



October 25, 2012

Ms. Danielle Holahan  
Project Director, Health Benefit Exchange Planning  
New York State  
Submitted via web form and email

**Re: Reducing Dental Health Disparities**

Dear Ms. Holahan,

In response to the recent New York Health Benefit Exchange panel discussion and request for comments on how the Exchange may be utilized to reduce health disparities, the National Association of Dental Plans (NADP) is writing to provide information on practices that are currently utilized to ensure that hard to reach and vulnerable populations have access to dental care. Included below find our known practices and recommendations on the three topics raised for feedback: consumer service functions, community providers and network adequacy, and data collection.

**Consumer Service Functions**

*NY Question: The insurance exchange will have a number of consumer assistance features that will enable consumers to choose a health plan that works for them. These features include a call center/hotline, website portal, and navigators and other consumer assistors. To ensure that hard to reach and vulnerable populations know about, feel comfortable with, and can access these services, what are examples of consumer service functions that have been successful in other settings? What made them successful?*

While there are a variety of outreach strategies to reach the vulnerable oral health population, one member's successful approach in increasing access to dental care in the Medicaid population used a two-pronged method of expanding dental networks and conducting outreach campaigns.

Many providers initially express hesitation about joining a Medicaid network. By eliminating the administrative red tape often accompanying government-sponsored programs, the company makes it easy for dentists to participate in their Medicaid network. Utilizing advanced technology and responsive customer service supports an efficient business model.

The goals of their outreach campaigns are to educate members on the importance of oral health and encourage them to visit the dentist. Outreach plans are customized based on factors such as the number of providers in the network, network composition, provider distribution in the state, cultural differences, cultural differences, receptiveness of grassroots and community-based

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organizations, and budgetary restrictions. Outreach materials are written in layman's terms and at a sixth grade reading level.

The success of an outreach plan is maximized by collaborating with the state client as understanding their goals assists in selecting the best outreach options. Outreach initiatives offered include attending health fairs, partnering with community organizations, sending annual reminder notices, sending postcards to members who have not had a dental visit in a given timeframe, conducting appointment assistance or reminder calls, providing articles to states for their member newsletters, partnering with health departments and community organizations to conduct dental screenings, sending member brochures explaining the periodicity schedule, distributing referral notepads to physicians and community organizations, and working with states to establish a dental home program.

Other approaches to consumer service to the Medicaid population include offering enrollees the support they need to make and keep dental appointments, including enhancing transportation assistance or providing case management services to help patients navigate the system (Pew Children's Dental State Report 2011).

Another model is being tested in California, Oklahoma and Pennsylvania where a Community Dental Health Coordinator (CDHC) provides preventive care and education to families and assists people in finding a dentist (Pew Children's Dental State Report 2011).

### **Community Providers & Network Adequacy**

*NY Question: The Exchange will review network adequacy, including the availability of Essential Community Providers, of insurance plans. What are some of the best practices to ensure that hard to reach and vulnerable populations have access to health services such as primary care, vision and dental care?*

There are areas of the country that have been designated as dentally underserved just as there are those that are medically underserved. Lack of access to dental care can result from a maldistribution of dentists and limited numbers of dentists who work within public programs. Medicaid reimbursement rates need to keep up with the growth in dentists' fees to encourage dentists to participate in public programs and treat more low-income children.

Not all essential community providers include dentists, so targets for their inclusion in dental networks should be flexible. Employers who hire minimum wage employees sometimes request their dental carrier contract with providers who work in community health centers, or provide similar services for a low income population. Carriers will contract with these providers and centers if allowed and if they meet a carrier's credentialing standards.

There is no single accepted network adequacy standard within the NAIC Model, state statute, or the commercial market. While large employers typically specify network requirements for their dental benefit programs, these are highly specific to the employer and geographic area of operation. Fewer than a dozen states have network standards applicable to dental and those are generally requirements carriers establish their own targets rather than state specified targets. Often these requirements apply only for dental HMOs.

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States have implemented standards for public programs, but they also vary widely with no discernible pattern for the differences other than cost factors and localized preferences.

### Data Collection

*NY Question: Data collection is an important tool for documenting health disparities on a population level. What are best practices on data collection (at the insurance plan level) to reduce disparities? What kinds of data should be collected, from whom should it be collected, and how should it be reported? Are there best practices on translating data into practice? If consumers are sensitive to providing personal data, how can this be addressed?*

True quality measures do not exist in dental care although utilization measures, such as office visits and percentage of population receiving sealants are collected in public programs. Office visits for segments of the population are also collected periodically by HHS's Agency for Healthcare Research and Quality (AHRQ) through the Medical Expenditure Panel survey (MEPS). HHS has initiated the Dental Quality Alliance (DQA), which includes a broad range of stakeholders. They are tasked to review and develop quality measures for oral health care. The DQA has just awarded a grant to test the viability of its initial measures. While these measures are not yet in use, NADP would recommend connecting to this organization for future data collection of quality and clinical performance measures.

NADP greatly appreciates the opportunity to provide these comments, and looks forward to answering any questions the state of New York may have in the future on dental inclusion within your state Exchange. While there is information on our website at [www.nadp.org](http://www.nadp.org), please contact myself or NADP's State Exchange Manager, Valentina Doyon ([vdoyon@nadp.org](mailto:vdoyon@nadp.org), 972.458.6998x103) at your convenience. Again, thank you for your time.

Sincerely,



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**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 over 90 percent of the 176 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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