July 27, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Sent via: www.regulations.gov

RE: CMS-2390-P and Medicaid and Children's Health Insurance Program (CHIP) Programs

Dear Mr. Slavitt:

NADP appreciates the opportunity to provide comments on the proposed rule CMS-2390-P regarding "Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability," published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register on June 1, 2015. The rule would revise existing standards for states and the delivery of Medicaid via managed care and also extends various requirements to Prepaid Ambulatory Health Plans (PAHPs).

In providing managed dental care in Medicaid, states may contract with Managed Care Organizations (MCOs), prepaid health plans, or PAHPs to deliver dental benefits. PAHPS may also be considered a capitated "carve out" from the global managed care arrangement.

Generally, the rule seeks to align Medicaid managed care provisions with Medicare Advantage (MA), Health Insurance Marketplace guidance or broad-market regulations; however, in several cases, the various regulations are not commonly applied to dental benefits. Our letter addresses these instances with specific background for your consideration along with the following general recommendations:

- **Recommendation**: Conduct a thorough review of state, MA, and Affordable Care Act (ACA) implementation of related regulatory topics specific to dental benefits and the impact the proposals could have on the delivery of dental benefits through Medicaid managed care. If the findings conclude that standards do not align or are not appropriate for dental, CMS should consider exempting dental PAHPs from the proposed rule.

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- **Recommendation**: Allow states flexibility to design and implement standards for their unique populations and programs that are appropriate and feasible for managed dental care.

NADP is concerned with the specificity of the rule, which sweeps in dental without consideration of the impact on a state's managed dental care policies. Specifically, NADP is most alarmed with the guidance on medical loss ratios, network adequacy, and quality standards.

Medical Loss Ratio

Beginning in 2017, CMS proposes rates for managed care plans, including PAHPs, must be set such that using the projected revenues and costs for the rate year, the plan would achieve an MLR of at least 85 percent. The standard would apply in all states at the proposed 85 percent level, which CMS believes "is the appropriate minimum threshold and is the industry standard for MA and large employers in the private health insurance market."

Specifically for dental benefits, an MLR is not applied in the private market or on Health Insurance Marketplaces through the ACA. This is largely due to the acknowledgment that dental premiums are 1/12th of medical premiums while dental plans and medical issuers perform the same basic administrative functions with similar structures (e.g. claim payment, customer service, network development, etc.). Dental carriers have fewer premium dollars to support similar administrative functions, which are critically important. For these reasons, loss ratio standards have not applied to dental insurance. The NAIC has recognized the impact of these fixed costs and suggests that lower loss ratios could be appropriate in some situations such as for limited benefit plans or lower premium products.[i]

A limited number of states have applied loss ratio standards to dental benefits in Medicaid, but at much lower levels than proposed. Managed dental care plans receive lower capitation rates per enrollee relative to health plans and have similar fixed costs and per enrollee costs and thus increased administrative expenses as a percentage of capitation received.

Medicaid managed care programs serve low income populations that require different levels of engagement and support than commercial markets, and states have addressed these needs with varied programs and levels of administration required of participating plans. Limiting administrative programs by utilizing an MLR jeopardizes critical social services supporting managed care such as care coordination, outreach programs, call campaigns, member/provider participation studies and education programs for parents and families developed by states. For example in California the managed dental plans have very specific requirements and metrics to meet that include onsite visits with all Medicaid dental providers, call campaigns to members and preventive service requirements. The administrative costs are potentially much higher than other state requirements and as such, the state has set a 70 percent minimum loss ratio.

Given the variation of Medicaid managed care populations and state approaches to administering their unique programs, NADP urges that a single nationwide loss ratio standard for dental is not appropriate.

- **Recommendation**: Allow states to set appropriate loss ratio levels, including lower levels for limited scope benefits, in consideration of their own program enrollees and administrative requirements.

Network Adequacy

The proposed rule requires states to establish time and distance standards for specified provider types, including: primary care (adult and pediatric), OB/GYN, behavioral health, specialists (adult and pediatric), hospitals, pharmacy, pediatric dental, and additional provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. CMS requests comments on whether a different type of standard, such as provider-to-patient ratios, should be used.

It's important to consider that the mix of providers delivering dental services is different from the providers delivering medical care. While medical care is delivered by a mix of primary care and specialty physicians, approximately 85 percent of dental care is provided by general dentists in an office setting, usually by a solo practitioner. Further, while specialists outnumber generalists in the medical context, the opposite is true in dentistry, as most dentists are generalists. General dentists are well-trained in the breadth of dental procedures commonly utilized for children. Nationwide, over 80 percent of dentists are general dentists in contrast to about 12.3 percent of physicians who focus on primary care. The American Dental Association recognizes nine dental specialties including pediatric dentists while the American Medical Association recognizes 36 medical specialties and 88 subspecialties.

While there is no single accepted network adequacy standard within an NAIC Model, statue or the dental benefits industry, states have established dental network standards for public programs due to concerns with more vulnerable populations and weaker access points potentially exacerbated by a low participation rate of dentists. States take a variety of approaches to measure adequacy based on their geography and provider availability including time/distance standards and provider-to-enrollee measures.

Dental provider availability and participation also vary by state as demonstrated by Dental Care Health Professional Shortage Areas (HPSAs) and can be impacted by the use of auxiliary personnel for delivery of certain services.

Minnesota has enacted a program to introduce and license a new mid-level dental professional or "dental therapists," who are authorized to perform a limited number of basic preventive and restorative dental procedures as part of the dental team. The law restricts their practice to settings serving primarily low income, uninsured, and underserved patients or in HPSAs. Under its Community Health Aide Program, Alaska implemented a similar program that allows new dental provider types or dental health aides to perform routine dental services under the supervision of a Tribal Health Organizations (THO) dentist. California law allows dental hygienists to perform certain procedures under remote dentist supervision, although it requires the hygienist to refer a patient to a dentist if more sophisticated procedures are needed.

- **Recommendation**: Allow states flexibility to determine appropriate standards and measurements for network adequacy given the geographic and provider availability they experience.

Quality Standards and Accreditation

In the rule, CMS outlines several approaches to assessing quality including accreditation and rating systems. Within the rules, states could meet the proposed accreditation requirement by either establishing their own review and approval process if it is at least as stringent as that used by a private accreditation entity or use evidence that an MCO or PAHP has obtained accreditation by one of the CMS-recognized private accrediting entities.

Generally, accreditation standards were developed for medical coverage and not available to dental carriers offering separate dental policies. Currently, no CMS-designated accreditation company has standards that are designed specifically for dental plans. CMS Marketplace standards specify that to the extent that accreditation standards specific to dental plans do not exist, then such plans would not be required to meet the accreditation timeline outlined in the ACA. Thus, dental-only issuers or medical issuers offering standalone plans have not been required to accredit those offerings on the Exchanges.

- **Recommendation**: Accreditation standards should not be applied to dental PAHPs until such time when all industry stakeholders develop and implement standards that are appropriate for the delivery of dental care.

In the proposed rule, states will also be required to establish a quality rating system (QRS) for Medicaid managed care plans that is based on three components: (1) clinical quality management, (2) member experience, (3) plan efficiency, affordability and management.

Existing development of quality evaluation programs and measurement is important to consider. States take a variety of approaches to monitor the delivery of managed dental health care services including quality improvement programs, written quality improvement plans, reporting of specific pediatric oral health performance measures and encouraging the use of reimbursement for caries prevention activities. However, states do not generally extend accreditation or QRS standards to managed dental contract or services. Additionally, stand-alone dental plans are not included in QRS and QHP Enrollee Survey requirements.

If the rule were to propose specific dental standards, they should refer to the Dental Quality Alliance (DQA) formed in 2008 at the request of CMS. NADP was part of the initial group of invited industry leaders and interested parties brought together to develop the structure and process that has become the DQA. The DQA is the only organization focused on dental quality improvement and measures, and while carriers may implement various risk assessment tools, the DQA remains the primary source for development of dental quality measures.

The DQA has identified, developed and conducted validity and reliability assessments of several performance measures. As per the initial charge from CMS to the DQA, the initial measures in development were pediatric focused. Recently, five DQA measures have been endorsed by the National

Quality Forum (NQF) after pediatric oral health performance measures were tested using administrative data from Florida and Texas Medicaid and CHIP programs. The five NQF-endorsed measures evaluate dental service utilization, oral evaluations, topical fluoride intensity and sealant use in children at elevated caries risk.

Most recently, CMS included the DQA measure of dental sealants for 6-9 year old children at elevated caries risk in its 2015 Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Child Core Set).

- **Recommendation**: Allow states to continue implementation of dental-specific quality improvement programs, contractors that administer these programs and validated enrollee survey tools for PAHPs until such time as appropriate accreditation, quality ratings systems and dental-specific survey tools are developed with all dental industry stakeholders. Further, CMS should utilize the Dental Quality Alliance as the standard for future quality measures in the dental industry.

NADP is appreciative for the opportunity to provide comments and is happy to provide further information. For any follow up or questions, please contact NADP's Director of Government Relations, Kris Hathaway at khathaway@nadp.org or (972) 458-6998x111.

Sincerely,

Evelyn F. Ireland, CAE
Executive Director
National Association of Dental Plans

NADP DESCRIPTION

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to more than 92 percent of the 191 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.

[i] National Association of Insurance Commissioners. Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation Service. July 2000.