IDA
Iowa Dental Association

666 Grand Ave, Ste 901
Des Moines, IA 50309
(515) 331-2298
info@iowadental.org

Dear Iowa Medicaid Enterprise:

The Iowa Dental Association and the Iowa Academy of Pediatric Dentistry, a state chapter of the American Academy of Pediatric Dentistry (AAPD), are writing to request you to take advantage of several flexible initiatives permitted by the Centers for Medicare and Medicaid Services (CMS) that can greatly strengthen oral health care for Iowans in Medicaid by supporting a strong provider network. We also urge clarification related to a critical issue in terms of the EPSDT dental periodicity schedule.

The COVID-19 pandemic has posed unique challenges for oral health care; two of the most significant challenges are: (1) a period of several months when dental services were limited to only emergency/urgent cases and (2) dental providers needed additional personal protective equipment (PPE) per recommendations from the Iowa Dental Board, CDC, OSHA, American Dental Association, and AAPD. Restricting dental practice to emergency/urgent cases was necessary in order to slow community spread, preserve medical supplies, and alleviate emergency departments as much as possible from the burden of caring for dental emergencies, rather than patients with COVID-19. Further, OSHA classified dental health care personnel in the very high exposure risk category. The need for additional PPE has been complicated by severe shortages in obtaining PPE, especially N-95 respirator masks for dental offices.

As Iowa allows dental practices to re-emerge and provide elective care beyond just emergency/urgent cases, we expect dentists who participate in children's Medicaid, Hawki, and the Dental Wellness Plan to face a significant backlog of medically necessary care. Therefore, it is critical for IME to act quickly to support oral health and the Medicaid dental provider network. Dentists are the backbone of the Medicaid dental program in Iowa.

The Association appreciates that IME has already taken steps to permit the use of teledentistry for Iowa Medicaid fee-for service members, Dental Wellness Plan members, and Hawki members. While the use of teledentistry is helpful in certain situations to *diagnose* dental problems, it does not provide an effective means to deliver dental *treatment*. The provision of dental treatment requires dental professionals to provide this care in person, which in turn requires dental offices to implement social distancing and to utilize significant additional PPE. Therefore, our specific requests, as supported by the CMS May 5, 2020 update to its document *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*[1], are:

- **We urge IME to submit an expedited SPA to CMS to provide for interim payment to dentists.** (*FAQ* Question IV. B. 1, p. 40)

[1] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

- **We urge IME to utilize the flexibility to temporarily increase payment rates for dentists.** (*FAQ* Question IV. B. 2, p. 40)

- **We urge IME to utilize the flexibility to increase payments for dentists during the emergency period.** (*FAQ* Question IV. D. 1, p. 42)

- **We urge IME to utilize the flexibility to provide a payment adjustment to dentists to account for increased PPE costs. IME should also consider utilizing its emergency funds to purchase and provide an immediate supply of N95 respirator masks for dentists who participate in Medicaid.** (*FAQ* Question IV. D. 2, pp. 42-43)

- **We urge IME to clarify that two or more exams may be provided from now until the end of 2020, depending on the needs of each patient.** Under Medicaid ESPDT law, IME must adopt a dental periodicity schedule. Due to the backlog of medically necessary oral health care that dentists will be treating, it should be recognized that the "every 6 month" standard includes language to allow flexibility based on a patient's need. In current circumstances this should be interpreted as allowing more than one exam/visit within a 6 month period. [2]

The complete CMS information referenced in this letter is included in the Attachment.
If you have any questions concerning this letter, please contact Laurie Traetow at laurie@iowadental.org or Dr. Matt Geneser at matt-geneser@uiowa.edu.

Sincerely yours,

Nathan Hehr, D.D.S.,
President, Iowa Dental Association

Michael Stufflebeam, D.D.S.,
President, Iowa Academy of Pediatric Dentistry

[2] https://www.aapd.org/globalassets/media/policies_guidelines/bp_recdentperiodschedule.pdf. "First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease."

ATTACHMENT

We draw your attention to the following FAQs from the CMS May 5, 2020 update to the document COVID-19 *Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies,* with emphasis added in **bold:**

Question IV. B. 1 (p. 40)-

B. Advance and Retainer Payments

1. During the public health emergency period, can states receive federal funding to provide advanced payments to providers as an interim payment and reconcile the advanced payments with actual processed claims at a later point?

Under state plan authority, states can submit a SPA to add an interim payment methodology that says, under certain specified conditions, states will make periodic interim payments to the providers. The interim payment methodology must describe how states will compute interim payment amounts for providers (e.g., based on the provider's prior claims payment experience), and subsequently reconcile the interim payments with final payments for which providers are eligible based on billed claims. The interim payment methodology would not be a prepayment prior to services being furnished, but rather would represent interim payments for services furnished that are subject to final reconciliation. **CMS will consider such SPAs on an expedited basis** and additional flexibilities with respect to the SPA submission and approval process may be available pursuant to emergency authorities under section 1135 of the Act. States should contact their designated reimbursement contact for technical assistance with the SPA submission process.

Question IV. B. 2 (p. 40)-

2. Is there flexibility to request/implement temporary rate increases or retainer payments in a 1915(i) SPA similar to those found in Appendix K for 1915(c) HCBS waivers?

States may increase Medicaid payment rates to offset losses to providers during the COVID-19 pandemic, if consistent with all applicable requirements, including section 1902(a)(30)(A) of the Act. FFP is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries. However, on March 22, 2020, CMS released a template that states may use to request a section 1115 demonstration to combat the COVID-19 public health emergency, which allows states to request authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency consistent with the limitations set forth in Appendix K. The template may be downloaded at this link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-applicationprocess/index.html.

Question IV. D. 1 (p. 42)-

D. Payment Rates and Methodologies

1. In what ways might states use the Medicaid disaster relief SPA template to increase payments to providers during the PHE?

States can use the Medicaid disaster relief SPA template to increase payments to providers during the emergency period. This includes, but is not limited to: increasing payments to providers that are seeing an influx in Medicaid patients as a result of the PHE; recognizing additional costs incurred through the provision of Medicaid services to COVID-19 patients; increasing payments to recognize additional cost incurred in delivering Medicaid services, including additional staff costs and/or personal protective equipment; adjusting payments to providers to account for decreases in service utilization but an increase in cost per unit due to allocation of fixed costs or an increase in patient acuity as a result of the PHE; or increasing payments for Medicaid services delivered via telehealth to ensure that Medicaid services are delivered in a safe and economical manner. The payment increases can take the form of dollar or percentage increases to base payment rates or fee schedule amounts, rate add-ons, or supplemental payments, depending on the applicability to the state's payment methodology for the provider and service categories. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act. SPA approvals and other COVID-19 related waiver documents may be found here: https://www.medicaid.gov/resources-forstates/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html.

Question IV. D. 2 (pp. 42-43)-

During the public health emergency, some providers are experiencing significant cost increases. Without knowing how much costs will increase right now, how should states approach making adjustments to Medicaid payment rates and methodologies to ensure that Medicaid costs are paid during the public health emergency period?

States have flexibility to make reasonable adjustments to Medicaid payments to better align Medicaid payments with the increased cost of providing services to Medicaid beneficiaries during the PHE under the Medicaid state plan through base and supplemental payments. **Such adjustments could include, but are not limited to, an increase resource utilization to account for the need for more personal protective equipment or other increased safety measures, but we would consider state's justification for increases in payment rates during the PHE.** We recognize the uncertainty and challenges states and providers are facing and will work with them on their proposals to increase Medicaid payments to help assure Medicaid patients have access to services. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act.