*. <https://ccf.georgetown.edu/2020/05/07/state-budget-cuts-to-medicaid-means-reduced-federal-funding-larger-total-cuts/>

<sup>5</sup> CMS. (2020). July 2020 Medicaid & CHIP Enrollment Data Highlights. *Center for Medicare and Medicaid Services*.

<https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

<sup>6</sup> As defined in 26 U.S. Code § 5000A and implementing regulations at 26 CFR § 1.5000A-2



demonstration. For example, section 6008(b)(3) of the FFCRA does not prohibit a state from eliminating an optional benefit from its state plan. Therefore, a state could eliminate dental services for individuals age 21 and above, and still comply with section 6008(b)(3) of the FFCRA.” (p.93)

NADP is deeply concerned that the IRF preamble explicitly invites states to cut adult dental benefits in Medicaid programs. In addition to bringing harm the enrollees who rely on Medicaid dental benefits, the IFR harms dental providers who accept Medicaid by reducing their patient population.

### **Public Health and Fiscal Impact**

The impact of the loss of dental benefits for Medicaid enrollees is well documented. When facing budget shortfalls, states have turned to adult dental benefits, and oral health suffers as a result. When Oregon cut its budget in March 2003, eliminating its comprehensive adult dental benefit in Medicaid, the state saw an 101.7% increase in dental related ER utilization, and a 98.8% increase in the cost of those visits.<sup>7</sup> Other states have experienced similar outcomes, including the untimely death of a Michigan woman from an untreated oral infection after she lost her Medicaid dental benefits in 2009 as the result of budget cuts.<sup>8</sup>

When an individual loses dental coverage, the effects on oral health can escalate after only a few months as caries and periodontal issues progress or pain manifests, sending patients to the ER for treatment. Any short-term savings from insufficient funding for preventive services in the dental office setting will quickly be outweighed by higher cost procedures performed in an emergency room after disease has developed. At a time when hospital capacity is being tested by the COVID-19 pandemic, it is critical that non-emergency patients be kept out of emergency departments through preventive care and regular treatment at a dental office. A combination of surging COVID-19 admissions and oral health emergencies is a recipe for severe strain on public health resources.

Oral health is key to overall health. Even for patients with less critical oral health conditions, the loss of dental coverage can increase health costs. Since publication of the 2000 Surgeon General’s Report on Oral Health, a growing body of research shows that access to dental treatment improves overall health and decreases the cost of medical care particularly for adults with periodontal disease. An analysis of Medical Expenditure Panel Survey (MEPS) found that when a preventive dental benefit was provided for adult Medicaid recipients in 2014, medical costs for patients with seven chronic conditions were lowered by a range of 31 to 67 percent.<sup>9</sup> Studies of commercial claims data yield similar findings.<sup>10</sup>

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<sup>7</sup> Wallace N, et al. (2011). The Individual and Program Impacts of Eliminating Medicaid Dental Benefits in the Oregon Health Plan. *American Journal of Public Health*, 101(11), 2144–2150. <https://doi.org/10.2105/AJPH.2010.300031>

<sup>8</sup> Connecticut Appropriations Committee. (2010). Testimony of Lisa Reynolds, Connecticut Oral Health Initiative. *CT.gov*. <https://www.cga.ct.gov/2010/appdata/chr/2010APP00311-R001507-CHR.htm>.

<sup>9</sup> <https://www.nadp.org/PressReleases/PressReleasesArchive/2017/11/23/nadp-analysis-shows-adults-with-medicaid-preventive-dental-benefits-have-lower-medical-costs-for-chronic-conditions>

<sup>10</sup> <https://www.whydental.org/about/oralhealth>

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If CMS does not return to its April guidance on MOE, NADP and its members fear there will be an extended period of lost oral health progress as states move to cut adult dental benefits and maintain enhanced FMAP dollars. Even if Congress does pass additional aid to local and state governments in a stimulus package, the IFR would allow states to cut benefits and retain higher rates of federal reimbursement.

When Medicaid oral health benefits are cut, they often take years to return. In Oregon, adult dental benefits took 10 years to be reinstated, and in California benefits cut in 2009 were not fully recovered until 2018. During that time, adults in Medicaid continued to utilize the ER for oral health issues and had worse oral health than when dental benefits were covered. Particularly, people of color and seniors saw the sharpest decline in oral health indicators.<sup>11</sup>

### Conclusion

The dental benefits industry is dedicated to ensuring that dental coverage is preserved for needy Americans and extended to those who do not have coverage. NADP strongly urges CMS to reconsider the language in the IFR and return to the MOE requirements of the April guidance. We appreciate the opportunity to comment on the interim final rule. Questions regarding our comments should be directed to Owen Urech, Government Relations Analyst at [ourech@nadp.org](mailto:ourech@nadp.org) or 972-458-6998 x108. Again, thank you for your consideration.

Sincerely,



Eme Augustini  
Executive Director

### NADP Description:

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental Indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

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<sup>11</sup> Singhal A, et al. (2020). Eliminating Medicaid Adult Dental Coverage in California Led to Increased Dental Emergency Visits and Associated Costs. *Health Affairs*, 34(5).

